

DRAFT
Standard Operating Protocol for Handover Communication
Action on Patient Safety (High 5s)

Description of the patient safety problem to be addressed by this Protocol

Safety in health care depends on effective communication: the complete, accurate, timely, unambiguous transfer of information that is understood by the person receiving it. Ineffective communication has been identified as a contributing factor or “root cause” in the majority of adverse events in health care.

Description of the handover process

Basic principles and rationale:

Handover of responsibility for a patient’s care from one provider or team of providers to another, often occurring at points of transition across settings, services, or levels of care, requires the effective and efficient communication of patient-specific information. This is most reliably accomplished through the use of a standardized, interactive approach that provides an opportunity for the new caregivers to ask questions and receive responses. Examples of handover scenarios include the following:

- Nursing change-of-shift report
- Physician sign-out to a covering physician
- Preoperative care team reporting to operative and anesthesia team
- Anesthesia provider or circulating nurse reporting to the post-anesthesia care staff
- Patient care unit nurse reporting to diagnostic testing staff
- Emergency department staff reporting to inpatient care staff about patient admission
- Emergency department staff reporting to receiving facility staff about patient transfer

While the details of the handover process may vary from one type of handover to another, the process for each of the different handover scenarios should be standardized.

A standardized approach to handover communication will include the following components:

1. Identification of the specific type of handover situation to which it applies
2. Who is, or should be, involved in the communication
3. What information should be communicated, for example ...
 - a. Diagnosis and current condition of the patient
 - b. Recent changes in condition or treatment
 - c. Anticipated changes in condition or treatment
 - d. What to watch for in the next interval of care
4. Opportunities to ask and respond to questions
5. When to use certain communication techniques (repeat-back; SBAR)

6. What print or electronic information should be available

Attachment A provides detailed flow diagrams of the steps and decision points in the handover process for several types of handover situations.

The context for handover communications:

Effective and efficient handover of responsibility for a patient's care must ensure effective communication of essential information without interfering with the continuity of the patient's care. It is therefore important to identify any patient care needs that must be provided for during the handover process, such as the following:

- Physical transfer of the patient to a new setting or service
- Specific treatments, such as medications, that must be provided at a specific time
- Unanticipated needs of the patient for assistance (meals, toileting, etc.)
- Unanticipated emergencies that might arise

Some handover situations may involve more than one professional discipline. In these cases, the most effective approach might be a multidisciplinary handover process rather than a separate handover conducted independently by each type of professional. The culture of the organization with respect to interdisciplinary collaboration and teamwork will determine the practicality and feasibility of this approach.

Detailed specifications for the steps in the process:

Attachment B provides, in tabular form, a listing of each step identified in the previously referenced flow diagrams, additional detail on how it will be done, who will participate, what information should be included, what tools are needed, and the inputs and outputs of the step. Attachment C provides a sample of forms that may be useful in the implementation and documentation of various types of handover communication.

Patient and family involvement:

The effectiveness of handover communication will, in some situations, be enhanced by participation of the patient and family. This involvement should be considered in the design of these standardized handover processes and, when appropriate, encouraged by conducting the handover in the presence of the patient and family.

Permissible adaptation of the handover communication process:

As noted above, the continuing patient care needs and the culture of the organization—the context—in which this process will be implemented, as well as the details of existing processes that interface with these transitions in care, will influence the implementation of the handover process. In this Standard Operating Protocol, we seek uniformity of the basic steps in the process, their interdependencies, and the minimum documentation and measurement requirements, while allowing some flexibility to accommodate integration into existing procedures of the individual organization,

such as the assignment of tasks during the handover, the use of specific communication techniques, and the format of the documentation and measurement tools.

Implementation Strategy for Standardized Handover Communication

Handover communication takes as many forms as there are handover scenarios. While there is general agreement that the quality and safety of health care depends on the availability of accurate patient information, the idea of standardizing the communication process may be resisted if not planned and implemented in a systematic manner with appropriate oversight, allocation of resources, and early engagement of the participants in the process.

