Patient Handoff and Information Fatigue

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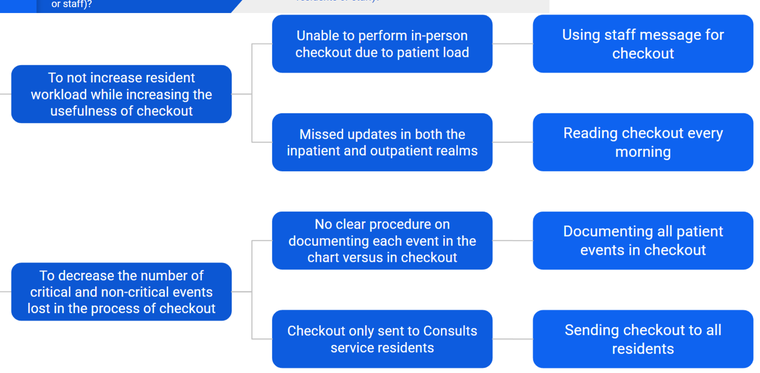
BACKGROUND:

Patient handoff is a GME-required competency for residency training and a crucial means of ensuring patient safety through structured communication. It is also acknowledged that "information fatigue" from electronic notifications is prevalent and burdensome to physician wellbeing. Perhaps with this in mind, the West Virginia University Department of Behavioral Medicine and Psychiatry's call checkout notes have historically only been distributed to the consult service. This has left important cross-coverage information unseen by most of the residency and inpatient attendings, and resulted in redundant documentation practices which can contribute to burnout.

1	Do you feel there is a need to improve hand off between on call residents and day team for overnight events at CRC?	Do you feel there is a need to improve hand off between on call residents and day team for overnight events at CRC?
2	Do you feel the new checkout system will significantly increase workload for day team residents?	Do you feel the new checkout system significantly increased workload for day team residents?
3	Do you feel a uniform checkout would decrease latency in day team follow up on overnight events?	Do you feel a uniform checkout was associated with decreased latency in day team follow up on overnight events?
4	How often do you miss critical events from overnight?	How often do you miss critical events from overnight?
5	How often do you plan to utilize the new plan for a residency wide AM checkout from the night team?	How often do you read the AM checkout from the night team?
6	Which problems have been lost in overnight handoff to day team?	Which problems have been lost in overnight handoff to day team?
7	Are you concerned that all residents getting a staff message each morning will contribute to message fatigue?	Have you felt that all residents getting a staff message each morning contributed to message fatigue?
8	How often do you feel non-critical events are missed due to lack of interval documentation (by residents or staff)?	How often do you feel non-critical events are missed due to lack of interval documentation (by residents or staff)?

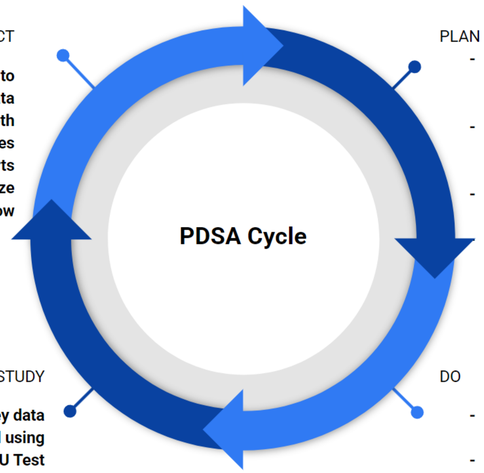
Improving handoff process by 20% as demonstrated by subjective reports on patient care and resident wellness



IMPROVEMENT ACTION PLAN

Stakeholders:

- All ~40 psychiatry residents and child psychiatry fellows.
- All inpatient unit attending physicians.
- Departmental administration who are routinely attached to pools in Epic. Required administrative approval for establishment of pools and creation by IT.



