Birmingham and Solihull Mental Health NHS Foundation Trust

WHAT Handover Policy

Policy number and category	**C41**	**Clinical**
Version number and date	**2**	**January 2024**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**May 2024**	
Next anticipated review	**May 2027**	
Executive director	**Executive Director Quality & Safety (Chief Nurse)**	
Policy lead	**Deputy Director of Quality and Safety**	
Policy author *(if different from above)*	**Head of Nursing and Allied Healthcare Professionals (Secure Care)**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

- Effective handover of information relating to patient care is crucial in the risk management of patients on a shift-by-shift basis on inpatient wards.
- The policy will provide a consistent process of conducting a shift handover for all employees including identified support and intervention.
- The policy responds to the Prevention of Future Death report issued by the coroner in 2016 relating to the effective handover of clinical information that is used to make clinical decisions on patient care.

Policy requirement

- Ensure that all inpatient wards have robust arrangements to ensure effective handover of patient clinical information.
- Ensure clinical handover is effective, timely, and factual.
- Ensure clinicians have the correct historical and immediate information about a patient to facilitate the assessment, planning, and management of clinical risk to maximise patient and staff safety across the organisation.
- Ensure all verbal clinical handovers are evidenced with written information.
- Ensure handovers across Trust inpatient wards follow a consistent format.
- Ensure that handover information is recorded and stored safely to protect confidential information in line with Information Governance requirements.
- The patient's RiO record remains the primary source for recording patient related information, not the WHAT handover document.

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Introduction

1.1. Rationale

1.1.1. Handover is described as '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 profession group on a temporary or permanent basis' (National Patient Safety Agency).

1.1.2. The fundamental intention of any handover is to achieve the efficient transfer of high-quality clinical information at times of transition of responsibility for patients' care. Shift work relies on effective continuity of information transfer which underpins all aspects of seamless continuity of care. The standardisation of handover contents and processes can improve patient safety by ensuring consistency in the exchange of information critical to safe and effective care. This can lead to increased service satisfaction for the patient as every member of staff working with a patient can begin where the last left off, aiding the recovery process. This also supports the delegation of tasks on a ward basis.

1.1.3. Handover of care is one of the most important procedures in healthcare, if carried out improperly it can be a major contributory factor to subsequent error and harm to patients. Lapses in information during handover can lead to mistakes being made, including delayed decisions relating to care, repeated investigations, incorrect diagnoses, and incorrect treatment. How the information is transmitted and recorded in the handover process has a major impact on the way it is retained and therefore acted on subsequently. The importance of handover processes and recording is escalating with the reliance on Bank and Agency staff, or staff working on wards that they are not familiar with to meet service need expectations. Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) recognises this and aims to ensure that the risks involved in the process of transferring clinical responsibility are minimised.

1.1.4. BSMHFT (referred to as 'Trust') staff deliver care in a variety of settings, shift patterns and clinical specialties and the complexity of the provision of care puts extra emphasis on the quality of information shared when one team or individual clinician hand over responsibility of care to the next. Therefore, having a standardised handover method supports the handing over of clinical information in an inpatient setting to staff that may not be familiar with the ward they are working on or when other professional groups visit the ward for example AHP/ACPC registered staff. The information contained within this document contains the minimum standard expected within the scope of the policy.

1.2. Scope

1.2.1. The aim of this policy is to provide direction and guidance for inpatient staff from all disciplines on the delivery of a safe and robust handover that preserves confidentiality and ensures that all important information is conveyed relevant to care of all patients to the staff group that are taking over their care.

1.2.2. This policy is primarily aimed at end of shift handovers to the incoming shift on inpatient units however may have some relevance to the handover of clinical information at other times.

1.3. Principles

1.3.1 The principal objectives of this policy are to:

- Ensure that all inpatient wards have robust arrangements to ensure effective handover of patient clinical information.
- Ensure clinical handover is effective, timely, and factual.
- Ensure clinicians have the correct historical and immediate information about a patient to facilitate the assessment, planning, and management of clinical risk to maximise patient and staff safety across the organisation.

