Clinical (Shift) Handover Tools & Care Plans

Last Modified on 16/07/2025 10:30 am ACST

Background

The NSQHS Standards discuss Communication at clinical handover, specifically:

Transitions of care occur when all or part of a patient's care is transferred between healthcare locations, clinicians, or different levels of care within the same location. This includes when:

- There is a change in clinician (for example, shift change)
- A patient is transferred to another health service organisation (for example, from hospital to an aged care home, another hospital, community nursing or a palliative care service)
- A patient is moved within an organisation (for example, to the general ward after surgery)
- A patient's care is discussed during multidisciplinary team rounds
- A patient is transferred for a test or appointment
- A patient is discharged.

Tools available to assist with this follow the below principle:

The standardised structure for all clinical handovers is iSoBAR:

- Identify
- Situation
- Observations
- Background
- Agree to a plan
- Readback

WA Health guidelines.

NSW Clinical Handover

Manage areas/wards in a given location

Existing functionality via Bed Management

As a system administrator

I want to be able to group multiple beds or rooms into a labelled area

IE: Neonatal Ward A

So that I can reference a physical area of the hospital in the CareRight system accurately.

Create a schedule of care

Phase 1

As a care planner

So that a standard minimum level of care is provided in a uniform manner

I want to be able to record the assessments/chart updates/activities that should be done

And the approximate frequency.

Example:

- A palliative patient may require PCOC, fluids, observations 3x a day, waterlow pressure risk at least once a day.
- A rehabilitation patient may require AROC, fluids, waterlow pressure risk at least once a day.

The Care Right system will be extended to create a Care Plan structure. Note that customers may develop their own Care Plan Assessments, ie a Picture Care Plan, with fine grained detail and clinical decisions built in.

In this scenario, the assessment would be extended with trigger automations to start the Care Plan structures shown below.

((Image))

The resulting plan contains many plan elements

((Image))

Plan a clinical handover on an individual patient

Phase 1

As a nursing staff member or similar medical professional,

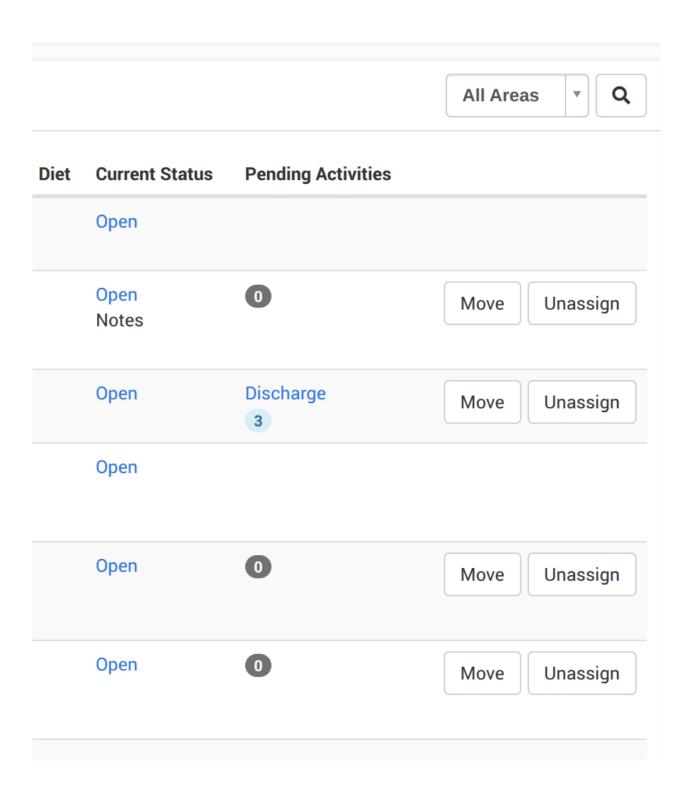
I want to be able to share pending activities during a clinical handover.

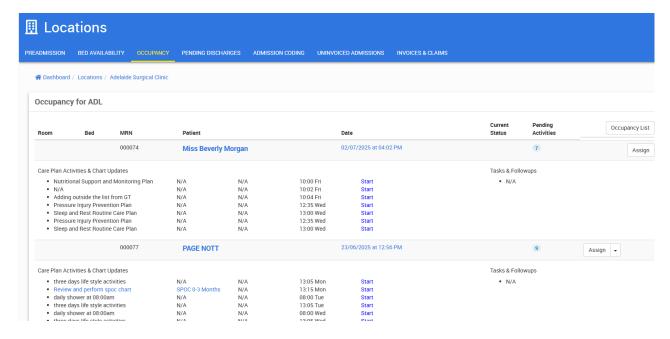
- On a mobile device such as an ipad or smart phone
- On a laptop on a cart

So that I have a comprehensive handover plan.

