

# NSW Safe Clinical Handover Program

Standard key principles across the care continuum

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# Leading Safe Clinical Handover – the Acute Care Taskforce



## History

- Commenced June 2005
- Multi-disciplinary membership
- The acute medical patient journey



## Previous work includes

- Avoidable Admissions
- Medical Assessment Units

# The platform was burning and the time was right

- RCA data
- The Special Commission of Inquiry (Garling)
- Australian Commission on Safety and Quality in Health Care — National Clinical Handover Initiative
- World Health Organisation — one of WHO's top 5 priorities
- Between the Flags — Recognition and management of the deteriorating patient
- MJA supplement, “Clinical Handover : Critical Information”  
— supplement of 14 papers published on 1st June 2009

# Special Commission of inquiry into Acute Care Services (Garling)

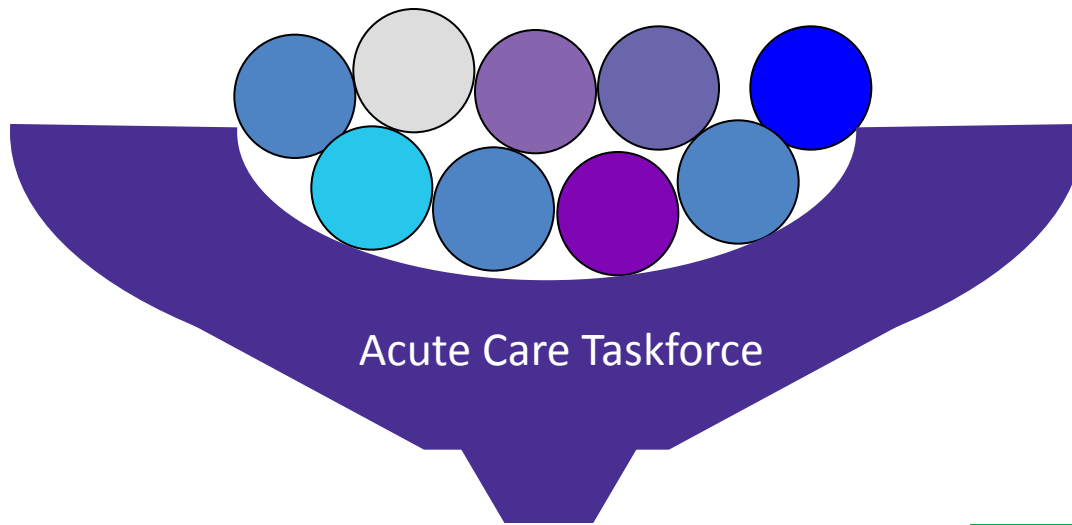
*Within 18 months, NSW Health should ensure that each hospital designs and introduces a mandatory shift handover policy...*

**Government response... Supported.**

# The NSW Safe Clinical Handover Program

- implementing standard key principles for clinical handover across the care continuum

# Distilling the key principles from the work of many



Standard Key Principles

Standard key principles + flexible  
standardisation

= System level change

# Standard Key Principles



**SAFE CLINICAL HANDOVER**  
KEY PRINCIPLES FOR SAFE AND EFFECTIVE HANDOVER

Clinical handover is the effective...  
...transfer of professional responsibility and accountability from 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.

• Safe Handover - Safe Handover guideline (2014, 2016) • Australian Government National Patient Safety Agency (2011)  
• The 2012 Guide to Clinical Handover Implementation - Australian Commission on Safety and Quality in Health Care (2012)

**Does your process for clinical handover meet these standard key principles?**

**1. Leadership**  
 Nominate a leader at each clinical handover.

**2. Valuing Handover**  
 Set the expectation that clinical handover is valued and an essential part of daily work. Ensure staff are available to attend for the handover of all patients relevant to them.

**3. Handover Participants**  
 Identify and invite handover participants (involve them in regular reviews of clinical handover processes).  
 Wherever possible, patients and carers should be recognised and included as handover participants.

**4. Handover Time**  
 Set an agreed time, duration and frequency for clinical handover to occur.  
 It is highly recommended that, where possible changes are in place to reinforce punctuality.

