Handoffs and Signouts

Question

It is well known that a common cause of medical errors is the communication breakdown that can occur between healthcare providers while transitioning or "handing off" patient care responsibilities. What tools can help my healthcare organization improve handoff communications?

Answer

Facilitating an effective transfer of patient care and patient information between healthcare providers is an important strategy for reducing medical errors and providing optimal patient care. Handoffs (the process of transferring responsibility for care) and signouts (the act of transmitting information about patients) have been linked to adverse clinical events in various healthcare settings.[1]

These processes heavily rely on sound communication and documentation. Yet, in busy clinical environments with numerous providers and staff members — as well as various technologies and systems — gaps and oversights can easily occur. In an analysis of more than 23,000 malpractice claims and lawsuits, communication failures were identified as a risk factor in 30 percent of the cases — with provider-to-provider communication issues present in 57 percent of those cases.[2]

To begin to tackle problems with handoffs and signouts, ask providers and staff members at your organization to identify:

- Situations in which transfers of care most commonly occur within your organization and between your organization and other care settings
- Communication barriers or risk factors that might hinder handoff communications (so that these issues can be addressed)

Examples of situations in which handoffs and signouts commonly occur include:

- Transfer of patients between primary and acute care settings (e.g., office practice to hospital, hospital to nursing home, etc.)
- Transfer of patients between departments (e.g., the emergency department and the inpatient unit)
- Transfer of patient care during a shift change
- Transfer of patient care between on-call providers
- Transfer of patient care as a result of communicating critical diagnostic results

Examples of barriers to handoff communication include:[3]

- Inadequate or misleading information
- Insufficient staffing and/or heavy workload responsibilities
- Lack of standardized procedures
- Ineffective communication and information exchange methods and systems
- Interruptions and distractions
- Lack of time for, or poor timing in, information exchange
- Inconsistencies in individual preferences regarding what information to share
- Organizational and cultural differences between healthcare settings

Standardized signout checklists can remind healthcare providers about important patient information to communicate to the next provider, such as the patient's diagnosis, medical history, lab/test results, recent changes in condition, current stage of treatment, potential complications, and so on. A number of techniques — such as SBAR and I PASS THE BATON — can be used as the basis for developing a checklist.

Additionally, the Agency for Healthcare Research and Quality (AHRQ) states that use of a standardized handoff bundle, including a signout format called I-PASS, might help reduce preventable adverse events associated with handoffs.[4] The I-PASS mnemonic is specified below:

- **I**llness severity: One-word summary of patient acuity ("stable," "watcher," or "unstable")
- **P**atient summary: Brief summary of the patient's diagnoses and treatment plan
- **A**ction list: To-do items that the clinician receiving signout should complete
- **S**ituation awareness and contingency plans: Directions to follow in case of changes in the patient's status, often in an "if–then" format
- **S**ynthesis by receiver: An opportunity for the receiver to ask questions and confirm the plan of care[5]

SBAR, I PASS THE BATON, and I-PASS offer healthcare teams a structured approach to communication that can help guide consistent transfer of essential information, which in turn can support more efficient teamwork, contribute to better patient outcomes, and decrease the risk of errors.

Resources

To learn more about improving communication and standardizing processes related to patient handoffs and signouts, see MedPro Group's *Risk Resources: Handoffs and Care Transitions*.

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[1] The Agency for Healthcare Research and Quality. (2016, July). Patient safety primer: Handoffs and signouts. Retrieved from www.psnet.ahrq.gov/primer.aspx?primerID=9

[2] CRICO Strategies. (2015). *Malpractice risks in communication failures: 2015 annual benchmarking report*. Retrieved from www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/Risks-in-CommunicationFailures

[3] The Agency for Healthcare Research and Quality, Patient safety primer: Handoffs and signouts; The Joint Commission. (2017, September 12). Inadequate hand-off communication. *Sentinel Event Alert*, 58. Retrieved from www.jointcommission.org/assets/1/18/SEA_58_Hand_off_Comms_9_6_17_FINAL_(1).pdf

[4] The Agency for Healthcare Research and Quality, Patient safety primer: Handoffs and signouts.

[5] Ibid.