Quality Improvement in Core Medical Training

Learning to Make a Difference to Handover

Dr Ruth Cordiner
Chief Resident, Glasgow Royal Infirmary 2016-2018

Dr Louise McKenna
Core Medical Trainee

Dr Kirsty Crowe
Core Medical Trainee

Dr Mark White
Core Medical Trainee

Dr Daniel Lynagh
Core Medical Trainee

Topics

The Chief Resident Role in Glasgow Royal Infirmary

Why QI?
Development of a Quality Improvement Forum

Quality Improvement &

Learning to Make a Difference Model

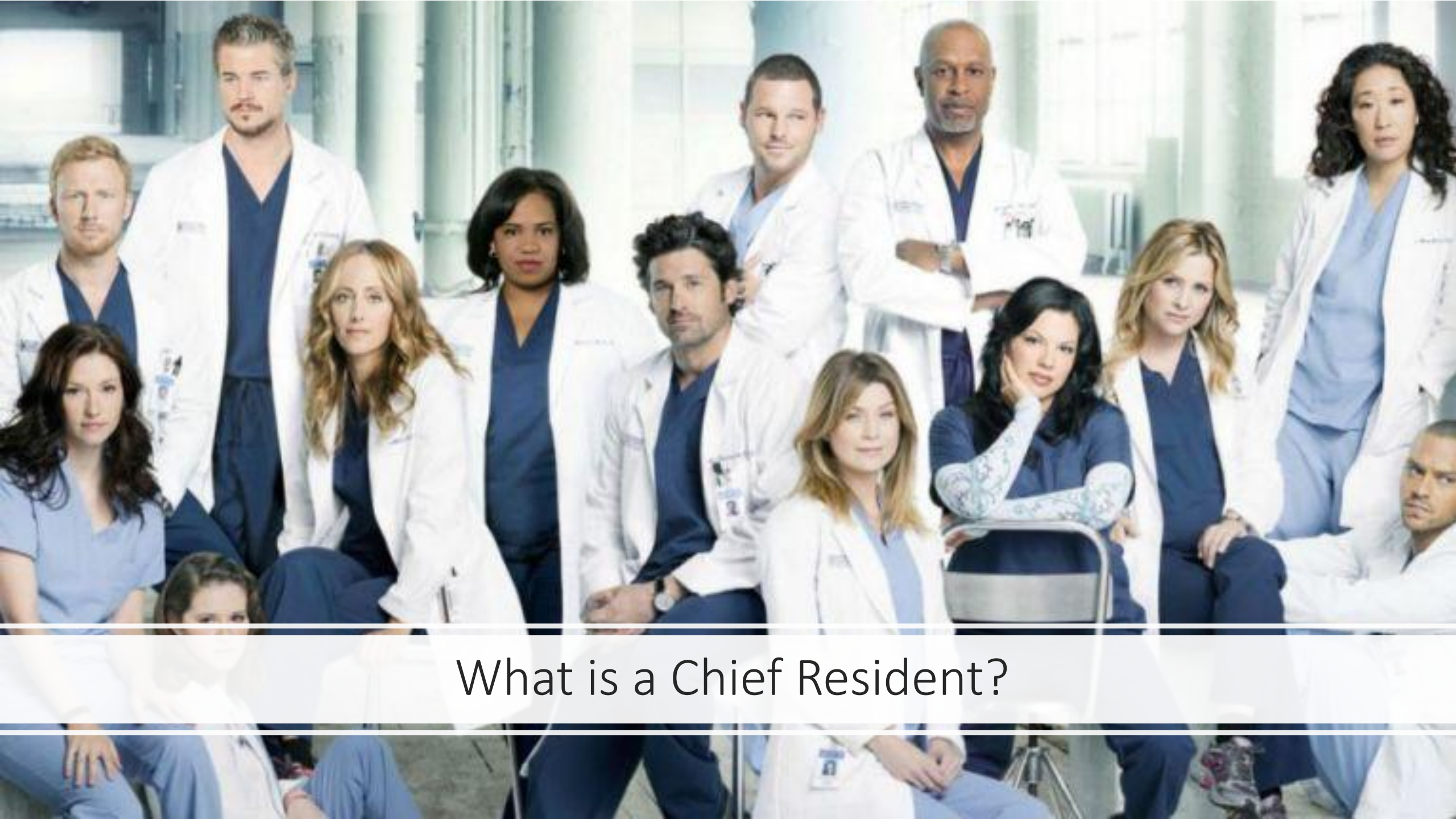
Real Life Quality Improvement in GRI
Bringing Change to Hospital Handover

Discussion Forum

The Chief Resident Role

Dr Ruth Cordiner

Chief Resident Glasgow Royal Infirmary
&
Specialty Registrar Diabetes and Endocrinology



What is a Chief Resident?

The US Model

- USA has utilised residency programmes for >100 years
- Nominated by other residents
- Multiple roles
  - Rota
  - Teaching
  - Educational Programme
  - Management Meetings
  - Advocate for doctors
  - Connection to senior doctors

The UK Model

- Developed by The Royal College of Physicians following a highlight in the Future Hospital Commission Report
- ***"Senior doctors in training working to build a stronger leadership, management and quality improvement skills"***
- Development of "The Clinical Leader"
  - Support aspiring clinical leaders to skills for future consultant post
  - Raise the profile to develop future senior leaders: medical directors, chief executives
- First pilot schemes seen in the UK from 2016

Results from UK Initial Pilot

Positive overall influence

Significant contribution to service improvement, education provision and junior doctor engagement

Implementation of locally tailored activities

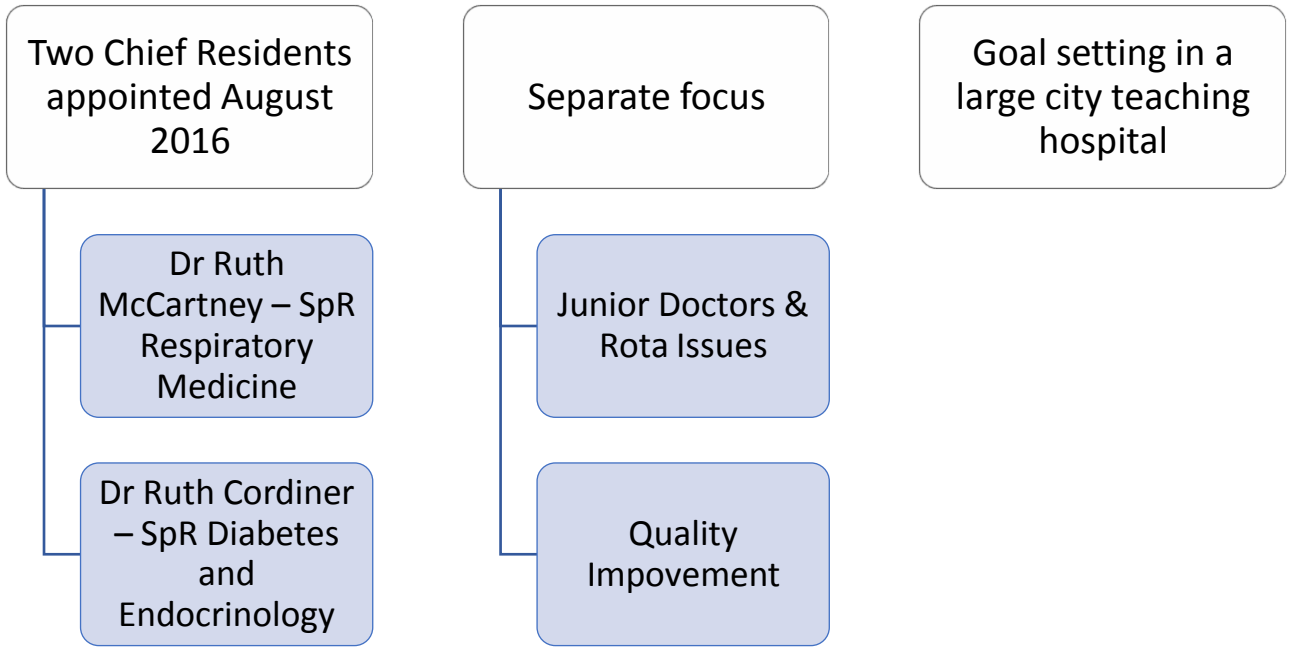
Personal leadership development

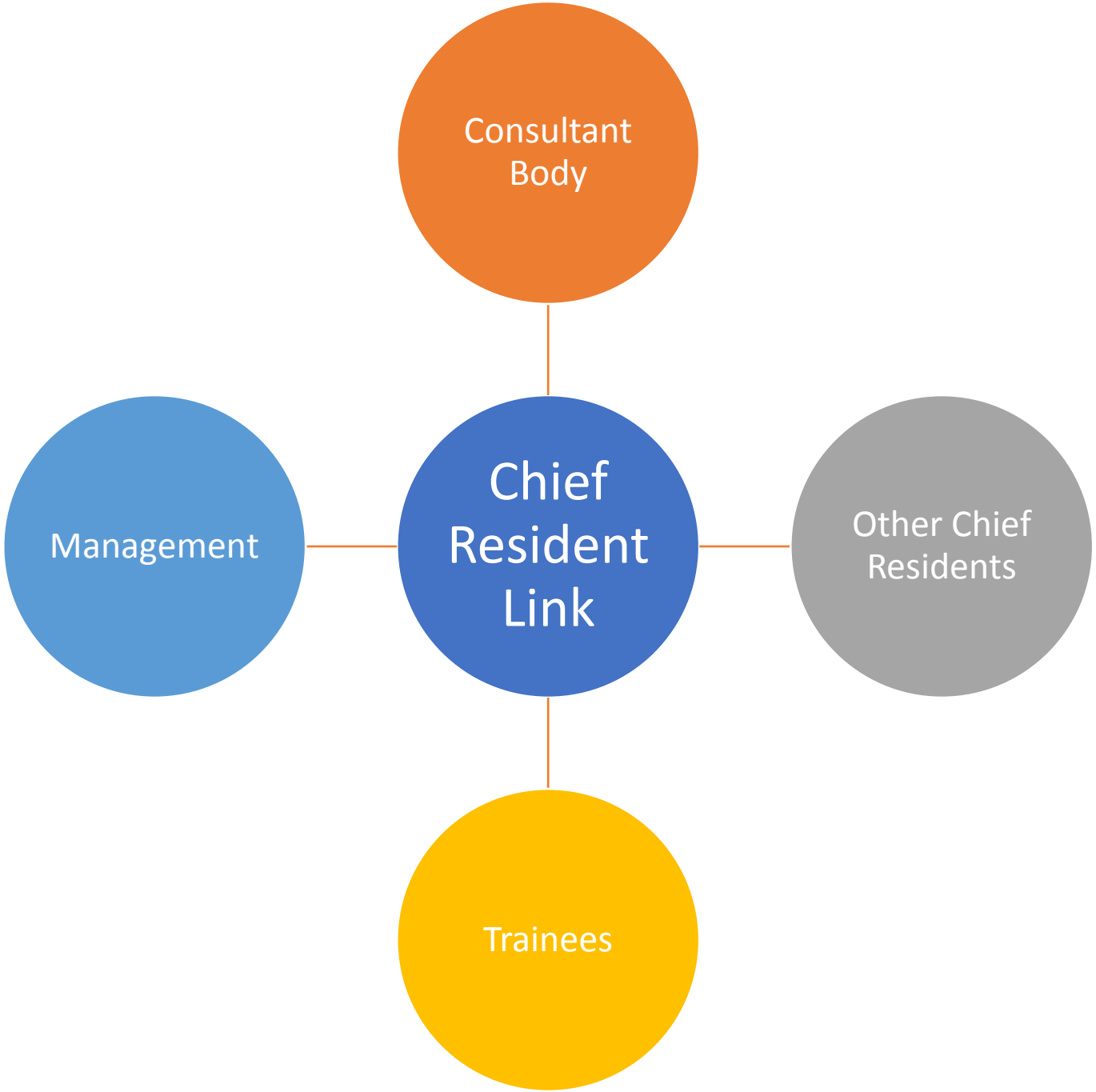
Direct exposure to senior management

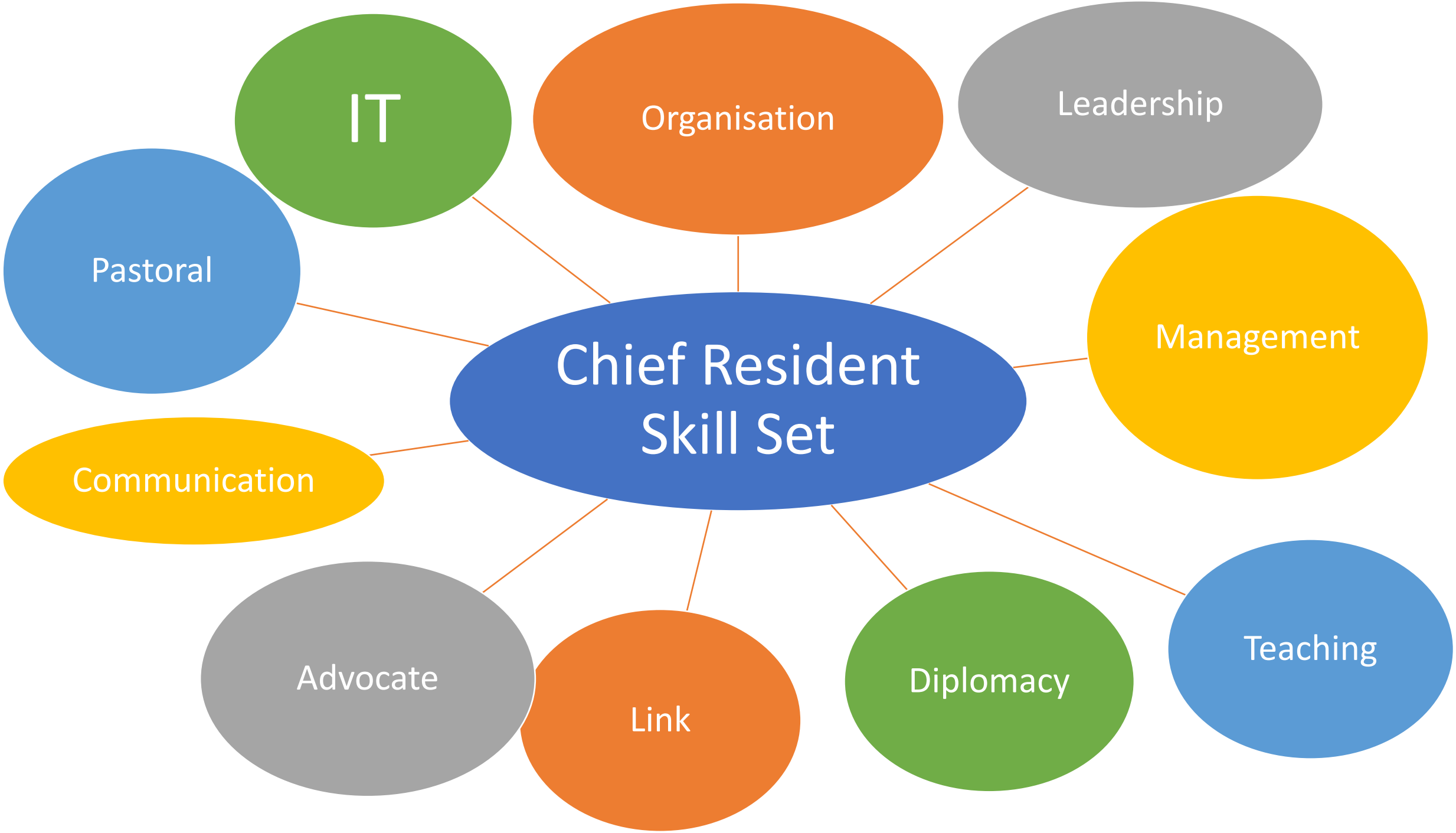
Enhanced medical engagement – “bridging role”

Development of a QI culture

The Chief Resident in GRI




Consultant Body
Management
Chief Resident Link
Other Chief Residents
Trainees


IT
Organisation
Leadership
Pastoral
Chief Resident Skill Set
Management
Communication
Advocate
Link
Diplomacy
Teaching


Buddy System
Mini M&M
Practical Sessions
QI Forum
Management Role
Festive Rota
Junior Doctor's Committee
Liaison with Clinical Director
Liaison with Specialty CR
Consultant Meetings
Doctor's Mess
Chief Resident

Learn to not take things personally

Understanding all aspects of an issue

Identifying goals

Liaise with other CR – past and present

Prioritise your areas of need

Understand and stick to your job description

You cannot always please everyone

Pick your battles

You cant' do everything

Learn to delegate

"Advice from Chief Residents"

Barriers in Implementation

- Split-site working
- Established University Teaching Program
- Training program commitments
- Junior doctor’s rotas
- Protection of the role
- Spare time!
- Boosting morale & generating volunteers

GRI Quality Improvement Forum

Curriculum requirement from Foundation Training

Implement Change on a Bigger Scale

Teamwork Towards Goals

Core Medical Trainees

- Personal experience in QI role
- Working towards achievement of CMT competencies
- Preparation for Senior Registrar role
- Support from Training Program Director, QI Leads
- Link with multiple doctor tiers to identify and implement areas of change
- Important role in medical receiving department
- Rotations within GRI for 1 year

Create a supportive culture for change in GRI

Setting-Up a Quality Improvement Forum

Identify Time

- Difficult!
- Meetings Friday 4PM
- Initial meeting combined with CMT TPD meeting August 2017

Meeting Space

Invites to Forum

Supportive Consultant Colleagues

- Dr Brian Neilly – Clinical Director for Medicine
- Dr James Boyle – CMT TPD North Sector
- Dr Malcolm Daniel – Health Foundation Quality Improvement Fellow
- Dr Brian Choo-Kang – eHealth Lead
- Medical Specialty Department Leads

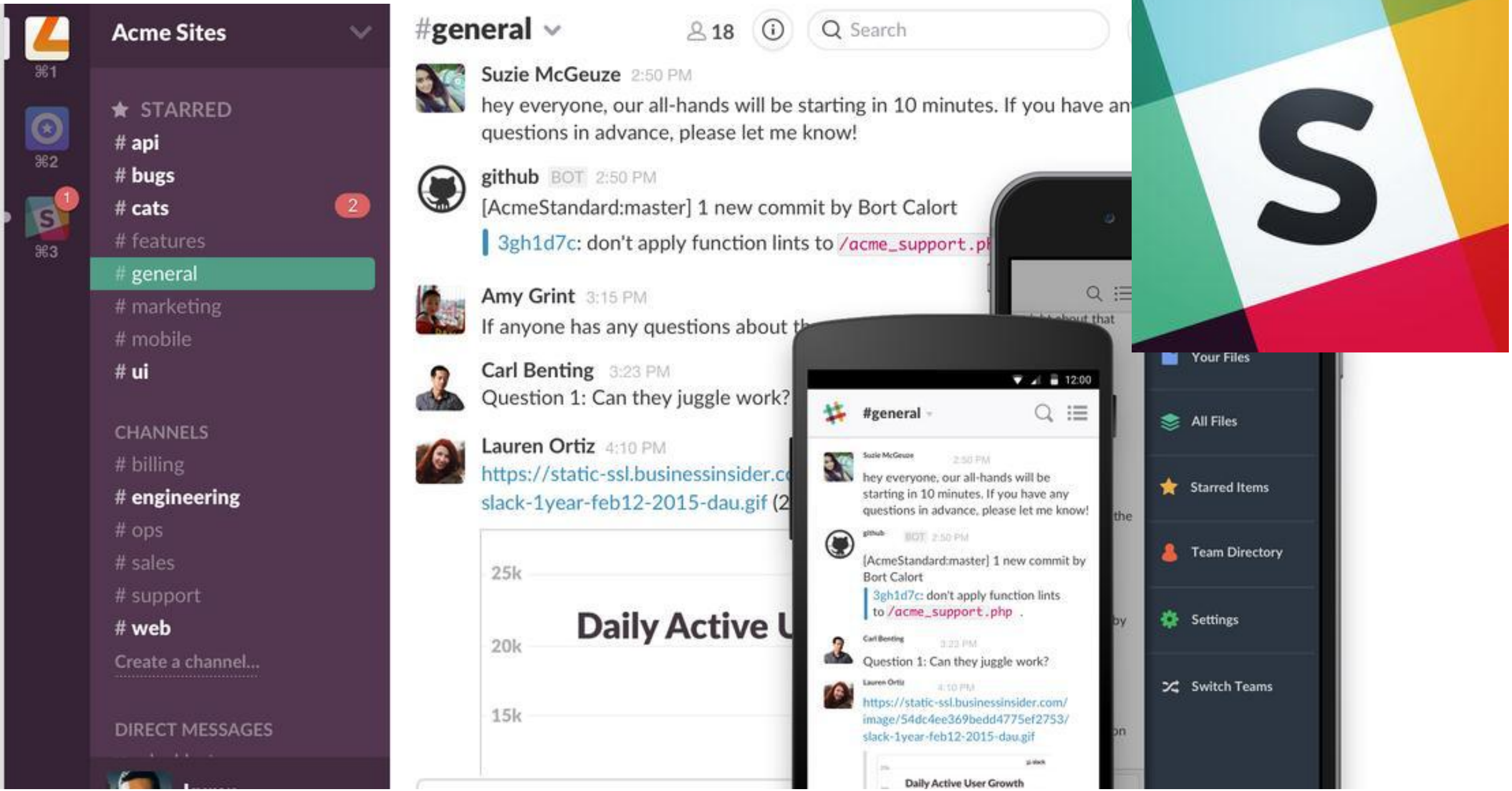
Setting Up a Quality Improvement Forum

Communication

- Email
- Slack-App
- Word-of-Mouth
- Consultant Specialty Meetings

Slack-App

- Communication “app”
- Allows group forum and subdivision into teams for tasks
- File sharing
- Goal setting
- Variable experience


Acme Sites
⌘1
⌘2
⌘3
STARRED
api
bugs
cats
2
features
general
marketing
mobile
ui
CHANNELS
billing
engineering
ops
sales
support
web
Create a channel...
DIRECT MESSAGES
#general
18
Search
Suzie McGeuze 2:50 PM
hey everyone, our all-hands will be starting in 10 minutes. If you have an
questions in advance, please let me know!
github BOT 2:50 PM
[AcmeStandard:master] 1 new commit by Bort Calort
3gh1d7c: don't apply function lints to /acme_support.ph
Amy Grint 3:15 PM
If anyone has any questions about th
Carl Benting 3:23 PM
Question 1: Can they juggle work?
Lauren Ortiz 4:10 PM
https://static-ssl.businessinsider.c
slack-1year-feb12-2015-dau.gif (2
25k
20k
15k
Daily Active U
12:00
#general
hey everyone, our all-hands will be starting in 10 minutes. If you have any questions in advance, please let me know!
[AcmeStandard:master] 1 new commit by Bort Calort
3gh1d7c: don't apply function lints to /acme_support.php .
Question 1: Can they juggle work?
https://static-ssl.businessinsider.com/image/54dc4ee369bedd4775ef2753/slack-1year-feb12-2015-dau.gif
Daily Active User Growth
Your Files
All Files
Starred Items
Team Directory
Settings
Switch Teams

Identifying Areas for Change

- Areas identified from Junior Doctor's Issues
- Regional Clinical Governance
- Patient Safety Issues
- National Training Survey
- GMC Visit
- Deanery Visit

Challenges in Forum Setup

- Time!
- Amalgamating with other QI projects
- On-call rotas
- Maintaining continuity
- Maintaining momentum
- Implementing change
- Challenges from individual group projects
- Group access to area of change

Dr Daniel Lynagh,
Core Medical Trainee 2

Quality Improvement & Learning to Make a Difference Model

What is LTMD?

- Royal College of Physicians/JRCPTB initiative

- Aim:
  - *“to support the learning and development of new and relevant skills in quality improvement methodology by trainees to enable them to deliver effective QI projects at the frontline”*

- Provision of resources, packs and training to support trainees in carrying out effective quality improvement

Audit


The audit cycle
Identify the audit topic
Set the standard
Design the method
Collect the data
Analyse the data
Was the standard met?
Implement change

Barriers to effective audit

- Purpose
- Perception
- Time
- Organisational inertia
- Lack of support
- Cultural factors

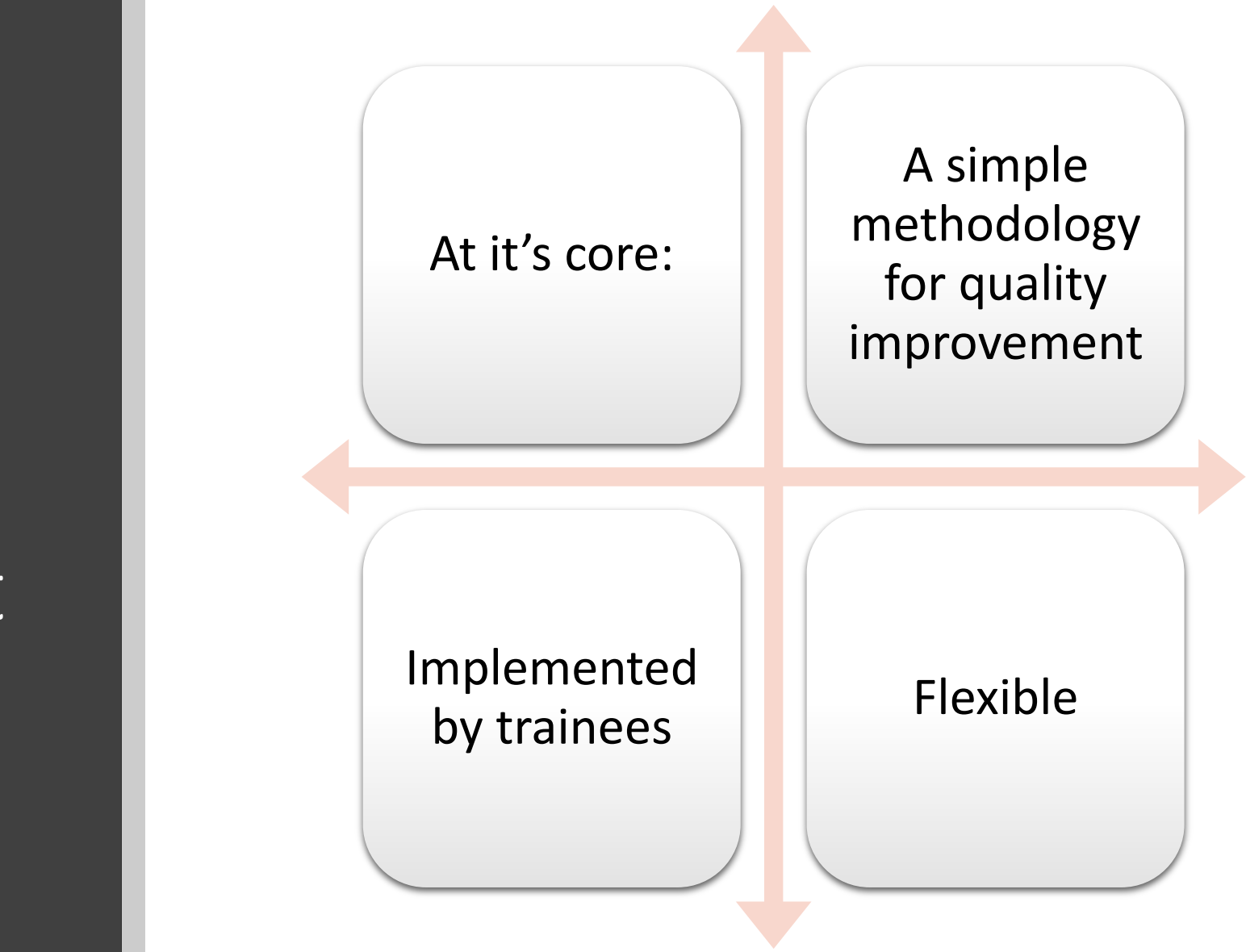
Quality Improvement

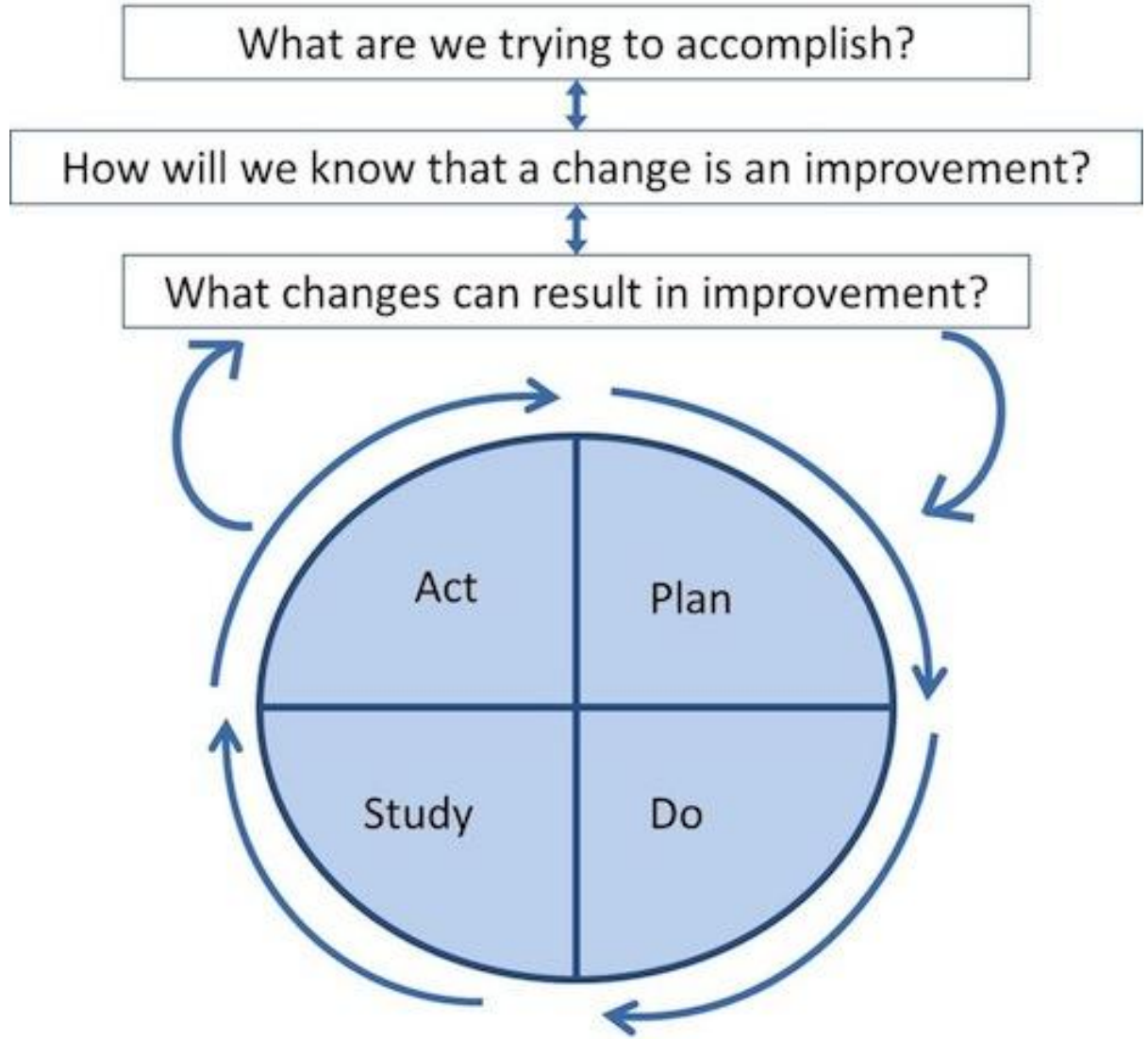
- Definition from "*Learning to Make a Difference*"
  - *"better patient experience and outcomes achieved through changing provider behaviour and organisation through using a systematic change method and strategies*"

So, What's Different?

- Data as a resource
- Focus on small changes
- Dynamic
- Engagement
- Visible results

The Model For Improvement




What are we trying to accomplish?
How will we know that a change is an improvement?
What changes can result in improvement?
Act
Plan
Study
Do

The Model For Improvement

- Three core questions

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in an improvement?

The Model For Improvement

- Three core questions

- What are we trying to accomplish?
  - SMART goals
  - Specific Measurable Attainable Relevant Timely

- How will we know that a change is an improvement?

- What changes can we make that will result in an improvement?

The Model For Improvement

- Three core questions

- What are we trying to accomplish?
- How will we know that a change is an improvement?
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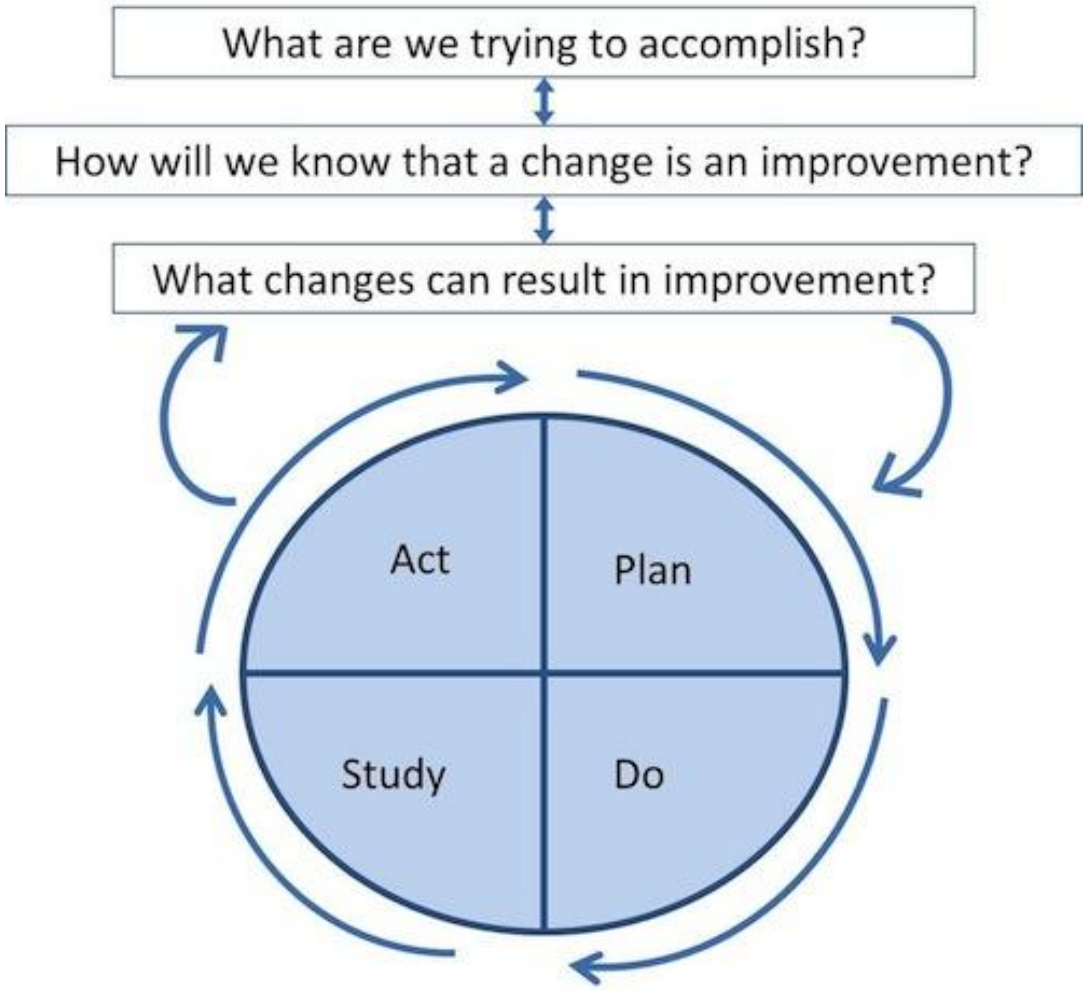


Plan, Do, Study, Act

- Plan
  - Largely covered by the three questions!
- Do
  - Make your changes
  - Record findings in a run chart
  - Document problems/unexpected findings
- Study
  - Comparing outcomes to predictions
  - What have we learned?
- Act
  - Plan for the next intervention/cycle
  - Refine changes until ready for wider implementation

Learning to make a difference

- Developing knowledge and skills
- Empowers junior doctors to effect real change
- Improve care and outcomes
- Realistic time scale
- Clinical leadership and team work
- Lifelong learning
- Transferrable skills
- Job satisfaction

Improving handover in Medical Receiving

Dr Kirsty Crowe (CMT2)

Dr Daniel Lynagh (CMT2)

Dr Louise McKenna (CMT2)

Overview

Strengths of a CMT-led Quality Improvement project

The Problem

Our proposed solutions

QI – practicalities (and realities)

Benefits of the CMT QI Forum

Mobilisation of trainees

Group of trainees with similar goals

Motivation to keep going

Access to senior support

The Problem.

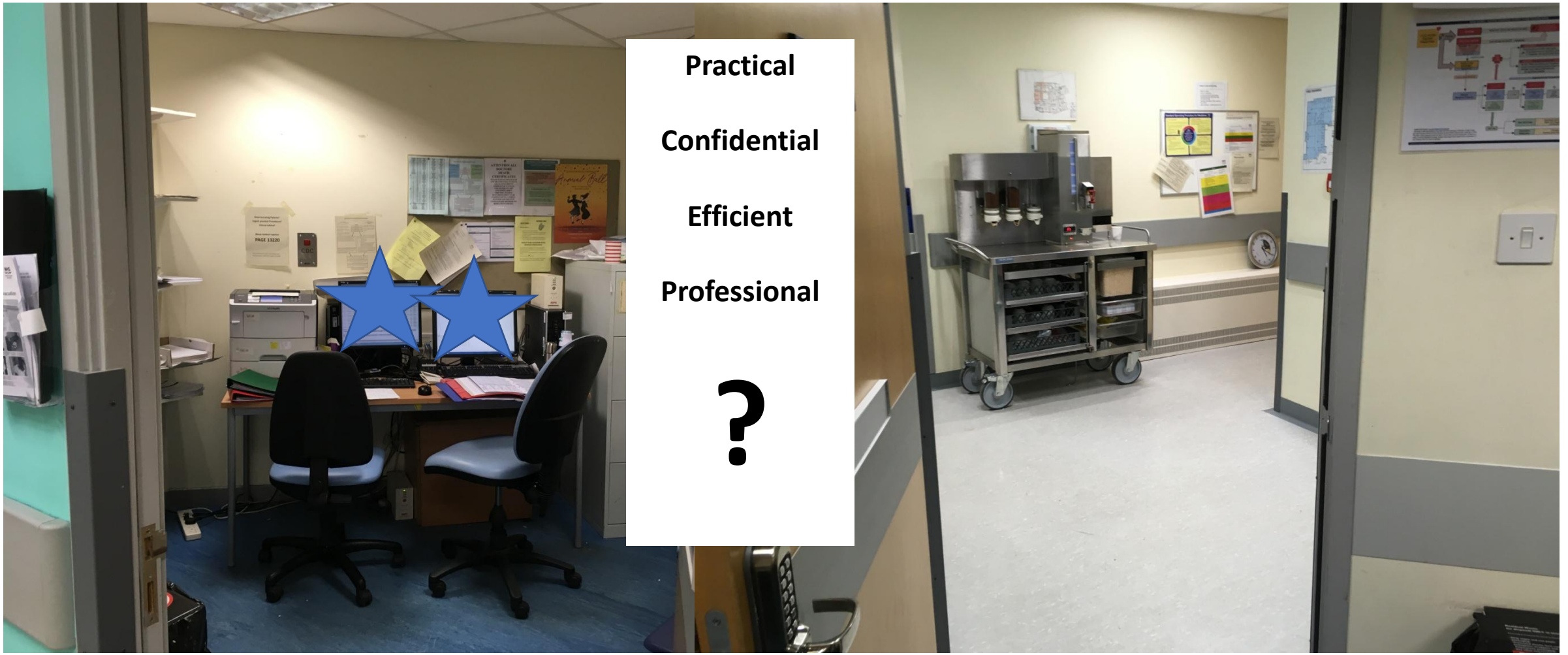
NHS Education for Scotland

Scottish Training Survey 2017:
NHS Greater Glasgow and Clyde

Green	Performing well for this indicator
Lime	Performing above average for this indicator
White	Performing is about average for this indicator
Pink	Performing below average for this indicator
Red	Performing poorly in this indicator
Grey	N<5
▲	Significant improvement in mean score since previous year
▼	Significant deterioration in mean score since previous year
–	No significant change in mean score

Post Specialty	Site	Response Count	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	Benchmark
Academic	Queen Elizabeth University Hospital	1								other
Academic	*Queen Elizabeth University Hospital*	*2*								*other*
Academic	University of Glasgow	1								other
Academic	*University of Glasgow*	*1*								*other*
Acute Internal Medicine	Glasgow Royal Infirmary	6								Core - Medical
Acute Internal Medicine	Glasgow Royal Infirmary	6								Foundation - Medical
Acute Internal Medicine	Glasgow Royal Infirmary	4								Higher - Medical
Acute Internal Medicine	*Glasgow Royal Infirmary*	*15*	–	–	–	–	–	▼	–	*Higher - Medical*
Acute Internal Medicine	Inverclyde Royal Hospital	9								Foundation - Medical
Acute Internal Medicine	Queen Elizabeth University Hospital	11	–	–	–	–	–	–	–	Core - Medical
Acute Internal Medicine	Queen Elizabeth University Hospital	6	▼	–	–	–	–	–	–	Foundation - Medical

13 doctors. One room/corridor…



The Solution(s)

- CMTs natural leader for change
- Trainee opinions gathered from questionnaires
- Interventions
  - Location change
  - Formalise CMT leadership
  - Standardised proforma

Selection of questionnaire feedback

Did you receive handover induction before working in AAU?

	Number	Percentage
Yes	4	15.4%
No	22	84.6%

"There was no induction at all."

Do you feel the current handover location is adequate?

	Number	Percentage
Yes	18	69.2%
No	8	30.8%

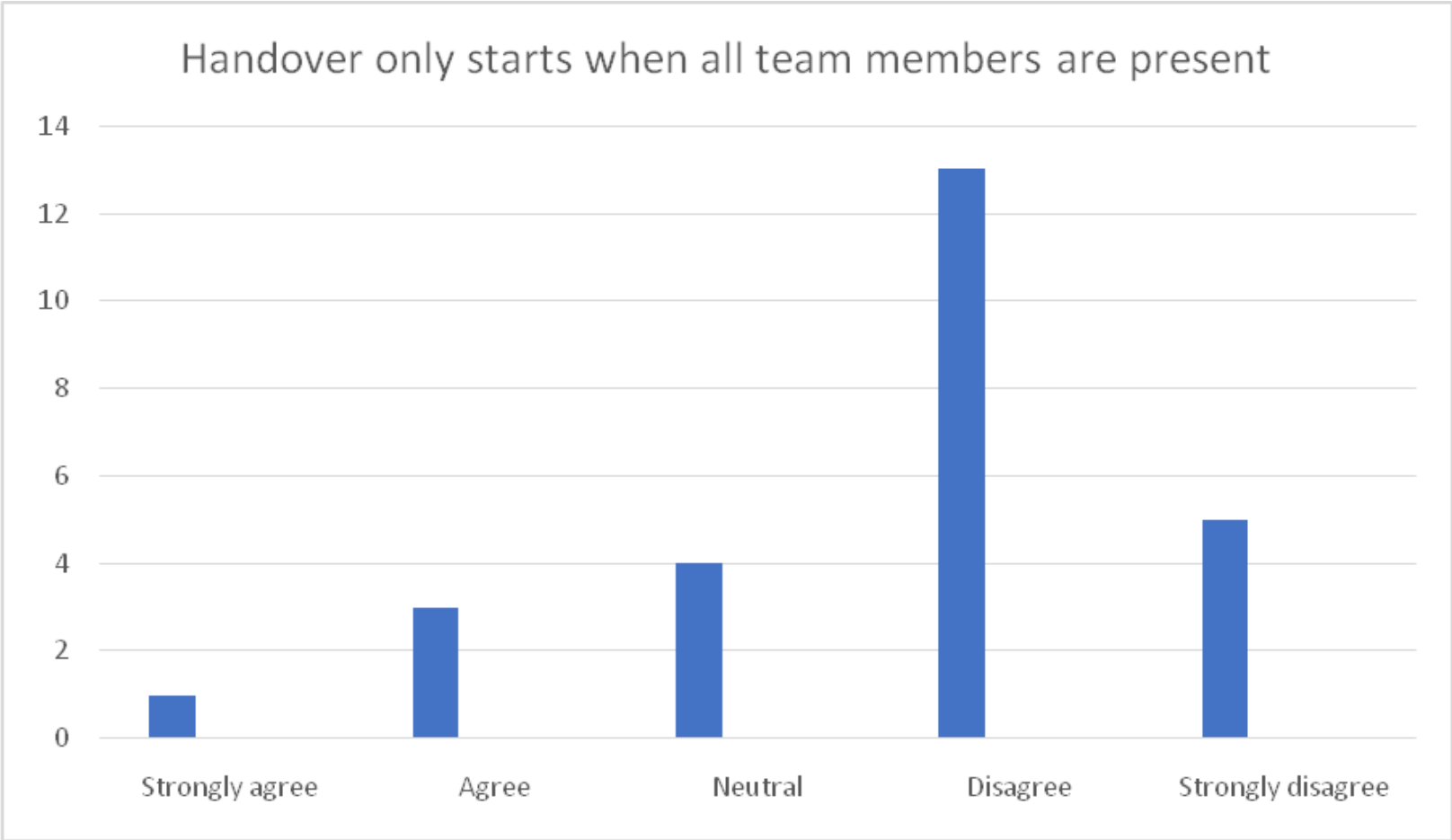
Is time allocated to handover adequate?

	Number	Percentage
Yes	21	80.8%
No	5	19.2%

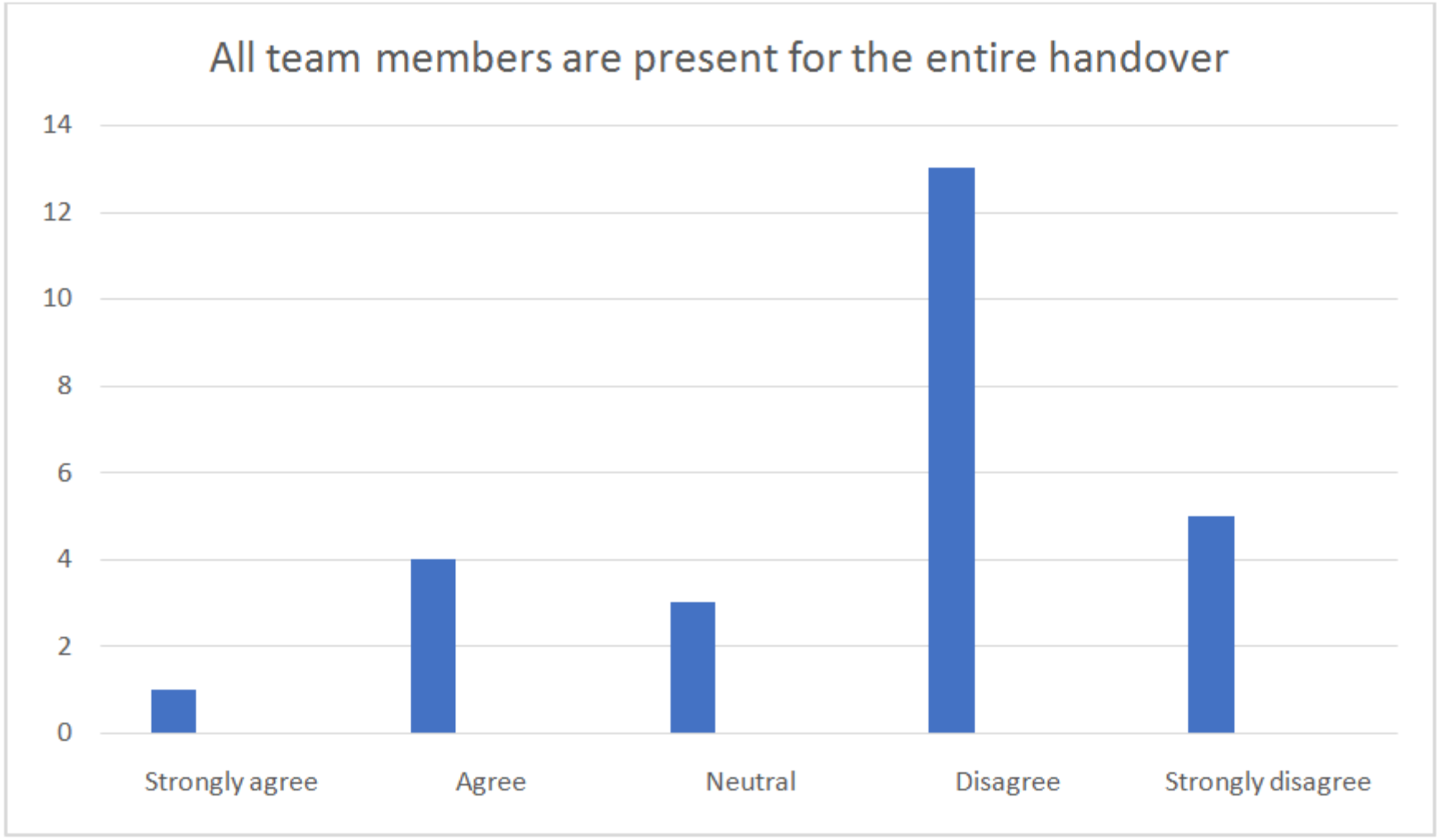
"When handover is more formal as it should be it requires more time (~30mins)"

"Handover time to be accounted for the rota shift times so that there is sufficient overlap between the day and night team for effective handover to take place."

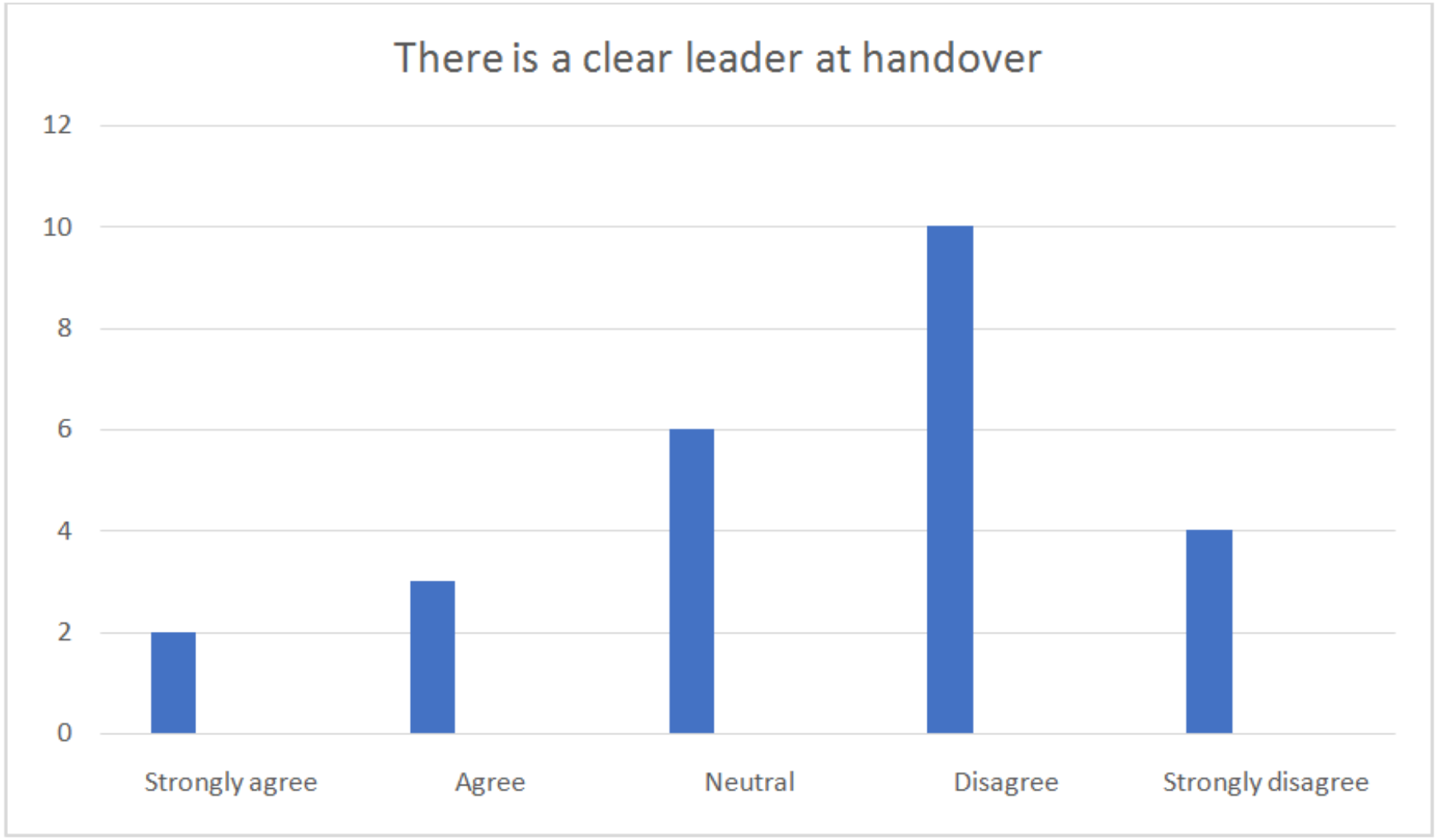
"Handover period might need to be longer for this to work."



“Sometimes inexperienced team members try to begin handover before all team members are present. I had to stop a day team FY2 handing over to the night FY1 because the night FY2 had not yet arrived (the day FY2 just wanted to go home).”



- “Feel shouldn’t have to stay for whole handover as just worked a 12 hour shift and different people everyday anyway”



“The quality of handover seems to be dictated by the fact that the day time/night team want to get home and a lack of senior supervision leads to poor quality handovers of sick patients, patients not being handed over, and often no handover at all of patients still to be seen. ”

Trainee feedback

"Not sure if handover needed to move to tearoom- I think room handovers were in was fine."

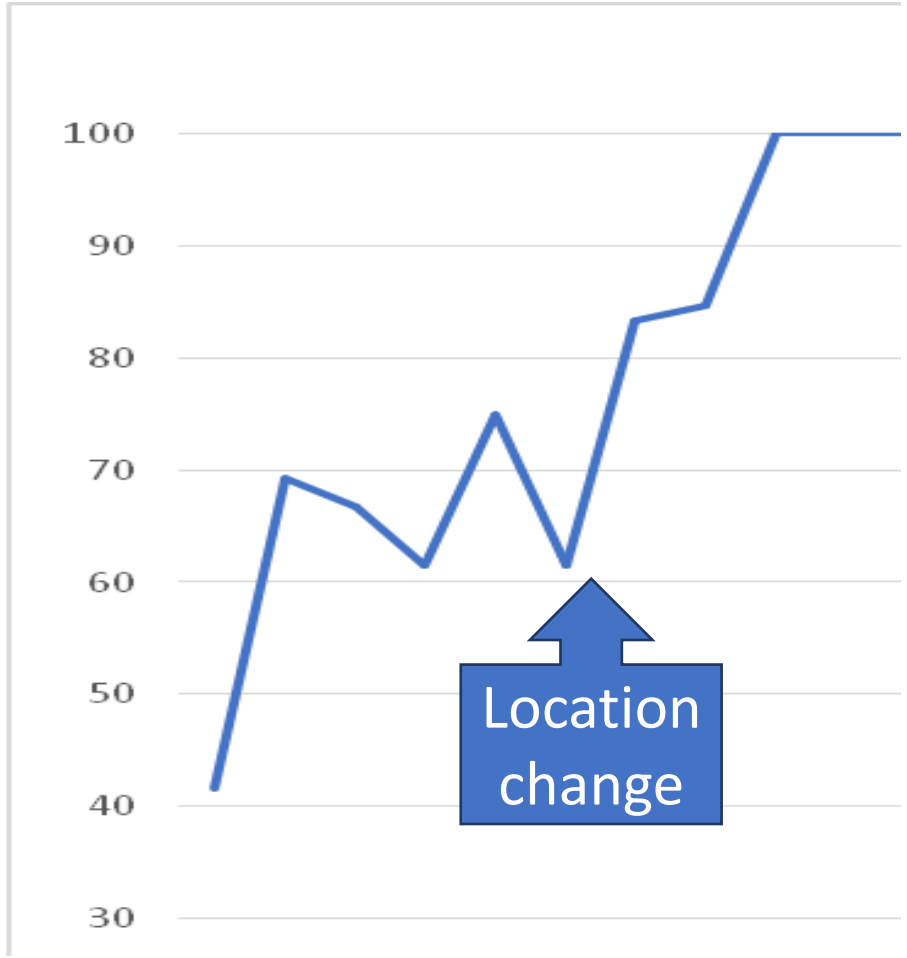
"Better now the venue the tea room."

"Prefer the tea room."

"Tea room much better than cramped doctors room on 50."

"Big improvement to the old room."

Handover Attendance Post-Intervention (%)



Intervention 2 – proforma with CMT leader

GRI HANDOVER PROTOCOL

QUALITY IMPROVEMENT

Based on RCP handover recommendations

Note – The most senior doctor present should be leading the AMU handover

1 – INTRODUCTIONS / ABSENCES ☐

- Are all team members present?
- Ensure everyone knows their role for the shift ahead.
- Ensure rota co-ordinators notified of unexpected absences

2 – WARD HANDOVERS (one at a time)

- DOME ☐
- CARDIOLOGY ☐
- RESPIRATORY ☐
- GENERAL MEDICINE ☐
- GASTROENTEROLGY ☐

For each handover

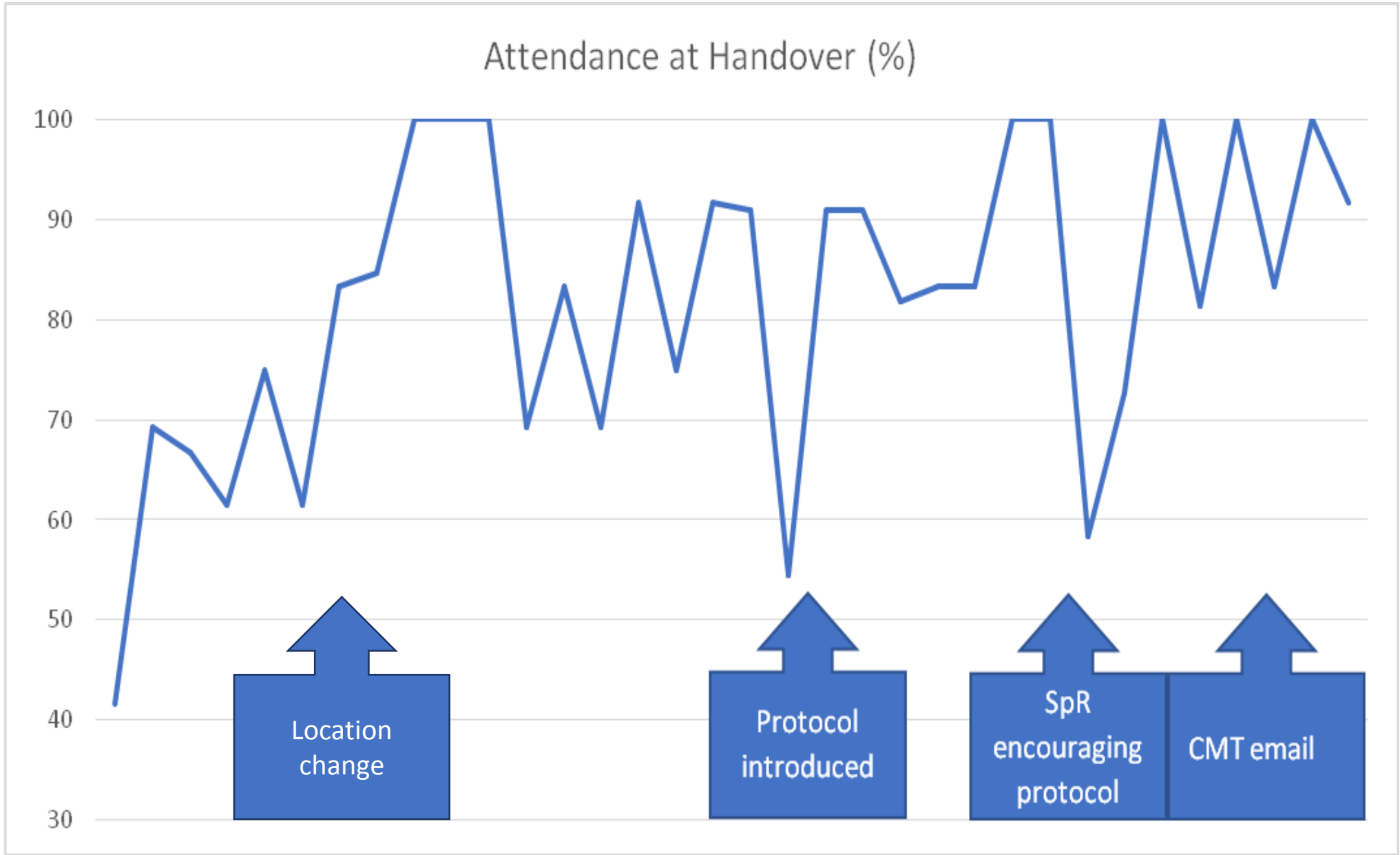
- Sick patients / "to be aware of"
- Outstanding tasks
- Patients to be seen
- Patients requiring senior review

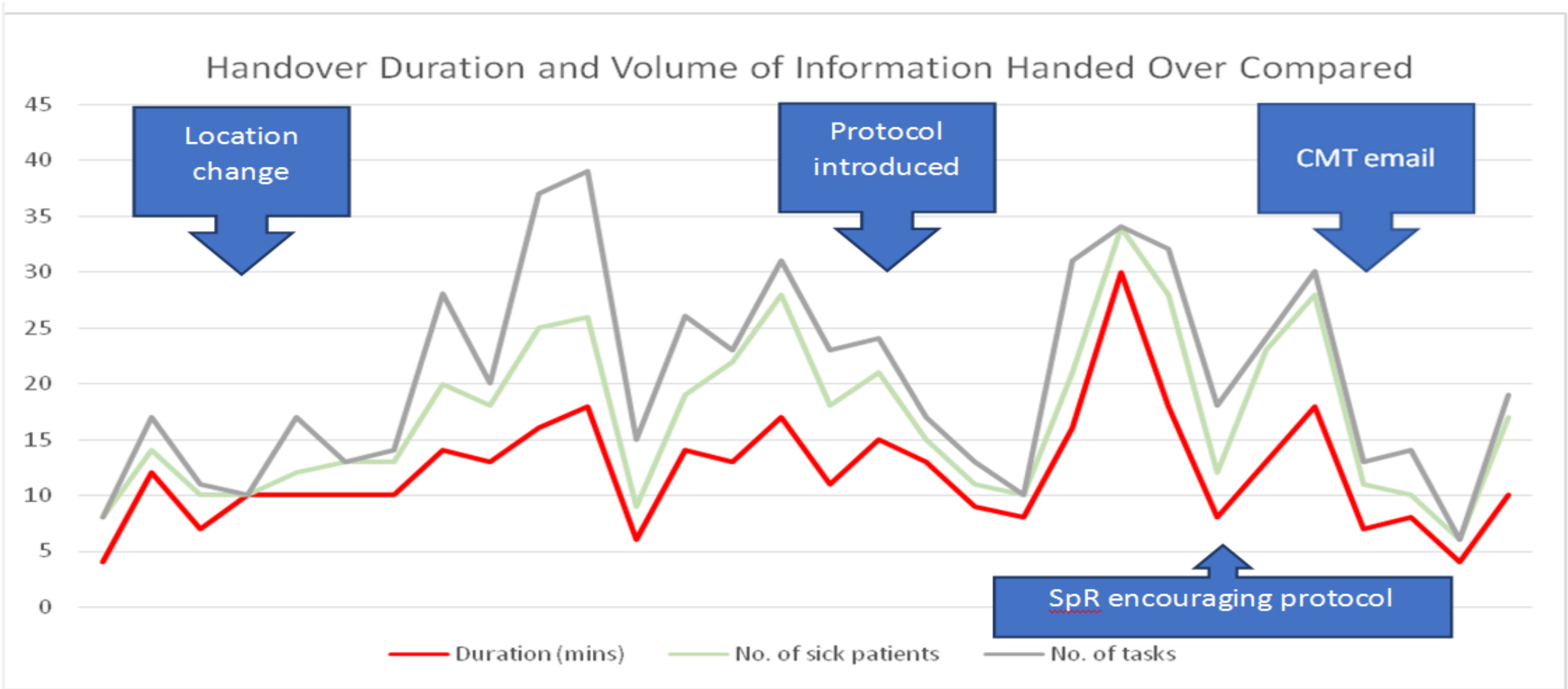
Ensure handing over patient NAME, CHI, and TREATMENT ESCALATION PLAN where possible

4 – DEATHS / EXPECTED DEATHS ☐

- Handover details of outstanding death certificates from previous shift, if any.

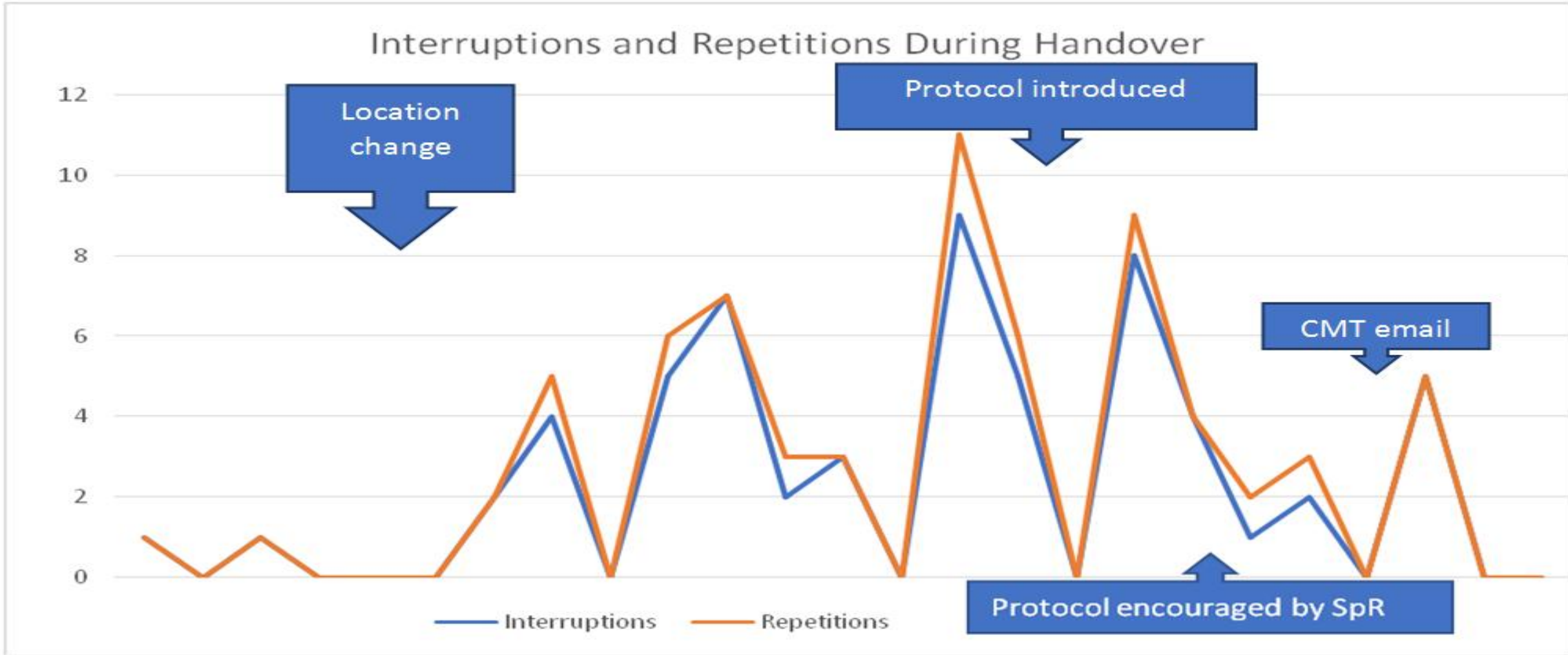
5 - MAJOR INCIDENTS / CONCERNS FROM PREVIOUS SHIFT ☐


Attendance at Handover (%)
100
90
80
70
60
50
40
30
Location change
Protocol introduced
SpR encouraging protocol
CMT email


Handover Duration and Volume of Information Handed Over Compared
45
40
35
30
25
20
15
10
5
0
Location change
Protocol introduced
CMT email
SpR encouraging protocol
Duration (mins)
No. of sick patients
No. of tasks

QI Practicalities (& Realities)

- Differing trainee opinions
- Peer apathy
- Assertive leadership
- Service provision pressures
- Communication issues
- Rota gaps/shift patterns
- Shop floor senior support
- Measuring handover quality


Interruptions and Repetitions During Handover
12
10
8
6
4
2
0
Location change
Protocol introduced
CMT email
Protocol encouraged by SpR
Interruptions
Repetitions

“The single biggest problem with communication is the illusion that it has taken place” – George Bernard Shaw

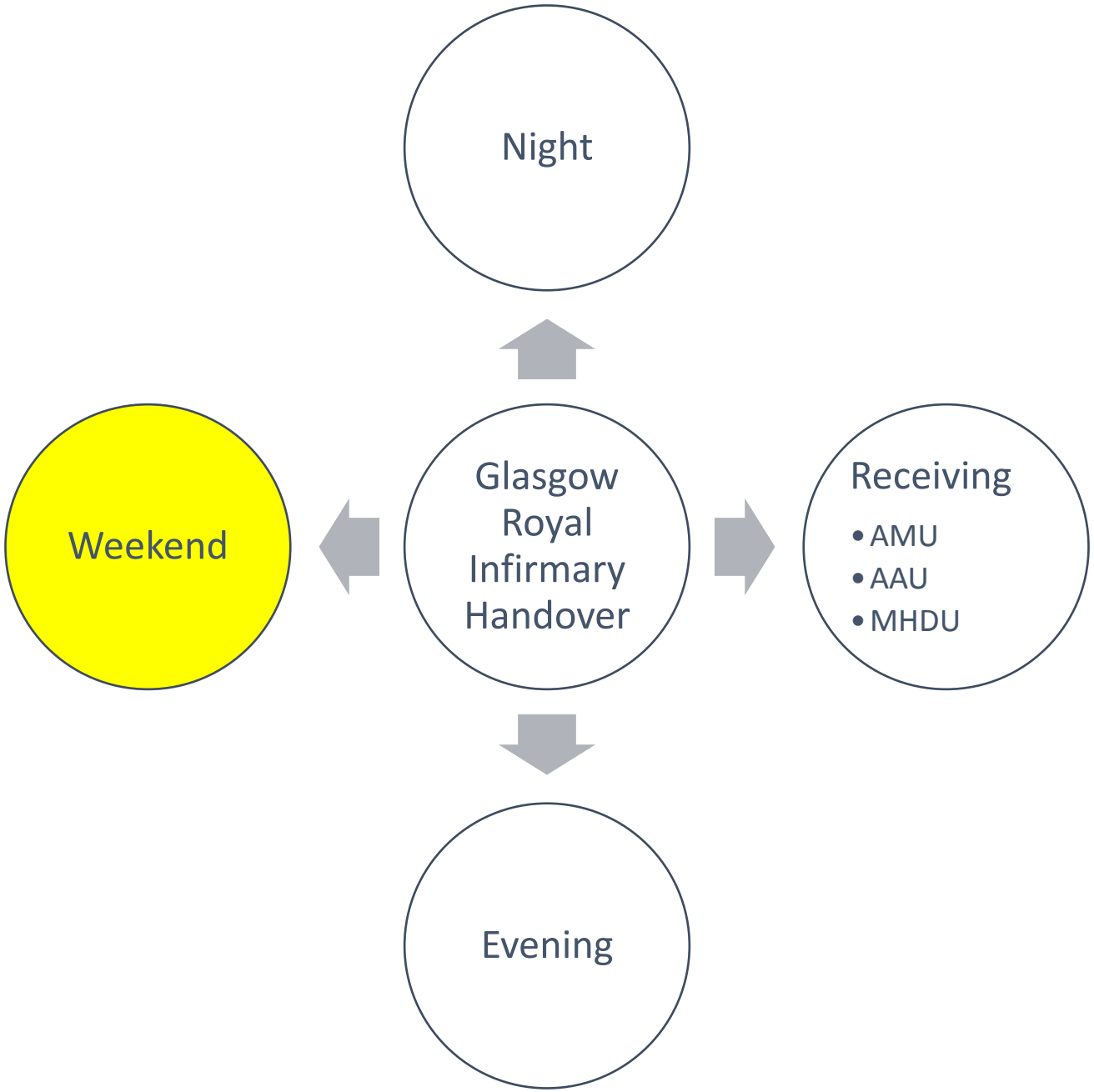
Mark White
and GRI QI team

Improving weekend handover

Handover

"Handover of care is one of the most perilous procedures in medicine, and when carried out improperly can be a major contributory factor to subsequent error and harm to patients."

Safe handover: safe patients' BMA


Night
Weekend
Glasgow Royal Infirmary Handover
Receiving
• AMU
• AAU
• MHDU
Evening

Weekend Handover

- Different team at the weekend

- May never have met patient
- May never worked in ward (or hospital)

- Key area of risk
- Unique handover needs

Weekend at Glasgow Royal Infirmary

“Downstream” wards
Junior doctor based with team led by ST3+
Total 6 junior doctors covering 18 wards*
FY2/CMT/GPST

Weekend at Glasgow Royal Infirmary

- Each ward had own method

- Written/typed

- Variable in content
- Variable in quality
- Variable in legibility
- Variable in location

Weekend handover

Bed 1	elective admission		Please see before going home.
Bed 6	ExCOPD	– Still needing O_2 ↑ CRP FRI ON oral ABIOS / NEBS / PRED ↑ O_2 Requirements.	Please escalate ABIOS if worse.
Bed 10	Alcohol withdrawal	– Still needing Diazepam.	Please check if improving.

Likely new pts on beds 4, 8, 12

		S	B	A	R
Bed 5	NAME	Alcohol withdrawal	Previous abstinence	well on Friday but family suport on sat	H sat, doesn't really need review as a planned D/C but nurses may want him to be seen before going home
Bed 17	NAME	1) Alcohol withdrawal with DTs, 2) Fall with facial injuries including clinically fractured nose 3) probable soft tissue infection	alcohol excess	Improving on Friday but perhaps over sedated	reduce diazepam as per protocol if no longer needing extra. Assessment of capacity as he may regain capacity as DTs get better (not got capacity today)
Bed 12	NAME	Cellulitis	recent self d/c with cellulitis, sarcoid, previous Tb	improving on Friday with IV antibiotics	IVOST sat if well then home Sunday
		Lots of empty beds on Friday so new patients will need seen.			

Quality of data

SBAR

RCP handover toolkit

BMA safe handover: safe patients

Quality of data

6 point scale

Modified SBAR

Six point scale

Basic details- Full name CHI and location

Working Diagnosis (situation)

Background

Current Rx and progress (assessment)

Clear reason for review (recommendation)

Escalation plan/ ceiling of care

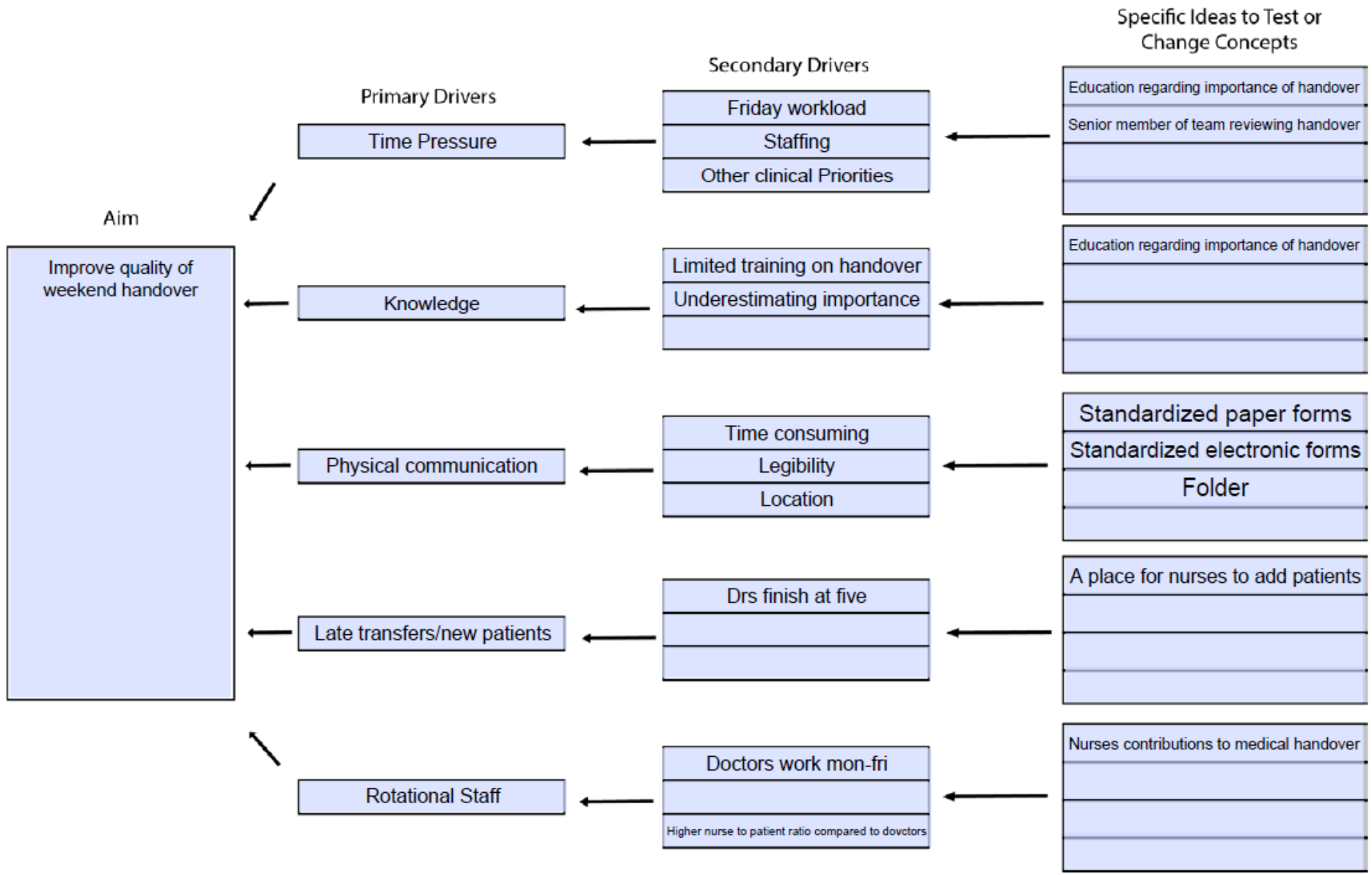
Aims

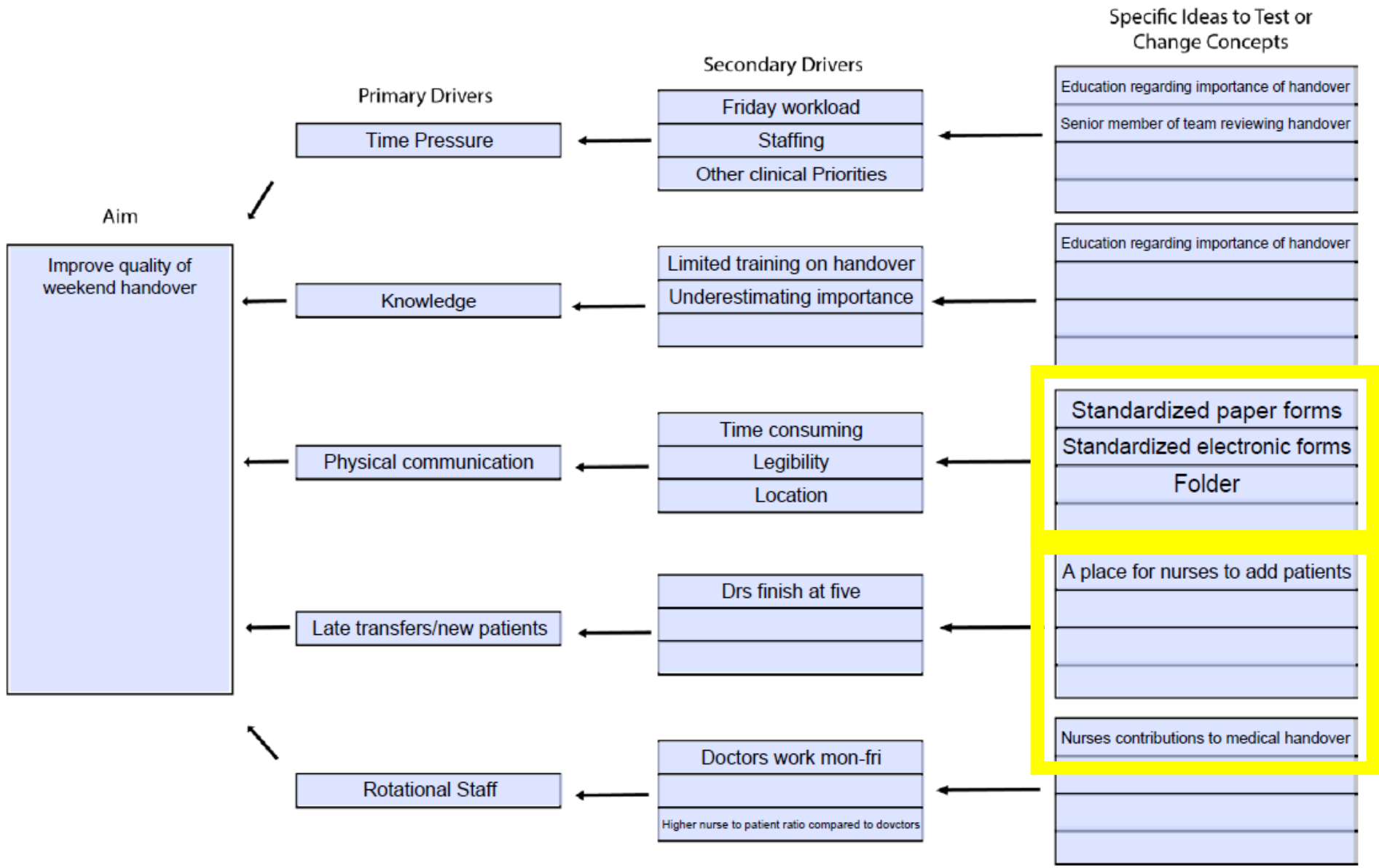
Standardise handover

Improve quality of handovers

Methods

- Setting: Medical wards at large teaching hospital (Excluding Geriatrics)
- Outcome: Quality of handover based on 6 point scale
- Interventions: Plan do study act cycles
- Data collection: Weekly
- Analysis: Run chart


Aim
Improve quality of weekend handover
Primary Drivers
Time Pressure
Knowledge
Physical communication
Late transfers/new patients
Rotational Staff
Secondary Drivers
Friday workload
Staffing
Other clinical Priorities
Limited training on handover
Underestimating importance
Time consuming
Legibility
Location
Drs finish at five
Doctors work mon-fri
Higher nurse to patient ratio compared to dovctors
Specific Ideas to Test or Change Concepts
Education regarding importance of handover
Senior member of team reviewing handover
Education regarding importance of handover
Standardized paper forms
Standardized electronic forms
Folder
A place for nurses to add patients
Nurses contributions to medical handover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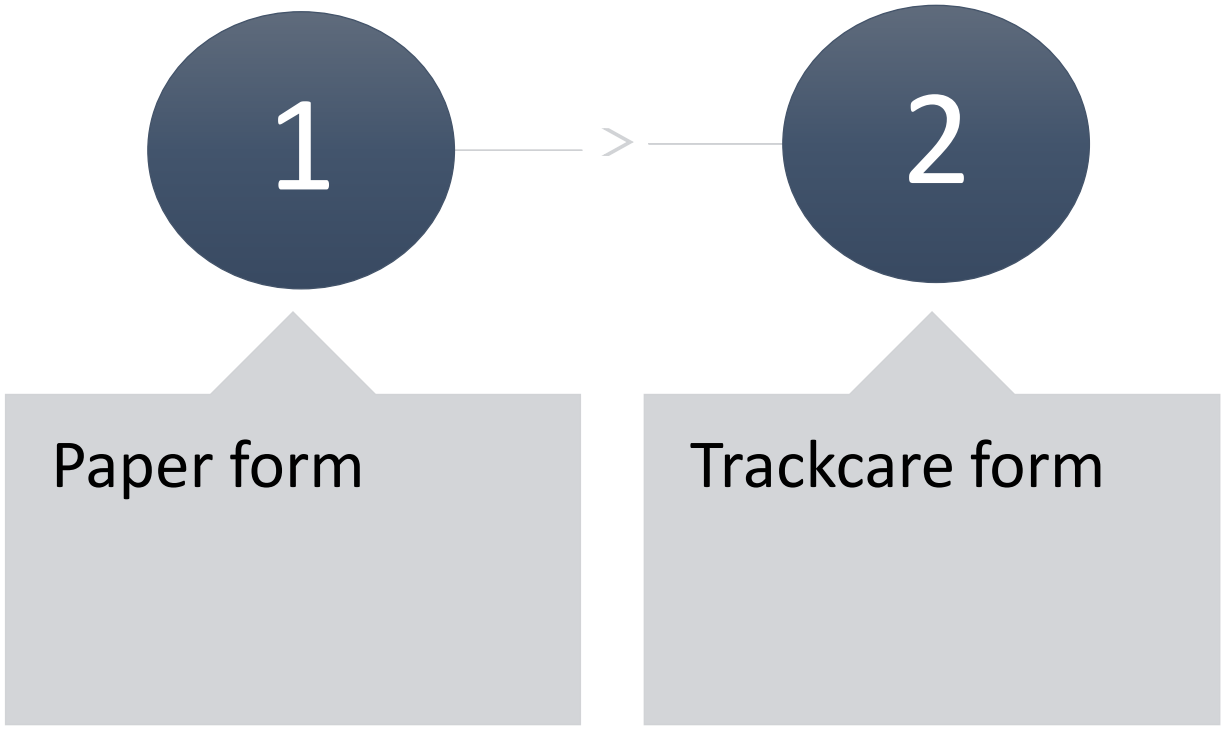
Interventions



Patient Details *Name and CHI or Patient Sticker*	**Situation** *Current diagnosis/problems*	**Background** *Relevant Past Medical History*	**Assessment** *Current progress/status, treatments etc*	**Recommendation** *Reason for review e.g. possible discharge, IV to oral switch*	**Escalation Plan** *Resus status, Ceiling of care e.g. HDU, ITU*

Weekend SHO Reviews Ward:_____ Date: _____

Request Item	Requested By	Start Date	Start Time	Priority	Specimen/s	Specimen Collection Time	Specimen Collection Date	Delete
Handover middle-tier	Dr Mark White1	23/04/2018	16:10	Routine				

Questions

Request Items	Question	The Answer to Question
Handover middle-tier	Review or To Be Aware	
Handover middle-tier	Diagnosis/problem list/diffential diagnosis (include any risks or warnings)	
Handover middle-tier	**Reason for handover**	
Handover middle-tier	Outstanding issues	
Handover middle-tier	Aims and limitations of treatment	

User Mark White1

Password

Update

Handover middle-tier

Request Details

Handover middle-tier

Test Visit No	
Status	Verified
Receiving Location	North Handover
Priority	Routine
Start Date	20/04/2018
Start Time	16:57
Requested By	Dr Mark White1
Responsible Clinician	
Patient Location when Requested	GRI Ward 28 Rheumatology/Ge
Processing Notes	

Scanned Documents

Annotate Annotated images can be reviewed in the Clinical Record under Documents>Annotation images

Images

Last Update User

: Mark White1

Audit Trail

Alert Messages

Handover Information

Review or To Be Aware **Review Sat & Sun**

Diagnosis/problem list/diffential diagnosis (include any risks or warnings) **new Friday PM 76 year old likely CAP but ddx PTE. CTPA outstanding. b/g**

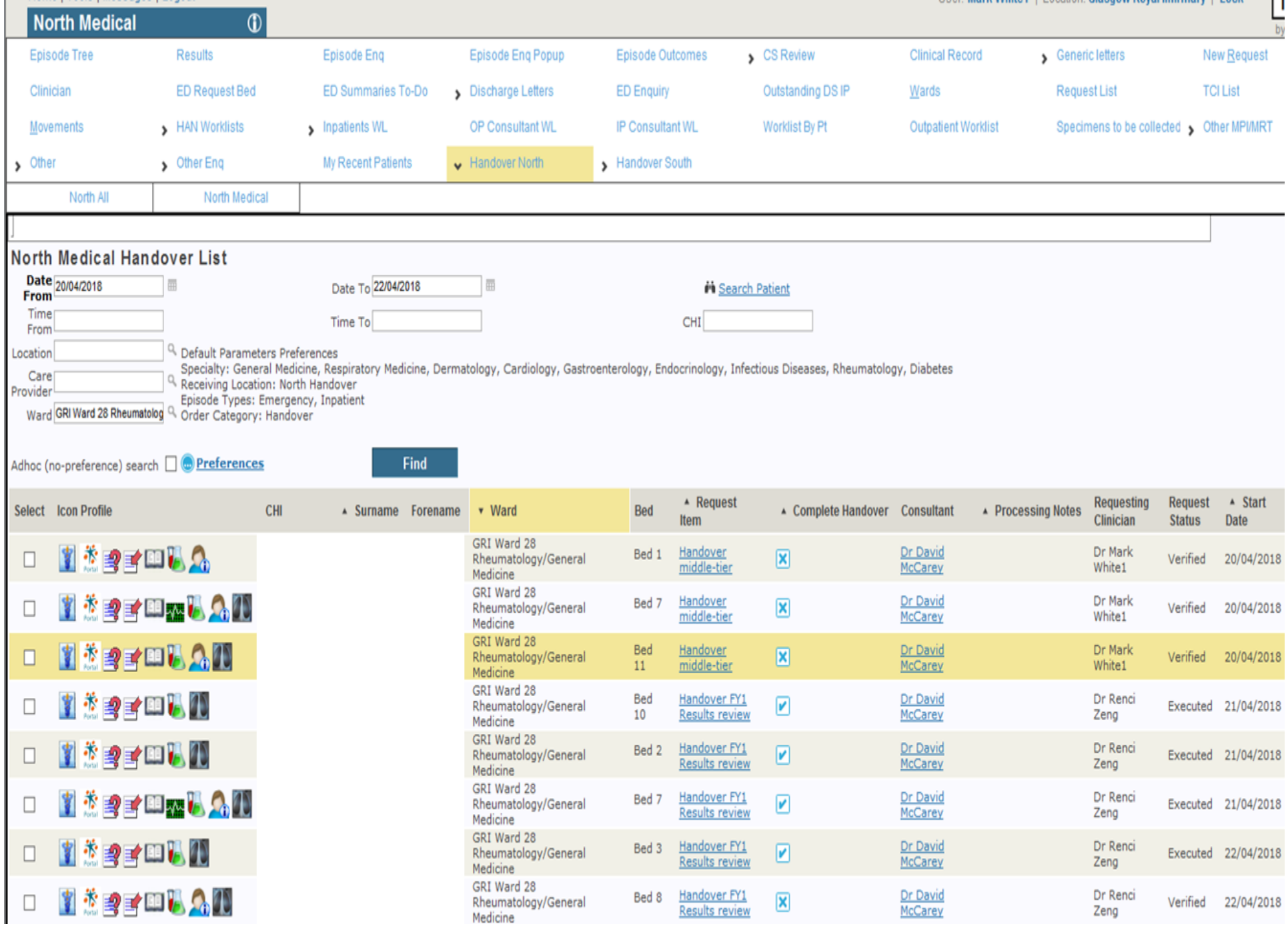
Reason for handover **Clinical concern**

Outstanding issues **chase CTPA if negative home**

Aims and limitations of treatment **currently for escalation**

Mark White1

Update


North Medical
Episode Tree
Results
Episode Enq
Episode Enq Popup
Episode Outcomes
CS Review
Clinical Record
Generic letters
New Request
Clinician
ED Request Bed
ED Summaries To-Do
Discharge Letters
ED Enquiry
Outstanding DS IP
Wards
Request List
TCI List
Movements
HAN Worklists
Inpatients WL
OP Consultant WL
IP Consultant WL
Worklist By Pt
Outpatient Worklist
Specimens to be collected
Other MPI/MRT
Other
Other Enq
My Recent Patients
Handover North
Handover South
North All
North Medical
North Medical Handover List
Date From 20/04/2018
Date To 22/04/2018
Search Patient
Time From
Time To
CHI
Location
Care Provider
Ward GRI Ward 28 Rheumatolog
Default Parameters Preferences
Specialty: General Medicine, Respiratory Medicine, Dermatology, Cardiology, Gastroenterology, Endocrinology, Infectious Diseases, Rheumatology, Diabetes
Receiving Location: North Handover
Episode Types: Emergency, Inpatient
Order Category: Handover
Adhoc (no-preference) search
Preferences
Find
Select
Icon Profile
CHI
Surname
Forename
Ward
Bed
Request Item
Complete Handover
Consultant
Processing Notes
Requesting Clinician
Request Status
Start Date
GRI Ward 28 Rheumatology/General Medicine
Bed 1
Handover middle-tier
Dr David McCarey
Dr Mark White1
Verified
20/04/2018
GRI Ward 28 Rheumatology/General Medicine
Bed 7
Handover middle-tier
Dr David McCarey
Dr Mark White1
Verified
20/04/2018
GRI Ward 28 Rheumatology/General Medicine
Bed 11
Handover middle-tier
Dr David McCarey
Dr Mark White1
Verified
20/04/2018
GRI Ward 28 Rheumatology/General Medicine
Bed 10
Handover FY1 Results review
Dr David McCarey
Dr Renci Zeng
Executed
21/04/2018
GRI Ward 28 Rheumatology/General Medicine
Bed 2
Handover FY1 Results review
Dr David McCarey
Dr Renci Zeng
Executed
21/04/2018
GRI Ward 28 Rheumatology/General Medicine
Bed 7
Handover FY1 Results review
Dr David McCarey
Dr Renci Zeng
Executed
21/04/2018
GRI Ward 28 Rheumatology/General Medicine
Bed 3
Handover FY1 Results review
Dr David McCarey
Dr Renci Zeng
Executed
22/04/2018
GRI Ward 28 Rheumatology/General Medicine
Bed 8
Handover FY1 Results review
Dr David McCarey
Dr Renci Zeng
Verified
22/04/2018

PDSA Cycles

- PDSA cycle 1- Introduction of standardised paper form on three wards
- PDSA cycle 2- Introduction of electronic handover system on three wards

- PDSA cycle 3- Expansion of electronic handover to seven wards
- PDSA cycle 4- Expansion of electronic handover to all non-receiving medical wards

Results

A total of 4 PDSA cycles were completed

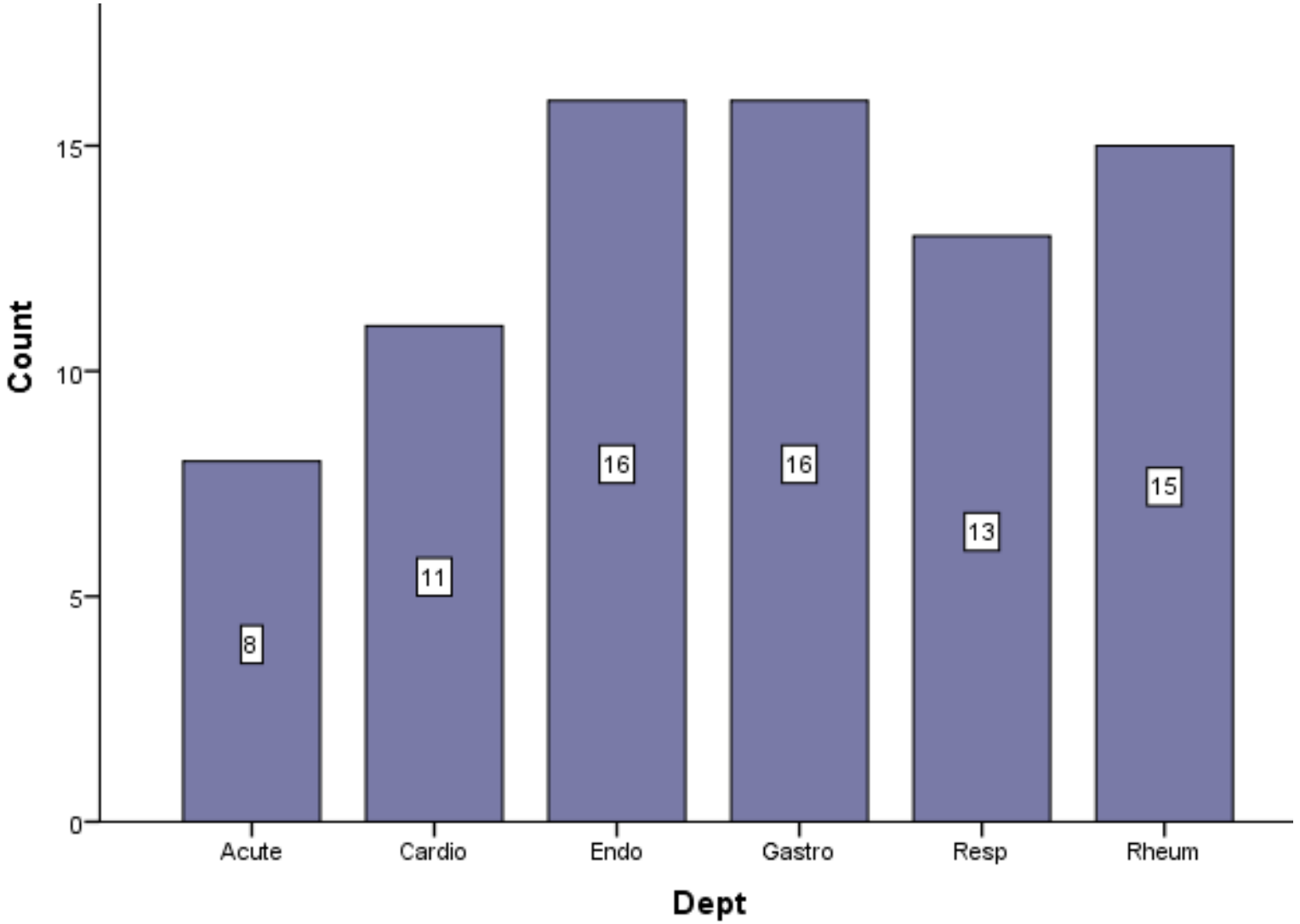
16 weeks data collection were performed

Total of 387 patients

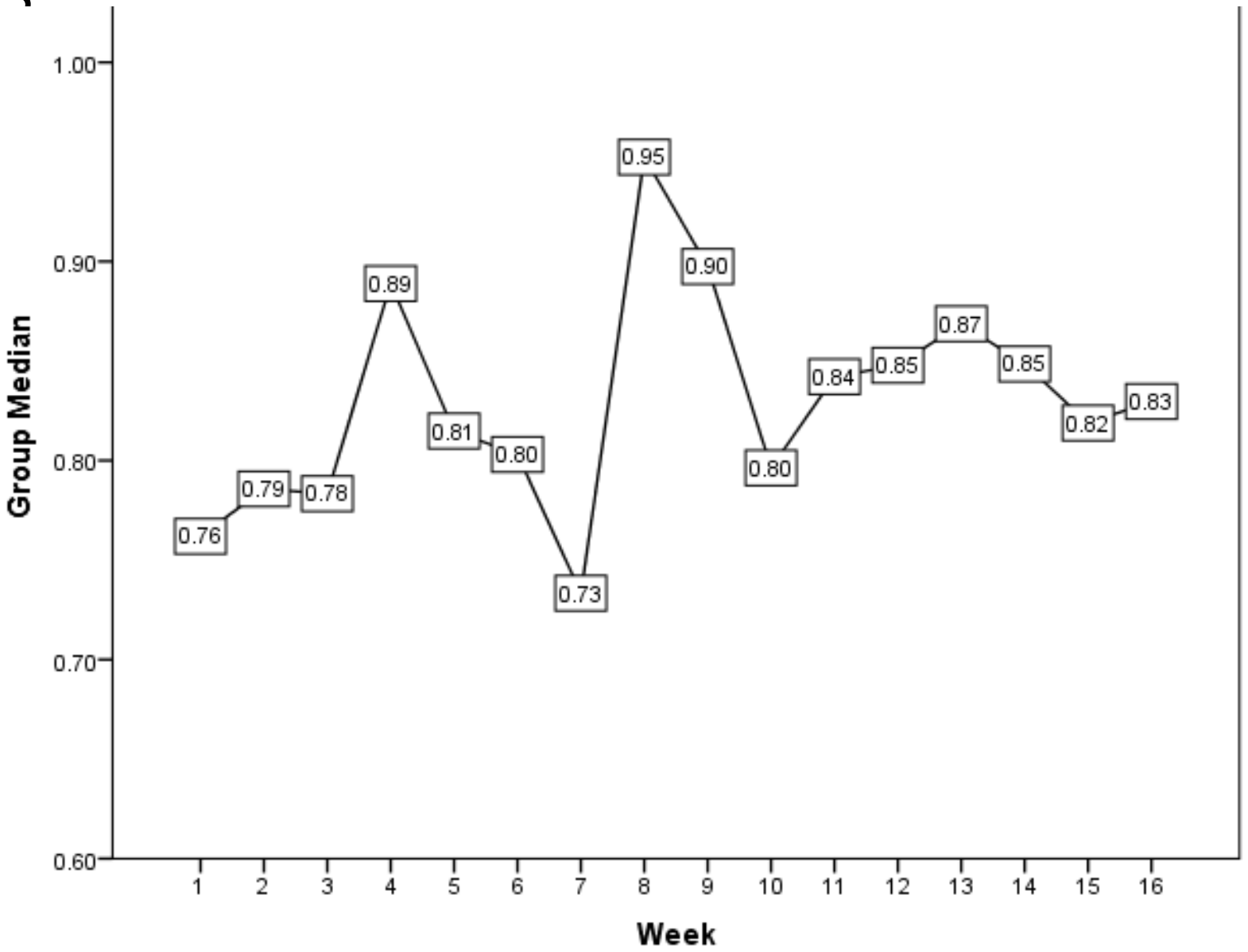
Results

	No of Patients	Percent	No of Weeks
Baseline	28	7.2	3
Paper	48	12.4	4
Electronic in 3 wards	42	10.9	3
Electronic in 4 wards	190	49.1	5
Electronic in all	79	20.4	1
Total	387	100.0	16

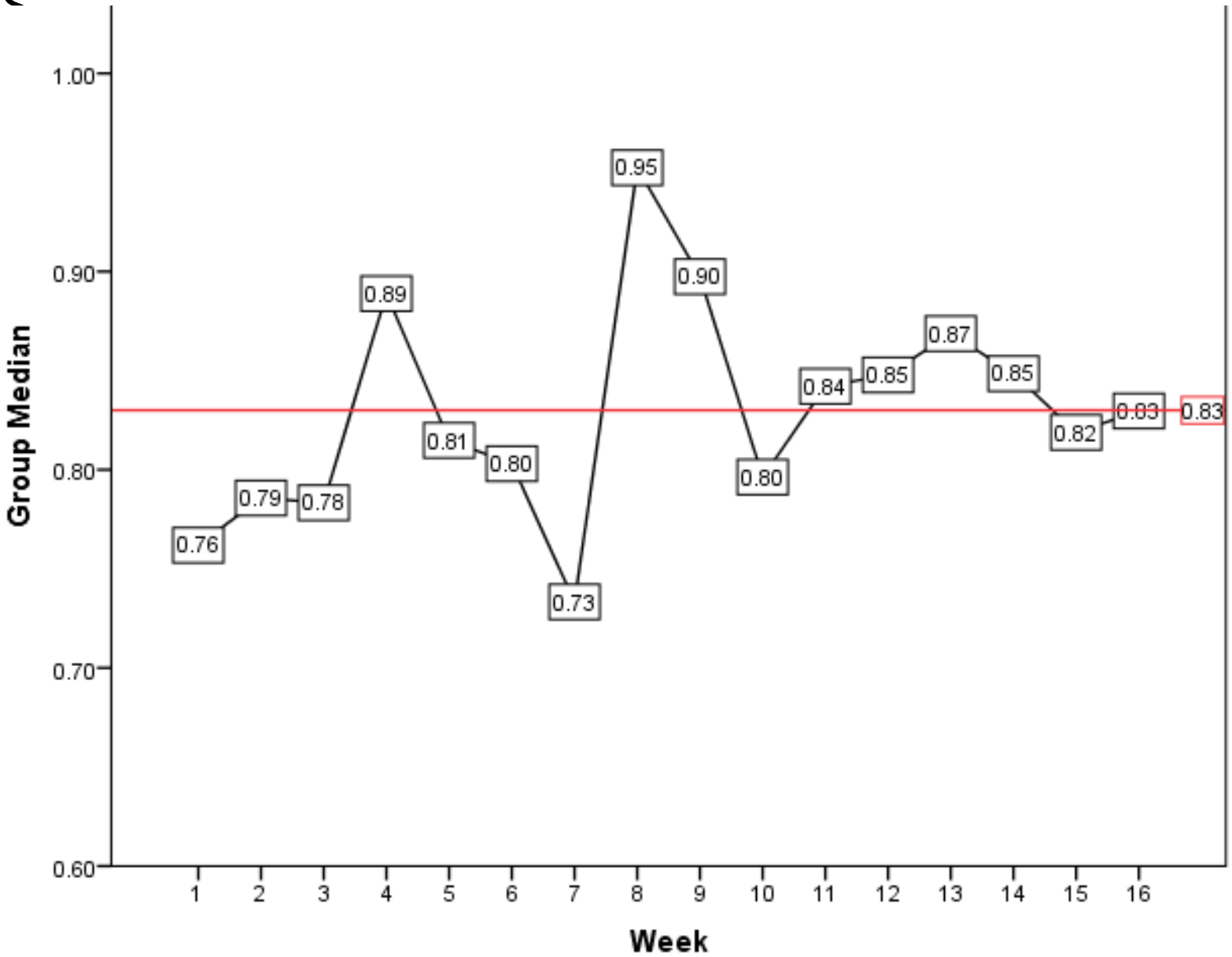
Week 16


Count
15
10
5
0
8
11
16
16
13
15
Acute
Cardio
Endo
Gastro
Resp
Rheum
Dept

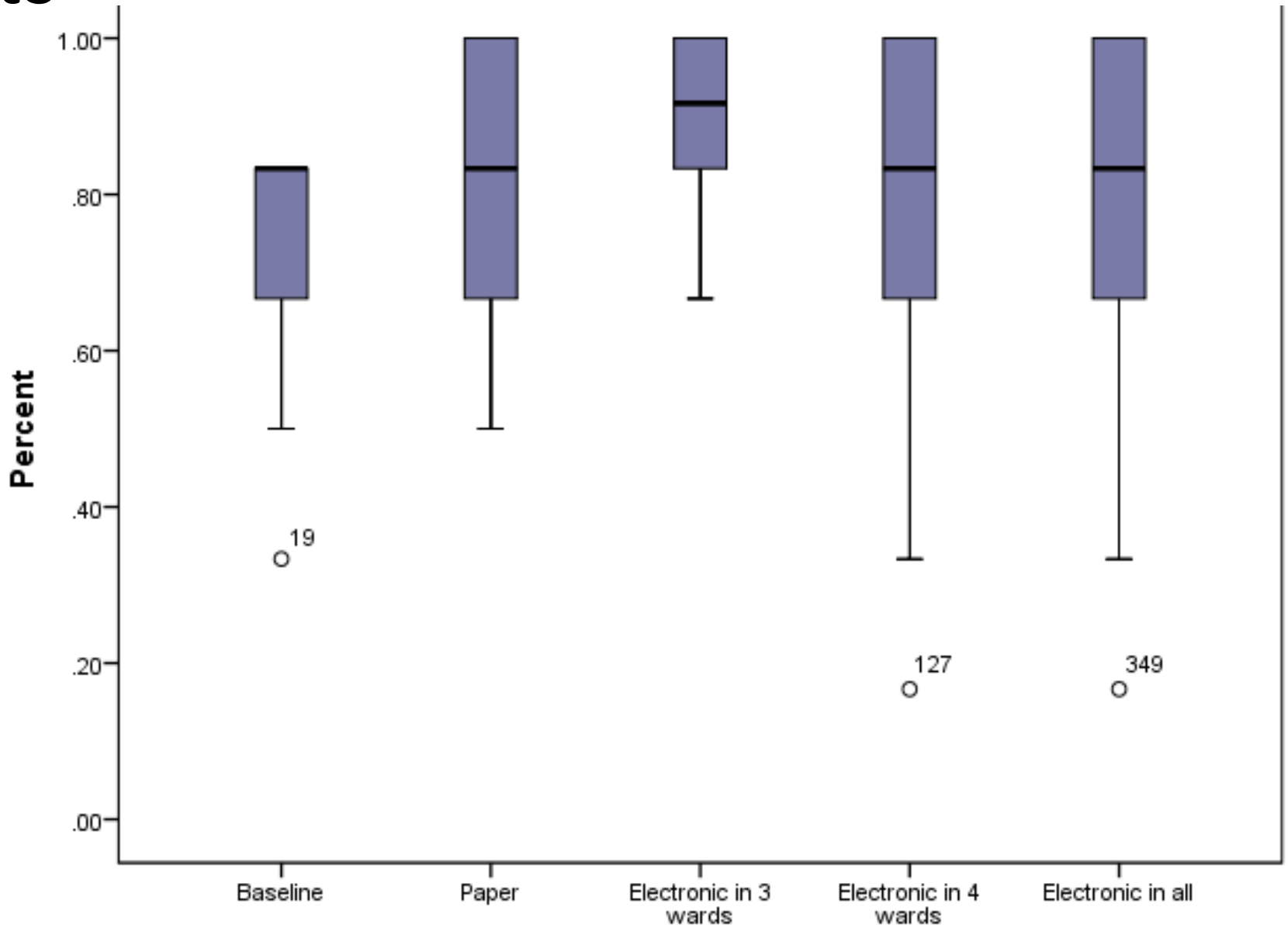
Results


Group Median
1.00
0.90
0.80
0.70
0.60
0.76
0.79
0.78
0.89
0.81
0.80
0.73
0.95
0.90
0.80
0.84
0.85
0.87
0.85
0.82
0.83
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Week

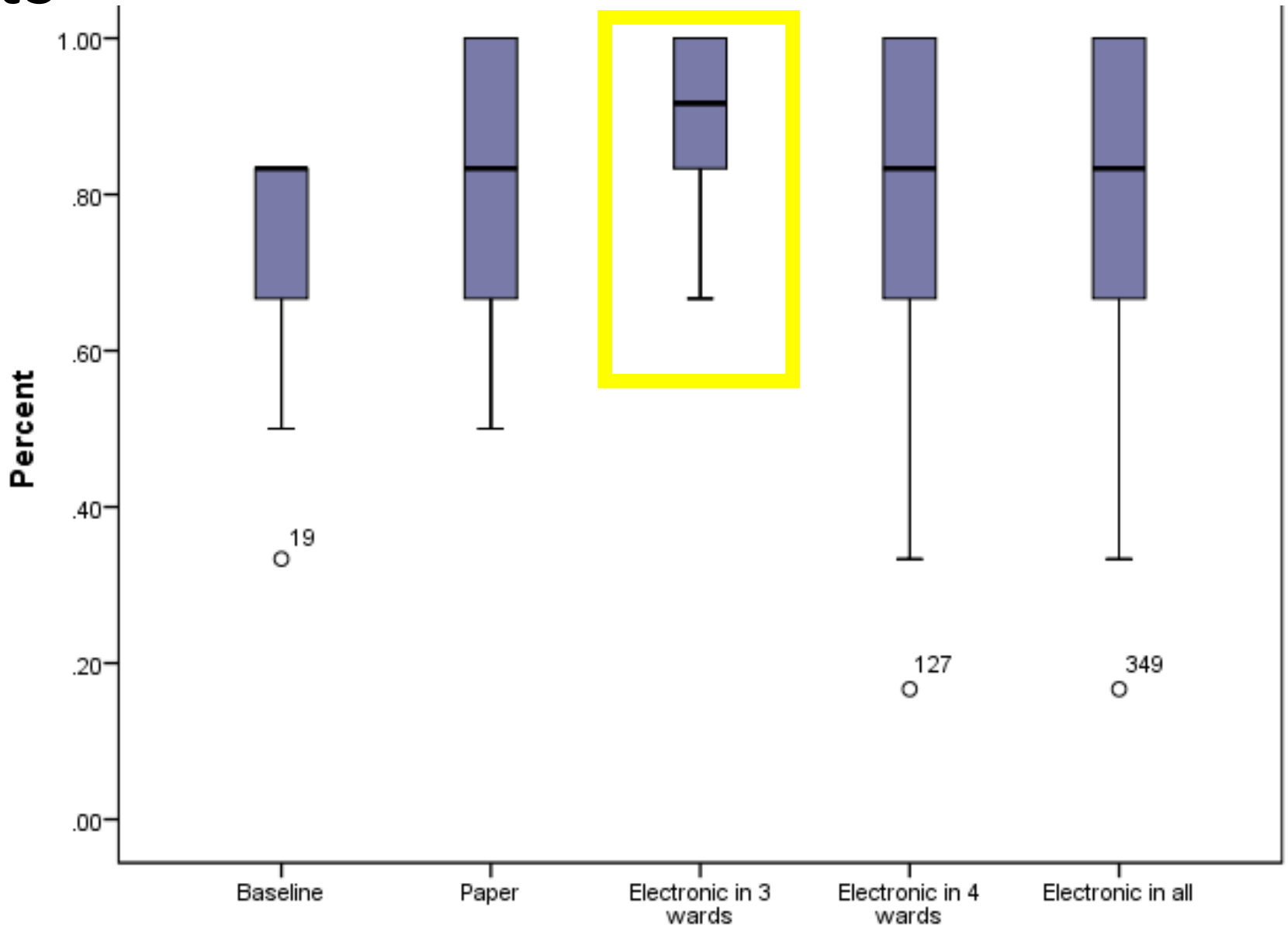
Results


Group Median
1.00
0.90
0.80
0.70
0.60
0.76
0.79
0.78
0.89
0.81
0.80
0.73
0.95
0.90
0.80
0.84
0.85
0.87
0.85
0.82
0.83
0.83
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Week

Results


1.00
.80
.60
.40
.20
.00
Percent
19
127
349
Baseline
Paper
Electronic in 3 wards
Electronic in 4 wards
Electronic in all

Results


1.00
.80
.60
.40
.20
.00
Percent
19
127
349
Baseline
Paper
Electronic in 3 wards
Electronic in 4 wards
Electronic in all

Conclusion

Standardized electronic handover system has been introduced effectively

Quality of information contained in handover is yet to show significant improvement

How the QI forum helped

How the QI forum helped

How the QI forum helped

Problem – Content of SHO to SHO handover from weekday to weekend teams are variable and non-standardised potentially leading to unnecessary patient reviews and poorer patient care at the weekend.

Aim - To improve the quality of handover content regarding patients for SHO review on downstream medical wards at the weekend

Outcomes- Adherence to quality standard (modified SBAR) for patient handover

How the QI forum helped

- Our plan was just to focus on one department (3 wards)

- Main intervention was to introduce a paper form
- “**Ideas for Future**
- New patients to ward
- Patients reviewed overnight
- Physical or electronic location of handover sheet
- FY1 handover (bloods, fluids, prescribing)”

How the QI forum helped

Sharing ideas (and data collection)

Senior involvement and leadership

Keen Consultants

Other work already that was already in the pipeline

How the QI forum helped

Adoption across departments

Rolling out- key in identifying leads to train department members

Training on eHandover

- Multiple grades of doctor and departments
- Different places and rota patterns

- Large unit

- CMT/FY2/GPST = 57
- FY1s= 48
- ST3+ = 20

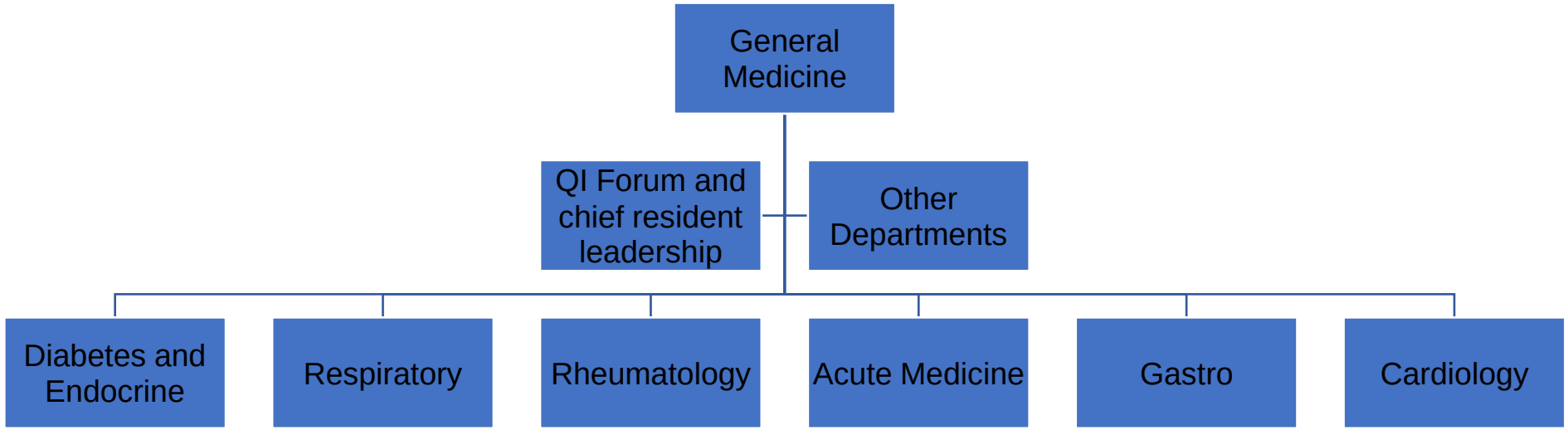
- Over 100 doctors plus others

Training on eHandover

Initially through identifying individuals working on pilot wards

Week to week

Not sustainable to do when expanded to whole medical unit.


General Medicine
QI Forum and chief resident leadership
Other Departments
Diabetes and Endocrine
Respiratory
Rheumatology
Acute Medicine
Gastro
Cardiology

Training leads

Ensure all doctors in dept trained

Recommended to make a list and tick off

How the QI forum helped

With QI forum

- Full adoption of standardised electronic system across whole medical department (18 wards)

Likely outcome without QI forum

- Paper forms may have been adopted over probably ~3 wards

How the QI forum helped

Sustainability

QI Discussion Forum

Could introducing a QI forum help your hospital?