A Study On Clinical Hand Over Communication at Fortis Escorts Heart Institute , New Delhi

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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)

Effective handover communication, a part of International Patient Safety Goal 2 (JCI), 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.

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

Objectives

- To identify the hand over documentation methods used by various departments in IPD within the hospital.
- To ensure proper documentation of hand over by doctors and nurses during interdepartmental transfers and during shift changes.

Methodology

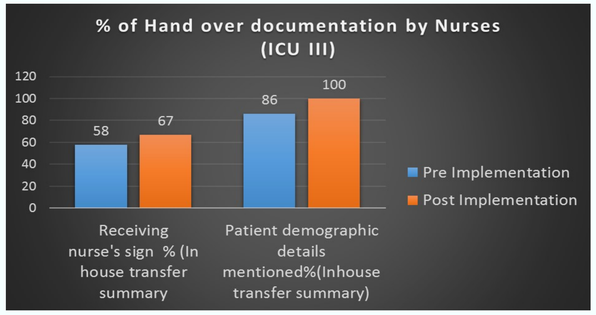
Study design: Pre Test- Posttest study
Study Population: IPD Patient records
Sampling Method: Non-Probability convenience sampling
Sample Size: 300 (Total)
100- Pre implementation
200- Post implementation
Data Collection: Data was collected by audit of IPD patient records on each floor with the help of a checklist.

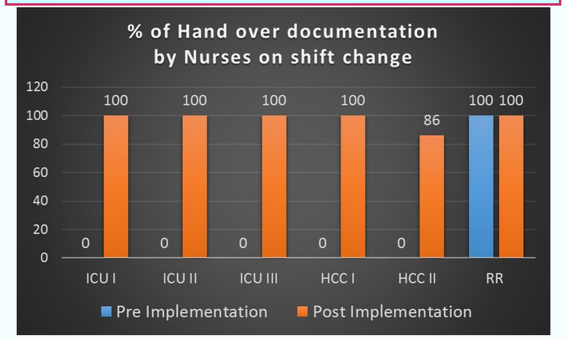
Findings

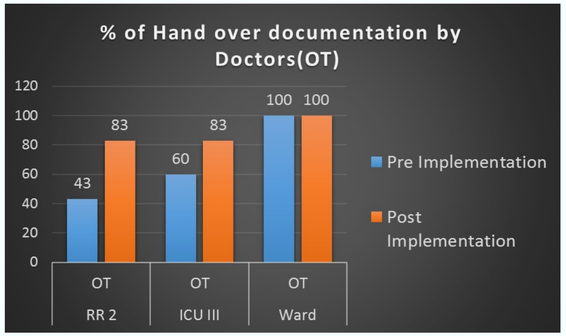
	Deficiencies in documentation of hand over	
Depart-ment	Documentation by doctors	Documentation by nurses
Emergency	Nil	Nil
Operation theatre	OT Notes not attached	Nil
Recovery	Receiving doctor's sign missing in In-house transfer summary	Patient demographic details missing
ICU I	1.Receiving doctor's sign missing in In-house transfer summary 2.Daily progress notes not attached 3.Management plan missing in In-house transfer summary	Nil
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
Heart command centre 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
Heart command centre 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
Gastro liver ICU	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

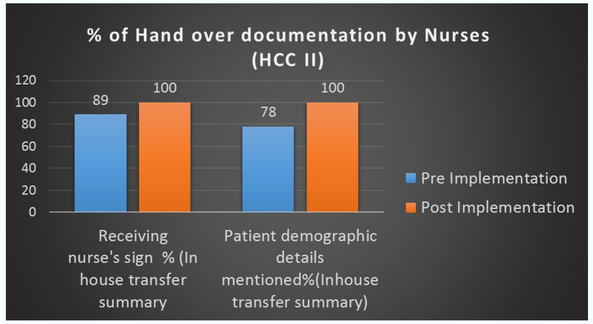
Intervention

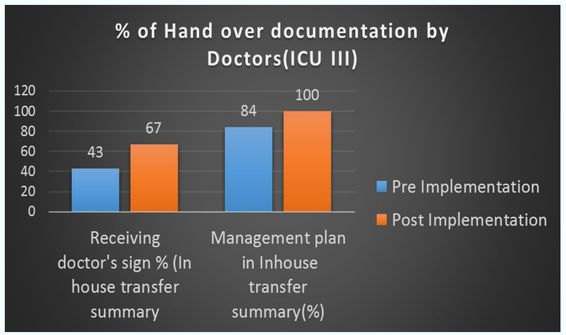
- Standard hand over formats introduced for nurses and doctors in WARDS, HCC I, HCC II, ICU I, ICU II, ICU III to ensure hand over documentation during shift changes.
- Education and training programs organized for the doctors and nurses for effective handover communication.
- Training of on-duty doctors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

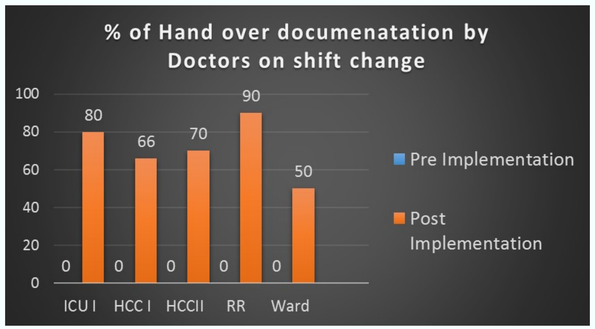












Suggestions

- 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 IPD records, it has been observed that verbal handovers are more commonly used than written handovers at FEHI. Post implementation of new hand over formats for nurses and doctors during shift changes, there has been a considerable improvement in hand over documentation. However, further improvement can be brought about if the practice becomes the culture of the organization.

SAFE HANDOVER = SAFE PATIENTS