

Handoffs and Signouts

Question

What tools can healthcare organizations and providers use to help improve verbal and written 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 thorough 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. 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, nursing home to hospital, 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

Next, ask providers and staff about communication barriers or risk factors that might hinder handoff communications and potential ideas for addressing them. Examples of barriers to handoff communication include:

- 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 settings³

[Standardized handoff 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.

Additionally, the Agency for Healthcare Research and Quality (AHRQ) states that using a standardized handoff bundle, such as [I-PASS](#), can help reduce preventable adverse events associated with handoffs.⁴

The I-PASS mnemonic is specified below:

- Illness severity: Provide a one-word summary of patient acuity — “stable,” “watcher,” or “unstable.”
- Patient summary: Offer a brief summary of the patient's diagnoses and treatment plan.
- Action list: Develop a to-do list that the clinician receiving signout should complete.

- Situation awareness and contingency plans: Be aware of what is going on and provide directions to follow in case the patient's status changes.
- Synthesis by receiver: Offer an opportunity for the receiver to ask questions and confirm the plan of care.⁵

Various tools offer healthcare teams a structured communication approach 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.

Resource

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](#).

Endnotes

¹ The Agency for Healthcare Research and Quality. (2024, June 15). *Patient safety primer: Handoffs*. Retrieved from <https://psnet.ahrq.gov/primer/handoffs>

² CRICO Strategies. (2015). *Malpractice risks in communication failures: 2015 annual benchmarking report*. Retrieved from www.candello.com/Insights/Candello-Reports/Communications-Report

³ The Joint Commission. (2017, September 12). Inadequate hand-off communication. *Sentinel Event Alert*, 58. Retrieved from www.jointcommission.org/resources/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-58-inadequate-hand-off-communication/

⁴ The Agency for Healthcare Research and Quality, *Patient safety primer: Handoffs*.

⁵ Ibid.

This document does not constitute legal or medical advice and should not be construed as rules or establishing a standard of care. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

MedPro Group is the marketing name used to refer to the insurance operations of The Medical Protective Company, Princeton Insurance Company, PLICO, Inc. and MedPro RRG Risk Retention Group. All insurance products are underwritten and administered by these and other Berkshire Hathaway affiliates, including National Fire & Marine Insurance Company. Product availability is based upon business and/or regulatory approval and may differ among companies.

© 2025 MedPro Group Inc. All rights reserved.