AMA

SAFE HANDOVER : SAFE PATIENTS

GUIDANCE ON CLINICAL HANDOVER
FOR CLINICIANS AND MANAGERS

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GUIDANCE ON CLINICAL HANDOVER FOR CLINICIANS AND MANAGERS

PREPARED BY THE AUSTRALIAN MEDICAL ASSOCIATION LIMITED
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Adapted from the British Medical Association's resource 'Safe Handover: Safe Patients.'

Dr Mukesh Haikerwal
President, Australian Medical Association

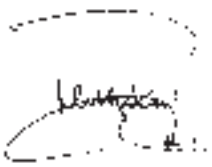
Dr Geoff Dobb
Chair, AMA Coordinating Committee of Salaried Doctors

Dr Tanveer Ahmed
Chair, AMA Council of Doctors-in-Training

FOREWORD

Clinical Handover is one of the most important issues to consider when ensuring the continuity of patient care. We are delighted to present this guide *Safe handover: safe patients* to assist our members and the health sector to achieve better patient outcomes through good clinical handover. In the face of the changing work patterns of the medical workforce, clinical handover is an increasingly essential practice. Health administrators, and medical and nursing professionals must work together to ensure good clinical handover practices are developed and maintained. Staff must be supported in their endeavours to achieve this – and this means having dedicated time and resources.

We are most grateful to our colleagues, the British Medical Association, for allowing us to adapt their resource for use in Australia and we thank our members from the Coordinating Committee of Salaried Doctors and Council of Doctors-in-Training for their contribution to the development of this guide. We commend this guide to you and hope that it will assist you and your colleagues on your continuing journey toward better patient care.



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CONTENTS

EXECUTIVE SUMMARY

This document:

- provides guidance to doctors on best practice in handover
- provides examples of good models of handover from which doctors and hospital managers can learn

Continuity of information is vital to the safety of our patients. With the changes in doctors' working hours and increasing demand for flexible work practices (e.g. part-time work) – both of which inevitably increase the number of individuals caring for each patient – the need for comprehensive handover of clinical information is more important than ever.

Good handover does not happen by chance. It requires work by all those involved, including organisations and individuals, and in some cases a change in culture. To acheive this:

- shifts must cross-over
- adequate dedicated time must be allowed
- handover should have clear leadership
- adequate information technology support must be provided
- support for the handover process must come from all levels of the medical team

Sufficient and relevant information should be exchanged to ensure patient safety so that:

- the clinically unstable patients are known to the senior and covering clinicians
- junior members of the team are adequately briefed on concerns from previous shifts
- tasks not yet completed are clearly understood by the incoming team

Handover is of little value unless action is taken as a result and:

- tasks are prioritised
- plans for further care are put into place
- unstable patients are reviewed in a timely manner

Lastly, a visit to hospital is only one part of a patient's total health care. The safe transfer of patient care requires effective handover between hospital and community.

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]

The aim of any handover is to achieve the efficient communication of high-quality clinical information at any time when the responsibility for patient care is transferred. Good handover is at the heart of an effective health care system and stands alongside patient clinical documentation, letters of referral and transfer and discharge documentation. Together, these make up the links in the chain of continuity of patient care. Handover requires systemic and individual attention and needs education, support, facilitation and sustained effort to ensure it maintains a position of importance in an already full working day.

Handover requires systemic and individual attention

Continuity of information is vital to the safety of our patients

THE INCREASING IMPORTANCE OF HANDOVER

Changing patterns of work in hospitals have created an even greater need for improved handover of clinical responsibility and information. Changing work patterns arise because:

- There is greater recognition of the effects of doctor fatigue and the risk that it poses for patient safety leading to an increasing focus on doctors' working hours and shift patterns. The AMA Safe Hours Campaign has been instrumental in bringing this issue to the fore in Australia
- Many doctors are now seeking a better balance between work and personal life and are increasingly requiring access to flexibility in their work and training
- As the medical profession continues to age, older doctors will scale down their work commitments
- The complexity of care has increased over recent decades. More technology, more data, more professionals and more support services are involved in the care of any one patient [2]

Consequently, robust handover mechanisms are of the utmost importance in ensuring patient safety [3] as:

- patient handover will happen more often, as different teams care for the same group of patients over the course of any given day
- there will be greater cross-cover between some specialties and an increasing multidisciplinary approach to care
- a doctor may have no regular daytime contact with the patients they are responsible for when they are rostered on in the out-of-hours period

THE TEAM APPROACH

FROM PERSONAL CONTINUITY TO SYSTEM CONTINUITY

The concept of personal continuity is outdated in a modern health care system where multiple health professionals and teams contribute to the care of a single patient. The team, rather than the individual, should be seen as the care provider. While overall personal continuity is valued by patients, it does not ensure quality of treatment. Reliance on personal continuity may legitimise the idea that there are patients for whom an individual is not responsible for, threatening organisational and team responsibility.[4, 5]

Traditional on-call work patterns, where the patient sees the same doctor or nurse day after day, masked the lack of structure and systems to support information transfer. It is therefore essential that the move away from personal continuity be supported by system continuity. The patient's experience of this is consistency and accuracy of knowledge and information between all multidisciplinary team members.

