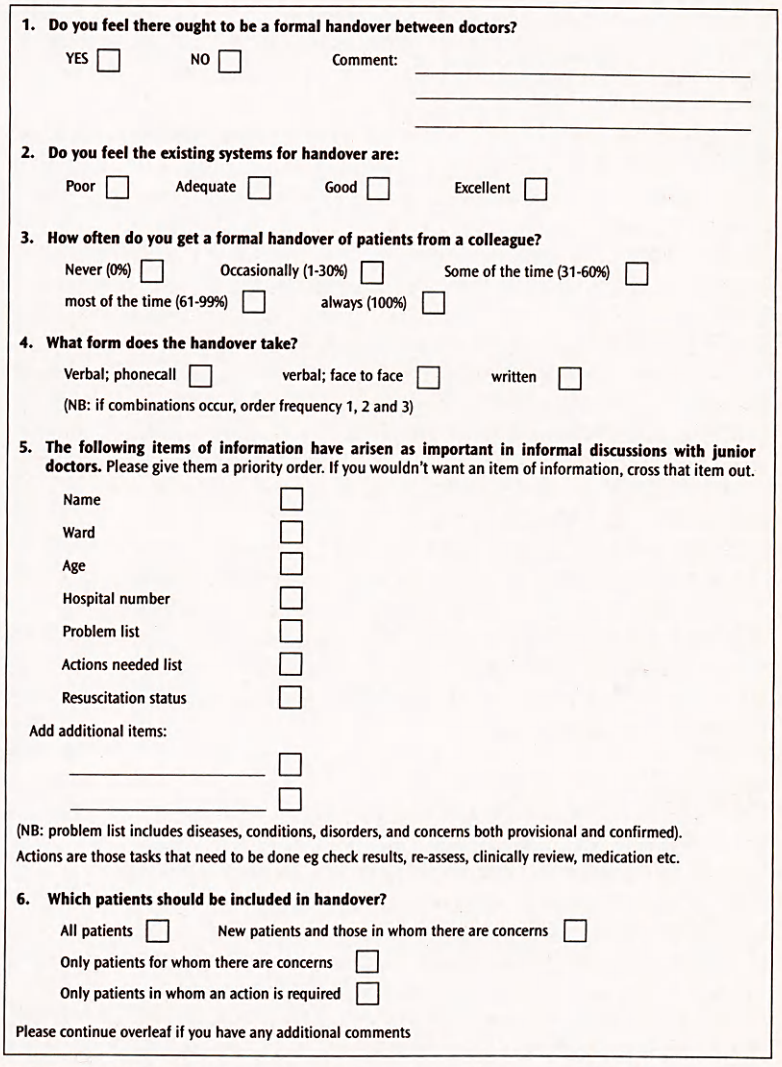
The junior doctor handover: current practices and future expectations

ABSTRACT—Restructuring junior doctors' patterns of work has led to several changes, including the increasing implementation of shift and partial-shift rotas. These changes heighten the necessity for good communication between the doctors responsible at different times for the patients. We sent a questionnaire to all junior doctors in two district general hospitals; the results showed that existing handover systems are frequently not as good as doctors would wish. In our opinion, the lack of advice and guidance on the structure of handover has impeded good practice, and a standard of professional practice needs to be set. Opportunities exist within the NHS to utilise information systems to obtain the necessary information and to improve the format of the handover.

Changes in work patterns and reduction in junior doctors' hours have brought an increasing implementation of shift and partial-shift rotas [1]. Good quality medical care therefore relies heavily on effective communication between doctors [2]. The General Medical Council's advice on standards of practice and care states that when a doctor is off duty he or she should make suitable arrangements for the patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors [3]. The NHS Management Executive guidelines on hours of work of doctors in training state that continuity of care must be protected by a handover period, save in exceptional circumstances [4]. There are, however, no standards or guidelines on when it should happen, its scope (who should be included), content (what should be included) or format (verbal, written, etc).

This article addresses the issue of 'handover' at house officer and senior house officer (SHO) grade when routine and emergency care of a group of patients is passed from one doctor to another doctor not familiar with those patients.



