

Contents

Preface — v

Acknowledgements — vii

Contributors — xix

Transcription conventions — xxi

Section 1 — 1

Background: safety, quality and communication in clinical handover — 3

Diana Slade, Suzanne Eggin, Fiona Geddes, Bernadette Watson, Elizabeth Manias, Jacqui Bear and Christy Pirone

1	Effective communication in clinical handover: challenges and risks — 5
1.1	Setting the scene — 5
1.2	Communication in clinical handovers — 6
1.3	Recognizing the role of communication in clinical handover — 6
1.4	Impact of organizational and institutional factors — 8
1.4.1	Physical constraints — 8
1.4.2	Rostering and scheduling — 8
1.4.3	Cultural diversity — 9
1.4.4	Employment conditions — 9
1.4.5	Interdisciplinary boundaries — 9
1.4.6	Hierarchical barriers — 10
1.4.7	Lack of clinical handover training — 10
1.5	Communicative risk factors in actual handover delivery — 11
1.5.1	Lack of structure — 11
1.5.2	Lack of adequate explanations about process — 11
1.5.3	Lack of patient involvement — 11
1.5.4	Excessive reliance on memory without reference to written documentation — 12
1.5.5	Poor quality of written medical records — 12
1.6	Responses designed to improve clinical handover communication — 13
1.6.1	Structural handover tools: 'SBAR' — 13
1.6.2	Flexible standardization and the minimum dataset — 14
1.6.3	Patient-centered care and bedside handover — 15
1.7	Gaps in clinical handover research and understanding — 16
1.7.1	Lack of empirical evidence of actual communication in handover — 16
1.7.2	Under-theorization of patient-centered care — 17
1.7.3	Lack of evidence and evaluation of standardization — 17

1.7.4	Lack of clarity about ‘flexible standardization’ and the minimum dataset — 18
1.7.5	Unclear allocation of responsibility for behavioral change — 18
1.8	The ECCHo project: an interdisciplinary language-based approach to communication in clinical handover — 18
1.8.1	ECCHo research framework — 20
1.8.2	ECCHo as a mixed methods translational research project — 20
1.8.3	Methods — 22
1.8.4	Translational research process — 23
1.9	Outline of this book — 24

Fiona Geddes, Diana Slade, Suzanne Eggins, Bernadette Watson,
Elizabeth Manias, Phillip Della and Dorothy Jones

2	Clinicians’ voices: what healthcare professionals say about handover practice — 25
2.1	Setting the scene — 25
2.2	Investigating clinicians’ perspectives on clinical handover — 28
2.2.1	In-depth interviews — 28
2.2.2	The survey data — 29
2.3	Adverse events associated with poor handover practice — 30
2.4	Issues and challenges in handover practices: the clinicians’ views — 32
2.4.1	Omission of significant information — 33
2.4.2	Changes and omissions in information across multiple shift-change handovers — 33
2.4.3	Lack of direct patient care by clinician handing over — 33
2.4.4	Lack of interaction in handovers — 34
2.4.5	Over-reliance on memory and lack of adequate written records — 35
2.4.6	Lack of mentoring of junior clinicians — 35
2.5	Clinicians’ responses to handover policy directions — 36
2.5.1	Clinicians’ use and evaluations of structured communication tools — 37
2.5.2	Adoption and perceived effectiveness of patient-centered handovers — 38
2.6	Clinicians’ suggestions to improve clinical handover — 39
2.6.1	Handover context — 39
2.6.2	Handover delivery — 40
2.6.3	General suggestions — 40
2.7	The need for education and training in handover communication — 40
2.8	Conclusion — 41

Section 2 — 43**Changing staff: clinical handovers at shift changes — 45**

Jeannette McGregor and Marian Lee

3 Emergency department medical handovers as teaching and learning opportunities — 47

- 3.1 A morning round in the emergency department — 47
- 3.2 Factors at play during emergency department medical handovers — 50
- 3.3 Clinical handover during ward rounds in the emergency department – a view from the literature — 52
- 3.4 The theory of practice – another way to see the practice of clinical handover — 53
- 3.5 Our research site, aims and methods — 54
- 3.6 Challenges to effective handover in public hospital emergency departments — 56
- 3.7 Emergency department medical handover practice – doings, sayings and relatings — 58
- 3.8 Clinician perspectives on handover practice — 61
- 3.9 Discussion — 63
- 3.10 Conclusion — 65

