**PDSA Cycle 1 – Handover Communication tool**

**Aim:** what are you trying to accomplish?

To continue to develop the use of specific tools to investigate if this can lead to 95% of patients transferring from surgical receiving with a medical handover over a 4 month period.

**Plan:** what will your test be?

During the second trial of our handover tool we employed a simple poster communicating why we are doing our trial and protocol for nursing and medical staff. We will then discuss the effective of the communication tool after with all the teams involved.

**Prediction:** what do you think will happen as a result of your test?

After discussion with both the clinical team involved I hope that they will be able to successfully carry out however as it’s a new tool it is difficult to predict if it will be successfully used by all members of the team

**Do:** what happened when you carried out your test?

Medical staff in Ward 7 found the form intuitive and clear. Nursing staff in Ward 7 didn’t find it difficult to get medical staff to fill in the form

Nursing staff in Ward 8 handed over information to medical staff in Ward 8 however left it in the nursing notes so it could of easily be overlooked

On 2 of the 6 forms no CHI or patient details were filled in.

Issues handover on the forms: Chase radiological scans, Book Bloods for following morning, Chase blood cultures.

One member of the medical staff suggested that form may overlap with items already documented in medical notes but agreed that it would provide a further safety net as this isn’t always the case.

**Study:** how did the results of your test compare with predictions?

6 Handover forms completed – 5 of which handing over key clinical information, the other handing over no information as there was nothing relevant to handover

* 3 forms handed over to chase a form of radiological study
* 1 form handed over the need to request bloods
* 2 Forms asked for certain blood tests and cultures to be chased

Unexpectedly no antibiotic levels were handed over though this may relate to the small sample size.

2 out of the 6 forms had no patient CHI information on them.

Nursing staffing Ward 8 unexpectedly placed the handover forms in the nursing notes, which is not unsurprising as not specific guidance was given.

**Act:** how will you change your previous test in light of what you have learned?

This cycle showed that a nursing and medical handover can be integrated if we use a simple and practical tool.

It showed some of the issues that can be handed over and that could be easily missed affecting patient management and safety.

For next time we need to focus on guidelines around how to use the forms and making them easily identifiable for medical and nursing staff.

Actions:

1 – Using the same tool with a different colour of paper and once again trialing it between Wards 7 and 8 to see if we get similar positive feedback

2 - Create a simple guideline for medical and nursing staff on how to use the handover sheet.

**PDSA Cycle 2 – Medical Handover Sheet**

**Aim:** what are you trying to accomplish?

To continue to develop the use of specific tools to investigate if this can lead to 95% of patients transferring from surgical receiving with a medical handover over a 4 month period.

**Plan:** what will your test be?

To reassess a simple handover document we have previously introduced for medical information that integrates with the current nursing SBAR used when patients are transferred between wards in the surgical department.

**Prediction:** what do you think will happen as a result of your test?

Staff should already be aware of this tool from the previous trial however ensuring everyone has the same drive to employ the tool maybe difficult. Furthermore, different staff will be involved due to the rotational nature of the receiving unit, mean it will be for many their first introduction offering more challenges.

**Do:** what happened when you carried out your test?

Both clinical teams were happy and enthusiastic to take part in the continuation of the trial.

3 forms were fully completed. However 2 patients weren't handed a over correctly as these both involved a nurse who didn’t usually work on the ward and was not aware of the tool. We noticed that when we communicated better (I .e. one to one with staff) about handing over the form directly to the doctor it had direct effect.

**Study:** how did the results of your test compare with predictions?

We had positive feedback from both sets of clinical teams with regards to the innovation of the tool, however this cycle highlighted that efforts needs to be made to ensure all staff are engaged because it works when the whole team are involved.

**Act:** how will you change your previous test in light of what you have learned?

This cycle showed that staff had an enthusiastic reaction to usefulness of the tool from both clinical team.

Actions going forward:

1 – Work on better and more direct communication between all those involved.

2 – There is a certain amount of ambiguity with regards to time forms are handed over as there isn’t an actual date or time on the sheet. We will edit the sheet so it has time and date for when the handover was completed.

