

Clinical Handover

Do we need it?

**What are the implications of
not having it?**

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Overview

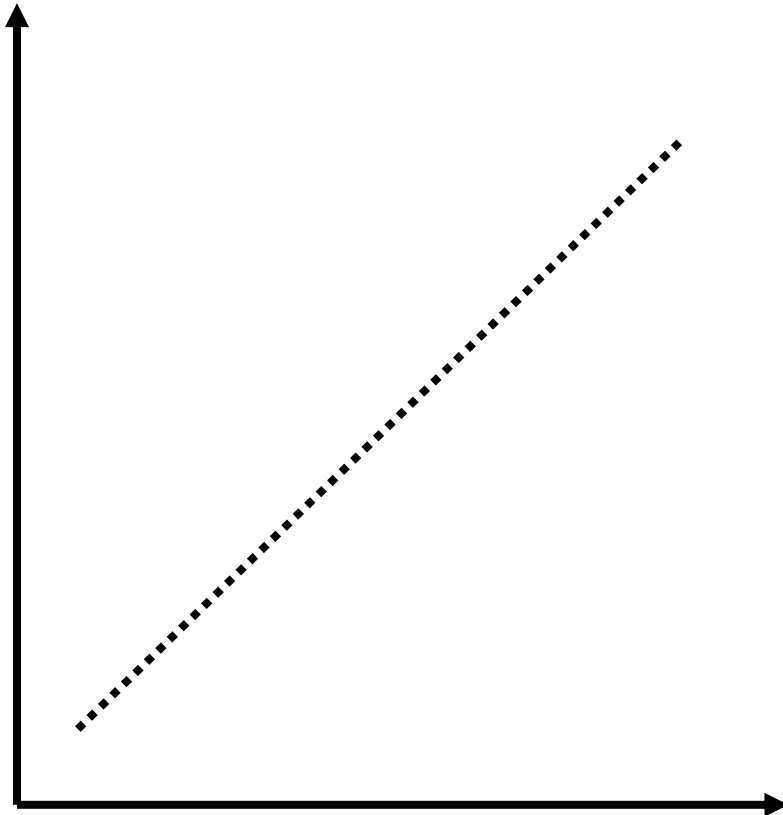
- Prevalence and effects of poor handover in medicine
- Factors which predispose to poor handover
- Incentives for improving handover

Dimensions of clinical handover

- Clinical handover: inter-clinician communication occurring at care interfaces:
 - Change of shift or roster within caring team
 - Handoff from one disciplinary team (eg doctor team) to another (eg nurse team)
 - Transfer of patient care from one specialty team (eg medical) to another (eg medical to surgical, ICU/CCU to general ward, etc)
 - Transfer of patient care from one institution to another
 - Transfer of patient care from hospital setting to community setting
- Handover procedures adapted according to:
 - Specific interface
 - Needs of participants
 - Intern-intern, intern-reg, reg-reg, EN-EN, EN-NUM

