

BRIDGING THE SHIFT GAP: AN AUDIT ON DOCTOR HANDOVER COMPLIANCE

Dissertation Submitted to



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in

Hospital and Health Management

by

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Under the Supervision and Guidance of

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TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Mr. Sanjay Sahu** (Student of IIHMR Jaipur, University), has successfully completed his internship training in Hospital Administration department from 10.03.2025 to 31.05.2025

During his aforesaid tenure, He has been found to be extremely honest, regular and sincere.

For Wockhardt Hospitals Ltd.,



Abhijeet Pagade
Manager - HR



CERTIFICATE

This is to certify that dissertation titled “**Bridging the shift gap: an audit on doctor handover compliance**” is a record of the research work undertaken by Sanjay Sahu in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his approach to the research study has been sincere, scientific, and analytical.

A handwritten signature in blue ink, appearing to read 'S. Gupta'.

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled “**Bridging the shift gap: an audit on doctor handover compliance**” is the Bonafide record of my original research work.

I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Signature



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ABSTRACT:

Effective clinical handover is a critical component of patient safety and continuity of care, particularly in hospital inpatient settings where patients transition between multiple teams across different shifts. This audit was undertaken to assess the level of compliance with standardized doctor handover documentation in a tertiary care hospital and to identify specific areas requiring improvement. The primary objective was to evaluate the completeness and accuracy of handover entries during shift changes and to examine the effectiveness of targeted interventions in improving compliance.

The audit was conducted in two phases: an initial audit followed by a re-audit after corrective actions were implemented. The methodology adopted was a retrospective observational audit of handover documentation across inpatient wards. A total of 212 handover files were reviewed in the initial phase, accounting for 636 shift entries (morning, afternoon, and night shifts). The documentation was assessed across 14 defined parameters, including time of handover, clinical events, pending investigations, procedure/consent, medication and diet changes, discharge instructions, and both doctor signatures. The re-audit phase was conducted with 100 additional files (300 shift entries) following interventions such as staff training, SOP reinforcement, and the introduction of visual reminders.

The initial audit revealed an overall compliance rate of 64.35%, with significant deficiencies in critical parameters like Time of Handover (27.83%), Procedure/Consent (56.92%), Clinical Events (58.96%), and Hand Over Taken By (57.86%). These gaps highlighted both systemic and behavioral challenges in consistent documentation. In response, practical and low-cost measures were introduced, including the use of standardized checklists, peer verification during night shifts, red stamp reminders near signature fields, and weekly compliance tracking.

Following implementation, the re-audit showed a substantial improvement, with the overall compliance rising to 82.65%. Marked progress was observed in key areas, including Time of Handover (70%), Procedure/Consent (75%), and Dual Signatures, indicating greater awareness and improved accountability. Parameters such as Doctor Referrals, Medication Updates, and Diet Changes also crossed the good compliance

threshold. However, some areas remained in the moderate range, suggesting the need for ongoing reinforcement and sustained oversight.

In conclusion, this audit demonstrated that structured interventions and routine performance feedback can significantly enhance documentation quality in clinical handovers. While notable progress was achieved, continuous training, integration of digital tools, and periodic re-audits are recommended to maintain high compliance and ensure that critical patient information is reliably communicated during transitions of care. Improving handover practices is not merely an administrative task but a core component of safe and effective clinical governance.

Keywords: Handover Compliance, Clinical Audit, Inpatient Documentation, Patient Safety, Shift Transition

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Lastly, I would like to thank my peers and everyone who encouraged and supported me directly or indirectly throughout this journey.

Sincerely,

Sanjay Sahu

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TITLE - Bridging the Shift Gap: An Audit on Doctor Handover Compliance

Background: - Effective handover between doctors during shift changes is a critical component of patient safety and clinical continuity. Inconsistent or incomplete documentation during handovers can lead to miscommunication, delayed interventions, and increased risk of clinical errors. At Wockhardt Hospital, the need to strengthen written handover practices was identified due to observed variability in how information was passed across shifts. Key elements such as time of handover, pending investigations, procedures, discharge plans, and confirmation by both giver and taker were not consistently recorded. To address these gaps and promote standardization, a clinical audit was conducted to evaluate the current compliance with doctor handover protocols.

