Joint Commission quality initiative reduces poor patient handoffs

By KEVIN B. O'REILLY (HTTPS://AMEDNEWS.COM/APPS/PBCS.DLL/PERSONALIA?ID=KOREILLY) — Posted Nov. 4, 2010

A Joint Commission quality improvement initiative has helped five hospitals around the country cut their rates of so-called defective handoffs by an average of 52%, according to an October news briefing organized by the health care accrediting body.

Ten hospitals -- among them Intermountain Healthcare LDS Hospital in Salt Lake City and Baltimore's Johns Hopkins Hospital -- are taking part in the commission's handoff communications project, part of the organization's Center for Transforming Healthcare.

The participating hospitals are proceeding at different speeds in making changes meant to decrease the number of dropped handoffs that can lead to patient harm and delays in care. However, the hospitals that fully implemented changes have improved their handoff communications by using best practices such as:

- Setting aside a quiet workspace devoted solely to sharing information about patients.
- Examining and improving the workflow of physicians, nurses, residents and others involved in handoffs.
- Developing and using standardized forms or other methods to transmit information that both the patient "senders" and "receivers" agree ought to be shared.

Because patient handoffs -- from the emergency department up to the floor, from the operating room to recovery, from the hospital to another facility and more -- are so frequent, the odds of some critical bit of information getting lost in transition are high, said Mark R. Chassin, MD, MPH, the commission's president.

4,000 chances for error

"One study estimated that the typical teaching hospital has 4,000 patient handoffs every day, or 1.6 million per year," Dr. Chassin said. "Think about those staggering numbers, and think about how many opportunities there are for miscommunication. Even a very high percentage of success is not good enough."

Bungled handoffs play a role in 80% of serious preventable adverse events, Dr. Chassin said. At baseline, he said, the hospitals participating in the project found that 70% of their handoffs "were defective and didn't give the caregiver receiving responsibility for the patient the opportunity to provide safe and effective care."

Setting a single standard for what critical information will be shared during the handoff process is key to protecting patients, said Kevin Tabb, MD, chief medical officer of Stanford Hospital & Clinics in California, which also is participating in the commission initiative.

"We called this, literally, 'getting everybody on the same page,' " Dr. Tabb said. "Senders and receivers, physicians and nurses, had to have the same expectations about what type of information needs to be given."

Starting early next year, the initiative's best practices will be pilot-tested among a broad variety of hospitals nationwide with the goal of having more data proving their effectiveness by the middle of 2011. The goal is to achieve a 90% rate of "successful handoffs," as measured by surveys of the patient senders and receivers involved. Connecting improved handoffs with superior patient outcomes will be the next area to measure, said officials involved in the initiative.

Hospitals that are accredited by the commission can access the Center for Transforming Healthcare's quality-improvement tools at no extra cost.