Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Transfer of Care Between Colleagues	Nursing Practice	07-019-00

EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 21, 2021	July 2024	07-019-00	3

APPLIES TO:
ALL Community Nurses

1. BACKGROUND:

1.1. Transfer of care (handover) involves the transfer of professional responsibility and accountability for some or all aspects of care for a client, or groups of clients, to another person, such as a clinician, nurse, or professional group, on a temporary or permanent basis. Within the Department of Health (Health), this could include transfers from nurse to nurse within a centre, community health nurse (CHN) to flight nurse, CHN to emergency department, or a provider in one facility or service to another (within or outside of Nunavut).

2. POLICY:

2.1. Details about a client's condition, treatment, and plan of care should be communicated thoroughly to the next provider or team and documented clearly.

2.2. A standardised approach to transfer of care is required. Nurses and other providers must formulate the information in their handover according to the "Situation, Background, Assessment, Recommendation (SBAR)" technique.

2.3. The client and their family member(s)/caregiver(s) (with client consent) should be involved in every transfer of care as they are the only constant factors in the care process.

3. PRINCIPLES:

3.1. Effective handover ensures safe and effective coordination and continuity of care.

3.2. Transfer of care should follow a structured format.

3.3. Effective communication (verbal, written, electronic) is fundamental to safe and efficient handover. Errors in communication can result in adverse client outcomes.

3.4. Safe transfer of care requires adequate time, privacy, and a calm environment, free from distraction.

3.5. Clients often need support from their families or caregivers during care transitions.

3.6. Successful transfer of care must account for client factors such as language, culture, wishes for care, and health literacy. Inuit Societal Values and Inuit Qaujimajatuqangit (IQ) principles should underpin client inclusion in transfer of care.

3.7. Comments made during handovers may inadvertently contribute to misdiagnosis or inappropriate treatment because of the influence of cognitive biases and stereotyping.

3.8. Leaders can facilitate safe transfers of care by providing resources and training and by creating embedded organisational awareness of the importance of safe handover.

4. **DEFINITIONS**:

SBAR: A standardised approach to information transfer and handover communication consisting of four categories.

- Situation: Problem, patient's symptoms, patient stability, or level of concern.
- Background: History of presentation, background information.
- Assessment: Assessment and differential diagnosis, where you think things are headed.
- Recommendation: Recommendations and action plan, what you have done, what you would like the other person to do.

CLINICIAN: Regulated healthcare providers – Community Health Nurses, Licensed Practical Nurses, Registered Nurses practising in Mental Health, Registered Psychiatric Nurses, Home and Community Care Nurses, Nurse Practitioners and Physicians.

5. **PROCEDURE:**

5.1. Whenever there is a change in the client's care provider, the following information shall be communicated using the SBAR technique, in a clear and concise report between colleagues, please see Appendix A for SBAR template:

- Name and role of provider handing client over, client's name
- Accurate information regarding diagnosis, investigations and results, consultations, treatments
- Pertinent past medical and surgical history; allergies
- Recent vital signs; input and output (if applicable) and any discrepancies from baseline.
- Recent or anticipated changes in the client's condition; emotional state
- Current medications (drug, dose, frequency, route) and time last given (to include IV infusions); accurate and complete transfer and documentation of medication information (medication reconciliation).
- Any outstanding orders to be processed and/or implemented.
- Plan of care, equipment requirements, follow-up appointments, client teaching
- Presence of any advance directives
- Contact information for the on-call physician
- Contact information for the client (if pertinent to transfer)
- Any other information important to the client's care

5.2. A departing clinician will create a list of all clients receiving ongoing or follow-up care at minimum of two working days before departing the community.

- In the event of an urgent or emergent departure from a community the clinician will develop the list as soon as possible.

5.3. The clinician will meet with the SCHP or immediate supervisor to review the list of clients and determine which clinicians will be taking over the care of each of the client.

- In the event that no other accepting clinicians are available the departing clinician will conduct a handoff of all clients to the SCHP or immediate supervisor.
- The SCHP or immediate supervisor will handoff the clients to another accepting clinician at a later date, until that point the SCHP or the immediate supervisor will be the MRP.

5.4. When and where possible and appropriate the departing clinician will inform the client that their care will be managed by a different clinician

6. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**
06-017-00 Morning Report

7. **REFERENCES**:
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Approved By:	Date: July 21, 2021
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Jenifer Bujold, a/Chief Nursing Officer	

APPENDIX A

S	**Situation**: Identify Client and age • Brief history of present illness	
B	**Background**: • Past medical history • Current Medications including dosage, route and frequency • Any IV infusions/antibiotics and when last given • Allergies • Most recent vital signs and any discrepancies from baseline • Pertinent lab results • Other clinical information • Any follow up appointments, teaching etc. • Presence of advance directives	
A	**Assessment**: What is the nurse's assessment of the situation. Differential diagnosis	
R	**Recommendation**: What does the nurse want done	