Effects of discontinuity

Handovers



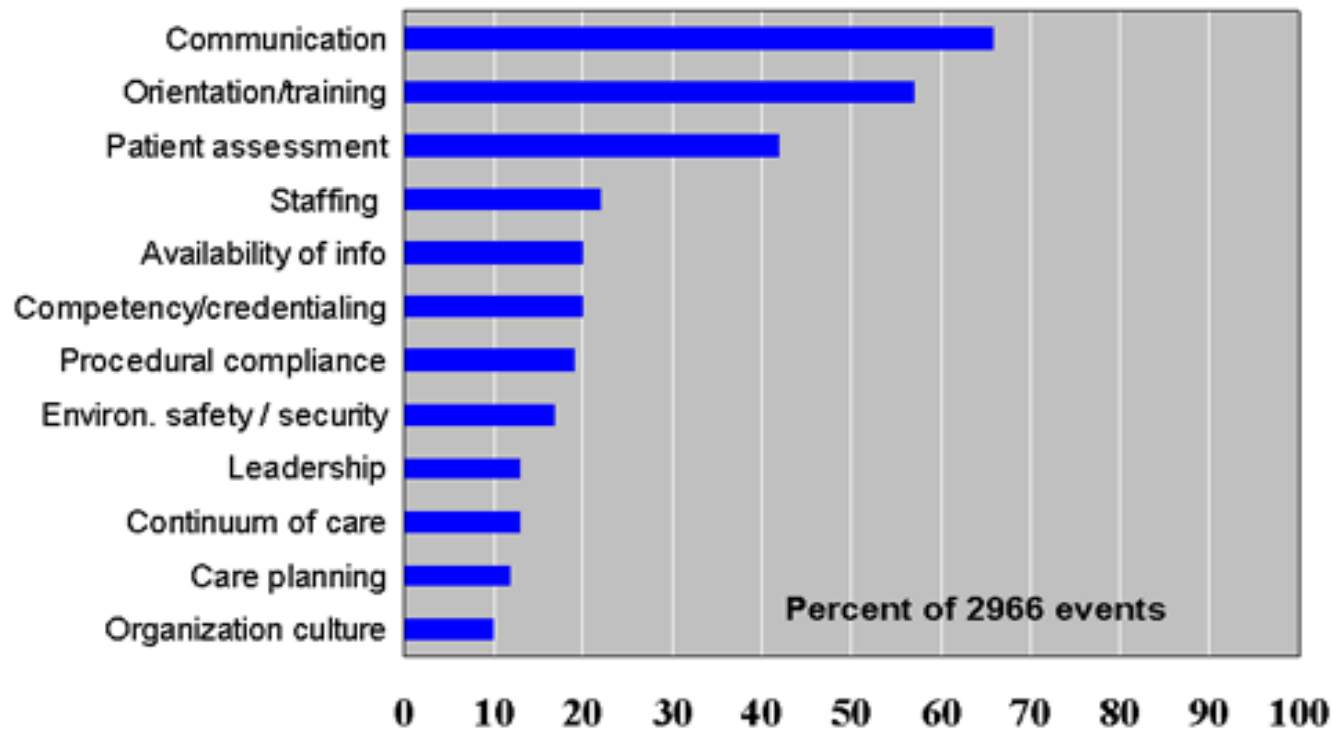
Decrease in hours worked

- Decreased duty hours increases discontinuity
 - 15 handovers per patient for 5 day LOS
 - 300 handovers per month per intern
 - 40% increase in last 5 years

Effects of ineffective handover

Root Causes of Sentinel Events

(All categories; 1995-2004)



Effects of ineffective handover

- Increased risk (3.5 fold) of preventable adverse events

Petersen Ann Intern Med 1994

- Delays in diagnosis

Pronovost J Crit Care 2002

- Decreased patient satisfaction

Bark et al Qual Health Care 1994 Griffith JGIM 1997

- Increased LOS and tests

Gottlieb Arch Intern Med 1991 Lofgren JGIM 1990

- Delays in test ordering and increased in-hospital complications

Laine JAMA 1993

Communication failures in clinical handover

- **Missing or incorrect information**

- **Inaccurate initial diagnostic evaluation**

Beach Acad Emerg Med 2003

- **Inadequate assessment of clinical condition**

Anwari 2002, Priest et al 2000

- **Medication omissions/commissions**

Kaboli Am J Man Care 2004

- **Code status**

Lee et al JGIM 1996

- **Inconsistent or incorrect translation**

Petersen et al 1994, McKnight et al 2001

- **Incorrect problem framing**

- ‘Covering’ clinician rather than usual doctor or team

- **Professional disagreement**

- Exacerbated by no face-to-face interaction

UK Junior Doctors Initiative

**A New
Generation
of Junior
Doctors?**



UK Junior Doctors Initiative



That's not what I meant...

- The most important outcome of a handover process is the message the receiver ends up with
- Ensure you fully support handover processes within your organisations
- It is vital that **YOU** don't end up saying, *when its too late*, “**That's not what I meant...**”

Erroneous translation

29 errors detected during requested read-back of 822 lab results.

Description of Errors

Description of Error	No. (%) of Occurrences
Incorrect name of patient	10 (34)
Incorrect test result	9 (31)
Incorrect specimen/test repeated	6 (21)
Recipient refused to repeat message	4 (14)
All	29 (100)

What predisposes to poor handover?

- Written or Verbal
 - Process not standardised in:
 - Aims and content
 - Time
 - Place
 - Participants
 - Failure to recognise/address facilitators/barriers to handover
 - No staff training in handover
 - No audit or review of handover

Anatomy of poor handover

- Failure to standardise
 - Templates, handover scripts
- Lack of updated information
 - Medications
 - Recent investigation results
- Interruptions
 - Protected time/space
- Limited access to computers/phone
- Missing participants
 - Multidisciplinary wherever possible
- Limited face-to-face verbal update
 - With interactive questioning
 - With read-back to ensure accuracy
- Lack of task prioritisation
- Limited verification of understanding
- Limited bedside handover
 - Positive**
 - Frame of reference (eyeballing patient)
 - Sense of ownership (introducing patient to handover doctor)
 - Negative**
 - Patient anxiety with jargon
 - Sensitive issues
 - Time consuming
 - Limited access to computers
- Over-emphasised privacy concerns

