

Handover in ICU- QI Project

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Abstract

Introduction: Effective communication during patient handover is essential to ensure safety, continuity, and quality of care in the ICU. Lapses in handover processes have been associated with medication errors, omissions, and adverse events. Recognizing these risks, our unit initiated a structured quality improvement project aimed at optimizing ICU handovers through targeted interventions.

Methods: A multidisciplinary team employed Plan-Do-Study-Act (PDSA) cycles to iteratively test and implement changes. Interventions included the introduction of a standardized SBAR handover template, designated protected handover time and space, senior clinician involvement, and environmental modifications to reduce distractions. Data collection involved direct observation over six months, focusing on key outcome and process measures: interruptions, start times, staff attendance, and information completeness.

Results: The baseline data indicated that only 55% of handovers were interruption-free, with staff attendance and punctuality at 92.5%, and information completeness at 85%. Post-intervention, interruptions decreased to 12.5%, staff attendance and start times improved to 97.5%, and information transfer accuracy increased to 90%. These results affirm the impact of structured communication and environmental controls.

Discussion: The project demonstrates that systematic interventions can significantly improve ICU handover quality. Standardization via SBAR, protected time, leadership, and minimization of distractions contribute to safer patient care. Challenges included staff adaptation and sustainability, which will be addressed through ongoing training and audits.

Conclusion: Structured, standardized handover processes in the ICU are effective in reducing interruptions, improving information transfer, and enhancing team communication. Embedding these practices as part of routine clinical workflows supports ongoing patient safety and quality of care.

