



Sticking to the Handover!

A Regional Audit of Weekend Handover in Acute General Surgical Units in Northern Ireland Phase 2

July 2018

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Background

Handovers are an integral part of daily medical practice in the United Kingdom (UK) and occur within and between professional groups and teams. It is a process that must be underpinned by appropriate planning and management to anticipate, recognise and prevent deterioration in the clinical condition of patients.

In Northern Ireland, the practice of ward based 'patient handover' on medical and surgical units, to ensure safe and effective continuity of care currently lacks standardisation and robust quality assurance. Poor decision-making, communication and documentation on ward rounds and during handover periods can be responsible for otherwise avoidable adverse events which impact on patient safety ^[1-3].

Patients should be involved in all decisions pertaining to their care. It is now accepted best practice that patients are also informed of any change in the team providing their care as part of any effective handover process ^[1, 2, 4].

Guidance from the Royal College of Physicians (RCP), the Royal College of Nursing (RCN), the General Medical Council (GMC) and the British Medical Association (BMA) all demonstrate the importance of good ward round documentation. They recommend that the use of checklists or systematic tools, keeping colleagues well informed when sharing the care of patients, and an appropriate duration and environment for handover can reduce omissions and variations in practice ^[1, 5]. Failings in handover at multiple levels were identified in in the Mid-Staffordshire NHS Foundation Trust Inquiry (known as the Francis Report, 2013) ^[6].

The impact of the European Working Time Directive on rota compliance, loss of the 'surgical firm structure' and increasing reliance on shift work make implementing good handover challenging. Guidance released by the Royal College of Surgeons in England (RCSE) addresses the fact that handover is the responsibility of every member of the surgical team. Increasingly, care is shared between teams; at times, no one single consultant is responsible for the care of a patient ^[4].

From a regulatory standpoint ^[7] handover is an important quality assurance indicator. The Regulation and Quality Improvement Authority (RQIA) explicitly assesses handover during its rolling programme of acute hospital inspections ^[8].

Across Northern Ireland standardised patient proformas are now part of practice in many medical and surgical units ^[7].

Handover is a skill to be taught, learned, practised and developed. It is an integral part of the working day, and requires the involvement of the entire surgical and multiprofessional team ^[4].

In a survey of Northern Ireland surgical trainees, 12% commented they had received formal training in handover practice. Whilst trainees recognised that handover was an integral and valued practice, 78% of respondents did not receive feedback on their contributions to this process ^[9].

A number of published case reports and presentations document local ^[9] and national ^[10-14] efforts to improve handover in surgical units. Of note, these particular interventions have not been embedded more widely in surgical handover practice. However, components of good handover practice were gleaned from these reports and informed development of the handover tool.

A key finding of the Francis report was recognition that failures in any hospital are exacerbated by a lack of effective communication across healthcare systems in sharing information and concerns ^[6]. In a more recent review of systems and processes within the Northern Ireland healthcare system, the Bengoa Report championed the need to ‘remove variation in practice to improve efficiency’ and to ‘innovate and change existing systems to improve outcomes’. Simply put; *“Do it right, do it better, Do it differently”* ^[15].

The O’Hara Inquiry into Hyponatraemia-related deaths exemplified the importance of adequate documentation, specifically that clinical notes should always record discussions pertaining to handover or change in care ^[16]. A formal recommendation of this inquiry was that record keeping be subject to *“rigorous, routine and regular audit”* ^[16]. The Northern Ireland Regional Quality 2020 Strategy recognises the need to devise *‘better ways of measuring the quality of our services’* ^[17].

Phase 2 Project Aim

To improve weekend handover documentation and communication within acute general surgical units in Northern Ireland by means of rapid cycle audit reviews following introduction of a sticker handover tool.

Project Objectives

- To improve the quality of documentation of weekend handover using Quality Improvement (QI) methodologies.
- To undertake rapid cycle quality improvement audits on the quality of documentation of weekend handover in participating surgical units following the introduction of a sticker handover tool.

Project Timeline

The work was divided into two phases.

Phase 1: Learning and Development (Oct 2016 - May 2017)

Collection of data and feedback from each Trust to explore a pragmatic and agreed approach to standardise handover, based on recommendations from the Project Team and Project Steering Group/Advisory Panel.

Phase 2: Action and Implementation (May 2017- Dec 2017)

Learning from phase one permitted rapid cycle quality improvement audits of handover practice in phase two within acute surgical departments.

Methodology

The standardised Weekend Handover Sticker developed in Phase 1 (Figure 1) was distributed to each participating acute general surgical unit through means of local teaching sessions.

In each unit, doctors participating in the Friday morning ward round were asked to complete a Weekend Handover Sticker which had been placed in the medical notes of each general surgical patient reviewed on the Friday morning ward round.

Twelve rapid cycle audits were performed to assess:

- if the stickers were used on the ward round.
- completeness of information recorded on the sticker.
- if teams changed their practice in relation to the Friday morning ward round.

A meeting of the Regional Project Team Working Group (appendix one) was convened to discuss any issues, results and further recommendations.

Figure 1: Weekend Handover Sticker

Weekend Handover Ward-Round

Patient status: **WELL / STABLE / UNWELL** Suitable for discharge: **Y / N**

Post op Day / Diagnosis: _____

Radiology Scan to review **Y / N** Awaited **Y / N** Detail: _____

Bloods
 Saturday **Y / N** Detail: _____
 Sunday **Y / N** Detail: _____

Abx **Y / N** Continue Switch oral Stop Sat/Sun
IV Fluids Continue and review Oral fluids
Nutrition _____

Special instructions (e.g. drain/catheter):

Issues/plan:

DNAR documented / not documented Dr signed _____

Sample Size

Each participating unit was asked to randomly select 20 patient charts, each week, for auditing. Due to ward pressures doctors may not have been able to audit the full complement of charts.

Data Collection and Analysis

- Designated data collectors (ranging from FY1 to CT2 Surgical trainees) were identified to perform weekly audits and champion the stickers in their unit under the supervision of a local consultant.
- Data were collected from Craigavon Area Hospital (Southern HSC Trust), Ulster Hospital (South Eastern HSC Trust) and Antrim Area Hospital (Northern HSC Trust).
- Data were collected between August and November 2017.
- Charts were to be audited within 12 hours of the Friday morning ward round.
- A standardised audit proforma was used for all data collection (Appendix 1).
- Data were forwarded securely to project co-leads and the Governance Department at Antrim Area Hospital for cleansing and collation.
- Data collation and auditing/review were concurrent, allowing tests of local change to be designed and tested over short periods of time.

