

# EMERGENCY DEPARTMENT SHIFT HANDOVER AND TRANSFER OF RESPONSIBILITY PROTOCOL

## *Protocol 12: Safe Continuity of Care Across Staff, Shift, Location, and System Transitions*

**DRAFT FOR CLINICAL, NURSING, GOVERNANCE, INFORMATION-SYSTEM, AND PATIENT-SAFETY REVIEW**

**Safety rule: Handover is not merely a report. It is the structured transfer of current information, uncertainty, outstanding work, authority, accountability, and contingency plans. No patient may be omitted, and responsibility does not transfer until an identified receiver has accepted it and can ask questions.**

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Effective date	[To be completed after approval]
Review date	[Normally 24 months after approval, or sooner after a serious handover incident or major guidance change]
Approved by	[Clinical Governance Committee / Executive Management / Medical Director]
Related protocols	Protocols 1-11; clinical documentation; critical results; medication safety; monitoring; consultation; admission; transfer; infection prevention; safeguarding; downtime; mass-casualty
Applies to	All ED medical, nursing, allied health, clerical, portering, security, ambulance, temporary/agency, student, and supervisory staff participating in patient care or operational handover
Supersedes	[Insert previous policy or “New protocol”]

## 1. Purpose

To establish a standardized, reliable, and auditable process for transferring patient-specific and department-wide responsibility at shift change, breaks, changes of clinical area, temporary cover, escalation, and other transitions within the Emergency Department.

## 2. Scope

This protocol applies to every patient physically present in, assigned to, or clinically owned by the Emergency Department, including patients in resuscitation, treatment rooms, waiting areas, corridors, observation spaces, ambulances awaiting offload, procedure areas, imaging, temporary overflow locations, and admitted patients boarding in the ED. It also applies to pending results, referrals, calls, tasks, and follow-up actions generated by the ED even when the patient has moved or left.

### 3. Core policy statements

- Handover shall be standardized, patient-centred, interactive, documented, and supported by an up-to-date electronic or paper patient list; memory alone is not an acceptable handover system.
- Each shift shall begin with a brief department safety huddle followed by a patient-by-patient clinical handover appropriate to medical, nursing, and multidisciplinary responsibilities.
- The outgoing team shall prepare before handover, identify the sickest and highest-risk patients first, update records, reconcile the patient census, and make outstanding work explicit.
- The incoming team shall arrive ready to receive handover, minimize avoidable interruptions, clarify uncertainty, read back critical actions, and explicitly accept responsibility.
- Patient identifiers, location, acuity, working diagnosis and uncertainty, clinical trajectory, treatment response, monitoring, pending results, outstanding tasks, escalation criteria, and disposition plan shall be communicated.
- Every outstanding task shall have a named owner, required action, priority, and expected completion or review time. “To be followed up” without ownership is unsafe.
- Responsibility for a patient shall never be assumed to transfer solely because a shift has ended, a note has been written, a message was sent, or a patient was moved.
- If handover is interrupted by an emergency, teams shall maintain immediate patient care, record where handover stopped, and resume from a reconciled list as soon as safe.
- Handover shall include admitted or referred patients still physically in the ED, patients temporarily away from the department, and patients with pending results or unresolved communication duties.
- Patient confidentiality shall be protected, but privacy shall not be used to justify omission of safety-critical information.
- No staff member shall be pressured to accept an unsafe, unclear, or incomplete handover without escalation. Staff may invoke a safety pause and seek senior review.
- Handover quality, omissions, delays, and related incidents shall be measured and used for learning rather than blame.

### 4. Definitions

Term	Operational definition
Clinical handover	The transfer of information, authority, accountability, and responsibility for some or all aspects of a patient’s care to another clinician or team, temporarily or permanently.
Shift handover	A planned transition of responsibility between outgoing and incoming staff at a rostered change of duty.
Operational handover	Transfer of department-wide information about staffing, capacity, equipment, hazards, flow, high-risk areas, and anticipated demand.
Patient-specific handover	Structured communication of current status, uncertainty, completed care, outstanding work, risks, contingencies, and disposition for an individual patient.
Transfer of responsibility	The point at which a named receiver acknowledges and accepts responsibility and has adequate information, opportunity for questions, authority, access, and capacity to act.
Outstanding task	Any investigation, treatment, review, communication, reassessment, consultation, documentation, or follow-up action not yet completed.

