

Publishable summary HANDOVER project

The policy objective of the HANDOVER project is to optimize the continuum of clinical care at the primary care hospital interface by informing EU healthcare policy makers and educators. HANDOVER aims to develop standardized toolkit for improving the handoff processes, that can be tailored to meet local and/or institutional needs.

This 3 year, EU FP-7, entitled HANDOVER, is the first major European study to assess patient transitions. The goal of the study is to identify and study patient handover practices and create standardized approaches to handoff communications in 6 European countries (i.e., Sweden, Poland, England, Italy, Spain, the Netherlands). The study includes a total of 12 hospitals, and has collected data from hundreds of physicians, nurses, patients and hospital managers.

The project aims to improve patient care in EU member states and in relation to patient mobility and cross border care among European countries. A major outcome of the research will be a deeper understanding of how variations in communication, culture, and technology use in nursing and medicine can lead to effective or suboptimal handoffs.

The discontinuity and variation of care that results from increasing handovers poses danger to patients. The safety of the handover process has been called into question by a number of different studies and national regulators. Handovers are often characterized by communication failures, environmental barriers and adverse care. We viewed the handovers as communication of information that was occurring in both written and verbal formats.

The study is a prospective, multi-method study (i.e., process maps, surveys, interviews, focus groups, observations) to directly assess patient handovers and shadow physicians and nurses providing care following patient handovers. Our aims are to:

(1) Identify the barriers and facilitators in the medical, social and technological contexts where patient handovers takes place; (2) Determine how variations in handoff processes lead to “near misses” and adverse outcomes; (3) Develop and assess tools and training programmes that are needed for implementation of a handoff training program; and, (4) Assess the cost effectiveness of future handover interventions.

Preliminary work has included mapping out the patient care handover processes in the different countries (process maps, artefact analysis), developing standardized tools to interview, focus groups, artefact analysis and develop shared taxonomy of near miss and adverse patient events.

An early milestone has been agreeing on shared definitions and methodology. We have interviewed over 160 healthcare providers, and have discovered that important and intricate relationships exist among the people, processes, technology, and clinical settings in which handovers occur. Significant differences were seen in the patient discharge, transfer, and rehabilitation processes in each of the 6 countries. We found great variation in practice and a lack of systems appreciation. These relationships have the potential to facilitate or impede the hand-off process and directly impact patient outcomes.

In our remaining 18 months we will focus developing a series of interventions including clinical practice guidelines, best practice indicators and an educational toolbox for under and postgraduate healthcare trainees.

Understanding the gaps in the content and dynamics of handovers from multiple perspectives using a variety of methods offers the possibility to create a standardized approach to handovers that is effective, efficient, and generalizable across disciplines.

Reducing the variation in handover practice while creating a standardized manner to teach, assess and accredit will improve patient safety and quality and endure better patient and carer well being.