Improving Handover in Obstetrics and Gynaecology Across the Thames Valley

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2014 - 2017

Aims

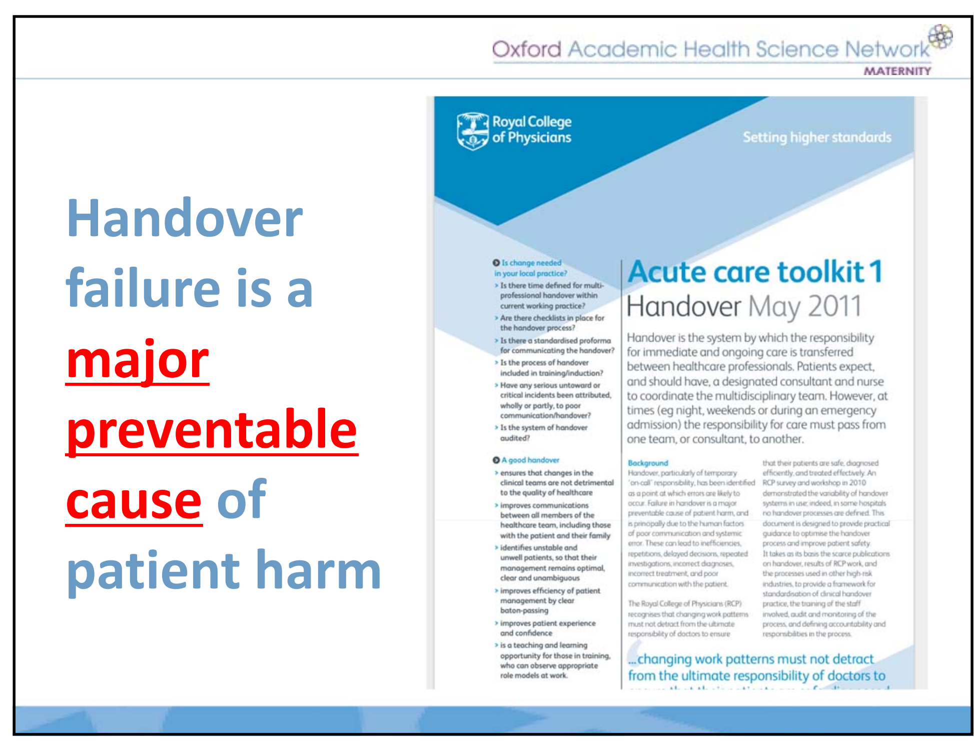
- Importance of handover
- Quality of handover in O & G in Thames Valley
- Overview of quality improvement project
- Raise awareness and share good practice

What is clinical handover?

"A process were there is the **transfer of professional responsibility** and **accountability** for all aspects **of patient care** to another person or professional group"[1]

The importance of good handover

- Pivotal to patient safety [2,3]
- Relays important information (**especially** with **EWTD, shift** working)
- Allows safe continuity of care and improves patient experience
- Opportunity for learning and training



Acute care toolkit 1
Handover May 2011

Handover is the system by which the responsibility for immediate and ongoing care is transferred between healthcare professionals. Patients expect, and should have, a designated consultant and nurse to coordinate the multidisciplinary team. However, at times (eg night, weekends or during an emergency admission) the responsibility for care must pass from one team, or consultant, to another.

Is change needed in your local practice?
- Is there time defined for multi-professional handover within current working practice?
- Are there checklists in place for the handover process?
- Is there a standardised proforma for communicating the handover?
- Is the process of handover included in training/induction?
- Have any serious untoward or critical incidents been attributed, wholly or partly, to poor communication/handover?
- Is the system of handover audited?

A good handover
- ensures that changes in the clinical teams are not detrimental to the quality of healthcare
- improves communications between all members of the healthcare team, including those with the patient and their family
- identifies unstable and unwell patients, so that their management remains optimal, clear and unambiguous
- improves efficiency of patient management by clear baton-passing
- improves patient experience and confidence
- is a teaching and learning opportunity for those in training, who can observe appropriate role models at work.

Background

Handover, particularly of temporary 'on-call' responsibility, has been identified as a point at which errors are likely to occur. Failure in handover is a major preventable cause of patient harm, and is principally due to the human factors of poor communication and systemic error. These can lead to inefficiencies, repetitions, delayed decisions, repeated investigations, incorrect diagnoses, incorrect treatment, and poor communication with the patient.

The Royal College of Physicians (RCP) recognises that changing work patterns must not detract from the ultimate responsibility of doctors to ensure that their patients are safe, diagnosed efficiently, and treated effectively. An RCP survey and workshop in 2010 demonstrated the variability of handover systems in use; indeed, in some hospitals no handover processes are defined. This document is designed to provide practical guidance to optimise the handover process and improve patient safety. It takes as its basis the scarce publications on handover, results of RCP work, and the processes used in other high-risk industries, to provide a framework for standardisation of clinical handover practice, the training of the staff involved, audit and monitoring of the process, and defining accountability and responsibilities in the process.

…changing work patterns must not detract from the ultimate responsibility of doctors to

Bad handover

- Handover is not always taken seriously
- Potentially dangerous for patients and staff
- Risk missing high risk / sick patients

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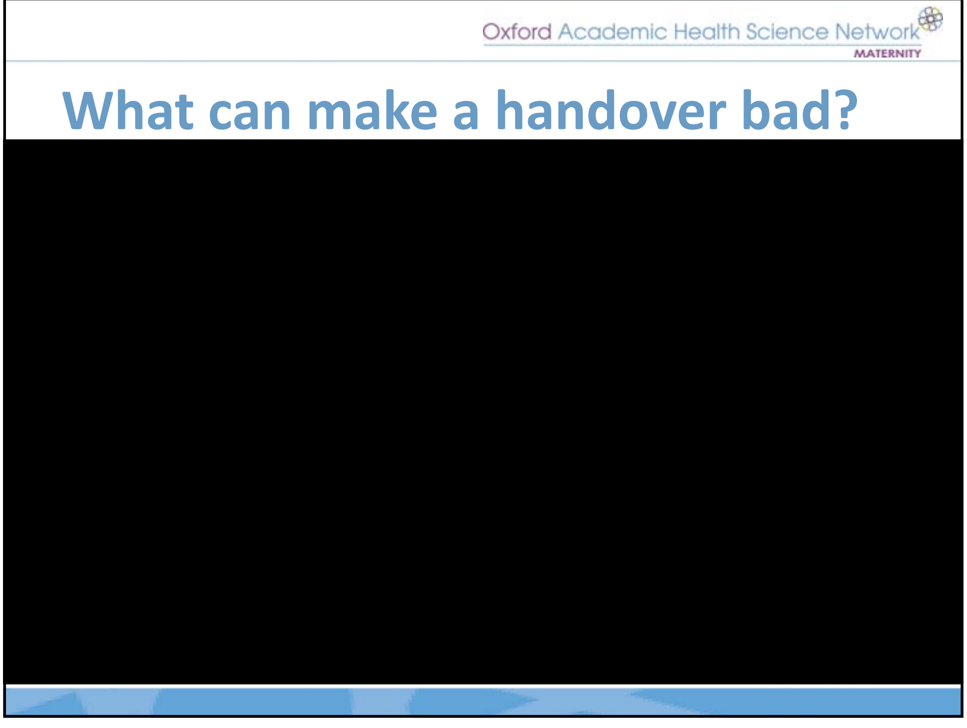
What can make a handover bad?



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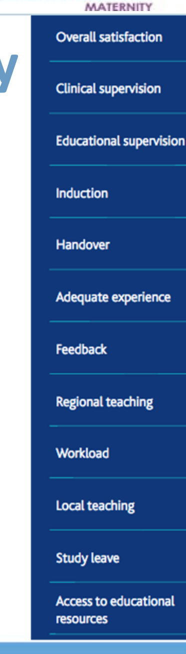
GMC National Training Survey

- Handover is seen as one of twelve essential areas of development required for all doctors in training (GMC)
- GMC national survey asks questions about the format of handover in each unit



