

# Safe handover: safe patients

Guidance on clinical handover for  
clinicians and managers




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# National Patient Safety Agency

Handover of care is one of the most perilous procedures in medicine, and when carried out improperly can be a major contributory factor to subsequent error and harm to patients. This has always been so, but its importance is escalating with the requirement for shorter hours for doctors and an increase in shift patterns of working. The National Patient Safety Agency recognises this and aims to ensure that the risks involved in the process of transferring clinical responsibility are minimised. It welcomes this guidance and hopes that it will help to achieve this goal.



**Professor Sir John Lilleyman**  
Medical Director  
National Patient Safety Agency



# General Medical Council

Effective communication lies at the very heart of good patient care. The General Medical Council recognises this and in its publication *Good medical practice* makes clear the expectation that doctors will 'keep colleagues well informed when sharing the care of patients'. The changing face of medical practice – and particularly the introduction of shift working – makes that requirement more important than ever. The GMC welcomes this guidance from the BMA Junior Doctors Committee as a very helpful contribution to this fundamentally important subject.



**Professor Peter Rubin**

Chairman of Education Committee  
General Medical Council



# Executive summary

## **This document:**

- provides guidance to doctors on best practice in handover
- provides examples of good models of handover that doctors and hospital managers can learn from
- aims to drive further developments in standardising handover arrangements in UK hospitals.

- Continuity of information is vital to the safety of our patients.
- With the move to shift patterns, which increase the number of individuals caring for patients, the need for comprehensive handover of clinical information is more important than ever.
- Good handover does not happen by chance. It requires work by all those involved, from organisations to the individuals involved:
  - shifts must coordinate
  - adequate time must be allowed
  - handover should have clear leadership
  - adequate information technology support must be provided.
- Sufficient and relevant information should be exchanged to ensure patient safety:
  - the clinically unstable patients are known to the senior and covering clinicians
  - junior members of the team are adequately briefed on concerns from previous shifts
  - tasks not yet completed are clearly understood by the incoming team.
- Lastly, handover is of little value unless action is taken as a result:
  - tasks should be prioritised
  - plans for further care are put into place
  - unstable patients are reviewed.

This guide contains practical advice, underlying principles and best practice examples from around the country. It has been written in partnership with the National Patient Safety Agency and the Modernisation Agency.

# The need for change

Changing patterns of work in the hospital setting have created a need for improved handover of clinical responsibility and information. There is a growing recognition that enhanced training and systems for effective and safe handover are essential to maintain high standards of clinical care.

## Changing working patterns

The implementation of the New Deal and European Working Time Directive for doctors in training has acted as a driver for change in the way that the medical workforce is organised in the UK.

- Full shift rotas have become the norm in many acute care settings as all time spent in the place of work is now counted as working time. This effectively limits doctors to spending a maximum of 13 hours in the hospital each day or to be non-resident on call.
- Different teams will be looking after the same group of patients over the course of any given day.
- A doctor may have no day-to-day contact with the patients they are responsible for in the out-of-hours period.
- There will be greater cross-cover between some specialties, and an increasing multidisciplinary approach to care.
- Resident and non-resident staff must be part of handover.

As a consequence of these changes, robust handover mechanisms are now of the utmost importance for patient safety.<sup>1</sup>

**A whole systems approach will, therefore, be necessary to enable effective handover of all necessary information and responsibilities.**

Good communication is essential between all doctors to protect the safety of patients when shifts are introduced.<sup>1</sup> In one study, junior doctors felt that existing handover arrangements were frequently not as good as they would have liked them to be.<sup>2</sup>

## Embracing safety

Patient safety, as part of clinical governance, is rightfully at the heart of the organisational structures of the NHS, as well as the wider public.

- *Building a safer NHS for patients* introduces the work of the National Patient Safety Agency in proactively raising awareness of patient safety issues. Good quality handover is essential to protect the safety of patients. Failure in this process, or poor quality handover, is a significant risk to patients.<sup>3</sup>
- It has been recommended that formal handover should become part of good professional practice.<sup>2</sup>
- Patients have suffered adverse consequences when handover goes wrong. The government's report *An organisation with a memory* cites an example involving the death of a patient.<sup>4</sup> Although a number of system failures were identified, it was noted that there was no formal face-to-face handover between the doctors involved.
- Patients expect doctors caring for them to share information, to minimise repetition and maintain safety.
- Patients expect their confidentiality to be respected in handling their personal information.
- Several recent coroners' cases have criticised systems where the failure to hand over information effectively was implicated in an adverse outcome.

Highlighting the organisational changes needed to tackle patient safety is vital. The National Patient Safety Agency has produced a document called the *Seven steps to patient safety*. This is a key document raising awareness of the required organisational change.<sup>3</sup>

# Continuity of information underlies continuity of care

‘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.’

## The **National Patient Safety Agency**

Perceptions and practice of handover vary across the country, between trusts, specialties and even within a single unit, reflecting that no single handover system is suitable for all.

