NHS
Institute for Innovation and Improvement

## *Releasing Time to Care*

The Productive Ward

# *Shift Handovers*

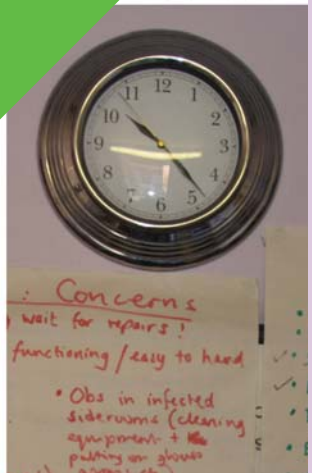
**Version 2**

**This document is for Ward Leader, Lead Nurse, Matron, Nursing Director, Directors with responsibility for improvement**

Shift Handovers

**SH**

***Releasing Time to Care***
The Productive Ward



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## DH INFORMATION READER BOX

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# *Introduction*

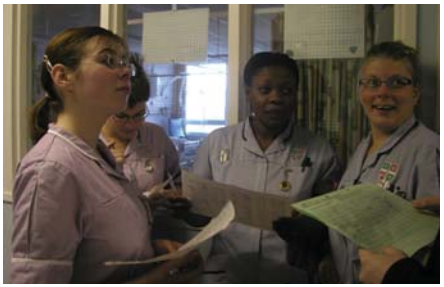
Shift handover is a crucial part of how nurses communicate with each other and that makes it a key process in any productive ward.

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 have a large effect on:

- improved patient outcomes
- avoidable errors
- reduction in repetition
- increasing safety
- improvements in patient satisfaction

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




pharmacy give us more
- Drs stand writing
round times - Drs To
cards. (Best times to ring)
tabard
it WORKS better.
- fact file.
- show infection control.
- checklist

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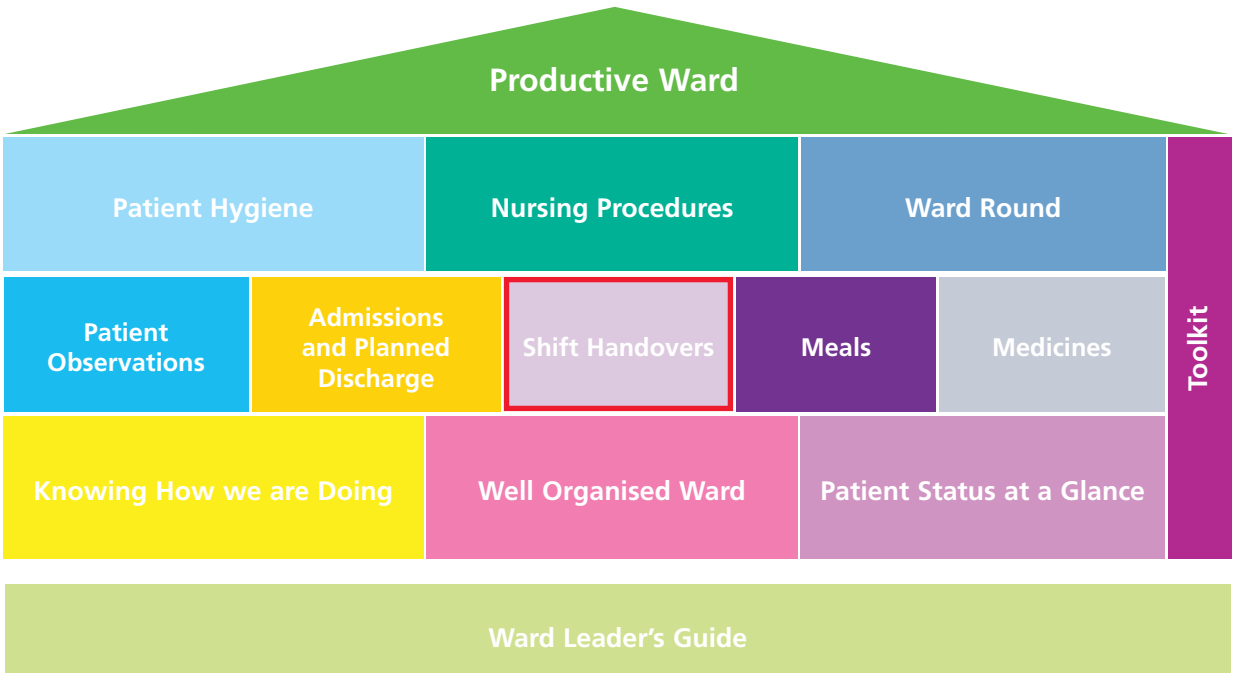
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# What is the Shift Handover module?

## 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 approached
- 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