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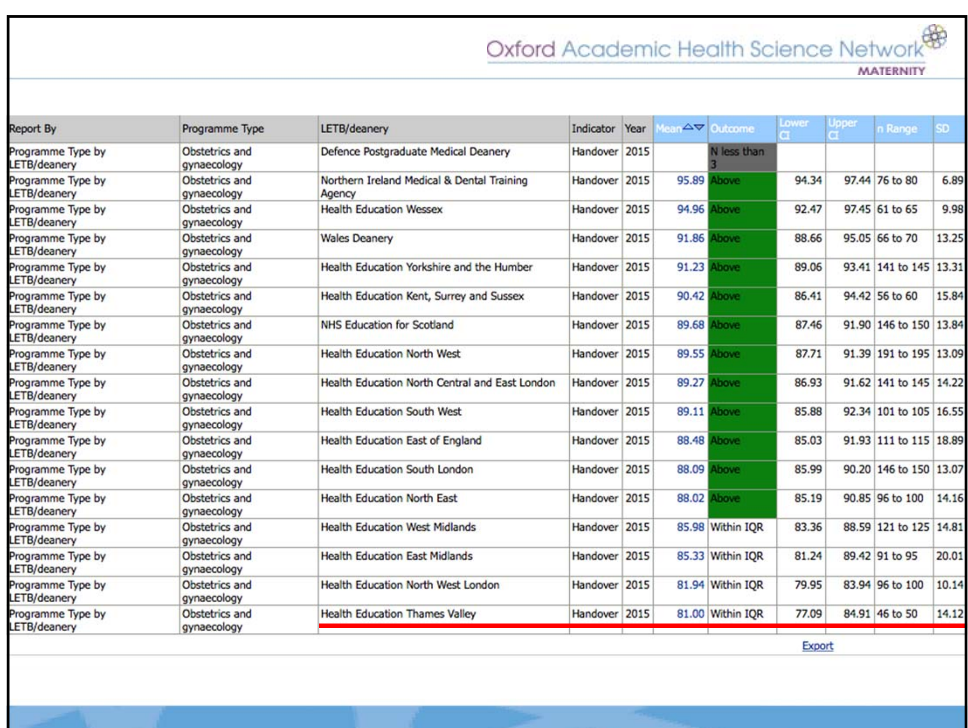
How would you describe handover arrangements in your unit?

- Organised meeting of doctors (separate O&G)
- Organised meeting of doctors (joint O&G)
- Organised meeting of doctors and at least 1 midwife / nurse (separate O&G)
- Organised meeting of doctors and at least 1 midwife / nurse (joint O&G)
- Phone / email handover
- No formal arrangement

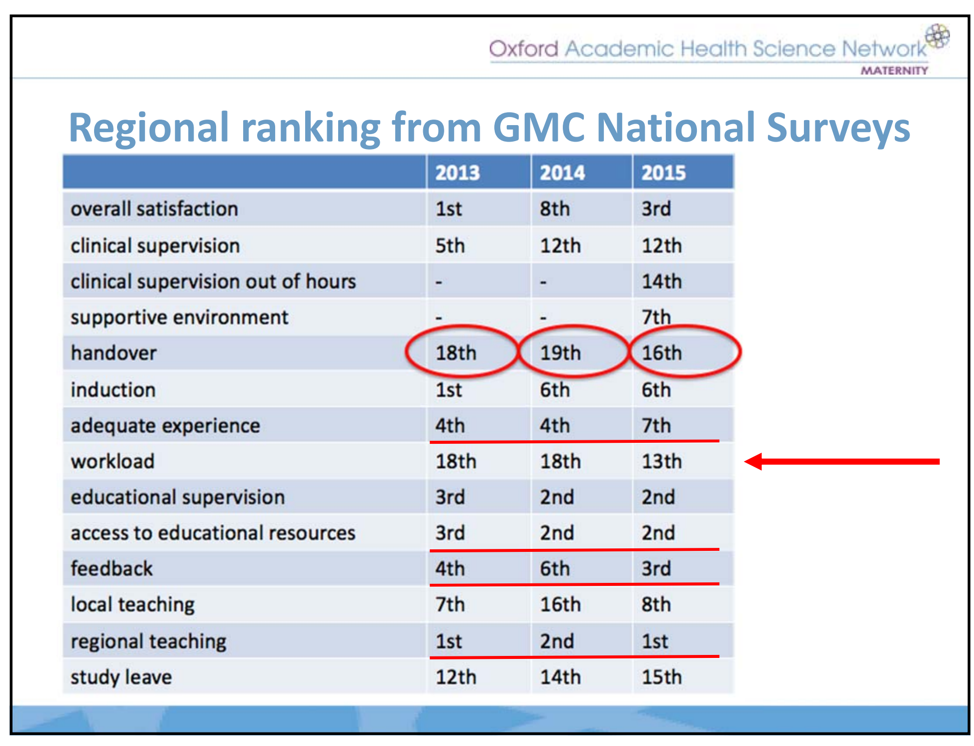
Quality of handover in the Thames Valley