1. Oversight of the implementation:

- a. Identification of the Oversight Group for the implementation project (governing body or senior leadership group)
- b. Assign a senior administrative leader to provide direct oversight of the implementation activities, assignment of staff, allocation of time for staff to do the work, and allocation of other resources
- c. Identify the various handover scenarios for which handover communication will be standardized (see page 2 for examples)
- d. For each of the handover scenarios, assign one or more representatives of the professional disciplines involved in that type of handover to guide the design, testing, and roll-out of the standardized communication process and to serve as role models and “champions” of the new process for their respective disciplines
- e. Assign a facilitator—a person with knowledge of communication methods and project management skills—to develop and manage the project work plan

2. Project work plan This should include a master work plan to identify the major tasks and milestones relevant to all of the handover scenarios and separate, more detailed work plans for each of the scenarios. All professional disciplines should be represented on the team that develops the master work plan.

- a. For the master work plan, develop a task list for oversight of the design, testing, training, implementation, and measurement of the standardized communication processes for each of the handover scenarios (see Attachment D for a sample task list for the master work plan)
- b. For each of the handover scenarios, develop a task list for design, testing, training, implementation, and measurement of standardized handover communication process—details may vary from one facility to another (see Attachment E for a sample task list for the individual scenario work plans)
- c. Identify milestones and their target dates to include at least the following:
 - i. Approval of the master project work plan including identification of the handover scenarios for which communication is to be standardized
 - ii. Approval of the project work plans for each of the handover scenarios (these individual work plans may run concurrently or sequentially, as appropriate to the complexity and resource availability of the organization)

- iii. Approval of the pilot test designs
 - iv. “Go-live” date for the pilot tests
 - v. Presentation of pilot test results to the oversight group
 - vi. “Go-live” date for full implementation (12-18 months following start date)
 - d. Identify dependencies and time frames for each of the project tasks
 - e. Identify deliverables and due dates for each of the project tasks
 - f. Assign resources to each of the tasks
- 3. Risk assessment of the proposed handover communication processes
 - a. For each of the handover scenarios, describe the proposed standardized communication process (for example, through the use of a flowchart) based on the prototypes presented in Attachment A
 - b. Identify for each of the steps in the process and for each linkage between steps, the ways that the process could break down or fail to perform its desired function (Attachment F)
 - c. Identify the possible effects that a breakdown or failure of the process could have on patients and the seriousness of the possible effects
 - d. Prioritize the potential process breakdowns or failures
 - e. Determine why the high-priority breakdowns or failures could occur
 - f. Implement controls, warnings, or protections to minimize the risk of harm to patients
- 4. Pilot test of the handover communication processes
 - a. Identify one or more pilot test sites—initially, this should involve a common, frequently occurring handover scenario, such as the nursing change-of-shift report on a general medical inpatient unit
 - b. Engage representatives from the pilot test site(s) to participate in the test design and implementation
 - c. Adapt the proposed handover communication process to the unique features of the pilot test site (for example, the specific timing and location of the handover)
 - d. Train the staff who will be participating in the pilot test of the new process—consider that these individuals will become the trainers for the rest of the hospital staff when the new process is ready for full implementation
 - e. Implement the new process on the pilot test unit
 - f. Measure consistency and timeliness of implementation of each of the steps in the process (see below for recommendations for specific measures)
 - g. Measure impact on other related or interfacing activities (such as continuing patient care activities during the handover)
 - h. Measure impact on patients
 - i. Analyze pilot test data and present to oversight group for decision on next steps, including possible redesign of the process

- j. Consider a second phase of pilot testing for other handover scenarios, or a repeat inpatient unit pilot test if there has been significant redesign, before proceeding to full, organization-wide implementation

5. Spread methodology

- a. Determine the sequence and timing of implementation on all other clinical units in the hospital and for the other handover scenarios
- b. Sequential implementation, rather than concurrent implementation, is recommended to provide for adequate pre-implementation training, oversight and coaching during the early phases of implementation, and monitoring of the new process

