



IMPLEMENTATION TOOLKIT

Standard Key Principles for Clinical Handover

Another initiative of

CARING TOGETHER
The Health Action Plan for NSW

NSW  **HEALTH**

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SAFE CLINICAL HANDOVER

KEY PRINCIPLES FOR SAFE AND EFFECTIVE HANDOVER

Clinical handover is the effective...

...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.

- Safe Handover: Safe Patients' guideline (AMA, 2006) • United Kingdom National Patient Safety Agency (2004)
- The OSSIE Guide to Clinical Handover Improvement – Australian Commission on Safety and Quality in Health Care (2009)

Does your process for clinical handover meet these standard key principles?

1. Leadership

- Nominate a leader at each clinical handover.

2. Valuing Handover

- Set the expectation that clinical handover is valued and an essential part of daily work. Ensure staff are available to attend for the handover of all patients relevant to them.

3. Handover Participants

- Identify and orient handover participants. Involve them in regular review of clinical handover processes.
- Wherever possible, patients and carers should be recognised and included as handover participants

4. Handover Time

- Set an agreed time, duration and frequency for clinical handover to occur.
- It is highly recommended that, where possible:**
 - strategies are in place to reinforce punctuality

5. Handover Place

- Set a specific location for clinical handover to occur.
- Preferably, clinical handover occurs:**
 - Face to face
 - In the patient's presence, where appropriate (bedside handover)

6. Handover Process

- Standardised Protocol:** Generate flow charts, scripts and cues for how clinical handover occurs each and every time. Your standard protocol should:
 - Clearly identify the patient, you and your role
 - State the immediate clinical situation of the patient
 - List the most important and recent observations
 - Provide relevant background/history to the patient's clinical situation
 - Identify assessments and actions that need to occur
 - Identify timeframes and requirements for transition of care
 - Promote the use of the patient record to cross-check information
 - Ensure documentation of all important findings or changes of condition
 - Ensure comprehension, acknowledgement and acceptance of responsibility for the patient by the clinician receiving handover

Clinical handover should be documented. Some examples of effective handover tools that aid clinical handover communication and documentation are explained in the implementation toolkit (e.g. ISOBAR, ISBAR, SBAR)

- Where the condition of a patient is deteriorating:** Escalate the management of these *patients as soon as a deterioration in condition is detected.*
- Other Critical Information:** Prioritise alerts for any other important information (e.g. outstanding actions, planned patient moves, Occupational Health and Safety risks impacting staff or patient safety).

SAFE CLINICAL HANDOVER

BACKGROUND TO HELP YOU MEET KEY PRINCIPLES

Clinical handover must be valued, supported and embedded

Objective

To contribute to optimal patient care by:

- Embedding the importance and value of effective clinical handover
- Standardising a set of high level key principles for all clinical handover

Origins of this document

The Acute Care Taskforce developed this document and the supporting implementation toolkit, following extensive consultation with Area Health Services, the Clinical Excellence Commission, the Australian Medical Association (NSW), the Greater Metropolitan Clinical Taskforce, other health priority taskforces and their sub-committees.

Cross-referencing of key principles has occurred with current guides published by the Australian Commission on Safety and Quality in Health Care and the Australian Medical Association.

Case for change

The Clinical Excellence Commission (Apr '09) reviewed Root Cause Analysis (RCA) and IIMS data (Jan '08—Apr '09), in relation to adverse events resulting from deficiencies in clinical handover.

All scenarios of clinical handover will benefit from standardisation of key principles, but the following were identified by RCA data as points of clinical handover that require the earliest priority for review:

- Community and General Practice to hospital
- Hospital to the community and General Practice
- Emergency Department to ward
- Multidisciplinary team handover
- Escalation of deteriorating patients
- High acuity to low acuity transfer (e.g. Intensive Care Unit to ward or recovery unit to ward)

- Nursing / midwifery shift to shift
- Junior to senior clinician
- Inter-facility transfer
- Between medical teams
- Transfer of mental health patients

Who should use this document?

This document should be used by all executive and clinical teams (medical, nursing and allied health) to improve clinical handover processes within and between teams. This document is supported by the **Clinical Handover Implementation Toolkit**.

A standardised process

Standardisation of handover will ensure effective, concise and complete communication in all clinical situations and facilitate care delivery.

Clinical handover does not just happen at the change of a shift

Clinical handover happens within and between teams. When reviewing clinical handover you need to consider situations where transfer of clinical information, responsibility and accountability impacts patient safety e.g.:

- 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 hospital
- Multidisciplinary team handover
- Patient transfers to, from and within the community

Although face to face handover is the preferred modality, it is recognised that many handovers appropriately require telephone communication.

Did you check all of the boxes on page i?

Even if you did, **this is not a paper exercise**. The *Clinical Handover Toolkit* will help you to:

1. Map your current clinical handover process.
2. Identify areas for process improvement.
3. Develop a plan to implement and continually re-evaluate your new process for clinical handover.

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Acknowledgements and Appreciation

Development of the standard key principles for clinical handover and supporting implementation materials is the result of distilling the existing work of many.

The standard key principles and supporting implementation toolkit are closely aligned with the work of the Australian Commission on Safety and Quality in Health Care and the "OSSIE Guide to Clinical Handover Improvement". Clinicians of the NSW health system should feel confident to use the OSSIE guide as an excellent supporting tool to the implementation of the standard key principles, outlined in this document.

The Clinical Handover Working Party was made up of Acute Care Taskforce Members and was responsible for the initial drafting and subsequent extensive review of the standard key principles, implementation toolkit and policy directive.

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The Acute Care Taskforce commenced work on standardising key principles for Clinical Handover in October 2008.

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In February and March 2009, experienced clinicians presented current clinical handover projects to the Acute Care Taskforce, generating the drive for the 'standard key principles'.

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An extensive consultation group received and gave comment on the 'standard key principles', implementation toolkit and policy directive associated with this project.

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Other experienced members of the health system have contributed valuable knowledge, experience and skills to the development of resources associated with the Clinical Handover Project.	
Professor Marianne Wallis	Griffith University, “ Bedside Nursing Handover and whiteboard assisted communication”
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Standardisation of handover...

...will ensure effective, concise and complete communication in all clinical situations and facilitate care delivery.

(2-page 'standard key principles' document)

The chain of accountability for a patient's health care journey cannot be broken. In a busy health system, with a mobile workforce, clinical handover is often inconsistent and undervalued for its importance. Clinical handover is a procedure that is potentially perilous for patient care.

The Acute Care Taskforce participated in extensive consultation with health leaders, expert clinicians and our valued health workforce across NSW in 2009.

This consultation process has resulted in the standardisation of clinical handover being given one of the highest priorities on the NSW Health agenda. A set of key principles have been developed during these consultations. This toolkit provides a "how-to" for individual hospitals to implement standard clinical handover practices. It also contains further background information on clinical handover.

More information, resources and contacts relating to the standardisation of key principles for clinical handover can be found at:

www.archi.net.au/e-library/clinical/nsw-handover

*Professor Jeremy Wilson (Co-Chair Acute Chair Taskforce)
Ms Vicki Manning (Co-Chair Acute Chair Taskforce)*

NOTE: The methodology, tools and templates that support this document are not mandatory or exclusive. Reference to other documents or guidelines to support local implementation of the standard key principles is endorsed.

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.^{1,2,3}

(1) Safe Handover: Safe Patients' guideline (AMA, 2006),
(2) United Kingdom National Patient Safety Agency (2004),
(3) The OSSIE Guide to Clinical Handover Improvement – Australian Commission on Safety and Quality in Health Care (2009)

Executive Summary

The Acute Care Taskforce has developed standard key principles that apply to all types of clinical handover. Work to improve clinical handover is supported locally, nationally and internationally:

- **NSW** – Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals Report and the 'Caring Together' implementation.
- **Nationally** – Australian Commission on Safety and Quality in Health Care – key focus for 2009.
- **Internationally** – World Health Organisation (WHO): High 5s priority – Communication during patient care handovers.

Project Objectives:

To contribute to optimal patient care by:

1. Embedding the importance and value of effective clinical handover.
2. Standardising a set of high level key principles for all clinical handover.

Levels of Implementation

There are different levels of implementation for the standard key principles:

- **State wide** – Development of standard key principles, supporting tools and policy directives. State-wide forums, road shows and monitoring of implementation progress.
- **Area Health Service wide** – High level implementation planning down and across clinical streams to prioritise clinical handover process review. Area Health Service evaluation and monitoring.

- **Facility wide** – Leveraging from established models for handover. Implementation planning down and across clinical streams to initiate local process review, evaluation and monitoring.
- **Local process** – Application of the standard key principles, with locally appropriate processes.

