



LINDSEY LODGE HOSPICE AND HEALTHCARE

Clinical Handover Policy

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1. Introduction

- 1.0 Handover is described as *“the 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”*

National Patient Safety Agency (2004)

1.2 The fundamental intention of any handover is to achieve the efficient transfer of high quality clinical information at times of transition of responsibility for patients' care. It is essential that this information is effectively communicated to promote and ensure safety and continuity of care.

2. Scope

- 2.1 This is a hospice wide policy and applies to all staff working in clinical services.
- 2.2 Handover of patient care is a core task for all members of the clinical team and applies to temporary, permanent and bank staff.
- 2.3 It applies to all shift/day changes.

3. Purpose

- 3.1 The purpose of this policy is to explain the roles, responsibilities and process for handover
- 3.2 This policy has been developed to ensure that the hospice has a systematic approach to handover that is evidence based
- 3.3 This policy determines the standards of handover which must be delivered by individuals and clinical teams.

4. Duties (Roles and responsibilities)

4.1 Board of Trustees

The Board of Trustees is responsible for ensuring a robust system of risk management within the hospice. This includes having a system to ensure safe clinical handover at transition of responsibility is occurring to protect patients and minimise clinical risk.

4.2 Director of Nursing

The Director of Nursing is accountable to the Board of Trustees for ensuring that there is a policy and procedure in place for the clinical handover of patients at shift/day changes and providing assurance that the local systems and processes in place to deliver this Policy are effective.

4.3 **Clinical Leads**

The Clinical Leads are responsible for the development of local systems and processes and ensuring that the process is effective and compliant with this Policy.

4.4 **All staff**

All staff are responsible for conducting the handover in line with the standards listed by ensuring that they actively participate in the handover. All staff are responsible for reporting any adverse incident that occurs relating to clinical handover which includes completing an incident report.

5. **Standards of Handover**

The following organisational issues must be agreed and defined for each clinical area where handover takes place. This provides clarity of the processes.

- Who is required to attend handover
- Clear identification of who is leading handover
- A designated time for handover
- A designated venue for handover
- An effective structure for handover for what and how the information should be communicated, recorded and retained

5.1 **Standard 1: The handover is conducted in a professional manner**

Everyone present should:

- a) Remain calm and respectful
- b) Use positive language
- c) Demonstrate active listening

5.2 **Standard 2: The handover is well planned**

- a) Handover will be reflective of the written record
- b) Information delivered will be relevant and up to date
- c) Information delivered will be linked to the care plan
- d) Meet the needs of the oncoming staff, knowledge should not be assumed

5.3 **Standard 3: The handover is effective in ensuring all clinical information is communicated safely and effectively**

5.4 **Standard 4: By the end of handover roles and responsibilities for team members will have been clearly identified**

- a) Identification of any outstanding actions and allocation of roles/responsibilities agreed and allocated

6. Process

6.1 Personnel with responsibility in the handover process

- 6.1.1 Nurse in charge/Named nurse (professional) must handover to the whole of the next team on duty at the beginning of the shift
- 6.1.2 Nurse in charge should ensure that the team are aware of any new staff including bank and students members of the team and that adequate arrangements are in place to familiarise them with the local systems and hospice geography
- 6.1.3 Involvement of shift leader/nurse in charge is essential. This ensures that appropriate management decisions are made, and that handover forms a constructive part of staff education, conveying the seriousness with which the hospice takes on this process
- 6.1.4 Tasks should be appropriately prioritised and delegated
- 6.1.5 There should be clarity as to who is responsible for ensuring key tasks are completed and how this is co-ordinated.

6.2 Time

- 6.2.1 Handover should occur at a designated time in all areas
- 6.2.2 The length of handover should be advised by local procedures. This duration of time allocated should be sufficient to allow handover to be factored in to working patterns to allow sufficient time for effective handover.
- 6.2.3 Every step must be taken to protect handover time as far as possible and while immediate engagement with clinical matters may occur on occasion be necessary, it is important to maintain the essential nature of effective handover.
- 6.2.4 Unnecessary interruptions should be avoided where possible.

