Quality Improvement Clinic

Featuring SBAR - structured communication tool

Safe Communication

Design, implement and measure: A guide to improving transfers of care and handover

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Contents:

"I got so used to the system being broken I prepared and copied my own handover sheet about my husband's condition – All the things I knew they needed to know and asked every time he was admitted.

I handed them to paramedics, A&E AND ward staff as the sheets had often disappeared by the time he had a bed. I do wonder where they all went!"

Acknowledgements

This guide was originally conceived and drafted by the Authors in their own time whilst they worked at the NHS Institute for Innovation and Improvement. Some of the examples and many of the ideas emerged as a result of the lead author's field work whilst completing the NHS Institute's Patient Safety Leader Programme, and through extensive discussions with the second author. Since the closure of the NHS Institute, additional material has been added by the second Author based on her experience of working as a QI practitioner. The guide is a working document and it is our intention to refresh it periodically as new learning emerges. A timeline for its production can be found on the back page.

Both Authors would like to thank the following for their contributions:

- Louise Jacox, Rebecca Bartholomew and the staff of the George Eliot Hospital
- Staff at the NHS Institute for Innovation and Improvement
- Staff at the Heart of England NHS Trust
- Fellows of the Improvement Faculty
- Sandra McNerney, script writer
- Georgette Houlbrook, Patient Representative, Wessex AHSN

References

This guide references some key documents that the Authors believe will help inform good practice: It is only a proportion of the good literature available! The topic of handovers and transfer of care continue to be researched and were a subject theme for The Health Foundation's Clinical Systems Improvement Programme (www.health.org) in 2012-2014. Despite research in this area, our experience in practice suggests that very few places have used a robust method to implement small scale or systems wide approaches to improve the many aspects of transfers of care that must be addressed in order to deliver a reliable service to patients.

If you have achieved this goal the Authors would love to hear from you and help spread the learning so that others can understand how they might adapt and adopt your learning to achieve reliable transfers of care in their own service. Please email nicola@qualityimprovementclinic.com

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Executive summary

There are many reasons why teams, departments or even whole organisations will want to improve the way handover or transfers of care happens for their patients and service users. Studies have identified clinical handover as a 'high risk scenario for patient safety (*Clinical Handover Literature Review*, 2008). They describe the dangers and consequences of poor handovers, highlighting 'discontinuity of care, adverse events and legal claims of malpractice. But the task of passing on important information happens in every care setting and between care settings (transfers of care) every day in patient's homes, backs of ambulances, community clinics, surgeries to name some. Although many of the examples we have been able to find easily are from hospitals, the information in this guide has been written for use in all settings.

There is also the human cost; the distress, anxiety and loss of confidence that we know poor handovers can lead to for patients, clients and their families and for staff too (see case study, Appendix A).

This guide is not about the justification for improving handovers; that is covered in detail in other documents such as the *OSSIE Guide to Clinical Handover Improvement* and the Royal College of Physicians' *Acute Care Toolkit: 1 Handover.* Nor is this guide a detailed manual for improving *every* aspect of your handover process.

Focusing mainly on good communication – one of the most important factors for safe and timely transfers of care – this guide, and the six step process at the heart of it, offers teams a practical improvement methodology that we know has worked well in many care settings.

It draws on some tried and tested tools that will help you, as a manager or clinician, to:

- link your improvements to the wider strategic aims of your organisation
- test, measure and understand the impact your changes are having
- use the sort of structured communication tools that are delivering significant improvements in safety and quality for care organisations and other safety critical industries across the world (e.g. SBAR, ISOBAR and IDEAL).

Many of the detailed tools and examples that you might want to use are included as appendices towards the end of the guide. This means you can move through the guide more swiftly, but have a wealth of examples and ideas at your fingertips if you need them.

Introduction

Welcome to this guide. It has been developed to help care teams and organisations make measurable improvements in the safety and quality of patient care by ensuring that, with every handover and transfer, the right **information** is given to the right **people** at the right **time** and in the right **way**.

> ***Handover [or transfer of care] is 'the handover 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' (****Bhabra G et al. 2007)*

We have used the word **transfers of care** in most, but not all, places in this guide. Transfers can include a **regular handover of care** at the end of a shift, or the **transfer of a person's care** to another ward, team, department, or service. This includes for example when a patient is transferred from a care home to a hospital or from a community team to a hospice. Transfers of care happen every day. They can be verbal or written; they can take place in a group or one-to-one; in person, or over the phone. But they all share the same purpose; to communicate vital information about a person in your care.

Why use this guide?

Many good resources already exist to help teams deliver safe and efficient transfers of care in different care environments (see Useful Resources, page 40). But, by working with frontline care teams, we have identified a gap when it comes to giving staff the detailed steps they need to **design, implement and measure** their improvements.

This *guide* aims to bridge that gap:

- It offers teams in all care environments a tried and tested methodology for transforming ideas and aspirations into sound improvement projects that link clearly with their organisation's wider aims and priorities.
- It introduces and explains some of the most useful transfer of care tools, including standardised communication tools such as SBAR (Situation, Background, Assessment, Recommendation), and directs you to some resources on form design that makes it easier to do the right thing.

Good communication is one of the factors which ensures safe and timely transfers of care. Advice on improving other factors is in National Leadership and Innovation Agency for Healthcare, *Passing the Baton - A Practical Guide to Effective Discharge Planning* (2008).

Where can things go wrong?

Poor transfer of care or handover communication is widely recognised as a major preventable cause of harm[i].

Good transfers of care rely on consistently good communication and there are many stages in a person's care journey where this can go wrong, including:

- shift to shift (continuity of care and ongoing assessment)
- across different professions (different staff groups often have different ways of communicating and their own hierarchies to navigate)
- between departments (e.g. in a hospital where patients might pass through many different departments)
- between different care settings (e.g. hospital and community where staff can have different communication styles and cultures).

The risks can be even higher when…

- people have complex needs (requiring more information to be handed over and remembered on a day-to-day basis)
- at weekends or holidays
- if junior staff are reluctant to ask for clarification from more senior staff or other professions
- where there is no written documentation, or what is written is unclear (e.g. too many abbreviations).

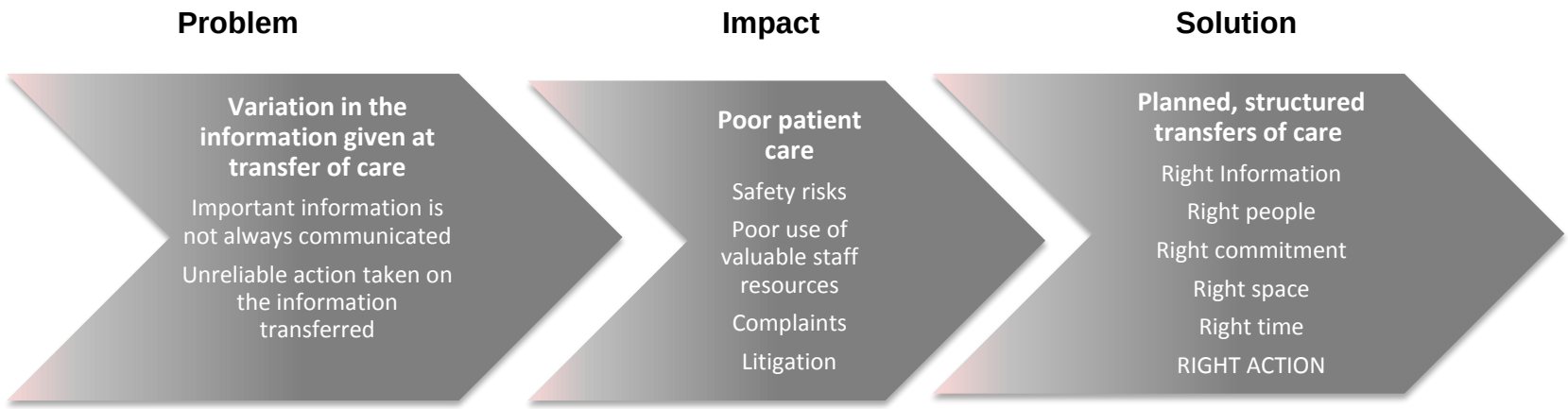
> ***'...only 2.5% of information from the first handover is retained at the final handover if there is no written record. If notes are taken, 85.5% of information is retained, but this rises to 99% when a standardised proforma is used*'***
>
> Bhabra G, Mackeith S, Monteiro P, Pothier DD, *An experimental comparison of handover methods (2007)*
>
> * Data taken over the course of five simulated handover cycles

More online...

The trouble with handovers is a useful video for understanding what happens to patients, families and staff when handovers are poor between different teams and care settings. It is a good resource to watch with your team to encourage involvement and stimulate discussion

‘Passing the baton’

In a relay race, how the baton is passed between the runners is pivotal to success or failure and it’s a useful analogy here; missed or misunderstood information can have a direct and even dangerous impact on the care of a patient.



There are two important techniques to ensure that the ‘baton’ is always passed correctly in the transfer of care:

- **Standardisation**: each participant follows the same procedure and communicates the same agreed content. This will have a positive impact on both the quality of care for patients and the productivity of the organisation.

- **Streamlining**: unnecessary steps in the process are identified and removed. Making transfers of care simple will reduce the risk (improve quality) and release time to care (improve productivity).

> ***‘Healthcare organisations [should] implement a standardised approach to handover communication between staff, change of shift and between different patient care units in the course of a patient transfer’***
>
> World Health Organisation Collaborating Centre for Patient Safety Solutions (2007)

Planned, structured transfer of care: what does it look like?

All of these checklist elements need to be in place to ensure the 'baton' is passed successfully and that the right information is given to the right people at the right time, in the right way...**every time**.

Good practice checklist*

What do we need?	What does it mean?	Do we have it?
1. Leadership	There is a nominated leader for each transfer of care/handover.	✓
2. Values	Transfers and handovers are valued as an essential part of care and preparation for handover is a priority.	✓
3. Right people	The appropriate people are involved.	✓
4. Specified time and place	A specific setting or place has been agreed where transfers of care can take place without interruption or distraction.	✓
5. Standardised process	There is an agreed process for transfers of care. This includes an agreed set of information to be covered in transfers (minimum data set). This is communicated in a structured way, is action-focused, assigns responsibility for actions and is supported by clear documentation.	✓

We will build on the checklist later in the guide, adding more detail and suggested measures for each of the five good practice elements.

* Checklist adapted from page 1 of the NSW [New South Wales] *Health Implementation Toolkit, Standard Key Principles for Clinical Handover*

How do you achieve it?

The second part of this guide shows you how to identify, plan and implement changes in a way that is most likely to deliver the planned, structured transfers of care you want to achieve. It is based on the **six step improvement process**:

For those who are familiar with running improvement projects, a summary of this guide for each of the six steps is included at Appendix M.

Start out

Start by finding out about any **existing policies** or **protocols** for transfer of care in your organisation. You may not know exactly what part of the transfer process you want to improve yet, or even how wide your focus will be (e.g. team, department or organisation). This is fine. The purpose of this first step is to get a clear idea of what is happening in your **current** transfer processes and start to understand where the problems and solutions might be found.

Observe a transfer of care and **record** the findings, but ensure that staff know they are not being *tested*. Transfers of care can be varied, depending on the time of day and who is doing it, so it's a good idea to observe several transfers.

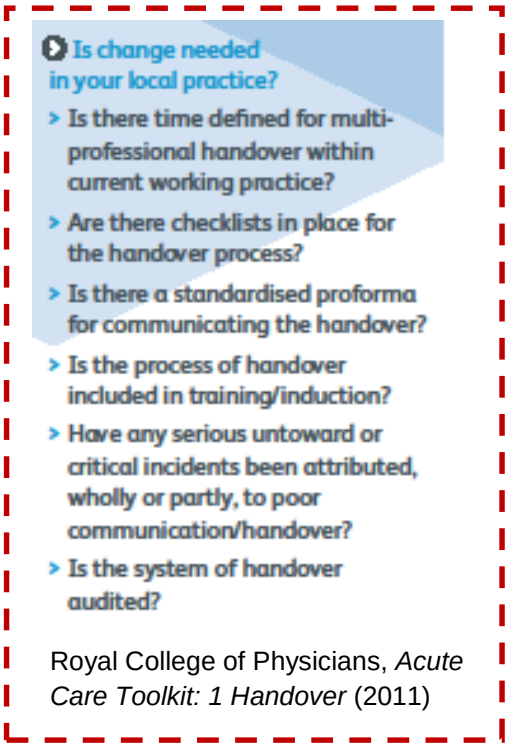
You can use:

- observation techniques (consider using photos and/or videos)
- staff, patient/client questionnaires
- group discussion and/or interviews.

Think about what happens before and after the transfer of care.

- How is information prepared for the transfer of care?
- Is information easy to find?
- What happens to documentation after the transfer of care?

You might start using observation and process mapping techniques to help you understand where the problems in your transfer of care processes might be, but they will be valuable tools later in the improvement process too, when you are gathering and generating ideas for improvement.

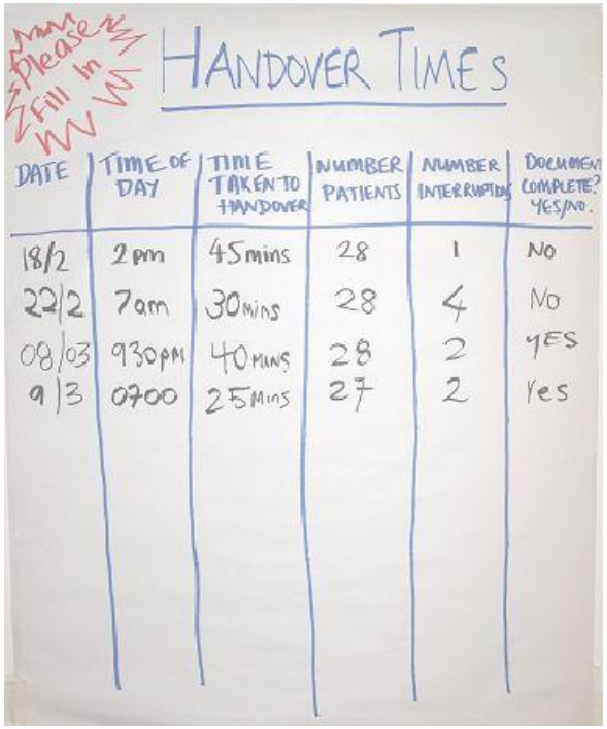


Royal College of Physicians, *Acute Care Toolkit: 1 Handover* (2011)

Measure the processes you are observing. You will need to do more detailed measurement later in your improvement project, but gathering some initial data here as part of your observations is a good idea.

You could:

- Time the transfer of information.
- Count the number of interruptions during the transfer of information.
- Count the number of times transfer of care documentation is completed.
- List the type information included in transfers of care and record how often this information is included in each communication.
- Measure how often the information is repeated.



More online...

For further ideas of how to **map** and **measure** current practice see resources section for links to:

- The **Quality and Value Toolkit** (process mapping, patient perspectives)
- **The Productive Ward** (acute), **Productive Mental Health Ward**, **Productive Community Hospital** and **Productive Theatre Handover**
- **The Productive General Practice** for general practice
- **The Care Homes Wellbeing Programme** for the care home sector

Some of these resources are still available on the NHS Institute's website at: www.institute.nhs.uk

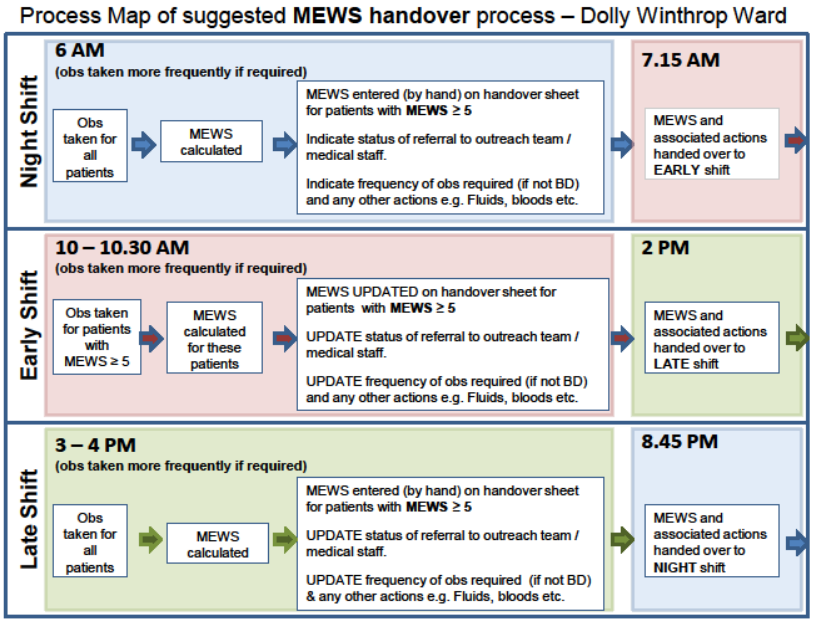
For alternatives contact us at www.qualityimprovementclinic.com

What does ‘good’ look like?

