Handover in Australia

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13 November 2012
Or.....
Dickens Disasters & Doctors
“Electric communication will never be a substitute for the face of someone who with their soul encourages another person to be brave and true.”

From The Wreck of the Golden Mary
Charles Dickens (1812-1870) British novelist
...I admire machinery as much as any man, and am as thankful to it as any man can be for what it does for us. But, it will never be a substitute for the face of a man, with his soul in it, encouraging another man to be brave and true...
Why does clinical handover matter? Or... Ongoing communication disasters?

Research has identified that:

- Ineffective communication is a major cause of critical incidents.
- The financial cost of critical incidents in Australia resulting from communication breakdowns or misunderstandings is estimated to be over $600 million pa.
- Poor clinical handover communication contributes to discontinuity of care, adverse events and malpractice claims.
- Communication errors found too be responsible for twice as many deaths as clinical inadequacy.
Poor communication fuels rise in NHS complaints

By Caroline Parkinson
Health editor, BBC News website

"Careless", "insincere" and "unclear" communication has fuelled a surge in complaints against the NHS in England, the health service ombudsman has said.

Her report says the NHS needs to improve the way it deals with patients unhappy with the care they have had.

It also highlights an increase in complaints about independent providers offering care to NHS patients.

A patients' group said the NHS needed a "cultural change" in the way it handled complaints.

The health service ombudsman is a "last port of call" for people unhappy with their NHS care or with how a complaint has been handled locally.

In all, it received 16,333 complaints in the year 2011-12.

But just under 11,000 of those were redirected to other organisations or back into the NHS complaints system.

Another 1,000 were withdrawn by the complainant.

The ombudsman investigated 4,399.

'Clear shift' needed
Is this your handover experience?

“unstructured, informal and error prone, with the majority of doctors noting that there is no standard or formal procedure for clinical handover”

Australian doctor describing handovers in his hospital, 2005*
National Standards & Guidelines
1. **Governance for Safety and Quality in Health Service Organisations** which describes the quality framework required for health service organisations to implement safe systems.

2. **Partnering with Consumers** which describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care.

3. **Preventing and Controlling Healthcare Associated Infections** which describes the systems and strategies to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise the consequences.

4. **Medication Safety** which describes the systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.

5. **Patient Identification and Procedure Matching** which describes the systems and strategies to identify patients and correctly match their identity with the correct treatment.

6. **Clinical Handover** which describes the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient’s care is transferred.

7. **Blood and Blood Products** which describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.

8. **Preventing and Managing Pressure Injuries** which describes the systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur.

9. **Recognising and Responding to Clinical Deterioration in Acute Health Care** which describes the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.

10. **Preventing Falls and Harm from Falls** which describes the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.
How important is handover elsewhere?

- World Health Organisation - one of the ‘High 5’ patient safety initiatives*
- Australian Commission on Safety & Quality in Healthcare – clinical handover has been one of their key priorities since 2007
  - National Clinical Handover Initiative Pilot Program
  - National Safety & Quality Health Service Standards

Improving patient safety, experience and outcomes

Effective Clinical Communication in Handover

Delivering a Healthy WA
ECCHo project aims

1. Investigate the range and complexity of clinical handovers nationally.
2. Identify features of effective spoken and written handovers.
3. Work collaboratively with healthcare professionals to evaluate, reflect on and develop their own clinical handover practices.
ECCHo project research partners

A national interprofessional collaboration

* University of Technology, Sydney (lead University)
* Curtin University, WA
* Adelaide University
* Flinders University
* Melbourne University
* University of Queensland
* ACT Government Health Directorate
* WA Department of Health
* NSW Department of Health
* SA Department of Health
EFFECTIVE CLINICAL HANDOVER COMMUNICATION

Improving Patient Safety, Experiences and Outcomes

PILOT STUDY: The Canberra Hospital Study
Nursing Handovers

PILOT STUDY: The Campbelltown Hospital Study
JMO Handovers

WA Country Health Service
In partnership with
Royal Perth Hospital

Public Report on Pilot Study
April 2009

Improving Clinical Handover
in Inter-hospital Patient Transfers

Presented to:
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

Clinical Handover Initiative (RF1 3760007)

Delivering a Healthy WA
Each state’s research focus

**NSW**
- Handovers (electronic, phone, written) when patients are transferred from the Emergency Department (ED) to a ward.
- Up to three longitudinal case studies following single patient journeys from triage in the ED to their transfer to the High Dependency Unit.

**ACT**
- Handovers when patients are transferred from the ED to a general medical ward and when they are transferred out to another ward, to the community or to another hospital.

**WA**
- Handovers (Teleconference & written) of patient emergency transfers from two regional EDs to a metropolitan public hospital.

**SA**
- Clinician-to-clinician handovers in mental health and the journey of mental health clients from entry to the ED onwards.
Methodology

Qualitative mixed methods

- Ethnographic observations on site
- Interviews with clinicians and managers
- Linguistic analysis of Audio and video recording of handovers and associated communication
- Participatory redesign of handover to improve practice
- Provide video-reflective feedback to participants
- Chart review of medical records across patient journey’s
Handover is important for:

- Patients
- Clinicians
- Accreditation

We know how and why this process can fail...

We know why we need to improve this process...

We need to ensure this knowledge guides our practice...

Every Patient Every Time
"Take nothing on its looks; take everything on evidence. There's no better rule."
- Charles Dickens, Great Expectations
Thank you

Delivering a Healthy WA