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A Framework to support Clinical Communication

Mater Health Services Brisbane

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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"The greatest problem in communication is the illusion that it has been accomplished." *George Bernard Shaw*

Introduction

Patient safety is now recognised as a priority for any health care system. The effective transfer of information between healthcare practitioners (handover) is a fundamental element of patient care and is an "important consideration in maintaining patient safety, work flow and quality care".[1 (p1), 2, 3 (p6)] The Australian Commission on Quality and Safety in Health Care (ACSQHC) has identified improving clinical handover as an important factor in ensuring that safe, continuous care is provided to patients within the Australian health care system.

> ***Clinical Handover*** *relates to and is defined as "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".*[1 (p8), 11]

Clinical handover offers the opportunity for clinicians to provide a clear picture of a patient's current condition or circumstances.[1, 8, 9, 11, 19] There is a general consensus in the literature that the purpose and primary objective of any clinical handover is the exchange of relevant, accurate patient-specific information and knowledge along with authority and responsibility for patient care.[1, 7, 14-16] The accuracy of this information and the style of handover used are identified as vital to the success of the handover process.[14,15]

Problems with communication are identified as one of the top five contributing factors to sentinel events in Australia and worldwide.[4]

In Queensland communication failure has been identified as a contributing factor in 20% of all reported public hospital sentinel events with staff to staff communication failure a sub-category in 13.7% of all sentinel events during 2005-2006. [4]

Poor communication and handovers between clinicians can lead to patients receiving the wrong treatment; delays in diagnosis and life threatening adverse events, as well as an increase in patient complaints, health care expenditure and length of hospital stay. [1, 4, 5, 7, 8-10, 13, 17, 19-23]

The risk for communication breakdown is increased where multiple care providers interact with a single patient.[1, 18]

Staff to staff interactions across disciplines, units or hospitals; staff to patient communication; and staff to family/carer/advocate exchanges have all been identified as contributors to clinical incidents and sentinel events. “Hierarchy, gender, ethnic background and differences in communication styles between nurses and doctors”,[2 (p508)] medical or technical language problems; patient consent issues; and cultural diversity issues have also been identified as potential contributors to communication breakdown, misunderstandings and error.

Historically no ‘best practice’ for improving hand-over communication within the health care setting existed. The SHARED Framework has therefore been developed to support clinical handover within Mater Health Services.

The SHARED Framework for Clinical Handover outlines and explains the essential components of clinical handover. These components are essential for the provision of safe and effective healthcare. The SHARED Framework assists clinicians to participate in comprehensive, appropriate and safe clinical communication irrespective of clinical setting.

Successful communication strategies, such as the SHARED Framework, and handover techniques are those that include a structured approach and the use of tools that are “sufficiently robust to cover the important data elements”.[8 (p27), 11, 25] Additionally, the inclusion of a written component to what has traditionally been a verbal process is shown to be beneficial for any clinical handover process.

Pothier, Monteiro, Mooktiar & Shaw (2005) demonstrate this in their pilot study which measured the amount of data lost during five consecutive handover cycles between nurses encompassing three different styles of handover. They showed that minimal data over five consecutive cycles of handover was lost when verbal and printed forms of handover were utilised simultaneously. All data was lost after three consecutive handover cycles when a verbal handover was used alone and 69% of data was lost after five cycles when a note-taking style of handover was used.[15]

A number of attributes for effective clinical handover are identified:

- ***Face to face communication*** *is the best means for ensuring responsibility for patient care is handed over appropriately.. Face to face communication assists handover to be an interactive, two way process where opportunity for questioning and verification is enabled between the giver and receiver of the information.*[7, 8, 11, 13]

- *The allocation of* ***sufficient time*** *for the handover and communication of up-to-date information is essential.*[7, 8, 13, 31]

- *The use of* ***common language and a standardised approach*** *are crucial, particularly for communicating critical information..*[7, 8, 30, 31] *The discipline of using common language and a standardised approach "under routine circumstances" assists "health professionals to normalise and organise their communication in a way that ensures greater understanding", particularly when time pressure and urgency demand accurate and reliable information exchange to ensure patient safety".*[20, 31] *(p462)*

- ***Forms and checklists*** *are extremely useful as they can be physically passed from one caregiver to another and filed in a patient's chart.*[13, 31]

- *It is important to recognise the need for and* ***place of the narrative*** *understanding and representation of a clinical situation in conjunction with a formalised approach and minimum data set for clinical communication (The SHARED Framework).*

SITUATION reason for admission/phone call > change in condition > diagnosis specific information

Who are you? Why are you communicating? Who are you communicating about?

