Building capacity to support human factors in patient safety

SITUATION **S**

BACKGROUND **B**

ASSESSMENT **A**

RECOMMENDATION **R**

West of England Academic Health Science Network

Acknowledgements

This toolkit has been developed based on the IHI SBAR toolkit developed by Kaiser Permanent, the NHS Institute for Improvement and Innovation toolkit and the WEAHSN QI Toolkit. Training materials have been developed and tested by Sirona Health and Care, North Bristol NHS Trust, and West of England Academic Health Science Network.

We would like to thank Karen Gleave, Stephen Early, Richard Thomas, Alan Howe, Robert McGuinness and Jane Hadfield for their work in the development of this project.

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Introduction

Aim

This toolkit has been developed by the Building Capacity to Support Human Factors in Patient Safety workstream delivered by the West of England Academic Health Science Network.

The overarching aim is to ensure that support staff are enabled to help create and work in environments that optimise their ability to deliver safe, quality, patient care. For the purposes of this workstream the focus is non-technical human factors i.e. leadership, teamwork and communication.

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Resources are available online to help you with implementation.
Weblink: http://www.weahsn.net/what-we-do/enhancing-patient-safety/collaborating-in-the-community/human-factors/

Recommended resources for all projects to complete are shown in **bold.** These include:

- ★ Project action plan
- ★ Project charter
- ★ Project team agenda
- ★ Training capacity plan
- ★ Monthly monitoring report
- ★ Measurement plan

About the West of England Academic Health Science Network

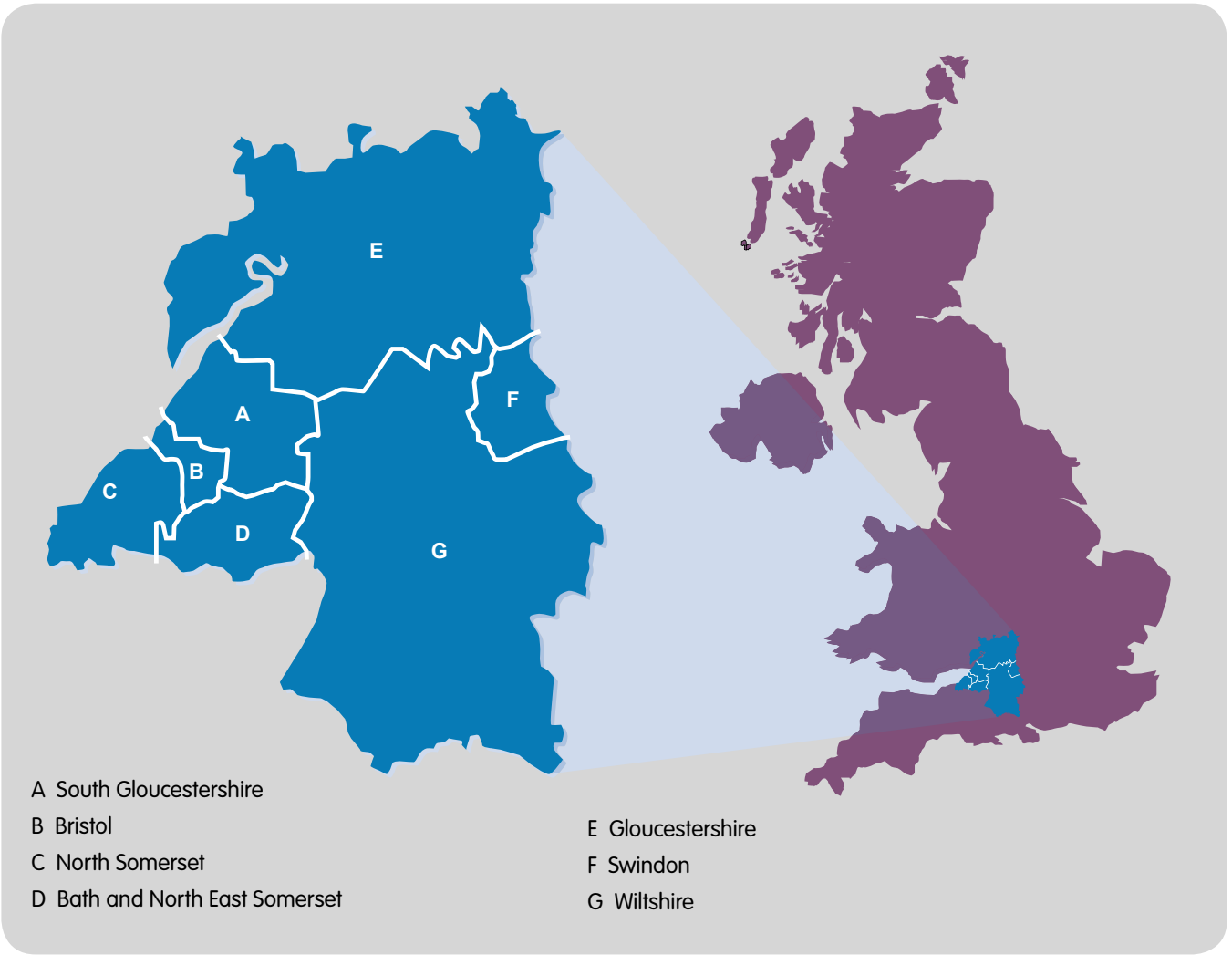
The West of England Academic Health Science Network (AHSN) is delivering positive healthcare outcomes locally and nationally by driving the development and adoption of new innovations and making a meaningful contribution to the economy.

