NATIONAL CLINICAL EFFECTIVENESS COMMITTEE

Tús Áite do Shábháilteacht Othar
Patient Safety First

Communication (Clinical Handover) in Maternity Services

National Clinical Guideline No. 5

Summary

An Roinn Sláinte
DEPARTMENT OF HEALTH

November 2014

Guideline Development Group
The National Communication (Clinical Handover) Sub-group/Guideline Development Group (GDG) was a work stream of the National Implementation Group – HSE/HIQA Maternity Services Investigations (HSE) under the governance of the Acute Hospitals Division, HSE. This group will be referred to as the GDG throughout this document. The GDG was supported by the Clinical Strategy and Programmes Division HSE; the Office of the Nursing and Midwifery Services Director, HSE; the Quality and Patient Safety Division, HSE; Patient Representative Groups; the National Ambulance Service; the Clinical Indemnity Scheme, (State Claims Agency); the Irish Association of Directors of Nursing and Midwifery (IADNAM); Health and Social Care Professionals Committee and the College of Anaesthetists, Royal College Physicians of Ireland; Royal College of Surgeons in Ireland and the Nursing and Midwifery Board of Ireland (NMBI), University College Dublin (UCD).

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Using this National Clinical Guideline
This guideline is intended to be relevant to all healthcare staff involved in the communication (clinical handover) of patient care in maternity services. It outlines the general and specific measures for clear and focused communication of information relating to the patient's condition, both urgent and routine, for in-patients and patients attending maternity hospital services in Ireland. This includes both stand-alone maternity hospitals and co-located maternity units in Ireland.

The full version of the National Clinical Guideline, is available on the website:
www.health.gov.ie/patient-safety/ncec

Recommendations are presented with practical guidance. The recommendations are linked to the best available evidence and/or expert opinion using the grades for recommendations. The National Clinical Guideline recommendations have been crossreferenced where relevant with other National Clinical Guidelines.

A full list of references can be found in the full version of the National Clinical Guideline.

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Disclaimer
The Communication (Clinical Handover) Sub-group/Guideline Development Group expect that healthcare professionals will use clinical judgement, medical, midwifery and nursing knowledge in applying the general principles and recommendations contained in this document. The National Clinical Guideline recommendations do not replace or remove clinical judgement or the professional care and duty necessary for each specific patient case. Recommendations may not be appropriate in all circumstances and decisions to adopt specific recommendations should be made by the practitioner taking into account the circumstances presented by individual patients and available resources.

National Clinical Effectiveness Committee (NCEC)

The National Clinical Effectiveness Committee (NCEC) is a Ministerial committee established as part of the Patient Safety First Initiative. The NCEC role is to prioritise and quality assure National Clinical Guidelines and National Clinical Audit so as to recommend them to the Minister for Health to become part of a suite of National Clinical Guidelines and National Clinical Audit.

National Clinical Guidelines which have been quality assured and recommended by NCEC for implementation provide robust evidence-based approaches to underpin or define models of care as appropriate. They provide guidance and standards for improving the quality, safety and cost-effectiveness of healthcare in Ireland. The implementation of clinical guidelines can improve health outcomes, reduce variation in practice and improve the quality of clinical decisions.

NCEC Terms of Reference

- Apply criteria for the prioritisation of clinical guidelines and audit for the Irish health system.
- Apply criteria for quality assurance of clinical guidelines and audit for the Irish health system.
- Disseminate a template on how a clinical guideline and audit should be structured, how audit will be linked to the clinical guideline and how and with what methodology it should be pursued.
- Recommend clinical guidelines and national audit, which have been quality assured against these criteria, for Ministerial endorsement within the Irish health system.
- Facilitate with other agencies the dissemination of endorsed clinical guidelines and audit outcomes to front-line staff and to the public in an appropriate format.
- Report periodically on the implementation of endorsed clinical guidelines.

In response to the *HIQA Patient Safety Investigation Report into Services at University Hospital Galway* (2013), the NCEC was requested by the Minister for Health to commission and quality assure a number of National Clinical Guidelines. The national clinical handover guideline is one of these guidelines.

NCEC in collaboration with the Acute Hospitals Division, HSE, Quality and Patient Safety and Clinical Strategy and Programmes divisions considered that the breadth and scope of this complex multi-disciplinary guideline requires a multi-phase approach. Phase 1 provides for clinical handover within in-patient maternity hospital services. This guideline published November 2014 was developed by a Guideline Development Group under the chairmanship of Ms Eilish Croke (Appendix 1). Phase 2 has commenced and focuses on clinical handover within acute hospital services including paediatric hospitals.

The National Clinical Guideline – Communication (Clinical Handover) in Maternity Services was quality assured by the NCEC and endorsed by the Minister for Health for implementation in the Irish health system.

Information on the NCEC and endorsed National Clinical Guidelines is available at:
www.health.gov.ie/patient-safety/ncec.

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Glossary of terms and definitions

Clinical Handover (sometimes called clinical handoff) refers to the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

Coroner's Report (April 2013): The Report by Coroner, Dr. Ciaran McLoughlin, following the inquest into the death of Savita Halappanavar.

Director of Nursing and/or Midwifery: Some maternity hospitals/units have a dedicated Director of Midwifery while others have a Director of Nursing and Midwifery.

Electronic patient record: An electronic patient record is a digital record of information about a patient, which provides patient information in real-time and securely to authorised users. It is analogous to the traditional patient's paper chart.

Emergency: An unexpected, serious event, which may be harmful for patients and requires an immediate response.

Flexible standardisation: The idea that effective clinical handover involves local interpretation of a standard in order to accommodate contextual factors (Australian Healthcare and Hospitals Association, 2009; Australian Commission on Safety and Quality in Health Care, 2013). This principle is particularly relevant to inter-departmental clinical handovers. The literature suggests that clinical handovers occurring between units should be approached somewhat differently to intra-departmental clinical handovers, including shift change clinical handover, since they require a greater degree of negotiation and collaboration between specialities and professions, whose priorities and information requirements can differ greatly (Beach et al. 2012; Hilligoss and Cohen, 2013).

HIQA Report (October 2013): *The Patient Safety Investigation Report on Services at University Hospital Galway (UHG)*.

HSE Report (June 2013): The Report on the HSE investigation into events which took place in UHG, relating to the death of Savita Halappanavar.

Inter-departmental: This relates to patient transfer between departments within a hospital or between two hospitals. e.g. ward to ICU within the same hospital or a different hospital.

