003516: Clinical Handover

Background

The transition of care between, and within, different sectors of the health system is a key point in the delivery of health care where adverse events and disruptions in the continuity of care can occur. The interface (or multiple interfaces) between subacute and community-based care and acute care, as well as within subacute care itself, can present a preventable safety risk to consumer and their carers.

Clinical handover formalises the transfer of professional accountability and responsibility from some or all aspects of care for a consumer, or group of consumers, to another person or professional group on a temporary or permanent basis (Australian Commission on Safety and Quality in Health Care, 2011).

Clinical handover for admission to a Community Indigenous and Subacute Service (CISS) is service specific (refer to service specific guidelines) and as a minimum includes:

- Three consumer identifiers (e.g. name, Unit Record (UR) number and date of birth)
- Appropriate and adequate clinical information and documentation which supports a seamless and safe continuum of care for the consumer.

Purpose and Intent

This procedure aligns with the Metro North Hospital and Health Service Clinical Handover Policy and provides an avenue to meet the mandatory requirements as outlined in the National Safety and Quality Health Service Standards (NSQHSS). This procedure details an appropriate process to ensure clinical handover within CISS is safe, consumer-centred, minimises risk of clinical error and helps to deliver positive consumer experiences and health outcomes.

Scope and Target Audience

This procedure applies to all CISS employees (permanent, temporary, casual, and including contractors and consultants) involved in consumer care, and other partners in care, including consumers.

Consumers

Consumers, families and carers are part of the consumer’s health care team and are to be included in the clinical handover process when discussing their plan of care and treatment options. Each service will have clear processes that outline how they involve the consumer in this process.

Principles

Responsibility and Accountability

CISS Service Line Safety and Quality Committees are responsible for ensuring that an effective clinical handover system is established, monitored and maintained at the local level.

The Standard 6 Responsible Officer and the Safe Handover and Documentation Committee are responsible for ensuring that clinical handover is conducted in accordance with this procedure, and that local Minimum Data Sets (MDS) and appropriate tools are established in each service through a standardised auditing process.
Each clinical area/service line should determine their own MDS of information, using agreed tools that are clear, consistent and fit for purpose for the local area and meet key criteria as outlined in this procedure.

**Procedure & Process**

With the implementation of this procedure, CISS staff will ensure the following are met:

- Clinical handover must occur whenever there is a change of responsibility and accountability – this occurs in a multitude of clinical situations and at transitions of care.
- The Key Principles (Appendix B) for safe and effective Clinical Handover must be implemented.

**Key Principles**

1. Leadership
2. Valuing Handover
3. Handover Participants, including consumers, carers and families
4. Handover Time
5. Handover Place
6. Handover Process (Standardised Protocol)
7. Escalation of the Deteriorating Consumer and Continuity of Care
8. Other Critical Information

- There are seven high risk areas for which clinical handover must occur. All CISS services are required to have clear protocol/s for these situations.

**High Risk Areas**

1. Escalation of the deteriorating consumer
2. Consumer transfers from another ward/clinical unit
3. Shift to shift change over
4. Consumer transfer for a test or appointment
5. Consumer transfer to another facility
6. Multidisciplinary team handover
7. Consumer transfer to and from the community

- **A communication tool must be used.** Communication tools are available for use in facilities to assist in the exchange of information and to improve communication by providing structure and a prompt to remind staff of the information necessary for inclusion.

- **A Minimum Data Set (MDS) for communication is in use in each area/service line.** The MDS must include all relevant information to be comprehensively transferred between healthcare professionals to safely deliver care. The MDS may include other sources of clinical handover such as referrals, requests, telephone handovers, discharge/transfer documents. All structured handover, transfer and discharge processes must include the use of three approved identifiers for each consumer.
• Important clinical handover information/variances must be documented in the medical record using approved clinical handover tools. Clinical handover documentation may include various communication tools such as checklist, care plans, pathways, transfer/discharge forms.

• The ISBAR/SBAR communication tool (APPENDIX C) has been endorsed for use to assist in the exchange of information and to improve communication.

![ISBAR/SBAR Communication Tool](image)

**Workforce training**

During staff orientation, all clinical staff will be informed and provided with information related to Clinical Handover. All clinical staff will be provided and informed with information related to Clinical Handover that is relevant to their specific work area. This will cover key principles of Clinical Handover as well as area-specific Clinical Handover processes.

