



**Centre for
Health Communication**

HELiCS as a tool for ongoing observation, improvement and evaluation of clinical handover

Public Report on Pilot Study

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ACSQHC acknowledges that the information contained in this one-year study presents initial developments and supports longer-term research and evaluation. The information presented here does not necessarily reflect the views of ACSQHC, nor can its accuracy be guaranteed.

Table of Contents

Abstract	3
Executive Summary	4
Introduction	6
General Project Procedure	7
Site-specific Progress and Findings	10
General Learnings	13
Evaluating HELICS – Stakeholder Feedback	13
Conclusions	14
References	15

Table of Figures

Table 1. Results of Reflexive Engagement, John Hunter Hospital Emergency Department	10
Table 2. Results of Reflexive Engagement, Royal Prince Alfred Hospital Intensive Care Services	11
Table 3. Results of Reflexive Engagement, Prince of Wales Hospital, Spinal Injury Rehabilitation Services.....	12

Abstract

This report sets out the achievements of the University of Technology Sydney / University of Melbourne project that formed part of the National Clinical Handover Initiative. These achievements include changes in handover practices at participating sites, and strengthened staff capacity to reflect on and intervene in their handover practices. The participating sites were an emergency department, an intensive care unit and a spinal rehabilitation unit. Their achievements are recorded and explained in the 'HELiCS Kit' developed for this project.

HELiCS, which is an acronym for 'Handover: Enabling Learning in Communication (for) Safety', is an approach to staff learning that centres on involving frontline clinicians in reflecting on practice using actual video footage of their handovers. The HELiCS Kit includes:

- 1) a 20-minute training DVD with examples of actual footage from the participating clinical sites, and visual examples of how handover practice improvements occurred in these sites;
- 2) a Resource Booklet that explains the video-based improvement procedure and details the achievements at three case study sites; and
- 3) a HELiCS web site (www.communicationsafety.org) with further visual and published resources, information about the reflexive redesign method, and an interactive forum where clinicians interested in sharing their experiences using video can go to discuss progress, solutions and problems.

The project has been successful in gaining participation from three clinical sites, in achieving improvements in those sites, and in generating interest in HELiCS from other researchers, departments and hospitals, nationally and internationally.

Executive Summary

Overview

This University of Technology Sydney / University of Melbourne project has focused on developing a video-ethnographic reflexive resource. This resource is named HELiCS: Handover: Enabling Learning in Communication (for) Safety. HELiCS has been designed to enable frontline staff to monitor and enhance their clinical handover practices. The resource has been developed in collaboration with medical, nursing and allied health clinicians and their patients interested in evaluating and redesigning handover practices. A total of more than 150 health care practitioners working in four clinical departments across three NSW Area Health Services provided their consent, participated in the use of video reflexive methods, and achieved handover practice improvements as part of this National Clinical Handover Initiative project.

Sites

The project gained involvement of an Emergency Service, Adult Intensive Care, Paediatric Intensive Care, and a Spinal Injury Rehabilitation Service.

Progress

HELiCS was used to engage clinicians in reflecting on practice and in formulating improvements at their own pace, in their own space, and respecting their and their patients' concerns. Over a period of ten months, the project achieved tangible change outcomes in three of the four departments. This and feedback received from participating staff suggests that the methodology has improvement relevance and impact.

Since completing the project, interest in HELiCS has been expressed by other clinicians in the participating organisations, as well as by organisations elsewhere in Australia and overseas. National progress includes three of the participating sites in this ACSQHC funded study committing internal resources for HELiCS continuation projects in neighbouring departments and units. One site has already assisted in funding and producing a HELiCS offshoot project focusing on engaging patients and family members in articulating their experiences of the Emergency Department, and staff responding to these stories with the aim of improving practice. International progress includes Rick Iedema's appointment as Visiting Professor at the Utrecht University Medical Centre to assist with the implementation of HELiCS across five Dutch Hospitals.

