GROUP TRAINING

for ward managers & ward professionals

MAP4E 16/1/KA202/23016
The project has been supported by the European Commission.

M1-SMALL GROUPS TRAINING

Ward managers & Ward professionals

AGENDA

- Basic on Handover
- Types and tools of handover
- Key aspects for handover good practices
- Conditions for successful handover implementation at Ward/department level
- Case studies, case reports
- Role plays and situational games

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Basic on Handover

Handover
What are we talking about?

- "..the process of passing patient-specific information from one caregiver to another, from one team of caregivers to the next, or from caregiver to the patient and family for the purpose of ensuring patient care continuity and safety." WHO

- The transfer of information (along with authority and responsibility) during transitions in care; to include an opportunity to ask questions, clarify, and confirm (AHRQ-TeamSTEPPS)

- 'the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.' (Australian Medical Association in their 'Safe Handover: Safe Patients' guideline . AMA, 2006)

Handover (or Hand-off)
Why is important?

- Handover communication might not include all essential information
- Gaps in communication can cause serious adverse events
- Breakdown in communication was the leading root cause of sentinel events reported to the Joint Commission
- Promotes a teaching learning environme
- Facilitates patient involvement

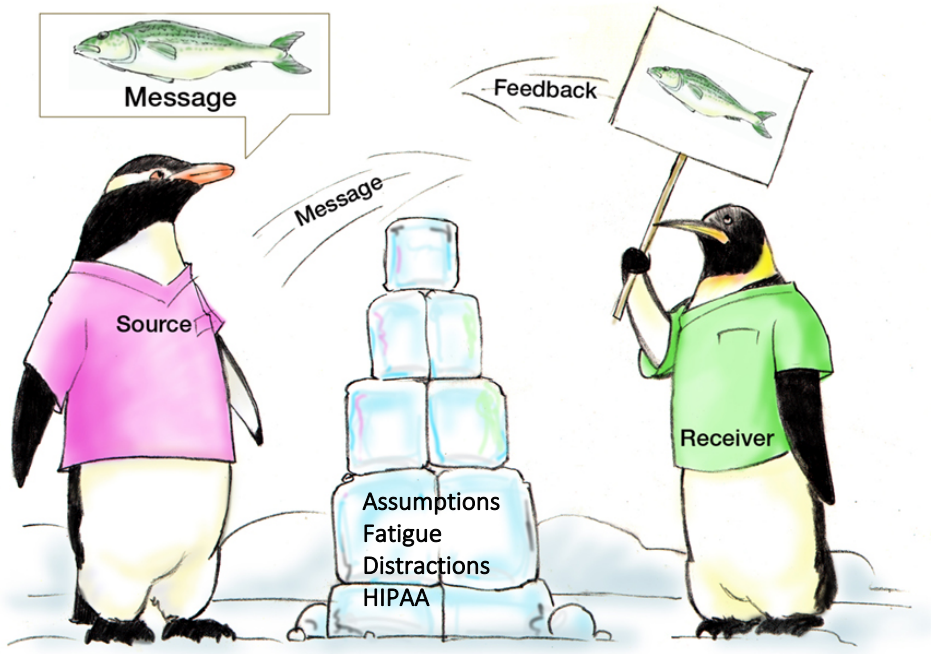
Handover or Handoff
A great opportunity for quality and safety

- Optimized Information
- Effective communication skills are vital for patient safety
- Responsibility–Accountability
- Enables team members to effectively relay information
- Uncertainty
- Verbal Structure
- Checklists
- IT Support
- Acknowledgment

Adapted from AHRQ-TeamSTEPPS

Communication is…

- The process by which information is exchanged between individuals, departments, or organizations
- The lifeline of the clinical team
- Effective when it permeates every aspect of an organization



Adapted from AHRQ-TeamSTEPPS

Effective Communication

Brief

Communicate the information in a concise manner

Clear

Convey information that is plainly understood

Complete

Communicate all relevant information

Timely

- Offer and request information in an appropriate timeframe
- Verify authenticity
- Validate information

Adapted from AHRQ-TeamSTEPPS

Example of ineffective communication

https://www.youtube.com/watch?v=CtdNQ-sfKg8

Communication Challenges

- Language barrier
- Distractions
- Physical proximity
- Personalities
- Workload
- Varying communication styles
- Conflict
- Lack of information verification
- Shift change

Adapted from AHRQ-TeamSTEPPS

Handover (or Hand-off)

Where patient care handover occurs?

