CLARITY PSO
A Patient Safety Organization

Clarity PSO, a Division of Clarity Group, Inc.
8725 West Higgins Road • Suite 810 • Chicago, IL 60631
T: 773.864.8280 • F: 773.864.8281
www.claritypso.com

Clarity PSO Learning Series

Topic: Patient Transfers and Delays in Medication Therapy

Handoff communication is a broad, overarching healthcare term that has been a significant point of discussion for healthcare safety. Though its name changes and many challenge the idea of standardizing the practice, handoff is used across the healthcare continuum to communicate the current state and care delivery of an individual patient. It is and has been an instrumental, powerful and absolutely necessary tool throughout healthcare's history. Yet, we are still far from effectively implementing this crucial tool. It is well-known that during transitions of care, whether they be within a department, across an organization or external (transfer or discharges), those moments of transition and a good/safe handoff are ***essential*** due to the ***extensive vulnerability for errors*** that may occur when a patient moves through the healthcare system.

There are numerous factors that may create failures in handoff, and a paucity exists when it comes to understanding the full breadth of these communication breakdowns. This gap in knowledge and lack of standard handoff practice exemplifies the need to continue to report these events to learn more about the origins of these failures. Below are several common causes of handoff failures:

- Time constraints
- Unstructured, informal, non-standardized handoffs
- Varying priorities amongst the delivering and receiving teams
- Lack of understanding differing priorities
- Individual communication styles
- Lack of education on how to perform good handoffs
- Lack of supportive Health Information Technology (HIT)
- Required multi-tasking and thus diverted attention while receiving and providing handoff
- Coordination issues
- Highly stimulating, distracting environments

This is a topic that continues to be a challenge and is identified throughout safety event reporting. This particular PSO Learning Series Report focuses on patient transfers (the majority being internal hospital transfers, i.e. patient admitted to the ED and then transferred to the ICU) and antibiotic medication therapy errors. As with many self-reported safety topics, patient transfer errors are likely to occur significantly more often than what is reported in safety event data because they are not always easily "seen" by providers (as compared to something like a fall that is very evident).

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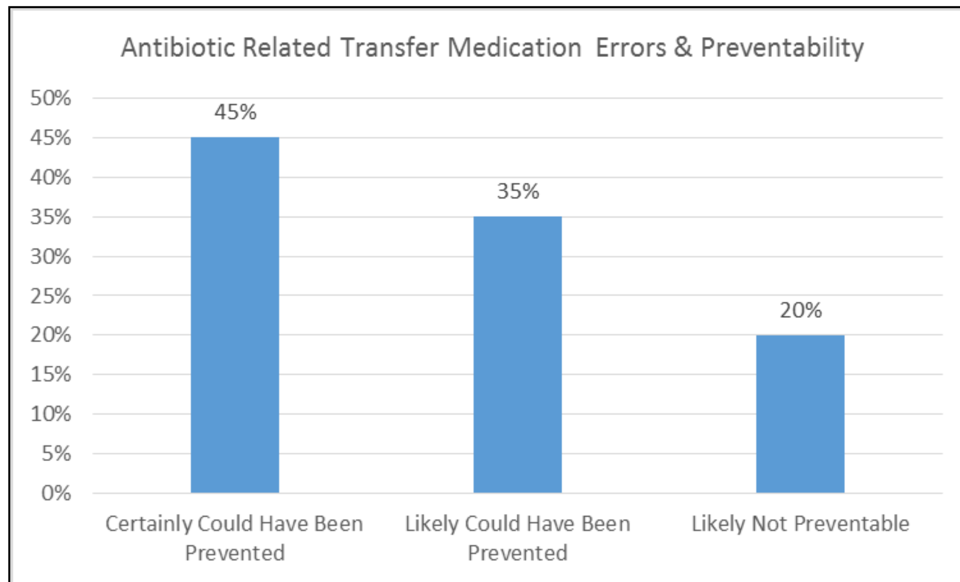
What We Learned

This quarter, 8% of medication errors reported to Clarity PSO were *directly* related to patient transfer and handoff errors. More than half of those events involved antibiotic medication therapy errors. The following graph depicts preventability of these errors.



It is interesting to consider why antibiotics are the most frequently reported medication within *directly related* transfer errors. Is it possible that this reporting is reflective of the organization's culture? Could this be related to punitive reporting or "pointing the finger" to avoid the accusation of being the provider who caused or created the error? Is it mere frustration on the provider's part that care was not completed or passed along properly?

In nearly all of these cases, the communication failure resulted in the delay of the patient receiving his or her antibiotic therapy. The following are themes noted throughout those late delivery of antibiotic specific events:

- 78% involved the transfer of the patient from the ED to the inpatient units
- 33% contained treatment orders to deliver 2 different antibiotics
    - Patient was transferred prior to starting the second antibiotic with the expectation that the receiving unit would complete the dosage
- Confusion regarding documentation of antibiotics administered and those awaiting delivery was evident in **100%** of the cases

From a care provider perspective, these events are an example of how the seemingly trivial detail of "giving report" or handing over a patient's care to the next provider(s) is utterly complex and thus requires the constant attention of the entire organization.

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Recommendations

Formally, we see handoffs occur only in parts of healthcare delivery. For example, the universal time out prior to a surgery. There are some providers who have developed their own organization-wide approaches and have found a fair amount of success in communication and handoffs. However, the complexity of handoffs does warrant the need for standard, national attention. In general, there is awareness of the importance to conduct good handoffs throughout the healthcare community for the safety of our patient. Yet, we are still challenged with the fact that poor handoffs occur far more often than they should and this routinely affects patient care and safety.

The following are resources to help you improve your patient handoffs and to reduce medication errors:

- AHRQ: Implementing Six Sigma and Resources
- John Hopkins Medicine: Implementing CUSP
- AHRQ: MATCH Toolkit for Medication Reconciliation
- AHRQ: CUSP Toolkit
- AHRQ: TeamSTEPPS 2.0
- IHI: Plan-Do-Study-Act
- AHRQ: TeamSTEPPS SBAR & I PASS the BATON
- Transferring the critically ill patient

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