PASSING THE BATON: MEDICAL ON CALL TEAM INCIDENT REPORTING AND THE NON-CONSULTANT HOSPITAL DOCTOR IN A GENERAL HOSPITAL

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Background Optimal clinical handover is necessary to improve clinical safety and reduce patient risk. Clinical handover in Our Lady’s Children’s Hospital Crumlin (OLCHC) occurs at the beginning and end of the on call shift. Clinical handover should be conducted face to face where possible, be conducted verbally using a standardised communication tool, and be supported with relevant, accurate and up-to-date documentation.

Aims To have a member of each subspecialty team attend evening handover to sign in attendance sheet. To handover patients using Identification Situation Background Assessment Recommendation (ISBAR) format.

Methods We collected data over a week-day period between 17/09/2018 until 28/09/2018 in OLCHC. This is a quality improvement project. Data was collected and documented from evening handovers. The following outcome measures were included; subspecialty attendance e.g. doctor from cardiology, respiratory, PICU etc sick patients handed over expected transfers handed over and whether ISBAR format had been used.

At the subsequent morning handover patient issues requiring medical review on call were recorded in order to identify patients who should have been highlighted to on call medical review on call. For each healthcare worker attending handover to sign in attendance sheet. To handover patients using Identification Situation Background Assessment Recommendation (ISBAR) format.

Results Over the ten days attendance was recorded at the morning and evening clinical handover. The number of subspecialty teams attending each evening handover is represented here.

<table>
<thead>
<tr>
<th>(Day)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Number of teams)</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

ISBAR format was used 56% of the time by the subspecialty team.

Several clinical risks represented above were not handed over to medical team on call:
• 1st night an unwell patient with cystic fibrosis
• 2nd night an infant with trisomy 21 and a serious congenital anomaly was admitted from a hospital transfer
• 6th night a patient was discharged from PICU
• 7th night two emergency cardiac transfers
• 10th night a seriously unwell patient on dialysis

Discussion There was incomplete attendance of subspecialties at clinical handover. ISBAR was frequently not used. There is scope for improvement in attendance and handover of subspecialty patients. In an attempt to make improvements to clinical handover we have begun to send a text message reminding all non-consultant hospital doctors to attend clinical handover and handover patients. We are in the process of collecting data to assess for improvement.