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Effective Communication During Patient Transitions Can Reduce Risk

When responsibility for care transfers as a patient moves from one setting to another, patient safety and quality of care can suffer. In these instances, the risk of a malpractice claim can increase.

An estimated 80 percent of serious medical errors involve miscommunication during a handoff between medical providers, according to the Joint Commission Center for Transforming Healthcare.[1] The following scenarios illustrate why the inpatient discharge is one of the most troublesome transition points.

Scenario 1

Robert Dunbar, age 65, was admitted to a rehabilitation center after successful knee replacement surgery. He was transported by ambulance from the hospital, but he arrived without a discharge summary or specific instructions from his orthopedic surgeon. When the staff at the rehabilitation center contacted the orthopedic surgery group about the discharge instructions, the group emailed the center a standard order for a post-knee arthroscopy. The orthopods at this facility had an arrangement with a local internal medicine group to provide medical management for their surgical patients during their hospital stays. Because of the patient's transfer to the rehabilitation center, he was not seen by an internist on the day of discharge. There was also confusion about who in the internal medicine group saw the patient last and whether the discharge summary was dictated. The rehabilitation center was told the matter would be "straightened out," and the necessary records would be provided "soon."

An aide at the rehabilitation center found the patient semi-conscious, pale and sweaty. A call to the IM group determined that the patient was a diabetic and severely hypoglycemic. The patient's condition was quickly addressed, and his hypoglycemia reversed, fortunately with no long-term consequences.

Scenario 2

Margaret Potter, a 72-year-old widow, was discharged from the hospital after an emergency admission for an acute MI. She was not a local resident but had been visiting her sister when she went to the hospital with severe chest pain and shortness of breath.

She was admitted to the service of a hospitalist who had successfully contacted the patient's PCP in her home state. The hospitalist learned she had a history of hypertension and was on a beta-blocker and diuretic, but was otherwise in good health, active and independent.

During her hospitalization, a cardiologist inserted a cardiac stent to relieve the blockage, and he added an anti-platelet to her medication regimen. At discharge, the cardiologist gave the patient two copies of her discharge summary and instructions—one for her and one for her PCP, a prescription for a two-week supply of the anti-platelet medication, and instructions to follow-up with her PCP when she returned home. The cardiologist did not personally send a discharge summary to the PCP. Instead, he relied on the patient to hand deliver the PCP a copy at her follow-up appointment.

Unfortunately, the patient did not go straight home. Instead, she extended her

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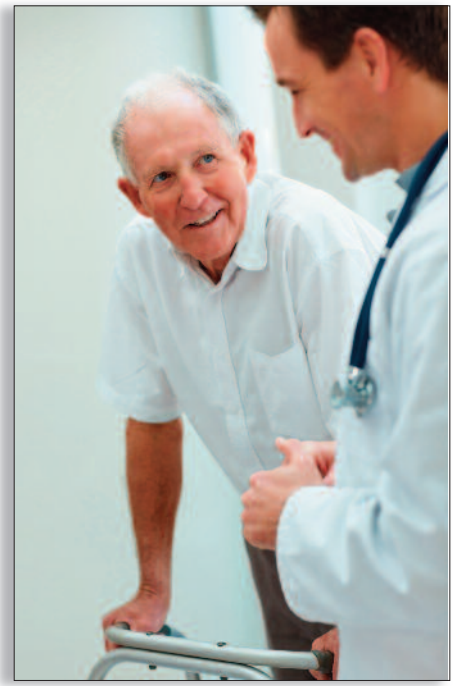
visit with her sister and made yet another stop before returning home. By that time, she had used up the two-week supply of the anti-platelet medication. She made an appointment with her PCP and explained to the receptionist that she had been hospitalized elsewhere for an AMI and had been told to follow-up with her own physician for cardiac rehabilitation. She was given an appointment for two weeks later. Before that appointment, the patient experienced a fatal MI.



Discussion

In both of the preceding scenarios, providers failed to exchange timely and essential patient information.

In **Scenario 1**, poor co-management by two specialists/groups resulted in delayed communication of relevant information. Co-management arrangements are increasingly common—particularly in facilities using hospitalists to provide inpatient care.

Surgical patients' medical needs are co-managed by hospitalists or designated internal medicine groups. Co-management goes beyond a traditional consultant in that the non-surgical specialist usually has greater accountability and a greater share of responsibility for the patient.

