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Improving Communication and Organization through Shift Leader Handover Report

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Abstract

Effective communication remains one of the most important factors to patient safety and organization in any hospital department. Accident and Emergency with its high levels of acuity remains an area at great risk for communication breakdowns. Breakdowns in communication increase errors and can interrupt the general flow of the ward causing disorganization and adverse patient outcomes. Handover from one shift to the next is a time where communication errors are at their highest. This paper takes a look at some of the barriers that can impede communication during handover in a busy Accident and Emergency department in Rwanda and how it identified the problem and came up with a solution to improve communication between shift leaders. It discusses in depth the steps that were taken to create a handover tool that was adopted in the department.

Keywords: Improving, Organisation, Shift Leader

Introduction and background

Good communication processes are essential for effective handover report.[1] Even though there is little evidence to show which kind of handover (written or verbal) is best practice, it is essential that handover report is done in an organized, clear and thought out manner. The needs for proper handover in an accident and emergency room (A/E) are even more intensified as A/E is dealing with higher acuity patients and multiple care providers.[2] According to Cheung et al. "When sentinel events occur, communication errors are deemed to be the root cause in about 70% of cases."[3]

Breakdown in communication can be seen at many different points in the patient care process.[1,3] When communication about the patient is not followed it causes adverse patient outcomes, ineffective time management and ultimately disorganization of the ward.[4] Handover report remains a time where communication needs are high. Many times nurses know about their patients, the general status of the department and issues that occurred during their shift. If, however, they do not have a system of letting the oncoming shift know this information, vital patient data is missed and errors occur.[1,5]

With the goal to reach the needs of the patients by 2020, the Ministry of Health in Rwanda launched a program called Human Resources for Health (HRH) to train nurses, doctors, and dentists in the latest standards of care.[6] Part of achieving these goals included training the nurses in A/E to focus on proper communication during handover report so that patients could receive optimal streamlined care. Many of the communication problems facing A/E can be traced back to lack of standards of communication from shift to shift.[1,3] A few simple steps can be taken to facilitate better communication which will lead to improved ward flow and ultimately better patient outcomes.

Context and Setting

At a referral hospital in Rwanda, A/E is divided into two sections: medical and surgical. Even though the nursing staff covers each specialty there are different medical groups that cover both specialties. Furthermore, the unit is divided into staff nurses, shift leader, unit manager and director of department. The shift leader in collaboration with the unit manager is in charge of the day to day running of the ward.

Handover though not standardized in A/E should take place automatically. It is considered essential for continuity of patient care.[5] Even though there was a form of verbal handover occurring, shift leaders reported that many times information was missing from the previous shift. Much of their time was spent trying to retrieve that information. They also stated that there wasn't a standardized way of reporting so that report became dependent on the skill of the previous shift leader. Nurses and shift leaders stated that it was unclear what should be reported in shift leader handover or in bedside rounds.

Evidence and Action

On observation by the unit manager it became clear that like any other A/E there were many issues both systemic and personal that caused breakdowns in communication. Figure 1 highlights six areas and how these areas affect each other in causing communication breakdowns and therefore ward disorganization.