Summary of Findings

Clinicians from each of the clinical sites where the handover project was undertaken designed solutions to handover challenges to suit their clinical settings. Details are provided below. Clinicians showed enthusiasm to design new handover solutions (please refer to the HELiCS DVD for visual evidence and individuals' affidavits). They expedited the new solutions into practice with great immediacy. These facts illustrate that it is beneficial to involve frontline staff in designing effective solutions for complex socio-organisational processes such as clinical handover. Further, they illustrate that the solutions designed by frontline staff can be implemented with speed because they are 'indigenous' to their own ways of working.

In short, the project demonstrated that HELiCS (video-reflexive learning to improve local practices) fits into the existing ecologies of clinical work because it is done by frontline clinicians (and, in some instances, patients) for frontline clinicians and their patients.

Another finding that is critical is that while the teams at each site formulated solutions that were site-specific, these solutions nevertheless harboured strong commonalities with one another. These commonalities include:

- junior staff need guidance distinguishing 'important' from 'less important' handover issues, and 'big picture' (overall treatment trajectory or patient cohort issues) from 'little picture' issues (specific patient-related issues);
- nursing and medical staff need to create a multi-disciplinary leadership so that information is shared cross-professionally and in a timely way, and;
- staff need to include a check with patients at some point during handover so that patients' insights and experiences are not lost to the processes of care and decision-making.

These findings bear out two important lessons:

First, reflexive learning involving frontline staff translates into solutions and improvements that suit specific patients and teams. We now know that these solutions and improvements can also have cross-institutional and policy relevance. This is not surprising of course: clinical teams face related problems across clinical sites and services. But it means that frontline staff targeting local problems may at the same time find themselves addressing larger reforms promoted by policy makers and health service managers. This project shows that reflexive learning provides the basis for connecting local practice and problem solving to policy reform and organisational change.

Second, frontline staff need to reflect on their own work using methods that go beyond clinicians' own understanding of and perspectives on practice. Video is unique in confronting staff with 'what really happens'. Video reminds staff of aspects of work that they have learned to forget, but which need to be brought to the fore because they are critical to enabling clinicians to change their practices. By reflecting on existing practice, its strengths and shortcomings, clinicians can 'flexibly' systematise their work; that is, in a way that remains sensitive to the specifics and dynamics of their workplace and patient population.

Introduction

Clinical handover and communication: key issues

The complexity of health requires that we communicate effectively about what clinicians know and do. It is through appropriate and effective communication about the clinical work that clinicians, patients and carers realise interpersonal trust in the organisational systems that support the clinical work. Such communication includes, but is not limited to, informed consent, a coherent case management plan and regular updates about progress and changes in clinical strategy or clinical handover.

Despite far-reaching institutional and technological changes, the handover has survived as a formalised process of verbal communication. One reason for its salience lies in clinicians' apparent need to talk about patients' progress face-to-face. While for legal reasons clear documentation about patient plans of care are essential (Forrester et al, 2005), verbal handover communication provides opportunities for dialogue about and questioning of the constantly changing circumstances of patients' medical conditions and a unit's available resources to deal with a patient cohort.

Clinicians involved in clinical handover require both shared structural knowledge and a common intelligence, also referred to as team resilience (Wears et al, 2008). In highly complex contexts, clinicians have to devise local solutions. This is because best practice findings produced by experts elsewhere may not (easily) suit existing processes, patients, and staffing arrangements.

Approach

This study focuses on engaging clinicians in the design of local solutions. The method developed for this study is a video-ethnographic one that involves frontline staff in reflecting on their own practices using real-life footage. We have named this resource HELiCS, which is an acronym for "Handover: Enabling Learning in Communication (for) Safety". The method that is at the heart of HELiCS ensures that frontline clinicians (and their patients) design handover systems together with the study facilitator(s). The method was originally developed as part of an Australian Research Council funded study (Carroll, Iedema & Kerridge 2008; Iedema et al 2006, 2007, in press a/b).

HELiCS was developed to enable frontline staff to drive much of the reflexive learning themselves. That is, the HELiCS Kit is about *Research Skill Transfer* from researchers to practitioners (Iedema and Carroll in press). Thus, the HELiCS Kit sets out what is needed to do video-ethnographic filming, to edit footage, to show footage back to clinical teams, to help teams enact specific solutions and improvements, and to evaluate these. The Kit also includes information about the ethics of gathering, editing and presenting visual data.

