Enhancing Safety and Quality through Effective Clinical Handovers

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BACKGROUND

According to the Joint Commission, communication failure was a contributing cause in 60% of sentinel events.
In SGH, our patients stay for an average of 6 days, which translates to a minimum of 19 nursing handovers, and this does not include handovers among and between different health care professionals, and departments when patient requires procedures/care.
Hence, there are abundant opportunities whereby a mis-communication can occur and result in harm to the patient.
In 2013, SGH Nurses led an initiative to promote effective and complete communication of information, especially at each shift change. The initiative aimed to

- Ensure patient care continues seamlessly and safely by ensuring effective and complete communication of information takes place at each shift change.
- Enhance patient and carer involvement in care by recognising and including them in the handover process

METHODS

A multi-prong approach was adopted in order to derive a standardized operating protocol and minimum dataset to improve clinical handover during shift change. The approach took into consideration the need to incorporate information technology during the handover process.

Observation Sessions

The Nursing Quality Management and Process Improvement teams conducted observation sessions in various medical and surgical wards. Nursing managers were informed of the observation sessions and a non-participatory observation approach was used. Field notes of the structure of the team, location of handover, presence of leadership, use of information technology, information passed and patients' responses etc, were taken.

Leveraging on E Platforms

Results of the observation sessions revealed that nurses were spending a considerable amount of time toggling back and forth through the different e-documentation and paper records during the handover process.

The Nursing Informatics team was then approached to advise on the optimal sequence and appropriate landing page(s) when using the e-platforms during handover. Key consideration points include:

- Ensure handing over of elements of the minimum dataset
- Ensure landing page provides an adequate overview (including appropriate time period) of the patient's vital signs or medication history.
- Minimize toggling back and forth between different e-documentations and paper records

Literature Review

A review of the literature was also undertaken to:

- Ascertain the critical success factors of an effective handover
- Evaluate the advantages and disadvantages of bedside handover.

Piloting

The revised handover process was piloted in one medical and one surgical ward over 2 weeks. Observation sessions and interviews with nurses and nurse managers were conducted during the pilot period. Results were then used to further refine the handover process.

RESULTS

A revised handover process was implemented across all inpatient wards and involves a structured approach, with a minimum dataset represented by the acronym RIMMS (**R**espect, **I**ntroduction/**I**dentity, **M**anagement, **M**edications, **S**afety/**S**urvey).
In recognition of patients and family being partners in care and to facilitate their involvement, handover is now conducted at the patients' bedside (apart from handing over of sensitive information).

Implementation Strategies

Communication

- A deck of slides detailing the handover process; which also include a step-by-step guide of using the e-documentations during handover, was made available to all nurses

Demonstration

- Video clips of how handover is done in the pilot wards were shown to the rest of the nurses.

Practice and Feedback

- Members of the Nursing Quality Management and Process Improvement teams were present in each ward to observe, provide guidance and feedback during the roll-out of the new process.

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GUIDE TO CLINICAL HANDOVER

Handover of individual patients USE "RIMMS"

R Respect patient's right to privacy
- Handover sensitive information **away from the bedside.**
- Ask patient permission for family members to stay during handover.

I Introduce and Identify
- Introduce nurse taking over care.
- Identify patient using two identifiers.

M Management
- Hand over patient's plan of care and impending procedures/investigations

M Medication
- Patient's list of medication via CLMM
- Nurse Charting for parameters including blood glucose.
- Check infusion rate

S Safety/Survey
- Check for phlebitis, skin integrity, patient's understanding of fall risk.

Perform the **4 Ps**
- Presence of pain
- Possession within reach
- Position
- Potty - toileting

Preliminary evaluation demonstrated that patients were pleased that they were updated on their treatment plans and given the chance to participate in care. Nurses narrated that they felt more confident taking over patient's care.

CONCLUSION

Good clinical handover is paramount to safe patient care, good patient experiences and outcomes. The revised handover process has enabled nurses to standardise the exchange of information and partner with patients and their families in the clinical handover process.