



**Northern Ireland Practice and Education Council for
Nursing and Midwifery**

Final Report

***‘Principles to enable safe, effective and person-centred
Handovers within acute settings in Northern Ireland’***

Phase One

July 2018

CONTENTS

Section		Page
	Acknowledgement	3
1.0	Introduction	4
2.0	Background	5
3.0	Project Plan	5
4.0	Methodology	6
5.0	Results	8
6.0	Discussion	11
7.0	Outcomes: Principles for an Effective Handover and Nursing Handover Prompt Sheet	13
8.0	Conclusion and Recommendations	19
9.0	References	21
Appendices	Appendix 1: Project Team Membership	22
	Appendix 2: Terms of Reference	23
	Appendix 3: Programme of work	25
	Appendix 4: Literature review	26
	Appendix 5: Effective Handover Survey Results	33
	➤ Table 1: Area of Practice	33
	➤ Table 2: Respondents by Banding	34
	➤ Table 3: Number of Handovers per day	34
	➤ Table 4: Time allocated and time taken for Handover	35
	➤ Table 5: Types of documentation respondents stated used for handover	36
	Appendix 6: Principles for an Effective Handover	42
	➤ Annex A: Nursing Handover Prompt Sheet	47

ACKNOWLEDGEMENT

As Chair of the Effective Handover Project Group, I would like to thank those staff from the five Health & Social Care Trusts, the Royal College of Nursing and the three Higher Education Institutes who gave freely of their time to contribute to the development of the Principles to enable Effective Handover in acute adult settings.

In particular, I wish to acknowledge the members of the Effective Handover Project Group who through their contribution, commitment, collaboration and partnership working, enabled the successful overall achievement of this project.

Finally, I wish to thank NIPEC's, administrative and information technology staff, for their significant contribution to the completion of this report.

Linda Kelly

**Assistant Director of Nursing: Safe and Effective Care
South Eastern Health & Social Care Trust
Chair of the Effective Handover Project Group**

1.0 INTRODUCTION

- 1.1 The Northern Ireland Practice and Education Council for Nurses and Midwives (NIPEC) engages with a wide range of stakeholders to identify the key priorities in health and social care for nursing and midwifery in Northern Ireland that inform NIPEC's Vision and Business Plans. A priority from a recent stakeholder event was that NIPEC would '***Develop principles to enable safe, effective and person-centred Handovers within acute settings in Northern Ireland.***'
- 1.2 There was a view presented at the NIPEC stakeholder event that handovers vary across the five HSC Trusts with regard to content, duration and approach. Adverse incidents (O'Hara, 2018, Keogh, 2013, HIQA, 2013, Francis, 2013 & NCEC, 2013) have highlighted the requirement for effective communication processes to underpin the provision of care. In addition The NMC Code (2015) '*requires nurses and midwives to provide a high standard of practice and care at all times through always practising in line with the best available evidence, communicating effectively*'.
- 1.3 The World Health Organisation (WHO) listed improved communications in handover in its top five safety solutions (2007), highlighting handover as the most frequent and significant communication process in the delivery of patient care, estimating that there are approximately 100 million handovers each year and that handover communication is responsible for 25 to 40 % of adverse events.
- 1.4 The nursing and midwifery 'change of handover' or 'shift report', as they are commonly referred to by the nursing and midwifery professions, is a communication process which occurs between two shifts of nurses or midwives with the specific purpose to communicate information about patients under their care (Lamond, 2000).Randell (2011). This suggests that Clinical Handover **refers to the explicit transfer of professional responsibility and accountability for a patient, or a group of patients, to another person or professional group, on a temporary or permanent basis**. Other common terms for this activity are: Shift Handover, Handoff or Nursing Report. For the purpose of this project, the term Handover will be used.

2.0 BACKGROUND

- 2.1 To date, there is limited evidence to determine which form of handover supports person centred practise for patients and their families, and for staff. Smeulers et al (2014) explored the available literature to determine the effectiveness of different nursing handover styles and concluded that at present there is limited high quality evidence.
- 2.2 To minimise the risk to individuals under our care, Randell (2011) suggests that there should be explicit agreement on: the location where handover takes place; the content and the degree of detail; the use of a structured approach; parameters around the duration and timings of handover, and identification of participants who need to be present; as well as exploring the actions that could be taken to minimise interruptions.

3.0 PROJECT PLAN

Project Aim

- 3.1 The aim of the project was to '***Develop principles to enable safe, effective and person-centred Handovers within acute settings in Northern Ireland.***'

Objectives

The objectives of the Project were to:

- 3.2 Develop an engagement strategy for key stakeholders.
- 3.3 Conduct a literature search and identify best practice in relation to safe and effective person-centred handovers.
- 3.4 Scope the relationship and interface with other clinical communication activities including Ward Rounds, Safety Briefs, Huddles, Multidisciplinary Team meetings, White Board Reports, ward and inter hospital transfers, and PACE Care Planning.

- 3.5 Identify and agree the core elements of a safe and effective person-centred handover.
- 3.6 Develop regional principles to be adopted across Northern Ireland that will:
- i. enable patients to take a lead role in their care
 - ii. support the delivery of person centred outcomes for safe and effective care and services
 - iii. satisfy the requirements of the NMC Code.
- 3.7 Identify proposals for implementation and spread, including challenges and signpost where further work may be required.
- 3.8 Make recommendations for suitability for spread in acute settings.
- 3.9 Consider impact of electronic notation within the recommendations.

4.0 METHODOLOGY

To deliver on the objectives the following actions were taken:

- 4.1 The Project Group was convened in June 2017 with representatives across nursing and midwifery including, service providers, education, system regulation and staff side (Appendix 1) to enable key stakeholders to be actively involved in this work. A HSC Trust Assistant Director of Nursing with responsibility for Safe and Effective Care, acted as the project chairperson. The members of the Project Group agreed terms of reference (Appendix 2) and a project plan which included the scope of this work (Appendix 3).

The initial phase focused on adult acute areas within Health and Social Care (HSC) Trusts, which would then inform the need for further work in the future. On-going evaluation of the management of the project was conducted through NIPEC. A literature search was conducted via Cumulative Index to Nursing and Allied Health Literature (CINAHL) using the search term 'Nursing Handover', 'Shift Handover', 'Hand-off' and 'Nursing Report'. The literature review is attached in Appendix 4.

4.2 Due to the very nature of nursing handover practice and the numerous interconnected activities at which information is shared (e.g. Ward Rounds, Safety briefs, Huddles, Multidisciplinary Team meetings, white board reports, ward transfers and inter hospital transfers) this project had the potential to become very complex. A phased approach was adopted in order to achieve the project aims. In the first instance, the work focused within Acute Adult Hospital settings to develop the initial principles for testing, with the view that further consideration would need to be given to review and adopt the principles, and to support the roll out across all clinical areas.

4.3 The views of staff involved in delivering care and carrying out handovers, as well as those who were delegated to carry out care, were sought through a questionnaire via survey monkey. Invitations to participate were sent to Bands 2-8 via the Executive Directors of Nursing, supported by the Effective Handover Project Group.

4.4 Nursing student preparation for the Nursing Handover was explored within the three universities through the members of the Project Team. The learning and teaching focus for Nursing Handover at the three higher education facilities in Northern Ireland (Open University, Queens University Belfast and the Ulster of Ulster) is based on developing effective communication strategies for each individual student. Preparation and practice of handover are provided through theoretical and practice modules throughout the degree programme, with students working with mentors to develop their communication skills. Each institution has its own method of preparing students for giving and receiving handover information by the use of case studies, small group work, simulation, peer and mentor review and formative and summative assessment strategies. There is not currently a specific focus on providing education to enable nurses to provide effective handovers either pre or post registration.

The principles of using a structured approach as suggested above would guide and support the critical thinking Nurse during handover discussion and reinforce and link practice to regional guidance for recording care such as PACE.

4.5 The NIPEC Recording Care Project has been focusing on a wide range of activities relating to nursing record keeping practice from 2009. In recent years, this has evolved into the PACE Project, which is taking forward further work to support the improvement of person-centred nursing care planning. Issues such as where

handover takes place, as well as what and how care is recorded, are being explored. Each Trust has a PACE Facilitator supporting the implementation of the PACE project. These individuals were asked to review the Principles for Effective Handovers, as they were in a position to offer feedback on how the principles could be operationalised within the PACE pilot sites.

