Joint Commission Center for Transforming Healthcare

The Joint Commission's Center for Transforming Healthcare aims to solve health care's most critical safety and quality problems. The Center's participants – the nation's leading hospitals and health systems – use a proven, systematic approach to analyze specific breakdowns in patient care and discover their underlying causes to develop targeted solutions that solve these complex problems. In keeping with its objective to transform health care into a high reliability industry, The Joint Commission will share these proven effective solutions with the more than 20,500 health care organizations it accredits.

Improving Transitions of Care: Hand-off Communications

Participating Hospitals:

- Exempla Lutheran Medical Center
- Fairview Health Services
- Intermountain Healthcare LDS Hospital
- The Johns Hopkins Hospital
- Kaiser Permanente Sunnyside Medical Center
- Mayo Clinic Saint Marys Hospital
- New York-Presbyterian Hospital
- North Shore-LIJ Health System Steven and Alexandra Cohen Children's Medical Center
- Partners HealthCare, Massachusetts General Hospital

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What is a Transition of Care: Hand-off Communications?

A hand-off is a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care.

To further define the roles, the **sender** is responsible for sending or transmitting the patient data and releasing the care of the patient to the **receiver,** who receives the patient data and accepts care of the patient.

The consequences of substandard hand-offs may include delay in treatment, inappropriate treatment, adverse events, omission of care, increased hospital length of stay, avoidable readmissions, increased costs, inefficiency from rework, and other minor or major patient harm.

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Why Tackle Hand-off Communications?

Miscommunication of all kinds is implicated as a major contributing factor of adverse events.

Breakdown in communication was the leading root cause of sentinel events reported to The Joint Commission between 1995 and 2006 (1) and one U.S. malpractice insurance agency's single most common root cause factor leading to claims resulting from patient transfer (2). Of the 25,000 to 30,000 preventable adverse events that led to permanent disability in Australia, 11 percent were due to communication issues, in contrast to 6 percent due to inadequate skill levels of practitioners (3).

(1) The Joint Commission Sentinel Event Data Unit.

(2) Andrews C, Millar S. Don't fumble the handoff. MAG Mutual Healthcare Risk Manager, 2005, 11(28):1–2 http://www.magmutual.com/mmic/articles/2005_11_28.pdf.

(3) Zinn C. 14,000 preventable deaths in Australia. BMJ, 1995, 310:1487 http://www.webmm.ahrq.gov/case.aspx?caseID=55.

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Update: December 22, 2014

Hand-off Communications Project: Participating Hospitals' Characteristics and Project Details

Hospital	Location	Type of hospital	Number of Beds	Internal Hand-offs			External Hand-offs		
				Emergency Department to Inpatient Floor	Intensive Care Unit to Inpatient Floor	Operating Room to Inpatient Floor	Post Acute to Hospital	Hospital to Post Acute	Sending Hospital to Receiving Hospital
Exempla Lutheran Medical Center	Colorado	Community	400	X					
Fairview Health Services	Minnesota	Academic	860	X				X To Long Term Care	
Intermountain Healthcare LDS Hospital	Utah	Community	350	X		X			
The Johns Hopkins Hospital	Maryland	Academic	1,041					X To Pediatric Home Care	
Kaiser Permanente Sunnyside Medical Center	Oregon	Tertiary Care	290	X				X To Long Term Care	
Mayo Clinic Saint Marys Hospital	Minnesota	Academic	1,265	X	X				
New York-Presbyterian Hospital	New York	Academic	2,298	X				X To Long Term Care	
North Shore-LIJ Health System Steven and Alexandra Cohen Children's Medical Center	New York	Academic	167	X		X			
Partners HealthCare, Massachusetts General Hospital	Massachusetts	Academic	899				X		X
Stanford Hospital & Clinics	California	Academic	450		X				

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Update: December 22, 2014

Measuring A Successful Hand-off Between Clinicians: Sender/Receiver

Expectations Out of Balance

- The expectation of the Receiver is to get the critical information needed in order to safely care for the patient.
- The expectation of the Sender is to be able to communicate the critical information to the Receiver in a timely manner.
- However, there is a disconnect between the critical information the Receiver actually receives versus the critical information the Receiver actually needs to care for the patient.
- Receivers experienced less successful hand-offs than Senders.*

*Statistically significant, P value = .001

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Update: December 22, 2014

Validated Root Causes for Transition of Care: Hand-off Communications Failures

All participating hospitals

		A	B	C	D	E	F	G	H	I	J
General	Culture does not promote successful hand-off, e.g. lack of teamwork and respect	x	x	x		x		x		x	x
	Expectations between sender and receiver differ	x	x	x		x		x		x	x
	Ineffective communication method, e.g. verbal, recorded, bedside, written	x				x		x	x	x	x
	Timing of physical transfer of the patient and the hand-off are not in sync		x			x	x	x		x	x
	Inadequate amount of time provided for successful hand-off	x	x	x		x	x				
	Interruptions occur during hand-off			x		x	x				
	Lack of standardized procedures in conducting successful hand-off, e.g. SBAR			x	x	x		x			
	Inadequate staffing at certain times of the day or week to accommodate successful hand-off					x	x				
	Patient not included during hand-off	x									
Sending	Sender provides inaccurate or incomplete information, e.g. medication list, DNR, concerns/ issues, contact information	x	x	x	x	x	x	x	x	x	x
	Sender, who has little knowledge of patient, is handing off patient to receiver	x		x	x	x			x	x	x
	Sender unable to provide up-to-date information, e.g. lab tests, radiology reports, because not available at the time of hand-off					x	x				x
	Sender unable to contact receiver who will be taking care of patient in a timely manner					x		x			
	Inability of sender to follow up with receiver if additional information needs to be shared						x				
	Sender asked to repeat information that has already been shared					x					
Receiving	Receiver has competing priorities and is unable to focus on transferred patient					x				x	x
	Receiver unaware of patient transfer					x			x		
	Inability for receiver to follow up with sender if additional information is needed						x				
	Lack of responsiveness by receiver	x									
	Receiver has little knowledge of patient being transferred					x					

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Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.

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Targeting Solutions for Specific Causes

Causes

- Culture does not promote successful hand-off, e.g. lack of teamwork and respect
- Ineffective communication method, e.g. verbal, recorded, bedside, written
- Inadequate amount of time provided for successful hand-off

Solutions

- **Make successful hand-offs an organization priority and performance expectation**
- **Teach staff on what constitutes a successful hand-off**
- **Standardize training on how to conduct a hand-off**
- **Engage staff – real time performance feedback, just-in-time training**
- **Sender uses standardized form, tool and method every time a hand-off occurs, e.g. checklists, SBAR tool**
- **Identify new and existing technologies to assist in making the hand-off successful and complete, e.g. electronic medical records, PDAs**
- **Develop and use standardized forms, tools and methods, e.g. checklists, SBAR tool**
- **Sender identifies and stresses key information and critical elements about patient when talking to receiver**
- **Sender synthesizes patient information from disparate sources prior to passing it on to the receiver**

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Targeting Solutions for Specific Causes (cont'd)

Causes

- Sender provides inaccurate or incomplete information, e.g. medication list, DNR, concerns/ issues, contact information
- Receiver has competing priorities and is unable to focus on transferred patient

Solutions

- **Sender provides details of patient's history and status when speaking with receiver**
- **Develop and use standardized forms, tools and methods, e.g. checklists, SBAR tool**
- **Sender synthesizes patient information from disparate sources prior to passing it on to the receiver**
- **Establish workspace or setting that is conducive for sharing information about a patient; e.g. zone of silence**
- **Hold staff managing patient's care responsible**
- **Examine the work flow of health care workers to ensure a successful hand-off**
- **Focus on the system, not just the people**

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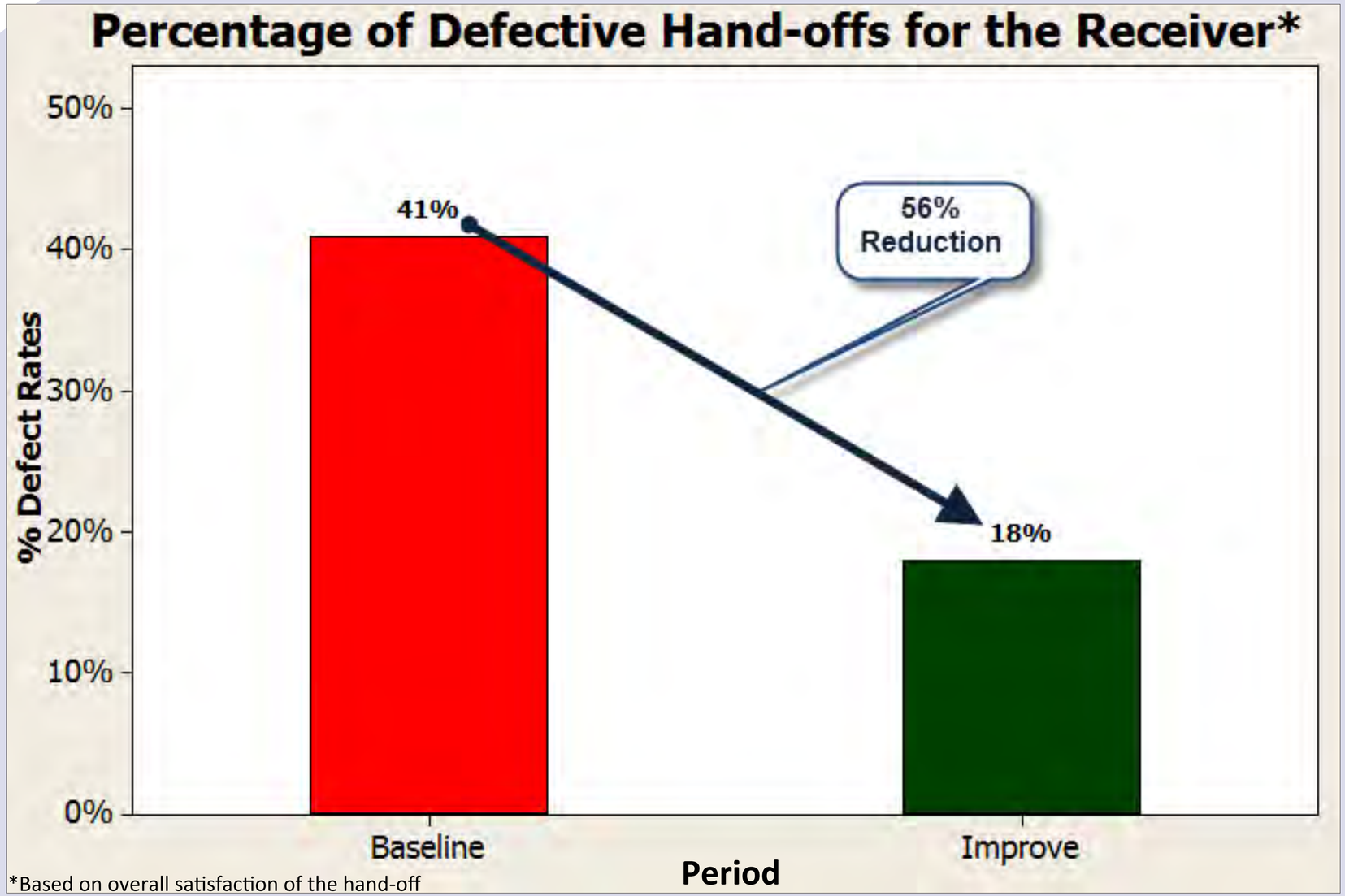
Hand-off Communications Performance Improvement Measure



*Based on overall satisfaction of the hand-off

This Bar Chart represents aggregated data from the participating hospitals (N=7) that have fully implemented solutions (p-value=0.007).

Note: The measurement system was revised for the launch of the Targeted Solutions Tool® based on our lessons learned to include the Senders as well as revising the metric from a satisfaction question to more of a patient focused question "Did the hand-off meet your needs to continue caring for the patient?"

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A Successful Hand-off is Critical

S H A R E

Standardize Critical Content

- Provide details of patient's history and status when speaking with receiver
- Identify and stress key information and critical elements about patient when talking with the receiver
- Synthesize patient information from disparate sources prior to passing it on to the receiver
- Develop and use key phrases to help standardized communications

Hardwire Within Your System

- Develop and use standardized forms, and tools and methods, e.g. checklists, SBAR tool
- Establish a workspace or setting that is conducive for sharing information about a patient, e.g. zone of silence
- Have patient present during hand-off discussion between sender and receiver
- State expectations about how to conduct a successful hand-off
- Focus on the system, not just the people

- Identify new and existing technologies to assist in making the hand-off successful and complete, e.g. electronic medical records, PDAs
- Ensure access to electronic medical record is available to all staff caring for patient
- Integrate process into electronic medical record application
- Provide post acute staff with access to hospital information systems (if part of the same health care system)
- Examine the work flow of health care workers to ensure a successful hand-off

Allow Opportunity to Ask Questions

- Use critical thinking skills when discussing a patient's case
- Share and receive information--as an interdisciplinary team--about the patient at the same time, e.g. "pit crew"
- Expect to receive all key information and critical elements about the patient from the sender
- Collect sender's contact information in the event there are follow-up questions
- Scrutinize and question the data

Reinforce Quality and Measurement

- Demonstrate leadership's commitment to implement successful hand-offs
- Utilize a sound measurement system to determine the real score in real time
- Hold staff managing patient's care responsible
- Monitor compliance of standardized form, tools and methods for hand-off between sender and receiver
- Measure the specific, high-impact causes of a poor hand-off and target solutions to those causes
- Use data as the basis for a systematic approach for improvement

Educate and Coach

- Teach staff on what constitutes a successful hand-off
- Standardize training on how-to conduct a hand-off
- Engage staff--real time performance feedback; just-in-time training
- Make successful hand-offs an organizational priority and performance expectation

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Developed by the participating hospitals,this is a compilation of solutions that are linked to specific root causes.

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