Changes in medical errors after implementation of a handoff program

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Changes in Medical Errors after Implementation of a Handoff Program


BACKGROUND
Miscommunications are a leading cause of serious medical errors. Data from multicenter studies assessing programs designed to improve handoff of information about patient care are lacking.

METHODS
We conducted a prospective intervention study of a resident handoff-improvement program in nine hospitals, measuring rates of medical errors, preventable adverse events, and miscommunications, as well as resident workflow. The intervention included a mnemonic to standardize oral and written handoffs, handoff and communication training, a faculty development and observation program, and a sustainability campaign. Error rates were measured through active surveillance. Handoffs were assessed by means of evaluation of printed handoff documents and audio recordings. Workflow was assessed through time–motion observations. The primary outcome had two components: medical errors and preventable adverse events.

RESULTS
In 10,740 patient admissions, the medical-error rate decreased by 23% from the preintervention period to the postintervention period (24.5 vs. 18.8 per 100 admissions, P<0.001), and the rate of preventable adverse events decreased by 30% (4.7 vs. 3.3 events per 100 admissions, P<0.001). The rate of nonpreventable adverse events did not change significantly (3.0 and 2.8 events per 100 admissions, P = 0.79). Site-level analyses showed significant error reductions at six of nine sites. Across sites, significant increases were observed in the inclusion of all prespecified key elements in written documents and oral communication during handoff (nine written and five oral elements; P<0.001 for all 14 comparisons). There were no significant changes from the preintervention period to the postintervention period in the duration of oral handoffs (2.4 and 2.5 minutes per patient, respectively; P=0.55) or in resident workflow, including patient–family contact and computer time.

CONCLUSIONS
Implementation of the handoff program was associated with reductions in medical errors and in preventable adverse events and with improvements in communication, without a negative effect on workflow. (Fundied by the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, and others.)
PREVENTABLE ADVERSE EVENTS — INJURIES due to medical errors — are a major cause of death among Americans. Although some progress has been made in reducing certain types of adverse events,1-3 overall rates of errors remain extremely high.4 Failures of communication, including miscommunication during handoffs of patient care from one resident to another, are a leading cause of errors; such miscommunications contribute to two of every three “sentinel events,” the most serious events reported to the Joint Commission.5 The omission of critical information and the transfer of erroneous information during handoffs are common.6 As resident work hours have been reduced, handoffs between residents have increased in frequency.7 Improving handoffs has become a priority in efforts to improve patient safety.8,9 The Accreditation Council for Graduate Medical Education now requires training programs to provide formal instruction in handoffs and to monitor handoff quality.9 However, few studies have rigorously evaluated the effectiveness of handoff-improvement programs.6,7,10

In a single-center study, we found that the implementation of a handoff program was associated with a reduction in medical-error rates and improvements in communications between residents at change of shift.11 After performing this study, we developed a bundle of interventions around a refined mnemonic, I-PASS (illness severity, patient summary, action list, situation awareness and contingency plans, and synthesis by receiver).12,13 We hypothesized that multicenter implementation of the I-PASS Handoff Bundle would lead to improvements in communication and patient safety.

METHODS

STUDY DESIGN

We conducted a prospective systems-based intervention study on inpatient units at nine pediatric residency training programs in the United States and Canada, after receiving approval from the institutional review boards at all participating institutions. Each site was assigned to one of three staggered intervention and data-collection waves from January 2011 through May 2013. At each site, we measured preintervention outcomes of interest for a 6-month period. During the following 6 months, the intervention was implemented.

Six months of postintervention data collection followed, matched by time of year to the preintervention data collection at that site. Data on medical errors, the quality of written and oral handoffs (as described below), and demographic characteristics and medical complexity were collected for all patients on the study units. During the intervention, all residents received training in handoff practices and were required to use I-PASS handoff processes while working on study units. However, only residents who provided written informed consent contributed additional observational, demographic, and survey data. Residents were offered small incentives (e.g., cookies and gift cards) to provide data.

