Small group block

1st training occasion

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

Handover

1st training occasion

Thematics

I. Introduction:
- brief presentation of the project MAP4E
- brief summary about the basics of patient safety
- description of the local training program

II. Requirements of the adequate handover practice

III. Handover techniques

I. Introduction

Brief presentation of the project MAP4E

Presentation of the project 1.

- The name of the project: „Methodology development and impact Assessment in Patient safety education for improving Effectiveness” (MAP4E)
- The aim of the project: Improving the effectiveness of patient safety education, and in order to achieve this working out methodological recommendation on the methods of effective education.
- Participants of the project:
  - Hungary (coordinator) - Semmelweis University Helath Services Management Training Centre
  - Poland (project partner) - Towarzystwo Promocji Jakosci Opieki Zdrowotnej w Polsce
  - Spain (project partner) - Ministerio De Sanidad, Servicios Sociales e Igualdad
- The subject of the project: patient safety and its education and training
  - WHO definition on patient safety: prevention of healthcare related errors and adverse events

Presentation of the project 2.

- The subject of the project: patient safety and its education and training
  - WHO definition on patient safety: prevention of healthcare related errors and adverse events
- Content of the project:
  - methodological research and development of patient safety education
  - training in three Hungarian and three Polish hospitals on a specific topic of patient safety
  - the Spanish partner provides professional support to the content of the project.

I. Introduction

Brief summary about the basics of patient safety

From a simple and ineffective medicine …

…to another much more effective and complex

Patient safety. What are we talking about ?

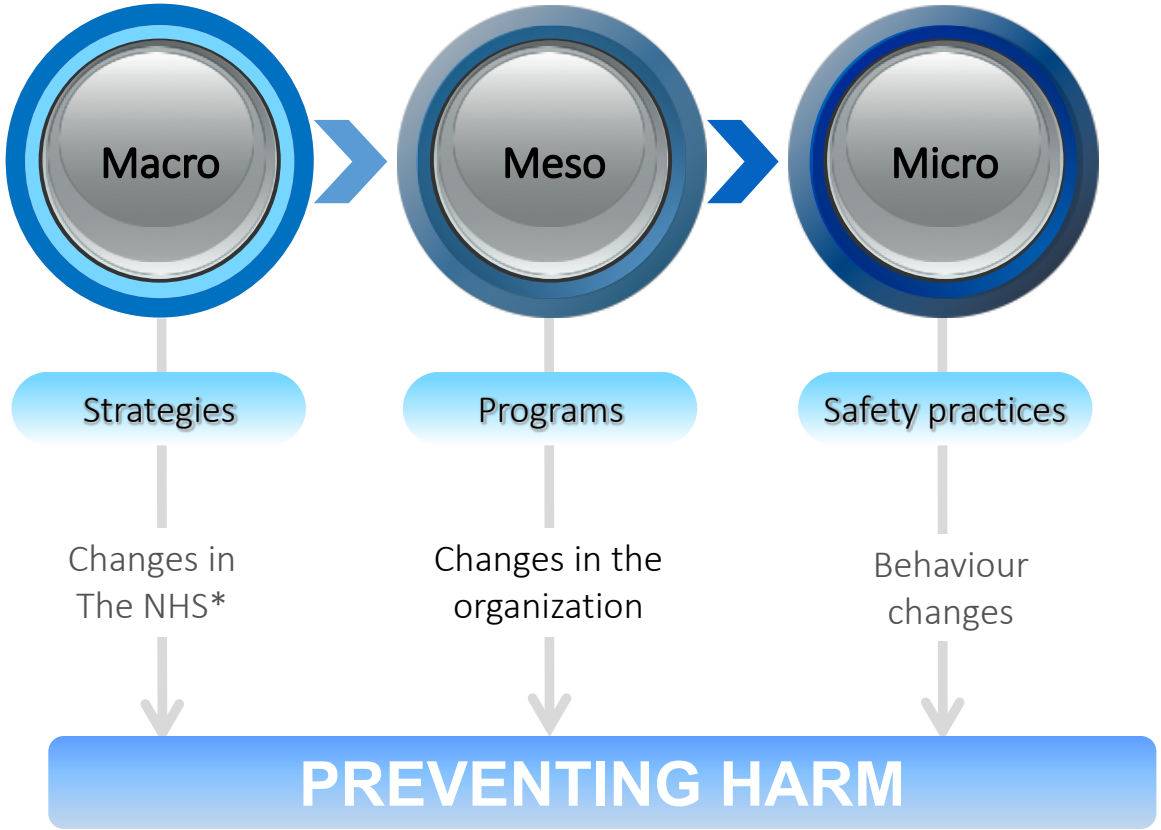
- “the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment” (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)

