Transitions of care may occur within organizations, between organizations, or between providers. Patients often undergo multiple transitions during a single episode of care as they are transferred between units or from one provider to another during shift changes. Improving Communication During Transitions of Care is designed to help organizations providing all types of health care services around the world coordinate and improve communication during transitions across the continuum of care. The book’s systematic and collaborative approach to improving communication compiles considerations based on evidence-based practices, guidelines, and strategies from organizations in the field. The book includes helpful tools and techniques as well as case studies illustrating initiatives implemented by health care organizations in a variety of settings and countries.

About Joint Commission Resources
Joint Commission Resources (JCR) is an expert resource for health care organizations, providing consulting services, educational services, and publications to assist in improving quality and safety, and to help in meeting the accreditation standards of The Joint Commission. JCR provides consulting services independently from The Joint Commission and in a fully confidential manner. Please visit our Web site at http://www.jcrinc.com.

About Joint Commission International
Joint Commission International (JCI) is a client-focused, results oriented, premier source of knowledge for health care organizations, government agencies, and third party payers throughout the world. It provides educational services, consulting services, and publications to assist in improving the quality, safety, and efficiency of health care services. JCI offers international and country specific accreditation programs and other assessment tools to provide objective evaluations of the quality and safety of health care organizations.

This book features bonus information on our Web site designed to provide additional examples and supplemental information.
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Consider the following scenario. A patient arrives at a hospital emergency department complaining of chest pain. A health care provider determines that the patient has suffered a mild heart attack. During the medication reconciliation process, a health care professional asks the patient about home medications but does not specifically ask about over-the-counter (nonprescription) medications, and the patient does not mention taking aspirin four times a day for arthritis pain. The patient is subsequently treated and released from the hospital with a prescription for the blood thinner warfarin.

What is the problem here?

The combination of aspirin and warfarin would put this patient at increased risk for bleeding. If information about all the patient's home medications had been communicated to the prescriber, the patient could have been told to discontinue the aspirin, thus avoiding a potential adverse drug event. This example illustrates the need for clear, complete communication during a transition of care.

The National Transitions of Care Coalition defines transitions of care as "the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change." Transitions of care are also known as handoffs/hand-offs or handovers/hand-overs. The primary objective of a transition of care is to provide accurate information about a patient's care, treatment, and services; current condition; and any recent or anticipated changes.

Transitions of care may occur within organizations, between organizations, or between providers. Patients often undergo multiple transitions during a single episode of care as they are transferred between units or from one provider to another during shift changes. Breakdowns in communication can occur during any transition of care and can often lead to adverse events. According to the World Health Organization (WHO) Collaborating Centre for Patient Safety Solutions,* communication breakdown during transitions of care was the leading cause of sentinel events reported to The Joint Commission between 1995 and 2006 (see Online Extras box; for a description of Online Extras, see page ix). In Australia, 11% of an estimated 25,000 to 30,000 preventable adverse events that led to permanent disability were due to communication issues. These and other findings were discussed in a Patient Safety Solution published in May 2007 to address the topic of communication during transitions of care.

To see the World Health Organization (WHO) Collaborating Centre for Patient Safety Solutions discussion and recommendations regarding communication during transitions of care, visit http://www.jcrinc.com/HCTC10/Extras/.

The Joint Commission and Joint Commission International (JCI) emphasize the importance of having a standardized approach to communication during transitions of care through their requirements for accreditation of health care

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* In 2005, the World Health Organization designated The Joint Commission and Joint Commission International (JCI) as the WHO Collaborating Centre for Patient Safety Solutions. As the only WHO Collaborating Centre dedicated solely to patient safety, The Joint Commission and JCI further advance the entire continuum of patient safety, including principles related to system design and redesign, product safety, safety of services, and environment of care (the physical environment), as well as offering proactive solutions for patient safety, whether based on empirical evidence, hard research, or best practices. A sentinel event, as defined by The Joint Commission, is an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. The phrase or the risk thereof includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. As defined by Joint Commission International, a sentinel event is an unanticipated occurrence involving death or major permanent loss of function, and an adverse event is an unanticipated, undesirable, or potentially dangerous occurrence in a health care organization.
organizations (see Online Extras box; for a description of Online Extras, see page ix).

In August 2009, the newly established Joint Commission Center for Transforming Healthcare embarked on a quality improvement project focused on communication during transitions of care (called “hand-off communications” in the project). A multidisciplinary team chosen by 10 leading hospitals and health systems in the United States set out to address the issues in transitions of care by using Robust Process Improvement™ (RPI), a problem-solving methodology developed by The Joint Commission. Through the use of RPI tools, the team sought to discover specific risk points and contributing factors and then to develop and implement solutions that would improve the effectiveness of communication during transitions of care. The project was expected to continue throughout 2010, culminating in the publication of the solutions in December. To follow the progress of the project, visit the center’s Web site at http://www.centerfortransforminghealthcare.org.

Joint Commission and JCI requirements are similar but different. Consult your Joint Commission or JCI accreditation manual for the specific requirements that apply to your health care organization.

The Purpose of This Book

Improving Communication During Transitions of Care is designed to help organizations providing all types of health care services around the world coordinate and standardize communication during transitions across the continuum of care. The book’s systematic and collaborative approach to improving communication compiles considerations based on evidence-based practices, guidelines, and strategies from organizations in the field.

A Note About Terminology

In this book, to prevent confusion and ensure consistency, the term patient is used throughout to represent any individual receiving care, treatment, or services within or by a health care facility. The terms caregiver and provider are used in this book in a broad sense, referring to any health care professional or facility that serves patients.

Overview of Contents

Improving Communication During Transitions of Care is divided into two parts. Part 1 outlines the challenges that caregivers face when communicating during transitions of care. Part 2 provides solutions for overcoming these challenges. It discusses initiatives that various organizations have developed to improve transitions of care and includes many examples of tools, such as forms, checklists, and procedures. A brief description of each chapter follows.

Chapter 1: Communication Challenges Between Caregivers

This chapter examines nearly a dozen types of transitions a patient may experience and the problems that can arise between personnel involved in the communication at these transition points. The discussion includes transitions within an organization and transitions between two separate care facilities.

Chapter 2: Patient Experience, Participation, and Understanding of Condition

This chapter provides information about the difficulties that patients face when trying to understand their diagnoses or conditions and to participate in their care. It includes information about inadequate discharge preparation, low health literacy, and language barriers.

Chapter 3: Medication Errors

As discussed in this chapter, medication errors often occur because the organization’s medication reconciliation process is inadequate or nonexistent. Another source of medication error is improper medication administration. An additional issue that can lead to error is lack of medication adherence by patients.

Chapter 4: Tools Applicable to Communication at Any Transition Point

This chapter provides a variety of tools to help standardize transitions of care at any point of patient transfer. The tools include those developed by The Joint Commission and by other organizations, along with sample forms and checklists. The chapter also features a discussion about using technology to streamline transition-of-care processes.
Chapter 5: Communication in Specific Situations
The unique considerations of specific transition points are the focus of this chapter. It includes examples of tools useful in such specific situations as a transition between a primary care physician and a specialty care provider, between an anesthesiologist and a postanesthesia recovery room nurse, at nursing shift changes, between the emergency department and another department or unit within the hospital, and between two separate care facilities.

Chapter 6: Monitoring and Evaluating Transitions of Care
This chapter includes information about conducting a failure mode and effects analysis on transitions of care and about what to look for when monitoring transition-of-care processes. In addition, the Care Transitions Measure™ tool is introduced and explained. This tool is used to monitor the transition between hospital and home. The chapter also includes descriptions of general performance improvement methodologies recommended by the Joint Commission Center for Transforming Healthcare.

Chapter 7: Case Studies on Transitions of Care
This chapter highlights initiatives that various organizations worldwide have developed to improve their transition-of-care processes. The case studies discuss the development and implementation of these initiatives as well as how they are monitored. Forms, checklists, and other tools are provided.