- Ensure all verbal clinical handovers are evidenced with written information.
- Ensure handovers across Trust inpatient wards follow a consistent format.
- Ensure that handover information is recorded and stored safely so as to protect confidential information in line with Information Governance requirements.
- Reduce duplication of record keeping.

1.3.2 *'The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately to support this.'*

2 The Policy

2.3 All inpatient staff of the Trust have a responsibility to receive a thorough handover of clinical information when they come on shift and provide a thorough handover of clinical information to incoming staff when they finish their shift. This will support decision making relating to patient care and risk management based on immediate and historical information about a patient.

2.4 If a member of staff arrives late the responsibility is on the member of staff to ensure they actively seek out a handover and this includes reading the WHAT forms and a discussion with the professional in charge of the shift before commencing clinical work.

3 The Procedure

3.3 Clinical Handover Process

3.3.1 Handover must include clinically relevant information including the transfer of key issues and concerns, tasks to be completed, and changes to management plans.

3.3.2 To ensure that safe appropriate clinical handover of patient care occurs, and their care continues with minimal interruption and risks:

3.3.3 Handover should have clear leadership and identifiable roles

3.3.4 Shifts need to be coordinated during the handover, and a shift allocation evident for staff to observe.

3.3.5 Adequate time must be allowed in rotas for members of the team to meet, share information, and clarify responsibility for ongoing care and outstanding tasks.

3.4 Who is required to attend handover?

3.4.1 There should be an understanding of who is required to attend handover. Senior input is essential if handover is to be effective and all grades of staff should ideally be involved. Professionals may require their own meetings, but all should be engaged in the formal shift handover regardless of profession if they are working directly with the patients as part of the team on shift.

3.4.2 Multidisciplinary handover is to be encouraged when practical; however, the information requirements for medical, nursing, and other allied health professionals may be different and this should be respected; it may be appropriate to have different arrangements for different staff groups.

3.4.3 It is an expectation that the following will be part of the handover:

3.4.4 Person in charge of outgoing shift who is delivering the handover.

3.4.5 Person in charge of incoming shift

3.4.6 All members of incoming shift if possible

3.5 Handover leadership

3.5.1 There should be clear identification of who is leading the handover. This may be the most senior person of the incoming shift or the designated person-in-charge for the shift. Tasks should be appropriately delegated, in terms of allocating tasks to those with the skills to undertake them most effectively in the patient's best interests, and to ensure the best use of the available team member's time with consideration given to overall workload and other demands on the team. There should be clarity as to who is responsible for ensuring key tasks are completed and how this is co-ordinated. For nursing teams this may require reporting back to the person-in-charge during the shift.

3.5.2 Handover should include the relevant group of patients receiving direct care. The nurse in charge of the shift must have a process for receiving clinical information for all patients in their sphere of responsibility throughout the duration of the shift that will contribute to the formal clinical handover at the end of their shift to the incoming shift. They are also responsible for communicating during the shift with staff should there be any significant clinical changes.

3.6 Designated time for handover

3.6.1 Start time of the handover should be as soon as the incoming staff come into the work area, to ensure that all staff are fully briefed on care received and care required, to allow for continued safe and effective care delivery.

3.6.2 Time should be factored in to working patterns to allow sufficient time for effective handover between incoming and outgoing workers. Shift end times must be noted and recorded, and all reasonable attempts made to ensure staff are able to leave on time having fulfilled their obligation at handover. Steps should be taken to protect handover time as far as possible and while immediate engagement with clinical matters may on occasion be necessary it is important to maintain the essential nature of effective handover. Unnecessary interruptions should be avoided where possible.

3.6.3 Staff should not feel pressured to rush handover, either by staff at the end of their shift or the incoming staff.

3.7 Handover structure

3.7.1 There should be an effective structure for what and how the information at handover is communicated, recorded, and retained. When conducting the handover all clinicians are expected to pass over information that is from the patients' care record to promote communication of factual, timely, and comprehensive information relevant to a patient's care.

3.7.2 No jargon or acronyms should be used in the handover process. All information must be transferred both verbally and in written format.

3.7.3 It is important that each area has a mechanism of recording that handover has occurred and that the agreed items are being handed over effectively between incoming and outgoing shifts.

3.7.4 Due to the patient specific information contained on handover records it is vital that confidentiality is maintained and therefore the records must be stored securely.

3.7.5 Where possible handover should take place in an appropriate private place where the details cannot be overheard by any unauthorised person in order to maintain patient confidentiality, as well as dignity and respect.

3.8 WHAT Handover tool

3.8.1 The Trust has adopted the WHAT handover tool. The WHAT handover tool is largely based on the SBAR tool that staff in the Trust are familiar with when handing information over emergency services following a medical emergency. The SBAR tool has a sound grounding in literature for quality improvements in communication between ward staff (Whittingham and Oldroyd 2014), rapid clinical decision making (Vardaman *et al* 2012), and management of risk on mental health wards (Renz *et al* 2013).

3.8.2 WHAT can be used effectively to escalate a clinical problem that requires immediate attention, or to facilitate efficient handover of information relevant to patient care between clinicians or other teams. WHAT aims to reduce the barrier to effective communication across different disciplines and levels of staff and creates a shared model around all patient handovers and situations requiring escalation, or critical exchange of information (handovers).

3.8.3 The acronym WHAT is memory prompt; easy to remember and encourages prior preparation for communication and reduces the incidence of miscommunications.

3.8.4 W = What happened

Identifying a patient's presentation on the shift (behaviour/mood, mental state, social inclusion, any 1:1 with staff, group attendance/ participation, engagement with others, personal care, leave taken/granted)

3.8.5 H = Historical information, and the Current risk/incidents in the last 7 days

Explain any significant risk prior to admission and current presenting risk; this is accessible through the Level 2 Risk Assessment link on the form.
Provide any significant information from past few days including leave, risks, and incidents. This allows staff to hand over both short term and longitudinal risk which should inform risk management on the ward.

3.8.6 A = Assessment

What assessments have taken place? Medication compliance/PRN, NEWS/physical observations, nutrition (food and fluid intake), clinical impression (any improvement in patient's presentation), therapeutic observations.

Based on any assessments, what happened on shift, and risk information – what is the clinical assessment of the patient.

3.8.7 T = Tasks to do

Explain what you need, is there anything outstanding? (admission, care plans, update risk assessment, bloods, ECG, order TTO's, etc), make suggestions and recommendations, what needs to happen next? Recommend review? (observations, medication, capacity, etc)

In addition there are 2 other requirements:

3.8.8 Positive statements

When giving handover staff should say something positive about what each patient has been doing during the shift, or draw attention to some positive quality they have, or if this is not possible something positive about the way in which staff supported the patient (positive appreciation). This should be individualised per patient, unless related to a group activity.

3.8.9 Other information

This is a box that allows for service/ward specific information.

3.9 Completing the WHAT handover document

3.9.1 All inpatient wards will complete a WHAT handover 3 times a day at the end of each shift (unless all staff are on a long day in which case a long day summary can be completed). It needs to be prepared before the handover and locked during the handover once the patient has been discussed.

3.9.2 Within the Prison Healthcare service the WHAT is incorporated into System1 however the guiding principles of appropriate handovers as outlined in this policy remain applicable in the prison healthcare setting.

3.9.3 Progress Notes

The WHAT handover tool means that we no longer need to write a shift summary in the progress notes as this would duplicate work, the WHAT form is now the shift summary.

To assist clinicians with having a chronological overview of patient activity the 'Admission consolidated notes' section of RiO can be used (see Appendix 1).

3.9.4 IMPORTANT: Entries should still be made by nursing staff on progress notes to give a full description of an intervention, assessment, or incident – The WHAT is a summary of this event as part of the shift and does not replace the need to fully document such information in the progress notes.

3.9.5 See Appendix 2 for examples of how respective progress note entries and WHAT handover forms may complement each other.

3.10 Sufficient and relevant information to include in handover.

3.10.1 Sufficient and relevant information should be exchanged to ensure patient safety and effective clinical care. This policy cannot be prescriptive about the specific issues to be handed over in each area, so each ward is encouraged to agree its own key issues for handover.

3.10.2 This is not an exhaustive list, but is intended as a guide:

- Patient presentation - mental and physical wellbeing
- Observations levels (or frequency of contact in the case of community teams) - Section 17 Leave escorted/ unescorted (or how many visits are offered per week in the case of community teams)
- Mental Health Act status - Informal/ detained under Mental Health Act
- Mental Capacity issues or DOLS – Capacity is assumed unless there is reasonable doubt of patient's presentation in which case this should be assessed and recorded.
- Risk, both nature and level (for example risk of falls, absconsion, harm to self, suicide, neglect, risk of harm to others), both immediate and historical.
- Medication - changes to medication/ omissions/ allergies
- Physical health investigations i.e. CT Scan, X-ray
- Blood investigations i.e., Clozapine/ lithium levels, blood sugars, drug screen
- Physical health assessment - BP (blood pressure), TPR (temperature, pulse and respiration), resuscitation status, blood sugar monitoring, nutrition and hydration, and the required frequency of this.
- End of Life Care
- Safeguarding alerts/ issues (children/ adults)
- Changes/ updates to care plans.
- New admissions/ discharge/ referrals
- MDT feedback

- Equality and diversity considerations (including effective communication needs, cultural sensitivities)
- Outstanding tasks
- Incidents
- Operational issues affecting the care of the client.
- Therapeutic Activities i.e. social events/ visitors/ward based.

3.10.3 Handover is of little value unless action is taken where needed. All team members including bank and agency staff should be aware of their responsibilities and need to ensure that:

- Tasks are prioritised to enable completion in a timely, effective, and safe manner.
- Plans for further care are put in place and clarified with all relevant parties.
- Patients are reviewed as often as required.
- Additional handovers are considered to further support the team, re-prioritise workload and identify new “at risk” patients and subsequent management plans.

4 Risk Management Accountabilities and Responsibilities

Post(s)	Responsibilities	Ref
All Staff	Responsible for adhering to the procedures as laid out in this policy, including ensuring that all information is recorded fully, accurately and on time in line with data quality policy requirements and trust data entry timeliness standards, and for reporting any failures to comply.	
Service, Clinical and Corporate Directors	Will ensure all staff in their areas are aware of and understand the policy and that it is implemented into practice within their areas of responsibility. Will investigate any failures to comply and ensure remedial actions are taken.	
Policy Lead	Ensure the policy is kept up to date - Coordination of monitoring and assurance.	
Executive Director	The Director of Nursing has overall responsibility for ensuring compliance with and timely review of this policy.	

5 Development and Consultation process:

Consultation summary	
Date policy issued for consultation	January 2024
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	**Date(s)**

Where received	Summary of feedback	Actions / Response

6 Reference documents

6.3 Renz, S.M., Boltz, M.P., Wagner, L.M., Capezuti, E.A. and Lawrence, T.E. (2013) Examining the feasibility and utility of an SBAR protocol in long-term care, Geriatric Nursing, 34 (4), pp. 295-301.

6.4 Vardaman, J.M., Cornell, P. Gondo, M.B., Amis, J.M., Townsend-Gervis, M. and Thetford, C. (2012) Beyond communication: the role of standardized protocols in a changing health care environment, Health Care Management Review, 37, pp. 88-97.

6.5 Whittingham, K.A. and Oldroyd, L.E. (2014) Using an SBAR - keeping it real! Demonstrating how improving safe care delivery has been incorporated into a top-up degree programme, Nurse Education Today, 34 (6), pp. 47-52.

7 Bibliography

None

8 Glossary:

8.3 **Handover** - A semi-structured exchange of information and awareness of the clinically relevant issues including the transfer of key issues, tasks, and changes in management plan from one care professional/ care team to another. The handover process can take place in different ways and at different times during the day, not just in scheduled meetings. For the purpose of the policy 'Handover' refers to the end of shift handover of information to the incoming shift.

8.4 **Shift** - Recurring periods in which different groups of workers do the same jobs in relay.

8.5 **Clinician** - A health professional with responsibility for patient care.

8.6 **Key Tasks** - Important actions which must be undertaken within the period of responsibility for care

8.7 **WHAT -** A structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety.

9 Audit and assurance

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Compliance	Head of Clinical Governance and Complaints	Incorporated into the ICR audit	Daily	Local CGCs

Quality	Deputy director of nursing	Clinical audit carried out by matrons	Annually	Trust CGC

10. Appendices :

- **Appendix 1 – Equality Impact Assessment**
- **Appendix 2 – How to access Consolidated Notes**

Appendix 1

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Policy	**WHAT Handover**		
Person Completing this policy	Zoe Cockbill	**Role or title**	Head of Nursing & AHPs
Division	SCCS	**Service Area**	SCCS
Date Started	24/01/24	**Date completed**	24/01/24
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
Describe scope, roles and responsibilities in relation to shift Handover.			
Who will benefit from the policy?			
Service Users & Staff			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
NA			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
Yes – ensures streamlined service delivery			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			
No			

Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
No				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this policy promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age				NA
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability				NA
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender				NA
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				
Marriage or Civil Partnerships				NA
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters				

Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity				NA
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity				NA
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief				NA
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation				NA
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment				NA
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights				NA
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				

If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				x

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.
If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

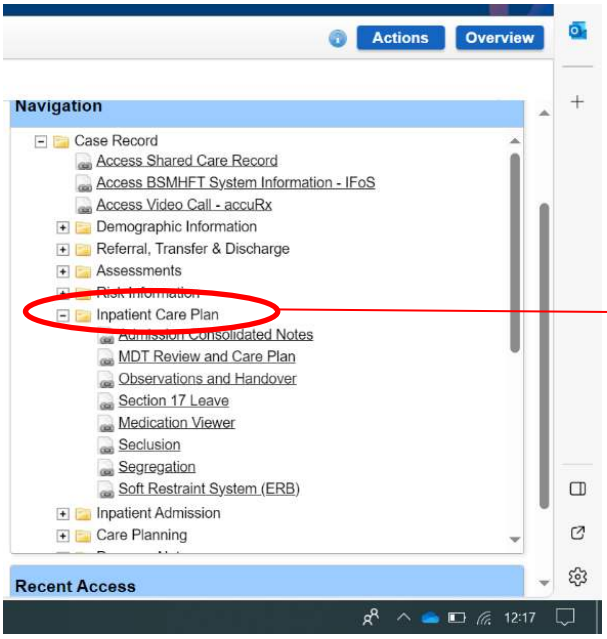
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
There is no negative impact identified in the analysis.
How will any impact or planned actions be monitored and reviewed?
Not applicable
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Not applicable
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2

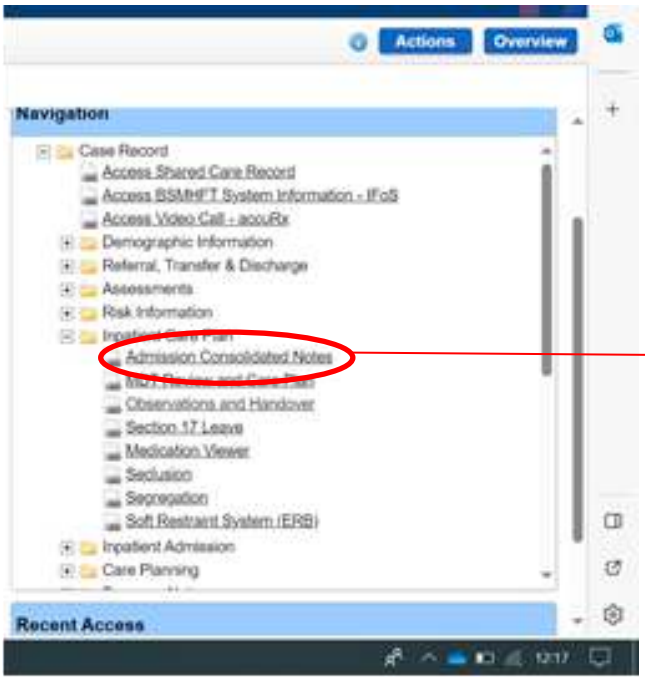
How to review consolidation of progress notes, WHAT Handover and MDT Part B

This new feature will pull through a chronological view of entries on RiO from the WHAT handover, progress notes, Seclusion MDT forms, Section 17 leave. . This is useful for being able to see a narrative overview of a patient, particularly when writing reports or returning from leave.

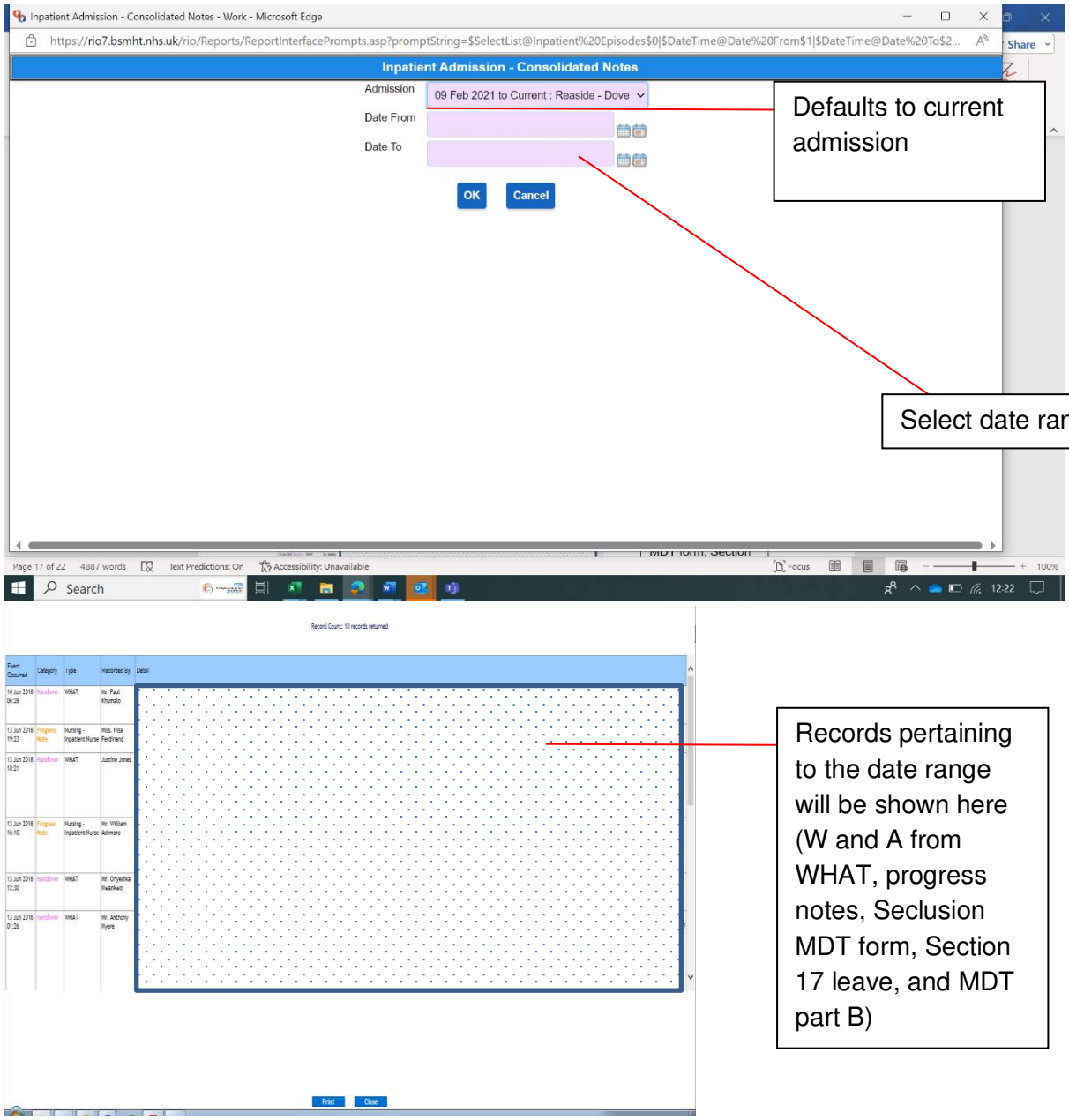
How to access consolidated notes:



From case summary select Inpatient Care Plan



Select Admission – Consolidated notes



By pressing the Ctrl and F key together you can search for key words – please note this will not filter your search, just highlight notes where the keyword is present.

