# Clinical Handover and Safety Briefing Policy

<table>
<thead>
<tr>
<th>Doc. Ref. No.</th>
<th>Ref no to track policy by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical handover and safety briefing policy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title of Document</th>
<th>Clinical handover and safety briefing policy</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Author’s Name</th>
<th>Sarah Whittle, John Sutton</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Author’s Job Title</th>
<th>Clinical nurse lead, Clinical nurse manager HMP Ashfield,</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dept / Service</th>
<th>Operations directorate nursing services, RRT, CHT, PCHS, Prisons, REACT, SPA and In reach.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Doc. Status</th>
<th>V1.0</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Based on</th>
<th>-</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signed off by</th>
<th>Clinical Cabinet</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Publication Date</th>
<th>21 December 2015</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Next review date</th>
<th>20 December 2017</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Distribution</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Consultation

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1.0</td>
<td>21/12/15</td>
<td>Clinical Cabinet</td>
</tr>
</tbody>
</table>

| | |
| | |
### Checklist for Approving Committee / Board

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a equality impact assessment been compiled?</td>
<td></td>
</tr>
<tr>
<td>Has legal advice been sought</td>
<td>No</td>
</tr>
<tr>
<td>Has the policy been assessed for its impact on Human rights?</td>
<td>No/yes/NA</td>
</tr>
<tr>
<td>Have training issues been considered?</td>
<td>Yes training done locally in teams</td>
</tr>
<tr>
<td>Have any financial issues been considered?</td>
<td>No</td>
</tr>
<tr>
<td>Will implementation be monitored?</td>
<td>As per Audit stipulations</td>
</tr>
<tr>
<td>Is there a cascade mechanism in place to communicate the policy?</td>
<td>No/yes/NA</td>
</tr>
<tr>
<td>- with staff</td>
<td></td>
</tr>
<tr>
<td>- with patients</td>
<td></td>
</tr>
<tr>
<td>- with the public</td>
<td></td>
</tr>
<tr>
<td>Are there linked policies / procedures?</td>
<td>Clinical policies</td>
</tr>
<tr>
<td>Has a review date been set?</td>
<td>No</td>
</tr>
<tr>
<td>Is this related to the core standards for better health?</td>
<td>No/yes/NA</td>
</tr>
</tbody>
</table>
October 2015

Sarah Whittle, John Sutton

All teams with a SOP in the appendix have produced this in accordance with their local needs.
# Policy for Clinical Handover and Safety Briefing

## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Purpose and scope</td>
<td>1</td>
</tr>
<tr>
<td>2 Background</td>
<td>1</td>
</tr>
<tr>
<td>2.1 Embracing Safety</td>
<td>2</td>
</tr>
<tr>
<td>2.2 The benefits of good handover</td>
<td>3</td>
</tr>
<tr>
<td>3 Principles of good handover and safety briefing</td>
<td>3</td>
</tr>
<tr>
<td>4 Audit</td>
<td>4</td>
</tr>
<tr>
<td>5 Safety briefing guide</td>
<td>5</td>
</tr>
<tr>
<td>6 SBAR</td>
<td>7</td>
</tr>
<tr>
<td>7 Handover of care to another service</td>
<td>8</td>
</tr>
<tr>
<td>8 Standard operation procedure (SOP)</td>
<td>8</td>
</tr>
<tr>
<td>9 References</td>
<td>9</td>
</tr>
<tr>
<td>10 Appendix 1 – SBAR Reporting</td>
<td>11</td>
</tr>
<tr>
<td>11 Appendix 2 - SOP for the prison healthcare service</td>
<td>12</td>
</tr>
<tr>
<td>12 Appendix 3 - SOP for the community nursing service</td>
<td>15</td>
</tr>
<tr>
<td>13 Appendix 4 - Standard operating procedure palliative care service</td>
<td>21</td>
</tr>
<tr>
<td>14 Appendix 5 - SOP Rapid Response service</td>
<td>22</td>
</tr>
<tr>
<td>15 Appendix 6 - SOP REACT Handover Protocol (BRI)</td>
<td>25</td>
</tr>
<tr>
<td>16 Appendix 7 - SOP REACT Handover Protocol (Southmead)</td>
<td>26</td>
</tr>
<tr>
<td>17 Appendix 8 - SOP Inreach service</td>
<td>27</td>
</tr>
<tr>
<td>18 Appendix 9 - SOP Single point of access(SPA)</td>
<td>28</td>
</tr>
<tr>
<td>19 Appendix 10 – SOP Out of Hours (OOH)</td>
<td>29</td>
</tr>
</tbody>
</table>
1 Purpose and scope

The fundamental aim of any handover is to achieve the efficient transfer of high quality clinical information at times of transition of responsibility for patients. Clinical handover is defined as “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” (Haig et al. 2006, Patterson 2008, Yee et al. 2009, Chaboyer et al. 2010).

Bristol Community Health has a commitment to the improvement and delivery of patient care. As part of improvement and safe delivery of care, risk assessment and fostering a culture of safety are key to improving patient safety within the organisation.

Safety Briefings aim to develop a working environment free of reprisal, whereby information regarding safety issues, near misses and other incidents are communicated freely in an open and transparent culture for learning and improvement.

