Clinical Handover in ICU Workshop Report
Acknowledgements

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1. Executive Summary

In response to the release of the National Safety and Quality Health Service Standards of which Clinical Handover forms a part (Standard 6), a workshop on clinical handover in ICUs was held at the 2013 ANZICS 7th International Conference on Safety, Quality, Audit and Outcomes Research in Intensive Care. The aim was to collect contextual information around clinical handover in the ICU, concentrating on how each of the criterions and required actions can be achieved.

The perspectives of ICU clinicians were collected and collated at the workshop. Major themes were identified and the narratives were synthesised for the purpose of presenting the information in a logical and coherent manner. A considerable amount of contextual information including barriers and enablers to addressing the criteria was obtained and is detailed in the results section of this report. The major themes were:

**Governance and leadership** – there was an identified need to: have strong clinical leadership in the handover process; establish written guidelines; use and adapt existing handover tools and guides; monitor the utility of these tools in clinical practice and periodically review them.

**Clinical handover processes** – it was deemed important to: distinguish clinical handover from other processes e.g. ward rounds; develop comprehensive structured handover processes including minimum mandatory components; ensure dedicated, uninterrupted time for handovers and senior clinical supervision; establish handover schedules, team member roles and responsibilities, and a culture of reviewing, monitoring and evaluating clinical handover; provide regular feedback for the purpose of quality improvement.

**Patient and carer involvement in clinical handover** – a diverse range of opinions on this topic were evident however, the more prevalent issues were to: inform patients and carers on the purpose of handover; balance involvement to achieve valuable contribution and handover efficiency; establish the role of carers; effectively manage patient privacy and confidentiality issues; and identify what is and isn’t appropriate information to share during handover.

When taken together, the results, criteria and actions required, informed the development of recommendations to address the National Standards for clinical handover.
2. Introduction

Routine transfer of complex clinical information between clinical staff is a process central to the functioning of an intensive care service. Errors of communication, when care of the patient is transferred, are common and can result in preventable adverse events.\(^1\)

Extensive work on clinical handover improvement was completed in 2006 by the Australian Medical Association (AMA)\(^2\), and 2010-2011 by the Australian Commission on Safety and Quality in Healthcare (ACSQHC)\(^3,4\). Since then, the ACSQHC has produced a document outlining ten National Safety and Quality Health Service Standards (National Standards) of which Clinical Handover forms a part (Standard 6)\(^5\).

The Clinical Handover Standard requires “clinical leaders and senior managers of a health service organisation implement documented systems for effective and structured clinical handover. Clinicians and other members of the workforce use the clinical handover systems”. The intention of the Standard is to “ensure there is timely, relevant and structured clinical handover that supports safe patient care”.

To ensure a co-ordinated approach to addressing this standard for ICU, the Australian and New Zealand Intensive Care Society (ANZICS) organised and held a workshop on clinical handover in ICU during the 7th International Conference on Safety, Quality, Audit and Outcomes Research in Intensive Care (SQAO), held in Sydney on 29 July 2013.

The aim of the workshop was to draw on the collective experience and knowledge of the workshop attendees to consider how ICUs can achieve the prescribed actions outlined in Clinical Handover Standard 6 (see Table 1). Content of the workshop has consequently been collated, with the results outlined in this report.
Table 1. Criteria and actions required to meet Clinical handover (Standard 6)

<table>
<thead>
<tr>
<th>Governance and leadership for effective clinical handover</th>
<th>Criterion will be achieved by:</th>
<th>Actions required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialties, including:</td>
<td>6.1.1 Clinical handover policies procedures and/or protocols are used by the workforce and regularly monitored</td>
<td>6.1.2 Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols</td>
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<td>6.1.3 Tools and guides are periodically reviewed</td>
<td>6.1.3 Tools and guides are periodically reviewed</td>
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</tr>
<tr>
<td>6.2 Establishing and maintaining structured and documented processes for clinical handover</td>
<td>6.2.1 The workforce has access to documented structured processes for clinical handover that include:</td>
<td>6.2.2 Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers</td>
</tr>
<tr>
<td>6.3 Monitoring and evaluating the agreed structured clinical handover processes, including:</td>
<td>6.3.1 Regular evaluation and monitoring processes for clinical handover are in place</td>
<td>6.3.3 Action is taken to increase the effectiveness of clinical handover</td>
</tr>
<tr>
<td>6.4 Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any clinical handover incidents</td>
<td>6.4.2 Action is taken to reduce the risk of adverse clinical handover incidents</td>
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</tr>
<tr>
<td>6.5 Developing and implementing mechanisms to include patients and carers in the clinical handover process that are relevant to the healthcare setting</td>
<td>6.5.1 Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use</td>
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Clinical handover processes