**Auditing CH processes**

The following Clinical Handover tools are used in CISS for the purposes of audit:

- Staff Survey - Clinical Handover (Appendix D)
- Clinical Handover - Observational Audit (Appendix E)
- For specific services in CISS a set number of audits are also required through the monthly audit program
- Alternative audit tools may be used to suit each Service Line for example: Ambulatory Services.

The CISS workforce will be provided with information on clinical incidents and each service will have clear action plans to assist with the reduction in related clinical incidents and complaints and improved consumer outcomes.
Consumer engagement

It is a mandatory and core requirement of NSQHS standards to ensure consumers, their carer's and families as appropriate are included as part of their health care team. NSQHS Standard 2 – Partnering with Consumers is an overarching standard which is embedded in the clinical handover requirements for consumers to actively participate in the communication of their care.

Legislation and other authority

- Queensland Health Clinical Handover Policy
- Queensland Health Clinical Handover Guideline
- Queensland Health Clinical Handover Implementation Standard

References and Benchmarking

- Australian Commission on Safety and Quality (ACSQHC) Implementation Toolkit for Clinical Handover Improvement 2011
- Australian Commission on Safety and Quality (ACSQHC) National Consensus Statement – Essential Elements for Recognising and Responding to Clinical Deterioration
- Department of Health Clinical Handover at the bedside brochure
- Metro North Hospital and Health Service Policy: Clinical Handover

Related Documents

- CISS Procedure: Provision of Care; Assessment, Care Planning, Ongoing Care and Discharge/Transfer
- CISS Procedure: Consumer Feedback, Compliments and Complaints
- CISS Procedure: Recognition and Response to Clinical Deterioration
- Metro North Hospital and Health Service Policy: Clinical Handover
- Metro North Hospital and Health Service Procedure: Clinical Incident and Disclosure Management

Relevant Standards

NSQHS Standard 2 – Partnering with Consumers
NSQHC Standard 6 – Clinical Handover
NSQHC Standard 8 – Recognising and Responding to Clinical Deterioration in Acute Health Care
Appendix A- Definition of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer</td>
<td>In this document the word Consumer also includes patient, client or resident</td>
</tr>
<tr>
<td>Fit for Purpose</td>
<td>Flexible standardisation in CH. Ensure the information is designed and integrated to fit the health service organisations particular context of the clinical handover, suited for its purpose</td>
</tr>
<tr>
<td>Minimum Data Set</td>
<td>The minimum set of information and content that must be contained and transferred in a particular type of clinical handover.</td>
</tr>
<tr>
<td>ISBAR</td>
<td>Introduction, Situation, Background, Assessment &amp; Recommendations</td>
</tr>
</tbody>
</table>

Appendix B- Key Principles for Clinical Handover

B.1 Leadership

As the person providing handover in whatever context, you should have knowledge about the consumer you are responsible and accountable for. As the leader of Clinical Handover you ensure all participants attend and are heard.

B.2 Valuing Handover

By making the necessary time and active listening, demonstrate that clinical handover is an essential part of daily work.

Allow the receiving person opportunity to clarify information and question issues pertaining to the care of the consumer (re-checking and read-back)

Using innovative solutions that suit your area and your requirements (for example paging, agreed times and locations for handover) can reinforce the importance of attendance and attentiveness.

B.3 Handover participants

Use face to face handover wherever possible.

Where appropriate, conduct it in the consumers’/carer’s presence and encourage their participation if possible (ensuring privacy and confidentiality).

Three approved consumer identifiers must be used during structured handover, transfer and discharge processes.

B.4 Handover Time

Make uninterrupted time for handover and handover in a timely manner – don’t wait to pass on essential clinical information.

For regular handovers, set an agreed time, duration and frequency. The routine will help sustain the process and ensure it is effective.

Inform consumers, carers and families about handover times should they wish to attend.

Make enough time to complete necessary documentation.

B.5 Handover Place

Set the location for clinical handover to occur, make it convenient and free from distractions.

To ensure consumers, carers and families are able to contribute to the plan of care; clinical handover should be conducted at the bedside, unless clinically inappropriate.
If the consumer requests that the clinical handover does not occur at their bedside (especially in shared rooms), this request must be respected.

Confidentiality concerns regarding the consumer must be considered in the handover process (any information of a sensitive or confidential nature is to be discussed away from the bedside).

