

i Handover

A new process and web-based system for clinical handovers

Category: Continuity of Care

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Aim

- Improve the clinical handovers process for junior doctors
- Increase continuity of patient care

Background

- Previous handovers not providing optimal care
 - Verbal
 - Open to personal style and memory
 - Not structured or formalised
- Junior doctors surveyed re handover practices
 - Potential ways to improve process
 - Research and education re what is essential for a good handover.

Methodology

- Existing handover practices reviewed
 - Small group interviews
 - Questionnaires
 - JMO suggestions for improvements identified
- Literature review of published opinion and guidelines inc. the BMA junior doctors committee Handover Guidelines
- Clinical handover application developed in-house by IT department – iHandover.
 - Trialed and modified with JMOs

Planning & Implementation

- Organisation and Administrative support
 - “Protected” rostered handover time between shifts
 - Remuneration for handover time
- Medical Education
 - Training in handover process
 - Handover rules and guidelines integrated into job descriptions
- iHandover computer program introduced
 - Log of all follow up patients and tasks with recorded actions
 - 24hr access throughout the hospital network



Planning and Implementation

Handover - Microsoft Internet Explorer provided by WAP

i-Handover

Show All Print Sort By: [Dropdown]

Sick Patient List

History	Plan	Division
Admitted 54 days ago, febrile neutropenic, C difficile colitis, ongoing colitis. BPO Lung Ca. Desaturating throughout day 88% RA, 82-83% SL O2. Transfused 2 units PRBCs today. ECG, CEs normal. Increased abd pain. Suspected PE	CTPA and ABCOPHIVA CT this afternoon, please RV results with radiologist and discuss with med reg. Dr Crombie is aware of events. repeat CTPA did not show PE but showed moderate pericardial effusion - does not appear to be clinically compromised at present. WD the med reg. CT AP showed nothing sig wrong.	Medical
75 yo gent prev w/ R & well but renal failure secondary to locally (with pelvic & para-aortic adenopathy) advanced prostate ca/poor response to hormone Tx & IRT bilateral nephrectomies. on 228 then R on 268 as Creat continuing to rise from 128 on admission to 536 today hopefully will improve thru xrt.	Daily bloods & review with Dr Daily to be called if problems. Paul Wilson - Creatinine down to 208 with 2nd kidney unobstructed. Not having a huge diuresis yet, N fluid 100 ml/24	Medical
Multifocal hospital acq. pneumonia (lines 248) H inf from apudum. Prob pre-existing COPD with tendency to low PaO2 & high PaCO2 hence care with FiO2. On N AspiFO Fluids	Daily review if worsening consider ring Dr Daily widen antibiotic cover. Paul Wilson - Stable on Sal (albeit with bad COPD + pneumonia). Not worsening O2 sat. Ceased fluids as not needed, added Lactinase (L/F - hard to access clinically)	Medical
Admitted with Pancreatitis (Day 21) with developing pseudocyst. BO demands. Developed aspiration pneumonia (ICU admission)	Became febrile since yesterday and inc WCC. ID n - for ceftriaxone. Septic work up again today - awaiting CRP (need to check) and need to rx in PM	Surgical
76 yo with long-standing COPD, AF, LVEF ~15%. Admitted with exacerbation of CCF and acute on chronic renal failure. Please review and check EUC.	If more short of breath or worsening renal function discuss with medical registrar regarding furosemide doses. JMO - Galundie + Sunday	Medical
2 days post-OR for dilation of oesophageal stricture. Also post chemo/RT for anal rx. Lower abd pain/w/ RCC. No bowel sounds today but small and stool in stoma. No peritonitis or fever. AVR please if this continues and culture blood & stff culture if splies temp.	as above	Medical
82 year old gentleman admitted with a fractured not after a fall. Bipolar hemiobliquely performed on the 28th. Recovering well - but today creatinine rose to 683 and K+ to 6.5. CC wired and drained ZL. Found to have low bladder neck obstruction.	Need EUC checked. Strict fluid balance also if post obstructive diuresis occurs. Let med reg know if concerned re worsening creatinine	Surgical

Pending Handover Requests

Ward/Bed	MRN	Name	Due By	Req By	Div.
CCU / 24	73	[Name]	03-08-05 (Sat)	R (RMO)	Medical
Followup 85yo with AF + LA fibrillos (on amiodarone + warfarin) + bilateral pleural effusions (on furosemide). Over weekend please check RFF & chart warfarin, check EUC & if worsening may need to decrease furosemide dose.					
Outcome					
SA / 23	04	[Name]	03-08-05 (Sat)	E (gastro)	Medical
Followup Check Ca and Troponin levels.					
Outcome					
2G / 21	42	[Name]	03-08-05 (Sat)	A. (ONC RMO)	Medical
Followup 60 yr old man with metastatic NSCLCA with mets to brain and abd. Please check bloods particularly Ca++ level. If high, will require MF's. If <3, please contact med reg as may need pivots.					

Planning and Implementation

i-Handover - Microsoft Internet Explorer provided by WAHS

i-Handover

Log Out
Add Request
Help
View Policy

SYDNEY WEST
NSW HEALTH

Context: JMO

Update Request

Patient Name: R J MRN: 4 Ward/bed: 2G / 3
Requested by: A (Onc RMO) at 16:34 on 21-Oct-05

Followup: 48 yr old with metastatic breast cancer. Admitted with fevers, headache and lethargy. Positive blood cultures (gram +ve cocci in clusters). Already on Vanc and gent. Please chase sensitivities.

Followed-up By:
Teamrole:
Status: On-going
Ward/Bed: 2G / 3

Outcome History (view only):
R C >>>SENSITIVITIES STILL PENDING. AFEBRILE AT PRESENT.

Outcome:

Update Record Cancel

Outcomes & Evaluation

- Questionnaire distributed to all junior doctors at Nepean Hospital 1 year post implementation
- Topics
 - Awareness of handover process and orientation
 - Preferred handover methods
 - perceived effects of the new method of handover on patient safety and workflows
 - Use patterns and acceptability of the new system

Outcomes & Evaluation

- Overall – very positive responses
- Major findings:
 - 85% believed the workflow was better or same with the new system
 - 66% believed it has led to better handovers
 - 71% believed the new system made their job easier

Outcomes & Evaluation

- **Majority of respondents commented on improvement in patient safety and continuity of care.**
- **Overall process and iHandover usability rated ≥ 4 on a likert scale (1-5) by 23 of 35 (66%) of respondents**

Lessons Learned

- Junior Doctor ownership of change process key to successful implementation
 - Ability to set requirements and test solutions
 - Close contact with developers lead to rapid product evolution to final design
- Junior Doctor M&M meetings can be a source of innovation
- Collaborative relationship with a supportive medical administration department essential to program success



Lessons Learned

- Multiple stakeholder wins: improved patient continuity of care and better junior doctor workflows

Future Scope

- Clinical Handover is important at every site!
- Since study the iHandover program has been expanded to Medical Registrar handovers
- Expansion to other hospital sites