Patients tell us they want continuity of care and their care to be co-ordinated, they expect nurses caring for them to share information, to minimise repetition and maintain safety. Patients also expect their confidentiality to be respected in handling their personal information.

This policy aims to ensure that patient care continues seamlessly and safely providing the next professional to care for the patient with pertinent information to begin work and to be aware of any patient safety or environmental issues.

If a team works in a situation where across a 24 hour period the care of a patient is passed from one person to the next they are expected to have a structured clearly defined handover for which there is a standard operating procedure that all staff are aware of. This must include documented and archived evidence of the handover.

The policy applies to all BCH staff involved in treating patients, including bank and agency staff. Handover will occur within and between teams in BCH as well as professionals in other organisations, typically general practitioners, city council staff, hospital staff and paramedics. This is not a definitive list.

This policy also defines and explains the SBAR tool (section 6) which all staff are expected to adopt when handing over patient information in all circumstances.

Good handover does not happen by chance; it requires work by all those involved, from organisations to individuals.

2 Background

The Francis Report, into care failings at Mid Staffordshire Foundation Trust, was published in 2013. It is noteworthy that the report mentions on numerous occasions the need for constructive handover processes and demonstrable accountability of staff. The Francis Report demonstrated that communication with patients and those closest to them requires staff to have ready access to the relevant information, and the time to impart it. It found that it is an essential part of the care of any patient that adequate information is handed over from shift to shift and between different clinical teams and departments. This requires good
recordkeeping, appropriate handovers and a caring attitude, promoting the easy recall of particular patients and their problems.

Working a shift pattern as many of BCH services do, increases the number of individuals caring for patients, highlighting the importance of a comprehensive handover of clinical information. Opportunistic listening in, may miss important aspects of information.

Poor handover can result in error and patient harm and in fragmented inconsistent care. “Patients have suffered adverse consequences when handover goes wrong. The Department of Health report, ‘An Organisation with a Memory’ (2013) cites an example involving the death of a patient. Although a number of system failures were identified, it was noted that there was no formal face-to-face handover between the doctors and nurses involved.”

2.1 Embracing Safety

Patient safety as part of clinical governance is rightfully at the heart of the organisational structures of the NHS, as well as the wider public.

Building a safer NHS for patients introduces the work of the National Patient Safety Agency in proactively raising awareness of patient safety issues. Good quality handover is essential to protect the safety of patients. Failure in this process, or poor quality handover, is a significant risk to patients.

Several recent coroners’ cases have criticised systems where the failure to hand over information effectively was implicated in an adverse outcome.

Safety Briefings have traditionally been a tool used by many industries nationally, these Briefings incorporated discussions regarding safety issues within the organisations, used on a daily basis, 24 hours a day and 7 days per week. The Institute for Healthcare Improvement developed a tool to increase safety awareness among front line staff and, to further develop the culture of safety within health. A core part of the Safety Briefing is to develop a working environment free of reprisal, whereby information regarding safety issues, near misses and other incidents are communicated freely in an open and transparent culture focused on learning and improvement.

The handover together with Safety Briefing guide provides communication between staff and other multidisciplinary team members. It includes essential information to reduce gaps in communications to reduce the potential for serious breakdown in continuity of care and to aid the reduction in harm to the patient and staff (Patient Safety Solutions 2007). The introduction of the safety aid of SBAR (Situation, Background, Assessment and Recommendation) together with the daily Safety Briefing brings structure to shift change/handovers within the healthcare team. The safety briefing has been found to aid the communication regarding potential patient and environmental safety problems and concerns on a daily basis. The safety briefing can be used to highlight and give a brief overview of current safety issues. Additionally this will be used to highlight potential risk factors that may occur on a daily basis. (Royal College of Surgeons Mar 2007).
A Safety Briefing is undertaken at the beginning of a handover. This will be a brief five minute maximum focus on pertinent issues specific to patient safety issues and environmental issue.

### 2.2 The benefits of good handover

Safety is protected – lapses in information handover can, and do, lead to mistakes being made.

Greater continuity of care – poor handover can lead to fragmentation and inconsistency of care.

Reduction of duplication – patients dislike having to answer the same questions over and over again.

Increased service satisfaction – every nurse attending a patient can begin where the last left off. Patient perception of professionalism is reaffirmed and improved.

Improvements in decision making through shared clinical decisions.

Provides a forum for teaching, team building and promoting team cohesion (Lally 1999, Randell 2011).

Provides an opportunity to reflect on the previous shift to plan future care and discussion with patients and their families. (Randell 2011).

Reduces stress by enabling staff to share problems and solutions (Johnson and Cowin 2013) and feel part of the team, having a shared approach, and clear accountability.

Professional protection – accountability has become more prominent with the move towards a more litigious culture within healthcare. Clear and accountable communication can protect a nurse against blame for errors which occur.

Job satisfaction – providing the best possible quality of care is highly rewarding and is fundamental to a nurse’s sense of job satisfaction.

Effective communication enables effective patient care and effective teamwork is a product of effective communication, which in turn enables effective teamwork.

### 3 Principles of good handover and safety briefing

Good Handover requires clinical leadership from senior staff, however all team members should work together to promote inter-team communication.

A positive and non-judgemental approach should be taken for inquiry into practice and rationale in order to identify risks, promote professional decision making, and agree the best evidence-based care.

