The Regulation and Quality Improvement Authority

# A Regional Audit of Weekend Handover in Acute General Surgical Units in Northern Ireland, Phase 1

November 2017

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Assurance, Challenge and Improvement in Health and Social Care

**Foreword**

Good handover of patients between teams is critical in ensuring safe, effective and truly patient centred care. I am delighted to endorse the work in this report which brings together audit, quality improvement, and patient safety work. The fact that this work was originally planned and trialled by doctors in the earliest stages of their training, and now supported regionally by senior clinicians, is convincing proof that Northern Ireland Health and Social Care is providing fertile ground to nurture and grow quality improvers at every stage of their journey.

The impact of a robust mechanism for surgical handover described in this report is strong encouragement for us all to listen to and support the ideas of those who daily deliver care to our population. Reducing variation and standardising processes around weekend handover doesn't constrain clinical autonomy. Instead, it gives healthcare professionals a shared knowledge of what is happening with a patient they may never have met before, as well as allowing them to focus on delivering their specialist skills.

I welcome the support that RQIA has given to this work and anticipate that clinical teams in disciplines beyond general surgery will find much to emulate.

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***(formerly Deputy Chief Medical Officer, Department of Health, Northern Ireland)***

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**Rationale**

Handovers are an integral part of daily medical practice in the United Kingdom (UK) and occur within and between professional groups and teams. Poor decision-making, communication and documentation on ward rounds and during handover periods can be responsible for otherwise avoidable adverse events which impact on patient safety [1-3].

Handover is a process that must be underpinned by appropriate planning and management to anticipate, recognise and prevent deterioration in the clinical condition of patients. Increasingly, patients expect to be involved in all decisions pertaining to their care. It is now accepted best practice that patients are informed of any change in the team providing their care, in any effective handover process [1, 2, 4].

Joint guidance from the Royal College of Physicians and the Royal College of Nursing demonstrates the importance of good ward round documentation, and recommends that the use of checklists or systematic tools can reduce omissions and variations in practice [1, 5]. Across Northern Ireland, standardised patient proformas are now part of practice in many medical and surgical units [6].

From a regulatory standpoint [7] handover is an important quality assurance indicator. The Regulation and Quality Improvement Authority (RQIA) explicitly assesses handover during its rolling programme of acute hospital inspections [7].

It is also a General Medical Council (GMC) requirement that *'colleagues are kept well informed when sharing the care of patients'* [8]. Failings in handover at multiple levels were identified in the report of the inquiry into the Mid-Staffordshire NHS Foundation Trust (the Francis Report, 2013) [9].

Loss of the 'surgical firm structure" (a Consultant and a number of doctors in training work together as a unit), and increasing reliance on shift work make implementing good handover challenging. Guidance released by the Royal College of Surgeons in England (RCSE) addresses the fact that handover is the responsibility of every member of the surgical team. A new pattern in patient care is recognised whereby often no one single consultant is now responsible for the care of a patient [4].
RCSE and British Medical Association (BMA) guidelines on safe handover practice include a minimum standard of expected discussion or documentation points, with similar guidance on duration and appropriate environment for handover [2, 4].

Handover is both a skill as well as a training opportunity that is to be taught, learned, practised and developed. Handover is an integral part of the working day, which requires the involvement of the entire surgical and relevant members of a multiprofessional team [4].

In a survey of surgical trainees in Northern Ireland, 13% (8 of 62) commented that they had received formal training in handover practice and that different grades of doctor often handover on separate occasions. Whilst it was recognised by trainees that handover was an integral and valued practice, 77% (54 of 62) of respondents did not receive feedback from senior staff on their contributions to this process [10].

A number of published case reports and presentations document national and local efforts to improve handover in surgical units [11-15]. Of note, it is uncertain how many of these interventions have informed handover policy regionally, or resulted in sustained local changes in handover practice.

In Northern Ireland, the practice of ward based 'patient handover' on medical and surgical units to ensure safe and effective continuity of care currently lacks standardisation and robust quality assurance due to no regional model or consistent approach across different hospitals.

A key finding of the Francis report was recognition that failures in any hospital are exacerbated by a lack of effective communication across healthcare systems in sharing information and concerns [9].

In a more recent review of systems and processes within the Northern Ireland healthcare system, the Bengoa Report (2016) championed the need to 'remove variation in practice to improve efficiency' and to 'innovate and change existing systems to improve outcomes'. Simply put; *"Do it right, do it better, Do it differently"* [16].

The Northern Ireland Regional Quality 2020 Strategy recognises the need to devise '*better ways of measuring the quality of our services'* [17]*.*

**Case Study: Antrim Area Hospital**

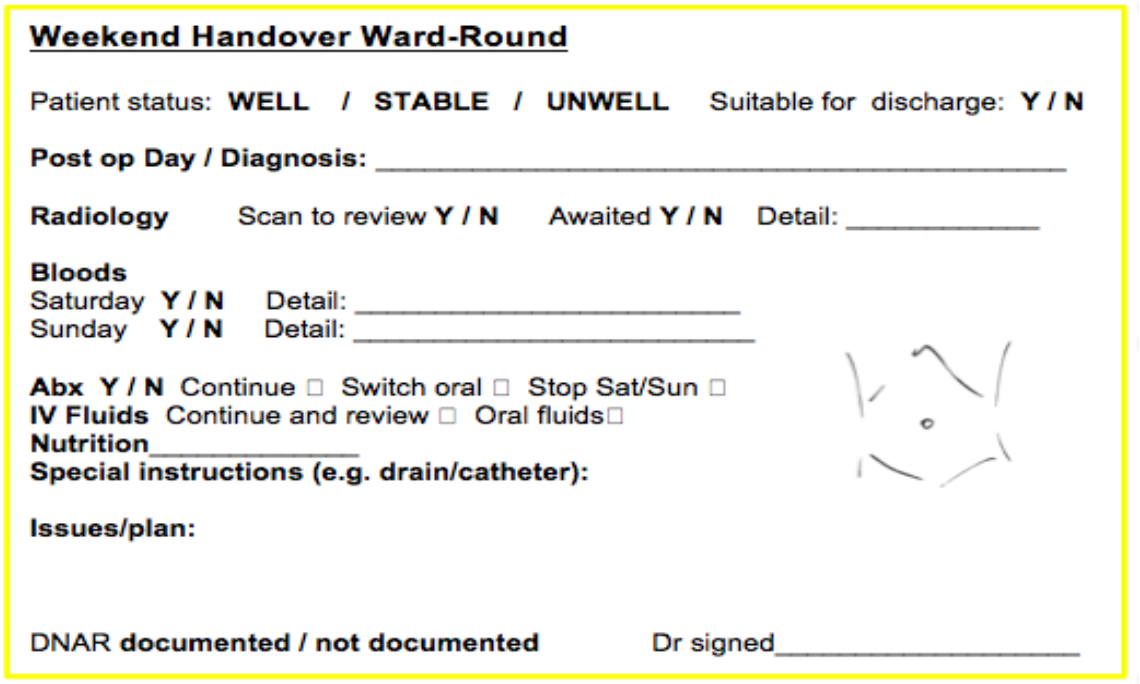
A Quality Improvement project arose from an audit of Friday ward rounds in the general surgical unit at Antrim Area Hospital in August 2015.

A review of 23 patient notes highlighted several key areas of documentation in need of improvement prior to the transition into out-of-hours weekend care. Less than 40% of patients (9 of 23) had a clearly documented weekend plan or diagnosis. Patient safety issues, including lack of documentation on requirements for blood monitoring and 'ceiling of care decisions' were present in over two-thirds of notes. In addition to a case note review, qualitative feedback was collected from the surgical staff (FY1 to Consultant Grade, n=28), which indicated that surgical staff did not feel that Friday ward rounds ensured patient safety over the weekend (mean satisfaction score: 5.69/10).

An adhesive label was subsequently designed for use by staff on the Friday ward round. This included key points in patient management to be considered by the accepting weekend team and was developed from guidelines of both Medical and Surgical Royal Colleges. This was redrafted and phased into practice using a Quality Improvement Plan-Do-Study-Act (PDSA) approach. This method used small cycles of change, following feedback from staff to test and refine a solution that worked well locally. The current working adhesive label is now embedded as standard practice within Antrim Area Hospital and augments the quality of handover between different grades of doctor (see Figure 1).

Rapid cycle audits took place over a six-month period following the sticker's introduction and demonstrated sustained improvements, with an average 'completeness' (i.e. all parts of the sticker completed) from a baseline of 27% to a peak of 90%. In May 2016, 100% of patients audited (n=40) in the same unit had a handover sticker present in the notes, with an 80% (32 of 40) completeness rate (see Figure 2).

**Figure 1: Antrim Handover Adhesive Sticker**



**Weekend Handover Ward-Round**

Patient status: **WELL / STABLE / UNWELL** Suitable for discharge: **Y / N**

**Post op Day / Diagnosis:** _____

**Radiology** Scan to review **Y / N** Awaited **Y / N** Detail: _____

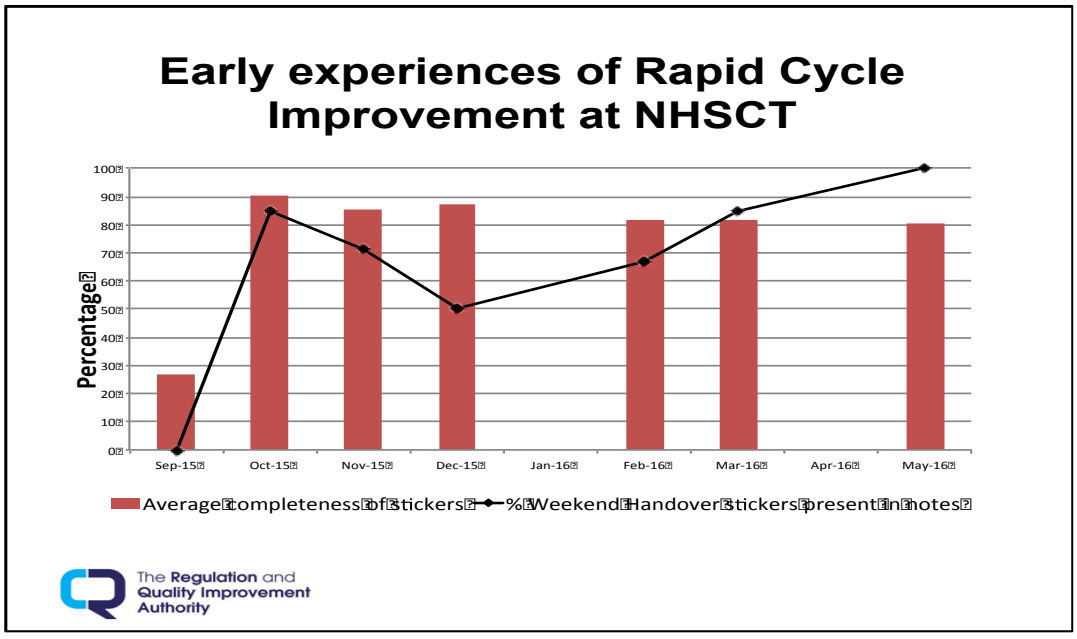
**Bloods**
Saturday **Y / N** Detail: _____
Sunday **Y / N** Detail: _____

**Abx Y / N** Continue ☐ Switch oral ☐ Stop Sat/Sun ☐
**IV Fluids** Continue and review ☐ Oral fluids ☐
**Nutrition**_____
**Special instructions (e.g. drain/catheter):**

**Issues/plan:**

DNAR **documented / not documented** Dr signed_____

**Graph 1: Change in 'completeness' rates of adhesive handover sticker following small cycles of change**




Note: due to staffing pressures on doctors in training in January and April data was not collected.

A similar survey was distributed again to assess staff satisfaction with handover practice, and mean satisfaction had significantly improved (*"The following checklist has been a useful addition to the Friday ward round to improve care of surgical patients over a weekend"*). Mean satisfaction score: 8.62/10, n=21, (see Table 1).

**Table 1: Pre and post intervention survey responses**

| Time | N= | Staff survey Statement | Rating (/10) |
|---|---|---|---|
| Aug 2015 | 28 | Friday morning ward rounds currently ensure patient safety over the weekend and facilitate continuity of care | 5.69 |
| Nov 2015 | 21 | The following checklist has been a useful addition to the Friday ward round to improve care of surgical patients over a weekend | 8.62 |

Qualitative feedback included consultant comments that ward rounds became more efficient, and urgent reviews of unstable patients were better directed and more easily highlighted (see Table 2).

**Table 2: Qualitative excerpts from feedback**

| Staff feedback (excerpts) |
|---|
| "A clear system for handover is needed that records all relevant details and this looks like it will work well" – Consultant |
| "Very useful if called to see a patient and have never met them before." – Junior Doctor |
| "These stickers are a good idea but Fridays can be busy and these take time to complete." – Junior Doctor |
| "Much improved weekend ward round when stickers are completed. More efficient and can get straight to the issue ensuring safer patient care provided it is filled in correctly." – Consultant |

This approach, where the Friday ward round became an important focus for handover and supported by a tested, standardised approach, improved efficiency and positively impacted on effective weekend ward rounds. It was also well supported and widely accepted by all grades of surgical staff and has been embedded into routine practice within the Antrim general surgical unit.

Further audits of the weekend stickers were carried out alongside the regional audit in March and April 2017, which showed sustained use of these stickers. However, following presentation of the project to Consultant Grades it was recognised that a more formal Quality Assurance process should be implemented and a monthly audit of documentation will now take place.

This learning has been shared within the Northern Trust at its Innovation and Quality Improvement Event, June 2016 and presented at the British Medical Journal BMJ International Forum for Quality and Safety in Sweden, April 2016. In September 2016 the project was awarded the Northern Ireland Safety Forum Innovation in Care Award.

**Project Aim**

To improve documentation and communication within acute general surgical units in Northern Ireland

**Project Objectives**

- To determine the nature of handover practice and audit quality of documentation in acute general surgical units across Northern Ireland
- To improve the quality of documentation of weekend handover using Quality Improvement methodologies
- To explore the introduction of a standardised approach to weekend handover in all acute general surgical units across Northern Ireland
- To determine the 'patient safety impact' of weekend handover through audit of internal reporting databases
- To convene a multi-disciplinary action group to guide appropriate development of this work.

