

**The Development and Implementation of a Framework for Best Practice With
Regard To Nursing/Midwifery Shift Handover**

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A Practice Project submitted to
Auckland University of Technology
In fulfillment of the requirements for the degree of
Master of Health Practice

2008

Faculty of Health and Environmental Studies

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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19th November 2008

ACKNOWLEDGEMENTS

The clinical handover project group, in particular Sue Stretton whose advice was critical to a successful project. Niki Houghton (who assisted with reviewing the literature), Anne Ellison (who assisted with the grind of data collection), and Belinda Macfie.

Peter Wynne-Jones, for support, patience and understanding.

The project management office and Ros Morell, for interpretation of results and Haidee Davis for being inspirational.

Liz Smythe for her support, belief in the project, and generosity of spirit.

Lynne Walker, for being a fun, fellow Masters Project student.

ABSTRACT

Any point at which transfer of information about the care or condition of a patient occurs, has the potential for communication to be ineffective or inadequate, leading to compromised care. This includes shift handover, ward /hospital transfers, discharge, individual transfer of care.

Handover of information among nurses/midwives occurs frequently. Continuity of care is fragmented due to the various shifts worked by nursing/ midwifery staff. Therefore a consistent approach to clinical handover is important to ensure effective, accurate information transfer.

With this project, I have acknowledged the problems that poor, or, no communication produces. I have explored different ways of handing over, by looking at studies nationally and internationally.

Current practice from three wards at Waikato hospital was identified from staff questionnaires and patient interviews. Best practice was then piloted on three wards (one of which was rural). Feedback from patients was overwhelmingly supportive of the new standardised process. Most nurses also supported the new handover practice.

Following feedback from staff and patients post trial, recommendations have been made for best practice. These recommendations have been supported with a package to acknowledge and facilitate a smooth implementation. This package includes guidelines, and a tool, as well as statements to address issues identified around privacy.

The challenge now is for strong leaders to support the organisation, and facilitate this change in practice.

1. INTRODUCTION

1.1 Background

To look at the reason for doing this project one must look at the background. The clinical board requested this project, in response to the Health and Disability Commissioner's findings from reports in New Zealand, from learning and experiences in hospitals overseas, as well as incidents and accidents reported at Health Waikato. Problems have been identified around patient safety and poor patient outcomes. Clinical handover is one aspect of these. Clearly this needs to be addressed at the executive level for real changes to be made.

At the executive level, Waikato District Health Board in 2007, commissioned a review of clinical governance at Waikato DHB. The purpose of the review of governance was to:

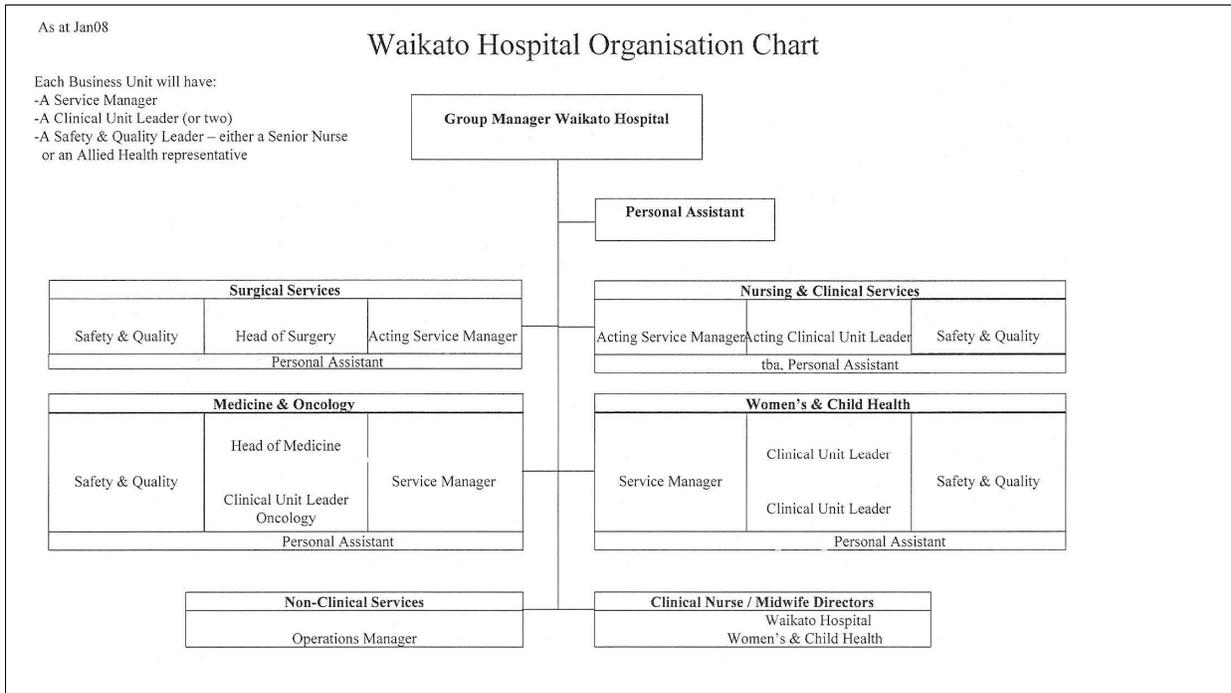
- Undertake an assessment of the present corporate and clinical governance arrangements in the WDHB and to establish the baseline against which improvement can be measured.
- Identify a better approach to corporate and clinical governance for the WDHB and the key components of that system.
- Provide a high level action plan for achieving this improved system and enhanced results that is consistent with Ministry of Health plans and objectives.

The review helped to answer two questions of importance to all staff:

- how the Board can know exactly what is happening deep within Health Waikato; and
- how to ensure that clinical staff can work together for the good of patients

The results of the review showed that there were unclear lines of reporting and that there were grey areas around accountability for quality and safety issues as well as financial responsibilities. Consequently the organisation is currently undergoing a considerable amount of change. Health Waikato now has to formally address its internal structures arising from the governance review, such quality committees within each service grouping. A quality professional leader will be working with the service manager, clinical unit leader and clinical nurse manager in a business unit. This will be at a senior level and gives a good indication of the priority the organisation will give to quality issues.

Figure 1. Diagram of new structure showing the addition of safety and quality roles into the services.



1.2 The beginning of the journey

My project really started in October last year, with a trip to Sydney to attend the Improving Clinical Handover conference. I was sent by the nursing directorate of Health Waikato, along with three other nurses, to look what was being done internationally to address problems around the transfer of information between health care professionals in order to improve patient outcomes. I would be leading a project group on my return, with the expectation that our project would result in a change of practice from the current ad hoc approach to the nursing shift to shift handover, to standardisation, and ultimately, that there would be an improvement in patient outcomes.

Doctors and nurses from as far afield as the UK and Canada spoke at this conference sharing lessons learnt from experience and studies. Some lectures were inspiring; others were difficult to listen to because they reinforced the terrible risk to patient safety of an inadequate and often absent handover. The clear message coming from these health care professionals was that handover requires systemic and individual attention, and that continuity of information is vital to the safety of our patients. With this in mind I returned home.

My first meeting on return from Sydney was with the clinical nurse director to write the scope of the project. I was also advised to meet with a Quality and Risk representative who informed me that the scope of the project was too broad and that as it was written my project would not succeed as others before it in our organisation had not. A large amount of work was being done, taking up a lot of time, with a disappointing result. She strongly advised me to speak with the new Project Management Office (PMO). This meeting turned out to be fortuitous.

I discovered that clinical handover was being given a key priority by the project management office, as it fitted in with the direction the organisation was going. This direction was working with the nursing service to learn from the National Health System for Innovation and Improvement in the UK, which has reviewed clinical care and how improvement methods and lean thinking can be applied within health care settings.

Many health care providers are finding that a new quality approach method using lean principles, which translated to health care, would emphasise patient service, safety standards, improved quality, staff satisfaction, and economic vitality, is the answer. Based on the Toyota production system, introduced in Japan, the lean system may be the answer to a health care organisations mandate to do more with less. Lean thinking differs from other quality initiatives in that it is about doing more with less- less human effort, less time, less space, less equipment- while providing patients with exactly what they want when they want it. The description sounds simple, but to work efficiently, lean methodology must take into account some rather complex ideas.

A primary concept underlying lean thinking is the elimination of waste. Proponents of lean thinking, not only in Japan but everywhere, use the Japanese word for waste, *muda* 無駄, when discussing any activity that uses resources but creates no value. In this context, muda is anything that creates mistakes, stockpiles unnecessary inventory, requires unnecessary process steps, moves employees from one place to another for no logical reason, forces workers to wait for an earlier snag to be fixed, or produces products/services that do not meet the demands of the customer. It is obvious then that waste has no place in lean thinking principles. The rationale behind eliminating waste is that by doing so an organisation can carry out the task of providing the customer/patients with what they want, when they want it, with the minimum of resources.

The result is a performance improvement method that, from the standpoint of a health care organisation, identifies the patient as the central focus and fashions its methods of operation to

create an environment driven by the values surrounding the patient. These values include patient safety, patient satisfaction, and appropriate care (Joint Commission Resources, 2006).

What would happen if lean thinking was introduced as a fundamental principal of health care? The time and steps needed to solve a problem should fall dramatically. The quality of care should improve because less information would be lost in handovers to the next specialist, fewer mistakes would be made, less elaborate information tracking and scheduling systems would be needed, and less backtracking and rework would be required. The cost of each cure and of the total system could fall substantially. If the medical system embraced lean thinking, first, the patient would be placed in the foreground, with time and comfort as key performance measures of the system. These can only be addressed, by flowing the patient through the system. By contrast, conventional thinking places the organisation in the foreground, to be efficiently managed, while the patient is left in the background, to wander through an organisational forest too full of trees (Womack & Jones, 2003)

An improvement initiative called the productive wards was introduced in the UK, with shift handovers being a key module (Rogers, 2007). It was recognised that to be able to protect the safety of the patient and diminish breakdowns in the communication process (which pose considerable risk to the patient) good quality handovers were essential (Rogers, 2007). In short, the project management office would like to support this project. The benefits would be that the PMO report directly to the board and as such extra resources could be called in as necessary. Also they would showcase the project as well as provide a project manager!

All this excitement was short lived as I realised I would need to meet with the Clinical nurse director and explain the advantages of having the project management office involved in the clinical handover project. The scope of the project had yet again been changed. At this next meeting, were several other clinical nurse directors. As I told my story, incredulously, I saw the lights go on and the excitement build when they realised that I was aware of the fit of this project within the vision and aims of the directorate! I informed everyone that the PMO would not be taking over, that the clinical nursing directorate would be the sponsors of the project, I would be the leader or clinical champion, and the PMO would provide a project manager to assist! The project was now given the green light. This project now had huge support at the highest level, and every opportunity to succeed.

It had became clear to me from listening to the speakers at the conference, that results from pilot studies done overseas had identified bedside handover as best practice (Alvarado et al., 2006). Also

that one could expect some resistance to any change in practice. I saw no reason to suppose that nurses at Waikato Hospital would be any less resistant to change. For this reason I decided to meet with the hospital's legal representative to ask about privacy issues around bedside handover. I was assured that the rights of the patient for information about his/her treatment were paramount and that the expectation around privacy could be dealt with by nursing skill and professionalism. In an attempt to substantially increase the sustainability of improvements for patients and health care services a process (National Health Service, 2005) has been developed for use by individuals and teams who are involved in local improvement initiatives. The sustainability model is a diagnostic tool that is used to predict the likelihood of sustainability for an improvement initiative. The sustainability guide provides practical advice on how you might increase the likelihood of sustainability for your improvement initiative.

Sustainability can be described as when new ways of working and improved outcomes become the norm. Not only have the process and outcome changed, but the thinking and attitude behind them are fundamentally altered and the systems surrounding them are transformed as well. In other words, the change has become an integrated or mainstream way of working rather than something added on. As a result, when you look at the process or outcomes one year from now or longer, you can see that at a minimum, it has not reverted to the old way or old level of performance. Further it has been able to withstand challenge and variation. It has evolved alongside other changes, and perhaps has continued to improve over time. Sustainability means holding the gains and evolving as required, definitely not going back (National Health Service, 2005)

The day of the first meeting had finally arrived (it had been postponed twice). The project was explained to the team and the team introduced to each other. The clinical handover group was chosen by myself and the clinical nurse director and was made up of a representative group of senior nurses within Waikato hospital and the rural hospitals. My role as the head of the team was explained to the clinical handover group. The project management office (PMO) assist with data collection the management of patient and staff surveys, and collation of results was under their jurisdiction. As leader I would draw on that as secondary data, I would do the analysis of results and sell the results to the organization. A last minute addition of the CD-ROM from the conference turned out to be a fortuitous. I played the lecture of the Canadian nurse (Alvarado, 2007) who had so inspired me. Her passion, dedication and commitment to improved communication between nursing shifts had the same effect on the others.

The aims of this project, which were developed after brainstorming and discussion amongst the clinical handover group are:

- To review relevant literature to identify best practice for clinical handover between nurses/midwives.
- To review the range of current nursing/midwifery shift handover practice and tools used within Health Waikato hospitals' inpatient areas.
- To undertake a gap analysis to identify areas where current practice deviate from the recommended best practice.
- To develop a framework for nursing/midwifery shift handover which reflects best practice.
- To develop appropriate processes and tools that may assist staff to implement best practice shift handover in their areas.
- To develop and action a communication plan to ensure project outcomes are disseminated to appropriate areas.
- To develop a process to evaluate the effectiveness of the framework.

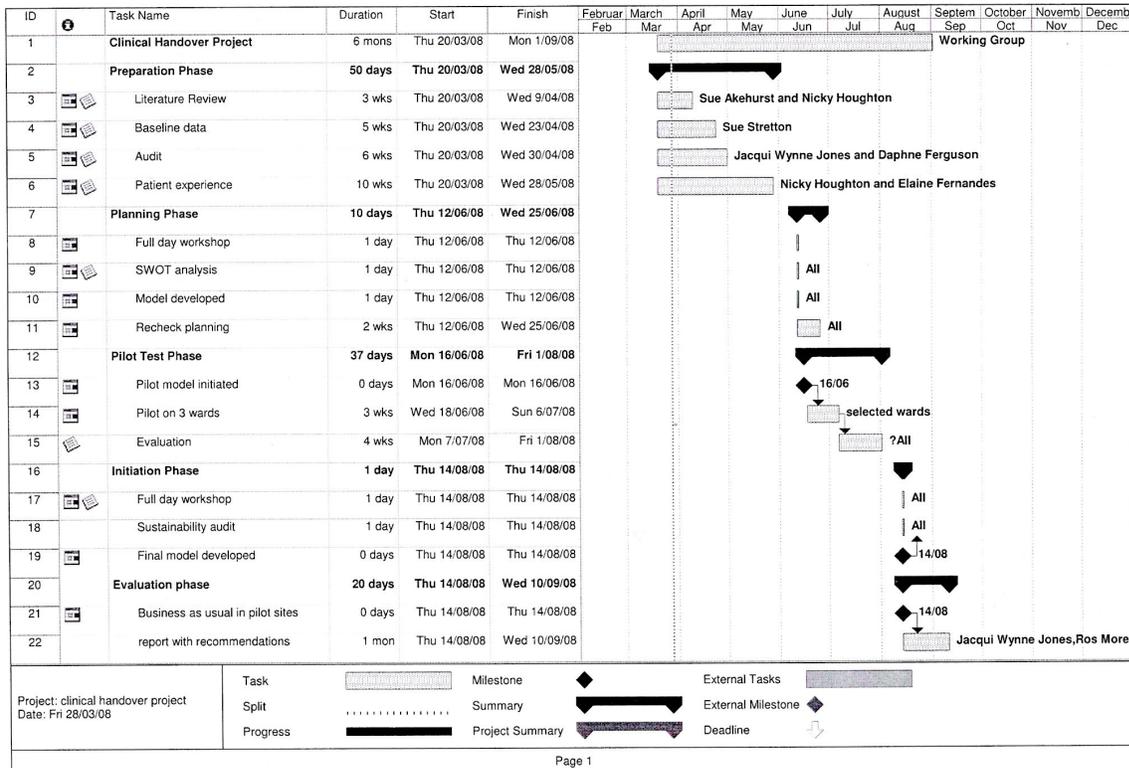
Following this meeting we heard that we had been given a sustainability score of 78 for this project from the project management office. This is a measurement of the likelihood of success of the project determined by the strength of the team, and so an indication of whether or not to proceed, (the score must be over 58 to predict a successful project) (Appendix 1).

Quality improvement often takes longer than expected to take hold, and longer still to become widely and firmly established within an organisation (Ham, Hunter, & Robinson, 2004). One of the primary reasons why quality improvement is difficult to integrate into an organisation is that many of the changes that are put into place fail to survive. Within the literature there is evidence of a high failure rate, up to 70% of organisational change (Beer & Nohria, 2000; Daft & Noe, 2001).

Because of this consultation and discussion between members of the group and a resultant tightening in the scope of the project to make it less broad and so maximise the opportunity for its success, a time line was redone and further tasks set.

For the final project scope, see appendix 2.

Figure 2.0 Timeline for clinical handover project.



A further meeting was organised for four months, but with regular communication to all team members to be provided by myself, and regular meetings with the project manager. Prior to the next meeting, a literature review would be completed, a questionnaire developed sent out and returned, information gathered from this and collated by the project management office. Further information would be gathered around current practice by interviews with nurses and on the pilot wards, and reviewing of incident reports in these areas. Consumer input would be obtained by interviews with patients. Much work to be done.

