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Lost in Translation: A Standardized, Interdepartmental Approach to Improve the Safety of Inpatient Transitions of Care

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Lost in Translation: A Standardized, Interdepartmental Approach to Improve the Safety of Inpatient Transitions of Care

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INTRODUCTION

Handoffs and transitions of care were identified by the 2016 institutional safety survey as a potential area for improvement at Jefferson.

The Agency for Healthcare Research and Quality Hospital Survey on Patient Safety Culture (AHRQ HSOPS) was administered to 869 housestaff at Jefferson. Of 639 respondents, only 43% viewed handoffs and transitions favorably.

This area also represents an area of concern nationally, as the national benchmark for perceived favorability regarding transitions of care is only 48%.

The Housestaff Quality and Safety Council (HQSLC), a group of 30 residents from 15 departments, performed a fishbone analysis to identify factors that contribute to the perception that transitions of care are unsafe. This analysis revealed that lack of standardization in handoffs contributes substantially to unsafe transitions of care.

AIMS

- During the 2016-2017 academic year physician perception of favorability regarding inpatient interunit handoffs will meet the national HSOPS benchmark without negatively impacting patient bed flow.
- All ACGME training programs at Thomas Jefferson University Hospital will expose their new trainees to standardized handoff training during orientation in June 2017 as well as adapt a framework for monitoring trainee compliance and proficiency.

MODEL FOR CHANGE

- Create Momentum
  - Each council member will seek physician and resident champions from within their departments
- Standardize Curriculum
  - We will create a Jefferson-specific training model that can then be adapted to suit the needs of a particular training program
- Assess Proficiency
  - The council will develop a framework to assess proficiency once learners are trained using the standard curriculum
- Measure compliance
  - Council Members will liaise with their departments and hospital administration to measure compliance with handoff tools

DISCUSSION

Successes

- We piloted two separate efforts to standardize the transition of care process and handoff content.
- Resident and faculty champions were identified within each department.
- Training of standardized handoff content at the time of housestaff orientation.

Challenges

- A resident-run initiative lacked the authority to influence changes in bed flow and information technology.
- Pace of change and faculty involvement level varies between units and departments.
- Change is quickly extinguished without consistent reinforcement from faculty and senior housestaff.

FUTURE DIRECTIONS

- Handoff Observation & Feedback Training for Faculty & Senior Residents
- Incorporation of Technology to assist in EHR handoff standardization
- Program-level Handoff Evaluations for Learners
- Reinforcement of Safe Handoff Culture