Term	Operational definition
Pending result	A requested test, report, image interpretation, culture, pathology result, or amended finding not yet reviewed and actioned by a responsible clinician.
Safety huddle	A brief structured team meeting to develop a shared picture of current risks, priorities, staffing, capacity, and anticipated events.
Handover interruption	Any event that diverts attention from the handover process before it is completed and responsibility is clearly transferred.
Unallocated patient	A patient for whom no named clinician or nurse can be identified as currently responsible.

## 5. Roles and accountability

Role	Minimum accountability
ED Clinical Lead / Medical Director	Approves the handover model, staffing overlap, escalation chain, minimum dataset, audit measures, and response to recurrent safety failures.
ED Nurse Manager / Nurse in Charge	Maintains the nursing handover process, patient-location reconciliation, staffing allocation, boarding oversight, and completion checks.
Outgoing senior doctor	Leads medical handover, prioritizes high-risk patients, confirms task ownership, identifies uncertainty and contingency plans, and resolves unallocated patients.
Incoming senior doctor	Receives and verifies the medical handover, allocates clinical ownership, clarifies priorities, accepts responsibility, and leads immediate post-handover review.
Outgoing assigned clinician	Updates the record and patient list, completes urgent work where possible, communicates status and uncertainty, and remains responsible until acceptance.
Incoming assigned clinician	Actively receives the case, verifies immediate priorities, reviews the patient when indicated, and documents or acknowledges assumption of care.
Outgoing assigned nurse	Updates observations, medications, devices, safety risks, care delivered, comfort needs, and outstanding nursing actions.
Incoming assigned nurse	Receives bedside or structured handover, checks the patient and equipment, accepts nursing responsibility, and escalates discrepancies.
Clerical / flow coordinator	Maintains an accurate location and disposition list, identifies arrivals/departures/duplicates, and supports reconciliation without substituting for clinical handover.
All staff	Attend punctually, protect the handover, use closed-loop communication, speak up about omissions, and report unsafe transitions.
Quality / patient-safety lead	Audits reliability and incidents, supports simulation and improvement, and monitors whether staffing and system design permit safe handover.

## 6. Handover architecture

Stage	Required action
1. Pre-handover preparation	Outgoing staff update clinical records and the live patient list, review urgent results, identify sickest patients, and prepare explicit task and contingency plans.
2. Department safety huddle	Outgoing and incoming leaders share census, capacity, staffing, environmental hazards, resuscitation activity, boarded patients, anticipated arrivals, and immediate operational risks.
3. High-risk patient handover	Resuscitation, unstable, deteriorating, recently sedated, behaviourally unsafe, or time-critical patients are handed over first and preferably at the bedside.
4. Patient-by-patient handover	Each remaining patient is reviewed using the approved structured format and linked to the current written/electronic record.
5. Task and result reconciliation	Outstanding actions, referrals, pending results, callbacks, transport, and disposition barriers are assigned to named owners with deadlines.
6. Explicit acceptance	Incoming medical and nursing leads confirm that all patients and areas are allocated and responsibility has transferred.
7. Post-handover safety round	Incoming staff promptly verify high-risk patients, equipment, infusions, observations, and urgent tasks; discrepancies are corrected immediately.

**Handover should answer five questions for every patient: What is happening now? What has changed? What remains uncertain? What must happen next, by when and by whom? What should trigger immediate escalation?**

## 7. Timing, location, and protected conditions

- Handover times and required staff overlap shall be defined in the roster and local configuration table.
- Outgoing and incoming staff shall be physically or virtually present together. A written list without interactive discussion is insufficient for active ED patients.
- Handover shall occur in a designated location that permits access to the patient list, clinical record, monitoring data, results, and communication systems while protecting confidentiality.
- Noise, avoidable phone calls, routine requests, teaching, and non-urgent administrative discussions shall be deferred. A nominated person should hold emergency communication devices where feasible.
- Immediate clinical emergencies take precedence. The handover leader shall pause, record the last completed patient, maintain the list, and resume safely.
- Staffing plans shall provide enough overlap for handover without routinely requiring unpaid or unsafe extensions of duty. Recurrent delay is an operational governance issue.
- Patients who are too unstable for group handover require direct bedside transfer with continued care and monitoring.