STUDY INSTITUTIONS

Nine pediatric residency training programs, ranging in size from 36 to 182 residents, were identified as data-collection sites through professional academic networks, as described elsewhere.14 Each site determined which study unit (all non–intensive care units) to include in the intervention. There was heterogeneity across sites with regard to medical complexity among patients. At baseline, no sites had a standardized handoff program in place.12

INTERVENTION

We developed the I-PASS Handoff Bundle through an iterative process based on the best evidence from the literature, our previous experience, and our previously published conceptual model.12,14 The I-PASS Handoff Bundle included the following seven elements: the I-PASS mnemonic, which served as an anchoring component for oral and written handoffs and all aspects of the curriculum16; a 2-hour workshop15 (to teach TeamSTEPPS16 teamwork and communication skills, as well as I-PASS handoff techniques), which was highly rated17; a 1-hour role-playing and simulation session17 for practicing skills from the workshop; a computer module18 to allow for independent learning; a faculty development program19,20; direct-observation tools21 used by faculty to provide feedback to residents; and a process-change and culture-change campaign,22 which included a logo, posters, and other materials to ensure program adoption and sustainability. A detailed description of all curricular elements and the I-PASS mnemonic have been published elsewhere and are provided in Table S1 in the Supplementary Ap-
We used a well-established surveillance process to measure our two-component primary outcome: rates of medical errors (preventable failures in processes of care) and preventable adverse events (unintended consequences of medical care that lead to patient harm). We also assessed nonpreventable adverse events, which were not expected to change after the intervention. At each site, a research nurse reviewed all medical records and orders on the study unit 5 days per week (Monday reviews included a review of the weekend), formal incident reports from the hospital incident-reporting system, solicited reports from nurses working on the study unit, and daily medical-error reports from residents, collected through daily postshift surveys. Two physician investigators who were unaware of whether a given incident occurred before or after the intervention classified each suspected incident as an adverse event (i.e., harm due to medical care), a near miss or error with little potential for harm, or an exclusion (i.e., an incident determined to be neither a medical error nor an adverse event) (70% agreement; kappa, 0.47; 95% confidence interval [CI], 0.44 to 0.50). Physician reviewers further classified all adverse events as preventable (i.e., due to a medical error) or nonpreventable (i.e., due to a medical intervention with no error in the medical care delivery process) (72% agreement; kappa, 0.44; 95% CI, 0.36 to 0.52). Discordant classifications were reconciled by discussion between the paired reviewers. Examples of errors and events are provided in Tables S2A and S2B in the Supplementary Appendix.

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data before and after the intervention, we used a
generalized-estimating-equation z-test, account-
ing for clustering according to observation ses-
sion with a fixed effect for site. This approach
was based on a Dirichlet distribution, which is a
distribution for the percentage of time that a
continuous variable (in this case, time) is in each
category. When the Bonferroni correction for
multiple testing was used, two-sided P values of
less than 0.025 were considered to indicate statis-
tical significance for the two-part primary hy-
pothesis test (postintervention change in rates of
overall medical errors and postintervention change
in rates of preventable adverse events across all
sites). Because the other tests of hypotheses (for
the main outcomes within each site as well as
other outcomes overall and within each site)
were more exploratory in nature, the Bonferroni
correction was not used, and two-sided P values
of less than 0.05 were considered to indicate sta-
tistical significance. All analyses were com-
pleted with the use of SAS/STAT software, ver-
sion 9.2 (SAS Institute).

On the basis of data from our single-site study,11
we determined that 6 months of data collection
at each site would be sufficient for more than
90% power to detect a 20% relative reduction in
overall error rates and for 80% power to detect a
28% relative reduction in the rate of preventable
adverse events at each site (alpha level of 0.025
with the use of a Bonferroni correction).

RESULTS

STUDY PATIENTS AND RESIDENT PHYSICIANS

We reviewed 10,740 patient admissions (5516 pre-
intervention and 5224 postintervention) for the
presence of medical errors. Length of stay, med-
ical complexity, and the sex and age of patients
did not differ significantly between the preinter-
vention and postintervention periods, nor did the
respective proportions of patients who were
white (41.2% and 41.4%, P=0.38) and who were
enrolled in public insurance programs (55.1% and
54.2%, P=0.61) (Table 1).

A total of 875 residents (representing 95.4%
of those approached) provided written informed
consent to participate. Response rates for post-
shift surveys used as part of medical-error sur-
veillance were similar in the preintervention and
postintervention periods (93.1% [1729 complet-
ed surveys] and 93.3% [1489 completed surveys],
respectively; P=0.88).

