Safer care through better handover

Author: Ruwani Rupesinghe

Aim

To deliver high-quality handover between on-call teams by using a standardised system 100% of the time.

As chief registrar, I was asked to improve medical handover. Five serious incidents and two critical incidents were identified over a 4-year period in which poor handover was deemed to be a contributing factor. The Royal College of Physicians (RCP) *Acute care toolkit 1* states that 'improvement and standardisation of handover are vital keys to improvement in efficiency, patient safety, and patient experience'.

Methods

A baseline survey was sent to doctors, nurses and the critical care outreach team about their views on the quality and safety of handover, together with suggestions for improvement.

Many reported 'variability', 'poor structure', 'lack of standardisation' and lack of awareness that (ward) handover existed. Foundation year 1 doctors (FY1) in particular felt 'uncertain' about whether they were meant to be contributing or were 'handing over information without knowing why'.

I tackled these issues by:

- introducing a checklist for the main handover meetings
- improving education by delivering teaching to the current FY1 cohort and incorporating a session on handover into future FY1 inductions
- inclusion of handover processes into individual speciality junior doctor handbooks
- exploring electronic handover.

Results

Snapshot surveys were carried out subsequent to the baseline survey.

- Ninety-two per cent report the quality of handover being good to excellent, compared with 39% at baseline.
- Fifty-six per cent believe handover is always safe, compared with 22% at baseline.
- Fifty-two per cent now report always knowing who is present, compared with 22% at baseline.
- Staff described feeling 'pleased with structured handover', 'significant improvement' and more 'confident […] there will be time designated (for them)'.

Variability continues and the checklist is not always used. Anecdotally, this is linked to whether a consultant is present or leading handover. Following trials of electronic handover, information technology fixes are awaited. In the interim, an adaptation of the RCP out-of-hours form is used.

Conclusion

The project began as a relatively simple task of improving handover but expanded into a labyrinth of activities. It will take time for some of the actions to bear fruit. Engagement has been a challenge but there is evidence of improvement in handover processes.■

Conflict of interest statement

None declared.

Author: Royal College of Physicians chief registrar, York Teaching Hospital NHS Foundation Trust, UK