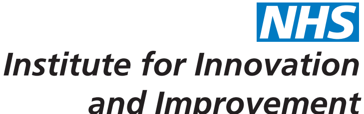


Releasing Time to Care

The Productive Mental Health Ward

Shift Handovers

Version 1

This document is for ward leaders, lead nurses, matrons, nursing directors and directors with responsibility for improvement

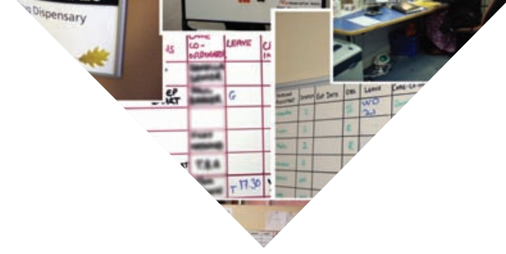
© Copyright NHS Institute for Innovation and Improvement 2008

Releasing Time to Care: The Productive Mental Health Ward - Shift Handovers is published by the NHS Institute for Innovation and Improvement, Coventry House, University of Warwick Campus, Coventry, CV4 7AL

This publication may be reproduced and circulated by and between *NHS England staff, related networks and officially contracted third parties only,* this includes transmission in any form or by any means, including photocopying, microfilming, and recording.

This publication is copyright under the Copyright, Designs and Patents Act 1988. All rights reserved. *Outside of NHS England staff, related networks and officially contracted third parties,* no part of this publication may be reproduced or transmitted in any form or by any means, including photocopying, microfilming, and recording, without the written permission of the copyright holder, application for which should be in writing and addressed to the Marketing Department (and marked 're: permissions'). Such written permission must always be obtained before any part of this publication is stored in a retrieval system of any nature, or electronically.

ISBN: 978-1-906535-54-4



Introduction

Shift handover is a crucial part of communication within your ward. A good shift handover will set up your team for a successful shift.

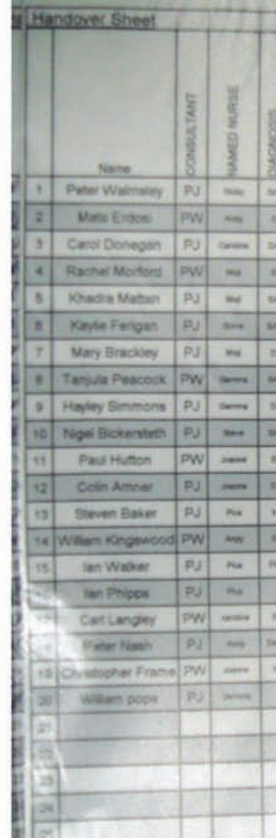
Shift handovers are often thought of as just a method to transfer responsibility for care to the next shift. The impact of a good handover is much bigger than this. A good handover can:

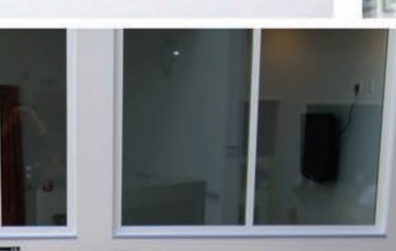
- improve patient outcomes
- avoid errors
- reduce repetition
- increase safety
- improve patient satisfaction
- have an impact on the patient journey

Getting handover right, however, is about good communication and much more. It means:

- exploring your whole approach to handovers
- making this process more patient-focused
- building on patients' values and cultural beliefs
- using handover to drive safety and quality for both patients and staff

NURSING TEAMS
SHARON
DEBBIE
GILL
MARGARET
JOANNE
LISA
VICKY
KAREN
JILL
MELANIE
CINDY
JULIE
JAYNE
DIANE C.
CLAIRE
TAMMY
NICK
LIZ
CAROLE
BERNI
STEVE
SAM
SHERIDAN
KATH
LAURA
TRACY
JEANETTE
KAY
ANDREA
DIANE
MALC
STUDENTS
08
KAYLI KIRKLAND - KATH · JOANNE 5/5 - 12/
MICHAEL WALMSLEY - TRACY - GILL 5/5 - 12/
LORNA HAYWARD - SHARON - KAY 5/5 - 12/
EMMA CLARKSON - NICK - JULIE 2/6 -
ZENA BURGESS - GILL - SHERIDAN
23/6 - 23/

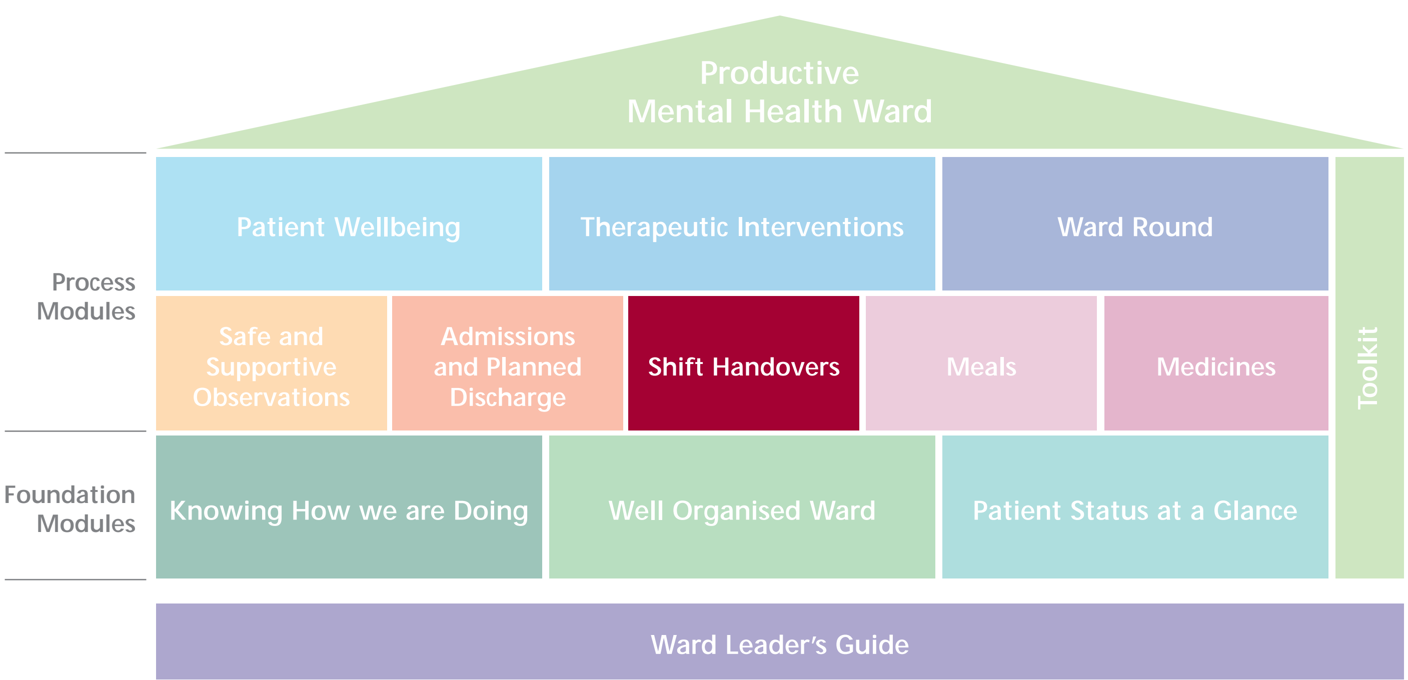

Handover Sheet
Name
CONSULTANT
NAMED NURSE
Peter Walmsley
Carol Donegan
Rachel Morford
Mary Brackley
Hayley Simmons
Nigel Bickersteth
Paul Hutton
Colin Amner
Steven Baker
William Kingswood
Ian Walker
Ian Phipps
Carl Langley
Peter Nash
Christopher Frame
William pope



Contents

Page	Contents
05	What is the Shift Handovers module?
08	What tools will I need?
11	Prepare
17	Assess
29	Diagnose
45	Plan
53	Treat
59	Evaluate
67	How can I make it stick?

These modules create a Productive Mental Health Ward



What is the Shift Handovers module?

What is it?

A practical and structured way to improve handover on your ward.

Why do it?

