

Resource Manual & Facilitator Guide

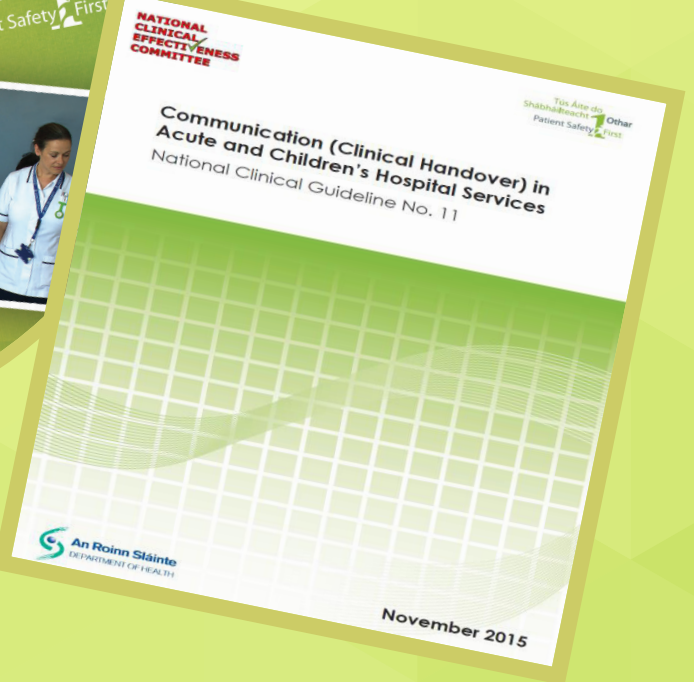
For Clinical Handover: An Inter-disciplinary Education Programme (2017)

Clinical Handover:
An Inter-disciplinary
Education Programme
(2017)


Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Clinical Strategy and Programmes Division

 Office of the
Nursing & Midwifery
Services Director

Tús Áite do
Shábháilteacht 1 Othar
Patient Safety 1 First



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Clinical Strategy and Programmes Division



Office of the
Nursing & Midwifery
Services Director

Table of Contents

| | |
|---|----|
| Contents | 1 |
| Glossary of Terms and Definitions | 2 |
| Introduction | 3 |
| Context | 4 |
| Management of Change | 6 |
| Development and Revision of Clinical Handover: | |
| An Inter-disciplinary Education Programme (2017) | 6 |
| Overview of Education Programme Content | 9 |
| Guide to Using the Resource Manual & Facilitator Guide and Video Recordings | 11 |
| Part 1: Introduction and Background to Clinical Handover | 13 |
| Part 2 (a): Shift Clinical Handover: Existing Practice | 15 |
| Part 2 (b): ISBAR ₃ : Shift Clinical Handover: Best Practice | 17 |
| Part 2 (c): ISBAR ₃ : Healthcare Assistant (HCA) Shift Clinical Handover: Best Practice | 21 |
| Part 2 (d) ISBAR ₃ : Shift Clinical Handover: 'Meet and Greet' and 'Hello, My Name is...' | 24 |
| Part 3 (a): Inter-departmental Clinical Handover - Existing Practice | 26 |
| Part 3 (b): ISBAR ₃ : Inter-departmental Clinical Handover - Best Practice | 28 |
| Part 4 (a): Communication of Information in relation to a Deteriorating Patient - Existing Practice | 31 |
| Part 4 (b): ISBAR: Communication of Information in relation to a Deteriorating Patient – Best Practice | 33 |
| Part 5 (a): Implementing Change: ISBAR ₃ and ISBAR | 36 |
| Part 5 (b): Implementing Change: Supporting Resources | 43 |
| Part 5 (c): Implementing Change: Best Practice Concepts for Clinical Handover | 45 |
| Part 6: Consolidating Change (Group Work) | 49 |
| Part 7: Conclusion | 51 |
| References | 52 |
| Appendices | 54 |
| Appendix 1: List of Abbreviations | 54 |
| Appendix 2 Shift Handover - A Training Programme for Nurses and Healthcare Assistants (2014) Group Membership | 55 |
| Appendix 3: Clinical Handover: An Inter-disciplinary Education Programme (2017) Group Membership | 55 |
| Appendix 4: National Communication (Clinical Handover) Guideline Development Group Membership (2015) | 56 |
| Appendix 5: National Clinical Guideline Recommendations (NCG, NCEC, DoH, 2015) | 58 |
| Appendix 6: ISBAR ₃ Template (Inter-departmental Handover) | 63 |
| Appendix 7: ISBAR ₃ Template (Shift Clinical Handover) | 64 |
| Appendix 8: ISBAR Template (Patient Deterioration) | 65 |
| Appendix 9: HSE Model of Change | 65 |
| Appendix 10: Sample Clinical Handover Prompts | 66 |
| Appendix 11 ISBAR ₃ Template for Shift Clinical and Inter-departmental Handover | 67 |
| Appendix 12: Sample Patient Status Communication Sheet for use during Shift Clinical Handover | 68 |
| Appendix 13: Safety Pause Information Sheet | 69 |
| Appendix 14: Sample Shift Clinical Handover Operating Procedure | 70 |
| Appendix 15: Sample ISBAR Template for Communication of a Deteriorating Patient | 71 |
| Appendix 16: Sample Evaluation Form | 72 |
| Appendix 17: Sample Certificate of Attendance | 74 |
| Appendix 18: Sample Observational Audit Tool for Shift Clinical Handover | 75 |
| Appendix 19: Audit Tool Sample Template: ISBAR ₃ Communication (Clinical Handover) Tool for Shift Handover | 77 |
| Appendix 20: Audit Tool Sample Template: ISBAR ₃ Communication (Clinical Handover) Tool for Inter-departmental Handover | 79 |
| Appendix 21: Audit Tool Sample Template: ISBAR Communication Tool for Communication in relation to a Deteriorating Patient | 81 |
| Appendix 22: Guidance for Audit Tool: Organisational Adherence to the Communication (Clinical Handover) in Acute and Children's Hospital Services NCG No. 11 | 82 |

Glossary of Terms and Definitions

Definitions used within the context of this document

Clinical handover (sometimes called clinical handoff) refers to the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. Clinical responsibility can only be transferred when responsibility is accepted by the designated individual clinician or clinical team as outlined in the policy of the healthcare organisation. The point at which responsibility is transferred and accepted needs to be agreed between both departments/parties, be explicit and be formally documented. Clinicians, accepting responsibility for patients, should conduct their own clinical assessment, as dictated by the clinical situation and as appropriate to their roles and responsibilities.

National Early Warning Score: A nationally agreed tool used to determine the degree of clinical acuity of a patient and involves a scoring system allocated on pre-determined clinical parameters. It is used in conjunction with the clinical judgement of the clinician and may act to guide decision making.

Emergency: An unexpected, serious event, which may be harmful for patients and requires an immediate response.

Flexible standardisation: The idea that effective clinical handover involves local interpretation of a standard in order to accommodate contextual factors (Australian Healthcare and Hospitals Association 2009; Australian Commission on Safety and Quality in Health Care 2013).

Guideline Development Group (GDG) is the Communication (Clinical Handover) Guideline Development Group, one of the sub-groups established by the National Implementation Group – HSE/HIQA Maternity Services Investigations.

Inter-departmental: This relates to the transfer of patients between departments within a hospital or between two hospitals e.g. ward to ICU within the same hospital or to a different hospital.

Inter-disciplinary: Integrates separate discipline approaches to work toward the best outcome for the patient.

Read-back: Verbally repeating back important clinical information from one healthcare professional to another.

Safety Pause: A brief discussion, between and with healthcare professionals, relating to important patient safety issues within a department.

The list of abbreviations is available in Appendix 1.

Introduction

The education programme was originally developed by Denise Doolan, Nurse Practice Development Facilitator, Midlands Regional Hospital, Tullamore, Co. Offaly and Mary Manning, Director, Nursing and Midwifery Planning & Development Unit (NMPD) in collaboration with Medical 2 Ward, Midlands Regional Hospital, Tullamore (MRHT) & HSE Communications in 2014 as part of the Productive Ward: Releasing Time to Care™ Project.

This revision (completed in 2017 by Denise Doolan and Eilish Croke, Appendix 3), reflects the recommendations of the National Clinical Guideline on Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No 11. (NCG11, NCEC, DoH, 2015).

Acknowledgement is given to those personnel for their kind support and assistance in developing the 2014 education programme (Appendix 2) and to those supporting the 2017 revision process (Appendix 3) including the NMPDU Dublin South Kildare Wicklow, NMPDU Midlands and the ONMSD.

Acknowledgement is also given to the National Communication (Clinical Handover) Guideline Development Group, as per Appendix 4, for the development of the National Clinical Guideline on Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No 11. (NCG No.11, NCEC, DoH, 2015).

Please note this programme has received NMBI (Nursing and Midwifery Board of Ireland) Category 1 Approval and has been awarded 4 CEU's (Continuing Education Units).

This Resource Manual and Facilitator Guide should be read in conjunction with the National Clinical Guideline on Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No 11. (NCEC, DoH, 2015).

All characters and locations identified in this education programme are wholly fictitious and any similarity to any person/s living or dead is unintentional.

Context

Clinical handover refers to the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. While clinical handover has been identified, both nationally and internationally, as a high risk step in a patient's hospital journey providing a unique opportunity for a range of healthcare professionals to work together to optimise patient safety, it is also recognised as an important source of error (NCG No. 11, NCEC, DoH, 2015).

Risks associated with clinical handover include inappropriate or delayed treatment, loss of trust and confidence amongst staff and patients in the performance of the healthcare system (NCG No. 11, NCEC, DoH, 2015).

In addition, recent adverse incidents (Keogh, 2013, HIQA, 2013, Francis, 2013 & NCEC, 2015) have highlighted the requirement for effective communication processes to underpin the provision of care while the National Standards for Safer Better Healthcare (HIQA, 2012) advocate *'Sharing of necessary information to facilitate the safe transfer or sharing of care, in a timely and appropriate manner and in line with relevant data protection legislation'* (2.3.3, Page 46) as a required standard for the provision of safe, quality care. Recommendation 9 of the National Clinical Guideline identifies the recognition of clinical handover as a clinical risk activity and suggests that healthcare organizations and frontline staff should ensure that participation at clinical handover takes priority over all other work except emergencies (NCG No. 11, NCEC, DoH, 2015). Similarly, Recommendation 8 advocates the inclusion of clinical handover as a clinical risk activity into organizational corporate and local risk registers (NCG No. 11, NCEC, DoH, 2015).

Traditionally, clinical handover skills were learned at local level rather than through formal education processes. This subsequently resulted in a plethora of approaches to both the content and function of clinical handover and particularly how it is given and/or received. It has been identified that poor handover processes may result in poor communication which may subsequently negatively impact on patient safety (Wong et al, 2008, WHO, 2007). Numerous barriers to effective clinical handover have also been identified such as informal structure, unnecessary content, lengthy duration, disturbances and lack of confidence.

While there is a limited evidence base to guide clinical handover, there is an urgency to improve and standardise the practice to optimise the process, contributing to seamless and reliable information transfer, minimising variability and reducing risks for patients.

Effective clinical handover can be enabled by having clear procedures, supportive work environments and educating staff on the potential work of handover on patient safety (NCG No. 11, NCEC, DoH, 2015). Within the National Clinical Guideline on Communication

(Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No 11. (NCEC, DoH, 2015) there are 28 key recommendations which support effective clinical handover (Appendix 5). The relevant recommendations for best practice in clinical handover are included in this education programme.

To support best practice, clinical handover should be *'(1) conducted face to face where possible, (2) conducted verbally, (3) supported with relevant, accurate, up-to-date documentation and (4) facilitate two-way communication processes'* (Recommendation 21, NCG No. 11, NCEC, DoH, 2015). To implement this, Recommendation 3 of NCG No. 11 (NCEC, DoH, 2015) states that clinical handover should be undertaken using a structured format; *'Inter-departmental and shift clinical handover should be conducted using the ISBAR₃ communication tool (Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk) as a structured framework which outlines the information to be transferred. The tool may be available in written format, but preferably electronically'* (Appendices 6 and 7). Recommendation 22 of NCG No. 11 (NCEC, DoH, 2015) states *'The ISBAR communication tool should be used when communicating information in relation to patients who are critically ill and/or deteriorating. Where a patient's condition and/or situation is deemed to be critical, this must be clearly stated at the outset of the conversation'* (Appendix 8). To support the implementation of these communication tools, Recommendation 15 of NCG No. 11 suggests that healthcare organizations must *'ensure that all staff have access to relevant, accurate and up to date sources of information during clinical handover'* (NCG No. 11, NCEC, DoH, 2015).

Recommendation 11 of NCG No. 11 (NCEC, DoH, 2015) advises that healthcare organisations should implement clinical handover procedures in compliance with the NCG and the national communication tools (templates) included in the NCG may be adapted to meet the local requirements of the healthcare organisation, individual departments, units or wards.

The utilisation of ISBAR₃ and ISBAR to support clinical handover aims to achieve the following key objectives:

- **Focused Communication**
- **Improved Patient Outcomes**
- **Reduced Near Miss/Adverse Incidents**
- **Reduced Repetition**
- **Improved Patient Satisfaction Rates**
- **Enhanced Safety and Effectiveness in the Delivery of Care**
- **Improved Quality of Information Disseminated in Handover**
- **Reduced Length of Handover**
- **Subsequent Increase in the Amount of Time available to Provide Care Directly to Patients**

Management of Change:

The effective management of change will underpin the successful implementation of the changes required to ensure best practice in clinical handover as part of the National Clinical Guideline (NCG No. 11, NCEC, DOH, 2015). The HSE Change Model (2014) provides a framework for change management as outlined in Appendix 9. The resources developed will be utilised to support all staff working in the Health Services to gain the knowledge, skills and confidence to approach change in a way that improves the prospect of a good outcome for patients, residents, service users, staff and communities.

These resources, within the HSE Change Model (2014), are based on experience of what works in practice and up to date research, and place a particular emphasis on the importance of engaging people in the process of change. This is the approach to change agreed by the HSE Management Team and by the Joint Information & Consultation Forum. The approach to change set out in Improving Our Services is stipulated in the Public Sector (Croke Park) Agreement 2010 – 2014 (Health Sectoral Agreement, 2.12) and its successor, the Public Sector Stability (Haddington Road) Agreement 2013 – 2016.

Development and Revision of Clinical Handover: An Inter-disciplinary Education Programme (2017)

The education programme was developed and revised to facilitate nursing and healthcare assistant staff within all clinical settings to implement best practice communication tools to support clinical handover. The programme can be adapted to suit other disciplines and incorporate the particular needs of individual clinical areas using the 'flexible standardization' approach.

It is underpinned by the aim of the National Clinical Guideline (NCG No. 11, NCEC, DOH, 2015) 'to optimise the process of clinical handover and improve patient safety by describing the elements that are essential for timely, accurate, complete, unambiguous and focused clinical handover in acute and children's hospital services in Ireland relating to the patient's condition, both urgent and routine' (NCG No. 11, NCEC, 2015).

Recommendation 13 of NCG No. 11 (NCEC, DoH, 2015) advocates that in relation to education and training 'healthcare organizations should provide staff with validated education and training, using a variety of techniques including workshops and simulation, to support the implementation and practice for clinical handover. This should be mandatory and form part of staff orientation/induction and ongoing in-service education'.

In addition, Recommendation 14 of NCG No. 11 advises that 'healthcare organizations should incorporate human factors training into all clinical handover that promotes a culture of openness and mutual respect between healthcare professionals and between healthcare professionals and patients' (NCEC, DoH, 2015).

This programme provides formal training in clinical handover processes incorporating a structured approach to handover communication. Following completion of the education programme, it is anticipated that all clinical handover between healthcare staff will be conducted using a structured communication tool in accordance with the NCG. This will promote standardization of practice, minimisation of variability and reduction of risk for patients (NCG No. 11, NCEC, DoH, 2015).

The education programme must be delivered using the accompanying video recordings, the Resource Manual & Facilitator's Guide, the Participant's Workbook and the National Clinical Guideline on Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No 11., (NCEC, DoH, 2015) as well other supporting resources where applicable. The duration of the education programme is approximately 4 hours to facilitate reflection, discussion and group work.

The innovative approach to education through the use of the video recordings will facilitate a greater learning opportunity for staff. The scenarios in the video recordings, which illustrate samples of best and existing practices, provide a practical demonstration of the principles of using a structured, standardised approach to clinical handover.

Within the programme, staff are also provided with the opportunity for role play and vignettes to consolidate the knowledge obtained while the module content is appropriate for staff to reflect on the quality of clinical handover practice across all care settings. Using this participatory approach supports Recommendation 14 (NCG No.11, NCEC, DoH, 2015) which advises the incorporation of 'human factors training into all clinical handover education that promotes a culture of openness and mutual respect between healthcare professionals and between healthcare professionals and patients.'

Prior to facilitating the education programme, facilitators should refer to 'Facilitating Learning in Groups; A Resource Manual for Facilitators working in Health and Social Care' (HSE, ONMSD, 2016) for planning and preparing delivery of the programme, facilitating and managing the learning process within the group during the programme and undertaking a review and evaluation of the programme once delivered.

Resources to be provided as required:

- National Clinical Guideline on Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No 11., (NCEC, DoH, 2015)
- Facilitating Learning in Groups; A Resource Manual for Facilitators working in Health and Social Care (HSE, ONMSD, 2016)
- Video Recordings available at www.hse.ie/clinicalhandover
- Resource Manual & Facilitator Guide available at www.hse.ie/clinicalhandover
- Participant's Workbook available at www.hse.ie/clinicalhandover
- ISBAR₃ (Inter-departmental & Shift Clinical Handover) & ISBAR (Patient Deterioration) Templates (Appendices 6, 7 & 8)
- Sample Clinical Handover Prompts (Nursing & HCA Shift Clinical Handover) (Appendix 10)
- Sample ISBAR₃ Template for Shift Clinical Handover (Appendix 11)
- Sample Patient Status Communication Sheet (Nursing & HCA Shift Clinical Handover) (Appendix 12)
- Safety Pause Information Sheet (Appendix 13)
- Sample Clinical Handover Operational Procedure (Nursing & HCA Shift Clinical Handover) (Appendix 14)
- Sample ISBAR Template for Communication of a Deteriorating Patient (Appendix 15)
- Sample Evaluation Form (Appendix 16)
- Sample Certificate of Attendance (Appendix 17)

The programme covers inter-departmental clinical handover, shift clinical handover and communication in relation to deterioration in a patient's condition and incorporates professional consultations such as:

- Team to team
- One profession to another
- and transitions of care such as
- Clinical handover of care at a change of a shift
- Clinical handover to and from a different level of care in the same hospital, e.g. between a ward and CCU/ICU
- Clinical handover to and from a different level of care between acute hospitals, e.g. transfer of patient for specialist care
- Inter-departmental clinical handover e.g. operating theatre/emergency department to ward
- Communication with patients and/or their relatives including parents/guardians of children as part of clinical handover (NCG11, NCEC, DoH, 2015).

It must be noted that there are differences between shift clinical handover and inter-departmental handover. Shift clinical handover involves handover of more than one patient while inter-departmental handover will focus on one patient being transferred from one department to another. ISBAR₃ can be used for both types of handover but may be tailored to individual settings e.g. emergency departments or wards using a flexible standardization approach (NCG No. 11, NCEC, DoH, 2015).

The nursing shift clinical handover is a communication process that occurs between two shifts of nurses where the specific purpose is to communicate information about patients under the care of nurses (Lamond, 2000). It is pivotal to the delivery of quality nursing care ensuring continuity and consistency (Hoban, 2003). An integral part of ward practice, shift clinical handover can occur at least twice a day where staff commencing duty receive details of the patients for whom they are responsible for the provision of care for the duration of that shift.

While there are several types of shift clinical handover including verbal, bedside and written (Scovell, 2010), only verbal handover is addressed in this context. When undertaking all types of clinical handover, all nurses and midwives must work within his/her scope of practice (NMBI, 2015).

Overview of Education Programme Content

The key message of the education programme is to demonstrate the mechanisms and tools which are required to conduct a clear comprehensive clinical handover that is structured using a standardised format and occurs within a timely manner.

The scenarios illustrating Shift Clinical Handover were developed and written in 2014 by the MRHT project team who worked in partnership with Nursing and Midwifery Planning and Development (NMPD), Tullamore & HSE Communications to develop the education programme (Appendix 2). Further scenarios were developed for the 2017 programme to reflect Inter-departmental Clinical Handover and Communication in relation to the Deteriorating Patient. The scenarios demonstrate a sample only of clinical handovers and all characters and locations identified in the education programme are wholly fictitious and any similarity to any person/s living or dead is unintentional.

The video recordings are approximately 34 minutes long and are divided into 14 parts with voiceover. They provide the opportunity to pause for reflection, discussion and group work where relevant:

- **Part 1: Introduction & Background to Clinical Handover:** including the aims and objectives of the education programme.
- **Part 2 (a): Shift Clinical Handover - Existing Practice:** comprising of a scenario simulating existing shift clinical handover practices.
- **Part 2 (b): ISBAR₃: Shift Clinical Handover - Best Practice:** comprising of a scenario simulating best shift clinical handover practices using ISBAR₃.
- **Part 2 (c): ISBAR₃: Shift Clinical Handover - HCA Handover:** comprising of a scenario simulating best shift clinical handover practices using ISBAR₃.
- **Part 2 (d): ISBAR₃:** Shift Clinical Handover 'Meet and Greet' and 'Hello, My Name is...': demonstrates the concepts of 'Meet and Greet' and 'Hello, My Name is...' where staff and patients meet and are introduced at the outset of the shift.
- **Part 3 (a) Inter-departmental Clinical Handover - Existing Practice:** comprising of a scenario simulating existing inter-departmental clinical handover practices.
- **Part 3 (b): ISBAR₃:** Inter-departmental Clinical Handover - Best Practice: comprising of a scenario simulating best inter-departmental clinical handover practices using the structured tool, ISBAR₃.
- **Part 4 (a) Communication of Information in relation to a Deteriorating Patient - Existing Practice:** comprising of a scenario simulating existing communication practices in relation to a deteriorating patient.
- **Part 4 (b) ISBAR:** Communication of Information in relation to a Deteriorating Patient – Best Practice: comprising of a scenario simulating best practice of communication in relation to a deteriorating patient using the structured tool, ISBAR.
- **Part 5 (a): Implementing Change: ISBAR₃ & ISBAR:** outlines the components of ISBAR₃ and ISBAR and their role in clinical handover.
- **Part 5 (b): Implementing Change: Supporting Resources:** outlines examples of supporting resources and how they may be used to support best practice. Please note these may vary in different care settings.
- **Part 5 (c): Implementing Change: Best Practice Concepts:** outlines key elements to support the best practice clinical handover process.
- **Part 6:** Consolidating Change/Group Work: provides the opportunity for staff to engage in group work to simulate scenarios and to practice the skills and knowledge gained in the education programme. Sustainability of the improvements made through implementation of the best practice clinical handover processes is also explored.
- **Part 7:** Conclusion: reviews the key message of the education programme.

Guide to Using the Resource Manual & Facilitator Guide and Video Recordings:

This Resource Manual & Facilitator Guide provides guidance that can be followed when delivering the education programme however please note that there may be variation in resources used in different care settings e.g. nursing models, patient communication boards, templates etc. Some elements of the programme may have to be adapted to the particular needs of individual clinical areas using the 'flexible standardization' approach.

The video recordings are not designed to be viewed as a stand-alone education experience, they are designed to stimulate discussion, reflection and group work on clinical handover processes.

As the programme content is delivered through a variety of teaching methodologies (Video Recordings, Reflective Practice & Group Exercises), A 'Participant Workbook' is also available to facilitate each participant to document key learning points from the video recordings and/or observations from reflective practice/group exercises. It can subsequently be used by participants as a reference document for clinical handover as required.

Prior to facilitating the education programme, please consider the following:

- Ensure all facilitators have familiarised themselves with NCG No. 11 (NCEC, DoH, 2015), the video recordings, Resource Manual & Facilitator Guide, Participant's Workbook and other supporting resources where applicable prior to facilitation of the programme.
- Plan the session and allow time for the video recordings and discussion (The education programme is approximately 4 hours in duration).
- Flip charts, 'post-its' and markers may be beneficial to support group work and participant feedback.
- Use a room that will be free from distractions.
- Ensure that all participants can view the screen.

Suggested Programme Outline

Welcome/Introductions/My Name is? (10 minutes)

Part 1: Introduction & Background to Clinical Handover

Part 2 (a): Shift Clinical Handover - Existing Practice

Part 2 (b): ISBAR₃: Shift Clinical Handover - Best Practice

Part 2 (c): ISBAR₃: Shift Clinical Handover - Healthcare Assistant Clinical Handover

Part 2 (d): ISBAR₃ Shift Clinical Handover - 'Meet and Greet' and 'Hello, My Name is...'

Part 3 (a): Inter-departmental Clinical Handover - Existing Practice

Part 3 (b): ISBAR₃: Inter-departmental Clinical Handover - Best Practice

Part 4 (a): Communication of Information in relation to a Deteriorating Patient - Existing Practice

Part 4 (b): ISBAR: Communication of Information in relation to a Deteriorating Patient - Best Practice

Part 5 (a): Implementing Change: ISBAR₃ & ISBAR

Part 5 (b): Implementing Change: Supporting Resources for Clinical Handover

Part 5 (c): Implementing Change: Best Practice Concepts

Part 6: Consolidating Change (Group Work)

Part 7: Conclusion & Programme Evaluation

Part 1: Introduction and Background to Clinical Handover:

Note to Facilitator: Prior to commencing the video recording, provide some background to the overall purpose of clinical handover within the healthcare setting, (Refer back to Context if required, Page 4) and explore anticipated learning outcomes and current perceptions of clinical handover.

Expected Learning Outcomes:

On completion of Part 1, participants should understand the purpose of conducting a clear, comprehensive, person-centred clinical handover within a timely manner using a standardised, structured format to achieve the following key objectives:

- Providing focused communication
- Enhancing patient safety
- Improving the delivery of care
- Reducing adverse incidents
- Reducing the time spent in clinical handover
- Improving the quality of clinical handover information

Voiceover outlines the aims and objectives of the education programme and includes the following text:

Clinical handover refers to the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

Good shift clinical handover, inter-departmental clinical handover and communication in relation to the deteriorating patient processes are essential to enhanced communication and safe and effective delivery of care with improved patient outcomes and satisfaction rates.

Shift clinical handover involves handover of more than one patient while inter-departmental handover focuses on one patient being transferred from one department to another.

Communication of information in relation to the deteriorating patient is also included within clinical handover.

This video was developed to educate nursing and healthcare assistant staff on how to conduct a clear, focused comprehensive, person-centred clinical handover within a timely manner using a standardised, structured format.

The video must be used in conjunction with the accompanying Resource Manual & Facilitator Guide, Participant's Workbook and the National Clinical Guideline on Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No 11. (NCEC, DoH, 2015).

The video shows how this approach to shift clinical handover, inter-departmental clinical handover and communication in relation to the deteriorating patient improves patient outcomes through:

- *Providing focused communication*
- *Enhancing patient safety*
- *Improving the delivery of care*
- *Reducing adverse incidents*
- *Reducing the time spent on clinical handover*
- *Improving the quality of clinical handover information*

Incorporated in this approach are the ISBAR₃ and ISBAR Communication Tools which are used to communicate the information required for exchange at handover thereby ensuring that the process is patient focused.

The ISBAR₃ tool can be used for both inter-departmental and shift clinical handover but may be tailored to individual settings such as emergency departments or wards using a flexible standardization approach. ISBAR₃ is the communication tool of choice for Shift Clinical Handover as recommended by the NCG.

The ISBAR tool is used to support communication in relation to the deteriorating patient.

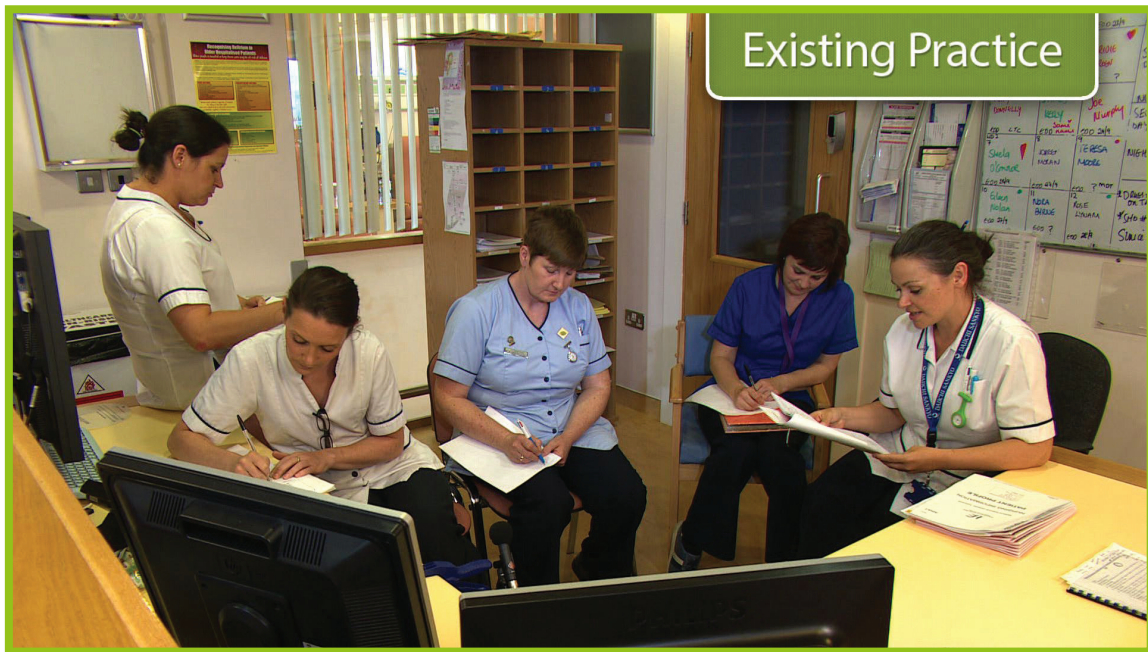
All references to patients either verbal or written are fictitious and were developed to support the training process within this video.