Who should use this document?

The information in this document will be useful to all executive and multidisciplinary clinical teams (medical, nursing and allied health) to improve clinical handover processes within and between teams.

The content and process redesign methodology of this document will be **most useful to** those undertaking clinical handover review and **process redesign at the local level** (e.g. unit managers, team leaders, senior clinicians).

Does this relate to the OSSIE Guide to Clinical Handover Improvement?

The Australian Commission on Safety and Quality in Health Care (ACSQHC) released the OSSIE Guide in March 2009. NSW Health has worked closely with ACSQHC to align principles and content of the two guides and encourages all clinicians involved in clinical handover redesign to review the OSSIE Guide.

<http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-05>

Future directions for clinical handover – “the bigger picture”

The standard key principles for clinical handover are designed to be applicable for implementation in all forms of clinical handover.

It is recognised that the launch and implementation of the key principles will be a springboard to further programs of work.

There are specific types of clinical handover that will require focused work at a state level to strengthen the standardisation and quality of handover processes.

Two possible examples are:

1. **Junior Medical Officer (JMO) to Junior Medical Officer Handover**

– JMOs are potentially very mobile across the health system, working in a variety of locations. For this reason, there is necessity for a higher level of handover process standardisation across the system for JMOs.

2. **Handover to and from General Practice**

– As patients move between primary care and public health facilities it is important to ensure effective clinical handover. A coordinated high level approach is required to supplement the consolidation of local communication and relationships.

How do I use this document?

1. Get some background in clinical handover - Pages 8-12



2. Take a closer look at the key principles - Pages 13-17



3. Brush up on redesign methodology - Pages 18-20

Appendix A – eLearning – it’s out there to support you.
Appendix B – Clinical Handover – Implementing Change.
Appendix C – An annual check up of clinical handover.



4. Decide on which models, tools and templates might be of help to you - Pages 21-36

Appendix D – Existing models of clinical handover.
Appendix E – Resources and useful links.
Appendix F – Tools.



All supporting tools and templates can be found at:

<http://www.archi.net.au/e-library/clinical/nsw-handover>



5. Review and redesign your clinical handover process

4

1.0 Matrix of Clinical Situations and Handover Options

There are a range of options for clinical handover that are considered to be "Recommended Options". Your task is to review the questions below and implement 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 patients.						
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	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4
	In the patient's presence (bedside handover)	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4
	Face to face verbal only	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4
	Checklist	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4
	In a common staff area	•••	•••	4 4 4	•••	4 4 4	•••
	Telephone handover	4 4 4	4 4 4	•••	4 4 4	4 4 4	4 4 4
	Mobile electronic tools	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4	4 4 4
	Detailed transfer letter	888	•••	888	•••	4 4 4	•••
Tape recording	888	888	888	888	888	888	888

** please refer to the Appendices to review some current examples of minimum data sets for existing models of clinical handover.

LEGEND	
4 4 4	Recommended Options
•••	Not Recommended
888	Should Never Occur

Handover Myth:....

...“Clinical handover only happens from shift to shift”
Have a look at the table.

2.0 Why we Need to Change

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.

2.1 Safe Handover : Safe Patients Guideline (Australian Medical Association, 2006)

This document provides examples of the potential effect of incomplete and substandard handover (see below).

Saturday morning handover	"Please take Mrs Smith's bloods, I think her kidney function may be deteriorating."
Saturday day shift	Mrs Smith's blood taken. Busy shift, so results not checked.
Saturday night handover	"Please check Mrs Smith's results."
Saturday night shift	Results chased and found with some difficulty after the ward insisted they had not been taken. Results appear normal.
Sunday morning handover	Handover interrupted by emergency call... Mrs Smith suffers a cardiac arrest.
Basic information was missing in the handover that could have saved a life.	<ul style="list-style-type: none"> • There were two Mrs Smiths on the ward. • The full reasons for the investigations were not explained. • An action plan following the investigations was not devised.

2.2 Clinical Excellence Commission (CEC) review of Root Cause Analysis and IIMS data

In April 2009 the Clinical Excellence Commission reviewed Root Cause Analysis data for evidence that clinical handover is a contributing factor to adverse patient events and outcomes.

The review found that approximately **300** incidents across NSW are subject to a **Root Cause Analysis** regarding 'Clinical Management'. Many of these are due to sub-optimal communication and clinical handover.

Close review of a selection of Root Cause Analysis incidents revealed that the points of clinical handover that should be the highest priority for process review are:

- Escalation of deteriorating patients
- High acuity to low acuity transfer (e.g. Intensive Care Unit to ward or recovery unit to ward)

- Junior to senior clinicians (particularly between medical teams)
- Inter-facility transfer
- Community and General Practice to hospital
- Hospital to community and General Practice
- Transfer of mental health patients
- Emergency Department to ward
- Multidisciplinary team handover
- Nursing / midwifery shift to shift

Garling Recommendation #56...

...Within 18 months, NSW Health should ensure that each hospital designs and introduces a mandatory shift handover policy, which includes, as a minimum: Pg 540.

- (a) A requirement that part of the handover occurs at the patient's bedside;*
- (b) A requirement that sufficient time designated for handover is built into the rostering system;*
- (c) A requirement for the information which is to be conveyed during handover; and*
- (d) A requirement that a written or electronic record be made of the handover*

2.3 Australian Commission on Safety and Quality in Health Care

Clinical handover is a key initiative for the **Australian Commission on Safety and Quality in Health Care** in 2009. The commission has made three major publications on clinical handover since 2008:

- "A Structured Evidence-based Literature Review regarding the Effectiveness of Improvement Interventions in Clinical Handover" (April 2008).
- "OSSIE Guide to Clinical Handover Improvement – for clinician-leaders and managers" (March 2009).
- "Clinical Handover: critical communication" – Medical Journal of Australia Supplement (1st June 2009).

Key findings of the literature review support the standardising of clinical handover:

- High risk scenarios for clinical handover are consistent with those that emerged in the CEC Root Cause Analysis data review.
- Minimum data set standardisation improved clinical handover.
- Standard operating protocols improved clinical handover.
- Education and training improved staff confidence in undertaking clinical handover.
- Effective change management is necessary to implement new clinical handover processes.

2.4 Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals

The **Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals**⁷ ("Garling Report" – November 2008) made extensive recommendations regarding the requirement for improved policy and process of communication in the hospital system. Clinical handover was specifically addressed in recommendation 56 and has been included in the first stage of the NSW Government "Caring Together" response for implementation.

2.5 World Health Organisation (WHO), Action on Patient Safety: High 5s

The World Health Organisation is committed to improvements in clinical handover, via its "Action on Patient Safety: High 5s":

- Managing concentrated injectable medicines.
- Assuring medication accuracy at transitions in care.
- **Communication during patient care handovers.**
- Improved hand hygiene to prevent health care associated infections.
- Performance of correct procedure at correct body sites.

3.0 Why Clinical Handover is Fundamental to Patient Care

Inadequate communication of key information, at the time of transfer of care, is often a contributing factor to incidents. The following stories demonstrate how relatively small details can impact on outcomes for patients.

These stories are actual events that have occurred due to poor clinical handover. Data has been reviewed from:

- IIMS Jan - April 2009.
- RCA's from Jan 08 - April 09; RCA reports reviewed where handover was listed as one of the top 3 system issues contributing to the incident.

All of the listed poor outcomes for patients should have been avoided and would benefit from the implementation of standard key principles for clinical handover.

3.1 Handover at patient transfer from ICU to Ward

Mr X was admitted to hospital with a brainstem stroke. Once there he deteriorated, was intubated and was transferred to ICU where he had a prolonged stay. Mr X was in and out of consciousness and had a tracheostomy which prevented him from speaking. While conscious he was able to do what was instructed of him.

At night time Mr X would become agitated and needed sedating and restraining. During these episodes Mr X removed his nasogastric tube about 3 times, and even did this on the night before he was transferred to the ward.

Handover from ICU to the Acute Stroke Ward was given verbally, it appeared incomplete and the content was not documented. During investigation it was not clear if information about the patient's night time agitation, sedating and restraining was communicated.

On the ward Mr X was not restrained or sedated during the night. Subsequently he removed his nasogastric tube and his tracheostomy tube. When he was found he was unresponsive and unable to be resuscitated.

3.2 Handover at transfer of care post renal transplant

Miss Y had **undergone a renal transplant in 2006** and was now being admitted to hospital in 2008 with septicaemia (fungus in urine and blood), hydronephrosis and acute renal failure requiring dialysis.

Stents are usually removed 4-6 weeks after transplant. On investigation it was found there had been a **failure in communication on discharge**. Following the initial procedure the ureteric stent remained in Miss Y. Communication about the stents removal did not occur.

