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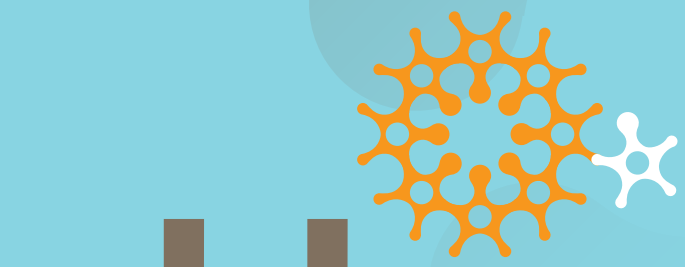


ahha

australian healthcare & hospitals association

ISSUES PAPER

2009

Clinical handover: system change, leadership and principles

Contents

1. Clinical Handover – Key Facts

Clinical Handover – Some Facts[1]

1. Clinical handover is a high risk scenario for patient safety. Dangers include discontinuity of care, adverse events and legal claims of malpractice (Wong et al, 2008)
2. Survey of Australian doctors revealed that 95% believed that there were no formal or set procedures for handover (Bomba and Praska, 2005)
3. An Australian study of emergency department handover found that in 15.4% of cases, not all required information was transferred, resulting in adverse events (Ye et al, 2007)
4. Survey of junior doctors in the UK discovered that 83% believe that handover processes were poor. Written handover was rarely received, accounting for only 6% of all handovers (Roughton and Severs, 1996)
5. A detailed analysis of nursing handover revealed that some handovers promote confusion and did not assist in patient care (Sexton et al, 2004)
6. Handover is among the most common cause of malpractice claims in the USA, especially among trainees, accounting for 20% of cases (Singh et al, 2007)
7. A survey among trainees in the USA suggested that 15% of adverse events, errors or near misses involved handover (Jagsi et al, 2005)

1 ACSQHC, 2009, *OSSIE Guide to clinical handover improvement for clinician-leaders and managers*, www.safetyandquality.org.au

Case Study Handover in an Emergency Department[2]

70 year old John Smith is shopping with his wife when he experiences severe chest pain. An ambulance is called, the ambulance officers take a brief history. The ambulance takes him to the emergency dept of the local hospital, a handover occurs with the triage nurse. John is allocated a bed and monitoring begins. The nurse allocated to John creates patient notes after taking a history and being given information by the ambulance officers. These notes are stored in the central area of the emergency department.

A young emergency doctor then sees John, it is busy so they do not get a chance to review the nurse's notes. The doctor takes another history and orders tests and medications.

The ECG is normal and John stabilises, however it is decided he should be seen by the cardiology registrar. It is early afternoon and a nursing shift change occurs. By 5pm he is ready to be discharged. A discharge letter is written and a prescription filled. During his six and half hours in emergency there have been 14 separate handovers of 10 different types. If John had stayed another hour there would have been a shift change for doctors involving another handover. Some patients stay in emergency departments for days[3].

2. Key issues in clinical handover

> Clinical 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[4]

The critical exchange of clinical and health information ('clinical handover') occurs repeatedly across healthcare settings and between health professionals throughout a patient/client journey. At stake is the health and wellbeing of patients and clients, their safety and the quality of care they receive. Examples of some key handover scenarios include:

2 This is an abridged version of a case study contained in ACSQHC, 2008, *Windows into Safety and Quality in Health Care 2008*, Sydney

3 AIHW hospital statistics 2006-07 Canberra 2008

4 Australian Medical Association Safe handover: Safe Patients. 2006 – adapted from the British Medical Association publication *Safe handover: safe patients – Guidance on clinical handover for clinicians and managers*

- ambulance to emergency department
- inter-professional (i.e. referral letter from general practitioners to specialists)
- hospital to community (i.e. discharge summaries provided to GPs, specialists or residential care)
- hospital to hospital (inter-hospital transfers)
- medical to nursing and vice versa (i.e. the exchange of clinical information between shifts or wards in an acute or residential care setting (see Diagram A).