MEDICAL ERRORS AND ADVERSE EVENTS

From the preintervention period to the postinter-
vention period, significant reductions were ob-
served for both components of our primary out-
come: the I-PASS Handoff Bundle was associated
with a 23% relative reduction in the overall medi-
cal-error rate across all sites combined (24.5 vs.
18.8 errors per 100 admissions, P<0.001) and a
30% relative reduction in the rate of preventable
adverse events (4.7 vs. 3.3 events per 100 admis-
sions, P<0.001). The rate of near misses and non-
harmful medical errors decreased by 21% (19.7
vs. 15.5 near misses and nonharmful errors per
100 admissions, P<0.001) (Table 2). There was
no significant change in the rate of nonpreven-
table adverse events (3.0 and 2.8 events per 100
admissions, P=0.79). Rates of errors that were
diagnostic, related to medical history or physical
examination, multifactorial, and related to ther-
apiest other than medications and procedures de-
creased significantly, whereas rates of errors
related to medications, procedures, falls, and nos-
comial infections did not change. In site-level
analyses, significant reductions in error rates were
observed in six of the nine participating institu-
tions (Table 3).

WRITTEN AND ORAL HANDOFF QUALITY

The 432 written handoff documents examined
yielded 5752 unique patient handoffs for evalua-
tion (Fig. 1), and the 207 oral handoff sessions
yielded 2281 unique patient handoffs (Fig. 2).
I-PASS implementation was followed by signifi-
cant improvements in the inclusion of all nine
written handoff elements evaluated and all five
oral handoff elements evaluated (see Tables S3
and S4 in the Supplementary Appendix for site-
level data). The mean duration of in-person oral
handoff sessions did not change significantly af-
after the intervention (duration before and after the
intervention, 2.4 and 2.5 minutes per patient, re-
espectively; P=0.55).