Miss Y now has a **failed renal transplant and is dependant on dialysis**.

3.3 Handover of patient transferring between hospitals

Mr T was being transferred between hospitals and was administered opiates en route; however this was not documented in his patient record.

On arrival, Mr T was admitted directly to the ward and his observations were documented outside the normal range (hypoxic and hypotensive). No communication took place between staff about these abnormal observations.

When the medical team came to see Mr T about 2 hours later they found him unresponsive with fixed "pin-point" pupils and a decision was made to administer Naloxone. Fortunately, the patient regained consciousness.

Is this a common problem?...

...It's midnight and the VMO is probably already in bed... Mrs Jones blood pressure is down a bit, she will be alright until the morning.

*Clinical Handover is fundamental to patient care – escalating the management of a deteriorating patient is essential.
There must be a process that Mrs Jones's care is not jeopardised by the hour of the day.*

3.4 Handover of patient at shift to shift change

Mrs Q had been admitted to hospital with pregnancy-induced hypertension.

When night staff were handing over their patients it was done in a rush, as they were keen to get home after a busy night. The handover was **conducted in the doorway** of Mrs Q's room, although Mrs Q was not involved and no opportunity was given for the day-staff to check any of the information in the charts.

The night-staff were also not keen to do the usual counts of medications with morning staff.

The night-staff handed over to the day-staff that Mrs Q's diastolic blood pressure was 95mmHg, although they did not mention that they had not administered the morning dose of her antihypertensive medication as prescribed.

Later in the morning, when the day-staff checked with the patient, she said she remembered her blood pressure being taken but no medication was given.

Her BP at this time was 160/100.

4.0 Standard Key Principles – The Extended Version

The 'Standard Key Principles' for clinical handover are applicable to all types of clinical handover. They will provide standardisation, but promote flexibility at the local level.

Supporting each of the 'Standard Key Principles' are a number of vital elements (below), that you should carefully consider prior to redesigning your current handover processes.

The following points closely align with the "OSSIE Guide to Clinical Handover Improvement" – Chapter 4: Simple Solution Development, released by the Australian Commission on Safety and Quality in Health Care, March 2009.

4.1 LEADERSHIP — Nominate a leader at each clinical handover.

- The larger the handover process (i.e. more handover participants) the more important the role of the leader becomes to manage clinical handover.
- The leader for handover must have a comprehensive understanding of the handover process and their role as the leader.
- The leader ensures that all participants attend and are heard.
- Immediate escalation of deteriorating patients for action must be undertaken by the leader.

Handover Issue:...

...*"Ok, I can lead... but what do I do?"*

The role of the leader is imperative to effective handover day.

Handover Issue:...

...*"I'm meant to lead handover today, can you do it?"*

Handover is fundamental to patient care – the leader must be committed.

4.2 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.

- Innovative solutions may be required to reinforce the importance of attendance at clinical handover.

Handover Issue:...

"If you need me, just page, I'm only in handover."

Some calls are important, but handover must be valued as fundamental to patient care.

4.3 HANDOVER PARTICIPANTS — Identify and orient handover participants. Involve them in regular review of the clinical handover process.

Wherever possible, patients and carers should be recognised and included as handover participants.

- Identify the staff that must be present for clinical handover to occur.
- In multidisciplinary teams, handover should be structured to allow staff to be present for patients relevant to them and then released.

4.4 HANDOVER TIME — Set an agreed time, duration and frequency for clinical handover to occur

It is highly recommended that, where possible, strategies are in place to reinforce punctuality.

- Clinical handover is not just at shift change, but every time a change of accountability and responsibility occurs – e.g. consider when a patient is transported from the ward to a test (refer to the matrix on page 8).
- Timeliness of handover is imperative to ensure a sustainable and effective process.

Handover Issue:...

...*"Sorry, we started a bit late."*

Handover must be timely, or people will just stop attending.

4.5 HANDOVER PLACE — Set a specific location for clinical handover to occur

Preferably, clinical handover occurs face to face and in the patient's presence, where appropriate (bedside handover).

Handover Issue:...

...*"What about patient confidentiality?"*

Some information is appropriate to hand over at the bedside and some is not. Use your clinical judgement, but involve the patient wherever you can.

- Taped handover is a practice that is considered inappropriate.
 - (Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals⁷ - Page 533) *"In my view, this process is manifestly inadequate and ought be discontinued."*
- If handover cannot happen face to face, then other options should be considered to ensure effective and safe clinical handover (refer to the matrix on page 8).
- Make sure that the handover place is as free from distractions as possible – e.g. pager noise, telephones and general ward noise.
- The Australian Commission on Safety and Quality in Health Care funded a pilot program into the development of a standard operating protocol for bedside nursing handover:
 - Griffith University Research Centre for Clinical Practice Innovation – "Bedside Handover and Whiteboard communication."
 - <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-05>

4.6 HANDOVER PROCESS — Define the clinical handover process:

4.6.1 STANDARDISED PROTOCOL — Generate flow charts, scripts and cues for how clinical handover occurs each and every time.

- Each process map must be relevant and developed for the particular clinical scenario and involve handover participants.
- Standardised scripts or cues in communication are available to assist in communication and documentation (See Appendices D – F).
- Taped handover is a practice that is considered inappropriate.
 - (Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals⁷ - Page 533) “ *In my view, this process is manifestly inadequate and ought be discontinued.*”

Each team needs to engage appropriate stakeholders (particularly the receivers of information) to review clinical handover processes.

Your standard protocol should:

Clearly identify the patient, you and your role

- There must be no mistaking the exact identity of the patient being handed over. Consider:
 - Patient name
 - Date of birth
 - Medical record number
 - Bed number

- In handover, there must be no mistaking for the person receiving handover, who you are and your current role in the delivery of safe care for the patient.
- Consider culturally and linguistically diverse interpreter requirements.

State the immediate clinical situation of the patient

- Is this a deteriorating patient, or are they stable or improving?
- Resuscitation status of the patient.
- What are the patient centred care requirements?

List the most important and recent observations

- Highlight any changes in the patient's condition, particularly any deteriorating observations.
- Identify the most relevant observations that must always be handed over.
- Observations must always include specific vital signs. They may also include a range of other observations, appropriate for the handover scenario (e.g. the level of independence/assistance in mobility would be important for in handover between physiotherapists).

Provide relevant background/history to the patient's clinical situation

This is the point in handover to sum up the patients relevant medical background, examinations, diagnosis and management in a few key points:

- Presenting problem with background history and current issues.
- Important examination and investigation results.
- Current diagnosis.
- Management to date – what has and has not worked?

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:

- A shared understanding of the current treatment plan.
- Identify and prioritise tasks that must be completed.
- Set accountability for tasks that must be completed.
- Plans and triggers for escalated communication to seniors.

Identify timeframes and requirements for transition of care

Make known the planned timeframes and requirements to progress a patient through their journey, whether it is to a higher or lower acuity of care.

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.

...OSSIE Guide to Clinical Handover Improvement (March 2009)



Engaging in verbal handover only, compared to verbal handover with some documentation, relies heavily on memory skills and has been classed as a high risk strategy (Bhabra et. al. 2007). The performance of doctors on simulated handover cycles showed that only 33% of information was retained after the first handover cycle and only 2.5% of information after five handover cycles (Pothier et al., 2005). However, using pre-prepared data sheets resulted in the full maintenance of data.



Ensure documentation of all important findings or changes in condition

- Determine what represents critical documentation for your clinical handover process, in both legal and patient care terms.
- It is recognised that documentation can include checklists, electronic tools and 'handover books' to supplement specific patient record documentation.

Ensure comprehension, acknowledgement and acceptance of responsibility for the patient by the clinician receiving handover

The transfer of critical information and risk mitigation plans, prior to transferring responsibility of a patient, cannot be ambiguous:

- Responsibility transfer and task acceptance – for example signing of handover sheets.
- Read-back critical information.
- Risk mitigation plans (If X happens, then call Y, because this patient will need Z).

4.6.2 WHERE THE CONDITION OF A PATIENT IS DETERIORATING — Escalate the management of these patients as soon as a deterioration in condition is detected.

- All PACE/MET/Patient Emergency calls that have occurred during the shift must be handed over.
- The Clinical Excellence Commission project – “*Between the Flags*” has developed significant resources regarding identification, management and communication of the deteriorating patient. Processes for clinical handover should also align with this work.
<http://www.cec.health.nsw.gov.au/moreinfo/betweentheflags.html>

4.6.3 OTHER CRITICAL INFORMATION — Prioritise alerts for any other important information (e.g. outstanding actions, planned patient moves, Occupational Health and Safety risks impacting staff or patient safety).