The HELiCS Kit was developed in collaboration with medical, nursing and allied health clinicians and their patients interested in evaluating and redesigning handover practices. A total of more than 150 health care practitioners working across three NSW Area Health Services provided consent and participated in the use of video reflexive methods as part of the National Clinical Handover Initiative. These people, their enthusiasm and their improvements are what infuses HELiCS with real potential and vitality.

Sites

Four settings were selected for their different types of clinical care: Emergency, where the care is fast-paced, (frequently) urgent, and oriented towards institutional transitions; Adult Intensive Care, where the care is also complex, highly technical, and of longer duration; Paediatric Intensive Care, where the care is complex, highly technical, but also

interpersonally (socially) complex, and a Spinal Injury Rehabilitation Service (inpatient and outpatient), where the care is more evenly-paced, complex socially and organisationally, and of long duration. In each of these settings, very different handover practices were evident, different problems arose, and different solutions to improving handover were formulated.

General project procedure

Deploying the video reflexive method that defines HELiCS followed a similar pathway in all the four sites. Here we explain this process in some detail.

1. Participation

First, organisations were approached to discuss the idea of deploying the video-ethnographic method and use the video footage for reflexive feedback with frontline clinicians. Then, clinicians in individual departments were approached.

On both occasions, project staff explained in detail what privacy and ethical ground rules would be applied. It was explained that staff could ask the filming to be stopped at any time by simply gesturing 'not now' (e.g. brief comment, shake of the head, or wave of the hand). Staff could ask for data to be wiped if it became apparent that compromising data had been captured. Staff could also make requests for particular things to be included in the filming. In that regard, the filming would not take place 'in a vacuum': considerable communication was to take place between the project staff and the clinicians about the contents, focus, duration and perspective of the video work (Iedema and Carroll in press). Additional rules included the following:

- Any patient-identifying information is to be removed from the recorded material (by erasing relevant sounds and images);
- The team is in control and determines which aspects of practice are filmed;
- Footage is stored on a password-protected computer and in a locked office accessible only to project staff;
- Raw footage is only handled and accessible by project staff;
- Public display of any footage can only occur with the explicit and written agreement of the relevant people;
- At the conclusion of the research, data will be stored in accordance with ethics or governance regulations applicable to our academic organisation, taking into account health service organisational rules and stipulations.

After hearing what the study sought to achieve and how, and what privacy and ethical ground rules would govern the use of video footage, most clinicians volunteered to participate. More than 150 staff across the four sites signed project consent forms.

A second meeting was arranged with the same clinicians. At this meeting, clinicians were asked to comment on handover. They were invited to speak about handover from any perspective they thought was important: how they were doing it, questions they had about how they or colleagues were doing it, concerns they had about the effectiveness of their (or colleagues') handovers, risks they knew about, and ideas they had about how to improve handover practice. This meeting concluded with an agreement between project staff and the clinicians about what to focus on in the study. Different teams chose (a combination of) different targets: medical ward rounds, nursing handovers, inter-professional communication, interdepartmental communication, handovers among junior staff members, end-of-week handovers, and handovers involving patients (and family members).

2. Observation

Next, project staff began their observations of agreed areas of handover practice. These observations were critical for project staff for gaining a broader awareness of why staff felt these handovers were important to focus on. A 24/7-observation process was adopted. This involved three project staff observing unit practices on a shift-basis. This shift-based presence ensured understanding and awareness of handover issues to reach rapid saturation.

3. Data collection

Once it was apparent to project staff what aspects led staff to choose these particular domains of handover to be focused on, the filming of these handover aspects started. As noted, this filming was subject to strict guidelines and agreements, as formulated above and as detailed in the governance statement that is included in the HELiCS Kit (Iedema and Merrick 2008).

Filming focussed on the specific operational and clinical areas that were originally identified as of interest, as carrying clinical risk, as having particular strengths and weaknesses, and as needing improvement. Researchers also identified aspects of clinical handover that were not initially identified by clinicians themselves. For example, footage was edited into the feedback DVDs that revealed handovers taking place in very busy and noisy corridors, leading to lack of information transferral, lack of attentiveness on the part of handover participants, and so forth. Footage was also produced of feedback comments made by colleagues from other professional backgrounds in order to spark discussion of issues across professional groups.