Handover should be at the same appropriate, prearranged time. This will vary from service to service but will be stated in the SOP for a service.
Individuals and organisations have a shared responsibility to ensure that safe continuity of information and responsibility between shift changes and passing the care of the patient outside the team takes place.

The key lead should be identified at each handover, this is likely to be the identified care co-ordinator for the day. The most senior member of staff in attendance should have responsibility for ensuring handover is conducted in accordance with policy.

Respect your colleagues, do not talk over them or interrupt them during handover. There is a lot of information to handover so relay and discuss only what is necessary.

Professionalism is expected at all times and adherence to Bristol Community Health Code of Conduct.

Avoid unnecessary interruptions. Frequent interruptions may affect the quality of information transfer (Castledine 2006, Streitenberger et al. 2006, Meisner et al. 2007).

The information provided during handovers influences the delivery of care to the patient and the safety of the staff.

When planning team handover consider;

- Allocate time for handover, which is included in the staff rota. Identify frequency and regular day/s and time. Team handover should be at a fixed time and of sufficient length.
- Allocated place for handover which is understood by all - this may be a team room or standing at a patient information board.
- All team members should understand the rationale for handover, know when and how it occurs.
- Adequate information technology support should be provided.
- Identify key people who need to attend.
- Interruptions, noise or disturbance should be avoided during handover.
- Handover will be documented using the care co-ordination handover method relevant to your service.
- Copies of the care coordination/ handover log will be available for audit and reference purposes. A system for record keeping and storage should be identified and used consistently in line with policy.

4 Audit

Handover will be audited regularly to ensure adherence to this policy and provide assurance for harm free care. There will be some questions added to the annual documentation audit to ensure handover and safety briefings are happening in all appropriate teams. The content of handover will be audited by services in line with their individual SOP.
5 Safety briefing guide

Safety Briefings have traditionally been a tool used by many industries nationally, these briefings incorporated discussions regarding safety issues within the organisations, used on a daily basis, 24 hours a day and 7 days per week. The Institute for Healthcare Improvement developed a tool to increase safety awareness among front line staff and to further develop the culture of safety within Health. Safety Briefings should always be given prior to handover.

A core part of the Safety Briefing is to develop a working environment free of reprisal, whereby information regarding safety issues, near misses and other incidents are communicated freely in an open and transparent culture for learning and improvement.

Purpose

The hand over together with safety brief guide provide a communication between staff and other multidisciplinary team members to include essential information to reduce gaps in communications to reduce the potential for serious breakdown in continuity of care and to aid the reduction in harm to the patient and staff. (Patient Safety Solutions 2007).

By the introduction of the safety aid of SBAR together with the daily Safety Briefing to bring structure to shift change handovers within the healthcare team. The safety briefing has been found to aid the communication regarding potential patient and environmental safety problems and concerns on a daily basis. The safety briefing can be used to highlight and give a brief overview of current safety issues. Additionally this will be used to highlight potential risk factors that may occur on a daily basis. (Royal College of Surgeons Mar 2007).

Aim

- To enable the seamless and safe practices to provide staff coming onto a working shift with pertinent information to enable effective and safe delivery of care. (Pothier el al 2005)
- To ensure that all staff understand and use the Ulysses incident reporting system appropriately.
- To enable an awareness of safety issues at all levels within the multidisciplinary team.
- To enable an awareness of potential problems from all levels of healthcare practitioners - to assess risk, to reduce risk 24 hours a day, 7 days a week.
- To allow development over a period of time a culture of safety, thus reducing risk, reducing errors to enable a higher level of quality of care.
- To enable a common understanding of the SBAR system to facilitate the provision of quality care within Bristol Community Health.

Important Elements of the Safety Briefing to be Successful in Practice

Certain elements are crucial to a successful sharing of information regarding safety issues within the working environment.

- Briefings must be brief
The Briefing will be held prior to the main handover, therefore time will be of the essence. Relevant information only will be discussed. A time limit of 5 minutes will be set. There will be an individual at each handover who will assume the lead role and guide the briefing accordingly.

- **Open and transparent culture**

  Safety Briefings encourage an open and transparent culture where any concerns or incidents can be raised and discussed openly. Managers and clinical leaders have a key responsibility to facilitate and support this culture.

- **Identify a list of Safety Issues in advance for discussion**

  There will be a matrix to guide the Safety Briefing this will provide advance common safety issues for discussion. In time staff will identify own issues for discussion, this will further enable individual accountability, enabling job satisfaction and autonomy within each individual job role. We are all responsible for not only our own safety but also the safety of our colleagues, our patients and our environment.

**Safety Briefing Matrix examples of areas relevant to identify potential safety risks to patients or environment**

*This is not a definitive list and may be added to.*

- Risks to patients e.g. two patients with same name, infections, high risk patients
- Infection Control - any current infection issues to alert or consider cross infection prevention measures
- Pressure ulcers
- Medicines management e.g. insulin
- Stock issues
- Near misses
- Incidents - include was de brief undertaken - if not arrange this
- Post incident learning - review/reflections
- Staffing issues
- Patients with serious mental health issues
- Unfinished duties - at change of shift
- Security prison issues
- Equipment - faults, missing
- Changes in practice
- Estates - any maintenance issues
Safety Briefing must be usable

The goal is for the Safety Briefing to be a usable tool within the working day. Therefore it must remain easy to use and easy to understand and therefore not become over complicated. The primary aim is to address safety issues. Topics may be added and also removed as required to enable the Briefing to remain short and effective to use in practice.

