



Government of Western Australia
Department of Health

WA Health Clinical Handover Policy

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1 Executive summary

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 basis¹

The Western Australian (WA) Health Clinical Handover Policy (the policy) details core principles and a prescribed structure that should be followed for all clinical handovers initiated within Department of Health WA services.

The aim of clinical handover (known hereafter as handover) is to achieve effective, high quality communication of relevant clinical information when responsibility for patient care is transferred.

Effective handover is vital in protecting patient safety. Evidence indicates that ineffective handover can lead to:

- incorrect treatment
- delays in diagnosis and treatment
- adverse events
- increased length of stay
- increase in expenditure
- unnecessary tests, treatments and communications
- patient complaints
- malpractice claims.¹⁻³

Standardisation of handover, as part of a comprehensive, system-wide strategy, will aid effective, concise and inclusive communication in all clinical situations and contribute to improved patient safety.³⁻⁵

In and of itself, effective handover does not guarantee quality care – the responsibility and information handed over still need to be acted upon.

1.1 Purpose

The aim of this policy is to implement a minimum practice level for handovers initiated by Department of Health, including shift handovers, intra-facility handovers, inter-facility handovers and discharges.

It is, however, expected that all clinicians operate at the highest level of best practice possible at all times.

This policy is designed to ensure the following elements exist across the Department of Health services:

- Clinicians have the skills and knowledge to adopt the handover principles detailed in this policy.
- High quality handover practice, as detailed in this policy, is considered core business, essential for safe and high quality care, and is carried out as a matter of routine.
- Appropriate resources (staff time, location and technological supports) are allocated for handover.
- The iSoBAR⁶ structure (Appendix A) is used in all handovers.

1.2 Scope

All Department of Health clinicians (medical, nursing, midwifery and allied health) providing health services on behalf of the Department of Health must comply with this policy in all handovers (acute and non-acute) initiated within the Department of Health, or Department of Health funded, services.

This policy is strongly recommended to all non-public health providers that interact with WA Health.

1.3 Review

This policy will as a minimum be reviewed by the Department of Health WA, three years from initial release, and every five years thereafter.

2 Policy

All patients who clinically need handover must receive it. This policy applies in all circumstances where a handover is required.

It is recognised that not all patients require a formal handover between all types of clinicians at each shift change. For example, all inpatients may be handed over between nursing staff during a shift change, but only a subgroup of those patients may be handed over between medical staff during a medical staff shift change.

It is recognised that there will be situations where exceptions to this policy will be necessary for best patient care. These exceptions must be justified and documented within the medical record.

Health care services must implement the principles listed in 2.1.

All principles in this policy are applicable to allied health, nursing, medical, and midwifery staff unless otherwise specified.

Organisations should consider implementation of the developmental principles (Appendix B – D).

Additional principles specifically relevant for the organisation should also be considered, e.g. culturally and linguistically diverse, mental health, maternity, or paediatric patients.

Health service organisations and departments must develop a documented process for handovers based on this policy.¹

See Appendix E for an evidence summary of each of the required and developmental principles.

2.1 Handover principles

2.1.1 Patient/carer involvement

- Where practicable, handovers should be conducted, in part, in the presence of the patient (e.g. at the bedside) or carer.
- Where practicable, the patient (and/or carer) should be invited to be involved in the handover.

2.1.2 Consistent structure and content

- All handovers, other than discharges, must use the iSoBAR⁶ tool to guide the content and structure of the handover in a manner that suits the clinical context. A suggested iSoBAR⁶ structure is provided in Appendix A.
- Use of a tool apart from iSoBAR⁶ must be approved by a Health Service.
- Handover content should be clear, concise, and use easily understood words with minimal, accepted, abbreviations.