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<tr>
<td>6.2.3 Action is taken to increase the effectiveness of clinical handover</td>
<td></td>
</tr>
<tr>
<td>6.2.4 The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance</td>
<td></td>
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</tbody>
</table>

Patient and carer involvement in clinical handover

| 6.5 Developing and implementing mechanisms to include patients and carers in the clinical handover process that are relevant to the healthcare setting | 6.5.1 Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use |
3. Method

3.1 Workshop

3.1.1 Participants

There were 90 registrants to the entire ANZICS SQAO Conference, including the Clinical Handover workshop.

3.1.2 Procedure

Prior to day of the workshop, potential participants were sent background notes (Appendix A), the National Standards for clinical handover, and clinical handover guides from both the AMA and the ACSQHC. Participants were informed there would be a specific focus on shift-to-shift, face-to-face handovers.

The workshop was structured so that one major criterion was addressed at a time. One hour was allowed for the first interactive session which addressed the criteria related to clinical handover processes (criteria 6.2 to 6.4). The following sessions were allocated around 30 minutes each – the second session focussed on governance and leadership for effective handover (criteria 6.1), the third session addressed patient and carer involvement in clinical handover (criteria 6.5).

Brief introductions were given at the beginning of each session. There were six tables and participants were in groups of up to 10 at each table which included a facilitator who helped guide discussions according to the questions posed (as outlined in Appendix A). The facilitators documented the group’s responses on a template containing the criteria and specific questions.

3.1.3 Data management and analysis

All completed templates were collected at the end of each session. Written responses were collated, recorded, organised and counted. Major themes were then identified and synthesised for the purpose of providing a comprehensive and coherent summary of the information shared.
4. Results

4.1 Governance and leadership for effective clinical handover

4.1.1 Addressing Criteria 6.1

‘Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialties, including: documented policy, procedures and/or protocols; agreed tools and guides.’

Summary of responses:

- ICUs need to establish written guidelines for various types of handover including handover types, timing, location, content, structure, methods for evaluation and potential improvement strategies.
- The use of existing handover tools and guides (see resources in Reference list) was generally agreed and recommended for use (perhaps with some local adaptations) in ICUs.
- Appropriate tools include checklists/proformas, handover module in clinical information systems or other electronic devices, multi-user handover summary documents. If new tools are required, they should be designed for purpose by local clinicians.
- It is important to have mechanisms in place that ensure periodic review of clinical handover policies, tools and guides and regular monitoring of their utility in clinical practice.
- Strong clinical leadership is essential to establishing a culture of improvement. ICU Directors (and perhaps other senior clinical staff) need to lead by example including modelling good handover technique, regularly review and assess unit handover practices, provide feedback, and engage staff in appropriate quality improvement strategies.
4.2 Clinical handover processes

4.2.1 Addressing Criteria 6.2 to 6.4

Criteria 6.2 ‘Establishing and maintaining structured and documented processes for clinical handover.’

Summary of responses:

- There is a need to distinguish and delineate between ward rounds, multidisciplinary team planning, and handover of care. For some units e.g. Paediatric ICUs, these functions and processes may be integrated. For adult ICUs however it was generally felt that each had different purposes particularly for morning or evening handovers where staff are required to transfer responsibility and accountability for care. It was generally thought that handover should be a brief, focussed overview of patient care during the shift, with key issues highlighted.
- ICUs need to develop comprehensive, structured handover processes using existing templates and tools (see resources in Reference list) that will require modification to fit with the type, size and role of each ICU, the type and purpose of handover, the location of handover and team members involved.
- A set of minimum mandatory components (e.g. patient identification, medical history including presenting problem/diagnosis, management plan including treatment limitations, significant events/change during shift, interventions/investigations) should be considered for inclusion in tools and/or electronic data capture.
- Establishing a schedule for all ICU handovers including the type, frequency, times, and documentation required for each is recommended.
- Ensuring dedicated uninterrupted time is paramount to effective handover (includes necessary documentation).
- Setting the location for handover will depend on the type and purpose of handover being conducted, the layout of the unit (e.g. individual patient rooms, availability of meeting rooms, whether there is adequate space for the number of clinicians doing the handover, etc.), and staffing requirements at the time of handover (e.g. if bedside nurse input is required then handover at bedside may be desirable or else relieving nurse will need to be arranged). Consideration should be given to the appropriateness of the location, efficiency in terms of both time and quality of handover, and effectiveness of the transfer of information while maintaining continuity of patient care.
• Determining who should be involved in handover will also depend on the type and purpose of handover. It is important however to involve the nurse looking after the patient irrespective of whether it is a nursing or medical handover. Medical handovers should involve senior clinical supervision and facilitation; handovers between junior medical staff only is strongly discouraged in ICU. Essentially, staff involved in handover will include members of both the outgoing and incoming team. Multidisciplinary morning handovers were seen as desirable. Team member roles and responsibilities in each type of handover need to be clear and explicitly stated in relevant documentation.

• Clinical handover at the bedside should at the minimum include an acknowledgement of the patient (if conscious) and/or family members/carers (see below for more information pertaining to patient and carer involvement).

• When deciding what to document, the following should be considered: ideally only document what is not documented elsewhere or highlight important aspects of cares documented elsewhere; if compliance with documentation is good and easily accessible then verbal handover can be brief; although the use of written notes are common they are hard to keep updated and can be misplaced; the best way of exchanging sensitive patient information in the unit; whether sign-off on information exchanged during handover is appropriate.

• Consideration could be given to recording verbal handovers for playback where required e.g. voice tags on Electronic Medical Record.

• There needs to be a mechanism for handing over information about patients “external” to the unit that have had contact with, or may require, the ICU service e.g. ICU outreach, liaison, Medical Emergency Team (MET) calls, etc.

• An emphasis on teaching handover to staff, including how to evaluate and provide feedback on processes, should be integrated into practice.

Criteria 6.3 ‘Monitoring and evaluating the agreed structured clinical handover processes…’ and Criteria 6.4 ‘Implementing a robust organisation-wide system of reporting, investigation and change management to respond to any clinical handover incidents’.

Summary of responses:

• Finding the balance between comprehensiveness and efficiency during handover will be a constant challenge that will require ongoing review, evaluation & monitoring processes to ensure effectiveness.

• When the need for improved handover processes are identified, targeted quality improvement strategies should be devised, implemented and evaluated.
- A culture of reviewing, monitoring, evaluating and improving handover must be established and maintained as an important clinical process.

- Clinical audit of handover processes using established standards are required for monitoring purposes. Structured audit tools applicable to the local ICU and type of handover being assessed should include compliance with minimum standards. Observational audits could include time taken per patient, number of distractions, interruptions and off-topic conversations, input from bedside nurses. Retrospective audit could involve reviewing required documentation, use of tools and/or templates, adverse events, complaints, use of outreach or medical emergency teams, readmissions to ICU, after hours discharge.

- Investigating and monitoring incidents, adverse events and near misses were highlighted as possible methods of evaluating the effectiveness of clinical handovers. There are a number of different systems across Australia and New Zealand that collect this information, however most are not mandatory and/or reliant on self-reporting, limiting the utility of the review process. It was also identified that there are difficulties in attributing incidents to handover practice.

- Subjective assessments on the handover process could be obtained from ICU staff via surveys, interviews, score cards and other relevant feedback mechanisms. Important feedback could include the value, accuracy and completeness of information handed over, determining how much information was given versus how much was received, whether actions and plans communicated during handover are followed, identifying strengths and weaknesses of the handover process, highlighting areas for improvement at the individual or unit level.

- Appropriate methods for regular feedback to staff on evaluations of handover practice need to be established. Methods of feedback could include direct, two-way process (e.g. provider and receiver of information handed over), individual performance report, formal audit of unit-level handover processes.

- Importantly, there must be adequate resources available for these processes.
4.3 Patient and carer involvement in clinical handover

4.3.1 Addressing Criteria 6.5

‘Developing and implementing mechanisms to include patients and carers in the clinical handover process that are relevant to the healthcare setting.’

Summary of responses:

How should patients and carers be involved?

- Engage with and inform patients (when conscious) and family (when present) of the purpose of handover, explain what is being done. Encourage them to listen and perhaps flag anything that is important e.g. incorrect information. Consider informing them about what the plan for the day is. Further and more detailed questions can be asked later e.g. during ward rounds or family meeting.
- Purposeful exclusion from handover is unlikely to be required however over-engagement of patients and carers has the potential to impact on handover efficiency
- Providing the opportunity for patients and/or their carers to give feedback regarding what they hear can be really important. They may be able to provide clarity around identification, history, allergies, sharing observations of subtle changes that might go unnoticed by clinical staff.
- Identify a key contact person who is able to represent the patient where appropriate.
- Establish the role of carers re: sharing information about the patient (initially and ongoing).
- Establish mechanisms to share information at a later time e.g. asynchronous journaling noting questions and important contributions, schedule family interviews.
- Patient and carer involvement in handover may be particularly relevant for long term ICU patients.
- Consider ‘formal engagement with family within 48 hours of admission’ for inclusion in standardised handover tool.

