Improving JMO clinical handover at all shift changes

Implementation Toolkit

SHPN (HSPI) 100536

Further copies of this document can be downloaded
from http://www.archi.net.au/e-library/safety/clinical/nsw-handover
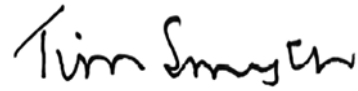
December 2010

Foreword

The Acute Care Taskforce is working to promote safe clinical handover in the NSW health system, with a special focus on clinical handover at all shift changes (weekdays and weekends) for Junior Medical Officers (JMO).

Changing medical work hours has benefited the work–life balance of medical officers, but leads to increased transfers of patient care between clinicians.
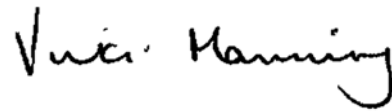
JMOs are the least experienced members of the medical workforce, and frequently move between wards, facilities and Health Services. Inexperience and variable or absent processes relating to clinical handover have been shown to present significant risks for patient care.

Ensuring that handover happens with consistency and quality, at all shift changes, will provide clarity of responsibility and accountability for all clinicians. Improving clinical handover by providing strong senior leadership and supervision of handover will enhance patient care, JMO learning, staff communication and confidence.

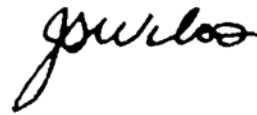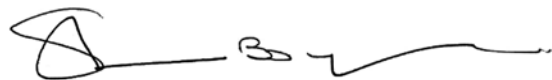Safe clinical handover is essential to patient care.

Dr Tim Smyth
Deputy Director-General, Health System Quality,
Performance and Innovation

Ms Vicki Manning
Acute Care Taskforce
Co-Chair

Professor Jeremy Wilson
Acute Care Taskforce
Co-Chair

Professor Steven Boyages
Chief Executive, Clinical Education and Training Institute

Dr Hamish Dunn
Chair, Junior Medical Officer Forum (CETI)

Contents

At a glance

Between the Flags (PD2010_026) and Safe Clinical Handover (PD2009_060) are two important mandates in the NSW health system that place a strong focus on effective and early clinical communication of changes to patient condition.

This document aims to assist facilities to implement locally appropriate clinical handover processes at all Junior Medical Officer (JMO) shift changes, improving the consistency and quality of clinical communication for better patient outcomes.

Both junior and senior medical officers, with metropolitan and rural representation, have collaborated in the writing of this document to ensure that it meets their needs.

Clinical handover definition

Clinical handover has a nationally and internationally recognised definition.

'…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.' [1,3,10.]

In your facility, does JMO clinical handover:

• happen at all shift changes?
• have a consistent process?
• promote quality clinical communication?
• improve patient care outcomes?

Three key elements have been defined to help improve JMO clinical handover

1 A communication framework for JMOs (ISBAR).
A communication framework using a minimum data set to guide clinical handover can ensure consistent and complete, yet concise, handover interactions.
– Detail on the ISBAR communication framework commences page 6.

2 Senior leadership: who and what should be handed over?
All JMOs require leadership and supervision from more senior clinicians (eg Registrars, Consultants) to determine which patients and what information have the greatest priority for handover.

– Detail on senior leadership at handover commences page 7.

3 Shift to shift handover: key principles for locally appropriate implementation.
JMO clinical handover processes must be appropriate to local needs and appropriate to the specific shift change (day, evening or night and on weekends).

All facilities have the flexibility to determine locally appropriate processes, but need to ensure that those processes (day, evening and night) meet a set of key principles.
– Detail on the key principles commences page 9.

But wait… who is a JMO?

For the purpose of this document, a JMO is defined as a medical officer who is a part of the prevocational training program of the NSW Clinical Education and Training Institute (CETI, formerly IMET):

• Australian medical school postgraduates, Year 1 and Year 2 and
• Australian Medical Council graduates, Year 1 and Year 2.

There is a broader intention to the program.

All facilities are encouraged to consider how the key elements of the JMO shift handover project can be transferred or tailored to other 'junior' doctors and other scenarios of handover (eg handover between medical teams or transfer between facilities or the community).

What is my responsibility?

There must be no point during a patient's journey where there is ambiguity about who has responsibility and accountability for that patient's clinical care.

Transfer of responsibility and accountability for patient care is important at several levels:

✓ Junior Medical Officers have a professional responsibility to prepare for and engage in effective clinical handover

✓ Registrars (or similar) have a professional responsibility to lead and supervise JMOs in clinical handover

✓ Consultants/VMOs/Staff Specialists have a professional responsibility to oversee the clinical handover process and education for JMOs

✓ Administrators have a professional responsibility to develop overlapping rosters that facilitate clinical handover at all JMO shift changes.

JMO perspective

The JMO perspective has contributed to all aspects of this document.

Clinical handover at JMO shift changes needs to improve because…

"Handover from weekday to weekend and back again is a big problem. By the end of the weekend the messages about sick patients have been lost"

"It is much safer and more effective when even minimal supervision of handover occurs"

"Morning handover meetings in our department have provided some of the best learning experiences. The consultants really participate and share their thinking processes with the junior doctors".

Detailed 'Case for Change' information can be found at Appendix A.

How to use this document

Continue to monitor and improve clinical handover processes.

1. **At a Glance – get a basic understanding (pp 3-4)**

2. **Understand why we must change (pp 5)**

3. **Get more detail on ISBAR, senior leadership and key principles that guide implementation (pp 6-12)**

4. **Access implementation supporting tools and templates and further back ground information (Appendices)**

5. **Review, redesign and implement processes for clinical handover at all JMO shift changes.**

6. **Don't forget to monitor, evaluate and revise your processes after implementation**

NOTE: Improvements in clinical handover are evolutionary.

Different teams will have different requirements, opportunities and challenges when improving clinical handover.

Facilities are encouraged to continually review and incrementally challenge their handover processes, in line with the overall objectives.

Why we must change

Why we must change

Improving clinical handover processes for JMOs at shift change is imperative because:

- The research literature and Root Cause Analysis evidence identify poor clinical handover as a significant contributing factor to many adverse patient events
- Quality Systems Assessment data shows that there are many times when clinical handover does not occur
- JMOs are highly mobile between wards, facilities and Health Services in the NSW public health system
- Processes for clinical handover can be highly variable
- JMOs are the least experienced in the medical team, have high work loads and are frequently fatigued through working shifts across 24 hours of the day
- JMOs want greater consistency and supervision in clinical handover procedures.

Detailed 'Case for Change' information can be found at Appendix A.

Root Cause Analysis case study

The following summary highlights the critical importance of effective clinical handover.

This incident also highlights the importance of immediate escalation of deteriorating patients and the essential requirement of senior supervision for Junior Medical Officers.

A 56 year old man was admitted for a significant elective abdominal/thoracic procedure. He became febrile on the fourth post-operative day, and required review by the after-hours JMO.

On the following day he began to experience respiratory symptoms and was again reviewed by the after-hours JMO who sought assistance from the intensive care unit.

The patient's condition further deteriorated and he developed multi-organ failure caused by overwhelming sepsis and died.

The Root Cause Analysis found that:

- The treating medical team had not received any information about febrile night episodes and, therefore, did not initiate further investigations or antibiotic treatment
- The handover process from night staff should require that all Clinical Review patients are notified to the Registrar and the morning nursing team leader
- All patients who were reviewed overnight should be included in the morning handover and morning rounds.

Key elements for implementation

1. A communication framework to facilitate clinical handover at JMO shift change (ISBAR)

The ISBAR framework represents a standardised approach to communication which can be used in any situation. ISBAR is based on 'SBAR' a system which was developed by the US Navy for use in nuclear submarines.

ISBAR stands for Introduction, Situation, Background, Assessment and Recommendation.[7]

A communication framework increases the consistency in the delivery of information. As yet, there is no evidence proving that one mnemonic is the gold standard. ISBAR is recommended because:

- It is well recognised in the current Safe Clinical Handover implementation plans of a number of Health Services
- It aligns with Between the Flags and DETECT training
- It is portable, memorable and easy to use
- It helps you to organise what you're going to say
- It is a generic communication framework that is applicable to both clinical and non-clinical settings
- Consistency of practice will benefit Junior Medical Officers who often move between facilities and Health Services.

