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Gloucestershire Safety & Quality Improvement Academy

Improving Clinical Handover in the ED

✔ Learning ✔ Improving ✔ Sharing

#TheGSQIAWay #TeamGSQIA **@gsqia**

The Safety Concern

Handover of patients between clinicians in the ED was leading to poor care:

- patients were being forgotten about!
- delays to test results being acted upon
- delays in imaging/ further tests
- deteriorating patients not being identified and escalated

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What we found

Twelve PSIs relating to clinician handover within the preceding six months (through DATIX)

Handover processes thought to be inefficient, slow, chaotic, noisy. Junior staff not confident in taking a handover, or that handed-over patients would be well looked after. (Staff survey)

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The Aim

1. Double the interval between PSIs related to clinical handover within four months

2. Reduce to zero the number of negative comments around handover on a repeat survey in four months

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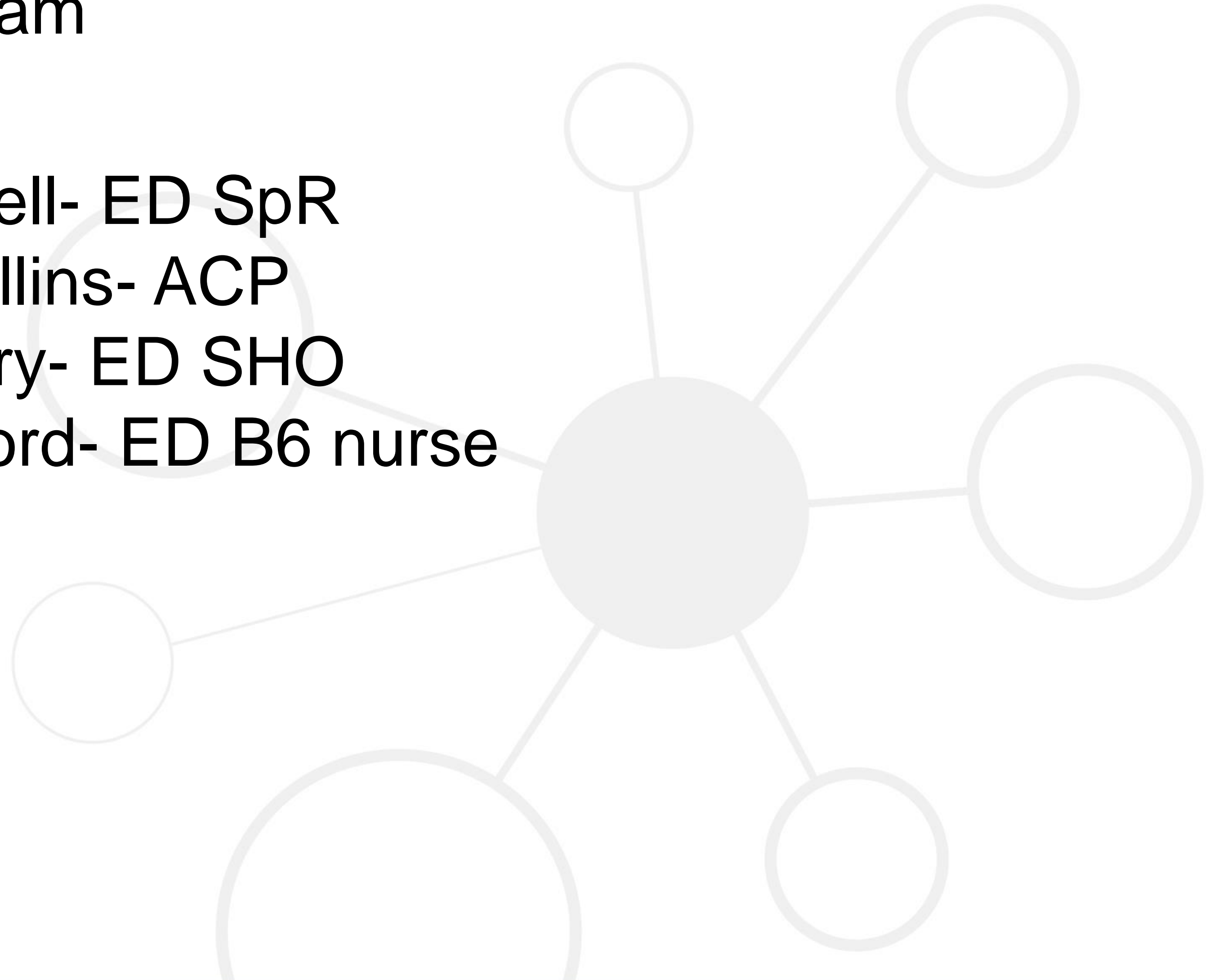
The QI Team

