MedPro Group
a Berkshire Hathaway company

Checklist

Reducing Risks Associated With Patient Handoffs

Communication failures in healthcare adversely impact patient outcomes and contribute to medical errors.[1] These failures can occur during patient handoffs, which are a common but risky activity. 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 study in the *Journal of Patient Safety* found that 40 percent of communication failures involved a failed handoff and 77 percent could potentially have been averted by using a handoff tool.[2]

Healthcare organizations should prioritize devising effective strategies for communicating when transitioning the responsibility for patient care and transferring critical patient information. This checklist is designed to help healthcare providers and staff assess their organizational handoff protocols and identify potential safety gaps.[3]

	Yes	No
Has your organization evaluated situations in which handoffs commonly occur during patient care and identified potential communication barriers or issues that might impede transitioning patient care?	☐	☐
Has your organization used the information gleaned from evaluations to develop a written policy for 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 processes, and can they clarify information and ask questions?	☐	☐

	Yes	No
Are healthcare providers and staff members encouraged to report problems and barriers associated with handoff policies and processes?	☐	☐
Does the handoff policy specify the minimum requirements for what information should be provided during a handoff? Does it include (as applicable):	☐	☐
• 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 findings?	☐	☐
• Recent changes in condition?	☐	☐
• Potential complications that might occur?	☐	☐
• Active problem list?	☐	☐
• Medications and allergies?	☐	☐
• Code status?	☐	☐
• Sender contact information?	☐	☐
Does your organization's handoff process include using standardized tools (forms, templates, and checklists) and communication techniques (e.g., I-PASS and SBAR)?	☐	☐
Does your organization's handoff process include interactive verbal communication (e.g., the opportunity for questions and answers), limited interruptions, a process for verification, and an opportunity to review relevant historical data?	☐	☐
When appropriate, does your organization use a warm handoff strategy to facilitate care coordination and patient transitions?	☐	☐
Has your organization considered using electronic handoffs to standardize the handoff process and improve accessibility and continuity of care?	☐	☐

	Yes	No
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 daily?	☐	☐
Do organizational policies designate responsibility for review, follow-up, and documentation of diagnostic test results, lab orders, and consultative reports?	☐	☐
Do organizational communication systems facilitate the handoff process and support communication efforts?	☐	☐
Does your organization audit its handoff processes to ensure that providers are following appropriate steps and using specified forms, tools, and checklists?	☐	☐

Resource

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

Endnotes

[1] Alder, S. (2025, April 2). Effects of poor communication in healthcare. *The HIPAA Journal*. Retrieved from www.hipaajournal.com/effects-of-poor-communication-in-healthcare/

[2] 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.

[3] This checklist is based on information from the following sources: Alder, A., Effects of poor communication in healthcare; Agency for Healthcare Research and Quality. (n.d.). *Tool: Handoffs*. Retrieved from www.ahrq.gov/teamstepps-program/curriculum/communication/tools/handoff.html; The Joint Commission. (2017, September 12). *Issue 58: Sentinel event alert: Inadequate hand-off communication*. Retrieved from www.jointcommission.org/en-us/knowledge-library/newsletters/sentinel-event-alert/issue-58