## 8. Pre-handover preparation by the outgoing team

- Reconcile all patients against the electronic tracking board, paper register, waiting areas, treatment spaces, temporary locations, imaging, ambulances, and admitted boarders.

- Confirm correct identifiers, location, triage category, responsible clinician/nurse, time of arrival, and current disposition status.
- Update the clinical note with significant assessment, working diagnosis, uncertainty, treatment, response, consultation, and current plan.
- Review newly available critical and time-sensitive results. Do not defer an immediately actionable finding solely because handover is approaching.
- Complete urgent treatments, reassessments, prescriptions, documentation, or escalation that cannot safely wait.
- Identify and mark high-risk patients, deterioration risks, infection precautions, safeguarding issues, treatment limitations, and behavioural or absconding risks.
- List each pending result, referral, call, transport arrangement, observation, procedure, medication, or review with a named owner and due time.
- Prepare a concise handover. Avoid reconstructing the entire history when only relevant background and changes are needed.
- Inform the handover leader immediately of any patient who is unallocated, missing, unexpectedly absent, or located outside an approved care area.

## 9. Department safety huddle

The safety huddle should normally be brief and led jointly by the outgoing and incoming senior medical and nursing staff. It creates the shared operational picture before individual cases are transferred.

Domain	Minimum content
Demand and capacity	Total census; waiting patients; resuscitation occupancy; boarded admissions; observation patients; ambulances awaiting handover; expected arrivals/transfers.
Sickest patients	Patients requiring immediate review, one-to-one observation, continuous monitoring, airway/vasoactive support, or time-critical intervention.
Staffing and roles	Medical, nursing, support and security staffing; skill mix; breaks; sickness; temporary staff; resuscitation roles; area assignments.
Flow and constraints	Bed availability; specialty delays; imaging/laboratory limitations; transport; isolation capacity; equipment failure; medication or oxygen shortages.
Safety hazards	Violence risk; infection exposure; environmental problem; fire/security concern; IT/downtime issue; unidentified patient; safeguarding or missing-person concern.
Anticipated events	Scheduled transfer, procedure, sedation, delivery, retrieval, VIP/security issue, mass gathering, severe weather, or surge trigger.
Immediate actions	Named owner and deadline for each department-level risk or operational intervention.

## 10. Patient-specific handover: minimum dataset

Element	Required handover content
Identification and ownership	Two identifiers; age; current location; assigned doctor and nurse; relevant specialty/consultant; infection/isolation status.

Element	Required handover content
Situation and severity	Presenting problem; triage/acuity; current physiological state; whether stable, concerning, unstable, or deteriorating.
Relevant background	Key history, comorbidity, allergy, medication, pregnancy, baseline function, treatment limitations, and social/safeguarding factors.
Assessment and uncertainty	Working diagnosis or syndrome; dangerous alternatives considered; important positive and negative findings; degree of uncertainty.
Trajectory and response	Changes in observations, symptoms, examination, mental state, pain, urine output, treatment response, or functional ability.
Care completed	Investigations reviewed; medication and fluids; procedures; consultation; communication with patient/family; documentation completed.
Outstanding work	Pending results, repeat tests, reassessment, medication, procedure, consultation response, transport, referral, prescription, certificate, or communication.
Disposition	Discharge, observation, admission, transfer, theatre/procedure, mental-health placement, or unresolved destination; barriers and escalation status.
Contingency and escalation	What deterioration is expected or feared; thresholds; immediate response; senior/specialty contact; resuscitation or ceiling-of-care status.
Responsibility	Named receiver for the patient and for each outstanding task; due time; read-back of critical actions.

