Handovers in resus: Quality Improvement for patient safety.

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EUSEM 2018 GLASGOW, 8-12 SEPTEMBER
THE EUROPEAN EMERGENCY MEDICINE CONGRESS
EUSEM EUROPEAN SOCIETY FOR EMERGENCY MEDICINE

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Background:

It is widely accepted that handover of patients carries significant potential risk. Information misunderstood or misinterpreted during handover can have a significant adverse impact on patient outcomes[1]. Anecdotally, this process within the Emergency Department at the Queen Elizabeth University Hospital (QEUH) was felt to be suboptimal, raising significant patient safety concerns.

Aim:

To introduce a structured and standardised approach to handovers in resus.

Methods :

6 key performance indicators (KPI's) were drawn up through reviewing current literature and discussion with the clinical team. Compliance with these was assessed for 50 handovers between the Scottish Ambulance Service (SAS) crews and the receiving clinical team in resus.

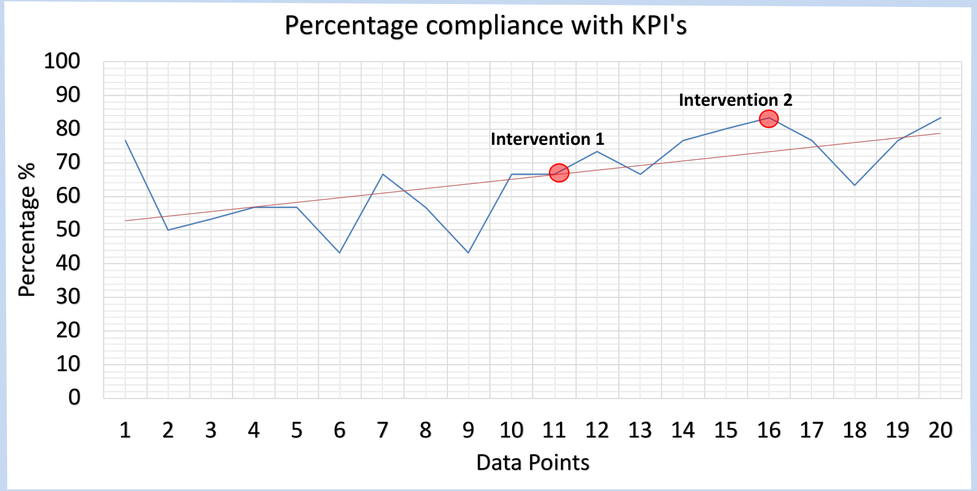
Following this, a number of interventions were implemented using the model for improvement and Plan- Do- Study- Act (PDSA) cycle, involving both paramedics and hospital clinicians. Staggered Interventions included:

1. *Information posters displayed within department, face to face 'hot' debrief with paramedic teams and highlighting KPI's during departmental handover meeting twice a day.*
2. *Increasing distribution of pocket- aide memoirs for SAS crews, skills & drills sessions with simulation training.*

Key Performance Indicators (KPIs)

1. Clearly identified team roles.
2. Acknowledgement of patient.
3. "Hands off/ Eyes on" during handover.
4. No interruptions from receiving team during handover.
5. Handover prior to transfer (unless clinical urgency).
6. Clarification sought on presence of next of kin.

Results



Mean compliance with KPI's before any interventions was 57% (median 3/6) this has improved to 78% (median 5/6) following interventions. Furthermore, the mean time of handovers has reduced from 170 seconds (30-752) to 83 seconds (50-132).

The KPIs with the most significant improvement in compliance are:

- "No interruptions from clinician" 34%→ 72%
- "Hands off handover" 50% → 88%

Further improvement should be sought in "clarifying presence of next of kin" as this KPI is currently achieved 40% of the time.

Conclusions & recommendations

It is well recognised that communication errors during handover account for a significant number of adverse clinical events[2]. The introduction of a standardised approach to handover has improved communication of time critical patients and thus positively impacted patient safety.

The interventions implemented have led to an improvement in our practice. To continue and sustain this trend it is recommended that skills & drills sessions with simulation are carried out regularly with nursing and medical staff and KPI's are also mentioned at departmental handover meetings at regular intervals . To ensure changes in practice are sustained, another cycle of data collection is recommended in 6 months.

References & Acknowledgements
1. Bost N et al. Clinical handover of patients arriving by ambulance to the emergency department – A literature review. International Emergency Nursing, October 2010. Volume 18: 210 – 220
2. Thakore S, Morrison W. Pre-hospital care: A survey of the perceived quality of patient handover by ambulance staff in the resuscitation room, Emerg Med J 2001;18:4 293-296

Special thanks to Dr. Douglas Maxwell for help and guidance with this work. Much of this project is the continuation of his previous work including work with Scottish Ambulance Service in creation and distribution of pocked aide memoirs.