SLHD Policy Compliance Procedure

Clinical Handover: Communicating for Safety	
TRIM Document No	
Policy Reference	SLHD_PCP2019_029
Related MOH Policy	Clinical Handover (PD2019_020)
Keywords	Handover; Communicating for Safety
Applies to	All Clinical staff
Clinical Stream(s)	All Clinical Streams
Tier 2 Sign-off	Dr Katherine Moore, Executive Director Clinical Governance and Risk Management
Date approved by SLHD Policy Committee	09/05/2019
Author	SLHD Clinical Governance Unit
Status	Active
Review Date	01/06/2024
Risk Rating (At time of publication)	H
Replaces	SLHD_PCP2017_021

Version History
v.1January 2019 v.2 May 2019 – Addition of Appendix II to incorporate links to Mental Health handover resources and associated renumbering of Appendices v.2 13/06/2019 – Updated all references to MoH Policy Clinical Handover (PD2019_020)

Handover: Communicating for Safety

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1. Introduction

The purpose of this policy is to enhance patient safety by ensuring systems and processes are in place to provide a consistent approach to clinical handover. The policy outlines key principles which are designed to guide and direct Sydney Local Health District (SLHD) staff to implement a minimum standard for conducting patient care handovers. Clinical departments/units/services must demonstrate the engagement of Patient/Carer/Family as key participants. This policy applies to all staff involved in the care of patients in SLHD.

Clinical handover is the effective transfer of professional responsibility and accountability for some or all aspects of care for a patient/s to another person or professional group on a temporary or permanent basis[1].

Clinical handover does not only happen at the change of shift, it happens within and between teams and is considered a time of risk for patients, where gaps in information transfer can impact patient safety.

Examples when hand over should occur include:

- Escalation of the deteriorating patient
- Patient transfers:
    - to or from another unit/clinic or facility
    - for a test, procedure or appointment
    - to, from and within community settings, including residential aged care
    - involving other teams (e.g. NSW Ambulance, patient transport)
- Shift to shift change over between:
    - Nursing staff
    - Medical staff
    - Allied Health staff
- Multidisciplinary team handover.

2. Aboriginal Health Impact

Aboriginal patients often have larger family groups visiting, and there may be several family members involved in making medical decisions for the patient. Involving the patient/carer/family in clinical handover can improve the experience of Aboriginal people in accessing health care, by reducing discrimination and other barriers and improving cultural safety

It is important that clinicians take this, and different levels of health literacy in to account when involving patients and their family members in clinical handover, and ensure that information is understood by and passed on to all those involved in decision making. This can be guided by the Aboriginal Hospital Liaison Officer where possible.

3. The Aims / Expected Outcome of this Policy Compliance Procedure

The aim of this policy is to provide a governance structure to support all elements of clinical handover and to demonstrate systems are in place to:

- Ensure a documented, consistent approach to clinical handover
- Apply the key principles for all types of clinical handover
- Engage with Patient/Carer/Family during clinical handover
- Monitor the effectiveness of clinical handover and documentation processes
- Develop an action plan for continuous quality improvement based on the outcomes of monitoring of handover.

4. Risk Statement

SLHD Enterprise Risk Management System (ERMS) Risk # 1 – Governance for Safety and Quality Care in Health Service Organisations:

Each time clinical information is handed over between health professionals there are potential risks associated with clinical incidents, adverse events or near misses relating to transfer of care.

5. Scope

- This document outlines the guiding principles and components of clinical handover for all Staff within the SLHD

6. Resources

Tools to support effective clinical handover, such as ISBAR, can be found at https://www.c4sportal.safetyandquality.gov.au/

7. Implementation

Chief Executive:

- Assign leadership responsibility, personnel and resources to implement and comply with this policy

Director Clinical Governance:

- Ensure that the policy is communicated to managers and health workers
- Ensure local monitoring and reporting processes are in place
- Address issues relating to compliance with this policy
- Take responsibility for the oversight of the development of action plans

Hospital, facility, clinical stream and unit/department managers:

- Set the expectation that clinical handover is valued and an essential part of patient care
- Develop documented processes for clinical handover based on this policy maximising consistency across all settings
- Ensure sufficient resources and staff training are in place to support clinical handover
- Demonstrate use of continuous quality improvement on lessons learned from the monitoring process and develop action plans in response at all levels

Clinical staff:

- Ensure individual work practices are consistent with the key principles for clinical handover

8. Key Performance Indicators and Service Measures

- All clinical departments and services are expected to participate in regular audits of clinical handover using the tools available in QARS (or other approved audit tools), to ensure compliance with this Policy Compliance Procedure and departmental/service specific protocols conducted at agreed frequency.
- Any incidents relating to clinical communication and handover must be documented in the incident management system
- Local evaluation of clinical handover processes must occur annually, alongside continuous review of incident data to identify incidence and trends in Clinical Handover related issues.

