Communication (Clinical Handover) in Acute and Children’s Hospital Services

National Clinical Guideline No. 11

Summary

November 2015
Guideline Development Group
The National Communication (Clinical Handover) 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; the College of Anaesthetists; Royal College Physicians of Ireland; Royal College of Surgeons in Ireland; the Nursing and Midwifery Board of Ireland (NMBI); the Health Information and Quality Authority (HIQA) and University College Dublin (UCD).

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 acute and children’s hospital 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 acute and children’s hospital services in Ireland.

This Guideline Summary should be read in conjunction with the full version National Clinical Guideline.

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

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

Reference of National Clinical Guideline
This National Clinical Guideline should be referenced as follows:

National Clinical Guideline No. 11
ISSN 2009-6267.
November 2015.

Disclaimer
The Communication (Clinical Handover) Guideline Development Group expects that healthcare professionals will use clinical judgement and knowledge/skills 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) was established as part of the Patient Safety First Initiative. The NCEC is a partnership between key stakeholders in patient safety. NCEC’s mission is to provide a framework for national endorsement of clinical guidelines and audit to optimise patient and service user care. The NCEC has a remit to establish and implement processes for the prioritisation and quality assurance of clinical guidelines and 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.

The aim of the suite of National Clinical Guidelines is to provide guidance and standards for improving the quality, safety and cost-effectiveness of healthcare in Ireland. The implementation of these National Clinical Guidelines will support the provision of evidence-based and consistent care across Irish healthcare services.

NCEC Terms of Reference

1. Provide strategic leadership for the national clinical effectiveness agenda.
2. Contribute to national patient safety and quality improvement agendas.
9. Establish sub-committees for NCEC workstreams.

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 Guideline for Communication (Clinical Handover) in Acute and Children’s Hospital Services is one of these guidelines.

The National Clinical Guideline for Communication (Clinical Handover) in Acute and Children’s Hospital Services has been quality assured by NCEC and endorsed by the Minister for Health for implementation in the Irish health system.

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Glossary of terms

Definitions within the context of this document

**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. Clinical responsibility can only be transferred when responsibility is accepted by the designated individual clinician or clinical team as outlined in the policy of the healthcare organisation. 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, should conduct their own clinical assessment, as dictated by the clinical situation and as appropriate to their roles and responsibilities.

**Coroner’s Report (April 2013)** The Report by Dr. Ciaran McLoughlin, Coroner, following the inquest into a maternal death in University Hospital Galway (UHG).

**Early Warning Score**: A guide used to determine the degree of clinical acuity of a patient and involves a scoring system allocated on pre-determined clinical parameters.

**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.

**Escalation protocol**: A protocol for guiding practitioners in responding to a sudden clinical deterioration in a patient’s clinical condition.

**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).

**Guideline Development Group (GDG)** is the Communication (Clinical Handover) Guideline Development Group, one of the sub-groups established by the National Implementation Group – HSE/HIQA Maternity Services Investigations.

**Higher Education Institutions (HEIs)** are all institutions that provide undergraduate and postgraduate education and training for healthcare professionals including continuous professional development education. For example: Universities, Institutes of Technology, Royal College of Physicians of Ireland (RCPI), Royal College of Surgeons of Ireland (RCSI). For the purposes of this guideline, Centres for Nurse and Midwifery Education are included in this definition.

**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 of Incident 50278.

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

**Inter-disciplinary**: Integrates separate discipline approaches to work toward the best outcome for the patient.
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.

National Implementation Group – HSE/HIQA Maternity Services Investigations was established to advise on and oversee the implementation of the HSE Report (June 2013).

Protected time: Designated time within the shift in a location free from interruptions and distractions and where no other task interferes with the delivery of the clinical handover information.

Read-back: Verbally repeating back important clinical information from one healthcare professional to another.

Safety pause: A brief discussion, between and with healthcare professionals, relating to important patient safety issues within a department.

The list of abbreviations is available in Appendix 1.
1 Clinical handover background

1.1 Need for National Clinical Guideline

This is the second National Clinical Guideline on Communication (Clinical Handover) commissioned by the NCEC following the HIQA/Galway Report (October 2013). Details of the wider context of these guidelines can be found in the Communication (Clinical Handover) in Maternity Services, National Clinical Guideline No. 5, page 9, available at the following link: http://health.gov.ie/wp-content/uploads/2015/01/National-Clinical-Guideline-No.-5-Clinical-Handover-Nov2014.pdf

Phase 1 was tasked with developing a national clinical guideline on communication (clinical handover) for in-patient maternity hospital services, this was completed and published in November 2014.

Phase 2 was tasked with developing a national clinical guideline on communication (clinical handover) within acute and children’s hospital services.

Effective clinical handover can be enabled by having clear procedures, supportive work environments and educating staff on the potential work of handover on patient safety.

To address this the agreed HSE process was that the Guideline Development Group (GDG) would make recommendations to the National Implementation Group – HSE addressing the issues relating to communication (clinical handover) in the HSE Report (June 2013), the Coroner’s Report (April 2013) and the Health Information & Quality Authority (HIQA) Report (October 2013).

1.2 Risks associated with clinical handover

Risks associated with clinical handover whether as part of shift or inter-departmental clinical handover or communication of information in relation to the deterioration in a patient’s condition, are similar and include:

- Inappropriate or delayed treatment being provided for patients including the delay in critical referrals which threaten the life, health or well being of patients in the acute hospital setting;
- Loss of trust and confidence amongst staff and patients in the performance of the healthcare system as a result of inaccurate and/or incomplete information;
- Inefficient use of time and resources leading to a breakdown in the continuity of care;
- Risks associated with poor clinical handover practices may be further compounded by:
  - Hierarchical structures in the health service
  - Interdisciplinary boundaries
  - Resistance to change
  - Lack of standardisation
  - Lack of effective implementation of the National Clinical Guideline on clinical handover
  - Lack of training.

1.3 Clinical and financial impact

While studies point to some economic benefits of improved communication practices, including clinical handover improvement initiatives (Hess et al. 2010; Yao et al. 2012), the overall evidence regarding cost benefits must be treated with caution. This caution is warranted since the evidence is based on the limited availability of published studies particular to clinical handover, the use of diverse models and methods for calculating costs across studies and the fact that studies were conducted at single sites and often involved specific patient sub-
groups. For example, the study by Hess et al. (2010) was conducted with reference to patients with respiratory disease, a patient sub-group with a high risk of hospital readmission. Similarly, the study by Carr et al. (2002) was a pilot study conducted at the ED at an urban, academic medical center. Hence the application of the findings from the economic evaluation literature may not be generalisable to the entire acute care sector or to the Irish acute care sector. Nevertheless, on the basis of demonstrable evidence from individual studies, the economic grounds for improving clinical handover practices may be justified.