## Standards

Standards of good handover practice are listed in Table 3.

**Table 3: Criteria for good handover practice**

| Criteria | Target | Reference |
|---|---|---|
| There should be a clear entry in each patient's notes on a Friday with a concise summary of management to date including: diagnosis, results of investigations, escalation of care, ongoing issues and plan highlighted for clinical and nursing staff | 100% | Safe Handover: Guidance from the Working Time Directive Party. The Royal College of Surgeons of England, March 2007 |
| There should be standardised multi-level handover practice and policy within each Trust involving both clinical and nursing teams that facilitates communication between care professionals (clinical, nursing and Allied Health) | 100% | British Medical Association. Safe Handover: safe patients. Guidance on clinical handover for clinicians and managers. London: BMA 2004 |
| Issues relating to handover, patient safety and unwell patients should be highlighted and discussed between healthcare professionals with evidence of action plans in place for receiving teams (clinical and nursing) over the weekend | 100% | Royal College of Physicians. Acute Care Toolkit 1: Handover, London RCP, 2011 |
| Adverse incidents (IR-1, SAI, Cardiac Arrests) occurring out of hours or directly/indirectly between the handover of patients should be recorded and escalated at weekly or appropriately designated ward meetings | 100% | Department of Health. The Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC. (Francis report). London: Stationery Office; 2013. |

**Project Timeline**

From October 2016 to May 2017 data and feedback concerning handover practice from each Trust will be collected. Analysis of this data will allow an agreed approach to standardise handover, based on recommendations from the Project Team and Project Steering Group/Advisory Panel.

**Methodology**

Each Trust was represented by at least one acute hospital. A single entry prospective audit of patient notes was undertaken. In addition, a survey was developed to gauge the perceptions of doctors in training concerning handover practice. Focus groups were held at local surgical audit meetings in each acute Trust (upon presentation of local audit results) to ensure representation of Consultant grades outside of the Project Team.

**Sample size**

- A minimum audit size of n=200 was agreed with 40 patient charts per Trust examined with the exception of the Royal Victoria Hospital (RVH) where results from 35 were submitted. This was based on the average number of inpatient beds in each of the hospitals participating in the audit
- The Northern Ireland Medical and Dental Training Agency (NIMDTA) circulated a survey to every registered Foundation and surgical trainee (n= 470).

**Data Collection and Analysis**

- Designated data collectors (ranging from FY1 doctors to surgical registrars) were identified to audit patient notes within their own individual Trust (supervised by a local Consultant Surgeon)
- Data were collected during January and February 2017
- An agreed standard proforma was used for all data collection
- Anonymised data were forwarded to the Governance Department in Antrim Area Hospital for cleansing and collation
- The Project Co-leads were responsible for audit design, analysis and presentation of the data in the report
- All findings and recommendations were discussed and verified by the Project Team and Steering Group/Advisory Panel.

**Inclusion and Exclusion Criteria**

- Only acute general surgical units were included in this audit. All other areas were excluded as data were being gathered to inform the baseline practice of surgical handover.

**Limitations**

- Data collected at one discrete point may not fairly represent the standard of documentation in each unit over time
- The proforma developed for this audit may need to be adapted in light of any future agreed standards for handover
- Clinical discretion was utilised by each data collector during the audit and therefore not all data points were defined by 'Yes' or 'No'. Data points identified as 'Not Applicable' (N/A) were excluded in the quantitative analysis in order not to bias the results. Reasons for recording 'N/A' for each measure were reviewed by the Project Team e.g. specific local reasons such as type of surgery or particular working practices. Where this has occurred this will be noted when applicable on each table within the report. Note this means not all numbers sum to 217.

**Results**

Results for each of the audit parameters are tabled with explanatory text. Minor comments on the data are provided to aid clarity whilst more general comments are reserved for the discussion section.

Three general points about these results:

- Some units had a variable understanding of the need to record some parameters such as resuscitation status, or where radiological investigations were neither required nor awaited
- The data collection proforma was subsequently revised for those areas in which there was considerable latitude in interpreting e.g. discharge documentation
- The impact of existing audit mechanisms for venous thromboembolism (VTE) in Antrim accounted for the 'not-applicable' scoring for the 'kardex-review' field. The audit proforma was subsequently clarified.

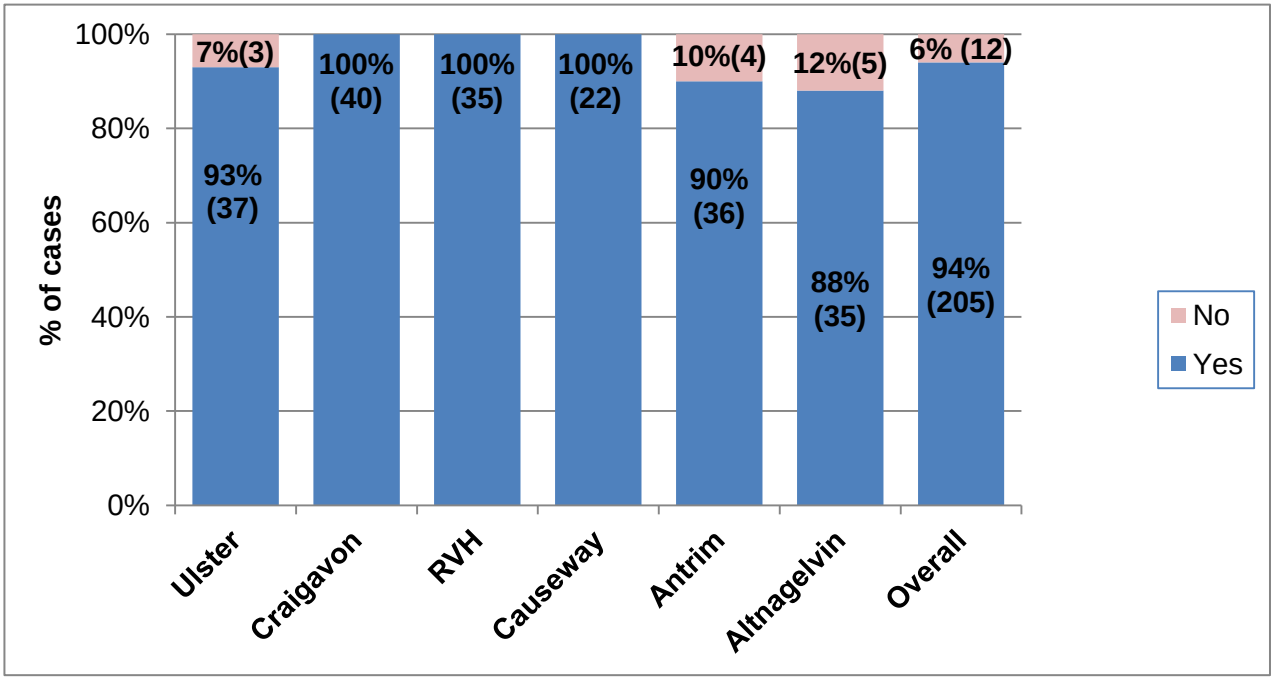
**Results Section 1: Review of documented entry in patient charts from Friday ward round**

**Table 4: Number of patient charts audited**

| Name of Unit | Number of patient charts audited |
|---|---|
| Ulster | 40 |
| Craigavon | 40 |
| Royal Victoria Hospital (RVH) | 35 |
| Causeway | 22 |
| Antrim | 40 |
| Altnagelvin | 40 |
| **Total** | **217** |

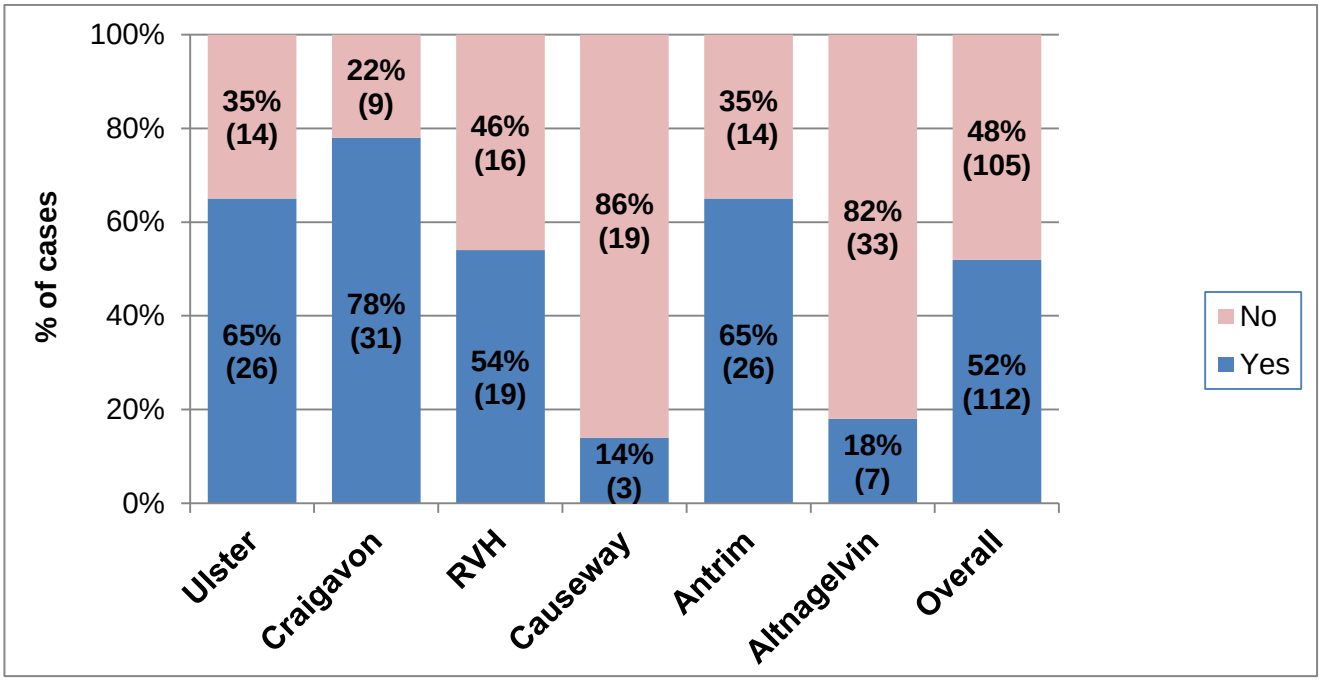
Each Trust was represented by one acute general surgical unit, with the exception of the Northern Health and Social Care (HSC) Trust, which was represented by both Causeway and Antrim Area Hospitals. Opportunity therefore arose for an additional auditing of 22 charts from Causeway.

**Graph 2: Name of most senior clinician on ward round (N=217)**



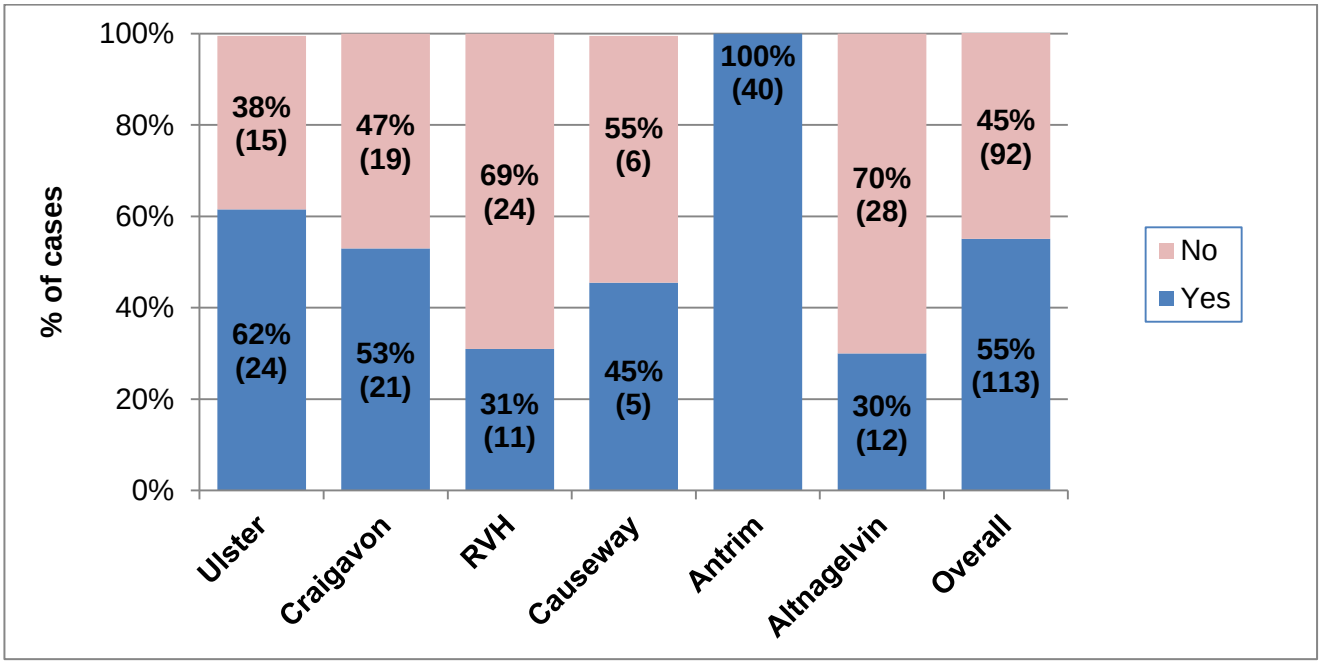

The names of the Consultant or senior registrar were documented on almost all occasions in all hospitals.

