Emergency Care Handover (ECHO)

Mark Sujan, Matthew Cooke, Peter Spurgeon
Warwick Medical School

Steve Cross, Simon Horniblow, United Lincolnshire Hospitals
Larry Fitton, Michelle Rudd, Oxford John Radcliffe
Pete Chessum, Heart of England
Matthew Inada-Kim, Royal Hampshire

THE UNIVERSITY OF WARWICK

NHS National Institute for Health Research

Funding + Participating Sites

- Project funded by NIHR SDO programme for 18 months (April 2011 – September 2012)
- 3 A&E departments (Boston, Heartlands, John Radcliffe)
- 2 Ambulance Services (WMAS, SCAS)

NHS National Institute for Health Research

Aims & Objectives

- To describe handover within the emergency care pathway
- To identify the potential for harm of handover failures
- To explore common organisational deficiencies and the impact of the organisational model of emergency care on the quality of handover

NHS
National Institute for Health Research

Why this project?

- Focus on pathway & inter-organisational, inter-departmental, inter-professional handover
  - Different cultures, language & terminology, goals & expectations
  - Broaden the focus towards a system-based approach ("beyond standardisation")
- Improvement science & safety engineering methods
  - Process mapping, Failure Mode & Effects Analysis
- Qualitative exploration of organisational factors
  - Semi-structured interviews

NHS
National Institute for Health Research

WP1: Potential for Harm

- Systematic description of handovers within the EC pathway
  - Observations, process mapping sessions
- Frequency assessment, communication styles
  - Observation + audio-recording of 3 types of handover (n=45 / handover type and site)
  - Post-handover questionnaire
- Systematic risk assessment
  - FMEA sessions
  - Contextualised failure trajectories (failure narratives)

NHS National Institute for Health Research

WP2: Exploration of Organisational Factors

- Exploration of:
  - Common organisational deficiencies
  - Local practices
  - Organisational model of emergency care

- Semi-structured interviews
  - Thematic analysis
  - N=10 - 15 / site

NHS National Institute for Health Research

WP3: Recommendations

- Integration of findings from systematic risk assessment and organisational factors
  - Thematic analysis
  - Comparison with literature
  - Focus group (July 16th)

NHS National Institute for Health Research

WARWICK

Emerging Results - FMEA

- No pre-alert for resuscitation patients
- Resuscitation handover – getting hands-on too soon
- Ambulance crew waiting in queue
- Full story not communicated
- Referral not accepted

NHS
National Institute for Health Research

Emerging Results - Themes

- Influence of national targets on local practices (-> Matthew's presentation)
- Maintaining the full story (social issues, handover without notes)
- The patient stuck in the system (allocation of responsibility)

NHS National Institute for Health Research

Acknowledgements

This project was funded by the National Institute for Health Research Health Services and Delivery Research (NIHR HS&DR) programme (project number 10/1007/26). Visit the HS&DR website for more information.

The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR programme, NIHR, NHS or the Department of Health.

NHS
National Institute for Health Research

Comments & Feedback

NHS
National Institute for Health Research

WARWICK