## *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

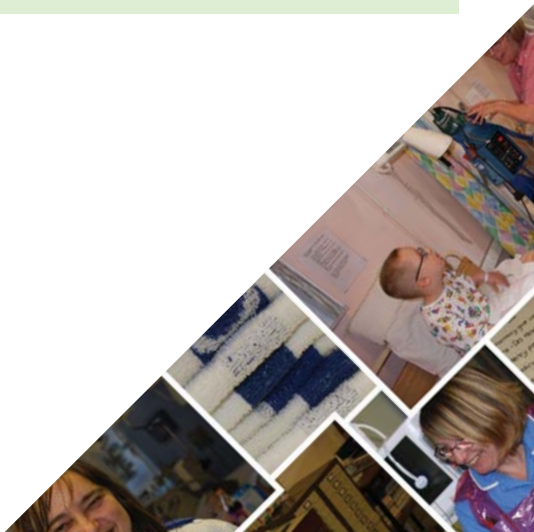
## *What it does not cover*

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 |

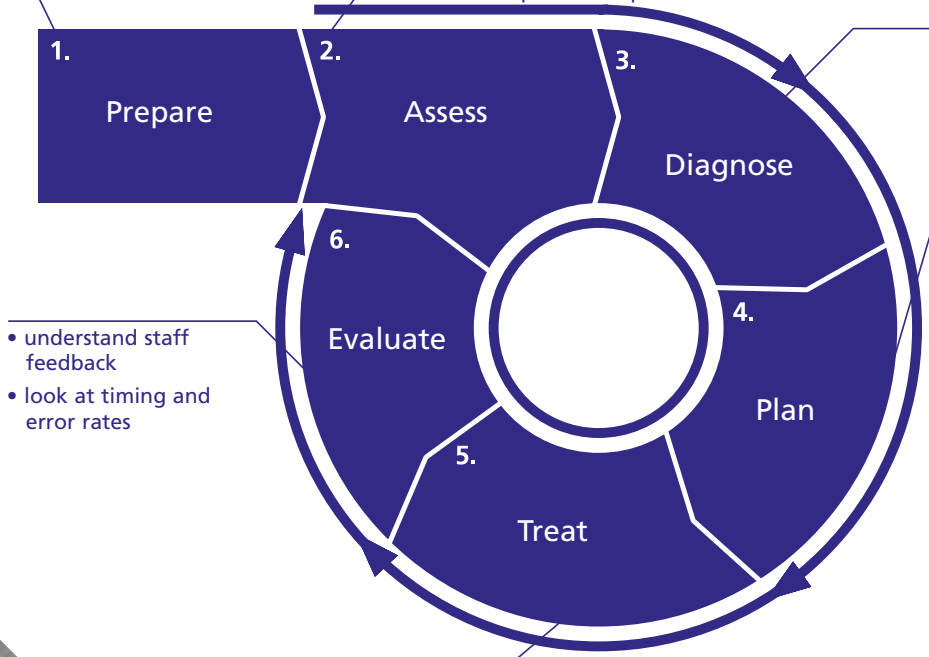
# *Creating your module baseline and keeping track of progress*

To help you know what your position is before you begin the Productive Ward and then actually see the progress you are making and maintaining, this module has its own 10 point check list. These are based on the characteristics of a Productive 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 Ward Healthcheck – see NHS Institute website for details.

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

To find the template for this module checklist, go to the back pages of the booklet. 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




- decide who will be involved
- talk to patients and staff
- take photos and video

- review the photos and video
- time the shift handover
- gather 'errors' data
- build process map

- review the description of a 'good shift handover'

- brainstorm and identify changes to the process
- prioritise what you wish to change

- understand staff feedback
- look at timing and error rates

- determine the test period
- run the shift handover the 'new way'
- time the shift handover regularly

# *Prepare*

# Prepare

**Step 1. Decide who will be involved:**
- 1 ward manager
- 1 ward sister
- all staff involved in patient care on the ward
- appropriate stakeholders, eg matron, medical staff


**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 handover?
- do they understand what is discussed in handover?
- would they like to be involved?
- 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 trust'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

If you don't have any trust information on patient satisfaction relating to handover, do your own snapshot audit/questionnaire of one handover!

**Step 9. Understand how long it takes:**

**Use Toolkit Tool No. 8**

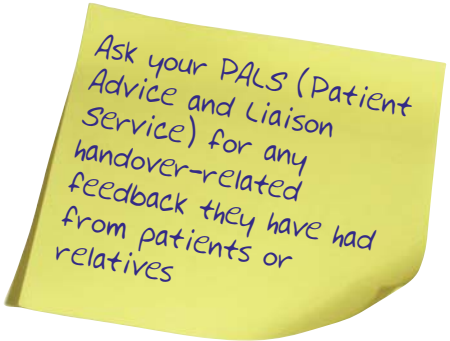
- time every handover for a week (from the start time and to when staff start to move away from the area where handover was done)
- record interruptions during these handovers – note why they happened

**Step 10. Obtain your trust policy or guidelines for handover:**

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

**Step 11. Consider best practice:**

- ask your Nursing Director for best practice guidance on handover



# Prepare - Milestone Checklist

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

| | 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 trust 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 focussed on the task? | ☐ |
| 5. Did the team focus on the area/process, not individuals? | ☐ |

# *Assess*

# 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 Ward

**TOTALISER V7**

Populate orange sections only

Green areas will self populate

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

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

# Assess

In this section:

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


## 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

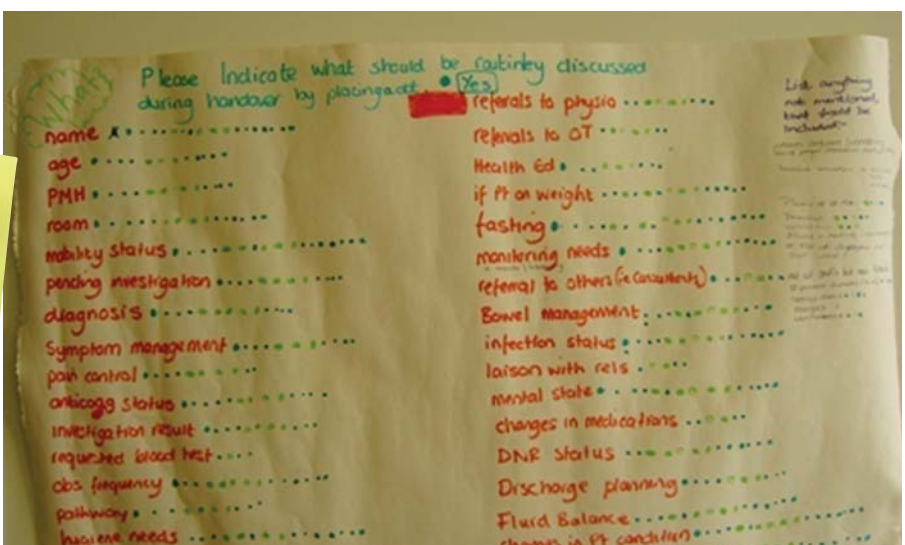
**Dot Voting**

- make sure everyone voting identifies their role on the ward - use different colour pens to show this. i.e. different colours for trained and untrained staff
- 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 family)
- now establish where else this information is found, e.g. patient status/information board. Could this be used as part of handover?

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 post-it notes any areas of waste. (See Toolkit No. 4). Then categorise the incidents of waste into the following five areas:

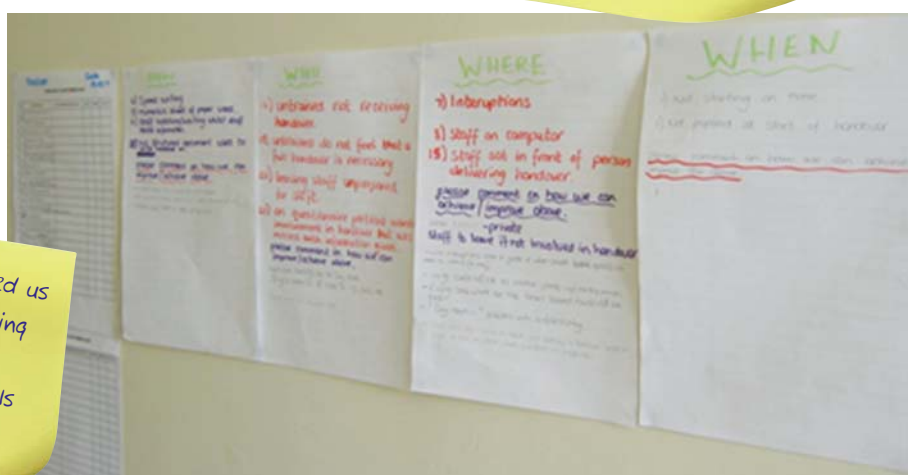
- who should be involved in handover?
- where should the handover be conducted?
- what information should be shared in the handover? (use your dot voting results)
- when should it start?
- how should it be conducted?

Include the results you have from timing the handover:

- you should have at least 14 readings (2 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 & 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 1 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 'per week' number 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 trust's patient survey and from interviewing patients. Categorise the information into the following areas:

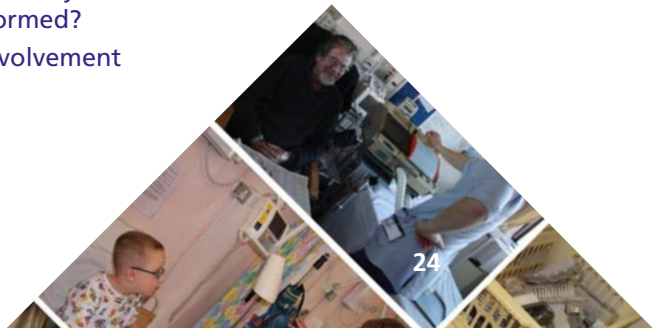
- what was the response when patients (and families) were asked if they wanted to be involved in nurse handover?
- were there any concerns raised by staff regarding sharing of information at handover?
- was there any indication that patients would feel they were getting a more personalised service or a have a better understanding of their care if they were involved in handover?
- would knowing what is said in handover reduce anxiety?

# *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 and cadets) understand what is said in handover and are they ready to start the shift fully informed?
- do staff feel patient involvement is important?

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 hospital policy and procedures? | • In relation to confidentiality and privacy and dignity |
| 2. | who is involved in handover? | • who needs to be involved?<br>• does everyone need to be involved and, if yes, to what degree?<br>• do staff understand their accountability in giving and receiving information?<br>• 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?<br>• what tools do we need?<br>• is handover done at the right time and is it started on time?<br>• does everyone know their role in handover?<br>• are there any guidelines on the ward? |
| 4. | what happens in handover? | • does everyone use the same format? If not why?<br>• is the quality of handover dependent on who is doing it?<br>• is handover non-judgemental and confidential?<br>• how do staff know when the handover is finished?<br>• how do staff collect or remember information given in handover? |
| 5. | post handover | • are staff ready to do their jobs?<br>• are instructions given or repeated after handover?<br>• do staff ever need to gain further information that should have been included in handover?<br>• are there other sources of information used on the ward? |

