Practical Guide for Clinical Handover in Residential Aged Care Facilities

August 2020

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Contents

The content of this Guide is aligned with the accompanying 2020 webinar Practical Guide to clinical handover in Aged Care Facilities that can be accessed at https://www.ourphn.org.au/education-notes/

Introduction.

What is the Purpose?

To support and assist clinicians, predominantly in aged care facilities, to provide effective clinical handover, consistent with relevant Standards.

To improve communication skills, in particular to general practitioners (GPs).

If you are watching the webinar refer to slide 2

Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient to another person or professional group. It involves the transfer of patient information between individuals or groups and is an important part of clinical care.

Clinical handover is undertaken in many different ways in aged care facilities.

The use of a standard process and principles for clinical handover has been shown to reduce communication errors between health professionals and improve patient safety and care.[1] The information transferred between clinicians should be relevant, accurate, clear and occur in timely manner.

The consequences of poor handover include waste of resources, unnecessary delays in diagnosis, treatment and care, repeated tests, missed or delayed communication of test results, and incorrect treatment or medication errors. Poor or absent handover has been identified as one of the most important preventable contributing factors to serious harmful events.[2]

1. Australian Commission on Safety and Quality in Health Care. 2010. *OSSIE Guide to clinical handover Improvement.* www.safetyandquality.gov.au/sites/default/files/2019-12/ossie_guide_to_clinical_handover_improvement.pdf

2. Australian Commission on Safety and Quality in Health Care. 2012a. *NSQHS Standards (first edition) fact sheet on clinical handover.* www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-first-edition-fact-sheet-clinical-handover

The purpose of this Practical Guide to clinical handover in Aged Care Facilities is to support and assist clinicians in residential aged care facilities to:

- Provide effective clinical handover consistent with relevant standards
- Improve communication skills, in particular when communicating with general practitioners (GPs).

This Guide and its associated webinar https://www.ourphn.org.au/education-notes/ are consistent with requirements outlined in relevant standards that are covered in the next section. However, it does not address, nor does it intend to address, all of the Standard's requirements. Individual organisations and facilities should still refer to the full Standard when looking to align their policies, processes and quality improvement initiatives with best practice.

Users are encouraged to watch the webinar along with the Guide.

In the Guide and webinar the terms 'patient' and 'resident' are used interchangeably, predominantly in the context of residential aged care facilities. It is acknowledged that 'consumer' and 'client' are also common terms used to describe people in residential care.

The terms 'clinical handover' and 'handover' are also used interchangeably. In other contexts they may also be referred to as 'handover communication'.

What is in this webinar?

- Overview of Standards
- What is clinical handover?
- Why is clinical handover important?
- Roles and responsibilities
- Principles
- How do I use ISBAR?
- Scenarios
- Resources and tools

If you are watching the webinar refer to slide 4

Standards.

Relevant Standards

National Safety and Quality Health Service Standards

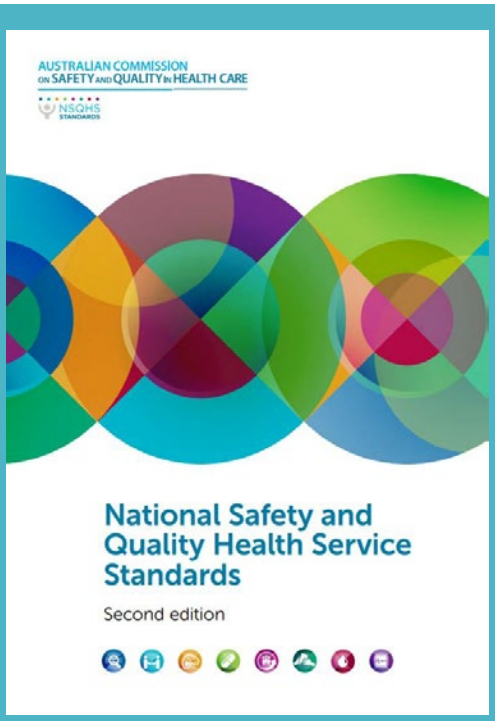
Standard 6: Clinical Handover

Aged Care Quality Standards

If you are watching the webinar refer to slide 5

Two relevant Standards that healthcare organisations may need to meet are outlined above.

National Safety and Quality Health Service Standards Standard 6: clinical handover.[3]



If you are watching the webinar refer to slide 6

The criteria to achieve this Standard are:

1. Governance and leadership for effective clinical handover
   - Health service organisations implement effective clinical handover systems.
2. Clinical handover processes
   - Health service organisations have documented and structured clinical handover processes in place.
3. Patient and carer involvement in clinical handover
   - Health service organisations establish mechanisms to include patients and carers in the clinical handover processes.

The intention of the Standard is to ensure that a timely, relevant and structured clinical handover occurs that is appropriate to the clinical setting and context and that supports safe patient care.

A full copy of the clinical handover Standard is contained in the National Safety and Quality Health Service Standards. It describes the criteria, items and actions required for health services to meet this standard and is available on the Commission's website at: www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard

3. Australian Commission on Safety and Quality in Health Care. 2012b. Standard 6 clinical handover – Safety and Quality Improvement Guide. www.safetyandquality.gov.au/sites/default/files/migrated/Standard6_Oct_2012_WEB.pdf

Aged Care Quality Standards - Standard 3 - Requirement (3)(e).[4]

The criterion to achieve this Standard is:

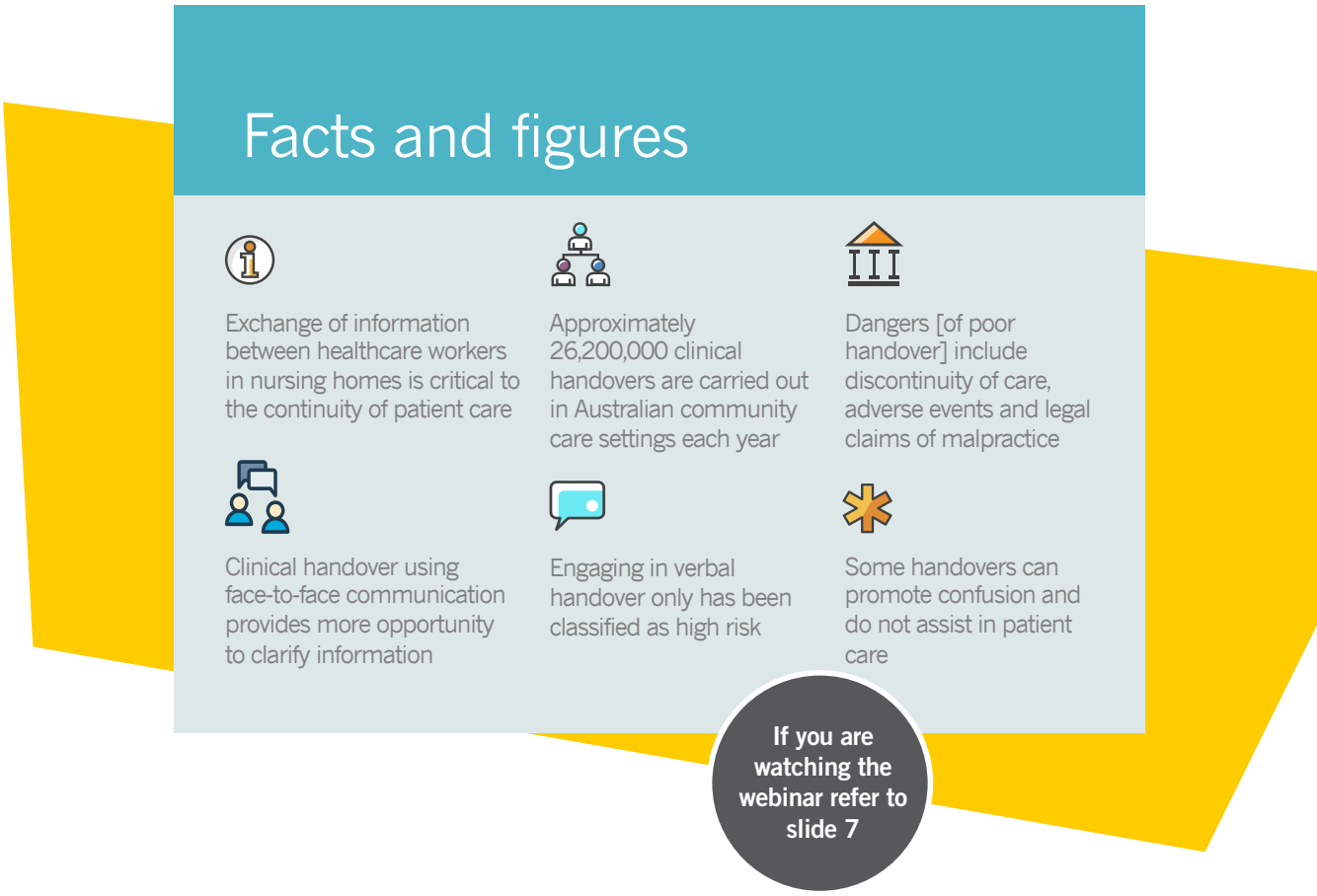
- Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

This Standard focuses on appropriate documentation and communication processes to ensure that safe and effective personal and clinical care is provided.

For further information go to: https://agedcare.health.gov.au/quality/aged-care-quality-standards

4. Australian Commission on Safety and Quality in Health Care. 2012c. https://agedcare.health.gov.au/quality/aged-care-quality-standards#Standard%203

Facts and figures.



