Summer Training at
Fortis Escorts Heart Institute,
New Delhi

On Clinical Handover Communication in IPD

By
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Under the guidance of
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MBA Hospital and Health Management
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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

CERTIFICATE

TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Dr. Vibhisha Khatri** student of **MBA Hospital and Health Management** from the IIHMR University; Jaipur has undergone summer training at **Fortis Escorts Heart Institute, OKHLA, New Delhi** from 1st April to 31st May, 2016.

The candidate has successfully carried out the study designated to her during summer training and her approach to the study has been sincere, scientific & analytical.

The internship is in fulfilment of the course requirements.

I wish her all success in all his future endeavours.

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A NABH and JCI Accredited Institute

May 31, 2016

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Vibhisha Khatri**, student of Indian Institute Of Health Management Research, Jaipur has successfully completed her internship in **Quality** department at **Fortis Escorts Heart Institute, New Delhi,** during the period from April 01, 2016 to May 31, 2016.

During her tenure she was found to be diligent, hardworking & sincere.

We wish her all the best for her future endeavor.

For **FORTIS ESCORTS HEART INSTITUTE**

AUTHORISED SIGNATORY

NABH Accredited

ACKNOWLEDGEMENT

I owe a great debt to all professionals at **FORTIS ESCORTS HEART INSTITUTE, OKHLA ROAD, NEW DELHI** for generously sharing their knowledge and time, which inspired me to do my best at this project study.

My heartfelt gratitude to **Dr. Ajay Singh (Deputy Manager-Quality), Fortis Escorts Heart Institute, Dr. Neha Arora (Team Leader-Quality)**, **Sister Sophy Lawrence and Dominic Savio(Quality Department)** for showing their keen interest in the study and for sharing their views in spite of their very busy schedule. It has been my privilege to work under their dynamic supervision at the Hospital.

I am extremely grateful to**Dr. Anand Bansal** (Medical Director),**Mr.Balkishan Sharma** (Head of HR Department), **Ms.Mallika Singh** (Assistant Manager) for the constant support and encouragement. This study would not have been possible without their support.

My sincere gratitude to **Dr. Ashok Kaushik (Professor Dean, IIHMR, Jaipur)** for his relentless support and guidance. My regards go to my guide at institute **Dr. Barun Kanjilal**for his very helpful attitude and valuable suggestions.

Dr. Vibhisha Khatri
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ABBREVIATIONS

CCU	Cardiac Care Unit
CSSD	Central Sterile Supply Department
CRR	Cath Recovery Room
DCC	Day Cath Centre
DPR	Daily Progress Report
ECG	Electrocardiography
EMR	Emergency
GL ICU	Gastro Liver Intensive Care Unit
HCC	Heart Command Centre
IPD	In-patient Department
ICU	Intensive Care Unit
JCI	Joint Commission International
NABH	National Accreditation Board for Hospital and Healthcare Providers
NABL	National Accreditation Board for Testing and Calibration Laboratories
OPD	Out-patient Department
OT	Operation Theatre
RR	Recovery Room

HOSPITAL PROFILE

ESCORTS HEART INSTITUTE AND RESEARCH CENTRE (EHIRC) is a renowned name in the field of cardiac surgery, interventional cardiology and cardiac diagnostic. The institute formally came into existence in October 1988; and was set up as a dedicated cardiac hospital to bring to India the best cardiac care, training of cardiac surgeon and cardiologists and also to conduct research of international standards. The Fortis group took over the hospital on 10th September 2005.

Now the *Escorts Institute and Research Center* is popularly known as ***Fortis Escorts Heart Institute*** (FEHI) which is pioneer in the field of fully dedicate cardiac care facility in India. Fortis health care is the fastest growing hospital network in India. Fortis Healthcare is led by the vision of late Dr. Parvinder Singh for creating an integrated healthcare delivery system in India.

Fortis Escorts Heart Institute has a vast poof of talented and experienced team of doctors, who are further supported by a team of highly qualified, experienced & dedicated support staff & cutting edge technology like the recently installed Dual CT Scan Currently, more than 200 cardiac doctors and 1600 employees work together to manage over 14,500 admissions and 7,200 emergency cases in a year.

The hospital today has an infrastructure comprising of around 310beds,5 CATH Labs, 9 Operation Theatres, 2 Heart Command Centers, and 2 Heart Stations besides an array of other world-class facilities. FEHI provides top and services in areas of acute care, invasive and non-invasive cardiology and state of the art surgical procedures, besides playing a leading role in prevention, early detection and the renewal of heart disease. A consumer forum (VOICE) has ranked its patient care and nursing services as No.1 in Delhi.

To spread cardiac care to more and more people FEHI has vast network of hospitals across the country. Also to cater the far flung areas, the institute has started with Community Outreach Programme. It provides high-class emergency services to patient including the facility for air ambulance. The institute also offers many cardiac preventive health checks.

FEHI launched its **Community Outreach Programme,** which started out with a vision to reach out to the health needs of population in the remotest community of the country, and has covered the states of Uttar Pradesh, Punjab, Bihar, Madhya Pradesh, Himachal Pradesh and Rajasthan.

MISSION

To be a globally respected health care organization known for clinical excellence and distinctive patient care.

VISION

To create a world class integrated health care delivery system in India, entailing the finest medical skills combined with compassionate patient care.

VALUES

Patient Centricity

- Commit to 'best outcomes and experience' for our patients.
- Treat patients and their care givers with compassion, care and understanding.
- Our patients' needs will come first

Integrity

- Be principled, open and honest.
- Model and live our 'Values'.
- Demonstrate moral courage to speak up and do the right things.

Teamwork

- Proactively support each other and operate as one team.
- Respect and value people at all levels with different opinions, experiences and backgrounds.
- Put organization needs before department / self-interest.

Ownership

- Be responsible and take pride in our actions.
- Take initiative and go beyond the call of duty.
- Deliver commitment and agreement made.

Innovation

- Continuously improve and innovate to exceed expectations.
- Adopt a 'can-do' attitude.
- Challenge ourselves to do things differently

ACCREDITATIONS

- Joint Commission International, USA
- NABH
- NABH (Blood Bank) Accreditation
- NABL

HOSPITAL LAYOUT

FEHI is a renowned name and has 2 buildings. The main building and the rehabilitation center both the blockas are on the opposite sides of the road which is connected through an underground tunnel which is basically meant for shuttles to take patients from one building to another.

REHABILITATION BLOCK/OPD BLOCK (Red Building)

INTRODUCTION

The outpatient department of FEHI, Delhi has a separate building for outpatients with Upper Basement, Ground Floor and First Floor having all the important service like Executive Health Checkup (EHC), various tests like X-ray, TMT, Echo, ECG etc.OPD consultation, Comprehensive Cardiac Checkup (CCC), Pharmacy etc.

FLOOR WISE DISTRIBUTION OF REHAB BLOCK

Lower Basement

Medical Records department

Pathology Laboratory

Upper Basement

Executive Health Centre

Gyaenocology

Echo

ECG

TMT

Ultrasound

Dental

Ground Floor- (OPD Block)

Help Desk

OPD Billing

Sample Collection Room

X-Ray

Mammography

Pharmacy

Report Room

Dialysis Centre

Consultant Rooms

Physiotherapy

Cafeteria

First Floor-(OPD Block)

OPD Billing

Three nurse counters

Two helping desk

Consultation chambers where specialized doctors in the following fields are available-

- Pulmonologist
- Neurology
- Gastroenterology
- Ophthalmology
- Laparoscopic and General Surgery
- Psychiatry
- Thoracic Surgery
- Pediatric surgery
- Urology
- Dermatology
- Diabetology
- Cardiology
- Cardiac surgery
- Vascular surgery
- Pediatric cardiac surgery

- Pediatric cardiology
- Pacemaker Clinic.

Second Floor

Cafe Jam Ja Jee

Third Floor

Centre for sight

Fourth Floor

Nephrology

Fifth Floor

Liver & Digestive Disease Institute

Sixth Floor

Under Construction

IPD Building

IPD Block Floor Wise Plan-

Basement-

- Blood bank
- Laboratory
- Pediatric Echo Lab
- Laundry
- Purchase Department
- Stores
- Library
- Auditorium
- Zonal Director's Office
- Board Room
- Administration Block
- Biomedical Engineering

Ground Floor-

- Emergency

- Heart Command Centre I, II
- Heart Station I and II
- ICU-I
- Patient Care Service
- Medical Director's Office
- Food and Beverages
- Cafeteria
- Dietician
- Security
- Pharmacy
- Counseling
- Billing
- Lounge
- International desk.
- TPA department

First Floor-

- Recovery I, II
- ICU II
- ICU III
- Anesthesia Room
- OT
- IT department

Second Floor–

- CSSD
- Board Room
- Doctors Office
- Catheterization Lab
- CATH Recovery

Third Floor

- Day Care Center
- Block A (Old) Ward-Bed no 301-331F
- Block B (New) Ward-Bed no. 332-359.

Fourth Floor-

- Cardiac Care Unit.
- Block A (Old) Ward-Bed no. 401 to 431F
- Block B (New Ward-Bed no. 432 to 453, PS I and II

Fifth Floor-

- Pediatric ICU.
- Pediatric Ward

ABSTRACT

Effective handover communication, a part of International Patient Safety Goal 2 (Joint Commission International), is one of the major challenges faced by the hospitals.It has been observed that a lack of formal training and formal systems for patient handover impede the good practice necessary to maintain high standards of clinical care. Thus, patient handover has been defined as a priority for patient safety, and research in this field is increasing rapidly.

There is a need for more systematic approach to establish valid measures of handover quality and safety, establish the causal effects of handover characteristics on safe care and identify best practices in safe handover and effective interventions within and across health-care settings.

In this study, 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.

This study aims at finding the current handover communication processes practiced by doctors and nurses at Fortis Escorts Heart Institute, identifying the challenges in effective handover across the hospital and further improving the hand over communication between nurses and doctors by implementation of standard formats for hand overs.

INTRODUCTION:

Clinical handover is 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 temporary or permanent basis. (AMA, 2006)

Clinical handover is an integral part of clinical care, practiced in a multitude of ways, in all healthcare settings, every day. Failures in clinical handover have been identified as a major preventable cause of patient harm. Poor handover can also lead to:

- Unnecessary delays in diagnosis, treatment and care
- Repeated tests
- Missed or delayed communication of test results
- Incorrect treatment or medication errors.

Handovers of patient care within a hospital occur
• between health care providers, such as between physicians and other physicians or health care providers, or from one provider to another provider during shift changes;
• between different levels of care in the same hospital such as when the patient is moved from one department to another.

Standardization of handover content and process will improve the safety of handover by ensuring consistency in critical information exchanges.

Joint Commission International, a commission on Accreditation of Healthcare Organizationsalso gives recommendations for hand over communication as a part of International Patient Safety Goal 2, which are as follows-

1) Standardized critical content is communicated between health care providers during handovers of patient care.

2) Standardized forms, tools, and methods support a consistent and complete handover process.

3) Data from handover communications are tracked and used to improve approaches to safe handover communication.

OBJECTIVES: -

1) To identify the hand over documentation methods used by various departments in IPD within the hospital.
2) To identify major deficiencies in hand over documentation by doctors and nurses and to recommend new corrective measures for effective documentation of the same.
3) To ensure proper documentation of hand over by doctors and nurses during interdepartmental transfers and during shift changes.

METHODOLOGY:

The study was done at Fortis Escorts Heart Institute, Okla., New Delhi over a period of 45 days i.e. from 13thApril to28th May. It is a Pretest-Posttest study design as it involves an intervention. Non-probability convenience sampling method was used to select the samples.

STEP 1: Audit of **100 IPD records** was done with a help of a checklist. Data was collected from patients' files on each floor.

STEP 2: Deficiencies in Handover documentation were identified for all the departments separately and then new standard formats were introduced for both doctors and nurses to improve the handover documentation. Also training programs were done for doctors and nurses.

STEP 3: Post implementation, audit of **200 IPD records** was done to check the compliance of the new formats and the effect of training programs on doctors and nurses. Again the data was collected from patients' file on each floor.

FINDINGS:

It was observed that the following documents are used at Fortis Escorts Heart Institute for Handover documentation:

1)**Triage Sheet**: This sheet is used in Emergency for documentation of patient details such as current patient condition, probable diagnosis, advised treatment details, advised medication etc. This sheet is filled by doctor on duty and the consultant.

2) **In House Transfer Summary**: This document is used for interdepartmental transfers of the patient in IPD. It is an important document for handover of the patient between departments as it contains details like, transferring units of patients, lab results, current issues, management plan, handover details (signature of transferring and receiving doctors and nurses).

3) **Operation Theatre Notes (OT notes)**: After completion of surgery, the surgeons write OT notes which contains the procedure and post-op instructions, medications to be given etc.

4) **Recovery Flow Sheet**: After surgery, the patient is transferred to recovery room. This document is used in Recovery Room and is filled by both doctors and nurses. This document contains details like diagnosis, procedure done, progress summary of the patient, regular monitoring and treatment details, and management plan etc.

5) **Cath Lab Flow Sheet**: This sheet is used when the patient is transferred to Cath lab for procedures like Angiography, PTCA etc. It contains hand over details and patient regular monitoring details in Cath Recovery Room.

