WA Country Health Service & Royal Perth Hospital

A joint venture in improving clinical handover
developing standardised clinical handover

Concepts, Processes and Tools
Project Deliverables

1. Analyse the patient safety risks associated with clinical handover with inter hospital patient transfers.

2. Develop minimum data set for our selected cohort (deteriorating IHPT) both Written & Verbal

3. Develop Toolkit to support implementation
Extent of the problem

- 350,000 ED presentations
- 110,000 separations
- 380,000 inpatient bed days
- 10,000 patient transfers to another acute care facility within Western Australia (WA).
- Over 7,000 of these Via RFDS / St Johns Ambulance/ Fire Emergency services
- Complex processes
  - Referral
  - Arranging patient transport
  - Rely too heavily on multiple players having local knowledge of the WA health system and the differing service delineations both within the Perth metropolitan area health services
  - WACHS is moving towards a model of central clinical coordination of all inter-hospital patient transfers and part of this project involves the development of clinical handover systems
  - Emerging picture of serious adverse outcomes from absent incomplete handovers
Tracing & remedying failures

Transfer of professional responsibility and accountability across multiple systems and providers / agencies / professional and volunteer groups.
Analysis of adverse events and incident

- Clarity of message
- Hierarchy of power influences
- Transfer of accountability
- Team and cross team work
Collaborative effort

Setting the scene...
Royal Perth Hospital
WA Country Health Service

Identify

Situation

Observation

Background

Agree a Plan
Same, same but different

Perth

Lake Grace
Trauma teams
Burns teams
Emergency teams

Identify

Situation

Observation

Background

Agree a Plan

Background
Psychiatric Emergency team
Neonatal resus teams
Multiple transport providers
Project Team

Left to Right: Adele Lake; Dr Christine Jorm; Prof. Chris Baggoley; Dr Ted Stewart-Wynne; Dr Geoff Masters; Pauline Crommelin

Madeleine Connolly and Jill Porteous absent
Handover is just words... **iSoBAR** is an answer

The Why, the What & ‘How will you know when you get there’?
4 Ps of Marketing

- **Product**
- **Price**
- **Place (distribution)**
- **Promotion**
350,000 ED presentations
7,000 transfers via 3 transport providers
Tracing & remedying failures

Transfer of professional responsibility and accountability across multiple systems and providers / agencies/ professional and volunteer groups

Product
a contour line of constant pressure

- I - Identify
- S - Situation
- O - Observation
- B - Background
- A - Agree a plan
- R - Read back

Product
Identify
- Introduce yourself & your patient

Situation
- Why are you calling?
- Briefly state the problem

Observation
- Recent vital signs & clinical assessment

Background
- Pertinent information related to the patient

Agree to a Plan
- What do you want?
- Given the situation what needs to happen

Readback
- Confirm shared understanding
- Who is doing what and by when?
SBAR

• Situation
• Background
• Assessment
• Recommendation

Missing
- Identify
- Read back

**SBAR REPORT TO A PHYSICIAN**

**BEFORE CALLING THE PHYSICIAN**
1. Assess the patient
2. Review the chart for the appropriate physician to call
3. Know the admitting diagnosis
4. Read the most recent Progress Notes and the assessment from the nurse of the prior shift.
5. Have available when speaking with the physician:
   - Chart, Allergies, Meds, IV fluids, Labs / Results

**SITUATION**
- State your name and unit
- I am calling about: (Patient Name & Room Number)
- The problem I am calling about is

**BACKGROUND**
- State the admission diagnosis and date of admission
- State the pertinent medical history
- A Brief Synopsis of the treatment to date

**ASSESSMENT**
- Most recent vital signs: BP, Pulse, Temperature
- The patient is or is not on oxygen
- Any changes from prior assessments, such as:
  - Mental Status
  - Respiratory rate/quality
  - Retractions / use of accessory muscles
  - Skin Color
  - Pulse / BP rate/quality
  - Rhythm changes
  - Neuro changes
  - Pain
  - Wound drainage
  - Musculoskeletal (pain, deformity, weakness)

**RECOMMENDATION**
- Do you think we should: (State what you would like to see done)
  - Transfer the patient to ICU or PCU?
  - Come to see the patient at this time?
  - Talk to the patient and/or family about the code status?
  - Ask for a consultant to see the patient now?
  - Other suggestion?
- Are any tests needed?
  - Do you need any tests like: CXR, ABG, ECG, Labs, CRP?
  - Others?
- Other?
- If a change in treatment is ordered, then ask:
  - How often do you want vital signs?
  - If the patient does not improve, when would you want us to call again?
**Identify**
- Introduce yourself & your patient

**Situation**
- Why are you calling?
- Briefly state the problem

**Observation**
- Recent vital signs & clinical assessment

**Background**
- Pertinent information related to the patient

**Agree to a Plan**
- What do you want?
- Given the situation what needs to happen?

**Readback**
- Confirm shared understanding
- Who is doing what and by when?
Price- cost to the patient
Place

View from 3 sides of Wyndham hospital
Place

Kununurra
Mud football, Derby
**Handover**

**Handover 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."  
(Australian Medical Association, 2007)

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### iSoBAR - a handover "how to"

**Hospital**

- Why is Clinical Handover a Challenge?
  - Good communication is at the heart of an effective clinical handover.
  - Inadequate handovers impact on patients and the organisation leading to adverse events such as:
    - Delays in treatment.
    - Patient complaints.
    - Litigation.
    - Sentinel events.
  - Communication failures have been identified as a significant factor in patient injuries and deaths from preventable adverse events.¹

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**Identify**

- Identify yourself (hospital, ward, sub-unit) and your patient (name, DOB, age, gender, location).

