Safe Clinical Handover

A resource for transferring care from General Practice to Hospitals and Hospitals to General Practice

CONTENTS

FOREWORD

Clinical handover is the effective 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]

Good clinical handover is essential for safe patient care, good patient experiences and excellent patient outcomes. This resource has been developed to support best practice in the two way transfer of care between general practice and hospital settings. The project has been a collaboration between the NSW Ministry of Health, the NSW Agency for Clinical Innovation, General Practice NSW and the Royal Australian College of General Practitioners (RACGP). It draws on the ongoing work undertaken by hospital staff and general practitioners across many organisations, including the work on the National Safety and Quality Health Service Standards, namely Standard 6 relating to Clinical Handover[2].

This document does not specifically reference the Personally Controlled Electronic Health Record or the shared electronic medical record (eMR). Developments in this area hold much promise for the exchange of information on a patient's health record. However, the use of a shared electronic health record does not substitute for good communication around transferring responsibility and accountability for care.

This resource supports best practice in the bi-directional clinical handover between general practice and hospital suggesting that hospitals and general practices work together to:

1. build a person-centred shared care culture

2. develop a shared understanding of the tasks and responsibilities of the hospital clinician and general practitioner

3. partner with patients, their families and carers in the clinical handover process, and

4. standardise the two-way exchange of information required to transfer care.
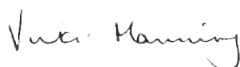
The importance of general practices, Medicare Locals, Aboriginal Community Controlled Health Services and Local Health Districts and Specialty Networks working together to develop a shared care culture that includes shared processes cannot be understated.

We would like to acknowledge Professor Teng Liaw and Dr Anett Wegerhoff for their input and guidance in drafting this resource.

We commend this resource to you.

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EXECUTIVE SUMMARY

> Transfer of care is the:
>
> … transfer of professional responsibility and accountability for some or all aspects of care for a patient… to another person or professional group on a temporary or permanent basis[1].

Health professionals and patients have indicated that the timely delivery of accurate communications around transfer of care could be improved.

This resource provides solutions and recommendations to improve clinical handover practices between general practices and hospital settings. For this to occur there needs to be strong leadership for a locally agreed vision that focuses on:

1. Building **collaborative relationships**

2. Establishing a **shared care culture locally**

3. Developing **established processes** that promote structured communication and are shared across the two settings.

Local Health Districts and Specialty Networks (LHDs/SNs), Hospitals, Medicare Locals (MLs), Aboriginal Community Controlled Health Services (ACCHS) and individual General Practitioners (GPs) and their practices will need to work together to develop these local solutions. While it is clear that individual patient needs will vary, this report makes five recommendations that will support improved transfers of care. Recommendations one to three pertain to both the hospital and general practice settings; recommendation 4 is relevant to the hospital setting and recommendation five is a focused on a systemic solution.

Recommendation 1 (see page 9)

The patient, their family and carer must be involved as a partner in the transfer of care decision making processes. This should include time for the patient, their family and carer to provide input, ask questions and the opportunity to clarify answers.

Recommendation 2 (see page 14)

Clear, succinct communication is essential for safe transfers of care. Clinical judgement will be required to determine the appropriate method. In many cases electronic communication will be the optimum method for simple transfers of care. Any mode must be supplemented by direct verbal communication from:

- the hospital medical team to GPs when action is required by the GP within 48 hours of hospital discharge.
- the GP to the hospital admitting medical officer about any referrals where there is a concern regarding the deterioration or potential deterioration of a patient.
- both GPs and hospital clinicians for a patient with complex needs.

Verbal communications may occur in person or via a telephone call.

Recommendation 3 (see page 14)

Medication reconciliation should occur at every transition of care to ensure a complete and accurate list of medications is available in the patient record.

- The GP should ensure that the patient's current medication list provided to the hospital is up to date.
- The hospital should ensure that the patient's medicines are reconciled at admission, at internal transfers and on discharge in order to provide a complete and accurate list to the GP at discharge.
- On receiving the discharge list of medications the GP should reconcile and update their records as necessary'.

The patient and/or carer should always receive any updated medication list(s).

Recommendation 4 (see page 15)

A patient, their family and carer must leave the hospital with a copy of their discharge communications, including an ongoing management plan. Patients should not be delayed in returning to the community as a result of pending tests and/or results.

Recommendation 5 (see page 15)

NSW Health should work to develop the infrastructure across the system to enable GPs to have access to electronic patient results in the hospital (e.g. PowerChart). This work will require support from Local Health Districts and Specialty Networks, individual General Practitioners, General Practices and Medicare Locals.

A minimum dataset (page 16) and suggested template (page 17) have also been developed to support this work.

DEFINITIONS

WHEN WE SAY	WE MEAN
acute care	the setting that provides care within a hospital. This may include staff in emergency departments, short stay units such as: medical assessment units (MAUs), surgical assessment units and inpatient wards.
carer	individuals providing unpaid support for others with ongoing needs due to a long-term medical condition, a mental illness, a disability or frailty. Examples may be a family member or a friend.
general practice	the medical specialty concerned with the planning and provision of the comprehensive primary health care to all members of a family on a continuing basis (medical home). This may include general practitioners, practice nurses and staff in Medicare Locals and Aboriginal Community Controlled Health Services.
governance	a process designed to ensure that standards are set, met, maintained and improved. It can involve consistent management, policies and shared guidance.
handover transfer of care	the transfer of professional responsibility and accountability for some or all aspects of care for a patient to another person or professional group on a temporary or permanent basis. _Also called: safe clinical handover, transfer of care._ _These terms are used interchangeably within this document to mean the same thing._
health care team	the broad team. This team may include staff in the private and public setting. Some examples of team members will include aboriginal health workers, allied health professionals, community health staff, discharge planners, medical officers (e.g. career, resident, junior), nurses (hospital and general practice), pharmacists, specialists (hospital and general practice) and, where relevant, residential staff (e.g. supported accommodation staff, residential aged care facility). It always includes the patient (and their family and carers).
ISBAR	an acronym that provides a simple, effective way of prioritising information when communicating about a patient and their situation • **Introduction**: identify yourself and the patient • **Situation**: state the patient's current problem and diagnosis • **Background**: state the recent, relevant clinical history for the patient • **Assessment**: provide clinical observations for the patient • **Recommendation**: provide what action you recommend and be clear about timeframes.
medical home, person-centred medical home	within a medical home patients, their families and carers have a continuing relationship with a particular clinician (usually a GP). This partnership is supported by a practice team and other clinical services in the 'medical neighborhood' who support the patients, their family and carers, as required. The medical home coordinates the care delivered by all members of a person's care team, which may sometimes include hospital inpatient care[3,4].
Medicare Local	primary health care organisation, funded by the Commonwealth government, established to coordinate primary health care delivery and tackle local health care needs and service gaps.
paid care worker	individuals providing paid support for others with ongoing needs due to a long-term medical condition, a mental illness, a disability or frailty. Examples include case manager, disability support worker, group home staff.
secure messaging	the secure transfer of information electronically that is encrypted on both sides
transfer of care	See handover

INTRODUCTION

Clinical handover is more than just the transfer of information it is the:

… transfer of professional responsibility and accountability for some or all aspects of care for a patient… to another person or professional group on a temporary or permanent basis[1].

The 2008 *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Garling report) recommended that NSW Health facilities should have a mandated clinical handover policy[5]. In 2009 NSW Health mandated six standard key principles for safe clinical handover in a hospital setting (Table 1)[6,7]. The RACGP Standards for General Practice provide standards for the sharing of patient information in primary care settings[8].

Combined with other handover projects there is now a solid foundation for structured communication in transferring the responsibility and accountability for the care of a patient (Figure 1)[9-11]. In addition this project draws on the experience of Medicare Locals (MLs). MLs are tasked with working closely with Local Hospital Districts (LHD), Specialty Networks (SNs) and Aboriginal

Community Controlled Health Services (ACCHS) to ensure that primary health care services and hospitals work well together to improve patient outcomes[12]. In 2011 the National Safety and Quality Health Service (NSQHS) Standards were introduced to standardise an approach to improve the quality of health care in Australia – Standard 6 is focused on handover[13].

> **Health professionals and patients have indicated timely delivery of accurate handover documents could be improved.**

Table 1: The six standard key principles for safe clinical handover[6]

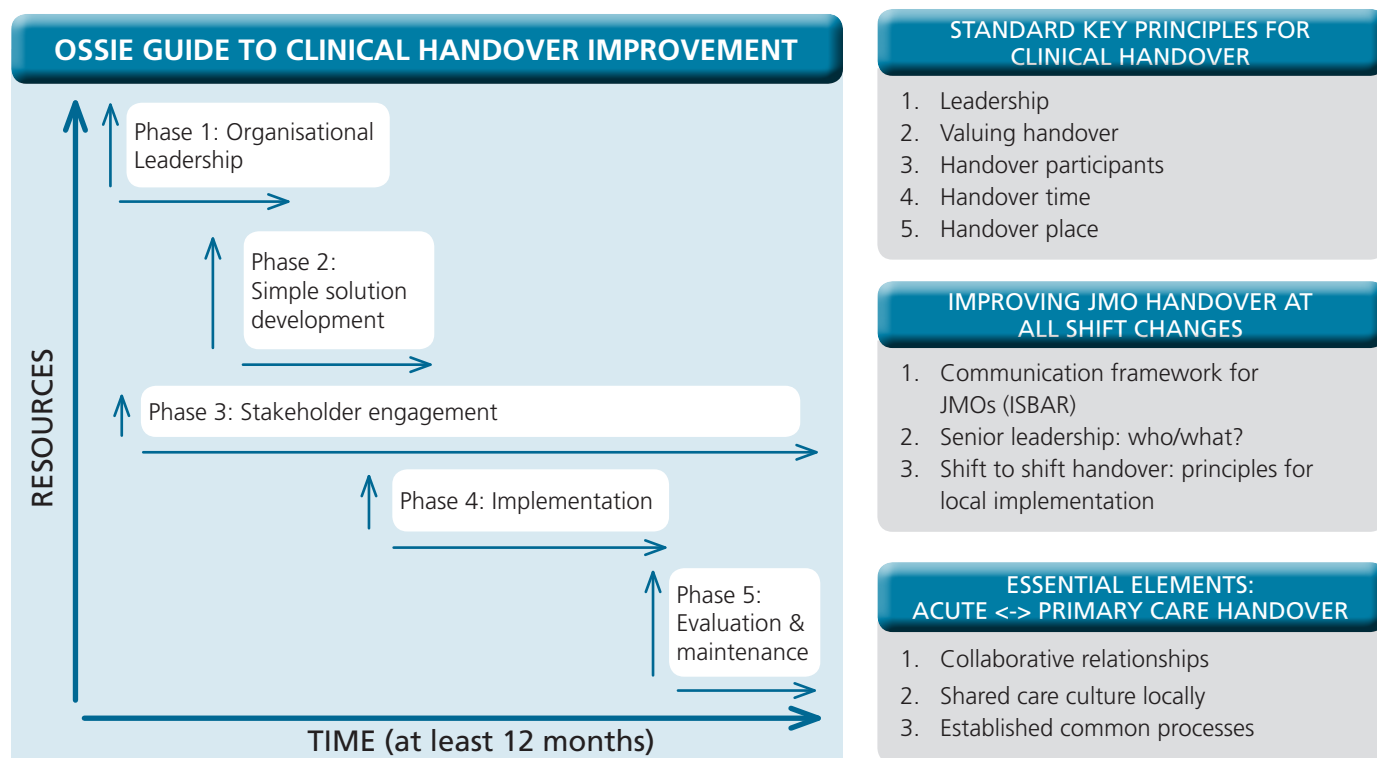|	
Leadership	• Requires senior leadership to highlight the value of handover and provide guidance • Clinical leaders to take responsibility for ensuring communications are provided and received
Valuing handover	• Set the expectation that clinical handover is an essential part of daily work • Establish processes for interdisciplinary team to work together
Participants	• Structured, simple and concise communication across care boundaries • Patients, their families and/or carers should always be involved in the handover process
Handover time	• Clinical judgment should inform timeframes for safe clinical handover • Discharge summaries should be provided on the day of discharge
Handover place	• Clinical judgment will be necessary to determine if handover should occur in person, by telephone, by paper and/or by electronic means
Process	Processes for sharing information across settings should be developed, with local guidance for: • The preferred transfer mode. • Receipt of the handover information. • Secure storage of transfer documentation. • Feedback loops to allow for the exchange of clinical information. • Ensuring patients, families and/or carers are involved in the handover process

The aim of this resource is to produce best practice for the processes around the bi-directional handover between general practice and the hospital setting. This resource doesn't suggest one approach for general practice and another for the hospital setting, rather it recommends taking a joint approach. It provides guidance on:

- building a person-centred, shared care culture.
- engaging patients and carers in the clinical handover process.
- standardising the two way exchange of information, clinical and otherwise.

A minimum data set (Table 5, page 16), a suggested template (Figure 2, page 17) and a provider leaflet (page 24) have been developed based on the evidence regarding safe clinical handover.

> **Local Health Districts, Hospitals, Medicare Locals, Aboriginal Community Controlled Health Services and individual GPs and their practices will need to work together to develop local solutions.**

Figure 1: Building safe clinical handover processes: adding the essential elements:

OSSIE GUIDE TO CLINICAL HANDOVER IMPROVEMENT

Phase 1: Organisational Leadership

Phase 2: Simple solution development

Phase 3: Stakeholder engagement

Phase 4: Implementation

Phase 5: Evaluation & maintenance

RESOURCES

TIME (at least 12 months)

STANDARD KEY PRINCIPLES FOR CLINICAL HANDOVER

1. Leadership
2. Valuing handover
3. Handover participants
4. Handover time
5. Handover place

IMPROVING JMO HANDOVER AT ALL SHIFT CHANGES

1. Communication framework for JMOs (ISBAR)
2. Senior leadership: who/what?
3. Shift to shift handover: principles for local implementation

ESSENTIAL ELEMENTS: ACUTE <-> PRIMARY CARE HANDOVER

1. Collaborative relationships
2. Shared care culture locally
3. Established common processes

THE FIVE QUESTIONS FOR SAFE CLINICAL HANDOVER: WHO? WHY? WHEN? HOW? WHAT?

