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Glossary

**CNM**: Clinical Nurse Manager  
**EWS**: Early Warning Score  
**HCA**: Healthcare Assistant  
**HIQA**: Health Information & Quality Authority  
**HSE**: Health Services Executive  
**IPC**: Infection Prevention & Control  
**ISBAR**: Identify, Situation, Background, Assessment & Recommendation  
**MRHT**: Midlands Regional Hospital, Tullamore  
**NCEC**: National Clinical Effectiveness Committee  
**NHS**: National Health Service  
**NMPD**: Nursing & Midwifery Planning & Development  
**ONMSD**: Office of the Nursing & Midwifery Services Director  
**PSAG**: Patient Status at a Glance  
**QPS**: Quality & Patient Safety  
**VIP Score**: Visual Infusion Phlebitis Score  
**WHO**: World Health Organisation
This Resource Manual & Facilitator Training Guide for Shift Handover was developed by Denise Doolan, Nurse Practice Development Facilitator and Project Lead and Mary Manning, Area Co-Ordinator, Productive Ward: Releasing Time to Care™ in collaboration with Medical 2 Ward, Midlands Regional Hospital, Tullamore (MRHT) & HSE Communications.

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Sandra Eaton, HSE Communications Officer, National Office

All characters and locations identified in the DVD and teaching resource are wholly fictitious and any similarity to any person/s living or dead is unintentional.

Please note this programme has received NMBI (Nursing and Midwifery Board of Ireland) Category 1 Approval and has been awarded 4.5 CEU’s (Continuing Education Units).
Introduction & Background to Shift Handover

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

While there are several types of handover including verbal, bedside, written and taped (Scovell, 2010), only verbal handover is addressed in this context. Traditionally, handover skills are learned at ward level rather than through formal education processes. This subsequently results in a plethora of approaches to both the content and function of handover and particularly how it is given and/or received. It has been identified that poor handover processes may result in poor communication which can subsequently negatively impact on patient safety (Wong et al, 2008, WHO, 2007).

Recent adverse incidents (Keogh, 2013, HIQA, 2013, Francis, 2013 & NCEC, 2013) have highlighted the requirement for effective communication processes to underpin the provision of care while the National Standards for Safer Better Healthcare (HIQA, 2012) advocate ‘Sharing of necessary information to facilitate the safe transfer or sharing of care, in a timely and appropriate manner and in line with relevant data protection legislation’ (2.3.3, Page 46) as a required standard for the provision of safe, quality care.

In tandem with this is the introduction of a structured, standardised approach to handover to achieve the following key objectives:

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

This education programme has been developed to support clinical areas in the implementation and sustainability of best practice handover processes by providing formal training in handover processes incorporating a structured approach to handover communication.
Introduction to Shift Handover: A Training Programme for Nurses & Healthcare Assistants

The education programme has been developed to support the implementation of recognised best practice communication tools. Such communication tools will enhance handover by providing staff with the necessary knowledge and skills to achieve these objectives.

It must be used in conjunction with the accompanying DVD and the supporting resources where applicable. The duration of the education programme is approximately 3 hours to facilitate reflection, discussion and group work.

The innovative approach to training through the use of the DVD will facilitate a greater learning opportunity for staff. The scenarios on the DVD, which illustrate best and existing practices, provide a practical demonstration of the principles of using a structured, standardised approach to handover and are designed to support education programmes on shift handover. Staff are also provided with the opportunity for role play and vignettes to consolidate the knowledge obtained while the module content is appropriate for staff to reflect on the quality of handover practice across all care settings.

Additional resources to be provided as required:

- ISBAR Template
- Patient Status Communication Sheet
- Handover Prompts
- Handover Operational Procedure
- Safety Pause Information Sheet
- Evaluation Form
Overview of DVD Content

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

The scripts for the individual scenarios were developed and written by the MRHT project team who worked in partnership with Nursing and Midwifery Planning and Development (NMPD), Tullamore & HSE Communications to develop the DVD. All characters and locations identified in the DVD and teaching resource are wholly fictitious and any similarity to any person/s living or dead is unintentional.

The DVD is approximately 17 minutes long and is divided into 10 parts with voiceover. It provides the opportunity to pause for reflection, discussion and group work where relevant:

- **Part 1: Introduction:** to handover and the aims and objectives of the education programme using voiceover.
- **Part 2: Existing Practice:** comprising of a scenario simulating existing handover practices.
- **Part 3 (a) : Best Practice:** comprising of a scenario simulating best handover practices using ISBAR.
- **Part 3 (b): HCA Handover:** comprising of a scenario simulating best handover practices using ISBAR.
- **Part 3 (c): Meet and Greet:** demonstrates how the concept of ‘Meet and Greet’, where staff and patients meet at the outset of the shift, works in practice.
- **Part 4 (a): Implementing Change: ISBAR:** outlines the components of ISBAR and its role in handover.
- **Part 4 (b): Implementing Change: Supporting Resources:** outlines samples of supporting resources and how they may be used to support best practice. Please note these may vary in different care settings.
- **Part 4 (c): Implementing Change: Best Practice Concepts:** outlines key elements to support the best practice handover process.
- **Part 5: Consolidating Change/Group Work:** provides the opportunity for staff to engage in group work to simulate scenarios and to practice the skills and knowledge gained in the education programme. Sustainability of the improvements made through implementation of the best practice process is also explored.
- **Part 6: Conclusion:** reviews the key message of the education programme.
Facilitator’s Guide to Using the Resource Manual and DVD:

- This resource manual provides a guide that can be followed when delivering the education programme however please note that there may be variation in resources used in different care settings e.g. nursing models, patient communication boards, templates etc. Some elements of the programme may have to be adapted to the particular needs of individual clinical areas.
- The DVD is not designed to be viewed as a stand-alone education experience, it is designed to stimulate discussion, reflection and group work on handover processes.
- As the programme content is delivered through a variety of teaching methodologies (DVD, Reflective Practice & Group Exercises), A ’Participant Workbook’ is also available for the purpose of facilitating each participant to document key learning points from the DVD and/or observations from reflective practice/group exercises. It can subsequently be used by participants as a reference document for Shift Handover as required.

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

- Ensure all facilitators have watched the DVD to become familiar with the content and have read the guidance notes prior to facilitation of the programme.
- Plan the programme and allow time for the DVD and discussion (The education programme is approximately 3 hours in duration).
- Flip charts, post-its and markers may be beneficial to support group work and participant feedback.
- Use a room that will be free from distractions.
- Ensure that all participants can see the screen. It will help to have the television higher than the eye level of participants, when seated, as this allows for clearer viewing.
## Suggested Programme Outline

<table>
<thead>
<tr>
<th>Part 1:</th>
<th>Introduction (10 minutes)</th>
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<tbody>
<tr>
<td><strong>Part 2:</strong></td>
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<td><strong>Part 5:</strong></td>
<td>Consolidating Change: Group Work (Scenarios/Problem Solving) / Sustainability &amp; Moving Forward (30 minutes)</td>
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<tr>
<td><strong>Part 6:</strong></td>
<td>Conclusion &amp; Programme Evaluation (10 minutes)</td>
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</tbody>
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Education Programme

Note to Facilitator: Prior to starting the DVD, provide some background to the overall purpose of Shift Handover within the healthcare setting, (Refer back to Introduction and Background to Shift Handover if required, Page 4) and explore anticipated learning outcomes and current perceptions of handover.

Expected Learning Outcomes:
Participants will understand how to conduct a clear, comprehensive, person centred handover within a timely manner using a standardised, structured format to achieve the following key objectives:

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

Discussion: Reflective Questions
- What are your thoughts on handover?
- What are the current challenges you face in handover?
Part 1: Introduction

Outlines the aims and objectives of the education programme using voiceover and includes the following text:

*Shift handovers are essential to good nursing communication and impact directly on the delivery of care and ward productivity.*

*As part of implementing the Releasing Time to Care (tm) module of the Productive Ward Series, the Shift Handover Module was introduced in the Midlands Regional Hospital, Tullamore.*

*This module focuses on developing practical and structured methods of improving ward handover.*

*To support the implementation process, the module team developed this training video which aims to educate nursing and healthcare assistant staff on how to conduct a clear, comprehensive, person centred handover within a timely manner using a standardised, structured format.*

*The video shows how this approach to shift handover improves patient outcomes through*

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

*Incorporated in this approach is the ISBAR Communication Tool which is used in tandem with the nursing process and a chosen model of nursing to identify the information that is required for exchange at handover thus ensuring that handover is patient focused.*

*All references to patients either verbal or written are ficticious and were developed to support the training process within this video.*
Part 2: Existing Practice

Note to Facilitator: Prior to commencing DVD, discuss learning outcomes.