Erasmus+

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

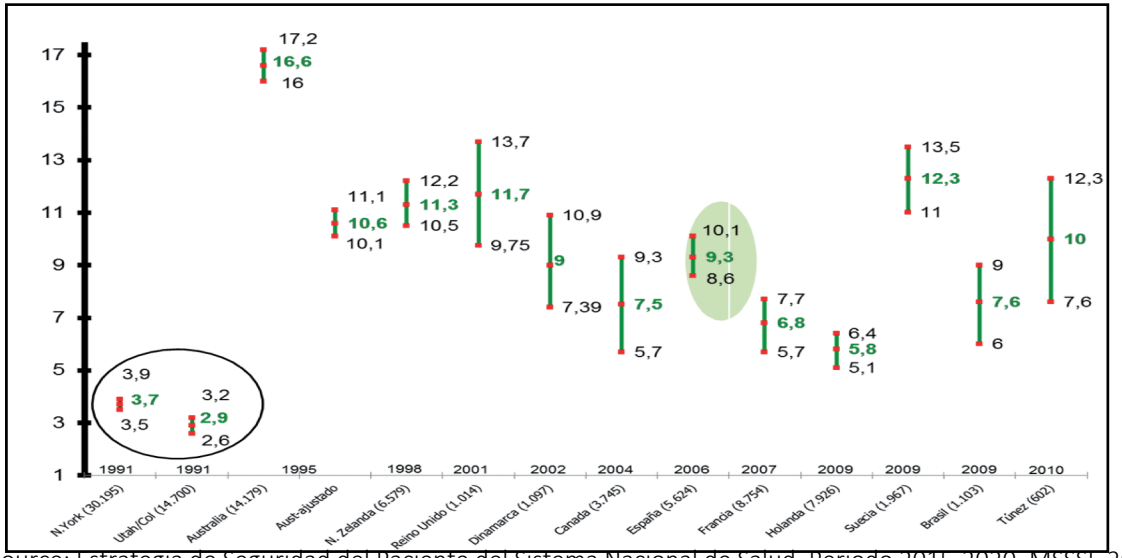
Lucian Leape. Harvard School of Public Health

Patient Safety levels



* National Health System

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



Source: Estrategia de Seguridad del Paciente del Sistema Nacional de Salud. Periodo 2015-2020. MSSSI, 2015

Error management

The incidence and nature of in-hospital adverse events: a systematic review

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ABSTRACT

Introduction: Adverse events in hospitals constitute a serious problem with grave consequences. Many studies have been conducted to gain an insight in to this problem, but a general overview of the data is lacking. We performed a systematic review of the literature on in-hospital adverse events.

Methods: A formal search of Embase, Cochrane and Medline was performed. Studies were reviewed independently for methodology, inclusion and exclusion criteria and endpoints. Primary endpoints were incidences of in-hospital adverse events and percentages of preventability. Secondary endpoints were adverse event outcome and subdivision by provider of care, location and type of event.

Results: Eight studies including a total of 74 485 patient records were selected. The median overall incidence of in-hospital adverse events was 9.2%, with a median percentage of preventability of 43.5%. More than half (56.3%) of patients experienced no or minor disability, whereas 7.4% of events were lethal. Operation (39.6%) and medication-related (15.1%) events constituted the majority. We present a summary of evidence-based interventions aimed at these categories of events.

Conclusions: Adverse events during hospital admission affect nearly one out of 10 patients. A substantial part of these events are preventable. Since a large proportion of the in-hospital events are operation- or drug-related, interventions aimed at preventing these events have the potential to make a substantial difference.

Adverse events (AEs) in hospitals are now widely agreed to be a serious problem, annually killing more people than breast cancer or AIDS.[1] An AE is usually defined as an unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge or death and caused by healthcare management rather than by the patient's underlying disease process.[2 3] Aside from the direct harm to the patient, AEs are a considerable financial burden to the healthcare system. In 1999, it was estimated that the total costs of preventable AEs in the USA lie between $17 billion and $29 billion annually.[4]

In recent years, the focus in thinking about AEs has shifted from the person approach—blaming individuals for errors—to the systems approach. The systems approach assumes that people will make mistakes, and that the system that surrounds them should provide a safety net for these mistakes. Therefore, efforts to eliminate AEs should be directed towards a particular system.[5] This new approach has shifted the focus of the debate on AEs from the legal consequences associated with personal responsibility, to a more constructive point of view, clearing the way for thinking about solutions.

In the aftermath of the 2001 Institute of Medicine report "To err is human,"[1] many large studies have been performed measuring AEs, some of them nationwide. Although many of these studies used similar methods, they report substantially different incidences. A general overview of data on in-hospital AEs is lacking.

To make the important step towards solutions, it is necessary to gain a more detailed understanding of this problem: what percentage of events is preventable, where do the majority of events happen and which type of event is the most frequent? This will enable identification of categories of AEs that are most susceptible to interventions to improve patient safety.

To gain an insight into the overall incidence, preventability, outcome and subdivision by location, provider and type of in-hospital AEs and the evidence related to relevant patient safety interventions, we conducted a systematic review of available data from the literature.

METHODS

Literature search

Two authors (ENV, MAR) independently performed a formal computer-assisted search of the medical databases Medline (January 1966 to February 2007), Cochrane and Embase (January 1980 to February 2007). Keywords used were "adverse events" and "preventable." Clinical studies published in peer-reviewed journals in the English language were identified. A manual cross-reference search of the eligible papers was performed to identify additional relevant articles.

