

**The Nightingale Project**

**Guidance for Safety Briefings, SBAR Handover, Huddles and End of Shift**

**Background**

Phase one of the Nightingale project seeks to address several key areas affecting the nursing workforce with the aim of enhancing communication which will in turn support multi-professional working and safe patient care. Additionally, a predictive rostering system is being developed as well as a review of the ward environment. Objectives were set by the Chief Nurse to improve systems and develop training to enable nursing staff to acquire the right skills and to feel confident as a member of the MDT. This will enable staff to give care in the right place, get it right the first time, involve patients and carers and build upon what is working well within the organisation and to share best practice.

**Overview**

The principle elements in phase one focus upon first hour safety briefings, SBAR-based bedside handover, mid-shift huddles and last hour team working & preparation for handover. The aim is to put in place robust processes to ensure we can care for our patients safely and consistently, to identify when unplanned activities affect routine care and adjust patterns of working and to work collaboratively as nursing teams to communicate and support each other at key stages in a 24-hour period.

The emphasis remains on teamwork, collaboration and compassion, and includes standardising formats, regardless of ward area or site, removing barriers to communication to support care between all member of the healthcare team including patients and their carers.

Tools have been developed to act as an aide memoire for staff in the first hour, middle of and last hour of a shift and reflect a desire to enhance care as a 24-hour service and to support staff to complete their shifts on time.

Training to support staff to adopt these tools and to enhance their existing skills is based upon the principles of the Circle of Care, a model for Compassionate Human Factors in Healthcare (SaIL 2016). The Circle of Care helps us think about, practise and demonstrate high quality compassionate care to which we all aspire to.

Circle of Care re-envisions compassionate healthcare by describing a multi-directional flow of care between healthcare professionals and their colleagues, patients and carers, and self-care. While recognising that many of the challenges facing healthcare professionals are systemic and environmental, Circle of Care proposes a Skills Compass which can help navigate the obstacles getting in the way of the flow of care which enhances resilience in both the individuals and in teams*.*

**Local drivers**

It is recognised that within the organisation we have an excellent cadre of staff however we are also aware that care is not always provided in a consistent way and we do not always get it right for our patients, students and staff. Developing a consistent approach to the first, middle and last hour of the shift streamlines processes with the aim of ensuring that all staff are aware of the expectations of them and also that patients have a positive experience.

**National drivers**

The Carter report (2016) highlights how unwanted variation and lack of consistency across a hospital can lead to decreased productivity and quality of care. The Nightingale Project seeks to address some of the variation which occurs in the first and last hour to ensure a consistent, patient-focused approach.

As highlighted in the document*Together we can- (*2012) the*Kings Fund emphasised the importance of* staff engagementfor both patients and staff. Engagement in the design of processes and in activities at all levels can transform the experience of both patients and staff. Both ‘can feel listened to and empowered and are able to influence and improve care’. At ward level we can include staff and patients in day to day beside handovers and by bringing the team together at the mid-shift and for safety briefings we believe that care and team resilience will improve.

1. **Safety Briefings at the start of every shift**

**Safety briefings** are a useful way to keep health and safety, including team and patient safety, at the forefront of the team’s minds and make them aware of current risks and hazards. Safety briefings are led by the nurse in charge (NIC) from the previous shift and are delivered to all staff on the incoming shift. This helps the team have a shared understanding of the ward needs and priorities, aligning them and fostering a good safety culture.

Briefings should be just as it says - brief – as people’s attention span is limited and the ward safety briefing should be no more than 15 minutes long.

Effective management of a team requires that all team members understand who each member is, their roles and capabilities. A simple introduction at the beginning of the brief will achieve this.

It’s important to include information regarding level of experience when staff are new to the team, e.g. if they are an agency nurse, new to the trust or have not yet acquired full competence in certain procedures. This process should include all personnel including students and observers.

The NIC of the new shift should introduce his/herself clearly and indicate who is their designated deputy (second in command) in their absence. \*The team may also allocate primary responder roles for unplanned event management.

\* Evidence shows that allocating staff to attend as primary responders to unplanned / adverse events and for other team members to cover their patients during these episodes can strengthen patient safety and communication.