## 11. High-risk patients and information that must be verbalized

- Resuscitation or peri-arrest patients; any recent cardiac arrest or return of spontaneous circulation.
- Airway risk, respiratory failure, escalating oxygen, non-invasive or invasive ventilation, severe asthma, pulmonary oedema, or chest drain.
- Shock, active bleeding, sepsis, vasoactive support, transfusion, dangerous arrhythmia, or severe hypertension with organ injury.
- Altered consciousness, stroke, seizure, meningitis concern, severe agitation, intoxication, self-harm risk, restraint, or sedation.
- Paediatric or neonatal high-risk illness; pregnancy, labour, postpartum complications, or fetal concern.
- Trauma, spinal precautions, burns, compartment/limb threat, time-critical surgery, or unexplained deterioration.
- Dangerous electrolyte, glucose, toxicology, anticoagulation, or medication issue; antidote or time-critical medication due.
- Pending critical result, discrepant imaging, culture requiring action, unreviewed ECG, or test likely to change immediate management.
- Referral or admission not yet accepted; disputed specialty; delayed transfer; boarded patient with active needs.
- Infection/isolation, safeguarding, child protection, elder abuse, sexual assault, custody, violence, absconding, or missing patient risk.
- Known allergy, difficult airway, limited venous access, blood refusal, implanted device, or other special precaution.
- Treatment limitation, advance decision, end-of-life plan, family disagreement, or ethical/legal concern.

## 12. Medical handover

- The outgoing senior doctor shall lead or supervise the sequence and ensure all medical areas and patients are represented.
- Cases shall be handed over from the current clinical record and live patient list. The receiver should have access to relevant observations, results, imaging, and notes.
- Unstable patients should be transferred directly to a named clinician with immediate bedside review rather than being left until the end of a group list.
- Each outstanding investigation, review, specialty call, procedure, prescription, discharge action, or result notification shall be assigned to an identified clinician.
- Clinical uncertainty shall be stated plainly. The handover must not convert a provisional diagnosis into a false certainty.
- The incoming senior doctor shall allocate each patient, confirm coverage for resuscitation and waiting areas, and resolve workload or skill-mix concerns.
- Where junior staff hand over to another junior clinician, a senior clinician shall remain available for unresolved risk, disagreement, or overloaded task lists.

## 13. Nursing handover

- Nursing handover shall include current observations and trends, early-warning score where used, oxygen, IV access, infusions, medications due, fluid balance, wounds, drains, devices, pain, mobility, pressure risk, nutrition, elimination, and comfort needs.
- Safety concerns shall include falls, delirium, self-harm, violence, absconding, restraint, safeguarding, isolation, communication difficulty, sensory impairment, and need for close observation.
- The nurse in charge shall reconcile patient location, acuity, staffing allocation, breaks, one-to-one requirements, and boarded patients before accepting the shift.
- Bedside handover should be used when direct visualization or equipment verification adds safety and can be performed with dignity and confidentiality.
- The incoming nurse shall check identity, patient condition, monitor/oxygen/infusion settings, lines and devices, and immediately due care. Discrepancies must be resolved before the outgoing nurse leaves when possible.
- Controlled drugs, keys, emergency equipment, resuscitation trolley status, fridge temperatures, and other operational items shall be transferred under the relevant local procedure.

## 14. Multidisciplinary and operational handover

- Relevant allied health, mental-health, pharmacy, social work, safeguarding, security, portering, ambulance, and bed-management actions shall be included when they affect immediate safety or flow.
- The handover shall not rely on specialty or support teams discovering outstanding requests solely through the electronic system.
- Operational issues requiring executive or hospital-wide response—such as severe crowding, bed block, equipment loss, oxygen limitation, unsafe staffing, or infection outbreak—shall be escalated beyond the ED and documented.
- Patients awaiting specialty review remain within the ED handover until responsibility has formally transferred under the approved consultation or admission protocol.

## 15. Outstanding tasks, pending results, and communication duties

- Every task shall identify the patient, action, priority, owner, due time, and escalation if not completed.
- Tasks shall be visible in an approved handover list, clinical record, task manager, or paper tracker that is accessible to the incoming team.

- The outgoing clinician retains responsibility for urgent results that become available before responsibility is accepted. The incoming owner assumes responsibility for identified pending results after acceptance.
- Critical results shall be communicated directly and closed-loop; they shall not be left only in a task list.
- Pending cultures, formal imaging reports, send-away tests, amended results, and post-discharge callbacks shall be transferred to the approved tracking system and named follow-up service.
- An outstanding specialty callback shall include whom to contact, when the request was made, clinical urgency, agreed response time, and escalation pathway.
- Tasks that cannot be safely transferred because the receiver lacks authority, competence, or capacity shall be completed by the outgoing clinician or escalated to a senior decision-maker.