Table 1: Number of charts audited in each participating Trust

Name of Unit	Number of Patient Charts Audited
Craigavon Area Hospital (CAH)	240
Antrim Area Hospital (AAH)	190
Ulster Hospital (UHD)	84
Total	514

Inclusion and Exclusion Criteria

Only acute general surgical units were included in this audit. All other areas were excluded as gathered data were exclusively related to general surgical practice.

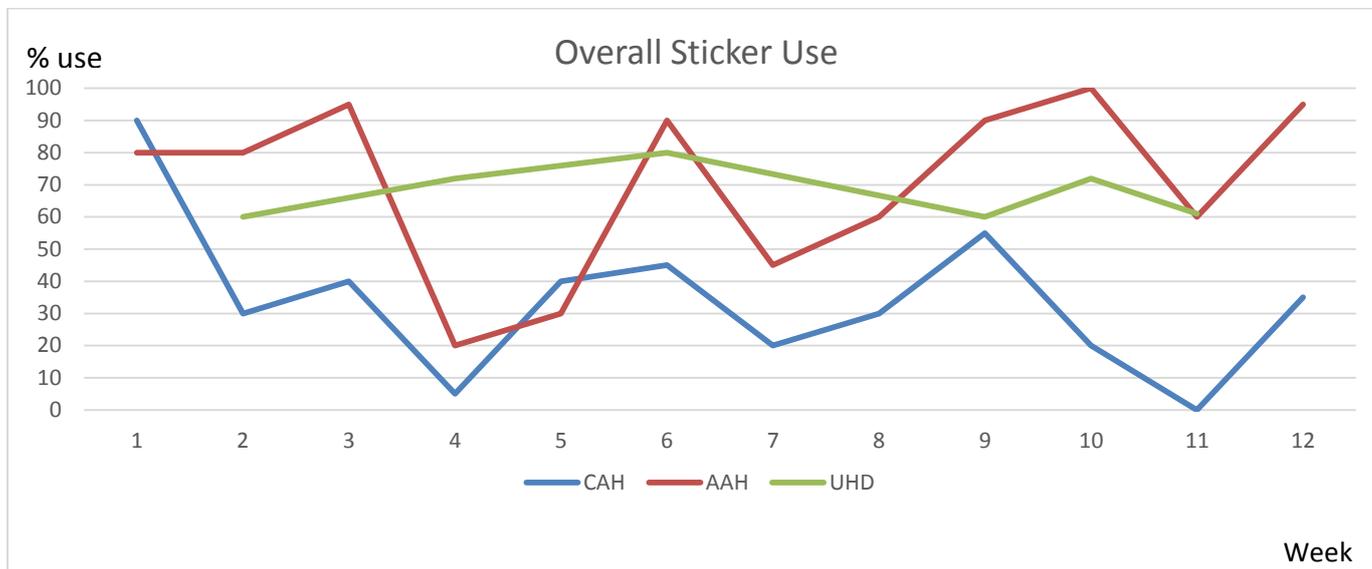
Limitations

- Due to variation in the staffing structure, working week and nature of consultant cover in the Emergency Surgery Unit, RVH, the sticker was not introduced and therefore no data were collected in the Belfast HSC Trust.
- Due to hospital pressures and other Trust commitments, there was a failure to recruit local data collectors and secure consultant supervision within the timeframe of this audit at Altnagelvin Area Hospital. This resulted in an inability to collect data for the Western HSC Trust.
- Time constraints and clinical commitments of data collectors led to variability in the number of charts audited in some units each week; therefore there is some discrepancy against the planned total sample size. For example, rostered night shift duties, annual and study leave, rota gaps in other ward areas requiring reallocation of doctors in training, all impacted on both completion as well as auditing of the patient charts.

Results

Overall Sticker Use

Figure 2: Percentage sticker use over 12 weeks in participating units



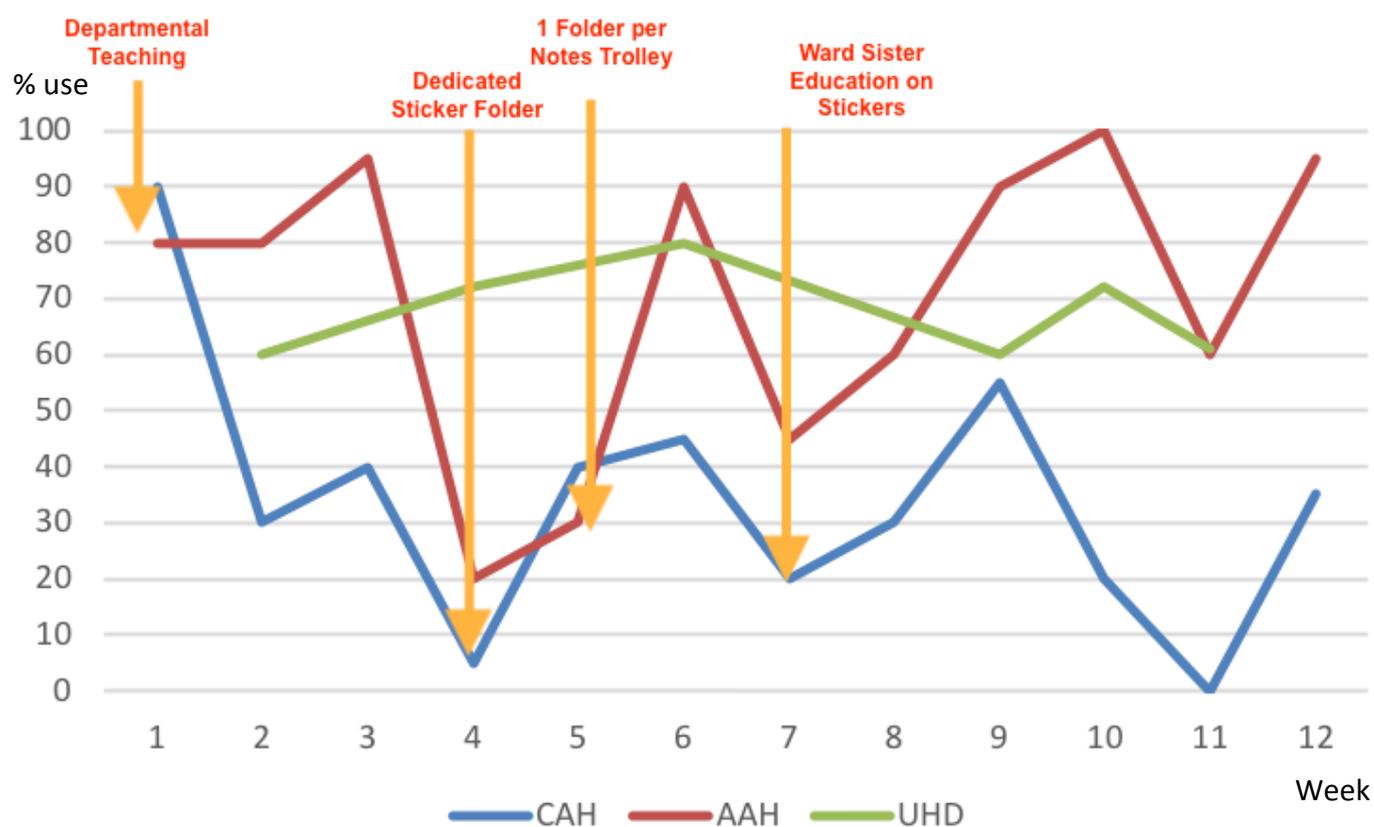
Over the 12 week period, there was considerable variability in sticker use. Feedback from data collectors indicated that this was most often due to lack of time on ward rounds, compounded in part by pressure on junior doctors to complete other clinical responsibilities, for example arrive in theatre on time; answer bleeps and see surgical admissions referred from the Emergency Department. It was reported that this was often exacerbated by staff shortages, particularly on a Friday morning, as some doctors were absent due to having completed night shifts, starting weekend night shifts, or prior to working weekend day shifts. Doctors in training, when on night duty, most often work Monday to Thursday night inclusive, and Friday to Sunday night inclusive. Thus there are often fewer doctors providing ward cover on Friday mornings.

