



Legal Matters

Mastering the Patient Handoff

John R. Clark, JD, MBA, NRP, FP-C, CCP-C, CMTE



“For by your words you will be acquitted, and by your words you will be condemned.”¹

Conveying all the information quickly and completely is key, especially in the fast-paced, sometime chaotic, and often stressful environment of transferring a patient from one care team to another. The patient handoff is often cited as the root cause of serious medical errors.² Providing critical and succinct patient information about the situation and the care provided during this transition can improve outcomes and eliminate errors.

Crowding and lengthy stays in the emergency department are the norm in many parts of the United States, and this increases the likelihood that patient handoffs need to be more complete. Overcrowding is not isolated to the United States. In the United Kingdom, just before Christmas (2022), *The Guardian* reported that nearly 1 in 4 ambulance patients in England (ie, nearly 24% of patients arriving at English hospitals by ambulance) waited over 1 hour to be treated in the emergency department (16,379 patients).³ This long wait time was 1 of the factors that prompted 10,000 National Health Service emergency medical service workers to go on strike in England and Wales at the end of December 2022.

A high-quality handoff seems like it should be a simple task; however, the reality is that failed handoffs are a chronic problem. The reasons for miscommunication during a handoff are plentiful. Often-cited reasons include language barriers; cultural or ethnic sensitivities; clinician training and expectations; inadequate, incomplete, or nonexistent documentation; and poor clinician attitudes. In 2006, the Joint Commission established a National Patient Safety Goal that focused on improving handoff communication. In 2010, that goal became a Joint Commission standard

requiring that “The organization’s process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient’s condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.”⁴ Despite this focus, not much has changed in the case law, and it seems that patient handoffs remain a common area of scrutiny in medical malpractice cases. Although communication errors seem simple to correct, a review of medical malpractice lawsuits demonstrates that communication issues are frequently cited as a contribution when a medical error is made. Poor communication is dangerous during patient handoffs, especially in the transport environment when the people with the knowledge of the patient have left the building. Good patient care is to maintain the continuity of care during the transitions.

Many of the articles written about improving handoff communication reference US Navy submariners who are trained to use “precise, unambiguous, impersonal and efficient” language to ensure safe transition between the officer on duty and the sonar technician to navigate safely. Commands, readbacks, and monitoring help bridge authority gradients and ensure the crisis-resistant performance vital to safety.⁵ Aviation is very similar, and readbacks are a part of our culture, so fitting that format into a handoff should not be alien. Rather than getting stuck on the exact format used, the most important part is that there is “valid and useful shared understandings between providers at transitions of care.”⁶

In 2010, a patient safety and medical education initiative at Boston Children’s Hospital looked to standardize and improve how patient care is handed off during

hospital shift changes. This led to the creation of the I-PASS Patient Safety Institute.⁷ After creation, the I-PASS protocol was tested in 9 pediatric hospitals and found to be effective in reducing patient harm from medical errors. It since has been implemented in hospitals nationwide. Data from the institute report that when the I-PASS checklist is used, it reduces medical errors by 23%.⁸ Although this is not an endorsement of this as the only handoff method, adopting a standardized approach to mitigate potential mistakes is proven to be valuable.

When completing a transport, critical information provided during the first handoff can help guide the care that is provided en route. The care that we provide during a transport needs to be clearly conveyed to the staff at the receiving hospital during the second handoff. The transport team’s responsibility includes ensuring the handoff should be free of errors.

A 2021 study led by the Program for Patient Safety and Quality at Boston Children’s Hospital looked at the impact of poor handoffs. The authors reviewed medical malpractice lawsuits filed between 2001 and 2011, looking at instances of communication failures, the type of communication error, and if the errors could have been prevented if the I-PASS system was in place.

Four hundred ninety-eight medical malpractice claims were selected at random from Candello.⁹ Fifty-three percent of claims with communication failures involved provider-patient miscommunication, and 47% involved provider-provider miscommunication. The information types most frequently miscommunicated were contingency plans, diagnosis, and illness severity. Most striking is that 40% of communication failures involved a failed handoff. The authors found that 77% of failures could have potentially

been averted by using a handoff tool like the one developed by the I-PASS Patient Safety Institute. In cases that involved communication errors, they were more expensive, with a cumulative payout of \$58 million compared with \$39 million in cases in which communication errors were not a factor.¹⁰

The I-PASS handoff program has been associated with improving patient safety by reducing miscommunications, medical errors, and injuries due to medical errors. The program uses a uniform structure for verbal and written communication based on the I-PASS mnemonic as follows:

- Illness severity
- Patient information: a comprehensive summary of the patient's condition and treatment plan
- Action list: a timeline of further actions and responsibility for those actions
- Situational awareness and contingency plans: a plan for what might happen
- Synthesis by receiver: ensuring that incoming medical providers understand what is being communicated

Another perspective can be found in a 2016 University of San Francisco master's in nursing capstone¹¹ that looked specifically at the handoff between emergency department and inpatient units. This study looked specifically at the emergency department handoff to an inpatient unit and found that the handoff is a conversation typically held over the phone to discuss the patient's status and plan for care, but it does not follow a standardized format. In this study, 90% of inpatient nurses were satisfied with the report from the emergency department nurse. However, 22% inpatient nurses did not believe that they received enough information to provide safe care for their patient, and 34.5% stated that they had been involved in an error or near-miss experience related to a lack of communication from the report. These comments should be very concerning and would benefit from standardization. Other issues associated with handoff included the following: 59% of inpatient nurses reported that the handoff was not given from the primary nurse, 44% of nurses stated that the report was not detailed enough, and 38% of nurses believed the report lacked organization.¹¹

The malpractice claims are only the tip of the iceberg. Statically, there are many more

communication errors that lead to poor outcomes than the ones that lead to litigation. One of the first reports to highlight medical errors that called attention to the patient handoff was the 1999 report *To Err is Human: Building a Safer Health System*,¹² which included the alarming statistic that as many as 98,000 Americans were dying annually because of medical errors (not just the handoff, all types of errors), but the link between communication failures and malpractice claims is well-known.

Inadequate handoff communication is a contributing factor to adverse events, including many types of sentinel events.¹³ The Joint Commission's sentinel event database includes reports of poor handoff communication causing adverse events, including wrong-site surgery, a delay in treatment, falls, and medication errors. Reviewing the Joint Commission database, clinicians who received a patient handoff reported that 37% of the handoffs were unsuccessful. Conversely, the clinician giving the handoff only reported 21% of handoffs were unsuccessful.¹⁴ The most common criticisms were delays, inattention, or a lack of knowledge about the patient being transferred. Other contributing factors to handoff communication failures included insufficient or misleading information, absence of safety culture, ineffective communication methods, lack of time, poor timing between the sender and receiver, interruptions or distractions, lack of standardized procedures, and insufficient staffing.¹⁵ The handoff failure is well studied in the physician community as well; a study by the Accreditation Council for Graduate Medical Education found that 69% of clinical learning environments did not have a standardized handoff process, and only 20% had some standardization.¹⁶

If your patient handoff has not been standardized and tracked in your quality program, this information should be used to drive changes in practice to create a standardized format for patient handoffs.¹⁰ Relying on checklists and readbacks is inherent in the aviation sector and can be used to model a handoff format if the I-PASS model is not workable.

As I told my daughter Caitlin when she was 5 years old, "Words are important; it is why we use them."

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John R. Clark, JD, MBA, NRP, FP-C, CCP-C, CFC, CMTE, is the chief operating officer of the International Board of Specialty Certification and legal advisor for the International Association of Flight and Critical Care Paramedics.