Improving in-hospital handoffs

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Here's some bad news for Internal Medicine Meeting presenters: Speakers systematically overestimate how well they're understood by listeners, said Vineet Arora, MD, FACP, MAPP. What's more, she said speakers tend to assume that listeners have all the same knowledge that they do.

Of course, it doesn't take a podium for someone to be a speaker. And in the hospital, any physicians who hand off patients may want to consider how well their messages are being understood, especially because patient safety is at stake, said Dr. Arora.

One study of pediatric handoffs, which are supervised in a dedicated room with protected time, asked senders and receivers which piece of information was most important for each patient. About 60% of the time, the most important piece of information was not communicated, despite the sender believing it had been, noted Dr. Arora, a hospitalist and associate chief medical officer at the University of Chicago Medicine.

“In this day and age, attention spans are so short, so how do you really pass off well?” she said. “It's about breaking through the babble and really getting that most important piece of information there.” On Thursday, Dr. Arora explained how to improve written and verbal communication during her talk, “Handoffs: Improving Patient Care Transitions within the Hospital.”

To prepare a good written signout, remember the acronym UPDATED, which Dr. Arora and colleagues developed as a rubric.

Updated daily progress. Include today's events in signout, rather than presenting patients as they appeared on admission. "A lot of times, it's not updated, it's not fresh," she said. "Just focus on today's events."

Problem list prioritized in order of importance. Many times, a signout will communicate that the patient was admitted for, say, deep venous thrombosis and taking heparin, despite the fact that the patient developed a gastrointestinal (GI) bleed on day five of hospitalization, noted Dr. Arora. "Then the GI bleed is problem No. 10 behind nutrition and IV fluids and [venous thromboembolism] prophylaxis," she said. "What you want to do is shuffle your problem list because remember, that most important piece of information has to go to the top."

Diagnosis in one-liner. For example, a patient may have been admitted with shortness of breath, but pneumonia would be the more appropriate diagnosis on signout. "By day three, somebody knows why this patient had shortness of breath, or at least presumed," said Dr. Arora.

Anticipatory guidance. Rather than "CIS and start abx" (culture if spikes and start antibiotics), consider more specific guidance, like "If patient has continued fever, start vancomycin," so the incoming physician doesn't have to guess which antibiotics to start, she said.

Too much information. Aim for three patients per page rather than one patient per page. CoPaGA (copy/paste gone amok) is a major offender here, Dr. Arora said. "Remember that 60% of [the time], the most important item is not communicated. Why is that?" she said. "Because people are fixating on other things."

Error-prone medications highlighted. Instead of a laundry list of medications without priority, make a point to check and highlight anticoagulants, antibiotics, narcotics, and insulin in particular, said Dr. Arora. "Those are the

four medications that cause the most problems in signouts and for our older patients [because] they're always changing." 1 Item added

Directions clear with rationale. "Keep in mind that you're kind of giving people a to-do list," so advising to check labs is not specific enough, she said. "Don't waste your other clinicians' time."

Verbal signouts tend to be more of a one-way dump of information than a dialogue, and it's hard to know if a receiver is really listening, Dr. Arora said.

In studies of hospitalist handoffs, passive listening behaviors are the norm: head nodding, eye contact, and affirmatory statements, she said. "A lot of 'Uh-huh, uh-huh, uh-huh,'" Dr. Arora said. "That is called back-channeling, and any geriatrician will tell you that demented patients are capable of back-channeling."

Clearly, these actions are not a good display of understanding. A better approach is using active listening behaviors, "which we don't see a lot of," such as note-taking, readback, and asking questions, she said. At the same time, there is a tension between too little information and too much. "I want to say this to all the hospitalists: I'm not here to tell you to read back everything. Nobody can remember that," said Dr. Arora. "You just read back the high-priority items."

In addition, not every patient needs a verbal handoff. "You could actually increase the capacity of the receiver to remember what you're saying through a philosophy called chunking," she said. Spend extra time on the sickest patients, with a good one-liner, to-do item, and if/then statement, and chunk the rest.

“You can say, ‘The rest of the patients, there's just a to-do item, I expect no problem, they are OK,’” said Dr. Arora. “That is more useful than, say, ‘Let's run through Mrs. Smith's problems. OK, nothing to do and she'll be fine.’ Just move forward.”

One final key for a good signout is minimizing interruptions, especially side conversations. She noted a concept in aviation called the sterile cockpit rule, in which conversations in the cockpit during the critical parts of takeoff and landing must only pertain to the plane.

“Why do they do this? Because in black-box recordings of crashes, they saw side conversations were impacting and derailing the takeoff and landing,” said Dr. Arora. “Now, that's what aviation does, and we need to think about a similar philosophy.”