## 16. Explicit transfer of responsibility

- Transfer occurs only after the receiver has been identified, has received adequate information, can access the patient and record, has an opportunity to ask questions, and explicitly accepts the patient or task.
- The outgoing team remains responsible until acceptance. This does not require the outgoing team to remain indefinitely when the incoming team is late or unavailable; such delay must be escalated immediately through the clinical and managerial chain.
- The incoming medical and nursing leaders shall state that the census has been reconciled and all patients/areas have named coverage.
- Where responsibility is shared, the boundaries must be explicit—for example, ED physician for resuscitation, specialty clinician for definitive plan, and ED nurse for ongoing bedside care.
- An admitted patient physically remaining in the ED shall have clearly documented medical and nursing responsibility consistent with Protocol 10 and local policy.
- An unallocated patient is an emergency systems defect. The senior medical and nursing leaders shall assign interim responsibility immediately and file or escalate the incident as required.

**Writing “handed over” is not enough. The record should identify the receiver, date/time, current risk, and the specific tasks or results accepted.**

## 17. Interruption, emergency, or incomplete handover

- Pause the handover and respond to the emergency. Do not continue a distracted parallel handover when critical information may be missed.
- Mark the last completed patient and maintain control of the live list.
- After the emergency, reconcile the patient census and resume from the interruption point; do not rely on memory.
- If the original receiver is no longer available, restart the affected patient handover with the new receiver.
- If handover cannot be completed within the planned period because of workload or crowding, escalate for additional senior staff, area-based handover, or protected continuation.
- Any patient omitted or discovered without clear ownership shall receive immediate clinical review according to risk and be reported through the safety system when harm or material risk occurred.

## 18. Remote, telephone, and electronic handover

- Remote handover may be used when face-to-face handover is not feasible, but shall remain synchronous and interactive for active clinical responsibility.
- Confirm identities and roles of sender and receiver, patient identifiers, contact-back details, and the intended responsibility being transferred.
- Use the same minimum dataset and read back critical information, medication, result, deadline, or contingency.



- Do not use unsecured personal messaging or social media for identifiable patient information unless expressly approved under local policy.
- Electronic lists support but do not replace verbal transfer for unstable or high-risk patients.
- If connectivity fails, use the approved telephone, radio, paper, or downtime process and document the handover once systems are restored.

## 19. Electronic systems, patient lists, and downtime

- The ED shall maintain one authoritative live patient-tracking source or a clearly defined reconciliation process between systems.
- Handover lists shall display only necessary clinical information, be access-controlled, time-stamped, and securely destroyed when no longer required.
- Copy-forward or auto-populated information must be verified. Outdated diagnoses, tasks, locations, or responsibility fields shall be corrected.
- Patient movements, discharge, admission, transfer, or death must be updated promptly to prevent ghost patients or silent omissions.
- During downtime, use numbered paper forms, a manual location board, task/result logs, and a named person responsible for later reconciliation with the electronic record.
- After system restoration, clinically relevant paper handover information and actions shall be entered or scanned according to local record policy.

## 20. Crowding, surge, and mass-casualty conditions

- Crowding does not reduce the minimum requirement for patient identification, severity, ownership, outstanding actions, and contingency planning.
- Use area-based or team-based handover only when every patient remains visible on a reconciled master list and overall accountability is retained by named senior leaders.
- Patients in corridors, waiting rooms, ambulances, overflow spaces, or non-standard areas shall be stated explicitly; location and monitoring limitations shall be escalated.
- In a declared mass-casualty response, use the approved incident command and abbreviated handover tools, while preserving identity, category, lifesaving interventions, destination, and current responsibility.
- If the volume of handover exceeds safe capacity, activate the local surge plan and seek hospital-wide support rather than silently compressing or omitting cases.

## 21. Temporary, agency, rotating, and junior staff

- All staff shall receive orientation to the local handover time, location, tool, electronic system, escalation chain, and documentation standard before independent duty.
- Temporary staff shall be paired with an identified senior contact and shall not be assigned responsibility beyond verified competence.
- Junior staff must be able to escalate uncertainty, excessive workload, or an unsafe task list without intimidation.
- Locums or rotating staff shall hand over unresolved administrative or follow-up duties as well as direct clinical care.
- Supervisors shall review handover quality and provide feedback as part of competency assessment.

