Gloucestershire Safety &
Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

Improving completion of patient transfer handover

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1. Area for improvement

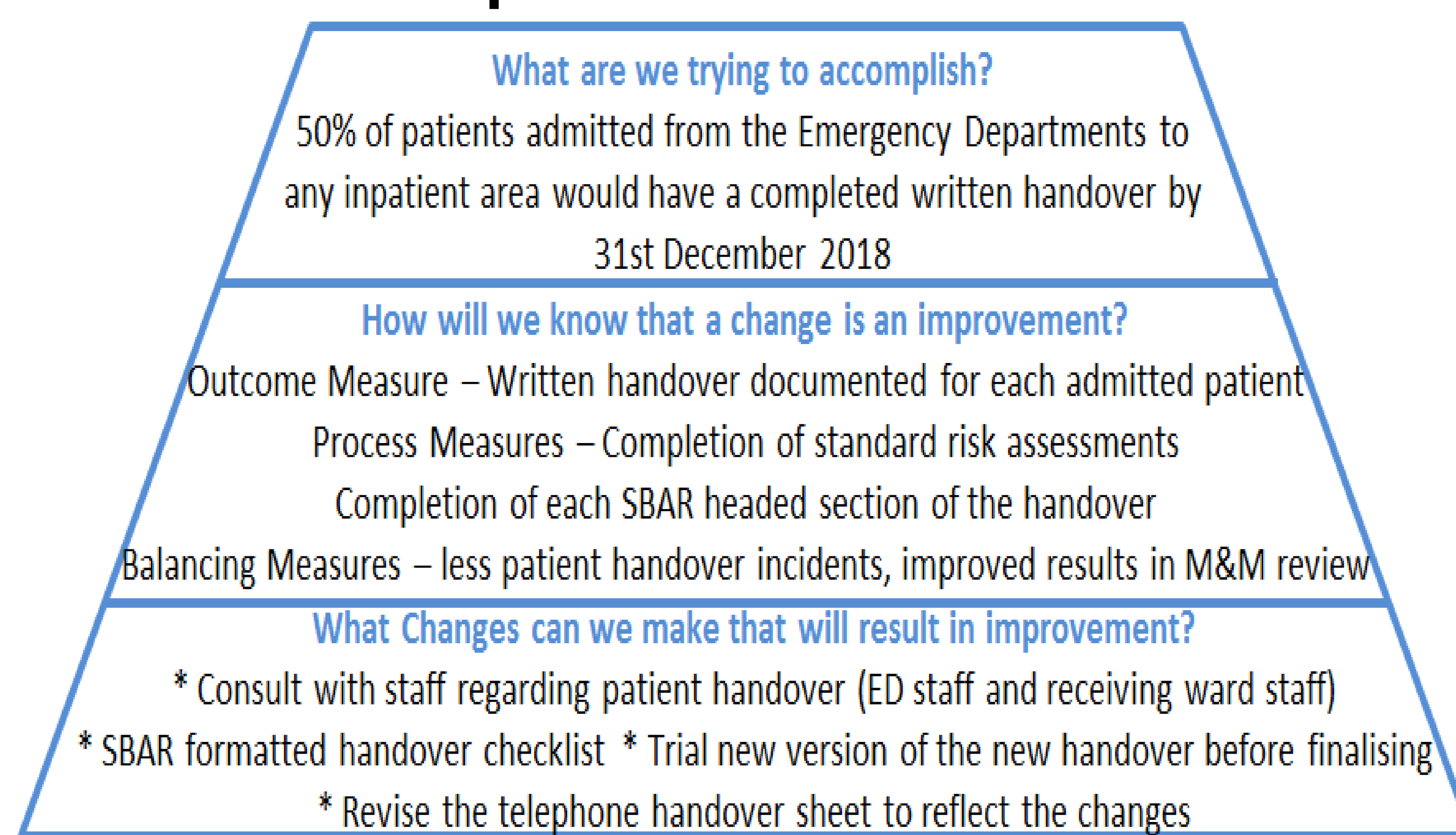
Communication is always highlighted as a weakness in critical incidents and patient complaints. One area consistently causing concern is the loss of information when a patient is transferred between clinical areas. Such transfers are unavoidable in healthcare practice, especially on admission from community to hospital.

