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KICK-OFF TRAINING

for hospital and ward managers and
professionals

MAP4E 16/1/KA202/23016

The project has been supported by the European Commission.



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M2/M3-KICK-OFF TRAINING

Hospital manager, Ward managers,
Ward professionals

AGENDA

- brief presentation of the project MAP4E
- brief summary on the basics of patient safety (Introduction to patient safety)
- importance of handover
- basics of handover
- general aspects of successful implementation at hospital level
- description of the local training program



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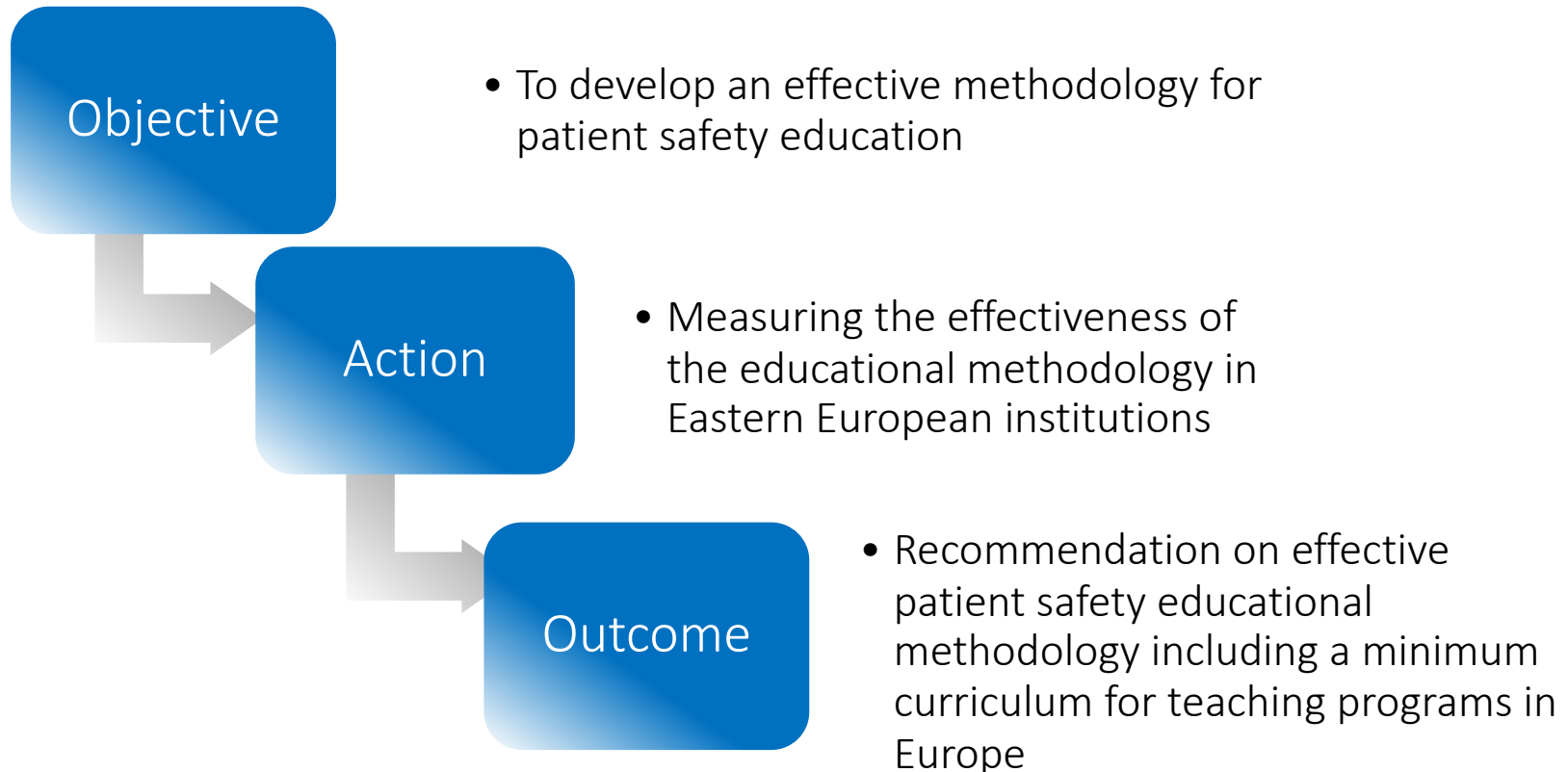
Brief presentation of MAP4E



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Principles of MAP4E project

Funded by Erasmus + KA2- Cooperation for Innovation and the Exchange of Good Practices . Strategic Partnerships for vocational education and training.





