The Newcastle upon Tyne Hospitals NHS Foundation Trust

Clinical Handover Policy

<table>
<thead>
<tr>
<th>Version No.:</th>
<th>4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective From:</td>
<td>27 April 2016</td>
</tr>
<tr>
<td>Expiry Date:</td>
<td>27 April 2019</td>
</tr>
<tr>
<td>Date Ratified:</td>
<td>16 November 2015</td>
</tr>
<tr>
<td>Ratified By:</td>
<td>Clinical Handover Group</td>
</tr>
</tbody>
</table>

1 Introduction

Handover of care … when carried out improperly can be a major contributory factor to subsequent error and harm to patients. This has always been so, but its importance is escalating with the requirement for shorter hours for doctors and an increase in shift patterns of working.

Professor Sir John Lilleyman Medical Director
National Patient Safety Agency

It is essential to ensure that critical information is effectively communicated as continuity of information is vital to the safety of our patients.

The increasing sub-specialisation in hospital care means that more teams are involved in patient management and an increased number of individuals potentially caring for a patient during their hospital stay therefore the need for comprehensive handover of clinical information has become more important than ever. The move to compliance with the European Working Time Directive (EWTD) for junior medical staff in August 2009 has resulted in increased cross-cover between specialties and sub-specialities within our organisation and teams providing cover out of hours are increasingly multi-disciplinary e.g. Hospital at Night (H@N) and outreach teams.

2 Scope

Handover of patient care is a core task for all members of the healthcare team but will particularly apply to those with a direct role in patient care where they need to hand over to another team or team member in an effective and efficient manner. This policy specifically applies to the handover between shifts in relation to the immediate care of patients. It applies to all situations where clinical care is transferred from one healthcare professional to another while the patient remains in the same care environment. This policy applies to all staff providing care and who must transfer their responsibilities at the end of a shift.

Handover applies to the end of every working shift, including day to night shift and back to day shift.

Handover does not apply to outcomes generated from MDT meetings or other multidisciplinary case conferences which should have their own mechanisms for
disseminating their conclusions.

This policy should be read in conjunction with the Transfer of Patients policy which applies to the situation where a patient moves from one area or ward or department providing care to another e.g. from ITU to a ward or to another hospital.

3 Aims

The purpose of this policy is to provide:

- A rationale for clinical handover
- A determination of the standards of handover which must be delivered by individual clinicians and clinical teams in NUTH
- A framework for handover based on the best evidence

4 Duties (Roles and responsibilities)

4.1 Trust Board
The Trust Board is responsible for implementing a robust system of risk management within the organisation. This includes having a system to ensure safe clinical handover.

4.2 Clinical Directors, Directorate Manager, Heads of Department
Responsible for ensuring there is a process for handover of patients at each change of junior and senior doctor period of responsibility.

4.3 Matrons, Ward Sisters and Charge Nurses
Responsible for ensuring there is a process in place for nurse handover and that the process is followed at every shift change.

4.4 All Staff
All staff are responsible for:

- Complying with this policy by ensuring they actively participate in the clinical handover process
- Completing an adverse incident reporting form in accordance with the Trust Policy for any error or omission that occurs relating to clinical handover

5 Definitions

Clinician – a health professional with responsibility for direct patient care

Shift – the period of work in which there is a designated responsibility to provide care

Handover – transfer of key issues, tasks and changes in management plan from one care professional to another.
Plan of care – the plan for the particular patient which should always be recorded in the patient care record or notes

Key tasks – important tasks which must be undertaken within the period of responsibility for care.

Record of handover – a record of the team members participating in handover

Handover summary sheet - a list of patients/tasks to be handed over

Risk factors – information which may identify that a patient’s condition may change or need review in the period of the shift

Situation, Background, Assessment, Recommendations (SBAR) – a mechanism used to frame conversations, especially critical ones, requiring a clinician’s immediate attention and action.