6) **Critical Care Flow Sheet**:This document is used in all the critical areas (ICU I, II, III, HCC I, II). It is filled by both the doctors and nurses and contains details of daily critical care monitoring, special instructions, procedure/treatment, doctor's instructions etc.

7) **Nurse Care Plan**: This sheet is used by nurses in all the departments. It contains details of timely regular monitoring of patients and updates of patient current status.

8) **Daily Progress Notes**: It is used by doctors in all the departments and contains doctors regular timely monitoring details, investigations advised, current patient status, action required etc.

Table 1: List of documents used for hand over by doctors and nurses in FEHI

Movements		Documents used by doctors for hand over	Documents used by nurses for hand over
Transfer Out	**Transfer In**		
EMR	**HCC I**	Triage sheet	NA
EMR	**HCC II**	Triage sheet	NA
EMR	**ICU I**	Triage sheet	NA
EMR	**ICU II**	Triage sheet	NA
EMR	**Ward**	Triage sheet	NA
EMR	**GL ICU**	Triage sheet	NA
EMR	**DCC**	Triage sheet	NA
OT	**RR 2**	OT notes	Nurse care plan
OT	**ICU III**	OT notes	Nurse care plan
OT	**Ward**	OT notes	NA
RR 2	**RR 1**	Recovery flow sheet	1.Nurse care plan 2.Hand over check list 3.Recovery flow sheet
RR 2	**Ward**	1.Recovery flow sheet 2.In house transfer summary	1.Nurse care plan 2.Hand over check list 3.In house transfer summary 4.Recovery flow sheet
RR 1	**Ward**	1.Recovery flow sheet 2.In house transfer summary 3.Daily progress notes	1.Nurse care plan 2.Hand over check list 3.In house transfer summary 4.Recovery flow sheet
ICU I	**ICU II**	1.In house transfer summary 2.Daily progress notes(EMR)	1.Nurse care plan 2.Critical care flow sheet 3.In house transfer summary
ICU II	**Ward**	1.In house transfer summary 2.Daily progress notes	1.Nurse care plan 2.Critical care flow sheet 3.In house transfer summary

ICU III	**Ward**	In house transfer summary	1.Nurse care plan 2.Critical care flow sheet 3.In house transfer summary
HCC I	**Cath Lab**	Cath Lab Flow Sheet	1.Cath Lab Flow Sheet 2.Critical care flow sheet 3.Nurse's chart
HCC I	**Ward**	In house transfer summary	1.Nurse care plan 2.Critical care flow sheet 3.In house transfer summary
HCC I	**OT**	Daily progress notes	1.Nurse care plan 2.Critical care flow sheet
HCC II	**Cath Lab**	Cath Lab Flow Sheet	1.Cath Lab Flow Sheet 2.Critical care flow sheet
HCC II	**Ward**	1.In house transfer summary 2.Daily progress notes	1.Nurse care plan 2.Critical care flow sheet 3.In house transfer summary
GL ICU	**Ward**	1.In house transfer summary 2.Daily progress notes	1.In house transfer summary 2.Clinical hand off report
CRR	**HCC I**	1.Cath Lab Flow Sheet 2.Post PTCA order chart	1.Cath Lab Flow Sheet 2.Nurse's Chart
CRR	**HCC II**	1.Cath Lab Flow Sheet 2.Post PTCA order chart	1.Cath Lab Flow Sheet 2.Nurse's Chart
CRR	**Ward**	1.Cath Lab Flow Sheet 2.Post PTCA order chart 3.In house transfer summary	1.Cath Lab Flow Sheet 2.Nurse's Chart 3.In house transfer summary
CRR	**ICU III**	1.Cath Lab Flow Sheet 2.Post PTCA order chart	1.Cath Lab Flow Sheet 2.Nurse's Chart
Ward	**Cath lab**	Cath Lab Flow Sheet	1.Cath Lab Flow Sheet 2.Nurse's Chart

Ward	**ICU I**	In house transfer summary	1.Nurse care plan 2.Critical care flow sheet 3.In house transfer summary 4.Daily nurse's assessment
Ward	**OT**	None	1.Nurse care plan 2.Daily nurse's assessment
DCC	**Cath lab**	Cath Lab Flow Sheet	1.Cath Lab Flow Sheet 2.Daily nurse's assessment

NOTE:

Documentation by doctors in ICU I is done in:

1) Hard copy of Daily progress notes attached in patient file.
2) Electronic Medical Record (EMR) is maintained as a soft copy in the system which contains all the patient details and it can be accessed as and when required.

Documents used by nurses for hand over during shift changes:

Recovery 1&2 : Hand over check list
GL ICU **:** Clinical Hand Off Report

ANALYSIS:

On the basis of audit of 100 IPD patient records, analysis was done. Firstly, department wise usage of different forms for handover was identified to see which specific form is used more commonly in the specific department and then deficiencies in that specific form were identified separately for different departments. Findings are shown below in the form of graphical representation.

FINDINGS:

[A] % of usage of different forms for Handover documentation by doctors and nurses in various departments:

1) EMERGENCY:

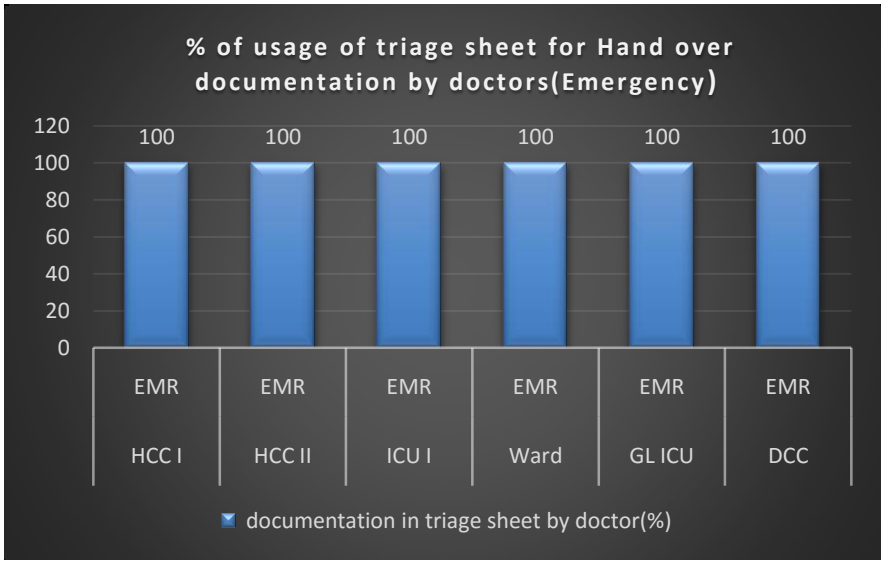

Figure 1

Figure 1 shows that in Emergency, the document used for handover by doctors is TRIAGE SHEET. For transfer of patient from emergency to Heart Command Centre (HCC), Intensive Care Unit (ICU), Gastro Liver Intensive Care Unit (GL ICU), Day Cath Centre (DCC) and ward, handover documentation is done in triage sheet.

2) OPERATION THEATRE:

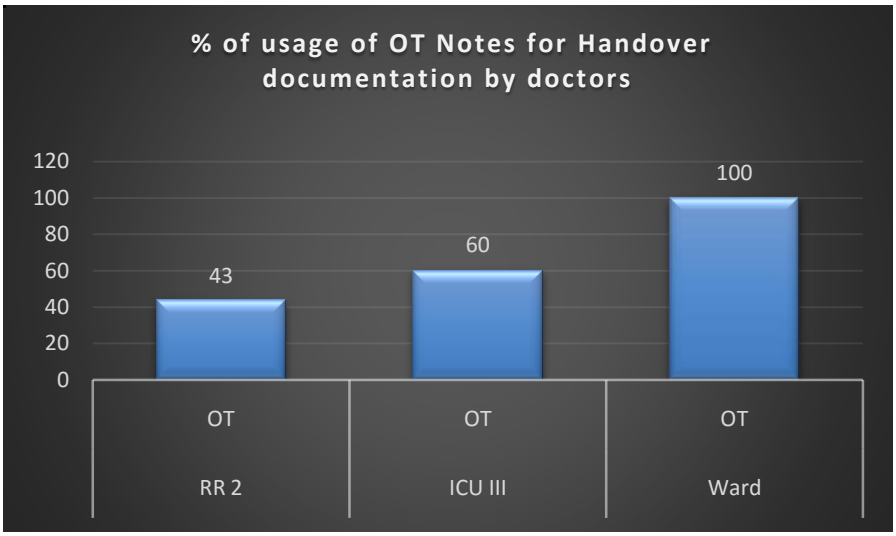

Figure 2

Figure 2 shows that when the patient is transferred from Operation Theatre (OT) to Ward, OT notes were attached in all the cases compared to transfers to Recovery Room (RR) and Intensive Care Unit where the compliance is little low.

3) RECOVERY 2

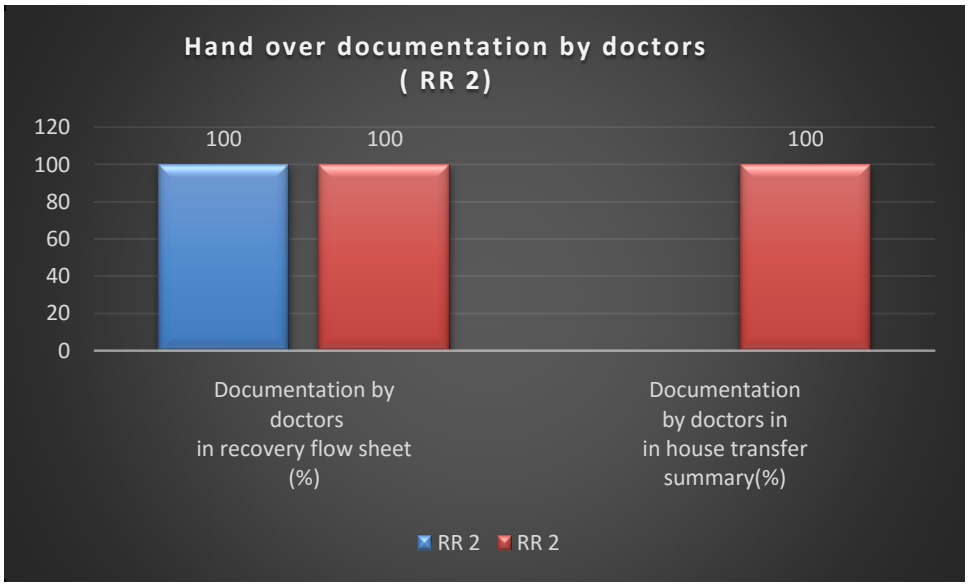

Figure 3.1

Figure 3.1 shows that documentation of handover by doctors is done in recovery flow sheet and in In-house transfer summary for transfers to RR 1 and wards respectively.

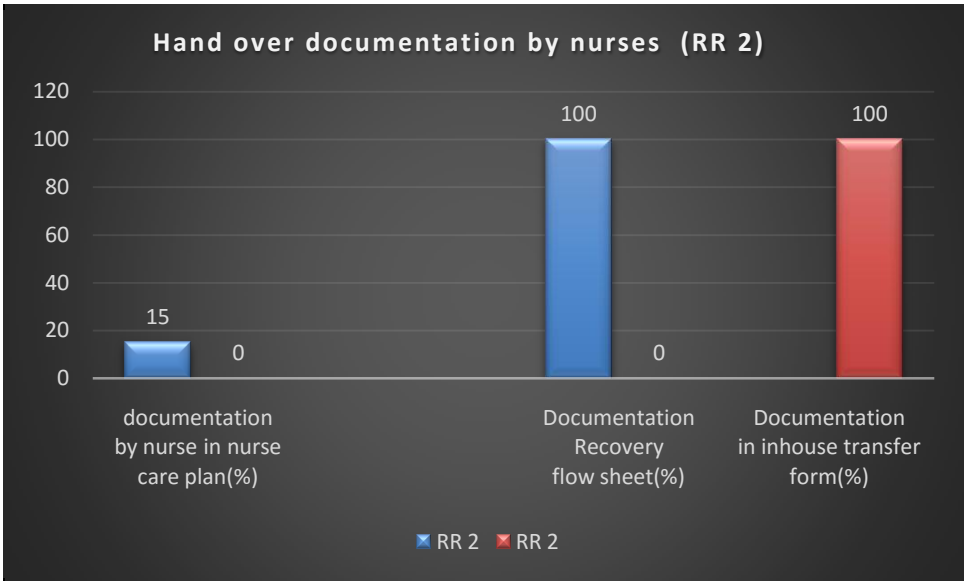

Figure 3.2

Figure 3.2 shows that In-house transfer form is used by nurses in recovery room 2 for transfer to ward while Recovery flow sheet is used more compared to nurse care plan for transfers to recovery room 1.