We are one of 15 AHSNs across England, established by NHS England in 2013 to spread innovation at pace and scale.

As the only bodies that connect NHS and academic organisations, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

Find out more at our website http://www.weahsn.net/

Follow us on Twitter at @WEAHSN



A South Gloucestershire
B Bristol
C North Somerset
D Bath and North East Somerset
E Gloucestershire
F Swindon
G Wiltshire

What is SBAR?

SBAR is a structured method for communicating critical information that requires immediate attention and action, contributing to effective escalation and increased patient safety (NHS Institute 2010). The SBAR tool originated in the US Navy Submarine Service and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA.

SBAR stands for:

- **Situation**. Patient/ client's details, identify reason for this communication, describe your concern.
- **Background**. Relating to the patient/ client/ service user/ resident significant history; this may include medications, investigations, treatments.
- **Assessment.** What is your assessment of the patient/ client or situation. This can include clinical impressions/ concerns, vital signs if relevant.
- **Recommendation.** Be specific, explain what you need, make recommendations, clarify expectations and confirm actions to be taken

Benefits

The National Patient Safety Agency (2007) identified that "the art of being able to communicate information succinctly and to make requests assertively was thought to be important in securing an appropriate response." The NPSA report recommended the use of structured communication tools like SBAR to improve communication and teamwork.

SBAR can also be used to effectively enhance handovers between shifts or between staff in the same or different clinical or care areas, and to escalate concerns about a deteriorating patient.

This package has been developed with an appreciation of the factors for successful behavioural change in adults in order to support human factors in patient safety. The training package includes a mixture of learning by listening (presentation and discussion) and learning by doing (taking part in role plays, simulations and practicing techniques in a model setting). There is also opportunity for self-assessment and reflection. The training package for support staff is supported by a corresponding training for supervisors, to support staff to put what they have learned into practice in their workplace. Case studies and scenarios have been developed in partnership with public contributors in order to make them relevant and applicable to the context.

The training package has been mapped against the national syllabus for the Cavendish Care Certificate. Therefore this package provides evidence-based communication skills training in line with national competencies.

Sirona Care and Health and **North Bristol NHS Trust** were appointed as the pilot site to develop the training package.

Sirona Care and Health provide a range of health and social care services in Bath and North East Somerset and South Gloucestershire including residential care homes, domiciliary care, and community hospitals. Specialist teams work with people with learning difficulties, both adults and children, as well as people with autism, and dementia. Sirona has approximately 2,000 staff members across Bath and North East Somerset, of this number approximately 1,800 are in roles that are directly patient facing.

The curriculum was developed by Sirona Care and Health based on how teams communicate, using communication tools such as SBAR to develop a baseline awareness, which is built upon and embedded during the training using scenarios. These scenarios were co-designed by the programme lead and service user representative to reflect realistic scenarios that staff might encounter.

In total, 385 staff had received training through induction by the end of 2015 in addition to the 50 staff who received training in the first pilot phase.

Evaluation findings

The initial phase of the pilot was to work with three teams (health visitors, learning difficulty day services, and extra care) in order to develop the training package and scenarios. Following this first PDSA (plan do study act) cycle, the training was adopted into induction for all new starters.

Comments from participants in the training include: "SBAR has made situations clearer and much easier to understand when it is used" and "SBAR has helped me to think about the way in which I pass on information, this will also allow me to think about how best to get straight to the point."

Stephen Early, service user involved in the pilot won the Sirona volunteer of the year for his commitment and inspirational impact on staff.

The full evaluation report is available at http://www.weahsn.net/what-we-do/enhancing-patient-safety/collaborating-in-the-community/human-factors/

Watch Stephen talk about his experience being part of the project at https://youtu.be/wO4bLRljOtQ

Stephen's story

Stephen Early is a service user and volunteer with Sirona who has been actively involved in the development of this training programme, from designing scenarios to reflect realistic situations that staff might encounter to giving talks at staff inductions.

This is Stephen's story, introduced by Karen Gleave, Project Lead for Sirona Care & Health.

