POLICY STATEMENT

Handover Education in Canadian Residency Programs

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residentdoctors.ca
Resident Doctors of Canada (RDoC) represents over 9,000 resident doctors across Canada. Established in 1972, we are a not-for-profit organization providing a unified, national voice for our membership. RDoC collaborates with other national health organizations to foster excellence in training, wellness, and patient care.
Resident physicians play a major role in Canadian health care, providing a significant portion of front-line services in both ambulatory and hospital settings. During a patient’s treatment course, however, the responsibility for patient care is transferred frequently between health care providers each day – a process termed handover, handoff, sign-out or sign-over. In this paper, handover will refer to the transfer of accountability for patient care.

Handover is a vulnerable time in patient care and a significant factor in adverse events. Recognizing the relationship between transfer of care and patient safety, the World Health Organization has prioritized communication in patient care handover as one of its High 5 Patient Safety Initiatives. In 2007 the Joint Commission on Accreditation of Healthcare Organizations similarly distributed standards focused on improving patient handovers.

Handovers in medical settings are frequent and often transpire under suboptimal circumstances. A survey found that 60% of Canadian surgical residents spent less than 5 minutes preparing for handover. Residents also rated nearly one-third of handovers from their peers as poor. Clinical uncertainty from inadequate handover is most likely to occur during times of reduced coverage, such as overnight and weekends, further compounding the risk.

National and international efforts to restructure resident work hours and reorganize service schedules have also identified the importance of handover and handover education. A primary concern with such changes has been the potential corresponding increase in patient handovers. With each handover there is increased risk of loss of information between care providers that could negatively impact patient care.

In many instances, the implementation of alternative call models has increased the number of daily handovers and their inherent risk to continuity of care and patient safety. In a recent RDoC survey this was cited as one of the top three reasons why 22% of residents opposed scheduling changes. Half of the respondents had either witnessed (33%) or been directly involved (16%) in an adverse event that they

### Table 1. Recommendations

RDoC believes that patient safety can be enhanced by improved handover education. We recommend that:

1. Each patient handover should incorporate direct verbal interaction between care providers. Given the complexity of the handover process, using both verbal and written communication will ensure safe and accurate transfer of patient care.

2. Handover should take place in a quiet area where distractions are minimal. Sufficient time must be allotted for the handover.

3. The handover process should employ evidence-based tools and be standardized for each clinical setting. There are a variety of mnemonics and aids that may be adapted to the particular needs of a clinical setting.

4. A formal handover curriculum should be an accreditation standard for medical education, reflecting the core competencies of the CanMEDS framework.

5. Physicians require both didactic and interactive training in handover. The interactive component is especially important, and supervised evaluation of handover should be part of the training curriculum. A senior or chief resident, faculty member, or program director should regularly observe each resident’s handover performance and provide formal feedback.
felt could have been prevented through better handover. Handover most often occurs after long hours on
call, and in the same survey nearly 80% of residents indicated that work-related fatigue had a negative effect
on patient care in the form of medical errors.9

As recognition of the risks associated with handovers grows, it is essential that residency programs develop
a formal handover curriculum that provides high-quality training to ensure patient safety and optimal care
across all settings.

Evidence

In recent years, increasing interest in the handover practices of medical trainees has identified key components
of effective handover as well as barriers that impede it.

Mode of Communication

Effective communication is fundamental to safe and efficient handover.10 Verbal communication is perhaps
the most important and frequently used method. A number of verbal techniques employed in complex indus-
tries, such as aviation, are also useful in medicine.11 One common verbal method is face- to-face hand-
over with interactive questioning and the use of structured communication.12 Other strategies include prior-
itizing the most unwell patients, providing anticipatory guidance on likely issues, and providing ‘to do’
lists.13 Despite the importance of and opportunity for verbal communication, residents frequently experience
multiple interruptions during handover sessions. Limited access to a quiet, dedicated space, inadequate
time for information transfer, and lack of supervision all decrease handover quality.14

Written handover strategies are often used to circumvent challenges that can arise from multiple verbal
handovers. These include misinterpretation, distortion of information through omission, or incorporation of
extraneous information that may depend on time of day and the experience or level of the trainee.4,14,15 Use of
simple, standardized handover sheets can decrease the number of inappropriate tasks, improve handover
completeness, and increase efficiency.16,17 However, the utility of handover sheets alone is limited by the
accuracy of information provided, since there is no opportunity for clarification.18 In addition, the daily task of
updating lists can be time-consuming.14

Electronic medical records are often cited as a means of decreasing information errors.19 However, these
systems are not without challenges as they still require care providers to manually enter information.20 Such
systems may be costly and require additional integrated computer support systems.21 Although technology
can improve handover, when used alone it can result in the omission of valuable patient data. For example,
use of a computer alert system alone rather than a phone call for critical lab results resulted in 45% of urgent
lab results going unchecked.22 Residents prefer verbal communication and the opportunity to ask questions
for clarification.