Purpose:

The purpose of this audit was to assess the accuracy and completeness of handover documentation across selected in-patient wards and to evaluate the impact of targeted training and process improvements. By identifying patterns of non-compliance and measuring improvement after interventions, the audit aimed to enhance communication practices, reduce clinical risks, and support continuity of care during shift transitions.

CHAPTER 1: INTRODUCTION

In hospital settings, clinical handover plays a vital role in maintaining the continuity and safety of patient care during shift changes. It refers to the structured transfer of key patient-related information, responsibilities, and tasks from one healthcare provider to another. Proper handover ensures that critical updates such as pending investigations, procedures, medication changes, and ongoing care plans are not lost or miscommunicated. When handovers are inconsistent, verbal-only, or poorly documented, it increases the risk of delays in treatment, duplication of work, or even adverse events.

Recognizing the importance of standardized handover practices, a clinical audit was conducted to assess the compliance of doctors with existing handover documentation protocols in a tertiary care hospital. This audit aimed to evaluate how thoroughly key components were being recorded, such as clinical events, referrals, investigations, consents, discharge plans, and time of handover, along with the presence of both giver and taker signatures.

The initial audit involved the manual review of 212 physical handover sheets from Level 4 and Level 5 inpatient wards. Common gaps identified included incomplete documentation of handover time, missing signatures, and lack of clarity regarding pending investigations or procedures. These findings indicated a need for improved training and structured documentation.

Following this, targeted interventions were implemented, including hands-on training sessions, reinforcement of standard operating procedures (SOPs), and the introduction of accountability measures like mandatory dual signatures and timestamp validation. To assess the impact of these corrective steps, a re-audit was carried out on 100 handover files, covering 300 shift entries.

This report presents the findings from both audit phases, compares compliance rates before and after the intervention, and highlights areas of improvement. Through this study, efforts were made to strengthen the handover process by promoting accurate documentation, enhancing accountability, and supporting clinical safety during patient care transitions.

1.1 Aim

To evaluate and improve the compliance of medical teams with doctor handover documentation protocols, ensuring that essential patient information is accurately communicated during shift transitions for safer and more coordinated care.

1.2 Objectives

1. To assess current handover practices:

Review handover sheets to determine the frequency and completeness of documentation across key parameters such as clinical events, pending investigations, procedures, discharge plans, and giver/taker signatures.

2. To identify gaps and inconsistencies:

Detect areas where documentation is lacking or inconsistent, such as missing time stamps or unrecorded procedural details, and understand potential factors contributing to these lapses.

3. To implement corrective measures:

Introduce targeted interventions including staff training, visual reminders, and reinforcement of standard operating procedures (SOPs) to promote consistent and accurate documentation.

4. To measure improvement post-intervention:

Conduct a re-audit to evaluate the effectiveness of the implemented changes, comparing results with the initial audit to assess progress in overall compliance.

5. To support long-term sustainability:

Recommend ongoing monitoring strategies and practical solutions—such as shift-wise reminders or periodic audits—to maintain improved handover practices and embed them into routine clinical workflow.

CHAPTER 2: REVIEW OF LITERATURE

This chapter presents a synthesis of key literature relevant to clinical handover practices, drawn from selected high-quality sources. Effective communication during clinical handover is essential to ensure patient safety and continuity of care. The studies reviewed span various healthcare contexts, including emergency departments, inpatient wards, and intensive care settings. The table below provides a summary of each study, focusing on authorship, location, sample size, sampling methods, and the major findings or salient features.

Table 2.1: Summary of Reviewed Literature

Author(s) (Year)	Study Location	Sample Size	Sampling Technique	Salient Features
Starmer et al. (2021)	USA	Multi-hospital study	Not specified	Demonstrated significant reduction in communication failures and medical errors with the implementation of the I-PASS handover tool.
ACSQHC (2012)	Australia	Literature review	Secondary data	Identified risks associated with clinical handover failures and advocated for structured frameworks and standardized tools.