Examples of this information type include:

- Broken equipment and other key Occupational Health Safety and Injury Management advice.
- Knowledge of planned patient movements for tests or ward transfers.
- Knowledge of specific and relevant shift staffing pressures.

Appendix A

eLearning – it's out there to support you

In addition to the attached models, tools and templates, there is also eLearning support that can help you to review your clinical handover process.

NSW Health utilises GEM for online learning. Follow the link <https://gem.workstar.com.au>. Once you have self registered, click on the eLearning link to find the 'Clinical Handover – Implementing Change'.

The module contains summarised Centre for HealthCare Redesign Methodology.

The University of Queensland also has an online course for Clinical Handover. The development of this course was funded by the Australian Commission on Safety and Quality in Health Care and contains 6 hours worth of material. The course is free to all healthcare workers in Australia. Just follow the link:

http://www.uqhealthinsitu.com.au/products/ACSQHC8300/ACSQHC8300_brochure.cfm

What is Gem?

January 2009

Flexible learning opportunities for NSW Health Staff

In 2005 NSW Health received funding to implement a state-wide clinical process improvement program. Known as "Redesign" the program provides a way for health staff to **improve the systems and processes** that are used to deliver clinical care.

Using a proven Redesign Methodology frontline staff can identify when there are issues or processes adversely impacting patient journeys and then develop and implement better ways of providing care.



In August 2007 NSW Health also started training Redesign specialists through the **Centre for Healthcare Redesign**. This strategy is designed to improve capability and replicate the Redesign project management methodology without the use of external partners.

The Centre for Healthcare Redesign can only facilitate training of approximately 60 students in the classroom each year, so to share the knowledge the curriculum has been converted into a source of e-learning packages that provide flexible & accessible training for anyone working in NSW Health.

Further courses are planned for the future.



Modules and assessments are done at your own pace and your results will be uploaded into the workforce system.

Where to find Gem:
<https://gem.workstar.com.au>

Seeking feedback

Staff can 'self register' at the above internet address.

This is a new way of doing business and any feedback you can provide will be gratefully accepted.



Everyone can make a difference

By providing an accessible learning package we are able to provide ongoing education to all of our staff irrespective of their geographical location.

This assists all staff to apply a consistent approach to process improvement and project management to ensure quality.

Redesign Topics

The platform offers a number of short courses.

Introduction to Project Management

- Project Management
- Scoping a project
- Deliverables & scheduling

Redesign Project Initiation

- Introduction to Redesign
- Introduction to PM
- Scoping a project
- Deliverables & Scheduling
- Communications management
- Team Dynamics
- Stakeholder management
- Risk & Issues management

Redesign Diagnostics

- Patient & Carer interviews
- Root Cause Analysis
- Data analysis
- Baseline KPI's
- Process mapping
- Issues collection
- Issues prioritisation
- Hypothesis generation
- Statistical Process Control
- Theory of Constraints
- Presenting the Findings

Redesign Solution Design

- Literature Review
- Problem solving
- Cost Benefit Analysis
- Solution Design Statements

Redesign Implementation

- Accelerating Implementation Methodology (AIM)

Contact Centre & Communications

- Patient & Carer experience

Clinical Practice Improvement

For more information please visit <https://gem.workstar.com.au> or email chr@doh.health.nsw.gov.au

Clinical Handover – Implementing Change

Redesign Methodology is extremely helpful at bringing structure to your thinking and improves your chances for successful review of your clinical handover process, in line with the standard key principles.

An easy summary version of the Centre for Healthcare Redesign methodology can be found on the Clinical Handover website:

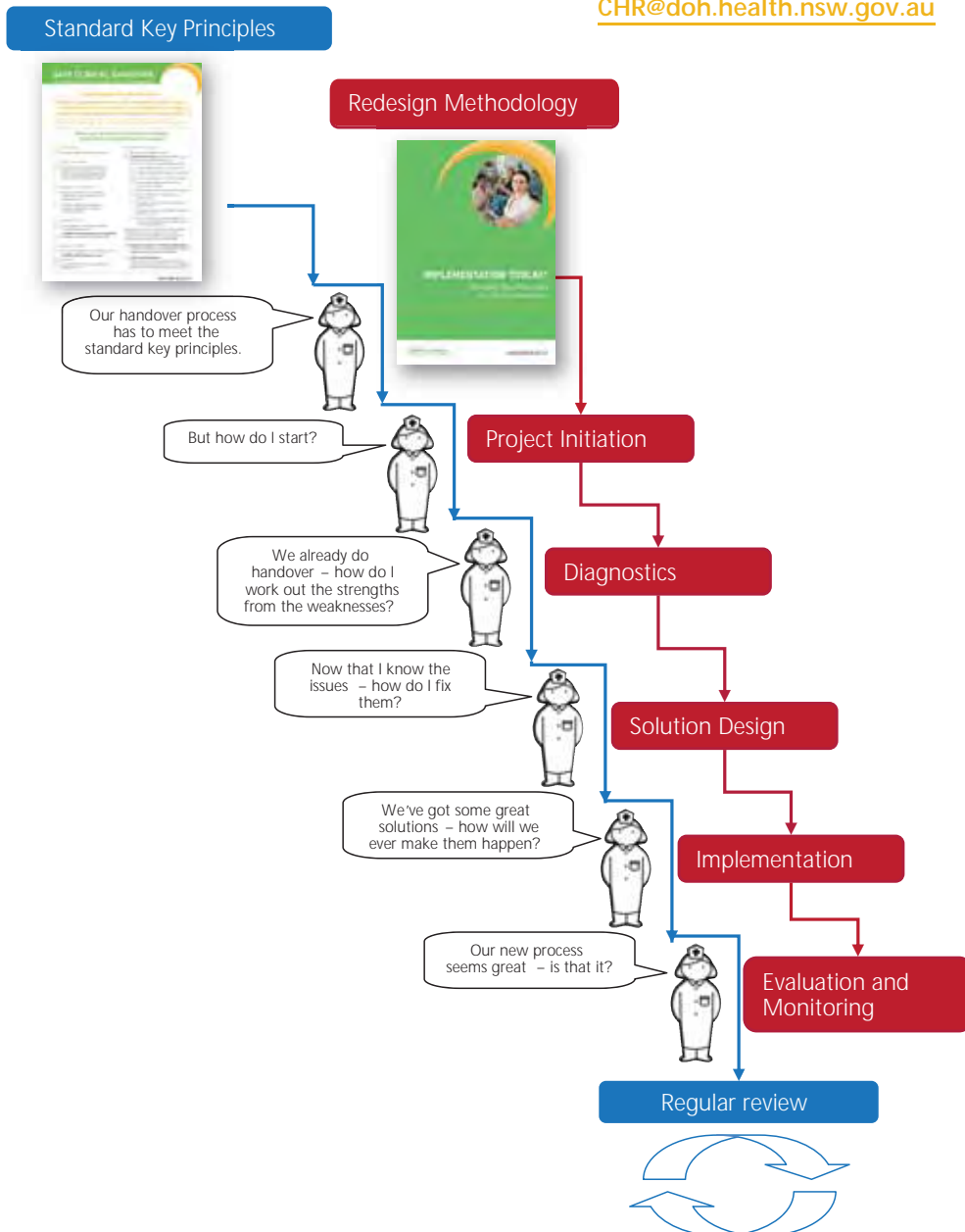
www.archi.net.au/e-library/clinical/nsw-handover

Supportive eLearning ('Clinical Handover – Implementing Change') is also available for you to use at:

<https://gem.workstar.com.au>

Contact - Centre for Healthcare Redesign

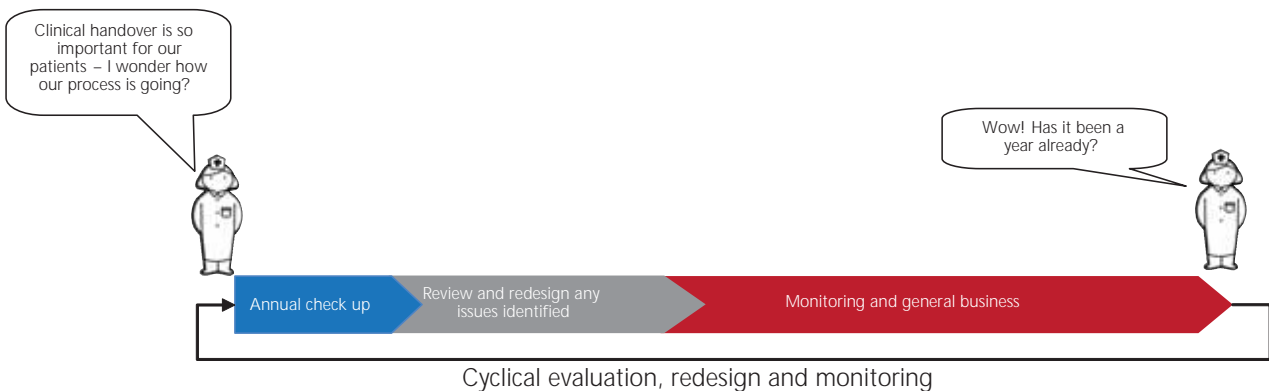
CHR@doh.health.nsw.gov.au



Appendix C

An Annual Check Up of Clinical Handover

Local evaluation of clinical handover process should be undertaken as part of an “annual check up”. The evaluation should be linked directly with the annual quality cycle to review local processes. For example:



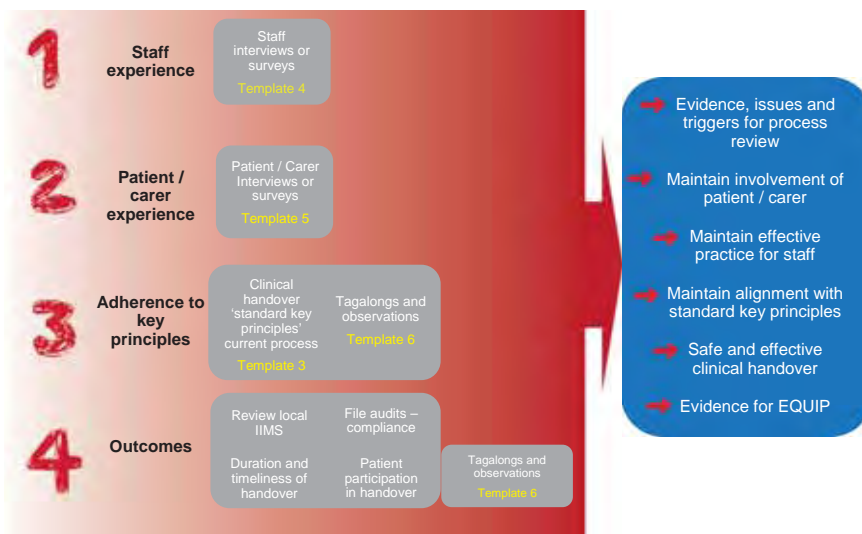
This Sounds Like a lot of Work!

If you’ve already done the work once, doing an annual check up will not be onerous and is good practice to ensure patient care.

There are a number of ways to evaluate your process of clinical handover. Below are four opportunities to consider. The good news is – **you already have the templates!** (Appendix F) – available to download at:

www.archi.net.au/e-library/clinical/nsw-handover

Local Evaluation of Clinical Handover - An Annual Checkup



Existing Models of Clinical Handover

Many excellent models of clinical handover exist in the NSW Health system, as well as interstate and internationally.

The models listed below represent a sample of current models in the NSW Health system that map to the 'Standard Key Principles' for clinical handover.

1. ISBAR: framework for communication.

Hunter and New England Area Health Service. (Funded by the Australian Commission on Safety and Quality in Health Care).



<p>I - INTRODUCTION</p> <p>Identify yourself (your name, role and location) and give a reason for calling.</p> <p>"I am calling because....."</p>
<p>S - SITUATION</p> <p>Give the patient's age and gender What is the patients's status now?</p> <p>A. Stable (but in danger of deterioration) b. unstable</p>
<p>B - BACKGROUND</p> <p>Give the relevant details such as presenting problems and clinical problems.</p>
<p>A - ASSESSMENT</p> <p>Put it all together (their current condition, risks and needs). What is their assessment?</p>
<p>R - RECOMMENDATION</p> <p>Be clear about what you are requesting. e.g. transfer/review/treatment?</p> <p>When should it happen?</p>

- Leadership** – Designed for one on one communication. The person handing over takes control as the leader.
- Valuing handover** – ISBAR has been adopted as an area-wide initiative for clinical handover and adopted from the top down. A suite of supporting tools have been developed and training is provided to all clinicians, managers, administrators and support services. Training program included as part of orientation and mandatory requirements.
- Handover participants** – The initiator and recipient of handover in all clinical situations.
- Handover time** – ISBAR is the designated framework for all verbal and written communication. ISBAR is used in all situations of clinical communication throughout the day.
- Handover place** – Applicable to all locations.
- Handover process** – please see summary below.

Before making the call:

1. Assess the patient
2. Read most recent notes
3. Have the chart in-hand if possible



I INTRODUCTION	
S SITUATION	
B BACKGROUND	
A ASSESSMENT	
R RECOMMENDATION	

Contacts can be found for the listed models on the Clinical Handover website

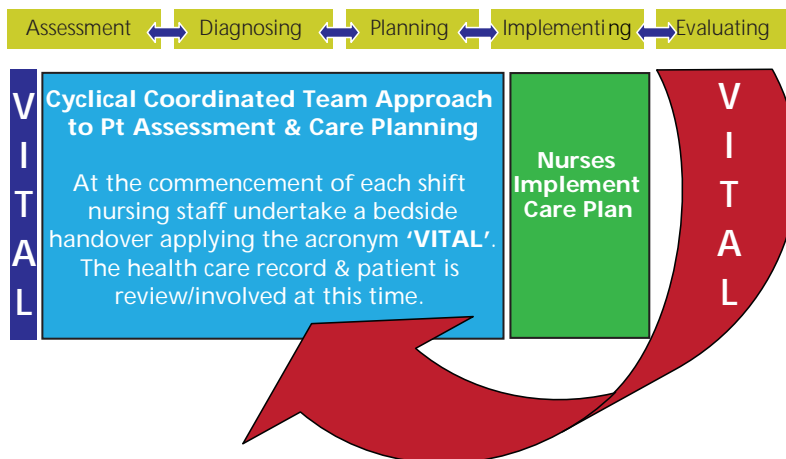
<http://www.archi.net.au/e-library/clinical/nsw-handover>

2. VITAL©: Nursing shift to shift and ward transfer handover.

South Eastern Sydney and Illawarra Area Health Service.
(© 2004-2007 O'Leary, Cade & Eagar)

1. **Leadership** – the outgoing nurse or nurse transferring patient.
2. **Valuing handover** –
 - a. Policy
 - b. Education
 - c. Developing Culture
 - d. Evaluation

3. **Handover participants** – Nursing staff and patients.
4. **Handover time** – At each nursing shift change. Handover lasts 15-30 minutes depending on the number of patients.
5. **Handover place** – Face to face at the patient's bedside. Evening handover occurs in a central location to avoid disturbing patients.
6. **Handover process** – please see summary below.



Content Outline of The 'I Do Vital©' Nursing Handover Process

I The 3 'I's'

Introduce self/team / ID patient /Infection control precautions /review alerts (i.e. wash hands etc).

Do Diagnosis & History

Refer to pt's diagnosis/history on handover sheet and/ or ask pt's to detail.

V Vital Signs & Observations

What were the last readings? What are my patient's current observations, resp rate / colour etc. What other observations are required? eg. Underwater seal drain, circulation observations etc. Are more frequent observations required?

I Input = Output

What is the patient's input and output? Does the patient need fluid balance monitoring? What is the

fluid balance? Is the patient displaying any signs of fluid imbalance? IV fluids & cannulae check.

T Treatment = Diagnosis

What treatment/medications is the patient receiving? Is this treatment appropriate for the patient's diagnosis? Is there any other treatment/ medications this patient should be receiving based on their diagnosis?

A Ambulation and Patient Safety

Can the patient move themselves around the bed independently? – if **no**, pressure area care is required. How does the patient mobilise? What falls risk strategies need to be implemented for this patient?

L© Legal and Patient Learning

What is written in the patient's medical record? Is all documentation complete? What does the patient / family need to learn today? e.g. Self monitoring, risk factors etc.

3. BEDSIDE PAEDIATRIC UNIT NURSING HANDOVER. North Coast Area Health Service.

- Leadership** – Nurse Unit Manager or In-charge of shift, to ensure that handover is undertaken at the bedside, safety checks completed and quality of handover.
- Valuing handover** – core business since 2007. Part of standard workflow for each shift.

- Handover participants** – Nursing staff, Intern (morning to afternoon shift), patients and carers, NUM.
- Handover time** – At each shift handover. Handover lasts 15-30 mins and is monitored by the leader to ensure timeliness.
- Handover place** – Bedside and face to face.
- Handover process** – see checklist below.