Discussion: Reflective Questions

- What are your thoughts on clinical handover?
- What are the current challenges you face in clinical handover?
- Are you familiar with the different types of clinical handover?

Part 2 (a): Shift Clinical Handover: Existing Practice

Note to Facilitator: Prior to commencing the video recording, discuss learning outcomes.



Expected Learning Outcomes:

On completion of Part 2 (a), participants should be able to:

- Discuss the deficits of existing shift clinical handover practices
- Identify internal and external forces affecting shift clinical handover processes
- Describe how ineffective shift clinical handover processes can influence patient outcomes

Voiceover introduces this section and contains the following text:

First let's look at what happens within the existing shift clinical handover. This clip demonstrates an example of shift clinical handover for two patients.

Note to Facilitator: When 'Discussion' graphic appears on screen, pause the video recording to facilitate opportunity for reflection and discussion.

The following points may be highlighted as part of the discussion to demonstrate the key elements of the existing practice that are of concern.

- Shift clinical handover for a busy ward.
- Arriving late, no clear start time, disorganised, sitting around, discussion of irrelevant information,
- Patient Communication Board not updated or used
- No identified leader
- Time Wasting
- Telephone ringing
- Distractions/Interruptions

Discussion: Reflective Questions

- What did you observe within that clip?
- What were the positive/negative aspects of the shift clinical handover process within the clip?
- Can you identify with this process?
- Are you familiar with this type of shift clinical handover?
- What are the key issues arising from this shift clinical handover?
- How would you solve these issues?

Part 2(b): ISBAR₃: Shift Clinical Handover: Best Practice

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes. It may be beneficial to focus participant attention to the onscreen ISBAR₃ graphics in this section of the the video recording.

Expected Learning Outcomes:

On completion of Part 2 (b), participants should be able to:


- Discuss how the process for best practice in shift clinical handover works
- Identify key elements affecting shift clinical handover processes
- Describe how effective shift clinical handover processes can influence patient outcomes




Voiceover introduces this section and contains the following text:

This example of best practice in shift clinical handover reflects the use of ISBAR₃ to handover all patients in the department, unit or ward as recommended by Recommendation 7 of the NCG. To support this best practice process, healthcare organisations and frontline clinical staff should ensure that participation at clinical handover takes priority over all other work except emergencies as is evident in this scenario. This is supported by Recommendation 9 of the NCG. The video clip shown here demonstrates an example of shift clinical handover for two patients. Let's have a look at how the process for best practice in shift clinical handover works.

Figure 1:



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



| ISBAR₃ Communication (clinical handover) Tool SAMPLE Shift Handover | |
|---|---|
| I Identify | <p style="text-align: center;">Identify:</p> <p style="text-align: center;">Lead handover person Individuals/Team receiving handover Patient(s)</p> |
| S Situation | <p style="text-align: center;">Situation:</p> <p style="text-align: center;">Location of patient(s) Brief summary of current status Is there a problem?</p> |
| B Background | <p style="text-align: center;">Background:</p> <p style="text-align: center;">Concise summary of reason for admission Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S₂O₂, (F_O₂), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate)</p> |
| A Assessment | <p style="text-align: center;">Assessment:</p> <p style="text-align: center;">What is your clinical assessment of the patient at present?</p> |
| R₃ Recommendation Read-Back Risk | <p style="text-align: center;">Recommendation:</p> <p style="text-align: center;">Specify your recommendations Read-Back: Recipients to confirm handover information Risk: Include the safety pause to identify possible risks</p> |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Note to Facilitator: Pause the video recording when Figure 1 is on-screen to set the context for the best practice process.

Note to Facilitator: Pause the video recording at this point to facilitate opportunity for reflection and discussion.

Discussion: Reflective Questions

- Are you familiar with this type of shift clinical handover?
- What are the main differences between this and the previous shift clinical handover process?
- What were the positive/negative aspects of the shift clinical handover process within the clip?
- How will this impact on the delivery of care?
- Do you think this could work in your setting?
- What are the possible challenges to implementing this shift clinical handover process?

Note to Facilitator: The following points may be highlighted as part of the discussion to demonstrate the difference between both existing and best practice shift clinical handover processes with reference to the relevant National Clinical Guideline (NCG No. 11, NCEC, DOH, 2015).recommendations:

Shift Clinical Handover Starts:

- **Clinical Handover is attended by the appropriate members of the healthcare team.** (Recommendation 6: Interdisciplinary Shift Clinical Handover: Healthcare organizations should implement interdisciplinary shift clinical handover where possible, to include junior and senior staff at every clinical handover during the 24 hour cycle).
- **All patients are included in the handover.** (Recommendation 7: Handover all Patients in the Department/Unit/Ward at Shift Clinical Handover: All patients in the department/unit/ward must be handed over at shift clinical handover).
- **Ward allocation completed and communicated for nursing and HCA staff.** (Recommendation 20: Clarification of Staff Roles and Responsibilities for Clinical Handover: Clinical handover policies should specify staff attendance, roles and responsibilities at clinical handover).
- **Clearly defined location for shift clinical handover, standing at Patient Communication Board) including confidentiality (Hinged door/shredder).** (Recommendation 16: Protected Area: Clinical handover should be conducted in an area with minimal distractions and interruptions and the organization should determine how this may best be accommodated at the department//unit/ward level. The location should take account of patient confidentiality).
- **Clearly identified leader.** (Recommendation 19: Designation of a Lead Healthcare Professional to Manage Clinical Handover: Clinical handover policies should designate a lead healthcare professional to manage the inter-departmental and shift clinical handover process).
- **Staff member given completed communication sheet and is identified to take telephone calls.** (Recommendation 20: Clarification of Staff Roles and Responsibilities for Clinical Handover: Clinical handover policies should specify staff attendance, roles and responsibilities at clinical handover).

- **Shift Clinical Handover starts on time.** (Recommendation 18: Protected Time for Shift Clinical Handover: Healthcare organizations should ensure there is mandatory protected time for shift clinical handover)
- **Structured Shift Clinical Handover using ISBAR₃ and Patient Communication Board.** (Recommendation 3: Clinical Handover – Structured Format: Inter-departmental and shift clinical handover should be conducted using the ISBAR₃ communication tool (Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk) as a structured framework which outlines the information to be transferred. The tool may be available in written format, but preferably electronically).
- **Lead nurse receiving shift clinical handover identifies key tasks to be completed where appropriate.** (Recommendation 20: Clarification of Staff Roles and Responsibilities for Clinical Handover: Clinical handover policies should specify staff attendance, roles and responsibilities at clinical handover).
- **Lead nurse recaps on specific safety issues where appropriate.** (Recommendation 5: Safety and Risk: Shift and inter-departmental clinical handover should promote a structure which allows for data verification, discussion, shared clinical decision-making and identification of operational issues and other factors that may impact on clinical care).
- **Opportunity for clarification.** (Recommendation 5: Safety and Risk: Shift and inter-departmental clinical handover should promote a structure which allows for data verification, discussion, shared clinical decision-making and identification of operational issues and other factors that may impact on clinical care).

Shift Clinical Handover Ends:

Shift Clinical Handover ends in a timely organised manner with no queries and all staff aware of roles and responsibilities, reminders etc.

Part 2 (c): ISBAR₃: Healthcare Assistant (HCA) Shift Clinical Handover: Best Practice

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes. It may be beneficial to focus participant attention to the onscreen ISBAR₃ graphics in this section of the video recording and to provide some background information on HCA involvement in clinical handover particularly where this may be a new initiative.



Traditionally, nursing shift clinical handover includes nursing staff only however as healthcare assistants are a vital part of the ward team, the education programme also introduces a formal HCA Shift Clinical Handover. Given that the information required by the HCA may not be as detailed as that required by the nurse, the HCA shift clinical handover may be implemented as a 'Split Handover' whereby they participate in a separate handover. This ensures that not all staff are away from direct patient care at the same time which supports the quality of patient care and may reduce possible interruptions (NHS, 2008).

Expected Learning Outcomes:

On completion of Part 2(c), participants should be able to:

- Discuss the importance of including the HCA in shift clinical handover to communicate key elements of patient care
- Identify the type of information that is required by the HCA to deliver care within his/her scope of practice
- Describe how effective shift clinical handover processes between the nurse and HCA can influence patient outcomes

Voice over introduces this section and contains the following text:


Healthcare Assistants play a vital role in the delivery of patient care and are an integral part of the ward team. As part of the best practice shift clinical handover process, the healthcare assistant is now formally involved in handover.


Previous practice involved an informal approach to communicating with the healthcare assistant where now the nurse in charge formally communicates relevant information, for example personal hygiene, mobility and dietary needs, to the healthcare assistant using ISBAR₃.

This video clip demonstrates an example of shift clinical handover for two patients between the nurse and the healthcare assistant. Let's look at how this works in practice

Note to Facilitator: Pause the video recording when Figure 2 is on-screen to set the context for the best practice process.

Figure 2





Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

| ISBAR ₃ Communication (clinical handover) Tool SAMPLE Shift Handover | |
|---|--|
| I Identify | <p style="text-align: center;">Identify:</p> <p style="text-align: center;">Lead handover person Individuals/Team receiving handover Patient(s)</p> |
| S Situation | <p style="text-align: center;">Situation:</p> <p style="text-align: center;">Location of patient(s) Brief summary of current status Is there a problem?</p> |
| B Background | <p style="text-align: center;">Background:</p> <p style="text-align: center;">Concise summary of reason for admission Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S₂O₂, (F₂O₂), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate)</p> |
| A Assessment | <p style="text-align: center;">Assessment:</p> <p style="text-align: center;">What is your clinical assessment of the patient at present?</p> |
| R ₃ Recommendation Read-Back Risk | <p style="text-align: center;">Recommendation:</p> <p style="text-align: center;">Specify your recommendations Read-Back: Recipients to confirm handover information Risk: Include the safety pause to identify possible risks</p> |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Note to Facilitator: Pause the video recording at this point to facilitate opportunity for reflection and discussion.

Discussion: Reflective Questions

- What did you observe within that clip?
- Can you identify with this process?
- Do you think this approach will work?
- How this will affect the delivery of patient care?

Part 2 (d) ISBAR₃: Shift Clinical Handover: 'Meet and Greet' and 'Hello, My Name is...'

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes.



Expected Learning Outcomes:

On completion of Part 2 (d), participants should be able to:

- Discuss the concepts of 'Meet and Greet' and 'Hello, My Name is...'
- Identify how 'Meet and Greet' and 'Hello, My Name is...'
 impact on the therapeutic relationship between patients and staff- Describe how 'Meet and Greet' and 'Hello, My Name is...'
 support effective communication processes and patient safety as part of shift clinical handover

Voiceover introduces this section and contains the following text:

A new initiative called 'Meet and Greet' has also been introduced as part of the new process. This facilitates the opportunity for staff coming on duty to be introduced to their patients by a member of staff from the previous shift. It supports Recommendation 2 of the NCG which states that healthcare organizations should aim to involve the patient, parents/guardians of children or carer(s) in the clinical handover process where appropriate. The 'Hello, My Name is....' concept which encourages healthcare staff to introduce themselves to patients is central to the 'Meet and Greet' process of handover and supports an effective therapeutic relationship between staff and patients.

This short clip demonstrates how this works.

Note to Facilitator: Pause the video recording to facilitate opportunity for reflection and discussion.

Discussion: Reflective Questions

- What did you observe within that clip?
- Can you identify with this process?
- Do you think this approach will work?
- How this will affect the delivery of patient care?

hello my name is...


Part 3 (a) Inter-departmental Clinical Handover - Existing Practice

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes.



Expected Learning Outcomes:

On completion of Part 3 (a), participants should be able to:

- Discuss the deficits of existing inter-departmental handover practices
- Identify internal and external forces affecting inter-departmental handover processes
- Describe how ineffective inter-departmental handover processes can influence patient outcomes

Voiceover introduces this section and contains the following text:

First let's look at what happens within the existing inter-departmental clinical handover.

Note to Facilitator: When 'Discussion' graphic appears on screen, pause the video recording to facilitate opportunity for reflection and discussion.

The following points may be highlighted as part of the discussion to demonstrate the key elements of the existing practice that are of concern.

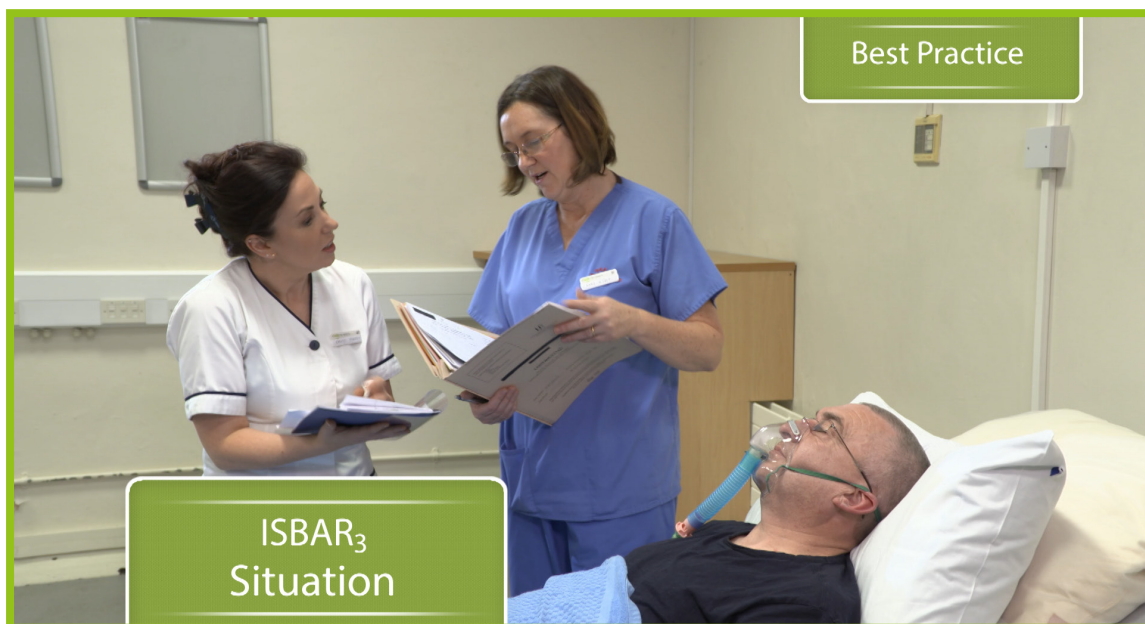
- No communication with ward prior to arrival
- Ward unprepared for admission
- Information vague, no background history given
- Relevant documentation missing
- No opportunity to clarify information – required to contact Emergency Department for further information

Discussion: Reflective Questions

- What did you observe within that clip?
- What were the positive/negative aspects of the inter-departmental clinical handover process within the clip?
- Can you identify with this process?
- Are you familiar with this type of inter-departmental clinical handover?
- What are the key issues arising from this inter-departmental clinical handover?
- How would you solve these issues?

Part 3 (b): ISBAR₃: Inter-departmental Clinical Handover - Best Practice:

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes. It may be beneficial to focus participant attention to the onscreen ISBAR₃ graphics in this section of the the video recording.



Expected Learning Outcomes:

On completion of Part 3 (b), participants should be able to:

- Discuss how the process for best practice in inter-departmental handover works
- Identify key elements affecting inter-departmental handover processes
- Describe how effective inter-departmental handover processes can influence patient outcomes

Voiceover introduces this section and contains the following text:

This example of best practice in inter-departmental handover reflects the use of ISBAR₃ as identified by Recommendation 3 of the NCG. Protected time must also be designated for inter-departmental handover as Recommendation 17 outlines. Let's have a look at how the best practice inter-departmental handover process works.

Note to Facilitator: Pause the video recording when Figure 3 is on-screen to set the context for the best practice process

Figure 3

| ISBAR₃ Communication (clinical handover) Tool SAMPLE Inter-departmental Handover | |
|--|---|
| I Identify | Identify: You Recipient of handover information Patient |
| S Situation | Situation: Location of patient as appropriate Brief summary of patient's current status Is there a problem? |
| B Background | Background: Concise summary of reason for interdepartmental handover Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S _p O ₂ , (F _i O ₂), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate) |
| A Assessment | Assessment: What is your clinical assessment of the patient at present? |
| R₃ Recommendation Read-Back Risk | Recommendation: Specify your recommendations Read-Back: Recipient(s) to confirm handover information and responsibility Risk: Include the safety pause to identify possible risks |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Note to Facilitator: Pause the video recording to facilitate opportunity for reflection and discussion.

Discussion: Reflective Questions

- Are you familiar with this type of inter-departmental handover?
- What are the main differences between this and the previous inter-departmental clinical handover process?
- What were the positive/negative aspects of the inter-departmental clinical handover process within the clip?
- How will this impact on the delivery of care?
- Do you think this could work in your setting?
- What are the possible challenges to implementing this inter-departmental clinical handover process?

Note to Facilitator: The following points may be highlighted as part of the discussion to demonstrate the difference between both existing and best practice inter-departmental clinical handover processes with reference to the relevant National Clinical Guideline (NCG No. 11, NCEC, DoH, 2015) recommendations:

- **Face to face handover:** (Recommendation 21: Clinical handover should be conducted face to face where possible, be conducted verbally, be supported with relevant, accurate and up-to-date documentation and facilitate two-way communication processes)
- **Relevant staff participating in inter-departmental handover,** (Recommendation 20: Clarification of Staff Roles and Responsibilities for Clinical Handover: Clinical handover policies should specify staff attendance, roles and responsibilities at clinical handover).
- **Protected time for inter-departmental handover** (Recommendation 17: Protected Time for Inter-departmental Clinical Handover: Protected time should be designated for inter-departmental clinical handovers)
- **Structured Inter-departmental Clinical Handover using ISBAR₃** (Recommendation 3: Clinical Handover – Structured Format: Inter-departmental and shift clinical handover should be conducted using the ISBAR₃ communication tool (Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk) as a structured framework which outlines the information to be transferred. The tool may be available in written format, but preferably electronically).
- **Lead nurse receiving inter-departmental clinical handover identifies key tasks to be completed where appropriate** (Recommendation 20: Clarification of Staff Roles and Responsibilities for Clinical Handover: Clinical handover policies should specify staff attendance, roles and responsibilities at clinical handover).
- **Lead nurse recaps on specific safety issues where appropriate** (Recommendation 5: Safety and Risk: Shift and inter-departmental clinical handover should promote a structure which allows for data verification, discussion, shared clinical decision-making and identification of operational issues and other factors that may impact on clinical care).
- **Opportunity for clarification** (Recommendation 5: Safety and Risk: Shift and inter-departmental clinical handover should promote a structure which allows for data verification, discussion, shared clinical decision-making and identification of operational issues and other factors that may impact on clinical care).

Part 4(a) Communication of Information in relation to a Deteriorating Patient - Existing Practice

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes.



Expected Learning Outcomes:

On completion of Part 4 (a), participants should be able to:

- Describe the deficits in existing practices of communication in relation to a deteriorating patient
- Identify internal and external forces affecting communication in relation to a deteriorating patient
- Describe how ineffective communication in relation to a deteriorating patient can influence patient outcomes

Voiceover introduces this section and contains the following text:

First let's look at what happens within the existing process for communication in relation to a deteriorating patient.

- What did you observe within that clip?
- What were the positive/negative aspects of the communication process in relation to the deteriorating patient within the clip?
- Can you identify with this process?
- Are you familiar with this type of communication process in relation to the deteriorating patient?
- What are the key issues arising from this communication process?
- How would you solve these issues?

Note to Facilitator: When 'Discussion' graphic appears on screen, pause the video recording to facilitate opportunity for reflection and discussion.

The following points may be highlighted as part of the discussion to demonstrate the key elements of the existing practice that are of concern.

- No sense of urgency
- Unprepared for telephone call
- Information vague, no background history given
- Relevant documentation missing
- Not assertive regarding actions required, no specific request made

Part 4(b) ISBAR: Communication of Information in relation to a Deteriorating Patient – Best Practice:

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes. It may be beneficial to focus participant attention to the onscreen ISBAR graphics in this section of the the video recording.



Expected Learning Outcomes:

On completion of Part 4(b), participants should be able to:


- Discuss how the process for best practice in communication of information in relation to the deteriorating patient works
- Identify key elements for effective communication in relation to a deteriorating patient
- Discuss how effective communication in relation to a deteriorating patient can influence patient outcomes

Voiceover introduces this section and contains the following text:


This example of best practice of communication in relation to the deteriorating patient reflects the use of ISBAR as identified by Recommendation 22 of the NCG.

Note to Facilitator: Pause the video recording when Figure 4 is on-screen to set the context for the best practice process.

Figure 4



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



| ISBAR Communication Tool SAMPLE Patient Deterioration | |
|---|--|
| I Identify | Identify: You Recipient of clinical handover information Patient |
| S Situation | Situation: Why are you calling? (Identify your concerns) |
| B Background | Background: What is the relevant background? |
| A Assessment | Assessment: What do you think is the problem? |
| R Recommendation | Recommendation: What do you want them to do? |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Let's have a look at how this process works.

Note to Facilitator: Pause the video recording to facilitate opportunity for reflection and discussion.

Discussion: Reflective Questions

- Are you familiar with this type of communication in relation to a deteriorating patient?
- What are the main differences between this and the previous communication process in relation to a deteriorating patient?
- What were the positive/negative aspects of the communication process in relation to a deteriorating patient within the clip?
- How will this impact on the delivery of care?
- Do you think this could work in your setting?
- What are the possible challenges to implementing this communication process in relation to a deteriorating patient?

Note to Facilitator: The following points may be highlighted as part of the discussion to demonstrate the difference between both existing and best practice communication in relation to the deteriorating patient processes with reference to the relevant National Clinical Guideline (NCG No. 11, NCEC, DoH, 2015) recommendations:

- **Deteriorating Patient** (Recommendation 22: The ISBAR communication tool should be used when communicating information in relation to patients who are critically ill and/or deteriorating. Where a patient's condition and/or situation is deemed to be critical, this must be clearly stated at the outset of the conversation) Lead nurse recaps on specific safety issues where appropriate

Part 5(a): Implementing Change: ISBAR₃ and ISBAR

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes. It may be beneficial to focus participant attention to the onscreen graphics in this section of the the video recording.

Expected Learning Outcomes:

On completion of Part 5 (a), participants should be able to:

- Describe ISBAR₃ and ISBAR
- Identify the context in which both ISBAR₃ (shift clinical and interdepartmental handover) and ISBAR are used (communication on patient deterioration)
- Discuss how ISBAR₃ is used in tandem with the nursing process and a chosen model of nursing to support the exchange of relevant focused information in a structured, standardized format in shift clinical handover
- Identify how ISBAR₃ is used to support the exchange of relevant focused information in a structured, standardized format in inter-departmental clinical handover
- Identify how ISBAR is used to support the exchange of relevant focused information in a structured, standardized format in communication on patient deterioration

Key Learning Points to be addressed by Facilitator:

The major learning points of the video recording are:

- Using ISBAR₃ and the relevant Model of Nursing to structure the type of information being exchanged within shift clinical handover,
- Using ISBAR₃ to structure the type of information being exchanged within interdepartmental clinical handover
- Using ISBAR to structure the type of information being exchanged in communication on patient deterioration

Voiceover introduces this section and contains the following text:

Within this section participants are given the opportunity to explore the practical application of the ISBAR₃ and ISBAR communication tools within shift and interdepartmental clinical handovers and for communication in relation to patient deterioration.

Note to Facilitator: Pause the video recording when the recommendations are listed on-screen to facilitate discussion.

ISBAR₃

Recommendation 3 of the NCG advocates the use of ISBAR₃ (Identify, Situation, Background, Assessment, Recommendation, Read-back & Risk) for use as a communication tool in shift and inter-departmental clinical handover as a structured format to exchange information. This is supported by Recommendation 4 of the NCG which advises that organizations should provide the necessary infrastructure to support effective clinical handover, including the availability of readily accessible patient information in electronic format. Where electronic clinical handover applications and templates are in use or being developed to support face-to-face clinical handover, they should incorporate ISBAR₃ for both shift and interdepartmental clinical handover (NCG No. 11, NCEC, DoH, 2015).

Note to Facilitator: Pause the video recording when Figure 5 is on-screen to support discussion.

Using ISBAR3 for Shift Clinical Handover:

Examples of information given under each heading of ISBAR₃ for Shift Clinical Handover are outlined in Figure 1. ISBAR₃ can be adapted to suit the clinical context or clinical handover setting to support the exchange of essential information using flexible standardization e.g. within this context to provide a structured, standardized approach to nursing and HCA shift clinical handover.

To support the use of ISBAR₃ in shift clinical handover at ward level, 'Clinical Handover Prompts' can be used by staff preparing to give handover. These prompts aim to guide the type of information exchanged under each heading of the communication tool, ISBAR₃ and are closely linked to the nursing model in use in individual clinical settings. The prompts are interchangeable with other models as required.

An example, developed from the Activities of Living within the Roper, Logan & Tierney Model of Nursing, is included in Appendix 10.

Figure 5

| ISBAR ₃ Communication (clinical handover) Tool SAMPLE Shift Handover | |
|---|--|
| I Identify | Identify: Lead handover person Individuals/Team receiving handover Patient(s) |
| S Situation | Situation: Location of patient(s) Brief summary of current status Is there a problem? |
| B Background | Background: Concise summary of reason for admission Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S _p O ₂ , (F _i O ₂), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate) |
| A Assessment | Assessment: What is your clinical assessment of the patient at present? |
| R ₃ Recommendation Read-Back Risk | Recommendation: Specify your recommendations Read-Back: Recipients to confirm handover information Risk: Include the safety pause to identify possible risks |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Note to Facilitator: The sample 'Clinical Handover Prompts' (Appendix 10) is for illustration only within this Resource Manual and Facilitator Guide.

Additional Points for Consideration:

- Recommendation 27 of the NCG advocates the inclusion of additional safety practices that provide greater situation awareness such as the National Early Warning Score, Irish Maternity Early Warning System, Irish Paediatric Early Warning System and Sepsis Management into clinical handover (NCG No. 11, NCEC, DoH, 2015). Within shift clinical handovers, this information can be included within the 'B' or 'Background' of ISBAR₃.
- The information exchanged as part of 'A' or 'Assessment' should correspond with the patient problems/nursing diagnoses documented within the care plan/nursing notes.

Note to Facilitator: Information exchanged under 'A' or 'Assessment' in ISBAR₃ for Shift Clinical Handover may be structured differently depending on the model of nursing in use. Facilitators may need to adapt this section of the education programme to meet local requirements in line with the flexible standardisation approach identified in the National Clinical Guideline (NCG No. 11, NCEC, DoH, 2015).

Using the 'flexible standardization' approach, information exchanged as part of shift clinical handover within the critical care or emergency settings may be tailored to the specific requirements of individual departments e.g. ventilator settings, admission status and bed availability.

Note to Facilitator: Pause the video recording when the recommendations are listed on-screen to facilitate discussion.

Using ISBAR₃ for Inter-departmental Clinical Handover:

As outlined in the NCG, there are some differences in inter-departmental and shift clinical handover, namely that inter-departmental clinical handover is utilised to support communication processes for one patient during transfer from one department to another e.g. emergency department to ward. However it must be noted that the type of information exchanged under each heading of ISBAR₃ for inter-departmental handover is similar to the information exchanged during shift clinical handover.

Examples of information given under each heading of ISBAR₃ for inter-departmental clinical Handover are outlined in Figure 2. ISBAR₃ can be adapted to suit the clinical context or clinical handover setting to support the exchange of essential information using flexible standardization e.g. within this context to provide a structured, standardized approach to inter-departmental clinical handover.

Note to Facilitator: Pause the video recording when Figure 6 is on-screen to support discussion.

Figure 6

| ISBAR₃ Communication (clinical handover) Tool SAMPLE Inter-departmental Handover | |
|--|---|
| I Identify | Identify: You Recipient of handover information Patient |
| S Situation | Situation: Location of patient as appropriate Brief summary of patient's current status Is there a problem? |
| B Background | Background: Concise summary of reason for interdepartmental handover Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S _p O ₂ , (F _i O ₂), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate) |
| A Assessment | Assessment: What is your clinical assessment of the patient at present? |
| R₃ Recommendation Read-Back Risk | Recommendation: Specify your recommendations Read-Back: Recipient(s) to confirm handover information and responsibility Risk: Include the safety pause to identify possible risks |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Similar to shift clinical handover at ward level, sample 'Clinical Handover Prompts' can be used by staff preparing for inter-departmental clinical handover where appropriate. These prompts aim to guide the type of information exchanged under each heading of the communication tool, ISBAR₃ and are closely linked to the nursing model in use in individual clinical settings. The prompts are interchangeable with other models as required.

A sample, developed from the Activities of Living within the Roper, Logan & Tierney Model of Nursing, is included in Appendix 10.

Note to Facilitator: The 'Clinical Handover Prompts' (Appendix 10) is for illustration only within this Resource Manual and Facilitator Guide.

Additional Points for Consideration:

- Recommendation 27 of the NCG advocates the inclusion of additional safety practices that provide greater situation awareness such as the National Early Warning Score, Irish Maternity Early Warning System, Irish Paediatric Early Warning System and Sepsis Management into clinical handover (NCG No. 11, NCEC, DoH, 2015). Within inter-departmental handovers, this information can be included within the 'B' or 'Background' of ISBAR₃.

The information exchanged as part of 'A' or 'Assessment' should correspond with the patient problems/nursing diagnoses documented within the care plan/nursing notes.

Note to Facilitator: Information exchanged under 'A' or 'Assessment' in ISBAR₃ for Inter-departmental Handover may be structured differently depending on the model of nursing in use. Facilitators may need to adapt this section of the education programme to meet local requirements in line with the flexible standardisation approach identified in the National Clinical Guideline (NCG No. 11, NCEC, DoH, 2015).

ISBAR


Recommendation 22 of the NCG advises the ISBAR (Identify, Situation, Background, Assessment & Recommendation) communication tool should be used when communicating information in relation to patients who are critically ill and/or deteriorating. Where a patient's condition and/or situation is deemed to be critical, this must be clearly stated at the outset of the conversation (NCG No. 11, NCEC, DoH, 2015).

To support the use of ISBAR, Recommendation 4 of the NCG outlines that organizations should provide the necessary infrastructure to support effective clinical handover, including the availability of readily accessible patient information in electronic format. Where electronic clinical handover applications and templates are in use or being developed to support face-to-face clinical handover, they should incorporate ISBAR for the urgent escalation of care (NCG No. 11, NCEC, DoH, 2015).

Note to Facilitator: Pause the video recording when the recommendations are listed on-screen to facilitate discussion.

Note to Facilitator: Pause the video recording when Figure 7 is on-screen to support discussion.

Figure 7



| ISBAR Communication Tool SAMPLE Patient Deterioration | |
|---|--|
| I Identify | Identify: You Recipient of clinical handover information Patient |
| S Situation | Situation: Why are you calling? (Identify your concerns) |
| B Background | Background: What is the relevant background? |
| A Assessment | Assessment: What do you think is the problem? |
| R Recommendation | Recommendation: What do you want them to do? |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Using ISBAR for Communicating Patient Deterioration:

The purpose of using ISBAR to communicate patient deterioration is to provide a clear, structured approach to communicating relevant focused information in a timely manner. Examples of information given under each heading of ISBAR for communicating patient deterioration are outlined in Figure 3.

Note to Facilitator: Pause the video recording to facilitate opportunity for reflection and discussion.

Discussion: Reflective Questions

- Are you familiar with ISBAR₃ and ISBAR as communication tools?
- Have you used ISBAR₃ or ISBAR prior to this (either in shift clinical/inter-departmental clinical handover or for communication on patient deterioration)?
- Do you think ISBAR₃ and ISBAR can support shift clinical /interdepartmental clinical handover/ communication on patient deterioration?
- How will using ISBAR₃ and ISBAR affect the delivery of patient care?
- Within the context of using ISBAR₃ for shift clinical/inter-departmental clinical handover and referring to the model of nursing used in your clinical area, is there additional information that should be included under each heading?

Part 5 (b): Implementing Change: Supporting Resources

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes.

Expected Learning Outcomes:

On completion of Part 5 (b), participants should be able to:

- Identify what the supporting resources are
- Discuss how they are used, where relevant, as part of shift and inter-departmental clinical handover or for communication of information in relation to the deteriorating patient to support a structured, standardized approach to the exchange of relevant information.

Voiceover introduces this section and contains the following text:

Within this section participants are given the opportunity to explore the supporting resources for use within shift and interdepartmental clinical handovers and for communication in relation to patient deterioration.

Note to Facilitator: Facilitators may need to adapt this section of the education programme to meet local requirements. Examples outlined are for illustration only, facilitators can utilise locally developed resources where appropriate.

Pause the video recording as each supporting resource appears on-screen to facilitate discussion.

ISBAR₃ & ISBAR Templates for Shift Clinical/Inter-departmental Handovers and Communication in relation to Patient Deterioration:

To support best practice in shift clinical handover, templates with defined headings to facilitate the exchange of standardised clinical handover information may be used as advocated by Recommendation 4, (NCG No. 11, NCEC, DoH, 2015). These templates can be developed to specific organisational needs and to reflect the information staff most frequently require. They provide prompts for the exchange of information and can lessen the opportunities for omissions.

One template example incorporates ISBAR₃, as outlined in Appendix 11, which can be used for both shift and inter-departmental clinical handover. This template is used by both the staff member giving and receiving handover to exchange information. Appendix 15 includes a sample template pertaining to communication in relation to patient deterioration. The template is used to provide information when escalating the patient's deterioration to the relevant member of the healthcare team.

Patient Status Communication Sheet: Interruptions to shift clinical handover are a common feature of a busy ward environment and frequently impact on the length of handover. This may have a direct effect on the amount of available time to provide patient care while the timing of scheduled shift clinical handovers may also co-incide with an increase in the number of enquires from families/significant others. To address this, strategies such as a Patient Status Communication Sheet may be implemented. This is a template completed by the nurse and will indicate the patient's status i.e. he/she is comfortable, whether or not the nurse needs to speak with the family member/significant other or if the family member/significant other is required to call back. At the outset of shift clinical handover, the nurse in charge identifies a staff member to address all interruptions for the duration of the handover. This staff member uses the completed Patient Status Communication Sheet to provide the information required to deal with the interruption. A sample template incorporating the Patient Status Communication Sheet is outlined in Appendix 12.

Guidance: Clinical Handover Procedures: Recommendation 11 (NCG No. 11, NCEC, DoH, 2015) advises organizations to implement clinical handover procedures in accordance with the recommendations and guidance within the National Clinical Guideline and in consultation with the relevant stakeholders. Local procedures should outline processes for the management, storage of and access to clinical handover records (Recommendation 10, NCG No. 11, NCEC, DoH, 2015). A sample of a Shift Clinical Handover procedure is included in Appendix 14. Depending on individual clinical settings, the process identified within the procedure may differ.

Discussion: Reflective Questions

- Do you think these resources can support shift clinical handover, inter-departmental handover or for communication of information in relation to the deteriorating patient?
- Can you think of other resources that may support shift and inter-departmental clinical handover or for communication of information in relation to the deteriorating patient?

Part 5 (c): Implementing Change: Best Practice Concepts for Clinical Handover

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes.

Expected Learning Outcomes:

On completion of Part 5 (c), participants should be able to:

- Identify what best practice in clinical handover involves
- Discuss how best practice concepts are incorporated into clinical handover to support a structured, standardized approach to the exchange of relevant information.

Voice over introduces this section and contains the following text:

Best practice clinical handover now incorporates a number of key elements to support the exchange of clear, comprehensive, person centred information in a timely manner using a standardised, structured format.

Note to Facilitator: Pause the the video recording when 'Discussion' graphic appears onscreen to facilitate the opportunity to explore each best practice concept individually.

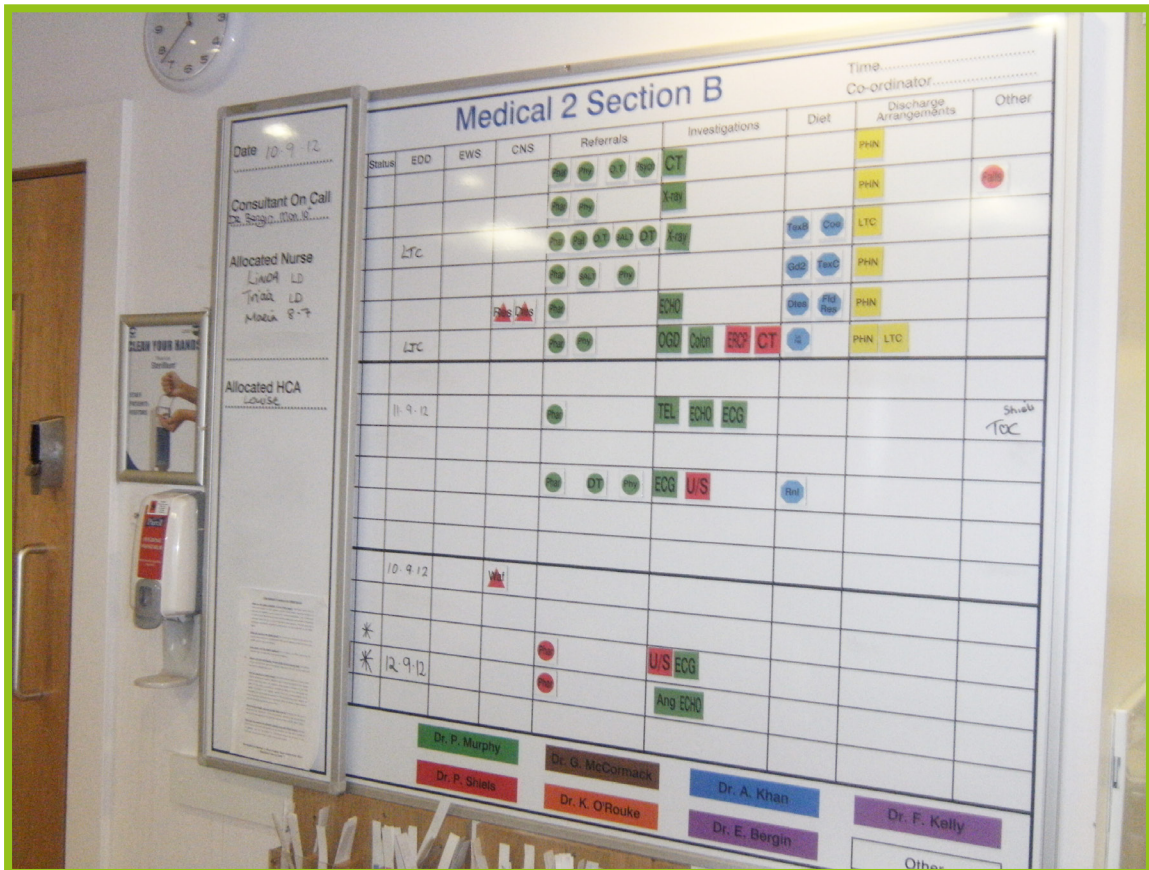
On the Move (Shift Clinical Handover): Feedback from staff identified concerns around the length of shift clinical handover, repetition and the discussion of irrelevant information. Strategies to address these issues were developed under the umbrella of 'On the Move' (NHS, 2008). This concept incorporates three distinct components relating to (a) the location of shift clinical handover: (b) receiving shift clinical handover standing at the Patient Communication Board and (c) using 'Meet and Greet' as an opportunity to introduce staff and patients, while exchanging relevant information at the bedside and facilitating a person centred approach by involving the patient.

Standing for shift clinical handover rather than sitting has been proven to reduce the length of handover by focusing staff on the most important issues. Involving the patient in shift clinical handover promotes a person-centred approach to handover however there are some limitations regarding confidentiality (Cahill, 1998, cited in Scovell, 2010).

Note to Facilitator: Refer back to Part 2 (b) and Part 2 (d): for examples of how 'On the Move' has been incorporated into the best practice process.

Patient Communication Boards (Shift Clinical Handover):

Facilitating shift clinical handover at the Patient Communication Board also supports handover by reducing repetition and providing standardized information. Depending on the individual design of the Patient Communication Board, these boards can be used to ensure that the patient information which is most frequently used is clearly accessible and understandable (NHS, 2008).



Note to Facilitator: The graphic above outlines a specific type of Patient Communication Board called 'Patient Status at a Glance' which is underpinned by the NHS (2008) concept of having the right information, ready to go, easily accessible and understood at a glance using the 3 second visualisation rule (Productive Ward - Releasing Time to Care™).

Facilitators may need to adapt this section of the education programme to meet local requirements. Examples shown are for illustration only.

Clear Roles and Responsibilities:



By clearly identifying specific roles and responsibilities, staff should be fully aware of:

- where they are allocated to
- who they are working with
- who the nurse in charge is
- who is nominated to address interruptions during clinical handover etc.

Specific roles and responsibilities should be addressed at the relevant part of clinical handover e.g. allocation to specific areas should be addressed prior to the start of report and in accordance with this, Recommendation 1 (NCG No. 11, NCEC, DoH, 2015), determines that local procedures to support clinical handover *'is explicit about when and to whom the transfer of responsibility occurs, during and following inter-departmental and shift clinical handover.'*

Key elements of care such as co-ordinating meal rounds, medicines rounds and patient observations should also be addressed here in addition to specific elements of individual patient care e.g. attending case conferences, discharge planning meetings etc. The purpose of clearly outlining roles and responsibilities lessens both the risk of interruptions and omissions to care (NHS, 2008) and supports the opportunity for the clear identification of priorities.

Safety and Risk:

In relation to safety and risk associated with clinical handover, Recommendation 5 (NCG No. 11, NCEC, DoH, 2015) advises that *'Shift and inter-departmental clinical handover should promote a structure which allows for data verification, discussion, shared clinical decision-making and identification of operational issues and other factors that may impact on clinical care.'*

ISBAR₃ – Risk:

The inclusion of the 'Safety Pause', (Appendix 13), provides the opportunity to identify or highlight specific safety issues that may arise and is best practice for clinical handover. It focuses on giving staff the 'heads-up' for the forthcoming shift in relation to issues that may arise. It is guided by the HSE QPS Directorate (2013) and focuses on safety issues relating to Patients, Professionals, Processes and Patterns. Recommendation 27 (NCG No. 11, NCEC, DoH, 2015) also supports the inclusion of briefings, safety pauses and huddles into practice for clinical handover.

ISBAR₃ - Read-Back (Identification of Priorities):

Clinical handover supports two-way communication and ISBAR₃ provides handover recipients with the opportunity to confirm handover information (Read-back) at the end of clinical handover. In addition, to consolidate the information exchanged at clinical handover, the nurse in charge can review/highlight priority issues/tasks to be completed relating to specific elements of individual patient care e.g. attending case conferences, discharge planning meetings etc. This opportunity should be used to identify or highlight patients who are acutely unwell, may be at risk of adverse incidents or require close monitoring.

Confidentiality

To maintain patient confidentiality (HSE, 2011) staff are required to comply with records management guidelines when using ISBAR₃ & ISBAR Templates for Shift Clinical/Inter-departmental Handovers and Communication in relation to Patient Deterioration. In accordance with Recommendation 10 (NCG No. 11, NCEC, DoH, 2015), healthcare organizations should outline their agreed processes for the management, storage and accessibility of clinical handover records within local policy.

Discussion: Reflective Questions

- Are you familiar with these best practice concepts?
- Do you think these best practice concepts can support clinical handover?
- How will the best practice concepts affect the delivery of patient care?

Note to Facilitator: Recommence the video recording at this point to demonstrate how the best practice concepts are integrated into the clinical handover process.

