They do it in McDonalds!: A new model for handover in team-based healthcare.

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THEY DO IT IN McDONALD’S!

A new model for handover in team-based healthcare

“So…..that will be 2 Big Macs, 4 medium fries, 3 hot apple pies, 1 vanilla shake and 2 small Cokes ….. is that right?”
CHANGING TIMES: DISEASE COMPLEXITY
CHANGING TIMES: HEALTHCARE PROFESSIONALS
CHANGING TIMES: HEALTHCARE TECHNOLOGY
COMPLEXITY IN 21st CENTURY HEALTHCARE
CLINICAL HANDOVER
CLINICAL HANDOVER

PROCESS:
- Formal
- Scheduled
- Standardised
- Structured

INFORMATION EXCHANGE:
- Complete
- Accurate
- Unambiguous
THEY DO IT IN McDONALD’S!

A new model for handover in team-based healthcare

“So…..that will be 2 Big Macs, 4 medium fries, 3 hot apple pies, 1 vanilla shake and 2 small Cokes ….. is that right?”
Human Factors in Patient Safety Training at RCSI

- Mandatory eight year professional training for trainee surgeons and emergency medicine doctors
- Specialist training programmes
- CPD programme for NCHDs
- Interdisciplinary MSc in Human Factors in Patient Safety
- Masterclasses for Consultants
Does Human Factors training make a difference?
Human Factors in Patient Safety: Topics

- Human factors and patient safety in hospital practice.
- Communication skills
- Professionalism
- Culture and diversity
- Resilience training
- Crisis management
- Conflict resolution
- Bullying in the workplace
- Safety Management Systems
- Teamwork
- Harm and open disclosure
- Decision-making
- Critical Incident analysis
- Motivational interviewing
- Emotional intelligence
- Ethical dilemmas
- Leadership
- Cognitive rehearsal
Teaching the new handover guideline

Communication (Clinical Handover) in Acute and Children’s Hospital Services

National Clinical Guideline No. 11

Summary
Oh No! not another guideline!
Guidelines are safety nets!
It’s the middle of the night........!
It's the middle of the night………!
<table>
<thead>
<tr>
<th>ISBAR Communication (clinical handover) Tool SAMPLE</th>
<th>Inter-departmental Handover</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I</strong> Identify.</td>
<td>Identify:</td>
</tr>
<tr>
<td>You</td>
<td>Recipient of handover information</td>
</tr>
<tr>
<td>Patient</td>
<td>Patient</td>
</tr>
<tr>
<td><strong>S</strong> Situation</td>
<td>Situation:</td>
</tr>
<tr>
<td>Location of patient as appropriate</td>
<td>Location of patient as appropriate</td>
</tr>
<tr>
<td>Brief summary of patient’s current status</td>
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</tr>
<tr>
<td>Is there a problem?</td>
<td>Is there a problem?</td>
</tr>
<tr>
<td><strong>B</strong> Background</td>
<td>Background:</td>
</tr>
<tr>
<td>Concise summary of reason for interdepartmental handover</td>
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<tr>
<td>Summary of treatment to date</td>
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</tr>
<tr>
<td>Baseline observations (current admission)</td>
<td>Baseline observations (current admission)</td>
</tr>
<tr>
<td>Vital Signs: BP, Pulse, Resp, S\textsubscript{O\textsubscript{2}}, FO\textsubscript{2} J, Temp, AVPU.</td>
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</tr>
<tr>
<td>IMENS (include previous IMENTS if appropriate)</td>
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</tr>
<tr>
<td>NEWS (include previous NEWS if appropriate)</td>
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</tr>
<tr>
<td><strong>A</strong> Assessment</td>
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<tr>
<td>What is your clinical assessment of the patient at present?</td>
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</tr>
<tr>
<td><strong>R</strong> Recommendation</td>
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</tr>
<tr>
<td>Specify your recommendations</td>
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</tr>
<tr>
<td>Read-Back: Recipient[is] to confirm handover information and responsibility</td>
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<td>Risk: Include the safety pause to identify possible risks</td>
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They do it in McDonalds!
“Readback” is child’s play!
Human Factors: Making it happen

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Dreams do come true!
DocIT:
Dreams do come true!
<table>
<thead>
<tr>
<th>Room</th>
<th>Patient Name</th>
<th>MRN</th>
<th>Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>3717A</td>
<td></td>
<td></td>
<td>Pls chart lactate, pls chart parameters, Immuno lab std, Pls chart magnesium, sleeping trouble, renal k + 3.4, 2 I.E. for cough.</td>
</tr>
<tr>
<td>3178</td>
<td></td>
<td></td>
<td></td>
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</table>
Please monitor vancomycin trough level, take level prior to 3rd dose. Currently prescribed vancomycin 1g bd, the dose as per the vancomycin calculator is 1g every 24 hours. Thanks.
Handover schema

Task

• Who?
• What?
• When?

Narrative

• Who?
• Why?
• What else?
PASSing a task handover system

- Patient-centred
- Accountability
- Simple
- Secure
PASSing a task handover system

- Patient-centred
  - Task follows the patient
  - User agnostic
- Accountability
- Simple
- Secure
PASSing a task handover system

- Patient-centred
- **Accountability**
  - Traceable
  - Auditable
  - Searchable
  - Transparent
- Simple
- Secure
PASSing a task handover system

- Patient-centred
- Accountability
- **Simple**
  - Easy to access
  - Easy to use
  - Works with other systems
- Secure
PASSing a task handover system

- Patient-centred
- Accountability
- Simple
- Secure
  - Data protection
  - Reliability
Unexpected consequences of dreaming

System

- Safer
- Proxy measures for quality and safety
- Business intelligence and workflow
- Automation and decision support
- Capture hidden health data
Unexpected consequences of dreaming

Staff

- EWTD and training benefits
- Medical education
- Improved morale and teamwork
Unexpected consequences of dreaming

Patients

Doctors can focus on patients and not a to-do list!
Human Factors: Making a difference to patient care and safety

- RCSI and HSE working together