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WORKSHOP REPORT

‘Passing the baton of care – the patient relay’

Australian Council for Safety and Quality in Health Care

**Tuesday 19 April 2005
Sydney**

Contents

1. Executive Summary.....	3
2. Introduction.....	4
3. Workshop Objectives.....	4
4. Emerging Issues for Clinical Handover.....	5
5. Draft National Principles for Clinical Handover.....	8
6. Identifying Priorities and Strategies for Change.....	9
7. Closing Summary.....	11

Appendices

- A: Background to Workshop
- B: Current Clinical Handover Improvement Strategies
- C: Clinical scenarios and priorities for change
- D: Workshop participants
- E: Workshop Program
- F: Participants feedback on the Workshop

1. Executive Summary

The Australian Council for Safety and Quality in Health Care (Council) hosted the *'Passing the baton of care – the relay of patient care'* Workshop in Sydney on 19 April 2005, to consult with a range of people about how the Council might usefully contribute to national improvements to clinical handover processes with a focus on enhancing patient safety.

The key outcome of the Workshop was a set of draft national operational principles to use as a guide to any improvements to clinical handover.

The importance of clinical handover was highlighted by three presentations portraying current initiatives to improve clinical handover practices in different settings:

- a South Australian Emergency Department (Professor Chris Baggoley);
- a Medical Assessment and Planning Unit in Queensland (Dr Cam Bennett); and
- nursing practice at a Sydney Hospital (Professor Judith Donoghue).

These presentations set the scene for group work discussions which identified emerging issues and ten draft operational principles for clinical handover.

To gain a sense of the relative priority of each of these principles, Workshop participants then applied these principles to varied clinical scenarios to determine which principles had greater significance in order to bring about a change to effect improvements in patient safety and continuity of care. This prioritising exercise aimed to give some direction to future action for participant organisations.

Participants reported that the Workshop was timely and extremely worthwhile as many workplaces are in the initial stages of planning clinical handover improvement activities. The draft principles may be used to guide health care and educational organisations and institutions to improve the structure and processes behind clinical handover in a nationally consistent way.

Participants asked Council to continue its facilitation of this issue by:

- making a public statement regarding the importance of clinical handover improvements to stakeholders in health and education settings;
- helping to develop processes to assist in making the national principles applicable to all health workers; and
- assisting in the development of clinical handover competencies and team skills training packages.

Council's current term ends on 30 June 2006, so Workshop participants were encouraged to take responsibility for implementing reforms to clinical handover in their respective workplaces and jurisdictions and to continue national efforts towards safe continuity of patient care.

2. Introduction

On 19 April 2005, Council hosted a Workshop to consult with a range of people about how the Council might usefully contribute to national improvements to clinical handover processes with a focus on enhancing patient safety.

Participants included nursing and medical professionals from a variety of public and private health care settings and tertiary education settings, consumer group representatives, administration and health policy staff. The Workshop was facilitated by Dr Norman Swan.

The title for the Workshop '*Passing the baton of care – the relay of patient care*', draws on the metaphor for patient care as a relay race complicated by the process of a baton exchange. This exchange has the potential for disasters culminating in dropping the baton, and being disqualified from the race. The baton represents patient information and responsibility for care. Similarly, patient care and responsibility "passes through" different health and medical professionals and through varied service delivery settings, and at each of these transitions or baton exchanges, the potential exists for negative or unsafe outcomes.

3. Workshop Objectives

In hosting the Workshop, the Council hoped participants could develop a set of draft national operational principles to assist in improving clinical handover practices. The specific objectives were to:

- work with stakeholders to learn from their experiences and gain advice on their views on areas for improvement and commitment to national work in the area of clinical handover;
- reach an agreement that clinical handover is an issue for patient safety and an area where improvements are required;
- obtain advice on how the Council could positively play a role in making improvement, including a recommendation on achievable action to be taken forward by the Council including identification of any priorities for targeting work; and
- create momentum for national improvement and launch stakeholder collaboration to drive improvements to clinical communication and handover for safe continuity of patient care.

4. Emerging Issues for Clinical Handover

Discussion throughout the morning session of the Workshop highlighted a number of issues that emerged as significant in developing operational principles for clinical handover.

Definition

Defining clinical handover was seen as important to establish a shared meaning for discussions. Participants were representative of a variety of professions, workplaces and geographical places within Australia, and as such different views on what constituted clinical handover were presented.