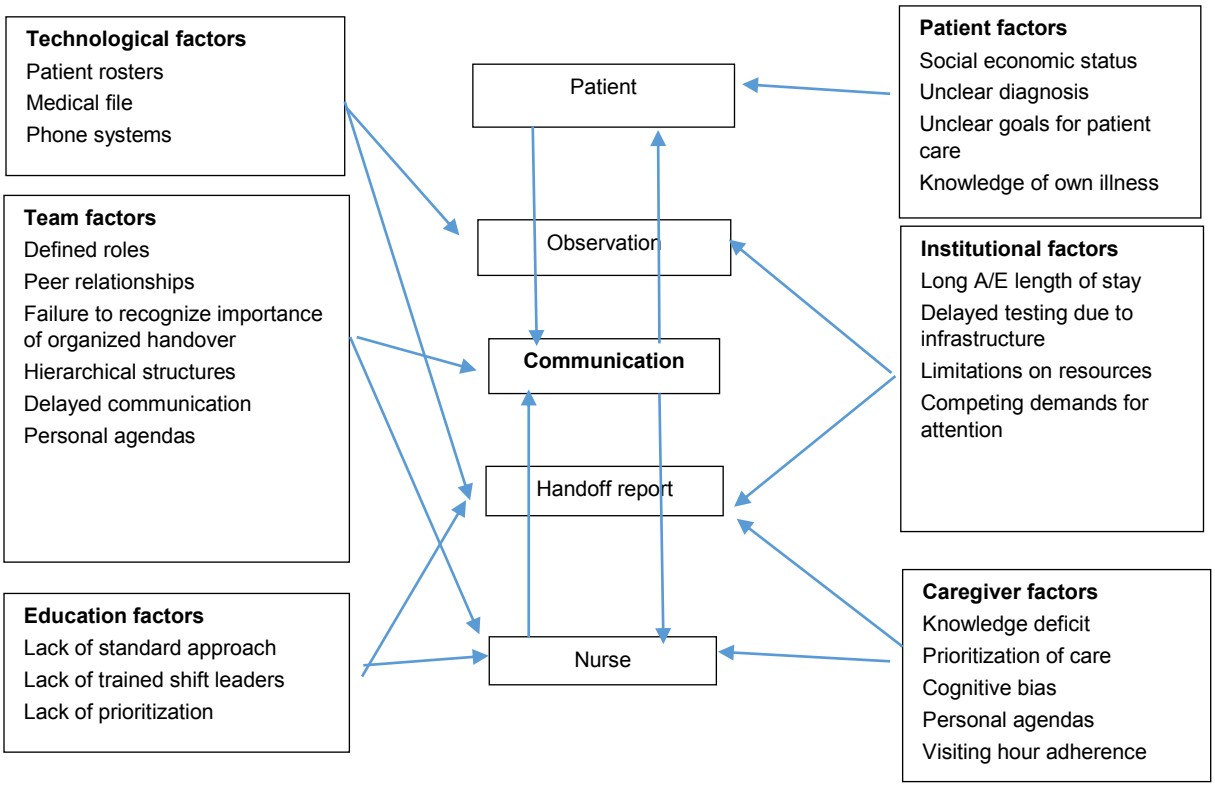

Figure 1. Conceptual framework modified from Improving Handoffs in the Emergency Department [3]

Out of the six areas the following two overarching barriers were identified as barriers to communication during ward handover.

a. Unprotected handover time

Shift leaders often reported that they did not have all the information they needed to run the ward because they had not received a proper handover. The shift leaders identified that a busy emergency department makes it difficult for them to find protected time to give handover to each other.[2,3]They observed that many times they would get pulled to help in a procedure, help a patient or family or get asked to do another task while they are trying to give a handover. This caused the report to become disjointed with key pieces of information missing.

b. Standardized Reporting

Because there was no standard template of reporting for the ward the shift leaders were often unsure about what needed to be included in the report. When the shift leaders were unable to communicate well with the next shift pertinent data was omitted and the potential to cause harm to the patient increased. Even though there was a general idea of what needed to be said there was no accountability of handover having occurred or of the issues that were discussed.

Identification of Solutions

The unit manager and the shift leader identified the problem and together with the HRH nurse met and decided that in order for communication to improve a handover report template needed to be created. Support for trialing a template in A/E to improve communication handover was also given by the division manager at the hospital. The unit manager identified the need for protected handover time and decided to have the shift leaders give report to each other before nursing ward rounds began, minimizing disturbances. These solutions addressed the overarching barriers of unprotected handover time and standardized reporting. The goal was to facilitate a new approach to handover which would improve communication within the shift leader team.

The initial report (Figure 2) was created with input from all stakeholders and trialed in accident and emergency in March of 2016. In order to encourage compliance two mandatory staff meetings were called explaining the new template and procedures. This ensured that all nursing staff in the department was aware of the new template and how to use it. The unit manager also made sure to be present in the mornings to ensure that handover was taking place according to the new guidelines. The reports were kept and checked weekly by both the unit manager and HRH nurse for completion.

Date/Shift:

SHIFT LEADER HANDOVER REPORT

ACCIDENT AND EMERGENCY

	MEDICAL	SURGICAL
ADMITTED PATIENTS		
TRANSFERRED		
DEATHS		
ESCAPED		
BEDS AVAILABLE		

PATIENTS TO BE ADMITTED	MEDICAL	SURGICAL	
TRANSFER FOR OUTSIDE TESTING	CT	MRI	OTHER

ALLOCATION FOR NEXT SHIFT	MEDICAL	SURGICAL	TRIAGE	SHIFT LEAD

HOSPITAL

BEDS AVAILABLE	MEDICAL M	MEDICAL F	SURGICAL M	SURGICAL F	ICU M	ICU F	ORTHO M	ORTHO F	PED M	PED F	VIP M	VIP F

EQUIPMENT ISSUES

MEDICAL

PATIENT:	AGE	MEDICAL DIAGNOSIS	PLAN

SURGICAL

PATIENT:	AGE	MEDICAL DIAGNOSIS	PLAN

Signature: _____ Name:_____ Signature: _____ Name:_____

Figure 2. Initial Shift leader handover template

Lessons learned

The unit manager, the shift leaders and the HRH mentor met on a monthly basis to discuss improvements that could be made to the template to facilitate communication. During these meetings changes were made to keep the template concise and to ensure that all vital data was communicated to the next shift (Figure 3).