Conducting the Safety Briefing

As Handover policy states all relevant Staff will convene at an appropriate location. Staff should be aware of the concept and purpose of the briefing and understand the non-punitive approach. Staff will re-visit the aims of the Safety Briefing prior to commencement if required.

- Staff involved in handover will convene at the appropriate time prior to next shift takeover
- Staff member to lead handover to explain purpose of the Briefing in the first instance, here it can be further explained that this process is non-punitive, whereby staff can highlight concerns regarding patient safety without fear of retribution. It must also be emphasised that the Briefing is to remain no longer than 5 minutes in duration.
- If there are no issues to be raised ensure that staff understand the aims of the safety brief and refer to common safety issues named in the matrix. These are examples and as such are not a definitive list and should not be used as a checklist.

Debriefing at the end of the shift

- Staff to reconvene at end of the shift either face to face at the allocated venue or on the telephone where this is appropriate for the team. There should be a conversation at the end of the shift with all staff.
- Staff to recollect any issues encountered during the shift.
- NIC to collect any data from the de-brief for audit purposes.
- Ask staff for their opinions of the Safety Briefing, suggestions for improvement.
- Re address plans for the next day's Briefing and handover.
- Managers to assess and evaluate the Safety Briefing process as an on-going measure of effectiveness.

6 SBAR

To further enable this effective use of communication the Situation, Background, Assessment and Recommendation Model should be used by health professionals to communicate clinical information safely and efficiently (See Appendix 2) (IHI 2006).

Within BCH the therapists often use a tool called SOAP notes (Subjective, Objective, Assessment and Plan). There is also a tool in EMIS used by the single
point of access that is PHEC (Problem, social History, Examination and Comment), both these tools can be considered to be a variation on SBAR that is acceptable to use.

The Institute for Healthcare Improvement states:

“The SBAR (Situation-Background-Assessment-Recommendation) technique, created by clinical staff at Kaiser Permanente in Colorado, provides a framework for communication between members of the health care team about a patient's condition. SBAR is an easy-to-remember, concrete mechanism useful for framing any conversation, especially critical ones, requiring a clinician’s immediate attention and action. It allows for an easy and focused way to set expectations for what will be communicated and how between members of the team, which is essential for developing teamwork and fostering a culture of patient safety.”

S=Situation (a concise statement of the problem)
B=Background (pertinent and brief information related to the situation)
A=Assessment (analysis and considerations of options — what you found/think)
R=Recommendation (action requested/recommended — what you want)

Using this simple format any relevant pertinent information may be passed via healthcare and other professionals. This will allow a streamlined handover of information, which will in turn highlight risk analysis of patient care and alert healthcare professionals to timely action and time frame required of that action.

7 Handover of care to another service

There are occasions when the patients care has to be handed over to another service such as a paramedic or to hospital staff. In these situations the SBAR tool should be used. An example of SBAR for this purpose is attached at Appendix 1. There are other circumstances when care is handed over in a planned way such as planned admission to nursing home when it is appropriate to use the CM7 as current practice. It should be noted however that the CM7 must be completed in full. There should also always be a timely verbal handover using the SBAR tool to ensure that information is up to date and giving the person receiving the handover an opportunity to ask questions.

8 Standard operation procedure (SOP)

Each service will have a different way to complete handover and safety briefing as each service will have slightly different needs. Any service with a team working across a 24 hour period or where the care of a patient is passed from one person to the next are expected to have a structured clearly defined handover for which there is a standard operating procedure that all staff are aware of.

The standard operating procedure for the handover and safety briefing should include:

- Who will be involved
- When, how often and for how long
- Where will it happen
- Who will lead the handover
Policy for Clinical Handover and Safety Briefing

- Who is responsible for ensuring it happens
- When the safety briefing will happen
- An outline of the appropriate content of handover and safety briefing
- Method of presentation of information
- Method of identifying and recording actions to be taken
- Details of archiving records of handover
- Audit process

9 References


Communications during Patient Handovers, Patient Safety Solutions, Volume 1, Solution 3, May 2007


Kirsty Gould – Clinical Nurse Manager HMP Eastwood Park
Laura Darrie – Clinical Service Manager HMP Bristol
Sarah Whittle – Clinical Lead Nurse
John Sutton – Clinical Nurse Manager HMP Ashfield

October 2015
10 Appendix 1 – SBAR Reporting

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 2 - SOP for the prison healthcare service

Who should be involved

There is a need to identify the key people who need to attend. Best practice includes all grades of staff from each clinical area.

Daily involvement of senior nurses and managers is essential. This ensures that appropriate level management decisions are made.

There will always be work which is ongoing during the handover time. Planning of routine and expected patient care will ensure that all staff are enabled and expected to attend handover. However in the event of an emergency care situation this will be prioritised for appropriate staff who will be updated by handover co-ordinator when possible.

