Clinical Handover Workshop

A Quality Improvement Approach to Clinical Handover

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Dr David Vaughan
Dr Catherine Diskin
Hello my name is...

www.hellomynameis.org.uk

# hello

my name is...

John
Session Aims
At the end of this session you will be able to....

- Make the case for effective and reliable Clinical Handover
- Outline the essential components of Clinical Handover and the need to adapt for specific contexts.
- Identify handover models, resources and supports.
- Use quality improvement methods to measure effective handover and change communication behaviours.
- Identify implementation barriers and strategies to overcome them.
- Appreciate the opportunity that Clinical Handover provides to shape and improve safety culture
Communication

“The single biggest problem with communication is the illusion that it has taken place”

George Bernard Shaw
Healthcare used to be a Simple System

“Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous”

Professor Sir Cyril Chantler
Healthcare is now a Complex System
NCEC Communication Guidelines
Clinical handover refers to the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

British Medical Association, 2012
Viewing Handover as a Procedure

- ‘**Handover** of care is one of the most perilous procedures in medicine, and when carried out improperly can be a major contributory factor to subsequent error and harm to patients’

- Professor Sir John Lilleyman,
- National Patient Safety Agency
Why is handover important?

• Handover is the essential communication for complex systems to function.

• Teams rely on good communication to function safely, effectively, efficiently and reliably.

• Failure of clinical handover is a major contributing feature of adverse events.

• Good handover promotes shared situation awareness
What is Situation Awareness?
Situation Awareness

“The perception of data elements, the comprehension of their meaning in context and the projection of their status in the near future”

Or put simply....

“Knowing what’s going on so you can make the best possible decisions”
The "It" Factor

• Situation Awareness
  • Perception
    • Gather the information
  • Comprehension
    • Recognise and Understand
  • Projection
    • Anticipate/Predict/Mitigate/Escalate
ISBAR

ISBAR is a structured method of communication shared mental model allowing the person giving the handover (transmitter) and the person receiving it (receiver) to do so in a standardised & predictable manner.
ISBAR

- **Identify**
  - Who am I and who am I talking about

- **Situation**
  - One sentence description of problem

- **Background**
  - Details that give information

- **Assessment**
  - What you think about the problem

- **Recommendation**
  - What you think needs to be done
ISBAR3 for Shift Handover

**ISBAR₃ Communication Tool**

<table>
<thead>
<tr>
<th>Isobar 3 Communication (clinical handover) Tool SAMPLE</th>
<th>Shift Handover</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I</strong> Identify</td>
<td>Identify:</td>
</tr>
<tr>
<td></td>
<td>Lead handover person</td>
</tr>
<tr>
<td></td>
<td>Individuals / Team receiving handover</td>
</tr>
<tr>
<td></td>
<td>Patient(s)</td>
</tr>
<tr>
<td><strong>S</strong> Situation</td>
<td>Situation:</td>
</tr>
<tr>
<td></td>
<td>Location of patient(s)</td>
</tr>
<tr>
<td></td>
<td>Brief summary of current status</td>
</tr>
<tr>
<td></td>
<td>Is there a problem?</td>
</tr>
<tr>
<td><strong>B</strong> Background</td>
<td>Background:</td>
</tr>
<tr>
<td></td>
<td>Concise summary of reason for admission</td>
</tr>
<tr>
<td></td>
<td>Summary of treatment to date</td>
</tr>
<tr>
<td></td>
<td>Baseline observations (current admission)</td>
</tr>
<tr>
<td></td>
<td>Vital signs: BP, Pulse, Reqs., LO, F.O., Temp, AVPU</td>
</tr>
<tr>
<td></td>
<td>IMEWS (Include previous IMEWS if appropriate)</td>
</tr>
<tr>
<td></td>
<td>NEWS (Include previous NEWS if appropriate)</td>
</tr>
<tr>
<td><strong>A</strong> Assessment</td>
<td>Assessment:</td>
</tr>
<tr>
<td></td>
<td>What is your clinical assessment of the patient at present?</td>
</tr>
<tr>
<td><strong>R</strong> Recommendation Read-Back Risk</td>
<td>Recommendation:</td>
</tr>
<tr>
<td></td>
<td>Specify your recommendations</td>
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<tr>
<td></td>
<td>Read-Back: Recipients to confirm handover information</td>
</tr>
<tr>
<td></td>
<td>Risk: Include the safety pause to identify possible risks</td>
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</table>

Adapted by GUG with permission from Dr S. Marshall, Monash University, Australia.

- **Recommendation**
- **Read-back**
- **Risk**
<table>
<thead>
<tr>
<th>Communication Problem</th>
<th>Potential Solution</th>
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<tbody>
<tr>
<td>(sender &amp; receiver)</td>
<td>All must be aligned with a safe organisational culture</td>
</tr>
<tr>
<td>Communication is a complex process</td>
<td>Leadership, Governance, Education, Teamwork &amp; Simulation</td>
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<tr>
<td>Not knowing what or when to communicate</td>
<td>Situation awareness tools (eg. EWS), involve patients &amp; families, MDT</td>
</tr>
<tr>
<td>Lack of opportunity</td>
<td>Safety Pause, Briefings, Debriefings, Time out</td>
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<td>Afraid to speak up (“hinting &amp; hoping”)</td>
<td>Team work; photo-boards; narrow the hierarchy</td>
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<tr>
<td>Poorly organised</td>
<td>ISBAR, I-PASS, Checklists</td>
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<tr>
<td>Lack of clarity</td>
<td>Read-back; critical language</td>
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<tr>
<td>Poor listening/ Inattention/distractions</td>
<td>Assertive &amp; closed loop techniques</td>
</tr>
<tr>
<td>Language &amp; culture barriers</td>
<td>Active listening skills, “sterile cock-pit”.</td>
</tr>
<tr>
<td></td>
<td>All of the above</td>
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<td>-----------------------------------------</td>
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Briefings

• Briefings, Safety Pause, Timeout, Huddles

4 COMPONENTS
• Everyone knows the game plan
• Psychological Safety is ensured
• Norms of conduct are discussed
• Expectation of excellence is set
The Safety Pause

**THE SAFETY PAUSE**

**QUESTION:**

**WHAT PATIENT SAFETY ISSUES DO WE NEED TO BE AWARE OF TODAY?**

**Examples**
- **Patients**: are there two patients with similar names; patients with challenging behaviour; wandering patients; falls risk; self harm risk; or deteriorating patients?
- **Professionals**: are there agency, locum or new staff who may not be familiar with environment/procedures?
- **Processes**: do we have new equipment or new medicinal products (are all staff familiar with these?); missing charts; isolation procedures required; or care bundles for the prevention and control of medical device related infections?
- **Patterns**: are we aware of any recent near misses or recently identified safety issues that affected patients or staff?

**Heads-up for today**
- Challenges e.g. illness related leave, staffing levels, skill mix, demand surges.
- Meetings/training sessions staff need to attend e.g. mandatory training.
- New initiatives/information e.g. new protocols; feedback from external groups.
- Any other safety issues or information of interest to the team – has this been communicated to the team e.g. notice board/communication book/ patient status at a glance (PSAG) board/ other communication system etc.

**Patient Feedback**
- Update on actions from recent patient feedback on their experience (complaints, concerns or compliments) that we need to be aware of today?
Assertive Communication Loop

Get persons attention

Reach decision

Express concern

Propose action

State problem
Critical Language - Learning to CUUS

• Concerned  “I’m Concerned about...”

• Uncomfortable  “I feel uncomfortable doing...”

• Unsafe  “I think this is unsafe”

• Stop  “Stop!”
I-PASS - a Mnemonic to Standardize Verbal Handoffs

Starmer et al, Pediatrics 2011 & NEJM 2014

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Changes in Medical Errors after Implementation of a Handoff Program


ABSTRACT

BACKGROUND
Miscommunications are a leading cause of serious medical errors. Data from multicenter studies assessing programs designed to improve handoff of information about patient care are lacking.

Illness Severity
- Stable, “watcher,” unstable

Patient Summary
- Summary statement
- Events leading up to admission
- Hospital course
- Ongoing assessment
- Plan

Action List
- To do list
- Time line and ownership

Situation Awareness and Contingency Planning
- Know what’s going on
- Plan for what might happen

Synthesis by Receiver
- Receiver summarizes what was heard
- Asks questions
- Restates key action/to do items
Task 1 – Components of Clinical Handover

• What are the key components of good clinical handover?

• What adaptations and supports are necessary for specific contexts?

• What processes and outcomes can be used as a measures of good clinical handover?
Flexible Standardisation

- **Recommendation 5**: Local clinical handover policies must be developed in compliance with the National Clinical Guideline. While national communication tools (templates) are included in the National Clinical Guideline, these templates may be customised locally to accommodate features of the healthcare organisation, individual department, ward or unit, in line with the concept of ‘flexible standardisation’.
Framework for Handover

Task 2 – Staff Engagement

How might we engage staff to improve clinical handover?

What are the barriers that impede good clinical handover?

Are there benefits for staff brought by improving clinical handover?
Influencing Behaviour

• 2 Questions

• Can I do it?
  • Education, Skills, Team Training
  • Is it safe for me?
  • Time
  • Make it easy to do the right thing

What’s in it for me?
• Improve safety
• Avoid errors, incidents & investigations
• Opportunity to improve team work & culture
QID Framework for improvement

A culture of person-centred quality care that continuously improves

- Leadership for quality
- Person and family engagement
- Staff engagement
- Use of improvement methods
- Measurement for quality
- Governance for quality
Using Quality Improvement ideas for Change

Will

Ideas

Execution
Stories
Encourage patient & family participation

Implement
Effective
Clinical
Handover

Primary Drivers
(Processes, Structure, Cultures)