- "Handover provides a very important part of that exchange of information, critical and vital to the continuity of care of your patient… a good handover would consist of a number of elements"[5]
- Approximately 26,200,000 clinical handovers are carried out in Australian community care settings each year[6]
- Clinical handover using face-to-face communication provides more opportunity to clarify information[7]
- Engaging in verbal handover only, compared to verbal handover with some documentation, relies heavily on memory skills and has been classified as high risk[8]
- Clinical handover is a high risk scenario for patient safety. Dangers include discontinuity of care, adverse events and legal claims of malpractice[9]
- A detailed analysis of nursing handover revealed that some handovers promoted confusion and did not assist in patient care.[10]

5. Royal Commission into Aged Care Quality and Safety 20 February 2019. Dr Tony Bartone. Transcript at https://agedcare.royalcommission.gov.au/hearings/Documents/transcripts-2019/transcript-20-february-2019.pdf

6. Australian Commission on Safety and Quality in Health Care. 2012b. Ibid.

7. Australian Commission on Safety and Quality in Health Care. 2012b. Op cit.

8. Australian Commission on Safety and Quality in Health Care. 2012b. Op cit.

9. Wong M.,Yee K. 2008. clinical handover Literature Review. eHealth Services Research Group University of Tasmania. Quoted in Australian Healthcare and Hospitals Association. 2009. clinical handover: system change, leadership and principles. https://ahha.asn.au/sites/default/files/docs/policy-issue/clinicalhandover.pdf

10. Sexton, A. et al. 2003. "Nursing handovers: do we really need them". Journal of Nursing Management. 12(1):37-42. Quoted in Australian Healthcare and Hospitals Association. 2009. clinical handover: system change, leadership and principles. https://ahha.asn.au/sites/default/files/docs/policy-issue/clinicalhandover.pdf

What is clinical handover?

As previously stated, clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient to another person or professional group. It involves the transfer of patient information between individuals or groups and is an important part of clinical care.[11]

What is clinical handover?

If you are watching the webinar refer to slide 8

Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient to another person or professional group. It involves the transfer of patient information between individuals or groups and is an important part of clinical care

ACSQHC, Clinical Handover Standard 6 Fact Sheet

If you are watching the webinar refer to slide 9

11. Australian Commission on Safety and Quality in Health Care. 2012b. Ibid.

An example of a poor clinical handover

Scenario
A poor example

If you are watching the webinar refer to slide 10

Tom said at his handover…

"Mrs. Song rang her call bell this morning and said she was feeling unwell.
Her husband visited yesterday, and he had mentioned she was unwell.
I gave her two Panadol, FFU (for feeling unwell).
I think you should call her GP, Dr Brown, and tell him that Mrs Song is unwell."

Tom did not document as he did not think it was important enough.

If you are watching the webinar refer to slide 11

Tom is a registered nurse and at the end his shift he gives the following handover to the evening staff.

"Mrs. Song rang her call bell this morning and said she was feeling unwell. Her husband visited yesterday and he had mentioned she was unwell and had a headache. I gave her two Panadol, FFU [meaning 'for feeling unwell']. I think you should call her GP, Dr Brown, and tell him that Mrs Song is unwell".

At completion of his shift, Tom does not think the matter is important enough to document that Mrs Song has been feeling unwell.

Reflection

Scenario reflection

What are the problems with this scenario?

Was the handover effective in transferring responsibility and accountability?

If you are watching the webinar refer to slide 12

Suggestions

Handover issues to consider include:

- Vague and unclear communication
- The made up acronym was confusing
- No assessment of Mrs Song was undertaken, nor was information collated
- The event was not documented.

As a result of the lack of assessment, lack of documentation and lack of clear handover, the incoming nurse did not monitor Mrs Song closely and did not ring her GP, Dr Brown. The next day Mrs Song deteriorated rapidly, suffered a stroke and was admitted to hospital.

Why is clinical handover important?

If you are watching the webinar refer to slide 13

Providing health care is complex. Transferring information through effective communication has been identified as one of the most important preventable contributing factors when serious adverse resident events occur.

An effective handover:

- Improves the experience of the resident and their family/carers, including when they are involved in handover
- Improves resident safety
- Improves actions and coordination of resident care
- Reduces the chance the resident and family member or carer need to repeat their story
- Improves the use of scarce health care resources and reduces unnecessary treatment
- Enables effective transfer of professional responsibility and accountability for care.[12]

12. Australian Commission on Safety and Quality in Health Care, Communicating for Safety Resource Portal, www.c4sportal.safetyandquality.gov.au/resources

What are the responsibilities of staff during transfer of care?

What is your role and responsibility?

If you are watching the webinar refer to slide 15

All staff have a key role and responsibility to ensure effective communication and transfer of information with relevant members of the team, and with residents and their significant others at every transitions of care.

