Passing the baton

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Aims

- To improve the communication and culture around handover at shift changes.
- To increase training and assessment opportunities by standardising 'post-take' ward rounds after the night shift for all night team medics.
- To improve patient safety.

Methods

Handover at Surrey and Sussex Hospitals NHS Trust (SASH) only officially happened once a day in the evening, and displayed silo working. It was constantly interrupted by attempts to refer new patients or emergency calls, and due to high workload, often overran into a Hospital at Night meeting, further reducing medical registrar availability. Mornings saw exhausted night doctors trying to find post-take ward rounds (PTWR; of which there were seven) to review their patients with, rather than the consultants finding them. Few work-based assessments were obtained, morale was low, and sleep was elusive due to unmet patient concerns.

Several workstreams were initiated:

- medical registrars were asked to brainstorm a better handover process which could be standardised
- negotiations started with emergency department (ED) to allow bleep-free handover
- Hospital at Night (H@N) programme development initiated
- morning PTWR process observed for several weeks to examine patterns of work and why night staff were not included
- doctors on night shifts were asked about their experiences especially in regards to training opportunities and morale.

Results

Several improvements have occurred, but some are still incomplete as culture takes a considerable amount of time to change.

Handover in the evening now occurs in a standardised way, mostly up to *Royal College of Physicians acute care toolkit 1* standards. It is bleep-free following extensive work with ED utilising a pre-handover huddle with the ED consultant and a post-handover catch-up, pre H@N meeting which is later to accommodate this. H@N is in an advanced stage of development and due to go live in June 2018. Morning PTWR will now start in the operations centre away from the acute medical unit (AMU) to allow executive oversight, easy colocation of night and day staff and to allow handover to morning coordinating consultant, who will review all patients seen by the night registrar who was usually missed due to ED commitments. As ED commitments are now covered by the AMU registrar, the night registrar is able to attend.

The most important aspects of team working were embedded in the recent national *Quality criteria for general internal medicine and acute internal medicine registrars* which the author co-authored, ensuring a gold standard of behaviour.

A review of doctors' views is needed before August 2018 to capture the impact of these changes.

Conclusion

Improvement projects involving culture change take more time but are possible especially if supported by national gold standards. ■

Conflict of interest statement

None.

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