The following definition evolved:

Clinical handover refers to the transfer of information from one health care provider to another when:

- *a patient has a change of location or venue of care, and/or*
- *when the care of/responsibility for that patient shifts from one provider to another.*

Levels and content of information involved

- When debating a definition of handover, the issue of what constitutes a minimum level and content of information arose. Participants discussed core information that needs to be covered to constitute effective and efficient handover.
- Handover can occur verbally, electronically or in written form. It comprises qualitative and quantitative information, and can operate at one or all of three levels. These levels reflect a gradual increase in the complexity of the information transferred:
 - factual information transfer, including quantitative, physiological data (such as heart rate and blood pressure measurements) and qualitative data (such as a change in behaviour, or psycho-social observations);
 - risk information transfer regarding the search for and identification of possible risks inherent in the situation, for example a post-operative patient possessing risks of obesity and a history of smoking; and
 - analysis of factual and risk information, linking risks and potential problems. These are communicated to the next staff member, with a plan for action in mind. In the above example, the risks may indicate a resultant possibility of chest infection or pneumonia. An action plan to prevent this eventuating would be a part of the handover.
- Qualitative and subjective information about the patient, such as psychosocial status, family issues, compliance with treatment, changes in behaviour or any other concerns need to have an opportunity to be voiced at handover. Objective data is a regular mainstay of handover agendas, but comments on the more personal aspects of patients are often overlooked.

Implications for the health care team

- In addition to providing the opportunity to transfer quantitative and qualitative patient information, handover can also provide a team building or capacity building function for health care teams, where staff members have an opportunity to discuss ideas in a safe and receptive environment.
- All Workshop participants recognised the importance of handover being multidisciplinary or interdisciplinary whenever possible and practicable. This ensures that a complete and holistic picture of the patient is transferred at the time of change of patient care or responsibility. It also is important for the multidisciplinary team, as it validates their contribution to the total patient care.

Essential elements of effective clinical handover

- System and organisational commitment were seen as integral to the success of improving clinical handover. Commitment to resource allocation, professional development, student training, performance development schemes, information and data systems, and the recognition of the time involved to effectively handover patient information are all examples of where the leaders and managers of health services can display their obligation to clinical and corporate governance.
- Improving information systems will be central to improving clinical handover. Various examples of electronic data templates were displayed and/or discussed during the workshop. Information systems need to be able to:
 - streamline the handover information required and provided;
 - provide checklists and prompts for core or minimum data;
 - be easily transferable between health care settings and sectors; and
 - provide opportunities to audit information and processes.
- Patients and/or carers must be involved in the clinical decision making, part of which is the awareness of and involvement in clinical handover. The extent of involvement is affected by many factors but the absence of involvement, or withholding information should be an exception.

Privacy issues

- The dichotomy between patient privacy and continuity of information was a topic of discussion. Some participants held the privacy and confidentiality of patients paramount which could ultimately mean some clinical and/or personal information is withheld at handover. Other participants, aiming for optimal duty of care, felt continuity of patient information was more significant to achieve maximum efficiency and effectiveness of information handover.

Barriers

While Workshop participants agreed the importance of clinical handover some barriers to effective clinical handover were identified:

- **Time.** A clinician's core business of physically caring for and treating patients is constantly being challenged by administrative, organisational and bureaucratic responsibilities. Handover demands time. While it was recognised that involvement of patients, carers and multidisciplinary teams is important, it has the potential to make handover more time consuming.
- **Communication skills and confidence.** Effective handover relies on effective communication. Health care staff are representative of a wide range of professions, backgrounds, cultures and experience, which has two effects. Firstly, the content and styles of communication can vary widely, with the potential of inhibiting consistency of handover practices. Secondly, the variety of professionals can present barriers to feeling confident enough to verbally handover patient information – some staff members can simply feel intimidated and lacking in the confidence required to present all information adequately. An example of this is a junior nurse or resident medical officer handing over information to a senior consultant.
- **Terminology.** Jargon exists in the health industry. The term 'handover' or 'hand off' implies a discontinuity of care, which is contradictory to efforts to improve patient safety. Similarly, terms such as 'discharge summary' do not create a sense of continuity of care and responsibility for patients.

Discussion of these issues was instrumental in the production of the draft national principles for clinical handover, outlined in the following section.

