



Session 31: Patient Handoffs

Facilitator Guide

- **Agenda and Learning Objectives (50 min)**
 - Discuss the importance of high-quality handoffs
 - Compare example handoffs to best practice standards
 - Analyze standardized models for handoff communication (Safer Sign Out, I-PASS, ED I-PASS)
 - Apply a standardized handoff tool (ED I-PASS) to common clinical scenarios
 - Review the unit's Essential Learning summary

- **Guidelines for Facilitators**
 - This module is appropriate for **any level learner** in emergency medicine and **may be led by a single faculty instructor**. If able, we recommend that you invite a **local expert** who can join (or lead) the teaching session and help create a robust discussion and inform local best practices at your institution.
 - The module should ideally be taught during a **50 minute** session. If necessary, it may be truncated closer to 30 minutes if discussion is limited.
 - The format of this teaching session is a mix of **large group discussion** of key learning points with interspersed **active learning opportunities**, which may be completed in small groups or individually.
 - **Be sure to fully review the provided discussion explanations and practice exercises** so you can effectively lead this session.
 - **Session Overview:** handoffs are becoming a focus of QI efforts throughout medicine as they are a common cause of medical error both within the ED as we handoff between providers and between the ED and admitting or consulting teams. There have been several standardized protocols proposed to improve the safety of signouts based on data from other industries requiring high-fidelity transfer of information such as aviation and the military. This session will allow residents to examine best practices in handoff communication and multiple standardized models. They will then incorporate best practices as they demonstrate handoff communication for hypothetical cases using the ED I-Pass tool.
 - **Preparation:** before you facilitate this learning module, be sure to **print out or otherwise distribute** copies of the [Safer Sign Out tool](#), the [ED I-PASS tool](#), and [Practice Handoff Cases](#) (for learners) that are found at the end of this document.

❖ **Part I – Introduction & Best Practice Analysis (20 min)**

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- **Consider this scenario:** You are taking sign-out from a fellow resident after a busy weekend overnight shift. It is scattered and there are several clarifying questions you have to ask to get important information. Several of the plans are incomplete and you are left with an unclear path for those patients. The resident signing out seems frustrated and you become frustrated also. You end up having to retake a history for several of the patients when their plan changes unexpectedly and you wonder how this could have gone better.

❖ **Discussion Questions with Teaching Points**

- **Why are handoffs important? What data do we have that this is a high-risk time?**
 - Handoffs, both at shift change and at admission, have been shown in multiple studies to be a high-risk time for patient care.
 - It has been shown that up to 60% of the time the most important piece of information is not relayed during handoffs.
 - Up to 70% of malpractice suits involve some aspect of communication, often between physicians.
- **Let's spend a few minutes discussing cases you have had that have gone poorly due to difficulties with the handoff process.** What did you learn from those experiences? What are some best practices you have seen for effective handoffs? What are some problems or pitfalls you've encountered? What is your "routine" when receiving a handoff?
 - Make sure examples are deidentified so as not to share protected health information or create an accusatory environment with other learners.
 - Monitor available time for this so as not to infringe on important content in other sections.
- **What are the most common "misses" or errors during handoffs that lead to poor patient outcomes or malpractice suits?**
 - A review from 2018 provided a list of risk mitigation practices for EM providers (deeper dive into each of these is beyond the scope this session):
 - Communication
 - Documentation
 - Reassessment
 - Thorough discharge instructions
 - Follow-up information
 - In-depth discussion with patients who are leaving AMA
 - A study from 2022 looked at over 300,000 claims and sought to evaluate the nature of communication and handoff failures. Nearly 50% of malpractice claims occur due to miscommunication (primarily omission of key information, most often this involves medication selection rationale and medications given/due) between providers or between providers and patients. Handoff failures led to malpractice claims settled at more than \$600,000 per claim.