Patterson et al Int J Qual Health Care 2004
Lee et al JGIM 1996
Petersen et al Jt Comm J Qual Improv 1998
Van Eaton et al J Am Coll Surg 2005
ACSQHC July 2005

Incentives to better handover

- Every hospital department should have explicit handover procedures
- Standardised procedures nation-wide would be preferable
- Managerial support for:
 - Overtime required
 - Template production; computer access; information systems
 - Training resources National Patient Safety Education Framework 2005
- Clinician buy-in by emphasising:
 - Improved quality and safety of care
 - Educational, feedback and mentoring opportunities
 - Team building
 - Efficiency dividends
 - Flexibility according to special needs

Minimum dataset in clinical handover

Clinical background

- List of patients ranked according to urgency
- Current major issue(s)
- Brief HPI and listing of active problems by system
- Recent procedures or significant events
- Current concerns and baseline status (eg mental/behavioural status, cardiopulmonary, vital signs, key investigations – FBC, MBA, ECG, etc)

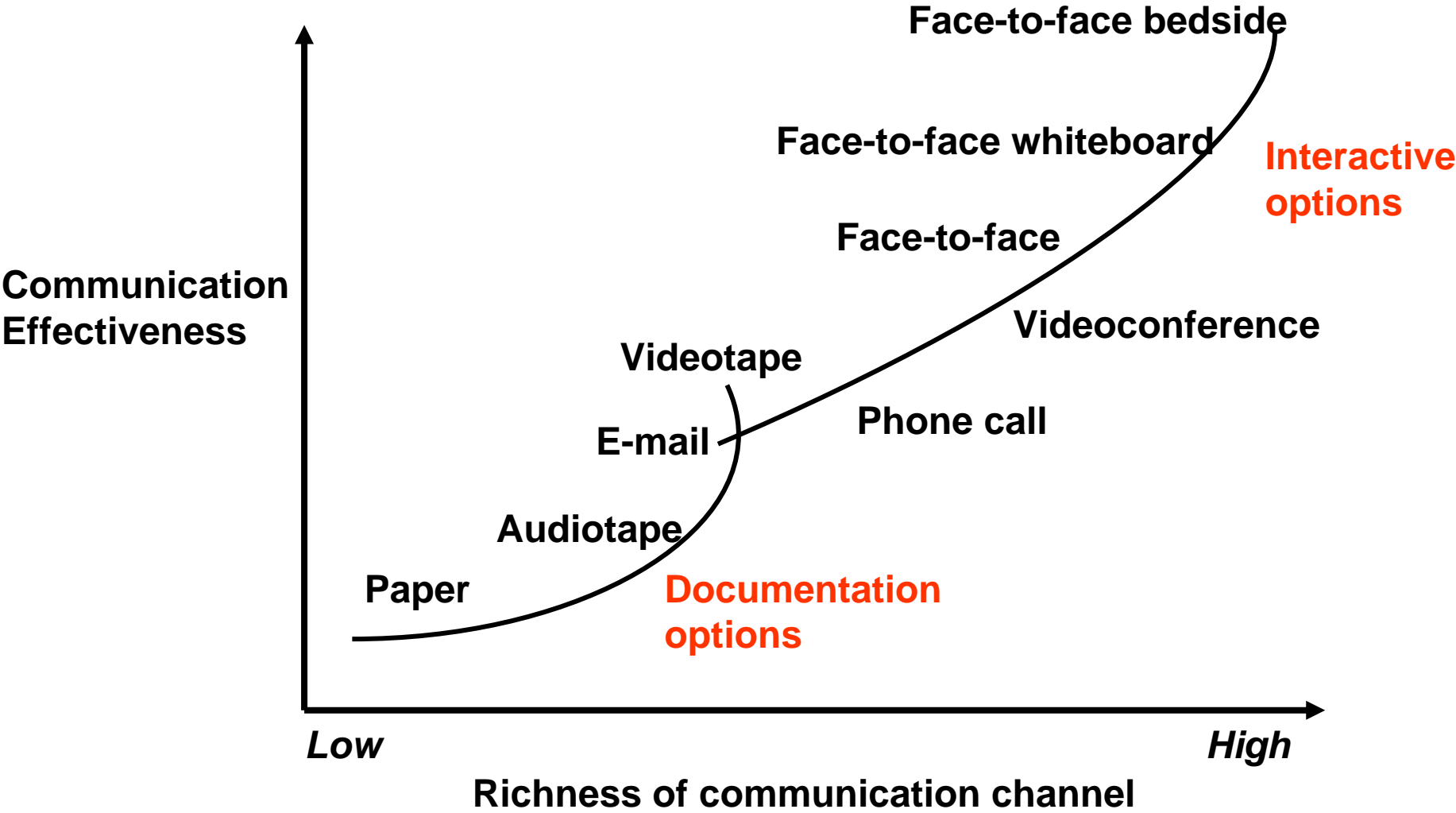
Tasks (what needs to be done, or might be anticipated)