- O&G handover is better than other specialities (GMC survey 2014)
- However, HEETV consistently ranks lowest in handover nationally (GMC national trainee survey 2013 – 2015)
- Handover has not improved despite School Board discussions, inclusion in induction programmes and regional teaching days

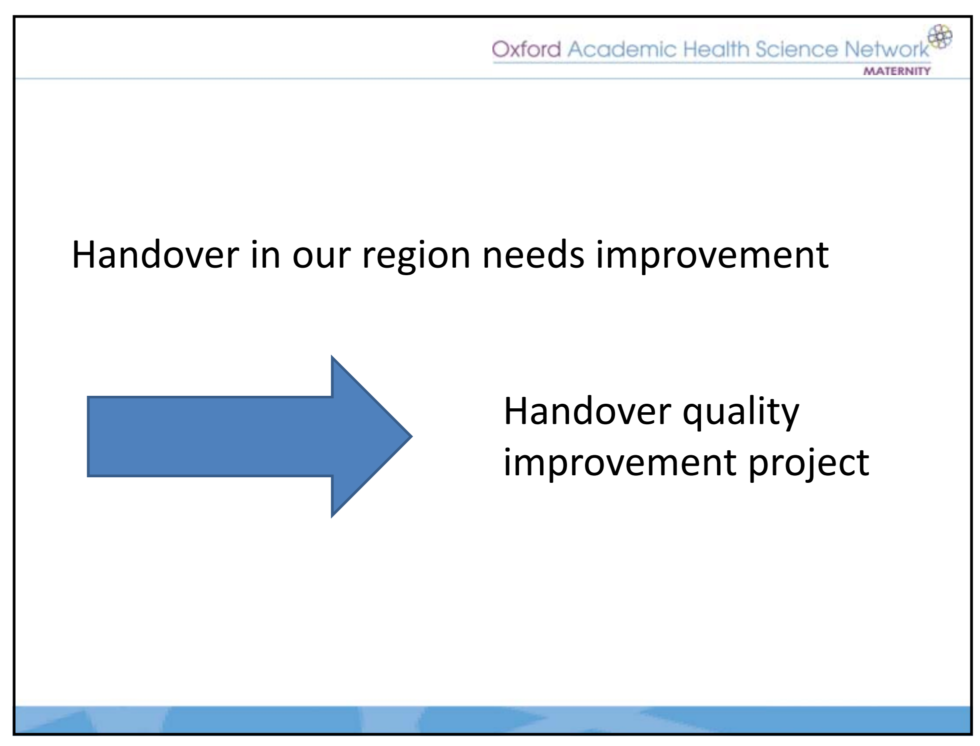


Report By	Programme Type	LETB/deanery	Indicator	Year	Mean	Outcome	Lower CI	Upper CI	n Range	SD
Programme Type by LETB/deanery	Obstetrics and gynaecology	Defence Postgraduate Medical Deanery	Handover	2015		N less than 3				
Programme Type by LETB/deanery	Obstetrics and gynaecology	Northern Ireland Medical & Dental Training Agency	Handover	2015	95.89	Above	94.34	97.44	76 to 80	6.89
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education Wessex	Handover	2015	94.96	Above	92.47	97.45	61 to 65	9.98
Programme Type by LETB/deanery	Obstetrics and gynaecology	Wales Deanery	Handover	2015	91.86	Above	88.66	95.05	66 to 70	13.25
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education Yorkshire and the Humber	Handover	2015	91.23	Above	89.06	93.41	141 to 145	13.31
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education Kent, Surrey and Sussex	Handover	2015	90.42	Above	86.41	94.42	56 to 60	15.84
Programme Type by LETB/deanery	Obstetrics and gynaecology	NHS Education for Scotland	Handover	2015	89.68	Above	87.46	91.90	146 to 150	13.84
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education North West	Handover	2015	89.55	Above	87.71	91.39	191 to 195	13.09
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education North Central and East London	Handover	2015	89.27	Above	86.93	91.62	141 to 145	14.22
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education South West	Handover	2015	89.11	Above	85.88	92.34	101 to 105	16.55
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education East of England	Handover	2015	88.48	Above	85.03	91.93	111 to 115	18.89
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education South London	Handover	2015	88.09	Above	85.99	90.20	146 to 150	13.07
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education North East	Handover	2015	88.02	Above	85.19	90.85	96 to 100	14.16
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education West Midlands	Handover	2015	85.98	Within IQR	83.36	88.59	121 to 125	14.81
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education East Midlands	Handover	2015	85.33	Within IQR	81.24	89.42	91 to 95	20.01
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education North West London	Handover	2015	81.94	Within IQR	79.95	83.94	96 to 100	10.14
Programme Type by LETB/deanery	Obstetrics and gynaecology	Health Education Thames Valley	Handover	2015	81.00	Within IQR	77.09	84.91	46 to 50	14.12