Abraham et al. (2012)	UK	Not specified	Narrative review	Emphasized the importance of leadership, environment, and interprofessional collaboration in enhancing handover safety.
Tamang et al. (2023)	Nepal	90 nurses	Simple random sampling	Found that structured handover improves communication accuracy, nurse satisfaction, and reduces omissions in patient care.
Kripalani et al. (2019)	USA	Review article	Literature-based	Highlighted the frequent communication lapses during care transitions and the utility of handover tools like SBAR.
Chan et al. (2025)	Hong Kong	55 interns	Convenience sampling	Evaluated simulation-based training and found improved competency in clinical handovers among junior doctors.
Manias et al. (2016)	Australia	Not specified	Qualitative study	Explored nursing bedside handovers

				and underlined the importance of patient involvement and mutual accountability.
NICE Guidelines (2018)	UK	Not applicable	Evidence summary	Provided structured guidance on implementing tools like SBAR and I-PASS to enhance handover quality.
Humphries (2020)	UK	Mixed methods (qual/quant)	Doctoral research	Investigated intra-hospital handover challenges and suggested organizational and educational reforms.
Royal College of Surgeons (2007)	UK	Not applicable	Expert recommendations	Recommended formal protocols for surgical handovers with emphasis on responsibility, documentation, and training.

2.2 Narrative Synthesis

The reviewed literature strongly supports the implementation of standardized handover protocols such as I-PASS and SBAR to reduce miscommunication, especially during transitions of care. Studies conducted in diverse settings—ranging from tertiary hospitals in the USA and UK to nursing practice in Nepal—demonstrate the global importance of clinical handover quality. Several works, including those by Starmer et al. and NICE, emphasize structured frameworks to minimize omissions and enhance clarity. Others, such as the Royal College of Surgeons report and Humphries’ thesis, suggest that organizational leadership, formal guidelines, and multidisciplinary education are critical to effective handover practices. Furthermore, the role of simulation and training, as evidenced by Chan et al., supports skill enhancement for junior healthcare professionals. This body of literature underpins the significance of investing in structured handover processes to ensure patient safety, operational efficiency, and staff accountability.

CHAPTER 3: METHODOLOGY

This clinical audit was designed to evaluate the completeness and accuracy of doctor handover documentation during shift changes in inpatient wards. The audit was carried out in two phases: an initial audit followed by a re-audit after targeted interventions were implemented.

3.1 Research Design

The study followed a retrospective observational audit design, carried out in two phases: an initial audit followed by a re-audit after implementing corrective actions. Both phases involved manual data collection and quantitative analysis of documentation compliance.

3.2 Study Setting and Duration

The audit was conducted in the inpatient wards (Level 4 and 5) of a tertiary care hospital, focusing only on admitted floor patients.

Initial Audit Duration: 20th March to 25th April 2025

Re-Audit Duration: 1st May to 20th May 2025

3.3 Sample and Tools

The audit reviewed physical handover documents maintained by doctors during shift changes.

Sample Size (Initial Audit): 212 handover files (636 entries across 3 shifts)

Sample Size (Re-Audit): 100 handover files (300 shift entries)

Audit Tool

A standardized doctor handover tool was used to assess the following key parameters:

- Clinical events

- Pending investigations/reports
- Procedure/consent details
- Discharge planning
- Medication/diet changes
- Time documentation
- Giver and taker signatures

3.4 Inclusion and Exclusion Criteria

Inclusion Criteria:

- Handover sheets of admitted floor patients
- Sheets recorded during morning, afternoon, or night shift changes

Exclusion Criteria:

- OPD, ICU, or emergency cases
- Incomplete or missing handover sheets

3.5 Data Analysis and Benchmark

Compliance was calculated using the following formula:

$$\text{Compliance \%} = (\text{Compliant Entries} \div \text{Total Entries}) \times 100$$

(Where Total Entries for initial audit = 636)

$$\text{Non-compliance \%} = 100 - \text{Compliance \%}$$

Audit Benchmark

The benchmark for ideal compliance was set at 100%, meaning all assessed fields should be properly documented on each handover sheet. Individual parameters were expected to meet at least 90% compliance, aligning with hospital standards for clinical communication and documentation practices.

3.6 Audit Tool and Review Process

A structured checklist based on handover SOPs was used to ensure uniform evaluation of each file. Observations were recorded in a tabulated format for both the initial and re-audit phases. The audit was conducted by the author Mr. Sanjay Sahu, under the guidance of Dr. Alka Ma'am.

