Interhospital Clinical Handover Form Procedure

1. Guiding Principles

The aim of clinical handover is to achieve effective, high quality communication of relevant clinical information between clinicians.

Effective handover is vital in protecting patient safety and **must be understood as an explicit transfer not just of information, but also of clinical accountability and responsibility**.

The Inter-hospital Clinical Handover process utilises iSoBAR principles endorsed by the WA Department of Health. These principles are outlined in the Department of Health Clinical Handover Policy which is to be read in conjunction with this procedure.

As this procedure directly relates to handover between facilities, it is to be read in conjunction with the WACHS Assessment and Management of Interhospital Patient Transfers Policy.

In the creation of the MR184 WACHS Inter-hospital Clinical Handover Form, the iSoBAR principles have been incorporated in a two-fold approach to guarantee best practice standards are maintained:

1. The verbal component described in this procedure, which occurs between clinicians at each facility.
2. The transfer form which outlines the minimum information requirements that each facility must address. This form also provides the evidence that a detailed written and verbal handover occurred.

The intent of the form is to avoid duplication of information and possible transcribing errors and to remain predominantly free-text with guidance to minimum data set. This is not an exhaustive list of required information, and additional pages may be required, as well as the inclusion of supporting documentation and clinical forms i.e. MR170 NIMC Medication Charts, and Observation Charts.

The documentation to record patient observations, care plan, changes and medications during a transfer / escort of the patient by a WA Country Health Service (WACHS) clinician is to be continued on the photocopied documentation that accompanies the patient, and which is received by the receiving hospital / clinician. This provides a seamless account of the patient picture and supports early recognition of the deteriorating patient.

Inclusions: All patients transferring from one facility to another which include adult, paediatric, maternity, neonates and mental health clients. Including a telephonic consult that occurs between a hub site and outlying site

Exclusions: Intra-hospital transfer, for example Emergency Departments to ward – this form may be applicable for use in some instances, but does not fall within the scope of this procedure and needs to be considered at a local level.

2. Procedure

This procedure documents the process to be followed once the decision is made to transfer a patient and there has been medical acceptance by the receiving site.
It is assumed the referring doctor has also:

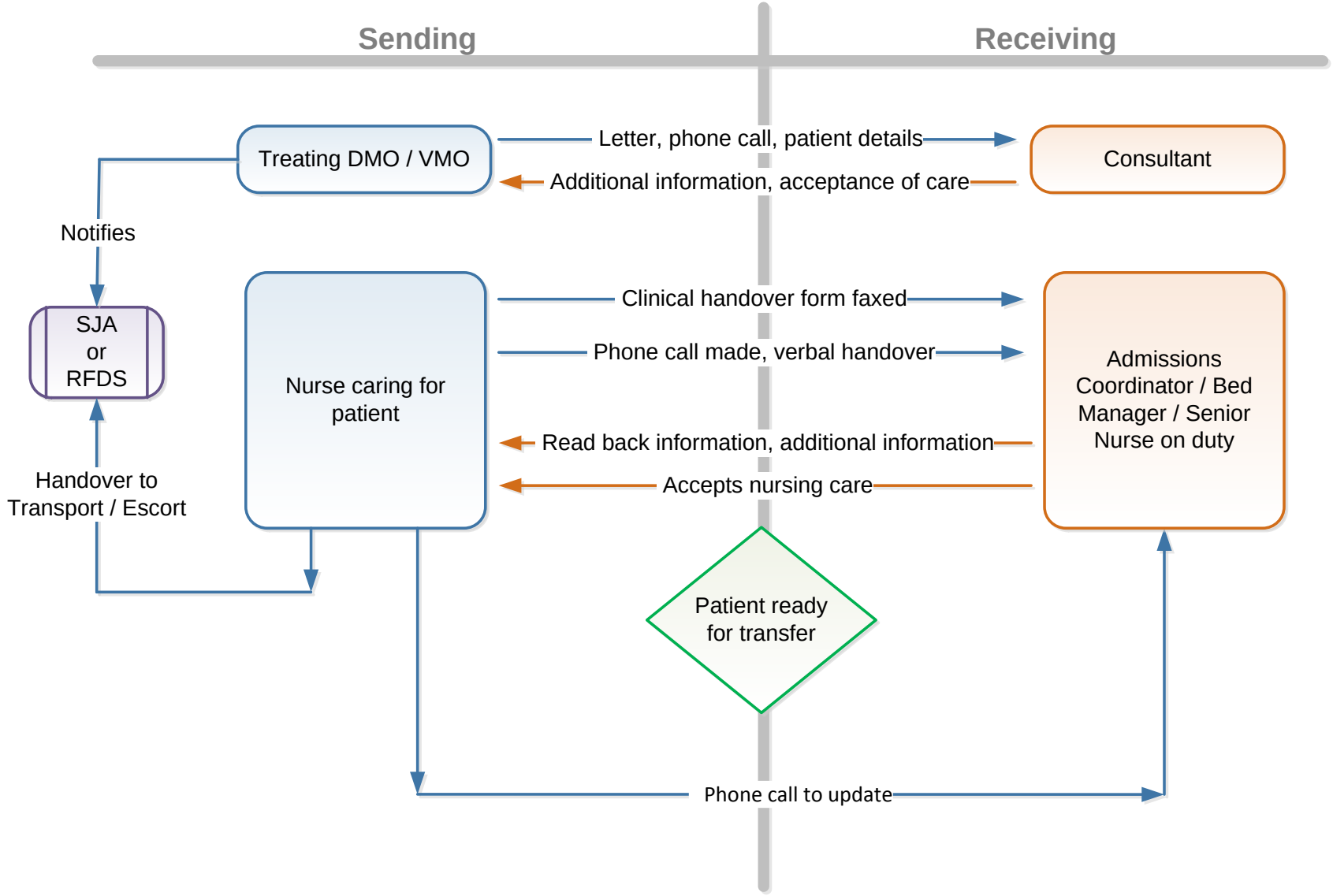
- Attained and documented patient/carer consent
- ensured risk assessment, clinical urgency and decided upon mode of transport
- informed the next of kin

