Handover & transfers of care

Step-by step measurement guide

For people who want to measure improvement

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Delayed discharges Home on time

Avoidable harm Harm free care

Frustrated staff Job satisfaction

Complaints A great reputation

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How do we know our change efforts are delivering improvements?

http://www.youtube.com/watch?v=Za1o77jAnbw

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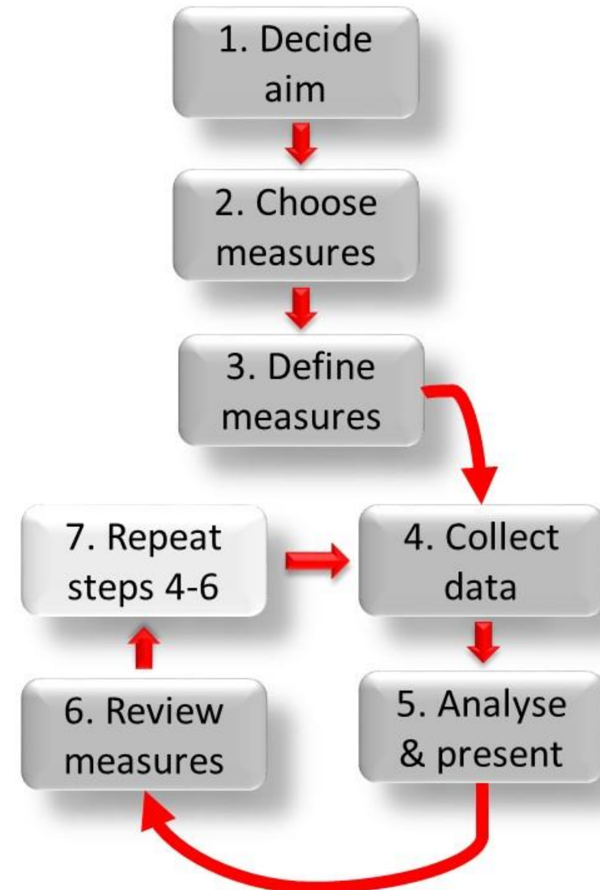
7 steps to measurement



7 Steps to Measurement, Measurement for Improvement, NHS Institute for Innovation and Improvement 2011

Step 1 – Decide AIM

Structured transfer of care/handover

in ……………

team/service

right each time by

…………

Have you involved your team?
Did you included a patient in your team?
Do you KNOW what' matters to them?

Steps 2 to 3 - Choose & define measures

Success =
Observed handovers

- Right people
- Right place
- Right time
- Right information
- Right record
- Right action
- Right patient outcome

Steps 4 to 7 - Collect, analyse, review

Plot results
e.g. observe 5 transfers/week

- 4 weeks to generate baseline (20 data points)
- Continue collecting to maintain performance and explore reasons if not

* This will tell you whether the changes you have made have improved transfer of care/ handover in YOUR service

A good handover….

- ensures changes in clinical teams are not detrimental to quality of care
- improves communications between all in care team, including patients and carers
- identifies unstable/unwell patients, for optimal, clear and unambiguous management
- improves efficiency of patient management by clear baton-passing
- improves patient experience and confidence
- Offers teaching/learning opportunities for trainees to observe appropriate role models

Adapted from the Royal College of Physicians, Acute Care Toolkit: 1 Handover (2011)

Choose your 1st improvement focus*

Right Information
Standardised protocol – correctly use the right process, capture and pass on right information in ……………..

team/service every time by

…………

Steps 2 to 3 - Choose & define measures

Success =
Observed handovers

- Used right template
- Communicated effectively
- Recorded critical information in notes

Steps 4 to 7 - Collect, analyse, review

Plot results
e.g. 5 transfers/week

- 4 weeks to generate baseline (20 data points)
- Continue collecting until small scale tests of change result in sustained improvement i.e. a reliable handover every time

* Example from NSW [New South Wales] *Health Implementation Toolkit, Standard Key Principles for Clinical Handover* http://www.archi.net.au/resources/safety/clinical/nsw-handover/standard

- Is time set aside for multiprofessional handover in current working practice?
- Are checklists in place for handover process?
- Is standardised proforma used for communicating handover?
- Is handover process included in training/induction?
- Any serious incidents attributed, wholly/partly, to poor communication/handover?
- Is system of handover audited?

Adapted from the Royal College of Physicians, Acute Care Toolkit: 1 Handover (2011)

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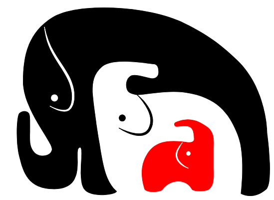
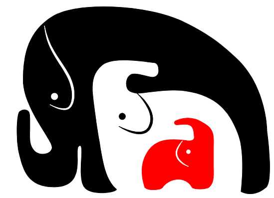
Small scale tests of change (PDSA)
(or ‘Eating the elephant one bite at a time!’)



PLAN		DO	STUDY	ACT
Choose your 1st change intervention	Choose & define your measure/s	Collect	Analyse & review	Examples
Standard information template to capture right information ……………. team/service every time by …………	**Success =** Team consensus on ‘must have’ information items	**Dot voting[1]** For all items listed by team	**Feedback results** i.e. All items for inclusion	Include all items voted for in initial form design
	Success = No. of form design features that meet industry standard test for usability	**Apply tests** (established industry standard) to information template/ form	Analyse results of tests and make recommendations for improvement	Make content & design changes in line with recommendations
	Success = Time taken to complete No. of critical points captured i.e. accuracy, completeness	**Undertake user testing** Staff in side room complete template for case scenario/s	Capture results of observations • 5 staff (different experience levels)	Undertake small scale tests 1,3,5 etc. Use simulation to reduce risk in early testing. Extend tests to small clinical area and then more conditions (e.g. at night, at weekend, with agency staff) Repeat amend & test cycle >80% reliability in use

[1] See page 9

Small scale tests of change (PDSA)
(or 'Eating the elephant one bite at a time!')



PLAN		DO	STUDY	ACT
Choose your 2nd change intervention	Choose & define your measure/s	Collect	Analyse & review	Examples

PLAN

Choose your 2nd change intervention

Use of Structured communication tool

to communicate information and escalate concerns effectively in

……………..

team/service every time by

…………

Choose & define your measure/s

Success =
No. of staff
- attending training
- OR e-learning
- OR team brief

Success =
% handovers observed where SBAR[1] used effectively*

*Define in advance

DO

Collect

Numbers trained in use of SBAR[1]

No. done correctly
Sample = 1 shift change/ ward/ team.
NB vary sampling times

Observed barriers

STUDY

Analyse & review

Plot results
e.g. no of staff trained (cumulative)

Plot results
e.g. 5 transfers/week
- 4 weeks to generate baseline (20 data points)
- Continue collecting until small scale tests of change result in sustained improvement

Explore
ways to overcome barriers

ACT

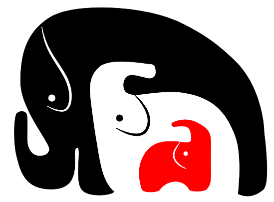
Examples

Behaviour change is your ultimate goal!

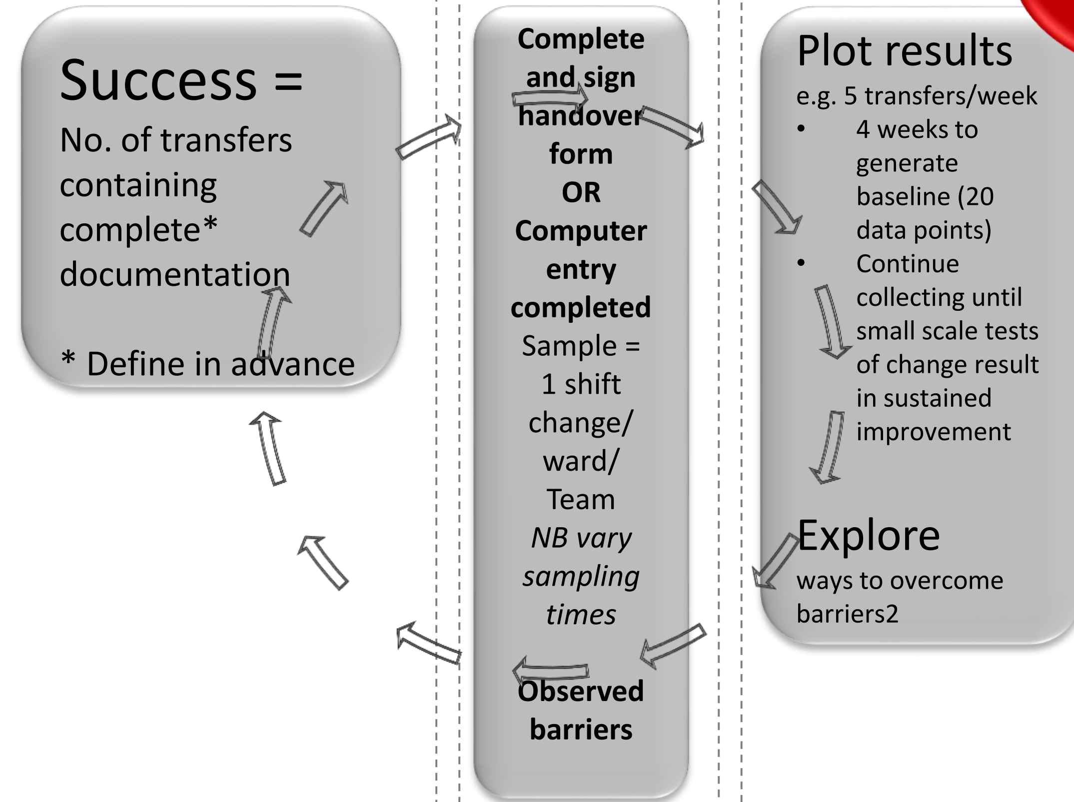
Revise training, SBAR prompts, feedback etc. to overcome barriers and achieve >80% reliability in communication and escalation

[1] See page 9

Small scale tests of change (PDSA)
(or 'Eating the elephant one bite at a time!')



PLAN		DO	STUDY	ACT
Choose your 3rd change intervention	Choose & define your measure/s	Collect data	Analyse & review	Examples



Safety feature: Information, there when you need it!

Include (file) handover sheet with other routinely accessed record (nursing or clinical record)

Remove barriers to computer data access

Create handover template for computer that doubles as record

Repeat test cycle >80% reliability in storage and retrieval

Choose your 2nd improvement focus*

Right people
Nominate a leader for each transfer of care

Right people
Involve appropriate people at all times

Right space
Place/room/phone/privacy

Right Information
Standardised protocol – correctly use the right process, capture and pass on every time

Right commitment
Valuing transfer of care as an essential part of care

Right time
Part of daily schedule/work plan

Right People

Leader is always known to all at handover

Relevant staff are always present and able to participate in every handover in ……….. Team

* Checklist adapted from the NSW [New South Wales] *Health Implementation Toolkit, Standard Key Principles for Clinical Handover*
http://www.archi.net.au/resources/safety/clinical/nsw-handover/standard

Steps 2 – 7

Apply measurement steps to second improvement focus

What other change is needed in your local practice?

What change interventions can you test?

Resources

Measurement Webex, Nicola Davey, Sign Up to Safety Campaign

http://tinyurl.com/SU2Smeasure

Safe Communication: *Design, implement and measure: A guide to improving transfers of care and handover* http://www.england.nhs.uk/signuptosafety/sip-resources/

7 Steps to measurement, Mike Davidge, NHS Institute for Innovation and Improvement http://www.youtube.com/watch?v=Za1o77jAnbw

SBAR resources www.institute.nhs.uk/SBAR

Royal College of Physicians Acute Care Toolkit 1: Handover https://www.rcplondon.ac.uk/resources/acute-care-toolkit-1-handover

IMPLEMENTATION TOOLKIT Standard Key Principles for Clinical Handover, NSW Health, 2009 http://www.aci.health.nsw.gov.au/resources/acute-care/safe_clinical_handover/implementation-toolkit.pdf

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