

# IMPROVING CLINICAL HANDOVER ALBURY WODONGA PRIVATE HOSPITAL

## THE ISSUE

It is widely recognised that communication failures are the leading cause of inadvertent patient harm. A Joint Commission for Hospital Accreditation study of 2455 sentinel events states that over 70% of those reported were due to communication failure (1). Our own auditing and risk management reporting system identifies and supports this trend.

The key objective of this project is to facilitate improved communication and patient safety enhancing the patient's experience and outcome of care, by the development, implementation and evaluation of a formalized tool and education process for clinical handover.

## THE SOLUTION

The education program developed, entitled the PACT Program, focuses on the following steps:

P - Patient Assessment

A - Assertive Communication

C - Continuum of Care for patient safety ensuring positive outcomes

T – Team work with trust

The PACT program was designed to enhance some current education programs already in place at AWPB.

These include:

- Basic Life Support and Medical Emergency Response criteria
- Patient Assessment Skills workshops

The aim is for a standardized approach to patient assessment and reportable parameters. The expected outcome is that clinical staff are able to identify early a deteriorating patient and to communicate effectively to the appropriate personnel preventing the clinical situation becoming more serious eg: medical emergency or sentinel event.

Action research and literature review with investigation of current tools to establish validity for change, has taken place prior to the development and implementation of an education package and communication tools. We sought to determine staff and Visiting Medical Practitioners' perceptions of clinical handover effectiveness and efficiency by survey and focus groups and reviewed current incidents where communication was identified as an issue.

## OUTCOMES AND BENEFITS

Benefits of the education package include

- Improved patient assessment skills;
- Standardisation of communication processes;
- Reportable patient care parameters;
- Promoting teamwork – facilitating trust and confidence;
- Framework of key criteria to be communicated during clinical handover;
- Enhanced communication skills to handover efficiently and effectively;
- Participants are focused and calm, decreased anxiety;
- Improved 'nurse to nurse' and 'nurse to doctor' communication

- All healthcare workers are on the same page;
- Develop a multi disciplinary language;
- Improved patient outcomes;

The education is delivered by multi modal methods of training including:

- Face to face workshops;
- Clinical competency assessment;
- Simulation/scenario based workshops;
- Web based on line tools;
- DVD.

The communication tool is based upon the SBAR principles. The tool is a Medical Record form whereby clinical handover communications and actions between nurses and doctors are documented in the patient's health record.

Flash cards were developed to act as a prompt checklist for using the SBAR tool in shift to shift handover. The flash cards are attached to staff ID badges

This PACT program is planned to be rolled out Ramsay wide.

References:

1. Leonard, M. Graham, S. Bonacum, D. The human factor: the critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Health Care* 2004; 13:85-90doi:10.1136/qshc.2004.010033