2. Why is improvement necessary?

Patient transfer handover failures typically contribute to a cascade of failures involved in adverse patient outcomes. The Morbidity and Mortality review April 2017—March 2018 outlined issues with poor handovers, transfers, omissions in initial assessment and delays in recording ECGs.

Both referring and receiving medical and nursing staff were dissatisfied with the quality of handover communication. Therefore the primary drivers for this quality improvement project were communication of patient care, documentation of patient care, patient complaints and staff dissatisfaction. Wide consultation with staff suggested that they were open to a Patient Handover checklist, replacing an existing model, which was rarely used.

3. Model for Improvement



4. PDSAs

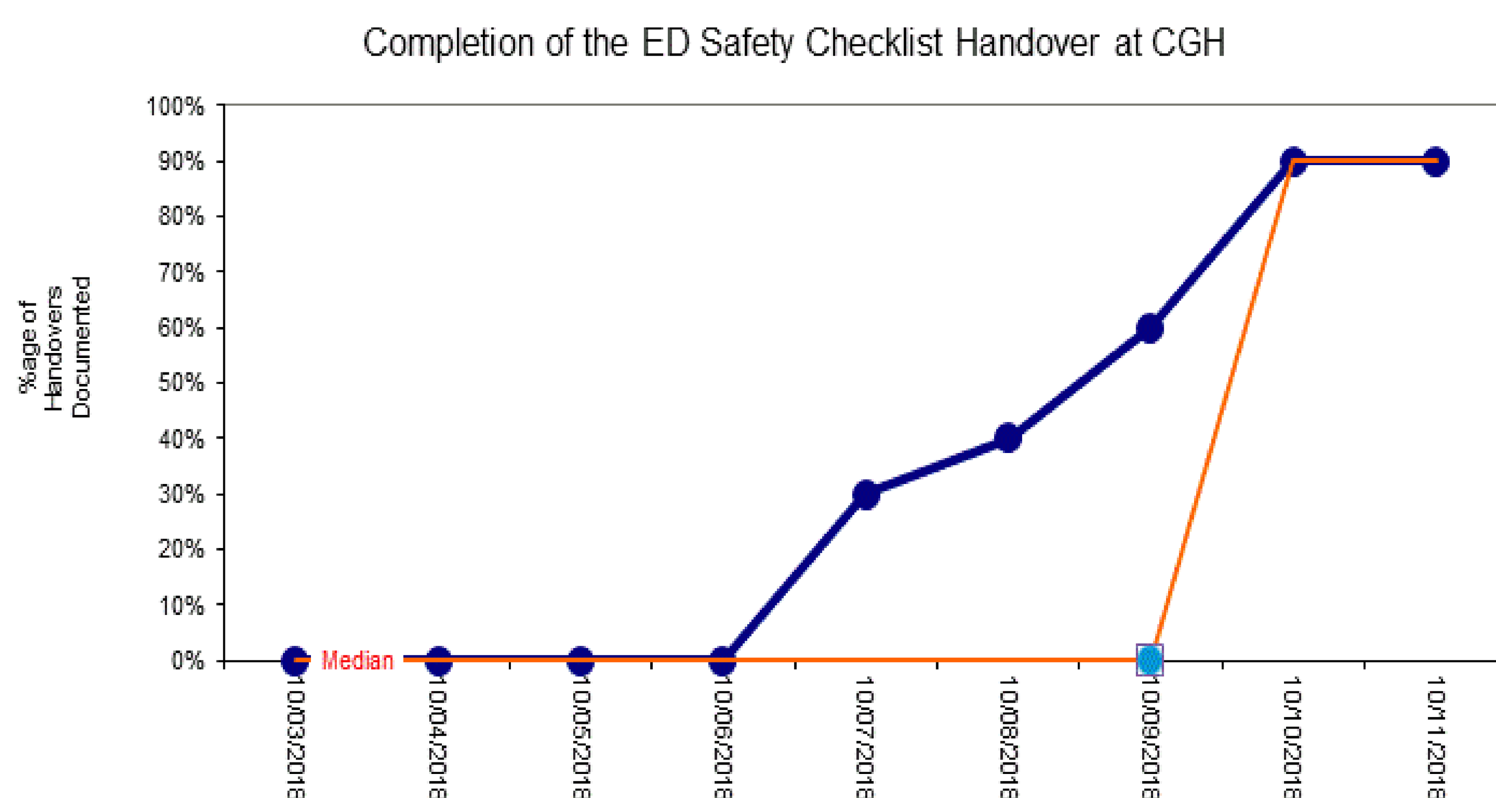
Much time was devoted to asking staff three questions:

1) What do you want to hear in a patient handover?
2) What do you want to say in a patient handover?
3) How would you like to structure this?