- **The following are general best practices to minimize error during patient handoffs. Briefly review the following and discuss how the norms at your institution align with these recommendations.**
 - Think of the mnemonic **TIPS** during the handoff: **T**iming, **I**nterruptions, **P**hysical environment, **S**tandardized communication. Each of these are very tightly intertwined during the handoff period. All of them have been suggested by the Joint Commission.
 - **Timing** - One study published in *WestJem* emphasized the importance of timing during handoffs. The team may need to set predefined times during the shift when signout happens.
 - **Interruptions** - Studies show that interruptions happen every 7-8 minutes in the ED. With interruptions, there is a 12% increase in errors. Setting a precise and protected time and involving an interprofessional team may minimize interruptions. The receiver may need to wait for all the information to be provided to them before asking clarifying questions (avoid interruptions).
 - **Physical environment** - Dedicating a particular location for handoff may help with safe transition. Critical care units, observation units, workstations and/or mobile workstations are all routinely used. Critical care units tend to have the highest interruptions. In some instances, such as handing off critically ill patients, including nursing staff may help passing on valuable information.
 - **Standardized communication** - There are several handoff tools which have been found to be effective with lowering errors. They will be discussed further in this module.
 - **Discuss additional handoff communication suggestions**, with include adapted recommendations from ALiEM's "10 Tips to Minimize Error at ED Sign-Out Rounds":
 - Use concise language - minimize unnecessary words or information.
 - Use precise language - when describing abnormal values, avoid ambiguity.
 - AVOID: The patient has a low blood pressure and elevated lactate.
 - BETTER: The patient has hypotension with systolics in the 90s and an initial lactate of 4.6.
 - Name your working diagnosis or differential explicitly. This ensures that important diagnostic considerations are not lost in translation.
 - AVOID: This is an elderly patient with AFib and abdominal pain so we are getting a CT. [moving on...]
 - BETTER: 70 yo M with AFib noncompliant with anticoagulation here with abdominal pain and exam concerning for possible mesenteric ischemia. CT is currently pending.
 - Include key special information about a patient, such as if the patient has special needs, or is deaf, or has a unique knowledge base (e.g., patient is a healthcare worker).
 - Start with the answer and tasks - lead with the diagnosis and disposition, if known, and specific action items that need to be done, if any.
 - Always have a disposition in mind, and if unsure, explain why you are uncertain and what additional information is needed to help decide disposition.
 - Ensure there is closed loop communication and the opportunity to ask questions.

- Let your patients know that another provider will be taking over their care and answer any questions they may have.
 - Try not to leave work for others - try not to sign out additional testing to be ordered, procedures, or consultations unless both parties agree that they are necessary and should be left with the oncoming clinician.
 - When anticipated, complete discharge instructions in advance of signout. The primary ED physician is best equipped to include relevant information, prescriptions, and follow-up planning. The physician who takes signout and discharges the patient should review these instructions, and make updates as necessary (incidental findings, etc).
- **What should you do after receiving a handoff?**
 - Re-triage the patients you received in signout. Clearly identify the patients you are most worried about and who are most active.
 - Review recent vitals, labs/imaging and other data to make sure there aren't unexpected abnormalities or loose ends not discussed at handoff.
 - If you primarily do "board rounds", be sure to visit the bedside of all "active" patients to determine your own clinical gestalt of their status and to introduce yourself as a new provider.
 - Consultants - Discussing handoff patients with consultants or admitting services may be difficult. It may help to reexamine the patients and review all available data before consulting.
 - When in doubt, return to the patient bedside to do your own history/physical or reevaluation when there are unexpected findings or if the patient is getting sicker.
 - **The following are examples of suboptimal handoff communication to promote discussion. As the facilitator, read the provided information for each patient to your learner group. Consider having a learner role play as the oncoming physician who will be assuming the care of this patient. Allow them (or the group as a whole) to ask clarifying questions. You may fill in the blanks for the case as you see fit. After each case, prompt discussion from the group about the strengths or weaknesses of the handoff communication. As time allows, ask a different learner to model improved handoff communication for the patient.**
 - **Patient #1:** Mrs. F is a 27-year-old female who presents with right lower quadrant pain that started today. She is sexually active and her last menstrual period was six weeks ago. Most recent vital signs are P 98, BP 102/74, RR 20, O2 Sat 98%, T 37.4 C. Labs are remarkable for hemoglobin of 7.4, but she thinks she has been told she has anemia (unknown baseline). Urine pregnancy test is currently pending- the plan is to get the pregnancy results before deciding if we should order an ultrasound or CT.
 - **Patient #2:** Mrs. B is a 68-year-old female with a history of dementia, postoperative day 9 from a right hip replacement. She was sent for evaluation of right leg swelling. P 90, RR 15, BP 148/72, O2 Sat 97%, T 37.8 C. Her ultrasound today was negative for DVT and she is pending transport back to her nursing home.
 - **Patient #3:** Mr. R is a 48-year-old male who recently arrived with SOB. He has a history of CHF and ESRD. Initial vitals were P 115, BP 190/110, RR 30, O2 Sat 80% on RA, T 37.1 C.