An analysis of early results from the questionnaires were telling, as nurses identified their frustrations around barriers to shift handover. These included issues around punctuality and disruptive behaviour. These results will be discussed in more detail in a later chapter.

1.3 Summary

The intention of this project was to develop and implement a framework for best practice with regard to nursing/midwifery shift handover within Health Waikato hospitals' inpatient areas. This was done by comparing current practice in the three trial wards to identify best practice gleaned from the literature, as well as and from interviews with patients and nurses in these areas. Following trialling of best practice, feedback was again sought from patients and nurses.

In the following chapters, as well as describing the progress of the project, and working within the project scope, I will present results as they developed, and discuss the issues and ideas that arose around change. Recommendations are then made for practice with tools for support.

2 LITERATURE REVIEW

With regard to shift handover processes, a range of published and unpublished pieces of literature between 2000 and 2008 were explored. Extensive searches were made of electronic databases including web sites. Articles were chosen based on their relevance and key links in nursing and management data bases to the project topic.

The aim of the review was to identify:

- Factors relating to clinical handover associated with patient safety
- Best practice for clinical handover between Nurses and Midwives
- Tools to implementation of best practice shift handover
- Positive influences and barriers to effective nursing handover.

For the purpose of this review clinical handover will be defined as ‘the transfer of information, responsibility and authority for a patients care between providers’ (Gregory, 2006). It is an established practice that involves the interchange of information between staff of separate duties and used to inform the oncoming shift of the condition of patients. The process is multifaceted with many dimensions to the way it is both delivered and perceived and innate risks due to the human factor in the transmission of critical information (Simpson, 2005).

The intention of this review is to identify key concepts for best practice in clinical handover and make recommendations to develop a best practice guideline to implement for the Nursing and Midwifery Handover Project Group.

2.1 Findings

In the constant changing hospital environment there is increasing focus on our ability as health professionals to provide improved quality care. The routine practice of clinical handover is one such area under scrutiny with the recognition that errors in communication sever continuity of care putting patient safety at risk (Dehlman & Wood, 2007). Annually significant numbers of medical malpractice claims, serious patient safety violations, some of which result in death, are the direct result of poor communication (Scalise, 2007) and ineffective handover practices (Kusterbeck, 2007).

Handover is the period at the beginning of a shift that is used to plan care, identify safety concerns and facilitate consistency of information. It is an influential guide to the administration of treatment providing focus and direction to nurses beginning their duty, and maintaining continuity of care delivery (Fenton, 2006). Nursing handover is often viewed as a ritual to be participated in three times a day, where (Alvarado et al., 2006) suggest that it should be regarded as the transferring of accountability between health professionals.

Over the past twenty years, changes in health care have affected reports in various ways. Nursing has become more complex and time pressed. At the same time patient acuity has increased dramatically. Communicating nursing care during the patients total hospital stay is a difficult task given the context of high patient turnover and time constraints (Catchpole et al., 2007). Simply put there is more information to give in a shorter period of time.

Primary nursing allows a comprehensive view of the patient, which also increases the volume of information that can be reported. Nursing practice has increased skills and attention devoted to physical assessment. Nurses focus on a patient in terms of systems. This has evolved to the practice of thoroughly reporting all findings including normal data. Technology has led to more lab results and procedures to report, and acutely ill patients may remain on a medical or surgical ward, rather than an ICU. These factors all influence the amount of information which can be provided to shift report. High levels of responsibility, accountability, autonomy and authority accompanied the transition from team to primary nursing reports. Patient reporting is a task that repeatedly tests a nurse's knowledge skills and communication (Thurgood, 1995).

International Focus

Internationally there is increasing interest and research being paid into the way in which both nursing and medical staff handover patient information. Many health care facilities have examined the routines and rituals that surround clinical handover and have developed and implemented strategies, guidelines and structure to improve system delivery. Other industries such as aviation and formula 1 racing offer practical expertise and experience in dealing with information transfer. Rather than replicating these concepts they have been adapted and merged into the health setting with some success, uch as lean thinking principles(Catchpole et al., 2007).

The National Health System Institute for Innovation and Improvement in the UK has reviewed clinical care and how improvement methods and lean thinking can be applied within health settings. An improvement initiative called 'The Productive Wards' was introduced, with shift handovers being a key module (Rogers, 2007). It was recognised that to be able to protect the safety of the

patient and diminish breakdowns in the communication process (which pose considerable risk to the patient) good quality handovers were essential (Rogers, 2007).

According to the (Institute of Medicine(IOM), 2003), ineffective communication among members of the health care team, patients and families is the major cause of medical errors. Communication failure also accounted for more than 60% of the root causes of sentinel events reported to the (Joint Commission on Accreditation of Healthcare Organizations(JCAHO), 2006). JCAHO responded to this alarming trend by including effective communication among its National Patient Safety Goals. While the goals had previously addressed the topics of communication failure as abbreviation use and report of critical laboratory values, JCAHO most recently turned its attention to hand-off communication (Wilson, 2007).

The JCAHO (Joint Commission on Accreditation of Healthcare Organizations(JCAHO), 2006) goals calls for a standardised approach to hand-off communication that in particular allows for the opportunity to ask and answer questions. Accurate, current information about a patients care, condition, and recent or anticipated changes, is essential to the continued safe provision of care. The role of the nurse as a patient advocate should be evident in a powerful way when the nurse provides a hand-off report to another care provider. This is the opportunity for the nurse, who perhaps knows that patient better than anyone else, to give relevant, patient- centred information and to identify any perceived problems in caring for the patient. Doing this in front of the patient, either during a bedside report or walking rounds, adds another layer of advocacy. The use of the communication tool SBARR is recommended to help nurses focus their communication efforts, especially in an emergency situation. The goal is clear, concise communication for continued effective care. Nurses and other health care providers should accept nothing less from each other- for the sake of their patients.

Hamilton Health Sciences in Canada identified issues and concerns regarding the effectiveness of their handover practices. This was supported by statistical evidence provided from the Joint Commission on Accreditation of Healthcare Organisations where almost 70% of sentinel events were due to communication breakdown. This communication breakdown was highlighted through event reporting and where staff had communicated their dissatisfaction with the irrelevance and often disparity of information received at shift changes (Alvarado et al., 2006). As a result the ‘Transfer of Accountability’ project was established with developed guidelines and a working plan for implementation. Standardising the approach used was found to improve the effectiveness, coordination and openness of information communicated (Alvarado et al., 2006).

In 2005, a report into Clinical Handover and Patient Safety was commissioned by the Australian Council for Safety and Quality in Health Care. It recognised the significance of information transfer between staff and the impact that this process had on patient outcomes. Poor handover practice was seen to lead to wrong treatment, delays in medical diagnosis, adverse and sentinel events, patient complaints, increased health care expenditure, longer hospital stays and potential litigation. Recommendations were directed at these key components; the system: establishing protocols, guidelines and safe staffing numbers; organisational culture: providing effective communication tools; and individual factors: handover training and promoting accountability within a supportive learning environment (Australian Council for Safety and Quality in Health Care, 2005).

Patient safety has been vastly improved by enhancing communication between staff involved in clinical handovers in an acute medical ward at the Royal Childrens' Hospital in Melbourne. A checklist was developed that requires that at every nursing handover, two staff go to the patient bedside and both check ongoing fluid and medication orders and treatment plans for continuing patient care. According to its creator, the tool has the potential to reduce adverse events related to medication errors or incorrect fluid orders by 90% (Anonymous, 2005).

National Focus

To keep from replicating the same errors and adverse events within our own hospital it is important that we learn from international and national experiences. These incidents cannot be ignored but rather need exploring so that cause and effects are identified and relevant changes are adopted to enhance patient safety (Bauer & Mulder, 2007).

New Zealand research on shift handover practices is very limited and what is identified is medical rather than nursing based. An internal survey at a large New Zealand teaching hospital of resident doctors in 2006 found that 84% believed that they should receive a formal handover at shift change but less than half felt that this occurred (Hsaio & Crawford, 2007). When compared to results from a study done 10 years ago in the UK it was seen that there had been very little change to practice and that there remained a need for significant improvement (Hsaio & Crawford, 2007).

Waikato Hospital internal audit , specifically examining nurses and the way in which handover is conducted between shifts. The aim was to deliver credible evidence to support change from present practice to a standardised handover and to provide compelling data for other national hospitals looking at this area.

Transparent documentation regarding Serious and Sentinel events, Health and Disability reports and patient safety initiatives support the development and implementation of strategies to improve shift handover. Recent Serious and Sentinel event reporting for the period 2002 – 2008 has identified the following areas of concern within New Zealand hospitals:

- Capital and Coast District Health Board reported the need for ‘improvement in verbal and written communication between staff’ and ‘review handover of care practice guidelines’ (Capital and Coast District Health Board, 2008). In two highlighted cases, significant injury was incurred by the patient, with death being the end result for one. A medical handover policy with relevant guidelines and procedure checklists are being developed.
- Waitemata District Health Board recommended ‘improvement to daily handover processes with sharing information, risks and clinical reviews’ and ‘review timing of transfers to avoid coinciding with handover’ (Waitemata District Health Board, 2007) . A current initiative is underway looking at the Transfer of Care of patients requiring review of nursing staff procedures at shift to shift handover.
- South Canterbury District Health Board review had four incidents where clinical handover had impacted patient outcomes, all four resulted in death. The handover process was seen to be ‘not clearly defined’ and ‘lacking clarity’. Actions to be implemented were to review the current hand over process and implement change.(South Canterbury District Health Board).
- Waikato District Health Board identified incidents where ‘sick patients should be handed over to the next shift’, ‘poor communication between staff’, ‘failure to handover abnormal results’, and ‘lacking clarity, process or handover responsibility’. In all cases patients incurred harm with two resulting in death (Waikato District Health Board, 2007). Waikato DHB has a current clinical handover project, initially focused on nursing with the aim to standardise this practice.

Most recently, problems in handover of clinical information and delays in radiology reporting at Wellington Hospital in 2004, led to a missed diagnosis of lung cancer (Capital and Coast District Health Board, 2007). An expert witness, Dr Garret, noted that poor communication and handover processes were major issues that influenced the quality of continuity of care that Mr A received. These issues are not peculiar to Wellington hospital but to all New Zealand hospitals and indeed worldwide. Given Mr As length of stay in hospital, he would likely have required upwards of 15

separate handovers of care. Unless careful attention is paid to improving the hand over process, the potential for mistakes arising out of poor communication is enhanced. In Mr A's situation, the decision to perform a better quality posterior-anterior chest X- ray was not passed on, and was simply overlooked.

The need for effective handover cannot be overstated. Dr Garret noted that "group cause analysis" of sentinel events indicates that poor communication is a contributing factor in 65% of cases, and that lack of continuity of care is a contributing factor in 12% of cases. Both of these factors contributed to the omission in Mr A's case. The other crucial factor was the lack of effective handover. In general, the effects of ineffective handover are multiple and include a 3.5-fold increase in preventable adverse events, delays in diagnosis, decreased patient satisfaction, increased length of stay in hospital, increased investigations performed, and delays in ordering tests. Dr Garret noted that there is a burgeoning literature outlining the importance of handover meetings in care and that workshops addressing handover of care in hospital settings are available in Australia.

The compiled reports consistently show irregular handovers, where information delivery varies, lack of clarity or process exists and significant impact on patients, whanau and community are an end result. (Seddon, 2007) Report on 'Safety of Patients in New Zealand Hospitals' reviewed the 21 District Health Board responses to the Health and Disability commissioners request for evidence of safeguards to prevent repetition of the Wellington Hospital case (05HDC11908). It was universally identified that standardising handover of care is needed and that a cooperative national approach would advance the change required more rapidly.

Handover influences

For us to recognise areas of breakdown in the handover process and to implement relevant improvements we first need to understand how those nurses using the current methods feel. A recent European study found that many nurses felt dissatisfied and irritated with the handover process (Meibner et al., 2006). An English study validated these findings with universal issues noted as 'frequent interruptions', 'poor quality leadership', 'lack of support from peers', 'lack of time', 'irrelevance', 'vague statements', 'unreliable information based on memory' and 'trivial conversation' (Davies & Priestly, 2006). By improving handover practice current expertise, promote nursing professionalism and practice is revealed (Kerr, 2002), and give nurses in turn a sense of true satisfaction with the delivery of consistent expert care (Meibner et al., 2006).

2.2 Styles of handover delivery

There is no one documented technique emphasising best practice. There are a variety of methods used to deliver patient information at shift change, verbal, written, taped, checklist and bedside (Pothier et al., 2005). Sexton et al. (2004) noted that the nature and transference of the handover directly affects the running of the following shift. (Pothier, Monteiro, Mooktiar, & Shaw, 2005) agreed that the style used plays an important role in the accuracy achieved at handover. The key to the success of a tool is the ability of the oncoming nurse to have full understanding of the necessary and appropriate information to thereby be able to continue effective and safe care.

Verbal:

Verbal handover is a commonly practiced method. A UK experiment on retention of data at handover, found that when a verbal format was used in isolation, minimal to no information was retained (Pothier et al., 2005). Other influences of handover can be due to the level of experience of the nurse or that the senior nurse on duty who may have had no contact with the patient is passing on the information (Davies & Priestly, 2005). In contrast a collaborative approach is where the nurse caring for the patient does the verbal handover. This ensures that the information is delivered in a current, knowledgeable and detailed way (Parker, 2004).

Written:

Written handover, either in note form or computer print out, provides a global framework of patient information (Parker, 2004). It is a documentation record and guide that should contain all the relevant facts including plan of care, occurrences, treatments and medications (Wilson, 2007). Regular updates should be made to reflect the patient's current situation, and to provide continuity and progression of care direction for the oncoming nurse. Checklists can also be used in combination with a written tool, providing a prompt and guide. A checklist is performed at the bedside with 2 nurses inspecting specific therapies, drug documentation and infusions. This establishes a systematic approach to reduce error (Alvarado et al., 2006).

Tape recorded:

Tape recorded methods require the outgoing nurse to record the handover information on to tape for the oncoming nurse. Although rare, significant mistakes can occur with incorrect or mixed patient data being presented (Wilson, 2007), and it is important that staff be allowed the opportunity for face-to-face discussion. This process can deprive the receiving nurse of this opportunity and the option to question and verify care (Meibner et al., 2006).

Bedside:

Bedside hand over were noted as the preferred option of transferring information (Seddon, 2007) and is a widely used method within developed protocols (Alvarado et al., 2006). It is seen as an opportunity to individualise and involve patients in their care (Caruso, 2007), yet despite it being viewed as the best way to transfer information it is not widely used in New Zealand hospitals (Seddon, 2007).

Staff voiced concerns regarding bedside handovers and the issues of patient confidentiality. By adhering to hospital privacy policies, involving the patient and by offering them options (family participation) these doubts can be relieved (Caruso, 2007). This format of handover also allows the patient the opportunity to ask and answers questions, further reinforcing our advocate role (Roberts, 2007) .

Interestingly patients express they feel reassured and comforted knowing oncoming staff have a clear and up to date knowledge of their needs (Alvarado et al., 2006). (Kelly, 2005) also found in her study that nurses conveyed an increased rapport with their patients following implementation of the bedside handover.

2.3 Barriers

The nursing handover has attracted criticism in the literature in relation to its continuing role in modern nursing. Criticisms include those related to time, expenditure, content, accuracy and derogatory terms in which patients are sometimes being discussed.

By acknowledging and then addressing barriers it provides us with the opportunity to avert errors and take a crucial step forward in patient safety initiatives.

Perception:

Handover is an established practice that involves interchange of information between nurses with the styles commonly used based on tradition and ritual (McCloughen, 2007). It is not viewed as a professional exchange of information but rather an informal pressured conversation where nurses are often ill prepared, under time constraints, have limited access to patient notes, and are distracted by frequent interruptions and idle chatting (Benson, Rippin-Sisler, Jabush, & Keast, 2007).

Some nurses felt that handover was often hurried and disjointed and that the information they received had little or no relevance for the oncoming team (Davies & Priestly, 2006). Where no structure exists, staff may feel there to be no benefit to patient care. To successfully address and correct handover issues it is essential that the perception of those involved in the practice is redefined.

It is important that issues that disrupt and devalue the process are removed and that the focus is shifted from it being a habit or routine (Arora, Johnson, Meltzer, & Humphrey, 2008), (Alvarado et al., 2006). This then develops a 'safety culture', where 'safe systems' such as effective handover are in place and error prediction, prevention and patient outcomes are improved (Seddon, 2007).

Time:

Nursing handovers can often be a lengthy process especially where clear guidelines of information type and delivery do not exist. Prolonged handover directly reduces the time spent in patient contact and it is often during this time that patient falls and other adverse patient events can occur (Davies & Priestly, 2006).

Baldwin&McGuinness (1994), reported that minimising the time spent on handover can reduce overtime, contribute to cost containment, and reduce the length of shift overlap as well as increase the time for other activities, such as continuing education, general ward meetings and direct patient care. Consequently, methods for the transfer of information between nurses on different shifts have recently come under scrutiny. (McKenna, 1997), reported that nursing handover report is a vital method of passing on essential information to nurses on the next shift. Nursing handovers traditionally take place in private; they can become lengthy, irrelevant or unprofessional. Alternative methods of handover, such as bedside reporting, or tape recording or writing reports, can help refine the process and make it more relevant to practice.

As nursing environments change there are increases in staffing needs, shift patterns and patient acuity pressures making time a precious commodity. Poor time management, lack of standardisation and training can all affect the delivery, timing and length of handover (Matic, 2007) . It is challenging to transfer responsibility and communicate effectively when a procedure has just started, when a patient's condition is unstable, or when multiple tasks are taking place (Gregory, 2006).