## 22. Patient and caregiver involvement

- Where appropriate, tell the patient who is taking over and what the immediate plan is.
- At bedside handover, confirm identity and invite the patient or caregiver to correct factual errors or mention new concerns, while avoiding discussion of sensitive information without consent.

- Patient or caregiver concern about deterioration shall be handed over as a clinical risk, not dismissed as non-clinical information.
- Use an interpreter or communication support where required. Do not rely on children or untrained relatives for safety-critical interpretation except in an immediate emergency.
- Protect privacy when discussing sexual health, mental health, safeguarding, substance use, custody, or other sensitive matters.

## 23. Confidentiality and information governance

- Conduct group handover away from public areas and use the minimum necessary identifiable information.
- Keep printed lists under direct control and place them in confidential waste after use; do not take them home or leave them in vehicles or public spaces.
- Use approved devices, systems, accounts, and secure transmission methods.
- Information may be shared without consent when necessary for direct care, immediate safety, safeguarding, or legal duty, but access should remain proportionate and documented where required.
- Confidentiality breaches shall be managed under the incident and information-governance procedures.

## 24. Failure, disagreement, or refusal to accept handover

- Clarify whether the problem is missing information, lack of capacity, role ambiguity, clinical disagreement, lateness, or refusal of responsibility.
- Complete immediate patient care and use the approved chain of command: incoming senior clinician/nurse, ED lead, on-call consultant, nursing supervisor, Medical Director, or executive as appropriate.
- Use safety advocacy tools such as CUS (“I am Concerned; I am Uncomfortable; this is a Safety issue”) and closed-loop communication.
- Document the delay, unresolved risk, persons contacted, interim owner, actions, and outcome.
- Do not abandon a patient or task because another person disputes ownership. Assign interim responsibility while the organizational dispute is resolved.
- Recurrent late, absent, or incomplete handovers require managerial review of staffing, scheduling, culture, and system design.

## 25. Documentation standards

- Date/time, sender and receiver names/roles, and form of handover.
- Patient-specific current assessment, significant change, uncertainty, and immediate plan when not already clear in the contemporaneous clinical record.
- Named transfer of responsibility for patient care and each outstanding high-risk task or pending result.
- Critical read-back, escalation criteria, contingency, treatment limitations, and unresolved disagreement.
- Department safety huddle risks, operational actions, owners, and deadlines.
- Interruption, omitted patient, unallocated responsibility, failed communication, or delayed receiver and resulting escalation.
- Post-handover review or correction when material discrepancies are found.
- Incident report reference where a handover failure caused or could have caused harm.

## 26. Quality indicators and audit

Indicator	Suggested measure
Census reconciliation	Percentage of shifts with documented reconciliation of all ED patients and care locations.

Indicator	Suggested measure
Named responsibility	Percentage of patients with named medical and nursing ownership after handover.
High-risk verbal handover	Percentage of high-risk patients with direct verbal transfer and contingency plan.
Outstanding task ownership	Percentage of sampled tasks/pending results with owner, due time, and escalation.
Interactive process	Percentage of observed handovers allowing questions and closed-loop confirmation.
Timeliness and attendance	Handover starts on time with required outgoing/incoming staff present.
Record accuracy	Agreement between live patient list, physical location, clinical record, and responsible team.
Post-handover verification	Percentage of high-risk patients reviewed within the locally approved interval.
Handover incidents	Omissions, delays, unallocated patients, missed results, medication lapses, deterioration, and complaints linked to handover.
Staff experience	Perceived clarity, workload, psychological safety, interruption burden, and adequacy of overlap.
Patient experience	Patient knows the current plan and who is responsible where appropriate.

