

## TRANSITION OF CARE: USE OF HANDOVER NOTES IN DOP INPATIENTS



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### BACKGROUND

The points of handover when patients move between clinicians are known as 'transitions of care' and these are recognised as times of high risk for patients as there is an increased risk of information being miscommunicated (World Health Organisation, 2016). Effective communication between clinicians when these transitions occur is essential to ensuring safe, continuous, and coordinated care (RCPsych, 2017; NICE Guidelines, 2021). They are key safety and quality issues especially for patients with complex needs. Poor documentation can lead to discharge delays, risks associated with inadequate or reduced care coordination, lack of availability of important diagnostic results and medication errors.

### AIMS

To improve the effectiveness and timeliness of clinical handovers between clinicians

### COMPARISON STANDARD (BEST PRACTICE/GOLD STANDARD)

I-PASS handover includes five major elements regarded as important for every handover—illness severity, patient summary, action list, situation awareness/contingency planning and synthesis by receiver.

### METHODS

NCHDs have a 'changeover' every six months (January and July). The outgoing NCHDs were notified to write a handover note in the clinical files of the DOP inpatients. They were given several reminders and an example on how to write a handover. The handovers were based on the PASS mnemonic (patient summary, action list, situation awareness, synthesis (Australian Commission on Safety and Quality, 2017). The consultants were informed by email of the planned audit and all assented.

### RESULTS OF 1<sup>ST</sup> AUDIT CYCLE

At the time of the first audit (January 2021) there were 29 inpatients. 8 were new admissions and so did not qualify for the audit.

Of the remaining 21 inpatients, 12 had handover notes with patient's history, diagnosis, risks identified and management plan (57% compliance). Three sectors had 100% compliance.

### INTERVENTION

I presented and discussed findings of the audit with colleagues on many occasions explaining the importance and benefit of this easy to apply method that can increase safety and reduce risk during changeover of NCHDs. I also printed I-PASS handover sheet and attached it to the front of the chart to make it easier for my NCHD colleagues to complete.

### RESULTS OF RE-AUDIT

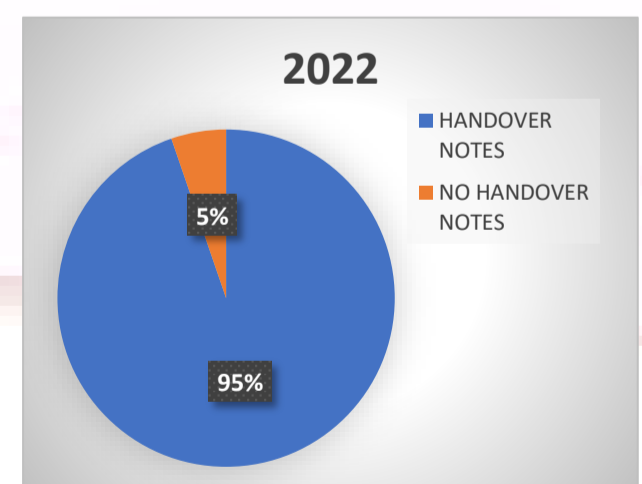
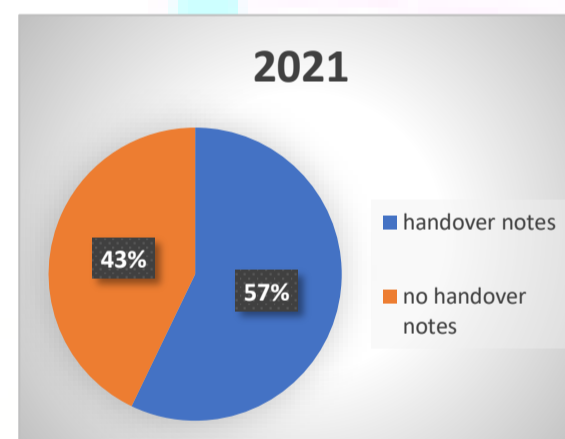
At the time of the reaudit there were 21 patients in the DOP. 2 did not qualify as NCHD was staying with the team for another 6 months. From remaining 19 patients, 18 had handover notes completed according to I-PASS template showing 95% of compliance.

### CONCLUSIONS

Poor documentation is a safety and quality issue. Although no single initiative has been found to address the issues in all contexts, handover notes support effective communication at transition points including clinical synopsis, alerts, recommendations for management and discharge plans. The current I-PASS handover is a simple tool to structure the handover.

Although initial compliance was 57% after teaching and familiarizing NCHDs and consultants with the benefits and use of I-PASS handover notes year later reaudit showed significant improvement as compliance was 95%.

Clinical handovers are a low-cost method of improving the quality of health service provision. This is very important as reduced quality of record-keeping may lead to less informed engagement between the new NCHD and the patient.



### REFERENCES

Transitions of Care: World Health Organisation, 2016.

Managing transitions when the patient has an eating disorder RCPsych College Report, 2017.

Improving documentation at transitions of care. Australian Commission on Safety and Quality in Health Care, 2017.

Transition between community and inpatient mental health settings. NICE Guidelines, 2021.