Study on The Assessment of Handover Compliance Rate of Doctors Working in Max Super Speciality Hospital Saket, Delhi

By

Monica Deo

Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2016-2018

The IIHMR University, Jaipur

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Monica Deo** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at **Max Super Speciality Hospital, Saket, New Delhi** from 5th February to 5th May, 2018.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

(Col.) Dr. Ashok Kaushik
Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Dr. Sandesh Sharma
Associate Professor
The IIHMR University, Jaipur

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MAX HEALTHCARE

Certificate of completion of Dissertation

The certificate is awarded to

Name- Dr. Monica deo

In recognition of having successfully completed her Dissertation in the department of

Name of Department – Operations

Has successfully completed her Project on

Assessment of handover compliance rate of doctors

Date- 5th February to 5th May, 2018

Organization – Max Super Specialty Hospital , Saket

She comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning

I wish her all the best for future endeavors

Dr. Sandeep
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Dr. Sandeep Mor
Deputy Medical Superintendent
Max super Specialty Hospital

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THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Assessment of Handover Compliance rate of Doctors** and submitted by **Dr. Monica Deo**, Enrollment No **IIHMR-U/01/2016-18/0444** under the supervision of **Dr. Sandesh Sharma**for award of MBA in Hospital and Health in Health and Hospitals of the University carried out during the period from 5th February to 5th May, 2018 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Monica Deo

Signature

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that all the ethical issues have been considered while collecting data for my dissertation titled **Assessment of Handover Compliance rate of Doctors.**

Signature

ACKNOWLEDGMENT

The dissertation opportunity with Max Super Specialty Hospital, Saket was a great chance for learning and professional development. I am also grateful for having a chance to meet so many wonderful people and professionals who led me though this internship period.

I am highly grateful and would like to express my deepest gratitude and special thanks to my mentor, Dr. Sandeep Mor, Deputy Medical Superintendent at Max Super Specialty Hospital, Saket, who in spite of being extraordinarily busy with his duties, took time out to hear, guide and keep me on the correct path and arranging all facilities to make life easier and allowing me to carry out my project at their esteemed organization during my dissertation time. I choose this moment to acknowledge his contribution gratefully.

I perceive as this dissertation project as a big milestone in my career development. I will strive to use gained skills and knowledge in the best possible way.

Sincerely,

Dr. Monica deo

Dr. Sandeep Mor

DMS (Deputy Medical Superintendent)

Max Super Specialty Hospital, Saket

Place: New Delhi

Date:

TABLE OF CONTENTS

TOPIC – HANDOVER COMPLIANCE OF DOCTORS

INTRODUCTION –

Clinical handover involves the transfer of accountability and responsibility of clinical information from one health professional to another. The main role of clinical handover is to transmit accurate, relevant and current details about the patients' care, treatment, health service needs, clinical assessment monitoring and evaluation, and goal planning. Inefficiencies of communication at clinical handover have been associated with irrelevant, missing or repetitive information, which can result in health professionals spending extensive periods attempting to retrieve relevant and correct information. In addition, ineffective handovers can cause major problems relating to lack of delivery of appropriate care and the possibility of misuse or poor utilisation of resources. Ineffective communication at transition points of care is the most common cause of catastrophic or sentinel events in hospitals. About 50% of adverse events occur from communication failures between health professionals. In view of the potential risks associated with clinical handover, it has been internationally as well as nationally recognised as a priority area for improvement by many key health care organisations.