What, and how much, clinical information should I hand over?

Appendix D has a summary to provide guidance on the clinical information that should be considered when handing over specific patient types:

- Medical
- Surgical
- Paediatric
- Psychiatry
- Obstetrics and Gynaecology
- Emergency Department.

Sufficient clinical information must be handed over to ensure transfer of responsibility and accountability for patient care.

Patients who are less stable or have changing management plans may require a detailed handover, while others who are relatively stable and with fewer outstanding tests or actions can be summarised more quickly.

Senior clinician supervision at clinical handover is important to help JMOs decide which patients, how much and which clinical information needs to be handed over. (See page 11 for further assistance.)

See Appendix D for more detail on the clinical information you should be considering at handover.

ISBAR templates are available to download:
http://www.archi.net.au/e-library/safety/clinical/nsw-handover

Hand over relevant clinical information in the ISBAR framework...

I IDENTIFICATION

Identify yourself, the patient and who you are talking to.
"I am (name and role), from (ward/facility) and I'm calling regarding (multiple patient identifiers, such as; name, age, gender, Ward/bed, Medical Record Number)"

S SITUATION

State the patient's diagnosis/reason for admission and the current problem.
"The situation is that I have a patient (age/ gender), who is (diagnosis/deteriorating/stable). My concerns are (clear and succinct concerns). The current presenting symptoms are (clear, current and relevant symptoms and observations)."

B BACKGROUND

What is the clinical background or context?
By way of background (Give pertinent information which may include: Date of admission / presenting symptoms / medication / previous recent vital signs / test results / status changes)

A ASSESSMENT

What do you think the problem(s) is? (Don't forget to have the current vital signs and a key problem list ready!)
"My assessment on the basis of the above is that the patient is…..   they are at risk of…..   and in need of…."

R RECOMMENDATION

What are you asking the person to do?
"My recommendation is that this patient needs (what test/action) by (who) within (timeframe)"
Repeat to confirm what you have heard.
Eg "I understand that I am to…. and you will…"

2. Senior leadership: deciding who and what to hand over at shift change

At the end of handover, the JMO receiving handover should have a clear understanding of:
- sick, deteriorating and unstable patients
- outstanding actions, procedures, tests or results to be reviewed
- other important factors that will impact work on the following shift.

JMOs are at the beginning of their careers and are developing their clinical experience and knowledge base. The leadership and supervision by senior clinicians is essential to help JMOs provide effective clinical handover.

Senior clinicians are defined as:
- Registrars
- Career Medical Officers
- Consultants
- Staff Specialists
- Visiting Medical Officers
- Senior Nurses.

Senior clinicians have experience that can help JMOs deliver the most important key messages for effective transfer of patient care in a complete yet concise manner.

The leadership roles required from senior clinicians include:
- oversee and implement handover processes
- attend and lead handover at JMO shift changes
- understand the signs and symptoms of deterioration
- recognise clinical risks and convey these concepts to JMOs
- prioritise which patients and what information is handed over
- Involve JMOs in clear prioritisation of patients and allocation of tasks.

Some examples of how senior leadership for JMO handover can be demonstrated include:

- Senior Medical Officers involving and guiding JMOs in clinical decision-making before and during clinical handover
- Senior Medical Officers attending and leading handover to manage clinical issues early and reduce call outs
- Using handover as a teaching opportunity
- Senior nurses facilitating the process of handover.

> **It is recognised that not all facilities have registrars rostered on all shifts with JMOs. In such facilities the role of the Registrar in handover could be filled by:**
> • **Career Medical Officers**
> • **Consultants**
> • **Staff Specialists**
> • **Visiting Medical Officers**
> • **Senior Nurses (for facilitation of the handover process, rather than clinical supervision).**

It is feasible that there may be occasions when senior clinicians are unable to attend and lead clinical handover.

In such instances, JMOs should have access to senior leadership in preparing their patient lists for shift handover.

Prior to handover, senior clinician leadership can include:
- JMOs consulting with senior medical staff, including Consultants, Staff Specialists and Visiting Medical Officers
- Registrars and JMOs should discuss which patients and what information to handover at shift change
- JMOs undertaking a face to face or telephone paper round with registrars prior to handover.

Which patients should be handed over?

- Sick or deteriorating patients (eg, PACE/MET calls or patients with unstable or deteriorating observations)
- Patients with significant changes in condition or management plan during the previous shift
- Important outstanding actions, including:
  – tests or procedures that need to be done
  – test results that need review
  – transfer of care planning (this includes inter-ward or inter-hospital care and also discharge to GP care)
- New patients

- Any patients you are worried about – do not discount your clinical acumen.

Do not discount your clinical acumen:

Deciding who should be handed over cannot be limited to a strict categorisation.

If for any reason you are concerned by any part of a patient's clinical situation or their management plan, this concern should be handed over to the oncoming shift.

Senior leadership at handover is an important part of clarifying and managing patient care concerns.

Do not wait for shift handover:

Escalation of concerns for any part of a patient's clinical situation or management plan must not be held back until shift handover (See PD2010_026).

According to the escalation protocols of DETECT and Between the Flags,[6] JMOs should escalate concerns about patients to senior clinicians immediately, rather than waiting for shift handover.

What else is important to hand over?

Handover of other information about environmental features may benefit the oncoming shift and should be led by registrars, including:
- critical care bed availability
- ward patient flow or bed pressure points
- staff levels or availability
- relevant contact persons if required
- any specific patient or equipment risks that are likely to affect JMO or staff safety.

NOTE: *The 'Concept Testing' final report for the JMO clinical handover project contains clear key messages from both junior and senior clinicians about the importance of senior leadership in clinical handover for junior clinicians. The report is available for download:* **http://www.archi. net.au/e-library/safety/clinical/nsw-handover**

3. Shift to shift handover: key principles for locally appropriate implementation

Improving the structure and senior supervision of handover (24/7) is aimed at enhancing patient care, JMO learning, staff communication and confidence.

Safe clinical handover is essential to patient care.

Local clinical situations vary depending on the facility, hour of day and day of week. For example:
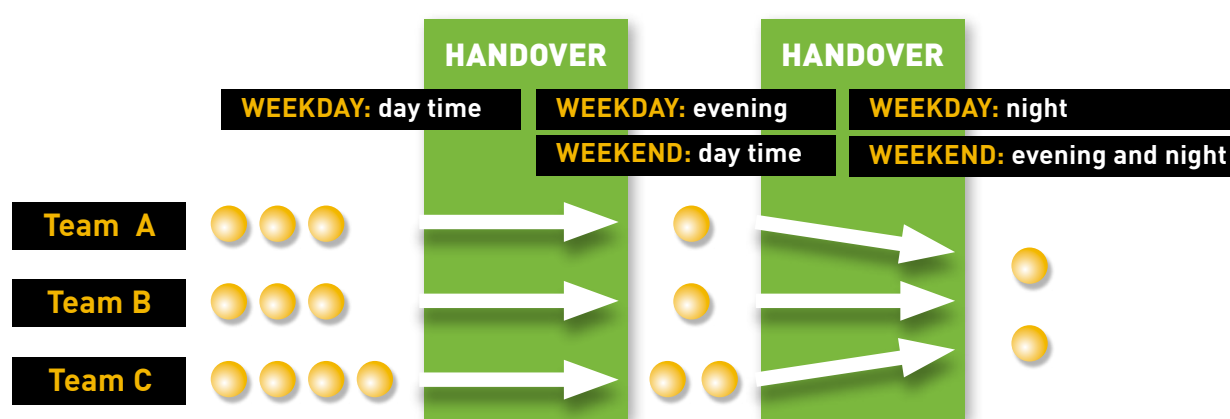
Safety and quality of care dictates that the fundamentals of handover are constant, regardless of the time, or day. However, facilities should consider variables that impact shifts across 24 hours of the day and 7 days per week, when determining locally appropriate clinical handover solutions.

