OUT OF HOURS Transfer Review 2019: A Quality Improvement Project

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Background

To ensure patient safety and continued care whilst maintaining patient flow throughout the hospital from the admissions unit to the wards, it is expected that each medical patient transferred between wards out of hours is reviewed by a member of the Hospital At Night team: the so-called "transfer review". Through our experiences we were concerned that transfer review is currently:

1) **Inconsistent –** with no clear instructions as to what to include.
2) **Inefficient -** lots of time spent by staff reviewing well patients, detracting from time that could spent responding to unwell or deteriorating patients.

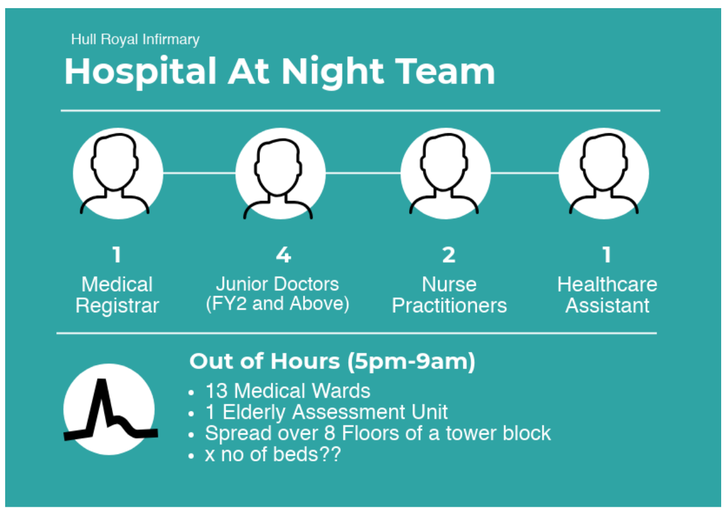


Figure 1 – HRI Hospital At Night Team – General Medicine

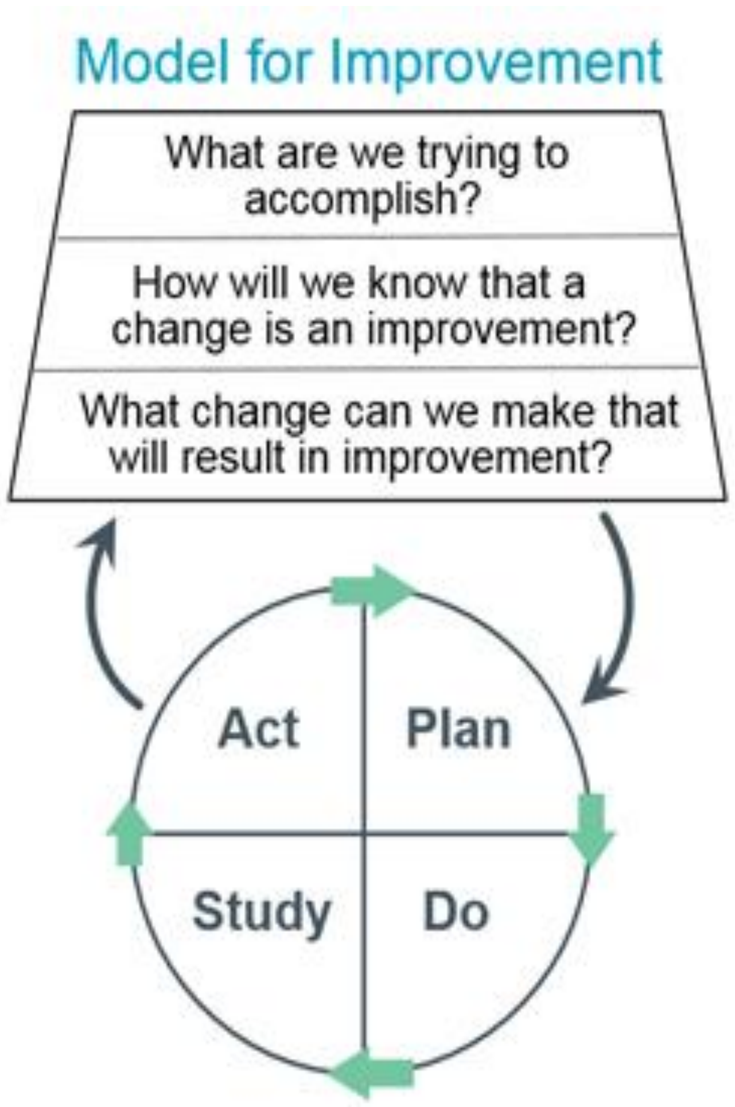


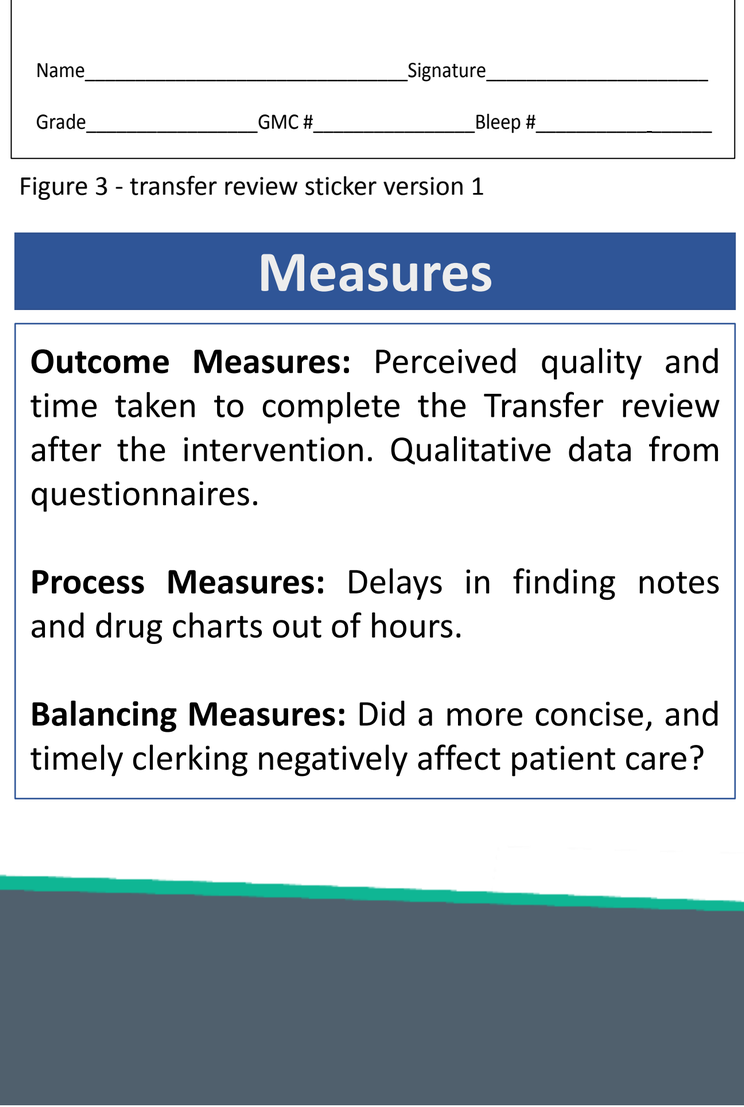
Figure 2 – Quality Improvement methodology – Plan Do Study Act

The Intervention

We aimed to improve ***consistency***, ***quality*** and ***efficiency*** of the transfer review by devising a sticker to act as prompt/proforma.

Methods – PSDA cycle 1

- We piloted the sticker on three separate night shifts, involving three different Hospital At Night teams between 02/01/19 and 08/01/19.
- Staff on duty were asked to completed a pre-intervention questionnaire to establish current practice and opinion at the 9pm handover.
- They were then asked to use a sticker in place of their standard practice, but advised to complete a full review according to their clinical judgement where appropriate.
- On completion of their shift staff were asked to complete a post-intervention questionnaire, designed to assess the impact of the sticker on quality of transfer review & time taken to complete transfer review. It asked whether a sticker would be of benefit if rolled out long-term, along with any suggested changes to the sticker.
- The data collected was Qualitative in nature.



Date_____Time_____ HEY_____

Patient Name_____

Date of Admission_____Current Ward_____DOB_____

Current active problems_____

_____

_____

Key investigation findings_____

_____

_____

NEWS_____(>5 = full review)

Clinical condition stable? (Y/N)_____(No = full review)

Nursing concerns? (Y/N)_____(Yes = full review)

Drug card review ☐

VTE Completed ☐

Ceiling of care documented ☐ _____

Resuscitation status documented ☐ _____

Name_____Signature_____

Grade_____GMC #_____Bleep #_____

Figure 3 - transfer review sticker version 1

Measures

Outcome Measures: Perceived quality and time taken to complete the Transfer review after the intervention. Qualitative data from questionnaires.

Process Measures: Delays in finding notes and drug charts out of hours.

Balancing Measures: Did a more concise, and timely clerking negatively affect patient care?

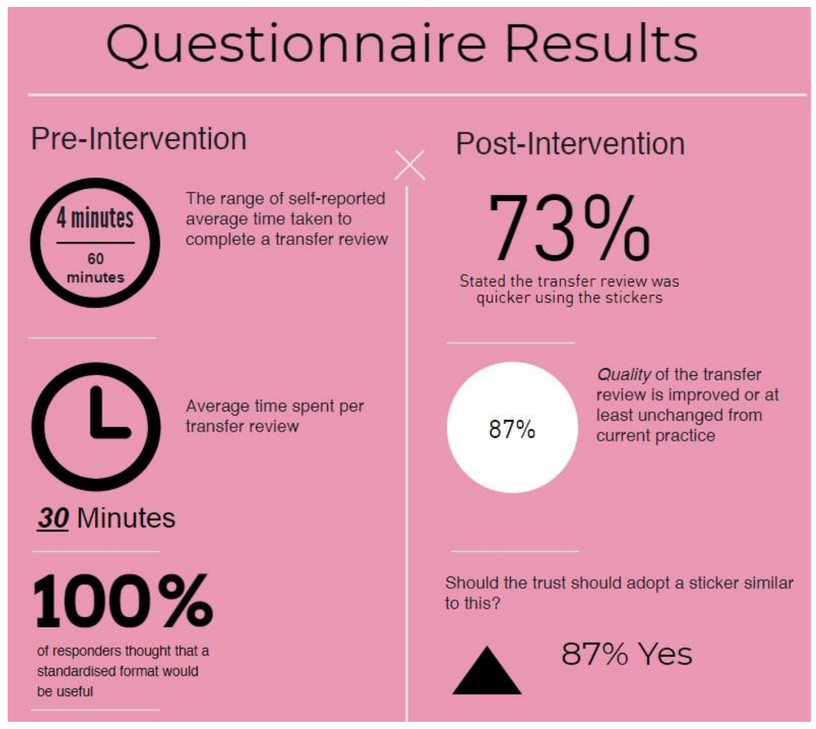


Figure 5 – Results summary

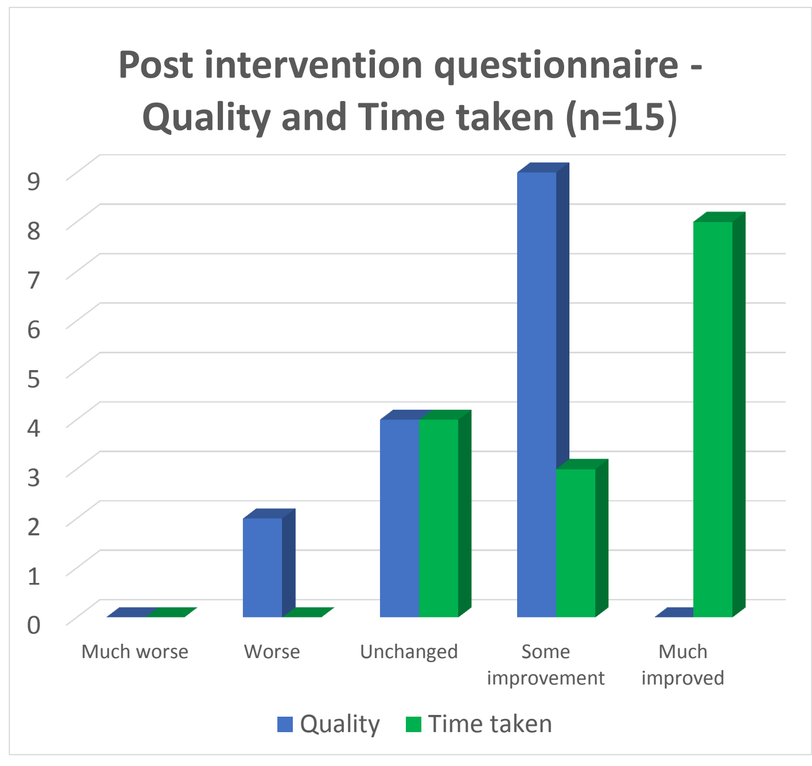


Figure 6 – Post intervention questionnaire results

Discussion

Analysis of the qualitative data from PDSA cycle 1 suggests that a standardised approach to the out-of-hours transfer review may make a real difference to the efficiency and effectiveness of the Hospital At Night team. A dominant theme to come out of this project was the perceived absence of a formal induction regarding Hospital At Night in general and the transfer review in particular. This is also something we hope to address as a group in future.

PDSA cycle 2

We have made some changes to the content of the sticker, after taking on-board feedback from our questionnaires, supervising consultant Dr Middleton & Dr Sega Pathmanathan (clinical lead for Hospital At Night).

We are planning PDSA cycle 2 with the updated sticker to reassess for impact on junior doctor efficiency out of hours and patient safety before engaging governance, seeking to role out this intervention permanently in the medicine directorate trust-wide.