A budget impact analysis (BIA) was conducted as part of the development of this clinical guideline and included an estimation of the cost of current practice and the cost of introducing a new standardised clinical handover protocol for all clinical staff, including the cost of staff training (Appendix 18 of the full guideline).

1.4 Aim and scope of this National Clinical Guideline

The aim of this National Clinical Guideline is to optimise the process of clinical handover and improve patient safety by describing the elements that are essential for timely, accurate, complete, unambiguous and focused clinical handover in acute and children’s hospital 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 care at a change of shift;
  - Clinical Handover to and from a different level of care in the same hospital, for example, between a ward and ICU/CCU;
  - Clinical Handover to and from a different level of care between acute hospitals, for example, transfer of a patient for specialist care;
  - Inter-departmental clinical handover e.g. operating theatre/emergency department to ward;
  - Communication with patients and/or their relatives including parents/guardians of children as part of clinical handover.

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

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

The National Clinical Guideline for in-patients and patients attending acute and children’s hospital services in Ireland is relevant and has been developed for all healthcare staff, doctors, nurses, health and social care professionals, healthcare assistants and other staff involved in the clinical care of patients in acute and children’s hospital services; and managers responsible for the development, implementation, review and audit of communication/clinical handover practice in individual hospitals or group of hospitals. The National Clinical Guideline also applies to education and training support staff involved in the organisation and delivery of the relevant education programme.
The public and patients will also find this guideline of interest as it outlines the general and specific measures for clear and focused communication of information relating to the patient’s condition, both urgent and routine and how these can and should be incorporated into quality measures to safeguard the quality of patient care.

This guideline makes recommendations on the process and content of clinical handover of patient care between healthcare staff; and communication between healthcare staff and patients/relatives including parents/guardians of children as part of clinical handover for in-patients and patients attending acute and children’s hospital services in Ireland.

This guideline does not cover:

- Routine recording of patient care in the patient’s medical chart used in acute and children’s hospital services.
- The nature of individual patient management or treatment.
- The response following communication of information e.g. where a patient is deteriorating or critically ill.
- Clinical handover in any other setting including the pre-hospital setting e.g. primary care and National Ambulance Service.

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. The basis for level of evidence and grade of recommendation are summarised in tables 1.8.1 and 1.8.2.

Where existing guidance was the only source used to guide a guideline statement/recommendation, this is specified. Where each guideline statement/recommendation is presented, we provide a rationale based on the published best evidence and also practical guidance to support the delivery of the guideline statement/recommendations. For most of the guideline statements, we provide supporting evidence at levels 1 and 2. For some of the guideline statements/recommendations, we relied on the best attainable evidence to hand, such as evidence from audits (level 3) or expert opinion (level 4), which included evidence from interviews and discussions with practitioners and other stakeholders.
Table 1.8.1 SIGN (2011) Grading criteria

<table>
<thead>
<tr>
<th>Grade</th>
<th>Grade descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1++</td>
<td>High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias (RCTs rated as high quality (+++) using the SIGN checklist for RCTs).</td>
</tr>
<tr>
<td>1+</td>
<td>Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias (RCTs rated as acceptable (+) using the SIGN checklist for RCTs).</td>
</tr>
<tr>
<td>1-</td>
<td>Meta-analyses, systematic reviews, or RCTs with a high risk of bias (RCTs rated as unacceptable (-) using the SIGN checklist for RCTs).</td>
</tr>
<tr>
<td>2++</td>
<td>High quality systematic reviews of case control, cohort studies, RCTs or before-and-after intervention studies (Rated as high quality (++) using the SIGN checklist for reviews).</td>
</tr>
<tr>
<td>2+</td>
<td>High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.</td>
</tr>
<tr>
<td>2-</td>
<td>Systematic reviews of case control, cohort studies, RCTs or before-and-after intervention studies with a possible risk of bias (Rated as acceptable (+) using the SIGN checklist for reviews).</td>
</tr>
<tr>
<td>2+</td>
<td>Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.</td>
</tr>
<tr>
<td>2-</td>
<td>Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal. Before-and-after intervention studies with a risk that the relationship is not causal.</td>
</tr>
<tr>
<td>3</td>
<td>Non-analytic studies, e.g. case reports, case series, post-implementation audit/review.</td>
</tr>
<tr>
<td>4</td>
<td>Expert opinion.</td>
</tr>
</tbody>
</table>

We also assigned a grade to each recommendation based on the A, B, C, D grading criteria contained in the SIGN guideline developer’s handbook (SIGN 2011). These grades indicate the relative strength of each statement/recommendation, providing a general indication of the comprehensiveness of published guidelines (Table 1.8.2). The A, B, C, D grading for each guideline statement was agreed by consensus among the members of the GDG.

Table 1.8.2: ABCD Criteria/Consensus Grade (SIGN 2011)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Grade descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>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.</td>
</tr>
<tr>
<td>B</td>
<td>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+.</td>
</tr>
<tr>
<td>C</td>
<td>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++.</td>
</tr>
<tr>
<td>D</td>
<td>Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+.</td>
</tr>
</tbody>
</table>

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation (SIGN 2011).
2 National Clinical Guideline recommendations

The recommendations are numbered 1 to 28 and are linked to the best available evidence and/or expert opinion. They are divided under the following topics:

| 1. Shift and inter-departmental clinical handover recommendations (1-7) |
| 2. Organisational recommendations (8-21) |
| 3. Deteriorating patient recommendation (22) |
| 4. Radiology recommendation (23) |
| 5. Laboratory recommendation (24) |
| 6. Additional recommendations (25–28) |

Acute and children’s hospital services should have systems in place to address all elements in this National Clinical Guideline. Clinical handover should be recognised as an inter-disciplinary team activity. Due consideration of the application and implementation of the recommendations for individual hospitals/units specific circumstances is required.

2.1 National recommendations

All recommendations are of equal importance and should be implemented without preference or bias.

2.2 Shift and inter-departmental recommendations

2.2.1 Clear transfer of responsibility for the patient

The following are responsible for implementation of recommendation 1: CEO, General Manager, Hospital Manager, Clinical Director and Director of Nursing of the healthcare organisation.

