



## IMPROVING PATIENT HANDOVER

### 1. Purpose

The purpose of this document is to summarise the evidence and share good practice on effective handover of teams because there is emerging evidence that patient handover is often a weak link in the delivery of care. In addition, there is no published method that forms the gold standard and there is large variation in practice.

### 2. Introduction

The implementation of the Working Time Directive has meant significant changes to the working patterns of junior doctors, with a decrease in continuity of care owing to shift working. In addition, the changing patterns of work in hospital settings mean different teams look after the same group of patients over the course of any given day. Patient handover between shifts and teams is therefore a necessary and vital part of practice in order to reduce the risk of medical errors. **It is important to optimise communication of critical information as an essential component of risk management and patient safety.** Information must be transferred in a written format because verbal information is prone to loss.

Handover data can also be used between shifts to prioritise outstanding clinical jobs and to create theatre lists.

Many organisations have published on safe handover, including the following:

- The British Medical Association's *Safe handover: safe patients* recommends use of pro formas and relevant IT support.<sup>1</sup>
- The Royal College of Surgeons of England's *Safe handover* recommends a minimum data set, adequate time set aside within working hours, an environment that prevents interruption, and involvement of all healthcare professionals.<sup>2</sup>
- In a survey by McCann et al. in a New Zealand tertiary hospital, the majority of respondents felt that an effective handover system should include a set location for handover, a standardised 'on call' sheet and training related to handovers.<sup>3</sup>
- In the USA, 31% of doctors in one survey had experienced clinical problems during their shift that could have been avoided if they had been prepared with an adequate handover.<sup>4</sup>
- An evaluation of handover practice by Bhabra et al. showed that only 33% of data transferred verbally was retained, while retention improved to 92% when verbal handover was supplemented by note-taking. A computer-generated, preprinted handover sheet improved data transfer to 100%.<sup>5</sup>
- Cleland et al. suggest that junior doctors should be trained and prepared for handover while still at medical school.<sup>6</sup>

The cornerstones for ensuring continuing care and efficiency of the handover process include regular reviews of the handover process, written guidelines for the content of handover, and the use of a prepared handover sheet.

### 3. Effective communication

#### 3.1 SBAR tool for improving communication within the team

The SBAR (situation – background – assessment – recommendation) tool, developed for health care by Leonard and colleagues, may be useful as it can be used to efficiently hand over individual patients in approximately 30–60 minutes.<sup>7</sup> Introducing a system such as SBAR into inter-professional communication not only improves the efficiency of communication, it also allows all members of the team lower down the hierarchy to add to the conversation in an organised fashion. The steps involved in using SBAR are:

- **Situation:** describe the specific situation about a particular patient, including name, consultant, patient location, vital signs, resuscitation status and any specific concerns.
- **Background:** communicate the patient's background, including date of admission, diagnosis, current medications, allergies, laboratory results, progress during the admission and other relevant information collected from the patient's charts.
- **Assessment:** this involves critical assessment of the situation, clinical impression and detailed expression of concerns.
- **Recommendation:** this involves the management plan, making suggestions and being specific about requests and time frame. Any order that is given, especially over the telephone or when discussed with a doctor who has been woken from sleep, needs to be repeated back to ensure accuracy.

Implementing SBAR may seem simple, but it takes considerable training from both an individual and an organisational point of view. It can be particularly useful in midwife/nurse-to-doctor communication, but it is also helpful in doctor-to-doctor conversations. Another example where this tool would add to clarity and improved care is the emergency call to a sleeping senior doctor for advice about patient management. The request for direct help should be made clear as part of the recommendation so there is no misunderstanding. Hospitals using SBAR have found that stickers near telephones and preprinted note pads are useful as they act as a visual prompt.

#### 3.2 SHARING tool for improving and standardising handover between teams

SHARING (Staff, High risk, Awaiting theatre, Recovery ward, Inductions, NICU, Gynaecology) is a mnemonic that represents the first letter from each clinical area in an average busy obstetrics and gynaecology department (Appendix 1, based on the handover pro forma used at the Norfolk and Norwich University Hospital). It is a structured form of written handover that takes place at the beginning and end of each shift. It is suitable for use in most hospitals with minimal changes to the subheadings. The draft document in Appendix 1 may be modified or expanded to allow more space for information to be added and for subheadings tailored to a particular unit's requirements.

