Clinical Handover

Purpose and Intent ........................................................................................................................................ 2
Scope and Target Audience ......................................................................................................................... 2
Procedure / process ................................................................................................................................ 2
Governance ................................................................................................................................................ 2
Key Principles for Clinical Handover ........................................................................................................ 2
A. Leadership .................................................................................................................................................. 2
B. Valuing Handover ..................................................................................................................................... 3
C. Handover Participants .............................................................................................................................. 3
D. Handover Time ......................................................................................................................................... 3
E. Handover Place ....................................................................................................................................... 3
F. Patient/Consumer Engagement and Clinical Handover ........................................................................... 3
G. Handover Process ................................................................................................................................... 4
H. Escalation of the Deteriorating Patient/Consumer and Continuity of Care .................................................. 4
I. Other Critical Information ........................................................................................................................ 5

Flexible Standardised Clinical Handover Process ..................................................................................... 5

Clinical Handover and Consumer Engagement .......................................................................................... 5

Workforce Training ..................................................................................................................................... 6

Audit process ................................................................................................................................................ 6

Related Documents .................................................................................................................................... 7

Relevant Standards ....................................................................................................................................... 7

Appendix 1: Key Principles of Clinical Handover ...................................................................................... 8
Appendix 2: ISOBAR .................................................................................................................................... 9
Appendix 3a: Clinical Handover Patient Information Sheet - Adults .......................................................... 10
Appendix 3b: Clinical Handover Patient Information Sheet – Paediatrics .................................................. 12
Appendix 4: Self Assessment of Clinical Handover .................................................................................... 14
Appendix 5: Clinical Handover Observational Audit Tool .......................................................................... 15

AUTHORISATION ......................................................................................................................................... 17
Purpose and Intent

Clinical handover formalises the transfer of professional accountability and responsibility 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 (Australian Commission on Safety and Quality in Health Care, 2011).

Clinical handover is Standard 6 of the National Safety and Quality Health Service Standards (NSQHS). The primary aim of the National Safety and Quality Health Service Standards are to protect the public from harm and to improve the quality of health service provision.

Communication problems are cited as a major contributing factor in up to 70% of hospital sentinel events. Effective clinical handover can reduce communication errors between health professionals and improve patient safety and care.

The intent of this procedure is to compliment Metro North Hospital and Health Service (MNHHS) Policy on Clinical Handover and to provide a localised system of flexible standardised clinical handover for Caboolture and Kilcoy Hospitals. This system will ensure that clinical handover within our organisation is safe, patient centred, minimising clinical error and incidents that delivers positive patient health outcomes.

Scope and Target Audience

This procedure applies to all clinicians practicing in Caboolture and Kilcoy Hospitals, and Woodford Correctional health facility. Clinicians are required to refer to the Work Unit Guidelines in each clinical unit for specific unit clinical handover practices.

Non-clinical staffs also have a key responsibility and accountability as front line staff for ensuring information they receive about the patient from multiple sources is:

- Appropriately managed and accurately transferred in a timely manner to ensure patient safety and continuity of care is maintained
- Communicated and escalated to the treating team and support staff to ensure safe continuity of care
- Communicated to clinicians when they have concerns about a patient’s condition.

Procedure / process

Governance

The governance arrangement for the National Safety and Quality Health Service Standards is the responsibility of the Caboolture and Kilcoy Hospitals, and Woodford Corrections Health Clinical Handover Working Party. The Working Party will monitor performance against the standards and accept accountability to align organisational activity with the organisations objectives.

Key Principles for Clinical Handover

The Key Principles for Safe and Effective Clinical Handover (Appendix 1) include:

A. Leadership

- As the person providing a handover in whatever context, you should have knowledge about the patient you are responsible and accountable for.
- As a minimum requirement the team leader (or equivalent) should have knowledge about every inpatient in the clinical unit. The leader ensures that all participants attend and are heard.
B. Valuing Handover

- Clinical Handover is an essential part of patient care, and is enhanced through staff allocating sufficient time and through using active listening techniques.
- Allow the receiving person the opportunity to clarify information and ask questions pertaining to the care of the patient (re-checking and read-back).
- Use innovative solutions that suit the clinical context and requirements (for example paging, agreed times and locations for handover) and reinforce the importance of attendance and attentiveness.