Achieving system continuity requires mechanisms to support the transfer of high-quality clinical information across shift changes. These should include:

- dedicated time in shifts for members of the team to meet, share information and clarify responsibility for ongoing care and outstanding tasks
- access to up-to-date summaries and management plans for all patients under a team's care
- reliable means to identify and contact the doctor who is responsible for a patient at any given time
- thorough induction and orientation to handover practices for new team members

THE TEAM APPROACH

FROM PERSONAL CONTINUITY TO SYSTEM CONTINUITY

Improving handover is likely to require changes to the culture and organisation of doctors and health professionals of all levels and disciplines. An understanding of the concept of both system and personal continuity should be supported by education and training.

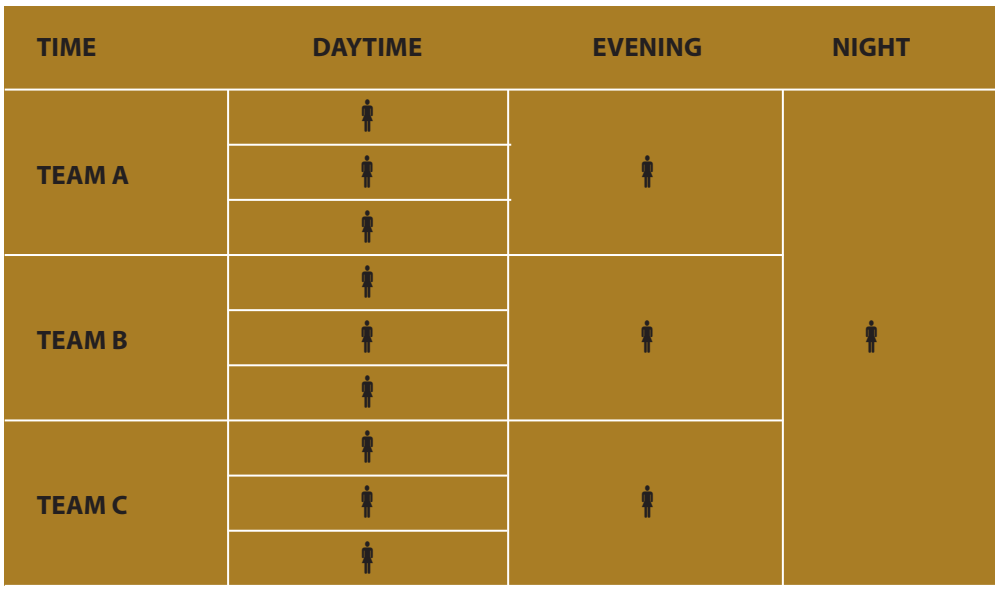

Figure 1: An example of a shift pattern over a 24hr period. Clear mechanisms must support the handover of information between doctors at the start and finish of each shift.

EMBRACING SAFETY

It is clear that Australian hospitals and doctors are increasingly recognising the importance of clinical handover and are moving to improve handover practices. There is growing recognition that enhanced training and systems for effective and safe handover are essential in maintaining high standards of clinical care.

AMA research demonstrates that doctors and other stakeholders in health care believe that the development and introduction of best practice clinical handover would be a significant positive step for the care of patients as well as assisting the introduction of more flexible work practices. [6]

Research commissioned by the AMA in 2003 found that it was generally accepted that handover in Australia is neither well taught nor well practiced. [6] This has been shown by research conducted in an Australian public hospital which revealed handover was unstructured, informal and error prone, with approximately 95% of doctors reporting that there was no standard or formal procedures used for handover. [2]

Coroners' cases have criticised systems where the failure to hand over information effectively was implicated in an adverse outcome.[7, 8] *Dr X said that she tried to tell the surgical registrar of the test results but that he was very busy. She was not expecting the discharge of the deceased over the weekend, and, as she explained "... I thought that I would speak with him on Monday or whenever I next saw him."* [7]

Clinical handover is not a well-researched area of health care. [9] Research conducted by Australian Council for Safety and Quality in Health Care revealed that there is a substantial gap in policy and research around clinical handover.

EMBRACING SAFETY

Patient safety, as part of clinical governance, is rightfully at the heart of the organisational structures of the Australian health care system, as well as being a principal concern of the wider public. The Patient Safety Education Framework developed by the Australian Council for Safety and Quality of Health Care recognises that continuity of care is an essential part of patient safety and expresses the importance of all health care workers following their organisation's guidelines for patient handover. The public expect that the doctors caring for them share information to minimise repetition and maintain safety. Patients also expect their confidentiality to be respected in handling their personal information.

GOOD PRACTICE IN HANDOVER

To ensure effective continuity of information, the handover must achieve a balance between comprehensiveness and efficiency. The information provided during handovers influences the delivery of care for the whole shift. [10]

Individuals and organisations have a shared responsibility to ensure that safe continuity of information and responsibility between shift changes takes place. Perceptions and practice of handover vary across the country, between areas, specialties and even within a single unit, reflecting that no single handover system is suitable for all.