2.1.3 Leadership and complete team involvement

- The most senior clinician available should lead the handover process and has responsibility for ensuring the handover happens in accordance with this policy.¹
- It is the responsibility of the most senior clinician available to decide which patients require handover.
- To ensure clarity, each area/service must identify the staff, including senior (e.g. consultant) staff, who are required to be involved in handovers.^{1, 7}
- All identified members of the clinical team(s) should support the handover process and be available to attend handovers where possible.^{1, 6}

2.1.4 Agreement on responsibilities and accountability

- Handover must be understood by staff as an explicit transfer, not just of information, but of clinical accountability and responsibility.
- Roles, responsibilities and accountabilities must be clearly described to, and agreed to by, all staff involved in handover.^{8, 9} This includes staff responsibilities:
 - regarding the patient, other staff and the organisation
 - with regard to patient risks and emergencies during handover
 - with regard to transfers and discharges.

2.1.5 Appropriate modality

- All inpatient handovers should include a verbal component wherever possible. That is, a current clinician responsible for the patient should speak directly to a receiving clinician prior to handover of responsibility or accountability.
- Handover should be conducted face-to-face wherever possible.^{10, 11}
- Handover modalities should conform to the *recommended* or *adequate* options detailed in Appendix F wherever practicable. Where not practicable, *Not recommended* modalities are permitted. *Should never occur* modalities are not permitted.
- Voice-recorded handover is not permitted under this policy.

2.1.6 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 test results, risk and functional assessments, x-rays, and clinical information.¹
- Where 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.

2.1.7 Supporting documentation

- All handovers must be supported by current, appropriate documentation (clinical notes, test results etc).¹⁰
- Handover tools must comply with this policy. These include:
 - mobile electronic tools
 - computer-generated patient information sheets.

2.1.8 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 condition is detected.
- Handover of patients of concern must be documented.
- Documentation should include:
 - pertinent clinical information (using the iSoBAR⁶ structure)
 - time and date of handover
 - details of at least one of each of the providing and receiving clinicians.

2.1.9 Education

- All staff must receive education on the site/service handover protocol and this policy. It is recommended that this occurs at the commencement of rotation or employment¹, and also following revisions of this policy.
- All staff should understand that they are required to comply with the site/service handover protocol and this policy for all forms of handover.

2.2 Policy responsibilities

2.2.1 Health Service Chief Executives

- will ensure the health services within their area of control have systems in place to make sure that effective and consistent agreed processes for handover are applied whenever accountability and responsibility for patient care is transferred
- will 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
- will clearly articulate organisational and individual accountabilities for handover.

2.2.2 Health Service Managers, Executive Directors, Clinical Directors, Heads of Services/Departments and other senior managers

- will provide organisational governance and leadership in relation to effective handover
- will develop, implement and monitor local processes that support employees and other persons providing health services on behalf of WA Health to achieve effective handover
- will bring this policy to the attention of staff to ensure its full implementation.

2.2.3 All WA Health employees

- will adhere to the principles and aims of this policy and ensure they operate in accordance with it
- will ensure their timely participation in the handover process
- will contribute to a culture which values handover
- will ensure that any incidents relating to handover are reported via the appropriate process.
- will acknowledge that provision of effective handover is part of the duty of care for all health care providers.

Appendix A – iSoBAR⁶

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

Appendix B – Developmental principles for shift handover

1. Shift handovers involving only nursing or midwifery staff should cover all inpatients for which responsibility is being handed over, identifying any:
 - patients of concern¹²
 - newly admitted patients (admitted during the previous shift).
2. As a minimum, shift handover involving medical officers should cover the following subset of inpatients:
 - patients of concern¹²
 - newly admitted patients.
3. Allied health staff should handover all inpatients who experience a shift change, e.g. emergency department and intensive care unit patients.
4. Consideration should be given to prioritisation of patients being handed over.
5. Interprofessional (multidisciplinary) shift handover should be implemented wherever practicable.
6. Shifts for staff involved in handover should have adequate crossover time for shift handovers.¹
7. Clinicians should ensure they conduct a thorough handover to ensure continuity of care if they are to be absent for extended periods, e.g. over weekends or on holidays.¹ This includes updating interim management plans.
8. State and site specific handover requirements should be observed and taught to junior staff before they are required to lead or initiate handovers.⁸

Appendix C – Developmental principles for intra- and inter-facility handover

1. 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 time of, or prior to, transfer.
2. 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.
3. Documentation that an intra- or inter- facility handover has occurred should be included in the medical record. This documentation should include:
 - pertinent clinical information (using the iSoBAR⁶ structure)
 - time and date of handover
 - contact details of at least one of each of the providing and receiving clinicians.