The roles of the internists and the orthopedic surgeon were not clearly defined in this case. There was uncertainty and confusion about who was responsible for dictating the discharge summary, who gave the discharge orders, and who wrote the discharge instructions for the patient and the rehabilitation center. As a result, the communication of needed clinical information was delayed, causing the patient's safety to be put at risk.

Roles and responsibilities and policies and procedures should be worked out, clearly defined and communicated to those in co-management arrangements *beforehand*. In addition to the patient safety risk, patients often pick up on this lack of communication and coordination. The patient may in turn perceive that the care provided is less than high quality, lose confidence and trust in the physician and staff, and become dissatisfied with the physician and the practice. If the patient's outcome suffers as a result, the potential for litigation will increase.

In **Scenario 2,** the hospitalist successfully contacted the patient's PCP upon admission and received the pertinent clinical information that helped him formulate Margaret Potter's treatment plan. However, the cardiologist dropped the ball at discharge.

Allowing the patient to hand-carry her discharge summary and instructions to her PCP showed poor judgment. Most hospitals have policies and procedures that direct the discharge information straight to the patient's PCP in a *timely* manner (e.g., within 24 or 48 hours of discharge).

The cardiologist also failed to find out what the patient's plans were upon discharge. Since the patient did not go directly home, the cardiologist's discharge instructions and two-week anti-platelet prescription put the patient at great risk. The cardiologist did not adequately educate the patient about her condition and treatment, the importance of following up with her PCP, the need for ongoing anti-platelet therapy and monitoring, or her need for cardiac rehabilitation.

The cardiologist should also have conveyed the discharge summary, discharge education and instructions, and his plan for follow-up and ongoing care by the PCP directly to the PCP. Had that occurred, when the patient returned home and contacted her PCP, the discharge instructions and orders could have already been placed in the patient's chart. Optimally, the PCP could have made the necessary referral for the patient's cardiac rehabilitation and called in the prescription for the anti-platelet. The inadequate communications led to a disruption in continuity of care that potentially played a role in the patient's death.

Hand-off/Transition of Care Tools

The Five-Ps were developed by Sentara Health Care in Norfolk, Va., to streamline the transfer of responsibility among caregivers and patient information.

Patient	Name, identifiers, age, sex, location
Plan	Patient diagnosis, treatment plan and next steps
Purpose	Provide a rationale for the care plan
Problems	Explain what's different or unusual about this specific patient
Precautions	Explain what's expected to be different or usual

Source: Sentara Health Care, Norfolk, Virginia, 2008

What Can We Learn?

Studies repeatedly have shown that it is during transitions of care that patient safety and quality of care are particularly at risk. Discharge from an inpatient setting is a particularly troublesome transition point, and poor communications are at the heart of many of the discharge and post-discharge patient safety issues.

For example, one study reported that 40 percent of 2,644 patients discharged had at least one pending test result at the time of discharge. Out of these, 10 percent required some action but the patients and their outpatient physicians were completely unaware of these results.[2] The following risk management strategies may help to improve patient safety and quality of care as they relate to patient discharges:

- **Do a risk assessment on the practice's transitions.** Identify where weakness could jeopardize patient safety—and take steps to correct those weaknesses. *In the case of PCPs, are consultants and specialists routinely provided with patient information at the time of referral? On the other side of the care transition, are consult results routinely sent to the referring physician in a timely manner?*
- **Review the practice's discharge summaries and patient discharge instruction forms.** While no patient discharge or transition of care will be the same, some standardization is good when it comes to discharge processes. Using a standard form or template helps improve the consistency and transmission of pertinent clinical information including:
  - Reason for admission
  - Condition on admission
  - Medication history (pre-admission, during hospitalization, on discharge)
  - Pertinent physical findings and test results during admission
  - Condition at discharge
  - Pending consultations or test results at time of discharge
  - Treatment plan at discharge
  - Discharge to information
  - Discharge instructions for patient or patient's caregiver
  - Follow-up required by the PCP
- **Develop discharge and other transition of care policies and procedures** with the practice's patients and venues in mind. Some physicians may only refer patients for admissions, others may provide inpatient care, and others still may not deal with inpatient care at all.
- **Include the patient and family members in the discharge planning process.** Soliciting their input and preferences and listening to their concerns helps improve efficiency and reduce anxiety**.** *Where will the patient be going upon discharge? Can the patient manage alone at home? Will there be a caregiver at home who can assist with the patient's post-discharge needs? Is the home physically safe to accommodate the patient (e.g., are there steps?) or are modifications needed before discharge? Is transitional care or rehabilitation needed first?*
- **Select a method of communication that is agreeable to all involved** and allows for the necessary exchange of information. (See "Hand-off/Transition of Care Tool" on the previous page.) This communication should be specific about each person's roles and responsibilities going forward. Ideally, patient hand-offs should be done in person, one provider to another. This allows for two-way communication where questions can be posed and answered.
- **Apply good documentation practices even if the transition of care or discharge information was exchanged verbally.** Any discussions with the patient, patient family members, or other providers involved in the patient's care should be carefully documented, as contemporaneously as possible.
- **Consider using checklists to help prevent communication breakdowns.** These can be tailored for a practice or specialty and serve as a tool to prompt the exchange of information and consistency among physicians. Also, if a practice or physician can show that a discharge checklist was practice policy and *routinely* completed, it might prevent or mitigate a claim. Some items to include are:
  - Discharge summary dictated
  - Discharge summary to PCP/referring physician
  - Patient given instructions regarding follow-up appointments with PCP, scheduled tests
  - Patient given medication list at discharge and new prescriptions to be filled
  - Family/caregiver received copy of discharge instructions

