

Victorian Travelling Fellowship Program

Improving Ward Junior Medical Staff Shift-to-Shift Handover – lessons from home and abroad.

Dr Karen McLean

Dr Zornitza Stark

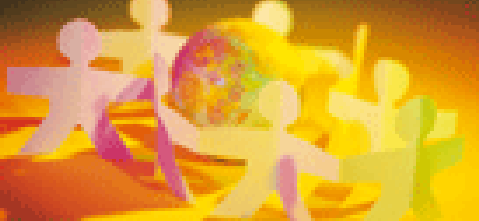
Bec Ziffer

Royal Children's Hospital



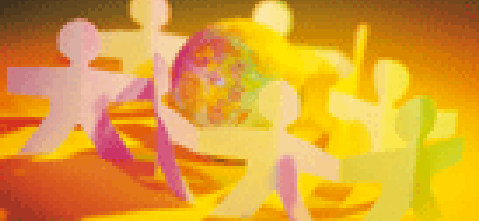
RCH JMS Handover Project

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



Clinical Handover

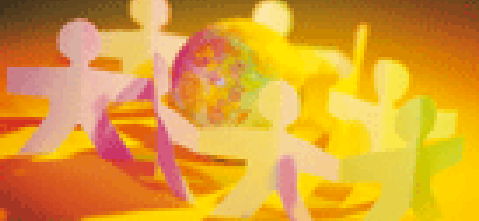
- “Clinical handover refers to the transfer of information from one health care provider to another when:
 - A patient has a change of location of care, and/or
 - When the care of a patient shifts from one provider to another.”
 - Australian Council for Safety and Quality in Health Care, May 2005



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Why does junior medical staff handover matter?

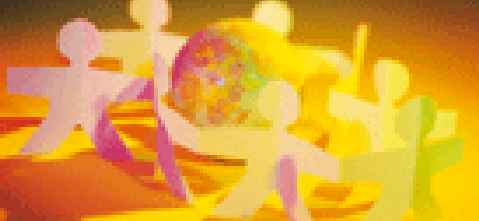
- Changing work practices for junior doctors have increased occasions of transfer of responsibility
 - 80 hour week in USA
 - European Working Time Directive
 - 58 hours in 2004
 - 48 hours in 2009



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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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Department of Human Services



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Melbourne*



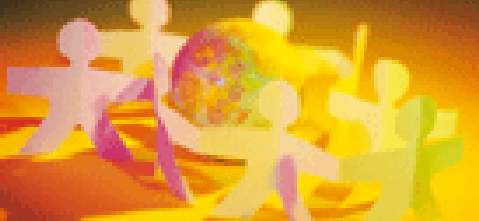
A Victorian
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initiative





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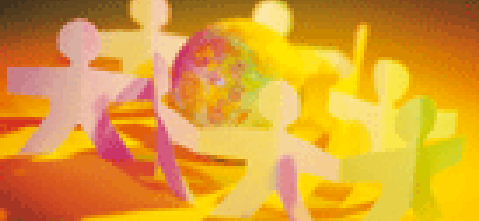
- 250 beds
- 32,000 admissions per year
- 4 general medical units
- 10 specialty inpatient medical teams
- 4 general surgical teams
- 4 subspecialty inpatient surgical teams
- PICU, NICU, ED



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Mon–Fri Day Evening Night

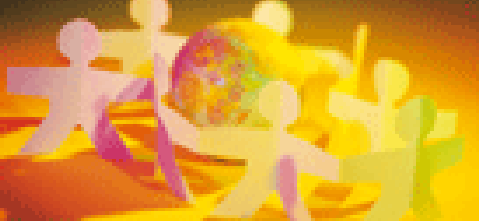
	Day	Evening	Night
General Medical	6 x reg 5 x res	1 x reg 1 x res	
Specialty Medical	8 x reg 10 x res	1 x reg 1 x res	2 x reg 2 x res
Surgical	7 x res	1 x res	