5.0 RESULTS

An Effective Handover survey was carried out during November 2017. There were 176 relevant respondents from Adult Acute Areas across the Health and Social Care Trusts with the majority of respondents from specialist areas. The results in detail are attached in Appendix 5.

In summary, respondents feedback can be consider under the following headings:

5.1 Frequency and time allocated

The frequency of handovers ranged from 1 to 5 per day. The allocated time for a handover ranged from 10 to 60 mins with the longest time being taken for the morning handover. Although handovers can last longer than planned, 66% (n=113) stated they had sufficient time for handover.

5.2 Location

The location for the handover was primarily the nurses' station or office with only 26 respondents stating that the handover took place at the bedside

5.3 Staff involved

The range of staff involved in each of the handovers varied. There would appear to be 3 main approaches for unregistered staff to obtain information on the individuals they are to provide care for:

- Verbal handover information given directly by registered staff to Nursing Assistant, with 72 % stating that unregistered staff attended the formal Nursing Handover.

- Respondents stated that 28% of HCA staff did not attend the Nursing Handover and Nursing Assistant communicate care delivery to other Nursing Assistants using verbal, written or electronic information, or a combinations of these.
- Electronic print outs from patient information systems. How these are used was not detailed.

5.4 Documentation

Respondents listed a wide range of documentation, and approaches, that were used as part of the handover. However, only 25% stated that the nursing or patient notes were used.

5.5 Patient Involvement

64% of respondents stated that Patients were not involved in the handover while 36% stated they were. Patient involvement ranged from:

- Introduction to staff coming on duty to familiarize them with the nurse looking after them. Consent is requested at the bedside from the patient prior to Bedside Handover, and there may be discussion or input from the patient during the process.
- One Band 6 respondent stated '*why would patients be involved in a nursing handover?*'
- Where patients were not directly involved, any information that they ask to be shared, is done so at their request.

5.6 Staff suggestions to ensure an 'Effective Handover'

There was a wide range of views as to what were the key principles of an effective handover as well as the main barriers which are summarised below under three main headings:

- **Structure:** a wide range of suggestions regarding the structure and format of handover were offered which included:

- Standardised format of handover sheet relevant to the functioning of the ward and the needs of the patient
- Handing over of essential information only, from a current source, the charts and nursing admission
- Concise information and enable staff to ask questions
- Use patient charts to avoid errors
- Adequate time for handover and for documentation
- Accurate safety brief
- Use SBAR
- Tape record the handover
- Record electronically
- Reduce interruptions e.g. by:
 - Protected time – no patient transfers into or out of the area
 - inform NOK times for enquiries – coordinate information sharing within the family which would protect handover time
- Only get a handover of the patients you are looking after, not the whole ward
- All staff on duty to get the handover
- Sufficient information to update staff who have had days off
- Pre-printed handover sheets with headings to ensure that every hands over the same vital information and space to write notes.

'A good template which reduces need for duplication and guides staff as to what to record at handover is essential.'

Respondent 112

- **Environment:** both at the patient's bedside and away in a quiet room were suggested, as well as the use of electronic recording
- **Staff:** individuals with effective leadership, communication and documentation skills were highlighted, with a specific focus on teaching the skills of an effective handovers for students and new staff. The value of feedback regarding the handover process was also identified.

'... staff to develop skills in giving clear concise relevant information to ensure safe and effective practice. Effective listening when handover is being given. Unnecessary interruptions to avoid loss of focus staff to develop their time management skills.'

Respondent 123

6.0 DISCUSSION

- 6.1 The importance of Effective Handovers continues to be a significant patient safety issue as highlighted in the Inquiry into Hyponatraemia-related deaths Report (O'Hara 2018). In addition, the House of Commons Health Committee Report into Nursing Workforce reinforced the importance of nurses having time and support to be able to handover safely (2018).
- 6.2 The practice of the Nursing Handover between registered nurses at Shift Handover is well established. During handover sessions, there is also the opportunity for delegation of aspects of care from registered to non-registered staff, which is then supervised by a registered nurse or midwife. However, evidence emerged from the survey responses that unregistered staff were giving instructions regarding care to other unregistered staff.

From the data collected, respondents recognised the importance of the Handover as an important communication process. While there was an understanding of what constituted an effective handover, frustrations on how to implement this in practice were highlighted. In particular the number of interruptions experienced; the quality of the information shared; and the skill of individuals giving the handover were cited as main areas for consideration.

It was reported that there was a limited use of the nursing records during handover, and an over reliance on the use of printed handover sheets, which are not a permanent record of nursing care. An electronic information-sharing system that works effectively could potentially improve communication and be more time effective compared with traditional paper based or verbal handover.

6.3 There were mixed views on carrying out handover at the bedside rather than within a closed room despite the evidence that this approach reduces interruptions. There is also emerging evidence that bedside handovers improve communication between nurses, and when nurses demonstrate their knowledge at the bedside this increases patient confidence in their care.

'I do think bedside handovers for nurses is something that is underrated. Some colleagues worry about privacy and confidentiality, however our medical colleagues manage to do this effectively. It would also engage the patient more and their care would be driven by them in terms of their nursing needs. This would then be reflected in how we then document as well.'

Respondent 21

'The project we are running on the introduction of end of bed handovers is making dramatic improvements in the quality of care.'

Respondent 112

6.4 The use of a structured approach to handover was highlighted within the literature reviewed and this was supported by the survey respondents.

'..... a good template which reduces need for duplication and guides staff as to what to record and handover is essential.'

Respondent 112

Bedside Handovers were also seen a mechanism where patients awareness of a nurse's knowledge, competence and professionalism increased. Although nurses highlighted concerns regarding confidentiality, McMurray et al (2011), Starr (2014) and Lupieri et al (2016) suggested that patients were less concerned and more interested in being equal partners in their care.

7.0 OUTCOMES

Principles of Effective Handovers and a Nursing Handover Prompt Sheet were developed to provide a structured framework which reflects both the literature and survey data. This approach enables patients to take a lead role in their care and support the delivery of person centred outcomes for care and service, while satisfying the requirements of the NMC Code

7.1 The Principles of Effective Handovers

The importance of Effective Handovers continues to be a significant patient safety issue. Recent adverse incidents (Keogh, 2013; HIQA, 2013; Francis, 2013; NCEC, 2013 & O'Hara 2018) have highlighted the requirement for effective communication processes to underpin the provision of care. In addition The NMC Code (2015) 'requires nurses and midwives to provide a high standard of practice and care at all times through always practising in line with the best available evidence, communicating effectively'.

The following 'Principles for an Effective Handover' were developed by individuals representing the five Health and Social Care Trusts, the three Universities, the Regulation Quality and Improvement Agency and the Royal College of Nursing, led by the Northern Ireland Practice and Education Council. The Principles are based on the findings from a comprehensive literature review and the data from a Regional survey. As Phase 1 of the project was completed in 2018 and focused on the Adult Acute setting, the Principles will be adopted and tested through the Person centred Assessment, Plan of Care and Evaluation (PACE) workstream of the Recording Care Project prior to full implementation.

The key principles are presented below under the headings: **What**, **Who**, **When**, **Where**, **How**:

WHAT is a Nursing Handover?

Nursing Handover refers to ***the explicit transfer of professional responsibility and accountability for a patient, or a group of patients, to another person or***

professional group, on a temporary or permanent basis (Randell 2011). In developing these principles, Handover is therefore considered as the formal transfer of professional accountability of care, epitomised by the sharing of information about an individual person or group of persons.

The process enables the nurse to share important information with the nurse taking on the responsibility of care. They in turn are accepting the professional and accountable responsibility for the nursing care of the patient and will be using the information shared to inform ongoing safe and effective person-centred care.

Each handover should facilitate the introduction of staff coming on duty to other staff members and to the patient and family (if present).

WHAT is not a Nursing Handover?

There are a number of other communication processes within the ward environment where important information is shared e.g. Ward Rounds, Safety briefs, Huddles, Multidisciplinary Team meetings, white board reports etc. However, during these activities, there is NOT a transfer of responsibility and accountability for a patient or group of patients.

WHO should be involved in the Nursing Handover?

To ensure continuity, the nurse in charge with authority to whom all other nurses report should have an understanding of the care and treatment plan relating to each patient. Therefore he/she should attend the handover where possible.

Nursing Handover is a duty of care between the nurse who currently holds the responsibility of care, to the nurse who will be assuming responsibility of that care, and the staff who will be participating in the delivery of care.

