



Quality Improvement Initiative to Improve Nursing Handover Process in Emergency Department

Shakuntla, Shoukath, Rachna, Melody, kiran, Dr. Tejprakash Sinha, Dr. Sanjeev Bhoi

Department of Emergency Medicine, JPNATC, AIIMS



Background

- Research has identified handovers as a risky time in the care process, when information may be lost, distorted or misinterpreted
Borowitz et al. 2008, Owen et al. 2009, Philibert 2009
- In 2001, the Institute of Medicine (IOM) reported that inadequate handoffs are "where safety often fails first"
J Grad Med Educ. 2012 Mar; 4(1): 4-8
- Usually handovers are time-consuming, lack consistency and are varied in style
Clark 2009; Kerr 2011; Sexton 2004
- Nurses, just like most healthcare professionals, receive no formal training in the handover process other than by modelling from peers and superiors
Van Eaton 2010
- Documentation drawn from the patient's chart in the shift following handover, showed dosage discrepancies in 23% of the handovers
- Delayed or not-executed care orders were found in 52% of the handovers
Journal of Advanced Nursing 71(5) - January 2015
- Ineffective handoffs can contribute to gaps in patient care and breaches (i.e., failures) in patient safety, including medication errors, wrong-site surgery, and patient deaths.
- Hughes RG, Rockville (MD):
Agency for Healthcare Research and Quality (US); 2008 Apr.

Problems Identified

- Nursing administrative handover is time consuming.

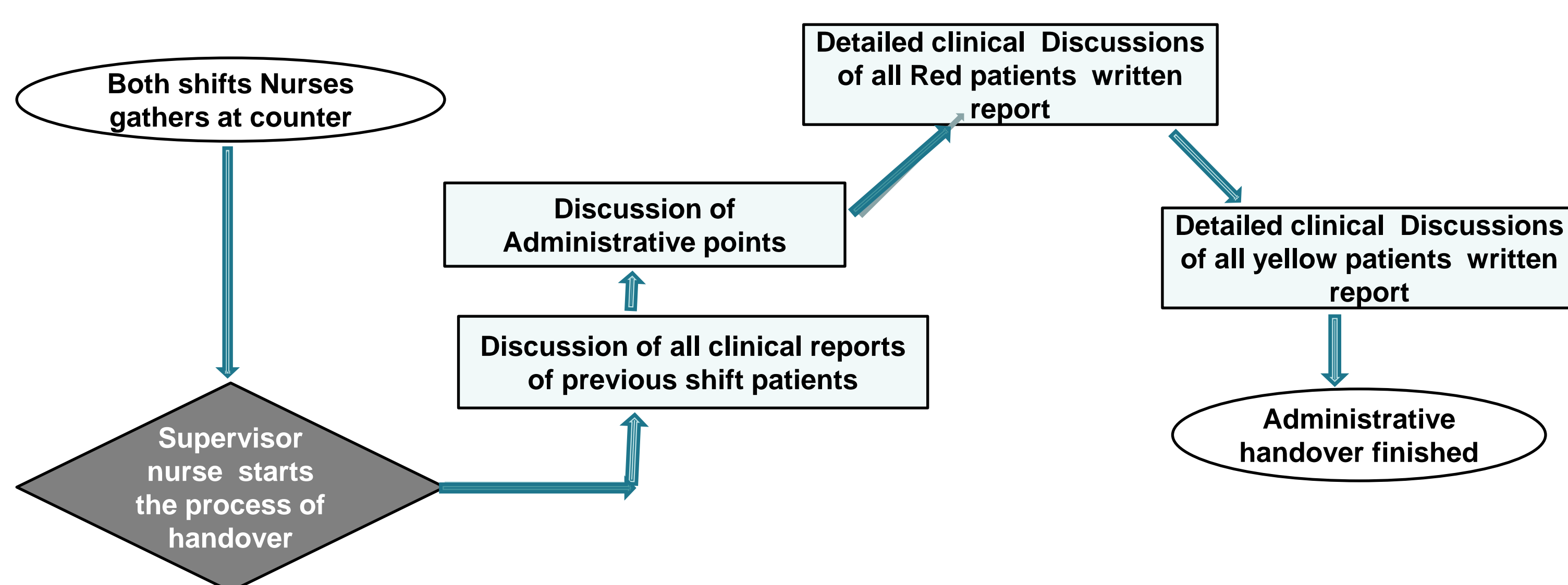
AIM Statement

- To decrease the Nurses Administrative Handover time by 50% from the Baseline (Median-15.5 min) over 3 months period (1st December 2017 -31st March 2017)

Quality Improvement Team

NAME	TEAM	ROLE IN TEAM
Dr. Sanjeev Bhoi	Team leader	Mentoring
Dr. Tejprakash Sinha	Team leader	Mentoring
Ms. Omana Vijayan	Team member	Coordination in clinical area
ED Sister Incharges (03)	Team member	Coordination in clinical area
Emergency Nursing Academics & Research Section Nurses (4)	Team member	Developing Modules & Data Collection
Ms. Vidhu	Team member	Data analysis
Clinical nurses	Team member	implementation in clinical area
QI Council members		coordination & implementation in clinical area)
Counter Nurses		filling the modules

Administrative Handover Process



Measurement

Process measure

- Decrease in time taken for counter handover
- Baseline median of counter handover time-15.5min

Outcome measure

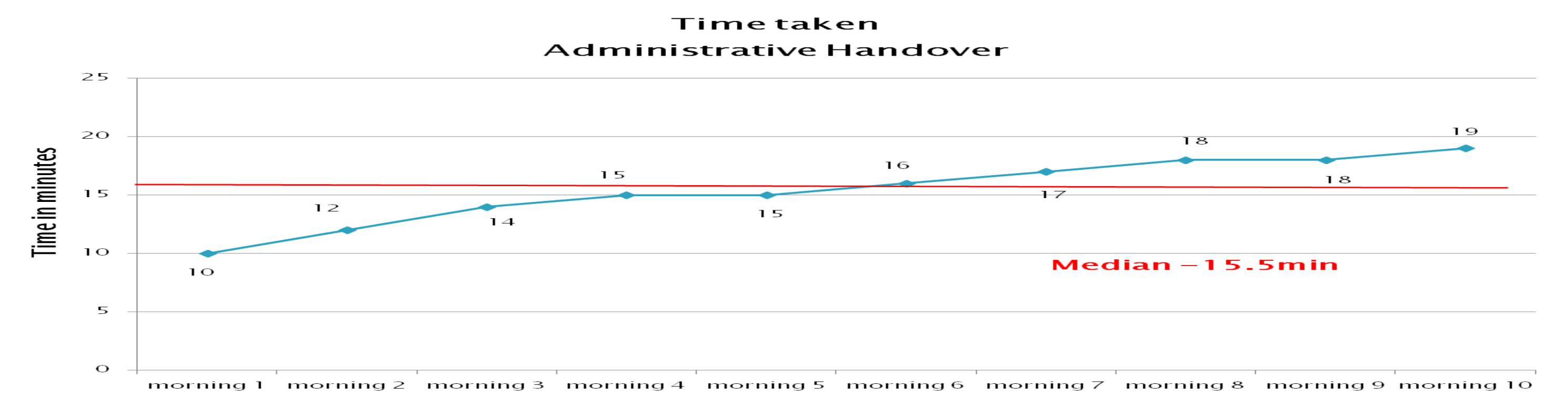
- Reduce duration of counter handover time

Data Collection

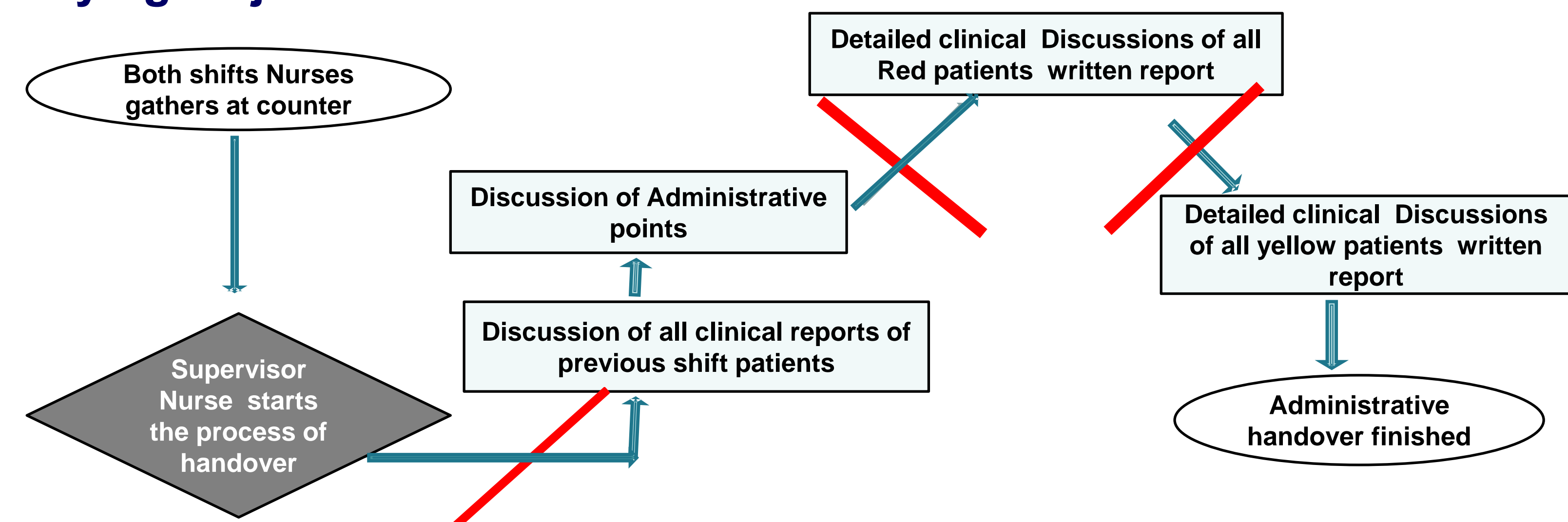
Administrative Handover time-

- Direct Observation Method
- Live data collection

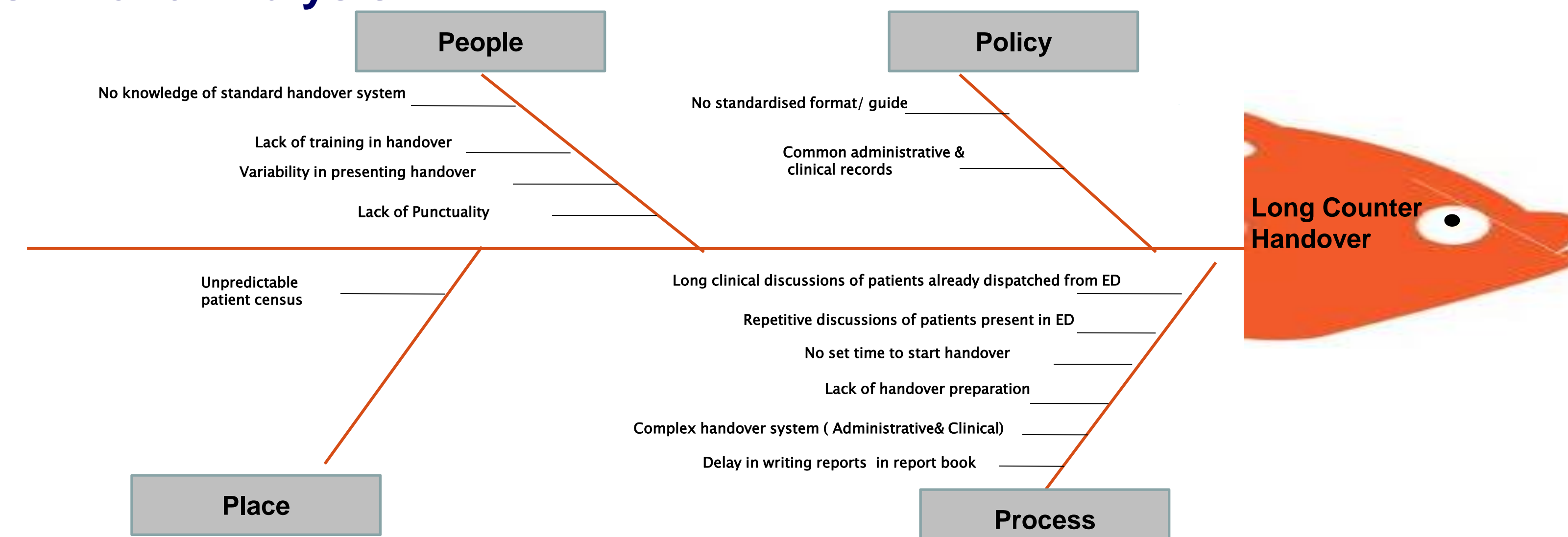
Baseline data (2nd week of Decemeber)



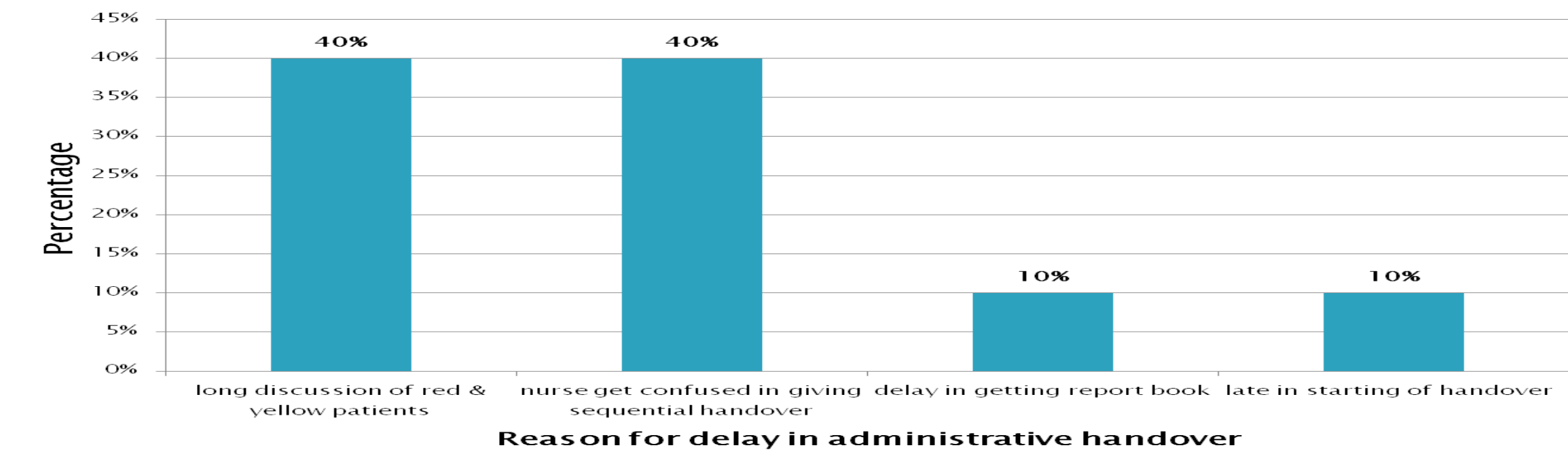
Identifying major bottlenecks.....



Fish-Bone Analysis



Pareto Chart



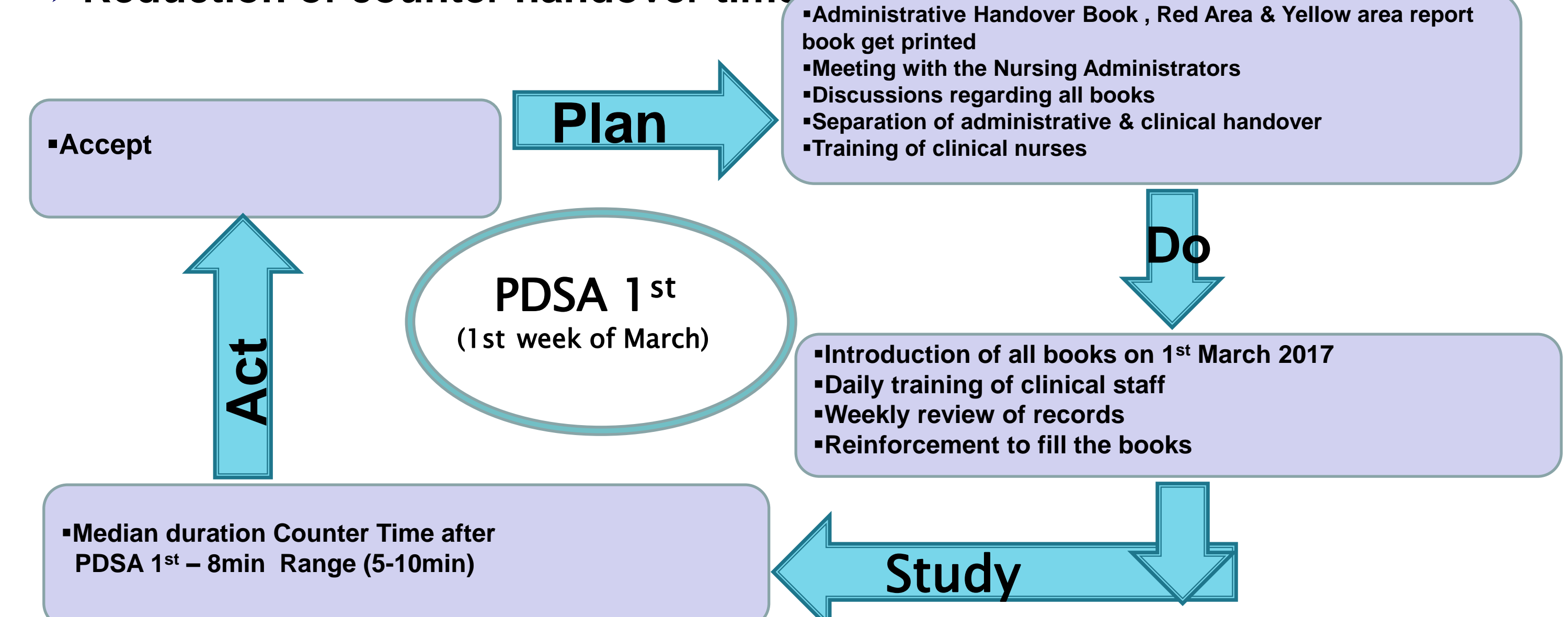
PDSA 1st (1st week of March)

Change idea

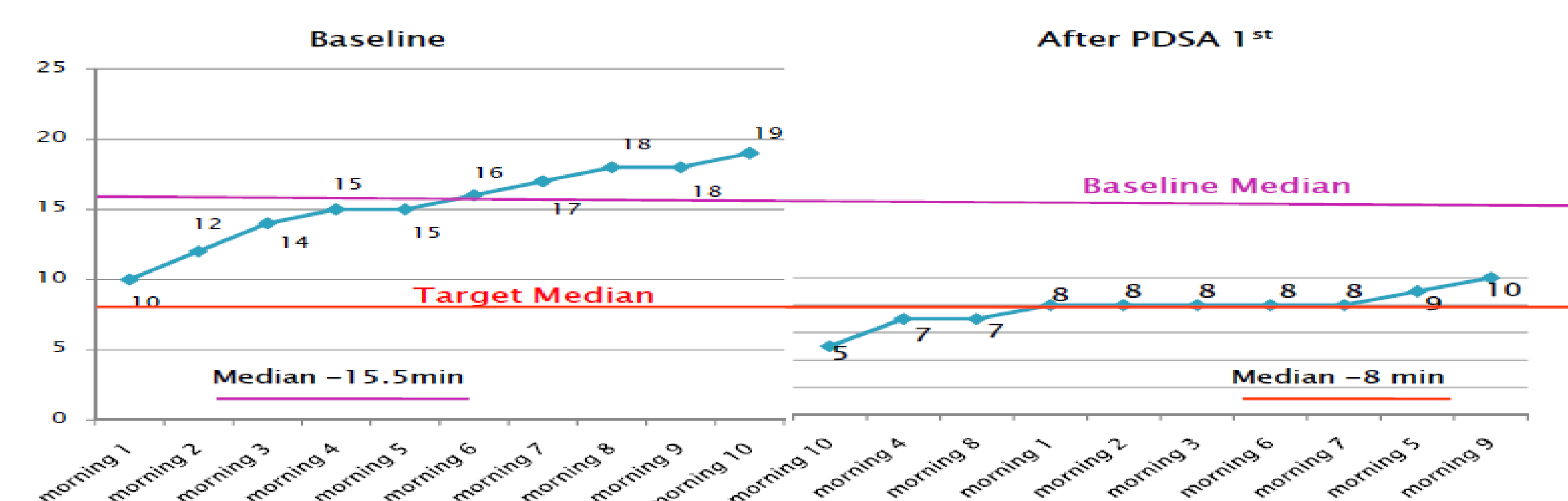
- Completely abolish previous handwritten books
- Introduction of Administrative Handover Format
- Separation of Administrative & Clinical Handover
- Introduction of Red & Yellow Area Report Writing format

Measure

- Reduction of counter handover time



Quality Improvement



Conclusion

- Separation of clinical & administrative handover significantly decreases the administrative handover time.
- Introduction of administrative handover format (ABC of handover) increases the quality of handover & decreases the chances of missing informations during handover.
- Decrease in administrative handover time increases the interest of nurses in taking clinical handover.