- The fundamental aim of any handover is to achieve the efficient transfer of high quality clinical information at times of transition of responsibility for patients.
- Shift work relies on effective information transfer to protect patient safety. Continuity of information underpins all aspects of seamless continuity of care. Discontinuity of information endangers continuity of care and patient safety.
- Research demonstrates that implementing change in an environment where procedures for information transfer are fragile may precipitate systems failings and endanger patient safety.<sup>5</sup>

### **Challenges to continuity of information**

- Increased numbers of patients under the care of a single team
- Frequency with which lead consultant changes
- Frequent movement of patients between wards and departments sometimes without the doctors' knowledge
- Involvement of multiple specialist teams

## Evolving away from personal continuity

Traditional on-call work patterns with personal continuity, in which the patient sees the same doctor or nurse day after day, have masked the lack of structure and systems to support information transfer. However, the concept of personal continuity is outdated in the modern NHS where multiple health professionals and teams will contribute to the care of a single patient.



Time	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	0	1	2	3	4	5	6	7	
Team A					⋮																				
Team B					⋮													⋮							
Team C					⋮																				
	<b>Daytime</b>									<b>Evening</b>							<b>Night</b>								

**Figure 1:** Illustration of the pattern of changes in doctor covering a ward’s patients throughout the 24hr period. Clear mechanisms must support the handover of information between doctors at shift changes.

Doctors and patients perceive continuity of care differently. While overall personal continuity is valued by patients, it does not ensure quality of treatment. It may also legitimise the idea that there are patients for whom an individual is not responsible and this threatens organisational responsibility.<sup>6,7</sup>

### Developing system responsibility

It is essential that the necessary move away from personal continuity should result in system continuity. The patient’s experience of this is consistency and accuracy of knowledge and information between all multidisciplinary team members. The team, rather than the individual should be seen as the care provider.

Achieving system continuity requires mechanisms to support the transfer of high quality clinical information across shift changes. These should include:

- time in rotas for members of the team to meet, share information, and clarify responsibility for ongoing care and outstanding tasks
- access to up-to-date summaries and management plans for all patients under a team’s care
- robust means to identify and contact the doctor who is responsible for a patient at any given time.

To ensure effective continuity of information, the handover must achieve a balance between comprehensiveness and efficiency.

Improving handover will require major changes to the culture and organisation of doctors of all grades and disciplines, an understanding of the concept of both system and personal continuity, and should be supported by education and training.

## Good handover benefits patients

- Safety is protected – lapses in information handover can, and do, lead to mistakes being made. This increases morbidity and mortality.
- Less discontinuity of care – poor handover can lead to fragmentation and inconsistency of care.
- Decreased repetition – patients dislike having to answer the same questions over and over again. Different individuals providing care will be accepted as long as existing team knowledge is retained.
- Increased service satisfaction – every doctor attending a patient can begin where the last left off. Patient perception of professionalism is reaffirmed and improved.

## Good handover benefits doctors

- Educational – better handover will be of daily benefit to practice and helps the development and broadening of communication skills. A well-led handover session provides a useful setting for clinical education.
- Professional protection – accountability has become more prominent with the move towards a more litigious culture within healthcare. Clear and accountable communication can protect a doctor against blame for errors which occur.
- Reduction of stress – having the information and feeling informed allows doctors to feel less unsupported and more in control of a patient's care.
- Job satisfaction – providing the best possible quality of care is highly rewarding and is fundamental to a doctor's sense of job satisfaction.

# Risk management

Inadequate handover of clinical information carries significant risks for individual clinicians, their organisations and for their patients.

Some specific areas of heightened clinical risk are highlighted below. Trusts should ensure that the facilitation of high quality handover is seen as a clinical governance issue at all levels within the organisation.

## **Communications:**

- laboratory staff, faced with a critical result, have difficulty contacting the doctor responsible for the patient, as they may be different from the doctor that requested the test
- from the perspective of ward staff or lab staff, it is often unclear which doctor is responsible for their patients, and they have to 'bleep' multiple doctors until they find the correct one
- printed patient lists are often mislaid at other patients' bedsides or around the hospital, risking confidentiality breaches.<sup>1</sup>

## **Patient risks:**

- working from memory may mean that information is not shared or incorrect information is passed on
- use of bed/bay numbers should be avoided to prevent misidentification
- use of unique identifiers prevents confusion in patients with similar sounding names
- all hospital patient systems must ensure that administrative data is up to date 24-hours per day. If location and responsible consultant are not accurately recorded and readily accessible this exposes the patients and the hospital to considerable risks.

## Handover omission endangers patient safety

Saturday morning handover	'Please take Mrs Smith's bloods, I think her kidney function may be deteriorating.'
Saturday day shift	Mrs Smith's blood taken. Busy shift so results not checked.
Saturday night handover	'Please check Mrs Smith's results.'
Saturday night shift	Results chased and found with some difficulty after the ward insisted they had not been taken. Results appear normal.
Sunday morning handover	Handover interrupted by emergency call... Mrs Smith suffers cardiac arrest.