HISTORY medical > surgical > psychosocial > recent treatments > responses and events

Important information relevant to the patient's current presentation.

ASSESSMENT results > blood tests > x-rays > scans > observations > condition severity

Relevant to the patient's current presentation; Observations, tests, assessments & results.

RISK allergies > infection control > literacy/cultural > drugs > skin integrity > mobility/falls

Relevant & important information to keep the patient safe.

EXPECTATION expected outcomes > plan of care > timeframes > d/c plan > escalation

What needs to be done? In what time frame & by whom? Anticipated responses & outcomes.

DOCUMENTATION progress notes > care path

Important & relevant information written in the appropriate clinical record.

Application

1. It is appropriate for SHARED to be integrated into all clinical settings and situations to support clinical handover across and between all disciplines.
2. The identified support tools (or locally developed tools where appropriate) will further facilitate this implementation/integration.
3. The framework aims to reduce gaps in patient care and safety that occur as a result of inadequate communication.

The Medical Record and Documentation

The role of the medical record is to provide a concise and appropriate record of a patients care. What is appropriate is defined through a number of policies and standards and in some cases legislation.

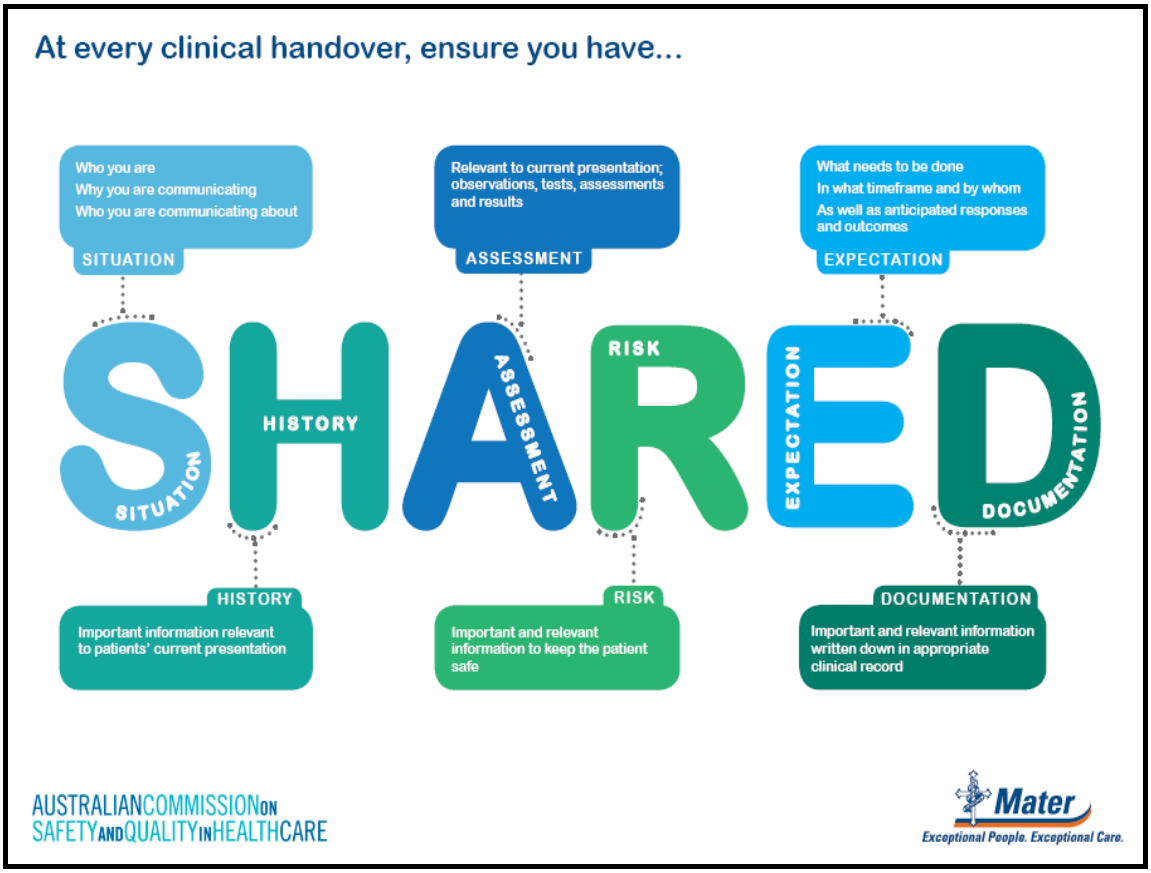
Clinical communication occurs habitually throughout the patients' journey. When this communication surrounds a change in a patients' condition or critical situation documentation of this exchange is imperative to support the provision of safe healthcare and to record the event.