**PDSA Cycle 3 – Medical Handover Sheet**

**Aim:** what are you trying to accomplish?

To continue to develop the use of specific tools to investigate if this can lead to 95% of patients transferring from surgical receiving with a medical handover over a 4 month period.

**Plan:** what will your test be?

To reassess a simple handover document we have previously introduced for medical information that integrates with the current nursing SBAR used when patients are transferred between wards in the surgical department. This cycle was going to focus on evaluating the tool over 5 day period rather than 1 or 2 day periods which had been done before

**Prediction:** what do you think will happen as a result of your test?

This cycle will be focusing over a slightly longer period of time and with that brings challenges with regards to ensure both momentum and continual use of the tool as clinical teams change on a daily basis The tool however is now more established with both nursing teams in both wards more engaged with it, so hopefully this will be reflected in its use.

**Do:** what happened when you carried out your test?

Good Engagement with staff in Ward 7 both medical and nursing staff.

Nursing staff on Ward 8 didn’t seem aware of the trial this had to be reiterated at several occasions.

Handover appeared to have helped several times with issues were handover that otherwise wouldn’t have been missed.

There several new staff members/bank where on ward 8 which led to several forms not being handed to medical staff

Staff on both ward still agreed this was a good tool and this should be used going forward.

There was partial use of the new date and time addition.

**Study:** how did the results of your test compare with predictions?

15 forms were completed altogether handing over a multitude of issues.

3 patients had no handover from Ward 7

Of the 6 out of the 15 handover forms weren’t given to the medical staff even though they were completed

83% of patients had a handover; this is good and shows that the vast majority and engaging with the process however as there are a large number of staff on Ward 7 continually changing its unsurprising this is not ubiquitous yet.

The more worrying thing was only 60% of handover were handed to medical staff in Ward 8 even though it was completed in all the cases. We need to work in future trial on boosting communication of nursing staff in 8 as well as encouraging medical staff to prompt nursing staff on handover

**Act:** how will you change your previous test in light of what you have learned?

This cycle has shown that in principle the tool works and has had a relatively high uptake; however we need to still work to ensure 95% of patients get a handover. For it to be used more effectively all staff need to have an awareness and buy into the reasoning for it to happen.

Actions:

1 - One thing highlighted was that our sheet had a section to “tick” for vanc and gent levels, however feedback from those involved highlighted that actually make this section of the form focused on the time would allow for more accurate planning of levels.

2 – We need to work to educate and inform the nursing staff in Ward 8 as this was highlighted a barrier to the flow of information, we will do this both with using the communication tool, direct engagement with nurses and their managers.

**PDSA Cycle 4 – Medical Handover Sheet**

**Aim:** what are you trying to accomplish?

To continue to develop the use of specific tools to investigate if this can lead to 95% of patients transferring from surgical receiving with a medical handover over a 4 month period.

**Plan:** what will your test be?

To reassess a simple handover tool we have previously introduced for medical information that integrates with the current nursing SBAR used when patients are transferred between wards in the surgical department. As we have refined our tool we are going to test it over a far longer period of time to assess better the impact of the tool. We also wanted to assess what happens when we use the tool in an out of hours setting i.e. over the weekend.

**Prediction:** what do you think will happen as a result of your test?

This trial is occurring over a longer period of time (2 weeks rather than 5 days). Therefore it will be far harder to engage and promote the use of this tool over a longer period of time as different teams of staff will be involved throughout the 2 weeks. It maybe therefore changeling to see how each tem engages differently with the tool.

**Do:** what happened when you carried out your test?

Our tool was used 32 times during normal working hours out of a possible 38 patients who were transferred. The amounts to the tool being used 84% of the time roughly in line with the uptake in the previous cycle. When the tool was used in an out-of hours context it was only used 38% of the time with the 8 patients that were transferred.

We analysed the patients who were transferred during hours and noted no forms were missed by nursing staff, however 38% of the handover forms where missing either an aspect of patient identification or the date and time.