### Critical incident review

1. Handover did not detail that there were two patients called Mrs Smith on the ward. Bloods were taken from the wrong Mrs Smith.
  2. The results of bloods taken from the incorrect patient were not chased by the team that knew the reason for the tests. They may have been cautious about a normal set of results from a patient known to have renal problems.
  3. The outgoing team did not fully hand over the reasons for investigation. The potassium kept rising over the weekend for the correct Mrs Smith affecting her safety. Later that weekend she suffered a hyperkalaemic cardiac arrest.
- A.** Why were her bloods not checked?
- B.** Where did the problem start?

# Good practice in handover

Individuals and organisations have a shared responsibility to ensure that safe continuity of information and responsibility between shift changes takes place. This chapter highlights practical advice on how to implement safe systems for handover.

Every hospital will need to develop its own handover policy. This will require a coordinated approach from managers, all grades of doctors and the rest of the multidisciplinary team. Significant organisational change will probably be needed to enable effective handover to occur.

Hospitals implementing the night-team model will require a handover process which brings the team together to receive information from all parts of the hospital to coordinate care in the out-of-hours period. This multidisciplinary and multi-specialty approach requires the greatest change in culture, but has the potential for the greatest benefits.

As well as the larger set piece handovers there will inevitably be smaller local handovers occurring daily (such as on ITU or admissions unit). The guidance below offers ways of ensuring these are of maximum benefit.

## The information provided during handovers influences the delivery of care for the whole shift.<sup>8</sup>

### Who should be involved?

The key handover to or from the night team should be multidisciplinary. Local handovers (such as on ITU or at a ward level) will be smaller involving relevant staff.

- Each trust needs to identify the key people who need to attend. The ideal model includes all grades of staff from each included specialty, subspecialty or ward as appropriate. The senior nursing cover for the night period (and bed management if different) should be present.
- Daily involvement of senior clinicians is essential. This ensures that appropriate level management decisions are made and that handover forms a constructive part of medical education conveying the seriousness with which the organisation takes this process.
- There will always be work which is ongoing during the handover time, especially in the evening. Virtually all aspects of care can wait for 30 minutes to ensure continued safety overnight. Individuals need to be allowed to attend, subject to emergency cover being defined.

- The handover leader (see below) should ensure the team are 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 of sufficient length.
- This period should be known to all staff and designated 'bleep-free' except for immediately life threatening emergencies.
- Shifts for all staff involved should be coordinated to allow them to attend in 'working time'. This is particularly important for the handover to, and from, the night team.
- Handovers will also be needed in the morning and at the change of other shifts (for example 5pm in some ward settings).

To ensure attendance at handover, the Homerton Hospital sends all the night-team staff a text bleep to remind them of the time and location of the handover meeting, ten minutes ahead of each handover.

### Where should handover take place?

- Handover should be at a fixed time and of sufficient length.
- Ideally this should be close to the most used areas of work (such as A&E or Admissions Unit).
- It should be large enough to comfortably allow everyone to attend.
- This should be free from distraction and not used by others at this time.
- It should have access to lab results, X-rays, clinical information, the internet/intranet and telephones.
- Many hospitals have chosen to use the night-team base as the handover room.

Distractions that can disturb the handover process include bleeps, telephones, relatives, nurses and other doctors.<sup>8</sup>

## How should handover happen?

The style of handover will vary depending on local need – whole hospital handovers to night teams, local handovers on specific units, community-based specialties or those covering several sites. However, all types need a predetermined format and structure to ensure adequate information exchange.

- Ad hoc handovers often miss out important aspects of care.
- Handover should be supervised by the most senior clinician present and must have clear leadership.
- Information presented should be succinct and relevant.
- Ideally, this can be supported by information systems identifying all relevant patients.<sup>1</sup>

The Royal College of Physicians has published guidance on handover, relevant to general medical staff. Included in this document is an example of a handover sheet that can be used to facilitate effective information transfer between colleagues.<sup>9</sup>

There are many ways in which developments in information technology can assist with the handover process. An electronic information-sharing system that works effectively can be time neutral for junior doctors compared with traditional paper based or verbal handover.<sup>10</sup> It may also contribute to safety, although this has not been demonstrated in any research to date.

- Regular review of the system, for example at clinical governance meetings, appraisal meetings and through monitoring incident reports, is advisable.
- The relevant senior consultant or the medical director, should have responsibility for ensuring handover happens as expected.

## What should be handed over?

Written (or IT based) handover should include:

- current inpatients
- accepted and referred patients due to be assessed
- accurate location of all patients
- operational matters, directly relevant to clinical care such as ICU bed availability
- information to convey to the following shift
- patients brought to the attention of the critical care outreach team (where appropriate)
- patients whose 'early warning scores' are deteriorating (where in use).

The following, as well as being included in the written handover, should be discussed within the handover meeting. This verbal handover is vital to highlight these issues:

- patients with anticipated problems, to clarify management plans and ensure appropriate review
- outstanding tasks, associated with their required time for completion.

When handing over information between colleagues, the avoidance of jargon and explanation of abbreviations is essential.<sup>11</sup>

## Information management solutions<sup>1</sup>

### **Patient information:**

- all hospital IT systems must ensure the administration data is up-to-date 24-hours per day. If the consultant and ward for a patient are not accurately kept, the junior doctor will not know which patients are under their care, and patients can get 'lost' in the hospital
- keeping patient lists on desktop computer or handheld devices needs careful security consideration, and avoidance of breaching the data protection act. Check local protocols in your trust\*

\* Further details about the Data Protection Act can be obtained from your trust's/hospital's Caldiott Guardian or Caldiott Committee who should be involved in guidelines on new IT facilities and innovative handover mechanisms.