Feedback indicated that sticker use improved when the consultant leading the Friday morning ward round was a local champion for the project.

Using Plan-Do-Study-Act (PDSA) QI methodology, a number of tests of change were employed. Examples of these in Craigavon Area Hospital (CAH) and Antrim Area Hospital (AAH) are demonstrated in Figure 3. These included: awareness and education of staff, designating a particular place for stickers to be kept on the ward (in a folder), increasing the number of folders so there was one on each patient notes trolley for ease of retrieval, and holding a meeting with ward sisters to encourage them to promote sticker use on ward rounds.

It is noted that whilst each intervention appeared to have a short-term beneficial effect on overall sticker use, none produced sustained change.

Figure 3: Examples of PDSA cycles testing small changes



Of the 514 charts audited, 57% (295 out of 514) had completed or partially completed stickers entered on the Friday morning ward round. The consistency with which each of these stickers was completed is assessed below. The lack of any stickers present in audited notes in CAH on week 11 presents throughout the graphs as a recurrent zero data point. Brief comments on the data are provided to aid clarity whilst more general comments are reserved for the discussion section.

For the purposes of data presentation, the clinical information captured within the fields on the stickers has been grouped into that relating to patient information, patient management plan, and professional documentation. These are plotted on time-series run charts (Figures 4 to 18) and, where relevant, comment provided to explain outlying or divergent results between the three units. Additionally, the results are compared with those from the baseline data collected in Phase one.

Patient Information

The section to identify patient status was well received and generally well completed (Figure 4*). This is one of the least time-consuming fields on the sticker, requiring circling a preprinted word to identify patient as “Well”, “Stable” or “Unwell”. Total completion rate of this section was 89% (459 out of 514).

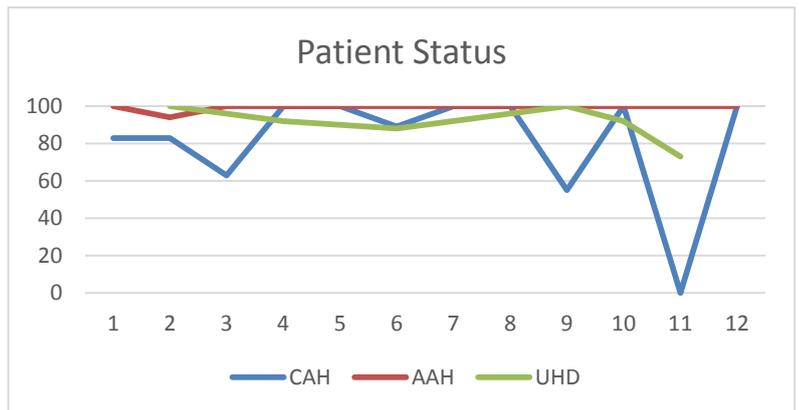


Figure 4: Patient Status

*Average Completion Rates: CAH 81% AAH 99.5% UHD 90%

The suitable for discharge section simply required circling YES/NO on the sticker. This was performed with a total completion rate of 56% (291 out of 514) (Figure 5*).

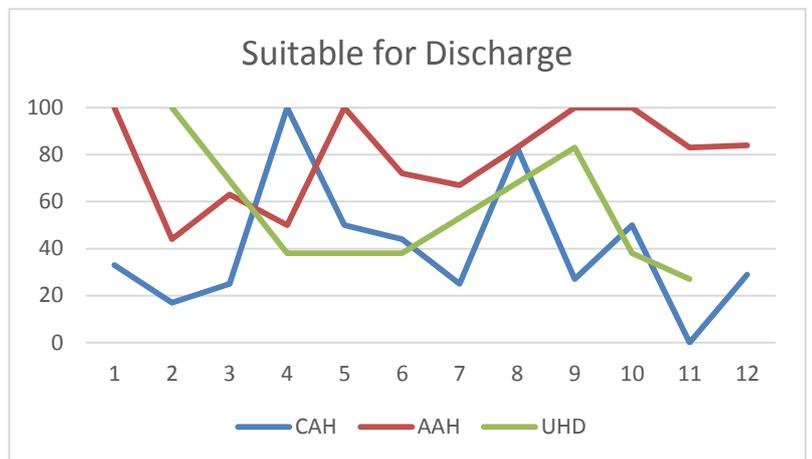


Figure 5: Suitable for Discharge

*Average Completion Rates: CAH 40% AAH 78% UHD 54%

The diagnosis section was well completed throughout, with a completion rate of 79% (406 out of 514) (Figure 6*).

