Hospital at Night and Handover Policy v1.0

Summary of proposals:

Immediate

Handover to progress according to agenda

Handover from day to night to move to earlier time of 21:00 to enable completion within shift

Introduce night to day handover within speciality during the routine week

Introduce night to day across specialities handover at weekend.

Use IT solution (CRS 24/7list) to create handover record

For the future:

Work to align shifts of junior doctors

Move to involve consultants in leading handover

Handover Policy at Kingston Hospital

July 2011

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1.Background and Introduction

Handover can be defined as the transfer of professional responsibility and accountability 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 (National Patient Safety Agency). The importance of doing it well is rather self evident and recognised by a number of organisations such as the NPSA and GMC (below):

"Handover of care is one of the most perilous procedures in medicine, and when carried out improperly can be a major contributory factor to subsequent error and harm to patients. This has always been so, but its importance is escalating with the requirement for shorter hours for doctors and an increase in shift patterns of working."

Professor Sir John Lilleyman
Medical Director
National Patient Safety Agency

"Effective communication lies at the very heart of good patient care. The General Medical Council recognises this and in its publication *Good medical practice* makes clear the expectation that doctors will 'keep colleagues well informed when sharing the care of patients'. The changing face of medical practice – and particularly the introduction of shift working – makes that requirement more important than ever.."

Professor Peter Rubin
Chairman of Education Committee
General Medical Council

The fundamental aim of any handover is to achieve the efficient transfer of high quality clinical information at times of transition of responsibility for patients. As alluded to in the above quotes current working practices threaten continuity of patient care. In particular the implementation of the New Deal and European Working Time Directive for doctors in training has forced change in the way that the medical workforce is organised in the UK. As a consequence full shift rotas have become the norm in many acute care settings and different teams will be looking after the same group of patients over the course of any given day. Further a doctor may have no day-to-day contact with the patients they are responsible for in the out-of-hours period.

As a consequence of these changes, robust handover mechanisms are now of the utmost importance for patient safety.[1]

Good handover does not happen by chance. It requires organisation, coordination of shifts and leadership. The priority is patient safety and handover requires the exchange of sufficient and relative information to ensure this. Information technology support is essential

Finally good handover benefits both patients, through safety and through decreased repetition as well as doctors through developing communication skills, reduction in stress through allocation of support and help with decision making and through improved job satisfaction from a job well done.

2. Aims and Objectives

This policy aims to ensure:

- Reliable, confidential and appropriate transfer of patient information from one medical shift to another.
- An awareness of the unwell or at risk and new admissions to one's specialty for discussion
- Teams are informed of new admissions and changes to inpatients overnight.

3. The current state of handover at Kingston:

Handover as recognised in the above document needs to occur at every transition of responsibility for our patients. In common with all hospitals handovers occur on many levels at many times during each day and between different groups of staff.

A formal Hospital at Night handover is well established at Kingston. It fulfils many of the criteria for good handover as it occurs in protected time in a location close to the areas of work and comprehensively covers patients across specialities who are of concern as well as those in the process of being admitted. Handover is currently lead by the medical registrar as the most senior medical member of the team on site at that time and it is attended by members of the medical, surgical and hospital site practitioner teams, though principally it is the medical teams who attend. The latter reflects the dominance of medical issues across specialities, though to an extent the timing of handover, whilst optimal for medical team handover is less favourable to the surgical shifts. Whilst the handover functions well there are areas that can be improved, principally there is no register and no formal handover of bed state issues, the handover is patient safety lead but does dwell on task handover to a certain extent. Handover tends to over-run beyond the 30mins allocated beyond employed shifts and there is no use of IT with tasks carried on a variety of paper or excel based lists. Furthermore due to the issue related to shifts and perhaps also a lack of perception of relevance attendance by the surgical teams is poor.

Most importantly whilst there is robust handover between day and night teams there is no formal multidisciplinary handover between the night and incoming day teams. Within the surgical specialities there is handover of information at the orthopaedic and trauma meetings and within medicine informal task and information communication occurs at the change of shifts and bleeps. There is further an awkward handover between an early oncall medical F1 who takes the ward bleep and hands-over to the oncoming day team.

4.0 Suggestions and proposals to improve Handover practices at Kingston:

These follow the suggestions for good handover from the BMA junior doctors committee guidance on handover (1)

Who should be involved?