**Study:** how did the results of your test compare with predictions?

The uptake and use of the tool was very much at the same level as had been in the previous cycle, which was encouraging bearing in mind that this was a trial over a far longer period of time and therefore the tool was going to be used by a larger number of clinical teams. Therefore it showed that despite rotation of staff uptake of the tool continued. However when analysing the data, uptake still varied to a certain extent with regards to what staff where on especially with regards to medical staff on ward 8 who at times did not always engage either due to lack of awareness or not having time to engage.

However a main positive from this cycle was the engagement from the nursing staff in Ward 8 who appeared to be engaging better with the tool and giving it to medical staff appropriately and effectively.

This cycle also highlighted the challenges of implementing the tool in an out-of hours context, as uptake was very low, this probably points to the lower medical staff at weekends and difficulties this provides when having effective medical handover.

**Act:** how will you change your previous test in light of what you have learned?

Over these 4 cycles we have showed that tool can be used and highlight key jobs and aspects of the management plan. However with an uptake of 84% work still needs to be to hit our 95% target.

This cycle took place towards the end of one of the 4 month FY rotations. So we plan to retest our tool once the new set of FYs is in place. It will allow us to see if the tool is robust enough to survive a rotation of FYs.

Action:

1 – Get all those FYs involved to answer a questionnaire about the effectiveness of the tool to feed into future cycles.

2 – Continue to use the tool permanently from now and reassess the uptake and effectiveness of the tool with the coming months.

3 – Hold back on further testing in an out of hours context until the tool is more established.

**PDSA Cycle 1 – Handover Communication tool**

**Aim:** what are you trying to accomplish?

To assess the use of specific communication tools to effectively communicate the objective and protocol involved in using the new handover tool.

**Plan:** what will your test be?

During the second trial of our handover tool we employed a simple poster communicating why we are doing our trial and protocol for nursing and medical staff. We will then discuss the effectiveness of the communication tool after with all the teams involved.

**Prediction:** what do you think will happen as a result of your test?

This simple poster should be easy to understand however there are multiple posters in each ward conveying numerous amounts of information and it therefore may get overlooked.

**Do:** what happened when you carried out your test?

I discussed at length with all the members of the clinical team who felt the form was too wordy and would be easily overlooked by all the other posters.

**Study:** how did the results of your test compare with predictions?

This cycle highlighted my fear from my prediction that getting an easily identifiable and effective form is difficult and work be need to be done to improve and ensure it’s more accessible to all those involved.

**Act:** how will you change your previous test in light of what you have learned?

Acting on feedback we had with regards to length and detail of our form we will plan to redo it.

Action:

1 - Redo the form to ensure it is more inviting and obvious and to reduce the amounts of word with the form. We can reassess this in a further trial cycle.

**PDSA Cycle 2 – Handover Communication tool**

**Aim:** what are you trying to accomplish?

To assess the use of a specific communication tools to effectively communicate the objective and protocol involved in using the new handover tool.

**Plan:** what will your test be?

During the third trial of our handover tool we employed a modified and more simplified poster communicating why we are doing our trial and protocol for nursing and medical staff. We will then discuss the effective of the communication tool after with all the teams involved.

**Prediction:** what do you think will happen as a result of your test?

This more simplified poster should be easy to understand large font and a simpler message. However the challenges from previous relating to the multiple posters in each ward conveying numerous amounts of information is still present and it therefore may get overlooked.

**Do:** what happened when you carried out your test?

I discussed at length with all the members of the clinical team who felt the poster was easier to understand and conveyed the message more effectively. However despite this it was still easily overlooked in the ward.

**Study:** how did the results of your test compare with predictions?

These finding highlight the limited effectiveness of simple posters and that my overriding worries of the poster being overlooked were confirmed once again. However what my discussions with colleagues revealed was something more unexpected. Several colleagues from both nursing and medical teas state that more direct form of communication including email and 1 to 1 briefings were actually more effective.

**Act:** how will you change your previous test in light of what you have learned?

Acting on feedback we had with regards to the poster, we want to do the following actions

Action:

1 – Keep the posters currently created in situ, whoever there isn’t a need to further issue these as they have been shown not to be overly effective.

2 – In further cycles focus on direct forms of communication such as emails or 1to1 briefings.