PSNet
PATIENT SAFETY NETWORK

Content analysis of patient safety incident reports for older adult patient transfers, handovers, and discharges: do they serve organizations, staff, or patients?

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https://psnet.ahrq.gov/issue/content-analysis-patient-safety-incident-reports-older-adult-patient-transfers-handovers-and

This study reviewed incident reports involving older adult patient transitions in geriatrics, cardiology, orthopedics and stroke to identify the types of transitions involved and whether reports included any evidence of individual or organizational learning. Half of all incident reports involved interunit/department/team transfers and the majority (69%) of incidents were related to pressure injuries, falls, medication, and documentation errors. Few incident reports referenced individual or organizational learning (e.g., team discussions, root cause analysis) to inform practice or policy changes. A prior WebM&M describes a medication error occurring during an intrahospital transfer between the ICU and interventional radiology.