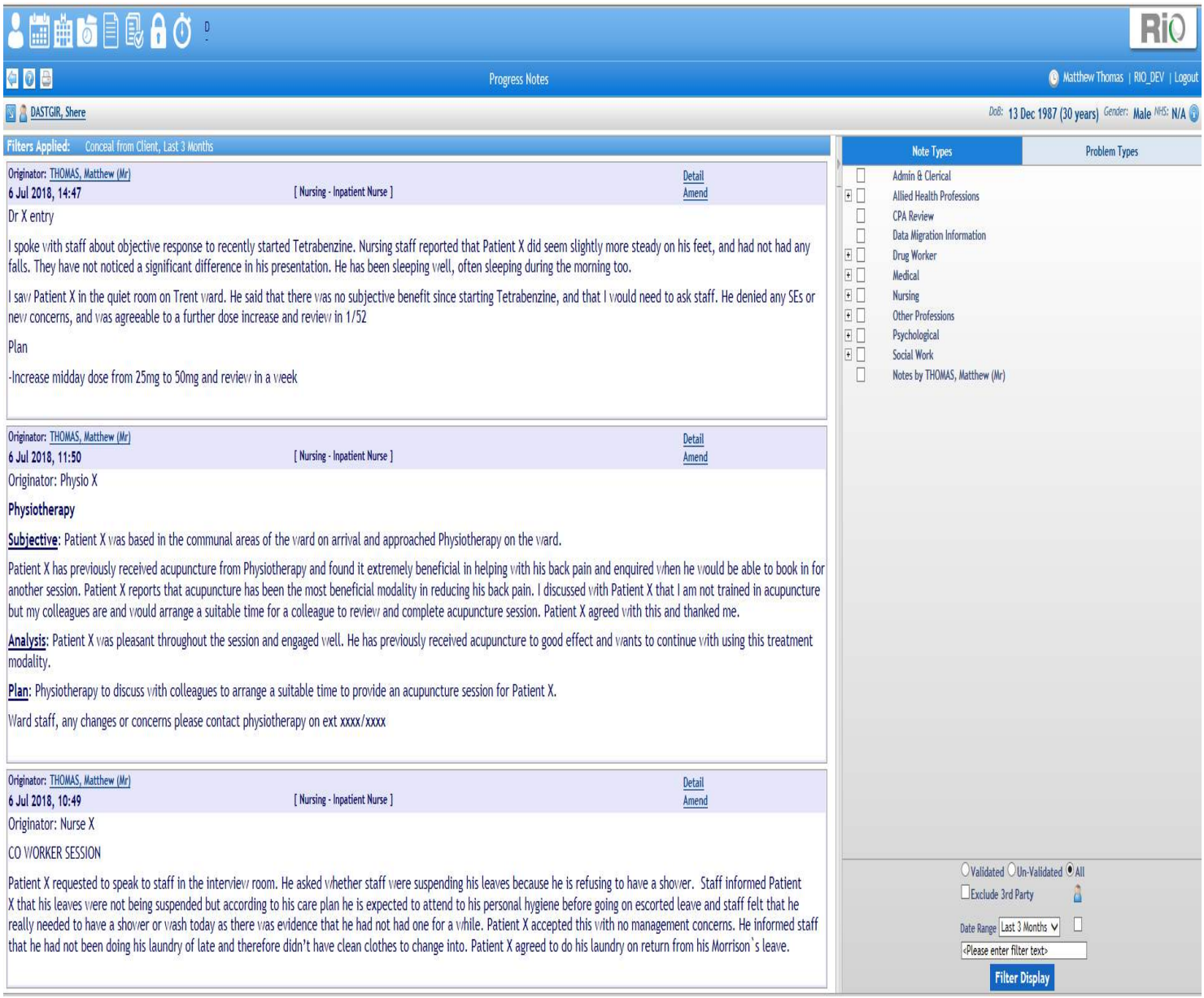
The longer the date range you search for the longer it will take to pull through the report.

The sections that are pulled through in this report are currently limited to WA parts of WHAT, progress notes, Seclusion MDT form, Section 17 leave form, and MDT part B.

Appendix 3 – the link between progress notes and WHAT.

Here is an example of how what is written in progress notes might be reflected in the WHAT handover so important information is captured in both parts of RiO but not duplicated.

A full entry (incident, assessment, 1-1 interaction) is made in the progress notes (above) and the important points are summarised in the WHAT handover (below).



DASTGIR, Shere DoB: 13 Dec 1987 (30 years) Gender: Male NHS: N/A

WHAT - Handover

Service user	DASTGIR, Shere Shere Shere Shere Shere - 1388589
Date/time	6 July 2018 14:58

Current admission

Admitted to	Reaside - Avon
Named nurse	
Consultant	
Diagnosis - Primary	F200 : Paranoid schizophrenia
MHA Section - Current	Pt III. Section 37 - Hospital order
Section 17 Leave - Granted	(no data)
Therapeutic Observation Level	(no data)

Progress Notes Viewer

Shift details

Select the shift: AM shift

W - What happened on shift

Patient's presentation on the shift including behaviour & mood, mental state, social inclusion, any 1:1 with staff, group attendance & participation, psychology, leave taken/granted, medication compliance, any safe wards initiatives used, reference to incidents with narrative to be found in progress notes.
When starting a new handover form it is recommended that you delete the previous contents and start afresh.

What

Patient X has had a busy morning since breakfast. He has been seen by the team Dr who increased his midday Tetrabenzine from 25mg to 50 mg. In his co-worker session concerns with his laundry were discussed. Later in the morning he was seen by the Physio who will look to set up acupuncture for him. Full detailed entries in progress notes.

H - Historical Information

Provide significant information from the last 7 days, describing any current risks. For example self-harm, attempted suicide, self-neglect, verbal aggression, physical aggression, threatening behaviours, boundary violation, absconding, restraints, seclusions.

Risks & incidents that have taken place over the last 7 days

Concerns over the last 7 days about his personal hygiene. Patient X has poor body odour and is vulnerable to being verbally abused by his peers on the ward.

Please refer to the Risk Assessment for comprehensive historical risk information.

Risk Assessment Last Updated	Assessment out of date	click here to access the Level 1 Risk Assessment	click here to access the Level 2 Risk Assessment

A - Assessment

Based upon on what happened on the shift and the associated risk what is the nurses' clinical impression. For example medication compliance, PRN, NEWS, physical observations, food and fluid intake, bad news mitigation. When starting a new handover form it is recommended that you delete the previous contents and start afresh.

Assessment

No concerns about mental state on the ward at present. Discussed reasons for not showering or doing laundry, it appears to be more that he doesn't feel like he needs to shower everyday and it is a hassle for him to do so, rather than any negative symptoms. Took the discussion about being presentable on his leave when he goes out well. Had breakfast and compliant with medication.

T - Tasks to be completed

Anything outstanding or any recommendations. For example hospital appointments, bloods, other AHP or medical reviews.

Tasks

- Remind Patient X to do his laundry on return from leave later this PM.

Inpatient Care Plan Last Updated	13/01/2016 11:48:33	click here to access the Inpatient Care Plan

Additional information

When giving handover staff should say something positive about what each patient has been doing during the shift, or draw attention to some positive quality they have, or if this is not possible something positive about the way in which staff supported the patient (positive appreciation).

Positive Statement

Patient X took the discussion about having a shower and doing his laundry well without becoming defensive or annoyed.

Other Information

Activity recording (in minutes)

1: Key worker sessions	25 ☐
2: Mutual help meeting	10 ☐
3: Ward based activity	10 ☐
4: Visit	☐ 10
5: Activity of daily living (ADLs)	5 ☐

Handover

Current user:	Matthew Thomas
Validation rights	True
Date and time of handover	6 July 2018 15:15
Updated by	Matthew Thomas
Updated on	6 July 2018 15:15