6. Communication plan

- a. Announcement of organization's decision and commitment to implement standardized handover communication as a participant in the WHO's *Action on Patient Safety* initiative
- b. Rationale for participation in the initiative:
 - i. Description of the problem to be addressed (inconsistent handover communication)
 - ii. The proposed solution (standardized handover communication)
 - iii. The costs and benefits of participation
 - iv. Incentives to clinical staff to participate (improved safety for patients; efficiencies and lower risk exposure for staff)
- c. Regular updates to all staff on the progress of the project work plan
- d. Feedback to all staff of measurement data collected and analyzed throughout the pilot test and implementation phases of the project
- e. Recognition of the contributions and successes of all staff participating in the project

7. Evaluation strategy

- a. Structural measures: In order to conduct comparative evaluation of the standardized handover communication processes across the participating hospitals, it will be necessary to collect certain demographic data about the hospitals and structural data about their respective standardized handover communication programs—see Attachment G for details
- b. Process measures: Develop measures to assess the following parameters during pilot testing and early (first year) implementation:
 - i. Consistency of performing critical steps in the new process
 - ii. Participation by all staff as specified in the process design
 - iii. Completeness of key activities (patient identification; required clinical data; number of questions by receiving caregivers)
 - iv. Time for completion of the new handover process
 - v. Effectiveness (follow-up calls for addition information or clarification)
- c. Outcome measures: Frequency of specified patient care events; error rates categorized by degree of harm

- d. Collect data using retrospective audit of documentation, interviews of participating staff, direct observation, incident reporting, active surveillance, or all of these techniques
 - e. Develop detailed measure specifications and data collection protocols—see Attachment G for details
 - f. Provide regular reports of aggregated and analyzed data to the oversight group and to all staff (see communication plan)
8. Maintenance and Improvement strategy
- a. Once the standardized handover communication processes have been implemented throughout the organization, regular monitoring of key parameters should continue for at least one year
 - b. Opportunities to improve efficiency and effectiveness of the process should be identified, prioritized and, as appropriate, acted upon
 - c. Evidence of “drifting” from the intended procedures should be analyzed to identify the reasons and to determine an appropriate response—for example: additional training; process redesign; technical support
9. Business case analysis for standardized handover communication [TBD]
10. References, including evidence base and other resources (Attachment H)

Sample Patient Hand-over Process Flow

(See next page for Flow Diagram)

What is the type of hand-over?

- Nursing change-of-shift
- Physician sign-out to a covering physician
- Physician sign-out to a hospitalist
- Transfer patient from ED to inpatient care unit
- Transfer patient from inpatient unit to a special diagnostic/treatment unit
- Transfer patient from preoperative preparation unit to the OR
- Transfer patient from the OR to the PACU
- Transfer patient from the PACU to inpatient care unit

Convene participants in the hand-over process

Obtain necessary documents to support the hand-over

Ensure continuity of patient care during the hand-over

“SBAR” model for handover communication:

Situation:

- Identify patient (at least two identifiers)
- Brief description of patient (age, gender)
- Primary diagnosis
- Relevant co-morbidities, allergies

Background:

- Current treatment or reason for transfer
- Recent changes in condition or treatment

Assessment:

- Current condition

Recommendation:

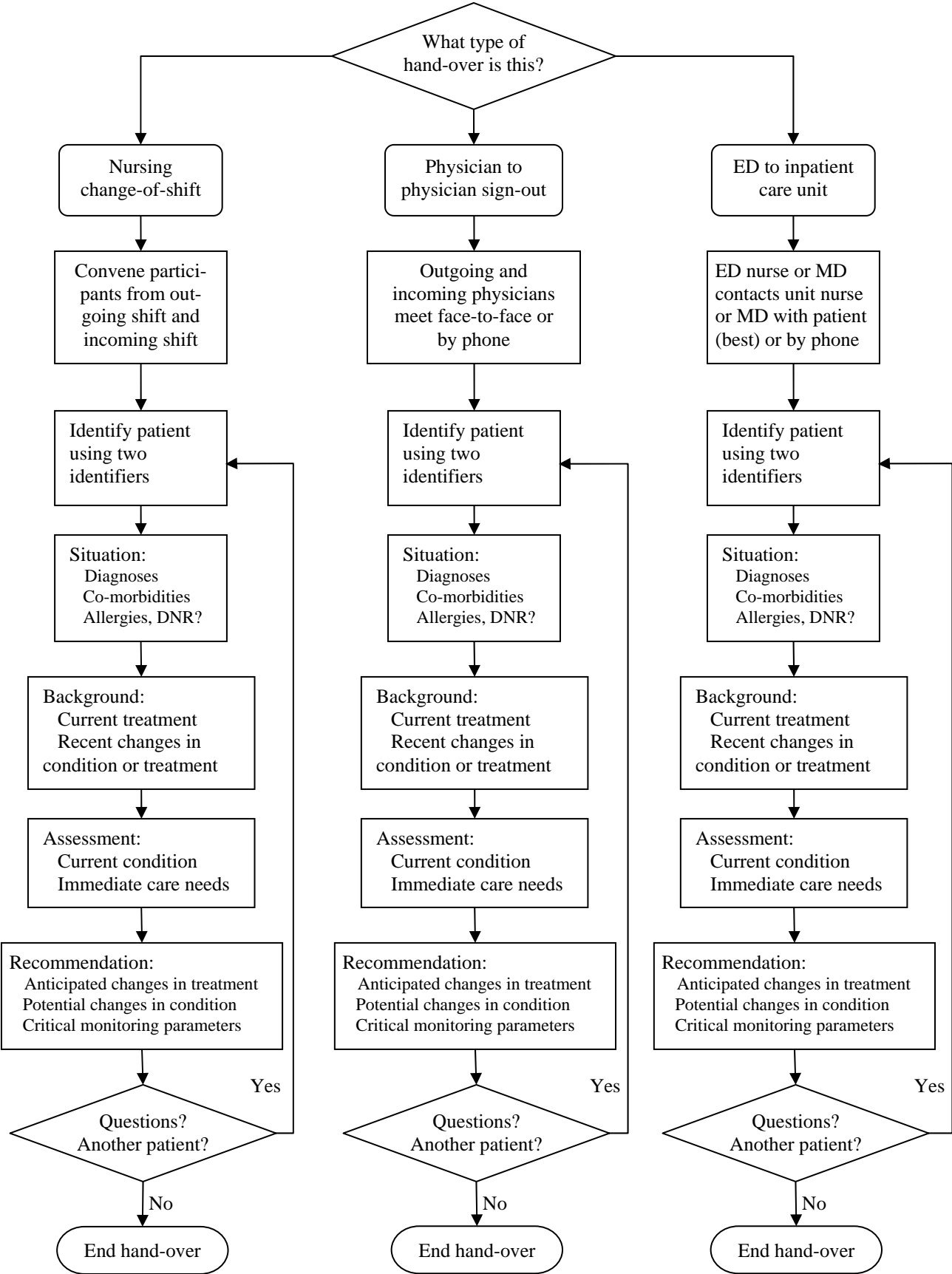
- Procedure to be done or anticipated changes in treatment
- Potential changes in condition
- Critical monitoring parameters

Are there any questions?

If no, repeat for next patient

End hand-over process

Sample Patient Hand-over Process Flow



Detailed Specifications for the Handover Process

(Sample chart to demonstrate format—will need more detail)

