Striking the right note in clinical communication

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JCI – Voluntary report of Sentinel Events
Root Cause Analysis – wrong patient, wrong site, wrong procedure

2004 through 2013 (N=1037)

Leadership 851
**Communication** 711
Human Factors 711
Information Management 377
Assessment 367
Operative Care 336
Physical Environment 96
Patient Rights 62
Anesthesia Care 52
Continuum of Care 38
Voluntary report of Sentinel Events
Root Cause Analysis – Op and Post op Complication

2004 Through 2013 (N=796)

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Voluntary report of Sentinel Events
Root Cause Analysis - Delay in Treatment

(Resulting in death or permanent loss of function)
2004 through 2013 (N=903)

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The good old days
The good old days
JCI Center for Transforming Healthcare identifies problems in handoffs

- Delayed or inappropriate treatment
- Adverse events
- Omission of care
- Increased length of hospital stay
- Avoidable readmissions
- Increased costs
- Inefficiency from rework
Increasing complex healthcare environment

- Flexi time, duty hours regulation, multi professional healthcare team
- Challenge to provide continuity of care
- Discontinuity creates opportunities for errors
- 4000 daily handoffs in an academic center
Handoffs causing patient harm

- 2006 Survey in MGH
- 238 residents in medicine and surgery
- 161 response (68%)
- Results
  - 50% reported patient harm due to problematic handoffs
  - 12% major harm to patient

From B&W to SMS, Twitter, QQ, Instagram, Tumblr, Facebook, Skype, WhatsApp...
Next day Ward Round

Doctor: 10% Glucose. OK
Nurse: 10% Glucose
Patient: IV drip
Afternoon
Check Drip,
Check Orders
BINGO

IV 10% Glucose
10% Glucose OKie

10% Glucose + (Saline)
10% Glucose + (Saline)

10% Glucose

10% Glucose + (Saline)
Increasing complex healthcare environment

• Barriers to good communication
  Too little information
  Too much information
  Limited opportunity to ask questions
  Interruptions
  Environment, e.g. too noisy
  Inconsistent standard
  Equipment failure
Increasing complex healthcare environment

• Define pertinent content
  Summary of history
  Required action

• Clarification and inquiry

Welsh et al. Nursing Outlook, 2010; 58: 148-154
Hospitalist Handoffs: a Systematic Review

- A formal handover process should be instituted at the end of shift or change of service (Class 1 Level of evidence C)
- Dedicated time during shift for verbal exchange of information (1C)
- Template or technology solution for assessing and recording patient information (1B)
- Training of new users (1C)
- Tracking for the correct hospitalist taking care of a patient after service change (1C)

Hospitalist Handoffs: a Systematic Review

• Verbal Communication Recommendation
  Interactive process is used during the verbal exchange (Class1 Level C)
  Ill patients given priority during exchange (Class1 Level C)
  Insight on what to anticipate and what to do during the verbal exchange (Class1 Level C)

Hospitalist Handoffs: a Systematic Review

- Pertinent Content Recommendations
  All patients handed off must be included
  Contents are up to date
  Kept in a centralized location, easy access
  Action items are highlighted
  Anticipated events are highlighted

Will system interventions improve communication in the “gray” zone?
Intervention Outcomes

• Face to face verbal communication and electronic template

39 IM interns, about 9,200 handoffs

Significant improvement in intern satisfaction and significant reduction in data omission

Reduction in near misses

Intervention Outcomes

• 84 Residents and 1255 patient admission

Significant reduction in medication error
33.8 to 18.8 per 100 admissions
(95% CI, 14.7-21.9; p < .001)

Significant reduction in preventable adverse
events 3.3 to 1.5 per 100 admissions
(95% CI, 0.51-2.4; p =0.04)

Starmer AJ. JAMA. 2013 Dec 4;310(21):2262-70
Increasingly complex healthcare institutions
Inter professional teams

Speak in one language

• Define pertinent content
  Summary of history
  Required action

• Clarification and inquiry
We got to strike the right note

Succinct

Timely Actions

Received
Conclusion

Ebony and Ivory live together in perfect harmony

Side by side on my piano keyboard…

Ebony, Ivory, oh

We all know that people are the same wherever you go

There is good and bad in everyone
We learn to live when we learn to give each other

What we need to keep, OUR PATIENTS SAFE
(survive, together alive)