



CLINICAL PRACTICE GUIDELINE

Clinical Handover

This document should be read in conjunction with the [Disclaimer](#)

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Definition

Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

Aims

- The standardisation of handover processes, as part of a comprehensive, system-wide strategy to ensure timely, effective, concise and inclusive clinical communications.
- To ensure continuity of patient care by effective clinical communication between departments and wards. .
- To guide effective clinical handover between midwifery and nursing staff at KEMH.
- To guide effective clinical handover between medical teams, particularly of newly admitted patients and “patients of concern.”

Diagnostic Imaging (DI) department – in hours Mon-Fri 8am-5pm

DI incorporates MRI, Radiology and Ultrasound Departments.

Patients who do NOT require handover

- Patients that are clinically stable and not requiring a nurse escort may be brought from the ward by the PCA or present independently to the Imaging Department, provided the request form has been signed by the requesting medical officer and the midwifery/nurse shift coordinator states on request form that no clinical handover is required.
- Patients with a midwife/nurse escort who remains with the patient in the department **do not** require a clinical handover.
- Correct patient identification and procedure matching protocols must be carried out (see patient ID and procedure matching guidelines).
- Once the imaging procedure has been completed and if the patient remains clinically stable the patient is returned to the ward with the PCA by chair or trolley, if non-ambulant.

Nurse escort and face to face handover required: Specific situations

The following situations **require nurse escort and face to face** clinical handover to the midwife / nurse:

- All patients requiring oxygen therapy.
- All patients with drains in situ.

- Patients that are experiencing regular painful uterine contractions at the time of the transfer.
- All neonates require a nurse/ midwife escort.
- All ambulance transfer patients admitted directly to the Imaging department.
- All patients requiring transfer to and from Adult Special Care.
- All patients with intravenous therapy in progress or those booked for interventional procedures.
- Patients requiring IV antibiotics should not come to the department until the administration is completed.
- All patients that have received opioid medication on the day of planned imaging who **do not fall** into the reportable levels of sedation and respiration rate as indicated on the KEMH M -ORC or A –ORC charts and the intravenous PCA chart. At handover the nurse / midwife accompanying the patient to the DI department must include the medication given, time and route of administration, the most recent sedation score and respiratory rate and if applicable details of any current oxygen therapy and pulse oximetry monitoring and plan for ongoing monitoring.
- The midwife /Nurse escort must bring all documentation supporting handover including medical notes, observation charts, medication charts and IV therapy orders.
- .
- If appropriate the nurse/midwife escort may return to ward/dept following Clinical Handover.

Procedure for patients requiring a clinical handover

- Identify the patient and procedure according to Diagnostic Imaging Department patient ID and procedure matching policy.
- Use the standardised mnemonic as a guide for Clinical Handover :
 - **I** IDENTIFY Introduce yourself and your patients
 - **S** SITUATION Admission diagnosis, current situation & status, the reason the patient is in the department
 - **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
- Document in the Inpatient Progress Notes, using the DI Clinical Handover sticker. Imaging midwives/nurses are to sign that they have received handover.
- Clinical handover must take place on transferring the patient back to the ward or other department with documentation signed by Imaging staff that handover to the area has occurred.
- Documentation of handover includes:
 - Date & time of handover

- Signature of midwife / nurse handing over care
- Signature of midwife / nurse accepting responsibility for care
- Completion of the DI Clinical Handover sticker in the Inpatient Progress notes (MR 250) or a written entry with all the details as above.

Clinical deterioration in Diagnostic Imaging

- The sonographer, radiographer or Medical Imaging Technologist (MIT) performing the imaging procedure shall notify the Registered Midwives/Nurse on duty.
- Immediate midwifery / nursing and medical care will be undertaken and the departmental RMO notified.
- Record a full set of vital signs on the appropriate observation and response chart and action as required.
- Notify the ward/clinical area and a RMO/RM/RN must escort the patient back and provide an appropriate clinical handover using iSoBAR guidelines, to the receiving area/ ward.

Medical handover: Diagnostic Imaging to Ward- Patient transfer

- Handover will be as per the iSoBAR mnemonic.
- The DI Resident shall verbally hand over the care of the patient to a member of the obstetric/gynae/medical team accepting responsibility for care of the patient (may be Team Resident, Team Registrar, Team Senior Registrar or Team Consultant).

Diagnostic Imaging department – out of hours

- A nurse is required to escort **and stay** with a patient attending the imaging department out of hours for **all Radiology and Ultrasound** examinations.
- MRI does not currently offer an out of hours service.