Recommendation 1: Healthcare organisation’s policy on communication (clinical handover) is explicit about when, and to whom, the transfer of responsibility occurs, during and following inter-departmental and shift clinical handover. Clinical responsibility can only be transferred when responsibility is accepted by the designated individual clinician or clinical team as outlined in the policy of the healthcare organisation.

Level of Evidence: 3
Grade of recommendation: D
References: Department of Health (Western Australia) 2013 [3]; NSW Department of Health 2009 [N/A]
Practical guidance
Clinical handover is defined 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’ (BMA 2004).

The point at which responsibility is transferred and accepted needs to be agreed between both departments/parties, be explicit and be formally documented identifying those relinquishing responsibility (outgoing team/individual) and those now responsible (incoming team/individual) for the patients care. Clinicians, accepting responsibility for patients, should conduct their own clinical assessment, as dictated by the clinical situation and as appropriate to their roles and responsibilities. The GDG acknowledge that there are situations when responsibility and accountability for patient care is not clearly defined. Local policy should identify who is responsible and accountable for the patient throughout their episode of care in the acute hospital.

2.2.2 Patient, parent/guardian and/or carer involvement.

The following are responsible for implementation of recommendation 2:
CEO, General Manager, Hospital Manager, Director of Nursing and Clinical Director of the healthcare organisation.

**Recommendation 2:** Healthcare organisations should aim to involve the patient, parents/guardians of children and/or carer(s) in the clinical handover process where appropriate. They should ensure that the patient, parents/guardians of children and/or carer(s) are provided with relevant, accurate and up-to-date information in relation to the patient’s condition, care and treatment. Patients or parents/guardians of children preferences should be considered whilst also meeting the requirements of confidentiality. The healthcare organisation should determine how this may be best accommodated at department/unit/ward level.

**Level of Evidence:** 3
**Grade of recommendation:** D
**References:** Barker 2013 [5]; Department of Health (South Australia) 2013a [3]; Department of Health (Western Australia) 2013 [3]

2.2.3 Clinical handover - Structured format

The following are responsible for implementation of recommendation 3:
CEO, General Manager, Hospital Manager, Director of Nursing and Clinical Director of the healthcare organisation.

**Recommendation 3:** Inter-departmental and shift clinical handover should be conducted using the ISBAR, 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, but preferably electronically.

**Level of Evidence:** 2- and 4
**Grade of recommendation:** D
**References:** South Australia Department of Health (2010) Clinical Handover Guidelines: Government of South Australia: Adelaide SA.
Practical guidance
Inter-departmental and shift clinical handover are somewhat different and therefore should be approached differently. Shift clinical handover usually relates to more than one patient where as inter-departmental clinical handover usually relates to one patient being transferred from one department to another. The ISBAR, clinical handover tool is the nationally recommended standardised tool for conducting clinical handover for both situations. It provides a standardised framework, at the same time permitting clinical handover to be tailored to the needs of each department, unit or ward, for example, in the emergency department patient admission status and bed availability may be included, in the inpatient wards they may want to include infection status, frailty score, Waterlow Score, social circumstances, and in the ICU they may want to include ventilation settings. This concept is known as ‘flexible standardisation’.

One international reviewer of this national clinical guideline, Dr. Vineet Arora, highlighted the importance of customising the template for use by the end-user “for folks to buy-in to using the template”. She also identified that every specialty is different so there may be specific fields that need to be customised.

Note: Flexible standardisation recognises the importance of ensuring that policies and procedures are relevant and appropriate for use in particular contexts of clinical handover. 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). Flexible standardisation allows clinical handover to be tailored to a local context recognising that health services will have differing functions, size and organisation with respect to service delivery mode, location and workforce.

Clinical handover should include key data items to be transferred and therefore agreement on what this critical data ought to be should be negotiated.

ISBAR, communication (clinical handover) tool sample for inter-departmental and shift clinical handover are given below. (Also available in Appendix 3 of this summary document or Appendix 12 of the full guideline). These templates should be included in education and training programmes.

Patients should not be transferred from department to department unnecessarily, except where there is a clinical need, reducing the need for clinical handover and enhancing patient safety and experience. Additional information on the Safety Pause is provided on the Safety Pause Information Sheet (2013), along with examples of safety issues that may arise, in Appendix 3 of this summary document or Appendix 13 of the full guideline.

2.2.4 Electronic clinical handover applications/templates
The following are responsible for implementation of recommendation 4:
CEO, General Manager, Hospital Manager and ICT managers of the healthcare organisation

Recommendation 4: Organisations should provide the necessary infrastructure to support effective clinical handover, including the availability of readily accessible patient information in electronic format. Where electronic clinical handover applications and templates are in use or being developed to support face-to-face clinical handover, they should incorporate the following communication tools:
• ISBAR, for both shift and interdepartmental clinical handover and
• ISBAR for urgent escalation of care.

Level of Evidence: 2-
Grade of recommendation: D
Practical guidance
Electronic applications and templates should be developed in consultation with healthcare staff.

HIQA (2015) recommends that all electronic early warning and clinical handover systems should be developed in line with National Clinical Effectiveness Committee (NCEC) quality assured National Clinical Guidelines. Computer learning algorithms and software driving the system should be developed with due consideration to the clinical parameters that have proven effectiveness. National Clinical Guidelines quality assured by NCEC and published by the Department of Health have been developed for use in healthcare organisations in Ireland only, taking into account specific requirements for the Irish healthcare setting (HIQA 2015).

Electronic tools should incorporate an anticipatory guidance element for the oncoming clinician or team for example highlighting deteriorating patients by providing the latest Early Warning Score/System (NEWS/PEWS).

Organisations should state in their policy, the approved electronic media that can be used to support clinical handover. Local solutions (systems, structures and personnel) should be facilitated by local ICT systems.

2.2.5 Safety and risk
The following are responsible for implementation of recommendation 5:
CEO, General Manager, Hospital Manager, Clinical Director and Director of Nursing of the healthcare organisation.

| Recommendation 5: Shift and inter-departmental clinical handover should promote a structure which allows for data verification, discussion, shared clinical decision-making and identification of operational issues and other factors that may impact on clinical care. |
| Level of Evidence: 3 |
| Grade of recommendation: 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 23 for further detail on the Safety Pause which can be utilised for risk assessment as appropriate. An example of operational issues could be bed availability, increased risk of cross-infection, staffing, etc.