5. Draft National Principles for Clinical Handover

Through group work the workshop participants established the following draft operational principles for clinical handover. The purpose of these principles is to guide work to make improvements to clinical handover with a focus on patient safety.

Draft Operational Principles for Clinical Handover

1. Patients and/or carers must be aware of and involved in clinical handover wherever possible and appropriate. This will facilitate participation in clinical decision making and improve awareness of the documentation of their health care.
2. There must be system commitment to clinical handover with respect to explicit accountability, resource allocation and Performance Development Systems.
3. Clinical handover requires adequate resources including time, money, space and a variety of tools. Providers should be aware of and practice relevant eHealth initiatives.
4. Clinical handover must be structured, efficient, effective and action oriented and must exist within and between all levels of health care. There must be strategies to ensure that those being communicated with have received, understood and will act on handover information.
5. Clinical handover should address qualitative as well as quantitative issues. Subjective concerns and psychosocial issues warrant attention equivalent to that given to objective data.
6. Clinical handover information must be accessible with an explicit, practical, minimum dataset emphasizing recent changes in that patient's care.
7. Where appropriate, clinical handover must be multidisciplinary to the maximum extent possible.
8. Training in clinical handover competencies, communication and team skills – based on the National Patient Safety Education Framework - are essential.
9. The principles of continuous improvement must be evident in the clinical handover process. This should include clear feedback loops in general patient care, and formal evaluation of clinical handover strategies.
10. Staff should be aware of the provisions of the Privacy Act so that while the privacy of individuals is protected during the handover process, the quality of handover is not limited by undue concern arising from misconceptions about privacy.

6. Identifying Priorities and Strategies for Change

After achieving consensus on the draft national principles for clinical handover, the workshop participants then applied these operational principles to specific clinical situations and identified priorities for change within these scenarios. These are outlined in Appendix C. This discussion revealed recurring areas needing change to create any improvements in clinical handover. These areas or 'themes' are listed below.

Key themes of required change

The key themes of the changes required to improve clinical handover evolved as:

1. Raising awareness of the importance of clinical handover for the whole health workforce;
2. Improving documentation;
3. Clarifying the structure of medical, nursing and allied health clinical handover;
4. Providing opportunities for training and professional development activities;
5. Facilitating organisational commitment;
6. Involving patients and carers; and
7. Including all relevant members of the multidisciplinary team.

Possible Strategies to improve clinical handover.

Workshop participants were keen for the draft operational principles to be as applicable as possible for all health workers, and offered some suggestions to improve clinical handover practices. These included:

- Council making a public statement regarding the importance of clinical handover improvements to stakeholders in health and education settings,
- Developing clinical handover competencies, and
- Developing training packages for team skills and clinical handover competencies.

Participants noted that Council wants to develop work in this area, but it will be within the constraints of the imminent end of its term in June 2006.

7. Closing Summary

Participants were asked to take what they had learned and felt was important from the Workshop back to their workplaces and spheres of influence and use it to improve patient safety through effective clinical handover. Similarly, the Council will consider the information and outcomes from the Workshop and identify what role it can usefully play to improve clinical handover for optimal patient safety. However, Council's term ends on 30 June 2006, so what it can do further in this area is limited.

This Workshop further informed and stimulated national commitment to work on improving clinical handover. Council believes that clinical handover is a key area for patient safety improvement.

Future directions are yet to be decided by Council, but the following were asked of Council by Workshop participants:

- a public statement regarding the importance of clinical handover improvements to stakeholders in health and education settings;
- assistance with developing processes to assist in making the draft national principles applicable to all health workers; and
- assistance with the development of clinical handover competencies and team skills training packages.

In closing the Workshop, Council's Chair, Professor Bruce Barraclough thanked participants for their efforts and encouraged them to return to their respective workplaces and jurisdictions to start and/or continue reforms to clinical handover processes.

APPENDIX A: Background to the Workshop

The Australian Council for Safety and Quality in Health Care (Council) was established in 2000 by the Australian Government Health Minister with the support of all the Health Ministers to provide national leadership for a collaborative approach to improving the safety and quality of health care. Priority areas were identified to facilitate this, including:

- Supporting those who work in the health care system to practise safely;
- Improving data and information for safer care;
- Involving consumers in improving health care safety;
- Redesigning systems of health care to facilitate a culture of safety; and
- Building awareness and understanding of health care safety.