Part 6: Consolidating Change (Group Work)

Note to Facilitator: Prior to commencing the video recording discuss learning outcomes. It may be beneficial to focus the participant's attention to the onscreen graphics in this section of the the video recording.

Expected Learning Outcomes:

On completion of Part 6 participants should be able to:

- Discuss how best practice clinical handover (shift, inter-departmental and communication regarding a deteriorating patient) processes work
- Identify the key elements affecting clinical handover and communication processes
- Describe how effective clinical handover and communication processes can influence patient outcomes
- Discuss how to sustain the improvements made through implementation of the best practice processes

Voiceover introduces this section and contains the following text:

Within this section participants are given the opportunity to participate in group work by simulating clinical handovers for shift, and inter-departmental clinical handovers and communication regarding a deteriorating patient using ISBAR₃, ISBAR and other supporting resources.

Note to Facilitator: Pause the video recording when 'Groupwork/Discussion' is displayed listed on-screen to facilitate discussion.

Facilitators and participants are required to develop fictional patient scenarios in order to provide the opportunity to simulate clinical handovers for shift, inter-departmental clinical handovers and communication regarding a deteriorating patient using ISBAR₃, ISBAR and the supporting resources.

The use of simulation in clinical handover is advocated by Collins (2014) to develop communication and clinical handover skills. To promote engagement and participation, these scenarios, relevant to the clinical setting, may be developed with the programme participants.

Note to Facilitator: As part of the group work facilitate the opportunity for discussion as below:

Discussion: Reflective Questions

- How will you implement the best practice clinical handover and communication processes in your area?
- How will you engage your colleagues to participate in the best practice clinical handover and communication processes?
- How will you sustain the improvements you have made?

Note to Facilitator: Discussion on sustainability incorporating audit and further improvements may be facilitated prior to the conclusion of the education programme.

Sustainability & Moving Forward:

Following the implementation of the NCG to support clinical handover and to sustain the best practice process, continuous audit and evaluation is required (NHS, 2008). This measurement or evaluation can be completed in a number of ways and can also facilitate the identification of further changes required. Recommendation 12 of the NCG advises that clinical handover practice is monitored and audited regularly by the relevant quality and patient safety committee of the healthcare organization. It is the responsibility of the chair of this committee to assure the Chief Executive Officer/General Manager that the audit is undertaken and any necessary continuous quality improvements are put in place (NCG No. 11, NCEC, DoH, 2015).

Data collection can occur through interviews, discussion, recording clinical handover or observational audit. Appendix 18 outlines a sample observational audit tool which can be utilised to support data collection. Appendices 19, 20, 21 and 22 provide mechanisms to audit ISBAR₃, ISBAR and compliance with the NCG. The ISBAR₃, (clinical handover) and ISBAR communication tools should be documented in the patient notes and audited as part of a documentation audit and as a step in a quality improvement process (NCG No. 11, NCEC, DoH, 2015). Evaluation outcomes can inform further improvements to the clinical handover process.

Depending on the methodology used for the audit and evaluation processes, a quality improvement cycle should be used to underpin these processes in order to inform further learning and opportunities for continuous improvement.

Part 7: Conclusion



Voice over introduces this section and contains the following text:

Good shift clinical handover, inter-departmental handover and communication in relation to the deteriorating patient processes are essential to improved patient outcomes and satisfaction rates.

By using a structured, standardised approach and incorporating specific communication tools such as ISBAR₃ and ISBAR, it is clear that the impact of this approach can demonstrate improvements in areas such as:

- Communication
- Patient Safety
- Delivery of Care
- Adverse Incidents
- Time spent on Clinical Handover
- Quality of Clinical Handover Information

Where best practice clinical handover processes have been implemented, these improvements have been achieved. Here is what some nurses think of the new shift clinical handover.

Note to Facilitator: Programme Evaluation to be completed as required (Appendix 16).

References

Cahill, J. (1998) Patient's Perceptions of Bedside Handovers. *Journal of Clinical Nursing*. 7 (4). 351-359. Cited in Scovell, S. (2010) Role of the Nurse to Nurse Handover in Patient Care. *Nursing Times* 24 (20), 35-39.

Collins, G. (2014) Using Simulation to Develop Handover Skills. *Nursing Times*. 110 (8) 12-14.

HSE Quality & Patient Safety Directorate (2013) *The Safety Pause Information Sheet: Helping teams provide safe quality care*. Health Service Executive: Dublin.

Department of Health (2013) *National Clinical Effectiveness Committee: National Early Warning Score: National Clinical Guideline No.1*. Department of Health, Ireland.

Department of Health (2014) *National Clinical Effectiveness Committee: Maternity Early Warning System: National Clinical Guideline No.4*. Department of Health, Ireland.

Department of Health (2014) *National Clinical Effectiveness Committee: Sepsis: National Clinical Guideline No.6*. Department of Health, Ireland.

Department of Health (2015) National Clinical Effectiveness Committee: *Communication (Clinical Handover) in Acute and Children's Hospital Services: National Clinical Guideline No.11*. Department of Health, Dublin, Ireland.

Department of Health (2015) *National Clinical Effectiveness Committee: Paediatric Early Warning System: National Clinical Guideline No.12*. Department of Health, Ireland.

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

Hoban, V. (2003) How to... Handle a Handover. *Nursing Times*. 99 (9) 54-55.

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

HIQA (2013) *National Standards for Safer Better Healthcare* HIQA, Dublin, Ireland.

HSE (2011) *HSE Standards and Recommended Practices for Healthcare Records Management*. HSE, Dublin, Ireland.

HSE Office of the Nursing & Midwifery Services Directorate (2014) ***Shift Handover: A Training Programme for Nurses and Health Care Assistants***. Health Service Executive: Dublin

HSE, Office of the Nursing & Midwifery Services Directorate (2016) ***Facilitating Learning in Groups; A Resource Manual for Facilitators working in Health and Social Care***
Health Service Executive: Dublin

HSE Change Management Resources (2014) ***HSE Change Model***.
Health Service Executive: Dublin

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

Lamond, D. (2000). The Information Content of the Nurse Change of Shift Report: A Comparative Study. ***Journal of Advanced Nursing***. 31(4), 794-804.

NMBI (2015) ***The Scope of Nursing and Midwifery Practice Framework***, NMBI, Dublin Ireland

NHS Institute for Innovation & Improvement (2008) ***Releasing Time to Care™, The Productive Ward. Shift Handovers, Version 2***. NHS, United Kingdom.

NHS Institute for Innovation & Improvement (2008) ***Releasing Time to Care™, The Productive Ward. Patient Status at a Glance, Version 3***. NHS, United Kingdom.

Roper N., Logan W.W. & Tierney A.J. (2000). ***The Roper-Logan-Tierney Model of Nursing: Based on Activities of Living***. Edinburgh: Elsevier Health Sciences.

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

Wong, MC., Yee, KC., Turner P. (2008) Clinical Handover Literature Review. Tasmania, eHealth Services Research Group, University of Tasmania. Cited in Collins, G. (2014) 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 Hand-Overs***. Patient Safety Solutions. Geneva, WHO.

Appendices

Appendix 1 List of Abbreviations

CNM: Clinical Nurse Manager

DoH: Department of Health

DML: Dublin Mid Leinster

DSKW: Dublin South Kildare Wicklow after this abbreviation

HCA: Healthcare Assistant

HIQA: Health Information & Quality Authority

HSE: Health Services Executive

IPC: Infection Prevention & Control

ISBAR: Identify, Situation, Background, Assessment & Recommendation

ISBAR₃: Identify, Situation, Background, Assessment, Recommendation, Read-Back & Risk

MRHT: Midlands Regional Hospital, Tullamore

NEWS: National Early Warning Score

NCEC: National Clinical Effectiveness Committee

NCG: National Clinical Guideline

NHS: National Health Service

NMBI: Nursing and Midwifery Board of Ireland

NMPDU: Nursing Planning and Development Unit

ONMSD: Office of the Nursing & Midwifery Services Director

PSAG: Patient Status at a Glance

QPS: Quality & Patient Safety

VIP Score: Visual Infusion Phlebitis Score

WHO: World Health Organisation

Appendix 2 Shift Handover: A Training Programme for Nurses and Healthcare Assistants (2014)

| Name | |
|---|---|
| Denise Doolan | Nurse Practice Development Facilitator & Project Lead, Productive Ward: Releasing Time to Care™, MRHT |
| Mary Manning | Director, NMPDU, Midlands & Area Co-ordinator, Productive Ward: Releasing Time to Care™ |
| Susanna Byrne | Director, NMPDU, Dublin South, Kildare & Wicklow |
| Alice Farrelly | Clinical Nurse Manager 2, Medical 2, MRHT |
| Clare O’Dea | Divisional Nurse Manager, Medical Directorate, MRHT |
| Fiona McMahon | Interim Director of Nursing, MRHT |
| Mark White | National Lead for Productive Ward, ONMSD |
| Nursing & Healthcare Assistant Staff | Medical 2, MRHT |
| Orlagh Claffey | Hospital Manager, MRHT |
| Philip Haynes | Productive Ward - Releasing Time to Care™, NHS Improving Quality, Lean Health Management |
| Sandra Eaton | HSE Communications Officer |

Appendix 3: Clinical Handover: An Inter-disciplinary Education Programme (2017)

| Name | |
|----------------------|--|
| Denise Doolan | NMPD Officer, NMPDU, Dublin South, Kildare & Wicklow |
| Susanna Byrne | Director, NMPDU, Dublin South, Kildare & Wicklow |
| Eilish Croke | Director, NMPDU, Midlands (2016 – Q1, 2017) |
| Judy Ryan | Interim Director, NMPDU, Midlands (2017) |
| Liz Roche | Area Director, NMPDU, DML |
| Mary Wynne | Interim Director, ONMSD |
| Claire Foley | Acting Nurse Practice Development Facilitator, MRHT |
| Celine Conroy | Group ADON – Sepsis (See Appendix 4) |

Appendix 4: National Communication (Clinical Handover) Guideline Development Group Membership (2015)

| Name | |
|------------------------------|---|
| Dr Dorothy Breen | Co-Chair |
| Ms Eilish Croke | Co-Chair |
| Ms Celine Conroy | Project Manager |
| Ms Emma Benton | Therapy Professions Advisor & Portfolio Manager (Diagnostic/Support Services), Clinical Strategy and Programmes |
| Dr Katherine Browne | Forum of Irish Postgraduate Medical Training Bodies – trainee nominee (surgical SpR) |
| Ms Claire Browne | National Clinical Programme for Paediatrics and Neonatology |
| Prof. Garry Courtney | NCL, National Acute Medicine Programme |
| Dr Eva Doherty | Director of Human Factors in Patient Safety RCSI |
| Prof. Gerard Fealy | Associate Dean for Research and Innovation UCD |
| Dr John Fitzsimons | Clinical Director for Quality Improvement, HSE Quality Improvement Division |
| Ms Maureen Flynn | Director of Nursing and Midwifery Quality Improvement Division, Lead Governance for Quality and Safety |
| Ms Noelle Gallery | Front line clinical nurse representing children's hospital services |
| Ms Mary Godfrey | Clinical Risk Advisor, State Claims Agency |
| Dr Miriam Griffin | Faculty of Pathology, RCPI |
| Dr Colm Henry | National Clinical Advisor, Group Lead Acute Hospitals, HSE (GDG Sponsor) |
| Mr Macartan Hughes | Head of Education and Competency Assurance, National Ambulance Service |
| Ms Catherine Killilea | Area Director, NMPDU, HSE South |
| Mrs Tanya King | IADNAM Representative, Director of Nursing (Mater Misericordiae University Hospital) |
| Mr Louis Lavelle | NAMP Programme Co-ordinator |
| Dr Gerry McCarthy | Emergency Medicine Programme, Consultant in Paediatric Emergency Medicine |
| Prof. Eilis McGovern | Director, National Doctors Training and Planning, HSE |
| Ms Colette Murray | Frontline clinical nurse representing acute hospitals |
| Dr Alan Moore | Consultant in Geriatric Medicine in Beaumont Hospital, Forum of Irish Postgraduate Medical Training Bodies – consultant nominee |
| Ms Bridie O'Sullivan | Chief Director of Nursing – representing Group CEO's |
| Dr Michael Power | NCL, Critical Care Programme |
| Ms Melissa Redmond | Patient/Service User Representative |

| | |
|----------------------------|--|
| Dr Anthony Ryan | Chair of the Quality and PCS committee of the Faculty of Radiologists, RCSI |
| Ms Mary Tierney | Patient Representative, member of Patients for Patient's Safety Group |
| Prof. Oscar Traynor | National Surgical Training Centre, RCSI – Representing the National Clinical Programme for Surgery |
| Ms Angela Tysall | Open Disclosure, Project Manager National Advocacy Unit, Quality Improvement Division, HSE |
| Ms Kathleen Walsh | Professional Officer, Standards of Practice and Guidance, NMBl |
| Dr Margo Wrigley | National Clinical Programme for Mental Health |

Appendix 5: National Clinical Guideline Recommendations (NCG No. 11, NCEC, DoH, 2015)

Shift and Interdepartmental Recommendations:

Recommendation 1:

Clear Transfer of Responsibility for the Patient: Healthcare organization's policy on communication (clinical handover) is explicit about when, and to whom, the transfer of responsibility occurs, during and following inter-departmental and shift clinical handover. Clinical responsibility can only be transferred when responsibility is accepted by the designated individual clinician or clinical team as outlined in the policy of the healthcare organisation.

Recommendation 2:

Patient, Parent/Guardian and/or Carer Involvement: Healthcare organizations should aim to involve the patient, parents/guardians of children and/or carer(s) in the clinical handover process where appropriate. They should ensure that the patient, parents/guardians of children and/or carer(s) are provided with relevant, accurate and up-to-date information in relation to the patient's condition, care and treatment, patient. Parents or guardians of children preferences should be considered whilst also meeting the requirements of confidentiality. The healthcare organization should determine how this may be best accommodated at department/unit/ward/level.

Recommendation 3:

Clinical Handover – Structured Format: Inter-departmental and shift clinical handover should be conducted using the ISBAR₃ communication tool (Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk) as a structured framework which outlines the information to be transferred. The tool may be available in written format, but preferably electronically.

Recommendation 4:

Electronic Clinical Handover Applications/Templates: Organizations should provide the necessary infrastructure to support effective clinical handover, including the availability of readily accessible patient information in electronic format. Where electronic clinical handover applications and templates are in use or being developed to support face-to-face clinical handover, they should incorporate the following communication tools:

- ISBAR₃ for both shift and interdepartmental clinical handover and
- ISBAR for urgent escalation of care

Recommendation 5:

Safety and Risk: Shift and inter-departmental clinical handover should promote a structure which allows for data verification, discussion, shared clinical decision-making and identification of operational issues and other factors that may impact on clinical care.

Recommendation 6:

Interdisciplinary Shift Clinical Handover: Healthcare organizations should implement interdisciplinary shift clinical handover where possible, to include junior and senior staff at every clinical handover during the 24 hour cycle.

