

# ACTION

FOR SAFER MEDICAL CARE



## Patient handovers

*Patient handovers — the temporary or permanent transfer of responsibility and accountability for some or all aspects of care for a patient or group of patients — are high risk points in patient care. Handovers occur within and across healthcare institutions and are taking on greater importance as healthcare providers become increasingly involved in multiple transfers of care. All handovers require the transfer of adequate and correct information to support patient safety and continuity of care. Effective communication between healthcare providers is also essential to safe patient handovers.*

### → CONSIDER THIS...

A 50-year-old patient diagnosed as having a left carotid dissection is transferred from a community hospital to a tertiary care centre for neurosurgical consultation. The neurosurgeon determines the patient is not a candidate for stenting or surgical intervention and orders heparin to be followed by warfarin. The patient's condition improves by the next day and his transfer back to the community hospital is approved. Heparin is discontinued temporarily for the ambulance transfer, and is to be restarted on arrival at the hospital.

The internist accepting the transferred patient receives an incomplete transfer record. It includes no information about any treatments, assessments, or medications administered at the previous hospital. The internist orders daily ASA. At shift change, another physician takes over the patient's care. That evening, the patient develops right-sided weakness and a speech deficit. A CT scan shows a left parietal stroke. Experts are critical of the lack of transfer of important clinical information by the neurosurgeon and of the internist for making treatment decisions in an information vacuum. Given the information did not arrive with the patient, the internist should have telephoned the transferring hospital for complete documentation.

A settlement is paid by the CMPA.

The CMPA has identified the following barriers to safe and effective patient handovers:

- setting (i.e. busy work environments with frequent interruptions)
- time constraints
- conflicting communication styles
- missing information
- lack of a standardized communication tool
- lack of training about safe patient handovers

**Team communication issues are present in almost 25% of all CMPA cases related to communication.**

**1829 cases**

Communication issues

**434 cases**

Team communication

**205 cases**

Physician-to-physician communication

In cases associated with poor physician-to-physician communication more than 80% of the patients involved were harmed by the care they received. Nearly 80% of cases involving poor physician-to-physician communication had unfavourable medico-legal outcomes for the physicians.

*Statistics are based on a recent 5-year study of CMPA medico-legal cases.*

### → WHAT DOES THIS MEAN FOR CMPA MEMBERS?

Inadequate handovers can be associated with delays in diagnosis, inappropriate treatment, and poor patient monitoring and follow-up.

Standardization of the handover process has been linked to a reduction in the number of errors related to information transfers. In addition, effective mechanisms for the transfer of information at transition points have been recognized as patient safety enablers.<sup>1</sup>

Physicians should strive to provide appropriate and accurate information at the time of all patient handovers. The communication should include all the relevant information to support effective care, patient safety, and continuity of care.

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### → RISK REDUCTION REMINDERS

Effective handovers can enhance care and help prevent harm to patients. The following points can assist physicians in managing risk:

1. When multiple physicians are involved, confirm that the reason for the transfer of care is clear to all physicians. Verify that the roles and responsibilities of each physician are clear to the patient and to the other physicians (and to other healthcare providers).
2. Verify that the appropriate consultant is aware of the patient's clinical condition and has agreed to the transfer of care.
3. Consider using a structured communication tool for sharing information during handovers.
4. Follow the institution's protocols for patient handovers, including the transfer of care related to consultations, as well as responsibilities for treatment and discharge decisions.
5. Ensure sufficient patient information has been provided.
6. Document relevant information for those assuming the care of the patient.
7. Consider reconfirming the clinical history directly with the patient, and then entering key elements of handover information in a paper or electronic log.

### → LEARN MORE BY ACCESSING THESE RESOURCES

#### **CMPA articles**

*Improving communication between physicians*

*Transfer of care can create problems*

*Collaborative care: A medical liability perspective*

#### **CMPA Good Practices Guide**

*Handovers*

*Follow-up of investigations*

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1. Accreditation Canada, Required Organization Practices Handbook, 2013

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