COVER SHEET

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FUNCTIONAL GROUP(S)	Clinical Governance
KEY TERMS	Clinical Handover, ISBAR, Key Standard Principles
SUMMARY	This procedure describes instructions for clinical staff for clinical handover implementing the ISBAR Framework, Key Principles of Clinical Handover and National Safety and Quality Health Service Standard 6 - Clinical Handover.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

NSW GOVERNMENT
South Eastern Sydney
Local Health District

Clinical Handover: Implementation of ISBAR Framework and Key Standard Principles

SESLHDPR/320

1. POLICY STATEMENT

Clinical handover refers to the transfer of responsibility amongst clinicians to ensure continuity of care whilst ensuring a smooth transition of accountability to a different clinician, clinical team, service or facility.

South Eastern Sydney Local Health District ensures that clinical handover undertaken by all staff working within the District follow the Key Standard Principles mandated by the NSW Ministry of Health Policy Directive PD2019_020 - Clinical Handover and the requirements under National Safety and Quality Health Service (NSQHS) Standard 6 - Communication for Safety.

2. BACKGROUND

This procedure outlines how South Eastern Sydney Local Health District implements the Key Standard Principles and meets the requirements of the NSQHS Standards.

As a minimum, all clinical services are responsible for ensuring that standardised work practices for clinical handover are developed for the key handover interfaces identified in Table 1 and ensuring clinical handover processes comply with NSQHS Standard 6 - Communication for Safety.

3. RESPONSIBILITIES

This procedure applies to all SESLHD facilities and streams, inclusive of all clinical disciplines.

3.1 General Managers will:

Ensure there are systems in place for the implementation of the SESLHD Procedure described below and the actions required to meet the key handover interfaces listed in Table 1.

3.2 Department Managers will:

Ensure effective implementation of the SESLHD Procedure described below and the actions required to meet the key handover interfaces listed in Table 1.

3.3 Clinical staff will:

Implement SESLHD Procedure described below and the actions required to meet the key handover interfaces listed in Table 1.
Whenever possible, include the patient in the handover process.

4. PROCEDURE

Use the resources on the Australian Commission on Safety and Quality in Healthcare (found here: Standard Key Principles for Clinical Handover) to assist you to locally assess and implement the standard key principles for clinical handover. Monitor and evaluate local clinical handover processes in line with the standard key principles for clinical handover and NSQHS Standard 6, monitoring and evaluation.

4.1 Clinical Handover in SESLHD

Formal clinical handover occurs at many points in the patient journey. Staff are required to participate in an effective clinical handover using a timely, relevant and structured process that results in transfer of responsibility and accountability for care. Information handed over must be supported by documentation in the healthcare record and / or on agreed tools / templates e.g. Care Plans, Discharge Summaries and relevant eMR documents.

4.2 Communication Script

The ISBAR script (Appendix B) Introduction, Situation, Background, Assessment and Recommendation / Request is the structured framework to be used when communicating clinical handover. The ISBAR provides a framework to ensure that relevant information is effectively communicated and transfer of responsibility is undertaken.

It is recognised that the transfer of information between clinical staff of all disciplines occurs in many **informal** ways throughout the day e.g. when staff leave ward for meal breaks, when a treatment plan is updated. ISBAR is the recommended communication script for use in these situations supported by documentation in healthcare records.

4.3 Patient Identification

To ensure the identity of the patient is confirmed and to meet the requirements for the National Safety and Quality Health Service Standards Standard 6 Communication for Safety–, all clinical handover situations must ensure the following patient identifiers are used:

- Patient's name and surname
- Date of birth
- Patient's MRN.

If one of these is not available - one of the following can be used:

- Patient's address checked against request form and patient armband
- Medicare card name check
- Veterans card check
- Passport for overseas patients
- Driver's license
- Aged care / seniors card as long as full name is on card and details match request form.

4.4 Key Interfaces

Clinical handover must be standardised to cover local purposes and be appropriate to the clinical context in which handover occurs. The following key interfaces require standardised work practices for clinical handover[1].