Issues for consideration:

- Patient privacy and confidentiality issues must be recognised and handled appropriately. This includes determining whether patient consent is required prior to sharing information with carers during handover. Emphasis on the duty-of-care to patient.
• Implement mechanisms to share information with appropriate people (requires recognition of complex interpersonal/family/social dynamics).
• The ability to engage, acknowledge and address issues raised by family members during handover.
• Appropriateness of involving patients in the handover process e.g. if purpose is a quick update on important events and exchange of clinically relevant information.
• Identifying circumstances where patient and/or carer involvement would be inappropriate e.g. sensitive issues the patient might not want shared, when family conflict is evident, when carers are not a nominated contact or are poor advocates for the patient, during transfer of asynchronous clinical information between health professionals.
• Potential for miscommunication given the terminology typically used during handover i.e. very clinically-oriented which may not be conducive to effective communication with laypersons.
• If communication with patients/carers during handover was mandated, it might influence what information is exchanged (e.g. important information may be omitted), and increase the amount of interruptions and time spent doing handovers. These likely scenarios highlight the potential for increased risk of error and inefficiencies in service delivery.
5. Recommendations

5.1 Addressing the National Standards for Clinical Handover

5.1.1 ICUs to give consideration to how they will meet the National Standards for clinical handover and take appropriate actions where required.

5.1.2 As this report provides specific ICU context to clinical handover, it can be considered as an adjunct to the National Standards.

5.1.3 A focus on shift-to-shift, face-to-face handovers is a good starting point from which ICUs can start to address the criteria specified, however there are various types of handovers (both internal and external to the ICU) that should also be factored in.

5.1.4 Establishing a set of minimum mandatory components for clinical handover process (e.g. transfer of information), documentation and reporting for Australian & New Zealand ICUs would standardise essential elements of care and enable consistency across ICUs (desirable due to transitions in workforce e.g. medical rotations, and evaluating health system performance).

5.2 Addressing criteria for governance and leadership for effective clinical handover

5.2.1 Local policies, procedures and/or protocols for handovers must be established and/or reviewed in light of the Standards and contextual information in this report.

5.2.2 The use of existing tools and guides with local ICU adaptations is appropriate.

5.2.3 Mechanisms for periodic review of clinical handover policies, tools and guides need to be developed.

5.2.4 Methods of regularly monitoring the utility of policies, tools and guides should be developed and implemented.
5.3 Addressing criteria for clinical handover processes

5.3.1 The purpose of clinical handover must be specified and delineated from other clinical processes such as ward rounds, team/unit planning etc.

5.3.2 ICUs need to develop comprehensive, structured handover processes using existing templates and tools that can be adapted to the local clinical setting.

5.3.3 Identifying the what, who, how, when and where of clinical handover in the ICU is a necessary component of developing a structured process for clinical handover.

5.3.4 Provision for documenting important handover information needs to be established and maintained.

5.3.5 Mechanisms for monitoring, evaluating and improving handover at the local ICU level should be integrated into practice.

5.3.6 ICU Directors (or delegate) need to provide strong clinical leadership for effective clinical handover by modelling good handover technique, participating in periodic review processes, providing feedback and engaging staff in quality improvement strategies.

5.3.7 Strategies for evaluating the effectiveness of clinical handover processes are required such as clinical, observational, and retrospective audits using established standards and tools, and subjective assessments provided by clinical staff.

5.3.8 Improve collection, reporting, and monitoring of incident data including those that could be attributed to clinical handover.

5.3.9 When issues are identified e.g. risk of adverse clinical handover incidents, inadequate information exchange, appropriate actions must be identified, implemented and reviewed.

5.3.10 Appropriate feedback mechanisms need to be established for the purpose of clinical practice improvement.

5.3.11 Resources need to be allocated to clinical handover review, monitoring, evaluation and improvement strategies, where appropriate.
5.4 Addressing criteria for patient and carer involvement in clinical handover

5.4.1 At a minimum, staff should acknowledge the patient and carers (if present), inform them about the process, whether they will be involving them in the handover or at some other time (e.g. ward rounds, family conference, etc.).

5.4.2 ICUs should give careful consideration to the role of patients and carer involvement in clinical handover and include this in relevant policies and procedures.

5.4.3 ICU clinicians should be mindful there could be important information that patients and/or their carers can contribute e.g. history, allergies, observations of subtle changes etc.