Step of process	Detail	Who? *	When?	Tools *	Input	Output
Convene participants	Specify participating staff, time to meet, anticipated duration, and location	Varies with type of handover—see flow diagrams If team, need leader	Precedes taking responsibility for patient care			
Provide for care of patient during handover	Must ensure continuity of care for routine & emergency patient needs	Ensure adequate staff to attend to patient's needs during handover	During handover	Acuity-based staffing plan		
Communicate patient-specific information	Specific information to be communicated, location, and format to be predetermined and standardized	Participants may be individuals or teams of caregivers or an individual who is representing a team	Depends on specific type of handover Precedes taking responsibility for patient care	Checklist; Patient records; Audiotape; MAR; test results	Information provided by outgoing caregivers; Questions by next caregivers	Summary of key information about each patient, clearly understood by new caregiver
Questions from incoming caregivers	There must be an opportunity for this	Anyone who is taking over any responsibility for a patient's care may ask for clarification or more information	During the handover process rather than later when there may not be time			
Conclusion	Summary of most important points	Team leader				

Sample “SBAR” form for standardizing and documenting nurse to physician report

SBAR report to physician about a critical situation

S	<p>Situation I am calling about <patient name and location>. The patient's code status is <code status>. The problem I am calling about is _____. I am afraid the patient is going to arrest.</p> <p>I have just assessed the patient personally:</p> <p>Vital signs are: Blood pressure ____/____, Pulse _____, Respiration____ and temperature _____</p> <p>I am concerned about the:</p> <p> Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual Pulse because it is over 140 or less than 50 Respiration because it is less than 5 or over 40. Temperature because it is less than 96 or over 104.</p>
B	<p>Background The patient's mental status is: Alert and oriented to person place and time. Confused and cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose. Eyes closed. Not responding to stimulation.</p> <p>The skin is: Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm</p> <p>The patient is not or is on oxygen. The patient has been on _____ (l/min) or (%) oxygen for _____ minutes (hours) The oximeter is reading _____ % The oximeter does not detect a good pulse and is giving erratic readings.</p>
A	<p>Assessment This is what I think the problem is: <say what you think is the problem> The problem seems to be cardiac infection neurologic respiratory ____ I am not sure what the problem is but the patient is deteriorating. The patient seems to be unstable and may get worse, we need to do something.</p>
R	<p>Recommendation I suggest or request that you <say what you would like to see done>. transfer the patient to critical care come to see the patient at this time. Talk to the patient or family about code status. Ask the on-call family practice resident to see the patient now. Ask for a consultant to see the patient now.</p> <p>Are any tests needed: Do you need any tests like CXR, ABG, EKG, CBC, or BMP? Others?</p> <p>If a change in treatment is ordered then ask: How often do you want vital signs? How long to you expect this problem will last? If the patient does not get better when would you want us to call again?</p>

From Leonard, Graham: Kaiser-Permanente; Accessed at <http://www.ihi.org>

Master Implementation Work Plan for the Handover Communication Process

(Incomplete sample work plan to demonstrate format)

Task name	Duration	Start date	Finish date	Dependencies	Resources
Define and assign oversight responsibilities					
Identify oversight group					
Identify senior administrator “contact” for resource decisions					
Assign representatives from each professional discipline					
Assign facilitator					
Development & approval of wk plan					
Initial draft of master work plan and plans for individual scenarios					
Review and revision of plans					
Approval of the work plans					
Risk assessment of the process to be implemented					
Identification & prioritization of failure modes					
Proposal for adaptation or redesign of the process					
Approval of adaptation/redesign					
Pilot test of the process					
Identify test sites/units					
...					
...					
Evaluation strategy					
...					

Implementation Work Plan for the Nursing Change-of-Shift Handover Process

(Sample individual scenario work plan: Need one for each type of handover)

Task name	Duration	Start date	Finish date	Dependencies	Resources
Define and assign oversight responsibilities					
Identify oversight group					
Identify nurse executive as “contact” for resource decisions					
Assign representatives from various care units					
Assign facilitator					
Development & approval of wk plan					
Initial draft of nursing change-of-shift handover work plan					
Review and revision of plans					
Approval of the work plans					
Risk assessment of the process to be implemented					
Identification & prioritization of failure modes					
Proposal for adaptation or redesign of the process					
Approval of adaptation/redesign					
Pilot test of the process					
Identify test sites/units/shifts					
...					
...					
Evaluation strategy					
...					