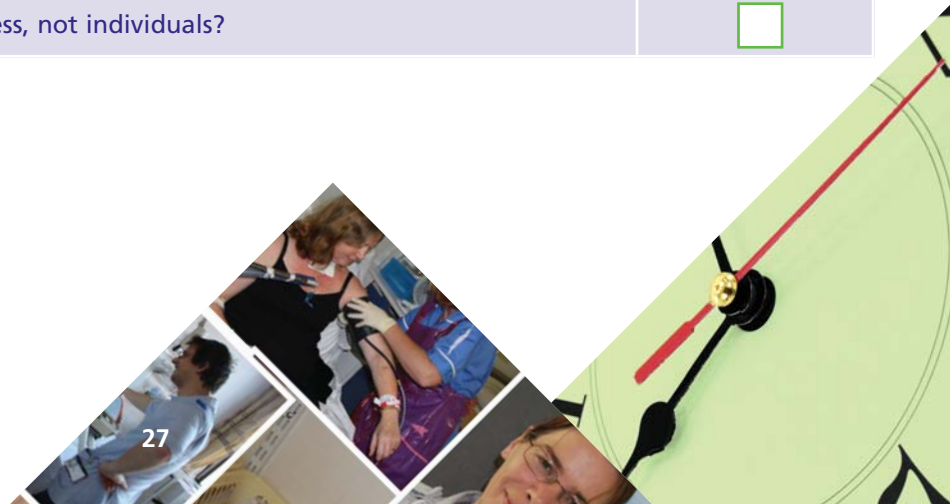
# Assess - Milestone Checklist

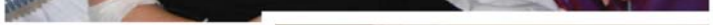
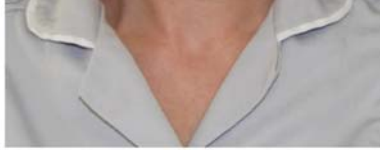
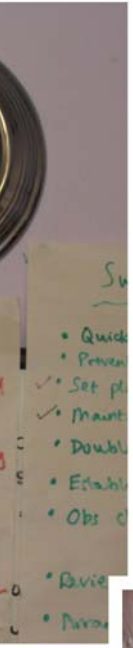
## Move on to 'Diagnose' only if you have completed ALL of the items on these checklists

| | Completed ✓ |
|---|---|
| 1. Carry out dot voting exercise to prioritise the information used in handover. | ☐ |
| 2. Analyse accidents & errors related to handover. | ☐ |
| 3. Understand the patient experience of handover. | ☐ |
| 4. Understand the staff experience of 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 focussed on the task? | ☐ |
| 5. Did the team focus on the area/process, not individuals? | ☐ |




Nailbrushes
10
Toothbrushes
10



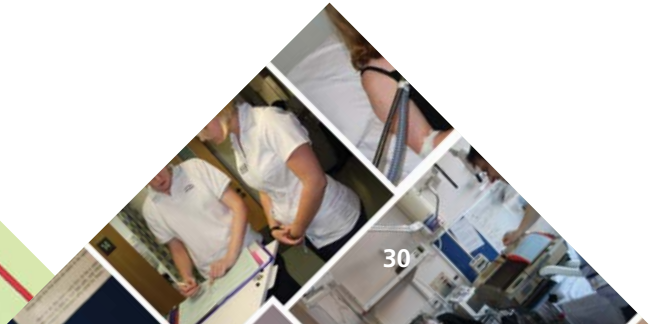



# *Diagnose*

# *Diagnose*

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 Ward. You can use them to start discussions and trigger ideas in your own team.



# *Diagnose:*

## *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 though that this isn't some sort of discipline measure, but something that recognises that 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.

# *Diagnose:*

## *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.

- think about this – for instance 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

# Diagnose:

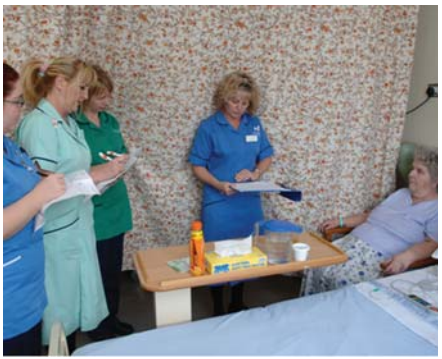
## Ideas that have worked. Example 3:

### On the move...

In redesigning their handover process, some teams have opted to hold part of their handover in one area or room and the other part in a different space – for instance in the bay area or round the patient's bed.

Some wards are introducing a 'bedside round' where the outgoing nurse and the on-coming team meet at the patients' bedsides:

- it gives the team a chance to discuss each patient's care plan and goals for the day
- it introduces the patient to the new team
- it could be a good option if your feedback from patients shows they want to feel more involved and know more about what's being discussed at handover



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.

# *Diagnose:*

## *Ideas that have worked. Example 4:*

### Safety factor...

Good handovers are an important driver for safe care.

- one trust has recognised this by including a safety briefing as a routine stage in 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 flagging up a patient who has had a fall, or is at risk of one, on the ward

# Diagnose:

## Ideas that have worked. Example 5:

### Room to read...

Consider whether your team has actually had enough time to read the handover briefing sheet 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 patients 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

# *Diagnose:*

## *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:

| Room | Name | Age | Cons | Diagnosis | Neuro | Invest | Resp. | CVS | GI | GU | PA Skin | Mobility | S/ T/ D |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A1 | | | | | | | | | | | | | |

# *Diagnose:*

## *Ideas that have worked. Example 7:*

### Split handovers...

You could think about splitting the handover meeting – holding one for trained staff and another for untrained members of the team. It means:

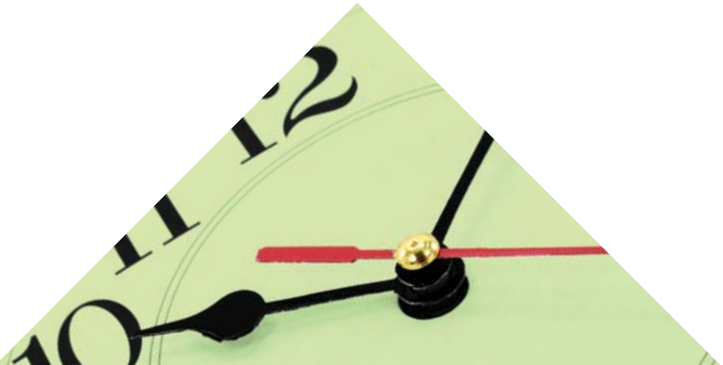
- students who may find the speed or language of the handover difficult can learn at a slower pace without hindering the whole team
- you don't have to take all staff off the ward at the same time – improving care for patients and reducing interruptions to the handover itself

## *Diagnose:*
## *Ideas that have worked. Example 8:*

### Highlight the priorities...

Based on observations and assessment of risk, the top five priority patients are being identified in some handovers.

Patients who may be at risk of a fall or dehydration, for instance, are clearly flagged up to the whole team at the start of the shift.



## *Diagnose:*
## *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, instead of folding them up in a pocket and taking them home at the end of the shift, they are kept in a central location so the next shift can benefit from them if needed.

# *Diagnose:*
## *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 meal rounds, medicines rounds and patient observations. You 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.

# *Diagnose – Milestone Checklist*

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

| | 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 focussed on the task? | ☐ |
| 5. Did the team focus on the area / process, not individuals? | ☐ |

# *Plan*

# Plan

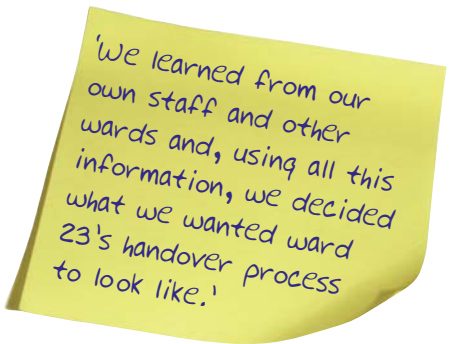
Using your team's expertise and the discussion around the examples, you will generate a number of things that will need to be done to implement your new handover process.

Discuss with the team what sort of handover process you want to achieve.

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

**What did we want to achieve?**

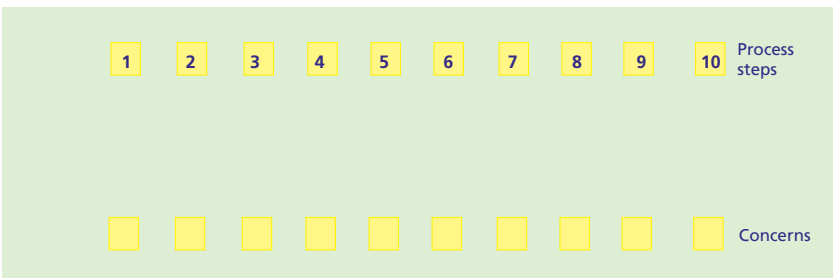
- **efficient**
  - information that is:
    - relevant
    - concise
    - not repeated
  - no interruptions
- **timely**
  - in allocated time - 30 minutes
  - starts on time
- **communicate the right information**
  - plan for today



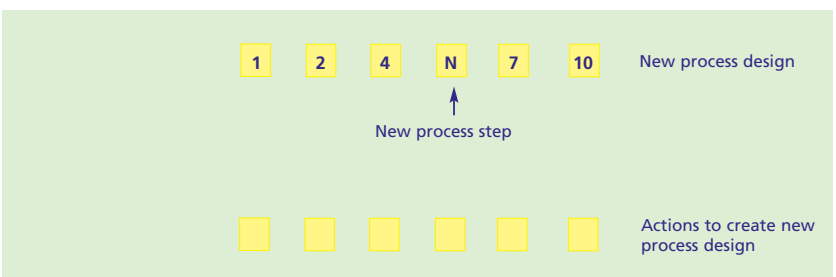
# *Create your 'new design'*

Use Toolkit Tool No. 10 to map your current handover process.

**Current State:**




**Future State:**



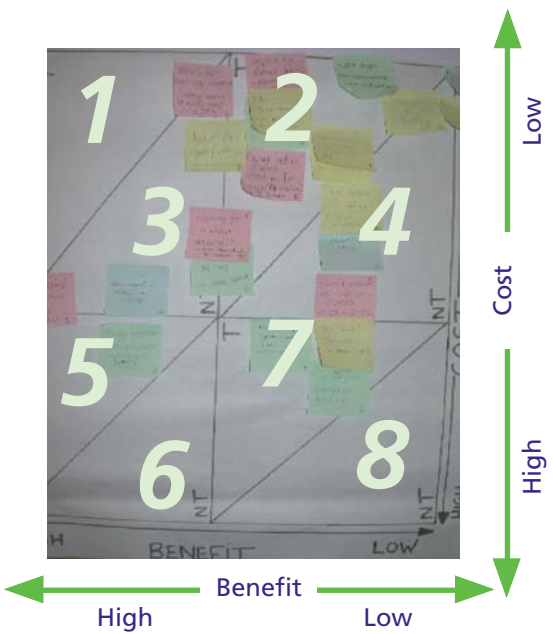

Now complete your 'new design' process map by continuing to use Toolkit Tool No. 10.