2.1 Procedure for clinical handover of the transferring patient

1. The clinical decision has been made in consultation with the multidisciplinary team and the patient themselves, to transfer the patient to appropriate level of care in a timely manner. This can occur between a hub and external site using Electronic Telehealth Conferencing Services (ETCS).
2. The medical officer or senior clinician has discussed with the receiving hospital, the patient requirements and determined acceptance of care.
3. The medical handover has occurred between the referring and receiving medical officers.
4. The medical officer or senior clinician documents the referral letter.
5. Nursing/midwifery staff responsible for the patient must complete the MR184 WACHS Inter-hospital Clinical Handover Form.
   - The photocopying of notes may be delegated as appropriate and made available, including any additional documentation that may be required to be sent to the receiving hospital.
6. The completed MR184 WACHS Inter-hospital Clinical Handover Form and any other relevant documentation is faxed to the most senior nurse/bed manager responsible for allocation of beds at the receiving site. This may be a unit manager, discharge coordinator, bed coordinator or Emergency Department registered nurse, depending on the destination site and staffing roles.
7. A verbal clinical handover between nursing clinicians must take place for all Inter-hospital transfers. This process is to be initiated by the referring site nurse/midwife, who phones the most senior nurse/bed manager for bed allocation at the receiving site. **Verbal handover is to occur via telephone with both nurses referring to the completed MR184 WACHS Inter-hospital Clinical Handover Form and the receiving nurse/midwife reading back the information to the sending nurse/midwife.**

8. The receiving clinician may request further information/documentation, in which case, this must be forwarded as soon as is practicable, and documented in the additional information section of the transfer form
9. 'Agree to Plan' and 'Read-back' processes are to continue until the receiving site is satisfied they have all the required information to safely accept care of the patient.
10. Acceptance of care by the receiving clinician, as well as provision of a full iSoBAR handover by the referring clinician, is evidenced by both parties completing the 'Read-back' section on page 2 of the MR184 WACHS Inter-hospital Clinical Handover Form.
    - If telephone / verbal handover is not possible, each site must document in the 'Read-back' section, the reasons why this did not occur
    - If receiving site unable to follow process of acceptance (not a WACHS site), the referring site must document in the ‘Read-back’ section that this did not occur.
11. The form is then filed in the patient’s medical record at each respective site.
12. Prior to the patient leaving the facility, the originating clinician provides a verbal update to the receiving hospital/clinician prior to the patient leaving the facility to update them on the patient’s current clinical condition and to confirm an expected time of arrival.

