CLINICAL HANDOVER

PROCEDURE©

DOCUMENT SUMMARY/KEY POINTS

- This document outlines the Standard Key Principles for Clinical Handover to be incorporated into all types of handover to ensure effective, concise and complete communication in all clinical situations.
- Clinical handover refers to the 'transfer of professional responsibility and accountability from some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis'.

CHANGE SUMMARY

- N/A- New document

READ ACKNOWLEDGEMENT

- All Medical, Nursing, Allied Health staff and students (including VMO's) involved in the care of patients should read and acknowledge they understand the contents of this document.
- Local manager to determine which staff not involved in patient care should read and acknowledge they understand the contents of this document.

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1 Purpose

This procedural document has been developed for the Sydney Children's Hospital Network (SCHN) to outline the processes required for clinical handover and ensure all clinical services or departments within the SCHN meet the requirements of the NSW Health Clinical Handover – Standard Key Principles Policy (NSW Health Policy Directive PD 2009_060).

2 Background

Clinical handover is described as the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another personal or professional group on a temporary or permanent basis. In this definition, the professional responsibility relates to the duty of care the clinician has for the patient/client, whilst the accountability is their obligation as a staff member and professional to their colleagues, organisation and professional body.

Throughout this document, **'patient'** is an inclusive term referring to all persons accessing the health service in an inpatient or outpatient setting.

Clinical handover is essential for ensuring effective continuity of care for patients in situations where multiple staff or teams are involved in providing care, either concurrently or sequentially or on a rotational basis. There must be no point during a patient's journey where there is ambiguity about who has responsibility and accountability for that patient's clinical care.

Millions of occasions of clinical handover occur every year in NSW health care. Each time clinical information is handed over there is an associated risk for the patient. With subsequent handovers, the magnitude of risk and potential adverse outcome multiplies.

In October 2009 NSW Health mandated the implementation of standard key principles for all types of clinical handover in NSW hospitals to aid effective, concise and complete communication in all clinical situations and facilitate care delivery. Standardising the key principles of clinical handover will contribute to improved safety of patient care.

This procedural document has been developed utilising evidence and is consistent with approaches endorsed by the Australian Commission on Safety and Quality in Health Care and the Australian Medical Association. This document outlines the guiding principles and components of clinical handover for all Medical, Nursing and Allied Health Staff within the SCHN.

This document applies but is not limited to the following situations: shift change, patient transfers, escalation of deteriorating patients, intra-hospital transfers, multidisciplinary handover and interdisciplinary handover.

3 The Standard Key Principles for Clinical Handover

The standard key principles for clinical handover are designed to be applicable for all forms of clinical handover. They provide standardisation whilst supporting flexibility at the local level.

3.1 Leadership

- A leader must be nominated at each clinical handover. Examples of this may include the Nurse in Charge at morning handover or the Consultant who is transferring care.
- The larger the handover process (i.e. more handover participants) the more important the role of the leader.
- The leader of an area (Nurse in Charge, Medical Consultant etc.) is required to be informed and have a comprehensive understanding of the condition and care requirements of the patients that they are accountable for.
- The leader ensures that all participants attend and are heard, and that transfer of information is concise
- The leader ensures immediate escalation of patients identified as deteriorating
- Where appropriate, the leader ensures documentation of the handover and allocation of responsibility for each patient

3.2 Valuing Handover

- Set the expectation that clinical handover is valued and an essential part of daily work.
- Ensure staff are available to attend the handover of all patients relevant to them
- Develop and review clinical rosters to ensure they support handover
- Implement solutions to reinforce the importance of attendance on time (e.g.: group paging)

3.3 Handover participants

- Identify staff that are required to be present for clinical handover to occur
- Orient handover participants including casual, pool and/or visiting staff
- Wherever possible, patients and carers should be recognised and included as handover participants.
- In multidisciplinary teams, handover should be structured to allow staff to be present for patients relevant to them and then released
- Regular review of the handover process must occur
- All staff members are required to attend handover in accordance with facility/department requirements, including during early morning and evening handover.
- All clinical staff is required to handover essential information about their patients before leaving the facility.

3.4 Handover Time

- Set an agreed time, duration and frequency for clinical handover to occur
- Where possible, implement strategies to reinforce punctuality
- Timeliness (start and finish) of handover is imperative to ensure a sustainable and effective process. Regular review and implementation of improvement strategies should occur as required.

- Adequate time for each component of clinical handover must be allotted and adhered to.

3.5 Handover Place

- Each clinical department and service must identify a specific location for clinical handover to occur.
- Make sure that the handover place is as free from distractions as possible – e.g. pager noise, telephones and general ward noise.
- Where possible, clinical handover must occur face to face and in the patient's presence.
- Within the Nursing Directorate, a portion of the handover should take place at the patient's bedside and involve the patient/family. In general ward areas this process includes completion of the Bedside Handover Checklist. Speciality areas (such as Intensive Care) should use departmental specific checklists/tools to support this process.
- If handover cannot happen face to face, then other options should be considered to ensure effective and safe clinical handover (refer to the matrix in Appendix I).
- Taped handover does not support two-way communication and is a practice that is considered inappropriate.

3.6 Handover Process

The ISBAR method is the preferred communication tool to be used when transferring information regarding patients within the SCHN.

