Yale NewHaven Health Bridgeport Hospital

103th Scientific Assembly & Annual Meeting
RSNA

CLINICAL AUDIT OF STANDARDIZED HAND OVER PROCESS IN INTERVENTIONAL RADIOLOGY :

IMPLEMENTATION OF A NEW TOOL FOR IMPROVING COMMUNICATION AND PATIENT SAFETY

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CLINICAL AUDIT

INTRODUCTION

- Hand over is the process of transferring information and responsibility from one provider to another
- Hand over is an old tradition among residents
- Few radiology residency programs formally teach hand over
- Little research has examined the content and effectiveness of the hand over process

RESULTS OF 1ST AUDIT

- Audit of resident hand over of 16 image guided procedures during a 4-week period in September 2016
  - The hand over was unstructured, variable and informal
  - The hand over lacked pertinent clinical information
  - A total of 6 adverse events were observed

METHODS

Topic: clinical audit of standardized hand over process in interventional radiology

Initial audit: September 2016

Data analysis: November 2016

Creation of proforma checklist

Use of the proforma in practice

Re-audit and data analysis: February 2017

METHODS

- Based on the results audit we developed a sign out sheet containing pertinent clinical information:

Sample

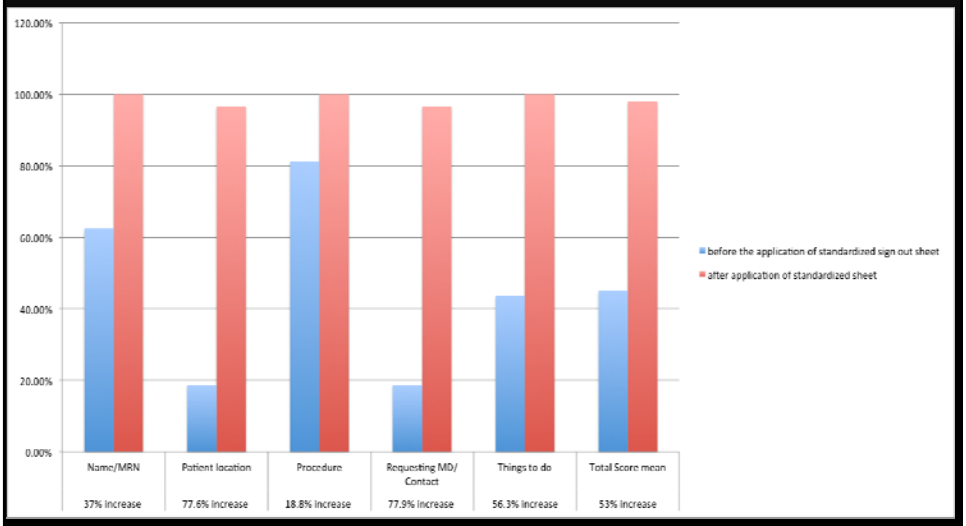
Sign out sheet

Name/MRN	Location	Procedure	MD/Contact	Notes	Things to Do
John Doe MR# 123456	North west 7 727-1	CT guided Pelvic abscess drainage	Dr Smith Pager# 3150	Fe on parenteral abscess · AVSS · WBC 17.0	☐ Consent ☐ NPO - midn ☐ Hold Heparin
John Doe MR# 123456	SICU Bed 6	Angiography + Embolization Anus GI bleed	Dr Jones Pager# 7130	· Hypotensive · BRBPR x4 · Hb 7.2	☐ CTA Abdomen/pelvis ☐ Consent ☐ PT/INR
John Doe MR# 123456	West ward 8 832-1	US guided right thoracentesis	Dr Adams Pager# 4503	· large effusion · Dyspnea	☐ Consent ☐ PT/INR ☐ Labs for Fluid
John Doe MR# 123456	West ward 3 931-B	S/P TACE For HCC	Dr Jordan Pager# 2483	· Diet as tolerated · PRN morphine	☐ Check NE notes ☐ Address pain control ☐ Discharge orders

RESULTS OF RE-AUDIT

- Re-audit of resident hand over of 30 image guided procedures during a 3-months period after applying the sign out checklist
  - ➢ Significant improvements in all categories
  - ➢ No adverse events

RESULTS OF RE-AUDIT



DISCUSSION

- Errors in communication are the most common preventable cause of disability and death in hospitals
- The main objective of resident hand over is the accurate transfer of information about the patient's current state and his or her plan of care
- Use of the new proforma checklist significantly improved the quality of hand over
- Improvements are a result of a completion of an audit process

CONCLUSION

- Hand over between residents could be haphazard, unstructured and informal without a standardized process in place
- Utilizing a proforma checklist significantly improves the quality of hand over and eliminates adverse events