**B. 6 Consumer Engagement and Clinical Handover**

- Always introduce yourself on each occasion (where appropriate) to the consumer, carer and family
- Involve the consumer, carer and family in the development of their plan of care
- Consider the use of a local Consumer Information Sheet
- Enable the consumer, carer and family to ask any questions or make comment about their plan of care.
- Do not use jargon, abbreviated words or phrases.
- Check information with consumer, carer and family.
- Involve consumers, carers and families in developing models of care or service provision.
- Seek continual feedback from consumers, carers and families on service improvement.
- Consider education opportunities for consumers, carers or family.

**B.7 Handover Process**

Standardised documentation that expands on each facilities communication tool helps to ensure each staff member is aware of their responsibility and accountability for clinical handover.

Use a written or electronic handover sheet and include the plan of care as well as any other critical information (for example: alerts, transfers, mental state assessment, Mental Health Act status or any consumer and/or staff safety issues).

---

The Standard process for handing over clinical information should include:

- Clearly identify the consumer, yourself and your role
- State the immediate clinical situation of the consumer
- List the most important or recent observations
- Provide relevant background/history to the consumer’s clinical situation
- Identify assessments and actions that need to occur
- Identify timeframes and requirements for transition of care
- Promote the use of the consumer record to cross-check information
- Ensure documentation of all important findings or changes of condition
- Ensure comprehension, acknowledgement and acceptance of responsibility for the consumer by the clinician receiving the handover.

Clinical Handover should be documented. Effective Handover tools that aid communication are SBAR, ISBAR
### B.8 Escalation of the Deteriorating Consumer and Continuity of Care

Clinical Handover is closely related to Standard 8: Recognising and Responding to Clinical Deterioration in Acute Health Care. Therefore, it is paramount that:

- ‘At risk/complex’ consumers are prioritised during clinical handover. It is important to ensure an escalation plan for after-hours care of these consumers is in place.
- Wherever possible nursing staff should attend the medical rounds for high risk consumers to facilitate safe, effective communication of the consumer condition.
- If the consumers condition deteriorates a handover should occur where their management is escalated (immediately) according to local procedures.
- Information about possible deterioration from the consumer, family or carer should be recognised and escalated according to local procedures.

Clinical handover and the plan of care should reference (where appropriate) and document the actions agreed in the event of clinical deterioration.

The clinical team must ensure that ongoing consumer care is able to continue during the handover period. This includes: the arrival of new consumers, especially unstable consumers, time specific treatments, unexpected emergencies, toileting and responding to consumer call bells.

### B.9 Other Critical Information

Prioritise alerts for any other critical information (for example: outstanding actions, planned consumer moves, occupational health and safety risks impacting on staff or consumer safety).

Local tools and work instructions developed by departments in relation to implementing clinical handover in their area must be in line with this overarching clinical handover procedure.

Forms can be effective handover tools. Apply the principles of good clinical handover to all documentation and processes that involve the transfer of consumer information.

Document all relevant information in the appropriate clinical record. Document telephone handovers using an appropriate clinical handover tool/document.
Appendix C- ISBAR Diagram

Remember ISBAR

**INTRODUCTION**
Identify yourself (name/role/location) and give reason for calling
“I am calling because...”

**SITUATION**
Give the patient's age/gender and status
a: Stable (at risk of deterioration)
b: Unstable

**BACKGROUND**
Give the relevant details:
- Presenting problems...
- Clinical history...

**ASSESSMENT**
Put it all together:
- Current condition/risks/needs
  - “My assessment is...”

**RECOMMENDATION**
Be clear about what you are requesting
- Transfer/review/treatment?
- When should it happen?
## Appendix D - CISS Staff Survey - Clinical Handover

**Staff Survey - Clinical Handover**

When answering the questions below, think about what has been your experience in the last seven days.

1. There are clear clinical handover policy/procedure/guideline in place on our ward.
2. Our ward has a documented process for reporting clinical incidents relating to shift clinical handover.
3. There is a structured shift clinical handover process in place on our ward (e.g. preparing for handover, transfer of responsibility & accountability).
4. There is a designated time and place for shift clinical handover on our ward.

