



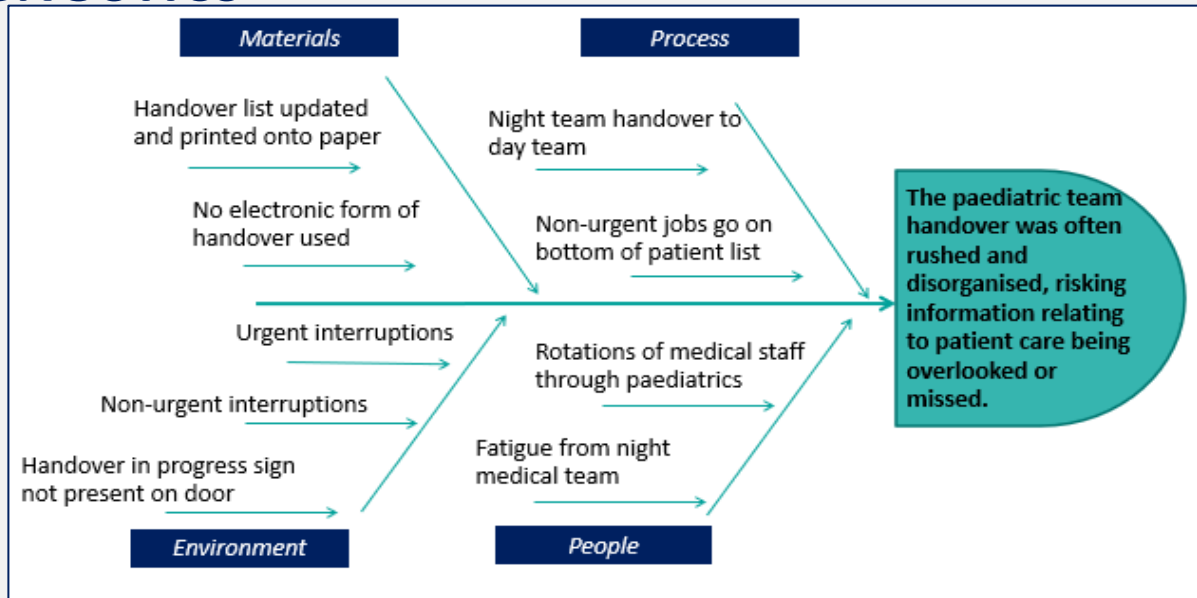
Improving the quality and safety of the paediatric team handover

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BACKGROUND

Guidance on clinical handover states that handover of care is one of the most perilous procedures in medicine and can be a significant contributory factor to subsequent error and harm to patients if done improperly. Following a local departmental paediatric quality and safety meeting in June 2020, concerns were raised about team handover; it was often rushed and disorganised, risking information relating to patient care being overlooked or missed.

DIAGNOSTICS



AIM

To assess and improve the quality and structure of daily team handovers on a paediatric ward from July to September 2020.