Risk Assessment for the Handover Communication Process

(Incomplete sample chart to demonstrate format)

Step of process (from Flow Chart)	Potential Failure Mode	Probable Effect	Frequency of failure*	Discover- ability*	Severity of effect*	RPN**	Possible Causes	Controls/ Protections
Convene participants	Participants not available							
	Participants distracted							
Provide for care of patient during handover	Insufficient staff to do handover and attend to patient							
Communicate patient-specific information	Incomplete information							
	Required documents not available							
Questions from incoming caregivers	Person with answers is not available							
Conclusion of handover	Unanswered question or ambiguity							

* Recommend simple 3-point (high, medium, low) or 5-point scale

** Risk priority number = Frequency x Discoverability x Severity

**Measurement & Evaluation Plan for the Handover Communication Process
(Incomplete sample measurement plan to demonstrate format)**

Measures	Type (#; rate; N/D)	Parameters	Collection method	Evaluation interval	Reporting
Structural measures:					
Type of organization (urban/rural; public/private; community/academic; etc.)					
Size of organization (beds; visits)					
Specific types of handovers					
Process measures:					
% of handovers completed according to protocol					
% of handovers interrupted					
% of handovers w/o needed documentation					
Average time for handover					
...					
Outcome measures:					
Potential errors intercepted by handover process					
Clinical errors occurred due to insufficient information					

Selected References and Resources for Handover Communication:

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15. Your Healthcare: Be Involved, Canadian Patient Safety Institute. (Available in 14 languages) Link: http://www.oha.com/Client/OHA/OHA_LP4W_LND_WebStation.nsf/page/Your+Health+Care+-+Be+Involved

Standard Operating Protocol Template

Action on Patient Safety (High 5s)

Revised 30 January 2007

Description of the problem to be addressed

Description of the process for solving the problem

- Basic principles

- High level description of the process

- Rationale

- The steps in the process, with flow diagram

- The context for the process

 - The larger system of which the process is a part

 - Direct interfaces with other processes

 - The physical environment

 - The cultural environment

- Detailed specifications for each step in the process

 - What is to be done?

 - How will it be done? (Specific actions)

 - Who will do it?

 - When is it to be done? (Dependencies)

 - What tools are needed to do it? (Forms, devices, technology, etc.)

 - What are the inputs? From where/to whom?

 - Physical

 - Informational

 - What are the outputs? To where/whom?

 - Physical

 - Informational

- Patient & family involvement

- Permissible adaptations

 - Variations from the “typical hospital” environment

 - Rationale for adaptation

Implementation strategy

- Oversight: Senior leadership; management; facilitator

- Project work plan

- Risk assessment (FMEA); risk control/protection/mitigation

- Pilot testing

- Spread methodology

- Communication plan

 - Argument for adoption (the problem; the solution; the cost; the incentives)

Evaluation strategy

- Measures

- Collection and analysis

- Reporting

Maintenance and improvement strategy

Business case

- Financial (ROI); image (marketplace positioning); infrastructure (long-term advantage)

References/Evidence base/other resources

**Comments of the WHO Collaborating Centre for Patient Safety Solutions
Communications Expert Panel on the Action on Patient Safety (High 5s)
Draft Standard Operating Protocol for Handover Communication
February 2007**

Key themes:

The standard operating protocol (SOP) strikes a balance between required basic elements and allowance for local or institutional flexibility. However, increased flexibility in design and implementation may be beneficial given the complexity and diversity of the settings to which the SOP will be applied. Respondents were divided as to whether electronic tools should be used to implement the SOP.

The SOP will set the clear expectation that handover communications must occur, and their reliable occurrence is a key step toward improving patient safety. Improvements may appear due to the Hawthorne effect: providers will reflect on how they conduct handovers, and perhaps identify ways to improve how they are done.

Involvement and engagement of senior and physician leadership will be vital to the successful implementation of the SOP. Influence can be achieved using locally developed business cases and assessments of current problem areas. Incentives/punishments can be used in later stages to promote adoption. The SOP should be integrated into existing hospital priorities and metrics.