Each clinical department and service must define a standard protocol for how clinical handover occurs each and every time. The standard protocol should:

- Clearly identify the patient, you and your role.
  - Verification of the patients' identification must occur prior to exchange of information.
  - Ensure that the participants in the handover process are aware of their role, and are clear that a transfer of responsibility and accountability is taking place.
- State the immediate clinical situation of the patient.
  - Immediately escalate care of patients identified as deteriorating.
- List the most important and recent observations.
  - Highlight any changes in the patient's condition, particularly any deteriorating observations.
- Provide relevant background/history to the patient's clinical situation.
  - Summarise the patients' relevant medical background, examinations, diagnosis and management in a few key points.
- Identify assessments and actions that need to occur.
  - It must be clear to the person(s) accepting accountability and responsibility for a patient's care, what needs to be done, when and by whom
- Identify timeframes and requirements for transition of care
  - Make known the planned timeframes and requirements to progress a patient through their journey

- Promote the use of the patient record to cross-check information
  - Where practical, incorporate the patient record into the handover process, so that direct cross-checking can occur between the information documented and what is handed over.
- Ensure documentation of all important findings or changes of condition
  - Determine what represents critical documentation for your clinical handover process, in both legal and patient care terms
  - Documentation can include checklists, electronic tools and 'handover books' to supplement specific patient record documentation
  - Within the Nursing Directorate, there must be documented completion of all checks on the Bedside Handover Checklist during shift to shift bedside handover.
- Ensure comprehension, acknowledgment and acceptance of responsibility for the patient by the clinician receiving handover
  - It is the responsibility of a staff member receiving clinical handover to ensure that they understand all information about the patient's condition. Clarification should be sought if there is misunderstanding or if documentation is not clear.
  - The transfer of critical information and risk mitigation plans, prior to transferring responsibility of a patient, cannot be ambiguous. Responsibility for transfer and task acceptance may be demonstrated by the signing of a handover checklist such as the 'Bedside Handover Checklist' or the 'Paediatric Departure Checklist – ED To Ward / Other Facility' on the back of the Emergency Department Paediatric Observation Chart.

4 Deteriorating Patients

- Clinical concerns should be escalated immediately as per the facility specific Clinical Emergency Response Systems (CERS) protocol.
- All Rapid Response calls that have occurred during the shift must be handed over.

5 Other Critical Information

- Other information may also need to be considered and prioritised such as outstanding actions, planned patient moves, Occupational Health and Safety risks and staffing.

6 Patient Confidentiality

- In determining the location for clinical handover to occur consideration should be given to privacy and patient confidentiality.
- Printed clinical handover sheets or patient identifier documents are to be disposed of at the end of each shift in a way that ensures patient confidentiality.

7 ISBAR Communication Tool

- The ISBAR communication tool should be used for communicating patient information. Communication tools have been shown to increase the consistency of the delivery of information (See Appendix II).

8 Monitoring

- The Director of Clinical Governance, Risk and Medical Administration provides governance and sponsorship over clinical handover across the SCHN.
- All clinical departments and services are expected to participate in regular audits of clinical handover to ensure compliance with this policy and departmental/service specific protocols.
- Any incidents relating clinical communication and handover must be documented on an incident notification form, in the Incident Information's Management System (IIMS).

9 Further information

- NSW Health Clinical Handover – Standard Key Principles Policy (PD 2009_060).
- Standard Key Principles for Clinical Handover- Implementation Toolkit
- National Safety and quality Health Service (NSQHS) Standards- Standard 6: Clinical Handover.

Appendix I: Clinical situations and handover options

There are a range of options for clinical handover that are considered to be "Recommended Options". Review the questions below and follow a clinical handover process that maps to the standard key principles and incorporates the most appropriate 'Recommended Options' identified.

WHY implement standard key principles?		Provide the best patient care by improving the transfer of clinical information, responsibility and accountability.						
WHAT clinical information is handed over?		Locally defined minimum data set that meets the key principles, ensuring the most important clinical information is handed over						
WHO should attend handover?		Key participants in the handover process are identified and available to attend the clinical handover of their parents.						
WHEN Should handover occur?		Escalation of deteriorating patient	Patient transfers to another ward	Shift to shift change over	Patient transfers for a test or appointment	Patient transfers to another facility	Multi- disciplinary team handover	Patient transfers to/ from the community
HOW should handover be delivered?	Face to face + checklist	✓	✓	✓	✓	✓	✓	✓
	In the patient's presence (bedside handover)	✓	✓	✓	✓	✓	✓	✓
	Face to face verbal only	✓	✓	✓	✓	✓	✓	✓
	Checklist	✓	✓	✓	✓	✓	✓	✓
	In a common staff area	•••	•••	✓	•••	•••	✓	•••
	Telephone handover	✓	✓	•••	✓	✓	✓	✓
	Mobile electronic tools	✓	✓	✓	✓	✓	✓	✓
	Detailed transfer letter	✗	•••	✗	•••	✓	•••	✓
	Tape recording	✗	✗	✗	✗	✗	✗	✗

LEGEND:

✓	Recommended Options
•••	Not Recommended
✘	Should Never Occur

Appendix II: ISBAR communication tool

I	**INTRODUCTION** Identify yourself by name, role and location Identify the patient *I am……. I am calling from…….* *I am calling about……. (name and age)*
S	**SITUATION** Explain what has happened to trigger this conversation *The reason I am calling is ……*
B	**BACKGROUND** Give relevant medical history and pertinent information which may include admission date/ medications/ test results/ status change *This is on the background of……..*
A	**ASSESSMENT** Explain what you think the problem is or say: *The patient's condition is…….* *They are in need of……*
R	**RECOMMENDATION/ REQUEST** Be clear about what you would like to see done such as treatment/ transfer/ test and when it should happen *I need you to see the patient in …….. (timeframe)*