



Handover Guide

This handover document is to ensure the effective provision of continuity of care to patients.

Handover Prompts

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Whilst the main function of handover is to provide continuity of care to patients, effective handover is about conveying important information to colleagues and maintaining the safety of patients in our care, clinicians must work in a way that minimises risk by ensuring your handover is effective.

Situation

Describe your concerns, be specific. List patient's name, location and bed number.

Differential Diagnosis: Signs and symptoms of patients on admission to your unit.

Date of admission

Background

Reasons for patient's admission, medical history, current medication, diagnostic results, procedures.

PMH (Past Medical History): Including a collection of information about previous medical conditions, surgeries, treatments, medications, allergies, and Immunisation. Be aware of triggers that could lead to adverse reactions in relation to mental illness.





DNAR (Do Not Attempt Resuscitation):
Establish the resuscitation status of all patients. Do not attempt resuscitation in the event of cardiac arrest.

Allergies: Medication, Food Allergies, Rhinitis (Hay Fever), Latex Allergy, Urticaria, Insect Bites or Stings.

Treatment/Interventions.

Fall Assessment and Prevention.

Assessment (as applicable)

- Vital Sign Assessment
- Skin Integrity Assessment
- Wound Dressings
- Assessment of Cannula Site
- Psychological-Capacity Assessment (patients with history of mental illness)
- Last Vital Signs: Blood Pressure, Heart Rate, Oxygen Saturation, Blood Glucose Level, Respiration Rate, Temperature, Pain Score.

Recommendations

- What is your recommendation
- Immediate Doctor review
- Escalate any deterioration to Doctor and Nurse in charge
- Administer oxygen
- Call outreach team
- Recheck vital signs
- Cannulate patients
- Pertinent test results
- Xray results.