**Graph 3: Date and Time (N=217)**



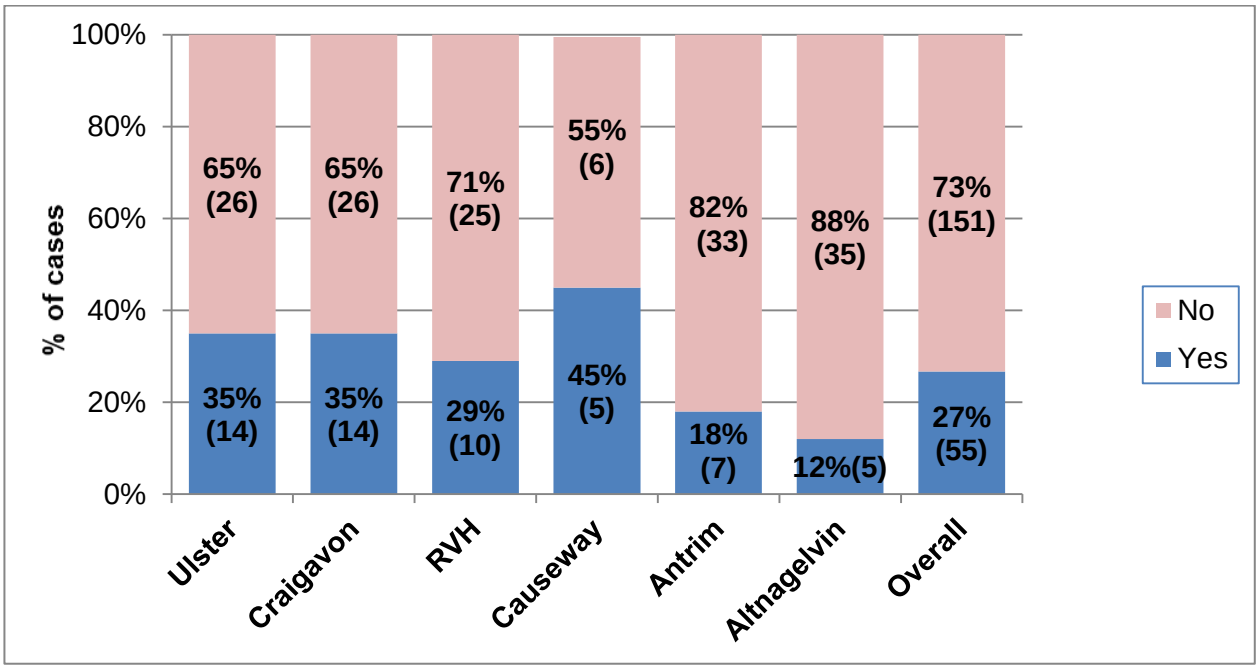

Date and time were inconsistently documented across all sites with 52% completion overall.

**Graph 4: Diagnosis or Primary Surgical Procedure named (N=205)**



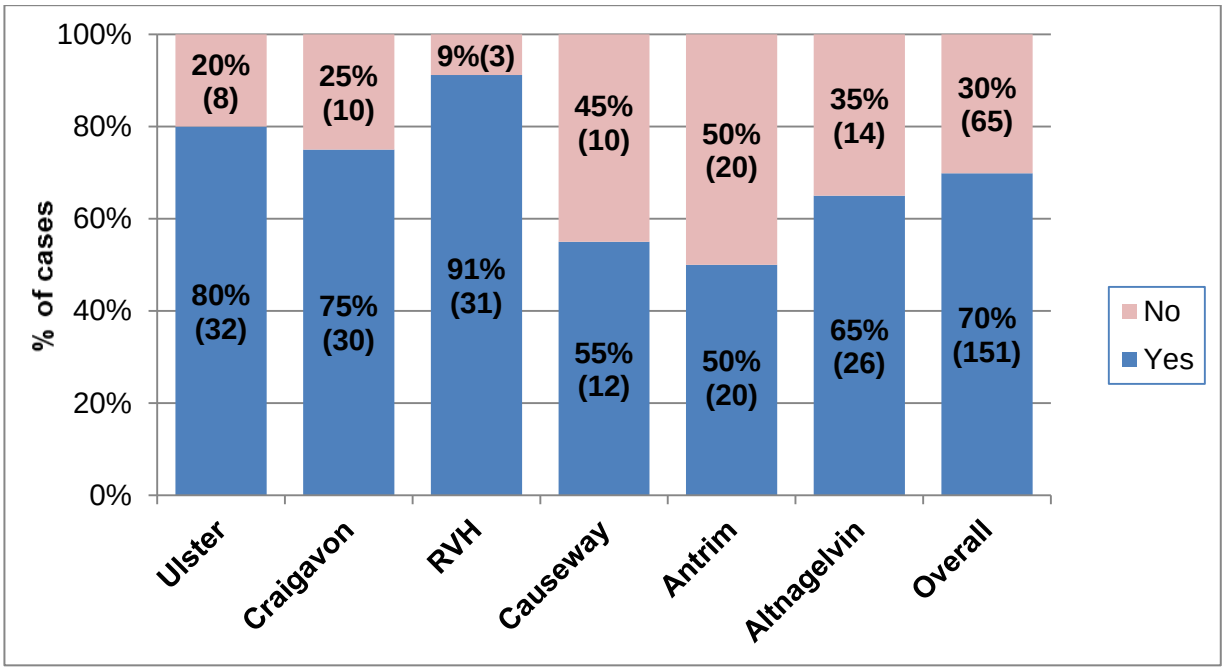

Diagnosis or primary surgical procedure was inconsistently documented in five out of six units.

**Graph 5: Day of admission or post-operative day (N=206)**



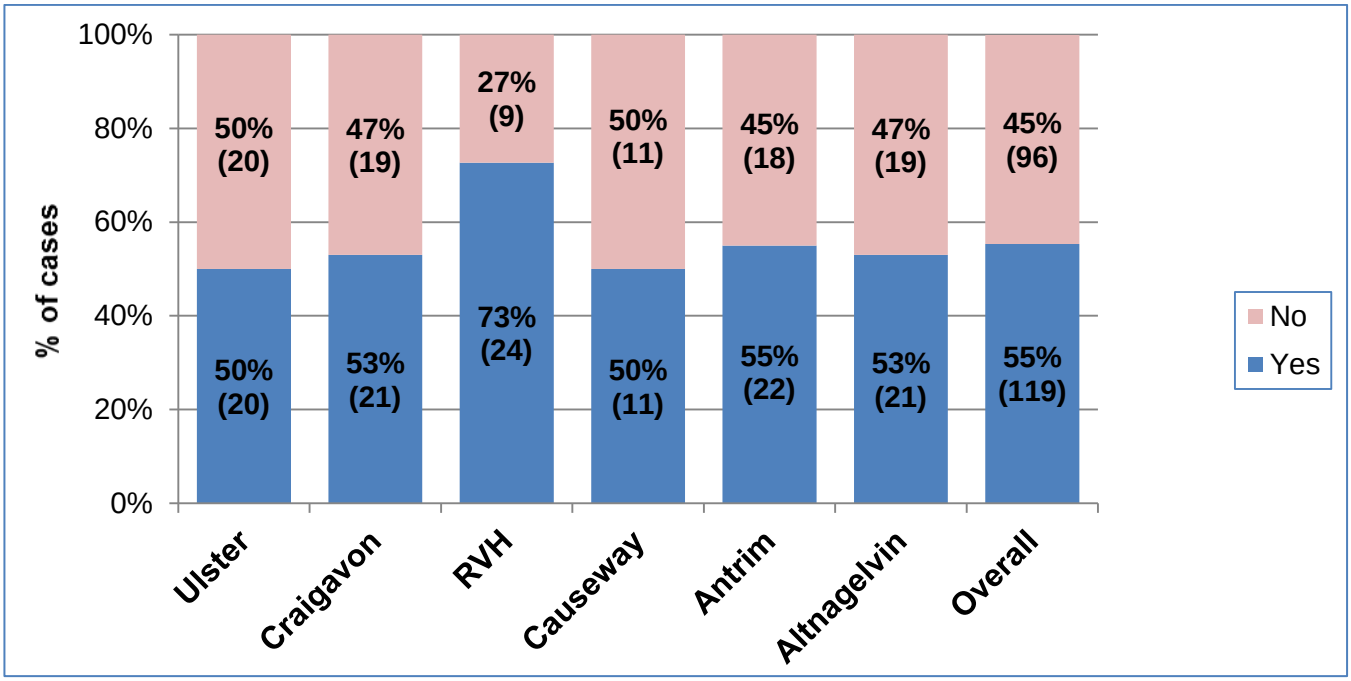

The majority of case notes referenced neither the patient's duration of stay nor post-operative recovery day.

**Graph 6: Relevant Physiological Observations (N=216)**



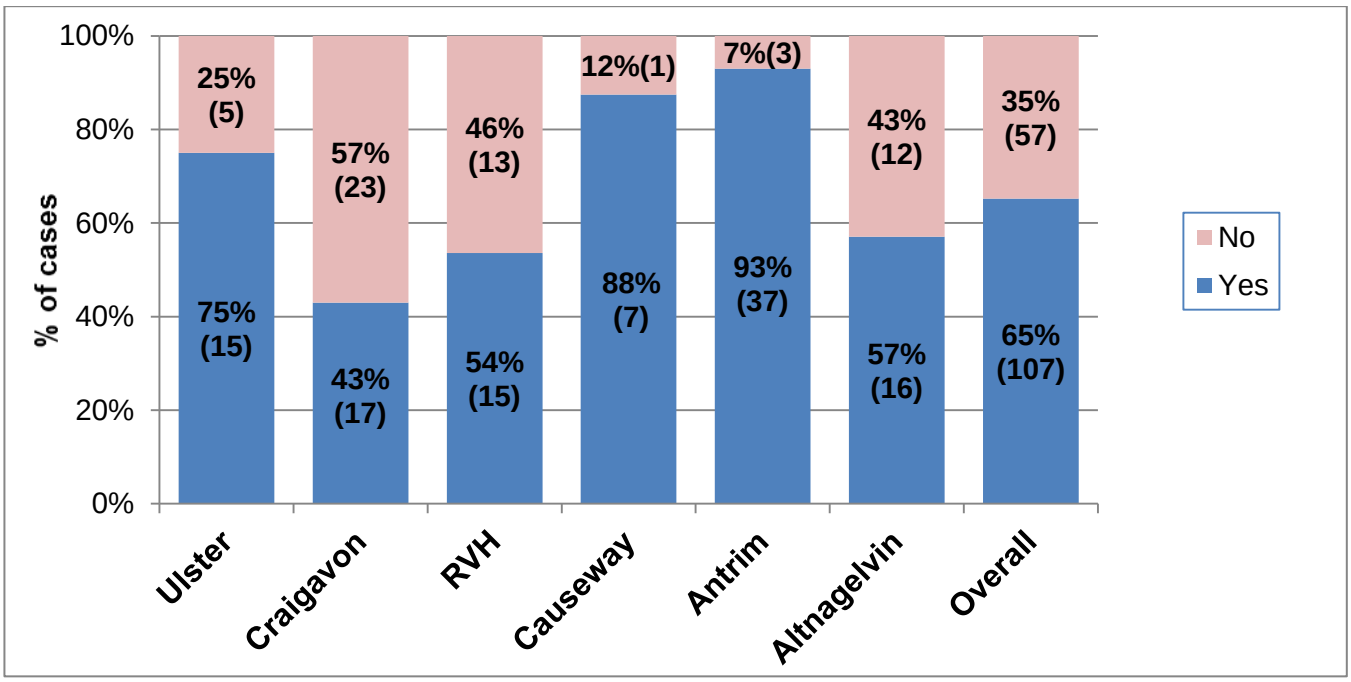

Documentation of the patient's physiological observations (pulse, blood pressure, temperature, respiratory rate and oxygen saturations) was variable, with an overall average of 70%.

**Graph 7: Examination findings (N=215)**




Examination findings were documented on average in 55% of cases.

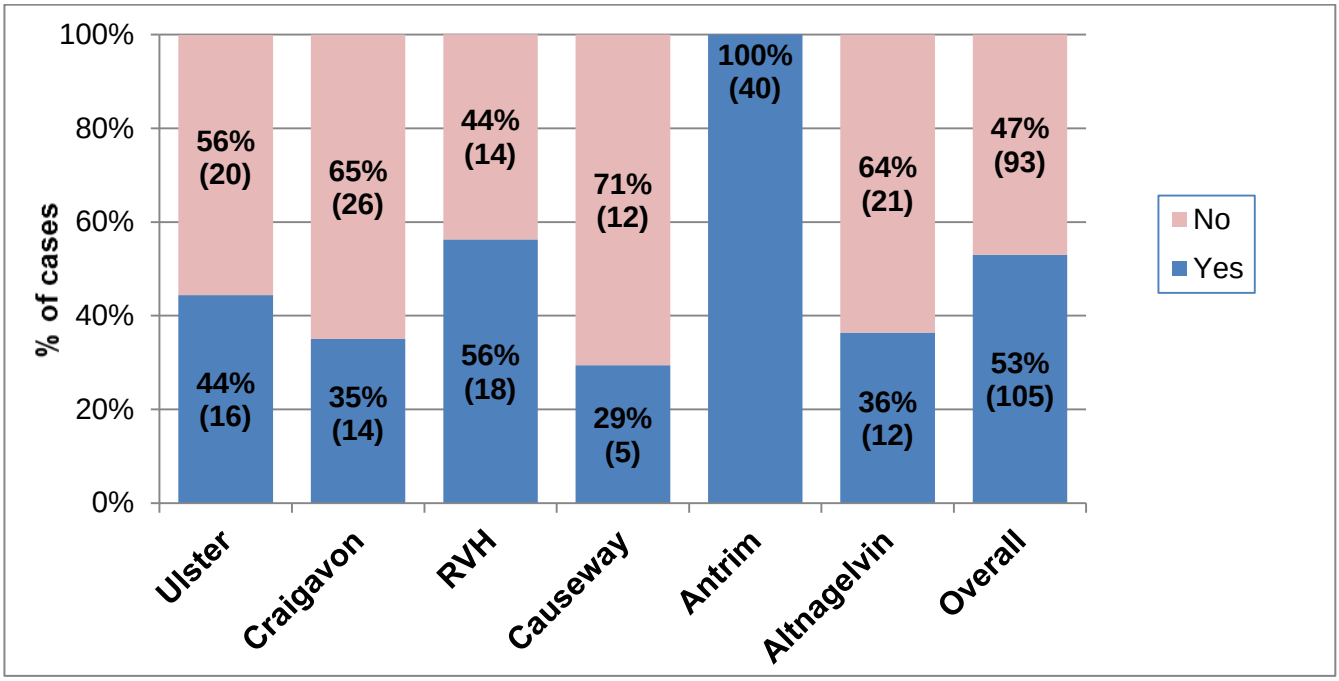
**Graph 8: Review of relevant* outstanding Radiological investigations (N=164)**