Emergency Centre (EC)

EC midwifery / nursing shift to shift

1. Ensure EDIS is current & complete prior to handover.
2. Handover should start on time – encourages punctuality, does not delay other staff and is an effective use of time.
3. The computer in the office 'nook' away from the main desk is to be used to guide handover –this is preferred for patient confidentiality.
4. All oncoming staff receive handover of all patients. Best practice is the nurse responsible for the patient's care should handover care to the nurse who will be providing care.
5. Use of iSoBAR mnemonic is mandatory.
6. Bedside component:
 - The handover may occur at computer – ease of access to info on EDIS
 - The handover sheet is not required

- It must include introduction of staff/patient as an absolute minimum (exceptions – e.g. patient asleep)
7. The Patient Safety Check includes:
 - Checking of the patient – including monitors, IV, IDC – this does not include additional observations beyond what is considered clinically appropriate nor does it mean you have to wake patient to check on them.
 - Checking of the observations (appropriate frequency, review required MR021)
 - Checking of the completeness of the Emergency Centre Assessment form (MR021).
 8. Documentation includes:
 - The date and time of handover
 - The signature of the nurse handing over care
 - The signature of the nurse accepting responsibility for care
 - The co-ordinator will accept responsibility for care while there is no allocation of the patients to individual nurses.
 - Completing the EC Clinical Handover section on Emergency Centre Assessment (MR021) form.

EC to Day Surgery Unit (DSU): Transfer

- The decision is made that a patient requires admission and direct transfer from EC to DSU.
- The EC co-ordinator contacts the DSU co-ordinator on speed dial 6455 and informs them of the transfer. Clinical handover occurs using the iSoBAR format.
- The patient shall be transferred at a time agreed between the co-ordinators.
- The mode of transportation shall be a clinical decision made by the staff in EC caring for the patient. Patients that require a bed or wheelchair transfer shall be escorted to DSU by either an EC or DSU midwife / nurse. This transfer process shall be a mutual agreement between both clinical areas.
- If the patient's medical condition is assessed as being suitable for transfer to DSU without an escort, this may occur.
- All patients transferred from EC to DSU without an escort must have a completed Intra-hospital Transfer Summary – Clinical Handover MR 208.50. When a patient is escorted to DSU from EC a face to face handover shall be given using the ISoBAR format.

EC to Ward 6: Transfer of patients

1. The process is as per Bed Booking System Emergency Centre (EC) to Ward 6 which includes:
 - The EC nurse entering all relevant patient information, including diagnosis onto the Enterprise Bed Management System (EBMS)

- The ward nurse allocated to care for the patient checking the patient information on the EBMS.
2. Ensure all documentation of clinical care is complete, including:
 - Emergency Centre Assessment (MR 021)
 - Medication Chart (MR 810.05)
 - Adult Observation Response Chart (MR285.02) - if medical review is required pre-transfer this must occur.
 3. **All** patients requiring transfer from EC to Ward 6 will be accompanied by a nurse from EC (preferably the nurse responsible for the patient's care)
 4. On arrival there must be a check of patient identity which involves:
 - asking the patient to state their full name, date of birth and address
 - checking against the details on patient ID band
 - if patient is unable to give this information and has had their identity confirmed on admission, then the details on the ID band will be checked by two nurses, one of whom must be the EC nurse
 5. Once the patient is settled into bed the handover must occur:
 - between the EC and ward nurse (face-to-face handover)
 - at the bedside
 - involving the patient and/or carer
 - as per iSoBAR mnemonic (mandatory)
 6. Before the EC nurse leaves the patient both nurses must complete a Patient Safety Check which includes:
 - Check of patient – includes “drains in/ drains out” monitors, IV, IDC
 - Check of observations (MR021)
 - Check of Medication Chart (MR 810.05)
 7. Documentation of handover includes:
 - Date & time of handover
 - Signature of nurse handing over care
 - Signature of nurse accepting responsibility for care
 - The EC Clinical Handover stamp may be used in the Inpatient Progress notes (MR 250) or a written entry with all the details as above.

Medical handover: Consultant-led in EC

Key points

1. **Time(s)** for Consultant led handover: 09:00 and 13:00 Monday to Fridays and at 10:00 on Saturday, Sundays and public holidays. Telephonic handover at 12:30 & 17:00.
2. **Venue/location:** At the nurses' station in the Emergency Centre (EC).
3. **Key people to attend handover:** Consultant rostered for gynaecology, EC Registrar, EC Resident and Nursing Shift Coordinator
4. **Leadership of handover:** Consultant rostered for gynaecology.