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MAP4E partners



Hungary (HU) –

Project leader; drafting recommendation on teaching material; developing, testing and evaluating educational methodology; composing final recommendations.



Poland (PL)–

Participation in developing and testing educational methodology; participation in evaluating results and composing final recommendations.



Spain (ES) –

Providing professional input based on best practices and experiences in patient safety; guidance on developing educational methodology; participation in evaluating results and composing final recommendations.



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Basic on Patient Safety



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Quality of care dimensions





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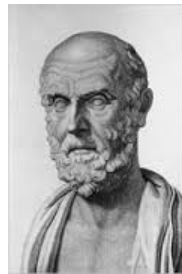
Patient safety background

- Code of Hammurabi (-1760?):

Medical liability

- Hipócrates (-460):

“Primum non nocere”



- Florence Nightingale (1820-1910):

Measures of prevention

- Philipp Semmelweis (1818-1865):

Hand hygiene

- Ernest Codman (1869-1940):
Registration of errors

- Beecher and Todd (1954)

Deaths associated with anesthesia and surgery (Ann Surg; 1954)

- Anesthesia Patient Safety Foundation (1985)

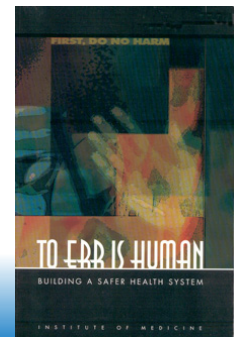
“Patient safety”

- Brennan et al: (1991)

Incidence of AE and negligence in hospitals (NEJ, 1991)

- IOM (1999):

To err is human



- System errors
- Patient safety has to be a priority
- Culture of safety



From a simple and ineffective medicine

...

