"That's not what I meant!"

Clinicians are becoming increasingly concerned at the potential risks of ambiguity and poor communication, especially when trying to maintain continuity of care across shifts. Jo Cumming and Mark Bradbury share their experience of bringing about improvements.

This article describes the journey the Royal Manchester Children's Hospital (RMCH) took within the Clinical Governance imperative when consultants realised that communication during medical handovers, especially by junior doctors (SHOs), was not up to standard. While this project started with a focus on improving handovers, it quickly uncovered issues that impact on many aspects of a clinician's work. We found ourselves visiting change and learning, case notes, and consent, eventually arriving at a learning package called "That's not what I meant!" - so named as we often found people thinking they had made themselves clear, only to find that they had not, with potentially fatal consequences.

RMCH is a multi-disciplinary teaching hospital, now part of the new Manchester Universities NHS Trust. The project team consisted of Consultants Mark Bradbury and Maureen Cleary, and Jo Cumming, Chartered Occupational Psychologist, Glentruim Change Agents. Starting with the 1999 intake of SHOs trainees the work has continued to evolve.

Why is it so important to focus on communication?

As we talked to clinicians, we found much time was wasted dealing with information that is not conveyed clearly. As it is likely that at least 80% of the working day is spent communicating in one form or other, the opportunities for misunderstandings and error are always present. Erroneous actions are taken because assumptions are unchecked, which increases the risks to patients and takes up time that could be better spent on patient care.

There are two aspects to this. First, the choice of *what* needs to be communicated. For example, in a medical handover - the active problem; things to be aware of/potential problems; what needs to be done by whom and when. The second is *how* this information is communicated. Is it clear and free from the miscommunication and misunderstandings that can result in a failure to carry through medical instructions, with potentially lethal consequences. In 'An organisation with a Memory - Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer' (DoH 2000), the 'Death of a Child' case catalogues a trail of communication errors. Poor delegation and handover of task responsibilities and inadequate notes were highlighted through the fatal sequence of events.

What was the picture at RMCH when we started?

We started with a literature search to find examples of best practice. Given the importance of medical handovers we were surprised to find few references although there were many from the nursing profession. More information was available on case notes. To provide a picture of the current situation at RMCH, the team's consultants chose consultants, registrars, SHOs and nursing staff for Jo to interview, involve in focus groups and observe. She also studied the documentation in use.

As the evidence was gathered it became clear that RMCH has its share of near misses.

- The Crash Team was called to a child but no one knew anything about the patient. There had been no handover and the case notes were not up to date. The Registrar on-call arrived soon after but the lack of information could have led to inappropriate or unnecessary interventions.
- A locum, new to the hospital was asked to do 'Bloods' but did not know the system. She had a 6 a.m. call and took a long time to find the right ward. She told the researcher she was unclear as to her role and what was expected of her. However, in the handover she had asked no questions and had been asked no questions to check her understanding.

"I feel totally demoralised"

- When called to the ward at 3 a.m., the SHO new to the unit found some of the medical notes had not been written up for five days. The combination of this plus no handover contributed to a feeling of being let down - "I feel totally demoralised".
- During a handover, after receiving information on the first three patients, the SHO realised that he needed to make notes. He started to tear off a piece of newspaper then found a scrap of paper on the floor and used that.
- A consultant was perceived as being against change. It turned out he was deeply concerned at the quality of case notes and handovers but had an overwhelming workload.

Drawing on best practice, Jo surveyed all SHOs and Registrars on their experience of handovers and case notes at RMCH. Many areas of good practice were identified. However, in some units they reported almost never:

- being asked questions to check their understanding or encouraged to ask questions
- having a handover free from distractions
- knowing the whereabouts of all the ill patients
- knowing enough about the poorly patients they needed to review
- being well informed about the unstable patients
- knowing enough about the interventions that they were expected to carry out
- being well enough informed about major problems or potential complications
- having enough information on which to base decisions
- having enough trouble shooting information to help anticipate problems
- feeling confident, from all the information available, that they could fulfil their role

From our experience across the NHS, we suspect the picture at RMCH is similar to that in other Trusts.

What is Best Practice?

The goal for medical handovers is to identify concerns and flag up potential problems through the transfer of prioritised information that is pertinent to the care of the patients. The case notes provide the opportunity to record critical data and review and capture the effect of past events. Both are at the heart of medico-legal responsibility and the ethics of good clinical practice.