Post-Audit Interventions

Based on the findings from the initial phase, the following corrective measures were implemented:

- Hands-on training sessions for medical staff
- Reinforcement of SOPs for doctor handovers
- Use of shift-wise reminders and visual aids in duty rooms
- Emphasis on dual accountability by mandating giver and taker signatures

The re-audit was planned to assess the impact of these interventions and measure improvement in compliance levels.

3.7 Ethical Considerations

The audit was conducted as part of an internal quality improvement initiative. Patient identity and personal health information were kept confidential. No direct patient interaction was involved; hence, informed consent was not applicable.

CHAPTER 4: RESULTS

Data Analysis

The clinical audit was conducted to assess the compliance of doctor handover documentation across various parameters in inpatient wards. A total of 212 handover sheets were reviewed in the initial phase of the audit, followed by a re-audit of 100 handover files, covering 300 shift entries after the implementation of targeted training and procedural interventions.

Sample Overview

- **Initial Audit:** 212 handover files were reviewed, comprising a total of 636 handover entries across three shifts (morning, afternoon, night).
- **Re-Audit:** 100 handover files were selected post-intervention, with a total of 300 shift entries examined using the same audit tool.

The handover entries were manually reviewed for completeness across a defined set of parameters based on hospital SOPs.

Table 4.1: Parameters Assessed

Each handover entry was evaluated against the following 14 key documentation parameters:

S. No.	Parameter	Definition
1	Date	The date on which the handover was documented
2	Time of Handover	Clear documentation of the exact time of shift handover
3	Shift	Indication of whether the handover occurred during Morning, Afternoon, or Night
4	Patient Name	Full name of the patient as per medical records

5	IPD Number	Unique Inpatient Department number assigned to the patient
6	Diagnosis	Documented medical diagnosis of the patient
7	Clinical Events	Significant changes in patient condition or interventions during the shift
8	Pending Investigations	Listing of unresolved diagnostic tests or reports
9	Procedure/Consent	Notes on scheduled procedures and whether required consents were obtained
10	Discharge Planning	Notes on discharge preparation or expected discharge timelines
11	Medication Changes	Any recent changes in prescribed medications during the shift
12	Diet Changes	Documentation of any updates in the patient's dietary plan
13	Giver's Signature	Signature of the doctor handing over the patient for accountability
14	Taker's Signature	Signature of the doctor receiving the handover to confirm receipt

Table 4.2: Initial Audit Results

The initial audit revealed the following compliance rates for each parameter:

Sr. No.	Parameter	% Compliance	% Non-Compliance	Compliance Level
1	Date	81.76%	18.24%	✓ Good
2	Time	27.83%	72.17%	● Poor
3	Shift	82.08%	17.92%	✓ Good
4	Specific Clinical Event	58.96%	41.04%	● Poor
5	Doctor Referrals	63.05%	36.95%	✓ Good
6	Modification in Medications	80.50%	19.50%	✓ Good
7	Modification in Diet	78.85%	21.15%	● Moderate
8	Pending Investigations	54.40%	45.60%	● Poor
9	Pending Reports	53.77%	46.23%	● Poor
10	Procedure/Consent	56.92%	43.08%	● Poor
11	Important Instructions (incl. Plan of Discharge)	66.04%	33.36%	● Moderate
12	Hand Over Given By	81.60%	18.40%	✓ Good
13	Hand Over Taken By	57.86%	42.14%	● Poor

14	Name of Doctor	67.92%	32.08%	 Moderate
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The initial audit showed that while certain fields like medication updates and basic patient information were often filled, key elements such as time documentation, pending investigations, and dual doctor signatures were frequently missing or incomplete. A lack of standardization, over-reliance on verbal updates, and limited awareness of medico-legal responsibilities were identified as contributing factors.

Interventions Implemented

Based on the gaps identified, the following measures were introduced:

- **Hands-on training sessions** for resident doctors focusing on handover quality and documentation standards
- **Reinforcement of Standard Operating Procedures (SOPs)** via posters and printed guides in duty areas
- **Visual cues and reminders** near doctor stations emphasizing mandatory fields
- **Mandating dual accountability**, requiring both giver and taker to sign off each handover
- **Daily checklist culture** encouraged to ensure all fields are considered during handover

These changes were aimed at cultivating habit-based improvements without overburdening the clinical workflow.