...to another much more
effective and complex





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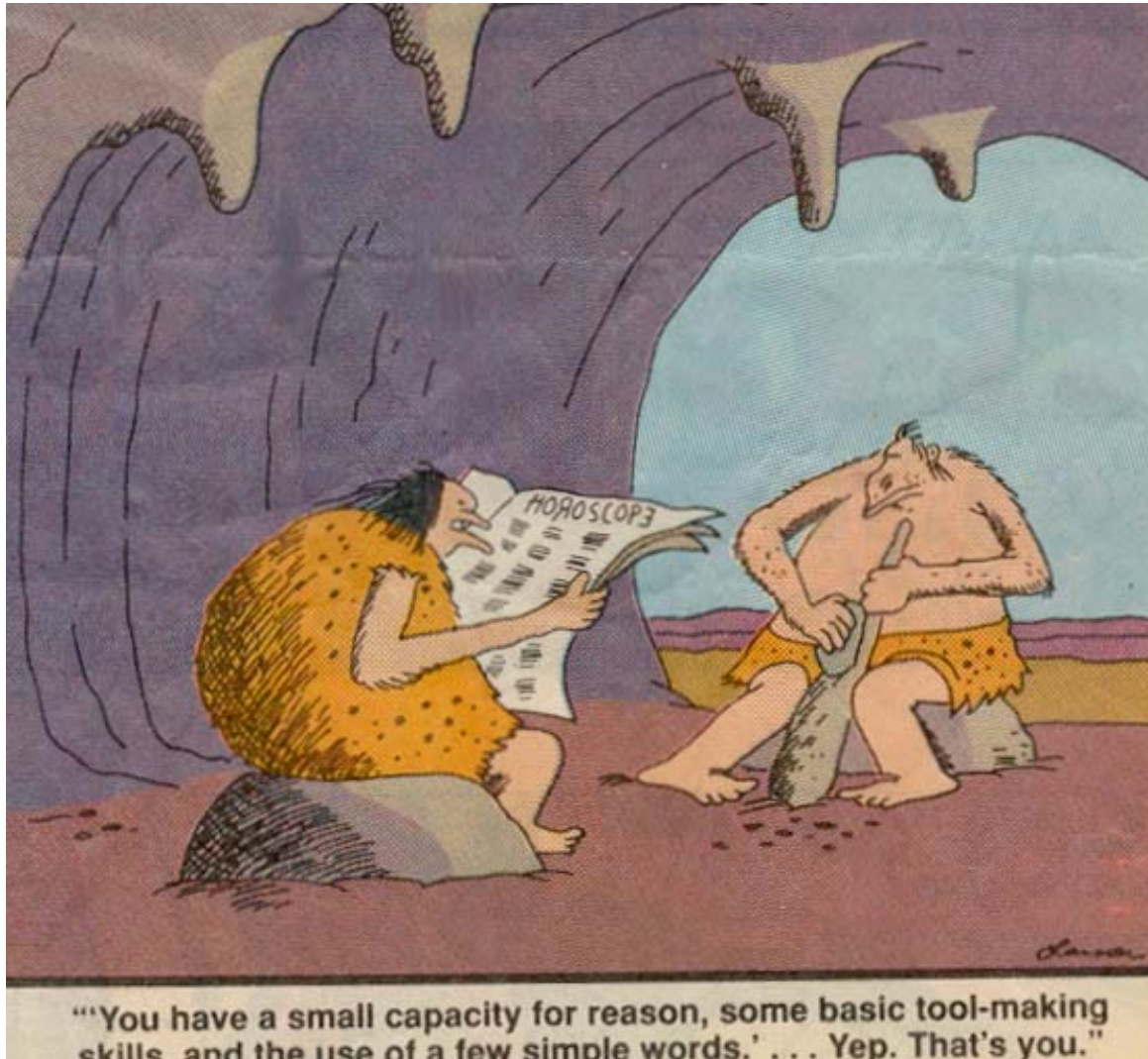
Patient safety. What are we talking about ?

- 👉 *“the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment” (WHO, ICPS, 2009)*
- 👉 *“the prevention of harm to patients.” (IOM)*
- 👉 *“the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes”. (Canadian Patient Safety Dictionary)*



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To Err is human





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Human beings make mistakes because the systems, tasks and processes they work in are poorly designed