Despite the vital nature of this information exchange the range of care and transfer settings along with different processes that exist today creates a complicated, inconsistent environment for proper handover. As a result, health care professionals may rely on patients or clients, family or caregivers as a primary source of this critical information, even though they may not possess the capacity, skills, knowledge or availability to do so.

2.1 High Risk Scenarios in Clinical Handover

"Clinical handover is a high risk scenario for patient safety with dangers of discontinuity of care, adverse events and legal claims of malpractice"[5]

The **major themes** identified in the literature relating to high risk scenarios in clinical handover can be summarised as follows:

- Inter-profession handover
- Inter-departmental handover
- Shift to shift handover
- Hospital to community handover
- Providing verbal handover only
- The use of abbreviation in handover
- Patient characteristics affect handover
- Characteristics of handover

5 Wong MC,Yee KC Clinical Handover Literature Review, eHealth Services Research Group University of Tasmania Aust,2008.

To achieve proper handover, healthcare professionals of varying clinical skill levels must be able to communicate and receive information from one another which is accurate, timely and understandable.

Opportunities currently exist to develop a genuinely co-ordinated national approach based on a common set of principles, through the involvement of healthcare providers representing the public and private sectors across the care continuum.

The AHHA has convened a national multidisciplinary group to develop practical policy options around clinical handover with reference to specific initiatives organised by the Australian Commission on Safety and Quality in Health Care (ACSQHC). The full list of participants in this Working Group can be found in section 6.

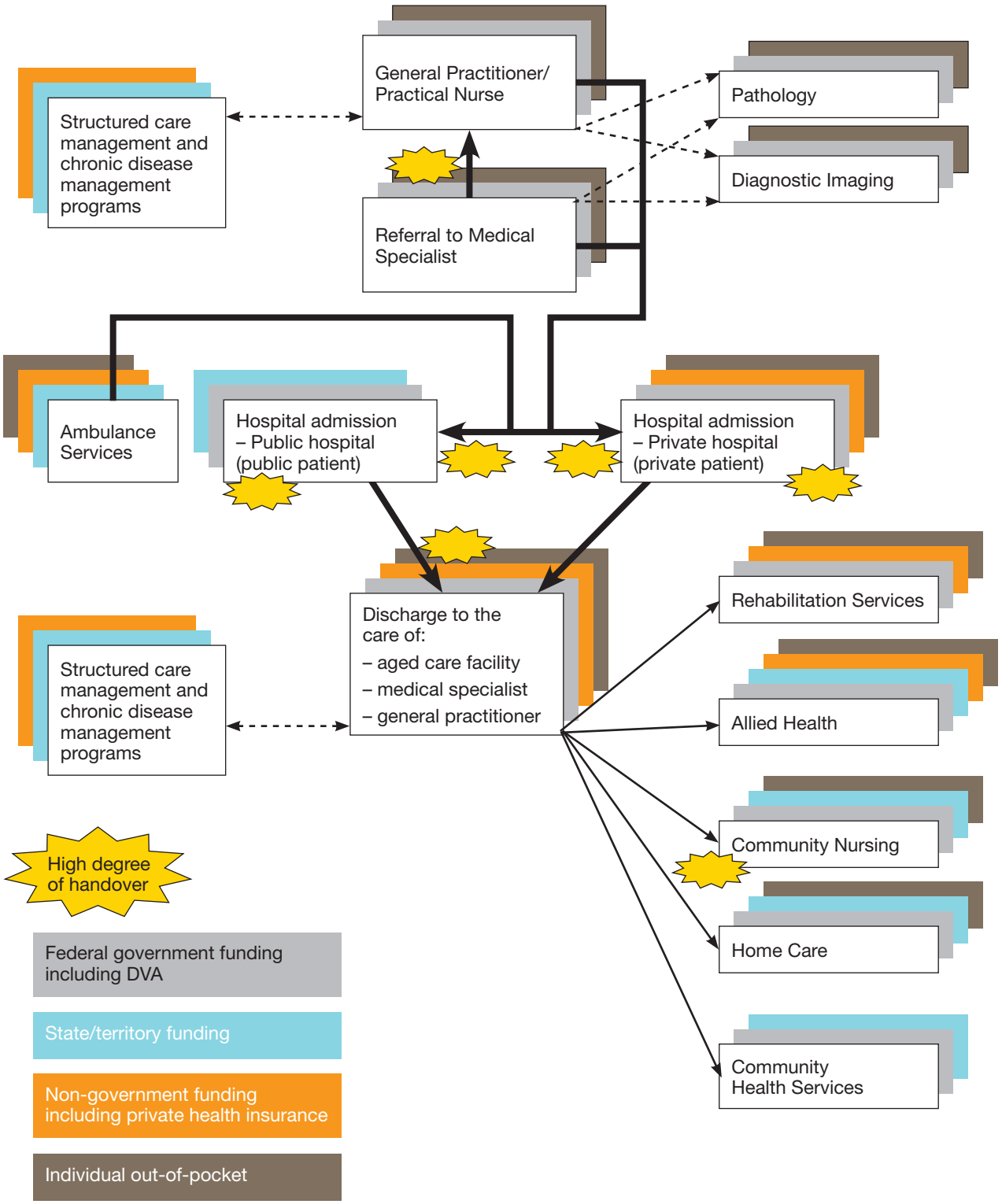
2.2 Snapshot of developments in clinical handover

