Government of **Western Australia**
Department of **Health**

Clinical Handover Guideline

1. Purpose

Clinical handover is 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 professional group on a temporary or permanent basis. The purpose of clinical handover (handover) is to achieve effective, high-quality communication of relevant clinical information that is understood and accepted by the receiver when responsibility for patient care is transferred.

Standardisation of handover, as part of a comprehensive, system-wide strategy, will aid effective, concise and inclusive clinical communication in all clinical situations and contribute to improved patient safety. In and of itself, effective handover does not guarantee quality care – the responsibility and information handed over still needs to be acted upon.

The aim of this non-mandatory guideline is to provide a resource for the Health Service Provider (HSP) to develop systems and processes, for the implementation of a minimum set of requirements for all types of handover involving the transfer of care of a patient within a WA health site or service.

The mandatory policy, titled WA Health Clinical Handover Policy is under the Clinical Governance, Safety and Quality Policy Framework.

2. Responsibilities

2.1 Health Service Chief Executives should:

- Ensure their health services have systems in place to comply with the policy.
- Ensure that effective and consistent agreed processes for handover are applied whenever accountability and responsibility for patient care is transferred.
- Ensure sufficient resources are in place to enable effective handover, staff training in handover, and on-going evaluation of the effectiveness of handover to occur.
- Clearly articulate organisational and individual accountabilities for handover.

2.2 Health Services Managers, Executive Directors, Clinical Directors, Heads of Service/Departments and Senior Managers should:

- Provide organisational governance and leadership in relation to effective handover.
- Develop, implement and monitor local processes that support employees and other persons providing health services on behalf of WA health system as employees of WA Health Service providers, to achieve effective handover.
- Bring this policy to the attention of staff to ensure its full implementation.

2.3 All WA Health Service Provider Employees working within WA health services should:

- Ensure their timely participation in the handover process.
- Contribute to a culture which values handover and safe effective clinical communication.
- Ensure that any incidents relating to handover are reported via the appropriate process.
- Acknowledge that provision of effective handover is part of the duty of care for all health care providers.

3. Core Principles

3.1. Handover Principles

3.1.1. Patient/Carer Involvement

- Where appropriate, handovers should be conducted, in part, in the presence of the patient (e.g. at the bedside) and if the patient has consented or it is clinically appropriate with family member and/or carer.
- Where practicable and appropriate, the patient (and/or carer) should be invited to be involved in the handover.

3.1.2. Consistent Structure and Content

- The ISoBAR tool should be used in a manner that suits the clinical context for all handovers to guide the content and structure of the handover in a manner that suits the clinical context, excluding discharge.
- Handover content should be clear, concise, and use easily understood words with minimal, accepted, abbreviations.

3.1.3. Leadership and Team Involvement

- The most senior clinician available should lead the handover process and has responsibility for ensuring the handover happens.
- The most senior clinician available should decide which patients require handover.
- Consideration should be given to criteria for the prioritisation of patients being handed over.
- To ensure clarity, each clinical unit should identify the staff, including senior (e.g. consultant) staff who are required to be involved in handovers.
- All identified members of the clinical team(s) should support the handover process and should be available to attend handovers where possible.

3.1.4. Agreement on responsibilities and accountability

- Staff should understand handover as an explicit transfer, not just of information, but of clinical accountability and responsibility.
- Roles, responsibilities and accountabilities should be clearly described to, and agreed to by, all staff involved in handover. This includes staff responsibilities with regard to:

- the patient, other staff and the organisation
- patient risks and emergencies during handover
- transfers and discharges.

- Shift Handovers for nursing and midwifery staff should cover all patients, for which responsibility is being handed over, identifying any:
    - Patients of concern
    - Newly admitted patients.
- Shift Handover for medical officers should cover the following patients for which they are transferring responsibility of care identifying
    - Patients of concern
    - Newly admitted patients.
- Allied Health staff should handover all inpatients for whom care is being transferred. For further information relating to allied health clinical handover, please refer to WA Health Allied Health Clinical Handover Guideline found at: http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13257

3.1.5. Appropriate Modality

- All inpatient handovers, other than at discharge, should include a verbal component that is a current clinician responsible for the patient speaking directly to a receiving clinician prior to handover of responsibility or accountability.
- Handover should be conducted face-to-face wherever possible.
- Handover modalities should conform to the recommended or adequate options detailed in the Appendix; this includes mobile electronic tools and computer- generated patient information sheets.
- Voice-recorded handover is not permitted under the WA Clinical Handover Policy.