This is improved from a documentation rate of 52% prior to sticker introduction in phase one.

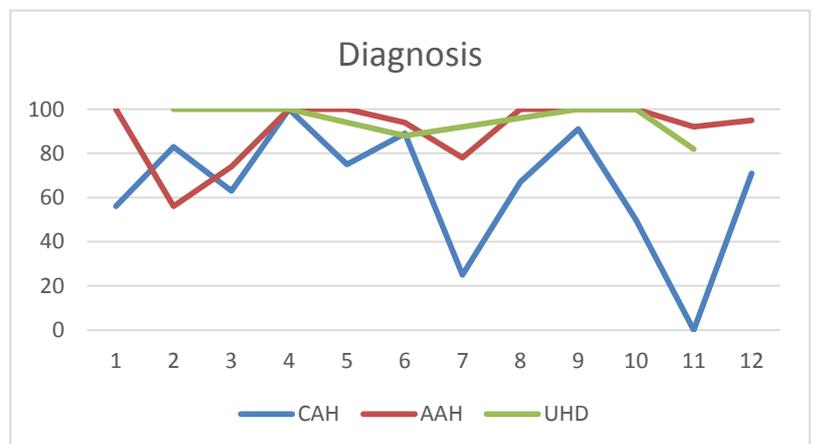


Figure 6: Diagnosis

*Average Completion Rates: CAH 64% AAH 91% UHD 95%

As demonstrated by the run chart, the completion of the Post-operative Day & Procedure section was variably completed. Feedback from some users indicated that information intended for this section was included in the 'Diagnosis' section.

Total completion rate was 59% (305 out of 514) (Figure 7*). This is an improvement on the 25% documentation completion rate prior to sticker introduction.

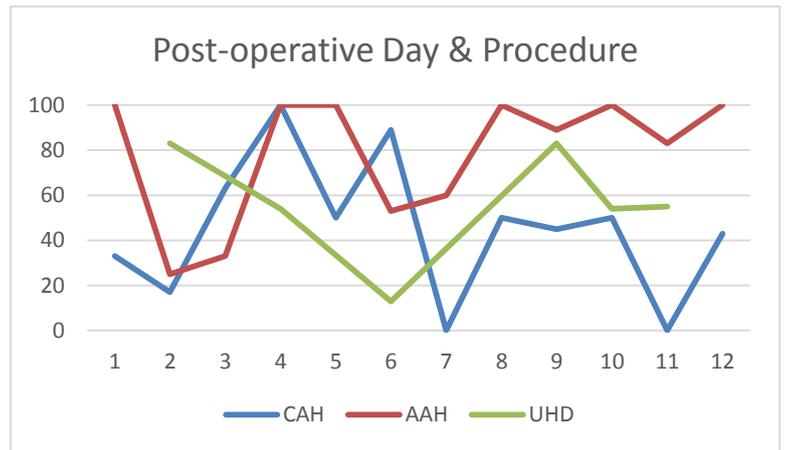


Figure 7: Post-op Day & Procedure
*Average Completion Rates: CAH 45% AAH 79% UHD 57%

This section documented relevant radiology previously completed, or planned radiology to be followed up over the weekend. Completion rate was 73% (376 out of 514) (Figure 8*), an improvement on the 49% documentation rate prior to sticker introduction.

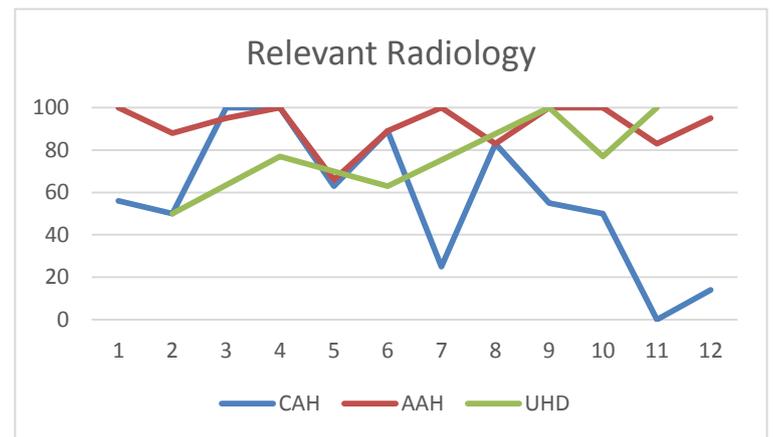


Figure 8: Radiology
*Average Completion Rates: CAH 57% AAH 92% UHD 78%

Patient Management Plan

This section allows for specifying which blood tests are required on which day for each patient over the weekend. Completion rate was 85% (439 out of 514) (Figure 9*)

This is an improvement on a documentation rate of 48% prior to sticker introduction.

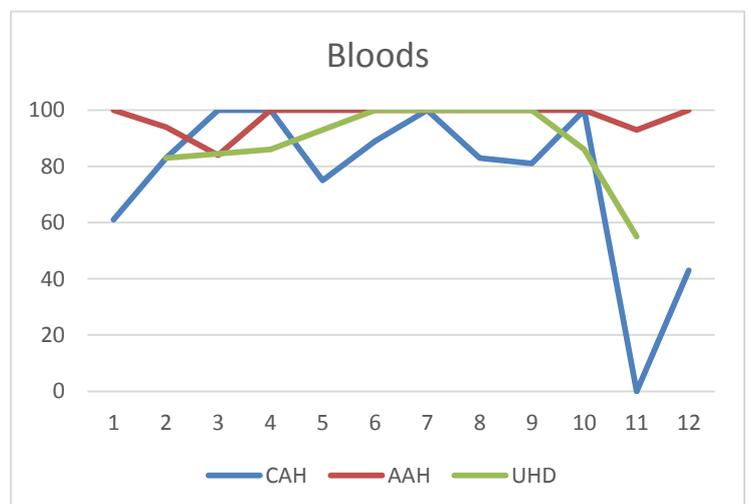


Figure 9: Bloods
*Average Completion Rates: CAH 76% AAH 97% UHD 85%

Completion of the antibiotic section was consistently high in AAH and UHD. It can be seen from the run chart that it was inconsistent in CAH. Partly this was an issue caused by overall low sticker use but also by users not completing this section if a patient was not on antibiotics rather than circling “No”.

Total completion rate was 69% (356 out of 514) (Figure 10*).

The Fluid Management section was well competed throughout, although it is seen to have decreased in CAH during the second half of the study. The reason for this is unclear, although local feedback included that some doctors felt that the need for supplementary fluids should be regularly assessed throughout the course of the weekend, rather than predetermined on a Friday. This resulted in not completing this field. Completion rate was 64% (329 out of 514) (Figure 11*).

This is an improvement on a documentation rate of 37% prior to sticker introduction.

The Nutrition section was less well-completed overall. Users reported that they felt this section should only be completed if there were specific instructions to be entered, e.g. to remain nil-by-mouth, or nasogastric-fed, or for total parenteral nutrition.

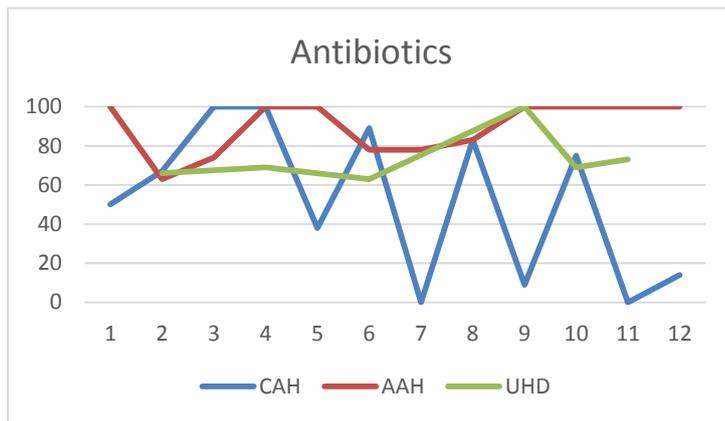


Figure 10: Antibiotics

*Average Completion Rates: CAH 52% AAH 90% UHD 73%

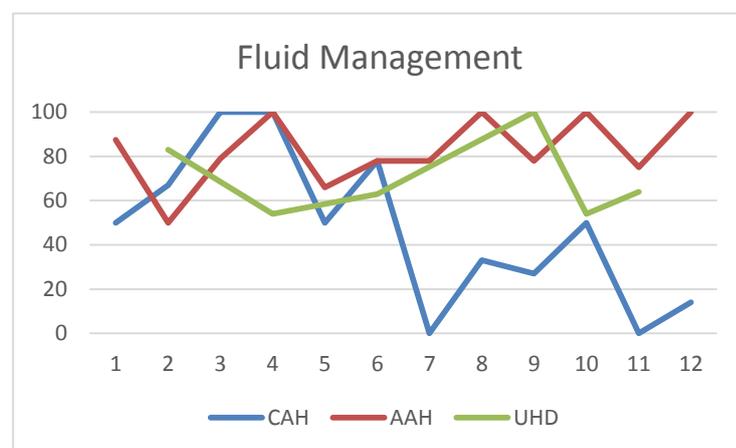


Figure 11: Fluids

*Average Completion Rates: CAH 47% AAH 82% UHD 70%

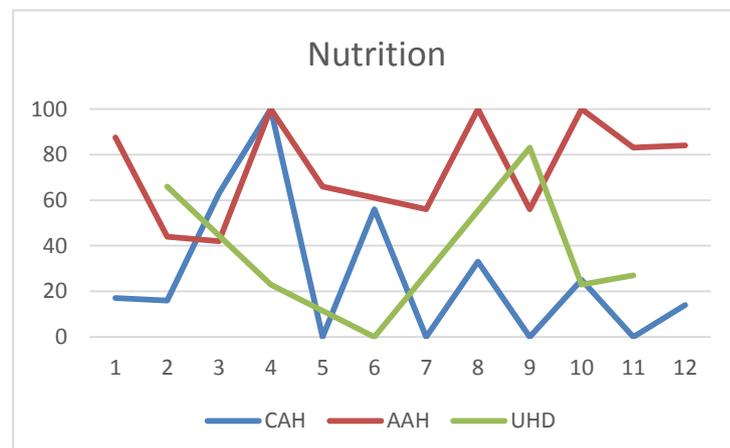


Figure 12: Nutrition

*Average Completion Rates: CAH 27% AAH 73% UHD 37%

As such, many felt that by leaving the section blank they were implying that the patient was suitable for a regular enteral diet.

Completion rate was 46%* (235 out of 514).

This is an improvement on a documentation rate of 30% prior to sticker introduction.

This special instructions field was frequently left blank in the absence of any instructions not already accounted for on the sticker. Completion rates were low in CAH and UHD and consistently high in AAH. This may represent different understandings of this field, or simply better compliance in AAH with filling all areas of the sticker.

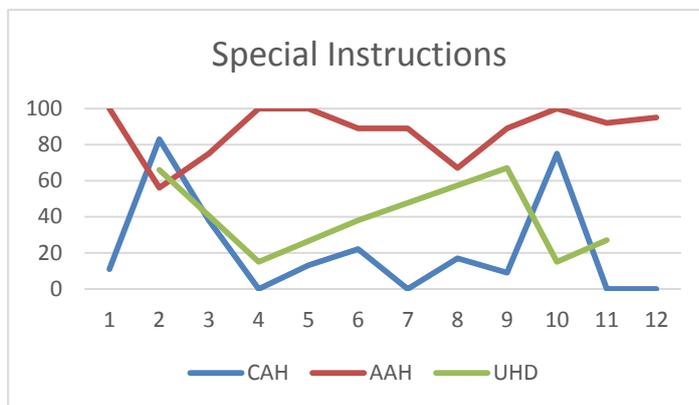


Figure 13: Special Instructions
*Average Completion Rates: CAH 22% AAH 87% UHD 38%

Total completion rate was 49% (252 out of 514) (Figure 13*).

Documentation of the outstanding issues with each patient, and the plan for their care over the weekend section was well received in all units and is reflected by a completion rate of 90% (464 out of 514) (Figure 14*).