The content of the DVD feedback materials was ultimately a practical compromise among: the concerns and interests first expressed by the clinical team, the sensitivities of team members, ethical and privacy constraints, observations made by project staff and their judgments about what clinicians needed to reflect on, and the necessarily limited array of video evidence obtained through the filming¹. The themes by which the feedback footage was arranged included:

- handover between disciplines
- event-triggered handovers (e.g. a very sick patient arrives in ED)
- time-triggered handovers (e.g. set handover routines)
- the difference between formal and informal handovers, and
- handovers between different levels of organisational or disciplinary seniority.

4. Reflection

The reflexive feedback meetings required much preparation. Compiled footage needed to be checked with a clinical site champion to ensure that the footage indeed reflected important handover issues and at the same time did not encroach on organisational or political issues that might disrupt the reflexive feedback progress. Particularly in cases where video data was deemed to be sensitive, advice was also sought from the clinicians who were portrayed in the footage. This ensured that medical as well as nursing and allied health staff were comfortable with footage being shown to the rest of the team. Explicit agreements were obtained from clinicians for particular kinds of feedback: 'only to my team', 'also to other team members', 'to other clinicians in this hospital', 'to clinicians in other hospitals', and so forth.

The footage was then shown at specially arranged and announced reflexive sessions. Some teams agreed to have several feedback sessions where others settled for only one. Showing

¹ Filming was limited by hard-drive and battery capacities on our camera, and by our inability to 'just film everything' and then view and analyse all the footage thus produced.

the edited video sections was preceded by explanations from project staff. This was to make sure that clinicians were reminded of the purpose of the filming of the particular aspects of practice. In particular, clinicians were reminded of specific issues they had raised with project staff before and during the observations and the filming, such as:

- 'What do junior staff handovers address and how do they work?'
- 'How/when do the nurses get to handover to doctors?'
- 'What do we do with the problem that senior staff may not need to know much detail, but junior staff need to learn what is important by practising detailed handovers in front of senior staff?'

If needed, project staff guided the reflexive sessions using the following organising questions:

- Were there any problems with this handover? If so, what were they?
- What went well in this handover, and how can we make sure this happens more often?
- Who was talking and who was not talking during this handover?
- Would the handover have benefited from input from other people or professions?
- What could make this handover operate better for all those involved?
- What changes to the organisation and structure of handover would be required to facilitate the more effective and efficient transfer of information and responsibility?
- What resources, if any, are required to make the proposed solutions work?

The reflexive sessions had significant practical and learning impact (Iedema et al. 2009; in press a/b). Clinicians' views on these sessions' were elicited separately as part of filmed evaluation interviews. Selections of these evaluation interviews are included on the HELiCS DVD and can be found on the HELiCS website (www.communicationsafety.org).

5. Redesign

The final reflexive session at each of the clinical sites aimed to bring together as many disciplines working within that clinical site as possible. During this reflective session project staff provided an overview of each handover solution proposed during preceding reflexive sessions. Time was set aside for clinicians to openly discuss which of the solutions were achievable and how. The meetings were oriented towards establishing what would be required to achieve the proposed changes in practice, when the changes were to be implemented, and who (in the team) was going to oversee the implementation and report back to project staff.

6. Evaluation

The experience of being involved in the HELiCS study and the practice improvement impact of HELiCS on handover processes were evaluated using observation and ongoing and exit (filmed) interviews. The results of these evaluations are included on the HELiCS DVD and are reported in the accompanying *Medical Journal of Australia* article (in press at the time of writing).

Site-Specific Progress and Findings

The following section provides an overview of handover and communication issues identified, how they contributed to communication and handover difficulties, and the proposed solutions for each of the clinical sites where HELiCS was deployed.

The four clinical sites and their progress towards the implementation of handover solutions are identified below.

1. John Hunter Hospital, Emergency Department Hunter New England Area Health Service

Staff from the Centre for Health Communication UTS began coordinating research activities with staff from John Hunter Emergency Department in early 2008. The deployment of the video-reflexive method involved medical, nursing, and allied health personnel in attending preparation and brain-storm meetings. Initial engagement sessions (the 'Participation' stage) occurred on 5 different occasions over a two to three month period. Observation occurred over a four-day period where three researchers observed handover and communication practices on a 24-hr rotating basis. Filming was started on the third day of this period as well, due to rapid project team saturation. Four reflective sessions and one implementation meeting were held.

Core results from the reflexive feedback sessions at John Hunter Hospital Emergency Department are presented in Table 1 below: 'Emergency Department - Issues, Problems & Solution'.

Table 1: Emergency Department - Issues, Problems & Solution

Issues	Problem	Solution	Objectives
Organisational		Medical and Nursing Team Leader Rounds	<ul style="list-style-type: none"> To assess baseline clinical information Communicate the plan of care To coordinate tasks to facilitate expedient patient care To respond to patient, family/care giver concerns and questions To minimise non-critical interruptions to handover To provide 'time-aside' for teaching and learning
Need to complement clinical and operational information	Uncertainty regarding the clinical and operational roles of colleagues		
Professional			
Need to develop the use of clinical judgement in handover	Vital educational opportunities are forfeited in favour of task completion		
Environmental			
Location of handover leads to frequent interruptions	Interruptions can provide emerging information or disturb to the flow of clinical information		

2. Royal Prince Alfred Hospital, Adult Intensive Care Services Sydney South West Area Health Service

The deployment of HELiCS at Royal Prince Alfred Hospital Intensive Care Services also involved both medical and nursing personnel. Initial engagement sessions ('Participation') occurred on four different occasions. Observation and filming occurred over a five-week period. A single researcher targeted pre-identified periods of handover and clinical activity.

Six reflexive sessions were undertaken at the time of writing. At these sessions, solutions to the challenges confronting handover and communication have been identified. The trial, implementation and evaluation of handover solutions designed during these feedback sessions will be ongoing thanks to senior level interest in the project (Dr Robert Herkes, Director of RPA ICU).

Core results emanating from the use of HELiCS at Royal Prince Alfred Hospital, Intensive Care Services are presented in Table 2 below: 'Intensive Care Services, Issues, Problems, & Solutions'.

Table 2: Intensive Care Services - Issues, Problems, & Solutions

Issues	Problem	Solutions	Objectives
Organisational		Incorporation of nurse handovers into medical rounds Medical shift change handover at the patient bedside	<ul style="list-style-type: none"> • To increase opportunities for teaching and leadership development • To verify contemporaneous clinical information • To bring together the ongoing clinical assessment of nursing staff and the objectives and goals of care • To complement historical data with immediate patient assessment • To build and encourage a supportive and inclusive clinical/organisational culture
Lack of inter-disciplinary handover due to incompatibility of handover times	Failure to link macro care planning to micro clinical data		
Professional			
Need to raise staff ability to bring clinical judgement to bear on determining information relevance for handover	Inappropriate approaches to the structuring of information leads to patient risk and missed opportunities for training leadership development		
Environmental			
Staff caring for patients in single rooms feel professionally isolated	Isolation increases clinical risk and limits informal support and training		

3. Prince of Wales Hospital, Spinal Injury Rehabilitation Services (inpatient and outpatient) South Eastern Sydney Illawarra Area Health Service

Staff from the Centre for Health Communication UTS began coordinating research activities with staff from Prince of Wales Spinal Injury Rehabilitation Services in early 2008. This unit had played a major role in earlier research projects involving video reflexive work. For this reason, the spinal team was comfortable with the study process and objectives.

The deployment of HELiCS involved medical, nursing and allied health personnel. Initial engagement sessions ('Participation') occurred on four different occasions over a two-month

period, while filming occurred over an eight-week period targeting pre-identified handover times and periods of clinical activity. Four reflexive sessions occurred and the implementation and evaluation of changes is ongoing at the time of writing.

Core results emanating from the use of HELiCS at the Prince of Wales Hospital, Spinal Injury Rehabilitation Service, are presented in Table 3 below: 'Spinal Injury Rehabilitation Service: Issues, Problems, & Solutions'.

Table 3: Spinal Injury Rehabilitation Service - Issues, Problems, & Solutions

Issues	Problem	Solutions	Objectives
Organisational		Improve multi-disciplinary dynamics of team meetings Provide collaborative teaching forums Elect a team leader to coordinate patient meetings	<ul style="list-style-type: none"> To enable professionals from medicine, allied health, and nursing to present the theoretical and practical issues that affect their work To facilitate the movement of staff between the outpatient and inpatient units. To promote a greater sense of shared care. To balance staff loyalty to their professional group with loyalty to the spinal unit.
Care planning engages different professionals as well as the patient.	Time and staffing restrictions meant that staff felt there were insufficient opportunities for communication with the patient.		
Professional			
Staff members need to determine who has the most appropriate expertise to address specific patient concerns or conditions.	The contributions of members of the health care team remain fragmented, creating uncertainty about expertise.		
Environmental			
Physical layout of the unit impacts on how professional groups interact and deal with patients.	Physical isolation of members of the health care team has the potential to restrict opportunities for supervisory support, education and socialisation.		

4. Sydney Children's Hospital, Paediatric Intensive Care Services (PICU) South Eastern Sydney Illawarra Area Health Service

There was strong interest in the project on the part of one PICU Senior Staff Specialist champion. His support was unable to counter managerial and organisational constraints and reservations about the project. This not only curtailed the progress of the handover project at this site, but rendered the study ineffective.

Initial engagement sessions occurred on four different occasions. Observation and filming occurred over a one-week period. PICU management stipulated that filming was only allowed to focus on the one Senior Staff Specialist's handover practices. This not only obviated a more comprehensive observation and assessment of the unit's handover practices, but also ruled out PICU team discussions about their existing practices and approaches. Negotiation across the PICU regarding potential solutions and improvements was also not possible. For these reasons, no reflective and handover redesign sessions were held. The Centre for Health Communication is continuing to work with staff at this site to identify opportunities for this project to be implemented.

General Learnings

There are commonalities among the solutions formulated by clinical staff across the three sites where interventions were devised and implemented. These include:

- junior staff need guidance on distinguishing important from less important handover issues;
- nursing and medical staff need to create a multi-disciplinary leadership so that information is shared cross-professionally and in a timely way
- staff need to include a check with patients at some point during handover so that patients' insights and experiences are not lost to the processes of care and decision-making

The specific solutions were unique to the clinical setting where they were devised. But their commonalities illustrate two things. First, practical solutions to clinical handover and communication risk can be devised 'bottom-up'. Second, these solutions may address the general intent of over-arching health policy reform initiatives. This puts paid to the opposition that is often imposed between 'local initiatives' and 'over-arching reform'. The assumption is that only over-arching reform and generalised guidelines can lead to systematisation. The work presented here harbours evidence that locally devised solutions have general relevance.

Evaluating HELiCS - Stakeholder Feedback

Stakeholder feedback was sought on an ongoing basis and upon conclusion of the study regarding the usefulness of the reflexive video feedback method for clinical practice improvement. We have included filmed evidence of these evaluations on the HELiCS DVD. Below are some extracts from feedback that was provided by clinicians in writing:

"It was good to feel that they [frontline clinicians'] are participating in and driving the project rather than being subjected to it."

- Registered Nurse from Intensive Care Services

"Handover is important, and this project can be a vehicle for change."

- Registered Nurse from Intensive Care Services

Clinicians were also involved in designing the contents of the HELiCS Kit. Draft packages of the HELiCS Kit were assessed by Registered Nurses from a clinical site that was not involved in the study or in the 'The National Clinical Handover Initiative' generally. Their comments included:

"Redesign seems adaptable to a variety of situation[s] and accounts for the different emphasis of an individual department, while allowing them to drive change from within their department, giving them ownership in the change."

- Registered Nurses from a Metropolitan
Emergency Department

Ongoing assessment of the solutions resulting from this project is taking place. Teams in addition to those originally drafted into the study are signing up to deploy HELiCS. Extension projects have been negotiated at Prince of Wales Emergency department and with the nursing department at Royal Prince Alfred Hospital.

