CLINICAL GUIDELINE FOR CLINICAL HANDOVER

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CLINICAL GUIDELINE SUMMARY

These Clinical Guidelines provide concise guidance to ensure that there is a system of effective communication between shift changes, which is intended to transfer essential information and highlight any associated risks necessary for the delivery of safe, holistic care of patients.

‘Patient’ will be the terminology used throughout this document and refers to patients, residents and service users.

The Trust monitors the implementation of and compliance with this clinical guideline in the following ways:

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The Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Chief Operating Officer.
1.0 INTRODUCTION

2.0 SCOPE

3.0 STANDARDS

4.0 RESPONSIBILITIES

5.0 MONITORING & REVIEW

6.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

APPENDICES

APPENDIX 1 – CLINICAL HAN DOVER STANDARD MONITORING TOOL

APPENDIX 2 – CLINICAL HAN DOVER RECORD

APPENDIX 3 – SHIFT CHECKLIST
1.0 INTRODUCTION

1.1 Clinical handovers focus upon the transfer of information and the establishing of a shared plan of care for the oncoming shift. It involves the accurate and reliable sharing of information that relates to the planning of patient care, the identification of safety concerns and the continuity of safe and effective care (based upon: Alvarado et al 2006).

1.2 The handover of information will predominately relate to the patient’s / resident’s health and will always include the following:
   - Discussion on the current presenting risk,
   - physical health observations and physical health care issues,
   - level of engagement and prescribed observation levels,
   - Mental Health Act (MHA) status,
   - leave status,
   - updating staff on current plans made in Multi-Disciplinary Teams (MDT) or care reviews,
   - any untoward incidents or occurrences,
   - allocation of tasks for the oncoming shift;

1.3 The clinical handover process will be undertaken at the commencement of each shift and is of particular importance to members of staff who have returned to work following days off from duty. Staff-members must ensure that they have given a comprehensive hand over as required to maintain safe practice.

1.4 The features of an effective clinical handover are recognised as: ensuring good communication; no / minimal interruptions; focusing upon relevant information; and prioritising the transfer of important information.

1.5 Clinical handovers will be undertaken in a clear, succinct manner, following a standardised system, allowing for effective, safe, risk focused communication between staff.

1.6 All contributions from staff attending the clinical handover should be heard with an expectation of challenge between members in an effort to achieve consensus.

2.0 SCOPE

2.1 This Clinical Guideline sets out the standards for Clinical Handovers within EPUT mental health inpatients.

2.2 This includes Mental Health wards, nursing homes and other teams within EPUT mental health inpatients where clinical handovers take place.
3.0 STANDARDS

3.1 Location

All clinical handovers will be undertaken in an area free from disruption, and the time dedicated will be protected from any non-emergency interruptions (NHS Institute 2008).

This will ensure that:
- All patient issues will be discussed free from the distraction of telephones, other healthcare professionals, relatives and patients;
- Discussions will remain private and not overheard.

3.2 Key Information to be included

At commencement of shift the oncoming nurse in charge walks the ward with outgoing nurse in charge to visibly confirm patients / residents. As a minimum clinical handover documentation should include an updated copy of the following for each patient / resident:

- patient’s / resident’s name;
- date of admission;
- current reason for admission
- physical health issues;
- diagnosis including physical illnesses
- named nurse / Care Co-ordinator;
- MHA (legal) status;
- level of engagement, therapeutic observation and leave status;
- summary of identified risks and risk status (where the zoning clinical risk management method is implemented, the patient’s / resident’s RAG status will be identified);
- presentation and any incidents in the previous 24 hours;
- summary of the plan of care and required interventions;
- current medication and any changes;
- any interventions that will impact on the staffing requirements (i.e. escorts)

The nurse leading the clinical handover should directly and verbally refer to:

- the patient / resident current physical and mental health presentations for the shift and identified health problems and required interventions, using the SBAR (Situation, Background, Assessment & Recommendation ) model of escalation, and the outcome provided / offered interventions;
- the medication chart to confirm all prescribed medicines are correctly dispensed and any omissions accounted for or corrected;
the ward / team / nursing home diary, to indicate the completion of tasks and planning the allocation of tasks;
o the ward / team / nursing home communication book, in reviewing any messages for the team or for individuals;

3.3 Staff Attendance

The clinical handover will be attended by:

- At least one qualified nurse from the outgoing shift or a person judged to be competent for areas that have been designated as not requiring a qualified nurse on duty
- The support worker who has been allocated to each patient / resident should handover those who have been in their care;
- All staff from the oncoming shift and, when possible, staff who are working long days;
- The team doctors (when available);
- Allied Health Professionals (when available)

Students and new staff to the area will attend clinical handovers as frequently as possible in addition to their start of shift handover. Senior students will be expected to be supervised by qualified staff to practice leading clinical handovers.

Other health and social care professionals who have input to the care of patients / residents can be asked to attend when appropriate.

3.4 Conducting the clinical handover

The clinical handover will commence on time, at the beginning of each shift, and all verbal exchange to be succinct, to the point and relevant to patient’s current presentation. It is the individual responsibility of each member of the oncoming team to ensure they attend on time to receive the information regarding the care of the patients / residents.

The nurse(s) who will be responsible for conducting the handover of information to the oncoming shift must be allocated at the beginning of the shift, allowing adequate time to prepare. To ensure the accuracy and enhance the quality of information that will be handed over the verbal exchange of information must be complemented through the use of written information such as the care records and the use of a written shift handover sheet (Appendix 2) or electronic screen where available.

The shift handover sheet (Appendix 2) must be used to hand over to the oncoming night staff and can be used again for the following morning shift hand over. The completed tool must then be signed by both the outgoing and oncoming nurse in charge to ensure all documentation is up to date, be appropriately stored as per record keeping policy requirements (CP9 Records Management Policy) either through electronic file management or within a suitable folder and secured at the team base.
All new admissions / transfers must be handed over with direct reference to the care record.

Mental Health Nurses in an in-patient or nursing home setting have 24 hour responsibility, therefore after each clinical handover the outgoing and oncoming nurses must account for the wellbeing and whereabouts of each patient including reflection upon mental state and condition. The Nurse in Charge has ultimate responsibility for ensuring this is undertaken as per Trust Engagement and Observation Clinical Policy, CLP8.

3.5 Supervision of Patients

The nurse in charge of the outgoing shift will allocate sufficient staff to be available in patient areas to maintain prescribed levels of observation / engagement.

Staff from the outgoing shift will not leave the ward / home until the handover ends, unless advised otherwise by the nurse in charge.

Allied health professionals attending the ward / unit outside of the handover times should have access to the handover sheets. They should be given the opportunity to ask questions and advised of any risks or details of the patient / resident they will be working with.

3.6 Time Management

All clinical handovers must commence promptly at the agreed scheduled shift start times.

All staff will ensure their timely attendance for the clinical handover. Staff not present at the formal handover will ensure that they receive a handover from the nurse in charge.

The duration of the clinical handover should be set by issues to be discussed on the day.

4.0 RESPONSIBILITIES

4.1 Ward Sisters / Charge Nurses / Home Managers or Team Leaders are accountable for ensuring all staff on their wards / teams / home are aware of the clinical guidelines and that they are competent to carry it out. The individual shift leader is responsible for implementing the clinical guidelines.

4.2 Clinical Leads and Clinical Managers are accountable for ensuring that their service areas are upholding the clinical guidelines at all times.

4.3 Qualified staff are expected to be competent to handover. In areas where a non-qualified person is required to handover, the qualified staff will ensure that the delegated person is competent to lead a handover.
5.0 MONITORING AND REVIEW

5.1 In order to achieve and ensure a high quality of practice a series of quality standards for clinical handovers have been established in the form of a monitoring tool, Appendix 1. This tool can be completed by any member of the team to audit and monitor the implementation of the clinical handover practice standards bi-monthly and / or at the discretion of the Ward Sister / Charge Nurse / Home Manager / Team Leader whose responsibility it is to ensure that regular audits of the clinical handover are undertaken.

5.2 Matrons / Ward Managers will monitor the completion of Appendix 1 through the Ward Sister / Charge Nurse / Home Manager / Team Leader’s appraisal and supervision. The monitoring tool can be used to report areas of concern, and to identify and implement changes to practice, along with providing advice on the review and appropriate changes to this guideline.

6.0 REFERENCE TO OTHER TRUST POLICIES / PROCEDURES

- Records Management Policy and Procedure CP9 and CPG9
- Engagement and Observation Clinical Policy CLP8
- Time off in Lieu Agenda for Change NHS Handbook 2014

END