NORTH COAST AREA HEALTH SERVICE NSW HEALTH

Place patient identification details please

HANDOVER AND SAFETY CHECKS MEDICAL UNIT – CHBH

- During Clinical Handover, occurring ND-AM and AM-PM shifts all nurses are responsible for the following mandatory checks SEVEN days a week.
- Both nurses involved in the handover are responsible for signing off that the following checks have been completed during the handover period.
- Please indicate if the check was performed by recording Y/N or N/A.
- Each new patient is required to have a mandatory Checklist in their bedside chart.
- If attending the check e.g. armbands will disturb a sleeping patient please note 'asleep' in comments.

DATE										
SHIFT	ND-AM	AM-PM	ND-AM	AM-PM	ND-AM	AM-PM	ND-AM	AM-PM	ND-AM	AM-PM
Handover from NCP attended										
Handover Teams Plan										
Medication Chart All Meds Given										
Allergy section of NIMC complete										
Patient Arm Band Correct										
Check IV Cannula Site, sticker insitu										
IV line changed (Mon, Wed, Fri) ✓ lines labelled										
IDC Drainage Bag changed (Sunday)										
Wounds: Wound Chart check dressing										
Mobility Score at bedside and in NCP correct										
Falls Risk score recorded ✓ Orange Armband										
Nebulizer Mask renewed at 1600hrs										
O2 and suction equipment functioning										
NURSES INITIALS										

4. **PVITAL: Bedside shift to shift handover, utilising the clinical file. Sydney South West Area Health Service.**

1. **Leadership** – ED Senior Medical Officer, ED Nursing Team Leader, ED Clinical Nurse Consultant.
2. **Valuing handover** – Dedicated clinical handover time. Established via education, policy and planning.
3. **Handover participants** – Senior staff. All members of the ED clinical team.
4. **Handover time** – Nursing shift to shift handover. Multidisciplinary twice a day (AM & PM).
5. **Handover place** – Bedside and face to face.
6. **Handover process** – see details below.

P – Present patient by name, age & presenting problem Visualise patient & orientate patient to oncoming shift.

V – Vital Signs - Discuss & refer to vital signs / all observation charts & trending patterns.

I – Input / Output – Discuss / refer to input & output patterns of the patient – refer to the fluid balance record.

T – Treatment & Diagnosis – Treatment so far – effects or expected effects. Is the treatment matching the condition and diagnosis of the patient? Type & frequency of observation appropriate. What is the Plan?

A – Admission or discharge – Is either appropriate? What is the plan?

L – Legal and documentation – Ensure the patient has completed documentation of all aspects of care (medication chart, medical & nursing relevant signatures). Are the observations and sequence of events recorded & managed? Is a plan documented?

5. SBAR: Communication framework for nursing on all wards. Northern Sydney and Central Coast Area Health Service.

- Leadership** – Nurse in charge of shift to lead and ensure SBAR is being used.
- Valuing handover** – A set time is allocated for handover. Guidelines have been written on the expectation of what handover will consist of. Audits occur bimonthly.
- Handover participants** – All nurses are involved and oriented to the program including; employee orientation, mandatory study days, endorsed guidelines, information sheets are distributed to casuals and agency, posters and ID.
- Handover time** – Nurses shift handover times, 45 minutes allocated for each shift handover and is facilitated by the leader to remain on time.
- Handover place** – Nursing handover room. Trial has commenced for bedside handover.
- Handover process** – see checklist below.

INITIAL ACTION	DESCRIPTION	THINGS TO INCLUDE
S = SITUATION (Give this information in no more than 10 seconds)	Identify the situation you are calling about.	Identify your name & designation, the patient's name, bed number and briefly state the problem. When it started, and how severe it seems to be.
B = BACKGROUND	Explain the circumstances leading up to this situation.	Admitting diagnosis. Number of days into hospital admission.
A = ASSESSMENT	What do you think the problem is?	Most recent vital signs and observations relating to the call. Is the patient in the Orange warning zone on the Observation Chart? (Don't give the patient's entire history only what is relevant to your call). State how severe the problem seems to be. Try to determine which body system is involved and be systematic in your approach.
R = RECOMMENDATION (Timeframe and priority for review of the problem)	What would you like to see happen to resolve the problem or what would you do to correct it? Nb: 'Recommending' is requesting specific advice or actions regarding alterations in the patient's plan of care, it is not diagnosing what is happening to the patient.	Ensure an appropriate timeframe for review. Clarify frequency of observations pertinent to the situation you have phoned about. When you will contact them again should the situation worsen.

6. THE PATIENT SAFETY HANDOVER CHECKLIST (PSHC): Nursing and Midwifery Clinical Handover. Sydney West Area Health Service.

1. **Leadership** – Midwife/Nurse Unit Manager or Team Leader.
2. **Valuing handover** – Mandatory process with AHS approved protocol. Different wards have local implementation strategies. Monthly compliance audits. Engaged with AHS clinical governance.
3. **Handover participants** – Nurses and Midwives (including students) in partnership with patients/carers. Oriented via AHS PSHC Procedure.
4. **Handover time** – Nursing and midwifery handover occurs at all shift change times and transfer between wards and facilities.
5. **Handover place** – Patient Safety Handover Checklist is completed with the patient at the bedside. Confidential patient information e.g. Diagnosis, is encouraged to occur outside the patient room or a secure area.
6. **Handover process** – see chart next page.

Patient Safety Handover Checklist - General Medical/Surgical/Ante Natal

Binding margin - no writing

SYDNEY WEST AREA HEALTH SERVICE | NSW HEALTH

Please tick **Eastern**
 Auburn Blacktown Blue Mountains
 Cumberland Mt Druitt Lithgow
 Westmead Westmead Portland Springwood

Integrated Health
 Community Health Facility

Ward

SWHR-0631(a)

M.F.N.N.

Hospital/Facility/Community Health Centre

Family name

Given names

Sex

DOB

Address

Ward/Unit

All sections must be completed at the patients bedside with handover nurse at the end of each shift

A variance and any action taken as a result of this process must be documented in patients progress notes

Medication incidents entered in IIMS

Please mark **Y = Yes** or **N = No** in all appropriate boxes and initial at the bottom

*'N/A' denotes not applicable for this patient

*'A' denotes - patient is absent from the ward

Patient Safety Handover Checklist	Date		Date		Date		Date		Date		Date		Date		Date	
	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm	am	pm
Acute changes in patient status = Medical review																
I am concerned about this patient - Yes/No																
Heart rate > 140 or < 40																
Systolic BP < 90mmHg or > 200mmHg																
Respiratory rate > 36 or < 8 per minute																
Altered level of consciousness or GCS change ≥ 2																
Medication administered as prescribed, documentation completed																
IV access site free from signs of infection																
IV fluids administered according to IV orders and documented accordingly																
Input/Output Fluid Balance Chart completed																
Daily weight recorded																
Correct ID band on patient																
Allergy band on patient																
Falls risk identified and falls band on patient																
Oxygen and suction equipment functioning																
Equipment monitor alarms audible with appropriate parameters set																
CTG/FHR completed as per Policy																
Initials: Nurse/midwife handing over care																
Initials: Nurse/midwife accepting care																

518558 1/09

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7. ACT SHARP: Communication for escalating management of a deteriorating patient. The Wollongong Hospital

1. **Leadership** – Designed for one on one communication. The person handing over takes control as the leader.
2. **Valuing handover** – ACT SHARP is linked to the implementation of PACE education, policy and publicity at the Wollongong hospital.
3. **Handover participants** – The communication initiator and recipients.
4. **Handover time** – ACT SHARP is the designated framework for verbal and written communication for when patients are deteriorating.
5. **Handover place** – Applicable to all locations.
6. **Handover process** – see summary below.

**IF CONCERNED ABOUT A PATIENT 'ACT'
ASSESS the patient ▲ COMMUNICATE (Sharp)**

TIMEFRAMES for MEDICAL R/V

- Repeat vitals more frequently until issue resolved
- Document nursing assessment & Actions
- Follow pace protocol if pace parameters breach
- Consider ICU CNC for escalation or medical delay

S - Situation:

Identify the primary problem.

- State your name and Ward/Unit.
- State the patient's name.
- State the primary problem and the changes noted.

H - History/Background:

Identify the relevant history.

- State relevant medical history.
- State diagnosis & pertinent factors preceding deterioration.

A - Assessment:

Relay the clinical observations obtained. Provide most concerning vital signs and assessment findings first.

R - Recommendations:

Relay nursing interventions attended, request further instruction and agree on an appropriate timeframe for review. Do not assume the least worst scenario. Triage, consider the most serious complications that could be occurring and obtain review on this basis.

P - Put it in Writing:

Documentation is a legal requirement & includes:

- Physical assessment.
- Vital observations.
- Interventions attended.
- Agreed recommendations and timeframes for review.