All staff coming on duty need to receive a Nursing Handover, including non-registered staff (e.g. nursing assistants).

The patient must be given the opportunity to be part of the handover of their care and this premise should be extended to the family of the patient where appropriate, giving due consideration to the patient's preferences.

WHEN should the Nursing Handover take place?

Handover must occur when the responsibility for a patient's care is transferred from one nurse to another.

Shift change: transfer of care:

Handover of care takes place every day at the shift changeover. Within care settings there may be different shift patterns, however, the most obvious shift change is the Night/Day and the Day/Night changeovers. In some care settings there may be additional shift changes during the working day and handover of care from the nurse going off shift to the nurse coming on shift must follow the same principals.

Short term temporary: transfer of care:

Handover of care of a patient for a temporary period of time, for example, where the patient requires a diagnostic test in a different department or attends for surgical intervention, occurs between the staff who hold the responsibility for the care and the nursing staff who will be assuming responsibility of the care. This may consist of a written or verbal handover, focusing on the greatest risk for the patient, following the same principles outlined in this paper.

WHERE should the Nursing Handovers take place?

The handover of the responsibility of each patient's care must be delivered as close to the patient's bedside as is practical and appropriate. This is to facilitate the involvement of the patient and to enable the safe and effective handover of nursing care.

HOW should the Nursing Handover be delivered?

Handover information should be generated from the each patient's permanent legal nursing record (In-patient Admission Booklet; the ongoing assessment; plan of care; and evaluation) and the associated contemporaneous care and treatment plans

Handover to be given using an agreed structured framework such as the Nursing Handover Prompt Sheet (See Appendix 6).

The information provided to be succinct and relevant.

The process to be supervised by the senior nurse present who has a professional duty to provide clear leadership and ensure interruptions are minimised.

There are many ways in which developments in information technology can assist with the nursing handover process. An electronic information-sharing system that works effectively can potentially improve communication and be more time effective compared with traditional paper based or verbal handover alone.

WHAT information should the Nursing Handovers include?

The information that is communicated at Handover should enable the nurse who is taking on responsibility for each patient to deliver timely safe and effective care which reflects the patient's preferences, their holistic needs and provides a clear plan for the next shift.

The use of a Nursing Handover Prompt Sheet (see Appendix 6) can assist nurses to embed a structured and systematic approach which enhances the communication process, thereby improving patient safety and reducing risk of omission of key data and information at handover. This will include:

Personal Details:

The patient's name (including preferred name); age; date and reason for admission; allergies and alerts (e.g. DNRCPR); past medical/surgical history; estimated date of discharge (EDD); and what is important to the patient.

Nursing Assessment:

How the patient is feeling, the patient's baseline ability and current status against daily activities; the patient's current clinical condition; their risk status (against the nursing risk assessments); and any incidents.

Plan of Care:

The current plan of nursing and medical care including referrals to other professionals (including discharge planning); and the aim of that care.

Evaluation:

The progress of the patient against the plan of nursing and medical care (including relevant AHP and specialist nurse plans of care) towards the aim of that care; the day since admission (e.g. Day 3); and relevant communication to/from the patient and family.

Information given at handovers will of course vary depending on the variables within care settings and the variables around individual patient: their length of stay and known information at the time of the handover. The registered nurse may then delegate aspects of care with the aim of promoting the best practice approach of person-centred care taking account of the individual needs and preferences of each patient.

The principles of using a structured approach as suggested above would guide and support the critical thinking nurse during handover discussion and reinforce and link practice to regional guidance for recording care such as PACE.

7.2 Nursing Handover Prompt Sheet

This Prompt tool has been developed to assist nursing staff to embed a structured routine which enhances the communication process, therefore improving patient safety and eliminating loss of data at nursing handover. Nursing Handover ***refers to the explicit transfer of professional responsibility and accountability for a patient, or a group of person, to another person or professional group, on a temporary or permanent basis*** (Randell 2011).

Professional Management of Nursing Handover

- Identify the Senior Nurse who will provide leadership throughout the handover
- Commence on time
- Finish on time
- Everyone who needs to be attending, is there on time
- All information required is available before the handover commences
- Arrangements on how to manage interruptions are agreed
- Where pre-prepared handover sheets are used, these are available and up to date at the outset

The Person	<ul style="list-style-type: none"> • Persons Name • Age • Consultant ~ Safety: Nursing risk assessments (such as infection status, DNR status, Allergies, Falls)
Medical Diagnosis	<ul style="list-style-type: none"> • Date of admission and/ or date of surgery or days post op • List relevant medical /surgical history by priority • Expected date of discharge
Medical Plan	<ul style="list-style-type: none"> • Diet • Medications • Intravenous therapy (IVs), Treatments • Diagnostic tests and procedures (including dates and results) • Consultations
Assessment of needs	<ul style="list-style-type: none"> • Acute ~ The person's main problem/need is ... and he/she will need ... i.e. what is the plan of care during the next shift? ~ Evaluate care to date and outline what change, progress or deterioration there has been ~ The next problem/need is ... etc.
Plan of Care	<ul style="list-style-type: none"> • Existing ~ The person's other problem/need is ... and he/she will need ... i.e. what is the plan of care during the next shift? ~ Outline what change, progress or deterioration there has been
Evaluation	<ul style="list-style-type: none"> • Emerging ~ A new problem/need for the person is ... and he/she will need ... i.e. what is the plan of care during the next shift?
Review	<ul style="list-style-type: none"> • Outstanding planned care yet to be delivered and update on discharge plan • Summary of communication with family

8.0 CONCLUSION AND RECOMMENDATIONS

The Effective Handover Project Report will be presented to the Chief Nursing Officer and Executive Directors of Nursing. The Effective Handover Principles will also be shared with the Central Nursing and Midwifery Advisory Committee highlighting the interface with the Recording Care workstreams. Although the Principles will have been reviewed for suitability for both adult and paediatric PACE sites, further testing may need to take place.

Specific issues to be considered:

- Nursing Assistant communication of care delivery to other Nursing Assistants across shift patterns.
- Registered Nurses giving a handover using documents other than the nursing record e.g. excel spread sheet/word document.

Recommendation 1:

The 'Principles for Effective Handover' (Appendix 6) should be integrated into the Recording Care Project and workstream. In line with the original Effective Handover Project Workplan (Appendix 3), phased testing will need to be undertaken. The full implementation of the Principles of an Effective Handover will be progressed by the Recording Care Steering Group.

Recommendation 2:

To ensure continuity, the nurse in charge with authority to whom all other nurses report, should have an understanding of the care and treatment plan relating to each patient. Therefore he/she should attend the handover where possible.

Recommendation 3:

Unregistered staff, i.e. Nursing Assistants, should attend the Nursing Handover where the registrant who is accepting responsibility for the patient or group of patients can ensure appropriate delegation of care.

Recommendation 4:

Further work should be considered which scopes the relationship and interface with other clinical communication activities including Ward Rounds, Safety Briefs, Huddles, Multidisciplinary Team meetings, White Board Reports, ward and inter hospital transfers and PACE Care Planning

Recommendation 5:

Through the 'Recording Care Project', discussions should take place with The ENCOMPASS programme of work to provide an appropriate facility to support the provision of an effective handover within a digital platform.

Recommendation 6:

Using a co-production approach, the impact of Nursing Handovers on the delivery of safe, quality nursing care should be measured.

9.0 REFERENCES

Department of Health/NCEC/Patient Safety First (Nov 2014) Communication (Clinical Handover) in Maternity Services National Clinical Principles No 5

Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, The Mid Staffordshire Foundation Trust, Stationary Office, London, United Kingdom

HQIA (2013) Patient safety Investigation Report into Services at University Hospital Galway (UHG) HIQA, Dublin, Ireland.