Medical Consultant (future-see below)
Medical SpR
Medical SHOs (take)
Medical ward cover
Surgical SpR (for the future)
Surgical SHO
ITU SHO
Night Nurse Practitioner

Juniors of the relevant specialities who currently attend should continue to do so, principally the outgoing and incoming medical and surgical teams covering the inpatient and oncall load. ITU involvement is highly desirable as it improves communication and decision making for the most unwell patients within the hospital and has the potential to improve timely discharge and admission in and out of the unit by linking the referring and receiving arms of the process. The Advanced Site Practitioner has knowledge of bed state pressures and management issues.

Nationally it is proposed that daily involvement of the most senior clinicians is essential. This ensures that appropriate level management decisions are made and that handover forms a constructive part of medical education conveying the seriousness with which the organisation takes this process. As such it is desirable and therefore a recommendation that future plans for improving handover should move to include the consultant body. Other changes to working practise will aid this transition-see below.

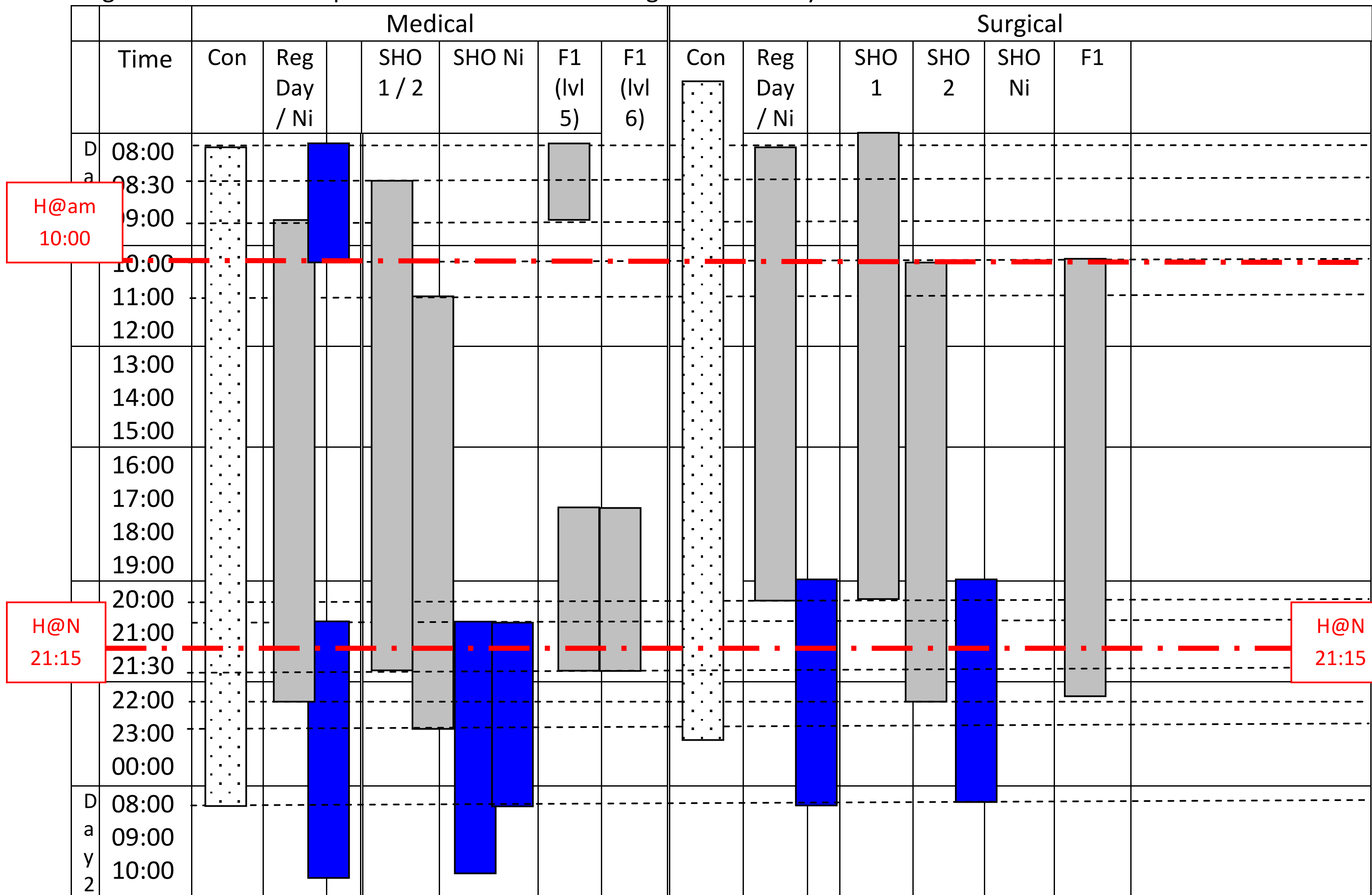
When and where?