Admission in primary care

Physician sign-out to a covering physician

Nursing change of shift

Transfer between units or facilities

Discharge of the patient back home/other facility

Across the continuum of care

Identifiable risks in Handover

- Breakdown in communication
- Frequency of interruptions
- Lack of space
- Time constraints
- Handover during the weekend
- Incomplete or omitted information
- Irrelevant information and repetition
- Speculation
- Non-compliance

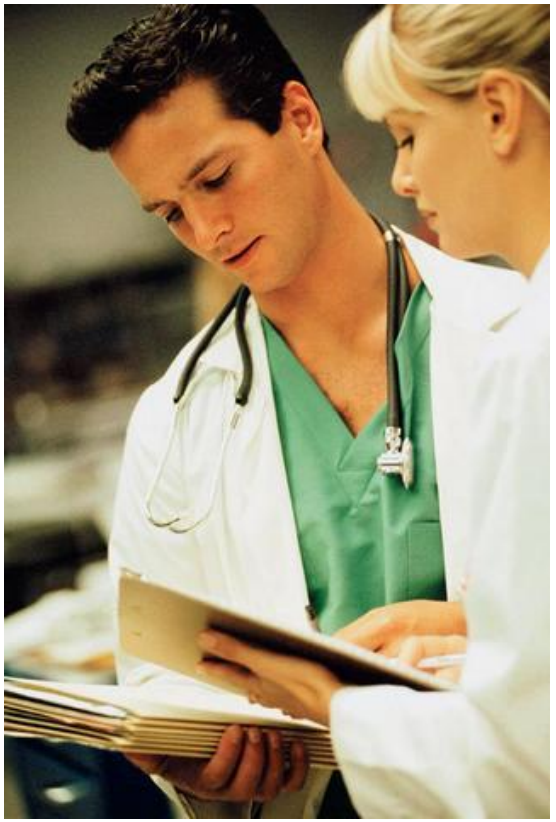
How often do we handover?

Patient handover will happen more often, as different teams care for the same group of patients over the course of any given day

Adapted form AMA. Guidance on clinical handover for clinicians and managers. 2006

Modes of Handover

- Face to face: at the patient's bedside, nursing station or staff meeting room
- Taped
- Written
- Over the phone



