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New Journal Article Details Developing a Conceptual Framework to Improve Inpatient Handoffs Between Units

(Oak Brook, Ill., February 24, 2015) Joint Commission Resources today released the March 2015 issue of The Joint Commission Journal on Quality and Patient Safety. The issue features an article and an accompanying editorial on developing a conceptual framework for emergency department-to-inpatient handoff negotiations, as well as an article on improving the work flow and blood collection process in the Emergency Care Center (ECC).

“Collaborating—or ‘Selling’ Patients? A Conceptual Framework for Emergency Department–to-Inpatient Handoff Negotiations,” by Brian Hilligoss, Ph.D., and colleagues, discusses how handoffs between units, such as of a patient from an emergency department to an inpatient unit, have received limited attention in literature compared to within-unit handoffs, including shift and rotation changes. In response, the authors developed a conceptual framework to stimulate discussions and guide thinking within hospitals where there are concerns about the quality and effectiveness of between-unit handoffs; the framework has research implications as well. The framework identifies and addresses factors to move the average handoff in the direction of collaborative, patient-centered exchanges and helps clinicians evaluate how their behaviors and skills impact patient handoffs and patient care.

In an accompanying editorial, “Crawling Before Walking: Beginning to Understand How Clinicians Communicate and Behave During Interunit Handoffs,” Christopher Beach, M.D., urges health care organizations to implement a negotiation...
framework, such as the one provided in the Hilligoss article, to improve not only handoffs between units, but a variety of practices at the bedside and beyond. Dr. Beach concludes that it is our responsibility and purpose “to ensure that the next party is prepared to act safely and effectively when caring for a patient.”

In the article, “Using Lean-Six Sigma to Reduce Hemolysis in the Emergency Care Center in a Collaborative Quality Improvement Project with the Hospital Laboratory,” by Charlotte Damato, B.A., M.A., and Dana Rickard, B.S., M.T., Sarasota Memorial Health Care System (SMHCS), Sarasota, Florida, focused efforts on improving preanalytical work flow and blood collection processes—both negatively affected by hemolyzed specimens—in the ECC. When hemolysis is detected in a blood specimen, blood may need to be re-collected.

Using Lean-Six Sigma tools, SMHC identified several areas for improvement and implemented solutions, including applying best practices for blood collection, developing an education plan and re-evaluating blood collection products. As a result of these interventions, hemolysis decreased in the ECC by 91 percent – from 9.8 percent to 0.88 percent. The success also expanded beyond the ECC as hemolysis decreased organization-wide by 59 percent – from 3.4 percent to 1.39 percent.

The remaining articles from the March 2015 issue are:

**Adverse Events**

**Monitoring the Harm Associated with Use of Anticoagulants in Pediatric Populations Through Trigger-Based Automated Adverse-Event Detection**

*Jason T. Patregnani, M.D.; Michael C. Spaeder, M.D.; Valere Lemon, RN; Yaser Diab, M.D.; Darren Klugman, M.D.; David C. Stockwell, M.D.*

Automated triggers built into electronic health record systems are an effective way to monitor for and identify medication errors. Anticoagulant-associated adverse events were examined through the use of an anticoagulant trigger panel. In a retrospective, five-year (September 2007–September 2012) observational study, four automated triggers were used to detect anticoagulant-related adverse events. The data suggest that when anticoagulants are appropriately prescribed and administered according to a specific protocol, few serious bleeding events are related to their use.
Teamwork and Communication

Enhancing the Effectiveness of Team Debriefings in Medical Simulation: More Best Practices

Rebecca Lyons, Ph.D.; Elizabeth H. Lazzara, Ph.D.; Lauren E. Benishek, Ph.D.; Stephanie Zajac, M.S.; Megan Gregory, M.S.; Shirley C. Sonesh, Ph.D.; Eduardo Salas, Ph.D.

Debriefings are among the most widely used form of feedback regarding team performance. Thirteen best practices for simulation debriefings are organized under three general categories: (1) preparing for debriefing, (2) facilitator responsibilities during debriefing, and (3) considerations for debriefing content. For each best practice, considerations and practical implications are provided to facilitate the implementation of the recommended practices.

Methods, Tools and Strategies

Development and Evaluation of an Electronic Health Record–Based Best-Practice Discharge Checklist for Hospital Patients


Checklists may help reduce discharge errors, but current paper checklists have limited functionality. In 2013 a best-practice discharge checklist using the electronic health record (EHR) was developed and evaluated in a four-phase trial. The checklist, consisting of 15 tasks was implemented as an EHR “smart-phrase” allowing for automatic insertion. The EHR checklist reminded physicians to complete discharge tasks, improved confidence, and increased process efficiency. These data reinforce the need for a formalized tool, such as a checklist, that residents can rely on to complete important discharge tasks.

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