Every hospital needs to develop its own handover policy. If possible, it is preferable that the general approach to handover is standardised across the hospital or institution to avoid confusion and potential gaps in information transfer when staff rotate to other areas. This should be developed in consultation with staff to ensure all relevant local issues are taken into account and requires a coordinated approach from managers, all levels of doctors and the rest of the multidisciplinary team.

THINK HANDOVER...

WHO ?	**should be involved**
WHEN ?	**should it take place**
WHERE ?	**should it occur**
HOW ?	**should it happen**
WHAT ?	**needs to be handed over**

GOOD PRACTICE IN HANDOVER

WHO SHOULD BE INVOLVED?

- Each hospital/unit needs to identify the key people who need to attend handover. Clinical Handover is equally important to all members of the medical team, both junior and senior. The ideal model includes all grades of staff from each included specialty, subspecialty or ward as appropriate. The nurse clinical coordinator should be involved in the major handover, usually the morning one
- Ideally, teams from all units should attend to ensure that they receive necessary patient information and make timely decisions about patient care and transfer. The multi-disciplinary or multi-specialty approach requires the greatest change in culture, but has the potential for the greatest benefits
- The involvement of senior clinicians is essential. This ensures that appropriate level management decisions are made and that handover forms a constructive part of medical education conveying the seriousness with which the organisation takes this process
- There will always be work that is ongoing during the handover time, especially in the evening. Virtually all aspects of care can wait for 30 minutes to ensure continued safety overnight. It is essential that individuals be allowed to attend, subject to emergency cover being defined
- The handover leader needs to ensure the team is aware of any new or locum members of the team and that adequate arrangements are in place to familiarise them with local systems and hospital geography

To ensure attendance at morning handover, Launceston General Hospital has made it a compulsory activity for all on-call physicians and representatives from all units. [11]

GOOD PRACTICE IN HANDOVER

WHEN SHOULD HANDOVER TAKE PLACE?

- Handover should be at a fixed time and of sufficient length
- The handover period should be known to all staff and designated 'pager-free' except for immediately life threatening emergencies
- Shifts for all staff involved must be coordinated to allow them to attend in working time. This is particularly important for the handover to, and from, the night team
- Main handover is generally held in the morning, however handover is also needed at the change of other shifts (for example 5pm in some ward settings). Morning handover allows the team to discuss overnight patient admissions, gives them a head start with their morning rounds and plan the day's work[12]
- In addition to the larger, more formal handover there will inevitably be smaller local handovers occurring daily (such as on ICU or admissions unit)
- As well as handover between shifts, doctors must conduct a thorough handover to ensure patient care is maintained if they are absent for extended periods, i.e. over weekends or while they are away on holidays

WHERE SHOULD HANDOVER TAKE PLACE?

- Ideally this should be close to the most used areas of work (such as DEM or Admissions Unit)
- It should be large enough to comfortably allow everyone to attend
- This should be free from distraction and not used by others at this time
- It should have access to lab results, X-rays, clinical information, the internet/intranet, and telephones

Distractions that can disturb the handover process include pagers, telephones, relatives, nurses and other doctors .[10]

GOOD PRACTICE IN HANDOVER

HOW SHOULD HANDOVER HAPPEN?

The style of handover will vary depending on local need – whole hospital handovers, local handovers on specific units, community-based specialties or those covering several sites. However, all types need a predetermined format and structure to ensure adequate information exchange.

- Ad hoc handovers often miss out important aspects of care and information
- Handover should be supervised by the most senior clinician present and must have clear leadership
- Information presented should be succinct and relevant
- Ideally, this can be supported by information systems identifying all relevant patients [3]
- Regular review of the system, for example at clinical governance meetings, appraisal meetings, through surveys, and monitoring incident reports, is required
- The relevant senior consultant or the medical director, should have responsibility for ensuring handover happens as expected

The Royal College of Physicians has published guidance on handover, relevant to general medical staff. Included in this document is an example of a handover sheet that can be used to facilitate effective information transfer between colleagues [13]

WHAT SHOULD BE HANDED OVER?

The information and level of detail that is included in a clinical handover session depends on several factors including the severity of the patient's illness and whether they are pending results of investigations and require prompt follow-up. The type and level of handover conducted is also influenced by the time of the day and week it is occurring (e.g. weekday vs weekend, night vs morning), the doctor to patient ratio and workflow. Priorities need to be set to ensure that the essential information is communicated and understood.

GOOD PRACTICE IN HANDOVER

Written (or IT based) handover should include:

- current inpatients
- accepted and referred patients due to be assessed
- accurate location of all patients
- operational matters directly relevant to clinical care such as ICU bed availability
- information to convey to the following shift
- patients brought to the attention of the critical care outreach team (where appropriate)
- patients who are unstable or whose clinical status is deteriorating

The following, as well as being included in the written handover, should be discussed within the handover meeting. All verbal and written handover should follow a similar structure and cover the essential information. This verbal handover is vital to highlight:

- patients with anticipated problems, to clarify management plans and ensure appropriate review
- outstanding tasks and their required time for completion

INFORMATION MANAGEMENT SOLUTIONS [3]

IT systems must be robust, rapid in access and operation and have the capacity to interface with other information systems (radiology and pathology). Unnecessarily complex systems or those that partition information invariably delay and limit access to information. All hospital IT systems must ensure the administration data is up-to-date 24-hours per day to ensure patients do not get 'lost' in the hospital and the treating doctor can clearly identify which patients are under their care.