- publish a 'live' list on the hospital intranet of the name and contact details for doctors covering each consultant's or specialty's patients at any given time
- electronic patient lists could be provided in a secure password protected manner on the hospital intranet.
- doctors could carry patient information on password protected hand-held computers, and synchronise their devices at the change of shifts
- hand held computers with wireless connections, allows voice as well as data communication. This could allow automatic routing of test results to the responsible doctor.

<b>Think handover...</b>	
<b>WHO</b>	should be involved
<b>WHEN</b>	should it take place
<b>WHERE</b>	should it occur
<b>HOW</b>	should it happen
<b>WHAT</b>	needs to be handed over

# Real examples

## Handover guidance

### Models of good practice

#### **District General Hospital handover**

The paediatric unit of a district general hospital coordinates handover well. Each morning a multidisciplinary 9.00am handover is held, led by the senior nurse on duty and the consultant of the week. This handover takes place in a specific room, and is ring fenced to ensure that it is not disturbed except in unforeseen emergency situations. All of the outgoing night team, and incoming day team attend and all patients on the paediatric ward and neonatal unit are discussed. A consultant led ward round then takes place seven days a week, involving the night medical team and daytime oncoming team.

An identical handover takes place at 4.45pm, where the day teams handover to the evening team – this is, again, consultant and senior nurse led. All patients are discussed and their management plans reviewed by the consultant of the week. Using a 'consultant of the week' model enhances continuity of care for patients throughout the seven-day period.

A further handover takes place at 9.30pm which is attended by the evening and night medical staff and is followed up by a discussion with the consultant on call for the night.

Patient safety is paramount by ensuring that each patient is properly handed over, and the most senior member of the medical staff available is present together with nursing staff involvement. Impromptu educational questions can be raised, and direction can be given by consultants for further management of patients.

#### ***Burnley General Hospital***

## Hospital at Night

The Hospital at Night model is one of the most complete ways to achieve compliance with the European Working Time Directive. It is a competency-based approach to clinical care and out-of-hours medical provision. Doctors, nurses and other healthcare workers work in teams that are not demarcated by traditional boundaries and work is allocated on the basis of skills and competencies. This approach to working relies on cooperation at all levels of the clinical team. Doctors working in shifts alongside senior nurses provide out-of-hours cover.

One of the major recommendations to come out of the pilot projects was that handover was an integral part of successful implementation of such an approach. Successful implementation relied

on medical and nursing teams communicating effectively and efficiently both within their teams and also with other teams and shifts.

The Hospital at Night pilot projects have all taken different approaches to handover but the overall focus has been that handover was a fundamental part of a safe working clinical team.

#### **A hospital-wide approach to handover**

All specialties including general surgery, orthopaedics, anaesthetics and general medicine are involved in a handover to the night team. The hospital 'stops' at 9pm so all teams handover together. Everyone is made aware of the sick patients in the hospital and the tasks that are to be completed during the shift. The advantage of a hospital wide approach is that everyone is aware of what is going on and there is a true team approach.

*The Homerton Hospital, London*

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.

#### **Intranet-based patient lists**

One trust is using an online, live patient list, which is accessible in a secure manner to all members of the team from any computer in the hospital. As well as giving details of the location and consultant team responsible for the patient, it gives summary of current problems, and the outstanding management issues.

This is particularly useful for the continuity of information and tasks across large numbers of patients, where it would be otherwise impractical to discuss them all on an individual basis. It also gives more robust confidentiality and data protection than lists printed from individuals' PCs or disks.

*Kings' College Hospital, London*

**A specialty specific approach to handover.**

The medical and surgical specialties have separate handovers. There is a designated handover area, which is the 'control centre' for the out-of-hours team. Nurses and doctors take part in the handover together. Clinical priorities are identified and tasks allocated to the most appropriate professional to carry it out.

*The Royal Liverpool University Hospital*

The multidisciplinary approach to handover is fundamental to the successful flow of information and its link to continuity of care.

# A message to junior doctors



We all hand over information about patients every working day. Many of us would accept that our present mechanisms for doing so are far from ideal. A scrap of paper left in the mess together with a rushed telephone call represents a real risk to our patients' quality of care.

This document sets out to change that. We will become increasingly reliant on high quality information to be able to look after our patients and it is imperative that the systems in place around us facilitate this:

- good IT
- time to handover
- a quiet place to do so
- coordinated shifts.

In turn, this will allow us to offer our patients even better care and improve the quality of our working lives.

Talking to fellow junior doctors in hospitals with really excellent handover arrangements in place, they all state that they cannot now imagine working in a system without them. All have seen good, comprehensive handover as being of enormous benefit to themselves as well as to their patients.

We have to get this right and the BMA is delighted to work with the National Patient Safety Agency and Modernisation Agency in taking a lead on improving handover and making hospitals and community care safer.