See Appendix C for more information on *"Points to consider for implementation across 24 hours"* **OR** download the 'Concept Testing' final report: *http://www.archi.net.au/e-library/safety/clinical/nsw-handover*

Key principles to guide the implementation at all JMO shift changes

The high-level principles that have been developed to support handover at JMO shift change are mapped directly from the 'Safe Clinical Handover' – standard key principles for clinical handover, developed in 2009.[10]

Principle category	Key Principles
Handover happens	Clinical handover occurs at all JMO shift changes
Handover leadership	Senior medical leadership in JMO shift handover
	Valuing JMO shift handover
Handover set-up	Prepare for handover by prioritising patient lists
	Key participant attendance at JMO shift handover
	Time allocation for JMO shift handover
	A designated JMO shift handover place
Handover process	The transfer of clinical information that is vital to continuity of patient care
	Two-way communication
	Tools to facilitate JMO shift handover

Implementing clinical handover at JMO shift changes must be appropriate to local needs.
Appendix E – High level implementation framework to assist local planning.
Appendix F – Implementation support tools and templates.

3.1 Handover happens

Clinical handover occurs at all JMO shift changes

Clinical handover is expected and occurs at every Junior Medical Officer shift change, regardless of specialty, in all facilities participating in the Clinical Education and Training Institute (CETI) prevocational training networks.

Essential elements for implementation

✓ Shift rostering to facilitate handover
✓ Participating in shift handover is written into position descriptions for JMOs and Registrars
✓ Appropriate supervision of JMOs is provided at shift handover.

HANDOVER
Handover is essential and must occur at shift change.
Electronic tools are supplementary and cannot replace processes of human interaction at handover.

3.2 Handover leadership

Senior medical leadership in JMO shift handover

Effective JMO handover at shift changes requires leadership from executive and clinical leaders to:

• be responsible for implementation of handover processes, and
• ensure registrar attendance and leadership of handover at JMO shift changes.

Essential elements for implementation

✓ Local executive sponsorship is essential to direct the implementation of clinical handover at all JMO shift changes
✓ Consultants/Staff Specialists / Visiting Medical Officers need to be responsible for clinical handover implementation across all shifts
✓ Registrars should attend and lead all JMO shift handover.

Valuing JMO shift handover

Set the expectation that JMO shift handover is a valuable and essential part of every shift.

Executive and clinical leaders sponsor JMO clinical handover through:

• policy
• monitoring and evaluation of processes and outcomes
• training programs.

Essential elements for implementation

✓ Shift rostering to facilitate handover
✓ Participating in shift handover written into position descriptions for JMOs and Registrars
✓ Appropriate supervision of JMOs is provided at shift handover
✓ All staff attending the handover must be made aware of the local processes and the importance of handover.

Not all facilities have Registrars rostered on all shifts with JMOs.
Consider other options: • **Career Medical Officers** • **Consultants** • **Staff Specialists** • **Visiting Medical Officers** • **Senior Nurses (eg After Hours Nurse Managers)**

3.3 Handover set-up

Prepare for handover by prioritising patient lists

Junior and senior clinicians work collaboratively (seeking and providing leadership) to prioritise patient lists for clinical handover.

Essential elements for implementation

✓ Registrars should be present and lead clinical handover prioritisation at all JMO shift changes.
  – Involve JMOs in clear prioritisation of patients and allocation of tasks
✓ When Registrars are unable to attend JMO shift handover, processes should be implemented to facilitate JMO prioritisation of patient lists, including:
  – face to face consultation between the JMO and Registrar before shift change, and
  – telephone ward rounds between the JMO and Registrar.

Key participant attendance at JMO shift handover

Identify the key participants for handover at each JMO shift change:
• night to day
• day to evening
• evening to night
• weekdays and weekends.

Essential elements for implementation

✓ Wherever possible, a Consultant/Staff Specialist or Visiting Medical Officer should be included as a key participant at JMO shift handover
✓ Registrars should be present at every JMO shift handover
✓ Facilities should consider local requirements when implementing JMO handover at all shift changes, with regard to specialty team handover, or whole of hospital handover
✓ Where appropriate, the inclusion of a senior nursing staff member should be considered.

Time allocation for JMO shift handover

• Set agreed times and durations for each shift handover across 24 hour /7 days per week
• It is highly recommended that, where possible, strategies are in place to reinforce punctuality.

Essential elements for implementation

✓ Shift handover must start on time and finish on time
✓ All key participants must be informed of the time for all relevant shift handovers
✓ Shift handover should be considered "pager-free" – except for emergency calls
✓ Shift rostering to facilitate handover.

A designated JMO shift handover place

• Set a specific location for each shift handover across 24 hour /7 days
• Wherever possible, the handover location should facilitate face-to-face interaction.

Essential elements for implementation

✓ Shift handover must occur in a consistent location. The location should:
  – be easy for all participants to attend
  – be quiet and free from distraction
  – promote face to face interaction
  – promote active and engaged interaction
  – have locally necessary IT or telecommunications facilities to allow engagement of all key participants.

3.4 Handover process

The transfer of information that is vital to continuity of patient care.

Implement a locally appropriate clinical handover process that guarantees effective transfer of the most important clinical information and responsibility and accountability for patient care:

- night to day
- day to evening
- evening to night
- weekdays and weekends.

> **The communication framework for JMO handover (ISBAR) aligns with Between the Flags and DETECT training.**

Use handover for educational purposes:

- Educational handover engages junior doctors, improves patient care and builds a strong handover culture
- Patients being handed over often provide excellent teaching opportunities
- Teach five-minute clinical pearls when possible
- Review emergency team calls (CERT/MET/PACE)
- Provide non-judgemental feedback on management of unwell patients.

Essential elements for implementation

✓ A process for JMO shift handover should be devised for each shift change across 24 hours.

✓ The process utilises the ISBAR communication framework.

✓ Handover should be guided by the prioritisation of patients under the direction of Registrars.

✓ The information detail for each patient should be relevant to their current clinical situation.

✓ Handover processes should be designed to integrate documentation of clinically important information with the permanent record.

✓ Handover should include other important environmental factors that may impact those working

on the subsequent shift, for example:

- – critical care bed availability
- – ward patient flow
- – staff levels/availability
- – relevant contact persons
- – any patient or equipment risks.

Two-way communication

- Design local handover processes to promote two-way communication, so that the receiver can ask questions and clarify any relevant information
- Accessibility and approachability of senior clinicians at handover promotes learning.

Essential elements for implementation

✓ Two-way communication should allow for real-time clarification of relevant information.

✓ A variety of methods are recommended for consideration, including:
- – face to face interaction
- – telephone conversation
- – reading back
  (information/tasks that you have documented)
- – repeating back
  (information that you have heard/understood).

> **Clinical handover must not include the use of Dictaphones or be taped**

Tools to facilitate JMO shift handover

Review existing models and adapt standard templates, tools and memory devices to facilitate JMO clinical handover at shift change.

Essential elements for implementation

✓ Tools utilise the standard ISBAR communication framework

✓ Tools are as generic as possible and resist overly specific adaptations

✓ Tools aid the documentation of clinical information, responsibility and accountability in the permanent record.

Appendices

Appendix A

A clear case for change

Quality Systems Assessment Data

In 2009 the Clinical Excellence Commission undertook its second Quality Systems Assessment (QSA) Survey of the NSW health system[5]. One of the 4 key topic areas investigated was clinical handover.

- The results of the 2009 QSA showed that, for medical teams, 14% reported that **no** time is spent on shift handover, and a further 18% reported that less than 10 minutes is spent.

