Medical handovers: an improvement opportunity

Safe medical care relies on accurate and timely communication of patient-specific information, pertinent to the delivery of such care. Modern medical practice that routinely involves transfer of patients between medical teams during a single episode of care has made the need for this communication far more important.

In the past, junior doctors working excessively long hours contributed substantially to the continuity of patient care. Such working patterns were littered with errors affecting patient wellbeing. The necessary reduction in junior doctors' working hours and the consequent introduction of shift patterns of work have resulted in information about patients requiring to be communicated across a series of clinical teams. This was highlighted in the Royal College of Physicians handover survey in 2010, which revealed that 27% of respondents identified situations in which care passed between teams of juniors three times or more within a 24-hour period (Royal College of Physicians, 2011).

For the purposes of this article a handover is defined as the transfer of professional responsibility and accountability for some or all aspects of the care of a patient or group of patients, to another person or professional group on a temporary or permanent basis (National Patient Safety Agency, 2004).

Although we can define a clinical handover, current practices have been criticized as being highly variable, unstructured and error-prone. A systematic review of doctors' handovers highlighted the lack of handover training for junior doctors and suggested that education about handover at the beginning of their postgraduate training was necessary (Raduma-Tomas et al, 2011). It further concluded that handover guides or proformas should be used to improve the structure of handover and increase the quality of information transferred.

What are the consequences of a poor handover?

Errors stemming from poor handover have been described in a variety of settings outside of medicine. Investigations into the Piper Alpha disaster in the North Sea indicated that poor handover notes were a key causal factor (Cleland et al, 2009).

There is no doubt that communication failures are a threat to patient safety. The evidence base was highlighted by the Joint Commission (2007) who found that over 60% of root causes of sentinel events reported to them were attributed to failures in communication.

While effective clinical handover is needed between each successive team involved in a specific patient's care, the introduction of hospital at night teams has led to particular attention being paid to the organization of the handover between the day team and the team that provides care overnight. Handovers to the hospital at night team that are based on best practice are relevant to almost all acute hospitals. Such handovers are arguably the most critical, given that they represent a transfer of care from the base specialty team to a multidisciplinary team, on a temporary basis. Elements of best practice in this type of handover may be incorporated into other types of daytime handover, such as from the acute receiving team to the specialty team. It is therefore worth looking at the hospital at night handover in greater detail.

How can hospital at night handovers be improved?

- Set a time and place that is free of interruptions and has senior supervision
- Standardize the process
- Use a handover proforma
- Provide training for junior doctors
- Institute effective audit of process and outcome.

The individual providing supervision must be seen by all participants as a credible clinical leader. While this will often be a middle grade medical trainee, there is no absolute requirement for this individual to be a doctor.

As part of a standardized process it is presumed that all participants will attend unless clinical need precludes this and the meeting should have a set format. This might involve the following order of discussion:

- Details of patients who need to be reviewed
- Details of patients 'to be aware of'
- Details of patients who need to be admitted
- Tasks that require completion.

Adherence to proformas will improve the structure of handover and increase the quality of the information transferred. This proforma can be based, for example, on a generic communication tool such as SBAR (situation, background, assessment, recommendation).

In a medical context situation refers to the patient's current clinical problem. Background includes any relevant past medical history or medication. Assessment is a summary of what was found on examination (this could include some form of early warning score) and the up-to-date results of relevant investigations. Recommendation includes any clinical interventions or outstanding investigations that should be undertaken or followed up. SBAR use was explored in an Australian study which found that junior doctors felt that it improved overall handover communication (Thompson et al, 2011): 'Specifically they perceived improvement in the structure and consistency of handover, they felt more confident receiving handover and they believed patient care and safety were improved'.

Conclusions

We have to improve clinical handover for the sake of the patients for whom we care. As has been suggested (Raduma-Tomas et al, 2011), junior doctors should receive

early training in handover. This would emphasize the importance and characteristics of a good handover and the possible adverse effects when it is not performed adequately. It should alleviate some of the fears and anxieties that junior doctors experience in relation to handing over patient care.

The training should be hospital based and relevant – it should include a presentation of an effective handover and appropriate use of a proforma, where this is in use. This type of training lends itself to role play. Junior doctors are then given the chance to practice handover in a relaxed non-clinical environment and receive peer and senior feedback.

'The Model for Improvement' (Langley et al, 2009) requires that when change is undertaken, data should be acquired which demonstrate that improvement has actually been accomplished. Such data could involve simple measures of process compliance such as proforma completion or, more importantly, assessing the impact on relevant outcomes such as the rate of adverse events. As hospitals move to using electronic patient records, online versions of handover proformas will facilitate a more dynamic approach to ongoing improvement of the handover process. BJHM

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KEY POINTS

- Hospital at night handovers are relevant to all acute hospitals and such handovers are arguably the most critical and therefore an appropriate place to start when trying to improve handovers.
- A standardized approach in conjunction with a proforma can improve the quality of information transferred at handover. SBAR (situation, background, assessment, recommendation) is one communication tool that can be used.
- Junior doctors should receive early training in handover.