Hospital Handover Improvements

CASE STUDY – Royal Blackburn Hospital

Sustaining Improvement: Factors driving successful change in hospital handover processes*

"I think the things we did right was around making sure we had a mixture of people around the table […]. We got everybody that needed to be a part of the work involved and there was a lot of focus on the importance of the meetings and making sure everyone had a voice."

ED Matron, Royal Blackburn**

THE CHALLENGE

Royal Blackburn Hospital (RBH) ED has roughly one third more ambulance attendances than any other hospital in the North West. In December 2019, just over 1,000 patients a week were brought by ambulance to ED.

RBH took part in the 'Every Minute Matters' handover improvement collaborative with 5 other North West hospitals with an aim at reducing handover times.

Since the collaborative has ended, RBH has retained lower handover times, unlike other hospitals which were part of phase 1 of the initiative.

FOR FURTHER INFORMATION, CONTACT:

Emily Gibbs, Knowledge Manager, NWAS, emily.gibbs@nwas.nhs.uk

Lynsey Dunn, Head of Digital Services, NWAS, lynsey.dunn@nwas.nhs.uk

Caroline Hargreaves, SPTL, NWAS, caroline.hargreaves@nwas.nhs.uk

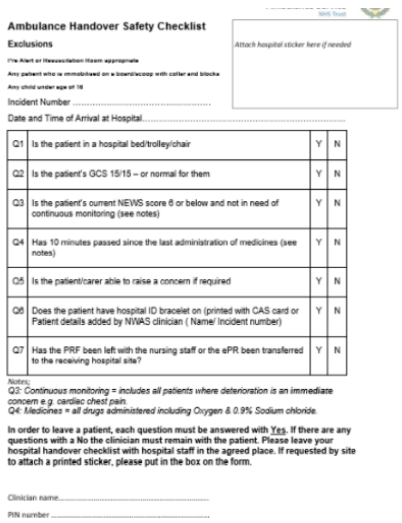
**All interviews have been anonymised to protect identity as per GDPR and terms outlined in consent form.

SUSTAINING IMPROVEMENT

In recent years, several initiatives have taken place at RBH, co-designed with NWAS, including traffic light systems, handover safety checklists and processes, escalation action cards, and communication channels to improve, and sustain, hospital handover times. Between 2020 and 2022, RBH has consistently retained lower numbers of long waits and average arrival to handover in comparison to others in the Collaborative Cohort.

To better understand the factors and processes which have resulted in this sustained improvement, the NWAS Evaluation and QI Teams visited Blackburn, interviewing six staff members (both RBH and NWAS) in July 2022. Observation notes were also taken. The interviews used a semi-structures narrative methodology. They were transcribed and were thematically coded.

The interviews were analysed alongside quantitative baseline data on average arrival to handover and long waits. This was to understand the factors of this improvement work through collaborative cultures, best practice, and QI methods used.



Ambulance Handover Safety Checklist

Exclusions

The Alert or Resuscitation Room appropriate

Any patient who is immobilised on a board/scoop with collar and blocks

Any child under age of 16

Attach hospital sticker here if needed

Incident Number .....

Date and Time of Arrival at Hospital.....

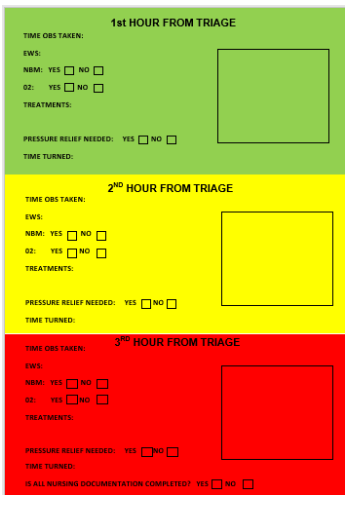
Q1	Is the patient in a hospital bed/trolley/chair	Y	N
Q2	Is the patient's GCS 15/15 – or normal for them	Y	N
Q3	Is the patient's current NEWS score 6 or below and not in need of continuous monitoring (see notes)	Y	N
Q4	Has 10 minutes passed since the last administration of medicines (see notes)	Y	N
Q5	Is the patient/carer able to raise a concern if required	Y	N
Q6	Does the patient have hospital ID bracelet on (printed with CAS card or Patient details added by NWAS clinician (Name/ Incident number)	Y	N
Q7	Has the PRF been left with the nursing staff or the ePR been transferred to the receiving hospital site?	Y	N

Notes:
Q3: Continuous monitoring = includes all patients where deterioration is an immediate concern e.g. cardiac chest pain.
Q4: Medicines = all drugs administered including Oxygen & 0.9% Sodium chloride.

