

Hospital Grand Rounds

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8:00 am-9:00 am, Children's National Auditorium, 2nd Floor Main

Wednesday, November 2, 2016

I-PASS:

Standardizing the Handoff Process to Improve Patient Care and Safety

Presented by Jennifer Everhart, MD

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Nancy Spector, MD

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Miscommunications, including communication failures at patient handoff, are a leading cause of serious medical errors. The multi-site I-PASS handoff study found that implementation of a bundle of interventions to improve resident physician communication during handoffs of patient care was associated with a 23% reduction in overall rates of medical errors and a 30% reduction in preventable adverse events—medical errors that result in harm to patients. Implementation was also associated with improvements in verbal and written communication without a negative impact on provider workflow or handoff duration. Children's National is currently re-implementing I-PASS structured handoffs as a member of the Society of Hospital Medicine's I-PASS Mentored Implementation Program.

Learning Objectives:

Attendees of this session will be able to:

- 1. Describe the role of communication failures in medical errors and preventable adverse events
- 2. Articulate the need for high quality patient handoffs to reduce the likelihood of communication failures
- 3. Describe the implementation of the I-PASS evidence-based handoff bundle and its impact on medical errors and patient safety





