SCRIPT

Welcome to Module 3 of the Safety Program for Perinatal Care-II (SPPC-II) Teamwork Toolkit. In this module, we will talk about communication and the various tools in the SPPC-II Toolkit for improving communication. We'll begin with a brief conceptual overview.

Communication is…

The process by which information is exchanged between individuals, departments, or organizations.

- Verbal or nonverbal
- The foundation of teamwork
- Effective communication skills are vital for patient safety

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Communication is the lifeline of a well-functioning team and serves as a coordinating mechanism for teamwork. Effective communication skills are vital for patient safety and interplay directly with other teamwork components, such as mutual support, and situational awareness, because it is the vehicle by which most teamwork tools and strategies are executed. Therefore, this module serves as the foundation to the other teamwork skills we present.

Communication is defined as the transfer or exchange of information from a sender to a receiver. More specifically, communication is a process whereby information is clearly and accurately conveyed to another person using a method that is known and recognized by all involved. It includes the ability to ask questions, seek clarification, and acknowledge the message was received and understood. One critical result of effective communication is a shared understanding between the sender and receiver(s) of the information conveyed.

Two considerations in communication are with whom and how you are communicating information.

- *With whom* you are communicating—that is to say, the audience—will influence how information is conveyed. For example, an information exchange with a lab technician may differ from an exchange with a physician.
- In terms of *how* you communicate, there are two major modes of communication: verbal and nonverbal.

We will cover standards of effective communication shortly. These relate primarily to verbal communication.

Nonverbal communication can take several forms. Written communication is common in healthcare. This form of nonverbal communication should adhere to many of the same standards we will discuss shortly. In addition, one should be mindful of standards associated with written communication, such as The Joint Commission's "Do Not Use" list of abbreviations.

More information about the "Do Not Use" List of Abbreviations can be found on The Joint Commission website.

Another form of nonverbal communication is body language. The way you make eye contact and the way you hold your body during a conversation are signals that can be picked up by the person with whom you are communicating. Body language plays a significant role in communication. In a face-to-face communication, words account for 7 percent of the meaning, tone of voice accounts for 38 percent of the meaning, and body language accounts for the remaining 55 percent. Although powerful, nonverbal communication does not provide an acceptable mode to verify, validate, or acknowledge the information exchanged.

A third form of nonverbal communication is visual cues. For example, the use of color coding for assignments, charts, scrubs, orders, and so on can help team members identify the information they need quickly.

To avoid making assumptions that can lead to error, you should verify in writing or orally any nonverbal communication, such as body language or visual cues, to ensure patient safety. The simple rule is, "When in doubt, check it out, offer information, or ask a question."

Ask: Can you provide examples from your work setting when nonverbal communication produced a breakdown in teamwork? Did you know the actual intent of the person?

Instructor Note: If responses to the questions above do not provide sufficient examples, the one below may be read aloud to participants.

- ***Examples:*** The nonverbal cues an emergency department doctor gives when looking at an electrocardiogram would quickly tell the nurse the severity of the situation and might lead to proactive action. Likewise, the nonverbal cues from the nurse's face might communicate the urgency of the situation and need for interruption to a doctor who is with a patient's family members.

Maternal and Perinatal Deaths and Injuries 2004-2015[1,2]

Top 5 Root Causes	Maternal Events (N = 131)	Perinatal Events (N = 348)	Op/Post-op Complication Events (N = 924)
Human Factors	97%	100%	88%
Communication	95%	100%	87%
Assessment	66%	100%	69%
Leadership	50%	77%	54%
Information Management	21%	20%	19%

Note: The majority of events have multiple root causes, so percentages may be greater than 100%.

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Human factors and communication breakdowns are identified as the primary root cause of maternal and perinatal deaths and injuries. According to The Joint Commission, these errors are reported over 80 percent of the time and represent the majority of repairable defects within the labor and delivery (L&D) unit.

Human factors refer generally to employee competency and staffing concerns. They specifically include staffing levels, staffing skill mix, staff orientation, in-service education, competency assessment, staff supervision, resident supervision, medical staff credentialing/privileging, medical staff peer review, other (e.g., rushing, fatigue, distraction, complacency, bias).

Communication causes capture breakdowns in oral, written, or electronic exchanges among staff, with and among physicians, with administration, and/or with patient or family members.

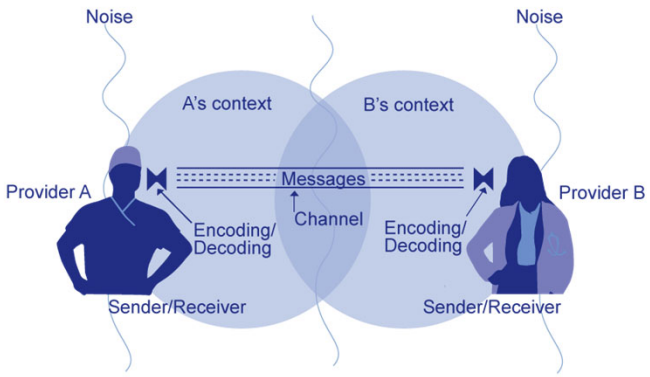
Other root causes for maternal and perinatal deaths and injuries are—

- Assessment (i.e., the adequacy, timing, or scope of assessment; pediatric,

psychiatric, alcohol/drug, and/or abuse/neglect assessments; patient observation; clinical laboratory testing; and care decisions),

- Leadership (i.e., organizational planning, organizational culture, community relations, service availability, priority setting, resource allocation, complaint resolution, leadership collaboration, standardization [e.g., clinical practice guidelines], directing department/services, integration of services, inadequate policies and procedures, non-compliance with policies and procedures, performance improvement, medical staff organization, nursing leadership),
- Information management (i.e., information management needs assessment, confidentiality, security of information, data definitions, availability of information, technical systems, patient identification, medical records, aggregation of data),
- Physical environment (i.e., general safety, fire safety, security systems, hazardous materials, emergency management, smoking management, equipment management, utilities management),
- Continuum of care (i.e., access to care, care setting, continuity of care, transfer of patient, and/or patient discharge)
- Care planning (i.e., planning and/or collaboration), and
- Medication use (i.e., formulary, storage/control, labeling, ordering, preparing/distributing, administering, and/or patient monitoring).

Basic Components and Process of Communication[3]



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Communication, both verbal and nonverbal, is complex and subject to distortion or misinterpretation as it is encoded and decoded between communicators. In verbal communication, ideas are first encoded, or created, when the sender speaks to the receiver. The receiver then decodes, or interprets, the message. The interpretation is affected by the context, auditory distractions, and the individual makeup of the participants involved in the conversation.

These seemingly insignificant elements comprise the overall communication system in which providers share information, ideas, and needs within the healthcare setting. Each aspect is interconnected and dependent on the influences and composition of the others, meaning a distraction or malfunction in the encoding process or any other component in the model impairs decoding and understanding.

The background and physical environment of the communicators influences the distribution and receipt of messages. Individuals are unique, and their experiences dictate how messages are created, shared, and understood. Knowing this, individuals in healthcare settings can affect the outcome of their interaction with

colleagues by realizing how to effectively share ideas and comprehend those of others.

Standards of Effective Communication

- Complete
  - Communicate all relevant information
- Clear
  - Convey information that is plainly understood
- Brief
  - Communicate the information in a concise manner
- Timely
  - Offer and request information in an appropriate time frame
  - Verify authenticity
  - Validate or acknowledge information

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Effective communication is complete.

- It communicates all relevant information while avoiding unnecessary details that may cause confusion.
- It allows time for patients and staff to ask and answer questions completely.

Effective communication is clear.

- It uses plain language, such as layman's terms, that patients and their families can easily understand.
- It uses common or standard terminology when communicating with team members.

Effective communication is brief and concise.

- Provide information that is brief, yet as complete as possible. Do not overexplain the situation; be concise.

Effective communication is timely. Consider ramifications of delayed communication.

- It offers and requests information.
- It avoids compromising a patient's situation by promptly relaying information.
- It notes times of observations and interventions in the patient's record.
- It updates patients and families frequently.
- It verifies the recipient received the intended message.
- It validates or acknowledges information received.

Ask (time permitting)**:** What could affect communication among team members?

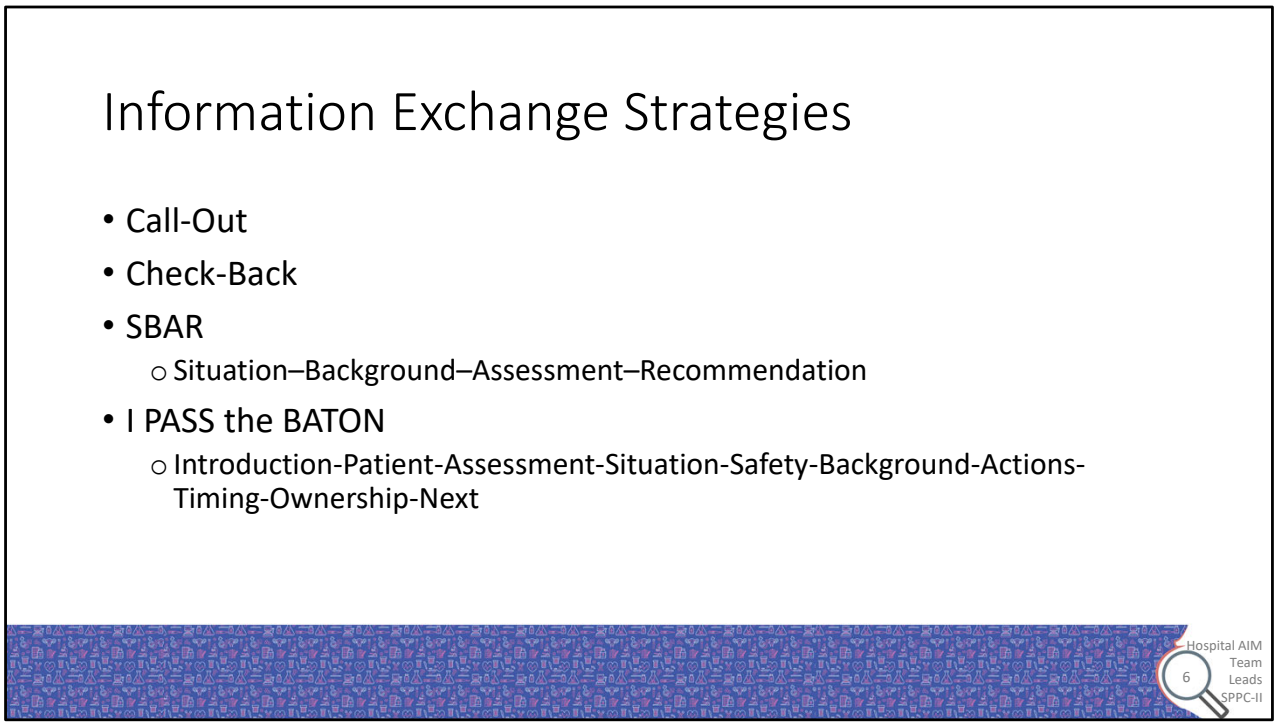
- Tip: You may wish to create a list of answers to the question on a flip chart and then compare those to the challenges listed on the next slide.

Example 1**:** applying the four elements of effective communication to a recommendation to proceed with a cesarean section for a laboring patient:

- Complete—it includes the medical reason for recommending a cesarean section and risks associated with not proceeding to a section;
- Clear—It is conveyed using plain language and avoiding medical jargon;
- Brief—It contains only the necessary information; and
- Timely—It is communicated to the patient as soon as possible after the decision has been made by the attending physician.

Example 2: A well-written discharge prescription is:

- Complete—It includes medication, dosage, and frequency.
- Clear—It is clearly written and legible.
- Brief—It contains only the necessary information.
- Concise—It is written before discharge and filled when the patient is ready to leave the hospital.



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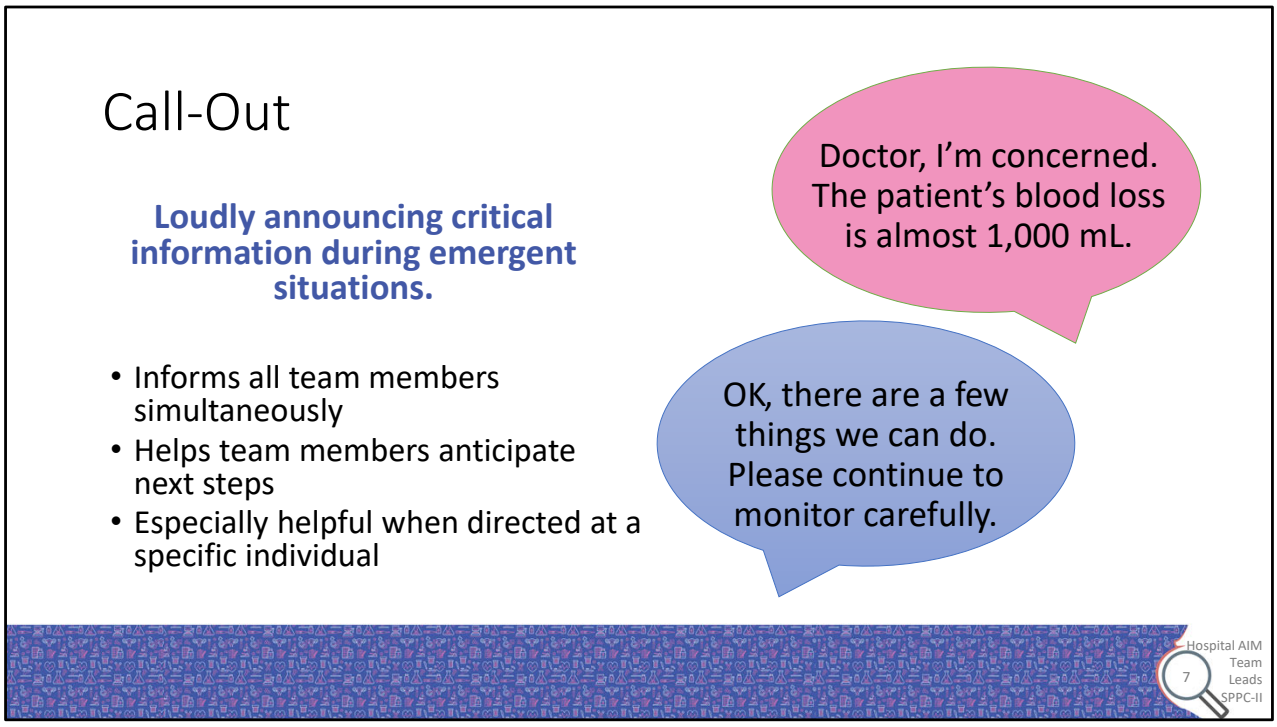
In this module, we will discuss the following four information exchange strategies:

- Check-Backs
- Call-Outs
- Situation—Background—Assessment—Recommendation (SBAR)
- I PASS the BATON.

Each of these communication strategies are simple to integrate into daily practice yet have been shown to improve team performance. They do so by helping to reduce errors associated with miscommunication and failure to share relevant and critical information.



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A call-out is a tactic used to convey critical information during an emergency. Critical information audibly announced in these situations helps the team anticipate and prepare for vital next steps in patient care. To assist with follow-through and attention to information shared in a call-out, direct the information to a specific individual.

For example, a nurse may say to an obstetrician, "Doctor, I'm concerned. The patient's blood loss is almost 1,000 mL." This is an example of a call-out. To close the loop, as you'll learn next, the doctor may reply, "OK, there are a few things we can do. Please continue to monitor carefully," or proceed with providing additional orders to manage the hemorrhage.

On your unit, what information would you want called out?