ACSQHC, Communicating for Safety Resource Portal

If you are watching the webinar refer to slide 16

All staff have a responsibility to ensure effective communication and transfer of information with members of the team, with residents and their significant others, and with relevant external parties at every transition of care, with consent.

Staff need to:

- Know the organisation's policies, processes, tools and forms
- Engage the resident, seeking their consent (or that of their caregiver) for transition and inviting their participation, and communicating what is happening
- Know with whom and when to communicate
- Know what minimum information is required to be communicated
- Have structured and effective communication skills to use with residents, families and carers, and other clinicians
- Ensure transfer of responsibility and accountability for care.[13]

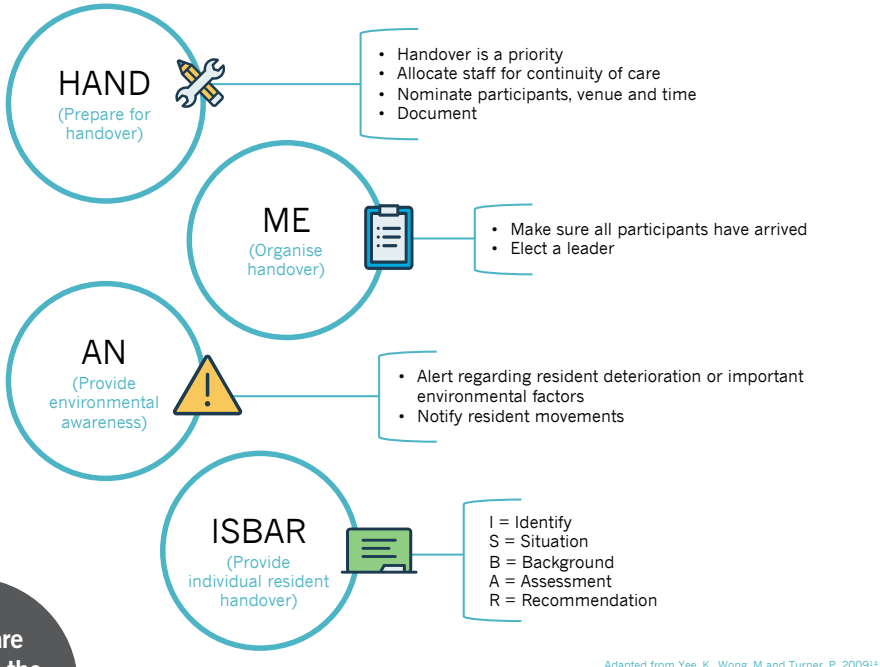
The Australian Commission on Safety and Quality in Health Care has a series of guides and tools that may further assist when looking to build skills in communicating for safety.
Refer to: www.c4sportal.safetyandquality.gov.au/resources

13. Australian Commission on Safety and Quality in Health Care, Communicating for Safety Resource Portal, www.c4sportal.safetyandquality.gov.au/resources

The principles of clinical handover.

Flexible standardisation based on clinical handover principles

If you are watching the webinar refer to slide 17



Adapted from Yee, K., Wong, M and Turner, P, 2009[14]

If you are watching the webinar refer to slide 18

14. Yee, K., Wong, M. and Turner, P. 2009. "'HAND ME AN ISOBAR': a pilot study of an evidence-based approach to improving shift-to-shift clinical handover". MJA. 190(11)S121.

Handover can occur in different ways, and the most appropriate way will depend on the circumstances.

For example:

- On the telephone with a clinician at another site, such as the resident's GP, or for an emergency
- Between two nurses (or other health professionals), the resident and significant other, such as when there is a shift handover
- During a scheduled case conference meeting involving the resident, their family/carers and health professionals
- Transferring a resident to paramedics that have arrived at the facility
- Before and at the end of shifts, which is often verbal and should be documented in the resident's notes.

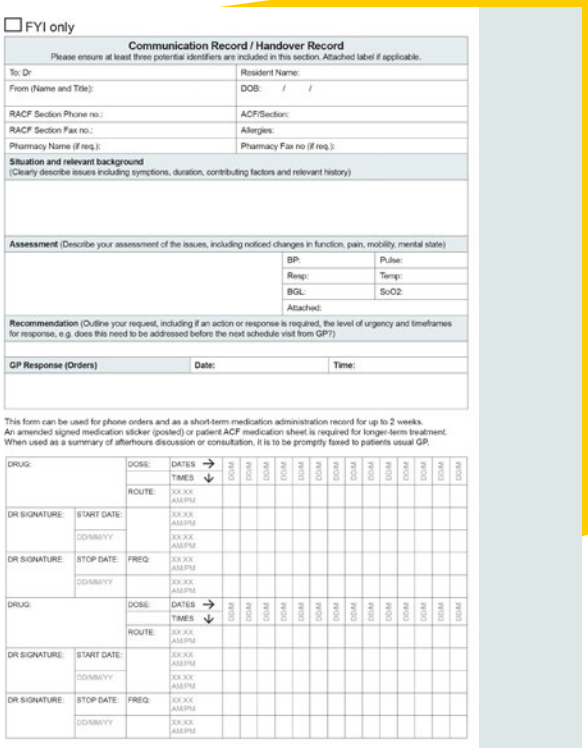
In the event information is sent by email, it is suggested to follow RACGP standards, and use a secure messaging system.[15]

Each facility may have their own policy and procedure that staff should be familiar with and follow.

