Huddle handoff communication tool improves process of addressing workplace violence in health care

(OAKBROOK TERRACE, Illinois, March 4, 2019) – Health care workplace violence is increasing in the United States, warranting more attention to processes that support safety for health care workers. A new study in the February issue of The Joint Commission Journal on Quality and Patient Safety details how a large academic hospital designed and tested a huddle handoff communication tool to improve its process for addressing the risk of violent patient events.

In the study “Using a Potentially Aggressive/Violent Patient Huddle to Improve Health Care Safety,” Lori A. Larson, RN, MAN, NE-BC, and co-authors established a multidisciplinary quality improvement (QI) team to design and test a huddle handoff communication tool—the Potentially Aggressive/Violent Huddle Form—using two iterative Plan-Do-Study-Act (PDSA) cycles.

An emergency department (ED) nurse initiates the huddle process by informing the admitting unit that a patient at risk for violence is being admitted. The admitting care team then calls the ED team so that both teams participate in the handoff call. The huddle process occurred for 21 transfers in the first PDSA cycle and 18 transfers in the second.

Findings showed that nurses from the ED and six medical units reported feeling safe during the transfer process 100 percent of the time during both PDSA cycles (vs. 55 percent at baseline). In addition, satisfaction with the process improved from 53 to 75 percent in the ED from the first to second cycle.

“These evidence-based quality improvement strategies have traditionally been used to address patient safety issues, but the innovation here lies in the authors’ application of these strategies
to workplace safety. This agitation handoff tool provides the receiving inpatient unit a comprehensive plan for managing potential violent episodes and anticipating additional behavioral needs to safely deliver care,” note Ambrose H. Wong, MD, MSEd, and co-authors, in an accompanying editorial.

Also featured in the February issue:

- “Unintentionally Retained Guidewires: A Descriptive Study of 73 Sentinel Events” (The Joint Commission sentinel event database)
- “In-Hospital Sequelae of Injurious Falls in 24 Medical/Surgical Units in Four Hospitals in the United States” (Four U.S. hospitals)
- “Audio-Recorded Discharge Instructions for Limited English Proficient Parents: A Pilot Study” (Seattle Children’s Hospital)
- “Inter-rater Agreement for Abstraction of the Early Management Bundle, Severe Sepsis/Septic Shock (SEP-1) Quality Measure in a Multi-Hospital Health System” (Cleveland Clinic)
- “Increased HCV Screening Yields Discordant Gains in Diagnoses Among Urban and Rural Veteran Populations in Texas: Results of a Statewide Quality Improvement Initiative” (Veterans Integrated Service Network 17, Texas)
- “The Feasibility of Automating Assessment of Concordance Between Advance Care Preferences and Care Received Near the End of Life” (Kaiser Permanente Southern California)
- “A Standardized Oxytocin Administration Protocol After Delivery to Reduce the Treatment of Postpartum Hemorrhage” (Summa Health, Akron, Ohio)

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**Note for editors**
The article is “Using a Potentially Aggressive/Violence Patient Huddle to Improve Health Care Safety,” Lori A. Larson, RN, MAN, NE-BC; Janet L. Finley, RN, MS, APRN; Tera L. Gross, RN, DNP, NE-BC; Ann K. McKay, RN, MS; Julie M. Moenck, MBC, PMP; Mary A. Severson, RN, PhD; and Casey M. Clements, MD, PhD. The article appears in The Joint Commission Journal on Quality and Patient Safety, volume 45, number 2 (February 2019), published by Elsevier.