Models of hospitals: These describe four types of acute hospitals in Ireland, as proposed by the National Acute Medicine Programme, Clinical Strategy and Programmes Division HSE; The models are: model 4 - tertiary hospital; model 3 - general hospital; model 2 - local with selected (GP-referred) patients; and model 1 - community/district hospitals.

Multi-disciplinary: Members of different disciplines (in this instances required to attend handover meetings) to be agreed by the organisation

National Implementation Group – HSE/HIQA Maternity Services Investigations: This was established to advise on and oversee the implementation of the HSE Report on NIMT 50278 and the subsequent recommendations of the HIQA Report (October 2013).

The Communication (Clinical Handover) Sub-group/Guideline Development Group: This is a sub-group of the *National Implementation Group – HSE/HIQA Maternity Services Investigations.* It is referred to as the Guideline Development Group (GDG) for the remainder of the document.

1 Clinical handover background

1.1 Need for National Clinical Guideline

As a result of the maternal death of Savita Halappanavar in 2012, the HSE established the National Implementation Group – HSE/HIQA Maternity Services Investigations in March 2013, to co-ordinate and oversee the implementation of recommendations from the HSE, HIQA and Coroner Reports. Poor communication was identified as contributing to Savita's death in all three reports.

The Communication Sub-group/Guideline Development Group(GDG) was set up by the National Implementation Group to develop a National Clinical Guideline with recommendations on Communication (Clinical Handover). This group will be referred to as the GDG through the remainder of this document.

1.2 Risks associated with clinical handover

Risks associated with clinical handover whether as part of shift or interdepartmental clinical handover or communication of information in relation to the deterioration in a patient's condition are similar and include:

- Delay in critical referrals leading to adverse incidents.
- Delay in treatments leading to increased risk of infection and/or exacerbation of infection or illness, which may lead to poor patient outcomes, death or prolonged hospital stays.
- Competence of staff.
- Lack of continuity of care.
- Waste of valuable time when inaccurate and/or incomplete information is provided.
- Inappropriate treatment being provided for patients.

Risks associated with poor clinical handover practices may be further compounded by:

- Hierarchical structures in the health service.
- Resistance to change.
- Lack of standardisation of clinical handover practices.
- Lack of effective implementation of the National Clinical Guideline on clinical handover.

1.3 Clinical and financial impact

Poor communication at clinical handover and in other situations has been identified as a contributing factor in adverse incidents where patient care is put at risk. In the UK, the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) (2005, 2012) highlighted communication failures between teams as a contributing factor to delays in referrals and in delivering appropriate essential care.

Holly and Poletick (2013) undertook a systematic review of literature on the transfer of information during nurse transitions in care. The findings demonstrate that information transferred may be random and variable, inconsistent and incongruent, inaccurate or absent and they suggest that a consistent guideline or framework may provide a formula for an optimal shift report.

The Joint Commission (USA) (2007) identified that timely, accurate, complete and unambiguous information that is understood by the recipient, reduces errors and results in improved patient safety. While no studies were identified that analysed the economic impact of clinical handover in maternity services, two studies were identified, which point to evidence that introducing a change to clinical handover practices can be cost effective in acute care settings (Hess et al. 2010, Yao et al. 2012). Hess et al. (2010) analysed the economic impact of a clinical handover improvement initiative for patients being discharged from a respiratory acute care unit to a

rehabilitation facility. The initiative involved supplementing written handoffs with verbal telephone reports. Using a historical control group of patients readmitted to the unit in the previous two years as the comparator, Hess et al. (2010) examined the economic impact of the initiative on readmission within 72 hours of discharge as the primary end point, with total cost, including readmission cost, being the secondary end point. The authors concluded that supplementing a written report with a verbal telephone report was associated with 'a significant reduction in cost', with the estimated median total cost of care significantly less following the introduction of the intervention.

Yao et al. (2012) used a staff education programme aimed at improving clinical handoff at the point of discharge as a case study to describe a method for prospective evaluation of the cost of a 'generic' health intervention. The endpoint in the economic analysis was 'expected monetary benefit', a measure of expected health gain in Quality Adjusted Life Years (QALY), and the comparator was the cost of treating adverse events in the absence of the intervention. Based on estimates for delivering the educational intervention in The Netherlands, Yao et al. (2012) calculated the net cost and reported that the intervention was 'highly cost-effective' at only about €214 per Quality Adjusted Life Year (QALY) gain.

It is envisaged that implementing this National Clinical Guideline will incur minimal cost to the system as a majority of units were identified, in the research conducted for this project, as being aware of the recommended tool for escalating care in relation to a deteriorating patient (ISBAR), and existing education via the COMPASS©/NEWS will continue to provide education in relation to the ISBAR communication tool. The COMPASS©/NEWS education programme is recommended for all staff in maternity units as non-pregnant patients must have the NEWS performed routinely. The IMEWS education programme also includes ISBAR. In addition the Irish Maternity Early Warning System (IMEWS) National Clinical Guideline No.4 contains the ISBAR communication tool.

$ISBAR_3$ will require additional explanation as it is not contained in the COMPASS©/NEWS education programme. The GDG recommends developing a web-based education programme and a mobile App of the ISBAR and $ISBAR_3$ mnemonic for use with hand-held devices in clinical areas to provide an explanation on their use in clinical handover. This will be developed in conjunction with existing IT expertise within the health system, and will be accessible by all healthcare workers free of charge. While it is anticipated that the App may incur an initial development cost, it is recommended that the App should be maintained and updated by the HSE IT service as part of its remit to provide and maintain IT support for HSE staff. Accordingly, ongoing maintenance should not represent an additional cost. The proposed app will provide education on using the recommended shift clinical handover tool/ inter-departmental clinical handover tool ($ISBAR_3$). The App will also allow ease of access to this National Clinical Guideline. A business case for this App will be required.

The GDG recommends that clinical handover practice should be audited and monitored by the relevant quality and safety committee of the healthcare organisation (Recommendation 6). It is acknowledged that this could have a budget impact for some maternity units, in terms of staff hours required to conduct audit; however such costs could be minimised by conducting audit of clinical handover in conjunction with standard audit activities already in place. The GDG also recommends that the healthcare organisation should ensure that there is mandatory protected time for shift clinical handover (Recommendation 15). It is acknowledged that this could have opportunity costs and therefore a budget impact for some maternity units, should it lead to the need for additional staff hours; however such costs could be minimised or eliminated with judicious rostering.

1.4 Aim and scope of this National Clinical Guideline

The aim of this National Clinical Guideline is to describe the elements that are essential for timely, accurate, complete, unambiguous and focused communication of information in maternity services in Ireland, relating to the patient's condition, both urgent and routine, to include the following:

- Professional consultations such as:
  - Team to team.
  - One profession to another.
  - Laboratory to team.
  - Radiology to team.

- Deterioration in a patient's condition.

- Transitions of care such as:
  - Clinical handover of patient care at a change of shift.
  - Clinical handover to and from a higher level of care (e.g. ambulance staff to ED/AMAU staff, Model 2/3 hospital to Model 4 hospital, ward to ICU/CCU, ICU/CCU to ward).
  - Communication with patients and/or their relatives, to ensure that a treatment plan is readily explained and understood.

The expected outcome is that all communication (clinical handover) between healthcare staff in maternity services will be conducted using a structured communication tool, promoting standardisation of practice and minimisation of variability, thus reducing risk for patients.

Note:

- Dealing with emergency/crisis situations will always take precedence and shift clinical handover should be provided for staff involved in the emergency/crisis situation when the emergency/crisis situation has been dealt with.

The British Medical Association (BMA), (2004) defined clinical handover as 'The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis'. The scope of this guideline means it applies to all doctors, midwives, nurses, health and social care professionals, healthcare assistants and other staff involved in the clinical care of patients in maternity services; and managers responsible for the development, implementation, review and audit of communication/clinical handover practice in individual hospitals or group of hospitals for use with service users who access maternity hospital services (maternity in-patients and patients attending maternity hospital services) in Ireland.

This guideline makes recommendations on the process of communication (clinical handover) and the content of communication (clinical handover) of patient care between healthcare staff; and between healthcare staff and patients/relatives for in-patients and patients attending maternity hospital services in Ireland.

This guideline does not cover:

- Routine recording of patient care in the patient's medical chart used in maternity units.
- The response following communication of information e.g. where a patient is deteriorating or critically ill.
- Clinical handover in any other setting.

1.5 Grading of recommendations

All decisions regarding the quality of evidence and the strength of recommendations were based on summaries of evidence from the literature review and the evidence was weighted according to the SIGN (2011) grading criteria. Recommendations arising out of published guidelines were also assigned scores according to the National Quality Assurance Criteria Score, published by the Health Information and Quality Authority (HIQA 2011). For the purpose of this summary document grade of recommendation only is shown (see Table 1.6.1).

Table 1.6.1 ABCD Criteria/Consensus Grade

Grade	Grade descriptor
A	At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population or; a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++
D	Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+

2 National Clinical Guideline recommendations

The recommendations are numbered 1 to 30 and are linked to the best available evidence and/or expert opinion. They are divided under the following topics:

Section	Subsection	Recommendation Number
Organisational Recommendations	• Recognition of clinical handover as a clinical risk activity. • Guidance. • Education and training. • Information giving and seeking. • Accessing information.	1-9
Clinical Handover Conduct	• Shift clinical handover. • Inclusion of all patients in the ward/unit at shift clinical handover. • Protected area. • Protected time for inter-departmental clinical handover. • Mandatory protected time for shift clinical handover. • Clear transfer of responsibility for the patient. • Designation a lead healthcare professional to manage clinical handover. • Clarification of staff roles and responsibilities for clinical handover. • Clinical handover process. • Safety Pause. • Radiology. • Laboratory. • Patient/carer involvement.	10-24
Clinical Handover Content	• Shift clinical handover - structured format/ common language. • Inter-department clinical handover - structured format. • Electronic clinical handover applications/ templates. • Communication of patient deterioration.	25-28
Additional Recommendations	• Education and training. • Guideline implementation.	29-30

Maternity hospitals need to have systems in place to address all elements in the National Clinical Guideline. Due consideration of the application of the recommendations for individual hospitals/units specific circumstances is required.

2.1 National recommendations

2.1.1 Organisational recommendations

Responsibility Recommendation 1:
CEO/General Manager/Hospital Manager of the healthcare organisation.

> **Recommendation 1:** Healthcare organisations recognise clinical handover as a clinical risk activity, and incorporate clinical handover into their risk register.
> **Grade:** D

Practical Guidance
Healthcare organisations should incorporate clinical handover into their corporate and local risk register. The GDG recognise that on-going care and patient safety must be ensured during the clinical handover period.

Responsibility Recommendation 2:
All healthcare staff.

> **Recommendation 2:** Participation at clinical handover should take priority over all other work except emergencies.
> **Grade:** D

Responsibility Recommendations 3-6:
CEO/General Manager/Hospital Manager of the healthcare organisation.

> **Recommendation 3:** Healthcare organisations review existing organisational clinical handover guidance (policies, procedures and guidelines) in collaboration with appropriate stakeholders, including healthcare staff, patients and their carers.
> **Grade:** D

Practical Guidance
Review of existing organisational clinical handover guidance is an essential step to provide the opportunity to reflect on current processes and to effectively implement Recommendations 4-6.

> **Recommendation 4:** Healthcare organisations develop a local policy in compliance with the National Clinical Guideline, in relation to clinical handover following consultation with relevant stakeholders.
> **Grade:** D

Recommendation 5: Local clinical handover policies must be developed in compliance with the National Clinical Guideline. While national communication tools (templates) are included in the National Clinical Guideline, these templates may be customised locally to accommodate features of the healthcare organisation, individual department, ward or unit, in line with the concept of 'flexible standardisation'.
Grade: D

Practical Guidance
Note: Flexible standardisation: The idea that effective clinical handover involves local interpretation of a standard in order to accommodate contextual factors (Australian Healthcare and Hospitals Association, 2009; Australian Commission on Safety and Quality in Health Care, 2013). This principle is particularly relevant to inter-departmental clinical handovers. The literature suggests that clinical handovers occurring between units should be approached somewhat differently to intra-departmental clinical handovers, including shift change clinical handover, since they require a greater degree of negotiation and collaboration between specialities and professions, whose priorities and information requirements can differ greatly (Beach et al. 2012; Hilligoss and Cohen, 2013).

Templates for ISBAR and $ISBAR_3$ communication tools should be adjusted for specific clinical circumstances such as the addition of a surgical check list for surgical areas as appropriate (See Appendix 2).