ACT

- **Used qualitative, subjective data and converted it to quantitative subjective data**
- **Could have used standardized scales for both resident burnout and patient safety, such as changes in the number of ORIGAMI reports**
- **Use a larger sample size**
- **Continuing with current checkout process for now**

PLAN

- **Concern for missing critical and non-critical events due to not all residents receiving inpatient and outpatient updates**
- **Additional concern that sending checkout to all residents could lead to increased workload and message fatigue**
- **Define patient safety as missed critical and non-critical events as well as latency**
- **Define resident wellness as usefulness of checkout and message fatigue**

STUDY

- **Gather pre- and post-survey data**
- **Given the use of Likert scales, data analyzed using Mann-Whitney U Test**
- **Results were significant for positive change in feeling that day shift residents would attend to overnight events quicker**
- **In summary, good response to change in overnight checkout, specifically in latency, and not felt to lead to message fatigue**

DO

- **Adjusting message recipient pool through Epic administration**
- **Making residents aware of the new recipient to checkout**
- **Pre-survey sent to all residents containing 8 questions**
- **Most variation in answer for question regarding if new process will increase resident workload**
- **Post-survey with 8 similar questions sent 5 months later**

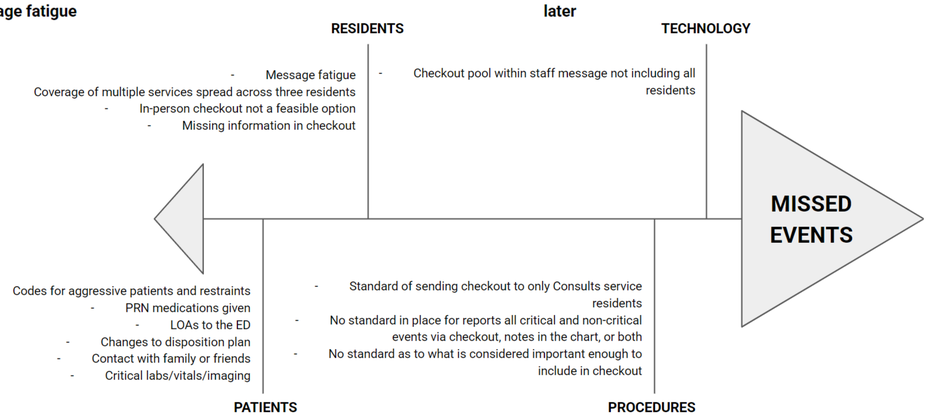
SMARTER OBJECTIVE:

Outcome: 20% reduction in patient safety concerns.
Secondary outcome: negative change in resident wellbeing

Indicator: 100% distribution of checkout to stakeholders

Target: all 4 Healthy Minds–Chestnut Ridge inpatient units (Adult, Intensive Care, Dual Diagnosis, Adolescent)

Timeframe: 9/23/24 – 1/23/25 (4 consecutive months)



RESULTS:

Pre-survey data indicated pronounced desire for checkout improvement and belief that this would reduce patient safety concerns, though with ambivalence regarding potential increased workload and information fatigue. 14/40 residents completed the pre-survey though unfortunately only 8 completed the post-survey. A two-tailed Mann-Whitney U test was utilized. The only post-survey response with statistical significance ($p < 0.05$) was question 3, though a few others approached it. Data does indicate signals indicating a lack of clear worsening of resident wellness by receiving a daily checkout message, and signals towards improving patient safety.

Question	**p-value** (two-tailed Mann-Whitney U)
1	0.30772
2	0.2187
3	**0.034**
4	0.92034
5	0.13362
6	N/A (qualitative)
7	0.08186
8	0.5485

SCALE UP PLAN:

This system can be further adapted to unit needs, as these are distinct patient milieus. The information gleamed can also be used as a springboard to better assess patient care needs at the system level, including psychiatric patients cared for at Ruby.

SUSTAINABILITY PLAN:

This system can be used to eliminate redundant documentation, which may contribute to wellbeing and assure its continuation. This can also facilitate the transition of junior residents to call roles, while practicing cogent documentation.

LESSONS LEARNT:

A universal checkout system is an important patient safety and educational practice, though the burden of information fatigue on resident wellbeing cannot be ignored. It is prudent to reduce redundancy, and it is possible to do this in a conscientious manner.

Do you feel a uniform checkout would decrease latency in day team follow up on overnight events?

Are you concerned that all residents getting a staff message each morning will contribute to message fatigue?

How often do you feel non-critical events are missed due to lack of interval documentation (by residents or staff)?