2.2 Clinical Handover Procedure Flowchart



3. Guidance Notes for Completion of the MR184 WACHS Inter-Hospital Clinical Handover Form

Identify

This section introduces and identifies the:

- facility
- patient
- next of kin, contact or guardian
- patient communication and cultural and religious needs
- identity of the clinician completing the form.

Situation

This section describes the reason for transfer and handing over.
Details of the following need to be documented in this section.

- The presenting complaint or diagnosis
- The reason for transfer.

Observation

The information in this section enables staff at the receiving hospital to gain a picture of the patient's current clinical status. To be included and considered in this section are:

- the most recent set of observations are recorded with time and date taken. If a history or trend is of value in handover, attach a copy of the Observation Chart (MR140). This will assist in prevention of transcribing mistakes.
- if there has been a delay in the transfer of greater than eight (8) hours or there has been a change in the patient condition, the patient's observations are to be documented under Additional Information on page 2 of the MR184 WACHS Inter-hospital Clinical Handover Form. Recognition and response to clinical deterioration must be escalated with accordance to local escalation action plans. This is to be handed over to receiving facility prior to the patient leaving the facility.

Background

The information in this section enables staff at the receiving site to allocate appropriate bed, nursing staff and resources, best suited to the patient and their condition. This is to include attention to potential risks, alerts and other requirements. Areas to consider documenting are:

- the patient's relevant past medical history (PMHx)
- medications (if the patient has an extensive list of medications, a copy of the NIMC is to be faxed accompanying the MR184 WACHS Inter-hospital Clinical Handover Form)
- the patient's 'not for resuscitation' (NFR) and/or Advanced Health Directive (AHD) status
- allergies – which need to be specified and allergy sticker applied to the form for heightened awareness.
- clinical alerts (for further definition, please refer to the WA Clinical Alert (Med alert) Policy)

- micro alerts and type of transmission-based precautions are required to be documented and discussed as this will influence the bed management and possible transport arrangements
- if the patient has been identified with risks related to falls, pressure area, venous thromboembolism (VTE) or bariatric, a copy of the relevant management plan is to accompany the MR184 WACHS Inter-hospital Clinical Handover Form during the transfer
- notation recorded on the patient's Dietary, Continence and Mobility status and requirements.

Agreed Plan

The information in this section documents what plans might already be in place or may need to be considered in the transfer of accountability.
The areas of trigger are:

- If the patient has an agreed plan with Mental Health and if there is - what is it?
- Are there Allied Health requirements and if yes, does the receiving site have the resource to meet the requirements, and have they made the Allied health team aware?

The area transport mode and estimated times of departure and are required to assist the receiving hospitals preparation to provide appropriate care of the accepted patient.

The referring medical officer must authorise and document:

- the most appropriate mode of transport for the patients clinical condition,
- the level of clinical escort required and
- the urgency of the patients transfer. These decisions can be documented in this section.

The free text area allows for further comment or additional instructions form the receiving hospital on the plan for the transfer.

Read-back

It is imperative in the goal of patient safety that there is a confirmed shared understanding. This can be achieved through proper read-back. This is where the receiver of the information repeats back verbally to the sender.

'Read back' lets the sender know the message has been received and provides an opportunity to correct any mistakes. This process assists in ensuring both referring clinicians and receiving clinicians have full knowledge of patient's condition, situation and requirements and are able to meet these requirements. Clarification must be made if unclear, and further notes may be documented on the form / copy of the form. It is only upon agreed understanding and acceptance of information that both clinicians document their name and designation, time and date of acceptance.

4. Delay in the Transfer of Patient Greater than Eight Hours

Should there be a delay in patient transfer of greater than eight (8), or there is a change in the patient's condition, the referring site nurse phones the receiving site prior to patient leaving the facility. The newly updated information and observations are documented in the 'additional observations' section on page 2 of the MR184 WACHS Inter-hospital Clinical Handover Form.