Recommendation 6: Clinical handover practice is audited and monitored by the relevant quality and safety committee of the healthcare organisation. It is the responsibility of the chair of this committee to assure the CEO/General Manager that the audit is undertaken and any necessary continuous quality improvement plans are put in place.
Grade: D

Practical Guidance
Audit tool templates for ISBAR, ISBAR and organisation compliance with the National Clinical Guideline are available and can be amended as appropriate.

Responsibility Recommendation 7:
CEO/General Manager/Hospital Manager of the healthcare organisation.

Recommendation 7: Healthcare organisations provide staff with education and training for their clinical handover policy. This should be mandatory and form part of staff orientation and ongoing in-service education.
Grade: D

Practical Guidance
Healthcare organisations should provide education and training on communication (clinical handover) to healthcare professionals together where possible.

Responsibility Recommendation 8:
CEO/General Manager/Hospital Manager of the healthcare organisation.

> **Recommendation 8:** Healthcare organisations should incorporate Human Factors Training into all clinical handover education and training, and promote a culture of mutual respect between professionals.
> **Grade:** D

Practical Guidance
Human factors refer to environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety (WHO, 2009). Human Factors Training will foster an environment of questioning and promote confidence of staff. This should include training in assertiveness and effective communication methodologies in order to promote a culture of openness in the interest of patient safety and quality.

2.1.2 Clinical Handover conduct

Responsibility Recommendation 9:
CEO/General Manager/Hospital Manager of the healthcare organisation.

> **Recommendation 9:** Healthcare organisations ensure that all staff have access to relevant, accurate and up to date sources of information during clinical handover. Electronic patient records, including diagnostic data, should be considered as a solution for providing relevant, accurate and up to date information for clinical handover.
> **Grade:** D

Practical Guidance
In terms of electronic patient records a collaborative national approach should be taken.

Responsibility Recommendation 10:
CEO/General Manager/Hospital Manager/Clinical Lead/Director of Nursing and/or Midwifery of the healthcare organisation.

> **Recommendation 10:** The healthcare organisation should implement multidisciplinary shift clinical handover where possible, to include junior and senior staff at every clinical handover during the 24 hour cycle.
> **Grade:** D

Practical Guidance
Co-ordination of rostering for multidisciplinary team members, within organisations, may provide an opportunity to achieve multidisciplinary team shift handover.

Responsibility Recommendation 11:
CEO/General Manager/Hospital Manager/Clinical Lead/Director of Nursing and/or Midwifery of the healthcare organisation.

> **Recommendation 11:** Shift clinical handover should incorporate a discussion around operational issues and identify factors that may impact on clinical care.
> **Grade:** D

Practical Guidance
Concerns in relation to operational issues should be escalated to senior hospital management in line with the agreed organisational processes. Refer to recommendation 21 for further detail on the Safety Pause which can be utilised for risk assessment as appropriate. An example of operational issues could be bed/cot availability, increased risk of cross-infection, staffing, etc.

Responsibility Recommendation 12:
All healthcare staff in the healthcare organisation.

> **Recommendation 12:** All patients in the ward/unit must be discussed at shift clinical handover.
> **Grade:** D

Responsibility Recommendation 13:
CEO/General Manager/Hospital Manager/Clinical Director of the healthcare organisation/ Director of Nursing and/or Midwifery of the healthcare organisation.

> **Recommendation 13:** Clinical handover is conducted in an area with minimal distractions and interruptions and the organisation should determine how this may be best accommodated at the ward/unit level.
> **Grade:** D

Practical Guidance
Healthcare organisations should consider relocating clinical handover to achieve recommendation 13 this with minimal distractions and interruptions where appropriate.

Responsibility Recommendation 14:
CEO/General Manager/Hospital Manager/Clinical Director/Director of Nursing and/or Midwifery of the healthcare organisation.

> **Recommendation 14:** Protected time should be designated for inter-departmental clinical handovers.
> **Grade**: D

Practical Guidance
Inter-departmental relates to patient transfer between departments within a hospital or between two hospitals, e.g. ward to ICU within the same hospital or a different hospital.

Responsibility Recommendation 15:

CEO/General Manager/Hospital Manager/Clinical Director/Director of Nursing and/or Midwifery of the healthcare organisation.

> **Recommendation 15:** The healthcare organisation should ensure that there is mandatory protected time for shift clinical handover.
> **Grade:** D

Practical Guidance

Healthcare organisations should give consideration to the most appropriate way to achieve this recommendation within their own organisation. Specific consideration should be given to clinical handover practice for NCHDs, due to the changing work patterns for this group. This could be facilitated by scheduling overlapping shifts, and mandating staff attendance.

Responsibility Recommendations 16-17:

CEO/General Manager/Hospital Manager of the healthcare organisation.

> **Recommendation 16:** The healthcare organisation's policy on communication (clinical handover) is explicit and clear about the transfer of responsibility during and following **inter-departmental** clinical handover. Clinical responsibility can only be transferred when responsibility is accepted by the team to which the patient is being referred.
> **Grade:** D

Practical Guidance

The point at which responsibility is transferred and accepted needs to be agreed between both departments/parties, be explicit and be formally documented. Clinicians, accepting responsibility for patients, must conduct their own clinical assessment of patients to confirm, as appropriate to the clinicians' role and responsibilities, clinical diagnosis and treatment plans provided during clinical handover.

> **Recommendation 17:** The healthcare organisation's policy on communication (clinical handover) must be explicit and clear about the transfer of responsibility during and following **shift clinical handover**. Clinicians, accepting responsibility for patients, must conduct their own clinical assessment of patients.
> **Grade:** D

Practical Guidance

The point at which responsibility is transferred during shift clinical handover needs to be agreed between both parties, be explicit and be formally documented. Clinicians, accepting responsibility for patients, must conduct their own clinical assessment of patients to confirm, as appropriate to the clinicians' role and responsibilities, clinical diagnosis and treatment plans provided during clinical handover.

Responsibility Recommendation 18:
The Clinical Director/Director of Nursing and/or Midwifery for the healthcare organisation

> **Recommendation 18:** Clinical handover policies should designate a lead healthcare professional to manage the inter-departmental clinical handover and the shift clinical handover process.
> **Grade:** D

Responsibility Recommendation 19:
CEO/General Manager/Hospital Manager of the healthcare organisation.