**Note: This criterion was not applicable in 53 cases as there were a significant number of case notes audited in which consideration of radiological investigations was deemed unnecessary. This could reflect a high number of elective patients, those awaiting discharge, or clinically stable patients not in need of extensive clinical review. These cases were excluded from the analysis*

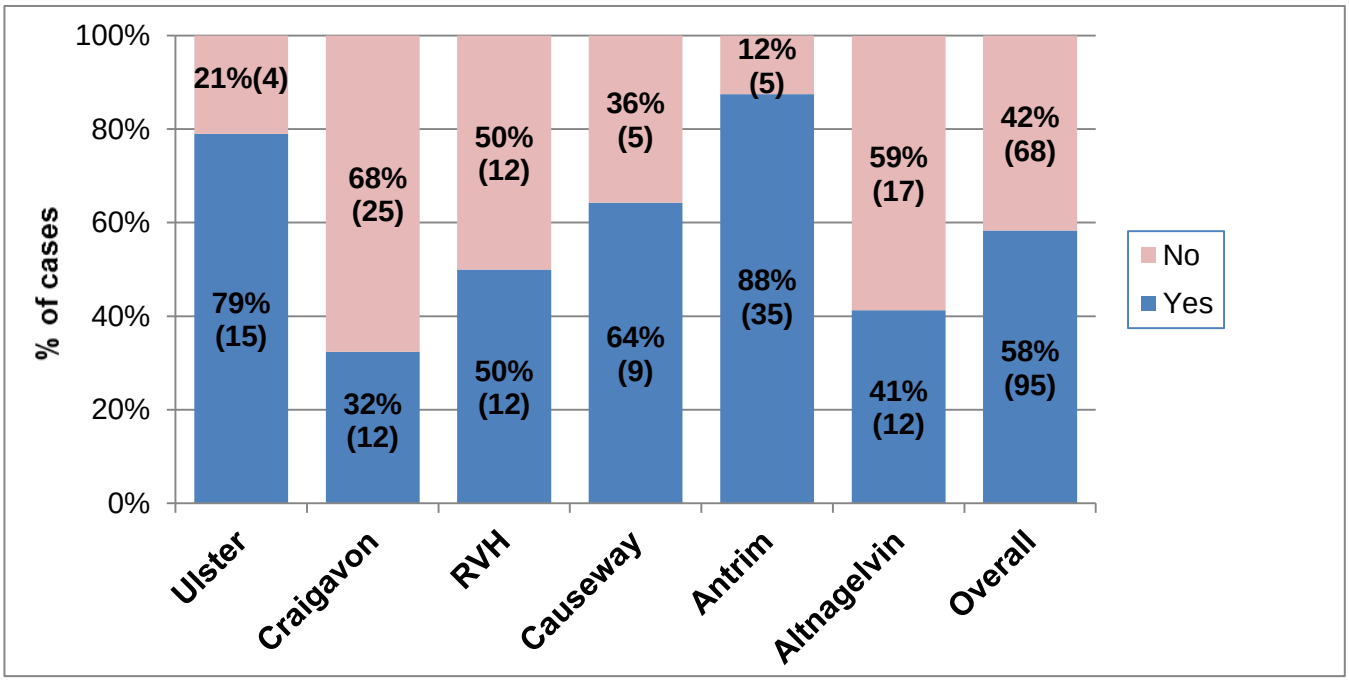
Documentation of radiological investigations or scans awaited was variable.

**Graph 9: Review of relevant blood results or bloods required (N=198)**



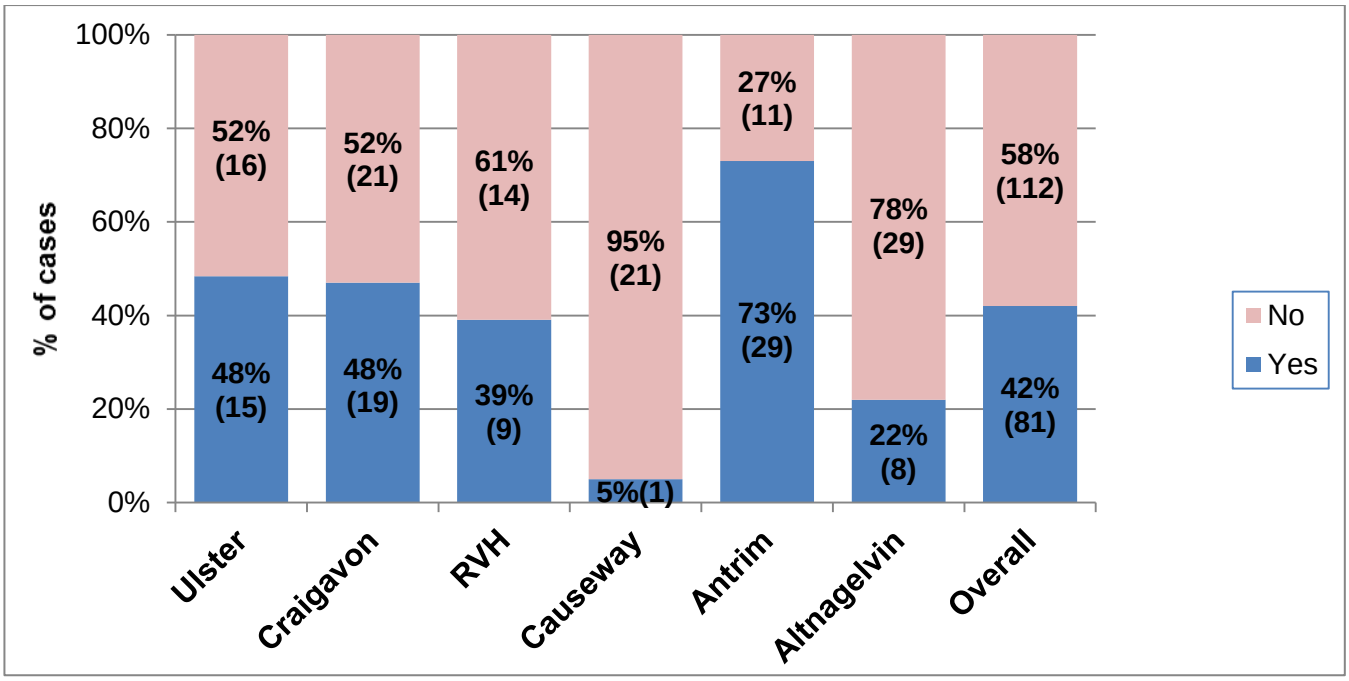

Requirements for blood monitoring over the weekend were frequently not documented.

**Graph 10: Antibiotic therapy (N=163)**



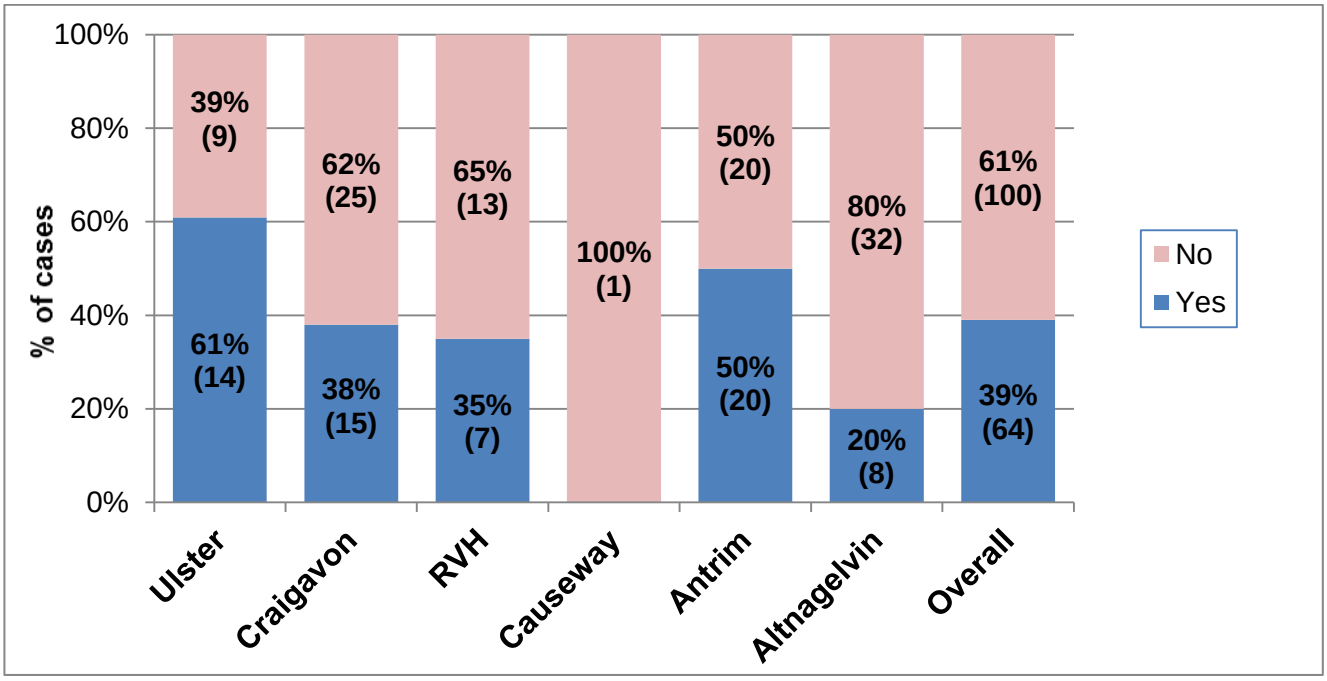

Documentation pertaining to antibiotic stewardship was variable.

**Graph 11: Fluid balance and/or intravenous (IV) fluid requirements (N=193)**




Documentation of hydration status and potential requirement or plan for IV fluid therapy over the weekend was inconsistent across all sites.

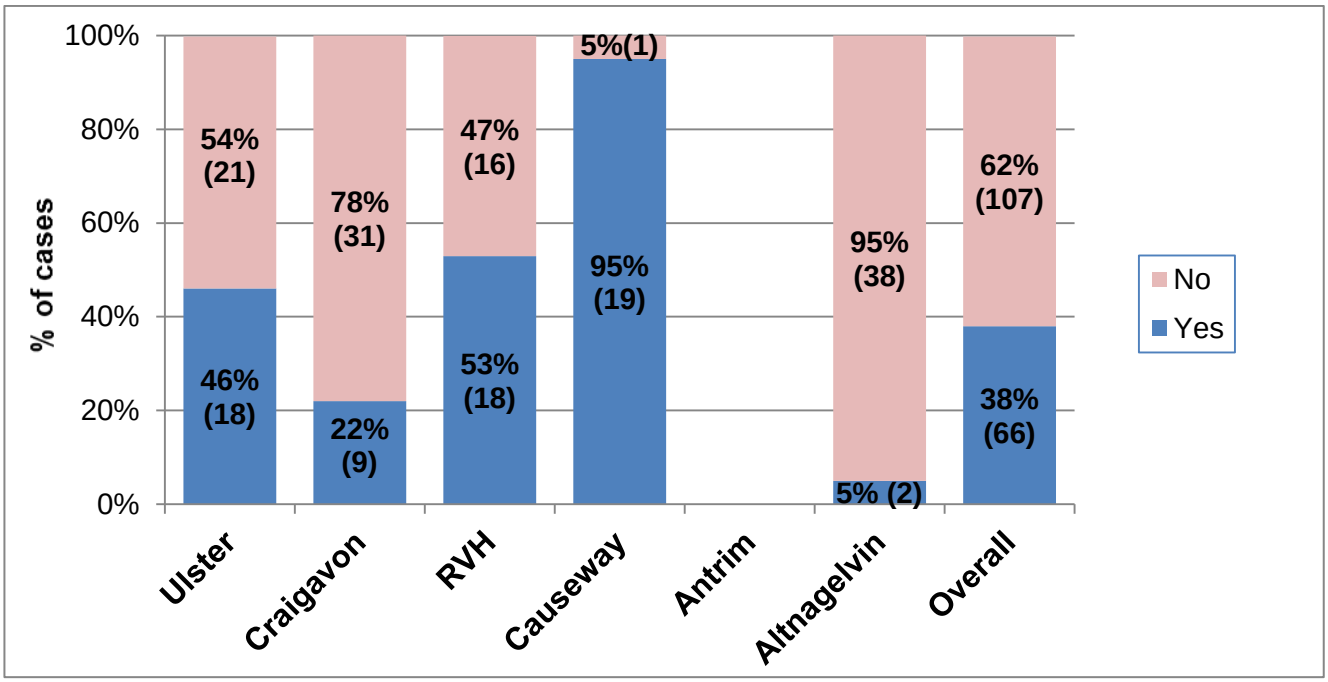
**Graph 12: Nutrition (N=164)**



**Note: This criterion was not applicable in 53 cases and may as in the case of Causeway, be due to the patients eating and drinking freely. These cases have therefore been excluded from the analysis*

Nutrition plans were documented in just over one third of cases (39%).

