Handover Improvement Initiative

Grassroots leads culture change in clinical handover

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"Handover of care is one of the most perilous procedures in medicine and when carried out improperly can be a major contributory factor to to subsequent error and harm to patients."

Professor Sir John Lilleyman
Medical Director National Patient Safety Agency

20% of 54,000 junior doctors surveyed said handover arrangements before and after night duty were informal or there were no arrangements made.
GMC Annual Survey 2013

Previous methods to improve handover have failed to address underlying key issues and cultural barriers to change.
Recognition of the inadequacies and failings in handover at Brighton Hospitals prompted the launch of the Handover Improvement Initiative, a trust-wide grassroots project with the following aims:

1. Understand the current problems within handover and the cultural barriers to change
2. Develop and implement solutions to ensure safe handover, high quality patient care and a better working environment for healthcare professionals
3. Promote a sustainable cultural shift

METHODS

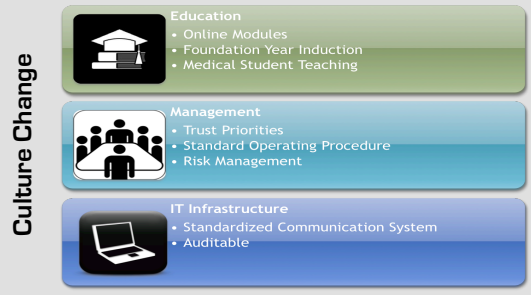
Qualitative data was obtained from semi-structured interviews of non-consultant doctors to decipher common themes and deficits in current handover practice. Data was analysed using Access coding software.

A Likert-type survey of 32 doctors was completed. Using RCP guidelines a temporary standardized handover proforma was implemented and re-audited.

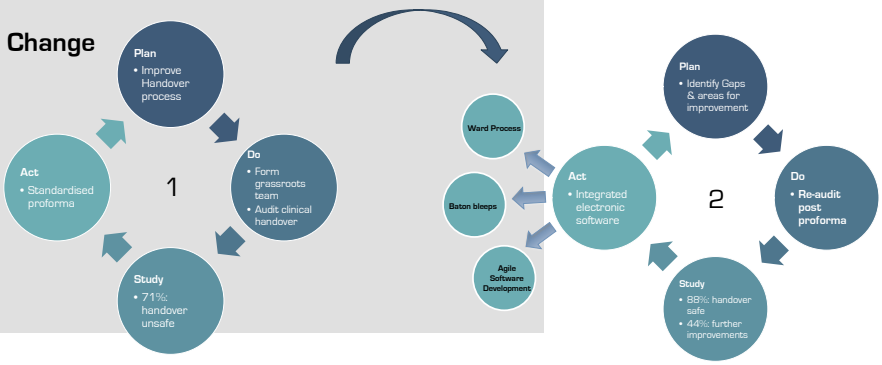
Key stakeholders were involved to source funding and produce a permanent electronic handover solution using agile software development.

Frontline staff were trained in safe handover through online modules, case studies and hospital induction teaching.

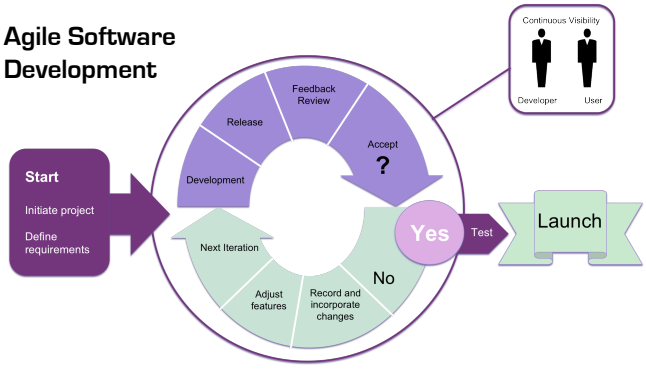
Enlisting doctors present for ≥2 years ensured sustainability.



Process Change



Agile Software Development



RESULTS

93% of doctors felt current handover practice needed improvement and 71% thought handover did not ensure patient safety (Chi-squared, p-value <0.001, n=32).

Word clouds were generated from semi-structured interviews. 51% of comments (n=57) regarding handover were not positive and identified areas for improvement as perceived by the grassroots.

Re-audit following implementation of the standardised proforma showed 88% felt the new system ensured better patient safety (p<0.01, n=25), with 44% requesting further improvements.

An integrated eOASIS handover software was developed and is pending trust-wide launch.

A standard operating procedure for handover was created and undergoing regular revision.

Key Points

•Improving Clinical Handover requires:

1. A collaborative approach to tackle cultural change and implement innovative solutions.
2. A combination of cultural, technological and system fixes.

•Continuous involvement and training of grassroots promotes sustainability.

•Fostering a shared vision in handover will improve patient safety.