# 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 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 | | | | ⊕ | |

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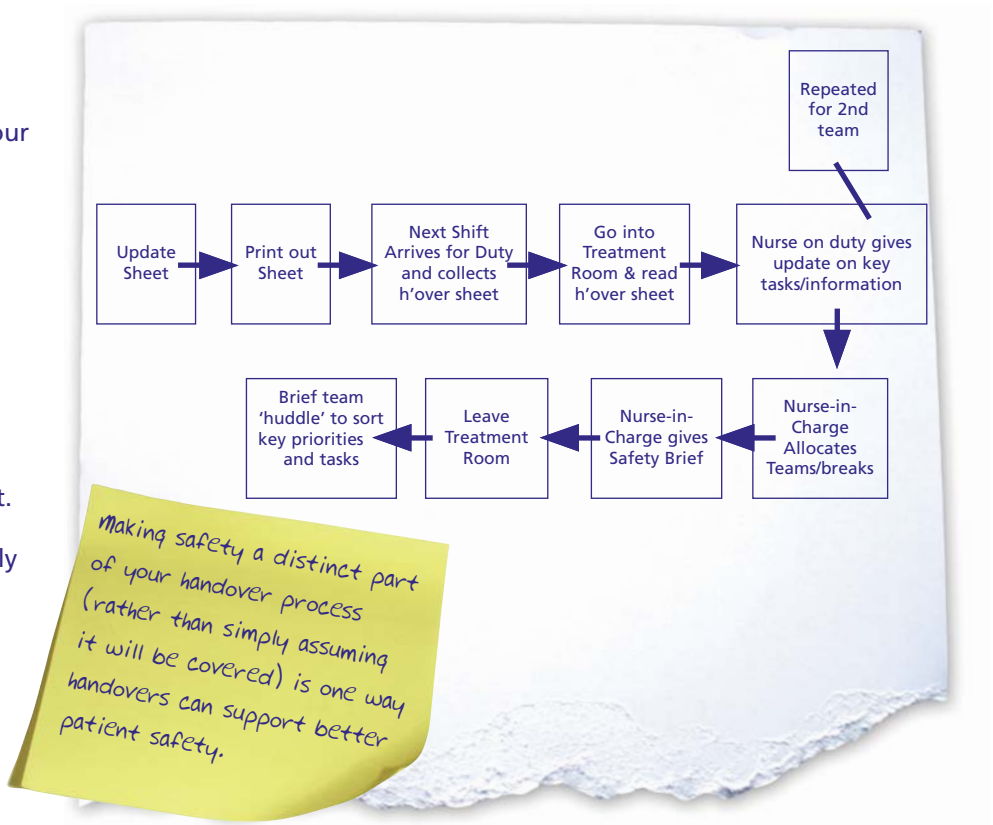
# Create a 'standard operating procedure'

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:



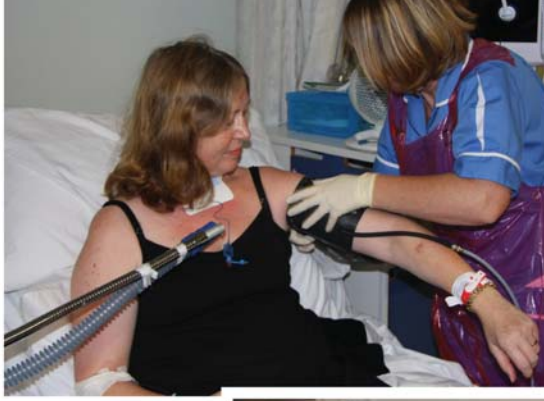
# Plan - Milestone Checklist

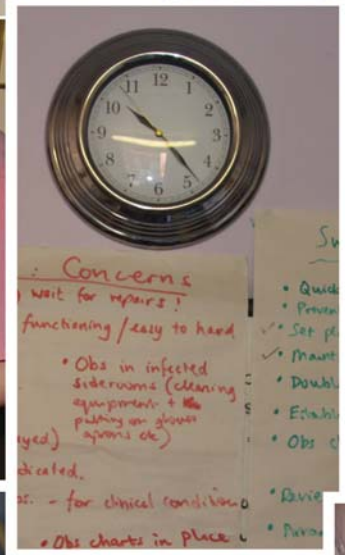
## Move on to 'Treat' only if you have completed ALL of the items on these checklists

| | 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 focussed on the task? | ☐ |
| 5. Did the team focus on the area/process, not individuals? | ☐ |




Concerns
wait for repairs!
functioning / easy to hand
Obs in infected
for clinical condition
Obs charts in place

# *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?
- do we have an improvement in staff experience?
- is the patients' experience better?
- have we reduced waste in any other way?

**Before the test starts:**

- determine period for the test, e.g. 'we will test the handover for one week'
  - long enough to allow failures
  - short enough to change and retest
- identify additional temporary data collection methods (e.g. 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 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*

| | 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 focussed on the task? | ☐ |
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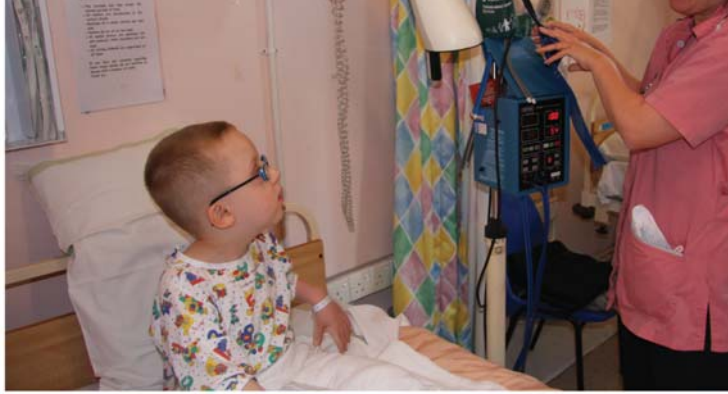