He was a difficult stick (AVF in LUE) and currently has a 22g in the right hand (unable to draw blood). Lungs sounded wet on the exam and he was working pretty hard. I gave him a sublingual nitroglycerin and started him on BiPAP. He was looking a little better when I left the room to come sign out.

❖ Part II – Review Standardized Handoff Tools (10 min)

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❖ Discussion Questions with Teaching Points

- **What is the potential benefit to a standardized method for handoffs?**
 - Improving transitions of care – also called patient handoffs – is a national patient safety priority as communication failures are a leading cause of medical error.
 - Organizations requiring high reliability (i.e., the military, airline industry, nuclear power) have developed ways to ensure that communication is organized and standardized.
 - Many advocate a similar process in medicine to reduce communication errors during patient handoffs. A study at one hospital showed a decrease of 50% in adverse events after the implementation of a standardized sign-out process.
 - Different models have been developed to promote the accurate transfer of patient care information. Three are detailed below.
- **Let's briefly review and discuss standardized handoff tools that have been developed.**
 - **Safer Sign Out** is a structured communication tool (paper-based form) that was developed for ED use in 2013 by the Emergency Medicine Patient Safety Foundation in collaboration with ACEP. **Using the [SSO summary and form example](#) handout, review the details and discuss with your group the pros/cons and feasibility of implementing SSO at your institution.**
 - **The Safer Sign Out model has 5 key components:**
 1. **Record** (sign out form, printed or computer generated) the patient information, vital signs, important clinical details, safety issues, and follow-up items on a paper form. This serves as a checklist, reference, and reminder tool.
 2. **Review** this form with the oncoming clinician in front of the computer so chart information is available. Allow time for Q&A. Minimize interruptions.
 3. **Round** at the bedside with the oncoming clinician to meet the patient and ensure communication of the plan. Ideally, Charge +/- patient RN should be included at this stage (will accomplish #4).
 4. **Relay the plan** to the other team members by discussing it with the nurse before, during, or after patient rounding.
 5. **Receive feedback** on the sign-out forms as they are reviewed by the oncoming clinician. After shift, paper forms may also be returned to the original clinician to provide follow up (outcomes) or for QA review.
 - **The "I-PASS" mnemonic** is a structured-communication tool that was primarily developed for **inpatient** handoffs. In a multi-institutional study, a handoff program using the "I-PASS" mnemonic was found to reduce medical errors (up to 37% adverse effect

reduction in some studies) and preventable adverse events in the inpatient pediatric setting.

■ **I-PASS stands for:**

- I: Illness severity (stable, watcher, unstable)
- P: Patient summary (presentation, course, plan)
- A: Action list (to-dos, including timeline and ownership)
- S: Situational awareness and contingency planning (if-thens)
- S: Synthesis by receiver -> receiver summarizes information and restates key points

- **ED I-PASS** has been more recently developed (2022) as a modification to the above for more appropriate use in the ED setting. One study that applied this tool (in addition to EMR templates/dot phrases) in a pediatric ED setting found a significant decrease in perceived loss of patient information during intershift handoffs. **Using the [ED I-PASS reference](#), review the details and discuss with your group how this could or should be implemented at your institution.**

■ **ED I-PASS stands for:**

- ED: Expected Disposition
 - Pending (“active” patient, TBD)
 - Discharge (include where)
 - Admit (include service, level of care)
- I: Illness Severity (stable, watcher, critical)
- P: Patient Summary
 - 1 liner with leading dx (if available)
 - Relevant details of presentation and ED workup
 - Include important results or abnormalities
- A: Action list
 - To-do list for the patient
 - Clearly establish ownership of tasks
- S: Situational awareness
 - Contingencies (if -> then scenarios)
 - Include patient/family updates, plans for consults, additional workup, or disposition pending action item results
- S: Synthesis by receiver
 - Concise “read-back”
 - Q&A

❖ **Part III - Handoff Practice Cases** (15 min)

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The final activity allows learners to practice patient handoffs using the ED I-PASS model. Pass out the [Handoff Practice Cases](#) (learner handout) to your group. Make sure they still have access to the ED I-PASS reference, provided above. Assign a case number to every learner in the room (count off to evenly distribute). Give learners 2-3 minutes to independently plan their handoff communication using the ED I-PASS model. Then, as a large group, ask for learner volunteers to share their sign-out for each case. Allow brief discussion after each case and provide your own coaching as needed. Keep in mind local institutional policies that might influence patient handoffs (e.g., are “boarding” patients managed by the ED or inpatient teams?). Your goal is to help prepare learners to be successful at any practice location after training.

Facilitator Cases with Explanations

- 1) Mrs. J is a 57-year-old female, with a history of poorly controlled diabetes. She presents with a rash to the groin that started as a pimple 2 days ago but has been spreading. Initial vital signs are P 142, BP 130/60, RR 24, O2 Sat 99%, T 38.2°C. Exam shows a fluctuant mass to the R labia with foul-smelling drainage, induration, erythema spreading to the lower abdomen and upper right thigh with +crepitus. Her EKG shows sinus tachycardia. She was a difficult stick and you just obtained access with an US-guided IV. Her labs and imaging are pending at the time of handoff.

Facilitator Tips: while practice may vary, the following should be considered and communicated during handoff:

- Worst first differential should include necrotizing fasciitis.
- Prompt initial treatment should include sepsis protocol, broad antibiotics including vanc/zosyn/clindamycin or similar, and ideally marking/monitoring wound margins.
- Labs/imaging should not delay emergent surgical consult.
- Learners will need to focus on communicating the severity of the patient's presentation, antibiotic administration, prompt involvement of consultants and anticipated disposition.
- Clear communication should include what is done, what needs to be done, and who is doing it.
- Discussion should focus on the urgency of surgical team evaluation/decision-making and rapidly obtaining imaging, in addition to contingency plans (how to navigate recs and results) and disposition planning (to OR vs step-down, ICU, etc).
- Example of handoff communication using the ED I-PASS model:
 - **ED I-PASS model:**
 - **Expected disposition-** Pending/active, will require admission
 - **Illness severity-** “Watcher”
 - **Patient summary-** “Patient is a 57 year old female with a history of poorly controlled diabetes. I am primarily concerned for necrotizing fasciitis involving the R labia, abdomen and upper thigh, but the differential includes cellulitis/abscess with sepsis. She is febrile and tachycardic to 142 with stable blood pressure. I obtained an US-guided IV and she will be getting 2L of IVF. I’ve ordered labs, cultures, antibiotics including vanc/zosyn/clinda, and CT imaging. I will call surgery for emergent consultation and mark the wound margins.
 - **Action list-** Follow up on CT results and surgery recommendations.
 - **Situational awareness-** Will need monitoring for responsiveness to fluids

and evolving septic shock. Advocate for timely CT and surgery evaluation.

- **Synthesis by receiver-** This is a 57 yo diabetic with possible necrotizing fasciitis to the groin and sepsis. She has gotten IVF, antibiotics are ordered and she is pending CT and surgery recommendations. I will monitor wound margins, responsiveness to IVF, and ensure prompt CT and surgery recommendations before admission to OR or ICU (hospital dependent).

- 2) Mr. P is a 52-year-old male with a history of alcohol use disorder who presented for suspected alcohol intoxication. Shortly after arrival, he became highly agitated and threatening towards staff, requiring chemical sedation. Triage vitals were P 105, BP 120/70, RR 13, O2 Sat 96% on RA, T 37.4°C. Exam was remarkable for slurred speech, poor coordination, and a right shoulder abrasion. At the time of handoff, the patient is 20 minutes s/p sedation, on a stretcher in the hall, and minimally responsive to painful stimuli.

