

Innovative Approaches to Enhancing Clinical Handover

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Introduction

Safe health care delivery for patients depends on effective communication between health care providers. The transfer of information between health care providers ideally should contain all relevant information, be accurate, timely, unambiguous and clearly understood. Breakdowns in communication have been identified as a significant contributing factor in serious adverse events in health care.

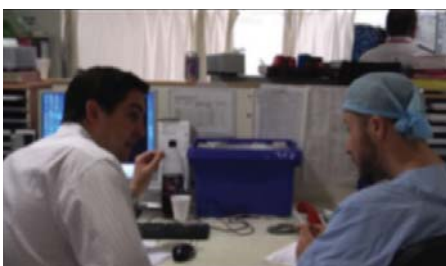
Definition

The definition of clinical handover provided by the UK National Patient Safety Agency and adopted by the Australian Medical Association in their 'Safe Handover: Safe Patients' guideline importantly centres on accountability and responsibility (not just information transfer):

Definition: "the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis"

Accountability refers to the act of accepting, acknowledging and assuming the responsibility for action/decision, encompassing the obligation to report, explain and be answerable for resulting consequences.

Responsibility is an action that acknowledges the requirement to complete/fulfil an action/decision, with a voluntary element (see Schedler, Andreas, 1999).



Clinical handover in practice is a highly variable activity that is not well understood and for which there are multiple models in different clinical settings and across clinical disciplines. There is not a well established evidence base for a best practice handover process. As a result there is also a lack of information to help clinicians and managers to better understand clinical information flows or how to make handover a more consistent and reliable part of patient care delivery.

Basic principles of handover

Handover of responsibility for a patient's care from one provider or team of providers to another, often occurring at points of transition across settings, services, or levels of care, requires the effective and efficient communication of patient-specific information. These transitions or handover situations also arise due to the need to organise clinical work into manageable shifts. Handover communication takes as many forms as there are handover scenarios.

Handover varies between settings. Some examples of factors that can influence handover are:

- the combination of medical and nursing and other clinical and non-clinical staff involved in the handover
- the available resources of the facility (e.g., time, space or access to electronic tools)
- types of patient conditions and patient acuity
- decision making about care
- an assessment of the patient

All handovers include:

- sharing information about patients, both historical and most importantly about likely future events
- the opportunity to ensure that the staff taking over understand the information
- transfer of accountability and/or responsibility for a patient or group of patients



It may be helpful (following Lillrank and Liukko, 2004) to view each handover scenario as a varying combination of:

- Standard processes (repetitive work such as some diagnostic tests with well defined boundaries enabling the development of a standard operating protocol)
- Routine processes (the majority of handover situations and involve patient assessment, clarification of the treatment plan and selection from alternatives)
- Non-routine processes (such as handover of the patient with a changing or rapidly deteriorating condition where there is uncertainty, a search for new information, and selection from alternatives requires constant adaptation and adjustment.

A better understanding of what people do during handover can inform development of tools and strategies to reduce gaps in the continuity of care and improve the safety of care delivery.

In order to develop effective tools and processes common data need to be recorded in each respective work domain where clinical handover is observed.

Studying Clinical Handover for Improvement

1. Common Data that can be recorded when clinical handover is observed:

- The standard time(s) for handover
- The location(s) in the work area where handover is conducted
- The participants in handover communication (outgoing and incoming)
- The length of time taken for handover (a range in minutes)
- Whether a common structure or set of rules are employed (eg, read-back)
- The minimum information transferred (clarity, brevity, and level of filtering required)
- What is excluded from handover (and the existence of other means for addressing what is not included)
- The level of interaction between staff members (eg, do new caregivers ask questions and receive responses?)
- The functionality of tools used (electronic media, checklists, handover sheets)
- What type of durable record is used and how it is accessed by the health care team.

2. The context for handover communications

The context for any handover also needs to be studied. The points below are examples of context issues:

Patient Care Needs

Effective and efficient handover of responsibility for a patient's care must ensure effective communication of essential information without interfering with the continuity of the patient's care. It is therefore important to identify any patient care needs that must be provided for during the handover process, such as the following:

- Physical transfer of the patient to a new setting or service

- Specific treatments, such as medications, that must be provided at a specific time
- Unanticipated needs of the patient for assistance (meals, toileting, etc.)
- Unanticipated emergencies that might arise

Need for multi-disciplinary or multi-professional handover

Most patient care involves more than one professional discipline. Sometimes quality patient care is best delivered by a multidisciplinary handover process. Where multiple medical sub-specialities are involved in a patient's care there are risks of incomplete handover and unsafe care. Ways to minimise these risks need to be considered as part of the context for handover communications.