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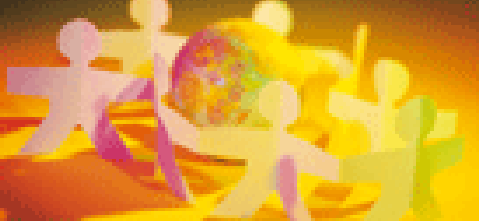
RCH morning handover audit

- Alternate weekdays in September 2006
- RMO quarters from 0715 - 08:30, then Blue Room until 09:00
- Recorded content using checklist



RCH Handover audit: results

- 11 days, 270 patients
- Much less consistency in practices for specialty medical and surgical units
- Specialty units often not receiving handover (conflict of priorities for night staff)
- No consistent content



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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

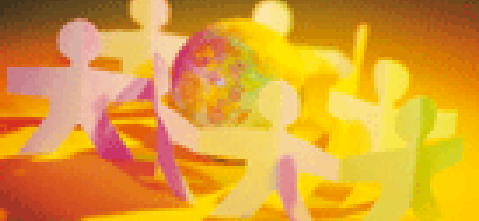




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VTFP - Travel Jan-Feb 2007

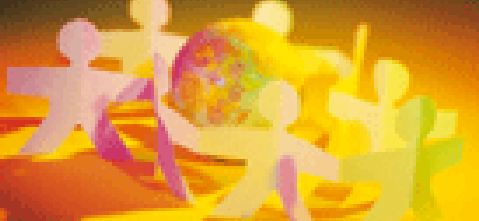
- Observed junior medical staff handovers (morning, afternoon and night)
- Met with junior and senior medical staff involved in handover improvements
- Met with Quality and Safety staff
- Received demonstrations of electronic systems



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Key lessons learned - travel phase

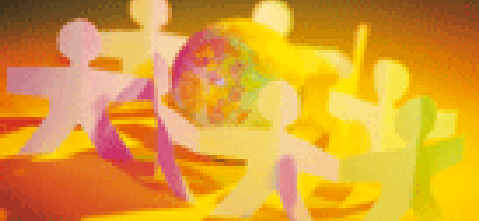
- Handover improvements should address process, content and documentation
- Checklist development should be situation specific
- Consistency of practice is important for patient safety



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Key lessons learned - travel phase

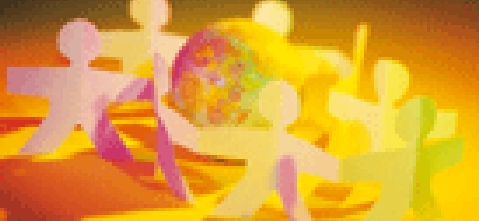
- System supports are crucial for good practice
- The best IT system is only as good as its users
- Having a designated leader of handover improves attendance & efficiency



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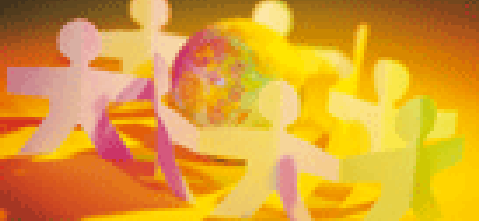
Development & pilot of Handover Toolkit

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



Improvement Process

- Assemble team
- Define current practice & safe handover
- Identify measurable outcomes
- Measure
- Decide how to achieve outcomes
- Pilot improvements
- Feedback and review
- Implementation with ongoing sustainability



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Department of Human Services

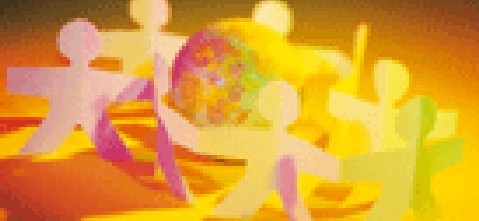


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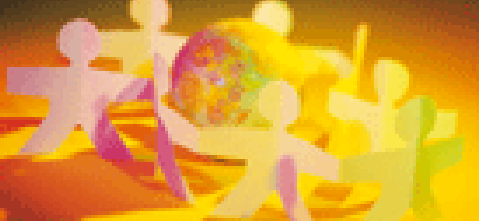