Are clinicians the only people with these issues? A Health & Safety Executive review (OTO 96003, 1996), reporting on the body of research on communication at shift handover in the nursing profession pointed to the parallels between continuous process tasks in industry and nursing care. "…. Both are delivered on a 24-hour basis by shift workers, who must communicate information on the human or technological systems they monitor and control across shift changes. In nursing, inaccurate communication or misunderstandings can lead to hazardous actions and medico-legal liability."

What can be learned from other sectors?

- The potential hazards of miscommunication are highlighted by the fact that 60% of 'stuck-pipe' incidents on oil platforms offshore happen within two hours of shift handover, mainly due to inadequate passing on of information.
- Following the Piper Alpha Disaster, the Cullen Report concluded that one of the many factors that contributed to the disaster was failure of transmission of critical information at shift handover. This led to the incoming shift taking actions that initiated the disaster. The report concluded that there were no written procedures for shift handover, the type of information written as notes and communicated at shift handover, was left to the discretion of the operator and there was no categorisation of important items to include in the handover.
- In the nuclear industry, information passes over more than one shift and the potential for error grows - as happened at BNFL's Sellafield works when highly radioactive material was discharged to sea. As a written description was carried forward over several consecutive shifts, the message "ejections from HASW" became "ex HASW washout". This ambiguity, coupled with transcription errors, as written log-book instructions were copied from page to page, led to misunderstanding and created the environmental hazard.

Implementing changes through a 'Whole Systems' approach

The RMCH research confirmed our experience that while well-designed procedures can reduce sources of error, real and sustained improvement is only achievable through a 'whole-systems' approach. We also knew that we needed to address people's attitudes, beliefs and skills plus the tasks, the structures within which they operated and the systems they used.

How did we go about introducing changes?

We designed a collaborative project, working with the 2000 intake of SHOs over six, two-hour sessions. There were two reasons for this. Firstly, to identify difficulties they might encounter in developing their practice. Secondly, to give them experience of implementing change, reporting back on what happened and reflecting together on their learning. Since much of their role from now on would involve working with patients, parents, and colleagues facing change, we explored blocks and resistance to change as well as looking at the systems, skills and structures that helped and hindered good practice.

"We may be criticised"

When the SHOs arrived they were keen to defend their skill at writing case notes and handovers and sceptical of the value of working on them. By the end of the first session they realised the need to improve their skills. They also identified potential hurdles:

- People are set in their practice. How do we recruit and bring on board others?
- We may be criticised
- What are the medico-legal implications of having handover notes not in the case notes file?
- What are the practicalities? Doing things differently is not always possible
- How will we make time to do it properly - "at 4.55 all hell breaks out"?

One SHO had a 'Eureka' moment - *"Just because I have told someone they may still not know what I know!!"*. Another insight was the realisation that *"The only important thing is the message the receiver ends up with."* These revelations helped them to appreciate why we were doing the project.

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How easy was it to bring about change?
When implementing their ideas for improvements, the SHOs reported difficulties with the multi-disciplinary system. At night one SHO covered eight units so it was physically almost impossible for them to receive a handover from each unit then hand back in the morning. This eased when the consultants arranged for two SHOs to be on-call at night. In turn this highlighted the need for good written handover notes. The SHO on-call first, from 10pm-2am, would not disturb the other SHO at 2am for an update if no immediate action was required.

After each session, to keep people not able to attend up to date, notes on progress and learning were distributed. However, in spite of positive feedback, attendance began to drop. Work to be assessed in exams was getting higher priority, there was no clear system for SHOs and Registrars to cover for each other during off the job training and some teaching was on offer to both groups at the same time. There was clearly tension between patient care and teaching. All SHOs, and most registrars and consultants received a report outlining the problems and describing Best Practice. However, a further evaluation showed few improvements. We decided to adopt a different strategy. Training would be delivered during the induction programme. So the learning package "That's not what I meant!" was born.

Including the learning package "That's not what I meant!" in the induction programme
Drawing on the work done so far we designed one session for each day of the induction programme: Change and Learning (1 hour); Improving Case Notes (2 hours); Improving Medical Handovers (2 hours) [1]. The team's consultants took radical steps to increase the likelihood that all the SHOs would come to, and stay at, the sessions. They told the Crash team where everyone was, in case of emergency, and the SHOs were then asked to turn off their 'bleeps'. They were told that they were expected to attend, even if they had been on-call overnight. It worked - they came, they stayed. Unfortunately, because of competing demands from the induction programme, we could not deliver the full sessions.