Appendix D – Developmental principles for discharge

1. A timeframe for a discharge summary to be forwarded to the receiving health care provider and to the patient/carer should be specified in the site policy and/or protocol.
2. 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
 - discharge medications (reconciled)
 - outstanding outpatient and medical appointments
 - ongoing and follow-up plans, with responsibilities assigned to specific professions, e.g. “General Practitioner to...”

Appendix E – Evidence

2.1 Handover principles

2.1.1 Patient involvement

Patients and carers are the only constants in a patient's care and as such their contribution in handover can be vital.

Evidence indicates that bedside handover improves patient safety¹³ through increased accuracy and timeliness of information.¹⁴ It also indicates a professional commitment to patient-centred care and can lead to improved patient satisfaction.¹⁴

2.1.2 Consistent structure and content

Teams trained to use a standardised handover technique exhibit improved handover communication, enhanced patient satisfaction and a reduction in the number of adverse events and near-misses.¹⁵

“Miscommunications and misunderstanding are most likely to occur when mental models held by incoming and outgoing personnel differ widely.”⁴ Introducing a similar structure to written and verbal handover across all Department of Health services will result in an alignment in mental models held across personnel and subsequently to a decrease in handover variance.^{5, 16}

Using iSoBAR⁶ to guide all handovers will ensure that:

- The information presented is limited to that which is necessary to provide safe care to the patient.⁴
- All clinicians involved have an opportunity to discuss the management plan, clarify information, and ask and respond to questions. Evidence indicates that feedback increases the accuracy of communication.⁴
- Verification of understanding occurs.¹⁰
- Responsibilities and planned actions are clearly understood by incoming team.

2.1.3 Complete team involvement

Involvement from all grades of staff, all units, and all professions, will ensure the maintenance of a team approach and continuity of patient care. This is especially important for complex cases or where multiple teams of professions regularly interact.³

2.1.4 Agreement on responsibilities and accountability

The following conditions should be met prior to a clinician accepting accountability for a patient:

- The clinician must be working within their scope of practice.
- Adequate information about the patient should be provided (see 2.1.1 Consistent structure and content).
- Formal authority and responsibility for the patient should be explicitly given and accepted.⁹

The involvement of senior clinicians ensures that management decisions can be made.

Junior staff learn clinical practice and culture through observation and interactions with staff members.^{3, 17} Efficient and consistent handovers led by senior staff provide opportunities for educating junior staff.

2.1.5 Appropriate modality

Face-to-face communication provides the receiver with supplementary information via qualitative aspects of communication, such as body language,⁴ and includes the opportunity to clarify information.¹⁸ It can also improve team cohesion and provide an education opportunity.³

Recorded handover, whilst beneficial for staffing requirements, has been shown to decrease patient safety due to the handover being less patient-focussed, less comprehensive, and having no opportunity for clarification.^{11, 16, 19, 20}

2.1.6 Appropriate environment

Interruptions disturb the flow of information²¹ and reduce concentration, which increases the potential for miscommunication and clinical errors.²²

2.1.7 Supporting documentation

Verbal handover without documentation relies on memory and is a high risk activity.²³

The introduction of 'redundancy', by way of written documentation, into communication reduces communication errors⁴ and improves continuity of care.²⁴

Research into five cycles of simulated nursing handovers indicated that:

- All patient information was lost after the third, verbal only, cycle
- 69% retained after five cycles using note-taking only
- data loss was negligible when using a formal, pre-prepared handover sheet.²⁵

Similar research into medical handovers indicated that:

- 2.5% of patient information was retained after five cycles of verbal-only handover
- 85.5% retained using note-taking
- 99% retained using a pre-printed, standardised proforma.²³