With the view that staff who are supported appropriately can provide the safest possible health care to consumers, the Council set up the Safe Staffing Taskforce (the Taskforce) in 2003. The Taskforce looked at a broad range of staffing variables including fatigue; rostering; skill mix; role mix; staff numbers; staff supervision and team functioning parameters and how to influence these to improve patient safety.

The Taskforce identified seven priorities for action, one of which was to **improve the continuity of care by improving clinical handover**. A literature review commissioned by the Taskforce highlighted the importance of clinical handover practices and the need for support in this area nationally. Key findings of the review included:

- Patient safety is compromised with the absence of systems, training and handover protocols. Possible consequences are delays in care, patient complaints, inappropriate treatment and risks of litigation;
- There is an international lack of clinical handover best practice. As such there is a great need for innovative developments of systems and strategies;
- What constitutes effective handover needs to be established;
- Evidence based guidelines for clinical handover need to be developed;
- Organisations should consider formal and clearly stated processes that include the requirements for the minimum information levels and the communication method.
- Combinations of verbal and written communication should be considered to maximise clarification of information and enable feedback if required.

Council has recently developed the **National Patient Safety Education Framework** (Framework), and the **Framework Bibliography**. The Framework identifies the knowledge, skills, attitudes, performance and behaviours related to patient safety for all health workers. The Section in the Framework entitled 'Working Safely' encompasses human factors such as fatigue and stress; team and leadership issues; organisational factors; and the issue of providing continuity of care. Safe continuity of care requires health care workers to share the responsibility for providing consistent care, treatment and information to patients, and to share the responsibility to relay information to each other in the event of the transfer of care of the patient. As such the Framework will be a significant resource for improving continuity of care and patient safety through clinical handover practices. The Framework is accessible on the Council website www.safetyandquality.org, and copies are available from the Office of the Safety and Quality Council (02 62894244).

APPENDIX B: WORKSHOP PRESENTATIONS

Current Clinical Handover Improvement Strategies

1. Clinical Handover and Emergency Departments.

Professor Chris Baggoley, Royal Adelaide Hospital

An Emergency Department (ED) is normally a place of uncertainty and unpredictability, but these characteristics are exacerbated in the arena of transition or clinical handover. Communication between ED and other health care settings can entail a written letter, facsimile, or a phone call. The barriers to this communication include the stress of ED, insufficient time, patients forbidding communication, and the communication simply being mislaid or lost. The other variable is that once a communication is received, there is no certainty that it will be acted upon.

The most common scenarios for handover are to and from ED and the patients' General Practitioner (GP), and between ED and General Medicine within the hospital.

GP to ED

A review of the literature revealed the following information

- Poor referral patterns are reflective of the poor relationship between GPs and EDs; the lack of feedback from ED to the referring GP; and the increasing specialisation of EDs.
- Referral letters from GPs, irrespective of the quality of the letters, have no impact on waiting times, time spent in ED, and communication back to the GP.
- Telephone calls
 - can significantly decrease patient's waiting times, and
 - are desirable for obtaining social history and qualitative information.
- Some initial efforts to improve communication indicate that this is a difficult area to affect change, and perhaps a systemic change is needed to produce the desired improvements.

ED to GP

A wide range of feedback from EDs to GPs exists, from nothing to detailed, superfluous written letters. There is potential to progress communication with a change in the system, as indicated by improvements in outcomes with a Victorian pilot study of facsimile notification to GPs of their patient's ED admission.

Improvement Strategies

Any attempts to improve the current systems of communication demand improving certainty in a system which is uncertain, changing, and unpredictable. **Oacis** programme is an electronic program currently being trialled in South Australia to assist discharge from an ED

and the handover of information and care back to a patient's GP. It also has an electronic program to replace the handwritten Progress sheets which are the norm when transferring a patient from ED to a general ward.

1. ED to GP

Oacisprogramme features include:

- pre-populated screen details - demographic details, pathology/imaging results, medications and diagnosis from previous hospital admissions;
- pick-list assisted fields - primary and secondary diagnoses, complications, procedures, services on discharge, discharge medications, and a hospital contact;
- free text fields - clinical synopsis, management plan, Allied Health/nursing notes, and
- a drop down list of local GPs to whom the data sheet can be forwarded on discharge.

2. ED to General Medicine

Oacisprogramme features a Clinical Order Management screen and a Service Detail Screen. These electronic screens allow clinicians to request referrals electronically, and to update the details of a medical consult.