Some electronic handover tools include:

- a 'live' list on the hospital intranet of the name and contact details for doctors covering each consultant's or specialty's patients at any given time

- a system that identifies those patients most in need of review and outstanding tasks for completion
- patient information on password protected hand-held computers (doctors synchronise their devices at the change of shifts)
- hand held computers with wireless connections that allow voice as well as data communication. This could allow automatic routing of test results to the responsible doctor

An electronic information-sharing system that works effectively can be time neutral for junior doctors compared with traditional paper based or verbal handover.[14] Patient information can be accessed from multiple points in the hospital and can be updated and referred to as patients move around the various units.

There are many ways in which developments in information technology can assist with the handover process by improving information delivery and exchange. While information technology is important, its use should not be viewed in isolation as the sole remedy to clinical handover. It is just one of the factors that influence the complex handover process. [15]

Example: Functions of an electronic handover system [16]

- Print a patient list for the specialty or units being covered
- Sort the list by ward and bed number, by consultant, by unit or by need for review
- Allow handover information to be entered efficiently (ideally with a single mouse click)
- Allow patients from other specialties for whom consultations have been requested to appear in the "patients to review list."

Taken from: Cheah, Amott, Pollard & Watters. *Electronic medical handover: towards safer medical care*. MJA 2005;183 (7):369-372

Some considerations:

- Electronic systems may not have the ability to allow users to enter all the required patient information needed for a thorough patient handover [16]
- Keeping patient lists on desktop computers or handheld devices needs careful security and adherence to relevant legislation regarding personal information and privacy. Electronic patient lists can be provided in a secure password protected manner on the hospital intranet
- As hospitals work on 'episodes of care' the challenge exists for the health care sector to develop information systems that provide comprehensive patient summaries. This not only enhances continuity of care but also avoids the patient information having to be recollected and redocumented on each presentation
- The system must be 'owned' by the doctors to enhance responsibility and ensure it is properly utilised [17]

EDUCATION

The ownership of handover and the quality of handover practices is related to the investment made by the organisation in the education of their medical teams. All levels of the medical staff require educational sessions that cover the handover protocol. This education needs to occur at the commencement of the clinical rotation or employment contract and should include:

- the content of handover including clinical notes, their legibility, detail and identification of authorship (i.e. clearly print your name), illustrated by examples of both good and bad practice and with supportive criticism of individuals in the workplace
- the medico-legal context of documentation, handover and discharge communication with case studies of the outcomes of inadequate practice
- how to use the available tools (i.e. electronic systems, proformas)

GOOD PRACTICE IN HANDOVER

HANDOVER AS A TEACHING TOOL

Due to time constraints, teaching is usually considered a valuable by-product of the handover session, not a primary goal. The art of teaching does not necessarily come naturally to doctors, but it can be learned and teacher training programs are useful in developing opportunistic teaching skills (e.g. *Teaching on the Run* developed by University of Western Australia).

In the face of increasing medical workforce shortages, increased doctor workloads and teaching demands, the use of good clinical handover practices may assist the team cope with service demands and meet some of the educational goals of the unit.

CHALLENGES TO CONTINUITY OF INFORMATION

- **Lack of dedicated time to complete patient notes and participate in handover**
- **Personal style, lack of structure and formality** [17]
- **Lack of effective information management technology and systems for sharing clinical information**
- **Increased numbers of patients under the care of a single team**
- **Frequency with which lead consultant changes**
- **Frequent movement of patients between wards and departments sometimes without the doctor's knowledge**
- **Involvement of multiple specialist teams**
- **Transfer to other health professionals in the community or other institutions**

GOOD PRACTICE IN HANDOVER

BEYOND INFORMATION TRANSFER

Clinical handover offers benefits in addition to the transfer of information from one team to another by providing opportunities for:

- doctors to seek second opinions
- junior doctors to seek supervision
- doctors to debrief
- reminders to be given to follow-up results
- the early referral of patients to other disciplines

RISK MANAGEMENT

Ineffective handover can lead to incorrect treatment, delays in diagnosis, life threatening adverse events, patient complaints, increased health care expenditure, increased length of stay, and a range of other effects. [9]

Poor handover carries significant risks for individual clinicians, their organisations and for their patients. Hospitals should ensure that the facilitation of high-quality handover is seen as a clinical governance issue at all levels within the organisation.

Some specific areas of heightened clinical risk are highlighted below.

