Policy for Clinical Handover

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Revisions

V1 Approved 15 March 2013

V2 Review of Version 1 March 2016

- Inclusion of the Alliance.
- Requirements of content of medical and nursing handover combined.

KEY WORDS

Medical Handover, Nursing Handover.

1 INTRODUCTION AND OVERVIEW

1.1 Continuity of information is vital to the safety of our patients. Effective handover needs to occur when shifts of staff change and patients move between areas within the hospitals or transfer between specialties.

1.2 All staff looking after an individual patient need to share relevant information about that patient.

1.3 Handing the care of a patient over to another multi-disciplinary team requires good communication and co-ordination. Good handover requires work by all those involved with responsibility for direct patient care. It also requires that clinical departments organise their services to facilitate effective handover.

1.4 There needs to be an embedded cultural awareness that handover is an essential and important aspect of clinical practice. Time and resource need to be dedicated to ensure that good handover is part of everyday clinical practice within UHL.

1.5 The fundamental objective of handover is to share relevant information to ensure that patients receive safe, efficient, high quality and responsive care. Clear lines of responsibility need to be identified for each patient. How handover is achieved and what is handed over needs to be clearly understood and shared by each specialty and monitored by each CMG.

2 POLICY SCOPE

2.1 This policy relates to all medical, nursing, and allied health professionals within UHL, including Bank and Agency staff, Locums and students.

2.2 This policy relates to all patients within UHL, including the Alliance.

3 DEFINITION OF HANDOVER

3.1 Handover is the transfer of responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or team/discipline on a temporary or permanent basis.

3.2 It is the transfer of all relevant information about an individual patient.

3.3 Effective handover is required when a patient moves between any area of the hospital to another (e.g. from a ward to endoscopy, from theatre to a ward, from ITU to a ward)

3.4 The term handover applies to transfer of care both within UHL and also from UHL to other health care partners such as community hospitals or care homes

3.5 Clinical handover provides a good opportunity to ensure all patients, or family and carers are involved and informed in care, treatment decisions and be able to respond to the following:

1. What is the matter with me?
2. What is going to happen today?
3. What is needed to get me home?
4. When am I going home?

4 ROLES AND RESPONSIBILITIES

4.1 Responsibilities within the Organisation

4.1.1 Chief Executive

Has the ultimate responsibility for the quality of care provided to patients within University Hospitals of Leicester. They have overall responsibility for implementation of this policy.

4.1.2 Executive Lead - Medical Director/ Chief Nurse

The Medical Director and Chief Nurse are jointly responsible for ensuring that when clinical handover takes place, it is done appropriately and in accordance with this policy. This includes ensuring there are appropriate systems in place to identify and train people to undertake clinical handover by overseeing the implementation and compliance with this Policy. The Medical Director and Chief Nurse are also responsible for ensuring there are appropriate systems in place for reporting compliance with this policy to the Board.

4.1.3 CMG Clinical Directors have a responsibility to ensure that:

- high-quality handover occurs between clinical teams for each patient in their CMG
- procedures are in place for handover between all groups of clinical staff within each department
- ensuring that each Consultant, Ward Sister and Allied Health Professional has satisfactory handover procedures in place for their patients and wards
- the implementation of Handover Guidance is audited in all their clinical areas

This responsibility can be delegated to Heads of Service.

4.1.4 Consultant, Ward Sister, Team Leaders and Head of Therapy Services

They have a responsibility for defining safe handover procedures in their clinical area and for monitoring these processes on a regular basis.

They are responsible for ensuring awareness of the importance of handover amongst their teams and for providing support and education as necessary.

4.1.5 All Clinical Staff

Handover is the responsibility of the clinical team looking after a particular patient and there is a responsibility for individual doctors, nurses and allied health professionals to handover accurate and timely information to colleagues.

All clinical staff should be aware of who is involved in handover, when, where, how and what are the handover arrangements within their area.

4.1.6 Hospital at Night (H@N) co-ordinators

The H@N co -ordinators are responsible for ensuring that the H@N handover process runs smoothly in line with the policy (Appendix 1) and that all junior doctors are in attendance. It is also their responsibility to ensure that the H@N handover attendance spreadsheet is completed and submitted.

5 POLICY STATEMENTS, STANDARDS*, PROCESSES*, PROCEDURES* AND ASSOCIATED DOCUMENTS

5.1 Where relevant, handover should be a multi-disciplinary team activity thereby reducing repetition within professional silos.

5.2 Where relevant, handover should be a teaching and learning opportunity for staff involved.

5.3 Individual clinical areas will have their own requirements for handover dictated by the complexity of the clinical work, the numbers of patients involved, their geographical distribution and their working patterns. It is therefore not possible to be prescriptive about handover arrangements but all areas should have pre-determined arrangements detailing how handover will occur (see section 6.5).

5.4 Hospital at Night handover:

5.4.1 All staff involved in H@N care must attend and comply with the requirements of the H@N handover process. This ensures all clinical staff available for work receive handover of all sick patients or patients requiring clinical intervention/review out of hours. This process also facilitates opportunity for registering onto the workload allocation system and receiving a hand held device for the allocation of Clinical jobs.

5.4.2 The process for H@N handover is documented in Appendix 1. Appendix 2 documents the current meeting time venues for each site.

5.4.3 Attendance at the H@N handover meetings is mandatory and is monitored by use of the H@N attendance spreadsheet that the co-ordinator fills in for each shift.

5.5 Specialty policy document

5.5.1 Each specialty will have an identified process that details the following for each

type of handover.

5.5.2 Who participates in handover

For effective handover senior input is essential with clear leadership during this process. Handover will be led by a suitably senior clinician who is responsible for the process. Multidisciplinary handover is to be encouraged when practical; however, the information requirements for medical, nursing and other allied health professionals are different and should be taken into account ensuring that all relevant information is shared between multidisciplinary groups. The need for multidisciplinary involvement should not be allowed to result in a handover which becomes unwieldy and inefficient.

5.5.3 When handover occurs

The time of handover should be clearly identified within each area and sufficient time should be allowed for handover. Different staff groups should be aware of handover time for colleagues and respect the need for others to focus on the process. Unnecessary interruptions should be avoided except for urgent matters.

5.5.4 Where handover occurs

Ideally handover should occur in a consistent place so that staff become familiar with this and time is not wasted looking for the venue. It should be free from distractions but within reasonable distance of the clinical area. Ideally there should be access to a networked PC to allow clarification of results if necessary. Nursing handover should also include a bedside handover. There may be some clinical areas where it is either impractical or unnecessary to have a face to face handover. CMGs should be clear where non face to face handover is occurring and have assurance that safe practice is being followed

5.5.5 How handover is be conducted

This will vary depending on the area but should follow a pre-determined format. Ad hoc handover often results in important information being omitted. The senior clinician/nurse/therapist present will provide supervision and clear leadership should be established. Information presented should be relevant and succinct.

It is recommended that the SBAR approach is followed for presenting information in a structured format (Appendix 3).

5.5.6 What information is to be relayed

Minimum dataset for patients handed over:

- demographics
- responsible consultant
- working diagnosis
- EWS/stability of the patient/if a review is needed, when and by whom
- management plan including fluid balance and nutritional requirements
- outstanding tests

- DNACPR status
- ceiling of care/End of Life status
- Infection Prevention status
- Risk Factors (e.g. Waterlow score, MUST score, VTE, Falls assessment, dementia screen if applicable)
- Other factors (e.g. DoLS, safeguarding)
- Medication issues
- Any information specific to that particular patient (e.g. pain control issues, communication needs of the patient)
- Estimated Date of Discharge
- Handover information is to be recorded electronically using the UHL approved platform, currently Nerve Centre

5.5.7 Responsibilities of and communication with stakeholders

On discharge from UHL, all patients will have a Discharge Summary to the General Practitioner which will detail the care received whilst in hospital and will handover the responsibility for care to the Primary Care team.

For patients transferred to another Hospital, details of care required will be included in the Discharge/Transfer letter.

For patients discharged to the care of the District Nursing team, details of care will be included in a District Nurse letter.

For patients being discharged to Community Hospital beds, a Medicines Administration Record (MAR) chart should be printed from Nervecentre immediately prior to discharge.

For patients discharged to a Care Home - a copy of the Discharge Summary should be provided and, where applicable, a copy of the District Nurse letter.

The above documents should be recorded on the UHL approved platform, currently ICE and/or Nervecentre.

6. EDUCATION AND TRAINING REQUIREMENTS

6.1 Clinical Handover is an integral part of being a health care professional. Guidance is available from relevant colleges – see Section 10.

6.2 Use of electronic handover (Nerve Centre) is included in the induction of all new clinical staff.

7 PROCESS FOR MONITORING COMPLIANCE

7.1 See Monitoring Compliance Table of Key Performance Indicators.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

9.1 Royal College of Physicians. 2011. Acute Care Toolkit 1. Handover May 2011

9.2 British Medical Association (2004) *Safe Handover: Safe Patients. Guidance on Clinical Handover for Clinicians and Managers*. BMA, London.

10. PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

POLICY MONITORING TABLE

The top row of the table provides information and descriptors and is to be removed in the final version of the document

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
H@N Handover attendance	H@N Lead	Sign sheets	Annually	ACACB
Handover takes place in each clinical area	Heads of Service and Matrons	Observational Audits	Annually	CMG Boards

Appendix 1

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Handover Meeting Schedule

For use at ALL H@N handover meetings

1. Please text / call all members of team 15 minutes prior to meeting start time and encourage them to attend early to prepare and complete handover sheets

2. Handover meetings to start at time specified: Projector to be on, NerveCentre loaded and displayed on screen
    a. AM: 09:00 (Bank Holidays / weekends)
    b. PM: 21:30 (every day)

3. Record attendance of all doctors as they arrive on the handover spreadsheet.
    a. If attending late, note this on separate audit sheet
    b. Also name on whiteboard in red pen
    c. Late attendees should not delay start time of meeting

SITUATION i.e. who is on Shift, staffing levels etc.

4. Meeting to be led by Co-ordinator to ensure each section is adequately covered

    a. Clinical aspects to be led by Incoming Med SpR

5. At start time, each team member to introduce themselves {role, grade, wards covered (for those finishing shift only)}

    a. Introductions in this order:
        i. Coordinator
        ii. Med SpR Incoming
        iii. Med SpR Outgoing
        iv. Incoming SHO's / FY1's
        v. Outgoing SHO's / FY1's

BACKGROUND i.e. what state is the hospital in currently?

6. Any sickness / shortages on rota for shift starting?
    a. Circle option on whiteboard and record details on audit form

7. NerveCentre review
    a. Document number of outstanding jobs on whiteboard for each ward area
        i. This would preferably be done prior to meeting starting to give team idea of job intensity in each area

8. AMU review
    a. Document number of admissions awaiting clerking on whiteboard for each of the AMU areas
        i. This highlights potential need for ward team to provide assistance to AMU

ACTIONS i.e. where will each team member be working?

9. Record which wards each team member will be primarily responsible for on whiteboard
    a. Remember to state, "If one ward area (including AMU) is very busy cross covering / help will be provided by all other team members as required"
    b. "You may be asked to perform jobs on other wards dependant on complexity of task and grade of doctor."

RESPONSE i.e. which patients need attention?

10. Outgoing staff invited to discuss "sick" patients with oncoming staff

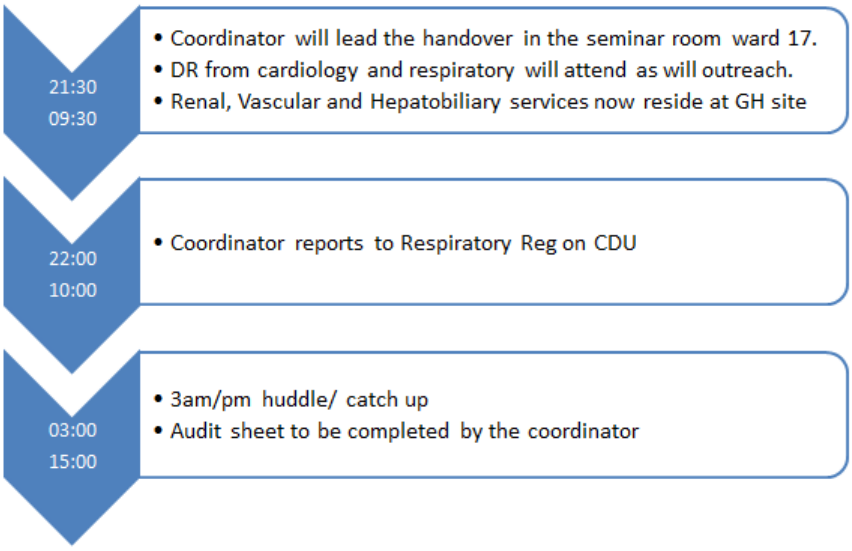
    a. Recurrent calls / attendances for review during on call period (>3)
    b. EWS >3
    c. Clinical concern
    d. Difficult consultation
    e. Undecided / difficult management plan (DNAR / escalation decisions)