Answers were collated and there was a high level of agreement across all grades of nursing staff. This resulted in a major re-draft of the ED Safety checklist, which was tested with staff, revised and re-tested in PDSA cycles (reflected in the outcome measures on the CGH completion graph). A final approved version commenced on 17th September 2018 after which there was dramatic improvement in documentation of all aspects of patient care within both EDs, exceeding our project aim.

This has been adopted quicker within CGH due to project staff working there clinically.

5. Measurement



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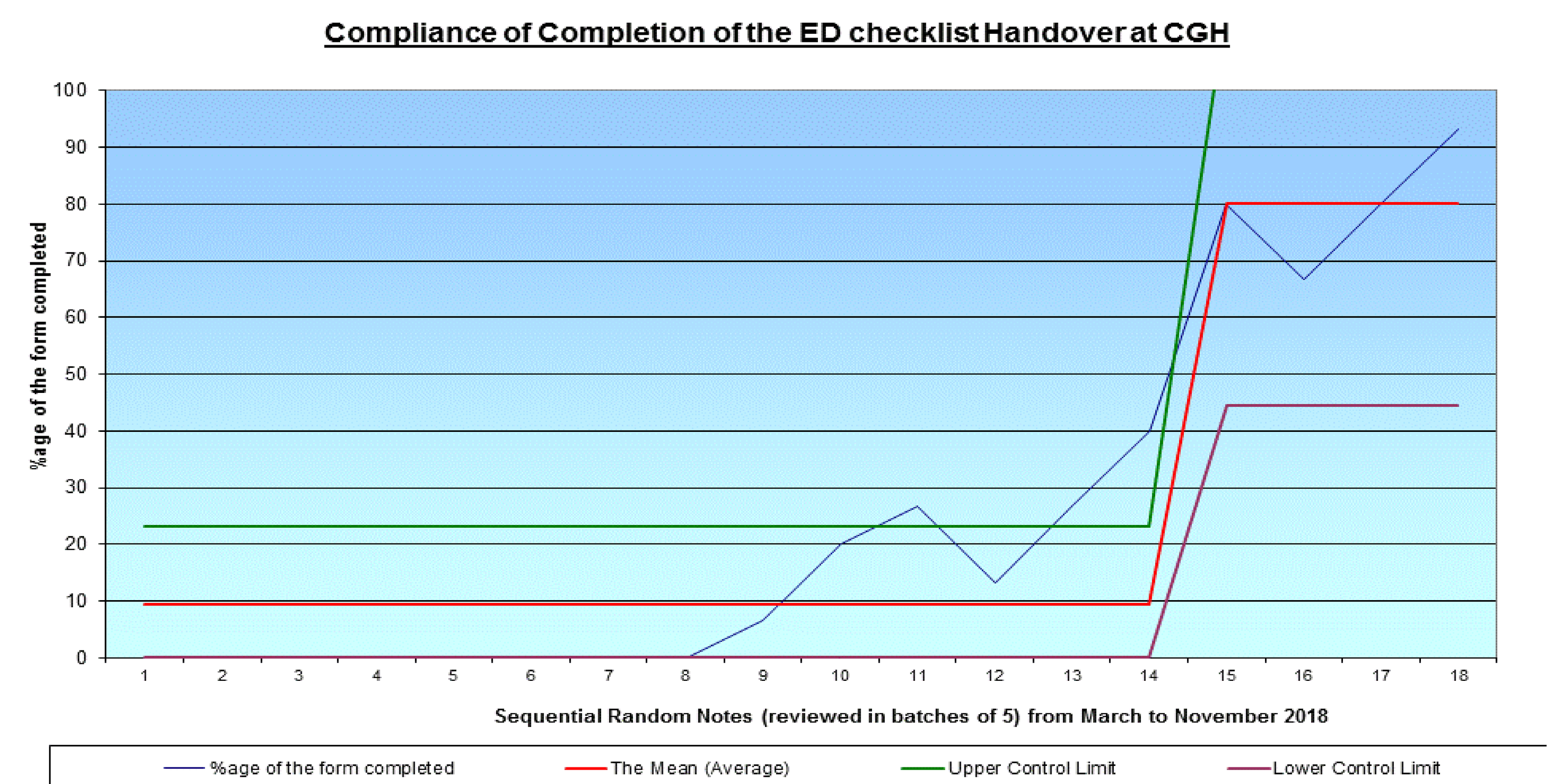