(4) **RECOVERY 1**

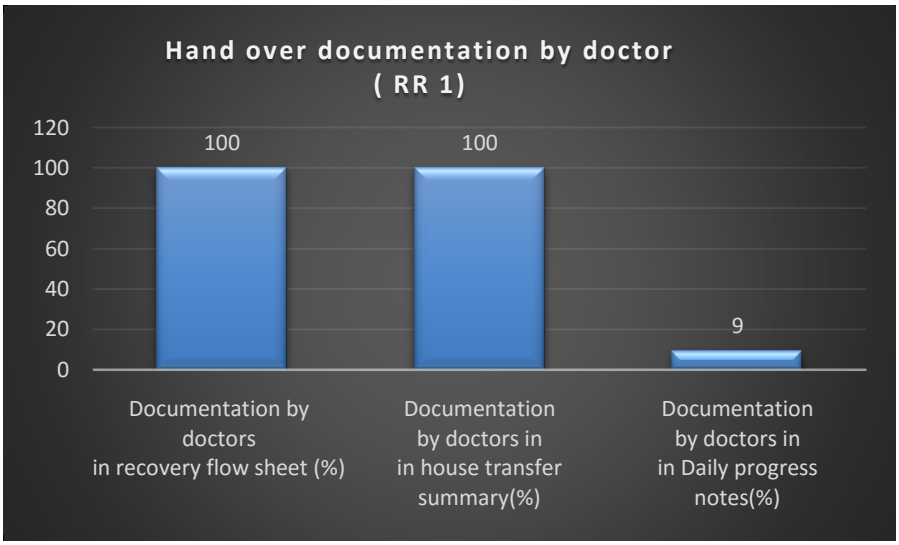

Figure 4.1

Figure 4.1 shows that handover documentation by doctors in Recovery room 1 is mostly in recovery flow sheet and In-house transfer summary. Only in 9% cases it was documented in daily progress notes.

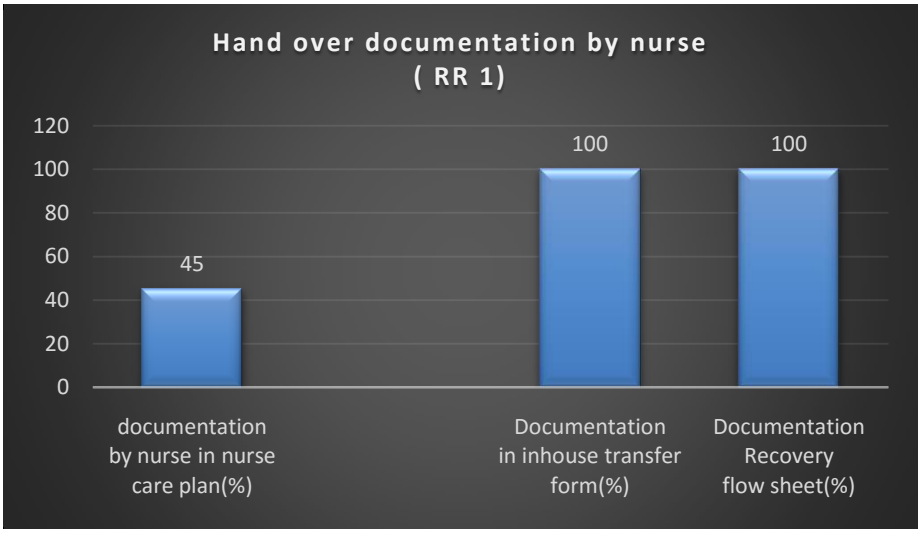

Figure 4.2

The above figure shows that handover documentation by nurses in Recovery room 1 is mostly by In-house transfer summary and recovery flow sheet compared to nurse care plan where only few handovers were documented.

(5) INTENSIVE CARE UNIT I

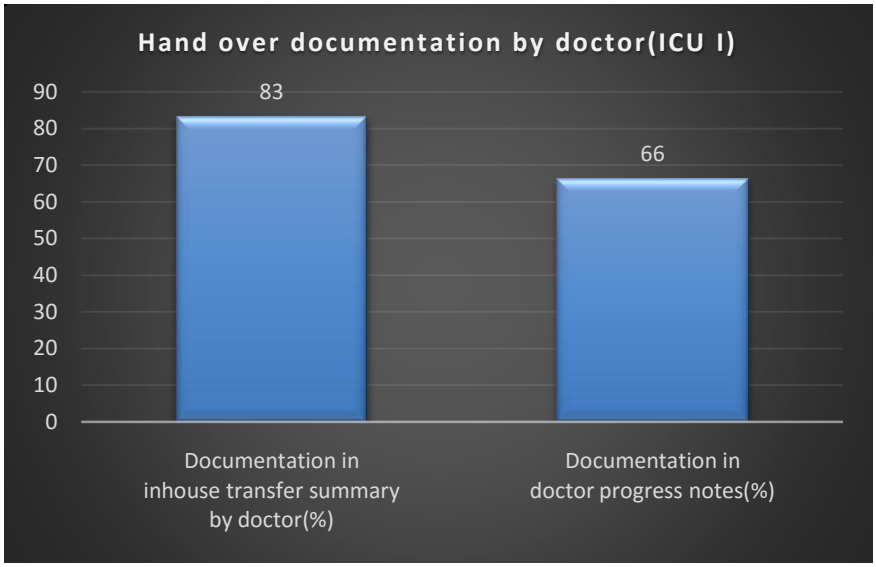

Figure 5.1

The above figure shows that for the purpose of handover documentation, In-house transfer summary is used more in comparison to daily progress notes by doctors in ICU I.

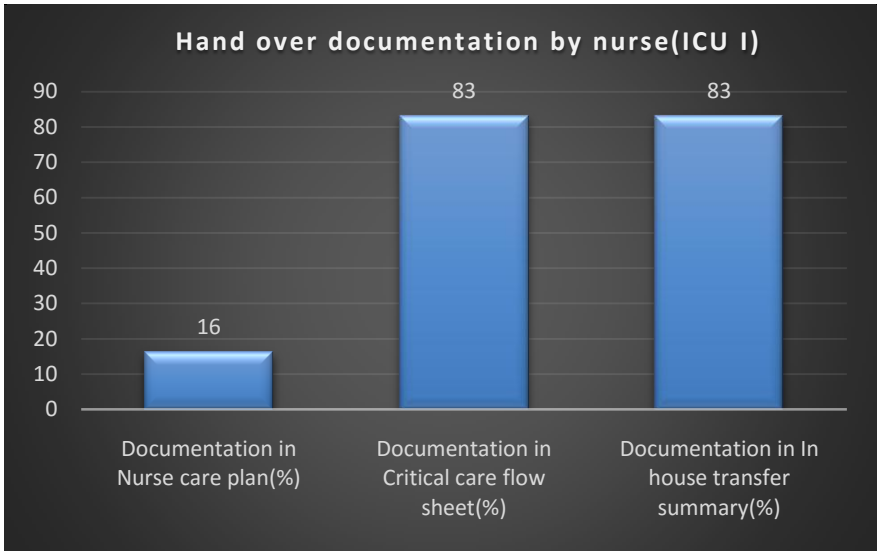

Figure 5.2

Figure 5.2 shows that, nurses in ICU I prefer critical care flow sheet and In-house transfer summary over nurse care plan for handover documentation.

(6) INTENSIVE CARE UNIT II

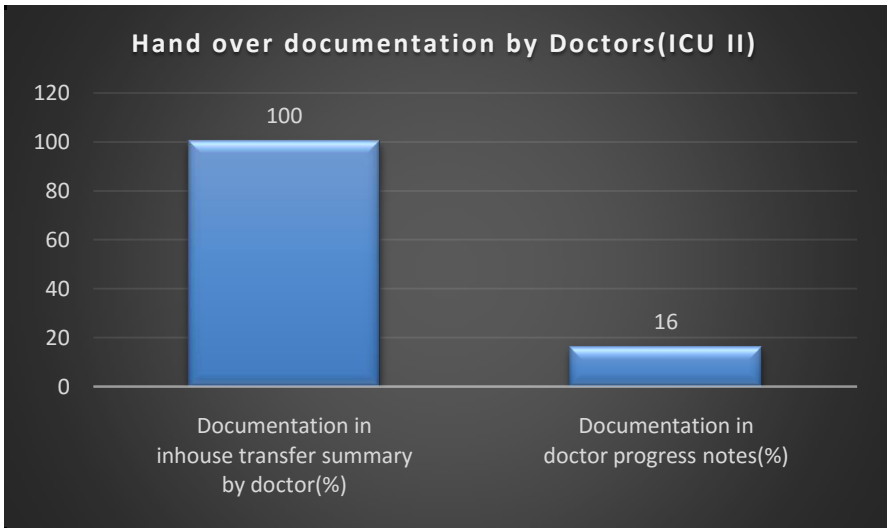

Figure 6.1

The above figure shows that handover documentation by doctors in Intensive Care Unit II (ICU II) is by In-house transfer summary. In only 16% cases it was also documented in Daily progress notes.

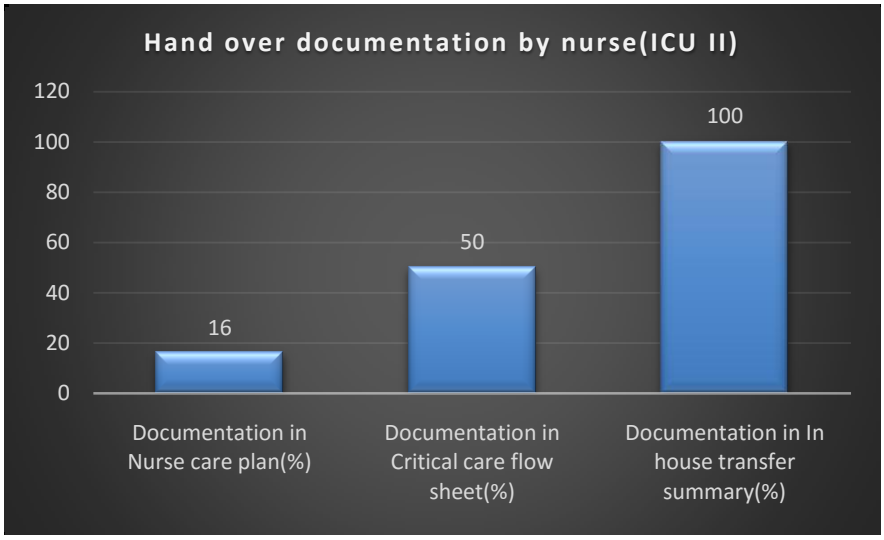

Figure 6.2

Figure 6.2 shows that handover documentation by nurses in ICU II is done preferably in In-house transfer summary compared to nurse care plan and critical care flow sheet.

(7) INTENSIVE CARE UNIT III

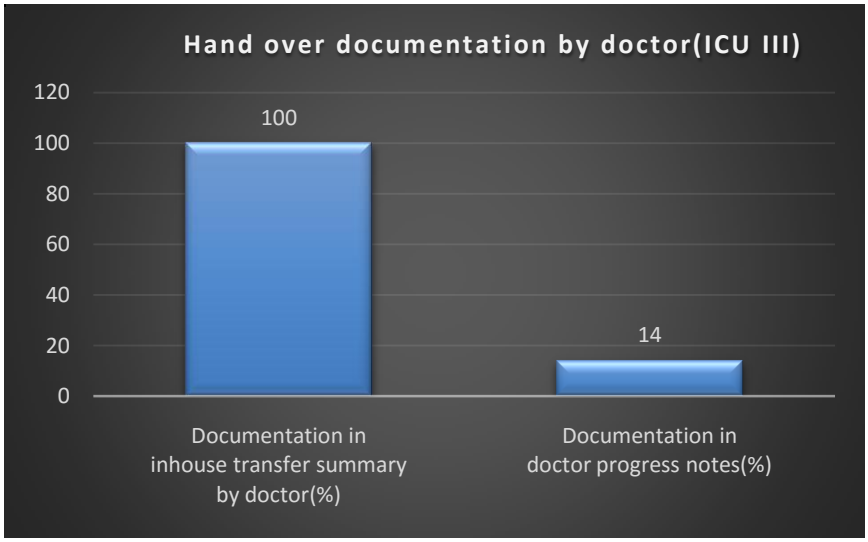

Figure 7.1

The above figure shows that doctors in ICU III prefer In-house transfer summary over daily progress notes for documentation of hand over.

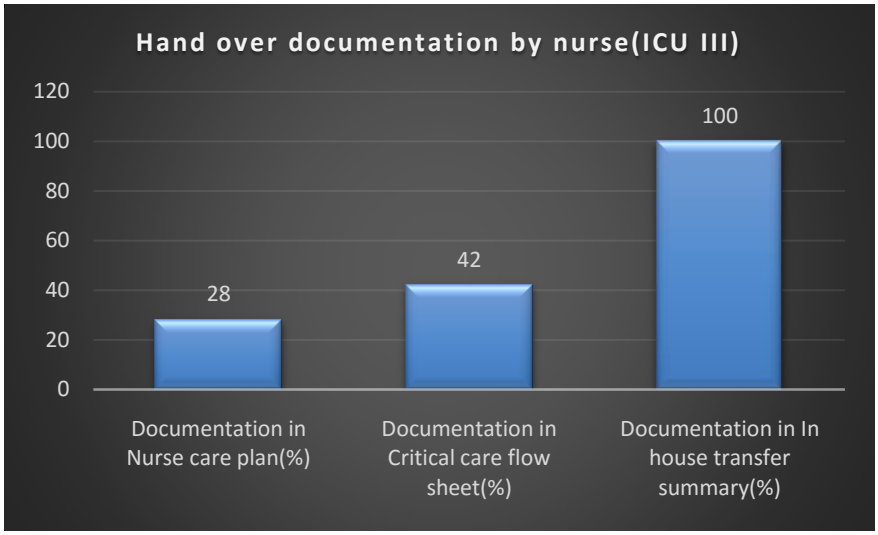

Figure 7.2

Figure 7.2 shows that like doctors, nurses in ICU III also prefer In-house transfer summary for handover documentation. However, critical care flow sheet and nurse care plan are also used to some extent.

