Improving Clinical Handover Through Effective Communication for Patient's Safety

Lau Gek Muay, Camet Annellee, Ho Wah Pong, Cruz Luisa Rico,
Chow Poh Kit, Rubia Ana Lielane, Li Wei Xiao

KK Women's and Children's Hospital
SingHealth

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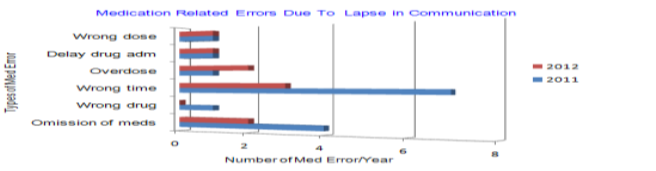
Nursing hand-over is an integral part of clinical practice and continues to occupy a salient role in the nurse to nurse; and nurse to doctor communication. However, nurses receive little formal training in this critical responsibility. Therefore, it is essential that an effective handover methodology be developed and nurses be adequately trained to better improve clinical handover of patient's care. According to Joint Commission on Accreditation of Healthcare Organizations (JACHO) Root Causes and Percentages for Sentinel Events (all categories) from Jan 1995 – Dec 2005, nearly 66% of all sentinel events reported are caused by ineffective communication.

Thus, the aim of the project is to create and implement a structured and standardised mental model tool for effective communication during handover to further improve patient's safety.

B

The recent practice prior to the project is, when the staff communicate with doctors, they often do not provide adequate key and complete information. This often leads to doctor having to seek clarification and verification from the staff. Doctors were unable to prioritize their duties or when important information were not conveyed, doctors were unable to feel the urgency to attend to the patient.

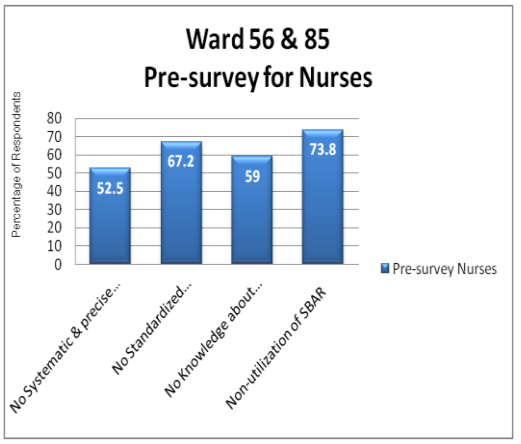
A team was formed consisting of representatives from nursing and risk management office to identify the gaps in the transferring and receiving of patient care. The team reviewed the Risk Management System Incidents from January 2011 to December 2012, to identify medication-related errors due to lack of proper handover of patient's information. During this period we observed 24 incidents of medication errors, such as omission of medication, wrong drug, wrong frequency, overdose, delay in drug administration and wrong dose.



Year	Omission of meds	Wrong drug	Wrong time	Overdose	Delay drug adm	Wrong dose
2011	4	1	7	1	1	1
2012	2	0	3	2	1	1

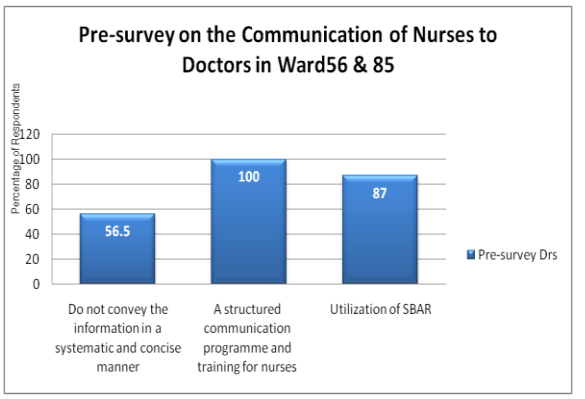
A

Using the Plan-Do-Study-Act (PDSA) Cycle, the team wanted to analyse and have a better understanding on the scope of the problem. We formulated a set of questionnaire, which was tested and validated by a team of nurses. Thereafter, we conducted a pre-survey involving two wards, namely Ward 56 and 85. In this survey both doctors and nurses were included.



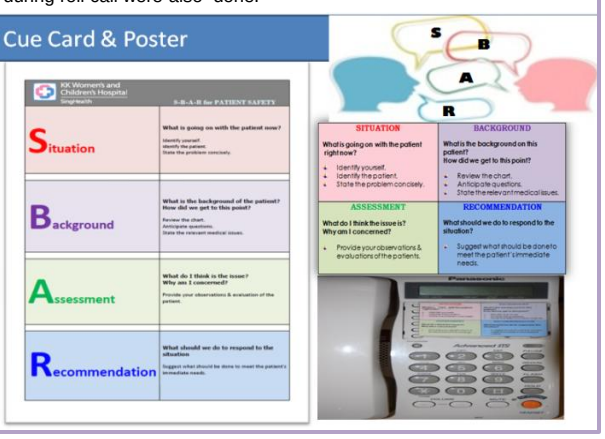
The pre-survey among nurses showed, 52.5% of the respondents agreed that the current nursing handover communication is not conducted in a systematic and precise manner. 67.2 % of the respondents agreed that there is no standardised format of communication. After identifying the gaps, we did a literature search, from the literature we had reviewed, SBAR which stands for Situation–Background–Assessment–Recommendation, is one of the standardised communication framework for effective communication and our team decided to utilise this tool. In the questionnaire, to determine the knowledge of the respondents, two questions were asked about SBAR. It showed that 59% of the respondents do not know SBAR and 73.8% do not know how to utilise it.

