Clinical Handover National Standard Six
Brighton Subacute Services
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Objectives

- Discuss why effective handover is critical for patient care
- Describe the essential elements of clinical handover
- Identify strategies for effective communication
- Discuss the risk factors impacting on clinical handover
- Identify sources of further information
• The intent of Clinical Handover Standard Six is to ensure there is timely, relevant and structured clinical handover that supports safe patient care.
Clinical handover—what’s the fuss?

• Transfers the responsibility and accountability for patients from one care provider to another
• Facilitates the mentoring of junior or new staff members – ROLE MODELLING
• Provides an opportunity for team building
• Great for teaching and learning
• Helps to develop situational awareness
Situational awareness

- Awareness and understanding of relevant information regarding the current task and environment
- Helps you make sense of information or events within your current context
- Assists effective decision making and performance

Perception $\rightarrow$ comprehension $\rightarrow$ prediction
Why is effective clinical handover so important?

- **Communication failure** is the leading contributing factor for SAC 1 (death or permanent harm) clinical incidents
- Good communication leads to better patient care, increased patient safety and satisfaction
- Handover is an international, national and local priority
- Bedside handover has the potential to improve the handover content, support staff and reflect a patient centered culture
Bedside handover guidelines

- Patient allocation completed by NUM or CN team leader
- Handover sheet updated, after consulting team leader
- Patients informed that handover will start soon
- Families can stay if patient wishes, visitors wait in the lounge
- Brief ‘huddle’ for confidential/sensitive matters and important changes
During Handover

• 3 identifiers
• Introduce incoming staff to patients
• Content – no need to repeat what is already on the handover sheet,
• Use SBAR & AIDET
• Do a safety scan- patient, environment, bedside chart
• Invite patient to comment or ask questions
Considerations

• Team leaders give NUM a short handover if NUM not present at handover
• Updated handover sheet essential
• Staff who start between regular handovers use the handover sheet as a guide
• Team leaders responsible for ensuring handover sheet is accurate and updated
• Team members responsible for ensuring all relevant info is conveyed to team leader
Strategies

• Actually move to bedside, not outside the room
• Involve the patient and family, as practical
• Avoid talking over patients and jargon
• Value handover as an essential part of patient care
• Keep it timely: evidence shows that bedside handover will save you time when used correctly
It’s all about…

• Mutual respect
• Collaboration
• Support

*Patients as our partners: “If it’s about me, not without me”*
Which other standards are met?

Standard 4: Medication Safety
Standard 5: Patient Identification and Procedure Matching
Standard 7: Blood and Blood Products
Standard 8: Preventing and Managing Pressure Injuries
Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care
Standard 10: Preventing Falls and Harm from Falls
Handover ABCs

- Nurses’ participation during handover varies according to their status, scope of practice, level of expertise and experience
- Everyone’s input must be respected and valued
- Requires preparation
- **Attentive** listening is essential
- Must be well organised
- Should provide environmental awareness
The basics

• Focus on what happens at the bedside
• Preparation
• Introduction
• Information exchange
• Patient involvement
• Safety scan
Protocol

• Clearly identify the patient, you and your role
• Provide relevant background and history
• Identify assessments and actions
• Identify timeframes and requirements of care
• Promote the use of patient record for cross-checking
• Ensure documentation of all important findings or changes in condition
• Ensure comprehension, acknowledgement and acceptance of responsibility for the patient
• Document the handover
Benefits

• Patient centred care valued by patients and staff
• Improved accuracy of communication
• Better understanding of patients’ conditions
• Patients are actually seen sooner in the shift
• Seeing patients prompts recall of important events and issues
• Continuity of care is improved
• Opportunity to teach and model professional behaviour
• Saves time…important to stick to framework
Risk factors

- Content omissions and errors
- Incomplete or unclear communication
- Lack of shared understanding
- Interruptions and distractions
- Hierarchy and power – defensive handovers
- Lack of training
- Being busy/time poor
Results of poor handover

• Poor coordination of care
• Delay in treatment
• Duplication
• Conflicting advice
• Wasted time
• Adverse events

*Taped handovers discouraged as a sole method of handover.*
Summary

- Miscommunication leads to adverse events, increasing patient mortality, morbidity and LOS
- Nurses are integral in leading the way in recognising and promoting the importance of handover
- A shift in thinking is needed for us to truly accept and value bedside handover
- The potential benefits and worldwide focus on effective handover underscore the importance of this issue
Nursing Skillmix: Transforming Care at the Bedside

Pillars of Transforming Care
- Safe and reliable care
- Vitality and teamwork
- Patient centred care
- Value added care processes
- Transformational leadership

Fundamentals of Patient Communication
- Acknowledge
- Introduce
- Duration
- Explanation
- Thank You

Moments of Truth
Key words at key times.

Important occasions of patient interactions where information should be exchanged and expectations matched.

Practice Partnerships
Together we share the care safely & interdependently.

We acknowledge and value the scope of practice of all staff and students.

We conduct safety scrums and clinical conversations with partners using SBAR
- Situation
- Background
- Assessment
- Recommendation

Patient-Centred Care
Providing patients with complete, customised information about their care team and their hospital experience.
- White-boards in patient rooms - names and photographs of patient care team
- Involving patients in daily ‘continuity of care conversations’ at the bedside
- Establish daily patient goals and preferences
- Improving discharge process

Rounding
Specific actions incorporated into one hourly nursing rounds can:
- Reduce the frequency of patient buzzer use
- Increase patient satisfaction
- Increase patient safety
- Free up to 40 minutes of nursing time per shift

Traffic Lights
To declare:
- Nurse-capacity for patient care
- When it is safe for new admissions

GREEN: able to take new patients safely
YELLOW: nearing capacity
RED: cannot safely accept another patient

Rewards and Recognition
Celebrating our clinical leadership on a daily basis
Further information and references

- Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Services Standards (NSQHSS), Standard 6, Clinical Handover.