2.1.8 Patients of concern

Failure to accurately and legibly record, and understand what is recorded, in patient notes contributes to a decrease in the quality and safety of patient care and an increase in cost.⁵

The Office of Safety and Quality in Healthcare report *From Death We Learn* has recorded instances of poor record keeping as an area for improvement every year of publication.²⁶⁻²⁹

2.1.9 Education

Optimisation of handover communication can only occur if all staff hold a similar understanding and 'mental model' of the process and expectations of them.⁴

Development principles for shift handovers (Appendix B)

Up to 50 percent of medical officers indicate that shift handover does not routinely occur amongst medical officers.⁵

Medical officers often do not have a clear indication of patients of concern until they are required to review them.⁵

Handover by allied health professionals is often limited, late or not conducted.³⁰

Development principles for intra- and inter-facility handovers (Appendix C)

Intra-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.⁹

Inter-facility transfers, particularly from hospital-based to community-based care, are becoming increasingly common and are often characterised by delayed and inaccurate communication.⁹

Detrimental outcomes from transfers not following these guidelines include: higher readmission rates; adverse effects on follow up management plans; and late actioning of diagnostic test results leading to delayed or incorrect diagnoses.³¹

Development principles for discharges (Appendix D)

Adverse outcomes from discharges that do not follow guidelines include:

- higher readmission rates
- adverse effects on follow up management plans
- late actioning of diagnostic test results leading to delayed or incorrect diagnoses.³¹
- delays in follow up and potential duplication.

Appendix F – Handover modalities matrix

Handovers initiated within WA Health should conform to the *recommended* and *adequate* modalities wherever practicable. *Should never occur* modalities are not permitted.

Why implement standard key principles?		Evidence indicates that standardisation of handover processes contributes to safer patient care. ^{3, 4}									
What clinical information should be handed over?		All handovers initiated by Department of Health staff should be structured using iSoBAR ⁶ (Appendix A).									
Who should attend handover?		Key participants in the handover process should be identified and available to attend the handover of their patients.									
When should handover occur?		Key participants in the handover process should be identified and available to attend the handover of their patients.									
How/ where should handover be delivered?	Interprof./ multidisc. team handover	Shift handover (continuous coverage)	Shift handover (non-continuous coverage)	Escalation of deteriorating patient	Patient transfers for a test or appointment	Patient transfers to another ward	Patient transfers to another facility	Inpatient to community handover	Inpatient to outpatient handover		
	Face to face (in the patient /carer presence) + written	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓		
	Face to face (in a common area) + written	✓	✓	✓	✓	✓	✓	✓	✓		
	Telephone + written	~	✓	✓	✓	✓	✓	✓	✓		
	Telephone only	~	~	✓	✓	✓	~	~	~		
	Written only	✗	✗	✓	✗	✓	~	✗	✓		
Voice recording	✗	✗	✗	✗	✗	✗	✗	✗			

Legend

✓✓	Recommended	✓	Adequate	~	Not recommended	✗	Should never occur
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Related policies and guidelines

This policy should be read in conjunction with:

- Admission, Readmission, Discharge and Transfer Policy for WA Health Services (Operational Directive 0445/13, 2013).
- Clinical Casemix Handbook 2012-2014 Version 3.0 (Performance Activity and Quality Division, 2012).
- National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care, 2012).
- NEHTA-0965:2011 eDischarge Summary – Structured Document Template v3.3.
- Emergency Rescue Helicopter Service Arrangements for Inter-Hospital Patient Transfer (Information Circular 0014/07, 2007).
- Guidelines for the Transmission of Client Identifiable Health Information by Facsimile Machine (Information Circular 0022/07, 2007).
- Mental Health Division, WA Department of Health. Clinical Risk Assessment Management (CRAM) in Western Australian Mental Health Services: Policy and Standards (2008).
- Patient Information Retention and Disposal Schedule Version 3 (Operational Directive 133/08, 2008).
- Transition Care for the Older Person (Operational Directive 0290/10, 2010).

Glossary

Accountability – The act of accepting, acknowledging and assuming the responsibility for action/decision, encompassing the obligation to report, explain and be answerable for resulting consequences³².

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.

Community patient – A patient who receives care in the home or other non-health care facility (including residential aged care facilities). See also patient, inpatient and outpatient.

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.

Health service/provider – Any person(s), hospital/health service providing a service to a consumer.

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.

Mental models – Personal assumptions, generalisations, rules, pictures and images that detail an individual's understanding of the world around them, what they expect, and how they will respond.

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.

Shift handover – The transfer of responsibility and accountability for some or all aspects of care for a patient, or group of patients, at the change of shift from the departing (group of) clinician(s) to the incoming (group of) clinician(s).

Department of Health Service – For the purpose of this policy, a *Department of Health Service* means all Department of Health-funded hospitals, health services and multi-purpose services established under the *Hospitals and Health Services Act 1927*. This includes the following entities:

- Metropolitan Health Services
- Joondalup Health Campus
- Peel Health Campus
- WA Country Health Service
- all other Department of Health WA funded health services.

References

1. Australian Medical Association. Safe handover: safe patients. Guidance on clinical handover for clinicians and managers. Canberra: Australian Medical Association; 2006.
2. Wong MC, Yee KC, Turner P. Clinical Handover Literature Review. Hobart: eHealth Services Research Group, University of Tasmania; 2008.
3. Australian Commission on Safety and Quality in Health Care (ACSQHC). The OSSIE guide to clinical handover improvement. Sydney: ACSQHC; 2010.
4. Lardner R. Offshore Technology Report OTR 96 003: Effective shift handover - A literature review. Edinburgh, Scotland: The Keil Centre; 1996.
5. Bomba DT, Prakash R. A description of handover processes in an Australian public hospital. *Aust Health Rev.* Feb 2005;29(1):68-79.
6. Porteous JM, Stewart-Wynne EG, Connolly M, Crommelin PF. iSoBAR--a concept and handover checklist: the National Clinical Handover Initiative. *Med J Aust.* Jun 1 2009;190(11 Suppl):S152-6.
7. Benson E, Rippin-Sisler C, Jabusch K, Keast S. Improving nursing shift-to-shift report. *J Nurs Care Qual.* Jan-Mar 2007;22(1):80-4.
8. Beach C. Lost in transition. *Case & Commentary: Emergency Medicine [serial on the Internet].* 2006; (February 2006): Available from: <http://www.webmm.ahrq.gov/case.aspx?caseID=116>.
9. Centre for Healthcare Improvement. Clinical handover: a strategy options paper. Brisbane: Queensland Health Patient Safety Centre; 2009.
10. Patterson ES, Roth EM, Woods DD, Chow R, Gomes JO. Handoff strategies in settings with high consequences for failure: lessons for health care operations. *Int J Qual Health Care.* Apr 2004;16(2):125-32.
11. O'Connell B, Penney W. Challenging the handover ritual. Recommendations for research and practice. *Collegian.* Jul 2001;8(3):14-8.
12. Australian Commission on Safety and Quality in Health Care (ACSQHC). National consensus statement: Essential elements for recognising and responding to clinical deterioration. Sydney: ACSQHC; 2010.
13. Chaboyer W, McMurray A, Johnson J, Hardy L, Wallis M, Chu FY. Bedside Handover: Quality Improvement Strategy to "Transform Care at the Bedside". *J Nurs Care Qual.* Oct 16 2008.
14. McMurray A, Chaboyer W, Wallis M, Johnson J, Gehrke T. Patients' perspectives of bedside nursing handover. *Collegian.* [Research Support, Non-U.S. Gov't]. 2011;18(1):19-26.
15. Velji K, Baker GR, Fancott C, Andreoli A, Boaro N, Tardif G, et al. Effectiveness of an Adapted SBAR Communication Tool for a Rehabilitation Setting. *Healthc Q.* [Research Support, Non-U.S. Gov't]. 2008;11(3 Spec No.):72-9.
16. Miller C. Ensuring continuing care: styles and efficiency of the handover process. *Aust J Adv Nurs.* [Review]. Sep-Nov 1998;16(1):23-7.