Benefits of Bedside Handover

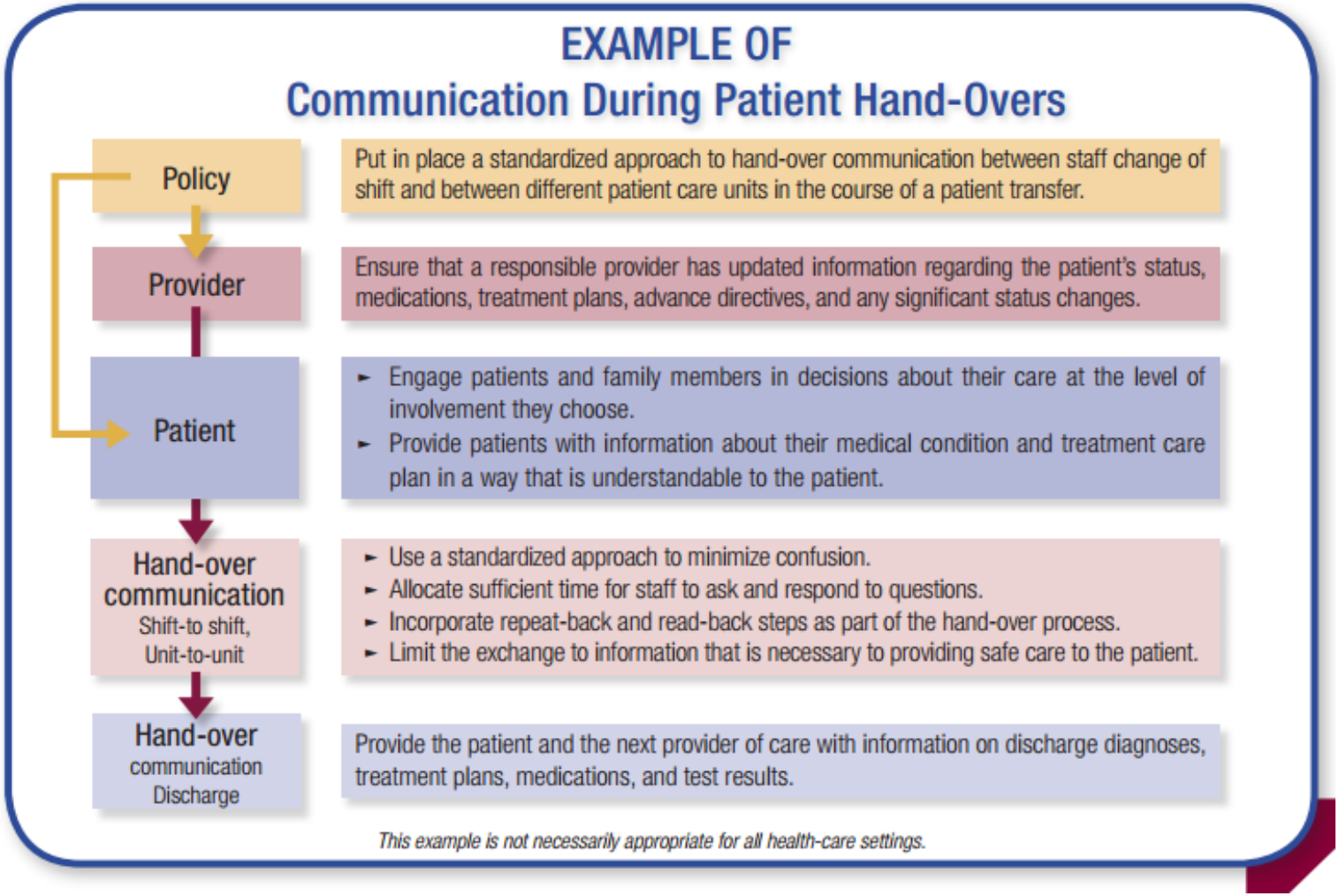
- Patients were better informed
- It gives patients the opportunity to be involved in their care
- Increases patient satisfaction
- Minimise errors
- Improving doctor-nurse-patient relationship

Handover Communication

- The information needs to be provided in a prioritized, clear, concise and chronological manner.
- Information should contain
  - patient care plan,
  - treatment,
  - current condition and a
  - any recent or anticipated changes.

https://www.youtube.com/watch?v=Cbvtk-slTyc

Components that make a good Handover



Source: *WHO (2007) Communication during patient handovers*

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Types and tools of handover

Information Exchange Strategies

- Situation – Background – Assessment – Recommendation (SBAR)
- Identification – Situation and status – Observation – Background and history – Assessment and action – Responsibility and risks (ISOBAR)
- Call-Out
- Check-Back
- Handoffs

SBAR Provides…

A framework for team members to effectively communicate information to one another

Communicate the following information:

- **S**ituation—What is going on with the patient?
- **B**ackground—What is the clinical background or context?
- **A**ssessment—What do I think the problem is?
- **R**ecommendation—What would I recommend?

SBAR Video

https://www.ahrq.gov/teamstepps/instructor/videos/ts_SBAR_NurseToPhysician/SBAR_NurseToPhysician-400-300.html

ISOBAR Provides…

Structured handover to ensure that staff are sharing relevant, concise and focused information.

Communicate the following information:

I	=	Identification
S	=	Situation and status
O	=	Observation
B	=	Background and history
A	=	Assessment and action
R	=	Responsibility and risks

ISOBAR - Identification

- Adequate identification of patients with three different identifiers adapted to the national legislation (e.g.: name, date of birth, medical record number)

ISOBAR - Situation and status

- The patient's current clinical status (e.g. stable, deteriorating, improving)
- Advanced directives and patient –centred care requirements
- Prospect of discharge or transfer

ISOBAR - Observation

- Informing the incoming team of the latest observations of the patient and when they were taken.
- It serves as a checking mechanism to identify deteriorating patients for emergency response assistance.
- Unit members have to be aware of local emergency response call criteria and process.

