I-PASS is an evidence-based handoff tool to keep our patients and team members safe. It provides a structure for verbal or written communication through a common language.

National data suggests that up to 70% of sentinel events – the most serious errors in hospitals – stem at least in part from miscommunications. Communication problems are especially apt to occur during hospital shift changes, when a patient’s care is transferred to incoming doctors and nurses – known in healthcare as the “handoff.”

The literature suggests that I-PASS at other hospitals has led to:
- Faster and more efficient handoffs
- Improvements in workflow
- 30% reduction in harm events
- 20% reduction in malpractice cases

Using I-PASS at Riley is predicted to result in:
- Fewer patients harmed each year related to handoff

“At Riley we look at every event or action that could possibly impact our patient’s safety. More than 80% of all events have communication as a contributing factor. To continue our journey to high reliability, we are undertaking an effort to standardize our handoffs through the use of the I-PASS tool. I know that we are all totally committed to making Riley as safe as possible and the I-PASS tool is one important component of our efforts.”

Matthew Cook
President
Riley Children’s Health

References:
- I-PASS this patient to you: can standardizing “handoffs” make care safer? Vector, Boston Children’s Hospital’s Science and Innovation Blog (2012)
- The I-PASS mnemonic and the occurrence of handoff related errors in adult acute care hospitals: a systematic review protocol. JBI Database of Systematic Reviews and Implementation Reports. (2018)