Recommendation 7:

Handover all Patients in the Department/Unit/Ward at Shift Clinical Handover: All patients in the department/unit/ward must be handed over at shift clinical handover.

Organisational Recommendations:**Recommendation 8:**

Recognition of Clinical Handover as a Clinical Risk Activity: Healthcare organizations should recognise clinical handover as a clinical risk activity, and incorporate clinical handover into their corporate and local risk registers.

Recommendation 9:

Recognition of Clinical Handover as a Clinical Risk Activity: Healthcare organizations and frontline staff should ensure that participation at clinical handover takes priority over all other work except in emergencies.

Recommendation 10:

Guidance: Healthcare organizations should review existing organisational clinical handover guidance (policies, procedures, protocols and guidelines) in collaboration with appropriate stakeholders, including healthcare staff, patients, parents/guardians of children, and carers. The local policy should clearly identify how clinical handover records are to be managed, stored and accessed.

Recommendation 11:

Guidance: Healthcare organizations should implement Clinical Handover procedures in compliance with this National Clinical Guideline, in consultation with relevant stakeholders. While national communication tools (templates) are included in the National Clinical Guideline, these tools (templates) may be customised locally to accommodate features of the healthcare organization, individual departments, units or wards.

Recommendation 12:

Guidance: Clinical handover practice is monitored and audited regularly by the relevant quality and patient safety committee of the healthcare organization. It is the responsibility of the chair of this committee to assure the CEO/GM that the audit is undertaken and any necessary continuous quality improvements are put in place.

Recommendation 13:

Education and Training: Healthcare organizations should provide staff with validated education and training, using a variety of techniques including workshops and simulation, to support the implementation and practice for clinical handover. This should be mandatory and form part of staff orientation/induction and ongoing in-service education.

Recommendation 14:

Information Giving and Seeking: Healthcare organisations should incorporate human factors training into all clinical handover education that promotes a culture of openness and mutual respect between healthcare professionals and between healthcare professionals and patients.

Recommendation 15:

Accessing Information: Healthcare organizations ensure that all staff have access to relevant, accurate and up to date sources of information during clinical handover. Electronic patient records, including diagnostic data, should be considered as a solution for providing relevant, accurate and up to date information for, and during, clinical handover.

Recommendation 16:

Protected Area: Clinical handover should be conducted in an area with minimal distractions and interruptions and the organization should determine how this may best be accommodated at the department//unit/ward level. The location should take account of patient confidentiality.

Recommendation 17:

Protected Time for Inter-departmental Clinical Handover: Protected time should be designated for inter-departmental clinical handovers.

Recommendation 18:

Mandatory Protected Time for Shift Clinical Handover: Healthcare organizations should ensure that there is mandatory protected time for shift clinical handover.

Recommendation 19:

Designation of a Lead Healthcare Professional to Manage Clinical Handover: Clinical handover policies should designate a lead healthcare professional to manage the inter-departmental and shift clinical handover process.

Recommendation 20:

Clarification of Staff Roles and Responsibilities for Clinical Handover: Clinical handover policies should specify staff attendance, roles and responsibilities at clinical handover.

Recommendation 21:

Clinical Handover Process: Clinical handover should

1. be conducted face to face where possible
2. be conducted verbally
3. be supported with relevant, accurate and up-to-date documentation and
4. facilitate two-way communication processes.

Deteriorating Patient Recommendation**Recommendation 22:**

Communication of Patient Deterioration: The ISBAR communication tool should be used when communicating information in relation to patients who are critically ill and/or deteriorating. Where a patient's condition and/or situation is deemed to be critical, this must be clearly stated at the outset of the conversation.

Radiology Recommendation**Recommendation 23:**

The Faculty of Radiology's QI Guidelines for the management of Critical, Urgent, and Clinically Significant and Unexpected radiological findings should be implemented in all locations. Consideration should be given to the utilisation of electronic solutions for

- a. critical and urgent results (as an adjunct to, and documentation of, direct voice to voice or face to face communication), and
- b. clinically significant and unexpected findings (where direct communication is not the standard) requiring follow-up.

Laboratory Recommendation

Recommendation 24:

Laboratories should have policies and assurance processes in place for clinical handover of critical results. A National Medical Laboratory Information System solution would greatly facilitate the reporting of critical laboratory results and should be implemented nationally.

Additional Recommendations

Recommendation 25:

Education and Training: Higher Education Institutes (HEI's) with responsibility to provide preparatory professional education, continuing education and professional development for all healthcare professionals should incorporate education and training on clinical handover practices for the deteriorating patient, inter-departmental and shift clinical handover within curricula in line with this National Clinical Guideline.

Recommendation 26:

Guideline Implementation: A communication (clinical handover) group should be established at national level to support national implementation of this guideline. This group should engage in staff consultation and apply quality improvement methodologies to ensure successful implementation and determine how communication tools such as the ISBAR3 and ISBAR can best fit with existing workflows and professional relationships.

Recommendation 27:

Additional Safety Practices: Healthcare organisations should support additional safety practices that enhance clinical handover in acute and children's hospital services leading to greater situation awareness among clinicians and inter-disciplinary teams, such as implementation of:

- The National Early Warning Score, National Clinical Guideline No. 1
- The Irish Maternity Early Warning System, National Clinical Guideline No. 4
- Communication (Clinical Handover) in Maternity Services, National Clinical Guideline No. 5
- Sepsis Management, National Clinical Guideline No. 6
- The Irish Paediatric Early Warning System, National Clinical Guideline No. 12
- and incorporating briefings, safety pauses and huddles into practice.

Recommendation 28:

Future Research: Future research into clinical handover should focus on strengthening the evidence of clinical handover effectiveness by using well designed, rigorous methods.

Appendix 6 ISBAR₃ Template (Inter-departmental Handover)



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



| ISBAR₃ Communication (clinical handover) Tool SAMPLE Inter-departmental Handover | |
|--|--|
| I Identify | <p style="text-align: center;">Identify: You Recipient of handover information Patient</p> |
| S Situation | <p style="text-align: center;">Situation: Location of patient as appropriate Brief summary of patient's current status Is there a problem?</p> |
| B Background | <p style="text-align: center;">Background: Concise summary of reason for interdepartmental handover Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S_pO₂, (F_iO₂), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate)</p> |
| A Assessment | <p style="text-align: center;">Assessment: What is your clinical assessment of the patient at present?</p> |
| R₃ Recommendation Read-Back Risk | <p style="text-align: center;">Recommendation: Specify your recommendations Read-Back: Recipient(s) to confirm handover information and responsibility Risk: Include the safety pause to identify possible risks</p> |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Appendix 7 ISBAR₃ Template (Shift Clinical Handover)



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



| ISBAR₃ Communication (clinical handover) Tool SAMPLE Shift Handover | |
|---|--|
| I Identify | Identify: Lead handover person Individuals/Team receiving handover Patient(s) |
| S Situation | Situation: Location of patient(s) Brief summary of current status Is there a problem? |
| B Background | Background: Concise summary of reason for admission Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S _p O ₂ , (F _i O ₂), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate) |
| A Assessment | Assessment: What is your clinical assessment of the patient at present? |
| R₃ Recommendation Read-Back Risk | Recommendation: Specify your recommendations Read-Back: Recipients to confirm handover information Risk: Include the safety pause to identify possible risks |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Appendix 8 ISBAR Template (Patient Deterioration)



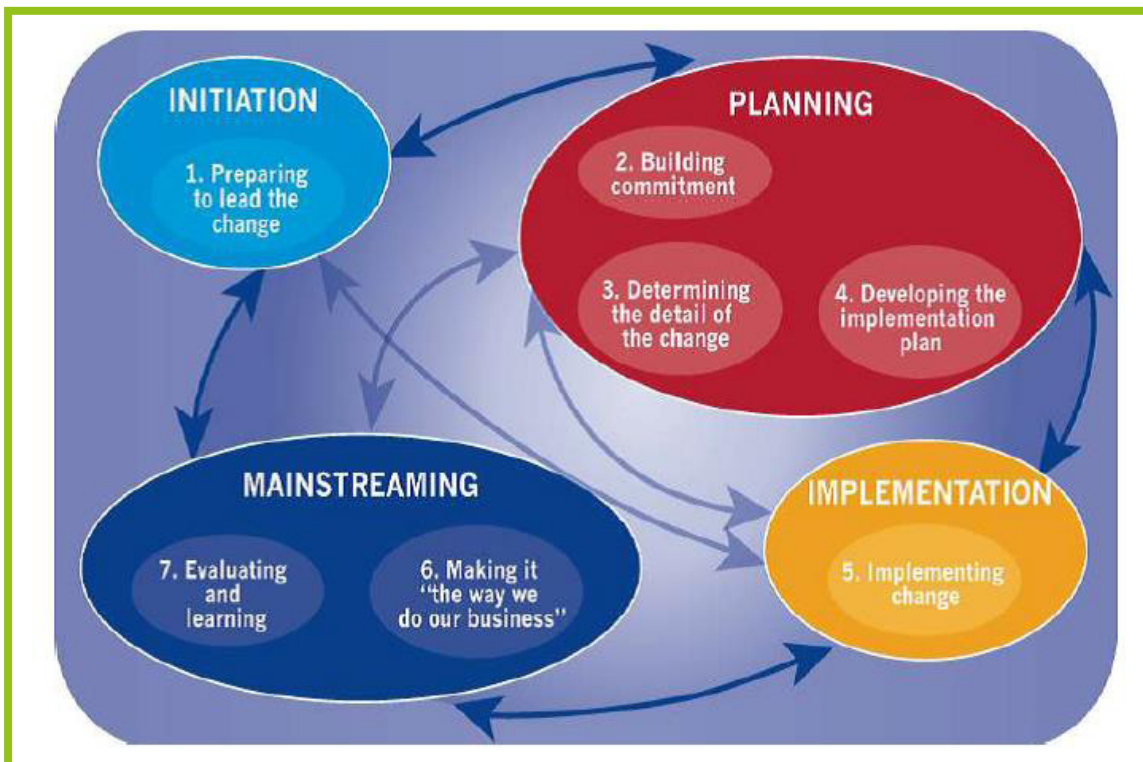
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



| ISBAR Communication Tool SAMPLE Patient Deterioration | |
|---|--|
| I Identify | Identify: You Recipient of clinical handover information Patient |
| S Situation | Situation: Why are you calling? (Identify your concerns) |
| B Background | Background: What is the relevant background? |
| A Assessment | Assessment: What do you think is the problem? |
| R Recommendation | Recommendation: What do you want them to do? |

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Appendix 9 HSE Change Model (HSE, 2014)



Model adapted from: Kolb, D. and Frohman, A. (1970), Huse, E. (1980), Neumann, J. (1989), Kotter, J.P. (1995) and Ackerman Anderson, L. and Anderson, D. (2001).

| Appendix 10 Sample Clinical Handover Prompts (Please note this list is for examples only and is not exhaustive) | | | |
|---|--|---|---|
| I = Identify | Patients Name, Age, Address or Place of Residence, Consultant, Date of Admission | | |
| S = Situation | Admitting Problem/Reason for Admission, Resuscitation Status, IPC Status, Allergies and Estimated Date of Discharge | | |
| B = Background | Current Treatments, Completed Investigations, Relevant Test Results, Vital Signs, NEWS, Frequency of Observations, Telemetry Relevant Past Medical/Surgical History, Living Conditions, Social History, 'This is Me' | | |
| A = Assessment: Activities of Living (Roper, Logan & Tierney, 2000) | | | |
| Activity | Trigger/Prompt | Activity | Trigger/Prompt |
| Maintaining A Safe Environment | Pressure Areas & Waterlow Score, IV Cannulae & VIP Score | Controlling Body Temperature | Temperature/Pyrexia |
| Breathing | Dyspnoea | Mobilising | Mobility, Falls Risk Assessment |
| Communicating | Cognitive Ability & Anxieties, Pain Assessment | Working & Playing | Impact on Ability |
| Eating & Drinking | Diet, Fluid Balance, Intake & Output & Weights | Expressing Sexuality | Gender |
| Eliminating | Continence, Bowel & Urinary Patterns, Indwelling Catheter | Sleeping | Normal Sleeping Patterns, Use of Medications, Techniques etc |
| Personal Cleansing & Dressing | Hygiene Needs | Dying | Date Anointed, Individual End of Life Care Preferences, Religious/Spiritual Requirements, |
| R₃ = Recommendation, Read-Back and Risk | | What needs to happen today/Nursing Needs/Concerns, Referrals, Pending Tests/Investigations/Procedures, Tasks to be completed, Discharge Plan, Overall Plan of Care, Other Comments or Actions needed, Clarification or Opportunity to confirm clinical information , Safety Pause | |

Appendix 11 ISBAR₃ Template for Shift Clinical and Inter-departmental Handover

| ISBAR ₃ Template for Shift Clinical and Inter-Departmental Handover | | | | | |
|--|--------------|---------------|----------------|----------------|--|
| | | | | | Version 1.0 2016 |
| Bed No. | I = Identify | S = Situation | B = Background | A = Assessment | R ₃ = Recommendation/Read-Back/Risk |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Appendix 12 Sample Patient Status Communication Sheet for use during Shift Clinical Handover

| Date: | | Completed By: | | | Please indicate Patient Status by inserting ✓ in the relevant column | | |
|---------|--------------|---------------------|----------------|-------------------------|--|--|--|
| Bed No: | Patient Name | Patient Comfortable | Speak to Nurse | Call Back after 11.00am | Comment | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Appendix 13 Safety Pause Information Sheet (HSE QPS, 2013)



We are all responsible... and together
we are creating a safer healthcare system



Quality and Patient Safety Directorate

THE SAFETY PAUSE: INFORMATION SHEET

Helping teams provide safe quality care

| | |
|-------------|---|
| Why | Safety awareness helps all teams to be more proactive about the challenges faced in providing safe, high quality care for patients. |
| Who | Team lead and available multidisciplinary team members. |
| When | Any time (aim for a maximum of five minutes). |
| How | Focus on things everyone needs to know to maintain safety. Based on one question 'what patient safety issues do we need to be aware of today' - resulting in immediate actions. The four P's below provide examples to prompt the discussion (any prolonged discussion on specific issues can be deferred until after the safety pause). |

| | | |
|-------------------------|--|--|
| THE SAFETY PAUSE | QUESTION: WHAT PATIENT SAFETY ISSUES DO WE NEED TO BE AWARE OF TODAY? | Examples <ul style="list-style-type: none"> ■ Patients: are there two patients with similar names; patients with challenging behaviour; wandering patients; falls risk; self harm risk; or deteriorating patients? ■ Professionals: are there agency, locum or new staff who may not be familiar with environment/procedures? ■ Processes: do we have: new equipment or new medicinal products (are all staff familiar with these?); missing charts; isolation procedures required; or care bundles for the prevention and control of medical device related infections? ■ Patterns: are we aware of any recent near misses or recently identified safety issues that affected patients or staff? |
| | | Heads-up for today <ul style="list-style-type: none"> ■ Challenges e.g. illness related leave, staffing levels, skill mix, demand surges. ■ Meetings/training sessions staff need to attend e.g. mandatory training. ■ New initiatives/information e.g. new protocols; feedback from external groups. ■ Any other safety issues or information of interest to the team – has this been communicated to the team e.g. notice board/communication book/ patient status at a glance (PSAG) board/ other communication system etc. |
| | | Patient Feedback <ul style="list-style-type: none"> ■ Update on actions from recent patient feedback on their experience (complaints, concerns or compliments) that we need to be aware of today? |

| | |
|--------------------|--|
| Follow-ups | Issues raised previously (confirm included on existing risk register if appropriate), solutions introduced or being developed. For those involved in the 'productive ward' initiative this is an opportunity to review the 'safety cross' data and any improvements. |
| Team morale | Recent achievements, compliments from patients and what works well. |

Acknowledgements:

The HSE Clinical Governance Development initiative wishes to thank the National Emergency Medicine Programme for assisting in the development of this information sheet. It has been adapted with permission from Clinical Microsystems "The Place Where Patients, Families and Clinical Teams Meet Assessing, Diagnosing and Treating Your Emergency Department" ©2001, Trustees of Dartmouth College, Godfrey, Nelson, Batalden and the IHI Safety Briefing tool Copyright © 2004 Institute for Healthcare Improvement.