Relationship of handover to the medical record

This will vary depending on the presence or absence of full or partial electronic records, the nature of the paper records and the type of handover. Handover information may be ephemeral in nature (ie of no interest in 8 hours time) or may be regularly referred to again (eg a discharge summary from an intensive care unit for a patient transferred to the ward). The nature of the handover information and the structure of extant records should determine this relationship.

The role of the handover in decision making and detection of the deteriorating patient

This will vary considerably. The presence or absence of processes for detection and management of the deteriorating patient will particularly influence the nature of after-hours medical handover.

Patient and family involvement

The effectiveness of handover communication will, in some situations, be enhanced by participation of the patient, carers and family. This involvement should be considered in the design of these standardised handover processes and, when appropriate, encouraged.

Quotes from staff at a Sydney metropolitan hospital Emergency Department:

Nurse: "No matter where you work, handover is always a problem."

Nurse - after being preoccupied with one particular patient: "I don't know any of my patients and I have to handover in a minute."

Doctor: "Nothing worse when getting a handover - the phone rings!"



Design Checklist to assist in the development of Standardised Operating Protocols for Clinical Handover Scenarios

<p>Have the minimum requirements for handover been met?</p>	<ol style="list-style-type: none"> 1. Is information shared about patients, both historical and most importantly about likely future events? 2. Is there the opportunity to ensure that the staff 'taking over' understand the information? 3. Is the transfer of accountability and/or responsibility for a patient or group of patients clear? <ul style="list-style-type: none"> • Face to face handover is safer, and should be used whenever possible (electronic or paper tools should only be support tools)
<p>Patient</p>	<ol style="list-style-type: none"> 4. Has the involvement of patients and carers in the handover been considered? <ul style="list-style-type: none"> • Their participation is particularly important when there are transitions in care, changes in routine, movement of patients or if the handover forms a focus for making new management decisions. Patients and or carers must also be kept informed of changes in clinical understanding and management plans (eg medications and procedures), and this communication should be recorded in the medical record. 5. Does the handover include the patient's concerns and relevant psycho-social issues?
<p>Task and Technology</p>	<ol style="list-style-type: none"> 6. Does the handover information contain an explicit, practical, minimum data set that is agreed and understood by all participants (SBAR and the NZ JUMP can provide more detailed guidance)? <ul style="list-style-type: none"> • This data set must include correct and accurate identification of the patient, together with a brief history. • The data set should emphasise recent changes in the patient's care. 7. Can the handover information be made accessible to staff to refer to when needed? 8. Should the handover information be stored permanently, as part of the medical record, or in other ways?
<p>Individual Clinical staff</p>	<ol style="list-style-type: none"> 9. Are clear lines of accountability and responsibility for care established and understood? 10. Is the senior clinician responsible for the patients care clearly identified at all times?
<p>Clinical Teams</p>	<ol style="list-style-type: none"> 11. Is it possible or appropriate to use the interaction during handover to provide an opportunity for active participation and decision making by relevant members of the health care team? 12. Is a leader clearly identified? 13. Is a multi-professional handover appropriate? <ul style="list-style-type: none"> • Some handover should include all members of the health care team. This is particularly important where a patient is being cared for by multiple clinical teams of differing clinical specialties.
<p>Work Environment</p>	<ol style="list-style-type: none"> 14. Is workplace training in clinical handover (including teamwork and communication) available? 15. Is it possible to develop methods for ongoing observation, monitoring and evaluation of handover as part of normal work? <ul style="list-style-type: none"> • These should form part of continual improvement of the process • A guide to developing such methods forms Appendix B
<p>Organisation and Management</p>	<ol style="list-style-type: none"> 16. Is there a system commitment to clinical handover at the senior executive and senior clinician level to ensure lines of accountability are clear and that appropriate resources (particularly staff time) are allocated for the handover?
<p>Institutional Context</p>	<ol style="list-style-type: none"> 17. Do staff share an understanding about the ethical and relevant legislative requirements to ensure appropriate confidentiality of patient information during the handover? <ul style="list-style-type: none"> • The safety of handover can be reduced by concerns arising from misconceptions about these requirements unnecessarily restricting the transfer of information.

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