Standardizing On-Call Resident Handover for the UAH Gastroenterology Rotation

Background: Handover is an essential aspect of patient care to carry out during the night and be aware of sick patients. St care settings, and SBAR format was found to be the most effe patient, Assessment and Recommendations or the plan going

At the University of Alberta, SBAR is a standardized method o trained on at the beginning of their residency.

Problem Statement: During the Gastroenterology rotation, th brought up to the Department over the years. This leads to al Baseline data: (n=32)

Surveys from Residents that have rotated through the UAH GI

- Only 47% of Residents stated that Handover was occurring Overall Handover was rated as poor quality 66% of the tim receiving all the required information
- Residents stress levels on the GI rotation call shifts were ra the lack of handover contributed to their stress levels.

Aim Statement: By September 2018:

Process Measures:

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- 80% of handover occurring consistently between 16:00-17
- 70% of handover utilizes the SBAR format

Outcome Measures:

- Increase number of handover to on call resident by 75%
- Increase quality of handover as per resident perspective by

Process Assessment: To understand the current process, a bi quality improvement tools were completed to identify improv

S	Situation: patient's / client's details - identify reason for this communication, describe your concern
В	Background: relating to the patient / client, significant history - this may include medications, investigations, treatments
Α	Assessment: your assessment of the patient / client or situation - this can include clinical impression, concerns, vital signs, early warning score
R	Recommendations: be specific - explain what you need, make suggestions, clarify expectations, confirm actions to be taken

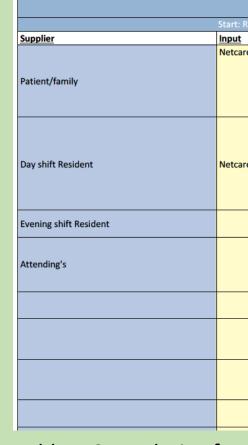


Table 1.0: Analysis of c

Figure 1: Sample Format of SBAR process

<u>Resident Survey</u> (internal medicine R1-R3 on GI rotation; n=32):

- Only 47% of Residents stated that handover as occurring often
- SBAR was used 25% of the time
- Residents quoted good quality of handover 34% of the time
- Most residents were R1s (69%)
- 25% of residents were confident that they received all necessary information at handover Most comments included:
 - Having a set time and place for handover
 - Making it mandatory for staff and residents to attend
 - There was never handover during the weekends

Collaboration & Communication Strategies:

Project team included an internal medicine resident (R3), a G quality consultant

The project team physician and resident facilitated teaching in residents about the interventions at the beginning of their G

Project Team Physician attended Department meetings to end about the new handover process and talked about the SBAR Further insight to the resident perspective on handover was (see Figure 3)



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tructu	red hand . This for	over	has	s been s	tudied in a w	l residents on task vide variety of heal ground on the	
of giving handover that all Internal Medicine Residents are						No S	
						issue that has bee s for residents.	n
g often				ts were	concerned tl	nat they were not	
						esidents stated tha	t Staf han
':30 du	iring the	wee	k				Con Qua
y 30%							
	erature re nt opport		-	Gemba	walk, survey	s, and various	PDS Proc
	I handover Process- SIPOC	ndover is complete					- H
print pt list per Attendings	<u>Process</u> Go to Unit	Outputs Updated pt. list- handwritten by the resident	<u>Customers</u> Patient/family		Issues: 1=Printing off patient lists may miss patients when attending's switch over (Netcare had not caught up) Give admitting diagnosis but may not be active diagnosis (Ex. Acute Chole)	Trouble Shooting . 1) If staff does not show up continue to page them	
	1) resident prints off lists under the attending's for both wards. May get a consult list as well if another resident gives it to them $\sum_{n \in N} \sum_{n \in N}$		Day shift Resid	ent	1=Difficult to find the consult list for inpatient consults And unsure how to pull the consult list	2) contact residents on team for handover if staff is not available	- SI
	Is Resident/Attending present?-YES Review the active pt. list-can be done over the phone or face to face		Evening shift R Attending's	esident	2=too many patients to go through an effective timeframe 2=many pages during handover No Handover- one will need to make assumption based on admitting diagnosis and netcare bloodwor	3) residents to use algorithms to help provide good handover	- R
	Resident -Document onto the pt. list important details	M			what's going on with the patient 3=GOC not known for patient		- 3
					3=sometimes this doesn't even happen and you have to assume based on admitting diagnosis and netcare bloodwork what's going on) 3=Overall difficult to predict stable patients to decompensate		- Ir Resi
rent hando	ver process and	l Identify	y areas	s of concern			- 6
	unpredictabl	e factors leading to de	Patient		unit clerk	<u>oom</u> not available (scoping, etc.) pages with no urgent issues <u>ar who</u> should give handover (R2/Fellow/Staff)	– N
	failed	Has follow up to tell the day time iss	tests/procedures	p at night		Netcare list may have no updated information	Deire
			y on service, hard	sident don't k <u>now any inpatients</u> to get away to get handover handover to colleagues		No standard GI Resident handover	Bank In or
		Don't	at info is relevant ask clarifying que helmed with <u>infor</u> i	estions		pages are not sent through	#2-D
			Resident		Equipment and		1. C
	_	gure 2: C ndover			bone diagram demons	trating issues identified in	2. S
				GI On-Call Handover \$	Survey		J. L
il phys	ician, and	d a			at this quick survey. It will help the GI Department improve 17:00 6	GI On Call Handover Survey How confident were you that you received all the essential information after handover?* Mark only one oval. 1 2 3 4 5	Les
				PGY 1 PGY2 PGY3 2. How often did Handover occur dur		Not at all confident Very confident In general, how are your stress levels during a GI call? * Mark only one oval.	
nternal medicine			2. How often did Handover occur during your GI Block?* Mark only one oval. 1 2 3 4 5 Never O Every day No stress at all O Very high				
I training blocks				3. Who gave handover when it did occur? * 8. How often would handover be a contributory factor to your stress levels on call? * Mark only one oval. Mark only one oval. Staff/Fellow 1 2 3 4 5 Both 1 2 3 4 5			
001110				4. Was SBAR used for handover?* Mark only one oval.	4 5 9	Rarely Very often In your opinion, did the lack of handover lead to any patients not receiving attention in time? * Mark only one oval.	
courage all GI Staff Format				Never used	·	Mark only one oval. 1 2 3 4 5 Not in my opinion O Strongly believe so	-
collected via surveys			Poor Quality		Any Comments to help us improve Handover	_	
		,		Figure 3: Surv	vey Given for Resident	input on handover	
							1- In



