The EWTD & Clinical Handover

DEBBIE DUPONT
PROJECT MANAGER
SALISBURY HANDOVER SYSTEM

With support from
The EWTD Effect
Sunday Times October 11th 2009
A series of “Avoidable Deaths”

- Information about an obstruction had not been passed on from one junior doctor to the next when they changed shifts.
- Information about a patient’s medical condition had become confused in handovers between specialist registrars.
- A patient underwent surgery as instructions were not passed on to the next shift.
- An emergency operation for a hernia was not handed to the next shift and the patient became “lost” in the hospital for 3 days.
What is Handover?

**BMA/NPSA (2004)**
The transfer of professional accountability as well as responsibility

**Royal College of Surgeons (2007)**
Handovers aim to convey high – quality and appropriate clinical information to incoming healthcare professional to allow the safe transfer of responsibility for patients

**OSSIE (2008)**
The transfer of professional responsibility for some or all aspects of care for a patient or group of patients, to another person or professional group on a temporary or permanent basis.

**Salisbury Foundation Trust**
The safe, effective, efficient and robust transfer of patient care from one individual or team to another individual or team
“Multiples handovers are inherently unsafe. Every handover is an accident waiting to happen”
John Black  President of the Royal College of Surgeons
October 2009

“Handover of patient care from one professional or team to another is one of the very high risk transactions of health care services”.
Royal College of Physicians : A Clinicians Guide to Record Standards (Part 2) 2008

NCEPOD  Caring to the End? Nov 2009

Better system of handover must be established including high quality legible medical record keeping.

Systems of communication between doctors and other health care professionals must improve.
THEY SAID WE HAD TO LISTEN MORE AND IMPROVE OUR COMMUNICATION SKILLS...

SPILLS WHAT SPILLS?

HE SAYS HE'S FORGOTTEN HIS PILLS!

BMA TOLD TO 'RADICALLY OVERHAUL' COMMUNICATIONS
Multiple surgical specialities looked after by a small team of people who are much less likely than before to know any of the patients ...and may have very little experience in that speciality

Knowledge from 6 medical teams being handed to two people with the risk of much information being lost
The Old Culture
Supporting evidence
Some Handover Components

- Multi-professional & formal
- Who, when & where
- Focused and structured – Identified Lead
- SBAR methodology
- Deteriorating / unstable / sick patients
- Urgency of review
- New admissions & those needing to be seen
- Potential problems
- Escalation/contingency plans
- Outstanding tasks – These are NOT handover
- Comprehensive and efficient
- RECORD KEEPING – vital. Electronic system recommended
### Demographics taken from PAS

### Admission Date & Post op date/days

### Diagnosis & PMH

### Bloods Past and future

### Risk Alerts Complications/Events

### User Audit trail

### Results Reporting Link

### External Transfer or Discharge

### Update/amend

### Weekend Task List

### Outlying patient numbers/view filter

### H@N Alert

### Location

### Named Consultant(s)

### Management Plan

### Outstanding Actions

### Risk Alerts

### Complications/Events

### Diagnosis & PMH

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<thead>
<tr>
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<tbody>
<tr>
<td>Anamury Suite A2</td>
<td>Aaron CABAN</td>
<td>Tanner</td>
<td>02/03/2023</td>
<td>Cervical injury</td>
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<td>Adm</td>
<td>Op</td>
<td>Diagnosis</td>
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<td>H</td>
<td>Amesbury Suite</td>
<td>Aaron CABAN</td>
<td>Tanner Dunn</td>
<td>19/09/2009</td>
<td>19/09</td>
<td>27/09/09 anterolateral flap from R thigh to L arm (sustained crush injury L arm on 19/09/09) OSA - CPAP at night</td>
<td>CCOT to oversee sleep apnoea</td>
<td>CPAP for sleep apnoea</td>
<td>elevate on 2 pillows Dalitaparin</td>
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<tr>
<td>W</td>
<td>Britford Ward 2.1</td>
<td>Aaron ATWILL</td>
<td>Finneran Henderson</td>
<td>29/09/2009</td>
<td>R Renal colic</td>
<td>CT scan OABs</td>
<td>Book CT scan</td>
<td>Fluids only</td>
<td>Cellulitis</td>
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<tr>
<td>H</td>
<td>Downton Ward 1.2</td>
<td>A ROBERT MA</td>
<td>Tanner Page</td>
<td>29/09/2009</td>
<td>05/10</td>
<td>Cholecystitis US - thick walled GB, sorts LFTs normal IDDM</td>
<td>Lap Chol 3/8 Reason for H@N Involvement Unstable diabetic</td>
<td>SSinsulin 1hrly BMs NMB</td>
<td>29/09</td>
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<tr>
<td>H</td>
<td>Whiteparish Ward 3.6</td>
<td>A J K TAPSTER</td>
<td>Finneran Henderson</td>
<td>18/08/2009</td>
<td>Likely ca lung Obstructive jaundice likely pancreatic malignancy Abdo USS mass head of pancreate recent wt loss Loss of appetite</td>
<td>ERCP pm today Reason for H@N Involvement Not for active resus - patient and family agreement</td>
<td>Palliative care referall</td>
<td>SW for discharge IVI NMB Mobilise with stick and assistance Fax 1</td>
<td>18/08</td>
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</table>
Please complete the following before adding to the H@N list