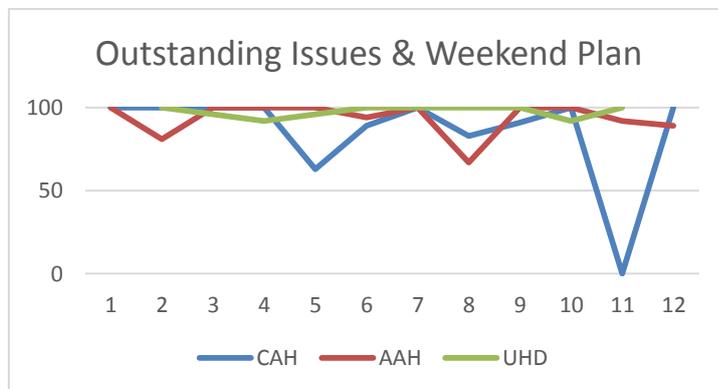


Figure 14: Issues & Plan
*Average Completion Rates: CAH 86% AAH 94% UHD 97%

This is an improvement on a documentation rate of 70% prior to sticker introduction.

An agreed ceiling of care and/or a plan regarding escalation were amongst the least frequently documented aspects of care in Phase 1.

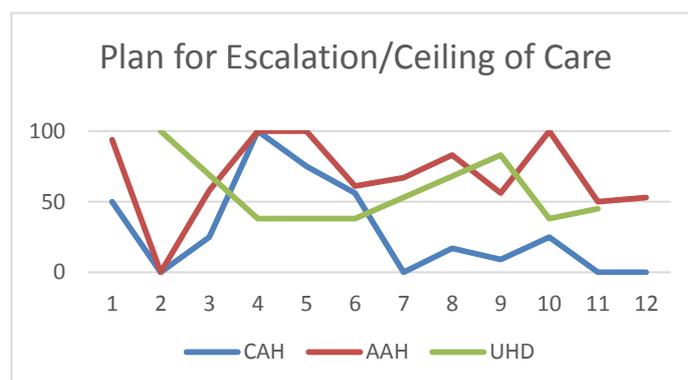


Figure 15: Escalation
*Average Completion Rates: CAH 29% AAH 68% UHD 57%

The use of these sections was mixed throughout the 12-week rapid-cycle audits. Feedback from users in CAH included that this section was only completed if a Do Not Attempt CPR (DNACPR) form was signed and in place, or if a defined ceiling of care had been placed at ward level.

Ceiling of Care and plan for escalation, completion rate was 48% (249 out of 514) (Figure 15*).

This is an improvement on a documentation rate of 13% prior to sticker introduction.

Completion rate for resuscitation status was 48% (248 out of 514) (Figure 16)*. This is an improvement on a documentation rate of 13% prior to sticker introduction.

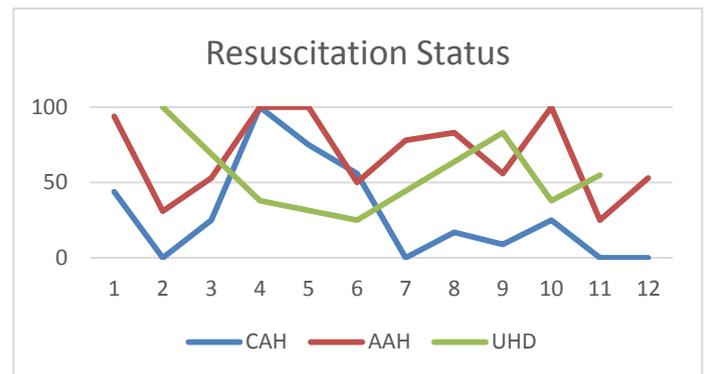


Figure 16: Resuscitation Status
*Average Completion Rates: CAH 29% AAH 69% UHD 56%

Professional Documentation

Completion rate for doctor's signature was 86% (445 out of 514) (Figure 17*).

This is a decline from a documentation rate of 96% prior to sticker introduction. This is likely to be within the bounds of normal variation, but could be explained by doctors focusing on the ward round rather than completion of the sticker.

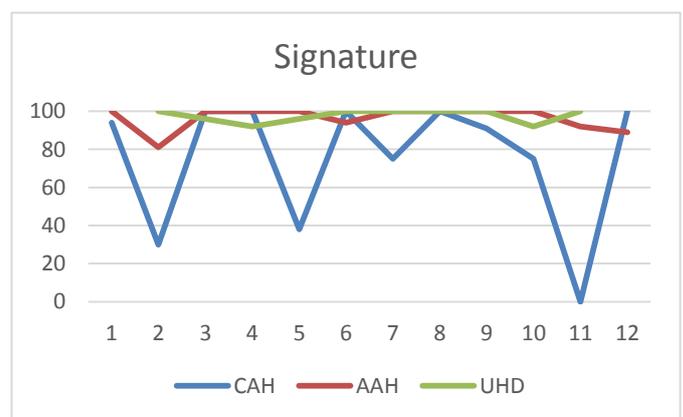


Figure 17: Signature
*Average Completion Rates: CAH 75% AAH 96% UHD 97%

Completion rate for GMC numbers and/or the grade of the doctor completing the documentation was 80% (412 out of 514) (Figure 18*). This is below the expected standard of 100%.

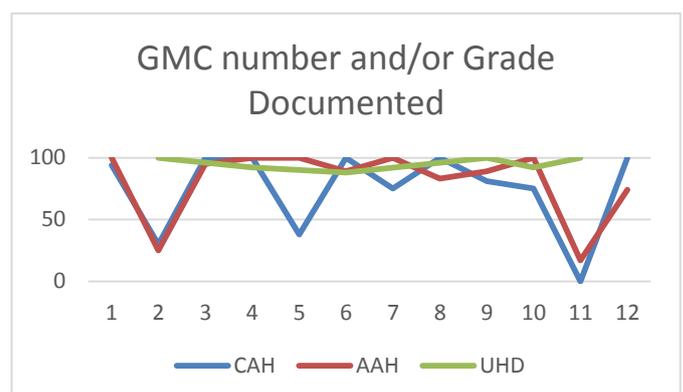


Figure 18: GMC Number & Grade
*Average Completion Rates: CAH 74% AAH 81% UHD 95%

Overall Sticker Effect

Comparisons between Phase 1 and Phase 2 show improvement in almost all aspects of documentation standards and of best practice. All indicators measured in both phases have been improved with the exception of the doctor's signature.