To give patients safe, reliable and dignified care by:
- reducing gaps and inaccuracies in handover information
- taking a patient-focused approach
- releasing staff time for direct patient care

To improve the experience for staff by:
- reducing repetition in information recording and transfer
- minimising the time staff spend looking for information
- maximising time for direct patient care
- building on the educational role of handover
- proactive patient pathway planning

What it covers

This module will help you determine the very best way to improve your handover by exploring:

- the best place for handovers
- who should be involved
- what tools to use
- how to evaluate your improved handover
- staff confidence
- sustainability

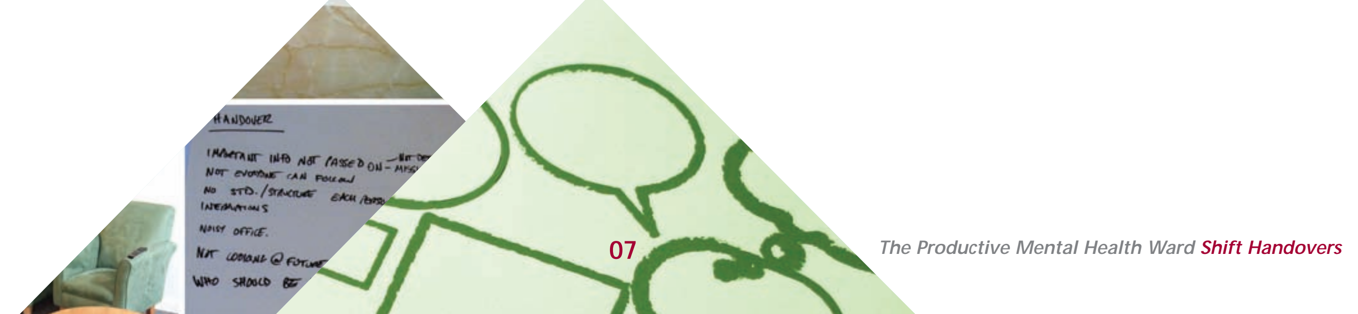
What it does not cover

In essence, this module will **not** prescribe what your best practice should be. This module will help **you** decide what a good handover process should look like and help **you** make that happen.

Learning objectives

The team will:

- understand what good preparation for a module is
- understand the basic stages of dot voting
- understand the basics of a standardised handover and why it is important
- define how to time a process before and after
- develop audits as a positive activity that helps sustain the new handover process



What tools will I need?

Tool	Toolkit reference number
Photographs	Tool no. 6
Video	Tool no. 7
Interviews	Tool no. 5
Timing Processes	Tool no. 8
Process Mapping	Tool no. 10
Cost/Benefit Analysis	Tool no. 11
Module Action Planner	Tool no. 12

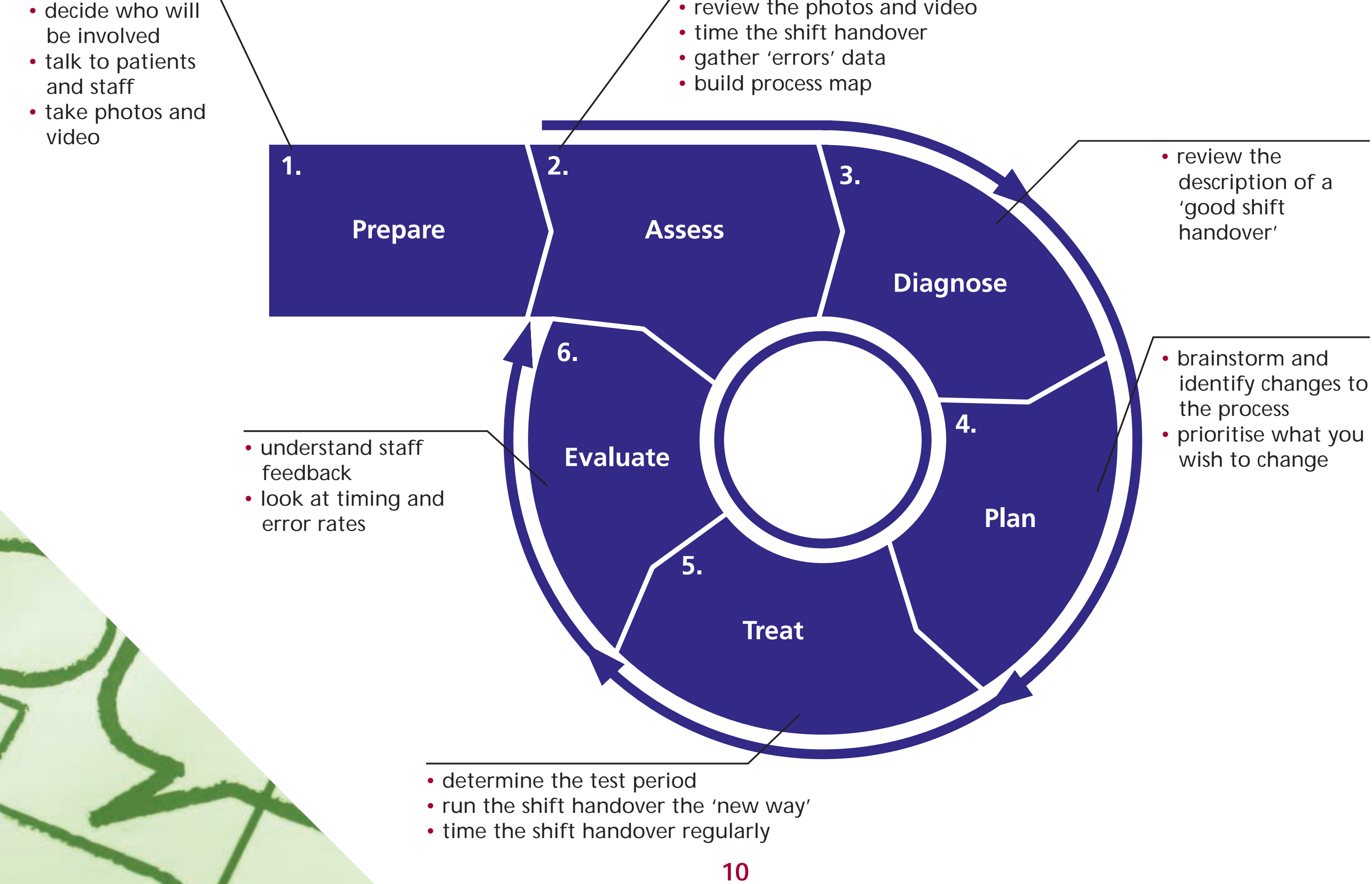
Creating your module baseline and keeping track of progress

To help you know what your position is before you begin The Productive Mental Health Ward and then actually see the progress you are making and maintaining, this module has its own 10 point checklist. These are based on the characteristics of a Productive Mental Health Ward in the area of the module. You will have carried out a complete assessment during your start up as part of the web-based Productive Mental Health Ward healthcheck.

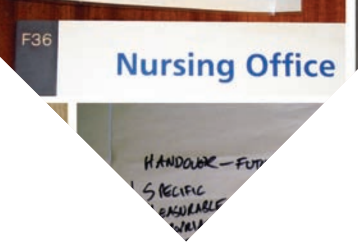
Remember… it is important to have your baseline measurement and regular measurements over a period of time.

To find the template for this module checklist, go to the back pages of the module. Here you will find an example template and a blank one for your use.

How will we do this on our ward - the 6 phase process



Prepare



Prepare

Step 1: Decide who will be involved
- one ward leader
- one senior nurse
- all staff involved in patient care on the ward
- appropriate stakeholders, eg, matron, clinical staff

This is a good opportunity to engage patients and families too

Step 2: Talk to staff
Use Toolkit tool no. 5 (Interviews) and ask:
- what is the general feeling towards handover on the ward?
- what causes problems?
- do staff feel prepared for their shift after the handover?
- what information do you receive and what do you think you need?
- are all staff involved, or are some excluded?
- does it affect their ability to do their job?

Step 3: Talk to patients
Use Toolkit tool no. 5 and seek guidance from your nursing director:
- what is the patient's experience of the ward environment during the handover period?
- do they understand what is discussed in handover?
- do they know who is responsible for their care?
- do they have concerns regarding the sharing of information?

Step 4: Take photographs
Use Toolkit tool no. 6

- include a picture of the room used for the handover process

Step 5: Video
Use Toolkit tool no. 7

- video the entire handover from start to finish
  - only share this with relevant staff
- keep the video in secure storage due to confidentiality issues

Step 6: Gather information from patient complaints

- look back over the past year and identify any complaints resulting from handover
- has the ward had any complaints where lack of information or poor communication has caused patient/relative complaints?

Step 7: Gather information from your organisation's patient surveys

Step 8: Gather information from incident reports

- look back over the last 50 incident reports
- look for any incidents or near misses regarding handover or omissions of information

Step 9: Understand how long it takes

Use Toolkit tool no. 8

- time every handover for a week (from the start time to when staff start to move away from the handover area)
- record interruptions during these handovers - note why they happened on a tally chart

Step 10: Obtain your organisation policy or guidelines for handover

- gain information regarding organisation policy for confidentiality
- consult Nursing and Midwifery Council (NMC) guidelines on accountability in information transfer
- what is your organisation's policy for dignity and privacy?