Jeannette McGregor and Marian Lee

4 Strengthening medical handover communication in emergency departments — 69

- 4.1 Introduction — 69
- 4.2 The unique features of the emergency department hospital environment — 70
 - 4.2.1 The high demand for emergency department services — 70
 - 4.2.2 The wide range of patients who visit emergency departments in Australian hospitals — 70
 - 4.2.3 The number of critical and acute unscheduled patients who present at Australian emergency departments — 71
 - 4.2.4 Most emergency department patients are undifferentiated — 71
 - 4.2.5 Time and safety are closely connected in emergency departments — 71
 - 4.2.6 Emergency departments are characterized by high levels of noise and constant interruptions — 71
- 4.3 The communication challenges of hospital emergency departments — 72
 - 4.3.1 Episodic care — 72

4.3.2	Challenges to building alliances between emergency department team members — 72
4.3.3	Poor access to clinical information — 72
4.3.4	Second language issues and poor health literacy — 73
4.3.5	Different grades of experience and applied knowledge — 73
4.3.6	Medical hierarchy of responsibility — 73
4.3.7	High safety stakes — 73
4.4	Five key principles of clinical handover practice — 74
4.4.1	Patient safety is at the center of clinical handover practice — 74
4.4.2	The transfer of responsibility and accountability is a core function of clinical handover — 75
4.4.3	Clinical handover is an organizational process — 75
4.4.4	Clinical handover depends on teamwork — 75
4.4.5	Clinical handover combines action, talk and relationships — 76
4.5	Five key principles of clinical handover communication — 76
4.5.1	Patient safety must be the focus of clinical handover communication — 77
4.5.2	The transfer of responsibility and accountability for ongoing patient care must be made explicit during clinical handover — 77
4.5.3	Clinical handover participants must make team decisions about how each patient's continuity of care is organized — 78
4.5.4	Clinical handover participants must actively share and discuss patient information with other team members during handover — 78
4.5.5	Clinical handover participants must negotiate both the informational and the interpersonal or interactional dimensions of clinical handover — 78
4.5.5.1	Informational aspects of clinical handover — 78
4.5.5.2	Interpersonal aspects of clinical handover — 79
4.6	Communication strategies to strengthen clinical handover — 80
4.6.1	Informational communication strategies: how to facilitate the exchange of information during clinical handover — 80
4.6.1.1	Prepare for clinical handover — 80
4.6.1.2	Manage the context — 81
4.6.1.3	Use a consistent framework to transfer information — 82
4.6.1.4	Make sure the information framework is logical — 82
4.6.1.5	Use signposts to structure information at the sentence level — 82
4.6.1.6	Explain your reasoning — 85
4.6.1.7	Maximize the effectiveness of your information delivery — 85
4.6.1.8	Don't assume knowledge — 86
4.6.1.9	Avoid using vague terms — 86
4.6.1.10	Provide your listeners with clear information distinctions — 86

4.6.1.11	Be aware that newcomers may not be familiar with medical terminology — 87
4.6.2	Interpersonal communication strategies: how to facilitate the relationship between speaker and listener during clinical handover — 87
4.6.2.1	Establish rapport with team members — 87
4.6.2.2	Make it clear who is responsible for outstanding tasks — 87
4.6.2.3	Indicate to the speaker when you want to add information — 88
4.6.2.4	Indicate to the speaker when you want to confirm information or ask a question — 88
4.6.2.5	Ask the speaker to clarify or provide further information — 88
4.6.2.6	Find out information you do not know with WH-questions — 88
4.6.2.7	Explain why you are asking — 88
4.6.2.8	Confirm information with yes/no questions — 89
4.6.2.9	Clarify information with assumptive questions — 89
4.7	Conclusion — 89

Marian Lee and Jeannette McGregor

5	Resource: transferring patient information to the emergency department medical team during clinical handover — 91
5.1	How to transfer patient information to the emergency department medical team during clinical handover — 92
5.2	Establishing and building a positive relationship with patients and with emergency department team members during clinical handover — 95

Suzanne Eggin and Diana Slade

6	Communication in bedside nursing handovers — 97
6.1	Introduction — 97
6.2	Setting the scene — 97
6.3	Background: research questions and data — 101
6.4	Summary of interactional and information issues in bedside handovers — 102
6.4.1	Interactional issues — 103
6.4.2	Informational issues — 104
6.5	Interactional issues in bedside handovers — 104
6.6	Informational issues in bedside handovers — 109
6.6.1	Structure and protocols — 109
6.6.2	Redefining the ‘minimum dataset’ — 111
6.6.3	Unstated assumptions: responsibility and accountability — 112
6.7	Conclusion: improving quality and safety in bedside handover — 113

