Richard Croteau, MD, executive director for patient safety initiatives for the Joint Commission on Accreditation of Healthcare Organizations, responds to questions about JCAHO's new handoff requirement under the 2006 National Patient Safety Goals.

**Q** Why did JCAHO select handoffs as a new goal requirement?

**Dr Croteau:** Breakdowns in communication have been identified as a major factor in sentinel events. In our review of sentinel events over the past 10 years, breakdowns in communication have been implicated in at least two-thirds of all types of sentinel events. Published studies show that at least half of communication breakdowns occur during handoffs. So this was seen as a requirement that could have a tremendous impact.

We started to address this in the 2005 goals with the requirement for medication reconciliation, which is a specific aspect of handoff communications. We went on to broaden it to other types of handoffs of critical information.

**Q** Will JCAHO define which handoffs need to be standardized?

**Dr Croteau:** At the very least, we will identify areas for attention. Some common examples of handoffs are the change of nursing shift, transfer of responsibility from one physician to another, and residents’ change of shifts. As it relates to the OR, it might involve transfer of the patient from the OR to the postanesthesia care unit (PACU) and from the PACU to the med-surg unit or ICU.

It remains a question whether we will establish a firm expectation that any or all of those must be addressed in a policy to standardize communications.

We will be looking for any type of handoff communication to ensure at least that there is an opportunity to clarify any ambiguous information. This might cause the most strain in organizations that use the practice of audio taping shift reports. Audio taping does not provide an opportunity for clarification. Some might say, “If something isn’t clear, we’ll call the nurse from the last shift at home.” But there is a barrier to doing that. The staff respects when others are off duty and may be less inclined to call and question something than if they were having a face-to-face conversation.

**Q** Is JCAHO going to recommend a method for standardizing handoffs?

**Dr Croteau:** There is no specific model. We will attempt to identify some good practices in health care as well as models from other fields that rely on effective communication.

At least we want to move in the direction of more standardized communication. There is plenty of evidence in the literature and in other fields that a standardized approach reduces errors in communication and improves safety.

**Q** Will JCAHO specify the roles of providers who must be involved in handoffs, such as those from the OR to the PACU?

**Dr Croteau:** We are not going to prescribe the specifics of standardizing the process. It is the organization’s choice. But once the organization has made that choice, we will look for them to do that consistently. The problem is variation. We are looking at reducing variation. That is what improves safety.
What research on hand-offs did JCAHO consider in developing this requirement?

Dr Croteau: I’m not aware of any studies on handoffs in health care. There have been studies in other fields. Like so much of what we do to improve patient safety, there are not the scientific studies you would like to see and often do see in other aspects of health care.

How will JCAHO surveyors judge compliance? What specifically do organizations need to have in place?

Dr Croteau: The survey process will be similar to the way we survey other requirements. We will determine what the organization’s process is, which may or may not be documented in a formal policy. We will determine compliance largely through interviews with the staff who should be implementing this process. We will examine, for example, are they aware of the process? And are they really doing it? We will also gather information through observation. We will likely be observing change-of-shift reports, what happens in the PACU, and so forth. We will be providing more detail in frequently asked questions (FAQs) on our web site.

We would suggest the following steps:

• Identify handoff situations in the organization.
• Identify the handoff situations that are the most important for patient safety. In other words, what would create the greatest risk if there were errors in communication?
• After identifying those situations, determine what your process is for minimizing the risk of poor communication.
• Instruct the staff in the process, including who should be involved in handoffs, what critical information must be communicated, and maybe what to do or what to avoid in a handoff.
• Assess how well this information has been communicated to the staff.

JCAHO’s National Patient Safety Goals are at www.jcaho.org. Look under Top Spots.

**JCAHO requirement on handoffs**

As part of the National Patient Safety Goal to improve the effectiveness of communication among caregivers:

• Implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions.