Communication Strategies to support safe and effective clinical handover and risk communication / escalation within teams by Acute Adult, Forensic and MHSOP service staff

Guideline Responsibilities and Authorisation

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Target Audience	Acute Adult and Forensic and MHSOP clinical staff
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
02	Chris Huxtable and Carole Kennedy	June, July 2015	Mental state examination Review of the shift leader / ACNM description Audit indicators
03	Carole Kennedy	October 2018	DASA updated EWS updated and removed ADDS Updated the MSE to World Health Organisation References and links included SBARR and shift lead updated
04	Kylie Balzer	July 2023	Document expanded to include clinical handovers and other clinical communication strategies based on communication of risk, aimed at decreasing adverse events, and providing high quality care delivery

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1 Overview

1.1 Purpose

The purpose of this guideline is to provide best practice communication principles and strategies for use in clinical practice within teams in the mental health environment in the acute adult, forensic and Mental Health Services for the Older Person (MHSOP).

This guideline will outline principles of practice for:

1. Clinical handovers in transitions of care delivery
2. Communication and escalation of risks within the team and multidisciplinary team
3. Strategies for overcoming barriers to effective communication

Effective communication between mental health clinical staff is essential for the communication of risk, providing high quality care, and reducing the risk of adverse events.

The implementation of this guideline will respect and uphold the principles under Te Tiriti o Waitangi.

All mental health and addictions staff are required to follow the requirements of the Te Whatu Ora Waikato Admission, Discharge and Transfer policy (1848).

1.2 Staff group

All staff working in clinical practice in the acute adult and forensic and MHSOP service.

1.3 Patient / client group

This guideline will support safe and effective team communication to enhance safety for tāngata whaiora receiving care delivery within the Acute Adult and Forensic and MHSOP service.

1.4 Exceptions / contraindications

This guideline does not specifically cover communication strategies with tāngata whaiora or whānau / key support persons. The guideline is intended to cover strategies in clinical team communication during practice delivery. This guideline does not cover clinical supervision processes, diffusion, or debriefs.

1.5 Definitions and acronyms

Clinical handovers	The transfer of professional responsibility and accountability for some or all aspects of care for a tāngata whaiora, or group of tāngata whaiora to another health professional or professional group on a temporary or a permanent basis. The clinical handover process does not reduce the need for comprehensive documentation in the tāngata whaiora clinical record.

Communication strategies	Strategies used in communication to provide the effective transfer and understanding of information
Dynamic Appraisal of Situational Aggression (DASA)	Dynamic Appraisal of Situational Aggression (DASA) is a tool to assess the likelihood that a tāngata whaiora will become aggressive within a psychiatric inpatient environment.
Handover sheet	A tool used by clinical staff members as an informal record to guide the delivery of care throughout the shift. The handover sheet is an informal record and are not subject to the clinical record retention requirements.
Huddles	Huddles are a brief stand up meeting that are structured and focused on enhanced staff communication and tāngata whaiora safety.
Mental State Examination	"Mental state examination involves assessment of the person's appearance, behaviour, conversations (through form and content), affect and mood, perception, cognition, insight and judgement." Terry Froggatt and Susan Sumskis (p.100, 2017)
SBARR	SBARR is a communication tool that provides a common and predictable structure to clinical communication. SBARR is the format used for clinical handovers, and can be used for communicating urgent situations or when requesting a review or escalation of care

2 Clinical management

2.1 Roles and responsibilities

Clinical staff

All staff in clinical practice need to be aware of and utilise best practice communication practices within their roles.

All clinical staff are to provide support to the clinical handover process and shared communication within their ward / area of practice.

Managers

Charge Nurse Managers need to ensure that best practice communication practices, and the processes for these within their context of care are a part of the orientation process for their ward / area.

Staff required to lead the clinical handover process need to specifically be oriented to the role of shift handover leadership, and role model the best practice processes for clinical handover.

Monitoring of communication practices is to be a part of the quality improvement processes within wards / areas, and feedback provided to staff at the ward / area team meetings.

Clinical Leadership roles

Best practice communication practices are to be promoted and supported by clinical leadership roles to advance their integration into practice.

2.2 Competency required

Staff are to have been provided information on this guideline and the current best practice communication processes specific to their area of practice within the ward / area during orientation.

Speaking up for Safety is a mandatory requirement for staff to attend in person training during orientation.

2.3 Equipment

- PFM boards
- Handover sheets as identified by the specific context of care
- Clinical workstation

2.4 Guideline

2.4.1 Clinical Handovers in transitions of care delivery

Clinical handovers occur constantly between shifts, during shifts e.g. when staff are going on meal break, on transfer between wards, discussion of care in a multidisciplinary team meetings, and on transfer between services e.g. to another unit or facility; to the community setting; and when the tāngata whaiora is going to an appointment or procedure. A standardised approach to clinical handovers is known to benefit the safety of tāngata whaiora, with flexibility being important for the delivery of relevant information to be adapted to the context of the service and situation.

Clinical handovers are an explicit transfer of clinical accountability and responsibility and not just the transfer of information. Clinical handovers include the handover of specific risks and needs for the individual tāngata whaiora, whānau and key support persons.

Whilst clinical handovers often occur within the nursing discipline, they may include any members of the multidisciplinary team as appropriate.

Handovers between shifts

Clinical handovers between shifts are the transfer of relevant tāngata whaiora information verbally that is required to transfer responsibility and accountability of care to the next shift. The relevancy of information to be communicated is based on the transfer of the responsibility and accountability of care delivery.

Clinical handovers are to be held in an area where information can be confidentially transferred and where there is access to the information on the PFM boards. The environment for clinical handover is to be respected and one in which disruptions and interruptions are minimised.

The clinical handover process is to have a designated lead person who may be a CNM / ACNM / CNS or a designated shift lead. Allocation of tāngata whaiora to staff needs to take into account continuity of care provision, and the acuity needs of the tāngata whaiora. The role of the clinical handover lead is to guide the staff to be punctual to

handover, concise and on-topic in their handover delivery, and promoting the environment that supports the delivery of key information appropriate to clinical handover.

The clinical handover is to be person centred based and utilise positive language (e.g Real language, real hope on the Te Pou website

https://d2ew8vb2gktr0m.cloudfront.net/files/resources/Real-language-real-hope.pdf

and positive words as identified within the Safewards programme who identify “In order to balance that natural tendency, we suggest that something positive is said about each patient at the handover, and that when difficult behaviour is described, potential psychological explanations are also offered. This will promote the positive appreciation of patients and reduce the likelihood of further conflict.” (Safewards website Accessed 17 July 2023)

Clinical handover content is to be clear, concise, and use easily understood words with the minimal use of Te Whatu Ora Waikato accepted abbreviations. All inpatient handovers are to include a verbal component with the current responsible member of the clinical staff speaking directly to a receiving member of the team taking over responsibility and accountability.

All tāngata whaiora are to be handed over during the clinical handover process and the process is to include the identification of any tāngata whaiora of concern and any newly admitted tāngata whaiora.

Te Whatu Ora Waikato uses the SBARR format for clinical handovers organisationally as per the Te Whatu Ora Waikato SBARR Communication Tool Guideline (5038).

As per the requirements of the Te Whatu Ora Waikato Medicines Management Policy (0138) the national medication chart and any other medication charts in use require to be reviewed by incoming staff with outgoing staff to ensure that the medication requirements of each patient are understood and any discrepancies or concerns are identified. Completion of any medication or treatment omissions can then be noted and planned for.

The first component of the handover will be the introduction of the tāngata whaiora by name and relevant identification details e.g. age. Please ensure that the information provided as to the tāngata whaiora identification cannot be confused with other tāngata whaiora on the ward. Patient Identification as part of the clinical handover process is as per the requirements of the Te Whatu Ora Waikato Patient Identification Policy (1539).

The following is a guideline to what may be covered within the SBARR format within the context of a mental health ward / area:

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Structure: SBARR	Content handover item (minimum)	
Background	Clinical status	Includes relevant mental and physical clinical history, current diagnosis and mental state exam. Key alerts and allergies to be provided.
	Summary of KEY nursing interventions	Includes completed and recommended interventions e.g. PRN medications Oversight of the medication chart is to be a part of the clinical handover process.
Assessment	Risk level and management strategies Physical health risks	Risk levels are only useful if qualified and include management strategies Risk communication will include current mental health risk, appropriate historical risk, Dynamic Appraisal of Situational Aggression (DASA), assessment and any interventions Management strategies based on physical health risks e.g. diabetes, falls harm prevention, VTE risks
	Social interactions	Observations and any changes
	Tāngata whaiora / Key support person requests	e.g. diet, activities / programmes, visits. Any follow up requirements.
	Changes to recovery / treatment plan	e.g. pending and reviewed investigation results for follow up; changes in medication; changes in discharge planning specific plans for the day and responsibilities e.g. MHA review – psychiatrist, whānau meeting, team meeting, hospital appointment Outcomes from multidisciplinary team meetings Referrals to external agencies, other disciplines
Recommendations	Care instructions	- Legal status and when review due date - Leave status - Levels of observation - Level of care delivery - Key risk factors and critical information
Response		Understanding confirmed and includes the current plan for the shift, highlighting key priorities