3.1.6. Appropriate Environment

- Environmental controls should be in place to limit non-critical interruptions to communication during handover.
- Wherever possible, the clinician initiating handover should ensure access to relevant supporting clinical information and appropriate documentation which can be viewed and reviewed by the receiving clinician.
- Where the use of alternate technologies is necessary, e.g. telephone or video-conference, the individual initiating the handover should ensure the environment conforms to the requirements above.
- Shifts for staff involved in clinical handover should have adequate crossover time for a thorough handover to ensure continuity of care.

3.1.7. Patients of Concern

- Patients should be handed over in accordance with their severity and clinical risk, as determined by a treating clinician.
- Management of a deteriorating patient must be escalated as soon as deterioration in a patient's condition is identified.
- Documentation should include the handover of patients of concern. Documentation should include:
    - Pertinent clinical information including a management plan as per the WA Health Acute Deterioration Policy.
    - time and date of handover
    - details of at least one of each of the providing and receiving clinicians.

3.1.8. Intra and Inter Facility Handover

Intra-facility and inter-facility patient transfers have been identified as a high risk situation for patients due to a combination of factors and complex interactions required to coordinate patient movement between clinical settings and between teams.

Inter-facility transfers, particularly from hospital-based to community-based care, are becoming increasingly common and are often characterised by delayed and inaccurate communication.

It is recommended that:

- All patients for which responsibility is transferred intra- or inter-facility should be formally handed over by one of the providing clinicians to one of the receiving clinicians at the time of, or prior to, transfer.
- In addition to a verbal component, inter-facility transfers should involve a detailed transfer document or discharge summary. This document should arrive prior to, or with the patient, and should include the same information as a discharge summary.
- Documentation that an intra- or inter-facility handover has occurred should be included in the medical record. This documentation should include:
    - relevant clinical information (preferably using the iSoBAR structure)
    - time and date of handover
    - contact details of at least one of each of the providing and receiving clinicians.

3.1.9. Discharge

- A discharge summary should be completed within 24 hours of a patient discharge and forwarded it to the relevant health care provider and to the patient/carer as per the HSP policy and/or protocol.
- Discharge summaries should include copies of:
    - primary and secondary diagnoses
    - treatment course to date, including relevant procedures and dates performed
    - relevant diagnostic test results and test results pending
    - a comprehensive list of medications the patient is prescribed at the point of discharge. Also explanation of any changes to the patient's medications prior to hospitalisation (i.e. reason for discontinuation of medication)
    - current allergy/adverse drug reaction status, including if any reaction occurred during hospitalisation
    - outstanding outpatient and medical appointments
    - ongoing and follow-up plans, with responsibilities assigned to specific professions such as GPs, community treatment teams.

3.1.10. Education

- All staff should receive education on the site/service handover protocol and the WA Health Clinical Handover policy.
- It is recommended that this occurs at the commencement of rotation or employment and also following revisions of this policy.
- All staff should understand and comply with the local policies and the WA health policy regarding handover of all types.

4. Definitions

Accountability – The act of accepting, acknowledging and assuming the responsibility for action/decision, encompassing the obligation to report, explain and be answerable for resulting consequences.

Adverse event – An incident where injury/harm is caused by medical management or complication thereof, instead of the underlying disease and results in an increase in the level of care and/or prolonged hospitalisation and/or disability at the time of discharge. Medical management refers to management under health care services.

Carer – a person who (without being paid) provides ongoing care or assistance to another person who has a disability, a chronic illness or a mental illness, or who is frail.

Clinical handover – Any situation in which professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, is transferred to another person or professional group on a temporary or permanent basis.1 *See also shift handover, inter-facility handover, intra-facility handover.*

Clinical team – The clinical team includes all health professionals participating in the delivery of care at all stages of a particular episode of care.

Clinician – A person, registered under the *Health Practitioner Regulation National Law (Western Australia) 2010*, mainly involved in the area of clinical practice. That is the diagnosis, care and treatment, including recommended preventative action, to patients. Clinicians include allied health professionals, medical officers, midwives, and nurses.