2.2.6 Interdisciplinary shift clinical handover
The following are responsible for implementation of recommendation 6:
CEO, General Manager, Hospital Manager, Clinical Director and Director of Nursing of the healthcare organisation.

| Recommendation 6: Healthcare organisations should implement interdisciplinary shift clinical handover where possible, to include junior and senior staff at every clinical handover during the 24 hour cycle. |
| Level of Evidence: 3 |
| Grade of recommendation: D |
| References: British Medical Association 2004 [3]; Department of Health (Western Australia) 2013 [3] |
Practical guidance
Co-ordination of rostering for interdisciplinary team members, within organisations, may provide an opportunity to achieve interdisciplinary team shift clinical handover.

2.2.7 Handover all patients in the department/unit/ward at shift clinical handover

The following are responsible for implementation of recommendation 7:
All healthcare staff in the healthcare organisation.

Recommendation 7: All patients in the department/unit/ward must be handed over at shift clinical handover.
Level of Evidence: 4
Grade of recommendation: D

Practical guidance
Shift clinical handover transfers responsibility and accountability for all relevant patients.

Patients requiring immediate review by the incoming team should be identified as part of this process. It should be identified in local policy how this can be achieved in individual hospitals, departments, units and wards.

2.3 Organisational recommendations

2.3.1 Recognition of clinical handover as a clinical risk activity

The following are responsible for implementation of recommendation 8:
Hospital Group Leads, CEO, General Manager and Hospital Manager of the healthcare organisation.

Recommendation 8: Healthcare organisations should recognise clinical handover as a clinical risk activity, and incorporate clinical handover into their corporate and local risk registers.
Level of Evidence: 3
Grade of Recommendation: D

The following are responsible for implementation of recommendation 9:
All healthcare staff.

Recommendation 9: Healthcare organisations and frontline clinical staff should ensure that participation at clinical handover takes priority over all other work except in emergencies.
Level of Evidence: 3
Grade of Recommendation: D

Practical guidance
The GDG recognise that patient safety and the provision of ongoing care must be ensured during the period of clinical handover.
2.3.2 Guidance

**The following are responsible for implementation of recommendations 10-12:**
CEO, General Manager, Hospital Manager, Clinical Director and Director of Nursing of the Healthcare Organisation.

**Recommendation 10:** Healthcare organisations should review existing organisational clinical handover guidance (policies, procedures, protocols and guidelines) in collaboration with appropriate stakeholders, including healthcare staff, patients, parents/guardians of children, and carers. The local policy should clearly identify how clinical handover records are to be managed, stored and accessed.

**Level of Evidence:** Existing guidance

**Grade of recommendation:** D

**References:** NSW Department of Health 2009 [N/A]; Australian Commission on Safety and Quality in Health Care 2012 [N/A]

**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.

**Recommendation 11:** Healthcare organisations should implement Clinical Handover procedures in compliance with this National Clinical Guideline, in consultation with relevant stakeholders. While national communication tools (templates) are included in the National Clinical Guideline, these tools (templates) may be customised locally to accommodate features of the healthcare organisation, individual departments, units or wards.

**Level of Evidence:** 3 and existing guidance

**Grade of Recommendation:** D

**Reference:** Department of Health (South Australia) 2013a, 2013b) [3]; Australian Commission on Safety and Quality in Health Care 2012 [N/A]; Australian Commission on Safety and Quality in Health Care (2010) [N/A]; Australia Healthcare and Hospitals Association (2009) [N/A]

**Practical guidance**
Where organisation policy deviates from the tools within the National Clinical Guideline the rationale for this deviation must be made explicit within the local policy.

The ISBAR3 clinical handover template (Appendix 3 of this summary document or Appendix 12 of the full guideline) is the nationally recommended standardised template for conducting clinical handover for both inter-departmental and shift clinical handover. The ISBAR communication template (Appendix 3 of this summary document or Appendix 14 of the full guideline) is the nationally recommended standardised template that should be used when communicating information in relation to patients who are critically ill and/or deteriorating (see Recommendation 22).

The templates provide a standardised framework while at the same time permitting clinical handover to be tailored to the needs of each department, unit or ward (see Recommendation 3).
**Recommendation 12:** Clinical handover practice is monitored and audited regularly by the relevant quality and patient safety committee of the healthcare organisation. It is the responsibility of the chair of this committee to assure the CEO/GM that the audit is undertaken and any necessary continuous quality improvements are put in place.

**Level of Evidence:** Existing guidance only  
**Grade of recommendation:** D  
**Reference:** Department of Health (South Australia) 2013a [3]; Commission on Safety and Quality in Health Care 2013 [N/A]

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**Practical guidance**  
Audit tools templates for ISBAR, ISBAR and organisation compliance with the national clinical guideline are available in Appendix 12 of the full guideline and can be amended as appropriate. Clinical leaders should be identified from within each organisation to champion clinical handover improvement initiatives.

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**2.3.3 Education and training**  
The following are responsible for implementation of recommendation 13:  
CEO, General Manager and Hospital Manager of the healthcare organisation.

**Recommendation 13:** Healthcare organisations should provide staff with validated education and training, using a variety of techniques including workshops and simulation, to support the implementation and practice for clinical handover. This should be mandatory and form part of staff orientation/induction and ongoing in-service education.

**Level of Evidence:** 2++  
**Grade of recommendation:** B  
**References:** Department of Health (South Australia) 2013a [3]; Department of Health (Western Australia) 2013 [3]

---

**Practical guidance**  
Healthcare organisations should provide protected time for healthcare professionals to attend education and training on communication (clinical handover), interdisciplinary where possible.

Quality improvement plans can be formulated following any audits undertaken by the healthcare organisation. This might include, for example, a requirement for additional education.

---

**2.3.4 Information giving and seeking**  
The following are responsible for implementation of recommendation 14:  
CEO, General Manager and Hospital Manager of the healthcare organisation.

**Recommendation 14:** Healthcare organisations should incorporate human factors training into all clinical handover education that promotes a culture of openness and mutual respect between healthcare professionals and between healthcare professionals and patients.

**Level of Evidence:** 3  
**Grade of recommendation:** D  
**Reference:** HSE Code of standards and behaviour (2009)
Practical guidance
Education and training programmes should include formal training on the use of a structured approach for clinical handover that supports a two-way process. Human factors refers 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 effective communication methodologies in order to promote a culture of openness in the interest of patient safety and quality.

