Clinical handover

Minimum dataset for handing over patient care

NSQHS STANDARDS

Identify

- ☐ Introduce patient/carer & staff
- ☐ Invite active patient/carer participation
- ☐ ID check – 3 patient identifiers

Situation

Why is the patient here & what is happening now?

- ☐ Primary diagnosis/reason for admission
- ☐ Significant events or complications
- ☐ Current status (awaiting test/procedure, fasting, on interim orders etc)

Background

What happened in the past that is relevant? What alerts exist?

- ☐ Relevant history
- ☐ Alerts – ADR/allergy/other (falls risk, infection precautions, cognitive status etc)
- ☐ Advance care plan (ARP, AHD, EPoA, SoC)

Assessment

What is the current status & what has changed from baseline?

- ☐ Obs/Q-ADDS & recent escalations
- ☐ Pain management
- ☐ Devices/invasive lines/access (intravascular device, IDC, pacing, oxygen, HFNP, IABP, VAD, ICC, drain, procedure access site)
- ☐ Critical monitoring alarms/histories
- ☐ Fluid balance & restrictions
- ☐ Infusions & orders
- ☐ Medication chart & flag high-risk (anticoagulants, vasoactives, cytotoxics etc)
- ☐ Pathology (APTT, INR, BGL, vanc level, K+ etc)
- ☐ Mobility aids & interventions
- ☐ Skin integrity & interventions

Recommendation

What needs to happen?

- ☐ Care plan/clinical pathway actions to follow-up (test results, consults, written orders)
- ☐ Critical actions for next 24 hours
- ☐ Discharge plan
- ☐ Patient/carer preferences & questions

Clinical handover process

Standardised process to effectively communicate current, relevant & accurate information

NSQHS STANDARDS

Actions

1) Prepare for **clinical handover** with relevant information at hand – use template **clinical handover prep**
2) Be aware of patient preferences
3) Organise relevant clinicians/others to participate
4) Structure handover using the **minimum dataset**
5) Encourage patient/carer/family involvement according to their preferences
6) Ensure responsibility & accountability for care is transferred

Additional checks when receiving or transferring care

- ✓ Orientate patient/carer on admission & provide supporting written information
- ✓ Determine patient's cultural & language needs
- ✓ Check bedside safety & communicate with patient/carer (equipment, buzzer, clutter-free)
- ✓ Confirm risk screening & referrals completed
- ✓ Update alerts, risks, referrals, mobility, estimated discharge date on electronic journey board
- ✓ Notify nursing staff about treatment/care changes, include patient/carer & document (medical/allied health)
- ✓ Sign-off relevant care plans/charts/pathways & record progress note
- ✓ Pre-discharge: notify carer/family; remove redundant IV devices; complete referrals & other arrangements (eg INR testing); provide discharge education, medications/scripts & other instructions
- ✓ Complete electronic discharge summary

Further information:

NSQHS standard communicating for safety
TPCH procedure (002991)
MNHHS policy (002043)
CEQ resources/bedside video

Clinical handover FAQs

Tips to support 'gold standard' bedside nursing handover

NSQHS STANDARDS

Does shift handover have to occur at the bedside?

Bedside handover that actively involves patients/carers is the minimum standard to support safe handover. Whenever practicably possible, the patient/carer must be given the opportunity to participate (all shifts).

Prepare patients on admission by explaining that bedside handovers occur at night time and they may be woken late for observations when necessary.

Ensure bedside charts are available for use during handover.

What is the minimum requirement to conduct bedside handover?

Use a structured approach following the standardised Heart Lung minimum dataset (ISBAR format).

Prioritise the **most important information**:

- Introduction to patient/carer (**I**)
- Why the patient is here and what is happening now (**S**)
- What has happened in the past that is relevant now, and any alerts/risks (**B**)
- What the current clinical status is and any changes from baseline (**A**)
- What needs to happen next (**R**)

Does patient ID have to be checked every time?

Yes, you must perform a check using the 3 approved patient identifiers:

- Name
- DOB
- URN

at every bedside handover even if you've checked on a previous occasion and/or the patient is already known to you. This is an important safety cross-check.

If vital signs are within normal limits do I need to state the Q-ADDS score?

You should always handover the current score and any elevated scores or escalations that occurred during the shift.

Include any outstanding actions for follow-up.

My patient does not have any ADRs/ allergies. Do I need to mention this?

Yes, ADR/allergy information should always be stated even if none are recorded or a white armband is in situ. This is to engage the patient/carer, verify accuracy and capture any missing details.

It is good practice to check medication chart documentation at this time.

There are no alerts or risks for my patient. Should I mention this?

As with ADRs/allergies, state whether <u>or not</u> other risks or alerts exist (falls risk, mobility, cognition, infection precautions etc). Re-visit whether the patient's status needs updating or follow-up.

It is good practice to check these details are documented on the relevant bedside charts/plans at this time.

Do I need to cover advance care plans (ACP) if my patient does not have one?

As with ADRs/allergies/other alerts, state whether <u>or not</u> an ACP is in place.

This serves as a prompt to consider any changed circumstances that warrant a plan to meet current patient preferences (eg ARP).

Optimise safe care transition

- ✓ **Patient rounding**: Conduct pre-handover to minimise interruptions
- ✓ **Protected handover**: Wherever possible, avoid interventions and patient movements during handover.
- ✓ **Staff huddle**: Include salient information relevant to the team (eg safety or OVP risks, METs, dying patients, specials)
- ✓ **Teamwork**: Assist colleagues with any patient care needs whilst handovers are in progress if you are free.

HLCRT17001 v3.0 (31.5.23)