Introduction

The topic of clinical handover of care was selected by the Trust Leadership Faculty as the focus of this project. The National Patient Safety Agency (NPSA) has defined clinical handover as a process where there is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. Handover of care is known to be one of the most perilous procedures in medicine. The increase in shift working as a result of the European Working Time Directive (EWTD) has increased the number of handovers taking place, and thus elevated the need for the quality of handover to be improved and regulated.

Failure in handover is a major preventable cause of patient harm and it is principally due to human factors of poor communication and systemic error.

Maidstone and Tunbridge Wells NHS Trust has encountered problems relating to the quality of its handover procedures. At the Local Academic Board meeting 23/11/2011 the issue of handover quality was discussed, and it was agreed that the quality of clinical handover needed to be addressed. Moreover, the GMC has identified the need for the KSS Deanery as a whole to improve the quality of clinical handover. This project therefore targets a Trust-wide, deanery-wide issue, the importance of which will only increase.

Our Aim

To investigate and improve the quality of clinical handover within medicine at Maidstone Hospital using the Plan, Do, Study, Act (PDPA) cycle.

Plan

To investigate current weekend handover practice within the medical directorate at Maidstone Hospital.

To identify areas of weakness in this current practice, using a variety of research methods.

To improve the quality of weekend handover, in order to meet the best practice standards for clinical handover as laid out by the Royal College of Physicians.

To implement an electronic handover, in order to be able to trace accountability.

To use the weekend handover model to create a ‘tool kit’ from this project that can be applied to other handovers within Medicine, other specialties, and across both acute sites within the Trust.

Do

1) Investigation of current weekend handover procedure within Medicine at Maidstone Hospital, and identification of issues:
• No current formal policy for weekend handover
• No fixed time and place for weekend handover
• No register of attendance for weekend handover
• No electronic record of weekend handover, use of hand written paper sheets only.

2) Staff survey of opinions and experiences of current handover procedures, including meeting with Lead Consultant for Medicine.

3) Survey of junior doctors working in Medicine regarding weekend handover, to be carried out again following improvements. Pre-implementation survey carried out in February 2012. Survey was emailed to the medical directorate, due to lack of response, data was then collected through distribution of paper copies of the survey. A response rate of 15 was deemed to be acceptable.

4) Liaison with PALS, and departmental Complaints Lead for Medicine in order to collate anecdotal examples of where clinical handover had adversely impacted on patients.

5) Comprehensive research into best practice, and creation of an informed electronic handover system based on shortcomings of the existing system against best practice.

Study

The survey was created in order to query the weekend handover system in Medicine against Maidstone Hospital against the key elements identified in best practice documentation, as well as observed and anecdotally reported issues. The results (see below) confirmed these hypotheses.

Pre-Implementation Survey (N=15)

• 15/15 respondents thought an electronic handover would be beneficial
• 12/15 thought a minimum data set for clinical information would be useful
• 13/15 thought the current computer software systems were inadequate
• 4/15 had experiences problems locating patients due to inadequacies of the live bed state, leading to temporarily lost patients

Pre vs. Post-Implementation Survey (N=15)

In April 2012, the new weekend handover system, designed by Dr. Justin Fegredo, was implemented. The team attended handover meetings in order to ensure it was being used. After a month of use, the post-implementation survey, based on the pre-implementation survey and possible further additions based on observation of the new system in use and the original research (such as a hand-back system, and a traffic-light system for ordering patients by urgency).

• 14/15 respondents thought the electronic pro forma increased the quality of the weekend handover.
• 1/15 thought the electronic pro forma decreased the quality of the weekend clinical handover because of the future possibility that it might prevent a verbal handover taking place.

Conclusions

• The introduction of the electronic pro forma has measurably improved opinion on the quality of clinical handover.

• Strong consensus is that the weekend face to face meeting is maintained, supporting best practice guidance that verbal handover should not be replaced, only supported, by electronic systems.

• A way of prioritising weekend jobs on the handover spreadsheet is required.

• Use of a simple hand-back system may be useful for teams returning to their patients following the weekend.

Future

Recommendations

1) Handover jobs on the electronic pro forma require ranking in terms of urgency. This was presented at and accepted by a Clinical Governance Meeting on 15th March 2012.

2) The name of the doctor completing the electronic handover pro forma has been made compulsory and will turn green if not filled in

3) A weekend medical handover ‘Gold Standard’ had been created, which includes both use of the electronic pro forma and Friday meeting, and summarises the best practice guidelines. The Gold Standard mandates a register of attendees at the Friday afternoon meeting being kept by the site practitioner.

4) The ward cover SHO will ‘wait in the Doctors’ Mess on Monday morning to give returning teams a quick hand-back on issues arising at the weekend with their patients. These issues will also be recorded in the archived electronic pro forma.

5) A short teaching session will be given to all new F1/F2 and OMT doctors regarding safe handover and handover practice at the Trust.

Project Reflections

Benefits
• Greater mutual appreciation and understanding of roles of manager and clinician

• Wider understanding of a common issue across the NHS and opportunity to benchmark against other Trusts, and health systems.

Challenges
• Resources – no time in job plans for project.

• Difficult to bring about behavioural change in a large organisation.

• Lack of information sharing cross-organisation – different departments and individuals unknowingly working on same issues.

• Restricted by long timesframes on related projects, particularly ePR.

References

1) National Patient Safety Agency (NPSA), Seven steps to patient safety (London, 2004)

2) The Royal College of Surgeons of England (RCSENG), Safe Handover (London, March 2007)

3) The Royal College of Physicians (RCP), Acute Care Toolkit 1: Handover (London, May 2011)

4) NHS Institute for Innovation & Improvement, Plan, Do, Study, Act (PDSA) http://www.institute.nhs.uk/quality_and_service_improvement_tools/plan_do_study_act.html (last accessed 01/02/2012)