RESIDENT WORKFLOW PATTERNS AND SATISFACTION

We collected 8128 hours of time–motion data
(preintervention period, 3510 hours; postinter-
vention period, 4618 hours). For all sites com-
bined, there was no significant change in the
percentage of time in a 24-hour period spent in
contact with patients and families (before and
after the intervention, 11.8% and 12.5%, respec-
tively; P=0.41), creating or editing the computer-
ized handoff document (1.6% and 1.3%, P=0.54),
<table>
<thead>
<tr>
<th>Site No.</th>
<th>Before</th>
<th>After</th>
<th>P Value</th>
<th>Before</th>
<th>After</th>
<th>P Value</th>
<th>Before</th>
<th>After</th>
<th>P Value</th>
<th>Before</th>
<th>After</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>days</td>
<td>no. of children (%)</td>
<td></td>
<td>no. of children (%)</td>
<td></td>
<td>years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>7.9±13.7</td>
<td>8.1±15.0</td>
<td>0.22</td>
<td>316 (61.6)</td>
<td>272 (67.0)</td>
<td>0.09</td>
<td>270 (52.6)</td>
<td>193 (47.5)</td>
<td>0.13</td>
<td>7.0±6.2</td>
<td>7.7±6.5</td>
<td>0.11</td>
</tr>
<tr>
<td>2</td>
<td>13.0±25.0</td>
<td>11.0±18.4</td>
<td>0.34</td>
<td>184 (62.8)</td>
<td>165 (67.9)</td>
<td>0.22</td>
<td>131 (44.7)</td>
<td>116 (48.1)</td>
<td>0.43</td>
<td>4.5±5.1</td>
<td>5.3±5.6</td>
<td>0.17</td>
</tr>
<tr>
<td>3</td>
<td>6.0±10.6</td>
<td>6.2±10.5</td>
<td>0.80</td>
<td>293 (55.8)</td>
<td>317 (59.9)</td>
<td>0.30</td>
<td>252 (48.0)</td>
<td>245 (45.5)</td>
<td>0.42</td>
<td>6.7±6.0</td>
<td>6.4±5.8</td>
<td>0.24</td>
</tr>
<tr>
<td>4</td>
<td>2.8±6.6</td>
<td>3.9±13.2</td>
<td>0.85</td>
<td>126 (21.9)</td>
<td>100 (20.3)</td>
<td>0.52</td>
<td>252 (44.1)</td>
<td>228 (46.5)</td>
<td>0.42</td>
<td>4.8±5.3</td>
<td>4.0±4.9</td>
<td>0.003</td>
</tr>
<tr>
<td>5</td>
<td>5.0±9.7</td>
<td>4.1±8.3</td>
<td>0.29</td>
<td>583 (61.6)</td>
<td>567 (58.3)</td>
<td>0.15</td>
<td>427 (45.1)</td>
<td>445 (45.9)</td>
<td>0.73</td>
<td>3.7±5.4</td>
<td>4.1±5.7</td>
<td>0.58</td>
</tr>
<tr>
<td>6</td>
<td>3.2±5.3</td>
<td>3.1±5.3</td>
<td>0.31</td>
<td>268 (29.4)</td>
<td>264 (29.6)</td>
<td>0.95</td>
<td>424 (46.5)</td>
<td>410 (46.0)</td>
<td>0.81</td>
<td>7.7±6.1</td>
<td>7.6±6.2</td>
<td>0.82</td>
</tr>
<tr>
<td>7</td>
<td>5.1±9.6</td>
<td>4.9±6.4</td>
<td>0.88</td>
<td>266 (51.3)</td>
<td>205 (47.7)</td>
<td>0.27</td>
<td>238 (45.9)</td>
<td>208 (48.4)</td>
<td>0.44</td>
<td>5.2±5.7</td>
<td>5.0±6.1</td>
<td>0.23</td>
</tr>
<tr>
<td>8</td>
<td>3.6±5.8</td>
<td>3.3±6.2</td>
<td>0.78</td>
<td>160 (46.4)</td>
<td>170 (48.7)</td>
<td>0.54</td>
<td>156 (45.2)</td>
<td>141 (40.4)</td>
<td>0.20</td>
<td>7.0±6.7</td>
<td>6.8±6.8</td>
<td>0.80</td>
</tr>
<tr>
<td>9</td>
<td>3.2±8.7</td>
<td>3.1±5.9</td>
<td>0.51</td>
<td>180 (20.7)</td>
<td>215 (24.0)</td>
<td>0.10</td>
<td>395 (45.5)</td>
<td>425 (47.4)</td>
<td>0.40</td>
<td>5.2±5.7</td>
<td>5.1±5.8</td>
<td>0.89</td>
</tr>
<tr>
<td>Overall</td>
<td>4.9±0.13</td>
<td>4.8±0.14</td>
<td>0.59</td>
<td>2376 (43.2)</td>
<td>2275 (43.6)</td>
<td>0.40</td>
<td>2545 (46.3)</td>
<td>2411 (46.3)</td>
<td>0.99</td>
<td>5.7±0.08</td>
<td>5.7±0.08</td>
<td>0.90</td>
</tr>
</tbody>
</table>

* Plus-minus values are means ±SD. Within each site, demographic characteristics before and after the intervention were compared with the use of the Pearson chi-square test for dichotomous variables and the Wilcoxon rank-sum (two-sample) test for continuous variables. For all sites combined, demographic characteristics before and after the intervention were compared with the use of the Cochran–Mantel–Haenszel test for dichotomous variables and a stratified Wilcoxon test for continuous variables, to account for site effects. Data on age, length of hospital stay, sex, insurance status, and race for all patients admitted to the study unit were obtained from hospital administrative databases at each site.

† Medical complexity was defined to be present for each patient whose condition could be classified as belonging to one of three commonly published categories based on International Classification of Diseases, 9th Revision, diagnostic and procedural codes: a complex chronic condition, neurologic impairment, or a condition for which technological assistance was required. 34
working at the computer (16.2% and 16.5%, P=0.81), or writing on printed copies of the handoff document (0.5% and 0.6%, P=0.19).

Significantly more residents reported having received handoff training after the intervention (60.3% before the intervention vs. 98.9% after the intervention, P<0.001). The proportion of residents who rated the overall quality of their handoff training as very good or excellent increased significantly after the intervention (27.8% before the intervention vs. 72.2% after the intervention, P<0.001).

