MedPro Group
a Berkshire Hathaway company

Checklist

PATIENT SAFETY & RISK SOLUTIONS

Reducing Risks Associated With Patient Handoffs

Patient handoffs are a common but risky activity in healthcare. Handoffs occur during shift changes, specialist referrals, patient transfers within a facility or to other healthcare facilities, on-call coverage situations, and more.

With every patient handoff, a potential risk exists for transfer of inaccurate or inadequate information, which can result in patient harm. Important treatment details can be forgotten or miscommunicated for various reasons, including "healthcare provider training and expectations, language barriers, cultural or ethnic considerations, and inadequate, incomplete, or nonexistent documentation . . ."[1]

Because communication breakdowns are a leading causes of medical errors, it is imperative for healthcare organizations to devise effective strategies for communicating when transitioning the responsibility for patient care and transferring patient information. This checklist is designed to help healthcare providers and staff evaluate organizational handoff protocols and identify potential safety gaps.

	Yes	No
Has your organization evaluated situations in which transfers of care commonly occur in the course of patient care and identified potential communication barriers or issues that might impede care transitions? Has this information been used to develop a written policy about handoffs?	☐	☐
Does your organization's handoff policy define the process for patient handoffs, including the specific roles of the sender and receiver as well as the expectations for verbal and written communication?	☐	☐

	Yes	No
Does the handoff policy specify the minimum requirements for what types of information need to be provided during a handoff (e.g., patient diagnosis, pertinent demographic information, test/lab results, medical history and physical exam results, current stage of treatment, any recent changes in condition, potential complications that might occur, active problem list, medications and allergies, ongoing or anticipated therapy, etc.)?	☐	☐
Are standardized checklists and communication techniques (e.g., Situation-Background-Assessment-Recommendation [SBAR], IPASS, and I PASS THE BATON) used as part of handoff protocols?	☐	☐
Does your organization's handoff process include interactive communications (i.e., include an opportunity for questions and answers), limited interruptions, a process for verification, and an opportunity to review relevant historical data?	☐	☐
Do healthcare providers and staff members receive training on handoff policies and protocols? Are they given the opportunity to clarify information and ask questions?	☐	☐
Are staff members encouraged to report problems and barriers associated with handoff protocols?	☐	☐
Does your organization audit handoff processes to ensure that providers and staff members are using appropriate forms, tools, and checklists?	☐	☐
Has your organization established a detailed process for exchanging patient information during shift changes, patient transfers within the organization, patient transfers to other healthcare facilities, patient transfers to other providers (e.g., specialists), and on-call coverage situations? Does your organization use standardized templates to support this process?	☐	☐
Has your organization established communication requirements related to on-call coverage, including (a) specific patient information that primary care providers should provide on-call physicians, and (b) expectations of on-call physicians for notifying patients' primary care providers about patient interactions and documenting phone calls in each patient's health record?	☐	☐

	Yes	No
Is a process in place for retrieving and following up on messages from your organization's answering service? Does this process occur on a daily basis?	☐	☐
Do organizational policies designate responsibility for review, follow-up, and documentation of diagnostic tests results, lab orders, and consultative reports?	☐	☐
Do the organization's manual and electronic communication systems facilitate the handoff process and support communication efforts?	☐	☐

To learn more information and identify best practices for patient handoffs, see MedPro's *Risk Resources: Handoffs and Care Transitions*.

[1] The Joint Commission. (2017, September). *Sentinel Event Alert 58: Inadequate hand-off communication*. Retrieved from www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-58-inadequate-hand-off-communication/