In order to leave a patient, each question must be answered with Yes. If there are any questions with a No the clinician must remain with the patient. Please leave your hospital handover checklist with hospital staff in the agreed place. If requested by site to attach a printed sticker, please put in the box on the form.

Clinician name.....

PIN number .....



1st HOUR FROM TRIAGE

TIME OBS TAKEN:

EWS:

NBM: YES ☐ NO ☐

02: YES ☐ NO ☐

TREATMENTS:

PRESSURE RELIEF NEEDED: YES ☐ NO ☐

TIME TURNED:

2ND HOUR FROM TRIAGE

TIME OBS TAKEN:

EWS:

NBM: YES ☐ NO ☐

02: YES ☐ NO ☐

TREATMENTS:

PRESSURE RELIEF NEEDED: YES ☐ NO ☐

TIME TURNED:

3RD HOUR FROM TRIAGE

TIME OBS TAKEN:

EWS:

NBM: YES ☐ NO ☐

02: YES ☐ NO ☐

TREATMENTS:

PRESSURE RELIEF NEEDED: YES ☐ NO ☐

TIME TURNED:

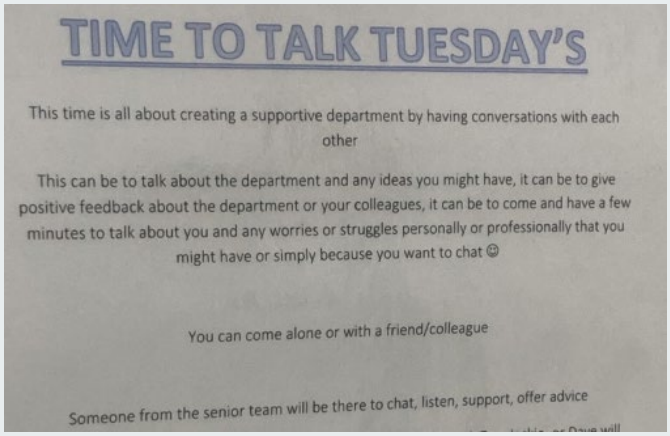
IS ALL NURSING DOCUMENTATION COMPLETED? YES ☐ NO ☐

*A full report on the findings of this work will be available in 2022.

KEY THEMES

Across the interviews conducted:

- The **collaboration** and **relationship** between NWAS and RBH were cited as key factors in the sustainment of the handover times:
  - "Staff are always accommodating. Because we come here a lot, we have a good rapport with the staff. We know them face to face better than the others" – Paramedic, NWAS
- RBH staff discussed a need to be **consistent** and **not giving up**, even during COVID pressures:
  - "Things did change, but they didn't at the same time. We had a red door and a green door. It took a couple of days for us to adjust but we were adamant that we wouldn't change the process and it didn't" – ED Matron, RBH
- RBH staff cited the role of driven **individuals (both NWAS and RBH)** who embedded success and **invested** their time into the improvement
- Staff discussed the requirement to have **support** from a wide array of healthcare representatives across the patient journey AND within the hospital itself e.g., Wards and clinical staff "on the ground"
- Interviewees suggested that the 'big problem' of hospital handover needed to be split into **smaller "manageable" processes**. Examples included:
  - Traffic Light system on patients
  - Corridor Care processes
  - Huddles / Celebration boards (communication channels)
  - Handover Safety Checklist
  - Action Cards
  - Alternative patient pathway routes (patient journey processes)



"Teamwork between RBH/NWAS is a big part of why this has been successful. With the introduction of the handover sheet, there is more flexibility within the patient journey."

RBH Deputy Directorate Manager (ED)

KEY FACTORS TO SUSTAINING SUCCESS

- Communication across services (and within the hospital) and good rapport across staff are key
- Corridor Care, whilst has associated risks, is cited as a key factor in reducing handover times:
  - "Visual" Monitoring tools can support corridor care (e.g., Traffic Light system)
  - Space and size of the hospital were frequently referenced
- Paramedics cited familiarity, communication, and consistency in processes as key to quick handover
- Building trust across staff and services is vital
- New ideas should be tried and tested regularly without upsetting current processes
- The handover checklist was well received once implemented and embedded
- The drive and determination of a few individuals resulted in wider implementation and success

3m 37s reduction on average — Arrival to Handover times in 2021/22 in comparison to 2018/19 baseline data

5% reduction in average arrival data — RBH has seen a 1m 12s (↓5%) reduction in comparison to the other cohort which has seen a 16m 25s increase (↑84%) in 2022/23 YTD, compared to 2018/19

0.8% of handovers over 60m — In comparison to the other cohort which experienced 10.4% of handovers over 60m for 2021/22

Royal Blackburn – Case Study Data

Average Arrival to Handover