A “handover” shall occur each time when an inpatient, emergency patient, day-care patient, observation patient:

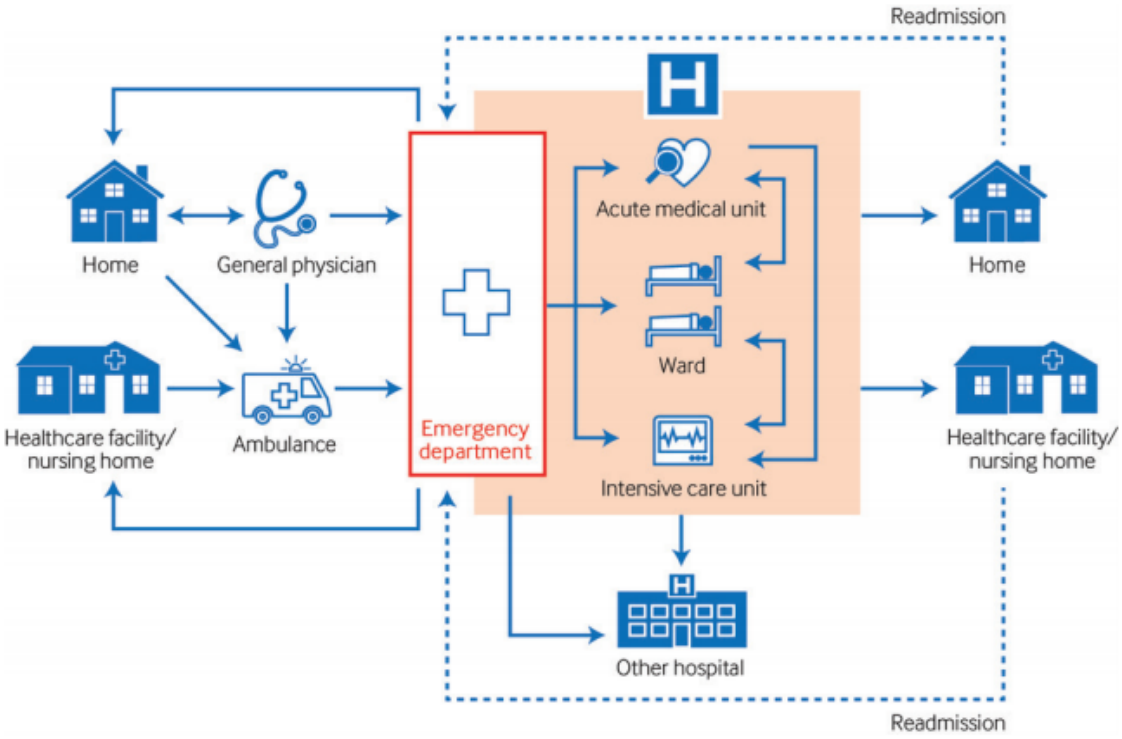
- Moves to a new level of care
- Is assigned to a different physician during duty change

Each of these situations requires a structured handover with appropriate communication.

Despite extensive measures available worldwide aimed at improving clinical handover processes, participating health professional’s experienced adverse events relating to clinical handover in seven areas. These were:

- Delays in treatment or procedure, or, prolonged treatment or procedure;
- Lack of monitoring information given on clinical assessment,
- Leading to patient deterioration; errors involving medications;
- Patient falls
- Disruptive, aggressive behaviour and confused state leading to injury
- Putting patients at risk of infection and putting infants at risk.
- Greater levels of innovation are needed in training and education, aimed at addressing the complex barriers to effective handover that exist in different health care organisations.

Effective communication is one of the JCI’s main patient safety goals and one of the elements assessed during hospital accreditation. Handover needs to fulfil the criteria of being timely, accurate, complete, unambiguous, and understood by the recipient.



OBJECTIVE

1- To evaluate the handover protocols are followed by doctors or not.
2- A determination of the standards of handover which must be delivered by individual clinician and clinical team.
3- A framework for handover based on the best evidence.

LICTERATURE REVIEW

Given the complexities of the healthcare environment, efforts to develop standardized handoff practices have led to widely varying manifestations of handoff tools. A systematic review of the literature on handoff evaluation studies was performed to investigate the nature, methodological, and theoretical foundations underlying the evaluation of handoff tools and their adequacy and appropriateness in achieving standardization goals.

