NURSING HANDOVER FOR ADULT PATIENTS GUIDELINES

1. Overall objective
   a) To ensure that patient care continues seamlessly and safely, providing the oncoming nurses with pertinent information to begin work immediately.
   b) To maintain the ongoing confidentiality of patient records.

2. Definition
   The nursing change of shift report or handover is a communication that occurs between two shifts of nurses whereby the specific purpose is to communicate information about patients under the care of nurses (Lamond, 2000).

3. Target users
   All nursing and midwifery staff involved in the transfer of patient information from one member of staff to another.

4. The patients to whom the guidelines are meant to apply
   All adult patients whose length of stay occurs between two shifts of nurses.

5. Local evaluation of practice
   A study undertaken in 2002 within Conwy & Denbighshire NHS Trust by the Deputy Director of Nursing and Clinical Leader in Ophthalmology revealed that a variety of methods were used to undertake handover. It was suggested as a result of this study that there was a need for Trust wide guidelines and the use of pre printed computerised patient handover sheets, which are currently used in some areas within the Trust. The pre printed sheet allows nurses to concentrate upon the verbal handover being given and is shredded at the end of each shift. These findings support the literature in that handover style appears to very much depend upon local circumstances.

6. Evidence
   The nursing handover process is considered to be a crucial part of providing quality care in a modern healthcare environment (Pothier et al. 2005) and the quality of a report given may delay an individual nurses ability to provide care for up to 1 to 2 hours (Hansten, 2003).
The shift report may occur in some areas up to three times a day. It may vary in length from a ‘full report’ lasting between 30 minutes up to an hour or longer to a ‘head line report’ which may give a quick overall patient update following a particular busy part of the day.

Currie (2002) in a study undertaken within an A&E department identified the following problem areas of handover:

- Information missed including patients missed out, poor nurse communication and handover not from the named nurse.
- Distractions including noise, interruptions and inattention of staff.
- Lack of confidentiality including no privacy at the nurses’ station, relatives in close proximity.
- No handover at the start of the shift, and not receiving any handover at all.

More recent research suggests that purely verbal type handovers are prone to serious data loss and that note taking plus verbal handover has serious weaknesses not previously demonstrated (Pothier, D. et al. 2005).

There are four main styles of handover reported in the literature (Miller, 1998; Sexton et al. 2004):

- Verbal handover
- Tape recorded handover
- Bedside handover
- Written handover

A pre-prepared sheet containing patient details can be used as a method of handover (Miller, 1998) although this takes time to prepare. A purely verbal handover without note taking may sometimes be used particularly when time is a factor (Miller, 1998). However, McKenna (1997) in Sexton et al. (2004) could not identify one single method as being superior. Situations may vary from one area to another in relation to numbers of patients, dependency, staffing levels and these factors will also influence methods selected. A ‘mix and match’ approach of methods very often may be adopted.

7. Recommendations

- Handover should not just be directed towards the nurse in charge. All nurses coming on to a shift need a handover.

- The start of the handover is also the best opportunity for the nurse in charge to formally hand over the controlled drug keys (if appropriate) to the oncoming person in charge of the shift.
• A safety briefing (please see appendix 1) is undertaken at the beginning of a shift handover. This should not extend the time of handover, should last only 2-3 minutes and the focus should be the specific patient safety issues for that clinical area on that shift. This information should be carried forward to the next shift and should simply highlight safety as a main priority.

• The Situation, Background, Assessment and Recommendation (SBAR) model can be used by any health professional to communicate clinical information about a patient’s condition (please see appendix 2).

• Commonly verbal handover is the selected method of handover, be it at the bedside, nurses station or ward office. In order to set a quality standard for each verbal handover, Currie (2002) proposes that each handover should be ‘CUBAN’:

C onfidential -Ensure information cannot be overheard; notes remain with you all the time and are ‘shredded’ at the end of the shift. They must not be taken out of the clinical area and must not become part of the patient’s case notes.

U ninterrupted -Utilise a quiet area where there are no distractions. Commence on time, at the beginning of the shift.

B rief -Keep information relevant; too much can be confusing. Do not pass on unnecessary or unethical information. Avoid labelling or stereotypes.

A ccurate -Ensure that all information is correct and that no patients are missed out. Care plans should be up to date at the beginning and the end of each shift. Information should be clear and concise and jargon should not be used. Remember bank staff or student nurses may be present.

N amed Nurse -Continuity is essential therefore the person who has looked after the patient should give the handover. Where 12-hour shifts take place, staff may not be on duty for more than two days at a time therefore continuity and more information may be needed.