The team conducted a pre-survey among doctors on their perspective of the current manner of communication with the nurses on patient care. 56.5 of the respondents felt that nurses do not convey the patient information in a systematic and concise manner. All the respondents felt that a structured communication programme and training will be beneficial for the nurses. 87% of the respondents agreed on the utilisation of SBAR for improving communication.



The initial intervention was to conduct a Scenario-–based Didactic Training on SBAR and to use SBAR format as a memory prompt for verbal communication during shift hand-over and referral to doctors and other department.

We reviewed our initial intervention, realised that to base on memory prompt can be challenging for staff to comply. We brainstormed for solutions and to reinforce the use of SBAR for verbal communication, cue cards and posters were created. Each staff from the piloted wards received an ID-sized SBAR cue card. This card was also pasted on the telephone at the nursing counter which serves as reminder when performing telephone referral to doctors or other department. An A4-sized SBAR poster was also created and pasted on the pneumatic tube door cupboard, with regular reinforcement during roll call were also done.



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Results after the didactic training and the implementation of the cue cards and posters, results showed 94.1% of the respondents believed that the use of SBAR as a verbal communication tool is systematic and precise. 95.6% respondents agreed that there is a standardised communication framework. 98.5% of the nurses has the knowledge about SBAR and had been utilising it during handover and referral.

POST-SURVEY in WARD 56 & 85 for NURSES

QUESTIONS	Yes	No
Do you find our current way of communication between nurses and doctors concise?	66 (97%)	2 (3%)
Is our current nursing communication conducted in a systematic and precise manner?	64 (94.1%)	4 (5.9%)
Is there a standardized framework of communication?	65 (95.6%)	3 (4.4%)
Is the communication between nurses and doctors effective and concise during emergency situation?	61 (89.7%)	7 (10.3%)
Do you know what is SBAR?	67 (98.5%)	1 (1.5%)
Do you know how to utilize SBAR in your daily communication at work?	67 (98.5%)	1 (1.5%)
Will you be utilizing SBAR as a framework of communication in your daily work?	67 (98.5%)	1 (1.5%)

A post-implementation survey was conducted among the doctor in-charge of the piloted wards. Results revealed that the nurses conveyed the patient information in a systematic and precise manner. 79% of the respondents were aware that the nurses in the piloted ward used SBAR and 66.6% were using it constantly during their communication with the doctors.

POST-SURVEY ON THE DOCTOR – NURSECOMMUNICATION AFTER THE INTERVENTION

QUESTIONS	Yes	No
Nurses convey the information in a systematic and concise manner.	20 (83.3%)	4 (33.3%)
Was the structured communication programme and training for nurses will be beneficial in transferring of information?	24 (95.8%)	0 (16%)
Are the nurses aware of SBAR as a communication tool?	24 (100%)	0 (0%)
Are you aware that ward 56&85 had been using SBAR to communicate with the doctor	19 (79%)	5 (20.8%)
Are the staff from these two wards constantly using SBAR during their communication with doctors?	16 (66.6%)	8 (33.3%)

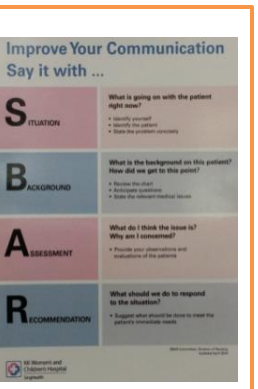
Majority of the nurses and clinicians in the pilot study recognised that the implementation of SBAR in the transferring and receiving of patient care information that will further enhance patient's safety.

RECOMMENDATION

With the success of the pilot study in the adoption of SBAR as a structured tool during shift handover and referral to improve patient safety, our team recommended the use of this format across all the Pediatric Wards.

SUSTAINABILITY & SPREAD

After the pilot study, the project was presented to the Senior Nursing Personnel at Division of Nursing. Simultaneously, Senior Management recognised the importance of having a structured format for an effective verbal communication and in compliance with the requirement of Joint Commission, decided to adopt SBAR as the tool to be used for verbal communication during shift handover and referrals across all the wards in KKH.



CONCLUSION

Nursing handover using SBAR makes the handover systematic and precise, the transfer of key information is complete and the continuity of care is not compromised.

Majority of the nurses benefited from the training on SBAR and the reminder prompts such as poster and cue cards for effective verbal communication. Both nurses and clinicians recognised that using the SBAR in communication helps to organise thoughts, keeps the communication process focus, and provides standardisation and consistency.

It is clearly essential to have a structured and standardised format of communication during handover and referrals.

ACKNOWLEDGEMENT

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