Handovers are an essential part of everyday nursing practice and a key part of ensuring patient safety, yet many happen at the end of a shift when staff are tired and waiting to go home.

‘We know from feedback that what makes nursing staff stressed and upset about their work patterns is always having to finish late, but often it’s because they want to give a good handover and they want to make sure they get it right,’ says RCN head of nursing practice Wendy Preston.

According to the RCN’s safer staffing survey, published last year, 65% of the more than 30,000 staff who responded said they worked additional time. A quarter said they worked an extra hour or more on their most recent shift.

‘I remember being in clinical practice and going home feeling that handovers were rushed,’ says Ms Preston. ‘You leave work asking yourself whether you’ve forgotten anything.’

A need for governance
She argues that handovers need the robust governance that is characteristic of other elements of nursing practice.

Jane Bruton, clinical research manager in the Patient Experience Research Centre at Imperial College London and a nurse for almost 40 years, would also like to see a more structured approach to handovers.

‘We’re not taught how to do it and there’s no competence measures for handovers,’ says Ms Bruton. ‘I’ve done it for years but really only learned by watching others. No one has ever said “this is how we do handovers here, this is the philosophy behind it, and here’s what we’re trying to achieve”.

It’s odd that such a central aspect of communication remains fairly unstructured.’

But she argues against a ‘one size fits all’ model, citing research she was involved with, which looked at patient and staff experiences of nurse handovers. ‘What we recommended was that you can’t standardise the practice because different areas have different needs,’ she says.

‘But what does help is your ward or area agreeing the purpose of a handover and what style you’re

Making handovers more effective
Handovers after a busy shift can be stressful and rushed, but improving the process is important to improving care and optimising patient outcomes

By Lynne Pearce
Mnemonics – acronyms that act as reminders for key information – can be used to standardise clinical handovers, helping staff to remember vital elements in their communication. Among the most frequently used are:

**SBAR**
- Situation including the patient's name, their consultant, their vital signs and any specific concerns
- Background when and why they have been admitted, any diagnosis, significant medical history, current medications, allergies, laboratory results and any progress since admission
- Assessment including vital signs, clinical impressions and any concerns
- Recommendation care management plan and time frame

RCNi Decision Support’s SBAR technique tool is at: rcni.com/SBAR-ds-tool

**ATMIST**
- Commonly used in managing trauma cases, often by paramedics handing over care to emergency department staff
- Age and background
- Time of the incident or onset of symptoms
- Mechanism of injury or medical complaint
- Injuries or findings
- Signs
- Treatment

ATMIST guide: tinyurl.com/atmist-guide

‘If nurses are using language in front of the patient that isn’t easy to understand, it feels very awkward’
Jane Bruton, clinical research manager, Patient Experience Research Centre, Imperial College London, pictured above

sets up the concept of the patient being a child and this kind of paternalistic care isn’t appropriate. ‘We’re expecting patients to go home and be able to self-care, take responsibility and manage their medication when they’ve not been involved in their care in hospital. You can’t expect them to suddenly understand everything at discharge.’

While some nurses worry that involving patients in handovers will lengthen the process, Ms Bruton says the nurse has got it slightly wrong, ‘For example, it may have looked like someone had a good night’s sleep when they didn’t. It’s not just about observations and care, but also how the patient is feeling. If care is truly patient-centred then the patient’s experience of it is important.’

Among the major frustrations for patients is when they are told something by one healthcare professional, but then another doesn’t have that information. ‘A nurse will say you’re not going to able to go home today, and the patient will say “but the doctor said I can”. It looks like you don’t know what’s happening,’ she says. ‘As a patient, you want to feel that staff know what’s going on, otherwise it’s unnerving.’

Regular checking in with each other throughout the day would help, she says.

**Avoiding paternalism**
Choice of language is another issue. ‘If nurses are using language in front of the patient that isn’t easy to understand, it feels awkward,’ says Ms Bruton. ‘It going to use based on your values and the setting.’
This should be communicated to all the members of the multidisciplinary team and, crucially, to patients too, says Ms Bruton. ‘Our experience was that patients were often much clearer about what a ward round was and they were unsure about handovers. Some weren’t even aware of it happening,’ she says.

**Bedside handovers**
Experiences of bedside handovers were variable, the researchers discovered, sometimes taking place outside rooms or bays. In some cases, even when patients were able to participate, they did not want to. ‘But the patient can add valuable information, especially
Bruton believes that improving communication actually makes nurses’ working lives easier. ‘You aren’t correcting mistakes later on, which can be much more time-consuming than concentrating on getting it right from the beginning,’ she says.

**Safety huddles**

Handovers in the community present particular challenges. With their clinical handovers happening just once a week, a district nursing team in Merseyside has found additional daily ‘safety huddles’ invaluable in improving communication and delivering better patient care.

‘We designed a template as a way of trying to reduce harm to our patients,’ says district nurse team leader and Queen’s Nurse Jane Hulme, who works for Mersey Care NHS Foundation Trust.

The trust provides specialist inpatient and community services for a catchment area of about 11 million people.

In practice, staff meet for about 15 minutes each morning after their first calls. ‘It’s a snapshot of the previous day and a preview of what’s coming,’ says Ms Hulme. Each session begins with a list of prioritised patients and the care they need, tracking whether it’s been delivered in a timely way.

For example, people with insulin-dependent diabetes or those nearing the end of life.

In one recent example, the team discovered that a patient who needed insulin twice daily had been missed from morning visits. A nurse was immediately dispatched to administer the medication, preventing an adverse incident.

The team has also established a safety huddle handover for the evening service, sharing information about any patients who may ring for help.

While the primary aim of the huddle is to improve patient safety, staff have benefited too, says Ms Hulme. ‘It’s provided really good support,’ she says. ‘We’re all lone workers and it can be quite daunting to go out to a patient’s house and be the only clinician, especially for staff who are new to the community and used to having others around them.’

**Safety net**

Staff also have a forum where they can escalate and have documented any concerns, she says. This includes incidents where patients don’t seem to be at home when the team calls. ‘Now we monitor calls where staff have not been able to see a patient. A senior member of staff will find out why this has happened so we have a safety net,’ says Ms Hulme. ‘Staff are much more relaxed and open to conversations about patients, she says. ‘And new staff feel much more able to ask questions and they are dealt with straight away.’

Since safety huddles began in 2016, they have been adopted by other teams in the area, including allied health professionals and specialist nursing teams, and in other parts of Liverpool.

A key challenge has been to persuade staff it is possible to convey all the information in 15 minutes. ‘It doesn’t replace a full clinical handover,’ says Ms Hulme. ‘But the huddles have had an effect on these too and they’re now quicker, with staff fully aware of complex patients because they are discussed every day. As a result, our weekly handovers are much slicker.’

Lynne Pearce is a health journalist.