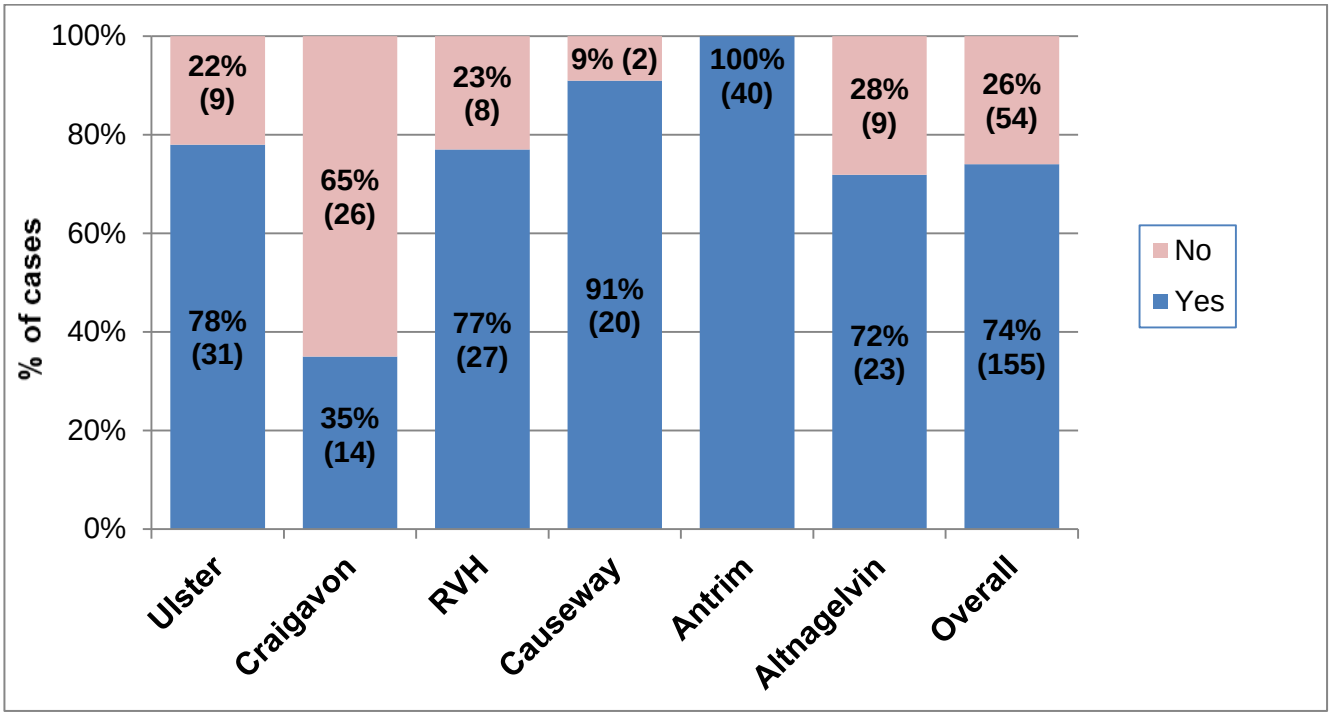
**Graph 13: Kardex - VTE/Analgesia/essential medications (N=173)**




*Note: This criterion was not applicable in 44 cases. Antrim Area Hospital feedback stated that Kardex review was not included in their standard weekend handover and that VTE prophylaxis and essential medications are issues that are addressed within 24 hours of admission. As such, they deemed this criterion 'not-relevant' in their data collection. These and other not applicable cases have ttherefore been excluded from the*

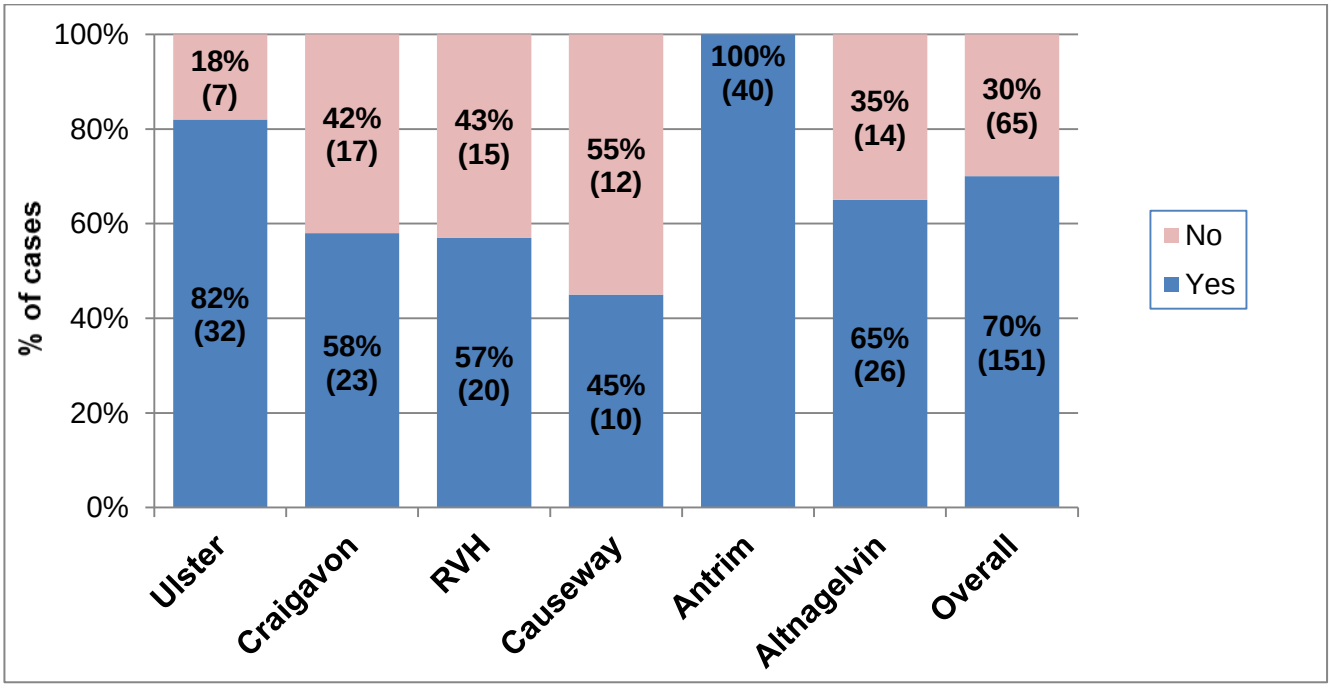
Kardex review (encompassing analgesic requirements, (VTE) prophylaxis or other essential medications) was inconsistently documented.

**Graph 14: Outstanding Issues (N=209)**



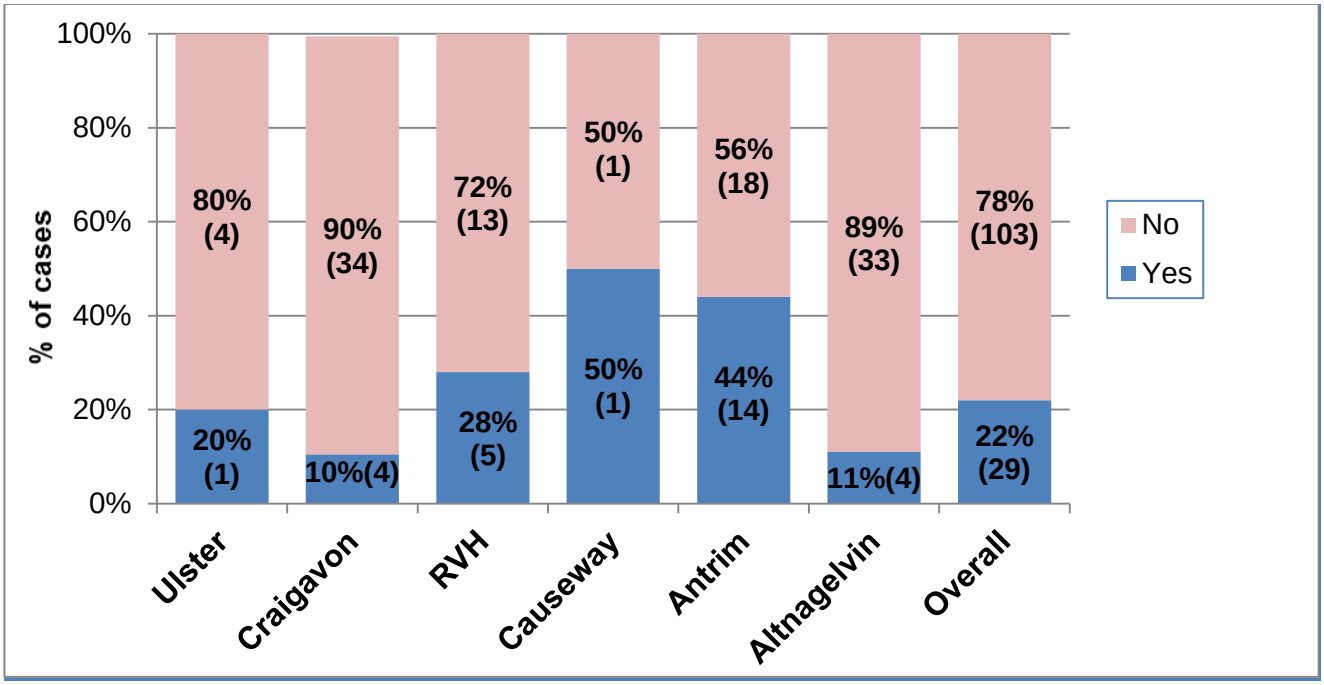

Outstanding patient issues were inconsistently recorded and highlighted to the incumbent weekend team.

**Graph 15: Plan for Weekend Team (N=216)**



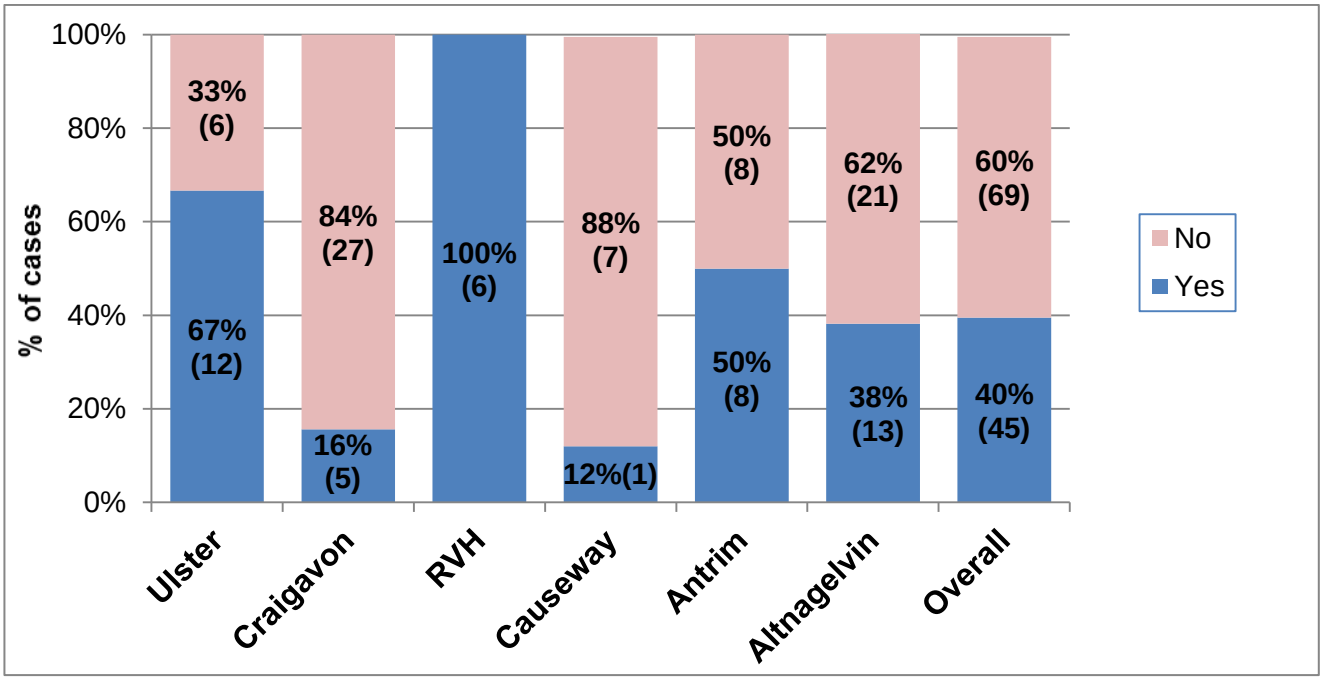
One unit recorded a defined plan for every patient for the incoming weekend team.

**Graph 16: Ceiling of Care / DNACPR (N=132)**



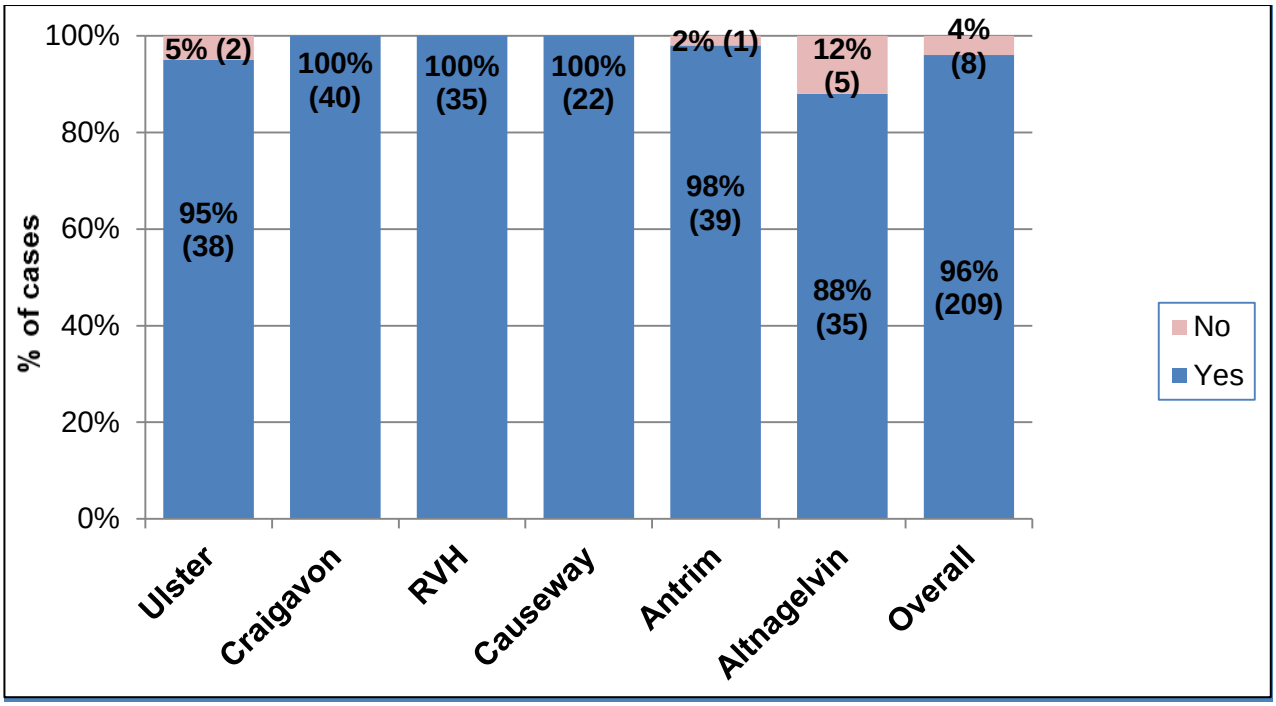

*Note: Documentation of escalation plans in the event of a patient deteriorating did not occur in the majority of patient notes. Further data collectors had assigned 'not applicable' in many cases. Subsequent discussions at the audit meetings illuminated these figures. In many cases there is an unspoken ward-round assumption that the default for all patients is for escalation to intensive care and/or CPR if needed.*

**Graph 17: Discharge instructions (N=114)**



*Note: a large number of data collection points were recorded as 'not-applicable'. A variety of reasons accounting for this including: many patients not expected to be discharged over the weekend and therefore this was not referenced in the handover.*

**Graph 18: Signed by Doctor (N=217)**




Generally doctors were consistent with signing the ward round entry in the patient notes.