It may be challenging to control the effectiveness of relationships and communication as tightly as the SOP lays out. The concepts of a relevant “recent change in condition or treatment” and what is “enough information” vary from individual to individual. Developing a single approach for all types of handovers may also prove difficult. For example, different approaches would be needed for an LPN transferring 64 patients in a long-term care facility at the shift change and for a handover involving a complex patient from one resident physician to another in the ICU.

Potential unintended consequences:

- The use of “templates” may encourage reporting only of what is asked and not the nuances, and inhibit separation of the standard from the unusual. The SOP should not prescribe a particular ordering of the information conveyed, in order to enable communication of “most important first.”
- Increased data entry requirements involved in electronic support for handovers may reduce staff willingness to adopt the system.
- Implementation may incur opportunity costs from additional time spent during handover communications, reduce ability to respond to “critical” pages and other things that require immediate action, and generate a lack of willingness to “cover” an update when someone is called away unexpectedly (such as for a code), possibly resulting in no update at all.
- Replacement of verbal updates with forms, and the use of these forms to support handovers in place of other paperwork, may cause gaps in the patient record.

Comments of the Communications Expert Panel on the Draft Standard Operating Protocol for Handover Communication

- Patient misidentification may result from using “copy and paste” features.
- Staff cynicism may surface if the SOP fails in adoption.

Suggestions for further development of this standard operating protocol:

Offer guidance on trade-offs to consider when tailoring the SOP to a particular setting and hospital culture. These trade-offs may include:

- Standardization vs. flexibility
- Efficiency vs. effectiveness
- Availability to give update vs. intimacy of knowledge
- Short-term vs. long-term information needs
- Direct vs. indirect audience

Encourage variable attention to patients during the communication based on their stability, the uncertainty around key decisions, and deviations from the nominal/expected situation. Allow flexibility in how patients are ordered in handover communications.

The importance of the receiving caregiver’s review of the medical record must be emphasized. Error can increase if the receiving person is less diligent and thinks the handover information is all he or she needs to know.

Learning from prior experience in the pilots should be incorporated into 5b of the Implementation Strategy. This could include how improvements will be added and paths to failure will be dropped.

Develop an internet-based Dashboard to track local results in as close to real-time as possible. The local results would be visible to the organization entering the results, and could be compared to other participating organizations nation-wide and globally. All data would reside in a central database. The components of the Evaluation Strategy would form the basis for the dashboard. Almost all sub-bullets of point 7 would lend itself to this approach, and Process Measures and Outcome Measures would be particularly important. As part of the dashboard, there could be a bulletin board for participating groups to post questions/problems and solicit feedback from others who might have the same problems or solutions.

Active surveillance and observation is a valuable component of the SOP. Ask the caregivers if they find the system reliable, easy to use, and valuable, and if they feel more effective in their job.

The burden of documenting what is primarily a verbal event might encourage updates by practitioners other than those who are most knowledgeable about previous activities. Any ways to reduce this burden or allow queuing of documentation to be completed at a slower-paced time (often end of shift) will be helpful.

Comments of the Communications Expert Panel on the
Draft Standard Operating Protocol for Handover Communication

Additional attention may need to be given to handovers at shift change. A “blackout” period of no transfers/handovers for the 30 minutes before and after a shift change may prevent errors resulting from the new shift coming on and assuming that a handover to another unit had occurred when it had not.

Read-backs should only be used when critical, often numeric or otherwise coded, information is first received verbally, which should not be during the handover if interruptions are minimized. Read-back has not been observed to occur in handovers in space shuttle mission control, nuclear power generation, ambulance dispatching, railroad dispatching, or the Canadian military.

For handovers including the patient, the handover could finish with a "teach-back" to assess patient/family understanding (for example, Kaiser's Nurse Knowledge Exchange at the bedside).

Summarize the SOP to an easily remembered sequence that could be put on a laminated card the size of a business card. This could be carried easily by the implementation teams for easy reference until the process is cemented.