Export

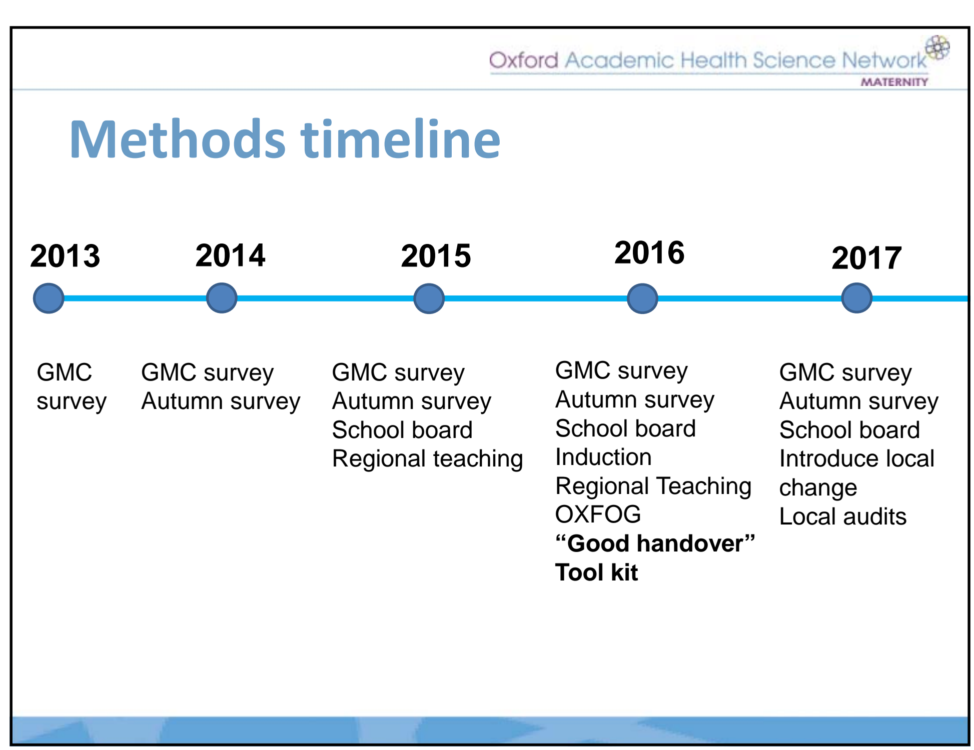


	2013	2014	2015
overall satisfaction	1st	8th	3rd
clinical supervision	5th	12th	12th
clinical supervision out of hours	-	-	14th
supportive environment	-	-	7th
handover	18th	19th	16th
induction	1st	6th	6th
adequate experience	4th	4th	7th
workload	18th	18th	13th
educational supervision	3rd	2nd	2nd
access to educational resources	3rd	2nd	2nd
feedback	4th	6th	3rd
local teaching	7th	16th	8th
regional teaching	1st	2nd	1st
study leave	12th	14th	15th