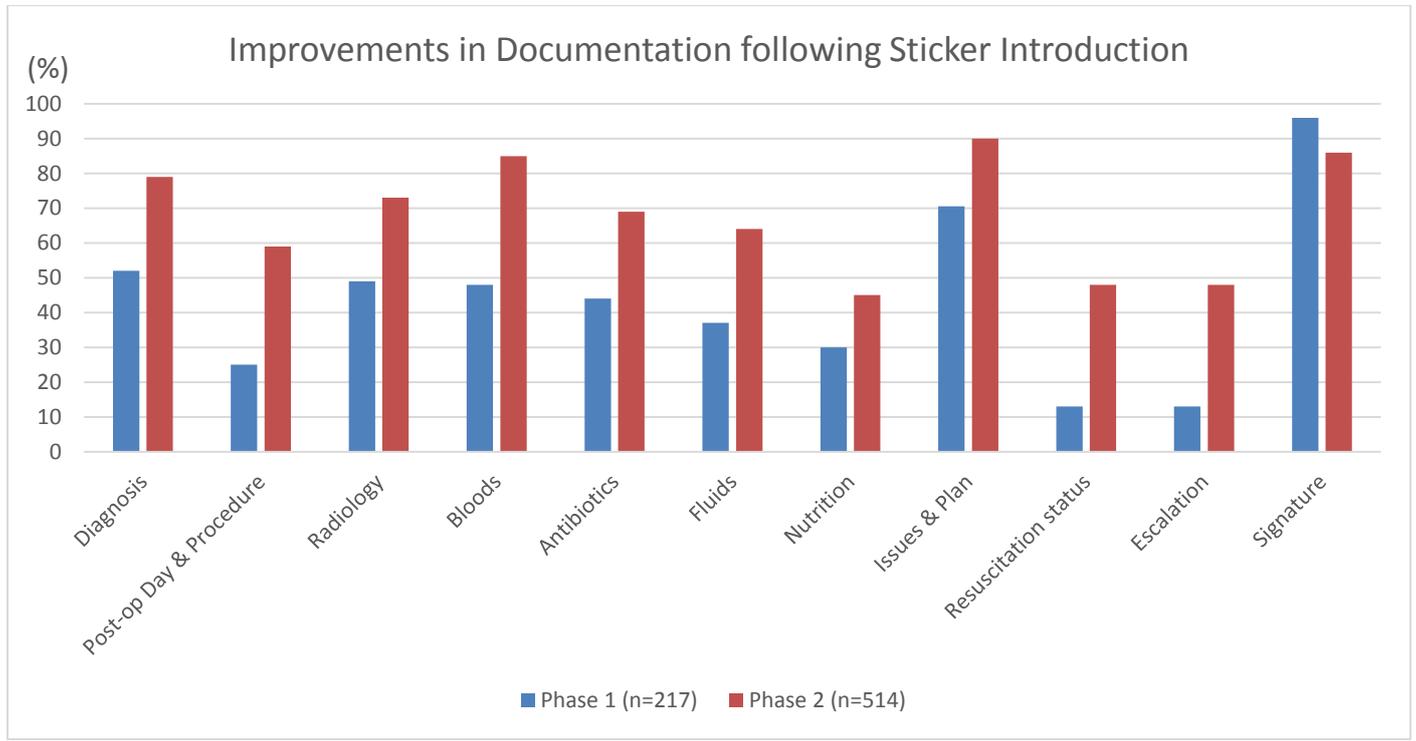
The documentation rates from each phase are illustrated in Table 2 and Figure 19.

Table 2: A Comparison of Documentation Rates Before (Phase 1) and After (Phase 2) Sticker Introduction

Documentation Standard	Phase 1 (based on N=217)	Average over 12-week Collection (Phase 2) (based on stickers used in N=295/514 charts)		% Improvement (%)
Diagnosis	52%	79%		27
Procedure/Postop Day	25%	59%		34
Radiology	49%	73%		24
Bloods	48%	85%		37
Antibiotics	44%	69%		25
Fluids	37%	64%		27
Nutrition	30%	46%		16
Issues/Plan	70.5%	90%		20
Ceiling of Care/DNAR	13%	DNAR	48%	35
		Escalation	48%	35
Signature	96%	86%		-10

Figure 19: Improvements in Documentation from Phase One baseline following Sticker

Introduction



Discussion and Learning Points

Handover is a human-dependent process, meaning its quality and content can be variable and context dependent. To maintain high standards of patient safety, standardisation is desirable to ensure reproducible, high quality handovers that facilitate junior medical staff, who move workplace every four to six months. Any attempts at a regional, uniform approach to surgical weekend handover require both excellent buy-in across the five health and social care (HSC) trusts and suitable flexibility to accommodate different working patterns and functions of the various units.

The audit (phase one) gathered baseline quantitative and qualitative data on the nature of surgical weekend handover in the five (HSC) Trusts. Whilst there were many examples of very good handover practice, there were deficits across the sites audited in documentation of key pieces of information; this included antibiotic stewardship, blood testing, DNACPR status and escalation plans.

In phase one, qualitative feedback from doctors in training and nursing staff identified a need for senior decision makers to clearly document their thought processes, so that junior medical staff and multidisciplinary teams can be quickly and reliably updated during out of hours reviews or when a patient became unwell. Building on these findings, and the learning from use of a sticker handover tool in one Trust, a sticker used on Friday ward rounds was proposed to improve compliance with standards of documentation and handover. The sticker itself is inserted into the patient notes and forms part of them; additionally it provides a useful and readily accessible collation of key information.

The results of the rapid cycle quality improvement audits in phase two show significant improvements, with an average of 28% increase in compliance with documentation for all domains excluding doctor's signature. Informal discussion between the project team members and the data collectors in each participating surgical unit allowed review and learning from the PDSA cycles. This informed the reasons for the variable completion rates week to week.

Work and rota patterns of doctors in training had a significant impact on both compliance with the audit standards as well as doctors' ability to collect data week to week. This was the reason given for the lack of data collection in week 11 in Craigavon Area Hospital. More generally, the pattern of variation in compliance seen in Antrim and Craigavon reflected the time available on a busy ward

round to review key treatment decisions and approaches. The busier the ward on a Friday, the less chance the sticker was completed fully.

Local consultant champions had a positive impact through assisting in sticker completion on Friday ward rounds, sharing results at departmental audit meetings and encouraging their consultant colleagues to utilise the sticker handover tool. Unfortunately the Project Team was unable within the project timeframe, to identify senior champions who could support this project in Altnagelvin and the RVH Emergency Surgical Unit.