Selection

In order to be able to reliably compare the data, we defined an AE as follows: an unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge or death and caused by healthcare management rather than by the patient's underlying disease process. All studies that used this or a similar definition to evaluate the incidence of AEs in adult hospital patients and that included a minimum of 1000 patient records were eligible for inclusion. Studies that evaluated errors without linking them to outcomes and studies relying only on computerised screening data were excluded. Studies that evaluated specific types of AEs only (for example, adverse drug events only) and studies that evaluated specific populations (for example, ICU patients only) were excluded. No abstract publications without subsequent full-text

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216

Qual Saf Health Care 2008;17:216–223. doi:10.1136/qshc.2007.023622

Adverse event: Harm caused by done or lacked activity during care and not originated from the illness itself. E.g.: wound infection, fall, decubitus, wrong-site surgery, wrong-patient surgery, hospital associated infections, etc.

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

Learning form other high risk industries

Human factors and patient safety behaviours

- Leadership
- Teamworking
- Effective communication
- Shared awareness
- Standardizing procedures
- Learning: simulation

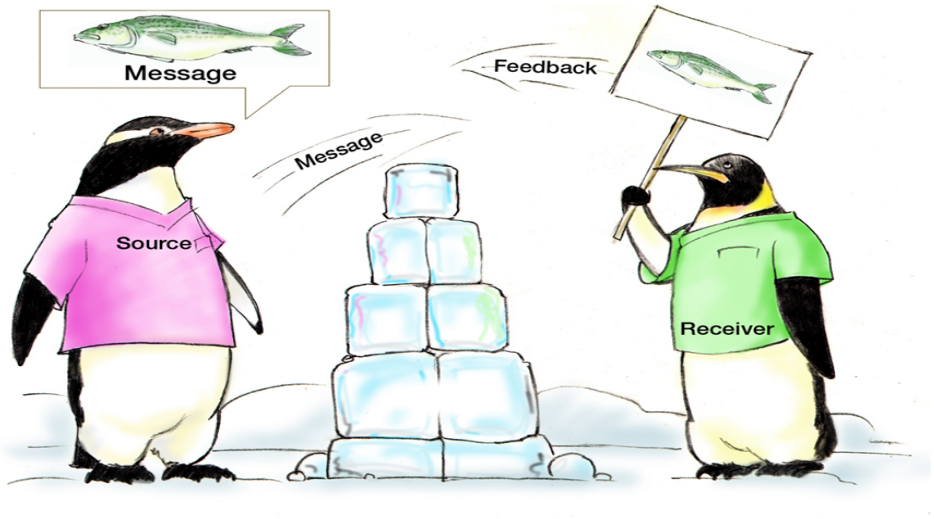
Handover – The chosen patient safety field to talk about

- In the background of severe adverse events communication errors are found quite often.
- Most of the communication errors are occured during handover processes.
- That is why one of the most critical process in patient safety is handover, which means the assignment of the control or responsibility for patient to someone else.

Communication is…

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

Assumptions
Fatigue
Distractions
HIPAA



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

Communication Challenges

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

Adapted from AHRQ-TeamSTEPPS

I. Introduction

Description of the local training program

Training at the hospital

- Introductory lecture
- 3 + 5 hour trainings (3 pcs) for staff of 3 chosen ward:
  - I. :
    Introduction
    Requirements of the adequate handover practice
    Handover techniques
  - II.:
    Self-assessment
    Identifying the fields to improve and developments
    Conditions and possibilities of the successful implementation
    Working out project plan for implementation and maintenance
- Evaluation of the implementation of developments (about 6 months later)
  - By external experts
  - Together with hospital staff

II. Requirements of the adequate handover practice

Handover

Definition of patient handover

- "..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)

Types of handover 1.

By location:

- **Interhospital:** between institutions (e.g.: referral, discharge, replacement, etc.)
- **Intrahospital:**

  - within hospital (e.g.: between medical units as emergency department and wards, between wards and diagnostic unit, operation room and postoperation ward, between wards and intensive care unit, between hospital and patient home, preparation for surgery, transfer to other wards, examination referral, etc.)

  - within ward (e.g.: shift to shift handover, substitution, etc.)

Types of handover 2.

By communcation channel:

- ❑written
- ❑verbal
- ❑both of them

By participants:

- ❑between care providers (e.g.: doctor-doctor, nurse-nurse at shift to shift handover, doctor-nurse, etc.)*
- ❑between care providers and patients or relatives (legal representative)

* The patient may also be involved in this case, but the responsibility for the care is transferred to another care provider.

Levels of handover

- handover at patient level
  - e.g.: handover of a given patient from one ward to another
- handover at ward/department level
  - e.g.: nursing shift change of a given ward
- handover at larger unit (more wards, dempartments) level
  - e.g.: night duty change of 2-4 wards
- handover at institute level
  - e.g.: hospital morning referal with chief medical doctors

Exercise 1: Identifying handovers

1. Let’s collect all the possible handover types that appear during the day on your ward.
2. Add duration of handover and its frequency to each type.
3. Draw the timeline of handovers occuring through the day.
4. How many time do you spend with handover each day?

Why should we deal with handover? 1.

