Implementing a new handover standard and using the 'SBAR' technique to improve quality of handover in psychiatry.

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Aim & Background

Aim

To improve quality and safety of an on-call email handover system through teaching sessions, introducing set handover criteria and using the SBAR (Situation, Background, Assessment, and Recommendation) handover technique.

Background

Poor quality handover can be at the root of clinical errors. The SBAR handover is increasingly used in acute medical specialities but this may also provide a useful framework in psychiatry.

In a multi-site psychiatric trust, daily written email handovers sent within a shared email chain were used to handover tasks to the on-call doctor. These emails varied in content and quality.

Method

Handover emails were assessed against set criteria for a three week period at three points:

1. Baseline
2. Following implementation of a new standard
3. Three months follow-up to determine long term compliance

<u>The compliance criteria:</u>

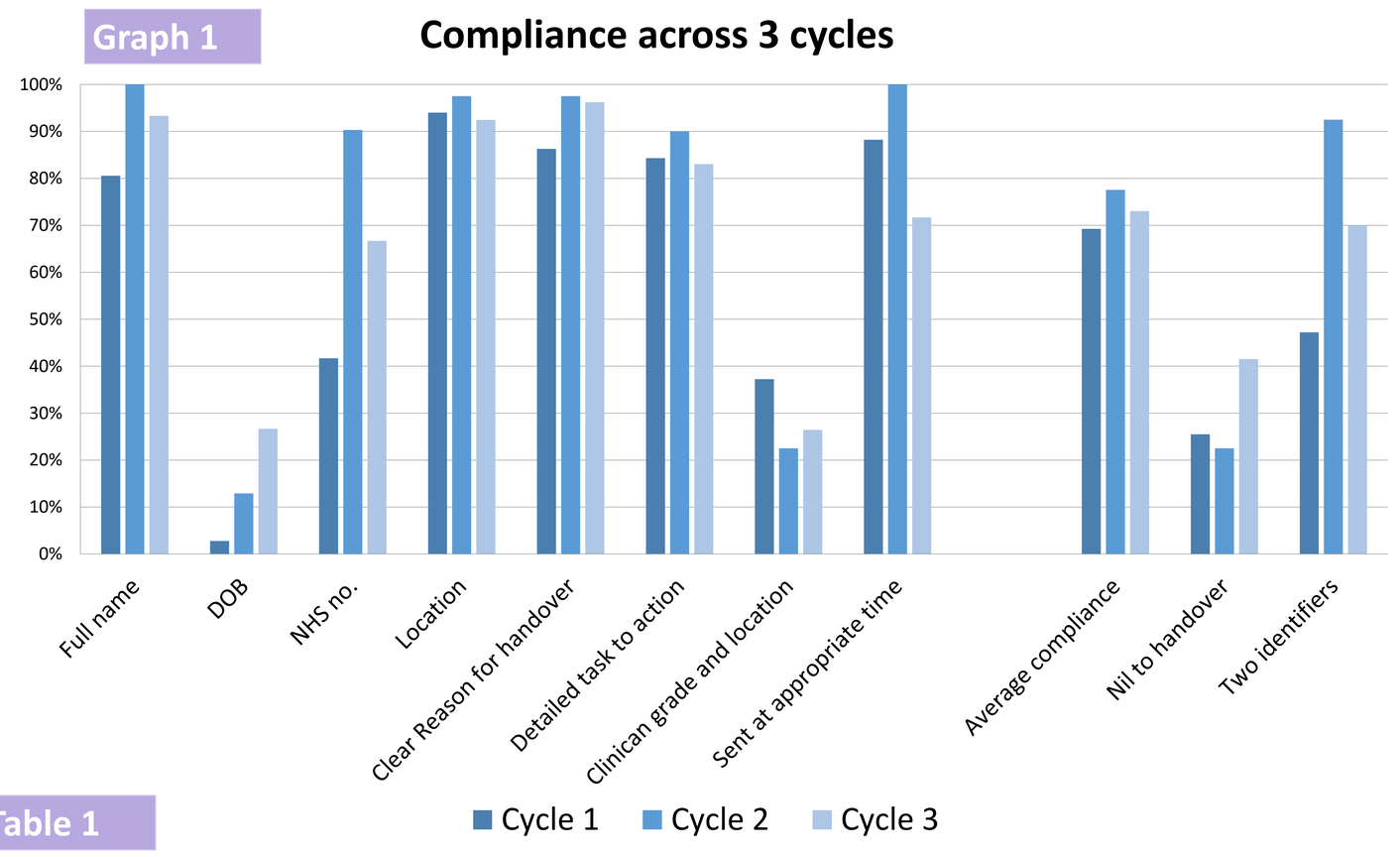
- Full patient name
- Location
- Date of birth
- Reason for handover
- Task required to action
- Clinician details
- Appropriate handover time.