HANDOVER INTERFACE	ACTIONS REQUIRED
Escalation of deteriorating patient	Incorporated in: SESLHDPR/284, SESLHDPR/697, SESLHDPR/705, SESLHDPR/340.
Patient transfers to another ward	Facilities should ensure that processes are in place to support Transfer of Care, highlighting clinical handover, risk assessment and documentation.
Shift to shift change over	• Facilities should ensure that formalised shift to shift handover processes map to the NSW MOH Standard Key Principles/NSQHS. This includes all disciplines. • Protected handover time should be built into rosters for all disciplines where practical. Where it is not practicable an alternative handover process must be stipulated at local site level, clearly documented through a local business rule and that is compliant with NSW MOH Standard Key Principles/NSQHS. • Facilities should ensure that clinical handover practice is designed within the context of patient case mix, clinical risk assessment, staffing levels, skill mix and location of work groups. • Where possible, nursing / midwifery shift to shift handover should occur face to face and in the patient's presence (bedside handover) unless clinical risk assessment identifies unfavourable effects. Mechanisms should be used to involve the patient / carer in the clinical handover discussions where appropriate. Where handover occurs away from the bedside there must also be a visual check of the patient and their environment by the person handing over and the person taking over care. • Consider multidisciplinary involvement in shift to shift handover especially where teams are co-located. • Where there is a long overlap time between shifts there is a need to ensure that there is clear delegation of responsibility for patient care while both shifts are present. • If handover cannot happen face to face, e.g. for RMOs and allied health with patients in different wards, then other formal models should be developed to ensure effective and safe clinical handover.
Patient transfers for a procedure, test or appointment	• Facilities should ensure that processes are in place to support Transfer of Care, highlighting clinical handover, risk assessment and documentation.
Patient transfers to another hospital	• Assess current practice against NSW MOH Standard Key Principles / NSQHS

	• Use LHD tools / forms i.e. Medical transfer of Care form to document handover.
Patient transferred to another treating team	• Assess current practice against NSW MOH Standard Key • Principles / NSQHS • Documented handover required in the healthcare record by the multidisciplinary team • Use ISBAR as core communication script and appropriate tools / forms to document handover.
RMO term changeover	• Assess current practice against NSW MOH Standard Key Principles / NSQHS • Use ISBAR as core communication script and local facility tools to document Clinical Handover.
Patient transfers to the community	• Assess current practice against NSW MOH Standard Key Principles / NSQHS • Use discharge summaries, transfer forms appropriate to the clinical community setting where the patient is being transferred.
Patient transferred to Non Government Care Provider and / or Third Party	• Assess current practice against NSW MOH Standard Key Principles/NSQHS • Documented handover required by the multidisciplinary team inclusive of communication of known risks to third party • When transferring care for an Aboriginal patient, an Aboriginal community controlled health service, transfer forms may require additional specific information • Use ISBAR as core communication script and local facility tools to document clinical handover.
Patient discharge (from inpatient or outpatient environment)	• Assess current practice against NSW MOH Standard Key Principles / NSQHS • Documented handover required in the healthcare record by the multidisciplinary team • Use ISBAR as core communication script and appropriate tools / forms to document handover • Electronic discharge forms to GPs • Patient related discharge information.

4.5 Staff Education

Ongoing training and education for clinical staff is the key to help improve and sustain clinical handover compliance. Facilities should ensure that education about clinical handover is incorporated into orientation practices in clinical departments and in regular education schedules e.g. HETI Module. The education should correlate with appropriate localised business rules / guidelines specific to the clinical situation and environment. Records of attendance at training are to be maintained. All staff delivering services to Aboriginal persons should have undergone the 'Respecting the Difference' training to consider the needs of Aboriginal and Torres Strait Island people.

4.6 Consumer Participation

Clinical handover requires the active participation of patients, consumers and carers in the planning, delivery and evaluation of the clinical handover systems. Patients are the common link in each clinical handover situation. Refer to NSQHS Standard 6.07 Clinical Handover.

[1] Adapted from NSW Health Guideline pg 6 (full reference)

5. DOCUMENTATION

Forms are available for the documentation of handover, including:

- SESLHD Patient Transfer Summary
- Medical Transfer and Retrieval Checklist
- SESLHD Pre and Post Procedure Handover
- SESLHD Medical Transfer of Care Summary
- SESLHD Emergency Department Clinical Handover at Transfer of Care
- SESLHD Physiotherapy Clinical Handover / Discharge Summary
- Transfer of Involuntary Patient between Mental Health Facilities
- SESLHD Residential Aged Care Facility Transfer / Discharge Summary
- Podiatry Handover
- Paediatric Handover Care Plan
- Neonatal Transfer Summary
- ICU / HDU Patient Transfer Summary
- Clinical Handover at Transfer of Care
- Occupational Therapy ISBAR Clinical Handover
- ISBAR Diabetes Education Transfer of Care
- Speech Pathology Transfer of Care
- Nutrition and Dietetics Transfer of Care

6. GOVERNANCE

The Clinical and Quality Committee is responsible for monitoring compliance with policy and tracking trends in incidents relating to clinical handover. Each facility is required to appoint a committee / local group to monitor clinical handover processes.

Incidents resulting from inadequate handover or information sharing are notified in IMS+. Principle Incident type is: Transfer of Care/Handover and Transport.