Step 11: Consider best practice

- ask your nursing director for best practice guidance on handover

Ask your PALS (Patient Advice and Liaison Service) for any handover-related feedback they have had from patients or relatives

Prepare - milestone checklist

Move on to 'Assess' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Decide who will be involved.	☐
2. Talk to staff.	☐
3. Talk to patients and family.	☐
4. Take photographs.	☐
5. Take video.	☐
6. Gather information from patient complaints.	☐
7. Gather information from patient survey.	☐
8. Gather information from incident reports.	☐
9. Understand how long it takes.	☐
10. Obtain organisation policy/procedures.	☐

Make sure all shifts are aware of progress – discuss as a part of shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed and answers agreed by all?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

Assess

Information from your Activity Follow analysis (Toolkit tool no. 3).

Use the results from the intended task tally to find out how much time your staff spend on shift handover. The total is measured in % of total time on the shift.

Releasing Time to Care

The Productive Mental Health Ward

TOTALISER

(orange)	Populate orange sections only
(green)	Green areas will self populate

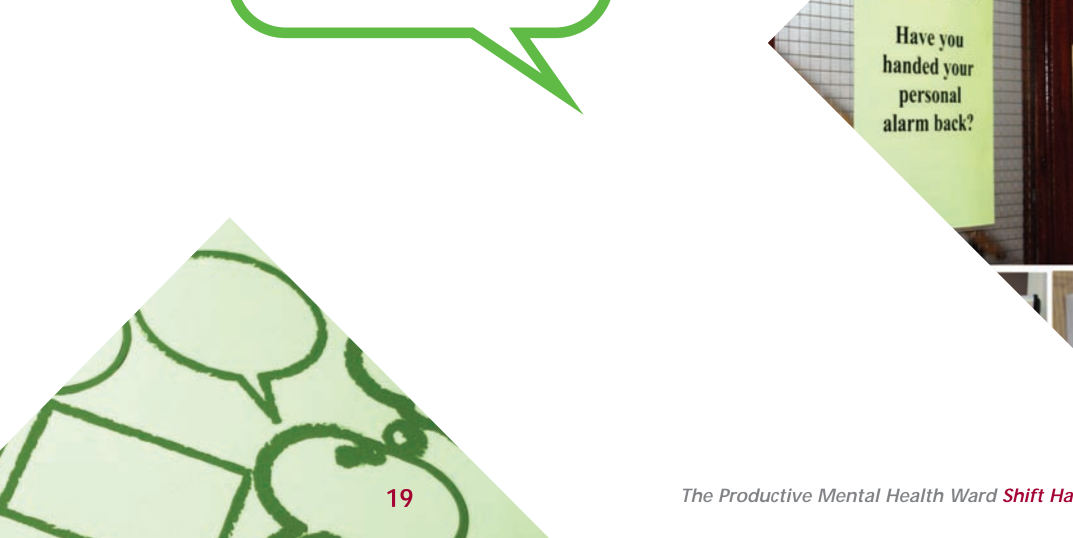
Total Observation Period =	12	Hrs (1hr = 1 Activity Follow Sheet)

		Cat	Code & Reason	Hour 6-7am	7-8am	8-9am	9-10am	10-11am	11-12pm	12-1pm	1-2pm	2-3pm	3-4pm	4-5pm	5-6pm	Total	Subsection Total

In this section:

- process
- accident and errors
- patient experience
- staff experience
- key questions to help you

remember to involve night staff



Process

Watch the video and create a list of information discussed in handover:

- let all staff have the opportunity to dot vote against the handover information they feel is most important to enable them to do their job
- make sure everyone voting identifies their role on the ward
    - use different colour pens or sticky dots to show this, ie, different colours for nurses and support workers
- help staff by doing the exercise in a quiet environment where their vote is not influenced by others
- using the list of information discussed in the handover, ask your staff to each put a dot against the information they feel should be routinely covered in a handover

- after everyone has voted, the information with the most dots is the core information you need to focus on
    - remember to include any information gleaned from talking to staff, patients and carers
- now establish where else this information is found eg, patient status/information board. Could this be used as part of handover?
- give each team member 10 votes and ask them to prioritise what they vote for
- more than one vote can be given to items on the list

An example of dot voting is illustrated in the photograph below:

It's a good idea to capture people's different roles on the dot vote - use different colours to indicate these

Watch the video again and record on sticky notes any areas of waste (see Toolkit tool no. 4). Then categorise the incidents of waste into the following five areas:

- who should be involved in handover?
- where should the handover be conducted?
- what information should be shared in the handover? (use your dot voting results)
- when should it start?
- how should it be conducted?

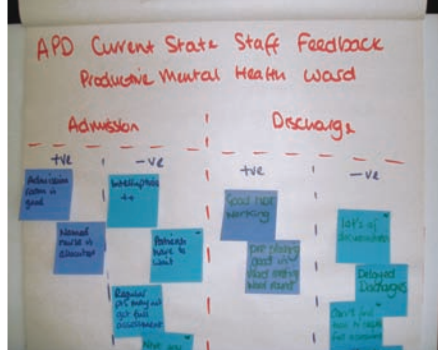
Include the results you have from timing the handover:

- you should have at least 14 readings (two or three per day)
- take the average – this is the average time taken before the changes

Do any readings seem too high or too low? If these are not typical, remove them and take the average from those left

Watching our video showed us that a lot of time was being wasted in handover by:

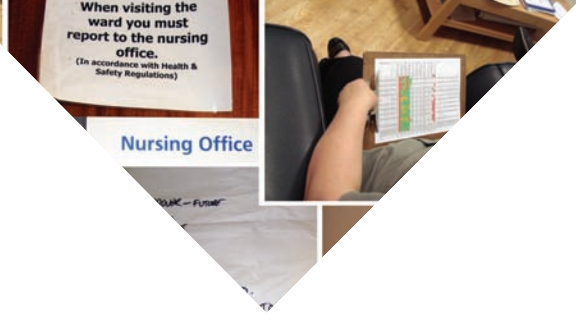
- repeating patients' details
- irrelevant long stories
- talking about care not relevant to discharge



Accidents and errors

From the last 50 incidents, draw out communication-related incidents:

- understand the time involved; for instance if there were five related incidents, and this period is over the last month, that's roughly one per week (use Toolkit tool no. 9)
- speak with staff to understand errors or near misses which may not be reported – try to estimate a number per week for these
- add the two together – this gives you your error rate before the changes



Patient experience

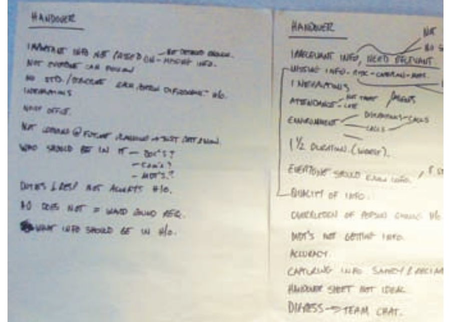
Summarise on a flipchart the information you have gathered from your organisation's patient survey and from interviewing patients. Categorise the information into the following areas:

- were there any concerns raised by staff regarding sharing of information at handover?
- use a discharge questionnaire
- what was the patient experience of the ward environment during handover?
- do patient's carers feel that they are updated on the patient's pathway after handover once changes are made?

Staff experience

From talking to staff, summarise their experience of handover management (use a flipchart here too):

- are there any factors of handover that frustrate staff?
- speak to student nurses - is there any educational value to handover?
- do staff (particularly students) understand what is said in handover and are they ready to start the shift fully informed?
- do staff feel informed about the patient's pathway?



Think about things that might hinder people's understanding at handover, such as the pace and any abbreviations used

Summary questions to help you

There are a lot of things to think about in the Assess stage and a lot of information to gather. Use these key questions to help you decide whether you have covered all the important areas.

1.	Are we following organisational policy and procedures?	• in relation to confidentiality and privacy and dignity
2.	Who is involved in handover?	• who needs to be involved? • does everyone need to be involved and, if yes, to what degree? • do staff understand their accountability in giving and receiving information? • as information is shared, is there an audit trail of what has been exchanged?
3.	How do we prepare for handover?	• do we prepare the environment - is it quiet with no interruptions? • what tools do we need? • is the handover done at the right time and does it start on time? • does everyone know their role in the handover? • are there any guidelines on the ward?
4.	What happens in handover?	• does everyone use the same format? If not why? • is the quality of the handover dependent on who is doing it? • is the handover non-judgemental and confidential? • how do staff know when the handover is finished? • how do staff collect or remember information given in the handover?
5.	Post handover	• are staff ready to do their jobs? • are instructions given or repeated after the handover? • do staff ever need to gain further information that should have been included in the handover? • are there other sources of information used on the ward?

Assess - milestone checklist

Move on to 'Diagnose' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Carry out dot voting exercise to prioritise the information used in the handover.	☐
2. Analyse incidents and errors related to the handover.	☐
3. Understand the patient experience of the handover period.	☐
4. Understand the staff experience of the handover.	☐
5. Understand any waste and categorise this into who, where, what, how and when.	☐

Make sure all shifts are aware of progress and discuss this as a part of the shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed and answers agreed by all?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

Diagnose

Diagnose - what does 'good' look like?