Interest in clinical handover has been growing for a number of years both nationally and internationally, particularly after the World Health Organization (WHO) launched the Nine Patient Safety Solutions in May 2007[6]. One of these solutions relates to "communication during patient handovers". Australia was well advanced in addressing this issue with the former Council for Safety and Quality in Healthcare. They raised awareness with the publication of a literature review and an important workshop in 2005. The current Australian Commission on Safety and Quality in Health Care (ACSQHC) is now leading a national clinical handover initiative and is also leading international collaboration on clinical handover. Recently the ACSQHC released the OSSIE Guide to Clinical Handover Improvement (the OSSIE Guide) which provides practical guidelines for clinicians and service providers to implement safe handover practices[7].

6 WHO launches "Nine patient safety solutions" News release Washington/Geneva 2 May 2007

7 ACSQHC, 2009, *OSSIE Guide to clinical handover improvement for clinician-leaders and managers*

Clinical Handover: Clinical Information Exchange throughout a Typical Patient Journey



Source: 360health Pty Ltd

Concerns about safety and quality are driving a wave of reforms around the world. Changes in healthcare delivery over the last 30 years have transformed many healthcare settings, particularly hospitals, into what could be argued are the most complex organisations in our society. This increase in technical complexity has brought with it the need to ensure the operational infrastructure and processes continue to support the basics of good care, teamwork, coordination, attention to detail and awareness of clinical deterioration.

In the United States mandated quality and safety measures have been introduced that are linked to payment systems. In the United Kingdom the National Patient Safety Agency is working to standardise handover arrangements in UK hospitals to bring about improvement in safety and quality.

In Australia our federal structure of government has given rise to a number of state agencies or groups that each have a mandate to bring about improvement in quality, safety and clinical governance. Clinical handover is either specifically or generally addressed by these organisations as breakdowns in clinical communication are major contributors to errors in patient care.

Each state has numerous pilots and initiatives underway in addition to the projects funded by the ACSQHC. State agencies include the NSW Clinical Excellence Commission, the Victorian Quality Council, Queensland Health Patient Safety Centre, Office of Safety and Quality in Health Care (Department of Health WA). Added to this body of work are the contributions of the Australian Medical Association (AMA), academic centres, area health services and individual hospitals. This amounts to considerable effort across many fronts to improve clinical handover and communication.

In 2006 the ACSQHC was established to lead and coordinate national improvements in safety and quality. Clinical handover is a priority program for the Commission. The purpose of their National Clinical Handover Initiative is to identify, develop and improve clinical handover in a range of healthcare settings. The first phase has included 14 pilot projects that developed practical and transferrable tools and solutions for improving handover.

It is not our intention in this paper to document in detail the many pilot programs and initiatives completed or underway, although links to some of these activities can be found in Appendix B. In bringing together the Clinical Handover Policy Group the AHHA is developing independent policy that will complement and feed into the work of the ACSQHC and other major bodies like the National Health and Hospitals Reform Commission.