A current, or providing, clinician is a clinician who is currently responsible for a patient and is handing over care to a receiving clinician.

A receiving clinician is a clinician who will accept responsibility for a patient for whom the receiving clinician is currently being given a handover.

Deteriorating patient – Any patient who exhibits physiological signs that their condition is worsening. Such signs may include, but not be limited to, vital signs recorded on a track and trigger observation chart.

Discharge – Discharge is the coordinated release process by which an episode of treatment and/or care to an individual patient is formally concluded from one healthcare service to a primary or non-acute healthcare service, for example to the care of a general practitioner, community-based private specialist, or community health service. Health service waiting areas, transit lounges and discharge lounges are not considered hospital accommodation unless the patient is receiving care or treatment in these areas.

iSoBAR6 – The mnemonic that must be used to guide the structure and content all clinical handovers initiated within Department of Health services. See Appendix A for details.

Inpatient – A patient who is admitted to a hospital or other health care facility for at least an overnight stay. *See patient, community patient and outpatient*.

Intra-facility transfer – The transfer of responsibility of a patient within one health service (under the same management), e.g. to/from operating theatre, departments or wards; inpatient to community mental health service; referral to a specialist; and escalation of a deteriorating patient. See also inter-facility handover.

Inter-facility transfer – The move of an admitted patient between healthcare services where: they were admitted and/or assessed and/or received care and/or treatment at one service; and were admitted and/or received treatment and/or care at the second service. Services in WA include, but are not limited to:

- hospitals
- community health services, e.g. mental health, child health, dental health
- prisons
- aged care facilities
- hospital in the home (HITH)

- rehabilitation in the home (RITH)
- transport providers, such as St John Ambulance Service and the Royal Flying Doctors Service

See also *intra-facility transfer.*

Near-miss – An incident that may have, but did not, cause harm, either by chance or through timely intervention.

Medical officer – A person, registered under the *Health Practitioner Regulation National Law (Western Australia) 2010* in the medical profession, whose primary employment role is to diagnose physical and mental illnesses, disorders and injuries and prescribe medications and treatment to promote or restore good health. Synonymous with medical practitioner

Medical record – Consists of, but is not limited to, a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care. Entries into the medical record are generally made by clinicians. The medical record can be either paper-based or electronic.

Mobile electronic tool – An electronic device which can be used to assist clinicians in preparation for, or during, handover. Examples of mobile electronic tools are: 'smart' phones (cellular phones with built-in applications and internet/network access), personal digital assistants (PDAs), and tablet computers

Outpatient – A patient, not hospitalised, who is being diagnosed or treated in an office, clinic or other ambulatory care facility. See patient, community patient and inpatient.

Patient – A person for whom a health service accepts responsibility for treatment and/or care. Synonyms include consumer and client. See also *community patient, inpatient and outpatient.*

Patient of concern – A patient that a clinician is particularly concerned about, as defined by the treating clinician.

Policy – A set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.

Protocol – A set of rules used for the completion of tasks or set of tasks.

5. References

- Recognising and responding to Acute Deterioration Policy (*to be published*)

- WA Clinical Incident Management Policy
- The National Safety Quality Healthcare Standards (NSQHS)
- WA Open Disclosure Policy

- WA Allied Health Clinical Handover Guideline
- Ossie Guide to Clinical Handover Improvement
- The End of Life Framework: :A statewide model for the provision of comprehensive care at end of life in Western Australia 2016
- National Consensus Statement: essential elements for safe and high-quality end-of-life care.
- The National Safety and Quality Healthcare Standards: Clinical Communication Resources
- Clinical Risk Management Guidelines for the Western Australian Health System

6. Appendix

6.1 ISOBAR

i	IDENTIFY	Introduce yourself and your patients
S	SITUATION	Describe the reason for handing over
o	OBSERVATIONS	Include vital signs and assessments
B	BACKGROUND	Pertinent patient information
A	AGREE A PLAN	Given the situation, what needs to happen
R	READBACK	Confirm shared understanding

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Review

This non-mandatory guideline will be reviewed and evaluated as required to ensure relevance and recency. At a minimum it will be reviewed within 3 years after first issue and at least every 5 years thereafter.

Version	Effective from	Effective to	Amendment(s)
			Original version

The review table indicates previous versions of this guideline and any significant changes.

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