Stephen is a service user living in one of our Extra Care Services, and currently is a volunteer with Sirona Care & Health and sits on the service user panel/forum.

I met Stephen just over a year ago when I approached members of the panel about working with me to provide a service user's perspective for the Sirona support worker induction on what it is like to receive a service.

Once Stephen started it became quickly apparent that he was a "natural" talking with people and able to get his message across about how important communication and human factors are when supporting people. Stephen is able to bring the scenarios alive for the audience, has made people laugh and at times brought people to tears.

Stephen is a very inspirational person and has touched the lives of many. It really shows the great value that service users can make to organisations and how they can help to shape future services.

Stephen's story

Unfortunately I've caught pneumonia about six or seven times, and on about four or five occasions I've been took into hospital… … because I was living by myself I've had problems with eating for about six years. … one of the things they do here is try and make me eat and drink so they make me a sandwich now and then, or every time they come in, no matter what they're going to do they always make me a cup of tea and put it in front of me, and I feel if they've made me a cup of tea, then I should drink it, even thought I don't feel thirsty if that makes sense, and when I go up to Karen's they the same, everyone does the same. "Tea Steve!" and it's great.

So one day the doorbell went and the lady came in and she was a support worker. I think she was, I'm not sure now. She came in and said [grunting] "Alright."

Well, straight away you know that you were not going to have a conversation with this lady about anything and the worst thing is that these sort of five, ten minutes ones which you might get spread out between the day, maybe three times, maybe four, not sure, all depends on what your needs are, are very important to everyone because it's communication. It's talking to someone.

And loneliness in these sort of places is quite bad actually because you know it has an effect on them and on their health as well. Because if you're feeling down, you're more likely I feel to get things wrong with you and depressed and things like that, so it's quite important when people come in that they're a bit… and say things. So when she came in I knew straight away I wasn't going to have a conversation with her.

Now if I was feeling a bit unwell or anything like that, or had troubles or things, I wouldn't have talked to her about it because I knew she wasn't in the right mood to receive any sort of information. And then she came and said, "Got to make you a drink." Now "got to", so that hit me home that "got to" is not "Oh, I'm going to make you a…", "Got to make you a drink. Can't understand why you can't do it yourself." That was a little whisper underneath the voice.

And then the sandwiches… "What do you want in your sandwiches?" I said, "Well anything please" and then again I heard her say, "Can't understand why you can't do it yourself" and then she left. And as soon as she left I got up and I chucked the tea down the sink, and I put her sandwiches in the bin because I wasn't going to eat or drink anything from someone who didn't' want to do anything for me and it made me feel really bad.

So that went on for about six or seven weeks. I stopped taking food, and when they did make me food I just tipped in the bin, and the drinks, because I felt like no one wanted to do it and they didn't understand me. They didn't' understand my problems. They just thought I was lazy. So it didn't matter if they came in happy or joyful, I would still do it. That was quite a bad experience.

And then a good experience was one lady come to see me, well lots of them. And they come in and ring the bell [brightly] "Hi Steve!" Straight away you know you're going to have a positive talk to that person and positive reaction. And you're going to say to that person if there is something troubling you, you're going to mention it to them, you know, "Oh I don't feel too good today… Oh I've got this problem" or whatever.

Stephen's story

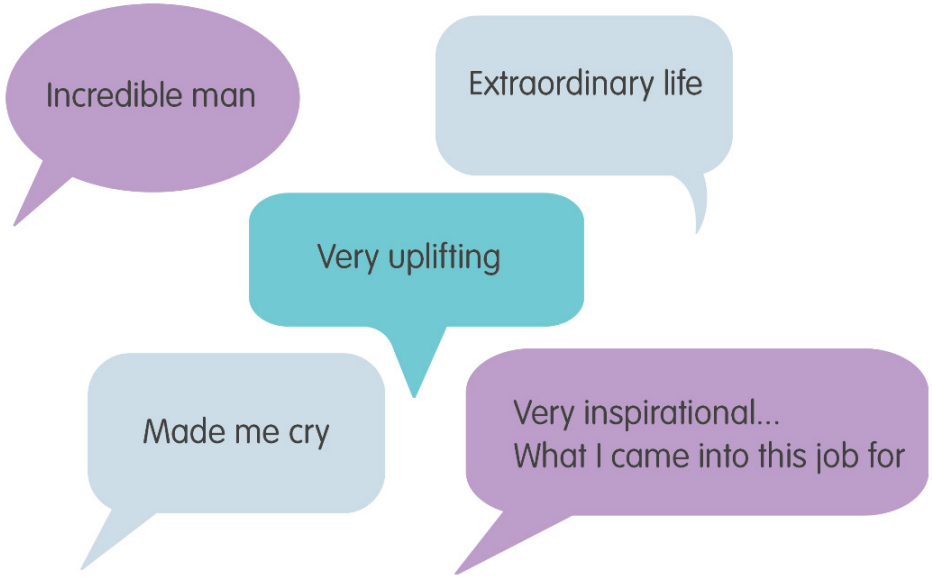
And the other thing is they come in and say, "What have you been up to today? What's been going on? What are you going to do this afternoon?" All them little things, you know, it helps the conversation to go through and it is brilliant. "Oh," she said, "Is it two sugars, Steve, innit? It's two innit?" Them little things, it's not like "Oh, I gotta make you a cup of tea" or anything like that. It's "I'm going to put in two sugars." Some don't even talk about it they just do it and bring it out and put on the table which is brilliant so it's them sort of things…