2.3.5 Accessing information

The following are responsible for implementation of recommendation 15:
CEO, General Manager, Hospital Manager and ICT Managers of the healthcare organisation.

Recommendation 15: 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, and during, clinical handover.

Level of Evidence: 3
Grade of recommendation: D
References: British Medical Association 2004 [3]; Department of Health (Western Australia) 2013 [3]; Department of Health (South Australia) 2013a [3]

Practical guidance
In terms of electronic patient records a collaborative national approach should be taken. Local solutions should be facilitated by local ICT systems.

2.3.6 Protected area

The following are responsible for implementation of recommendation 16:
CEO, General Manager, Hospital Manager, Clinical Director of the healthcare organisation and Director of Nursing.

Recommendation 16: Clinical handover should be conducted in an area with minimal distractions and interruptions and the organisation should determine how this may be best accommodated at the department/unit/ward level. The location should take account of patient confidentiality.

Level of Evidence: 3
Grade of recommendation: D
References: British Medical Association 2004 [3]; Department of Health (Western Australia) 2013 [3]; NSW Department of Health 2009 [N/A]

Practical guidance
Healthcare organisations should consider identifying the most appropriate venue for different types of clinical handover to achieve this where appropriate. For example, bedside and/or non-bedside clinical handover appropriate to the clinical situation.

Visual cues can be used to minimise interruptions/distractions such as a sign on the door ‘DO NOT DISTURB - Clinical Handover in progress’.
2.3.7 Protected time for inter-departmental clinical handover

The following are responsible for implementation of recommendation 17:
CEO, General Manager, Hospital Manager, Clinical Director and Director of Nursing of the healthcare organisation.

Recommendation 17: Protected time should be designated for inter-departmental clinical handovers.
Level of Evidence: 3
Grade of recommendation: 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 from one hospital to another hospital.

Protected time: Designated time within the shift in a location free from interruptions and distractions and where no other task interferes with the delivery of the clinical handover information.

2.3.8 Mandatory protected time for shift clinical handover

The following are responsible for implementation of recommendation 18:
CEO, General Manager, Hospital Manager, Clinical Director and Director of Nursing of the healthcare organisation.

Recommendation 18: Healthcare organisations should ensure that there is mandatory protected time for shift clinical handover.
Level of Evidence: 3
Grade of recommendation: D
References: Australian Resource Centre for Healthcare Innovations 2013 [N/A]; British Medical Association 2004 [3]; Department of Health (Western Australia) 2013 [3].

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.

Protected time: Designated time within the shift in a location free from interruptions and distractions and where no other task interferes with the delivery of the clinical handover information.

The GDG recognise that patient safety and the provision of ongoing care must be ensured during the period of clinical handover.
2.3.9 Designation of a lead healthcare professional to manage clinical handover

The following are responsible for implementation of recommendations 19:
The Clinical Director and Director of Nursing for the healthcare organisation.

**Recommendation 19:** Clinical handover policies should designate a lead healthcare professional to manage the inter-departmental and shift clinical handover process.

**Level of Evidence:** 2-

**Grade of recommendation:** D

**References:** Department of Health (Western Australia) 2013 [3]; British Medical Association 2004 [3]; NSW Department of Health 2009; Department of Health (South Australia) 2013a [3]

2.3.10 Clarification of staff roles and responsibilities for clinical handover

The following are responsible for implementation of recommendation 20:
CEO, General Manager and Hospital Manager of the healthcare organisation.

**Recommendation 20:** Clinical handover policies should specify staff attendance, roles and responsibilities at clinical handover.

**Level of Evidence:** 3

**Grade of recommendation:** D

**References:** Department of Health (Western Australia) 2013 [3]; British Medical Association 2004 [3]

**Practical guidance**
This should be decided in consultation with relevant healthcare staff.

2.3.11 Clinical handover process

The following are responsible for implementation of recommendation 21:
All healthcare staff in the healthcare organisation.

**Recommendation 21:** Clinical handover should:
1) be conducted face to face where possible, (L of E, 3, G of R, D).
2) be conducted verbally, (L of E, 2++, G of R, C).
3) be supported with relevant, accurate and up-to-date documentation (L of E, 2++, G of R, C).
4) facilitate two-way communication processes (L of E, 2++, G of R, C).

a) Pre-recorded clinical handover **MUST NOT** be used for shift or inter-departmental clinical handover in any circumstances (L of E, Existing guidance only, G of R, D).

b) Organisations should state in their policy, the approved electronic media that can be used to support clinical handover.

**Level of Evidence:** see L of E above
**Grade of recommendation:** see G of R above

**References:** British Medical Association 2004 [3]; Royal College of Surgeons of England 2007; Department of Health, South Australia 2013a [3]; New South Wales Department of Health 2009.
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.

Pre-recorded clinical handover MUST NOT be used for shift or inter-departmental clinical handover in any circumstances. However, video recorded handover can be used as an education tool to promote reflective learning.

2.4 Deteriorating patient recommendation

2.4.1 Communication of patient deterioration

The following are responsible for implementation of recommendation 22:

CEO, General Manager, Hospital Manager, Clinical Director and Director of Nursing of the healthcare organisation

Recommendation 22: The ISBAR communication tool should be used when communicating information in relation to patients who are critically ill and/or deteriorating. Where a patient’s condition and/or a situation is deemed to be critical, this must be clearly stated at the outset of the conversation.

Level of Evidence: 1+ (Marshall et al. 2009), 2- (Remaining studies)

Grade of recommendation: B

References:
South Australia Department of Health 2013a
The National Early Warning Score, National Clinical Guideline No. 1 (DoH 2013)
Levels of Critical Care, National Standards for Adult Critical Care Services, Joint Faculty of Intensive Care Medicine of Ireland (2011)
Irish Maternity Early Warning System (IMEWS), National Clinical Guideline No. 4 (DoH 2014),
Irish Paediatric Early Warning System, National Clinical Guideline No. 12 (DoH 2015)
Sepsis Management, National Clinical Guideline No. 6 (DoH 2014)

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. NEWS/IMEWS/PEWS should be included as part of the communication. 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 or 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, identified in the Levels of Critical Care, National Standards for Adult Critical Care Services 2011, Joint Faculty of Intensive Care Medicine of Ireland, see Appendix 15 of the full guideline.
2.5 Radiology recommendation

2.5.1 Radiology

The following are responsible for implementation of recommendation 23:
CEO, General Manager and Hospital Manager of the healthcare facility.

