

## Handover Documents Headings and Definitions, Approved

Handover over of patient care from one professional or team to another is one of the very high risk transactions of health care services.

Paper handover documents will be used in many cases until fully electronic systems are in routine practice. Paper documents should use a subset of these headings to ensure that patient critical information is conveyed while minimizing the risks associated with completing long paper forms.

There are several types of handover including hospital at night, weekend and consultant team to consultant team. Each type of handover may use a different subset of the headings. Suggested headings for paper transactions are illustrated in the attached table.

Headings/ Sub-headings	Definition / illustrative description of the type of clinical information to be recorded under each heading
<b>Date</b>	The date of creation of the handover document.
<b>Time</b>	The time of creation of the handover document.
<b>Patient Details</b>	
- Patient surname, forename	
- Date of birth	
- NHS number	
- Gender	
- Current location	This could be a ward or theatre.
- Intended location	If patient is changing ward.
<b>Clinical Details</b>	
- Date of admission	
- Expected date of discharge	The date the patient is currently expected to be discharged from hospital.
- Responsible consultant	The name of the consultant who is currently responsible for the patient's inpatient care.
- New responsible consultant	The name of the consultant who is accepting responsibility for the patient's inpatient care.
- Diagnosis/ Problem list/ Differential diagnosis	This would include working diagnoses or differential diagnoses. This could include multiple entries. Relevant previous medical history.
- Mental capacity	The Mental capacity of the patient to make decisions about treatment etc...example is an Independent Mental Capacity Advocate (IMCA) required for decisions relating to discharge destination, medical treatment, ability to consent etc. Any information given to a significant other in relation to this matter.
- Advance decisions to refuse treatment and Resuscitation status	Whether or not there is Do Not Resuscitate or Advance Decisions to refuse treatment information in the notes.
- Mental state	e.g. Depression, anxiety, confusion, delirium.
- Patient at high risk	This patient is at high risk of deterioration and will need an immediate response if called.

- Allergies	Allergies, Drug Allergies and Adverse Reactions.
- Risks and warnings	Can include: Indication of Severity of illness; Religion e.g. Jehovah's Witness; Early Warning Scores, Vital Signs, Seriously Abnormal Pathology Results, Patient with particular needs, any clinical Alerts.
<b>Reason for Handover</b>	Clinical Reason e.g. Low Potassium, immediately post-op, unstable medical condition.
<b>Management Plan</b>	
-Clinical narrative (consultant to consultant team handover only)	Very brief narrative description of the in-patient episode.
- Current treatment/ Investigations	Treatments (inc referrals) carried out including investigation results awaited or planned.. Recent operations including post-op instructions. Succinct Information.
- Aims and limitations of treatment and Special instructions	The current aim of treatment including limitations to treatment and communication issues e.g. not for ITU.
- Escalation plan	Who needs to be contacted in the event of significant problems or patient deterioration include e.g. seniority/name/contact details of person to be called.
• agreed with patient or legitimate patient representative (Y/N)	Can include: treatment, expected outcomes, risks and alternative treatments if any.
<b>Outstanding Issues</b>	
-Tasks which must be done	Include timescales. (Appropriate seniority of staff for each task).
-Tasks to be done if possible	(e.g. test review, pre-discharge documents) criteria for discharge including who may discharge the patient.
- Information given to patient and/or authorised representatives	This can include: Relatives and Carers; Specific verbal advice and details of any discussions; Written information including leaflets, letters and any other documentation. Differentiation required between information given to patients and carers and any other authorised representatives.
<b>Doctor Handing Over</b>	
- Name	
- Grade	
- Specialty	
- Bleep number/Contact details	
<b>Doctor Receiving Hand Over</b>	
- Name	
- Grade	
- Specialty	
<b>Senior Clinical Contact</b>	If there is a particular requirement to call a specific person e.g. consultant or SpR.

In the electronic environment some of these fields will be automatically completed.

## Recommended Headings for paper proformas

Headings/Sub-headings	Consultant team handover	Night handover	Weekend handover
<b>Date</b>	✓	✓	✓
<b>Time</b>	✓	✓	✓
<b>Patient Details</b>	✓	✓	✓
- Patient Surname, Forename			
- Date of Birth	✓	✓	✓
- NHS Number	✓	✓	✓
- Gender	x	x	x
- Current Location	x	✓	✓
- Intended Location	x	x	x
<b>Clinical Details</b>	✓	x	x
- Date of Admission			
- Expected date of discharge	✓	x	x
(- Discharge over weekend? Yes/No)*	x	✓	✓
- Responsible consultant	✓	✓	✓
- New responsible consultant	✓	x	x
- Diagnosis/ Problem List/ Differential Diagnosis	✓	✓	✓
- Mental Capacity	✓	x	x
- Advance decisions to refuse treatment and Resuscitation Status	✓	x	x
- Mental State	x	x	x
- Patient at high risk	x	x	x
- Allergies	✓	x	x
- Risks/Warnings	✓	x	x
<b>Reason for handover</b>	✓	✓	✓
<b>Management Plan</b>			
- Clinical narrative	✓	x	x
- Current treatment/ Investigations	✓	x	x
- Aims and Limitations of Treatment and Special Instructions	x	✓	✓
- Escalation plan			
• Agreed with patient or legitimate patient representative (Y/N)	x	x	x
<b>Outstanding issues</b>			
- Tasks to be done	x	✓	✓
• Task which MUST be done			
• Tasks to be done if possible	x	x	x
- Information given to patient and/or authorised representatives	✓	x	x
<b>Doctor Handing Over</b>	✓	✓	✓
- Name			
- Grade	x	x	x
- Specialty	x	x	x
- Bleep Number/Contact Details	✓	✓	✓
<b>Senior clinical contact</b>	x	x	x
(Proforma accepted by; name, bleep, date, time)*	✓	x	x

\* These headings appear in paper proformas only