

NON-TECHNICAL SKILLS

Doctors' shift handovers in acute settings



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Patient handover in healthcare encompasses two main factors. First the exchange of patient information detailing the patient's current condition, ongoing treatment and developments or complications. Second the transfer of responsibility and accountability for a patient from one caregiver to another. Handovers are considered a high risk process where communication failures can cause problems in the continuity of patient care and potentially contribute to the occurrence of an adverse event. The aim of this research project was to examine doctor handovers in acute medical admissions units using observations and interviews.

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A review of the literature was conducted¹ of studies of hospital doctors' handovers to identify the main methods and findings. A total of 32 papers was identified with the most common methods utilised being observations and interviews. This research indicated that the majority of the research conducted had focused on the handover meeting, with pre and post handover phases rarely examined.

The next phase involved data collection from two Scottish hospitals' acute medical units to construct a hierarchical task analysis (HTA) of medical shift handovers². In order to complete the HTA in the first hospital, three stages of data collection were conducted; handover observation (n = 32), semi-structured interviews (n = 13) and focus groups (1). The final HTA encompassed the pre and post handover stages, together with an analysis of tasks completed during the handover meeting. The analysis was used to create a HTA diagram of the critical tasks that should be completed at each stage of the handover process. The main findings suggest that critical tasks can sometimes be omitted in the pre-handover stage, usually in response to task demands or time pressure. Another HTA was carried out in a second hospital (paper in prep).

The final phase was an analysis of the types of failure modes most prominent across the pre-handover in the first hospital. The healthcare failure mode and effects analysis (HFMEA) was used, a prospective analysis tool which calls for a healthcare team (n = 9) to identify any failure modes, their causes and their effects. Identified failure modes included; not all patient information updated and overlooking confirming a treatment plan.

Publications

¹Raduma Tomas, M.A., Flin, R., Yule, S.J. & Williams, D. (2011). Doctors' handovers in hospitals: A literature review. *BMJ Quality & Safety*, 20, 128-133. <http://qualitysafety.bmj.com/content/20/2/128.abstract>

²Raduma Tomas, M.A., Flin, R., Yule, S., & Close, S. (2012). The importance of preparation for doctors' handovers in an acute medical assessment unit: a hierarchical task analysis. *BMJ Quality and Safety*, 21, 211 – 217. <http://qualitysafety.bmj.com/content/21/3/211.short>