Transforming Clinical Handover in Nursing with ISBAR
RN Cheung Tsui Ying

Department of Surgery RHTSK
21 handovers per patient for 7 days

180 handovers per month per nurse

• Discontinuity of patient care
• Risk of error
• Lose some information

That’s why a quality handover is so important!
The most commonly identified contributing factors of reported SEs were related to process, communication and staff.

The HA Annual Report on Sentinel and Serious Untoward events (2012-2013)

The Top 9th Clinical Risk in HKEC (2015-2016): Clinical Handover & Communication

- Miscommunication / communication breakdown / inadequate handover among team members
Handover before program:

- No Standardization
- Missing/incorrect/non-updated/superfluous information
- Inconsistent/incorrect translation
- Excessive time decreased duty hours & increased discontinuity
- No staff training/tools/audits/review

Ideal handover:

- Updated/correct information
- Involvement of right person, timely manner
- Reduce duplication
- Reduce the commonest reason of adverse events

Transform Handover:

- Standardized

Need For Change in Practice
How can we do better for the transfer of information?

System
- Flexible standardization
- Minimum clinical dataset
- Iterative improvement
- Well-trained staff

Human factors
- Situational awareness
- User-centred design process
- Acceptance of human limitations
- Educational, feedback, mentoring opportunities

Device
- ISBAR tool
- Globally used
- Simple & focus
- A shared mental model
**IDENTIFY**
Patient with identifiers
Patient’s name, bed no, age, functional information & psychosocial status

**SITUATION**
Describe the correct situation
Reason for admission, Dx if known

**BACKGROUND**
Deliver previous Hx, current medication
Food & drug allergy

**ASSESSMENT**
What do I think the problem is?
Latest clinical investigations, vital signs, pain score, Lab result, Consultation or procedure

**RECOMMENDATION**
Request for action
Actions required after handover
Risk factor

**AS ISBAR Handover Tool**

**Identify**
- Patient’s Particulars or Affx: [ medication label ]
- Name: ____________________________
- Sex: Male [ ] Female [ ]
- Age: ____________________________
- Bed No.: ____________________________
- Special Information: ____________________________

**Situation**
- Date of admission: ____________________________
- Type of admission: [ ] Clinical [ ] Emergency
- Diagnosis of admission: ____________________________
- Reason of admission: ____________________________

**Background**
- Past history of medical & surgical conditions, mental illness: ____________________________
- Current medications: ____________________________
- Allergy: [ ] Yes [ ] No

**Assessment**
- P/E:
  - Investigations: [e.g. XR, USG, CT, labs, urine]
- Consultation: [ ] Medical [ ] Cardiac [ ] Anaes [ ] PT [ ] MSW [ ] Dietitian [ ] OT [ ] Others
- Operation / Procedure:
  - Present: ____________________________
  - Vital signs: ____________________________
  - Pain score: ____________________________
  - Diet: ____________________________
  - IVF: ____________________________
  - Wound / Skin: ____________________________
  - Others: ____________________________

**Risks:** [ ] Fall [ ] PU [ ] Suicide [ ] Violence [ ] Others

**Recommendation**
- Current Health Problem: ____________________________
- Recommendation: ____________________________
ISBAR Breakdown in Clinical Handover

**IDENTIFY**
- Introduce patient: name, sex, age, bed no
- Accommodation
- Functional information
- Special information

**Situation**
- Date and type of admission
- Reason for admission
- Diagnosis if known
- Vital signs and stability if current status

**Background**
- Relevant history of medical & surgical conditions, mental illness
- Current medications
- Allergy history

**Assessment**
- Key clinical assessment & investigation
- Operation/procedure
- Current status, treatment, intervention
- Current health problem/working diagnosis
- Risks & management issues

**Recommendation**
- What need to be done/review
- Investigation/treatment underway or that need monitoring
- Plan
- Seriousness of patient condition and degree of vigilance for patient safety
ISBAR 5 elements case study

**Identify** – Bed 7, Wong Yi, M/74, lives with family, walks with stick, language: Mandarin

**Situation** – Admitted via A&E on 11-6-2014 for epigastric pain, tea-color urine & chills

**Background** – HT, IHD on Aspirin, allergy to egg


**Recommendation** – Monitor blood results, I&O – pending blood culture results & MRCP appointment – inform Dr. if increase fever/chills/pain
Empower staff

Confirmation of information

Consistent

Clarification

Training Tips
# Nursing Observational Audit

**Topic:** Individual patient handover with ISBAR framework

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<thead>
<tr>
<th>Criteria</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Remarks</th>
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<tbody>
<tr>
<td>1 Identify</td>
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<tr>
<td>1.1 Three identifiers used (Bed no, name, age, gender, HN)</td>
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<td>1.2 Other special information of patient (lives alone, social isolation, guardian, AIDL, mobility, continence, language barrier, NEP)</td>
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<td>2 Situation</td>
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<td>2.1 Date of admission</td>
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<td>2.2 Diagnosis of admission</td>
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<td>2.3 Situation of patient on admission - state the chief complaint, relevant treatment and test results</td>
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<td>2.4 Vital signs &amp; patient's stability on admission if relevant</td>
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<td>3 Background</td>
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<td>3.1 Relevant past medical, surgical &amp; mental history</td>
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<td>3.2 Current medications</td>
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<td>3.3 Allergies</td>
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<td>4 Assessment</td>
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<td>4.1 Key clinical assessment &amp; investigation</td>
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<td>4.2 Current health problem / working diagnosis</td>
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<td>4.3 Operation / procedure</td>
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<td>4.4 Current status / trends / management plan / treatment / intervention</td>
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<td>4.5 Risks &amp; management issues (fall, pressure ulcer, suicide, allergies, deteriorating patient)</td>
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<td>5 Recommendation</td>
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<td>5.1 What need to be done / review, by whom, when and of what</td>
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<td>5.2 Investigations / treatment underway or that need monitoring</td>
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<td>5.3 Plan of care</td>
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<td>5.4 Seriousness of the patient’s condition &amp; degree of vigilance required to ensure patient safety</td>
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<td>5.5 No recommendation</td>
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<td>6 ISBAR was used to structure communication. It was executed in a sequential fashion.</td>
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**Total Score**

**Compliance Percentage:**

**Date:**

**Auditor:**

**Name:**

**Ward / Unit:**

**Auditor's Signature:**
Result (1)

Compliance Rate of handover with ISBAR

Female ward: 95%
Male ward: 93%
Result (2)

Time reduction on nursing handover

- 2.42min/case to 1.86min/case (23% reduction) 1-week duration A to P shift
- 3.5min/case to 2.5min/case (29% reduction)
Result (3)
Staff feedback on ISBAR handover

Handover style acceptance

Handover time acceptance

Update and accurate information

Reduction in irrelevant information

Effective

Pre Post
Challenges

Challenge (1)
Open and noisy environment causes interruption

Solution
Allocating extra staff

Solution
Training of assistants

Solution
Different rostering system

Challenge (2)
Nurses unwilling to change

Solution
Providing feedback & mentoring opportunities

Solution
Praises to conforming staff

Solution
Cooperative environment

Solution
Emphasis improved care

Solution
Further training & education
Acknowledgements

- DOM Ms. Monica Ng
- Ward Manager Ms. Candy Chan
- Ward Manager Ms. M.L. Ng
- Ward A8 & B8 Nursing Staff
Thank you