Services

provement Selection and Implementation Plan- PDSA Time: July 9 to S						
le 2: Gaps identified contributing to inconsistent handover and interve						
p	Intervention Implemented					
set Time and Place	Determined handover to occur on 5C4 round 16 handover					
Standardization	 SBAR training was administered to all Resider program in July 2018 Algorithms of common GI issues were available and in the Handover Education Binder locate 					
ff not providing ndover	 Dr. Kohnansal provided an update of the base current U of A Staff Gastroenterologists durin 					
nsistency of Good ality Handover	 Audit sheets filled out to monitor the state of Residents were also resurveyed post interver 					

Sept 3, 2018 entions implemented to bridge these gaps L6:30-17:00 as the ideal time and place for ents through the U of A Core GIM Bootcamp able to Residents during orientation session ed on 5C4 GOC/ICU involvement GOC/Pertinent comorbid Bleeding (See GI algorithm) lepatic encephalo GCS/Scoring Escalate therap Lactulose administration To do list that evening seline data and SBAR education session to the ing their department of handover being given in real time ention Date & Time On call (Ward-W, Startf/Fellow- (Yes-Y, No- Startod (Ward-W, S Porton Startod (Ward-A Results- A Total of 51 handover days were audited cess Measures: landover overall occurred 82% of the time (increased from 27%) - Handover only came from one inpatient team 18% of the time - Of all the days that no handover was received for either team, it all occurred during the weekend shift come Measure: esidents stated 33% of the time the quality of handover was good quality (unchanged from previous) 3% of residents were confident that they received all the necessary information (up from 25%) dents: lo residents thought that handover contributed significantly to their stress levels (reduced from 38%) force Ownership, Measurement, & Continuous Improvement: der to sustain and spread the efforts to reduce the number of incomplete inpatient bowel preps, we plan to start PDSA 🗦 ec 2018 where we will try to: ontinue to bring up Handover within the GI Department Meetings to encourage staff to continue to provide Handover hare Handover process in the orientation manual for Internal Medicine Residents at the beginning of their rotation ncourage handover over the weekend sons Learned: Why this QI matters Changing culture of providing handover from senior staff members have been proven difficult **To Patients** and will take time and encouragement to adapt change Improving patient care through adequate handover on follow- up tests, etc. Culture Eats Strategy for breakfast - Peter Drucker **To Albertans** Increasing integrated care Process change requires thorough communication, inclusion of all key stakeholders, and To the healthcare frontline QI champions to initiate and pave the way for sustainable change system Empowering Residents to ask for handover and gain skills to give effective handover Improving communication themselves are essential and outcomes stitute for Healthcare Improvement Clinical Tools: Implementing SBAR

BAR was used 53% of the time (increased from 25%) mpact: 6% of residents rated GI call as very stressful post intervention, unchanged from previous



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Strategic Clinical Improvement Committee Partnerships in Action