## 27. Education, competency, and implementation

- All ED staff shall receive orientation and competency-based training in the approved handover tool, closed-loop communication, escalation, confidentiality, and downtime process.
- Training shall include simulation of interrupted handover, deteriorating patient, pending critical result, disputed responsibility, crowding, temporary staff, and IT failure.
- Clinical and nursing leaders shall observe handovers periodically and provide structured feedback.
- Implementation shall include local workflow mapping, staff overlap review, pilot testing, baseline audit, patient-list validation, and approval of forms and electronic fields.
- The policy shall be reviewed after a serious incident, major change in staffing or information systems, or updated national/international guidance.

## 28. References and source frameworks

1. World Health Organization Collaborating Centre for Patient Safety Solutions. Communication during patient handovers. Patient Safety Solution, 2007.
2. Agency for Healthcare Research and Quality. TeamSTEPPS: Handoff tool, SBAR, closed-loop communication, call-out, and check-back resources. Current online curriculum.
3. The Joint Commission. National Performance Goals for Hospitals, effective January 2026: process for handoff communication and opportunity for discussion between giver and receiver.
4. The Joint Commission. Sentinel Event Alert 58: Inadequate hand-off communication. 2017.
5. World Health Organization. Emergency Care Toolkit and Standardized Emergency Unit Clinical Forms.
6. Royal College of Emergency Medicine. Guidelines for the Provision of Emergency Medical Services. January 2025.
7. Royal College of Emergency Medicine. The Management of Emergency Department Crowding. 2024.
8. NHS England. Safe Communication: Design, Implement and Measure. 2015.

9. Local legislation, professional standards, information-governance policy, electronic-record policy, staffing and roster policy, incident-response policy, and specialty responsibility agreements.

## Annex A. One-page shift handover workflow

Step	Action	Minimum requirement
1	Prepare	Update record/list; review urgent results; identify high-risk patients; list tasks and contingencies.
2	Reconcile	Match electronic/paper census with every physical care location and temporary area.
3	Huddle	Share demand, capacity, staffing, hazards, sickest patients, constraints, and immediate actions.
4	Prioritize	Hand over unstable and time-critical patients first, preferably at bedside.
5	Communicate	Use structured patient-by-patient handover linked to the current record.
6	Assign	Name owner, priority, due time, and escalation for every outstanding task/result.
7	Clarify	Receiver asks questions; critical actions and uncertainty are read back.
8	Accept	Incoming medical and nursing leads confirm patient and area responsibility.
9	Verify	Incoming team reviews high-risk patients, equipment, observations, and immediate actions.
10	Correct	Resolve discrepancies, omissions, or unallocated patients and report material failures.

## Annex B. Shift-start safety huddle card

Prompt	Record / action
Census and locations	Waiting: ___ Treatment: ___ Resus: ___ Boarded: ___ Observation: ___ Ambulances/overflow: ___
Sickest / highest risk	Names/locations and immediate needs: _____
Staff and skill mix	Medical: ___ Nursing: ___ 1:1: ___ Gaps/agency/junior staff: _____
Capacity and flow	Beds, specialty delays, imaging/lab/transport constraints: _____
Hazards	Violence, infection, equipment, oxygen, medication, environment, IT: _____
Expected events	Transfers, procedures, retrievals, arrivals, surge/weather/security: _____

Prompt	Record / action
Actions	Action / owner / deadline: _____

## Annex C. Patient-specific handover template

Field	Handover entry
Identity / location / owner	_____
Situation and severity	_____
Relevant background	_____
Assessment / diagnosis / uncertainty	_____
Trajectory and response	_____
Care completed	_____
Outstanding tasks / pending results	Action: _____ Owner: _____ Due: _____
Disposition / barriers	_____
Escalation / contingency	_____
Receiver / acceptance	Name / role / date-time: _____

## Annex D. High-risk verbal handover checklist

Check	Confirm
Current physiological risk	Airway / breathing / circulation / neurology / bleeding / sepsis / other
Recent change	Deterioration, treatment response, sedation/procedure, transfer, or new result
Critical support	Oxygen/ventilation, infusions, blood, drains, monitoring, restraint/1:1 observation
Time-critical action	Medication, repeat test, review, procedure, transfer, or escalation due by: _____
Pending result / referral	What, expected when, owner, callback/contact, and escalation
Ceiling of care	Resuscitation status, treatment limits, advance plan, family discussion
Contingency	Expected failure mode and immediate response
Receiver read-back	Critical action repeated and accepted: Yes / No