11. Any other patients / jobs to be discussed with assistance of NerveCentre on projector

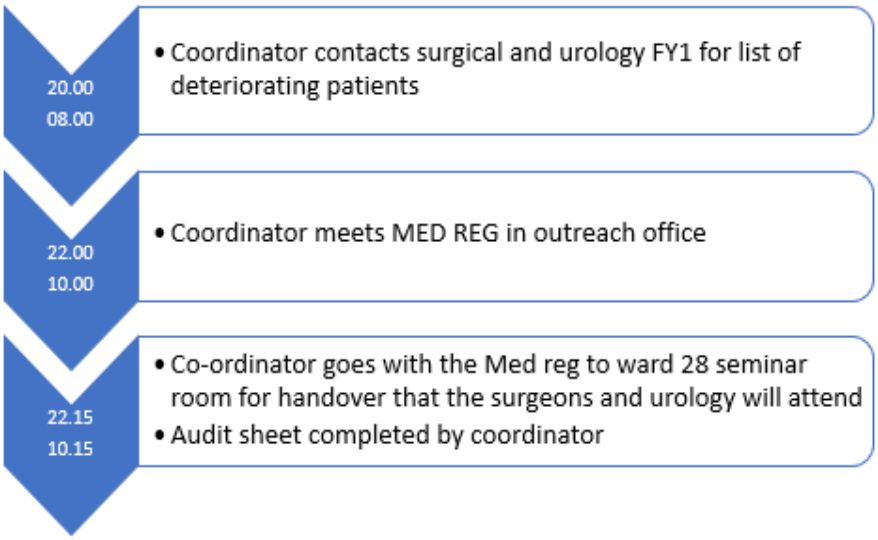
12. Ensure that handover spreadsheet is complete and submitted *only once*– this is the responsibility of the co-ordinator.