- The pattern of the health service has been changed:
  - the exchange of the entire staff between shifts and daytimes are rather frequent
  - various providers are involved in the care of the same patients' group during the day
  - daily contact of a doctor with his/her patients is usually not relevant
  - professionals of different disciplines work together in the care of a given patient
  - Beside full-time associates temporary or part-time employees are also involved in patients' care

Adapted from: Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

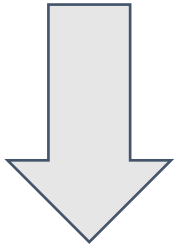
Why should we deal with handover? 2.

❑ Patient's care has been speeded up:

- the number of simultaneously cared patients by a team has been increased
- providers are more tired at the end of workin time which means a risk of patient safety
- patients spend shorter time in hospital, patient rotation is more rapid
- patients' care has become more complex, and accordingly more technologies and data, various specializations and supportive services are involved in the care of a certain patient
- patients are transferred between various wards, organizational units, sometimes without awareness of the doctor
- care of certain patients is performed by multidisciplinary teams

Adapted from: Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Why should we deal with handover? 3.



The continuity of the personal relationship between provider and patient is terminated, that must be replaced with the continuity of the system.

Adapted from: Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of system continuity

- ❑ time in rotas for members of the team to meet, share information, and clarify responsibility for ongoing care and outstanding tasks
- ❑ access to up-to-date summaries and management plans for all patients under a team's care and modification of management plan if adequate
- ❑ robust means to identify and contact the doctor who is responsible for a patient at any given time
- ❑ thorough introduction and briefing on handover practice is necessary for all new collegues

Adapted from: Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

The aim of the handover

To ensure the continuity and safety of patient care, high-quality clinical information should provided to participants on time in order to provide the adequate care for the patients in the adequate time.

In case of incorrect handover ...

- ❑ patient may receive inappropriate treatment,
- ❑ diagnosis may be delayed,
- ❑ time of hospital treatment may streched,
- ❑ continuity of care may break,
- ❑ critical adverse events may occur,
- ❑ patient complaints and claims can be expected,
- ❑ cost of care may increase.

Exercise 2:
Examples of errors and „near misses”

1. Tell some cases in which mistakes or near mistakes happened because of inadequate handover processes?
2. What happened/nearly happened with the patient in these cases? What were the consequences in the patient’s further care?
3. What was the matter with the handover in these cases? What was missing or what was inadequate during handover?

4. Tell some cases when - related to handover - you felt „how good is that I have mentioned/told/done sg.,
   - so that the patient didn’t get in trouble,
   - now it’s sure, it wasn’t me who had made the mistake.

The most common deficiences related handover

- ❑ Missing relevant information of patient
- ❑ Unnecessary information
- ❑ Poor communication
- ❑ More symbolic than effective
- ❑ Frequent disturbance
- ❑ Missing of interaction between care providers
- ❑ Unclear responsibilities
- ❑ Broken communication between professionals
- ❑ Leaving out of patients partially or fully from handover procedure

Adapted from: H Draschler, W Kicken, M van der Klink, S Stoyanov, H P A Boshuizen, P Barach: The Handover Toolbox: a knowledge exchange and training platform for improving patient care, BMJ Quality and Safety, 2012

Causes of the deficiences are mostly:

- ❑ Missing of regulation and protocolls
- ❑ Lack of time for handover and related trainings
- ❑ Behavior and organisational culture factors like:
  - missing of holistic approach to patient care
  - blame culture

Adapted from: S Stoyanov, H Boshuizen, O Groene, M van der Klink, W Kicken, H Draschler, P Barach: Mapping and assessing clinical handover training interventions; BMJ Quality & Safety, 2012

Good handover benefits patients

- Patient safety is protected by reducing the number of adverse events that can lead to adverse events, damage or in the worst case to death.
- Continuity of care increase, less fragmentation would happen.
- Repetitions are decreased by not asking the same questions from patients over and over again.
- Patient satisfaction is growing in providing service and care.

Adapted from: Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Good handover benefits care providers

- Good practice of handover is a good opportunity for everyday training and for developing communication skills.
- Clear and transparent communications provide professional protection to caregivers if they are accused of failure.
- Stress is reduced by the fact that the provider feels, he/she has adequate information about the patients' care, it is under their control.
- Employee satisfaction increase by experiencing professionalism and high quality care.

Adapted from: Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – evidence based elements 1.

Face to face communication

- ❑ offers more opportunities for clarify information (e.g.: „Read-back” or „Check-back”, briefing, etc.)
- ❑ offers opportunities for socal interaction, education and team-building

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare

Requirements of adequate handover – evidence based elements 2.

Documentation

- ❑ helps to avoid forgetting information

  (according to a handover study only 33% of information was retained after the first handover cycle and only 2.5% of information was retained after five handover cycles, while using pre-prepared data sheets resulted in the full maintenance of data)

- ❑ can minimalize repetitions
- ❑ can shorten the length of handover

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare

Requirements of adequate handover – flexible standardization 1.

Unified practice can improve patient safety, because it makes the process of handover:

- ❑ clear
- ❑ accountable
- ❑ quicker,
- ❑ complete,
- ❑ known and followable for everyone.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare

Requirements of adequate handover – flexible standardization 2.