When To Use a Call-Out

- Whenever information needs to be urgently communicated
- As an emergent event unfolds
  - E.g., when there are signs of a patient beginning to hemorrhage
- Updates during emergent events
  - E.g., call-out when hemorrhage exceeds 1,000 mL

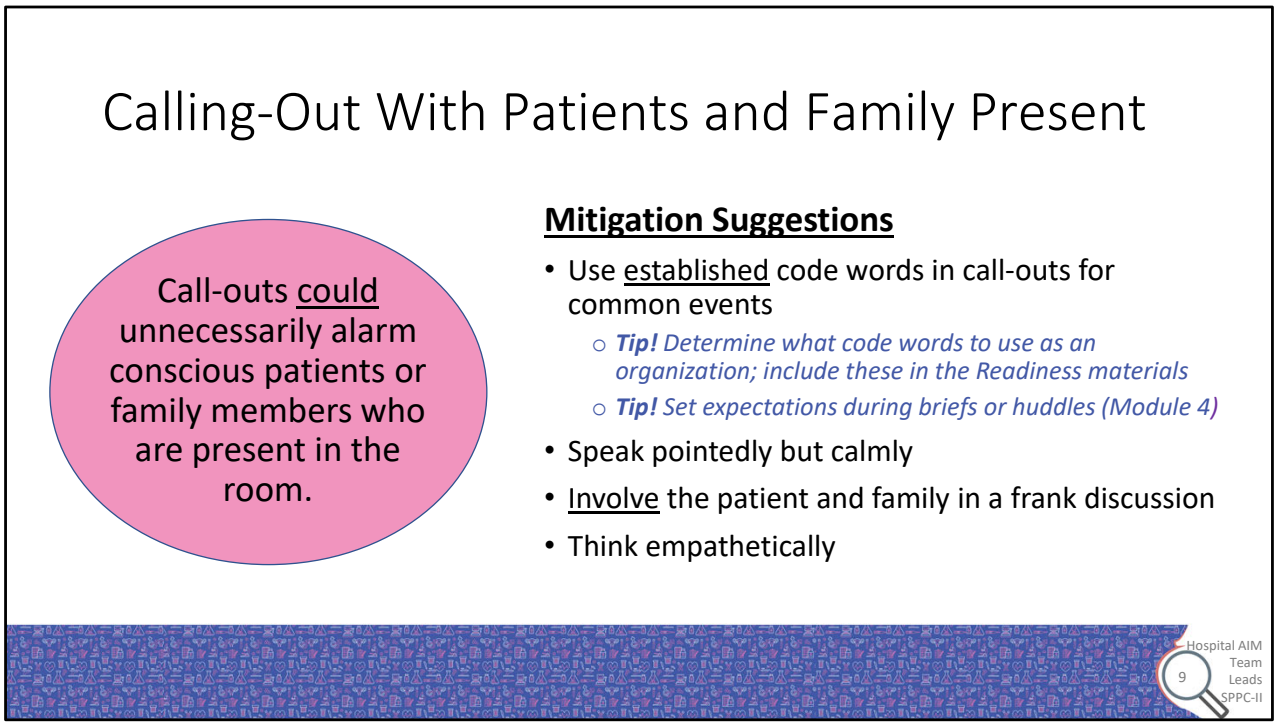
Tip! Pair call-outs with assertive statements, power words, and the two-challenge rule to really drive home your message (see Module 5)

SCRIPT

Call-outs aren't a tool that you'll necessarily be using on a daily basis, but they are ones that are useful under certain circumstances. Because the nature of the call-out is to relay critical information *immediately*, call-outs are most helpful during emergent events, such as a hemorrhage, and when team members are co-located. Even if team members aren't co-located, the spirit of a call-out is maintained when you immediately relay your observations to your team members as directly and quickly as soon as you notice something awry.

Call-outs will continue to be useful as events unfold, particularly once a rapid response team is present or the primary care team members are all co-located and attending to the patient together. In these moments, call-outs ensure that the entire team hears the same information simultaneously and are able to adapt quickly.

In the event of a hemorrhage, it's recommended to always call-out when blood loss exceeds 1,000 mL. While every case is unique and 1,000 mL for some cases, like C-sections, may not be out of the realm of normal, it is still wise for the team to have awareness by the time hemorrhage reaches 1,000 mL.



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One critical point to discuss is the appropriateness of using a call-out when family is present. While patient safety will always take precedence, you can run the risk of unnecessarily alarming the patient or the patient's family if you use a call-out in their presence, while they are awake and conscious. Aside from spiking their fears, it's possible that the resulting worry might add to the confusion and noise of what is going on in the room, especially if there is an emergency.

Therefore, we highly encourage you to consider the use of code words. Your organization may already have certain codes you use for common events. Definitely continue to use these. If you don't, consider suggesting to your department that they decide on uniform code words and include them in the Readiness materials of the 4 Rs package. If you choose to use code words, it is critical that they are used consistently and that all staff understand what they mean.

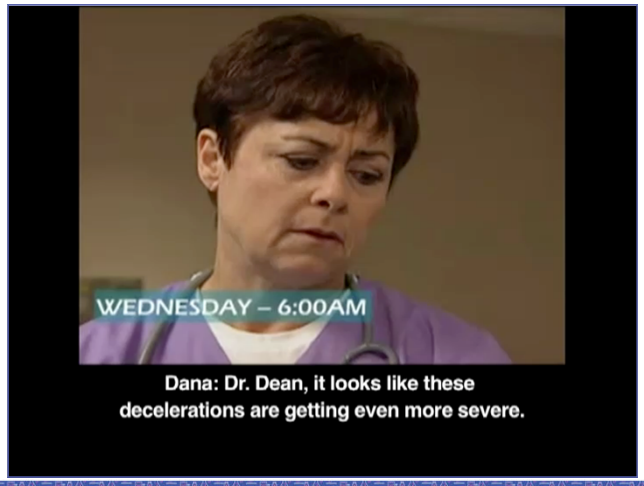
In cases where no standard codes already exist, consider discussing with your colleagues how to appropriately communicate information to each other when a family member or patient is present. Huddles and briefs are a great opportunity for having these conversations. We will discuss Huddles and Briefs in Module 4.

Although the traditional model is to immediately send the family out when an emergency is unfolding, many places are moving to allowing the family to stay. In these cases, it is essential to have a clinician communicate with them honestly and transparently. A physician or nurse should speak with them as the call-out is occurring, explaining the situation, what the risks are, and what is being done about the problem, so that they know what to expect and how to behave. Of course, there may be situations in which it is more appropriate to ask family to leave the room. However, even in these cases it's important to keep the worried family in the loop as events unfold, whether they are in the room or not.

In the end, thinking and acting empathetically towards the patient and her family are essential. If you find yourself having to use a call-out in front of a patient, always prioritize her care. It may involve speaking assertively but calmly so that, even if there is a concern, the patient and the family also remain calm as they will be looking to you for clues regarding the severity of the situation.

Call-Out Demonstration

Click video to watch



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In this short clip, you will see the nurse, Dana, demonstrate a call-out during labor. Notice how Dana communicates critical information to the physician as she becomes aware of it. Please note the technique is the focus, as the event is not an obstetric hemorrhage event.

Assessing the Team's Call-Outs

- Team members verbally confirmed critical information
- The team was anticipating future actions
- Information was directed by name for response and feedback
- Sense of urgency but professionalism

What else did you see?

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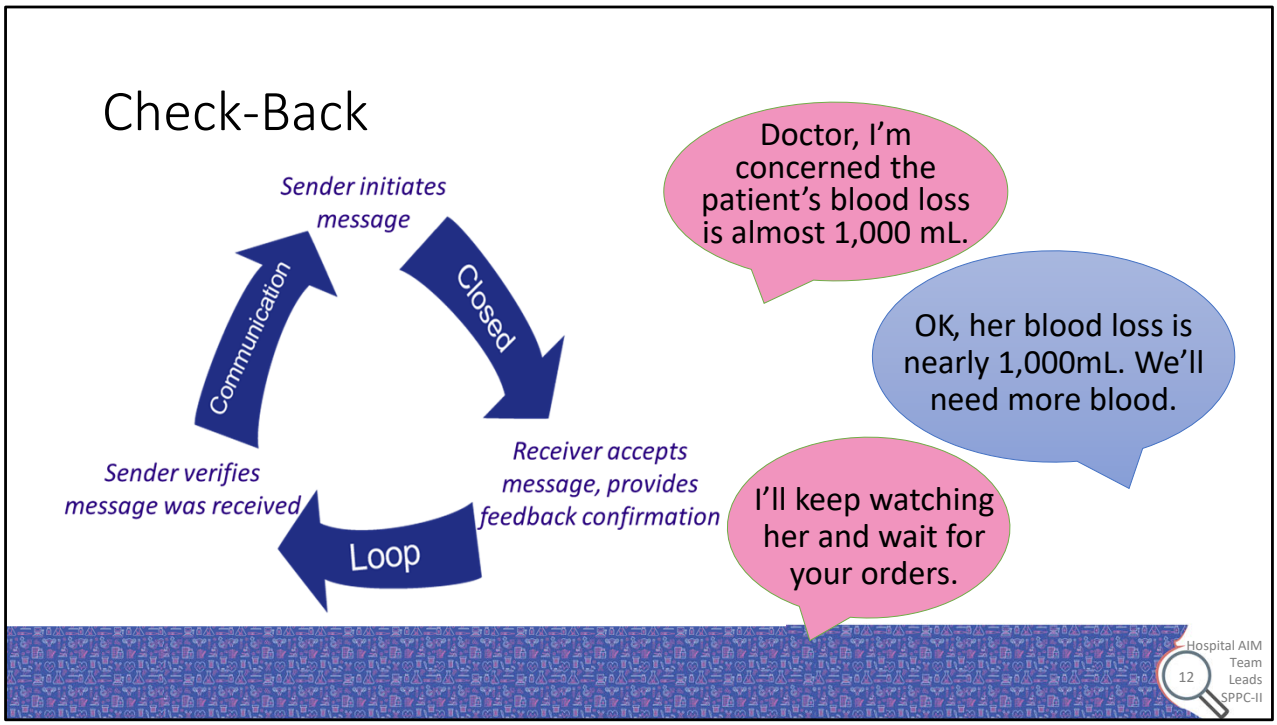
How did the call-outs made by the nurse and intern aid the team during this emergent labor and delivery event?

- Team members verbally confirmed critical information about the presence and duration of decelerations.
- The team was anticipating future actions, including a possible C-section and call to attending.
- Information was directed by name to Dr. Dean for response and feedback.
- Team members communicated a sense of urgency but also calmness and professionalism.

Did you notice anything else?



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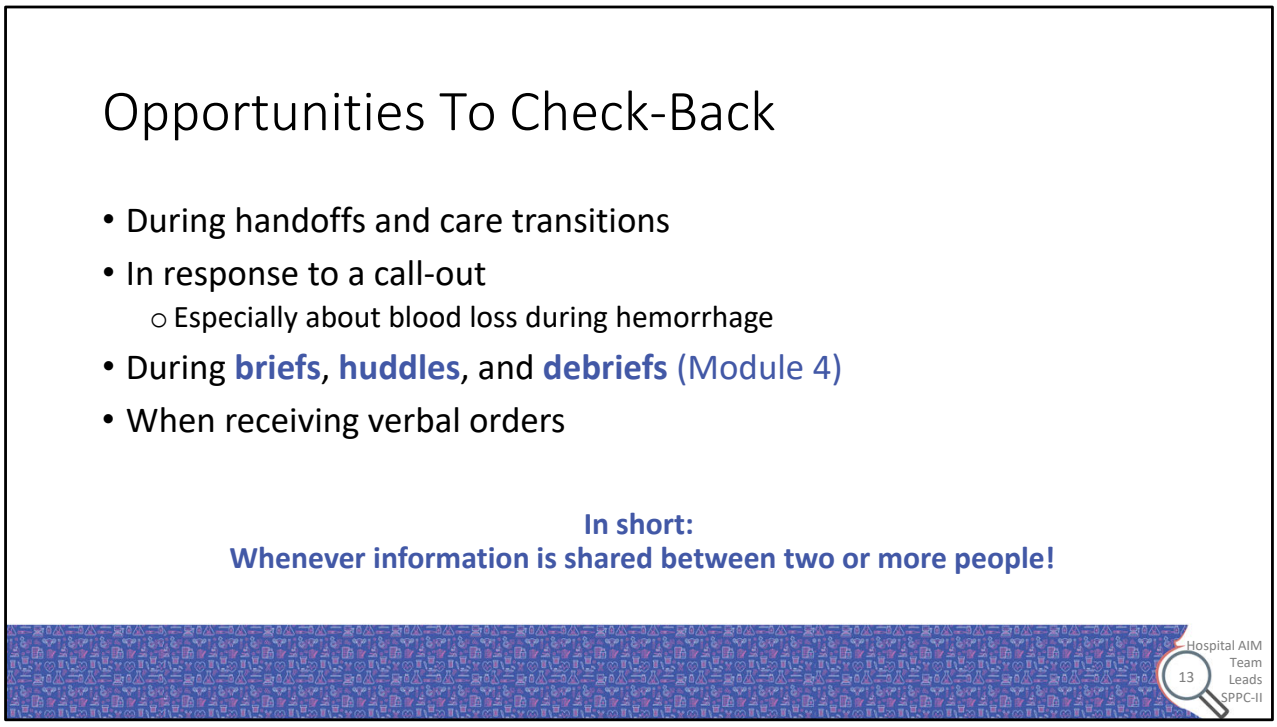
A check-back is a closed-loop communication strategy to verify and validate information exchanged between two people. The strategy entails the sender initiating a message, the receiver accepting the message and confirming what was communicated, and the sender verifying the correct message was received.

As an example, the message sender calls out information about the patient's status by saying, "Doctor, I'm concerned blood loss is approaching 1,000 mL." The receiver acknowledges receipt of this message by confirming the information by saying, "OK, her blood loss is nearly 1,000mL. We'll need more blood." The sender can now verify the correct message was received or otherwise clarify the original message further. By the end of this cycle, the sender and receiver both know information was communicated correctly.

A check-back is an effective tool for all members of the team, including patients and their family members. For example, patients and families can use the check-back to verify the receipt of care instructions or confirm understanding of which symptoms to monitor.

Check-backs create a critical opportunity to confirm that everyone involved in the conversation is on the same page. If they are not on the same page, check-backs give the sender a chance to clarify the message until everyone has a similar understanding.



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Unlike call-outs, check-backs have a wide range of applications and are a handy tool that you will likely use constantly both in your daily clinical practice as well as personal life. You may even already be doing this naturally on your own, as it's a fairly simple strategy for confirming that you understood what someone has told you.

When talking about patient care and clinical practice, you will find check-backs are particularly helpful in these situations:

- Use a structured communication strategy like SBAR during handoffs and care transitions and confirm that you have understood the information using a check-back. You may also use the check-back as an opportunity to clarify points of confusion.
- It's also essential to use a check-back as a response to a call-out so that everyone knows that the message was heard and understood. During a hemorrhage event, it's especially important to acknowledge and confirm you have heard the blood loss measurement correctly.
- Briefs, huddles, and debriefs are other rich opportunities to employ a check-back as a lot of information and planning occur during these team meetings. Check-backs will ensure that you and the entire team have a shared cognitive map and similar understanding about how to proceed by the end of these

meetings. You will learn more about briefs, huddles, and debriefs later today when we reach Module 4.

- Confirming verbal orders is essential, especially to make sure that you didn't mishear or misspeak the orders. It's a simple and quick means to prevent a medication error.

In short, use a check-back whenever information is shared between you and another team member. Get in the habit of feeling comfortable repeating information to your teammates and prompting them to use check-backs with you. If possible, it's helpful to restate the information slightly differently, in the way you understood it so your team mate can confirm the information was received as intended.

Note:

- SBAR is covered later in this module.
- Briefs, Huddles, and Debriefs are covered in Module 4.

Check-Back Demonstration

Click video to watch

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This video will demonstrate what a check-back might look like in practice. Please be aware that the scenario is unrelated to an obstetric hemorrhage event. Focus on the technique rather than the context. As you watch, observe who the team members are, how they completed the check-back, and what communication errors they avoided

Check-Back Video Discussion

- Who were the team members involved?
- How did they complete the check-back?
- What communication errors were avoided?

Discussion:

Who was the sender? Who was the receiver?

Pharmacist was the sender.

Resident was the receiver.

How did the sender and receiver "close the loop"?

The pharmacist says, *"correct."*

What communication errors were avoided?

Pharmacist did not rely on memory to give correct dosing information.

Resident wrote the exact dosing instructions to avoid depending on memory and could check back using notes since the dosing was more complicated by dilution.

Errors caused by misunderstood dosage amounts or drugs with similar-sounding names were avoided.