To improve clinical handover practices there needs to be a locally agreed vision for safe clinical handover. To achieve this vision collaborating teams should ask the five questions of clinical handover: who, why, when, how and what?

Table 2: The five questions for bi-directional general practice to hospital handover

Who?	**Hospital** e.g. specialists, ED physician, JMO, nurse, pharmacist **Primary Care** e.g. GPs, GP practices, ACCHS* **Patients**, their families and carers
Why?	Essential for the delivery of safer patient journeys and better patient experiences
When?	At all transfers of professional responsibility and accountability for some or all aspects of care for a patient moving between the hospital and primary care settings
How?	1. Collaborative relationships 2. Shared care culture locally 3. Common processes
What?	• Minimum data set for communication (Table 5, page 16) • Shared, common template using ISBAR for structured, concise communications (Figure 2, page 17)

Communication with other health care providers should be considered, such as Community Health.

Who?

This resource provides guidance for staff who are responsible the bi-directional transfer of care of patients between hospitals (including Hospital in the Home) and general practice. It covers referral, admission and discharge of patients. The patient, their family and carer should always be included as a participant in the transfer of care process.

This resource does not address specific communications for the transfer of care for patients to and from Residential Aged Care Facilities (RACF), short stay (day only procedural patients) and community health. However, the principles can be applied to any setting, both within and outside the health sector (e.g. Home Care).

Health professionals should be mindful of communicating with all members of the health care team, this will often include community health. Shared communications across the health care team are particularly important when the recommendations are for multiple providers.

Why?

The health system is complex. Safe clinical handover is essential for the delivery of better patient journeys across the entire health system. An improved patient experience of care is an important outcome from enhanced transfer of care.

The case for change in transfer of care processes is supported in literature, root cause analysis (RCA) and coronial investigations[14]. There is evidence that the poor exchange or delayed sharing of information between health professionals negatively affects continuity of care[15-17]. In turn this may negatively impact patients through increased medication errors[18,19], higher readmission rates[16,20] and unnecessary delays in diagnosis, treatment and provision of test results[11].

In addition to impacts on the patient these factors also increase the cost of providing health care.

Issues remain with both the content and delivery of handover information. Current evidence suggests that a significant proportion of discharge summaries are not received by general practice[21]. Additionally health professionals[22], patients[23-25] and carers[26] suggest that their information needs are not met by existing approaches to sharing information.

National Safety and Quality Health Service (NSQHS) Standards

The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They have been designed for use by all health services and can be used as part of an internal quality assurance mechanism or an external accreditation process. This resource links closely with three of the ten standards:

Standard 1: Governance for Safety and Quality in Health Service Organisations

Standard 2: Partnering with Consumers

Standard 6: Clinical Handover

The purpose of *Standard 6: Clinical Handover* is to ensure there is timely, relevant and structured clinical handover that supports safe patient care. Standard 6 recommends:

1. **Governance and leadership** for effective clinical handover through effective clinical handover systems

2. Clinical handover **processes** that are structured and documented

3. **Patient and carer** involvement in clinical handover processes.

Standard 6 has an implementation toolkit for clinical handover improvement[27]. While focused on the hospital setting it is an excellent resource for understanding how to establish a case for change in any organisation and implementing solutions to improving safe clinical handover.

When?

The communication about clinical handover should occur on the day that responsibility for a patient is to be transferred. Where transfer is from a hospital to general practice there should be an established process to ensure that outstanding tests or pending results do no delay a patient returning to the community.

This guidance has been developed specifically for the transfer of care (in both directions) between general practice and the hospital setting. Some examples include:

- referral to hospital (e.g. emergency department, medical assessment unit, pre-anaesthetic clinic)
- discharge from hospital to a patient's medical home (e.g. usual care GP)

However, the principles outlined will be useful to guide communications between the wider health care team. This resource encourages communication with all relevant health professionals across the multidisciplinary team.

Clear processes around clinical handover are particularly important for patients with complex and chronic conditions (see page 15 for further information).

How?

A recent systematic review found that most interventions for improving handover were multi-component and primarily aimed at facilitating the coordination of care and communication between hospitals, primary care providers and pharmacists[28].

This resource identifies three essential elements to safe clinical handover between general practice and hospital settings:

1. Building collaborative relationships
2. Developing a shared care culture locally
3. Establishing common, structured processes

1. Building collaborative relationships

Building collaborative relationships is everyone's responsibility. It requires a commitment from both the general practice and hospital leadership teams. Developing robust, collaborative relationships should decrease the information gaps between general practice and hospital care and place the patient at the centre of care.

> **Building collaborative relationships is everyone's responsibility; it requires strong leadership.**

Language is important when building collaborative relationships. Each professional group has their own specific language. Where possible, avoid acronyms and overly clinical language in handover documentation and communications. This ensures that the entire health care team, including the patient, their family and carer, can participate in decisions regarding transfer of care.

There are two types of collaborative relationships that are important: those between health professionals and those with the patient, their family and carer.

Relationships between health professionals

Health professionals (e.g. hospital staff, general practice teams) often have differing expectations for handover communications[14,29]. To bridge these gaps, relationships between health care professionals are important.

Building collaborative relationships across care boundaries should lead to improved health outcomes, enhanced satisfaction and empowerment for patients and/or carers, a more efficient use of resources and enhanced job satisfaction for team members. It has been demonstrated that introducing a multidisciplinary care coordination team can reduce hospital admission rates and improve stakeholder satisfaction[20].

> **Working together will improve patient experiences and strengthen relationships across settings.**

Relationships with the patient, their family and carer

The principle of collaboration extends to the patient, their family and carer. Patient's priorities about the timing of transfer should be considered using a patient-centred approach. There are three main tenets of patient-centred care:

1. The needs of the patient come first[30];

2. Nothing about me without me[30-32]: transparency and involvement of patients and family members in each clinical decision; and

3. Every patient is the only patient: customisation of care at the level of the individual[30].

Additionally, there is considerable evidence that involving patients and/or their substitute decision makers in clinical handover improves both patient experience and outcomes[14,33]. Involving patients in a meaningful way may require education and empowerment for both staff and patients and/or carers, particularly in improving understanding of their medications[23,24].

Patients should be:

- involved as an active participant in the handover process.
- informed of their clinical progress and changes in clinical management.
- given time and opportunities to ask questions, clarify information and provide feedback.

However, patients are often in a vulnerable state; they may be anxious, have side effects from medication or have functional/cognitive impairment[33-35]. Additional support or input from a patient's family or carer may be useful in these instances.