(Adapted from the work of Cowan et. al 2018)

A handover sheet may be completed by nursing staff for their use during the shift. As identified in the Releasing Time to Care Shift Handover module "Standardised handover information sheets keep handover information consistent, help avoid gaps and can be customised to reflect the information staff have said they most need at handover".

Following the handover transfer of care a face to face introduction to the allocated registered nurse and other staff as appropriate involved in the tāngata whaiora care is to occur. This mihi (greeting / introduction) is to create a relationship / connection with the tāngata whaiora, and to become aware of any pressing needs of the tāngata whaiora / key support persons. As required an interpreter should be made available as per the Te Whatu Ora Waikato Interpreters and Translation procedure (0137).

See the appendix A for key principles to follow in the clinical handover process.

Handovers of tāngata whaiora within the hospital (for procedure, treatment, or to another ward)

The following apply to the transfer of tāngata whaiora within the hospital environment:

- All tāngata whaiora transferred from one clinical area to another clinical area require the handover of care to be documented in the clinical record. This includes details of the transfer time indicating a transfer of professional responsibility and accountability.
- Patient Identification processes occur as per the Te Whatu Ora Waikato Patient Identification Policy (1539)
- The SBARR format is used for handover
- Clinical alerts are identified e.g. FYI flags, allergies, infection prevention and control precautions, EWS modification, Not For Resuscitation (NFR) status
- Significant current risks
- The designated levels of observation are maintained as per the Mental Health and Addictions Levels of Observation across all Mental Health and Addiction Inpatient Services Procedure (5238)
- As required an interpreter should be made available as per the Te Whatu Ora Waikato Interpreters and Translation procedure (0137)
- The health professional providing the handover of care is fully aware of the current risks and needs of the individual tāngata whaiora
- Awareness of the cognitive, emotional, and psychological needs and support required for tāngata whaiora during the transfer process
- Any checklists / documents required within the transfer of care process are completed

Handovers to Community Services and External Services

In addition to the above requirements for handovers for transfers within the hospital the requirements for discharge as detailed in the Te Whatu Ora Admission, Discharge and Transfer policy (1848) must be met.

2.4.2 Communication and escalation of risks within the multidisciplinary team

Communication and escalation of risk can occur throughout the shift in addition to being communicated in the clinical handover process. Mechanisms for communication of clinical risk within practice include and may not be limited to:

- The use of huddles
- Continual risk communication, documentation and escalation
- Speaking up for safety

Huddles

Huddles are brief (e.g. 10 minutes) stand up meetings involving members of the multidisciplinary team present on the ward / in the area. The goal of a huddle is to offer an opportunity for team members to coordinate care, delegate tasks, and troubleshoot issues that have arisen during a shift. Huddles provide an opportunity for current situation awareness, based on the knowledge that changes occur throughout shifts. Huddles need to be a healthy environment for staff to communicate and create an open dialogue.

Huddles held in wards are based on the discretion of the Charge Nurse Manager. Structured processes are to be in place for the staff in respect to the huddle within the context of care delivery.

The Institute for Health Care Improvement (2019) has a five item huddle agenda that can be adapted for use which includes:

1. Safety and quality concerns and successes in the past day or shift
2. Safety and quality issues for tāngata whaiora on today's schedule
3. Review of tracked issues (previously identified issues)
4. Announcements and information to share

Another way of looking at huddles is to look back on the shift, looking forward to what may happen during the shift / day and having an overall unit picture (Goldenhar, Brady, Sutcliffe, Muething, 2013)

"Look Back" – what changes have occurred since the clinical handover

"Look Forward" – what to expect for the rest of the shift based on risk / issues identified

"Integrate" – encouraging collaboration e.g. delegating of tasks, troubleshooting, and staff needs

Risk communication and documentation

At any point in the shift that new risks are identified (e.g. from conversations, clinical handover, huddles, multidisciplinary team meetings, ward rounds) these are to be documented in the tāngata whaiora clinical record, and communicated to all required members of the multidisciplinary team. CNMs / ACNMs / Shift Leads / Medical Staff must keep risk at the forefront of their thinking and promote continual situational awareness of how to mitigate, communicate and manage these risks.

