GUIDELINE

Clinical Handover

Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

Aim

To ensure the safe and appropriate handover of an infant's care from team to team and shift to shift.

Risk

Handover is a high-risk area for patient care errors. There is an increased risk of error and miscommunication during handover if a structured clinical handover process is not adhered to.

Definition

Clinical handover is an explicit 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.

Background

Structured clinical handover has been shown to reduce communication errors and to improve patient safety and care. Critical information is more likely to be accurately transferred and acted on if a structured clinical handover process is adhered to.

There is an increased risk of communication errors and miscommunication at transitions of care. Ineffective communication at clinical handover is also associated with clinicians spending more time retrieving the relevant information which can result in inappropriate care, and poor use of resources.

When a standardised and structured clinical handover process is followed, all relevant participants know the minimum information that needs to be communicated during

handover. See WA Health Clinical Handover Policy (MP 0095/18) for detailed clinical handover processes.

Also refer to Australian Commission on Safety and Quality in Health Care - NSQHS Communicating for Safety Standard.

iSoBAR Clinical Handover

A consistent structure and content must be used for all handovers within Neonatology as follows:

IDENTIFY:	Name and UMRN
SITUATION:	Birth Gestation, Clinical scenario, reason for admission
OBSERVATION:	Cardiovascular & respiratory observations Respiratory support (ETT size, depth of insertion, confirmation of placement, FiO2 & settings), Tone, reactivity, infusions, other concerns
BACKGROUND: (Relevant Past Problems)	Maternal history Labour/Birth history Resuscitation Medications
	Surgery (if relevant) • Intra/post op echo details (if done). • Details of procedure. • Intra-operative surgical problems/complications.
	Anaesthesia (if relevant) • Itemise any ETT, vascular and surgical drain • manipulations and difficulties. • Analgesia. • Blood losses and Fluid/blood product administration. • Any arrhythmia details
AGREE A PLAN/ ASSESSMENT:	What needs to happen Assessment of clinical status
RECOMMENDATION READBACK (Confirm shared understanding):	Clinical priorities in management, investigations/Procedures, desired feeding plan, parental consents Communication with parents

Neonatal Admission to SCN3/SCN2

Medical and midwifery/nursing staff accompanying the infant, must handover to the receiving medical and nursing staff as per the Handover and Transition to the Neonatal Unit Guideline. Follow the iSoBAR format and ensure all relevant staff are available for a **Stop, Look and Listen** handover whilst the infant is stable on the resuscitaire. Ensure resuscitaire is plugged into a power source.

If the infant is unstable, then it may be appropriate to move the infant in to their admission incubator and stabilise prior to handover. In this circumstance the transferring and receiving team must formulate a plan to maintain safety of the infant during the transfer from the resuscitaire to the incubator. It's the responsibility of the Team Leader to allocate staff roles accordingly.

Cardiac Patients Returning From PCC

Most neonates undergoing cardiac surgery will have their immediate post-op care in PCC with most returning to NICU within the next 24 hours. The anaesthetist remains in charge of the patient until handover to neonates is completed. Chest drains should be connected to suction (15-20cm H2O) prior to handover.

Following handover, transfer transport monitoring to bedside monitoring. Review infusion concentrations and if changing inotrope infusion use the 'double pumped' method, i.e. the original infusion should only be stopped once the new infusion has reached the infant.

- ABG should be taken within 10-15 minutes of admission.
- FBC/ U+E/ Ca/ Mg/ coagulation profile should be checked.
- X-ray to check ETT, NGT, drain and line positions and lung and heart status.
- An ECG should be considered.

Surgical Patients

Post-Operative Handover

Medical Clinical Handover

Whenever there is a change of shift the infants in the NICU need to be handed over to the next shift using the Neonatal Medical Handover Chart. This needs to take place at the bedside for all patients in SCN3 and at the bedside for new admissions and patients of concern in SCN2.

The following situations also require a **written** handover in the progress notes MR420:

1.Transferring an Infant from Level 3 to a Level 2 Area or vice versa

2. KEMH to 3B

3. KEMH to KEMH Post Natal Ward

4. KEMH/PCH to peripheral hospital

1. Transferring an Infant from Level 3 to a Level 2 Area or vice versa

At 0830 and 1630 the SCN3 Consultant will identify any suitable/likely infants that can be transferred out of SCN3 (i.e. to SCN2/HDU/2W) and inform the SCN3 Coordinator.

Step 1	Complete the **Neonatal Intra/inter Hospital Medical Transfer Summary** will be written (MR440.02) of the identified infants to include: • A relevant comprehensive summary of Situation, Observations, Background, Assessment and Recommendations (iSoBAR) • The destination of infant.
Step 2	The Problem List MR485.03 and Flow Chart MR485.02 must be up to date.
Step 3	The infant should have a complete review of all relevant charts and a full physical examination if one has not been completed in last 48 hours (either a Weekly Check MR485.02 or a Discharge Check on the MR410).
Step 4	A member of the medical team will then contact a member of the receiving medical team and after conducting a full verbal handover will document under the Transfer Summary: "Infant 'A' handed over to Dr 'B', and then sign/print/designation.
Step 5	No infant will be transferred to another location until these steps are undertaken.

2. Transferring an Infant from KEMH to PCH 3B

The Consultant on service will authorise infants that are to be transferred to 3B and inform the Coordinator in that area. Then **Follow STEPS 1 to 5** above. For complex infants, this should be a Consultant to Consultant handover.

3. Transferring an Infant to KEMH Postnatal Ward

The Consultant/SR/Reg on service will authorise infants that are to be transferred and inform the Coordinator in that area. Follow **STEPS 1 to 5** then contact the Postnatal Ward RMO. If transfers occur overnight the infant can be handed over in the morning when RMO starts shift. This will require the RMOs meeting with the SCN2 registrar when they collect their pagers at 0800.

4. Transferring an Infant from KEMH/PCH to a Peripheral Hospital

The Consultant/SR on service will authorise infants that are to be transferred inter-hospital and inform the Coordinator in that area. Then **Follow STEPS 1 to 5** above. In addition, complete NaCS Transfer letter.

Nursing Clinical Handover

All patients are required to have a nursing entry in progress notes each shift and with any change in condition. Handover using the:

- iSoBAR format.
- iSOFT Clinical Manager Nursing Handover Chart.
- Relevant medical record forms.
- **PATIENT SAFETY BEDSIDE CHECKLIST** must be completed.

iSOFT iCM Nursing Handover Chart		
IDENTIFY	Name & UMRN	
SITUATION	First Name: GA: CGA: Actual age: BW: _____ g CW: ___g (+/-) Diagnosis: Current problem:	
OBSERVATION	Ventilation: S/V if none Back Transfer hospital (if applicable): Phototherapy: Date started/date ceased Head scans: Day1: Day7: Day28: (or N/A) write extra USS here Immunisations: (birth Hep B, DTP/Paliv etc, or N/A) Eye checks: (or N/A) Referrals: simple referrals. For complex referrals write 'see Referral/Social Work file'	
BACKGROUND (Relevant Past Problems)	Maternal/Birth history: Resolved problems: (problem & date) Medications: EPDS: SW: Just name as will still have social file for complex patients.	
ASSESSMENT	MLs/kg: Nutrition: write all lines in situ here with infusions as well as milk orders.	NUTRITION ROOM Milk type and total volume in 24 hours - enter information in the green section on right DIET: scroll down to find MILK ROOM enter in the lower green box.
READBACK	Clarify ward round changes and any concerns: Only write info not added into other sections.	

The following situations also require a written handover in the progress notes MR420 as follows:

1. Transferring infants from one area to another (SCN3/2, HDU, 2W, Satellite)
2. Transferring an Infant from KEMH to PCH Ward 3B
3. Transferring an Infant to KEMH Postnatal Ward (PNW)
4. Transferring an Infant from NICU to a Peripheral Hospital

Transferring infants from one area to another (SCN3/2, HDU, 2W, Satellite)

Step 1	No infants within the NICU are to be moved without first discussing with the Coordinator /CNC /On-service SR or Consultant).
Step 2	All paperwork must be up to date.
Step 3	The allocated nurse will then contact the nurse (or midwife) taking over and conduct full verbal handover and beneath the medical documented Transfer Summary (if applicable), write: • "Infant 'A' transferred to 'X' nursery. Care handed over to RN/RM/EN 'B'" and then sign/print/designation.
Step 4	No infant will be transferred to another location until these steps are undertaken

Transferring an Infant from KEMH to PCH Ward 3B

The Consultant on service will authorise infants that are to be transferred to 3B and inform the Coordinator in that area. Then **Follow Steps 2 to 4** above.

Transferring an Infant to KEMH Postnatal Ward (PNW)

The Consultant/SR/Reg on service will authorise infants that are to be transferred and inform the Coordinator in that area. **Follow step 2 to 4**, on arrival at PNW both transferring and accepting staff to sign **Clinical Handover Transfer Stamp**.

Transferring an Infant from NICU to a Peripheral Hospital

The Consultant/SR on service will authorise infants that are to be transferred to a peripheral hospital and inform the Coordinator in that area. If the infant is medically or socially complex the SR or Consultant should make the transfer call to the Peripheral Hospital Paediatrician. After the peripheral hospital has agreed to accept the infant from **both** the medical & nursing staff, nursing staff to complete the following:

- All nursing paperwork up to date.
- MR430 Admission and Discharge Form.
- Interhospital Transfer Form MR440.

See Discharge Process Guideline and Discharge: Medical Check and Follow-Up for further information.

Related CAHS internal policies, procedures and guidelines
Clinical Handover – PCH Operational Manual
Identification of the Infant

Transition and Transfer from Neonatal Intensive Care Unit to a PCH Inpatient Unit
Intrahospital Transport of Neonate
Handover and Transition to the Neonatal Unit
Discharge Process Guideline
Discharge: Medical Check and Follow-Up

References and related external legislation, policies, and guidelines
WA Health Clinical Handover Policy MP 0095/18

Useful resources (including related forms)
NSQHS Standard 6: Communicating for Safety / Communication at clinical handover.

This document can be made available in alternative formats on request.

Document Owner:	Neonatology		
Reviewer / Team:			
Date First Issued:	August 2014	Last Reviewed:	Nov 2023
Amendment Dates:	May 2024, Cardiac Post-op Handover section amended as Cardiac Post-Op Handover guideline rescinded.	Next Review Date:	Nov 2026
Approved by:	Neonatology Coordinating Group	Date:	11/12/2023
Endorsed by:	Neonatology Coordinating Group		
Standards Applicable:	NSQHS Standards:		

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