In all scenarios, the key principles of clinical handover should be adhered to. Four key principles[16] are outlined below, and an example of a clinical handover form is provided below and in Attachment 1.

Paper form to assist staff to practise standardised and better handover

If you are watching the webinar refer to slide 19



☐ FYI only

Communication Record / Handover Record

Please ensure at least three potential identifiers are included in this section. Attached label if applicable.

To: Dr	Resident Name:
From (Name and Title):	DOB: / /
RACF Section Phone no.:	ACF/Section:
RACF Section Fax no.:	Allergies:
Pharmacy Name (if req.):	Pharmacy Fax no (if req.):

Situation and relevant background
(Clearly describe issues including symptoms, duration, contributing factors and relevant history)

Assessment (Describe your assessment of the issues, including noticed changes in function, pain, mobility, mental state)

	BP:	Pulse:
	Resp:	Temp:
	BGL:	SpO2:
	Attached:	

Recommendation (Outline your request, including if an action or response is required, the level of urgency and timeframes for response, e.g. does this need to be addressed before the next schedule visit from GP?)

GP Response (Orders)	Date:	Time:

This form can be used for phone orders and as a short-term medication administration record for up to 2 weeks.
An amended signed medication sticker (posted) or patient ACF medication sheet is required for longer-term treatment.
When used as a summary of afterhours discussion or consultation, it is to be promptly faxed to patients usual GP.

DRUG:		DOSE:	DATES →	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M
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	DD/MM/YY		XX:XX AM/PM												

15. RACGP (2017) Standards for general practices, 5th edition, https://www.racgp.org.au/download/Documents/Standards/RACGP-Standards-for-general-practices-5th-edition.pdf
16. Australian Commission on Safety and Quality in Health Care. 2010. Ibid.

Principle 1 – Preparation

Allocate staff roles to reduce disruption and maintain safe resident care and ensure all participants are aware of the venue and time of handover.

Prior to handover clinicians should collate information and obtain relevant documents. For example, refer to the paper form to assist staff to practise best practice clinical handover based on the ISBAR technique at Attachment 1.[17]

Step 1: HANDover Preparation

- H = Hey it's handover time
- A = Allocate staff for continuity of care
- N = Nominate participants, venue and time
- D = Document on written sheets and resident notes

Principle 2 - Organisation

Make sure all participants have arrived before starting the handover, and that the handover will be supervised by a designated leader who assumes responsibility.

Step 2: ME

- M = Make sure all participants have arrived. For example:
  - Patients/residents
  - Senior clinicians
  - Junior clinicians
  - Managers
  - Allied health professionals
  - GP
  - Ambulance/paramedics
- E = Elect a leader

Principle 3 – Environmental awareness

Handover should ensure that staff are notified about, and potentially 'alerted' about, residents who may require significant levels of care or attention; those who may be deteriorating; any relevant occupational safety issues that may impact on safety; and potential patient movements. All staff should be aware of the clinical and environmental context in which they will be working.

Step 3: AN

- A = Alerts
- N = Notifications

Principle 4 - Transfer of responsibility and accountability for resident care

Handover of a resident must be achieved through a standardised process and include the transfer of accountability and responsibility to another team member.

ISBAR is a simple and flexible structured approach for handover which was adapted for use in a National clinical handover Initiative project by Hunter New England Area Health Service.

Step 4: ISBAR
(for an individual resident)

- I = Identify
- S = Situation
- B = Background
- A = Assessment
- R = Recommendation

Note that there are variations on ISBAR in clinical safety literature, including ISOBAR, SHARED and SBAR.

17. Australian Commission on Safety and Quality in Health Care. 2010. Ibid.

How do I use ISBAR?

ISBAR is a simple, structured framework to use during clinical handover[18] that is now used widely around Australia. The steps are outlined below which have been adapted.[19]

18. Australian Commission on Safety and Quality in Health Care. 2010. Ibid.
19. Australian Commission on Safety and Quality in Health Care. 2010. Ibid.

I = Identification

Identify yourself to the other clinician and outline the reason for the handover.