Keogh, B. (2013) Review into the Quality of Care and Treatment Provided by 14 Hospitals Trusts in England, NHS, United Kingdom

Lamond, D. (2000) The Information centred of the nurse in charge of shift report: a comparative study, *Journal of Advanced Nursing* 314

Nursing and Midwifery Council (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*. London: NMC

O'Hara, J. (2018) The Inquiry into Hyponatremia -Related Deaths Report. www.ihrdni.org

Randell R., Wilson S., and Woodward P. (2011) The importance of the verbal shift handover report: multisite case study, *International Journal of Medical Informatics* 80 803-812

Smeulers, M., Lucas, C. & Vermeulen, H. (2014) Effectiveness of different nursing handover styles for ensuring continuity of information in hospitalised patients. Cochrane library

Project Team Membership

Organisation	Representative
SEHSCT (Chair)	Linda Kelly Assistant Director of Nursing: Safe and Effective Care
NIPEC (Project Lead)	Bernadette Gribben Associate Senior Professional Officer
BHSCT	Lynn Wightman, Senior Manager Nursing
BHSCT	Marian Mulholland, Clinical Co-ordinator for Acute Medicine
BHSCT	Front line staff
NHSCT	Ruth Bailie , Senior Nurse Corporate Nursing
NHSCT	Front line staff
SEHSCT	Jane Patterson, Patient Safety Officer – Safe and Effective Care
SEHSCT	Front line staff
SHSCT	Josephine Matthews Lead Nurse SEC & Outpatients
SHSCT	Front line staff
WHSCT	Donna Keenan, Assistant Director of Nursing: Governance, Safe & Effective Care
WHSCT	Front line staff
QUB	Florence Mitchell Lecturer in School of Nursing
UU	Debbie Goode Lecturer in Nursing
OPEN UNIVERSITY	Donna Gallagher Staff Tutor, Nursing Senior Lecturer, Nursing
RQIA	Thomas Hughes Inspector Healthcare Team
Union	RCN: Rita Devlin Head of Professional Development Officer (to review and provide critical reading of project outputs) Unison: invited to participate

Terms of Reference

*Develop principles to enable safe, effective and person-centred Handovers
within acute settings in Northern Ireland*

1. Purpose of the group

The purpose of the Project Group is to develop principles to enable safe, effective and person-centred Handovers within acute settings in Northern Ireland. The group will inform the Chief Nursing Officer, through the Chair of the group, of achievements, ongoing work and concerns or challenges. The group will also review information in relation to HSC trust/ organisation work relating to handovers for overlap and duplication. It may, on occasion, provide advice and guidance to related project groups.

2. Membership of group

Membership of the group should be drawn from practitioners with extensive experience of handovers across day and night shifts. If a member is unavailable, an appropriate member of staff should be nominate to attend on his/her behalf, providing the relevant required information in advance for the alternate member to participate appropriately.

3. Quorum

Quorate membership is 50% of the total membership number. Representation from three out of five trusts is required for decision making within this quorate membership.

4. Frequency of meetings

The Project Group will meet initially to agree the Project Initiation Document, and at significant points agreed with the project group, to review the data collected and at a final meeting on 14th December 2017 to review and sign off the final report.

5. Record of meetings

NIPEC staff are responsible for agenda setting, record keeping and circulation of relevant papers in collaboration with the Chair of the group. The group identified that the preference was to record actions arising, rather than detailed minutes.

6. Accountability of the working group

The Project Group is accountable through the Chair to the Chief Nursing Officer (CNO). In addition, NIPEC, as project coordinator is also accountable through the Chief Executive to the CNO. The role and responsibilities of the members of the project group are:

- Tor 1* Agree a project plan, timescales and methodology for the project and develop a detailed work programme to meet the objectives outlined.
- Tor 2* Contribute to the achievement of the project aims and objectives.
- Tor 3* Undertake the work required to deliver the project objectives within the agreed timescales and resources as outlined in the project plan.
- Tor 4* Participate in respectful, open debate welcoming and providing constructive challenge.
- Tor 5* Manage information related to the project responsibly, ensuring confidentiality when required.
- Tor 6* Organise and undertake consultations with relevant stakeholders ensuring a coordinated approach across all relevant organisations as required.
- Tor 7* Actively participate in testing the final principles.
- Tor 8* Participate in shared learning across organisations.
- Tor 9* Provide advice to other regional groups as required.
- Tor 10* Disseminate the work of the project within their organisation as appropriate.

Programme of Work
June 2017 – December 2017

	Activity	Target	Related objective
1.	Establish an Project Group – including chair and identification of membership	June 2017	4.1
2.	Agree plan to complete project, including terms of reference and programme of work	June 2017	4.1
3.	To conduct a literature search and identify best practice in relation to safe and effective person-centred handovers	Aug 2017	4.2
4.	Scope current handover practice in each HSC Trust and identify areas of best practice		4.3
5.	The methodology to be used is as follows :		
i	<ul style="list-style-type: none"> • Develop template to collect data to scope current handover practice 	July 2017	4.3
ii	<ul style="list-style-type: none"> • Pilot template, review and amend template 	Aug 2017	4.3
iii	<ul style="list-style-type: none"> • Carry out data collection across the five HSC Trusts and using collaborative, inclusive and participatory approaches 	Aug 2017	4.3
iv	<ul style="list-style-type: none"> • Analyse Data 	Oct 2017	4.3
6.	Scope relationship and interface with other clinical communication activities including Safety Briefs, Huddles and Ward Rounds	Aug 2017	4.3
7.	Produce a draft version of the principles and circulate for testing	Oct 2017	4.4 4.5
8.	Obtain feedback from registrants through a range of inclusive approaches	Oct 2017	4.3
9.	Develop draft report and agree with the project group	Nov 2017	4.6 4.7 4.8
10	Consider approaches to evaluate the impact of the implementations of the principles	Nov 2017	4.6
11.	Complete final report	Oct 2017	4.6 4.7 4.8
12.	Agree amendments with the project group before presentation to NIPEC Chief Executive and then to Central Nursing and Midwifery Advisory Committee for acceptance and further dissemination as agreed	Dec 2017 Revised to Mar 2018	4.6 4.7 4.8

Literature Review and References to support the Effective Handover Project

1.0 Introduction

- 1.1 The NIPEC 2015 stakeholder event was planned with the clear intention of engagement with a wide range of stakeholders to help inform NIPEC's Vision (2016 – 2019) and Business Plan (2016 – 2017) by listening and eliciting stakeholders' views so that their needs and ideas would help shape what NIPEC aims to achieve. Participants were asked to identify the key priorities in health and social care for nursing and midwifery in Northern Ireland over the following year.
- 1.2 One of the priorities from the 2015 stakeholder event was for NIPEC to '*Develop guidance to enable and support comprehensive and effective handover within acute settings in Northern Ireland*' in collaboration with the five Health and Social Care Trusts.

2.0 Background

- 2.1 The nursing and midwifery change of handover or shift report is a communication process that occurs between two shifts of nurses or midwives with the specific purpose to communicate information about patients under the care of nurses or midwives (Lamond, 2000). Randell (2011) suggests that Clinical Handover refers to the transfer of professional responsibility and accountability for a patient, or a group of patients, to another person or professional group, on a temporary or permanent basis. Other common terms for this activity are: Shift Handover, Handoff or Nursing Report. For the purpose of this paper, the term Handover will be used. It is pivotal to the delivery of quality nursing care ensuring continuity and consistency (Hoban, 2003). An integral part of ward practice, handover can occur at least twice a day where those staff commencing duty receives details of the patients for whom they are responsible for the provision of care for the duration of that shift.
- 2.2 There are several types of handover including verbal, bedside, written and taped (Scovell, 2010). Handovers respond to local content and will vary according to the

specialty, the patient's condition, the severity and stability of the patient's condition and the workload of staff. Although verbal face to face predominate, taped handovers or web based handovers have also been used. Brandly et al would suggest that Bedside Handovers are increasing in popularity over recent years as they are seen to be more patient focused and actively involve patients in their care. However there is limited evidence to determine which form of handover supports person centred practise, for patients and their families, and for staff. Additionally, Smeulers et al (2014) explored the available literature to determine the effectiveness of different nursing handover styles and concluded that at present there is limited high quality evidence.

- 2.3 Factors which impact on handovers include the professionals familiarity with the patient, sense of responsibility for care, presence of senior staff and also an opportunity to provide training, support staff and encourage team cohesiveness (Kerr 2002)
- 2.4 Traditionally, handover skills are learned at ward level rather than through formal education processes. This subsequently results in a plethora of approaches to both the content and function of handover and particularly how it is given and/or received. Randell et al (2011) highlighted that shift handovers often start late, not all staff who should attend are present and interruptions are expected.
- 2.5 Recent adverse incidents (Keogh, 2013, HIQA, 2013, Francis, 2013 & NCEC, 2013) have highlighted the requirement for effective communication processes to underpin the provision of care. The Francis Report into care failings at Mid Staffordshire Foundation Trust highlighted a number of problems associated with Shift Handover. Problems included inadequate, inconsistent and sometimes non-existent handover between nursing staff. This failure to effectively carry forward patient information between shifts resulted in important aspects of care being missed. The report discusses the need for more effective handover of patient information which requires staff to have ready access to relevant information, and the time to communicate it.
- 2.6 The NMC Code (2015b) *'requires nurses and midwives to provide a high standard of practice and care at all times through always practising in line with the best available evidence, communicating effectively'*.