Resources and Useful Links

There are a number of useful resources to review in line with your work on clinical handover:

NSW Health Clinical Handover website:

www.archi.net.au/e-library/clinical/nsw-handover

The Australian Commission on Safety and Quality in Health Care has committed to “The National Clinical Handover Initiative”:

<http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-05>

There are a number of very useful resources and links available on the National Clinical Handover Initiative website, including:

- 1 **OSSIE Guide to Clinical Handover Improvement** - A guide for reviewing and implementing new processes in clinical handover and is very closely aligned with this Toolkit.
- 2 **Literature review** – “A Structured Evidence-based Literature Review regarding the Effectiveness of Improvement Interventions in Clinical Handover”.
- 3 **Medical Journal of Australia Supplement** – published 1st June 2009.
- 4 **14 Pilot projects** are funded around Australia and are detailed on the website:
 - 4.1 Hunter New England Area Health Service – “ISBAR”
 - 4.2 University of Queensland Centre for Health Innovation and Solutions, Queensland Health Patient Safety Centre and Med-E-Serv Pty Ltd. – “Leading Clinical Handover”
 - 4.3 North East Valley Division of General Practice – “Transfer to hospital envelope”
 - 4.4 West Australian Country Health Service – “Identification and Development of standard clinical handover initiatives”
 - 4.5 South Australian Department of Health Clinical Systems Unit – “Communication, training and team training to support handover using TeamSTEPS”
 - 4.6 Griffith University Research Centre for Clinical Practice Innovation – “Bedside Handover and Whiteboard communication”
 - 4.7 Tasmania: Department of Health and Human Services – “Nursing and Medical Handover in General Surgery, Emergency Medicine and General Medicine and the Royal Hobart Hospital”
 - 4.8 Humanities and Social Sciences, University of Technology, Sydney – “Tools for ongoing observation, monitoring and evaluation of handover in order to ensure handover practices are resilient in the workplace”
 - 4.9 Albury-Wodonga Private Hospital – “The “PACT” (Patient Assessment; Assertive Communication; Continuum of Care; Teamwork with Trust) Program: communication training and team training to support handover”

- 4.10 Mater Health Services Brisbane Limited –
“SHAREing Obstetric Care: Clinical handover between VMOs and Midwives”
- 4.11 St John of God Health Services – *“Effective communication in the handover of private mental health patients to community health practitioners”*
- 4.12 Deakin University – *“Inter-professional communication and team climate in complex clinical handover situations”*
- 4.13 GP Partners – *“Improving Residential Aged Care facilities to Hospitals clinical handovers”*
- 4.14 South Australian Department of Health in collaboration with the University of Tasmania – *“SafeTECH – Safe tools for electronic clinical handover”*

**Australian Medical Association –
“Safe Handover : Safe Patients”**

<http://www.ama.com.au/node/4064>

**Clinical Excellence Commission –
“Between the Flags”**

<http://www.cec.health.nsw.gov.au/moreinfo/betweentheflags.html>

**World Health Organisation –
high 5s priorities for action**

<http://www.who.int/patientsafety/solutions/high5s/en/index.html>

Appendix F

Tools

1. Templates

A range of useful templates are available to help you as required in the review and redesign of your clinical handover process.

These templates relate directly to Appendix B, “*Clinical Handover – Implementing Change*” in this document.

All templates are available for download from the clinical handover website:

www.archi.net.au/e-library/clinical/nsw-handover

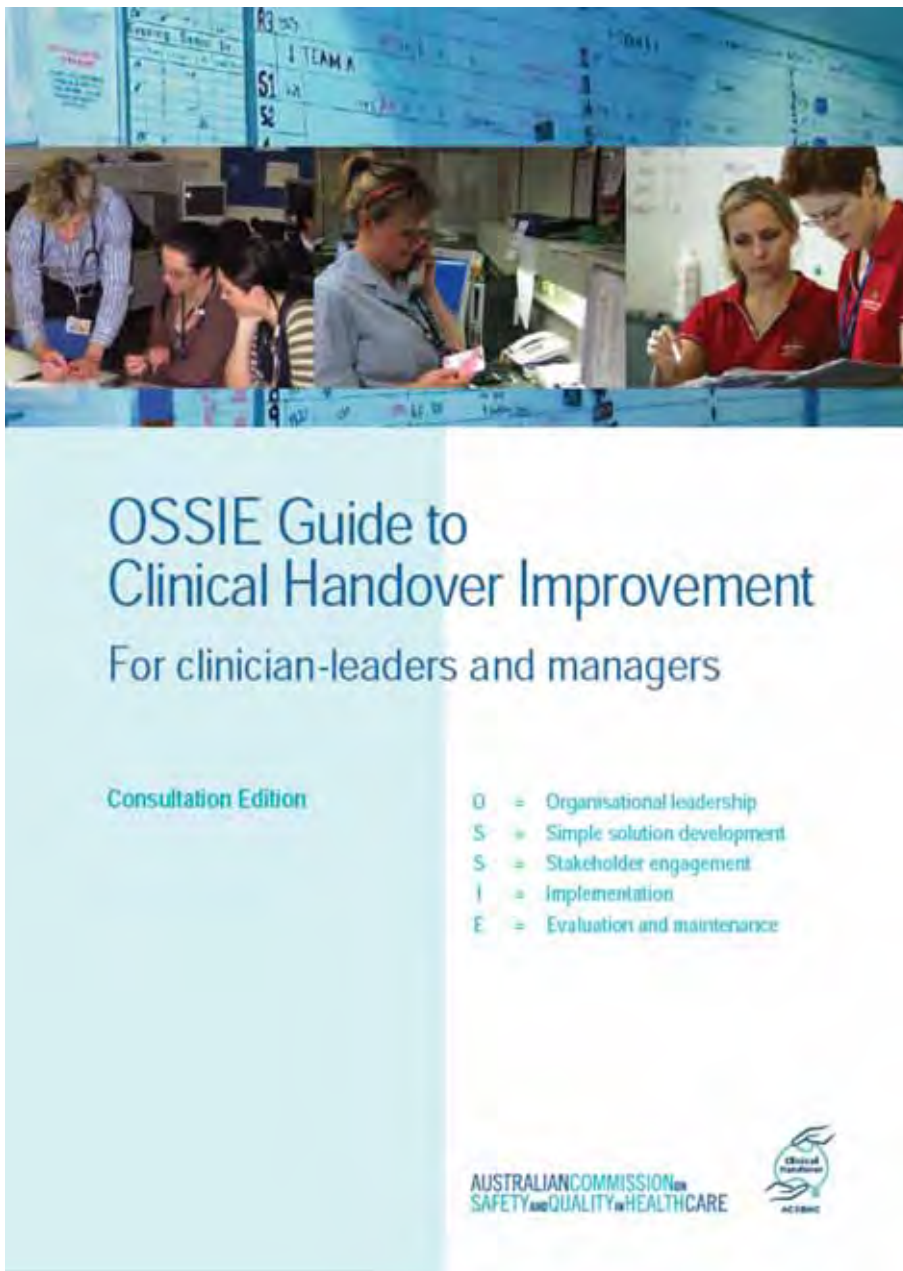
TEMPLATE			Reference to summary of “Clinical Handover – Implementing Change” www.archi.net.au/e-library/clinical/nsw-handover
Project Management	Template 1	Project Management Plan	Project Initiation
	Template 2	Communication Plan	Project Initiation
Clinical Handover Process Review and Redesign	Template 3	Clinical Handover ‘Standard Key Principles’ Current Process	Diagnostics
	Template 4	Clinical Handover Staff Interview	Diagnostics
	Template 5	Clinical Handover Patient/ Carer Interview	Diagnostics
	Template 6	Tag Along/Observations	Diagnostics
	Template 7	Flow Chart example	Diagnostics
	Template 8	Handover Issues Log	Diagnostics
	Template 9	Issues Prioritisation	Diagnostics
	Template 10	Solutions Prioritisation	Solution Design
	Template 11	Solution Design	Solution Design

2. OSSIE Guide to Clinical Handover Improvement

The Australian Commission on Safety and Quality in Health Care (ACSQHC) released the "OSSIE Guide" in March 2009.

NSW Health has worked closely with ACSQHC to align principles and content of the NSW Health clinical handover project and encourages all clinicians involved in clinical handover redesign to review the OSSIE Guide.

<http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-05>



3. Common Clinical Handover Mnemonics

A. ISOBAR - (REF. OSSIE Guide to Clinical Handover Improvement - Australian Commission on Safety and Quality in Health Care - March 2009)

I = Identification

S = Situation and Status

O = Observations

B = Background and History

A = Assessment and Actions

R = Responsibility and Risk Management

Note: if ISOBAR is being used to guide telephone handover, staff also need to clearly state their name and clinical role.