C. Handover Participants

- Use face to face handover wherever possible.
- Where appropriate, conduct it in the patient’s/carer’s presence and encourage their participation if that is possible (ensuring privacy and confidentiality).

D. Handover Time

- Make 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 patients, carers and families about handover times should they wish to attend.
- Make enough time to complete necessary documentation.

E. Handover Place

- Set the location for clinical handover to occur, make it convenient and free from distractions.
- To ensure patients, consumers, carers and families are able to contribute to the plan of care clinical handover should be conducted at the bedside, unless clinically inappropriate.
- Confidentiality concerns regarding the patient must be considered in the handover process (any information of a sensitive or confidential nature is to be discussed away from the bedside).

F. Patient/Consumer Engagement and Clinical Handover

- Always introduce yourself on each occasion (where appropriate) to the patient/consumer, carer and family.
- Involve the patient/consumer, carer and family in the development of their plan of care.
- Consider the use of a local Patient/Consumer Information Sheet (see Appendix 5 for an example).
- Enable the patient/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 patient/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 patients/consumers, carers or family.
G. Handover Process

- Standardised documentation that expands on each facility’s 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 patient/consumer and/or staff safety issues).

- Do not use taped handover, as it prevents clarification.

- The standard process for handing over clinical information should include:
  - Clearly identify the patient, yourself 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. Caboolture Hospital endorses ISOBAR as the effective handover tools.

H. Escalation of the Deteriorating Patient/Consumer and Continuity of Care

- Clinical handover is closely related to Standard 9: Recognition and Management of the Deteriorating Patient and the National Consensus Statement (ACSQHC). Therefore it is paramount that:
  - ‘At risk/complex’ patients/consumers are prioritised during clinical handover. It is important to ensure an escalation plan for the after-hours care of these patients is in place.
  - Wherever possible nursing staff should attend the medical rounds for high risk patients to facilitate safe, effective communication of the patient condition.
  - If the clinical condition of a patient deteriorates a handover should include escalation of care and management (immediately) according to local procedures.
  - Information about possible deterioration from the patient/consumer, family or carer should be recognised and escalated according to local procedures (Ryan’s Rule).

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

- The clinical team must ensure that ongoing patient/consumer care is able to continue during the handover period. This includes: arrivals of new patients/consumers, especially unstable patients, time specific treatments, unexpected emergencies, toileting and responding to patient call bells.
I. Other Critical Information

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

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

- Clinical handover for inter hospital transfers should follow the standardised clinical handover procedure when transferring a patient from one facility to another. Refer to the Metro North Hospital and Health Services Inter Hospital Transfers Procedure PROC005.

Flexible Standardised Clinical Handover Process

The National Safety and Quality Health Service Standards identify the importance of standardisation to improve patient safety. However, the standardised clinical handover process, minimum data sets of information and participants must be designed and integrated to fit the context of the patient needs and participating clinicians.

Minimum data set for each unit in relation to Clinical Handover should include:

- The purpose of the handover and information they are required to know and handover

- The local method and structure format for the clinical handover which must include:
  - What time the handover will occur, that is, whenever there is a change of responsibility and accountability
  - Who is responsible to lead the handover, and each participants role
  - Where the handover will occur. The organisation expects that handover will occur at the bedside unless deemed inappropriate for specific patient circumstances
  - The method of handover e.g. face to face, telephone, electronic device

- The Key Principles of Clinical Handover (Appendix 1)

- The agreed tool to structure the handover. ISOBAR (Appendix 2) has been endorsed as the tool for use throughout the organisation to assist in the exchange of information and to improve communication.

- Patient engagement and education. A patient advice sheet is available for use in the clinical units/wards (Appendix 3)

Clinical Handover and Consumer Engagement

The consumer should be involved in the clinical handover process, and the following should be taken into consideration throughout the handover:

- If the patient requests that the clinical handover does not occur at their bedside (especially in shared rooms, this request should be respected).

- Involve the patient, carer and family in the development of their plan of care

- Enable the patient, carer and family to ask any questions or make comment about their plan of care
• Always introduce yourself to the patient, carer and family
• Do not use jargon, abbreviated words or phrases
• Check information with patient, 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 educational opportunities for patients, carer or family
• Consideration be given to confirming if the patient can hear you clearly

Workforce Training

All staff will be informed and provided with information related to Clinical Handover that is relevant to their designated work area. This must cover key principles of Clinical Handover as well as area-specific Clinical Handover processes, including scripts, flowcharts and local tools in use.

During orientation programs, all staff will be informed and provided with information related to Clinical Handover. Within clinical units new staff will be orientated in the clinical handover process unique to that area including identification of team leaders and Medical Emergency Team (MET) criteria.

The training should also include: seven high risk areas for Clinical Handover which are as follows:

• Escalation of the deteriorating patient
• Patient transfers to another ward/clinical unit
• Shift to shift change over
• Patient transfer for a test or appointment
• Patient transfer to another facility
• Multidisciplinary team handover
• Patient transfer to and from the community

i-Learn Education is available for staff on Clinical Handover at the Bedside.

Audit process

Each clinical unit will be required to monitor performance against the standards and provide feedback to the Clinical Handover Committee via their respective unit/ward clinical management structures e.g. Service Improvement Group. The Clinical Handover Committee may facilitate audits on global issues in order to monitor facility performance.

A variety of tools have been developed, however utilising the principles of flexible standardisation the clinical unit may self-determine how to audit clinical handover and what relevant aspects of clinical care on which to focus. The focus of the audit may change to identify, for example, on trends in PRIME CI or complaints issues.

The following Clinical Handover tools will be used for the purposes of audit:

• Clinical Handover Self-Assessment Tool (Appendix 4)
• Clinical Handover Observational Tool (Appendix 5)

For Inpatient Unit’s a set number of audits are also required through the clinical weekly audit program documented in the Audit Procedure and Audit Schedule.
Related Documents

- Queensland Health Clinical Handover Policy
- Queensland Health Clinical Handover Guideline
- Queensland Health Clinical Handover Implementation Standard
- Australian Commission on Safety and Quality in Healthcare (ACSQHC) Implementation Toolkit for Clinical Handover Improvement 2011
- Australian Commission on Safety and Quality in Health Care (ACSQHC) National Consensus Statement – Essential Elements for Recognising & Responding to Clinical Deterioration
- Department of Health Clinical Handover at the bedside brochure
- National Safety and Quality Health Service Standard 6 Clinical Handover – Facility Audit Tool
- National Safety and Quality Health Service Standard 6 Clinical Handover – Shift to Shift & Patient Audit Tool
- National Safety and Quality Health Service Standard 6 Clinical Handover – Ward/Unit Audit Tool
- NSW Health Clinical Handover Implementation toolkit 2009
- NSW Health Hunter New England Local Health Service District, Quality Matters Newsletter – Clinical Governance: Providing Quality, safe and excellence (June 2012)
- OSSIE Guide to Clinical Handover Improvement (ACSQHC)
- Patient Safety Unit – Ryan’s Rule Staff Information Sheet
- Sydney South West Area Health Service (SSWAHS) – NSW Health Clinical Handover Guideline (October 2007)
- The Medical Journal of Australia – ISOBAR – a concept and handover check list: the National Clinical Handover Initiative
- Health Service Directive – Patient Safety
- Health Service Directive – Guideline for Clinical Incident Management
- MNHHS Clinical Incident Management Procedure

Relevant Standards

- National Safety and Quality Health Service Standards: Standard 1 – Governance for Safety and Quality in Health Service Organisations
- National Safety and Quality Health Service Standards: Standard 2 – Partnering with Consumers
- National Safety and Quality Health Service Standards: Standard 5 – Patient Identification and Procedure Matching
- National Safety and Quality Health Service Standards: Standard 6 – Clinical Handover
- National Safety and Quality Health Service Standards: Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Healthcare
Appendix 1: Key Principles of Clinical Handover

**Note:** At Caboolture and Kilcoy Hospitals the preferred tool used to conduct Clinical Handover is ISOBAR (see Appendix 2).

---

**Key Principles of Clinical Handover**

Clinical handover formalises the transfer of professional accountability and responsibility 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 (Australian Commission on Safety and Quality in Health Care, 2011).

The following are the key principles of a safe and effective clinical handover:

<table>
<thead>
<tr>
<th>1. Leadership</th>
<th>6. Handover Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>A leader is nominated at each Clinical Handover</td>
<td>A standardised protocol is used each and every time Handover occurs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Valuing Handover</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is clearly identified – three forms of identification</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Handover participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff are available to attend for all patients relevant for them</td>
<td>Staff name and their role is provided</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Handover Time</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned start time, duration and frequency occurred</td>
<td>Patient record is used to cross check information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Handover Location</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A specific location was set for Handover</td>
<td>Comprehension, acknowledgement and acceptance of responsibility for the patient by clinician receiving handover occurred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Handover was Face to Face</th>
<th>An effective communication aid e.g. SBAR, ISOBAR is utilised</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Handover was via telephone</th>
<th>Written handover lists are used as required</th>
</tr>
</thead>
</table>

| Handover occurred by the bedside with the patient where appropriate | Where the condition of a patient is deteriorating; the management of these patients is escalated as soon as a deterioration in condition is detected |
## Appendix 2: ISOBAR

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Appendix 2 - ISOBAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Identify</td>
<td>Introduce yourself and your patient (3 identifiers) check ID band for name, DOB and URN</td>
</tr>
<tr>
<td>S</td>
<td>Situation</td>
<td>This step includes the patient’s current clinical status (e.g. stable, deteriorating, improving), advanced directives and patient-centred care requirements including the prospect of discharge or transfer</td>
</tr>
<tr>
<td>O</td>
<td>Observation</td>
<td>This step ensures the incoming team is informed of the latest observations of the patient and when they were taken. It serves as a checking mechanism to identify deteriorating patients for emergency response assistance. Unit members need to be aware of local MET criteria</td>
</tr>
<tr>
<td>B</td>
<td>Background and History</td>
<td>This step provides the incoming team with a summary of background; history (the presenting problem, background problems and current issues); evaluation (physical examination findings, investigation findings and current diagnosis); as well as management to date and whether it is working.</td>
</tr>
<tr>
<td>A</td>
<td>Assessment and Actions</td>
<td>This step is to ensure that all tasks and abnormal or ending results are clearly communicated. Most importantly, there must be an established and agreed management and escalation of care plan, which could include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● A shared understanding of what conditions are being treated or, if the diagnosis is not known, clear communication of this fact to everyone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Tasks to be completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Abnormal or pending results (must include recommendations and the agreed plan and who to call if there is a problem)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● A plan for communication to the senior in charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Clear accountability for actions.</td>
</tr>
<tr>
<td>R</td>
<td>Responsibility and Risk Management</td>
<td>Clinical handover must include the transfer of responsibility as staff are leaving the institution. This can only be achieved through acceptance of tasks by the incoming team, which is best ensured by face-to-face handover. Where risks are identified for a patient, clinical risk management strategies (such as for infectious disease alerts or alerts for DVT prophylaxis) should be clearly communicated. Responsibility transfer and task acceptance ideally includes accepting handover sheets or signing of handover sheets.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Read back of critical information is helpful, especially in situations where face-to-face handover is not possible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risks and management plans should be included in handover when required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Staff should not accept responsibility until handover complete and willing to accept accountability</strong></td>
</tr>
</tbody>
</table>
Appendix 3a: Clinical Handover Patient Information Sheet - Adults

What is clinical handover at the bedside?

Various staff will be involved in your care at different points in time.

Clinical handover is the sharing of information about you (the patient), between on-duty staff and the staff who will take over your care.

Performing the clinical handover at your bedside involves you in your care and allows staff to discuss and ensure care continues as planned. Clinical handover can occur between nurses, doctors and other health professionals.

Why is clinical handover important?

Clinical handover is necessary to help keep you safe. It ensures that important information about your care and medical condition is accurately passed on between staff. For example from the nursing shift going off duty to the nursing shift coming on duty.

Want to know more?

Please talk to your on-duty nurse or other healthcare professional.

More information about clinical handover can be found in the following publications:
- Implementation Toolkit for Clinical Handover Improvement
- National Safety and Quality Health Service Standards
- OSSIE Guide to Clinical Handover Improvement
- Australian Charter of Healthcare Rights.

All of the above publications can be found at the Australian Commission on Safety and Quality in Health Care website at www.safetyandquality.gov.au

To provide feedback or a compliment, or to make a complaint, please contact hospital staff.
What happens during clinical handover at the bedside?

During clinical handover, you will be introduced to staff taking over responsibility for your care. Information shared may include:
- your medical history
- your current clinical condition
- tests and procedures that you have had or that are scheduled
- your need for assistance with everyday tasks, such as showering and toileting
- plans for your discharge, even if it is a few days away.

The staff will review your bedside chart(s) together. You may be asked to provide feedback and clarification regarding your medical care.