For example:

- I am Donna Southwood, a registered nurse, (name and role) calling from Sun Aged Care because Mrs Betty Smith, 82 years old, from room 22 (three approved resident identifiers) is unwell and I'd like your advice. Is this a convenient time to talk?

S = Situation

Provide an overview about what's been happening with the resident during the relevant shift.

For example:

- "I have a resident, Mrs Smith, 82 years, (age and gender), who is:
  - stable but I have concerns – as she has had a 'cold' for the last four days and her condition is not improving"
  - unstable and is rapidly deteriorating – as her blood pressure has dropped from 150/70 to 100/60 during the afternoon"
- "The presenting symptoms are light headedness and instability when standing".

B = Background

Provide relevant history and information. This may include date of admission, presenting symptoms, medications, recent vital signs, test results and changes in health status.

For example:

- "I am particularly concerned as Mrs Smith has a history of unstable hypertension and she has recently commenced on new medication".

A – Assessment

Complete an assessment that considers:

- Vital signs and investigations undertaken
- What needs to be done for the resident.

For example:

- "The resident's condition is ....."
- "And they are at risk of ....."
- "And they are in need of .....".

R = Recommendation

Provide what needs to be done and be clear about what you are requesting and the timeframes.

For example:

- "I recommend that Mrs Smith be reviewed by her GP, Dr Brown – and request that Dr Brown assess the resident this afternoon to determine whether her blood pressure medication should be given in the evening, or whether she should be admitted to hospital for further assessment".

Clinical scenario.

Scenario
A good example

If you are watching the webinar refer to slide 21

Maggie, a registered nurse, is looking after Mrs Dowton today. After breakfast Mrs Dowton became irritated and aggressive, and subsequently had a fall. As a result of the fall, she has a skin tear on her left arm and is complaining of pain in her right hip. Maggie has decided to contact Mrs Dowton's GP, Dr Lee.

In preparation for the handover to Mrs Dowton's GP, Maggie completed an ISBAR form, including three resident identifiers, name, date of birth and facility wing room number.[20] An example is at Attachment 2.

20. At least three approved resident identifiers are required each time identification occurs.

Resident identifiers may include:

- Resident name (family and given names)
- Date of birth
- Gender
- Address (including postcode)/Aged Care Facility room number
- Healthcare record number
- Individual Healthcare Identifier (IHI)

Australian Commission on Safety and Quality in Health Care. 2019. Correct identification and procedure matching. https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/correct-identification-and-procedure-matching/action-65

☐ FYI only

Communication Record / Handover Record Please ensure at least three potential identifiers are included in this section. Attached label if applicable.	
To: Dr **Lee**	Resident Name: **Mrs Joan Dowton**
From (Name and Title): **RN Maggie Cox**	DOB: **9 / 4 / 36 (86 Years)**
RACF Section Phone no.: **02 3456 789**	ACF/Section: **Sun Aged Care, Moon 3**
RACF Section Fax no.: **02 4567 892**	Allergies: **NIL**
Pharmacy Name (if req.): **–**	Pharmacy Fax no (if req.): **–**

Situation and relevant background
(Clearly describe issues including symptoms, duration, contributing factors and relevant history)

S = Irritable and agressive; fell over; skin tear L) arm; dressed;
2 x Panadol for R) hip pain

B = Mr Dowton (husband) passed away 3 months ago; anti depressant medication commenced

Assessment (Describe your assessment of the issues, including noticed changes in function, pain, mobility, mental state)

A = Stitches not required for skin tear; observation stable; settled; R) hip pain not eased by panadol	BP: **140 / 84**	Pulse: **120**
	Resp: **24**	Temp: **36°**
	BGL: **–**	SaO2: **–**
	Attached: **–**	

Recommendation (Outline your request, including if an action or response is required, the level of urgency and timeframes for response, e.g. does this need to be addressed before the next schedule visit from GP?)

GP to advise urgently by 2pm 2/2/20 if hospital review requested

GP Response (Orders)	Date: **2/2/2020**	Time: **1145hr**
Hospital review R) hip, possible fracture, required asap. Arrange for ambulance		

This form can be used for phone orders and as a short-term medication administration record for up to 2 weeks.
An amended signed medication sticker (posted) or patient ACF medication sheet is required for longer-term treatment.
When used as a summary of afterhours discussion or consultation, it is to be promptly faxed to patients usual GP.

DRUG:		DOSE:	DATES	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M
			TIMES														
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If you are watching the webinar refer to slide 23

Maggie then rang Mrs Dowton's GP shortly before lunch.

I = Introduction

Maggie identified herself and the reason for the call.

"Hello Dr Lee, I am Maggie Cox, a Registered Nurse from Sun Aged Care. I am calling about your patient Mrs Joan Dowton, DOB: 9/4/36 in Moon Wing, Room 3

S = Situation

Maggie then provided Dr Lee with an overview of the situation.