The medical record (and bedside chart) should be reviewed in conjunction with the receipt of a verbal handover to allow the identification of additional safety concerns.

Support Tools

Examples

Poster -

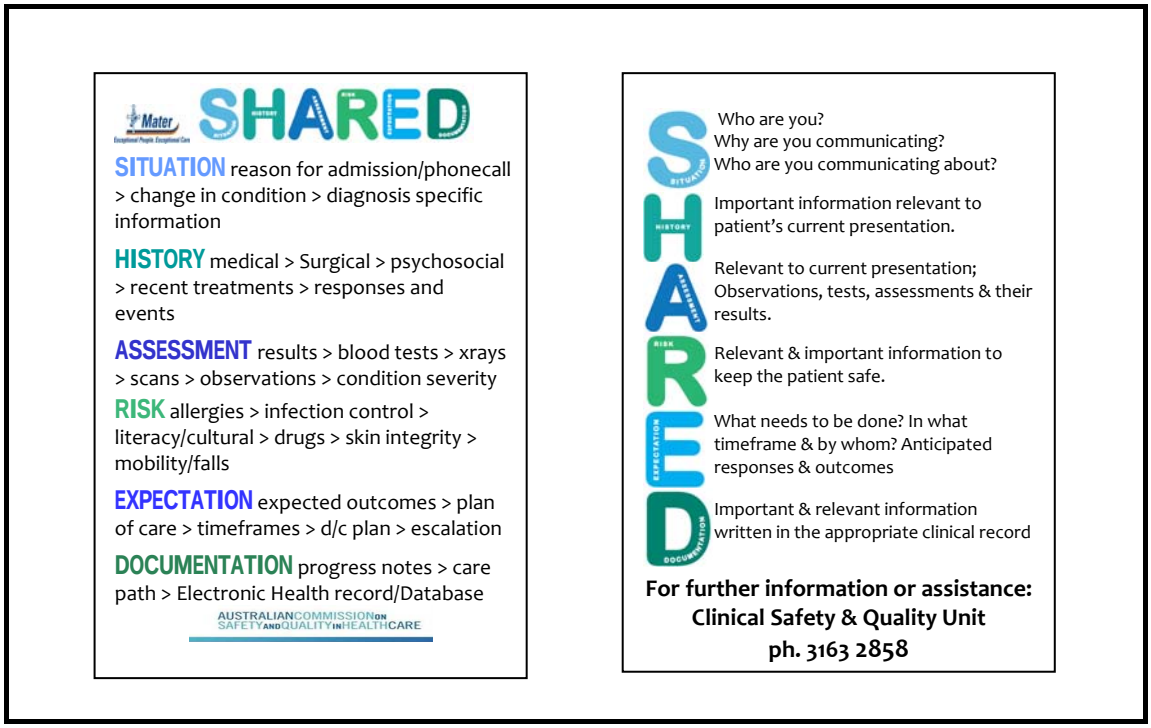


The poster provides a prompt for you within your clinical work area. It is anticipated that you will use SHARED in every instance of clinical handover.

The poster provides a reminder for you to collect up to date information, observations and assessments relevant to your patients' current condition prior to contacting the doctor in any handover situation.

It is also expected that the poster acts as a trigger for you to document your clinical communication following every instance of phone or verbal handover.