Expected Learning Outcomes:
Participants will understand;

- The deficits of existing handover practices
- Internal and external forces affecting shift handover processes
- How ineffective handover processes can influence patient outcomes

Voiceover introduces this section and contains the following text: *First let’s look at what happens within the existing handover.*
Note to Facilitator: When ‘Discussion’ graphic appears on screen, pause DVD to facilitate opportunity for reflection and discussion.

Discussion: Reflective Questions

- What did you observe within that clip? / What were the positive/negative aspects of the handover process?
- Is this what happens in your setting? / Are you familiar with this type of handover?
- What are the key issues arising from this handover?
- How would you solve these issues?

Note to Facilitator: Recomence DVD at this point to demonstrate the key elements of the existing practice that are of concern.

- Shift handover for a busy ward
- Arriving late, no clear start time, disorganised, sitting around, discussion of irrelevant information
- Patient Communication Board not updated or used
- No identified leader
- Time Wasting
- Telephone ringing
- Distractions/Interruptions
Part 3 (a): Best Practice

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

**Expected Learning Outcomes:**
Participants will understand:
- How the best practice handover process works
- Key elements affecting shift handover processes
- How effective handover processes can influence patient outcomes

Voiceover introduces this section and contains the following text:
*This best practice handover process has been developed by the Releasing Time to Care (tm) Productive Ward module team in the Midlands Regional Hospital, Tullamore. It incorporates a number of Releasing Time to Care (tm) principles as well as using recognised communication tools such as ISBAR. Let’s have a look at how the best practice handover process works.*
Note to Facilitator: Pause DVD at this point to facilitate opportunity for reflection and discussion.
The following points may be highlighted as part of the discussion to demonstrate the difference between both existing and best practice handover processes:

Handover Starts:
- Ward allocation completed and communicated for nursing and HCA staff
- Clearly defined location for handover, standing at Patient Communication Board including confidentiality requirements (Hinged door/shredder)
- Clearly identified leader
- Staff member given completed communication sheet and is identified to take telephone calls
- Handover starts on time
- Structured Handover using ISBAR and Patient Communication Board
- Lead nurse receiving handover identifies key tasks to be completed where appropriate
- Lead nurse recaps on specific safety issues where appropriate
- Opportunity for clarification

Handover Ends:
Handover ends in a timely organised manner with no queries and with all staff aware of individual roles and responsibilities etc.

Discussion: Reflective Questions
- Are you familiar with this type of handover?
- What are the main differences between this and the previous handover process?
- What were the positive/negative aspects of the handover process?
- How will this impact on the delivery of care?
- Do you think this could work in your setting?
- What could be the challenges to implementing this handover process?
Part 3 (b): Health Care Assistant (HCA) Handover

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

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

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

Voice over introduces this section and contains the following text:
*Healthcare Assistants play a vital role in the delivery of patient care and are an integral part of the ward team. As part of the best practice handover process, the healthcare assistant is now formally involved in handover.*
*Previous practice involved an informal approach to communicating with the healthcare assistant where now the nurse in charge formally communicates relevant information, for example personal hygiene, mobility and dietary needs, to the healthcare assistant using ISBAR.*

*Let’s look at how this works in practice*

**Note to Facilitator:** Pause DVD at this point to facilitate opportunity for reflection and discussion.

**Discussion: Reflective Questions**

- What did you observe within that clip?
- Is this what happens in your setting?
- Do you think this approach will work?
- How this will affect the delivery of patient care?
Part 3 (c): Meet and Greet

Note to Facilitator: Prior to commencing DVD discuss learning outcomes.

Expected Learning Outcomes:
Participants will understand:
- The concept of Meet and Greet
- The importance of Meet and Greet in affecting the therapeutic relationship between patients and staff
- The importance of Meet and Greet in supporting effective communication processes and patient safety as part of handover

Voiceover introduces this section and contains the following text:
A new initiative called ‘Meet and Greet’ has also been introduced as part of the new process. This facilitates the opportunity for staff coming on duty to be introduced to their patients by a member of staff from the previous shift. This short clip demonstrates how this works.
Note to Facilitator: Pause DVD to facilitate opportunity for reflection and discussion

Discussion: Reflective Questions

- What did you observe within that clip?
- Is this what happens in your setting?
- Do you think this approach will work?
- How this will affect the delivery of patient care?
Part 4 (a): Implementing Change: ISBAR

Note to Facilitator: As there is no voice over in this part, when the graphics appear on screen, pause the DVD to discuss ISBAR.

Expected Learning Outcomes:
Participants will understand:
- What ISBAR is
- How it is used in tandem with the nursing process and a chosen model of nursing to support the exchange of relevant information in a structured, standardised format.

ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer of critical/essential information. It originates from SBAR, the most frequently used mnemonic in health and other high risk environments such as the military. The “I” in ISBAR within this context identifies the individual patient.

ISBAR is used as a communication tool in clinical handover particularly in relation to the National Early Warning Score (NCEC, 2013). It is a generic communication tool and can be adapted to suit the clinical context or handover setting to support the exchange of
essential information e.g. within this context to provide a structured, standardised approach to nursing and HCA handover.

**Key Learning Points to be addressed by Facilitator:**

- The major learning point of the DVD is using ISBAR and the relevant Model of Nursing to structure the type of information being exchanged.
- The purpose of ISBAR within handover is very specific to give a clear, structured approach, communicating relevant information in a timely manner.
- Literature pertaining to handover frequently refers to ISoBar where the ‘o’ of ISoBAR refers to ‘Observations’. In this best practice process the ‘O’ is incorporated into the ‘S’ or ‘Situation’ of ISBAR to reflect not only the vital signs but also other data for example the frequency of observations, Blood Sugars/Telemetry etc.
- In addition, ‘Recap, Review&Responsibilities’ is included within the ‘Recommendation’ section to provide the opportunity for clarification of any issues arising and for staff to be aware of specific responsibilities.

**Examples of Information given under each heading of ISBAR are:**

- **Identify** = Name, Age, Address or Place of Residence, Consultant, Date of Admission
- **Situation (Observations)** = Admitting Problem/Reason for Admission, Relevant Past Medical/Surgical History, Resuscitation, IPC Status, Current Treatments, Completed Investigations, Relevant Test Results, Allergies and Estimated Date of Discharge.
- **Background** = Living Conditions, Social History and tools such as ‘This is Me’, for example, which may be used for patients with dementia/cognitive impairment.

**Note to Facilitator:** Information exchanged under ‘Assessment’ may be structured differently depending on the model of nursing in use.

Facilitators may need to adapt this section of the education programme to meet local requirements. Examples shown below are based on the Activities of Daily Living used as part of the Roper, Logan & Tierney Model of Nursing and are for illustration only within this resource manual.

**Assessment** = Examples for inclusion in handover include:

- **Maintaining Safe Environment**;
  - Pressure Areas and Waterlow Score
  - IV Cannulae and Visual Infusion Phlebitis Score
Eating and Drinking:
- Dietary Requirements
- Assistance with Dietary Requirements
- Fluid Balance
- Intake and Output
- Weights

Mobilising:
- Mobility
- Falls Risk Assessment

The information exchanged here should correspond with the patient problems/nursing diagnoses documented within the care plan.

Recommendations (Recap, Review & Responsibilities):
- What needs to happen today
- Nursing Needs
- Concerns
- Outstanding Referrals
- Pending Tests/Investigations/Procedures
- Discharge Plan or Overall Plan of Care
- Any Other Comments or Actions needed
- Safety Pause

Discussion: Reflective Questions
- Are you familiar with ISBAR as a communication tool? / Have you used ISBAR prior to this (either in handover or as a general communication tool)?
- Do you think ISBAR can support handover?
- How will ISBAR enhance the exchange of information at handover?
- How will using ISBAR affect the delivery of patient care?
- Referring to the model of nursing and assessment process used in your clinical area, is there additional information that should be included under each heading of ISBAR?
Part 4 (b): Implementing Change: Supporting Resources

Note to Facilitator: As there is no voiceover in this part, when the graphics appear onscreen, pause the DVD to discuss locally developed supporting resources as relevant.

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

Expected Learning Outcomes:
Participants will understand;
- What the supporting resources are
- How they are used as part of handover to support a structured, standardised approach to the exchange of relevant information.

ISBAR Template: To support best practice, handover templates with defined headings to facilitate the exchange of standardised handover information may be used. These can be developed to specific organisational needs and to reflect the information staff most frequently require. They provide prompts for the exchange of information and can lessen the opportunities for omissions (NHS, 2008). One template example incorporates the handover communication tool, ISBAR, as outlined in Appendix 1. The template is used by both the staff member giving and receiving handover to exchange information. From a nursing perspective, it must be noted this template is used in conjunction with the nursing care plan and should reflect a synopsis of the information contained within.

Handover Prompts: This has been developed to guide the type of information exchanged under each heading of the communication tool, ISBAR, and is closely linked to the nursing model in use in individual clinical settings but is interchangeable with other models as required. It is used by staff preparing to given handover as a reminder of the required information under each heading of ISBAR. An example, developed with the Activities of Living as part of the Roper, Logan & Tierney Model of Nursing is included in Appendix 2.

Note to Facilitator: Refer back to Part 4 (a): Implementing Change: ISBAR for further explanatory details on the information included in the Handover Prompts.
**Patient Status Communication Sheet:** Interruptions to handover are a common feature of a busy ward environment and frequently impact on the length of handover. This may have a direct effect on the amount of available time to provide patient care while the timing of scheduled handovers may also co-incide with an increase in the number of enquiries from families/significant others. To address this, strategies such as a Patient Status Communication Sheet may be implemented. This is a template completed by the nurse and will indentifies the patient’s status i.e. he/she is comfortable, whether or not the nurse needs to speak with the family member/significant other or if the family member/significant other is required to call back. At the outset of report, the nurse in charge identifies a staff member to address all interruptions for the duration of handover. This staff member uses the completed Patient Status Communication Sheet to provide the information required to deal with the interruption. An example template incorporating the Patient Status Communication Sheet is outlined in Appendix 3.

**Handover Operating Procedure:** To support the best practice handover process, an operating procedure is used to outline the purpose of handover, how it is conducted, who should participate and the roles and responsibilities of those participating in handover. Depending on individual clinical settings, the details of the operating procedure may differ. An example of an operating procedure is included in Appendix 4.

**Discussion: Reflective Questions**

- Do you think these resources can support handover?
- Can you think of other resources that may support handover?
Part 4 (c): Implementing Change: Best Practice Concepts

Expected Learning Outcomes:
Participants will understand;

- What best practice in Shift Handover entails
- How best practice concepts are incorporated into handover to support a structured, standardised approach to the exchange of relevant information.

Voice over introduces this section and contains the following text:

*The best practice handover now incorporates a number of key elements to support the exchange of clear, comprehensive, person centred information within a timely manner using a standardised, structured format.*

Note to Facilitator: Pause the DVD when ‘Discussion’ graphic appears onscreen to facilitate the opportunity to explore each best practice concept individually

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

Standing for handover rather sitting has been proven to reduce the length of handover by focusing staff on the most important issues (NHS, 2008). Involving the patient in handover promotes a person-centred approach to handover however there are some limitations regarding confidentiality (Cahill, 1998, cited in Scovell, 2010).
Note to Facilitator: Refer back to Part 3 (a): Best Practice for examples of how ‘On the Move’ has been incorporated into the best practice process.

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

Note to Facilitator: The graphic above outlines a specific type of Patient Communication Board called ‘Patient Status at a Glance’ which is underpinned by the NHS (2008) concept of having the right information, ready to go, easily accessible and understood at a glance using the 3 second visualisation rule. Facilitators may need to adapt this section of the education programme to meet local requirements. Examples shown are for illustration only.
Clear Roles and Responsibilities:

By clearly identifying specific roles and responsibilities, staff should be fully aware of where they are allocated to, who they are working with, who is the nurse in charge, who is nominated to address interruptions during handover etc. Specific roles and responsibilities should be addressed at the relevant part of handover e.g. allocation to specific areas should be addressed prior to the start of report. Key elements of care such as co-ordinating meal rounds, medicines rounds and patient observations should also be addressed here in addition to specific elements of individual patient care e.g. attending case conferences, discharge planning meetings etc. The purpose of clearly outlining roles and responsibilities lessens both the risk of interruptions and omissions to care (NHS, 2008).

Safety Pause: A ‘Safety Pause’ provides the opportunity to identify or highlight specific safety issues that may arise and is best practice for handover. It focuses on giving staff the ‘heads-up’ for the forthcoming shift in relation to issues that may arise. It is guided by the HSE QPS Directorate (2013) and focuses on safety issues relating to Patients, Professionals, Processes and Patterns. Further details are outlined in Appendix 5.

Identification of Priorities;
To consolidate the information exchanged, the opportunity is provided at the end of handover for the nurse in charge to review/highlight priority tasks/issues to be completed relating to specific elements of individual patient care e.g. attending case conferences, discharge planning meetings etc. In addition, this opportunity should be used to identify or highlight those patients who are acutely unwell, may be at risk of adverse incidents or require close monitoring.
Confidentiality;

In accordance with confidentiality and records management guidelines staff are required to dispose of completed templates at the end of each shift to maintain patient confidentiality (HSE, 2011).

Discussion: Reflective Questions

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

Note to Facilitator: Recomence DVD at this point to demonstrate how the best practice concepts are integrated into the handover process
Part 5: Consolidating Change

Note to Facilitator: As there is no voice over in this part, pause DVD when graphics appear onscreen to discuss learning outcomes and provide the opportunity for group work.

Expected Learning Outcomes:
Participants will understand:
- How the best practice handover process works
- Key elements affecting shift handover processes
- How effective handover processes can influence patient outcomes
- Discuss how to sustain the improvements made through implementation of the best practice process

Facilitators/Participants are required to develop fictional patient scenarios in order to provide the opportunity to simulate a handover using ISBAR and the supporting resources.

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

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

Discussion: Reflective Questions
- How will you implement the best practice handover process in your area?
- How will you engage your colleagues to participate in the best practice handover process?
- How will you sustain the improvements you have made?

Note to Facilitator: Discussion on sustainability incorporating audit and further improvements may be facilitated prior to the conclusion of the education programme.
**Sustainability & Moving Forward:** To sustain the best practice handover process, continuous audit and evaluation is required (NHS, 2008). This measurement or evaluation can be completed in a number of ways and can also facilitate the identification of further changes required. Data collection can occur through interviews, discussion, recording handover or observational audit. Appendix 6 outlines a sample observational audit tool which can be utilised to support data collection. Evaluation outcomes can inform further improvements to the handover process.
Part 6: Conclusion

Voice over introduces this section and contains the following text:

Good shift handovers are essential to good nursing communication and impact directly on the delivery of care and ward productivity.

By using a structured, standardised approach and incorporating specific communication tools such as ISBAR, the nursing process and a specific nursing model, it is clear through a comparison of existing and best practice that the impact of this approach can demonstrate improvements in areas such as:

- Communication
- Increased Productivity with less time spent on Handover
- A focused approach to Handover
- Inclusion of Relevant Staff
- Use of the Patient Communication Board
- Patient Safety

Where the best practice handover process has been implemented, these improvements have been achieved. Here is what some of the nurses in Tullamore think of the new handover.

Note to Facilitator: Programme Evaluation to be completed as required.
References


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


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


## Appendices

### Appendix 1 ISBAR Template

<table>
<thead>
<tr>
<th>Bed No</th>
<th>I = Identify</th>
<th>S = Situation</th>
<th>B = Background/ Biography</th>
<th>A = Assessment/ ADL's</th>
<th>R = Recommendations/ Responsibilities/Requests</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

*Appendix 1 ISBAR Template from Nursing & Healthcare Assistant Handover Template, Midlands Regional Hospital Tullamore (Releasing Time to Care ™), Version 1.0, 2013*
## Appendix 2 Handover Prompts (Please note this list is for examples only and is not exhaustive)

<table>
<thead>
<tr>
<th>I = Identify</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name, Age, Address or Place of Residence, Consultant, Date of Admission</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S = Situation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitting Problem/Reason for Admission, Relevant Past Medical/Surgical History, Resuscitation Status, Current Treatments, IPC Status, Completed Investigations, Relevant Test Results, Allergies and Estimated Date of Discharge</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(O = Observations)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Signs, EWS, Frequency of Observations, Telemetry</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B = Background &amp; Biography</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Conditions, Social History, ‘This is Me’</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A = Assessment: Activities of Living (Roper, Logan &amp; Tierney, 2000)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Trigger/Prompt</td>
</tr>
<tr>
<td>Maintaining A Safe Environment</td>
<td>Pressure Areas &amp; Waterlow Score, IV Cannulae &amp; VIP Score</td>
</tr>
<tr>
<td>Breathing</td>
<td>Dyspnoea</td>
</tr>
<tr>
<td>Communicating</td>
<td>Cognitive Ability &amp; Anxieties, Pain Assessment</td>
</tr>
<tr>
<td>Eating &amp; Drinking</td>
<td>Diet, Fluid Balance, Intake &amp; Output &amp; Weights</td>
</tr>
<tr>
<td>Eliminating</td>
<td>Continence, Bowel &amp; Urinary Patterns, Indwelling Catheter</td>
</tr>
<tr>
<td>Personal Cleansing &amp; Dressing</td>
<td>Hygiene Needs</td>
</tr>
<tr>
<td><strong>R = Recommendations, Responsibilities &amp; Requests</strong></td>
<td><strong>What needs to happen today/Nursing Needs/Concerns, Referrals, Pending Tests/Investigations/Procedures, Tasks to be completed, Discharge Plan, Overall Plan of Care, Other Comments or Actions needed, Safety Pause</strong></td>
</tr>
</tbody>
</table>
**Appendix 3 Patient Status Communication Sheet (Handover): Section A**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Completed By:</th>
<th>Bed No:</th>
<th>Patient Name</th>
<th>Patient Comfortable</th>
<th>Speak to Nurse</th>
<th>Call Back after 11:00am</th>
<th>Comment</th>
</tr>
</thead>
</table>

Please indicate Patient Status by inserting ✓ in the relevant column.
Appendix 4 Handover Operating Procedure:
The main objective of handover is to improve patient outcomes by enhancing communication, reducing the risk of near misses/incidents and reducing the length of handover with a subsequent increase in direct patient care time.

Our goal is to reduce our average handover time to 20 minutes however we acknowledge that it may take longer than this. We also hope to reduce repetition, avoid irrelevant information/duplication, interruptions and to facilitate staff to finish work on time.

In order to achieve our goals the following points must be followed:

- Handover to start on time with staff standing at the PSAG boards.
- Handover in Progress signs to be used to create awareness and reduce the possibility of interruptions.
- The nurse giving handover to be clearly identified and staff allocated to relevant areas prior to the start of handover.
- The Nursing and HCA handover (ISBAR) template (available in the nurse’s station) to be used by the nurse giving handover to communicate relevant information.
- It is the responsibility of the nurse giving handover that he/she is prepared prior to handover by completing the Nursing and HCA handover (ISBAR) template and the Patient Status Communication Sheet template (available in the nurse’s station) and ensuring the PSAG board is updated.
- The Nursing and HCA handover (ISBAR) template to be used by each nurse/HCA to document relevant information received - Patient Profiles are no longer being used as part of handover.
- It is the responsibility of the nurse receiving handover to use the patient profile/healthcare record throughout the shift to support the information received in handover.
- The HCA to receive handover with relevant information prior to the start of the main handover.
- The completed Patient Status Communication Sheet to be given to a nominated staff member who has been identified to take all interruptions/telephone calls.
- At the end of handover, the nurse in charge to identify any priorities of care or any safety issues arising.
- All staff to participate in ‘Meet and Greet’ in order to meet the patients they have responsibility for on each shift.
- Confidentiality must be maintained at all times by shredding invalid completed ISBAR templates/Patient Communication Sheets as appropriate at the end of your shift.
Appendix 5: The Safety Pause Information Sheet

THE SAFETY PAUSE: INFORMATION SHEET

Helping teams provide safe quality care

Why
Safety awareness helps all teams to be more proactive about the challenges faced in providing safe, high quality care for patients.