…unfortunately the people, some of the residents we have here, I call them my family because they are they're all my family, and I tell them that. Anyway, they've got problems some of them and some of them suffer with memory loss, Alzheimer's, so they're not able and some of them can't speak properly and they cannot relay to the support workers what it means, what they mean to us and they mean everything.

I call all of my support workers "my ladies" because that's what they are. They're my ladies. And they're here… if it wasn't for them I wouldn't be here, they mean so much. Doesn't matter if they come in and make me a cup of tea or just the simplest of things like help me taking off my shoes. My legs swell up around about half past two in the afternoon. They come in and take my shoes off and they always make me a cup of tea when they do it, and they have a little chat whilst they do it, and it means so much.

And I'm able when I go on my induction days to translate to them what they actually mean to people like me and the rest of the residents what they're doing. Their job's just as much important as a doctor or anyone like that because they're doing something to help and they're not only helping in the sense of doing something like giving someone tablets at the right time or doing some domestic or whatever or making sure someone eats. They're actually talking to that person, which is fantastic, which makes them feel good.

… if I can hit that one person at induction day and she stays doing caring for maybe ten years? So she might see thousands and thousands of people on her journey through her career. If she carries that through, with all of them, what a magnificent difference that's going to make! So that's how I think of it.



Implementing SBAR in your organisation

In order to implement SBAR in a sustainable way in your organisation, and to be able to measure the impact of this intervention, we recommend a structured Quality Improvement framework for implementation.

Quality Improvement science is the application of a systematic approach using specific methods and techniques in order to deliver measurable improvements in quality, care and safety.

The processes we describe can be adapted to meet the needs of your staff, service users and organisational context. Our approach uses the methodology developed by the Institute of Health called the **IHI Model of Improvement.**

You can find out more about the Model for improvement through our **QI toolkit**, available through our West of England Academy http://www.weahsn.net/what-we-do/west-of-england-academy/

For an introduction to PDSA cycles watch this video https://youtu.be/xzAp6ZV5ml4

The IHI Model for Improvement

There are three questions to ask when developing implementation projects shown to the right.

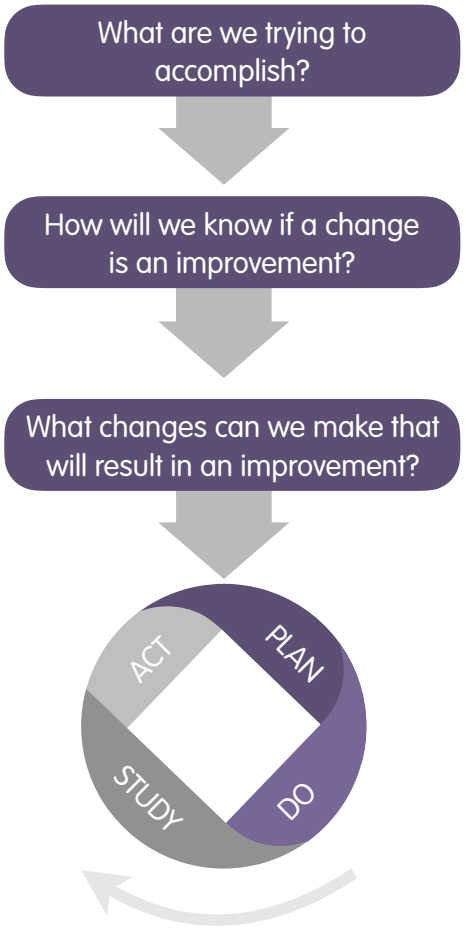
These are then followed by rapid cycle improvement using PDSA.

Plan, Do, Study, Act is an effective method that helps teams plan the actions for their model, test it on a small scale, and review before deciding how to continue.

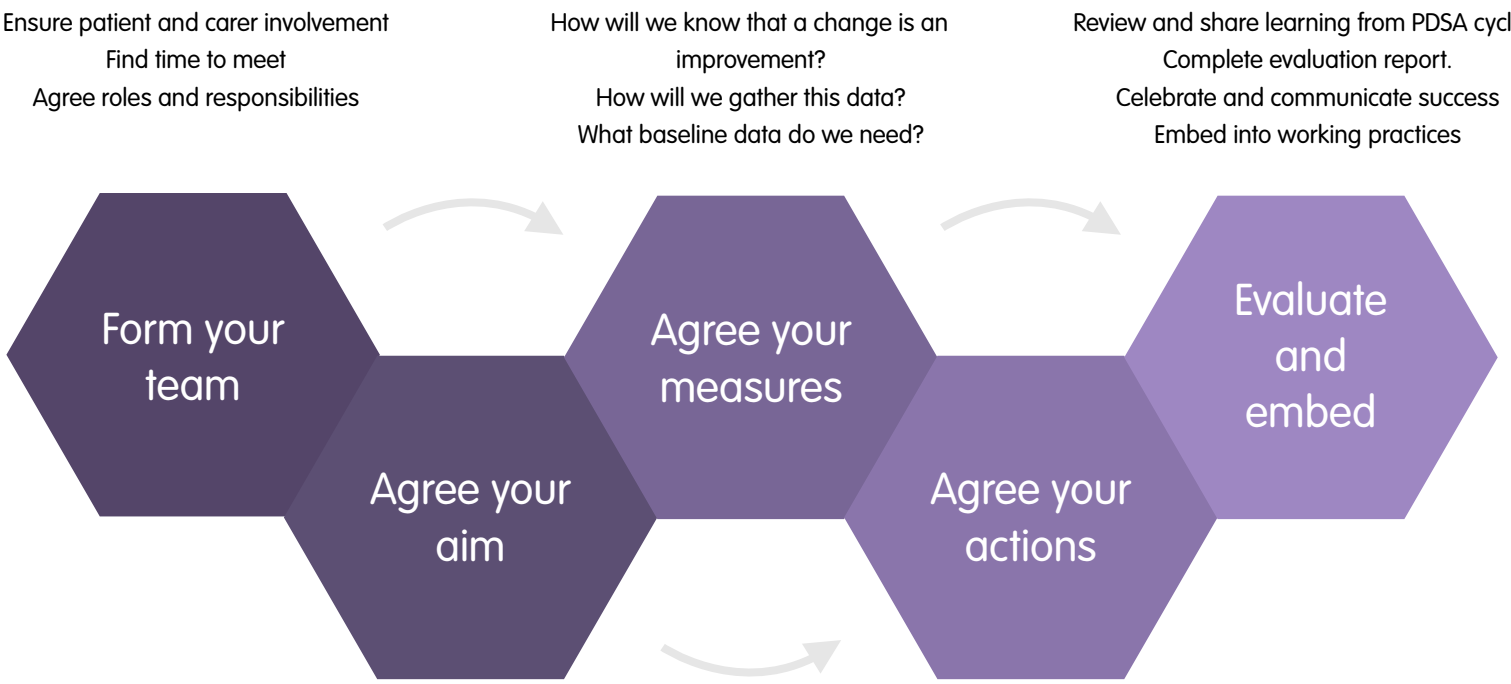
Using PDSA cycles are a fantastic way of taking ideas, trying them in practice, learning what works, and what doesn't to help you achieve success.

You can then broaden the scale of the test, or adjust your ideas through more than one PDSA cycle — it make take a few before the idea starts to work reliably.

For a fun way to introduce a team to quality improvement, check out this blog post http://www.weahsn.net/2016/01/anyone-for-tennis/



Step by step guide to implementing SBAR



1. Form your team

This can be quite an informal team, but should represent all the areas that are affected by the proposed change. Including the right people is critical to success.

Roles in your project team

★ **Project Executive Sponsor**—Patient Safety Collaborative Board member for your organisation;

★ **Champion(s)**– this could be your Patient Safety Lead or Quality Lead;

★ **Technical expertise** – this could be your Training or Practice Development Lead;

★ **Operational/ project leader/ implementation support** – this needs to be someone with the organisational skills who is able to support you in delivering the project;

★ **Public contributors** – our experience in the pilot has identified that public contributor involvement early on is crucial to success.

★ **Specialist input** on quality improvement and human factors is available from the WEAHSN project lead.

If you need to gain agreement from your senior management team, you will need to demonstrate the benefits and how these will be realised in your organisation. There is evidence that strong support from senior managers and clinical champions is crucial to success. Think about how you can make this support visible to your teams, for example this may be a pledge in your Sign Up to Safety plans, or your senior leaders may attend the first training session to launch the programme.

Your project charter

As part of this step, start your **project charter**. This is a document which has some simple questions to help you scope and plan your work.

You can find out more about project charters in our QI toolkit at http://www.weahsn.net/what-we-do/skills-knowledge-development/quality-improvement-tools/quality-improvement-toolkit/qi-toolkit-project-charter/

Who else needs to be involved?

The other crucial step at this stage is considering **who** needs to be involved, consider also who your target audience is for training – think about whether there are any areas with enthusiasm for SBAR or who will be willing to help you spread implementation to others. Consider who your facilitators will be. Do you have existing facilitators in-house, will your need to recruit experience, or procure from an outside source? Are any of your public contributors willing to be part of the training team? If you do not have public contributors involved how might you recruit them?

Resources to help you at this stage...

★ **Project action plan**
★ **Project charter**
★ Example email to team members to invite them to group
★ **Example team meeting agenda**
★ Example terms of reference
★ Example business case
★ **Training capacity plan**

2. Agree your aim

When starting an improvement project, it is important to clearly define your aim. This is what you want to achieve by the end of the project. Agreeing the aim in your team is crucial to success.

Top tips for developing your aim

★ It must be **specific** and **measurable**. It cannot simply be "to improve" or "to reduce".

★ The aim should be meaningful to patients / service users and their families. When developing your aim it can be helpful to involve your service user representative to understand the patient voice.

★ Data can be used to better understand what the big quality issues are, and may help to define a suitable aim.

★ The aim should be **achievable**, **relevant** to your organisation's goals and service user needs, and have a clear **timeframe** for completion.

Once you have defined your aim, you can use a tool called a **driver diagram** to structure your thinking and choose priorities for action. You can find out more about how to put together a driver diagram at http://www.weahsn.net/what-we-do/west-of-england-academy/improvement-resources-and-tools/the-improvement-journey/steps-in-the-improvement-journey/step-3-plan-and-implement-the-changes/logic-model-or-driver-diagram/

Discuss in your team – **What are we trying to accomplish?**

Describe the behavioural change(s) you are aiming to achieve and the impact on care for example: **100% of escalations of EWS (early warning scores) done using structured communication tool by March 2017.**

If you are stuck – think through a recent incident or complaint in the organisation, for example using the Yorkshire Contributory Factors Framework.

Consider both **patient** and **staff** factors (e.g. morale, turnover). There is evidence that improving employee engagement and staff satisfaction has a correlation with improved outcomes for patients.

In many cases you will have some kind of communication training in place in your organisation, so discuss in your group how human factors and SBAR can be embedded into this training

Once you have agreed your aim add this to your project charter and project team terms of reference.

Risks and issues

Once you have your aim agreed, as a team, consider what risks and issues may prevent you from achieveing your aim.

An **issue** is something that is happening. A **risk** is something that might happen. Please use your own organisational risk management scoring for likelihood and impact of risks occurring.

The status of a risk can be open (action required), accepted (all mitigation in place, no action required), closed (risk or issue has been closed).

Resources to help you at this stage...

★ Risks and issues log

3. Agree your measures

How will we know that a change is an improvement? We use measurement to understand if a change has been successful.

Top tips for carrying out a survey

★ **Keep it simple**! Try and use simple and direct language. Ask about one idea per question.

★ **Keep it balanced.** Use a mixture of positive and negative language – for example "on average, how happy are you at work…" and "on average, how frustrated are you with …"

★ **Keep it accessible.** Shorter surveys have a higher response rate. What are the key questions you want to ask and the measures you want to track over time. Try and keep to one side of A4 and leave plenty of room for people to write their responses. If you are carrying out your survey online, SurveyMonkey is a good tool to use www.surveymonkey.com/ but remember that not all staff can access computers every day.

★ **Keep it ranked and rated.** Using scales like "how are we doing… excellent/ good/ fair/ poor" or "how much do you agree with this statement… strongly agree/ agree/ disagree/ strongly disagree/ neither agree nor disagree" is a good way to get numerical (quantitative) data on attitudes and behaviours.

Collecting data

Data can be collected in two ways -- as **quantitative** data (i.e. numbers and statistics) or **qualitative** data (stories and descriptive information). Both types can be really valuable, particularly when looking at behaviours and culture.

Surveys are one way to gather both types of data.

Another question to consider is when you will collect the data. In order to show that there has been a change, you need to know what the situation was before you made the change, in order to compare with the situation after the change. This information about your current state is called the **baseline.**

You may already have a way to measure where you are or some existing information -- for example a recent staff survey.

In your team, think about:

- What data will we collect? You can use the measurement plan to define this.
- Who will collect the data?
- Where will we record this data? For example in an Excel spreadsheet or on a database.
- Who will submit the monthly monitoring report?

The safety climate questionnaire is a tool developed by NHS Education for Scotland to measure staff morale and perception of teamwork, communication and leadership. If you don't have a baseline measure, e.g. safety barometer or staff survey, we recommend you carry out one prior to starting training in your team, in order to have a baseline measure.

Once you have carried out the questionnaire you can use the outcome meeting template in order to review. An Excel spreadsheet for inputting data and analysing the outcomes is available as part of this toolkit.

Resources to help you at this stage...

★ **Measurement plan**

★ **Monthly monitoring report**

★ Safety Climate Question instructions, tool, and outcome report

★ Ask 5 tally chart

★ The A-Z of Measurement for Improvement (NHS IQ)

More measurement tools available online

Different types of measures

There are different types of measures:

- **Process measures**, e.g. the number of sessions delivered each month, number of staff trained in each session, number of public contributors involved in training sessions.
- **Outcome measures**, e.g. staff attitude survey of perception of communication within the team and safety attitudes, and confidence with using SBAR before and after the intervention
- **Balancing measures**, e.g. number of 999 call outs from residential homes before and after training delivered, staff sickness and turnover rates.

What can you measure?

We can **count** something, e.g. the number of patients who have diabetes in a given population, or the number of serious adverse events in a given time period.

We can use **ratios** which consider of two numbers, a numerator and a denominator. Sometimes this number is expressed as a **percentage**. For example if there are 5 adverse events each year in a 250 population, that is 0.02 adverse events per person (ratio) or a 2% adverse event rate (percentage).

Reasons for measuring:

- Measurement for **judgement**: where measures are used to judge us against performance targets, other Trusts, etc. Improvement is not about judgement, however, you can use measures to judge and manage your own progress
- Measurement for **diagnosis**: where data is gathered to understand the process, to see if there is a problem and how big it is. This is a useful technique, especially early in your work, for example, to really understand the demand and capacity at a bottleneck in the process
- Measurement for **improvement**: where a few specific measures, linked to the your objectives and aims, demonstrate whether the changes are making improvements
- Measurement for **sustainability**: to ensure the changes and the improved outcomes are maintained and are part of everyday practice. These are long term measures linked to organisational aims
- Measurement for **spread**: specific measures to demonstrate the extent to which learning and change principles for improvement have been adopted.

Run charts

A run chart is a tool for improvement which shows how your project is going.

To show that things have improved you need to show the things that have changed, and that the change is not a one off. You must consider whether the change has been sustained. Run or control charts allow you to see if this has happened.

For more information on run charts visit http://www.weahsn.net/what-we-do/west-of-england-academy/improvement-resources-and-tools/the-improvement-journey/steps-in-the-improvement-journey/step-4-test-and-measure-improvement/run-charts/

4. Agree your actions

The doing part is made up of rapid, small 'plan, do, study, act' (PDSA) cycles to test and implement change in real life settings. More information on using PDSA cycles for improvement is available at http://www.weahsn.net/what-we-do/west-of-england-academy/improvement-resources-and-tools/the-improvement-journey/steps-in-the-improvement-journey/step-3-plan-and-implement-the-changes/model-for-improvement/

Communication

★ What communications approach will you take to tell people about human factors – can you do an article in a team newsletter or a launch event? Be sure to brief or train those likely to receive SBAR communications, as well as those giving them.

★ Give positive feedback – this is vital to embed a change in behaviour. You can go to team briefings to raise awareness about the training, and/or hold drop in events.

★ Review the SBAR tools and agree which you will use or whether you'll develop your own. Hand-outs, posters, stickers and notepads placed near telephones have all helped other teams.

★ How will you communicate the changes? http://www.health.org.uk/commskit/ is a really useful resource in planning your communications activities.

Some questions to consider when putting together your plan:

- **What** – will you use the training package as it is? do you need to adapt it to a particular context? Will you run the training as a separate session or incorporate into existing training?
- **When** – when will you run the training? For the "Start with SBAR" we recommend this is done at induction, so consider how new starters will be booked in and where this fits with the rest of your induction plans. How will you training and update existing staff?
- **Where** – do you have an education centre or team base to deliver the training from? Do you need to book a venue? Where are your teams located?
- **How** – how many sessions will you run per month?

Barriers and enablers for change

Particularly when implementing changes to behaviour it is vital to think about what barriers there are to the target behaviour you would like to change, and how you can support staff (enablers) with the change. Research in Yorkshire and Humber AHSN has identified some factors to consider and they have produced a Behaviour Change Toolkit.

The barriers and enablers tool included in this toolkit guides you step by step through this process.

Developing your faculty

One of the aims of the project is to develop a faculty with knowledge of human factors as it relates to teamwork, communication and leadership. The bring-build-buy map can help you identify your faculty.

At the end of each PDSA cycle, consider whether you adopt, amend or abandon. If you decide to abandon a particular line of testing, consider with the team why this is and what alternatives might work better.

Resources to help you at this stage...

★ PDSA test log
★ Action log
★ Barriers and enablers plan
★ Bring-build-buy map

5. Evaluate and embed

All WEAHSN projects are subject to evaluation. The evaluation process is two-fold, one for your internal use to see whether the changes you've made have had an impact and also as part of our overall evaluation of the training programme. There are four levels of evaluation for the training:

1. Organisational/ team level

In order to assess the impact at an organisational/ team level, we recommend using the Patient Safety Climate questionnaire or a similar tool if one is already in place in your organisation. Carry out this survey before and after the intervention in your teams, in order to assess the impact on morale, teamwork, communication and leadership. You can also collect feedback from staff to measure awareness using the Ask 5 tally form.

2. Individual level

Prior to training, attendees are asked to complete a self-assessment. At the end of the training session, attendees are asked to complete a post-training evaluation. These provide a comparison in levels of knowledge and confidence before and after training.
These questionnaires are a mixture of quantitative and qualitative questions including some open-ended prompts to examine the perceptions of staff following the training. This includes feedback for the facilitator.

3. Impact on patients/ service users

It is difficult to measure and directly quantify the impact on patients and service users using only numerical data however quantitative data is just as valuable, although more time consuming to capture and analyse. However our pilot study showed a strong positive impact on public contributors involved in developing and delivering the training, and they shared stories with us of the impact they felt it had on them. Therefore you may find it helpful to gather these patient stories in order to understand this impact.

4. Facilitator evaluation

All facilitators of the training sessions are invited to take part in the facilitator evaluation in order to assess how we can improve the training package. This will consist of in-depth telephone interviews using an interview guide. With permission, audio will be recorded and transcribed. Thematic analysis will be used to examine patterns and themes.

Resources to help you at this stage...

- ★ Template evaluation report
- ★ Example emails to senior management team

Celebrate good times, come on!

★ Don't forget to celebrate! We'd love to hear how you have implemented this toolkit and feature on our website and newsletters. Please send photos and case studies to your WEAHSN project contact.
As you evaluate your progress display the stories, photos, quotes and results so that everyone can see your progress.

If you would like more help with your evaluation, please use the online Evaluation Toolkit. This is a step-by-step guide to evaluation. Using it will give you more confidence that you have made a robust plan for your evaluation. There are also links on the Evaluation Toolkit website to further resources should you want to know more. This toolkit has been developed by WEAHSN and Avon Primary Care Research Collaborative and is available online at URL TBC

Recommended resources

WEAHSN Quality Improvement Academy http://www.weahsn.net/what-we-do/west-of-england-academy/

Healthcare Quality Improvement Partnership. **A guide to quality improvement methods** https://www.rcseng.ac.uk/healthcare-bodies/docs/guide-to-quality-improvement-methods

Healthcare Quality Improvement Partnership. **E-learning for QI for public contributors** http://elearning.hqip.org.uk/introduction-to-qi/

Method Kit cards for workshop planning. Free download at https://methodkit.com/shop/methodkit-for-workshop-planning/

NHS Education for Scotland. **Train the Trainer Toolkit: a practical guide to help others facilitate learning in the workplace.** http://www.nes.scot.nhs.uk/media/2042600/trainthetrainers__final_.pdf

NHS Institute for Innovation and Improvement. **A Handy Guide to Facilitation.** http://systems.hscic.gov.uk/p3m/rigorous/products/handyguide.pdf

NHS IQ. **A-Z of Measurement** http://www.nhsiq.nhs.uk/media/2581374/a-z_measurement_glossary_q9.pdf

Safer Care. **Human Factors for Healthcare. Trainer's manual and Course Handbook.** http://patientsafety.health.org.uk/sites/default/files/human_factors_in_healthcare_trainer_manual_en_march_2013.pdf

Skills for Care. **Care Certificate Resources.** http://www.skillsforcare.org.uk/Standards/Care-Certificate/Care-Certificate.aspx

Yorkshire and Humber AHSN. **Behaviour Change ABC for Patient Safety Toolkit.** http://www.improvementacademy.org/resources/abc-for-patient-safety-workshop-and-toolkit/

Health Foundation. **Communication Kit.** http://www.health.org.uk/commskit/

Yorkshire **Contributory Factors Framework**. http://improvementacademy.org/resources/an-evidence-based-framework-for-investigating-safety-incidents/

WEAHSN and Avon Primary Care Research Collaborative **Evaluation Toolkit** URL TBC

Online toolkit

All the tools referred to in this toolkit and more are available online at http://www.weahsn.net/what-we-do/enhancing-patient-safety/collaborating-in-the-community/human-factors/

The pilot found that using supporting resources like ID badge sized cards, posters and stickers to go by telephones, and using SBAR on other documents, e.g. handover sheets, can help reinforce learning and use in practice.

Editable versions of cards, posters and stickers are also available to download at http://www.weahsn.net/what-we-do/enhancing-patient-safety/collaborating-in-the-community/human-factors/

References and further reading

References, evidence base and further reading are available at **http://www.weahsn.net/what-we-do/enhancing-patient-safety/collaborating-in-the-community/human-factors/**

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