Project aims

1. To evaluate the use of ISBAR₃ during clinical handover in a busy children's hospital
2. To increase awareness of the usage of ISBAR₃ as a tool of communication among physicians and healthcare professionals.
3. To promote use of a structured handover framework amongst medical students.

Methods This is a prospective study. A team of medical students attended the morning handover meeting over a period of five weeks, and collected data on the use of ISBAR₃. Points were allocated for each component of the framework that was addressed. All data was completely anonymised. The data was then compiled and analysed. We included all patients that were admitted through the Emergency Department; excluded from the dataset were all surgical patients, and patients transferred from other clinical centres.

Result A total of 39 admissions were handed over during the duration of the study. Of these, only one handover fulfilled all elements of the ISBAR₃ framework. Parameters were omitted in each of the 38 other cases. The three criteria fulfilled most frequently were: Name, Age and Presenting Complaint and scoring 97%, 89%, 97% respectively. The three most commonly omitted aspects were from the R₃ (RISK) of the ISBAR₃. This includes : Infection Control, Child Protection, Safety for Discharge, and Infection Control, scoring 10.2%, 7.7%, and 7.6%, respectively.

Conclusion It is clear that the ISBAR₃ tool is not being routinely utilised in handover meetings. The impact these findings have on patient care cannot be directly evaluated. Notably, 'Risk' the most commonly omitted parameter. Hence, we have identified an area of clinical practice with scope for improvement. We plan to re-audit this area, following dissemination of information, in order to complete the audit cycle.

P152

IMPLEMENTATION OF A BILIRUBIN MONITORING DOCUMENT IN THE NEONATAL ICU AND POSTNATAL WARD SETTING AT UNIVERSITY MATERNITY HOSPITAL LIMERICK

Kerrie Hennigan*, Rizwan Khan, Niazy Al-Assaf. *UMHL, Limerick, Ireland*

10.1136/archdischild-2019-epa.507

Introduction Transcutaneous (TcB) and serum bilirubin (SBR) levels are often monitored during the neonatal period in order to decide if a newborn requires phototherapy. Other details, however, are required to assess the infant's risk factors and threshold of treatment¹. Gestational age, ABO/Rh incompatibility and Direct Coombs test (DCT) are important amongst other risk factors¹ to guide our management.

Aim To improve clarity and safety when recording TcB and SBR results by creating a one-page document encompassing all necessary pieces of information.

Method Our trial bilirubin monitoring document consisted of 3 sections. The first section is a standard Phototherapy nomogram¹ followed by a section for details such as name, chart number, gestational age, date of birth, time of birth, DCT status and other risk factors. The third section consists of a table with columns for date, time of blood sample, age in hours, TcB, SBR, risk line, risk Zone² and plan. Moreover, we

included 8 rows for continual monitoring. Three months after implementation and education of this trial document, a survey was carried out amongst midwives and neonatal nurses in UMHL. Various questions were asked regarding the clarity and safety of the new document when compared with the old way of documenting. Feedback and comments were collected and analysed.

Results 24 individuals responded to the survey. Of these, 58% found the old way of documenting 'unclear' whereas 20% found it 'very unclear'. 21% found the new document 'clear' and the remaining 79% found it 'very clear'. 71% found the new document 'easy to use' and the remaining 29% found it 'very easy to use'. 33% found the new document to be 'safer' and the remaining 67% found it 'much safer' to use when compared with the old way of documenting. Suggestions received included creating a column for the doctor's signature next to the plan and also to include a line for the mother's blood group in the second section.

Discussion Prior to implementation of this new document, all of these details were scattered throughout the chart making it difficult for another doctor to ascertain the information when it comes to interpreting a new bilirubin result for a particular newborn. Survey response was in favour of using our new document, due to its clarity, ease of use, enhanced safety and continuity of care. We plan to consider adding the suggested changes and finalising this document as a quality improvement initiative.

P153

AN AUDIT OF ADHERENCE TO NATIONAL GUIDELINES ON COMMUNICATION DURING CLINICAL HANDOVER IN THE UNIVERSITY HOSPITAL OF LIMERICK (UHL)

Husnain Mahomed*, Peter O'Reilly, Siobhan Gallagher. *University Hospital Limerick, Limerick, Ireland*

10.1136/archdischild-2019-epa.508

Introduction Clinical handover is defined as 'the transfer of professional responsibility and accountability for someone all aspects of care for a patient, to another person or professional group on a temporary or permanent basis.' It has been identified as a high risk step in the patients hospital journey that can lead to delay in treatment and loss of trust and confidence amongst staff and patients.

Aims To assess the quality of clinical handover in UHL PD as recommended by the Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No. 11 HSE (2015).

Methods A standardised proforma was used to assess the quality of our handover for all medically admitted patients in UHL PD. The audit team chose 10 randomised weekdays to collect information looking at the five aspects: suitability, patient safety, patient confidentiality, standardised communication tool (ISBAR), record keeping. A re-audit will be carried out after an education session to staff.

Results Handover was prioritised over other jobs 0% of the time. Staff had accurate up to date information 20% of the time. Room was inappropriate for handover, too small, not private. Clinical protected time but not adhered to. Handover policy clear. Handover timely in 80% of cases. Handover face to face, no read back, no ISBAR, no safety pause. 8-14 interruptions (late attendance, non-urgent bleeps)