Frimley Health NHS
NHS Foundation Trust

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Improving the Safety of Nursing Shift Handover

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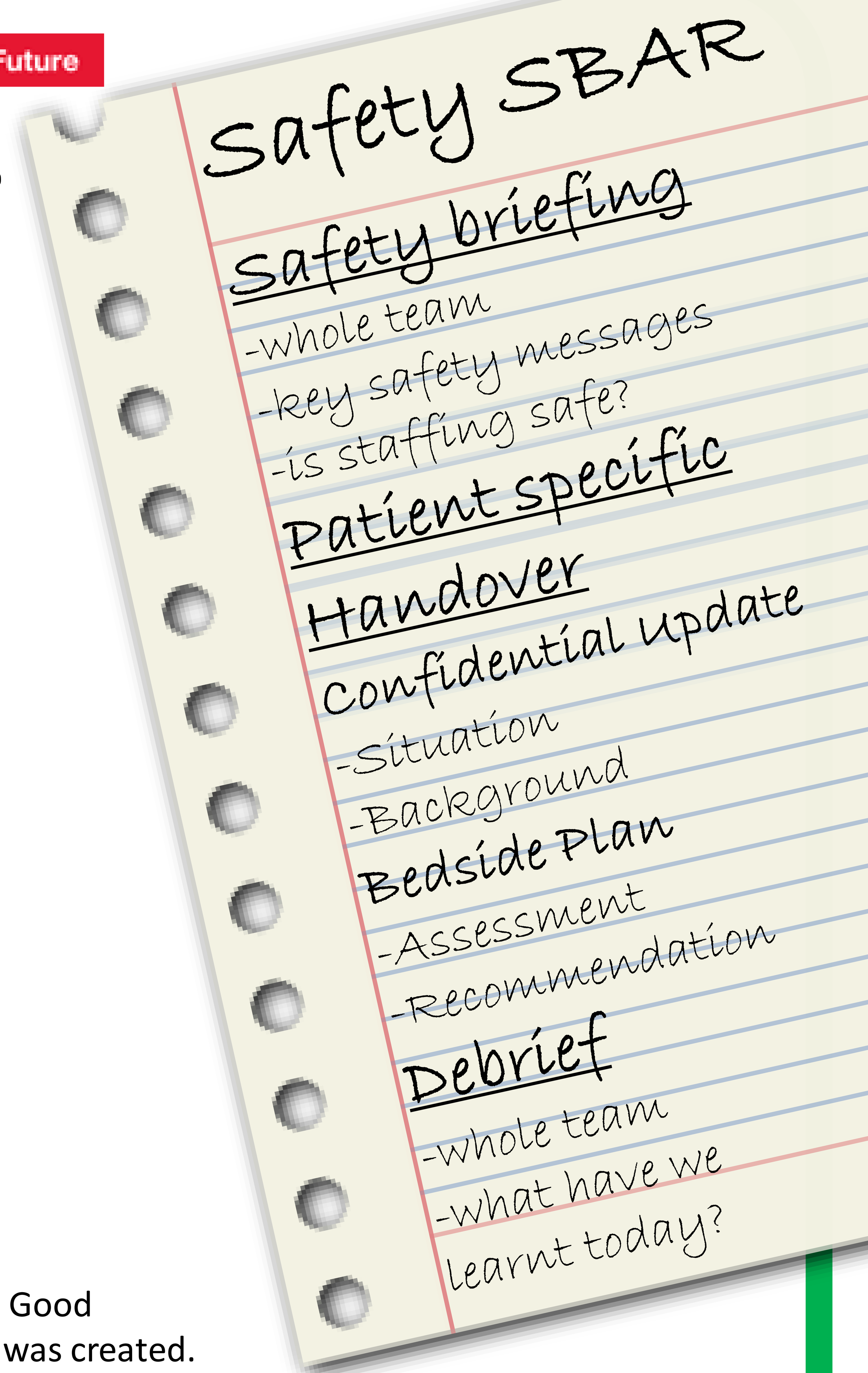

Aims

As part of the National Sign Up To Safety campaign Frimley Health NHS FT is working to improve the safety of clinical handovers across the whole of the organisation.

The current phase of the project is about nursing shift handover in ward areas.
We are focusing on improving:

- Situational awareness
- Patient engagement
- Creating a supportive and learning culture

Methods

Current practice was reviewed through observation, staff questionnaires and patient feedback. Consideration was given to safety practices from other industries, such as aviation, oil & gas and rail. Good practice within our organisation and the wider healthcare services were reviewed and "Safety SBAR" was created.

Ward based leadership and co-design of the Safety SBAR handover model has allowed for local variation while maintaining the key principles. Training has been provided to staff at all levels from students and care assistants to department managers and clinical Matrons. Safety SBAR workshops are now part of the preceptorship programme and included in the nurse in charge half day master classes. Bespoke training packages have been arranged for individual departments as required and facilitated by the Sign up to Safety Matron and ward Sisters.

There is a strong focus on local ownership of the changes to handover with patient and staff safety being the key drivers for improvement.

Ward knowledge of key patient safety issues for current shift	
No briefing	Safety briefing
38%	78%

95% Patients in Safety SBAR pilots areas said they witnessed bedside handover

Results

Safety briefings are one of the biggest changes to most handovers and we have been able to demonstrate an improved "total ward knowledge" of key safety issues from 38% before implementation to 78% afterwards. This means that even if a member of staff is not directly responsible for the care of a patient they are aware of patients who are high risk of falls, have been detained under the mental health act or are requiring input from the critical care outreach team.

In the initial review of handover practice 60% of staff on the pilot wards told us that information was missed or incorrect at handover at least 2-4 times a week. In the initial pilot areas using Safety SBAR this reduced to 27%. Patient engagement has also improved; bedside handover was witnessed by patients in 95% of pilot sites in April 2016 (compared to 74% in October 2015).

How do you feel?

What are we going to do differently tomorrow?

Well done

How can we make patients, staff and visitors feel safe, cared for and listen to

Further Actions

Creating a safe place where staff can debrief together as a team has been seen as one of the more controversial parts of Safety SBAR. A cultural shift from wanting to get home as quickly as possible to learning and celebrating each day will take time.

An effective and timely handover is essential to allowing this work to progress as expecting staff to stay late after shift to debrief will create a negative environment and may exclude some members of the team.

How did you make a difference today?

Our clinical handover journey so far
https://www.england.nhs.uk/signuptosafety/2016/07/08/victoria-murray/

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Sign up to SAFETY