Swing Tag -



The swing tag provides you with access to the SHARED framework and its components at all times throughout your working day. It provides an easy to carry, easy to read double sided prompt.

One side of the swing tag offers examples of the types of information that you should seek for each component of SHARED. The opposing side offers the same information as the SHARED poster displayed within your clinical area.

Phone Handover Guide –

The SHARED phone handover guide can be found at the front of every end of bed chart and close to staff telephones within each ward area.

The SHARED phone handover guide is for you to use as a prompt to the information you should gather and provide as part of your communication of a critical situation or change in patient condition handover to the DOCTOR.

The SHARED phone handover guide may also be a useful preparatory prompt for face to face situations as well.

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SHARED

Framework for communicating a critical situation, or change in patient condition

Before calling the Doctor:

1. Assess the patient
2. Review the chart and identify who you should call
3. Read the most recent progress notes, care path & assessments from the previous shift
4. Have available when speaking to the Doctor the end of bed chart

S	SITUATION	▪ Identify the situation you are calling about ▪ Identify yourself – name, designation & where you are ▪ Identify your patient
H	HISTORY	▪ Any relevant history – obstetric/antenatal, medical, surgical, psychosocial ▪ Anything from the current admission including any treatments, responses and events
A	ASSESSMENT	▪ Your assessment ▪ Recent vital signs, trends and/or anomalies ▪ Recent tests and results – bloods, urine etc. ▪ Response to any treatment or intervention so far
R	RISK	▪ Be aware of any risk the patient has ▪ Allergies ▪ Infection control ▪ Medications
E	EXPECTATION	▪ What do you and your patient expect to happen ▪ What does the VMO expect to happen ▪ By whom and by when Know what to do or who to speak to if any of these expectations aren't met! SPEAKING UP FOR SAFETY
D	DOCUMENTATION	Complete an "I have SHARED" sticker and place in the progress notes. Document the specifics of the communication including information you provided and any outcomes including drugs, plan of care, review or follow-up etc. All telephone orders must be written and read back to the Doctor, drug orders must be heard and signed by two RN's or RM's.

I Shared Sticker –

The ”I SHARED….” sticker should be completed and placed in the patients’ chart below your documentation of any clinical handover communication that occurs between yourself and a DOCTOR.

It is important for you to remember to include both a summary of the information you communicated to the DOCTOR as well as the changes that the DOCTOR requests are made to the patient’s plan of care as a consequence of your clinical handover communication.

Carepath Inserts -

Each time you collect a patient from recovery you should complete a SHARED Recovery Room Handover carepath insert.

You should use the SHARED Recovery Room Handover insert as a tool to support the transfer of your patient from recovery.

The SHARED Recovery Room Handover insert is designed to capture and act as a prompt for the information handed over to the transfer midwife/nurse/primary carer from the recovery room midwife/nurse.

The SHARED Recovery Room Handover insert is designed to assist you to provide safe, effective post operative care.

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Post C-Section Recovery Room Handover (Mother)

Unit Record Number:
Surname:
Given Names:
DOB: Sex:

Affix PT Identification Label Here

DATE	TIME

CRITERIA OF PATIENT STATUS ON DISCHARGE FROM RECOVERY

PACU discharge assessment score of ≥8, temperature ≥35.5 C, pain score ≤5/10

KEY: Indicate Yes with ✓ Indicate No with ———

	Recovery Nurse to provide information below in handover	Yes/No	*Transfer Nurse* to complete when receiving handover and accepting patient from recovery
SITUATION	Gestation _____wks		P _____ ☐ Singleton ☐ Multiple x _____
	Procedure		☐ Elective C-Section ☐ Emergency C-Section
	Indication		
	Anaesthetic Type		☐ LA ☐ GA ☐ SA ☐ SEDATION
	Premedication		
	Intra-Operative Medications		Spinal Morphine
			Other
HISTORY	Obstetric / Antenatal(relevant)		
	Medical (relevant)		
	Surgical (relevant)		
	Psychosocial (relevant)		
	Complications / Incidents		
ASSESSMENT	Vital Signs stable		**BP P R T SpO2**
	Comfort maintained/stable		Pain score ____/10
	IV access		
	Indwelling Catheter insitu		
	Drains insitu		
	EBL in OT		
	Dressing dry and intact		
	Wound closure		
	PV loss		☐ Small ☐ moderate ☐ large
RISK	Risks		
	Allergies		
	Infection control Alerts		
	VTE Prophylaxis		☐ drug therapy ☐ TEDs ☐ SCDs ☐ leg movement encouraged
EXPECTATION -PLAN OF CARE	Pain management		☐ Spinal / Epidural ☐ PCA
			☐ Other ☐ PRN ☐ Regular
	Post Op Orders IVT		☐ Additives
	Antibiotics		
	Anti-emetics		
	VTE prophylaxis		☐ Clexane ☐ Heparin
	O2		_____lpm via ☐ nasal prongs ☐ mask
	Other Medications		
DOCUMENTATION			Matrix completed and received
			Medical Orders read and followed
			Other Documentation captured in progress notes / variance notes as applicable