Smoking breaks will be worked on a ‘one in, one out’ basis. There will be no variation of this. It is essential all breaks are coordinated by the Nurse in charge (NIC). All staff who smoke must be mindful of the work commitments of the NIC when requesting breaks. It is expected that smoking breaks are taken after clinical duties. A smoking break is part of your ‘official break’ it is not in addition to your break time to consume food or drink.

When and where should handover take place?

- Handover should be at a fixed time and of sufficient length.
- This period should be known to all staff.
- Shifts for all staff involved should be coordinated to allow them to attend in ‘working time’.
- The location should be large enough to comfortably allow everyone to attend.
- The location should be free from distraction and not used by others at this time.

How should handover happen?

- Handover should be supervised by the most senior nurse present and must have clear leadership.
- Information presented should be succinct and relevant.
- Handover will be supported by a paper copy handover sheet and Action Log.
- Regular review of the system, for example at clinical governance meetings, appraisal meetings and through monitoring incident reports, is required.
- The most senior nurse in attendance should have responsibility for ensuring handover happens as expected.

What should be handed over?

- Relevant clinical information
- Relevant past medical history
Policy for Clinical Handover and Safety Briefing

- Care plans and care plans requiring review
- Pending external appointments and specific directions e.g. Nil by mouth
- Relevant clinical observations/abnormal clinical observations
- Actions required
- Outstanding actions
- Patients discussed at complex case reviews
- Relevant substance misuse history and current treatment plans
- On-going care
- Identify patients where there is concern about their physical health
- Mobility issues
- Wound care
- Patients with serious mental health issues
- Infection control issues

This is not a definitive list and may be added to.

Implementation of Handover

Morning handover 7am

- Night nurse to handover to day staff.
- Action log to be updated by night nurse signed and filed.
- Identified nurse in charge (NIC) to commence new Action Log for the day.
- Primary Care Team handover will take place in the healthcare staff room
- Substance Misuse Team Handover will take place in the C3 office
- Any staff sickness must be highlighted to the nurse in charge
- Nurse in charge to highlight breaks and ensure that lunch cover has been allocated.
- NIC to highlight any Assessment, Care in Custody and Teamwork (ACCT) reviews (information located in Off Duty file) and identify who will attend these. Also document this information on Action Log.
- Following general handover, all to leave to relevant areas.
- Senior Nurse on duty is to supervise and support handover. Offer advice to NIC
- Senior Nurse needs to highlight staff training and any meeting times.
Policy for Clinical Handover and Safety Briefing

Lunchtime handover

- Band 6 nurse will co-ordinate hand over.
- NIC to update and take Action Log to handover.
- NIC to check with GP prior to handover, any relevant information, concerns or issues to share.
- Senior Nurse to cascade ‘Safety Briefing', relevant information, updates, prison notices, organisational information. Information shared to be documented on action log. Any relevant notices are to be attached to Action Log.
- Wing nurses to give general hand over.
- Band 6 will manage the Action Log. Staff from ALL areas will need to sign for their own actions to confirm they have completed required task.

Evening handover

- All areas to report to C3 office after duties completed.
- All areas include
  - Primary Care nurse
  - Substance misuse nurse
- All staff to update and sign action log if required.

Audit Process

Handover will be audited formally on a monthly basis during 2015, thereafter a programme will be decided upon by the clinical manager in discussion with the BCH audit lead.

Audit checks will be carried out by the Clinical Service Manager or clinical band 7 Nurse. A copy of the daily hand over document and the daily Action Log will be taken and scrutinised. Quality of the handover process will be assessed and challenged if necessary.

On a daily basis, the senior band 6 nurse will co-ordinate the handover process wherever possible and monitor quality of information and the effectiveness of communication during handover. They will identify issues as they arise and challenge staff accordingly.

A copy of the Action Log will be kept on a daily basis for audit and reference purposes.

A copy of the daily handover document will be kept on a daily basis for audit and reference purposes.
Appendix 3 - SOP for the community nursing service

Introduction
Bristol Community Health aims to provide the highest standards of patient care and recognises that a systematic, safe and co-ordinated approach to handover is central to this.

Handover is the accurate, reliable communication of task relevant information across shift changes. It involves 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. (Chaboyer et al 2010, Hiag et al. 2006, Lardner 1996, Patterson, 2008, Yee et al 2009).

Background
Poor handover can result in error, patient harm, and fragmented, inconsistent care. Continuity of information is vital to patient safety and underpins all aspects of seamless care.

Staff in integrated Community Healthcare Teams work rotas and shift patterns. This increases the number of individuals providing care for patients and highlights the importance of a comprehensive handover of clinical information.

Effective communication enables effective patient care. Effective teamwork includes effective communication, which in turn enables effective teamwork.

Format for Handover
A care co-ordinator must be identified for each shift.

The care co-ordinator is responsible for leading and facilitating the handover.

Key people who need to attend handover should be identified at the beginning of the shift.

Handovers should be face to face and involve all professional elements of the team.

Where teams are not located in the same room, innovative solutions to communication in handover should be agreed and recorded.

There should be an allocated place for handover, which is known and understood by every member of the team e.g. standing at the T Card Board.

Interruptions, noise or disturbance should be avoided during handover.

Safety Briefing must be prioritised as an essential component of handover.

Frequency
The day to day co-ordination of community nursing duties to deliver safe patient care should be conducted daily and incorporate staff working early and late shifts.

