References:

1. British Medical Association. (2004) Safe handover: safe patients. Guidance on clinical handover for clinicians and managers. London: British Medical Association
2. Australian Medical Association. (2006) Safe handover: safe patients. Guidance on clinical handover for clinicians and managers. Australia: Australian Medical Association. (ABN:37008426793).
3. Victorian Quality Council. (2006) Clinical handover. Results arising from a clinical handover survey circulated to all Victorian public health services. Victoria: The Victorian Quality Council Safety and Quality in Health
4. The Joint Commission International. (2007) Communication during patient hand-over. Patient Safety Solutions. 1(3): 1-4.

Additional Information:

Australian Council for Safety and Quality in Health Care. (2005) Passing the baton of care – the patient relay. Workshop report. Australian council for safety and quality in health care. Sydney: Office of the Safety and Quality Council.

British Medical Association. (2004) Safe handover: Safe patients. Guidance on clinical handover for clinicians and managers. London: British Medical Association.

Chaboyer W, McMurray A, Johnson J, Hardy L, Wallis M, Chu FYS. (2008) Bedside handover-Quality improvement strategy to transform care at the bedside. J Nurs Care Qual. 23(14): 1-7.

Davies S and Priestly MJ. (2006) A reflective evaluation of patient handover practices. Nurs Stand. 20(21): 49-52.

Gandhi TK. (2005) Fumbled handoffs: one dropped ball after another. Ann Intern Med. 142:352-8.

Hilton L. (2004) How to handle handoffs without dropping the ball. Nursing Spectrum. [cited 23 December 2008]. Available from: http://nsweb.nursingspectrum.com/cfforms/GuestLecture/Handoffs.cfm.

Merriam-Webster.com [homepage on the internet]. (2000) Definition of autonomy. [cited 2 April 2008]. Available from: http://www.merriam-webster.com.

Patterson ES, Roth EM, Woods DD, Chow R, Gomes JO. (2004) Handoff strategies in settings with high consequences for failure: Lessons for health care operations. Int J Qual Health Care. 16(2): 125-32.

Schroeder SJ. (2007) Improving intershift handoff and patient safety. LPN. 3(2): 22-3.

Segen J. (2002) Concise dictionary of modern medicine. New York: McGraw-Hill.

Shendell-Falik N, Feinson M, Mohr BJ. (2007) Enhancing patient safety-Improving the patient handoff process through appreciative inquiry. J Nurs Adm. 37(2): 95-104.

Solet DJ, Norvell JM, Rutan GH, Frankel RM. (2005) Lost in translation: Challenges and opportunities in physician-to-physician communication during patient handoffs. Acad Med. 80(12): 1094-9.

The American College of Obstetricians and Gynecologists. (2007) Communication strategies for patient handoffs. Obstet Gynecol. 109(6): 1503-5.

The Joint Commission. (2008) National patient safety goals hospital program. [cited 25 November 2008]. Available from: http://www.jointcommission.org/PatientSafetyNationalPatientSafetyGoals/08_hap_npsgs.

Vineet A and Johnson J. (2005) A model for building a standardized hand-off protocol. Jt Comm J Qual Patient Saf. 32(11): 646-55.

World Health Organization and The Joint Commission International. (2007) Communication during patient hand-over. Patient Safety Solutions. 1(3): 1-4.

Other additional articles are available upon request.

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Research Highlight

Research Highlight

Who is this for?

- Medical policy and decision makers
- Medical practitioners
- The Patient Safety Council and its Secretariat

Disclaimer

The views, interpretations, implications, conclusions and recommendations expressed in this paper are those of the authors alone and do not necessarily represent the opinions of the other investigators participating in the project nor the views or policy of the Ministry of Health Malaysia

Purpose of this summary

To inform policy makers, stakeholders and health care providers on the current practices of handoff communication in MOH hospitals and the need for improvement

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Handoff Communication Process in MOH Hospitals

Issue

Handoff communication process refers to "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"[1]. This is also termed "handover", "clinical handover" and "pass over".

Handoff communication process is crucial for continuity of care and in maintaining patient safety[1-3]. Ineffective communication in healthcare service may lead to potential medical errors, compromising patient safety.

Key Messages

- Most doctors surveyed in the study did not have a structured approach for handoff communication in terms of having a standard procedure or checklist.
- A standard approach for handoff communication in MOH hospitals should be developed and implemented.
- Training of all health care providers must include effective handoff communication

Action Points

1. Effective handoff communication should be incorporated into educational curriculum and continuous professional development (CPD) for health care providers. It is proposed that training modules be developed and implemented for both undergraduate and postgraduate medical curriculum.
2. A standardised approach to handoff communication most suitable to the needs of individual organisations must also be implemented in each health care organisation. It should include the following:
   - Establish clear lines of responsibilities, explicit communication and clear escalation strategies to ensure effective handoff communication
   - Put in place a standardised handoff protocol and model handoff documentation e.g. use of structured checklist or proforma, in presence of a specialist/consultant (for hospitals with specialist)
   - Use of SBAR (Situation, Background, Assessment and Recommendation) technique[4]
   - Use of electronic technology
3. To have in place national patient safety goals and policies to be championed by the National Patient Safety Council.

Summary of Action Points for Policy Makers

- Incorporate handoff communication into training and education programmes
- Put in place national patient safety goals and policies
- Incorporate handoff communication into quality improvement activities

Summary of Action Points for Health Care Providers

- Develop and implement a standardised approach to handoff communication process in health care organisations
- Senior clinicians to champion handoff communication in their respective organisations

Background

Handoff communication is a complex process, occurring between multiple providers/provider groups and in diverse setting. It is a challenge to balance between comprehensiveness and efficiency (the extent to which time and/or resource is well used for the intended task). A predisposition towards efficiency will be at the expense of comprehensiveness, thus, increasing the risk of patient safety incidents.

Although the importance of safe handoff communication is globally acknowledged, research to guide development of best practices of handoff communication within the medical industry is limited internationally and there was scarcity of information that we could find in Malaysia.

This study aimed to describe the various handoff communication processes in Ministry of Health hospitals, the methods used and the experience of doctors in relation to handoff communication.

Method

A cross-sectional study was conducted in 15 randomly selected MOH hospitals in Peninsular Malaysia, Sabah and Sarawak. This study included state hospitals, district hospitals with specialist and district hospitals without specialist. Nurse coordinators sent out self-administered structured questionnaires to all doctors in participating hospitals and collected the completed questionnaires.

The questionnaire consisted of the following components: handoff communication process, who does it, when, and if there was supervision, whether structured, at the interfaces of on-call to office hour personnel and vice versa. In addition, doctors were asked about their perceptions on elements of an adequate/good handoff communication practice.

This research highlight series is based on research done by the institute and its collaborators on health system policy issues in Malaysia.

Key Findings

- The most common methods for handoff communication reported were by phone (post-call* 54.5%; pre-call* 56.0%) and briefing sessions (post-call 52.0%; pre-call 51.7%).
- About two thirds of doctors reported to have a structured time# for handoff communication (post-call 68.6%; pre-call 67.6%).
- Less than a quarter had a standard practice/procedure for handing over (post-call 25.1%; pre-call 14.6%).
- Less than 10% had a standard checklist/ form for handing over.
- Only about one third (post-call 37.9%; pre-call 27.8%) of doctors reported to handoff in the presence of a specialist/consultant.
- Only about half (51.9%) of doctors felt positively about their current handoff communication process.

* call: a specific period of time (usually after office hours) during which a doctor must be available when requested, ready to respond and attend to the medical needs of patients
* post-call: at the end of calls, pre-call: at the beginning of calls
\# structured time: a specific and dedicated time for handoff process