If the authors were to repeat this quality improvement project, it would be useful to assess the implication of poor handover on infant care. For example missed/late blood samples or delayed discharge.

Message for others The message conveyed by this project is that every ward should have an effective handover and that with using simple measures dramatic differences can be made. This project identified a lack of effective handover on a postnatal ward which led to delayed or missed patient care. Using a handover tool designed following staff feedback, handover between staff members improved significantly and this positively impacted on patient care.

Effective handover helps ensure patients receive appropriate and timely care. Potentially serious results are not forgotten. Staff members improved significantly and this positively impacted on patient care.

Effect of changes It is hoped that there will be improved communication in the delivery unit resulting in better anticipation and safer care, fewer crash calls for middle grade paediatricians, higher levels of staff confidence and improved parent confidence in the staff caring for their baby.

Lessons learnt We hope to learn how to devise a safe means of communicating essential information between teams.

Measurement of improvement Analysis will be qualitative and will focus on staff satisfaction and suggested points for improvement. Parent satisfaction will be assessed via patient surveys. Quantitative assessment of delivery outcomes cannot be undertaken within this short timescale because the number of significant neonatal resuscitations is low.

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