The EPIC Project
(Excellent Practice in Communication)
Nursing Clinical Handover Practices:
A Best Practice Implementation Project.

Kylie Wright  Quality & Accreditation Manager on behalf of the CNC Research Group
Liverpool Hospital

Falls Prevention Network Forum
20th May 2016
Clinical Handover

The nursing handover normally occurs at the beginning of a nurse’s shift and is considered an important nursing ritual and essential for continuity of care.\textsuperscript{1-8}

Clinical communication problems are a major contributing factor in 70\% of hospital sentinel events leading to an increased risk for adverse events.\textsuperscript{13}
Clinical Handover

Standard 6
Best Practice Implementation Project

• Audit of nursing clinical handover practices
• Implement evidence based practice recommendations
• Increase staff compliance with nursing clinical handover best practice recommendations
The Joanna Briggs Institute

The International Research and Development arm of the School of Translational Science based within the Faculty of Health Sciences at the University of Adelaide.
JBI Best Practice Recommendations
Nursing Clinical Handover

4 x observational studies
2 x systematic reviews
2 x observational studies
1 x prospective pre/post interventional clinical study
6 x non-analytic studies or articles based on expert opinion
1 x guideline
Methods

Phase 1 - A baseline audit was conducted measuring 7 best practice recommendations

Phase 2 - Implementation of targeted strategies

Phase 3 - A follow up audit.
Phase 1 - Baseline audit

7 Criteria
Best Practice
Recommendations
Audit Criteria (7)

1. Verbal (face to face) communication has occurred
2. Standardised documentation has been used
3. The patient has been identified
4. Relevant History of the patient has been stated
5. Detailed observations of the patient have been stated
6. The handover process includes an agreed plan of care for the patient
7. Transfer of responsibility of the patient from one nurse/shift to another nurse/shift has occurred
Criteria 1
Verbal (face to face) communication has occurred

This criteria is deemed met if:-

• The handover has occurred at the bedside in the presence of the patient (and family members if applicable).

• The nurse/s from the concluding shift must communicate face to face to the nurse/s on the preceding shift

• Engage in discussion about care coordination with the patient/family members in a face to face manner.
Criteria 2
Standardised documentation has been used

This criteria is deemed met if handover has been delivered using standardised documentation including one of the following:

- electronic nursing handover tool
- ISBAR
- pVITAL
- clinical pathway
- NICU handover tool & flow chart
- Emergency flowchart
- ICU flowchart
Criteria 3
The patient has been identified

This criteria is deemed met if:-

• the patient’s full name has been stated clearly in the handover communication and the patient’s identification (ID) band has been checked.
Criteria 4
Relevant History of the patient has been stated

This criteria is deemed met if the reason for hospital admission and relevant medical/clinical history has been clearly stated.

This must include:

- Presenting symptoms/events on admission and provisional diagnosis
- A brief synopsis of treatment to date / test results – including recent MET & CRC calls, Falls etc
- Relevant medical history and co-morbidities
Criteria 5
Detailed observations of the patient have been stated

This criteria is deemed met if:-

• reference to the patient’s vital sign status, frequency and relevant observations have been stated

• bedside observations charts are checked together

* Falls Risk Assessment
Criteria 6
The handover process includes an agreed plan of care for the patient

This criteria is deemed met if:

- the nutritional status is mentioned
- the care required for the following shift is clearly described, and
- assessments / tests/ procedures / medications / documentation
- This included falls prevention strategies / FRAMP
Criteria 7
Transfer of responsibility of the patient from one nurse/shift to another nurse/shift has occurred

This criteria is deemed met if

• time has been provided to clarify and ask any questions (nurse and/or patient, parent, family member) and

• the nurse/s receiving handover accepts responsibility and accountability for care.
Phase 2 - Implementation of targeted strategies

• Identify barriers underpinning the gap between actual practice and best practice
• Implement tailored strategies
Phase 3 – Follow up phase

- Identify improvement in compliance with best practice
- Establish if improvement (if any) had been sustained
- Identify remaining areas of improvement

No variations to criteria, sample size, characteristics or location

Conducted over a 4 week period

Approval by SWSLHD Research Ethics Committee
RESULTS
Results Phase 1 – Baseline Audit

Criteria Legend

1. Verbal (face to face) communication has occurred. (330 of 330 samples taken)
2. Standardised documentation has been used. (330 of 330 samples taken)
3. The patient has been identified. (330 of 330 samples taken)
4. Relevant history of the patient has been stated. (330 of 330 samples taken)
5. Detailed observations of the patient have been stated. (330 of 330 samples taken)
6. The handover process includes an agreed plan of care for the patient. (330 of 330 samples taken)
7. Transfer of responsibility of the patient from one nurse/shift to another nurse/shift occurred. (330 of 330 samples taken)
Results Phase 2 – Interventions

Clinical Handover Education Bundle

• Video
• Posters listing the 7 criteria
• Lists for bedside notes
• ID cards
• Generic PowerPoint presentation
• Ward handover champions

(worked with Falls Champions)
Video – Incorrect vs Correct Handover

https://youtu.be/Rn6r_hFWP0Q
Results Phase 3
Follow-up Audit (6 months)

All Teams - Aggregated

<table>
<thead>
<tr>
<th>Criterion</th>
<th>02/02/2015 - Baseline Cycle</th>
<th>27/08/2015 - Follow Up Cycle 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>46</td>
<td>93</td>
</tr>
<tr>
<td>2</td>
<td>93</td>
<td>90</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>98</td>
</tr>
<tr>
<td>4</td>
<td>64</td>
<td>67</td>
</tr>
<tr>
<td>5</td>
<td>37</td>
<td>87</td>
</tr>
<tr>
<td>6</td>
<td>41</td>
<td>96</td>
</tr>
<tr>
<td>7</td>
<td>64</td>
<td>69</td>
</tr>
</tbody>
</table>

Compliance %

Criteria Legend
1. Verbal (face to face) communication has occurred. (330 of 330 samples taken)
2. Standardized documentation has been used. (330 of 330 samples taken)
3. The patient has been identified. (330 of 330 samples taken)
4. Relevant history of the patient has been stated. (330 of 330 samples taken)
5. Detailed observations of the patient have been stated. (330 of 330 samples taken)
6. The handover process includes an agreed plan of care for the patient. (330 of 330 samples taken)
7. Transfer of responsibility of the patient from one nurse/shift to another nurse/shift occurred. (330 of 330 samples taken)
Discussion

- Consumer participation
- Incorrect vs Correct handover video
- Governance
Conclusion

• Clinical communication problems are a major contributing factor in hospital sentinel events.

• The findings showed how audit may be used to promote best practice and that focussed education can have an immediate impact on clinical practice.

• Some criteria measured did not improve to a great degree leaving plenty of room for improvement → sustainability audits

• Transferable to multidisciplinary clinical handover practices
No conflicts of interests to declare

Acknowledgements

The research team

Kylie Wright, Q&AM
Craig Wainwright, CNC
Amanda Chapman, CNC
Cecilia Astorga, CNC
Charmaine O’Connor, CNC
Kelli Flowers, CNC
Louise Smith, CNC
Nevenka Francis, CNC
Tanghua Chen, CNC
Anna Thornton, DN&MS
Gia Vigh, Librarian
Ros Sleeman, Consumer Representative

Kylie Wright, Quality & Accreditation Manager
Liverpool Hospital
Kyliem.wright@sswahs.nsw.gov.au
References

11. Wong MC, Yee KC, Turner P. Clinical handover literature review. eHealth Services Research Group, University of Tasmania, Australia. 2008 (Level IV)