

# Technology Enhancing Hand-off Communication

Improving Caregiver Communication with Technology

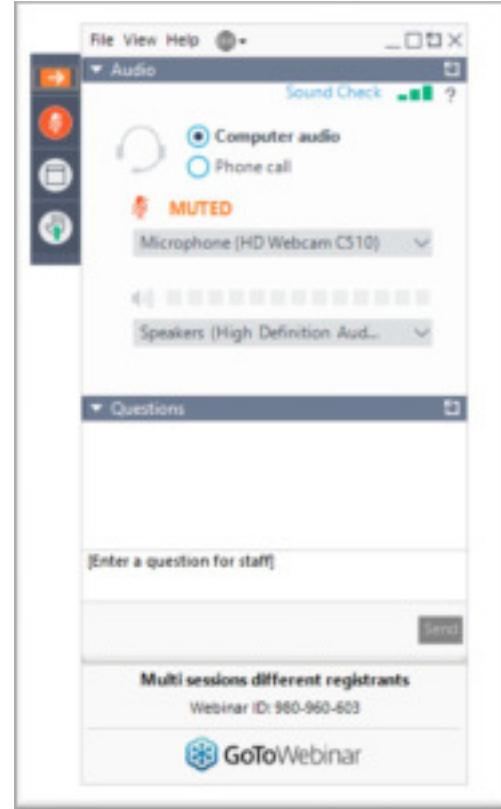
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September 25, 2019

By Dr. Alana McGolrick  
DNP, RNC-OB, C-EFM

# Questions

- A recording will be available following the webinar
- To ask a question during the webinar, enter your question into the chat box located in the GoToWebinar panel on the right side of the screen





# About PeriGen

- Comprehensive labor and delivery patient safety platform incorporating PeriGen's ***NICHD-validated Artificial Intelligence decision support tools***.
- ***Leveraging evidence-based medicine*** with 50 peer-reviewed publications: *American Journal of Obstetrics and Gynecology*, *Becker's Journal of Healthcare Information Management*.
- PeriWatch Vigilance® is an early warning system that works with an existing EFM to ***quickly & consistently*** identify patients who may be developing a potentially worsening condition.
- 330 clients nationally

# Disclaimer

- This presentation includes information from The Joint Commission and other sources (designated on the slides). The following studies were not conducted by PeriGen.

## Our Presenter

- Dr. Alana McGolrick
- DNP, RNC-OB, C-EFM
- PeriGen Chief Nursing Officer
- With significant perinatal experience, Dr. McGolrick leads PeriGen's efforts to expand and enhance clinical education, customer outcomes and publishing



# Agenda

- Background
- Contributing Factors
- Hand-off
- The Joint Commission
- Clinical Decision Support Tools
- Summary

# Objectives

At the conclusion of this program, the participant will be able to:

1. Demonstrate knowledge and understanding of communication failures in the health care environment.
2. Describe the foundations of effective hand-off communication.
3. Identify three major components of high-quality hand-off communication.



Do you feel comfortable leaving a loved  
one in the hospital?

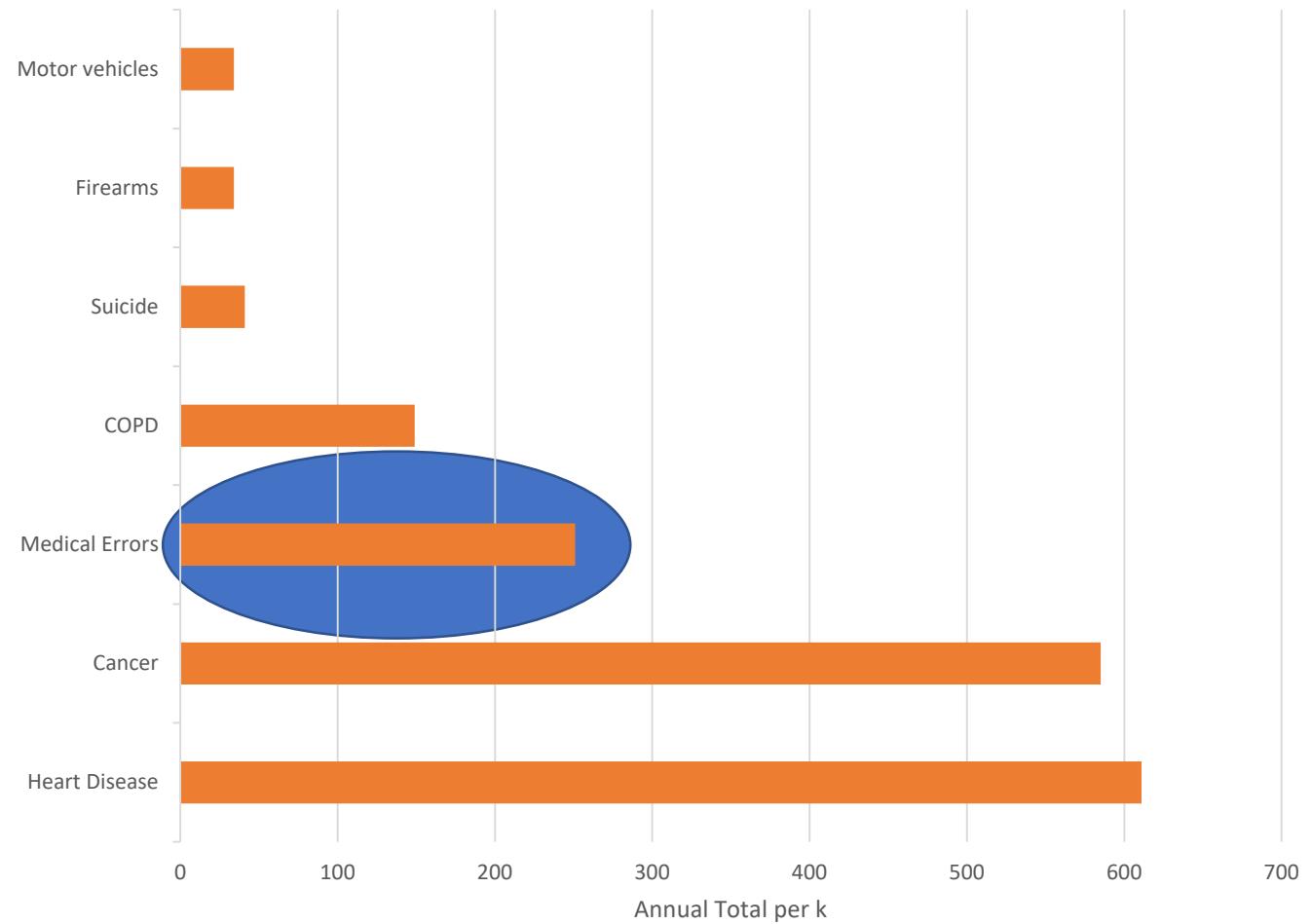
# Background

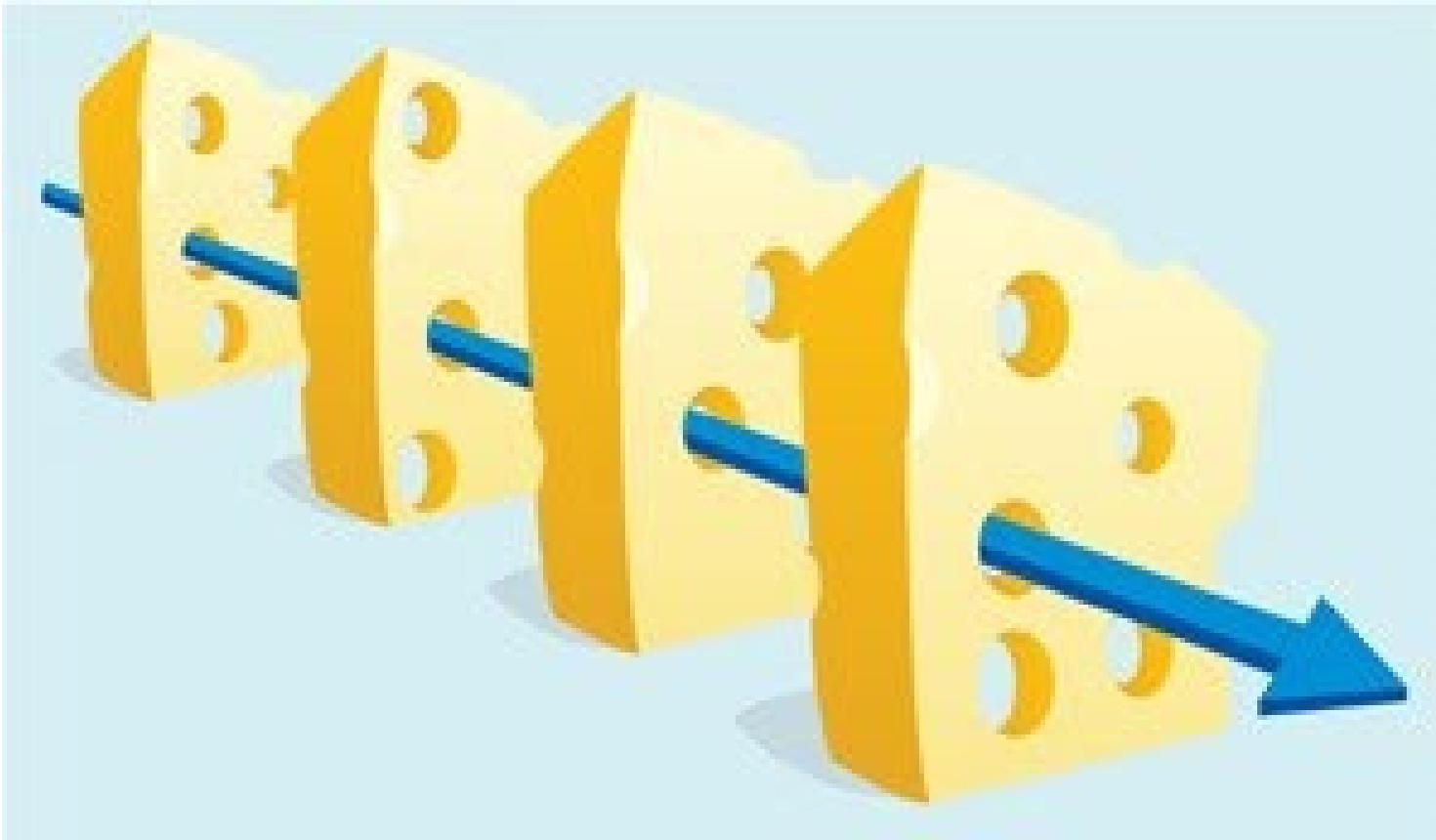
- Landmark publication ‘To Err is Human’
- 2016 study by CRICO
  - 1700 deaths
  - 30% malpractice cases
  - \$1.7 billion in malpractice costs
- 2019 The Joint Commission
  - Sentinel Event quarterly data
  - Inadequate hand-off communication

(CRICO Strategies, 2015; Kohn et al., 1999; The Joint Commission, 2014)

# The Numbers Don't Lie

Listed Cause of Death





## Falling Short

- Insufficient or misleading information
- Delays
- Interruptions
- Lack of standardization
- Staffing
- Non-compliance

(The Joint Commission, 2017)



## Change of Shift Report

- Written
- Oral
- Recorded
- Beside

## Hand-off

- Defined as:
  - Transfer of information
  - Acceptance of patient care responsibility
  - Via effective communication

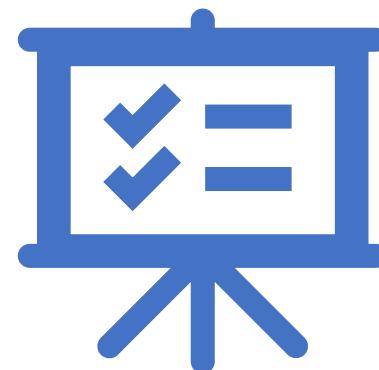
# Poll: What hand-off format do you use at your facility?

- SBAR
- Walking rounds
- Electronic check list
- Paper check list
- Other



# Poll: Do you have a formal hand-off staff education program?

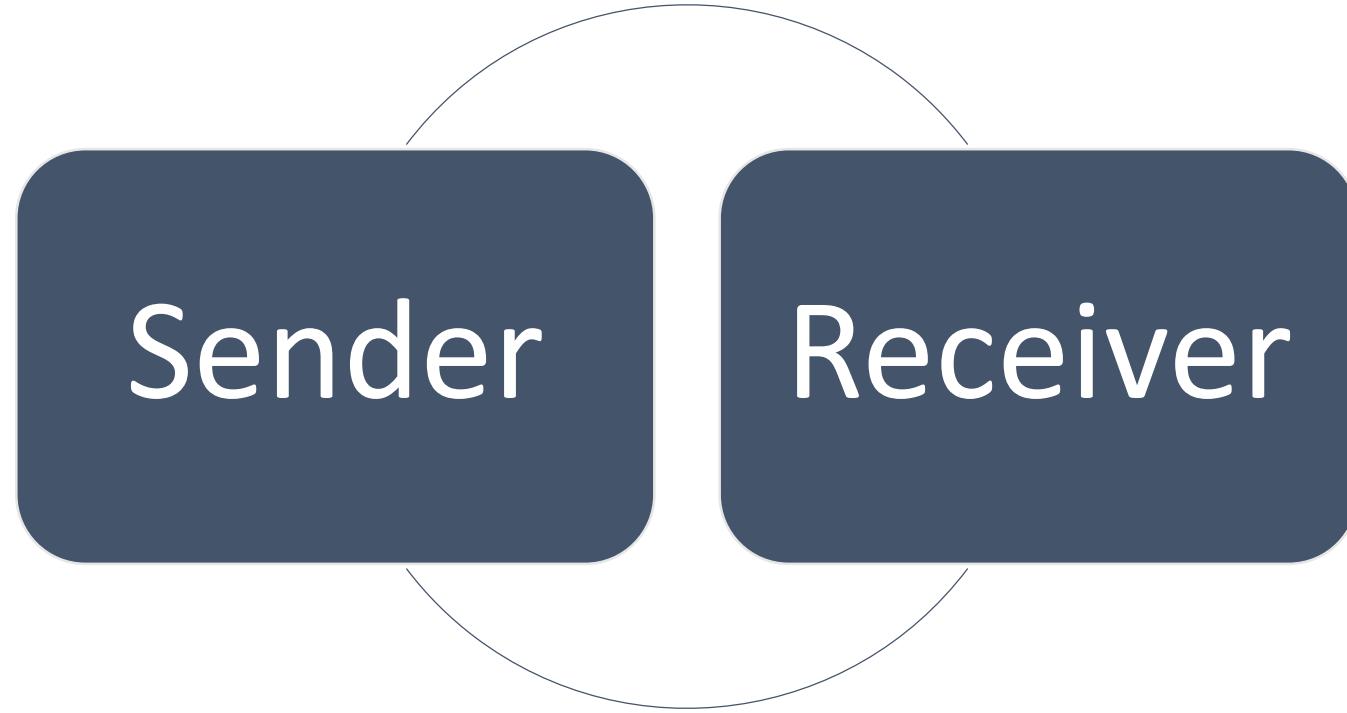
- Yes
- No
- Unsure



# Poll: How long should a hand-off last during patient transitions?

- 5 minutes
- 10 minutes
- 2 minutes
- No time limit





## The Delicate Balance

(The Joint Commission, 2017)



# Opportunity for Error



2006 National Patient Safety Goal



2010 Embedded as a Standard

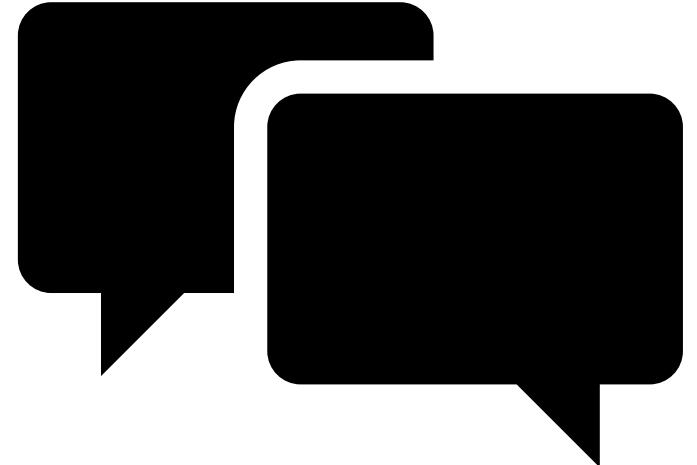


Provision of Care, Treatment, and Services

# The Joint Commission Timeline

# Achieving High Quality Hand-off

- Leadership support
- Standardize critical content
- Face-to-face hand-off
- Educate both sender and receiver roles
- Use technology
- Monitor the program
- Share success



(The Joint Commission, 2017)

# Clinical Decision Support Tools

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Simple calculator or processor designed to electronically assess the patient

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Provides clinically relevant patient information to the clinician

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Identifies at-risk patients

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Assist the clinician with decision-making

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Improves patient care outcomes and reduces error potential

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# Poll: Do you currently use clinical decision support tools at your hospital?

- Yes
- No
- Unsure



The right  
information

To the right  
person

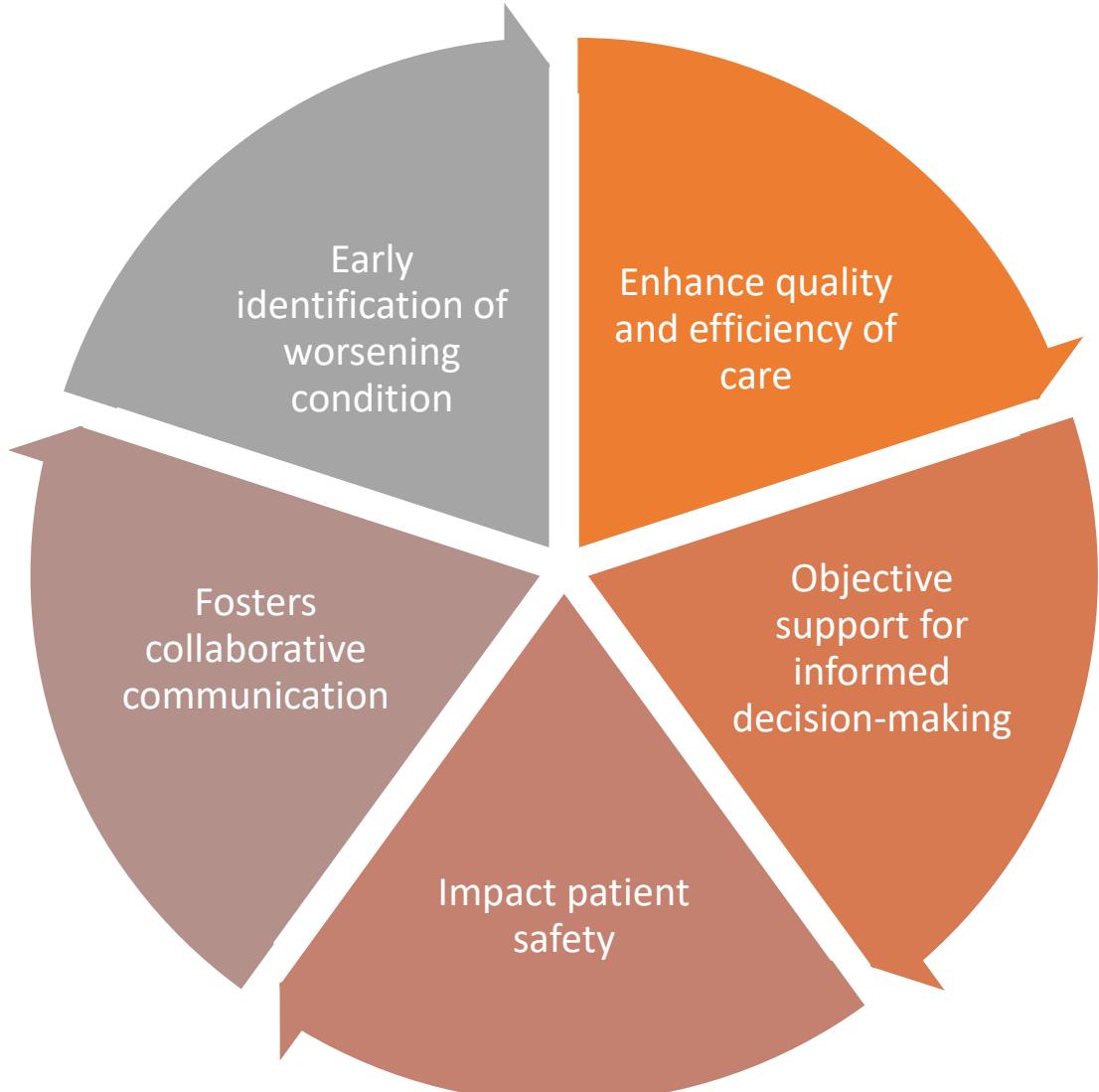
In the right  
intervention  
format

Through the  
right channel

At the right  
time in the  
workflow

# The 5 Rights

# Impact on Patient Care





PeriWatch Vigilance®

The background features a series of concentric circles in light blue, medium blue, and dark blue. A red wavy line, resembling an ECG or pulse trace, starts from the left, passes through the light blue circle, then the medium blue circle, and ends at the right edge of the dark blue circle.

# Single Patient Screen



Summary data

Event Marker indicates a specific type of event detected in the fetal tracing

15/30 min view

4-12 hour view

Slider window

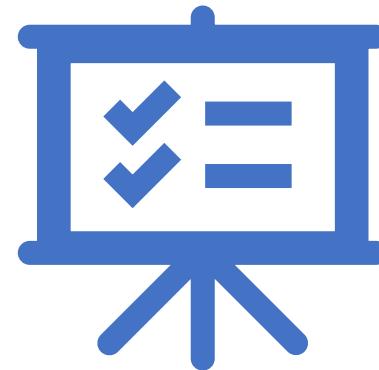
Patient status

Maternal vital signs

Labor progress

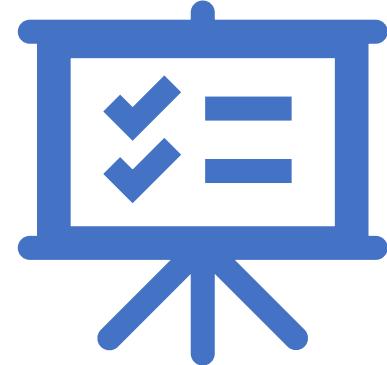
# Poll: Do you feel technology enhances patient hand-off?

- Yes
- No
- Unsure



# Poll: Would you like to talk to someone on our team 1:1?

- Yes, I would be interested in a demonstration to learn more
- Yes, I am a customer & want to see what's new
- Yes, I'd like to talk with the webinar speaker
- Thanks, but I'm good for now



## Summary

- Aim for high quality hand-offs
- Requires leadership, resources and reinforcement
- Concurrent assessment of process
- Establish expectations
- Utilize technology to remain objective

A survey will appear when the presentation has ended and in the follow up email.

**We value your feedback**

For presentation questions, contact  
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Thank You



# References

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*Available upon request*