ISOBAR - Background and history

- Summary of background
- History: the presenting problem, background problems, current issues)
- Evaluation: physical examination findings, investigation findings and current diagnosis
- Management to date and whether it is working

ISOBAR - Assessment and actions

- Ensure that all tasks and abnormal or pending results are clearly communicated.
- Establishing and agreeing management and escalation of care plan, which could include:
- a shared understanding of what conditions are being treated or, if the diagnosis is not known, clear communication of this fact to everyone,
- tasks to be completed,
- abnormal or pending results (must include recommendations and the agreed plan and who to call if there is a problem),
- a plan for communication to the senior in charge,
- clear accountability for actions.

ISOBAR - Responsibility and risks

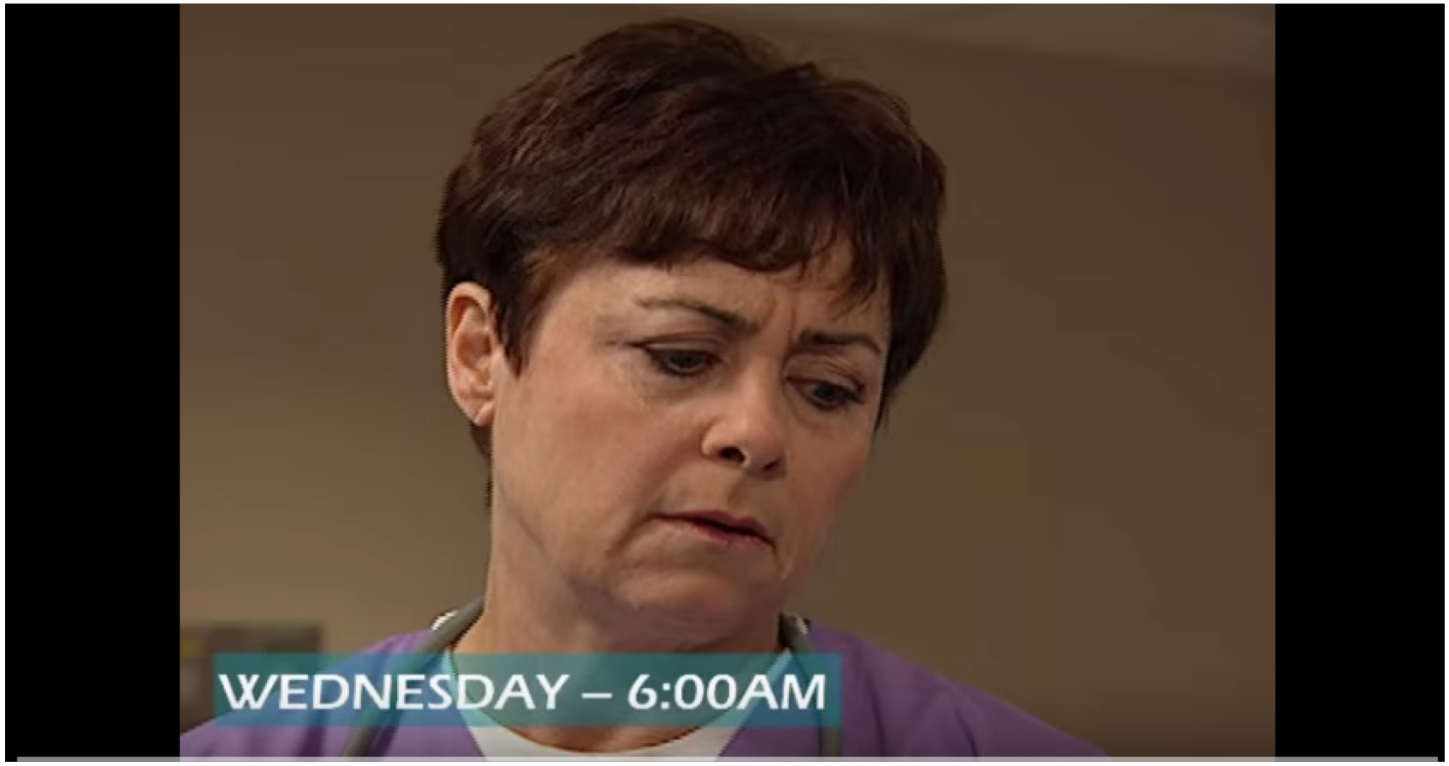
- Responsibility transfer and task acceptance ideally includes accepting handover sheets or signing of handover sheets.
- Read back of critical information is helpful, especially in situations where face-to-face handover is not possible.
- Risks and management plans should be included in handover when required (e.g. for infectious disease alerts or alerts for DVT prophylaxis)