**Recommendation 23:**
The Faculty of Radiology’s QI 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.

- **Level of Evidence:** 4
- **Grade of recommendation:** 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 Appendix 16 of the full guideline.

Identification of implementation requirements around the PeerVue system is the responsibility of the Radiology National QI Programme Steering Committee, RCPI.

Where these systems are not in use, this should be incorporated in the healthcare organisation’s corporate and local risk registers.

2.6 Laboratory recommendation

2.6.1 Laboratory

The following are responsible for implementation of recommendation 24:
Acute Hospital Services HSE, CEO, General Manager and Hospital Manager of the healthcare facility.

**Recommendation 24:**
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.

- **Level of Evidence:** 4
- **Grade of recommendation:** D
Practical guidance
Governance and implementation requirements around the MedLIS system are 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 Appendix 17 of the full 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. Involving laboratory staff in multi-disciplinary team ‘huddles’ etc. may provide this education.

2.7 Additional recommendations

2.7.1 Education and training
The following are responsible for implementation of recommendation 25-27:
Higher Education Institutions (HEIs) and Professional Regulatory Bodies

Recommendation 25: Higher education institutions (HEIs) with responsibility to provide preparatory professional education, continuing education and professional development for all healthcare professionals should incorporate education and training on clinical handover practices for the deteriorating patient, inter-departmental and shift clinical handover within curricula in line with this National Clinical Guideline.
Level of Evidence: Existing guidance only.
Grade of recommendation: D
References: Department of Health (South Australia) 2013a [3].

Practical guidance
Education and training programmes should include formal training on a structured approach that supports clinical handover as a two-way process and promote assertiveness by asking questions and seeking clarification as outlined in recommendations 13 and 14.

2.7.2 Guideline implementation

The following are responsible for implementation of recommendation 26:
Health Service Executive

Recommendation 26: A communication (clinical handover) group should be established at national level to support national implementation of this guideline. This group should engage in staff consultation and apply quality improvement methodologies to ensure successful implementation and determine how communication tools such as the ISBAR and ISBAR can best fit with existing workflows and professional relationships.
Level of Evidence: 4
Grade of recommendation: D

Practical guidance
The GDG encourage:
• Sharing of ideas and locally developed resources to avoid unnecessary duplication of work amongst healthcare organisations.
• Monitoring behaviour as part of measuring the effectiveness of implementing this guideline.
The national implementation group could decide how this could be facilitated.
2.7.3 Additional safety practices

The following are responsible for implementation of recommendation 27:
Acute Hospital Services HSE, CEO, General Manager and Hospital Manager of the healthcare facility.

**Recommendation 27:** Healthcare organisations should support additional safety practices that enhance clinical handover in acute and children’s hospital services leading to greater situation awareness among clinicians and inter-disciplinary teams, such as implementation of:
- The National Early Warning Score, National Clinical Guideline No. 1
- The Irish Maternity Early Warning System, National Clinical Guideline No. 4
- Communication (Clinical Handover) in Maternity Services, National Clinical Guideline No. 5
- Sepsis Management, National Clinical Guideline No. 6
- The Irish Paediatric Early Warning System, National Clinical Guideline No. 12.

and incorporating briefings, safety pauses and huddles into practice.

**Level of Evidence:** 4
**Grade of recommendation:** D

**Practical guidance**
Quality improvement capability will be required for successful implementation and sustainability of this guideline. Therefore the national group should apply quality improvement methodologies, such as engagement strategies, testing, and measurement. This group should develop electronic resources to support implementation of the guideline.

HIQA (2015) recommend the implementation of ICT to support electronic early warning and clinical handover systems. This should be considered in the context of a standards based approach, the wider ICT agenda and the e-Health Strategy (DoH 2013), for example, timing of implementation may be part of a larger move towards electronic health record systems.

2.7.4 Future research

The following are responsible for implementation of recommendation 28:
Health Service Executive

**Recommendation 28:** Future research into clinical handover should focus on strengthening the evidence of clinical handover effectiveness by using well designed, rigorous methods.

**Level of Evidence:** 4
**Grade of recommendation:** D

**Practical guidance**
The GDG support the recommendation from one international reviewer that comparative effectiveness studies on the use of different organising frameworks and mnemonics should be undertaken.
3 National Clinical Guideline development process

3.1 Aim of National Clinical Guideline
The aim of this National Clinical Guideline is to optimise the process of clinical handover and improve patient safety by describing the elements that are essential for timely, accurate, complete, unambiguous and focused clinical handover in acute and children’s hospital services in Ireland, relating to the patient’s condition, both urgent and routine.

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 the 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 implementing the guideline
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 draft guideline was circulated for consultation to a wide variety of national stakeholders including: GDG members who distributed to their representative groups, the National Clinical Programmes via programme managers and clinical leads, the Office of the Nursing and Midwifery Director (ONMID), HSE, Hospital Group CEOs, Hospital Group Directors of Nursing, Clinical Directors, Director’s of Nursing and Hospital CEOs in all acute hospitals, the Irish Medical Council, NEWS contacts in all acute hospitals and others. Eighty one respondents provided feedback on the guideline using the online survey and email. A total of 286 individual comments/suggestions were received.

Additionally the draft guideline was submitted to two international experts in the field of clinical handover for peer review. These two leading experts were chosen by the GDG based on their many years of research and publications on the topic of clinical handover for both adult and children’s services.

The international reviewers for this guideline were:
- Dr Vineet M Arora, MD MAPP, Associate Professor and Assistant Dean for Scholarship and Discovery, Director, GME Clinical Learning Environment Innovation, Pritzker School of Medicine, University of Chicago, IL, USA.
- Dr. Amy Starmer, MD, MPH, Director of Primary Care Quality Improvement and Assistant Professor of Pediatrics at Boston Children’s Hospital and Harvard Medical School, USA.

Both international reviewers complimented the guideline for its quality and comprehensiveness and provided suggestions/advice from their experience and previous research 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 2018 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 Hospital Group Leads, CEO, General Manager and Hospital Manager have 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.

