

Training requirements for student placements

Clinical handover learning module – Transcript

December 2015

Slide 1

Welcome to this learning module on Clinical Handover.

In line with the 6th standard from the Australian Commission for Safety and Quality in Healthcare, clinical handover must be utilised by allied health staff and students to ensure there is timely, relevant and structured transfer of patient information supporting safe patient care.

Slide 2 – Learning Objectives

By the end of this module you should be able to:

- Define clinical handover and why it is important.
- Describe when clinical handover must occur and what should be included, and,
- Be aware of tools and resources to assist in effective clinical handover.

Slide 3 – What is Clinical Handover?

Clinical Handover is the process whereby professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, is transferred to another person or professional group on a temporary or permanent basis.

Slide 4 – Why is Clinical handover important?

Although clinical handover is vital for patient safety, research indicates that it is not something that is done well on a national or international scale. It is a major preventable cause of patient harm where approximately a third of adverse events may be associated with handover. Greater than 7 million handovers occur each year in Australian hospitals and more than 26 million occur in community care settings. If it is done poorly it can result in unnecessary delays, repeated or incorrect care, or patient harm.

Slide 5

Students are frequently involved in clinical handovers as they are often required to take over part or all of a patient's care and then feedback or hand back care to their supervisor, other staff or students.

Times for clinical handover include any situation where care is transferred from one clinician to another. For example, at change of rotations, before and after an accrued day off (ADO), between regular and after hours services, on patient discharge, or in emergent situations such as sick leave. Clinical handover can be either written or verbal.

Slide 6 – Elements to an effective clinical handover

Elements to an effective clinical handover include:

1. There must be a nominated LEADER for each clinical handover
2. There is an agreed set time, duration and frequency and participants arrive on time.
3. Participants must be identified, oriented and involved in a regular review of the clinical handover processes. Patients and carers should be recognised and included as participants where possible.
4. There must be a specific agreed location where handover is to occur, ideally face to face.
5. There must be a standardised process

Clinical handover can be either written or verbal.

Slide 7 – Patient-centred approach

Where possible, clinical handover should encompass a patient-centred approach to improve practice and ensure that patients remain at the centre of care. Patients are often a valuable source of information and may detect errors or miscommunications. You can include patients in clinical handover by firstly informing the patient of the transition of care. For example: Mrs Smith, Jody will be your audiologist next week as I will be away.

Secondly, you may have the patient present at the handover. For example, a physiotherapist for an evening shift may come to meet and treat a patient with the regular ward physiotherapist prior to the change of shift.

And lastly, you could ask a patient if they have questions or comments. For example, a pharmacist may ask a patient: I have in my handover that you have stopped taking aspirin. Is that correct?

Slide 8 – Read back

Another important component of effective handover is ensuring comprehension, often referred to as “read back”. By reporting back key points the clinician receiving handover ensures understanding and accepts responsibility for the patient.

Slide 9 – SBAR as a communication model

When standardised processes for clinical handover are used staff are more likely to acquire and understand the information.

SBAR is one example of a standardised communication model and can be used for verbal and written handovers.

So what does SBAR stand for?

- S is for situation. Address who is the patient and why are they here.
- B is for background. What is the history relevant to this current admission?
- A is for assessment. What is the patient's current condition?
- R is for recommendation. What do I need to know to continue care of this patient?

Slide 10 – Tools and resources

SBAR is only one example of a communication tool that is available for handover. You should check with your supervisor if there is a preferred communication tool where you are working, for example a checklist which is placed on your lanyard. The following video shows allied health staff providing clinical handover using a standardised communication tool.

Slide 11 – Vignette

A neurology-social worker begins with a poor handover but with prompting from the rehabilitation social worker using SBAR the optimal clinical handover is ultimately achieved.

Phone rings (rehab social worker calling the neuro social worker)

Rebecca: 7 North Rebecca Social Worker speaking

Mary: Hi Rebecca, it's Mary here from Rehab. I've just spoken with the rehab physio, John, and he mentioned something about a patient Mrs. Wilson who was transferred to us today. I've heard nothing about her and since I know you've been working with her I was just wondering if I could get some information as I feel I'm a bit behind the eight-ball now.

Rebecca: I didn't even know she was going across to you today, I've only seen her a couple of times and I've written everything in the notes. Did you get the file?

Mary: No, I don't think they've come over yet.

Rebecca: Well, I know there's some carer issues that you'll need to look into and that's probably the main thing I reckon. Once you've read the notes you can give me a call back and we can go over anything that's not clear or any further information.

Mary: Look Rebecca I need a proper handover using the ISBAR before I can take responsibility for the patient

*Rebecca: OK, Sorry. Let's start again. Mrs. Wilson is a 76 year old lady who had a CVA 15 days ago. Her major physical disability is a right hemiplegia, and Mrs. Wilson also has some really significant social issues. **Background** is that Mrs. Wilson was referred to me on the 3rd day of her admission, mainly because nursing identified some early carer issues. Mrs. Wilson was the full time carer for her husband prior to her admission. He has Parkinson's disease and he requires full assistance with all his ADL's.*

Mary: Do you know if there's any other family involved?

Rebecca: She has a daughter in Coff's Harbour who seems quite involved with her Mum and a son, I believe, in Bathurst. The daughter's considering relocating to Sydney to help her parents out but that's not an actual definite thing as yet.

Mary: Ok So is there anyone looking after Mr. Wilson at the moment?

Rebecca: The daughter's in their home at the moment. There's also been some concern around Mrs. Wilson's cognitive functions, and I know that the OT is commenced some testing but I believe

that further cognitive assessment will be required in rehab so that the rehab team can determine if she has the capacity to make decisions about where she goes after rehab. The testing's really important given the uncertainty around Mrs. Wilson's carer options. We might need placement unfortunately for her husband and maybe her if she doesn't achieve her mobility goals when she's in rehab.

Mary: Yeah, Ok, it sounds like a complex case, particularly if the daughter doesn't relocate.

Rebecca: Yeah, sure is. So basically my current **assessment** is that there are some carer issues that need to be addressed. Possibly a cognitive impairment that may impact on her ability to make decisions which also may have an impact around discharge planning. I **recommend** that Mrs. Wilson's carer options are explored thoroughly and that she also undergoes further cognitive assessment. And of course family support. Explore that as well. Would you be able to phone her daughter tomorrow – she sounded pretty distressed.

Mary: Yeah, absolutely, I'll call them first thing, and I'll see Mrs. Wilson tomorrow and check where she's up to. Thanks Rebecca for the handover, it's much appreciated.

Rebecca: If I can help in any way just call me

OK, wonderful thank-you. Bye.

Slide 12 – Take home message

So what are the key take home messages? You must provide clinical handover for every transfer of care, try to include the patient where ever possible and read back key information.