6.3 Place

- 6.3.1 Handover should be conducted in a designated room which accommodates the team and is confidential. A Do Not Disturb sign should be used to prevent interruptions and reception should be aware of handover times to prevent routine telephone calls being put through.

6.4 Structure

- 6.4.1 All handovers should have a pre-determined format and structure to adequate information exchange and patient safety.
- 6.4.2 The SBAR Communication tool is the template of choice for clinical handover. (See Appendix 1).
- 6.4.3 All staff using a paper form of handover must have the updated copy at the start of each sheet. It is every staff member's individual responsibility to ensure that these are kept and disposed of in confidential waste.

6.5 Information that must be included at handover

- 6.5.1 This policy cannot be prescriptive about the specific issues to be handed over in each area. Each area should develop an agreed list of key issues for handover
- 6.5.2 Sufficient and relevant information should be exchanged to ensure patient safety and effective clinical care.
- 6.5.3 However, certain common, core safety information must be discussed at shift/day change
- 6.5.4 This is not an exhaustive list, but is intended as a guide:
- Patient, name, age. Diagnosis
 - Next of kin, Known allergies, Reason for admission/attendance
 - DNACPR status, Level of care
 - End of life document, Known pressure areas, Fast track status
 - Any D.O.LS., Safeguarding, Mental Capacity issues
 - Advance Care Plan status
 - Pertinent medical history
 - Risks
 - Changes/updates to care plans
 - Referrals, discharges, new admissions, number of attendances
 - MDT feedback
 - Outstanding tasks
- 6.5.5 Handover is of little value unless action is taken where needed. All team members must be aware of their responsibilities and need to ensure that :
- Tasks are prioritised to enable completion in a timely, effective and safe manner with any understanding of who is undertaking them
 - Plans for further care are put in place and clarified
 - Unstable/deteriorating patients are reviewed to ensure that an adequate anticipatory care plan is put in place and acted upon

7. Implementation and monitoring

- 7.1 Each clinical lead in conjunction with the Director of Nursing, will review all the current handover arrangements and identify how they plan to meet the standards outlined in the document
- 7.2 All staff should be made aware of the local arrangements for handover and use the agreed process
- 7.3 Clinical leads, in conjunction with the Director of Nursing will coordinate monitoring of compliance with this Policy on a regular basis via audit. This will be biannual.
- 7.4 Awareness of this Policy and procedure, and its utility, will be part of the ongoing discussions with new staff on clinical induction, and will form part of supervision and reflective practice approaches
- 7.5 Clinical leads will consult on any further collective training and support required through the policy review process and monitoring of compliance of this policy via audit
- 7.6 Training will be provided locally within the various settings in which staff are currently working

8. References

National Patient Safety Agency (2004) Safe Handover, safe patients: Guidance on clinical handover for clinicians and managers. BMA Junior Doctors Committee

NHS England (2010) <https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/SBAR-Implementation-and-Training-Guide.pdf>

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Appendix 1

S **Situation:**
 I am (name), a nurse on ward (X)
 I am calling about (child X)
 I am calling because I am concerned that...
 (e.g. BP is low/high, pulse is XXX temperature is XX,
 Early Warning Score is XX)

B **Background:**
 Child (X) was admitted on (XX date) with
 (e.g. respiratory infection)
 They have had (X operation/procedure/investigation)
 Child (X)'s condition has changed in the last (XX mins)
 Their last set of obs were (XXX)
 The child's normal condition is...
 (e.g. alert/drowsy/confused, pain free)

A **Assessment:**
 I think the problem is (XXX)
 and I have...
 (e.g. given O₂/analgesia, stopped the infusion)
 OR
 I am not sure what the problem is but child (X)
 is deteriorating
 OR
 I don't know what's wrong but I am really worried

R **Recommendation:**
 I need you to...
 Come to see the child in the next (XX mins)
 AND
 Is there anything I need to do in the meantime?
 (e.g. stop the fluid/repeat the obs)

Ask receiver to repeat key information to ensure understanding

The SBAR tool originated from the US Navy and was adapted for use in healthcare by
 Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

If you require further copies quote SC043