**Results Section 2 - Handover practices and weekend working patterns within surgical units**

Qualitative feedback on handover practice and weekend working patterns can be found in Table 5

**Table 5 – Qualitative feedback on handover practice**

| Name of Unit | |
|---|---|
| **Ulster** | • Consultants in Ulster Hospital work in teams of three to ensure continuity of care. Consultants from each team verbally handover patients to weekend Consultant on Call with one team utilising weekend handover stickers<br>• Saturday and Sunday morning handover begins at 8am and is attended by admitting Consultant, registrar, two F2/CT doctors (day and night) and F1<br>• There are two F1 doctors working the long weekend, with one responsible for the orthopaedic ward<br>• All surgical patients (including outliers, HDU/ICU) are reviewed over the weekend<br>• Continuity exists for newly admitted patients<br>• Consultant surgeon on call Mon-Friday (daytime) is Consultant on call Saturday-Sunday (night-time) and is therefore present for the ward round at the weekend. |
| **Craigavon** | • Each team has a handover sheet which should be updated daily by the F2/CT. Not updated over the weekend<br>• Emergency Consultant of the Week starting on Friday 8am and continuing to the following Friday 8am. Some consultants opt to dictate a formal handover note<br>• Registrar and F2/CT on Surgeon of Week cover from Monday to Sunday, working 8-5 during the week and 8am-8pm at the weekend<br>• Registrar 48 hour cover Saturday 8am-Monday 8am<br>• All surgical inpatients (including outliers) are reviewed over the weekend<br>• Team will occasionally split up ward round to review patients more efficiently<br>• F1s do not have a formal role in the handover process<br>• All acute admissions are completed by F2/CT, reviewed by the registrar later and by Consultant on the post take ward round. |

| Name of Unit | |
|---|---|
| **RVH 'Emergency Surgical Unit'** | • Daily handover takes place in dedicated seminar room from 8am-8:30am. Entire surgical team is present, usually with a ward nurse manager in attendance<br>• Each patient is discussed and if necessary scans are reviewed or delegated to be requested. Updated patient lists for existing patients are expected to be printed for distribution at this meeting<br>• General Surgery at the Royal Hospital facilitates emergency admissions only. There are two Consultant work streams, 'Upper GI' and 'Lower GI'<br>• Does not follow a 'typical working week':<br>1. Upper GI team consists of one consultant, registrar, F2/CT and 2 F1s. Consultants change on Friday morning<br>2. Lower GI (as above) but Consultants change on Wednesday morning<br>3. Dependent on working practice of Consultants, on handover day an additional verbal handover takes place following morning meeting<br>4. There is maintained continuity with junior team<br>• Saturday and Sunday registrar 24 hour on call. At the weekend, one FY2/CT works with one Consultant and registrar on call rounds with the other Consultant. One FY1 per team at the weekend. |
| **Causeway** | • Handover meeting takes place each morning at 8am. FY1 attendance not mandatory<br>• No formal patient handover list<br>• Emergency Consultant Monday –Thursday with a weekend Consultant Friday – Sunday<br>• Colorectal MDT takes place on Friday morning, therefore<br>• Following MDT, 'grand round' takes place where Consultants handover their patients to the weekend Consultant<br>• Weekend working team consists of Consultant, Registrar, F2/CT and F1. |
| **Antrim** | • Daily Handover takes place between CT/FY2 and registrar with Consultant on Call. Consultant during week changes on daily basis, with weekend Consultant working Friday-Sunday<br>• FY1s handover tasks informally and often do not attend handover |

| Name of Unit | |
|---|---|
| | with surgical team<br>• Weekend handover consists of a Friday ward round incorporating use of the weekend handover stickers, with the aim to include as much information as possible for the weekend team<br>• Working pattern at weekends includes a Consultant and Registrar with an FY2/CT and two FY1s. Working pattern depends on Consultant, but most elect to divide a ward round between themselves and the Registrar<br>• The ward round includes every surgical patient in the hospital, including outlier patients on medical wards<br>• FY1 collates all jobs from each ward round with the help of the SHO, and makes use of a half-day FY1 to assist with jobs<br>• Registrars work 48 hours on Call with FY1 and CT/FY2 working long day shift patters Friday – Sunday. |
| **Altnagelvin** | • Morning handover involves the Consultant, the Registrar, FY2/CT and day-time FY1 on call, receiving handover from the night team. The night team comprises of one FY2/CT doctor and one FY1<br>• Handover is conducted for all new admissions, including referrals from medical wards, any patients on the surgical wards who might require emergency intervention and any discharged patients<br>• Ongoing plans for patients are usually written onto Word documents and placed into the “Weekend handover” folder – this would take precedence over writing the weekend plan on the daily review of the patient on the Friday<br>• Every surgical patient is reviewed on the ward round, by either Consultant or registrar. New admissions are admitted by surgical Core trainees, with Registrar review as required for acutely unwell patients. Day-time FY1s conduct routine tasks on surgical wards and review patients who appear to be deteriorating unless they are acutely unwell to require more senior review in first instance<br>• The daytime Core trainees and FY1s will hand over to the night-time CT/FY2 and FY1 at approximately 8pm. The Registrar on call is contactable when further advice/assistance is required. |

**Results Section 3: Survey of Doctors in Training**

A survey relating to trainees' perceptions of handover was disseminated by NIMDTA via email to Foundation and surgical trainees (N=470) (see Appendix 2)). One further email reminder was sent to complete the survey, which remained open for three weeks. Total response rate was 17% (79 of 470), consisting of FY1 to ST7 participants. FY1/FY2 comprised 66% (52 of 79) of respondents and surgical trainees (CT1-ST7) the remaining 34% (27 of 79).

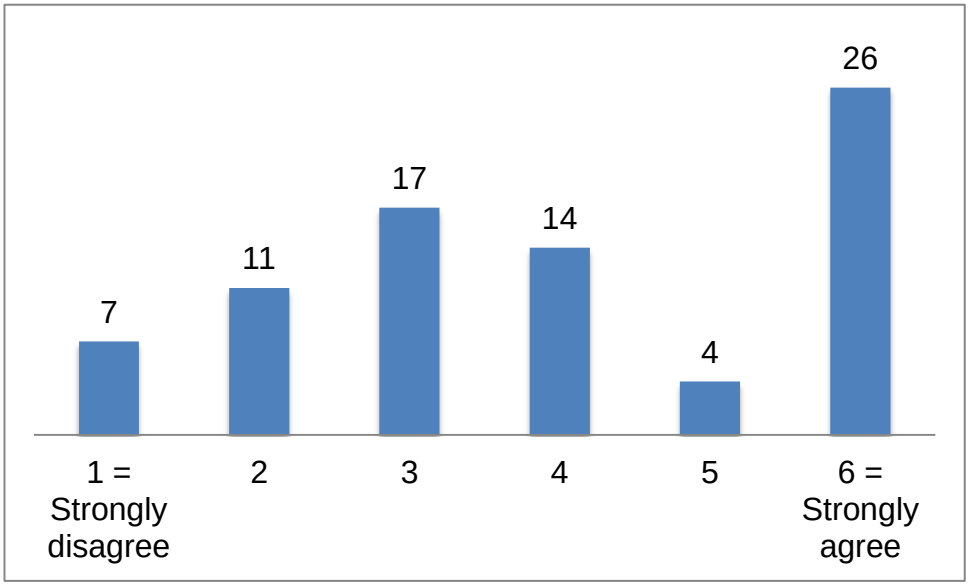
The survey contained statements pertaining to trainees' perception of the role of documentation in handover and its impact on patient safety and continuity of care. Trainees responded using a 6-point Likert scale, 1 (Strongly Disagree) to 6 (Strongly Agree), (see Table 6 and Graphs 19-22). Open text questions were included, relating to trainees' experiences of handover and their understanding of what handover should entail.

Statements relating to trainees' perceptions of Handover in the surgical units in which they are working or have most recently worked are detailed in Table 6. (Average rating = average score based on a Likert scale where 1=*strongly disagree*, 2=*disagree*, 3=*somewhat disagree*, 4=*somewhat agree*, 5=*agree* to 6=*strongly agree*).

**Table 6: Average ratings**

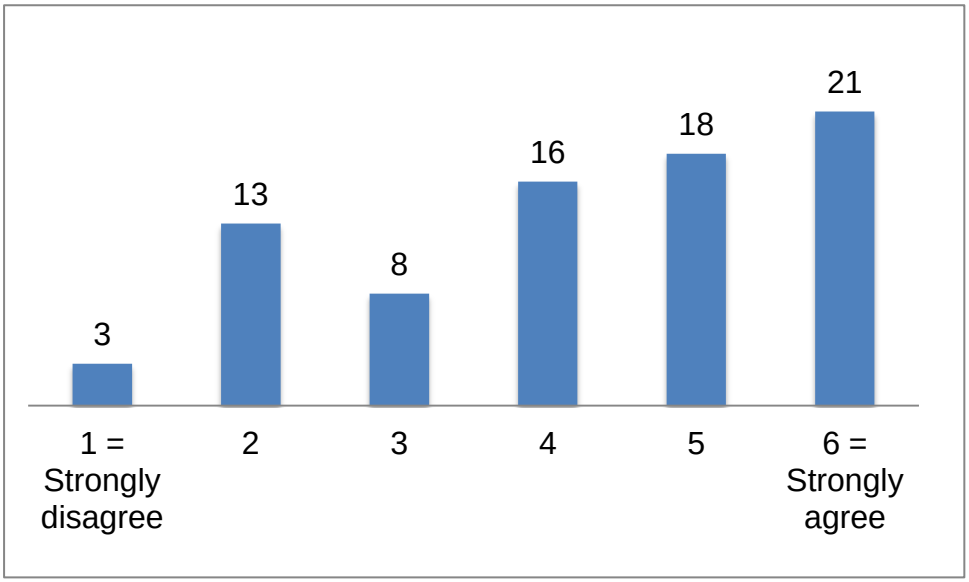
| Statement | Average rating |
|---|---|
| Documentation in patient notes is an integral part of handover in the surgical unit which you are working (or most recently have worked) | 3.95 |
| The Friday morning ward round in your surgical unit contributes to continuity of care over the weekend | 4.22 |
| Improvement in the Friday morning ward round would improve weekend handover | 4.75 |
| Improvement in the Friday morning ward round would improve patient safety over the weekend | 4.78 |

**Graph 19: Trainees' (n=79) response to the statement, "Documentation in patient notes is an integral part of the handover in your unit"**



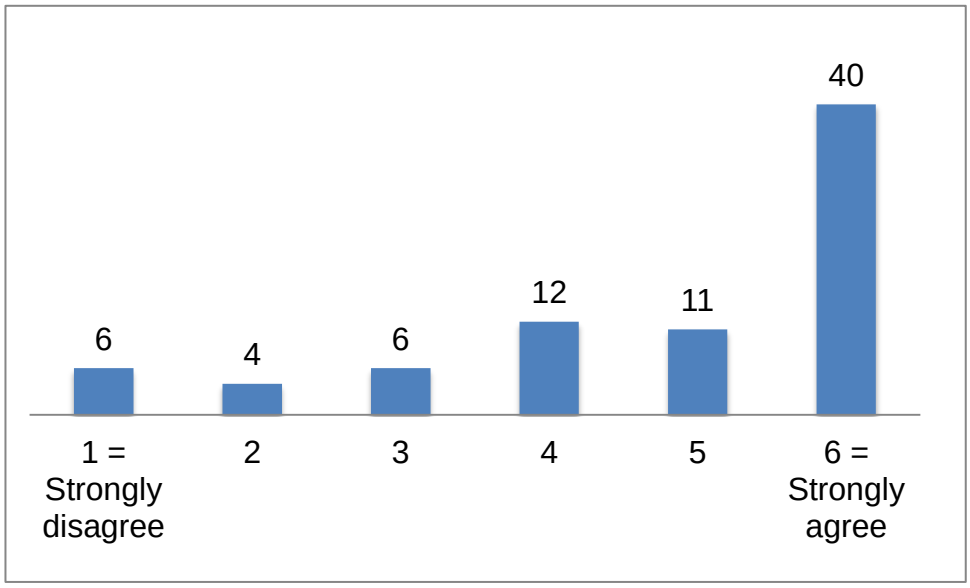

There was a varied perception of the importance of documentation as a handover tool, with an average rating of 3.95. Approximately one third of respondents strongly agreed that documentation was integral to the handover process.