Check-Back Discussion Answers

- Who were the team members involved?
  - Sender = pharmacist
  - Receiver = resident
- How did they complete the check-back?
  - Resident repeated the order; pharmacist confirmed
- What communication errors were avoided?
  - Did not rely on memory
  - Avoided misunderstandings and miscommunications

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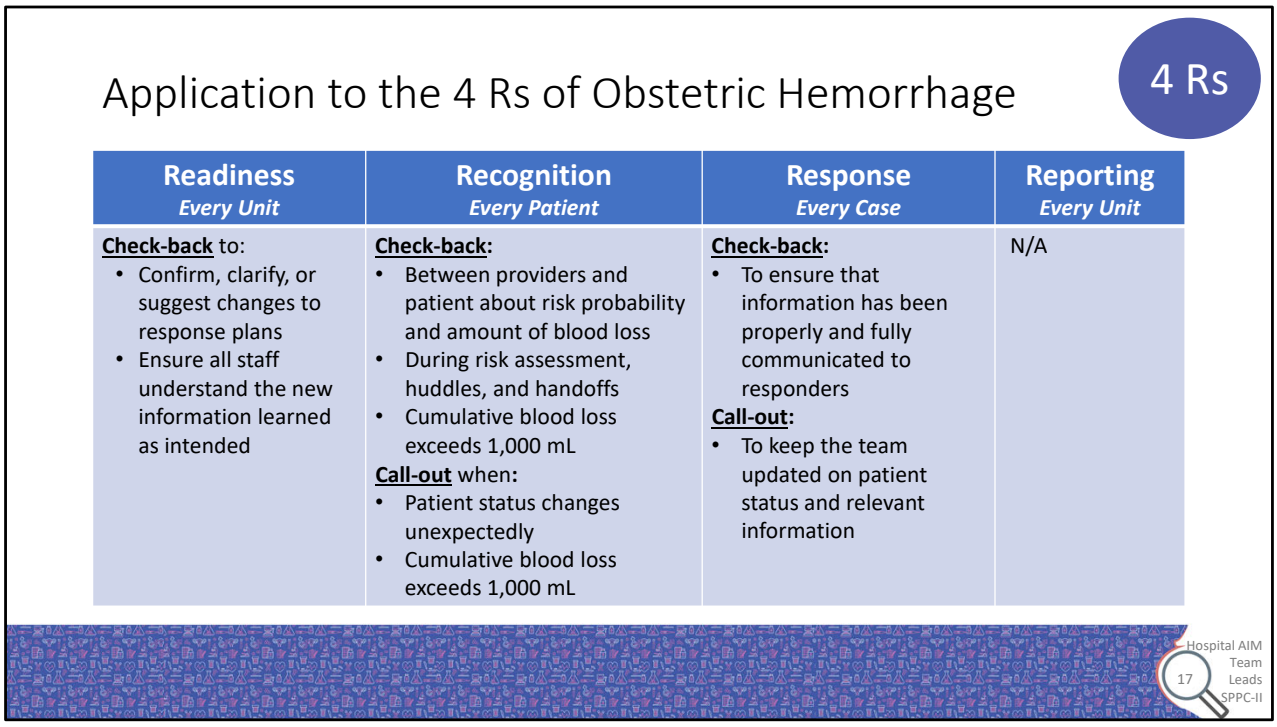
In the demonstration, the pharmacist was the sender who initiated the conversation. The resident was the receiver. In order to ensure that the information the pharmacist communicated was understood as intended, the resident repeated the orders back to the pharmacist, who closed the loop with a verbal assurance that the order had been understood. Had the resident misunderstood the order, the pharmacist would have offered correction until he could confirm the resident had the same understanding.

Communication errors were further avoided in that neither the pharmacist nor the resident relied on memory. The pharmacist used notes to give correct dosing information and the resident wrote down the exact dosing instructions. The use of notes was especially helpful as dosing was more complicated by dilution. Furthermore, errors caused by misunderstood dosage amounts or drugs with similar-sounding names were avoided.



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Because there are many opportunities to use call-outs and check-backs across numerous situations, these two tools are useful at nearly every point in the 4 Rs framework. Check-backs are especially useful at every step because we can always benefit by restating the information we receive in a way that signals to our teammates that we have understood and provides them with an opportunity to correct us if and when we've misunderstood or confirm that we are all on the same page. This strategy applies from planning, preparing, responding, and learning.

Call-outs may be a little bit more limited in their direct applicability within the 4 Rs framework. While it's always important to share critical information in a timely manner, call-outs will be especially helpful in the recognition and response to an unfolding event. They are most effective when all or the majority of team members are in the same space and able to hear a team member's call-out.

At the readiness stage:

Check-back to:

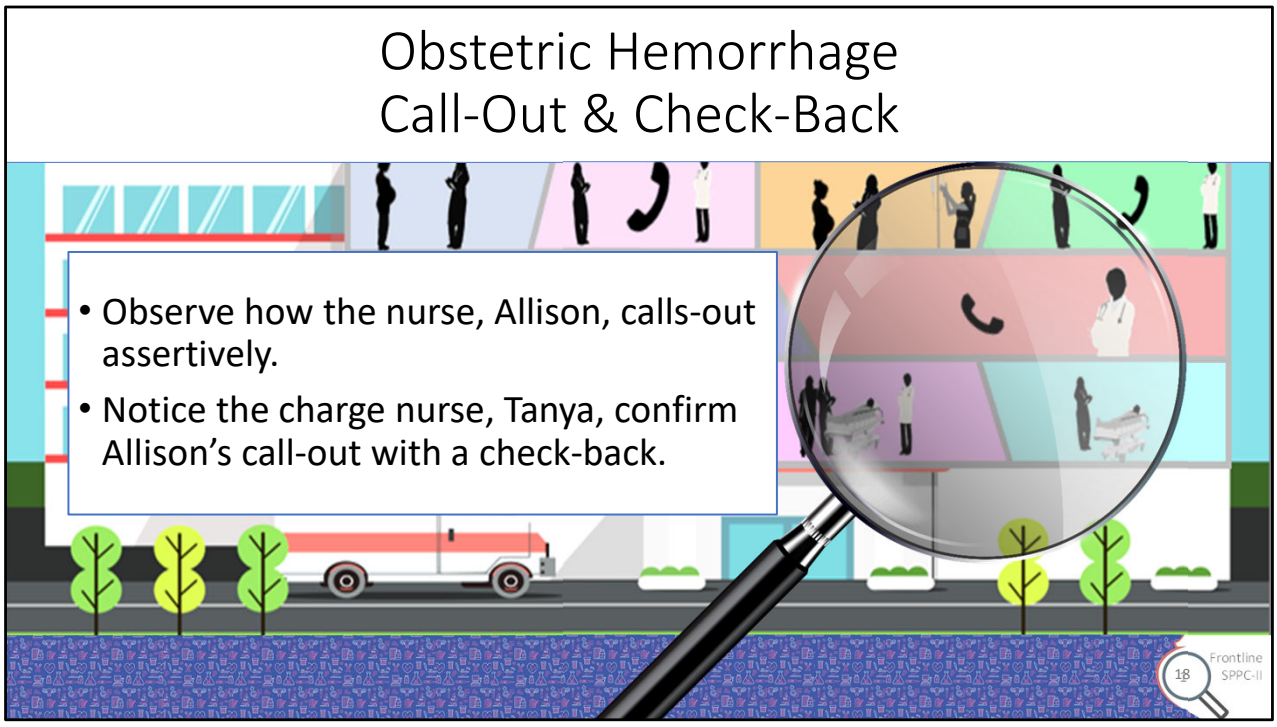
- Confirm, clarify, or suggest changes to response plans
- Ensure all staff understand the new information learned as intended

When recognizing a hemorrhaging patient:

- Use check-backs between providers and the patient during risk assessment and when communicating risk probability, and amount of blood loss
- Use check-back to confirm or clarify information communicated during handoffs or huddles
- Use call-outs when patient status changes unexpectedly
- Use call-out and check-back when cumulative blood loss exceeds 1,000 mL

When responding to a hemorrhage case:

- Use check-backs with responders to ensure that information has been properly and fully communicated
- Use call-outs during the incident response to keep the team updated on patient status and relevant information



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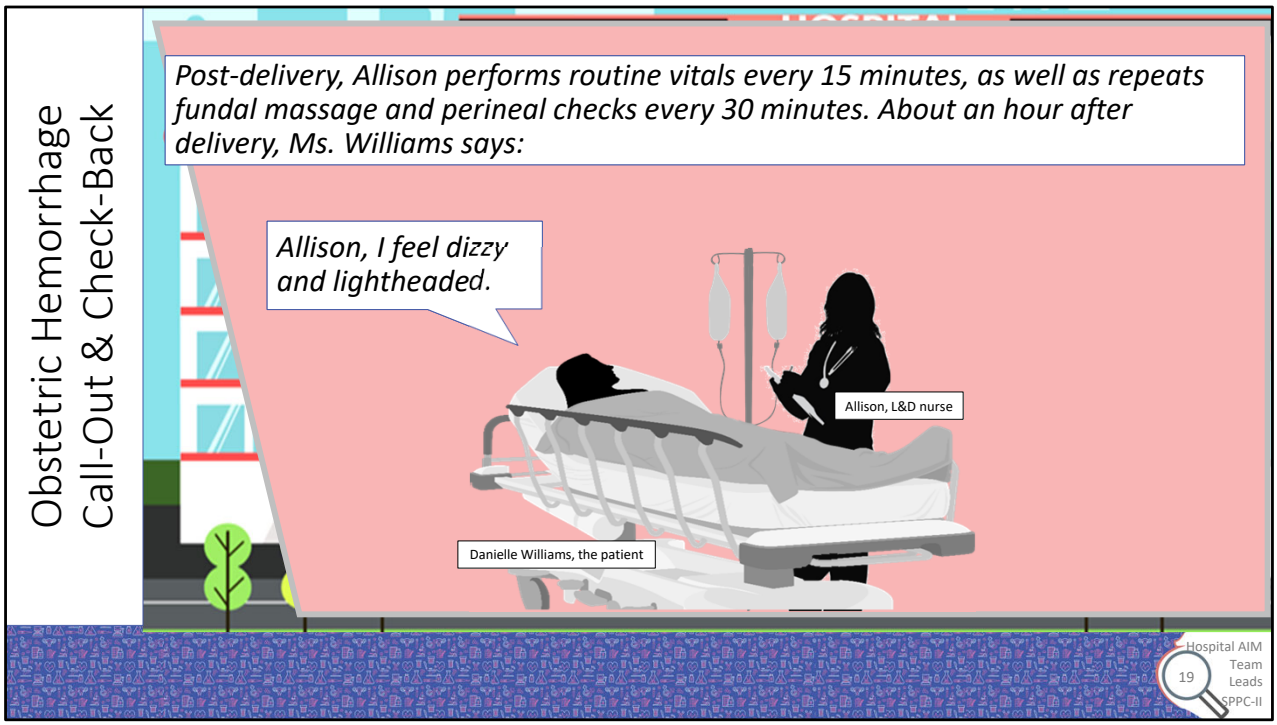
The next few slides are a deeper dive into a section from the obstetric hemorrhage master scenario that you saw in the introduction module (Module 1). Observe how the nurse, Allison, calls-out assertively. Then notice the charge nurse, Tanya, confirm Allison's call-out with a check-back.



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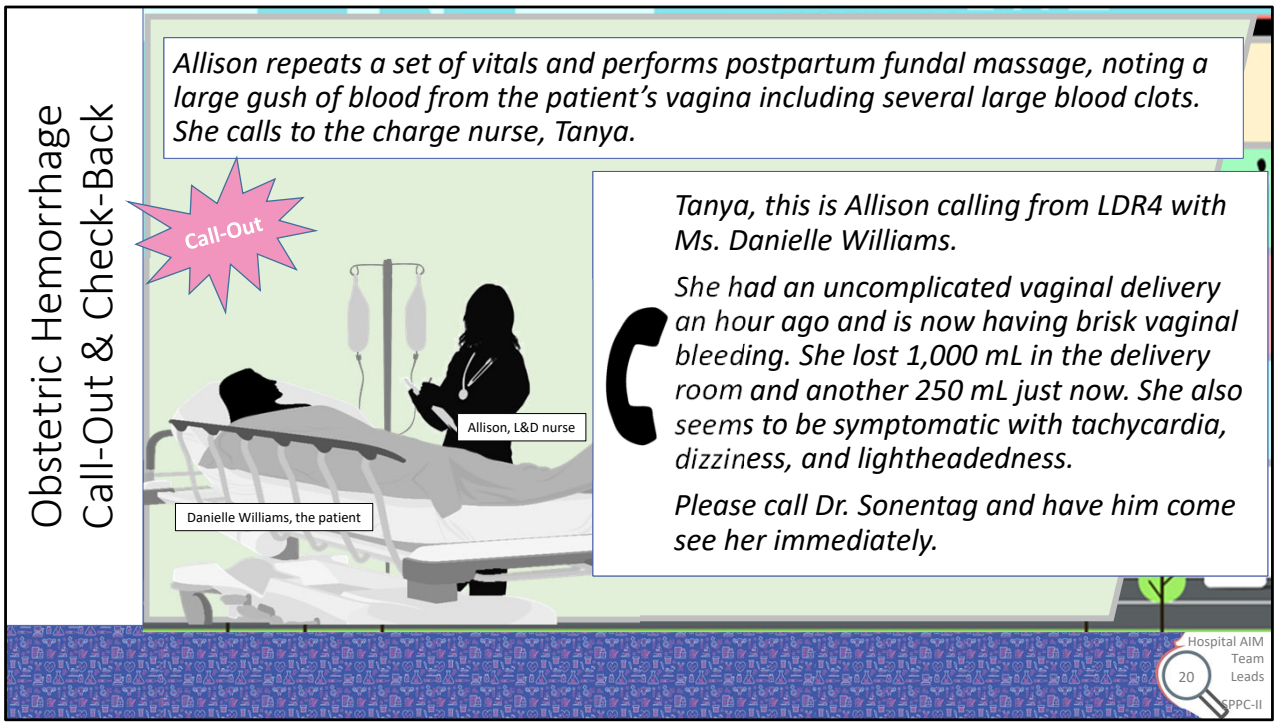
To refresh your memory, after Ms. Williams delivers, Allison performs routine vitals every 15 minutes, and repeats fundal massage and perineal checks every 30 minutes. About an hour after delivery, Ms. Williams mentions that she is feeling slightly dizzy and lightheaded, signs consistent with possible hypovolemia and hemorrhage.



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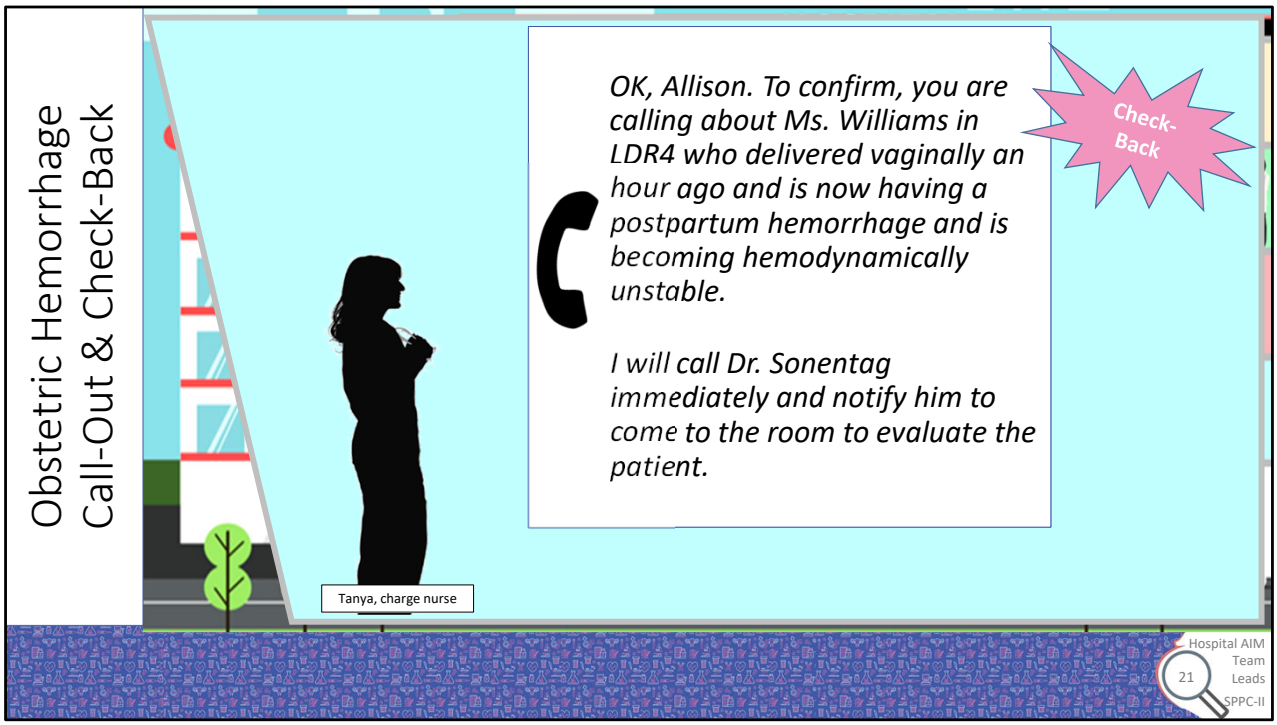
Allison repeats a set of vitals and performs postpartum fundal massage, noting a large gush of blood from the patient's vagina including several large blood clots. She calls to the charge nurse, Tanya, to notify Dr. Sonentag that Ms. Williams is bleeding again. "Tanya, this is Allison calling from LDR4 with Ms. Danielle Williams. She had an uncomplicated vaginal delivery an hour ago and is now having brisk vaginal bleeding. She lost 1,000 mL in the delivery room and another 250 mL just now. She also seems to be symptomatic with tachycardia, dizziness, and lightheadedness. Please call Dr. Sonentag and have him come see her immediately."