A handwritten signature in black ink, appearing to read 'S. Eccles', with a long horizontal stroke extending to the right.

**Mr Simon Eccles**

Chairman

United Kingdom Junior Doctors Committee

British Medical Association

## A message to consultants

Consultants rightly place themselves at the centre of maintaining excellence of care for patients. Through leadership, motivation and continued modernisation, consultants press forward positive change for patients. The long-term commitment consultants have to their organisations, often reaching 20-30 years, gives them vital insight into what works best for patients. There must be robust consultant support for the handover process and encouragement to multidisciplinary teams to become involved, in order to maximize the benefits for the teams, but most of all for patients.

Consultants need to ensure that they handover information about their most critically ill patients to covering colleagues. They should highlight problems where intervention may be necessary. It is not possible, nor desirable for consultants to maintain a 24-hour, 7 day a week control of individual patient decision-making. Handover and team working allows continuity and forward planning that is ultimately in the best interests of patients.

Like so many initiatives, consultant involvement and leadership are vital to the success of handover. Indeed in many areas of best practice, such as ICU and A&E, this is already the case. Consultants need to build and share this experience to promote a hospital-wide approach to caring for patients.

This is another area where consultants, central to clinical teams, can make a real difference in improving patient care and reducing risks to patients.



**Dr Paul Miller**

Chairman

Central Consultants and Specialists Committee

British Medical Association



# A message to medical managers



Communicating what we do, what we have done and what we plan to do for our patients lies at the very heart of clinical care. We have evolved traditions of communication within the profession – which now must be changed and adapted, given the changes in the ways we must all work in the future to comply with the European Working Time Directive.

Fundamentally, what matters is the safety and wellbeing of patients in our care. As we move from the individual doctor-based approach to a team-based culture, from on-call to full shift working, so must the systems and processes of information exchange become considerably more sophisticated and precise.

For medical managers this means, firstly, providing support for whatever system of handover is in place in the trust. However, as a major component of the organisation's risk strategy and clinical governance, it also means that medical managers will need to develop mechanisms to be able to satisfy themselves that handover arrangements are in place, that they are robust, that they are adhered to – and most importantly – that they are working.

A rigorous approach to handover of vital patient care information, however, should not take the form of a stand-alone initiative, the sole province of the doctor in training. It should form part of an overarching, trust-wide policy of teamworking, based on appropriate and effective sharing and use of patient care information. The medical manager has a key role to play in ensuring that the underlying structures and processes are in place and that doctors and other clinical staff are totally supported in achieving effective handover, whatever their specialty or location.

A handwritten signature in black ink that reads 'Jenny Simpson'.

**Professor Jenny Simpson OBE**  
Chief Executive  
British Association of Medical Managers

# A message to postgraduate deans and clinical tutors

An essential aspect of postgraduate medical education is learning from working with patients. The European Working Time Directive, Changing the Workforce initiative and Modernising Medical Careers will impact on the way that patient care is delivered and will present new opportunities to make learning for doctors in training more effective. As training becomes more concentrated those with responsibility for medical education must learn new skills to magnify every learning opportunity.

Handover without senior input is a lost opportunity and can encourage confidence without corresponding increase in competence. The 'post-take' ward round has always been an effective way of reviewing clinical decisions and encouraging learning. New ways of working will require new ways of learning. Consultants and specialist registrars will need to learn how to use formal handover, often away from the bedside for effective use of time, to stimulate learning and encourage self-reflection at the same time as ensuring transfer of essential information.

This guide challenges the medical profession to think carefully about the clinical governance issues involved in handover and to consider how technology and effective communication can be used to ensure patient safety. The challenge for postgraduate deaneries, and those with responsibility for medical education in the trusts, is to develop skills in consultants and specialist registrars to use formal handover sessions as learning opportunities. Postgraduate deans and medical royal colleges will also need to consider how existing quality assurance processes can be used to encourage trusts to embrace these important changes.



**Professor Jacky Hayden**

Dean of Postgraduate Medical Studies  
University of Manchester





# A message to medical students and medical schools



We have paid a great deal of attention in recent years to modernising the undergraduate medical curriculum. Most of the effort has gone into changes in curriculum structure and delivery. Some effort has gone into making sure that the knowledge base that we are teaching is up to date. I have the impression that rather less effort has been directed to ensuring that our graduates are equipped to deal with the organisational aspects of healthcare delivery that they are going to meet from their first day as PRHOs. Important areas such as patient safety are just beginning to find their way into the formal curriculum.

The European Working Time Directive has already had a major impact on junior doctors' working patterns. It is impossible for there to be individual continuity of care by juniors when the working week is limited to 48 hours. This problem is likely to be exacerbated with the introduction of the more structured training programmes envisaged in Modernising Medical Careers. Properly structured and managed handovers will be essential for patient safety and optimal care.

The BMA guidance document *Safe handover: safe patients* is a timely reminder of the importance of this area within the curriculum. Part of our instruction in communication skills must focus on communication between professionals. Good handover procedures must form part of this.

A handwritten signature in black ink, appearing to read 'Sam Leinster', written in a cursive style.