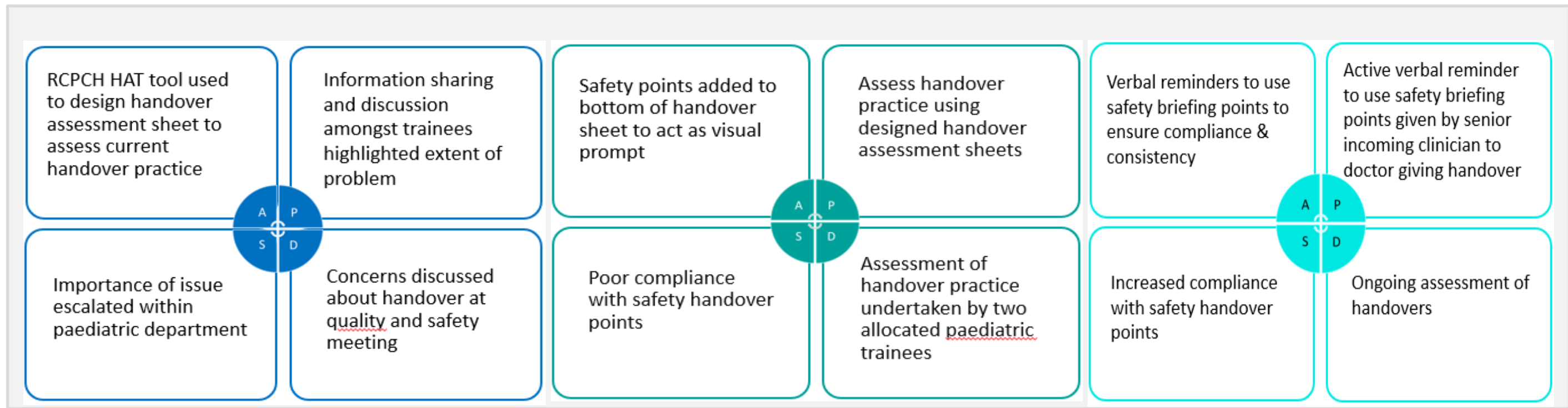
MEASUREMENT

Handover practice was assessed regularly by two individual paediatric trainees to obtain baseline measurement of compliance with key handover points as directed by the RCPCH handover assessment tool.

CHANGE IDEAS

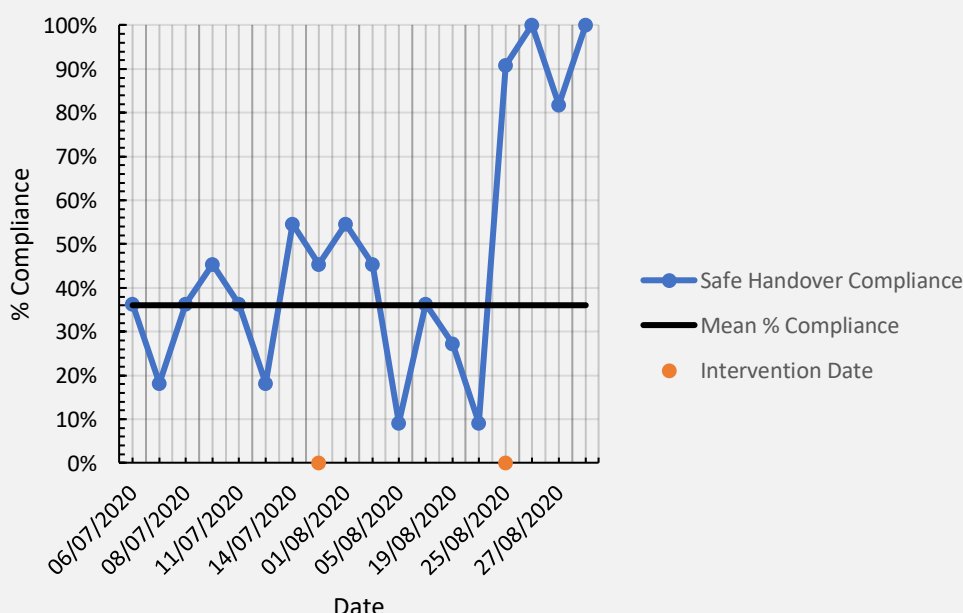
- Design handover assessment sheet to informally assess content & structure of daily handovers
- Share extent of problem with medical team at regular quality & safety meetings
- Add safety points to the bottom of the handover list to act as a visual prompt, comprising key areas:
 - **safety briefing** (sick/deteriorating patients, high risk therapies, similar names, safeguarding), **ward management** (staffing levels, bed status), **interesting/complex cases**.

PDSA cycles



RUN CHART

Safe Handover Compliance



RESULTS

- Baseline measurement showed a median percentage of 36% with safe handover points
- Following the addition of safety briefing points to the bottom of handover lists, compliance increased to 45%, and then 95% following a verbal reminder to use them

CONCLUSIONS & REFLECTIONS

- Assessing several factors within the paediatric team handover was an ambitious task.
- Introducing safety briefing points at the bottom of the handover lists helped to provide a structured handover and ensured that the team were well informed when sharing the care of patients.
- It was difficult to maintain consistency and standards with the rotational nature of staff and emphasis on the use of the safety briefing points may often be needed when transferring clinical responsibility.

References

- Safe handover: safe patients. Guidance on clinical handover for clinicians and managers, BMA.
- RCPCH Handover Assessment Tool