

*Is there a Framework for improving
Patient Handover*

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Extensive Previous Work

- Context specific
- Discipline specific
- Observational
- Outcomes??
- Australian Council on Safety and Quality in Healthcare – 2005
 - “Passing the Baton of Care – the Relay of Patient Care”





Passing the baton

- This concept is wrong
 - Not one person to another but rather coordinated and non-linear





The purpose of handover

- In relation to direct patient care
 - To provide information transfer and continuity of care^{1,2,3}
 - To prioritise tasks^{1,2}
 - To plan for further care^{1,2}
 - To review unstable patients^{1,2}
 - Reminder to check results³
 - Debriefing³
 - To provide a fresh perspective therefore reduce fixation errors⁴
 - To empower patients with information and a sense of involvement in their own care⁵





The purpose of handover

- At a wider level
 - To educate and supervise staff ^{3,6}
 - To review policies ⁶
 - Bed management ^{6,7}
 - To foster teamwork e.g. enhance group motivation and morale, social support, socializing ⁶
 - As a ritual function: initiation into the language, practice and culture ⁶

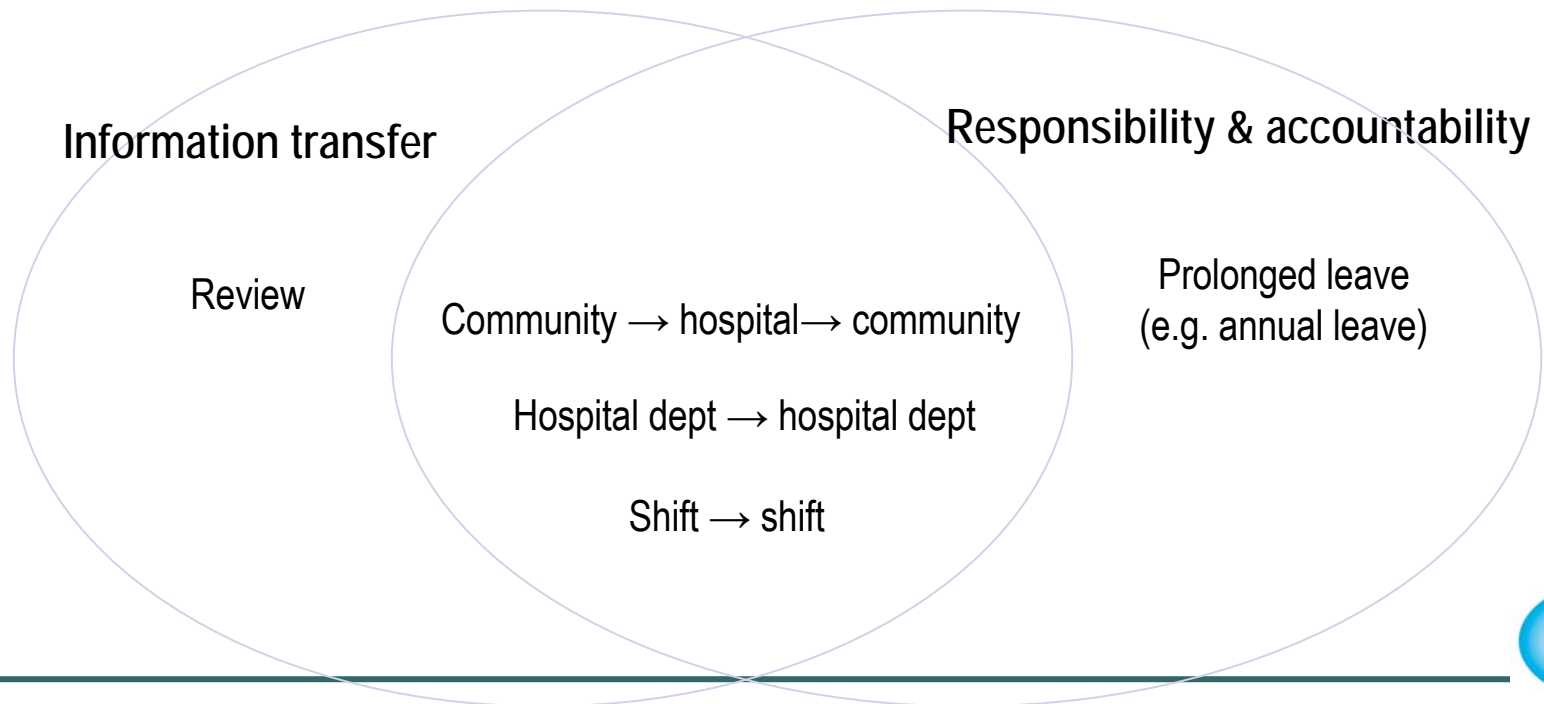




The purpose of handover

Handover is *'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.'*¹

Clinical handover refers to the transfer of information and professional accountability and responsibility between individuals





System

Teamwork
Organisational culture
Leadership

Information transfer

Review

Community → hospital → community

Hospital dept → hospital dept

Shift → shift

Responsibility & accountability

Prolonged leave
(e.g. annual leave)





System

Teamwork

Organisational culture

But where do the problems occur?

Where should we focus our resources?

**And how do we measure whether it has
made an impact?**

Shift → shift





Questions

Information transfer

1. What information is currently communicated?
2. Is there a minimum dataset of information that must be communicated?
3. In what format should information best be communicated?
4. What is the best vehicle by which it should be communicated?
5. Where is the best place to transmit information?





Questions

Responsibility and accountability

1. Are junior staff accepting responsibility at handover for patients they do not have clinical skills to manage?
2. Are issues escalated appropriately at point of handover?
3. Are there clear guidelines for transfer of responsibilities between healthcare providers?
4. Is responsibility/accountability documented?
5. Responsibilities in teams?





Questions

System

1. What can be done at a system level to promote effective transfer of information and accountability?
2. What political factors influence the system's approach to managing handover?
3. Professionalism vs industrial model of care?





Policy Gaps

Information transfer

- Need to have a good definition or framework for studying handover
- Need to standardise definitions
- Need greater commitment at hospital, jurisdictional and national level to research, develop and test systems to support handover
- Need to investigate how this work should be prioritised

Responsibility/ accountability

- Need to know how many clinicians are credentialed and whether delineation of responsibility is mentioned
- Work is needed to identify whether it is necessary to make explicit the responsibility / accountability held by clinicians e..g. in contracts

System

- Little evidence on whether there is a culture of encouraging/ tolerating escalation of issues?
- Need to investigate whether staffing levels /mix appropriate to ensure that sick patients are adequately managed?
- Need to know whether credentialing is standardised at jurisdictional or national level





Practice Gaps

Information transfer

- Need to know what information needs to be handed over
- Need to know whether standardisation of work processes reduces need for handover
- Need to know what format data should best be presented
- Need to know best vehicle in which to deliver handover

Responsibility/ accountability

- Need to know whether junior staff are accepting responsibility at handover for patients they do not have clinical skills
- Need to know reasons why issues don't get escalated

System

- Need to know whether a good culture/ team influences handover
- Need to know how to measure good teamwork
- Need to know at a jurisdictional / national level where handover is good
- Need to know what tools for standardising care delivery are being implemented and the impact on reducing information loss





Evaluation Gaps

Information transfer

- Need to know how to best measure a successful and poor handover (process vs outcomes measured)



Responsibility/ accountability

- Need to know how best to assess culture within an organisation

System

- Limited work on sustainability, generalisability and transferability of projects demonstrated to improve information transfer





Where to now?

- We want to develop a research framework
- Identify gaps
- Initiate high priority projects