Before you move on to the 'Plan' stage where you will need to discuss and agree the changes you want to make, work through the following examples with your team.

They give snapshots of handover improvements from hospitals implementing The Productive Mental Health Ward. You can use them to start discussions and trigger ideas in your own team.

Ideas that have worked - example 1

Making a stand

Have you identified that your handovers last too long, with too much repetition and discussion of irrelevant information?

- try asking everyone to stay standing during handover – it can help people stay more focused on the most important issues
- make sure your team understand this isn't a discipline measure, but something that recognises their time is just as valuable as yours

> The stand-up meeting is a well-known technique in top companies - it could work for you.

Ideas that have worked - example 2

Location, location, location...
In the 'Assess' stage of the module you will have considered where else the information staff feel is most important might be found:

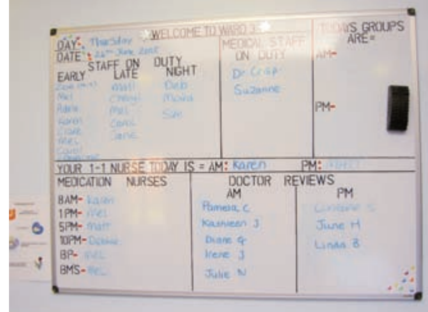
- is a lot of the information you need to share at handover already on the patient status/information board?
- if it is, why not hold your handover meeting, or part of it, around this?
  - it could save a lot of repetition and help reduce gaps and errors in information

Ideas that have worked - example 3

Ward nurse role
To ensure that your ward has a visibly present trained nurse available to work with and talk to patients during each shift, consider designating a 'ward nurse' on each shift.

This designated nurse is responsible for supporting patients who are not engaged in groups, activities or observation.

To ensure continuity, the ward nurse on each shift hands over to the on-coming ward nurse.



While our main handover gives everyone on the ward an overview of all the patients and issues, the short briefing that follows gives the smaller teams a chance to discuss their priorities and designate tasks

Ideas that have worked - example 4

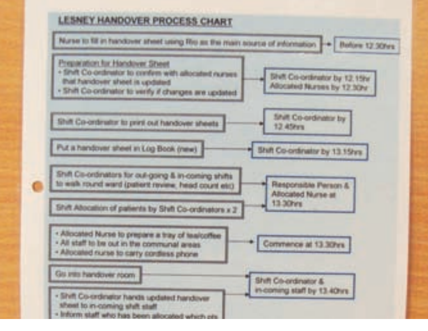
Safety factor

Good handovers are an important driver for safe care:

- one organisation has recognised this by including a safety briefing as a routine stage of their redesigned handover process
- by separating this out as a discrete part of the briefing, it highlights the importance of the information and focuses everyone's attention on specific safety issues, such as patient observations, mental health act status and individual risks such as potential risks to self or others

Ideas that have worked - example 5

Room to read
Consider whether your team has actually had enough time to read the handover briefing sheet, or look at the Patient Status at a Glance board before the handover formally commences. For some wards this is an important step before a handover – it gives everyone a chance to familiarise themselves with the patient location and issues before the verbal briefing gets underway.



Although it's good for staff to have the time to read the information first - some staff have emphasised the need to verbally state crucial information rather than just leaving people to read it themselves

Ideas that have worked - example 6

Standardised information

Standardised handover information sheets keep handover information consistent, help avoid gaps and can be customised to reflect the information staff have said they most need at handover.

These don't have to be complex, as this example shows:

Handover Sheet — Date: 10/11/07 — Shift: Afternoon — Shift Coord: Moji

					RISK							Mental State															
	Name	CONSULTANT	NAMED NURSE	DIAGNOSIS	TRAIT	PHYSICAL RISK	PATIENT TO OTHERS	PATIENT TO STAFF	PATIENT TO SELF	PATIENT TO PROPERTY	OBS	MOOD	BEHAVIOUR	APPEARANCE	PERCEPTION	ORIENTATION	MENTAL HEALTH ACT	LEAVE		OT	ABUSE - GIVING	ABUSE - RECEIVING	DRUG	ALCOHOL	Care Plan	NEXT ACTIONS, WHO AND WHEN	DONE
1		PJ	MOJI	PD	L	L	L	L	L	L	1	S	I	UH				S17	I							ENCOURAGE HOME LEAVE	
2		PJ	NICKY		H	H	L	L	H	H	1	A	B					UE	D							OFFER 1:1, TRANQS	
3		PJ	GEMMA		H	H	H	H	H	H	1	AS	B	UH				S17	D		V	V			PICU	1:1 MEDS	
4		PW	MOJI		H	L	L	L	L	H	1	A	I		H			S17	D							ENCOURAGE BUDGETTING, OFF WARD TO VENT	
5		PJ	MOJI		H	H	H	H	L	H	2	AD	B		H			S17	S		V	V			RESTART CLOZAPINE	COMPLIANCE	
6		PJ	STEVE		H	H	L	L	H	L	1	S	I	H	VH	C		ESC	S				Y			COMPLIANCE	
7		PW	STEVE		H	H	L	L	L	L	1	E						S17	I							ABSCONTION	
8		PJ	GEMMA		H	H	L	L	L	L	1	S						S17	S							MRI SCAN	
9		PW	CAROLINE		H	H	L	L	L	L	1	E						S17	I						S/V	CHASE S/V	
10		PW	NICKY		H	H	L	L	L	L	1	E		UH				S17	I			V		Y		COMPLIANCE	
11		PJ	ANDY		H	H	L	L	L	L	1	S	I					UE	S					Y	REST BITE	? AWAY FROM WOMEN	
12		PJ	JOANNE		L	L	L	L	H	H	2	S	I	UH		C		NAO	I						LOOK AFTER LIGHTS	DIET, CHECK FOR ABUSE	
13		PW	NICKY		H	H	L	L	L	L	1	E	I					S17	I							MONITOR BM BP	
14		PJ	ANDY		H	H	H	L	L	H	1	E	I	D	V			S17	I				Y		TRANSFER	BE UP FORENSIC REP	
15		PJ	CAROLINE		H	H	L	H	H	L	1	E	DIB					UE	S		V		Y			1 WEEK STAY DISCHARGE	
16		PJ	PUB		H	H	M	L	L	L	1	E						ESC	I					Y			
17		PW	CAROLINE		H	H	L	L	L	L	1	E	I		VH			S17	I					Y		COMPLIANCE, HYGIENE	
18		PJ	ANDY		L	L	L	L	H	H	1	S	I	UH		C		S17	S		V					ENCOURAGE FOOD [illegible] TAKEN OFF [illegible]	
19		PJ	NICKY		H	H	H	H	L	H	1	A	B		VH			NAO	D		V		Y	Y		COURT TODAY	
20		PW	GEMMA		H	H	H	L	L	L	1	E	DBR	D	VH			S17	S		V	V				COMPLIANCE	

Ideas that have worked - example 7

Split handovers
You could think about splitting the handover meeting - holding one for qualified nurses and another for support workers.

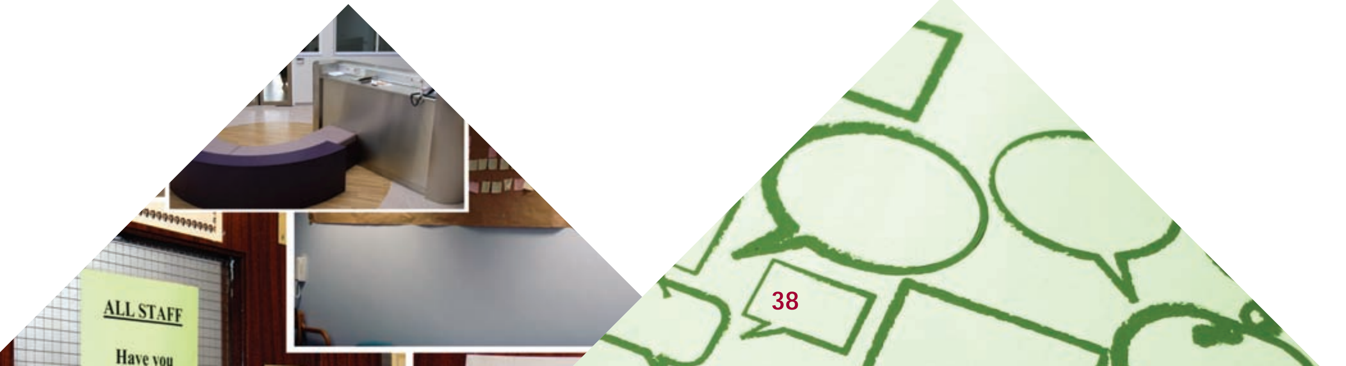
It means:
- students who may find the speed or language of the handover difficult, can learn at a slower pace without hindering the whole team
- you don't have to take all staff off the ward at the same time - improving care for patients and reducing interruptions to the handover itself

Ideas that have worked - example 8

Highlight the priorities
Based on observations and assessment of risk, the top five priority patients are identified.