5. **Consultant role:** To lead the handover process.
6. **Principles of handover:** as per the WA Health Clinical Handover Policy (November 2013) and WNHS Clinical Handover Policy. This includes use of the iSoBAR mnemonic.
7. **Key information at handover round:** apart from patient information, includes information such as planning for the day, staffing levels and experience, competing responsibilities, new policies, audits, etc.
8. **Documentation of handover:** In the patient's clinical record. A 'Clinical handover stamp' is available. A Consultant telephone handover register is to be securely maintained in EC.
9. **Where handover documents are archived:** A record of attendances will be stored securely in EC.

Procedure

Monday - Friday

1. During the weekdays (Monday to Friday) the rostered Gynaecology Consultant will be physically present along with the team of doctors on call for gynaecology and the nursing shift coordinator at 09:00.
2. The outgoing Consultant for the morning session will ring the incoming Consultant at 12.30 to telephonically handover care. This will be recorded in the Consultant telephone handover register securely maintained in EC.
3. The incoming Consultant will be physically present along with the team of doctors on call for gynaecology and the nursing shift coordinator at 13:00.
4. The outgoing Consultant for the afternoon session will do an informal round with the EC Registrar and the nursing coordinator between 16.30 and 17.00 and will ring the incoming Consultant for the evening/night at 17:00.
5. The incoming Consultant need not be physically present for the 17:00 handover if off campus. A telephonic handover by the outgoing Consultant to the incoming Consultant is acceptable. This should be recorded in the Consultant telephone handover register, securely maintained in EC.

During the weekends and public holidays

1. The rostered Gynaecology Consultant will be physically present along with the team of doctors on call for gynaecology and the nursing shift coordinator at 10:00.
2. The outgoing EC Registrar will do an EC ward round with the EC Resident and the Nursing Coordinator between 16.30 and 17.00 and will ring the Senior Registrar and the Consultant to keep them updated.
3. The clinical handover will be recorded in the patient chart. A stamp 'Clinical Handover' may be used in the patient's clinical records.

Compliance with this procedure will be monitored through three monthly audits (as per the WNHS NSQHS Audit Framework and the results will be communicated to the relevant staff.

Medical handover: EC to Ward: Patient transfer

1. Handover will be as per the iSoBAR mnemonic.
2. The EC Resident shall discuss any patient that merits admission with the Registrar, Senior Registrar or Consultant responsible for EC before arranging for admission of the patient to the ward.
3. In-hours the EC Resident shall verbally hand over the care of the admitted patient to a member of the medical team accepting responsibility for care of the patient (may be Team Resident, Team Registrar, Team Senior Registrar or Team Consultant).
4. **After-hours** the EC Resident shall verbally hand over the care of the admitted patient to the Resident covering the wards.
5. For patients admitted overnight, the admitting EC Resident will contact the respective Team Resident, Registrar, Senior Registrar or Consultant the following morning between 07:30 and 08:00 and provide a verbal handover.
6. The admitting doctor will also enter the patient's details in the Clinical Handover Register as a record that handover has occurred. This register is maintained in EC.

Compliance with this process will be monitored through three monthly audits (as per the WNHS NSQHS Audit Framework 2014) and the results will be communicated to relevant staff.

Medical handover: Gynaecology patients- After hours

Monday – Friday: Wards

- The after-hours EC Resident arrives at 1600hours and assists the EC Registrar.
- At 1645 hours the Resident from each team that has Ward 6 or gynaecology patients meets in the EC tearoom to provide a brief clinical handover to the after-hours EC Resident.
- The handover sheet to be used at this meeting is the iCM report. The attendees and the time of the meeting shall be documented on the handover sheet.
- The after-hours EC resident contacts the night EC Resident between 2000 and 2400 hours and provides clinical handover to them. This handover shall be recorded on the handover sheet.
- Significant events occurring overnight on the wards shall be handed over to the oncoming teams by the night Registrar (Integrated Training Program- ITP 3 or 4).
- The annotated handover sheet shall be filed in EC for audit purposes.
- The morning ward round documentation shall include a reference to clinical handover having occurred and the information provided e.g. “no significant events per clinical handover” or “clinical handover received on hypertensive episode from Dr X.”
- Every morning, ward round entry in the medical notes shall either have “CH” written in the margin or a handover sticker.

Monday – Friday: ASCU or other patients of concern

- The in hours team Registrar or Senior Registrar shall review all patients of concern prior to leaving the hospital.
- A team representative shall be present in ASCU at 1715 hours to review their patients of concern with the oncoming night Senior Registrar.
- An entry shall be made in the medical notes to indicate that this has occurred. If there has been Consultant notification this should also be indicated in the medical notes. ‘CH’ or a handover sticker should be placed in the margin beside the entry.
- In the morning, the night or Senior Registrar shall contact the Registrar or Senior Registrar of the primary team with any relevant events. This information may be relayed per phone and then documented in the patient’s notes MR 250 via the blue sticker available in ASCU. The blue ASCU GP notification form is also to be completed and filed under the correspondence section of the patient’s notes.
- Morning documentation in the medical notes shall include an entry that indicates that handover has occurred and the information that was provided e.g. “no significant events per clinical handover” or “clinical handover received from Dr X on hypotensive episode”.

Saturday – Sunday: EC & Ward 6 patients (EC Residents & Registrars)

- **0800:** Night Resident to EC Registrar and Resident. Using EDIS discuss the EC patients and then use the iCM handover tool to discuss the ward 6 patients.
- **1000:** The EC Registrar provides a clinical handover of the EC and Ward 6 patients to the EC Consultant.
- **1800 or 2000:** Clinical handover shall occur between the EC Registrar and night Resident. This includes:
 - An EDIS clinical handover by the EC Registrar to the EC nursing co-ordinator and night Resident.
 - An iCM clinical handover of Ward 6 patients by the EC Registrar to the night Resident.
 - A telephone call to the Senior Registrar and EC consultant to advise of any current patients of concern in EC or Ward 6.

Saturday – Sunday: ASCU or other patients of concern

- The Senior Registrar presents to oncoming Registrars at the end of the 9:30pm Labour ward (LW) ASCU rounds on Friday, Saturday and Sunday evening.
- The outgoing Senior Registrar presents patients to the oncoming Senior Registrar on Saturday and Sunday morning at the end of the LW ASCU round.
- Morning documentation on ASCU patients should include a CH in the margin and a reference to clinical handover, i.e. “clinical handover from Dr. X to Dr. Y”.

MFAU: Midwifery shift to shift

1. The outgoing shift ensures OB Trace Vue chalkboard (patient list) is current - all the information is relevant, complete & current. The triage midwife has overall responsibility for the chalkboard but all staff are responsible for keeping the triage midwife well-informed and updating OB Trace Vue.
2. The outgoing L&BS shift coordinator (in liaison with the outgoing triage midwife) allocates for the oncoming staff. There will be occasions where the allocation will need to be changed.
3. The oncoming staff assembles in L&BS Midwives Tearoom.
4. The Clinical Handover (CH) should start on time – staff receive their patient allocation.
5. The L&BS/MFAU Huddle (Patient Safety Huddle) occurs prior to the staff leaving the Midwives Tearoom – this should cover messages which are relevant to both areas. The Huddle is the opportunity to provide important patient information of which all staff need to be aware of (e.g. deteriorating patient, baby abduction risk, security risk). It also includes other information such as staffing issues; discharges; bed status; OSH issues and planned in-service. The Huddle should only take approximately 3 -5 minutes.
6. MFAU staff shall report to the MFAU Triage Room (not the main office) where the allocation can be discussed if necessary. This may require input from both triage midwives. The MFAU Huddle occurs and provides information/issues specific to MFAU which also need to be handed over to all staff.
7. The oncoming staff may collect CH sheet which should provide a general picture of all patients in MFAU if they choose.
8. The outgoing staff need to prepare and be ready for handover.
9. All staff shall use the standardised iSoBAR mnemonic for CH. iSoBAR aims to facilitate a complete but comprehensive handover, supported by the written CH sheet. It should include all relevant data, be accurate, unambiguous, clear and occur in a timely manner.
10. Handover between the triage midwives shall occur in the Triage Midwife Room. Another midwife will be designated to take all calls/queries during the handover. This handover includes a brief handover of all patients as well as other issues (e.g. house-keeping issues, staff numbers, equipment, stock concerns). The clinical content will differ from the staff providing bedside care, instead a less detailed handover with more of a MFAU/LBS overview.
11. The oncoming staff move to their allocated patients to undertake bedside/chair side CH and receive face- to- face handover of their patients.
 - Where possible and appropriate for the patient, handovers should be conducted in part in the presence of the patient (e.g. at the bedside for inpatients – not outside the door). ‘Appropriate for the patient’ includes a clinical judgement re the patient’s need for rest.

- If there are concerns re patient confidentiality or sensitive information clinical judgement should be exercised. The patient's consent must be obtained before involving family/carers in CH.
12. When the triage midwife has a clinical load they should complete the handover of allocated patients at the bedside after the triage-to-triage handover. If the oncoming triage midwife is not required to care for the same patient(s) then they should accompany the outgoing triage midwife so the information does not need to be repeated.
 13. Documentation of the CH process also includes the checking of bedside charts and documentation in the medical records (MR 225/226 or 250 if in use).