At this stage, it is useful to consider what ‘good’ would look like for the people in your care. One way of thinking about this is to consider what processes and behaviours you would want to see happen for yourself or a member of your family whose care is being transferred to another person or team. If you don’t usually include patients in your improvement work, we’d encourage you to ask their opinion, and if you want to do more see the link below on experienced-based design.

Use what you have learnt from your observations, measurements and process mapping and compare your current processes with the elements in the good practice checklist. (see Appendix B for examples of questions you can use to prompt discussion and generate ideas with staff, patients or clients.)

You could use process mapping to map communication of information between shifts, teams or departments.



More online...

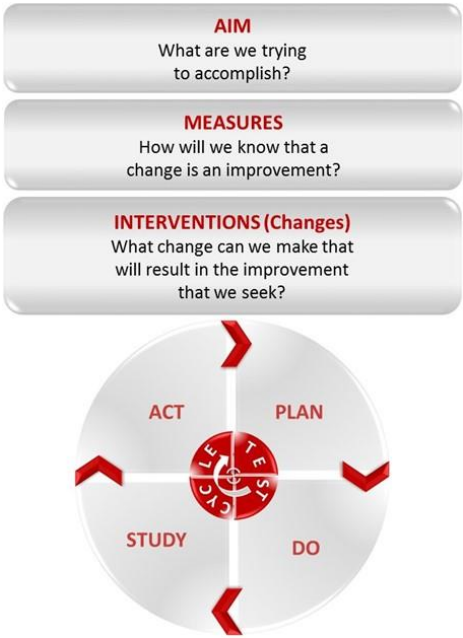
Find out more about how to use:

- Experienced based design
- Process mapping
- Root cause analysis (including the ‘Five whys’)

Define and scope

Once you have identified and captured what 'good' looks like in your transfer of care processes, and started to identify what you need to improve in your own systems, the next key step is to define a clear **aim** for your project.

This is where the **Model for Improvement** published in *The Improvement Guide (Langley et al. 1996)* can help you. Whatever your project and however big or small, the Model for Improvement will give you a simple, adaptable and thorough framework for developing, testing and implementing changes. Using the Model for Improvement means your changes are more likely to lead to the improvement you set out to make. (For more information on the Model for Improvement, see Appendix C.)



The Model for Improvement. Langley, Nolan, Nolan, Norman & Provost. The Improvement Guide, Josse Bass, 1996

What are we trying to accomplish?

This is the first question in the Model for Improvement. Being clear about the **aim** of the work will improve your chances of success. Using a SMART aim is one way to focus your project. (For more on SMART aims see Appendix D.)

Example – project aim: *'By December 2015, reduce the time the team spends on transfer of care (productivity) AND make the information handed over or transferred appropriate, easy to remember, easy to understand and easy to act upon (quality)'.*

Link your improvement project to your organisation's strategic aims

A project that meets the practical, day-to-day needs of your team and your patients or clients, *as well as* the priorities of the organisation you work for, will be much more likely to succeed.

Your organisation, health community or commissioning group will have a number of key issues identified as priorities. We know that matching your improvement programme to your organisation's 'big issues' will help its success.

You can find your 'big issues':

- in the organisation's business plan or annual report
- on the trust or commissioning group website or intranet
- by asking your project sponsor

Examples of 'big issues' include:

- delays in discharge
- safeguarding
- patient experience
- patient harm
- workforce efficiency.

Capturing and tracking the link

You can track the links and test your ideas using simple 'driver diagrams'.

This type of diagram can be useful to generate interest and commitment from your sponsor, your project team and others you are working with. It will also help you understand the impact of improvement work undertaken at the front line and its contribution to the organisation's high-level performance targets.

Find a good sponsor

It is important that your project is supported by an enthusiastic and empowered sponsor.

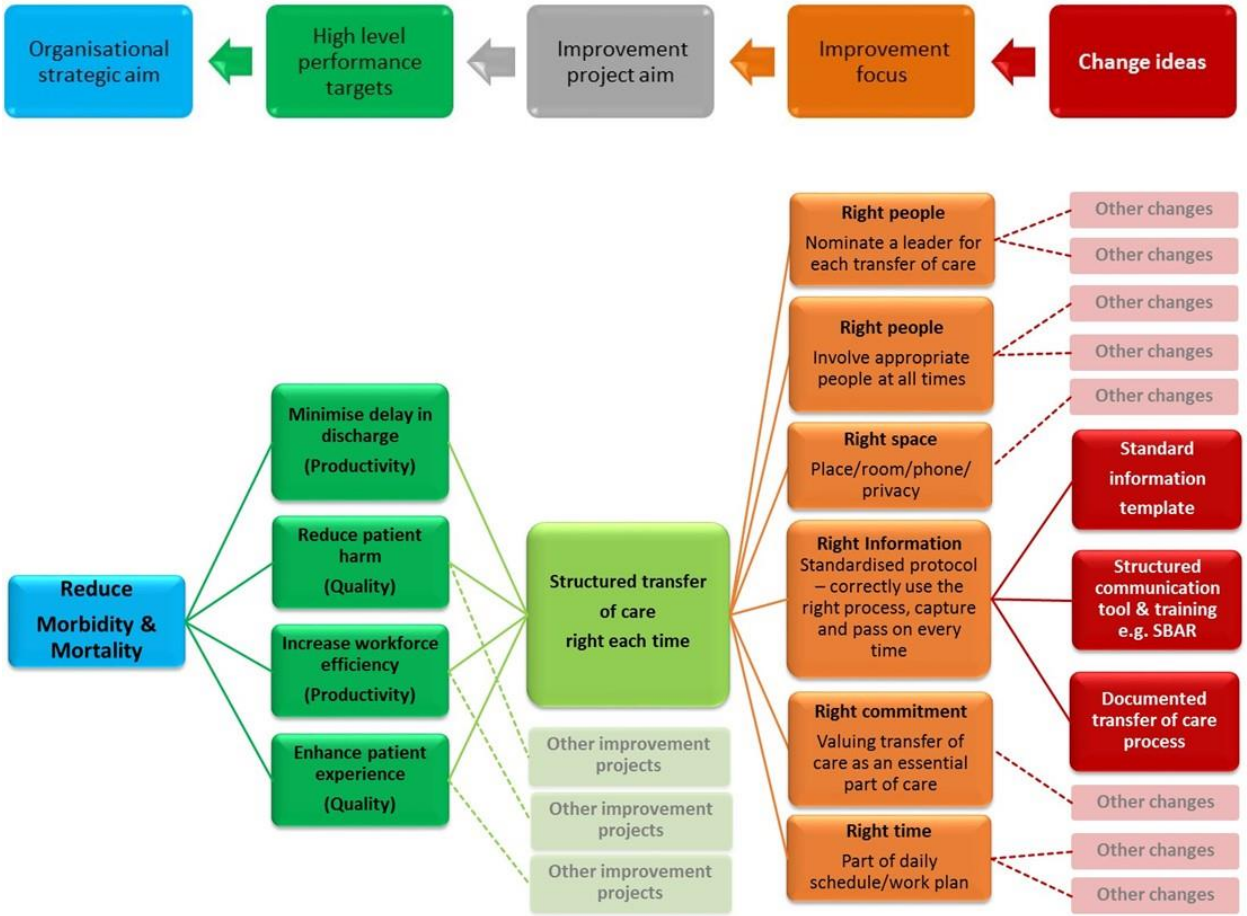
The right sponsor will:

- provide high-level support for your project
- offer advice
- help to engage other team members
- link your improvement project aim to your organisation's big issues/ strategic aims
- help remove obstacles to progress.

This might be:

- Director of Nursing or Matron
- Medical or Clinical Director
- Practice or Care Home Manager

Example driver diagram linking a transfer of care improvement aim to the organisational aim of reducing mortality.



Throughout the guide you will see how you can build on this basic diagram, adding on your improvement project **measures** and your change **interventions** as you develop them.

More online...

Click here for more information about using driver diagrams in your improvement work

What is the scale of your improvement project?

You may be using this guide to make a small change in the way you manage transfers of care, or you might be trying to make a change across your whole organisation, or even across the local care community. Whatever level you are working at, you need to set the scope of your project at the start to ensure it is manageable and achievable. Go where you think there is most need or where there is most enthusiasm. A success early in the project is vital to help stimulate enthusiasm and spread the good work.

Engage staff, patients and users and set up your project team

Engaging stakeholders

Think about different ways to engage stakeholders (staff, patients and service users) and convince them of the importance of improving transfers of care.

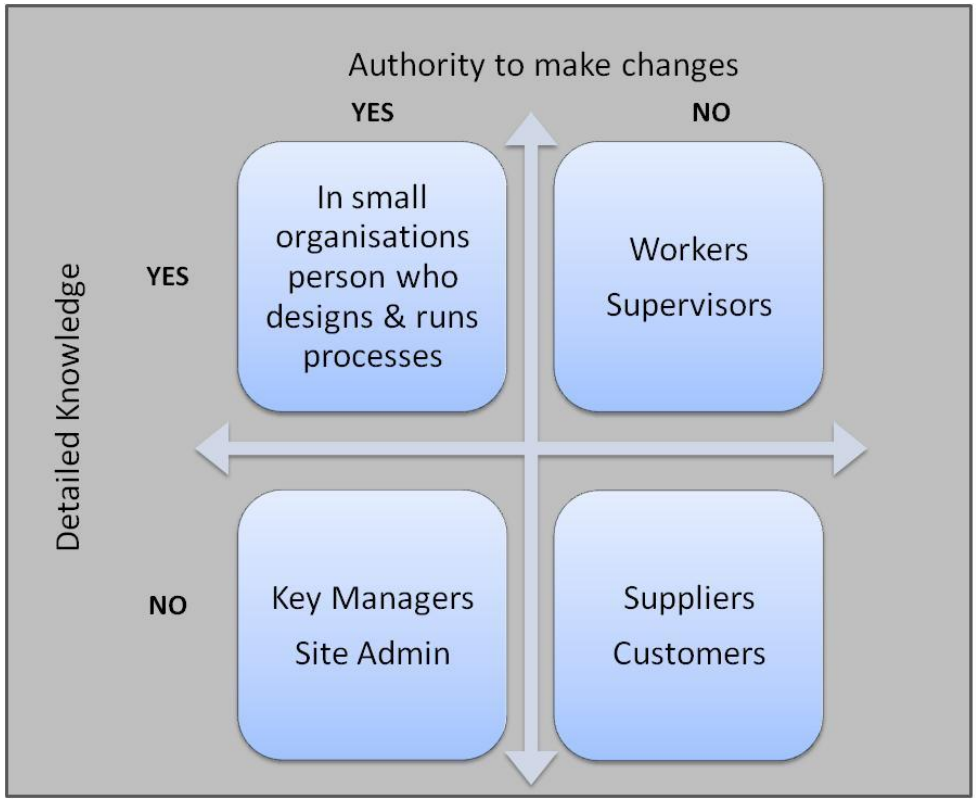
As well as patient stories, you can use evidence and recommendations from the transfer of care 'Useful resources' at the back of this guide. The 'Clinical engagement' page of the NHS Institute's Quality and Service Improvement Tools has further suggestions.

Everyone wants to deliver good care; using patient stories (like the one at Appendix A) or staff experiences can help teams commit to change and improvement. The film: *The trouble with handovers* is a powerful reminder about why it is so important to transfer the right information to the right person at the right time.

Who to include in your team?

Finding the right people to champion the project and drive it forward with insight and enthusiasm is crucial. Consider what each team member can offer; do they have expert knowledge and/or are they empowered to make decisions? This simple grid tool can help you identify what each team member will be able to bring to the project. Examples of the team selection grid for different settings are at Appendix E

Project team 'knowledge and empowerment' grid



- Senior leadership is essential. Identify a clinical or service champion who will be a visible and active supporter of your improvement project.
- Include staff who are actually involved in the transfers of care on a day-to-day basis - both those who deliver and receive the communication.
- Consider who else might use the transfer of care information. For example, might the physiotherapists use or update information about falls risk on the nursing shift handover document?
- Have you included someone from the IT team?
- Include people who can relate their experience of the transfer of care, e.g. the patient, resident or client. As a minimum, consider how you will get their input to the transfer of care process. Videoing people talking about their experiences can be a particularly powerful tool and is not difficult to set up. The experience based design toolkit provides further guidance on interviewing and filming individuals.

Putting it all together

By this stage, you and your team will have agreed the aim and scope of the improvement and how it fits with your organisation's wider strategic aims and targets. It is a good idea to capture this in one place, using a simple template such as the one shown in Appendix F. It will be a useful focus for further discussions with sponsors and others.

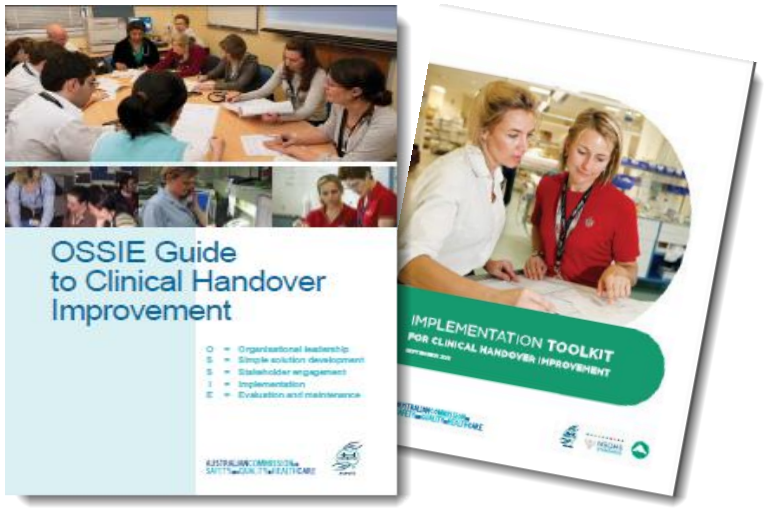
Sustainability

Sustaining your improvements should never be an afterthought. Sustainability is a crucial and integral part of any successful improvement project. It is something you need to be planning for from the start and will run through every aspect of your improvement work; from how you engage leaders, staff, patients and clients in developing, testing and implementing changes, to celebrating success at the end of your project.

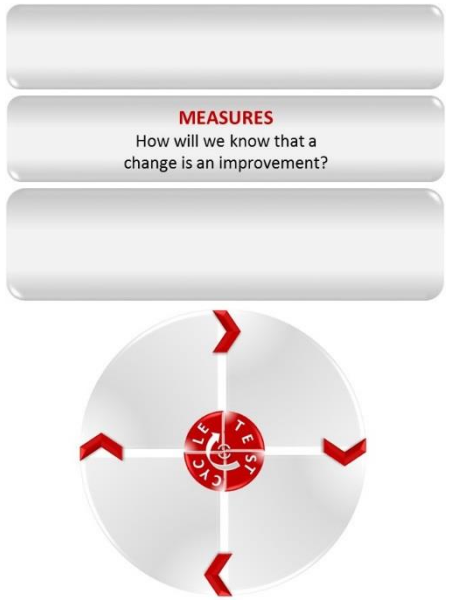
See **Step 6: Sustain and share** (page 38) for more information about sustainability.

Further reading

The OSSIE Guide to Clinical Handover Improvement and the associated implementation toolkit are highly recommended for anyone involved in improving handover or transfer of care in any care setting.



Measure and understand



Measurement for improvement does not have to be onerous; it is about using a few specific measures, linked to your project aim to answer the question: 'How will I know that my changes have made an improvement?'

You will want to use some process measures for your change ideas and also your improvement focus, and you will want to at least one outcome measure for your improvement project aim.

For your overarching **improvement aim** you might want to choose a process measure and an outcome measure from the list below:

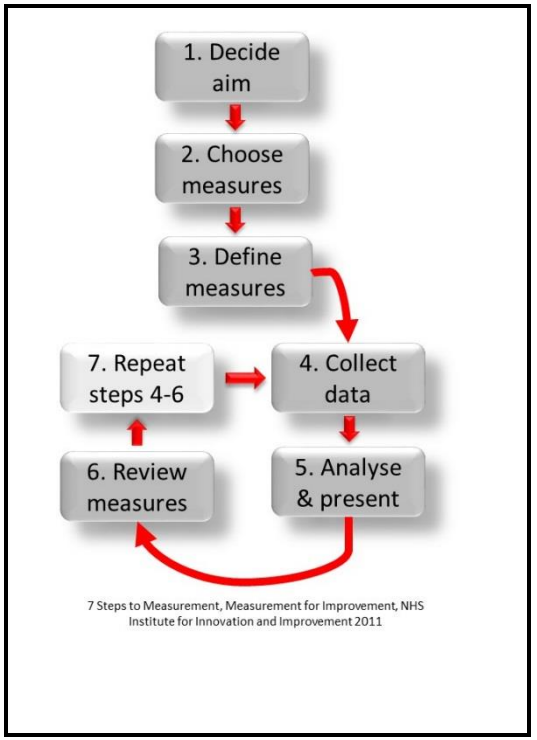
- No. of transfers right each time– based on your definition of 'right' *(Process measure)*
- No. of staff who know which patients are at risk of fall *(Outcome measure)*
- No of patients who get diagnostic tests when requested *(Outcome measure)*
- No. of staff who know who is in charge of handover and get the information they require for their job *(Outcome measure)*
- No. of times when number of staff involved in handover and time taken is within agreed limit *(Outcome measure)*

You will find some more on measures for the smaller pieces – after we have described the 7 steps to measurement.