Any significant delays in transferring a patient may trigger a Clinical Incident notification through Datix CIMS.

5. Documents for Transfer

It is important for continuity of patient care - in particular, in the recognition of the deteriorating patient, that the relevant documentation is provided to the receiving hospital and is available to clinicians escorting the patient. Documents are required to be photocopied and escort the patient. The health records being transferred with a patient must be transported in such a way as to ensure ongoing confidentiality of the health record and restrict inappropriate persons from accessing the health record.

Where a patient is being transferred to another facility, the referring clinical team is to ensure the provision of a **copy** of relevant health records are transferred to the receiving hospital including:

- MR1 or Trauma Chart (if transferred from an emergency department)
- MR184 WACHS Inter-hospital Clinical Handover Form or Neonate Transfer Form (MR182).

As required:

- If transferring by RFDS / ERHS, include RFDS Transfer Form and Envelope / Checklist (WACHS Transfer Envelope may be used as a substitute)
- MR111 WACHS Nursing Admission, Screening and Assessment Tool - Adults
- MR120 WACHS Adult Nursing Care Plan
- Medication Chart
- Observation Charts
- Intravenous Fluid Chart
- Recent pathology reports
- Electrocardiographs (ECGs)
- Allied Health summary report and care plan
- Medical Imaging records, such as x-rays, CT Scan, MRI, ultrasound
- Mental Health documentation
- Not For Cardiopulmonary Resuscitation / Advance Health Directive.

A checklist is provided on page 2 of the MR184 WACHS Inter-hospital Clinical Handover Form to assist in the documents that may be required to escort the patient.

In preparing the documents to accompany the patient, ensure there are enough blank episodes of recording available to ensure the escort has room to document observations recorded through transport process.

6. Definitions

Clinical Handover	A situation in which professional responsibility and accountability for some, or all aspects of care for a patient, or group of patients, is transferred to another person or professional group on a temporary or permanent basis.
Inter-hospital Transfer	The move of an admitted patient between health care services where: they were admitted and /or assessed and / or received care and/or treatment a tone service; and where admitted and/or received treatment and/or care at the second service. Services in WA include (but are not limited to): • hospitals • community health services, e.g. mental health, child health, dental health • prisons • aged care facilities • Hospital in the Home • rehabilitation in the home • transport providers, such as St John Ambulance Service and the Royal Flying Doctor Service.
iSoBAR	The mnemonic that must be used to guide the structure and content of all clinical handovers initiated with the Department of Health services.
Clinician	A person, registered under the *Health Practitioners Regulation National Law (Western Australia) Act 2010*, mainly involved in the area of clinical practice. That is the diagnosis, care and treatment, including recommended preventative action, to patients. Clinicians include allied health professionals, medical officers, midwives and nurses.
Consultation	Medical advice from a medical officer within a hospital or one who is not located within the facility via ETS, RFDS, Hub hospital or tertiary hospital.
Current, sending or referring Clinician	Is the clinician who is currently responsible for a patient and is handing over care to a receiving clinician.

A receiving clinician	Is a clinician who will accept responsibility for a patient for whom the receiving clinician is currently being given a handover.

7. Roles and Responsibilities

7.1 Referring Hospital

The referring hospital is responsible for:

- ensuring the patient has one identiband in situ and that patient identification occurs at each point of care transfer
- providing an appropriate clinical escort in the absence of an available suitable clinical escort by the transport provider
- providing appropriate clinical equipment as required to the transport provider
- providing medications to treat the patient during transfer where the transport provider cannot provide them.

7.2 The Receiving Hospital

The receiving hospital is responsible for:

- being prepared to provide appropriate care of the accepted patient
- providing clinical advice for the interim management of the patient as required.