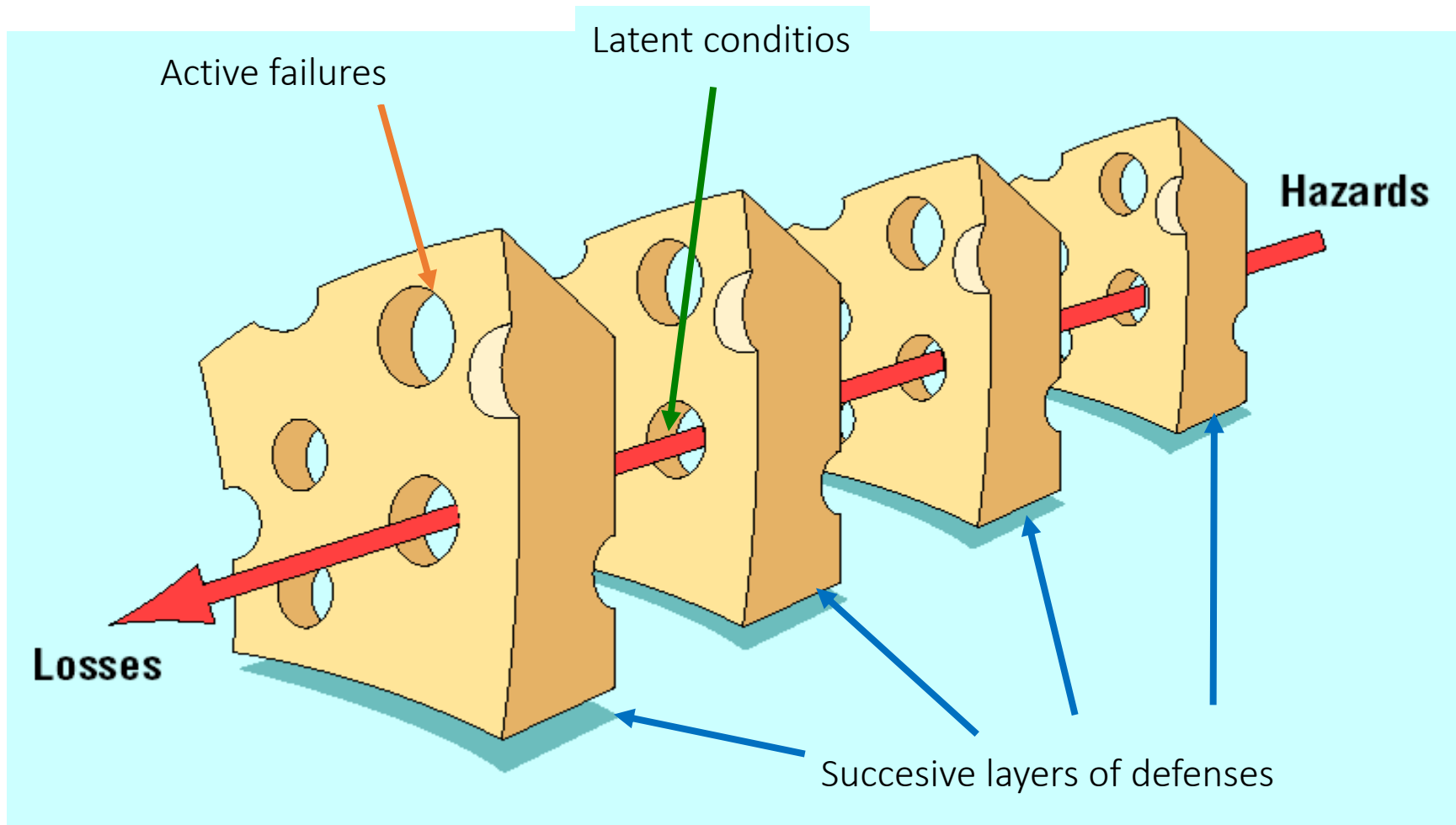
Lucian Leape. Harvard School of Public Health





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Reason's Swiss Cheese Model



Source: Reason J. Human error: models and management. BMJ. 2000;320:768–70.

doi: 10.1136/bmj.320.7237.768.



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What patient safety means?

Sense that clinical errors exist

Actions to prevent them

Follow the evidence to control them

Enquire into adverse events

Take appropriate improvement measures

Your responsibility



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Patient Safety levels

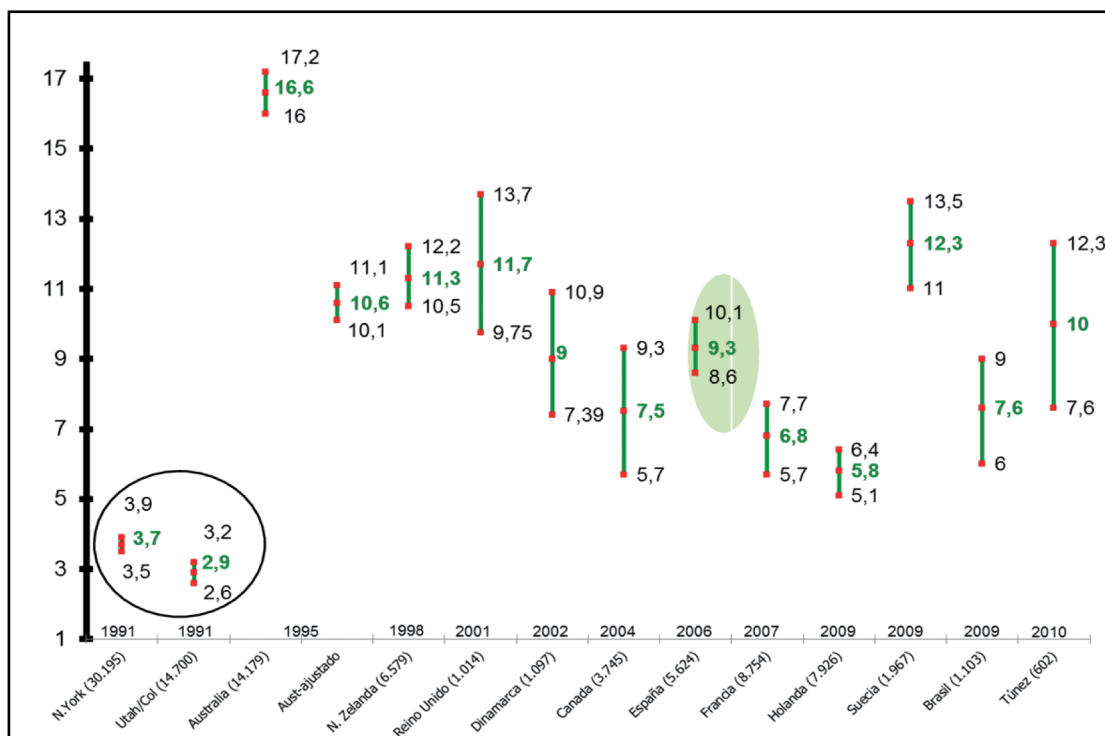


* National Health System



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Frequency of adverse events in hospitals: 9,2% (IC95%: 4,6-12,4%)



Source: National Patient Safety Estrategy from the Spanish's National Health System 2015-2020. MSSSI, 2015



De Vries EN et al. The incidence and nature of in-hospital adverse events: a systematic review. *Quality & Safety in Health Care*. 2008;17(3):216-223.



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Learning from other high risk industries

Human factors and patient safety behaviours

- Leadership
- Team working
- Effective communication
- Shared awareness
- Standardizing procedures
- Learning: simulation





World Health
Organization

WHO Patient Safety Program

2005-2006:
Clean care is safer care

2008:
Safe surgery safe lives

2017:
Medication without harm

2010:
Antimicrobial resistance



Actions

- Patient for patient safety
- Reporting & learning system
- Patient safety solution
- High 5's
- Research
- Education and training
- Knowledge & management

<http://www.who.int/patientsafety/>

Good practices recommended

AHRQ Evidence for PSP (2013)	NQF PSP for better healthcare (2010)	JC National PS goals (2014)	WHO Nine patient safety solutions (2007)
HAIs <ul style="list-style-type: none"> •Hand hygiene •CLABSI, VAP •CAUTI MEDICATION <ul style="list-style-type: none"> •High risk medications •Medication reconciliation •NO dangerous abbreviations SURGERY	HAIs <ul style="list-style-type: none"> •Hand hygiene •CLABSI, CAUTI, VAP •SSI, MDRO MEDICATION <ul style="list-style-type: none"> •High risk medications SURGERY	HAIs <ul style="list-style-type: none"> •Hand hygiene •CLABSI, CAUTI •SSI MEDICATION <ul style="list-style-type: none"> •Medication reconciliation SURGERY	HAIs <ul style="list-style-type: none"> •Hand hygiene MEDICATION <ul style="list-style-type: none"> •High risk medications •Medication reconciliation •“Look alike, sounds alike” SURGERY
OTHER <ul style="list-style-type: none"> •PU, Falls, Patient safety culture Handover	OTHER <ul style="list-style-type: none"> •PU, Falls •Culture Handover	OTHER <ul style="list-style-type: none"> •Patient Identification Handover	OTHER <ul style="list-style-type: none"> •Patient Identification Handover



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Emerging threats for patient safety

Watch out!

- Increase in multimorbidity: complex cases
- Increasingly complex care: multidisciplinary teams
- Budget constraints
- Antimicrobial resistance: to do 'more with less'



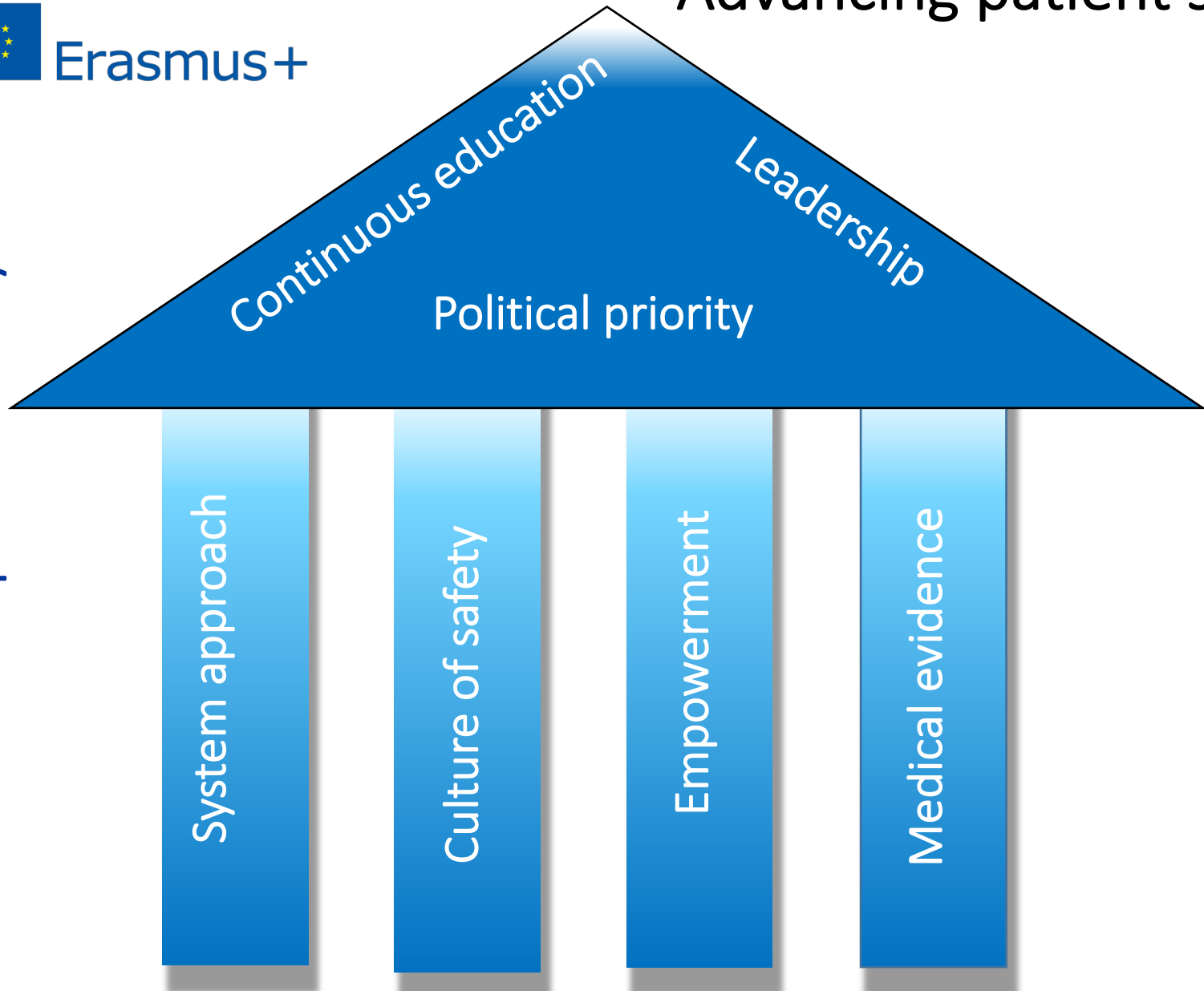
Adapted from: Patient Safety 2030. NHS. 2015



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Advancing patient safety

Pillars of patient safety



Adapted from: Patient Safety 2030. NHS. 2015



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Severe adverse events: background

- communication errors are found very often
- most of them are connected to handover processes
- It is the basis for transferring care of patients across shifts and across care settings
- critical for maintaining continuity and safety of patient care
- inadequate practice of handover can lead to unnecessary readmissions, medication errors, diagnostic follow-up errors and physical harms
- significant extra costs for the hospitals



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Basic on Handover



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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)