Online Extras
You will find bonus features related to this book on the Joint Commission Resources Web site. These Online Extras include additional examples and supplemental information. As shown earlier in this introduction, look for the box with the online extras icon. The Online Extras for this book are available at http://www.jcrinc.com/HCTC10/Extras/.

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References


Chapter 5

Communication in Specific Situations

Chapter 1 discusses issues in communication between providers during transitions of care. This chapter discusses strategies for improving communication between providers during transitions. Sample forms and checklists are provided as available.

Between Primary Care Physicians and Other Specialty Care Providers
When a primary care physician believes that a patient needs care that is outside his or her expertise, he or she may enlist the help of another specialty care provider by requesting either a consultation or a referral (see Sidebar 5-1 for essential elements to be communicated prior to consultation or referral). A consultation is a request for an advisory opinion. A referral is a request for the other specialty provider to assume responsibility for managing a patient's condition.

The American Academy of Family Physicians has developed a consultation/referral request form (see Figure 5-1, page 72) to help primary care physicians and other specialists communicate better during consultation or referrals. The primary care physician fills out the form and sends it to the subspecialist before the patient's appointment. The form includes instructions about what the primary care physician is asking the subspecialist to do and what type of follow-up information the primary care physician would like to receive from the subspecialist. For example, if the primary care physician is requesting a consultation, he or she may check off or tick the appropriate box on the form asking the subspecialist to confirm diagnosis, to advise as to diagnosis, or to suggest medication or treatment. The primary care physician also may request a follow-up telephone call, periodic status reports, or a written report after the consultation by marking a box on the form.

Between Hospitalists and Other Physicians or Service Units
Patients can be particularly vulnerable during transitions of care between hospitalists and other physicians or service units. To assist with these transitions of care, hospital medicine programs should develop standardized processes for communication during transitions of care. Key goals for such standardized processes should include the following:

- The process is reproducible.
- The process is interactive (allowing the receiver to review historical information, verify information, and ask questions).
- The information transferred during the process is up-to-date and accurate.

Sidebar 5-1. Essential Elements to Be Communicated Prior to Consultation or Referral

When requesting a consultation or a referral, the primary care physician should communicate the following elements to the specialist prior to the patient's appointment:

- Date of referral or consultation request
- Patient's name
- Patient's date of birth
- Primary care physician's name and contact information
- Reason for the consultation or referral
- Patient's relevant medical history, diagnoses, and past or current treatments
- A list of the patient's current medications
- Relevant laboratory or diagnostic test results
- Predisposing factors or triggers
- Verbal instruction or educational materials provided to the patient
- Level of urgency
- Patient's and family's fears and concerns

Know the patient’s date of admission and admitting diagnosis.

Read the most recent progress notes from both the physician and the nurse who worked the previous shift.

Some nurses are intimidated by physicians, but when a nurse has a particular concern about a patient that needs to be passed on to the physician, it is important that the nurse be assertive. Nurses also should not hesitate to ask physicians questions if they do not understand the instructions they have been given regarding the patient’s care.

In some cases, it may be helpful for nurses to use written tools, such as the SBAR technique, to aid them in communicating with physicians. For more information about SBAR, see Chapter 4.

### Figure 5-5. Handoff Protocol/Checklist

- Administrative data
  - Patient name/age/gender/family
  - Date of admission to unit
- Problem list
  - Medical history
  - Reason for admission to unit
  - Current medical problems
- Current status
  - Neurology: consciousness and sedation score
  - Cardiovascular status: BP, heart rate, and rhythm
  - Respiratory status: respiratory rate, oxygen saturation, oxygen supplementation, and mechanical ventilation
- Medications
  - Regular medications
  - Medications in continuous infusion
  - Feeding
- Lines and invasive devices
  - IV lines and fluids input
  - Nasogastric tube and input/output
  - Urinary catheter and urine output
  - Endotracheal tube and secretions
- Results
  - Laboratory results
  - Radiology results
- Events during the last shift
  - Hemodynamic
  - Respiratory
  - Infection
  - Other
- Hands-on checking
  - Running fluids
  - Medications in continuous infusion
  - Mechanical ventilation
  - Monitor alarms
  - Dressings
- Tasks expected to be done
  - Laboratory tests and imaging studies (pending results or need to order)
  - Procedures
  - Consultations
  - Others

This checklist can help ensure that important information is not overlooked during a change-of-shift report.


