Improving the Medical Handover in the Acute Mental Health Setting

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Background

Effective handover has long been recognized as an essential component of patient care. The Medical Director of the National Patient Safety Agency, Professor Sir John Lilleyman, describes the medical handover as "the most perilous procedure in medicine, and when carried out improperly can be a major contributory factor to subsequent error and harm to patients".

The problem:

- ***Where?*** Belfast Health and Social Care Trust, Northern Ireland
- ***Who?*** Two junior doctors covering the Mental health out of hours rota. One in the acute adult inpatient unit and one covering multiple subspecialties in other inpatient sites.
- ***What?***

1. Doctors covering areas they are unfamiliar with and handing over to people with whom they don't normally work

2. Patient safety issue with increased risk of adverse incidents secondary to poor communication

- Why? No formal handover system in place leaving doctors to source who they need to handover to and decide what needs handed over

Aims

Specific - 80% of psychiatry SHOs within the BHSCT rate the medical handover a "good" or "excellent" by six months
Measureable – we will measure the views of SHOs through serial questionnaires
Achievable – we believe this is a realistic aim
Relevant – effective handover is widely considered an integral component of providing safe patient care
Time-related - six months timeframe, to include August changeover, to establish changes and ensure any improvements are sustained

Methods

Population: All SHOs covering the 1st on call out of hours rota within the BHSCT
Intervention:

- Produce a template covering all areas to be discussed at handover
- Allocate protected time to ensure all relevant staff were able to attend
- Senior medical cover to be present at handover

Comparison: Serial questionnaires of SHOs about their personal views of the handover process
Outcome: Measuring the overall opinion of SHOs along with their confidence in the handover process in ensuring patient safety

Example Template

On duty: 9am-5pm 5pm-9pm 9pm-9am

Date:

Ward 1

New patients

Name & H+C	Background	Presenting issues	Outstanding jobs
Voluntary Detained			Physical Bloods ECG Other:
Voluntary Detained			Physical Bloods ECG Other:

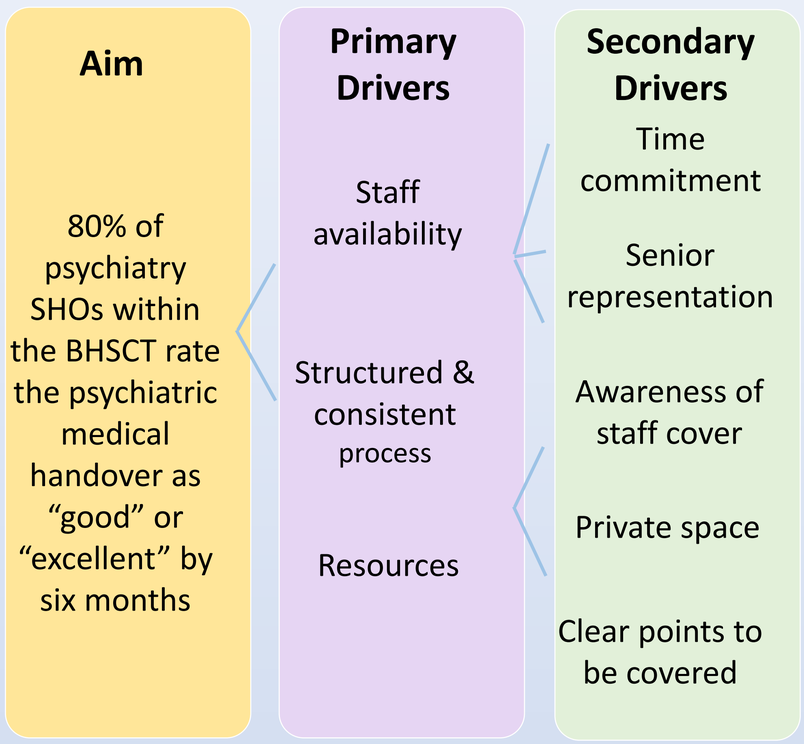
Unwell patients

Name & H+C	Background	Issues	Plan
Voluntary Detained			
Voluntary Detained			

Other Jobs/To be aware

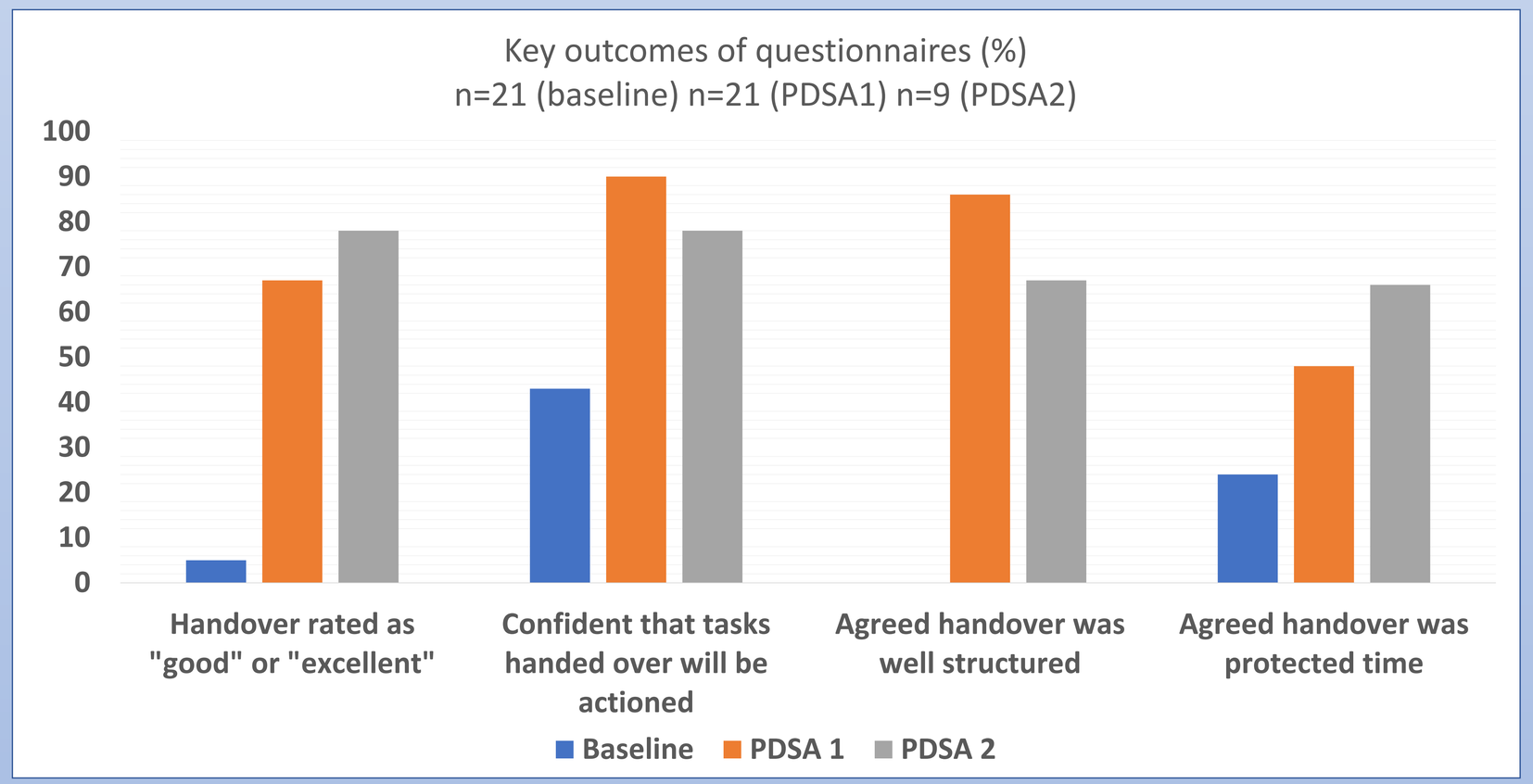
Name & H+C	Background	Jobs/To be aware

Driver Diagram



Results

- 21/29 (72%) response to questionnaires 1&2
- At baseline only 1 person (4.7%) rated the handover process as "good" or "excellent"
- Following our initial interventions this rose to 14 people (67%)
- Confidence that tasks handed over would be appropriately actioned rose from 9 (43%) to 19 (90%)
- Negative feedback focused on the difficulty handing over to the widespread community sites covered out of hours



Adapting project – PDSA Cycle 2

- PDSA cycle 2 reviewed how the template was being used and optimised the layout accordingly. A further page was included to cover the peripheral sites and a morning teleconference was arranged with the busiest peripheral site (CAMHS inpatient unit)
- We also aimed to optimise the handover process at the weekend. Difficulties were noted when staff on a Friday needed to handover tasks to be done on a Sunday (or Monday on a long weekend). This was achieved with a whiteboard on which all jobs for all days of the weekend could be documented and reviewed daily by those on call rather than relying on tasks to be passed on by up to 4 different SHOs.
- The questionnaire to assess these further changes occurred following medical changeover and there was a noted decline in response rate.

Discussion

What are the barriers to a good handover?

- Ensuring protected time and involvement of multiple staff from different sites
- Clear communication of expected handover procedure and ensuring this is done consistently
- Ensuring changes are continued beyond project period, particularly following changeover of staff

Critical Analysis

Limitations

- Involved staff covering a wide geographical area and related practical difficulties of attending handover
- Risk of inconsistent application of handover process following staff changeover
- Paper forms being used for handover which may be lost
- Poorer response rate to third questionnaire which was following staff changeover

Conclusion and Next Steps

Implementing change can be difficult.
Although we have not yet reached our aim of 80% SHO rating the handover as "good" or "excellent", outcomes were significantly improved, particularly after the initial interventions.
Given the importance of a safe and effective handover we will continue to review and further improve the process.
The poorer response to the questionnaire following changeover stresses the importance of persisting with improvements. The handover process will be given more emphasis during the induction for new doctors.
Looking forward we will create a digital, live version of the handover document which will be accessible by all relevant staff via a shared drive. This will improve consistency of use as well as ensure patient data is more secure.