9. Key principles for safe and effective clinical handover

The key principles provide a framework to guide the structure and process for a safe clinical handover.

9.1 Standard key principles

9.1.1 *Patient/Carer/Family involvement*

- Emphasis on a culture where Patient/Carer/Family are partners in care.
- In line with patient's wishes Patient/Carer/Family are supported to be involved in clinical handover.
- Identify and document the patients care goals, preferences and needs.
- A system for early identification of Aboriginal and Torres Strait Islander patients and processes are in place for notifying the Aboriginal Liaison Support officer.
- Interpreter service or other communication assistance is provided as required.

9.1.2 *Leadership*

- Nominate a leader at each clinical handover meeting.
- The leader must have a good understanding of the local handover process and of their role as leader.
- Ensure the patient and their Patient/Carer/Family is prepared regarding the handover process.
- The leader must support and orientate new staff to the handover process.
  Handover participants
- Handover is attended by relevant members of the multidisciplinary team who;
    - Arrive prepared with up-to-date information and knowledge of the patient's clinical situation
    - Are provided the opportunity to ask questions and to seek clarity

9.1.3 *Handover time*

- Routine handover (ie shift to shift handover) must occur at an agreed time with expectations around duration of handover clearly communicated.
- Ensure the handover process remains interruption free (with the exception of emergencies).
- Have in place strategies to reinforce punctuality and maximise focus of attendees e.g. minimise paging and texting.

9.1.4 *Handover place*

- Handover where possible should occur at the bedside and in the presence of the patient.
- Establish an agreed location for handover.
- Ensure access to patient results and records.

9.1.5 *Handover process*

Develop tools such as flow charts, bedside safety scan checklists (see example in Appendix V) and scripts to help keep clinical handover relevant, succinct and consistent.

A documented and approved process must be developed and adopted by each clinical unit/department. See Appendix II for MH specific resources, and Appendix IV for a suggested Allied Health processes.

ISBAR is the preferred communication tool in SLHD. See Appendix I for information and Appendix II for MH specific resources.

- Clinical concerns are escalated immediately as per the local Clinical Emergency Response System (CERS) protocols.
- All Rapid Response Calls and Clinical Review Calls that have occurred during the preceding shift must be discussed at the beginning of any subsequent handover. This is applicable to Nursing, Medical and Allied Health clinicians.
- Processes for clinical handover should align with the Between the Flags Program.
- Refer to Appendix II for MH specific resources.

9.2 Patient Confidentiality

- Patient privacy must be maintained at all times.
- Care must be taken where sensitive information about the patient is handed over, avoiding shared areas where possible.
- Clinicians should be aware of the surrounding environment.
- Printed or written clinical handover sheets or patient identified documents are to be disposed of at the end of each shift in a way that ensures patient confidentiality.

9.3 Documentation

- Documentation of findings, management plans or changes of clinical condition must be made in compliance with local guidelines/Policy.
- Develop and implement systems and tools to support structured clinical handover that is relevant to the healthcare setting and specialities.
- Processes and tools should be reviewed regularly.
- Cross-check documentation has occurred in eMR and on paper when using hybrid systems.
- Local processes should include the requirement for clinicians to refer to patient charts (paper or eMR) to demonstrate trends or tasks that remain outstanding.
- Where available and SLHD clinicians should use Cerner PowerChart/CHOC to document Clinical Handover.

10. Definitions

Clinical handover	Clinical handover is the effective transfer of professional responsibility and accountability for 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. Professional responsibility relates to the person's duty of care to the patient/client and accountability is their obligation to the organisation and to colleagues.
Critical Information	Information that has a considerable impact on the patient's health, wellbeing or ongoing care (Physical or psychological). The availability of critical information may require a clinician to reassess or change a patient's comprehensive plan.
Deterioration	The process of a patient's clinical condition becoming progressively worse. Includes physical, mental and cognitive deterioration.