Date/Shift:

SHIFT LEADER HANDOVER REPORT

ACCIDENT AND EMERGENCY

	MEDICAL	SURGICAL
ADMITTED PATIENTS		
TRANSFERRED		
DEATHS		
ESCAPED		
BEDS AVAILABLE		

PATIENTS TO BE ADMITTED TO WARD	MEDICAL	SURGICAL	
TRANSFER FOR OUTSIDE TESTING	CT	MRI	OTHER

ALLOCATION FOR NEXT SHIFT	MEDICAL	SURGICAL	TRIAGE	SHIFT LEAD

HOSPITAL

BEDS AVAILABLE IN WARD	MEDICAL M	MEDICAL F	SURGICAL M	SURGICAL F	ICU M	ICU F	ORTHO M	ORTHO F	PED M	PED F	VIP M	VIP F

EQUIPMENT ISSUES/UPDATES

CRITICAL AND NEW MEDICAL

PATIENT/BED:	AGE	MEDICAL DIAGNOSIS	PLAN

CRITICAL AND NEW SURGICAL

PATIENT/BED:	AGE	MEDICAL DIAGNOSIS	PLAN

Signature: _____ Name:_____ Signature: _____ Name:_____

MEDICATIONS IN SAFE

	DAY 1	NIGHT 1	DAY 2	NIGHT 2	DAY 3	NIGHT 3	DAY 4	NIGHT 4	DAY 5	NIGHT 5	DAY 6	NIGHT 6	DAY 7	NIGHT 7
PETHIDINE														
DIAZEPAM														
MORPHINE														
PHENOBARBITAL														
NALOXONE														
FENTANYL														

Figure 3. Final Shift leader handover template

Progress

The handover report was readily available in the department and completed most of the time. The shift leaders filled out the handover report with relevant patient data and information. They most often filled out the critical and new cases for both the surgical and medical side. They were also consistent in filling out the medication count in the safe. Allocation for the next shift along with counts for patients in the emergency department (including admitted patients, deaths and transfers, escaped and beds available) were also completed on a shift by shift basis. In general, the shift leaders and unit manager stated that the tool gave them a good overview of what was occurring in the department. They were able to more easily identify which critical patients were a priority and work towards solving the problem in A/E based on priority. They also were able to use the handover report as evidence to show that they were tracking their patients and advocating for their patients by level of acuity.

Even though the report was completed regularly there were some areas that were rarely filled out. Particularly it was noted that the section on "beds available in ward" was not completed. Both the shift leader and unit manager stated that this section though helpful was not being completed because the hospital bed status was not given until later into the shift. They felt that they could not accurately portray what the bed status was since they were not able to receive an accurate count prior to filling out the report. All stakeholders agreed that they wanted to keep this section on the handover report to show that they were asking for bed numbers on a regular basis. The "transfer for outside testing" was also not regularly completed by the shift leaders. Shift leaders stated that they had an idea of who needed to be transferred and often forgot to put it on the report.

Next steps

In A/E the team will need to meet to decide next steps for the handover report. The unit manager and shift leaders will need to evaluate why certain areas of the report are not being filled out. A questionnaire along with focus group will need to be made to see the reason why certain parts of the report are considered more valuable than others. Already identified by the unit manager and team, some edits need to be made to reflect what the nurses and shift leaders continue to see as vital information. Particularly in regards to certain areas of the report (outside testing) it has been identified that the shift leaders will need extra training and education on why this is a vital area of the report. The unit manager will also need to set a meeting time and place to discuss further changes and auditing of the current report. If the necessary changes can be made and staff can continue to use the report to reflect their needs in A/E, the department should have a more streamlined approach to advocating for their critical patients and a clear handover.

Results

On a hospital wide level, the results of implementing the shift leader report in A/E was disseminated to upper management including the division manager. The lessons learned in A/E along with the benefits and challenges were discussed. The report along with lessons learned from A/E were shared with all nurse unit managers at a meeting in April 2017 with the goal of implementation of the report in all wards.

Potential application and further steps

At the meeting it was highlighted that differing units have specific needs and it was agreed that the report would have to be altered to reflect the needs of each unit. It was agreed that the nurse unit managers would edit the report and meet to evaluate each other's edits. Follow up and monitoring of these next steps will be needed to ensure that the report remains streamlined and reflects vital information for each specific ward. Using a standardized report in all units will move the nursing department to a more streamlined and cohesive approach to handover. A/E will continue to share their feedback with implementing the report in their ward and support other nurse managers in working towards implementation in their respective units.

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