Babies Need Better Handover

A Local Quality Improvement Project

Dept of Paediatrics & Neonatology, Antrim Area Hospital

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Background:

- Prior to August 2019, handover for the postnatal ward took place on a ward diary – not always face to face
- Relied on a colleagues handwriting to handover/communicate tasks
- Mistakes looked inevitable

- **Antibiotic doses** not given for suspected neonatal sepsis
- Missed **clinical reviews**
- Missed **blood monitoring**

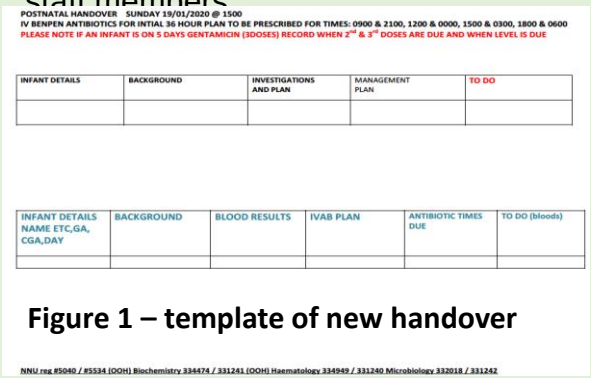
- Substandard care given
- Poor communication
- Reduced staff morale

Strategy for Change:

- Typed handover (fig.1) updated 3 times daily on shared computer login
- Verbal face to face handover each time staff changes
- Senior Paediatrician to meet with postnatal ward SHO daily for queries

Aims:

1. Ensure each baby receives appropriate and safe care
2. Reduce number of missed clinical reviews, antibiotics and blood monitoring
3. Enable better communication between staff members



POSTNATAL HANDOVER SUNDAY 19/01/2020 @ 1500

IV BENPEN ANTIBIOTICS FOR INTIAL 36 HOUR PLAN TO BE PRESCRIBED FOR TIMES: 0900 & 2100, 1200 & 0000, 1500 & 0300, 1800 & 0600

PLEASE NOTE IF AN INFANT IS ON 5 DAYS GENTAMICIN (3DOSES) RECORD WHEN 2nd & 3rd DOSES ARE DUE AND WHEN LEVEL IS DUE

INFANT DETAILS	BACKGROUND	INVESTIGATIONS AND PLAN	MANAGEMENT PLAN	TO DO

INFANT DETAILS NAME ETC,GA, CGA,DAY	BACKGROUND	BLOOD RESULTS	IVAB PLAN	ANTIBIOTIC TIMES DUE	TO DO (bloods)

NNU reg #5040 / #5534 (OOH) Biochemistry 334474 / 331241 (OOH) Haematology 334949 / 331240 Microbiology 332018 / 331242

Figure 1 – template of new handover

Methods:

- New proforma developed (all of team consulted)
- Questionnaire at end of 6 month trial period to all staff members using new handover
- X2 re-audits completed at 8 and 10 months (each over weeklong period)
- Any incident forms identified

Results:

- **No further incidents** of missed antibiotic doses, blood monitoring or missed reviews on audit/re-audits
- **Daily verbal handover** at all changes of shift
- Daily morning **'huddle' with senior staff** to discuss postnatal ward queries

Conclusion:

- Simple measures of a typed handover, verbal handover and daily meeting with senior doctor **effective**
- Ensuring **each baby got a better handover**

Impact:

- **Improved care** for our babies
- **Improved patient safety** with reduced errors
- **Improved staff communication**
- **Improved staff morale** – doctors, nurses and midwives

Reference:
McLaughlin, D. McAlister, P., Turner, S. Post-Natal QI Project – Antrim Area Hospital, 2019-2020