Literature

Literature cited by the Australian Commission on Safety and Quality in HealthCare (2010) – *the OSSIE Guide to Clinical Handover Improvement*[1] highlights the importance of robust handover practices in the medical profession:

- Handover is among the most common causes of malpractice claims in the USA, especially among trainees, accounting for 20% of cases (Singh et al, 2007)
- A survey among trainees in the USA suggested that 15% of adverse events, errors or near misses involved handover (Jagsi et al, 2005)
- Survey of junior doctors in the United Kingdom discovered that 83% believed that handover process was poor. Written handover was rarely received, accounting for only 6% of all handovers (Roughton and Severs, 1996)
- Incorporating simple documentation processes into clinical handover ensured full maintenance of clinical data transferred, compared to 97.5% attrition of clinical data by relying solely on verbal handover and memory (Pothier et al, 2005).

A NSW Health commissioned literature review by the Advisory Board (2010) – *Best Practices for Physician Handoffs*[12] identified that ineffective clinical handover procedures for medical officers contributed significantly to adverse events in the USA, specifically:

- Communication problems were the major source of 65% of hospital sentinel events between 1995 and 2004 (Runy, 2008), and that the risk of an adverse event increased with the number of times they were transferred between units, physicians and teams.
- One insurance company alone attributed $173 million in losses to events related to clinical handover (Hoffman, 2007), and that over half of these events entailed severe injury.

The same literature review also identifies methods for improving handover, including:

- Increased face to face rostered time for physicians to handover in a quiet room (Buckley, 2007)
- Read backs allow for the clarification of information and reduction in misconceptions following handover (Gesensway, 2006)
- Formalised early education for JMOs in clinical handover process and importance shifts attitudes towards clear responsibility for patient care (Solet et al, 2005)
- Increasing two-way communication in handover improves anticipation of next steps for patient care and bolsters the learning process for JMOs (Buckley, 2007).

A literature review commissioned by the Australian Commission on Safety and Quality in HealthCare (2008) – *A Structured Evidence-based Literature Review regarding the Effectiveness of Improvement Interventions in Clinical Handover*[14] identified risks associated with clinical handover, including:

- inexperience of clinical staff
- poor communication behaviours
- lack of communication quality/content
- lack of standardised protocols
- health professional fatigue.

The clinical handover guide published by the Australian Medical Association (2006) – *Safe Handover : Safe Patients*[3] identifies a number of themes consistent with the above literature to underline the importance of clinical handover processes, including:

- recognition of the effects of doctor fatigue
- rapidly increasing complexity of care for patients
- safe work hours, creating the requirement for shift changes and hence handover
- greater cross-over between specialty teams and the multidisciplinary team
- the fact that a doctor may have no day time contact with a patient, yet be responsible and accountable for that patient's safe clinical care during rostered out-of-hours periods.

JMO perspective

All work relating to the JMO clinical handover project has been developed in close consultation with JMO representatives of the CETI JMO Forum.

The case for change message from the perspective of these Junior Medical Officers is clear:

- Clinical handover at JMO shift changes needs to improve because…

  "JMO handover is where lots of important information gets missed."

  "Handover from weekday to weekend and back again is a big problem. By the end of the weekend the messages about sick patients have been lost."

  "Establishing continuity of care for a patient in a way that will ensure that issues or events that occur outside of business hours do not just fall through the cracks and that deteriorating patients are picked up earlier rather than later."

  "If we don't change we risk worse outcomes for patients, including death, lack of ownership

of patient care, deskilling and constant 'fire fighting' as opposed to care based on having the complete picture."

"It is much safer and more effective when even minimal supervision of handover occurs."

"Morning handover meetings in our department have provided some of the best learning experiences. The consultants really participate and share their thinking processes with the junior doctors."

Appendix B

Wider issues that require consideration

Junior doctors

The immediate scope of this project and document is focused on the most junior doctors who are within the first two years of graduation, but the key elements and objectives should also be considered for implementation in all facilities that employ any junior doctors during the day, evening or night.

Junior doctors could refer to:
- residents in their third or later year of work
- overseas graduate doctors who are newly employed in the NSW health system
- newly appointed accredited or non-accredited registrars.

According to the Dreyfus model of professional development[4], all doctors are continually developing their clinical skills and competency in clinical handover. The closer doctors in a facility are to the novice end of the scale, the greater the level of structure and supervision that should be put in place to support their development.

The implementation of structured and standardised clinical handover should be considered for all doctors, rather than limited to the specific project scope of the most junior doctors in their first two years of prevocational training.

Dreyfus Model [4]

Considering the Dreyfus model will help facilities plan their local implementation of the JMO clinical handover project. That is:

- Facilities, specialties or times of the day where there are limited staffing resources to provide junior doctors with senior leadership and supervision should consider greater degrees of clinical handover process standardisation and structure
- Facilities, specialties or times of the day where there are greater opportunities to access senior clinicians as leaders of clinical handover can implement processes that are more flexible to immediate clinical and staffing demands and have a greater focus on clinical management plans and developing junior staff.

Page 7-8 provides more information on the role of senior leadership in JMO handover.

Pages 9-12 provides more information on key principles to consider when implementing processes that support junior doctors.

Appendix D describes clinical information to consider when handing over a patient.
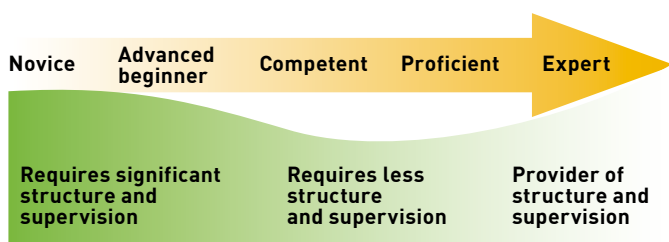
Rostering shift overlap to facilitate clinical handover

The first objective of this project is: 'That clinical handover between JMOs occurs at all shift changes'.

The first principle to guide implementation is: 'Handover happens: clinical handover occurs at all JMO shift changes'.

Rostered shift overlap is an essential element to ensure that handover occurs at all JMO shift changes.

The Acute Care Taskforce has explored project synergies with the Rostering Centre of Excellence.

Facilities are encouraged to maintain local implementation momentum and explore innovative practices for appropriate shift overlap to facilitate handover.

Some basic innovative rostering models should be considered and implemented, where appropriate. For example:

1. Change from rostered day shifts to staggered shifts to provide shift overlap and continuity of patient care from day to evening. Alternate on weekly basis.

	Orthopaedic Registrar 1	Orthopaedic Registrar 2
Mon	0700 to 1530	1300 to 2100
Tues	0700 to 1530	1300 to 2100
Wed	0700 to 1530	1300 to 2100
Thurs	0700 to 1530	1300 to 2100
Fri	0700 to 1530	1300 to 2100

Dreyfus Model

Novice | Advanced beginner | Competent | Proficient | Expert

Requires significant structure and supervision | Requires less structure and supervision | Provider of structure and supervision

2. Increase in team staffing levels to provide for shift overlap and evening cover. Alternate on weekly basis. There is a benefit in the reduction in rostered overtime shifts.

	Aged Care JMO1	Aged Care JMO2
Mon	0800 to 1630	1500 to 2300
Tues	0700 to 1530	1500 to 2300
Wed	0700 to 1530	1500 to 2300
Thurs	0700 to 1530	1500 to 2300
Fri	0700 to 1530	1500 to 2300

Appendix C

Points to consider for implementation across 24 hours

Facilities should consider a range of points when implementing locally appropriate clinical handover processes, 24 hours per day and 7 days per week.

- Are you implementing a whole of hospital or specialty team clinical handover meeting? The size of hospital may determine whether specialty team or whole of hospital based handovers are implemented
- What is the local pattern of shift times? Staggered shift times will require local consideration as to how the important information at handover is not skipped for some staff
- What are the hospital and work load pressures across the 24 hour clock? These may impact the purpose and structure of the handover meeting? (eg Patients who have been unwell over night vs outstanding tasks or new admissions during the day)
  - Day to evening handover may require greater process structure to ensure all key information is condensed to the fewer number of oncoming staff.
  - Night to morning handover may have greater opportunity for detailed handover, case presentations and teaching relating to patient care during the night shift.