The co-ordination of care for patients who require case management and longer term care planning should be conducted once a week minimally.
Timing
The handover should be conducted at 12.30 or thereabouts.

Duration
Start and finish time or handover should be recorded with an aim to ensure efficient handover within 30 minutes.

Content of Handover

Safety Briefings
Safety briefings should aim to develop a working environment free of reprisals; an open and transparent culture for learning and improvement; whereby information regarding risks and safety issues, near misses and other incidents are communicated freely, and all staff feel at liberty to discuss concerns.

Safety briefings aim to achieve improvements in:
- Safety and Risk Management
- Quality and Harm free care
- Improved patient experience of continuity, communication, and co-ordination of care
- Reduced Duplication

Safety Briefings should cover any urgent issues relating to:

<table>
<thead>
<tr>
<th>Risks to patients</th>
<th>e.g. Unstable/unwell patients, 2 patients with the same name, unstable diabetes, serious mental health issues.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Issues</td>
<td>Includes self-neglect.</td>
</tr>
<tr>
<td>Risk to staff</td>
<td>e.g. lone working environment. Capacity.</td>
</tr>
<tr>
<td>Near Misses</td>
<td></td>
</tr>
<tr>
<td>Incidents</td>
<td>include undertaking of debrief with team</td>
</tr>
<tr>
<td>Post Incident learning</td>
<td>review, changes to practice.</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>e.g. grade 3, non-concordance and high risk patients.</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>e.g. current infection issues to alert, to consider cross infection prevention measures.</td>
</tr>
<tr>
<td>Medicines management</td>
<td>e.g. insulin</td>
</tr>
<tr>
<td>Stock issues</td>
<td>Stock for clinical delivery now and anticipated.</td>
</tr>
<tr>
<td>Unfinished duties at shift change</td>
<td></td>
</tr>
</tbody>
</table>

Handover information
Sufficient and relevant information should be exchanged to ensure patient safety. It is unnecessary to handover straightforward completed task to the team e.g. “I visited Mrs Smith and did her dressing” Therefore only changes in patient status, changes in plan of care, unfinished duties should be discussed and recorded.
Identification of patients

Patients who are clinically unstable or who have high level complexities, safeguarding or lone working risks must be prioritised.

Patients visited, outstanding patients

Patient discussed at complex case reviews

Patients who have complex or non-healing wounds, and those with pressure ulcers.

Presentation of information

Information should be clinically relevant and handed over succinctly using SBAR:

SBAR

Situation:

Patient name, EMIS no, reason for visit, presenting condition or problem e.g. routine bi weekly visit for dressing to Right leg wound following fall. E.g. Call out or GP practice visit request.

Background:

Relevant medical and mental health history

Relevant social and family history

Relevant medication e.g. Diabetes type 2 on once daily insulin.

Assessment:

Relevant general observations e.g. changes in function, general survey,

Relevant clinical observations including EWS score.

Recommendations:

Actions taken

Actions required

Plan for next practitioner visiting

Record Keeping

Identify and record actions using the daily handover and care co-ordination record (appendix A)

Actions required to fulfil duties of care must be prioritised and recorded for the subsequent shift.

The staff member responsible for ensuring each action is implemented and evaluated must be identified and recorded.
Information Governance and Audit

A system for storage of the handover and care co-ordination record should be identified and used consistently in line with the BCH information governance policy.

Copies of the daily handover and care co-ordination record should be retained confidentially for audit purposes.

See separate document for:

Integrated Community Healthcare Team handover and care coordination record
# Integrated Community Healthcare Team

## Handover and Care Coordination Record

<table>
<thead>
<tr>
<th>Date:</th>
<th>Team:</th>
<th>Co-Ordinator:</th>
<th>Staff Present (List Names + initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Start Time: | | | |
|-------------| | | |

| Finish Time: | | | |
|--------------| | | |

<table>
<thead>
<tr>
<th>Patient Name + EMIS number</th>
<th>Description of task</th>
<th>Allocated to</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|                           |                    |              |          |
|                           |                    |              |          |

|                           |                    |              |          |
|                           |                    |              |          |

<p>| | | | |
|                           |                    |              |          |
|                           |                    |              |          |</p>
<table>
<thead>
<tr>
<th>Patient Name+ EMIS number</th>
<th>Description of task</th>
<th>Allocated to</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4 - Standard operating procedure palliative care service

Time and place of handover

Handover will take the format of a board review and will happen at the patient information boards. It will happen at approximately 10.30 every day.

People who will attend

There will be an informed representative from each of Bristol care coordination centre, Palliative care home support, Hospice at home and an administrator every day between Monday and Friday. Bristol care coordination centre will not attend at the weekends.

Handover from Marie Curie nurses completing night shifts

The Marie Curie nurses phone the coordinator at the end of their shift and use the Marie Curie handover prompt sheet to handover all relevant clinical information. The details are recorded on the liaison sheet and copied into EMIS by the coordinator.

Safety briefing

Safety briefing will happen at the start of the handover lasting for approximately 5 minutes. If there are no issues to be raised the coordinator ensures that staff understand the aims of the safety brief and refer to common safety issues named in the policy.