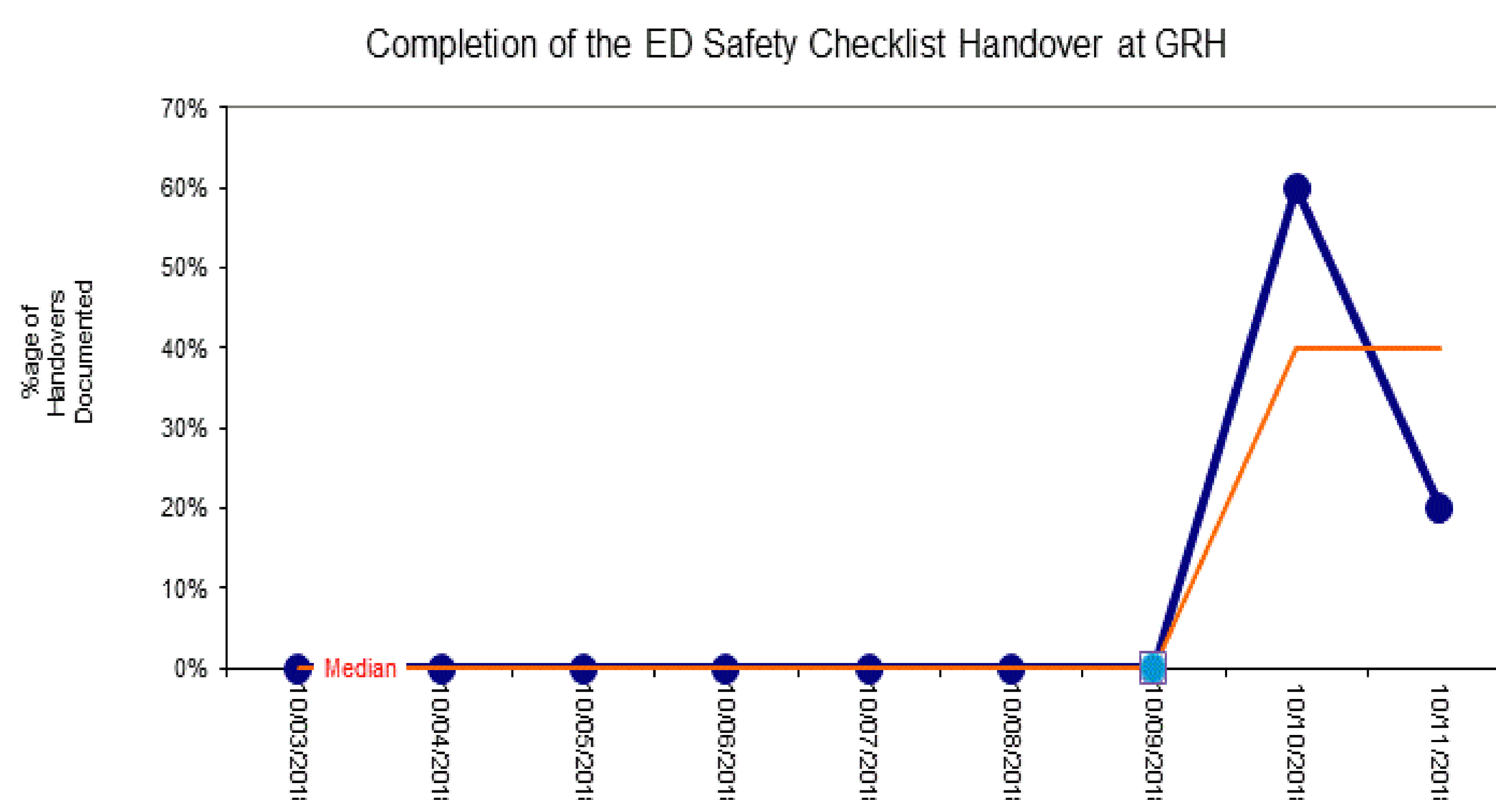

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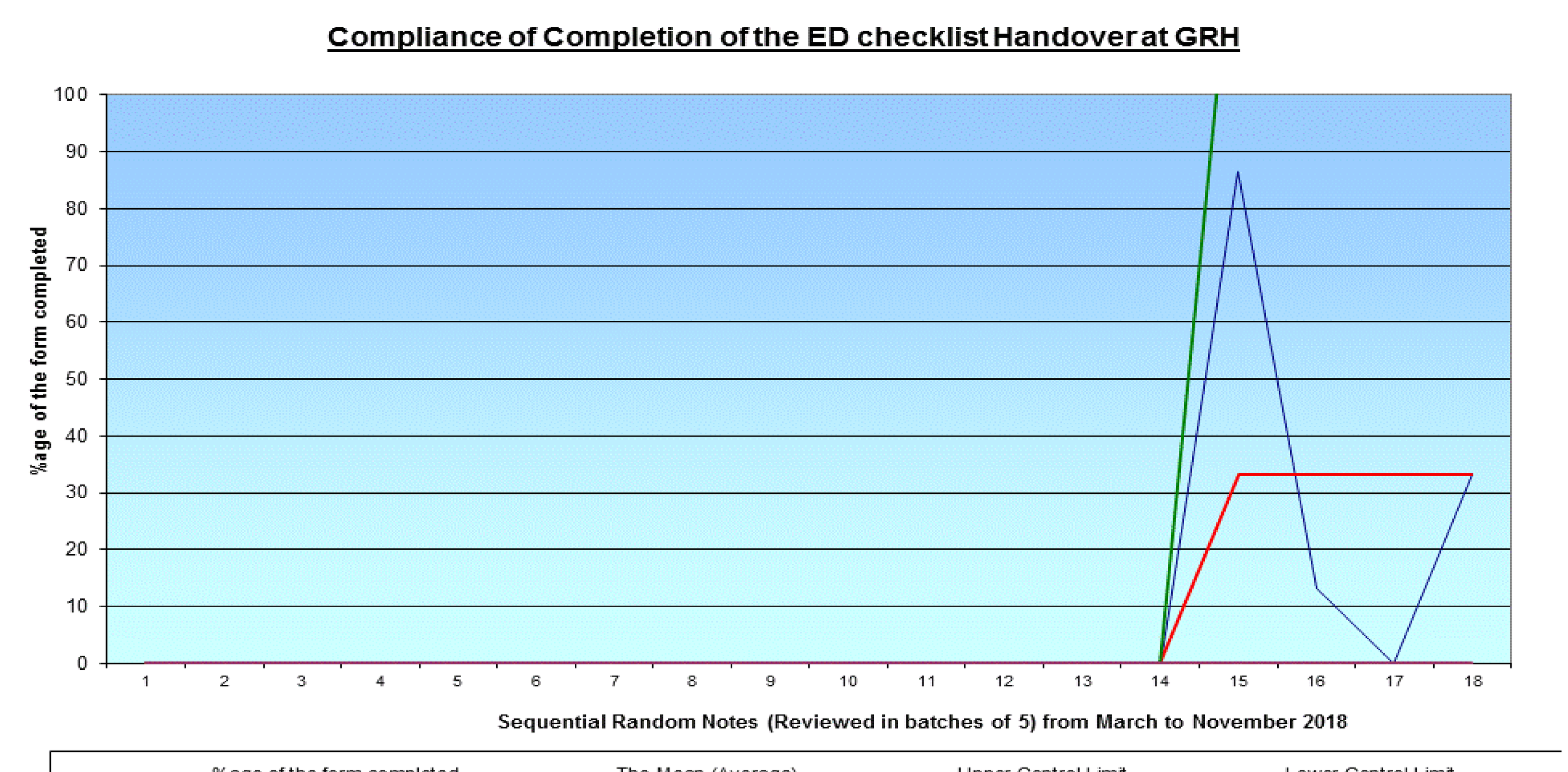

6. Opportunistic improvements

Staff responses to our questioning enabled us to also include:

- Moving the infection control and falls risk assessments
- Changing the pressure ulcer risk assessment, at the request of Tissue Viability
- Changing the property checking process to support another Silver QI project
- Allocating an admission status to ensure unstable and critical patients are escorted by registered nurses

7. Next steps

The initial in-hospital patient transfer is from the Emergency Department to the first in-patient setting. There remain other intra-hospital transfers, which are equally weak. The next phase of this project will be to work with the admission assessment areas to improve the second patient transfer handover Trustwide.