7.3 The Referring Medical Officer

The **referring** medical officer caring for the patient prior to transfer is responsible for:

- assessment and medical management (including stabilisation) of the patient
- determining the need for initiating the transfer. Refer to the WACHS Assessment and Management of Interhospital Patient Transfers Policy
- ensuring that the patient and the patient's nominated next of kin are informed of the requirement of transfer and that this is documented in the health record, including the risks to the patient during transfer
- determining the clinical urgency of the transfer (this assessment is to be made in consultation with specialist expertise at the receiving hospital and with trained retrieval specialists)
- determining the receiving hospital and brokering a bed.
- determining the most medically appropriate means of transferring the patient and booking the transport provider (this function is dependent on the transport provider's policies)
- determining and arranging appropriate clinical escorts or other escorts as required, such as police, in liaison with the senior nurse on duty

- advising the transport provider if the patient's clinical condition should change, prior to departure, as clinical changes require a change in the transfer arrangements, such as the requirement for a higher level of clinical escort or additional monitoring equipment
- preparing the patient for transfer, including completing all relevant documentation
- providing clinical handover to the clinical team transferring the patient and the receiving hospital.

7.4 The nurse / midwife caring for the patient

The nurse / midwife caring for the patient prior to transfer is responsible for:

- preparing the patient for transfer, including coordinating all relevant documentation, patient transfer envelope/ checklist, medications, staff and clinical equipment required for transfer. Noting there is sufficient space on documentation for recording of observations, progress notes and medications within the photocopied documentation
- completion of the MR184 WACHS Inter-hospital Clinical Handover Form and other relevant documentation and faxing it to the receiving hospital
- telephoning receiving hospital and having a dialogue with the receiving hospital senior nurse and confirming what is being read back is accurate and has been interpreted correctly
- signing and acknowledging that a verbal handover has taken place.
- booking the transport provider (this function is dependent on the transport provider's policies)
- arranging for any logistical requirements for the transfer, such as meals for staff / patient, taxi vouchers or other fares as required for transferring the patient
- arranging for any necessary pick-up of the transferring team, such as arranging for RFDS staff to be transferred from the airport to the hospital
- travel arrangements for the return of the transferring team if not RFDS and mode of transport is by road. Refer to the WACHS Assessment and Management of Interhospital Patient Transfers Policy
- confirming that the patient's nominated next of kin are informed of the impending transfer
- providing a verbal handover with the patient escort (or transport provider clinician) on patient's condition utilising the ISoBAR format
- telephoning the receiving hospital with updated information should the patient's condition change, and prior to departure, notifying the receiving hospital of the expected time of arrival.

In the absence of access to a medical officer (on-site or via telephone), the senior nurse / midwife on duty is to assume responsibility for the medical officer's responsibilities within their level of registration, and scope of practice.

7.5 The senior nurse / midwife or bed manager at receiving hospital

The senior nurse / midwife or bed manager at the **receiving hospital** is responsible for:

- receiving the MR184 WACHS Inter-hospital Clinical Handover Form and reading back the contents to the nurse/midwife caring for the patient at the sending hospital, to ensure the information has been correctly interpreted by the receiver
- signing the acceptance of care and accountability for the patient
- ensuring appropriate resources are allocated to receive the patient at the estimated time of arrival
- ensuring that the department expected to receive the patient has received the handover and is prepared.

8. Compliance

It is a requirement of the WA Health Code of Conduct that employees “comply with all applicable WA Health policy frameworks."

A breach of the Code may result in Improvement Action or Disciplinary Action in accordance with the WA Health Discipline Policy.

WACHS staff are reminded that compliance with all policies is mandatory.

9. Evaluation

Monitoring of compliance with this document is to be carried out by the Safety and Quality Team, every six (6) months by providing information on the percentage of patients not receiving a verbal and written handover and trending the reasons for this.

Clinical Risk staff are to provide six (6) monthly reports on clinical incidents related to handover.

10. Standards

National Safety and Quality Health Care Standards: 6.1.1, 6.1.3, 6.2.1, 6.3.1

11. Legislation

Health Practitioners Regulation National Law (Western Australia) Act 2010

12. Related Forms

MR184 WACHS Inter-hospital Clinical Handover Form

MR111 WACHS Nursing Admission, Screening and Assessment Tool - Adults

MR120 WACHS Adult Nursing Care Plan

13. Related Policy Documents

WACHS Assessment and Management of Interhospital Patient Transfers Policy

WACHS Interhospital Patient Transfer – Referral for Examination by a Psychiatrist Policy

WACHS Patient Discharge, Escort, Transfer and Transportation Clinical Practice Standard

WACHS Sedation for Mental Health Patients Awaiting RFDS Transfer from Northern and Remote Regions Guideline

