Fact Sheet: Handover of Care

Handover of some or all aspects of client care from one healthcare professional to another is high risk for client safety, if not done well. Ineffective communication of information may lead to delayed medical intervention or diagnosis, failure to provide appropriate nursing care or a decrease in efficiency caused by repeated tasks or tests (Smeulers, Lucas & Verulen, 2014). The purpose of this fact sheet is to discuss the importance of handover of care, what elements should be included in a handover of care, barriers to successful handovers and suggestions to improve the handover of care.

Handover of care refers to the sharing of client information from one health care provider to another. It enables a seamless continuation of care and the transfer of responsibility and accountability for the client, on a temporary or permanent basis. Handovers of care give staff the opportunity to discuss client history, treatments that may have occurred or are upcoming, communicate any problems and concerns that may have arisen and share the existing care plan. Successful handover prepares the next healthcare provider to safely assume the responsibility of the care and be prepared to make informed decisions (Merten, van Galen & Wagner, 2017).

The handover process should be organized, efficient and include opportunities for questions and clarification of information. Handovers also provide an opportunity for client involvement in verifying history, correcting misinformation and clarifying key points related to their care. Handovers should occur when possible in places that allow clients the chance to hear what is being said (Spinks, Chaboyer, Bucknall, Tobiano & Whitty, 2015).

Accreditation Canada (2019) recommends the information shared during a handover of care be based on the clinical circumstances, and should include the following:

- client's full name;
- contact information for the primary healthcare provider;
- client's clinical condition;
- history of allergies and medications, clinical tests, treatments, and pending results;
- planned interventions and needed evaluations;
- possible problems and consideration of strategies should problems arise; and
- planned goals for the client.

RNs should follow their employer policy on handover of care. If a policy is not in place or in need of revision, NANB advises that you advocate for policy revision or development to support and improve nursing practice.

There are many barriers to successful handovers of care, such as:

- **Ineffective communication styles**
  Communication styles can interfere with the effective transfer of information. When possible, face-to-face discussion allows for interactive questioning in which clarifications can be made and questions can be asked for further understanding.
- **Failure to use standardized communication tools**
  A structured approach for handovers, including interactive questioning, helps to verify the information being transferred. The use of standardized tools should facilitate communication for the entire healthcare team.
- **The setting**
  Handovers often occur in busy workplaces. Frequent interruptions may lead to incomplete transfer of information and decreased recall.
- **Time constraints**
  Multi-tasking, unscheduled events, and not allotting sufficient time for handovers can impede the transfer of key information. Handovers at end-of-shift, during periods of emergency situations on a unit, or during times of understaffing are high-risk for information to be missed in the handover of care.
- **Missing information**
  Omitting critical information such as significant health history, clinical updates or outstanding tasks may result in harm to clients.
- **Lack of training**
  Lack of formal training and employers support regarding handovers have been identified as barriers to performing handovers effectively (The Canadian Medical Protective Association, n.d.).

The Registered Nurses Association of Ontario (2014) Care Transitions Best Practice Guideline advises that in order "to avoid repetition, duplication or omission of critical client information during information exchanges between settings or health-care providers, discussion and documentation should be streamlined and standardized to ensure clear and accurate transfer of information" (p.30). Important information can be lost when multiple handovers occur. If you are assuming care of a client, it may be prudent to reconfirm the clinical history directly with the client, and then to enter key elements of handover information in a paper or electronic record. Any formal transfer of responsibility for care, for example, from one clinical service to another, should be recorded in the client's record.

Accreditation Canada (2019) suggests that client safety can be improved by employing documentation tools and communication strategies. Depending on the work setting, different handover mechanisms may be used. The most common modes of handover are verbal report, recorded audio report or written report. A combination of verbal and written report is often required - the written report ensures information is captured and retained while the verbal communication offers a ''clearer'' picture of the client (Smeulers, Lucas & Verulen, 2014).

The goal of handover is to communicate important and relevant information about the client and the plan of care. Handover of care should include the concepts of 'what – how – where'.

- **What** information will be included (health history, present care interventions and status, future care plan)?
- **How** will it occur (recorded, written, face-to-face, or a combination thereof)?
- **Where** will it occur (at the bedside or in a designated location for staff only)?

Employers should have a policy and procedure regarding handover of care. The policy and procedure should outline the modes of handover, the mechanisms to use, where the handover should take place and the documentation of the handover of care.

If you have additional questions about this document, please contact NANB at practiceconsultation@nanb.nb.ca.

References

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