Format of handover

The person who is coordinating for that day will lead the handover; they will allocate roles to each person in attendance so that there is a person who will report and update from each system used: EMIS, Spreadsheet, Liaison sheet and Handover sheet. All the patients on the board will be reviewed every day. All actions and details of who will be responsible for taking and evaluating them are recorded on the relevant systems at the time of or just after handover.

Audit process

The handover process will be audited regularly.
Aims & Objectives
The objectives of this SOP are to:

- Ensure staff have guidance needed to use the co-ordinator sheet framework effectively.
- Promote team and caseload management.
- Establish safe and consistent practices to maximise patient benefits and enhance patient outcomes.
- To have a stored communication pathway which documents the allocation and completion of patient related tasks

Organisation of handover and safety briefing
The handover will take place three times a week on Monday, Wednesday and Friday at about 12.30 lasting approximately 30 minutes. It will be in the team room, with as many members of the shift in attendance as possible. The safety briefing will take 5 minutes at the start of handover following the checklist on the back of the care coordination sheet.

The handover will be led by the coordinator for the day using the care coordination sheet, the diary and the white board in combination with input from the team. Staff will feed back information from their interactions with the patients verbally using the SBAR tool format.

How to use the co-ordinator sheet
The co-ordinator sheet is formatted simply for clarity of information to be documented and communicated between staff. It has been designed as a means of recording outstanding tasks to be completed or allocated by the co-ordinator during their shift.

The document should be completed using black ink only, following trust documentation guidelines.

The allocated co-ordinator for the shift is to complete the header boxes when starting the document, stating the date and their name.

The co-ordinator sheet is formatted in 4 columns; Patient Name, Task, Allocated To, Initials. Information is required to be entered into each column to document completion of task.

When a task is identified the co-ordinator must enter information in the patient name and task columns.

When the co-ordinator wishes to delegate a task to a staff member they enter the prospective member of staffs’ initials into the ‘Allocated To’ column. When they have communicated the task request to the staff member they should place their initial beside that of the staff members. This process is vital to ensure that the communication pathway between the staff member and co-ordinator is recorded.
Once an allocated task has been completed, the member of staff who has completed the task is to put their initial into the ‘Initials’ column. Only once this is completed is the task deemed to be completed.

**Starting a new sheet**

Any un-initialled tasks from the last sheet must be transferred onto the sheet to be started. Once the transfer of outstanding tasks is completed then the previous sheet is to be collated for archiving. This document is to be archived for 6 years or as BCH policy advises during this time.

### DAILY CO-ORDINATOR SHEET

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>TASK</th>
<th>ALLOCATED TO</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In reality this is an A4 size form
<table>
<thead>
<tr>
<th>Category</th>
<th>AM Safety Briefing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INFECTION CONTROL</strong></td>
<td></td>
</tr>
<tr>
<td>Risk/complex patients</td>
<td></td>
</tr>
<tr>
<td>Outbreaks</td>
<td></td>
</tr>
<tr>
<td>Large wounds/complex wounds</td>
<td></td>
</tr>
<tr>
<td><strong>EQUIPMENT/MEDICAL ALERTS</strong></td>
<td></td>
</tr>
<tr>
<td>Missing items/damaged</td>
<td></td>
</tr>
<tr>
<td><strong>SECURITY/HEALTH AND SAFETY</strong></td>
<td></td>
</tr>
<tr>
<td>Patients with same name</td>
<td></td>
</tr>
<tr>
<td>Risk assessment/register</td>
<td></td>
</tr>
<tr>
<td>Lone working alerts</td>
<td></td>
</tr>
<tr>
<td>Estates/building/environmental issues</td>
<td></td>
</tr>
<tr>
<td>Health and safety/manual handling</td>
<td></td>
</tr>
<tr>
<td><strong>INCIDENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Incident forms completion</td>
<td></td>
</tr>
<tr>
<td>Post incident form discussion/lessons learnt</td>
<td></td>
</tr>
<tr>
<td>Medication errors</td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNICATION</strong></td>
<td></td>
</tr>
<tr>
<td>Staffing</td>
<td></td>
</tr>
<tr>
<td>Weekend rota</td>
<td></td>
</tr>
<tr>
<td>Mental capacity/concordance/awareness/safeguarding</td>
<td></td>
</tr>
<tr>
<td>Weekly BCH bulletin</td>
<td></td>
</tr>
<tr>
<td>Clinical diary</td>
<td></td>
</tr>
<tr>
<td>Medication management issues</td>
<td></td>
</tr>
<tr>
<td>Staffing rota next day</td>
<td></td>
</tr>
<tr>
<td>Briefing comments</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6 - SOP REACT Handover Protocol (BRI)

The Emergency Department at BRI use paper documentation which is scanned onto the MEDWAY system. REACT document in the ED notes and also use a REACT assessment tool for documentation, before transferring information onto EMIS.

Once the ‘actions’ are completed, the handover sheet will be stapled to the patient’s notes and filed in a lockable cabinet, ready to be archived.