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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 environment
- Facilitates patient involvement





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Handover or Handoff

A great opportunity for quality and safety

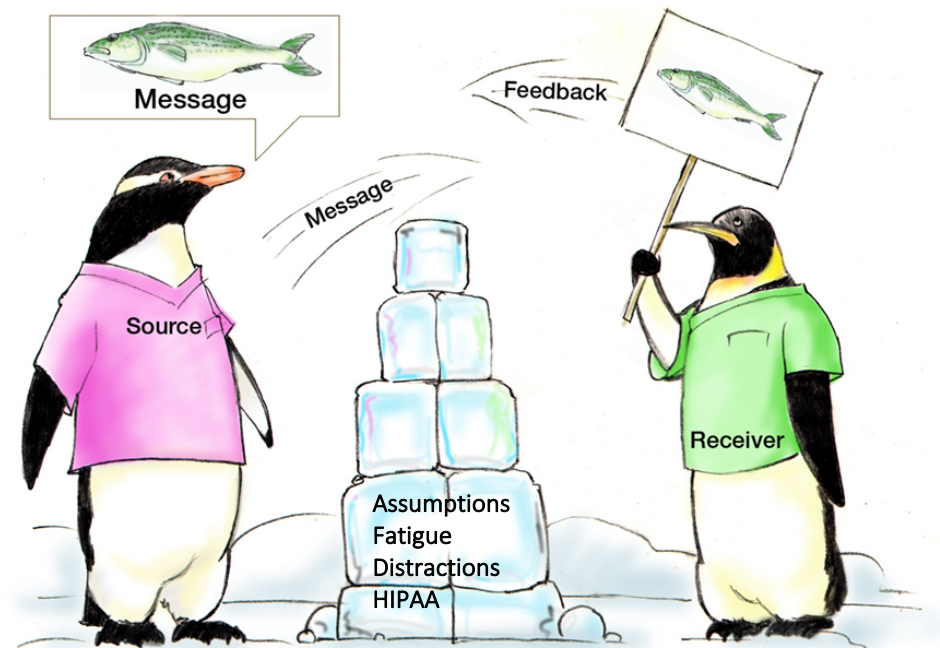
- Optimized Information
- Effective communication skills are vital for patient safety
- Responsibility–Accountability
- Enables team members to effectively relay information
- Uncertainty
- Verbal Structure
- Checklists
- IT Support
- Acknowledgment





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





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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



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Communication Challenges

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



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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



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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



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How often do we handover?

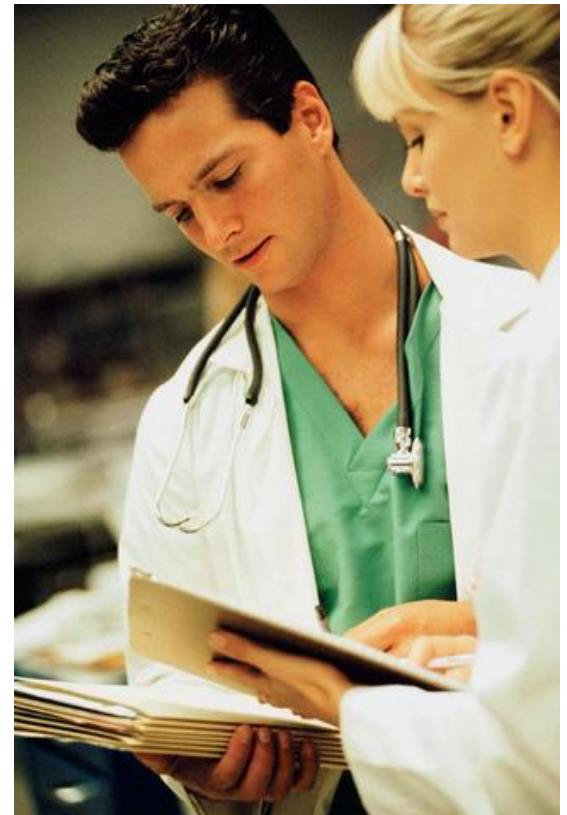


Patient handover will happen more often, as different teams care for the same group of patients over the course of any given day



