

Improving Patient Safety through a new Clinical Handover Procedure

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Aim

Within 6 months develop a patient focused, standardised Clinical handover procedure for the Paediatric Unit CHBH that would improve the safety of Clinical care, improve communication with Parents and improve the efficiency of the Unit overall

Background

- Handover frequently starting late and running over time
- Staff seeking further information following Handover
- Patients without correct ID / information
- Emergency equipment not routinely checked
- Parents not aware of the 'plan of care'
- Missed tests / procedures / medications
- Ward poorly staffed during Handover time despite double staffing

Diagnostic Phase

- NUM closely observed what took place during Handover
- NUM observed the Unit / Reception during Handover time
- Evaluation of Nursing Care Audits / IIMS reports over the previous 12 months
- Spoke with Parents and staff
- Investigated what happens elsewhere
- Literature search

Conclusions

- 1 Handover style varied in style and quality - no agreed best approach / level of experience of nurse
- 2 Parents left waiting at reception during Handover which took place in a room away from the Clinical area
- 3 Other clinical units were utilizing new Handover styles successfully
- 4 Some incidents would have been avoided with better information during Handover

Planning & Implementation

- Identification of stakeholders – patient, parent, nursing staff, Junior Medical Officer
- Bedside identified as the best place for Handover to occur
- Decision to combine Handover with safety checks
- Formal checklist developed – ID band checked, IV cannula check, emergency equipment checked, Medication chart checked, Patient allergies recorded

Barriers to implementation

- Staff saw it as their right to conduct Handover as they preferred
- Perception that patient's confidentiality could be breached
- Belief that completing bedside safety checks as part of Handover would make Handover too lengthy
- Perception that Handover is the domain of health care workers – no value in involving patients or carers
- Handover taking place after-hours – difficult to supervise

Outcomes & Evaluation

- 83% reduction in medication errors (sustained)
- Audit of checklists – 100% compliance
- Parent satisfaction 9.6 / 10
- Nursing Care Audits - improvement in emergency equip.
- JMO routinely attending 1400 clinical handover
- Handover not taking any longer, time saved as efficiency improved

Lessons Learned

- Change is challenging, find someone on your side
- Give stakeholders consistent feedback
- Celebrate wins – eg reduction in errors
- Be prepared for it to take some time but don't give up

Future Scope

- Rollout of patient focused Clinical Handovers into other Clinical Units CHBH