1911 Version 2

Clinical Handover of Care in Community Hospitals

POLICY

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Partners in Care

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1. Introduction

"Handover of care … when carried out improperly can be a major contributory factor to subsequent error and harm to patients."

Professor Sir John Lillyman, Medical director

***NPSA Reference :** Safe handover: safe patients Guidance on clinical handover for clinicians and managers NPSA & BMA (2004).*

1.1 Continuity of clinical information is vital to the delivery of safe, effective high quality patient care.

1.2 The interface where clinical information transfers is a point in care pathways where the risk of incomplete transfer of information could potentially compromise care delivery.

1.3 At each point where clinical handover takes place it is essential that the information transferred is accurate, relevant and structured to contribute to safe patient care.

1.4 This policy includes transfers of care during ward clinical shift/duty handovers, providing clinical information to Medical Practitioners in and out of hours and transfer of care to other providers, both urgent and/or planned.

2. Statement/Objective

2.1 The clinical handover policy aims to ensure that all Community Hospitals have robust arrangements to ensure effective handover of patient clinical information.

2.2 Effective, timely, factual clinical handover will maximise patient safety across the organisation and Health community.

2.3 Standardisation of processes will act to ensure all relevant information is transferred at clinical handovers.

2.4 All verbal clinical handovers will be complemented with written information.

3. Roles and Responsibilities

3.1 The Assistant Director of Community Hospitals is responsible for ensuring clinical handover systems and processes are effective, efficient and adhered to.

3.2 Community Hospital Matrons are responsible for ensuring clinical handover of care meets the required standards set by the organisation and is embedded in clinical practices in line with Torbay and South Devon NHS Foundation Trust policy.

3.3 Ward managers or Nurse in charge are responsible for ensuring clinical handover is carried out effectively and embedded in daily work.

3.4 Community Hospital clinical staff are responsible for adhering to this clinical handover of care policy, Discharge and Transfer of Patients from Community Hospital (2113)

4. Clinical Handover at Shift/Duty Change Over

4.1 Accurate, factual, contemporaneous clinical information will form the basis of the clinical handover at the point when staff shift/duty end and commence.

4.2 No jargon or acronyms may be used in the clinical handover process.

4.3 Information will be transferred both verbally and in written format.

4.4 All staff on duty must receive the key clinical risk information e.g. risk of falls, if patient is confused, vital signs.

4.5 Electronic handover sheets will be used at each clinical handover and updated at the end of each duty as directed by the Nurse in charge.

4.6 Copies of previous electronic handover sheets must be stored electronically in accordance with the Trust`s Information Governance requirements.

4.7 Clinical handover information relating to the individual patients must also be clearly recorded in the patient medical record.

4.8 Handover documentation will be in a standardised format to include as a minimum initials and NHS number, date of birth, diagnosis, Medical Practitioner leading on the care and any key events/outstanding actions/risk issues.

4.9 Staff will be allocated specific responsibilities for areas of patient care as directed by the Nurse in charge.

4.10 All staff must carry a copy of the current clinical handover on all patients during their duty.

4.11 At the end of their duty this information must be destroyed via confidential waste and not left within uniform pockets and taken home.

Clinical Handover When Accepting a New Patient From Another Hospital

4.12 The decision to accept a patient to the Community Hospital will be at the discretion of the Nurse in charge.

4.13 Transfers to the Community Hospital must initially be assessed using the Situation, Background, Assessment and Recommendations (SBAR) communication tool (See appendix 1).

4.14 No jargon or acronyms must be used in the clinical handover of patients.

4.15 Consideration of the current inpatients dependency levels on the ward must be undertaken before accepting a patient.

4.16 Infection Control risks must be considered before accepting a patient.

4.17 Availability of specialist equipment must be considered prior to accepting a patient.

4.18 Skills and competences of staff to deliver specific care requirements must be considered before accepting a patient.

Clinical Handover When Accepting a Direct Admission Patient

4.19 The decision to accept a patient directly into the Community Hospitals from home will be at the discretion of the Nurse in charge.