Modes of Handover

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





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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

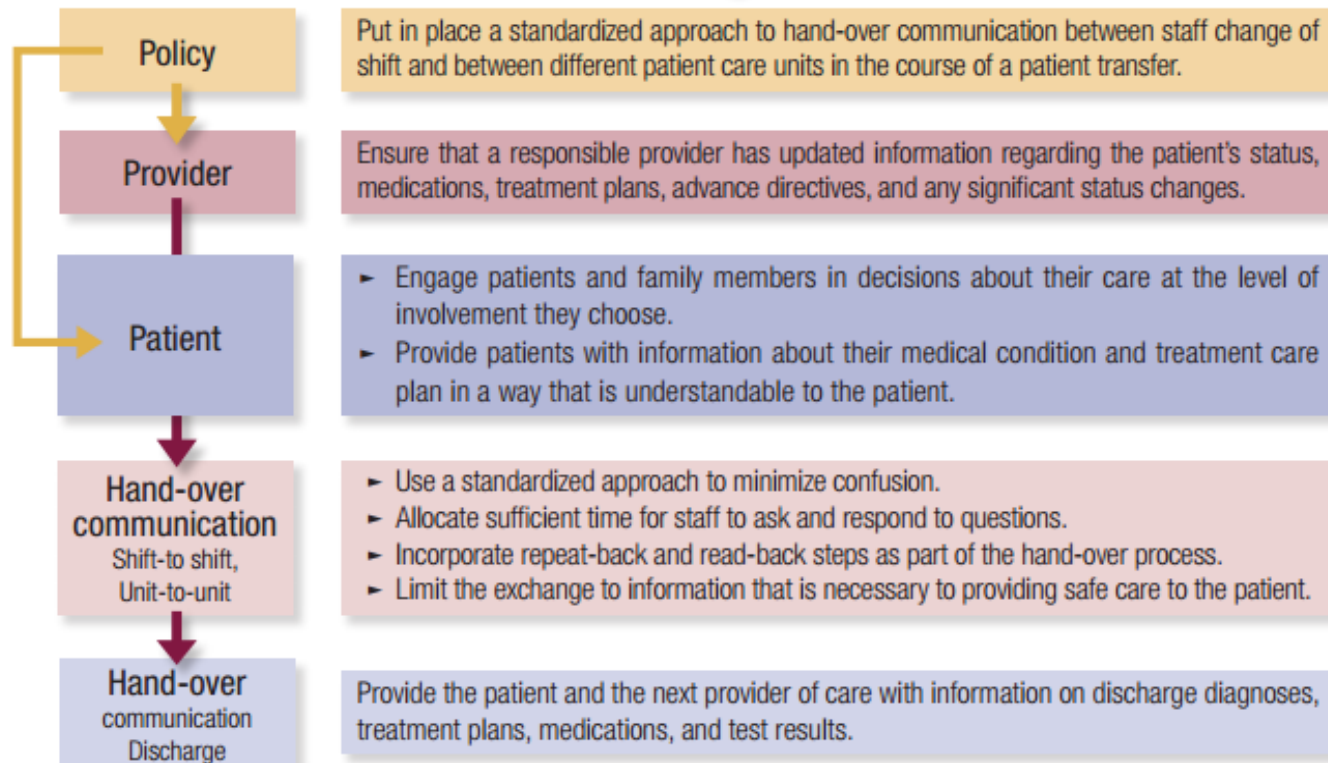
- The information needs to be provided in a prioritized, clear, concise and chronological manner.
- Information should contain
 - patient care plan,
 - treatment,
 - current condition and a
 - any recent or anticipated changes.



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Components that make a good Handover

EXAMPLE OF Communication During Patient Hand-Over



This example is not necessarily appropriate for all health-care settings.

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



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Successful implementation at hospital level

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 tranquil 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 whenever you can.



- 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



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.



Education handover

- All levels of the medical staff require educational sessions that cover the handover protocol.
- The content of handover includes all clinical notes and 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



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Local training program

- Target population: choosing the Wards to participate in the training
- Duration of the training program
- Organization of the training program at the hospital



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Questions?



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