• Use a structured approach to enable all staff to focus on handing over what is relevant, avoiding overload and passing on irrelevant information. Information relayed should follow the 5 P’s rule:

  • P1 Patient’s name, diagnosis, doctor and past relevant history (if this information is not on handover information sheet)

  • P2 Patient’s date/reason for admission and/or date post op

NURSING HANDBOVER FOR ADULT PATIENTS GUIDELINES

Date validated: May 07
Date operational: June 07
Date to be reviewed: June 08
• **P3** Present restrictions? nil orally, fluids only, diabetic diet, non-weight bearing etc.

• **P4** Plan of Care;
The patients main problem/need is........... and will need ........
The next problem/need is...........and will need ...........etc

• **P5** What part can you play in the next shift? The handover should show progression (Please see appendix 3 for aide memoir)
This problem/need centred approach sits nicely with care planning. The accuracy of content is a crucial factor in the provision of excellent nursing care (Hoban, 2003). Handover in this way must be disciplined and **commence on time** and staff members participating must have their information ready at the onset.

• Pre-prepared handover sheet. Pothier et al. demonstrated in their 2005 pilot study that the use of a pre-prepared handover sheet that is passed to the next shift in conjunction **with** a verbal handover, almost entirely eliminates the loss of data during handover. Improving loss of data will almost surely impact upon the quality of patient care. These authors recommend that nursing and medical staff should consider the introduction of facilities to prepare patient data sheets and introduce them into the handover process.

8. **Audit**
It is recommended that audit of handover practice should be undertaken on a directorate basis and a handover evaluation tool is available for any area wishing to review/streamline practice within their Directorate/Division. Please see appendix 4.

9. **Summary**
Research demonstrates that written handovers may prove to be more accurate and a much less time consuming method. It is interesting that Parker (1992) cited in Hays (2003) suggests that as doctors and other health professionals record their observations in the knowledge that their assessments will be read and acknowledged by their colleagues, then nurses should follow suit. In this way valuable time could be saved and documentation would have to be clear, concise and maintained on a regular basis.
However, verbal handovers remain the popular way of communication at shift report; this method augmented with a pre-prepared handover sheet will avoid the loss of vital information that may result in serious patient morbidity or mortality (Pothier et al. 2005).

10. **References**

NURSING HANDOVER FOR ADULT PATIENTS GUIDELINES

Date validated: May 07
Date operational: June 07
Date to be reviewed: June 08


Safety Briefing

Health & Safety is EVERYONE’S responsibility, by recording and communicating safety issues we will greatly improve safety for our patients, our colleagues and ourselves.

Safety briefings will highlight areas of concern during the previous shift by informing the on-coming staff of any safety issues and the necessary action taken or required.

The following is a list of examples of issues that should be considered at shift / report handovers to promote and improve patient safety. It is to assist in identifying actual or potential safety risks to patients and does not deter from each individual’s responsibility and accountability to safeguard patients whilst in their care. This is not a definitive check list and must not be used as such.

- Risks to patients: e.g. 2 patients with same names
- Near misses
- Incidents
- Post incident learning - reviews / reflection
- Staffing (nursing & medical)
- Patients with mental health issues
- Unauthorised persons / visitors
- Security
- Equipment, faults, etc.
- Unfinished duties at shift change
- Infection control / isolation
- Changes in treatment e.g. drug discontinuation
- Changes in practice e.g. change in lancets for blood glucose testing.
- Estates Referrals e.g. regarding maintenance requests

This is a live record and needs to be accessible to ALL staff on all shifts

The safety briefing record must be retained as evidence that Health & Safety issues have been discussed and communicated at each hand-over where applicable.

Incomplete actions must be followed through and may be brought forward on the next briefing sheet.
Appendix 2

SBAR REPORTING

BEFORE CALLING:
1. Assess the patient
2. Know the admission diagnosis
3. Read most recent events / progress
4. Have available: Observation Chart, Fluid Balance Chart, Drug Chart, Latest Laboratory Results, DNR Status
5. Be sure you are calling appropriate team / physician

WARD: ___________________________
DATE: ___________________________
TIME OF CALL: _____________________
REPORTING NURSE: ___________________
PERSON CONTACTED: _______________
TIME PATIENT REVIEWED: ____________

SITUATION

State your name and area of work
“I am calling about ……. ” (Give patient name and location)
“The situation is ………….” (Briefly outline the problem)

What it is
When it started
How severe
MEWS score

BACKGROUND

“The background is ……………”

State admission diagnosis and date of admission
Give brief, relevant medical history and treatment to date

ASSESSMENT

“My assessment is ……………………”
List changes in the patient’s condition, which give cause for concern:
AIRWAY e.g. Is the airway patent? Noisy breathing? Is the patient receiving OXYGEN?
BREATHING e.g. Respiratory rate, breathing pattern, SpO2, skin colour,
CIRCULATION e.g. Pulse rate, rhythm changes, blood pressure, CRT
DISABILITY e.g. AVPU assessment, change in GCS, pain assessment, blood glucose
EXPOSURE e.g. wound drainage, urine output
State here if you are concerned that the patient is rapidly deteriorating and at risk of cardiac arrest