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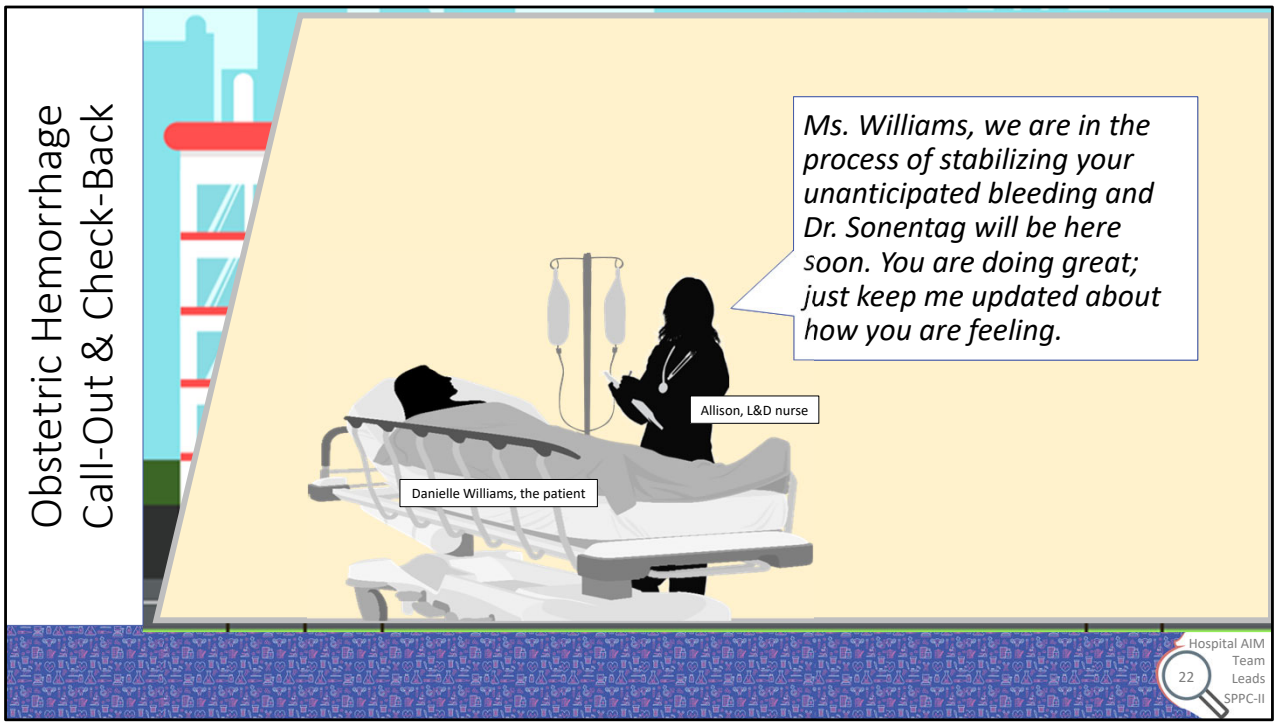
In order to confirm the information that was just relayed, Tanya uses a check-back to confirm the information. She says, “OK, Allison. To confirm, you are calling about Ms. Williams in LDR4 who delivered vaginally an hour ago and is now having a postpartum hemorrhage and is becoming hemodynamically unstable. I will call Dr. Sonentag immediately and notify him to come to the room to evaluate the patient.”



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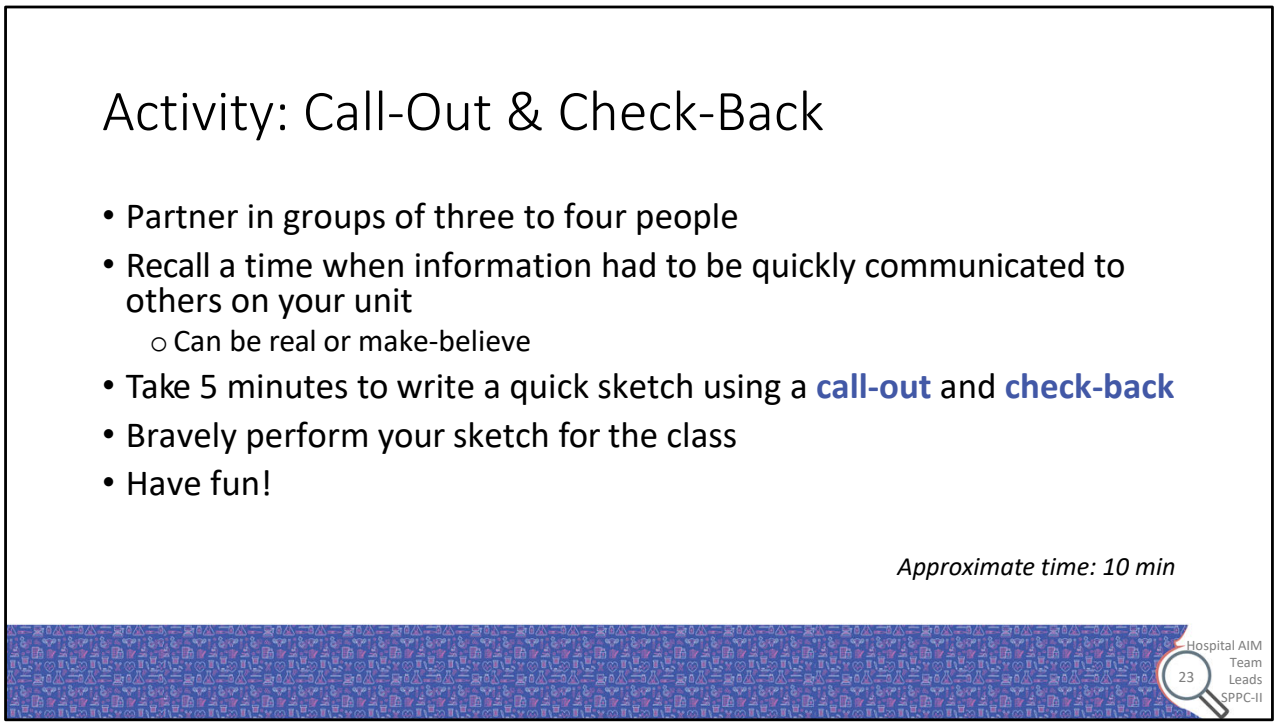
While they wait for Dr. Sonentag, Allison updates Ms. Williams about her current situation while simultaneously helping her remain calm.



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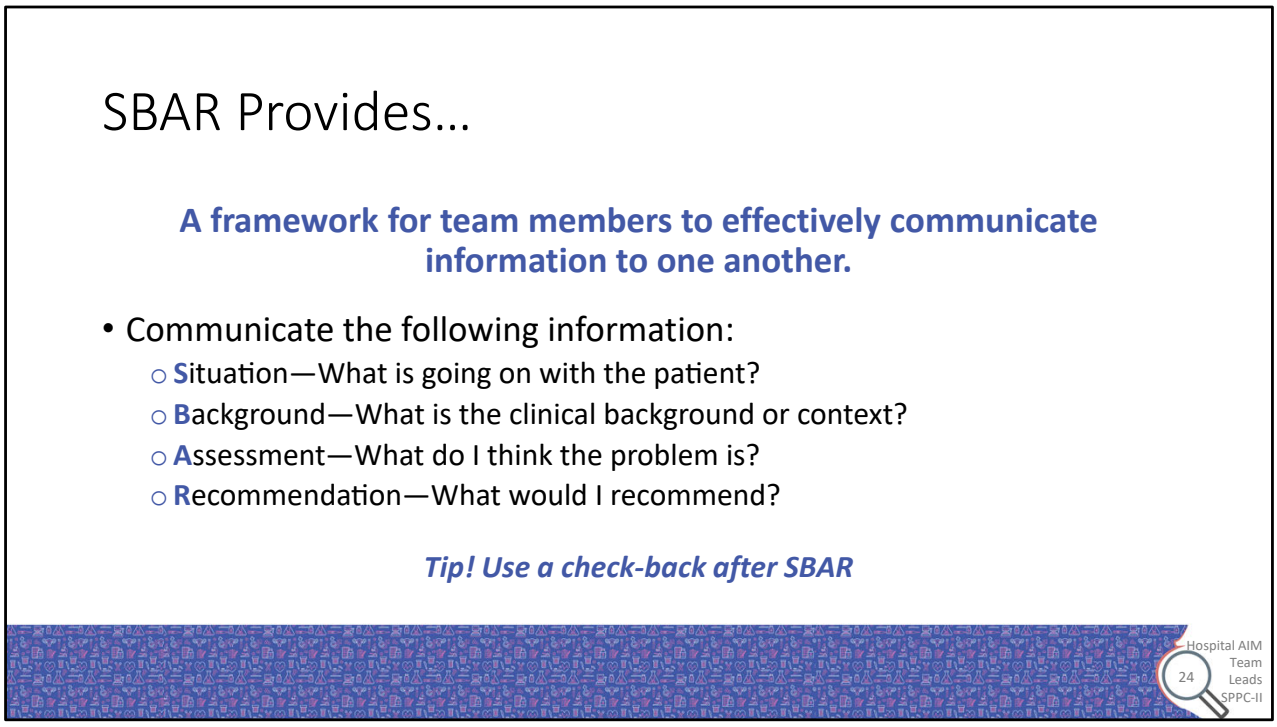
Let's do an activity. I'd like you to partner in groups of three or four and think of a recent event on your unit where information had to be quickly communicated. Maybe it's a request for help, sharing emergent information, or routine communications. The event can be real, loosely based on real events, or totally made up. However, you only have 5 minutes to sketch together a script that integrates a call-out and check-back.

Have fun with this. Silliness for this activity is encouraged, even if that's not your typical unit culture. I'll be asking at least one brave group to perform their sketch for the class.



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The SBAR technique provides a standardized framework for members of the healthcare team to communicate about a patient's condition. It can be used to structure a general conversation or patient care transitions.

In phrasing a conversation with another member of the team, consider the following:

- Situation—What is happening with the patient?
- Background—What is the clinical background?
- Assessment—What do I think the problem is?
- Recommendation—What would I recommend?

You may also refer to this as the ISBAR, where "I" stands for "Introductions."

- Introduction—What is your name and role on the team?

Think about whether you have used SBAR in your institution. If so, how was it used? What was the result of its use? What were the challenges to implementing the use of SBAR and how were these challenges overcome?

Although SBAR is typically used as a communication tool between clinical staff, it can also be modified for use by the patient to communicate with the care team. For example, your facility could instruct patients to use SBAR to enable them to share information about their own situation, background, assessment, and recommendations, or to ask the care team about their care.

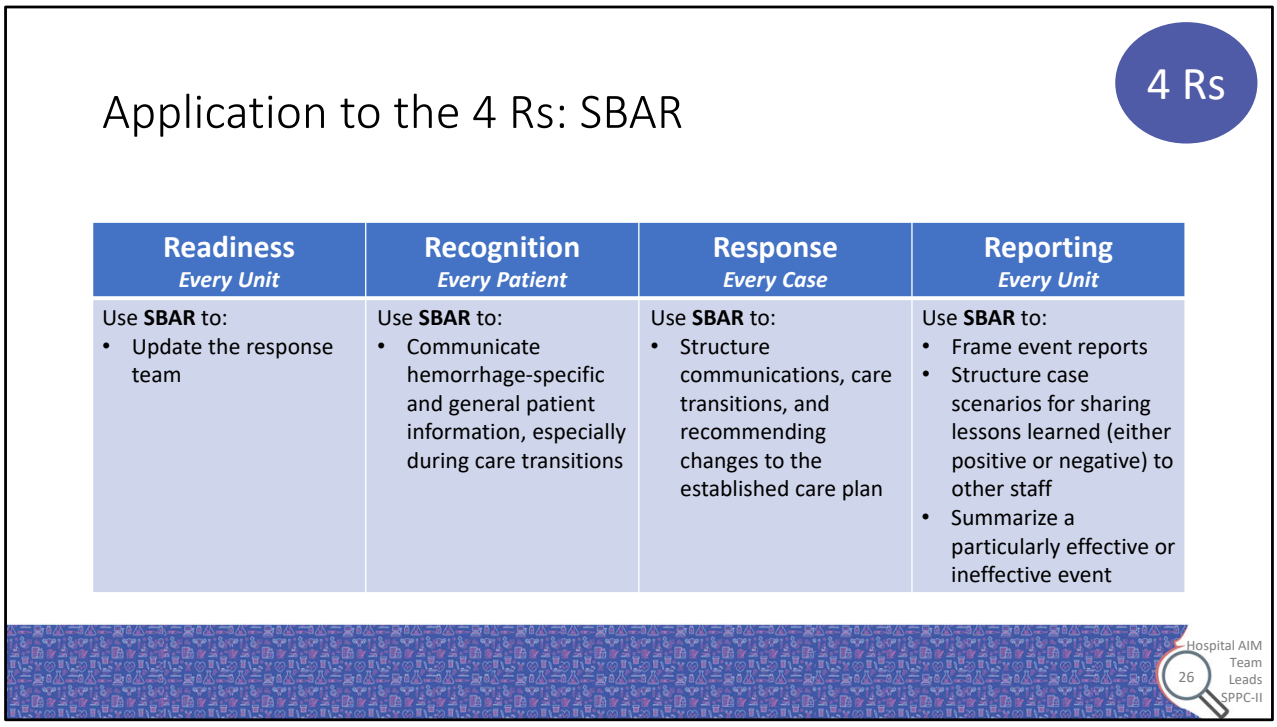
Of course, as with most of the tools in this toolkit, you can integrate several at once. Consider including a check-back at the end of an SBAR exchange to ensure information has been reliably and completely communicated.

When Is SBAR Useful?

- Care transitions and handoffs (e.g., during shift changes)
- Requesting a response during emergent events
- Providing updates about a patient or emergent event
- Problem solving and suggesting solutions

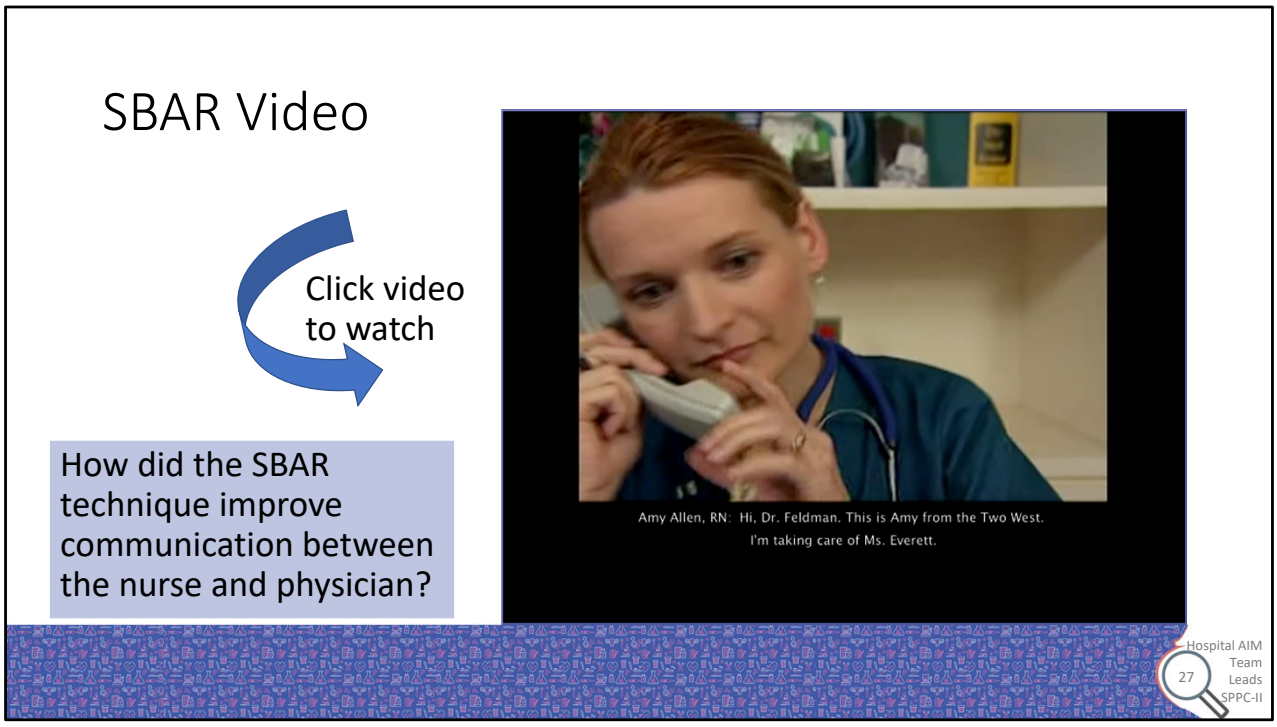
SCRIPT

You may find SBAR is useful in a variety of situations including care transitions such as shift changes and other handoffs; requesting a response during emergent events; while providing updates to other team members or the patient and family members; and when problem solving or suggesting solutions.