### Sidebar 5-5. Tips for Improving Communication from Nurses to Physicians

To help nurses improve their communication with physicians, nurses can do the following:

- Address the physician by his or her name.
- Have pertinent patient information, including the patient’s chart, readily available.
- Clearly express any concern about the patient and the reason for that concern.
- Provide a recommendation or plan for follow-up.
- Focus on the patient problem, not mitigating circumstances.
- Be professional and assertive but not aggressive.
- Continue to monitor the patient problem until it has been resolved.
Another major effort to improve the hospital discharge process is called Project BOOST (Better Outcomes for Older adults through Safe Transitions). The Project BOOST case study in Chapter 7 provides a detailed description of the development and implementation of this program. In 2008, the year Project BOOST began, six sites participated. Twenty-four more sites joined the program in 2009. By mid-2010, an additional 36 sites had joined. The program continues to expand, including the launch of a BOOST community site to facilitate communication among participating hospitals and, beginning in fall 2010, a tuition-based model of the program.

When patients are discharged from the hospital, they often lack the knowledge and resources to adequately participate in their own care. According to the National Transitions of Care Coalition, improving patient education will create better-informed consumers, which in turn will improve transitions of care.

One strategy that specialty care providers can use to improve patient education is to speak in plain language (see Sidebar 5-9, page 92; see also Sidebar 4-4 in Chapter 4, page 61). Providers should avoid the use of specialized medical terminology when possible, or they should define the medical terms using simple words and short sentences.

To help patients better understand discharge instructions, specialty care providers should have a variety of teaching methods ready to meet the needs of patients with different learning styles. These methods include verbal instructions, written materials, video recordings, models, pictures, audio recordings, and drawings.

Some organizations have developed tools or checklists to help coordinate transitions of care between specialty care providers and patients and families (see Figure 5-11, pages 93–95). Key points to be included in transition-of-care tools include the following:

- Diagnosis
- Treatment options
- Follow-up care
- Medications, including potential side effects or complications
- Who is responsible for which aspects of the patient's care
- What information will be shared with other providers and within what time frame
- What resources are available to assist the patient after discharge

Whenever possible, patients should be involved in their care, including their discharge planning (see Sidebar 5-10, page 96, for opportunities for patient and family involvement).

Sidebar 5-8. Project RED

The Project RED (Re-Engineered Discharge) intervention is a patient-centered, standardized approach to discharge planning and discharge education, initially developed through research funded by the Agency for Healthcare Research and Quality (AHRQ), the lead federal agency charged with improving the quality, safety, effectiveness, and efficiency of health care. AHRQ recently has funded Joint Commission Resources (JCR) to provide customized training and technical assistance to several health systems implementing the Project RED intervention in their hospitals. Project RED aims to improve the patient's preparedness for self-care and to reduce the likelihood of readmission.

The Project RED intervention redesigns the workflow process and improves patient safety by using a discharge advocate who follows 11 discrete, mutually reinforcing action steps shown to improve the discharge process and decrease hospital readmissions. The three key elements of the Project RED intervention include the discharge advocate, the after-hospital care plan, and a follow-up phone call to the patient by a clinical pharmacist a few days after discharge, intended to review medications.

Patients who have a clear understanding of their after-hospital care instructions, including how to take their medicines and when to make follow-up appointments, are 30% less likely to be readmitted or to visit the emergency department than are patients who lack this information.

Patient Continuity of Care Questionnaire

The Patient Continuity of Care Questionnaire (see Figure 5-12, pages 97–99) is a tool developed in Canada by members of the Department of Psychology at the University of Regina in Regina, Saskatchewan, and members of the Department of Medicine at Lakeshore General Hospital in Pointe-Claire, Quebec. It contains questions about the information patients received before hospital discharge as well as questions about
• Improved accessibility of the patient’s discharge plan to all caregivers through the health care system’s electronic records

Following implementation of the quality improvement program, Care Transitions Measure scores initially increased significantly over the first three months. However, they then began to decline due to extenuating circumstances (a rumor that the hospital was in financial trouble and reassignment of nurses to different wards). The study also demonstrated that the quality of transitions of care at discharge, as determined by CTM-3 scores, was a significant predictor of emergency department returns within 30 days of discharge.

