



Hand overs in Emergency Medicine a point of ambiguity

Authors

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Abstract

Handovers in emergency department is a transfer of care of patients from one shift to another. Communication failure during this process is one the leading cause of providing a low quality handoff, which in turn result into a suboptimal care and jeopardize patient safety. In this paper we are trying to highlight this process and review some literature can aid emergency physicians to come up with a safe and effective sign out.

Introduction

Emergency department is a unique environment to practice medicine. Its uniqueness comes from the dynamic nature and the crucial of actions and decisions taken in an area where there is no place for error.

Routinely the emergency physicians start their day by signing in at the beginning of their shift and end it by signing out. The ED's hectic nature and the high frequency of interruptions make this communication process very difficult which in turn may result in medical errors. ^[1]

Medical error is defined as: "a commission or omission with potentially negative consequences for the patient that would have been judged wrong by skilled and knowledgeable peers at the time it occurred, independent of whether there were any negative consequences." ^[2]

Lately, medical errors and its effects on patient safety have been brought to the attention of the people and the health care providers. ^[3]

In 1999 Kohn and Colleagues made an estimate about the number of medical errors in the United States. They found that medical errors were

responsible for 44.000 to 98.000 deaths each year. ^[4]

Most of the medical errors were found to be as a result of poor communication. ^[5] Deficiency in communication between physicians was noted to be as results of interruptions and the frantic atmosphere in ED.

A review of literature was done to focus on the sign in-sign out process, and found that this vital step was not formal and not following any standards.

In this review we will try to bring the attention and shed some light on this of crucial part emergency physicians daily routine, which in turn will result in a better safety outcome to our patients and our colleagues.

Discussion

The sign out or handoff process is a vital step at the beginning and ending of shifts for all emergency physicians (EPs).

The importance of this process came from its ability to reduce medical error.

The Joint commission has found that 70% of all medical errors occur due to communication interruptions and half of those errors are at the hand over process.^[6]

The fast-paced and hectic atmosphere has made the Emergency department more susceptible to errors than other departments.^[7]

A recent attention has been brought to the hand over process and certain techniques and standardized methods were tried in order to eliminate medical errors. Methods of standardization were with the use of sign-out templates, computerized sign-out and improve verbal communication, the latter proved to be better in transition of patients information's.^{[9][10][11]}

In order to conceptualize the ED handoffs the American College Of Emergency Physicians (ACEP) had published an article recently and made recommendations to make more efforts to close the gap between the ideal sign-out and the current state.^[11]

Establishing a proper verbal communications is an important matter and requires effort to ensure its effectiveness and this can be done through educating physicians by a standardized verbal education programs and doing more research on this topic.^[12]

Teaching of the residents about the proper sing-out is another useful tool on the way of standardization, Sinha et al had mad a study surveying emergency medicine programs handoffs process and she noted that 89.5% of the residency programs had no written policy and no didactic in 75%.^[13]

Elements of ED handoffs was introduced by the Joint Commission to standardize this process, The Joint Commission emphasize the introduction of a checklist and the use of Situation, Background, Assessment, Recommendation (**SBAR**), electronic format and repeat back technique. Also reduce interruption as part of environmental control in ED with team based training and education.^[14]

SBAR, I PASS the BATON, the 5-Ps, SIGN OUT and HANDOFF are all handoff templates that were found in the medical literature but all are

hospital-based and not practical to implement in Ed setting.^{[15][16][17][18][19]}

The ACEP had made recommendations in their recently published article "Improving Handoffs in the Emergency Department". These recommendations were:

- Reducing the number of Unnecessary Handoffs
- Limit Interruptions and Distractions as much as is Practicable
- Provide a Succinct Overview
- Make Information Readily Available for Direct Review
- Encourage Questioning and Discussion of Assessments
- Account for All Patients
- Signal a Clear Moment in Transition of Care
- Communicate Outstanding Tasks, Anticipate Changes, and have a Clear Plan.^[20]

In conclusion, Sign-out process is a patient safety issue and a ground zero for potential medical errors. Improving communication, reducing the interruptions during the hands off and using checklist can help to minimize the risks associated with this process and shorter handoffs period, also establishing standardized education programs for the physicians as well as the residents. Further researches in this area also can facilitate standardization process. Finally, we have an ethical obligation to our colleagues, patients and ourselves to provide high-quality handoff. Physician compliance with these measures is of paramount priority to have a safe and fruitful sign-out.

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