**Professor Sam Leinster**

Dean

School of Health Policy and Practice

University of East Anglia

# Conclusion

- Good doctor to doctor handover is vital to protect patient safety
- Multi-disciplinary handover is important to ensure all groups of staff are updated with current patient information
- With the increase in shift pattern working, the importance of good handover has never been so high
- Systems need to be put in place to enable and facilitate handover. These systems, although based on a generic model, must be adapted to local needs
- Continuity of care is paramount to protect patient safety; continuity of care is underpinned by continuity of information
- Safe handover = safe patients

# References

- 1 Junior Doctors Committee (2003) Making IT work for hospital Juniors: Supporting Working Practices and Training with the New Contract and the EWTD. London: British Medical Association.
- 2 Roughton V & Severs M (1996) The Junior Doctor Handover: current practices and future expectations. *The Journal of the Royal College of Physicians of London* **30**: 213-4.
- 3 National Patient Safety Agency (2004) *Seven steps to patient safety*. London: National Patient Safety Agency.
- 4 Department of Health Expert Group (2000) *Organisation with a memory*. London: Department of Health.
- 5 Cook RI, Render M & Woods DD (2000) Gaps in continuity of care and patient safety. *BMJ* **320**: 791-94.
- 6 Veenstra M, Pettersen KI & Sjetne IS (2000) *Patients experiences at 21 Norwegian Hospitals*. Lorenskog: HELIEF Foundation for Health Services Research.
- 7 Krogstad U, Hotoss D & Hjortdahl P (2002) Continuity of hospital care: beyond the question of personal contact. *BMJ* **324**: 36-8.
- 8 Currie J (2002) Improving the efficacy of patient handover. *Emergency Nurse* **10**: 24-7.
- 9 Royal College of Physicians Handover Reference  
[www.rcplondon.ac.uk/pubs/handbook/gpt/gpt\\_handbook\\_app4.htm](http://www.rcplondon.ac.uk/pubs/handbook/gpt/gpt_handbook_app4.htm)
- 10 Young R, Horsley S & McKenna M (2000) The potential role of IT in supporting the work of junior doctors. *The Journal of the Royal College of Physicians of London* **34**: 366-70.
- 11 Hoban V (2003) How to...handle a handover. *The Nursing Times* **99**: 54-5.
- 12 de Leval MR, Carthey J, Wright DJ, Farewell VT and Reason JT. Human factors and surgical outcomes: A multi-centre study. *Journal of Thoracic and Cardiovascular Surgery* 2000; **119**: 661-67.
- 13 Carthey J, de Leval MR and Reason JT. The 'human factor' in cardiac surgery: Errors and near misses in a high technology medical domain. *Annals of Thoracic Surgery*, 2001; **72**: 300-305.

# Appendix I – New Deal & EWTD

## The New Deal

The implementation of the New Deal for doctors in training has acted as a driver for change in the way that the medical workforce is organised in the UK.

In recent years, more doctors have moved away from the traditional on-call model to patterns of work more appropriate to their workload intensity. Full shift rotas have become the norm in many acute care settings. This will often mean different teams looking after the same group of patients in the course of any given day. As a consequence, robust handover mechanisms are of the utmost importance.

### New Deal rest requirements

Rota type	Minimum time between duties (h)	Minimum Time off duty (h)	Rest
On call	12	48 + 62 every 28 days	OOH incl. 5 hours continuous at night
24-hour partial shift	8	48 + 62 every 21 days	6 hours incl. 4 hours continuous at night
Partial shift	8	48 + 62 every 21 days	OOH period
Full shift	8	48 + 62 every 21 days	Natural breaks only

- OOH (out-of-hours) – all time outside normal working day Mon-Fri.
- All working patterns are entitled to natural breaks – 30 minutes continuous break after approximately four hours of duty.

## The European Working Time Directive

Doctors in training will benefit from a phased introduction of the EWTD. All other staff groups – and most other employees – are already protected by this legislation. The EWTD is essential health and safety legislation designed to protect the individual from the potentially damaging effects of working excessive hours and to ensure that they are adequately rested. Enforcement of the legislation is the responsibility of the Health and Safety Executive. The limits for working hours under the EWTD are summarised in the boxes below. These limits are in addition to those already provided by the New Deal, which continues to apply.

### Average working hours per week for doctors in training

<b>August 2004</b>	58 hours
<b>August 2007</b>	56 hours
<b>August 2009*</b>	48 hours

\* In exceptional circumstances a country may apply for an extended deadline up to 2012 with a 52-hour interim limit

### Rest provisions from August 2004

11 hours continuous rest in every 24-hour period  
Minimum 20 minute break when shift exceeds 6 hours  
Minimum 24-hour rest in every 7 days **or**  
Minimum 48-hour rest in every 14 days  
Minimum 4 weeks annual leave  
Maximum 8 hours work in 24 for night workers (if applicable)

Further details are contained in *Time's Up – a guide on the EWTD for junior doctors* which can be accessed at [www.bma.org.uk/ewtd](http://www.bma.org.uk/ewtd)