Who
Team lead and available multidisciplinary team members.

When
Any time (aim for a maximum of five minutes).

How
Focus on things everyone needs to know to maintain safety. Based on one question ‘what patient safety issues do we need to be aware of today’ - resulting in immediate actions.

The four P’s below provide examples to prompt the discussion (any prolonged discussion on specific issues can be deferred until after the safety pause).

Examples
- **Patients**: are there two patients with similar names; patients with challenging behaviour; wandering patients; falls risk; self harm risk; or deteriorating patients?
- **Professionals**: are there agency, locum or new staff who may not be familiar with environment/procedures?
- **Processes**: do we have: new equipment or new medicinal products (are all staff familiar with these?); missing charts; isolation procedures required; or care bundles for the prevention and control of medical device related infections?
- **Patterns**: are we aware of any recent near misses or recently identified safety issues that affected patients or staff?

Heads-up for today
- Challenges e.g. illness related leave, staffing levels, skill mix, demand surges.
- Meetings/training sessions staff need to attend e.g. mandatory training.
- New initiatives/information e.g. new protocols; feedback from external groups.
- Any other safety issues or information of interest to the team – has this been communicated to the team e.g. notice board/communication book/patient status at a glance (PSAG) board/other communication system etc.

Patient Feedback
- Update on actions from recent patient feedback on their experience (complaints, concerns or compliments) that we need to be aware of today?

Follow-ups
Issues raised previously (confirm included on existing risk register if appropriate), solutions introduced or being developed. For those involved in the ‘productive ward’ initiative this is an opportunity to review the ‘safety cross’ data and any improvements.

Team morale
Recent achievements, compliments from patients and what works well.

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

An initiative of the Quality and Patient Safety Directorate, May 2013
For further information see www.hse.ie/go/clinicalgovernance
# Appendix 6 Sample Observational Audit Tool

<table>
<thead>
<tr>
<th>Section: Handover Type:</th>
<th>Date:</th>
<th>Time Handover started at:</th>
<th>Time Handover finished at:</th>
<th>Duration:</th>
<th>Audit Completed By:</th>
<th>Comments:</th>
</tr>
</thead>
</table>

**Audit Instructions:** Please answer Yes/No or N/A and comment to provide evidence where appropriate.

1. Does handover start on time?

2. Where does handover take place?

3. Do staff stand at the PSAG board?

4. Are signs used to indicate report is in progress?

5. Who is involved?

6. Is it clear who is giving report?

7. Is it clear who the nurse in charge receiving handover is?

8. Are staff allocated to specific areas prior to report?

9. Does the nurse handing over use the ISBAR template to exchange information?

10. Is the PSAG board updated prior to handover?

11. Is the Patient Status Communication Sheet completed?

12. Who is the Patient Status Communication Sheet given to in order to address any interruptions?

13. Was a nurse identified prior to handover to address any interruptions?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Was a nurse identified prior to handover to address any interruptions?</td>
<td></td>
</tr>
<tr>
<td>14. Do the staff receiving handover use ISBAR to document information received? (Are patient profiles used)</td>
<td></td>
</tr>
<tr>
<td>15. How is it conducted? (Is the ISBAR format used)</td>
<td></td>
</tr>
<tr>
<td>16. What information is given at handover? (Relevance)</td>
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<tr>
<td>17. At the end of handover, does the nurse in charge identify any priorities of care or any safety issues arising for nursing staff?</td>
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</tr>
<tr>
<td>18. Were there any interruptions during nursing handover?</td>
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<tr>
<td>19. Did the HCA receive handover using ISBAR prior to the start of the main handover?</td>
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<tr>
<td>20. Did the HCA use the ISBAR template to document relevant information during handover?</td>
<td></td>
</tr>
<tr>
<td>21. At the end of handover, does the nurse in charge identify any priorities of care or any safety issues arising for HCA staff?</td>
<td></td>
</tr>
<tr>
<td>22. Were there any interruptions during HCA handover?</td>
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</tr>
<tr>
<td>23. Is ‘Meet and Greet’ completed?</td>
<td></td>
</tr>
<tr>
<td>24. Is confidentiality maintained? (Shredding)</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations:**

Signed:                      Date:  

Signed:                      Date: