Improving patient safety through changes to the handover process
Dr Nadia Stock & Dr Nick Roper. University Hospital North Tees, Stockton, TS198PE
nadiastock@doctors.net.uk

Introduction
Handover is a crucial element in patient flow but has also been shown to be one of the riskiest points in a patient’s journey (1). Increasing numbers of patients passing through assessment units coupled with the requirement for shorter shifts for doctors, has increased the importance of robust handover processes (2). This study aimed to assess the handover system within our admissions unit and make subsequent changes to improve patient safety.

Previously junior doctors on the unit were responsible for the patients they had clerked during that shift. If their shift finished before the evening handover they were expected to pass on any remaining jobs to one of the other junior doctors, but with no real system to support or enforce this. An electronic jobs list existed but was frequently not kept up to date. Evening handover was haphazard and could take up to 45 minutes to do as none of the junior staff knew the patients, other than those they had individually clerked.

Methods
Consultants, junior staff and nurses were surveyed to see how confidently they felt they knew which doctor was looking after which patient. They were also asked how well the electronic jobs list was kept up to date, and how often jobs were found at the evening handover that should have been done or acted upon earlier in the day.

Initial Results
There were 33 responders to the initial survey, ranging from FY1s and junior nurses to consultants and senior matrons. The majority (64%) felt unconfident that they knew which doctor was looking after which patient, and 76% were unconfident that the electronic jobs list was kept up to date at any particular point in the day (Graph 1 and Graph 2). 83% of responders felt that jobs were sometimes or frequently found at evening handover that should have been done or acted upon earlier in the day (Graph 3).

Results

Comments
• Never know which doctor is aware of which patient.
• Needs an afternoon handover so at least somebody at evening handover has a clue about what is going on with the EAU patients.
• It would be helpful to have the nursing coordinator there during handover.

Implementation of changes
Under the new system junior doctors divide up responsibility on the ward so that each day one CMT/ACCS or F2 level doctor is “in charge” of each half of the ward. Their names are displayed on a whiteboard so the Consultants and multidisciplinary team know which doctor to approach about which patient. An additional afternoon “board round” was introduced, led by the Consultant or SpR with senior nurse input. This includes updating the jobs list, checking that the afternoon team know who the sick patients on the ward are, and chasing outstanding jobs.

Evening handover processes were formalised, with two junior doctors each responsible for handing over all the current patients on the unit and any remaining jobs from ‘their side’ of the ward. Shift patterns were changed so that the junior doctors doing ward cover (who previously had their own separate handover meeting) could also attend the main evening handover and get input from the medical registrars for any patients they were concerned about.

Comments
• Easier to know which doctor to ask to do jobs now.
• Handover at 9.30pm seems to be much slicker.

Conclusions
Overall the majority of responders felt the changes meant they were more likely to know which doctor was responsible for which patient. The jobs list was more likely to be kept up to date, and there were fewer jobs found at evening handover that should have been done earlier in the day. Overall 85% of those involved felt that the changes had improved patient safety on the unit.

Future plans
Further plans to have an early morning board round with the nursing staff and incorporate checking if VTE assessments have been done at the time of handover are currently in progress.

References