> ## Recommendation 1
>
> The patient, their family and carer must be involved as a partner in the transfer of care decision making processes. This should include time for the patient, their family and carer to provide input, ask questions and the opportunity to clarify answers.

Person centred medical home

The essential elements of safe clinical handover are underpinned by the concept of the *person centred medical home*. In terms of integrated and coordinated care, the concept of a *medical home* or having a regular provider within a healthcare team is increasingly recognised to improve population health planning and strengthen integration, coordination and continuity of care for patients[25,36].

The *person centred medical home* includes a patient-chosen clinician to be responsible for a patient's ongoing and comprehensive, whole-person medical care. This clinician is usually a GP. In a medical home, patients, their families and carers have a continuing relationship with a particular GP; this partnership is supported by a practice team, and other clinical services in the *medical neighborhood* who wrap around the patient and their families as required. The medical home coordinates the care delivered by all members of a person's care team, which may sometimes include hospital inpatient care. The medical home ensures that each person experiences integrated (joined-up) health care[37].

Under this approach a *GP Inreach* program is facilitated in the hospital setting. Therefore the medical home is always informed and consulted at admission, able to access progress during admission (e.g. virtually) and informed and consulted at discharge. This approach builds on a shared care approach where care isn't *handed over*, but shared. Many of the problems inherent in clinical handover fall away.

While a 2007 survey found that 96% of Australian adults surveyed have a regular doctor (or a *medical home*)[38], this may not be true for all patients. For example: children and young people, patients with a mental illness and patients with an intellectual disability. See page 22 for further information on specific patient populations that may have additional or complex needs.

It is the role of the hospital staff to communicate with a patient's *medical home*. LHDs and SNs should consider how they work with MLs to develop a process for identifying a medical home for patients who do not have a coordinating clinician (e.g. GP), particularly for patients with complex needs.

2. Developing shared care culture, locally

Building collaborative relationships can assist in developing a culture of shared care; this culture must be developed at a local level. A shared care approach is one where care isn't 'handed over', but shared across a multidisciplinary team led by the medical home.

Clarity of roles and responsibilities is vital for a shared care culture. This can be achieved using a medical home model where a single clinician is the hub of care, often the GP. For shared care to work a patient, their family and carer should:

- be able to identify who is the patient's coordinating clinician (e.g. usual care GP);
- know who is responsible for care at each transition point; and
- know who to contact and how to contact them[39].

> **Clarity of roles and responsibilities is vital for a shared care culture.**

Under a shared care culture the health care team values the different views of each member and supports communication that is bi-directional. Using a shared care approach mitigates many of the problems inherent in clinical handover.

The leadership within primary and acute care organisations play an important role in setting the agenda and developing a culture that promotes good communication between the settings. There are many opportunities for LHD/SNs to work with MLs to develop joint projects, including:

- Developing a shared contacts database with contact details for local GPs and hospitals. This could also include details for allied health professionals (e.g. pharmacists) and relevant agencies.
- Implementing a common template to guide handover communications.
- Developing business rules around handover documentation and communications (e.g. GP to call triage nurse to inform ED patient requirements).
- Clarifying the roles and responsibilities of each member of the health care team.
- Facilitating shared education opportunities between health professional groups as well as between health professionals from different settings of care.
- Developing an appropriate language for building a shared care culture.

Table 3 Guidance to support a shared care culture

Collaborative engagement	Type	Examples
Executive sponsorship involving LHD/SNs and MLs	Formal governance relationship	Memorandum of Understanding to demonstrate joint executive support regarding financial decisions
Committee representation from both ML, ACCHS and LHD	Formal governance relationship	Acute and Primary Care Advisory Committee
Primary care and consumer representatives on relevant LHD and ML Committees	Formal governance relationship	LHD Clinical Council
Change to practices in hospitals to support coordinated care and assist to build relationships between hospitals and primary care	Workforce	GP Liaison Nurse Aboriginal Liaison Officer Discharge Nurse[48] Community Liaison Pharmacist[49] Clinical Pharmacist[50]
Formally agreed process for GP inreach at LHD/SN facilities	Formal governance relationship	GP (medical home) is included as a partner in the inpatient stay of a patient
Combined education sessions to improve understanding of roles and increase shared language	Education and training	Training clinicians in the key concepts of discharge[51] and referral[52] letters
LHD/SN/ML programs for junior staff	Education and training, Leadership development	Formal process (e.g. committee or working group) for bringing together junior staff from general practice and acute settings to foster collaboration

A shared care approach for safer care: pathology and diagnostic imaging

Poor handover processes can lead to duplication of pathology and diagnostic imaging. This results in preventable distress to the patient and can potentially cause harm by exposing patients to unnecessary radiation.

All handover communications should include a concise description of recent and relevant pathology results. Recent and relevant diagnostic imaging scans (e.g. CD or film) are particularly important when handing over care to another health professional. Where possible, patients should be encouraged to take existing scans when presenting at the emergency department.

GP access to PowerChart in the NSW Health system would mitigate some of these potentially harmful problems. Until this is possible hospital pathology and radiology reports should be sent to general practice in a usable format.

Follow up appointments

Obtaining **follow up** appointments after hospital discharge can be difficult for patients. If recommendations are urgent or complex, hospital staff should telephone the relevant health professional (e.g. GP, specialist, Practice Nurse, physiotherapist). Clinical judgment will be necessary to determine who should make that telephone contact; it may be a discharge planner. If a call is necessary it should be conducted in a quiet room.

Patients and/or carers should also be informed of the outcomes of these calls.

3. Established processes

Research suggests that improved processes and systems are required to bridge the communication gap between different settings[40]. Additionally, using a structured approach to admission and discharge has also been shown to reduce inappropriate use of non urgent hospital beds[41].

Common processes for robust, structured communication should be developed locally across both primary and acute care settings to encourage a shared philosophy for safe clinical handover. These processes should focus on ensuring:

- timely communications and prompt delivery of accurate handover information
- there is a locally supported structured template to provide structured communication of handover information
- formal shared governance processes that develop clarity around the accountability and responsibility at transition points.

Evidence demonstrates that formal, written handover transmits information more reliably than informal communication, particularly in conjunction with a verbal component[44]. Table 3 outlines the risks and benefits for using different modes of delivery considering the following dimensions:

- use of time
- ease of use
- delivery and receipt
- financial cost
- security.

To ensure timely delivery of communications electronic communications are encouraged as the optimum method for all transfers of care (e.g. email, secure messaging, web portal). As Table 4 notes this mode is not without its challenges, particularly in the current environment where primary care and the hospital setting are not linked electronically.

Structured communications

Simple mnemonics have been piloted as part of the National Clinical Handover project; these include HAND ME AN ISOBAR, ISOBAR, iSoBAR, SBAR, ISBAR and SHARED. There is no evidence that one mnemonic is better than another[11]. Although ISBAR has been demonstrated to improve the content and clarity for non face to face inter-professional handover[42] in hospital settings. These benefits are generalisable to the primary care setting.

