Safety First

Using a safety briefing tool to improve the quality of handover

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Problem:

- Handover lacks structure.
- It is difficult for the receiving team to absorb and process information given to them.
- The team are unable to identify at risk patients which compromises patient care.

Background:

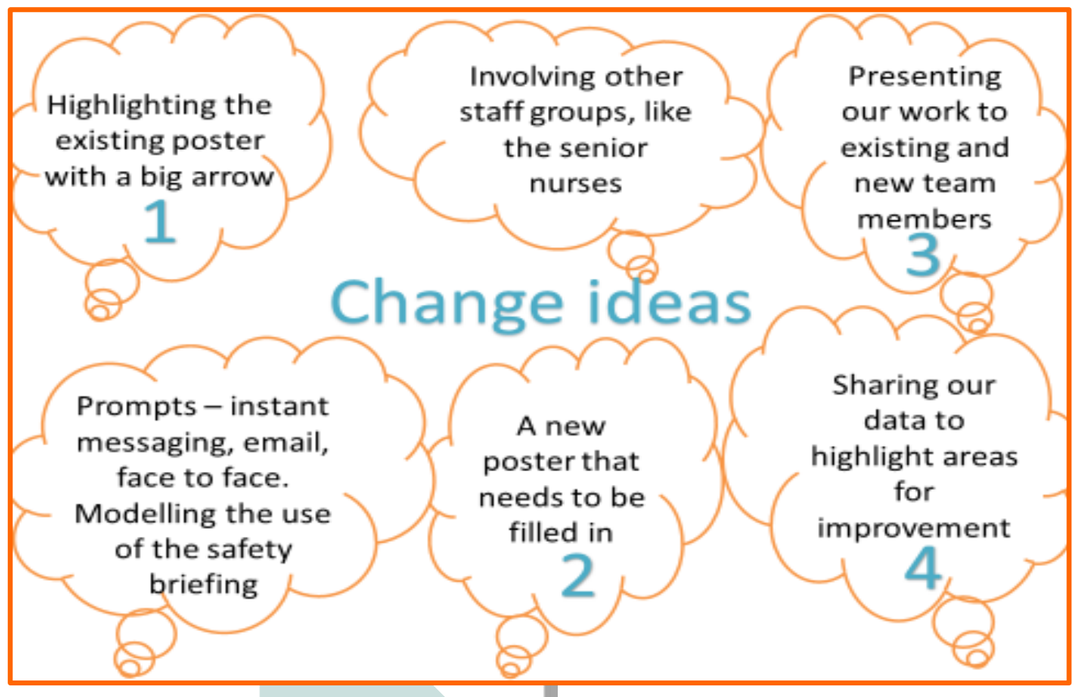
- Failures at handover are recognised as a key cause of preventable harm to patients [1]
- The poor quality of our handover was frequently raised by trainees as a cause of concern [2]
- A safety briefing tool had been displayed in the office for over a year but was used in < 1 in 10 handovers.

Aim:

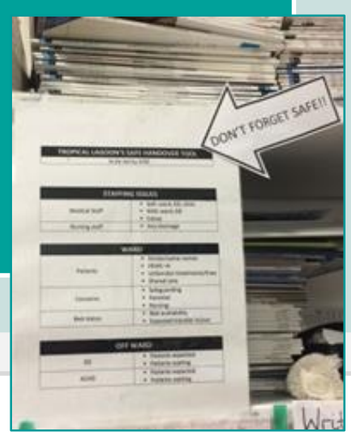
For a comprehensive safety briefing to be provided at the start of every handover by September 2018.

Measure:

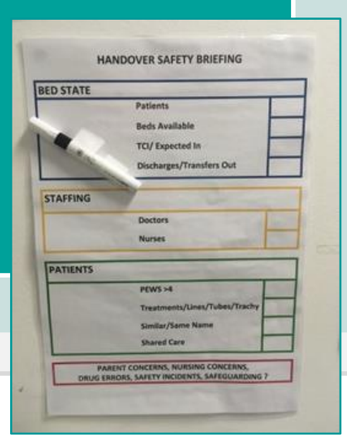
Safety briefing in full at the start of handover.



PDSA 1
The Big Arrow

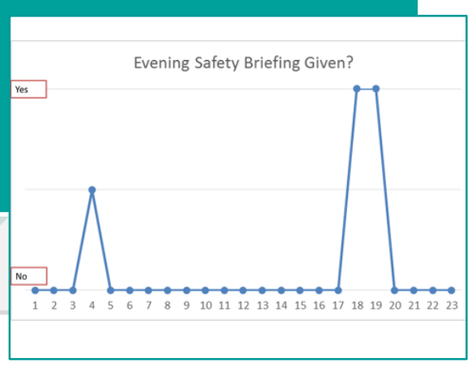


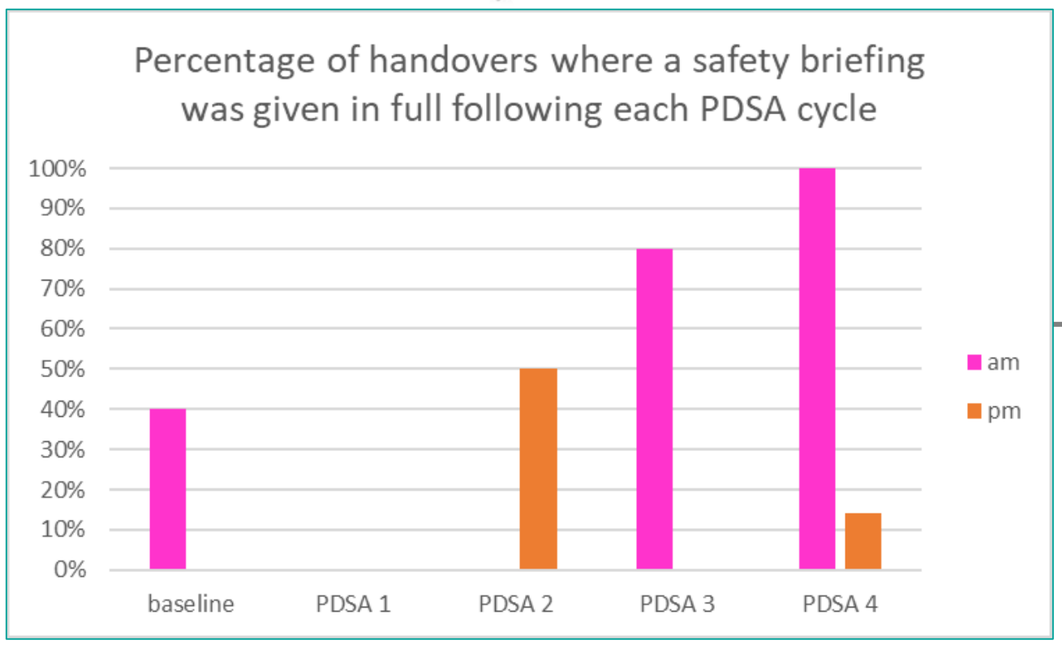
PDSA 2
The Poster



PDSA 3
Presenting our work

PDSA 4
Sharing our data





Reflections & Learning:

- We have achieved our aim at morning handovers.
- Feedback about the tool has been positive
- Use of the safety briefing in evening handovers remains poor.
- Our next steps are to explore the reasons for this.

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[1] World Health Organization. 10 Facts on patient safety. 2014 http://www.who.int/features/factfiles/patient_safety/en/. [2] General Medical Council National Training Survey 2018 https://www.gmc uk.org/education/how-we-quality-assure/national-training-surveys

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