Sam Pestell- ED SpR
Jaimie Collins- ACP
Daisy Perry- ED SHO
Beth Burford- ED B6 nurse



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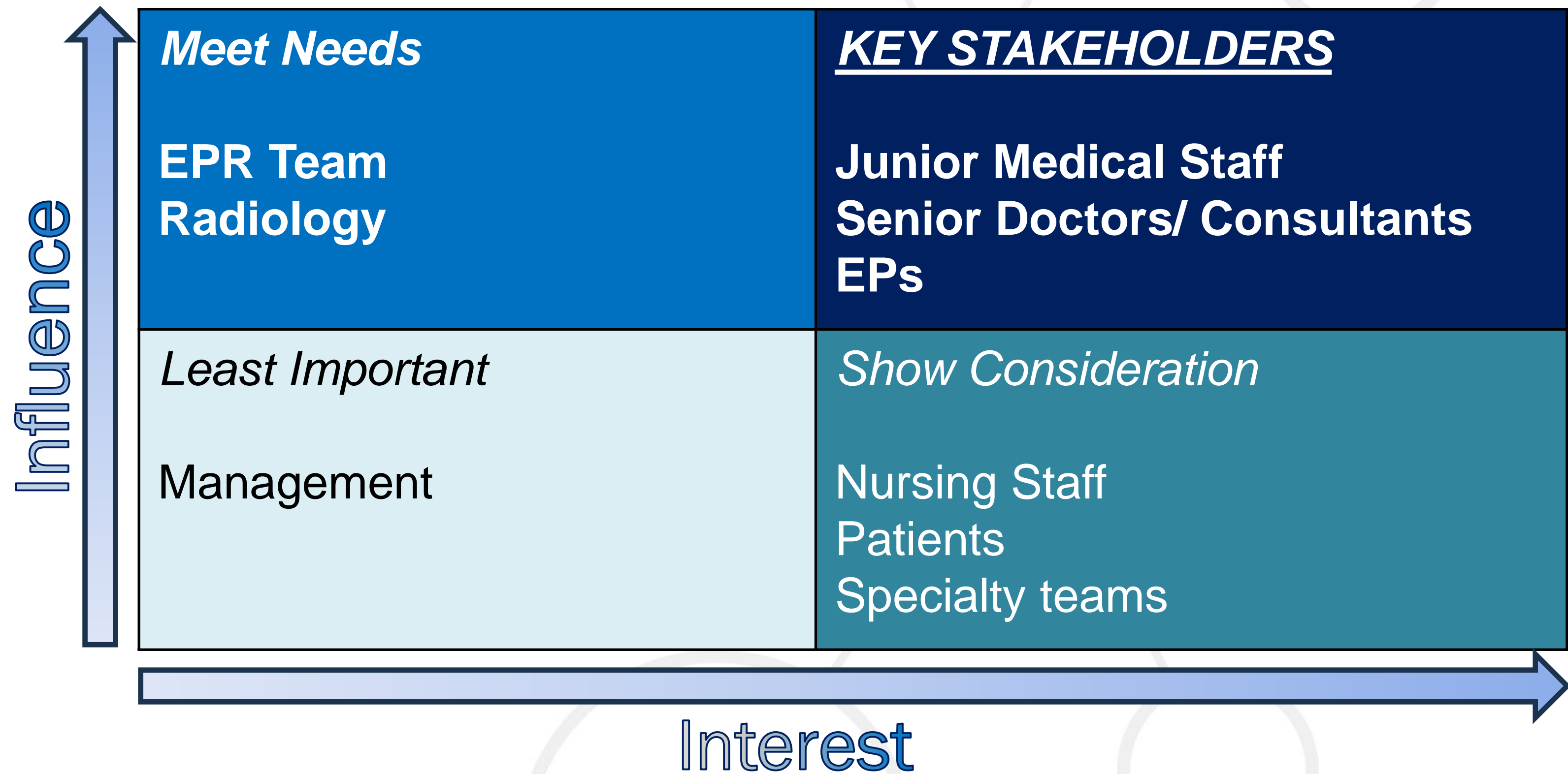
Stakeholders



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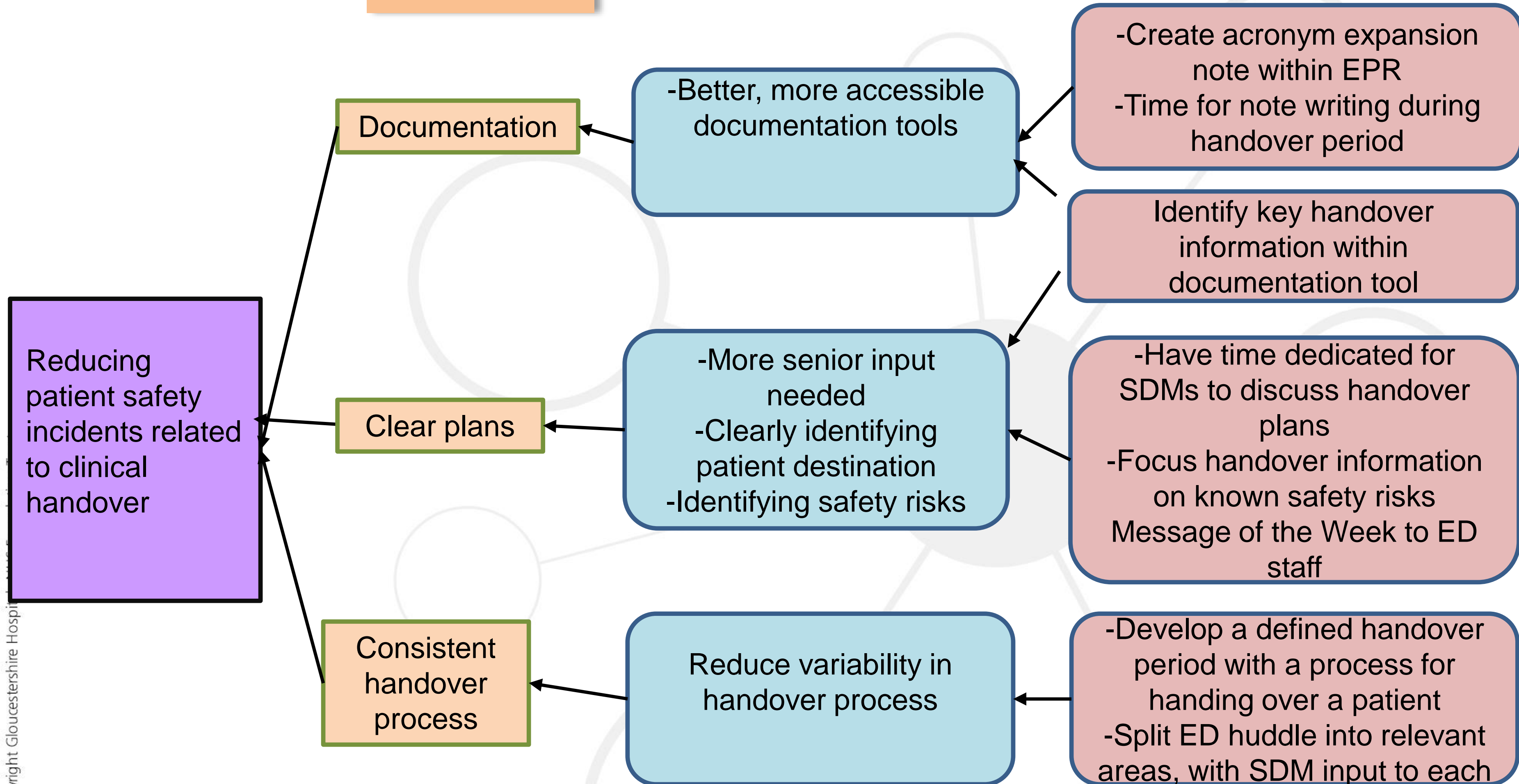

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Challenges Identified

Team factors:

- Variability in handover processes
- Morning handover delaying time home for night staff
- Failure to seek senior support in decision making

Equipment and resources:

- Small space to handover (20+ people in small room in afternoon)
- No large screen to focus attention
- Minors physically distant to Majors (though changed in January)
- No pre-existing EPR note around handover

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Challenges Identified

Organisational factors

- Increasing number of patients remaining in ED for long periods
- Multiple similar attendances/ plans (e.g. awaiting HAT assessment)