Facilitator Tips: while practice may vary, the following should be considered and communicated during handoff:

- Explanation of why or why not labs are ordered, including POC glucose.
- Explanation of why or why not imaging is ordered to rule out traumatic injuries (fracture, brain bleed, etc).
- Explanation of what, if any, treatment is planned beyond “awaiting clinical sobriety”.
- Safety plan for the patient s/p chemical sedation, including monitoring (consider ETCO2), reevaluation needs (timeline), and risk for withdrawal.
- Time-permitting, further discussion may focus on challenges of giving and receiving signout on patients who are altered/agitated.
- Example of handoff communication using the ED I-PASS model:
 - **ED I-PASS model:**
 - **Expected disposition-** Currently active, anticipated discharge
 - **Illness severity-** “Watcher”
 - **Patient summary-** This is a 52 yo M with alcohol dependence here with suspected alcohol intoxication. He required sedation with 2 mg of Versed and 5 mg of Haldol for agitation and threatening behavior. His most recent vitals are significant for mild tachycardia to 105. His exam shows a R shoulder abrasion but no other signs of trauma. I’ve asked the RN to check a POC glucose and move the patient to a monitored room including ETCO2. I will update you with any concerning results.
 - **Action list-** Monitor repeat vitals, monitor for clinical sobriety or withdrawal symptoms and escalate care as needed.
 - **Situational awareness-** Chart review shows prior visits without withdrawal symptoms and ED visit 3 days ago with elbow abrasion documented, XR negative, CT brain negative at that time.
 - **Synthesis by receiver-** 52 yo M with likely alcohol intoxication, required chemical sedation, and pending POC glucose. He has no new trauma and is at low risk for alcohol withdrawal. He will require monitoring and serial exams for sobriety with anticipated discharge.

- 3) Mrs. A is a 66-year-old female who you recently admitted to step-down with presumed sepsis. She presented with fever and cough for 3 days. She has a history of CHF (EF 40%) and is compliant with home meds. Most recent vital signs are P 120, BP 100/60, RR 28, O2 Sat 95% on 2L O2 (new), T

39.4°C. Exam was significant for rhonchi at the right base, mild increased work of breathing, and trace BLE edema. EKG is at baseline. CXR shows a RLL pneumonia. WBC is 19. Initial lactic acid is 4. You have ordered antibiotics and 1 L of IVF. The patient is admitted and has been boarding in the ED for the past 1 hour.

Facilitator Tips: while practice may vary, the following should be considered and communicated during handoff:

- Attention should be paid to the tenuous status of a patient with HFrEF and sepsis requiring fluid resuscitation, including determination of volume status (POCUS?, UOP?), IVF volume planned, antibiotics ordered, and reevaluation needs.
- Explanation of what, if any, continued care is needed by the ED team (per norms of management for “admitted” patients who are boarding in the ED)
- Regardless of responsibility (above), it should be recognized that the ED team is likely best equipped to recognize evolving septic shock and respiratory failure, both of which are risks for this patient.
- Example of handoff communication using the ED I-PASS model:
 - **ED I-PASS model:**
 - **Expected disposition-** Currently admitted
 - **Illness severity-** “Watcher”
 - **Patient summary-** 66 yo F with HFrEF (EF 40%) is admitted for RLL pneumonia and sepsis. She was tachycardic to 120 and hypotensive to 100/60 on arrival. Her initial lactate was 4. She is getting ceftriaxone/azithromycin and 1L of IVF based on POCUS IVC collapse.
 - **Action list-** monitor while in the ED
 - **Situational awareness-** Will need monitoring for responsiveness to fluids, evolving respiratory failure, or progression to septic shock requiring vasopressors.
 - **Synthesis by receiver-** This is a 66 yo F with heart failure, current volume depletion, pneumonia and sepsis. She is getting gentle IVF and antibiotics and has been admitted. I will follow up her repeat vitals, repeat lactic, and reevaluate her respiratory status while she is boarding in the ED.

- 4) Young Mr. B is a 4-year-old boy with 2 days of severe, non-bloody diarrhea and non-bloody, non-bilious vomiting. He was referred by his pediatrician, Dr. Eyeluvkids. His older sister just recovered from a similar illness. Initial vitals were P 136, RR 24, BP 94/60, O2 Sat 97%, T 37.2°C. Exam was significant for mild non-focal abdominal tenderness without peritonitis and delayed capillary refill of 4 seconds, but was otherwise normal. At the time of handoff, he is receiving his first normal saline bolus.