COMMUNICATIONS:

- Laboratory staff, faced with a critical result, have difficulty contacting the doctor responsible for the patient, as they may be different from the doctor that requested the test
- From the perspective of ward staff or lab staff, it is often unclear which doctor is responsible for their patients, and they have to page multiple doctors until they find the correct one

PATIENT RISKS:

- Working from memory may mean that information is not shared or incorrect information is passed on
- Use of bed/bay numbers should be avoided to prevent misidentification
- Use of unique identifiers prevents confusion in patients with similar sounding names
- Hospital patient systems must ensure that administrative data is up to date 24-hours per day. If location and responsible consultant are not accurately recorded and readily accessible this exposes the patients and the hospital to considerable risks

DOCTOR RISKS:

- Omission of important information
- Information overload

HANDOVER OMISSION
ENDANGERS PATIENT SAFETY

SATURDAY MORNING HANDOVER	**'Please take Mrs Smith's bloods, I think her kidney function may be deteriorating.'**
SATURDAY DAY SHIFT	**Mrs Smith's blood taken. Busy shift so results not checked.**
SATURDAY NIGHT HANDOVER	**'Please check Mrs Smith's results.'**
SATURDAY NIGHT SHIFT	**Results chased and found with some difficulty after the ward insisted they had not been taken. Results appear normal.**
SUNDAY MORNING HANDOVER	**Handover interrupted by emergency call... Mrs Smith suffers cardiac arrest.**

HANDOVER OMISSION
ENDANGERS PATIENT SAFETY

CRITICAL INCIDENT REVIEW

1. Handover did not detail that there were two patients called Mrs Smith on the ward. Bloods were taken from the wrong Mrs Smith.

A. WHY WERE HER BLOODS NOT CHECKED?

2. The results of bloods taken from the incorrect patient were not chased by the team that knew the reason for the tests. They may have been cautious about a normal set of results from a patient known to have renal problems.

B. WHERE DID THE PROBLEM START?

3. The outgoing team did not fully hand over the reasons for investigation. The potassium kept rising over the weekend for the correct Mrs Smith affecting her safety. Later that weekend she suffered a hyperkalaemic cardiac arrest.

REAL EXAMPLES

At the **Department of Emergency Medicine, Royal Brisbane and Womens' Hospital**, handover is assisted by the use of an electronic 'live' patient list.

Formal handover occurs in conjunction with a 'ward round' of the emergency department and coincides with the changeover of the registrar and consultant shifts - at 0800, 1230, 1500, 1800 and 2230. During the handover, every patient in the department is reviewed. Pertinent patient information is discussed and management plans are annotated against a printed patient list. Following handover, the patient information is then updated on the electronic system and includes:

- Patient name, UR number, age/DOB
- Triage category, diagnosis and patient location
- Treating nurse and doctor plus senior doctor involved if known (e.g. the registrar or consultant who has been involved with the case)
- General disposition e.g. will go home, will need to be admitted medically/surgically or ongoing investigations
- Key investigation or management plans e.g. awaiting CT Head, to go home if NAD

Using the electronic system assists with a more efficient handover, with benefits including:

- multiple users at any one time access this information (including those off-site)
- information is linked with other databases
- all users can update as they go
- information assists with staff and bed planning in advance of final diagnosis

Informal handover also occurs between Resident Medical Officers (RMOs) at change of shifts or when referring patients to inpatient teams.

Without a structured handover, efficient patient care is extremely difficult. The bigger the hospital department the more individuals involved with patient care (patients, nurses, RMOs etc.) and the greater the need for clear, concise clinical information to be transmitted to the caring team.

Dr Alexandra Markwell
Department of Emergency Medicine, Royal Brisbane and Womens' Hospital.

REAL EXAMPLES

At the **Liverpool Hospital** there is a formalised handover process that takes place at the changeover of shifts on the wards. Patients that require investigations, review or follow up in the after hours period are included on a handover form. This form is reviewed by the after hours overtime medical officer.

Details on the handover form include:

- a patient sticker (name, medical record number, DOB)
- patient location
- medical history
- current & outstanding issues – includes an indication of whether the consultant/ registrar is aware of these issues

The handover form is used as a reference by staff at the handover sessions held at the change of shifts, between day and evening shifts, as well as evening to night shifts. There is also a tick-box column on the form that allows the intern or resident to keep track of the issues which were flagged as requiring attention during their shift.

There is a formal handover that occurs between 2230 and 2300 in the medical staff room. The night medical registrar facilitates the handover and ensures that patients who require attention are discussed and that the written handover is completed.

In addition, there is a morning handover meeting in which the medical registrar discusses the medical admissions that have occurred overnight. This meeting serves as both information sharing and education. It is an opportunity for the intern/resident to discuss any problems experienced or interesting cases during the night shift. In addition, the intern or resident may be asked to research and discuss a topic based around an issue that may have come up on a night shift during their term.

This handover process was developed by the Liverpool Resident Medical Officers' Association with support from the General Clinical Training Council, with input from both junior and senior staff.

Dr Peter Lim
Liverpool Hospital

REAL EXAMPLES

Handover has been operating in the **Paediatric Department at Royal Darwin Hospital** for about 20 years. Our staff have realised the value of these handovers and have essentially continued them as they were originally set up.

Handovers are held at 8am and 4pm.