"Mrs Dowton, 86 years, has been irritable and aggressive, and fell over this morning. She has a skin tear on her left arm. The skin tear has been cleaned and dressed and does not require stitches. She is complaining of pain in her right hip and has been administered two Panadol tablets (1000 mg of paracetamol)."

B = Background

Maggie then provided GP Lee with some additional background information.

"As you may recall, Mrs Dowton's husband passed away earlier this year and she has commenced a new antidepressant medication."

A = Assessment

Maggie then provides Dr Lee with an overview of Mrs Dowton's condition.

"Mrs Dowton's observations are stable, BP 140/85, but her pulse rate is higher than usual, 120/minute compared to 100. Her behaviour has settled and her skin tear has stopped bleeding. She is able to mobilise slowly but I am concerned as she continues to complain of right hip pain. She states that the paracetamol has not eased the pain".

R = Recommendation

Maggie then asks… "Before I call an ambulance would you like to review Mrs Dowton?" Dr Lee advises Maggie that an ambulance should be called as soon as possible. Maggie called the ambulance. She then updates Mrs Dowton's clinical notes, speaks to Mrs Dowton about what has been recommended and obtains her agreement to be transferred to hospital, contacts Mrs Dowton's next of kin, prepares documentation for the paramedics, and waits for the ambulance to arrive.

Scenario reflection

What did Maggie do well in her handover?

What could have been improved?

Was the handover effective in transferring responsibility and accountability?

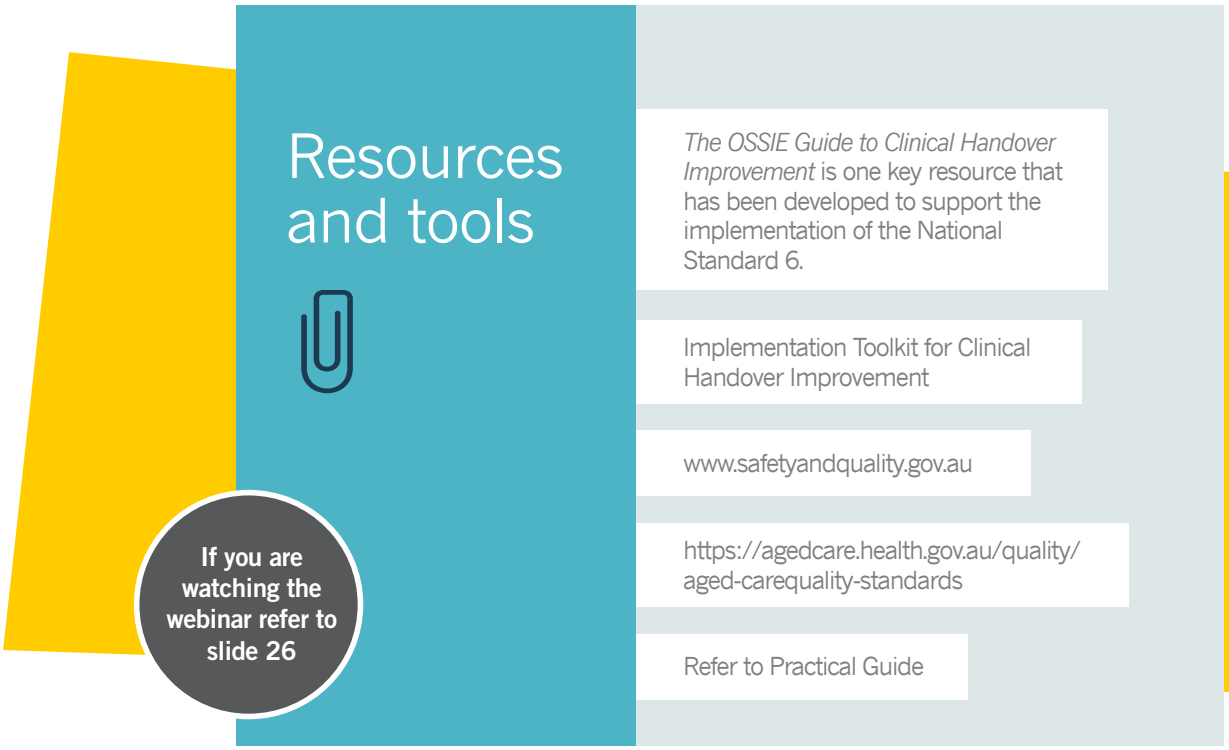
If you are watching the webinar refer to slide 24

Scenario Reflection – Pause the video for 2 minutes

Key messages.