1. **Do you feel there ought to be a formal handover between doctors?**
   YES ☐ NO ☐ Comment: _____
2. **Do you feel the existing systems for handover are:**
   Poor ☐ Adequate ☐ Good ☐ Excellent ☐
3. **How often do you get a formal handover of patients from a colleague?**
   Never (0%) ☐ Occasionally (1-30%) ☐ Some of the time (31-60%) ☐
   most of the time (61-99%) ☐ always (100%) ☐
4. **What form does the handover take?**
   Verbal; phonecall ☐ verbal; face to face ☐ written ☐
   (NB: if combinations occur, order frequency 1, 2 and 3)
5. **The following items of information have arisen as important in informal discussions with junior doctors.** Please give them a priority order. If you wouldn't want an item of information, cross that item out.
   Name ☐
   Ward ☐
   Age ☐
   Hospital number ☐
   Problem list ☐
   Actions needed list ☐
   Resuscitation status ☐
   Add additional items:
   _____ ☐
   _____ ☐
   (NB: problem list includes diseases, conditions, disorders, and concerns both provisional and confirmed).
   Actions are those tasks that need to be done eg check results, re-assess, clinically review, medication etc.
6. **Which patients should be included in handover?**
   All patients ☐ New patients and those in whom there are concerns ☐
   Only patients for whom there are concerns ☐
   Only patients in whom an action is required ☐

Please continue overleaf if you have any additional comments

Fig 1. Questionnaire to junior doctors about the current handover system and their views of changes needed.

Methods

A questionnaire was designed regarding the nature, content and frequency of handover information (Fig 1) and sent to all 118 pre-registration house officers and SHOs in Portsmouth HealthCare Trust

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and Portsmouth Hospitals Trust. The survey covered all district general hospital-based medical and surgical specialties.

The questionnaire evaluated current practice and enabled the users (the junior doctors themselves) to articulate their needs in terms of the scope and content of a handover. They were asked to state how important they regarded a formal handover, to assess existing systems and to specify preferred form and content. Respondents were also encouraged to add any relevant comments.

Results

Sixty of the 118 questionnaires were returned completed (a response rate of 51%). Of the 60 respondents, 87% agreed that there should be formal handover, 32% felt that existing systems were poor, 50% adequate, 17% good, and only one person thought that existing systems were excellent. Only 16% of the respondents always received formal handover, 18% received it most of the time (frequency 60–99%), 25% sometimes (30–59%) and 43% occasionally (1–29%). Handover took place verbally on 94% of occasions (phone, 46%; face-to-face, 48%) and was written on 6% of occasions.

Table 1 shows which patients the respondents felt should be included in the handover, and Table 2 the information that should be included, listed in order of importance. A frequent additional comment was that time should be allowed for handover during normal working hours and that it should not happen in a junior doctor's own time.

Table 1. Which patients should be included in handover?

	Response (%)
All patients	12
New patients and those with medical concerns	35
Only those with medical concerns	32
Only patients for whom action is required	20

Table 2. What information should be included in handover?

Order of importance	Information
1	Patient's name
2	Ward
3	Problem list
4	Actions needed list
5	Age
6	Resuscitation status
7	Hospital number

Discussion

Our results show that junior doctors feel a definite need for formal handover, and that existing systems are rarely as good as they would like them to be. In our view, a standard of professional practice should be set regarding handover between clinical teams. Lack of advice and guidance on the structure of handover has so far impeded good practice. It is not necessary to include all patients in a handover, but all new patients, any with medical concerns and those requiring specific actions should be included.

The best format, whether verbal or written, is as yet unknown and needs further research. It may be that the expansion of information technology within the NHS could be utilised to good effect. Easy access to patient identifiers and clinical information through hospital and clinical information systems may help to create an efficient and effective handover system.

We recommend that formal handover should become a part of good professional practice, with guidance from the Royal Colleges. This would enable improvements to be made and their effects audited.

References

1 Charlton BG. Service implications of the Calman Report. *Br Med J* 1993;**307**:338–9.
2 Cybulska E, Rucinski J. Communication between doctors. *Br J Hosp Med* 1989;**41**:266–8.
3 The General Medical Council. *Duties of a doctor: good medical practice.* London: GMC, 1995.
4 National Health Service Management Executive. *Hours of work of doctors in training.* London: HMSO, 1991.

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