Patients who may be at risk of self-harm, self-neglect or violence are clearly flagged-up to the whole team at the start of the shift - using handover or the Patient Status at a Glance board.

	Name	Con	N. Nurse	MHA	Obs	Leave	Next Action
1	T.H.	P.J	CAROLINE			ESC	Regular 1:1
2	J.C	P.J	STEVE			NAO	72 HR com 15/7
3	D.H	P.W	NICKY			NAO	72 HR com. 16/7 AM
4	K.F	S.C.	MOTI	2		NAO	
5	J.B	P.J	JOANNE			NAO	

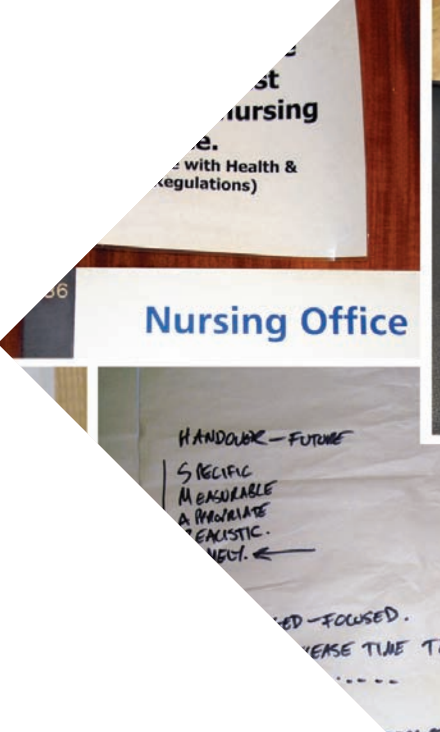


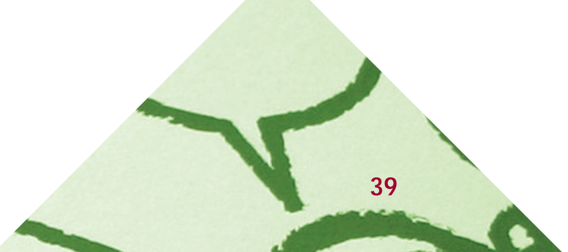
Ideas that have worked - example 9

Notes don't leave the ward
Some wards are creating a special file and place for briefing sheets so information stays on the ward where others can use it.

This means where team members have made their own notes on the standardised handover sheets, there is a reduced risk of accidentally taking them home at the end of the shift, and so risking patient confidentiality.

They are kept in a central location so the next shift can benefit from them if needed.



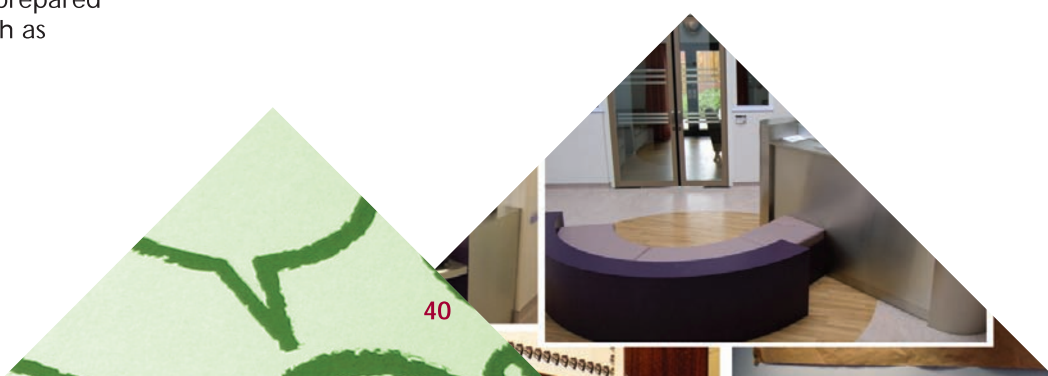


Ideas that have worked - example 10

Clear roles and responsibilities
While this is a fairly obvious subject, it is often glossed over with the assumption that staff members are clear about who is doing what during the shift. Unfortunately this is frequently not the case.

Clear roles and responsibilities should mean that roles and responsibilities are confirmed, in detail, during the handover. This not only means who is looking after which patients but also who needs to be ready and prepared for certain activities such as psychological support, ward round meals and patient observations. Go into detail about where these processes should be starting from and which direction around the ward the process should take so that processes and tasks do not clash.

One approach to this is to produce a daily named action sheet during ward round, which is reviewed during handover.



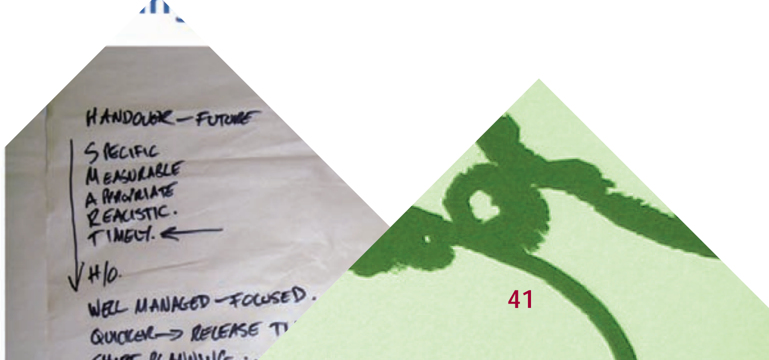
Ideas that have worked - example 11

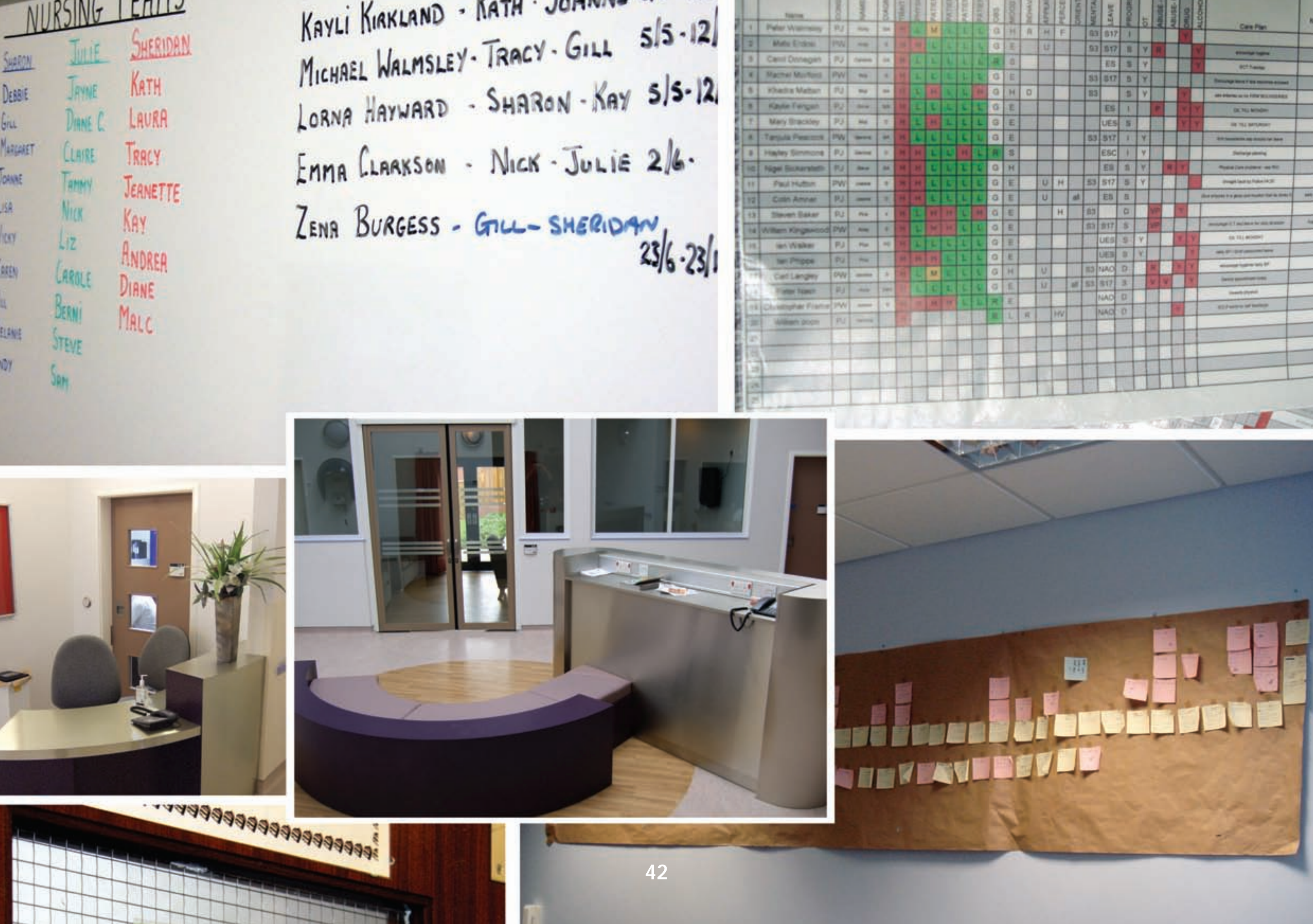
Using time wisely

Time released as a result of improving processes can get swallowed up by day-to-day issues. To make sure that doesn't happen, plan a structured programme of events for staff development and supervision.

LESNEY WARD HANDOVER MODEL 2008

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
1340hrs < ---------------------- Handover between AM and PM Shift ---------------------- >						
1355hrs < ---------------------------------- Any Other Business ---------------------------------- >						
1410hrs 1500hrs Monday to Sunday						
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Audits by Charge Nurses - Updating notes & care plans by Named Nurses	Teaching sessions	Case Presentations by Named Nurses	1 Safeguarding Children Supervision by Sarah Turner x monthly 2 3 4	Business Meetings Joint Meetings Monthly Presentation of audits by Charge Nurses	▪ Clinical Supervision ▪ E Learning on mandatory training available from the intranet	▪ Clinical Supervision ▪ E Learning on mandatory training available from the intranet




KAYLI KIRKLAND - KATH
MICHAEL WALMSLEY - TRACY - GILL
LORNA HAYWARD - SHARON - KAY
EMMA CLARKSON - NICK - JULIE 2/6
ZENA BURGESS - GILL - SHERIDAN
SHARON
DEBBIE
JULIE
JAYNE
DIANE C
CLAIRE
TAMMY
NICK
LIZ
CAROLE
BERNI
STEVE
SAM
SHERIDAN
KATH
LAURA
TRACY
JEANETTE
KAY
ANDREA
DIANE
MALC

Diagnose – milestone checklist

Move on to 'Plan' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Carefully work through the examples with the team.	☐
2. Openly discuss each example.	☐
3. Consider the examples against your own environment.	☐
4. Ask staff for new ideas, possibly building on the examples shown.	☐

Make sure all shifts are aware of progress – discuss as a part of shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

Plan

Plan

Using your team's expertise and the discussion around the examples, you will generate a number of things that will need to be done to implement your new handover process.

Discuss with the team what sort of handover to achieve.

To help you, this was how one ward described their ideal handover:

What did we want to achieve?

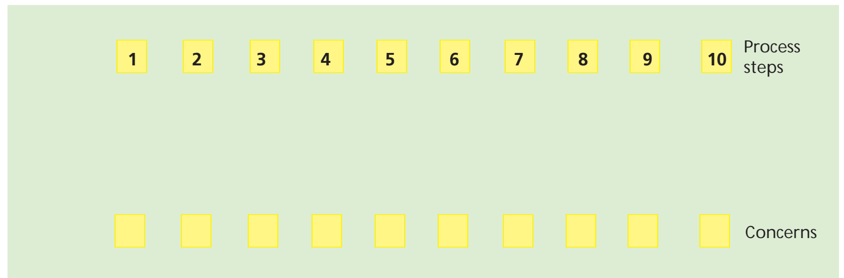
- **efficient**
  - information that is:
    - relevant
    - concise
    - not repeated
  - no interruptions
- **timely**
  - in allocated time - 30 minutes
  - starts on time
- **communicate the right information**
  - plan for today
  - proactive planning for future events
  - patient pathway planning

Using Patient Status at a Glance led the team to suggest using their board as part of their handover

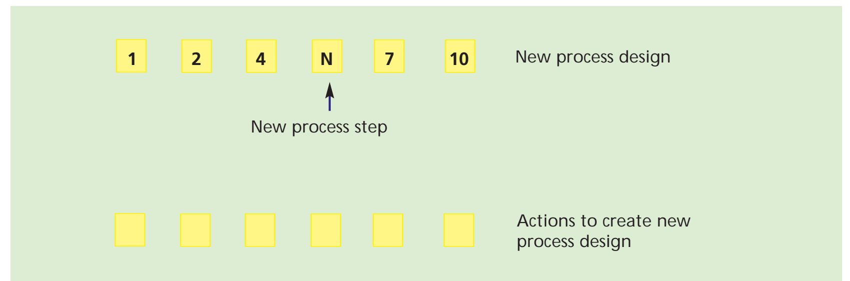
Create your new design

Use Toolkit tool no. 10 to map your current handover process.

Current State:



Future State:

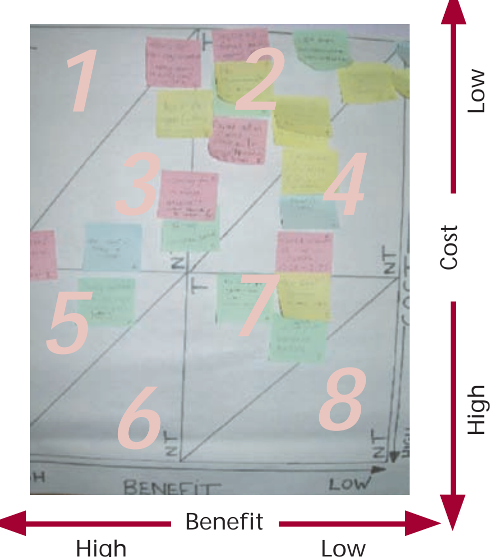


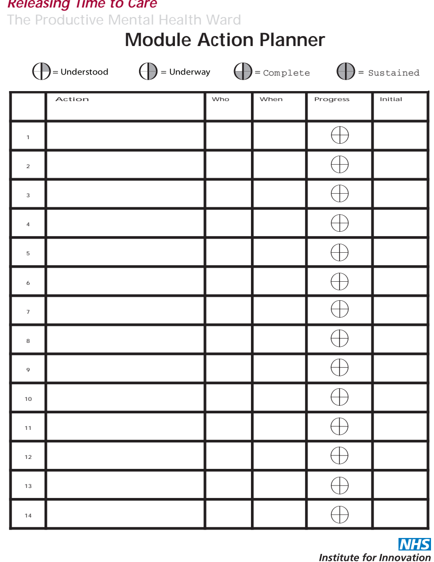
Now complete your new design process map by continuing to use Toolkit tool no. 10.

Plan how you will implement your new handover process

Use Toolkit tool no. 11 (Cost/Benefit Analysis) and tool no. 12, (Module Action Planner) to create your implementation plan. Display the plan by putting your completed Module Action Planner sheet in a prominent position on the ward.

Use your judgement to prioritise within each triangle and then list the problems.





Releasing Time to Care
The Productive Mental Health Ward

Module Action Planner

= Understood = Underway = Complete = Sustained

	Action	Who	When	Progress	Initial
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					

NHS
Institute for Innovation and Improvement

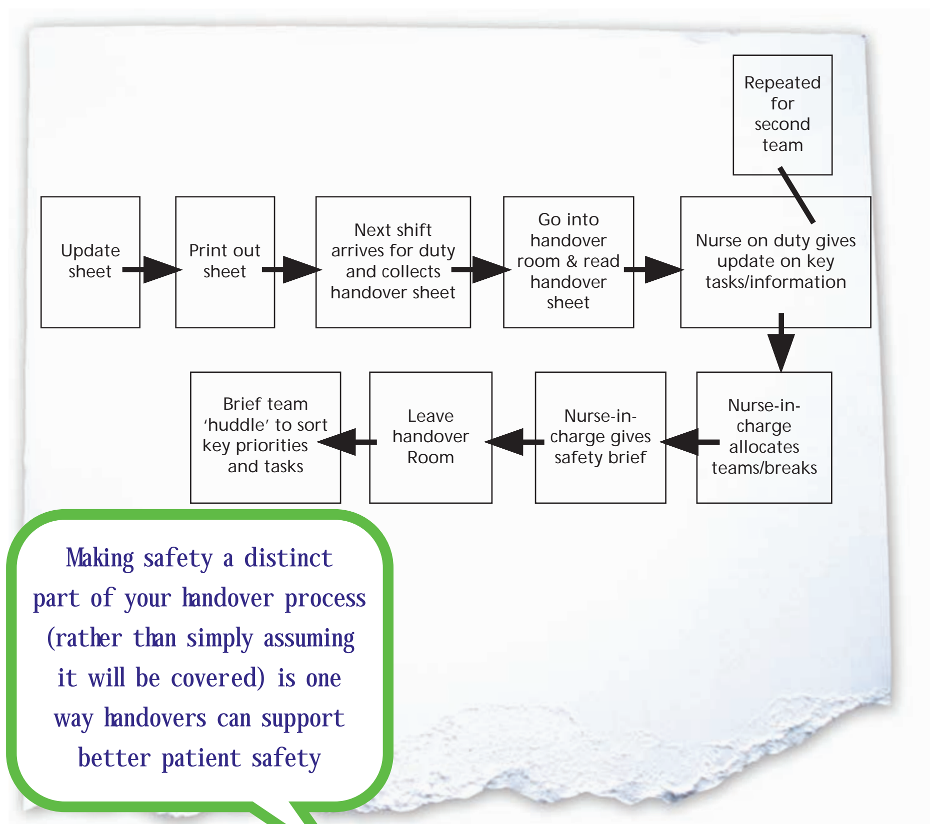
Create a standard operating procedure

The Module Action Planner sheet you have created now contains a prioritised list of all of the things that need to be done to create your newly-designed handover.

A number of these things may involve a change in working practice from your staff. For example, ensuring the room is prepared for handover to avoid interruptions. It is important to summarise the new handover working practices in a standard operating procedure. This can be on a flip chart or an A4 document.

This is a simple exercise that clearly communicates the new way of working. It has the added benefit of helping to set the standard for new staff.

An example standard operating procedure is featured opposite:



Fire door keep shut

Fire door keep shut

When visiting the ward you must report to the nursing office.
(In accordance with Health & Safety Regulations)

F36 Nursing Office

Plan - milestone checklist

Move on to 'Treat' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Consider examples of ideas that have worked.	☐
2. Consider results of the 'Assess' section.	☐
3. Create new design map.	☐
4. Create prioritised schedule on Module Action Planner sheet.	☐
5. Create process standard operating procedure.	☐

Make sure all shifts are aware of progress and discuss this as a part of the shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed and answers agreed by all?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

Treat

Treat

What are we testing?

- are we sticking to the new process?
- have we saved time on the handover?
- are we now making fewer errors?
- does it feel calmer?
- is it more patient centred/focused?
- is the patients' experience better while handover is in progress?
- have we reduced waste in any other way?

handed your
personal
alarm back?

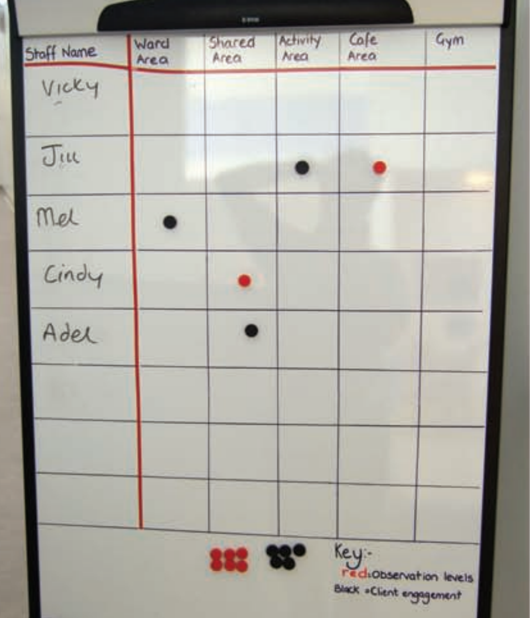
Fire door
keep shut

Fire door
keep shut

When visiting the
ward you must
report to the nursing
office.
(In accordance with Health &
Safety Regulations)

F36

Nursing Offic



WARD

HANDOVER

ROOM

HANDOVER – FUTURE
SPECIFIC
MEASURABLE
APPROPRIATE
REALISTIC.
TIMELY.
H/O.
WELL MANAGED – FOCUSE
QUICKER → RELEASE T
SHIFT PLANNING....
STRUCTURED
QUIET LOCN NO IN

Before the test starts:

- determine period for the test, it should be:
  - long enough to allow failures
  - short enough to change and retest
- identify additional temporary data collection methods (eg, add five minutes at the end of the handover to get feedback)
- agree the time collection method and who will do it
- agree the way to collect error data and who will do it
- set the start and end dates
  - and communicate them!
- update all staff personally on progress at handover meetings across all shifts
- post large notices on the ward detailing the process you have gone through and the standard operating procedure

During the test:

- get daily feedback from staff and patients on how they feel the new process is working
- take after photos and video during the test period
- invite visitors from senior management/multidisciplinary team to view the handover and give their comments
- time the handover rigorously

Treat - milestone checklist

Move on to 'Evaluate' only if you have completed ALL of the items on these checklists

Checklist	Completed ✓
1. Test period defined.	☐
2. All staff informed.	☐
3. Try out (test) the new handover process.	☐
4. Time new process.	☐
5. Get staff, patient and family feedback on the new handover process.	☐
6. Video the new process.	☐

Make sure all shifts are aware of progress and discuss this as a part of the shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed and answers agreed by all?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

Evaluate

Evaluate
Step 1 - collect information

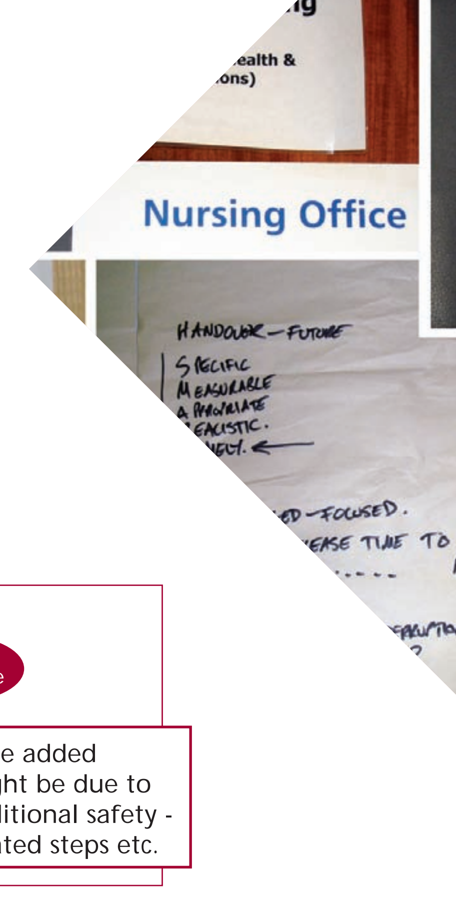
A) Gather the data:
- how long did it take?
- were there any incidents?
- any increase in reliability?

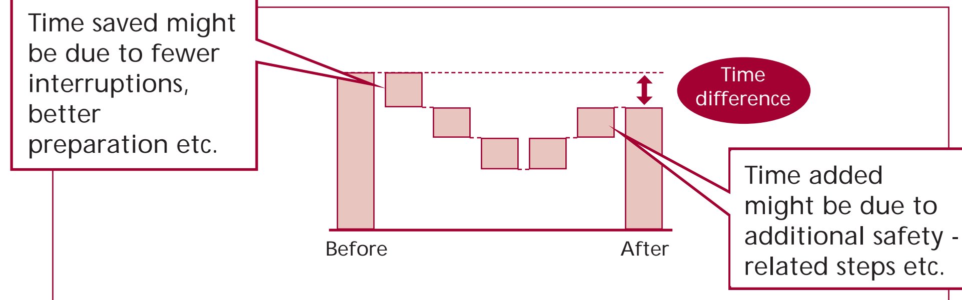
B) Talk to staff:
- how do you feel the new process is working?
- is it giving you the right information?
- is there anything that could be better?

Step 2 - analyse the information

Did the changes make it quicker?
- how much time was saved?
- how much time was added back to achieve the objectives of improved patient safety and improved patient experience during the handover period?

A chart such as the one below can help in understanding where time was spent or saved on different activities. Post the chart up in the ward to show staff and patients what has changed since you started.





Step 3 - further improvements

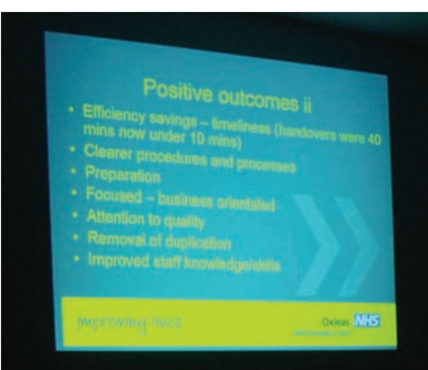
Decide where there are still opportunities for improvement, eg,

- reuse saved time - can this be invested in education, training, team supervision, case review, increase in direct care time and patient safety improvement work?

Step 4 - communicate success!

Don't forget to tell staff and patients, what you've achieved.

This slide is from one ward's presentation after they redesigned their handover process. It uses data and real quotes from staff to bring the improvements to life.



