Medical Handover

Handover is a crucial part of patient care to ensure continuity and to provide the best possible and safe care to patients. However, as times change and service demands increase, it is easy for this process to become rushed or to lose sight of who should be involved. NZRDA led a significant piece of work in 2007 that saw markedly improved handover. However, with the passage of time and increase workloads since then, improved awareness of the handover process and how it ought to be conducted may be necessary.

The attached document is a culmination of discussions amongst the NZRDA National Executive and Delegates. It should be read as a guideline of who to include in the handover process, when handover should occur and how long the process should be.

It is important to remember that the individual doctor is not the sole care provider and that the wider medical team, including nurses, physiotherapists and other relevant medical professions, also contribute to the overall medical care of a patient.

If your handover looks nothing like that which is described in the attached document, please let us know. NZRDA is meeting the chief medical officers next month and will be discussing this issue, therefore your feedback on this document would be very welcomed.

Handover for DOCTORS

The concept of (sole) personal continuity or individual "continuity of care" is outdated in our modern health care system. In today's system, multiple members of a wider medical team contribute to the medical care of a single patient, alongside other health professionals contributing to overall care. The medical team, rather than the individual, should be seen as the care provider. While overall personal continuity is valued by patients and retains an important role in our medical systems, it does not of itself ensure quality of treatment.

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This paper is about doctors' handover. The key elements described below are not necessarily appropriate for clinical handover other than medical, where case conferences and ward based multidisciplinary team meetings are a more appropriate forum.

This paper focuses on achieving system continuity and the required mechanisms to support the transfer of high-quality clinical information across shift changes. These should include:

- Dedicated time in shifts for members of the team to meet, share information and clarify responsibility for ongoing care and outstanding tasks
- Access to up-to-date summaries for all patients under a team's care as needed.
- Reliable means to identify and contact the doctor who is responsible for a patient at any given time.
- Thorough induction and orientation to handover practises for new team members

Clinical handover must be viewed by the organisation as an essential element in doctors working lives.

An understanding of the concept of both system and personal continuity should be supported by education and training. Clinical handover must be viewed by the organisation as an essential element in doctors working lives and supported accordingly. This may require a change in culture amongst both management and doctors alike. However, the benefits to doctors and ultimately patients mandate a better process than we may currently rely on. Whilst we all handover now, it is sometimes not good handover and therefore fails to capitalise on the benefits but imposes or continues risks for doctors and their patients.

Good handover has been shown to change culture, increase doctor participation, improve

supervision of after-hours work, improve educational value and reduce clinical risk for patients.

Ineffective handover can lead to incorrect treatment, delays in diagnosis, life threatening adverse events, patient complaints, increased health care expenditure, increased length of stay, and a range of other effects. Worse still poor handover carries significant risks for individual clinicians, hospitals and for their patients. Hospitals should ensure that the facilitation of high-quality handover is seen as a clinical governance issue at all levels within the organisation.

Good handover benefits both PATIENTS AND DOCTORS

- Safety is protected – lapses in information handover can, and do, lead to mistakes being made. This increases morbidity and mortality.
- Greater continuity of care – poor handover can lead to fragmentation and inconsistency of care.
- Decreased repetition – different individuals providing care will be better accepted as long as existing team knowledge is retained.
- Increased service satisfaction – every doctor attending a patient can begin where the last one left off. Patient perception of professionalism is reaffirmed and improved, and doctor's confidence supported.
- Increased efficiency of the healthcare system and improvement to patient care through timely investigation and diagnosis, management and discharge.
- Clear and accountable communication can protect against errors and identify "gaps" in our system that can be rectified in a timely fashion.
- Reduction of stress – feeling informed and having up to date information enables doctors to feel more confidently in control of a patient's care. Doctors have found that handover can be a useful experience that gives them the opportunity to involve appropriate specialties early, for example intensive care. There is ability to discuss cases with other specialties in an open environment improving overall patient care and doctors learning.
- Education – handover provides development and practise of communication skills and a well-led handover session provides a useful setting for clinical education at all levels.
- Job satisfaction - providing the best possible quality of care is highly rewarding and is fundamental to a doctor's sense of job satisfaction.

Handover processes

What do we need?

Good handover does not happen by chance. It requires work by all those involved, including organisations and individuals, and in some cases a change in culture. Handover requires systemic and individual attention, needs education, support, facilitation and sustained effort to ensure it maintains a position of importance in an already full working day.

Good handover does not happen by chance.

Main handover is normally in the morning and will receive the most focus in this paper. However, handover to the teams continuing care in the evening and particularly to the overnight team and prior to weekends or rostered days off, is also required. Whilst not as "big" as the morning handover, the importance of night handover must not be underestimated. Handover of weekend patients on a Friday or before days off and other "mini" handovers will also be occurring as units require such as ICU and ED.

Who should be involved?