The process for doing this needs to be carefully considered at local level to allow for coverage at break times etc

The Trust and ward bed status are shared along with staffing levels, patients deemed at risk, the current Trust safety signals and the ward Big four which indicatesthe top four practises, new initiatives or risk factors highlighted as important for that area.

Repeat any key messages if necessary and allow the team to ask questions – this helps with understanding and clarification of actions required by the team members.

It can be hard to recall everything that’s been said; a \*handover sheet issued to staff will be useful. Undertake this in front of the patient at a glance board / live bed state and have a visual display of the safety signals and Big four for people to refer to.

**NOTE: Safety message** – confidentiality is at risk if handover sheets are misplaced- and updating records should be undertaken at the original sources.

**Elements of the Safety Briefing**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Elements of Safety Briefing** | **What is it?** | **Who’s responsible for updating the information?** | **Frequency of Update** | **Source of information** |
| **Big 4** | **Key ward messages on patient safety and quality of care. May include local incidents\* that require immediate action and learning.** | **Sister / Charge Nurse / Deputy Charge Nurse** | **Monthly – or as appropriate** | **Locally determined; based on sources from Chief Nurse, SIOH, key messages for the ward / risks factors for the ward, Datix** |
| **Safety Signals** | **Trust wide communication on patient safety, learning from never events, introduction of new protocols** | **Dr Adrian Hopper, Patricia Snell and Directors of Nursing** | **No set frequency** | **Email from Medical Director** |
| **At risk patients** | **Describes those patients deemed at risk. E.g. falls, pressure ulcers, triggered NEWS/PEWS.** | **Bedside nurse & NIC** | **Each shift** | **Bedside Nurse, Patient, e-noting,** |

**\*as appropriate**

1. **SBAR Handover**

Clinical handover practices are recognised as being an essential component in the effective transfer of care between health practitioners.

The point where a patient is “handed over” from one nurse to another is significant in maintaining continuity of care and research suggests that doing this poorly can present significant safety issues for patients.

Literature (Anderson et al, 2014) suggests that an effective handover is one that is carried out at the patient’s bedside, uses a structured standardised tool and is delivered with effective communication. It is also essential that the individual receiving the handover actively listens to the information presented.

Handover of patients should occur in the last 15 minutes of the shift once the staff coming on duty have checked in and received a safety brief. The handover should be delivered at the patient’s bedside and should commence with the new staff member introducing themselves to the patient and explaining that they are going to receive a handover of care from the nurse on the previous shift.

Staff members need to be conscious of confidentiality of patient information.

Bedside handover should be conducted by the outgoing nurse using the **SBAR** framework:

**S = Situation**

* Name and age
* Reason for admission and diagnosis

**B = Background**

* Past medical history and treatment to date

**A = Assessment**

* Key risk factors to be highlighted again e.g. risk of falls
* Physical – obs charts, fluid balance, NEWS
* Psychological – Mental state, confusion, compliance with treatment
* Social – lives on own, “This is me” document

**R = Recommendation**

* What is the plan? i.e. EDD, regular nebs, physio
* Medicine handover

The handover should be succinct and only contain the key information that is required to ensure quality of care and patient safety.

The staff member delivering the message should allow the nurse receiving the handover to ask clarifying questions.

It is difficult for staff to recall all information and therefore the nurse receiving the handover should be in possession of a handover sheet.

**NOTE: Safety message** – confidentiality is at risk if handover sheets are misplaced- and updating records should be undertaken at the original sources.

1. **Mid-shift huddles**

Huddles are a useful way to improve communication amongst members of a team.  The Nightingale Project mid-shift huddle uses an aide memoire to guide the staff member leading the huddle. This is to standardise where possible the communication that takes place in a huddle to support patient safety and efficiencies in ward activities.

The purpose of the mid-shift huddle is to enhance situational awareness for both the nurse in charge and for all the team members which enables effective team working and communication, improved quality of care and patient experience and strengthens team resilience.  It has also been reported to improve staff satisfaction as they can actively contribute toward decisions about care plans and re-deployment of resources.