**DISCUSSION**

We found that implementation of the I-PASS Handoff Bundle across nine academic hospitals was associated with a 23% relative reduction in the rate of all medical errors and a 30% relative reduction in the rate of preventable adverse events. We also found significant decreases in rates of specific types of medical errors, including diagnostic errors. Site-level reductions in the overall rate of medical errors were observed at six of the nine participating sites. As anticipated, the rate of nonpreventable adverse events did not change. The quality of written and oral handoff communications significantly improved, which provided evidence that the I-PASS Handoff Bundle was successfully implemented across multiple sites and was likely to have accounted for the observed reduction in medical errors. This error reduction occurred without an increase in the time required to complete handoffs or a decrease in residents’ direct contact time with patients. These findings support calls from professional and federal bodies to improve the patient-handoff process.

### Table 2. Incidence of Medical Errors, Preventable Adverse Events, and Medical-Error Subtypes before and after Implementation of the I-PASS Handoff Bundle.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Before Implementation (N=5516)</th>
<th>After Implementation (N=5224)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall medical errors</td>
<td>1349 (24.5)</td>
<td>981 (18.8)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Preventable adverse events</td>
<td>261 (4.7)</td>
<td>173 (3.3)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Near misses and nonharmful medical errors</td>
<td>1088 (19.7)</td>
<td>808 (15.5)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Medical-error subtype</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Errors related to diagnosis (incorrect, delayed, omitted)</td>
<td>184 (3.3)</td>
<td>111 (2.1)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Errors related to therapy other than medication or procedure</td>
<td>112 (2.0)</td>
<td>77 (1.5)</td>
<td>0.04</td>
</tr>
<tr>
<td>Errors related to history and physical examination</td>
<td>43 (0.8)</td>
<td>0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Other and multifactorial errors</td>
<td>239 (4.3)</td>
<td>106 (2.0)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Medication-related errors</td>
<td>660 (12.0)</td>
<td>580 (11.1)</td>
<td>0.28</td>
</tr>
<tr>
<td>Procedure-related errors</td>
<td>83 (1.5)</td>
<td>85 (1.6)</td>
<td>0.49</td>
</tr>
<tr>
<td>Falls</td>
<td>13 (0.2)</td>
<td>8 (0.2)</td>
<td>0.37</td>
</tr>
<tr>
<td>Nosocomial infections</td>
<td>15 (0.3)</td>
<td>14 (0.3)</td>
<td>0.79</td>
</tr>
</tbody>
</table>

### Table 3. Incidence of Medical Errors before and after Implementation of the I-PASS Handoff Bundle, According to Site.

<table>
<thead>
<tr>
<th>Site No.</th>
<th>Admissions Reviewed</th>
<th>Medical Errors</th>
<th>Before</th>
<th>After</th>
<th>Before</th>
<th>After</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no. total no. (no./100 admissions)</td>
<td></td>
<td>no. total no. (no./100 admissions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>511 406</td>
<td>276 (54.0)</td>
<td>121 (29.8)</td>
<td>0.001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>294 242</td>
<td>76 (25.9)</td>
<td>38 (15.7)</td>
<td>0.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>526 538</td>
<td>296 (56.3)</td>
<td>214 (39.8)</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>586 496</td>
<td>95 (16.2)</td>
<td>47 (9.5)</td>
<td>0.003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>951 974</td>
<td>210 (22.1)</td>
<td>253 (26.0)</td>
<td>0.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>911 893</td>
<td>131 (14.4)</td>
<td>92 (10.3)</td>
<td>0.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>521 430</td>
<td>99 (19.0)</td>
<td>87 (20.2)</td>
<td>0.67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>346 349</td>
<td>72 (20.8)</td>
<td>58 (16.6)</td>
<td>0.20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>870 896</td>
<td>94 (10.8)</td>
<td>71 (7.9)</td>
<td>0.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>5516 5224</td>
<td>1349 (24.5)</td>
<td>981 (18.8)</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Changes in Medical Errors with a Handoff Program

This work builds substantially on our previous single-institution study, in which we found that implementing a prototype handoff-improvement program was associated with reductions in medical errors. We designed our current study to address several limitations of the single-center study. First, we performed a multicenter study to improve study generalizability. Second, we collected data on preintervention and postintervention error rates at the same time of year at each site, to control for potential time-of-year confounding. Third, with the help of experts at multiple sites, we simplified the mnemonic and developed a more robust curriculum to enhance the generalizability, implementation, and sustainability of the intervention.