Handover needs to occur whenever there is a need to transfer information about patients. Whilst the hospital at night handover is well established, changes in responsibility occur at other times and in particular there is a need to replicate robust handover for the transition between night and returning or oncall day teams at weekends and bank holidays in particular.

The current shift patterns of work for the junior doctors is shown below (figure 1.).

Weekend patterns are not shown as they are not significantly dissimilar to the weekday shifts and encompass the current and proposed handover times. They are however described below the table*.

Figure 1. Current Shift patterns for medical and surgical teams July 2011



*At a weekend the shifts for medicine day F1 and SHOs are one shift of 8 to 8 and one of 8:30 to 21:30

4.1 Day to night handover:

This starts currently at 21:15 in the Astor ward seminar room on level 3 of the surgical block and continues for approximately 30mins, meaning that it finishes beyond the end of some medical shifts. The current start time captures the majority of medical and surgical junior staff and is optimal being beyond the peak time for activity on the wards and the demands of oncall admissions. For the surgical rota an earlier handover will have occurred with the earlier shift change and for this reason is less optimal from a surgical perspective and helps in part explain why attendance is lower. Handover also does not align with the day surgical registrar and the most senior members of the medical and surgical body who are likely to be off site by the time of the start.

As the current system works well and complies with EWTD and work demands it is proposed that presently there is no change but either the shift could start 15minutes later ie 8:45 am or recognition of the finish time in the medical shift needs to be made. Further that a review of the shift patterns in surgery is made to see if they can be aligned to those in medicine as this would greatly facilitate cross disciplinary handover.

Compliance with national acute access targets which aim for all acute admissions to be seen within 12hours of admission by a senior decision maker will mandate a change in the onsite shift pattern for senior staff. To achieve the 12hour review target a 10pm finish will be needed which would bring the hospital at night handover into the oncall remit of for the oncall consultant and enable senior clinician involvement in handover.

4.2 Night to day handover

Handback of patients who became unwell overnight to the incoming ward based teams is the main handover issue during the working week when the sparse night teams are joined by the significantly greater number of regular ward doctors. It is suggested that this can be done most efficiently within the individual divisions. For all specialities it is suggested that a member of each ward team take handback of issues overnight on their ward from the overnight teams in a predefined location. This can occur at different times in different divisions to meet shift changes. For instance in medicine this may be best done at 8:45/9:00 prior to the start of the working day. This can most effectively be done through attendance on the AAU where the night team will be on their post take ward. ? for surgery.

At weekends and bank holidays the need for formal multidisciplinary handover is more apparent.

Challenges exist in achieving an acceptable time for night to day handover. Routine working in surgery starts at 8 and in medicine between 8:30 and 9, whilst acute admissions review in medicine is underway from 8 am. It is preferable or handover to occur at the start and end of shifts to inform incoming teams of issues and allow prioritorisation of tasks and reduce repetition. Due to EWTD restrictions however the ideal time to start would not include the day registrar whilst night handover remains at 21:15. Work demands also suggest a later time would be more appropriate as the issues for new admissions will be more apparent after the PTWR.

Whilst accepting that the time is not ideal it is suggested that handover occur on a weekend and bank holiday at 10am. This would capture the on call medical consultant who will have completed most of the reviews of the new admissions. It is a relatively quiet time for the oncall team and would allow initial job completion by the ward doctors. This should follow the agenda and format of hospital at night. An earlier handover for the arriving teams will have taken place. All patients of concern will need to be recorded on the CRS 24/7 list.

5. How should handover happen and what should be handed over?

Ad hoc handovers often miss out important aspects of care.