## Appendix II – Sources of further information

British Medical Association	<a href="http://www.bma.org.uk">http://www.bma.org.uk</a>
General Medical Council	<a href="http://www.gmc-uk.org">http://www.gmc-uk.org</a>
National Patient Safety Agency	<a href="http://www.npsa.org.uk">http://www.npsa.org.uk</a>
Modernisation Agency	<a href="http://www.modern.nhs.uk">http://www.modern.nhs.uk</a>
Royal College of Physicians	<a href="http://www.rcplondon.ac.uk">http://www.rcplondon.ac.uk</a>

# Appendix III – Royal College of Physicians Good Practice



## Royal College of Physicians

### Standards of good practice to improve continuity of care

1. A patient should know the name of the medical team responsible for his or her care.
2. A medical team should know the name and location of every patient under its care.
3. Medical teams should not routinely have patients outlying from their home wards.
4. A single medical team should be responsible for a patient's care at any one time.
5. Doctors should have sufficient protected time for patient handover.
6. On transfer of care, a patient's new team should have immediate access to all necessary clinical information.
7. Out of hours (evenings, nights, and weekends), doctors should be aware of the patients under their care who are particularly unwell.
8. Each clinical action and annotation in patient notes should be traceable to the doctor concerned.
9. A patient's resuscitation status must be stored sensitively, but also accessible immediately.
10. Doctors should know the outcome of their decisions.
11. When designing junior doctors' medical rota, the first priority should be daytime continuity of care on the wards.
12. A discharge letter, summary or report should leave the hospital within 24 hours of a patient's discharge.

# Appendix IV – Common Pitfalls During Handover

## Common pitfalls during handover

The Human Factors and Arterial Switch Operation study collected data on operations performed by 21 UK cardiac surgeons in 16 centres over eighteen months. During the study, researchers were present at operating theatre to ICU handovers.<sup>12,13</sup>

- Healthcare professionals sometimes try to give verbal handovers at the same time as the team taking over the patient's care are setting up vital life support and monitoring equipment. Unless both teams are able to concentrate on the handover of a sick patient, valuable information will be lost. The importance of written handover information must be stressed.
- Roles and responsibilities are not always clear during handover and this can lead to omissions, for example, if one staff member assumes that another will verbally update the team taking over the care of a patient.
- Checklists and written updates are important and often under-utilised. They provide important sources of information for the team who has taken over care of the patient during the following shift. When such information is incomplete or omitted it has a knock on effect of increasing the workload of the staff who have taken over the patient's care because they have to spend a significant proportion of time chasing information.
- It is important that nursing staff are made aware of critical features in the medical management of a patient that will affect care during the next shift. Similarly, medical staff must be aware of specific nursing issues that may affect care. Multidisciplinary team handover helps minimise these omissions.
- Fragmentation of information at the point of handover is a major problem. It is important to avoid multiple concurrent conversations between individuals and let one person (a nominated lead) speak at a time to everyone. This reduces the opportunities for conflicting information to be given.
- Handover is a two way process. Good handover practice is characterised by the team who are taking over the patient's care asking questions and having the opportunity to clarify points they are uncertain of. They should not be passive recipients of information.



# Appendix V – Safe Handover: Safe Patients – One day event summary

## Background

Effective handover is of vital importance to the safety of patients. The British Medical Association's Junior Doctors Committee has been working closely with the National Patient Safety Agency (NPSA) and NHS Modernisation Agency to produce this crucial guidance on clinical handover.

It is important that this guidance is widely used and accepted throughout the United Kingdom. In order to facilitate this process a one-day handover event was held at the NPSA in London on Wednesday 21 July 2004.

Clinicians and managers attended the event as well as representatives from the NPSA, NHS Modernisation Agency, Department of Health, Nursing and Midwifery Council, postgraduate deaneries, NHS Litigation Authority and the BMA. The delegates at this conference ratified the contents of this booklet and produced a list of priorities and actions for the future.

These action points are detailed below, and the BMA will ensure that the external bodies listed continue to develop their work on good handover. Patient safety is paramount in all of our healthcare institutions and it is vital that the recommendations below are put into practice.

## Priorities for action

1. The Healthcare Commission should ensure, by regular inspections, that handover mechanisms in each organisation provide safe continuity of information in order to maximise patient protection and patient safety.
2. Postgraduate deans and the medical royal colleges should include effective handover practice as an essential criterion for granting educational approval of a training grade post.
3. Training Institutions, in conjunction with the General Medical Council, should develop and implement undergraduate handover training modules for every medical school, and handover training modules should also be included in every postgraduate curriculum in the UK.
4. Competency in handover, and in medical record writing, should feature as an aspect of all training or continuing professional development appraisals and assessments throughout the medical career structure, from medical schools onwards.
5. Each trust, NHS region, medical royal college, statutory body and other organisation connected with patient safety, or the education, training or representation of doctors, must identify and appoint a responsible handover champion.
6. The Department of Health and National Patient Safety Agency should develop and publish a standardised handover protocol and model handover documentation in conjunction with the British Medical Association.
7. The Department of Health should mandate each trust to have an effective handover policy as well as ensure that appropriate handover is built into each and every rota.
8. Trusts should ensure that information systems are in place to support handover processes.
9. The Healthcare Commission should include inspections of handover mechanisms and procedures in their measure of the performance of NHS trusts.
10. The National Patient Safety Agency and Department of Health should begin work on the standardisation of the format of medical records and ensure that attention is given to ensuring the patient record is optimal, in order to facilitate effective handover of information to protect the safety of each patient within the host institution.
11. The National Patient Safety Agency and Department of Health should develop generic medical handover guidelines to aid trusts in producing specific speciality and hospital based handover protocols.