5.4.4 Policies and procedures must address patient privacy and confidentiality issues.

5.4.5 If patients and carers are to be involved in the handover process (or part thereof), clinicians need to ensure that what is communicated is clear, concise, appropriate, and understandable to laypersons.
6. Conclusion

Building on existing work completed by both the AMA and ACSQHC, the aim of the Clinical Handover workshop was to draw on the collective experience and knowledge of the workshop attendees to consider how ICUs can achieve the prescribed actions outlined in Clinical Handover Standard 6 of the National Safety and Quality Health Service Standards. Participants were asked to address each of the criterions via group discussions that were guided and documented by facilitators in each group.

The results demonstrated a substantial amount of contextual information about clinical handover from an ICU perspective. A number of enablers and barriers to addressing the criteria were also identified. The collective responses informed a number of recommendations for consideration by relevant ICU staff (such as directors and nurse unit managers), related departments (such as clinical governance units), and health service planners (for monitoring and reporting purposes).
7. References

8. Appendices

8.1 Appendix A

8.1.1 Background notes for the SQAO 2013 Handover Workshop.

The SQAO 2013 workshop will provide an opportunity to focus on aspects clinical handover in the intensive care unit.

Routine transfer of complex clinical information between clinical staff is a process central to the functioning of an intensive care service. Errors of communication, when care of the patient is transferred, are common and can result in adverse events.

Importantly the workshop will focus on ICU handover in the context of the recently published National Safety and Quality Health Service Standards. A copy of this document has been distributed prior to the workshop. There are ten Standards; Clinical Handover is Standard 6. The intention of this standard is to "ensure there is timely, relevant and structured clinical handover that supports safe patient care". While of course there are multiple types of handover in the ICU, the focus for the workshop will be on shift-to-shift, face-to-face medical and nursing handover.

We will draw on the collective experience and knowledge of the workshop attendees to consider how ICUs can achieve the prescribed actions outlined in Clinical Handover Standard 6. Content of the workshop will be collated to inform a draft document that provides broad recommendations for Intensive Care Units on ways to undertake, monitor the effectiveness of, and involve patients and carers in the ICU handover process.
Interactive Session 1. The handover process in the ICU.

“Health service organisations should have documented and structured clinical handover processes in place” (Criteria 6.2 to 6.4)

For shift-to-shift, face-to-face, clinical handover in the ICU please consider;

- Where and when handover should occur?
- Who should attend?
- Effective ways of structuring the handover process?
- Are there mandatory elements that should always be communicated as part of the transfer of care process?
- Is there evidence to support one particular handover process over another?
- Should the model be the same regardless of unit type/size etc.?
- What should be documented versus what remains verbal?

Interactive Session 2. Governance and Leadership for effective handover.

“Health service organisations implement effective clinical handover systems” (Criteria 6.1.)

For clinical handover in the ICU please consider;

- What tools can we use to help guide and ensure compliance with established ICU handover process & should they be mandated?
- How do we evaluate the effectiveness of clinical handover?
- What processes should we have in place to ensure that the handover process is periodically reviewed and improved?
Interactive Session 3. Patient and carer involvement in clinical handover.

“Health service organisations establish mechanisms to include patients and carers in clinical handover processes” (Criteria 6.5)

Clearly this standard poses particular challenges in the ICU environment.

For clinical handover in the ICU please consider;

- How can patients and /or carers be involved and contribute to the handover process?
- What are the challenges?
- Are there any circumstances where patient and/or carer involvement would be inappropriate?
- What would the model look like?

For session four we move away from the guidelines and consider how an ICU electronic clinical information system can enhance, maintain and monitor our handover processes. This session will be lead by the NSW ICCIS implementation team.

- Brief overview of the Intensive Care Clinical Information System Program
- Review the evidence around the enhanced effectiveness of clinical handover using an Intensive Care Clinical Information System
- Current electronic record functionality for clinical hand over
- Capturing outcomes of the SQAO Clinical Handover Workshop for the ICCIS Implementation Planning Study to design and build an ICCIS.
### 9. Glossary

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACSQHC</td>
<td>Australian Commission on Safety and Quality in Healthcare</td>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>ANZICS</td>
<td>Australian and New Zealand Intensive Care Society</td>
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<tr>
<td>ICCIS</td>
<td>Intensive Care Clinical Information System</td>
</tr>
<tr>
<td>ICCMU</td>
<td>New South Wales Intensive Care Coordination and Monitoring Unit</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>SQAO</td>
<td>International Conference on Safety, Quality, Audit and Outcomes Research in Intensive Care</td>
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Advocate for intensive care throughout Australia and New Zealand