The tools have so far been accepted by Medical Registrars, but still require adaptations to produce a less cumbersome product.

2. Nursing Shift Handover.

Professor Judith Donoghue, University of Technology and The St. George Hospital, Sydney

Handover serves multidimensional functions of:

- Providing pertinent clinical information;
- Depicting patterns of patient care and ward management styles;
- Demonstrating professional competence and identity; and
- Providing opportunities to share experiences provide personal support and promote understanding.

Problems with current handover practices:

1. handover occurs in an office, or station away from the patient. There is no opportunity to 'eyeball' the patient, or include them in the handover.
2. inefficient method of nurses coming in one or two at a time to relay information to those on the next shift.
3. increasing numbers of casual or agency nurses who do not possess patient history knowledge. (In addition to this, these nurses may not be fully aware of organisational cultures or system practices.)
4. time allocated for handover considered excessive
5. patient information handed over is not at the right level – it is often seen as superfluous or insufficient.

Improvement Strategy

Changes were instituted to the process, location and documentation of handover. There was a two to two handover during the day, and a two to one handover for night shift. The handover occurred in the patient's room, and a computer generated form provided unchanging patient information and enabled new information to be added.

Verbal handovers were taken over the phone from an ED nurse when a patient was admitted from ED. This information was documented in the medical record.

Post anaesthetic care unit handovers were given verbally from the nurse accompanying the patient back to the ward.

Outcomes

- consistent recording of patient information
- handover in patient's room enables 'eye-balling' and subsequent clarification of issues
- patients introduced to next nurse at handover
- more efficient use of handover timing: 10-30 mins for five patients
- clinical coordinator aware of all issues and changes to management/discharge planning for all patients.

3. Passing the Baton – The Relay of Patient Care.

Dr Cam Bennett, Royal Brisbane and Women's Hospital

Medical Assessment and Planning Unit (MAPU)

MAPU is an innovative approach to improve the efficiency of health care, and patient outcomes. It provides an important function where patients enter a truly multidisciplinary health facility and receive early multidisciplinary assessments by medical, nursing and allied health staff specifically assigned to each of the eight medical units that use the MAPU.

There are scheduled multidisciplinary meetings held daily, and medical consultants lead these meetings twice each week. The rostering of the medical staff ensures a twenty four hour admitting cycle and sufficient time each morning for handover of patients by the night staff – House Officers and Night Registrars, as well as Admitting Registrars and Interns. The admitting team meets the rest of the multidisciplinary team after this to complete the handover process.

Outcomes

- night staff receive supervision;
- night staff are less stressed, being given a chance to feedback information after their shift, and knowing the outcomes of their work. They have a greater sense of being part of a team;
- the consultant receives information on new patients within twenty four hours of admission, by the doctor who admitted them;
- improved facilitation of discharge planning with coordination of the multidisciplinary team;
- length of hospital stay reduced by approximately 1.5 days.

APPENDIX C: Clinical Scenarios and the changes required to adhere to the draft operational principles

Scenario	Comments and required changes to current system	Principle (see page 8)
GP referral to another health professional	<p>Involve patients and carers, including gaining consent and in the choice of health professional. This should be obligation free.</p> <p>IT systems need to be fine tuned to facilitate this transfer and to reflect professional input.</p> <p>Any handover should include all health professionals involved in the care of the patient, and indicate a commitment to case conferencing.</p> <p>Providing feedback to the referring GP.</p>	<p>1, 10</p> <p>3</p> <p>7</p> <p>9</p>
Handover of patient care at nursing shift change	<p>Patient communication should be open and their input welcomed for handover.</p> <p>Training is needed in handover competencies and teamwork. A consistent national educational strategy would be recommended.</p> <p>Minimum data sets, checklists and IT content proformas would assist regular nursing handover practices.</p> <p>Data sheets should have flags that trigger appropriate actions.</p>	<p>1, 10</p> <p>8</p> <p>3, 6</p> <p>3, 4</p>
Handover of patient care at RMO shift change	<p>Sufficient time needs to be allocated by the system for adequate handover.</p> <p>Information management systems need to be created and used nationally.</p> <p>The system of medical clinical handover needs to be more structured and consistent nationally.</p> <p>Training in the giving and receiving of handover information is required for all levels of medical staff.</p>	<p>2, 3, 6</p> <p>3</p> <p>4</p> <p>8</p>
Handover of patient care between an institution and GP	<p>GP informed of admission and discharge (transfer).</p> <p>Flags inherent in admission handover to trigger telephone contact if deemed necessary, and to trigger appropriate action during admission.</p> <p>GP decides if further input of information required.</p> <p>Electronic discharge/transfer summary to GP.</p> <p>Audits of electronic discharge/transfer information.</p>	<p>4, 9</p> <p>2, 4, 6</p> <p>7, 9</p> <p>3, 4</p> <p>9</p>
Patient care transition between ward and operating theatre.	<p>Clarification of informed consent, explicit postoperative instructions and carer information.</p> <p>Written checklists and instructions need to be a part of handover to and from ward/OT. Patient concerns and carer requirements need to be documented.</p> <p>Training on improving communication handover practices is required.</p> <p>Clinical audits of this transition needed.</p>	<p>1</p> <p>3, 5, 6</p> <p>8</p> <p>9</p>

