Electronic Patient Handover (EPH) Policy
Version 2.0

Policy Statement:

Key Points:

The purpose of this policy is to provide a clear standard to provide instruction for staff with regard to the Trust's approach to the use of Electronic Patient Handover (EPH)

- To standardise patient handover information across the Trust
- To improve communication within the multidisciplinary team responsible for the patients clinical care
- To provide accurate and current Infection Control information in a timely manner to support clinical interventions
- The EPH system will provide 'visual alerts' to remind staff to complete further clinical intervention/s within agreed policy timescales. This will include, Peripheral Venous Cannula (PVC) removal, Visual Infusion Phlebitis Score (VIP) and MRSA screening.
- **EPH is now fully archived in the iCare Vortal under Services. This can be printed when required e.g: Healthcare Governance investigations, transfers to other Trusts.**
- Increase the presence of visibility of the nursing staff and directly involve the patient in their care and decision making whilst maintaining patient confidentiality.

Paper Copies of This Document

- If you are reading a printed copy of this document you should check the Trust's Policy website (**http://sharepoint/policies**) to ensure that you are using the most current version.

Ratified Date: 8th September 2008
Ratified By: Professional Governance Nursing Forum
Review Date: 31st July 2010
Accountable Directorate: Corporate Nursing
Corresponding Authors: Debbie Tidmarsh, Lynn Fisher, Julia Jackson, Janet Hunt

Meta Data

Document Title:	Electronic Patient Handover (EPH) Policy v2.0
Status	**Active:** the approved and current version
Document Author:	Debbie Tidmarsh – Lead Project Nurse debbie.tidmarsh@heartofengland.nhs.uk Lynn Fisher – Matron lynn.fisher@heartofengland.nhs.uk Julia Jackson – Matron julia.jackson@heartofengland.nhs.uk Janet Hunt – Corporate Nurse janet.hunt@heartofengland.nhs.uk
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Related documents	• Access to Health Records Policy • Clinical Governance & Controls Assurance Strategy • Records Management Policy • Security and Confidentiality of Patient Information • Data Quality Strategy • Display Screen Equipment Policy • Management, Security and Disclosure of Confidential Information Policy • Record Keeping in Health Care Policy • ICT Policies and Procedures • Patient Administration Policies and Procedures • ICT Assigned Information Security Responsibilities Policy • Policy on the Use of the Intranet • Policy for the Use of Portable Devices • Risk Management Policies and Procedures • Information Governance Policy • NHS Confidential Code of Practice • ICT Overarching Policy
Superseded documents	Electronic Patient Handover Policy v1.0
Relevant External Standards/ Legislation	• Nursing and Midwifery Council • Health Care Professions Council • General Medical Council • Guidelines for Records and Record Keeping, Nursing & Midwifery Council [2009] • Freedom of Information Policy • Data Protection Act
Key Words	electronic patient handover eph

Revision History

Version	Status	Date	Consultee	Comments	Action from Comment
1.0	approved	02/09/08	EPH Committee	Consultation Period complete	Actions from comments completed
	ratified	02/10/08	Nursing, Midwifery and AHP Committee	Ratified	Risk section revisited and completed
1.1	reviewed	07/07/09	Professional Governance Forum	Consultation period in progress Consult with IT Governance Manager	Revisit policy
2.0	approval	03/0909	Matrons Business Meeting	Approved via Chair	
2.0	For ratification	08/09/09	Professional Governance Forum		

Table of Contents

1. Circulation

This Policy applies to all Trust staff working in in-patient areas within the Heart of England Foundation Trust (HEFT) whether in a permanent or temporary role that access Electronic Patient Handover (EPH).

2. Scope

This Policy applies to all Trust staff who access and input data on EPH and applies to all in-patient groups of patients.

3. Definitions

EPH is a computer held record of patient handover information to be accessible within the multidisciplinary team in order to share information and improve the access to high quality clinical information.

4. Reason for development

The purpose of EPH and the development of this policy is to provide clear guidance and instruction to all staff with regards to the Trust's approach to the utilisation and management of EPH.