ISBAR provides a simple and effective way of prioritising information when communicating about a patient and their situation:

- **Introduction**: identify yourself, your role and the patient; make the space for a two-way conversation with feedback loops.
- **Situation**: state the patient's current problem and diagnosis, this may only be a provisional diagnosis.
- **Background**: state the clinical history for the patient.
- **Assessment**: provide clinical observations for the patient and an assessment of the patient's current status.
- **Recommendation**: provide what actions you recommend for the receiving clinician and be clear about timeframes.

ISBAR is a well established communication tool for inter-professional communications. Additional techniques for improving clinician-patient communications should be considered to support clinicians to gain trust and communicate with people who are nervous, anxious, and feeling vulnerable.

AIDET[SM] is one such example[43], it includes the following concepts:

- **Acknowledge**: greet people with a smile and use their names if you know them. Attitude is everything. Create a lasting impression.
- **Introduce**: Introduce yourself to others politely. Tell them who you are and how you are going to help them. Escort people where they need to go rather than pointing or giving directions.
- **Duration**: Keep in touch to ease waiting times. Let others know if there is a delay and how long it will be. This is especially important in planning for transfer between settings.
- **Explanation**: Advise others what you are doing, how procedures work and whom to contact if they need assistance. Communicate any steps they may need to take. Make words work. Talk, listen and learn. Make time to help. Ask, "Is there anything else I can do for you?"
- **Thank you**: Thank somebody. Foster an attitude of gratitude. Thank people for their patronage, help or assistance. Use reward and recognition tools.

Table 4 Modes of transfer of information in clinical handover – benefits and risks

Transfer mode	Benefits	Risks
Patient delivery	• can be immediate • can empower patient	• can be misplaced • patient may not understand the process • proof of receipt may be difficult
Telephone	• enables notification of a patient's follow up needs • enables an opportunity for clinicians to have a dialogue • provides an opportunity to note what is urgent or requires review/monitoring • inexpensive	• requires local processes for receipt and storage of verbally shared information • can be time consuming to locate health professionals over the phone
Mail	• if already in place, requires no change • inexpensive	• delivery can be delayed • no proof of receipt • requires local governance (process) to ensure receipt, review and storage
Fax[45]	• fast and simple • inexpensive • proof of receipt possible by return fax	• human error (fax number) • potential to breach patient privacy • requires local governance (process) to ensure receipt, review and storage
Email[28,45-46]	• fast and simple • secure (with appropriate safeguards) • timely transfer of information • preferred option for many GPs[47] • can allow for delivery notification	• requires email with encryption, otherwise possible privacy breach • requires regular maintenance of service directories with contact details • requires governance (rules) • difficult to determine appropriate hospital clinician to take receipt
Secure messaging[28]	• fast and simple • secure • allows for delivery into health professionals own IT system • can allow for delivery receipt	• bidirectional encryption • central storage of information • requires financial investment • must communication across diverse IT systems
Web portal[28]	• fast • secure • can foster a shared approach • can allow for delivery receipt	• requires investment in systems • requires internet connection • requires appropriate encryption, otherwise risk of privacy breach
Face to face	• builds collaborative relationships • develops culture of shared care • enables an opportunity for a clinicians to have a dialogue with the entire health care team, including the patient	• can be time consuming including travel time • requires a process of change management

No single mode can substitute for good communication which involves clear, concise and structured statements. Clinical judgment will be required to decide when a chosen mode should be supplemented with direct verbal communications (e.g. urgent or complex). At a minimum direct verbal communications should occur:

- from the hospital medical team to GPs when action is required by the GP within 48 hours of hospital discharge,
- from the GP to the hospital admitting medical officer about any referrals where there is a concern regarding the deterioration or potential deterioration of a patient,
- where a patients' needs are complex.

Verbal communications can occur in person or via a telephone call.

Recommendation 2

NSW Health should work to develop the infrastructure across the system to enable GPs to have access to electronic patient results in the hospital (e.g. PowerChart). This work will require support from Local Health Districts and Specialty Networks, individual General Practitioners, General Practices and Medicare Locals.

Recommendation 3

Clear, succinct communication is essential for safe transfers of care. Clinical judgement will be required to determine the appropriate method. In many cases electronic communication will be the optimum method for simple transfers of care. This mode must be supplemented by direct verbal communication from:

- the hospital medical team to GPs when action is required by the GP within 48 hours of hospital discharge.
- the GP to the hospital admitting medical officer about any referrals where there is a concern regarding the deterioration or potential deterioration of a patient.
- any health professional for a patient with complex needs.

Verbal communications may occur in person or via a telephone call.

What?

Safe transfer of care requires:

- the acceptance of responsibility and accountability for patient's care,
- an ability to prioritise tasks for individual patients,
- the expertise to set plans for further care,
- the competence to review unstable patients in a timely manner[53],
- involvement of patients, families and/or their carers in an open, continuous dialogue.

The recommended data set for clinical handover between hospitals and GPs is outlined at table 5, page 16. A suggested template is also included at Figure 2, page 17. This template has been developed to guide two-way communications and support consistency in the content and format of information that needs to be shared as patients move between general practice and hospitals and hospitals and general practice. This consistency is essential to ensure a common understanding by patients and clinicians in hospitals, the community and general practice. The guidance also aligns with the suggested elements for the Personally Controlled Electronic Health Record[54]. The key elements within the template are structured around ISBAR. This includes information that:

- identifies the patient, their carer status and their clinical contact points,
- outlines the situation, reason for referral, urgency and provisional diagnosis,
- provides relevant medical history,
- includes a clinical assessment with recent test results as well as pending results,
- clearly states recommendations for action and includes a prioritised and personalised ongoing management plan.

This information should be signed off by an appropriate medical officer with follow up contacts noted.

The importance undertaking a medication reconciliation as part of this process should not be understated. The literature provides clear evidence of significant risk associated with poor medication management at points of transfer of care[21].

In addition to the information outlined in the recommended data set health professionals should also consider including the following information in handover communications:

- Patient's cognitive status[39],
- Details that patient is unable and/or unwilling to provide[55],
- Verbal instructions or educational materials supplied to patient to date[55].

Recommendation 4

Medication reconciliation should occur at every transition of care to ensure a complete and accurate list of medications is available in the patient record.

- The GP should ensure that the patient's current medication list provided to the hospital is up to date.
- The hospital should ensure that the patient's medicines are reconciled at admission, at internal transfers and on discharge in order to provide a complete and accurate list to the GP at discharge.
- On receiving the discharge list of medications the GP should reconcile and update their records as necessary.

The patient and/or carer should always receive any updated medication list(s).

Recommendation 5

A patient, their family and carer must leave the hospital with a copy of their discharge communications, including an ongoing management plan. Patients should not be delayed in returning to the community as a result of pending tests and/or results.

Special considerations: patients with complex needs and/or chronic conditions

Health professionals should consider patients additional needs when transferring responsibility and accountability for care. The NSW Health *Care Coordination Reference Manual* outlines considerations that should be made for[64]:

- People with physical impairment
- People with additional health issues
- Carers and/or people with carers
- Social care and support issues
- People with disability
- People with dementia and/or delirium
- People from rural and remote areas
- People from culturally and linguistically diverse (CALD) backgrounds
- Aboriginal and Torres Strait Islander People
- Children
- Vulnerable patients
- Homeless people.

While the above guidance is written for the hospital setting the principles can guide decisions in any setting.

Additionally, **mental health patients** should have their psychiatric discharge summaries sent to the patient's:

- clinical psychologist/psychiatrist at the same time as the GP;
- named pharmacist; and
- dentist, if there are oral health issues.

Handover between hospital and general practice settings: what are the documents?

Clinical judgement will be required to determine what information is necessary to provide to the receiving clinician.

Discharge summaries are produced during a patient's stay in hospital as an admitted or non-admitted patient and issued when or after a patient leaves the care of the hospital. Planning for discharge should be initiated on admission to an acute facility. The primary function of a discharge summary is to support the continuity of care when the patient returns to the care of their primary/community healthcare providers. The primary recipients of the discharge summary are healthcare providers who were providing patient care prior to the hospital stay[56]. Discharge summaries must be completed before a patient leaves the hospital.

If a patient dies in hospital a **notification of death** should be communicated to the patient's medical home,

this is usually their GP. Informing the GP of a patient's death should be part of the hospital process for *Death – Extinction of Life and the Certification of Death*[57].

In short stay services such as day only or planned day only services may use a **short stay summary** for uncomplicated patients instead of a full discharge summary. Such summaries are outside the scope of this document.

The GP should be regarded as the primary source of referrals, post-discharge. **Cross-referrals** between physicians should occur in consultation with the patient's general practitioner[58].

The usual healthcare provider will often be the GP, however transfer of care documents should be sent to other health professionals involved in care (e.g. community health staff, allied health professionals, psychiatric discharge summaries to the clinical psychologist/psychiatrist).

Table 5 The minimum information data set for handover based on ISBAR

	Minimum information data set	Handover to: Hospital	Handover to: GP
IDENTIFY	**Patient demographics**[55]: unique patient identifier, name (first, family and preferred, full address, phone number, gender, date of birth and age, indigenous status[59]/ethnicity, preferred language.	✓	✓
	Special needs: e.g. vision impaired, intellectual disability, interpreter required.	–	–
	Carer status: is carer/has carer (name, relationship and contact information)	–	–
	GP/Aboriginal Medical Service (AMS): name and contact information[55]	✓	✓
	Admitting Medical Officer (AMO) +/− registrar: name and contact information[39]	✗	✓
SITUATION	Reason for referral, including the specific question posed by referring care provider and expectations of the consultant[55]	✓	✓
	Provisional diagnosis/diagnosis[39]: stable or unstable	✓	✓
	Level of urgency[55]	✓	✓
BACKGROUND	Relevant medical history, including co-morbidities, past and current treatment and list of suspected predisposing factors or triggers[55]	✓	✓
	Known allergens adverse drug reactions (ADRs)	✓	✓
	Advance care plan or directive, where relevant[60]	✓	✓
	Other services involved in the ongoing care of the patient	✓	✓
	Vaccinations, recent and/or relevant	✓	✓
ASSESSMENT	Clinical assessment		✓
	Recent surgery, radiology, pathology (abnormal) results[55,61-62] including pending results[39]	✓	✓
RECOMMENDATION	Clear and concise recommendations for what you want the receiving clinician to do[55] and a timeframe for when, including any follow up appointments[62]	✓	✓
	Prioritised plan for ongoing management	✓	✓
	Ongoing management plan for medications with: • Current medications[28,39,55,61-62] • Recent changes (e.g. brand, dose), reason for change[19,56,63] • Dose instructions[56] • Duration[56] and/or date to cease • Quantity dispensed[56] and/or ongoing supply requirements	✓	✓
	Review and sign off by medical officer	✓	✓
	Date prepared[55]	✓	✓
	Follow up contacts	✓	✓

Figure 2: Sample template Transfer of Care

I	**Patient demographics**	**GP/AMS/AMO details**
	Carer status	Special needs
S	**Diagnosis** (for this episode of care) *On referral this may be a provisional diagnosis that includes specific presenting symptoms.On discharge it is usually a confirmed diagnosis. It should note the level of urgency and if the patient is stable or unstable.*	
B	**Allergies and other adverse reactions**	
	Clinical history *Including social history (and if relevant, advance care plan, where appropriate); recent surgery; significant events in hospital; treatments given; recent/relevant vaccinations.*	
A	**Clinical assessment** *Relevant reports: surgery, pathology and radiology. Should include abnormal results and results to be followed up.*	

	1.	**RECOMMENDATIONS FOR CARE/ACTION** *including ongoing management plan and timeframes for action.*
	2.	**Ongoing management plan for medications** *including prescriptions required.*

Current medication	Dose	Frequency	Commenced	Change	Supply comments
name and strength				*include reason for change*	*qty dispensed, duration and/or date to cease*

Ceased medications	Date ceased	Reason for ceasing	
recently ceased			

	3.	**Follow up** *e.g. pending test results pathology and INR monitoring, suture removal*
	4.	**Appointments** *be clear if these still need to be made, provide assistance for urgent appointments* a) GP appointment *e.g. appointment made for April 9, 2pm Dr… (location, contact)* b) Specialist appointments *e.g. appointment made for April 20 3pm Dr… (location, contact)* c) Allied Health appointments *e.g. Physiotherapist appointment to be made within two weeks of discharge.*
R	5.	**Other services providing care to patient** *e.g. Hospital in the Home, Community Nursing, Aboriginal Medical Service, Connecting Care, HealthOne, ComPacks etc.*
	6.	**Advance care plan or directive,** if available

Follow up contacts	
Pathology	Tel:
Radiology	Tel:
Medical records	**Tel:**
Name	Contact Number
Signature	Position	Date

Access to further information: Provide direct unit telephone numbers NOT the hospital switch; hours of operation would be also useful. Referring GPs should also provide their direct contact numbers.

RELEVANT RESOURCES

NSW Health policy directives and supporting documents:

- Discharge Policy for Emergency Department at risk people PD2005_082[65]
- Clinical Handover – Standard Key Principles PD2009_060[6]
- Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals – PD2011_015[66]
- Care Coordination: From Admission to Transfer of Care in NSW Public Hospital – Reference Manual[64]
- Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospital – Staff Booklet[67]
- Care Coordination Patient Brochure[68]
- Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients – PD2012_042[59]
- Mental Health Clinical Documentation PD2010_018[69]
- Mental Health Clinical Documentation – Redesigned Guidelines GL2008_016[70]
- Transfer of Care from Mental Health Inpatient Services PD2012_060[71]

Other documentation:

- Safety and Quality Improvement Guide Standard: Clinical Handover[13]
- RACGP Standards for General Practices[8]

Health Education and Training Institute resources:

- Clinical handover – ISBAR
- Continuity in medication management
- Building effective teams
- Working in culturally diverse contexts.

