Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title: **Version:** **Reference Number:**	**Clinical Handover/transfers of care Policy for all inpatient Mental Health Services** **1** **CL124**
Scope:	
This policy applies to all staff working within inpatient mental health clinical services. All inpatient services must ensure that their handover arrangements are in line with this policy.	
Purpose:	
The purpose of this document is to make measurable improvements in the safety and quality of patient care by ensuring that, with every handover and transfer, the right information is given to the right people at the right time and in the right way. It will explain the roles, responsibilities and process for the transfer of high quality information, where transition of responsibility for immediate care of service users is occurring.	
Requirement for Policy	
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. It has been recommended that formal handover should become part of good professional practice.	
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Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
CL042	Physical Health Policy
CL122	Safeguarding Families Policy
HR043	Induction Policy
Policy Associated Documents:	
TAD_CL124_01	Adult Handover Sheet
TAD_CL124_02	RHSD Handover Sheet
TAD_CL124_03	Older People
TAD_CL124_04	Specialist Services
Other external documentation/resources to which this policy relates:	
	Safe communication - design, implement and measure. A guide to improving transfers of care and handover (august 2015)
	Quality improvement clinic

CQC Regulations **This policy supports the following CQC regulations:**	
Regulation 9	Person centred care
Regulation 10	Dignity and respect
Regulation 12	Safe care and treatment
Regulation 13	Safeguarding service users from abuse and improper treatment
Regulation 17	Good governance

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1. INTRODUCTION

This policy has been developed to ensure the improvement in the safety and the quality of patient care by ensuring that with every handover and transfer the right **information** is given to the right **people** at the right **time** and in the right **way**.

Transfers of care can include a regular handover of care at the end of a shift, or the **transfer of a person's care** to another ward team department or service.

Transfers of care happen every day. They can be verbal or written, they can take place in a group or one to one, in person or over the phone. But they all share the same purpose; to communicate vital information about a person in your care.

All inpatient Mental health clinical services within the Trust must ensure that their handover/ transfers of care arrangements are in line with this Policy.

What is Effective Handover?

Handover is the transfer of professional responsibility and accountability for some or all aspects of care for a service user, or group of service users, to another person or professional group on a temporary or permanent basis.

Handover is the transfer of any relevant clinical issues which need to be known and/or tasks and changes in management care plan, which need to be undertaken within the period of responsibility for care.

Handover promotes and ensures continuity of care; promotes the professional status of the organisation; and promotes awareness with staff of all the relevant events to ensure service user safety and appropriate Risk Management approaches.

The information being transferred in Handover must be accurate and factual.

2. SCOPE

All NHS organisations have a duty of care to all service users at all times. There will be situations, in the care pathway, where transition of responsibility for this care will be required, and it is expected that all staff involved in these processes should ensure that the duty of care is maintained at all times. Effective handover of service user clinical information is a key component of continuity of quality of care.

Effective information transfer ensures the protection of service users and minimises clinical risk. Continuity of information underpins all aspects of a seamless service providing continuity of care and service user safety.

Handover must achieve a balance between comprehensiveness and efficiency.

This policy is aimed at reducing the risk to both the service user and the organisation as far as is practicably possible, optimising the quality of care and safety by using sound methods of communication during clinical handover/ transfers of care.

It applies to:

- All clinical staff with service user contact

- All staff in receipt of service user information
- This includes temporary, permanent, bank and agency staff

It applies to all nurse shift changes/transfers of care where transition of responsibility for immediate care of service users is occurring.

The handover will vary from service user to service user depending on their individual circumstances; however the standards, outlined in this document should be applied in all circumstances, where appropriate.

3. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

Trust Board of Directors - Have a responsibility for ensuring a robust system of risk management within the Trust. This includes having a system to ensure safe clinical handover at key transitions of responsibility for immediate care of service users is occurring to ensure the protection of service users and minimise clinical risk

Executive Director of Nursing - Is accountable to the Board of Directors for ensuring there is a procedure in place for the clinical handover of patients at nurse shift changes and providing assurance that the local systems and processes in place to deliver this policy are effective.

Associate Medical Directors - Have responsibility for ensuring medical staff wherever possible attend and contribute to this clinical handover.

Associate Directors - Have responsibility for ensuring professional staff involved in service user care wherever possible attend and contribute to this clinical handover.

Matrons in each service line – Have responsibility for ensuring the process in place for nurse handover at shift changes on their wards and that the process is effective and compliant with this policy.

Inpatient service managers - Have responsibility for ensuring the process in place for nurse handover at shift changes on their wards and that the process is effective and compliant with this policy.

Ward/Team Manager in each service – Have responsibility for ensuring that a Shift Leader is allocated for every shift change and the handover process is followed at every shift change.

Shift Leader (This could be the Nurse in Charge or Team Leader depending on the environment) – Has responsibility for conducting the handover in line with the standards listed at section 3 of this policy and includes:

- Prioritising and delegating tasks
- Ensuring that competent staff are allocated to complete the delegated tasks
- Ensuring that any staff (external/contractors etc.) that are working within their clinical environments, are briefed about potential risks which may compromise their Health and Safety, should they be realised, and make necessary provision to reduce or remove that risk.

All Clinical staff, or administrative staff who support them – Are responsible for:

- Complying with this policy by ensuring they actively participate in the clinical handover process
- Reporting any error or omission that occurs relating to clinical handover

4. OUTCOME FOCUSED AIMS AND OBJECTIVES

The following overarching standards have been identified for ensuring the smooth transfer of service user information, service user care and safe management of inpatient wards in the Trust. Specialist services will have locally agreed additions. These standards will be used as the basis for auditing clinical handover practices at nurse shift changes/transfers of care, within the Trust.

Standard 1: The handover is conducted in a professional manner

Personal Accountability. Everyone present should:

a) Remain calm and respectful.

b) Use positive language.

c) Demonstrate active listening.

Standard 2: The handover is well planned

a) Handover will be reflective of the written record.

b) Information delivered will be relevant and up to date.

c) Information delivered will be linked to the care plan

d) Clinical information will reflect the recovery ethos.

e) Meet the needs of the staff receiving the handover, knowledge should not be assumed but checked out.

Standard 3: The handover is effective in ensuring all clinical and service user related information is communicated safely and appropriately

a) All service users will be physically observed by the nurse in charge of the oncoming and outgoing shift.

b) Where relevant any incidents, complaints, learning from SUI"s, positive events, and risk issues will be raised.

c) The therapeutic observation level of every service user will be noted and reviewed.

d) Anyone requiring increased therapeutic observations, seclusion, or nursing away from others will be discussed and reviewed

e) Any service user whose behaviour has been unusual for that particular service user will be discussed.

f) Any use of crisis management/positive behavioural support plans will be discussed

g) Any service user displaying physical health problems will be discussed.

h) The ward atmosphere will be commented upon.

i) The ward bed state \ head count will be reviewed

Standard 4: By the end of the handover roles and responsibilities for team members will have been clearly identified.

a) (RHSD) Security/safety checks will be completed

b) Ward Diary will be reviewed to identify any outstanding actions and allocation of roles/responsibility accordingly.

c) Therapeutic observations will be allocated.

d) Any specific clinical interventions will be allocated.

e) Physical health appointment will be allocated.

f) Bank staff or staff unfamiliar with the ward will be provided with an induction to the ward/service and given an introduction to service users.

g) Emergency response roles such as Fire, incident response and ILS will be allocated.

5. GLOSSARY

Clinical Handover – A semi-structured exchange of information and awareness of the clinically relevant issues including the transfer of key issues, tasks and changes in management plan from one care professional/care team to another. The handover process can take place in different ways and at different times during the day, not just in scheduled meetings.

Service User – The term is used to describe any person who uses services managed by the Pennine Care NHS Foundation Trust.

Shift – Recurring periods in which different groups of workers do the same jobs in relay.

Risks – Information which may identify that a patient's condition may change or need review in the period of the shift.

Clinician – A health professional with responsibility for Service user care.

Key Tasks – Important actions which must be undertaken within the period of responsibility for care.

Situation, Background, Assessment and Recommendation (SBAR) – A structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased Service user safety.

Out-of-hours – The out of hours is the time period between 17:00 hours to 09:00 hours Monday to Friday and for the entire duration of weekends and bank holidays.

6. PROCESS FOR NURSE HANDOVER AT SHIFT CHANGES

Local Procedure for Handover

Each borough/service line will set out its local procedure for delivery of the following handover standards.

Personnel with responsibility in the Handover Process

The Shift Leader must handover to the whole of the next team on duty at the beginning of that shift. This allows for members of the team from the previous shift to be present on the ward to maintain safety and deliver service user care. Every member of the next shift must be allowed to attend.

The Shift Leader of handover facilitation should ensure that the team are aware of any new staff including bank or agency staff members of the team, and that adequate arrangements are in place to familiarise them with local systems and ward / hospital geography in line with the Local Induction Policy.