- Clinical Handover is equally important to all members of the medical team, both resident doctors and SMO's. The ideal model includes all levels of staff and each specialty, subspecialty or ward as appropriate. The nurse clinical coordinator should be involved in the major handover, usually the morning one.
- Ideally, teams from all appropriate unit/teams should attend to ensure that they receive necessary patient information and make timely decisions about patient care and transfer.
- The involvement of senior clinicians is essential. This ensures that:
    - appropriate level management decisions are made, and
    - handover forms a constructive part of medical education, and
    - the seriousness with which the organisation takes this process is conveyed.
- Clinical handover requires a leader who should be senior and be skilled in the process. This may require education for the individuals concerned.
- There will always be work that is ongoing during the handover time however virtually all aspects of care can wait for 30 minutes to ensure continued safety overnight. It is essential that individuals be allowed to attend, subject to emergency cover being defined.
- The handover leader needs to ensure the team is aware of any new or locum members of the team and that adequate arrangements are in place to familiarise them with local systems and hospital geography.

When should handover take place?

- Handover should be at a fixed time and be of sufficient length
- The handover period should be known to all staff and designated 'pager-free' except for immediately life-threatening emergencies
- Shifts for all staff involved must be coordinated to allow them to attend in working time. This is particularly important for the handover to, and from, the night team.
- Main handover is generally held in the morning however handover is also needed at the change of other shifts, handover to the evening, weekend and night teams. Morning handover allows the team to discuss overnight patient admissions, gives them a head start with their morning rounds and plan the day's work.
- In addition to the larger, more formal handover there will inevitably be smaller local handovers occurring daily (such as on ICU or admissions unit).

To ensure attendance at morning handover, handover should be a compulsory activity for all on-duty doctors.

Where should handover take place?

Distractions and interruptions during handover meetings undermine the efficacy of the handover process, and therefore potentially compromises patient care and safety. Processes should be implemented to eliminate any interruption to handover meetings, including those from pagers, telephones, whanau, and clinical staff not otherwise involved in the meeting. Any interruption should only be for urgent matters that absolutely cannot wait until after the meeting has concluded.

- Ideally this should be close to the most used areas of work.
- It should be large enough to comfortably allow everyone to attend.
- This should be free from distraction, physically appropriate e.g. in size, ventilation and lighting and not used by others at this time.
- It should have access to lab results, X-rays, clinical information, PMS, the internet/intranet, and telephones.

How should handover happen?

- Ad hoc handovers often miss out important aspects of care and information
- Handover should be supervised by the most senior clinician present and must have clear leadership. Leaders may require training in how to manage this process.
- Information presented should be succinct and relevant
- Ideally, this will be supported by information systems identifying all relevant patients – electronic handover systems are ideal.
- Regular review of the system, for example at clinical governance meetings, appraisal meetings, through surveys, and monitoring incident reports, is required
- The relevant senior consultant or the medical director, should have responsibility for ensuring handover happens as expected.

What should be handed over?

The information and level of detail that is included in a clinical handover session depends on several factors including the severity of the patient's illness and whether there are pending results of investigations that require prompt follow-up. The type and level of handover conducted is also influenced by the time of the day and week it is occurring (e.g. weekday vs. weekend, night vs. morning), the doctor to patient ratio and workflow. Priorities need to be set to ensure that the essential information is communicated and understood.

Written (or IT based) handover should include:

- Current inpatients
- Accepted and referred patients due to be assessed
- Accurate location of all patients
- Team allocation
- Information to convey to the following shift
- Patients who are unstable or whose clinical status is deteriorating

Verbal handover is vital to highlight:

- Patients with anticipated problems, to clarify management plans and ensure appropriate review
- Outstanding tasks and their required time for completion
- Anticipated patient arrivals and forward planning

Sufficient and relevant information should be exchanged to ensure patient safety so that:

- The clinically unstable patients are known to the senior and covering clinicians
- Members of the team are adequately briefed on concerns from previous shifts
- Tasks not yet completed are clearly understood by the incoming team.

Information management

IT systems must be robust, rapid in access and operation and have the capacity to interface with other IT systems (radiology and pathology). Unnecessarily complex systems or those that partition information invariably delay and limit access to information. All hospital IT systems must ensure the administration data is up-to-date 24 hours per day to ensure patients do not get 'lost' in the hospital and the treating doctor can clearly identify which patients are under their care.

The ability to update the system at handover as patients transfer teams and provision of a written printout for team members of the patients under their care at the end of handover is essential.

Beyond Information Transfer

Clinical handover offers benefits in addition to the transfer of information from one team to another by providing opportunities for:

- Doctors to seek second opinions
- Doctors to seek supervision
- Doctors to debrief
- Reminders to be given to follow-up results
- The early referral of patients to other disciplines.

Summary

Good handover has been shown to change culture, increase doctor participation, improve supervision of after-hours work, improve patient outcomes and reduce risk and improve educational value.

To achieve good handover:

- **Shifts must overlap.**
- **Adequate dedicated time must be allowed.**
- **Handover should have clear senior leadership.**
- **Appropriate facilities must be provided.**
- **Adequate information technology support must be provided.**
- **Support for the handover process must come from all levels of the medical and management team.**