Impact:

On patient care

- more nurses on ward during handover
- key tasks getting done much sooner
- ward team understands what they should be doing
- elements of care delivered more consistently and reliably - eg, patient observation maximises safety, physiological intervention is targeted at the most appropriate patients and actions identified during the ward round are followed up

On staff

- more time for education, supervision
- knowing who is responsible for doing what for each patient

Total time saved > 6 hours per day

I am confident I know what I am doing on the shift

I have highlighted high risk patients verbally and visually for the team

My staff have more time available for personal development

I get time to reflect on things

Staff Name
Ward Area
Shared Area
Activity Area
Cafe Area
Gym
Vicky
Jill
Mel
Cindy
Adel
Key:-
red: Observation levels
Black = Client engagement

F36
WARD
HANDOVER
ROOM

Evaluate - milestone checklist

Move on to 'Evaluate' only if you have completed ALL of the items on these checklists

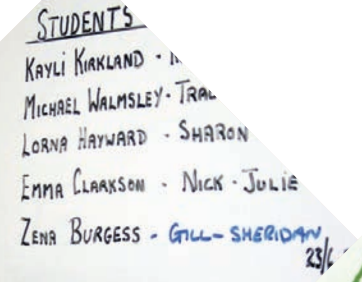
Checklist	Completed ✓
1. Talk to staff, patients and carers about the new handover process, record comments.	☐
2. Look at before and after process times.	☐
3. Look at before and after reliability score.	☐
4. Communicate success!	☐

Make sure all shifts are aware of progress and discuss this as a part of the shift handover

Effective teamwork checklist	Tick if YES
1. Did all of the team participate?	☐
2. Was the discussion open?	☐
3. Were the hard questions discussed and answers agreed by all?	☐
4. Did the team remain focused on the task?	☐
5. Did the team focus on the area/process, not individuals?	☐

How can I make it stick?

Monitor and audit continually	• continue to monitor time taken, at least once a day - discuss this if required, but review it monthly • conduct a process audit once a month (at least) - to ensure basic changes made are being followed • display your standard operating procedures clearly
Ensure leadership attention	• get your matron or equivalent to carry out the monthly process audit • ensure you (ward leader) discuss audit results with ward staff at least once a month (even if for five minutes in a 20 minute catch-up meeting) • ensure changes made and timings/reduced errors achieved are brought to the attention of senior leadership
Do not stop improving	• encourage ward staff to continue to find new and better ways of doing things - it is not about doing this once and then applying standard operating procedures, but about improving them continually



Learning objectives complete?

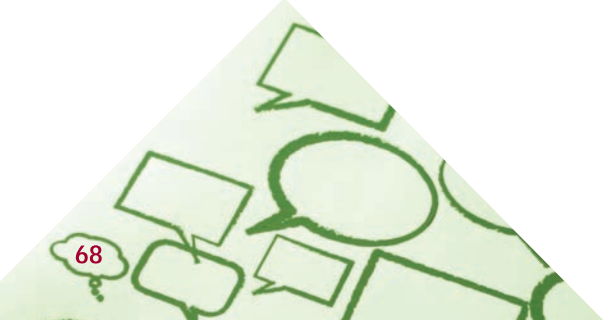
Three learning objectives were set at the beginning of this module.

Test how successfully these objectives have been met by asking three team members (of differing grades) the questions in the grid opposite. Ask the questions in the first column and make an assessment against the answer guidelines in the second column.

- if all three team members' responses broadly fit with the answer guidelines then the learning objectives of the module have been met

- note the objectives where the learning has only been partly met and think about how you can change the way you approach the module next time

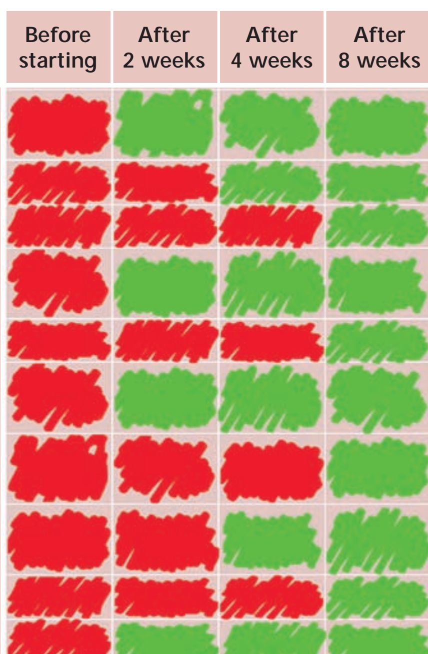
Remember: the results of this assessment are for use in implementing this module and are not in any way a reflection on staff aptitude or performance.



Question (ask the team member)	Answers for outcome achieved
Describe the things you need to do in the prepare stage of the module?	• find out organisational policy • find out patient satisfaction • talk to staff • find out accident information • video the process • time the process • find out what best practice examples exist
Explain the idea around dot voting	• summarises the team's views on what information is more important than others • allows the whole team to contribute • very useful to communicate to the wider team
Define a standardised handover and why it makes things better	• important tool for communication • key to sustaining new handover process • agreed by the team, not by an individual • ensures all of the information the team has decided is important is communicated • makes sure everyone knows what to expect in each handover
Explain how to time a process before and after	• time every handover for a week (from the start time to when staff start to move away from the handover area)
Where do audits fit into the handover module and how are they used?	• ensure people are carrying out the new handover process • should be quick • based on the standard handover procedure created by the team • never stop using audits

10 point checklist

Example



The grid to follow allows you to measure your performance against the 10 point checklist for this module. You should shade in the boxes according to your achievement of the measure. Your progress is clearly visible.

You should continue to monitor monthly.

10 point checklist Shift Handovers	Before starting	After 2 weeks	After 4 weeks	After 8 weeks
The handover takes the time agreed and is always in the same place at a specific time				
A patient board is used to show patient status and what needs to be done during the shift				
The patient board is referred to during the handover process				
Preparation time is given and is used to capture all necessary information				
Staff know where the information is coming from and who is responsible for it				
The shift handover supports discharge management and patient pathway				
Regular and random audits are conducted on the handover and use of the board				
Staff feel they spend less time looking for information				
Staff feel they receive the information they require to deliver safe and effective care				
Patients don't feel like they are being asked the same questions again and again				

HANDOVER

IMPORTANT INFO NOT PASSE
NOT EVERYONE CAN FOLLOW
NO STD./STRUCTURE EACH
INTERRUPTIONS
NOISY OFFICE.
NOT LOOKING @ FUTURE PLAN
WHO SHOULD BE IN IT
DUTIES & RESP NOT ALWA
HO DOES NOT = WARD
WHAT INFO SHOULD BE

When visiting the ward you must report to the nursing office.
(In accordance with Health & Safety Regulations)

Acknowledgements

Thank you to all staff at:
The Oakwell Centre, Kendray Hospital, Barnsley PCT
North Staffordshire Combined Mental Health Trust
Oxleas NHS Foundation Trust
Birmingham and Solihull Mental Health NHS Foundation Trust
Basingstoke and North Hampshire NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Royal Liverpool and Broadgreen University NHS Trust
Luton and Dunstable Hospital NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Central Manchester and Manchester Children's University Hospitals NHS Trust
NHS Institute for Innovation and Improvement, and staff from our improvement partners, who have had an input into this document

This module has been developed by:
Liz Ward, Clinical Facilitator, NHS Institute for Innovation and Improvement
Nick Downham, Associate, NHS Institute for Innovation and Improvement
Helen Bevan, Director of Service Transformation, NHS Institute for Innovation and Improvement
Maggie Morgan-Cooke, Interim Head of Productive Ward, NHS Institute for Innovation and Improvement
Kate Jones, Head of Safer Care programme, NHS Institute for Innovation and Improvement
Sean Manning, Senior Associate, NHS Institute for Innovation and Improvement
Neil Westwood, Associate, NHS Institute for Innovation and Improvement
Cathy Adcock, Improvement Manager, Luton and Dunstable Hospital NHS Foundation Trust
Bruce Gray, Improvement Manager, Luton and Dunstable Hospital NHS Foundation Trust
Lizzie Cunningham, Clinical Facilitator, NHS Institute for Innovation and Improvement
Cathie Blackwell, Clinical Facilitator, NHS Institute for Innovation and Improvement
Christine Wike, Clinical Facilitator, NHS Institute for Innovation and Improvement
Debbie Llewellyn-Sims, Clinical Facilitator, NHS Institute for Innovation and Improvement
Heather Palin, Clinical Facilitator, NHS Institute for Innovation and Improvement
Eileen Stonock, Clinical Facilitator, NHS Institute for Innovation and Improvement
Val Newton, Clinical Facilitator, NHS Institute for Innovation and Improvement

Website: For more information please visit www.institute.nhs.uk/productivementalhealthward

Contact the Productive Mental Health Ward team:
productivementalhealthward@institute.nhs.uk

ISBN: 978-1-906535-54-4
Copyright © NHS Institute for Innovation
and Improvement 2008 all rights reserved