5. Our ward includes clinicians, patients and carers in the shift clinical handover review process.
   - Never
   - Rarely
   - Some of the time
   - Most of the time
   - All of the time

6. Sensitive patient issues are managed confidentially.
   - Never
   - Rarely
   - Some of the time
   - Most of the time
   - All of the time

7. During shift clinical handover I receive all the information I need to safely care for my patients.
   - Never
   - Rarely
   - Some of the time
   - Most of the time
   - All of the time

8. Shift clinical handover takes place at the patient’s bedside.
   - Never
   - Rarely
   - Some of the time
   - Most of the time
   - All of the time

9. High risk patient information is discussed at shift clinical handover (e.g. for example: A.D.D score, falls risk, rehabilitation risk).
   - Never
   - Rarely
   - Some of the time
   - Most of the time
   - All of the time

10. A bedside safety scan/environmental scan is performed at shift clinical handover on our ward.
    - Never
    - Rarely
    - Some of the time
    - Most of the time
    - All of the time

11. Safety issues are identified during the bedside safety scan/environmental scan.
    - Never
    - Rarely
    - Some of the time
    - Most of the time
    - All of the time

12. The patient is provided with written information describing bedside handover on our ward (e.g. patient brochure or fact sheet).
    - Never
    - Rarely
    - Some of the time
    - Most of the time
    - All of the time

13. The patient participates in bedside shift clinical handover on our ward when able to do so.
    - Never
    - Rarely
    - Some of the time
    - Most of the time
    - All of the time
### Appendix E- Clinical Handover auditing tools

#### Clinical Handover - Observational Audit

<table>
<thead>
<tr>
<th>Unit:</th>
<th>Date:</th>
<th>Time:</th>
<th>Auditor:</th>
</tr>
</thead>
</table>

Consumer’s identification is verified by confirming a minimum 3 core identifiers: Name, DOB and UR Number

Record planned start time of shift to shift clinical handover
Record actual start time of shift to shift clinical handover
Record planned finish time of shift to shift clinical handover
Record actual finish time of shift to shift clinical handover

- Identify e.g. specify consumer and who handover is directed to
- Situation e.g. specific priority concerns e.g. risk, mental state, physical deterioration
- Background e.g. relevant clinical background e.g. presenting problem, medication
- Assessment
- Recommendation e.g. specific actions required, timelines, transfer of responsibility

Did the handover outline patient risks and alerts; prioritisation of patients; CM&O issues; staffing allocation?

Does the consumer identify as Aboriginal and/or Torres Strait Islander Yes, No or Not Stated

Is the consumer from a linguistically diverse population? Yes, No or Not Stated

Were there any interruptions during clinical handover?

Was the consumer asked if they wish to participate in clinical handover?

Did the consumer participate in clinical handover?

If Yes: Did staff greet the consumer and introduce themselves by name and position to the consumer?

Comments:
## Document History

<table>
<thead>
<tr>
<th>Custodian</th>
<th>Assistant Director of Allied Health, Subacute Services, CISS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk rating</td>
<td>High (15)</td>
</tr>
<tr>
<td></td>
<td>MNHHS Risk Management Procedure</td>
</tr>
<tr>
<td>Compliance evaluation and audit</td>
<td>All clinicians participate in Clinical Handover</td>
</tr>
<tr>
<td></td>
<td>It is expected there will be 100% compliance with the CISS Clinical Handover Procedure. This will be monitored by audits conducted within the services;</td>
</tr>
<tr>
<td></td>
<td>• Monthly Clinical Audit</td>
</tr>
<tr>
<td></td>
<td>• Annual Health Record Documentation Audit – Referral information, Care Planning, discharge notes and transfer documentations</td>
</tr>
<tr>
<td></td>
<td>• Clinical Handover observation audits</td>
</tr>
<tr>
<td></td>
<td>• Clinical Handover – Consumer and Staff Satisfaction surveys</td>
</tr>
<tr>
<td>Replaces Document/s</td>
<td>Clinical Handover Procedure – CISS (August 2015- August 2018)</td>
</tr>
<tr>
<td>Document replaced</td>
<td>Clinical Handover v1 June 2015</td>
</tr>
<tr>
<td>Key stakeholders</td>
<td>Nursing Directors - CISS</td>
</tr>
<tr>
<td></td>
<td>Allied Health Team Leaders - CISS</td>
</tr>
<tr>
<td></td>
<td>Safe Handover and Documentation Committee</td>
</tr>
<tr>
<td>Marketing Strategy</td>
<td>The procedure will be implemented through the CISS Safety and Quality Unit. QHEPS will be used to publish the document and ensure accessibility to the CISS workforce</td>
</tr>
<tr>
<td>Key words</td>
<td>Clinical, Handover, ISBAR, consumer, NSQHS</td>
</tr>
</tbody>
</table>

## AUTHORISATION

Assistant Director Allied Health

Signature                      Date

Executive Director
Community Indigenous and Subacute Services

Signature                      Date

The signed version is retained by the relevant Safety and Quality area, Metro North Hospital and Health Service.