2.3 Relevant Australian Inquiries

There have been many inquiries over the years into failures of the health system particularly when they have resulted in death and disability. In recent times the Forster Inquiry in Queensland followed the activities of Dr Jayant Patel and the Garling Report in NSW followed the Coronial inquest into the death of Vanessa Anderson. The recommendations of these inquiries have given rise to structural and organisational changes to bring about improvement in quality and safety.

2.3.1 The Garling Report

The Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals ("the Garling report") had a wide ranging brief. The Final Report extensively analysed factors affecting communication between health professionals and the impact that poor communication has on patient safety and the efficient operation of hospital services. Clinical handover is arguably the most important communication mechanism to ensure patient safety. The Commission took a lot of evidence and heard about many individual projects to improve clinical handover. Despite the value of these individual projects the Commission found that "**they had not yet delivered system-wide improvement**".

Garling found that despite significant effort across all jurisdictions, the piloting of countless projects and initiatives the evidence is that system wide improvement to good clinical handovers remains elusive.[8]

Garling Report noted that, in NSW handover on change of shift is not mandatory, and there is no NSW Health state-wide policy applying to shift handover [what is the situation in other states and territories?]. Garling recommended that:

Within 18 months NSW Health should ensure that each hospital designs and introduces a mandatory shift handover policy, which includes, as a minimum:

a. *a requirement that part of the handover occurs at the patient's bedside;*

b. *a requirement that sufficient time designated for handover is built into the rostering system;*

c. *a requirement for the information which is to be conveyed during handover; and*

d. *a requirement that a written or electronic record be made of the handover*

The Garling Report also acknowledged appropriate training and coaching was required along with shift handover being based on a multi-disciplinary team approach.

2.3.2 The National Health and Hospital Reform Commission

The National Health and Hospital Reform Commission has produced its final report, *A Healthier Future for all Australians*[9]. Based on its interim report, the NHHRC identified promoting improved safety and quality as one of the critical challenges facing the Australian health system. Clinical handover between shifts in hospitals is one of the critical issues to improve safety and quality.

Critically, the NHHRC identified strong national leadership as a pre-requisite to system wide change. Whilst the NHHRC identified the existing ACSQHC as the lead national body it noted that its mandate was time limited and lacked a statutory base which prevented it from fulfilling this national leadership and monitoring role.

The NHHRC proposes that a permanent national body be established and charged with leading and co-ordinating safety and quality in all Australian health care settings. The NHHRC noted the need for cultural change to improve and strengthen clinical governance in Australian hospitals. The need for clinician engagement and leadership is a theme that comes across consistently in both the Garling and NHHRC Reports.

The NHHRC also noted that the will for implementing change around safety and quality is high. Despite this positive attitude and understanding of what needs to be done they also flagged the many barriers and frustrations to achieve more than **'marginal, piecemeal improvement'.** Despite significant investment, many initiatives around quality and safety have not proved to be sustainable, as they have not been implemented system-side. This cannot continue in the future and requires further work to identify sustainable approaches for good quality handover.

The NHHRC suggest the following matters must be addressed:

- Need for closer alignment between research and clinical practice
- Research culture within Australia's major public hospitals needs to be revived
- Need to change the culture of the health system so that research and knowledge transfer are recognised as essential prerequisites to improving patient outcomes
- Too few staff with too little time with too many patients
- Top down and bottom up approach, innovate locally and share nationally
- Clinical governance has to be linked to accountability

9 NHHRC, released 27 July 2009

- Investment in health information technology
- Strategic gap in leadership and vision
- Engage front line staff more fully.

The NHHRC concluded that existing approaches to safety and quality are too peripheral to guide the systematic reform that is required for improvements in the health system of the future[10].

These reviews provide us with the imperative to move forward with national coordination and leadership of critical safety and quality measures such as clinical handover.