RECOMMENDATION

“I recommend that you …… / I would like you to ………….”
State what you would like to see done e.g. Come to assess the patient immediately,
Review DNR status; consider transferring the patient to Critical Care
“How long will you be?” (Ensure you are given a time for the patient to be assessed)
“Is there anything specific you would like me to do now?”
E.g. CXR, ABG, ECG, Contact Outreach Team
Appendix 3

Improving the effectiveness of Nursing Handover

Handover should be  “**CUBAN**”

- **C**onfidential
- **U**ninterrupted
- **B**rief
- **A**ccurate
- **N**amed - nurse  
  
  *(Currie, 2002)*

**Use the 5 P’s…………………..**

**P1.** Patient’s name, age, doctor, past medical history, allergies

**P2.** Patient’s reason for admission date of admission, days post op

**P3.** Present restrictions
  i.e. Do Not Resuscitate, Nil By Mouth, Free Fluids, Non Weight Bearing, Diabetic Diet

**P4.** Plan of care
  i.e. The patient’s main problem/need is......................
  and he/she will need the following......
  The patient’s next problem/need is.................... & so on

**P5.** Progress
  Report must be progressive: Must contain what needs to happen in the next shift
Appendix 4

Conwy & Denbighshire NHS TRUST

HANDOVER AUDIT TOOL – MARP handover© 2003 Brigid Reid

Aim: To observe a team of practitioners handing over the care of patients. NB If ‘handover’ does not directly involve patients, the post ‘handover’ will need to be observed to see how contact with patients is established (or not).

Criteria for sampling: Internal and external auditor to identify different handover opportunities throughout the audit period. At least two different opportunities should be identified.

Sample size: Can be any size but ideally it should involve the majority of the caseload within the ward/department.

Key notes: In undertaking this audit the following expectations should be clarified by the external and internal reviewers –

‘Handover’ has become a nursing institution and is often a victim of either
- tradition – “we’ve always done it like this”
- fads/fashions – moving to a new mode lock, stock and barrel eg taping/walking around
- social needs of staff – that is not to say recognising you are working together as a team on a shift is important as long as it does not jeopardise the main aim ie patient care

The practice of communication from shift to shift needs to
- progress (rather than just report) patient care (staff can often become ‘stuck’ in approaches and need to revisit them as a team)
- focus on patients as individuals and their nursing needs (rather than merely medical diagnosis and actions or labelling of patients)
- be a learning experience for all concerned (are there opportunities for questions to meet the knowledge needs of oncoming nurses)
- meet the needs of oncoming staff (whose knowledge base should not be assumed rather checked out eg “when were you last here?” and avoid non specific directions eg “all care” which can mean different things to different people
- utilise other means of communication as appropriate eg patient notes, meeting patients, mdt meetings, medical ward rounds ie a mix and match approach can be more effective than one mode.

The questions asked effectively direct you to summarise using your professional judgement and where possible giving specific examples to aid staff’s understanding of those judgements at feedback.

NURSING HANDOVER FOR ADULT PATIENTS GUIDELINES
HANDOVER AUDIT TOOL

1. Identify how oncoming members of staff are greeted and what information is appropriately offered about the shift experienced and shift anticipated:

2. In what spirit is information exchanged?

3. What attempt is made to ascertain what the receiving practitioner already knows and what they need to know?

4. Where is the handover occurring? Has this been actively decided for/with each patient?
5. Does the oncoming practitioner meet every patient?

6. Would each patient (or their relative/carer) be able to tell you who is caring for them at that point in time?

7. When during contact with the patients do the practitioners make their intentions clear?

8. If care is being discussed in the patient’s presence are they actively involved?

9. Are patient’s goals clearly reflected in the documentation?
10. Does the nurse check documentation and care plans following the handover report?

11. How long does the handover take?

12. Is any other information outside of patient care, discussed during the handover?

Additional Comments
11. Written
November 2006

12. Review
November 2007

<table>
<thead>
<tr>
<th>Author</th>
<th>Alexandra Buckley</th>
<th>Job title</th>
<th>Divisional Lead Nurse – Practice Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate</td>
<td>Division of Surgery &amp; Anaesthesia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Title of Working Group:**

**Members of the Working Group:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Consultation has taken place with:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Date consulted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Clinical Leaders</td>
<td></td>
<td>June 2006</td>
</tr>
<tr>
<td>Information Governance Manager</td>
<td></td>
<td>January 2007</td>
</tr>
</tbody>
</table>