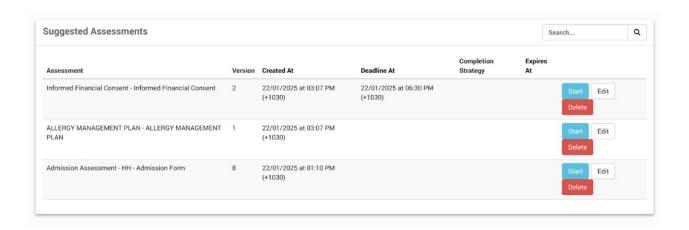
Location Occupancy > Suggested Assessments

In the pending activities column of location occupancy, a number of actions are surfaced.





Current Patient Record > Suggested Assessments has been extended to show deadlines



Further work will take place to surface pending tasks, followups in a similar area.

Further work will take place to ensure chart updates are requested in this area.

See a list of patients/beds in my area I am responsible for

As a nursing staff member,

I want to see a subset of the patient occupancy relevant to my area (ward or similar)

So that I can focus on the specific patients relevant to me.

- A fast filter for searching by MRN, patient name, bed number.
- A way to expand this list to show the assessments, tasks, etc and the due dates.

| In other systems, this is presented with a strong focus on the full list of assessments and activities. |
|---|
| On viewing the activities that are due soon, under each patient record a number of items would be listed. |
| Perform a clinical handover on an individual patient |
| Phase 1 |
| As a nursing staff member, |
| With the other staff member I am handing over to |
| I want to note using an ISBAR methodology, and a custom ISBAR assessment; things like: |
| Which family member(s) the patient wanted present |
| That the patient is comfortable (pain free) |
| Which staff member I am handing over to. |
| The approximate time of handover |
| So that my handover preparation is complete. |
| As a nursing staff member |
| When I do my handover at the patient journey board/huddle/planning (away from the bedside) |
| I want to see |
| Recent assessments |
| Clinical notes |
| |
| As a nursing staff member |

When I am at the bedside

I want to note/be able to one click see:

- That I have confirmed the patient identity using at least three (3) approved patient identifiers (photo, wristband, name
 + dob?)
- Which family member(s) are present if relevant
- Relevant clinical history and current clinical situation, including infectious status, diet/fluid/supervision requirements, invasive or implanted devices and medications
- Review of the most recent recorded set of observations noting any trends, recent clinical review and/or rapid response calls and resultant management plans
- Assessment of recent test results which require follow-up, for example, scans, x-rays and blood tests
- Identification of timeframes and requirements for transition of care/discharge
 - Later scope: Plan a transfer, export records as paper.
 - o One click plan discharge?
- Cross-check information in the patient's health care record/s including medications and observations to support the handover communication
- Note any to patient/family/carer concerns
- Acceptance of responsibility for the care of the patient by the clinician receiving handover.

Accept handover for an individual patient

Phase 1

As an incoming staff member/clinician

When a handover for the patient is occuring

And I view the record

I want to see a button for accept handover

So that I can record:

• I'm now responsible

- I've read everything I need to know
- There's a date/time log of handover

Dashboard - see my ward and patients

Phase 1 - Bed Management

As a nursing staff member

When I have accepted handover

I want to see occupancy and ward specific detail relevant to me

So that I can easily return to a work list.

Administrative notes - Safety/other incidents

Phase 1 - Bed Management

As a nursing staff member,

I want to record when something not specific to a patient occurs

For example, equipment malfunction

So that incoming staff can see the general status of the ward.

Reporting - Have an audit trail of handovers

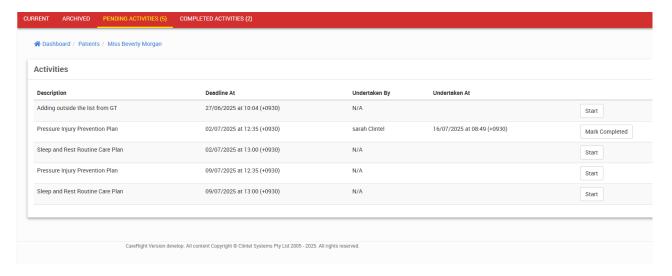
Phase 1

As a clinical coordinator/unit manager

I want to be able to see who did what when

So that I can audit the clinical care and make improvements.

Activities - Have an audit trail of pending and completed activities



CURRENT ARCHIVED PENDING ACTIVITIES (5) COMPLETED ACTIVITIES (2)

😭 Dashboard / Patients / Miss Beverly Morgan

Activities

| | Description | Deadline At | Completed By | Completed At |
|--|---|-----------------------------|---------------|-----------------------------|
| | Nutritional Support and Monitoring Plan | 27/06/2025 at 10:00 (+0930) | sarah Clintel | 15/07/2025 at 08:53 (+0930) |
| | N/A | 27/06/2025 at 10:02 (+0930) | sarah Clintel | 16/07/2025 at 08:49 (+0930) |
| | | | | |

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