- Two-way communication is a consistent requirement across 24 hours
- What do local executive and clinical leaders need to do to ensure that clinical handover is a priority at all shift changes?
- Can you get consultant commitment to lead handover and act on clinical management issues immediately, potentially reducing the need for call outs?
- How can Registrars be supported (including innovative rostering) to attend and coordinate clinical handover?
- Who are other senior clinicians that may be able to facilitate the process of clinical handover, when Registrars or Consultants are unavailable?
- Are there clear senior contact persons to provide support to JMOs between shifts, to reduce the risk of issues being held over until shift change handover?
- JMOs need support at all shift changes. No clinician should ever feel isolated
- How can you reinforce attendance and punctuality at all shift change handovers?
- Type and size of handover (specialty team vs whole of hospital) will determine physical location requirements (room, IT and telecommunications requirements)
- When and how can educational opportunities be incorporated?
- When and how can you get staff together (face to face) and facilitate a collegial atmosphere?
- Training programs in clinical handover must be accessible to staff working on all shifts
- Evaluation and monitoring should involve handover on all shifts
- What is the appropriate communication requirement to other disciplines (eg Nursing) so that shift handover is as uninterrupted as possible?
- Templates should be supplementary and act as memory prompts to the shift handover process
- Templates should not detract from the natural two-way human interaction required for effective communication.

Appendix D

Clinical information to consider when handing over a patient

The right clinical information needs to be handed over to ensure transfer of responsibility and accountability for patient care.

Patients who are less stable or have changing management plans may require a detailed handover, while others who are relatively stable and with fewer outstanding tests or actions can be summarised more quickly.

Senior clinician supervision of JMOs at clinical handover is important to help decide which patients, how much and which clinical information needs to be handed over. (See pg 7 for further assistance)

The exact structure of how you handover clinical information will also be dependant on the scenario of handover.

For example: you would pay particular attention to the initial introduction if you were waking a consultant in the middle of the night, as compared to when you are handing over at shift change to one of your peers.

In total, the detailed handover example shown below would take no more than 2 minutes to deliver.

I	**Information:**	My name is John Smith. I am an RMO2, in Westmead, Emergency Department
S	**Situation:**	The situation is that I am requesting admission for Mrs Jane Jones, who is an 80 year-old woman with an acute exacerbation of chronic left ventricular failure
B	**Background:**	By way of background, she presented with gradually progressive SOB over 3 days, with exertional chest heaviness, and is now SOB at rest and experiencing PND.
		She was admitted under Dr X 2 months ago with a non-STEMI AMI, Type 2 Diabetes Mellitus and hypertension.
		She is currently on aspirin, perindopril, diltiazem and gliclazide.
		She has had allergies to penicillin, and is an ex-smoker and does not drink or use sleeping tablets.
		She lives alone.
A	**Assessment:**	On assessment, she has signs of left and right heart failure with CO_2 retention: central cyanosis, asterixis, respiration 16, saturations 88% on room air. Her vital signs include BP 145/88, regular pulse 70 bpm and JVP slightly elevated. She has moderate peripheral oedema and medium-coarse bisbasal crackles.
		The CXR shows interstitial and alveolar oedema, ECG sinus rhythm with new lateral t-wave flattening, TNT elevated at 0.4, EUCs showing mild hyponatraemia (Na 130) and renal impairment (Cr 142) but normal K (4.0). LFTs, Glc, CMP, FBC and coags normal.
		She has left ventricular failure associated with a non-STEMI and has been commenced on Oxygen (6L/min), aspirin, frusemide, fluid restriction and therapeutic enoxaparin and will be monitored and have serial ECGs and TNTs. The diltiazem has been withheld by the team.
R	**Recommendation:**	My recommendation is that this patient needs admission by the Cardiology team in a monitored CCU bed and will need an Echo within 24 hours.

Some basic information you should consider when handing over different patient types.
The information in the following table shows the type of information for six broad patient types that should be considered to ensure a concise, but comprehensive and effective handover.

	Medical (with multiple co-morbidities)	Surgical	Emergency Department
I	– What is your name? – What is your surname? – What is your position in the Hospital? – Which Hospital are you calling from? – Which part of the Hospital are you calling from?	**No change**	**No change**
S	– Why are you calling me? – What is the patient's name (first name followed by surname)? – How old is the patient? – What gender is the patient? – What is/are the problem/s or diagnosis/es?	**No change**	**Add:** – Has the patient been admitted or accepted by a specialty team. – Is the patient scheduled under the Mental Health Act, do they need a nurse special?
B	– What is/are the presenting symptom/s? – How bad are these symptoms? – What relevant problems has the patient had previously? – What medications is the patient on? – What allergies does the patient have? – Does the patient smoke, drink or use benzodiazepines? – Why does the patient need to be treated in hospital rather than at home or in the clinic?	**Remove:** – "How bad are these symptoms" **Add:** – Has the patient had a recent surgery? If so, what surgery and when? – When did the patient last eat or drink?	**Add:** – What is their pre-morbid status and social situation? – Any important linkages with out of hospital care / General Practice.
A	– What are the patient's vital signs (appearance, comfort, BP, pulse rate and rhythm, JVP, respiratory rate, temperature and urine output)? – What are the salient clinical signs that support the diagnosis and indicate the severity? – What are the key investigations/ procedures – planned or results? – What are the problems and treatments you have begun in order of importance? – Is the patient/carer up to date with the diagnosis and treatment plan?	**Add:** – Is the patient having DVT prophylaxis? – What intravenous fluids are being administered and at what rate? – What antibiotics are being administered? – What analgesia is being utilised?	**Add:** – Are they fasting, or limited oral intake? – Can they take oral medications? – Any outstanding consultations or reviews – Where should the patient go when they finish in ED? – Is the transfer paperwork complete?
R	Your recommendations for ongoing care with clear timeframes that facilitate the transfer of responsibility and accountability for patient care. Read back to prevent misconceptions and clarify what you have understood.	**No change**	**No change**

Most of the fundamental information is standard, regardless of the patient type, but please pay attention to the key differences identified against the standard medical patient example.

Obstetrics and Gynaecology	Mental Health	Paediatrics
No change	**No change**	**No change**
	Add: – Is the patient in the ED, Ward, Community? – Is the patient in seclusion? – Is the patient under the Mental Health Act?	**No change**
Add: – Is the patient pregnant? – How many weeks gestation? – If in labour, what is the Cervix dilation? – Information relating to the CTG trace	**Remove:** – "How bad are these symptoms" – Why does the patient need to be treated in hospital rather than at home or in the clinic? **Add:** – How long has this patient been in care? – Do they have a primary carer? – Accommodation? – How/why did this person get brought to hospital? – Substance abuse?	**Add:** – Birth history (antenatal, perinatal etc) – Developmental & growth assessments (growth charts) – Social/family issues – Vaccination status
	Add: – What is the patient's current mental state? – Are they distressed, suicidal or wanting to harm others? – If in the ED what was the result of the examination by the medical officers? – Key MSE findings? – What risks (to self/others) have been identified?	**No change**
No change	**Add:** Specific recommendation relating to: – Location for treatment – Medications – What other teams should be involved?	**No change**

Appendix E

Implementation framework to assist facilities with JMO clinical handover

OSSIE	Key Task	Task Description	Key lead
O **Organisational Leadership**	Sponsorship	Identify executive and clinical sponsors & link with other governance structures.	Facility General Manager
	Project team	Identify relevant team members, eg Consultant, Registrar, JMO, Nursing representatives	Sponsors
	Local authority and champions	Engage local Clinical Training Council and other senior clinicians	Sponsors
S **Simple Solution Development**	Investigate existing local practices	Utilise focus groups, available data, observations, and surveys	Project Team
	Design local clinical handover processes	Identify barriers and motivators. Ensure processes are specific to the needs of day, evening, night and weekend shifts.	Project Team
S **Stakeholder Engagement**	Prepare for investigation of existing practice	Engage staff in necessary focus groups and develop analytical surveys of existing practice	Project Team
	Develop a strong communications plan	key messages defined at all levels: Executive, Consultant, Registrar, JMO, Nursing etc.	Project Team
	System communications	Regular effective communications at all levels defined in the communication plan – Clear case for change	Project Team
I **Implementation**	Mandated implementation	Necessary policy and review of position descriptions to implement ISBAR and handover processes	Sponsors
	Supporting tools and templates	Develop standard generic communication templates and tools in ISBAR format	Project Team
	Pilot Implementation	Implement pilot processes in day, evening and night	Project Team
	System Implementation	System implementation of updated clinical handover processes, following pilot evaluation review	Project Team
E **Evaluation and Maintenance**	Develop evaluation plan		Project Team
	Pre-evaluate pilot location		Project Team
	Post-evaluation of pilot location, review and appropriate redesign of handover processes		Project Team
	Cyclical evaluation and monitoring with term changes		Project Team

The framework below is a framework to assist facilities plan and implement the outputs of the JMO clinical handover project. This framework is not mandatory to use, but will assist facilities to guide their implementation planning, utilising the OSSIE format recommended by the Australian Commission on Safety and Quality in Health Care.