An initiative of the Quality and Patient Safety Directorate, May 2013

For further information see www.hse.ie/go/clinicalgovernance



Appendix 14 Sample Shift Clinical Handover

Operating Procedure:

To support effective shift clinical handover in accordance with the National Clinical Guideline on Communication (Clinical Handover) in Acute and Children's Hospital Services, National Clinical Guideline No 11. (NCEC, DoH, 2015), the following points must be adhered to when undertaking the shift clinical handover process;

- Shift Clinical Handover to start on time with staff standing at the Patient Communication Boards.
- Shift Clinical Handover in Progress signs to be used to create awareness and reduce the possibility of interruptions.
- The nurse leading shift clinical handover must be clearly identified
- Staff must allocated to relevant areas prior to the start of shift clinical handover.
- The Nursing and HCA handover (ISBAR₃) template must be used by the nurse leading shift clinical handover to communicate relevant information.
- It is the responsibility of the nurse leading shift clinical handover that he/she is prepared prior to handover by completing the Nursing and HCA handover (ISBAR₃) template and the Patient Status Communication Sheet template and ensuring the Communication Board is updated.
- The Nursing and HCA shift clinical handover (ISBAR₃) template must be used by each nurse/HCA to document relevant information received
- It is the responsibility of the nurse receiving shift clinical handover to use the patient profile/healthcare record throughout the shift to support the information received in shift clinical handover.
- The HCA must receive shift clinical handover with relevant information prior to the start of the main handover.
- The completed Patient Status Communication Sheet must be given to a nominated staff member who has been identified to take all interruptions/ telephone calls.
- At the end of shift clinical handover, the nurse in charge to identify any priorities of care or any safety issues arising in accordance with ISBAR₃.
- All staff must participate in 'Meet and Greet' and 'Hello, My Name is...' in order to meet the patients they have responsibility for on each shift.
- Confidentiality must be maintained at all times

Appendix 15 Sample ISBAR Template for Communication of a Deteriorating Patient

| ISBAR Template for Communication in relation to Deteriorating Patient | | | | | Version 1.0 2016 |
|---|--------------|---------------|----------------|----------------|--------------------|
| Bed No. | I = Identify | S = Situation | B = Background | A = Assessment | R = Recommendation |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |


Appendix 16 Sample Evaluation Form

- Thank you for participating in the Clinical Handover Education Programme. I hope you found the sessions relevant and interesting.
- Please take a few minutes to complete this evaluation form and place it in the box provided. Your comments will guide us to any changes we may need to make for similar days in the future
- Please indicate the extent to which you agree / disagree with each of the following statements by placing a tick (√) in the box of your choice

| Programme Structure | Strongly Agree | Agree | Disagree | Strongly Disagree |
|--|-----------------------|--------------|-----------------|--------------------------|
| The programme was well organised | | | | |
| The environment was satisfactory | | | | |
| Modules were clear and informative: | | | | |
| Introduction | | | | |
| Part 1: Introduction & Background to Clinical Shift Handover | | | | |
| Part 2 (a) Shift Clinical Handover: Existing Practice | | | | |
| Part 2 (b) ISBAR ₃ Shift Clinical Handover: Best Practice | | | | |
| Part 2 (c): ISBAR ₃ Shift Clinical Handover - Healthcare Assistant Handover | | | | |
| Part 2 (d): ISBAR ₃ Shift Clinical Handover Meet & Greet & 'Hello, My Name is...' | | | | |
| Part 3 (a): Inter-departmental Clinical Handover – Existing Practice | | | | |
| Part 3 (b): ISBAR ₃ Inter-departmental Clinical Handover – Best Practice | | | | |
| Part 4 (a): Communication of Information in relation to a Deteriorating Patient – Existing Practice | | | | |
| Part 4 (b): ISBAR: Communication of Information in relation to a Deteriorating Patient – Best Practice | | | | |
| Part 5: (a): Implementing Change: ISBAR ₃ & ISBAR | | | | |
| Part 5 (b): Implementing Change: Supporting Resources | | | | |


| | | | | |
|---|-----------------------|--------------|-----------------|--------------------------|
| Part 5 (c): Implementing Change: Best Practice Concepts for Clinical Handover | | | | |
| Part 6: Consolidating Change for Clinical Handover (Group Work) | | | | |
| Part 7: Conclusion | | | | |
| Content | Strongly Agree | Agree | Disagree | Strongly Disagree |
| The programme met its outcomes | | | | |
| Modules kept my interest | | | | |
| Modules were the appropriate length | | | | |
| The group work/workshops helped my learning | | | | |
| The course will be of practical benefit to me | | | | |
| Participant Workbook was beneficial as educational tool/for future reference | | | | |
| Video recordings were beneficial as educational tools | | | | |
| I would be grateful if you would answer the following questions, which would assist me in planning future study days | | | | |
| Was the programme structured to suit your needs? (E.g. timing of sessions, amount of sessions) | | | | |
| Was there any additional topic that could have been included to meet your department needs? (If yes, please indicate your profession/ department) | | | | |
| Any other comments | | | | |
| Many thanks again for participating on the day and thank you for taking the time to complete this evaluation. | | | | |

Appendix 17: Sample Certificate of Attendance



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Tús Aite do
Shábháilteacht 1 Othar
Patient Safety 1 First



Office of the
Nursing & Midwifery
Services Director

Sample Certificate of Attendance

Has Attended the
**Clinical Handover: An Inter-Disciplinary Education
Programme
(2017)**
On

Name of Service:

(NMBI Category 1. Approval CEUs 4 (2018 - 2020))

Programme Facilitator

Appendix 18 Sample Observational Audit Tool for Shift Clinical Handover

| Ward: | Date: | Time started at: Time finished at: Duration: | Audit Completed By: | Comments: |
|---|-------|--|---------------------|-----------|
| Audit Instructions: Please answer Yes/No or N/A and comment to provide evidence where appropriate. | | | | |
| 1. Does shift clinical handover start on time? | | | | |
| 2. Where does shift clinical handover take place? | | | | |
| 3. Do staff stand at the Patient Communication Board? | | | | |
| 4. Are signs used to indicate shift clinical handover is in progress? | | | | |
| 5. Who is involved? | | | | |
| 6. Is it clear who is giving shift clinical handover? | | | | |
| 7. Is it clear who the nurse in charge receiving shift clinical handover is? | | | | |
| 8. Are staff allocated to specific areas prior to shift clinical handover? | | | | |
| 9. Does the nurse handing over use the ISBAR ₃ template to exchange information? | | | | |
| 10. Is the Patient Communication Board updated prior to shift clinical handover? | | | | |
| 11. Is the Patient Status Communication Sheet completed? | | | | |
| 12. Who is the Patient Status Communication Sheet given to in order to address any interruptions? | | | | |

| | |
|--|-------|
| 13. Was a nurse identified prior to shift clinical handover to address any interruptions? | |
| 14. Do the staff receiving shift clinical handover use the ISBAR ₃ template to document information received? (Are patient profiles used) | |
| 15. How is it conducted? (Is the ISBAR ₃ Communication Tool used) | |
| 16. What information is given at shift clinical handover? (Relevance) | |
| 17. At the end of shift clinical handover, does the nurse in charge identify any priorities of care or any safety issues arising for nursing staff? | |
| 18. Were there any interruptions during shift clinical handover? | |
| 19. Did the HCA receive handover using ISBAR ₃ prior to the start of the main shift clinical handover? | |
| 20. Did the HCA use the ISBAR ₃ template to document relevant information during shift clinical handover? | |
| 21. At the end of shift clinical handover, does the nurse in charge identify any priorities of care or any safety issues arising for HCA staff? | |
| 22. Were there any interruptions during HCA shift clinical handover? | |
| 23. Is 'Meet and Greet and Hello, My Name is...' completed? | |
| 24. Is confidentiality maintained? | |
| | |
| Recommendations: | |
| Signed: | Date: |
| Signed: | Date: |

Appendix 19 Audit Tool Sample Template: ISBAR₃ Communication (Clinical Handover) Tool for Shift Handover (NCG No. 11, NCEC, DoH, 2015)

Note: The ISBAR₃ communication (clinical handover) tool should be documented in the patient notes and audited as part of a documentation audit and as a step in a quality improvement process.

Was the handover face to face, telephone supported by follow-up documentation etc?
Please specify:

| | | Yes | No |
|--|-------|-----|----|
| Was the handover documented? | | | |
| Date: | Ward: | | |
| Did the communication (clinical handover) identify that all patients in the unit were handed over? | | | |
| Did the documentation contain the following as part of the ISBAR ₃ communication (handover) tool? | | | |
| | | Yes | No |
| Identification | | | |
| Identity of the lead handover person evident | | | |
| Identity of individual(s), team receiving the handover | | | |
| Identity of patient(s) | | | |
| Situation | | | |
| Location of patient(s) | | | |
| Brief summary of current status | | | |
| Was a problem identified? | | | |
| Background | | | |
| Concise summary of reason for admission | | | |
| Summary of treatment to date | | | |
| All baseline observations (current admission) BP; Pulse; Resps; SpO ₂ ; Temp; AVPU; NEWS/PEWS/IMEWS (Previous NEWS/PEWS/IMEWS if appropriate) | | | |

| | Yes | No |
|--|------------|-----------|
| Assessment | | |
| Evidence of patient assessment | | |
| Recommendation | | |
| Were recommendations made re: care of patient? | | |
| Read-back | | |
| Is there evidence of read-back to confirm clinical handover information? | | |
| Risk | | |
| Was the safety pause included in the handover? | | |
| Were there any risks identified? | | |
| Is there evidence of acceptance of responsibility and accountability for patient care? | | |

Observational studies may also be carried out to audit communication in relation to handover.

Appendix 20 Audit Tool Sample Template: ISBAR₃ Communication (Clinical Handover) Tool for Inter-departmental Handover (NCG No. 11, NCEC, DoH, 2015)

Note: The ISBAR₃ communication (clinical handover) tool should be documented in the patient notes and audited as part of a documentation audit and as a step in a quality improvement process.

Was the handover face to face, telephone supported by follow-up documentation etc?
Please specify:

| | Yes | No |
|------------------------------|-----|----|
| Was the handover documented? | | |

Date: _____ Ward: _____

Did the documentation contain the following as part of the ISBAR₃ communication (handover) tool?

| | Yes | No |
|--|-----|----|
|--|-----|----|

Identification

| | | |
|--|--|--|
| Identity of the person providing handover evident | | |
| Identity of individual(s), team receiving the handover | | |
| Identity of patient | | |

Situation

| | | |
|---|--|--|
| Location of patient | | |
| Brief summary of patient's current status | | |
| Was a problem identified? | | |

Background

| | | |
|--|--|--|
| Concise summary of reason for inter-departmental clinical handover | | |
| Summary of treatment to date | | |
| All baseline observations (current admission) BP; Pulse; Resps; SpO ₂ ; Temp; AVPU; NEWS/PEWS/IMEWS (Previous NEWS/PEWS/IMEWS if appropriate) | | |

| | Yes | No |
|--|------------|-----------|
| Assessment | | |
| Evidence of patient assessment | | |
| Recommendation | | |
| Were recommendations made re: care of patient? | | |
| Read-back | | |
| Is there evidence of read-back to confirm clinical handover information? | | |
| Risk | | |
| Was the safety pause included in the handover? | | |
| Were there any risks identified? | | |
| Is there evidence of acceptance of responsibility and accountability for patient care? | | |

Observational studies may also be carried out to audit communication in relation to handover.

Appendix 21 Audit Tool Sample Template: ISBAR Communication Tool for Communication in relation to a Deteriorating Patient (NCG No. 11, NCEC, DoH, 2015)

Note: The ISBAR communication tool should be documented in the patient's notes and audited as part of a documentation audit and as a step in a quality improvement process.

| | | |
|---|------------|-----------|
| Date: | Ward: | |
| Was the communication face to face, telephone etc? Please specify: | | |
| | Yes | No |
| Was the communication documented? | | |
| Date: | Ward: | |
| Did the documentation contain the following as part of the ISBAR communication (handover) tool for patient deterioration? | | |
| | Yes | No |
| Identification | | |
| Identity of individual communicating deterioration | | |
| Identity of individual(s) receiving communication | | |
| Identity of patient | | |
| Situation | | |
| Was the reason for calling identified? | | |
| Were concerns identified? | | |
| Background | | |
| Was the relevant background documented? | | |
| Assessment | | |
| Was there evidence of patient assessment? | | |
| Recommendation | | |
| Were any recommendations documented for this patient? | | |

| | Yes | No |
|-------------------------------|------------|-----------|
| Patient Outcome | | |
| Stabilised | | |
| Transferred HDU/ICU | | |
| Transferred to other facility | | |
| Death | | |

Observational studies may also be carried out to audit communication in relation to patient deterioration.

Appendix 22 Guidance for Audit Tool: Organisational Adherence to the Communication (Clinical Handover) in Acute and Children’s Hospital Services NCG No. 11 (NCG No. 11, NCEC, DoH, 2015)

| | | | |
|--|------------|-----------|-----------------|
| Date: | Hospital: | Signed: | |
| Each recommendation must be included in the organisational audit of compliance with the NCG and level of compliance identified as follows: | | | |
| Recommendation No. | | | |
| | Yes | No | Evidence |
| Fully compliant | | | |
| Partially compliant | | | |
| Non-compliant | | | |
| If partially or non-compliant organizations must put a Quality Improvement Plan in place identifying how compliance can be achieved within agreed timelines. | | | |



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Clinical Strategy and Programmes Division



Office of the
Nursing & Midwifery
Services Director