Each healthcare professional has a role to play in minimising the risk of communication failures through adherence to best practice as recommended in this National Clinical Guideline, e.g. providing clear and focused communication of information relating to the patient’s condition, both urgent and routine. Furthermore, each healthcare professional is responsible and accountable, within their professional scope of practice, for maintaining competence in communication (clinical handover) of patient care and 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 3 audit tool templates:
- ISBAR, communication tools (inter-departmental and shift clinical handover)
- ISBAR communication tool for communication in relation to a deteriorating patient
- Organisational compliance with the National Clinical Guideline
### Appendix 1: List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>BIA</td>
<td>Budget Impact Analysis</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>CCU</td>
<td>Coronary Care Unit</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>G of R</td>
<td>Grade of Recommendation</td>
</tr>
<tr>
<td>GDG</td>
<td>Guideline Development Group</td>
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<tr>
<td>GM</td>
<td>General Manager</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HEI</td>
<td>Higher Education Institutes</td>
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<tr>
<td>HIQA</td>
<td>Health information and Quality Authority</td>
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<td>HSE</td>
<td>Health Service Executive</td>
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<td>ICT</td>
<td>Information and Communication Technology</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>IADNM</td>
<td>Irish Association of Directors of Nursing and Midwifery</td>
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<tr>
<td>ISBAR</td>
<td>Communication Tool: Identify, Situation, Background, Assessment, Recommendation</td>
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<tr>
<td>ISBAR\textsuperscript{3}</td>
<td>Communication tool (Identify, Situation, Background, Assessment, Recommendation\textsuperscript{1}, Read-back\textsuperscript{2}, Risk\textsuperscript{3})</td>
</tr>
<tr>
<td>L of E</td>
<td>Level of Evidence</td>
</tr>
<tr>
<td>MedLIS</td>
<td>National Medical Laboratory Information System</td>
</tr>
<tr>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>NAMP</td>
<td>National Acute Medicine Programme</td>
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<tr>
<td>NCEC</td>
<td>National Clinical Effectiveness Committee</td>
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<tr>
<td>NCHD</td>
<td>Non Consultant Hospital Doctor</td>
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<td>NCL</td>
<td>National Clinical Lead</td>
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<td>NEWS</td>
<td>National Early Warning Score</td>
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<td>NIMIS</td>
<td>National Integrated Medical Imaging System</td>
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<td>NMBI</td>
<td>Nursing and Midwifery Board of Ireland</td>
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<td>NMPDU</td>
<td>Nursing and Midwifery Practice Developments Unit</td>
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<tr>
<td>NSW Health</td>
<td>New South Wales Department of Health</td>
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<tr>
<td>ONMSD</td>
<td>Office of Nursing and Midwifery Services Director</td>
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<tr>
<td>PCS</td>
<td>Professional Competence Scheme</td>
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<td>PEWS</td>
<td>Paediatric Early Warning System</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<td>RCPI</td>
<td>Royal College of Physicians of Ireland</td>
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<tr>
<td>RCSI</td>
<td>Royal College of Surgeons in Ireland</td>
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<tr>
<td>RCT</td>
<td>Randomised Controlled Trial</td>
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<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
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<tr>
<td>UCD</td>
<td>University College Dublin</td>
</tr>
<tr>
<td>UHG</td>
<td>University Hospital Galway</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</tbody>
</table>
## Appendix 2: Guideline Development Group

### Terms of Reference
The terms of reference for the GDG are available in the full version National Clinical Guideline.

### Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Dorothy Breen</td>
<td>Co-Chair</td>
</tr>
<tr>
<td>Ms. Eilish Croke</td>
<td>Co-Chair</td>
</tr>
<tr>
<td>Ms. Celine Conroy</td>
<td>Project Manager</td>
</tr>
<tr>
<td>Ms. Emma Benton</td>
<td>Therapy Professions Advisor &amp; Portfolio Manager (Diagnostic/Support Services), Clinical Strategy &amp; Programmes</td>
</tr>
<tr>
<td>Dr. Katherine Browne</td>
<td>Forum of Irish Postgraduate Medical Training Bodies - trainee nominee (surgical SpR)</td>
</tr>
<tr>
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<td>National Clinical Programme for Paediatrics and Neonatology</td>
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<td>Associate Dean for Research and Innovation UCD</td>
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<td>Dr. John Fitzsimons</td>
<td>Clinical Director for Quality Improvement, HSE Quality Improvement Division</td>
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<td>Ms. Maureen Flynn</td>
<td>Director of Nursing and Midwifery Quality Improvement Division, Lead Governance for Quality and Safety</td>
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<td>Ms. Mary Godfrey</td>
<td>Clinical Risk Adviser, State Claims Agency</td>
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<td>Dr. Miriam Griffin</td>
<td>Faculty of Pathology, RCPI</td>
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<td>Dr. Colm Henry</td>
<td>National Clinical Advisor, Group Lead Acute Hospitals, HSE (GDG Sponsor)</td>
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<td>Mr. Macartan Hughes</td>
<td>Head of Education &amp; Competency Assurance. National Ambulance Service</td>
</tr>
<tr>
<td>Ms. Catherine Kililea</td>
<td>Area Director, NMPDU, HSE South</td>
</tr>
<tr>
<td>Mrs. Tanya King</td>
<td>IADNAM Representative, Director of Nursing (Mater Misericordiae University Hospital)</td>
</tr>
<tr>
<td>Mr. Louis Lavelle</td>
<td>NAMP Programme Co-ordinator</td>
</tr>
<tr>
<td>Dr. Gerry McCarthy</td>
<td>Emergency Medicine Programme, Consultant in paediatric emergency medicine</td>
</tr>
<tr>
<td>Prof. Elis McGovern</td>
<td>Director, National Doctors Training and Planning, Health Service Executive</td>
</tr>
<tr>
<td>Ms. Colette Murray</td>
<td>Front line clinical nurse representing acute hospitals</td>
</tr>
<tr>
<td>Dr. Alan Moore</td>
<td>Consultant in Geriatric Medicine in Beaumont Hospital, Forum of Irish Postgraduate Medical Training Bodies -consultant nominee</td>
</tr>
<tr>
<td>Ms. Bridie O’Sullivan</td>
<td>Chief Director of Nursing and Midwifery – representing Group CEOs</td>
</tr>
<tr>
<td>Dr. Michael Power</td>
<td>NCL, Critical Care Programme</td>
</tr>
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<td>Ms. Melissa Redmond</td>
<td>Patient/Service user Representative</td>
</tr>
<tr>
<td>Dr. Anthony Ryan</td>
<td>Chair of the Quality and PCS committee of the Faculty of Radiologists, RCSI.</td>
</tr>
<tr>
<td>Ms. Mary Tierney</td>
<td>Patient representative, member of Patients for Patient’s Safety group.</td>
</tr>
<tr>
<td>Prof. Oscar Traynor</td>
<td>National Surgical Training Centre, RCSI – Representing the National Clinical Programme for Surgery</td>
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<td>Open Disclosure, Project Manager National Advocacy Unit, Quality Improvement Division, HSE</td>
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<td>Ms. Kathleen Walsh</td>
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</tr>
<tr>
<td>Dr. Margo Wrigley</td>
<td>National Clinical Programme for Mental Health</td>
</tr>
</tbody>
</table>
Appendix 3: Summary of tools to assist in implementation of National Clinical Guideline