2.4 Technology Infrastructure Gains

The NHHRC's recently released paper on electronic health records points out the lag in health IT investment compared to other industries despite the knowledge that e-health is one of the most important enablers of personal health management and quality health care. They go on to say;

> The timely and accurate communication of pertinent, up to date health details of an individual can enhance the quality, safety and continuity of health care.
>
> Current health information systems are disjointed, which often results in health care professionals operating with incomplete or incorrect patient information. It is estimated that up to 18 per cent of medical errors are a result of inadequate availability of patient information.[11]

There are a number of initiatives underway regarding the development and use of technologies that will be critical to improving clinical handover:

1. The National E-Health Transition Authority (NEHTA) is building the essential "building blocks" required to electronically exchange information in an accurate, consistent and timely manner and has included two key components of clinical handover in its initial development work: discharge summaries and referrals;
2. The 'National eHealth Strategy' was commissioned by the Australian Health Ministers' Advisory Council that provides a high-level roadmap for future development;

10 NHHRC Interim Report p.346

11 NHHRC Supplementary Paper, *Person-controlled Electronic Health Records*, page 1

3. The Commonwealth Government has committed to a National Broadband network, capable of transmitting large medical files, films and records from one provider to another.

Electronic data capture incorporated as a component of clinical handover has the capacity to act as a catalyst to drive change. It will:

- Facilitate the exchange of accurate and timely information between healthcare professionals, whether within a facility, within a community (i.e. mobile or remote delivery) or across sectors;
- Enable the evaluation of clinical handover performance indicators and associated auditing;
- Provide the basis for funding payments and 'pay for performance' incentives;
- Provide aggregate data for future research, quality initiatives and cost/benefit analyses; and
- Meet growing career expectations within the healthcare workforce surrounding the use of technologies.

3. Principles to Guide Action

> Why is clinical handover not done consistently well when we know it carries such high risks? How does this relate to governance, resourcing (time and money), the structure of the health system and professional responsibility in multi-disciplinary care?

There are several compelling principles that should underpin the development and implementation of clinical handover in Australia. While specific initiatives and some hospital and area-wide policies may reflect these principles, there is no consistency or agreement across the country – and possibly within single sites and between individual professionals. This is unquestionably resulting in significant differences of approach and emphasis between service providers, areas and states/territories in the safety and quality of care provided.

Other system issues need to be addressed in parallel with clinical handover developments, including overall monitoring and public reporting of service performance, organisational

culture and system change, unreasonable resource pressures on hospitals and health services, problems attracting sufficient staff and the meaningful engagement of consumers.

The AHHA believes that a nationally-consistent and universal set of principles guiding clinical handover will bring about significant improvements in healthcare for patients, and ultimately cost savings for governments and consumers. Such principles will make it easier to collect and report data in a consistent way in order to compare outcomes and improve services.

The diversity of handover situations and local circumstances must be capable of being maintained or adapted under any form of national guidelines or data collection requirements.

The National Health Service (NHS) in the United Kingdom has developed a guide for staff called *Seven steps to patient safety* (second edition, 2004). Though they apply to safety across the board, the AHHA believes these steps could be adapted to form the principles underpinning clinical handover in Australia; from national guidelines to state-wide, local and organisational practices and policies:

- Positive handover-focussed culture
- Leadership and support
- Accountability and responsibility guided by robust clinical governance
- Risk management
- Promotion of internal and public reporting
- Involvement of clinicians and consumers
- Learning and sharing good practice
- Systematic implementation

In Australia, work has been undertaken in NSW by the Acute Care Taskforce on developing a set of state-wide clinical handover principles stemming from the recommendations of the Garling review. These principles mirror those above and provide a practical checklist. They are available from the NSW Health Acute Care Taskforce. You can access related materials on the Australian Resource Centre for Healthcare Innovation (ARCHI) if you are a member.

4. Recommendations

Taking account of the work that is already underway through the Australian Commission on Safety and Quality in Health Care (ACSQHC), and suggestions put forward by the National Health and Hospitals Reform Commission the AHHA makes the following recommendation to ensure clinical handover is centrally embedded in the health system as reform is implemented.

