Handover & transfers of care
Step-by step measurement guide

For people who want to measure improvement
Author: Nicola Davey
August 2015

Delayed discharges  Home on time
Avoidable harm      Harm free care
Frustrated staff    Job satisfaction
Complaints           A great reputation
How do we know our change efforts are delivering improvements?

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

7 steps to measurement

1. Decide aim
2. Choose measures
3. Define measures
4. Collect data
5. Analyse & present
6. Review measures
7. Repeat steps 4-6

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

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
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

- 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?

* 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

Adapted from the Royal College of Physicians, Acute Care Toolkit: 1 Handover (2011)
Small scale tests of change (PDSA) (or ‘Eating the elephant one bite at a time!’)

**PLAN**

Choose your **1st change intervention**

- Standard information template to capture right information every time by

---

**DO**

Choose & define your measure/s

- **Success** = Team consensus on ‘must have’ information items
- **Success** = No. of form design features that meet industry standard test for usability
- **Success** = Time taken to complete No. of critical points captured i.e. accuracy, completeness

Collect

- Dot voting\(^1\)
  - For all items listed by team
- Apply tests (established industry standard) to information template/form

Analyse & review

- Feedback results i.e. All items for inclusion
- Analyse results of tests and make recommendations for improvement
- Undertake user testing
  - Staff in side room complete template for case scenario/s

Capture results of observations

- 5 staff (different experience levels)
- Repeat amend & test cycle

**ACT**

Examples

- Include all items voted for in initial form design
- Make content & design changes in line with recommendations
- 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)

---

\(^1\) See page 9
Small scale tests of change (PDSA) (or ‘Eating the elephant one bite at a time!’)

<table>
<thead>
<tr>
<th>PLAN</th>
<th>DO</th>
<th>STUDY</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choose your 2nd change intervention</td>
<td>Choose &amp; define your measure/s</td>
<td>Collect</td>
<td>Analyse &amp; review</td>
</tr>
<tr>
<td>Use of Structured communication tool to communicate information and escalate concerns effectively in team/service every time by</td>
<td>Success = No. of staff • attending training • OR e-learning • OR team brief</td>
<td>Numbers trained in use of SBAR(^1)</td>
<td>Plot results e.g. no of staff trained (cumulative)</td>
</tr>
<tr>
<td></td>
<td>Success = % handovers observed where SBAR(^1) used effectively*</td>
<td>No. done correctly Sample = 1 shift change/ward/team. NB vary sampling times</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>*Define in advance</td>
<td>Observed barriers</td>
<td>Explore ways to overcome barriers</td>
</tr>
</tbody>
</table>

\(^1\)See page 9
Small scale tests of change (PDSA) (or ‘Eating the elephant one bite at a time!’)

<table>
<thead>
<tr>
<th>PLAN</th>
<th>DO</th>
<th>STUDY</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choose your 3rd change intervention</td>
<td>Choose &amp; define your measure/s</td>
<td>Collect data</td>
<td>Analyse &amp; review</td>
</tr>
<tr>
<td>Success = Documented transfer of care No. of transfers containing complete* documentation Accessible to every time by</td>
<td>Complete and sign handover form OR Computer entry completed Sample = 1 shift change/ward/Team NB vary sampling times</td>
<td>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 Observed barriers</td>
<td>Explore ways to overcome barriers</td>
</tr>
</tbody>
</table>

* Define in advance

**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**
- Leader is always known to all at handover
- Relevant staff are always present and able to participate in every handover in ............ Team

**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

---

* 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


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