Improving handover and escalation of patients outside of neonatal units

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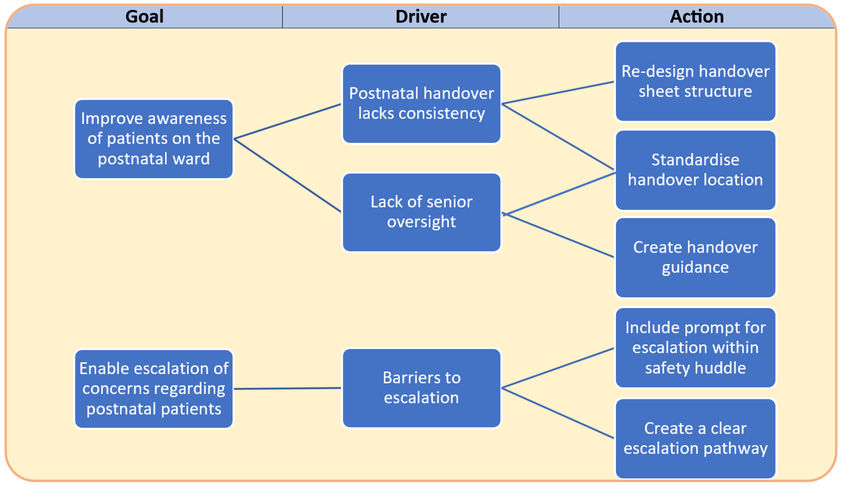
Background:

Effective handover of patients is crucial in healthcare, and effective communication between teams is critical to ensure patient safety and quality of care[1]. Handover of postnatal patients is often undertaken between junior members of staff separate from the handover of patients on the neonatal unit. This presents barriers to senior awareness and effective escalation of these patients. This project aimed to improve handover and escalation of postnatal ward patients by implementing targeted interventions.

Methods:

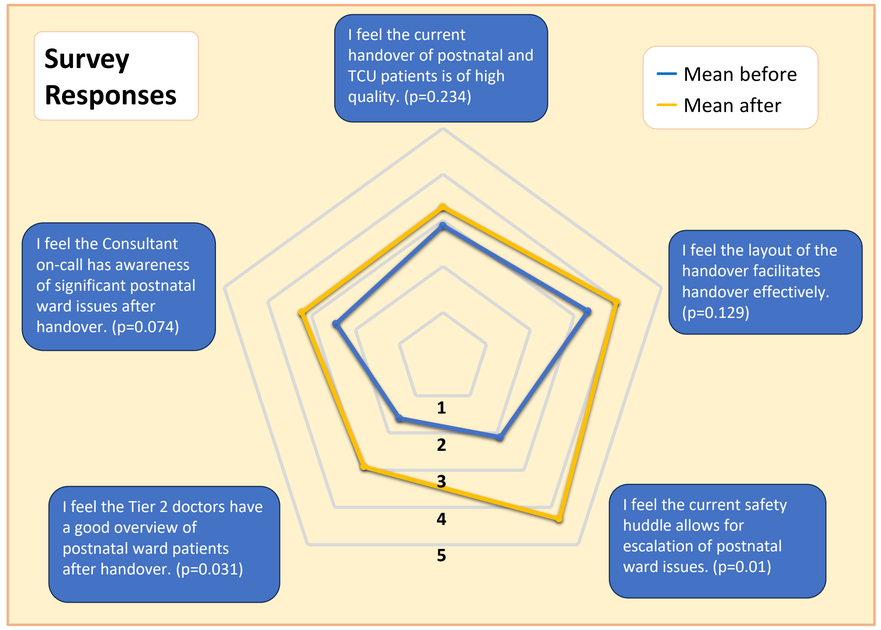
The project was conducted using Plan-Do-Study-Act (PDSA) cycles. Interventions included embedding a prompt specifically for escalation of postnatal ward patients within the existing safety huddle, standardizing the location, documentation, and staff involved in handover, and creating a clear pathway for escalation of concerns. The service was evaluated using questionnaires to assess staff perceptions of handover and escalation.

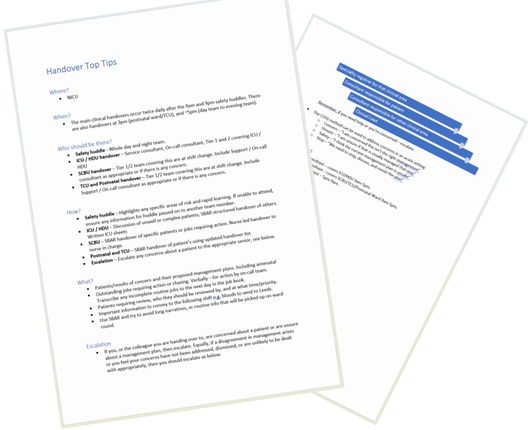


Measures:

The handover perception survey was used to measure staff perceptions of handover on the postnatal ward. Process measures included: the perceived quality of handover, format of the handover, perceived opportunity to escalate patients, and perceived awareness regarding postnatal ward patients of senior staff.

Acknowledgements:
Thank you for the support and cooperation of the all the staff involved in the care of newborns in Bradford during this project.





SOP for handover and escalation of patients cared for by the neonatal team in different areas.

An example of the twice daily MDT Safety huddle which includes ward clerks, pharmacists, the nursing team, and the medical team for all patient areas.

Data/Results:

The project yielded a moderate improvement in staff perceptions concerning the quality of the handover process, the layout of the handover, and the awareness of postnatal ward patients by consultant staff (14% (p=0.23), 20% (p=0.13), 32% (p=0.08)). Notably, a substantial improvement was observed in the perceived opportunities for escalating concerns and the awareness of post-handover patients by Tier 2 doctors (104% (p=0.01), 81% (p=0.03)).

Discussion:

The interventions implemented in this project resulted in improvements in staff perceptions of handover and escalation of patients on the postnatal ward. The success of the project was due to engagement of staff and building upon already established processes and behaviours within the department. The next steps in the project include further PDSA cycles to address areas of non-significant improvement such as the quality of postnatal handover and consultant awareness of patients, assessing the impact on patient outcomes, and disseminating our experience to other units.

References:
1. Smaggus, A., & Weinerman, A. S. (2016). Handover: The fragile lines of communication. Canadian Journal of General Internal Medicine, 10(4).