As per the requirements of key procedures within the ward / area / service escalation of risk must occur to medical staff, After Hours Coordinators, the Operations Manager, and the Clinical Director. Staff must discuss with their Charge Nurse Manager during orientation the requirements for escalation pertinent to their role during orientation.

It is essential that any staff including ancillary staff are able to raise a risk, or potential risk at any time with a CNM / ACM / Shift Lead.

As per the requirements of the Early Warning Scoring System for the Deteriorating Patient Policy (1540) and Procedure (1541) the escalation of a clinically deteriorating patient must occur.

Speaking up for safety

Speaking up for safety is the Te Whatu Ora Waikato tool respectfully raising issues. Information on Speaking Up for Safety is available on the Te Whatu Ora intranet page

https://intranet.sharepoint.waikato.health.govt.nz/Pages/Speaking%20up%20for%20Safety-Have%20you%20got%20my%20back.aspx

A refresher on the C.O.D.E. (Checks, Options, Demands, Elevates) can be found here:

https://intranet.sharepoint.waikato.health.govt.nz/Pages/Speaking-Up-for-Safety-refresher.aspx

2.4.3 Strategies for overcoming barriers to effective communication

The following strategies are important for overcoming barriers in effective communication:

- Voice concerns
- Ask questions
- Share information
- Create a healthy communication environment
- Reduce interruptions and distractions
- Use structured communication tools
- Reduce jargon and the use of abbreviations
- Speak clearly and at a pace that the receiver can follow
- Check back for understanding

(Guttman et al. 2021)

3 Patient information

It is important that tāngata whaiora, and key support persons are aware of the staff caring for them on a shift, and know who to approach regarding any concerns. Tāngata whaiora need to be kept informed of any changes that occur during the shift.

4 Audit

4.1 Indicators

- 10 point checklist Shift Handovers in the Releasing Time to Care. The Productive Mental Health Ward module on shift handovers
- Issues related to communication arising from incidents and tāngata whaiora complaints

4.2 Tools

- Releasing Time to Care. The Productive Mental Health Ward Module on shift handovers
- Learning from adverse event processes

5 Evidence base

5.1 Bibliography / References

- Adapted by Caro Swanson, service user lead, from 'Recovery Language' by Otto Wahl. *Real Language, real hope. Te Pou o te Whakaaro Nui Published 11 February 2021. Accessed 18 July 2023* https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/communication-clinical-handover
- Australian Commission on Safety and Quality in Health Care Communication at clinical handover. Accessed 17 July 2023 https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/communication-clinical-handover
- Cowan, D.; Brunero, S.; Luo, Z.; Bilton, D. & Lamont, S. (2018) *Developing a guideline for structured content and process in mental health nursing handover,* International Journal of Mental Health Nursing, 27, 429-439.
- Froggatt, T. & Sumskis S. (Ed). (2017). Assessment of mental health and mental health illness: In Procter, N. (Ed) Hamer, H.P. (Ed) McGarry, D. (Ed), Wilson, R.L. (Ed) & Froggatt, T. (Ed) *Mental Health A person-centred approach.* (p.p. 93-120) Cambridge University Press, United Kingdom.
- Goldenhar, L.M., Brady, P.W., Sutcliffe, K. & Muething, S. (2013). Huddling for high reliability and situation awareness. BMJ Quality & Safety, 22, (11), p.p. 899-906.
- Guttman, O. T.; Lazzara, E.H.; Keebler, J.R.; Webster, K.L.W.; Gisick, L.M.; and Baker, A.L. (2021). Dissecting Communication Barreiers in Healthcare: A path to enhancing

communication resiliency, reliability and patient safety. *Journal of Patient Safety,* 17, (8).