Staff will use discretion when discussing sensitive information.

Why is my involvement in clinical handover at the bedside important?

Research indicates that patients who are involved in their care, are more likely to have better health outcomes.

If you prefer, ask a friend or family member to advocate on your behalf to ensure you have the necessary information to make informed decisions and choices about your care.

How can I be involved in the handover of my care?

As a patient, you have the right to speak up, ask questions or raise concerns about your care:
- during clinical handover at the bedside
- if you feel a mistake has been made
- if anything is unclear or requires clarification
- if you are unsure of your rights (you should have received a copy of the Australian Charter of Healthcare Rights when you were admitted)
- if something is culturally important to you
- to help staff better understand your needs.

If you do not wish to be involved in the clinical handover please advise the staff on duty and your decision will be respected.

Appendix 3b: Clinical Handover Patient Information Sheet – Paediatrics

Why is my involvement in clinical handover at the bedside important?

Research indicates that children, whose parents/carers are involved in their care, are more likely to have better health outcomes.

If you prefer, ask a friend or other family member to advocate on your child’s behalf to ensure you have the necessary information to make informed choices about their care.

Want to know more?

Please talk to your on-duty nurse or other healthcare professional.

More information about clinical handover can be found in the following publications:
• Implementation Toolkit for Clinical Handover Improvement
• National Safety and Quality Health Service Standards
• OSSIE Guide to Clinical Handover Improvement
• Australian Charter of Healthcare Rights.

All of the above publications can be found at the Australian Commission on Safety and Quality in Health Care website at www.safetyandquality.gov.au.

To provide feedback or a compliment, or to make a complaint, please contact hospital staff.

Why is clinical handover important?

Clinical handover is necessary to help keep your child safe. It ensures that important information about your child’s care and medical condition is accurately passed on between staff. For example from the nursing shift going off duty to the nursing shift coming on duty.

For further information please contact:

Clinical handover at the bedside

for all parents, families and carers.

Involving parents and carers as partners in their children’s care, a new era in healthcare.
What is clinical handover at the bedside?

Various staff will be involved in the care of your child at different points in time.

Clinical handover is the sharing of information about your child between on-duty staff and the staff who will take over the care of your child.

Performing the clinical handover at your child’s bedside involves you in their care and allows staff to discuss and ensure care continues as planned. Clinical handover can occur between nurses, doctors and other health professionals.

What happens during clinical handover at the bedside?

During clinical handover, you will be introduced to staff taking over responsibility for your child’s care. Information which may be shared, includes your child’s:

- medical history
- current clinical condition
- tests and procedures
- need for assistance with everyday tasks, such as showering and toiletting
- plan for the day (e.g. sleep times)
- plans for discharge, even if it is a few days away.

The staff will review your child’s bedside chart(s) together.

You may be asked to provide feedback and clarification regarding medical care.

Staff will use discretion when discussing sensitive information.

How can I be involved in the handover of my child’s care?

As a parent/carer, you do have the right to be involved in the care of your child.

- During clinical handover at the bedside, be sure to speak up if you have questions or concerns.
- Do not be afraid to tell the staff if you feel a mistake has been made.
- If anything is unclear, tell the staff at handover and request clarification.
- Know your rights. Upon admission you should have received a copy of the Australian Charter of Healthcare Rights.
- Tell staff what is important to you so they better understand your child’s needs.

If you do not wish to be involved in the clinical handover please advise the staff on duty and your decision will be respected.

Appendix 4: Self Assessment of Clinical Handover

Thank you for completing this audit tool. Please apply the tool once only to each and individual type of clinical handover, for example shift to shift handover, MDT handover, referral meetings and Individual patient handovers. This tool can be completed by anyone involved in the audit as well as an observer.

NAME OF ASSESSOR:…………………………………………………………………………………………

TYPE OF HANDOVER ASSESSED:…………………………………………………………………………

DATE AND TIME OF ASSESSMENT: ………………………………………………………………………

<table>
<thead>
<tr>
<th>1. Leadership</th>
<th>6. Handover Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>A leader is nominated at each Clinical Handover</td>
<td>A standardised protocol is used each and every time Handover occurs</td>
</tr>
<tr>
<td>2. Valuing Handover</td>
<td></td>
</tr>
<tr>
<td>Staff are available to attend for all patients relevant for them</td>
<td>Staff name and their role is provided</td>
</tr>
<tr>
<td>3. Handover participants</td>
<td></td>
</tr>
<tr>
<td>Participants are identified and orientated</td>
<td>Relevant background/history of patient’s clinical condition is provided</td>
</tr>
<tr>
<td>Participants are regularly involved in a review of Handover processes</td>
<td>Alerts are identified</td>
</tr>
<tr>
<td>Participants and carers are involved in Handover</td>
<td>Assessments and actions identified</td>
</tr>
<tr>
<td>Participants are punctual to planned Handover</td>
<td>Most important and recent observations noted e.g. ADDS score</td>
</tr>
</tbody>
</table>