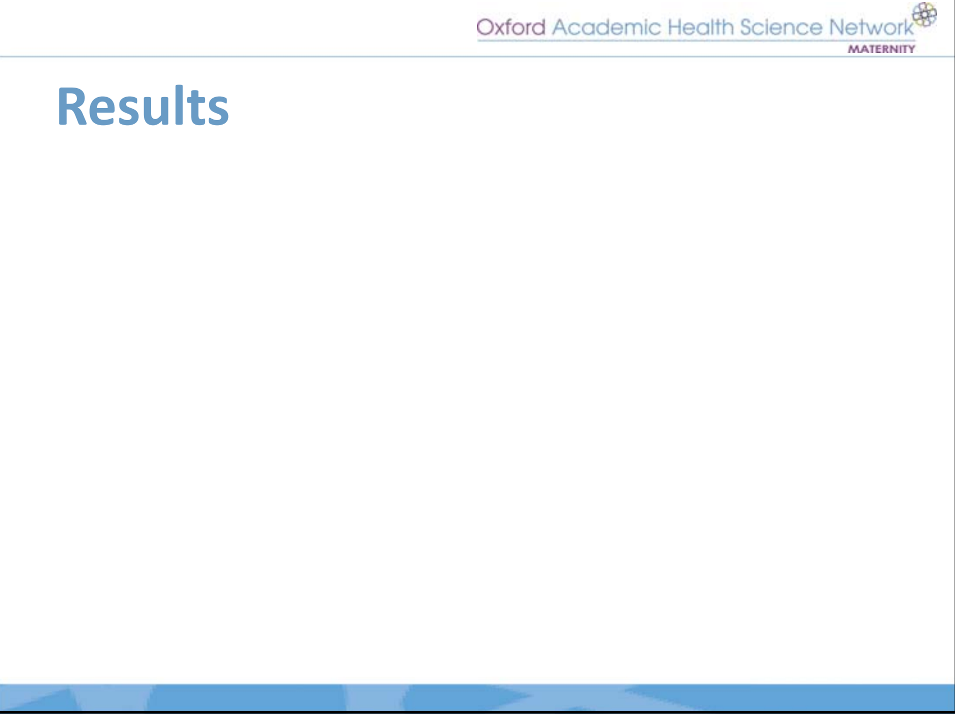
Aims of QIP

- To understand how trainees feel about handover in more detail
- To establish main concerns and identify possible solutions
- To establish what makes a good handover (based on highly scoring units and evidence)
- To implement changes and improvements regionally (initially obstetrics)



Autumn survey questions (2014 – 2016)

- Which of the following best describes your unit's handover arrangements?
- Are all the medical team members present at your handover?
- Is your handover multidisciplinary?
- Is the consultant present?
- Do you use a formal handover tool (SBAR)?
- Do you use printed or electronic sheets?
- Do you feel labour ward, gynae, and antenatal / postnatal ward handover promotes patient safety?
- Do you feel handover needs improvement and if so why?



Demographics

UNIT	2014	2015	2016
Horton	0	1	0
John Radcliffe Hospital	13	27	16
Buckinghamshire NHS Trust	10	9	6
Royal Berkshire Hospital	1	9	9
Wexham Park Hospital	3	9	6
Milton Keynes University Hospital	0	4	8
TOTAL	**27**	**59**	**45**

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Percentage of Trainees who considered handover unsafe?

Clinical area	Labour Ward	AN/PN Ward	Gynaecology
2014	11.5%	21%	14%
2015	14.5%	42.6%	32.5%
2016	12%	37.7%	42%

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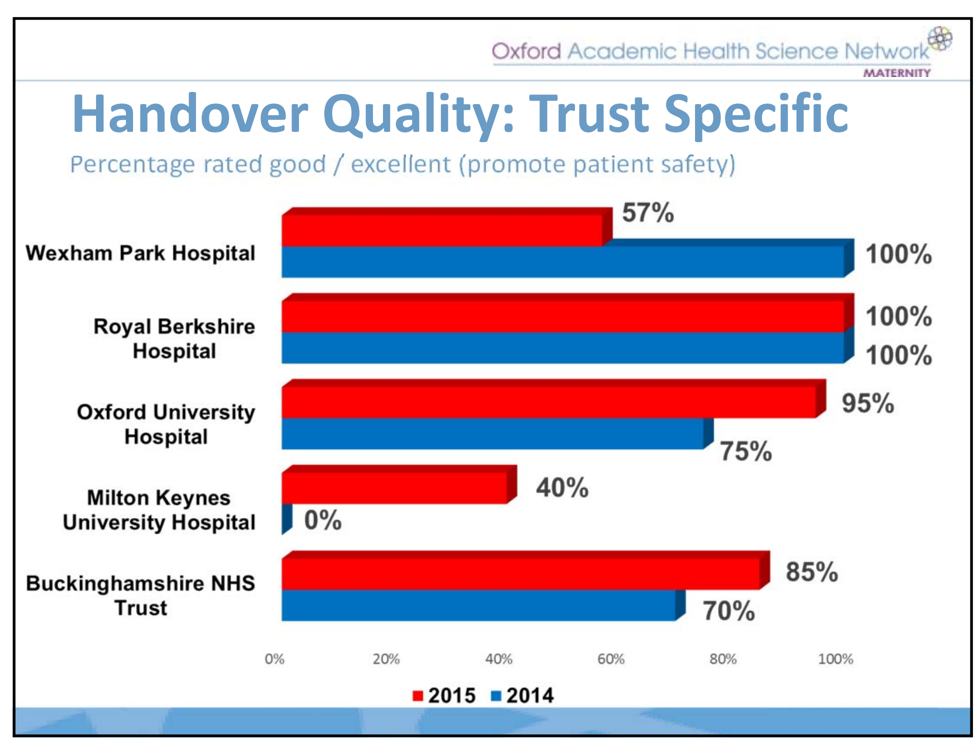
Handover Arrangements

