Joint Commission Center for Transforming Healthcare
Tackles Miscommunication Among Caregivers
Top U.S. Hospitals Identify Causes, Develop Targeted Solutions to Save Lives

(OAKBROOK TERRACE, IL – October 21, 2010) An estimated 80 percent of serious medical errors involve miscommunication between caregivers when responsibility for patients is transferred or handed-off. Recognizing this as a critical patient safety issue, a group of 10 leading U.S. hospitals and health care systems teamed up with the Joint Commission Center for Transforming Healthcare to use new methods to find the causes of and put a stop to these dangerous and potentially deadly breakdowns in patient care.

Health care organizations have long struggled with the process of passing necessary and critical information about a patient from one caregiver to the next, or from one team of caregivers to another. A hand-off process involves “senders,” the caregivers transmitting patient information and releasing the care of the patient to the next clinician, and “receivers,” the caregivers who accept the patient information and care of the patient.

The Hand-off Communications Project began in August 2009. During the measure phase of the project, the participating hospitals found that, on average, more than 37 percent of the time hand-offs were defective and didn’t allow the receiver to safely care for the patient. Additionally, 21 percent of the time senders were dissatisfied with the quality of the hand-off. Using solutions targeted to the specific causes of an inadequate hand-off, participating organizations that fully implemented the solutions achieved an average 52 percent reduction in defective hand-offs.

The 10 hospitals and health systems that volunteered to address hand-off communications as a critical patient safety problem are:

- Exempla Lutheran Medical Center, Wheat Ridge, Colorado
- Fairview Health Services, Minneapolis, Minnesota
- Intermountain Healthcare LDS Hospital, Salt Lake City, Utah
Although The Joint Commission requires accredited organizations to use a standardized approach to hand-off communications, breakdowns in communication have been a leading contributing factor in sentinel events, which are unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof. In addition to patient harm, defective hand-offs can lead to delays in treatment, inappropriate treatment, and increased length of stay in the hospital.

Recognizing that there is no quick fix, the Center and the participating hospitals set out to solve the problems through the application of Robust Process Improvement™ tools. RPI is a fact-based, systematic, and data-driven problem-solving methodology that allows project teams to discover specific risk points and contributing factors, and then develop and implement solutions targeted to those factors to increase overall patient safety and health care quality.

Barriers to effective hand-offs experienced by receivers include incomplete information, lack of opportunity to discuss the hand-off, and no hand-off occurred. Senders identified too many delays, receiver not returning a call, or receiver being too busy to take a report as reasons for hand-off failures.

“These 10 organizations are leading the way in finding specific solutions to the complex problem of hand-off communication failures,” says Mark R. Chassin, M.D., M.P.P., M.P.H., president, The Joint Commission. “A comprehensive approach that focuses on systems is the only way to ensure that the many caregivers upon whom patients rely are successfully communicating vital information during these transitions in care.”

The targeted hand-off solutions from the Center, which are described using the acronym SHARE, address the specific causes of unsuccessful hand-offs. SHARE refers to:

- **Standardize critical content**, which includes providing details of the patient’s history to the receiver, emphasizing key information about the patient when speaking with the receiver, and synthesizing patient information from separate sources before passing it on to the receiver.
- **Hardwire within your system**, which includes developing standardized forms, tools and methods, such as checklists, identifying new and existing technologies to assist in making the hand-off successful, and stating expectations about how to conduct a successful hand-off.

- **Allow opportunity to ask questions**, which includes using critical thinking skills when discussing a patient’s case as well as sharing and receiving information as an interdisciplinary team (e.g., a pit crew). Receivers should expect to receive all key information about the patient from the sender, receivers should scrutinize and question the data, and the receivers and senders should exchange contact information in the event there are any additional questions.

- **Reinforce quality and measurement**, which includes demonstrating leadership commitment to successful hand-offs such as holding staff accountable, monitoring compliance with use of standardized forms, and using data to determine a systematic approach for improvement.

- **Educate and coach**, which includes organizations teaching staff what constitutes a successful hand-off, standardizing training on how to conduct a hand-off, providing real-time performance feedback to staff, and making successful hand-offs an organizational priority.

In addition to hand-off communications, the Center is aiming to reduce surgical site infections (SSI) following colorectal surgery through a new project launched in August 2010 in collaboration with the American College of Surgeons. Participating organizations include the Mayo Clinic, OSF Saint Francis Medical Center, Cedars-Sinai Medical Center, North Shore-LIJ Health System, Cleveland Clinic, Stanford Hospital & Clinics and Northwestern Memorial Hospital. The solutions for this project are expected to be published in the fall of 2011.

All Joint Commission-accredited health care organizations have access to the solutions through the Targeted Solutions Tool™ (TST), which provides a step-by-step process to measure performance, identify barriers to excellent performance, and implement the Center’s proven solutions that are customized to address an organization’s specific barriers. The first set of targeted solutions, created by eight of the country’s leading hospitals and health care systems working in collaboration with the Center, focuses on improving hand hygiene. Accredited organizations can access the TST and hand hygiene solutions on their secure Joint Commission Connect extranet. The targeted solutions for hand-off communications are currently being pilot tested to prove their effectiveness in demographically diverse hospitals and
will be added to the TST in the second half of 2011. A project to reduce the risk of wrong site surgery is also in process. Future projects are expected to focus on preventable hospitalizations, medication errors, and other aspects of infection control.

**Statements from the Center's participating hospitals**

“The communication that is involved in patient transfers is a critical concern that can have a severe impact on care. Therefore, we are pleased to participate in The Joint Commission’s Hand-off Communications Project to find ways of improving this process. I am proud of our employees and their efforts. It is rewarding to know that their work combined with similar activities at the other project participant sites will help improve patient-centered health care across the country.”

*Michael J. Dowling, president and CEO, North Shore-LIJ Health System*

“This work demonstrates a new and exciting way to deliver safer care. By collaborating with leading institutions around the country, we’re identifying proven strategies that improve communications during critical points of transfer for our patients.”

*Mark Eustis, president and CEO, Fairview Health Services*

“Patients’ safety is greatly enhanced when we have smooth and effective communication hand-offs as patients move across care settings. So, patients everywhere will benefit from what we and the other leading health care programs have learned in this collaborative effort with The Joint Commission. This initiative greatly increases the chances for good, safe continuity of care for everyone.”

*Susan Mullaney, administrator, Kaiser Permanente Sunnyside Medical Center*

“Partners HealthCare frequently collaborates with other institutions across the nation on patient quality and safety initiatives -- but has never worked with such a comprehensive group at the same time. This collaboration has produced results beyond the capability of any single participant and validates The Joint Commission's proposition that critical issues in health care can be addressed in a rigorous and thoughtful way. I know that our patients, and patients across the country, will reap benefits from this work.”

*Terrence O’Malley, M.D., medical director, Non-Acute Care Services, Partners HealthCare, Massachusetts General Hospital*

“We know that breakdowns in communication that can occur when patients are handed-off from one caregiver to another are a leading cause of patient harm and medical errors. Few areas within the spectrum of patient care give us such an enormous opportunity to improve patient outcomes and reduce mistakes as improving these communications. The Joint Commission’s initiative in this area is a welcome start.”

*Ronald R. Peterson, president, The Johns Hopkins Hospital and Health System, and executive vice president, Johns Hopkins Medicine*

“We believe that this has been an outstanding project and we are thrilled to have been a participant. Hand-off communication is critical to the patient care process. Being able to identify
where there are breakdowns in the hand-off process and focus on where we can improve, as well as develop targeted solutions, will improve the quality of care our patients receive."

Kevin Tabb, M.D., CMO, Stanford Hospital & Clinics

"Exempla Lutheran Medical Center is proud to participate in the Joint Commission Center for Transforming Healthcare’s critical initiative to improve the quality of hand-off communications. We know how important it is to communicate accurately and effectively when we transfer patients from one caregiver to another. But what is it that interferes with those communications? Working with the Center and the other participating hospitals, and with the use of Lean Six Sigma, we identified some of the critical barriers to effective communication to establish processes that can be replicated to consistently make patient transfers safer. We are committed to working with the Center and the other participating hospitals to help solve these complex patient safety issues and share best practices."

Grant Wicklund, president and CEO, Exempla Lutheran Medical Center

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For more information about the Joint Commission Center for Transforming Healthcare, visit www.centerfortransforminghealthcare.org.

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Established in 2009, the Joint Commission Center for Transforming Healthcare aims to transform American health care into a high-reliability industry that ensures patients receive the safest, highest quality care they expect and deserve. The Center’s participants – the nation’s leading hospitals and health systems – use a proven, systematic approach to analyze specific breakdowns in care and discover their underlying causes to develop targeted solutions for health care’s most critical safety and quality problems. The Center is a not-for-profit affiliate of The Joint Commission, which shares the Center’s proven effective solutions with its more than 18,000 accredited health care organizations. Learn more about the Center at www.centerfortransforminghealthcare.org.