Handover is a ubiquitous feature of health care. At least 7 million handovers occur annually within Australian hospitals.1 At times, its very existence is almost unnoticed — many health professionals do not think of a telephone referral as “handover” — and at other times it is seen as a mundane chore that has to be done in addition to the “real” work of clinical staff. There can be complacency with current practices and little recognition of the high-risk nature of handover.

Handover is noticed when things go wrong. One recent tragic failure was that of an elderly Aboriginal man left to die on an airstrip in the Northern Territory.2 The man had pneumonia and failure was that of an elderly Aboriginal man left to die on an airstrip in the Northern Territory. Before his evacuation, a nurse and district medical officer discussed the possibility of a family escort travelling with him. Although this had previously been recommended by his referring doctor, neither the acuity of the patient’s condition nor his personal circumstances (poor English and frailty) were clearly communicated, and no escort accompanied him. This was the first inadequate handover.

After 9 days of treatment, he was discharged. The paperwork for his discharge was processed on a Friday, including a fax to his local community health centre advising of his scheduled Monday discharge. This fax was not seen or acted upon by the community health facility. Was this, then, handover at all?

There was no checking system between the travel service and the community health centre, and it was presumed that there would be someone to collect the patient on his return from Katherine to the community. However, this was not the case. The patient was left by the pilot, alone at the airstrip some distance from town. On the Thursday, 3 days after the man was left at the airstrip, the police were informed that he was missing. His body was found the following Monday. He had died — alone, dehydrated and suffering from pneumonia.

Since this tragic incident, the Northern Territory Government has taken steps to standardise and improve handover processes. The coroner’s report of the incident endorsed these steps as long as handover improvement was continual — the standardised processes would only be valuable if they were actively implemented and maintained.

Problems that can arise from poor communication at handover include incorrect medications being given, delays in treatment or failure to give it, unnecessary repetition of diagnostic tests, and preventable readmissions. These failings waste time, strain health care resources and cause harm to patients. Health care professionals need to acknowledge that handover is a high-risk situation and that it is an element of their work that is integral to the delivery of safe patient care. Our own serious adverse events should not be the trigger for actions to standardise handover practice. We can learn from the mistakes of others to ensure safe transfer of information, responsibility and accountability in patient care.

Clinical handover is defined as “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”.3 Accountability and responsibility are critical terms in this definition, as “transfer of information is irrelevant unless it results in action that is appropri-
on standardised clinical handover tools (page S141), in which clinicians were informed of the dangers of poor handover. The article by Chaboyer et al on communication via whiteboards (page S137) focuses on understanding how to use whiteboards in a systematic and planned way to improve handover. A shared understanding may also be promoted using technological solutions, as described by Silvester and Carr in a study of a shared electronic health record (page S113).

### The effects of health care culture and organisational structure

The complexity of health care means that maintaining the continuity of patient care is a challenging process. As the article by Botti et al on maximising patient safety in complex handover situations (page S157) states, “it is unlikely that any one improvement strategy will be appropriate for all.” Training in communication within a team seems to be a helpful strategy, as demonstrated by Stead et al in a study of TeamSTEPPS (team strategies and tools to enhance performance and patient safety) (page S128). This project used an existing program to train staff in using a standardised handover tool (SBAR) and in communication and teamwork in and around the handover.

Some aspects of handover have been only tangentially addressed by the National Clinical Handover Initiative. It has been suggested that communication errors sit on the “dark side of measurement,” where less-developed measures mean that problems are ignored. We still know little about the measurement of safe handover. In addition, the significance of documentation (including letters and notes, some of which are held by the patient) and its relationship to verbal handover has not yet been adequately explored. Research on ways of using documentation to optimise handover is crucial to ensure that electronic records are designed to provide maximum safety for patients.

Handover should be viewed as part of the provision of safe patient care, rather than as extra, unnecessary work. Good handover means that lapses in continuity of care, errors and harm will be reduced, whether patients are in the community or in hospital, undergoing a series of investigations, being prepared for surgery, recovering or dying. Clinicians and managers need to be aware that providing good handover requires an understanding of its purpose, leadership, protected time, a systematic approach, and a supportive clinical environment. Good handover takes effort.

### Competing interests

None identified.

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(Received 6 Nov 2008, accepted 19 Feb 2009)