Suzanne Eggins and Diana Slade

7	Resource: communicating effectively in bedside nursing handovers — 115
7.1	Introduction — 115
7.2	Training design — 115
7.2.1	Dimensions of a good bedside handover — 116
7.2.2	Interactional dimensions of bedside handover: the CARE communication protocol — 117
7.2.3	Informational dimensions — 117
7.2.4	Use of transcribed examples from actual handovers — 120
7.2.5	Information structure on ward sheets — 120
7.3	Conclusion: changing practice through targeted training — 123

Section 3 — 127

Changing sites: clinical handovers when patients move — 129

Suzanne Eggins and Diana Slade

8	Clinical handover in context: risks and protections across a hospital patient's journey — 131
8.1	Setting the scene — 131
8.2	Good – but there are gaps — 135
8.3	The paradox of clinical handover: a risk-minimizing and risk-creating event — 136
8.4	Clinical handover as a risk repair and educational resource — 138
8.5	Handover as a safety risk: poor and poor communication — 143
8.6	Summary of barriers to safe and effective handovers — 152
8.6.1	Attitudes to interactivity and assertiveness in the hospital context — 152
8.6.2	Deference to role hierarchy or discipline boundaries, in particular junior with more senior doctors and nurses with doctors — 152
8.6.3	The persistence of an outdated attitude that excludes patients and carers from the handover — 153
8.6.4	Lack of confidence or skills in communicating in spontaneous, fast-paced, multi-party, patient-inclusive interactions — 153
8.7	Strategies to maximize the safety benefits of clinical handover — 153
8.7.1	Organizational strategies — 153
8.7.2	Communication strategies — 154
8.7.3	Mentoring and leadership strategies — 154
8.8	Conclusion — 154

Fiona Geddes, Phillip Della, Edward Stewart-Wynne and Dorothy Jones

**9 Interhospital transfer of rural patients:
an audit of 'patient expect' documentation — 157**

- 9.1 Setting the scene — 157
- 9.2 Background: research question, approach and data — 158
- 9.2.1 Research approach and sample — 159
- 9.2.2 iSoBAR for interhospital transfer and audit — 163
- 9.2.3 Qualities of the 'patient expect' call — 166
- 9.3 Identify — 169
 - 9.3.1 Patient identification — 169
 - 9.3.2 Clinician identification — 172
 - 9.3.3 Determining clinical responsibility and accountability — 173
 - 9.3.4 Diffusion of personal responsibility and accountability — 175
 - 9.3.5 Delegation of responsibility and accountability — 175
- 9.4 Situation and Observations — 177
- 9.5 Background — 180
- 9.6 Agreed plan — 188
- 9.7 Readback — 189
 - 9.7.1 Compliance — 189
 - 9.7.2 Accessibility — 190
 - 9.7.3 Readability — 190
 - 9.7.4 Endurability — 191
- 9.8 Summary: expanding the concept of written clinical communication — 193

Section 4 — 197

Changing disciplines: clinical handovers in interprofessional teams — 199

Fiona Geddes, Phillip Della, Edward Stewart-Wynne and
Dorothy Jones

**10 iSoBar: An innovative framework and checklist for clinical rounds in an
interprofessional student training ward — 201**

- 10.1 Setting the scene — 201
- 10.2 Background: research question, approach and data collection — 203
- 10.2.1 Mnemonics and checklists — 204
- 10.2.2 iSoBAR for ward rounds — 205
- 10.3 Research site and approach — 206
- 10.4 Results — 215
 - 10.4.1 Setting the scene — 216
- 10.5 Summary — 232
 - 10.5.1 Informational recommendations — 232
 - 10.5.2 Interactional recommendations — 233