Benefits include:

- Improving communication with patients and between members of multidisciplinary team
- Reducing patient handover time to increase the presence and visibility of nursing staff in patient areas
- Standardising documentation and practice with the aim of reducing future duplication of patient records
- Improving consistency and continuity of care whilst maintaining patient confidentiality
- Improving patient care by ensuring that all members of the multidisciplinary team have access to the same information
- The information contained in EPH can be used to identify trends, for example monitoring Date of Discharge, Length of Stay or identifying the numbers of patients waiting for intermediate care

5. Key Outcomes

- To standardise patient handover information across the Trust
- To improve communication within the multidisciplinary team responsible for the patients clinical care
- To provide accurate and current Infection Control information in a timely manner to support clinical interventions

- To record and monitor the patients Modified Early Warning Score / Paediatric Early Warning Score (MEWS / PEWS) which can be accessed by the ward team and the Critical Care Outreach Team (CCOT). **Until this system is 'live' please note MEWS and PEWS are purely for recording purposes on EPH and the paper documentation remains the trigger for alerting the CCOT and Medical Teams**

- The EPH system will provide 'visual alerts' to remind staff to complete further clinical intervention/s within agreed policy timescales. This will include, Peripheral Venous Cannula (PVC) removal, Visual Infusion Phlebitis Score (VIP) and MRSA screening

- Increase the presence and visibility of the nursing staff and directly involve the patient in their care and decision making whilst maintaining patient confidentiality

- Enhance the current bed management systems

6 Electronic Patient Handover Policy Standard

6.1 Data Protection

The Trust has a legal duty to keep all written and electronic identifiable patient information confidential and secure. It is strictly forbidden for anyone to access information relating to their own family, friends, acquaintances, staff members, or because they recognise a name.

All staff using EPH must ensure that patient information is managed in a confidential and secure manner and must adhere to Health Care Governance, Data Protection / Caldicott policies and Trust ICT Policies and Procedures. Failure to do so may result in disciplinary action being taken, in line with Trust Policy.

- These obligations arise out of the common law duty of confidentiality, professional body regulations and staff employment contracts

- Staff should refer to the ICT Assigned Information Security Responsibilities Policy for further guidance. Any instances of actual or potential breeches of confidentiality and security must be reported using the Trust's Risk Management Reporting Policies and Procedures

- Breaches regarding confidentiality of information within EPH will result in disciplinary action being taken in line with the Trusts ICT Overarching Policy (points 8, 9 & 10)

- For data protection purposes, the EPH System is audited monthly to assess correct usage

- All clinicians using EPH will take personal responsibility whenever they access the system. Do not let anyone else use your user ID or password

- If the access is found to be inappropriate, this should be reported using the Trust's Risk Management Reporting Policies and Procedures system (IR1) and may result in disciplinary action being taken

IF YOU HAVE ANY CONCERNS REGARDING THE INAPPROPRIATE USE OF ELECTRONIC HANDOVER PLEASE CONTACT THE IT DEPARTMENT AND HEALTH CARE GOVERNANCE

6.2 Record Keeping / Documentation

All clinical staff have a responsibility to maintain accurate clinical records. Professional staff should follow their individual professional body's guidelines ie, Nursing and Midwifery Council, Health Care Professions Council and the General Medical Council.

"Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow". *Guidelines for records and record keeping, Nursing & Midwifery Council (July 2007)*

Electronic Patient Handover provides access to all information submitted to the application including previous admissions which can be viewed by clicking the 'Patient Search' link from your Handover Homepage: enter a name or PID and confirm the patient you want to view. It can also be accessed via the Trust's iCare Vortal where you will be required to enter your EPH username and password. A history of inpatient admission will be displayed, if Handover information is available you will see the 'view' link in the EPH column clink on the link and the information will be displayed and can be printed out.

Information should be factual, consistent, and accurate. Text speak, meaningless phrases and jargon should not be used.

All wards to develop agreed list of abbreviations which can be referred to

Information within EPH forms part of the patients clinical notes

6.3 Infection Control

6.3.1 Cleaning

The computer keyboards, CoWs (Computers on Wheels), Panasonic Toughbooks and CfH1's (Connecting for Health 1) need to be cleaned weekly at a minimum with a detergent wipe as advised by Infection Control

Plastic covers should be used on keyboards unless they are the specialist keyboards supplied by Infection Control. These specialist keyboards and the CfH1's will indicate when they require cleaning

6.3.2 Movement

During ward closures due to outbreaks of infection, portable computer devices are not to be moved to other wards. This is necessary to prevent the spread of infection

