INTRODUCTION

“Residency is an essential dimension of the transformation of the medical student to the independent practitioner. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident... This concept (graded and progressive responsibility) is one of the core tenets of the American Graduate Medical Education.”

RESIDENT WELL-BEING

“In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Self care is an important concept of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training.”
RESIDENT WELL-BEING
- Enhance professional relationships
- Minimize non-physician obligations
- Protect time with patients
- Address the safety of residents and faculty
- Implement policies that encourage optimal resident well-being
- Provide access and educational tools regarding mental health assessment and outreach as needed

RESIDENT FATIGUE
“There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies. Each program must have policies that ensure coverage of patient care in these situations, and they must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.”

DUTY HOURS
“Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four week period, inclusive of all in-house clinical and educational activities, all work done from home, and all moonlighting.”
EXAMPLE

- Week 1 – 86 hours
- Week 2 – 86 hours
- Week 3 – 60 hours
- Week 4 – 60 hours

In this example, the resident goes over the “80 hours per week rule” for the first two weeks, but is overall in compliance with guidelines because it is really only 73 hours averaged out for the last four weeks.

DUTY HOURS

“Residents should have eight hours off between scheduled clinical work and education periods.”

“Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.”

“Residents must be scheduled for a minimum of one day in seven free of clinical work and education (when averaged over four weeks).”

DUTY HOURS

“Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.”

“Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions to care, and/or resident education.”
DUTY HOUR EXCEPTIONS

A resident may elect to remain or return to the clinical site in the following circumstances:

- To continue to provide care to a single severely ill or unstable patient
- Humanistic attention to the needs of a patient or family
- To attend unique educational events

*These still count toward the 80 hour weekly limit; the exceptions are mainly to the 24 hour continuous patient care rule

PATIENT HANDOFFS

Institute of Medicine estimates up to 100,000 patients die in U.S. hospitals annually due to errors in their care.

Failures in communication are a leading cause of adverse events in healthcare.

Issues around communication, continuity of care, or care planning cited as root cause in >80% of reported sentinel events.

PATIENT HANDOFFS

More turnover of patients and personnel
- Increasing use of night float
- Decreasing resident duty hours
- RN turnover and staffing concerns

Healthcare is more specialized
- Multiple specialists can be involved in a patient's care
- More providers taking care of patients at any given time
PATIENT HANDBOFFS
One of the leading causes of medical errors is a breakdown in communication
- Can occur at all levels

Effective communication is important to:
- Facilitate continuity of care
- Eliminate preventable errors
- Provide safe patient environment

CALLS TO IMPROVE HANDBOFFS
Joint Commission, 2006
- National Patient Safety Goal: A standardized approach to handoff communication

WHO, 2006
- Prevention of handover errors is part of the “high fives” patient safety solutions

Institute of Medicine, 2008
- Teaching programs should train residents in handoffs

EFFECTIVE HANDBOFFS
Transfer of patient information as well as responsibility from one clinician to another

Occurs at multiple times:
- Admission from ED to floor
- Resident to resident at shift change
- Consults

Exchange should be interactive, and provide a safe environment to ask questions and clarify information
POTENTIAL BARRIERS
Lack of time
Hierarchies
Defensiveness
Varying communication styles/language barriers
Distraction
Fatigue
Conflict

HANDOFF FEATURES
Physical environment must allow for effective communication
- Avoid noisy nursing stations

Standardization
- Use same order or template

Language
- Use standardized abbreviations
- Common terminology for specialty, i.e. PPROM, IOL, GDMA1

HANDOFF MODELS
I PASS the BATON
ANTICipate
SBAR
ISBARQ
5 P's
THE “5 P’S”
- Patient: name, how they identify, age, sex, location
- Plan: diagnosis, treatment plan, next steps
- Purpose: provide a rationale for the care plan
- Problems: other problems with this patient
- Precautions: differences/unusual things about this patient

THE OBSTETRIC HANDOFF
- Gravity/Parity
- Reason for admission
- Plan for induction or augmentation
- Things to “watch out for” during shift
- Pertinent medical history/medications
- Postpartum issues
- Other pertinent issues

OBSTETRIC HANDOFF EXAMPLE
MP is a 39 yo G1P0 at 37w4d who presented to triage today for
an NST and was found to have elevated blood pressures of
145/80 and 144/75 on repeat four hours later. We are inducing
her for gestational hypertension. Her pregnancy is
complicated by AMA. Her cervix is 1 cm dilated, 40% effaced,
and -3 station. She is being induced with misoprostol. FHT
have been reactive and reassuring and she is not contracting.
PreE labs and P:C ratio have been collected. She has been on
81 mg aspirin throughout this pregnancy for prevention of
preE, but is not taking any other medications. She is GBS
positive and will get penicillin prophylaxis in labor.
THE GYNECOLOGY HANDOFF

- Specific surgery and date it occurred
- Pain medication regimen
- Instructions for advancing the patient
- Incision care
- Medical history/home medications
- Disposition

POSTOPERATIVE GYN HANDOFF EXAMPLE

SF is a 37 yo G3P3003 patient who underwent robotic assisted total laparoscopic hysterectomy with bilateral salpingectomy today, indicated due to a history of AUB-L and chronic pelvic pain. The surgery was uncomplicated and EBL was 50 cc. She has norco and motrin ordered for pain control overnight. She has a history of anxiety on Lexapro, which is ordered for her. She has a foley in place that can come out tonight with adequate urine output. She has a regular diet ordered for her. Incisions are covered with dermabond. She should be able to go home tomorrow once the foley is out and she is able to urinate on her own. Prescriptions for discharge are already printed.

IMPORTANT NOTE

Your specific program will have a certain way and order in which they do handoffs, and it won’t always be like the previous examples. As long as it is effective and gets the point across in a way that is conscientious of patient care and creates the best possible outcome for the patient, that is what matters the most.

Be organized and concise. The incoming resident(s) should be able to “know the patient” after the sign out.