17. Beach C, Croskerry P, Shapiro M. Profiles in patient safety: emergency care transitions. *Acad Emerg Med*. [Case Reports Research Support, Non-U.S. Gov't]. Apr 2003;10(4):364-7.
18. Lardner R. *Safe Communications at Shift Handover: Setting and Implementing Standards*. Edinburgh: The Keil Centre; 1999.
19. Webster J. Practitioner-centred research: an evaluation of the implementation of the bedside hand-over. *J Adv Nurs*. [Research Support, Non-U.S. Gov't]. Dec 1999;30(6):1375-82.
20. Sexton A, Chan C, Elliott M, Stuart J, Jayasuriya R, Crookes P. Nursing handovers: do we really need them? *J Nurs Manag*. Jan 2004;12(1):37-42.
21. Iedema R, Merrick ET, Kerridge R, Herkes R, Lee B, Anscombe M, et al. Handover--Enabling Learning in Communication for Safety (HELiCS): a report on achievements at two hospital sites. *The Medical journal of Australia*. [Multicenter Study Research Support, Non-U.S. Gov't]. Jun 1 2009;190(11 Suppl):S133-6.
22. Parker J, Coiera E. Improving clinical communication: a view from psychology. *J Am Med Inform Assoc*. Sep-Oct 2000;7(5):453-61.
23. Bhabra G, Mackeith S, Monteiro P, Pothier DD. An experimental comparison of handover methods. *Ann R Coll Surg Engl*. Apr 2007;89(3):298-300.
24. Kennedy J. An evaluation of non-verbal handover. *Prof Nurse*. Mar 1999;14(6):391-4.
25. Pothier D, Monteiro P, Mooktiar M, Shaw A. Pilot study to show the loss of important data in nursing handover. *Br J Nurs*. Nov10-23 2005;14(20):1090-3.
26. Healthcare OoSaqi. *From Death We Learn: Lessons from the Coroner* [Online]. East Perth: Western Australian Department of Health; 2006 [cited 17 March 2011]. Available from: http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/From_Death_We_Learn2006.pdf.
27. Healthcare OoSaqi. *From Death We Learn: 'speak for the dead to protect the living'* [Online]. East Perth: Western Australian Department of Health; 2007 [cited 17 March 2011]. Available from: http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/FromDeathWeLearn2007.pdf.
28. Healthcare OoSaqi. *From Death We Learn* [Online]. East Perth: Western Australian Department of Health; 2008 [cited 17 March 2011]. Available from: <http://www.health.wa.gov.au/circularsnew/attachments/365.pdf>.
29. Healthcare OoSaqi. *From Death We Learn* [Online]. East Perth: Western Australian Department of Health; 2009 [cited 17 March 2011]. Available from: http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/11604_from_death_we_learn_24418web.pdf.
30. Next Challenge, WA Country Health Service. *Back to the Bush: WACHS Allied Health Clinical Handover Project*. Perth: Department of Health Western Australia; 2009.
31. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *Jama*. [Research Support, N.I.H., Extramural Research Support, U.S. Gov't, P.H.S. Review]. Feb 28 2007;297(8):831-41.

32. Jorm C, Iedema R. Innovative approaches to enhancing clinical handover [Online]. Sydney: Australian Commission on Safety and Quality in Health Care and University of Technology, Sydney; 2008 [cited 17 March 2011]. Available from: [http://www.health.gov.au/internet/safety/publishing.nsf/Content/com-pres_2008-Int-Forum/\\$File/InnAppEnhClinHover.pdf](http://www.health.gov.au/internet/safety/publishing.nsf/Content/com-pres_2008-Int-Forum/$File/InnAppEnhClinHover.pdf).
33. Carers Australia. About Carers. [Online] [cited 14 November 2011]; Available from: <http://national.carersaustralia.com.au/?/national/section/2:about-carers>.

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