Term 1 – 10 Weeks	Term 2 – 10 Weeks	Term 3 – 10 Weeks	Term 4 – 10 Weeks	Implementation supporting tools & templates
				– OSSIE guide – section 3 (pg 15) – "Clinical Handover – Implementing Change": 1.0 Project Initiation

				– OSSIE guide – section 4 (pg 37)
				– "Clinical Handover – Implementing Change":
				  2.0 Diagnostics & 3.0 Solution Design
				– JMO clinical handover:
				  - Key principles checklist

				– OSSIE guide – section 5 (pg 27)
				– "Clinical Handover – Implementing Change":
				  1.0 Project Initiation
				– JMO clinical handover:
				  - Key messages from concept testing final report
				  - How to run a focus group

				– OSSIE guide – section 6 (pg 41)
				– "Clinical Handover – Implementing Change":
				  4.0 Implementation
				– JMO clinical handover:
				  - ISBAR templates
				  - ISBAR training
				  - Education and Evaluation

	Pilot activities should not cease during evaluation review			- OSSIE guide – section 7 (pg 47)
				- "Clinical Handover – Implementing Change":
				  5.0 Evaluation
				  - JMO clinical handover:
				  - key principles checklist
				  - Education and Evaluation

Appendix F

Implementation Support

A range of templates, tools and links exist.

Facilities are encouraged to review the tools and templates available to guide locally appropriate implementation of JMO clinical handover.
The listed guides, templates and tools are neither mandatory nor exclusive.

JMO clinical handover implementation supporting tools and templates:

The listed tools and templates have been developed specifically to assist implementation of the JMO clinical handover project.

These tools can be supplemented by the tools and templates produced, as part of Safe Clinical Handover: standard key principles for clinical handover (2009). All listed tools and templates can be accessed on the NSW Health Safe Clinical Handover webpage:
http://www.archi.net.au/e-library/safety/clinical/nsw-handover

- Clinician's Summary – a 12 page version of this document designed to summarise the key elements of JMO clinical handover into a more consumable format for clinicians
- 1-pagers – single page summaries to deliver highest-level key messages targeted at both junior and senior clinician's
- Key messages for local implementation of JMO clinical handover – basic key messages that should be aimed at multiple levels of the organisation to engage clinicians to review, design and implement processes for JMO clinical handover.
  The final 'Concept Testing' report is available for download and contains key messages from junior and senior clinicians about their own experiences with implementing the JMO clinical handover project.
- Key principles implementation checklist – a checklist that can be used as an audit tool and/or implementation progress tool to show how local clinical handover processes currently map to the key principles for clinical handover at all JMO shift changes.
- How to run a focus group summary – a summary developed by Qld Health of the steps required to successfully organise and run a focus group.
  http://www.health.qld.gov.au/chipp/documents/32372.pdf
- Education and Evaluation – Observed Simulation Clinical Exam (OSCE) & Mini-CEX evaluation are considered useful when defining local training and evaluation programs for JMOs. The following article describes the implementation of OSCE and Mini-CEX. The article contains a number or online appendix resources.
  JM Farnan, JAM Paro, RM Rodriguez, ST Reddy, L Horwitz, JK Johnson, VM Arora. Hand-off Education and Evaluation: Piloting the Observed Simulated Hand-off Experience (OSHE). Journal of General Internal Medicine, DOI 10.1007/s11606-009-1170-y. November 19, 2009.
  http://www.springerlink.com/content/n4m37g374355q4r2/
- Basic ISBAR templates – ISBAR templates have been adapted from the existing work of Hunter New England Health Service and made available across NSW. Copies of these templates can be downloaded from the Safe Clinical Handover webpage, including:
  – Lanyard prompt card
  – ISBAR note pad
  – ISBAR A3 poster
  – ISBAR telephone stickers

- ISBAR training – Hunter & New England Health Service has developed standard training tools for the implementation of ISBAR across a health service. All tools and resources have been shared and made available for download via the Safe Clinical Handover webpage.

Existing guides:

Implementation Toolkit – Standard Key Principles for Clinical Handover, (NSW Health 2009)

The Implementation toolkit is a 'how-to' booklet aimed at those reviewing of their local clinical handover processes in line with the standard key principles for all scenarios of clinical handover.

The toolkit contains further background regarding the case for change, expanded points for the standard key principles, summarised process redesign methodology, examples of existing clinical handover models, supporting templates and many useful links.

The implementation toolkit has undergone extensive system wide consultation and been endorsed by the Acute Care Taskforce.
*http://www.archi.net.au/e-library/safety/clinical/nsw-handover*
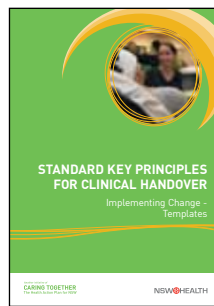
Clinical Handover – Implementing Change (NSW Health 2009)

Process Redesign Methodology in this document is designed solely as a helpful guide and is not mandatory. The document and the templates referenced are available to download from the Clinical Handover website:
http://www.archi.net.au/e-library/safety/clinical/nsw-handover

Some templates of specific relevance to the JMO clinical handover project are:

- Template 1 – Project Management Plan - Reviewing your clinical handover process is a small scale project. All projects require some structure to give them the best possible implementation success.
- Template 2 – Communications Plan - Communication management helps you to ensure that you communicate with stakeholders using the most appropriate methods.
- Template 4 – Clinical Handover Staff Interview - Interview as many staff members as possible, so that you can gain an overall understanding of how the current process is working from a range of points of view.
- Template 6 – Tag Along / Observations - Gain an insight into the clinical handover process from an objective point of view that no other data can provide.
- Template 7 – Flow chart example - See an example of how a flow chart can help you to understand your clinical handover process.
- Template 8 – Handover Issues Log - Consolidate all of the process issues you identify into one place.
- Template 9 – Issues Prioritisation - Be strategic, work out which issues you should tackle first.
- Template 10 – Solutions Prioritisation - The unfortunate reality is that not all of your solutions are likely to be implemented. You have to prioritise.
- Template 11 – Solution Design - Detail the solutions that you have decided to progress with.
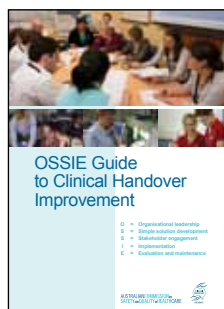
OSSIE Guide to Clinical Handover Improvement,

(Australian Commission on Safety and Quality in Health Care 2010)

The OSSIE guide assists readers to design, implement, evaluate and maintain clinical handover improvement programs that contain a standardised process and content data set.

The framework presented in the OSSIE guide is based on research conducted on medical and nursing shift to shift handover within the acute care hospital setting. The principles align with those of the NSW Health standard key principles for clinical handover and may be applicable to other handover situations, including multidisciplinary, primary care and community handovers.

www.safetyandquality.gov.au/internet/safety/ publishing.nsf/Content/PriorityProgram-05

A Guide for the Safe Use of Electronic Clinical Handover Tools,

(SA Health & the Australian Commission on Safety and Quality in Health Care 2010)

The guide is designed to assist all stages of the design and use of electronic handover systems. The research was oriented around the implementation of an electronic tool to support different forms of clinical handover in each of the hospitals.

