



➤ **Is change needed in your local practice?**

- > Is there time defined for multi-professional handover within current working practice?
- > Are there checklists in place for the handover process?
- > Is there a standardised proforma for communicating the handover?
- > Is the process of handover included in training/induction?
- > Have any serious untoward or critical incidents been attributed, wholly or partly, to poor communication/handover?
- > Is the system of handover audited?

➤ **A good handover**

- > ensures that changes in the clinical teams are not detrimental to the quality of healthcare
- > improves communications between all members of the healthcare team, including those with the patient and their family
- > identifies unstable and unwell patients, so that their management remains optimal, clear and unambiguous
- > improves efficiency of patient management by clear baton-passing
- > improves patient experience and confidence
- > is a teaching and learning opportunity for those in training, who can observe appropriate role models at work.

# Acute care toolkit 1

## Handover May 2011

Handover is the system by which the responsibility for immediate and ongoing care is transferred between healthcare professionals. Patients expect, and should have, a designated consultant and nurse to coordinate the multidisciplinary team. However, at times (eg night, weekends or during an emergency admission) the responsibility for care must pass from one team, or consultant, to another.

### Background

Handover, particularly of temporary 'on-call' responsibility, has been identified as a point at which errors are likely to occur. Failure in handover is a major preventable cause of patient harm, and is principally due to the human factors of poor communication and systemic error. These can lead to inefficiencies, repetitions, delayed decisions, repeated investigations, incorrect diagnoses, incorrect treatment, and poor communication with the patient.

The Royal College of Physicians (RCP) recognises that changing work patterns must not detract from the ultimate responsibility of doctors to ensure

that their patients are safe, diagnosed efficiently, and treated effectively. An RCP survey and workshop in 2010 demonstrated the variability of handover systems in use; indeed, in some hospitals no handover processes are defined. This document is designed to provide practical guidance to optimise the handover process and improve patient safety. It takes as its basis the scarce publications on handover, results of RCP work, and the processes used in other high-risk industries, to provide a framework for standardisation of clinical handover practice, the training of the staff involved, audit and monitoring of the process, and defining accountability and responsibilities in the process.

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## Improvement and standardisation of handover are vital keys to improvement in efficiency, patient safety, and patient experience.

### When handover occurs

Examples of when handover of care occurs include:

- > between shifts, eg to the 'Hospital at Night' team
- > new acute admissions, which incur the added complexity of:
  - incorporating handover of multiple responsibilities (including receiving emergency admissions while initiating and following up on investigations or therapies for those recently admitted)
  - handover while initial assessment is still underway, before decisions on diagnosis, treatment or admission have been made
  - handover while the patient is still between care settings (eg while still *en route* between the community and hospital)
- > when responsibility for a patient changes, eg specialist or team change
- > when patients are moved, eg to wards, departments or operating theatres.

### Standards for clinical handover

There is a limited evidence base for clinical handover standards. Furthermore, the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) report,<sup>1</sup> RCP data (survey and workshop findings)<sup>2</sup> and work undertaken by the Health Foundation<sup>3</sup> all identify handover as a high-risk step in patient care pathways, and conclude that standardisation and description of the handover process, within the general medical setting, is generally poor.<sup>1</sup> Moreover, despite guidance from the RCP,<sup>4</sup> the BMA,<sup>5</sup> and a stipulated requirement in training

standards from the General Medical Council (*Tomorrow's doctors*)<sup>6</sup> and the Foundation Programme curriculum,<sup>7</sup> there has been only patchy improvement.

How information is transmitted and recorded has a major impact on the information retained (and therefore acted on) in the handover process. Over a typical weekend, where there will be as many as five shift handovers; only 2.5% of information from the first handover is retained at the final handover if there is no written record. If notes are taken, 85.5% of information is retained, but this rises to 99% when a standardised proforma is used (Bhabra *et al* 2007).<sup>8</sup>

Internationally, increasing attention has been paid to improving the quality of handover. In Australia, the Commission for Healthcare Quality and Safety has established a dedicated work stream that has included pilot initiatives and a literature review, leading to the publication of the OSSIE guide to clinical handover improvement (organisational leadership, simple solution development, stakeholder engagement, implementation, evaluation and maintenance).<sup>9,10</sup>

In the UK, the Academy of Medical Royal Colleges (AoMRC) has published national standards for the information to be transmitted at handover in electronic and in paper handover systems.<sup>11</sup>

However, handover remains highly variable, dependent on the human factors of beliefs, perceptions and communication. The urgency of the current situation demands that pragmatic,

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### RCP handover survey April 2010: the problem

- > Handover with transfers in responsibility are frequent:
  - handover is most commonly passed between consultants and their junior teams once or twice within 24 hours (69% and 66% respectively), but 27% of respondents identified situations in which care passed between teams of juniors three times or more within 24 hours.
- > When the acute or 'covering' consultant changes, active consultant participation in handover is uncommon (acute take handover: 34%; service handover: 32%; hospital-wide handover: 9%). Handover may only occur between trainees, so the consultant may not be explicitly aware of their responsibilities.
- > 91% stated that they knew what constituted 'good' handover.
- > When handover occurs as part of the general medical take, it is only verbal (no documentation) in 50% of cases.
- > 38% reported instruction on handover process during trust induction.
- > 18% reported education on handover with the trust.
- > 34% reported no handover time timetabled into working patterns.
- > 33% agreed that handover was currently done well.
- > 72% believed that handover was an important issue.
- > 80% felt that there was a need to understand how to implement handover. ■

sensible approaches are taken, founded on experiences in both healthcare and in other high-risk industries.