Flexibility is important, because :

- ❑ specialities of professions are different (e.g. cardiology vs. psychiatry),
- ❑ preferencies of wards and forms of care are different (e.g. acut vs. chronic care),
- ❑ structure of the wards are different,
- ❑ work conditions of wards are different,
- ❑ patient characteristics are different.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare

Requirements of adequate handover – standardized handover

Flexible standardized handover means:

- ❑ Every participant is aware of
  - ❑ the purpose of handover,
  - ❑ what information have to be handed over,
  - ❑ what and how to document;
- ❑ It is assured that :
  - ❑ each participant is able to take part in the handover,
  - ❑ participants are on the handover in time,
  - ❑ participants are able to hand over the relevant information.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare

Requirements of adequate handover – participants 1.

- Participants of handover must be identified. In this context participating in handover means equal importance to younger and senior collegues.
- Handovers of large units should be multidisciplinar.
- If it is possible, chief nurse should be involved in the main handovers between doctors.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – participants 2.

- If more specialities are involved in the care of a given patient, all the relevant specialities should participate in the handover in order to get the relevant information about the patient.
- Senior collegues should always be involved in the handover in order to achieve high-professional decisions and so the handover could also be a consuctive part of training .
- The leader of the handover should make sure that all the participants know each other and the new collegues are aware of the geographic and system specialities of the hospital.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – patient empowerment

The role of patient empowerment:

- ❑ Patient is the common link between the different handovers.
- ❑ If the handover of information occurs in the presence of the patient, the patien has a checking , strenghtening role in it. To achieve this one should try to use a language that can be properly understood by the patient.
- ❑ Patient satisfaction raise.
- ❑ It can give the opportunity for the patient to get information about his or her condition and care (generally it is a legal commitment , too.)
- ❑ By all the above it could improve patient safety.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – time factor

- Patient handover should be held in a fix time and with an adequate length.
- Time of handovers should be known by all the collegues and patient care should be planned in the way where no intervention happens during this time except life-threatening care.
- Patient care should be planned like collegues are able to participate in handover processes.
- Main, overall handovers are generally held in the morning, but there are many different handovers during the day.
- Thorough handover is required not just in case of shifts but in case somebody was far away for a longer period (e.g. weekend, vacation).

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – venue

- ❑ Handovers are generally held near to the most frequently used area of the ward.
- ❑ Venue should be enough large for all collegues to be able to participate.
- ❑ If it is possible, venue should be in a place where disturbance not occure and where other people don't stay. (Disturbance could be bleeping, phone-call, relatives, collegues not related to handover, etc.)
- ❑ Venue should have access to lab and X-ray results, clinical informations and should have telephone and internet connection .

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – how to do 1.

- The way handover should be done depends on its size: it could be for the whole hospital, for a department or a ward, etc, but in all cases it needs to be done in a structured and pre-formed way.
- Ad hoc handover can lead to forgetting information to give.
- The most senior collegue should supervise the handover, and it must be clear to everyone who leads the handover.
- The given information should be relevant and succint.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – how to do 2.

- The handover process could be supported by some information-technology solution, in this case the system should identify all the relevant patients.
- Handover process should be checked up regulary e.g. by surveys, case reports, management meetings, etc.
- It is the responsibility of the medical director or the head doctor to make handovers realize in the required way.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – information to share 1.
(in case of handover at ward level)

- Written or IT based handover should include:
  - current inpatients
  - accepted and referred patients due to be assessed
  - accurate location of all patients
  - operational matters directly relevant to clinical care such as ICU bed availability
  - information to convey to the following shift
  - patients brought to the attention of the critical care outreach team
  - patients who are unstable or whose clinical status is deteriorating

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – information to share 2.
(in case of handover at ward level)

- ❑ All verbal and written handover should include:
  - ❑ patients with anticipated problems, to clarify management plans and ensure appropriate review
  - ❑ outstanding tasks and their required time for completion

When handing over information between collegues, the avoidance of jargon and explanation of abbreviations is essential.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – information management

- ❑ All hospital IT systems must ensure the administration data is up-to-date 24-hours per day. It should always be visible which patient belongs to which ward.
- ❑ During handover data protection acts should be kept, all handover processes should comply with the law.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

Requirements of adequate handover – education and training

- Local handover processes should be educated to all levels of doctors and nurses.
- In case of new collegue, education should involve:
  - content of handover, good and bad practices to visualize its importance, and supporting report on his or her practice
  - availability, purpose, and user guide of available educational materials
  - medical-law aspects of documentation, handover and discharge
  - adequate using of tools applied in the local handover processes.

Adapted from: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
Safe handover: safe patients Guidance on clinical handover for clinicans and managers, NHS National Patient Safety Agency

III. Handover techniques

The sources of this chapter: OSSIE Guide to Clinical Handover Improvement; Australian Commission on Safety and Quality in Healthcare
SBAR Communication Standardization in Arizona; Arizona Hospital and Healthcare Association

Exercise 3: SBAR 1.

Scenario:

Don Krum, DOB 2/3/34, was admitted three days ago with a diagnosis of congestive heart failure. Yesterday the patient was transferred from CICU to your floor. This is your first day having the patient, and the patient's second day on your unit. Breakfast trays are being picked up by the nurse aides and you are giving the morning medications to the patient. You ask him how he is feeling and he says great, especially since he is off that crummy jello and bland food from CICU. He goes on to tell you that he really enjoyed breakfast, especially the bacon, and he wants the same breakfast tomorrow. Also, he enjoyed last night's dinner and wants to know if he could have it again because it was so tasty. You notice his am weight is up 2 pounds from his weight when he is was in CICU. You check the dietary order and notice it says, "Regular diet". He has increased edema in his feet and his blood pressure is slightly elevated this am (164/102) from last night's pressure of 152/98.

Exercise:

You are this patient's nurse and need to call the physician to provide this information to him as you want to avert any complications. You also feel perhaps some diuretic is indicated because the blood pressure is rising, the weight is up, edema is occurring and there have been no diet or fluid restrictions. Tell these information to the doctor.

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

Tools to introduce

1. Hand me an ISOBAR
2. **SBAR**
3. ISOBAR

- ❑ They can be used in every type of handover.
- ❑ They are simple and can be easily learnt.
- ❑ They can be generally apply (in all specialities) and are well-tried.

***Tools** give **frame** to handover* → *this make handover **standardized**, but The exact content should be added by the **professions** (**medical content**) And the **staff** of the ward (content related to **local specialities**)* → these make handover felixible

III. Handover techniques

Hand me an ISOBAR

HAND ME AN ISOBAR

HAND: Prepare for handover

H = Handover time

- Hey, it is handover time, an importan clinical task.

A = Allocate staff

- Allocate staff for continuity of patient care. During handover it is essential that emergency patient care is delivered by staff. Clear allocation of staff members is essential to reduce disruptions and ensure safe patient care during handover.

HAND ME AN ISOBAR

N = Nominate participants, time and value

- The attendance of key staff should be determined. This should include incoming and outgoing team members who are directly responsible for the care of the patient to be handed over.
- The handover process should have a clear starting time and a venue which provides minimal disruptions.

D = Documentation

- Prior to handover the clinicans should obtain and update necessary documents. All essential information should also be clearly documented in patient progress notes.
- Documents used for handover should also be available at handover time.

HAND ME AN ISOBAR

ME: Organize handover

M = Make sure all participants have arrived

- Clinicians should be provided with paid and protected time to attend handover.
- Punctuality during handover sessions is important and should reflect the professionalism of clinicians involved.

E = Ensure leadership is provided during handover

- The handover of patients during a shift change should be supervised by a designated leader. This is usually the role of the most senior clinician present.
- The leader should ensure that all relevant communication items are covered in a timely manner.

HAND ME AN ISOBAR

AN: Provide environmental awareness

A = Alerts, attention and safety

- Handover should include notification about patients who might require significant levels of care or immediate attention; are deteriorating or who might deteriorate; or present occupational safety issues.
- Information should be provided about the condition of the work environment (e.g. plumbing problems) that may impact on safety.

HAND ME AN ISOBAR

N = Notice patient and staff movements and numbers

- Potential patient movements should be highlighted so that incoming teams can devise plans to manage their workload.
- Staffing numbers and arrangements may also need to be described.

HAND ME AN ISOBAR

ISOBAR: individual patient handover

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

III. Handover techniques

SBAR

SBAR - Why should we use it?

- When using SBAR, the speaker must organize his / her thoughts, outline the information, know what he/she is asking for, and then can effectively convey the information.
- Any profession can apply at any level, so it can be used as a whole hospital. ("We speak one language")
- It's very easy to remember, recall, use.
- Clear, short, concise.
- Classify the information to be delivered and help prioritize it.
- Also suitable for other situations (e.g.: communication with relatives).
- Method that can also be used in writing.

SBAR - Acronym

Situation – what is going on now

Background – what has happened

Assessment – what you found/think is going on

Recommendation – what you want done

Situation – What is going on now 1.

- ❑ Introduction (participants, patient)
- ❑ Patient identification
- ❑ A brief description of the actual status (what is the problem, when it started, how happend, how severe it is, what is the main complain etc.)

Situation – What is going on now 2.

- This part should take about 8-12 seconds because it is suppose to immediately grab the listener's attention and convey the immediate need.
- It should also be brief because the listener will start to "fade out" of listening if you go past 8-12 seconds.
- This may be the greatest challenge with SBAR because some are not used to getting straight to the point. It may take practice.

Background – What has happened 1.

- Background is what has recently been going on with the patient that now has changed
- Clinical background: known facts and data that are relevant (eg, diagnosis direction, date of addmission, medicine sensitivity, current medicines, related history, relevant laboratory values)

Background – What has happened 2.

- One only needs to convey information that is relevant to this issue.
- All relevant information should be available from the documentation.

Assessment – What you found/think is going on 1.

- What we think about the situation? How we see the problem (what do we think is in the background?)
- The patient's current clinical status: test results, vital parameters, symptoms etc.)
- On-going examinations, interventions, tasks to be performed

Assessment – What you found/think is going on 2.

- Especially focuses on changes in the shift.
- This section is where you share what you think the problem is or an assessment of the situation.

Recommendation – What you want done

- Recommendation about how to continue care: what should be done, what kind of examinations should be happen, the parameters that need strict monitorizing, considering transmission to other ward, unit., etc.
- In case of any reccomendation time, duration, etc. of suggested intervention should be signed.
- In case of not having any recommendation, this fact has to be signed and think on together .

SBAR - some other aspects

- At each point only the relevant, important information should be shared, the purpose is not mentioning all the available information.
- Sometimes knowing what not to say as important as knowing what to say.
- Bilateral communication is one of the criteria of effective handover , so at least at the end of the handover „Is there any question?” should be asked.

SBAR Video

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

SBAR - samples

- SBAR Communication Worksheet SBAR-001
- SBAR Communication Worksheet SBAR-002
- SBAR Communication Worksheet SBAR-005
- SBAR Communication Worksheet SBAR-006

Source: Safer Healthcare www.SaferHealthcare.com

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SBAR Communication Worksheet

This is not part of the medical record

Patient Name:	Patient Date of Birth: / /
Date: / /	Time: AM PM
Location:	Room Number:

Pre-call preparation: Gather the following information: Patient's name; age; chart. Rehearse in your mind what you plan to say. Run it by another nurse if unsure. If calling about pain, when and what was last pain medication? If calling about fever, what was the most recent temperature? If calling about an abnormal lab, what was the result of the last test? What is the goal of your call? Remember to start by introducing yourself by name and location. Use area below as a checklist to gather your thoughts and prepare.

☐ **Situation**
Briefly describe the current situation.
Give a clear, succinct overview of pertinent issues.

☐ **Background**
Briefly state the pertinent history.
What got us to this point?

☐ **Assessment**
Summarize the facts and give your best assessment.
What is going on? Use your best judgement.

☐ **Recommendation**
What actions are you asking for?
What do you want to happen next?

☐ **Follow-up Action (Next Steps):** Document the call and "read back" orders to ensure accuracy. Is there a change in the plan of care? Yes No

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Topic:		
Date: / /	Time: AM PM	Location:

☐ **Situation**

☐ **Background**

☐ **Assessment**

☐ **Recommendation**

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SBAR Shift Report Hand-off Guide

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1. Situation

☐ Patient ☐ Room #
☐ Admitting Physician ☐ Admitting Diagnosis / Secondary Diagnosis
☐ Most Current / Pertinent Issues

2. Background

Discuss only elements that have recently changed or are pertinent to this patient

☐ Admit Date _____ Anticipated Date of Discharge _____
☐ Physician / Ancillary Consults
☐ Psych. ☐ Surgical ☐ PT/OT ☐ Speech ☐ Wound Care ☐ Other
☐ Date / Time last seen by Physician _____
☐ Allergy _____
☐ Code Status / DNR _____
☐ Patient / Family Concerns
☐ Medications (pertinent issues / effectiveness) ☐ Immunization status
☐ Recent Interventions / Effectiveness _____
☐ Abnormal Labs _____
☐ Vital Signs ☐ Temp ☐ Pulse ☐ Respirations ☐ O_2 Sat.
☐ Pain status ☐ Location ☐ Score ☐ Modalities Used ☐ Effectiveness
☐ IV ☐ Type ☐ Amount ☐ Site ☐ Issues
☐ Drains / Tubes
☐ Wounds / Dressings
☐ Type ☐ Location ☐ Color ☐ Edema ☐ Temp ☐ Change in Size
☐ Decubiti ☐ Stage ☐ Location ☐ Treatment

Systems: Discuss only systems pertinent to this patient

☐ Neurological / Mental Status
☐ Level of consciousness ☐ Speech Pattern ☐ Dementia ☐ Confusion ☐ Depression
☐ Lungs / Respiratory
☐ Lung sounds (rales, rhonchi, wheezes)
☐ Cough (productive (description), dry)
☐ Shortness of breath, difficulty breathing, orthopnea
☐ Respiratory rate
☐ Oximetry
☐ O_2 @ _____ liters / per _____
☐ Cardiovascular ☐ Heart Rate ☐ Regularity ☐ SOB ☐ Edema
☐ GI ☐ Appetite changes ☐ Diet type ☐ Thickened Liquids ☐ TPN ☐ Weight
☐ Abdominal Tenderness ☐ Distention ☐ Vomiting ☐ Nausea ☐ I @ ___ ml / ___
☐ Last Bowel Movement ☐ Constipation ☐ Diarrhea ☐ Colostomy
☐ GU ☐ Catheter ☐ Urine Color ☐ Dysuria ☐ Frequency ☐ Last UTI ☐ O @ ___ ml / ___
☐ Musculoskeletal ☐ Pain ☐ Mobility Issues ☐ Positioning ☐ Fall risk status
☐ Assistive Devices ☐ Wheel Chair ☐ Cane ☐ Walker ☐ Other
☐ Skin ☐ Temperature ☐ Condition ☐ Edema ☐ Hematoma
☐ Discharge Plan / Issues ☐ Case Management ☐ Patient / Family Education
☐ Other _____

3. Assessment

☐ What do you think is going on with the patient?
☐ Do you have concerns about this patient? If yes, are they mild, moderate or severe?
☐ Discharge planning issues or concerns that need to be addressed

4. Recommendation

☐ Care / Issues requiring follow-up
☐ Orders requiring completion / follow-up
☐ Pending treatment / tests
☐ Issues / Items left undone that require follow-up

To order additional copies of this hand-off report guide, call 303-298-8083 or visit www.SaferHealthcare.com

Use this checklist to gather your thoughts and structure your hand-off report. Use the note space below to make additional notes pertaining to the report as needed.

