

# Guidance notes on handover and review

## Guidance notes on handover and review

The Royal College of Radiologists (RCR) is aware that the nature of on-call work for both consultants and trainees is changing, with more and more departments extending their normal hours of working and the increasing range and complexity of on-call work in general.<sup>1</sup> This document outlines the principles for good handover and review between radiology colleagues (trainee to consultant and consultant to consultant).

Handover is the process by which ongoing patient events are discussed between a doctor finishing a period of work, shift or period of on-call and the doctor taking over responsibility for those patients. Within the context of radiology this will typically include information about any imaging investigations or interventions planned but not yet undertaken or any outstanding reports on investigations. Other matters, such as ongoing discussions with referrers or the need to communicate results, as well as anything else that the 'outgoing' doctor considers to be relevant, should be discussed. The purpose of handover is to ensure that patient care is seamless when members of staff change. Ideally, this should take place face-to-face, but may occur over the telephone. Email is a suboptimal medium for use in handover as the sender cannot be certain that the message has been received and there is no opportunity for clarification or discussion. Its use is therefore not encouraged.

The principles of and responsibilities for good handover apply as in any other area of clinical work; that is, the safe handover of professional responsibility and accountability.<sup>2,3</sup> Principles include:

- Being prepared with a prioritised and concise summary
- Being current, only referring to past cases if they seem likely to be re-referred (for example, additional examinations proposed but not yet confirmed as necessary)
- Using of professional language that enables clarity about the clinical situation
- Encouraging and enabling challenge, requesting clarity by recipient should be respected and lead to a professional exchange

- Wherever possible, the handover should be supported with patient identification information to avoid subsequent confusion or errors of omission or commission
- Using a standardised template that will facilitate clear communication but not avoid the need to individualise on a case-by-case basis
- Including 'at risk situations' or learning that may be pertinent to safety in the subsequent session (for example, complex case discussions or changing skill mix within the imaging department due to shift changes).

### Review of examinations

Review of examinations is the process by which imaging investigations undertaken by a trainee during a period of work, shift or on-call period are checked by a supervising consultant. Ideally, this should be face-to-face, as it represents an important teaching opportunity. It is recognised that this is not always possible but it is important that feedback on all cases is given. Feedback should be considered an essential and integral part of on-call education for trainees and represents an excellent opportunity to undertake workplace-based assessments.

### Integration of outsourcing into departmental workflows

With the increased imaging activity taking place out of hours, many departments have taken the decision to outsource this activity to teleradiology companies to avoid an adverse impact on their imaging services during the day. It is important that there is clear communication between clinicians at the referring trust and the reporting radiologist and it is expected that these arrangements will be agreed between the trust and the relevant company. However, it is recognised that in many cases, subsequent review of the acute imaging will take place and there may be additional findings that influence patient management. Furthermore, there may be additional clinical information that was not available to the radiologist generating the original report. Ad hoc reviews of outsourced investigations, that influence clinical decision-making, should also

be recorded on the radiology information system (RIS).

It is important that imaging departments using outsourced services have mechanisms to 'take ownership' of studies that were performed on an urgent basis out of hours. This is particularly important for trauma imaging where it is not unusual for additional findings to become apparent after the initial report.

### **Action in the event of unexpected information technology (IT) failures and staff absence**

It is the radiologist's responsibility to ensure that any IT failures or staff absences that are or are imminently likely to interrupt the provision of a safe service are escalated through the agreed means within their trust. In most cases this would mean at least escalating to their consultant on call and radiography management on call. Ensuring that all staff are aware of what to do on these occasions should be part of the induction to participating in the on-call service and, in addition, the information should be in written form and easily available within the department.

Approved by the Clinical Radiology Faculty Board: 26 June 2015.

## References

---

1. The Royal College of Radiologists. *Standards for providing a 24-hour diagnostic radiology service*. London: The Royal College of Radiologists, 2009.
2. [www.rcplondon.ac.uk/resources/acute-care-toolkit-1-handover](http://www.rcplondon.ac.uk/resources/acute-care-toolkit-1-handover) (last accessed 21/09/2015)
3. Australian Commission on Safety and Quality in Healthcare. *Implementation toolkit for clinical handover improvement*. Darlinghurst: Australian Commission on Safety and Quality in Healthcare.

## Citation details

The Royal College of Radiologists. *Guidance notes on handover and review*. London: The Royal College of Radiologists, 2015.

Ref No. BFCR(15)6  
© The Royal College of Radiologists,  
September 2015.

For permission to reproduce any of the content contained herein, please email:  
permissions@rcr.ac.uk

This material has been produced by The Royal College of Radiologists (RCR) for use internally within the specialties of clinical oncology and clinical radiology in the United Kingdom. It is provided for use by appropriately qualified professionals, and the making of any decision regarding the applicability and suitability of the material in any particular circumstance is subject to the user's professional judgement.

While every reasonable care has been taken to ensure the accuracy of the material, RCR cannot accept any responsibility for any action taken, or not taken, on the basis of it. As publisher, RCR shall not be liable to any person for any loss or damage, which may arise from the use of any of the material. The RCR does not exclude or limit liability for death or personal injury to the extent only that the same arises as a result of the negligence of RCR, its employees, Officers, members and Fellows, or any other person contributing to the formulation of the material.

**The Royal College of Radiologists**  
63 Lincoln's Inn Fields, London WC2A 3JW  
**Tel:** +44 (0)20 7405 1282  
**Email:** enquiries@rcr.ac.uk [www.rcr.ac.uk](http://www.rcr.ac.uk)



A Charity registered with the Charity Commission No. 211540