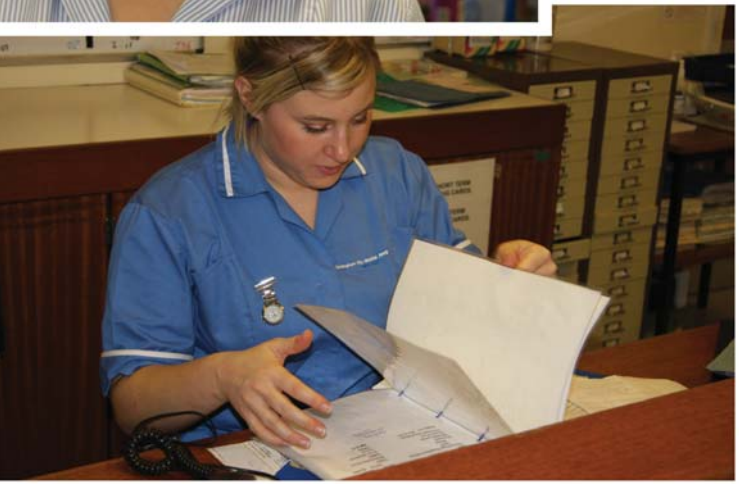


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- show inspector round.
- checklist

# *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:**

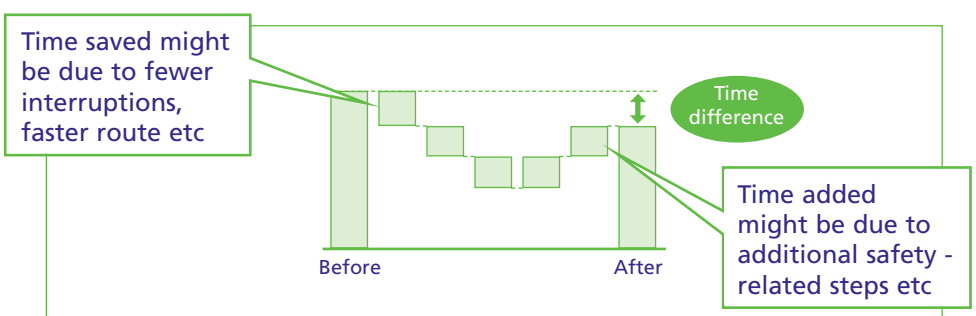
- how do you feel the new process is working?
- is it giving you the right information?
- is there anything that could be better?

# Step 2: analyse the information

**A) 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?

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*

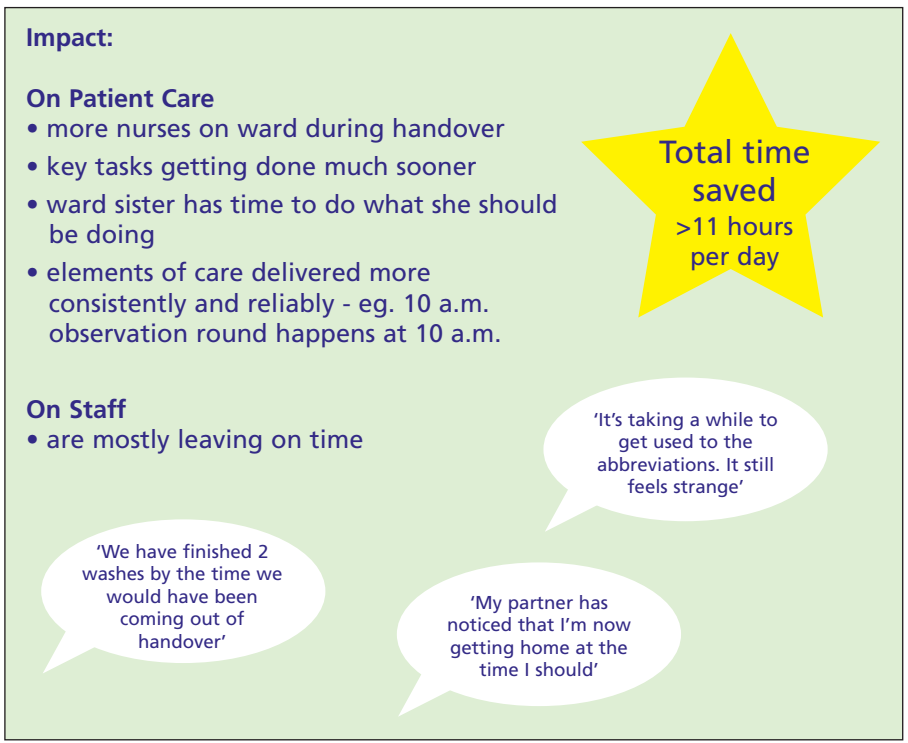
Decide where there are still opportunities for improvement e.g.