In a study by (Sexton et al., 2004), the question was asked about whether we really need nursing handover?. An attempt was made to address the content of nursing handover when compared with formal documentation sources. Twenty-three handovers, covering all shifts from one general medical ward were audio taped. Their content was analysed and classified according to where, within a ward's documentation systems, the information conveyed could be located.

Findings of results showed that almost 84.6% of information discussed could be located within existing ward documentation structures and 9.5% of handover content involved discussions related to ongoing care or ward management issues that could not be recorded in an existing documentation source. This study was limited in that the results were representative of only one ward in one Australian hospital. Specific documentation sources were also not checked to determine their content. The authors did conclude that stream lining the nursing handover may improve the quality of the information presented and reduce the amount of time spent in handover.

Technology:

With increases in the diversity of clinical scenarios and health technology, there is an expectation on staff to be expert. There also exists escalating pressure on the information and time provided at handover (Matic, 2007). It is important then that higher acuity and more complex patients with multiple therapies and interventions have handover adjuncts in place, such as bedside checklists, enabling all aspects of care to be disseminated accurately and in a standardised format so that important information such as changes in patients' conditions are not missed.

Changing technology can also generate havoc for the handover process. Innovations such as portable phones, cell phones and pagers can cause interruptions, fragment discussion, create inconsistencies, and misunderstanding (Kalisch et al., 2007). (Matic, 2007) felt that with these advances and the various forums available to relay information, staff must not forget or overlook the basics and importance of clear concise communication.

A qualitative study of shift handover practice and function from a socio- technical perspective by (Kerr, 2002), concluded that handover is a complex system based on several sound socio-technical principles and that the value of this nurse-to-nurse communication should be acknowledged. The multiple functions highlight the knowledge and expertise currently hidden within handover, which could be promoted in terms of nursing professionalism. An example is the role modeling and teaching that occurs when an experienced or expert nurse hands over to a junior nurse.

Environmental and cultural:

Often handover is attempted in an area on the ward that is central, busy and is used for multiple functions (tearoom, family conference etc.). It is important that a space is chosen and set and that it is a separate private place, away from distractions, noise, phones, outside staff and patients (Kerr, 2002).

Cultural barriers include but are not exclusive to hierarchy, gender, ethnicity, personality and literacy (Haig, Sutton, & Whittingham, 2006). With the diversity of our health system attention needs to be paid to the way we communicate and interact with our colleagues, by simply taking care, minimising the use of slang, abbreviations and acronyms communication pathways can be improved (Scalise, 2007).

Drawing on an ethnographic study of an ICU(intensive care unit) that explored nursing culture, (Philpin, 2006) identified ritual and symbolic elements inherent in the bedside handover and that in addition to the manifest purpose of bedside handovers in ICU of transferring essential information, these ritual and symbolic elements also articulate the underlying values of this social group. An example is respect, an emphasis on safety, importance of family involvement as well as professionalism and acknowledgement of differing levels of experience of nurses between shifts.

A change in culture within the organisation with support from peers and leadership (Meibner et al., 2006) that discourages interruptions and poor communication during the handover process would minimise miscommunication and information failing to be conveyed correctly (Patterson, Roth, Woods.D, Chow, & Gomes, 2004).

Anxiety.

(Evans, Pereira, & Parker, 2008), after looking at discourses of anxiety in nursing practice, warn that attempts to restructure ritualised hand over practices via the use of guidelines, and rules about what is to occur in this handover time, holds the prospect of nurses being faced with an anxiety at the commencement of their shift that can manifest in a number of ways. The ritual alleviates anxiety, at least in the short term (Freud S & Breuer J, 1885). Removing the ritual does not alleviate the anxiety. Therefore attempts to eliminate the ritual raise the problem of how then the nurses will work in the context of this anxiety. If the aim is to remove the ritual, then other ways to assist nurses to work in the context of anxiety need to be considered concurrently, otherwise the

prospect is that anxiety will either immobilise the nurses or find another form of expression, establishing another discourse of anxiety.

2.4 What makes a handover effective?

Focus:

It is important that an organisational focus on patient safety exists with significance placed on the mechanisms for delivering clinical information. As nurses we must take responsibility for our professional practice by valuing and delivering effective handover and collaboratively take shared ownership to ensure safe guidelines are followed (Arora et al., 2008), (Battles, Leonard, & Mistry, 2007). There needs to be a culture agreement, accepting that the handover process is to happen every time and everywhere (Battles et al., 2007).

(Davies & Priestly, 2006) felt that the handover should be focused on ongoing care; it should be current, consistent and progressive, providing the new nurse with clear direction. Giving structure and attention to information delivery also provides significant opportunity for teaching and learning (Davies & Priestly, 2006).

Standardisation:

Standardising handover is about providing structure and consistency of method and information delivered throughout the clinical environment. By standardising the process you develop a non negotiable base that addresses core issues that all areas face (safety etc.) yet has the flexibility for adaption in specific environments (Arora et al., 2008).

Despite there being no documented best practice model (Meek, 2007) standards and guidelines that aim to improve clinical handover reflective of current literature and practice should be developed. There are key, non-negotiable factors suggested to be within the framework, such as: identification factors, current diagnosis, relevant medical conditions, safety issues (risk assessment, security issues), significant changes, medications and related observations (PCA and pain scoring), care required for oncoming shift (pending tests, outstanding calls), and family needs and concerns (Benson et al., 2007).

There are many examples of handover tools used by nurses at shift change that are valid and reliable. For Samples of these see appendix 3.

For samples of handover forms used by nurses at shift change, see appendix 3.

The process is identified as essential to nursing practice in terms of enhancing continuity and effectiveness of patient care (McCloughen, 2007). (Gregory, 2006) agreed that by establishing this process missed information can be eliminated and complete information sharing between staff promote. This can enrich staff satisfaction and clinical experiences and recover value in the handover process (Alvarado et al., 2006).

Effective leadership:

A fundamental part to establishing a successful handover process is creating clear guidance and direction on the floor that mirrors best practice guidelines. (Catchpole et al., 2007) believed that by providing a defined coordinator or leadership role, support, clarity, and direction through the shift would be given and then passed on for the following duty.

Strong management is imperative to the sustainability of any change. Effective leaders need to assist the organisation in preparing for change and then go on to deal with that change (Hill, 2007). It requires the leader to have vision, direction, consultation, communication, education, engagement, champions, reinforcement and integration of good practice by modelling and motivation. Success will rest on each area owning the value of effective handover and developing educational plans and strategies for implementation (Benson et al., 2007) that include training in communication and professionalism (Arora et al., 2008).

Communication:

To communicate skilfully is crucial to providing coordinated care and clarity of understanding for both patients and staff in times of transition (Arora et al., 2008). Lack of understanding or miscommunication of information during handover is often a determining factor in critical patient events (Simpson, 2005). Poor communication between providers can result in lost information; lack of action, misinterpretation or misdirected care (Gregory, 2006).

Many organisations have recognised the impact poor communication has on patient outcomes and have gone on to institute effective communication training and tools. The SBARR technique, recently implemented at the Waikato District Health Board assists staff to communicate by following a structured easy-to-remember mechanism (Haig et al., 2006).

By delivering a succinct and structured process, errors, confusion, and misunderstanding can be averted. (Gregory, 2006) and (Roberts, 2007), affirm this and emphasise that ‘health care providers should accept nothing less from each other’.

Documentation:

Current and updated clinical documentation, such as medical or nursing notes and care plans should be the basis for handover. This gives clear indication of what has been done and what needs to be done for the following shifts (Davies & Priestly, 2006) . Care plans are a valuable resource in the handover process, giving the oncoming nurse an inclusive holistic view of patient care, yet often they are not referred to at all (Wilson, 2007).

Care plans were used as the main focus of nursing handover in research using an information exchange model (Clemow, 2006). The aim of this study was to report on nurses experience and practice development through change in style of nursing handover from office based to using care plans and related documentation as the main source of information exchange. The first audit results from the staff perception questionnaires identified both advantages and disadvantages in the new handover process. The reported advantages identified that the processes challenged their usual practice and encouraged reflective practice. It prevented office dwelling and therefore improved priority and time management.

In this study, the change from the traditional office based nursing handover to utilising documentation at the patient bedside significantly improved not only the accessibility of nurses for patients but also the nurse's satisfaction and the improvement in documentation. The importance of considering the context of nursing and best practice of handover from a range of options appeared to be significant in this study.

Legal and professional responsibility dictates that all aspects of nursing care be clearly recognised. Handover documentation forms a guarantee that evolving changes in a patient condition and care are firmly fixed in a clear structure (Stevens, 2008). Suggested frameworks may be a computer generated report tool or checklist providing documented evidence that is presented to the oncoming staff and updated for subsequent shifts (Wilson, 2007).

2.5 Recommendations

The patient and their wellbeing remains at the core of clinical handover practice. Worldwide recognition is being paid to the impact handover has on health outcomes with clear indication both internationally and nationally for review and change of clinical handover methods. Although there is very little documentation specifically regarding New Zealand nursing handover practices we can take much from international experience and incorporate our own data from the current audit to create an efficient and pertinent tool for the Waikato District Health Hospital.

Priority needs to be paid to the following areas:

- Clear written guidelines need to be developed that include the process of reporting, minimal content required, time frames, environmental expectations and identification criteria for bedside handover. Guidelines must consist of non negotiable information including identification, care plans and safety
- Provision of a standardised template to ensure accurate and succinct information delivery. This should involve a combined written and verbal process with flexibility to be adapted to differing services and the addition of handover adjuncts such as bedside handover and checklists
- Utilisation and ongoing education on effective communication, inclusive of SBARR guidelines
- Established proficient leadership and guidance for all clinical areas, promoting a learning environment and open communication
- Improved documentation of the clinical handover process in line with legal and professional expectations. Clear links to be defined between the reported data at handover and current patient care plans
- Developed education plan for implementation, drawing on principles of accountability for professional practice. This will include provision of appropriate resources, skill days, in-service training and addition into orientation education

- It is important that the process is measurable, and able to be easily evaluated so that modification and improvements can be made in a smooth and quick fashion

2.6 Summary

Clinical handover is an area of profound importance, having significant and sometimes irreversible effect on patient wellbeing. (Wong & Yee, 2007) believe that a good clinical handover process will, in theory ensure good continuity of care through adequate and accurate information transfer. By compiling handover processes (written, verbal and bedside) loss of patient data is significantly reduced (Pothier et al., 2005), and when full data is delivered in a consistent and concise manner, is received and clearly understood, patient safety and quality of care is improved (Davies & Priestly, 2006).

With recognition of changing shift patterns(for both medical and nursing staff), high staff turn-over (with nurses being lured overseas for extra pay and better conditions), increasing patient acuity(many patients have comorbidities) and over-flow of specialties into other areas(pressure on bedflow from MOH guidelines),it is imperative that effective and safe handover practices are established to maintain high standards of clinical care. By acknowledging and understanding staff views of both positive and negative influences on clinical handover we can better address and implement constructive change to the process.

Although this practice is a routine recurring event and there is no documented best practice guideline, there remains sufficient current literature both internationally and nationally to guide the development of an efficient and effective framework. This can then be disseminated throughout the District Health Boards to encourage a cooperative standardised national framework.

3 PREPARATION

In order to establish current handover practice feedback was sought from staff as well as patients in wards X, Y and Z. This feedback was gathered from a questionnaire for staff, interviews with patients and data collected retrospectively from incident forms from the three trial wards. In this chapter, these results are examined, and decisions are made around how to address the gaps between best practice and current practice and the development of appropriate guidelines to support the new process.

The second meeting of the clinical handover group was held in June. At this meeting, the results of patient and staff audits in the pilot wards were presented, and discussions occurred around an appropriate handover tool.

The audit which was carried out over a period of three weeks in order to establish current handover management, included handover style, tools, environment, issues raised, and suggestions. The return rate was over 100 with the audit being distributed to a wide range of wards at Waikato hospital as well as Taumaranui, Thames, Rhoda Read and Matariki, rural units under the Waikato District Health Board. This was a good representation of the population of nurses at the hospital. The audits were hand delivered and a phone call followed up a few days later.

Results from pre-trial staff questionnaires (see appendix 4).

Duration of handover and duplication of information is a common complaint. Further queries sent out to the participating areas to establish a baseline for handover duration. Feedback indicated that staff behavior had been highlighted as disruptive at times, and poor punctuality was an issue.

There was overwhelming interest in having a standardized structure for handover as well as some interest in bedside handover.

Clear trends surfaced. Handover is predominantly given to all staff within an office setting. This may be given by the coordinator or by the nurse who has cared for a group of patients. Individual handover usually follows where patients are handed on to the next nurse. Bedside hand over does occur but it is often only for complex patients. Handover sheets are commonly used and found to be a useful tool but there is a risk that the information has not been updated.

When collating the information, the decision was made to categorise statements into subsets within questions. A high rate of return was received (109 returned out of 138). For questions one (what is your current practice at nurse hand over at each shift change?), and two (Do you use electronic support?), collating the general consensus of one form per location/ward was considered acceptable as the answers from the staff of a particular ward were the same.

Comments were offered in relation to the following questions:

Q3. What works well for you in your current handover practices?

Q4. What does not work well for you in your current handover practices?

Q5. What suggestions do you have for improving/changing handover practices? These forms were counted individually in order to identify the level of concern and the trends within that sector.

The collated feedback offered the following response:

- The handover is done away from the patients in order to maintain confidentiality.
- The patient is not aware of what is said in handover at all unless it is at the handover that occurs when the patient first arrives on the ward (from delivery suite).
- From nursing staff to staff context, there were concerns around privacy.
- Handover was given staff to staff in the staff room. In only exceptional cases, when the patient's condition was unstable, was the handover done at the bedside.
- One nurse said that the handover is between nurses; the family may be discussed, but are not included in the discussion.
- The handover is primarily nurse / medical focused and occurs in the nurse's office with nursing staff only, except when a nurse starts at eleven am.
- The handover is not at the bedside, as other patients and confidential information are discussed.
- One nurse said handover was indirect with requests written by the nurse in the cardex.

Diagrams and results of current practice from nurses' questionnaires can be seen at the end of this project. (Appendix 4)

Summary of pre trial results from the patient surveys.

Patient interviews were conducted by the quality and risk coordinator for the Clinical Management project group. The patients were asked about their experiences with the exchange of information

between nurses during their stay and their answers provided a powerful insight into the vulnerability and fear they had experienced when in hospital. Examples are as follows:

- Patients felt much better with two nurses at the bedside and felt more comfortable with an obvious transfer of knowledge at the bedside.
- One comment made was that the nurse was only a kid but went to get help.
- I would like to know what was happening, but wasn't told anything.
- One patient said that they forgot half of what was said, and that a friend at the bedside would be good, as they couldn't hear much of what was said either.
- Another patient said he felt frightened because staff kept asking if drugs had been given, because they were not signed for.
- One patient said she felt alone at night and struggled to get through the night. Patients felt alone at night and struggled.
- One comment made by a patient was, that at the changeover of the shift, there needs to be more consultation with the patient.
- Another patient said that staff always said they would come back after the handover, but they never did. This is something he remembered.
- The patients wanted family involvement, and said they received different messages from midwives about family staying.

Results from pre trial patient questionnaires (see appendix 5).

The results from these patient questionnaires did stimulate much discussion with everyone agreeing about the importance of empowering the patient with information about their own condition, and their right to be given information and be involved in the plan of care.

Data was also collected and compared from incident forms over the past year for each trial ward, and site visits were undertaken to establish a baseline of what current practice was.

Summary of information, from site visits, and incident forms.

There were common issues around complaints and these were:

- Poor, or no, orientation of staff around handover.
- Missed medications.
- Absent handovers.

- Missed diagnostics from poor communication.
- No standardization of checking patients' identity, medication charts or risks.
- Nurses doing bedside handover of high acuity patients were also coordinating.
- Ward Z (rural) was also running a team nursing trial.
- Ward Y was also trialing a new care plan.

For Quality and Risk data comparisons for the handover project- pretrial in wards X, Y and Z (rural), see appendix 6.

Lively discussion also occurred, at this second meeting, around the appropriate handover tool to use for the pilot study.

Issues of concern for the project management team were around:

- Duplication of what was already covered in the nursing care plan and nursing admission sheet.
- Whether or not the nurses should sign off the check list.
- What prompts should be used on the checklist.
- Ensuring any new document developed would fit with any new models of care, and the new care plan.
- Address issues of concern from health and disability commissioner reports.
- The difference between the global handover which is a brief summary including patients name,age, diagnosis, consultant ,and key interventions,it is given by the charge nurse in the office to a group of nurses and involves technical knowledge.The bedside handover, is between nurses includes documentation including identification of risks,and involves the patient.

Following much discussion and debate, it was agreed that:

- The global handover was identified as being at the macro level, and for technical information to be shared between nurses. It is also provides an opportunity for key messages and concerns to be relayed about hospital bed flow, and safety issues. This is the opportunity for strong leadership from the clinical nurse manager as she leads, guides and mentors staff. This should only take ten to fifteen minutes.

- The bedside handover was seen as being at the micro level. This being the opportunity for the nurse to introduce herself, get verification of identity from the patient, assess the current status of the patient, and to communicate with the patient about the plan of care. Also it is the opportunity for the nurse to listen to how the patient journey is progressing, from the patient's point of view. The focus is very much on patient involvement.
- The decision made was that the checklist should be a prompt to lead the nurse to important documentation, such as the medication chart and nursing care plan. The list should include the key areas where problems have been identified. These include missed medications, changes in the patient's condition, communication with the patient around tests and procedures, as well as the plan of care.