- Handover Models
- Supporting materials & factors
- Training
- Implementation
- Measurement & Observation
- Staff
- Patients & Families
- Governance
- Management, Leadership & Culture

Secondary Drivers
(Activities leading to 1 drivers)

- ISBAR/ISBAR3/IPASS
  Align with other communication behaviours
- Posters, leaflets, telephone pads, stickers
- Handover sheets, electronic templates
- Local policy – user friendly
- Environment – rooms, seats, noise
- Education – effective & engaging
  Simulation/ Readback
- Video
- Communicate implementation strategy
  Start small – One ward, Focus on morning/evening handover
- Observe & measure the process to provide regular feedback
  Safety measures – trigger tool/incidents/culture/climate
- Learn about staff attitudes and beliefs to handover
  Acknowledge & protect time required for handover
  Senior clinician presence at handover
  Safe space – to challenge or remind
  Acknowledge, celebrate & reward success
- Stories
  Encourage patient & family participation
- Risk register to support implementation
  Audit
- Organisational safety priority & long term commitment
  Senior clinical & executive sponsorship
  Resources
Using Quality Improvement ideas to help implement ISBAR

• Introducing ISBAR is a complex change that needs leadership, attention and support

• Education needs to be fun. Practise & become familiar with “new” language.

• Focus on the vital behaviours
  - Say the words to get the structure “The situation is...”
  - Difficult bits are Situation & Recommendation
  - Focus on set piece handovers e.g morning handover
  - Use readback as a learning tool
  - Measure the process, display it and give rapid feedback

• Align ISBAR with other communication structures (e.g. written notes, handover sheets)
Using Quality Improvement ideas to help implement ISBAR

### ISBAR Process Measure

<table>
<thead>
<tr>
<th>Date</th>
<th>Week 1</th>
<th>Week 2</th>
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<tbody>
<tr>
<td>1</td>
<td>ISBAR</td>
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<td>18</td>
<td>ISBAR</td>
<td>ISBAR</td>
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</tbody>
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Score
ISBAR Implementation

SBAR Implementation

% SBAR word opportunities
Time

Individual feedback
Team feedback

% SBAR word opportunities
ISBAR Notes

• 11 Essential components of a hospital note
  1. Patient ID
  2. Date
  3. Time
  4. Context
  5. Situation
  6. Background
  7. Assessment
  8. Recommendation
  9. Signature
  10. Print Name
  11. Medical Council Number

• Improvement Process
  • Education
  • Prompts
  • Measurement and feedback
  • Twice a week, up to 10 charts if available
  • - Individual (out of 11)
  • - Bundle (11 out of 11)

• Changes
  • - More education
  • - Individual feedback
  • - Consultant ownership
ISBAR Notes Implementation

### SBAR Notes

<table>
<thead>
<tr>
<th>Week</th>
<th>Items</th>
<th>Bundle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wk 1</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Wk 2</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Wk 3</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>Wk 4</td>
<td>60%</td>
<td>70%</td>
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<tr>
<td>Wk 5</td>
<td>80%</td>
<td>90%</td>
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<tr>
<td>Wk 6</td>
<td>100%</td>
<td>100%</td>
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<td>Wk 7</td>
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<td>Wk 11</td>
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<tr>
<td>Wk 12</td>
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</tbody>
</table>

Weeks:
- 20-Apr
- 27-Apr
- 05-May
- 09-May
- 18-May
- 25-May
- 30-May
- 03-Jun
- 07-Jun
- 17-Jun
- 22-Jun
- 29-Jun

- Education and visual reminders
- Named consultant
- Re-education and individual feedback

Dr. A
Dr. B
Dr. C
Dr. D
Dr. E
### ISBAR Tips

Use the words Situation, Background etc. to start each section

| “The Situation is…” | •Like a headline; keep it brief, one line if possible!  
•Relevant to a time frame eg. now, this shift, today |
| --- | --- |
| “The Background is…” | •What led to this situation  
•Underlying diagnosis and investigations if relevant |
| “My Assessment is…” | •Summarise observations, PEW score and relevant examination findings  
•Say what you think the problem is |
| “My Recommendation is…” | •Say what you think should happen  
•Always suggest a realistic timeframe for whatever action is required |

Encourage a read back
IHI Collaborative Model for Learning

www.ihi.org
Conclusions

• Clinical handover is a procedure within a complex system

• How might we start to improve?
  • Who will work with you?
  • Who will sponsor & support you?
  • Where can you try something next week?
  • How can you observe, measure and feedback to teams?
  • Are there staff in your organisation with Quality Improvement training?

Start before you’re ready! Go!!
Resources

• National Clinical Excellence Committee Guidelines No. 5 & No. 11
• HSE Quality Improvement Division

• HSELand  www.hseland.ie
• Institute for Healthcare Improvement (IHI)  www.ihi.org
• Health Foundation  www.health.org
• Agency for Healthcare Research & Quality (AHRQ)  www.ahrq.gov
• Liberating Structures  www.liberatingstructures.com