It provides guidance to clinicians, medical administrators, quality and safety staff and health informatics professionals. Overall, the project found that change management was particularly critical when implementing electronic systems to assist clinical handover. It is critical that the approach to implementation emphasises that the electronic tool should support, and not replace, processes for handover.

http://www.safetyandquality.gov.au/internet/ safety/publishing.nsf/Content/PriorityProgram-05_ SafeTECH
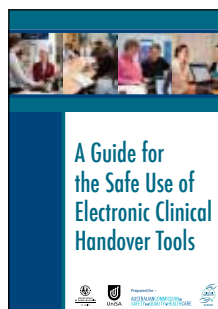
Safe Handover: Safe Patients Guide,

(the Australian Medical Association 2006)

The AMA Safe Handover: Safe Patients guide was adapted from the British Medical Association's resource of the same name.

It was developed to assist the health sector to achieve better patient outcomes through good clinical handover. The guide pays attention to the increasing requirement for effective clinical handover in the face of changing work patterns and the need for clinicians and administrators to work together.

The basic principles of this document, relating to 'Who, When, Where, How & What' align with the clinical handover principles of NSW Health.

www.ama.com.au/node/4064

CD and Video support

JMO clinical handover – video vignettes and DVD

Helpful video vignettes can be viewed directly via the Safe Clinical Handover webpage. Individual vignettes address topics such as:

- Benefits for JMOs/Registrars/Consultants
- Benefits for patients
- Roles at handover
- Involvement of nursing

These videos are available to be viewed at *http://www.archi.net.au/e-library/safety/clinical/nsw-handover* A DVD of all video vignettes is also available on request via: *HSPIB@doh.health.nsw.gov.au*

ISBAR video vignettes

(Developed by Hunter and New England Health Service) 5 vignettes that show how the ISBAR communication framework can help clinicians communicate the key messages of clinical care effectively and quickly:
http://www.archi.net.au/e-library/safety/clinical/nsw-handover

Safe Clinical Handover – implementation support CD

Implementation support CD that includes standard PowerPoint presentations, video vignette resources and toolkit resources. Copies can be requested via email at:
HSPIB@doh.health.nsw.gov.au

e-Learning links to assist with clinical handover

http://www.archi.net.au/e-library/safety/clinical/nsw-handover

GEM platform

"Clinical Handover Implementing Change" and project management modules – will assist you with the process of reviewing and redesigning local clinical handover. All NSW Health employees can register on this website using their NSW Health email address.
https://gem.workstar.com.au

Between the Flags – DETECT Training

(Authors: K Fraser, M Berry and A Pile, DETECT Manual 1st Edition 2009)
http://www.cec.health.nsw.gov.au/programs/between-the-flags.html

http://nswhealth.moodle.com.au

University of Queensland

The University of Queensland has developed an online course in clinical handover as part of the Australian Commission on Safety and Quality in Health Care: National Clinical Handover Initiative.
http://www.uqhealthinsitu.com.au/products/ACSQHC8300/ACSQHC8300_brochure.cfm

Appendix G

Prevocational Training Networks in New South Wales

http://www.imet.health.nsw.gov.au/www/472/1001127/displayarticle/1005452.html

Network	Hospitals	Accreditation status
1	Balmain Hospital	R
	Dubbo Base Hospital	T5
	Royal Prince Alfred Hospital	T5
2	Bankstown-Lidcombe Hospitals	T5
	Campbelltown Camden Hospital*	T3^
3	Broken Hill Base Hospital (PGY2 only)	R
	Canterbury Hospital	T3
	Concord Repatriation General Hospital*	T5
4	Fairfield Hospital*	T3
	Liverpool Public Hospital	T5
	The Tweed Hospital	T3
5	Port Macquarie Base Hospital	T5
	Royal North Shore Hospital	T5
	Ryde District Hospital	T3
6	Hornsby Ku-ring-gai Health Service	T5
	Manly Hospital	T3^
	Mona Vale Hospital	T3^
7	Gosford District Hospital*	T5
	Wyong Hospital	T3
8	Albury Base Hospital	T3
	Griffith Base Hospital	R
	St George Hospital and Community Health Service*	T5
	Sutherland Hospital	T3
	Calvary Kogarah Hospital	R
9	Lismore Base Hospital	T5
	The Prince of Wales Hospital*	T5
10	Gundagai General Practice Service PGY2 only	GP
	St Vincent's Hospital	T5
	Wagga Wagga Base Hospital & Community H. S.	T5
11	Shellharbour Hospital	T3
	Shoalhaven District Memorial Hospital	R
	Wollongong Hospital*	T5
	Bulli Hospital	R
	Port Kembla Hospital	R
	Coledale Hospital	R

Network	Hospitals	Accreditation status
12	Armidale Rural Referral Hospital (PGY2 only)	R
	Belmont District Hospital	T3
	Calvary Mater Newcastle	T3^
	James Fletcher Hospital	R
	John Hunter Hospital	T5
	The Maitland Hospital	T3
	Manning Rural Referral Hospital	T3
	Royal Newcastle Centre	T3
	Tamworth Rural Referral Hospital	T5
	Northwest General Practice (PGY2 only)	GP
13	Auburn Hospital	R
	Bathurst Base Hospital	R
	Blacktown Hospital/Mt Druitt Hospital	T3
	The Children's Hospital at Westmead (PGY2 only)	R
	Coffs Harbour Health Campus	T5
	Orange Base Hospital	T5
	Westmead Hospital	T5
14	Hawkesbury District Health Service	T3
	Nepean Hospital	T5
15	Bega District Hospital (PGY2 only)	R
	Calvary Health Care ACT	T3
	The Canberra Hospital	T5
	Goulburn Base Hospital	R
	Isabella Plains Medical Centre	GP
	Interchange General Practice	GP

Key

*   May contain terms at other sites not listed in the Networks
T3 3 Term Home Hospital
T5 5 Term Home Hospital
R   Rotation Hospital
GP PGPPP pilot, GP service
^   Requesting to become 5 Term Home Hospital

Useful references

The JMO clinical handover toolkit has not sought to reinvent the wheel, but rather channel work from existing sources into one place that provides a JMO specific context to clinical handover improvement.

Each of the references listed below has its own detailed listed of references and can be accessed on demand.

1. Australian Commission on Safety and Quality in Health Care (2010). *The OSSIE Guide to Clinical Handover Improvement*. Sydney, ACSQHC
   www.safetyandquality.gov.au/internet/safety/ publishing.nsf/Content/PriorityProgram-05

2. Australian Commission on Safety and Quality in Health Care. National Clinical Handover Initiative.
   www.safetyandquality.gov.au/internet/safety/ publishing.nsf/Content/PriorityProgram-05

3. Australian Medical Association (2006). *Safe Handover : Safe Patients.* Kingston, AMA.
   www.ama.com.au/node/4064

4. Batalden et al (2002). *General Competencies and Accreditation in Graduate Medical Education*. Health Affairs, vol 21(5): pp103-11)

5. Clinical Excellence Commission (2010). *Quality Systems Assessment: 2009 clinical handover data*. Sydney, CEC.
   http://www.cec.health.nsw.gov.au/programs/qsa. html

6. Clinical Excellence Commission (2010). Between the Flags Program.
   http://www.cec.health.nsw.gov.au/programs/ between-the-flags.html

7. Hunter and New England Area Health Service (2009). ISBAR revisited: **I**dentifying and **S**olving **BAR**riers to effective clinical handover - Project toolkit
   www.safetyandquality.gov.au/internet/safety/ publishing.nsf/Content/PriorityProgram-05_ISBAR

8. JM Farnan, JAM Paro, RM Rodriguez, ST Reddy, L Horwitz, JK Johnson, VM Arora. Hand-off Education and Evaluation: Piloting the Observed Simulated Hand-off Experience (OSHE). Journal of General Internal Medicine, DOI 10.1007/s11606-009-1170-y. November 19, 2009.
   http://www.springerlink.com/content/ n4m37g374355q4r2/

