



The American College of
Obstetricians and Gynecologists

WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 517 • February 2012

(Reaffirmed 2016. Replaces No. 367, June 2007)

Committee on Patient Safety and Quality Improvement

This document reflects emerging concepts on patient safety and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Communication Strategies for Patient Handoffs

ABSTRACT: Handoff communication, which includes up-to-date information regarding patient care, treatment and service, condition, and any recent or anticipated changes, should be interactive to allow for discussion between those who give and receive patient information. It requires a process for verification of the received information, including read-back or other methods, as appropriate.

Patient handoffs are a necessary component of current medical care. Accurate communication of information about a patient from one member of the health care team to another is a critical element of patient care and safety; it is also one of the least studied and taught elements of daily patient care. One of the leading causes of medical errors is a breakdown in communication. This breakdown may occur between clinicians at any level of the health care system. Communication failures also have been found to be a leading cause of preventable error in studies of closed malpractice claims (1, 2). In the era of collaborative care, effective clinician-to-clinician communication is important to facilitate continuity of care, eliminate preventable errors, and provide a safe patient environment.

Communication is the process by which information is exchanged between individuals, groups, and organizations. In order to be effective, communication should be complete, clear, concise, and timely. Barriers to effective communication include factors such as lack of time, hierarchies, defensiveness, varying communication styles, distraction, fatigue, conflict, and workload.

One predictable and critical communication event is the patient handoff. A handoff may be described as the transfer of patient information and knowledge, along with authority and responsibility, from one clinician or team of clinicians to another clinician or team of clinicians during transitions of care across the continuum. It should include an opportunity to ask questions, clarify, and confirm the information being transmitted. As part of its standard of provision of care, treatment, and services, The Joint Commission requires that the “process for hand-off communication provides for the opportunity for discussion between the giver and the receiver of patient information” (3). Consideration should be given

to the implementation of a standardized approach for handoff communication. A process for guiding the handoff process should include the following:

- Interactive communications
- Limited interruptions
- A process for verification
- An opportunity to review any relevant historical data (4)

Properly executed handoffs are interactive and include the opportunity for questions and answers. A handoff may occur during the transfer of care in any of several circumstances, including from one on-call physician to another, from the office physician to the hospital laborist or vice versa, or from the generalist obstetrician-gynecologist to the specialist. It also may occur between the attending physician and a resident or between the attending physician and nursing staff. Every important aspect of the patient's condition and circumstance must be accurately communicated and acknowledged from one party to the other for a safe and effective handoff to occur. Communication at the time of the handoff should result in a clear understanding by each clinician about who is responsible for which aspects of the patient's care. E-mail may constitute an appropriate form of handoff if receipt is acknowledged. Voice mail or other unacknowledged messages, however, do not constitute an acceptable form of handoff.

Both patient handoffs and ongoing clinical communication can be improved to promote high-quality medical care. Factors that may affect communication processes—physical environment, confidentiality, language, organizational culture, communication method, and documentation—should be addressed.

Physical Environment

The physical environment in which the interaction takes place may hinder effective communication. For example, a noisy nursing station is a less desirable setting for communicating handoff information than a quiet conference room located away from other distractions. Having discussions in an environment without distractions will enhance communication during handoffs. Clinical acuity of the patient's condition must be considered in deciding the circumstances, the setting, and the content of the handoff communication. Consideration should be given to conducting handoffs in the patient room as appropriate.

Confidentiality

Care must be taken to maintain patient confidentiality by allowing only those involved with her care to hear or view protected health care information. Consideration of privacy when transmitting patient information is also important. Physicians must be aware of and comply with Health Insurance Portability and Accountability Act regulations.

Language

Language differences may interfere with the accurate transfer of information. Using standardized medical terminology avoids errors in communication that may occur when colloquialisms are used. The use of abbreviations, other than those that are well known and widely accepted, should be discouraged. Common terminology for interpretation of the fetal heart rate tracing has been standardized by the National Institute of Child Health and Human Development, the American College of Obstetricians and Gynecologists, and the Society for Maternal–Fetal Medicine (5). This terminology also has been adopted by the Association of Women's Health, Obstetric, and Neonatal Nurses and the American College of Nurse–Midwives. Awareness of cultural, professional, and gender differences in communication style is also an important factor in how clinical information is presented and received.

Organizational Culture

A primary person or team should be identified as responsible for each patient. The method of access to the primary contact should be clearly established, and a backup system should be identified in case the primary contact is unavailable (6).

The hierarchy of personnel, particularly in teaching settings, also may inhibit the transfer of important information about the patient (7). For example, when information about the patient's care is being conveyed, a first-year resident or nurse should be made to feel as comfortable talking with the senior attending physician as with another resident. Every member of the health care team that is present should be encouraged to participate

in and contribute to the transfer of information without reluctance. Senior physicians should also serve as role models for attentive listening and the elicitation of concerns from other team members.

Communication Method

Ineffective organization of the information by the sender and lack of attention by the receiver are two significant barriers to the effective transfer of vital information. Structured forms of communication, such as the Situation-Background-Assessment-Recommendation (also referred to as SBAR) technique, should be considered. Communication may be verbal, written, or both (8). The Joint Commission requires that staff use a record and read-back process before taking action on a verbal order or verbal report of a critical test result (3). Verbal communication includes a face-to-face conversation or a telephone call. Face-to-face exchange of information is generally the preferred form of verbal communication because it allows direct interaction among those present. Not only may questions be asked and answered, but also further nonverbal information may be expressed by body language and facial expression. Written communication may assist the person conveying clinical information in organizing his or her thoughts and presenting important details. It also allows the receiving party to have a paper-generated or computer-generated hard copy of information for reference. However, written communication lacks the subjective interpersonal aspect of verbal communication. The most effective handoff of patient information includes both verbal and written components (9).

