Nursing/Midwifery Shift to Shift Bedside Handover – Process Flowchart

The patient as an active participant

All patients are asked if they wish to participate in Bedside Handover. Some patients may not be able to participate, such as those that are experiencing confusion, decreased level of consciousness or who have expressed a wish not to participate.

It is recommended that patients be advised on admission that they will be invited to participate at the bedside handover if awake. Patients not wishing to participate should have supporting documented evidence.

Shift Coordinator

- Attend bedside handover for own patients if relevant.
- Receive an update from oncoming staff in each team/ partnership after bedside handover has been completed.

Identify
Situation
observations
Background
Agree to plan
Readback

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Preceding Staff

- Update Journey Boards – Key information
- Update handover sheet
- Inform patient of pending handover
- Discuss with patient if/and whom they would like to be present at handover, including family/carers
- Ensure patient is comfortable e.g. pain free

Exchange sensitive information during huddle to avoid confidentiality issues

Outgoing Team Leader

- Organises HUDDLE to exchange confidential / clinical information
- Huddle led by previous shift coordinator
- To include all oncoming staff if possible

99% retention rate is achieved using verbal handover combined with accompanying pre-printed handout containing all relevant patient information

Exchange Clinical Information

- Use ISoBAR to guide handover,
- Identify patients requiring clinical escalation, new admissions & pending discharges, at risk patients
- Clarify any clinical requirements
- Proceed to bedside patient/carer handover

Safety Scan – Bed Area

- Introduce staff to patient/carer
- Avoid medical jargon
- Check patient ID band/risk alerts
- Check ORC & escalation requirements
- Check medications given and signed
- Check infusion orders to attached bags
- Check PIVAS
- Check outputs and other documents
- Safety Checks as per ward protocol
- Check call bell is within reach

Assess your own patient and check care has been implemented

Background and Agree to Plan

- Invite patient/carer to confirm / clarify with any identified **RISKS** - ADL, Falls, Cognition, Concerns, Pathways in use
- Staff to discuss (with patients/carer) care requirement of previous and next shift
- Review Nursing Careplan

Communicate to the patient /carer when you plan to review them this shift

Readback – Confirm Priorities

- Ask patient if they have any final questions.
- Ask oncoming staff if they have any questions

Final confirmation for next shift's activities

PROCEED TO NEXT PATIENT

Adapted from: QLD Health "Clinical Handover at the Bedside Checklist" 2010