**5. Handover Place**  
 Set a specific location for clinical handover to occur. Preferably, clinical handover occurs:  
 Face to face  
 In the patient's presence, where appropriate ( bedside handover)

**6. Handover Process**  
 Define the clinical handover process.  
**Standardised Protocol:** Generate flow charts, scripts and cues for how clinical handover occurs each and every time. Your standard protocol should:  
 Clearly identify the patient, role and your role  
 State the immediate clinical situation of the patient  
 List the most important and recent observations  
 Provide relevant background/history to the patient's clinical situation  
 Identify assessments and actions that need to occur  
 Identify timeframes and requirements for transition of care  
 Promote the use of the patient record to access their information  
 Ensure documentation of all important findings on changes of condition  
 Ensure comprehension, acknowledgement and acceptance of responsibility by the patient by the clinician receiving handover

Clinical handover should be documented. Some examples of effective handover tools that use clinical handover communication and documentation are explained in the implementation tool (e.g. DOBAR, SBAR, QBAR).

**Where the condition of a patient is deteriorating:** Escalate the management of these patients as soon as a deterioration in condition is detected.

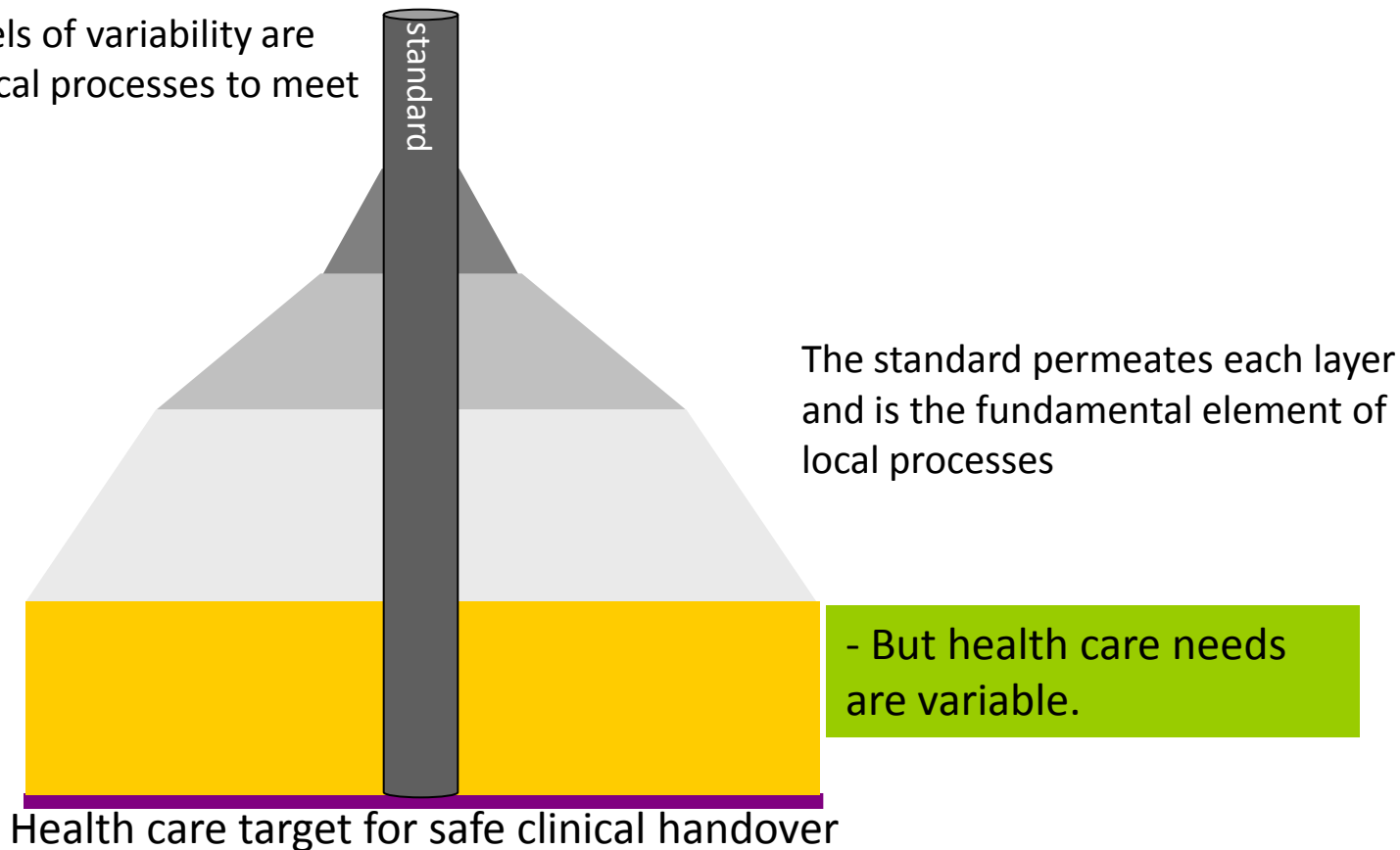
**Other Critical Information:** Provide alerts for any other important information (e.g. outstanding actions, planned patient moves, Occupational Health and Safety risk impacting staff or patient safety).

