Exnovation: Enabling frontline staff to devise suitable solutions to handover challenges

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The HELICS Workshop

• **Purpose:** to familiarise workshop participants with HELICS as handover codesign technique

• **Outcomes:** participants will be able to:
  – discuss the benefits of codesign using video data
  – specify the ground rules of HELICS
  – list the stages involved in implementing HELICS

HELICS: Handover Enabling Learning in Communication for Safety

A research consultancy provided by the
Centre for Health Communication UTS &
The University of Melbourne to the
Australian Commission on Quality and Safety in Healthcare

The National Clinical Handover Initiative
Clinical Handover is ...

"... the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis".

"... a high risk scenario for patient safety with dangers of discontinuity of care, adverse events and legal claims of malpractice".

Handover communication & process complexity

Clinical risk is heightened by:
- interrupted communication and memory processes,
- multiple concurrent tasks and multi-tasking,
- intensified communication.

Proceduralising handover

MIST:
- Mechanisms of Injuries
- Injuries sustained or suspected
- Signs (Vital)
- Treatment given

SEAR:
- Situation
- Background
- Assessment
- Recommendation

FAST HUG:
- Feeding
- Analgesia
- Sedation
- Thromboembolic prophylaxis
- Thromboembolic prophylaxis
- (elevation of the)
- Head of the bed,
- Ulcer prophylaxis
- Glucose control
Can we fully systematise handover?

- Yes: in routine work that has well-defined boundaries enabling the development of a standard operating protocol for handover.
- No: in non-routine work that requires ongoing assessment, clarification of plans, and re-selection from options.

Handover: Sources of complexity

- Level of care uncertainty
- (Non) standard time(s) for handover
- (Variable) location where handover is conducted
- (Different) participants in the handover (mono- vs multi-disciplinary interaction)
- (Changing) length of time devoted to handover

Handover: Managing complexity

- Decisions about information to be transferred / information to be excluded
- Levels of 'interactivity' among staff during handover
- (Non) use of handover tools (IT, checklists, etc)
- Other kinds of documentation
### Multi-disciplinary Handover

**Problems Identified**
- Lack of clinical ‘ownership’ of patient care (nursing)
- Planning of care inadequately implemented due to lack of interdisciplinary communication
- Dangers of discontinuity of care
  - Nurse led (facilitated by senior medical staff) handovers at ward round

**Intervention**
- Improved continuity of care
- Educational opportunities
- Clinical team building

**Outcomes**
- Visual verification of information
- Precise
- Concise
- Professional format
- Time reduced <15-30 mins

### Medical Handover

**Problems Identified**
- Communication is prone to interruptions
- Out-dated information
- Time intensive >45 mins

**Intervention**
- Handover at the patients bedside led by the senior registrar

**Outcomes**
- Visual verification of information
- Precise
- Concise
- Professional format
- Time reduced <15-30 mins

### Outcomes

- Opportunities for dialogic education
- Coordination between disciplines
- Availability of contemporaneous information
- Early insight into emerging, potential, or previously unrecognised problems
- Opportunity for the negotiation of supervisory support
HELiCS: lessons learned from four sites intervening in handover

- Bedside patient check
- Multi-disciplinary handover
- Cross-hierarchy communication
- Checklist support
- Agreed interruption rules
- Systematised documentation process

Methodology

- Participation
- Observation
- Filming
- Reflexive Sessions
- Implementation
- Ongoing self-evaluation

Patient safety & 'qualitative intervention research'

- 'Hard science' controls the experimental environment; this method goes for complexity
- Undervalued as a means for health service and clinical process improvement
- Transferable learnings include:
  - Technical knowledge outcomes
  - Social outcomes: enthusiasm, engagement, optimism
- Emphasis shifts
  - from: 'expert researcher' as arbiter of 'what is evidence'
  - to: collaborative practitioner-researcher relationship that leads to new ways of working / knowing