Involvement of Shift Leader is essential. This ensures that appropriate management decisions are made, and that handover forms a constructive part of staff education, conveying the seriousness with which this organisation takes this process.

Every member of the next shift must make themselves available to attend and actively participate in the clinical handover process.

The ward/team manager within the clinical service should ensure that there is safe and secure storage and archive of the electronic version of each clinical handover sheet. This is a requirement of the Care Quality Commission and provides an audit trail of clinical information. A master copy of the handover sheet information must be stored and retained for 2 years, in line with the Records Management Code of Practice for Health and Social Care 2016.

Time

Length of handovers should be advised by local procedures.

Dependent upon the local systems in place for staff working practices, there will be either two or three handovers per day. All staff must be on time and ready to attend the handover at the start of their shift. Staff will ensure access to clinical notes during the handover, along with the communication book and the ward diary (if applicable).

The times dedicated to handover should be known to all staff.

Place

Handover should be conducted in a designated room which accommodates the team and is confidential when discussing sensitive information. Arrangements should be made for the handover to be carried out in an environment that limits interruptions and disturbances.

It is recommended that a Do Not Disturb Sign is used to prevent interruptions. The Shift Leader of the previous shift has the responsibility for ensuring that whilst the handover is taking place, they have made appropriate arrangements to observe and support the service user group.

Handover may include a bedside review or around the service user boards. Care must be taken when discussing sensitive information.

Method

All handovers to have a pre-determined format and structure to ensure adequate information exchange.

Methods for handover may vary within the differing parts of The Trust (for instance, verbal, written, electronic including Paris) this should be made explicit at a local level.

The Division's Nurse Lead will oversee the development of a handover template/s to be used in their respective division's clinical areas taking account of whether it's an inpatient or community setting. All templates need to be signed off for use by the Division's Nurse Lead. There must be no deviation from the templates approved for use by the Division's Nurse Lead.

All staff using a paper form of handover must have the updated copy at the start of each shift.

The shift leader will have the responsibility for ensuring that handover takes place as planned.

All issues of clinical risk, raised at handover should be supported by individual and current risk management/care plans.

It is the responsibility of the Shift Leader to keep a record of the names and designation of attendance at each handover.

Written, or electronic handovers must be updated at the end of each shift and have the date and time of the update clearly documented.

Clinical divisions may want to further develop tools, in line with best practice, to support the handover process.

7. SBAR COMMUNICATION TOOL

'Situation, Background, Assessment and Recommendation' (SBAR) tool is an example of a communication tool that can be used for handover (see figure 1). SBAR is especially useful to support handover during Service User transfers between settings.

SBAR can be used very effectively to escalate a clinical problem that requires immediate attention, or to facilitate efficient handover of information relevant to Service user care between clinicians or other teams.

The written documentation should be recorded using permanent ink and be readable when photocopied or scanned. It should be written clearly, legibly and in such a manner that they cannot be erased. It should also be accurately dated, timed and signed.

If a handover book is used the SBAR format can still be utilised to record information. The example found in **Figure1** can be adapted to suit different services. Please see 4.1.5 for examples of information to be exchanged which could be used as headings on the SBAR.

Safe Wards

SBAR communication tool can be adapted to include positive words and bad news mitigation. This information can also be added to other handover sheets/ books.

Positive Words

When giving handover staff should say something positive about what each Service user has been doing during the shift, or draw attention to some positive quality they have, or if this is not possible something positive about the way in which staff supported the Service user(positive appreciation). In addition, if any difficult or disruptive behaviour is reported, a possible psychological understanding of the patient's behaviour must be offered.

For further information see Safewards – Positive Words

Bad News Mitigation

Be aware of occasions and events that might generate angry or upset reactions. In each handover discuss as a team the issue of bad news and share knowledge about patients in order to predict who might receive unwelcome news and how support is going to be offered. Either work with the multidisciplinary team in the ward round to express the bad news sympathetically, or intercept the Service user after it has happened.

For further information see Safewards – Bad News Mitigation

Sufficient and Relevant Information

Sufficient and relevant information should be exchanged to ensure Service user safety and effective clinical care. This policy cannot be prescriptive about the specific issues to be handed over in each area so each division is encouraged to agree its own key issues for handover.

This is not an exhaustive list, but is intended as a guide:

- Service User presentation – mental and physical wellbeing
- Observations levels (or frequency of contact in the case of community teams) – Section 17 Leave escorted/unescorted (or how many visits are offered per week in the case of community teams)
- Mental Health Act status – Informal/detained under Mental Health Act
- Mental Capacity issues or DOLS
- Risk, both nature and level (for example risk of falls, absconsion, harm to self, suicide, neglect, risk of harm to others)
- Medication – changes to medication/omissions/allergies
- Physical health investigations i.e. CT scan, X-ray

- Blood investigations, for example, Clozapine/lithium levels, blood sugars, drug screen
- Physical health – BP (blood pressure), TPR (temperature, pulse and respiration), resuscitation status, blood sugar monitoring, nutrition and hydration
- End of Life Care
- Safeguarding alerts/issues (children/adults)
- Incidents
- Changes/updates to care plans
- New admissions/discharge/referrals
- Multidisciplinary team meeting (MDM) feedback
- Equality, diversity and human rights considerations (including effective communication needs, cultural sensitivities)
- Outstanding tasks
- Untoward occurrences
- Operational issues affecting the care of the client
- Activities i.e. social events/visitors

Handover is of little value unless action is taken where needed. All team members including bank and agency staff should be aware of their responsibilities and need to ensure that:

- Tasks are prioritised to enable completion in a timely, effective and safe manner
- Plans for further care are put in place and clarified with all relevant parties
- Unstable patients are reviewed as often as required
- If busy, additional handovers are considered in order to further support the team, re-prioritise workload and identify new “at risk” patients
- Any Service user who is considered at risk of deterioration has an adequate care plan to prevent or manage this as effectively as possible and that it is acted on accordingly

8. LINKS TO RELEVANT NATIONAL STANDARDS

SBAR – Situation – Background – Assessment – Recommendation 2008

SBAR was initially developed by the US Navy and adapted for use in the healthcare environment by staff at Kaiser Permanente in Colorado, USA. SBAR is a nationally recognised tool to improve communication between all members of staff. It is an easy to remember mechanism that can be used to frame communications or conversations, facilitating a structured way of communicating information that requires a response from the receiver. It enables staff to clarify what information should be communicated between members of the team, and how. It can help to develop teamwork and foster a culture of Service user safety. The SBAR process consists of 4 x standardised stages or prompts that help staff to anticipate the information needed by colleagues and formulate important communications with the right level of detail:

S = Situation (a concise statement of the problem)

B = Background (pertinent and brief information related to the situation)

A = Assessment (analysis and consideration of options – what you found/think)

R = Recommendation (action requested/recommended – what you want)

CQC Regulation 12: Safe Care and Treatment

The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

Providers must make sure that the premises and any equipment used is safe and where applicable, available in sufficient quantities. Medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.

Providers must prevent and control the spread of infection. Where the responsibility for care and treatment is shared, care planning must be timely to maintain people's health, safety and welfare.

CQC understands that there may be inherent risks in carrying out care and treatment, and they will not consider it to be unsafe if providers can demonstrate that they have taken all reasonable steps to ensure the health and safety of people using their services and to manage risks that may arise during care and treatment.

Clinical Handover Policy Version 2.0 August 2016 10 Nursing and Midwifery Council (NMC) – Code of Conduct – Preserve Safety

Staff should make sure that Service user and public safety is protected. They should work within the limits of their competence, exercising ‘duty of candour’ and raising concerns immediately whenever they come across a situation that puts the patients or public safety at risk. They should take necessary actions to deal with any concerns where appropriate.

Nursing and Midwifery Council (NMC) – Code of Conduct – Practice Effectively Staff

Should assess needs and deliver or advise on treatment or give help (including help and rehabilitative care) without too much delay and to the best of their abilities, on the basis of the best evidence available and best practice. Staff should communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. Staff should also reflect and act on any experience they receive to improve their practice.

Nursing and Midwifery Council (NMC) – Record Keeping

Good record keeping is an integral part of nursing and midwifery practice and is essential to the provision of safe and effective care. Good record keeping whether as an individual team or organisational level, has many important functions:

- Providing documentary evidence of service delivered
- Promoting better communication and sharing of information between members of the multidisciplinary team
- Help to identify risk and enabling early detection of complications

- Making continuity of care easier and improve accountability
- You should beware of, and develop, your ability to communicate effectively within teams. The way you record information and communicate is crucial. Other people will rely on your records at key communication points, especially during handover, referral and in shared care

9. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

10. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

11. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

12. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

13. MONITORING

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

14. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

15. REFERENCES

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