

**Improving Patient Safety through a new Clinical  
Handover Procedure  
Safety Category**

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# Aim

Within 6 months develop a patient focused, standardised Clinical handover procedure for the Paediatric Unit CHBH that would improve the safety of Clinical care, improve communication with Parents and improve the efficiency of the Unit overall

# Background

- Handover frequently starting late and running over time
- Staff seeking further information following Handover time
- Patients without correct ID / information
- Emergency equipment not routinely checked
- Parents not aware of the 'plan of care'
- Missed tests / procedures / medications
- Ward poorly staffed during Handover time despite double staffing

# Methodology

- NUM closely observed what took place during Handover
- NUM observed the Unit during Handover time
- Evaluation of Nursing Care Audits / IIMS reports
- Root causes identified:
  - Handover away for Clinical area
  - Key people not involved
  - No agreed best approach

# Planning & Implementation

- Alternative methods investigated
- Identification of stakeholders – patient, parent, nursing staff, Junior Medical Officer
- Bedside identified as the best place for Handover to occur
- Formal checklist developed – ID band checked, IV cannula check, emergency equipment checked, Medication chart checked, Patient allergies recorded

# Outcomes & Evaluation

- 83% reduction in medication errors (sustained)
- Audit of checklists – 100% compliance
- Parent satisfaction 9.6 / 10
- Nursing Care Audits - improvement in emergency equip.
- JMO routinely attending 1400 clinical handover

# Lessons Learned

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- Change is challenging
- Consistent feedback
- Keep on keeping on

# Future Scope

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- Rollout of patient focused Clinical Handovers into other Clinical Units CHBH
- Support for NUMs