I = IDENTIFICATION OF PATIENT

This step ensures patients are correctly identified. Patient identification should include three identifiers, for example:

- Patient name
- Date of birth
- Medical record number

S= SITUATION

This step includes:

- The current clinical status (e.g. Stable, deteriorating, improving) and advanced directives.
- patient-centred care requirements including the prospect of discharge/transfer.

O = OBSERVATION

This step ensures the incoming team is informed of the latest observations of the patient and when they were taken. It serves as a checking mechanism to identify

deteriorating patients who might benefit from emergency response assistance. Unit members need an awareness of local emergency response call criteria and process.

B = BACKGROUND AND HISTORY

This step provides the incoming team with a summary of background information, current problems, evaluation and management to date.

- History (presenting problems background problems and current issues).
- Evaluation (physical examination findings, investigation findings and current diagnosis).
- Management to date and whether it is working.

A = ASSESSMENT AND ACTIONS

This step is to ensure that all tasks and abnormal or pending results are clearly communicated to the incoming team. Most importantly, there must be an established and agreed management plan and a plan for escalation of care.

- A shared understanding of what conditions are being treated, or, if the diagnosis is not known, that this is also clear to everyone.
- Tasks to be completed.
- Abnormal or pending results (must include recommendations and agreed plan and who to call if there is a problem).
- The plan for communication to the senior in charge.
- Accountability for actions needs to be clear.

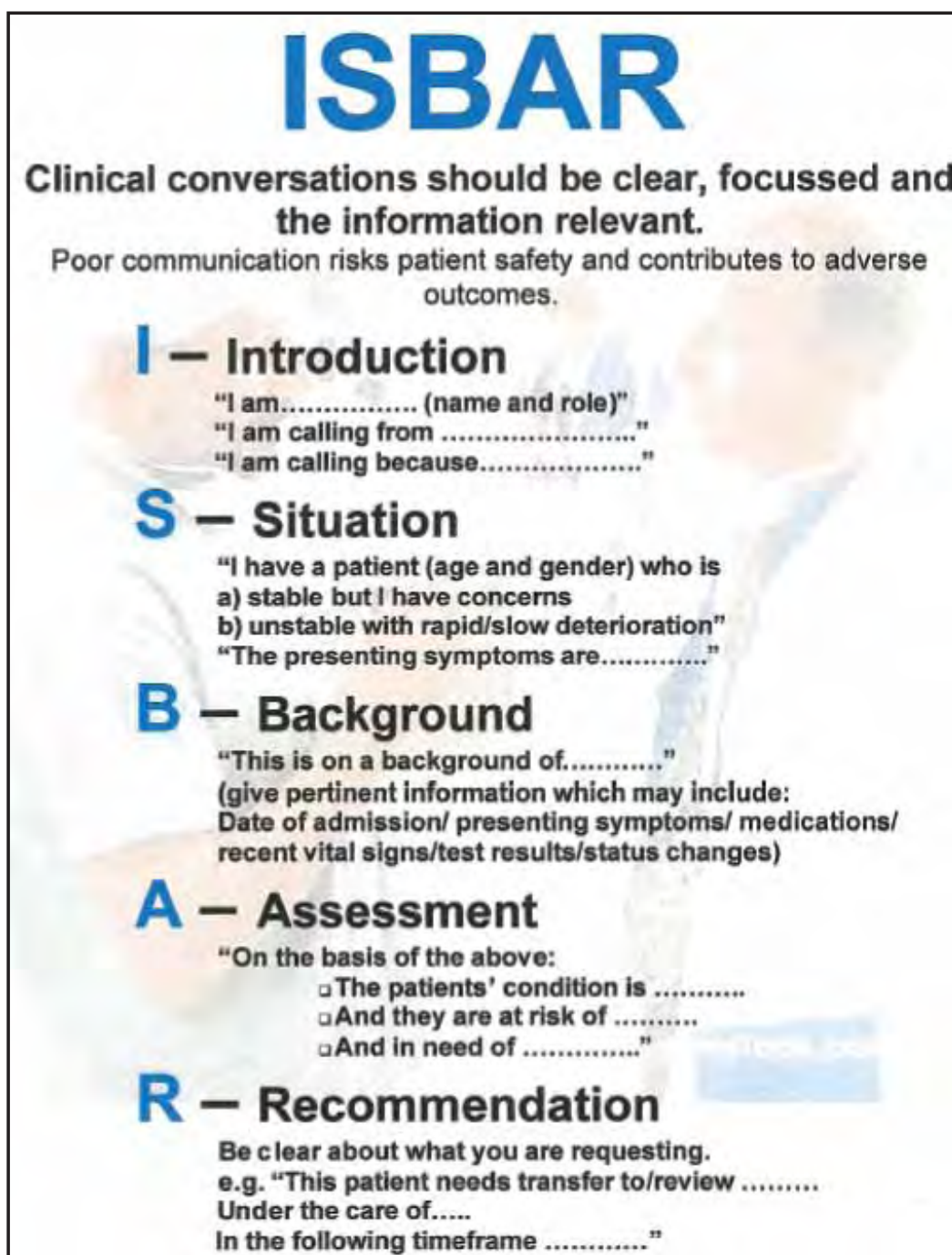
Example: Mr X had rectal bleeding in the early part of the shift. The surgical team think he has a bleeding diverticulum. The bleeding seems to have stopped but he is on 2 hourly observations and you need to repeat the haemoglobin in 4 hours.

R = RESPONSIBILITY

Clinical handover must include the transfer of responsibility as staff are leaving the institution. This can only be achieved through acceptance of tasks by the incoming team. This is best ensured by face-to-face handover. Where risks are identified for a patient, clinical risk management strategies, such as for infectious disease alerts for alerts for DVT prophylaxis, should be clearly communicated.

- Responsibility transfer and task acceptance ideally includes accepting handover sheets or signing of handover sheets.
- Read-back, of critical information, especially if the situations where face-to-face handover is not possible.
- Risks and management plans, for instance: 'his ulcer may bleed again, if this happens he needs to go to theatre, Dr Smith is aware of this and available tonight'.

B. ISBAR - (As used by Hunter and New England Area Health Service – Inter-Hospital Transfer)



ISBAR

Clinical conversations should be clear, focussed and the information relevant.
Poor communication risks patient safety and contributes to adverse outcomes.

I – Introduction
“I am..... (name and role)”
“I am calling from”
“I am calling because.....”

S – Situation
“I have a patient (age and gender) who is
a) stable but I have concerns
b) unstable with rapid/slow deterioration”
“The presenting symptoms are.....”

B – Background
“This is on a background of.....”
(give pertinent information which may include:
Date of admission/ presenting symptoms/ medications/
recent vital signs/test results/status changes)

A – Assessment
“On the basis of the above:
 The patients' condition is"
 And they are at risk of"
 And in need of"

R – Recommendation
Be clear about what you are requesting.
e.g. “This patient needs transfer to/review"
Under the care of.....
In the following timeframe"

C. SBAR – (As used by Northern Sydney and Central Coast Area Health Service)


GUIDELINES FOR COMMUNICATING WITH A PHYSICIAN "SBAR"

Prior to contacting the Medical Officer (MO) rapidly conduct a patient assessment

- Identify appropriate MO to call
- Read the most recent progress notes & review medication chart
- Have all patient charts and progress notes when speaking with MO

S **SITUATION**

- State your name and unit
- I am calling about - *state patient's name*
- The reason I am calling is.....



B **BACKGROUND** – utilising medical terminology

- State reason for patient admission, their diagnosis and recent procedures
- State pertinent medical history
- A brief synopsis of treatment to date

A **ASSESSMENT** - Most recent observations and state any changes in:

• Resp Rate, BP, Pulse (regularity/quality) Temp	• ECG – Rhythm changes	• Neurovascular limb observations
• Oxygen Therapy, Oxygen Saturation	• Alcohol Withdrawal (AWS)	• Skin colour
• Neurological (GCS) & Mental state	• Urine output, Fluid Balance	• Wound drainage
• Pain - PCA/ analgesia/ severity	• Diabetes – Blood Glucose Level (BGL)	• Gastric- NGT, bowels, vomiting

R **RECOMMENDATIONS**

Discuss actions that you would like to happen for the patient

- Come and review patient within an acceptable time frame, when to notify of further change in condition
- Organise an alternative team to review patient
- Transfer patient to ICU, ward, or alternative hospital
- Talk to patient and/or family

PLEASE DOCUMENT THIS COMMUNICATION IN THE PATIENT'S MEDICAL RECORD USING SBAR FORMAT

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