Facilitator Tips: while practice may vary, the following should be considered and communicated during handoff:

- Most likely diagnosis (gastroenteritis) and why more concerning diagnoses are less likely.
- Determination of volume status, resuscitation plan, and reevaluation needs.
- Parameters of improvement that would allow for safe discharge vs admission.
- Communication plan for the family and the patient’s pediatrician, including who will do this.
- Example of handoff communication using the ED I-PASS model:
 - **ED I-PASS model:**

- **Expected disposition:** Currently active, anticipated discharge
- **Illness severity:** Stable
- **Patient summary:** 4 yo M with vomiting, diarrhea, +sick contacts concerning for gastroenteritis. His vitals show tachycardia to 136 but are otherwise normal. Exam suggests dehydration but is otherwise benign. He is getting a chem panel, 2 mg of Zofran, and 20 cc/kg IVF bolus. I have updated his family about the current plan, including anticipated discharge if he improves and tolerates PO.
- **Action list:** Monitor vitals, review chemistry results, and reevaluate the patient for possible PO trial and discharge.
- **Situational awareness:** The patient's pediatrician referred him here and will need an update upon disposition. Contact info is in the chart.
- **Synthesis by receiver:** This is a 4 yo M with likely gastroenteritis and dehydration. We are waiting on a chem panel, reevaluation after IVF, and PO trial. If he can be discharged I will update his pediatrician.

5) Mr. C is a 72-year-old male with a history of severe dementia, prosthetic aortic valve on warfarin, who had a ground level fall causing an occipital hematoma. He is DNR/DNI and his family is at bedside. Initial vitals were P 68, RR 16, BP 180/120, O2 Sat 93% on RA, T 36.8°C. Exam is significant for GCS 11 (E3 V3 M5) with baseline GCS 14 (confusion), c-spine tenderness (moaning), large occipital hematoma and oozing blood from a 4 cm laceration. Initial labs are significant for a hemoglobin of 11.4 (at baseline) and an INR of 3.7. At the time of handoff, he is pending CT imaging.

Facilitator Tips: while practice may vary, the following should be considered and communicated during handoff:

- Worst first differential to include traumatic intracranial hemorrhage with evolving herniation.
- Explanation of what imaging is ordered to rule out traumatic injuries (CT brain/c-spine vs CT panscan) and why.
- Explanation of what treatment has been or should be provided.
- Inclusion of DNR/DNI status and specific if-then treatments depending on discussion with family (degree of respiratory support, invasive procedures, surgery); if this is not established it should be clearly identified who will communicate with the family.
- Status of laceration repair; if not completed, clearly identify who will be responsible.
- Example of handoff communication using the ED I-PASS model:
 - **ED I-PASS model:**
 - **Expected disposition-** Currently active, will likely require ICU admission
 - **Illness severity-** Critically ill
 - **Patient summary-** 72 yo M with dementia (GCS 14 at baseline for confusion) is here after a GLF with concern for intracranial bleeding and possible herniation. His vitals are sig for hypoxia to 93% improved on 2L NC and HTN to 180/120. His exam shows an occipital hematoma with laceration and a GCS of 11. He has received hypertonic saline and is pending CT panscan. He has a prosthetic valve and is on warfarin with an INR of 3.7; he will require AC reversal if CT shows ICH. He is DNR/DNI. I will repair his laceration before leaving.
 - **Action list-** Monitor for clinical deterioration, follow up CT results, reverse warfarin as needed, consult neurosurgery +/- trauma surgery as needed (institution dependent), update his family, admit to the ICU

- **Situational awareness-** He is confirmed DNR/DNI by family at bedside but they would like to be updated with results and will decide on any other critical interventions.
- **Synthesis by receiver-** 72 yo M with dementia, on Coumadin, with concern for traumatic intracranial bleeding and herniation. He is currently a GCS of 11 and requires 2L O2. He is DNR/DNI. He is pending CT imaging, will likely require neurosurgery consult, and further interventions should be discussed with the family at bedside.

