You’re the patient. At what point in your ED care do you want to be particularly sure that everything goes right? At the end of a 24-hour shift, or maybe during a code next door? Not necessarily! It may be when your physician transitions your care to another physician. The handoff is one of the most error-prone processes in healthcare – including in the rural ED!

In 2006, the Joint Commission identified the root cause of all reported sentinel events (“An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.”). A whopping 65% were due to communication errors – more than any other factor! Dropping the communication baton is tragically common.

There are several rural ED care transition flash points, each with unique risks:

**Patients waiting to be seen by private physician** – The ED has a responsibility for the welfare of all patients physically present in the ED. A plaintiff successfully sued an ED on the basis of failure to act when a patient died from a ruptured aortic aneurysm while waiting in the ED to see the private physician.\(^1\)

**Between ED shifts** – Handoff patients at the bedside. ED physicians should not rush to leave at shift-end and oncoming physicians should be on-time out of respect to colleagues who have been up all night!

**Admissions to the hospital** – Admitting physicians should ideally see the patient in the ED (bedside handoff). Hospitals should have an established process for resolving disagreements between ED and admitting physicians regarding need for admission.

**Transfers to another hospital** – EMTALA mandates certain communications prior to transfer. Complete written ED records transferred with the patient (or transmitted) should support a succinct, yet thorough, telephone conversation with the accepting physician.

To minimize the patient health and liability risks associated with care transitions:

- Mandate bedside care transitions. Involve the patient in the history and subsequent plan story!
- Promote consistent communication techniques, such as SBAR (situation, background, assessment, and recommendation).\(^2\)
- Consider a policy that states all patients in the ED are to be evaluated by the ED physician unless the private physician is physically present.
- Empower the Chief of Staff to adjudicate (preferably in real time) any persistent disagreements regarding admission appropriateness.
- Document in the ED chart physician names and the care transition time.

Please forward this brief to your staff and colleagues. Also, please contact me with comments or questions at clintmack@cloudnet.com.
