The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

Clinical Handover

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: July 2011
Current: July 2019
Review due: July 2022

Background: This statement was first developed by Women's Health Committee in July 2011 and most recently reviewed in July 2019.

Funding: The development and review of this statement was funded by RANZCOG.

1. Plain language summary

A structured approach to clinical handover of patient care is important for all areas of obstetrics and gynaecology. Maternity care is an area of particular risk and vulnerability for the pregnant woman and her newborn/s since they will frequently require care from multiple professionals particularly during labour, birth and the postnatal period. Episodes of care commonly result in change of care locations, involvement of junior staff and care falling on holiday periods or weekends. This makes it particularly important that all professionals involved in care have accurate, relevant and timely transfer of information.

2. Summary of recommendations

Recommendation 1	Grade
All organisations providing maternity and gynaecological services should have a formalised approach to clinical handover. [1]	Consensus-based recommendation
Recommendation 2	**Grade**
All organisations providing maternity and gynaecological services should establish written guidance on clinical handover and ensure appropriate resources to enable an efficient, meaningful, and quality handover process.	Consensus-based recommendation
Recommendation 3	**Grade**
All organisations providing maternity and gynaecological services should adopt a structured handover tool to help ensure that staff are sharing relevant, concise and focused information	Consensus-based recommendation
Recommendation 4	**Grade**
Access to a woman's record of care including for maternity patients' antenatal visits and all pathology and imaging results should be made available to clinical teams accepting care.	Consensus-based recommendation
Recommendation 5	**Grade**
Clinical handover should be embedded in a quality change cycle which includes audit.	Consensus-based recommendation

3. Introduction

Clinical handover has been defined by the Australian Commission for Safety and Quality in Healthcare (ACSQH) 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. The need for clinical handover is usually triggered when:

- A patient has a change of location of care; and/ or
- When the care of a patient shifts from one provider to another.

Clinical handover is an essential part of good clinical practice and is a high-risk area for patient safety. The Australian Commission for Safety and Quality in Healthcare (ACSQH) devotes standard 6 of the National Safety and Quality healthcare Standards (2012) to defining the components of a safe and effective clinical handover process. Although the Medical Council of New Zealand (MCNZ) as part of their "Good Practice Guide" state that it is important to use effective handover procedures and communicate clearly with colleagues, New Zealand currently lacks specific National guidance on the structure or components of clinical handover.

Poor transfer of care or handover communication is widely recognised as a major preventable cause of harm. Safe transfer of care relies on consistently good communication and there are many stages in a person's care journey where this can go wrong, including:

- when there is a change of shift
- when more than one professional group is involved in providing care
- when patients pass through many different departments
- when care settings change
- when patients have complex needs requiring more information to be conveyed
- at weekends or holidays
- if there is an organizational culture such that junior staff are reluctant to ask for clarification from more senior staff or other professions
- where there is no written documentation, or what is written is unclear

Recognising that the development of a more formalised and consistent approach to clinical handover would be a major change for many organisations ACSQH funded a National Clinical Handover Initiative to develop a tool that would enable an organisation to develop a robust clinical handover process when it became clear that there was a link between clinical handover and safe care.

4. Discussion

Success in establishing an effective clinical handover appears to be dependent upon the culture of an organisation and their commitment to provide leadership for the process and the resources to ensure clinical handover is successful. Adequate uninterrupted time needs to be allocated for the process. Senior staff need to be actively engaged in the handover. All staff need to be supported and provided with training in communication, and teamwork skills.

Recommendation 1	Grade
All organisations providing maternity and gynaecological services should have a formalised approach to clinical handover. [1]	Consensus-based recommendation
Recommendation 2	**Grade**
All organisations providing maternity and gynaecological services should establish written guidance on clinical handover and ensure appropriate resources to enable an efficient, meaningful, and quality handover process.	Consensus-based recommendation

There is general acceptance and emerging evidence to show that a structured approach to clinical handover increases the likelihood that the right information is communicated and retained. Only 2.5% of information from the first handover is retained at the final handover if there is no written record. If notes are taken, 85.5% of information is retained, but this rises to 99% when a standardised proforma is used[i].

A number of structured approaches to clinical handover have been developed including ISBAR, iSoBAR, SBAR, SHARED, and Hand me an ISOBAR. These tools are checklists which support structured communication that enables information to be transferred accurately between individuals reducing the need for repetition and the likelihood for errors. The acronyms assist clinicians to remember the information required for handover as the structure is shared, it also helps staff anticipate the information needed by colleagues and encourages assessment skills. The \Australian Commission of Quality and Safety in Healthcare *Clinical Handover Standard 6: Clinical Handover* document provides an excellent summary of these approaches.

5. Specific examples

5.1 Labour

For women in labour it is essential that the information provided includes all risk factors, progress in labour including any departure from normal labour, all pain relief and medications administered, and information regarding the woman and her partner's expectations and wishes regarding their care.