Recommendation CH1 – Governance and System Leadership

The AHHA supports the NHHRC recommendation that the ACSQHC be established as an independent and permanent statutory authority with responsibility and accountability for clinical handover within Australia's health system. This will require the relationship of the ACSQHC and state bodies to be defined. The reporting mechanisms of the state bodies should be aligned to their relevant state parliament rather than the government of the day. This will ensure transparency.

State and Territory governments are encouraged to follow the lead of Western Australia and make clinical handover mandatory in all public and private hospitals.

Recommendation CH2 – National Standards

The AHHA supports current initiatives underway for the creation of national health standards for all health services. As part of this set, we believe performance measures and guidelines for clinical handover should be developed and mandated as a priority to the national data set.

The AHHA recommends that ACSQHC work in tandem with NEHTA in continuing to prioritise clinical handover specifications, including minimum data sets, to be developed for internal use in all Australian public and private hospitals, in the first instance. This would include handover from shift-to-shift and from ward-to-ward, and could be based on the OSSIE guide. Once these standards are implemented, this work should be immediately extended to data sets and processes required of primary, community and aged care.

The level and priority for standardisation should also be driven based a patient acuity levels.

Recommendation CH3 – Support for 'flexible standardisation'

In recognition that clinical handover occurs multiple times throughout Australia's health system, the AHHA supports ACSQHC's concepts regarding 'flexible standardisation'. That is, national models and processes are required, but augmented with the flexibility to accommodate the realities within a local ward, unit or institution.

Standard models and policies can be created and leveraged cross-sector, with flexibility for healthcare delivery at a local level. From a patient's perspective, clinical handover should be a seamless experience, regardless of jurisdiction or funder.

Recommendation CH4 – Clinical Engagement

The AHHA strongly supports the recommendations of both Garling and the NHHRC that clinical engagement and systemic cultural change are prerequisites to improved clinical communications. Resources must be allocated to change management if cultural change is to be seen. Examples include Clinical Senates now established in several states.

Recommendation CH5 – The Economic Case for Clinical Handover

When budgets are under pressure staff time for clinical handover is often relinquished in the drive for 'efficiency savings'. This can be a false economy. Preliminary results from the ACSQHC pilot projects suggest that organised handover saves time and creates savings. The AHHA recommends that ongoing research and evaluation be undertaken to fully understand the economic case for differing handover processes and models.

Recommendation CH6 – Investment in technologies

Effective clinical handover occurs with the communication (both transmission and receipt) of timely and accurate patient/client information between care providers. As such, the AHHA recommends that the Commonwealth Government ensures essential and adequate investment in relevant technologies required to ensure effective handover.

Priority should be given to investing in healthcare environments that care for the highest acuity of patients, along with those environments representing the highest frequency of clinical handover (refer to Recommendation CH2).

The full value of these investments can only be achieved if our workforce has been properly trained in these technologies and understand their impact to workflow. These training requirements need to be reflected in budgets and staff schedules.

Recommendation CH7 – Workforce Issues

Workforce diversity must be respected in the creation, introduction and rapid adoption of effective clinical handover models and processes. Specifically,

- A vast skill differential exists between healthcare professionals throughout the care continuum.
- The healthcare workforce is comprised of both full- and part-time professionals.
- English is often a second language in some cultures and care settings.
- Technology/ computer skills vary widely across the sector.

Recommendation CH8 – Rewards for Success

AHHA believes that clinical handover is such an important component of quality and safety that national recognition should be provided for the delivery of exemplary clinical handover systems and tools. Recognition can be provided through financial incentives and national award recognition.

5. Case studies

5.1 Aged Care Home Transfer-to-Hospital Envelope Trial[12]

Transfer of residents from Aged Care Homes (ACH) to hospital is known as one of the highest risk clinical handover scenarios. This is due to Aged Care Home staff, ambulance officers and hospital staff using different communication modalities which in turn generates a high risk of communication failure.

In 2008, the Australian Commission on Safety and Quality in Health Care, through the National Clinical Handover Initiative, funded a one-year trial to evaluate the efficacy of the Aged Care Home Transfer-to-Hospital Envelope. The Envelope operates as a container for documentation and features a checklist of key clinical and other handover information needed when a resident is transferred from an ACH to hospital.

