Clinical handover: critical communications

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Handover is a ubiquitous feature of health care. At least 7 million handovers occur annually within Australian hospitals.[1] At times, its very existence is almost unnoticed — many health professionals do not think of a telephone referral as "handover" — and at other times it is seen as a mundane chore that has to be done in addition to the "real" work of clinical staff. There can be complacency with current practices and little recognition of the high-risk nature of handover.

Handover is noticed when things go wrong. One recent tragic failure was that of an elderly Aboriginal man left to die on an airstrip in the Northern Territory.[2] The man had pneumonia and had been evacuated to Katherine Hospital. Before his evacuation, a nurse and district medical officer discussed the possibility of a family escort travelling with him. Although this had previously been recommended by his referring doctor, neither the acuity of the patient's condition nor his personal circumstances (poor English and frailty) were clearly communicated, and no escort accompanied him. This was the first inadequate handover.

After 9 days of treatment, he was discharged. The paperwork for his discharge was processed on a Friday, including a fax to his local community health centre advising of his scheduled Monday discharge. This fax was not seen or acted upon by the community health facility. Was this, then, handover at all?

There was no checking system between the travel service and the community health centre, and it was presumed that there would be someone to collect the patient on his return from Katherine to the community. However, this was not the case. The patient was left by the pilot, alone at the airstrip some distance from town. On the Thursday, 3 days after the man was left at the airstrip, the police were informed that he was missing. His body was found the following Monday. He had died — alone, dehydrated and suffering from pneumonia.

Since this tragic incident, the Northern Territory Government has taken steps to standardise and improve handover processes. The coroner's report of the incident endorsed these steps as long as handover improvement was continual — the standardised processes would only be valuable if they were actively implemented and maintained.

Problems that can arise from poor communication at handover include incorrect medications being given, delays in treatment or failure to give it, unnecessary repetition of diagnostic tests, and preventable readmissions. These failings waste time, strain health care resources and cause harm to patients. Health care professionals need to acknowledge that handover is a high-risk situation and that it is an element of their work that is integral to the delivery of safe patient care. Our own serious adverse events should not be the trigger for actions to standardise handover practice. We can learn from the mistakes of others to ensure safe transfer of information, responsibility and accountability in patient care.

Clinical handover is defined as "the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis".[3] Accountability and responsibility are critical terms in this definition, as "transfer of information is irrelevant unless it results in action that is appropriate to the patients' needs".[1] When this governance view is taken of handover, the minimum required information elements and handover processes become more evident. Indeed, clinicians have a duty of care to ensure that effective handover occurs.[4]

The poor outcomes that arise from poor handover, as well as the scarcity of existing evidence,[5] have motivated the Australian Commission on Safety and Quality in Health Care to work on developing evidence-based solutions for improving handover. The articles in this supplement are contributed by teams participating in the Commission's National Clinical Handover Initiative. Each provides a view into how handover can be improved. There are several common themes addressed in these articles, which are described below.

The need for "flexible standardisation"

Although the concept of flexible standardisation may seem contradictory, teams have found that both flexibility and standardisation are essential. This may mean implementing a minimum dataset, such as SBAR (situation–background–assessment–recommendation) while still allowing for customisation to ensure that it meets the needs of the local clinical context. Several of the articles describe the implementation of different standardised tools for improving handover: Yee et al (on shift-to-shift clinical handover) (*page S121*);[6] Wood et al (on handover from inpatient private mental health care to the community) (*page S144*);[7] Clark et al (on improving communication between hospital staff at handover) (*page S125*);[8] and Belfrage et al (on handover from the aged-care home to the emergency department) (*page S117*).[9]

The importance of clinician involvement in the quality improvement process

Most of the articles touch, in some way, on the importance of engaging clinicians throughout the clinical handover improvement process. This ensures ownership of the process and a proper understanding of the local setting. User involvement is creatively addressed in the studies by Iedema et al (on enhancing communication to improve patient safety) (*page S133*)[10] and Porteous et al (on the design and testing of a comprehensive handover form) (*page S152*).[11] The former allows clinicians to create their own handover solutions, while the latter involves clinicians in the implementation of an existing standardised tool.

Methods for ensuring that handover results in a shared understanding of information

As handovers occur frequently in health care, understanding what each type of handover is for and how it should be presented is essential for ensuring confident and competent handover by all staff. A standardised approach to handover can help clarify the purpose and content of handovers and reduce confusion. Such an approach needs to be easy to use so it can be easily taught and recalled, as demonstrated by Hatten-Masterson et al in a study of enhancing clinical communication in a private maternity hospital (*page S150*).[12] This point is also made in the article by Quin et al

on standardised clinical handover tools (*page S141*),[13] in which clinicians were informed of the dangers of poor handover. The article by Chaboyer et al on communication via whiteboards (*page S137*) focuses on understanding how to use whiteboards in a systematic and planned way to improve handover.[14]

A shared understanding may also be promoted using technological solutions, as described by Silvester and Carr in a study of a shared electronic health record (*page S113*).[15]

The effects of health care culture and organisational structure

The complexity of health care means that maintaining the continuity of patient care is a challenging process. As the article by Botti et al on maximising patient safety in complex handover situations (*page S157*) states, "it is unlikely that any one improvement strategy will be appropriate for all".[16] Training in communication within a team seems to be a helpful strategy, as demonstrated by Stead et al in a study of TeamSTEPPS (team strategies and tools to enhance performance and patient safety) (*page S128*).[17] This project used an existing program to train staff in using a standardised handover tool (SBAR) and in communication and teamwork in and around the handover.

Some aspects of handover have been only tangentially addressed by the National Clinical Handover Initiative. It has been suggested that communication errors sit on the "dark side of measurement",[18] where less-developed measures mean that problems are ignored. We still know little about the measurement of safe handover practice. In addition, the significance of documentation (including letters and notes, some of which are held by the patient) and its relationship to verbal handover has not yet been adequately explored.[5] Research on ways of using documentation to optimise handover is crucial to ensure that electronic records are designed to provide maximum safety for patients.

Handover should be viewed as part of the provision of safe patient care, rather than as extra, unnecessary work. Good handover means that lapses in continuity of care, errors and harm will be reduced, whether patients are in the community or in hospital, undergoing a series of investigations, being prepared for surgery, recovering or dying. Clinicians and managers need to be aware that providing good handover requires an understanding of its purpose, leadership, protected time, a systematic approach, and a supportive clinical environment. Good handover takes effort.

Competing interests

None identified.

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