Improving the environment of handover: a quality improvement project

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Aims

It has been well documented that clinical handover is a high-risk time for patient safety. This problem has only been exacerbated by more handovers taking place with the European working time directive coming into effect. At a district general hospital, it became apparent that clinical handover was not running as well as it could be. As junior doctors, we decided to focus on ways in which it could be improved to prompt attendance at handover and how the environment in which handover takes place could be better in order to improve patient safety.

Methods

The previous handover register was initially audited by collecting data on the available handover registers in the folder. A questionnaire was given to the junior doctors taking part in handover, using a ranked scale of 1–5 on whether they agreed or disagreed with statements relating to the handover register and handover itself. The register was redesigned and several other measures were put in place to try to help doctors attend handover on time and to minimise distractions during the handover time. The questionnaire was repeated several times during the course of the project.

Results

The initial handover register was fully completed 1/330. There was an improvement to 50/52. This is a percentage increase of 95.85%. Looking at the questionnaire, which was based on a ranked scale of 1 as strongly disagree and 5 as strongly agree, the doctors' perception of whether the handover register was easy to use showed an improvement of a mean of 1.9 prior to any changes to 4.67. Clear leadership of the handover rose from 2.1 to 4.67 at the end of the quality improvement project. Whether handover was distraction free showed an improvement from 1.5 to 4.44, with a peak seen after the sign on the doctors' office door was put in place asking the nurses to not interrupt, unless it was an emergency of 4.83. The perception of whether the handover culture was safe rose from 1.7 to 4.78.

Conclusions

The attendance at handover has improved throughout the project, with the corresponding improvement seen in the documentation of the register of handover. This has all led to a change in the handover culture within the medical specialties and ultimately improved patient safety. ■

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