These resources are available online at:
http://nswhealth.moodle.com.au/login/index.php

CLINICAL SCENARIOS:
The challenges to achieving successful general practice-hospital and hospital-general practice clinical handover

The following **clinical scenarios** are based on reports from clinicians, coroner's findings and Root Cause Analysis data.

Scenario 1

Mrs X was admitted for an elective cholecystectomy. Her current health problems included non-insulin dependent diabetes and schizophrenia which were managed by her regular GP, with additional support provided from a private psychiatrist for her mental health problem.

There was no documentation about her pre-existing conditions in the pre-admission assessment notes or in any referral documents. When reviewed on admission to the surgical ward her previous medical record did not note her pre-existing conditions. The cholecystectomy was performed uneventfully.

In the initial post-operative period, Mrs X was reported to be stable and mobilising well around the ward. However, over the next two days she became increasingly withdrawn, uncooperative, uncommunicative and eventually refused to get out of bed.

Mrs X underwent a complete battery of tests and was admitted to a mental health unit.

Scenario 2

Mr T, a 55 year old was discharged from a large metropolitan teaching hospital following a myocardial infarction. During his admission, Mr T underwent an angioplasty and stent insertion into one of his coronary arteries.

Mr T was discharged after 4 days and felt well. Mr T was required to take antiplatelet therapy (clopidogrel and aspirin) for at least 12 months to prevent further occlusion of his coronary artery.

Mr T was given a copy of his discharge summary and 5 days' supply of medication.

Mr T did not receive information or did not understand his role in seeing his GP within 5 days to receive a prescription for his antiplatelet medication. Mr T did not take any further medication after the 5 days' supply ran out. As Mr T felt well and was relieved at surviving his heart attack, he did not follow up with his GP.

Four months after being discharged from hospital, Mr T developed chest pain and took himself to hospital. Further investigations revealed Mr T had developed a re-occlusion of his coronary artery and had a further myocardial infarction (heart attack).

Scenario 3

Mrs W, a 78 year old presented to the Emergency Department (ED) with palpitations and dyspnoea due to atrial fibrillation (AF) with a rapid ventricular response. She was treated with intravenous magnesium phosphate and a stat dose of sotalol, with good rate control, and discharged home. She was not anticoagulated or given anti-platelet therapy.

She presented to her usual GP three days later with light-headedness, fatigue, headache, and dyspnoea. Physical examination was unremarkable. Differential diagnosis included pulmonary embolism, but also stroke given the AF, headache, and light-headedness. Initial investigations revealed a strongly positive D-dimer. Mrs W was referred back to the local hospital following a phone call to the Director of ED, and was accompanied by a standardised referral letter.

Based upon the GP referral information, Mrs W was anticoagulated with Enoxaparin, and admitted to the CCU. No brain imaging or investigation for pulmonary embolism was performed.

Mrs W was discharged on Enoxaparin and Warfarin. The GP was contacted by the treating team to request outpatient supervision of anticoagulation as a clear diagnosis was not established. The GP organised a ventilation/perfusion (V/Q) lung scan and a cerebral CT scan. The V/Q scan indicated a low probability for pulmonary embolism. The CT showed an old basal ganglia infarct, and a possible recent adjacent infarct.

Scenario 4

An adult patient with a chronic complex clinical history of severe depression, self-neglect, atrial fibrillation, urinary retention, stroke and deteriorating cognition died at home of a large pulmonary embolus following a recent hospital admission. The coroner's findings noted:

- no discharge summary was prepared by the hospital.
- no written care plan was provided for the community agencies involved in the patient's post hospital care.
- these documents would have provided additional information to focus and manage care.

Applying the Essential Elements

1. Collaborative relationships

- In the majority of situations the GP should be acknowledged as the lead clinician who manages the patient before and after a hospital admission. As such a patient's GP should be informed of their patient's hospital admission.

- Mr T was not treated as part of the health care team. He was not made aware of the importance of seeing his GP for follow up and/or did not understand how vital it was to continue the antiplatelet therapy.

- Both verbal and written instructions should be provided to patients and/or their carers. Some clinicians use a colour code to highlight the relative importance of tasks that the patient and/or carer has been asked to do.

- It may be necessary to provide the same information more than once to patients who have mental health problems like Mrs X. Other groups that may require additional support include older, Aboriginal and cultural and linguistically diverse (CALD) patients.

- Patients should be informed of their clinical progress and empowered to be in control of their care, including self-care. Mr T's handover sessions should have provided clear information on self-management and included an opportunity for the patient, their family and carer to ask questions, clarify information provided and provide feedback to the team.

- The importance of collaborative relationships between general practice and ED is highlighted through the communication regarding the Mrs W's clinical management.

- The use of written management plans and the sharing of these plans between acute and primary care providers will support the building of collaborative relationships.

2. Shared care culture

- The hospital should develop a communication strategy with referring doctors; this should include pre-admission, admission and discharge communications.

- The hospital staff have the responsibility of providing patients with information and ensuring that the patient understands their responsibility in accessing follow up care, ensuring that the discussion was undertaken and documented in the clinical record.

- The GP's referral communication for Mrs X failed to include relevant medical history (Background) that would assist the hospital in delivering the most appropriate care for her.

- The hospital has the responsibility of ensuring that the clinical information and ongoing management plan is shared with the patient, their regular GP and any other health professionals providing ongoing care (e.g. case manager).

- The provision of a hospital discharge summary to patient's usual care GP and knowledge of available resources in general practice enables effective ongoing management of the patient's care.

- Direct contact with the patient's GP prior to discharge would have highlighted Mr Ts urgent post discharge needs within the community.

- Including the patient and/or carer in the handover process strengthens the health care team by empowering the patient to know when to seek help.

3. Common processes

- Patients enter and exit the hospital in many ways. It is important that the processes for communicating about the transfer of care at these entry/exit points are clear for both acute and primary staff. These processes should be developed in partnership with hospital staff and local GPs.

- Health care teams should use a commonly agreed template with a structured communication framework (e.g. ISBAR) for written and verbal communication. This will assist clinicians to include clear and concise clinical information during the clinical handover process.

- The ongoing management plan should document the active clinical problems, current treatment, modifications undertaken and who is responsible for what across the continuum of care. It should be shared electronically between the hospital and the GP and be provided to the patient, their family and carer.

- It may be important to use a number of methods for communication. An example is a follow up phone call to the GP to briefly discuss the written discharge information if this issue is complex or urgent.

- There should be a process in place for ensuring a GP is informed after a patient has a hospital admission.

- Mrs W's GP provided a standard referral letter with appropriate information that clearly stated initial investigations, the preliminary diagnosis and clear recommendations for the ED.

CONCLUSION

The transfer of care between general practice and hospital settings poses risks for safe patient care. Health care professionals and patients, their families and carers have indicated that delivery of timely, accurate handover communications could be improved.

Making improvements will require a commitment from local leadership. This resource provides a minimum dataset (page 16) and suggested template (page 17) that could guide LHDs/SNs, Hospitals, MLs, ACCHS and individual GPs and their practices to work together to develop these local solutions.