- 2.7 It has been identified that poor handover processes may result in poor communication which can subsequently negatively impact on patient safety (Wong et al, 2008, WHO, 2007, O'Hara 2018). There is a view presented at the NIPEC stakeholder event (2015) that handovers vary across the five HSC Trusts with regard to content, duration and approach. Burton et al (2016) caution that it may not be necessary to introduce a standardised handover, however, teams need to agree the model of handover and develop a clear structure, content and style as different areas will have different needs.
- 2.8 Randell et al (2011) highlighted that while technology may support effective handovers, healthcare professionals are able to identify relevant pieces of information, providing additional detail and explanation when required presenting this in a coherent story, which is 'circumstantially sensitive and relevant'.
- 2.9 Following a Systematic Literature review on Clinical Handovers, expert consultation and an examination of current clinical handover practice within HSC Trusts in Northern Ireland, it has been noted that the topic of handovers in general have received considerable attention lately, however, the studies designed so far '*are at a high risk of bias, generate only local knowledge or have been designed to generate effectiveness data*' and '*high quality evidence of the effectiveness of nursing handover style for ensuring continuity of information in hospitalised patients is lacking*' (Smeulers et al)(2014)

A Cochrane Systematic Review that was undertaken to identify the effectiveness of different nursing handover styles, found from the 2178 citations only 28 were considered potentially relevant. After a further independent review of these full texts, no eligible studies were identified and the authors concluded that there was no evidence available to support conclusions about the effectiveness of any particular nursing handover styles. (*Cochrane database of systematic Reviews, issue 6.* Smeulers et al 2014).

As a consequence, uncertainty about the most effective practice remains. Research efforts should focus on strengthening the evidence around the effectiveness of nursing handover styles using well designed, rigorous studies.

- 2.10 According to current knowledge, the following guiding principles can be applied when redesigning the nursing handover process: Face-to-face communication, structured documentation, patient involvement and use of IT technology to support the process that could be taken to minimise interruptions. Essential elements included: timely, accurate, complete, unambiguous and focused communications of information and recommends a structured communication tool promoting standardisation of practice and minimising variability thereby reducing the risk for patients. Randell (2011) suggests that there should be explicit agreement on: the location where handover takes place; the content and the degree of detail; the use of a structured approach; parameters around the duration and timings of handover, and identification of participants who need to be present; as well as exploring the actions
- 2.11 Patient participation in handover is one aspect of patient-centered care, where patients are considered partners in care. Understanding the patient's perspective provides a foundation for nurses to tailor their bedside handovers to reflect patient's thoughts and beliefs and encourage their active involvement in decision-making. Although nurses highlighted concerns regarding confidentiality, McMurray et al (2011), Starr (2014) and Lupieri et al (2016) suggested that patients were less concerned, and were more interested in being equal partners in their care. Bedside handovers were also seen a mechanism where patients awareness of a nurse's knowledge, competence and professionalism increased as a result of bedside handover
- 2.12 One quality improvement project implemented Bedside Handover in nursing. Using Lewin's 3-Step Model for Change, 3 wards in an Australian hospital changed from verbal reporting in an isolated room to Bedside Handover. Practice guidelines and a competency standard were developed. The change was received positively by both staff and patients. Staff members reported that Bedside Handover improved safety, efficiency, teamwork, and the level of support from senior staff members. Wong, MC. Yee, KC. & Turner P. (2008).
- 2.13 Another Australian study highlighted the importance of not only the information sharing that takes place, in addition it emphasised the interactive process which

needs to be present during a handover for communication to be effective (Eggins & Slade) (2015).

2.14 In recent years, there has been significant attempts to develop structures and process to increase effectiveness, such as:

- the 'ABCDE' in Imperial College London (Farhan 2012)
- ISBAR (Identity Situation, Background, Assessment and Recommendation) often used alongside a 'Safety Briefing'
- REED Model (Record, Evidence, Enquire and Discuss) Nursing Standard. 201428(20) 44-48, Alison Tucker, Healthcare at Home Kings Fund, London. P Fox, Royal United Hospital Bath, England.

3.0 References

- Bradley, S. & Mott, S., (2013) Adopting a patient centred approach: an investigation into the introduction of bedside handover to three rural hospitals. *Journal of Clinical Nursing* 23 (13-14)
- Burton, J., Norton, C., Smyth, N., Ward, H. and Day, S. (2016) Nurse Handover: patient and staff experiences. *British Journal of Nursing*. Vol 25. No. 7
- Department of Health /NCEC/ Patient Safety First (Nov 2014) Communication (Clinical Handover) in Maternity Services National Clinical Guidelines No 5
- Eggin S. and Slade D (2015) Communications in Clinical Handover: Improving The Safety and Quality Of The Patient Experience. *Journal of Public Health Research* 2015 Nov 17, 4(3): 666
- Farhan, M., Brown, R., Woloshynowych, M., & Vincent, C. (2012) The ABC of Handover: a qualitative study to develop a new tool for handover in the Emergency department
<http://emj.bmj.com/content/early/2012/01/03/ememed-2011-200199.long>
- Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, The Mid Staffordshire Foundation Trust, Stationary Office, London, United Kingdom
- Hoban, V. (2003) Careers: How to handle a handover *Nursing Times* 99 (9) 54-55
- HQIA (2013) Patient safety Investigation Report into Services at University Hospital Galway (UHG) HIQA, Dublin, Ireland
- Kerr M.P. (2002) A qualitative study of shift handover practice and functions from a social-technical perspective, *Journal of Advanced Nursing* 37 (2) 125-134
- Keogh, B. (2013) Review into the quality of care and Treatment provided by 14 hospitals Trusts in England, NHS, United Kingdom
- Lamond, D. (2000) The Information centred of the nurse in charge of shift report: a comparative study, *Journal of Advanced Nursing* 31(4)

Lupieri G., Creatti, C., Palese, A. (2016) cardiothoracic surgical experience on bedside nursing handovers: findings from a qualitative study. *Intensive and Critical care Nursing*. 35, 28-37

McMurray, A., Chayboyer, W., Wallis, M. et al (2011) Patients Perspective of bedside nursing handover. *Collegian* 18,1,19 -26)

Nursing and Midwifery Council (2015) .*The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*. London: NMC.

O'Hara, J. (2018) The Inquiry into Hypernatremia -Related Deaths Report. www.ihrdni.org

Randell R., Wilson S., and Woodward P. (2011) The importance of the verbal shift handover report: multisite case study, *International Journal of Medical Informatics* 80 803-812

Scovell, S (2010) Role of the Nurse to Nurse Handover in patient Care. *Nursing Times* 24(20), 35-39

Smeulers, M., Lucas, C. & Vermeulen, H. (2014) Effectiveness of different nursing handover styles for ensuring continuity of information in hospitalised patients. Cochrane library

Starr, L. (2014) Bedside Handovers and confidentiality - can they co-exist? *Australian Nursing and Midwifery Journal*. 22,1,21

Wong, MC. Yee, KC. & Turner P. (2008) Clinical Handover Literature Review. Tasmania, ehealth Services Research Group, University of Tasmania, Cited in Collins, G (2004) Using Simulation to Develop handover skills. *Nursing Times* 110(8) 12-14

World Health Organisation (2007) Collaborating Centre for Patient Safety Solutions. Communication during Patient Handovers. Patient safety Solutions. Geneva WHO

Effective Handover Survey Results November 2017

1.0 Areas of Practice

The survey was carried out during November 2017. There were 176 relevant respondents from Adult Acute Areas across the Health and Social Care Trusts with the majority of respondents from specialist areas. A number of areas (22%) indicated that they have previously been involved with projects which aimed to improve the handover process.

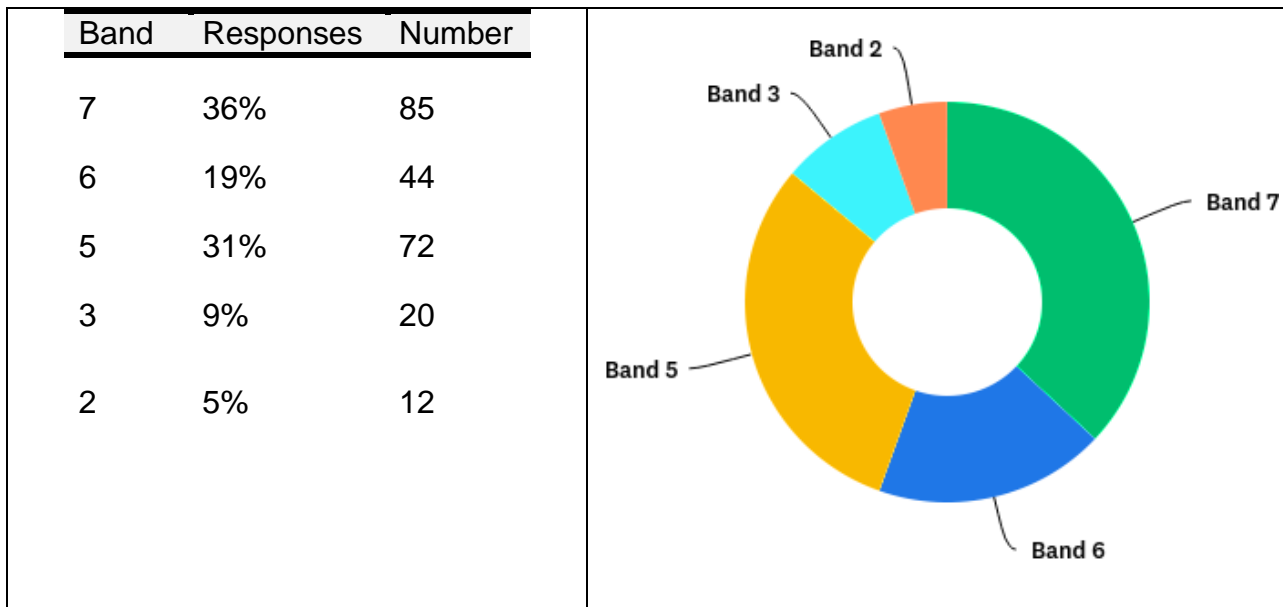
Table 1: Area of Practice

Area of Practice	Responses
General Medicine	20.5 %
General Surgery	8.5 %
Specialist Areas	71%
<p>Including:</p> <p><i>Ambulatory Care, Cancer and Specialist Services, Cardiology, Clinical decisions, Critical Care, Dermatology, Dialysis, Renal, Emergency Care, Fractures, Gynaecology, Haematology, Hepatology, Nephrology & transplant Palliative Care, Plastic surgery and maxillofacial, Stroke & medicine, Trauma, Orthopaedics & Vascular</i></p>	

The pie chart illustrates the distribution of responses across three categories: Specialist Area (71%), General Medicine (20.5%), and General Surgery (8.5%). The Specialist Area is represented by a large yellow slice, General Medicine by a green slice, and General Surgery by a blue slice.

The majority of responses were Band 7; however, over 14% of respondents were un-registered staff (Bands 2 & 3).

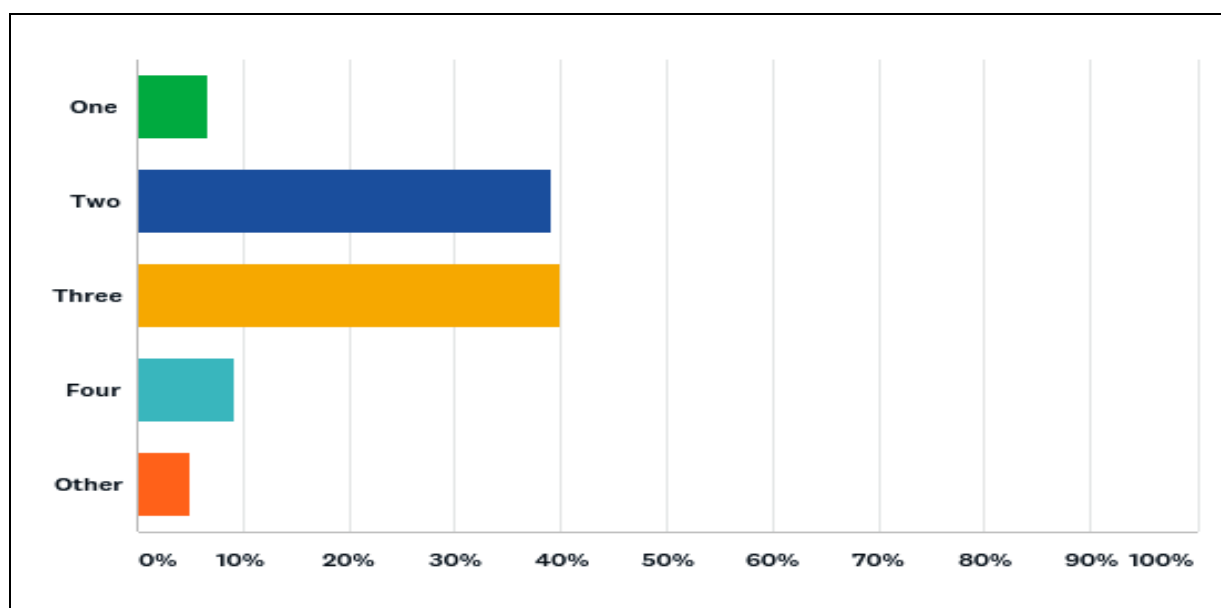
Table 2: Respondents by Banding



1.1 Handover Frequency and time allocated

Respondents indicated that the majority of wards had two or three handovers per day (Range from 1 to 5). The number of handovers in an area was not consistent, for example general ward areas reported between 2 and 4 handovers per day. There were reports of 4 handovers from a wide range of areas, including: General Medicine, General Surgery, Palliative Care, Oncology, Gynaecology and Plastics Surgery. Those areas which reported 1 handover, worked in specialist roles such as Macmillan Nurse Specialist.

Table 3: Number of Handovers per day



The time allocated for handover and the actual time taken ranged from 10 mins to 60 mins.

The most common time allocated for each shift was:

- morning 30 minutes (range from 10-60 minutes)
- midday 15 minutes (range from 10-30 minutes)
- afternoon 10 minutes (range from 10-30 minutes)
- night 30 minutes (range from 10-40 minutes)

Although handovers can last longer than planned, 66% (n=113) stated they had sufficient time for handover. Of those who stated that there was not sufficient time for handover, 37% were Band 5, 28%, were Band 7, 21% were Band 6.

Table 4: Time allocated and time taken for Handover

	Morning	Mid-day	Afternoon	Night
Stated number of handovers	156	92	67	123
Within allocated time	37%	62%	60%	35%
In excess of allocated time	54% *	34%	33%	60% **
NB: *22% of handovers were reported as taking double the time allocated **16% of handovers were reported as taking double the time allocated				
Range in mins	(5-25)	(5-15)	(5-30)	(5-30)
Less than allocated time	8%	4%	7%	5%
Range in mins	(5-10)	(5-10)	(5-15)	(5-10)

1.2 Location

Respondents stated that the majority of handovers take place at the nurses station (n=109), office (n=73) and bedside (n= 26). A range of other venues were also listed which included the Day Room (n=9), Staff Room (n= 4), Clinical room/procedure room (n=6) and 'Away from patients' (n =6). Handovers were reported as been given to all staff for the

entire ward, or a registered nurse handed over within a bay area based on the group of patients for whom the nurse would be delivering care.

1.3 Staff involved in Handover

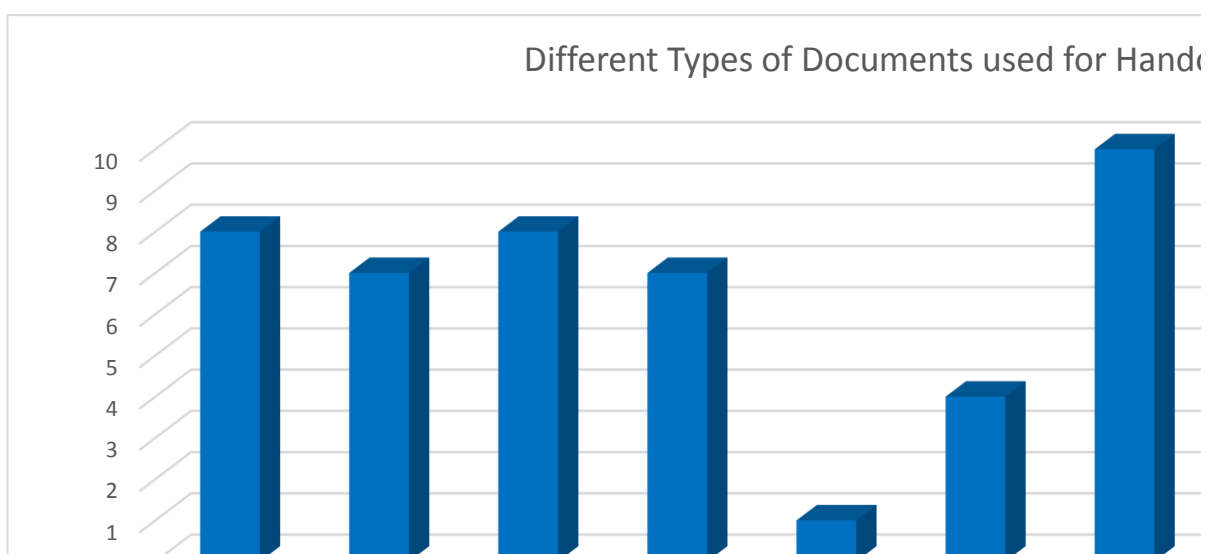
Respondents indicated that Bands 2-7 attend Handover. Band 7s are usually Ward Sisters/Charge Nurses, Band 6 are usually Deputy Ward Sisters/Charge Nurses, Band 5 are Staff Nurses and unregistered staff are generally Bands 2 and 3. There would appear to be 3 main approaches for unregistered staff to obtain information on the individuals they are to provide care for:

- Verbal Handover information given directly by registered staff to HCAs, with 72 % stating that unregistered staff attended the formal nursing handover.
- Nursing Assistant to Nursing Assistant communicate care delivery using verbal, written or electronic information or combinations of these. Respondents stated that 28% of HCA staff did not attend the nursing handover.
- Electronic print outs from patient information systems. How these are used was not detailed

1.4 Documentation used for Handovers

When asked '*what documents do you use for the Handover*', 25% (n=15) stated the nursing or patient notes. Other responses, which were not all documents, can be seen in Table 5.

Table 5: Types of documentation respondents stated are used for Handover



1.5 Patient involvement

64% of respondents stated that Patients were not involved in the handover while 36% stated they were. Patient involvement ranged from:

- Introduction to staff coming on duty to familiarize them with the nurse looking after them. Consent is requested at bedside from patient prior to bedside handover and there may be discussion / input from them during handover.
- One Band 6 respondent stated *'why would patients be involved in a nursing handover'*.
- Where patients were not directly involved, any information that they request to be forwarded, is done so at their request.

1.6 Minimising and Managing Interruptions

Respondents indicated that interruptions were an issue in almost all areas and managing these was *'almost impossible'*. Types of Interruptions reported included phone calls, bleeps, MDT Colleagues, relatives and patient call bells/buzzers. In particular, problems regarding the lack of space, complexity of patient care and the pressure for admissions at all times as well as multidisciplinary team activities were identified.

Approaches to reduce interruptions included:

- ensuring patients are comfortable before starting handover
- carrying out the handover within a closed room with signs on the door
- sufficient staff to remain on the ward to attend to patient needs
- visitors asked to leave the ward during handover
- multidisciplinary team asked not to interrupt except in an emergency
- providing advanced information and asking relatives not to phone during handover times.

Respondents also stated that staff behaviours during handovers needed to be addressed to maximise outcomes and reduce interruptions including:

- turning off mobile phones
- refocusing the conversations
- not talking over each other

- actively listening
- good time keeping.

A small number of respondents who were involved in Handover Projects described that when handover moved nearer to patient's e.g. within each bay or bedside, interruptions were reduced.

1.7 Respondents suggestions for key principles for an Effective Handover

Responses indicated that effective communication within the team was important in order to support and ensure safe and effective practice, continuity of care and workload prioritisation. The key principles identified by respondents highlighted the importance of:

- Attendance of all appropriate staff at handover including the most senior nurse on duty, the nurse who has cared for the patient, and where possible, the patient.
- Uninterrupted time to carry out handover (with the patient, in the bay or in a quiet area).
- Practitioners with highly developed communication skills to ensure all salient issues are clearly articulated during the handover.
- The use of agreed structure and processes including:
 - the use of patient nursing notes and end of bed charts
 - an atmosphere and culture conducive to facilitating questions and issues to be raised
 - agreed ground rules or ways of working
 - use of pre-printed sheets with information on each patient.

In addition, respondents identified the following information as necessary for an effective handover:

General:

- *Concise safety brief at the start*
- *Patient centred - accurate, correct, factual, relevant, essential, appropriate, concise and succinct*
- *Detailed, current and up-to-date*
- *Exceptional information (e.g.*

Specific:

- *Nursing Assessment details – activities of daily living, – individual needs and dependency,*
- *History*
- *Evaluation of care, changes to care, variances, investigations, tests, results and*

- | | |
|--|---|
| <p><i>medications required outside of normal medications times)</i></p> <ul style="list-style-type: none"> • <i>Patients and family requirements, wishes and goals</i> • <i>Where the patients are in the ward, bed number or room number</i> • <i>Prioritise ill patient and those patients in most need of review</i> | <p><i>NEWS</i></p> <ul style="list-style-type: none"> • <i>Nursing care plan (agreed)</i> • <i>Risk Assessments, Safety issues, Allergies and DNAR status</i> • <i>Medical Assessment, Diagnosis & History, and plan of treatment</i> • <i>Reason for admission and symptoms</i> • <i>Tasks (completed/outstanding)</i> • <i>Discharge plan and transition form</i> • <i>Estimated date of discharge</i> |
|--|---|

1.8 Respondents identified obstacles to Effective Handovers

The main obstacles highlighted by respondents are presented under the headings:

- **Process:**
 - lack of leadership – facilitating pertinent questions/comments and addressing unnecessary chatting
 - no handover sheet or poorly completed or not updated handover sheet
 - inaccuracies, irrelevant facts or omission of relevant information
 - deviating from the handover
 - absence of patients nursing/medical notes to use for handover
 - lack of structure – to provide an effective summary and prevent deviation from the relevant information
 - too much time given or not enough time given.

- **Environment:**
 - noisy
 - no privacy
 - not confidential
 - lack of space
 - open-ward handover.

- **Individual staff lack of:**
 - knowledge of the patients
 - effective communication skills
 - professionalism and respect

- documentation skills.
- **Interruptions:**
 - MDT members wanting to hand over or obtain information
 - telephone calls
 - visitors and relative requesting information
 - buzzers or alarms
 - other areas wanting to transfer patients in and out of ward
 - staff being called away
 - sorting staffing out and covering shifts.
- **Miscellaneous:**
 - High patient acuity and Large workload
 - Poor staffing levels
 - High dependence on bank and agency staff who do not know the routines etc.

1.9 Improved Handover

Suggestions from respondents on how to improve handovers can be considered under the headings:

- **Structure:** a wide range of suggestions regarding the structure and format of handover were offered which included:
 - Standardised format of handover sheet relevant to the functioning of the ward and the needs of the patient
 - Handing over of essential information only, from a current source, the charts and nursing admission
 - Concise information and enable staff to ask questions
 - Use patient charts to avoid errors
 - Adequate time for handover and for documentation
 - Accurate safety brief
 - Use SBAR
 - Tape record the handover
 - Record electronically
 - Reduce interruptions e.g. by:
 - Protected time – no patient transfers into or out of the area

- inform NOK times for enquiries – coordinate information sharing within the family which would protect handover time
- Only get a handover of the patients you are looking after, not the whole ward
- All staff on duty to get the handover
- Sufficient information to update staff who have had days off
- Pre-printed handover sheets with headings to ensure that every hands over the same vital information and space to write notes.

'A good template which reduces need for duplication and guides staff as to what to record at handover is essential.'

Respondent 112

- **Environment:** both at the patient's bedside and away in a quiet room were suggested, as well as the use of electronic recording
- **Staff:** individuals with effective leadership, communication and documentation skills were highlighted, with a specific focus on teaching the skills of an effective handover for students and new staff. The value of feedback regarding the handover process was also identified.