Fiona Geddes, Edward Stewart-Wynne and Phillip Della

11 Resource: interprofessional ward round handovers — 235

- 11.1 Better bedside communication — 235
- 11.1.1 For better bedside communication — 236
- 11.2 Informational structures: i-S-o-B-A-R — 236
- 11.3 Preparation — 237
- 11.3.1 Time management — 237
- 11.3.2 Team composition — 238
- 11.3.3 Organization — 238
- 11.4 Guidance on following the steps in the iSoBAR protocol — 238
- 11.4.1 I is for Identify — 238
- 11.4.2 S is for Situation — 239
- 11.4.3 O is for Observations — 239
- 11.4.4 B is for Background — 240
- 11.4.5 A is for Agree to a Plan (Actions) — 241
- 11.4.6 R is for Readback — 242
- 11.5 Summary of resources — 244

John Walsh, Nayia Cominos and Jon Jureidini

12 Maintaining and generating knowledge in interprofessional mental health handovers — 245

- 12.1 Introduction — 245
- 12.2 Language and communication — 246
- 12.3 Successful teamwork communication: polite, respectful and inclusive — 248
- 12.4 Participation and turn-taking in meetings — 248
- 12.5 Preservative handover exchanges — 250
- 12.6 Generative handover exchanges — 252
- 12.7 Generative handover interactional strategies — 255
- 12.7.1 Clarification — 255
- 12.7.2 Repair — 255
- 12.7.3 Challenge — 256
- 12.7.4 Pedagogic scaffolding — 257
- 12.7.5 Referencing — 258
- 12.7.6 Evaluation — 258
- 12.7.7 Elaboration, abstraction and integration — 259
- 12.7.8 Summary of generative communication strategies — 262
- 12.8 Conclusion — 263

John Walsh, Nayia Cominos and Jon Jureidini

13	Patient voice: including the patient in mental health handovers — 265
13.1	Introduction — 265
13.2	Patient voice — 265
13.3	Identifying patient voice — 268
13.3.1	Acknowledging — 268
13.3.2	Distancing — 268
13.4	The frequency of patient voice — 269
13.5	Forms of patient voice — 271
13.6	The function of patient voice in effective clinical handover — 275
13.7	Discussion — 276
13.8	Conclusion — 277

Christy Pirone, John Walsh and Nayia Cominos

14	Resource: mental health clinical handover audit tool (mCHAT) — 279
14.1	Introduction — 279
14.2	How to use the mCHAT — 279
14.3	Handover environment — 281
14.4	Handover organization — 282
14.5	Informational process and outcomes — 283
14.5.1	Informational process — 283
14.5.2	Informational outcomes — 283
14.6	Interactional practices — 283
14.6.1	Team leader's communication — 283
14.6.2	Team members' communication — 287
14.7	Collating and reflecting on the audit results — 289

Section 5 — 291

Integrating ECCHo outcomes — 293

Suzanne Eggins, Fiona Geddes and Diana Slade

15	iCARE³: an integrated translational model of effective clinical handover communication — 295
15.1	Setting the scene — 295
15.2	Accumulating problems as systemic risks in clinical handover — 299
15.3	Interpreting risk: applying a systems approach to clinical handover — 301
15.4	Identifying types of communication risks in clinical handover — 302
15.4.1	Latent factors and active errors in clinical handover — 302
15.5	Managing communication risks: the iCARE ³ model — 306
15.6	Contextual constraints in iCARE ³ : participants, scheduling, environment and resources — 307

15.6.1	Communicative context 1: Involving all relevant participants —	308
15.6.2	Communicative context 2: Scheduling —	308
15.6.3	Communicative context 3: Environment —	309
15.6.4	Communicative context 4: Resources —	310
15.6.5	Context and handover: summary —	310
15.7	Effective information is structured information: iSoBAR in iCARE ³ —	310
15.7.1	CARE-1 Information quality: Concise, Accurate, Reasoned, Explicit —	311
15.8	Handover as an interactive event: recipient design and iCARE ³ —	312
15.8.1	CARE-2 in spoken handovers: Connect, Ask, Respond, Empathize —	314
15.8.2	CARE-3 in written handovers: Compliant, Accessible, Readable, Enduring —	315
15.9	iCARE ³ as a response to accumulating risks across the patient's journey —	316
15.10	Clinical handover assessment and risk matrix (CHARM) —	316
15.11	CHARM questions —	320
15.11.1	Purpose of handover —	320
15.11.2	Assessing contextual risks —	320
15.11.2.1	Participants —	320
15.11.2.2	Scheduling —	320
15.11.2.3	Environment —	321
15.11.2.4	Resources —	321
15.11.3	Assessing informational risks —	322
15.11.4	Assessing interactional risks —	322
15.12	Conclusion —	322
 References — 325		
Index — 337		