Print "PDF version"

What's New in the Patient Safety World

February 2022

Communication Failures and Malpractice

It should come as no surprise that communication issues are a major contributor to malpractice claims, since communication issues are contributing factors in the majority of our root cause analyses into serious adverse events. But there has been little actual data published on the role of miscommunication in malpractice claims.

In a new study researchers reviewed a random sample of malpractice claims from 2001 to 2011, collected in CRICO Strategies' Comparative Benchmarking System, a national claims database (Humphrey 2021). They identified communication failures in 49% of claims. Moreover, claims with communication failures were significantly less likely to be dropped, denied, or dismissed than claims without (54% versus 67%, $P = 0.015$) and total costs were higher for those claims with communication failures. Of those claims with communication failures 53% involved provider-patient miscommunication and 47% involved provider-provider miscommunication. Communication errors among medical staff most often occurred between the attending physician and the nursing staff (37%), attending physicians between specialties (30%) and within a specialty (19%). Specific information types most frequently identified were contingency plans, diagnosis, and illness severity. The researchers found that **40% of communication failures involved a failed handoff and that 77% could potentially have been averted by using a handoff tool**.

The focus on handoffs is also not surprising, since the senior author of the study was Chris Landrigan, M.D., M.P.H., Co-Founder of the I-PASS Patient Safety Institute, whose work we have highlighted in our many columns on handoff issues (listed below). Handoffs occur between multiple types of healthcare providers and always represent potential opportunities for error. Handoffs should be done using structured formats, such as I-PASS or one of the other tools highlighted in the columns below. But equally important, handoffs should be conducted in a venue in which interruptions and distractions are minimized, ample time is allotted, and the receipient of the handoff is an active participant, asking questions and acknowledging important points.

Read about many other handoff issues (in both healthcare and other industries) in some of our previous columns:

May 15, 2007	"Communication, Hearback and Other Lessons from Aviation"
May 22, 2007	"More on TeamSTEPPS™"
August 28, 2007	"Lessons Learned from Transportation Accidents"
December 11, 2007	"Communication…Communication…Communication"
February 26, 2008	"Nightmares….The Hospital at Night"
September 30, 2008	"Hot Topic: Handoffs"
November 18, 2008	"Ticket to Ride: Checklist, Form, or Decision Scorecard?"
December 2008	"Another Good Paper on Handoffs".
June 30, 2009	"iSoBAR: Australian Clinical Handoffs/Handovers"
April 25, 2009	"Interruptions, Distractions, Inattention…Oops!"
April 13, 2010	"Update on Handoffs"
July 12, 2011	"Psst! Pass it on…How a kid's game can mold good handoffs"
July 19, 2011	"Communication Across Professions"
November 2011	"Restricted Housestaff Work Hours and Patient Handoffs"
December 2011	"AORN Perioperative Handoff Toolkit"
February 14, 2012	"Handoffs – More Than Battle of the Mnemonics"
March 2012	"More on Perioperative Handoffs"
June 2012	"I-PASS Results and Resources Now Available"
August 2012	"New Joint Commission Tools for Improving Handoffs"
August 2012	"Review of Postoperative Handoffs"
January 29, 2013	"A Flurry of Activity on Handoffs"
December 10, 2013	"Better Handoffs, Better Results"
February 11, 2014	"Another Perioperative Handoff Tool: SWITCH"
March 2014	"The "Reverse" Perioperative Handoff: ICU to OR"
September 9, 2014	"The Handback"
December 2014	"I-PASS Passes the Test"
January 6, 2015	"Yet Another Handoff: The Intraoperative Handoff"
March 2017	"Adding Structure to Multidisciplinary Rounds"
August 22, 2017	"OR to ICU Handoff Success"
October 2017	"Joint Commission Sentinel Event Alert on Handoffs"
October 30, 2018	"Interhospital Transfers"
April 9, 2019	"Handoffs for Every Occasion"
November 2019	"I-PASS Delivers Again"
August 2020	"New Twist on Resident Work Hours and Patient Safety"
September 29, 2020	"ISHAPED for Nursing Handoffs"
May 25, 2021	"Yes, Radiologists Have Handoffs, Too"

References:

Humphrey KE, Sundberg M, Milliren CE, et al. Frequency and Nature of Communication and Handoff Failures in Medical Malpractice Claims. Journal of Patient Safety 2021; December 15, 2021 - Volume - Issue -

https://journals.lww.com/journalpatientsafety/Abstract/9000/Frequency_and_Nature_of_Communication_and_Handoff.98936.aspx

I-PASS Patient Safety Institute
https://www.ipassinstitute.com/

The Truax Group
Healthcare Consulting
www.patientsafetysolutions.com

http://www.patientsafetysolutions.com/

Home

Tip of the Week Archive

What's New in the Patient Safety World Archive