12 http://www.health.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-05_NEVDGP. Accessed 16/5/09.

The trial involved 26 Aged Care Homes, the emergency departments of six major Melbourne metropolitan public teaching hospitals and the Ambulance Service of Victoria. Evaluation was undertaken by written survey and face-to-face interviews.

An evaluation demonstrated that the Envelope improved clinical handover (and subsequently, clinical outcomes), while raising awareness of the need for standard operating procedures for clinical handover between ACH's and hospitals.

The study recommends that the ACH Transfer-to-Hospital Envelope be implemented on a National level. It was recognized that implementation of this strategy should not be cost prohibitive and that it would be necessary to educate and harness the support of residential aged care providers, ambulance services and hospital emergency department staff nationwide.

5.2 HELiCS – Handover Enabling Learning in Communication for Safety[13]

HELiCS is a video-based method used to improve clinical handover. Video captures aspects of how clinicians work and communicate that are not visible to the naked eye. Video provides an opportunity for frontline clinicians to observe, question, restructure and evaluate their handover practices.

The project involved collaborating with 3 inpatient health care providers in 3 NSW Area Health Services and was funded by the Australian Commission on Safety and Quality in Health Care. These services ranged from emergency health care, intensive care and long term rehabilitation. In each case following observation and capture on video, there was handover redesign and improvement. It also highlighted the strength of each of the services.

This work highlights that the approach to handover depends on clinical speciality and organisational circumstances. For example, in ED there is a wide range of activities and short length of stay. In intensive care, handovers may involve in-depth deliberations about diagnostic and prognostic matters. In rehabilitation, patients may stay for months and have multiple re-admissions. Handovers focus on holistic well being of the patients and aim to foster patient independence.

13 Iedema R, Merrick ET. HELiCS: Handover-Enabling Learning in Communication for Safety. Sydney: Australian Commission on Safety and Quality in Health Care & University of Technology, Sydney, 2008.

5.3 Improving handover for chronic disease patients in East Arnhem Land[14]

The Gove District Hospital Clinical Handover Project aimed to achieve the best possible continuity of care for patients with chronic diseases by:

- Identifying chronic disease clients on hospital admission.
- Developing a simple process for the chronic disease care plan to move between acute and remote health services
- Developing an effective system for notifying chronic disease nurses when their clients are admitted to hospital.
- Increasing the number of rural prescriptions discharged with the patient to the community.
- Improving the timeliness of delivery of discharge medications to remote communities.

The successful adoption of these changes has reduced the risk of failure of handover for chronic disease patients in East Arnhem Land.

5.4 Revolving Doors – Effective communication in the handover of mental health patients to community health practitioners[15]

St. John of God Health Services Ltd (NSW Services) Clinical Handover project addresses the needs of patients with mental health illness as they transit care form the private hospital setting to their community practitioner(s).

This innovative project is creating a three-way communication protocol where hospital practitioners, community practitioners and patients all contribute. A recent survey of general practitioners, conducted to inform the development of the three-way protocol, highlighted the importance that community practitioners place on diagnosis, medications, follow-up arrangements and the patient's risk of self-harm.

14 Australian Commission on Safety and Quality in Health Care (October 2008), Windows into Safety and Quality in Health Care 2008, ACSQHC, Sydney.

15 Australian Commission on Safety and Quality in Health Care (October 2008), Windows into Safety and Quality in Health Care 2008, ACSQHC, Sydney

5.5 Reducing Risk by Moving Clinical Handover to the Bedside – Sydney South West Area Health Service[16]

The clinical handover at Campbelltown Hospital Emergency Department was moved to the bedside with an opportunity for patient input and staff viewing of the patient and the relevant monitoring equipment and infusion devices.

The change arose from repetitive clinical incidents occurring in ED. Missed, duplicated, incorrect medication, lack of recognition of a sick or deteriorating patient; and lack of reference to results was a basis for error.

Staff also complained about time lost correcting problems from the previous shift – clarifying if interventions/treatments were actually carried out as indicated at handover; and finding information eg. the patient medical record, medication and observation charts was also time consuming and provided no clinical value.