SCRIPT

From response to reporting, SBAR is an excellent way to structure conversations at every stage in the 4 Rs framework. It can be used in the Readiness stage to communicate with response teams. During the Recognition stage, SBAR can be used to communicate both hemorrhage-specific and general patient information across the continuum of care. When responding to obstetric hemorrhage, SBAR might be used to structure communications with a special emphasis on recommending whether to proceed with or change the established care plan given how events unfold. Finally, SBAR might be useful at the Reporting stage to frame event reports, structure case scenarios for sharing lessons learned, or summarizing a particularly effective or ineffective event for posterity and continuous learning.



SCRIPT

Let's review how to properly use the SBAR technique. In this video, the patient's condition has worsened, resulting in a call to the physician on call. Please be aware that the scenario is unrelated to a case involving obstetric hemorrhage. Focus on the use of the SBAR technique for structuring information rather than the context.

While you watch, think about how the SBAR technique improves communication between the nurse and physician.

Instructor Note:

- Play the video by clicking on it.

SBAR Video Debrief

- How did the SBAR technique improve communication between the nurse and physician?
  - **I**—The nurse identified herself and the reason she was calling
  - **S**—The physician was quickly made aware of Mrs. Everett's deteriorating situation
  - **B**—The nurse provided the background of the DVT diagnosis and all current labs
  - **A**—The recent assessment of the patient has led the nurse to call the physician with her concerns
  - **R**—The recommendation was initiated by the nurse for additional labs and a plan was discussed for future care

How did the SBAR technique improve communication between the nurse and physician?

- The nurse identified herself and the reason she was calling.
- The physician was quickly made aware of Mrs. Everett's deteriorating **Situation**.
- The nurse provided the **Background** of the DVT diagnosis and all current labs.
- The recent **Assessment** of the patient has led to the nurse to call the physician with her concerns.
- The **Recommendation** was initiated by the nurse for additional labs and a plan was discussed for future care.

  *Some find **Recommendation** difficult as they attempt not to diagnose but give broader indirect suggestions that may not provide clear or concise patient information.

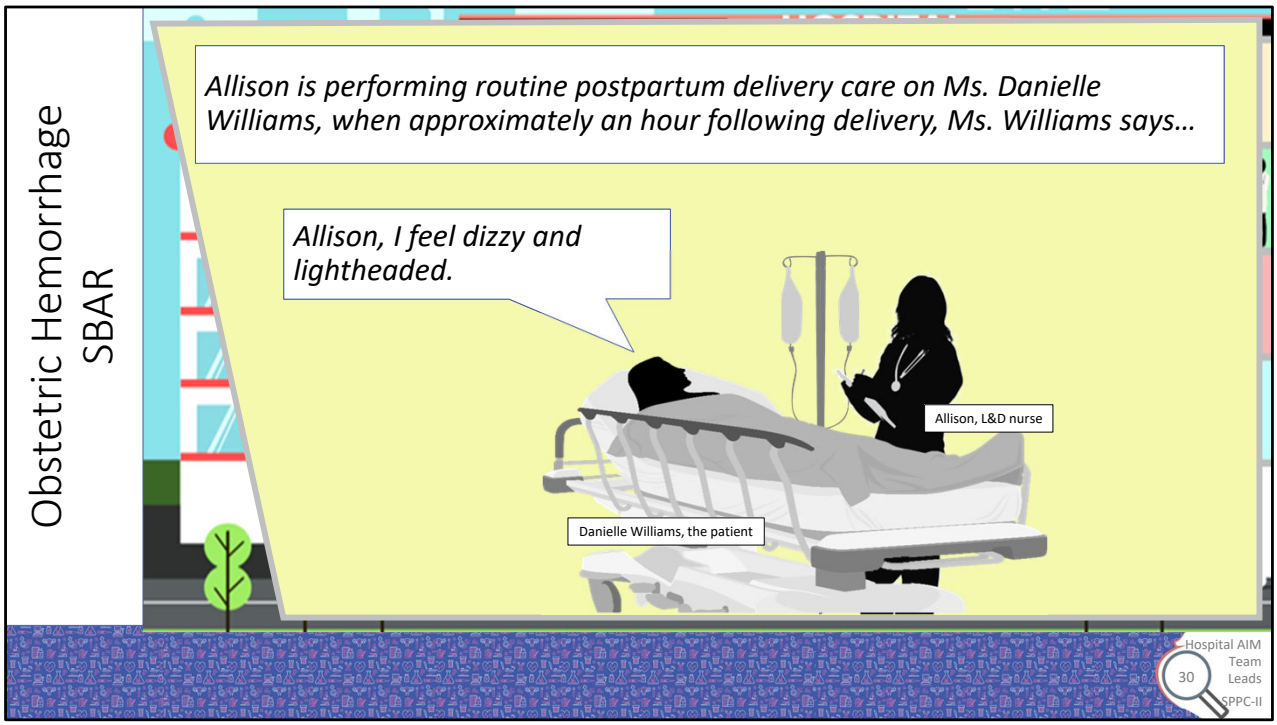
Obstetric Hemorrhage
SBAR

SCRIPT

The next few slides are from the hemorrhage master scenario when the obstetrician, Dr. Sonentag, comes to check on patient Danielle Williams at her bedside nurse's request. At this point, there is an opportunity for the use of SBAR.

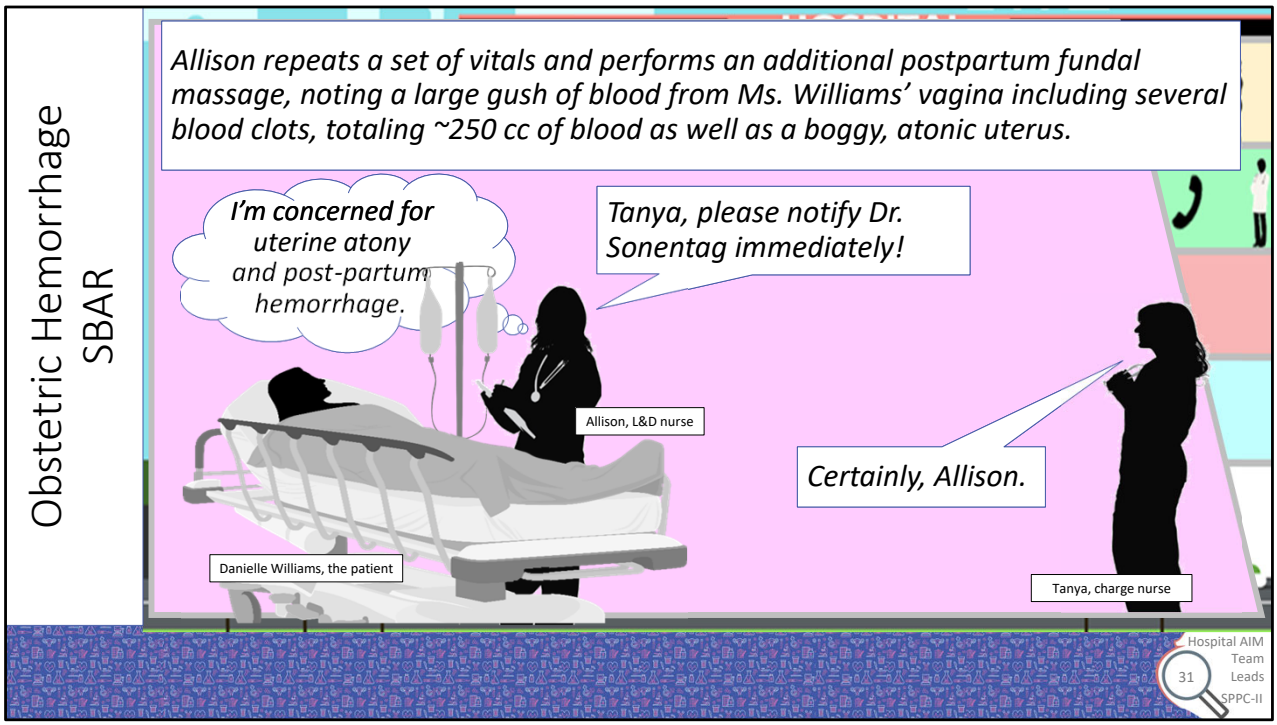
As you read through this expanded section from our scenario, think about how the bedside nurse, Allison uses SBAR to structure her communication with Dr. Sonentag. If you were Allison, what would you say to Dr. Sonentag?

Remember that Allison should still use good communication standards (which include complete, clear, brief, and timely dialogue), but she should also Identify herself, explain the Situation with the patient, provide clinical Background, Assess the current problem, and Recommend a plan.



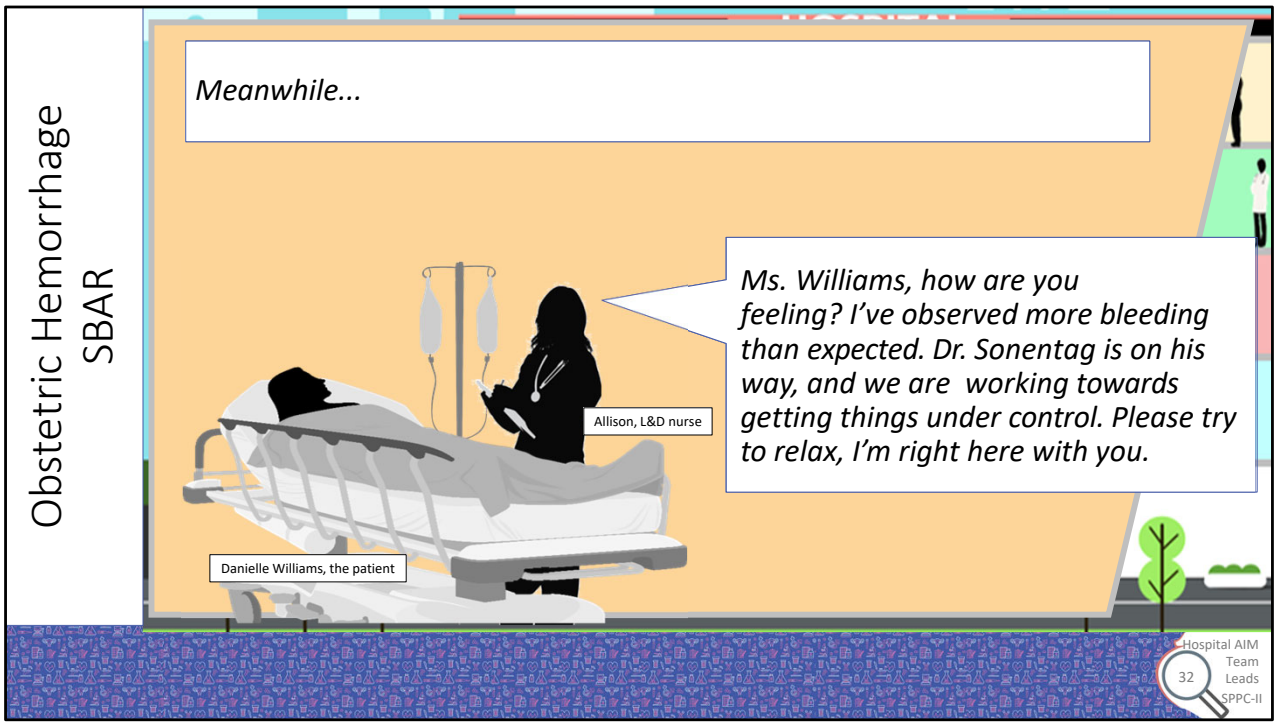
SCRIPT

Allison is performing routine postpartum delivery care on Ms. Danielle Williams, when approximately an hour following delivery, Ms. Williams mentions that she is feeling dizzy and lightheaded.



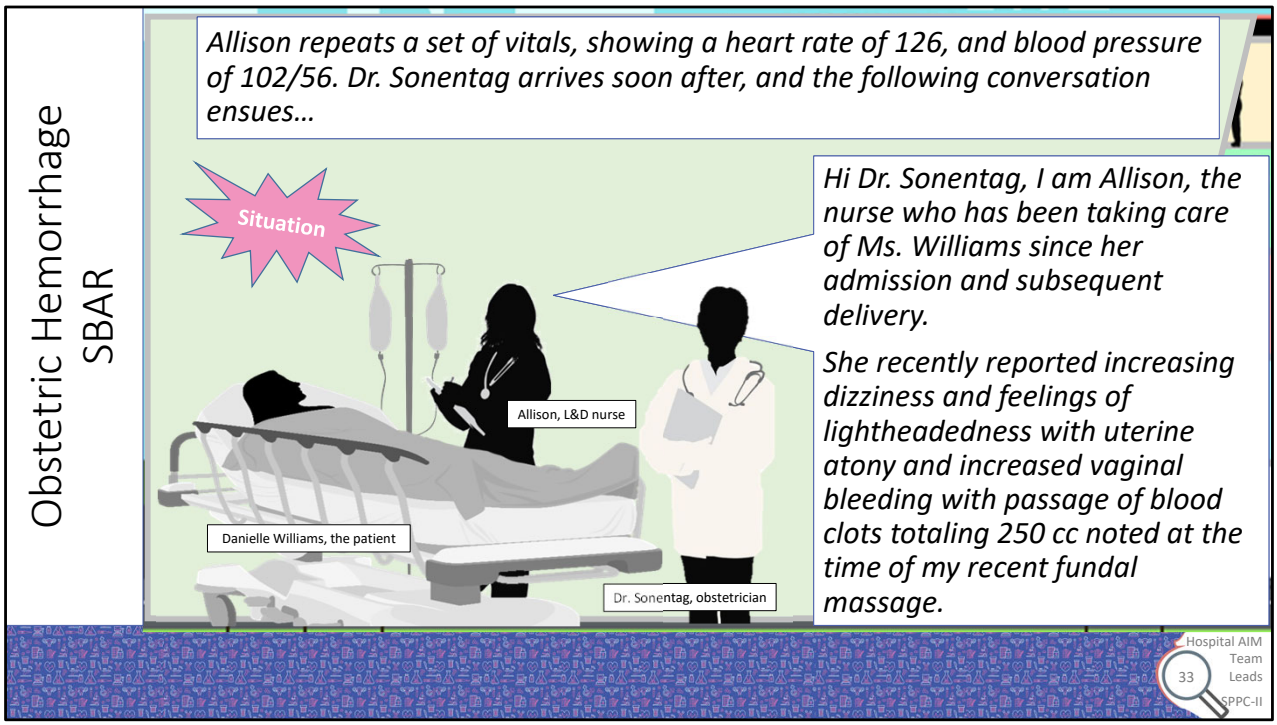
SCRIPT

Allison repeats a set of vitals and performs an additional postpartum fundal massage, noting a large gush of blood from Ms. Williams' vagina including several blood clots, totaling ~250 cc of blood as well as a boggy, atonic uterus. Allison is concerned for uterine atony and postpartum hemorrhage and calls to the charge nurse to notify Dr. Sonentag.



SCRIPT

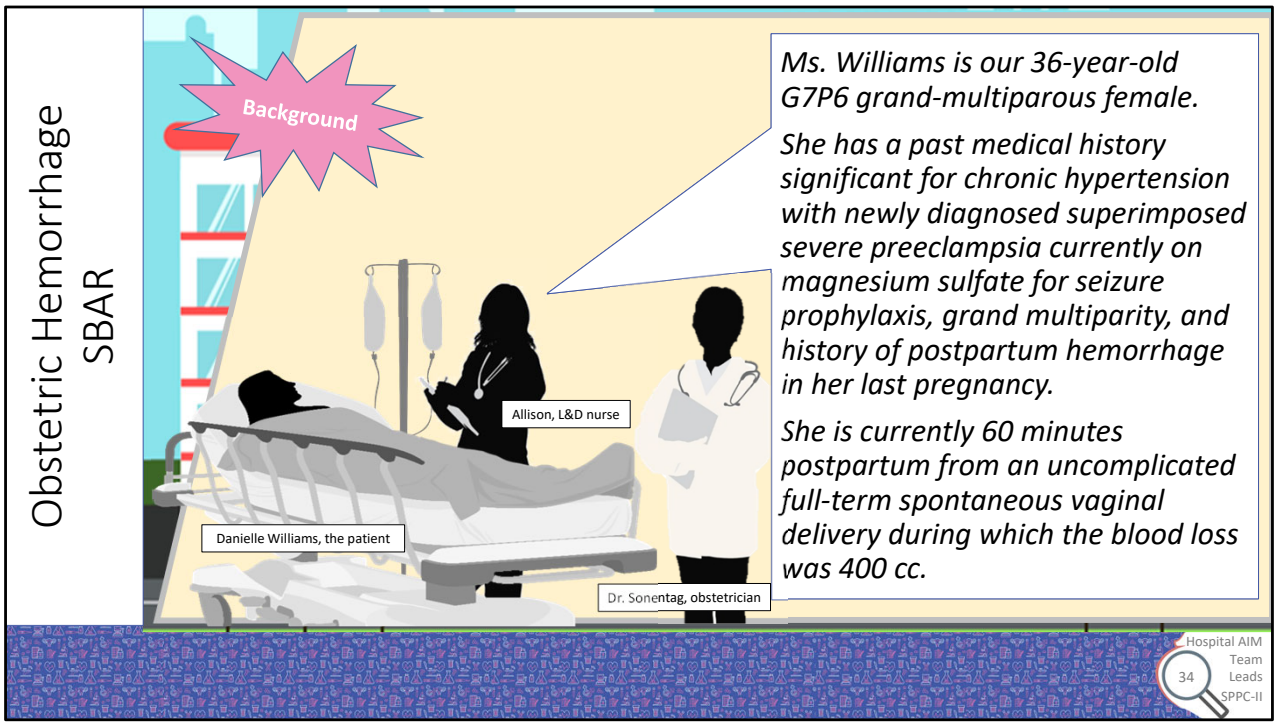
In the meantime, Allison checks in with the patient: "Ms. Williams, how are you feeling? I've observed more bleeding than expected. Dr. Sonnentag is on his way, and we are working towards getting things under control. Please try to relax, I'm right here with you."