Call-Out is…

A strategy used to communicate important or critical information

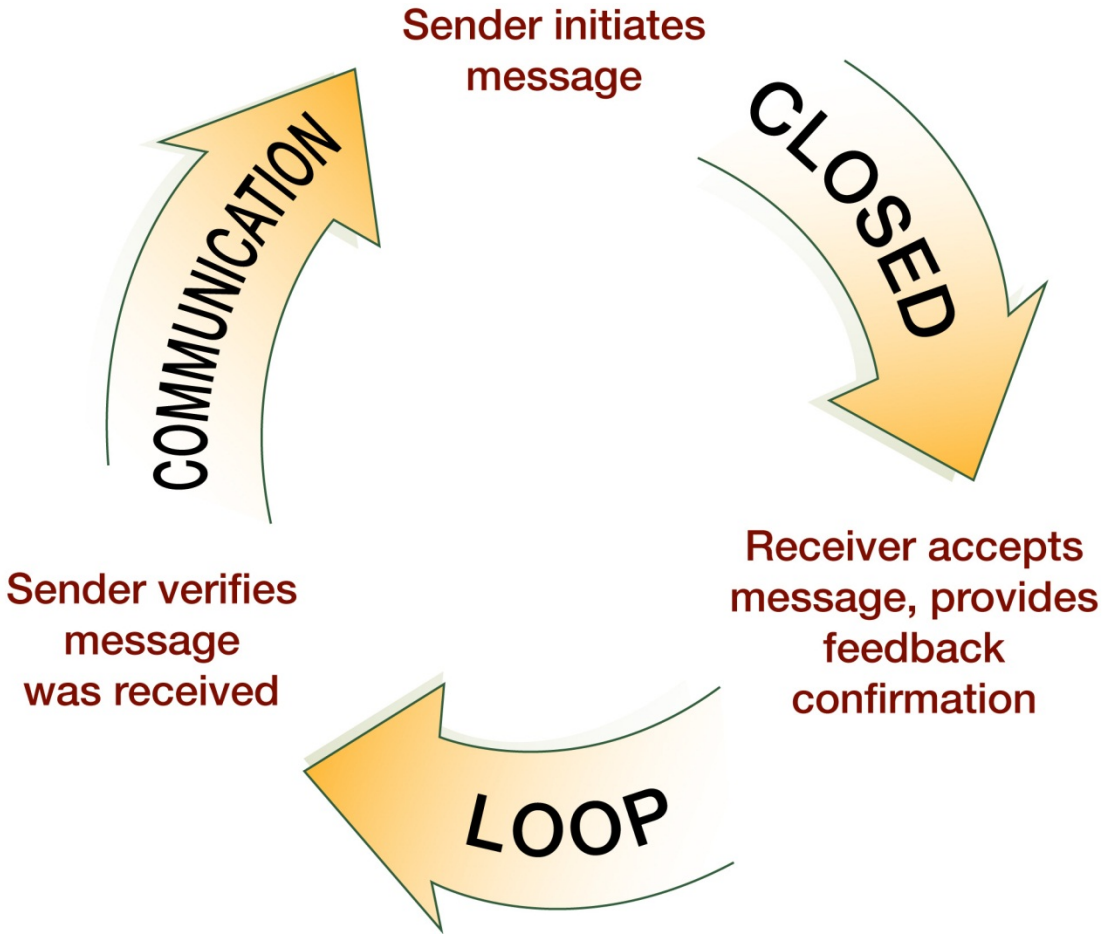
- It informs all team members simultaneously during emergency situations
- It helps team members anticipate next steps

