Medical Acute Take Handover

Theme | Quality Improvement Project (QIP)

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SaTH Improvement Hub

The Shrewsbury and Telford Hospital NHS Trust

REASON WHY?

Following a local audit, it became clear that areas of the Medical Acute Take Handover presented opportunities for improvement. In particular, variation in the leadership structure, timings, content. This resulted in safety concerns as important information could be missed. A survey was conducted and it was found that the handover did not meet the requirement for a safe and effective handover.

SMART AIM

S SPECIFIC M MEASUREABLE A ACHIEVABLE R RELEVANT T TIME-BOUND

Improve how colleagues feel about the content and structure of a Medical Acute Take Handover by 1st September 2024. To improve the structure and standardization of handover at our hospital in concordance with Royal College of Physicians (RCP) recommendations for good clinical handover

PLAN

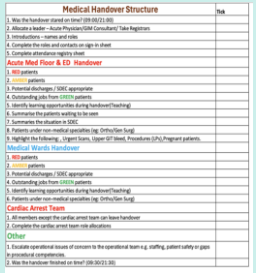
The interventions were guided by the RCP Acute Care Handover Toolkit.
It was decided to create a medical handover template that includes all essential components to ensure a safe and efficient handover process.
A dedicated room was assigned for handovers, and information regarding the timing and required attendees was communicated to the team. The room was equipped with IT resources, including a mobile TV screen, a large central table, and 12 chairs.
Key actions included:
- Disseminate the handover structure to the team
- Testing a sign-in sheet with roles and bleep numbers to enhance communication.
- Developing a whiteboard in the handover room for the team to update.
-Improving IT resources available during handover
- Ensuring handovers start promptly, and enforcing punctuality among all team members.
- Involving consultants in the process
- Improving communication regarding staffing shortages.

DO

A sign-in sheet was introduced, and emails were sent outlining the expectations for handovers, including the time, location, and process. A structured handover document was also provided, which needed to be completed at each session.

Initially, handovers were held in a library room due to a lack of clinic space. Later, a dedicated room in the PRH admin hub became available, equipped with IT resources, a mobile TV screen, and a large central desk with 12 chairs. This room became the designated space for 9am and 5pm weekday handovers. The 9pm and weekend handovers continued in the AMU Pacing Room for convenience.

Laminated copies of the handover template were distributed for use during sessions.



Medical Handover Structure

Acute Med Floor & ED Handover

Medical Wards Handover

Cardiac Arrest Team

Other

An initial survey was conducted to assess the current process, followed by two audit cycles, each lasting four weeks. The first cycle followed the initial handover format, and after analysis, adjustments were made for the second cycle.

STUDY

QIP methodology was adopted with plan, do, study, act (PDSA) cycle. An attendance board and document enlisting the format of handover, was required to be completed at each handover session (Figure 1). An initial survey was conducted to assess the current situation followed by 2 cycles of QIP, with each cycle lasting 4 weeks. In the first cycle attendees followed the format of handover and following analysis a second cycle was introduced with some changes to the initial format followed by analysis of results.
The survey had 30 responses constituting 30% consultants, 27% specialty doctors/registrars, 27% senior house officers and 16% advanced clinical practitioners. Half of HCP's participated in medical handover at least 1-2 times per week. On a scale of 1 to 10 (with 1 being highly ineffective and 10 being highly effective), 70% rated the overall effectiveness of current medical handovers to be 6 and above. 60-80% felt satisfied with the different types of information exchanged during handovers. 75% identified lack of ideal handover location as an obstacle and nearly 2/3rd responded that standardized protocols and IT tools were lacking. Documentation and record keeping was of reasonable standards in just above half of responders while remaining rated it as poor. Overall, the results demonstrate a positive improvement in several key areas of the handover process in line with RCP guidance following our interventions. We will continue to improve the learning outcomes from the handover process in the near future.

	PDSA 1	PDSA 2
Leader allocation	100%	100%
Sign in sheet completion	81%	96%
?Red? and ?Amber? patient handover from acute take	96%	96%
Summary of patients waiting to be seen	71%	79%
Highlighting urgent scans, procedures, upper GI bleeds, antenatal cases	68%	92%
?Red? and ?Amber? patient handover from medical wards	93%	100%
Unwell patients from non-medical specialties	75%	88%
Cardiac arrest team allocations	84%	96%
Learning point discussion at handover	59%	58%
Operational issues for escalation	50%	83%

ACT

The new process will be adopted as it has made an improvement to the handover. In particular, having a dedicated space and time to meet ensures all colleagues are able to conduct a successful handover.
Overall, the results demonstrate a positive improvement in several key areas of the handover process in line with RCP guidance following our interventions. We will continue to improve the learning outcomes from the handover process in the near future.

ACKNOWLEDGEMENTS & REFERENCES | Dr Navya Basavaraju, Dr Sam Craik, ACP Hazel Green, Consultant Dr Nawaid Ahmad, Consultant Dr Shakawan Ismaeel, Consultant Dr Thimmegowda Govindagowda.