This resource also recognises that the current IT infrastructure across NSW will need enhancements to bring about changes regarding optimum communications for all transfers of care.

Finally, this resource makes the following five recommendations for these collective teams to focus on.

RECOMMENDATION 1 *(see page 9)*

The patient, their family and carer must be involved as a partner in the transfer of care decision making processes. This should include time for the patient, their family and carer to provide input, ask questions and the opportunity to clarify answers.

RECOMMENDATION 2 *(see page 14)*

Clear, succinct communication is essential for safe transfers of care. Clinical judgement will be required to determine the appropriate method. In many cases electronic communication will be the optimum method for simple transfers of care. Any mode must be supplemented by direct verbal communication from:

- the hospital medical team to GPs when action is required by the GP within 48 hours of hospital discharge.
- the GP to the hospital admitting medical officer about any referrals where there is a concern regarding the deterioration or potential deterioration of a patient.
- both GPs and hospital clinicians for a patient with complex needs.

Verbal communications may occur in person or via a telephone call.

RECOMMENDATION 3 *(see page 14)*

Medication reconciliation should occur at every transition of care to ensure a complete and accurate list of medications is available in the patient record.

- The GP should ensure that the patient's current medication list provided to the hospital is up to date.
- The hospital should ensure that the patient's medicines are reconciled at admission, at internal transfers and on discharge in order to provide a complete and accurate list to the GP at discharge.
- On receiving the discharge list of medications the GP should reconcile and update their records as necessary.

The patient and/or carer should always receive any updated medication list(s).

RECOMMENDATION 4 *(see page 15)*

A patient, their family and carer must leave the hospital with a copy of their discharge communications, including an ongoing management plan. Patients should not be delayed in returning to the community as a result of pending tests and/or results.

RECOMMENDATION 5 *(see page 15)*

NSW Health should work to develop the infrastructure across the system to enable GPs to have access to electronic patient results in the hospital (e.g. PowerChart).

APPENDICES

ACI NSW Agency for Clinical Innovation

SAFE CLINICAL HANDOVER
THE TWO WAY COMMUNICATION BETWEEN GENERAL PRACTICE AND HOSPITALS

> Clinical handover is more than just the transfer of information it is the: …transfer of professional responsibility and accountability for some or all aspects of care for a patient… to another person or professional group on a temporary or permanent basis[1].

Health care professionals and patients, their families and carers have all expressed a desire to improve the content, timeliness and accuracy of handover communications.

The health system is complex, and safe clinical handover is essential for the delivery of better patient journeys. Both health professionals and patients suggest that their information needs are not met by the existing approach to transfer of care. There is evidence that the poor exchange and delayed sharing of information between health professionals negatively affects continuity of care[2-5]. This includes increased medication errors[6,7], higher readmission rates[4,8] and delays in diagnosis, treatment and provision of test results[9].

The five questions for bi-directional general practice-hospital handover

Who?	**Hospital** e.g. specialists, ED physician, Junior Medical Officer, nurse, pharmacist **Primary Care** e.g. GPs, GP practices, ACCHS **Patients**, their families and carers
Why?	Essential for the delivery of safer patient journeys and better patient experiences
When?	Transfer of professional responsibility and accountability for some or all aspects of care for a patient moving between the hospital and primary care settings.
How?	1. Collaborative relationships 2. Shared care culture locally 3. Common processes (e.g. common IT/software systems)
What?	• Minimum data set for communication • Shared, common template using ISBAR for structured, concise communications

> **Local Health Districts, Hospitals, Medicare Locals and individual GP practices must work together to develop local solutions.**

Excellent, safe, coordinated care

PATIENTS NEED

- Care that aligns to the principles of "nothing about me, without me"
- To be treated with respect
- To receive coordinated care
- To be given information in a way they can understand (written and verbal)
- The time and opportunity to ask questions and receive answers
- For their unique needs to be identified and addressed (e.g. patient is a carer; patient has specific triggers).

STAFF IN GENERAL PRACTICE NEED

- A clear, concise diagnosis
- To know what has changed, including recommendations?
- A discharge summary on day of transfer of care
- Relevant test results, including pending results.
- A concise medication list, including ceased medications and the rationale for any changes
- Clear management recommendations
- Contact details for the acute setting (not the switch board) and other services involved in ongoing care.

STAFF IN HOSPITALS NEED

- What has prompted the referral along with a provisional diagnosis and the patient's current status
- Clear succinct information on relevant clinical issues
- Relevant clinical history
- Investigations that have been performed or are pending, including pathology and imaging results (films/other media)
- Current medications
- Information on social history and strategies for personalised care
- Information on allergies/ adverse drug reactions
- Contact details for usual care GP.

Flexible standardisation: These have been identified as the primary fields that should be available on a *Transfer of Care Document.* Clinical judgement will be necessary and specialty units may require additional information. **Hospital to General Practice specific fields are noted in bold blue text.**

ACI NSW Agency for Clinical Innovation

Sample template Transfer of Care

I	Patient demographics	GP/AMS/AMO details
	Carer status	Special needs
S	**Diagnosis** (for this episode of care) *On referral this may be a provisional diagnosis that includes specific presenting symptoms.On discharge it is usually a confirmed diagnosis. It should note the level of urgency and if the patient is stable or unstable.*	
B	**Allergies and other adverse reactions**	
	Clinical history *Including social history (and if relevant, advance care plan, where appropriate); recent surgery; significant events in hospital; treatments given; recent/relevant vaccinations.*	
A	**Clinical assessment** *Relevant reports: surgery, pathology and radiology. Should include abnormal results and results to be followed up.*	

R	1.	**RECOMMENDATIONS FOR CARE/ACTION** *including ongoing management plan and timeframes for action.*
	2.	**Ongoing management plan for medications** *including prescriptions required.*

Current medication	Dose	Frequency	Commenced	Change	Supply comments
name and strength				*include reason for change*	*qty dispensed, duration and/or date to cease*
Ceased medications	**Date ceased**	**Reason for ceasing**			
recently ceased					

	3.	**Follow up** *e.g. pending test results pathology and INR monitoring, suture removal*
	4.	**Appointments** *be clear if these still need to be made, provide assistance for urgent appointments* a) GP appointment *e.g. appointment made for April 9, 2pm Dr… (location, contact)* b) Specialist appointments *e.g. appointment made for April 20 3pm Dr… (location, contact)* c) Allied Health appointments *e.g. Physiotherapist appointment to be made within two weeks of discharge.*
	5.	**Other services providing care to patient** *e.g. Hospital in the Home, Community Nursing, Aboriginal Medical Service, Connecting Care, HealthOne, ComPacks etc.*
	6.	**Advance care plan or directive,** if available

Follow up contacts

Pathology	Tel:
Radiology	Tel:
Medical records	**Tel:**

Access to further information: Provide direct unit telephone numbers NOT the hospital switch; hours of operation would be also useful. Referring GPs should also provide their direct contact numbers.

Name	Contact Number	
Signature	Position	Date

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