Title: WA HEALTH ALLIED HEALTH CLINICAL HANOVER GUIDELINE

This Revision Issued: 28 October 2015

Background
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. The WA Health Clinical Handover Policy details core principles and a prescribed structure that should be followed for all clinical handovers initiated within Department of Health WA services.

Scope
This guideline applies to all WA Health Allied Health Professionals undertaking inter-facility clinical handover within allied health (it may also be used for intra-facility handover between allied health services).

Definitions
Allied Health Professional (AHP) - includes the professions of dietetics, speech pathology, physiotherapy, occupational therapy, social work, psychology, audiology and podiatry.

Inter-Facility - this may include transfer of care from one facility to another including:
- Clinical handover of care to another hospital or to another agency.
- Inpatient to outpatient where e-referral is not available.
- Clinical handover to community-based service.

Clinical handover - 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.

Statement for this Guideline
In accordance with the WA Health Handover Policy, all patients who clinically need handover must receive it.

All instances of inter-facility patient transfer require formal handover, as do permanent intra-facility transfers between service-areas (e.g. from general medical ward to rehabilitation ward, from inpatient to outpatient service).

It is recognised that for circumstances other than inter-facility patient transfer, not all patients require a formal allied health handover on all occasions. In some instances, informal handover that complies with the Principles (described below) may be sufficient. It is the responsibility of each individual clinician to determine whether appropriate care/services will be provided by the receiving clinician in the absence of formal handover, and if in doubt, the formal process must be completed.

For agencies requiring specific referral forms (e.g. Silver Chain), these may be completed instead or in addition to the WA Health Allied Health Clinical Handover Form (Appendix A). iSoBAR principles and content requirements must be used.

Where a referral is being made to non-allied health services or to seek the assistance of a more appropriate service provider to manage a patient/clinical condition, a simpler referral process may also be used.

Regardless of the nature of the clinical handover, the nature and content of patient information conveyed must be documented in the medical record to support patient safety and continuity of care.

The aim of clinical handover is to achieve effective, high quality communication of relevant clinical information when responsibility for patient care is transferred between facilities providing allied health
Handover must be understood as an explicit transfer of clinical accountability and responsibility, not just information. Standardisation of handover, as part of a comprehensive system-wide strategy, aids effective, concise and inclusive communication of relevant information when responsibility for patient care is transferred between allied health facilities and professionals. Effective standardised handover assists staff moving between facilities, staff receiving handover from multiple facilities and student clinical training. It is vital to protecting patient safety and the timeliness and quality of care received.

Evidence indicates that ineffective handover can lead to:
- incorrect treatment
- delays in diagnosis and treatment
- adverse events
- increased length of stay and readmission rates
- increase in expenditure
- unnecessary tests, treatments and communications
- patient complaints
- malpractice claims

Inter-facility clinical handover has been identified as a high-risk situation for patients due to a combination of factors including complex interactions required to coordinate patient movement between clinical settings and teams. Inter-facility handover includes the clinical handover of patients: to another hospital or agency; from inpatient to outpatient settings where e-referral is unavailable; or to a community-based service.

All patients for which responsibility is transferred between facilities should be formally handed over from the providing clinicians to the receiving clinicians at the time of, or ideally prior to, transfer. In addition to a verbal component, inter-facility transfers must involve detailed written handover information. This documentation should arrive prior to, or with the patient.

Transfer of care, particularly from the inpatient environment, is multidisciplinary and not specific to allied health. However, detailed allied health specific clinical handover considers a number of important aspects of client care that may not be included in generic handover including:
- Therapeutic needs and goals of the patient.
- Community aspects of patient care.
- Change in patient acuity and transition to different level of care.
- Transition between clinical and community environments.
- Transition of care to different care providers with different skill sets, knowledge and resources.

Value of Clinical Handover
Clinical handover is imperative for client safety and continuity of care, particularly from the client’s perspective. In addition to client benefits, effective clinical handover can also increase efficiency and prevent duplication or revision of previous information and services. Handover supports the development of networks and provision of clinical education through second opinions, treatment outcomes and new protocol provision.

Responsibilities
All WA Health allied health employees are required to comply with the WA Health Clinical Handover Policy and ensure they operate in accordance with the principles and aims of this guideline. Employees will:
- Acknowledge that handover is part of the duty of care for all health care providers.
- Ensure their complete participation in the handover process contributes to a culture that values handover.
- Ensure all clinical handovers use the iSoBAR process, as documented in this guideline, to guide the content and structure of the handover in a manner that suits the clinical context.
Principles of Inter-Facility Allied Health Clinical Handover

All clinical handover must comply with the principles of clinical handover in accordance with the WA Clinical Handover Policy. The following describes the key principles from the WA Clinical Handover Policy (bolded) and their application to allied health inter-facility clinical handover, as appropriate.

1. **Patient/carer involvement** - Where practicable, handovers should be conducted, in part, in the presence of the patient or carer.
   As a minimum, clients/carers should be engaged in decision making regarding client goals and Agreed Plan where it is not possible to conduct handover in their presence.

2. **Consistent structure and content** - All handovers, other than discharges, must use the iSoBAR tool to ensure consistent content and structure. Handover content should be clear, concise, and use easily understood words with minimal, accepted, abbreviations.

   Using iSoBAR format to guide allied health inter-facility handover will ensure that:
   - The information presented is limited to that which is necessary to provide safe care to the patient.
   - All clinicians involved have an opportunity to discuss the management plan, clarify information, and ask and respond to questions.
   - Verification of understanding occurs.
   - Responsibilities and planned actions are clearly understood.

   Refer to Appendix A (WA Health Allied Health Clinical Handover Form) utilising the iSoBAR format.

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

   Where multidisciplinary allied health clinical handover is required, the primary or lead clinician is to provide the verbal and written handover to the primary or lead clinician from the receiving team in consultation with all care providers.

4. **Agreement on responsibilities and accountability** - Handover must be understood by staff as an explicit transfer, not just of information, but of clinical accountability and responsibility.

   Roles, responsibilities and accountabilities must be clearly described, and agreed to by all staff involved in handover.

   Factors to be considered include scope of practice, availability of resources (e.g. Staff, equipment) and adequacy of the patient information. Discussion regarding roles, responsibilities and accountabilities should occur between the sending and receiving site as part of the Agreed Plan.

5. **Appropriate modality** - All inpatient handovers, other than discharge, must include a verbal component. Handover should be conducted face-to-face wherever possible. Handover modalities must conform to the recommended or adequate options detailed in Appendix B. Voice-recorded handover is not permitted.

   Verbal handover ensures that the receiving clinician/s are aware of the handover and allows for the development of an Agreed Plan with the receiving site that considers the receiving clinician’s scope of practice, skill level and available resources.

6. **Appropriate environment** - Environmental controls should be in place to limit non-critical interruptions to communication during handover and should consider access to relevant medical records and results.

7. **Supporting documentation** - All handovers must be supported by current, appropriate documentation (e.g. Clinical notes, test results). Verbal handover without documentation relies on memory and is a high risk activity.

   Written documentation reduces communication errors and improves continuity of care.

8. **Patients of concern** - Patients should be handed over in accordance with their severity and clinical risk, as determined by a treating clinician. Management of a deteriorating patient must be escalated as soon as deterioration in condition is detected. Handover of patients of
concern must be documented.

9. **Education** - All staff must receive education on the site/service handover protocol and this policy. It is recommended that this occurs at the commencement of rotation or employment, and also following revisions of this policy.

Allied health must receive education on inter-facility clinical handover and this guideline.

**At Risk Populations**

Handover breakdown has been identified as most likely to occur in ‘at risk’ populations including Aboriginal clients, clients living in remote communities or in non-standard housing situations (e.g. caravan, stations) and shared care paediatric clients.²

Handover must consider local context and needs from both a client and receiving site perspective. Particular consideration should be given to:

- Timeliness of handover for outer metropolitan and rural and remote community clients when equipment (e.g. non-standard) or home modifications need to be organised prior to discharge home.
- Access to databases (e.g. webPAS or TOPAS) to obtain more client information/contact details or details of future appointments which may not be accessible by rural services or external agencies.
- Understanding of the geographical and outreach service constraints of the outer metropolitan and rural/remote environment where clients may have infrequent or limited access to allied health services or where clients are transient.
- Understanding the scope of service provision available in rural and remote hospitals and health services.
- Understanding the role delineation, clinical expertise and service capacity of the rural and remote allied health clinicians who may operate in a rural generalist environment across the continuum of care.
- The availability of equipment in rural/remote contexts and within external agencies and time required to access necessary equipment not held in stock.
- Importance of providing numerous contact details for clients including next of kin particularly for transient clients, or those without traditional contact means e.g. phone.
- Access to standardised or specialised patient care protocols, care/education information and programs particularly for non-tertiary care providers.

**WA Health Allied Health Clinical Handover Form (iSoBAR Template for Allied Health Inter-Facility Handover)**

A standardised template for inter-facility allied health handover (the Form) has been developed, which may also be used for intra-facility handover between allied health services. It should be noted that the Form aims to support the concise capture of pertinent and relevant handover information. It is expected that comprehensive or specific assessments will be attached to provide further detail as necessary.

Where sections of the Form do not apply/ are irrelevant to the patient, these should be clearly marked “Not Applicable” or “Not Relevant”, or may refer to a specific attachment. Each iSoBAR section of the Form should be completed, as follows:

**Identify**

- Introduce your patient and the location of the sending site.
- Identify the relevant professions that the handover applies to (which may be multiple) for multidisciplinary handover.
- Ensure adequate contact details for the client including carer/guardian/next of kin and their awareness of the transfer.

**Situation**

- State the primary diagnosis and other relevant diagnoses/problems that are specific to the reason for handover. Include primary interventions during this admission/episode e.g. surgery/procedures.
• Note the planned date for transfer of the patient.
• Describe the reason for handover/transfer relevant to the receiving professionals.

Observations
• Document the current clinical situation.
• Note relevant observations and pertinent assessment findings (detailed relevant/specific assessments can be added as attachments to the handover).

Background
• Specify relevant past medical history.
• Specify relevant investigations undertaken and their results.
• Specify relevant interventions during this episode of care.
• Note specific alerts and risks including Falls, Pressure injury, Allergy/Adverse Drug Reaction and Infection. If these are not assessed or not relevant to the patient indicate “Not known/Not assessed”. Provide comment as necessary and attach specific assessments and documentation to provide further detail. Information on other precautions/alerts (e.g. Behavioural or home visiting risks may also be added as comments).
• Specify relevant social/home issues that require consideration/awareness by the care providers, in particular communication barriers, mobility issues, family and domestic violence history and child at risk.

Agreed Plan
• This should be developed in conjunction with the client (and/or relevant carers when client is unable) and the receiving clinician(s) and specifically consider the service capacity of the receiving site and clinicians.
• Note the client goals.
• Detail specific intervention/s required, the level of urgency and required frequency of the intervention given the skills and resources of the receiving site.
• Note follow-up appointments that have been made or will be required.
• Note any requirements for equipment to be provided by the receiving site
• Specify attachments to the handover and ensure provision of relevant assessments, investigations and specific treatment programs/protocols.
• Provide contact details for other contributors for a multidisciplinary handover.

Readback
• Confirm shared understanding of handover.
• Document method/s of handover (Appendix B), and contact details and signature of receiving and sending clinicians.
• Receiving clinicians should utilise the Form when receiving a verbal handover and sign in the Readback box also noting the contact details of the sender. On receipt of written handover from the sending site the receiving clinician shall also sign to acknowledge handover prior to adding the Form to the medical record. It is not necessary to return the signed form to the sender.

Form Completed By
• This section shall be completed by either the sending clinician who has completed the Form or by the receiving clinician if documenting the receipt of a verbal handover, to indicate who has completed the Form.

OUTCOME
For all allied health clinicians to provide effective inter-facility clinical handover.
SOURCES OF REFERENCE

National Safety and Quality Health Service Standard 6

1 OD 0484/14 WA Health Clinical Handover Policy (2013)


This guideline should be read in conjunction with:

1 OD 0484/14 WA Health Clinical Handover Policy (Nov 2013)

National Safety and Quality Health Service Standard 6: Clinical Handover

KEY WORDS

allied health, clinical handover, inter-facility, handover, documentation

Printed copies of this document are uncontrolled

RISK STATEMENT: Non-compliance with this policy will:

- Breach legislative requirements
- Breach National/State/Hospital policy
- Breach professional standards
- Breach mission & values

☐ Impact on patient quality of care ☒

☐ Impact on patient safety ☒

☐ Other:

Endorsing Authority: Acting/Director General, Clinical Services and Research

Endorsed by: Dr Gary Geelhoed

Policy Author: Chief Health Professions Office and WA Country Health Service

Executive Sponsor:

1st Issued on: 28 October 2015

Next review due: 28 October 2016

Version: Version 1

References (Standards):

National Standard/s Clinical Handover NSQHS 6

Legislation OD 0484/14 WA Clinical Handover Policy, 2013

Standards

Related Documents National Safety and Quality Health Service Standard 6: Clinical Handover
### APPENDIX A: WA HEALTH ALLIED HEALTH CLINICAL HANDOVER FORM

<table>
<thead>
<tr>
<th>IDENTIFY</th>
<th></th>
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<tbody>
<tr>
<td>Handover to:</td>
<td>☐ Physio ☐ OT ☐ Speech ☐ Diet ☐ Pod ☐ Soc Work ☐ Psych ☐ Other:</td>
</tr>
<tr>
<td>Handover to (site name):</td>
<td></td>
</tr>
<tr>
<td>Primary language spoken:</td>
<td></td>
</tr>
<tr>
<td>Does this client identify as:</td>
<td>☐ AB ☐ TSI ☐ ATSI</td>
</tr>
<tr>
<td>Interpreter required:</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Carer/Guardian/NOK:</td>
<td></td>
</tr>
<tr>
<td>Carer/NOK Contact No.:</td>
<td></td>
</tr>
<tr>
<td>Relationship to client:</td>
<td></td>
</tr>
<tr>
<td>Aware of transfer:</td>
<td>☐ Yes ☐ No</td>
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</tbody>
</table>

### S Principal diagnosis/Relevant problems

<p>| |</p>
<table>
<thead>
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<tbody>
<tr>
<td>Admission/First Appointment Date:</td>
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<tr>
<td>Planned Transfer Date:</td>
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<tr>
<td>Reason for handover/transfer</td>
</tr>
</tbody>
</table>

### O Clinical Situation: Relevant Assessments/Observations

<p>| |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Relevant Past Medical History</td>
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<tr>
<td>Relevant Interventions/Investigations</td>
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### B Relevant Past Medical History

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<tbody>
<tr>
<td>Precautions/Alerts</td>
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<tr>
<td>Falls Risk</td>
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<tr>
<td>Pressure Injury Risk</td>
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<tr>
<td>Allergy</td>
</tr>
<tr>
<td>Adverse Drug Reaction</td>
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<tr>
<td>Micro alert (infection)</td>
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<tr>
<td>Other/Comment:</td>
</tr>
</tbody>
</table>
### Relevant Social/Home Situation

**BACKGROUND**

### Client Goals

**Intervention Required**

- What is the level of urgency?
- Frequency of intervention recommended

**Client consent for referral/handover obtained**

- Yes
- No

**Follow up appointments required**

(Provide site/clinic/location/date and time if booked):

### AGREED PLAN

**Attachments to be forwarded**

- Pathology/Imaging Results
- Copies of relevant medical records
- Regimes/Programs/Guidelines/Post Op Orders
- Allied health assessments
- Other: Please specify

**Total no. pages attached excl. this form:**

### Multidisciplinary Form - Other Contributors to this Handover Form

<table>
<thead>
<tr>
<th>Name:</th>
<th>Designation:</th>
<th>Contact No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Designation:</td>
<td>Contact No:</td>
</tr>
<tr>
<td>Name:</td>
<td>Designation:</td>
<td>Contact No:</td>
</tr>
</tbody>
</table>

### Handover made to receiving clinician via

- Phone
- Face to Face
- Email
- Fax

<table>
<thead>
<tr>
<th>Name of receiving clinician:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site:</td>
<td>Designation:</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>Date/Time:</td>
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</table>

<table>
<thead>
<tr>
<th>Name of sending clinician:</th>
<th>Signature:</th>
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<tbody>
<tr>
<td>Site:</td>
<td>Designation:</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>Date/Time:</td>
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</table>

### Form Completed By

- Name: Signature:
- Contact Number: Date/Time:
Appendix B: Clinical Handover Modalities Matrix
Handovers initiated within WA Health should conform to the *recommended* and *adequate* modalities wherever practicable. *Should never occur* modalities are not permitted.

<table>
<thead>
<tr>
<th>Why implement standard key principles?</th>
<th>Evidence indicates that standardisation of handover processes contributes to safer patient care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What clinical information should be handed over?</td>
<td>All handovers initiated by Department of Health staff should be structured using iSoBAR.</td>
</tr>
<tr>
<td>Who should attend handover?</td>
<td>Key participants in the handover process should be identified and available to attend the handover of their patients.</td>
</tr>
<tr>
<td>When should handover occur?</td>
<td>Interprof. / multidisc. team handover</td>
</tr>
<tr>
<td>How / Where should handover be delivered?</td>
<td>Face to face (in the patient / carer presence) + written</td>
</tr>
<tr>
<td>Face to face (in a common area) + written</td>
<td>🔄</td>
</tr>
<tr>
<td>Telephone + written</td>
<td>~</td>
</tr>
<tr>
<td>Telephone only</td>
<td>~</td>
</tr>
<tr>
<td>Written only</td>
<td>✗</td>
</tr>
<tr>
<td>Voice recording</td>
<td>✗</td>
</tr>
</tbody>
</table>

**Legend**

- 🔄: Recommended
- 🔄: Adequate
- ~: Not recommended
- ✗: Should never occur