There were differences in interpretation within the participating units as to how some fields on the sticker were to be completed e.g. 'nutrition', 'antibiotic', 'fluid balance' and 'special instructions' fields. This variation could be explained by the manner in which local data collectors were briefed, as well as local ward practice on the units. Therefore there is a requirement for further review of these specific fields to ensure a consistent understanding of what is being asked. This variation could also be reduced through both Deanery and surgical departmental induction and training, as well as discussion at surgical governance meetings where a definitive agreement can be made on data being recorded.

The handover standards audited have a direct impact on patient care, safety and experience, especially during the out of hours period and at transitions of care. Due to necessity, immediate responsibility for patients and their care changes during their hospital stay, including nights and weekends. This shows that important information regarding patients' overall goals of care should be easily accessible for those involved in delivering care. Patients may deteriorate and decisions about escalating antibiotic therapy or appropriateness of intensive care unit transfer will most likely only have been discussed on ward rounds amongst a small number of people. This can lead to uncertainty within the surgical teams working out of hours, resulting in inappropriate or wrong decisions being made and leading to undignified or futile interventions towards the end of a patient's life.

This handover sticker has the potential to reduce costs and improve patient experience through reduction of unnecessary venepuncture and blood testing over the weekend, by specifying the tests required, thus reducing the practice of 'routine' blood testing. The audit showed an improvement in documentation of specific required blood tests which increased from a baseline of 48% to 86%. This should be explored in further audit and quality improvement work.

Improvement in recording antibiotic plans contributes to improved antibiotic stewardship with reduced chance of antibiotic resistance and reduced costs of parenteral antibiotic administration

including nursing time and likelihood of drug dosing errors. The sticker tool may act as a trigger to prompt decision makers to appropriately convert intravenous antibiotics to oral equivalents and thus facilitate more timely discharge from hospital with reduction in length of stay.

Senior surgical consultants, nursing staff and allied health professionals highlighted that bringing essential information into one area of the patient record allows proactive progression of management plans and clarity of decision making. This is invaluable during busy weekends and was felt to reduce the length of time weekend review teams require to review a patient and their clinical record. It was remarked that patients do not have two days of 'down-time' at the weekend, but, for example, antibiotics can be de-escalated to more appropriate oral equivalents, discharge planning can proceed, and rates of nutritional supplementation increased confidently.

Following the presentation of baseline phase one data at surgical audit meetings there was support from doctors in training and nursing staff for clear discussions and decisions relating to cardiopulmonary resuscitation and escalation of care. Whilst many senior decision makers valued this anecdotally there were some who felt these decisions were 'obvious', a view not shared universally. Clear documentation of these decisions on the handover sticker has advantages in not only ensuring a uniform understanding of the goals of care but also in stimulating, where appropriate, discussions with patients and their families about these issues in-hours during the working week. These discussions should not be left until a patient is critically unwell and therefore unlikely to be able to fully participate in decision making.

The regular Audit and Governance meetings held in each surgical department are a logical forum in which to present and review the results of the sticker handover tool. Several units already have embedded regular VTE and antibiotic stewardship audits, and, following the O'Hara report^[16], it is recommended that regular audits of fluid balance management and documentation should be performed. The sticker handover tool would be an efficient and useful way of capturing basic compliance with documentation and handover standards on a recurrent basis. This would give surgical departments good insight into, and quality assurance of, the holistic care that is being delivered.

The use of small cycles of change provided deeper learning as to the reasons for different rates of compliance with the audit standards in relation to use of the sticker. The rapid cycle audits demonstrate the need to embed good practice through small incremental changes. As previously outlined, rota and workplace issues including ward coverage and senior support and buy-in all had clear impacts on the quality of handover.

This project was based on doctors working in acute surgical units. Any future work to develop handover should involve the wider multidisciplinary team including nursing staff. This may, for example, drive data collection in those units where there is a constant turnover of medical staff and teams, for example in the Emergency Surgical Unit in the RVH (see Phase 1 Report section on 'handover practices and weekend working patterns'). This may have facilitated use and review of the sticker tool in that location.

Permanent staff, including consultant staff, associate specialist grade doctors, and nursing staff would be ideally placed to coordinate sticker audits. It would be instructive to observe whether the same peaks and troughs of sticker completion observed in this project would still occur if the project was managed by permanent staff members. The Ulster Hospital, because of some consultant champions aiding use and review of the sticker tool, saw a more flat profile in the percentage compliance across the twelve weeks of data collection.

Finally, the generic learning from this project into the use of a specific handover tool whose implementation at several sites is reviewed using QI methods could translate well into other clinical disciplines such as medicine, paediatrics and obstetrics.

Recommendations

1. Provide training in handover and its essential components at both Trust and NIMDTA inductions for all doctors in training.
2. Current doctors working in senior or non-training posts should undertake education and awareness of best handover practice as part of their continuous professional development.
3. Senior decision makers present on ward rounds should ensure ward round members have adequate time to document essential handover information for weekend and out of hours teams.
- 4a. The handover sticker (or its components) should be used as a focus for both quality assurance and quality improvement of handover.
- 4b. Results of compliance with essential elements of handover should be presented and discussed at departmental audit and governance meetings.
5. Surgical teams should, where appropriate, be proactive in discussing and documenting with patients their preferred goals of care including decisions about resuscitation and intensive care unit transfer in advance.
6. The handover sticker should be reviewed and modified to improve the clarity of documentation in the following four sections:
 - nutrition
 - antibiotic
 - fluid balance
 - special instructions
7. A guidance document should be provided to ensure a definitive agreement on data being recorded on the surgical sticker handover tool.

References

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Weekly Friday Sticker Completion Audit Proforma

	Week											
	1	2	3	4	5	6	7	8	9	10	11	12
	n=											
Sticker Present in Notes?												
Patient status section completed?												
Suitable for discharge section completed?												
Diagnosis section completed?												
Post op day/surgical procedure section completed?												
Radiology section completed?												
Bloods section completed?												
Antibiotics section completed?												
IV Fluids section completed?												
Nutrition section completed?												
Special Instructions section completed?												
Issues/plan section completed?												
DNAR section completed?												
Escalation to HDU/ICU section completed?												
Signed by Doctor?												
Grade or GMC Number recorded?												



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