Clinical Handover

What is clinical handover?
• Transfer of professional responsibility and accountability of some or all aspects of patient care (individual or group of patients) to another individual or a group (of doctors) on a temporary or permanent basis (1)
• Not just a transfer of information, it’s a transfer of accountability and responsibility - “This is now MY patient” – this is vital for junior doctors to understand

Is clinical handover dangerous?
• Of course. This is why people are focusing more on clinical handover. As junior doctor hours reduced in North America/Europe, there are more handovers, and this has resulted in more clinical errors. Many patient safety errors are due to handover issues and a lack of communication. Less hours = more handovers = more opportunity for communication breakdown
• The situation is similar to Chinese whispers, the more handovers involved, the more information is lost and this can compromise patient care. You’re trying to create a mental model of the patient to the next person.
• Many RCAs and errors come down to patient communication.
• Medical school – not much emphasis on how to speak to other colleagues but this is one of the most common activities performed by junior doctors (speaking to other registrars or consultants)

When does clinical handover occur?

• End of term handover (eg. at the end of your geriatrics term you need to handover to the next intern doing your term)

• Weekend handover (eg. if you want particular investigations or management plans implemented over the weekend)

• Transfer of care between different departments (eg. ED to wards)

• Wards to the community (common for junior doctors) – discharge summary, phone call to the GP

• Shift to shift

Case #1: It’s the evening shift, you’ve seen a surgical patient with chest pain, we need to handover to the night team

• Stressful to speak in a large group (eg. the evening shift to night shift handover)

• Helps to have some structure.
• ISBAR was shown to improve JMO perception of handover communication (2)
  
  o Introduction – who you are, what your role is, patient’s name, MRN, location
  
  o Situation – what’s happening at the moment (eg. ATSP with hypotension), I’m a bit worried about this patient
  
  o Background – what are the issues that led to this situation? Day 2 post hip surgery. What led to this phone call?
  
  o Assessment – what is the problem? Take in the history, examination and investigations (ECG, troponin), what do you think is going on?
  
  o Recommendation – what should be done, what do you want to be done, what is your goal for the handover?
  
• Download the ISBAR app  https://itunes.apple.com/au/app/isbar/id465890292?mt=8

• Common errors
  
  o Including too much information – choose only the important points without filling the handover with unimportant information – however, this takes skill and experience and is harder than it sounds
  
  o Lack of preparation – being disorganized and not being clear as to what you want the next team to do

Case #1: Example response - “James, do you have anything to handover?” <Medical registrar>
  
  o I was the intern covering 8W1, asked to see Mr Joe Smith, a 76 year old man who developed chest pain
  
  o Day 2 post R NOF surgery, uncomplicated, but developed some anaemia
  
  o Developed chest pain, tightness, and ECG showed non specific ST-T changes, that the medical registrar thought weren’t significant and were on his old ECG, and we thought we’d do a troponin
  
  o I’d like you to chase the troponin. If normal, repeat in 3 hours. If raised, please ring the medical registrar, and they’ll need a monitored bed, consider anticoagulation, and ring the cardiology registrar

• Anticipatory guidance
  
  o Make a recommendation as to what needs to be done with the information
  
  o Whenever you ask someone to chase a result, tell them what to do with the information
  
  o Start thinking ahead during the day (much better than getting a night intern to make the decision at 4 am)
Fantastic learning as well, part of becoming an experienced clinician is being able to predict what will happen in a day or two (eg. patient with a NSTEMI chest pain, if they get more chest pain then they’ll need an urgent cardiology review +/- cath)

- **Structure of clinical handover may change (the inverted pyramid model)(3)**
  - For example, if you are calling someone at home, you may want to begin with what you want “eg. I want phone advice”, “I need you to come and review this unwell patient”, “I am informing you of something” to help the person you are calling to get into the appropriate frame of mind

- **Key tips**
  - Practice with your colleagues
  - Getting a summary into less than 2 minutes is an art form
  - Worth thinking about the handover before you do it
  - Know what the goal of your handover is
  - Think about anticipatory guidance
  - Doctors don’t always like structure “I can do it better” but stick to ISBAR!

**References**

1. AMA. Safe handover, Safe Patients: Guidance for clinical handover for clinicians and managers. 2006 PMID: 21310805