(8) HEART COMMAND CENTRE I

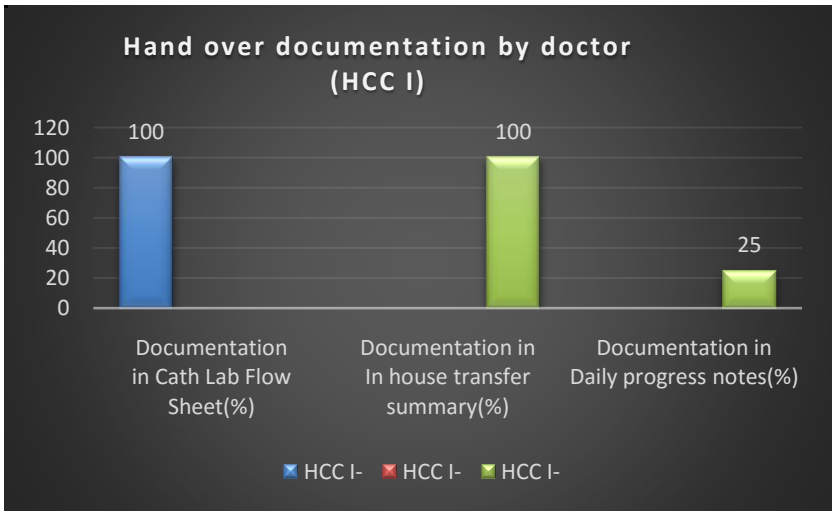

Figure 8.1

Figure 8.1 shows that on transfer of patient from HCC I to Ward, doctors prefer to document the handover in In-house transfer summary compared to daily progress notes. And transfer of patient to Cath lab is documented positively in Cath lab flow sheet for all the cases.

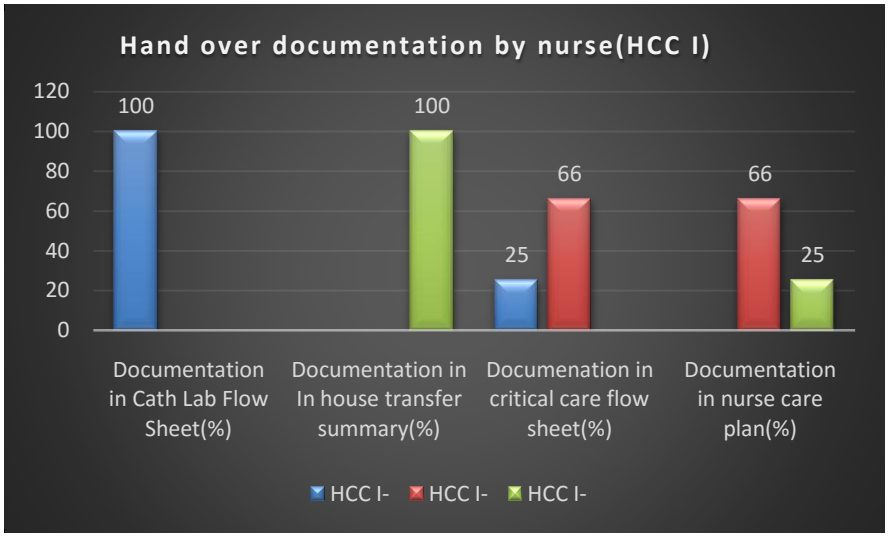

Figure 8.2

The above figure shows handover documentation by nurses in HCC I. It reveals that when the patient is transferred to Cath lab, Cath lab flow sheet is the form of choice. On transfer to Ward, nurses prefer to document the handover in In-house transfer summary over nurse care plan and transfer to Operation Theatre is documented in both nurse care plan and critical care flow sheet.

(9) HEART COMMAND CENTRE II

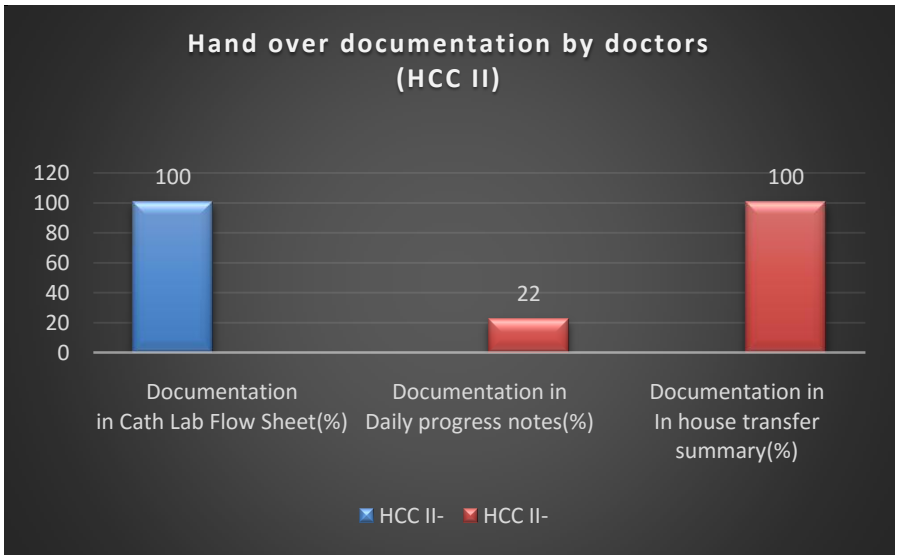

Figure 9.1

The above figure shows that transfer of patient from HCC II to Cath lab is documented by doctors in Cath lab flow sheet. And for transfer of patient from HCC II to Ward, doctors prefer to document the handover in In-house transfer summary over Daily progress notes.

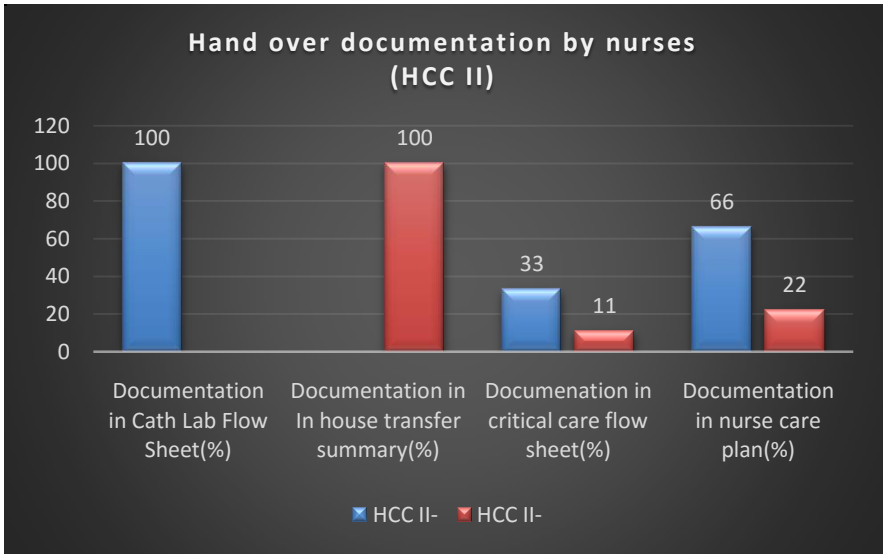

Figure 9.2

Figure 9.2 demonstrates that handover documentation by nurses is commonly done in Cath lab flow sheet on transfer of patient from HCC II to Cath lab. And documentation of transfer to Ward is done preferably in In-house transfer summary.

(10) GASTRO-LIVER INTENSIVE CARE UNIT:

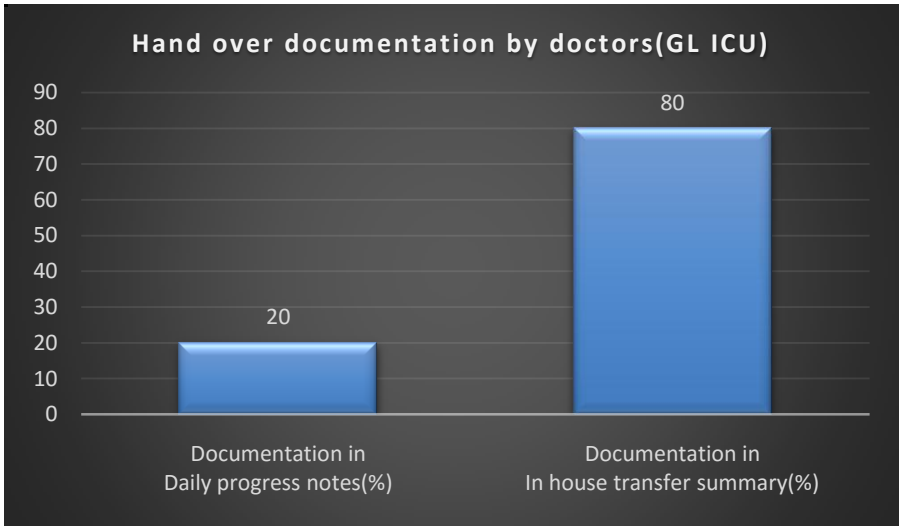

Figure 10.1

Figure 10.1 shows that doctors prefer In-house transfer summary over Daily progress notes to document the transfer of patients from GL ICU to other departments.

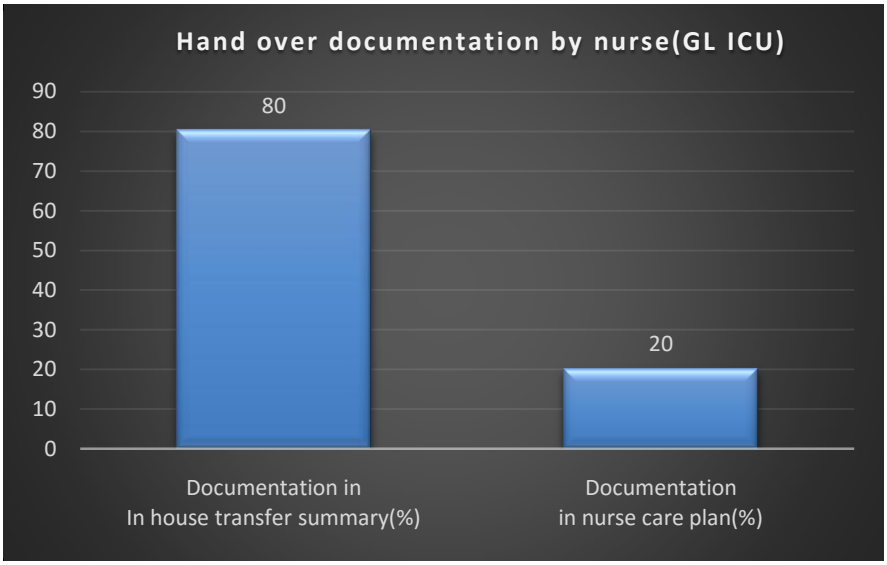

Figure 10.2

Figure 10.2 shows that nurses prefer In-house transfer summary over nurse care plan to document the transfer of patients from GL ICU to other departments.