| 4. Handover Time | |
| Planned start time, duration and frequency occurred | Patient record is used to cross check information |

| 5. Handover Location | |
| A specific location was set for Handover | Comprehension, acknowledgement and acceptance of responsibility for the patient by clinician receiving handover occurred |
| Handover was Face to Face | An effective communication aid e.g. SBAR, ISOBAR is utilised |
| Handover was via telephone | Written handover lists are used as required |

| Handover occurred by the bedside with the patient where appropriate | Where the condition of a patient is deteriorating: the management of these patients is escalated as soon as a deterioration in condition is detected |
### Appendix 5: Clinical Handover Observational Audit Tool

**Ward/Unit/Department Audit tool:** For EACH clinical handover (CH) observation opportunity, please complete the Audit tool questions that are applicable to your specific area and return to the Clinical Handover Portfolio holder in your area and or your areas Safety and Quality Officer. Minimum one every 3 months.

<table>
<thead>
<tr>
<th>CH Date: / /</th>
<th>CH Time: __ <strong>:</strong> __</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditor Position:</td>
<td>Auditor Name:</td>
</tr>
</tbody>
</table>

**Identified High Risk Area (7):**

If “Transfer”

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>T/F Form</td>
</tr>
<tr>
<td>Bookings</td>
<td>Face to face</td>
</tr>
</tbody>
</table>

**Location Type:**

- Inpatient
- Outpatient
- Day Procedure

**Ward/Area/Depart:**

### Leadership

1.1 Is there an obvious clinical leader for this patient handover?  [ ] Yes  [ ] No

### Valuing Handover

2.1 Are interruptions kept to a minimum during the handover?  [ ] Yes  [ ] No

### Handover Participants

3.1 Are all key participants available for handover?  [ ] Yes  [ ] No

3.2 Did the handover take place in the patients/carers presence?  [ ] Yes  [ ] No  [ ] N/A  [ ] Unable

#### Consumer – If the patient is sedated and no family present go to Q 4.1

3.3 Has the patient/carer been given the opportunity to be involved/clarify information or ask questions?  [ ] Yes  [ ] No  [ ] Unable

3.4 Did the patient ask questions?  [ ] Yes  [ ] No  [ ] Unable

3.5 Has the patient or family/carer identified any variances (issues)?  [ ] Yes  [ ] No

3.6 If yes, was the variances documented, escalated?  [ ] Yes  [ ] No  [ ] N/A

### Handover Time

4.1 Do participants arrive on time?  [ ] Yes  [ ] No  [ ] N/A

4.2 Do participants complete all of their patients for handover?  [ ] Yes  [ ] No  [ ] N/A

### Handover Place

5.1 Where does handover take place?

- [ ] Bedside
- [ ] Nurses Station
- [ ] Out of Ward
- [ ] Ward Corridor
- [ ] Staff Tearoom
- [ ] Other ..........................................................

### Handover Process – Standardised Protocol (SBAR Minimum Data Set, Checklist)

6.1 Is a handover tool used or followed? If yes, name tool

- [ ] SBAR, ISBAR, ISOBAR, SHARED, MDS (Minimum Data Set)
- [ ] Assessment forms, Care record/plan, Pathways
- [ ] Checklists
- [ ] Profile form, Transfer Form
- [ ] Handover Sheet
- [ ] IT (Pt Flow Manager)
- [ ] Referral Forms
- [ ] Other ..........................................................