Call-Out Video



https://www.youtube.com/watch?v=CFkIaDzd8AY

Check-Back is…



Check-Back Video

https://www.youtube.com/watch?v=AKtNLP8jQ7s

"I PASS THE BATON"

Introduction:	Introduce yourself and your role/job (include patient)
Patient:	Identifiers, age, sex, location
Assessment:	Present chief complaint, vital signs, symptoms, and diagnosis
Situation:	Current status/circumstances, including code status, level of uncertainty, recent changes, and response to treatment
Safety:	Critical lab values/reports, socioeconomic factors, allergies, and alerts (falls, isolation, etc.)
THE	
Background:	Comorbidities, previous episodes, current medications, and family history
Actions:	What actions were taken or are required? Provide brief rationale
Timing:	Level of urgency and explicit timing and prioritization of actions
Ownership:	Who is responsible (nurse/doctor/team)? Include patient/family responsibilities
Next:	What will happen next? Anticipated changes? What is the plan? Are there contingency plans?

“I PASS THE BATON” Video

https://www.youtube.com/watch?v=TV16rNKjk6I

Other Example Handoff Tools

- ANTICipate
  - **A**dministrative Data; **N**ew clinical information; **T**asks to be performed; **I**llness severity; **C**ontingency plans for changes
- I PASS
  - **I**llness severity; **P**atient Summary; **A**ction list for the new team; **S**ituation awareness and contingency plans; **S**ynthesis and “read back” of the information
- SHARQ
  - **S**ituation; **H**istory; **A**ssessment; **R**ecommendations/Result; **Q**uestions

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Key aspects for handover good practices

The ‘Standard Key Principles’ for clinical handover

- **Leadership.** Must have a comprehensive understanding of handover process and ensures that all participants attend to handover and understand it
- **Valuing handover.** Clinical handover is valued and essential part of daily work
- **Handover participants.** Identify handover participants involving them in a regular review of clinical handover process
- **Handover time**. It is every time a change of accountability and responsibility occurs (including transporting a patient from the ward to the place to perform a diagnostic test. Timeliness of handover is imperative to ensure a sustainable and effective process

The ‘Standard Key Principles’ for clinical handover

- **Handover place.** Set a specific tranquile location for clinical handover to occur. Preferably, clinical handover occurs face to face and in the patient’s presence, where appropriate (bedside handover).
- **Confidentiality:** Some information is appropriate to hand over at the bedside and some is not. Use your clinical judgement, but involve the patient wherever you can.

IMPLEMENTATION TOOLKIT. Standard Key principles fro Clinical Handover.
NSW Department of Helath. Sydney. Australia:
https://www.aci.health.nsw.gov.au/resources/acute-care/safe_clinical_handover/implementation-toolkit.pdf

Conditions for successful handover implementation al Ward/department level

Good practice in handover

- Every hospital needs to develop its own handover policy
- The general approach to handover should be standardised across the hospital
- It should be developed in consultation with staff to ensure a successful process
- Clinical Handover is equally important to all members team, both juniors and seniors

Education handover

- All levels of the medical staff require educational sessions that cover the handover protocol.
- The content of handover includes all clinical notes adn other important documentation of the patient (legibility, detail and identification of authorship)
- It is necessary to know how to use the available tools (i.e. electronic systems, preforms)
- Teacher training programs are very useful

Teamwork Actions

- Communicate with team members in a brief, clear, and timely format
- Seek information from all available sources
- Verify and share information
- Practice communication tools and strategies daily (SBAR, call-out, check-back, handoff)

Thinking handover

Who?

- Teams from all/specific units
- Both junior and senior

When?

- Main handover preferable held in the morning
- between shifts

Where?

- Close to the most used areas of work
- Free from distraction

How?

- Format and structure to ensure adequate information exchange: Communication tools
- It must have clear leadership

What?

- Priorities need to be set to ensure that the essential information is communicated and understood.

