Clinical Handover Guideline

Reference no.: CG-CLIN/4214/23

1. Introduction

This guideline outlines what is required to ensure a safe and effective clinical handover for any patient.

Clinical handover is a process where there is 'the transfer of professional responsibility and accountability for some or all aspects care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis'.

The importance of effective handover between shifts and between health care professionals is well recognised. Incomplete or delayed informed can compromise safety, quality and the patients experience of healthcare.

Communication improves when handover involves the patient and is carried out using a structured approach. The World Health Organisation recommends the use of SBAR (Situation, Background, Assessment, Recommendation) as a tool to standardise handover communications.

2. Aim and Purpose

This document provides a Trust-wide approach for staff to follow when undertaking clinical handovers. The purpose of this is to set the expectation for a consistent approach to the undertaking of clinical handovers. A Trust-wide SBAR approach to clinical handover will standardise our approach to deliver improvements in efficiency, patient safety and patient experience.

3. Definitions, Keywords

Situation, Background, Assessment, Recommendation (SBAR)

SBAR is an easy to use, structured form of communication that enables information to be transferred accurately between individuals. SBAR was originally developed by the United States military for communication on nuclear submarines, but has been successfully used in many different healthcare settings, particularly relating to improving patient safety.

SBAR consists of standardised prompt questions in four sections to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition and the likelihood for errors. As the structure is shared, it also helps staff anticipate the information needed by colleagues and encourages assessment skills. Using SBAR prompts staff to formulate information with the right level of detail.

4. Main body of Guidelines

1. Please refer to the Trust Policy for Information Governance, the Standard Operating Procedure for the Management of Clinical Handover Sheets and the Trust policy for internal professional standards. It is expected that the clinical handover process respects a patients' right to confidentiality and that colleagues engage in a professional, courteous and civil manner.
2. Accurate, timely and relevant information is essential to deliver high quality patient care. Records should be kept preferably in electronic format but may be in paper form. All clinical handover should be undertaken using the SBAR format.
3. The core principle for an effective patient handover is with a standard handover in a written proforma, in conjunction with a face-to-face verbal handover is encouraged with an opportunity for questions to seek clarity as required. This principle can be adapted locally as practicable.
4. It is expected that clinical areas will be clear when clinical handovers occur and have consistency with their approach for process, including documentation.

5. References

- National Patient Safety Agency (NPSA), Seven steps to patient safety (London, 2004)
- NICE guideline 94, March 2018
- National Patients Safety Agency. Safe handover: safe patients. Guidance on clinical handover for clinicians and managers. London. British Medical Association, 2004. Available from: https://www.bma.org.uk/-/media/Files/.../safe%20handover%20safe%20patients.pdf
- Mascioli S, Laskowski-Jones L, Urban S, Moran S. Improving handoff communication. Nursing. 2009; 39(2):52-55
- Tucker A, Brandling J, Fox P. Improved record-keeping with reading handovers. Nursing Management. 2009; 16(8):30-34
- World Health Organisation. Communication during patient hand-overs. Switzerland. WHO Press, 2007. Available from: http://www.who.int/patientsafety/solutions/patientsafety/PSSolution3.pdf
- SBAR Communication Tool, NHS England and NHS Improvement, available at: https://www.england.nhs.uk/wp-content/uploads/2021/03/qsir-sbar-communication-tool.pdf
- Trust Policy for Information Governance
- Standard Operating Procedure for the Management of Clinical Handover Sheets

6. Documentation Controls (these go at the end of the document but before any appendices)

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	1	24/08/2023	Lucy Nankivell, Maria Spencer	Learning following an audit of clinical handovers
	2	02/10/2023	Lucy Nankivell,	Following feedback from Dr Robinson
Intended Recipients: Clinical staff at the time of shift changeover				
Training and Dissemination: This guideline will be disseminated through the role out of bedside handover, Trust-wide at nursing shift handover. Compliance with this guideline can be monitored through the evolving ward assurance, and quality assurance programmes.				
Development of Guideline: Lucy Nankivell **Job Title:** Head of Clinical Improvement and Transformation				
Consultation with: Donna Bird; Director of Nursing Maria Spencer; Quality and Service Improvement Facilitator Gillian Campbell; Head of Pediatric Nursing Jo Harrison-Engwell; Lead Midwife for Guidelines, Audit and Quality Improvement Gis Robinson, Interim Executive Medical Director				
Linked Documents: Trust Policy for Information Governance Standard Operating Procedure for the Management of Clinical Handover Sheets Trust policy for internal professional standards Trust Policy for Information Governance				
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