Additional notes:

PLEASE COMPLETE SIGNATURE LOG ON FRONT OF CAREPATH

Recovery Nurse providing handover:	☐ Primary MW/RN ☐ Meal Relief ☐ Other_____	Initial
Transfer Nurse receiving handover	☐ Primary MW/RN ☐ Meal Relief ☐ Team leader ☐ Other_____	Initial
Ward Midwife receiving handover	☐ Primary MW/RN ☐ Meal Relief ☐ Team leader ☐ Other_____	Initial

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POST C SECTION RECOVERY ROOM HANDOVER 290 / 802

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MMH / MMPH / MPH-R
Well Term Newborn -
37 completed weeks> 2500g Carepath

Unit Record No:_____
Surname: _____
Given Names: _____
DOB: _____ Sex: _____
AFFIX PT IDENTIFICATION LABEL HERE

AT BIRTH to Handover **BIRTHDAY** ☐ **Day 0** (baby born after 12 MD) ☐ **Day 1** (baby born between 12 MN and 12 MD)

SITUATION

Delivery Date: Time: Gestation:_____ Wks ☐ Singleton ☐ Multiple x _____

Delivery: ☐SVD ☐VE ☐FD ☐ Elective CS ☐ Emergency CS ☐Other.....

☐Boy ☐Girl ☐Apgar Score - One minute ..... Five minutes..... Ten minutes.....

HISTORY

☐ Resuscitation at birth ☐ Suction ☐Mask O2 ☐ IPPV ☐ Intubation ☐Other.....

Complications / Indications Complete variance as applicable

KEY - Using the provided Reference Guide on page…
Initial the appropriate column and write appropriate comment or referral

ASSESSMENT

Initial Examination by Midwife (All infants will have detailed examination by accredited practitioner within 48 hours of birth)

Examination	Normal	Variance	Examination	Normal	Variance	Comment / Paediatric Referral	Initial
Weight			Respiratory				
Head circumference			Abdomen				
Length			Cord Vessels x 3				
Skin			Periphery(upper)				
Head and Neck			Periphery (lower)				
Neurological			Spine				

Initial Observations **Time:**

					Initial
Temp / HR / Resps	T:	HR:	R:	**BGL** - Blood Glucose Level	
Colour Pink Mottled Pale				**Vomits** Colour / Mucous S = Small M = Medium L = Large	
Urine S = Small M= Medium L = Large				**Meconium**	
Method Of Feeding				**Attachment & Position** I = Independent P = Partial Assist T = total Assist	

Suck: A = Offered but does not attach – not interested
B= Interested but does not attach
C = Attaches – on and off
D = Attaches but has an uncoordinated suck
E = Good nutritive sucking – short feed
F = Good nutritive sucking – Long feed

ID Limb Bracelet insitu x 2

Medication	Given	Not Given	Parents Undecided	Reasons/Actions
VIT K ☐ oral ☐ IMI	Initial	Initial	Initial	
Hep B	Initial	Initial	Initial	
HBIG	Initial	Initial	Initial	

RISKS

Risk Indicators requiring variance actions according to policy: ☐ Maternal Temperature in labour > 38⁰
☐ IV Antibiotics (infection control alerts) ☐ Cord Blood Taken ☐ pH ☐ Group & Coombs
☐ Maternal Diabetes (type)..... Commence Variance insert for infant of Diabetic Mother
☐ GBS ☐ PROM (how long) ..... ☐ Lactate ☐ NAS ☐Apgar< 7 at 1 minute ☐ Meconium Liquor
☐ Other…

