Acute Psychiatric Unit Clinical Handover Procedure

1. Guiding Principles

Effective communication between mental health (MH) workers, and between mental health staff and consumers is an essential element in high quality care and in the reduction of adverse events.

Nursing and multidisciplinary clinical handover occurs using a structured process by which information is exchanged and which identifies the consumer's specific needs, confirms and clarifies risks, promotes safety and agrees on care plans. Clinical handover includes the consumer.

This procedure outlines how WACHS MH inpatient units ensure effective and safe handover between nursing shifts and between members of the MH multidisciplinary team providing care. Mental health consumers are to be active participants in handover. The ISoBAR structure underpins all clinical handover in WACHS.
This procedure does **not** address intrahospital or interhospital clinical handover.

2. Procedure

2.1 Nursing handover is to occur at the commencement of each nursing shift, seven days per week. The Shift Coordinator is responsible for leading handover to incoming nursing staff.
2.2 Multidisciplinary clinical handover is to occur each weekday morning. The Shift Coordinator is to lead handover to the multidisciplinary treating team.
2.3 Clinical handover is to occur in an appropriate meeting room or space that ensures confidentiality and effective communication. During this time there is to be sufficient staff on the unit to ensure patient safety. All incoming staff are to attend handover.
2.4 Handover reports are to be compiled using an appropriate electronic or paper-based document (e.g. Patient Journey Board), and updated each shift under the supervision of the Shift Coordinator. These documents are to follow the ISoBAR structure.
2.5 Incoming staff are to be provided with handover sheets (copies of the handover report) on which they may make additional personal notes relevant to the handover process. All staff participating in handover should ensure a verbal exchange of information accompanies the written handover document and that there is scope for incoming staff to clarify and ask questions about each consumer.
2.6 A two-step process is to be evident in MH inpatient unit handover: (i) the exchange of confidential/clinical information between staff and (ii) the involvement of the consumer/carer in further information sharing.

2.7 It is recognised that 'bedside' handover in MH inpatient units is different to handover in wards where consumers are mainly non-ambulatory, and where ward routines do not commonly require the consumer to be awake at the time of morning shift change.
2.8 Documentation is to made of any consumers not wishing to participate in handover.
2.9 If the consumer is not directly involved in the handover process, the incoming responsible nurse for each consumer is to ensure relevant information is discussed with the consumer as soon as is practicable after handover.
2.10 Other duties not related to specific patients may also be discussed including issues regarding general management of the unit.
2.11 At the end of each shift, it is the responsibility of each staff member to ensure their handover sheets are disposed appropriately and in accordance with WACHS staff confidentiality agreement.
2.12 There is a nurse allocated as Fire Warden for each shift who is responsible for emergency evacuation in case an emergency response is required. This must be recorded on an appropriate notice board on a shift by shift basis.

3. Definitions

Nursing handover	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 clinical handover process does not negate the requirement of comprehensive documentation and review of the patient's health record.
Multidisciplinary clinical handover	The transfer of information about some or all aspects of care of a patient, or group of patients, to another person in the multidisciplinary team. The handover process does not negate the requirement of comprehensive documentation and review of the patient's health record.
Handover report	The master document, electronic or paper-based, that records the required information necessary for the nursing or multidisciplinary handover of a patient. This report is subject to the MP 0002/16 Patient Information Retention and Disposal Schedule
Handover sheet	A tool used by the nurse or multidisciplinary team member, usually based on a copy of the handover report and supplemented by the staff member through the handover process. Handover sheets are informal records and are **not** subject to the Patient Information Retention and Disposal Schedule.
ISoBAR	Step by step process that provides a sequential approach to giving and receiving handover.

4. Roles and Responsibilities

Clinical Director
Has overall responsibility for ensuring that services are delivered in accordance with this procedure.

Consultant Psychiatrist
Is responsible for the medical management of patients in accordance with this procedure.

Clinical Nurse Manager
Is responsible for the implementation of this procedure.

All Staff
All staff are required to work within this procedure.

5. Compliance

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Evaluation

This procedure is to be reviewed every five (5) years

7. Standards

National Safety and Quality Healthcare Standards (First edition): 1.7, 1.8, 2.2, 6.2
National Safety and Quality Healthcare Standards (Second edition): 1.7, 1.10, 2.6, 4.3, 6.8
National Standards for Mental Health Services: 1, 2, 3, 6, 10

8. Legislation

Mental Health Act 2014 (WA)

9. References

Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist

10. Related Forms

MR184 WACHS Inter-hospital Clinical Handover Form

11. Related Policy Documents

WACHS Adult Psychiatric Inpatient Services - Referral, Admission, Assessment, Care, Treatment and Discharge Policy

12. Related WA Health Policies

OD 0484/14 WA Health Clinical Handover Policy

13. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework
Mental Health Policy Framework

14. Appendix 1 – Application of ISoBAR framework to Mental Health Inpatient Handover

This document can be made available in alternative formats on request for a person with a disability

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Appendix 1 – Application of ISoBAR framework to Mental Health Inpatient Handover

I = Identification

- Introduce the patient – name, date of birth, gender, Unique Medical Record Number (UMRN).
- If indigenous and from remote community, identify region and family group.
- Identify if the patient requires an interpreter and or is from a CALD background.
- Identify if there is a 'boarder'.
- Identify/clarify where possible personal support person /nominated person
- Identify if the patient has a guardian or financial administrator

S = Situation and Status

- Diagnosis and admission date.
- Reason for admission/transfer.
- Principle presenting problem.
- Mental Health Act status and any changes.
- Current clinical status (stable, deteriorating, improving).
- Estimated date of discharge.
- Visits or appointments attended.

o = Observation

- Mental state examination from current shift and previous shift, noting any changes
- Risk assessment from current shift and previous shift, noting any changes
- Physical observations, including vital signs if relevant.

B = Background and History

- Presenting /current issues and background past history
- History – presenting background and current issues
- Evaluation to date – physical exam, test results
- List current medications, allergies
- Management to date; whether this is working
- Relevant physical health issues

A = Assessment and Actions

- Any outstanding issues that require addressing throughout shift
- Abnormal or pending results
- Nursing interventions (i.e. 1:1; management plan, PRN medication, referrals to external agencies, other disciplines, attendance to ward programme, feedback from leave or family meetings)
- Medical interventions (assessment/reviews, medication changes, medical investigations)
- Multidisciplinary Team interventions (family counselling, financial assistance, accommodation search
- Specialist consults, including therapy.
- Relevant physical health issues including falls, pressure, VTE risks
- Outcomes from multidisciplinary team meetings.

- Leave arrangements.
- Requests for further opinion (Psychiatrist, Legal representative, MH Law Centre, Chief Psychiatrist).
- Mental Health Tribunal review (when scheduled, documentation).
- Clear accountability for actions.
- Given the situation, what is the plan; tasks to be completed?
- Level of urgency.
- Outstanding MHA notifiable events to the Office of the Chief Psychiatrist.

R = Responsibility, Risk Management and Readback

- Identification of any risk factors and risk level
- Identification if patient is on visual observations including frequency and when next due.
- Allergies.
- Infection control issues.
- Current management plan.
- Medication changes and PRN usage.
- Clarify and check for shared understanding.
- Who is responsible for what and when.
- Repeat of critical information.