❖ Deep Dive Questions [Time-Permitting]

If you have time available, consider prompting the following questions. Keep in mind, there are no clear guidelines for “correct” answers. However, it may be beneficial for learners and faculty to share perspectives on these topics.

- What are the advantages and disadvantages of rounding at a computer compared to rounding at the bedside? Is there a method to optimize or incorporate both?
- When is it appropriate or inappropriate to change the “plan” for a patient who was signed out to you by a colleague?
- Related to the above, what should you do when you disagree with the assessment or treatment plan created by a colleague?
- Are there any “always” or “never” sign-out tasks? What procedures, discussions, or other tasks for patient care should routinely be managed by the primary provider and what is reasonable to hand off?
- How safe is your institution’s current signout process and should any changes be made?

❖ Essential Learning Summary (5 min)

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- Recruit and answer any final questions from the group.
- Review essential take-aways from the learning session and/or send this to learners for spaced repetition after the meeting:
 - Transitions of care such as shift change handoffs are performed every shift, commonly exclude important clinical details, and are medico-legally high-risk.
 - Use of a structured method of sign-out reduces the risk to our patients, conveys the information necessary to continue their treatment, and improves patient care.
 - Consider the mnemonic TIPS: Timing, Interruptions, Physical environment, Standardized communication. Make handoff time uninterrupted time with dedicated space and unambiguous communication.
 - Standardized handoff tools have been shown to reduce errors. Using a method such as ED I-PASS requires practice and deliberate attention, but will leave you feeling better about your communication and overall patient safety.

❖ Paired Asynchronous References

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The following are vetted FOAM references that are strategically paired with this module. Learners may access these on the [FoEM website](#) (Learner Resources -> Foundations III) and review them before or after the learning session.

- [SAEM's Transfer of Care Video](#)
- [10 Tips to Minimize Errors at ED Sign-Out Rounds](#)
- [JHQ ED I-PASS Abstract](#)

❖ Attributions

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<https://www.jointcommission.org/resources/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-58-inadequate-handoff-communication/>.

The Safer Sign Out model has 5 key components:

1. **Record** (sign out form, printed or computer generated) the patient information, vital signs, important clinical details, safety issues, and follow-up items on a paper form. This serves as a checklist, reference, and reminder tool.
2. **Review** this form with the oncoming clinician in front of the computer so chart information is available. Allow time for Q&A. Minimize interruptions.
3. **Round** at the bedside with the oncoming clinician to meet the patient and ensure communication of the plan. Ideally, Charge +/- patient RN should be included at this stage (will accomplish #4).
4. **Relay the plan** to the other team members by discussing it with the nurse before, during, or after patient rounding.
5. **Receive feedback** on the sign-out forms as they are reviewed by the oncoming clinician. After shift, paper forms may also be returned to the original clinician to provide follow up (outcomes) or for QA review.

Sample Sign Out Form

Safer Sign Out Form (v12)

☐ Check if No Patients Signed Out Off-Going Clinician: _____ Receiving Clinician: _____ Date Shift Started: _____

Patient Name & Age	Problem List & Key Issues	Pending	Dispo	Receiving Clinician's Notes
Room: _____	Diagnosis/CC: _____ Key Issues: _____ Potential Safety Issues or Precautions? _____		Home _____ Admit _____ Transfer _____ NH _____ TBD _____	☐ Rounded on Patient ☐ Included/Informed Nurse
Room: _____	Diagnosis/CC: _____ Key Issues: _____ Potential Safety Issues or Precautions? _____		Home _____ Admit _____ Transfer _____ NH _____ TBD _____	☐ Rounded on Patient ☐ Included/Informed Nurse
Room: _____	Diagnosis/CC: _____ Key Issues: _____ Potential Safety Issues or Precautions? _____		Home _____ Admit _____ Transfer _____ NH _____ TBD _____	☐ Rounded on Patient ☐ Included/Informed Nurse

This form is a Quality Assurance Tool and is **NOT** part of the medical record

Modified from: Fuller D. Implementation Presentation for Safer Sign Out. American College of Emergency Physicians. Accessed July 7, 2023.