## Annex E. Outstanding tasks and pending-results tracker

Patient / ID	Task or result	Priority	Owner	Due time	Escalation if delayed	Completed / time

Patient / ID	Task or result	Priority	Owner	Due time	Escalation if delayed	Completed / time

## Annex F. Transfer-of-responsibility checkpoint

Requirement	Yes / No / details
All patients and physical care areas reconciled	
Every patient has named medical and nursing coverage	
High-risk patients directly handed over	
Outstanding tasks/results have owners and deadlines	
Critical actions and contingencies read back	
Unresolved disagreement or workload risk escalated	
Incoming senior doctor accepts responsibility	Name / date-time: _____
Incoming nurse in charge accepts responsibility	Name / date-time: _____

## Annex G. Nursing bedside verification checklist

Check	Status
Identity, location, allergy, infection/isolation	
Current observations, trend, early-warning score	
Airway/oxygen/monitor settings and alarms	
IV access, infusions, medications due, fluids/blood	
Lines, drains, wounds, devices, splints/restraints	
Pain, cognition, mobility, pressure/fall risk, comfort	
Safeguarding, violence, self-harm, absconding, 1:1 need	
Investigations/procedures/transport pending	
Patient/caregiver understands immediate plan	
Discrepancies corrected or escalated	

## Annex H. Handover interruption recovery checklist

- Address the emergency and identify who retains the live patient list.
- Mark the last patient fully handed over.
- Reconcile census and locations before restarting.

- Confirm whether receiver or team composition changed.
- Restart any partially communicated high-risk patient from the beginning.
- Review tasks/results generated during the interruption.
- Complete explicit acceptance and post-handover verification.
- Report any omission, delay, or unallocated responsibility that created material risk.

## Annex I. Remote or telephone handover record

Field	Record
Sender and callback	_____
Receiver and role	_____
Patient identifiers / location	_____
Reason responsibility is transferring remotely	_____
Structured handover completed	Yes / No
Critical information read back	_____
Tasks/results accepted	_____
Date/time responsibility accepted	_____
Communication failure / contingency	_____

## Annex J. Shift handover audit tool

Audit item	Result
Handover occurred at approved time/place with required staff	Yes / No / N/A
Department safety huddle completed	Yes / No / N/A
Patient census and locations reconciled	Yes / No / N/A
High-risk patients identified and verbally handed over	Yes / No / N/A
Minimum patient dataset used consistently	Yes / No / N/A
Clinical uncertainty and trajectory communicated	Yes / No / N/A
Outstanding tasks/results have owner and due time	Yes / No / N/A
Receiver had opportunity for questions/read-back	Yes / No / N/A
Medical and nursing responsibility explicitly accepted	Yes / No / N/A
Post-handover review of high-risk patients completed	Yes / No / N/A
No unallocated or omitted patient identified	Yes / No / N/A
Confidentiality and secure list disposal maintained	Yes / No / N/A

## Annex K. Local configuration table

Local element	Approved configuration
Medical handover times and overlap	[Insert approved times and minimum overlap]

Local element	Approved configuration
Nursing handover times and overlap	[Insert approved times and minimum overlap]
Designated handover location	[Insert location / backup location]
Approved structured tool	[ISBAR / I-PASS / local tool and template location]
Authoritative patient list / tracker	[System, owner, update standard]
High-risk marking method	[Electronic/paper visual identifier]
Post-handover review interval	[Locally approved by acuity]
Task and pending-result system	[System and accountability model]
Late/absent receiver escalation	[Clinical and managerial chain]
Downtime handover process	[Forms, storage, reconciliation owner]
Temporary staff orientation	[Responsible role and evidence of completion]
Audit owner and frequency	[Name/role and schedule]
Confidential waste / list disposal	[Location and process]

## Annex L. Approval and sign-off

Review / approval role	Name	Signature	Date
Emergency Department Lead			
Nursing Director / ED Nurse Manager			
Medical Director / Clinical Governance			
Information Systems / Health Records			
Patient Safety / Quality Lead			
Hospital Executive Approval			

Implementation note: This draft becomes operational only after local handover times, staffing overlap, authoritative patient list, task/result ownership system, escalation chain, downtime process, and training requirements are approved and tested.