Performance Improvement Methodologies

The Joint Commission Center for Transforming Healthcare recognizes the applicability of certain general performance improvement methodologies in addressing communication during transitions of care. Robust Process Improvement (RPI), a problem-solving methodology developed by The Joint Commission, uses a variety of tools to discover specific risk points and contributing factors and then to develop and implement solutions that will improve the effectiveness of communication during transitions of care.

RPI is a set of strategies, tools, methods, and training programs adopted by The Joint Commission for improving its business processes. Application of RPI increases the efficiency of business processes and the quality of The Joint Commission’s products and services. A robust process is a process that consistently achieves high quality by doing the following:
• Recognizing and seeking the voice of the customer
• Defining factors critical to quality
• Using data and data analysis to design improvement
• Enlisting stakeholders and process owners in creating and sustaining solutions
• Eliminating defects and waste
• Drastically decreasing failure rates
• Simplifying and increasing the speed of processes
• Partnering with staff and leaders to seek, commit to, and accept change

The RPI toolkit includes methodologies that have been proven effective in many sectors, including health care, and have been used to achieve dramatic improvements in quality and in cost. These methodologies include Lean Six Sigma, Work Out, and formal change management methods. Lean Six Sigma and Work Out produce the best technical solutions. In addition, all the tools in the RPI toolkit have strong philosophical underpinnings that drive and sustain change, such as the value of an empowered work force, the desire for efficiency, and the goal of excellence.

Lean Six Sigma, Work Out, and change management are the basic “tool sets” within RPI. These methodologies have long, illustrious histories, each with supporters and detractors. The phrase Robust Process Improvement was coined because The Joint Commission recognized the richness of each of these tool sets and the advantage of a variety of approaches. Each of the tool sets is explained in detail in the following pages.

One of the many strengths of RPI is the combination of technical proficiency in data-driven problem solving (through Lean Six Sigma and Work Out) with the multiplier effect of formal change management processes. The inclusion of change management recognizes that a great technical solution is often not enough for sustainability. Recognizing the needs and ideas of people who are part of a process—and who are charged with implementing a new solution—is important in building acceptance and accountability.

Six Sigma

Six Sigma is a statistical model that measures a process in terms of defects. Six Sigma enables an organization to achieve quality by using a set of strategies, tools, and methods designed to improve processes so that less than 3.4 defects (errors) exist per million opportunities, and processes are as near to perfect as possible. Sigma, or the Greek letter $\delta$, is the symbol for standard deviation in statistics. Standard deviation levels help us understand how much the process deviates from perfection.

Six Sigma is also a philosophy of management that emphasizes the following:
• The importance of understanding factors critical to quality and customer expectations
• The measurement and analysis of data
• The implementation of solutions designed to improve processes to affect the most statistically significant sources of variation
• Sustaining these solutions

For a link to the Care Transitions Measure, visit http://www.jcrinc.com/HCTC10/Extras/.
CASE STUDY: TRANSITION FROM THE HOSPITAL TO HOME HEALTH SERVICES IN QATAR

When patients are ready to be discharged from the hospital but still require health care services in the home, it is important to make the transition of care from hospital to home as smooth as possible for patients and family members. At the Hamad Medical Corporation (HMC), in Doha, Qatar, staff members from the hospital and home health services have been taking steps to ensure that patients and families receive timely, appropriate, and safe care in the home immediately after discharge.

HMC is comprised of five hospitals and also provides many other services, such as home health care. In Qatar, health care is primarily funded by the government, and the HMC is a government entity that is overseen by the Supreme Council of Health. Home health services is a relatively new service offered by HMC, says Vicki Alexandra Scruby, assistant executive director, Home Health Services at HMC. “In the past there was some care provision in patients’ homes, but the service was somewhat fragmented without an explicit structure,” says Scruby. “Now, our services are more comprehensive and structured with case management, and we’ve expanded to serve more patients. Patients and families are very receptive to the service. They like the concept of receiving care in the home.”