'... staff to develop skills in giving clear concise relevant information to ensure safe and effective practice. Effective listening when handover is being given. Unnecessary interruptions to avoid loss of focus staff to develop their time management skills.'

Respondent 123

PRINCIPLES FOR AN EFFECTIVE HANDOVER

The importance of Effective Handovers continues to be a significant patient safety issue. Recent adverse incidents (Keogh, 2013; HIQA, 2013; Francis, 2013; NCEC, 2013 & O'Hara 2018) have highlighted the requirement for effective communication processes to underpin the provision of care. In addition The NMC Code (2015) '*requires nurses and midwives to provide a high standard of practice and care at all times through always practising in line with the best available evidence, communicating effectively*'.

The following '*Principles for an Effective Handover*' were developed by individuals representing the five Health and Social Care Trusts, the three Universities, the Regulation Quality and Improvement Agency and the Royal College of Nursing, led by the Northern Ireland Practice and Education Council. The Principles are based on the findings from a comprehensive literature review and the data from a Regional survey. As Phase 1 of the project was completed in 2018 and focused on the Adult Acute setting, the Principles will be adopted and tested through the Person centred Assessment, Plan of Care and Evaluation (PACE) workstream of the Recording Care Project prior to full implementation.

The key principles are presented below under the headings: **What**, **Who**, **When**, **Where**, **How**.

WHAT is a Nursing Handover?

Nursing Handover refers to ***the explicit transfer of professional responsibility and accountability for a patient, or a group of patients, to another person or professional group, on a temporary or permanent basis*** (Randell 2011). In developing these principles, Handover is therefore considered as the formal transfer of professional accountability of care, epitomised by the sharing of information about an individual person or group of persons.

The process enables the nurse to share important information with the nurse taking on the responsibility of care. They in turn are accepting the professional and accountable responsibility for the nursing care of the patient and will be using the information shared to inform ongoing safe and effective person-centred care.

Each handover should facilitate the introduction of staff coming on duty to other staff members and to the patient and family (if present).

WHAT is not a Nursing Handover?

There are a number of other communication process within the ward environment where important information is shared e.g. Ward Rounds, Safety briefs, Huddles, Multidisciplinary Team meetings, white board reports etc. However, during these activities, there is NOT a transfer of responsibility and accountability for a patient or group of patients.

WHO should be involved in the Nursing Handover?

To ensure continuity, the nurse in charge with authority to whom all other nurses report should have an understanding of the care and treatment plan relating to each patient. Therefore he/she should attend the handover where possible.

Nursing Handover is a duty of care between the nurse who currently holds the responsibility of care, to the nurse who will be assuming responsibility of that care, and the staff who will be participate in the delivery of care.

All staff coming on duty need to receive a Nursing Handover, including non-registered staff (e.g. nursing assistants)

The patient must be given the opportunity to be part of the handover of their care and this premise should be extended to the family of the patient where appropriate, giving due consideration to the patient's preferences.

WHEN should the Nursing Handover take place?

Handover must occur when the responsibility for a patient's care is transferred from one nurse to another.

Shift change: transfer of care:

Handover of care takes place every day at the shift changeover. Within care settings there may be different shift patterns, however, the most obvious shift change is the Night/Day and the Day/Night changeovers. In some care settings there may be additional shift changes during the working day and handover of care from the nurse going off shift to the nurse coming on shift must follow the same principals.

Short term temporary: transfer of care:

Handover of care of a patient for a temporary period of time, for example, where the patient requires a diagnostic test in a different department or attends for surgical intervention, occurs between the staff who hold the responsibility for the care and the nursing staff who will be assuming responsibility of the care. This may consist of a written or verbal handover, focusing on the greatest risk for the patient, following the same principles outlined in this paper.

WHERE should the Nursing Handovers take place?

The handover of the responsibility of each patient's care must be delivered as close to the patient's bedside as is practical and appropriate. This is to facilitate the involvement of the patient and to enable the safe and effective handover of nursing care.

HOW should the Nursing Handover be delivered?

Handover information should be generated from the each patient's permanent legal nursing record (In-patient Admission Booklet; the ongoing assessment; plan of care; and evaluation) and the associated contemporaneous care and treatment plans.

Handover should be given using an agreed structured framework such as the Nursing Handover Prompt Sheet within Annex A.

The information provided to be succinct and relevant.

The process to be supervised by the senior nurse present who has a professional duty to provide clear leadership and ensure interruptions are minimised.

There are many ways in which developments in information technology can assist with the nursing handover process. An electronic information-sharing system that works effectively can potentially improve communication and be more time effective compared with traditional paper based or verbal handover alone.

WHAT information should the Nursing Handovers include?

The information that is communicated at Handover should enable the nurse who is taking on responsibility for each patient to deliver timely safe and effective care which reflects the patient's preferences, their holistic needs and provides a clear plan for the next shift.

The use of a Nursing Handover Prompt Sheet (see Annex A) can assist nurses to embed a structured and systematic approach which enhances the communication process, thereby improving patient safety and reducing risk of omission of key data and information at handover. This will include:

Personal Details:

The patient's name (including preferred name); age; date and reason for admission; allergies and alerts (e.g. DNRCPR); past medical/surgical history; estimated date of discharge (EDD); and what is important to the patient.

Nursing Assessment:

How the patient is feeling, the patient's baseline ability and current status against daily activities; the patient's current clinical condition; their risk status (against the nursing risk assessments); and any incidents.

Plan of Care:

The current plan of nursing and medical care including referrals to other professionals (including discharge planning); and the aim of that care.

Evaluation:

The progress of the patient against the plan of nursing and medical care (including relevant AHP and specialist nurse plans of care) towards the aim of that care; the day since admission (e.g. Day 3); and relevant communication to/from the patient and family.

Information given at handovers will of course vary depending on the variables within care settings and the variables around individual patient: their length of stay and known information at the time of the handover. The registered nurse may then delegate aspects of care with the aim of promoting the best practice approach of person-centred care taking account of the individual needs and preferences of each patient.

The principles of using a structured approach as suggested above would guide and support the critical thinking nurse during handover discussion and reinforce and link practice to regional guidance for recording care such as PACE.

Nursing Handover Prompt Sheet

This Prompt tool has been developed to assist nursing staff to embed a structured routine which enhances the communication process, therefore improving patient safety and eliminating loss of data at nursing handover. Nursing Handover **refers to the explicit transfer of professional responsibility and accountability for a patient, or a group of person, to another person or professional group, on a temporary or permanent basis** (Randell 2011).

Professional Management of Nursing Handover

- Identify the Senior Nurse who will provide leadership throughout the handover
- Commence on time
- Finish on time
- Everyone who needs to be attending, is there on time
- All information required is available before the handover commences
- Arrangements on how to manage interruptions are agreed
- Where pre-prepared handover sheets are used, these are available and up to date at the outset

The Person	<ul style="list-style-type: none"> • Persons Name • Age • Consultant ~ Safety : Nursing risk assessments (such as infection status, DNR status, Allergies, Falls)
Medical Diagnosis	<ul style="list-style-type: none"> • Date of admission and/or date of surgery or days post op • List relevant medical/surgical history by priority • Expected date of discharge
Medical Plan	<ul style="list-style-type: none"> • Diet • Medications • Intravenous therapy (IVs), Treatments • Diagnostic tests and procedures (including dates and results) • Consultations
Assessment of needs	<ul style="list-style-type: none"> • Acute ~ The person's main problem/need is ... and he/she will need ... i.e. what is the plan of care during the next shift? ~ Evaluate care to date and outline what change, progress or deterioration there has been ~ The next problem/need is ... etc.
Plan of Care	<ul style="list-style-type: none"> • Existing ~ The person's other problem/need is ... and he/she will need ... i.e. what is the plan of care during the next shift? ~ Outline what change, progress or deterioration there has been
Evaluation	<ul style="list-style-type: none"> • Emerging ~ A new problem/need for the person is ... and he/she will need ... i.e. what is the plan of care during the next shift?
Review	<ul style="list-style-type: none"> • Outstanding planned care yet to be delivered and update on discharge plan • Summary of communication with family



For further Information, please contact:

NIPEC

Centre House
79 Chichester Street
BELFAST
BT1 4JE
Tel: 0300 300 0066

This document can be downloaded from the NIPEC website

<http://www.nipec.hscni.net>

March 2018