Allied Health Clinical Handover Policy

1. 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 MP0095/18 WA Health Clinical Handover Policy details core principles and a prescribed structure that is to be followed for all clinical handovers initiated within Western Australian Department of Health services.

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 services. Effective handover is vital in protecting patient safety. 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, assists with 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 protect 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.

Allied health professionals work across a number of program areas and clinical settings. Handovers from acute to community, community to hospital, acute to subacute and inter-hospital handovers have been identified as high-risk situations for patients due to a combination of factors including complex interactions required to coordinate patient movement between clinical settings and teams.[2]

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
- essential home modifications and assistive technology to allow access to self-care

2. Policy Statement

All WA Country Health Service (WACHS) patients who clinically need handover must receive it.

All patient transfers require handover. It is recognised that not all patients require a formal allied health handover on all occasions. In some instances, informal handover that complies with the principles (described in 2.1) may be sufficient. It is the responsibility of each individual clinician to determine whether appropriate care/services are to be provided by the receiving clinician in the absence of formal handover, and if in doubt, the formal process must be completed using the MR66 WACHS Clinical Handover (Allied & Community Health) Form or Community Health Information System (CHIS) letter template.

Allied health professionals employed in designated program areas (e.g. mental health, aged care) may be required to complete handover using program specific forms/processes.

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 be used.

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

As per the Clinical Handover Matrix, handover should include a verbal (face to face, telephone or telehealth) component plus a written handover. This documentation should arrive prior to, or with the patient.[1]

2.1 Principles of 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 clinical handover, as appropriate.

2.1.1 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 the Agreed Plan, where it is not possible to conduct handover in their presence.

2.1.2 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 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.

2.1.3 Leadership and complete team involvement - Involvement from all levels 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.

2.1.4 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.

2.1.5 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 the Clinical Handover Matrix. 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.

2.1.6 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.

2.1.7 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.

2.1.8 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.

When handing over vulnerable clients or families it should be noted if they may be difficult to contact to ensure continuity of services is maintained.

2.1.9 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 clinical handover and this guideline. Education is available via eLearning.

2.2 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 CHIS) 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
- the 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.

2.3 WACHS Allied Health Clinical Handover Using iSoBAR

iSoBAR is a simple step by step handover process that provides a sequential approach to giving and receiving information. Standardised medical record forms and letter templates have been developed that meet iSoBAR principles and content requirements, which are to be used for handover between allied health services. If e-referral is used then the handover form is attached to the e-referral (do not write the iSoBAR into the e-referral).

Standardising the handover process is a simple and effective way to ensure good continuity of patient care. The standardised template aims to support the concise capture of pertinent and relevant handover information. Comprehensive or specific assessments are to be attached to provide further detail as necessary. Where sections of the form do not apply or are irrelevant to the patient, these are to be clearly marked “Not Applicable” or “Not Relevant”, or may refer to a specific attachment. The following information guides the completion of an iSoBAR allied health handover.

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 consent for the handover.

Situation

- State the principal diagnosis, presenting concerns and problems that are specific to the reason for handover. Include primary interventions during this admission or episode of care.
- Note when this admission or episode of care commenced and 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 social/cultural/home issues that require consideration or awareness by the care providers, in particular communication barriers, mobility/transport issues, preferred contacts, challenges with contacting, other agencies involved, family and domestic violence history, violence and aggression, cognitive impairment, self-harm and suicide, seclusion and restraint, and child at risk.
- Specify relevant past medical history and background.
- Specify relevant interventions and investigations including their results.
- Note specific alerts and precautions including falls risk, pressure injury risk, allergy/adverse drug reaction, malnutrition and infection. Provide comment as necessary and attach specific assessments and documentation to provide further detail. Include information on other precautions / alerts (e.g. behavioural or home visiting risks).

Agreed Plan

- This is to 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 and current planned actions.
- Detail specific intervention(s) required, the 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.
- Note if there are 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 and contact details of receiving and sending clinicians.

- Receiving clinicians should also utilise a written handover form when receiving a verbal handover and sign the 'Readback' section also noting the contact details of the sender. On receipt of written handover from the sending site, the receiving clinician should 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

- Provide the name of the clinician who has completed the handover form. This is usually the sender but may be the receiver who is documenting a verbal handover.

3. Definitions

Allied Health Professional (AHP)	Includes, but not limited to, the professions of dietetics, speech pathology, physiotherapy, occupational therapy, social work, psychology, audiology and podiatry.
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.

4. Roles and Responsibilities

All WACHS 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 policy. Employees are to:

- 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 policy, to guide the content and structure of the handover in a manner that suits the clinical context.
- Complete training on local and program specific clinical handover policy and requirements.

5. Compliance

This policy applies to all WACHS Allied Health Professionals undertaking clinical handover within allied health.

WACHS staff are reminded that compliance with all policies is mandatory. Failure to comply with this policy may constitute a breach of the WA Heath Code of Conduct (Code). The Code is part of the Integrity Policy Framework issues pursuant to section 26 of the Health Services Act (HAS) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professional and agency staff) and persons delivering training or education within WACHS.

6. Evaluation

The WACHS Allied Health Leadership and Governance Team is to undertake review of this policy as per the WACHS policy review schedule.

7. Standards

National Safety and Quality Health Service: Standard 6 – Communicating for Safety

8. References

Back to the Bush: WACHS Allied Health Clinical Handover Project 2009. Next Challenge and WA Country Health Service (2009)

Government of Western Australia. Carers Recognition Act Perth: State Law Publisher; 2004.

National Safety and Quality Health Service Standard 6 – Communicating for Safety

WA Health Clinical Handover Matrix

WA Health Clinical Handover Policy

9. Related Forms

MR66 WACHS Clinical Handover (Allied and Community Health) Form

10. Related Policies

MP0095/18 WA Health Clinical Handover Policy

This document can be made available in alternative formats on request for a person with a disability

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