Note: All five HMC hospitals have been accredited by Joint Commission International (JCI). Home Health Services was accredited by JCI’s Care Continuum program—designed to assess a variety of community-based care settings such as home care, assisted living, long term care, and hospice care—on 28 October 2009.

Implementation
To improve the transition of care from the hospital to the home, staff reviewed case management and discharge planning processes. “We introduced a liaison case manager position within the hospital to facilitate transitions from the hospital to the community with home health services,” says Scruby. “New referrals to home health services come to the liaison’s attention before patients are discharged. The liaison identifies the high-risk patients and will assess those patients and family members before discharge in order to proactively plan for the patients’ care in the home.” The liaison will assess the patient’s needs for medical equipment and devices, wound care treatments, venipuncture and intravenous medications, mechanical ventilation, and so on. If necessary, a home visit to assess the environment may be initiated as well.

Many patients continue to receive home health services for several months or years, and these patients may return to the hospital for care at certain times. “Every day, we receive the admission list from the emergency department so that we can identify any of our patients and get involved in their discharge process as well,” says Scruby. “For our existing patients and new referrals, it is important to be proactive in planning care for patients in the home. In this way, we can prevent complications with complex patient discharges or with patients who require lots of medical equipment in the home.”

Although home health services at HMC are nurse led, a multidisciplinary team plans and coordinates care to meet individual patient needs. “This approach is a major factor in our success, and our patients and their families appreciate interdisciplinary care delivery,” says Scruby. To support this approach, case conferences are held with all members of the multidisciplinary team present, including the home care physicians. Each patient has a unique medical record for home health services in which all members of the multi-disciplinary team plan and document the care given to a patient. This process enables all health professionals to access information about a patient and the care being provided by another member of the team. “This is certainly useful when a home care patient is admitted to an inpatient facility and discharge is being planned as it provides background about past care provision and previous health care requirements,” says Scruby.

Staff members in home health services also work closely with patients and family members to coordinate care, enabling them to be proactive in meeting the patient’s needs in the home. “We communicate with patients and family members closely prior to discharge,” says Scruby, “We talk about what’s going to happen when the patient is discharged home, how often we will visit, what we can do for them, what to do if there is a problem out of hours, and also discuss any of their fears.” Because of the open lines of communication between
staff and patients or family members, Scruby notes that patients and family members are very proactive in phoning if there is an issue. Finally, home health staff members assess patients and caregivers or family members for their education needs. For instance, if patients will be discharged home with oxygen therapy or wound care dressing changes, patients and caregivers will be given specific education in those areas. “A patient educator role has been developed to go out to patients who might need extra education in a particular area,” says Scruby. “And our pharmacists will also go out to educate patients on their medications.”

**Barriers**

Even with the improved case management processes and the implementation of the liaison case manager in the hospital, staff in home health services struggle at times to ensure that patients have a smooth transition to home health services. “For example, we cannot perform miracles when we’ve been given short notice on a complex discharge for a patient requiring lots of medical equipment in the home,” says Scruby. In addition, HMC would like to improve the medication reconciliation process for those patients transitioning from the hospital to home health services. New referrals come to home health services with a written referral from the physician along with a list of the patient’s medications.

“The clinical pharmacist and physician review the medications on admission, as well as the liaison case manager or a case manager in the home health services,” says Scruby. “At times, it can be difficult to assess the medications the patient was taking at home and what he or she will be taking upon discharge from the hospital. We are looking at electronic systems to improve medication reconciliation and make it more simplified.”

**Results**

Overall, the initiation of the liaison case manager role in the hospital has improved patient transitions from receiving care in the hospital to the home. In addition, monitoring whether current patients receiving home health services have been admitted to the hospital helps staff prepare for those patients’ eventual discharge back to the home. “To further evaluate our progress in transitioning patients to the community with home health services, we look at patient satisfaction surveys, quality management indicators, and survey results from Joint Commission International,” says Scruby.