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**Situation**

- Why are you calling? Briefly state the problem, what, when, where, when awake, present date and diagnosis.

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**Observation**

- Most recent vital signs. Include in (HR, BP, SpO2, etc).

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**Background**

- Information related to the patient. Include all current relevant medications, allergies, FHx, test results, plans and time done - comparison to previous records. Baseline status. Relevant social information.

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**Agree a plan**

- Give the situation, what needs to happen? What are you wanting (advice, orders or transfer)? What is the level of urgency? What is the plan?

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**Readback**

- Clarify and check for shared understanding. Who is responsible for what and by when?

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¹: Clinical handover is vital to all members of the health care team; clear communication and accountability strengthen our capacity to plan and manage the care required by our patients.
Handover is just words... iSoBAR is an answer

Putting it into practice - Role Play
Pitfalls
**Surname**

**Given Names**

**DOB**

**Address**

**Postcode**

**Gender**

**Date**

**Time**

**Medicare No.**

**Ambulance fund number**

**DVA colour and number**

**Contact person/INOK**

**Contact No.**

**NFR status documented**

**Aware of transfer**

**Organ donor**

**Contact person/NOK**

**Usual GP/Contact No.**

**Primary language spoken**

**Interpreter required**

**Referring hospital contact person:**

**Name**

**Contact number**

**Principle diagnosis/problem**

**Other diagnoses/problems**

**Reason for transfer**

**Airway**

- patent
- unremarkable

**Breathing**

- shallow
- unremarkable

**Colour**

- cyanotic
- unremarkable

**Circulation**

- warm/hot
- unremarkable

**Skin**

- moist/clammy
- unremarkable

**Pulse**

- slow
- unremarkable

**Behavioural**

- requires physical restraint
- regular

**AIRWAY MANAGEMENT PLAN**

- Airway compromise relayed to transport provider

**Vital signs**

<table>
<thead>
<tr>
<th>Temp.</th>
<th>Pulse</th>
<th>Resp rate</th>
<th>B.P.</th>
<th>SpO2</th>
<th>O2 rate/device</th>
</tr>
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<tbody>
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- Intravenous (IV) access
- IV fluids charted
- Second IV access
- Fluid balance chart
- No access required
- Failed IV access
- Central venous line
- Time last voided
- Fasted from
- Food
- Fluids
- Intercostal catheter
- Nasogastric tube
- Other

**Current episode medications**

- (refer to Medication Chart for time last given)

**Effect**

- Mental Health Act
- Voluntary
- Involuntary
- Risk assessment

**Drug Allergy**

- (state drug/reaction)

**Past relevant medical history**

- Relevant Social issues

- Dietary needs
- Mobility
- Forensic
- Bariatric Client
- Mobility
- Microbiological
- Pre/Post area

**Bed arranged with:**

- Confirmed bed

**IRA transfer form faxed to receiving hospital**

- Yes
- No
Handover is just words... iSoBAR is an answer

‘How will you know when you get there’?
Roll out “ready or not”

- Change ready environment
- Staff encouraged to implement in their context
- The tools and educational support
- Examples - Bed side, patient transfer, allied health referrals...........
- Evaluation of innovation spread
- Variable results
After the trial

The good

- There is less waffle in the communication, and it’s more succinct
- It prompts us to ask the right questions
- It helps us cope with the high turn over of staff
- We used to have bits of paperwork often go missing, so the isobar form has ensured that a comprehensive summary is passed on
- It has helped to change the culture and increase staff awareness of safety issues associated with verbal handover
- The tools are great

The bad

- Focused on the form
- Seen as a medical responsibility especially the A and R
- Looking for a mandate
Lessons learnt

What worked

- Focusing on a problem that was real and recognized by clinicians
- Clinician lead - not top down
- On the ground engagement and listening
- Marketing expertise
- Diffusion of innovation
- KISS
Lessons learnt

What didn’t

• Form can become the focus rather than the concept

• Delays in implementation of enabling initiatives (care coordination, RFDS funding arrangements etc)

• Engagement with and of transport providers

• Under scoped we were n’t equipped for the extent of implementation that a change ready environment demanded
Making it stick - A good proposal for change?

- Based on best evidence
- Well presented and attractive
- Concrete messages
- Clear targets
- Different format for different audiences
Questions?
Diffusion of innovation
Getting ready to change

**iSoBAR toolkit developed**

Understand/diagnose YOUR issues in YOUR context

Plan your SPECIFIC change
Conduct a SMALL test
STUDY results and
Act on them in next small test
keep testing & expanding target

**SOURCE Easy Guide to CPI NSW health**
iSoBAR - Getting ready to change

- **Context**

- **Define issues / problem to be resolved - do you need to collect data?**

- **Describe what you are trying to achieve with whom - Be specific NOT just ‘improve’ handover**

How will you know the change is an improvement?

- **Plan and conduct a SMALL test, how will you STUDY the results before moving on to second test?**