Whatever you choose to measure, there are seven basic steps to follow:

The 7 steps to measurement

1: Decide project aims	You will have already done this.
2: Choose your measures	You may have a long list of possible measures, so you need to narrow these down to the most appropriate.
3: Define your measures	Be clear about exactly what you are measuring.
4: Collect data	Think about **what**, **who**, **how** and **when** to measure and establish a **baseline**.
5: Analyse and present results	There are many tools to help you do this, including: bar charts to understand common problems • run charts or statistical process control (SPC) charts to demonstrate your progress • photos, videos and stories.
6: Review measures	Look at the data regularly. What does it tell you? What should you do next?
7: Keep going	Repeat steps 4 – 6.



More online...

[7 steps to measurement video]

[Measuring for improvement (Improvement Leaders' Guide)]

[Handover and transfers of Care – *Step-by-step measurement guide*]

Choose your measures and start collecting your baseline data

You should not be spending lots of time collecting data! From your long list of things you could measure, just pick a few.

For your improvement project aim pick a process or outcome measure that will tell you whether you have achieved your aim. It should be something that is meaningful to you and your team. Outcome measures are often more meaningful to patients, but are more frequently affected by changes that are beyond your control. Process measures can appeal to patients and carers too e.g. the number of transfers of care in your weekly sample that are judged to be right – particularly if patients have been involved in creating the definition of 'right' e.g. the community rehabilitation therapists meet in the team office at 4.30pm and handover all planned actions for patients by completing the agreed online template.

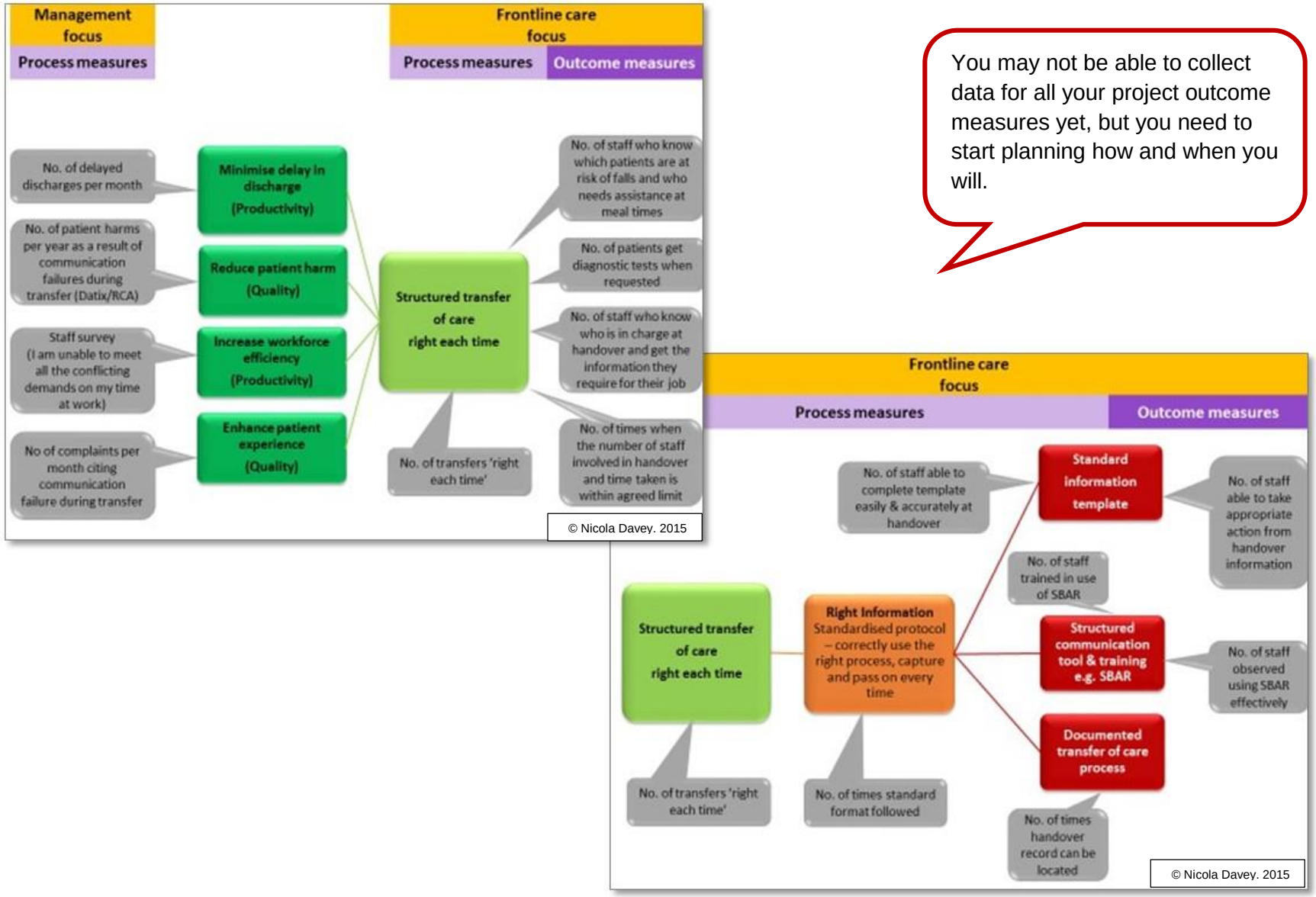
Remember, you may not see changes in these measures until you have made and sustained several smaller changes, or even carried out several improvement projects.

So the choice on data collection is a balance between ease and reliability of collection and whether it can inform your next action. Whatever you decide **you should pick at least one and start collecting this data now**. This will give you your baseline for the improvement project. If you don't collect your baseline data now, it will be difficult to prove your changes have made an improvement later.

There are often lots of things that need fixing, and your next piece of work will help you decide where to start (your **first improvement focus)**. From all your change ideas you will then need to select the **first change intervention**. In the box below and on the next page we have given some examples of process and outcome measures that focus on frontline care. We have also included process measures with a management focus so that you can see the connection between your work and your organisation's strategic objectives.

Improvement Focus: Right information	No of times standard format followed *(Process measure)*
Change intervention 1: Standard information template	No. of staff able to complete handover template easily & accurately a handover (*Process measure*) No of staff able to take appropriate action from handover information (*Outcome measure*)
Change intervention 2: Standard information template	No of staff trained in use of structured communication tool *(Process measure)* No of staff observed using structured communication tool effectively *(Outcome measure)*

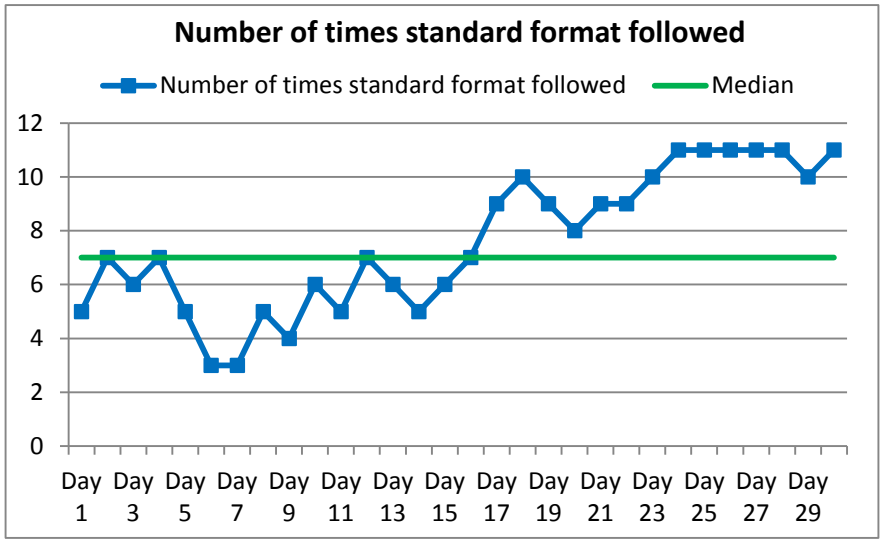
Driver diagram showing process and outcome measures from management and frontline care perspectives

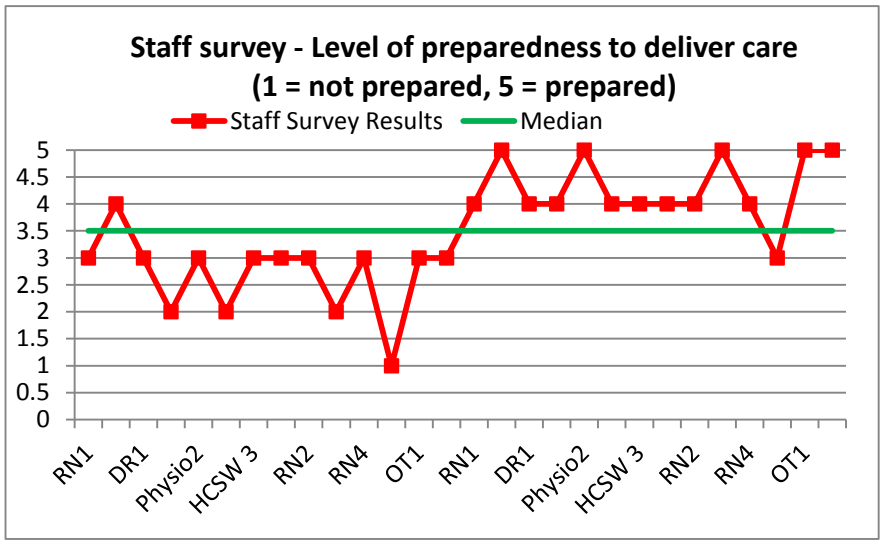


Capture and display the data

Plotting your data in a **run chart** is a simple way to see the variation in the system and if any improvements have been made. You need 25 data points before doing any analysis, so using more frequent data (weekly or daily, in favour of monthly or quarterly) is better. You can look for a 'run' of seven points or more - all up, all down, or all above or below the median value. The run will tell you if an improvement has been made.

Example run charts capturing project outcome data



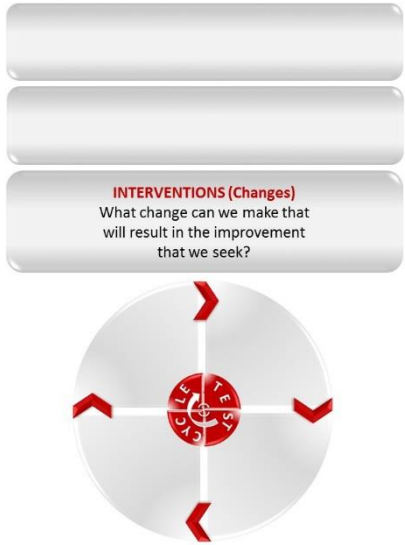


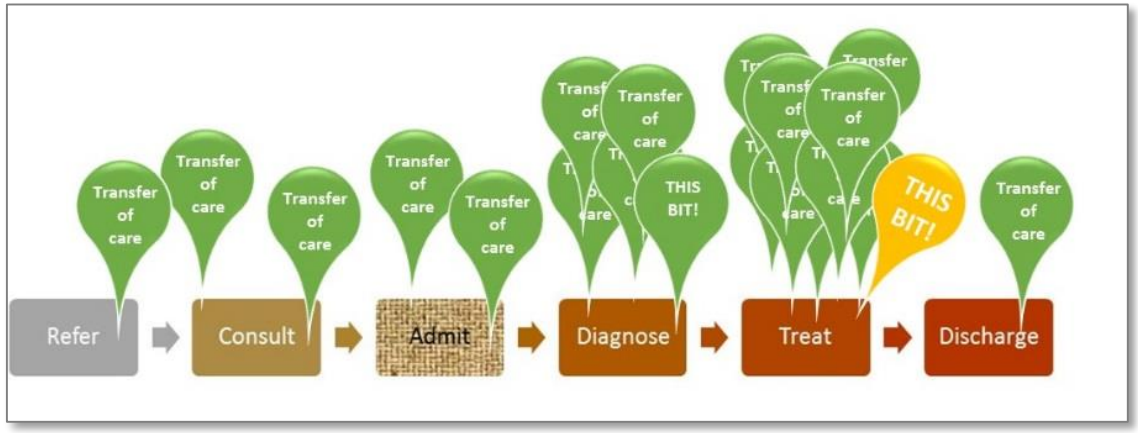
More online...

Click here for more about using run charts and simple statistical measures

Design and plan

Once you have mapped your current process and compared data about your transfers of care with best practice, you need to decide where to start – this will be your initial **improvement focus**. You may want to dig deeper into your current transfer of care processes using process mapping and root cause analysis techniques such as the 'Five whys' to help you understand how your transfer fits into the bigger picture.





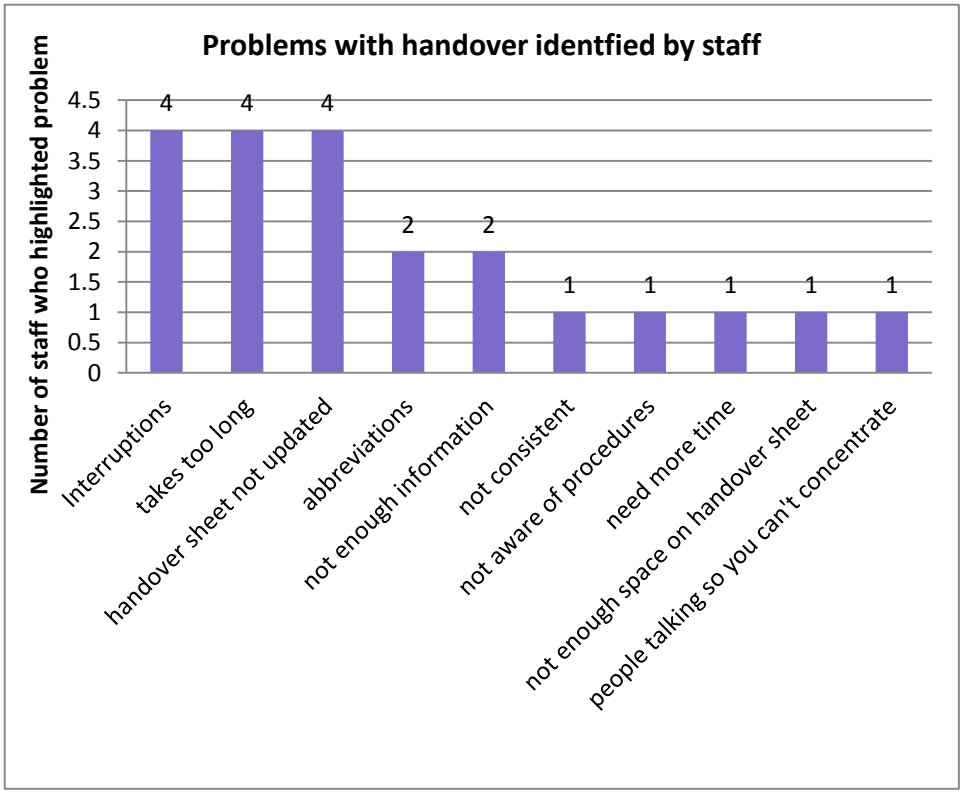
Revisit the driver diagram on page 15. The suggested **improvement focuses** are drawn from the good practice checklist mentioned earlier in the guide (for full list see pages 45-46).

Focus your improvement effort on something in this list that you believe will help achieve your improvement project aim. For example, you predict that finding a quiet place to communicate without interruptions will help speed up the handover or transfer of care process. Working with your project team, choose one area as **your first improvement focus**. There are different ways of doing this and you might choose to generate change ideas first before finally deciding where to focus.

All the good practice elements are interlinked and they may all need to be worked on at some point. Some changes may be developed very quickly (e.g. moving the location of handover); others may take a longer (e.g. changing the culture to place a higher value on transfers of care and give them priority over other tasks).

Where to start?

Look at your current process map and data. Which aspects of the process need improving first? You could use a bar chart to display the results from a staff survey and then focus your initial improvement on the most commonly-reported problems.

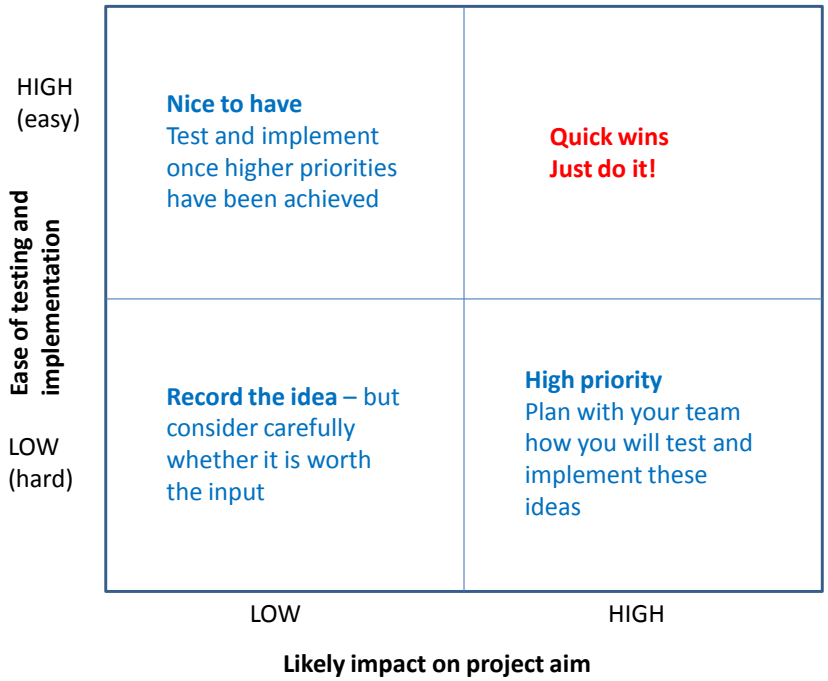


Pareto analysis is a simple technique that helps you to focus efforts on the problems that offer the greatest potential for improvement by showing their relative frequency or size in a **descending bar graph**.

Pareto's principle, the '80/20' rule, asserts that for many events, roughly 80% of the effects come from 20% of the causes. For example, if documentation is not completed, the process takes longer and information may be missed or mistakes made.

You could use a priority matrix to categorise your improvement ideas. Quick wins can be tested and implemented immediately. High-priority changes may take more planning and resources to achieve.

Example priority matrix



A good handover

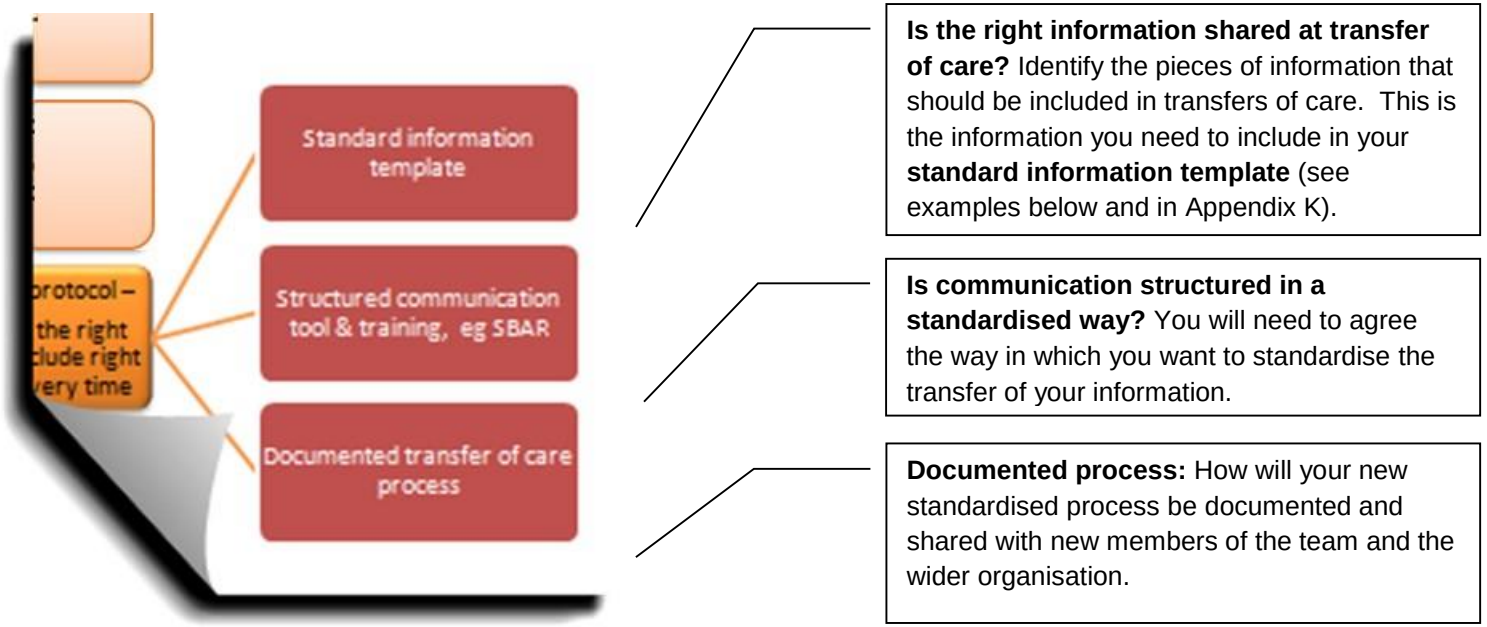
- ensures that changes in the clinical teams are not detrimental to the quality of healthcare
- improves communications between all members of the healthcare team, including those with the patient and their family
- identifies unstable and unwell patients, so that their management remains optimal, clear and unambiguous
- improves efficiency of patient management by clear baton-passing
- improves patient experience and confidence
- is a teaching and learning opportunity for those in training, who can observe appropriate role models at work.

Royal College of Physicians, *Acute Care Toolkit: 1 Handover* (2011)

Generate improvement ideas

Working with your team and using all the data and observations you already have, you can now focus more fully on generating ideas for changes. These help you select your 'change interventions'. There are lots of examples of change interventions in the many handover resources that already exist (see Useful resources on Page 40). Use these to stimulate discussion about what is possible in your setting. Remember improvement is context specific, so solutions that work for one team in one place don't easily transplant to another team in another place. Some adaption is often required in order for adoption to follow. The approach described in this guide can be used to 'check out' of test a proven intervention and optimise its effect in a different place.

As an example, we have used the development of a **standardised process** to illustrate how you could develop and test some change interventions.



Design your change intervention(s)

Design your own ‘standard transfer of care’ template

Let’s take one of these change interventions - **standard transfer of care template** – and look at how you might go about developing, testing and implementing it. Below is an example of an information template sheet that could be used in a hospital ward for a transfer of care. You may want to trial this one, but it is better if your transfer of care template includes information which is specific and relevant to your own care environment. A similar approach may be used in general practice for referral letters.

Example information template for nursing shift handover (more examples in Appendix K)

Example from the George Eliot Hospital

ISOBAR Handover Form
Date: AUTOMATIC

Bay 1&2 - NURSING NEEDS

Remember to Readback Patients who are New or Acutely Ill

IDENTIFY		SITUATION				OBS		BACKGROUND				ASSESSMENT (complete what is relevant)								RECOMMENDATION (What needs to happen today)	
												Essential Care Needs									
Bed	Patient Name DOB Age	Reason for hospital admission	Resus Status LCP	Medically Fit for Discharge	EDD or Home Today?	MEWS / Outreach AVPU	Obs frequency	Diabetes Type	Relevant past medical history	Treatment in progress	Section 2 completed	VTE	Mobility and Falls Risk	Pressure Ulcer Prevention	Diet & Feeding	Urine/Bowel concerns	Infection Control	Risk of harm to self or staff	Nursing Needs and/or concerns	Tests/ procedures /assessments required or booked	Other comments or Actions Agreed
Example	Name DOB AGE (automatic)	working diagnosis - why patient is in hospital on THIS visit	NFR = Not for Resus LCP = Liverpool Care Pathway	Y = Yes	Expected Date of Discharge OR Home Today	Latest MEWS Score if ≥ 4 OR = Under Outreach Team AVPU = Indicate level of	Frequency of OBS required (if not	Type 1 Type 2	Any other relevant co-morbidities, e.g. Cancer, Pacemaker, COPD, Asthma, Dementia?	include any current treatment, medications and/or specialist referrals	Will fill in automatically when entered in social needs	Has patient had VTE assessment Y = Yes	Can sit out Can stand Walks assisted Requires hoist Falls Risk	pressure sores grade 1,2,3,4,U date referred to TV nurse 2 hrly mattress type turns	NBM = Nil By Mouth Special Diet (specify) Needs help with feeding	indicate if concerns with urine or bowel output catheter in situ?	In isolation (why) Other infection control issues	Y = Yes (specify sensitively) (include risk of absconding)	indicate where relevant: IVAB, Peg Feeds (start time & rate) IVI fluids, O2 therapy Care Bundles, any other issues	include OT washing and dressing assessment, surgery, CT, MRI, specialist referrals etc. with date due	include any other issues or actions which need to be addressed and agree a timeframe
1	John Smith 04/08/1920 92	Seizures secondary to UTI			08/06/11	4 OR A	QDS	Type1	COPD Ca Prostate			Y	2 to transfer High Risk	Grade 2 L heel Referred 10/2/11	Diabetic diet	catheter			IVAB O2 2L prongs	MH referral 31/5/11	Priority
2	Jenny Blogge 27/01/1925 88	Repeated falls at home	NFR LCP	Y	Home Today				Ca Bowell Osteoporosis	Pain relief	given	Y	Hoist High Risk	High Risk Support Mattress	Soft Diet Encourage to feed						

Make it your own

Now create your own standard information template.

The quality of care you give is reflected in the quality of communication you use every day. The documentation needs to reflect this by including the right information. This information is called the **minimum data set**.

During the planning stage of your project you will have chosen your SMART aim. But whatever priorities you have chosen, transfers of care should always:

- communicate the right information
- focus on the goals of the patient/client
- clarify any significant changes easily
- be **action focused** – what needs to be done, by when and ***by whom***
- **prioritise** patients/clients with the most time-critical needs
- Include only information which is essential and adds value; try to stay focused on the information that is essential to be transferred at that point.

More online...

The emishealth eHandover electronic handover system has been development at Barking, Havering and Redbridge University Hospitals NHS Trust Community Services. Based on standard Microsoft tools that are readily available in most trusts, initial studies have demonstrated that eHandover is delivering an improvement in safety, productivity and staff satisfaction.

Consider including:

- your identity and role
- patient/client identifying information (at least 2 pieces is recommended, e.g. name, date of birth, patient ID, location)
- immediate clinical situation of the patient
- most recent observations/MEWS score (status of referral to critical care outreach team where appropriate)
- reason for admission/referral/discharge
- relevant medical history, results of investigations, treatment to date, current medications
- current safety/risk factors and associated care plans (diabetes, allergies, falls, pressure areas, nutrition, catheter, urine and bowel, infection control, cannula)
- recommended actions, timeframes and who is responsible (tests/investigations, specialist referrals, discharge etc). **This is really important: What do you need the person receiving the transfer of care to do?**

Remember to clarify/confirm understanding and transfer of responsibility.

Further guidance on the minimum data set is available in *A Clinician's Guide to Record Standards*

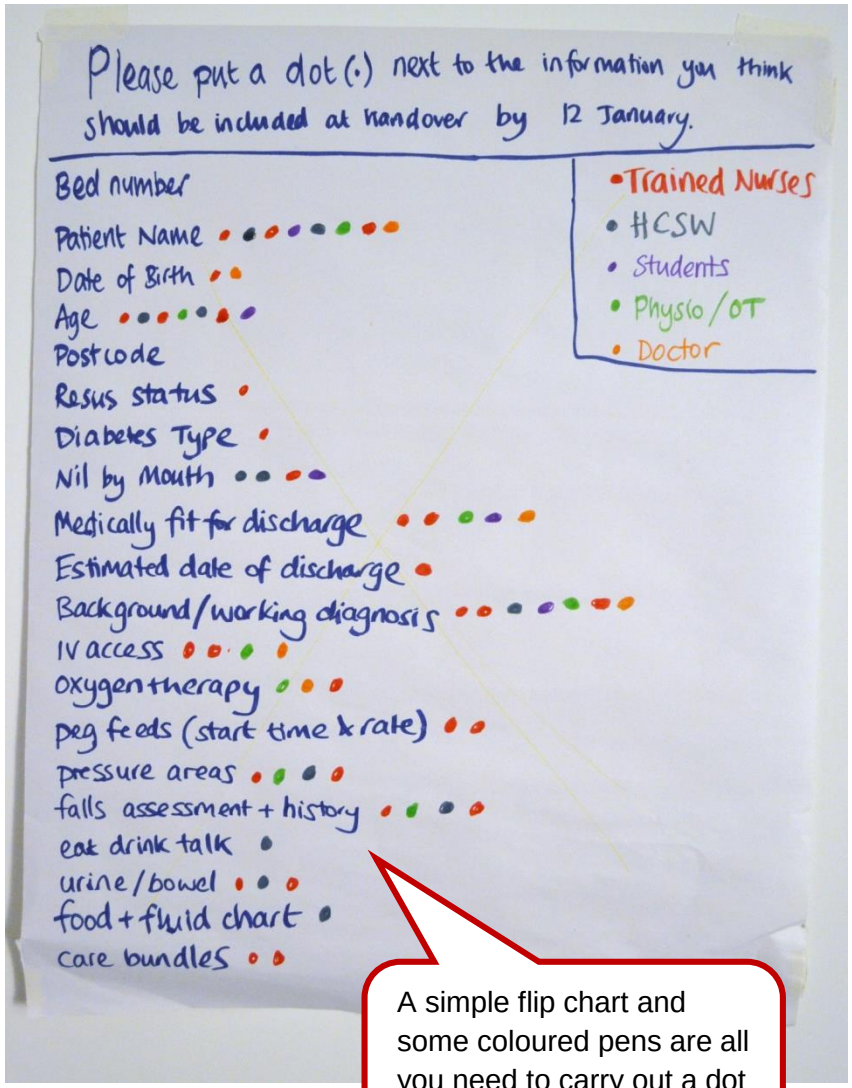
Use ‘dot voting’ to define your ‘minimum data set’

Dot voting is one simple way to collect the opinions of those involved in the transfer of care about which pieces of information should be included in a standard template. For more information on dot voting, see Appendix G.

Now think about where else this information is found. Does it need to be included in the transfer of care template, or is it readily available elsewhere, e.g. on a patient whiteboard which could be used as part of the transfer of care?

Improvement projects should aim to reduce, not increase work. Changes should avoid duplication of task wherever this is safe to do.

You should now have a complete list of all the information you will include in your new standard template. The next step is to organise this information using a structured communication tool such as SBAR (see page 31).



A simple flip chart and some coloured pens are all you need to carry out a dot voting exercise.

Using ‘structured communication tools

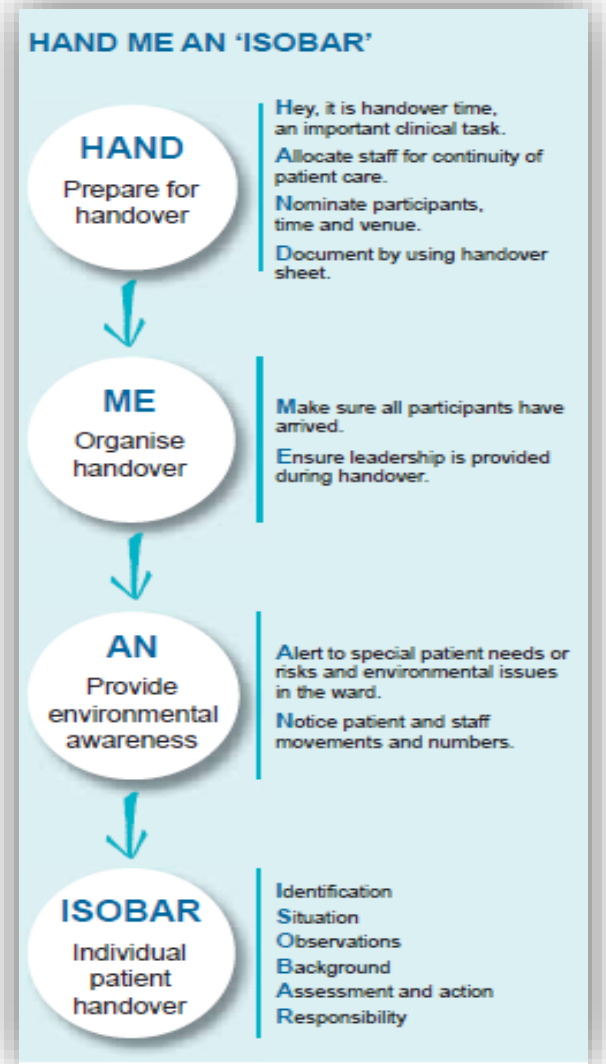
Structured communication tools are easy-to-remember mechanisms that you can use to frame conversations, especially critical ones, requiring someone’s (e.g. a clinician’s) immediate attention and action. These tools enable you to clarify **what** information should be communicated between members of the team, and **how**. They can also help develop teamwork and foster a culture of patient safety.

SBAR is one example. It stands for: **Situation, Background, Assessment, Recommendation.** The tool consists of standardised prompt questions within four key sections, helping to ensure that staff are sharing concise and focused information.

SBAR:

- encourages staff to communicate assertively and effectively, reducing the need for repetition
- helps staff anticipate the information needed by colleagues
- prompts staff to formulate information with the right level of detail.

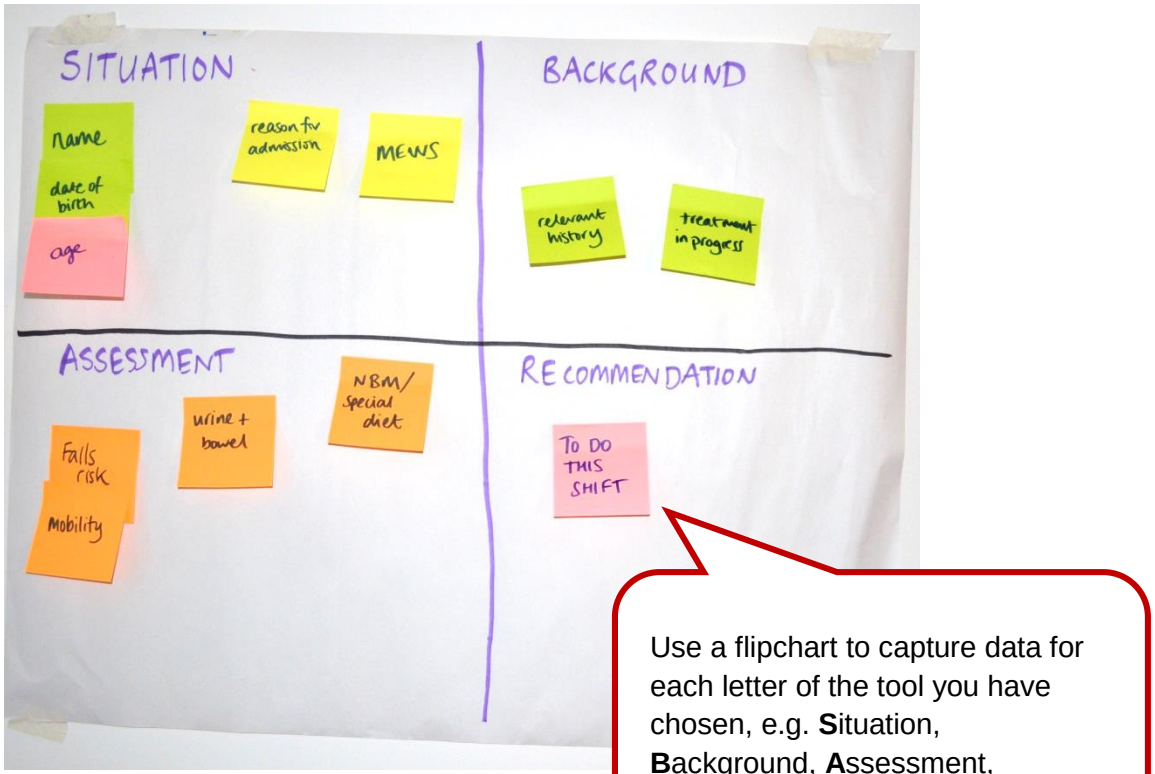
‘HAND ME AN ISOBAR’ is another example of a structured communication tool. Developed by the Royal Hobart Hospital in Tasmania, it is one of several examples featured in the OSSIE Guide to Clinical Handover Improvement (Australian Commission on Safety and Quality in Healthcare).



Once you have chosen the structured communication approach you want to use, you need to arrange your minimum data set accordingly.

You could:

- put all the pieces of information you want to communicate onto sticky notes
- put up flipcharts on the wall – **one for each letter of the tool you have chosen**, e.g. SBAR, ISOBAR, RSVP etc.
- in the case of shift handovers, include a flipchart for a safety briefing at the beginning or end
- ask the team to move the sticky notes to the flipchart they think is most appropriate.



Use a flipchart to capture data for each letter of the tool you have chosen, e.g. **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation.

More online...

For prompt cards and other resources to help you use SBAR in several different settings (including acute, primary care and community mental health) see:

There are lots of good examples of standard protocols in the OSSIE Guide to Clinical Handover Improvement.

The ABC of handover is another model which prompts the communication of clinical and operational issues between shifts

RSVP is a similar structured communication tool developed by Portsmouth Hospitals.

The next step is to design your template based on these information groups.

- Decide how you will indicate which patients are priorities and add this to your template.
- Prompt the person receiving the transfer of care to clarify and **read back** the information and confirm they are taking over responsibility for care from this point.

Don't worry about getting too technical with document function and layout for your initial testing of the template. Try finding someone in your team or organisation with some spreadsheet or word processing skills to mock one up for you. Or simply draw one by hand for your initial testing.

Document your standard process

As well as standardising the information you are going to communicate, you need to also standardise the process for communication. You will develop this process and test your change interventions for the other areas of good practice. You will also need to test the best way to document your standard process and communicate it to everyone involved. An example of a documented process is attached at Appendix K.

Choose and review your measures

Once you have developed your change interventions, you will need to decide which measures will be most helpful. Choose just a couple of measures that you think give the best feedback about the impact of your change intervention. Whatever you choose, make sure the data can be collected quickly and easily, e.g. if you choose to measure whether or not something happens in a particular way, the answer can be simply 'yes' or 'no'.

Think of measurement of change interventions as providing a 'before' and 'after' snapshot of each test.

Developing your measures for improvement is an iterative process. In some cases, you will only be able to refine your measures once you have designed your test of change. For example, you can't measure whether the new process is followed until you have defined what the new process is.

Appendix H uses the 'good practice checklist' and shows some suggested measures that you might want to consider for each improvement intervention. You will notice that these often overlap.

Pilot and implement

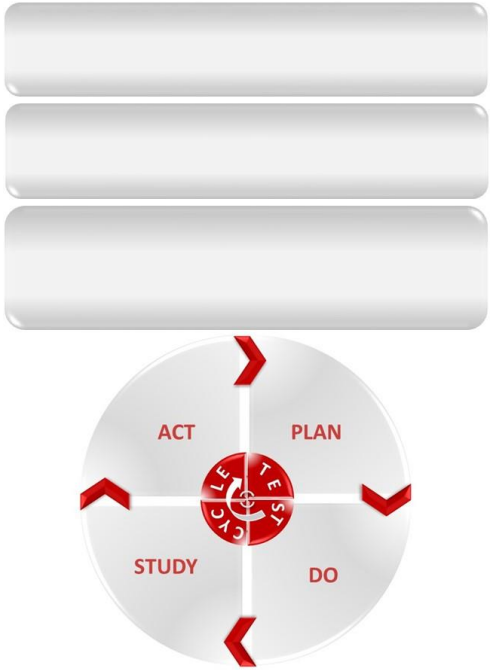
This is where you use the 'plan, do, study, act' (PDSA) cycles in the Model for Improvement. The tests are repeated until a reliable change has been established (see Appendix I & J for worked examples)

Plan: Plan which change intervention you will test (e.g. structured transfer of care sheets), where you will test them, who will support you and how you will train and inform all staff.

Do: Train your test team and start using the tools. Experience has shown that implementation works best when staff are fully involved and encouraged to develop or modify their own version of your change intervention (see 'Flexible standardisation' on page 37).

Study: Assess the impact of the intervention using the measures you have agreed and refined. One of the most useful measures of success will come from staff feedback.

Act: Is your intervention ready to be implemented? If not you will need to run the PDSA test cycle again. If it is ready for implementation, you will need to plan how you will roll it out to the wider department or organisation and, crucially, how you will sustain the improvement in the long term.



More online...

Click here for more on the Model for Improvement and PDSA:

Example: PDSA cycle to test a standard transfer of care template (form)

Plan: (what, where, when, who, how) Keep your initial testing small. Test on: • one patient, resident or client • one bay or unit • half a ward, or a floor • one shift • variety of transfers of care (early / late shift / nights). **TIP: Use the test documentation for handover or transfer of care alongside the old format during testing to minimise risk and ensure continuity of care.**	**Do:** Continue the testing for as long as you need; it may be a few days, weeks or even longer, depending on your service. You may find that the same information might not be relevant for all types of transfers. **TIP: You may need to repeat the test cycle a few times to find the transfer of care documentation and processes that work best for your team.**
Study: During each test, capture what happens using your chosen measures and record them. This will allow you to study the results and feedback. From this data, you can then work out your next action and plan your next test. Consider these questions: • Are the fields on the documentation *all* adding value for your patients/residents/clients? • Has everyone been involved? • How will information be updated in the template and whose responsibility will it be? • Do those people have the appropriate technical skills to do this? • What training is needed to roll this out further? • Does the layout help staff find information easily? • Do we print the transfer of care documentation as a record and if so how? **TIP: When observing tests it is important to note the factors that may lead to variability (eg what information gets included or left out when it's 'busy' and when it's 'quiet').**	**Act:** Increase the size of your test as you gain confidence in the new transfer of care design. Keep going until you are happy that the format is suitable to be tested for a longer period on its own and not alongside the old process. See **Appendix I** for a detailed example of how one team used PDSA to test a new handover template.

Plan for implementation

Once you are confident that your design is about right, start to plan your tests for **implementation**.

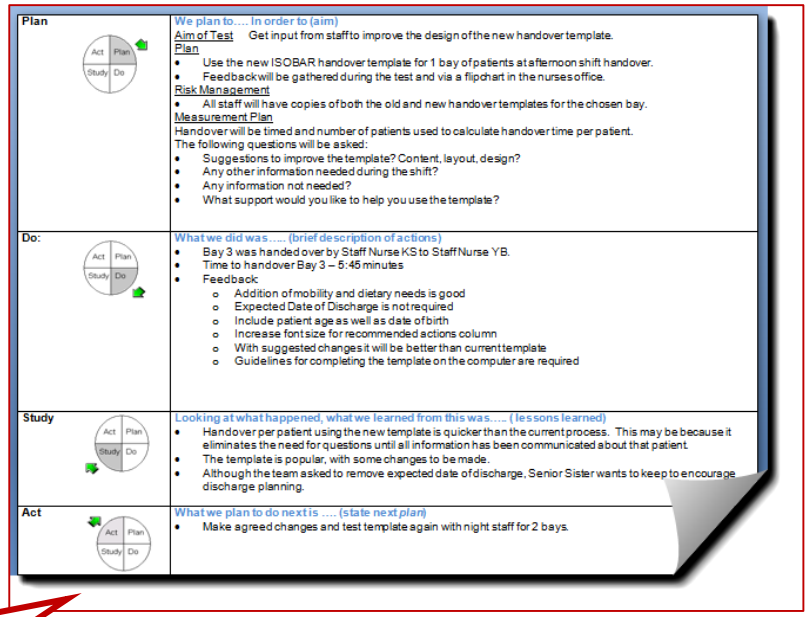
We have used the development of a standard information template as our change intervention example. But, of course, this is just one change that could help you to meet your improvement project aim. You may now want to look at other change interventions before rolling out to whole teams or your wider organisation. Consider what works best for your project:

Either way, before you implement your new transfer of care process, you will need to plan tests to manage any risks associated with stopping the old process. You will also need to engage and educate the teams involved.

As you plan your tests for implementation, think about:

- **Training** – Training will be required for initial implementation and will be ongoing to ensure new team members understand the transfer of care process.
- **Documentation** – What documentation, policies and procedures are required and who will be responsible for updating documentation over time?
- **Resourcing** – What resources are required to implement the change (e.g. printers, electronic devices)?
- **Measurement** – Plan which measures will be used during and after implementation and make sure these are visible to stakeholders.
- **Engaging stakeholders** – Continue to engage stakeholders and communicate the rationale for change (see page 16).

(Adapted from Langley, Moen et al, *The Improvement Guide 2nd Edition* (2009))



Plan

We plan to…. In order to (aim)

Aim of Test Get input from staff to improve the design of the new handover template.

Plan

- Use the new ISOBAR handover template for 1 bay of patients at afternoon shift handover.
- Feedback will be gathered during the test and via a flipchart in the nurses office.

Risk Management

- All staff will have copies of both the old and new handover templates for the chosen bay.

Measurement Plan

Handover will be timed and number of patients used to calculate handover time per patient.

The following questions will be asked:

- Suggestions to improve the template? Content, layout, design?
- Any other information needed during the shift?
- Any information not needed?
- What support would you like to help you use the template?

Do:

What we did was …. (brief description of actions)

- Bay 3 was handed over by Staff Nurse KS to Staff Nurse YB.
- Time to handover Bay 3 – 5:45 minutes
- Feedback
  - Addition of mobility and dietery needs is good
  - Expected Date of Discharge is not required
  - Include patient age as well as date of birth
  - Increase font size for recommended actions column
  - With suggested changes it will be better than current template
  - Guidelines for completing the template on the computer are required

Study

Looking at what happened, what we learned from this was…. (lessons learned)

- Handover per patient using the new template is quicker than the current process. This may be because it eliminates the need for questions until all information has been communicated about that patient.
- The template is popular, with some changes to be made.
- Although the team asked to remove expected date of discharge, Senior Sister wants to keep to encourage discharge planning.

Act

What we plan to do next is …. (state next *plan*)

- Make agreed changes and test template again with night staff for 2 bays.

To reduce risk and increase user acceptance you might want to use a **Simulation** – this could involve staff trying out the new system using a case study?

See Appendix J for a detailed example of how one team used PDSA to test the implementation of a new transfer of care process.

‘Flexible’ standardisation

You may need to run small tests with each team so that they can make small adjustments that work for them. Instead of a rigid approach, consider ‘flexible’ standardisation. This allows teams or departments to make small changes of their own that are shown (by measurement) to improve things in their setting. But there still need to be a control in place to avoid ad-hoc changes and many different versions being used across your organisation.

One method is to implement a control group to decide what can be changed and what has to stay. This decision may be linked to the priorities outlined in your project plan which reflect the organisation’s big issues. For example, if you have linked the transfer of care project to length of stay, you may want to ensure that expected date of discharge stays in all documents.

Spreading Good Practice

As you achieve improvements in your transfer of care process it is really important to spread your good practice throughout the system in which you work.

Think about which teams, departments or communication processes you could target next. For example, if you started by improving communication when transferring patients between wards or departments within your organisation, could you adapt the same communication tool for discharging patients from hospital to care homes, rehabilitation and primary care services?

- For more information on how to do this, see Sarah W Fraser, *Accelerating the Spread of Good Practice: A Workbook for Healthcare* (2002).

Sustain and share

‘The most successful organisations are those that can implement and sustain effective improvement initiatives leading to increased quality and patient experience at lower cost.’

Sustainability Model and Guide

We have already said at the start of this guide that sustaining your improvements should never be an afterthought, but something to consider at the very beginning of your improvement work. Naturally, however, sustainability is something you will want to consider as you roll out and share the new processes you have developed and refined.

> *‘Senior leadership engagement and clinical leadership engagement in your project are two of the key factors in sustaining project improvements’*
>
> *NHS Sustainability Guide*

The **Sustainability Model** and **Sustainability Guide** are valuable resources which will help you build sustainability into the fabric of your improvement work.

- The **Sustainability Model** is a diagnostic tool that will help you identify strengths and weaknesses in your implementation plan and predict the likelihood of sustainability for the improvement initiative.
- The **Sustainability Guide** provides practical advice on how you might increase the likelihood of sustainability for your improvement initiative.

