Patient Handover: Initiating a Practice, Assessing practicalities

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The practice prior to initiation of patient handover project

- On-call team sees 25 – 40 patients / day [A&E + MAU]
- Consultant reviews all patients on 5pm or 8am round
- Patients transferred to treatment wards
- Ward-based teams: patients not missed; doctor-nurse communication easy; fewer ward rounds
- No formal handover; individual initiative
- Junior doctors unaware of RCP guidelines
- Specialist consultation request forms faxed to secretary
The practice prior to initiation of patient handover project

**Problems**

- Delay in review of patients by team on treatment ward:
  - danger for critically ill
  - increased length of stay
- Patient under “wrong” firm impairs continuity of care
- Lapses in patient care – risk management issues
The patient handover project

Aims of the project

1. To raise awareness of the importance of patient handover
2. To initiate this practice by encouraging effective communication
3. To assess practicalities.
   - Timing of the handover meeting in a working day
   - Increase in workload due to time spent on handover
   - Effect on the rest of the day’s work
   - Consideration of hours worked by all doctors, particularly outgoing on-call team
4. To enhance consultant-led training of junior doctors
5. Ongoing assessment of quality & quantity of handover
   - Audit of handover process
   - Questionnaire survey of doctors & nurses
   - Assess improvements in junior doctors’ training
   - Crude indicators
     Assessing bed occupancy, length of stay, complaints rate and death rates before and after (NOT carried out due to other changes in working conditions likely to affect these)
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The new practice:

*Introduced in March 2001 at MAU, Rochdale Infirmary. 3 months pilot at Birch Hill Hospital prior to the move of the MAU. Discussions at junior & senior levels to raise awareness of patient handover and proposed change in practice were carried out before the pilot period

- All junior medical staff to use Royal College of Physicians handover forms
- The on call consultant starts post-take ward rounds at 8.00 am as usual
- Consultant-led handover 9.00 – 9.30 am for which the post-take ward round is temporarily suspended
- Incoming and outgoing on-call teams, all available junior medical doctors, the bed manager and the nurse in-charge at MAU are expected to attend
- Should be bleep-free (apart from emergencies)
- A record of the proceedings and an attendance register is maintained.
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The process of handover

• Brief presentation of all patients admitted, critically-ill inpatients on the wards throughout the hospital and referrals from other departments

• Contribution from specialist registrars in areas of their expertise encouraged

• Formal referral forms sent in the usual way and a copy filed in the case notes as record. The junior doctor for the team receiving the referral liaises with the consultant, reducing delay in specialist management.

• Patient confidentiality to be maintained at all times.

Attendance register and documentation of handover process kept on MAU
The patient handover project

Educational value of patient handover

• Learning management of ‘hot’ cases.
• Instant specialist opinion from participating consultants & registrars.
• Stimulates juniors to ‘think on their feet’ and educate each other from individual experiences.
• An opportunity to identify patients with interesting clinical signs or requiring specialist procedures.
• Improvement in junior doctors’ communication skills.
The patient handover project

Service benefits:

An effective patient handover is useful:
- In improving patient care
- In ensuring continuity of care
- In speedy management and reduction in bed occupancy/length of stay
- In training of junior doctors in management of acute medical conditions
- In improving communication skills
Outcome of the project

Recorded handover meetings April- December 2001
(No. of days in a month that the handover should take place)

April - 11 days (26) = 42%
May - 17 days (27) = 63%
June - 13 days (26) = 50%
July - 11 days (26) = 42%
August - 5 days (27) = 19%
September - 8 days (25) = 32%
October - 7 days (26) = 27%
November - 10 days (26) = 17%
December - 15 days (26) = 58%

Overall - 97 days (235) = 28%
10

Results %

1st cycle n = 8  2nd cycle n = 19

1st cycle questionnaire: 20 sent 8 returned
2nd cycle questionnaire: 30 sent 19 returned
Are you aware of Royal College Guidelines surrounding handover?

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Has the implementation of the new handover scheme -

- Improved care: 75% in 1st cycle, 63% in 2nd cycle
- Speeded up investigations: 50% in 1st cycle, 63% in 2nd cycle
- Resulted in reduced bed occupancy: 11%
Is the new scheme helpful in training junior medical staff?

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How do you think training could be improved?

More time to be devoted to training
Good rotation and good communication
More medical and nursing staff are required
Post-take ward rounds are better learning places
Make medical input less fragmented
The outcome: general impressions

- The awareness of the responsibility of handover is increasing
- The process of proposed handover was greeted with interest and enthusiasm by the majority
- Communication between professionals has improved
- Night on call teams can go off duty soon after the handover meeting following delegation of jobs pending after post take rounds
- Patients get booked to the appropriate wards
- Patients requiring specialist attention are reviewed sooner
- Any problems encountered are now discussed more freely among colleagues
Problems identified whilst the project was ongoing

**Medical Staff**
- Morning post-take ward rounds may take too long for the teaching session to be fitted in
- Lack of awareness & understanding of the handover process
- Perception of increase in workload
- Consultants’ fixed commitments following post take rounds

**Nursing staff**
- Inadequate levels of staffing on Medical Admissions Unit
- Increasing workload with large number of patients passing through the unit
- An impression among a few of the nurses that it is a ‘doctors’ meeting (rather than a multidisciplinary one)
THE MAJOR PROBLEM

Split site working:
The Medical Department was partially moved to the Rochdale Infirmary site leaving the majority of acute medical beds at Birch Hill. The two hospitals are 3 miles apart. The move meant that more junior medical staff were required to cover 2 separate on-call rotas providing 2 fully fledged cardiac-arrest teams. This resulted in reduced availability of medical SHOs, impairing continuity of care & training. This was compounded by recruitment problems.
Suggested solutions

*Modifications that were made to address the difficulties:*

- All patients admitted by the on-call team are handed over to the incoming team and ward-based doctors at the Infirmary. Any other doctor on site at that time is encouraged to attend.
- The directorate formally agreed to cancel the morning fixed commitments of the on-call consultant.
- Seriously ill patients are retained at the Infirmary site so that they can be regularly reviewed by the on-call team.
- If necessary these patients are handed over by phone to the receiving team.
The way forward

• To continue with the current system and educate new staff members in the handover process within the Trust.

• To continue to address the problems encountered enabling the handover system to become an increasingly integral part of patient care

• To continue to audit the process and identify ways of improving education and implementing ideas for change when needed.