The meeting ended with a plan for key members of the handover group to meet again in two weeks time as two of the pilot wards did not have electronic support for their handover sheets. The group felt this was a standard we should adhere to, given the support this document provides to the nurse throughout her shift.

The pilot group meeting two weeks later was the opportunity to finalise the structure and content of the checklist, and talk about supports that needed to be in place to assist the pilot wards. Supports included project champions, and the use of the health care assistant to do a vigilance round, to protect this handover period. The receptionist is to be involved with minimising interruptions, by ensuring messages are taken over the handover half hour rather than interrupting the nurses. A suggestion was also a rest time scheduled at the hand over time to keep distraction to a minimum. This would need to be negotiated with management and the particular wards.

The global handover sheets were discussed, as a tool for support and information. It was decided that these should be developed by individual nurse leaders, for the best fit for their patient groups and areas. (For the final checklist, see appendix 7)

A date for commencement of the pilot was set for the 11th of August over a four week period involving three wards, as this would give plenty of time for bedding in of a new process. The next meeting was set for the 26th September to give time to report on the results of the pilot from the nurses and the patients. In the meantime, we, as leaders of the pilot wards, were to educate and inform our staff about the new process and encourage them to read the literature review and results

of pilot patient and nurses' questionnaires. (For an example of the posters used in the wards, see Appendix 8)

The results from data collection provided clear messages for the project group for a way forward, as well as insight into the resistance to change that one could expect from the nurses. Patients overwhelmingly supported being involved in the handover and welcomed the communication and input into their plan of care. Some nurses expressed concerns around privacy issues in rooms with more than one patient, this was noted.

The pilot group planned to address these concerns with guidelines and tools to support the new process. It was acknowledged by the group that education and support of the nurses prior to the commencement of the trial would be crucial to a successful outcome.

4 IMPLEMENTATION

On the 11th of August 2008 the pilot for the clinical handover project began in wards X (my ward), Y (a maternity ward), and Z (a rural hospital). These wards were chosen by the quality and risk team. My ward, because I was the project leader and so could easily supervise the pilot, Z because of the particular issues that arise with a rural hospital, and the remaining ward because of particular incidents that had occurred there involving clinical handover.

The new process includes a succinct global handover, followed by a handover at the bedside involving the patient, also a checklist with reference to all documentation.

Although there had been much discussion and education around this, as well as advertising of it on the focus board (including a copy of the literature review and audits on these chosen wards), the nurses on my ward looked quite surprised when informed that today was the day!

For a clinical champion, I had the ORL(otorhinolaryngology) educator come in early, and she accompanied one of the night nurses to hand over to the nurses down one end of the ward, the other nurses went with the second night nurse to the other end of the ward. The health care assistant came in early to do a vigilance round and I stayed by the phone to prevent phone calls coming through to interrupt the nurses. Happily all seemed to go well and the night nurses got off duty on time.

Obstacles I had worried might occur were nurses getting off duty late, or refusing to comply with the process. The emphasis throughout the pre-trial time was on safety for the patient, and safety for the nurses' practice. As leader, this is how I endeavoured to get the nurses on board. I also talked with the nurses about the changes that had occurred in our practice with the move from team to primary nursing over the years.

I emphasised the recommendations from the Health and Disability commissioner's findings from incidents around clinical handover and encouraged them again to read the literature review.

I reminded the nurses that although we wouldn't wish to turn the clock back, years ago the nursing supervisor did a walk round with the nurse coordinator every shift and this involved a bedside handover. This isn't new, we have moved away from the bedside and now it is time to return.

Week two, and I am not totally convinced that everything is being handed over at the bedside. My reason for this is that yesterday the agency afternoon nurse came to tell me that two of the patients

she was looking after had no observations documented for the shift! I informed her that if the observation sheet had been sighted at the bedside, this would have been picked up, and the morning nurse could have addressed the issue at the time. What disappointed me was that I had just given the staff a presentation on the clinical handover project and both these nurses were there!

Clearly I would need to demonstrate to the nurses what my expectations were. This I did after the next global handover. A role play was acted out. One of the nurses was the patient, another handed over the patient to me. This caused great hilarity as we engaged with the patient. It also gave me the opportunity to point out what my expectations were by asking questions around risk assessment. For example, what was the falls risk score? Were there any medical alerts? Was there a restraint form filled in? I felt the role play was accepted in the spirit that was intended, as an example of what was best practice.

Week three and I invited the project manager, Ros, to come up and observe some of the handovers at the bedside. I took the opportunity to observe as well, and so did the Ophthalmology nurse specialist (Pip). Ros and I were pleased with what we observed on the whole, although Ros said the nurses didn't ask the patient if they were happy to have the relatives stay during the handover, and didn't look for the wrist label to identify the patient. Ros acknowledged that both nurses may well already know the patient. However, I pointed out that sometimes wrist labels are cut off patients to insert IV luers. I commented that it would be good to observe when the patients were of higher acuity, and there were more complexities. Overall we felt the process was being adhered to.

Pip, the CNS, felt that the Ophthalmology day casing patients could do with a simpler process and that we could perhaps laminate the checklist and ask nurses to refer to that on the way around with the integrated care plans. She felt that the process wasn't running as smoothly as it could. We all agreed that this sounded like a good idea and I suggested I would bring all these issues up at the next ward meeting.

Also, I prepared a PowerPoint presentation about where we were with the project and about the background and findings from the literature review. Although a copy of our very comprehensive literature review was up on the focus board for all to read, I suspected that many nurses had not taken this opportunity. I presented to the nurses, giving them the opportunity to ask questions, and listening to them. At the global handover each day I took the opportunity, as CNM, to emphasise the safety aspects for the patient and for the nurse's practice of the bedside handover. The nurses were also given an opportunity to raise any concerns they had. One problem that the nurses had

encountered was after hours. The emergency department was still sending patients up on handover time. I informed the nurses I would take this up with the duty managers., and enter discussion with the emergency department staff. The handover time must be protected.

Regular updates in the form of e-mails to the clinical handover group continue to provide support, encouragement and motivation especially to the pilot wards.

On completion of the trials a huge basket of goodies and thank you cards arrived at each ward for the nurses. This was from the clinical handover project group and did much to boost morale.

Issues identified from the trial were, some resistance to change, the importance of leadership, and lack of documentation to fully support the process.

Resistance.

The nurses in ward X had previously remained in the office following the global handover, which was given by the CNM or co-ordinator. Following allocation the am nurses came into the office also and individual nurses handed over again to the nurse taking over her/his patients. There was no systematic way of meeting and greeting the patients and often no reference to the care plan or any other documentation. Some of the nurses continued to linger in the office, and were reluctant to move on to the bedside directly following the global handover. They were resistant to change, as this had become a social time as well and they were comfortable with the old way of doing things.

In an effort to eliminate resistance to change in the workplace, managers historically used an autocratic leadership style with specific guidelines for work, an excessive number of rules, and a coercive approach to discipline (Burrit, 2005). The resistance, which occurred anyway, was both covert, (such as delaying tactics or passive-aggressive behaviour) and overt (openly refusing to follow a direct command). The result was wasted managerial energy and time and a high level of frustration.

Today, resistance is recognised as a natural and expected response to change (Burrit, 2005). Contemporary managers immerse themselves in identifying and implementing strategies to minimise or manage this resistance to change. One such strategy is to encourage subordinates to speak openly so that options can be identified to overcome objections. Likewise, workers are encouraged to talk about their perceptions of the forces driving the planned change so that the manager can accurately assess change support and resources. In addition, managers should be sure

to plan for and create short-term wins, so that followers can recognise and celebrate progressive change along the way (Burrit, 2005).

The nurses were gently reminded that the handovers were at the bedside now, and the patients included in the process, which was now a structured one, with the checklist to guide them. I reminded the nurses that they needed to go promptly to the bedside in order to ensure their am colleagues did not get home late. They took this in good spirit.

Planned change as a collaborative process.

Although this change was planned and the nurses had been prepared for it, realistically the change was top down. The clinical board and the nursing directorate were responding to findings nationally from the Health and Disability commissioners reports, and internationally, from incidents that had adversely affected patients outcomes. This was supported also from incidents at our hospital and the quality and risk department had plenty of evidence of these. In this sense the change was not collaborative.

When change agents fail to communicate with the rest of the organisation, they prevent people from understanding the principles that guided the change, what has been learned from prior experience, and why compromises have been made. Likewise subordinates affected by the change should thoroughly understand the change and how it affects them as individuals. Good open communication throughout the process can reduce resistance. (Marquis & Huston, 2008)

Leaders must ensure that group members share perceptions about what change is to be undertaken, who is to be involved and in what role, and how the change will directly and indirectly affect each person in the organisation. This was especially apparent in research(Gradwell, 2004), which examined the impact of the leader's communication of a planned change on the leadership team's credibility to carry out that change.

The easiest way for a manager to ensure that subordinates share this perception is to involve them in the change process. When information and decision making are shared, subordinates feel they have played a valuable role in the change. (Marquis & Huston, 2008) suggest that to encourage and maintain motivation within the team, staff must feel empowered to develop their own initiatives. Change agents and elements of the system- the people or groups within it- must openly develop goals and strategies together. All must have the opportunity to define their interest in the change, their expectation of the outcome, and their ideas on strategies for achieving change.

It is not always easy to attain grassroots involvement in planning efforts. Even when managers communicate that change is needed and that subordinate feedback is wanted, the message often goes unheeded. Some people in the organisation may need to hear a message repeatedly before they listen, understand, and believe the message. If the message is one that they do not want to hear, it may take even longer for them to come to terms with the anticipated change.

Nurses in the wards were not involved in the grassroots planning for the change in the clinical handover process. Perhaps this could have been done better. The decisions were made at the level of the clinical board and nursing directorate level. However, it was done with the best of intentions, and these were, to improve patient safety, and safety in nursing practice, and ultimately improve outcomes for our patients. My job as leader was then, to get this message across to the nurses to get their buy in. I had to persuade them and then keep them motivated and on track. Communication was the key throughout.

Documentation.

Because of the focus on documentation in the pilot study I was able to identify early on the inadequacies of our care planning. We had already been made aware of this with the feedback from accreditation, however this new process highlighted the issue.

In the 1990s, at Waikato Hospital, integrated care plans had been developed for elective surgery patients in particular but also for other diagnostic patient groups. These clinical pathways had not been fully developed or adhered to, and in the meantime we had moved away from the nursing process. No clear goals were identified, and importantly no documentation of evaluation of meeting any goals of care was evident. This resulted in a working group of senior nurses and allied health members being set up. From this group, new patient admission forms, goals of care (patient and nurse and patient), care plans, discharge planning documents and guidelines on how to evaluate and document the goals were being trialled in another part of the hospital just as our handover project was underway.

At the completion of the project, and after consultation with the clinical nurse director, our ward was added to the trial wards for the care plans. This new documentation has given weight to our checklist and to the whole handover process as it pulls together and reinforces risk identification giving clarity to the important issues. It also gives importance back to the nursing process.

Watkins undertook considerable work in the clinical area before the introduction of the bedside handover, to address the use of care plans due to the move from nurse-centred to patient-centred care. (Watkins, 1997) With the benefit of hindsight, this would have been a wise move prior to the commencement of our project.

Nurses should be continually assessing their patients and planning and evaluating care. Although we view the terms assessment, problem identification, planning, implementation and evaluation as separate progressive steps, in reality they are inter-related. This is because nurses are continually with their patients and therefore each stage merges so that the whole process forms a continuous circle or cycle of events (McFarlane & Castledine, 1982).

The care plans that were in use while the trial was on were not adequate. They addressed the daily changes of care the patient was receiving, but there were no goals of care set by the patient or the nurse. There was therefore no evaluation of the care. The nursing process had not been followed. Once the trial was over and the trial of the patient admission sheet and nursing care plans was underway on ward X, the documentation seemed to all fit and the process flow. On reflection, and in the perfect world, it would have been best to trial and then bed down the new care plan practice before commencing the clinical handover project.

Leadership

Throughout the pilot study, at times, I felt the weight of the responsibility of leadership upon me. I realised how important my role was to the success of the clinical handover project. Also, the nurses needed my continuing encouragement, enthusiasm and motivation to continue. In Watkins' 1997 study, acting as the change agent, the factors identified by Douglas as important in effecting change to the bedside handover were relevant. They are:

- Identifying the need for change and believing it is worthy of action.
- Enthusiasm and endorsement by the leader.(Watkins, 1997)

Leadership is an important issue related to how nurses integrate the various elements of nursing practice to ensure the highest quality of care for clients. There are two critical skills that every nurse needs to possess to enhance professional practice. One is a skill at interpersonal relationships. This is fundamental to leadership and the work of nursing.

The second is the skill of applying the problem solving process. This involves the ability to think critically, to identify problems, and to develop objectivity and a degree of maturity or judgement.

Leadership skills build on professional and clinical skills. (Hersey, Blanchard, Johnson, & Dewey, 2001) identified the following three skills needed for leading and influencing: diagnosing, adapting, and communication.

Among the important personal leadership skills is emotional intelligence. Based on the work of (Goleman, 1995), relational and emotional integrity are hallmarks of good leaders. This is because the leader operates in a crucial cultural and contextual influencing mode. The leader's behaviour, patterns of actions, attitude, and performance have a special impact on the team's attitude and behaviours and on the context and character of work life. Followers need to depend on role consistency, balance, and behavioural integrity from the leader.

The four set skills needed by good leaders are self awareness, self management, social awareness, and relationship management. These leadership skills are crucial to the work of leadership. The chaos and complexity of the seismic shifts in health care structure, delivery, form, technology, and content have made visible the urgent need for leaders to emerge, mobilize, and encourage followers.

Leaders are key to bridging the efforts of followers with the goals of the organisation. This is both tricky and risky and may be overwhelming (Porter-O'Grady, 2003). Good leaders are anchors to the vision and the larger goal, guides to coping and being productive, and champions of energy and enthusiasm for the work.

As clinical champion of the clinical handover project for the hospital I was committed to ensuring the project was a success. My job was to motivate the team and keep energy levels up by showing commitment and enthusiasm. As a member of the clinical board I felt a responsibility to ensure the goals of the organisation were being met. As CNM of a trial ward, I felt totally responsible for selling the new process to my nurses and making it work. I was keenly aware that for the change to be sustained, the nurses had to see the benefits for themselves. I tried to keep my message simple, and focus on, safety for the patients, and safety for the nurses' practice.

5 RESULTS

The day of the final meeting for our clinical handover project group. arrived. After welcoming everyone, I asked for feedback from the pilot areas.

Firstly, ward Z.

The CNM had adapted the handover structure to fit the particular culture. At the rural hospital, everyone knows the patients because the town is so small. The staff mix is also different from a big hospital in that there may be only one registered nurse on the shift with health care assistants and nurse aids. The co-ordinator of the previous shift handed over at the bedside to the co-ordinator of the incoming co-ordinator using the bedside checklist.

The response from the nurses was positive. The response from the patients was very positive. In fact, patients were now sitting up waiting for the nurse and offering their hand to get their wrist label checked! The process would continue.

From the post-natal ward, ward Y.

A positive response from the nurses with some of the doubters turning into champions of the project after reading the literature review! A very positive response from the patients who loved having the opportunity to have their voice heard. Also there was a double check of identity as the baby's wrist label was checked as well. The process would continue.

From my ward, ward X.

A very positive response from the patients, who love being introduced to their nurse. Some nurses comply with the process more thoroughly than others. We will continue with the process but the checklist may need some refining. Works best with higher acuity patients. The new care plans we are trialling are a good fit for the whole process.

The CNMs were commended for their leadership by the PMO, and I made mention in particular of how impressive this was, because one of these people did not have the support her manager, yet still managed a positive outcome. Another had grave reservations initially about the response of her

nurses to such a big change. For myself, I was delighted with how seamlessly my nurses had adapted to the change.

Summary of results from post trial staff and patient questionnaires

Results from post trial patient and staff questionnaires were presented at this meeting.

See appendix 9 and 10.

Overwhelmingly, patients supported the bedside handover. They enjoyed being included in their plan of care and sharing information.

Sixty-nine percent of nurses supported the bedside handover, with those who didn't voicing concerns around privacy.

The CNMs from the trial wards were now asked to determine what they thought the likelihood of the changes to the handover being sustained were.

Importantly, the project was given a high sustainability score. See appendix 11.

This was a tremendous boost to me as the clinical champion of the project, as I felt the seeds have been well and truly set, to begin rolling this process out to the remainder of the hospital and so make a real difference to patient safety and outcomes.

6 RECOMMENDATIONS AND CONCLUSION

Recommendations for the new handover

Following the effort put into this body of work, one must look at the learnings, and plan a way forward that ensures clear messages, are delivered. A succinct, well structured, standardized clinical handover, that is current and supports documentation, is the communication we must expect, to ensure safety for the patient and the nurses practice. Here are the recommendations:

- That the clinical handover process be rolled out to the rest of the DHB, with guidelines and the recommended handover tool.
- That the process be extended, to include interdepartmental and inter hospital transfers.
- That nurses receive information around privacy issues.
- That a package is made available from the Project management office as a resource for other wards .This is to ensure the success of a new process, and an audit tool is to be included.
- That the importance of strong leadership to support the organisation with this new process be acknowledged.
- That nurses be made aware of the power this process gives to the documentation, in particular the care plan.
- That resistance is to be acknowledged as part of the change process.

I urge senior nurses and managers of hospitals in New Zealand, to accept these recommendations for a robust clinical handover process that will strengthen communication, and so provide increased safety for the patient and their nurses' practice. The new clinical handover process is a good fit with the lean thinking principles and productive wards. Improved patient outcomes must follow. The way we will know they have improved ,is to revisit incident forms post the new process.and monitor the change ,by regular audits from the nursing directorate.Only then will we truly be able to see the difference this new process has made.

Conclusion

Support for this project came from Waikato DHB, and the clinical nurse directorate, in order to address issues of poor patient outcomes, which were identified from Health and Disability reports and from incidents nationally, and internationally, that resulted in poor patient outcomes. The scope of this project was for nurses shift to shift handover but it is my hope that the process will extent to inter departmental, and inter hospital transfers.

Clinical handover practice is not straight forward. There is not one best way of doing things. Evidence does show that a combination of ways does work. These include, verbal, written and bedside handover involving the patient.

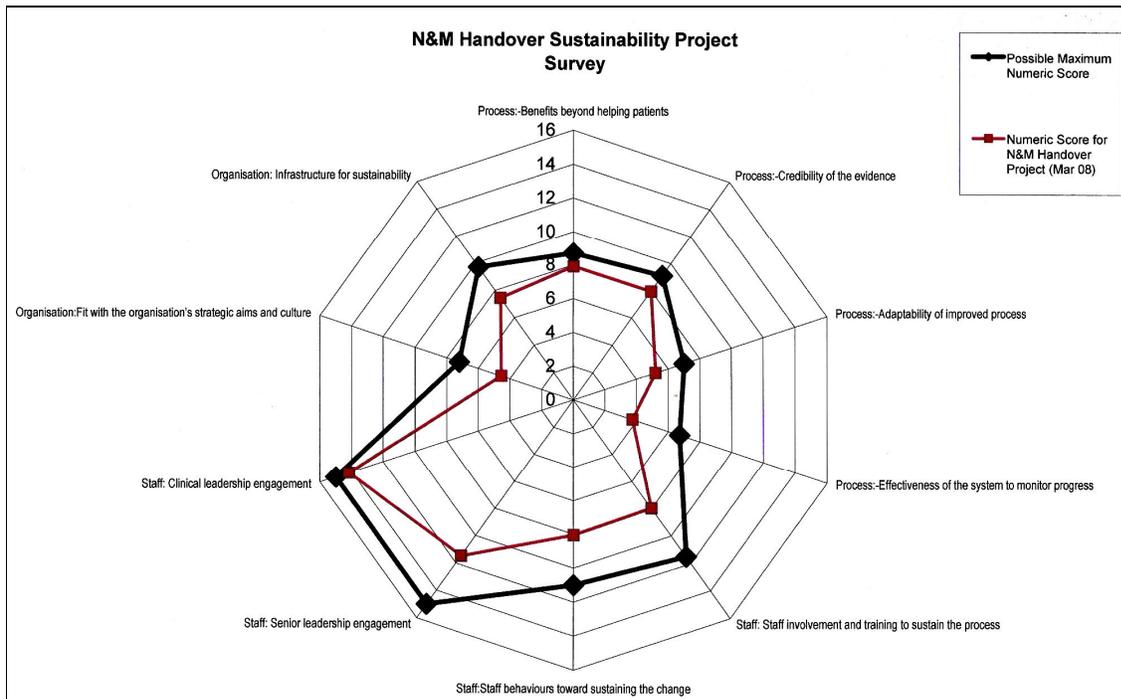
The focus on patient safety and on the safety of the nurses' practice has meant that most nurses support the new process. Those who don't had issues around privacy, with patients in rooms with other patients. These issues have been acknowledged, and addressed in the implementation tools with a statement from the hospital lawyer around the rights of the patient to be fully informed, and the expectation that dealing with issues around patient privacy is part of the expectation around nursing professionalism (see appendix 12). Patients overwhelmingly supported the new handover process and in particular enjoyed the input into their plan of care.

This study has not been just a project for me, rather, a mission to improve safety for the patient and for the nurses' practice. It will be a challenge to change something that has become so entrenched in nursing practice, but the gains will make the change worthwhile. The joy for me, with this project, has been in working with other nurses, to promote safety for the patient, and for our nurses' practice. My wish is simply that the patient's voice be heard, and that patients' outcomes improve.

7 APPENDICES

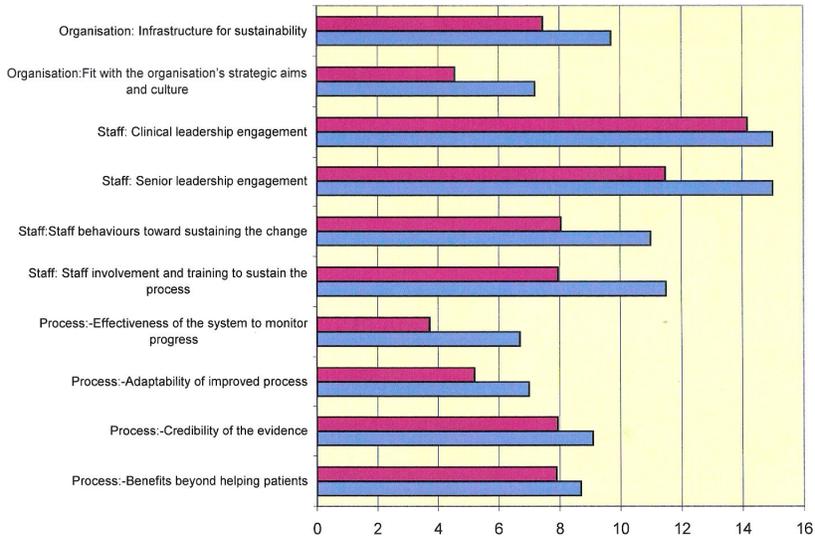
Appendix 1-Tables/Graphs showing sustainability scoring.

N&M Handover Sustainability Project Survey	Possible Maximum Numeric Score	Numeric Score for N&M Handover Project (Mar 08)
Process:-Benefits beyond helping patients	8.7	7.9
Process:-Credibility of the evidence	9.1	7.9
Process:-Adaptability of improved process	7	5.2
Process:-Effectiveness of the system to monitor progress	6.7	3.7
Staff: Staff involvement and training to sustain the process	11.5	8.0
Staff:Staff behaviours toward sustaining the change	11	8.1
Staff: Senior leadership engagement	15	11.5
Staff: Clinical leadership engagement	15	14.2
Organisation:Fit with the organisation's strategic aims and culture	7.2	4.6
Organisation: Infrastructure for sustainability	9.7	7.5
Total	100.9	78.4
Total No. Surveyed		10



N&M Handover Sustainability Project Survey

■ Numeric Score for N&M Handover Project (Mar 08)
 ■ Possible Maximum Numeric Score



	Process: Benefits beyond helping patients	Process: Credibility of the evidence	Process: Adaptability of improved	Process: Effectiveness of the system to	Staff: Staff involvement and training to	Staff: Staff behaviours toward	Staff: Senior leadership engagement	Staff: Clinical leadership engagement	Organisation: Fit with the organisation's	Organisation: Infrastructure for sustainability
■ Numeric Score for N&M Handover Project (Mar 08)	7.9	7.9	5.2	3.7	8.0	8.1	11.5	14.2	4.6	7.5
■ Possible Maximum Numeric Score	9.1	9.1	7	6.7	11.5	11	15	15	7.2	9.7

Appendix 2-Project Scope

	Project Scope
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Title	Nursing/ midwifery shift handover project
Prepared by	Carey Campbell
Group	Nursing / Midwifery Directorate
Date	February 2008
Version	FINAL
Project Statement	The intention of this project is to develop and implement a framework for best practice with regard to nursing/ midwifery shift handover within Health Waikato hospitals' inpatient areas.
Objectives	<ul style="list-style-type: none"> • To review relevant literature to identify best practice for clinical handover between nurses/midwives. • To review the range of current nursing/ midwifery shift handover practice and tools used within Health Waikato hospitals' inpatient areas • To undertake a gap analysis to identify areas where current practice deviate from recommended best practice. • To develop a framework for nursing/ midwifery shift handover which reflects best practice • To develop appropriate processes and tools that may assist staff to implement best practice shift handover in their areas • To develop and action a communication plan to ensure project outcomes are disseminated to appropriate areas • To develop a process to evaluate the effectiveness of the framework
Strategic Linkage	<p>This project supports the tenets of clinical governance and the direction outlined in the Health Waikato Quality Plan, the DAP and the DSP.</p> <p>This project is directly linked to the strategic aims of Waikato DHB's Nursing and Midwifery Strategic Plans (2007-2011), hence the sponsors of this project being the Nursing and Midwifery Directorate.</p> <p>This project is part of the Star suite of projects/ initiatives.</p>
Background	<p>Any point at which transfer of information about the care or condition of a patient occurs has the potential for communication to be ineffective or inadequate leading to compromised care. This includes shift handover; ward/ hospital transfers; discharge; individual transfer of care. Handover of information among nurses/midwives occurs frequently and continuity of care is fragmented due to the various shifts worked by nursing/midwifery staff. Therefore a consistent approach to clinical handover is important to ensure effective, accurate information transfer.</p> <p>A number of incidents and patient complaints have direct links to poor communication at handover. Communication issues may be exacerbated by such aspects as increasing cultural diversity in our workforce and workload demands. This can, at times, be linked to differences in staff cultural backgrounds and where English is not a first language. Despite dealing with issues on a case by case basis, these problems continue to occur. A systematic and standardised approach to handover may improve the quality of clinical handover and therefore improve quality of care and reduce risks resulting from this poor communication.</p> <p>Whilst it is noted that effective transfer of clinical information may be linked to other disciplines, this is outside the scope of this immediate project. This, however, does not restrict the outcomes from this project from being used in the future for the benefit of interdisciplinary handover or other discipline's handover.</p>

Approach	<ul style="list-style-type: none"> • Literature review and identification of best practice from the literature • Audit and document current Health Waikato hospitals practice around clinical handover • Record and evaluate lived patient experiences • Collect baseline data related to clinical handover incidents • Determine sustainability of project (Programme Office audit tool) • Analyse Health Waikato practice against best practice (GAP analysis) • Develop model for standardised approach to clinical handover based on best practice relevant to and useful in the Health Waikato context • Pilot model in Ward X Waikato Hospital, Women's Assessment Unit Waikato Hospital, and Taumarunui inpatient ward. • Evaluation of pilot model and modification made if appropriate • Deliver product of Handover Model to Nursing Directorate and STAR Steering Group with recommendation to implement across organisation
Completion Criteria	<ul style="list-style-type: none"> • Health Waikato framework for nursing/ midwifery shift handover is authorised and available for implementation • Any processes and tools required are developed, documented and available for use • Evaluation process of pilot is completed with recommendations • Objectives of project have been met.
Exclusions	This project will not include handover processes with other disciplines.
Projected Benefits	<ul style="list-style-type: none"> • Improved communication resulting in a reduction in preventable adverse events • Potential to be used as concise effective documentation tool • Potential for use as communication tool in a variety of contexts between different roles. • Increase staff satisfaction from better teamwork/ collaboration with peers forming closer relationships and understanding/ appreciation of each other. • Increase patient satisfaction by decreasing error/ confusion from miscommunication • Improve care across the continuum • Sustainable model for implementation
Internal Stakeholders	<ul style="list-style-type: none"> • Nurses/midwives working in inpatient areas • Managers • Clinical Board • Communications – including Vis comm. • Quality and Risk • Learning and development • Nurse Education / Education & Support Unit • Other HW Staff/ members of MDT • IS • PMO
External Stakeholders	<ul style="list-style-type: none"> • Patient and families • Consumer trust advocates
Implications for Maori	<ul style="list-style-type: none"> • Maori constitute 22% of the Waikato population • Improved staff communication of patient needs will contribute to improved health outcomes. • Strong links with Kaitiaki and cultural assessment/ interventions is crucial
Project Structure and Resources.	<ul style="list-style-type: none"> • Health Waikato Executive • STAR Programme Steering Group • Project Sponsors – Nursing and Midwifery Directorate • Project Leader (ability to co-opt other members if required) – Jacquie Wynne-Jones

	<ul style="list-style-type: none"> • Project Group (see list below) • Project Manager, Programme Management Office • Q & R • Communication / Viscom 										
Key milestones and timeline	<p>Project will be completed in six months (August 2008)</p> <p>Milestones:</p> <ol style="list-style-type: none"> 1. Project Scope agreed and signed off (2 wks) 2. Complete literature review. (3 wks) 3. Complete audit of current practice (3 Wks) 4. GAP analysis and patient interviews (2 wks) 5. Develop new model for trial (3 wks) 6. Test model in three pilot sites (3 wks) 7. Evaluation and recommendations (4 wks) 8. Tolerances and slippage (6 wks) 										
Project relationships and linkages	<ul style="list-style-type: none"> • Early Warning Systems • Care planning and Discharge Planning • SBARR 										
Financial Summary	<p>Project costs shall be met from within current budget.</p> <p>Sponsors will authorise any specific expenses during project timeframe.</p> <p>Managers of team members to approve time release for project team members</p>										
Risk management	<table border="1"> <thead> <tr> <th data-bbox="406 976 909 1050">Risks associated to the project.</th> <th data-bbox="909 976 1409 1050">Risk Mitigation</th> </tr> </thead> <tbody> <tr> <td data-bbox="406 1050 909 1228"> <ul style="list-style-type: none"> • Staff opposition to change </td> <td data-bbox="909 1050 1409 1228"> <ul style="list-style-type: none"> • Representation on group • Education package effectively delivered • Regular communication • Identification of champions </td> </tr> <tr> <td data-bbox="406 1228 909 1302"> <ul style="list-style-type: none"> • Communication strategy not meeting people's needs </td> <td data-bbox="909 1228 1409 1302"> <ul style="list-style-type: none"> • Strong link with communications department </td> </tr> <tr> <td data-bbox="406 1302 909 1491"> <ul style="list-style-type: none"> • Time Resource for project group </td> <td data-bbox="909 1302 1409 1491"> <ul style="list-style-type: none"> • Project leader will structure meeting time to measure progress. • Project leader and Quality Support person will meet regularly • Timely reporting of exceptions to framework and issues to sponsors. </td> </tr> <tr> <td colspan="2" data-bbox="406 1491 1409 1627"> <p>Risks we are exposed to if we do not proceed with the project.</p> <ul style="list-style-type: none"> • Continued patient and staff incidents/ complaints • Potential for significant adverse patient outcomes • H & D Cases in other DHBs consumer's rights </td> </tr> </tbody> </table>	Risks associated to the project.	Risk Mitigation	<ul style="list-style-type: none"> • Staff opposition to change 	<ul style="list-style-type: none"> • Representation on group • Education package effectively delivered • Regular communication • Identification of champions 	<ul style="list-style-type: none"> • Communication strategy not meeting people's needs 	<ul style="list-style-type: none"> • Strong link with communications department 	<ul style="list-style-type: none"> • Time Resource for project group 	<ul style="list-style-type: none"> • Project leader will structure meeting time to measure progress. • Project leader and Quality Support person will meet regularly • Timely reporting of exceptions to framework and issues to sponsors. 	<p>Risks we are exposed to if we do not proceed with the project.</p> <ul style="list-style-type: none"> • Continued patient and staff incidents/ complaints • Potential for significant adverse patient outcomes • H & D Cases in other DHBs consumer's rights 	
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Project Opportunities	<table border="1"> <thead> <tr> <th data-bbox="406 1627 909 1680">Opportunities</th> <th data-bbox="909 1627 1409 1680">Strategy</th> </tr> </thead> <tbody> <tr> <td data-bbox="406 1680 909 1858"> <ul style="list-style-type: none"> • Enhanced relationships • Improved clinical communications • Shared understood language • Increased patient/ staff satisfaction • Improved patient flow • Increased patient involvement in care </td> <td data-bbox="909 1680 1409 1858"></td> </tr> </tbody> </table>	Opportunities	Strategy	<ul style="list-style-type: none"> • Enhanced relationships • Improved clinical communications • Shared understood language • Increased patient/ staff satisfaction • Improved patient flow • Increased patient involvement in care 							
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<ul style="list-style-type: none"> • Enhanced relationships • Improved clinical communications • Shared understood language • Increased patient/ staff satisfaction • Improved patient flow • Increased patient involvement in care 											

Project group: NB: the project leader has the ability to co-opt other members as appropriate

Jacquie Wynne-Jones	CNM: ENT/ eyes	Project leader
Sue Akehurst	CNM: HDU	
Daphne Fergusson	CNM: Taumarunui	
Nancy Pomfrett	RN: Thames	
Niki Houghton	NE: ENT	
Elaine Fernandes	CRN	
TBA	Mental Health rep	
Diane Kemp	CMM – Ward Y - Midwifery rep	
TBA	Maori Health rep	
Anne Ellison	CNM, General Surgery	
Ros Morell	Project Manager, PMO office	
Rhonda McKelvie	Practice Development facilitator	
Sue Stretton	Q&R support	

Sign-off
(signatures
required)

Project Sponsor

Date

Project Sponsor

Date

Project Sponsor

Date

Project Leader

Date

Appendix 3-Samples of Handover Forms

Hand-off Form	
SITUATION:	Patient Sticker
Dx:	Admit Date: _____
CC:	
BACKGROUND:	
Med Hx	
Allergies	
Code Status	
Interventions / Responses	
ASSESSMENT:	
Neuro	Vital Signs (include pain)
Respiratory	
Cardiac	Accu Checks
GI / GU	
Musculoskeletal	Abnormal Labs
Skin	XR results
Psychosocial	Lines / Fluids
RECOMMENDATIONS:	
Goals	
Consults	
Test / Treatments	
Discharge Needs	
<u>Admission</u>	<u>Daily</u>
Reconciliation	Turn q 2 hrs
CHF / AMI / Pneumonia Indicators	Fall Protocol
	Restraint Protocol
<u>Discharge</u>	
Pneumonia Vacc	

Figure 3. The hand-off form can be used by nurses at shift change.

Davies & Priestly, 2006).

BE D EXT	NAME	DIAGNOSIS PROCEDURE	TIME DAY POST	GENERAL NURSING CARE		CURRENT INFORMATION e.g. x-ray, CT, Path, Discharge	DIET
15.3 156	(SURNAME Given) (UR) (SURGEON) 59 Wodonga	Appendectomy perforated 17/10 Hx: Type 2DM Allergies	3	IVC IVT IV AB BGL	DRAIN PCA IDC		FF Low Fat
15.4 157	(SURNAME Given) (UR) (SURGEON) 76 Wodonga	Chest pain F.I 19/10 Hx: Lung Ca 07, Cardiac Allergies: Morphine		IVC IVT IV AB BGL	DRAIN PCA IDC	Telemetry	LWD
16.1 158	(SURNAME Given) (UR) (SURGEON) 56 WODONGA	SBO 19/10 Hx: SBO Allergies		IVC IVT IV AB BGL	DRAIN PCA IDC	AWDS AXR PM	FAST
16.2 159	(SURNAME Given) (UR) (SURGEON) 40 Leeton	TAH 17/10 Hx: Allergies	3	IVC IVT IV AB BGL	DRAIN PCA IDC	Home Sun	LWD
16.3 160	(SURNAME Given) (UR) (SURGEON) 92 Yackandandah	Laceration R) leg Debridement R) Calf 6/10 Donor R) thigh Hx: Arthritis Allergies: Morphine	7	IVC IVT IV AB BGL	DRAIN PCA IDC	STRICT RIB Falls Risk Ripple mattress	LWD
16.4 161	(SURNAME Given) (UR) (SURGEON) 28 Wodonga	Cholelithiasis 19/10 Hx: G4 P4 Smoker Allergies		IVC IVT IV AB BGL	DRAIN PCA IDC	Breast Feeding Day Leave	FF Low Fat
17.1 162	(SURNAME Given) (UR) (SURGEON) 71 Tallangatta	Cholecystitis Hx: DM-2 ^BP Anxiety Allergies		IVC IVT IV AB BGL	DRAIN PCA IDC		FF Low Fat

WODONGA REGIONAL HEALTH SERVICE

(Wodonga Regional Health Service)

Keeping PACE: A sample report

Here's a sampling of notes a nurse might keep using a PACE template to improve oral shift report:

- P:** Room 49, S.J. Lake, 50 y.o. female, s/p stroke 10/6.
L-sided weakness, expressive aphasia.
Hx: HTN, CAD, type 2 DM, NKDA.
N.P.O. HOB up 45 degrees.
- A:** Aspiration precautions. High fall risk.
VS/neuro q4: stable. Lungs clear. Normal active BS.
SpO₂ 94% on 2 liters NC.
PTT 65, Heparin gtt @ 1200 units/hr.
- C:** Next PTT @ 1300.
OT later this a.m. re: ADLs.
Family meeting @ 1530 w/ SW.
Plan: PEG tube placement later this week.
Plan: for d/c to LTC facility next week if possible.
- E:** Communicates well using word board.
Denies pain.

(Schroeder, 2006)



(UNIT) Nursing Standards for Patient Safety During Transfer of Accountability

- This information must be communicated when transferring care of the patient
- Each nurse is responsible for documenting that the process of **Transfer of Accountability** and **Patient Safety Checklist** is complete
- Patient's name, age and diagnosis should be stated first

Plan of Care

- | | |
|---|---|
| <ul style="list-style-type: none">- Code status- Past medical history relevant to current situation- Complications- Patient/family goals for next 12 hours | <ul style="list-style-type: none">- Shift orders and future one-time orders- Consults- Infection control- Medication administration issues |
|---|---|

Patient Status Review

Vital Signs

Pain

Neurological

Cardiovascular

Respiratory

Gastrointestinal

Genitourinary

Musculoskeletal

Integumentary

Reproductive

Discharge Planning

Family, psychosocial, spiritual, cultural/ linguistic issues

Lab Work &

Diagnostic Tests

Intravenous &

Invasive

Lines/Drains

Bedside Patient Safety Checklist

- | | |
|---|--|
| <ul style="list-style-type: none">- Armband on patient (or photo)- IV solutions & infusions; matches MAR | <ul style="list-style-type: none">- Allergies & alerts reviewed- Monitor alarms on- Risk concerns (e.g. restraint use) |
|---|--|

(Alvarado et al., 2006).

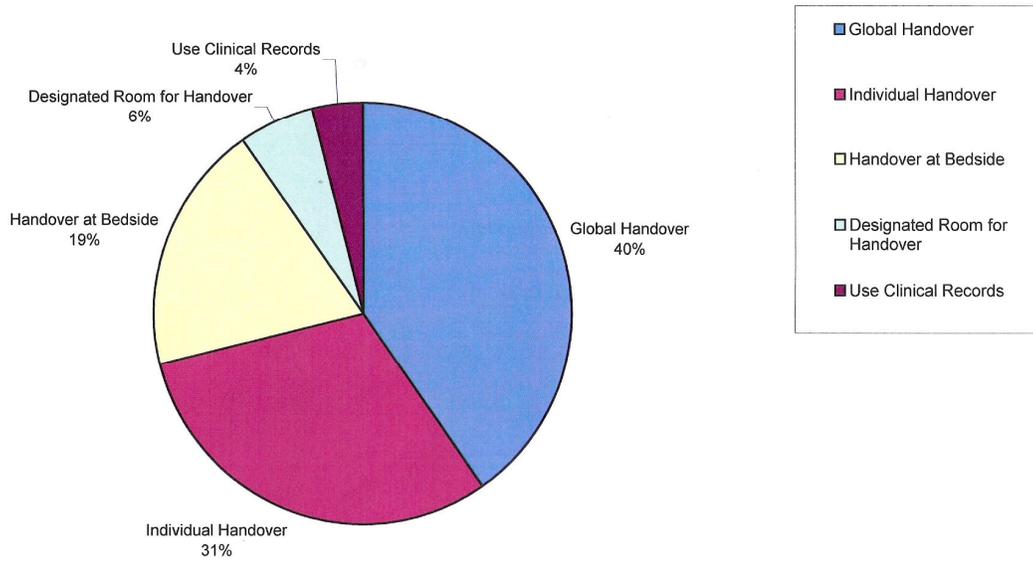
Handover Report Template

1 Patient Name		3 Primary MD																																																																																																																									
2 Admission Date Complaint Diagnosis		4 Significant History																																																																																																																									
5 Assessment		9 IV	11 LABS																																																																																																																								
LOC/Mentation PAIN Psych/Soc/Spirit Neuro GI Abd Diet BS BM GU Musculoskeletal Activity 6 Fall Status		Gauge Site Fluid Rate <hr/> 10 Intake Po .. IV .. Other Restrictions Output Foley Void NG Ostomy JP / Hemovac Chest Tubes other	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;"></th> <th style="width: 20%;">WBC</th> <th style="width: 20%;">RBC</th> <th style="width: 20%;">H/H</th> <th style="width: 20%;">PT</th> <th style="width: 20%;">INR</th> <th style="width: 20%;">PTT</th> <th style="width: 20%;">Platelets</th> </tr> </thead> <tbody> <tr> <td>PRNs/Treatments/Events</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___7</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___8</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___9</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___10</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___11</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___12</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___1</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___2</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___3</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___4</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___5</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___6</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>___7</td> </tr> </tbody> </table>		WBC	RBC	H/H	PT	INR	PTT	Platelets	PRNs/Treatments/Events															___7								___8								___9								___10								___11								___12								___1								___2								___3								___4								___5								___6								___7
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14 Changes in condition (new clinical findings)		17 New Orders																																																																																																																									
15 Consults		18 Discharge Plans																																																																																																																									

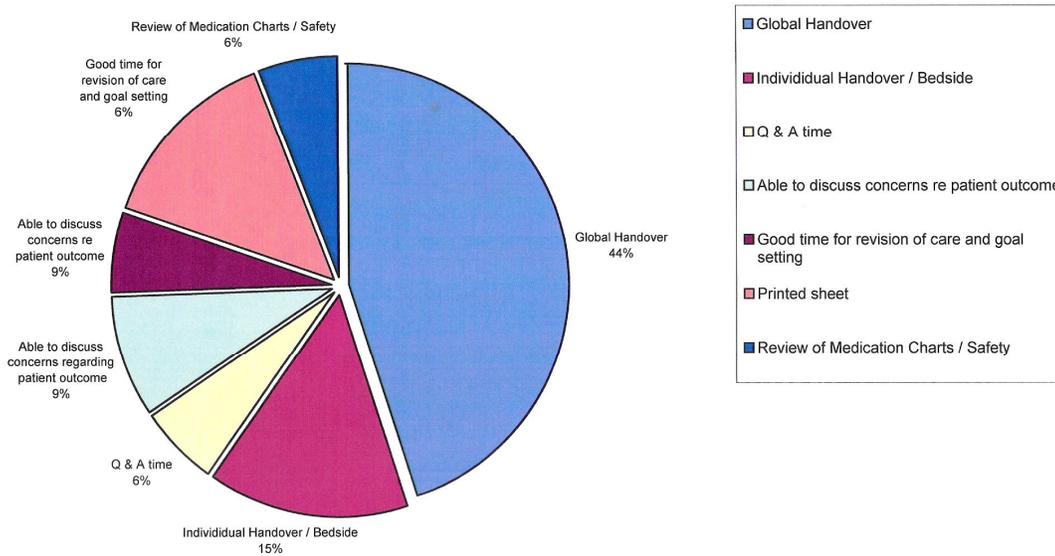
(Wilson, 2007)

Appendix 4- Results from pre-trial staff questionnaires

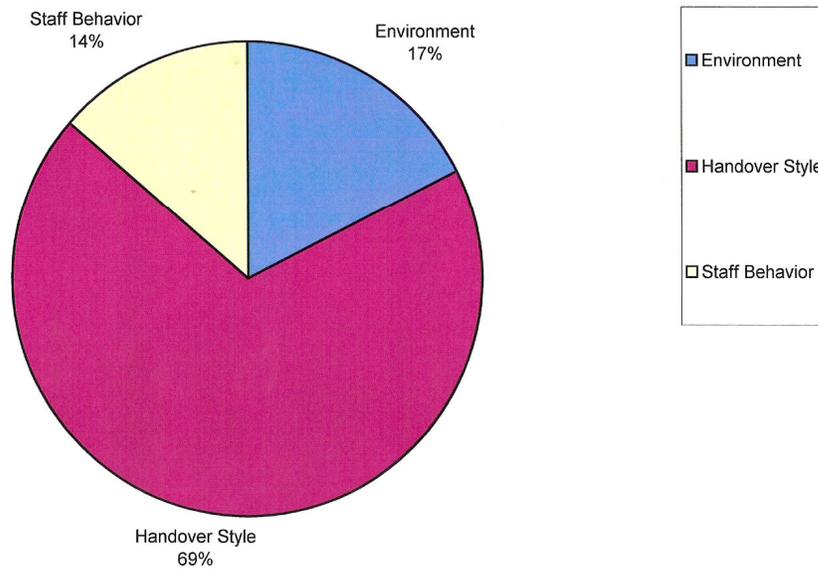
Current Practice in Nursing Handover



What works well for you in your current handover practices?



What does not work well for you in your current handover practices?



Appendix 5- Results from pre-trial patients questionnaires

Nursing and Midwifery Clinical Handover Project

Pre pilot PATIENT Questionnaire

Demographic information:

60% female

40% male

Age range:

20 - 30	26%
31 – 40	20%
41 – 50	0
51 – 60	0
61 – 70	0
71 – 80	20%
81 >	34%

Room configuration:

Single room	47%
Double room	27%
4 bed room .	20%
6 bed room	6%

Q3. When each shift finishes, do you think your nurse / midwife hands over your care to the next nurse/midwife?

60% patients thought there was some kind of handover

33% not sure

6% did not think so.

Q4. If No (to the previous question) how do you think the next nurse / midwife finds out about your care?

- Some patients thought that the staff 'just knew', read the notes or asked the patient.
- One patient commented that she liked it when the staff came to introduce themselves.

Q5. Would you like handover to happen at your bedside so you can be involved?

Yes	54%
No	34%
Not bothered	12%

Q6. If No - why not? Please comment.

- I trust them
- maybe the nurses should be with the doctor when they come round
- Depends on the scenario but yes - you should be involved
- Privacy - what happens at present is enough
- no reason really
- waste of nurses time, better they talk - can use their language, more efficient
- not interested
- nurses currently come at the start of the shift to discuss care needed

Q7. Does handover currently happen at the bedside?

Yes	6%
No	46%
Sometimes	13%

Q8. If Yes, are you involved in the discussion?

26% currently involved in the hand over discussion

Q9. Do you feel it would be valuable for you and your family to be involved in discussions with the nurses about your care? (Rated on chart 1 to 6 with 1 being least valuable and 6 being most valuable) , .

1	0
2	13%
3	13%
4	13%
5	20%
6	40%

73% respondents grade 4 and above

Q10. When your care is discussed at the bedside, do you have any concerns about confidentiality or your privacy?

13%	Concerned about privacy
66%	No concerns about privacy

Q11. Comments re privacy:

- Everybody is sick and nobody takes any notice anyway
- Worried about my details but not worried about sharing information. Worried about other patients
- If there was a room full of people I would not like them knowing my personal issues
- Do not want others knowing my business

Q12. Overall, please rate the level of confidence you feel that the 'nursing / midwifery staff will provide appropriate care for you.

1	0
2	0
3	0
4	20%
5	40%
6	40%

100% respondents replied indicated levels of confidence in the upper three rating levels.

Comments:

- Felt much better with 2 people at the bedside. Felt more comfortable with obvious transfer of knowledge at the bedside
- I forget half of what is said. A friend would be good - I can't hear. The nurse is only a kid but went to get help. I would like to know what is happening - they don't tell you anything.
- Felt fear - staff kept asking me if drugs had been given as they weren't
- charted. Felt alone at night time - I struggled. Change over needs to be more consultative . Staff said they would come back but never did. I really remember that. .
- Wanted family involvement. Different messages from midwives re family staying.

Appendix 6- Quality and Risk Data

Comparisons for Nursing and Midwifery Handover Project – Pre Trial in Ward Y, X and Z (rural) March/April 2008

	Ward X	Ward Y	Ward Z (rural)	Comment
Medication incidents reported	31 = 2.8/month	28 = 2.5/month	23 = 2.09/month	July 06 – June 07 = 11 months
Complaints	1	7	Nil	4 Sept 07 – 26 Feb 08
Incidents	23	18		4 Sept 07 – 26 Feb 08

Note – the data only reflects those reviewed with a component of issues which resulted from handover practices or those which could be improved on by handover practices – using key words communication, handover, near miss, falls, medication, pharmacist, infection control, and transfusion error.

Complaint verbatim:

Ward X – communication, patient not introduced to ward, no assistance from staff, (note patient had a baby); no staff when monitor alarmed, monitor removed with no communication; no pre-warning of transfer, Paediatrician not informed.

Ward Y – patient felt down at handover (nurse unable to assist then); inappropriate reply by nurse to question re clot in leg; baby’s crib not changed for 4 days, patient bed not made for 4 days; patient felt neglected when baby would not feed/crying, contradicting advice, medications (including pain relief) late or missed or charted as given (but not); heel prick test overlooked, lack of general advice re expected norms of baby behaviour; lack of communication re surgery

Ward Z - nil

Incident verbatim:

Ward X – medication (morning vs night – error picked up), two doses vs one; meds not given; luer left in 5 days; Dr request for 2 hourly post op BP not actioned (communication from time of theatre); hourly drops not administered for 9 hours (documentation); falls and care plan not started on admission – fall; O2 not charted; discharge prescription with wrong patient details picked up by family at home; checking of trache tapes (securing).

Ward Y – medication error on chart, charting issues (stickers on drug, signing), drug allergy not documented correctly – patient given two doses before stopped (patient no real allergy), patients admitted from ED incorrect patient label on med chart – picked up by Y, no documentation in clinical file between 1430 and 2300 – no one allocated to look after patient – IV drugs missed; blood specimen never sent for processing – later had transfusion; baby not handed over to staff (found in room by self); meds

given to wrong patient in same room; phlebitis scale 3 from cannula; provisional HIV positive test not reviewed for some time;

Ward Z (Rural) – wrong patient labels, medications given – not signed for (check drug, date, time, route); missed med doses (up to two days), family administering meds, high falls risk patient left in toilet for 3 minutes – pulled catheter out; patient declining meds not documented; meds administered which should have been withheld (CT scan procedure) – unclear documentation; care plan not updated (recent audits had highlighted poor documentation); Issue with two different tablets in one bottle not documented; graseby pump turned off for procedure – recheck of site, pump and tubing (including time and second signature) not documented by nurse; drug doses not counter signed; incorrect controlled drugs documentation; overdose of meds given; transfers from WPH – no wound care plan, drug chart, nurse discharge letter, no patient history (stated hip not knee).

Site visits:

Ward X – (ward includes a combination of longer stay, day stay and medical outliers).

Incidents - Staff reported most incidents include leurs, patients being transferred to the ward with no wrist bands (usually from ED), some slips and falls.

Complaints – two re paediatric patients (a nurse has taken a special interest in this area, upskilling ongoing).

Handover practices – currently a very pro-active ward.

