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

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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)

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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)

Conclusion Upon department discussion it was agreed to introduce a safety pause, read-back and an ISBAR system to optimise time, patient safety and communication. Punctual attendance was stressed, as was up to date information being assigned to the ward clerk in the morning.

P154 IMPROVING THE HAEMOGLOBINOPATHY SCREENING PROGRAMME FOR HIGH-RISK PATIENTS IN A TERTIARY MATERNITY HOSPITAL IN DUBLIN, A PILOT QUALITY IMPROVEMENT INITIATIVE

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Introduction A more coordinated haemoglobinopathy screening is desired across European countries¹. A non-funded pilot screening programme was implemented in six Irish maternity units in 2005². It aims to identify patients with haemoglobinopathies such as sickle cell disease and thalassemia, by screening patients from high-risk ethnic origins.

As screening involves identifying disease carriers, ensuring informed consent is vital. Since the introduction of an electronic healthcare record in the Rotunda hospital in November 2017, patients no longer sign consent forms before blood samples are taken. Attendance rates at haematology clinics are poor, it is proposed that this is due to lack of education about screening and lack of early contact with results².

Aim To ensure appropriate information sharing between laboratories.

To ensure parents are fully informed of the benefits of screening and that their consent to testing is recorded.

To ensure correspondence is sent to all families informing them of positive test results and arranging a follow up appointment with haematology.

To establish a successful pilot programme that can be expanded to all other maternity units.

Methods A cross-hospital working group was established. Following a literature review, the HSE Change Model was used as an organisational development model². An information leaflet, a consent form and a letter informing parents of abnormal results were developed. A standard Operating Procedure was agreed which outlines how screening will proceed uniformly across all hospitals.

Further Steps These improvement initiatives are being implemented in the Rotunda.

An organisational development approach is used to ensure that consent is obtained and positive test results are acted upon. Rates of attendance at haematology OPD will be reviewed following implementation of changes.

Following successful implementation, the initiative will be replicated in the other pilot hospitals and ultimately in all maternity hospitals in Ireland.

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P155 IMPROVING PATIENT SAFETY IN A TERTIARY CENTRE THROUGH THE INTRODUCTION OF A STANDARDISED ADMISSION DOCUMENT FOR PAEDIATRIC PATIENTS

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Background There was a lack of uniformity in the initial medical admission documentation for patients admitted under general paediatrics at the Royal Hospital for Children, Glasgow. There was no standardised medical admission document used for admitting patients. Thus significant variability was seen in terms of quality of initial medical admission documentation and crucial elements of the paediatric history were frequently omitted. A method of improving and standardising care through improving documentation was sought.

Objective To enhance patient safety through improved documentation of admissions under general paediatrics. A standardised admissions document was introduced with the aim of reducing medication omissions, improving medication reconciliation and standardising documentation, to include all crucial elements of the paediatric history in one document.

Methods A standardised admissions document was created and introduced using the Plan Do Study Act (PDSA) Cycle ¹. The document included all essential components of the paediatric history. Six essential criteria were identified for inclusion in the initial paediatric admission documentation. These included: Medication reconciliation, Social work involvement, Smoking in the household, Immunisation history, Birth History and Developmental History. The admission document was intended to be used by all junior paediatric and GP trainees in the clinical decisions unit for the admission of all patients under general paediatrics.

The notes of 40 patients pre-intervention and 40 patients post-intervention were reviewed. The notes were reviewed for documentation of the 6 essential criteria as defined above.

Results Significant improvements were seen across all domains after the introduction of the admission document. A marked improvement in medication documentation was noted post-Intervention. Complete documentation of medications rose from 45% pre-intervention, to 75% post intervention. Immunisation history documentation improved from 55% to 87.5%. Birth history documentation improved from 60% pre-intervention to 87.5% post intervention. The most significant improvements were observed in documentation of Social work involvement (15% pre-intervention to 82.5% post-intervention), Developmental history (22.5% pre-intervention to 95% post-intervention) and Household smoking history documentation (22.5% pre-intervention to 85% post-intervention).

Conclusion The introduction of a standardised admissions document is a simple tool by which to improve care and standardise documentation of all paediatric admissions. Having a specific admissions document is shown to improve patient safety by reducing medication omissions by implementing medication reconciliation in the admissions document. A standardised document allows for a focused paediatric history encompassing all essential domains to be obtained for every child on their initial admission to the department, thereby reducing omissions of important medical information.