Nurses International
Oncology Clinical Skills

Name of the Procedure/Rubric/*Rationale*: End of Shift Report/Handover

Step	Procedure	Yes	No	Remarks
1.	**Update electronic handover sheet with client information on:** ❏ Code status ❏ Date of admission ❏ Age and Gender ❏ Admitting Diagnosis ❏ Medical history including allergies ❏ Diet ❏ Activity ❏ Isolation status ❏ Social history ❏ Changes in condition ❏ Laboratory Results ❏ Pending tests and results ❏ Discharge Planning ❏ Sensitive information such as HIV status			
2.	**Inform the client about the handover.** *Allow client to prepare for the handover including what contribution they may want to make.*			
3.	**With client's permission, family members are allowed to stay at the client's bedside during handover.** **Other visitors should be asked to leave the room during handover.**			
4.	**Collect client's file, charts, etc necessary to refer during handover.**			
5.	**Go to the client's bedside for handover with the incoming nurse for the shift.** *Bedside handover allows clients to participate with nurses in their care. It gives them confidence in your knowledge and ability to care for them. clients are an important source of*			

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	information. **However, if the client is uncomfortable with a bedside handover, then you can conduct handover at the nurses station for that client.**			
6.	**Greet the client, family members and introduce the oncoming nurse to the client and family.**			
7.	Provide accurate and detailed information to the oncoming nurse on: **1. Date and reason for admission** **2. Relevant medical history including new referrals** **3. Reconfirm allergies with client and family** **4. Laboratory tests ordered/sent/reports received** **5. Treatments and client response** **6. Last time pain medication given (Assess client for pain during handover)** **7. Nursing care plan and client response** **8. Assess for lines, drains, dressings, wounds** **9. Safety concerns** **10. Discharge planning** **11. Recommendations for future care** Use following acronyms to prompt information sharing during bedside handover: **SBAR** S: Situation – chief complaint, current status B: Background – previous history A: Assessment –result of assessment, vital signs and symptoms R: Recommendation – suggested and anticipated changes, critical monitoring **ISOBAR** I: Identify the client and staff S: Situation and status O: Observations, MET calls etc.			

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	B: Background A: Accountability R: Risk management			
8.	**a. Provide accurate information on Chemotherapy (past, present , future):** ❏ Name of the drug ❏ What the drug was used to treat and why ❏ When it was administered ❏ How it was administered - Dose, rate, route ❏ Any reactions that occurred ❏ Reactions, side-effects or toxicities to watch for **b. Provide information on Radiotherapy:** ❏ Type of radiotherapy used ❏ Why it was used ❏ When it was provided ❏ How it was provided Duration, area, Dose (high dose/low dose) ❏ Reactions to watch for ❏ Future considerations **c. If chemotherapy is being actively infused during handover, both nurses must:** ❏ Check the rate ❏ Ensure lines are correctly connected ❏ Chemotherapy is correctly administered			
9.	**Maintain client confidentiality.** ● Sensitive information can be shared away from the bedside ● Staff should lower their voices when sharing sensitive information ● Sensitive information may be recorded on the handover sheet *Sensitive information may include:* *• Blood tests of a diagnostic nature (eg. HIV positive);* *• Communicable disease information (eg. Hepatitis);* *• Psychiatric issues (eg. suicidal, ethanol abuse)*			

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	•*Code status ("Not for resuscitation" orders, End of life considerations)* • *Some family issues (eg. conflicts, domestic violence);* • *Anything else clients identify they wish to be held in confidence.*			
10.	**Provide client with opportunities to seek clarification, ask questions, and confirm information.** Family members should be invited to participate in the handover with the client's consent.			
11.	**Oncoming nurses must undertake safety scan:** a. client physical scan b. The client's call bell is in reach c. Suction, oxygen or other equipment are in working order and easily accessible d. Dressings, drains, intravenous fluids and infusion pumps are secure and correct e. The general tidiness of the area is conducive to safe mobility and ease of access f. Any other checks that may be specific for that client (eg. use of bed rails, height of the bed etc)			
12.	**Before leaving the client bedside oncoming nurse should:** ❏ **Ask questions if further clarification is needed** ❏ **Inform the client when the nurse will return to see the client.**			
13.	**Same process is repeated by the oncoming nurse during the handover session with the next shift nurse.**			

Reference:
Chaboyer, W., McMurray, A., Wallis, M. & Chang, H.Y. (2008.) Standard Operating Protocol for Implementing Bedside Handover in Nursing, Griffith University, Australia. Accessed from: https://www.safetyandquality.gov.au/sites/default/files/2019-06/bedside-handover_sop.pdf