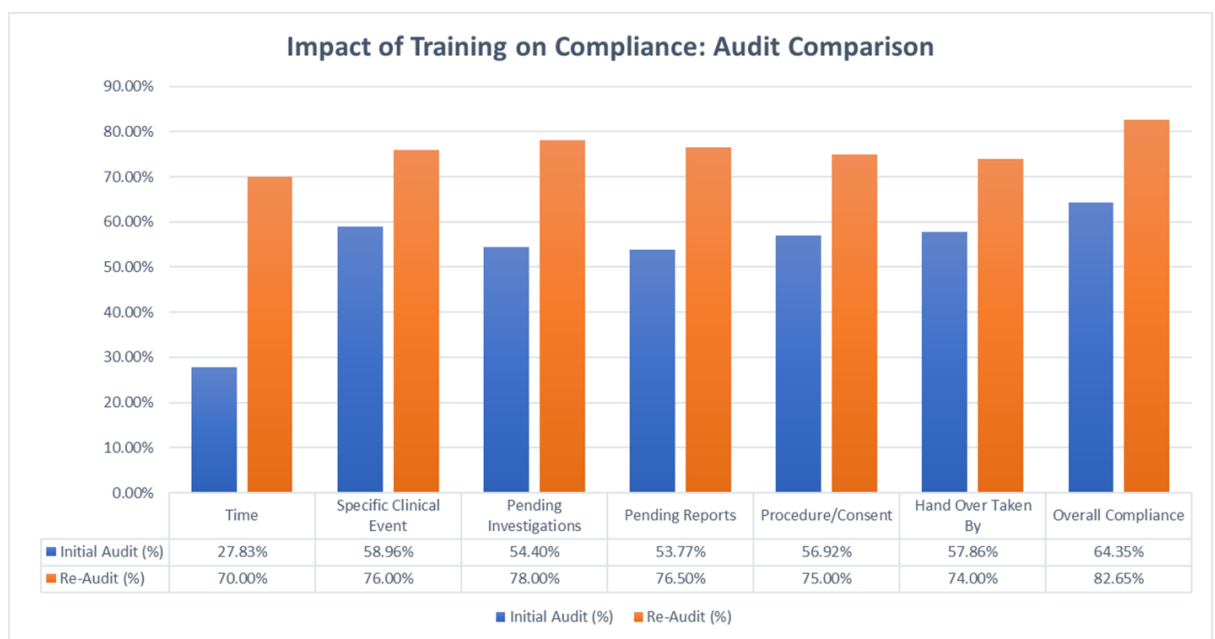
Table 4.3: Re-Audit Results (Post-Intervention)

S.No	Parameter	Re-Audit Compliance (%)	Compliance Level
1	Date	90%	✓ Good
2	Time	70%	● Moderate
3	Shift	91%	✓ Good
4	Specific Clinical Event	76%	● Moderate
5	Doctor Referrals	80%	✓ Good
6	Modification in Medications	89%	✓ Good
7	Modification in Diet	82%	✓ Good
8	Pending Investigations	78%	● Moderate
9	Pending Reports	76.5%	● Moderate
10	Procedure/Consent	75%	● Moderate
11	Important Instructions (Discharge)	79%	● Moderate
12	Hand Over Given By	88%	✓ Good
13	Hand Over Taken By	74%	● Moderate

14	Name of Doctor	85%	✓ Good
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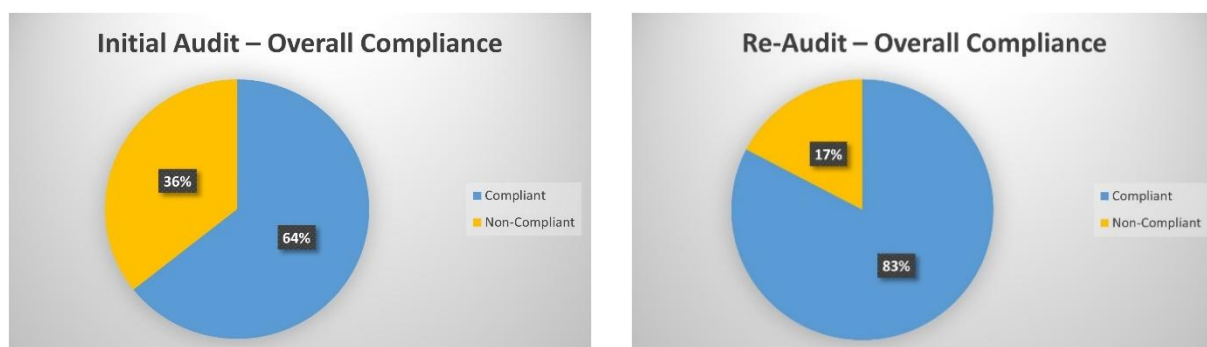
The re-audit results show overall improvement in handover documentation following targeted interventions. Parameters like Date, Shift, and Medication Changes achieved “Good” compliance, indicating better adherence to protocols. However, areas such as Time, Procedure/Consent, and Pending Investigations remained in the “Moderate” range, suggesting some gaps persist. Ongoing training, supervision, and accountability measures are recommended to strengthen these areas further and ensure consistent, high-quality documentation.

