

Improvement in Handover

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Handover

1. Scale of the Problem
2. Definitions
3. Why do things go wrong?
4. Clinical Human Factors
5. Opportunities
6. Plan for today

Context

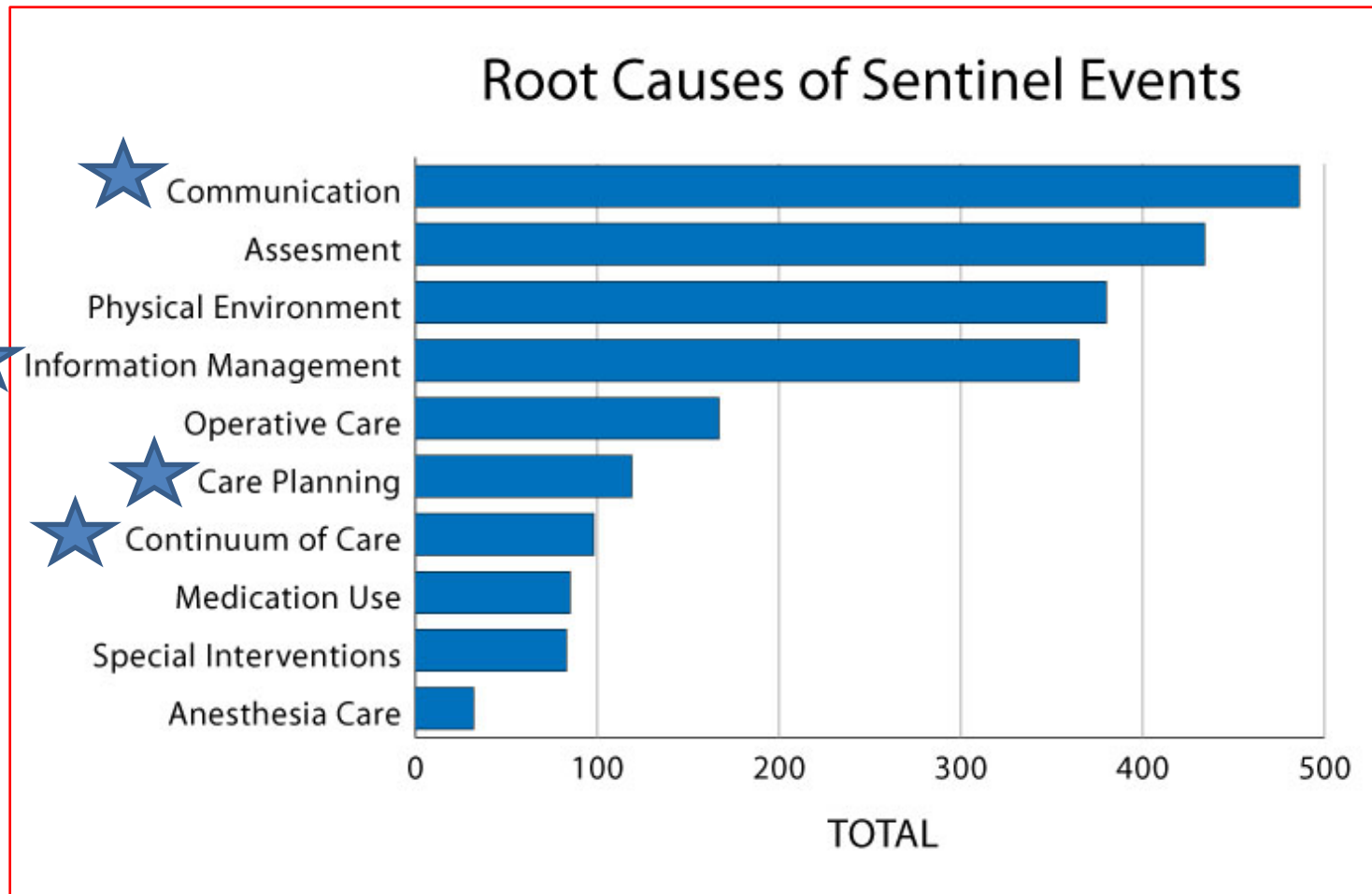
1. Scale of the problem

Information & care transfers are everywhere...

2. Challenges

Traditional Medical models

Joint Commission 2004-11

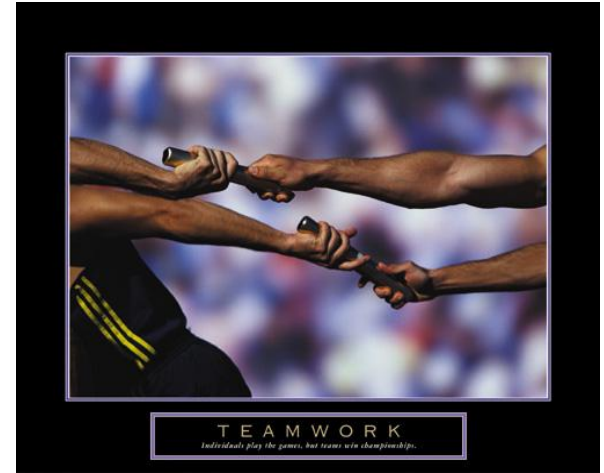


Handover is...

Safe transfer
of
Information
+
Responsibility

From one team to another

Metaphors



The Baton change metaphor sums up what improvement practice and training can accomplish.

Medical Handover is **Far** more complex
is **Far** less standardised
is within a **Far** more safety critical industry
but we train our clinicians in handover **Far** less...

Where is the Research and Evidence ?

How do we measure the process ?



Tri Modal Types

Geographical

One location to another e.g. Home to hospital

Chronological

Shift change e.g. Early to late shift in the same department

Silo

Specialty to specialty referral e.g. Ambulance to ED

Tri modal Methods

Verbal

Pure verbal handover results in 67% of information being lost after the first handover.

97% is lost by the fifth handover

Written

Groups taking notes retained 87% of the important data, with 85.5% retained after the fifth handover

Computerised

A computerised handover tool supporting Verbal / Written

The preferred system is probably is at least bimodal.

The optimal one being tri modal comprising of all of the above.

Tri modal Goals

Safe

To reduce the commonest reason for Adverse Events

Effective & Efficient

Right person, right place, **first** time

Reliable

Standardised, Reproducible, Resilient

Analysis Handover Failures



Clinical Human Factors

Optimise or Impair Human Performance

1. Personnel
2. System
3. Devices
4. Environment

Personnel

Situational Awareness

Communication

Staffing Adequacy

Dampened Hierarchy

Acceptance of Human Limitations



Systems

Processes / Pathways / Policies

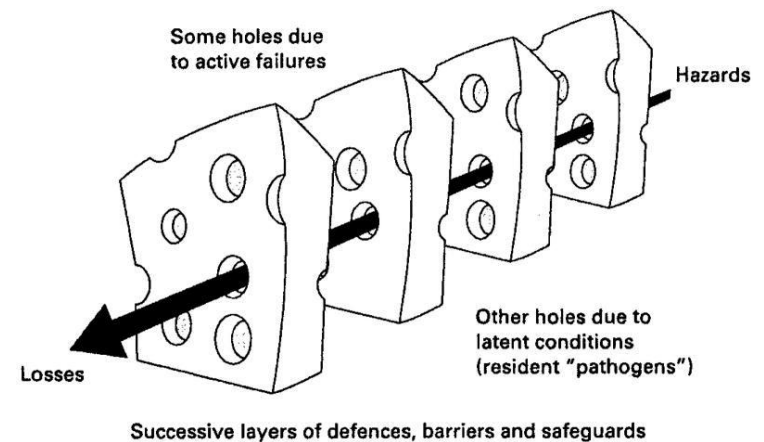
Aligned goals

Formal Structured handover meeting

Sterile Cockpit

Standardised Procedures / Geography

Well trained staff



Devices

Engineering (Handover Tools)

Equipment (PDAs, Wi Fi, Computer interfaces)

Multimodal Handover / Communication Templates

Measurement



Environment

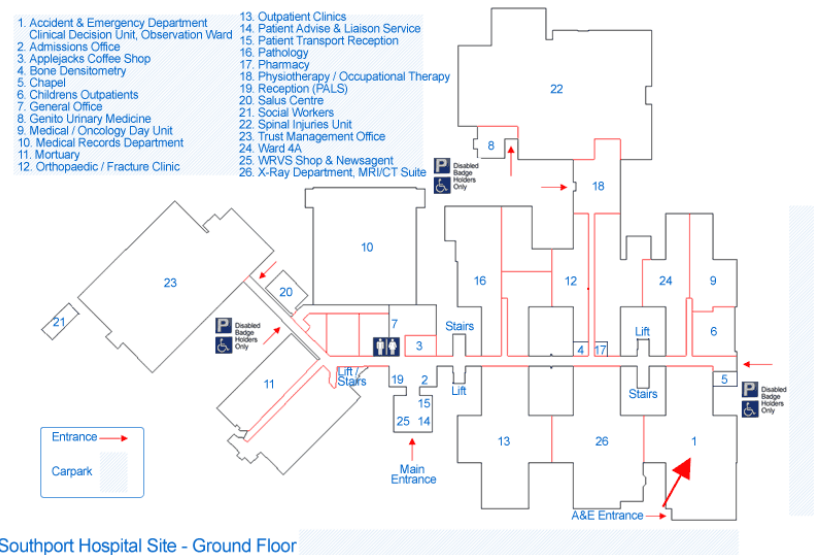
Layout

Geography

Line of Sight

Noise / Distractions

Time Pressures



Opportunities

To Engineer a Resilient & Safer system

- Injection of Human Factors and Systems thinking

Integration of different health care providers

Improved communication is critical

- IT, written, verbal, non verbal, hierarchies, teams

Summative, visible effect everywhere

Questions

1. What is the evidence?
2. What is the big picture?
3. What is local experience?
4. What are the Risk Themes?
5. How can we think proactively about these?

Today's program

AM

(10:15 – 12:30)

10:15 ECHO study overview (Dr. M.Sujan)

10:30 National picture, barriers (Prof. M.W.Cooke)

Coffee (11:15-11:30)

11:30 Improvement Experiences (Dr P.Chrispin/ Dr A.Rose)

12:10 Risk Themes for PM (All)

Lunch (12:30-13:30)

PM

(13:30 – 16:00)

13:30 Group work & Discussion of Risk Themes (All)

- What are promising interventions / solutions?

14:00 Shuffle (All)

Coffee (14:30-14:50)

14:50 Groups Feedback (All)

15:20 Plenary: Themes and Directions