**Graph 20: Trainees' response (n=79) to the statement, "The Friday morning ward round contributes to continuity of care over the weekend"**



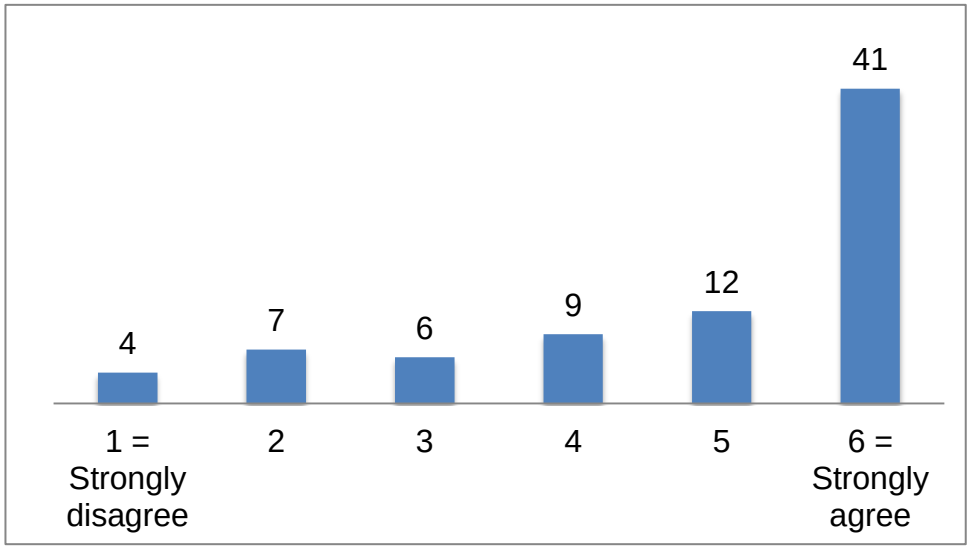

49% of trainees felt that the Friday morning ward-round facilitated continuity of care over the weekend.

**Graph 21: Trainees' response (n=79) to the statement, "Improvement in Friday ward round documentation would improve weekend handover"**




Sixty-five percent of trainees agreed or strongly agreed that improvement in the Friday morning ward round documentation would improve weekend handover.

**Graph 22: Trainees' response (n=79) to the statement, "Improvement in the Friday ward round documentation would improve patient safety over the weekend"**

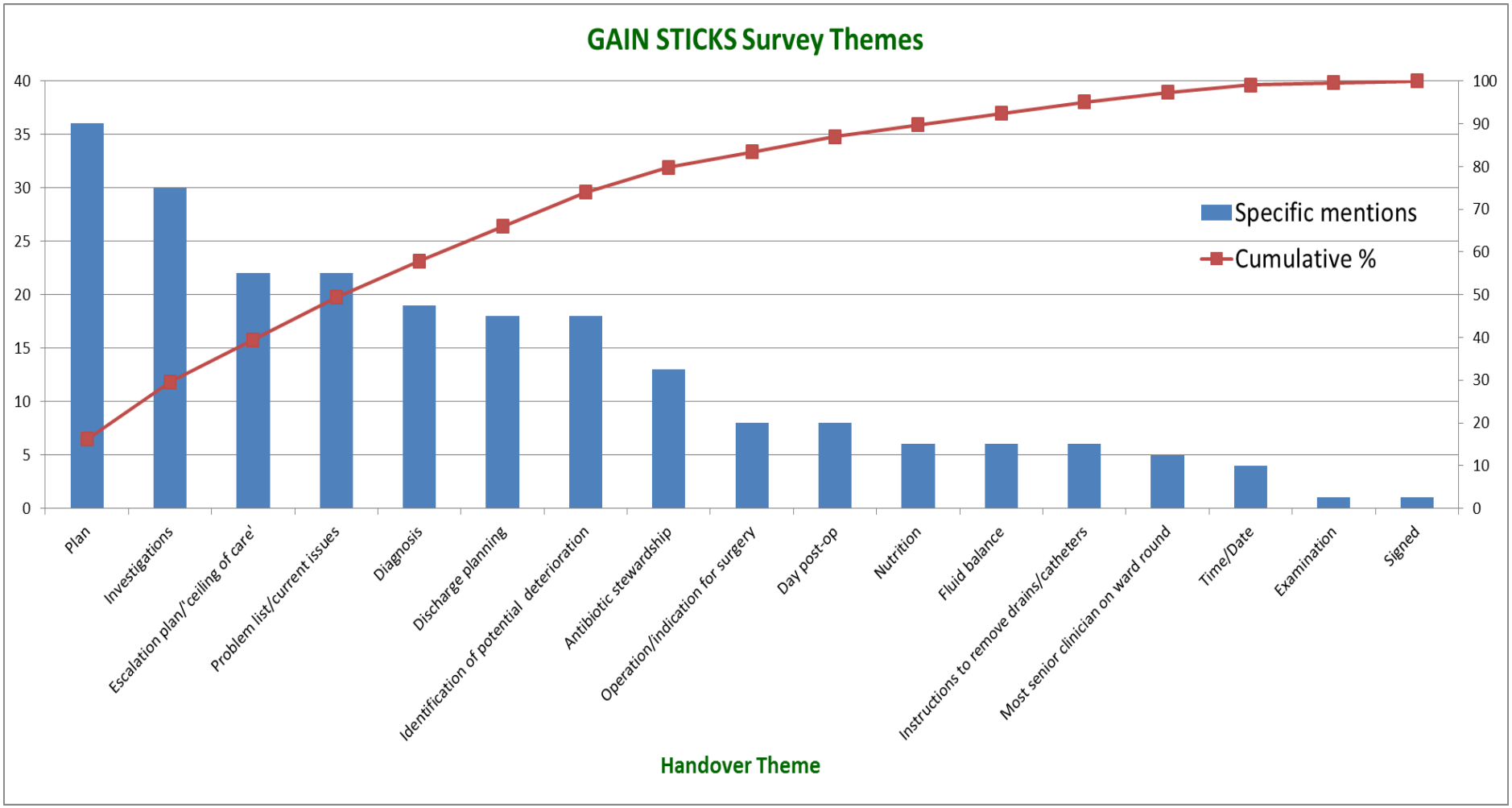



Sixty-seven percent of trainees agreed or strongly agreed that improved documentation would improve patient safety over the weekend.

Trainees were asked to list what they felt were the most important things to be documented on the ward round for the purposes of continuity and patient management during the handover period. Trainees were asked to list up to ten responses, most commonly mentioned responses are detailed in Graph 23.

Common themes included '*Diagnosis*', '*Investigations required or awaited*', clearly defined '*management plan'* and a need for a pre-determined '*ceiling of care'* or escalation plan. Many trainees made separate references to problem lists or issues and made specific reference to the importance of documenting anticipated causes or reasons for a patient's decline over the weekend e.g. low saturations in a post op patient, and increased risk of infection. Interestingly, 80% of the responses concerned communication between clinical teams about key patient management decisions. This suggests that a handover tool rather than a 'yes/no' tick box checklist may hold greater value in this setting in improving handover.

**Graph 23: RQIA STICKS survey themes:** Trainee responses tabulated as specific references to the statement, *"For the purposes of continuity and patient management what are the most important things to be annotated on the ward round?"* The left hand axis signifies the number of occasions a theme was mentioned by participants. The right hand axis is the percentage of each theme mention to the total number responses.



Trainees were further asked to outline how handover is conducted in the surgical unit that they have most recently worked in, and to include their experiences of good and poor handover practice. These responses have been anonymised and therefore comparisons cannot be drawn between units and only describe general trends emerging from responses.

**Morning Handover Meeting**

Generally, handover takes place in a dedicated space with time protected for handover. Handover is usually attended by more senior members of the team and presented by the FY2/CT, usually with a Consultant present. FY1s do not routinely attend handover in some units and they handover informally amongst themselves before beginning work on the ward. In some units, attendance of the entire surgical team with nursing staff is expected.

> *"Handover from night team in doctors room on surgical ward. Led by surgical SHO +/- registrar on overnight to surgical team during the day. Day F2/CT and registrar always present, consultants sometimes present."*

> *"F1s either do not attend weekend handover or attend rarely as they start working from jobs lists and preparing for ward round at the start of each morning when the rest of the surgical team is handing over."*

> *"Daily sit down handover with all members of surgical team and nurses. Review of investigations and written handover patient list."*

> *"SHOs meet and exchange the bleep with a quick chat about any problem cases"*

> *"For F1s, we handover any outstanding jobs and make the F1 taking over of any sick patients. There is no formal handover that F1s are included in"*

> *"Consultant on call and surgical team meet and discuss new patients admitted from day before/overnight/medical referrals. F1's often aren't present for handover"*

> *"30 minute handover every morning and review of scans with consultants and junior staff present"*

**Focus on newly admitted patients at Morning handover**

Morning handover is dedicated in most Units to the discussion of newly admitted patients overnight. Patients who are unwell, have recently returned from ICU, or are at risk of deterioration are often not discussed.

> *"Informally at the computer going through the take. Sometimes sick patients are discussed. But there is usually not a run down of patients on the ward"*

**Use of existing handover tools**

In addition to morning handover meetings, there were a variety of other handover tools mentioned. Examples include use of 'patient lists', dictated Consultant Handover sheets and standardised proformas or stickers. Many trainees commented that documentation was often vague and incomplete. A common area of perceived good practice was the use of weekend stickers, as well as when verbal and documented handover were effectively combined. Trainees commented that Friday was often the busiest day of the week and handover could be an added time constraint.

> *"Sheets on desktop computer with list of each consultant's patients - mainly used for that team rather than for weekend."*

> *"Each consultant team writes a handover list for over the weekend. Not consistently done by all teams."*

> *"Each team makes our weekend handover sheets with all patients on including their diagnosis and management plan."*

> *"Inaccurate patient lists, and not updated information or management plans has been the cause of issues at times."*

> *"Checklist stickers placed in notes on a Friday which ensure that the major points are summarised."*

> *"Proforma sticker is useful and standardised."*

> *"When F1s frantically try to fill in a multitude of handover proformas for the weekend with limited time!"*

> *"Whole lists of current inpatients provided by our going teams that are kept up to date over weekend."*

**Ward rounds**

The audit findings indicate that, in general, every surgical patient is reviewed by a Consultant or registrar at the weekend. In some units, there are two ward rounds per day. Some trainees commented on their experience of a “Grand round’ where the outgoing consultant formally handed over each patient to the weekend consultant. Of note, the presence of nursing staff did not feature in any of the comments relating to ward rounds.

> *“Ward round on a Friday morning with the weekend consultant. Not all of the weekend doctors were necessarily present”*

> *“One unit hands over from one surgeon of the week to another on the Friday morning ward round. Patient formally informed that care has been passed over to next consultant present on ward round.”*

**Consultant handover**

Trainees commented in detail on the role of the Consultant in the handover process. There were many good examples of Consultant led handover, joint ward rounds or grand rounds and dictated Consultant notes. Some trainees commented that they were often unaware of which patients had been handed over at Consultant to Consultant level. There was criticism that very junior trainees often complete handover proformas without senior oversight.

> *“X-ray meeting discussing scans of current patients, handover of Thursdays take, joint ward round between consultant on currently and consultant taking over for weekend and week to come.”*

> *“Dictated Consultant to Consultant handover of each patient when Consultants transfer COW [Consultant of the Week] role.”*

> *“Consultants personally hand over management plans for sickest patients to each other.”*

> *“Patients may be handed over directly at consultant to consultant level e.g. corridor conversation, trust email but junior trainees unaware.”*

> *“We use a handover proforma sticker. Unfortunately this is filled in by F1s with the exception of one consultant.”*

**Dissemination of local audit results**

Each local unit was asked to present the findings of the audit of their own weekend handover documentation to their monthly audit meetings. Where possible, a member of the Project Team was present to clarify the aims and objectives of this work. Feedback was sought from Consultants present at each meeting.

**Table 7: Presentation dates**

| Hospital | Date Presented |
|---|---|
| **Causeway Hospital** | 07/04/17 |
| **Antrim Area Hospital** | 12/04/17 |
| **Royal Victoria Hospital** | 12/04/17 |
| **Ulster Hospital** | 13/04/17 |
| **Craigavon Area Hospital** | 21/04/17 |
| **Altnagelvin Area Hospital** | 10/05/17 |

Feedback received about the nature and objectives of the project was widely positive. There was a recognition in all surgical units that handover is an important aspect of surgical care and patient safety.

Antrim Area Hospital has adopted a standardised weekend handover sticker into its working practice for over 18 months and recognised whilst this is a useful tool, more could be done at Consultant level to support this handover tool's appropriate use on a Friday. Causeway Hospital agreed in principle that a standardised weekend handover would be beneficial, but question how this would be implemented across all Trusts.

Ulster Hospital supported the project and need for improved handover processes. They commented that one Team (consisting of three consultants) has been using a standardised handover sticker, which has been received positively by trainees working in the unit. Additionally the use of a formalised sticker was of greatest benefit when patients were reviewed by doctors in training and/or consultants who were unfamiliar with the patient.

Consultants at Craigavon Area Hospital were supportive of the introduction of a standardised weekend handover and commented that a tool like the weekend sticker used at Antrim Area Hospital would integrate well in their unit.

The Emergency Surgical Unit at Royal Victoria Hospital does not follow a traditional 'weekend' working pattern but the work was positively received. It was recognised that any quality improvement project here would require extra focus given the rapid Consultant turnover and the exclusively acute patient setting.

**Review of Incidents and Significant Events arising due to Weekend Handover**
A number of processes and mechanisms exist that may capture the patient safety impact of poor handover. These include:

- Cardiac arrest audits and data
- Incident Report forms (IR1) entered by local ward and clinical staff
- Significant Event Audit (SEA) and Serious Adverse Incident (SAI) reports
- Morbidity and Mortality (M&M) reporting including Medical Certificate of Cause of Death (MCCD) and local M&M meetings.

The project team wanted to understand if there were coding and reporting mechanisms that explicitly identified ‘handover’, ‘communication’ or ‘weekend working’ as a factor. For example, a poor handover between teams may be either a cause, effect, or both of an adverse outcome. It may be a contributory factor to a patient safety incident, or may have in some other way resulted in harm. In order to understand if there were fields in existing databases of IR1, SEA, SAI data that could be interrogated, or ways in which this could be captured, the team approached governance leads, resuscitation officers, and members of the Health and Social Care Board.

It was ascertained that there were no explicit data collected whereby handover or weekend working could be both identified and readily searched to monitor trends or evaluate the impact of changes or improvement initiatives in these areas. Additionally, where poor communication or handover was identified in a subsequent report, this was often buried in the text of the report or recommendations and could not be detected other than by a manual trawl of the detail of each report.

A regional system for completing the MCCD and reviewing all deaths locally at governance meetings is now being rolled out and implemented in Northern Ireland with monthly governance meetings whereby all deaths are reviewed. This process is in its infancy and its impact on identifying communication and handover practice as a theme is currently unknown.

## Discussion

Handover is of increasing importance in today's clinical environment and has become a focus for quality assurance and regional inspection [7]. The transitions, boundaries and interfaces of care between clinical teams that are observed at weekends can result in patient harm if information flow and quality is not kept robustly intact.

The standard of Friday ward round documentation in surgical units across Northern Ireland was inconsistent, with an average of 30% of patient notes (65 of 216 -see Graph 15) not having a clearly defined weekend plan for the receiving surgical team. Significant variation in the recording of: awaited or required radiological investigations (65% - 107 of 164), blood results (53% - 105 of 198), information about antibiotic therapy (58% - 95 of 163), and fluid balance (42% - 81 of 193) was also found (see Graphs 8-11). Important areas of patient management including nutritional requirements and escalation planning and DNACPR status were inconsistently recorded in every unit.

Whilst handover takes many forms and different levels in each Trust, the majority of trainees who responded to the survey felt that improved Friday ward round documentation would improve both handover and patient safety over the weekend. Many units utilise different handover processes including patient lists, but these are often not updated for weekend teams and therefore often not utilised. Verbal handover at Consultant or registrar level is often good but junior surgical staff are not always fully informed of the weekend plan and indeed many FY1 doctors, who traditionally review and look after patients on the ward, feel excluded from the handover process.

It is clear from the information submitted and presented through this audit, that there are elements of excellent handover practice throughout Northern Ireland including use of Consultant led grand ward rounds, daily handover meetings and use of standardised handover proformas or stickers. Increasingly, patients are being involved in the handover process in some surgical units. Two surgical units have begun to utilise standardised handover tools to good effect, with positive trainee and consultant feedback. There has been a major emphasis in topical and scientific literature on the role of *checklists* in safeguarding patients, with the most notable success in surgery being the implementation of the 'World Health Organization Surgical Safety Checklist' [18]. Whilst checklists are useful in ensuring that the detailed steps in patient management are adhered to, arguably a handover tool should allow key information pertinent to on-going patient management to be captured in a form that best fits each local unit.

In guidelines produced by the Royal Colleges of Physicians, Nursing and Surgeons in England [1] handover is acknowledged as a key opportunity to identify patients who are at emergent risk of clinical deterioration and may require escalation planning. It is encouraging that many trainees in Northern Ireland recognised the importance of escalation planning and identifying issues or potential reason for concern in patient management. Unfortunately key areas such as antibiotic stewardship, blood monitoring, DNACPR status and escalation plans, and nutrition were poorly considered in the handover notes audited in this project, suggesting that this is an area that may also be

poorly implemented in practice. These are also critical areas impacting upon patient safety, experience and dignity.

A number of surgical consultants present at various audit meetings reflected on decisions which are not explicitly documented, discussed or handed over. These could reflect a dichotomy between the world of the surgical consultant and surgical doctors in training. As an example, it may indeed not be 'common sense' to refer a patient to the intensive care unit if they deteriorate. Explicitly documenting 'for full escalation' may aid a consultant colleague unfamiliar with a complex patient to make a speedy decision rather than review the whole of the patient's journey.

By clearly documenting the rationale for e.g. antibiotic changes, estimated date of discharge, and whether a patient's fluid balance is to progress in a particular direction can both save time and improve quality of decision making at the weekend for surgical doctors in training. Doctors in training would thus be empowered to take decisions and to proactively progress the management of patients rather than 'treading water' until Monday morning.

Handover should not be overlooked as a teaching and learning opportunity. Training and education for trainees to gain knowledge and understanding of good handover practice is provided by NIMDTA through a module in its iQUEST registrar development programme. However this is of a generalist nature and is only a half-day session. Repeated workplace-based training is required to embed good handover practice for all grades of staff. In the development of any of quality improvement measure to improve or standardise handover, education and training will be central to any sustained change.

This project was overall very positively received by the Consultant workforce when presented at respective local audit meetings. Nursing staff present also enthusiastically championed mechanisms for improved handover of information between the multi-professional surgical team. Surgical audit meetings in Northern Ireland take place on a protected date each month, where clinical projects are presented and issues relating to departmental management and patient safety are discussed. This meeting usually encompasses Morbidity and Mortality review, which is a long-standing measure of quality assurance in surgical practice. In this project, data were unable to be extrapolated relating to Handover and adverse patient outcomes from existing reporting databases such as Incident Reporting Forms (IR-1) and Serious Adverse Events (SEAs) or Incidents (SAIs).

In summary, the project has demonstrated instances of very good examples of handover practice in each acute general surgical unit. Some challenges remain including accurate documentation of basic information such as ward round date, time and diagnosis, in addition to the transfer of patient specific management plans and clinical decisions between teams. Whilst handover between similar grades of clinician is good, handover across grades is not as well embedded, with some of the most junior and least

experienced members of the weekend team feeling excluded and disempowered by the handover mechanisms currently in place.

Attempts to develop a surgical handover tool have been well received in each of the units audited and should be assessed further to examine the impact on improving acute general surgical handover at weekends.

**Recommendations**

In order to improve the quality and completeness of weekend handover documentation the following recommendations are made:

1. Training in, and awareness of, documentation best practice should form part of the induction for every doctor in training in Northern Ireland.
2. The sticker handover tool piloted and currently used in Antrim Area Hospital should be evaluated for use in acute general surgical units within Northern Ireland. This sticker will provide a central focal point to record relevant information required for good weekend handover.
3. All new and existing clinical staff involved in handover should be made aware of the regional tool and, where appropriate, given training.

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**Project Membership**

| Name | Designation | Organisation |
|---|---|---|
| **Project Co-Leads** | | |
| **Dr Aidan Bannon** | FY2 Doctor in Training | Northern Ireland Medical and Dental Training Agency (NIMDTA) |
| **Dr Ben Edgar** | CT1 Surgical Doctor in Training | NIMDTA |
| **Dr Gareth Lewis** | Consultant Acute Medicine | Northern HSC Trust (Antrim Area Hospital) |
| **Regional Project Team Working Group** | | |
| **Ms Eunice Minford** | Consultant Surgeon | Northern HSC Trust (Antrim Area Hospital) |
| **Mr Philip Davey** | Consultant Surgeon | Northern HSC Trust (Causeway Hospital) |
| **Mr Stephen Kirk** | Consultant Surgeon | South Eastern HSC Trust (Ulster Hospital) |
| **Ms Lynn Darragh** | Consultant Surgeon | South Eastern HSC Trust (Ulster Hospital) |
| **Mr Barry Clements** | Consultant Surgeon | Belfast HSC Trust (Royal Victoria Hospital) |
| **Mr Colin Weir** | Consultant Surgeon | Southern HSC Trust (Craigavon Area Hospital) |
| **Mr Michael Harron** | Consultant Surgeon | Western HSC Trust (Altnagelvin Area Hospital) |
| **Mrs Martine McNally** | Clinical Governance Manager | Northern HSC Trust |
| **Mrs Mary Neeson** | Lead Nurse | Northern HSC Trust |
| **Regional Project Steering Group/Advisory Panel** | | |
| **Dr Cathy Jack** | Medical Director | Belfast HSC Trust |
| **Professor Keith Gardiner** | Postgraduate Medical and Dental Dean | NIMDTA |
| **Dr Niall Leonard** | Undergraduate Sub Dean | South Eastern HSC Trust |
| **Dr Kate Scott** | Foundation Programme Director | Northern HSC Trust |
| **Mrs Olive MacLeod** | Chief Executive | Regulation and Quality Improvement Authority (RQIA) |
| **Ms Ruth McDonald** | Assistant Clinical Governance Manager | Northern HSC Trust |

| | | |
|---|---|---|
| **Dr Jackie McCall** | Clinical Director | HSC Patient Safety Forum |
| **Dr Anne Kilgallen** | Chief Executive | Western HSC Trust |
| **Name** | **Designation** | **Organisation** |
| **Data Collectors** | | |
| **Dr Emma Broughton** | FY1 Doctor in Training | NIMDTA |
| **Mr Conor Warren** | ST7 Surgical Doctor in Training | NIMDTA |
| **Dr David McBriar** | FY1 Doctor in Training | NIMDTA |
| **Dr Samantha Scullion** | FY1 Doctor in Training | NIMDTA |
| **Dr Jenine Jones** | FY2 Doctor in Training | NIMDTA |
| **Dr Conor McCann** | FY2 Doctor in Training | NIMDTA |
| **Dr Niall Gallagher** | FY2 Doctor in Training | NIMDTA |
| **Dr David Holmes** | FY2 Doctor in Training | NIMDTA |

**Appendix 1**

## Regional RQIA Audit Friday Ward Round

**Summary Information for Audit:**

- 40 patient notes should be audited from each acute general surgical unit
- Selection of notes should be random
- *Single entry audit of the Friday ward round note;* for the purpose of this audit is interpreted as the weekend Handover ward round
- Ideally audit of notes should take place within 24 hours of Friday ward round
- Options for the audit criteria include 'Yes', 'No' or 'Not Relevant', whereby:
    1. **'Yes'** means that there is reference or inclusion of the audit criteria in the note
    2. **'No'** means that there is no reference or inclusion of the audit criteria in the note in a situation where it would be deemed clinically relevant
    3. **'Not relevant'** means that the audit criteria is not relevant to the patient's care and management
- 'Not relevant' has been included in the audit to help rationalise interpretation of data and as such it may be important for the surgeon to briefly review the admission to date. Clinical discretion is advised.
  For example:
    1. Documentation of Ceiling of care/DNAR status in a fit and healthy 20-year old patient with appendicitis is not relevant (as escalation would be presumed).
    2. Discharge instructions in an unwell day 1 post op patient is most likely not appropriate and therefore not relevant
    3. Reference to antibiotics in a patient with suspected biliary colic and normal inflammatory markers at the time of entry is not appropriate and therefore not relevant
- Audit should be supervised by a senior member of the surgical team
- This is a funded project and time taken to audit can be claimed back. RQIA stipulates that audit should not take place during hours of work if a claim form is to be submitted

## Regional RQIA Audit Friday Ward Round

**Date of Audit: _____**

***Answer either Yes, No or N/A (not relevant)***

| **Patient ID number** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Named Consultant/Senior Registrar** | | | | | | | | | | |
| **Date and time** | | | | | | | | | | |
| **Diagnosis or Procedure named** | | | | | | | | | | |
| **Day of admission or Day Post Op** | | | | | | | | | | |
| **Relevant Observations** | | | | | | | | | | |
| **Examination findings** | | | | | | | | | | |
| **Review of relevant Radiology/Radiology awaited** | | | | | | | | | | |
| **Review of relevant blood results/Bloods required** | | | | | | | | | | |
| **Antibiotics** | | | | | | | | | | |
| **Fluid balance and/or IVF requirements** | | | | | | | | | | |
| **Nutrition** | | | | | | | | | | |
| **Kardex (VTE/Analgesia/essential Rx)** | | | | | | | | | | |
| **Outstanding Issues** | | | | | | | | | | |
| **Clear Plan for weekend team** | | | | | | | | | | |
| **Ceiling of Care documented / DNAR** | | | | | | | | | | |
| **Discharge instructions** | | | | | | | | | | |
| **Signed by Doctor?** | | | | | | | | | | |

**Regional RQIA Audit Friday Ward Round**
**Collated Data Feedback**

**Name:**

**Grade:**

**GMC:**

**Local Surgical Unit:**

**Please provide a short bullet point summary outlining weekend handover in your local surgical unit (max 150 words):**

**Please outline the working pattern of the surgical team at the weekend in your local unit (max 150 words):**

**Local Unit feedback on audit design (to include concerns about representation of data):**

**F1/F2/CT/Registrar Name/Signature:**

**Supervising Consultant Name/Signature:**

**Please return collated data excel document and page 3 and 4 of this document to ruth.mcdonald@northerntrust.hscni.net within 10 working days of your audit.**

**Appendix 2**

**Regional Trainee Survey of Handover Practice**

RQIA Weekend Handover Survey (draft for NIMDTA Quality Management Group)

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We thank you for your participation in this survey.

This work forms part of a regional Quality Improvement Project to improve documentation of weekend handover in acute general surgical Units in Northern Ireland. We would appreciate your views based on your experiences as a foundation or surgical trainee in the most recent surgical unit that you have worked.

We recognise that handover may vary in each surgical Unit depending on working patterns. For the purposes of this work the terms ***'Weekend', 'Friday morning ward round' and 'handover***' should be interpreted as the last ward round before a temporary or permanent change in Consultant management.

All responses are anonymous.

1. Documentation in patient notes is an integral part of handover in the surgical unit in which I am working (or have most recently worked) (1=strongly disagree, 6= strongly agree)

2. The Friday morning ward round in your surgical unit contributes to continuity of care over the weekend (1 = strongly disagree, 6= strongly agree)

3. Improvement in the Friday ward round documentation would improve weekend handover (1 = strongly disagree, 6= strongly agree)

4. Improvement in the Friday ward round documentation would improve patient safety over the weekend (1 = strongly disagree, 6=strongly agree)

5. For the purpose of continuity of care and patient management, what are the most important things to be annotated in the notes on the Friday morning ward round? (Free text, list up to 10, max 50 words.)

6. Please outline briefly how handover is conducted in the surgical Unit that you are working (or have most recently worked):

7. Please provide any examples of good handover practice from your current or previous surgical training posts (free text, max 50 words)

   (b) Please provide any examples of poor handover practice from your current or previous surgical training posts (free text, max 50 words)

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