Clinician's opinions regarding the handover quality were obtained via a survey using numerical rating scales from 1-10 (1 = strongly disagree, 10 = strongly agree).

Results

Some areas of compliance at baseline were poor. Average compliance at baseline was 69.3% versus 77.6% post education and implementation of a new standard. This dropped to 73.0% at follow-up. Long-term compliance of individual criteria varied (see graph 1).

Graph 1



The uptake and correct use of the SBAR handover style was measured. Post education and standardisation this was used fully 29.0% of the time and this dropped to 7.4% at follow up (see graph 2). This was despite 87.5% of clinicians voting to continue with the SBAR after the implementation period and 100% choosing to continue at three month follow-up.

Clinician opinion of handover also increased from an average score of 7.94 at baseline to 8.51 but dropped to 8.31 at follow up (see table 1).

Graph 2

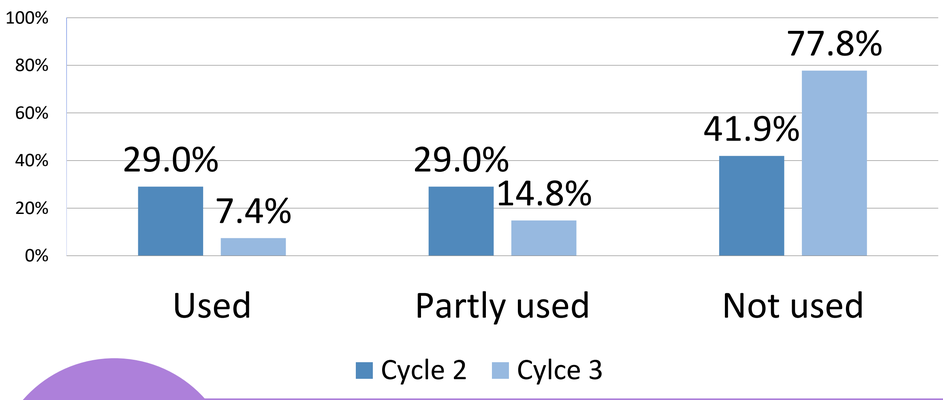


Table 1

Clinicians opinion handover 1 = strongly disagree, 10 = strongly agree	Cycle 1 N = 15	Cycle 2 N = 8	Cycle 3 N = 13
The handover system is safe	8.2	8.6	8.4
The handover system is reliable	7.6	8.4	8.2
The handover system is easy to use	8.3	8.0	8.7
The handover emails are clear	7.6	7.8	7.9
The handover emails are detailed	7.6	8.5	8.0
The handover emails include adequate patient identifiers	7.8	9.1	7.9
The handover emails clearly state what needs to be completed	7.8	8.4	8.6
I feel able to produce a high quality email	8.3	8.9	7.9
I understand what should be included in a handover email	8.3	8.9	9.2

Conclusion

The findings suggest that the implementation of a set criteria and use of handover frameworks can improve handover quality and consistency. However, without regular re-education the quality and compliance can fall. This could be addressed by providing teaching on handover quality and standards at key times such as junior doctor changeover periods.