Performing the handoff in a routine time and manner also can improve the sharing of information. Patient handoffs should take priority over all other duties except for emergencies (6). The TeamSTEPPS™ system developed by the Agency for Healthcare Research and Quality and the United States Department of Defense, which is available to the public online, is an evidence-based teamwork system to improve communication and teamwork skills among health care providers (10). It includes strategies to enhance information exchange during transitions of care. The TeamSTEPPS™ program includes the "I PASS THE BATON" mnemonic, as shown in [Table 1](#), which may facilitate the process for handoffs and health care transitions (10).

Documentation

The written component of the handoff may be produced by hand or electronically. One of the main advantages of an electronic medical record is that it eliminates illegibility. Illegible handwriting has been shown to be a major contributor to errors in patient care. Although there is no universally accepted protocol for all of the information that a written handoff should contain, there are several key elements that should be present in any transfer of patient care, whether oral or written. These include pertinent demographic information, a brief history and

Table 1. “I PASS THE BATON” Mnemonic for Handoffs and Health Care Transitions ↩

I	Introduction	Introduce yourself and your role or job (include patient)
P	Patient	Name, identifiers, age, sex, location
A	Assessment	Present chief complaint, vital signs, symptoms, and diagnosis
S	Situation	Current status or circumstances, including code status, level of (un)certainity, recent changes, and response to treatment
S	SAFETY Concerns	Critical lab values or reports, socioeconomic factors, allergies, and alerts (eg, falls or isolation)
The		
B	Background	Comorbidities, previous episodes, current medications, and family history
A	Actions	What actions were taken or are required? Provide brief rationale
T	Timing	Level of urgency and explicit timing and prioritization of actions
O	Ownership	Who is responsible (person or team) including patient or family?
N	Next	What will happen next? Are there anticipated changes? What is the plan? Are there contingency plans?

Modified from Agency for Healthcare Research and Quality. TeamSTEPS™: national implementation. Available at <http://teamsteps.ahrq.gov>.

the results of a physical examination, an active problem list, medications and allergies, pending test results, ongoing or anticipated therapy, key patient values and preferences, and any other critical information, which should be documented in the patient’s medical record if not already present. Using the Situation-Background-Assessment-Recommendation technique as a guide may facilitate the documentation process, as necessary. Such information as code status, psychosocial status, family issues, and long-term care issues also may be included as circumstances warrant.

Conclusion

Providing a safe health care environment for patients must become the hallmark of future health care. By improving both the processes for communication between clinicians and the transfer of information among members of the health care team, the care that patients receive will be optimized; ideally, the process will be seamless. Studies are currently underway to determine the most effective methods to perform and teach the transfer of patient information. Physicians must strive to improve their communication skills, not only with each other, but also when interacting with other members of the health care team. Awareness of the importance and challenges of effective communication and implementation of effective communication processes, especially as it relates to handoffs, will help decrease errors that result in adverse events and provide a safe patient environment.

References

1. Kachalia A, Gandhi TK, Puopolo AL, Yoon C, Thomas EJ, Griffery R, et al. Missed and delayed diagnoses in the emergency department: a study of closed malpractice claims from 4 liability insurers. *Ann Emerg Med* 2007;49:196–205. [\[PubMed\]](#) ↩
2. Singh H, Thomas EJ, Petersen LA, Studdert DM. Medical errors involving trainees: a study of closed malpractice claims from 5 insurers. *Arch Intern Med* 2007;167:2030–6. [\[PubMed\]](#) [\[Full Text\]](#) ↩
3. The Joint Commission. Comprehensive accreditation manual. CAMH for hospitals: the official handbook. Oakbrook Terrace (IL): Joint Commission; 2010. ↩
4. Agency for Healthcare Research and Quality. Patient safety primers: handoffs and signouts. Available at: <http://psnet.ahrq.gov/primer.aspx?primerID=9>. Retrieved July 28, 2011. ↩
5. Macones GA, Hankins GD, Spong CY, Hauth J, Moore T. The 2008 National Institute of Child Health and Human Development workshop report on electronic fetal monitoring: update on definitions, interpretation, and research guidelines. *Obstet Gynecol* 2008;112:661–6. [\[PubMed\]](#) [\[Obstetrics & Gynecology\]](#) ↩
6. Williams RG, Silverman R, Schwind C, Fortune JB, Sutyak J, Horvath KD, et al. Surgeon information transfer and communication: factors affecting quality and efficiency of inpatient care. *Ann Surg* 2007;245:159–69. [\[PubMed\]](#) [\[Full Text\]](#) ↩
7. Greenberg CC, Regenbogen SE, Studdert DM, Lipsitz SR, Rogers SO, Zinner MJ, et al. Patterns of communication

breakdowns resulting in injury to surgical patients. *J Am Coll Surg* 2007;204:533–40. [PubMed] [Full Text] ↩

8. Institute for Healthcare Improvement. SBAR technique or communication: a situational briefing model. Available at: <http://www.ihl.org/knowledge/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx>. Retrieved July 28, 2011. ↩
9. Arora VM, Manjarrez E, Dressler DD, Basaviah P, Halasyamani L, Kripalani S. Hospitalist handoffs: a systematic review and task force recommendations. *J Hosp Med* 2009;4:433–40. [PubMed] ↩
10. Agency for Healthcare Research and Quality. Team STEPPS™: national implementation. Available at: <http://teamstepps.ahrq.gov>. Retrieved July 28, 2011. ↩

Copyright February 2012 by the American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, posted on the Internet, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher. Requests for authorization to make photocopies should be directed to: Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400.

ISSN 1074-861X

Communication strategies for patient handoffs. Committee Opinion No. 517. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2012;119:408–11.