MONASH University

Inter-professional communication and team climate in complex clinical handover situations: issues for patient safety in the private sector

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The purpose of this quality improvement project is to develop clinical handover tools that can be used to reduce the risk of miscommunication in the post-operative recovery process. A team of researchers from Deakin and Monash Universities has been funded for the study from the Australian Commission on Safety and Quality in Health Care. The study will be conducted in the Post Anaesthetic Care Unit (PACU) of two private hospitals (Epworth Healthcare and Cabrini Health) and one public hospital (The Alfred Hospital) in Victoria.

The specific aims of this study are to:

1. Identify current handover patterns and processes
2. Identify the quality and safety issues affecting Inter-professional communication during clinical handover in the PACU
3. Measure team performance and safety culture
4. Develop tools and strategies to improve communication on transfer.

Inter-professional clinical handover in complex clinical situations such as the PACU are associated with high risk. Analysis of data from the Australian Incident Monitoring Study (AIMS) identified communication failure as a contributing factor in 14% of PACU incidents (Kluger et al, 2000). The interdisciplinary nature of work in PACU necessitates cooperation and collaboration among team members to prevent communication errors and compromised patient safety. Not surprisingly, team performance is influenced by complex cultural, behavioural and environmental factors that must be considered when developing interventions to improve outcomes in complex handover situations

A comprehensive research program using four data sources across three study sites will be used in this study. Multi-dimensional data collection methods will include observations of clinical handover, focus group interviews with department managers and clinicians, staff survey on team climate and safety culture, and aggregated analysis of critical incident reports related to communication. Approximately 150 PACU staff at each site, including anaesthetic, nursing and surgical clinicians will be invited to participate. Data on approximately 100 episodes of clinical handover will be collected at each site and focus on the inter-professional interactions that occur during the clinical handover of patients who have undergone abdominal or orthopedic surgery.

This project will contribute to improving quality and safety of patient care by identifying processes to reduce the risk of miscommunication during clinical handover. The potential benefits include: the development of a model to identify and evaluate practices related to clinical communication in PACUs; an assessment of practice differences between private and public PACUs; and an understanding of the feasibility and staff acceptability of different methods used to improve patient safety.

An important anticipated outcome of this project is the identification and rich description of common patterns of behaviour and behavioural markers associated with good practices, effective inter-professional communication and interdisciplinary working relationships within high-risk clinical settings that are critical to achieving desired patient outcomes. It is anticipated that behaviours adversely influencing the attitudes and behaviours of clinician team members will also be identified. These findings will, in turn, be used to inform the development and implementation of a framework of strategies and tools to assist clinicians improve clinical handover performance and measure the effectiveness of communication interventions, thereby helping to reduce clinical risk within the PACU.