Adapted form AMA. Guidance on clinical handover for clinicians and managers. 2006

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Case studies, case reports

STORIES

The following stories demonstrate how relatively small details regarding communication can impact on outcomes for patients.

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STORY 1

Handover at patient transfer from ICU to Ward

Mr. X was admitted to hospital with a brainstem stroke. Once there he deteriorated, was intubated and was transferred to ICU where he had a prolonged stay. Mr. X was in and out of consciousness and had a tracheostomy which prevented him from speaking. While conscious he was able to do what was instructed of him.

At night time Mr. X would become agitated and needed sedating and restraining. During these episodes Mr. X removed his nasogastric tube about 3 times, and even did this on the night before he was transferred to the ward.

Handover from ICU to the Acute Stroke Ward was given verbally, it appeared incomplete and the content was not documented. During investigation it was not clear if information about the patient's night time agitation, sedating and restraining was communicated.

On the ward Mr. X was not restrained or sedated during the night. Subsequently he removed his nasogastric tube and his tracheostomy tube. When he was found he was unresponsive and unable to be resuscitated.

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STORY 2

Handover of patient at shift to shift change

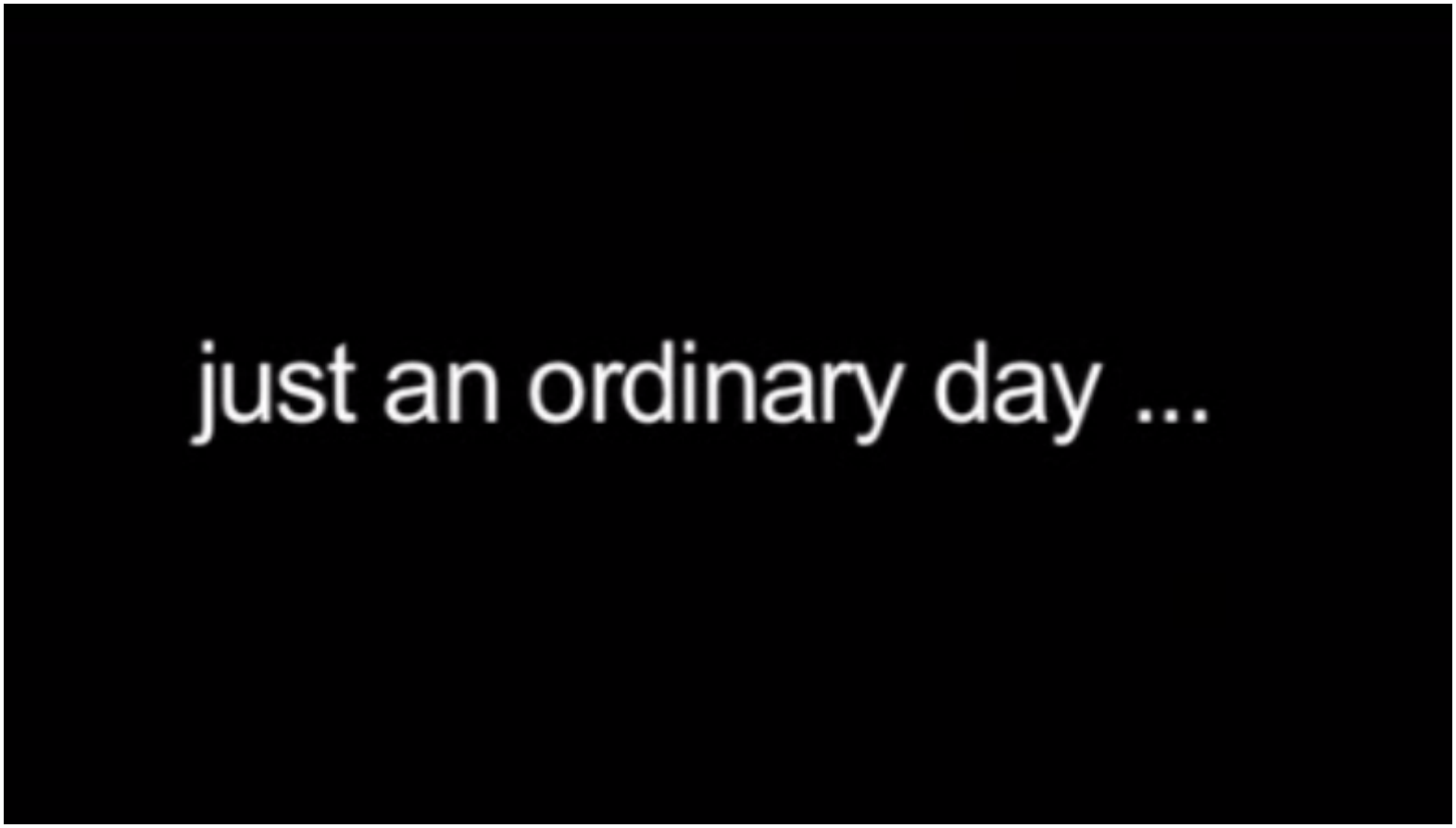
Mrs. Q had been admitted to hospital with pregnancy induced hypertension. When night staff were handing over their patients it was done in a rush, as they were keen to get home after a busy night.