9. NSW Department of Health (2009). *Policy Directive, Clinical Handover: Standard Key Principles (PD2009_060)*. Sydney, NSW DoH.
   www.archi.net.au/e-library/clinical/nsw-handover

10. NSW Department of Health (2009). *Implementation Toolkit: Standard Key Principles for Clinical Handover*. Sydney, NSW DoH.
    www.archi.net.au/e-library/clinical/nsw-handover

11. NSW Department of Health (2009). *Standard Key Principles for Clinical Handover: Implementing Change – Templates*. Sydney, NSW DoH.
    www.archi.net.au/e-library/clinical/nsw-handover

12. NSW Department of Health commissioned literature review (2010). *"Best Practices for Physician Handoffs"*. The Advisory Board Company. Washington, DC.
    www.archi.net.au/e-library/clinical/nsw-handover

13. Tomas. M.J.W., Pirone CJ, Turner P (2009). *A Guide for the Safe Use of Electronic Clinical Handover Tools*, South Australian Department of Health, Adelaide, SA.
    www.safetyandquality.gov.au/internet/safety/ publishing.nsf/Content/PriorityProgram-05

14. Wong et al. *"A Structured Evidence-based Literature Review regarding the Effectiveness of Improvement Interventions in Clinical Handover"* – Australian Commission on Safety and Quality in Health Care, April 2008
    www.safetyandquality.gov.au/internet/safety/ publishing.nsf/Content/PriorityProgram-05

Acknowledgements

The JMO clinical handover project has progressed from initiation to implementation with significant energy from a large number of clinicians and managers within the health system.

The Acute Care Taskforce acknowledge the work of the Health Service Performance Improvement Branch in the program management for the JMO shift change clinical handover project and further thank those who have directly contributed and collaborated on this important project.

The JMO clinical handover project has benefited from alignment and collaboration with existing health strategies and clinical handover guides.

- The Australian Commission on Safety and Quality in Health Care – National Clinical Handover Initiative
- The Australian Commission on Safety and Quality in Health Care – OSSIE Guide to clinical handover improvement (2010)
- The Australian Medical Association – Safe Handover: Safe Patients Guide (2006)
- Hunter and New England Area Health Service – ISBAR communication framework strategy
- The Clinical Excellence Commission – Between the Flags program: recognition and management of the deteriorating patient
- Clinical Education and Training Institute (formerly IMET) – JMO Forum.

A Core Work Group was responsible for the intense activity required to develop the toolkit and templates associated with the JMO clinical handover project.

Core Work Group

- IMET – JMO forum representatives (x7)
  - Dr Hamish Dunn (Hornsby, Manly, Mona Vale)
  - Dr Penelope Aligiannis (Bankstown)
  - Dr Joanna Dargan (John Hunter, Maitland, Belmont, Mater, Taree, Armidale, Tamworth)
  - Dr Lucy Cho (Wollongong, Bulli, Port Kembla, Shoalhaven, Shellharbour, Nowra)
  - Dr Christine Velayuthen (St Vincents, Wagga)
  - Dr Pip Bunting (Wagga Wagga)
  - Dr Katelyn Priester (Albury, St George)
- Prof Jeremy Wilson (Co-Chair Acute Care Taskforce, Professor of Medicine, Clinical Associate Dean, UNSW SWS Clinical School)
- Ms Vicki Manning (Co-Chair Acute Care Taskforce, DON&M, St George Hospital)
- Dr Annette Pantle (Acute Care Taskforce member, Clinical Excellence Commission)
- Dr Kim Hill (Acute Care Taskforce member, Director Clinical Governance, HNEAHS)
- Prof Julie Johnson (Acute Care Taskforce member, Associate Professor and Deputy Director, Centre for Clinical Governance Research, Faculty of Medicine, UNSW)
- Dr Michele Harris (DMS, Sutherland Hospital)
- Dr William Lancashire (Director, ICU, Port Macquarie Hospital, Rural Health Priority Taskforce member)
- Mr Ian Richards (JMO clinical handover project office
- The Health Service Performance Improvement Branch – program management.

The Acute Care Taskforce tested all outputs of the Core Work Group broadly through clinicians, managers and executive members of the NSW Health system and associated health agencies. The time spent and depth of critique provided by diverse members of the health system has added to the strength of the final JMO clinical handover strategy.

Organisations, Committees and Groups who were consulted in the testing of project documentation and strategy.

NSW Health Services
- The Children's Hospital at Westmead
- Greater Southern Area Health Service
- Greater Western Area Health Service
- Hunter and New England Area Health Service
- North Coast Area Health Service
- Northern Sydney and Central Coast Area Health Service
- South Eastern Sydney and Illawarra Area Health Service
- Sydney South West Area Health Service
- Sydney West Area Health Service.

NSW Health Agencies
- Agency of Clinical Innovation
- Clinical Education and Training Institute (formerly IMET)
- Clinical Excellence Commission.

NSW Health Priority Taskforces
- Ministerial Taskforce for Emergency Care
- Surgical Services Taskforce
- Rural Health Priority Taskforce
- Intensive Care Taskforce.

NSW Department of Health Branches
- Health Service Performance Improvement Branch
- Rostering Centre of Excellence
- Clinical Safety, Quality and Governance Branch
- Nursing and Midwifery Office
- Workforce Development and Innovation Branch.

Related Health Agencies
- Australian Commission on Safety and Quality in Health Care
- Australian Medical Association, Council of Doctors in Training.

JMO Clinical Handover Concept Testing Facilities
- Campbelltown Hospital
- Dubbo Base Hospital
- John Hunter Hospital
- Prince of Wales Hospital
- Sutherland Hospital
- Wagga Wagga Base Hospital.

The Acute Care Taskforce is a multi-disciplinary taskforce reporting to the Director General of NSW Health.

Acute Care Taskforce Membership

Acute Care Taskforce (ACT)

- Prof Jeremy Wilson Co-chair
  (Professor of Medicine, Clinical Associate Dean, UNSW SWS Clinical School)

- Ms Vicki Manning Co-chair
  (DON&M, St George Hospital)

- Ms Amanda Larkin
  (General Manager, Campbelltown and Camden Hospitals)

- Dr Anett Wegerhoff (GP, Camden)

- Mr Bill McKennariey
  (Consumer Representative, Tweed Heads)

- Ms Clare Quinn (Manager Speech Pathology, Prince Of Wales Hospital)

- A/Prof Debra Thoms
  (Chief Nursing Officer, Nursing and Midwifery Office)

- Ms Helen Eccles
  (DON&M, Manly and Mona Vale Hospitals)

- Prof Julie Johnson
  (Associate Professor and Deputy Director, Centre for Clinical Governance Research, Faculty of Medicine, UNSW)

- Ms Karen Lenihan (Area DON&M, GSAHS)

- Ms Katharine Szitniak
  (DON&M, Royal Prince Alfred Hospital)

- Dr Kim Hill (Director Clinical Governance, HNEAHS)

- Mr Kim Nguyen
  (Allied Health Manager, Greater Newcastle Cluster, HNEAHS)

- Mr Matthew Lutze
  (Nurse Practitioner, Canterbury Hospital)

- Mr Nicholas Marlow
  (Area Manager Acute/Post Acute Care (APAC) NSCCH Acute Care Taskforce)

- A/Prof Paul Middleton
  (Director, Ambulance Research Institute Senior Medical Adviser, Ambulance Service of NSW)

- Mr Raj Verma
  (Director, Health Service Performance Improvement Branch)

- A/Prof Stephen Wilson
  (Director - Population Health Program St Vincent's Hospital)

- Prof Teng Liaw
  (Director, General Practice Unit, Liverpool Hospital, SSWAHS)

Now resigned

- Dr Jacqui Close
  (Staff Specialist, Geriatrician at Prince of Wales Hospital)

- Dr Annette Pantle
  (Director, Clinical Improvement, Clinical Excellence Commission)

- A/Prof Christopher Poulos
  (Network Clinical Director Southern Hospitals Network, SESIAHS)

Thank you.