Appendix D: Workshop participants

Name	Position/Organisation
Chris Baggoley	Director, Emergency Department Royal Adelaide Hospital
Ben Battisson	Director, National E-Health implementation Group. Australian Government Department of Health and Ageing.
Graham Beaumont	Clinical Excellence Commission of NSW
Cam Bennett	Executive Director, Internal Medicine Services. Royal Brisbane and Women's Hospital Service District
Steven Bollipo	Gastroenterology Registrar, Launceston General Hospital
Phillip Boyce	University of Sydney and Sydney West Area Health Services
Veronica Carey	Associate Charge Nurse, Royal Victorian Eye and Ear Hospital
Kaye Challinger	Acting Director, Acute Services, Central Northern Adelaide Health Service. Royal Adelaide Hospital
Kirsty Cheyne-Macpherson	Director, Office of the Safety and Quality Council
Duncan Cooke	Royal Hobart Hospital
Rachel Darmody	Department Officer, Office of the Safety and Quality Council
Kay de Mestre	Nurse Unit Manager, North Coast Area Health Service (Ballina Hospital)
Judith Donoghue	University of Technology Sydney & South East Illawarra Health Service
Maxine Drake	Health Consumers Council (WA)
Peter Dunn	Emergency Services Commissioner, A.C.T. Emergency Services Authority
Ann Fogarty	Nurse Unit Manager, Sunshine Coast Private Hospital
Iwona Gileff	Flinders Medical Centre
John Hall	Australian College of Ambulance Professionals
Ailsa Hawkins	Director Clinical Services (Nursing) Operations, Manager Oncology & Haematology. Newcastle Mater Misericordiae Hospital
Warwick Hough	Director, Workplace Policy Department. Australian Medical Association
Cliff Hughes	CEO, Clinical Excellence Commission, NSW.
Joe Ibrahim	Royal Australasian College of Physicians
Ian Kamerman	Australian College of Rural and Remote Medicine
Draginja Kasap	Royal Australian College of Medical Administrators
Teresa Howarth	Saint Vincents Hospital Sydney

Name	Position/Organisation
Marie Jump	Newcastle Mater Misericordiae Hospital
Garry Lane	Head of General Internal Medicine, Western Hospital, Victoria
Coral Levett	Australian Nursing Federation
Harry Lovelock	Director of Policy, RANZCP
Diane McCarthy	Nurse Unit Manager, POWH Randwick
Wayne McDonald	Hunter New England Clinical Governance Unit
Russell McGowen	Consumers Health Forum of Australia
Alison McMillan	Manager, Clinical Governance Unit, Department of Human Services VIC
Susan Mitchell	Consumers Health Forum of Australia
Charles Mitchell	Queensland Health
Cathy Mitchell	Department Officer, Office of the Safety and Quality Council
Cathie O'Neill	Catholic Healthcare Services
John Palmer	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Prue Power	Executive Director, Australian Healthcare Association
Jane Reuter	ACT Health
Michele Rumsey	Royal College of Nursing Australia
Ian Scott	Queensland Health
Hannah Seymour	Senior Medical Registrar, Royal Perth Hospital, Committee for Physician Training
Sue Sinclair	Director of Nursing, Affinity Health, St George Private Hospital
Norman Swan	Facilitator
Ahmed Tanveer	NSW Representative, Australian Medical Association Council of Doctors in Training
Ron Tomlins	Discipline of General Practice, Western Clinical School, Westmead University of Sydney
Angela Wearne	ACT Health
Leanne Wells	Manager Policy & Development/Principal Adviser Mental Health, Australian Divisions of General Practice
Jill White	Council of Deans of Nursing and Midwifery Australia and New Zealand
Amy Zelmer	Consumer representative, Cochrane Collaboration