NSW HEALTH

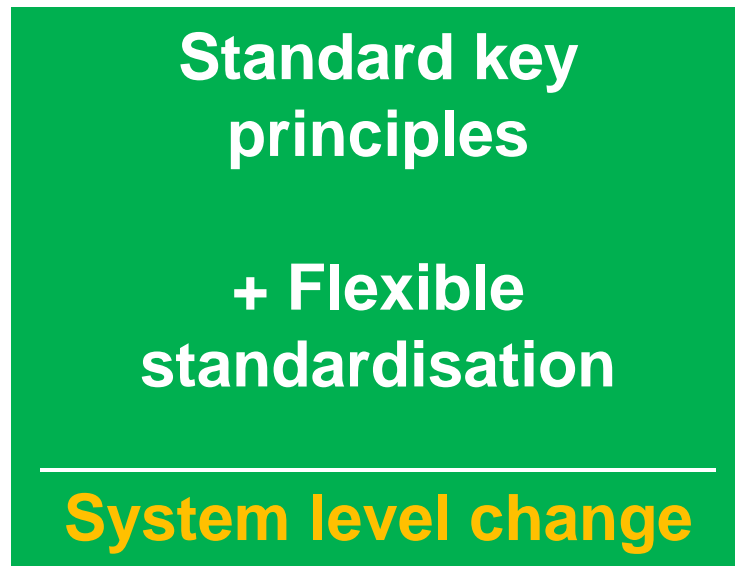
1. Leadership
2. Valuing handover
3. Handover participants
4. Handover time
5. Handover place
6. Handover process

# Flexible standardisation... **one size does not fit all**

Controlled levels of variability are required for local processes to meet local needs



# Locally appropriate implementation



Top down



Bottom up

Clinician designed and owned, but with direction from cascading of standardisation.

# Collective Accountability

Flexible standardisation, but there is accountability at multiple layers, e.g.:

- Acute Care Taskforce
- Executive Leaders
- Clinicians

# Collective Accountability...

## Acute Care Taskforce

- Implementation monitoring
- Foster and share innovation in clinical handover

# Collective Accountability...

## Executive Leaders

- Develop implementation plans.
- Support local process development.
- Share with peers and generate momentum through networking

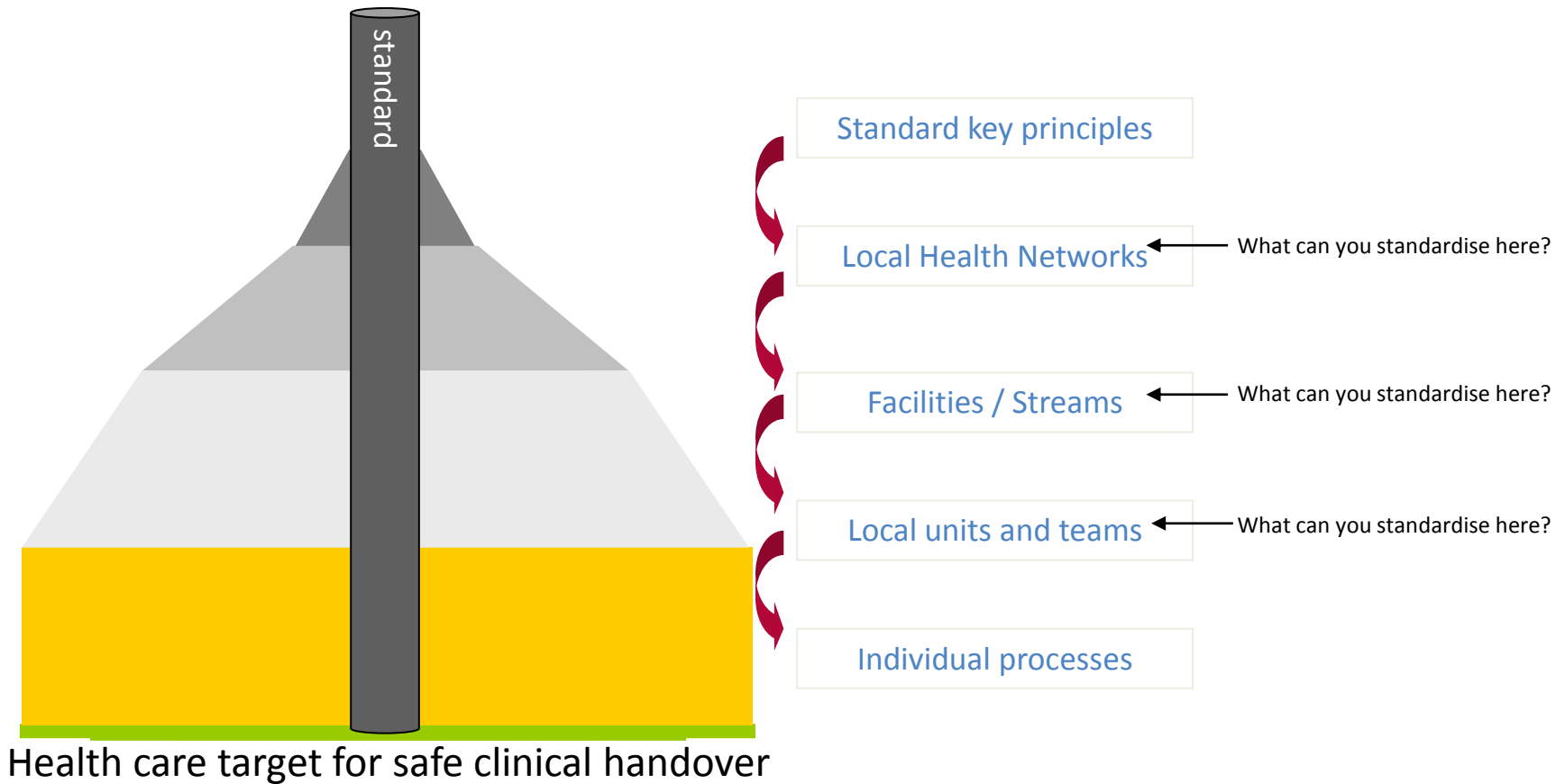
# Collective Accountability....

## Clinicians

- Value and implement safe clinical handover.
- Communicate early and effectively.
- Transfer accountability throughout the patient journey.
- Network and reduce process variability wherever possible.

# Collective Accountability...

## what does it look like?



# Implementation Momentum

- **2010** – 11 out of 11 Health Services identified implementation governance and strategy
- **2010** – 11 out of 11 Health Service site visits demonstrated implementation governance and strategy
- **2011** – transition of governance and strategy to 19 Health Networks

# Implementation Momentum

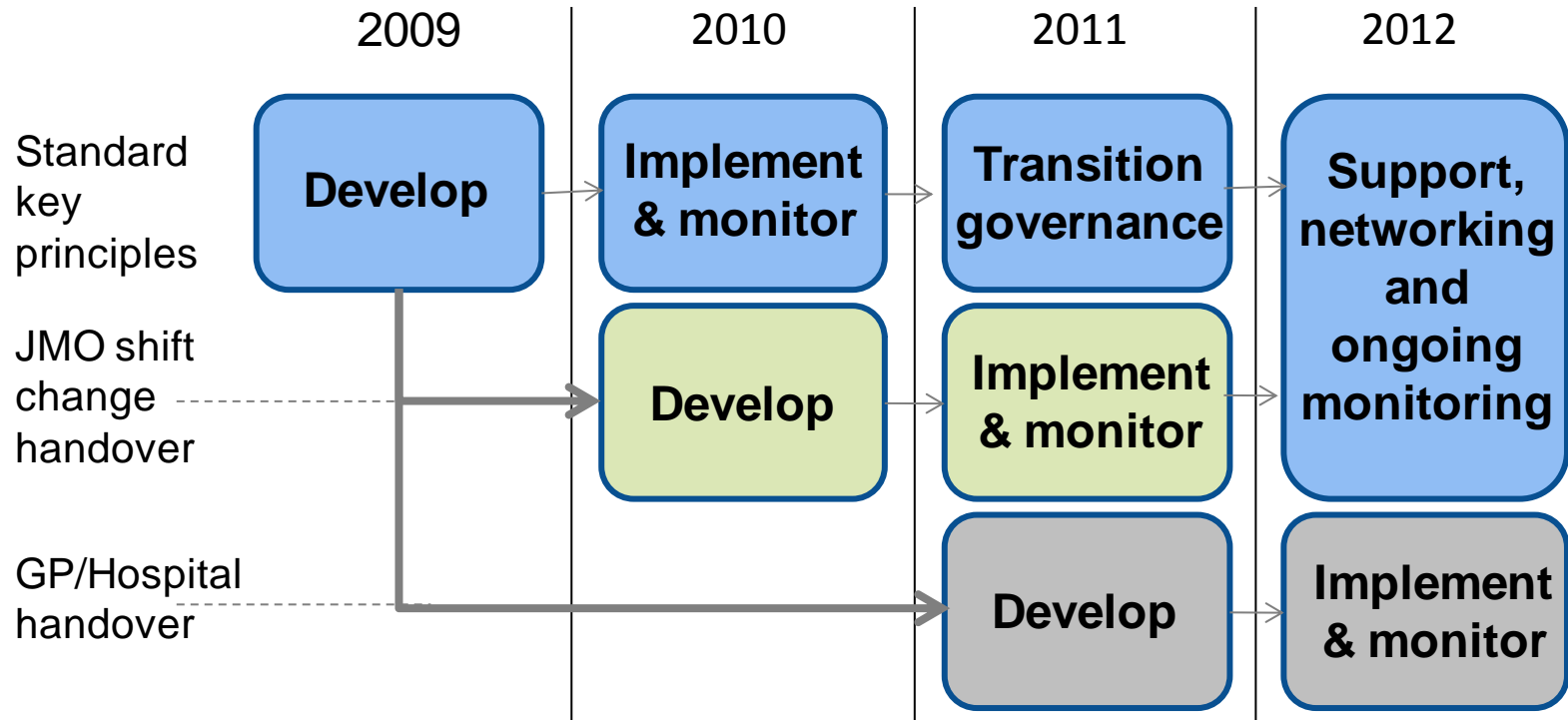
- **2011 - *Draft*** results from the Clinical Excellence Commission Quality Systems Assessment (2010) show that the NSW Safe Clinical Handover Program has improved clinical handover implementation most effectively at the facility level
- **i.e. coordinating strategy across the facility, rather than independent and individual projects in wards**

## DATA:

*85% at the facility level agreed / strongly agreed that 'The statewide Safe Clinical Handover Program has assisted our department/unit to implement and/or improve our clinical handover process.'*

# System level key principles

## + foci on 2 specific state-level projects



# Resources and contacts:

[www.archi.net.au/e-library/safety/clinical/nsw-handover](http://www.archi.net.au/e-library/safety/clinical/nsw-handover)

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