TYPE OF HANDOVER	2014	2015	2016
Organised Meeting of Doctors: Separate Obstetrics and Gynaecology handover	30%	43%	35.5%
Organised Meeting of Doctors: Joint Obstetrics and Gynaecology handover	9%	18%	11.1%
Organised Meeting of Doctors and at least 1 midwife / nurse: Separate Obstetrics and Gynaecology handover	19%	15%	15.5%
Organised Meeting of Doctors and at least 1 midwife / nurse: Joint Obstetrics and Gynaecology handover	42%	24%	37.7%
Phone / email handover	0%	0%	0%



Main Issues: often perceived as "unsafe"

- "Obstetrics superior to gynaecology"
- "Often a staff conflab rather than a patient centred"
- Consultant not always present and not MDT
- Frequent interruptions (bleeps, phone, prescriptions, chatting)
- Overly length and often not in "working time" for staff
- Inappropriate use of language (when describing challenging women)
- Lack of formality, seriousness and respect for process

Good practice

- Trainee suggestions (2014 – 2016)

Units / regions deemed "good" or "excellent" at handover

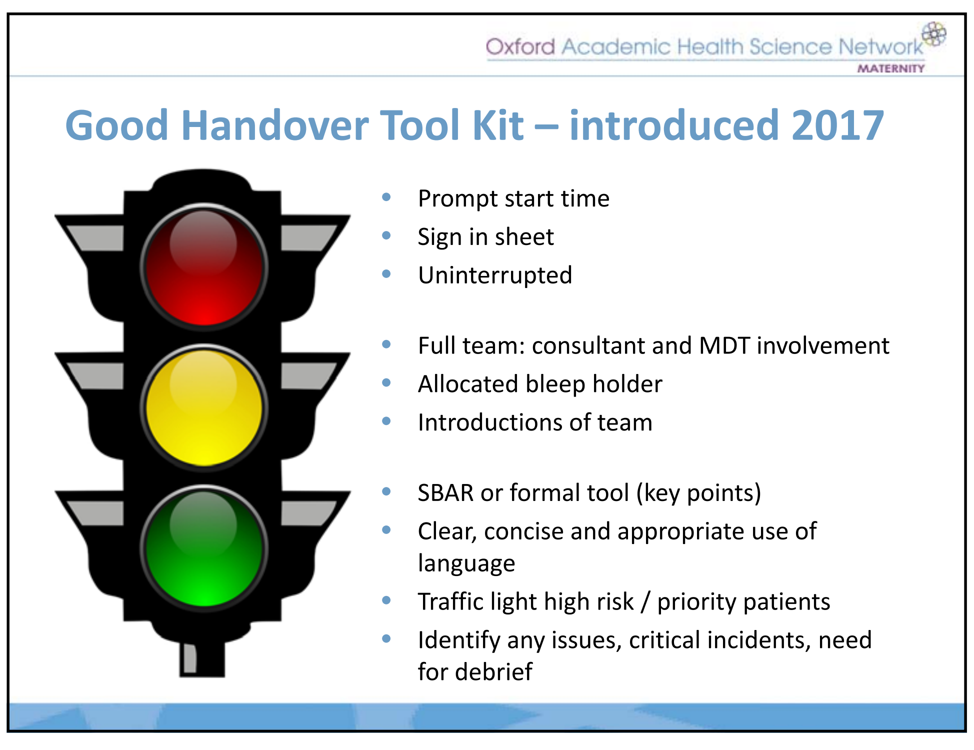
- Royal Berkshire NHS Trust trainees
- Wessex Region trainees

Royal Berkshire Hospital – 1st in HEETV

- Two daily handovers (08:00 and 20:00)
- Prompt start and formal process
- MDT (obstetricians, anaesthetists, midwives)
- Consultant presence mandatory
- High risk / priority patients highlighted
- Printed sheets for gynaecology handover (yellow sheet)

