The Joint Commission Issues New Sentinel Event Alert on Inadequate Hand-off Communication

Communication Failures a Major Contributor to Adverse Events in Health Care

(OAKBROOK TERRACE, Illinois – September 12, 2017) – Communication failures in U.S. hospitals and medical practices were at least partly responsible for 30 percent of all malpractice claims resulting in 1,744 deaths and $1.7 billion in malpractice costs over five years, according to a 2015 study.1 The Joint Commission has issued a new Sentinel Event Alert to provide hospitals and other health care settings with seven recommendations to improve communication failures that occur when patients are transitioned from one caregiver to another or from one team of caregivers to another.

The alert also reviews contributing factors to such “hand-off communication” failures, solutions, research, quality improvement efforts, and The Joint Commission’s related requirements.

“When a patient is handed off to another health care provider for continuing care, treatment or services, the type of information the receiving provider needs may not be the information the sender provides. This misalignment is where the problem often occurs during hand-off communication,” said Ana Pujols McKee, MD, executive vice president and chief medical officer, The Joint Commission. “Failures in hand-off communication can result in a sequence of misadventures and adverse events which can include medication errors, medical complications, readmissions and even loss of life. We encourage health care organizations to use our new Sentinel Event Alert to help improve their own hand-off communication process.”

The seven recommendations to improve hand-off communication include:

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1. Demonstrate leadership’s commitment to successful hand-offs and other aspects of a safety culture.

2. Standardize critical content to be communicated by the sender during a hand-off—both verbally and in written form.

3. Conduct face-to-face hand-off communication and sign-outs between senders and receivers in locations free from interruptions—include multidisciplinary team members, the patient and family, as appropriate.

4. Standardize training on how to conduct a successful hand-off.

5. Use electronic health record capabilities and other technologies to enhance hand-offs.

6. Monitor the success of interventions to improve hand-off communication and use the lessons to drive improvement.

7. Sustain and spread best practices in hand-offs and make high-quality hand-offs a cultural priority.

The full alert and an accompanying infographic are available on The Joint Commission website.

Sentinel Event Alert is published periodically by The Joint Commission. It identifies specific types of sentinel and adverse events and high-risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences. The Joint Commission’s Patient Safety Advisory Group — composed of external members such as nurses, physicians, pharmacists, risk managers and other professionals — advises on topics and content for Sentinel Event Alert. The advisory group is presided over by Ana Pujols McKee, MD, executive vice president and chief medical officer, The Joint Commission.

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The Joint Commission
Founded in 1951, The Joint Commission seeks to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. The Joint Commission accredits and certifies more than 21,000 health care organizations and programs in the United States. An independent, nonprofit organization, The Joint Commission is the nation’s oldest and largest standards-setting and accrediting body in health care. Learn more about The Joint Commission at www.jointcommission.org.