SCRIPT

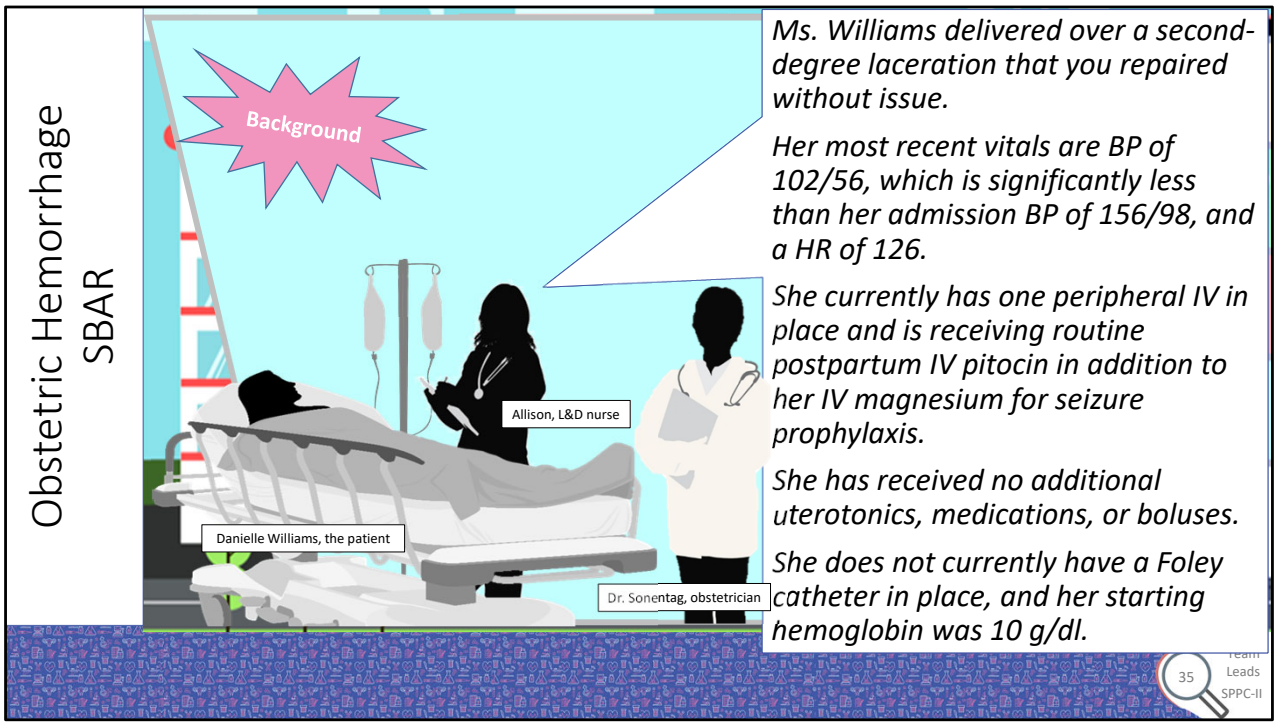
Allison repeats a set of vitals, showing a heart rate of 126 and blood pressure of 102/56. Dr. Sonentag arrives to Danielle's room soon after, and Allison begins by explaining the situation.

"Hi Dr. Sonentag, I am Allison, the nurse who has been taking care of Ms. Williams since her admission and subsequent delivery. She recently reported worsening dizziness and feelings of lightheadedness with uterine atony and increased vaginal bleeding with passage of blood clots totaling 250 cc noted at the time of my recent fundal massage."



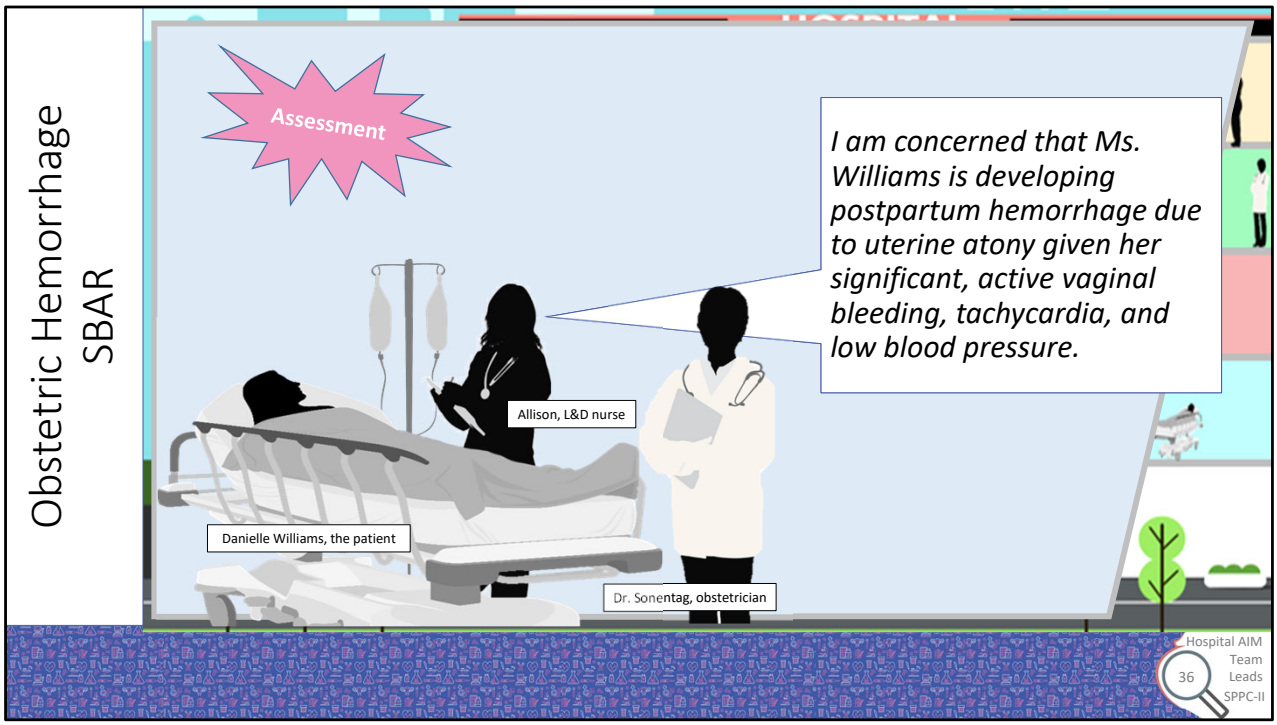
SCRIPT

Allison continues by telling Dr. Sonentag a little about Ms. Williams' background. She says: "Ms. Williams is our 36-year-old G7P6 grand-multiparous female. She has a past medical history significant for chronic hypertension with newly diagnosed superimposed severe preeclampsia currently on magnesium sulfate for seizure prophylaxis, grand multiparity, and history of postpartum hemorrhage in her last pregnancy. She is currently 60 minutes postpartum from an uncomplicated full-term spontaneous vaginal delivery during which the blood loss was 400 cc."



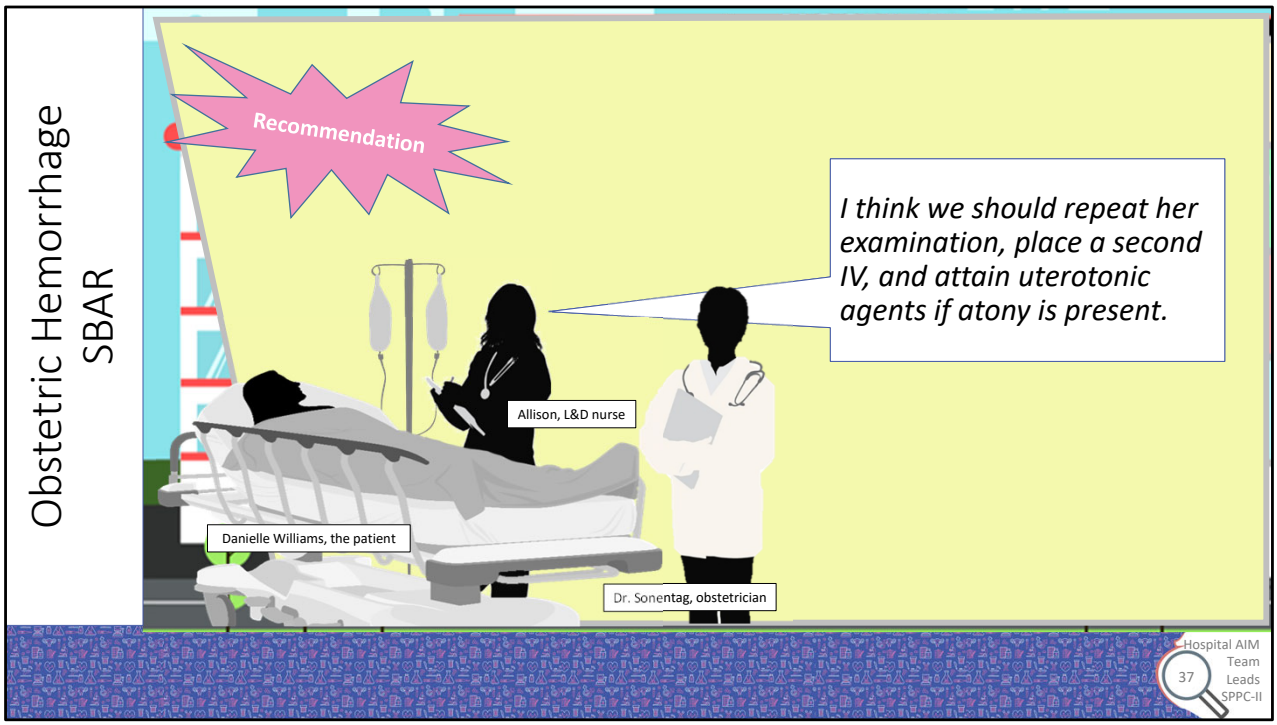
SCRIPT

Allison tells Dr. Sonentag a little about Ms. Williams' background: "Ms. Williams delivered over a second-degree laceration that you repaired without issue. Her most recent vitals are BP of 102/56, which is significantly less than her admission BP of 156/98, and a HR of 126. She currently has one peripheral IV in place and is receiving routine postpartum IV pitocin in addition to her IV magnesium for seizure prophylaxis. She has received no additional uterotonics, medications, or boluses. She does not currently have a Foley catheter in place, and her starting hemoglobin was 10 g/dl."



SCRIPT

Allison then provides her assessment of the situation: “I am concerned that Ms. WIlliams is developing postpartum hemorrhage due to uterine atony given her significant, active vaginal bleeding, tachycardia, and low blood pressure.”



SCRIPT

Finally, Allison offers her recommendation: “I think we should repeat her examination, place a second IV, and attain uterotonic agents if atony is present.”

Handoffs

The transfer of the responsibility of patient care to a different provider or healthcare professional.

- Reasons for Handoffs:
  - Shift changes
    - E.g., nurse to nurse
  - Hemorrhage and other emergent events
    - E.g., primary care to rapid response team
  - Location transfer
    - E.g., triage (antenatal/home) to inpatient (L&D)
    - E.g., L&D to postpartum room

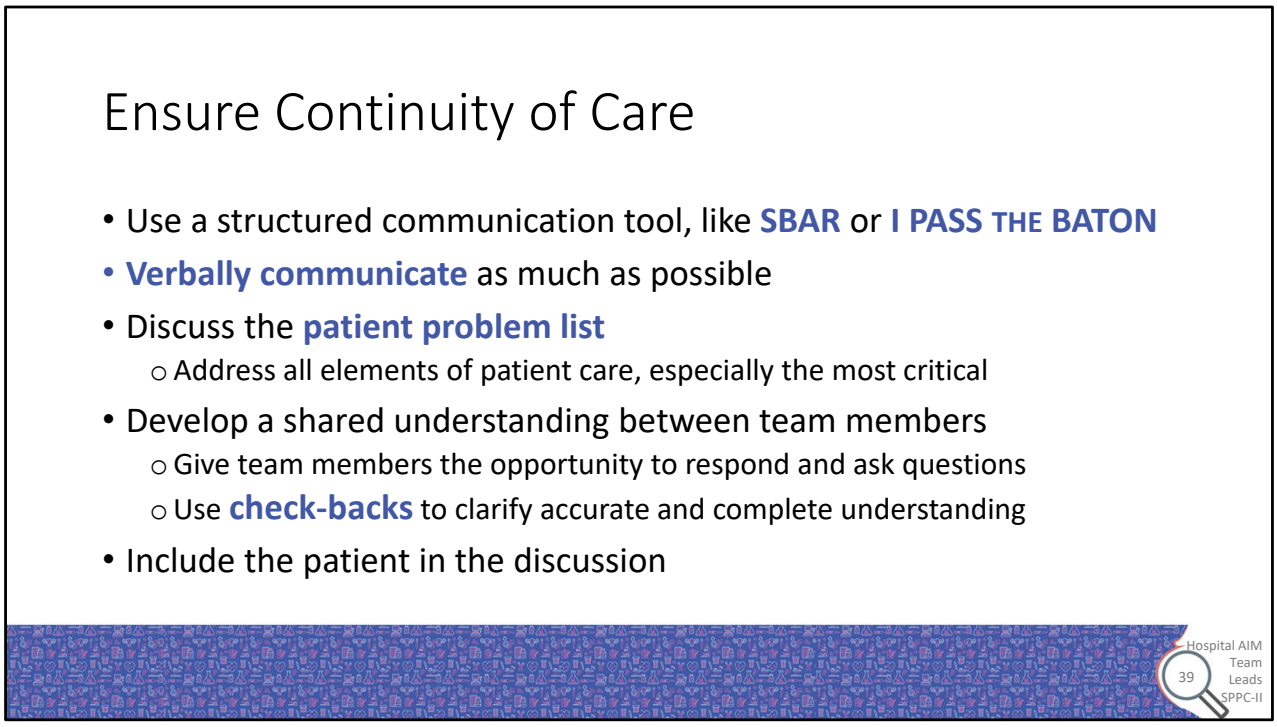
SCRIPT

Handoffs involve the transfer of the responsibility of patient care to a different provider or healthcare professional. Handoffs occur across the entire healthcare continuum in all types of settings and for various reasons. Some reasons for handoffs include shift changes, wherein one provider is being temporarily relieved of duty by another provider; during hemorrhage and other emergent events when specialized responders may take over care responsibilities for a patient; or location transfers, wherein patient care is transferring between providers as part of normal care such as from triage to the inpatient labor and delivery unit to the postpartum room.

It's estimated that a typical teaching hospital may experience more than 4,000 handoffs every day. However, sometimes handoffs are conducted too casually, when they should be structured and focused to ensure continuity of care. In these cases, there is increased risk that necessary information about the patient might not be communicated.

Ask:

When do you typically use handoffs in your unit?
What do you think makes an effective handoff?



SCRIPT

The primary objective of a good handoff is to provide accurate information about a patient's health history, treatment and services, current condition, and any recent or anticipated changes to the patient's status or plan of care, including contingency plans. Handoff discussions should include knowledge about the degree of certainty and uncertainty regarding a patient, such as whether a diagnosis has been confirmed or the patient's response to treatment. This is why a structured communication tool, such as SBAR or I PASS the BATON, which you'll learn about in a few minutes, are helpful. When used properly, these tools help providers communicate completely by providing reminders about what information needs to be shared and communicated clearly and by providing a known structure for sharing information.