The morning handover lasts 15-20 minutes depending on the clinical activity and the number of admissions. It is attended by all registrars and RMOs and by a number of consultants. In practise there is always at least one consultant present. The purpose of the handover is to ensure that staff coming on to the wards during the day are aware of new admissions overnight and any significant changes in the condition of children who are already inpatients. The principal person involved is the night registrar who reports on the activities they have managed between 10pm and 8am and on admissions that have occurred prior to the commencement of their shift – between 4pm and their shift starting at 10pm.

The evening handover is usually shorter and involves principally the registrar who will be responsible from 4pm onwards plus his RMO. The registrars and RMOs from the wards who have worked during the day are required to be present. This handover is usually part shared by the consultant who will be on call for that night.

Electronic patient lists are utilised to sort the patient details by ward, unit, consultant, and include major diagnoses and demographic details.

The emphasis is entirely on ensuring that staff are aware of new admissions, their clinical condition and any change in condition of existing inpatients. Another important part of a handover is the reporting of outliers as occasionally paediatric patients will be in medical

or surgical wards and these are always mentioned. We do not incorporate a significant teaching component into the handover meetings in the interests of time. The medical students attached to the unit attend the morning handover and learn incidentally from the reports of the patient's clinical status.

Our system is relatively simple and we believe it ensures that staff are aware of seriously ill patients and new patients and that this results in satisfactory continuity between shifts.

Professor Alan Walker AM

Paediatric Department, Royal Darwin Hospital

HOSPITAL DISCHARGE SUMMARY EXAMPLES

THE BAD

PATIENT ADDRESS: C/- Post Office, Heston Qld

TO: Dr at Heston

SUMMARY

Mrs JB was admitted to St Marina's Hospital on the 1/4/2006 for CABG. She confessed to the anaesthetists that she had had a cigarette the day before. She was taken off the list. May benefit from antidepressant.

PAST MED HX unchanged

MEDICATION unchanged/ plus nicotine patches

Signed,
Dr Wilson, RMO

HOSPITAL DISCHARGE SUMMARY EXAMPLES

THE GOOD

PATIENT ADDRESS: 59 Curry Ave, Heston Qld

TO: Dr D Howe
Heston Hospital (Visiting Dr for Heston)
Remote Area Nurse Sister B Daley, Faulding St Clinic, Heston

SUMMARY

Mrs JB admitted 1/4/2006 for CABG.

Unfortunately Mrs JB had been smoking prior to her admission for CABG at St Marina's Hospital under Dr Brown. It is departmental policy given the bad anaesthetic and post-operative outcomes related to peri-operative smoking that all non-critical CABG surgery patients are counselled and re booked for a later date within the next 6-8 weeks.

Mrs JB was receptive to counselling and has been prescribed nicotine patches which she finds useful. She has been supplied with a private script for these to be filled prior to travel, as there is no pharmacy at Heston.

After discussion with the psychiatry team Mrs JB was commenced on Cipramil during this admission as it was thought she was experiencing significant symptoms of depression. Mrs JB also received counselling for social problems related to the fact she is the sole supporting grandmother of five children. She has been seen by the social worker who is helping her negotiate a carers pension to help ease her financial situation.

HOSPITAL DISCHARGE SUMMARY EXAMPLES

We have contacted the nurse at Heston who is going to talk to Mrs JB about formal respite foster care for her grandchildren whilst she is in hospital for her procedure.

PAST MEDICAL HX

- NIDDM 10 years retinopathy and nephropathy (next eye check 3/6/2006)
- HTN/IHD x 20 years; history of AMI Jan 2006
- Hypercholesterolaemia controlled
- Smoking
- Depression
- Social problems

THIS ADMISSION

Mrs JB's BP was elevated in hospital and her perindopril dose has been doubled to 8 mg.

- Discharge K = 4.7 Cr = 120 Hb = 137
- Discharge BP=135/85 PR 60
- Discharge wt=87Kg

DISCHARGE MEDICATIONS

- INCREASED; Perindopril 8 mg daily please check electrolytes and BP early next week
- Atenolol 50mg BD
- Simvastatin 40mg nocte
- Aspirin 150mg daily – please restart until final notification of readmission for surgery
- Metformin 1.5grams BD
- NEW; Nicotine patches 25mg daily
- NEW; Cipramil 10mg nocte (please increase to 20mg in 2 weeks time)

HOSPITAL DISCHARGE SUMMARY EXAMPLES

PLANNED READMISSION FOR 18/5/2006

Nurse in charge of the theatre list is the 'CABG rebooking nurse' available through switch on ext 2519. If she has not contacted Heston clinic within the next 2 weeks please contact her or myself to confirm the above admission date.

Please notify us if she gets increasing SOB or chest pain before readmission.

Sincerely,
Dr E Wilson
St Marina's Hospital
Pager 758
RMO for Dr M Brown

Discharge summary examples provided by Dr Emma Spencer, Physician, Royal Darwin Hospital and Director of Physician Training.

BENEFITS OF HANDOVER

GOOD HANDOVER BENEFITS PATIENTS

- Safety is protected – lapses in information handover can, and do, lead to mistakes being made. This increases morbidity and mortality
- Greater continuity of care – poor handover can lead to fragmentation and inconsistency of care
- Decreased repetition – patients dislike having to answer the same questions over and over again. Different individuals providing care will be accepted as long as existing team knowledge is retained
- Increased service satisfaction – every doctor attending a patient can begin where the last one left off. Patient perception of professionalism is reaffirmed and improved
- Increased efficiency of the healthcare system and improvement to patient care through timely investigation and diagnosis, management and discharge

GOOD HANDOVER BENEFITS DOCTORS

- Professional protection – accountability has become more prominent with the move toward a more litigious culture within healthcare. Clear and accountable communication can protect against wrongful attribution of responsibility for errors that occur
- Reduction of stress – feeling informed and having up to date information enables doctors to feel more confidently in control of a patient's care. Doctors have found that handover can be a useful experience that gives them the opportunity to involve appropriate specialties early, for example intensive care. There is ability to discuss cases with other specialties in an open environment
- Educational – handover provides development and practice of communication skills and a well-led handover session provides a useful setting for clinical education
- Job satisfaction – providing the best possible quality of care is highly rewarding and is fundamental to a doctor's sense of job satisfaction

Good handover has been shown to change culture, increase doctor participation, improve supervision of after-hours work and improve educational value. [11]

CONCLUSION

- Good clinician handover is vital to protect patient safety
- Multi-specialty clinical handover is important to ensure all clinicians are updated with current patient information
- Dedicated and remunerated time for clinical handover is essential
- The importance of good handover has never been so high due to the decreased hours of work and increase in shift changeover, and due to the general increase in the pressure on the hospital system to 'do more with less'
- Systems need to be put in place to enable and facilitate handover. These systems, although based on a generic model, must be adapted to local needs
- Continuity of care is paramount to protect patient safety and is underpinned by continuity of information
- Safe handover = safe patients

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APPENDIX I
TIPS FOR MORNING REPORT

Fassett, R G & Bollipo, S J. Morning report: an Australian experience. Medical Journal of Australia 2006; 184: 159-161.

Tips for establishing, organising, running and evaluating morning report

ESTABLISHING MEETINGS

- Evaluate the existing handover procedure and recognise the need for improvement
- Get support from the Director of Medicine, the hospital administration and the quality improvement unit
- Allocate an hour for meetings and protect it from interruptions, ward rounds and conflicting meetings

ORGANISATION

- Choose a location within the department to maximise attendance
- Choose a room that is small enough to encourage active participation and personal interaction
- Make attendance compulsory for the on-call physician, physician trainee and Year 2/Year 3 postgraduate doctors on night duty. Encourage all physicians to attend
- Provide facilities such as a television, video player, data projector, x-ray viewing box and whiteboard to encourage enhanced case presentations
- Provide coffee, tea and breakfast to create a friendly atmosphere and encourage social interaction

APPENDIX I
TIPS FOR MORNING REPORT

RUNNING A MEETING

- Insist on complete, accurate case presentations and discourage casual, brief presentations. A complete, uninterrupted presentation takes only 5 minutes
- Focus discussions on management of the patient in question
- Give positive feedback in public, saving any negative feedback to be discussed privately after the meeting. This avoids public humiliation, embarrassment or intimidation
- Start the meeting on time and finish early wherever possible. The chairperson should ensure the meeting does not extend unnecessarily
- Education should be a by-product of case discussions and not the primary focus

EVALUATION

- Conduct periodic formal evaluation by questionnaire-based surveys
- Obtain ongoing informal feedback by involving the group in discussions about improvement of the handover process
- Implement changes in response to feedback to complete the quality improvement cycle

APPENDIX II
SOURCES OF FURTHER INFORMATION

Australian Medical Association	http://www.ama.com.au
Australian Commission on Safety and Quality in Health care	http://www.safetyandquality.org
British Medical Association	http://www.bma.org.uk
General Medical Council	http://www.gmc-uk.org
National Patient Safety Agency	http://www.npsa.nhs.uk
Royal College of Physicians	http://www.rcplondon.ac.uk

APPENDIX III
ROYAL COLLEGE OF PHYSICIANS

GOOD PRACTICE

Standards of good practice to improve continuity of care

1. A patient should know the name of the medical team responsible for his or her care
2. A medical team should know the name and location of every patient under its care
3. Medical teams should not routinely have patients outlying from their home wards
4. A single medical team should be responsible for a patient's care at any one time
5. Doctors should have sufficient protected time for patient handover
6. On transfer of care, a patient's new team should have immediate access to all necessary clinical information
7. Out of hours (evenings, nights, and weekends), doctors should be aware of the patients under their care who are particularly unwell
8. Each clinical action and annotation in patient notes should be traceable to the doctor concerned
9. A patient's resuscitation status must be stored sensitively, but also accessible immediately
10. Doctors should know the outcome of their decisions
11. When designing junior doctors' medical rota, the first priority should be daytime continuity of care on the wards
12. A discharge letter, summary or report should leave the hospital within 24 hours of a patient's discharge