> **Recommendation 19:** Clinical handover policies should specify staff attendance, roles and responsibilities at clinical handover.
> **Grade:** D

Practical Guidance
Clinical handover policies should be decided in consultation with relevant healthcare staff.

Responsibility Recommendation 20:
All healthcare staff in the healthcare organisation.

> **Recommendation 20:** Clinical handover should be conducted:
> 1) face-to-face where possible, **Grade of Recommendation**: D
> 2) verbally, **Grade of Recommendation**: C
> 3) be supported with relevant documentation **Grade of Recommendation**: C
>
> Taped clinical handover must **NOT** be used in any circumstances
> **Grade:** D

Practical Guidance
It is recognised that there are occasions where 'face-to-face' clinical handover is not feasible. Clinicians should recognise that there is increased risk with this method and utilise all available tools to reduce this risk and enhance the quality of the clinical handover.

Responsibility Recommendation 21:
CEO/General Manager/Hospital Manager of the healthcare organisation/All healthcare staff.

> **Recommendation 21:**
> The Safety Pause should be utilised during shift clinical handover to provide an opportunity to clarify and discuss any aspect of a patient's care.
> **Grade:** D

Practical Guidance
Additional information on the Safety Pause is provided in the Safety Pause Information Sheet (Appendix 3).

Responsibility Recommendation 22:
CEO/General Manager/Hospital Manager of the healthcare organisation.

Recommendation 22:
The Faculty of Radiology's QA Guidelines for the management of Critical, Urgent and Clinically Significant and Unexpected radiological findings should be implemented in all locations. Consideration should be given to the utilisation of electronic solutions for:
a) Critical and Urgent results (as an adjunct to, and documentation of, direct voice to voice or face-to-face communication), and
b) Clinically Significant and Unexpected findings (where direct communication is not the standard) requiring follow-up.
Grade: D

Practical Guidance
PeerVue software is part of the NIMIS system and was recently purchased by the HSE. This software is currently being installed in public hospitals. The system permits radiologists to issue "Alerts" to Clinicians with varying levels of urgency. The system does not replace the conventional report as issued for all radiological investigations. Additional information on PeerVue is available in the full version National Clinical Guideline.

Responsibility Recommendation 23:
Acute Hospital Services HSE/CEO/General Manager/Hospital Manager of the healthcare facility

Recommendation 23:
Laboratories should have policies and assurance processes in place for clinical handover of critical results. A national medical laboratory information system solution would greatly facilitate the reporting of critical laboratory results and should be implemented nationally.
Grade: D

Practical Guidance
The purpose of the National MedLIS Project is to deliver a single national standardised laboratory information system, replacing the multiple disparate systems currently in use. Governance and implementation requirements around the MedLIS system is the responsibility of the National Medical Laboratory (MedLis) Project Board. Where the MedLIS system is not in use, this should be incorporated in the healthcare organisation's corporate and local risk registers.

Refer to full version National Clinical Guideline for overview of MedLIS. Education and training are key vehicles in the clinical handover pathway. It is recognised that there is often a knowledge gap regarding laboratory results where staff receiving results are not always aware of the importance of the results. The involvement of laboratory staff in multi-disciplinary team 'huddles' etc. may provide this education.

Responsibility Recommendation 24:
CEO/General Manager/Hospital Manager and Lead Clinician of the healthcare organisation.

Recommendation 24:
The healthcare organisation should aim to involve the patient and/or carer(s) in the clinical handover process, ensuring that the patient and/or carer(s) are provided with up to date factual information in relation to the patient's condition, care and treatment, encouraging and taking into consideration their preferences whilst also meeting the requirements of confidentiality. The healthcare organisation should determine how this may be best accommodated at unit level.
Grade: D

2.1.3 Clinical handover content

Responsibility Recommendation 25:
CEO/General Manager/Hospital Manager and Clinical Director/Director of Nursing and/or Midwifery of the healthcare organisation

> **Recommendation 25:**
> Shift clinical handover should be conducted using the ISBAR$_3$ communication tool (Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk) as a structured framework which outlines the information to be transferred. The tool may be available in written format and preferably electronically.
> **Grade:** D

Practical Guidance
ISBAR$_3$ tool sample (see Appendix 2), should be included in education and training programmes. ISBAR$_3$ for Shift Handover is a new communication tool developed by the GDG adapted from ISBAR.

Responsibility Recommendation 26:
CEO/General Manager/Hospital Manager and Clinical Director of the healthcare organisation.

> **Recommendation 26:** Inter-departmental clinical handover should be conducted using the ISBAR$_3$ communication tool as a structured framework which outlines the information to be transferred. The tool may be available in written format, but preferably electronically.
> **Grade:** D

Practical Guidance
Examples of inter-departmental clinical handover are:
- Maternity ward/unit to maternity ward/unit
- Maternity ward/unit to HDU/ICU
- Maternity ward/unit to operating theatre
- Maternity ward/unit to SCBU/NICU/paediatrics

ISBAR$_3$ tool samples, in (Appendix 2), should be included in education and training. Patients should not be transferred from department to department, if possible, except where there is a clinical need, reducing the need for clinical handover and enhancing the patient experience.

Responsibility Recommendation 27:
CEO/General Manager/Hospital Manager of the healthcare organisation.

> **Recommendation 27:** Where electronic clinical handover applications and templates are in use or being developed, they should incorporate the ISBAR$_3$ communication tool.
> **Grade:** D

Practical Guidance
Electronic applications and templates should be developed in consultation with healthcare staff.

Responsibility Recommendation 28:
CEO/General Manager/Hospital Manager of the healthcare organisation.

> **Recommendation 28:** The ISBAR communication tool should be used when communicating information in relation to deteriorating and/or critically ill patients.
>
> Where a situation is deemed to be critical, this must be clearly stated at the outset of the conversation.
> **Grade:** B

Practical Guidance
The GDG recognise the time critical element of communication in relation to patient deterioration. However, using the ISBAR communication tool does not prohibit parties from seeking clarification to enhance understanding of the critical nature of patient deterioration, and may be sought at any point during the communication process if required.

Communication in relation to the deteriorating patient using the ISBAR communication tool does not include clinical handover of responsibility.

The GDG recognise the importance of a response to communication on deteriorating and/or critically ill patients, however the scope of this guideline does not include the response/care intervention e.g. resuscitation and care escalation such as transfer to ICU. It is important to recognise that the deteriorating patient may be critically ill requiring Level 2 Care or Level 3 Care, further details in Appendix 4 (Levels of Critical Care, National Standards for Adult Critical Care Services 2011, Joint Faculty of Intensive Care Medicine of Ireland).

The Care Pathway for the Deteriorated Critically ill Pregnant Woman (Appendix 4) as outlined in the Guidelines for the Critically ill Woman in Obstetrics (HSE 2014) and the Irish Maternity Early Warning System (IMEWS), National Clinical Guideline No. 4 (DoH, 2014) should be adhered to.

See ISBAR tool sample, also available in (Appendix 2)

2.1.4 Additional recommendations

Responsibility Recommendation 29:
Higher Education Institutions (HEIs), Professional Regulatory Bodies

> **Recommendation 29:**
> Higher Education Institutions (HEIs) with responsibility to provide preparatory professional education, continuing education and professional development for all healthcare professionals should incorporate communication (clinical handover) practice within curricula.
> **Grade:** D

Responsibility Recommendation 30:

Recommendation 30:
A communication (clinical handover) group should be established at national level to support national implementation of this guideline.
Grade: D

Practical Guidance
The role of the group in providing support which includes the development of Terms of Reference should be defined by the HSE.

The Terms of Reference should include:
- Education on communication (clinical handover) through various methods such as web, use of an App, road shows etc.
- Access to the guideline, the ISBAR and $ISBAR_3$ templates
- Evaluation and audit to ensure implementation and measure impact of the guideline to support continuous quality improvement.

3 National Clinical Guideline development process

3.1 Aim of National Clinical Guideline

The aim of this National Clinical Guideline is to describe the elements that are essential for timely, accurate, complete, unambiguous and focused communication of information in maternity services in Ireland.

3.2 Methodology and literature review

This guideline was developed from a systematic review of literature, complimented with evidence from expert input and extensive stakeholder consultation. Whilst being developed, the guideline was continuously assessed using AGREE II Tool. Further details of the methodological processes and literature reviewed can be found in the full version National Clinical Guideline.

3.3 Financial impact of condition/disease

The budget impact analysis supports the National Clinical Guideline recommendations. Further detail is available in the full version National Clinical Guideline.

3.4 External review

The international reviewers for this guideline were:

- Ms. Eleanor R Robinson, Honorary researcher Nuffield Department of Surgical Sciences, UK. Author of a recent systematic review on intra-hospital handover.
- Dr Kwang Chien Yee, Senior Lecturer in Medicine, University of Tasmania, Australia.
  Ms. Ming Chao Wong, University of Tasmania
  Co-authors of the OSSIE Guide to Clinical Handover Improvement Australian Commission on Safety and Quality in Health Care.

The guideline was commended for its quality and comprehensiveness and more detail on the feedback received and resulting amendments are available, as are the details of national review, in the full version National Clinical Guideline.

3.5 Procedure for update of National Clinical Guideline

This National Clinical Guideline is due for review in November 2017 under the governance of the Acute Hospitals Division, HSE. Following this it will be submitted to the National Clinical Effectiveness Committee for review and endorsement.

3.6 Implementation of National Clinical Guideline

The HSE and all healthcare organisations are responsible for dissemination and implementation of the guideline including the provision of education in using the recommended communication tools. Further detail is available in the full version National Clinical Guideline.

3.7 Roles and responsibilities

Within each organisation the CEO/General Manager/Hospital Manager has overall corporate responsibility for the implementation of the guideline, to ensure that there is a system in place for the safe and effective communication (clinical handover) of patient care.

All healthcare staff are responsible and accountable, within their professional scope of practice, for adhering to this National Clinical Guideline and for maintaining competence in communication (clinical handover) of patient care. All healthcare staff must be aware of the role of appropriate delegation in using this guideline.

Further details on roles and responsibilities are available in the full version National Clinical Guideline.

3.8 Audit criteria

To ensure that this guideline positively impacts on patient care, it is important that implementation is audited. Audit is recommended to support continuous quality improvement in relation to the implementation of the National Clinical Guideline.

Audit tool templates have been developed to assist the audit of communication (clinical handover) practice and are available in the full version National Clinical Guideline.

There are 4 audit tool templates:

- ISBAR communication tool (deterioration in a patient's condition)
- $ISBAR_3$ Communication (handover) tool – Shift handover
- $ISBAR_3$ Communication (handover) tool – Inter-departmental handover
- Sample audit tool adherence by organisations to the Communication (Clinical Handover) in Maternity Service in Ireland National Clinical Guideline.

Appendix 1: Guideline Development Group

Nominee	**Position**
Ms. Eilish Croke	Chair
Ms. Celine Conroy	Project Manager
Dr. Ulrich Bartels	Consultant Obstetrician/Gynaecologist, Mayo General Hospital
Ms. Emma Benton	Therapy Professions Advisor & Portfolio Manager (Diagnostic/Support Services), Clinical Strategy & Programmes
Ms. Anne Bergin	Research Officer
Ms. June Boulger	Patient Advocacy Unit, Quality and Patient Safety Division, HSE
Dr. Ciaran Browne	National Lead for Acute and Palliative Care Services
Ms. Bernie Connolly	Professional Advisor, Midwifery, NMBI
Prof. Garry Courtney	Clinical Lead, National Acute Medicine Programme (to consult with as required)
Ms. Carmel Cullen	HSE Communications
Prof. Gerard Fealy	Associate Dean for Research and Innovation UCD and Communication (handover) project Methodologist.
Dr John Fitzsimons	Paediatric Consultant, Quality and Patient Safety Division, HSE
Ms. Mary Flynn	HSE Midwifery
Ms. Maureen Flynn	National Lead Quality and Safety Governance Development, Quality and Patient Safety Division, HSE
Mr. Paul Gallen	Ambulance Service
Ms. Mary Godfrey	Clinical Risk Advisor, State Claims Agency
Dr. Miriam Griffin	Consultant Histopathologist and Cytopathologist - Clinical Director & Project Manager, National MedLIS Project (to consult with as required)
Dr. Mark Hehir	JOGS, Specialist Registrar Obstetrics and Gynaecology, Coombe Women & Infants University Hospital.
Dr. Colm Henry	National Lead Clinical Director Programme (to consult with as required) Quality and Patient Safety Division, HSE
Mr. Louis Lavelle	AMP Programme Coordinator, Quality and Patient Safety Division, HSE
Dr. Ciara Martin	Emergency Medicine Programme, Consultant in paediatric emergency medicine
Dr. John Murphy	Neonnatology, National Clinical Lead, Neonatology
Ms. Margaret Philbin	IADNAM, Director of Midwifery, Rotunda Hospital
Dr. Michael Power	National Clinical Lead, Critical Care Programme (to consult with as required)
Ms. Melissa Redmond	Patients for Patient Safety Champions Network, Quality and Patient Safety Division, HSE
Dr. Anthony Ryan	Faculty of Radiology
Dr. Terry Tan	Consultant Anaesthetist, Coombe Hospital
Ms. Angela Tysall	Open Disclosure, Project Manager National Advocacy Unit, Quality and Patient Safety Division, HSE

Terms of reference

Phase 1: The Guideline Development Group will:

1. Develop a project plan with defined timelines.

2. Define the scope of the project.

3. Explore the use of electronic systems in healthcare communication and make recommendations to the National Group re: IT and alert solutions, identifying interim solutions.

4. Make recommendations on the implementation of an evidence based communication tool and a National Clinical Guideline, that when implemented and utilised nationally, will assist clear and focused communication of information relating to the patient's condition, both urgent and routine to include the following:
   - Professional consultations such as:
     - Team to team;
     - One profession to another;
     - Laboratory to team;
     - Radiology to team.
   - Deterioration in a patient's condition in maternity services.
   - Transitions of care such as:
     - Handover of patient care at a change of shift;
     - Handover of patient care including to a higher level of care (e.g. Ambulance staff to ED/AMAU staff, Model 2/3 hospital to Model 4 hospital, Ward to ICU/CCU);
     - Communication with patients and/or their relatives, to ensure that a treatment plan is readily explained and understood;
     - Communication on discharge of a patient.

5. Develop a Guideline to assist healthcare staff and service users' decision making about the process of communication and handover between healthcare staff and patients/relatives.

6. Liaise with clinical staff representing different grades of seniority and settings to include midwives, nurses and doctors etc, at different stages of the project as appropriate from:
   - Stand-alone maternity units;
   - Large co-located units;
   - Small co-located units;

7. Provide regular progress reports to the National Implementation Group – HSE/HIQA Maternity Services Investigations and provide a final report to include the sub-group's recommendations by end 2014.

8. Develop, agree and recommend audit tools, for healthcare staff, to reflect the recommendations of this group.

For details of national review and contributions see full version National Clinical Guideline. No conflict of interests were declared by the members of the GDG.

Appendix 2: ISBAR and ISBAR$_3$ Communication Tools

ISBAR Communication Tool

ISBAR Communication Tool SAMPLE Patient Deterioration	
I Identify	**Identify:** You Recipient of handover information Patient
S Situation	**Situation:** Why are you calling? (Identify your concerns)
B Background	**Background:** What is the relevant background?
A Assessment	**Assessment:** What do you think is the problem?
R Recommendation	**Recommendation:** What do you want them to do?

Reproduced and adopted with permission from Dr S. Marshall, Monash University, Australia.

ISBAR$_3$ Communication Tool

ISBAR$_3$ Communication (clinical handover) Tool SAMPLE Shift Handover	
I Identify	**Identify:** Lead handover person Individuals / Team receiving handover Patient(s)
S Situation	**Situation:** Location of patient(s) Brief summary of current status Is there a problem?
B Background	**Background:** Concise summary of reason for admission Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S_PO_2, (F_iO_2), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate)
A Assessment	**Assessment:** What is your clinical assessment of the patient at present?
R$_3$ Recommendation Read-Back Risk	**Recommendation:** Specify your recommendations Read-Back: Recipients to confirm handover information Risk: Include the safety pause to identify possible risks

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

ISBAR$_3$ Communication (clinical handover) Tool SAMPLE Inter-departmental Handover	
I Identify	**Identify:** You Recipient of handover information Patient
S Situation	**Situation:** Location of patient as appropriate Brief summary of patient's current status Is there a problem?
B Background	**Background:** Concise summary of reason for interdepartmental handover Summary of treatment to date Baseline observations (current admission) Vital Signs: BP, Pulse, Resps, S_PO_2, (F_iO_2), Temp, AVPU. IMEWS (include previous IMEWS if appropriate) NEWS (include previous NEWS if appropriate)
A Assessment	**Assessment:** What is your clinical assessment of the patient at present?
R$_3$ Recommendation Read-Back Risk	**Recommendation:** Specify your recommendations Read-Back: Recipient(s) to confirm handover information and responsibility Risk: Include the safety pause to identify possible risks

Adapted by GDG with permission from Dr S. Marshall, Monash University, Australia.

Appendix 3: Safety Pause – information sheet

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality and Patient Safety Directorate

We are all responsible…and together
we are creating a safer healthcare system

An Roinn Sláinte
DEPARTMENT OF HEALTH

THE SAFETY PAUSE: INFORMATION SHEET

Helping teams provide safe quality care

Why	Safety awareness helps all teams to be more proactive about the challenges faced in providing safe, high quality care for patients.
Who	Team lead and available multidisciplinary team members.
When	Any time (aim for a maximum of five minutes).
How	Focus on things everyone needs to know to maintain safety. Based on one question *'what patient safety issues do we need to be aware of today'* - resulting in immediate actions. The four P's below provide examples to prompt the discussion (any prolonged discussion on specific issues can be deferred until after the safety pause).

THE SAFETY PAUSE

QUESTION:

WHAT PATIENT SAFETY ISSUES DO WE NEED TO BE AWARE OF TODAY?

Examples

- **Patients:** are there two patients with similar names; patients with challenging behaviour; wandering patients; falls risk; self harm risk; or deteriorating patients?
- **Professionals:** are there agency, locum or new staff who may not be familiar with environment/procedures?
- **Processes:** do we have: new equipment or new medicinal products (are all staff familiar with these?); missing charts; isolation procedures required; or care bundles for the prevention and control of medical device related infections?
- **Patterns:** are we aware of any recent near misses or recently identified safety issues that affected patients or staff?

Heads-up for today

- Challenges e.g. illness related leave, staffing levels, skill mix, demand surges.
- Meetings/training sessions staff need to attend e.g. mandatory training.
- New initiatives/information e.g. new protocols; feedback from external groups.
- Any other safety issues or information of interest to the team – has this been communicated to the team e.g. notice board/communication book/ patient status at a glance (PSAG) board/ other communication system etc.

Patient Feedback

- Update on actions from recent patient feedback on their experience (complaints, concerns or compliments) that we need to be aware of today?

Follow-ups	Issues raised previously (confirm included on existing risk register if appropriate), solutions introduced or being developed. For those involved in the 'productive ward' initiative this is an opportunity to review the 'safety cross' data and any improvements.
Team morale	Recent achievements, compliments from patients and what works well.

Acknowledgements:
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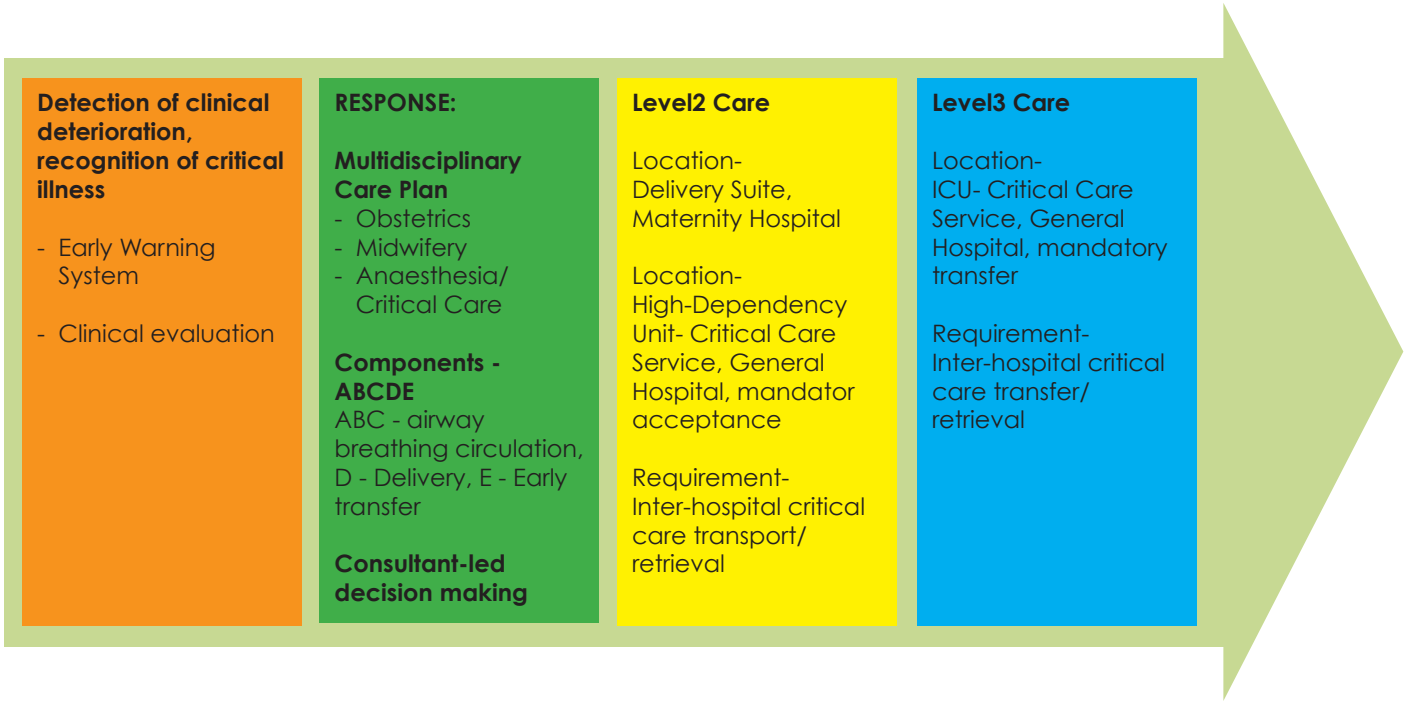
An initiative of the Quality and Patient Safety Directorate, May 2013

For further informaton see www.hse.ie/go/clinicalgovernance

Tús Áite do Shábháilteacht Othar
Patient Safety First

Appendix 4: Care pathway for the deteriorated critically ill pregnant woman

Care pathway for the deteriorated critically ill pregnant woman



Acute Care	Level 0	Hospital ward clinical management
	Level 1	Higher level of observation eg. PACU
Critical Care	Level 2	Active management by critical care team to treat and support critically ill patients with primarily single organ failure
	Level 3	Active management by critical care team to treat and support critically ill patients with two or more organ failures
	Level 3 s	Level with regional / national service

Reference: *Guidelines for the Critically Ill Woman in Obstetrics (HSE, 2014)*

Appendix 5: Glossary of terms and abbreviations

Definitions within the context of National Clinical Guideline

See Section 1.1 of this Summary version

Abbreviations

AGREE	Appraisal of Guidelines Research and Evaluation
AMAU	Acute Medical Assessment Unit
AMP	Acute Medicine Programme
BMA	British Medical Association
CCU	Coronary Care Unit
CEO	Chief Executive Officer
DoH	Department of Health
ED	Emergency Department
GDG	Guideline Development Group
GP	General Practitioner
HDU	High Dependency Unity
HEIs	Higher Education Institutions
HIQA	Health information and Quality Authority
HSE	Health Service Executive
IADNM	Irish Association of Directors of Nursing and Midwifery
ICU	Intensive Care Unit
IMEWS	Irish Maternity Early Warning System
ISBAR	Communication Tool (Identify, Situation, Background, Assessment, Recommendation)
ISBAR3	Communication tool (Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk)
IT	Information Technology
JOGS	Junior Obstetrics and Gynaecology Society
MedLIS	Medical Laboratory Information System
NCEC	National Clinical Effectiveness Committee
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NCHD	Non-consultant Hospital Doctor
NEWS	National Early Warning Score (NEWS).
NICU	Neonatal Intensive Care Unit
NIMIS	National Integrated Medical Imaging System
NMBI	Nursing and Midwifery Board of Ireland

NIMT	National Incident Management Team
OSSIE	Organisational leadership, Simple solution development, Stakeholder engagement, Implementation, Evaluation and maintenance
QA	Quality Assurance
QALY	Quality Adjusted Life Years
SCBU	Special Care Bayb Unit
SIGN	Scottish Intercollegiate Guidelines Network
UCD	University College Dublin
UHG	University Hospital Galway
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

Department of Health, Hawkins House, Hawkins Street, Dublin, Ireland
Tel: +353 1 6354000 • Fax: +353 1 6354001 • www.health.gov.ie