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WARD JUNIOR MEDICAL STAFF SHIFT-TO-SHIFT HANDOVER SAMPLE TEMPLATE

Patient admission: written template

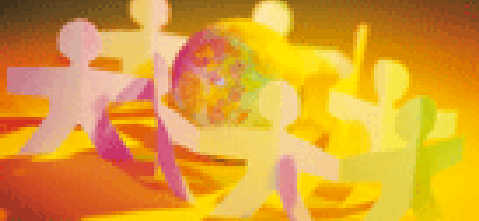
Name, Age, UR	Unit		Location
	Consultant		
	INFORMED: Y/N		
Reason for admission: (diagnosis or diagnostic/ management problem)			
Past medical history			
Brief history of presenting complaint			
Investigations & results			
Management (e.g. drugs, fluids)			
Plan for ongoing management & discharge criteria			
Outstanding tasks			
Need for review (circle)	Urgent, <30 minutes	Within 1 -2 hours	On routine ward round



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Pilot of toolkit

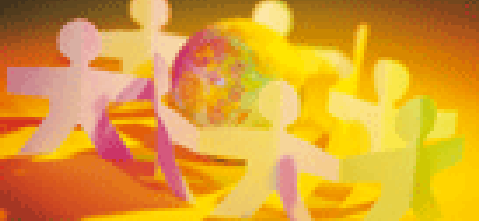
- Specialty Medical Morning Handover
- Improvement Process followed
- 2 week handover pilot mid-year
 - Education of participants & supervisors
- Satisfaction surveys



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Pilot results

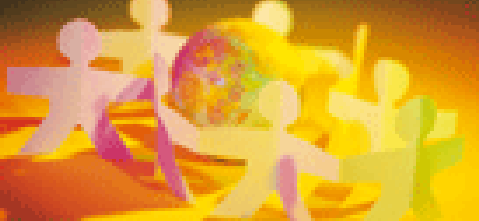
KPI	Pre-pilot	Pilot
Supervision by fellow	None	100%
Place: Blue Room	RMO quarters	100% blue room
Time \leq 45mins	Mean 44 Range 5-75	Mean 38 Range 29-47
Attendance by all units	N/A	100%



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Pilot Results

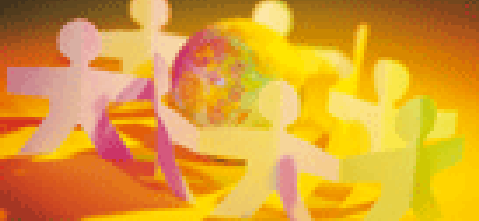
KPI	Pre-pilot	Pilot
Structured order of units	None	Structure followed
IT support used	Available but not used	Used 90% of time
Education discussions	1 in 11 days	50 in 10 days



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Pilot Results

KPI	Pre-pilot (11 days)	Pilot (10 days)
Number of admissions	24	41 (88% increase)
Number of reviewed patients	47	94 (120% increase)
Content	Name: 99.3% Presenting complaint: 81.5% Diagnosis: 39.6% Management plan: 35.6%	Name: 100% Presenting complaint: 100% Diagnosis: 100% Management plan: 100%



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Pilot results

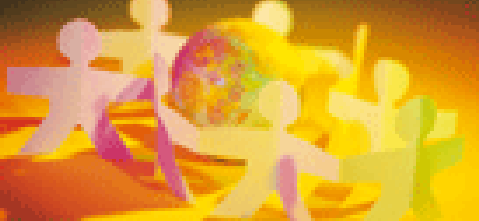
- User feedback overwhelmingly positive
- Additional benefits:
 - Increased feedback to night staff
 - Discussion of referrals
 - Spread of influence to Gen Med handover



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Where to now?

- Hospital executive approved three month trial
- Preliminary data suggests sustained change
- Other handovers at RCH



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Further information

Phase 1 Travel report:

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

For further information:

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