6.1 Monitoring and Evaluation

Regular review of clinical handover should be performed in collaboration with managers, clinicians and consumers at ward / divisional / facility levels.

Agreed KPI are reported to the SESLHD Clinical Quality Council including:

- SAER and Clinical Reviews –identified handover issues
- IMS+ reports of inadequate handover
- CERS Reviews identifying inadequate handover
- Compliance of attendance at medical handover
- Documentation audit of clinical handover records (this should not be restricted to shift to shift nursing handover, should include transfer forms etc.)
- Observational audits all disciplines shift to shift handover
- Reports of quality activities
- Staff and patient surveys
- Patient complaints
- Patient / consumer experience survey results relating to clinician handover
- Number of staff completing handover training – orientation

7. REFERENCES

- NSW Ministry of Health Policy Directive PD2019_020 - Clinical Handover – Key Standard Principles
- National Safety and Quality Health Services – Version 2 – Standard 6 – Communicating for Safety Standard Clinical Handover Page 44
- Australian Commission on Safety and Quality Health Care – Ossie Guide to Clinical Handover
- Australian Commission on Safety and Quality Health Care – Implementation Toolkit for Clinical Handover Improvement
- Australian Commission on Safety and Quality Health Care – Communicating for Safety Resource Portal

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
Sept ember 2013	1	Converted to procedure and re-formatted by Scarlette Acevedo, District Policy Officer
Sept ember 2013	2	Revised by Kim Brookes, SESLHD Patient Safety and Consumer Feedback Manager
September 2013	2	Approved by Prof George Rubin, Director Clinical Governance
November 2013	3	Added hyperlink to PACE procedure for adults and maternity inpatients
April 2015	4	References updated and endorsed by Executive Sponsor
March 2018	5	Revised by Lyn Woodhart, SESLHD Patient Safety manager and endorsed by Executive Sponsor
May 2018	5	Processed by Executive Services prior to publishing
September 2021	6	Minor review by Patient Safety Manager. Updated links. Approved by Deputy Director of Clinical Governance and Medical

Appendix A

SAFE CLINICAL HANDOVER

KEY PRINCIPLES FOR SAFE AND EFFECTIVE HANDOVER

Clinical handover is the effective...

"...transfer of professional responsibility and accountability from 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."

- Safe Handover: Safe Patients' guideline (AMA, 2006)
- United Kingdom National Patient Safety Agency (2004)
- The OSSIE Guide to Clinical Handover Improvement – Australian Commission on Safety and Quality in Health Care (2009)

Does your process for clinical handover meet these standard key principles?

1. Leadership

- ☐ Nominate a leader at each clinical handover.

2. Valuing Handover

- ☐ Set the expectation that clinical handover is valued and an essential part of daily work. Ensure staff are available to attend for the handover of all patients relevant to them.

3. Handover Participants

- ☐ Identify and orient handover participants. Involve them in regular review of clinical handover processes.
- ☐ Wherever possible, patients and carers should be recognised and included as handover participants

4. Handover Time

- ☐ Set an agreed time, duration and frequency for clinical handover to occur.
- ☐ **It is highly recommended that, where possible:** strategies are in place to reinforce punctuality

5. Handover Place

- ☐ Set a specific location for clinical handover to occur.

Preferably, clinical handover occurs:

- ☐ Face to face
- ☐ In the patient's presence, where appropriate (bedside handover)

6. Handover Process

- ☐ **Standardised Protocol:** Generate flow charts, scripts and cues for how clinical handover occurs each and every time. Your standard protocol should:
  - ☐ Clearly identify the patient, you and your role
  - ☐ State the immediate clinical situation of the patient
  - ☐ List the most important and recent observations
  - ☐ Provide relevant background/history to the patient's clinical situation
  - ☐ Identify assessments and actions that need to occur
  - ☐ Identify timeframes and requirements for transition of care
  - ☐ Promote the use of the patient record to cross-check information
  - ☐ Ensure documentation of all important findings or changes of condition
  - ☐ Ensure comprehension, acknowledgement and acceptance of responsibility for the patient by the clinician receiving handover

Clinical handover should be documented. Some examples of effective handover tools that aid clinical handover communication and documentation are explained in the implementation toolkit (e.g. ISOBAR, ISBAR, SBAR)

- ☐ **Where the condition of a patient is deteriorating:** Escalate the management of these *patients as soon as a deterioration in condition is detected.*
- ☐ **Other Critical Information:** Prioritise alerts for any other important information (e.g. outstanding actions, planned patient moves, Occupational Health and Safety risks impacting staff or patient safety).

Appendix B – ISBAR 'Introduction, Situation, Background, Assessment, Recommendation'

Note: Used with permission from Hunter New England Local Health District.