Task factors

- Patients requiring individualised plan, often with senior guidance

Education/ training factors

- Lack of awareness of handover as a risk-generating process
- Lack of awareness of features of EPR allowing standardised notes

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Measures

Outcome	Process	Balancing
Number of datix/ PSIs raised in four months following project	Whether a clear process was used in ED huddles	Attendances
Repeat survey of junior staff regarding handover	Time taken to complete ED huddle/ handover	Number of patients handed over
	Use of introduced acronym expansion/ handover note	Change in layout of ED- Minors area moving

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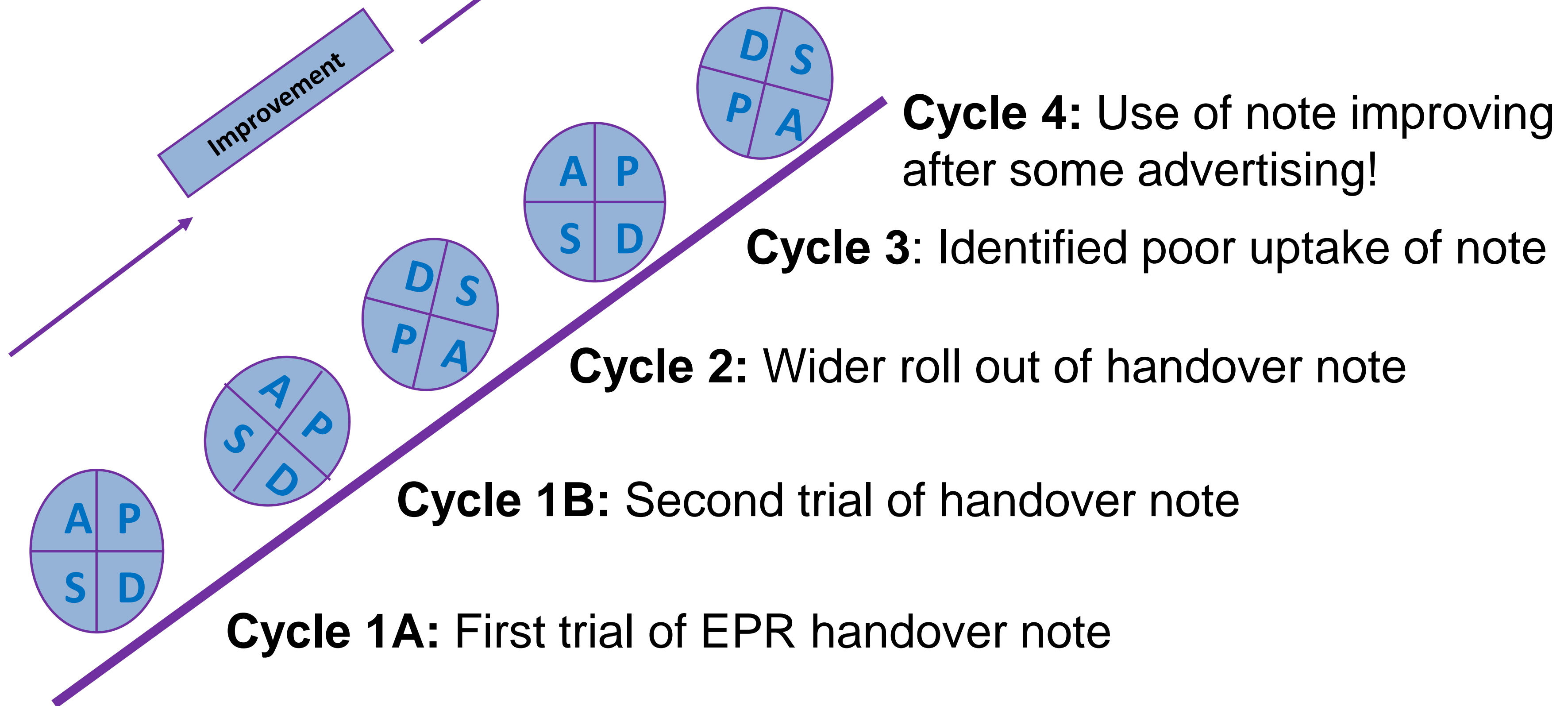
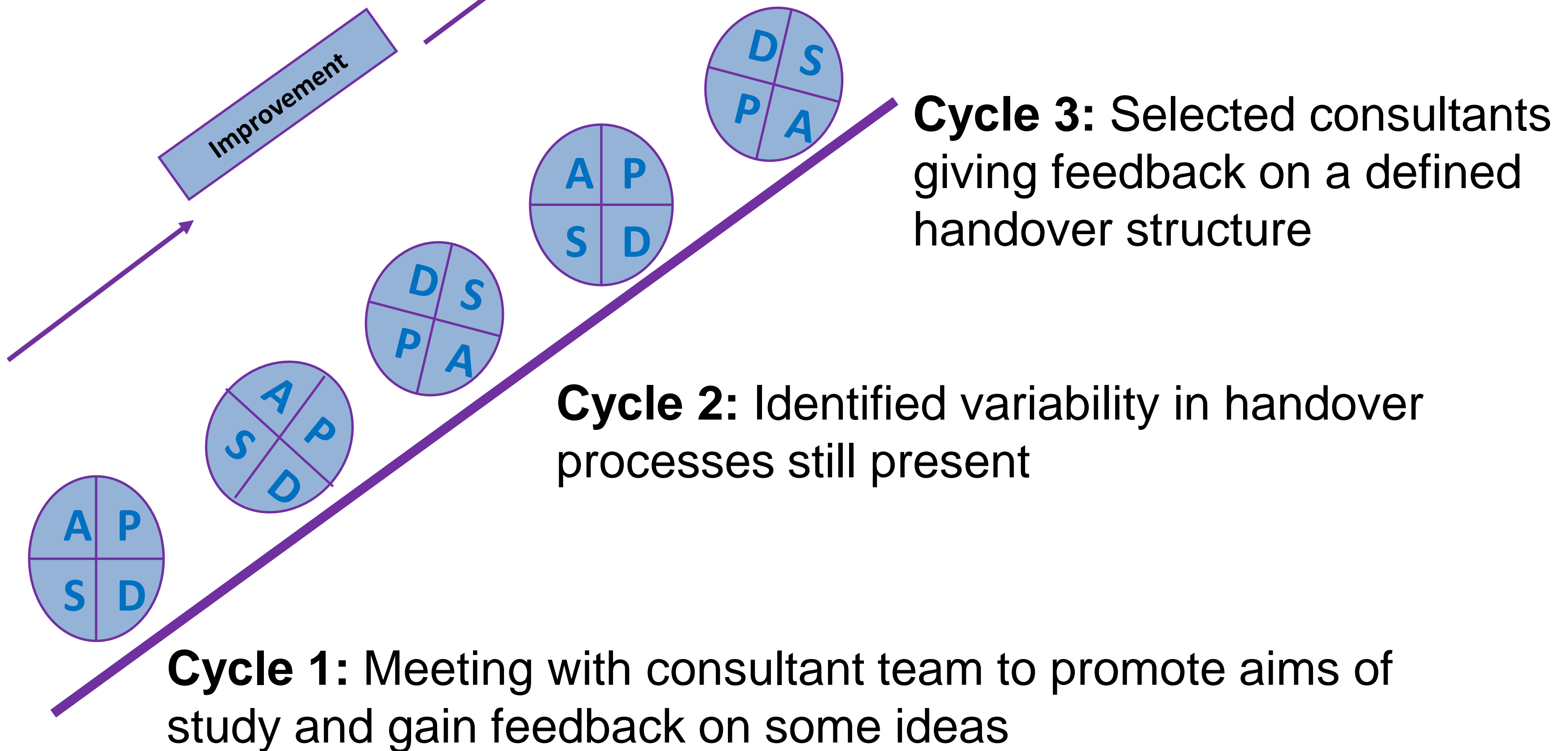
PDSA Cycles- handover note



PDSA Cycles- huddle format



Measurements- Process

1st and 2nd PDSA cycles used to gain feedback about information included and layout of note

3rd PDSA cycle- we looked at use of the note- really poor! Only 1 of 28 morning handovers used it in a week

Realised this was likely an advertising issue- dedicated two weeks to promoting use and saw a small (but meaningful) increase in use to 6/24 handovers in a week in PDSA cycle 4

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Measurements- Key results and balancing

- Still awaiting results from Datix Audit
- Junior Doctors to be re- surveyed
- Lots of changes to the department in the last few months
  - New layout
  - Busier than ever!
  - New permanent medical staff and PAs

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Lots still to do!

Formal/ final data assessment (for past 6 months)

Re- run junior staff survey

Feedback from consultant body on improvements to handover process

New doctor induction- Excellent chance to promote changes to incoming doctors

Perhaps looking to address other factors identified

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