Appendix 2

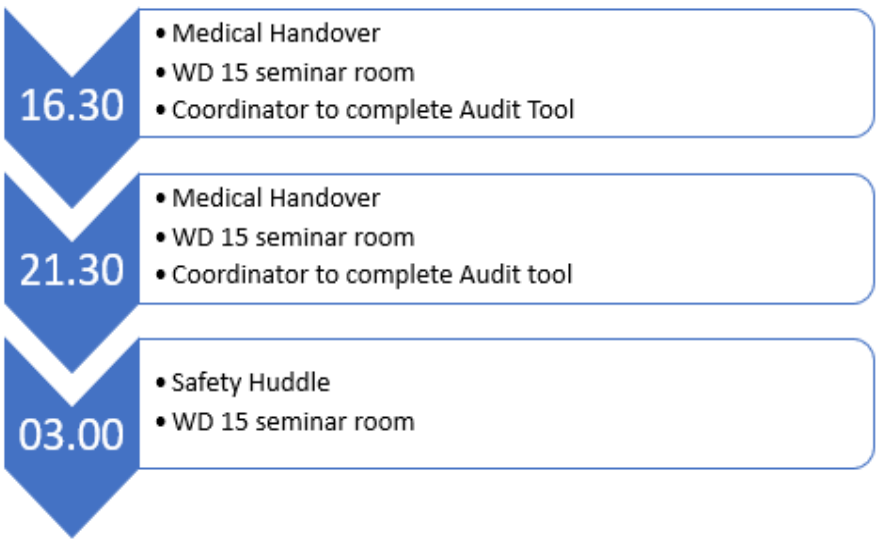
GH



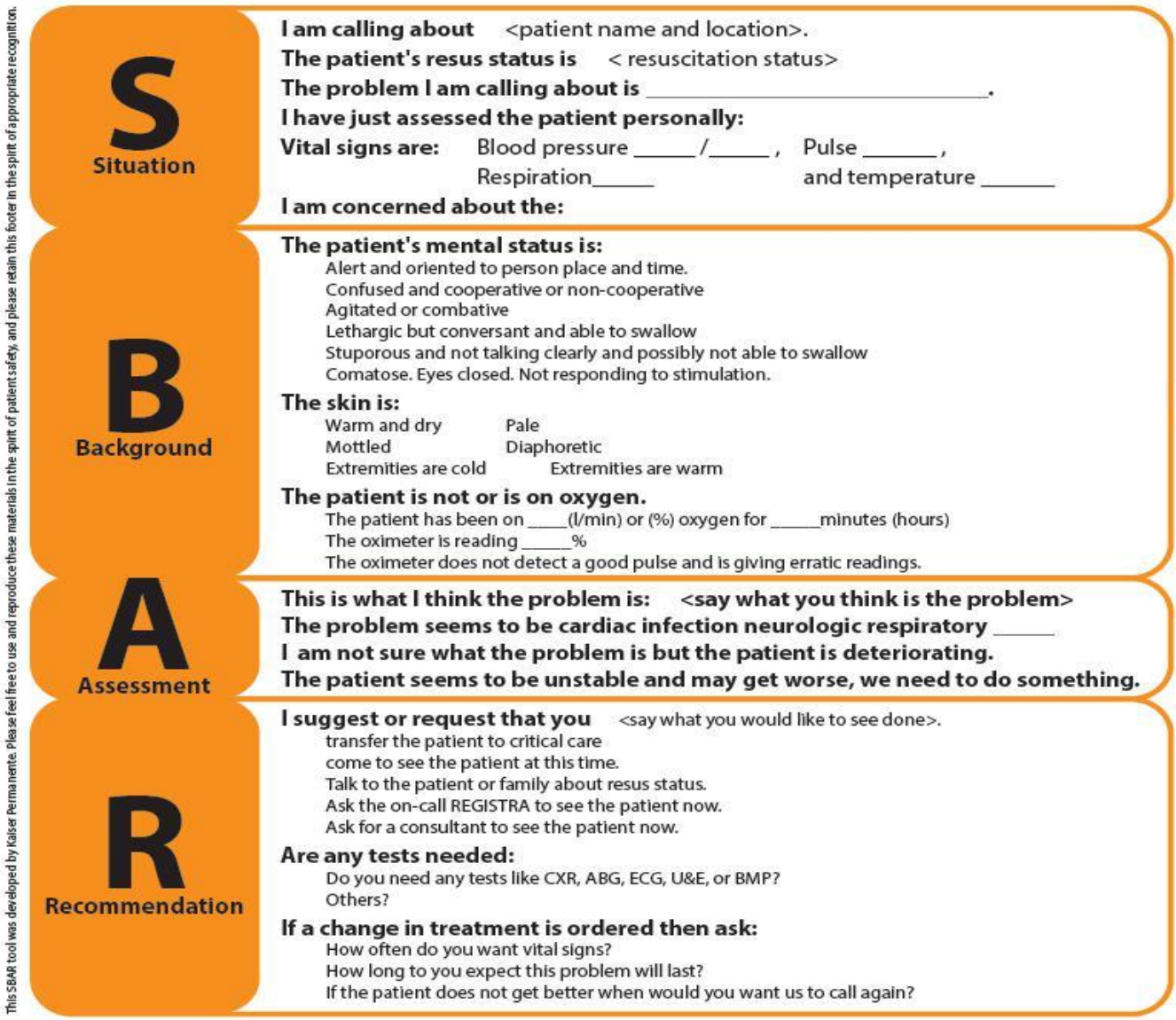
LGH



LRI



Appendix 3



S — Situation

I am calling about <patient name and location>.
The patient's resus status is < resuscitation status>
The problem I am calling about is _____.
I have just assessed the patient personally:
Vital signs are: Blood pressure _____/_____, Pulse _____,
Respiration_____ and temperature _____
I am concerned about the:

B — Background

The patient's mental status is:
Alert and oriented to person place and time.
Confused and cooperative or non-cooperative
Agitated or combative
Lethargic but conversant and able to swallow
Stuporous and not talking clearly and possibly not able to swallow
Comatose. Eyes closed. Not responding to stimulation.

The skin is:
Warm and dry Pale
Mottled Diaphoretic
Extremities are cold Extremities are warm

The patient is not or is on oxygen.
The patient has been on ____(l/min) or (%) oxygen for _____minutes (hours)
The oximeter is reading _____%
The oximeter does not detect a good pulse and is giving erratic readings.

A — Assessment

This is what I think the problem is: <say what you think is the problem>
The problem seems to be cardiac infection neurologic respiratory _____
I am not sure what the problem is but the patient is deteriorating.
The patient seems to be unstable and may get worse, we need to do something.

R — Recommendation

I suggest or request that you <say what you would like to see done>.
transfer the patient to critical care
come to see the patient at this time.
Talk to the patient or family about resus status.
Ask the on-call REGISTRA to see the patient now.
Ask for a consultant to see the patient now.

Are any tests needed:
Do you need any tests like CXR, ABG, ECG, U&E, or BMP?
Others?

If a change in treatment is ordered then ask:
How often do you want vital signs?
How long to you expect this problem will last?
If the patient does not get better when would you want us to call again?

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