![Handover Protocol Diagram](image-url)
Appendix 7 - SOP REACT Handover Protocol (Southmead)

The Emergency Department at Southmead is paperless and REACT document on Cerner/Lorenzo, Emis (for all patients except South Gloucestershire)

1. Patient referred to REACT/In-Reach Team in the Southmead Emergency Department setting
2. Patient seen by REACT and outcome documented in EMIS/Hospital Computer systems
3. If outstanding follow-up required for patient, and staff change over is due, then a handover sheet is completed (See appendix 1)
4. Handover sheet left in patient referral book for next shift staff to pick up
5. Actions completed as requested on handover sheet and all actions taken documented in patients notes.

Following the paperless documentation of the Emergency Department, actions completed via the handover sheet are documented electronically. The handover sheet should then be filed and archived with referral books.

![Handover sheet image]
**17 Appendix 8 - SOP Inreach service**

In-Reach document in primarily on EMIS and summarise in patient medical notes. The tracking form is used as a working document and handover sheet.

<table>
<thead>
<tr>
<th>Patient details (Sticker)</th>
<th>Date/Time Admitted</th>
<th>Date of tracking</th>
<th>MRT Area Time Spent</th>
<th>Plan/Outstanding investigations/ treatments/ recommendations</th>
<th>Lead HCP</th>
<th>Outcome and Date (if stopping tracking record time)</th>
<th>Comments/Reason not Ax/ Barriers to discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location/ Bed Hospital GD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital GD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Document treatment/ plan on Rapid In-Reach tracking form with name of lead HCP for that patient (appendix 1)

List outstanding investigations/ treatments in plan on tracking form with tick box to be followed up the next day (dated)

Document above (plan/ recommendations/ outstanding investigations) in notes on EMIS

Discussion at end of day between Rapid In-Reach staff members and tracking forms updated

All documents containing patient data/ info (handover, Ax forms etc) taken to SRRT for storage.
Appendix 9 - SOP Single point of access (SPA)

Frequency
Handover happens twice daily with updates throughout the shift.

Format
07.30 Every morning: Face to face handover of any outstanding referrals/issues between Out of Hours Nurses and SPA Case Manager.

18.45 Every evening: Face to face handover of any outstanding referrals/issues between SPA Case Manager (day staff) and Out of Hours Case Manager including Rapid Response capacity for the following morning.

A communication board is the primary method of Handover between Case Managers and is kept up to date throughout the day containing the following:

- Safety briefing
- Referral information
- Rapid Response Capacity established from conference calls and discussions with Rapid Response Team co-ordinators.
- The predicted Out of Hours Capacity for the following evening.
- Name of the on-call ANP for R/R clinical issues.
- Name of the on-call Tactical manager with contact details.

For every referral accepted:

- There is a verbal handover of patient information from SPA Case Manager to Rapid Response Co-ordinator.
- The information is passed in an SBAR format and includes any alerts documented on EMIS or Health and Social Care systems (Liquid Logic and Corporate Flagging) pertaining to risk and access problems.

Documentation
All documentation is entered onto EMIS by Case Manager in an SBAR format using EMIS headings:

- Problem (Situation)
- History (Background relevant medical history, allergies etc.)
- Social (additional information regarding home environment and formal support)
- Examination (Assessment)
- Comments (Recommendation)

Audit
All telephone calls into and out of SPA are recorded. These recordings are kept for 7 years and can be reviewed if required.
19 **Appendix 10 – SOP Out of Hours (OOH)**

**Format for Handovers**

Handovers are a mixture of faxed / E-mailed / verbal from Community Nursing teams and Rapid Response teams (RRT).

Face to face handover between team members.

**Frequency**

Handovers are undertaken nightly to allocate visits for the shift and also to discuss any patients of concern.

**Timings**

OOH Case Managers arrive on shift at 18.00 and receive referrals from RRT / Community Nursing Teams by e-mail or fax.

Face to face handover with the SPA case manager takes place where pending referrals and team capacity for the following day is discussed.

OOH case managers contact each RRT every evening to check for any visits and to discuss any issues.

At 19.00 the OOH team arrive and verbal handover is given.

As calls come throughout the shift, SPA admin take the details, entering any alerts and then passing the referral to the case manager (until 01.00hrs) or the Community Staff Nurses on duty (between 01.00 – 07.30) who will triage the call and then allocate/handover as appropriate.

**During handover**

The safety briefing is given, a case manager pairs up the staff and allocates the visits taking into account geography / need of visit / skill mix. (Out of Hours staff always visit in pairs for staff safety).

Details of the visits are verbally handed over to staff who record these details in their diaries. Any known alerts or safety issues regarding the visits are also handed over to the staff members who are visiting.

On returning to the office, staff handover the visit outcomes to the case manager and to the SPA admin who record outcome on the spreadsheet.

Staff telephone community nursing bases and Rapid Response Teams to leave messages first hand regarding their visits on the answer machines. All these calls are made using the office telephones which records the calls and are kept for 7 years.

**All Documentation is entered onto** EMIS by nurses in an SBAR format using EMIS headings:

- Problem (Situation)
- History (Background relevant medical history)
- Social (additional information regarding home environment and formal support)
- Examination (Assessment)
Comments (Recommendation)

Audit Trail

All visits are recorded in the main team diary with who has been allocated the visit recorded alongside. This is updated should re-allocation have been necessary.

Referrals are kept by SPA admin in a folder, and details are recorded on a spreadsheet.

Diaries are held for 7 years.

Landline telephone calls made are recorded and kept for 7 years.