

Policy Applies to:

All Mercy Hospital nursing 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 nursing care and the processes by which relevant information is transferred between providers of care.

Definitions:

Nursing Model of Care: The way in which nursing services are designed and delivered at a departmental or organisational level. Elements of a model of care should include:

- Patient centred
- Collaboration and teamwork
- Effective communication strategies
- Evidence based

Clinical Handover: The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person on a temporary or permanent basis.*

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 Clinical / shift Coordinator to increase situational awareness e.g. high-risk patients or procedures, safety issues, workload issues, anything that affects the delivery of care.

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

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

Collaborative Model of Care

The Collaborative Model of Nursing Care includes elements of team nursing and patient allocation. In McAuley Ward & Coolock DSU, it refers to a team of two or more nurses, providing care to an identified group of patients (in collaboration with and under the direction of a Registered Nurse (RN)).

Teams are made up of a combination of RNs and Enrolled Nurses (ENs). The actual composition of a team will vary according to the skill mix of the rostered staff and the clinical needs at that time. Some examples are:

- RN; EN;
- RN; RN (New Graduate)
- RN; RN

Within this model, RNs and ENs provide nursing care based on clinical Best Practice for their group of patients.

- Teams are identified on Trendcare patient allocation lists and/or on whiteboards.
- Each nurse within a team, is assigned a group of patients.
- Each nursing team receives clinical handover for their combined group of patients from staff on the preceding shift.

Team Nursing

- In Manaaki, a team leader and team members provide nursing care to a group of patients.
- A nurse is assigned to care for a group of patients at each stage of the patient's journey.
- As the patient moves from area to area e.g. admission to theatre to recovery & discharge, patient care is transferred from one nurse to another.

Clinical Handover *(see also Transfer of Patients Policy)*

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

- In inpatient, ward based areas, handover occurs every day at the time of the shift change-over/start of shift.
- Handover usually occurs in the nursing station/office but may take place at the bedside.
- Handover may follow a body systems framework or the care pathway specific to that patient's surgery.
- Discussion of physiological signs should include reference to the Mercy Hospital Modified Early Warning Score (MEWS).
- Following handover, each nursing team shall visit the patients in their team and introduce themselves, while at the same time making an initial assessment of the patient.
- Where a patient's care is complex or the patient's condition is compromised, it is recommended that handover occurs at the bedside. This supports continuity, appropriate clinical assessment and patient engagement in the ongoing plan of care.

Break Handover

- Occurs between the nurse responsible for the patient and the nurse who is assuming responsibility for the patient. In the first instance this should be the other nurse in the team (dependent on their scope of practice).
- Is a verbal handover focusing on identification of the patients; their current situations and any risks for the patients during the break.

Operating Theatre

- The theatre nurse utilises the 'Theatre to PACU Nurse Handover' ISBAR model to guide verbal handover to the PACU nurse.

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

- In McAuley Ward and Coolock DSU the 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

- When a patient's condition requires escalation to the Senior Nurse on-call or Credentialed Specialist, concerns and requests for assessment or treatment should be communicated using ISBAR (appendix 1).

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 feedback forms.
- 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 Learning Package & Quiz (Clinical Orientation)
- Handover of patients from DSU to theatre (Coolock DSU)
- Nursing Care Guidelines for PACU (PACU)
- PACU Handover Sheet (PACU)

References:

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http://www.rch.org.au/rhcpg/hospital_clinical_guideline_index/Nursing_clinical_handover/

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Appendix 1- ISBAR Communication Tool:

Prior to calling:

1. Assess the patient
2. Discuss your concerns with your senior nurse first in order to prioritise the call
3. Know the admitting diagnosis
4. Read the most recent progress notes and the assessment from the nurse and/or doctor on the previous shift
5. Have available: Observation Chart and latest MEWS, Progress notes, Drug chart, Fluid Balance, Lab results

I	<p><u>Identify Yourself:</u> Name, position and department / hospital</p> <p><u>Patient:</u> Name</p> <p>Date of admission and diagnosis/ operation</p> <p>Age/ Sex/ Location</p>
S	<p><u>Situation</u> <i>A concise statement of the problem</i></p> <p>State the reason for your call: "I'm calling you because I am concerned about..."</p> <p>If it's a matter of urgency, say so and provide the reason why, e.g. low blood pressure and heart rate.</p>
B	<p><u>Background</u> <i>Pertinent and brief information related to the situation</i></p> <p>Tell the story:</p> <p>Current problem</p> <p>Relevant history, relevant examination, relevant test results, brief synopsis of treatment to date</p>
A	<p><u>Assessment</u> <i>What you found/think is going on</i></p> <p>Most recent vital signs and any changes from prior assessments:</p> <p>BP ___ Heart Rate ___ Respirations ___ Temperature ___ Urine output ___</p> <p>___ / Fluid Intake ___</p> <p>Sedation Score ___ MEWS ___ Is the patient on O₂? ___</p> <p>Other : Pain ___ Wounds ___ Blood Loss ___ Musculo-skeletal (weakness) ___ Auscultation ___</p>
R	<p><u>Recommendation</u> <i>State what you would like to see done</i></p> <p>Are there any tests required? E.g. CXR, ECG, Blood tests etc.</p> <p>Are there any medications/fluids required?</p> <p>What change in the treatment plan is required?</p> <p>How often do you want vital signs?</p> <p>If the patient doesn't improve when should they be called again?</p>

REMEMBER:

- Document the change in condition
- Who you spoke to
- Orders given
- Treatment instigated
- Plan of care and patient response to care