### Essential processes and methods

Improvement and standardisation of handover are vital keys to improvement in efficiency, patient safety, and patient experience. Handover should be 'owned' by the trust or hospital, who accept responsibility for ensuring that the systems and conditions are in place to allow effective handover, eg overlapping duty times; rationalisation of shift patterns of different roles (doctors and nurses); and the provision of an appropriate environment. Furthermore, doctors can learn from other professionals' experience and adopt or adapt the practice for collaborative transprofessional use, eg nurses have more experience of shift working, and therefore of handover.

There is a need to define common core principles for handover, which can be adapted locally. For example, a standardised proforma for written handover is essential, preferably in conjunction with face-to-face verbal handover. The sickest patients may require bedside handover, in the presence of senior medical staff, as is often seen in intensive care units. Furthermore, in the current technological climate, where possible, electronic handover processes should be encouraged. All standardisation should be AoMRC-compliant.

Education and training will be essential, and need to cover generic and local requirements, the use of specific terminology, how to prioritise patients and work, and training in specific communication techniques and skills. Observation; feedback and coaching on clarity; and acknowledgement and confirmation of information received between the handover teams, would improve the process. This process requires monitoring to enable continued improvement. >

## for free handover sample templates



## Recommendations for good standardised clinical handover

### Standardised clinical handover should:

- > be embedded in hospital policy and culture (documentation, seminars, discussions and champions)
- > involve training in handover and communication (induction agenda, cross-professional education)
- > be tailored to local/unit needs, eg different priorities in A&E, acute assessment unit (AAU), general ward handovers
- > be recognised as a multiprofessional team activity, reducing repetition within professional silos
- > command designated time and location within the job plan/shift patterns
- > determine clear arrangements for ongoing care of patients
- > define who must be present, including senior (consultant) staff.

### The handover process should:

- > define leadership responsibility (not necessarily medical staff)
- > define who is relinquishing responsibility and who is now responsible for ongoing care (including scope of responsibility and specific tasks)
- > standardise an order of proceedings, eg proforma (see 'Draft example template' available online – details on p4) to avoid omissions and discourage discussion deviation (eg to staff and bed availability)
- > standardise the systems of communication, eg SBAR (situation, background, assessment, recommendations), both verbal and documented; repetition to confirm shared understanding is valuable
- > standardise the system of documentation (see 'Draft example template' available online – details on p4)
- > define the immediacy of review by incoming team via red–amber–green patient risk assessment, where red is haemodynamic/respiratory instability, unclear diagnosis, sepsis; amber is response to prescribed treatment requires close monitoring; green is stable and discharge planned
- > ensure that the handover is communicated effectively to the patient and, where relevant, to family and carers.

### Monitoring and evaluation should entail:

- > an audit or review of the process: staff participation/attendance; use of checklists; completeness of documentation; duration of session; and of the role of handover in any local adverse events addressed in reflective practices (eg after action review)
- > feedback from participants, through structured interviews
- > assessment of impact on efficiency (length of stay), staff and patient satisfaction
- > maintaining, rewarding and disseminating information about improvements. ■

### RCP workshop May 2010: summary

Effective standardised handover:

- > requires cultural and organisational change, recognising the importance of this process
- > is required for patient safety
- > must engage a representative from all levels of the team, including the multidisciplinary team, to minimise the potential for 'human factor' errors (eg communication, omissions, errors in perception)
- > is of increasing importance with changing medical working patterns in line with the European Working Time Directive (EWTD)
- > requires protected time, standard systems and training for all staff
- > needs improved record keeping and communication. ■

### Useful resources

A pdf version of this document, along with draft examples of handover documents, can be downloaded from our website:

- > [www.rcplondon.ac.uk/resources/handover-example-templates](http://www.rcplondon.ac.uk/resources/handover-example-templates)

### References

- 1 National Confidential Enquiry into Patient Outcome and Death. *Emergency admissions: a journey in the right direction?* Executive summary. London: NCEPOD, 2007. [www.ncepod.org.uk/2007report1/Downloads/EA\\_summary.pdf](http://www.ncepod.org.uk/2007report1/Downloads/EA_summary.pdf) [Accessed April 2011]
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- 10 The Australian Commission on Safety and Quality in Health Care. *Clinical handover and patient safety literature review*. Sydney: ACSQHC, 2005.
- 11 Academy of Medical Royal Colleges. *A clinician's guide to record standards – parts 1 and 2*. London: AoMRC, 2008.

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