Select a H@N Option

- [ ] H@N Team to be aware
- [ ] H@N Team to review

When To Review This Patient

- [ ] Review times not selected

Lap Chol 3/8
Reason for H@N Involvement

Please select a review time

Add to H@N list  Cancel
Information is transported From Cons/Day List

Quick link to Day Lists

Urgency of review

Printable according to user requirement

Update/amend

Results Reporting

Reason for Referral
### Cardiology

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<th>Ward</th>
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<th>Blood</th>
<th>Handover</th>
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<td>29/09</td>
<td>REVIEW</td>
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<td></td>
<td>12/02/1973</td>
<td>0600014</td>
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<td></td>
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<td>IDDM</td>
<td>30/09</td>
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### Trauma & Orthopaedics

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<tr>
<th>VTE</th>
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<td>Whiteparish Ward 3.6</td>
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<td>Finneran Henderson</td>
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<td></td>
<td>ERCP pm today Reason for H@N Involvement</td>
<td>Likely ca lung Obstructive painfull jaundice likely pancreatic malignancy Abdo USS mass head of panceas recent wt loss Loss of appetite</td>
<td>18/08</td>
<td>AWARE</td>
<td>4 - 8 hrs</td>
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<td></td>
<td></td>
<td>06/09/1953</td>
<td>0600123</td>
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### Plastic Surgery

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<tbody>
<tr>
<td></td>
<td>Amersbury Suite A2</td>
<td>Aaron CABAN</td>
<td>Tanner Dunn</td>
<td>19/09</td>
<td>19/09</td>
<td>CCOT to oversee Reason for H@N Involvement CPAP</td>
<td>27/09/09 anterolateral flap from R thigh to L arm (sustained crush injury L arm on 19/09/09) OSA -CPAP at night</td>
<td>19/09</td>
<td>REVIEW</td>
<td>2 - 4 hrs</td>
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<td></td>
<td></td>
<td>02/03/1973</td>
<td>0600101</td>
<td></td>
<td>21/09</td>
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<td>21/09</td>
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Outcomes

- Sick patients clearly identified
- Care guidance via management plans
- Early medical awareness
- Priority of review = timely assessment
- Relevant information = Review by right person
- Reduction in risk of data input error
- Central database = ↓ in lost information
- Patients are visible not “lost”
- ↓ Risk of misunderstood information
- Information sharing = continuity of care
Measurable Achievements

- Saving Junior doctors time
- Virtually 100% attendance at handover
- Staff feedback and continued compliance = sustainability
- Handover risk reduced on Trust Risk Register
- Clinical Governance and Data Protection met (24 hour access)
- Inter-professional sharing of information
- No major system changes required
- Generic, easy implementation, seamless integration
- Successfully installed in other Trusts
Measurable Achievements

13% compliance ↑ 98% identifying sick patients at handover prior to night shift

Staff relying on handwritten notes to support verbal handover have an IT system enhancing safe, effective and efficient handover between individuals & teams Trust wide 24/7
Educational Elements of a Good Handover

- Advanced communication skills
- Leadership & Facilitation
- Structure / process
- Key principles for safe handover
- Recognition of an “At Risk Patient”
- Clinical Governance & Data Protection
- Multidisciplinary team working

Royal College of Surgeons:
Achieving an effective handover is the duty of every doctor. It is also a skill that needs to be taught, learned, practiced and developed.
Escalation

Early Warning Scoring System:

Links with the Track and Trigger escalation pathway

- Abcess
- Appendicitis
- Non-peritonitic cholecystitis and biliary colic
- Diverticulitis
- Reducible hernia with no evidence of strangulation
- Po bleeding (haemodynamically stable)

- Acute pancreatitis
- Small bowel obstruction
- Large bowel obstruction
- EWSS > 3
- A rise in EWSS > 2

- Trauma cell
- Haemodynamically unstable patient
- Ischaemic limb
- Peritonitis due to any cause
- Suspected aortic abdominal aneurysm
- Irreducible hernia
- Strangulated hernia
- EWSS > 5

Can be managed by the H&N team

SpR/ST must be informed

SpR/ST must assess the patient
Monday – Friday
5pm
Verbal Handover from out-going teams to on-call SHO

Sick patients listed on the H@N system by out-going teams (5pm)

5- 8:30pm
H@N IT system updated by on-call SHO

8:30 pm
Verbal handover of sick patients by T&O SHO to H@N team supported by the H@N list

8am
T&O SHO takes verbal handover from H@N Team

Saturday & Sunday
8am
T&O SHO takes verbal handover from H@N Team

SHO discusses Management plan for sick patients listed on the H@N IT system with on-call SpR/Consultant

During the day
SHO/SpR update H@N IT system

8am
T&O SHO takes verbal handover from H@N Team

Trauma Meeting
SHO feedback overnight events supported by H@N List

NB
Every stage of this process is Underpinned by the EWSS Escalation flow chart
A Voyage of Discovery

- Lack of understanding both medical & nursing staff
- Nursing handover was on a pedestal
- Need to apply same principles
- Development of risk tool
- Return to Bedside Handover
Challenges We Met

- Implementing handover system within all specialties
- Meeting needs of different clinical groups
- Supporting shift and rota changes
- Embedding system use into Trust culture
- Sustainability

Your Challenges

Ask yourselves 2 questions

1. Are you confident that good quality handover is occurring routinely in your organisation?

2. Can you demonstrate to an external monitoring agency that your organisation has good quality handover? (Dr Andrew Gibson)
HANDOVER IS NOT A CHOICE.

It is all about communication but it is dependant on personal **accountability** and personal **responsibility** to ensure our patients come to no harm when under our care whether as an individual or a team.
"I hope you don't mind me bringing a few medical students in to see you."