Approach – CNM does a global handover (all staff at once) takes about 10-15 minutes. Nurses do a bed side handover for higher acuity patients discuss airway (view with torch), secretions, humidifier, nebs, suction, drains, wounds, NG feed rates, flushes, line changes, IV fluids, mobility, Pu, referrals sent, meds (takes 5 minutes for a simple visit, 10 for higher acuity patient and 15 if new nurse has not met the patient before).

Comments: Nurse rates this practice as good when between two staff of the same experience level.

Downside: timing as the nurses doing high acuity patient handover is often coordinating (multiple demands on time).

Patient label checks are not standard practice. Medication charts are not checked unless the patient is new. Allergy/alert discussion occurs during nurse 1-1. Monitoring of alarms – not an issue as problem equipment sent for repair. Risks are discussed (eg falls, restraint).

Ward – (includes ward, maternity, ED, HDU) running a team nursing trial – have not addressed handover issues yet (should not be an issue as everyone should document as they go – note this still does not record the actual handover, nor check content) –

issue is not documenting the plan of care. Could make use of SBARR process in handover.

Incidents – marked increase in medication incidents and problems eg drugs written QID and not given 4x day – issue is nursing practice, omission errors; size of drug room (very small, more than two staff – distractions).

Complaints – very few, mainly re communication.

Handover practices - original handover long winded, now use a printed sheet (name, dob, diagnosis, details of admission) - ; handovers often require the info that is not written down. Bedside handover is not supported (cite privacy); note this is for the entire handover to be done at the bed. Do not tend to get full details in handover eg name is, age is etc if the patient has been in a while; this was cited as an issue by CNE – might say the patient has diarrhoea but not that they were admitted with a fall, or had previous CVAs. Losing details in handover – staff refer to different forms eg ED, care plan or verbal – no consistency. (Did not like the care plan as you don't know the new patients to create the plan from – felt they should use ED form as this includes prioritising reason for presentation, Drs problem list and plan. Updates are often not done on care plan for patient change.

Approach – generic handover (10-15 minutes) then to patients bed side to discuss the patient plan of care (includes level of risk eg falls etc) for HDU patients primarily.

Patient labels are not checked, checking of med charts vs infusions is not standard practice, neither are allergy/alert review (stated it is one of the first things to view in patient file; usually talk about pump monitoring; risks (restraint/falls) are usually documented on care plan. Falls are on handover sheet but not usually discussed. Complications are discussed especially for HDU patients; goals for next shift are discussed eg you need to start this referral if you have time; infection control – usually on sheet – not always discussed. BP not normally discussed unless out of range; family discussed especially if issues with access and carers staying.

Comments – see their beliefs re privacy, team nursing trial – results of trial for handover project may differ between trial areas; use of SBARR in handover; losing detail in handover (this becomes an issue if there is no time to read patient files before beginning cares). No guidelines for content of typed handover sheet; would like a checklist when doing handover sheet eg NSTEMI (Cardiac) day 1 (lack of this knowledge was an issue for the EN who did not know what stage of care patient was up to).

Ward Y – maternity. Trialling a new care plan – this is highlighting gaps in the handover document eg that handovers are not discussing antibiotics.

Incidents - mainly communication problems – staff to staff eg I was not told the patient was on antibiotics. Medication – missed doses as not handed over.

Complaints - primarily re poor communication

Handover practices – use a daily run sheet (includes consultant, patient – some info is reasonably static ie G/P, Del, Blood, Baby). CNM finding gaps from current handover practice eg staff know the patient has high BP from handover, but not what the reading was or what was being done about it. If the nurse knows the patient meds are not usually discussed;

Approach CNM tries to be at afternoon shift handover. This handover takes 30-45 minutes off the ward; am = 15 -30 minutes. Not meeting staff needs as there is not enough detail. Staff write their own notes also. No bedside handover unless a complicated patient – not the norm. When a patient is transferred in from Delivery Suite there is a brief bedside handover. Different people give different quality and detail – some talk about everything they have done in the shift. Others commented they only needed who, why, background to pregnancy, baby ok/not; meds charted – oral due ..., IV due ... There is no guideline for what to include.

Violence, social, family abuse; drainage – what is draining/amount, wound ooze, NG feeds, IV fluids, mobility, referrals are discussed. Meds – sporadic handover, patient label, allergy/alerts and risks are not handed over.

Comments: Staff would engage in detail if they had to obtain the info which is currently pre-printed. Nurses identify errors are picked up when checking charts after handover which were not discussed at handover eg urine test done three days prior with high glucose but not followed up. Does new staff know the significance of info for handover? Think use of SBARR would be excellent.

Summary of information:

Common issues - Complaints	Common issues - Incidents	Common approaches to handover	Not standard practice to check	Standard practice to check (where relevant)	Be aware of
Communication re equipment, clinical norms, transfer, treatment; staff to staff re not receiving information in handover	Medication – time, overdose, missed, documentation, not withheld, Leur left in Drs request for obs not done	Global with CNM 10-15 minutes (name, dob, diagnosis, details of admission) then bedside for higher acuity patients	Patient labels Medication charts Infection control BP	Secretions, humidifier, nebs, suction, drains, wounds, NG feed rates, flushes, line changes, IV fluids, mobility, Pu, referrals	Handover at bedside is good when between two staff of similar experience Nurse doing bedside handover of high acuity patient often co-ordinating (time/attention demands)
No/poor orientation to ward;	No falls/care plans started on admission	Airway, secretions, humidifier,	Allergy/alert review		Taumarunui running team
Contradicting advice given to	Allergy/alert documentation		Risk – falls/restraint		

<p>patient;</p> <p>Medications late, missed, charted as given (but not);</p> <p>Diagnostics overlooked</p>	<p>Patient not allocated a nurse at handover</p> <p>Specimens not sent for processing</p> <p>Patient documentation – labels, transfer, wrist bands</p> <p>Equipment procedures not followed</p>	<p>nebs, suction, drains, wounds, NG feed rates, flushes, line changes, IV fluids, mobility, PU, referrals sent, meds (5 minutes simple, 10 complicated, 15 if new nurse)</p>	<p>Infection control</p>	<p>sent, meds, family issues, pump monitoring</p>	<p>nursing trial – what impact on handover process?</p> <p>Y – trialling new care plan – info useful for handover</p> <p>Use of SBARR supported for handover tool</p> <p>Handovers often require the info that is not written down eg High BP is written down or handed over but not the reading or what action is required</p> <p>No guidelines for content of handover sheet – risks identified with new staff not aware of significance of eg raised glucose result therefore do not handover</p> <p>Gaps/presumptions of knowledge obvious when patient and nurse have met before or when patient has been in some time</p> <p>Handover the current presenting symptom eg diarrhoea not what they were admitted for eg CVA/Fall</p> <p>Some detail is</p>
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					expected to be obtained from clinical file following handover
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DRAFT 7

Pilot Bedside Handover – Checklist

- Introduction
- Inform woman of following handover
- Check with woman if visitors are to stay or leave for duration of handover
- Patient verification – verbal / ID check
- Cultural requirements – is a patient spokesperson required/present?

SITUATION:

- Reason for admission/delivery
- Current situation
- Patient situation – ask woman how she feels / how is she?

BACKGROUND:

- Relevant obstetric /medical history
- Allergy / alerts
- Parenting issues?
- Cultural/ personal requirements (care plan)

ASSESSMENT: (mother & baby)

- Post partum assessments
- Medications
- Vital signs BP, temp etc
- IV site / FBChart
- Bloods / test results
- Care plan

RECOMMENDATIONS:

- Goals/ requirements for shift
- Time frames / Outcomes

RESPONSE:

- Woman & staff

Nursing & Midwifery Clinical Handover Project



Benefits

Safety for patients:-

- Improved communication
- Involvement in plan of care
- Medication errors reduced
- Patient more involved and better informed

Safety for nurses / midwives:

- Transfer of accountability
- Timely, accurate communication
- Reinforcement of documentation

Improved satisfaction for both patient & nurses / midwives:

About the Project

Clinical Champion:
Jacqui Wynne-Jones

Project Sponsor:
Sue Hayward

Project Manager:
Ros Morell

Project End Date:
October 2008

Contact

For more information about Nursing & Midwifery Clinical Handover project, please contact:



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Front of Menzies

Clinical Handover Questionnaire

Suggestions for improving/changing handover practices

- 1 : 1 handover for complex patients
- Bedside handover for all patients
- bedside handover for complex patients
- Beside handover
- Clear understanding for all staff
- concise structure for handover
- Co-ordinator to do verbal handover on all shifts
- Education nurses to be concise and to the point
- Historical events / major issues / family concerns
- hospital wide standardised system
- If patient needs to be present for handover use a private room
- include handover of medication chart and care plan at bedside
- individual handover rather than whole ward
- Individual handover should be enough, and the co-ordinator should meet and do handover at the bed
- Interruption free – person to person
- long handover time night staff to day staff
- More beside handover
- More computers x 2
- More specific and with guidelines
- PM miss out global – just do individual
- Proper office for handover
- Punctuality
- Recorded Handover
- SBARR
- SBARR to focus
- Set standards of presenting information
- Should use SBARR approach
- Sign off required objectives not met
- Standardised handover routine at bedside
- Standardised tool for handover
- start on time
- Streamline information and do at bedside
- Strict start and finish time
- Structured handover
- Taped / recorded handover
- Use of patient notes at bedside

Nursing and Midwifery Clinical Handover Project-Post Pilot STAFF questionnaire

Q1. Purpose of handover
Rated by order of importance

7.0	Understand requirements for current patient care
6.8	Family contact
6.8	Mental comprehension
6.5	Update on patient condition e.g. stable / unstable or level of acuity
6.4	Checking patient details e.g. name, allergies, alerts
6.1	Diagnosis
5.8	Mobility levels
5.5	Risk factors e.g. falls or pressure areas
4.8	Medications – what and when
4.8	Observations
4.7	Procedures due / preparation for procedure

Q2. On average, how well do you think the current handover process in your ward achieves the above objectives? (Rated on a scale of 1 – 6 with 1 being least effective and 6 being most effective)

1	2.9%
2	5.9%
3	11.8%
4	35.3%
5	35.3%
6	8.8%

Categories 1, 2 and 3 = 20%
Categories 4,5 and 6 = 80%

Q3. In the current handover process, is the patient and / or their family / whanau involved in any way?

95% respondents said yes

Q3 Comments:

- Ask questions, verify plans for the day
- Bedside handover, patient or patient family will be involved
- Being in the room - opportunity for dialogue, check patient id etc
- Co-ordinator handover at patient bedside
- Discuss pain relief/medication/other cares next due. Baby cares and feeding requirements

- Discussion around day / planning / prompt discharge planning
- Families / whānau wishes are written in the cardex and discussed at handover.
- Greeting / farewell from nurses
- Greeting the family /whanau when entering the room and verbally confirming plan and condition of patient
- Handover at the bedside patient involved
- If at bedside
- If awake (night shift)
- If awake or present - could be at a procedure or asleep. Try to get through alot of patient handovers so it is not a leisurely chit chat!
- In the morning, patient usually asleep
- Keeping patient informed of their progress
- Meeting of nurses who are taking over each shift - they are made aware of family / visitors
- Often it is the verbal / communicating between patient and family with staff that is conveyed in the handover as part of the patient care process.
- Opportunity given for patient input
- Patient able to ask questions regarding care and often husbands/mothers will also get involved if present at handover
- Patient feels more involved with their care and can ask questions re future or ongoing care
- Patient gets an understanding of what previous caregiver has told new caregiver. Gets a chance to voice own priorities and clarify information
- Patient knows who the nurse on duty is taking over care
- Patient may remember something that they think is important and remind the handover nurse of it
- Patient sometimes adds more information or questions
- Patients get to listen to what is being said, have opportunity to know when changeover actually happens
- Plan of care for immediate shift discussed and future plans with regards to discharge
- Provide their perspective - family interact with current and new nurse
- The patient often adds to information or asks questions, sometimes staff clarify things with patient
- The patient is included in the handover - introduced to next staff member, questioned about planned care
- The women are involved in formulating their plan for their care over the next shift and they are invited to verify /correct information about themselves
- Usually not unless directly asked for their input
- We do bedside handover so patient and family can listen and ask any advice
- When a family member is present, the patient will be asked of it's ok for them to be involved in handover
- While in the process of handing over the nurse gets to visualise the patient, id and they get to put their input in and bring up any concerns
- Yes - meet oncoming co-ordinate - introduction etc (only if patient awake though)

Q4 Does clinical handover occur in rooms occupied by more than one patient?

92% respondents said yes

Q5. If clinical handover occurs at the bedside in your ward does this occur in rooms occupied by more than one patient?

60% respondents said yes

Q6. Do you feel there are privacy / confidentiality issues with handover at the bedside?

85% respondents said yes

Q6 Comments

- Feel unable to discuss sensitive information pertinent to the patient as it may be asked by the other person / their family therefore unable to maintain confidentiality
- Definitely if patients are in multi bedded rooms. Curtains do not exclude sound. There is also an issue if family / friends are present and no opportunity is taken to confirm with the patient if they should leave.
- Even if permission is asked of patient and she will say yes, often I feel that patient doesn't feel able to say no. Too shy to rock the boat. Handover has to be heard by other patients regardless of how quiet we are
- Details discussed re patients condition even in quiet voice, carries to others in room
- Some patients may not want certain details mentioned if in a 4 bed room
- Privacy compromised in 4 bed room. Need to handover in office then go to bedside and check labels , introduce yourself first and ask patient if she has any concerns or whisper
- Other patient's visitors may hear information but this is not any different to Doctor's rounds in multi-bedded rooms
- Lack of privacy - other patients can hear in the room
- There is a lack of privacy because of other patients and family in the room
- Some information gets missed at the bedside if the rooms are full
- State of lochia, nipples, perineum discussed in shared room not good
- Ask if ok to talk in front of visitors - talk quiet
- Especially in the 6 bed room
- Basic info only given and patient / visitors are asked for privacy if needed. Can be things patients don't want visitors /family aware of
- When patient's relatives are around, nurses need to ask them to wait out in the lounge or have to get consent if they are happy with relatives being around
- Some things handed over are embarrassing e.g. Bowel or bladder habits
- There is little or no privacy in 6 bed room. Curtains will not stop people listening
- Especially in a 6 bed room - drawing curtains does not block out the sound
- Because we are talking about many aspects of the patient's care, including what medications they are on etc, however we try to talk quietly and behind the curtain if possible
- Even when speaking quietly others can overhear
- Take care not to divulge certain info in open where it can be overheard
- Sensitive info is not discussed at the bedside - general info is
- Tend to discuss q's raised by pt in quiet room.
- In rooms occupied by more than 1 patient.
- If visitors present in beds next door they can overhear info but no more than later in shift.
- Other patients can overhear or visitors
- Can modify info discussed if too many visitors in room
- Other pt hear what is said, a lot of elderly patients have hearing loss so need to speak louder
- In a shared room there is no privacy
- Things maybe discussed that the pt did not realise was going to be discussed
- Embarrassment for other patients

Q7. Please rate how your current handover process assists with educating the Patient about their condition. (Rating scale of 1 – 6, with 1 being least effective and 6 being most effective)

1	5.6%
2	8.3%
3	25.0%
4	41.7%
5	13.9%
6	5.6%

Categories 1, 2 and 3 = 39%
Categories 4, 5 and 6 = 61%

Q8. Please rate whether the change in handover process has had a positive impact on patient care and satisfaction. (Rating scale of 1 – 6, with 1 being least effective and 6 being most effective)

1	5.6%
2	8.3%
3	25.0%
4	30.6%
5	27.8%
6	2.8%

Categories 1, 2 and 3 = 39%
Categories 4, 5 and 6 = 61%

Q9 Please rate your overall satisfaction with the new clinical handover system. . (Rating scale of 1 – 6, with 1 being least effective and 6 being most effective)

1	5.6%
2	5.6%
3	13.9%
4	50.0%
5	22.2%
6	2.8%

Categories 1, 2 and 3 = 25%
Categories 4, 5 and 6 = 75%

Q9 Comments

- As Co ordinator, do not know enough facts/information about the patients on the ward but your main responsible for them all.
- I'm generally happy to have the opportunity to make women's care as continuous as possible and handing over in her presence ensures everyone is on the same page about her needs and future care.
- I feel we are improving as the process goes on - some staff taking longer to get on board. I don't think the generic handover of all the patients is needed or working well. Almost a waste of time if all patient information is put onto handover sheet
- When handing over late at night, many patients are asleep and resent being woken to check ID or discuss condition.
- When you handover a patient, the person taking over can do a quick assessment of their patient. The patient knows who is their nurse, you can discuss times e.g. express, visits to the NBU to feed baby.
- Bedside handover good. However, I feel we need a more in depth handover of all patients due to the fact that staff often have to leave the ward and work elsewhere and patients taken over at short notice.
- Don't always feel it is appropriate to handover at the bedside when the woman is asleep especially when they are generally tired and busy with newborn baby.
- It takes longer having 2 handovers - the generic one and the bedside one.
- 1/4 hour not long enough night to morning with a full ward. Phone calls from other areas during handover causes problems.
- Change in PM shifts as verbally not appropriate as can wake patients up at 2300 (quiet bedside/office discussions necessary).
- Find uncomfortable talking about patients during end of pm handover to night shift as some patients are asleep. AM to PM is fine - nights to AM is fine.

