**Handoffs - Questions**

1. Issues around communication include all of the following except:
   
   A. They are the lead contributor to sentinel events.
   B. Communication of information by a sender is often overestimated.
   C. The quality of communication is independent of the receiver.
   D. Communication causes more medical errors than clinical inadequacy.

2. What are some hand off strategies in medicine and other industries to improve safety and quality?

3. What is a sentinel event and what has been shown to contribute to these events?

4. What are important components of the written hand off? What are the important components of the verbal hand off?

5. What does the term “read back” refer to? How is it pertinent to hand offs? Is it crucial or just “icing on the cake”?
Handoffs – Answers

1. Issues around communication include all of the following except:
   Correct Answer: C. The quality of communication is independent of the receiver.
   Read back is the process by which the receiver repeats the salient points about the hand off to confirm that the receiver and sender of the information are on the same page. It is crucial to assure that what was meant to be communicated by the sender is heard by the receiver and ensures a shared mental model of the patient.

2. What are some hand off strategies that have been proven in other industries to improve safety and quality?
   Strategies that improve safety include: face to face communication, limited interruptions, updated printed summary, opportunities to ask questions, information relayed in a structured format, specific contingency plans, use of readback, delaying transfer of responsibility when there are concerns, unambiguous transfer of responsibility and scanning historical data before and after

3. What is a sentinel event and what has been shown to contribute to these events? What is the most common contributor to a sentinel event?
   A sentinel event is an unanticipated even that results in the death or serious physical or psychological injury to a patient and is not related to the natural course of the patient’s illness. The most common contributor in root cause analysis to sentinel events is failures in communication.

4. What are important components of the ideal hand off?
   One should include a brief one liner about the patient including pertinent past medical history, reason for admission and current condition. Next there should be a systematic approach to communicating the needed information including active problems and contingency planning with specific instructions. Finally there should be read back from the receiver with the opportunity to ask questions.

5. What does the term “read back” refer to? How is it pertinent to hand offs? Is it crucial or just “icing on the cake”?
   Read back is the process by which the receiver repeats the salient points about the hand off to confirm that the receiver and sender of the information are on the same page. It is crucial to assure that what was meant to be communicated by the sender is heard by the receiver and ensures a shared mental model of the patient.