One of the major concerns about resident duty-hour limits is that although sleep deprivation increases the risk of performance failures and medical errors, reducing work hours leads to more patient handoffs and the potential for more handoff-related errors. However, our study shows that the risk of handoff-related errors can be significantly reduced. Implementing handoff-improvement programs such as the I-PASS Handoff Bundle may potentiate the effectiveness of work-hour reductions, because doing both together may concurrently reduce both fatigue and handoff-related errors.

Our study design precludes definitively establishing a causal link between implementation of the I-PASS Handoff Bundle and improved patient safety. However, we believe it most likely that the safety improvements were due to our intervention because we saw parallel improvements in handoff processes, which was a plausible mech-

Figure 1. Percentage of Written Handoff Documents That Included Key Data Elements (All Sites Combined).

Key quality elements evaluated for written handoffs included an illness-severity assessment, patient summary (defined as a written handoff of at least three of the following: summary statement, ongoing assessment, and active plans), to-do list (defined as a clearly written list of “to-do” items or a statement of “nothing to do”), contingency plans (defined as an indication of what to do if adverse contingencies occurred, or an explicit statement that no adverse contingencies were anticipated), allergy list, code status, medication list, dated laboratory tests, and dated vital signs. In the analysis of all sites combined, significant improvements were seen in every category. In the site-level analyses, significant improvements were observed in the frequency of inclusion of illness severity (nine of nine sites), a patient summary (six of nine sites), a to-do list (five of nine sites), and contingency plans (nine of nine sites) (Table S3 in the Supplementary Appendix). A total of 432 written handoff documents that included 5752 unique patients were reviewed (a mean of approximately 13 patients per written handoff document).
After intervention

P<0.001 for all comparisons

Figure 2. Percentage of Oral Handoffs That Included Key Data Elements (All Sites Combined).

Key elements evaluated for oral handoffs included an illness-severity assessment, patient summary (defined as an oral handoff of at least three of the following: summary statement, events leading up to admission, hospital course, ongoing assessment, and active plans), to-do list (defined as a clearly articulated list of "to-do" items or a statement of "nothing to do"), contingency plans (defined as an indication of what to do if adverse contingencies occur, or an explicit indication that no adverse contingencies were anticipated), and readback by the receiver (defined as readback mostly performed with small correction required or readback fully performed without need for correction). In the analysis of all sites combined, significant improvements were seen in every category. In the site-level analyses, significant increases were observed in the frequency of inclusion of illness severity (nine of nine sites), a patient summary (seven of nine sites), a to-do list (seven of nine sites), contingency plans (seven of nine sites), and readback (nine of nine sites) (Table S4 in the Supplementary Appendix). A total of 207 oral handoff sessions that included 2281 patients were reviewed (a mean of approximately 11 patients per handoff session).

The reason for this is unclear, because significant improvements in written and oral handoff processes were observed at all sites. Because error rates are the product of numerous interacting hospital structures and processes, it is possible that institution-specific factors, such as variation in the ascertainment of error data, inconsistent implementation of the program, or other unmeasured factors, were responsible for the lack of improvement in error rates at some sites. Our study may also have been underpowered to detect improvements in error rates at some sites. Further research on the role of site-specific factors might explain these variations.

Our intervention focused on pediatric inpatient units; the extent to which the I-PASS Handoff Bundle is applicable to other disciplines, specialties, and settings is not yet known. Future studies will be required to determine the broader applicability of the intervention.

We chose to combine several educational and process changes into a single bundled intervention because numerous successful patient-safety interventions have used this approach. Although bundling appears to have been effective in this instance, it prevents us from determining which elements of the intervention were most essential.

In conclusion, we found that implementation of the I-PASS Handoff Bundle was associated with significant reductions in medical errors and preventable adverse events. Site-level changes in error rates were observed at most participating institutions.
The opinions and conclusions expressed herein are solely those of the authors and should not be construed as representing the opinions or policy of any agency of the federal government.

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APPENDIX


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REFERENCES

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