

Intraoperative Handover Audit

M. A. Radwan, J. Rajagopalan

¹ Clinical fellow of Anaesthesia at Manchester University Foundation trust, Manchester ,UK

² Consultant of Anaesthesia at Manchester University Foundation trust, Manchester ,UK

Background

Intraoperative handovers are a routine and an integral part of anaesthetic practice, and failures in communication may lead to morbidity and mortality.

Methodology

117 anaesthetic Recall charts were checked between April 2021 and June 2021 .

In addition to an online survey which was distributed to the staff members of the MFT anaesthetic department (OXFORD Road Site).

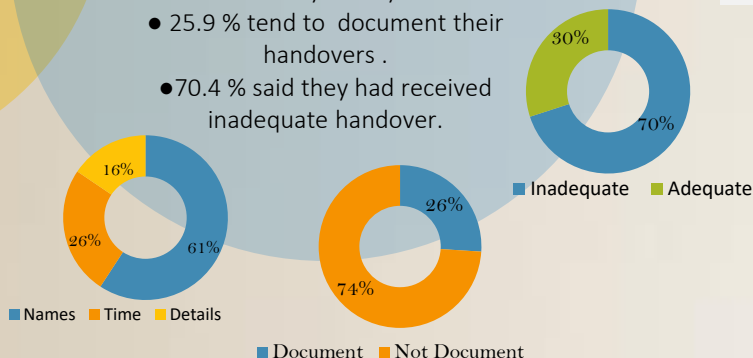
Objectives

Our aim was to determine the quality of the current intraoperative handover documentation practices and compare this to AAGBI and RCOA practice standards.

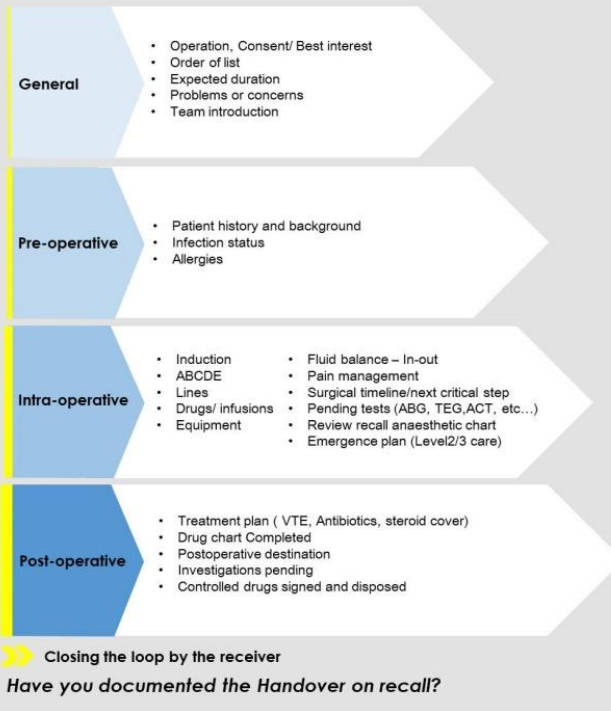
Results

Out of the 117 charts

- 61% had names of staff taking over.
 - 26% had the handover timing.
 - 16 % had handover details.
- The Staff survey mainly showed :
 - 25.9 % tend to document their handovers .
 - 70.4 % said they had received inadequate handover.



Give Proper Informative Patient Handover



Conclusion

Increased awareness in handover practices will hopefully encourage action in improving potential patient safety issues.

As the current method of handovers does not ensure staff adherence to a standardized handover technique, we have designed and introduced a laminated handover checklist in each operating room as an “aide-memoire” and a re-audit is planned to be done in 3-6 months afterwards.