Safe handover:
Guidance from the Working Time Directive working party

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

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The Royal College *of* Surgeons *of* England

Introduction

The introduction of full-shift working as a response to the progressive implementation of the European Working Time Directive (EWTD) has put the spotlight on patient and doctor safety. Effective handover between shifts is vital to protect patient safety and assist doctors with clinical governance. Good handovers also provide an excellent training and review opportunity, and these must be maximised in a climate of shortened hours and streamlined training.

The transfer of a patient to the care of the oncoming team is the point at which the patient is most vulnerable on their journey through the health care system. Poor or incomplete information is often handed over with potentially disastrous consequences. Achieving an effective handover is the duty of every doctor. It is also a skill that needs to be taught, learned, practised and developed.

Aim

This guide aims to bring together, in a succinct manner, the main features of a successful handover. There is not a 'one-size-fits-all' guide to the effective handing over of patients, but there are good practice principles that surgeons should be aware of. This guide is intended for surgeons, and other members of the surgical team. It will also be relevant to hospital administrators who are responsible for designing rotas and ensuring EWTD compliance.

What is a handover?

Handovers aim to convey high-quality and appropriate clinical information to oncoming healthcare professionals to allow for the safe transfer of responsibility for patients. Good handovers are essential in providing continuity of care, patient safety and error avoidance. The aim is to ensure that after handover all members of the team will have the same understanding and set of priorities. Individual surgeons have a duty to accept responsibility for the assessment and continuing care of every patient admitted under their name until they are formally transferred to the care of another doctor and to ensure the formal handover of patients to an appropriate colleague following periods on duty (see the College's *Good Surgical Practice*, cited in the section on further reading, below).

What are the common difficulties?

Handing over information on a large number of patients involving care delivered by a number of clinicians (for example, in handovers to or from the Hospital at Night team) can be complex and demanding. Information must be selected for significance and priority. Too much 'inessential' information clouds the picture. In addition, admission processes that simply admit patients to the next available bed (even if that is not within the appropriate specialty area) can render locating patients around the hospital a difficult process. In some cases, a member of the team may even be required to travel to another site to see a patient. Furthermore, patients may need to be transferred to a remote site during the shift, creating a requirement for inter-shift transfers of care. Handovers are often multiprofessional in nature and this means that different professionals will have different information requirements, thus increasing the complexity of the process.

Separating the emergency and elective surgical workloads would go some way towards simplifying the handover process.

Who is responsible?

Patients will still generally be admitted under the care of a named consultant surgeon, who has ultimate responsibility for their care until transferred to the care of another senior colleague if appropriate. However, the reduction in working hours and an increase in shift working mean that it is impracticable for one person to provide care for individual patients throughout their hospital stay.

The reality is that the *surgical team* is now the responsible body for continuing patient care. This means that the consultant surgeon must provide effective leadership and each member of the team must understand both his or her own responsibilities and those of other team members. Effective handover should ensure this.

Clinical governance

Trusts must take steps to ensure that the resources and facilities for handovers are appropriate. Sufficient time must be set aside within working hours; an appropriate environment is also required (as discussed below) and clinicians must be supported to provide good handovers to facilitate patient safety.

What is required for a successful handover?

- Recognition that the handover is a valuable training opportunity for junior surgeons. To be effective it must therefore be led by the most senior clinician present. The leader's role is, however, not merely to convey information but to encourage interaction and questions from all team members.

- A short introductory briefing to facilitate situational awareness. All members of the team should posses a shared understanding of the plan of action and of what is required of them.

- Adequate time set aside within working hours. We would recommend up to 30 minutes for a large specialty or for Hospital at Night handovers. Smaller-scale handovers (eg ward- or intensive therapy unit-based) may not require as much time. Non-essential work should stop during handover and it should be dedicated as 'bleep-free'. It is useful to have the handover at set times during the day or night so that staff always know the time – punctuality is a key requirement.

- An environment that prevents interruptions from phones, bleeps, other staff, relatives and patients, and ensures patient confidentiality. This is a clinical governance issue and Trusts must ensure an appropriate environment for handover.

- The involvement of all healthcare professionals, including appropriate clinical and non-clinical staff. There is a balance to be struck between comprehensiveness and efficiency. A good principle is to provide more extensive information on patients who are particularly unwell or at high risk of deterioration.

- A clear method of contacting the doctor responsible for a particular patient is needed.

- Awareness of potential risks – for example, the misidentification of patients, breaches of confidentiality, ensuring continuing care and assigning tasks and responsibilities clearly.

Good practice

Surgeons should check that:

- the patient knows the name of the person responsible for their care;
- the team members know the name and location of every patient under their care (both within and outside the base hospital);
- if at all possible, all patients under the care of the team should be co-located; hospital design can play a significant role here and the involvement of management is essential;
- a single team is responsible for a patient at any one time;
- sufficient protected time is set aside for handover and that this takes place within working hours;
- when transferring care to an oncoming team, they have access to all necessary clinical information about patients;
- out-of-hours doctors are aware of all patients who are particularly unwell – proactive risk assessment will be vital;
- each clinical action and annotation in patients' notes is traceable to the doctor concerned; and
- patient information is stored sensitively, but also accessibly. The potential for using electronic information sharing should be explored (eg personal digital assistants, 'live lists' of patients and their responsible consultant surgeon on hospital PCs), but whiteboards and paper-based handovers also work well. Consideration must be given to confidentiality at all times – so electronic information must be password-protected and should comply with Trusts' data protection rules.

The handover

- The handover is a two-way process to provide and receive information, and gives an opportunity to ask questions.
- Nursing and clinical staff should make each other aware of relevant issues.
- Handovers must be focused and structured – one speaker at a time.
- Checklists might help in the management of common conditions.
- Handover arrangements should be reviewed as part of the clinical governance strategy to ensure they are appropriate.

Handovers at a glance

> Begin with a short briefing to make all team members aware of the plan for the shift, and of what is expected of them – 'situational awareness'.
> Facilitate a structured team discussion, ensuring clarity from the outset.
> Establish and develop contingency plans – 'what to do if…'
> Encourage questions and communication within the team – there are no 'stupid questions'.

As a minimum ensure the following information is imparted:

> patient name and age;
> date of admission;
> location (ward and bed);
> responsible consultant surgeon;
> current diagnosis; and
> results of significant or pending investigations.

Also include:

> patient condition;
> urgency/frequency of review required;
> management plan, including 'what if...';
> resuscitation plan (if appropriate);
> consultant surgeon contact details/availability;
> operational issues (eg availability of intensive care unit beds, patients likely to be transferred); and
> any outstanding tasks.

Further reading

This document is intended to provide brief guidance on the main principles of good handover practice. For further information, readers might wish to access:

> British Medical Association. *Safe handover: safe patients. Guidance on clinical handover for clinicians and managers.* London: BMA; August 2004. (see http://www.bma.org.uk/ap.nsf/Content/Handover.)

> The Royal College of Surgeons of England. *Good Surgical Practice*. London: RCSE; September 2002.

> Cheah LP, Amott DH, Pollard J, Watters DA. Electronic medical handover: towards safer medical care. *Med J Aust* 2005; **183**: 369–372.

> Hobbs A. *Team Self-Review: improving teamwork and reducing error*. Healthcare Risk Report; May 2005

> Flin R, Yule S, McKenzie L, Paterson-Brown S, Maran N. Attitudes to teamwork and safety in the operating theatre. *Surgeon* 2006; **4**: 145–151.

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