Policy Applies to: All Mercy Hospital staff involved in the delivery of patient care.

Rationale:

Mercy Hospital is committed to providing a safe environment for patients and staff. Important components of this are the safe and efficient delivery of care and the processes by which relevant information is transferred between providers of care.

Cultural Considerations

Clinical handover is undertaken in a manner that the patient deems to be culturally safe, allows for independence of expression and individual choice for patients and their whānau. Staff will be familiar with the Mercy Tikaka Best Practice booklet and use it's guidance to ensure culturally safe clinical handover practice.

Definitions:

Clinical Handover involves the transfer of:

- Clinical information.
- Nursing responsibility.
- Nursing accountability.

Head to Toe Assessment: The systematic examination of the body from head to toe using techniques that may include, observation/inspection, palpation, percussion, and auscultation.

Huddle: A brief unit based gathering of staff led by the ACN/ shift Coordinator to increase situational awareness e.g. high-risk patients or procedures, safety issues, ensuring patients cultural safety is being met, workload issues, anything that affects the delivery of care.

Break: Time away from the patient for more than 10-15 minutes; e.g. tea or meal break, attending a meeting or education sessions.

ISBAR: Communication tool for use between health professionals involved in the clinical care of a patient (appendix 1)

Clinical Handover

The handover of patients is the communication link between different shifts, at breaks, between departments and provides continuity of patient care and reduces risk of adverse events. It is important that handover information is pertinent and communicated in a timely and concise manner.

- Patient handover occurs every day either at the time of the shift change-over/start of shift, or when staff are handing over the care of a patient to another clinician.
- Patient handover, (shift to shift) on **Inpatient wards** takes place both in the nursing office as well as at the patient bedside.
- The oncoming staff will make an initial assessment of:
  - The patient

- The bed space environment
- Oxygen and Suction.
- Observation Chart.
- Medication Chart.
- EWS/PEWS

- Following this handover, each nursing team shall review their patients Clinical Record.
- Use of handover sheets

Break Handover

- Occurs between the nurse responsible for the patient and the nurse who is assuming responsibility for the patient. It may or may not be the nurse on the same team.
- Is a verbal handover focusing on identification of the patients; their current situations and any risks for the patients while the nurse is absent from the ward.

Operating Theatre

- The theatre nurse utilises the 'Theatre to PACU Nurse Handover' ISBAR model to guide verbal handover to the PACU nurse. SWTICH & PITT Stop are used in MOT and PACU

Head to Toe Assessment

- PACU utilises the Patient Assessment Tool to guide clinical handover and standardise communication between PACU and ward nurses, thus ensuring continuity of care.

Huddle

- A huddle is used as a means of identifying and communicating safety issues affecting patients/staff, priorities for the shift and planned events that will occur during the shift.
- The timing of the huddle depends on the area, but all staff are expected to attend.

ISBAR

- ISBAR is the recommended communication tool when contacting Credentialed Specialists, (see Clinical Services Work Manual).

Implementation

- Clinical orientation for new staff outlines the models of care and handover process.
- Orientation to each clinical area will provide more in-depth instruction on the model and its application to that setting.

Evaluation

- Staff satisfaction; feedback from biennial staff survey.
- Patient satisfaction from patient online Cemplicity Questionnaires

- Incidents/complaints review.

Associated Documents

Policies

- Adverse Reaction to Medications
- Clinical Records Management
- Consent
- Discharge of Patients
- Emergency Management
- Falls Prevention and Management
- Family Violence
- Nursing Scope and Expansion of Practice
- Patient Assessment
- Patients – Restraint Minimisation
- Resuscitation
- Transfer of Patients
- Venous thromboembolism

Clinical Services Work Manual

- Alcohol Withdrawal Guidelines
- Bed Rails
- Cardiac Arrest
- Day Surgery Discharge
- Emergency Equipment
- ISBAR Communication Tool
- Modified Early Warning System

Other

- Direction and Delegation HealthLearn course & face to face session (Clinical Orientation)
- Calderdale Framework
- Handover of patients from DSU to theatre (Coolock DSU)
- Nursing Care Guidelines for PACU (PACU)
- PACU Handover Sheet (PACU)

Click here for health navigator resource on patient centred care

Sources

Australian Medical Association (2006). Safe handover: safe patients. AMA Clinical Handover Guide. AMA, Sydney; Accessed from: http://ama.com.au/node *

Institute for Healthcare Improvement (2013) SBAR toolkit poster template Accessed from: http://www.ihi.org/knowledge/Pages/Tools/SBARToolkit.aspx

West Coast District Health Board (2010); ISBAR Communication Tool for Health Professionals