



Victorian Travelling Fellowship Program

IMPROVING CLINICAL HANDOVER: WHY, WHAT AND HOW.

RACP Congress Professional Skills Day, 12 May 2008

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Workshop objectives

- Why clinical handover is important
- What must be considered when improving handover practice
- How to approach improvement in a practical way





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Outline of Workshop

- Background on RCH Handover project
- Lessons from VTFP Travel
- Handover Improvement Toolkit overview
- Improvement process: decision time
- Outcomes of RCH pilot of Toolkit
- Key lessons
- Question time





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Clinical Handover

- “Clinical handover refers to the transfer of information from one health care provider to another when:
 - A patient has a change of location of care, and/or
 - When the care of a patient shifts from one provider to another.”
 - Australian Council for Safety and Quality in Health Care, May 2005





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Why does junior medical staff handover matter?

- Changing work practices for junior doctors have increased occasions of transfer of responsibility
 - 80 hour week in USA
 - European Working Time Directive
 - 58 hours in 2004
 - 48 hours in 2009





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What is the evidence?

- Few published trials concerning clinical handover
- Descriptive articles more common, including electronic handover tools
- Much work from a variety of bodies regarding ideal handover and barriers to handover





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RCH JMS Handover Project

- Literature review
- Audit of RCH practice
- International lessons
- Handover Improvement Toolkit
- Pilot of toolkit
- Future scoping





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VTFP - Travel Jan-Feb 2007

- University of Washington Medical Centre, Seattle, USA
- Cincinnati Children's Hospital, Cincinnati, USA
- Hospital for Sick Kids, Toronto, Canada
- Great Ormond Street Hospital, London, England
- University Hospital of Wales, Cardiff
- Royal Alexandra Hospital, Paisley, Scotland
- Burnley General Hospital, England
- John Radcliffe Hospital, Oxford
- Homerton Hospital, London
- National Hospital at Night team, NHS, London





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VTFP - Travel Jan-Feb 2007

- Observed junior medical staff handovers (morning, afternoon and night)
- Met with junior and senior medical staff involved in handover improvements
- Met with Quality and Safety staff
- Received demonstrations of electronic systems





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Key lessons learned: travel

- Handover improvements should address process, content and documentation
- System supports are crucial for good practice
- Having a designated leader of handover improves attendance & efficiency





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Key lessons learned: travel

- Consistency of practice is important for patient safety
- Checklist development should be situation specific
- The best IT system is only as good as its users





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Questions?

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Handover Improvement Toolkit

- Aims to provide guidelines and process for handover improvement
- Shift-to-shift, ward Junior Medical Staff
- Based on literature and lessons from travel





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Handover Improvement Toolkit

- Background
- Readiness checklist
- Guidelines for process, content and documentation
- Improvement process flow-chart
- Sample templates for handovers
 - New admissions & patient reviews





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Improvement Process

- Assemble working group
 - SMS, JMS, other
- Designate process owner and reporting lines
- Define current practice
 - Process, content, documentation
- Define safe handover
 - Consider educational opportunities





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Improvement Process

- Identify measurable outcomes
 - For example, if handover was safe, then:
 - Details x and y always stated for patient
 - Overall session would run same way
 - Attendees would include x, y, and z
- Measure (how far from ideal?)



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Improvement Process

- Decide how to achieve outcomes
 - Process, content, documentation
 - Decision tables for working group
- Pilot improvements
 - Timing
 - Education
 - Measure





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Improvement Process

- Feedback and review
 - All stakeholders
 - Refine as required
- Implementation with ongoing sustainability
 - Will require intermittent audit





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Group Exercise

Apply Toolkit into practice:
improve a handover





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Setting for improvement:

Morning handover

Night staff to Day staff

Specialty Medical Units





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RCH background

- 32,000 admissions per year
- 250 inpatient beds
- 200 junior medical staff
- 6 General Medical Teams
- **10 Specialty Medical Teams:**
 - Adolescent Medicine
 - Respiratory Medicine
 - Cardiology
 - Renal Medicine
 - Haematology
 - Gastroenterology
 - Neurology
 - Oncology
 - Endocrinology
 - Rehabilitation Medicine





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RCH medical ward staff

	Evening	Night	Day
General	1 Registrar 1 Resident	2 Registrars 2 Residents	6 Registrars 5 Residents
Specialty	1 Registrar 1 Resident		8 Registrars 10 Residents

Informal handover 2100-2130

Formal handover 0830-0900

Informal handover





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JMS Handover: existing practices

- 07:45 Some specialty JMS arrive (Card/Onc)
- 08:30 All other specialty JMS arrive
- 08:30 All night staff move to Blue Room for General Medicine handover
- 09:00 Handover ends – Night Team leave
Night Team may page specialty JMS to hand over (unpaid time)

On average, 3/10 units observed to receive handover

Education: 1 instance in 11 days

Wide variation in content

High level of dissatisfaction among specialty JMS





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Develop a handover protocol

Group tasks:

- **Group 1: Process**
Time, place, structure, supervision, attendance
- **Group 2: Content**
Consistent content for admissions, reviews – templates vs checklists
- **Group 3: Content**
Discharges, education, documentation
- Identify key performance indicators





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OUTCOMES

RCH Handover Improvement Project

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Specialty Med Morning Handover

- Set time
- Set place
- Set structure
- Supervised
- Multidisciplinary
- Templates for admissions and reviews
- Measure outcomes: audit and satisfaction surveys





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SMMH Outcomes: Costs

- **Time:** extension of working hours for JMS
- **Money:** \$30,000 to set up; \$62,000 per annum to run
- **Staff:** implementation, supervision, administration, re-evaluation and troubleshooting





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SMMH Outcomes: Benefits

- Increased efficiency

Duration	Pre-SMMH	SMMH
Mean	44 min	29 min
Range	5-75 min	15-37min





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SMMH Outcomes: Benefits

- Increased comprehensiveness

Per session	Pre-SMMH	SMMH
% of units receiving handover	30%	90%
Mean number of admissions	2.0	4.4
Mean number of reviews	4.3	11.9





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SMMH Outcomes: Benefits

- Improved consistency of content

Admissions	Pre-SMMH	SMMH
Name	99.3%	100%
Presenting complaint	81.5%	100%
Diagnosis	39.6%	93%
Management plan	35.6%	100%





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SMMH Outcomes: Benefits

- Increased user satisfaction
- Education
- Feedback
- Team work
- Forum for discussion
- Discharge planning





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Improving handover: Key overall lessons

- Engagement is crucial
 - Executive level
 - SMS
 - JMS





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Key overall lessons

- Working group membership
 - Relevant decisions
 - Decisions owned by those required to change
- Timing of change
- Communication plans





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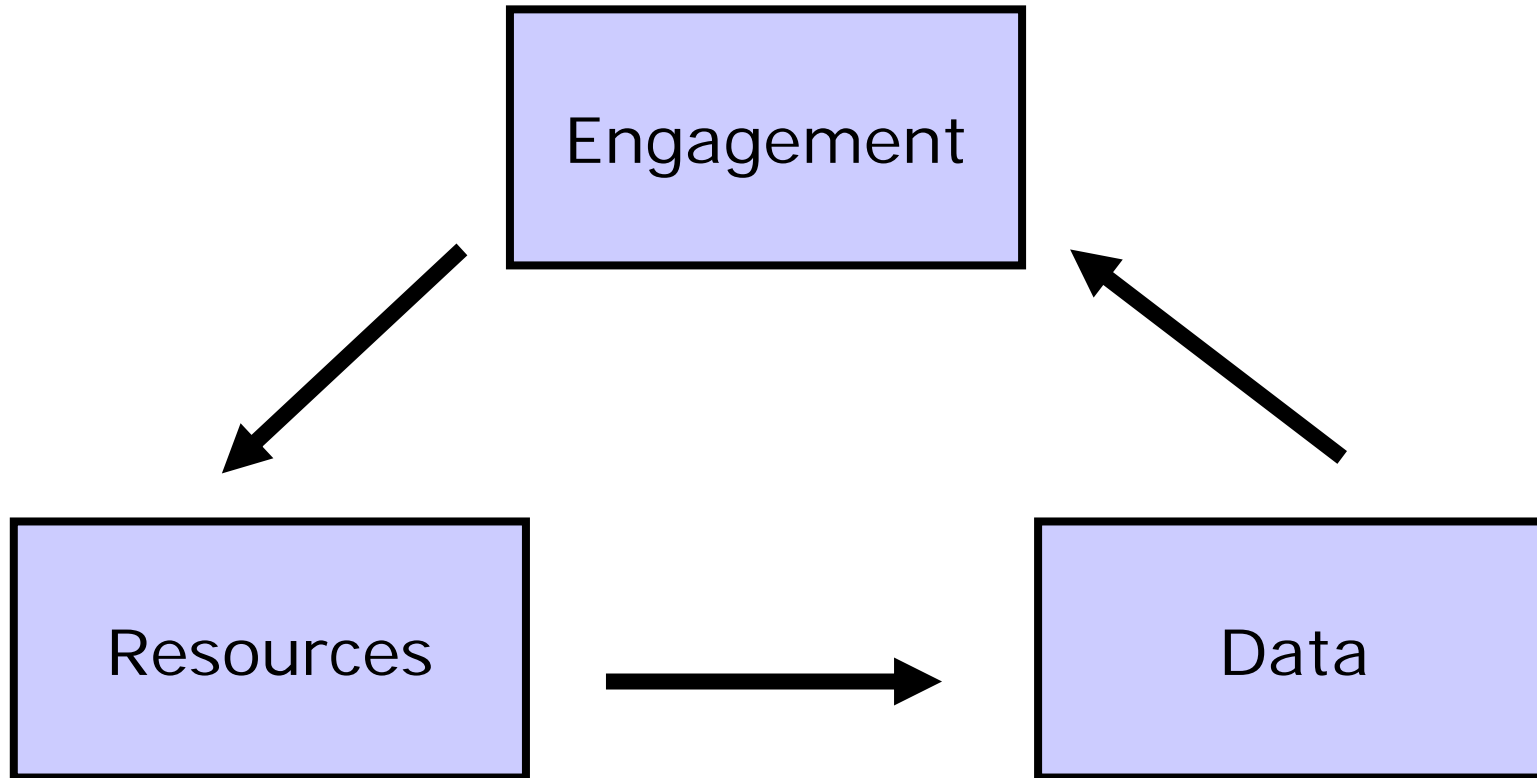
Key overall lessons

- Resources will be required
 - Staff - especially project management experience
 - Time - especially SMS/JMS
 - Money - start-up and ongoing costs
- Measure what you do





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- Victorian Travelling Fellowship Program
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Questions?

For further information:

- Phase 1 Travel report:

<http://health.vic.gov.au/travelfellowships/2006.htm>

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