During a handoff, you cannot assume that the person accepting responsibility for a patient will read or understand written or nonverbal communications, so it's important to verbally communicate as much information as possible. Handoffs are an opportunity to develop a shared understanding between team members so it's important that all information communicated is acknowledged by the recipient.

Until your teammate has provided a verbal confirmation of understanding, you should not relinquish your responsibility. Give your team member the opportunity to respond to and ask questions. Handoffs are a good time to review and have fresh eyes evaluate the situation for both safety and quality. If you yourself are the one taking over patient responsibilities, use check-backs to repeat what you have understood and clarify any concerns or information gaps.

When appropriate, you should include the patient or family in the handoff discussion. Doing so not only keeps patients apprised of their own care but can also help you maintain continuity of care. Patients can sometimes provide details that providers may not have access to.

Application to the 4 Rs: Handoffs

4 Rs

Readiness *Every Unit*	Recognition *Every Patient*	Response *Every Case*	Reporting *Every Unit*

N/A	**During Handoffs:**
	• Review patient problem list
	• Communicate hemorrhage risk:
	  • Throughout care *(predelivery → delivery → postpartum)*
	  • During shift changes
		During Handoffs:
		• Consult the unit-standard OB hemorrhage emergency management plan and checklists
			N/A

SCRIPT

As we've discussed, handoffs are foundational to care and so they are especially relevant to the Recognition and Response stages of the 4 Rs framework. During recognition of obstetric hemorrhage, you should review the patient problem list and communicate the risks or realities of hemorrhage whether the care transition is occurring during shift changes or as a natural progression of the patient's care continuum. In the response stage of an obstetric hemorrhage, consult the unit-based OB hemorrhage emergency management plan and checklists during your handoff.

"I PASS THE BATON"

- **I**ntroduction: Introduce yourself and your role/job (include patient)
- **P**atient: Identifiers, age, sex, location
- **A**ssessment: Present chief complaint, vital signs, symptoms, and diagnosis
- **S**ituation: Current status/circumstances, including code status, level of uncertainty, recent changes, and response to treatment
- **S**afety: Critical lab values/reports, socioeconomic factors, allergies, and alerts (falls, isolation, etc.)

THE

- **B**ackground: Comorbidities, previous episodes, current medications, and family history
- **A**ctions: What actions were taken or are required? Provide brief rationale
- **T**iming: Level of urgency and explicit timing and prioritization of actions
- **O**wnership: Who is responsible (nurse/doctor/team)? Include patient/family responsibilities
- **N**ext: What will happen next? Anticipated changes? What is the plan? Are there contingency plans?

SCRIPT

I PASS the BATON is another mnemonic for remembering information to be shared during a patient handoff. As you may notice from our discussion about SBAR, there are some familiar features such as the situation, background, and next steps. However, the advantage of I PASS the BATON is it is more nuanced, so when referenced you may be less likely to omit critical information during a handoff.

I PASS the BATON begins with an introduction of yourself and your job role, assuming this information isn't already known by the person to whom you're handing off responsibility. Next is an introduction to the patient and their basic characteristics such as name, age, and sex. The first "A" stands for assessment, which involves articulating the chief complaint, current vital signs, symptoms, and diagnosis. The first "S" reminds you to share information pertaining to the current situation, including present status, level of uncertainty, recent changes, and any response to treatment. The second "S" stands for safety and prompts you to share any details that might compromise or affect patient safety such as critical lab values, cultural or socioeconomic factors that might make the patient vulnerable, allergies, and alerts.

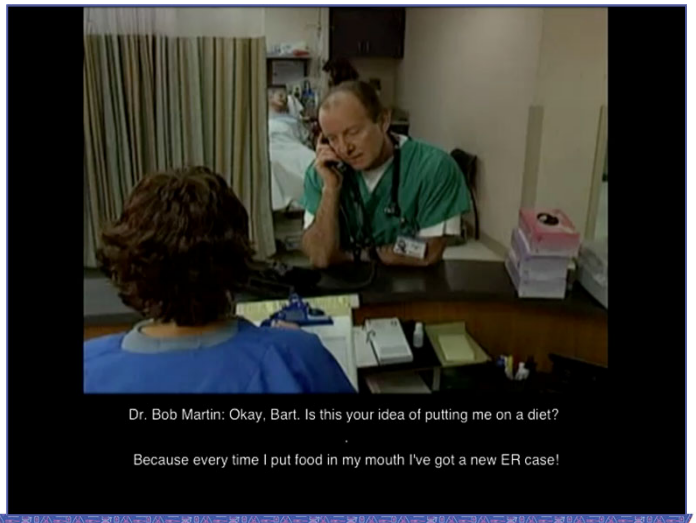
"B" stands for background and reminds you to share patient and family history. "A" refers to actions that have been taken or are required for the patient along with a rationale for

why these were undertaken or needed. The "T" reminds you to think about timing, such as level of urgency or the prioritization of actions, while "O" refers to ownership and requires you to explain specifically who is responsible for each action. Finally, "N" stands for next and reminds you to end the handoff with what the care plan dictates is the next step in care, whether any changes are anticipated, what the rest of the current care plan articulates, and whether there are any contingency plans in place.

I PASS THE BATON Video

Click video to watch

What was effective or ineffective in this handoff?



SCRIPT

As you watch this short video, see how many elements of the I PASS the BATON mnemonic you observe. Please note that the scenario does not relate to an obstetric hemorrhage. We encourage you to focus on the technique, rather than the context. What made this an effective or ineffective handoff?

Handoff Video Discussion

- What elements were covered by Dr. Smith?
  - Overlap in some of the elements
- What might have been improved?
  - Greater details about timing the chest squirting
  - Detailing next steps and a contingency plan
  - Opportunity for questions and discussion from Dr. Martin
- What was good about this handoff?
  - Short but communicated critical information
  - Dr. Martin used a **check-back**

SCRIPT
What elements of I PASS the BATON did you see represented in the previous video?

You might have observed that Dr. Smith did not provide his name or role but that Dr. Martin knew exactly to whom he was speaking, so the introduction might have been unnecessary. However, Dr. Smith began the handoff by sharing a bit about the patient, including his sex, age, and name, which he quickly followed with the assessment that the patient has viral cardiomyopathy, frequent episodes of congestive heart failure, presenting with acute anterior MI and early cardiogenic shock. Dr. Smith described the situation as the patient reporting sensations of ripping pain and that he already has access to past and present electrocardiograms with labs drawn and pending. Dr. Smith reiterated that the patient's background is one of viral cardiomyopathy, and clarified it's not coronary artery disease. As part of the patient's background and safety concerns, Dr. Smith reported that the patient has had aspirin and heparin, and was starting integrilin, and was not receiving beta-blockers or nitroglycerin due to his hypotension. He suggested the next action would be squirting the chest to rule out dissection. He transferred ownership to both Dr. Martin and Hal.

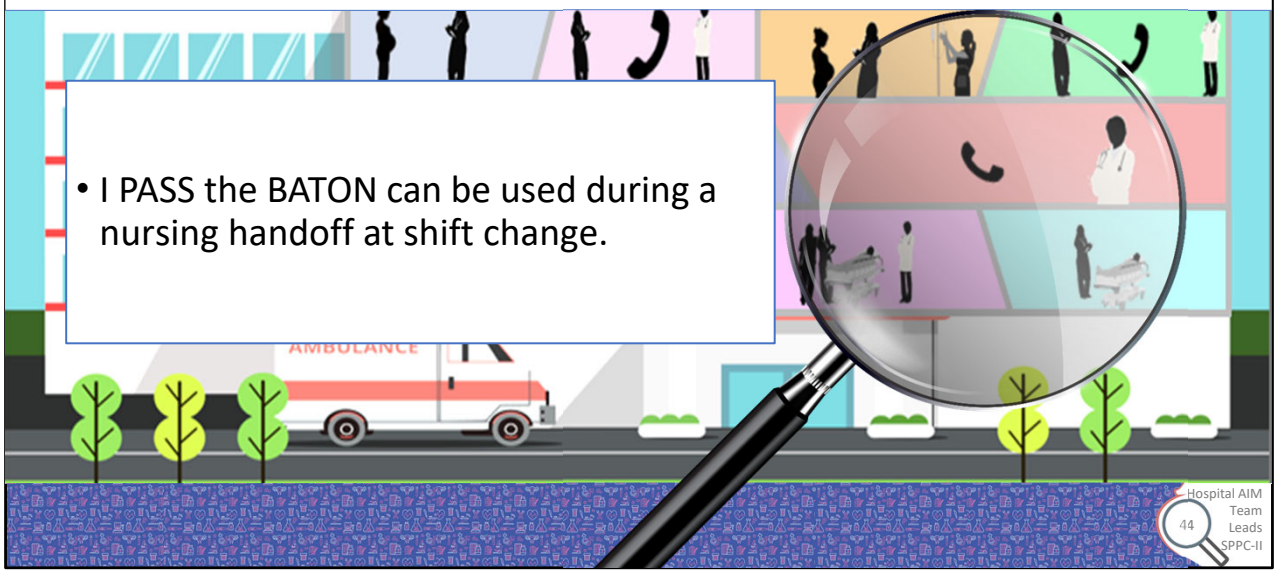
You might notice that there is sometimes overlap in the different I PASS the BATON elements or that they might be presented out of order of the mnemonic. That's OK.

I PASS the BATON is simply another tool you can draw on to help you ensure that you have communicated fully and completely all the critical information about the patient. As you become accustomed to using the strategy during handoffs, it will start to feel more natural to you.

Now, what about this particular handoff do you think could have been improved? Dr. Smith did not appear to provide details regarding the timing of actions or clear next steps, so he might have given more detail about when the chest squirting would and should take place as well as for any other explicit next steps in the care plan. He might even have asked Dr. Martin if he had anything additional to add or questions. Dr. Smith also might have summarized the results of the EKGs rather than leaving Dr. Martin to read them for himself.

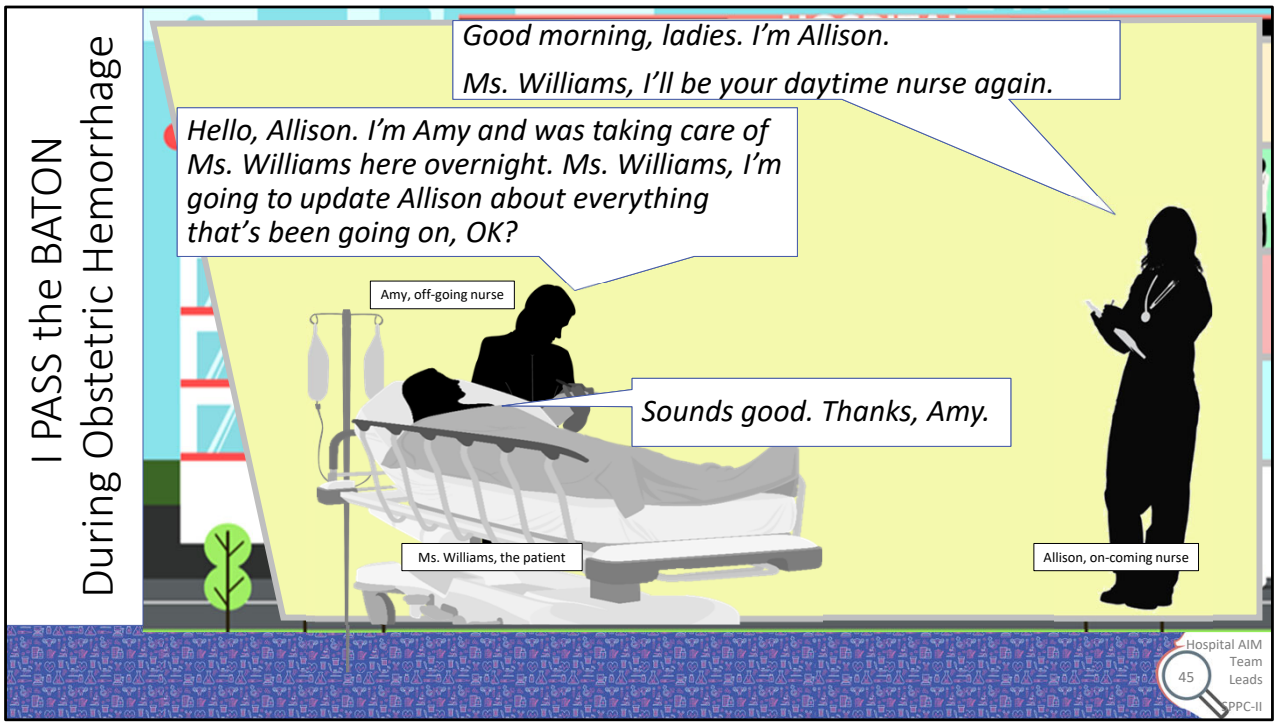
Overall, this was a good handoff that touched on nearly all the aspects of the I PASS the BATON mnemonic. Importantly, it was fairly concise, even with the banter between the two doctors, and critical information was shared. Dr. Martin even used a check-back, wherein he repeated the information that Dr. Martin communicated to him in his own words.

Obstetric Hemorrhage
I PASS the BATON



SCRIPT

In this short comic strip, we will demonstrate how I PASS the BATON might be used during a nursing handoff at shift change while a patient is experiencing an obstetric hemorrhage.



SCRIPT

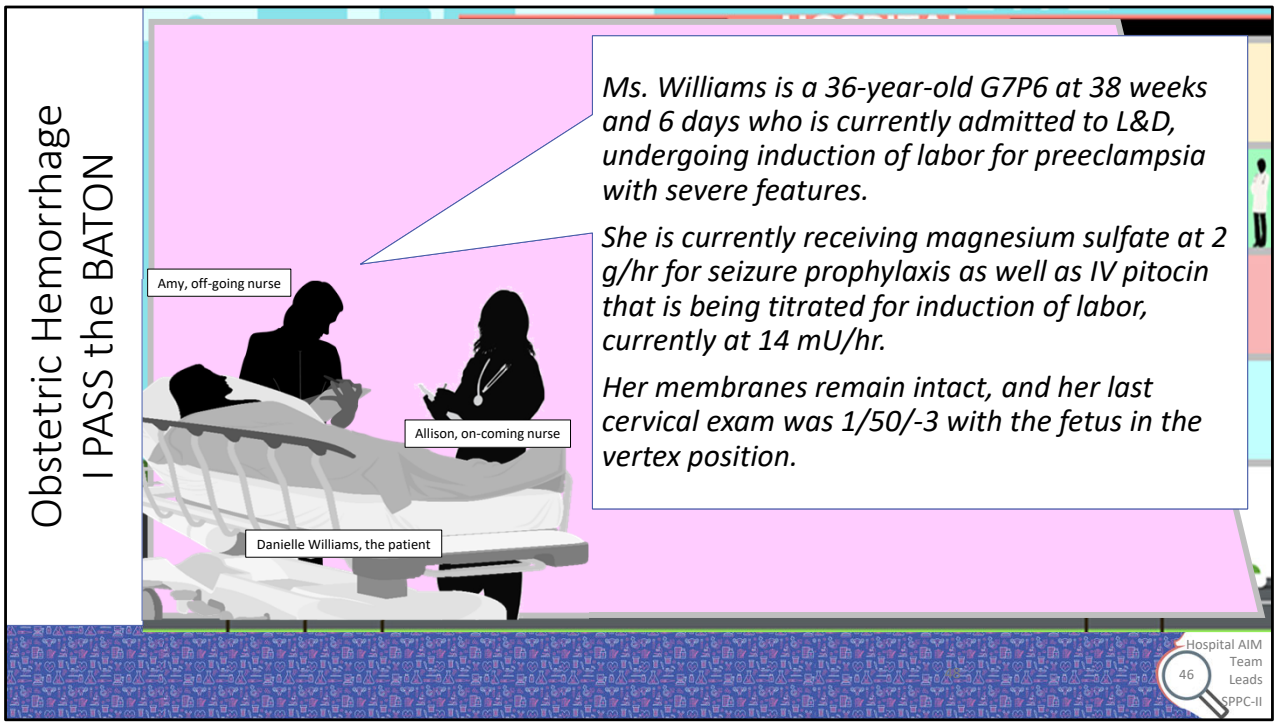
During a shift change, the off-going nurse, Amy, is turning over the care of Ms. Williams to the oncoming nurse, Allison. The patient, Ms. Williams, is present and being included in the conversation so she is fully aware that a different nurse will be taking care of her. She is given an opportunity to respond with whether she is ready before the handoff formally starts.