A suggestion for an agenda is tabled in appendix 2 and is loosely based on the Conwy & Denbighshire NHS Trust's policy. It follows a path from general operational issues before moving through individual issues on the wards then on the admitted patients. Each section is broken into surgical and medical sections and focuses on patient issues rather than general tasks. Throughout the CRS 24/7 list should be displayed and updated. During the handover of issues with patients on the ward and on take the list will be cleaned and modified. A number of patients will remain on the list who were identified at previous handovers and these should then be updated before the list is printed for each member of the team and one for a record.

6. IT support.

Currently lists of tasks are carried by the junior teams either in paper form or held on excel sheets on the computer.

CRS offers a limited ability to add patients of concern onto an electronic list (the practical guide is printed below in appendix 3). It supplies accurate information regarding location and can be printed to form a legible paper list for the teams to carry. CRS has a number of less ideal features as an IT handover tool, principal being the time required to log in and the counter intuitive method of access and transferring information, plus its inability to link data and task completion across the system. However the list is clear, when printed and accessible for all from any terminal. For it to work it needs to have the information to be inputted, ideally before the handover meeting eg when seeing a new unwell or deteriorating patient and in the process of using the system for other functions eg ordercomms. This needs to be covered in induction.

Appendix 1. Task proforma

Whole Hospital Handover

Agenda

Item No.	**Task**	**Person Responsible**
Pre meeting	CRS handover list to be prepared	All
1. Welcome	Introduce any locum doctor to the meeting. Ensure attendance recorded. Turn on CRS, display 24/7 list	Med Cons/SpR/Nurse Lead F1 medicine
2. Register	Complete attendance sheet	All doctors. It is the individual responsibility of each member of the team to complete this.
3. Safety briefing Nurse Lead	Overview. Any issues eg flu/major incident / bed state	ASP
4. ICU	ICU bed state/admissions/ discharges	Anaesthetist/ASP
5. Name and location of patients of concern (MEWS scoring)	Surgical Medical Add to CRS	Surgical docs Medical docs Surgical/medical F1s
6. Decisions on action required, management and time of next review.	Delegation of outstanding tasks to appropriate staff Add to CRS handover sheet	Consultant or medical registrar Surgical/medical F1s
7. Any problems with admissions?	Surgery Medical Add to CRS handover sheet	Surgical docs Medical docs Surgical/medical F1s
8. Handover list	Review remaining patients on CRS 24/7 list	Medical Consultant / SpR Medical F1
9.Time for next overnight meeting if required. Close of handover meeting		Medical SpR
10. Outstanding tasks handover	Routine tasks	All docs

Appendix 2 Attendance form

Date	Day team		Night Team	
Speciality / Grade	Name		Name	
	Print	Signature	Print	Signature
A. S. Pract.				
Medical Consultant				
SpR(day)				
SpR (night)				
SHO (early)				
SHO (late)				
SHO (Night)				
F1 level 5				
F1 level 6				
Surgical SpR				
SHO				
Locum Grade				
Other				

Additional Comments:

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Appendix 3

Hospital at Night handover - generating and using the 24/7 patient list on CRS

Contents

1. How to view the 24/7 list

2. add patient to 24/7 list

3. remove patient from 24/7 list

4. Give a priority 1 to 3 for the patient

5. add a sticky note to the patient with details and instruct to use SBAR format in this free text box; how to view the note

