Faculty Supervision of the House Staff Handoff Process: The Time Has Come

The Accreditation Council for Graduate Medical Education is taking bold new initiatives to make residency education more accountable to the public. If this is not done by the Accreditation Council for Graduate Medical Education, it will surely be legislated by governmental agencies that are paying the bill for Graduate Medical Education training, which would include requirements for more direct observation of a trainee’s performance, documentation of the trainee’s individual clinical outcomes, and educational outcomes of the residency training program. The creation of “the milestones” makes it easier to document specific behaviors and performance on specific tasks.

Previously, some of our faculty ratings were a result of supervisory “gestalt” rather than direct observation of the task by the trainee/learner. Direct observation is the only way to discern the difference between what the learner “can do” versus what the learner “actually does.” This has been well described in faculty development sessions at our institution with Dr. Eric Holmboe of the American Board of Internal Medicine, as well as by Dr. Louis Pangaro at the Clerkship Directors of Internal Medicine meeting in October, 2005. The fact that a learner has the knowledge, skills, and attitude of a particular task does not mean this automatically translates into desired behaviors at the bedside, thus the need for more direct supervision and direct observation in all of our training programs. This is the essence of competency-based education. This direct observation will be applied to the Entrustable Patient Activities. No Entrustable Patient Activity is more important than the process of “handoffs.” No Entrustable Patient Activity requires more direct observation and supervision than the handoff process if we are to increase the patient safety culture and environments in our teaching hospitals.

The process of handoffs has been studied for some time. As a consequence of the mandated changes in house staff duty hours, we have an average of 5.2 handoffs per day per patient in the United States. This number is chilling in the mathematical calculation of risk for each patient in the process. Programs have tried selecting the faculty members who best model the knowledge, skills, and attitudes of the handoff process to teach and define this process for residents with various success rates. The handoff process gets more complicated with fewer people to sign out to as we approach night float or night medicine (Figure). Of note, sign-outs at 4:30 PM take approximately the same amount of time as sign-outs at 9:30 PM and sign-ins at 7:30 AM. This quickly becomes a game of “telephone” with great potential to forget or drop important information that should have been passed along to the next provider. There also is great variability of faculty involvement in the handoff process in most programs. This has to be addressed in the new era of milestones, landmarks, and Entrustable Patient Activities, and is particularly important in light of the rapid expansion of hospitalist programs across the country. Hospitalists on the teaching service are generally assigned to resident-specific teams. Each team averages 16 or 17 patients. The physician who knows each patient the best is the supervisory hospitalist faculty member. Why have they not been drawn more into the sign-out process? We believe that this is the paradigm shift that must

Figure The patient handoff.

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take place and be evaluated in the Next Accreditation System. We have tried this in our own residency training program. All patients were signed out by the resident team in our electronic sign-out system (Patient Documentation Transfer System). As in most programs, sign-outs are supervised by our fourth-year Chief Residents. Unlike most programs, face-to-face sign-outs cannot and will not proceed until the sign-outs are reviewed, corrected, and approved by the faculty. This is followed by constructive feedback on accuracy given to the trainee. The faculty are not present at the actual sign-outs, but they are entirely responsible for the information entered into the electronic handoff system. Our faculty initially were not happy about this new requirement until they saw the rate of unacceptable errors, which was reduced once they participated. Direct observation of this process was an eye-opening experience for the faculty in our program. We have created this as a required milestone evaluation for the trainee to develop individual “process improvement.” This will eventually be a certified Entrustable Patient Activity in our program.

The next step in information flow was to require feedback to the hospitalist the following morning on the results or follow-up of each sign-out from the day before. This was supplemented by any additional information on change of status (eg, a code, a rapid response, an adverse event, or a critical laboratory test) that occurred since the handoff. The program requires that this information be entered into the electronic system, again supervised by nocturnists from our Night Medicine Program. Each hospitalist on the service, teaching and nonteaching, receives a summary before entering the hospital the following morning. They, in turn, can review the events and the required documentation in each patient’s chart, with feedback to the trainee on how to improve both the flow and the accuracy of information in this important legal record.

To be sure, a considerable amount of work is required for supervision and documentation. But this is the “process improvement” in housestaff supervision we are all being challenged with. With the duty hours requirements, fatigue prevention systems (all in the name of safety), and exponential increase in the number of handoffs in our academic medical centers, the only way to achieve “process improve-

References