4.20 Admissions to Community Hospitals must initially be assessed using the SBAR communication tool (see Appendix 1).

4.21 No jargon or acronyms must be used in the clinical handover of patients.

4.22 Consideration of the current inpatients dependency levels on the ward must be undertaken before accepting a patient.

4.23 Infection Control risks must be considered before accepting a patient.

4.24 Availability of specialist equipment must be considered prior to accepting a patient.

4.25 Skills and competences of staff to deliver specific care requirements must be considered before accepting a patient.

4.26 The admitting Medical Practitioner must attend the Community Hospital ward and fully clerk the patient on their arrival or provide specific clerking information that arrives with the patient along with necessary Patient Medication and Administration Record (PMAR) and fully clerk the patient on their arrival within core working hours and during out of hours by the Out of Hours Doctor service.

Clinical Handover for Urgent Transfer

4.27 If a patient deteriorates suddenly an urgent 999 call must be made.

4.28 The staff member making the call must be clear on the reason for the 999 call and the clinical status of the patient.

4.29 The staff member making the 999 call will be required to provide the call handler with all the information requested verbally.

4.30 On arrival of the Paramedic team, the Nurse in charge will provide all the core vital information to the team including incident details, vital sign Early Warning Score (EWS) of the patient.

4.31 Actions taken at the time of the incident/sudden deterioration of the patient must be recorded in the medical /nursing records.

4.32 Infection Control risks must be clearly communicated to the Paramedics.

4.33 All Medical and Nursing records must be transferred with the patient to ensure staff receiving the patient have all the required clinical information.

4.34 The Nurse in charge will telephone the accepting Accident and Emergency department and provide all the relevant information including any infection risks.

4.35 The Nurse in charge of the patients care will ensure the transfer is clearly communicated to the patient and their relatives and/or carers and rationale for the decision in a timely fashion.

4.36 Where relatives /carers of the patient cannot be contacted, ensure this information is transferred to the accepting hospital and staff on duty are aware.

Clinical Handover for Planned Transfer (Across local NHS Health Community Provider)

4.37 A decision made to transfer a patient to a neighbouring hospital/unit for provision of medical care e.g. possible wound debridement, necessitates that the Medical Practitioners provide a verbal clinical handover to the accepting clinician.

4.38 The Medical Practitioner transferring the care will ensure all medical records accurately reflect the medical needs of the patient and rationale for the transfer.

4.39 The Nurse in charge of the patients care will ensure a verbal transfer is provided to the receiving hospital/unit using the format set in an appropriate handover document, ie. SBAR communication tool.

4.40 The Nurse in charge of the patients care will ensure all Nursing and Medical documentation is transferred with the patient in a transfer bag for safety and security.

4.41 The Doctor or the Nurse in charge of the patients care will ensure the transfer is clearly communicated to the patient, their relatives and/or carers and the rationale for the decision.

Clinical Handover for Planned Care (Outside of Area)

4.42 A decision made to transfer a patient to a neighbouring hospital/unit outside of area for provision of medical care e.g. possible wound debridement, necessitates that the Medical Practitioners provide a verbal clinical handover to the accepting clinician.

4.43 The Medical Practitioner is responsible for ensuring a transfer letter is prepared to be transferred with the patient containing all the pertinent information relating to the patient including past medical history, current medication, current medical needs, test and investigations undertaken and care provided up to the point of transfer.

4.44 The Nurse in charge of the patient's care will ensure a verbal transfer is provided to the receiving hospital/unit using the format set in an appropriate handover document, ie. SBAR communication tool.

4.45 The Nurse in charge of the patient's care will ensure all Nursing and Medical documentation of the episode of care is photocopied and transferred with the patient.

4.46 The Doctor or the Nurse in charge of the patient's care will ensure the transfer is clearly communicated to the patient, their relatives and/or carers and the rationale for the decision.

Clinical Handover for Requesting an Urgent Out of Hours Visit

4.47 The Nurse in charge of the patient will request a visit from the Out of Hours Doctors service i.e. Devon Docs where deemed necessary.