Summary of tasks – list of tasks to be competed with in the shift period

6 Standards for Handover

The following organisational issues must be defined for each area where handover takes place. Each Directorate must agree its process and complete the attached template (Appendix 1) to clarify the specific processes in place. Similarly each professional group who may provide handover across directorate boundaries must agree and document their specific processes.

• There should be an understanding of who is required to attend handover
• There should be clear identification of who is leading handover
• There should be a designated time for handover
• There should be a designated venue for clinical handover
• There should be an effective structure for what and how the information at handover should be communicated, recorded and retained.

6.1 There should be an understanding of who is required to attend handover

• All grades of staff should be involved in handover. 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 respected and it may be appropriate to have different arrangements for different staff groups. The quest for multidisciplinary involvement should not be allowed to result in a handover which becomes unwieldy and inefficient
• For medical handover, Consultant presence is particularly valuable for those areas with high workloads out of hours and where there is a need to prioritise tasks e.g. Delivery Suite, ITU, Assessment unit and evidence of consultant to consultant handover should be recorded.
• For medical handover all staff that are present at each handover are identified on the record of handover.
• Nursing handover should refer the relevant group of patients receiving direct care. The nurse in charge must receive handover for all patients in their sphere of responsibility. For the nursing handover in critical care this may include all patients if the nurse is in charge or the one or two patients receiving direct care.

6.2 There should be clear identification of who is leading handover

• The lead for handover should be identified and recorded in the directorate’s process for handover procedure note. This should be recorded by exception for nursing staff where it would be expected to be the nurse in charge of the shift/group of patients.
• Tasks should be appropriately prioritised – urgent clinical situations or changing situations must be identified and acted on before routine tasks are undertaken.
• Tasks should be appropriately delegated - tasks should be allocated to those with the skills to undertake them most effectively in the patient’s best interests and to ensure the best use of the available team member’s time with consideration given to overall workload and other demands on the team. Training opportunities for junior team members should still occur with appropriate supervision when this is available.
• There should be clarity as to who is responsible for ensuring key tasks are completed and how this is co-ordinated. For nursing teams this may require reporting back to the nurse in charge during the shift.

6.3 There should be a designated time for handover

• Handover should occur at a designated time in all areas.
• The duration of time allocated should be sufficient to allow for handover to be factored in to working patterns to allow sufficient time for effective handover. All reasonable attempts should be made to ensure staff are able to leave on time having fulfilled their obligation at handover.
• Steps should be taken to protect handover time as far as possible and while immediate engagement with clinical problems may on occasion be necessary it is important to maintain the essential nature of effective handover.
• Unnecessary interruptions should be avoided where possible

6.4 There should be a designated venue for clinical handover

• Clinical teams must identify a space or location which is adequate in size to permit attendance and participation of all involved.
• A consistent venue may be preferred.
• The space or location must allow for patient confidentiality particularly for walk around handovers to enable patients to be viewed.
• Nursing handover may be conducted standing to reduce the time spent at handover, if possible in view of the patient and/or an overview board. In patient areas the adherence to patient confidentiality must be maintained. If handover is not possible in view of the patients, staff must be allocated to
monitor patients during handover.

- There may be a need for a networked PC to be available depending on the methods used to support handover
- Sometimes telephone handover may be appropriate e.g. where work does not take place at a single location.

6.5 There should be an effective structure for communication at handover

- Information should be exchanged to pass on tasks and issues and to ensure patient safety.

- The template for handover must use the SBAR model. This facilitates making an appropriate recommendation which ensures that the reason for the communication is clear. This is particularly important in situations where staff may be uncomfortable about making a recommendation i.e. those who are inexperienced or who need to communicate up the hierarchy.

6.6 Sufficient and relevant information should be exchanged to ensure patient safety

- This policy can not be prescriptive about all of the specific issues to be handed over in each area and each directorate is encouraged to agree its own key issues for handover. However, certain common, core safety information must be discussed at shift change in a ‘Team Safety Brief’, and the nurse in charge of each ward or department is responsible for ensuring this is made available in a clearly marked folder, for all of the Multi-disciplinary team (appendix 2)

- Tasks not yet completed must be clearly understood by the incoming team – tasks which are urgent must be prioritised and flagged as such with a clear understanding of who is undertaking them.

