Government of **Western Australia**
Department of **Health**

Handover in Western Australia

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What's the situation?

Poor handover communication and documentation significantly contributes to adverse events and even patient deaths

The WA Clinical Handover Policy (the policy) mandates the implementation of key principles and a prescribed structure for all handovers initiated within WA Health services

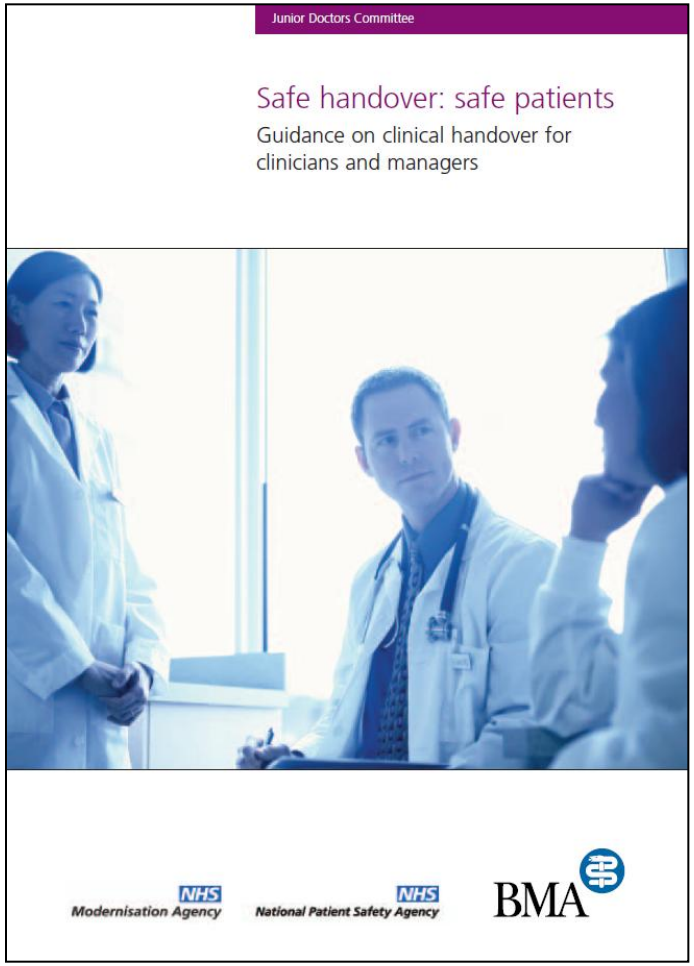
iSoBAR

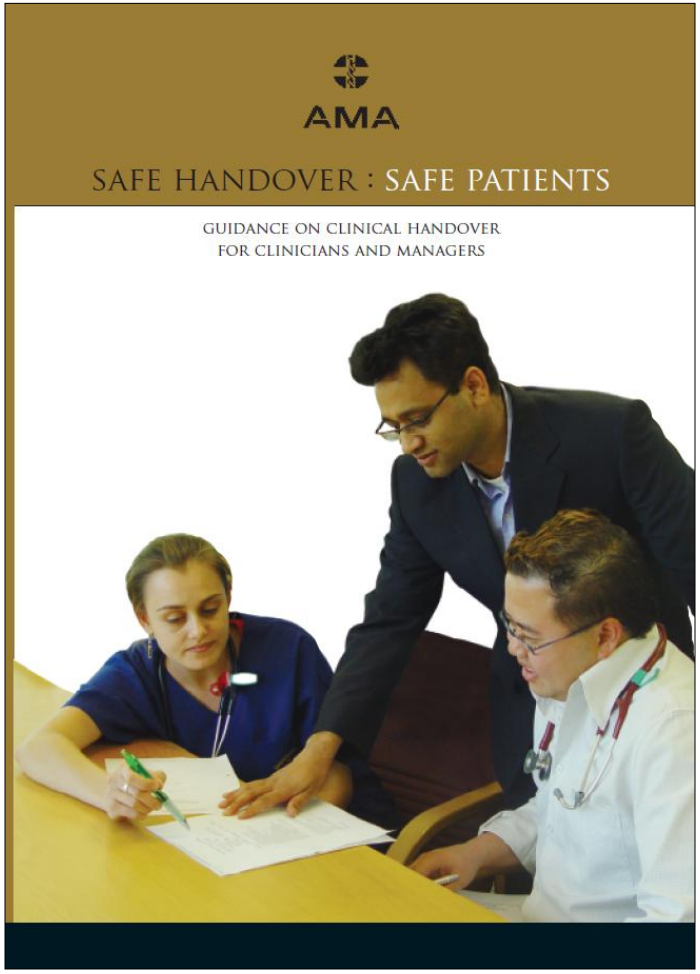
Background:
What's it all about?

- Australian Commission on Safety and Quality in Health care
- Research completed Australia wide showed varied processes for handover affecting the safety of patients.
- National consensus statement RRCD
- WA roll out of standard process for giving safe handover - iSoBAR

Clinical Handover
ACSQHC

Safe Handover: Safe Patients, 2006





Why now?

- Increasing complexity
- Increased handovers
- Examples of poor communication
  - Blue spells
  - Runover

Protect the patients

- Effective handover is vital in protecting patient and client safety. Evidence indicates that ***ineffective*** handover can lead to:

- incorrect treatment
- delays in diagnosis and treatment
- adverse events
- increased length of stay
- increase in expenditure
- unnecessary tests, treatments and communications
- patient complaints
- malpractice claims.

- *Standardisation of handover, as part of a comprehensive, system wide strategy will aid effective, concise and inclusive communication in all clinical situations and contribute to improved patient care*

Verbal & Telephone handover

- Have the information ready. Know what you are going to say!
- **i:** Identify yourself/the patient
- **S:** Why are you calling, briefly state the reason/problem. How severe is it? State the admission date and diagnosis
- **o:** What are the current observations? Any IV lines/drains
- **B:** Information related to the patient. Current Meds, allergies IV fluids, test results (date and time done-comparison to previous results) Resuscitation status. Relevant social information
- **A:** What is your assessment? Given the situation, what needs to happen? What are you wanting? Review, advice, orders or transfer? What is the level of urgency? What have you done so far? What is the plan?
- **R& R** What has been recommended? Clarify and check the for shared understanding. Who is responsible for what and by when

Remember to document

What next?

- **Role out of CH policy - Sept 2011-May 2012**
- **OPH Policy - Oct 2011**
- Review of patient related handover documentation in all clinical areas. Sept – Dec 2011
- Implementation of Escalation stickers for patient notes - Order
- Clinical, Allied Health and Medical staff to work together on ward based handovers/huddles Oct –Dec 2011
- New data system – iSoBAR handover sheet development and trial by Ward 4. Oct 2011- Jan 2012
- Roll out of data system education to clinical/provider inc: JMO & CNM after hours groups. Jan-March 2012
- Implementation of bedside handover –face to face in all areas- May 2012
- **May-June 2012 Clinical Handover processes fully operational**
- Audit processes 3 month intervals

What difference will it make?

- Increase accountability and responsibility of individuals and teams
- Increase the quality of the handover of information
- Increase patient safety – reduce adverse events and Clinical incident forms
- Improve correct clinical coding – ABF – better funding for Service episode
- **Keep our patients safe!**

How are we doing?

In 2011/12:

- 83 patients sustained significant or severe harm as a result of staff miscommunication of clinical information*
- an additional 728 patients sustained moderate harm*

* Based on all CIMS and SAC 1 reports submitted to the Patient Safety Surveillance Unit for the period 1 July 2011 and 30 June 2012

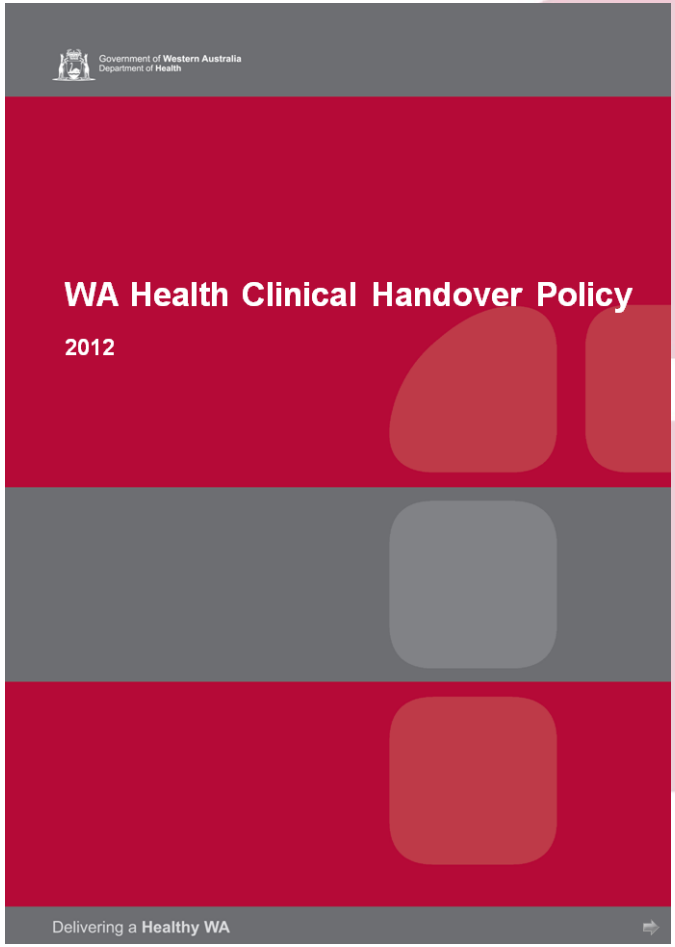
SAC 1 Data: Clinical Incidents with Communication as a Contributory Factor

During July 2011 and June 2012, 76 of 123 (62%) SAC 1 clinical incident investigation reports submitted identified communication as a contributory factor.

- SAC 1 Incidents categories where communication was identified included:
- The suicide of a patient in an inpatient unit
- Maternal death or serious morbidity associated with labour or delivery
- Retained instruments or other material after surgery requiring reoperation or further surgical procedure
- Haemolytic blood transfusion reaction resulting from ABO incompatibility
- Procedures involving the wrong patient or body part
- The absconding of a mental health patient
- Delay in recognising / responding to clinical deterioration
- Fetal complications
- Misdiagnosis and subsequent mismanagement
- Patient absconding with adverse outcome
- Unexpected death of a mental health patient
- Other incidents resulting in serious harm or death of a patient.
- Sixteen of the 76 reports referred to handover
- three investigation reports contained the term ISOBAR

WA Clinical Handover Policy

- Involve patient where practicable
- Standardised format (iSoBAR)
- Senior clinician led
- Include all appropriate staff
- Document patients of concern



Don’t panic

- Change the culture
- Not all patients need handover
- Clinical care must always come first
- Document

WA Health Handover Resource Portal

http://intranet.health.wa.gov.au/osqh/handover/