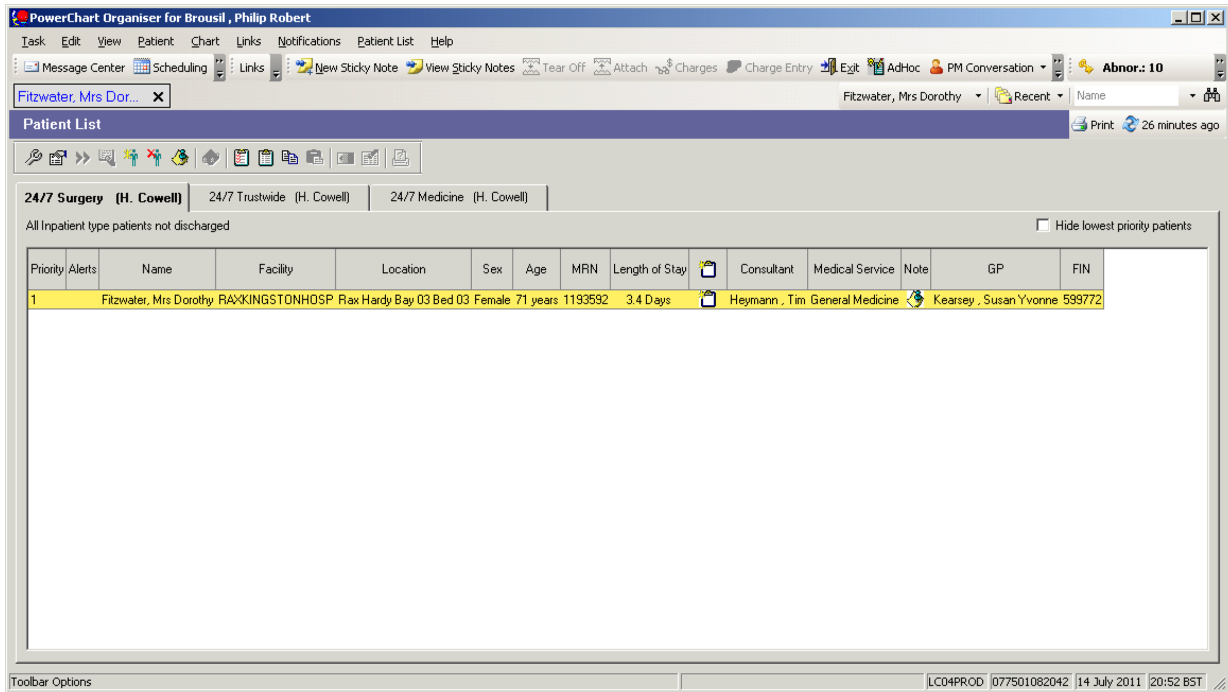
6. generate and print the list

7. save it to file (notionally anyway until this issue is fixed)

1. How to view the handover list:

Open powerchart

Go to 'View' and select 'patient list'



If the 24/7 tab does not appear, you can add it to your list of views by the following:

Click on the ‘spanner’ icon on the middle left of screen.

Highlight the 24/7 trustwide list and click the → arrow in middle of pop up and it will be added.

2. add patient to 24/7 list

Open the patient file on CRS

Select ‘patient’ from the menu bar at the top and hover over ‘add patient to patient list’

‘24/7 trustwide’ will appear on the right.

3. remove patient from 24/7 list

Have the list of 24/7 patients up on CRS

Highlight patient by clicking on the patient to be removed ONCE

Select ‘patient list’ from the menu bar at the top of the screen and select ‘remove patient from list.

4. Assign a priority 1 to 3 for the patient

Open you ‘24/7 trustwide’ list on CRS

Right click on the appropriate patient and select ‘display priority’ and select your priority for the patient.

5. add a sticky note to the patient with clinical details (free text box)

Two ways of doing this:

a. in the 24/7 view right click and select ‘add/view sticky note’
    i. in the free text box please give patient details in SBAR format (situation, background, assessment, recommendations)
    ii. it is also possible to edit the old sticky note
b. open the patient file and select ‘patient’ and ‘add/view sticky note’
    a. for both methods writing over the old note and clicking ‘apply’ will change it permanently

6. generate, onscreen view and print the 24/7 list

Open ‘explorer menu’ in the CRS application page (see below)

On the right choose 24/7 trustwide from ‘custom list’ (see below)

In the filter below choose ‘all’ consultants and ‘all’ wards’ and ensure the number of ‘notes’ selected is over 5 (these are the number of sticky notes for a patient that will be shown on the report)

Hit execute and the list will appear on screen ready to print (see below)

7. save this list to file (for official record of handover)

Open the report as instructions shown in ‘6’ above.

Instead of printing the report select ‘save to file’ from the ‘task’ option on the top bar.