Wessex (4 units) – 2nd position nationally

- Electronic / written sheet **100%** (*74 – 86%*)
- Multidisciplinary **100%** (*52%*)
- Sign sheet and absences at handover recorded **75%** (*0%*)
- Minimal interruptions (phones, bleeps diverted, signs) **87%** (*0%*)
- High visibility vests / lanyards for on-call team **100%** (*0%*)
- Formal tool used SBAR **77%** (*69%*)



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Local Audit Results 2017

	OUH	MK	WPH	BUCKS
Average time to handover	15 mins (reduced from 30)	23 mins (reduced from 38)	Not yet recorded	20 mins (reduced from 30)
Improvements made	Prompt start time Consultant and MDT Improved language	Sign in sheet Prompt MDT	Introductions High-risk identified MDT	Prompt start time Formalised (introductions, SBAR, MDT) Sign in sheet
Improvements required	Sign in sheet Mimise interruptions Combine obs & anaesthetics	Reduce time to handover Minimise interruptions	Prompt start time Lateness Minimise interruptions	Gynae handover to be improved
Shared learning	Consultant presence and a prompt start time made it more efficient	Discuss important issues affecting the team after handover	Antenatal workload and high risk patients being discussed Sign in sheet	Encouraged a non-urgent bleep/phone free zone between 8-9 Reduce the number

Limitations to implementing certain changes

- Unable to prescriptive
- Unable to standardise process fully as there are local unit differences
- Shared MDT handover not practical (different working times)
- Electronic or sheets (do not have infrastructure to support this)

The future – a need for change of culture

- Raise awareness for the need to improve handover
- Introduce a regional approach to good handover
- Consider common transferable themes to raise standards (AHSN SOP)
- Encourage units to individualise their approach (share successes)
- Lets continue the conversation and make further improvements

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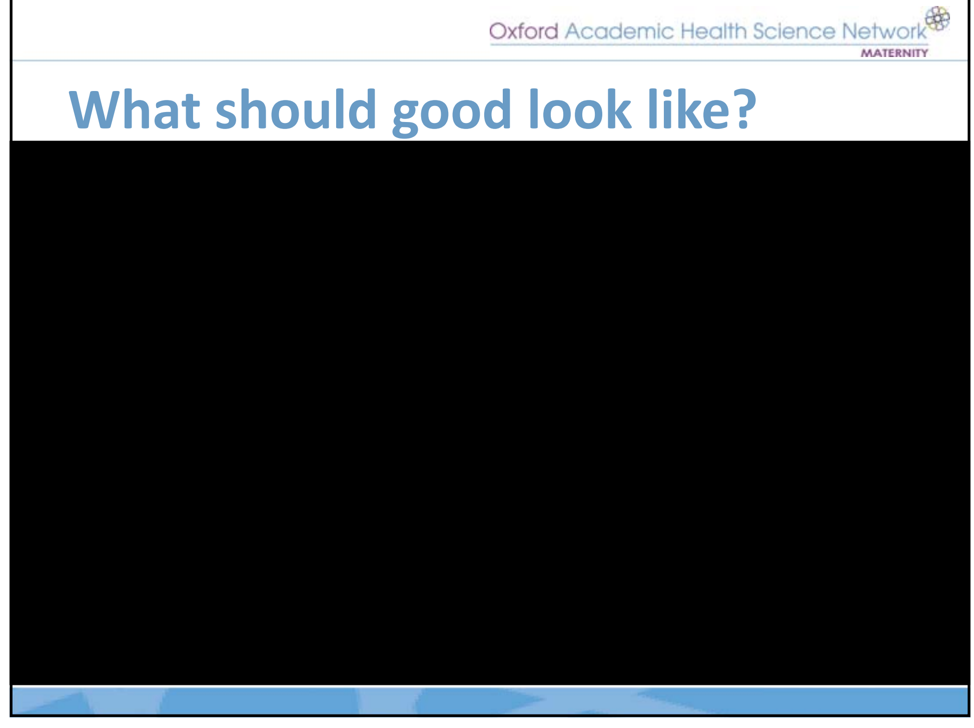
What should good look like?



References

- National Patient Safety Agency (NPSA), Seven steps to patient safety (London, 2004)
- The Royal College of Surgeons of England (RCSENG), Safe Handover, (London, March 2007)
- The Royal College of Physicians (RCP), Acute Care Toolkit 1: Handover (London, May 2011)
- GMC National Training Survey Reports 2013 - 2016

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Thank you
Questions