- Specific actions using ‘if-then’ statements, including criteria mandating repeat review
- Warning of pending information (eg investigation results, consultant recommendations, review by another specialty team, etc)
- Contingency planning – what may go wrong, what to do about it, and who to call
- What has or has not worked before (eg response to frusemide, analgesia)

Context

- Code status (DNR; recent changes or family discussions)
- Difficult family or psychosocial situations, staff concerns re safety

Enriching communication



Verbal handover

Where should handover occur?

- Designated place free of excessive noise and with phone and computer access
- Minimise disruptions (urgent pages only)

When is the optimal time for handover?

- Designated time when both parties can be present and pay attention (requires adequate overlap of shifts/rotas)
- Sufficient time (15-30 mins) for interactive questions and bedside review if necessary

How should verbal communication be performed?

- Face-to-face allowing for questions
- Verbalise data in standardised format for each patient
- Read-back for all essential 'to-do' tasks
- Adjust length and depth of review according to baseline knowledge of parties involved

Written handover

Standardised template

- *Identification data*
 - Patient name, age, gender, UR no, ward/bed no.
 - Admission date, primary consultant
- *Clinical minimum dataset*

Reliable transmission

- *Sent to, received, read, understood, and acted upon by incoming clinician*
- *Can be combined with verbal handover serving as a take-away summary*

Sample clinical handover sheet

Patient ID (label)	Ward/ bed	Consultant	Diagnoses/ problems	Ix	Rx	Plan

- Could be computerised on PDAs

What can you do to improve handover?

- Get used to using the written MDS
 - Stop relying on memory
- Test to make sure the recipient understands the issues and has had any doubts, uncertainties clarified
- Present a contingency plan
 - If this happens do this and contact this person
- Pass it on
 - Make sure the next person in the chain is aware of the plan

Situation-specific handover guidelines

- Emergency medicine
 - Includes when registrars can leave their shift based on number of patients waiting in ED

Prince Alfred Hospital Guidelines 2003
- Doctor-nurse handover
 - Interdisciplinary ward rounds Zwarenstein et al 2002
- Interhospital transfers
 - Reasons for transfer; structured referral summaries
- Discharge/outpatient care
 - Structured discharge summaries, clinic letters, ED letters

Situation-specific handover guidelines

Nurse-nurse handover

Bernick et al 1994, RCH 2003, Currie 2002, Hansten 2003, Donoghue 2005

Current problems

- Handover occurs in office or station away from the patient.
- Inefficiency of nurses coming in one or two at a time to relay information to those on the next shift
- Casual or agency nurses with no patient history knowledge, organisational familiarity
- Time allocated for handover considered excessive
- Patient information handed over not at the right level – seen as superfluous or insufficient

Strategies

- Patient communication and input welcomed
- Training in handover competencies and teamwork
- Minimum data sets, checklists and IT content proformas
- Data sheets with flags that trigger appropriate actions

Situation-specific handover guidelines

Hospital-GP handover ACSQHC 2005

- GP informed of admission and discharge (transfer)
- Flags inherent in admission handover to trigger telephone contact if deemed necessary and appropriate action during admission
- GP decides if further input of information required
- Electronic discharge/transfer summary to GP
- Audits of electronic discharge/transfer information

Situation-specific handover guidelines

Ward-OT handover

- Clarification of informed consent, explicit postoperative instructions and carer information
- Written checklists and instructions need to be a part of handover to and from ward/OT. Patient concerns and carer requirements need to be documented
- Training on improving communication handover practices is required
- Clinical audits of this transition needed

Role of computerised handover

- Web-based handover integrated with electronic medical records Kim et al 2003, Moen et al 1998, Menke 2001
- Caution: IT solutions cannot substitute for a 'successful communication act'

In an emergency room the replacement of a phone call for critical lab results with an electronic results-reporting system with no verbal communication resulted in 45% (1443/3228) of urgent lab results going unchecked

Ash et al JAMIA 2004

Kilpatrick, Holding BMJ 2001

Evaluating effectiveness of clinical handover

- No audit tool in literature
- Sentinel event analysis (pre/post)
- Observational studies
 - 360° practice review
 - Time-motion studies