The Importance of Handoff and Ownership: A Case of Pre-Operative Hypoglycemia

Peter Maloley, MD; Spencer Robinson, MD; Adrianna Shuey, DO; Gale Etherton, MD; Mahliqha Qasimyar, MD; Kate Muir, MD

Organizational Leadership
- ❑ Roles/Responsibilities
- ❑ Rules/Policies/Procedures
- ❑ Resources
- ❑ Teamwork

Risky Supervision
- ❑ Climate/Culture

Unsafe Practices
- ❑ Communication
  - ❖ *Content*
  - ❖ *Audience*
  - ❖ *Occasion*
  - ❖ *Purpose*
  - ❖ *Confidentiality*
  - ❖ *Documentation*
- ❑ Human Factors
  - ❖ *Information Technology*
  - ❖ *Equipment*
  - ❖ *Fitness for Duty*
  - ❖ *Scheduling*
  - ❖ *Training*
  - ❖ *Resources*
- ❑ Environment
  - ❖ *Interpersonal*
  - ❖ *Physical*

Unsafe Performance
- ❑ Active Error
  - ❖ *Slip*
  - ❖ *Lapse*
  - ❖ *Mistake*
- ❑ Violation

Patient Safety First

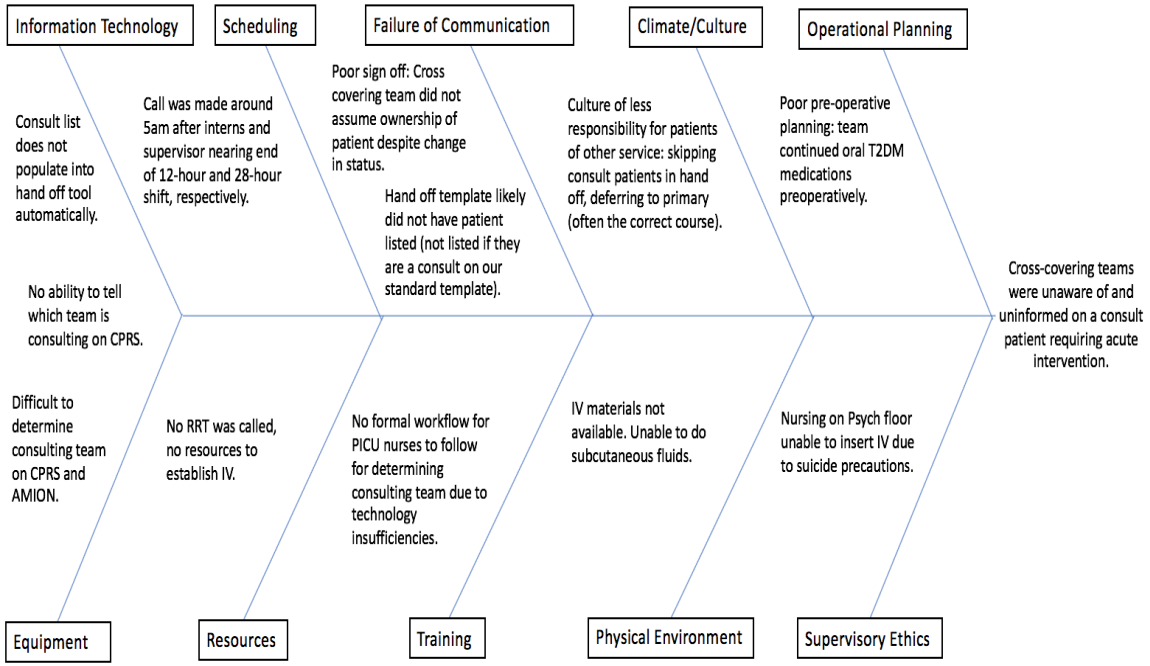
What Happened?

A 56-year-old male was admitted in the Psychiatric ward. An academic team was consulted for diabetes management but did not make cross-cover aware of the patient. His oral anti-hyperglycemics were not held the day of an elective surgery, for which he was NPO.

1. **At 0500, nurse found the patient had a blood sugar of 50. Two cross-cover teams were contacted in sequence; however, both teams reported they did not manage or know the patient.**
2. **The appropriate team could not be identified, and nursing called the first cross cover team for an emergency consult for management of hypoglycemia.**
3. **The patient did not have an IV and was NPO. Based on the duration of hypoglycemia, the patient was given juice/snack to avoid an irreversible change in his medical status.**
4. **Consequently, his elective surgery was delayed.**

Cross-covering teams were unaware of and uninformed on a consult patient requiring acute intervention.

Why Did this Happen?

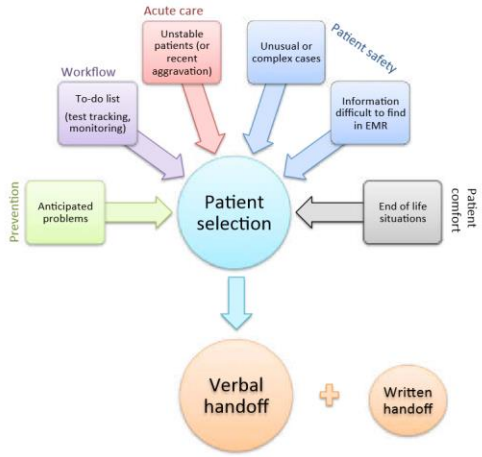


Proposed Safety Action Plan:

- **Instruct team supervisors to add consults to academic team lists and the shift handoff tool in CPRS.**
- **Implement a training lecture to refine handoff skills.**
- **Standardize "Are there any consults we haven't discussed?" as a part of effective handoff.**

What We Can Do to Prevent These Events:

Implementing a check list on the hand off to guide verbal communication and avoid extensive information (see below)[1].
Practitioners MUST take ownership of nurse calls until a transfer of care is established, but they must also make it explicitly known that a fully informed decision can only be made by the primary team.



1. Blondon KS, Wipfli R, Nendaz MR, Lovis C. Physician handoffs: opportunities and limitations for supportive technologies. *AMIA Annu Symp Proc*. 2015;2015:339–348. Published 2015 Nov 5.