ISBAR	Acronym for the following structured communication tool Appendix 1): Stands for; Introduction, **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation.
REACH	REACH is a system that helps patient/carer/family's escalate their concerns with staff about worrying changes in a patient's condition. It stands for Recognise, Engage, Act, Call, Help is on its way

11. Consultation

SLHD Recognising and Responding to Clinical Deterioration Steering Committee

SLHD Executive Director of Nursing and Midwifery

SLHD Executive Director of Medical Services

SLHD Executive Director of Clinical Governance and Risk

SLHD Director of Allied Health

12. References

- NSW Health, Clinical Handover (PD2019_020)
- NSW Health Draft Clinical Handover Policy (2019)
  Australian Medical Association – Safe Handover: Safe patients" Guidance on clinical handover for clinicians and managers. Canberra (2006)
  https://ama.com.au/sites/default/files/documents/Clinical_Handover_0.pdf
  The OSSIE guide to Clinical Handover Improvement – Australian Commission on Safety and Quality in Healthcare (2009)
- https://www.slhd.nsw.gov.au/BTF/ISBAR.html
- Between the Flags Program http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/between-the-flags
- https://www.slhd.nsw.gov.au/btf /
- Responding to Needs of People with Disability during Hospitalisation
  https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_001.pdf

13. National Safety and Quality Standards, 2nd ed

Communicating for Safety Standard Recognising and Responding to Acute Clinical Deterioration in health care Standard.

Comprehensive Care Standard

Communicating for Safety Standard

Recognising and Responding to Acute Deterioration Standard

Appendix I – ISBAR Handover tool

ISBAR – Clinical Handover	
Introduction	✓ Introduce yourself, your role and location ✓ Introduction of team members ✓ Identify patient with 3 approved identifiers ✓ Acknowledge and include Patient/Family/Carer when present
Situation	✓ State the immediate clinical situation ✓ State particular issues, concerns or risks ✓ Identify risks – deteriorating patient, falls, allergies, Blood transfusion, limitations to resuscitation, security concerns
Background	✓ Provide relevant clinical history referring to medical record and/or eMR
Assessment	✓ Work through A-G physical assessment ✓ Refer to observations, medication and other clinical information relevant to the patient ✓ Summarise current risk management strategies ✓ Have observations breached CERS criteria?
Recommendations	✓ Recommendations/plan for this shift ✓ Refer to medical record or eMR ✓ Provide expected date of discharge ✓ List further assessments and actions required by whom and when ✓ State expected frequency of observations ✓ Request that receiver repeat back important observations

Appendix II – SLHD Mental Health specific resources

Template for shift-to-shift handover processes for MH staff - Shift to Shift Clinical Handover

ISBAR in Mental Health

Indicators of Deterioration in Mental Health Patients.

Appendix III – SLHD Nursing shift to shift Handover process.

Nursing Handover – Part 1 Overview

- <15 minutes in length, confidential handover outlining sensitive information, critical information, patient risks, changes in clinical condition, changes in resuscitation status and overview of new admissions.
- Given by outgoing team leader to all oncoming team members.
- Consider inclusion of non-clinical staff particularly in relation to patient and staff safety.
- It is not mandatory to present all patients in the brief. Only those that meet the criteria outlined above.
- Document onto an approved SLHD handover tool based on local protocols.

Examples of Risks: Aggression, blood transfusions in progress
Examples of changes in clinical condition/Critical information: CERS calls in last 24 hours, changes in mental state, and limitations to resuscitation, increase in frequency of observations
Examples of incidents: fall, Pressure Injury, medication error

Nursing Handover – Part 2 Bedside

- **Introduce** all team members and their roles to patient and family. Speak to and invite the patient and family to contribute to handover if they are able and wish to do so. Enquire with patient around comfort and pain. Explain that the team will "refer to computer/papers" during handover.
- Confirm patient's **identity** using three approved patient identifiers – name, DOB and MRN, or name, DOB & address where supported by local protocols ie. Community Mental Health. Ensure paper and eMR documents referred to in handover all align.
- Ask patient if they have any **allergies**. Confirm armband and eMR align.
- Identify any overdue or incomplete tasks/assessments. If using eMR this would be done through Care Compass.
- Refer to **patient's medical record** (if using eMR this would be done through Patient Summary Page) and outline:
    - Summary of relevant background and current clinical situation
    - Emphasis any **critical information** that may prompt reassessment or changes in comprehensive care plan
    - Review of the most recent set of observations noting any trends
    - Review medication and fluids and confirm against orders
    - Review of risk assessments and required actions
    - Assessment of outstanding test results which require follow-up, for example, scans, x-rays and blood tests
    - Confirm completion of all documentation.
- Conduct **Bedside Safety scan** (develop and use an agreed local tool)
- Identify **patient goals** and preferences
- Transition of care/**discharge planning** - timeframes and requirements
- Ask **patient and family** if there is anything else they would like to add or if they have any questions.
- Update bedside communication/mobility boards to acknowledge acceptance of responsibility for the care of the patient by the clinician receiving handover.