<https://www.acep.org/siteassets/uploads/uploaded-files/acep/membership/sections-of-membership/qips/toolbox/safer-sign-out-presentation.pdf>

ED I-PASS stands for:

- **ED: Expected Disposition**
 - Pending (“active” patient, TBD)
 - Discharge (include where)
 - Admit (include service, level of care)
- **I: Illness Severity**
 - Stable
 - Watcher
 - Critical
- **P: Patient Summary**
 - 1 liner with leading dx (if available)
 - Relevant details of presentation and ED workup
 - Include important results or abnormalities
- **A: Action list**
 - To-do list for the patient
 - Clearly establish ownership of tasks
- **S: Situational awareness**
 - Contingencies (if -> then scenarios)
 - Include patient/family updates, plans for consults, additional workup, or disposition pending action item results
- **S: Synthesis by receiver**
 - Concise “read-back”
 - Q&A

Tool modified from: Yanni E, Calaman S, Wiener E, Fine JS, Sagalowsky ST. Implementation of ED I-PASS as a Standardized Handoff Tool in the Pediatric Emergency Department. J Healthc Qual. 2023;45(3):140-147. doi:10.1097/JHQ.0000000000000374

Instructions: The following are clinical summaries of ED patients you need to sign-out to the oncoming physician. Essential case information is included, but you'll need to fill in the blanks of care that you provided based on the clinical scenario. Your facilitator will assign you a case (or cases) to prepare for handoff using the ED I-PASS model (see separate reference handout). All cases will be discussed with the large group.

1. Mrs. J is a 57-year-old female, with a history of poorly controlled diabetes. She presents with a rash to the groin that started as a pimple 2 days ago but has been spreading. Initial vital signs are P 142, BP 130/60, RR 24, O2 Sat 99%, T 38.2 C. Exam shows a fluctuant mass to the R labia with foul-smelling drainage, induration, erythema spreading to the lower abdomen and upper right thigh with +crepitus. Her EKG shows sinus tachycardia. She was a difficult stick and you just obtained access with an US-guided IV. Her labs and imaging are pending at the time of handoff.
2. Mr. P is a 52-year-old male with a history of alcohol use disorder who presented for suspected alcohol intoxication. Shortly after arrival, he became highly agitated and threatening towards staff, requiring chemical sedation. Triage vital signs were P 105, BP 120/70, RR 13, O2 Sat 96% on RA, T 37.4 C. Exam was remarkable for slurred speech, poor coordination, and a right shoulder abrasion. At the time of handoff, the patient is 20 minutes s/p sedation, on a stretcher in the hall, and minimally responsive to painful stimuli.
3. Mrs. A is a 66-year-old female who you recently admitted to step-down with presumed sepsis. She presented with fever and cough for 3 days. She has a history of CHF (EF 40%) and is compliant with home meds. Most recent vital signs are P 120, BP 100/60, RR 28, O2 Sat 95% on 2L O2 (new), T 39.4 C. Exam was significant for rhonchi at the right base, mild increased work of breathing, and trace BLE edema. EKG is at baseline. CXR shows a RLL pneumonia. WBC is 19. Initial lactic acid is 4. You have ordered antibiotics and 1 L of IVF.
4. Young Mr. B is a 4-year-old boy with 2 days of severe, non-bloody diarrhea and non-bloody, non-bilious vomiting. He was referred by his pediatrician, Dr. Eyeluvkids. His older sister just recovered from a similar illness. Initial vitals were P 136, RR 24, BP 94/60, O2 Sat 97%, T 37.2 C. Exam was significant for mild non-focal abdominal tenderness without peritonitis and delayed capillary refill of 4 seconds, but was otherwise normal. At the time of handoff, he is receiving his first normal saline bolus.
5. Mr. C is a 72-year-old male with a history of severe dementia, prosthetic aortic valve on warfarin, who had a ground level fall causing an occipital hematoma. He is DNR/DNR and his family is at bedside. Initial vitals were P 98, RR 16, BP 168/92, O2 Sat 93% on RA, T 36.8 C. Exam is significant for GCS 11 (E3 V3 M5) with baseline GCS 14 (confusion), c-spine tenderness (moaning), large occipital hematoma and oozing blood from a 4 cm laceration. Initial labs are significant for a hemoglobin of 11.4 (at baseline) and an INR of 3.7. At the time of handoff, he is pending CT imaging.