For the purpose of this report, clinical handover includes communication between the change of shift, communication between care providers about patient care, handoff, records and information tools to assist in communication between care providers about patient care. Patient safety includes the variables that limit or affect preventable adverse patient outcomes and errors.

Handover of care … 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)

It is essential to ensure that critical information is effectively communicated as continuity of information is vital to the safety of our patients.

The changing profile of physician work hours has increased the need for effective handover. As demands for high value care increase, handover is likely to remain a key target for quality improvement interventions.

The increasing sub-specialization in hospital care means that more teams are involved in patient management and an increased number of individuals potentially caring for a patient during their hospital stay therefore the need for comprehensive handover of clinical information has become more important than ever.

Having effective communication is one of the main recommendations and priorities highlighted by Joint Commission International (JCI). Likewise the World Health Organization's (WHO) report (2009) indicated clearly that communication is one of the vital issues that affects patient safety.

Breakdown of communication is the leading cause of medical errors and sentinel events. Many previous studies have shown that ineffective communication during handovers has led to medical errors. Li *et al.* also found that a poor handover process was a significant contributor to medical error in intensive care units.

The Australian Commission on Safety and Quality in Health Care has evaluated the handover process after implementing the handover guidelines. They found that distractions during handover were related to ineffective communication and additional time spent on handovers. Regular distractions such as telephone alerts, approaching of patients' relatives and medical staff interrupting increase the length of handovers and result in important information not being passed on effectively.

A study by Currie also reported that the longer handover time has led to lower attention spans of both reporting and receiving staff during handovers. During transfer of patients, information regarding tests undertaken and treatment or care received is transferred between healthcare providers to formulate a plan for continued care.

Patient transfer in and out of ICUs is more complex due to their condition and the need for intensive monitoring. Patient transfer has been recognized as an area facing more communication problems due to cultural differences, work-load challenges and differences in clinical specialties. Found that taking calls and interrupting the conversation during handovers led to instances where important patient information was missed, which later jeopardized patient safety.

A survey by the Agency for Healthcare Research and Quality found that 49% of respondents stated that important patient-care information is 'lost during shift changes. A failure to communicate important information during handover will often have a negative influence on care. For example, in one study 56.9% of handovers where clinicians did not transfer information pertinent to a patient's care resulted in delayed communication with inpatient units or delayed and/or missed therapy.

The barriers to handover can be classified into three major categories: the performance of individuals; environmental factors; and system factors.

At times, health care workers do not pay the correct amount of attention to the handover process, and this can lead to an increased amount of adverse events and embarrassing situations among health care professionals because the clinicians involved in the handover do not actively listen and instead end up "doing" everything at the same time. A lack of communication leads to consequences with regard to decision-making and impairs the health care system; this may result in repetition of examinations which have already been performed.

OPERATIONAL DIFINITION-

The passing of the care of one or more patients to the doctors working on the next shift, by informing them of tests ordered management issues and evolving or resolving problems.

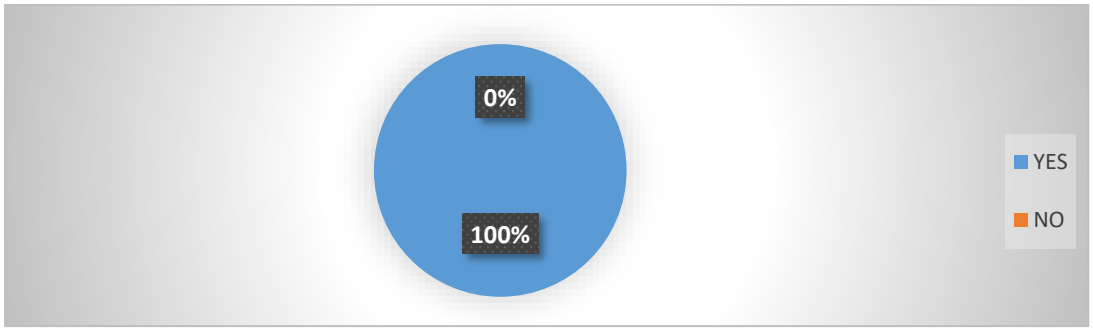
MATERIAL AND METHODS–

- **STUDY DESIGN**- Analytical study
- **RESEARCH APPROACH** – Qualitative and Quantitative
- **SAMPLE TECHNIQUE**- simple random sampling
- **LOCATION** –Max super speciality hospital saket .
- **PRIMARY DATA** –Structured checklist
- **SECONDARY DATA** –NABH, JCI& other guidelines.
- **DATA COLLECTION PROCEDURE-** Checklist
- **DATA ANALYSIS PROCEDURE:**Data will be evaluated on the basis of the checklist which will be prepared then it will get noted into the excel sheet and after the evaluation of everything it will represented in the form of graphs.

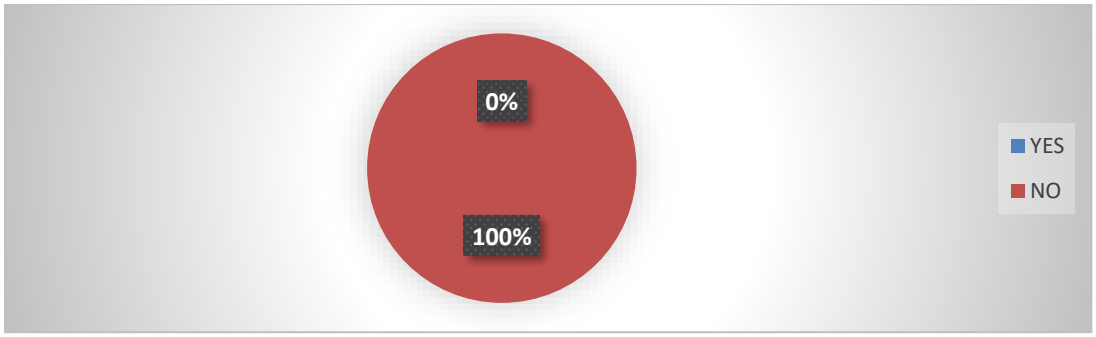
DATA EVALUATION PRESENTATION

To collect the data and evaluate the scenario of handover within the organisation a checklist has been formed which includes following questions

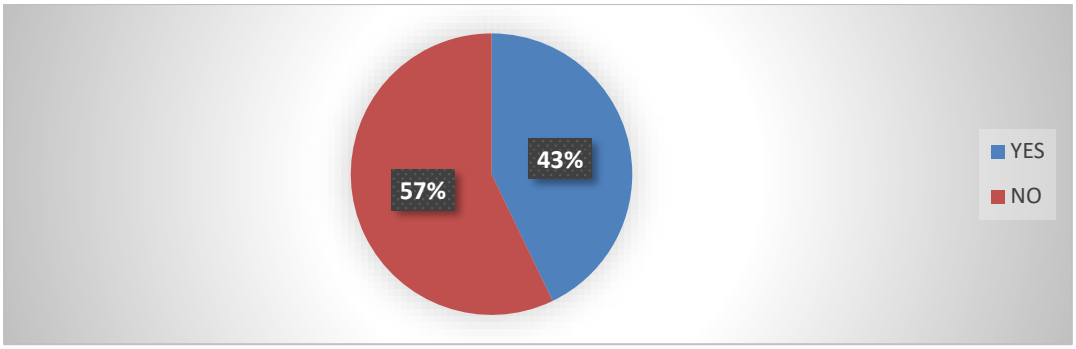
1- 1-Is it important to maintain the handover duty register?



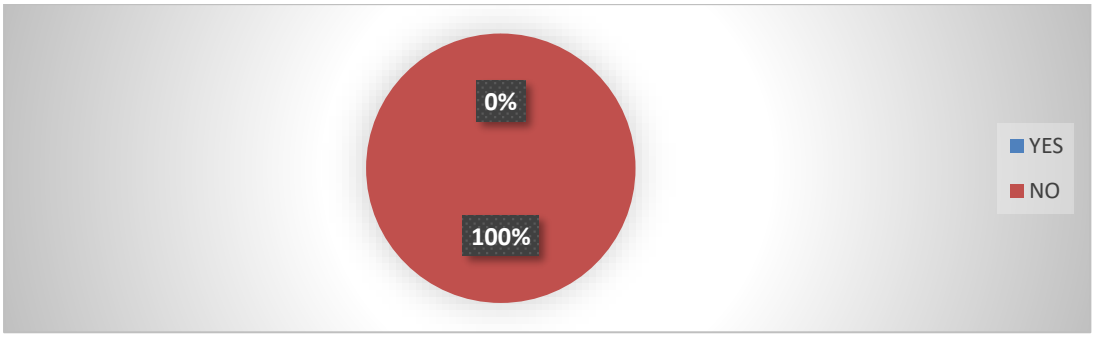
2-Is the format of the handover register of doctors appropriate?



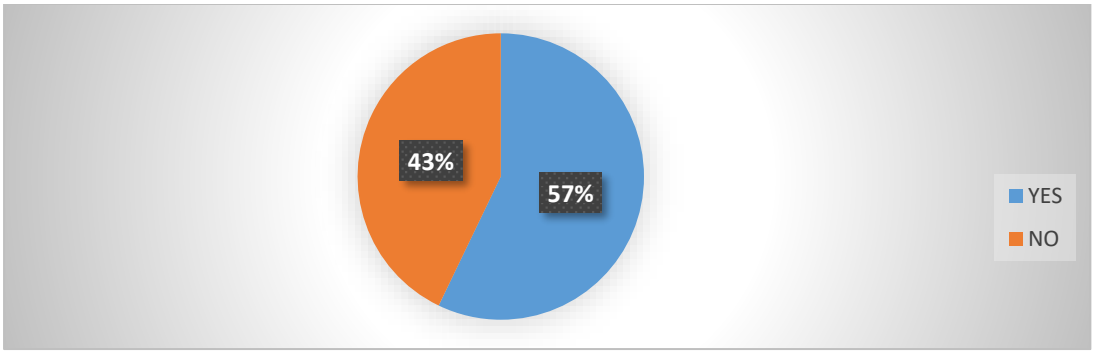
3-Handover note should be done manually or technically?



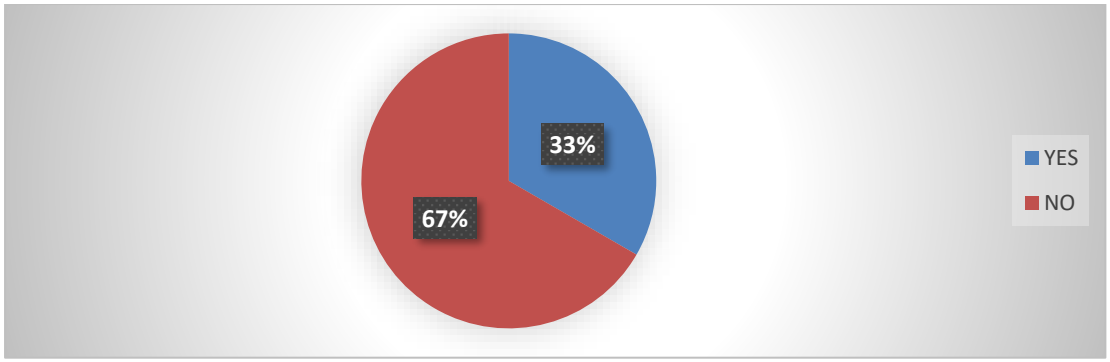
4- Is it easy to fill the format of the handover register?



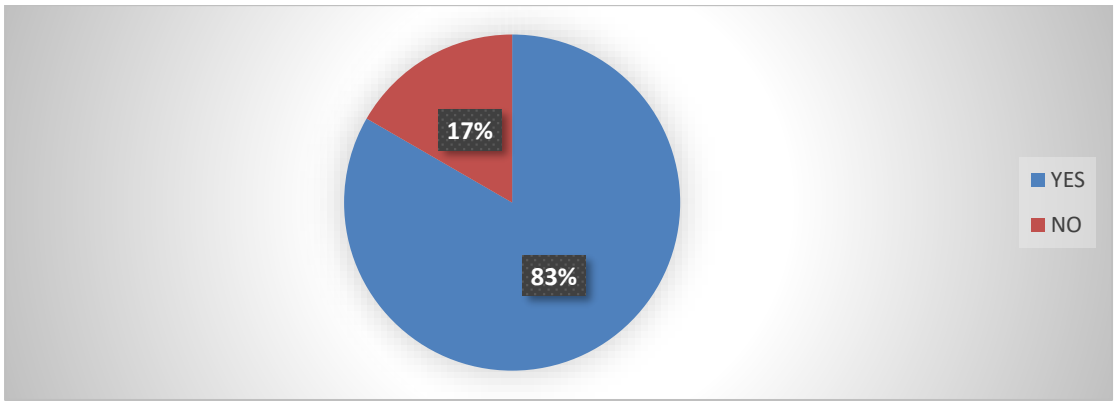
5- Do you think abbreviation should be use while doing any entry into the pre-printed format for duty handover of doctors?



6- Do the doctors wants to maintain the filling format of handover register?



7- Do the doctors are aware about that exactly what kind of abbreviations they can use in case of duty handover?



OBSERVATION-

- Handover communication is at some level lacking behind in all the departments.
- Some of the departments are following their own form of format related to handover of doctors like gasterology, nephrology
- The format which is used by doctors in some of the departments are also not proper because there is as such no record that to whom the doctors are handovering their duty according to their shifts.
- As per the doctors response they are unable to maintain the register because of their workload, according to them at the same time they have to take care of their patients and they have to enter the notes into the CPRS on time because if they will not enter the note into the CPRS on time then that will be a reason of risk or we can say that can cause a level of discomfort for the patients also.
- In some of the departments if the register are getting signed but not on daily basis.
- The attitude of the doctors is also not up to the mark regarding the handover of their duties.

RECOMMENDATIONS

- We can set or design a pre-printed and format for the doctors so that they can easily carry that paper along with them easily handover their duty records.
- Those pre-printed format should be stick into the files and proper record should be maintained on monthly basis.
- We can also set a SBAR format for the doctors but not like the nurses are doing it.
- We can also ask the doctors to write the priority level of things into the handover register as per the work load of them.

CONCLUSION

During this study I have observed that handover is one of the most important factor for the doctors to reduce the life risk of the people because by the help of maintaining the handover register it will be easy for the doctors to share their responsibilities among their colleagues by mentioning all the details of the patients in that particular handover format because the basic aim of this study is to transmit accurate, relevant and current details about the patients' care, treatment, health service needs, clinical assessment monitoring and evaluation, and goal of planning of several different challenges of treatment and it should be maintained on daily basis to avoid the adverse events and make the doctors more responsible towards their duties and prepare an organisation according to the JCI & NABH norms and I am very thankful to my mentor Dr.sandeep Mor who has topic and also helped me to get the awareness regarding the norms and guidelines of the handover communication of the doctors.

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SYNOPSIS

TOPIC:

HANDOVER COMPLIANCE OF DOCTORS.

MENTOR:

DR. SANDEEP MOR (max hospital saket)

DR.SANDESH SHARMA (IIHMR university)

SUBMITTED BY:

DR.MONICA DEO

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