APPENDIX E : WORKSHOP PROGRAM

9.30am	<i>Registration / Tea and Coffee</i>
10.00am	<p>Welcome, introduction and purpose of the workshop</p> <p>‘Passing the baton of care - the patient care relay’</p> <ul style="list-style-type: none"> • Professor Cliff Hughes, Australian Council for Safety and Quality in Health Care
10.30am	<p>Presentations on examples of clinical handover improvement strategies</p> <ul style="list-style-type: none"> • Professor Chris Baggoley, Royal Adelaide Hospital, SA • Professor Judith Donoghue, St George Hospital, NSW • Dr Cam Bennett, Royal Brisbane and Women’s Hospital Service District, QLD <p>Question time to panel of presenters</p>
11.45am	<i>Morning tea</i>
	<p>Establishing operational principles for clinical handover</p> <ul style="list-style-type: none"> • Group work to establish a set of operational principles for clinical handover processes across multiple settings
12.45pm	<i>Lunch</i>
1.15pm	<p>Summary of the operational principles for clinical handover</p> <p>Applying operational principles for clinical handover and identifying priorities for change</p> <p>Group work to:</p> <ul style="list-style-type: none"> • apply principles to 2 specific examples in the health care environment; and • identify the highest priority areas for change to allow these principles to be applied.
3.00pm	<i>Afternoon tea</i>
3.15pm	Possible strategies for Council to promote improvement in clinical handover
3.50pm	<p>Next steps for Council</p> <ul style="list-style-type: none"> • Professor Bruce Barraclough, Australian Council for Safety and Quality in Health Care
4.00pm	Workshop close

APPENDIX F: Feedback from Workshop Participants

There were fifty two participants, and 39 questionnaires were completed and returned.

Question	Outcome
How relevant was the workshop?	90% of received questionnaires indicated workshop was very relevant.
Did you feel that you were encouraged to take an active part in the workshop?	74% of received questionnaires indicated that participants were very encouraged to actively participate, and 26% were encouraged to do the same.
Do you think the working group sessions were structured appropriately to achieve the workshop goals?	63% of received questionnaires indicated that the groups were structured very appropriately and 37% appropriately in order to achieve workshop goals.
How did you find the workshop organisation (before/during the workshop)?	84% of received questionnaires indicated that participants found the pre-workshop organisation good, and 16% found it adequate.

Aspects of the workshop that were particularly liked

- The structure of examples, principles and application;
- The open, collegiate approach;
- Gentle but hard working
- Good networking and interactivity;
- Good presentations;
- Pre-reading;
- Format – the involvement of consumers
- Progressive exposure to clinical handover situations by initial presenters
- Well organised and facilitated– encouraged participation;
- Workgroups structured well;
- Broad discussion at primary and secondary care level;
- Diversity of participants was helpful;
- Practical and goal oriented;
- It felt as though something was achieved by the end of the day;
- Venue, accessibility, food.

Aspects of workshop that were particularly disliked

- Could have come up with more practical solutions;
- No sense of other initiatives being progressed in the same theme;
- Some physical attributes of venue:

How future workshops can be improved

- Use the people in the room to drive the change;
- Delegate list with participant organisations prior to the Workshop;
- Participant list and Council contacts prior to the workshop;
- Invitations sent out earlier, so more clinicians can attend;
- Communicate directly with hospitals that are Affiliated Health Organisations. Information takes too long to filter down from AHS, if it does at all;
- Mix and remix tables for different sessions;
- More presence from the private sector – health funds, catholic healthcare, private hospital associations;
- Needed more input from junior medical and nursing staff.

Further comments on clinical handover improvement strategies and practical suggestions for possible directions that could be taken.

- Council could work together with the National e-Health Transition Authority in the development of National Standards among other things;
- Need active engagement of all the relevant Colleges;
- It is essential that implementation strategies be identified and resourced;
- Workshops and seminars on Clinical Handover in different hospitals around Australia to increase awareness;
- Further workshops to discuss actual strategies would be useful to progress this important issue.