Click here to access the Sustainability Model and Guide

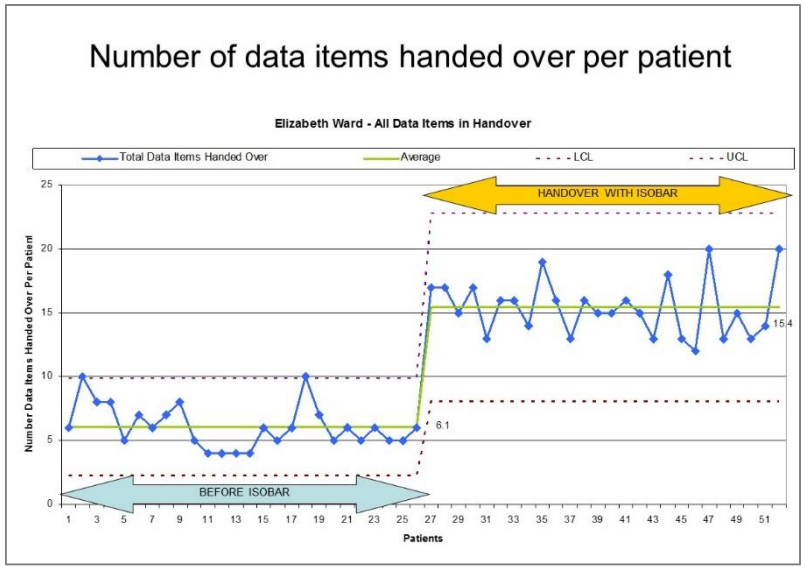
Share and celebrate success

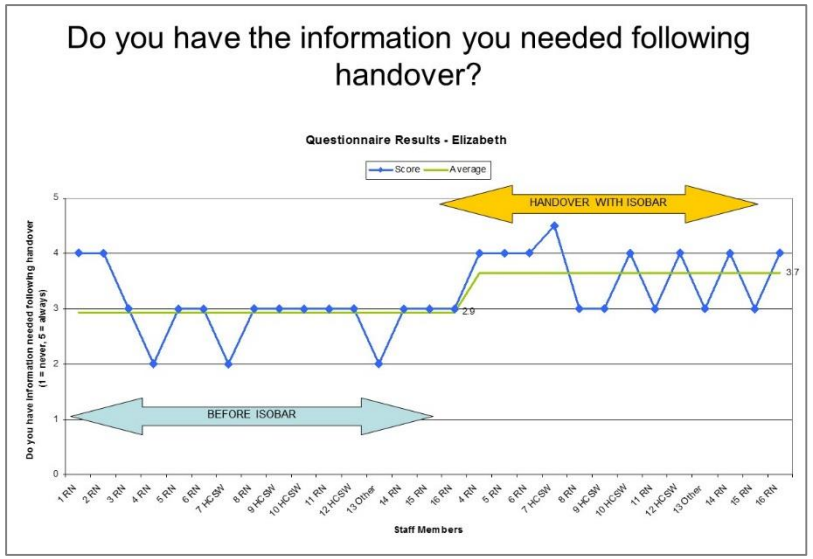
Tell people how well the new handover or transfer of care is working. Not only do those doing it need to know, but tell other wards, teams, departments, directors and the whole organisation to spread the good practice and gain recognition for the hard work the team and all the staff have done. Consider how you can spread the word using:

- team meetings and existing transfer of care meetings
- one-to-one conversations
- posters (see Appendix L)
- newsletters
- individual letters/emails.

Keep measuring....

Agree to measure processes and outcomes periodically to ensure you are sustaining improvements and that staff aren't tempted to return to old ways of working.





Useful resources

Reports and standards

- OSSIE Guide to Clinical Handover Improvement http://www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/ossie-guide/
- Implementation Toolkit for Clinical Handover Improvement http://www.safetyandquality.gov.au/wp-content/uploads/2012/02/ImplementationToolkitforClinicalHandoverImprovement.pdf
- Communication During Patient Hand-Overs, World Health Organisation Collaborating Centre for Patient Safety Solutions (2007) http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution3.pdf
- Safe handover: safe patients - Guidance on clinical handover for clinicians and managers, BMA Junior Doctors Committee, www.bma.org.uk
- Acute Care Toolkit: 1 Handover, Royal College of Physicians (2011) http://www.rcplondon.ac.uk/resources/acute-care-toolkit-1-handover
- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital, Academy of Medical Royal Colleges (2008) https://www.rcoa.ac.uk/sites/default/files/FPM-clinicians-guide2.pdf
- 'Passing the Baton - A Practical Guide to Effective Discharge Planning', National Leadership and Innovation Agency for Healthcare http://www.wales.nhs.uk/sitesplus/829/page/36467
- Clinical Handover Literature Review, The eHealth Services Research Group, University of Tasmania for the: Australian Commission on Safety and Quality in Health Care (ACSQHC) 2008. MC Wong, KC Yee, P Turner. http://www.safetyandquality.gov.au/wp-content/uploads/2008/01/Clinical-Handover-Literature-Review-for-release.pdf
- Safe Clinical Handover. A resource for transferring care from General Practice to Hospitals and Hospitals to General Practice http://www.aci.health.nsw.gov.au/resources/acute-care/safe_clinical_handover/Safe_Clinical_Handover.pdf
- *An experimental comparison of handover methods* Bhabra G, Mackeith S, Monteiro P, Pothier DD, Ann R Coll Surg Engl. 2007 Apr;89(3):298-300 http://www.ncbi.nlm.nih.gov/pubmed/17394718

Tools and guides

- The Improvement Guide, Langley, Moen et al. Jossey-Bass, 1996, 2nd Edition 2009
- The trouble with handovers video http://www.focusbiz.co.uk/the-trouble-with-handovers/
- NSW [New South Wales] Health Implementation Toolkit, Standard Key Principles for Clinical Handover http://www.aci.health.nsw.gov.au/resources/acute-care/safe_clinical_handover/implementation-toolkit.pdf
- Quality and service improvement tools (process mapping, patient perspectives) http://www.institute.nhs.uk/qualitytools

- The Productive Series: http://www.institute.nhs.uk/productives
  - The Productive Ward (shift handovers module)
  - The Productive Mental Health Ward (shift handovers module)
  - The Productive Operating Theatre (handover and teamworking modules)
  - The Productive Community Hospital (handover module)
- The Care Homes Wellbeing Programme http://www.institute.nhs.uk/carehomes
- Experience Based Design Toolkit http://www.kingsfund.org.uk/projects/ebcd
- Model for Improvement (including PDSA) http://www.institute.nhs.uk/pdsa
- Improvement Leaders' Guides:
  - Process Mapping, Analysis and Redesign http://www.nhsiq.nhs.uk/media/2594717/ilg_-_process_mapping__analysis_and_redesign.pdf
  - Measuring for improvement http://www.nhsiq.nhs.uk/media/2541082/improvement_leaders_guide_-_measurement_for_improvement.pdf
- The 7 steps to measurement video https://www.youtube.com/watch?v=Za1o77jAnbw
- Run charts and simple statistical measures (including a video guide) www.institute.nhs.uk/spc
- Root cause analysis (including the 'Five whys') http://www.institute.nhs.uk/rca
- eHandover https://www.emishealth.com/products/ehandover/
- Structured communications tools
  - SBAR http://www.institute.nhs.uk/sbar
  - The ABC of handover http://emj.bmj.com/content/early/2012/01/03/emermed-2011-200199.full
  - HAND ME AN ISOBAR http://www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/ossie-guide/
  - RSVP http://www.workforce.southcentral.nhs.uk/pdf/NESC_RSVP_0209.pdf
- Sustainability Model and Guide http://www.evidenceintopractice.scot.nhs.uk/media/135265/sustainability_model.pdf
- *Accelerating the Spread of Good Practice: A Workbook for Healthcare* Sarah W Fraser, (2002). Via Amazon.

Case studies and presentations

- Using a communication framework at handover to boost patient outcomes, Christie, P and Robinson, R, Nursing Times, 1 December, 2009, Vol 105, No 47 www.nursingtimes.net
- Improving hospital weekend handover: a user-centered, standardised approach Mehra A and Henein C. *BMJ Qual Improv Report* 2014;**2**: doi:10.1136/bmjquality.u202861.w1655 http://qir.bmj.com/content/2/2/u202861.w1655.full
- Improving the safety of patient transfer from AMU using a written checklist, Hindmarsh D, Lees L, Acute Med. 2012;11(1):13-7. http://www.ncbi.nlm.nih.gov/pubmed/22423341

Appendices

Appendix A: Ollie's story

This case study tells the story of a real NHS patient. The patient did not die as a result of a series of errors and was thankfully not 'clinically harmed'. But he could have been, as his care was compromised more than once through poor handover practices.

Overview of situation:

Over a one year period Ollie, as he was known to his friends, was admitted to hospital at least 3 times. As well as the condition he was admitted for, Ollie had epilepsy which was well controlled with medicine. After the first admission, he and his wife, Georgette, got to know the routine. Georgette would hand a copy of Ollie's current prescription record to the Ambulance Crew, they would take notes and hand it back to her. By the time she met up with Ollie in A&E, his prescription record would have disappeared, and so she went armed with another copy to hand in. Within 24 hours he would have passed through the Medical Admissions Unit and be on a ward, and his prescription record would once again be incomplete. So Georgette would provide a further copy of his current prescription.

Snapshot:

In the last year of his life Ollie was admitted to hospital several times. Even though his wife, Georgette, developed an 'A&E survival pack' to keep him safe, her planned 'information handovers' failed to result in an accurate prescription for his regular epilepsy medicine.

On one occasion, the prescription was written, but Georgette and Ollie knew that the dose of his epilepsy medication was wrong. They pointed this out twice on the first day, and again on the second day. It was eventually corrected.

Georgette is clear that these poor practices were not the result of bad clinicians, but on gaps in information transfer and lack of clarity and/feasibility for task completion amongst team members. Georgette continues to share this story and hopes that one day there will be no gaps.

Although Ollie understood that going one day without his epilepsy medicine was unlikely to trigger a seizure, he still got anxious – and he knew that this anxiety COULD make a seizure more likely. This worried Georgette too!

The patient perspective

Both Ollie and Georgette were reassured by staff that they had been heard and that the error would be corrected. But when it remained unchanged for a second day Georgette felt she had to stay, all day as it turned out, until it was put right. Whilst they both knew and understood that a small delay would not trigger a seizure, their confidence was dented, and they remained anxious throughout the hospital stay.

Staff perspective

For many staff this story will not be unusual. It may even be common place. But it is unlikely that many instances will be reported or counted as service failures as the outcome is classified as 'patient received medicine and no adverse event'. Negative impacts on patients such as 'anxiety' are rarely captured, and it is usually only when a catastrophe occurs that the effect of serial failures become visible to the staff who have been involved along the way.

> Insanity: doing the same thing over and over again and expecting different results.
> *Albert Einstein*

We can become accustomed to the way things are, and frequently accommodate shortcomings by 'working around' the barriers to deliver what is most urgently needed. Although evidence shows that the human brain has a limited memory capacity, meaning that an existing task must be dropped to make way for a new one when the 'list is full', the way we work doesn't reflect this knowledge.

If you haven't already done so, you could start thinking about what you might change and how you will know if this results in an improvement!

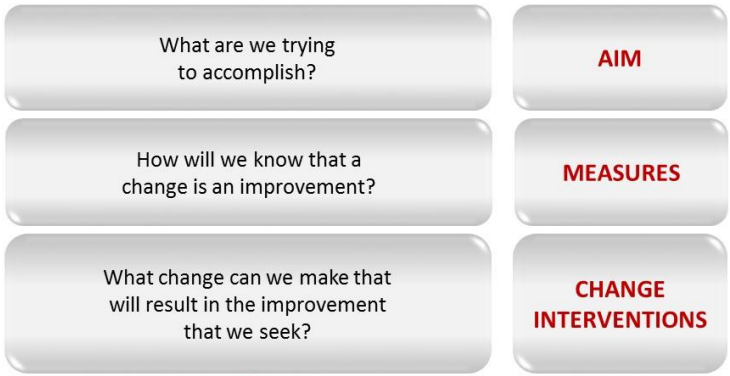
Appendix B: Good practice checklist – examples of questions to prompt discussion and generate ideas

What do we need?	What does it mean?	Think about…
Leadership	There is a nominated leader for each transfer of care/handover.	• Who should have overall responsibility for the transfer of care? This would involve ensuring participants attend; introducing and orientating new team members; prioritising urgent elements of transfer of care.
Values	Transfer and handovers are valued as an essential part of care and preparation for handover is a priority.	• How can we ensure information transfer is confidential and non-judgemental? • How is the importance of transfer of care reinforced in the team, department or organisation? (culture) • What training is required to ensure staff understand their accountability in relation to giving and receiving information? Who will design and deliver this training? How will staff be released from clinical duties to attend training? • How will patients or clients understand their role in transfer of care? • Do staff and patients or clients have guidelines on transfer of care?
Right people	The appropriate people are involved.	• Who needs to attend the transfer of care (think about multidisciplinary handover)? Do they need to be present for whole transfer or just part of it? • At what points do patients, clients and carers want to be involved in the transfer of care process? • How will students and junior staff get the most learning opportunities from handover? • Who will cover the unit while transfer of care occurs? • What happens in emergencies? • How can interruptions be prevented? • Who will be involved in regular review and audit of transfer of care processes? • Who will prepare information and documentation for transfer of care?

What do we need?	What does it mean?	Think about…
Specified time and place	A specific setting or place has been agreed where transfers of care can take place without interruption or distraction.	• When should the transfer of care happen? • How does this relate to time of shift change? • How long should the transfer of care take? • How can we ensure it starts on time? • Does the transfer of care process need to be different depending on the time of day? • Where should the transfer of care happen? • Is the environment quiet with no interruptions? If not, how can interruptions be reduced? • Does any part of transfer of care happen with the patient or in a public area? • How and where is confidential information transferred?
Standardised process	There is an agreed process for transfers of care This includes an agreed set of information to be covered in transfers (minimum data set). This is communicated in a structured way, is action-focused, assigns responsibility for actions and supported by clear documentation.	• What information would be included in a standard transfer of care template or electronic handover record? (The minimum data set.) • How much of this information overlaps with other disciplines? How could multidisciplinary transfer of care be most effective? • How and when in the process will the person receiving the transfer of care ask questions, confirm understanding and accept responsibility for the patient/client? • Do you want to use structured communication tools (eg SBAR, ISOBAR, RSVP etc.) or develop your own? • What happens to documentation following the transfer of care? How could it be designed to go directly into patient notes? • How is the agreed transfer of care process documented? How do new staff and patients/clients find out about the process?

Appendix C: The Model for Improvement

The Model for Improvement gives you a simple, adaptable and thorough framework for developing, testing and implementing changes. Using the Model for Improvement means your changes are more likely to lead to the improvement you set out to make.



Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd Edition). Jossey Bass, San Francisco (2009) [v]

The first thing you need to do when using the model is answer these three key questions

Then you carry out the 'plan, do, study, act' (PDSA) cycles. These cycles are used to test an idea by trialling a change and assessing its impact. The key to PDSA cycles is to repeat them; keep testing small changes until they deliver the sustainable improvement you are looking for.

- **Plan** the change and how you will test it.
- **Do** the change and tests.
- **Study** the data before and after the change and learn from it.
- **Act** on the learning by refining the change and planning another PDSA cycle to test it.

More online...

For more on the Model for Improvement see:

- Quality and service improvement tools
- Improvement Leaders' Guides – *Process Mapping, Analysis and Redesign*

Appendix D: SMART aims

SMART aims are a good way to ensure your project aim is clearly defined.

Set a SMART improvement project aim:

Specific: Have a clear and specific improvement aim, e.g. ‘structured transfer of care, right each time’.

Measurable: Ensure data is available to measure the scale of the problem and your success in addressing it.

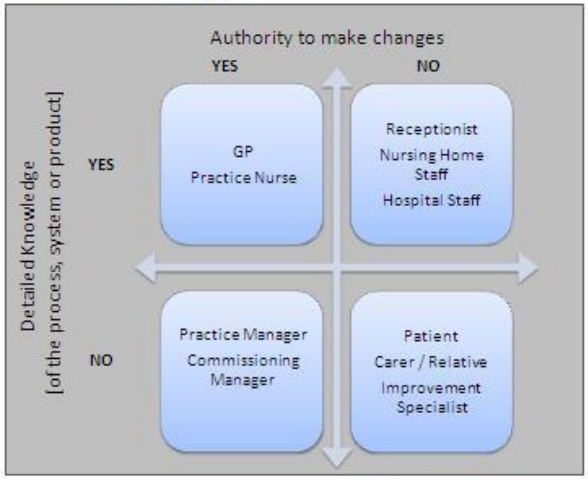
Achievable: Set a suitable challenge and don’t be afraid to set your aim high. Resist setting your aim too low just to improve your chances of succeeding.

Realistic: Consider the factors beyond your control which may limit the impact of the project, e.g. closure of a unit for refurbishment; major staff changes; availability of sponsor.

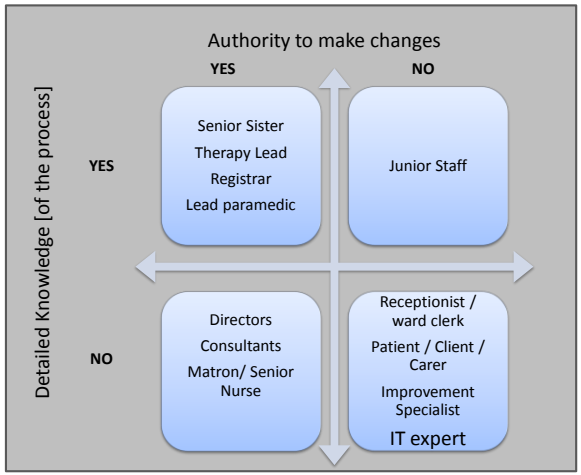
Time: Set a deadline and stick to it, e.g. by December 2015.