Appropriate name the file based on time and date and save it in the appropriate directory (to be confirmed)

MetaFrame Presentation Server - Windows Internet Explorer

https://acute-rax-prod. Live Search

File Edit View Favorites Tools Help

MetaFrame Presentation Server Page Tools

Applications

Top Up

A&E	Accession Result Entry	AppBar	Appointment Book	Aps Maintain Case
Collection Inquiry	Daily Reports	Dept Order Entry	Explorer Menu	CLDBTOOLS
HIM Chart Coding	HIM Request Queue	HIM Task Queue	HIM Tracking	Information Request
Label Reprint	Order Result Viewer	P2 Sentinel	PMLocator	PMOffice
Patient Location History	PowerChart	PowerVision	SN Report Builder	Specimen Login
Surgical Scheduling Report	Surginet	Visual Explorer	WorkList Request	

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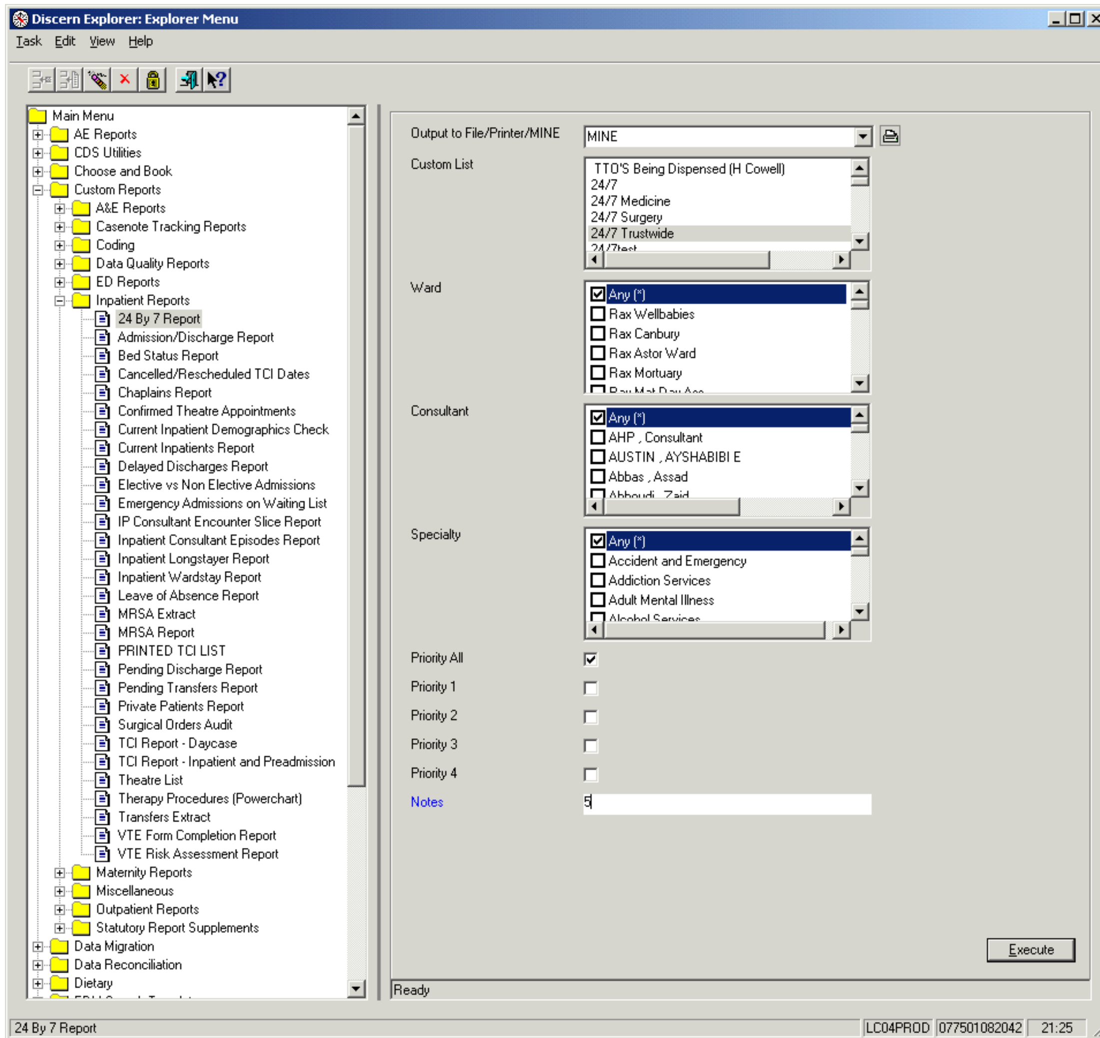

