Improving clinical handover for new patient admissions across two surgical wards over the period of 9 months

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Acknowledgement to: Dr Cicely Culmer, Dr Keerthana Veerapatherar, Dr Faisal Shahzad

Aim:

To improve clinical handover from emergency department to the two surgical wards by printing ECASCARD documentation (A&E electronic clerking) when patients are transferred.

Method:

Three PDSA cycles were designed over 9 months in two adult general surgical wards Kings A and B in our district general hospital.

The first implementation was putting posters up at nursing stations to highlight the need for printing out ECASCARD documentation, and provide a visual prompt when taking verbal handover.

The second implementation was to add a separate section on the nursing staff SBAR handover sheet to remind and empower staff to ask for a printed ECASCARD summary document.

Background:

Transfer represents a significant transition point in the patient pathway, for both patient and staff. Handover (or handoff) facilitates continuity of care where information and professional responsibilities are transferred.

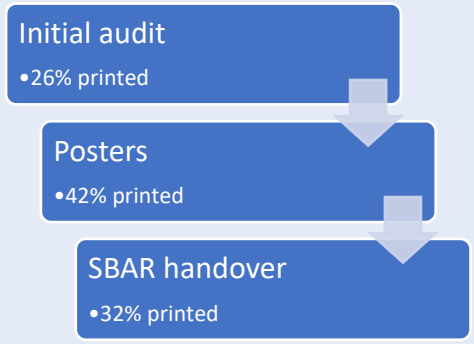
Improving the Continuity of patient care Through Identification and implementation of Novel patient handoff processes in Europe

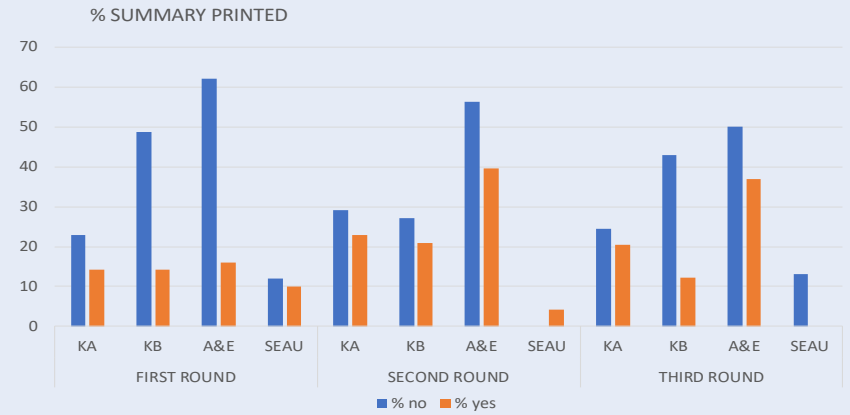
A largescale European study[2] concluded over a quarter of adverse events related to patient safety is due to lack of appropriate handover communication.

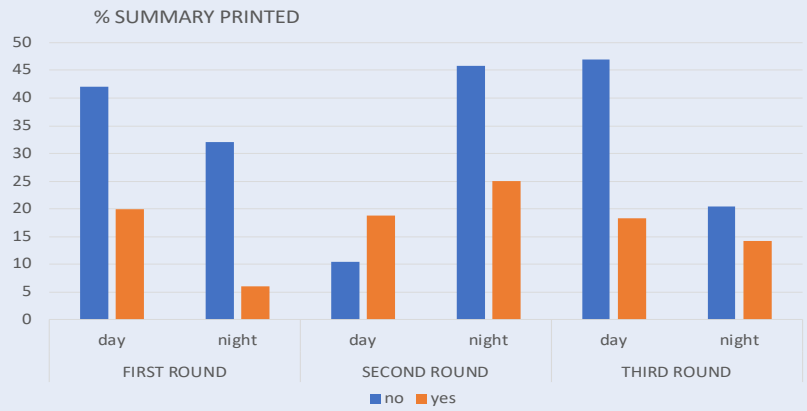
Errors in handover have been implicated in as many as 80% of errors and preventable harms[3].

Our project was designed to improve handover for new patient admissions. ECASCARD is a tool where the clerking doctor in ED documents the reason for admission of the patient.

Results:







Conclusion:

PDSA1 showed only 26% of patients admitted had the appropriate ECASCARD documentation in the patient notes folder. Although this improved to 43% after the posters were placed, this improvement was not sustained. However it is important to note COVID-19 came into effect half way through the PDSA2. PDSA3 showed a final 32% of patients had ECASCARD printed. No trends were identified in relation to timing of handoff, which would presumably reflect a difference in staffing. No trends were identified in relation to patient location (at the time of handoff or destination ward). Vast improvements and culture change are required, including shared understanding of who has ownership of responsibility to print handover, challenging perception that all staff have access to electronic records.

[2] Barach P. Handover: improving the continuity of patient care through identification and implementation of novel patient handover processes in Europe. Project website, 2015.
[3] Solet DJ, Norvell JM, Rutan GH, Frankel RM. Lost in translation: Challenges and opportunities in physician-to-physician communication during patient handoffs. Academic Medicine. 2005