The handover was conducted in the doorway of Mrs Q's room, although Mrs. Q was not involved and no opportunity was given for the day-staff to check any of the information in the charts.

The night-staff were also not keen to do the usual counts of medications with morning staff. The night-staff handed over to the day-staff that Mrs. Q's diastolic blood pressure was 95mmHg, although they did not mention that they had not administered the morning dose of her antihypertensive medication as prescribed.

Later in the morning, when the day-staff checked with the patient, she said she remembered her blood pressure being taken but no medication was given. Her BP at this time was 160/100.

STORY 3



http://www.who.int/patientsafety/education/learning_from_error/en/

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Role plays and situational games

SBAR Exercise

Create a SBAR example based on your role.

SBAR Exercise

Scenario:

Rose Harris, DOB 5/3/50, was admitted two days ago after being in the ED with chest pain. Her history is that she was at the mall with a friend when she had a sudden onset of excruciating pain in the middle of her back and was short of breath. 911 was called and they transported her to the ED. Serial enzymes and EKG were negative for cardiac episode. Her blood pressure upon arrival to the ED was 182/108. The physician was going to send the patient home from the ED however the patient's daughter insisted she be admitted and worked up for what had caused the pain. GI consult, cardiac consult and internal medicine were all ordered and nothing was determined to be the cause. Her blood pressure has been normal since being admitted. You are called to the patient's room where Ms. Harris is complaining of chest pain and is short of breath. She says it has been "…coming on for a about the last 30 minutes, but has been getting really bad in the last few minutes." There is no pain radiating down her arm and she describes the pain like a "knife going through my back". She scales her pain at a "9" on a scale of 1 to 10, and is grimacing. Her IM and IV Morphine for pain was discontinued yesterday and all she has ordered is Tylenol #3 for pain. Her blood pressure is 192/112.

Exercise:

You are this patient's nurse and want to call the physician to inform him about the sudden onset of pain. It is, of course, Friday night at 9pm and the physician on call is not familiar with Ms. Harris. You think perhaps a cardiac episode is occurring and the pain medication is not adequate for this incident. Use SBAR to convey this information to the physician.

Source: Arizona Hospitall and Healthcare Association: SBAR Communication Standardization in Arizona

Check-Back exercise

Create a Check - Back example based on your role.

Check-Back exercise

Scenario:

One member of the team calls out, "BP is falling, 80/48 down from 90/60." Another team member verifies and validates receipt of the information by saying, "Got it; BP is falling and at 80/48, down from 90/60." The original sender of the information completes the loop by saying, "Correct.“

Adapted from: https://www.ahrq.gov/teamstepps/instructor/fundamentals/module3/igcommunication.html#checbackis

Check-Back exercise

Scenario:

You decided to discharge your patient. Now you are talking to him. You have every documents that is needed for discharge, and you are just handing them to him. You think it's very important for the patient to know his medications exactly and correctly, so you want to tell him in details and check back if he understands it well.

Medications:

acenocoumarol 1 mg once in every second day in the morning

enalapril 5 mg every day once in the evening

Exercise:

Tell the patient his medications and check it back!

Questions?

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The project has been supported by the European Commission.