Clinical Handover

A Coroner's Perspective

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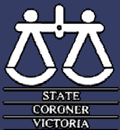
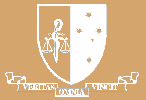
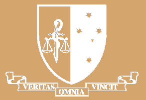




Specialist Investigations Unit

Specialist Investigations Unit

- Clinical Liaison Service
  - Assist the coroner to investigate health related deaths
    - Case selection
    - Clinical interpretation of key patient safety issues
    - Identification of relevant clinicians
      - Statements
      - Experts
      - Distribution of Findings
    - Liaison between coroners and clinicians
- Work Related Liaison Service



Case Study

Clinical Summary

- D1: Referred to **'S1'** with a bowel obstruction from a Private Hospital ED
- D2: Laparoscopy → laparotomy
- D3-7: Daily review by **'S1'** before annual leave; Handed over to **'S2'**
- D8-10: Daily review by **'S2'**
- D11: Deterioration at 13:00h: **'S2'** was unavailable; **'S3'** asked to review patient
- D12: **'S4'** contacted about acute deterioration at 05:30h; arrested in ICU

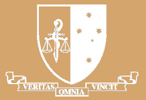
Autopsy

1. Peritonitis
2. Hypertensive heart disease

Expert Opinion

- Initial management was "entirely appropriate"
- Signs of sepsis and possibly peritonitis present on D10
- Only chance of survival was with a laparotomy and peritoneal drainage
- No surgeon was familiar with the seriousness of the situation

Coroner's Case Number: 2010/02



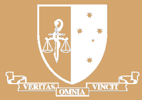
Case Study (ctd)

Coronial Findings

- A deficiency in care in that the high white cell count was not communicated to treating doctors until the morning on D12
  - The high white cell count had been phoned through to the ward by the Pathology Service at 17:00h on the D11 and should have been conveyed to **'S3'**
- If **'S3'** had been aware of the high WCC he would have commenced intravenous antibiotics and had a raised index of suspicion if his observations became at all unstable.

Practice Improvements

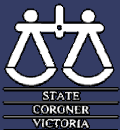
- The Private Hospital developed a new Work Practice on Reporting Investigation Results
- The Surgical Group changed its practice for ordering non-routine blood tests

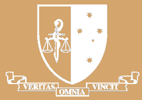


Case Study (ctd)

Coronial Findings (ctd)

- Clinical handover between surgeons:
  - D7: S1 → S2: Face to face at the bedside
  - D11: S2 → S3: Telephone handover in semi-urgent situation
  - D11: S3 → S2: Handover did not occur
  - D11: S2 → S4: Handover did not occur
- The independent expert stated:
  - *"…the best system is to have one person directly responsible for the post-operative care of the patient……. If this is not possible and a group of two or more are responsible then it is important that the lines of communication are open and frequent and all caring members are familiar with the seriousness of the patient's condition."*
- The Surgical Group refined their system of handover:
  - Rosters and leave arrangements:
    - Weekly on-call rosters
    - Bed side handovers
  - Handover process:
    - The on-call surgeon was fully updated about any potentially unstable patients

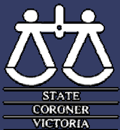


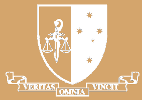


Case Study (ctd)

Conclusions

- It could not reasonably be concluded that the covering arrangements between surgeons of the Surgical Group were so deficient that they represented causal factors in the death. Certainly there was room for improvement
- A number of issues were not specifically addressed in this finding, including:
  - Was it permissible, indeed were nurses encouraged, to contact consultants directly when they had concerns about the condition of a patient





More Cases

2350/01: Failure to handover critical information to the treating surgeon (ward based / supervision)[1]

2998/98: Failure of effective handover from paramedics to ED staff. Line used for flushing was contaminated (environment)[2]

1364/01: Past history of severe drug allergy not transcribed from paper to computerised medical records (written communication)[3]

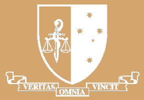
739/02: Post-operative orders not clearly written[4]

1670/02: Failure to handover clinical information to NICU consultant[5]

1294/03: Incomplete clinical information provided to radiologist; delay reporting back to ED[6]

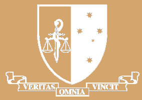
1999/00: Scanty medical and nursing documentation resulted in dehydration and progressive pneumonia being unrecognised[7]

1 CC Ed 1, Dec 2003; **2** CC Ed 2, Feb 2004; **3** CC Ed 3, May 2004; **4** CC Ed 4, Aug 2004 **5** CC Ed 5, Nov 2004; **6** CC Ed 5, Nov 2004; **7** CC Ed 7, Dec 2005



Questions Arising from Cases

- What is the current situation with clinical handover?
  - Do we have a standard?
  - How widely is it practiced?
- What systems will minimise loss of relevant clinical information?
  - Is IT the answer?
  - Protocols? Guidelines?
- What is a safe handover?
  - Do junior clinicians understand when to handover clinical information? When is handover needed?
  - Should it be task orientated?
  - Clinical information? How much?
  - Written or verbal?
  - Timeliness?



‘(Coroners) speak for the dead to protect the living’

Ontario Coroners’ Motto – from Thomas D’Arcy McGee MP (1825-1868)