Handover ED to AMU

Arne Rose
Consultant EM / PEM
Heart of England Hospitals

“I felt the baton, but...” Dwain Chambers

NCEPOD – Emergency Admissions (2007)

- Only 35 % of hospitals had an agreed handover protocol
- Of those who did have, 15% of their clinicians where not aware of it

Handover ED – AMU. The Problems

- Large volume of patients, often complex
- Many fairly low acuity, some very sick
- Potential for deterioration
- Both areas a communicative minefield
- 2 large teams – docs & nurses
- Doctors are bad at handover
- Parallel handovers nurses & clinicians
- Time taken for handover

The Situation at Heart of England...

Solihull: MIU with a small AMU

Co-ordinator to co-ordinator (phone), often senior face to face

Good Hope: DGH

Electronic on ED/AMU system, after 2100 bleep to Med SpR

Heartlands: large teaching hosp. with super-specialties

1 dedicated phone line, junior clinician to AMU co-ordinator (nurse) – soon to go online

Pros & Cons

Solihull – verbal & face to face

+ low threshold, easy communication	- response is person specific, not standardized

Good Hope – online & safety net overnight

+ no refused referrals, very quick	- safety?? / admission rate?

Heartlands – phoneline & referral protocol

+ standardized practice, capture of MEWS etc.	- lots of arguments and delays, response person specific

Safe handover to AMU – what does ED want?

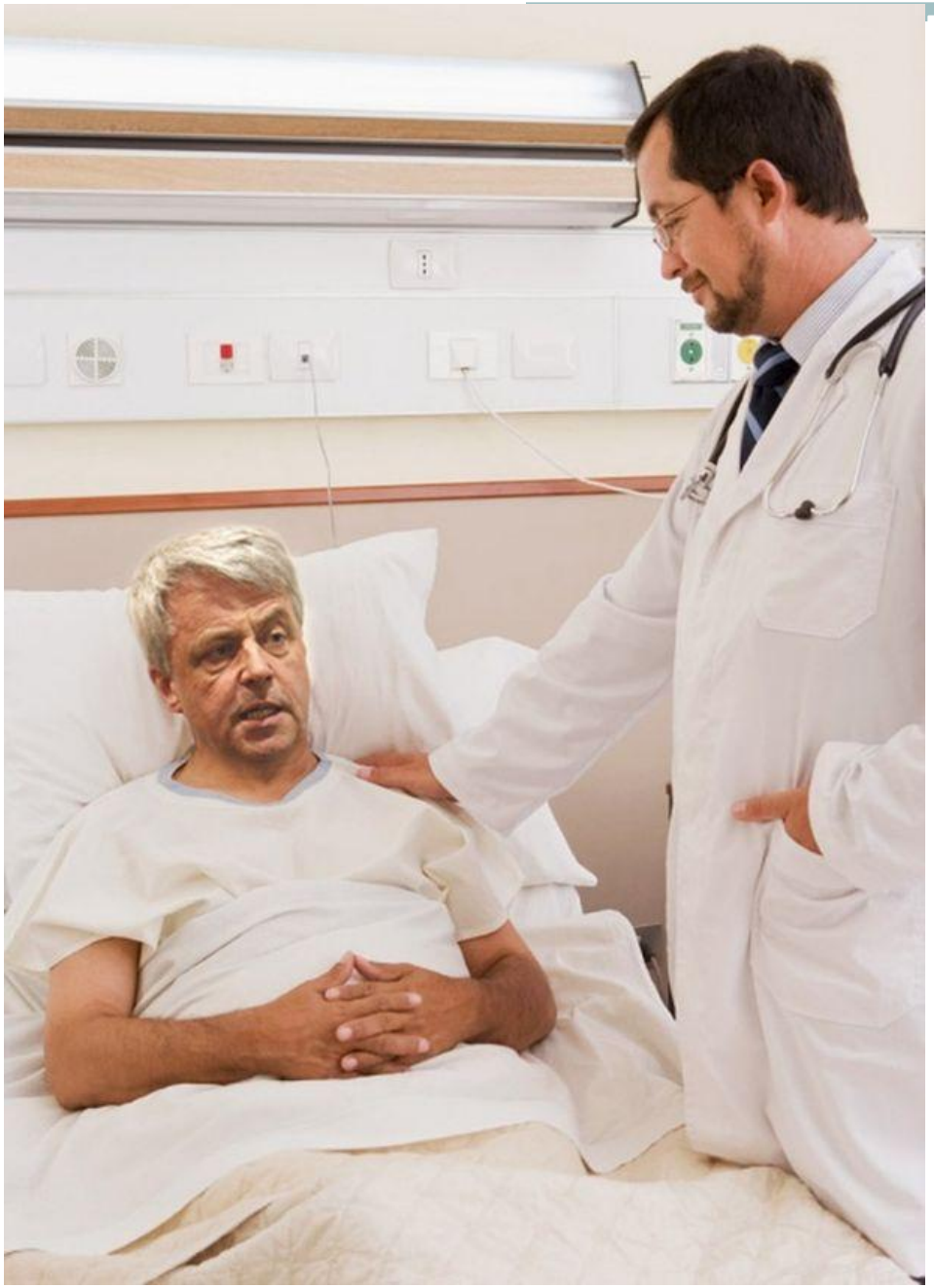
- Safe
- Fast
- Consistent response
- Prioritization
- Consistent (maximum) time interval
- Avoid blockage

Safe handover from ED – what does AMU want?

- Safe
- “appropriate” - No specialty outliers
- Highlight the sick ones
- Highlight outstanding investigations
- ‘Who can go home today?’
- No task overload
- Evenly spread workload

The paediatric experience

- SUI 2008
- Communication / handover failure
- Process work: process mapping, streamlining
- Work on safety and co-operation
- Referring to SpR only
- Nurse rotation
- Electronic alert system
- Electronic ED pt management system in Paeds
- Only 3 types of patients: opinion, short-stay, admission
- Handover sheet



Handover – which patients?

- Think of streams!!!
- Opinion (minimize) - 2-4 hours
- Observation / short stay (4-24 hours)
- Admission (> 24 hours)
- Complex elderly (different needs)
- Pts for specialty areas (stroke unit, CCU, heart failure, elderly)

Handover - How?

- Human factors are important!
- Buy-in from both parties
- Works better when people know each other (rotation, working group)
- Works better on a senior level – easy access to senior opinion
- People like to ‘handle’ things (white board, paper, screen) – manual & visual cues
- Have a dynamic handover overview sheet (electronic)

Handover - What?

- Demographics
- Diagnosis + max. 2 differentials
- Opinion- observation - admission
- Problem list
- MEWS etc.
- Tests to chase
- EDD & discharge criteria
- Social state – in the elderly

When?

- As early as possible (task management)
- Early Senior review crucial
- …BUT system needs to be dynamic, so important changes can be documented.
- Have a MEWS trigger and a code red
- Have obs close to transfer
- Have a completion / hand-off / sign-on function

Suggested Principles

- Agree on common standards (with SAM)
- Think about human factors big time
- Go for senior to senior clinician for sick ones and the opinion pts
- Online for the rest?
- 3-5 types of patients – different queues / areas
- Streaming
- Agree on maximum transfer / handover time??
- Have a safety net (code red / overnight)

Suggested Common Standards

- Unified way of referring (SBAR or similar)
- Unified mandatory items:
- MEWS or similar
- Diagnosis / Differentials
- Problem list
- Plan
- Senior sign-off function
- EDD
- No hand-backs / arguments

- Dynamic system

Please ask me some questions.
Thank you

?