A) Sample Templates for the ISBAR₃ communication tools for inter-departmental and shift clinical handover

<table>
<thead>
<tr>
<th>ISBAR₃ Communication (Clinical Handover) Tool SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-departmental Handover</td>
</tr>
<tr>
<td><strong>I</strong> Identify</td>
</tr>
<tr>
<td><strong>Identify:</strong></td>
</tr>
<tr>
<td>You</td>
</tr>
<tr>
<td>Recipient of handover information</td>
</tr>
<tr>
<td>Patient</td>
</tr>
<tr>
<td><strong>S</strong> Situation</td>
</tr>
<tr>
<td><strong>Situation:</strong></td>
</tr>
<tr>
<td>Location of patient as appropriate</td>
</tr>
<tr>
<td>Brief summary of patient’s current status</td>
</tr>
<tr>
<td>Is there a problem?</td>
</tr>
<tr>
<td><strong>B</strong> Background</td>
</tr>
<tr>
<td><strong>Background:</strong></td>
</tr>
<tr>
<td>Concise summary of reason for interdepartmental handover</td>
</tr>
<tr>
<td>Summary of treatment to date</td>
</tr>
<tr>
<td>Baseline observations (current admission)</td>
</tr>
<tr>
<td>Vital Signs: BP, Pulse, Resps, SpO₂, Temp, AVPU.</td>
</tr>
<tr>
<td>NEWS/PEWS/IMEWS (include previous NEWS/PEWS/IMEWS if appropriate)</td>
</tr>
<tr>
<td><strong>A</strong> Assessment</td>
</tr>
<tr>
<td><strong>Assessment:</strong></td>
</tr>
<tr>
<td>What is your clinical assessment of the patient at present?</td>
</tr>
<tr>
<td><strong>R</strong> Recommendation</td>
</tr>
<tr>
<td><strong>Recommendation:</strong></td>
</tr>
<tr>
<td>Specify your recommendations</td>
</tr>
<tr>
<td>Read-Back: Recipient(s) to confirm clinical handover information</td>
</tr>
<tr>
<td>Risk: Include the safety pause to identify possible risks</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ISBAR₃ Communication (Clinical Handover) Tool SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shift Clinical Handover</td>
</tr>
<tr>
<td><strong>I</strong> Identify</td>
</tr>
<tr>
<td><strong>Identify:</strong></td>
</tr>
<tr>
<td>Lead clinical handover person</td>
</tr>
<tr>
<td>Individuals/Team receiving clinical handover</td>
</tr>
<tr>
<td>Patient(s)</td>
</tr>
<tr>
<td><strong>S</strong> Situation</td>
</tr>
<tr>
<td><strong>Situation:</strong></td>
</tr>
<tr>
<td>Location of patient(s)</td>
</tr>
<tr>
<td>Brief summary of current status</td>
</tr>
<tr>
<td>Is there a problem?</td>
</tr>
<tr>
<td><strong>B</strong> Background</td>
</tr>
<tr>
<td><strong>Background:</strong></td>
</tr>
<tr>
<td>Concise summary of reason for admission</td>
</tr>
<tr>
<td>Summary of treatment to date</td>
</tr>
<tr>
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<td><strong>Assessment:</strong></td>
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<td>What is your clinical assessment of the patient at present?</td>
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<td>Specify your recommendations</td>
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</tbody>
</table>

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B) Safety Pause information sheet

THE SAFETY PAUSE: INFORMATION SHEET

Helping teams provide safe quality care

<table>
<thead>
<tr>
<th>Why</th>
<th>Safety awareness helps all teams to be more proactive about the challenges faced in providing safe, high quality care for patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>Team lead and available multidisciplinary team members.</td>
</tr>
<tr>
<td>When</td>
<td>Any time (aim for a maximum of five minutes).</td>
</tr>
<tr>
<td>How</td>
<td>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).</td>
</tr>
</tbody>
</table>

**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:**
The HSE Clinical Governance Development Initiative wishes to thank the National Emergency Medicine Programme for assisting in the development of this information sheet. It has been adapted with permission from Clinical Microsystems: “The Place Where Patients, Families and Clinical Teams Meet Assessing, Diagnosing and Treating Your Emergency Department” ©2001, Trustees of Dartmouth College, Godfrey, Nelson, Batalden and the IHI Safety Briefing tool Copyright © 2004 Institute for Healthcare Improvement.

An initiative of the Quality and Patient Safety Directorate, May 2013
For further information see www.hse.ie/go/clinicalgovernance
C) Sample Template for the ISBAR communication tool for communication in relation to a deteriorating patient

<table>
<thead>
<tr>
<th>ISBAR Communication Tool SAMPLE</th>
<th>Patient Deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I Identify</strong></td>
<td><strong>Identify:</strong></td>
</tr>
<tr>
<td></td>
<td>You</td>
</tr>
<tr>
<td></td>
<td>Recipient of clinical handover information</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
</tr>
<tr>
<td><strong>S Situation</strong></td>
<td><strong>Situation:</strong></td>
</tr>
<tr>
<td></td>
<td>Why are you calling?</td>
</tr>
<tr>
<td></td>
<td>(Identify your concerns)</td>
</tr>
<tr>
<td><strong>B Background</strong></td>
<td><strong>Background:</strong></td>
</tr>
<tr>
<td></td>
<td>What is the relevant background?</td>
</tr>
<tr>
<td><strong>A Assessment</strong></td>
<td><strong>Assessment:</strong></td>
</tr>
<tr>
<td></td>
<td>What do you think is the problem?</td>
</tr>
<tr>
<td><strong>R Recommendation</strong></td>
<td><strong>Recommendation:</strong></td>
</tr>
<tr>
<td></td>
<td>What do you want them to do?</td>
</tr>
</tbody>
</table>

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