Portable devices used in bays or rooms that are closed due to infection must be cleaned when they are removed from the infected area in accordance with Trust Policy

6.4 Downtime

6.4.1 Planned Downtime

All planned downtime will be communicated to users, prior to the date, via a message on the login screen

Wards should ensure that they update the EPH prior to the planned system downtime and print out any required copies

If any copies are required during the planned downtime BHH and SH should follow the steps in unplanned downtime below

6.4.2 Unplanned Downtime

The EPH will be backed up and stored every thirty minutes and printouts will be available for BHH, GHH & SH from Reception and Enquiries at BHH

In the event of unplanned downtime the following will apply at:

- **Birmingham Heartlands Hospital**
  - Printouts of the last stored data will be available from Reception and Enquiries if they are needed
  - A member of staff should to go Reception and Enquiries to collect and sign for the printout
- **Solihull & Good Hope Hospitals**
  - Printouts of the last stored data will be available from BHH Reception and Enquiries if they are needed
  - Wards should ring BHH Reception and Enquiries and ask for a copy of the printout to be faxed via a safe haven fax machine
  - The name of the person requesting the copy and the fax number will be recorded by staff in the BHH Reception and Enquiries.

6.5 Shredding

All handovers must be shredded at the end of the shift and not taken out of the clinical environment

6.6 Passwords

Passwords for appropriate access for all disciplines to EPH can be obtained by completing a Heartsol application form on the intranet which can be found under the letter H. For nurses, this will need to be done with the senior sister/charge nurse or professional development nurse for that area to ensure appropriate access is given to new users. Medical Staff and Allied Healthcare Professionals also are required to complete a heartsol application form on induction. Student Nurses obtain passwords via their Placement Lead i.e.: Undergraduate Clinical Dean/Practice Placement Manager

Passwords need to be changed every 45 days and cannot be changed on wireless networks, only on a desk top computer

6.7 Admit Discharge & Transfer (ADT)

All staff who are regularly required to Admit, Discharge and Transfer patients on the HISS system will need ADT training which is to be organised through the IT training department

Out of Hours Discharge and Transfer facilities are now available via EPH. This sends an e-mail directly to the Out of Hours HISS personnel to ensure up to date information to assist the ward census bed management information

EPH is fully archived in the iCare Vortal under Services. This can be printed when required e.g: Healthcare Governance investigations, transfers to other Trusts.

6.8 Updating HISS

The HISS system should be updated by appropriately trained staff within an hour of the patient being admitted, transferred or discharged as outlined in the Patient Administration Policies and Procedures.

6.9 Clinical Bank Staff

Clinical bank staff will be given a password and training on local induction at the Clinical Bank Office.

Clinical bank staff must adhere to the same rules and regulations within this policy.

Clinical bank staff starting work later than the normal shift time should seek EPH handover from the Nurse in Charge.

6.10 'Walk Round' Standard

EPH 'walk round' should where possible take place at the patient's bedside by the registered nurse, with the involvement of the patient.

EPH 'walk round' should where possible take place between each shift to enable increased visibility of staff and prioritisation of patient care.

EPH will facilitate the early visual assessment of patients to identify deterioration of condition, urgent reviews, unstable and at risk patients enabling appropriate clinical decisions to be made.

EPH is to be used in conjunction with other clinical documentation including observations, fluid balance charts, prescription sheets and risk assessments.

The EPH which is printed off to aid the sharing of patient information will not be accessible to those Health Care Professionals or others who are not directly involved in the patients care or treatment.

7. Responsibilities

7.1 Individual Responsibilities

7.1.1 Chief Executive

The Chief Executive retains overall responsibility for the development of the Trust's policies however may delegate operational responsibility for the development and implementation of policies created by nursing staff to the Chief Nurse.

7.1.2 Executive Directors

Executive Directors are responsible for ensuring that, where the principles described in this policy affect their areas of accountability, the guidance and standards are complied with and integrated into practice.

7.1.3 Medical Directors

Medical Directors are responsible for ensuring that, where the principles in this policy affect their areas of accountability, the guidance and standards described are complied with and integrated into practice and delegated where necessary.

7.1.4 Chief Nurse

The Chief Nurse is responsible for the development of the Policy for EPH and its implementation. The Chief Nurse will delegate this operational responsibility to all Matrons.

7.1.5 Matrons

Matrons are responsible for ensuring and monitoring compliance with the EPH policy within nursing disciplines and can obtain this information from the audit data supplied to Ward Managers and IR1s.

Where deviation from the principles and guidance provided in this policy are detected, Matrons will report concerns regarding non-compliance through Heads of Nursing and work with senior managers who hold operational accountability for clinical areas to address aspects of non-compliance and implemented corrective action plans.

They will support Ward Managers and Heads of Department to ensure that staff are adequately supervised and that their competence is maintained following training.

7.1.6 Ward Managers

Ward Managers are operationally responsible for ensuring that staff under their supervision who complete EPH are compliant with this policy

Ward Managers are operationally responsible for local dissemination and implementation of the policy

Monthly audits regarding EPH use and compliance will be sent to Ward Managers

Ward Managers will be operationally responsible for ensuring that staff are appropriately trained and maintain a local training record

7.1.7 Heads of Departments

Heads of Departments are responsible for monitoring that staff under their supervision complete EPH and are compliant with this policy

Heads of Departments are responsible for monitoring local dissemination and implementation of the policy

Heads of Departments will be responsible for monitoring that Ward Managers are ensuring that staff are appropriately trained and maintaining an up to date local training record

7.1.8 Individual Staff Responsibilities

Any member of staff involved in the use of EPH is responsible for undertaking appropriate training and adhering to the policy, this will include all nurses, AHPs and Doctors

The EPH is a vital aspect of continuity of care and the continuity of information is vital to the safety of patients. Therefore the following standards must be achieved:

- Each Healthcare Professional is accountable for their individual entries on the EPH
- Each user will log on using their individual personal password in line with Trust Policy which will be audited monthly and monitored by IT and Ward Managers
- Every patient must be admitted on the Trust's HISS system within one hour of arriving on the Ward following the Trusts Patient Administration Policies and Procedures
- The patient will be allocated to a bed space on EPH which will be updated when the patient moves bed spaces within the clinical environment
- A patient's EPH information can be discharged or transferred to another ward via EPH using the transfer and discharge icons
- EPH should be updated where possible at the patient's bedside, with the involvement of the patient
- EPH is to be updated as a minimum once each shift or more frequently if a change in the patient's condition occurs
- Information should be factual, consistent, accurate and abbreviations, text speak, meaningless phrases and jargon should not be used
- Date of Discharge is to be updated daily to support effective bed management systems

7.2 Board and Committee Responsibilities

7.2.1 Trust Board Responsibilities

The Trust Board has the overall responsibility to ensure that the Trust Policies support operational practices which result in the delivery of an effective service and delegates where appropriate to the Operational Board

7.2.2 Quality & Safety Committee

The Quality and Safety Committee has the responsibility to ensure that Trust policies support operational practices which result in the delivery of an effective service

7.2.3 Professional Governance Forum

The Professional Governance Forum (PGF) has the responsibility for ensuring all nursing policies are logged (PGF); follow the correct procedures in relation to policy development, approval (Nursing and Midwifery Board) and final ratification (PGF)

7.2.4 Nursing & Midwifery Board

The new Nursing and Midwifery Board will have the responsibility of providing review and approval of all nursing and midwifery policies

8. Training Requirements

The Trust is aware that the initial successful implementation of this policy is reliant on adequate support and effective training for all staff

- Initial introductory training on EPH will be provided by each individual ward cascade trainer or IT trainer
- Further training can be provided in response to an identified individual / speciality needs

Ward Managers will be responsible for ensuring that staff are appropriately trained and maintain a local training record

9. Monitoring and Compliance

Compliance with this policy will be monitored through monthly reports to the Nursing and Midwifery Board, Healthcare Governance, Medical & Surgical Business Units and EPH meetings in relation to:

Monitoring of access, training and any general activity

- Monthly audits regarding EPH use and compliance will be sent to Ward Managers
- Any identified incidents will be reported via the Trust's Incident Reporting Policy
- Non compliance with the agreed policy standards will require the completion of an IR1

10. Attachments

Attachment 1: Equality & Diversity – Policy Screening Checklist
Attachment 2: Equality Action Plan / Report

Attachment 1: Equality and Diversity - Policy Screening Checklist

Policy/Service Title: Electronic Patient Handover Policy v2.0	Directorate: Corporate Nursing
Name of person/s auditing/developing/authoring a policy/service: Lynn Fisher / Julia Jackson / Debbie Tidmarsh	
Aims/Objectives of policy/service:	

Policy Content:

- For each of the following check the policy/service is sensitive to people of different age, ethnicity, gender, disability, religion or belief, and sexual orientation?
- The checklists below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant with equality legislation.

1. Check for DIRECT discrimination against any group of SERVICE USERS:

Question: Does your policy/service contain any statements/functions which may exclude people from using the services who otherwise meet the criteria under the grounds of:		Response		Action required		Resource implication	
		Yes	No	Yes	No	Yes	No
1.1	Age?		X				
1.2	Gender (Male, Female and Transsexual)?		X				
1.3	Disability?		X				
1.4	Race or Ethnicity?		X				
1.5	Religious, Spiritual belief (including other belief)?		X				
1.6	Sexual Orientation?		X				
1.7	Human Rights: Freedom of Information/Data Protection		X				

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

2. Check for INDIRECT discrimination against any group of SERVICE USERS:

Question: Does your policy/service contain any statements/functions which may exclude employees from operating the under the grounds of:		Response		Action required		Resource implication	
		Yes	No	Yes	No	Yes	No
2.1	Age?		X				
2.2	Gender (Male, Female and Transsexual)?		X				
2.3	Disability?		X				
2.4	Race or Ethnicity?		X				
2.5	Religious, Spiritual belief (including other belief)?		X				
2.6	Sexual Orientation?		X				
2.7	Human Rights: Freedom of Information/Data Protection		X				

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING DIRECT DISCRIMINATION =							
3. Check for DIRECT discrimination against any group relating to EMPLOYEES:							
Question: Does your policy/service contain any conditions or requirements which are applied equally to everyone, but disadvantage particular persons' because they cannot comply due to:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
3.1	Age?		**X**				
3.2	Gender (Male, Female and Transsexual)?		**X**				
3.3	Disability?		**X**				
3.4	Race or Ethnicity?		**X**				
3.5	Religious, Spiritual belief (including other belief)?		**X**				
3.6	Sexual Orientation?		**X**				
3.7	Human Rights: Freedom of Information/Data Protection		**X**				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
4. Check for INDIRECT discrimination against any group relating to EMPLOYEES:							
Question: Does your policy/service contain any statements which may exclude employees from operating the under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
4.1	Age?		**X**				
4.2	Gender (Male, Female and Transsexual)?		**X**				
4.3	Disability?		**X**				
4.4	Race or Ethnicity?		**X**				
4.5	Religious, Spiritual belief (including other belief)?		**X**				
4.6	Sexual Orientation?		**X**				
4.7	Human Rights: Freedom of Information/Data Protection		**X**				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING INDIRECT DISCRIMINATION =							

Signatures of authors / auditors: **Date of signing:**

Attachment 2: Equality Action Plan/Report

Directorate: Nursing Directorate

Service/Policy: Policy for Electronic Patient Handover

Responsible Manager: Mandie Sunderland

Name of Person Developing the Action Plan: Janet Hunt; Debbie Tidmarsh

Consultation Group(s): Nursing & Midwifery Board, Professional Governance Nursing Forum

Review Date:

The above service/policy has been reviewed and the following actions identified and prioritised.
All identified actions must be completed by: _____

Action:	Lead:	Timescale:
Rewriting policies or procedures	Janet Hunt/Debbie Tidmarsh	31/07/09
Stopping or introducing a new policy or service	Janet Hunt/Debbie Tidmarsh	31/07/09
Improve /increased consultation	Janet Hunt/Debbie Tidmarsh	31/07/09
A different approach to how that service is managed or delivered		
Increase in partnership working		
Monitoring	Janet Hunt/Debbie Tidmarsh	31/07/09
Training/Awareness Raising/Learning		
Positive action		
Reviewing supplier profiles/procurement arrangements		
A rethink as to how things are publicised		
Review date of policy/service and EIA: this information will form part of the Governance Performance Reviews	Janet Hunt/Debbie Tidmarsh	31/07/09
If risk identified, add to risk register. Complete an Incident Form where appropriate.	Janet Hunt/Debbie Tidmarsh	31/07/09

When completed please return this action plan to the Trust Equality and Diversity Lead; Pamela Chandler or Jane Turvey. The plan will form part of the quarterly Governance Performance Reviews.

Signed by Responsible Manager: _____ Date: _____