In the wake of this medical staff changeover, I am concerned that NHS Trusts would be unable to respond to major terrorist incidents. Most doctors (F1/F2 and surgical middle-grades) were not issued with bleeps for the first 48 hours at our hospital. Some waited over a week for a bleep due to administration problems and bleeps not having been returned to the switchboard by departing doctors. In addition, major incident policy was not discussed at the induction days for any of the new medical staff – even those working in accident and emergency.

The solution – all doctors should be given bleeps as soon as they arrive in the hospital or, failing this, have their mobile phone details recorded for disaster purposes only. All doctors should be given the single-sided information sheet on major incident policy which should also be posted in areas frequented by doctors. All doctors should have staggered pre-induction visits to familiarise themselves with their new hospital layout.

With these recent events, I find it deeply concerning that some trusts continue failing to provide any training on their major incident policy and strongly agree with the authors' conclusion that more needs to be done to address this urgently. Have they considered repeating their audit?

Reference

1. <www.mmc.inquiry.org.uk>.

AUTHORS' RESPONSE

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We agree that there is still much that needs to be done to improve the preparation of doctors to respond to major incidents despite our previous audit which highlighted this need and the terrorist incidents in London and Glasgow in the intervening time. It is worth noting that during the 7 July bombings in London, the mobile phone system was not effectively functioning in the hospital where our original audit was carried out and this alone can clearly not be relied on as a sole means of communication.

Within the new structure of MMC, trainee doctors are changing jobs more frequently making it more important than

ever to have vital knowledge such as major incident policies distributed to people within structured induction sessions.

We hope to repeat a loop of the audit as we are concerned that the situation has not really improved since our original study.

COMMENT ON

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G Bhabra, S Mackeith, P Monteiro, DD Pothier. An experimental comparison of handover methods. *Ann R Coll Surg Engl* 2007; **89**: 298–300

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Audit of handover practice

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We compliment Bhabra and colleagues on a well thought-out study that highlights the issue of handover, which is becoming more relevant to the surgical community with the implementation of shift patterns of working. Their experiment demonstrated the varying reliability of handover methods and the possible loss of data which could compromise patient care.

Their evidence that a pre-printed sheet of patient data almost entirely eliminates data loss is compelling. This method, however, is time consuming and would require doctors to access a computer terminal several times during a busy shift.

At our institution, a recent audit of handover practice demonstrated an issue of poor data transfer between shifts. We designed standardised handover sheets, with fields for the required patient identifiers and clinical data. These sheets were located in clinical areas and completed by hand during shifts. Re-audit after implementation found that data transfer improved from 50.2% to 78.3%, and the proportion of injuries without a recorded side fell from 42% to 11%. Our sheets are practical, inexpensive, portable, and readily accessible to be updated during shifts and we believe this to be a good alternative to computerised handover.