It is usual for the most senior doctor on the delivery suite to be responsible for the process of handover. This individual would be expected to complete the form and participate in a team discussion with the departing and incoming teams prior to leaving. However, it is important to ensure that the process of handover, with its valuable educational messages, does not deprive junior members of the team of their opportunities to practise and improve their handover skills. Junior trainees should be involved and assist in the collation of data for the handover, and as they gain confidence can lead some and eventually all of a handover.

SHARING represents an aide memoir that takes little time or effort provided that the team updates it from time to time during their shift. Thus, the handover document should be treated as a 'live' working document rather than a piece of paper to complete minutes before handover. Use of the SHARING pro forma throughout the preceding shift can make handover more efficient and ensure important messages get passed

on even in the busiest units. Ideally, the handover should be composed on a delivery suite PC and a copy printed for the incoming team. One copy should be signed and stored in paper or electronic form to confirm who was present and allow an audit trail of what information was handed over.

The handover process should also aim to include a management plan for each patient (possibly using a tool such as SBAR) so that the incoming team can immediately prioritise their duties.

The document should contain all patients in the delivery suite, those awaiting induction of labour and planned caesarean sections, patients with problems on the ward as well as new admissions during the shift. Other patients likely to benefit from this documentation are patients on other specialty wards as they would then be less likely to be omitted from ward rounds. This would also minimise the time lost between referring the patients and reviewing them.

#### 4. Conclusion and recommendation

The transfer of a patient to the care of the incoming team is a point at which the patient is vulnerable on their journey through the healthcare system. Poor or incomplete information can delay care, lead to confusion or, occasionally, lead to disastrous consequences. Achieving effective handover is the duty of every doctor. It is a skill that needs to be taught, learned, practised and developed. SHARING is an effective standardised handover pro forma to be used in obstetrics and gynaecology. The use of this type of standard pro forma can not only improve recording of patient diagnosis and handover of care, but can also be used to establish at a glance how busy a unit is. It can be used to record the details of handover for future risk management assessments.

#### References

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3. McCann L, McHardy K, Child S. Passing the buck: clinical handovers at a tertiary hospital. *N Z Med J* 2007;120:U2778.
4. Borowitz SM, Waggoner-Fountain LA, Bass EJ, Sledd RM. Adequacy of information transferred at resident sign-out (in-hospital handover of care): a prospective survey. *Qual Saf Health Care* 2008;17:6-10.
5. Bhabra G, Mackeith S, Monteiro P, Pothier DD. An experimental comparison of handover methods. *Ann R Coll Surg Engl* 2007;89:298-300.
6. Cleland JA, Ross S, Miller SC, Patey R. "There is a chain of Chinese whispers...": empirical data support the call to formally teach handover to prequalification doctors. *Qual Saf Health Care* 2009;18:267-71.
7. The Institute for Healthcare Improvement and NHS Institute for Innovation and Improvement. *Situation, Background, Assessment and Recommendation (SBAR)*. London: IHI and NHS Institute for Innovation and Improvement; 2006.

This good practice guidance was produced on behalf of the Safety and Quality Committee by **Dr E M A L Toeima MRCOG, Norwich**; **Dr E P Morris FRCOG, Norwich**; **Dr P P Fogarty FRCOG, Belfast**.

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The RCOG will maintain a watching brief on the need to review this guidance.

**Appendix 1**

Improving handover pro forma: SHARING

Date: ..... Time: .....

**Staff:**

| Departing team | New team     |
|----------------|--------------|
| Consultant     | Consultant   |
| ST 5-7         | ST 5-7       |
| ST 1-2         | ST 1-2       |
| Anaesthetics   | Anaesthetics |

**High risk:**

| Delivery suite: |          |      |
|-----------------|----------|------|
| Room            | Problems | Plan |
| Room            | Problems | Plan |
| Room            | Problems | Plan |
| Room            | Problems | Plan |
| Room            | Problems | Plan |
| Room            | Problems | Plan |
| Room            | Problems | Plan |

ICU/HDU .....

Antenatal patients with problems

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Postnatal patients with problems

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**Awaiting theatre:**

Emergency list ..... Elective list .....

**Recovery ward:** .....

**Inductions**

Post-date low risk .....

Others/high risk .....

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**NICU:**            Opened/Closed

**Gynaecology ward**

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