Conclusion

Over a period of ten months, the project was successful in achieving change outcomes in three of the four settings. The fact that the resource was taken up and applied by clinicians themselves to achieve change in their settings demonstrates that the methodology has improvement relevance and impact across a variety of institutional, clinical, and organisational structures. Additionally, interest in HELiCS has been expressed by colleagues of those who were involved in the project for deployment in other departments. This means that HELiCS has the potential to encourage spontaneous spread.

These study activities were synthesized into a resource for frontline staff across the health care sector. This resource, since named HELiCS (thanks to Dr Dorothy Jones of WA Health!) seeks to transfer the skills needed to run its video reflexive feedback method to frontline staff themselves. This transfer ensures that practice improvement is not necessarily dependent on high-cost projects, academic researchers, or expensive facilitators. HELiCS transfers the learning and reflexive skills to those interested in seeking to improve their own handover processes.

HELiCS is designed to enable clinicians to deploy reflexive redesign in their own clinical settings. Included in the HELiCS Kit are:

1. Booklet: Guide to the video-based feedback and reflexive redesign (HELiCS)
This booklet contains instructions for clinicians on how to use the resource.
2. An interactive DVD
This includes footage of clinical handovers from various clinical settings. It also includes visual evidence of the reflective process, showing clinicians engaging with and collaborating to redesign their communication and clinical practices.
3. Ethical and governance documents designed to facilitate the use of HELiCS by frontline clinicians in the knowledge that they are meeting privacy and ethical standards.
4. An interactive Internet web-based resource (www.communicationsafety.org) designed to provide additional resources and information for clinicians and managers interested in engaging in their communication and handover practice. This site also includes a forum for clinicians where they can discuss and share HELiCS related matters and ideas.

The central consideration of our design of HELiCS is the ease of use and accessibility of the resource for clinicians. We look forward to HELiCS being adopted by staff as a means to intervene in the taken-for-granted aspects of their own work. As such, we hope HELiCS will really make a difference.

References

- Forrester, K., Duffield, C., Roche, M., & Merrick, E. (2005). Clinical handover: can we afford the time? *Journal of Law and Medicine*, 13(2), 176-179.
- Carroll, K., Iedema, R., & Kerridge, R. (2008). Reshaping ICU ward round practices using video reflexive ethnography. *Qualitative Health Research*, 18(3), 380-390.
- Iedema, R., Long, D., Forsyth, R., & Lee, B. (2006). Visibilizing clinical work: Video ethnography in the contemporary hospital. *Health Sociology Review*, 15(2), 156-168.
- Iedema, R., Forsyth, R., Georgiou, A., Braithwaite, J., & Westbrook, J. (2007). Video-research in health: Visibilizing the effects of computerizing clinical care. *Qualitative Research Journal*, 6(2), 15-30.
- Iedema, R., & Merrick, E. (2008). HELiCS: Handover - Enabling Learning in Communication for Safety: A Handover Improvement Kit. Sydney: Centre for Health Communication UTS & Australian Commission on Safety & Quality in Health Care.
- Iedema, R., Merrick, E., Kerridge, R., Herkes, R., Lee, B., Anscombe, M., Rajbhandari, D., Lucey, M., & White, L. (2009). 'Handover - Enabling Learning in Communication for Safety' (HELiCS): A Report on Achievements at Two Hospital Sites. *Medical Journal of Australia*, 190 (11): S133-S136.
- Iedema, R., Merrick, E., Rajbhandari, D., Gardo, A., Stirling, A., & Herkes, R. (in press). Viewing the taken-for-granted from under a different aspect: a video-based method in pursuit of patient safety. *International Journal for Multiple Research Approaches*.
- Iedema, R., & Carroll, K. (in press). Discourse research that intervenes in the quality and safety of clinical practice. *Discourse & Communication*.
- Wears, R.L., Perry, S.J., Anders, S., & Woods, D. (2008). Resilience in the Emergency Department. In E. Hollnagel, C.P. Nemeth, & S.W.A. Dekker (Eds.), *Remaining sensitive to the possibility of failure* (pp. 193-210). Aldershot: Ashgate.