Note: The elements within this checklist are not intended to be comprehensive but rather a starting guide to assist in organizing a plan of communication.

Notes:

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Critical Situation Report Checklist

Patient: | Time: AM PM

Location: | Date: / /

Situation

- ☐ Introduce yourself
- ☐ The patient I am calling about is _____ *patient's name*
- ☐ The situation I am concerned about is _____
- ☐ The patient's code status is _____

Background

- ☐ Here is the supporting background information.
- ☐ The patient's vital signs are:
  - ☐ Blood pressure: ____ / ____
  - ☐ Pulse: _____
  - ☐ Respiration: _____
  - ☐ Temperature: _____
  - ☐ Pain (Scale 1 2 3 4 5 6 7 8 9 10)
- ☐ The patient's mental status is...
  - ☐ alert and oriented to person, place and time
  - ☐ confused and... ☐ cooperative ☐ non-cooperative
  - ☐ agitated and / or combative
  - ☐ lethargic but conversant and able to swallow
  - ☐ stuporous / not talking clearly and possibly unable to swallow
  - ☐ comatose / eyes closed / not responding to stimulation
- ☐ The patient's skin is...
  - ☐ warm and dry ☐ diaphoretic ☐ mottled
  - ☐ pale ☐ extremities are cold ☐ extremities are warm
- ☐ The patient... ☐ is not on oxygen ☐ is on oxygen
  - ☐ The patient has been on _____ (l./min.) or (%) oxygen for _____ minutes (hours)
  - ☐ The oximeter reads _____ %
  - ☐ The oximeter does not detect a good pulse and is giving erratic readings
- ☐ The patient is allergic to: _____

Assessment

- ☐ In assessing the situation, I think the problem is _____ *state problem*
  - ☐ The problem seems to be ☐ cardiac ☐ infection ☐ neurologic ☐ respiratory
  - ☐ I am not sure what the problem is, but the patient is deteriorating
  - ☐ The patient seems to be unstable and may get worse. We need to do something.

Recommendation / Request

- ☐ I recommend or request that you _____
  - ☐ transfer the patient to critical care
  - ☐ come to see the patient right away
  - ☐ talk to the patient or family about the code status
  - ☐ add / change orders to _____
- ☐ Do you want to have any tests done?
  - ☐ CXR ☐ ABG ☐ EKG ☐ CBC ☐ BMP ☐ Others
- ☐ If a change in treatment is ordered, ask...
  - ☐ how often do you want vital signs?
  - ☐ how long do you expect this problem will last?
  - ☐ if the patient does not get better, when would you want us to call again?

Notes

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Exercise 4: SBAR 1. (Again)

Scenario:

Don Krum, DOB 2/3/34, was admitted three days ago with a diagnosis of congestive heart failure. Yesterday the patient was transferred from CICU to your floor. This is your first day having the patient, and the patient's second day on your unit. Breakfast trays are being picked up by the nurse aides and you are giving the morning medications to the patient. You ask him how he is feeling and he says great, especially since he is off that crummy jello and bland food from CICU. He goes on to tell you that he really enjoyed breakfast, especially the bacon, and he wants the same breakfast tomorrow. Also, he enjoyed last night's dinner and wants to know if he could have it again because it was so tasty. You notice his am weight is up 2 pounds from his weight when he is was in CICU. You check the dietary order and notice it says, "Regular diet". He has increased edema in his feet and his blood pressure is slightly elevated this am (164/102) from last night's pressure of 152/98.

Exercise:

You are this patient's nurse and need to call the physician to provide this information to him as you want to avert any complications. You also feel perhaps some diuretic is indicated because the blood pressure is rising, the weight is up, edema is occurring and there have been no diet or fluid restrictions. Use SBAR to convey this information to the physician.

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

Exercise 4: SBAR 1. (A possible solution)

S: Good morning, Doctor Smith! I'm Mary Marley, the actual nurse in the 1st and 2nd room. I'd like to indicate according to our patient, Don Krum, that his weight has grown and his blood pressure has elevated in the past period.

B: Don Krum is 83 years old, and was admitted 3 days ago with a diagnosis of congestive heart failure to the CICU, from where he was transferred to our ward.

A: Don Krum is fine, his appetite is good. Actually there is no diet ordered to him, but from his narration I conclude that he had some at CICU. Since he is in our ward, his weight has been up 2 pounds, I can see edema on his feet and his blood pressure has been also elevated from last night's pressure of 152/98 to 164/102.

R: According to these results and seeing that the patient doesn't get any diuretic, I think it would be better to overview Don Krum's medication and diet with a doctor's eye.

Exercise 5: SBAR 2.

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 paracetamol #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

III. Handover techniques

ISOBAR

ISOBAR:

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 (e.g.: name and surname, 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.
- ❑ Readback 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)

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Thank you for your attention!

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