The Malpractice Risk of Poor Patient Hand-offs at Your Practice

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Some call it the black hole, some the missing link, some just an oversight. Whatever the term, when physicians handoff patients, there are opportunities for gaps in coverage, improper or inaccurate transmission of critical patient data, or simply information lost that could have serious repercussions and potentially lead to malpractice claims.

In fact, in many respects, the patient hand-off process can be like the childhood game of telephone. With each conversation there are opportunities for missed or lost critical patient information.

One study reported by *American Medical News* estimated that botched hand-offs play a role in 80 percent of serious preventable adverse effects and that a staggering 70 percent of handoffs in hospitals participating in a recent research study were defective.

While troubling, the fact there are mistakes or oversights made is also not surprising. Each day thousands of hand-offs are made at hospitals and medical offices nationwide.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines a “hand-off” as "a contemporaneous, interactive process of passing patient-specific information from one caregiver to another for the purpose of ensuring the continuity and safety of patient care."

In the real world, the process is often not near as formal or systematic. Among colleagues who work together frequently, or physicians who are overwhelmed with other tasks, the process can often be nothing more than a hurried passing of a chart or a cursory phone call.

Indeed, the daily examples of poor hand-offs are numerous and troubling. It could be a hospitalist who simply forgot to highlight important information about a spike in a patients’ blood pressure or change in medication during a hospital stay to a primary-care physician. It could be a surgeon who neglected to provide information to a nurse, or any one of thousands of other scenarios.

Taken together, poor patient hand-offs account for millions of dollars in claims, lost reputations and of course most importantly, poor patient care and outcomes. Researchers in *Health Affairs* report that, "inadequate care coordination, including inadequate management of care transitions, was responsible for $25 billion to $45 billion in wasteful spending in 2011 through avoidable complications and unnecessary hospital readmissions."

We are always looking for ways to help physicians minimize risk. As healthcare becomes more complex, and more caregivers are involved in the system, I try to encourage medical-

professional liability specialists and the physicians they work with to pay special attention to the hand-off process. There are several steps I know from reviewing claims and speaking to physicians can make a big difference. These include:

• Confirm all critical patient information in writing. Studies have shown there are more errors when verbal communication alone is used.

• Try to hand off patients to other physicians face-to-face so questions can be answered and there is less of a chance of a misunderstanding. If not possible (and we know it can be difficult) at least make a personal phone call.

• Involve the patients' family and caregivers when you can. Make sure they know when a new physician is on board and what he/she will be doing as well as who to call if they have questions. Provide them with a written plan of treatment when possible so they know what to expect.

• We've seen a lot of claims generate from poor communication with family members and I can't stress enough the importance of making sure they are aware of the situation and what is happening.

Some physicians also follow "the 5 Ps" – a process developed by a health system in Virginia to help ensure better handoff. This process includes:

1. **Patient:** Name, identifiers, age, sex, location

2. **Plan:** Patient diagnosis, treatment plan, next steps

3. **Purpose**: Provide a rationale for the care plan

4. **Problems**: Explain what's different or unusual about this specific patient

5. **Precautions**: Explain what's expected to be different or unusual about the patient.

There are also many sources of information and guidance on the topic of handoffs. I encourage physicians to use guidance from others. But most importantly to work with your staff and colleagues to come up with a plan that works for you. Then write it down and stick to it. The result will be fewer errors, less hassle for you, better outcomes, and more satisfied patients.