Nursing Handover

Site Applicability

St. Paul's and Mount St. Joseph Hospitals: Acute Care inpatient units, Emergency, and Critical Care units

Practice Level

Basic: RN, RPN, LPN

- ESN and SN in consultation with, and with support from most responsible nurse.

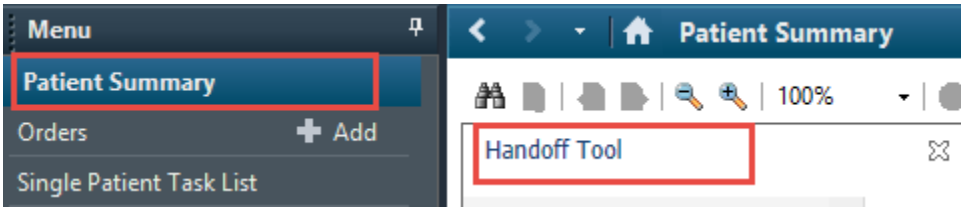
Need to Know

- Nurse-to-nurse handover is the transfer of accountability and responsibility of patient care between nurses at various stages of the patient's hospital stay (e.g. transfer from unit to unit or another site, shift change, transfers of care mid-shift, or break relief).
- Nurse-to-nurse hand over includes both written and verbal components, with opportunity for questions / clarifications.
- In areas where Bedside Shift Report has been implemented, nurse-to-nurse handover is conducted at the bedside with patient and family (when appropriate) involvement. Prior to handover at the bedside, the nurse confirms who may participate with patient (Temporary Substitute Decision Maker or other).
- Updating the bedside whiteboard and reviewing the care priorities with patients and family aligns with Providence Health Care's values regarding person and family centred care.

Guideline

Verbal component of handover:

- The nurse holding responsibility of care connects with the nurse who will be assuming responsibility for the patient's care (in person or by phone), or nurse covering (e.g. charge nurse, break relief partner).
- It is recommended that nurses use the handover tool located in the *Patient Summary* in Cerner when conducting handover.



- The nurse conducts a comprehensive verbal handover, which includes but is not limited to:
    - Patient identification
    - Clinical status of the patient (e.g. diagnosis, severity of illness)
    - Code status
    - Clinical safety alerts (e.g. allergies, infection control & Hazardous Drug/cytotoxic precautions)
    - Current vital signs, and ongoing assessments / protocols (e.g. CIWA-ar)
    - Priorities of care (e.g. urgent tasks pending, critical laboratory results)
    - Current medications (e.g. time sensitive, pertinent)
    - Patient specific concerns (e.g. mobility parameters; vision/hearing aides)
- Both nurses conduct safety checks (patient ID, IV tubing, fluids, medications, lines, and equipment), when handover is being conducted in person.
- Allow time for questions and clarifications.

Once complete, nurses document the completion of the handover report in PowerChart.

Written component of handover:

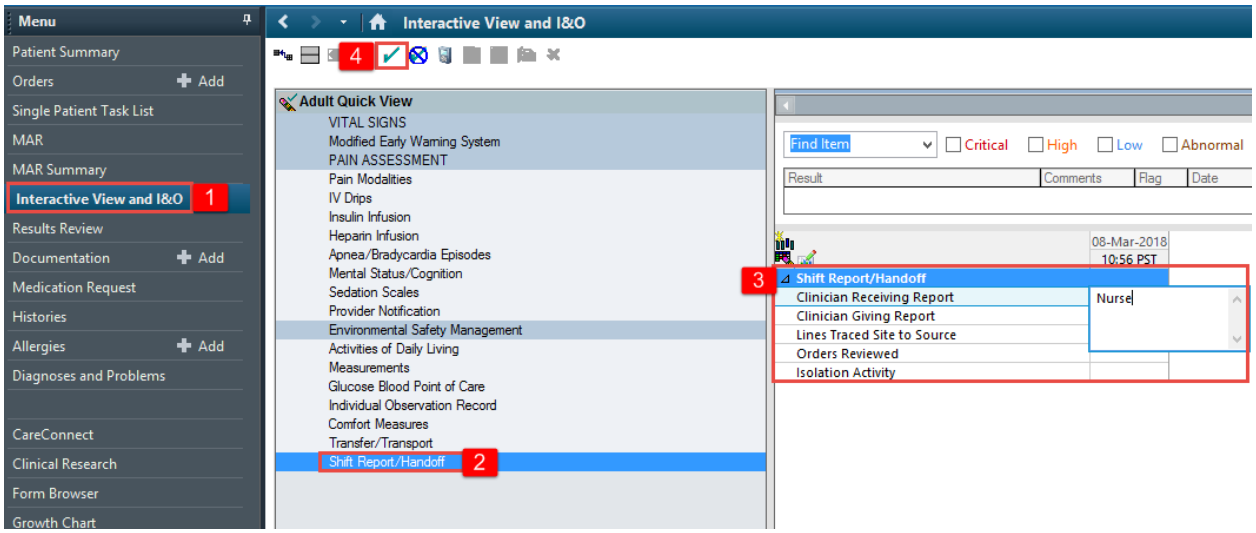
- The nurse holding responsibility for patient care ensures the documentation tools used during handover are complete and up-to-date.
- The nurse completes the *Shift Report/Handoff* transfer documentation after giving verbal handover.

Updating bedside whiteboard

- Nurse receiving the patient information assesses the patient and updates the white board as needed. **For Whiteboard use, refer to Nursing and Allied Health Whiteboard Use guidelines** (pending).

Documentation

- Bedside whiteboards
- Nurses are to chart in *Shift Report/Handoff Tool* in Interactive View and I&O.



Patient and Family Education

- Explain to the patient (& family where appropriate) the purpose of safety checks, including checking the patient identification wristband and asking for name and date of birth.
- Explain to the patient (& family where appropriate) the purpose of the bedside whiteboard – it is a daily communication tool that everyone is welcome to use, including the patient and family.
- In areas where handover is done at the bedside, explain to the patient (& family where appropriate) the purpose of handover, and assess any privacy concerns.

Related Documents

1. Unit-specific patient welcome pamphlets (e.g. Welcome to Medicine)
2. B-00-12-10076 - Admission of Patient to PHC Acute Care Nursing Unit.
3. B-00-07-10076 - Transport from MSJ: Urgent Life, Limb or Threatened Organ (LLTO) and Higher Level of Care (HLOC).
4. B-00-16-10014 - Transfer - Mental Health Inter-Hospital to SPH - After Regular Hours.
5. B-00-16-10009 - Transfer of Patient from Mental Health Program to Urban Health Program on 8A.
6. B-00-11-10181 – Policy- Transferring Patients to Next Appropriate Level of Care.

References

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Definitions

Nurse-to-nurse hand over is the transfer of accountability and responsibility of the patient's care from one nurse to another for the purpose of ensuring patient safety and continuity of care. This may include some or all of the aspects of care for the patient (i.e. transfers of care for a test, procedure or break relief). To promote patient safety, handover includes a combination of tools, either written or electronic clinical handoff tools, AND whenever possible a verbal exchange (in person or on the phone), with the opportunity for questions/clarifications, and done with clear, concise, and efficient communication.

Family is defined by the patient. When the patient is unable to define family, the patient's substitute decision maker provides the definition. Family members are the people who provide the primary physical, psychological, or emotional support for the patient. Family is not necessarily blood relatives. Family members are encouraged to be involved and supportive of the patient/resident and are integral to the overall well-being of the patient.

Person and Family Centred Care is an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, the people we serve and their families.

Persons and Groups Consulted

PHC Clinical Nurse Leader Group

PHC Nurse Educator Group

PHC Advanced Practice Nursing Group (NP and CNS)

Practice Consultants, Professional Practice

Developed By:

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Nurse Educator, Generalist

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