(11) CATH RECOVERY ROOM

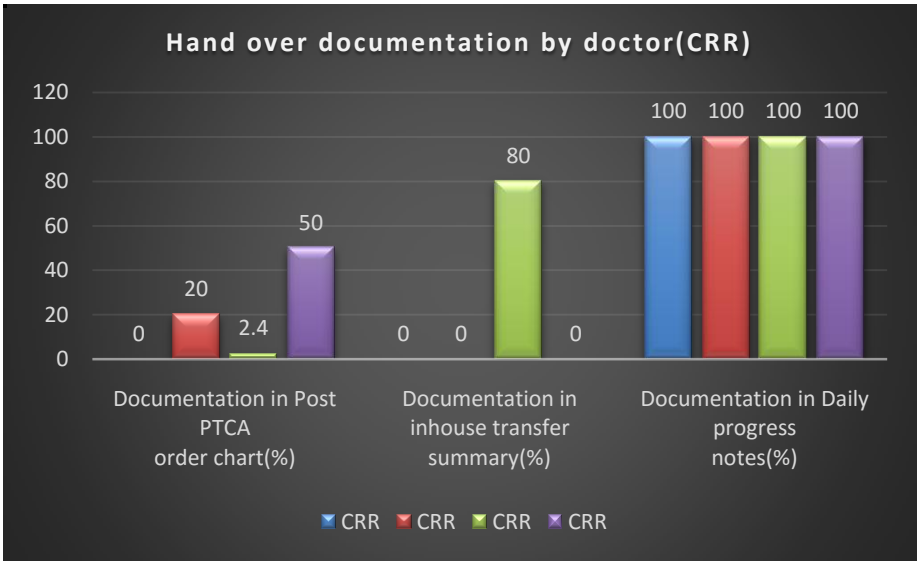

Figure 11.1

The above figure shows that Daily progress notes is the document of choice used by doctors in Cath recovery room for handover documentation of transfer of patients from CRR to HCC I, HCC II, Ward and ICU III

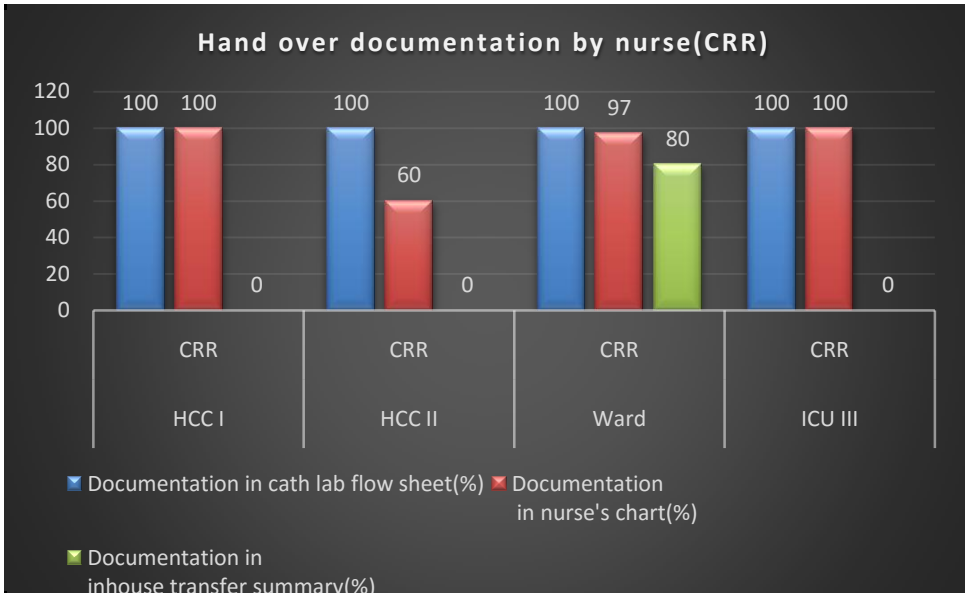

Figure 11.2

Figure 11.2 shows that for the transfers from CRR to ICU, HCC, nurses document the handover in both Cath lab flow sheet and nurse's chart. However, in case of transfer to Ward, In-house transfer summary is also filled along with the other two documents.

(12) WARD

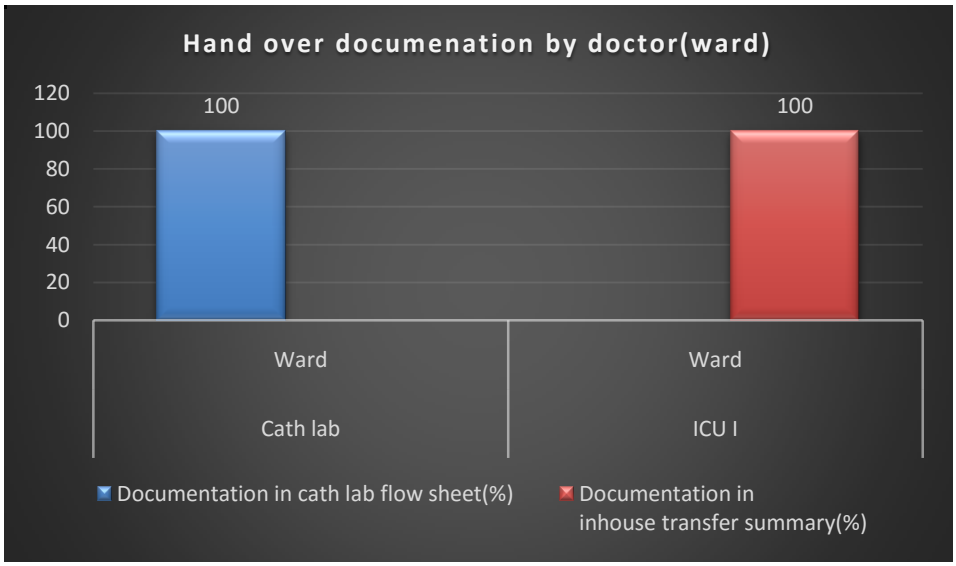

Figure 12.1

The above figure shows that doctors document the handover in In-house transfer summary on transfer of patient from Ward to ICU I while documentation is done in Cath lab flow sheet on transfer to Cath lab.

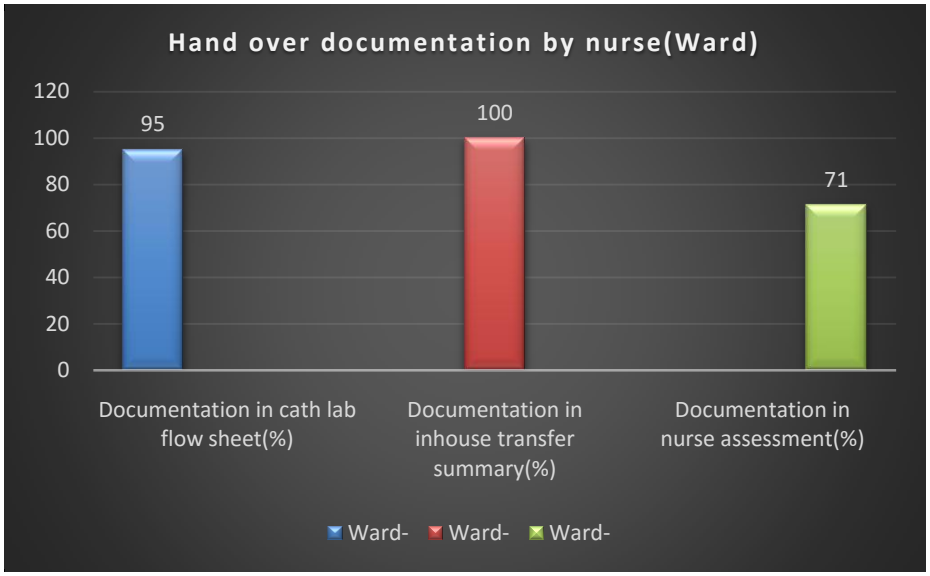

Figure 12.2

Figure 12.2 shows that the preferred document for handover communication used by nurses in Ward is Cath lab flow sheet for transfer to Cath lab, In-house transfer summary for transfer to ICU I and Nurse's assessment sheet for transfer to OT.

[B] Deficiencies in handover documentation by doctors and nurses (department wise)

Handover communication is considered complete only when there is documentation at both the ends i.e. any note or signature of the doctors and nurses at transferring end of the patient and receiving end of the patient. Lack of documentation at one end is considered as incomplete handover documentation and hence it is identified as a deficiency.

Further, the forms and documents used by the doctors and nurses should be completely filled i.e. it should carry all the necessary details present on the form. If any parameter is not filled or the form is incomplete, it is considered as a deficiency in handover documentation.

The following table illustrates the deficiencies identified in documentation of handover by doctors and nurses in various departments:

Table 2: Deficiencies in handover documentation

	Deficiencies in documentation of hand over	
Department	Documentation by doctor	Documentation by nurse
EMR	Nil	Nil
OT	OT Notes not attached	Nil
RR 2	Nil	Nil
RR 1	Receiving doctor's sign missing in In-house transfer summary	Patient demographic details missing
ICU I	1.Receiving doctor's sign missing in In-house transfer summary 2.Daily progress notes not attached 3.Management plan missing in In-house transfer summary	
ICU II	Receiving doctor's sign missing in In-house transfer summary	Receiving nurse's sign missing in in-house transfer summary
ICU III	1.Receiving doctor's sign missing in In-house transfer summary 2.Management plan missing in In-house transfer summary	1.Receiving nurse's sign missing in in-house transfer summary 2.Patient demographic details missing
HCC I	Receiving doctor's sign missing in In-house transfer summary	1.Receiving nurse's sign missing in in-house transfer summary 2.Patient demographic details missing
HCC II	Receiving doctor's sign missing in In-house transfer summary	1.Receiving nurse's sign missing in in-house transfer summary 2.Patient demographic details missing
GL ICU I	Receiving doctor's sign missing in In-house transfer summary	1.Receiving nurse's sign missing in in-house transfer summary 2.Patient demographic details missing
CRR	1.Receiving doctor's sign missing in In-house transfer summary 2.Transferring doctor's sign missing in Cath lab flow sheet 3.Management plan missing in In-house transfer summary	Patient demographic details missing
Handover documentation on shift change	No documentation in any of the departments	No documentation in Ward, ICU, HCC

Implementation:

- Standard hand over formats introduced for nurses and doctors in WARDS, HCCI, HCC II, ICU I, ICU II, ICU III to ensure hand over documentation during shift changes.
- Education and training programs organized for the doctors and nurses for effective handover communication.
- Training of on-duty doctors and nurses regarding proper hand over documentation.

Two different nurse's hand over check list formats are designed for wards and critical care areas. Following parameters have been included in the check list:

Check list for Wards

1.Information regarding: • Procedures done • Doctor's visit • Old reports and records • Pending reports and investigations • Diet plans • Medication missed/pending
2.Check for: • Bedside label, ID band, date on cannula • Medication cupboard • Medical equipment • Working status of oxygen /suction
3.Critical information /Special note

Check list for Critical areas (ICUs and HCCs)

1.ID bands, bedside label, call bell, Patient belongings, old reports and records, pending reports and investigations, diet plan, important order to be followed, fasting status should be verified.
2.Medication: • Medication missed or pending • Highlight, counter sign and labelling of high risk medications.
3.Skin status of the patient, any drain, sheath/central line/ART line, surgical site, Foley's catheter to be shown to the next staff.
4.Demonstration check: • Working status of oxygen flow/suction pressure • Monitor /Spo2 parameter • Backflow of CVP, arterial line

(a)One hand over check list format has been designed for doctors for documentation during shift changes.

(b)In ICUs, Hand over documentation will be carried out in critical care flow sheet.

Following parameters have been included in the check list:

Check list for Doctors

1.Patient details 2.Diagnosis 3.Problem 4.Current Status 5.Action required

- Post implementation, an audit of **200 IPD records** was done. The analysis of the collected data shows that there has been a considerable improvement in the handover documentation by doctors and nurses. Following graphs shows comparison of hand over documentation pre and post implementation.
- It is very evident in the graphs that post implementation there is an improvement in the documentation process. However, further improvement can be brought about if the practice becomes the culture of the organization.

Note: The new handover formats are attached in Annexure-I.

FINDINGS:(Post implementation)

1) **OPERATION THEATRE**

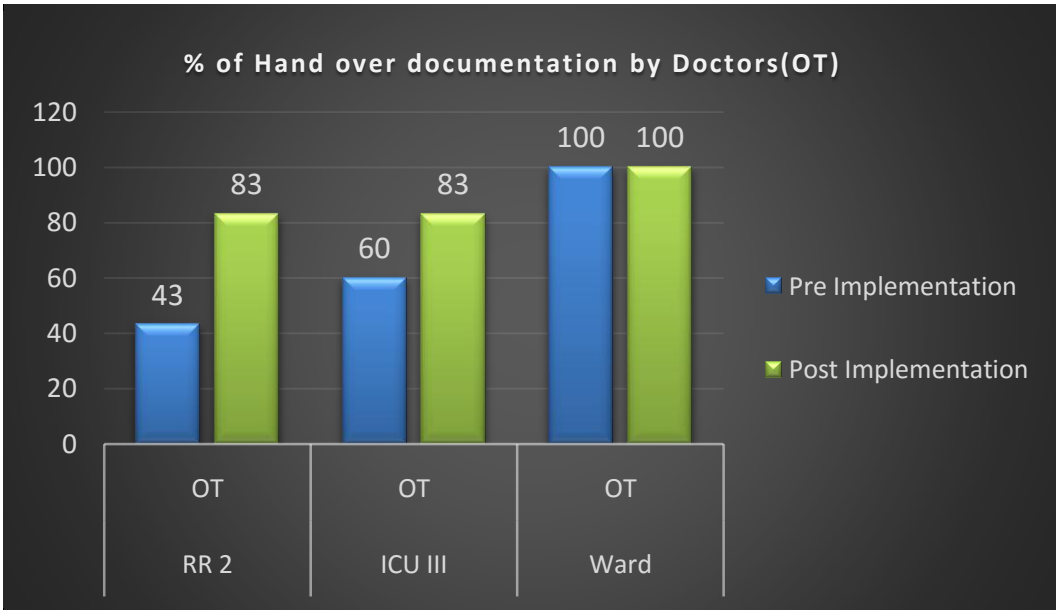

Figure 13

Figure 13 shows that handover documentation is very good on patient transfers from OT to Ward. However, the compliance is a bit less on transfers from OT to RR 2 and from OT to ICU III. These areas require improvement.

2) INTENSIVE CARE UNIT I

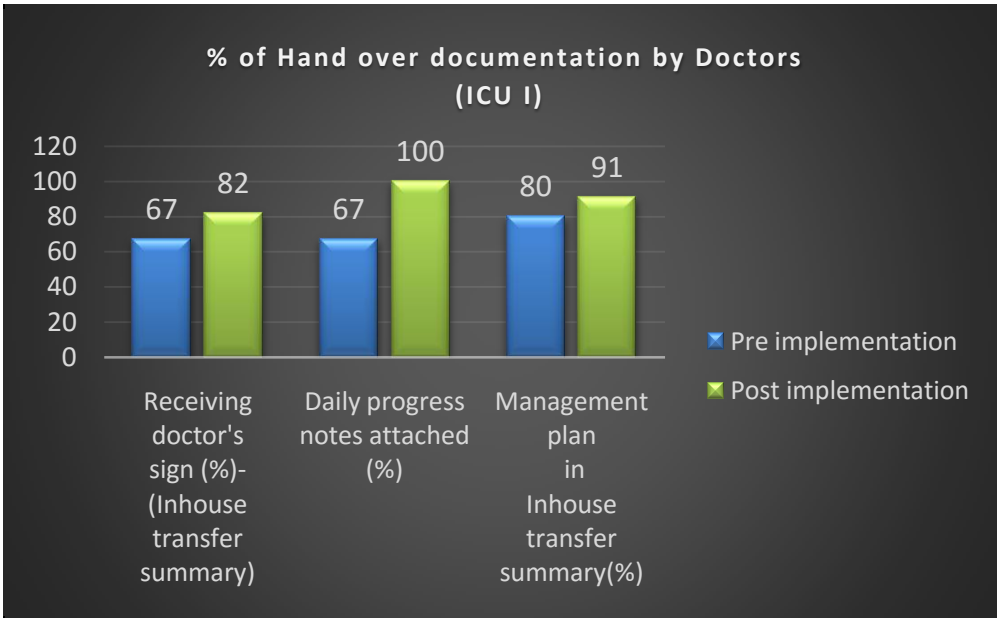

Figure 14

The above figure shows an improved compliance of handover documentation by doctors in ICU I. Areas of concern which need improvement are receiving doctor's sign in in-house transfer summary and attachment of daily progress notes in patient record.

3) RECOVERY ROOM 1

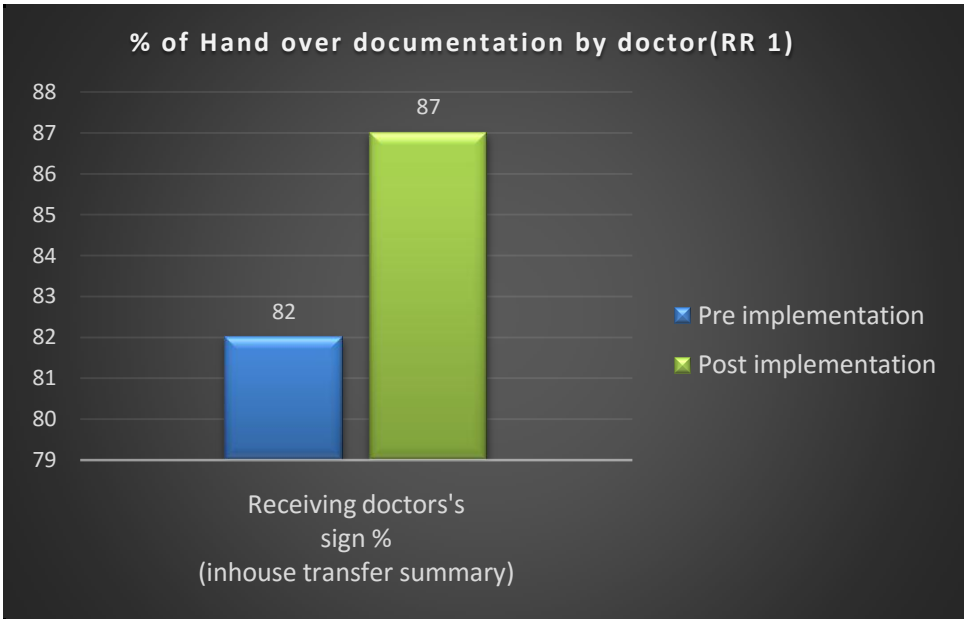

Figure 15.1

Figure 15.1 shows an improvement in the documentation by doctors post implementation.

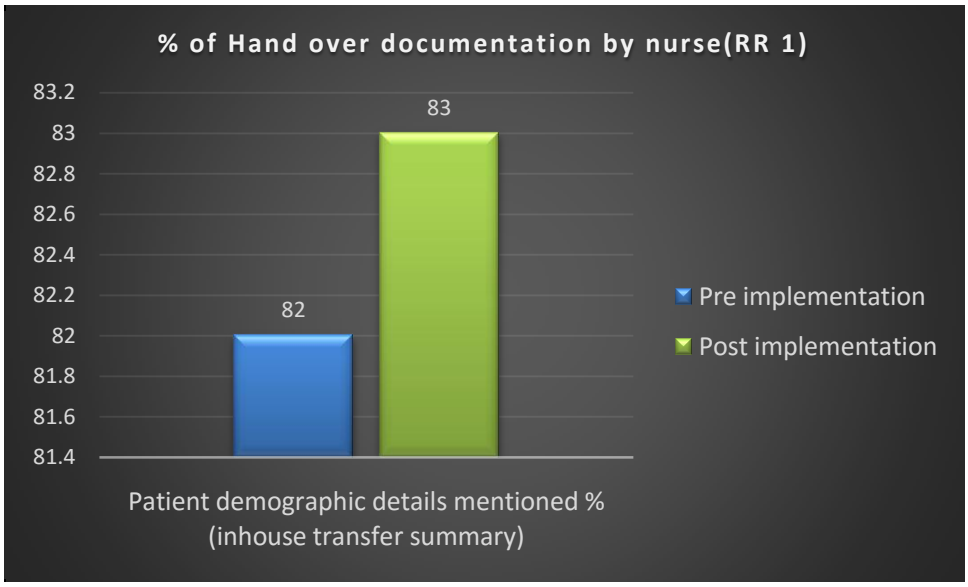

Figure 15.2

Post implementation there is improved documentation by nurses in RR 1 and the In-house transfer summary forms are complete. But, there is still a scope of improvement.

4) INTENSIVE CARE UNIT II

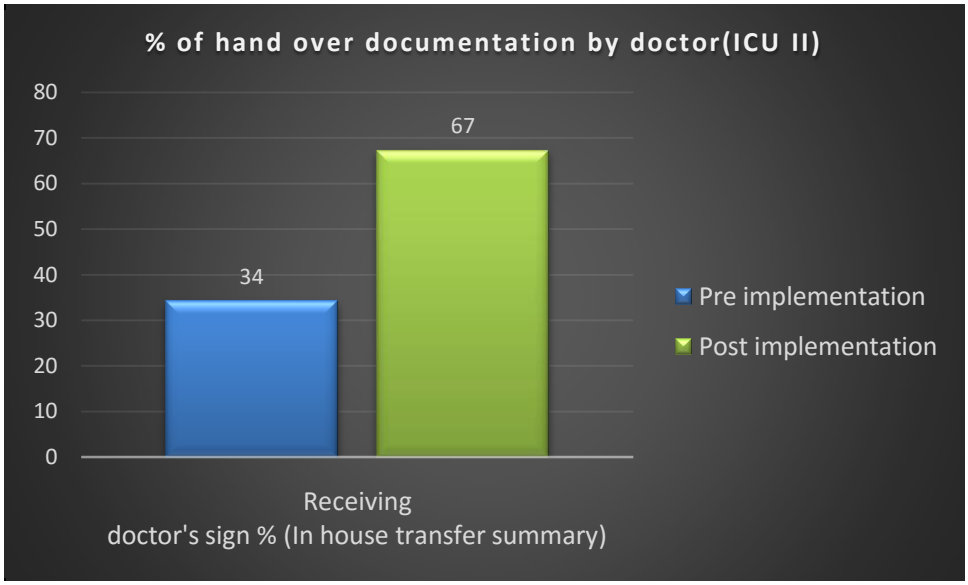

Figure 16.1

Figure 16.1 and 16.2 shows a commendable increase in compliance of In-house transfer summary from doctor's and nurse's side post implementation. It can be further improved with on-duty trainings and reinforcement.

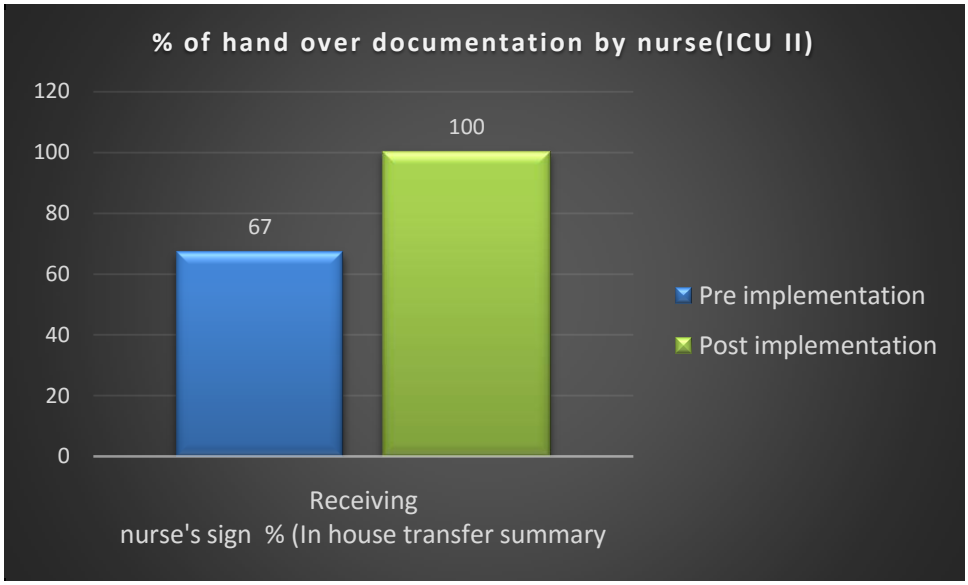

Figure 16.2

5) INTENSIVE CARE UNIT III:

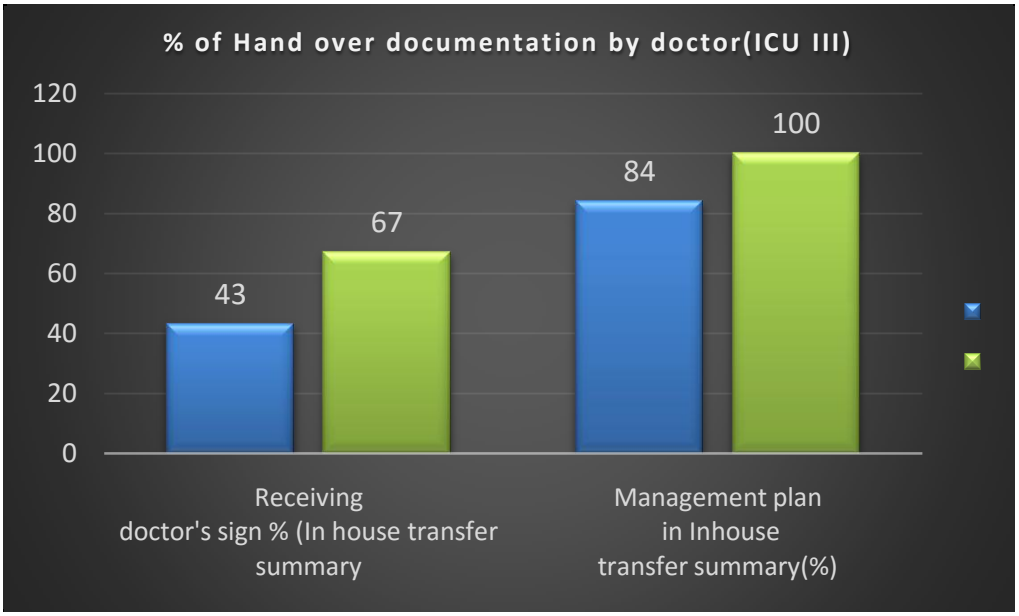

Figure 17.1

Figure 17.1 and 17.2 shows a commendable increase in compliance of In-house transfer summary from doctor's and nurse's side post implementation. It can be further improved with on-duty trainings and reinforcement.

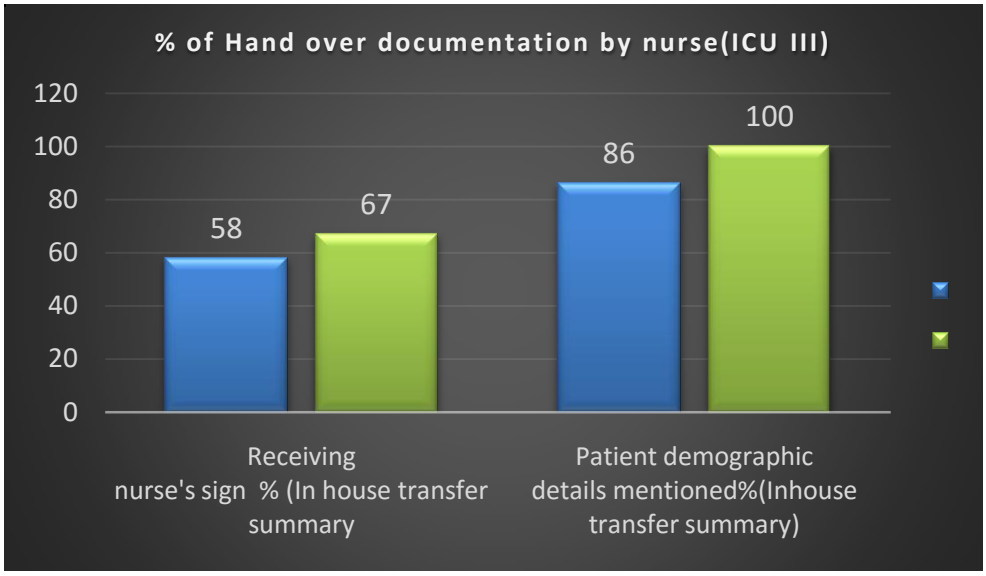

Figure 17.2

6) HEART COMMAND CENTRE I

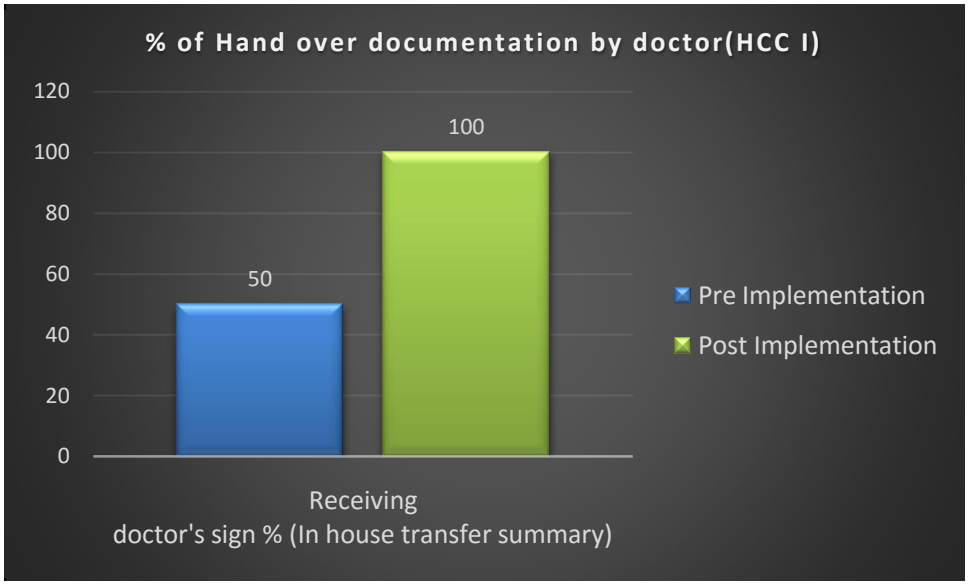

Figure 18.1

Figure 18.1 shows excellent compliance in documentation by doctors in In-house transfer summary post implementation.

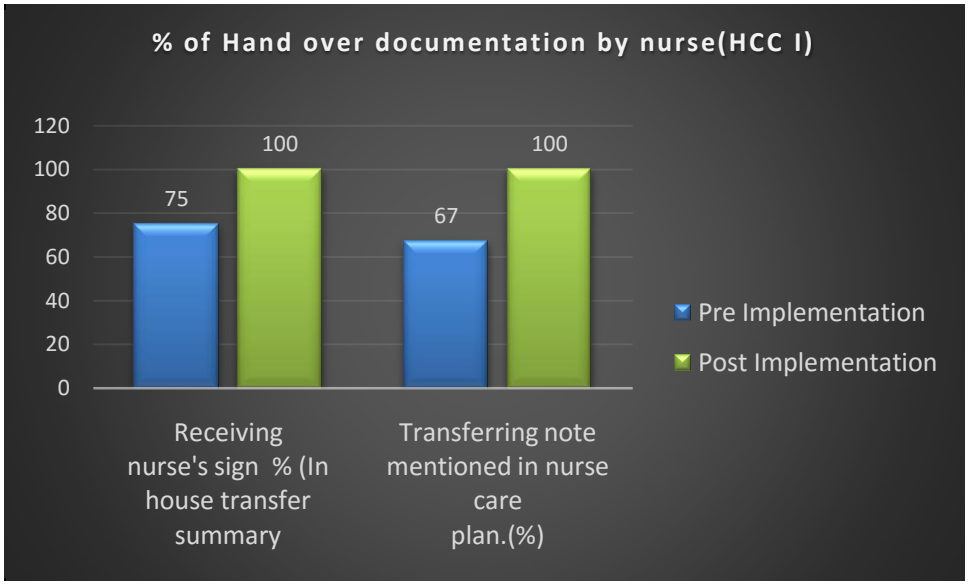

Figure 18.2

The above figure shows excellent compliance in handover documentation by nurses in In-house transfer summary and nurse care plan post implementation.

7) HEART COMMAND CENTRE II

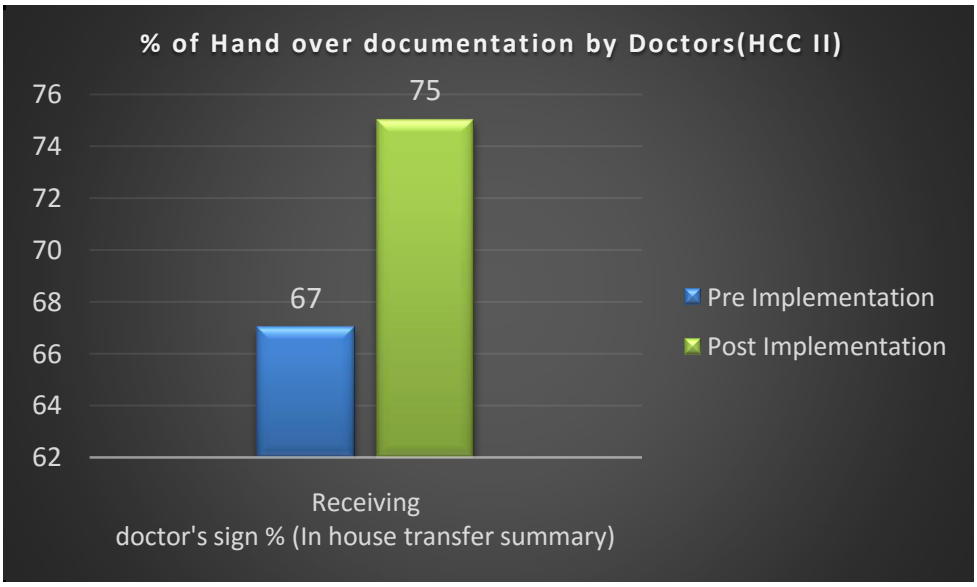

Figure 19.1

Figure 19.1 and 19.2 shows the improved compliance of documentation in In-house transfer summary by doctors and nurses respectively. The compliance of nurse's documentation is excellent while on doctors' side, still there is a scope of improvement.

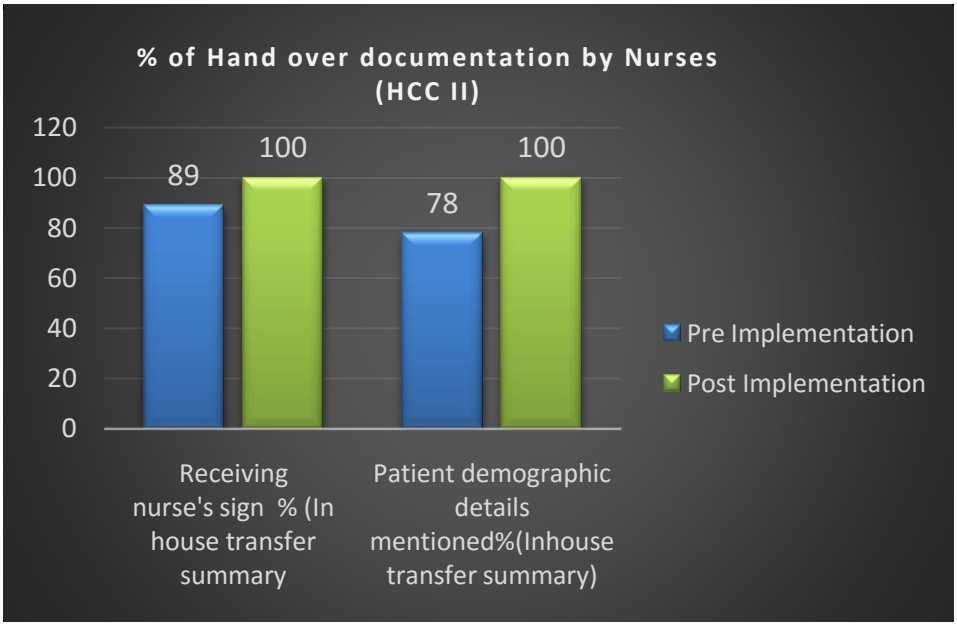

Figure 19.2

8) CATH RECOVERY ROOM

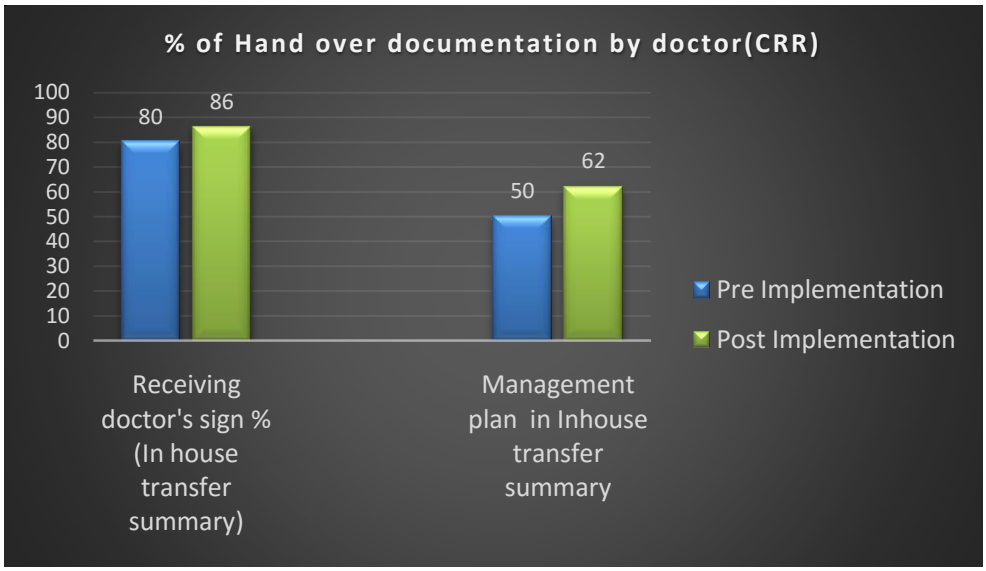

Figure 20.1

Figure 20.1 and 20.2 shows the improved compliance of documentation in In-house transfer summary by doctors and nurses respectively. The compliance of nurse's documentation is excellent while on doctors' side, still there is a scope of improvement.

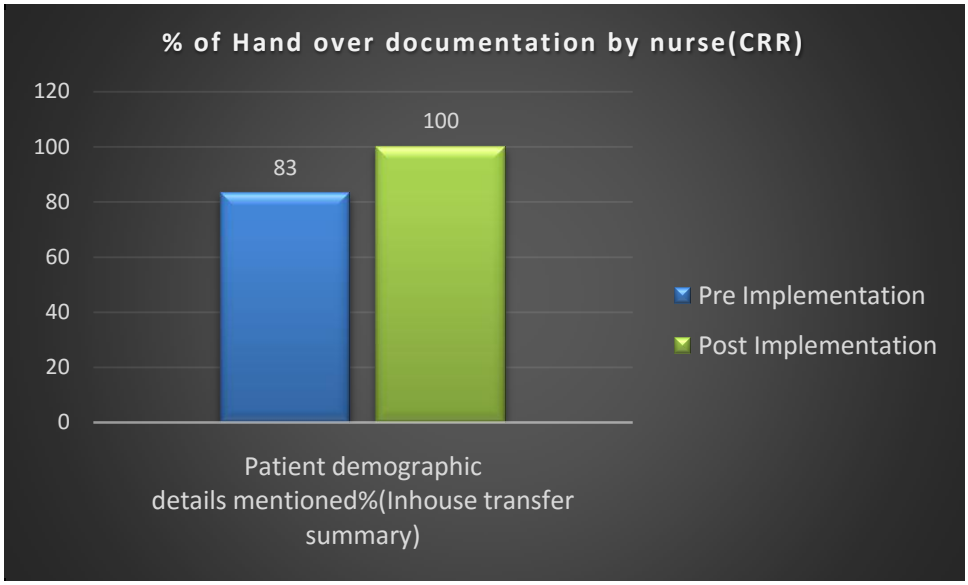

Figure 20.2

Intradepartmental hand over documentation by nurses

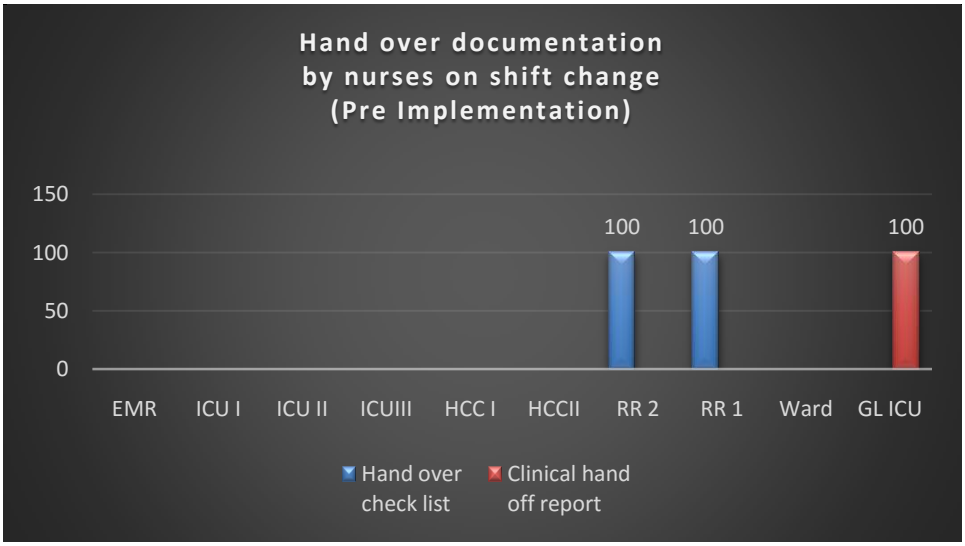

Figure 21.1

The above figure shows that except for recovery and GL ICU, there is no hand over documentation by nurses in any other department. New hand over formats needs to be introduced.

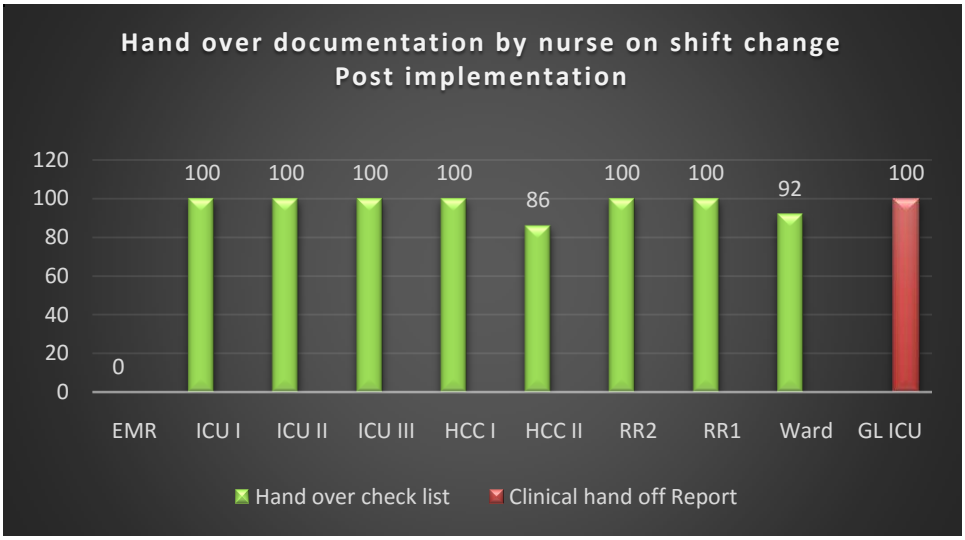

Figure 21.2

The above figure shows that post implementation of new formats, the compliance of handover documentation by nurses on shift change is quite high. However, more reinforcement of the new format is required in HCC II and Ward.

Intradepartmental hand over documentation by doctors

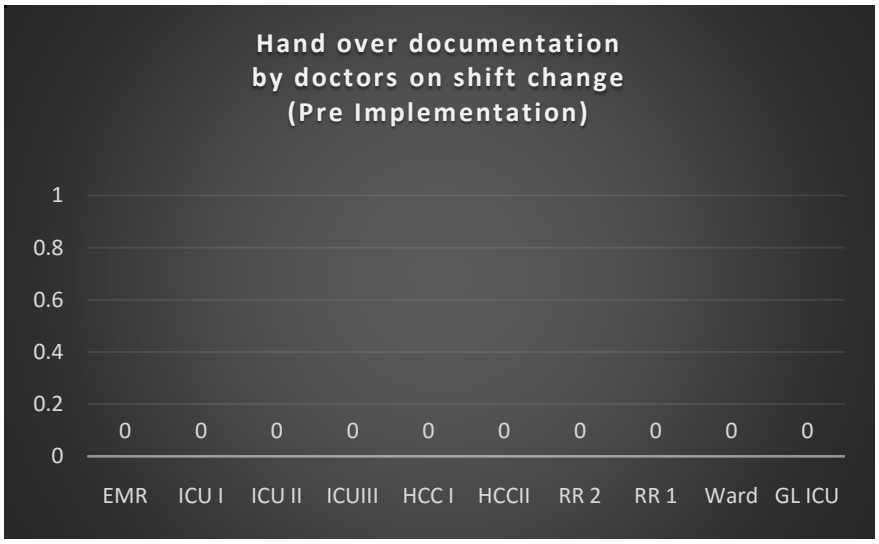

Figure 22.1

Figure 22.1 shows that there is no hand over documentation by doctors on shift change in any of the areas. New formats for handover needs to be introduced.

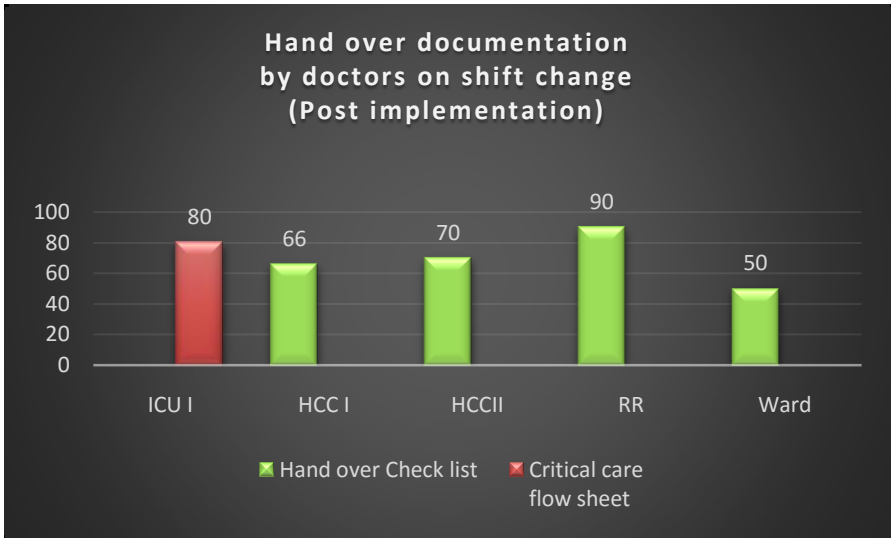

Figure 22.2

Figure 22.2 shows that, post implementation of new handover formats, there has been a considerable improvement in handover documentation by doctors on shift change. However, more reinforcement in required in Ward and HCCII.

Suggestions:

- Education and training programs to be organized for the doctors and nurses for effective handover communication.
- Regular monitoring and reinforcement of the newly introduced hand over formats.
- Also reinforce the use of standard hand over formats already implemented by the hospital.

Conclusion:

Good clinician handover is vital to protect patient safety. The importance of good handover has never been so high due to the decreased hours of work and increase in shift changeover, and due to the general increase in the pressure on the hospital system to 'do more with less'. Systems need to be put in place to enable and facilitate handover.

By reviewing of IPD records with sample size 100, it has been observed that verbalhandovers are more commonly used than written handovers at FEHI.The handover documentation by nurses during shift change is practiced only in Recovery Rooms and GL ICU.

Post implementation of new hand over formats for nurses and doctors during shift changes, an observation of 200 IPD records shows 92% hand over documentation by nurses in Wards, 100% documentation in HCC I, ICU I, ICU II, ICU III and 86% hand over documentation in HCC II and documentation by doctors is 66% in HCC I, 70% in HCC II, 90% in RR, 50% in wards, 80% in ICU I.As far as interdepartmental hand over documentation is concerned, there has been a considerable improvement post training of on-duty doctors and nurses. However, there is a scope for further improvement.

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ANNEXURE-I

1) **Handover documentation format introduced for doctors on shift change**

NAME	Diagnosis:	DOCTOR 1:
AGE	Problem:	
IPD NO.		
BED NO.	Current Status:	DOCTOR 2:
EPISODE DOCTOR	Action Requiuted:	
NAME	Diagnosis:	DOCTOR 1:
AGE	Problem:	
IPD NO.		
BED NO.	Current Status:	DOCTOR 2:
EPISODE DOCTOR	Action Requiuted:	
NAME	Diagnosis:	DOCTOR 1:
AGE	Problem:	
IPD NO.		
BED NO.	Current Status:	DOCTOR 2:
EPISODE DOCTOR	Action Requiuted:	
NAME	Diagnosis:	DOCTOR 1:
AGE	Problem:	
IPD NO.		
BED NO.	Current Status:	DOCTOR 2:
EPISODE DOCTOR	Action Requiuted:	
NAME	Diagnosis:	DOCTOR 1:
AGE	Problem:	
IPD NO.		
BED NO.	Current Status:	DOCTOR 2:
EPISODE DOCTOR	Action Requiuted:	
NAME	Diagnosis:	DOCTOR 1:
AGE	Problem:	
IPD NO.		
BED NO.	Current Status:	DOCTOR 2:
EPISODE DOCTOR	Action Requiuted:	

2) **Handover document formats for nurses on shift change.**

NAME:	REG.NO.			IPD. NO			DIAGNOSIS:		
UNIT:									
SHIFT & DATE	M	E	N	M	E	N	M	E	N
Explain									
Patient profile (DOA,under Doctor, diagnosis, treatment)									
Old Reports & records (X ray, CT, Lab, MRI, Old CD)									
Pending lab reports & Investigations									
About diet, I/O chart									
Important order to be followed (RBS, ABG, All investigations)									
Any medication missed & pending									
Pending Consultations									
Shown to the next staff									
gh									
Drain (ICD, any abdominal drain, romo drains)									
Skin status of the patient with Braden score									
Foley's catheter/ condom									
Tracheostomy/ endotracheal tube									
Pts Belongings (Dentures, Spectacles)									
Demonstration/ Check									
Monitor/Spo2 parameters with clear wave forms									
Back flow of CVP,arterial line									
Functioning of ICD drain with column movement									
Working status of Oxygen									
Working status of suction									
Tracheal suctioning									
Handed over by: (Name & ID)									
***Received by:*(Name & ID)**									

Critical Areas: ICU, HCC

Recovery

NAME:				AGE:		SEX:		UHID
UNIT:								
DATE:	+							
SHIFT:	M	E	N	M	E	N	M	E
ASPECTS								
q								
Old Reports & Records (Lab reports, Xray, CT, MRI, Old CDs, HS)								
Pending lab reports and investigations								
About diet, I/O chart								
Important order to be followed (RBS, ABG, All investigations)								
Any medication missed & pending					p			
Fasting status (For tests,OT)								
Pending referrals								
Shown to the next staff								
Peripheral IV, CVP line, arterial line etc.(Check site for redness,skin peel)								
Drain (ICD, any abdominal drain, romo drains)								
Intact Epidural catheter								
Colostomy, jejunostomy, ileostomy stomas and bags								
Skin status of the patient with Braden score								
Foley's catheter/ condom								
Tracheostomy/ ministracheostomy								
Ryle's tube								
Pts Belongings (Dentures, Spectacles)								
Demonstration/ Check								
Monitor/Spo2 parameters with clear wave forms								
Back flow of CVP,arterial line								
Colostomy bag dressing,emptying								
Functioning of ICD drain with column movement								
Working status of Oxygen								
Working status of suction								
Tracheal suctioning								
Handed over by: (Name & ID)								
Received by:(Name & ID)								

PATIENT NAME:	REG NO:		
DOA:	CONSULTANT:		
ROOM NO.			
DATE:	**N**	**M**	**E**
PROCEDURES DONE			
DOCTORS VISITED +PENDING REFERALS			
Old Reports & Records (Lab reports, Xray, CT, MRI, Old CDs, HS)			
Pending lab reports and investigations to be done			
Diet plans			
I/O chart			
Any medication missed/ pending/to be indented			
Drain (ICD, any abdominal drain, romo drains, catheter)			
Check			
BED SIDE LABEL + ID BAND+SAFETY SIGNAGE	YES/NO	YES/NO	YES/NO
Fall Prevention Explained	YES/NO	YES/NO	YES/NO
DATE ON IV CANNULA / IV SETS(VIP SCORE)	YES/NO	YES/NO	YES/NO
MEDICATION CUPBOARD	LOCKED/ CLEAN	LOCKED/ CLEAN	LOCKED/ CLEAN
CALL BELL/BEDS SIDERAILS/ REMOTE WORKING	YES/NO	YES/NO	YES/NO
MEDICAL EQUIPMENT	YES/NO	YES/NO	YES/NO
ALPHA BED /DVT PUMP	YES/NO	YES/NO	YES/NO
Working status of Oxygen/ suction	YES/NO	YES/NO	YES/NO
CRITICAL INFORMATION /SPECIAL NOTE			
Handed over by: (Name & ID)			
Received by:(Name & ID)			

Ward