Allison (On-coming nurse): "*Good morning, ladies. I'm Allison. Ms. Williams, I'll be your daytime nurse.*"

Amy (Off-going nurse): "*Hello, Allison. I'm Amy and was taking care of Ms. Williams here overnight. Ms. Williams, I'm going to update Allison about everything that's been going on, OK?*"

Ms. Williams (Patient): "*Sounds good. Thanks, Amy.*"

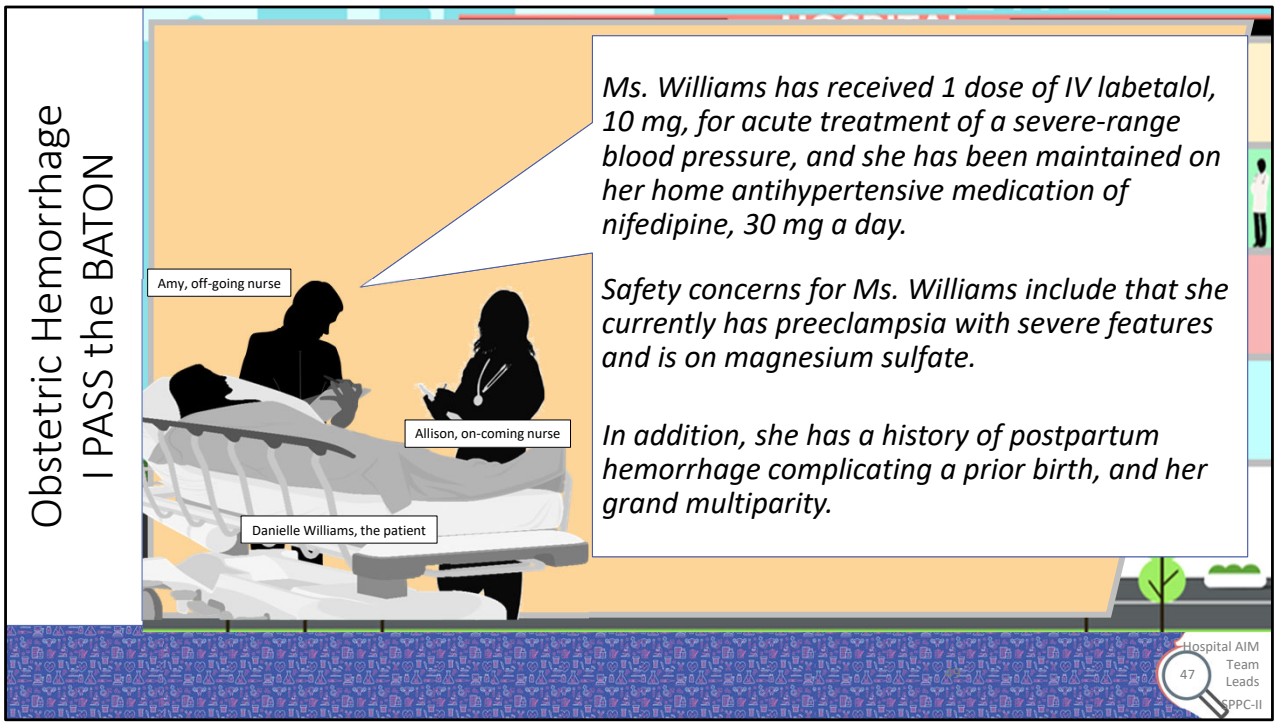
You will note that all aspects of "I" are covered.



SCRIPT

Amy explains, “Ms. Williams is a 36-year-old G7P6 at 38 weeks and 6 days who is currently admitted to L&D, undergoing induction of labor for preeclampsia with severe features. She is currently receiving magnesium sulfate at 2 g/hr for seizure prophylaxis as well as IV pitocin that is being titrated for induction of labor, currently at 14 mU/hr. Her membranes remain intact, and her last cervical exam was 1/50/-3 with the fetus in the vertex position.”

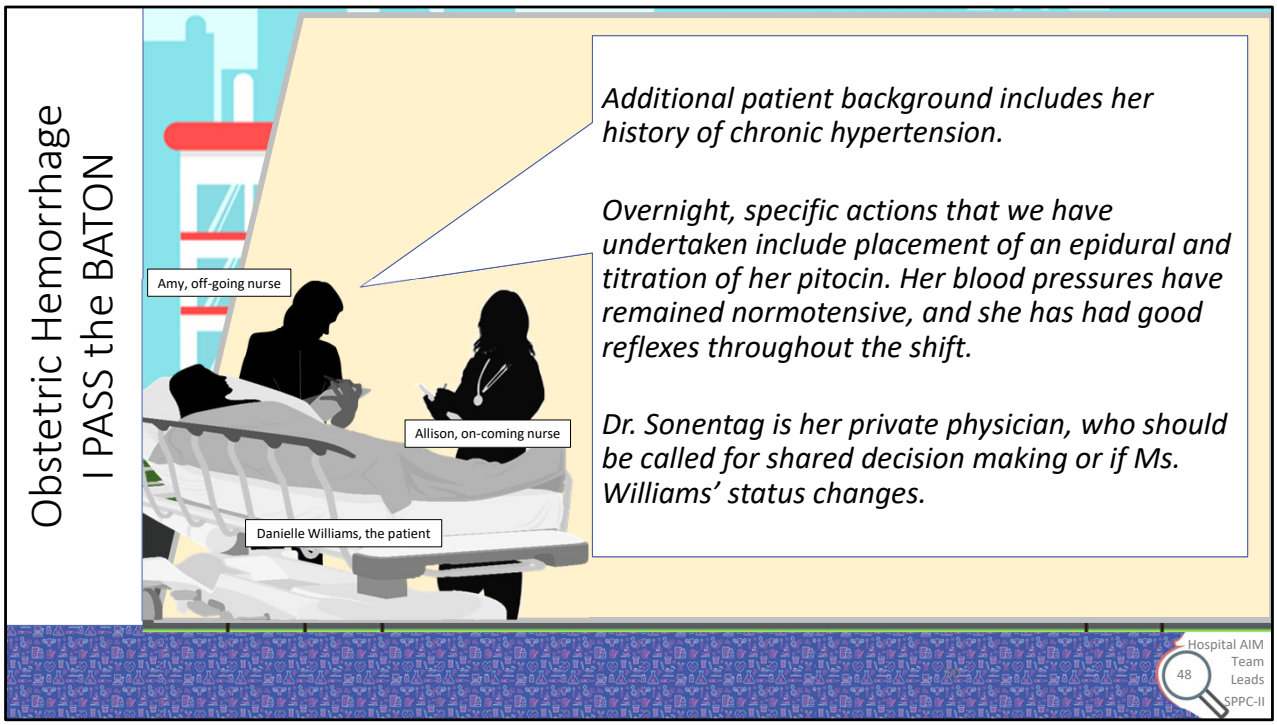
By beginning the handoff with Ms. Williams’s patient information, diagnosis, current status and medications, and her most recent exam results, Amy has covered the first three P-A-S elements in the mnemonic.



SCRIPT

Off-going nurse Amy continues to explain recent actions taken: “Ms. Williams has received 1 dose of IV labetalol, 10 mg, for acute treatment of a severe-range blood pressure, and she has been maintained on her home antihypertensive medication of nifedipine, 30 mg a day. Safety concerns for Ms. Williams include that she currently has preeclampsia with severe features and is on magnesium sulfate. In addition, she has a history of postpartum hemorrhage complicating a prior birth, and her grand multiparity.”

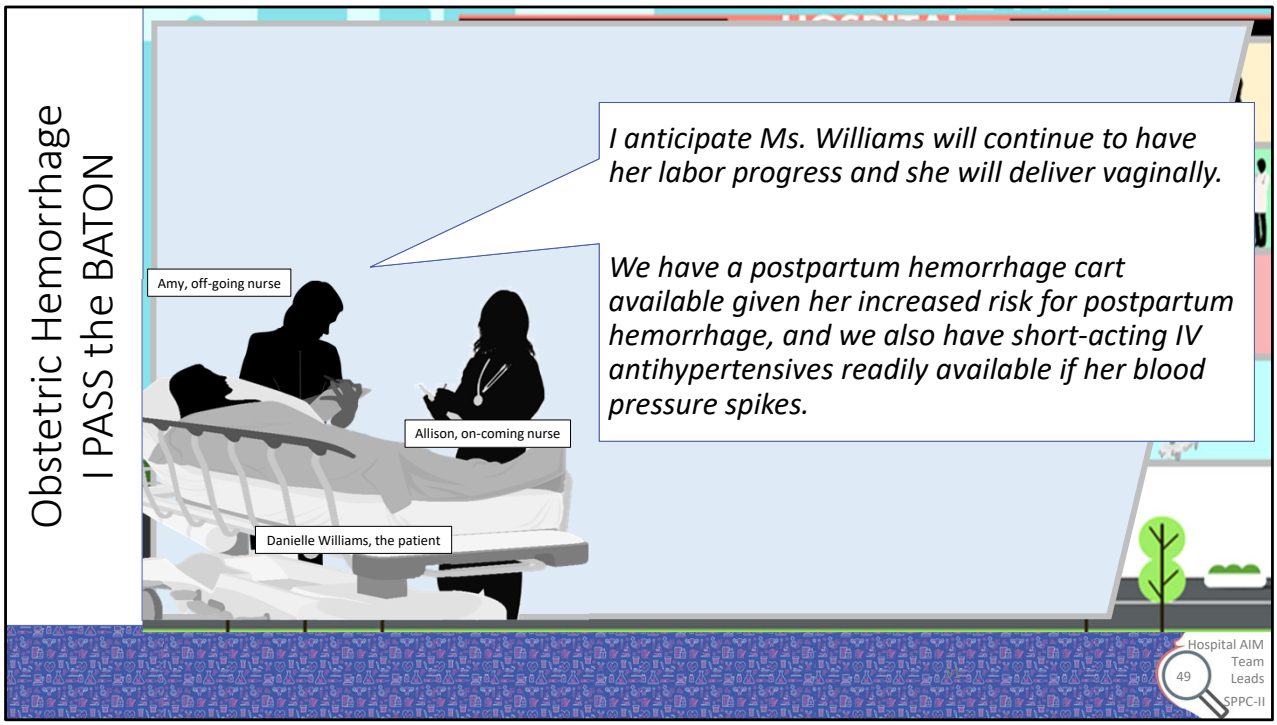
Amy has provided safety information and actions taken, according to the second “S” and second “A” in the mnemonic. She has also shared some of Ms. Williams’ history, according to the “B” for background in “BATON.”



SCRIPT

Amy elaborates on Ms. Williams' history and current actions taken by saying, "Additional patient background includes her history of chronic hypertension. Overnight, specific actions that we have undertaken include placement of an epidural, and titration of her pitocin. Her blood pressures have remained normotensive, and she has had good reflexes throughout the shift."

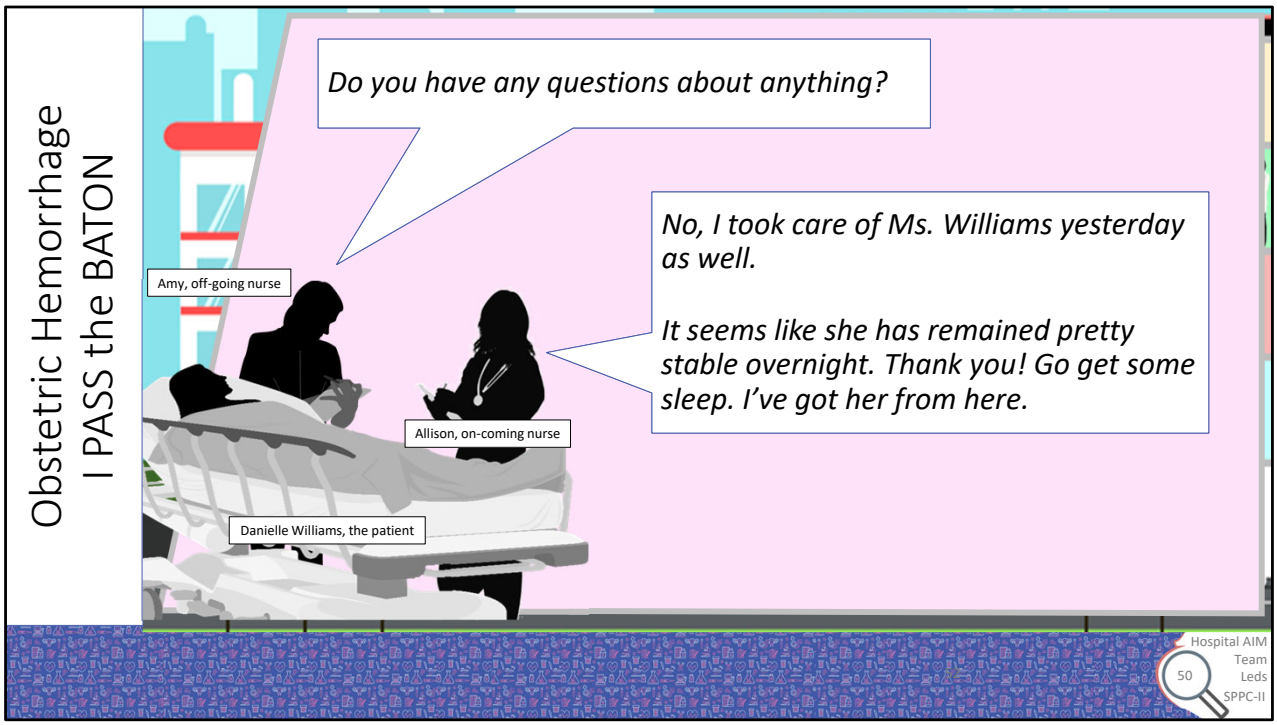
Amy describes who has ownership of Ms. Williams' care by telling Allison, "Dr. Sonentag is her private physician, who should be called for shared decision making or if Ms. Williams' status changes."



SCRIPT

Amy finishes with what is expected to happen next and availability of resources in the event of possible changes to the patient's status: "I anticipate Ms. Williams will continue to have her labor progress and she will deliver vaginally. We have a postpartum hemorrhage cart available given her increased risk for postpartum hemorrhage, and we also have short-acting IV antihypertensives readily available if her blood pressure spikes."

At this point, Amy has addressed nearly all aspects of I PASS BATON.



SCRIPT

Amy asks if Allison has any questions, inviting a check-back. Allison says, "No, I was taking care of Ms. Williams yesterday as well. It sounds like she has remained pretty stable overnight. Thank you! Go get some sleep. I've got her from here."

To improve the hand-off, Allison might have summarized the major points and anticipated next-steps as she understood them, giving everyone in the room an opportunity to confirm or correct her understanding. Amy, however, did a good job for her part.

Discussion

- Which communication tools do you think your staff will easily adopt?
  - Call-out | Check-back | SBAR | I PASS the BATON
- What do you think will be hurdles to using these tools in your facilities?
- What ideas can you share to potentially overcome some of the hurdles?
- How would you modify the tools so that your staff might use them?

SCRIPT
Now that you've learned about the communication tools and strategies we have for improving teamwork let's talk about their feasibility, any barriers you expect to have with adopting them, concerns you have with their utility, applicability, or friendliness, and ideas you might have to improve upon them or encourage their use.

I want you to feel open to sharing your thoughts, ideas, and concerns. And remember: these tools can always be modified in order to be made more useful, if that's what you need. It's not so much about the exact structure of the tool (e.g., SBAR or I PASS the BATON) as it is in having a unit-recognized procedure for organizing your communications and ensuring information has been correctly and similarly understood by everyone involved.

Summary

- Communication is the foundation to effective teamwork
  - Clear, Complete, Brief, & Timely
- Four simple strategies to improve communication:
  - Call-Out
  - Check-Back
  - SBAR
  - I PASS THE BATON
- Use these strategies together!

SCRIPT
Communication is the foundation to effective teamwork. To be effective, it should be clear, brief yet complete, and timely. In this module, we reviewed four simple strategies that you can immediately begin using and promoting at your home organizations to improve teamwork. These include call-outs, check-backs, SBAR, and I PASS the BATON.

Encourage the use of multiple strategies together. Check-backs can and should be used to confirm information shared during call-outs and communicated with the SBAR and I PASS the BATON mnemonics.

References

1. Joint Commission on Accreditation of Healthcare Organizations. Sentinel Events Statistics: Root causes of sentinel events. 2015. http://www.jointcommission.org/sentinel_event.aspx.
2. Joint Commission on Accreditation of Healthcare Organizations. Sentinel Event Data: Root Causes by Event Type, 2004-2015. 2016. https://hcupdate.files.wordpress.com/2016/02/2016-02-se-root-causes-by-event-type-2004-2015.pdf.
3. (Adapted from) Dayton E, Henriksen K. Communication failure: basic components, contributing factors, and the call for structure. Joint Commission Journal of Quality and Patient Safety. 2007 Jan;33(1):34-47. PMID: 17283940.

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