Fumbled handoffs can lead to medical errors

August 7 2009

Poor communication of the outcomes of medical tests whose results are pending at the time of a patient's hospital discharge is common and can lead to serious medical errors in post-hospitalization medical treatment.

A new study by researchers from the Regenstrief Institute and the Indiana University School of Medicine has found that hospital discharge summaries are grossly inadequate at documenting both tests with pending results and information about which doctors should receive the post-discharge test results. The findings appear in the September 2009 issue of the Journal of General Internal Medicine.

During a hospital stay tests are ordered by emergency department physicians, generalists, specialists, hospitalists and other medical staff. Test results such as those indicating positive blood culture, uncontrolled thyroid or declining kidney function can require post-discharge treatment but results of some tests may not be ready for weeks after the patient leaves the hospital. Most patients are unaware that test results are pending.

The new JGIM study identified 668 hospital discharges with pending test results. The researchers analyzed the discharge summaries and found them deficient.

- Although all the patients had pending test results - only 16 percent of the 2,927 tests with pending results were mentioned in the discharge summaries

- Only 67 percent of discharge summaries indicated which primary care outpatient doctor was responsible for following up with the patient after discharge.

Since the researchers looked retrospectively at the discharge summaries, they were able to see if test results reported after discharge called for a change in the patient treatment plan or management.

"We found that a huge number -- 72 percent -- of test results requiring treatment change were not mentioned in discharge summaries. So an outpatient provider likely would not even have known that the results of these tests needed to be followed up. In the patient safety arena, this is what you call a 'fumbled handoff' - and it leads to medical errors." said Martin Were, M.D., MS., first author of the study. Dr. Were is a Regenstrief Institute investigator and an assistant professor of medicine at the IU School of Medicine.

While it is easy to blame busy health-care providers for poor quality of discharge summaries, the problem largely reflects a failure in the system, according to Dr. Were. Similarly, in its seminal report 'To Err is Human', the Institute of Medicine advocates for changes in current systems to improve patient safety. "Our study highlights the need to improve how information is communicated to the outpatient follow-up providers," said Dr. Were, who is also an internist.

Source: Indiana University (news : web)