When transitions of care are not given the attention they deserve, patient safety and quality of care suffers. However, an effective flow of clinical information going in both directions can be beneficial in reducing the potential for error and injury.

1 Joint Commission Center for Transforming Healthcare. Improving Transitions of Care: Hand-off Communications, June 2012 (Updated May 13, 2013). www.centerfortransforminghealthcare.org/assets/4/6/CTH_Hand-off_commun_set_final_2010.pdf

2 Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005; 143(2): 121-128.

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"I Pass the Baton" Technique

This technique is recommended by the Department of Defense's Patient Safety Program to provide an optimal structure to improve communication during transitions in care. It should include opportunities to confirm receipt, ask questions, clarify information and verify that the information is understood. This technique is designed to assist with both simple and complex handoffs.

I	Introduction	Individuals involved in the handoff identify themselves, their roles and jobs
P	Patient	Name, identifiers, age, sex, location
A	Assessment	Present chief complaint, vital signs, symptoms and diagnosis
S	Situation	Current status and circumstances, including code status, level of certainty or uncertainty, recent changes and response to treatment
S	Safety Concerns	Critical lab values and reports, socioeconomic factors, allergies and alerts, such as risk for falls
the		
B	Background	Comorbidities, previous episodes, current medications and family history
A	Actions	Detail what actions were taken or are required and provide a brief rationale for those actions
T	Timing	Level of urgency and explicit timing, prioritization of actions
O	Ownership	Who is responsible (nurse/doctor/team), including patient and family responsibilities?
N	Next	What will happen next? Any anticipated changes? What is the plan? Any contingency plans?

Source: Department of Defense Patient Safety Program, "Healthcare Communications Toolkit to Improve Transitions in Care," 2008.

Other Resources

There and Home Again, Safely: Five Responsibilities of Ambulatory Practices in High Quality Care Transitions. Sokol PE and Wynia MK, writing for the AMA Expert Panel on Care Transitions. American Medical Association, Chicago IL 2013.
www.ama-ssn.org/resources/doc/patient-safety//ambulatory-procedures.pdf

Improving Transitions of Care: Handoff Communications, June 2012 (Updated May 13, 2013). Joint Commission Center for Transforming Healthcare.
www.centerfortransforminghealthcare.org/assets/4/6/CTH_Hand-off_commun_set_final_2010.pdf

AHRQ Patient Safety Primer: Handoffs and Signouts. Agency for Healthcare Research and Quality.
http://psnet.ahrq.gov/primer.aspx?primerID=9

Safer Sign Out—a patient-centered, team-based innovation that was developed by the Emergency Medicine Patient Safety Foundation (EMPSF) to improve the safety and reliability of end of shift patient handoffs.
www.empsf.org/safersignout.html

American Academy of Family Practice (AAFP) Guidelines for Interaction in Hospitalist Models: Communication between the Receiving Inpatient Care Management Physician and the Referring Primary Care Physician.
www.aafp.org/about/policies/all/hospitalists.html

Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, Society of Academic Emergency Medicine. J Gen Intern Med. 2009 August; 24(8): 971–976.
www.ncbi.nlm.nih.gov/pmc/articles/PMC2710485/

AHRQ Project RED (Re-Engineered Discharge) Toolkit—a patient-centered, standardized approach to discharge planning and discharge education. March 2013 Update. Project RED improves patient preparedness for self care and reduces preventable readmissions and post-discharge ED visits. AHRQ Publication # 12(13)-0084.
www.ahrq.gov/professionals/systems/hospital/toolkit/index.html

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