Visiting Midwifery Service (VMS): Shift to shift

- The midwife who is working the next day notifies the coordinator when she finishes her shift, by text or telephone, the number of patients being handed over, and leaves a message on the VMS answering machine stating the expected visits for the following day, including type of patient and location.
- New Postnatal, Antenatal, Gynaecological, Breast Feeding Centre and Special Care Nursery referrals are received from the Hospital Manager by 6:00am every morning and are delivered by the orderly to the VMS office in a sealed envelope.

VMS midwife going off duty: Handover process

- For any patient requiring further visits, the midwife writes on the **original** VMS referral a brief handover stating why the visit is required and the date to visit.
- The referral is placed in the **Handover Tray for Current Clients** in the VMS office.
- The notes and pathways may be at the patient's home or in the VMS office depending on individual patient needs. A more detailed handover is written on the appropriate pathway or MR255 Visiting Midwifery Service Follow-up document.
- **Adolescent patients** are handed over to the Adolescent Service as soon as the Adolescent Midwife is on duty.
- **Agnes Walsh Lodge (AWL)**

The midwife visiting the postnatal women and their babies in AWL on the 2nd floor is usually the VMS co-ordinator.

Co-ordinators of VMS: Handover process

- Shift coordinator will listen to the answering machine for messages including individual midwives report of visits for that day.
- Specific information from the previous coordinator is provided in the Coordinator's Diary in the VMS office. The VMS Coordinator's manual and the Orientation booklet are available in the VMS office for further information.
- The VMS coordinators receive a Stork Perinatal Database list of postnatal discharges each morning by email. This list is cross referenced with the new

postnatal referrals received and all other new referrals are noted on this list. A copy of the list including the name of the midwife visiting the patient is retained by VMS for a minimum of 3 months as a reference guide.

- The coordinator allocates the new referrals plus any referrals carried forward from the Handover tray by facsimile, hospital secured email, or copy for those midwives coming into the office. The original referral is kept in the current midwife's file in the VMS office until further handover or discharge.

Wards (Inpatient): Midwifery / nursing shift to shift

1. The outgoing shift prepares the clinical handover (CH) sheet, ensuring all the information is relevant, complete and current. The shift coordinator has overall responsibility for the CH sheet, but all staff are responsible for keeping the coordinator well-informed and updating the sheet.
2. The outgoing shift coordinator completes the patient allocation for the oncoming staff. There will be occasions where the allocation will need to be changed.
3. The oncoming staff assembles in a pre-arranged area – consider factors such as minimising interruptions and patient confidentiality.
4. All oncoming staff collect a copy of the CH sheet which will provide a general overview of all patients in the ward.
5. Clinical handover should start on time.
6. The midwifery / nursing staff receive patient allocation.
7. A Ward Huddle (Patient Safety Huddle) occurs prior to the staff moving to the bedside for handover and should only take approximately 3 -5 minutes. The Huddle is the opportunity to provide important patient information which all staff need to be aware of (e.g. deteriorating patient, baby abduction risk, security risk). It may also include other information such as staffing issues, discharges, bed status, OSH issues and planned in-service etc.
8. All staff shall use the standardised iSoBAR mnemonic for CH. iSoBAR aims to facilitate a complete but comprehensive handover, supported by the written CH sheet. It should include all relevant data, be accurate, unambiguous, clear and occur in a timely manner.
9. The staff move to their allocated patients to undertake bedside CH. As far as practicable handover should be:
 - Face- to- face
 - Be conducted in part in the presence of the patient (e.g. at the bedside for inpatients). This allows oncoming staff to be introduced and to check the patients at the beginning of the shift.
 - “Appropriate for the patient” using clinical judgement (e.g. patient's need for rest, mental health issues, complex care patients, concerns re confidentiality)
 - The patient's consent must be obtained before involving family/carers in CH.
10. The co-ordinator to co-ordinator handover includes a brief handover of all patients as well as other relevant issues (e.g. house-keeping issues, staff numbers,

equipment, stock concerns). This shall occur in an area where interruptions are kept to a minimum. The content will differ from the staff providing bedside care to a less detailed more overall handover.






11. Recording of the CH process includes documentation of the checking and completing of the Patient Safety Checklist (“Drains in & out”, observation chart, medication chart and care plans/clinical pathways). Names and initials of outgoing and incoming staff are required.

Related policies

Department of Health WA: [OD 0484 / 14 Clinical Handover Policy](#)

Related WNHS policies, procedures and guidelines

WNHS policy: [Clinical Handover](#) (previously W073)

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