## Delegates

The following delegates attended the one-day handover event and contributed to the discussions and creation of the priority outcome above:

<b>Name</b>	<b>Position &amp; organisation</b>
Dr Janet Anderson	Consultant Paediatrician & Tutor Support, Royal College of Paediatrics & Child Health, London
Ms June Andrews	Director, Centre for Change & Innovation, Scottish Executive Health Department, Edinburgh
Dr Robin Arnold	Chairman, Central Consultants Specialists Committee Psychiatry Subcommittee, British Medical Association, London
Dr Dan Ash	President, Royal College of Radiologists, London
Dr Simon Calvert	Chair, Junior Doctors Committee IT Working Group, British Medical Association, London
Dr Geoff Copland	Director of Clinical Training, Gold Coast Hospital, Southport, Australia
Ms Alison Dalby	Human Resources Advisor, University College London Hospitals NHS Trust, London
Dr John Dyet	Clinical Specialty Advisor for Radiology, National Patient Safety Agency, London
Mr Simon Eccles	Chairman, Junior Doctors Committee, British Medical Association, London
Dr Peter Ehrhardt	Consultant Paediatrician & Medical Director, East Lancashire Hospitals Trust, Burnley
Ms Georgina Fletcher	Human Factors Specialist, National Patient Safety Agency, London
Dr Rajat Gupta	Member, Junior Doctors Committee, British Medical Association, London
Professor Jacky Hayden	Dean of Postgraduate Medical Studies, North Western Deanery, Manchester
Mr Keith Haynes	Head of MPS Risk Consulting, Medical Protection Society, Leeds
Dr Paul Helliwell	Clinical Specialty Advisor for Dental Services, National Patient Safety Agency, London
Dr Sara Hunt	Specialist Registrar in Anaesthetics, Association of Anaesthetists of Great Britain & Ireland, London
Ms Candace Imison	Project Lead, Hospital at Night, Department of Health, London
Dr Geoffrey Lewis	Member, Junior Doctors Committee, British Medical Association, London
Professor Sir John Lilleyman	Medical Director, National Patient Safety Agency, London
Dr Andrew Long	Chairman, National Association of Clinical Tutors, London
Dr David Macklin	Deputy Chairman, Junior Doctors Committee, British Medical Association, London

Dr Susan Mallett	Consultant Anaesthetist, Royal College of Anaesthetists, London
Dr Robin Mann	Development Manager, Health Informatics Unit, Royal College of Physicians, London
Mr John Mercy	Professional Adviser, Adult Nursing, Nursing & Midwifery Council, London
Ms Vicky Monaghan	Working Time Directive Project Lead (Homerton), Department of Health, London
Dr David Morris	Director of Medical Training, Woman's & Children's Hospital, Adelaide, Australia
Mr Paul Mulligan	European Working Time Directive Project Lead, Guy's & St Thomas' Hospital NHS Trust, London
Dr Stuart Nicholls	Consultant Paediatrician, Royal College of Paediatrics & Child Health, London
Professor Dianne Parker	Patient Safety Strategy Development, Department of Health, London
Ms Cathy Peck	Learning Programmes Manager, NHS University, London
Professor Roy Pounder	Clinical Vice-President, Royal College of Physicians, London
Dr Andrew Rowland	Chairman of English RJDC Chairs, British Medical Association, London
Ms Joan Russell	Assistant Director, Emergency Care, National Patient Safety Agency, London
Ms Lynne Saunders	CNST Risk Management Assessor, NHS Litigation Authority, London
Ms Elaine Stevenson	Assistant Director, Older People, National Patient Safety Agency, London
Dr Andrew Thomson	Junior Doctors Committee Hours of Work & Medical Staffing Team, British Medical Association, London
Ms Judith Whittam	Change Agent, Change Agent Team, Department of Health, London
Dr Melissa Whitten	Trainee Chair, Royal College of Obstetricians and Gynaecology, London
Ms Stephanie Wilson	Lecturer, Centre for Human Computer Interaction Design, City University, London

Full proceedings of this event are available from the British Medical Association.

# Appendix VI – Contributors

## **British Medical Association Junior Doctors Committee**

Miss Emma Bywaters  
Dr Simon Calvert  
Mr Simon Eccles  
Dr Graeme Eunson  
Dr David Macklin  
Dr Chris McCullough  
Dr Andrew Rowland  
Dr Andrew Thomson

## **British Medical Association Central Consultants and Specialists Committee**

Dr Paul Miller

## **University of Manchester**

Professor Jacky Hayden

## **University of East Anglia**

Professor Sam Leinster

## **General Medical Council**

Professor Peter Rubin

## **British Association of Medical Managers**

Professor Jenny Simpson

## **National Patient Safety Agency**

Professor Sir John Lilleyman  
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