- more space is needed to record more detail on the standardised handover sheet

# *Step 4: communicate success!*

Don't forget to tell people, 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:



# Evaluate - Milestone Checklist

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

| | Completed ✓ |
|---|---|
| 1. Talk to staff, patients and relatives 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? | ☐ |
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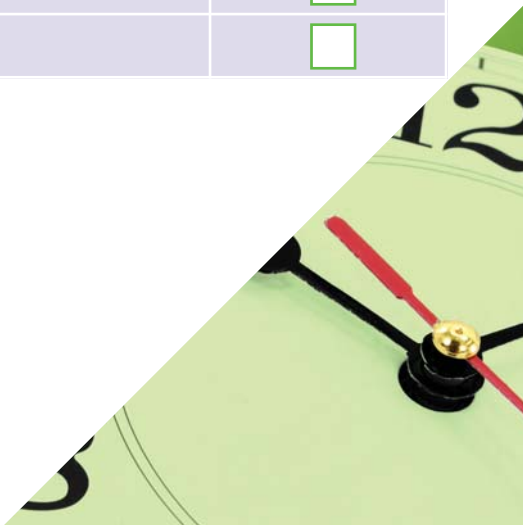


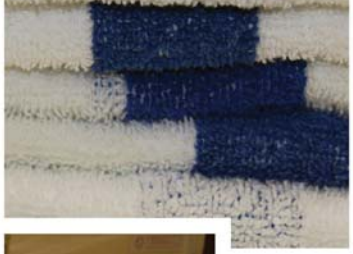

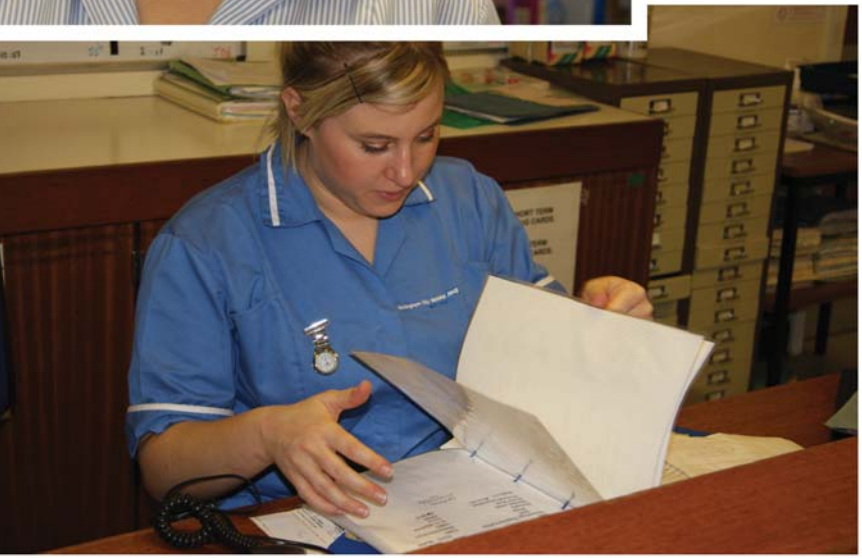


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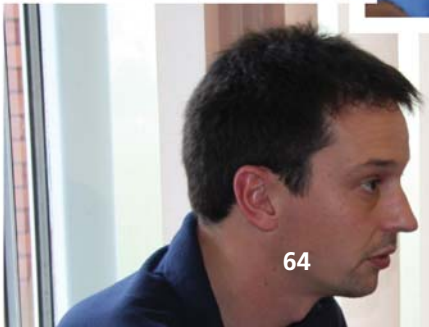
- checklist




# 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<br>• conduct a process audit once a month (at least) – to ensure basic changes made are being followed<br>• display your SOP (standard operating procedures) clearly |
| Ensure leadership attention | • get your Head of Nursing or equivalent to carry out the monthly process audit<br>• 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)<br>• 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?*

Five 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 to follow. Ask the questions in the 1st column and make an assessment against the answer guidelines in the 2nd 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.**

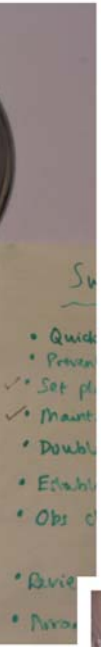
| Question (ask the team member) | Answers for outcome achieved |
|---|---|
| Describe the things you need to do in the prepare stage of the module? | • find out hospital policy<br>• find out patient satisfactions<br>• talk to staff<br>• find out accident information<br>• video the process<br>• time the process<br>• find out what best practice examples exist |
| Explain the idea around dot voting | • summarises the teams views on what information is more important than others<br>• allows the whole team to contribute<br>• very useful to communicate to the wider team |
| Define a standardised handover and why it makes things better | • important tool for communication<br>• key to sustaining new handover process<br>• agreed by the team, not by an individual<br>• ensures all of the information the team has decided is important, is communicated<br>• 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 area where handover was done) |
| Where do audits fit into the handover module and how are they used? | • ensure people are carrying out the new handover process<br>• should be quick<br>• based on the standard handover procedure created by the team<br>• never stop using audits |

# *10 Point Check List*

**Example:**

| | Status 1 | Status 2 | Status 3 | Status 4 |
|---|---|---|---|---|
| The grid to follow allows you to measure your performance against the 10 point check list for this module. You should shade in the boxes according to your achievement of the measure. Your progress is clearly visible.<br><br>**Status 1:** Before module is implemented<br>**Status 2:** After 2 weeks of implementation<br>**Status 3:** After 4 weeks of implementation<br>**Status 4:** After 8 weeks of implementation<br><br>You should continue to monitor monthly | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| 10 Point Check List<br>Shift Handovers | Status 1 | Status 2 | Status 3 | Status 4 |
|---|---|---|---|---|
| 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 | | | | |
| A pre-prepared handover sheet 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 | | | | |
| 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 | | | | |

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10
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