Handover Methods

The fundamental question of what information to include is critical to safe, timely and effective handover.

Identifying patients who are at risk of deterioration is difficult, even for the most experienced clinicians.23 In-
tuitively, physicians should focus on those patients who are most ill and may require intervention in the near
future. However, physicians cannot reliably prioritize patients for handover based on illness severity. While
Physiologic Scoring Systems (PSS)24,25 can predict patient deterioration, these scores have yet to be applied
in the context of prioritizing patients at handover.
Promising research by Bittman et al.\(^2\) describes a novel scoring system to prioritize handover by illness severity using the pneumonic IHAND:

1. Investigations pending,
2. Currently located in a High acuity unit,
3. Abnormal vital signs in the preceding 24 hours,
4. Newly admitted in the last 24 hours, and
5. Dying.

Use of this tool in a large academic tertiary care centre has shown moderate success in predicting which patients to emphasize during handover.

Independent of the mode, certain information is universally essential:\(^{1,4,27,28}\)

1. Identifying patient information
2. Current clinical status
3. Code status
4. Pending investigations
5. Tasks to be completed

To ensure this information is included, acronyms or mnemonics have become the most frequently used tools for standardizing content. This principle is borrowed from high-reliability organizations where high-quality outcomes are expected despite frequent unexpected events, and where the results of missed information could be catastrophic, much like modern hospitals.\(^2\)

According to Risenburg\(^4\) there are at least 24 mnemonics for handovers described in the literature as of 2008. The most cited (70%) is SBAR (Situation, Background, Assessment, Recommendation). One study showed that internal medicine residents preferred the mnemonic SIGNOUT (Sick or DNR, Identifying data, General hospital course, New events of the day, Overall health status/clinical condition, Upcoming possibilities with plan, rationale, Tasks to complete overnight with plan, rationale) when compared to SBAR. The I-PASS (Illness severity, Patient Summary, Action list, Situation awareness, Synthesis by receiver) study group has implemented their handover tool in approximately 9 pediatric hospitals in both the United States and Canada.\(^2\)

Handover tools are used more often in medical specialties than surgical specialties.\(^5\) Despite the wide availability of standardized handover tools, a recent study revealed that 0 of 8 Canadian surgical programs surveyed used them. When handover did occur in these programs, code status was rarely included and the attending physicians were present only half of the time.

The Canadian Medical Protective Association\(^3\) has recently included handover education as part of its Good Practices Guide, which provides examples of structured communication approaches without endorsing a specific mnemonic, as few have yet been validated.\(^4\) While there is little data regarding the content of formalized handover, a one-size-fits-all mnemonic will likely not apply to all clinical scenarios or meet the needs of all practice settings.\(^4,3\)

Other health care disciplines face similar handover challenges.\(^3\) Literature from the nursing profession highlights the impact of communication problems, time constraints, environmental issues, and human factors such as high patient loads and long shifts on effective handover. Organizational hierarchy and social cul-
tutes have also been shown to impede communication and handover. Efforts to improve handover practices among nurses mirror those described in medical literature. Standardized handover, concurrent verbal and written handover, and face-to-face handover are techniques that have been used successfully to improve the quality of patient handover among nurses. However, there is little evidence that any specific structure is beneficial in all clinical settings.

Educational Curriculum

Recognizing the complexity of handover, the Accreditation Council for Graduate Medical Education recommends that all training programs have formal curricula in patient handover that incorporate key competencies. This recommendation is strengthened by the observation that trainees’ handover skills improve as they gain seniority, implying handover is a learned skill. Published curricula have taken various forms that include didactic sessions, interactive workshops and web-based modules. In general these programs improve trainee-perceived preparedness for handover, and are believed to improve care. Interactive programs were seen by residents as most successful. Direct supervision and feedback on handover skills were also viewed as valuable components of a handover curriculum.

Currently there is a paucity of formal handover education in Canadian postgraduate medical training programs. Most residents develop their handover skills through informal observation of senior residents or staff physicians. RDoC’s 2013 National Resident Survey revealed that only 1 in 6 residents received training as part of orientation, while only 2 in 10 received handover training during an academic half-day, or as part of another dedicated session.

Conclusions

Effective patient handover is essential to ensure patient safety and optimal medical care. Despite this, most residents in Canada do not receive formal training in this essential area. A variety of educational methods, including formal didactic sessions and observation with feedback from more senior physicians, have been shown to improve handover skills. While standardized tools may improve consistency and accuracy of handover, the clinical environment and time barriers to efficient handover must also be addressed. Each residency program should tailor handover curriculum and tools to meet the unique needs of its clinical settings. Additionally, current literature primarily describes outcomes related to handover practices in discipline specific settings. An important area for further investigation may include the implementation of standardized handover at a system or institutional (i.e. hospital) level.
References


