IMJ
Official Journal of the Irish Medical Organisation

Ir Med J; June 2026; Vol 119; No. 6; P117
18th June, 2026

ICU Handover: A Persistent Vulnerability in Critical Care Settings

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Dear Editor,

Efficient clinical handover is fundamental to ensuring continuity of patient care. Effective communication during transitions not only reduces the risk of patient harm and missed diagnoses but also strengthens patient confidence in hospital systems. Critically ill patients frequently have complex and evolving management plans, and although intensive care units (ICUs) maintain high levels of vigilance, handovers can sometimes assume a routine and transitional character.

Transitions such as theatre-to-ICU and ICU-to-ward represent some of the most common changeovers for patients admitted to intensive care. In the absence of a consistent structure, important clinical information may be overlooked during these transfers. Recent literature highlights that ICU discharges and intra-hospital transfers are high-risk events that require structured communication and clear accountability.[1] It has been estimated that nearly 80% of adverse events are linked to miscommunication during patient handovers.[2]

To address this challenge, several structured communication tools have been developed. Frameworks such as ISBAR, I-PASS, and ICU-PAUSE have been widely adopted in ICUs worldwide and have demonstrated value in improving the quality and completeness of information exchanged during handovers.[3] However, systematic reviews suggest that while structured handover interventions improve process measures, their overall effectiveness ultimately depends on local culture, adequate training, and consistent implementation.[4]

It is also important to recognise that the transfer of information is not synonymous with the transfer of responsibility. Emerging research on ICU-to-ward transitions emphasises the need for explicit definition of clinical responsibility and contingency planning.[1] Essential aspects of patient care—such as follow-up of pending investigations, escalation of therapy, and decisions regarding limitations of care—must be clearly assigned. In practice, however, reliance on templates alone may fail to prioritise critical patient information appropriately.

Environmental factors also influence the quality of handovers. Shift changes are often time-pressured and prone to interruptions. Organisational research has demonstrated that workload, competing priorities, and cognitive stress can significantly impair communication

quality.[4] Institutional commitment is therefore necessary to address these barriers, including the provision of protected time for handovers across clinical settings.

ICU handover should be regarded as a core clinical competency. Formal training and assessment in structured handover practices may help ensure that critical information is consistently communicated. Rather than relying on a single rigid tool, institutions should encourage the use of flexible frameworks alongside periodic audits to identify opportunities for improvement.

Ultimately, every handover should be approached with the same diligence as any clinical intervention. Indeed, every handover should be regarded as a life-saving intervention.

Declarations of Conflicts of Interest:
None declared.

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