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Task Edit View Help
Main Menu
AE Reports
CDS Utilities
Choose and Book
Custom Reports
A&E Reports
Casenote Tracking Reports
Coding
Data Quality Reports
ED Reports
Inpatient Reports
24 By 7 Report
Admission/Discharge Report
Bed Status Report
Cancelled/Rescheduled TCI Dates
Chaplains Report
Confirmed Theatre Appointments
Current Inpatient Demographics Check
Current Inpatients Report
Delayed Discharges Report
Elective vs Non Elective Admissions
Emergency Admissions on Waiting List
IP Consultant Encounter Slice Report
Inpatient Consultant Episodes Report
Inpatient Longstayer Report
Inpatient Wardstay Report
Leave of Absence Report
MRSA Extract
MRSA Report
PRINTED TCI LIST
Pending Discharge Report
Pending Transfers Report
Private Patients Report
Surgical Orders Audit
TCI Report - Daycase
TCI Report - Inpatient and Preadmission
Theatre List
Therapy Procedures (Powerchart)
Transfers Extract
VTE Form Completion Report
VTE Risk Assessment Report
Maternity Reports
Miscellaneous
Outpatient Reports
Statutory Report Supplements
Data Migration
Data Reconciliation
Dietary
Output to File/Printer/MINE
MINE
Custom List
TTO'S Being Dispensed (H Cowell)
24/7
24/7 Medicine
24/7 Surgery
24/7 Trustwide
Ward
Any (*)
Rax Wellbabies
Rax Canbury
Rax Astor Ward
Rax Mortuary
Consultant
Any (*)
AHP , Consultant
AUSTIN , AYSHABIBI E
Abbas , Assad
Specialty
Any (*)
Accident and Emergency
Addiction Services
Adult Mental Illness
Priority All
Priority 1
Priority 2
Priority 3
Priority 4
Notes
5
Execute
Ready
24 By 7 Report
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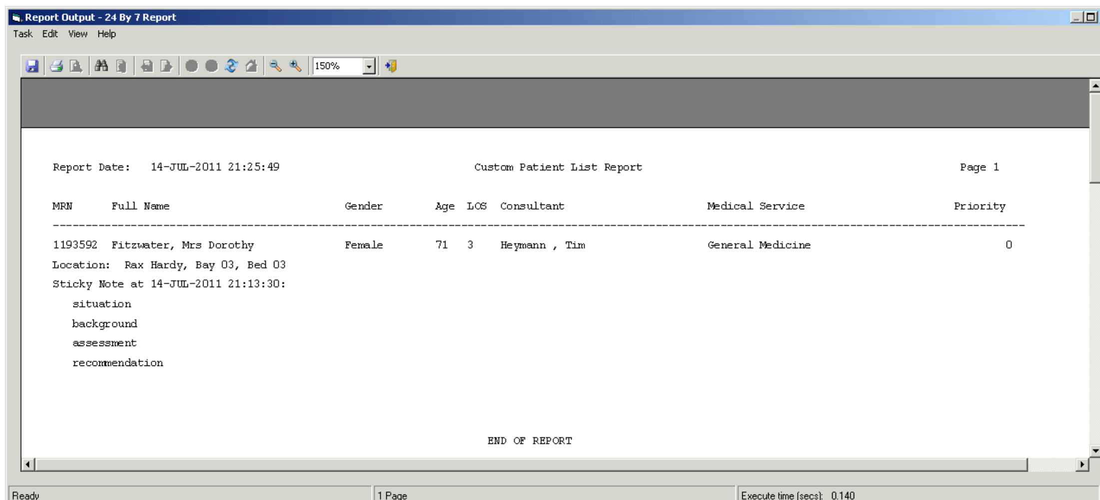
21:25



Report Output - 24 By 7 Report
Task Edit View Help
150%
Report Date: 14-JUL-2011 21:25:49
Custom Patient List Report
Page 1
MRN Full Name Gender Age LOS Consultant Medical Service Priority
1193592 Fitzwater, Mrs Dorothy Female 71 3 Heymann , Tim General Medicine 0
Location: Rax Hardy, Bay 03, Bed 03
Sticky Note at 14-JUL-2011 21:13:30:
situation
background
assessment
recommendation
END OF REPORT
Ready
1 Page
Execute time (secs): 0.140

References

1 Junior Doctors Committee (2003) Making IT work for hospital Juniors: Supporting Working Practices and Training with the New Contract and the EWTD. London: British Medical Association.