- It is important that any change to patient’s condition or management plan is then recorded in the notes and that the handover summary does not become a substitute for the patient record.

- Unstable patients must be reviewed – a mechanism within each clinical area is defined to identify at risk or unstable patients using the EWS or PEWS score already in place in the Trust.

- The communication needs of patients should be handed over for example if the patient is blind, Deaf, has a learning disability or needs an interpreter

- Adequate information technology support must be provided where required and handover records stored according to Trust Policy.
6.7  Issues for specific professional groups

6.7.1  Medical
All medical staff working a full shift should participate in handover unless dealing with an urgent or emergency situation e.g. cardiac arrest or busy in theatre. Consultant staff should handover care of patients to colleagues if they are not available for advice/out of Newcastle/on annual leave/study leave should ensure this is recorded/understood by the dept. The default position will be to seek the advice of the relevant consultant on call unless specific alternative arrangements are specified in the clinical record.

6.7.2  Community nursing team
Telephone handover may be appropriate for some groups who must document that handover.

6.7.3  Physiotherapy
Handover to the clinical team
Where there is a requirement for physiotherapists to handover patients with active problems to other professionals including medical and nursing staff e.g. on completion of an emergency intervention during an on call episode, this will be provided verbally and documented in the patients’ medical record and physiotherapy record.

Handover to the physio team - Other details of the physiotherapy handover should be documented in the specific process for Physiotherapy and recorded on the template

Pharmacy – Directorates must agree with their Pharmacy leads which specific drug information must be routinely recorded at handover. E.g. Infusion pumps and drug allergies

6.8  Retention of records of handover

It is important that each area has a mechanism of recording that handover has occurred and that the agreed items are being handed over effectively between shifts. This record must be stored electronically.

All electronic records of handover should be retained for 2 years and each department or directorate must agree how they will ensure this happens such that the records are available for audit and review.

IT support – Many clinical areas are using shared drives to create and save patient/work lists. This is encouraged and specific areas of the shared drives should be reserved for Handover records if this fits the process for that area. When setting up shared folders, appropriate consideration must be given to accessibility across the network by staff who work across a number of wards e.g. Junior Doctors.
6.9 Confidentiality

It is essential that all information relating to a plan of care or change in a plan of care for any patient is recorded only in their clinical record – including clinical impressions, working diagnoses, discussion with senior colleagues and plans of management. This information must be updated before going off shift and must be the exclusive vehicle for communicating management plans and changes. Summary sheets can be easily, misinterpreted or lost and then the key clinical information may not be transferred to the clinical record and result in no action being taken. This is particularly important when a plan is made which may encompass several shift changes e.g. removal of drains or catheters.

Due to the patient specific information contained on handover sheets it is vital that confidentiality is maintained and therefore printed handover sheets must be disposed of in confidential waste at the end of use and it is the responsibility of each member of staff to do so. Any handover information which contains patient identifiable information should not be entered into a portable electronic device. Recording handover details on personal phones or other hand-held devices is not allowed because of the possibility of patient identifiable data remaining on the device after the shift breaching patient confidentiality.

Recording patient identifiable information in personal notebooks which are then taken out of the trust is discouraged and any pages must be disposed of in the confidential waste.

7 Training

It is expected that arrangements for handover will be outlined to new staff as part of local induction and any necessary training provided. Additional support on the use of SBAR tools and tips for effective handover will be available in the training section of the intranet together with a list of further resources that areas may wish to use to further their develop their handover effectiveness.

8 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.
9 Monitoring compliance

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit Method</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Handover process to be documented in a written procedure note for each Team.</td>
<td>Audit of handover protocols</td>
<td>Clinical Handover Group</td>
<td>Clinical Risk Group</td>
<td>Annual to commence April 2016</td>
</tr>
<tr>
<td>The written record of each handover must be retained in line with the Trust Corporate Records Policy.</td>
<td>Audit of handover record</td>
<td>Clinical Handover Group</td>
<td>Clinical Risk Group</td>
<td>Annual to commence April 2016</td>
</tr>
</tbody>
</table>

10 Consultation and review

The Clinical Handover policy has been developed and reviewed by a Clinical Handover Group comprising representatives from Medical, Nursing, Allied Health Professionals, Pharmacy and Clinical Governance. The policy was developed and reviewed to ensure that handover practice promotes safe patient care. The professional groups represented on the Handover Group were invited as stakeholder and directorate representatives to contribute their expertise and specific requirements to the policy content. The group members were also asked to review and comment on the advanced policy draft to ensure accuracy and completeness of content prior to submission to the Clinical Policy Group.

11 Implementation and Monitoring (including raising awareness)

Each directorate will need to review all the current handover arrangements in their specialty and identify on the attached template (appendix 1) how they plan to meet the standards outlined in this document. They must establish standards which can be audited on a regular basis with clear evidence of the accountability within the directorate for review of the audit results. Once the Directorate templates are completed the Directorate should ensure that all staff are made aware of the local arrangements for handover and use the agreed process.

12 References

- Safe handover, safe patients: Guidance on clinical handover for clinicians and managers. BMA Junior Doctors Committee, 2004
- Safe handover: Guidance from the Working Time Directive working party. The
• Improving clinical handovers: creating local solutions for a global problem. Johnson and Arora. *Quality and Safety in Health Care* 2009;18;244-245

• Handover and SBAR tools
  http://www.rcseng.ac.uk/service_delivery/working-time-directive/docs/Safe%20handovers.pdf
  http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar_-_situation_-_background_-_assessment_-_recommendation.html
  http://medicaleducator.co.uk/the-importance-of-a-good-handover-between-doctors.html
  http://www.medicalhandover.com/

13 Associated documentation

• Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital guideline.
• Discharge policy
• Transfer of patients policy
Appendix 1

Directorate Handover Procedure Note Template

1 Introduction

Continuity of information is vital to the safety of our patients. The need for effective handover processes has been repeatedly highlighted by national patient safety reports.

It is essential that critical information is effectively communicated as an essential component of risk management and patient safety.

The arrangements for the handover in the ……………..Directorate are contained in this document.

2 Handover – Medical Staff
   • Time(s) of handover
   • Venue/location
   • Key people to attend handover
   • Leadership of handover
   • Consultant role
   • What key information must be contained in handover
   • How the handover is documented
   • How tasks are prioritised
   • How task are delegated
   • Responsibility for completion of tasks
   • Where handover documents are archived

3 Handover – Nursing Staff
   • Time(s)
   • Venue/location
   • Key people to attend handover
   • Leadership of handover
   • What key information must be contained in handover
   • How the handover is documented
   • How tasks are prioritised
   • How tasks are delegated
   • Responsibility for completion of tasks
   • Where handover documents are archived
4 Handover – Multidisciplinary
- Time(s)
- Venue/location
- Key people to attend handover
- Leadership of handover
- Consultant role
- What key information must be contained in handover
- How the handover is documented
- How tasks are prioritised
- How tasks are delegated
- Responsibility for completion of tasks
- Where handover documents are archived

5 Handover - Therapy Services
- Time(s)
- Venue/location
- Key people to attend handover
- Leadership of handover
- Consultant role
- What key information must be contained in handover
- How the handover is documented
- How tasks are prioritised
- How tasks are delegated
- Responsibility for completion of tasks
- Where handover documents are archived

6 Handover – Other
- Time(s)
- Venue/location
- Key people to attend handover
- Leadership of handover
- Consultant role
- What key information must be contained in handover
- How the handover is documented
- How tasks are prioritised
- How tasks are delegated
- Responsibility for completion of tasks
- Where handover documents are archived

7 Confidentiality

It is essential that all information specific to any patient is recorded only in their clinical record – including clinical impressions, working diagnoses with senior colleagues and plans of management. This information must be updated before going off shift and must be the exclusive vehicle for communication management plans and changes.
Summary sheets can be easily misinterpreted or lost and the key clinical information may not result in action. This is particularly important when a plan is made which may encompass several shift changes e.g. removal of drains or catheters.

Due to the patient specific information contained on handover sheets it is vital that confidentiality is maintained and therefore the printed handover sheets must be disposed of in confidential waste at the end of use and it is the responsibility of each member of staff to do so.

8 Monitoring

The Directorate Standards will be monitored as outlined in the Clinical Handover Policy i.e. Annual Audit of procedure notes and practice.
<table>
<thead>
<tr>
<th>No.</th>
<th>Safety Issue</th>
<th>Specific Issues</th>
<th>Report Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Deteriorating Patients</td>
<td>All patients with NEWS at medium risk. If 3 in 1 category or &gt;5, identify any interventions required and discuss the requirement for any variances</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Infection Control Issues</td>
<td>Details of any outbreaks Special precautions Screening required VIP charts</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Patient identification</td>
<td>Patients with similar names Patients who are unable to wear or refuse to wear an identification band</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Patients; - DNR order - Expected deaths/dying pathway</td>
<td>List all patients names and Hospital Numbers</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>FOCUS</td>
<td>Patients at risk of falls Patients at risk of pressure ulcers Confused &amp;/or wandering patients</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Assessments &amp; investigations</td>
<td>Are any assessments required or results requiring review eg; - VTE - Dementia - Bloods or X-rays</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Incidents or Complaints</td>
<td>Details of significant clinical incidents (including near misses or complaints)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Service Disruption</td>
<td>Anything likely to disrupt patient care eg; - e-record downtime - Safety bulletin/alert information - Staffing issues</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Communication</td>
<td>Any patients who are Deaf, blind, have a learning disability or need an interpreter</td>
<td></td>
</tr>
</tbody>
</table>

Handover From ……………………………………………………………………………………………………………………………
Handover to …………………………………………………………………………………………………………………………………
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis  Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. Assessment Date:  **16th November 2015**

2. Name of policy / strategy / service:
   - Clinical Handover Policy

3. Name and designation of Author:
   - Lesley Kay, Consultant Rheumatologist & Clinical Director for Patient Safety and Quality.
   - Suzanne Medows, Senior Nurse Practice Development

4. Names & designations of those involved in the impact analysis screening process:
   - Suzanne Medows, Senior Nurse Practice Development, Lucy Hall, Equality and Diversity Lead

5. Is this a:  
   - Policy ✓  
   - Strategy  
   - Service  

   Is this:  
   - New  
   - Revised ✓  

   Who is affected  
   - Employees ✓  
   - Service Users  
   - Wider Community  

6. What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?  
   - The purpose of this policy is to provide, a rationale for clinical handover, determination of the standards of handover which must be delivered by individual clinicians and clinical teams in NUTH and a framework for handover based on the best evidence.

7. Does this policy, strategy, or service have any equality implications?  
   - Yes x  
   - No  

   This has been addressed within the final policy document

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
   - See below
### Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Interpreting service E&amp;D training</td>
<td>Clinical errors can occur if there is inadequate understanding of communication needs Add to 6.6 - SM</td>
<td>No</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>Chaplaincy Team available for advice</td>
<td>There may be times when it is important to include patients spiritual needs in the hand over</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Age</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
<td>Interpreting service E&amp;D training</td>
<td>There is a duty under the NHS Information Standard to ensure that disabled people’s communication and information needs are identified and met at all stages of patient care. Clinical errors can occur if there is inadequate understanding of communication needs Add to 6.6 - SM</td>
<td>No</td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Maternity / Pregnancy</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any
significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement?  Yes  No  

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No

PART 2

Name:
Suzanne Medows

Date of completion:
16th November 2015

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)