Guidelines for effective patient handover for physicians can be found at:

http://www.rcplondon.ac.uk/pubs/handbook/gpt/GPTguide.pdf

APPENDIX IV
COMMON PITFALLS DURING HANDOVER

The Human Factors and Arterial Switch Operation study collected data on operations performed by 21 UK cardiac surgeons in 16 centres over eighteen months. During the study, researchers were present at operating theatre to ICU handovers. [18, 19]

- Healthcare professionals sometimes try to give verbal handovers at the same time as the team taking over the patient's care are setting up vital life support and monitoring equipment. Unless both teams are able to concentrate on the handover of a sick patient, valuable information will be lost. The importance of written handover information must be stressed
- Roles and responsibilities are not always clear during handover and this can lead to omissions, for example, if one staff member assumes that another will verbally update the team taking over the care of a patient
- Checklists and written updates are important and often under-utilised. They provide important sources of information for the team who have taken over care of the patient during the following shift. When such information is incomplete or omitted it has a knock on effect of increasing the workload of the staff who have taken over the patient's care because they have to spend a significant proportion of time chasing information
- It is important that nursing staff are made aware of critical features in the medical management of a patient that will affect care during the next shift. Similarly, medical staff must be aware of specific nursing issues that may affect care. Multidisciplinary team handover helps minimise these omissions
- Fragmentation of information at the point of handover is a major problem. It is important to avoid multiple concurrent conversations between individuals and let one person (a nominated lead) speak at a time to everyone. This reduces the opportunities for conflicting information to be given
- Handover is a two-way process. Good handover practice is characterised by the team who are taking over the patient's care asking questions and having the opportunity to clarify points they are uncertain of. They should not be passive recipients of information

APPENDIX V
AMA CAMPAIGNS

AMA SAFE HOURS CAMPAIGN

The AMA Safe Hours Campaign is based on the *AMA's National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors*. This Code of Practice was adopted by AMA Federal Council in 1999 and was developed via a thorough consultation process with the medical and hospital sector. The work of the AMA now stands as the accepted standard for safe working hours for hospital doctors in Australia.

Many hospitals in Australia have now taken measures to review their medical rostering and work practices in light of the AMA's Safe Hours campaign, however much more still needs to be done. In May 2006 the AMA conducted an online survey of hospital doctors' working hours and shift patterns. Results showed that the majority of hospital doctors continue to have working hours and patterns that pose unsafe risks of fatigue. A full report of the survey is available on the AMA website: **http://www.ama.com.au/web.nsf/doc/WEEN-6UWAUH**

AMA WORK LIFE FLEXIBILITY PROJECT

The AMA's Work Life Flexibility project seeks to address the emerging trends in the composition of the medical workforce and the growing divergence between the aspirations of junior doctors and present medical training and workplace practices. The project aims to encourage the adoption of greater flexibility in medical training and workplace arrangements by promoting cultural change in the medical profession, its institutions and the hospital sector. The objective is to make part-time medical training and work, job sharing and other family friendly practices a legitimate and accessible option for doctors.

For more information on AMA campaigns go to: **www.ama.com.au**

APPENDIX VI
WRITING GROUP

Australian Medical Association Council of Doctors-in-Training

Dr Peter Lim

Dr Alexandra Markwell

Dr Leigh Dahlenberg

Dr David Chapman

Australian Medical Association Coordinating Committee of Salaried Doctors

Dr Geoff Dobb

Dr Barbara Bauert

Dr Roderick McRae

Adapted from the British Medical Association's resource *Safe handover : safe patients, Guidance on clinical handover for clinicians and managers* with the permission of the British Medical Association.

FOR MORE INFORMATION CONTACT YOUR AMA OFFICE

FEDERAL OFFICE
PO Box 6090 KINGSTON ACT 2604
Ph. 02 6270 5400 Fax. 02 6270 5499
Website. http://www.ama.com.au/

ACT BRANCH
PO Box 560 CURTIN ACT 2605
Ph. 02 6270 5410 Fax. 02 6273 0455

NEW SOUTH WALES BRANCH
PO Box 121 ST LEONARDS NSW 1590
Ph. 02 9439 8822 Fax. 02 9438 3760

NORTHERN TERRITORY BRANCH
PO Box 41046 CASUARINA NT 0811
Ph. 08 8927 7004 Fax. 08 8927 7475

QUEENSLAND BRANCH
PO Box 123 RED HILL QLD 4059
Ph. 07 3872 2222 Fax. 07 3856 4727

SOUTH AUSTRALIAN BRANCH
PO Box 134 NORTH ADELAIDE SA 5006
Ph. 08 8267 4355 Fax. 08 8267 5349

TASMANIAN BRANCH
147 Davey St HOBART TAS 7000
Ph. 03 6223 2047 Fax. 03 6223 6469

VICTORIAN BRANCH
PO Box 21 PARKVILLE VIC 3052
Ph. 03 9280 8722 Fax. 03 9280 8786

WESTERN AUSTRALIAN BRANCH
PO Box 133 NEDLANDS WA 6909
Ph. 08 9273 3000 Fax. 08 9273 3073

AUSTRALIAN MEDICAL ASSOCIATION
(ABN 37 008 426 793)

PO BOX 6090, KINGSTON ACT 2604