Fig. 4.1: Comparative Analysis of Compliance: Initial Audit vs Re-Audit



This bar chart illustrates the compliance percentages for each of the 14 handover parameters in both the initial audit and the re-audit. The comparison highlights the improvements achieved after implementing targeted interventions such as training, SOP reinforcement, and accountability measures. Notable increases are observed in parameters like Time of Handover, Procedure/Consent, and Hand Over Taken By, indicating enhanced documentation practices. However, a few areas still show moderate compliance, suggesting the need for continued focus and monitoring.

Fig 4.2: Overall Handover Documentation Compliance – Initial Audit vs Re-Audit



This pie chart compares the overall average documentation compliance before and after the intervention. The initial audit showed a compliance rate of 64.35%, which improved to 82.65% in the re-audit. This improvement reflects the effectiveness of the corrective measures implemented, such as structured training, standardized formats, and increased accountability in the handover process.

Table 4.4: Results of Initial Audit vs Re-Audit

Parameter	Initial Audit (%)	Re-Audit (%)	Change
Time of Handover	27.83	70.00	+42.17%
Clinical Events	58.96	76.00	+17.04%
Procedure/Consent	56.92	75.00	+18.08%
Hand Over Taken By	57.86	74.00	+16.14%
Doctor Referrals	63.05	80.00	+16.95%
Modification in Medications	80.50	89.00	+8.50%
Modification in Diet	78.85	82.00	+3.15%

Important Instructions/Discharge	66.04	79.00	+12.96%
Overall Compliance	64.35	82.65	+18.30%

This analysis confirms that the documentation process became more robust and reliable following the interventions, particularly in time-sensitive and accountability-related fields.

Summary of Key Improvements

- Time documentation, previously the weakest area, saw a dramatic rise in compliance.
- Accountability parameters (such as “Hand Over Taken By”) improved
-
- substantially, promoting shared responsibility.
- Clinical content (events, investigations, and consents) showed consistent enhancement.
- No parameter fell in the “Poor” category after re-audit, suggesting systemic improvement.

CHAPTER 5: DISCUSSION

This audit was undertaken to assess the quality and consistency of doctor handover documentation during shift transitions in inpatient wards. The aim was to identify existing gaps, implement corrective actions, and evaluate improvements in compliance with standard handover protocols.

The initial audit revealed a significant lack of consistency in the documentation process, with an overall compliance rate of 64.35%. While some parameters such as Date, Shift, and Patient Identification consistently showed good compliance, other critical areas like Time of Handover (27.83%), Clinical Events (58.96%), Procedure/Consent (56.92%), and Signature of Handover Taken By (57.86%) were found to be poorly documented. These gaps highlighted the absence of a standardized process and suggested that important clinical information was at risk of being overlooked during patient transitions.

Several contributing factors were identified. Time pressure during busy shifts, reliance on verbal communication, and a lack of visual or system-based reminders appeared to be the primary reasons for under-documentation. In many cases, even when handovers occurred, key details were either partially noted or omitted altogether. The inconsistent use of signatures, especially from the receiving doctor, pointed to a lack of shared accountability.

In response to these findings, structured interventions were introduced. These included:

- Training sessions for medical staff on the importance of comprehensive handovers
- Reinforcement of existing Standard Operating Procedures (SOPs)
- Placement of visual reminders in doctors' duty areas
- Mandatory emphasis on completing time stamps and signatures for every shift

The re-audit, conducted after these interventions, demonstrated substantial improvement, with overall compliance rising to 82.65%. The most notable improvement was seen in the Time of Handover, which increased from 27.83% to 70%, reflecting enhanced awareness and adherence. Similarly, parameters such as Procedure/Consent, Clinical Events, and Dual Signatures also showed marked improvement, indicating a shift toward more structured and accountable documentation practices.

Despite this progress, certain parameters such as Pending Investigations, Discharge Planning, and Taker's Signature still showed moderate compliance, suggesting the need for continued monitoring and reinforcement. These fields are critical for ensuring continuity of care and minimizing communication-related clinical risks, especially during high-volume patient transfers.

The improvements seen in the re-audit affirm that simple, practical interventions can lead to measurable enhancements in documentation culture. However, sustaining this change will require periodic re-training, continuous oversight, and potentially integrating electronic handover tools to streamline the process.

This audit highlights the crucial role of standardized handover documentation in patient safety and care coordination. A well-documented handover is not merely an administrative task but a key component of clinical communication and risk reduction. Encouraging a consistent and accountable handover process is essential in improving both patient outcomes and staff coordination.

5.1 Limitations

The following limitations were observed during the course of this clinical audit:

1. Retrospective Design

The audit was based on a retrospective review of documentation, limiting the assessment to what was already recorded. Any verbal communication or undocumented clinical decisions during handovers could not be captured.

2. Limited Scope

The audit was conducted in selected inpatient wards of a single tertiary care hospital. As a result, the findings may not be generalizable to other departments or institutions with different patient volumes and documentation practices.

3. Sample Size Constraint

Although the sample size (212 initial files and 100 re-audit files) was adequate for internal analysis, it may not be large enough to reflect broader compliance trends across various clinical areas.

4. Exclusion of Verbal Handover

The audit focused exclusively on written documentation. The quality and completeness of verbal handovers, which are integral in clinical practice, were not evaluated.

5. No Outcome Analysis

The audit measured process compliance only and did not assess how incomplete handovers affected patient safety, continuity of care, or adverse events. Therefore, the clinical implications of documentation gaps remain unquantified.

6. Potential Observer Bias

Data collection and interpretation were performed manually by the audit team. In cases with incomplete or unclear documentation, there may have been subjective judgment in determining compliance.

7. Time-Bound Snapshot

The audit represents a specific time frame and does not account for fluctuations in compliance over longer periods. Seasonal staff rotations or varying patient loads may influence documentation trends.

5.2 Strengths of the Study

The clinical audit on doctor handover compliance presented several strengths that contributed to the reliability and usefulness of its findings:

1. Practical Relevance

The audit addressed a critical aspect of inpatient care — the quality of handover documentation — which directly impacts patient safety, continuity of care, and clinical accountability. Its focus on real-time practices makes the findings highly relevant and actionable for hospital operations.

2. Structured Audit Tool

A standardized checklist covering 14 clearly defined handover parameters ensured uniformity in data collection. This helped reduce variability in interpretation and made it easier to measure compliance objectively across different shifts.

3. Before-and-After Comparative Design

The two-phase structure, involving both an initial audit and a re-audit after corrective interventions, allowed for a comparative analysis. This design helped demonstrate the direct impact of the interventions on compliance rates.

4. Targeted Interventions

The study incorporated low-cost, practical, and easily implementable solutions such as visual prompts, SOP reminders, and staff training. The positive results achieved through these measures underscore the strength of audit-driven quality improvement.

5. Cross-Shift Analysis

By including handovers from morning, afternoon, and night shifts, the study captured a more comprehensive view of documentation practices across different working hours, allowing for a more complete and balanced interpretation.

6. Action-Oriented Outcomes

The audit not only identified compliance gaps but also translated those insights into specific, context-based recommendations that can be realistically applied in day-to-day hospital settings.

7. Internal Validity

Since the audit was conducted within a single hospital, under consistent policy and supervision, it ensured uniformity in operational processes, strengthening the internal validity of the findings.

CHAPTER 7: CONCLUSION

This clinical audit was undertaken to evaluate the completeness and accuracy of handover documentation between doctors during shift changes in inpatient wards. The findings revealed a number of gaps in compliance with established documentation protocols, particularly in critical parameters such as time of handover, clinical event updates, procedure/consent records, and dual doctor signatures.

The initial audit reflected an overall compliance rate of 64.35%, highlighting a lack of consistency in how essential patient information was recorded and transferred. This inconsistency posed potential risks to communication, accountability, and continuity of care.

Following the implementation of structured interventions—including staff training, SOP reinforcement, and visual reminders—marked improvements were observed. The re-audit showed an overall compliance increase to 82.65%, with significant progress in previously weak areas such as time documentation, procedure recording, and accountability through dual signatures.

The audit demonstrated that simple, targeted actions can bring about measurable improvements in clinical handover practices. However, some parameters remained in the moderate compliance range, indicating the need for continued emphasis on standardization, real-time checks, and a culture of shared responsibility.

In conclusion, the study reinforces the importance of a structured, well-documented handover system in ensuring safe and seamless patient care. Handover documentation should not be seen as a routine formality but as a vital part of clinical communication. Continued monitoring, regular feedback, and periodic audits will be essential to sustain and build upon the improvements achieved through this initiative

7.1 Recommendations

While the re-audit reflected a notable improvement in overall handover compliance—from 64.35% to 82.65%—certain critical gaps persisted in specific documentation areas. To address these issues and ensure sustainable compliance, the following targeted and practical recommendations are proposed:

1. Time Field Entry

Remaining Gap:

Despite improvement, some shift entries continued to omit the exact time of handover, which is essential for legal traceability and clinical accountability.

Recommendation:

Incorporate a printed prompt such as “Time: ____” in bold near the top of the handover form. This visual cue draws attention during documentation. Additionally, during ward rounds, the use of a red pen or highlighter can help supervisors quickly verify time entries, promoting a habit of consistent recording.

2. Procedure/Consent Field

Remaining Gap:

This field was frequently marked as “N/A” or left completely blank, even in cases where procedures were pending or consents were taken verbally but not documented.

Recommendation:

Introduce a checkbox beside the field reading “✓ Tick if not applicable.” This approach encourages active acknowledgment rather than passive omission. It also reduces the tendency to bypass the field, ensuring better transparency and accountability.

3. Night Shift Entries

Remaining Gap:

The audit revealed that handover completeness during night shifts was slightly lower compared to day shifts. Fatigue, reduced supervision, and understaffing may contribute to this trend.

Recommendation:

Appoint a “handover buddy” RMO during night shifts, rotated weekly, to cross-check

handover forms before they are filed. This small peer-review mechanism can improve accountability and help catch missing fields early without placing an additional burden on already busy clinicians.

4. Signature Gaps

Remaining Gap:

Occasional cases of missing “handover taken by” signatures were noted, especially during shift changes involving new or rotating doctors.

Recommendation:

Introduce a red stamp reminder beside the signature fields with the label:

“Both Signatures Mandatory”

This simple visual marker can improve compliance by reminding both the outgoing and incoming doctors to complete the handover process formally and fully.

5. Sustaining Documentation Consistency

Remaining Gap:

Although initial compliance improved after training, a gradual decline in documentation quality was observed over time, suggesting a need for regular reinforcement.

Recommendation:

Post weekly compliance rates in the RMO duty room using simple formats like bar charts or posters. For example:

“This Week’s Compliance: 86% → Let’s Aim for 90%!”

Such visual feedback helps maintain awareness, encourages healthy competition, and reinforces the importance of consistent documentation.

6. Onboarding of New RMOs

Remaining Gap:

New RMOs often lacked clarity regarding standard handover procedures, leading to inconsistent documentation during their initial weeks.

Recommendation:

Provide a 1-page laminated SOP quick-reference guide for handover documentation.

Distribute this guide during orientation and paste copies inside RMO file cabinets and

nurse stations. This ensures immediate access to protocol and reduces reliance on verbal instructions.

Summary

These recommendations are specifically tailored to the documented gaps identified in the re-audit. They are practical, low-cost, and designed for real-world clinical settings. Together, they promote:

- **Standardization** of documentation
- **Consistency** across shifts and staff
- **Accountability** through better supervision and signage
- **Sustainability** via ongoing visual feedback and orientation

Implementing these measures will help institutionalize strong handover practices, minimize communication errors, and improve overall patient safety in the hospital environment.

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