



Queensland
Trauma Education

TRAUMA TEAMS

Clinical handover

Role play

Facilitator resource kit

CSDS



Clinical Skills Development Service



Queensland Trauma Education

The resources developed for Queensland Trauma Education are designed for use in any Queensland Health facility that cares for patients who have been injured as a result of trauma. Each resource can be modified by the facilitator and scaled to the learners needs as well as the environment in which the education is being delivered, from tertiary to rural and remote facilities.

Developed by

Dr Frances Williamson, Emergency Staff Specialist – Metro North Health

Reviewed by

Kimberly Ballinger, Simulation Educator – Clinical Skills Development Service

Education Working Group, Statewide Trauma Clinical Network – Clinical Excellence Queensland

Queensland Trauma Education

Trauma teams – Clinical handover: Role play – Facilitator resource kit

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About this training resource kit

This resource kit provides healthcare clinicians with the knowledge on how to effectively perform clinical handover in the setting of chest trauma.

National Safety and Quality Health Service (NSQHS) Standards



Target audience

Emergency department medical and nursing clinicians

Duration

30 minutes

Group size

Suited to small group participation

Learning objectives

By the end of this session the participant will be able to:

- Demonstrate the effective clinical handover of a patient suffering chest trauma utilising cognitive aids and handover tools.
- Model an effective clinical handover by demonstrating succinct, clear and structured delivery of clinical information.

Facilitation guide

1. Facilitator to utilise facilitator guide to introduce clinical handover and facilitate discussion around challenges faced and the rationale for utilising handover tools.
2. Facilitator to divide participants into two groups.
3. Allocate one participant in each group as the clinician performing handover and others as a recipient of handover.
4. Issue each clinician performing handover a different case and allow participant to review patient information and clinical details.
5. Group one to perform handover without referencing any patient information and group two is to perform handover utilising handover tools/cognitive aids.
6. Review and discuss the accuracy of each handover and benefits of utilising handover tools.

Supporting resources

- Clinical Practice Procedures: Other/Clinical handover

Overview of clinical handover

80% of serious medical errors involve miscommunication between clinicians in the transfer of care of patients (1). Handover is common in trauma care, between prehospital and hospital teams, Emergency and inpatient teams and between hospitals. A successful handover involves clear and succinct communication, collaboration and information gathering. The use of a cognitive aid can improve the retention of knowledge and streamline the process ensuring the important clinical care is communicated and continued (2).

Further reading

Handover practises of nurses transferring trauma patients from intensive care units to the ward: A multimethod observational study	
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Publication	Australian Critical Care Journal
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Link	https://bit.ly/3fAxRqj
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OOSIE Guide to Clinical Handover Improvement	
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Organisation	Australian Commission on Safety and Quality in Healthcare
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Link	https://bit.ly/3ljbRCK
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Patient handover between ambulance crew and healthcare professionals in Icelandic emergency departments: a qualitative study	
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Publication	Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine
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Link	https://bit.ly/3fAxMt1
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Supporting resources

Clinical Practice Procedures: Other/clinical handover	
Source	Queensland Ambulance Service
Link	https://bit.ly/3rs88fz

Role play

Case study 1

26yo female. Driver of car involved in high speed collision vs pole. Entrapped for 30 minutes, extricated by QLD Fire and Emergency Service. On initial ambulance arrival she was unconscious, GCS 4 E1V1M2. R pupil 3mm, L pupil 2mm. Seen to move all limbs to pain. Cool peripherally, pale. No respiratory distress. Temp 34.5deg. HR 120, BP 100/80mmHg. Sats 90% RA, O2 applied via NRM, sats now 98%. Seatbelt abrasion to R chest and abdomen. She has had 250mls NSaline IV via an 18g cannula in her L forearm, 50mcg fentanyl IV and 8mg IV ondansetron as seemed to be grimacing in pain. Her R chest wall has bruising and subcutaneous emphysema on palpation. She has a cervical collar and pelvic binder for mechanism. Unknown PMHx, medications or allergies.

Case study 2

45yr old male. Driver motor bike crash vs tree. His PMHx, medications and allergies are unknown. He was thrown 5 meters into scrub. Passer-by witnessed the event; the patient had been swerving between traffic prior to the crash. On the police arrival he was unconscious and breathing. On the ambulance arrival he was in arrest. His heart rate was 145, with no cardiac output. He was GCS 3, pupils were 4mm and sluggish. He had no respiratory effort and was cyanotic. He had bilateral needle decompression of his chest with a hiss of air from the Right side.

At this stage he had improvement with his vital signs, his HR was then 100, palpable radial pulse and sats 90% 15L NRB. He was intubated with 50mg IV ketamine, 50mcg IV fentanyl and 100mg IV rocuronium at 07.24hrs, which is 45 minutes ago. He then underwent bilateral thoracostomies with a second release of air on decompression of his Right chest. He has a cervical collar and binder in situ.

Other treatments he has received are a further 2mg Iv midazolam, 50mcg IV fentanyl and 1L NSaline IV. His HR is now 110 and BP 90/60mmHg, sats 97% via ETT FiO2 1.0. He had a grade 2 view and the size 9 ETT is 24cm at teeth. The crash occurred near his home and the police have contacted his family.

Case study 3

98yr old female. Found by nursing home staff at the bottom of a flight of 10 stairs. She has a large laceration to the top of her head with ongoing bleeding despite the bandage applied. She is GCS 14, confused to place which is normal for her. She has been moving all limbs to command. She has a large skin tear to her Left forearm which has been dressed. Her HR is 80 and she is in AF. Her breathing is shallow with no evidence of abdominal or pelvic injury. Her BP is 160/80mmHg which is normal for her. She is on ramipril 5mg mane, atenolol 10mg nocte and warfarin 5mg nocte.

She is allergic to penicillin with a rash resulting. She has received 5mg IV morphine, the wound management as stated and a cervical collar as precaution. Her resp rate is 18 and sats 92% RA. Her daughter is aware she has been transported to hospital. She has a history of emphysema but not on home oxygen.

Case study 4

36yr old female. Riding her horse when it took a jump and she fell off. She landed heavily on her Right hand side. She was winded but able to call the ambulance for help. On arrival she was speaking in words only, has significant Right chest pain and tenderness, crepitus and subcutaneous emphysema to palpation. Her sats were 96% on RA and oxygen was applied via Hudson mask at 6L. Her abdomen is soft, no bruising or wounds. She is tender in the back of her neck so a collar has been applied. 15mg IV morphine, 8mg IV ondansetron and 250mls NSaline IV have been given prior to arrival at the hospital. Her HR is 80, she is peripherally warm and well perfused. Her BP is 130/70mmHg. She takes sertraline 100mg daily for depression but has no allergies. Her GCS has been 15 with no history of LOC and she was wearing a helmet.

Question and answer guide

1. When does clinical handover occur in the emergency department?

Timing of handover is dependent on patients clinical status. Ideally occurs before patient is moved to hospital bed. However, if patient is unstable, patient should be moved to hospital trolley immediately and hospital team to commence immediate primary survey to identify and treat potential life threats.

2. Who performs clinical handover?

- Pre-hospital clinicians including QAS officers or retrieval medical officers.
- Hospital medical and nursing clinicians
- Hospital allied health
- Any staff member needing to communicate important clinical information at any point in the patient journey

3. What handover tools are available?

Many handover tools available but not all are tailored for trauma patient handover. Use tool that is appropriate for patient presentation.

4. What features are useful in handover tools?

- Key information
- Structure
- Prompts
- Standardised
- Provides cognitive aid when cognitive load is a burden

5. What is the main information required for the clinician taking over care of the trauma patient?

- Patient identification
- Times
- Mechanism of Injury
- Injuries
- Signs – observations
- Treatment
- Other Red flags/concerns

6. How is the clinical information organised?

- Structured
- Standardised
- Clear and succinct

7. What strategies have been successful with:**a. A noisy trauma room?**

Ensure clear role allocation and communicate patient priorities by ensuring quiet at times when the team needs to hear important information like clinical handover

b. An unstable patient?

Use clear, closed loop communication and follow a structured approach to clinical handover.

c. Unknown team members?

Use alternate strategies like calling team members by their roles e.g., airway doctor, ensuring eye contact, clear, closed loop communication.

8. What can disrupt a clinical handover? How is this mitigated?

Noise, chatter, performing tasks. Ensure all team members are hands off and listening to clinical handover.

Supporting documents

The following supporting documents are provided for this role play.

NSW Ambulance Service IMIST- AMBO Handover Protocol

IMIST-AMBO covers the standard way paramedics hand over information about patients to ED clinicians

- I** – Identification
- M** – Mechanism / Medical complaint
- I** – Injuries / Information related to the complaint
- S** – Signs
- T** – Treatment and Trends

- A** – Allergies
- M** – Medication
- B** – Background history
- O** – Other information

IMIST-AMBO aligns with the ISBAR mnemonic for handover.

Ambulance paramedics are asked to:

1. Review handover details pre-arrival
2. Maintain a 20-30 second period where the patient remains on the stretcher and deliver IMIST information uninterrupted
3. Encourage questions on completion of IMIST and again at the end of AMBO
4. Treating paramedic to remain with the patient during handover

ED clinicians are asked to:

1. Ensure the handover remains interruption free
2. Ask questions during the two provided opportunities, between IMIST and AMBO and upon completion of IMIST-AMBO
3. Observe 'Hands off, Eyes on', a 20-30 second period provided when the patient stays on the Ambulance trolley until the IMIST information is delivered
4. Identify team leaders

ISOBAR Handover Tool

<p style="text-align: center;">I</p> <p style="text-align: center;">IDENTIFICATION</p>	<p>IDENTIFICATION</p> <p>DATE: ____/____/____ TIME: _____</p> <p>• Hello it's _____ calling from _____</p> <p style="text-align: center;"><small>(Name) (Ward)</small></p> <p>• I'm calling about patient _____ who was admitted with...</p> <p style="text-align: center;"><small>(Patient Name) (Name presenting diagnosis)</small></p>
<p style="text-align: center;">S</p> <p style="text-align: center;">SITUATION</p>	<p>SITUATION</p> <p>• The problem I am calling about is _____</p> <p style="text-align: center;"><small>(Name Problem)</small></p> <p>which has changed over the last hours from _____ to _____</p> <p>• I have just assessed his/her vital signs and they are:</p> <p>BP: _____</p> <p>HR & Rhythm: _____</p> <p>RR: _____</p> <p>Temp: _____</p> <p>Urine Output: _____</p> <p>Fluid Balance Status: _____</p> <p>ECG: _____</p> <p style="text-align: center;">DOES THIS PATIENT MEET MET CALL CRITERIA IF YES CALL A MET CALL</p>
<p style="text-align: center;">O</p> <p style="text-align: center;">OBSERVATIONS</p>	<p>OBSERVATIONS</p> <p>Neurologically the patient is:</p> <p><input type="checkbox"/> Alert & Orientated to TPP</p> <p><input type="checkbox"/> Pupils are equal and reactive</p> <p><input type="checkbox"/> Obeying command</p> <p><input type="checkbox"/> Agitated & Combative</p> <p><input type="checkbox"/> Lethargic but rousable</p> <p><input type="checkbox"/> Stuporous & not talking clearly</p> <p><input type="checkbox"/> Aphasic / Dysphasic</p> <p><input type="checkbox"/> Obtunded (less than full mental capacity)</p> <p><input type="checkbox"/> Not responsive to painful stimuli</p> <p><input type="checkbox"/> Flexing / Extending to painful stimuli</p> <p>The patient's skin is:</p> <p><input type="checkbox"/> Warm & dry</p> <p><input type="checkbox"/> Hot to touch</p> <p><input type="checkbox"/> Pale</p> <p><input type="checkbox"/> Mottled</p> <p><input type="checkbox"/> Diaphoretic/Clammy</p> <p><input type="checkbox"/> Extremities are cold</p> <p><input type="checkbox"/> Extremities are warm</p> <p><input type="checkbox"/> Pulses Present/Absent/Thready</p> <p><input type="checkbox"/> Capillary refill time is:</p> <p><input type="checkbox"/> Capillary return is < 3sec</p> <p>• Does the patient look generally unwell Y / N</p> <p>• The patient has been on _____ L of Oxygen via mask / NP for _____ /Time and SpO₂ is _____</p> <p>• I am having difficulty detecting a good reading & trace from the probe</p> <p>• I have auscultated the pt's chest and it sounds _____</p> <p>• The patient appears to have an increased work of breathing</p> <p style="text-align: center;">OBSERVATIONS SHOULD BE DONE ½ HOURLY UNTIL SITUATION IS RESOLVED</p>
<p style="text-align: center;">B</p> <p style="text-align: center;">BACKGROUND</p>	<p>BACKGROUND</p> <p>• The patient has a relevant past history of _____</p> <p>• State any Allergies the patient may have</p> <p>• The patient is on _____ and currently has _____ running</p> <p style="text-align: center;"><small>(State Current Medications) (State what Fluids)</small></p>
<p style="text-align: center;">A</p> <p style="text-align: center;">ASSESSMENT</p>	<p>ASSESSMENT</p> <p>• The problem appears to be _____</p> <p style="text-align: center;"><small>(e.g. Cardiac, Respiratory, Neuro, Renal)</small></p> <p>• I think the patient is experiencing _____ (Name the Problem)</p> <p>• The patient is deteriorating and unstable</p>
<p style="text-align: center;">R</p> <p style="text-align: center;">REQUEST</p>	<p>REQUEST</p> <p>I would like you to: (say what you want & why)</p> <p>• Review the patient</p> <p>• Help identify the problem to aid in calling consultant</p>

SBAR Handover Tool**S****Situation:**

I am (name), (X) nurse on ward (X)
I am calling about (patient X)
I am calling because I am concerned that...
(e.g. BP is low/high, pulse is XX temperature is XX,
Early Warning Score is XX)

B**Background:**

Patient (X) was admitted on (XX date) with
(e.g. MI/chest infection)
They have had (X operation/procedure/investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of obs were (XX)
Patient (X)'s normal condition is...
(e.g. alert/drowsy/confused, pain free)

A**Assessment:**

I think the problem is (XXX)
And I have...
(e.g. given O₂/analgesia, stopped the infusion)
OR
I am not sure what the problem is but patient (X)
is deteriorating
OR
I don't know what's wrong but I am really worried

R**Recommendation:**

I need you to...
Come to see the patient in the next (XX mins)
AND
Is there anything I need to do in the mean time?
(e.g. stop the fluid/repeat the obs)

Ask receiver to repeat key information to ensure understanding

The SBAR tool originated from the US Navy and was adapted for use in healthcare by
Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

Ambulance Victoria Retrieval Handover




I	Identification	Identify clinician / self & their role, introduce the patient – age, sex, name
R	Retrieval	Retrieval reason From which referrer to which location
M	Mechanism of Injury / Presenting complaint	Specific explanation of the patient's presenting problem and history of presenting complaint
I	Injuries / Interventions	Top to toe summary Include what interventions have been performed to help stabilise the patient
S	Signs / Symptoms	Looks at the assessment of the patient Requires details of the patient's current vital signs and GCS
T	Treatments / Trends	Identifies treatment that was required such as sedation / paralysis

A	Allergies / Alerts:	Include what type of reaction Any infection control precautions
M	Medication:	Patient's usual medication
B	Background History:	Patient's medical history Any advanced care directives and limitation of treatment orders
O	Other information:	Relevant social information Family awareness and involvement Ensure complete patient documentation including imaging & investigations

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Queensland Ambulance Handover Tool

 **Trauma Handover**

Name: _____ **Age:** _____

Mechanism/Time: _____

Neurology: _____

Injuries H - T: _____

Interventions: _____

Pharmacology: _____

Rocuronium time: _____

Vital Signs: Stable / Unstable

PMHx: _____

Medications: Anticoagulants

Allergies: _____

Urgent needs: _____

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ATMIST Handover Tool

ATMIST Handover	
Age	
Mechanism	
<ul style="list-style-type: none">• Speed, impact, time trapped, etc...	
Injuries	
<ul style="list-style-type: none">• Found, suspected...• C-spine, head, chest, abdo, pelvis, long bones...	
Signs & Symptoms	
<ul style="list-style-type: none">• Airway, breathing, circulation• RR, HR, SaO₂, ETCO₂	
Treatment	
<ul style="list-style-type: none">• Immobilisation, IV access/drugs, warming, etc.	

Debriefing guide

Role play objectives

Demonstrate the effective clinical handover of a patient suffering chest trauma utilising cognitive aids and handover tools.

Example questions

Exploring diagnosis

- What are the benefits to using a handover tool?
- Which tool was the easiest to use?
- Which tool gave you the most information?
- In what format could each tool be used?
- Where else in the patient journey does handover occur?
- Does communication via phone differ from in person?

Discussing management

- Where do you document the clinical handover information?
- Does this form part of the patient clinical documentation?
- When do you relay information to the team?

References

1. Joint Commission Center for Transforming Healthcare releases targeted solutions tool for hand-off communications. (2012). *Joint Commission perspectives. Joint Commission on Accreditation of Healthcare Organizations*, 32(8), 1–3.
2. Evans, S. M., Murray, A., Patrick, I., Fitzgerald, M., Smith, S., & Cameron, P. (2010). Clinical handover in the trauma setting: a qualitative study of paramedics and trauma team members. *Quality & safety in health care*, 19(6), e57.
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Visit csds.qld.edu.au/gte

Email CSDS-Admin@health.qld.gov.au

Phone [+61 7 3646 6500](tel:+61736466500)