When team members have clear situational awareness they are able to gather and interpret relevant information that allows teams to think and plan ahead. This allows for timely re-adjustments to activity affected by unplanned events or delays and supports team members to care effectively for patients and reprioritise work to allow then to finish care or handover within their shift times.

The huddle should be a *brief* episode, undertaken in a protected, pre-agreed time slot to enable all team members to be present where possible.

It should take place both on the day and the night shift.

It is designed for all members of the nursing team, including SNP's when present, to actively contribute. On occasions other multi-disciplinary team members may attend the huddle and would also be encouraged to speak where relevant.

Its purpose is three fold:

* for the NIC to check-in with the team to hear about the status of all team members and the area of the ward they are responsible for and for the NIC to give an update on any changes in the trust status or new admissions.
* for staff to provide a verbal update on patient’s condition changes and bed status and to ask for additional help or raise any other concerns
* for the team to be aware of the need for flexibility and to re-adjust work plans, provide support to each other where needed

 An effective huddle benefits from the huddle taking place every shift in a place where the team can all attend, uninterrupted where possible, not being rushed, the dialogue is two-way with an opportunity for all to speak and to ask questions and using open questioning and supportive language.

1. **Last Hour: – Hand over preparation & Check-out: Team leave together**

**The last hour aide memoire** is a practical guide to help staff structure their last hour of a shift to support continuous safe care twenty-four hours a day with outgoing staff leaving together and on time (Check-out).

Each team member has a set of role specific prompts designed to foster open dialogue to strengthen the teams’ resilience when unplanned events have disrupted care planned and to aid task completion. Through closer working, teams can offer advice and, where required, re-configure task allocation in the occurrence of disruptive events to ensure all staff and patients feel supported.

At 06.30 or 18.30 the NIC needs to gather the latest information to create the incoming teams’ safety briefing and the team members need to work together to make the patients feel safe and cared for.

For a safe ward its important the team are all able to share concerns, freely be able to ask for and receive help and have awareness of each other status in terms of workload. Where staff have good awareness they may be able to more readily anticipate and plan for disturbances or unplanned events that detract from important task completion and high quality patient care.

**Nurse in Charge**

It’s important for the NIC to check-in with each nurse in charge of a set of patients or a bay to obtain an overview of the patients and to share & offer support to the plan for last hour.

The NIC may need to consider re-allocation of staff for any unplanned/ acute disruptions that have affected care in one area to support the principle of leaving together and on time.

The NIC is responsible for ensure the PSAG boards and handover sheets are accurate.

**Nursing Assistant**

The nursing assistant and staff in a runner/ floating position play a vital role in the team at this stage as they are more freely available to respond to patient’s care needs and visitors queries and to settle the ward in readiness for the shift change: as they are more mobile they are able to have effective situational awareness and to recognise and alert the NIC to where there may be a problem or to flex their prioritise to support bedside nurses and the NIC to make the ward safe.

**Bedside Nurse**

The bedside nurses should check-in with each patient and their family or carers if present, review trends in, and update e-noting/ bedside notes/ charts, complete time critical medications, flagging any patients they have concerns about and updating their section of the handover sheet by 07:15/19.15.

**NOTE: Safety message** – care is twenty-four hours a day – update your patient records regularly throughout the shift and handover outstanding tasks or issues verbally and via the hand over sheet

**References**

Anderson J, Malone L, Shanahan K, Manning J (2014) Nursing bedside clinical handover – an integrated review of issues and tools. Journal of Clinical Nursing 24 (662-671)

Carter Review (2016) Operational productivity and performance in English NHS acute hospitals: An independent report for the Department of Health.

Little J (2014) Learning through ‘‘huddles’’ for health care leaders why do some work teams learn as a result of huddles and others do not? The Health Care Manager, 33 (4): 335–341

Martin H, Ciurzynski S (2015) Situation, background, assessment, and recommendation–guided huddles improve communication and teamwork in the emergency department. Journal of Emergency Medicine 41(60: 484-488

NHS Institute for Innovation (2010) Safer Care: SBAR Implementation Guide. Coventry

Simulation and Interactive Learning Centre & Clod Ensemble’s Performing Medicine programme (2016) Circle of Care at Guy’s and St Thomas’ NHS Foundation Trust.