How was the session on Change and Learning received?
Some of the group grasped the purpose of the session and were able to articulate what they would like from it *"to have the confidence to ask when I am not sure".* Several were puzzled as to what change and learning had to do with them, and were concerned that we were not covering medical knowledge. They became less sceptical when we moved on to an exercise where they explored the response and resistance they might expect from patients, parents, other professionals and other professionals when they asked them to make changes. They began to understand the complexity of change, and why it can be difficult to achieve, when we explored how changing just one 'lever' of change (systems, people, tasks or structures) sets up a reaction in all the others. During the session the SHOs expressed their fears and anxieties about making mistakes in the coming year which enabled us to open up a discussion.

Meeting the needs of different learning styles
The activities in all the sessions were varied and included case studies, input and experiential exercises. One was based on the aptly named game of 'Consequences' (sometimes called Chinese Whispers). Sheets of paper with a medical term at the top were handed out face down. When the trainer said "Go!" everyone copied the term on their sheet onto the line below. They then folded over the original so only their writing showed and passed it on for the next person to copy - and so on. Time pressure was added to represent reality. When the sheets were unfolded, the word phosphocysteamine had turned into cyclophosphomide by the bottom of the page - a salutary lesson in the need to write legibly and copy accurately. (This is one area where the eventual use of IT will make a big difference.)

We also developed a Best Practice Handover Model, (see below). This demonstrates the different responsibilities for the Giver of information and the Receiver - the person taking over the shift. A 'Prompt Card' reminds people what to include in the notes they prepare. (Previous attempts within RMCH to improve this procedure had not achieved the quality of information required. Notes tended to be backward rather than forward looking. The focus was often on the diagnosis, available in the case notes, rather than on the active problem that required action.) This card prompts the clinician to prioritise the non-routine patients; note the active problem for each patient; list things to be aware of/potential problems; clarify what needs to be done by whom and when.

[1] Thanks to David Pitts, Creative Learning Associates, for his creative interactive learning activities

BEST PRACTICE MEDICAL HANDOVER MODEL

	Giver of information	Receiver of information
Before	♦ Decide on priority patients ♦ Note priority information as on prompt card, write clearly ♦ Decide on time & location free from distractions ♦ Inform Receiver	♦ Ensure you have a pen & a pad on which to make notes ♦ Remind yourself what you need from the handover ♦ Check with the Giver that you know the time & place
During	♦ Talk through priority patients, referring to notes ♦ Answer any questions ♦ Check understanding is shared ♦ (Optional – given Receiver the notes)	♦ Actively listen ♦ Question to clarify ♦ Note what you think are the priorities ♦ Check your understanding ♦ Make notes
After	♦ Ensure your case notes reflect what was covered in the handover ♦ Reflect on your effectiveness, note improvements to make next time you hand over	♦ Refer to notes ♦ Carry out interventions ♦ Update case notes ♦ Reflect on your effectiveness, note improvements to make next time you get a handover

Ideally, the Giver talks through the notes with the Receiver, so following Best Practice - having two sources of information, in this case verbal and written. However, in the event that a verbal handover is not possible, the notes give the oncoming clinician a quick overview of the non-routine patients.

As well as exercises to develop their communication skills, we helped the group step back and take a broader view. When asked to consider who has a stake in a quality handover, they identified patients, parents, other professionals, administration, medical defence and other professional staff. They saw how having better quality information would give them more confidence in a range of situations.

How can we sustain the learning?

To help sustain the learning we asked each SHO to identify the recurring issues in their unit and understand how they should be represented in the case notes. Sharing this information will broaden the trainees' knowledge about clinical problems so they feel better prepared. This will facilitate the design of a 'virtual ward' to be used by the clinical tutors when they assess the trainees' learning about handovers and cases notes. This will help us to see if further training is necessary.

What were our conclusions … and where next?

Our learning from the project is that the communication issues we are aiming to improve have wide ranging consequences. While it is important for trainees to develop their skills and understanding, we need to find a way of developing the skills of all clinicians. As similar skills are required, a session on Consent will be developed and added to the portfolio of materials.

To achieve excellence, we will need to continue working on attitudes, skills, systems and structures. In particular, decisions need to be taken on how to balance patient care and the education of the junior doctors.

While working with junior doctors helps them develop their skills, it is unlikely that real change will take place unless the people they work with on a day to day basis are using the same models. The Department of Medicine & Dentistry is supporting multi-disciplinary projects within Trusts in the north-west of England. The new development programme will be designed and trialled in collaboration with the clinical tutors who will have responsibility for the ongoing delivery of the workshops.

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