Appendix E: Team Selection Grid Examples

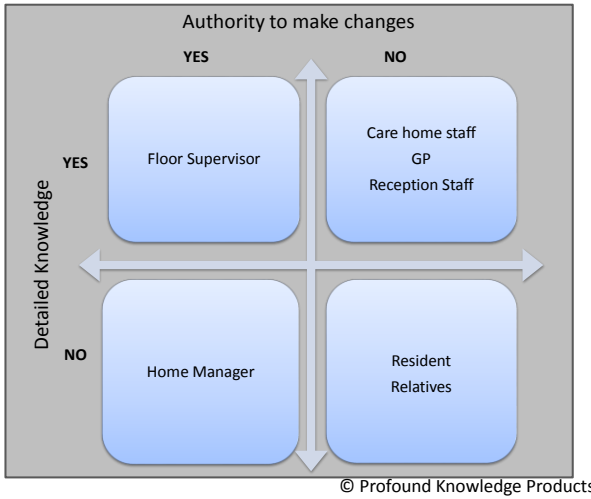
GP Practice Example



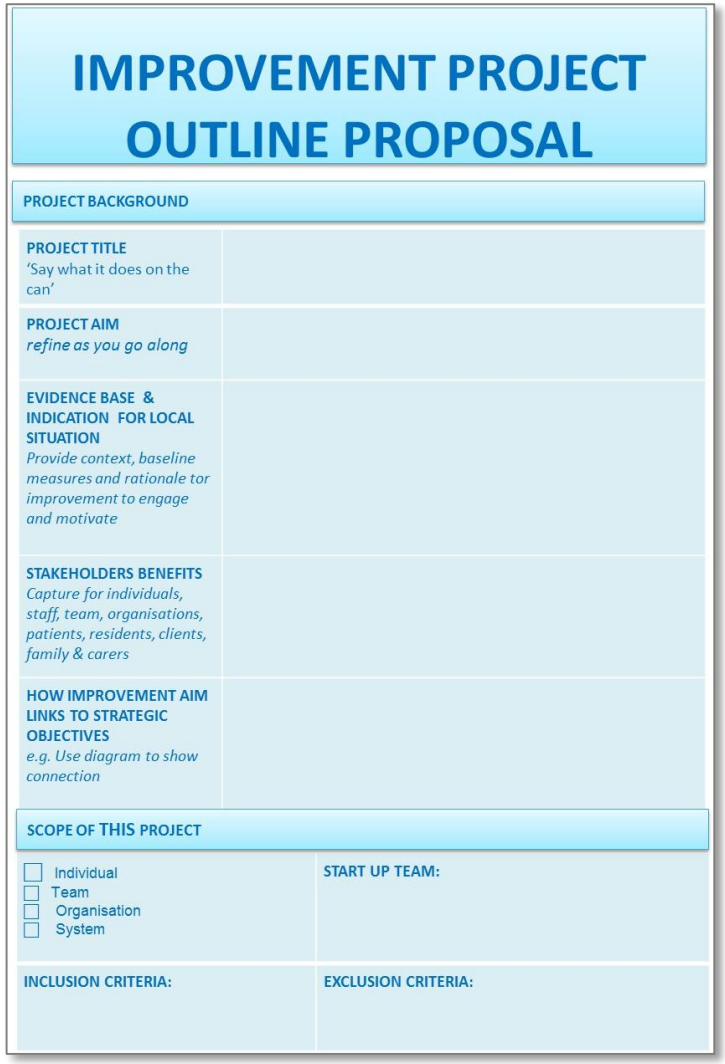
Acute example



Residential home example



Appendix F: Example project template



IMPROVEMENT PROJECT OUTLINE PROPOSAL

PROJECT BACKGROUND

PROJECT TITLE 'Say what it does on the can'	
PROJECT AIM *refine as you go along*	
EVIDENCE BASE & INDICATION FOR LOCAL SITUATION *Provide context, baseline measures and rationale tor improvement to engage and motivate*	
STAKEHOLDERS BENEFITS *Capture for individuals, staff, team, organisations, patients, residents, clients, family & carers*	
HOW IMPROVEMENT AIM LINKS TO STRATEGIC OBJECTIVES *e.g. Use diagram to show connection*	

SCOPE OF THIS PROJECT

☐ Individual ☐ Team ☐ Organisation ☐ System	**START UP TEAM:**
INCLUSION CRITERIA:	**EXCLUSION CRITERIA:**

Adapted from outline in the OSSIE Guide to Clinical Handover Improvement. Available on Slide Share at www.qualityimprovementclinic.com

Appendix G: Dot voting

Dot voting is a simple way to collect input from the whole team about the information that should be included in your communication tool.

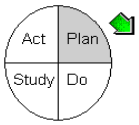
- Using your observation of the current transfer of care process, create a list of all the information which is currently discussed.
- Add any additional information that should perhaps be included; either because it is recommended best practice or because staff/patients/clients want to see it included.
- Let all staff have the opportunity to vote by sticking or drawing a dot next to the information they feel is most important in enabling them to provide good quality care.
- Remember to include both the staff who are **delivering** and **receiving** the transfer of care. This might mean involving individuals from outside your immediate team if you are transferring patients between units/departments.
- Use different colour pens to identify different roles, e.g. different colours for trained and untrained staff.

After everyone has voted, the information with the most dots is the information you need to focus on.

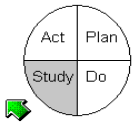
Appendix H: Good practice checklist – suggested measures

What do we need?	What does it mean?	Suggested measures
Leadership	There is a nominated leader for each transfer of care/handover.	• Staff survey – is leadership clear and does leader fulfil role? • Do new team members understand the process? • Is leader indicated on transfer of care process checklist (if used)?
Valued	Transfer and handovers are valued as an essential part of care.	• Number of interruptions • Staff/patient/client survey - do individuals value & understand the transfer of care process? • How many patients/clients know who is in charge of their care? • Do transfer of care guidelines exist and are they visible? • Number of staff trained in transfer of care process • Is documentation completed?
Right people	The appropriate people are involved.	• Staff time invested in transfer of care (including preparation time) • Staff/patient/client satisfaction with transfer of care process • Number of incidents in unit/on floor during transfer of care • Is documentation completed?
Specified time and place	A specific setting or place has been agreed where transfers of care can take place without interruption or distraction.	• Number of interruptions • Staff /patient/client survey – are timing and location appropriate? • Time transfer of care - does it start on time and how long does it take? • Staff time invested in transfer of care
Standardised process	There is an agreed process for transfers of care. This includes an agreed set of information to be covered in transfers (minimum data set). This is communicated in a structured way, is action-focused, assigns responsibility for actions and supported by clear documentation.	• Is documentation complete? y/n • Length of time for transfer of care • Staff/patient/client survey – is appropriate information included in transfer of care? Is anything missing or not required? • Audit of transfer of care – is standard communication process followed each time? • Number of pieces of information in minimum data set which are communicated • Number of pieces of documentation filed in patient notes (or wherever process says they should be) • Number of outstanding actions not completed at end of shift.

Appendix I: Example PDSA for testing a new handover template

Plan 	**We plan to…. in order to (aim)** Aim Get staff input to improve the design of the new handover template. Plan • Use the new ISOBAR handover template for 1 bay of patients at afternoon shift handover. • Feedback will be gathered during the test and via a flipchart in the nurses office. Risk Management • All staff will have copies of both the old and new handover templates for the chosen bay. Measurement Plan Handover will be timed and number of patients used to calculate handover time per patient. The following questions will be asked: • Suggestions to improve the template? Content, layout, design? • Any other information needed during the shift? Or not needed? • What support would you like to help you use the template?

Do: 	**What we did was….. (brief description of actions)**
	• Bay 3 was handed over by Staff Nurse KS to Staff Nurse YB.
	• Time to handover Bay 3 – 5:45 minutes
	• Feedback:
	  ○ Addition of mobility and dietary needs is good
	  ○ Expected Date of Discharge is not required
	  ○ Include patient age as well as date of birth
	  ○ Increase font size for recommended actions column
	  ○ With suggested changes it will be better than current template
	  ○ Guidelines for completing the template on the computer are required
	  ○ More practice using SBAR and readback is required for it to feel comfortable

Study 	**Looking at what happened, what we learned from this was….. (lessons learned)** • Handover per patient using the new template is quicker than the current process. This may be because it eliminates the need for questions until all information has been communicated about that patient. • The template is popular, with some changes to be made. • Although the team asked to remove expected date of discharge, Senior Sister wants to keep to encourage discharge planning.
Act 	**What we plan to do next is …. (state next *plan*)** • Make agreed changes and test template again with night staff for 2 bays. • Deliver more training and practice opportunities using SBAR with readback

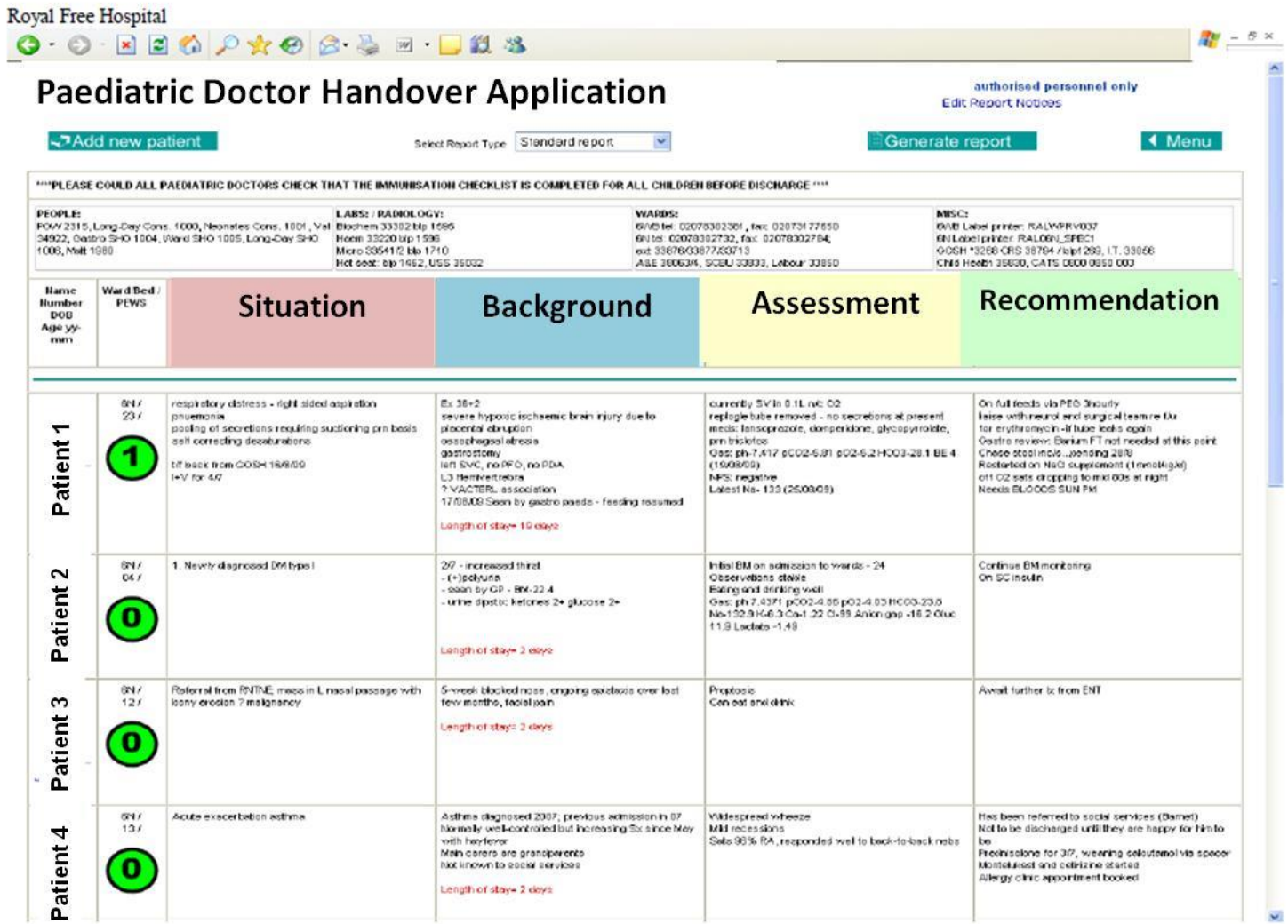
Appendix J: Example PDSA for testing new transfer of care process

Plan 	**We plan to…. In order to (aim)**
	Aim of Test To test the new transfer of care process.
	Plan
	• Use the new transfer of care process for one week starting Monday 15 Nov.
	• Feedback will be gathered via
	  ○ clinical champions observing process, flipchart in the staffroom
	  ○ staff questionnaire at the end of the week, client questionnaire during transfer of care
	Risk Management
	• Nominated champions who know the process deliver training on each shift.
	• Further support provided by Director of Nursing, Team Leaders and IT helpdesk.
	• Newsletter to all staff and posters in department.
	• Information sheet provided to clients at transfer of care to explain new process.
	• IT department ensure all staff have access to new IT system.
	• New printer with double sided functionality borrowed from IT department.
	Measurement Plan
	Following measures collected
	• Time taken to transfer care
	• Number of interruptions
	• Was documentation complete
	• Was new process followed
	• Staff preparedness to deliver care surveyed
	• Client experience surveyed at each transfer of care

Do: 	**What we did was….. (brief description of actions)**
	• New transfer of care process trialled for one week with team
	Feedback:
	• Time to transfer care reduced, but not enough data at night.
	• Documentation complete 100% when measure collected
	• Some staff observed did not follow standard process
	• Feedback from staff:
	  ○ Process works well and staff do not want to return to old process
	  ○ Complaints from staff relating to IT glitches initially were resolved by day 3
	  ○ New printer worked well
	  ○ Transfer of care document already being tested by physio team.
	• Feedback from clients
	  ○ Client experience is positive

Study 	**Looking at what happened, what we learned from this was….. (lessons learned)** • New process is well received and staff do not want to return to old process • More training is required to ensure all staff follow correct process • Further measurement is required but time to transfer care appears to be reducing. • Use of documentation has improved
Act 	**What we plan to do next is …. (state next *plan*)** • Continue to use new process • Deliver more training in new process and in the importance of measurement • Support physio team to test new process

Appendix K: Examples of standardised communication templates



Royal Free Hospital

Paediatric Doctor Handover Application

authorised personnel only
Edit Report Notices

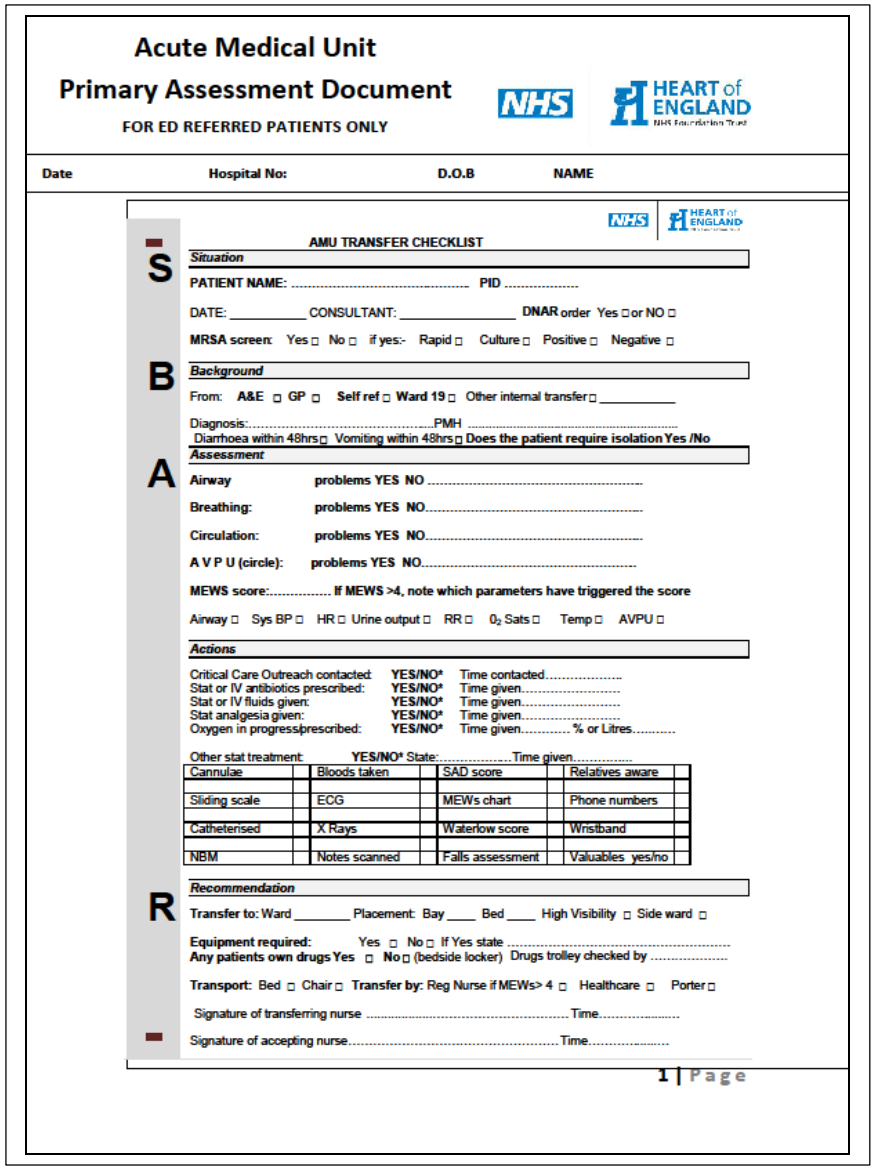
Add new patient | Select Report Type: Standard report | Generate report | Menu

****PLEASE COULD ALL PAEDIATRIC DOCTORS CHECK THAT THE IMMUNISATION CHECKLIST IS COMPLETED FOR ALL CHILDREN BEFORE DISCHARGE ****

PEOPLE:	LABS: / RADIOLOGY:	WARDS:	MISC:
POW 2315, Long-Day Cons. 1000, Neonates Cons. 1001, Vac 34922, Gastro SHO 1004, Ward SHO 1005, Long-Day SHO 1006, Matt 1980	Biochem 33302 blp 1595 Haem 33220 blp 1596 Micro 335412 blp 1710 Hot seat: blp 1462, USS 35002	GNB tel: 02078302261, fax: 02078177650 GN tel: 02078302732, fax: 02078302764; ext 33878/33877/33713 ASE 360634, SCBU 33933, Labour 33850	GNB Label printer: RALWPRV037 GN Label printer: RAL06N_SPEC1 GOSH *3268 CRS 38794 /dept 269, I.T. 33958 Child Health 35630, CATS 0800 0850 003

Name Number DOB Age yy-mm	Ward Bed / PEWS	Situation	Background	Assessment	Recommendation
Patient 1	6N / 23 / 1	respiratory distress - right sided aspiration pneumonia pooling of secretions requiring suctioning prn basis self correcting desaturations bf back from GOSH 18/8/09 I+V for 4/7	Ex 38+2 severe hypoxic ischaemic brain injury due to placental abruption oesophageal atresia gastrostomy left SVC, no PFO, no PDA L3 hemivertebra ? VACTERL association 17/08/09 Seen by gastro paeds - feeding resumed Length of stay= 19 days	currently SV in 0.1L n/c O2 replogle tube removed - no secretions at present meds: lansoprazole, domperidone, glycopyrrolate, prn triclofos Gas: ph-7.417 pCO2-6.91 pO2-6.2 HCO3-28.1 BE 4 (19/08/09) NPS: negative Latest Na- 133 (25/08/09)	On full feeds via PEG 3hourly liaise with neurol and surgical team re tiu for erythromycin -if tube leaks again Gastro review: Barium FT not needed at this point Chase stool incls ...pending 28/8 Restarted on NaCl supplement (1mmol/kg/d) ott O2 sats dropping to mid 80s at night Needs BLOODS SUN PM
Patient 2	6N / 04 / 0	1. Newly diagnosed DM type I	2/7 - increased thirst - (+)polyuria - seen by GP - BM-22.4 - urine dipstic ketones 2+ glucose 2+ Length of stay= 2 days	Initial BM on admission to wards - 24 Observations stable Eating and drinking well Gas: ph 7.4371 pCO2-4.65 pO2-4.65 HCO3-23.6 Na-132.9 K-6.3 Ca-1.22 Cl-98 Anion gap -16.2 Gluc 11.9 Lactate -1.49	Continue BM monitoring On SC insulin
Patient 3	6N / 12 / 0	Referral from RNTNE, mass in L nasal passage with bony erosion ? malignancy	5-week blocked nose, ongoing epistaxis over last few months, facial pain Length of stay= 2 days	Proptosis Can eat and drink	Await further bx from ENT
Patient 4	6N / 13 / 0	Acute exacerbation asthma	Asthma diagnosed 2007; previous admission in 07 Normally well-controlled but increasing Sx since May with hayfever Main carers are grandparents Not known to social services Length of stay= 2 days	Widespread wheeze Mild recessions Sats 98% RA, responded well to back-to-back nebs	Has been referred to social services (Barnet) Not to be discharged until they are happy for him to be Prednisolone for 3/7, weaning salbutamol via spacer Montelukast and cetirizine started Allergy clinic appointment booked

Reproduced with permission of Dr Sebastian Yuen



Acute Medical Unit

Primary Assessment Document

FOR ED REFERRED PATIENTS ONLY

Date Hospital No: D.O.B NAME

AMU TRANSFER CHECKLIST

S

Situation

PATIENT NAME: ..... **PID** .....

DATE: _____ CONSULTANT: _____ **DNAR** order Yes □ or NO □

MRSA screen: Yes □ No □ if yes:- Rapid □ Culture □ Positive □ Negative □

B

Background

From: **A&E** □ **GP** □ **Self ref** □ **Ward 19** □ Other internal transfer □ _____

Diagnosis:..... PMH .....

Diarrhoea within 48hrs □ Vomiting within 48hrs □ **Does the patient require isolation Yes /No**

A

Assessment

Airway **problems YES NO** .....

Breathing: **problems YES NO**.....

Circulation: **problems YES NO**.....

A V P U (circle): **problems YES NO**.....

MEWS score:..... **If MEWS >4, note which parameters have triggered the score**

Airway □ Sys BP □ HR □ Urine output □ RR □ 0_2 Sats □ Temp □ AVPU □

Actions

Critical Care Outreach contacted: **YES/NO*** Time contacted.....
Stat or IV antibiotics prescribed: **YES/NO*** Time given.....
Stat or IV fluids given: **YES/NO*** Time given.....
Stat analgesia given: **YES/NO*** Time given.....
Oxygen in progress/prescribed: **YES/NO*** Time given..... **% or Litres**.....

Other stat treatment: **YES/NO*** State:..... Time given.....

Cannulae	Bloods taken	SAD score	Relatives aware
Sliding scale	ECG	MEWs chart	Phone numbers
Catheterised	X Rays	Waterlow score	Wristband
NBM	Notes scanned	Falls assessment	Valuables yes/no

R

Recommendation

Transfer to: Ward _____ Placement: Bay ____ Bed ____ High Visibility □ Side ward □

Equipment required: Yes □ No □ If Yes state .....
Any patients own drugs Yes □ **No** □ (bedside locker) Drugs trolley checked by .....

Transport: Bed □ Chair □ **Transfer by:** Reg Nurse if MEWs> 4 □ Healthcare □ Porter □

Signature of transferring nurse ..... Time.....

Signature of accepting nurse..... Time.....

1 | Page

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Standard Nursing Handover Procedure - HAND ME AN ISOBAR - Example

1. Prepare for Handover H – Hey its handover time A – Allocate staff for continuity of care. N – Nominate participants, time and venue D – Document using the handover sheet.	**Participants** – all trained staff on incoming shift, handover given by registered nurses for Bays 1&2 then Bays 3&4. HCSW have separate handover after main handover. **Time** - Starts promptly at: **7am, 1pm and 8:45pm** **Venue** - in the handover office just off the ward. **Continuity of Care** - During handover, cover is provided for the ward by the trained staff member not giving handover & the HCSW on the incoming shift. Before going to handover, the RN for bays 1&2 should tell the RN for bays 3&4 that s/he is going off the ward to conduct handover. This makes it clear that the RN for bays 3&4 is responsible for the whole ward during this time. The RN for bays 1&2 should remind the RN for bays 3&4 about any patients who may require special attention during this time (e.g. high MEWS, risk of harm etc.). **Handover Sheet** – Updated by outgoing team & printed for each of the incoming team (Trained & HCSW).
2. Organise Handover M – Make sure all participants have arrived E – Ensure leadership is provided during handover	All participants in handover should arrive promptly. Handover is lead by the outgoing team.
3. Provide Environmental Awareness A – Alert to special patient needs or risks and environmental issues N – Notice patient and staff movements and numbers	At the beginning of handover, the outgoing team should highlight to the incoming team any issues affecting the whole ward, which might include: • Staffing levels (sickness or other absence) • New team members • New procedures or equipment in use • Any health and safety hazards (broken equipment etc.) • HCSW on the incoming team are given essential safety information to allow them to start patient care during handover
4. Individual Patient Handover I – Identify S – Situation O – Observation B – Background A – Assessment R – Recommendation *(Social needs, discharge planning)* READBACK	• Handover is given verbally, using the ISOBAR handover sheet to support what is discussed. • Each patient is handed over the same way using the **ISOBAR** format, reading from left to right across the sheet. • The registered nurse for bays 1 & 2 (and then for bays 3&4) will then give handover for EACH patient, reading from left to right across the form • You only need to read out ***social needs and discharge planning*** information for patients who are about to go home or who need action to prepare for discharge. • Readback - After each **new or acutely ill patient**, the incoming lead nurse for that patient **reads back** the critical points to confirm that s/he has understood the patient's needs. • After handover the lead nurse for each bay will provide handover to the HCSW's for their bays. This reduced handover will include essential care needs and any actions which need to be carried out that shift.

Appendix L: Example of how a poster can be used to spread the word about new processes

ISOBAR: *Standardising Nursing Handover*

George Eliot Hospital NHS
NHS Trust

Louise Jacox, Senior Sister George Eliot Hospital louise.jacox@geh.nhs.uk
Alison Cole, NHS Institute for Innovation and Improvement alicole@live.co.uk

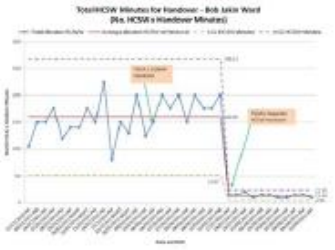
Critical incident investigations revealed handover communication failures at George Eliot Hospital. Best practice recommends a structured, standardised approach to handover (National Institute of Clinical Excellence 2007, World Health Organisation 2007).

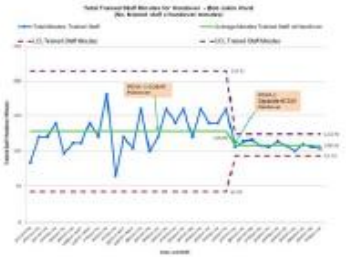
I – Identify
S – Situation
O – Observation
B – Background
A – Assessment
R - Recommendation

SBAR is a structured communication tool originally developed by the US military and adapted for use in healthcare for handover and escalation scenarios (The NHS Institute for Innovation and Improvement 2010). Following the example of a number of healthcare organisations in Australia (Australian Commission for Safety and Quality in Healthcare, 2010), two new elements were added to highlight the importance of correctly communicating the patient's identity and latest observations.

A standardised handover process was developed through participation in the NHS Institute's Patient Safety Leader programme. The ISOBAR tool standardises handover and documents essential patient safety information including falls risk, pressure ulcer prevention, dietary needs and infection control. The tool was tested and revised using PDSA cycles. Following sustained improvement on one ward, the tool was spread to all wards in the Trust.

Outcomes include improved communication of patient safety information and reduction in handover time.





Staff surveys and handover audits indicate clinically relevant information is communicated more often using the ISOBAR tool.

Accurate reporting of patient safety information has improved, for example, reporting of VTE assessments is now 100% on some wards.

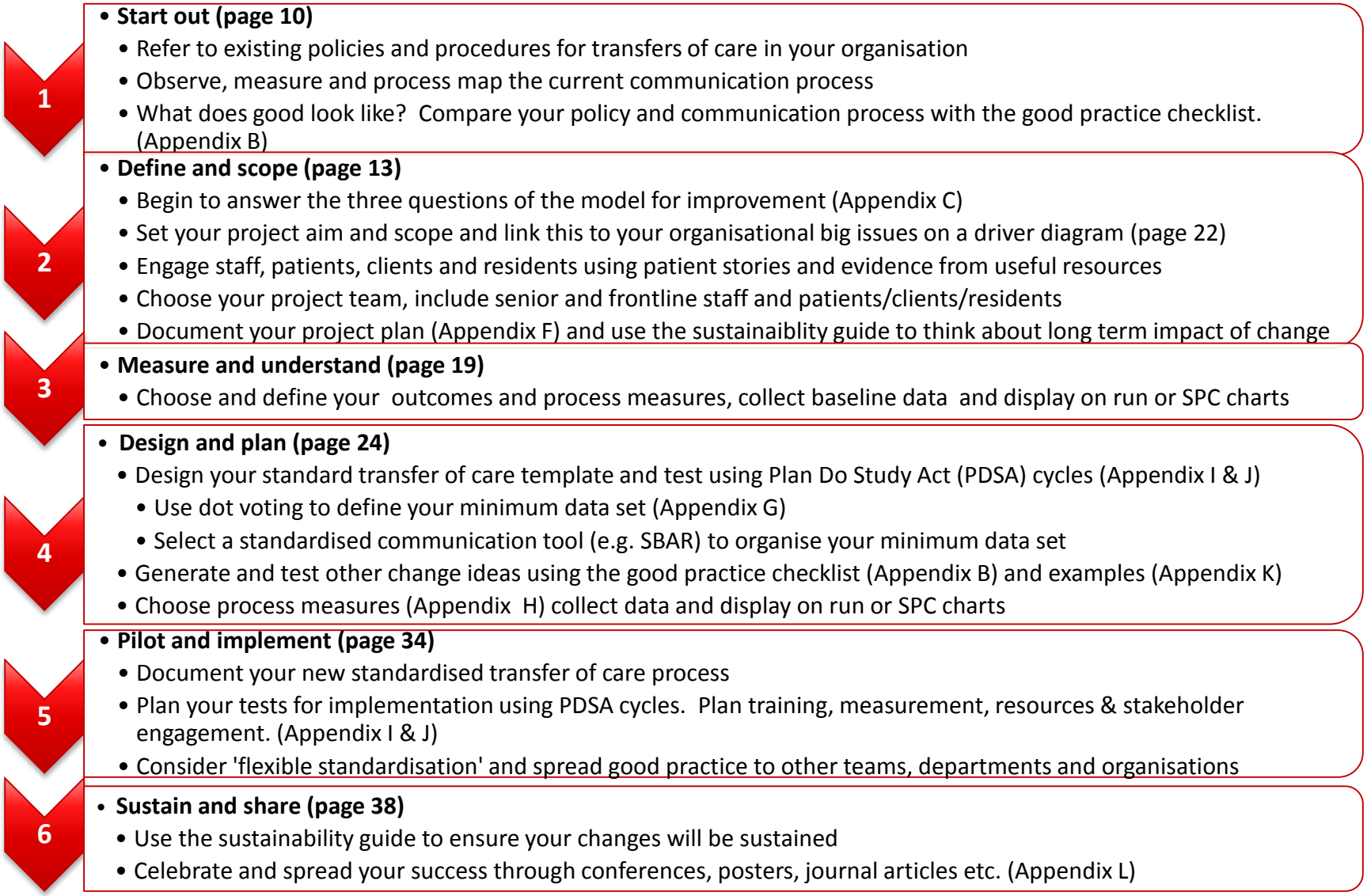
Early indications are that both pressure ulcers and falls may be reducing following the rollout of ISOBAR across the Trust and work continues to track this improvement.

Bob Jakin ISOBAR Handover Form — **Bay 1&2 - Nursing Needs** — Remember to Readback Patients who are New or Acutely Ill

Date: 17/05/2012

IDENTIFY		SITUATION					OBS		BACKGROUND			ASSESSMENT (complete what is relevant)								RECOMMENDATION (What needs to happen today)	
												Essential Care Needs									
Bed	Patient Name DOB Age	Reason for hospital admission	Resus Status	LOF	Medically Fit for Discharge	EDD or Review Today	NEWS / Outreach Alert / Trend	Oxy Requirmt	Diabetes Type	Relevant past medical history	Treatment in progress	VTE	Mobility and Falls Risk	Pressure Ulcer Prevention	Diet & Feeding	Urine/Bowel concerns	Infection Control	Cannula	Nursing Needs and/or concerns	Tests/ procedures /assessments required or booked	Other comments or Actions Agreed
1	Joe Bloggs 29/02/1920 92	abdo pain, weight loss pneumonia	DNAR		N	22/05/2012	7	Hourly	2	gastric ulcer CCF CVA	o2 15L IVAB IVI	Y	high	grade 1 but not sac	ng tube NBM	catheter	IVI	16/05/12	ng feed 125ml/hr over 10 hrs, all care, nurse upright	CT abdo/chest tba	repeat obs 1 hr unless CT scan take outreach

Appendix M: Summary of the six step improvement process for transfer of care



Product timeline

2011-2012 - First learning phase

QI project, Patient Safety Leaders Programme, NHS Institute for Innovation and Improvement

Ali Cole, Quality Improvement Project Lead. Nicola Davey, Topic Expert

Staff at George Eliot Hospital NHS Trust (see acknowledgements on page 3)

2012, First deisgn and testing phase

Sandra McNerney, Freelance Writer

Focus Groups x 2, NHS Institute Associates, Fellows and Critical Friends

2013-2014 - Second learning phase

Nicola Davey, Quality Improvement Practitioner, Quality Improvement Clinic Ltd

Ali Cole, QI Practitioner and Topic Expert

2014-2015 - Second design and testing phase

Nicola Davey, Quality Improvement Practitioner, Quality Improvement Clinic Ltd

Rachel Hammel, Learning Expert, Quality Improvement Clinic Ltd