Recommendation 3	Grade
All organisations providing maternity and gynaecological services should adopt a structured handover tool to help ensure that staff are sharing relevant, concise and focused information	Consensus-based recommendation

A critical component of an effective clinical handover process is to ensure that all the relevant patient information is at hand. This means ensuring that all tests and investigations results are available, the woman's care during their stay is clearly documented including any discussions held with the woman in relation to their care.

For all women admitted to a birthing facility there must be ready access to a record of her antenatal visits and all pathology and imaging results that have been performed during or before her pregnancy.

When the care to that point in time has not been provided by the hospital staff, and this information is not part of the hospital record, then the clinician responsible should ensure the woman has a copy of her care and this should be supplemented with personal contact from the previous care provider to the accepting clinical team.

For labouring women there must be detailed contemporaneous records of all examinations (including vaginal examinations) and assessments, recording of maternal observations, interventions, details of the liquor, progress, heart recordings and all medications administered in the course of the labour.

Recommendation 4	Grade
Access to a woman's record of care including for maternity patients antenatal visits and all pathology and imaging results should be made available to clinical teams accepting care.	Consensus-based recommendation

In order to provide safer patient care, the clinical handover process should be subjected to regular audit. The purpose of audit is to measure compliance with policies and protocols and to monitor the frequency and severity of adverse events in relation to clinical handover. This information can be used to improve practice.

Recommendation 5	Grade
Clinical handover should be embedded in a quality change cycle which includes audit.	Consensus-based recommendation

5.2 Locums

There should be a comprehensive clinical handover with the Locum prior to and upon completion of the placement.

6. References

Australian Commission on Safety and Quality in Health Care. 2010. Guide to Clinical Handover Improvement
https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/ossie.pdf

7. Relevant background material

- Australian Commission on Safety and Quality in Health Care, Safety and Quality Portal Communicating for Safety https://www.c4sportal.safetyandquality.gov.au/
- eMJA: Clinical handover: Critical Communications
http://www.mja.com.au/public/issues/190_11_010609/jor11299_fm.html
- Health Quality and Safety Commission New Zealand Clinical Handover Improvement Project
http://www.hqsc.govt.nz/our-programmes/other-topics/quality-and-safety-challenge-2012/projects/clinical-handover/
- NZ Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)
http://www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines
- Victorian Dept of Health Clinical Handover Standard 6: Clinical Handover.
https://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwjmv5-T-svgAhVJf30KHY9VC94QFjABegQICRAC&url=https%3A%2F%2Fwww2.health.vic.gov.au%2FApi%2Fdownloadmedia%2F%257B9350B651-3885-4DD2-B618-D4E624EEC210%257D&usg=AOvVaw35qQjKPHNQWis2x9cGfeRO
- Improving Patient Handover, RCOG Good Practice No.12, Dec 2010.
https://www.rcog.org.uk/globalassets/documents/guidelines/goodpractice12patienthandover.pdf
- National Midwifery Guidelines for Consultation & Referral 3rd Edition Issue 2, 2014.
http://issuu.com/austcollegemidwives/docs/guidelines2013/1
- NICE Quality statement 4: Structured patient handovers Emergency and acute medical care in over 16s, September 2018. https://www.nice.org.uk/guidance/qs174/chapter/Quality-statement-4-Structured-patient-handovers
- Bhabra G, Mackeith S, Monteiro P, Pothier DD, An experimental comparison of handover methods (2007)

8. Links to other College statements

Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)
http://www.ranzcog.edu.au/component/docman/doc_download/894-c-gen-15-evidence-based-medicine-obstetrics-and-gynaecology.html?Itemid=341

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair and Board Member
Dr Gillian Gibson	Deputy Chair, Gynaecology
Dr Scott White	Deputy Chair, Obstetrics and Subspecialties Representative
Associate Professor Ian Pettigrew	Member and EAC Representative
Dr Kristy Milward	Member and Councillor
Dr Will Milford	Member and Councillor
Dr Frank O'Keeffe	Member and Councillor
Professor Sue Walker	Member
Dr Roy Watson	Member and Councillor
Dr Susan Fleming	Member and Councillor
Dr Sue Belgrave	Member and Councillor
Dr Marilyn Clarke	ATSI Representative
Associate Professor Kirsten Black	Member
Dr Thangeswaran Rudra	Member
Dr Nisha Khot	Member and SIMG Representative
Dr Angela Brown	Midwifery Representative
Ms Ann Jorgensen	Community Representative
Dr Rebecca Proctor-Mackenzie	Trainee Representative
Prof Caroline De Costa	Co-opted member (ANZJOG member)

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in July 2011and was most recently reviewed in July 2019. The Women's Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the November 2013 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix A part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.