Random hospital wide clinical audits and reviews were conducted to identify how the problems occurred and why staff were not identifying important information at handover.

Senior nurses with collaboration of medical staff developed an education and clinical handover process that would be consistently utilised through ED and wards of the hospital.

The change required a systematic process for handover and critical education. Senior clinicians and management were involved with the design and delivery of the education.

In ED, all staff were educated about the importance of handover and the reasons for change. The clinical record would be amalgamated into one (nursing/obs and medical clinical record). The handover would occur at the bedside.

Since changes were made, there has been a reduction in clinical incidents reported.

5.6 Clinical Handover in a 35 bed private wing attached to a public hospital in semi-rural NSW within SWAHS

Information was provided by a senior nurse who has worked in the hospital for ten years.

The handover process is guided by the protocol of the Area Health Service. The model used for clinical handover is a tape-recorded handover at the end of each shift.

16 http://www.archi.net.au/e-library/clinical/clinical-handover. Accessed 14/5/09

All incoming staff gather in a side room to listen to the recording. It takes about 30 minutes and generally works well (8 out of a 1-10 scale). Handover sheets are used which saves repetition of patient details, diagnosis and treating doctor. After the handover, staff check their patients' notes, then the patients, their medications and their care plan.

Negative aspects of this mode of handover:

- Some staff are too long winded when recording.
- Poor speech – there are often difficulties in understanding taped speech, especially from staff with foreign accents. This wastes time as the tape has to be re-wound and played again. Sometimes it is impossible to determine what has been recorded.
- Young graduates are too nervous about recording.
- No hand over education.

Handover at discharge was deemed to be problematical because of:

- Poor discharge documentation and lack of co-operation from medical staff regarding communication with GPs.
- No standard information is provided to patients especially regarding medications – a major problem with elderly patients. This information cannot be given by nurses.

Possible solution – give them a dose administration pack on discharge.

6. Acknowledgements

6.1 Group Members

AHHA Clinical Handover Working Group

Chair: Ms Annette Schmiede, Health Consultant

Contributors via teleconference and email

Professor Steven Boyages, Chief Executive, Sydney West Area Health Service (NSW)

Ms Nicole Brooke, Senior Lecturer, Faculty of Nursing, Midwifery & Health, University of Technology, Sydney (NSW)

Mr Peter Brown, Cancer Voices Australia (NSW)

Ms Barbara Cass, Associate Manager, Palliative Care Unit, Peninsula Health (VIC)

Ms Rosio Cordova, Assistant Director, Clinical Governance, Sydney West Area Health Service (NSW)

Ms Tess Dellagiacoma, Senior Business Analyst, Business Improvement Directorate, Department of Ageing, Disability and Home Care (NSW)

Ms Anne Hayward, Clinical Handover (Shift-to-Shift) Project, St Vincents & Mercy Private Hospital (VIC)

Ms Tamsin Kaneen, Project Officer, Australian Commission on Safety and Quality in Health Care (NSW)

Dr George Margelis, Industry Development Manager, Digital Health Group, Intel Australia (NSW)

Ms Jacqueline Milne, NSW

Mr Paul Morgan, Special Projects Manager, The Mater Hospital (NSW)

Dr David Mountain, Emergency Staff Specialist, Sir Charles Gairdner Hospital (WA)

Ms Heather Neubauer, Management Adviser (Residential), RSL Care (QLD)

Ms Rowena Richardson, Team Leader, Patient Safety Centre, Queensland Health (QLD)

Ms Lissa Smith, Director, 360 Health (NSW)

Mr Scott Trueman, Queensland Health (QLD)

Associate Professor Merrilyn Walton, Centre for Innovation in Professional Health Education and Research (CIPHER), University of Sydney (NSW)

Australian Healthcare & Hospitals Association
Ph +61 2 6162 0780
Fax +61 2 6162 0779
Email admin@aushealthcare.com.au
PO Box 78
Deakin West ACT 2600
www.aushealthcare.com.au
ABN 49 008 528 470