No Longer Lost in Translation

eClinical Handover

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eClinical Handover Objectives

- To replace the manual clinical handover book used at the Multidisciplinary Clinical Handover meeting with an electronic process. The book was a record of those patients discussed at the clinical handover meetings and was reviewed monthly by the Patient Care Committee.

- To create a handover system/process to assist clinicians to review patients and delegate tasks at clinical handover.

- Align the design of eClinical Handover and the handover process with the guiding principles of SSWAHS Clinical Handover Policies.

- Prove that benefits can be achieved from utilising an electronic clinical handover system to review patients, assign tasks and provide a handover list and task list for clinicians.

- Reduce reliance on informal &/or verbal handovers that are dependent on clinicians personal style, attention level and memory.

- Provide a record of handover information available in the eMR to support clinicians involved in the patients’ care.
An integrated electronic clinical handover

- Uses Cerner™ PowerChart, PowerForms & tasklist functionalities
- Incorporated into the electronic medical record
- Information is entered at any time from any location
- Patients are reviewed & information updated at the Handover meeting
- Handover information can be viewed by authorised users throughout the hospital
Handover Orders

There are two general types of orders used in the system:

1. Group of orders that are used to designate a patient as requiring handover. These orders contain a general description of the reason for handover.

2. Single order that is used to order a job that needs to be performed by the next shift [Handover task].

The handover orders are created in the ‘Orders’ tab.
**Designating a patient as requiring handover**

When a handover order is selected, a PowerForm automatically opens to collect information relating to the relevant history and current condition.

### Handover Details

**Reason for Handover**
- Acute 24 hour admission or last 12 hours
- PT Vaso Unwell
- PT Unstable
- Unexpected deterioration clinical
- Unexpected deterioration Behavioural

**Problem/Issue**
- No intake for 24 hours
- Unusual discharge today
- Top 2/3 baseline CT 7
- Pt. Pending for others
- Given regular metoprolol and digoxin initially.

**Assessment**

**Clinical Summary**
- Presented for regular students, went into rapid AF, asymptomatic and history of same, an metoprolol/gpoxin and calcium.
- Given usual evening meds, admitted overnight. Baseline bloods taken.

**Plan**
- Review, it hasn't shaven with usual meds could consider an ambrotoas per Dr. Patel.

**Has the consultant been contacted about this issue?**
- Yes
- No

**Handover list maintenance**
- Discuss Pt at next handover
- Remove Pt from list

**Handover Action History**

<table>
<thead>
<tr>
<th>Action Requested</th>
<th>Position Responsible</th>
<th>Date/Time Requested</th>
<th>Status</th>
<th>Date/Time Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review</td>
<td>Medical Officer</td>
<td>20-01-2009 22:10:44</td>
<td>Ordered</td>
<td></td>
</tr>
</tbody>
</table>
The patient condition is given a rating of severity [Handover Priority].

If a job is known to be required by the next shift, a handover task order can be initiated.

The handover task box will open if the task order required response is YES.
The handover task order collects information relating to:

1. When the job needs to be done

2. A freetext description of the task

3. Ability to either designate an individual or a position to perform the job

4. Both orders are signed at the same time
Each patient listed on the eClinical Handover List is reviewed at the clinical handover meeting. At the commencement of each shift, clinicians can view the handover list, identify those patients under their care and review the patient’s electronic medical record documentation.
Clinicians at the clinical handover meeting & on the wards can open the **Handover Form via the patient’s flowsheet**
Detailed information on the patient’s clinical condition, management plan, transfer of care etc continues to be documented in the paper medical record. Information within the Handover Form is a brief summary only.
Outcomes

- Functionality is easy to use & requires minimal training resources
- Information may be entered in real time (in 46% of cases data was entered at the ward level)
- Improved legibility of information eliminates the potential for misinterpretation & difficulties associated with deciphering handwritten notes
- Communicates key patient care management tasks, which is especially useful between shifts
- Reduces data duplication for patients that require discussion across several handover meetings. There was a significant increase in the number of patients discussed at more than one clinical handover meeting (from 18% to 74%)
- Improvement in the information entered for key clinical handover data items. There was a significant improvement in identifying the position responsible for actions to be attended the next shift (from 2.5% to 80%)
- An auditable record of clinical handover information with easy access to current and past clinical handover information
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