4.48 Prior to telephoning the Nurse in charge will ensure all relevant documentation is available to provide all the salient information to the On-Call service including most recent early warning score/vital signs.

4.49 The Nurse in charge is responsible for requesting the time frame for the visit, ie. within 1 hour /2 hours.

4.50 The Nurse in charge should ensure documentation is updated to reflect the request for an urgent visit.

5. Training

5.1 Training for staff in the policy is provided as part of induction and orientation to the Community Hospital ward on appointment.

5.2 Hospital ward meetings will be utilised to disseminate the content of the policy.

5.3 Community Hospital Matrons are responsible for ensuring staff are provided with updates where appropriate when the policy has any changes or additions.

6. Monitoring, Audit, Reviewing and Evaluation

6.1 Datix will be utilised to identify where clinical handover has resulted in an incident or where errors in clinical handover are identified.

6.2 The Hospital Matron/Deputy Matron will ensure feedback of incidents to staff where clinical handover has been a contributing factor to enable learning and improvement.

7. References

7.1 Handover Policy ~ Countess of Chester Hospital NHS Foundation Trust (2006).

7.2 Clinical Handover Policy ~ The Newcastle upon Tyne Hospitals NHS Foundation Trust (2011).

7.3 Safe Handover ~ Safe Patient’s Guidance on clinical handover for Clinicians and Managers - NPSA & BMA (2004).

7.4 Productive Community Hospital Handover module.

8 Appendices

8.1 Appendix 1 ~ Situation, Background Assessment & Recommendation (SBAR) Tool.

Appendix 1

SBAR COMMUNICATION TOOL

Patient's Name:	NHS NO:	DOB:

A communication tool that offers a structured approach to enable the concise delivery of relevant information. Please use this prompt when accepting a patient.		
WARD:	DATE:	TIME:

Situation:	
Patient's Address	Does the patient live alone?
Next of Kin:	Name: Relationship: Contact No:
Which ward and hospital is referring the patient?	
Name & Role of person referring patient:	Name: Role:

Background:	
What are the patient's GP details?	Name: Practice:
What is the patient's current diagnosis?	
What is the patient's relevant past medical history?	
Does the patient suffer from any allergies?	
Diabetic, Insulin/ NIDD?	

Have there been any recent admissions to hospital?
Have the NOK been informed of the transfer?
Has the patient been diagnosed with Dementia?
Are there any doubts about the patient's mental capacity? Yes ☐ No ☐ If Yes, Has their mental capacity been assessed? Yes ☐ No ☐ Has a Best Interest decision been made with regard to admission/ transfer? Yes ☐ No ☐ Has this decision been documented? Yes ☐ No ☐

Name:	NHS NO:	DOB:

Assessment:
Observations:
What investigations have been undertaken?
What is the patient's early warning score (EWS)? Are they on oxygen therapy?
Infection risk- MRSA, CDT, Norovirus, D&V, Single room required?
Is the patient confused, wandering or noisy at night?
What mobility aids and assistance is required? Have any assessments been done?
Bowels/ continence situation
Patient's last Waterlow score: Does the patient have any pressure ulcers? Yes ☐ No ☐ If Yes, Grade: Site: Ask the referring person: 'was the pressure ulcer present on admission to your care setting?' Yes ☐ No ☐
Is the patient on any 'special' drugs?
Eating/ dining requirements- special diet, N/G tube, PEG feed
Resus status/ TEP? Discharge summary to transfer with patient
Nursing Needs e.g. 1:1 nursing
Daytime problems:

Recommendation:	
Reason for transfer	
Treatment/ Management plan	
Any other factors that may need consideration?	
Are they any outstanding appointments/ diagnostic tests?	
Signature:	**Print Name:**

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from Health and Welfare decisions to Finance and Property decisions.

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all Health and Social Care Practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the Practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that Health and Social Care Practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

> **"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)**

All Torbay Care Trust workers can access the Code of Practice, Torbay Care Trust Mental Capacity Act 2005 Policy, Torbay Care Trust Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare http://icare/Operations/mental_capacity_act/Pages/MCA.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control training annually as part of their mandatory training programme.