- [ ] No

6.2 Is the patient, staff member and their role identified at the beginning of CH?  [ ] Yes  [ ] No

6.3 Does the staff member providing handover identify the patient using the pt’s full name, UR and DOB (3 core identifiers)? OPD may use address instead of UR.  [ ] Yes  [ ] No
### Procedure: Clinical Handover

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Options</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.4</td>
<td>Please indicate information source.</td>
<td>- ID band</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Photo</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient or Carer</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient address (OPD)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- CIMHA</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- HBCIS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- OSIM</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Other IT Systems</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Accompanying-Documentation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6.5</td>
<td>Is this handover related to an invasive procedure?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.6</td>
<td>If yes, was the staff member observed using the Procedure Matching Process or WHO Safety Surgical checklist (operative) for identification of the correct patient, procedure, and side/site of procedure?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.7</td>
<td>Was this documented?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.8</td>
<td>Has the immediate clinical situation of the patient been handed over?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.9</td>
<td>Has the person handing over included the most recent observations or relevant assessments, i.e. Peri operative record, ADLs, mobility, cognition etc?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.10</td>
<td>Does the Handover identify the assessments and actions that need to occur?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.11</td>
<td>Have timeframes and requirements for transition of care been handed over?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.12</td>
<td>Has the presenting problem with background history and current issues been handed over?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.13</td>
<td>Is the patient’s resuscitation status (Acute Resuscitation Plan or Advance Health Directive) been handed over?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.14</td>
<td>Have both staff (deliverer and receiver of handover) cross checked information with relevant documentation ie; Notes, MERT Criteria, Medications etc</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.15</td>
<td>Has the relevant information been documented? E.g. Consent, Medical notes PRA/ Care record, Medication sheet/MAP, Observation chart with MERT criteria</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.16</td>
<td>Did staff have the opportunity to ask questions to clarify the information that has been provided to ensure understanding and acceptance of responsibility?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6.17</td>
<td>Is an Environment/Safety Scan conducted during the handover process? E.g. IDC check, attachments, lines, O2, SCDs, Sats monitoring, fluid Mx etc</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Deteriorating Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.1</td>
<td>If the patient is demonstrating signs of clinical deterioration, has a plan of care been handed over to respond to this clinical deterioration? E.g. If (X) happens, then call (Y) because this patient will need (Z) to occur.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes what is the plan?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Current MERT Criteria</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Clinical Review</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- ARP in place/required</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Other Critical Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.1</td>
<td>Did you observe critical information specific to the patient being handed over? E.g. test results, bed moves, cognition, allergies, transport, behavioural etc</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>8.2</td>
<td>Are patients’ cultural/ religious beliefs/ interpreter needs identified/ reported during the handover process?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>8.3</td>
<td>Is patients privacy maintained and information discussed in a professional manner?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

002554 Version No: 02 Effective date: 05/2017 Review date: 05/2020 Printed versions are uncontrolled.
Document History

<table>
<thead>
<tr>
<th>Custodian</th>
<th>Deputy Director of Medical Services, Caboolture Hospital, Metro North HHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk rating</td>
<td>Medium</td>
</tr>
<tr>
<td>Compliance evaluation and audit</td>
<td>Annual completion, evaluation and implementation of improvements based on</td>
</tr>
<tr>
<td></td>
<td>• Clinical Handover Self-Assessment Tool</td>
</tr>
<tr>
<td></td>
<td>• Clinical Handover Observational Tool</td>
</tr>
<tr>
<td>Replaces Document/s</td>
<td>RCKHS0865 Clinical Handover Procedure – Redcliffe / Caboolture and Kilcoy Hospitals</td>
</tr>
<tr>
<td>Document replaced</td>
<td>July 2016</td>
</tr>
<tr>
<td>Key stakeholders</td>
<td>• Caboolture, Kilcoy and Woodford Corrections Health Executive</td>
</tr>
<tr>
<td></td>
<td>• Clinical Handover Working Party</td>
</tr>
<tr>
<td>Marketing Strategy</td>
<td>Hospital wide email from approving authority including monthly reporting in newsletter to staff</td>
</tr>
<tr>
<td>Key words</td>
<td>RCKHS0865, Clinical Handover, ISOBAR, Patient engagement, Minimum Data Set, Standard 6; 002554</td>
</tr>
</tbody>
</table>

AUTHORISATION

Signature                               Date

Dr Anand Choudhary
Deputy Director of Medical Services and Chair of Clinical Handover Committee, Caboolture and Kilcoy Hospitals, Metro North Hospital and Health Service

Signature                               Date

Dr Lance Le Ray
Executive Director – Caboolture, Kilcoy and Woodford Corrections Health

The signed version is retained by the Service Improvement Unit.