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GUIDELINE ON CLINICAL HANDOVER IN THE EMERGENCY DEPARTMENT

1. PURPOSE AND SCOPE

1.1 This document is a guideline for the Australasian College for Emergency Medicine and relates to ensuring effective clinical handover.

1.2 The guideline is applicable to emergency departments in general.

2. INTRODUCTION

2.1 The Australian Commission for Safety and Quality in Health Care (ACSQHC) and the Australian Medical Association (AMA) define clinical handover as '*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*'[1].

2.2 There are few established, evidence-based standards on which to base any guideline or recommendation[1,2]. However a series of articles by teams participating in the ACSQHC's National Clinical Handover Initiative, provide new insights into how medical handovers, in general, can be improved[3].

2.3 Standardisation is an important component of safe and effective communication in high risk industries[4]. To promote optimal care of emergency patients, handover should be accomplished in an effective, orderly, and predictable manner[4].

3. PROCEDURE AND ACTIONS

3.1 Each department should establish and implement a standardised clinical handover procedure suitable to the specific working environment and demands.

3.2 Every member of staff has a responsibility to ensure handover of care within the emergency department, on discharge, or on transfer to another person or professional group on a temporary or permanent basis.

3.3 Handover should be accomplished in an effective, orderly, and predictable manner.

3.4 Scheduled handover round times should occur at the start of each shift as well as other times as dictated by service demands.

3.5 Scheduling should allow protected time for handover rounds to occur during rostered working hours.

3.6 Recognised models for effective team communication and content that can be used as a basis for safe handover include iSoBAR[5,6] and the SBARS[4,7] models.

3.7 Handover round staffing should reflect the multidisciplinary needs of emergency department patients.

3.8 Consultant medical staff should supervise handover to ensure safe clinical decision making and efficiency.

3.9 Handovers should be documented in a manner to allow all staff to readily access continued care arrangements.

3.10 Ideally, each patient should be made aware of the clinical handover. The new doctor should introduce themselves, and review clinical details as required to ensure accurate diagnosis and management.

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