EXPECTATION PLAN OF CARE

Skin to Skin contact initiated within first hour of birth • Time Commenced..... • Time Completed: .....
• Initial breast Feed: ..... …

Seen by Paediatrician / medical staff ☐ yes ☐ no

Temperature on discharge from Birth Suite/Recovery .....⁰C

Documentation ☐ Medical orders Read ☐ Any additional information documented in progress notes

Transferred to ☐ **NICU** ☐ **SCN** ☐ **Post Natal Unit** **Time** .....

Discharged ☐ **to Home care –** Homecare notified & Discharge checklist completed
☐ **Home –** Discharge checklist completed

Birthsuite/Recovery Nurse/MW providing handover:	☐ Primary Nurse / MW ☐ Meal Relief ☐ Other_____
Transfer Nurse receiving handover	☐ Primary Nurse / MW ☐ Meal Relief ☐ Team leader ☐ Other_____
Ward Midwife receiving handover	☐ Primary Nurse / MW ☐ Meal Relief ☐ Team leader ☐ Other_____

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WELL TEAM NEWBORN – 37 COMPLETED WEEKS 290 / 802

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Post Operative Recovery Room Handover

Unit Record Number:
Surname:
Given Names:
DOB: Sex:

Affix PT Identification Label Here

DATE | TIME

CRITERIA OF PATIENT STATUS ON DISCHARGE FROM RECOVERY

PACU discharge assessment score of ≥8, temperature ≥35.5 C, pain score ≤5/10

KEY: Indicate Yes with ✓ Indicate No with —

	Recovery Nurse to provide information below in handover	Yes/No	*Transfer Nurse* to complete when receiving handover and accepting patient from recovery
SITUATION	Procedure		Type:
	Anaesthetic Type		☐ LA ☐ GA ☐ SA ☐ SEDATION
	Premedication		
	Intra-Operative Medications		Antibiotic
			Analgesia
			Anti-emetic
			Other
HISTORY	Medical (relevant)		
	Surgical (relevant)		
	Psychosocial (relevant)		
	Regular Medications		
	Complications / Incidents		
ASSESSMENT	Vital Signs stable		BP P R T SpO2
	Comfort maintained/stable		Pain Score _____/10
	IV access		☐ Cannula patent ☐ Fluids maintained (if applicable)
	Indwelling Catheter insitu		☐ Free Drainage ☐ Hourly measures
	Drains insitu		☐ Unclamped ☐ Vacuum
	Dressing dry and intact		☐ Dressing Reinforced
	Ooze visible		☐ small ☐ moderate ☐ large
	Wound closure		☐ Suture ☐ Staple
	Blood loss		Estimate in OT_____ mls Estimate in Recovery_____ mls
RISK	Allergies		
	Infection control Alerts		
	Skin Integrity		
	VTE Prophylaxis		☐ drug therapy ☐ TEDs ☐ SCDs
EXPECTATION -PLAN OF CARE	**Post Op Orders** Analgesia		☐ Spinal / Epidural ☐ PCA
			☐ Other ☐ PRN ☐ Regular
	IVT		☐ Additives
	Antibiotics		
	Anti-emetics		
	VTE drug prophylaxis		☐ Clexane ☐ Heparin
	O2		_____lpm via ☐ nasal prongs ☐ mask
	Other Medications		

Additional information:

PLEASE COMPLETE SIGNATURE LOG ON FRONT OF CAREPATH

Recovery Nurse providing handover:	☐ Primary Nurse ☐ Meal Relief ☐ Other_____	Initial
Transfer Nurse receiving handover	☐ Primary Nurse ☐ Meal Relief ☐ Team leader ☐ Other_____	Initial
Ward Midwife receiving handover	☐ Primary Nurse ☐ Meal Relief ☐ Team leader ☐ Other_____	Initial

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Binding Margin – Do Not Write
Do Not Reproduce By Photocopying
All Clinical Form Creation And Amendments Must Be Conducted Through Health Information Services.

POST OPERATIVE RECOVERY ROOM HANDOVER 290

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