Improving Medical Handover at Fairfield General Hospital: a Quality Improvement Project
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Aims
This QIP aims to address some of the ongoing variabilities from the RCP standardised practice by implementing a simple paper based tool to improve the quality, structure and documentation of the medical handover at Fairfield General Hospital.

Background
Handover is the system by which the responsibility for immediate and ongoing care is transferred by health care professionals (1). This may occur at any point where the responsibility for a patient’s care changes e.g. from day to night team, or the handover of new acute admissions between healthcare teams. Despite a limited evidence base for clinical handover standards, handover has been identified as a high-risk step in the patient pathway (1,2,3) and it has been shown that where a standardised proforma for handover is used and this information is documented, 99% of information is retained between the healthcare teams (4).

The Royal College of Physicians published their 1st Acute Care Toolkit (Handover) back in 2011(1), with clear recommendations for good standardised clinical handover. It was identified that only some of these standards were embedded in the routine handover practice at Fairfield General Hospital. In particular it was identified that there was no standardised proforma by which to structure and document the handover proceedings, and a paper based solution was required whilst transitioning to an electronic patient record.

Method
The handover documentation was reviewed for all day and night handovers in medicine for a 2 week period from 7/10/17 to  20/10/17 inclusive. This was audited against the standards suggested by the RCP acute care toolkit for handover (1) and the generic medical record keeping standards from the Academy of Medical Royal Colleges (5).

This included a total of 28 handovers. Plan, do, study, act cycles were then used to develop, and implement a paper based handover system, developed and then modified using feedback from the junior doctors and AMU consultants.

After implementing the tool, 14 days of handover documents were reviewed retrospectively from between 23/3/18 and 6/4/18 i.e. 28 handovers. This deliberately included the Easter bank holiday weekend to measure documentation of handover during a period when effective communication of handover is of vital importance to patient safety, due to care being provided by on call teams in multiple shift changes.

The data pre and post handover documentation tool was then compared to assess whether the tool was effective.

Results

Figure 1. Bar chart showing the difference in recorded documentation of handover structure before and after implementation.

- Location of handover: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 0%, Post: 60%

- Time of handover: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 0%, Post: 61%

- Consultant presence: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 22%, Post: 22%

- Handover lead: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 0%, Post: 22%

- Record of staff present: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 70%, Post: 100%

Figure 2. Bar chart showing the improvement in the quality of handover information after implementation of the paper tool.

- Identification of unwell patients: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 0%, Post: 87%

- Patients awaiting clerking: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 0%, Post: 100%

- Patient ID other than name: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 9%, Post: 100%

- Patient location: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 0%, Post: 100%

- Adequate patient clinical details: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 23%, Post: 100%

- Record of outstanding tasks: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 18%, Post: 100%

- Resuscitation status: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 9%, Post: 100%

- Record of clinical priority: Pre implementation (%), n handovers = 23 vs Post implementation (%), n handovers = 22
  - Pre: 0%, Post: 100%

Conclusions
- This project has demonstrated that implementing a simple, paper, handover documentation proforma can enhance the quantity and quality of information transferred at handover and contribute to improved communication and patient safety.
- The biggest gains post implementation were found in the quality of information recorded about patients.
- The simple tool acts as an aide memoire to ensure all important areas of handover are discussed.
- Although the improvements gained to medical handover by this QIP are not nationally new findings, the implementation of this tool has made significant improvements to handover and patient safety locally.

References