- Clinical handovers serve different functions and are more than just a transfer of information
- Effective handover enables actions to be taken to provide appropriate and safe resident care
- Think carefully about which attendees should be present at a handover
- Be prepared, clear, focused and organised
- Ensure the resident, their family or significant others are involved, consulted and participate as appropriate
- Consider factors that affect clinical handover:
  - Change of shift times
  - Having a quiet space for communication
  - Avoiding interruptions (phones and resident/staff queries)
  - The amount of time available
- Provide relevant and accurate information and data in a timely manner, being careful to avoid acronyms and jargon that may confuse others
- Ensure the resident's files and records are up to date following the handover.

Resources and tools for implementation.



Several useful resources are:

- The OSSIE Guide to clinical handover Improvement is one key resource that has been developed to support the implementation of the National Standard 6.
- Implementation Toolkit for clinical handover Improvement.
- www.safetyandquality.gov.au

Several tools to assist support clinical handover are attached:

- Attachment 1: Communication record / handover record.
- Attachment 2: Communication record / handover record completed

References.

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Australian Commission on Safety and Quality in Health Care. 2012a. https://agedcare.health.gov.au/quality/aged-care-quality-standards#Standard%203

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Attachment 1: Communication record / handover record.

☐ FYI only

Communication Record / Handover Record Please ensure at least three potential identifiers are included in this section. Attached label if applicable.	
To: Dr	Resident Name:
From (Name and Title):	DOB: / /
RACF Section Phone no.:	ACF/Section:
RACF Section Fax no.:	Allergies:
Pharmacy Name (if req.):	Pharmacy Fax no (if req.):
Situation and relevant background (Clearly describe issues including symptions, duration, contributing factors and relevant history)	
Assessment (Describe your assessment of the issues, including noticed changes in function, pain, mobility, mental state)	

	BP:	Pulse:
	Resp:	Temp:
	BGL:	SoO2:
	Attached:	

Recommendation (Outline your request, including if an action or response is required, the level of urgency and timeframes for response, e.g. does this need to be addressed before the next schedule visit from GP?)		
GP Response (Orders)	**Date:**	**Time:**

This form can be used for phone orders and as a short-term medication administration record for up to 2 weeks.
An amended signed medication sticker (posted) or patient ACF medication sheet is required for longer-term treatment.
When used as a summary of afterhours discussion or consultation, it is to be promptly faxed to patients usual GP.

DRUG:		DOSE:	DATES →	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M
			TIMES ↓																
		ROUTE:	XX:XX AM/PM																
DR SIGNATURE:	START DATE:		XX:XX AM/PM																
	DD/MM/YY		XX:XX AM/PM																
DR SIGNATURE:	STOP DATE:	FREQ:	XX:XX AM/PM																
	DD/MM/YY		XX:XX AM/PM																
DRUG:		DOSE:	DATES →	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M
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DR SIGNATURE:	STOP DATE:	FREQ:	XX:XX AM/PM																
	DD/MM/YY		XX:XX AM/PM																

Attachment 2: Communication record / handover record completed.

☐ FYI only

Communication Record / Handover Record Please ensure at least three potential identifiers are included in this section. Attached label if applicable.	
To: Dr **Lee**	Resident Name: **Mrs Joan Dowton**
From (Name and Title): **RN Maggie Cox**	DOB: **9 / 4 / 36 (86 Years)**
RACF Section Phone no.: **02 3456 789**	ACF/Section: **Sun Aged Care, Moon 3**
RACF Section Fax no.: **02 4567 892**	Allergies: **NIL**
Pharmacy Name (if req.): **–**	Pharmacy Fax no (if req.): **–**

Situation and relevant background
(Clearly describe issues including symptions, duration, contributing factors and relevant history)

S = Irritable and agressive; fell over; skin tear L) arm; dressed;
2 x Panadol for R) hip pain

B = Mr Dowton (husband) passed away 3 months ago; anti depressant medication commenced

Assessment (Describe your assessment of the issues, including noticed changes in function, pain, mobility, mental state)

A = Stitches not required for skin tear; **observation stable; settled;** **R) hip pain not eased by panadol**	BP: **140 / 84**	Pulse: **120**
	Resp: **24**	Temp: **36°**
	BGL: **–**	SoO2: **–**
	Attached: **–**	

Recommendation (Outline your request, including if an action or response is required, the level of urgency and timeframes for response, e.g. does this need to be addressed before the next schedule visit from GP?)

GP to advise urgently by 2pm 2/2/20 if hospital review requested

GP Response (Orders)	**Date: 2/2/2020**	**Time: 1145hr**

Hospital review R) hip, possible fracture, required asap.
Arrange for ambulance

This form can be used for phone orders and as a short-term medication administration record for up to 2 weeks.
An amended signed medication sticker (posted) or patient ACF medication sheet is required for longer-term treatment.
When used as a summary of afterhours discussion or consultation, it is to be promptly faxed to patients usual GP.

DRUG:		DOSE:	DATES	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M	DD/M
			TIMES														
		ROUTE:	XX:XX AM/PM														
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