MedPro Group
a Berkshire Hathaway company

Checklist

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. A recent study found that 40 percent of communication failures involved a failed handoff, and 77 percent could potentially have been averted by using a handoff tool, according to the *Journal of Patient Safety*.[1]

Because communication breakdowns are a leading causes of medical errors, healthcare organizations should prioritize devising 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 your organization used the information gleaned from evaluations 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?	☐	☐
Do healthcare providers and staff members receive training on handoff policies and procedures, and do they have the opportunity to clarify information and ask questions?	☐	☐

	Yes	No
Are healthcare providers and staff members encouraged to report problems and barriers associated with handoff policies and procedures?	☐	☐
Does your organization's handoff policy specify the minimum requirements for what types of information need to be provided during a handoff (e.g., pertinent demographic information; patient diagnosis, including severity; patient summary, including background information, assessments, and treatment plans; dated vital signs and test/lab results; medical history and physical exam results; recent changes in condition; potential complications that might occur; active problem list; medications and allergies; code status; and sender contact information, etc.)?	☐	☐
Does your organization's handoff process include using standardized tools (forms, templates, and checklists) and communication techniques (e.g., SBAR, IPASS, and I PASS THE BATON)?	☐	☐
Does your organization's handoff process include interactive communication (e.g., the opportunity for questions and answers), limited interruptions, a process for verification, and an opportunity to review relevant historical data?	☐	☐
Does your organization's handoff policy encourage conducting handoffs face-to-face? When face-to-face is not possible, do handoffs occur via telephone or video conference?	☐	☐
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?	☐	☐
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?	☐	☐
Is a process in place to retrieve and follow up on messages from your organization's answering service on a daily basis?	☐	☐
Do organizational policies designate responsibility for review, follow-up, and documentation of diagnostic test results, lab orders, and consultative reports?	☐	☐

	Yes	No
Do the organization's manual and electronic communication systems facilitate the handoff process and support communication efforts?	☐	☐
Does your organization audit its handoff procedures to ensure that providers and staff members are following appropriate procedures and using specified forms, tools, and checklists?	☐	☐

For more information on patient handoffs, see MedPro's *Risk Resources: Handoffs and Care Transitions*.

Endnotes

[1] Humphrey, K. E., Sundberg, M., Milliren, C. E., Graham, D. A., & Landrigan, C. P. (2022). Frequency and nature of communication and handoff failures in medical malpractice claims. *Journal of Patient Safety, 18*(2), 130-137.