14. Related WA Health Policies

Clinical Handover Policy

Clinical Incident Management Policy (2015)

15. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

16. Appendix 1: Richmond Agitation-Sedation Scale (RASS)

(accessed from the WACHS Sedation for Mental Health Patients Awaiting RFDS Transfer From Northern and Remote Regions Guideline)

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

Contact:	Nurse Coordinator Patient Flow (P. Jolly)		
Directorate:	Nursing and Midwifery Services	**TRIM Record #**	ED-CO-15-57742
Version:	3.00	**Date Published:**	3 April 2019

Appendix 1

Richmond Agitation-Sedation Scale (RASS)

1. Patients with acute mental illness, substance abuse, drug overdose or other clinical conditions can exhibit a spectrum of behaviour from extreme agitation to heavy sedation.
2. An objective assessment tool can be used to describe this more accurately. The Glasgow Coma Scale was developed for ranking the level of coma in head injured patients. It was not designed for assessing sedated patients, nor does it score increased levels of arousal.
3. The Richmond Agitation-Sedation Scale (RASS) has been widely used in Intensive Care environments to help communicate the status of patients in a standardized manner and to enable titration of sedation to an optimal level.
4. The RASS has application for aeromedical practice in helping to better communicate and record patient behaviour in a standardized manner.
5. The RASS ranges from +4 to -5. At one extreme, +4 represents a very combative, violent patient, who is considered dangerous to staff. At the other extreme, -5 represents a patient who is unrousable, with no response to voice or physical stimulation. A score of 0 equates with a patient who is alert and calm.
   (See table below.)

Clinical handover

1. WACHS clinical staff requesting RFDS transport must provide a RASS score of the patients in order for the RFDS doctor to assess the flight request. A RASS can be used to document peaks of agitation or sedation, particularly in relation to administration of drugs. Patients should ideally have a target score of 0.
2. A RASS should be recorded prior to handover. Recording of this score provides a quantitative measure of agitation or sedation which will be useful when cases are audited. The formal assessment requires no more than three steps: observing the patient, or speaking to them, or physical stimulation.

References

Sessler CN, Gosnell M, Grap MJ, Brophy GT, O'Neal PV, Keane KA et al. The Richmond Agitation-Sedation Scale: validity and reliability in adult intensive care patients. Am J Respir Crit Care Med 2002; 166:1338-1344.

Ely EW, Truman B, Shintani A, Thomason JWW, Wheeler AP, Gordon S et al. Monitoring sedation status over time in ICU patients: the reliability and validity of the Richmond Agitation Sedation Scale (RASS). JAMA 2003; 289:2983-2991

Richmond Agitation-Sedation Scale (RASS)		
Score	**Term**	**Description**
+4	Combative	Overtly combative, violent, immediate danger to staff
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive
+2	Agitated	Frequent non-purposeful movement, fights ventilator
+1	Restless	Anxious but movements not aggressive vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to *voice* **(>10 seconds)**
-2	Light sedation	Briefly awakens with eye contact to *voice* **(<10 seconds)**
-3	Moderate sedation	Movement or eye opening to *voice* **(but no eye contact)**
-4	Deep sedation	No response to voice, but movement or eye opening to *physical* stimulation
-5	Unrousable	No response to *voice or physical* stimulation

Procedure

Observe patient.

- Is patient alert and calm? **(score 0**)
- Does patient have behaviour that is consistent with restlessness or agitation using the criteria listed above? **(score 1 to 4)**

If the patient is not alert, in a **loud speaking voice** state the patient's name and direct the patient to open their eyes and look at the speaker. Repeat once if necessary. Can prompt patient to continue looking at speaker.

- Patient has eye opening and eye contact, which is sustained for more than 10 seconds. **(score -1)**.
- Patient has eye opening and eye contact, but this is not sustained for 10 seconds. **(score -2)**.
- Patient has any movement in response to voice, excluding eye contact? **(score -3)**.

If patient does not respond to voice, **physically stimulate** patient by shaking shoulder and then rubbing sternum if there is no response to shaking shoulder.

- Patient has any movement to physical stimulation **(score -4)**.
- Patient has no response to voice or physical stimulation **(score -5)**.