- Bedside handover has positive and negative attributes. I'm sure it will improve over time.
- Bedside handover can reduce medication error, improved the care and management of the patients. Privacy issues need to be improved. Very satisfied with bedside handover.
- I have found we have been able to pick up things that have been missed or have questions about, that if we didn't do a bedside handover we would spend time in our shift wondering and feeling frustrated trying to figure it out. Patient feels involved and in the know about their care.
- Takes extra time to achieve - usually go over finish time. Good on morning and pm shift but hard to do at night shift as pts asleep, noise by staff wakes them and hard to see through chart. Disruptions or interruptions - trying to handover and pt asks for things - ie.e bells ring.
- Takes time to adapt and get used to a process - therefore the handover can be lengthy.
- Interruptions disrupt the process e.g. other nurses, family, visitors arriving, bells ringing, other patients interrupting.
- Difficult to answer.
- Improved communication focus and being precise. Assists staff to focus on improving handover skills.
- most staff not involved with bedside handover.
- New process room for improvement we will meet there.
- I feel if patients input are required, the nurses dedicated to pt care should do this during the shift.
- This handover system probably works for am/pm shift overlaps but for one else - ineffective at nocte and in the morning.
- Bedside handover is a glossed over summary of pt 'true' handover.
- Lack of time, going into overtime for handover. Co-ordinator only having handover pointless at times as co-ordinator may not even be around ward if busy in ED.
- It has to be persevered with a the concept is okay.

Please indicate your current shift pattern

1	Full rostered and rotating shift	80.0%
2	Morning shift only	8.6%
3	Afternoon shift only	2.9%
4	Night shift only	5.7%
5	Weekends only	0.0%
6	Other	2.9%

Appendix 10-Post Trial Data/Results-Patients



Post Pilot PATIENT Questionnaire data collation

Demographics:

- 10% Male
- 90% Female

Age Range:

- 15 – 20 10%
- 21 – 30 30%
- 31 – 40 10%
- 41 – 50 0
- 51 – 60 20%
- 61 – 70 20%
- 71 – 80 10%
- 81 > 0

Room Configuration:

- Single room 20%
- Double room 20%
- Four bed room 30%
- Six bed room 30%

Q.5 Does handover happen at your bedside?

YES 100%

Pre pilot :

YES 6%

NO 46%

SOMETIMES 13%

Q6. If Yes, are you involved in the discussion?

YES 90%

NO 10%

Pre pilot: YES 26%

Q7 Do you feel it is valuable for you and your family to be involved in discussions with the nurses about your care? (Rated on a scale of 1 – 6, with one being the least valuable and 6 being the most valuable).

70% rated 5
30% rated 6

Therefore 100% rated the value of being involved at over level 5 or greater

Pre pilot:

0 rated 1
13% rated 2
13% rated 3
13% rated 4
20% rated 5
40% rated 6

Pre pilot 60% rated level 5 and greater that it would be valuable for them and their family to be involved in discussions with nurses/midwives about their care
This compares to 100% now rating level 5 and above.

Q8. When care is discussed at the bedside, do you have any concerns about confidentiality or your privacy?

YES 10%
NO 90%

Pre pilot:

YES 13%
NO 66%

Q9. if Yes – please explain.

- The nurses keep me informed
- They are not talking around you but talking to you. Might be concerned about privacy if there was something really serious
- Did not like shared room – if I wanted to ask personal questions it was too public
- Very helpful – I know what has been told to the next person and you know who is looking after you
- Might have concerns about privacy in a shared room
- The nurses are discrete when discussing more sensitive issues. You know there is a changeover of staff and it helps continuity – we know who is looking after us – It is about us.

Q10. Overall please rate the level of confidence you feel that the nursing/ midwifery staff will provide appropriate care for you. (Rated on a scale of 1 – 6, with one being the least confident and 6 being the most confident).

20% rated 5

80% rated 6
Therefore 100% rated level 5 or greater in their confidence of being given appropriate care.

Pre pilot: 20% rated 4
40% rated 5
40% rated 6

Q11. At handover, do the nurses/ midwives check your ID label?
YES 30%
NO 30%
SOMETIMES 40%

Q12. At handover do the nurses / midwives check your drug chart?
YES 100%

General comments:

- Haven't had a name band for 2 days and the pump for the drugs isn't working
- Found the lack of consistency of information difficult. Liked it when there was some continuity with staff
- Staff used the check list

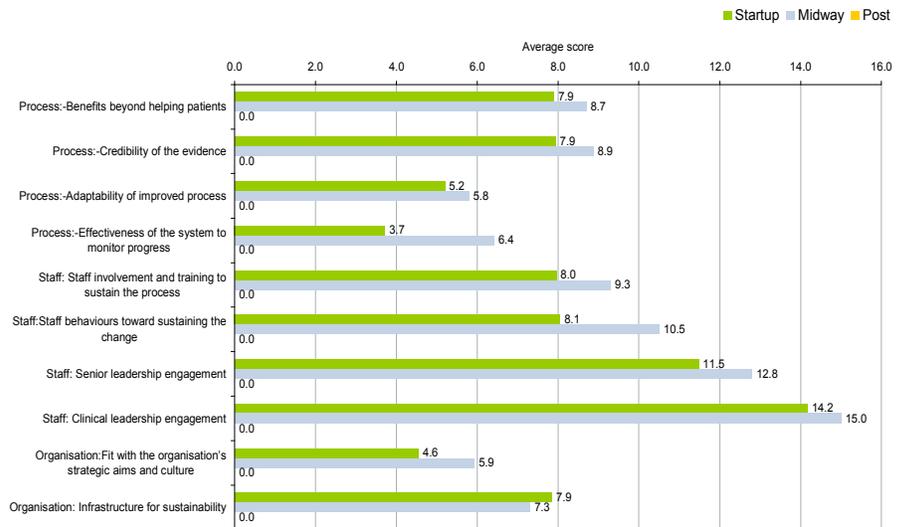
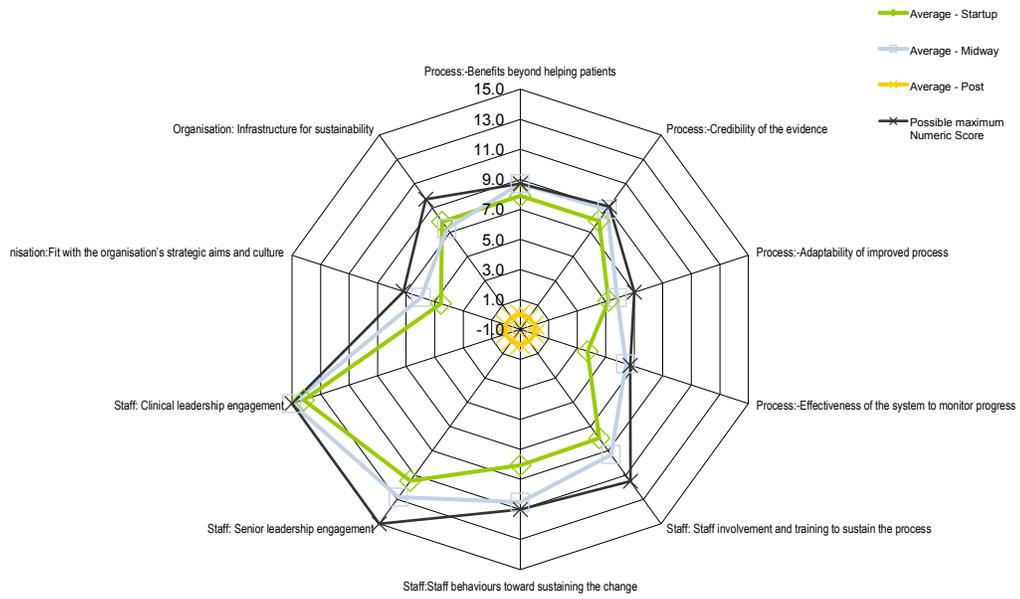
Appendix 11-NHS Sustainability Model - Calculation Tool

Project name:

Nursing & Midwifery Clinical Handover

	Possible maximum Numeric Score	March 2008 Average - Startup	September 2008 Average - End
Process:-Benefits beyond helping patients	8.7	7.9	8.7
Process:-Credibility of the evidence	9.1	7.9	8.9
Process:-Adaptability of improved process	7	5.2	5.8
Process:-Effectiveness of the system to monitor progress	6.7	3.7	6.4
Staff: Staff involvement and training to sustain the process	11.5	8.0	9.3
Staff:Staff behaviours toward sustaining the change	11	8.1	10.5
Staff: Senior leadership engagement	15	11.5	12.8
Staff: Clinical leadership engagement	15	14.2	15.0
Organisation:Fit with the organisation's strategic aims and culture	7.2	4.6	5.9
Organisation: Infrastructure for sustainability	9.7	7.9	7.3
Total	100.9	78.8	90.6
	Sample size (n)=	10	12

Disclaimer: This excel file calculates the sustainability tool developed by the NHS Institute for Innovation and Improvement.



Appendix 12-Implementation Package



Patient information for Bedside Handover

At each nursing shift change, your care is handed over from your previous nurse to the one on the next shift. This is an important part of your care and ensures:

- You know who is looking after you
- Your nurse knows who you are
- Your care and treatment is passed on to the next nurse
- You know what is going to happen in the next shift
- Your family / whanau can be involved if you wish them to be

Handover involves the use of a check list. You will be informed that handover is about to happen and it should take the same format each time.

Please be reassured that the nurses take a sensitive approach to handover and are always careful how and what they discuss at your bedside, but as this is a patient safety issue, they will be discussing your care, medication and treatment plans.

You should expect the following:

- Introduction to the new nurse
- If visitors are present, you will be asked if you prefer them to wait outside during handover
- Your patient ID label will be checked
- Reason for admission and current situation
- Background history, medical alerts or allergies
- Medications
- Observations and IV and/ or wound sites
- Blood tests or other tests required
- Your care plan
- Requirements for the next shift, plans and time frames

This is **your** time – please take the opportunity to be involved and ask questions or make corrections if you think the information is not accurate.



Staff information for bedside handover

Background:

In every setting, the transfer of information regarding the care or condition of a patient raises the potential for inadequate or ineffective communication with the risk of care being compromised as a result. This includes shift handover, ward/ hospital transfers, discharge and individual transfer of care. For nurses and midwives, shift handover occurs frequently and may be additionally complicated by the variety of shifts worked in different areas, which further fragments continuity of care. A consistent approach to clinical handover is vital to ensure effective, accurate information transfer.

Poor communication at handover is a frequent component of incidents and complaints in the clinical setting. Other factors contributing to communication issues include cultural diversity where English is not a first language, as well as workload demands. A systematic and standardised approach to handover improves the quality of clinical handover, assists in the clear transfer of accountability from shift to shift and improves continuity of care.

A project was initiated to plan and pilot the bedside handover process. The intention was to develop and implement a framework for best practice with regard to nursing and midwifery shift handover within Health Waikato hospitals inpatient areas.

Bedside handover is known to demonstrate improved satisfaction and safety benefits for patients and nurses / midwives

Safety for patients

- Improved communication
- Medication errors reduced by over 80%
- Involvement in plan of care
- Patient and family more involved and better informed

Safety for nurses / midwives

- Clear transfer of accountability
- Timely, accurate communication
- Reinforcement of documentation

Project planning included

- A hospital wide survey of current handover practises
- A literature review
- Filming and recording patient experiences
- Review of incident forms relating to handover processes on the three pilot areas
- Staff questionnaires and patient interviews pre and post pilot on the three pilot areas
- Development of an handover tool for use at the bedside

Evaluation of the pilot wards:

Clear gains were demonstrated for both patients and staff.

Patients:

- 100% handover occurred at the bedside and involved patients and family in discussions
- Increase in patient awareness of the value of being involved in handover
- Confidence in care provision increased
- Increase reassurance for patients knowing who their nurse was for the shift
- 90% patients reported they had no concerns relating to privacy

Staff:

- Improved satisfaction with the handover process
- Improved involvement of patient and family in discussions – clearly demonstrated in patient comments
- Improvement in the education of patient and family relating to the patient’s condition and treatment
- More timely management of medications and other procedures

However, staff concerns with privacy increased through the pilot phase.

Bedside handover is considered best practice and if managed sensitively and carefully is not a privacy issue because it fulfils the recommendations of the HDC Code of Rights.

RIGHT 4 Right to Services of an Appropriate Standard

- 1) Every consumer has the right to have services provided with reasonable care and skill.
- 2) Every consumer has the right to have services provided those comply with legal, professional, ethical, and other relevant standards.
- 3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
- 4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
- 5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Bedside handover is the recommended standard for Waikato Hospital inpatient areas. It is acknowledged that each area has its specific requirements and the handover tool will be adapted accordingly.

Staff involvement and feedback is vital for any practice change and concerns may be raised at your ward planning meetings for the initiation and ongoing sustainability of this process.



Privacy Statement

One of the major concerns nurses raise repeatedly against the use of bedside handover is that of privacy. Following the handover pilot phase in three inpatient areas, 100% nurses raised the process as a privacy issue.

An effective handover is known to have a large effect on:

- Improved patient outcomes
- Avoidable errors
- Reduction in repetition
- Increasing safety
- Improvement in patient satisfaction

The issue of privacy has been discussed at length with Ngaire Coddington, Legal Counsel (medico legal) / Privacy Officer. Her response is detailed below.

Staff should ensure effective and clear communication of the patient's status/condition and required medications to the oncoming shift. This is of much greater importance than concerns over perceived privacy which in a shared bed ward setting is minimal.

The applicable law in relation to bedside handover of care is the Code of Health and Disability Services Consumers' Rights Regulation 1996, specifically, rights 4 (i.e., ALL of the sub rights listed from (1) to (5) under right 4) and 5 and the Health Information Privacy Code 1994, specifically Rule 11(1)(b),(c) primarily, and if handover of care has to be done without the patient being consulted - i.e. where the patient is unconscious or unable because of e.g. dementia or head injury etc - the 11(2) would apply and sub rule (3).

Staff need to ask the patient whether they agree to having family members present for handover of care. If they do, then clearly staff should be asking family and friends etc to leave the bedside while handover is in progress. Where the patient is unable (because they might be unconscious or be mentally incompetent etc) to say whether they mind or not then staff should be asking the patient's representative if they are there or if not, simply ask others to leave the bedside while handover of care is being done. If it is necessary to have family present e.g. because they may actively be helping our staff to care for the patient while they are in hospital, then obviously in that instance family should stay so that they are involved in discussions etc.

There is never going to be a blanket "one statement fits all scenarios" statement because every case will always turn on its own facts and staff will have to adjust the way they communicate matters accordingly to fit each and every case.

Obviously tone of voice and manner will be important with bedside handover - staff should avoid shouting and raising their voice when doing this so that they are not unnecessarily interfering in the patient's and anyone else's privacy.

Bedside handover, providing it is managed in a sensitive and careful manner fulfils the requirements of the Health and Disability Commission Code of Rights, in Right 4 and 5.

RIGHT 4

Right to Services of an Appropriate Standard

- 4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
- 5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5

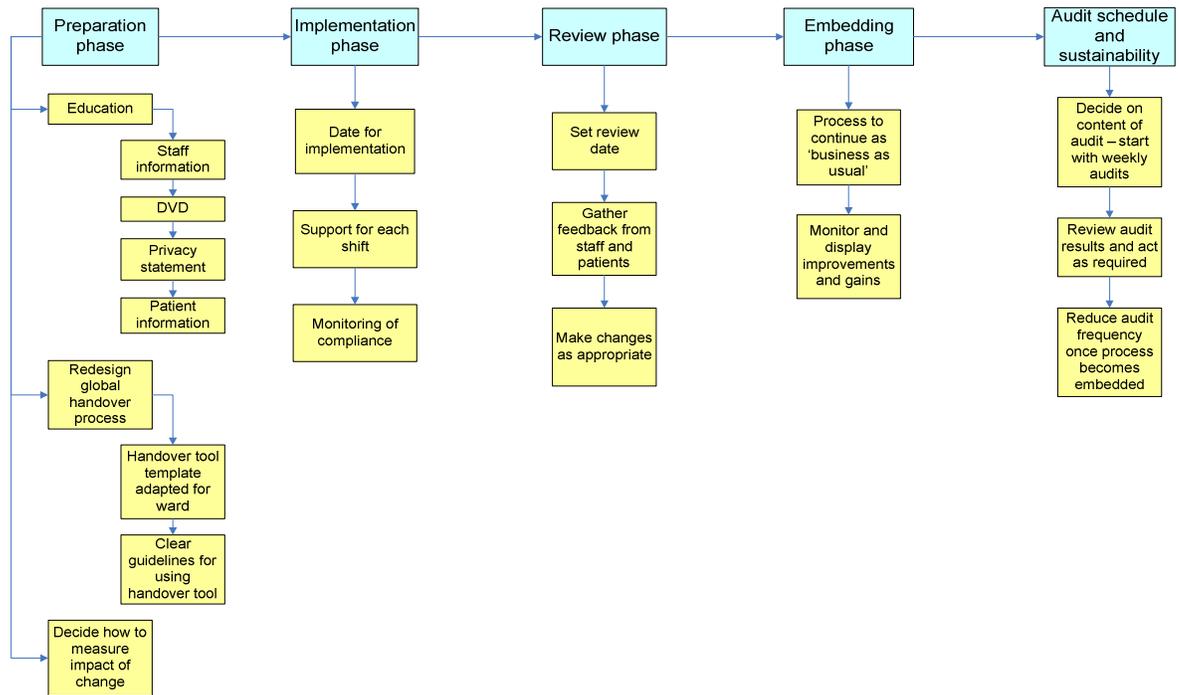
Right to Effective Communication

- 1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

Bedside Handover Implementation Programme-Audit Tool

DRAFT 3

Bedside handover implementation programme



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