Appendix IV - SLHD Clinical Handover in Allied Health

The purpose of the clinical handover in Allied Health is to transfer patient information between shifts/ rosters (e.g. Weekend to week day, morning to afternoon), between services (e.g. Acute to Rehabilitation, from one ward therapist to another), between facilities, in times of unexpected or planned leave (e.g. Sick leave, holidays etc) and between service types (e.g. Inpatient to outpatient/ community service / Residential aged care facilities). Handover also provides a forum for teaching, team building, and promoting team cohesion.

Clinical handover occurs in multiples situations for Allied Health. Each situation has very different requirements to ensure patient and staff safety

The minimum requirements and expected timeframes for each type of handover are detailed below:

Handover Opportunity	Example	Minimum Expectations	Time Frame
Handover of clinical contact / interventions / assessment / therapy	Documentation of clinical contact, therapy, assessment	• Clinical documentation as per local Clinical Documentation Policy • Recognised forms or medical records per local guidelines	• Immediately following intervention or as per local policy / guidelines.
Handover from therapist to therapist / shifts	Planned leave, from weekday to weekend/on-call, between part time employees	• Written handover as per departmental guidelines and policies	• Must be prepared prior to handover event.
Unplanned handover between therapists/ shifts	Unplanned leave	• Phone contact with relevant handover provided to Senior • Thorough review of clinical documentation in Clinical record	• As soon as leave is known or at commencement of shift (minimum) • Prior to seeing patient

Handover between wards	ICU → ward, acute → sub acute/rehabilitation	• Verbal handover / triage/ written handover as per departmental guidelines and policies.	• In advance when aware of transfer. • In event of unplanned transfer, handover should occur as soon as possible once aware of transfer (within 4 working hours).
Handover between facilities in the Health Service	Inter-hospital transfers within Health Service, transfer to outpatient services within Health Service	• Written handover as per departmental guidelines and policies. • Verbal handover ('flagging') of patient appropriate prior to written handover, however, written handover is required.	• In advance/prior to transfer if aware of transfer. • In event of unplanned transfer, handover should occur as soon as possible once aware of transfer (within 4 working hours).
Handover Opportunity	**Example**	**Minimum Expectations**	**Time Frame**
Handover between disciplines	Referrals, case conferences, deteriorating patients	• Case conferences: Verbal handover appropriate if attending case conference. In absence of attendance, written handover should be provided to appropriate person.	• Case conferences: handover should be prepared prior to handover event in absence of attendance. Online handover for attendance.
Handover between disciplines (cont)	Referrals, case conferences, deteriorating patients (cont)	• Referrals: Verbal referrals where appropriate followed by online referral(as required per local policies) and should be recorded in relevant medical records to reflect referral. • Deteriorating patients: Immediate verbal handover (per DETECT framework). Written handover should be	• Referrals: Immediately as appropriate with documentation of referral in relevant medical records. • Deteriorating patients: Immediately with all handover.

		provided for patients of concern. Should be recorded in the relevant medical record.	
Handover between services / Transfer of care	External to Health Service – ADHC, community health, Residential Aged Care Facility (RACF), General Practitioner (GP)	• Written handover is required for all handover of information • Verbal handover ('flagging') appropriate prior to provision of written handover, but not as an alternative to written handover.	• Dependant on service and as per local guidelines / service guidelines. • RACF and GP handover should be immediately on discharge of patient and should be reflected in relevant medical records.
Discharge of Care	End of episode of care with no further transfer of care	• Written handover per clinical documentation guidelines. All discharges of care episodes should be reflected in the relevant medical record.	• Immediately following discharge of care.

Appendix V SLHD – Bedside Safety Scan

Bedside safety scan: A standing item checklist designed specifically for each ward/unit which may include any of the following and other items to check during or immediately after bedside handover;

Call bell within reach of patient, patient comfort, Bedside communication board up to date, mobility board up to date, name of nurse updated, equipment functioning correctly (e.g. suction, air & oxygen), alarm parameters, access to mobility aids, drips, drains, cannula and catheters checked (noting insertion date and plan for removal), wounds, completion of GCS, Circulation observations, diet modifications, bed rest, fluid restrictions, fluid balance, bowels, REACH information for patient and family, VTE prophylaxis, physical environment and pain.