- Institute for Healthcare Improvement (2019) Patient Safety Essentials Toolkit Huddles. https://www.ihi.org/resources/Pages/Tools/Huddles.aspx Accessed 18 July 2023.
- Queensland Government Patient Safety Unit Clinical Governance at the Bedside Checklist. Accessed 17 July 2023 https://www.health.qld.gov.au/__data/assets/pdf_file/0028/429067/ch-checklist.pdf
- Releasing Time to Care. The Productive Mental Health Ward Shift Handovers Version 1.
- https://intranet.sharepoint.waikato.health.govt.nz/RefDocs/Nursing%20and%20Midwifery/Handover%20-%20releasing%20time%20to%20care.pdf
- Safewards website – Positive words https://www.safewards.net/interventions/positive-words Accessed 17 July 2023

5.2 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions AWOL (Absent Without Official Leave) procedure (3555)
- Mental Health and Addictions BAO Be Aware of – Crisis assessment and treatment service procedure (2712)
- Mental Health and Addictions Courtyards procedure (0516)
- Mental Health and Addictions Courtyards in OPR1 procedure (6441)
- Mental Health and Addictions Leave Adult Mental Health Inpatient Wards procedure (2184)
- Mental Health and Addictions Leave Puawai Inpatient Wards procedure (6266)
- Mental Health and Addictions Levels of Observation across All Mental Health and Addiction Inpatient Services procedure (5238)
- Mental Health and Addictions Professional Supervision for Registered / Enrolled Nurses in the Mental Health and Addictions Service procedure (0332)
- Mental Health and Addiction Puawai Internal Security procedure (2687)
- Mental Health and Addictions Searching of Mental Health Service Users in Relation to Illicit Substances and Dangerous Articles procedure (1862)
- Mental Health and Addictions Sexual Safety in Mental Health and Addictions Inpatient Units procedure (6265)
- Mental Health and Addictions Use of Personal Restraint in Mental Health and Addictions Inpatient Setting procedure (1865)
- Mental Health and Addictions Use of Safety Garments in Inpatient Mental Health and Addictions Service procedure (5788)
- Mental Health and Addictions Whānau Inclusive Practice guideline (5795)

- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others (5241)
- Te Whatu Ora Waikato Admission, Discharge and Transfer policy (1848)
- Te Whatu Ora Waikato Credentialling of Health Practitioners policy (0004)
- Te Whatu Ora Waikato Direction and Delegation of Enrolled Nurses policy (3003)
- Te Whatu Ora Waikato Early Warning Scoring System for the Deteriorating Patient policy (1540).
- Te Whatu Ora Waikato Early Warning Scoring System for the Deteriorating Patient procedure (1541)
- Te Whatu Ora Fall risk assessment, minimisation and management policy (1705)
- Te Whatu Ora Waikato Interpreters and Translation procedure (0137)
- Te Whatu Ora Waikato Health Care Support Worker policy (1832)
- Te Whatu Ora Waikato Medicines Management policy (0138)
- Te Whatu Ora Waikato Patient Identification policy (1539)
- Te Whatu Ora Waikato SBARR Communication Tool guideline (5038)
- Te Whatu Ora Waikato Professional Supervision for Allied Health procedure (0536)
- Te Whatu Ora Waikato Venous Thromboembolism Risk Assessment and Prophylaxis policy (1449)

5.3 External Standards

- Ngā Paerewa Health and disability services standard NZS8134:2021

Appendix A – Key principles for clinical handover

Preparation	• Allocation of tāngata whaiora • Scheduling of the clinical handover • Update clinical records, documentation, and have charts and information ready e.g. medication chart
Organisation	• Assigned lead for the clinical handover • Scheduled time for verbal handover to occur • Use of standardised clinical handover format (SBARR) • Organisation of any required personnel e.g. interpreters • Context appropriate handover documents agreed with the team are available • Organisation of the relevant staff to be present, and the ward / area to have staff coverage for safety
Environmental Awareness	• Positive environment e.g. language • Minimise interruptions and distractions • Confidentiality
Transfer of responsibility and accountability	• Ensure oncoming staff have all the information they need to take over the responsibility and accountability for the care of the tāngata whaiora – ask the incoming staff if they have any questions
Tāngata whaiora / key support person needs	• Ensure the needs of tāngata whaiora are met whilst clinical handover is in process • Provide a mihi (introduction / greeting) of oncoming staff and address any immediate current needs of tāngata whaiora • Ensure the voice of the tāngata whaiora, key support persons, and whānau is included within the clinical handover process • Complete a safety scan