

Short title: Handover

1. Purpose

The purpose of this statement is to promote safe, effective and timely clinical handover of patients between anaesthetists or interventional specialist pain medicine physicians with other healthcare professionals involved in their care.

Effective handover ensures that relevant clinical information, responsibility and accountability for patient care are communicated clearly and appropriately, particularly when there is a transfer of care, change in clinical responsibility or transition between clinical environments.

2. Scope

This statement applies to anaesthetists, interventional specialist pain medicine physicians (interventional SPMPs), and trainees from both groups who are involved in the care of patients requiring anaesthesia, interventional procedures, procedural sedation or related critical or perioperative care.

It applies to clinical handover occurring at any stage of the patient journey, including, but not limited to:

- transfer of responsibility between anaesthetists or interventional SPMPs;
- handover between anaesthesia or interventional SPMPs and other medical, nursing and allied health practitioners associated with transfer of patients between operating theatres, procedural areas, recovery areas, intensive care and other clinical environments;
- handover during rest breaks, changes in shift, rostered duties or periods of leave;
- handover of patients receiving ongoing perioperative or critical care; and communication of relevant information during urgent or unplanned transfers of care.

The principles apply regardless of the clinical setting and should be adapted to the complexity and acuity of the patient, the circumstances of the handover and the local organisational context.

Clinical handover does not transfer professional accountability for care unless responsibility has been appropriately accepted by the receiving practitioner.

For SPMPs, this document should be read in conjunction with FPM position statement PS11(PM) which details the clinical standards expected in interventional pain medicine.

3. Introduction

The major responsibility of the anaesthetist during anaesthesia, sedation, major regional analgesia or other interventional procedures is to provide care for the patient and to be continuously present throughout the procedure and recovery. In certain circumstances, it is necessary for the anaesthetist to hand over that responsibility and accountability, for example, in situations of prolonged anaesthesia, handover may be advantageous to the patient by preventing undue fatigue of the primary anaesthetist. Handover is required for temporary relief, where the primary anaesthetist must leave the patient but will return to resume management of the patient; and also for permanent handover, where the primary anaesthetist must leave the patient under the care of another anaesthetist for the remainder of an anaesthetic, or when handing over care at the end of an anaesthetic. Such handovers should not compromise patient safety provided that appropriate procedures are followed.

At the completion of anaesthesia or SPMP intervention, the care of the patient will be transferred to the care of another healthcare professional in a hospital unit-based location including the post anaesthesia care unit (PACU / recovery room), intensive care unit (ICU), or high dependency unit (HDU). Unless formal handover to another suitably qualified and available medical practitioner has occurred, the anaesthetist or SPMP retains responsibility for ensuring that the patient recovers safely from anaesthesia in an area appropriate for that purpose, including accountability for the management of the patient recovering from anaesthesia, particularly while in the PACU.

ANZCA has endorsed the ACSQHC Clinical Handover Guide.¹ The value of effective and structured clinical handover is emphasised in Australian National Safety and Quality Health Service standards.² The precise tool or process used should be one that is standard across an institution and supported by appropriate training.

4. Protocol for transfer of responsibility during anaesthesia

The primary anaesthetist must be satisfied as to the competence of the relieving anaesthetist to assume management of the patient and should ideally hand over responsibility only at a time when the clinical status of the patient is stable and no foreseeable adverse events are likely to occur.

The relieving anaesthetist must be willing to accept responsibility for the patient and must have had all information relevant to the safe management of the patient adequately explained.

The following matters must be communicated by the primary anaesthetist and understood by the relieving anaesthetist:

- 4.1 The patient's identity.
- 4.2 The patient's health status must be reviewed having regard to past history and the present condition.
- 4.3 A description of the anaesthetic technique including drugs, intravascular lines, airway security, fluid management, untoward events and any foreseeable problems plus the plans for further intraoperative and postoperative management.
- 4.4 The current state of the surgical procedure and its implications for the management of anaesthesia.
- 4.5 Observations of the patient according to college professional document *PG18(A) Guideline on monitoring during anaesthesia* as shown by the anaesthetic record.
- 4.6 A check to ensure correct functioning of the anaesthesia delivery system, monitoring devices in use and any other equipment which is interfaced with the patient.
- 4.7 Notification of the handover to the operating surgeon/proceduralist and to the consultant anaesthetist (in the case of a trainee).
- 4.8 The nature of the handover, that is, whether temporary (with an expected duration) or permanent.
- 4.9 In the case of temporary relief, the relieving anaesthetist should not change the anaesthetic management substantially without conferring with the primary anaesthetist, except in an emergency and the primary anaesthetist must be available to return at short notice.

In exceptional circumstances, for brief absences in which temporary delegation of monitoring and observation to a suitably trained and skilled healthcare practitioner occurs, the handover principles in *PG18 Anaesthesia monitoring* apply. In these circumstances, primary responsibility for the patient remains with the anaesthetist.

5. Principles for handover at completion of anaesthesia or interventional procedure

- 5.1 The anaesthetist or proceduralist is responsible for ensuring that the patient recovers safely from surgery and anaesthesia or an interventional procedure (eg CVAD placement, interventional SPMP procedure) in an area appropriate for that purpose as specified in college professional document *PS04(A) Position statement on the post-anaesthesia care unit* including recovery room, PACU, ICU, HDU.
- 5.2 Care of and responsibility for the patient following an episode of care for sedation, major regional analgesia, or anaesthesia is shared between the anaesthetist, the practitioner performing the procedure, and any healthcare practitioner who assumes responsibility while working within their delegation and recognised scope of practice. There must be effective communication between all health professionals sharing care of the patient.
- 5.3 The anaesthetist or interventional SPMP is responsible for recognising, managing and documenting adverse effects that may be related to the anaesthetic technique or procedural intervention. This includes a responsibility to inform patients and/or caregivers of any future healthcare matters relevant to the conduct of the technique.
- 5.4 When a patient is to be discharged from medical care on the same day that sedation or anaesthesia has been administered, the anaesthetist or SPMP must ensure that the patient and/or caregivers are provided with protocols for post-anaesthesia/post intervention care (see college professional documents *PG15(POM) Guideline for the perioperative care of patients selected for day stay procedures* and *PG06(A) Guideline on the anaesthetic record*). The same applies to post-procedural care by an interventional SPMP (see also *PS11(PM) Procedures in pain medicine clinical care standard*).
- 5.5 Patients should be involved in the discussion about who is looking after them. If there is anything that requires disclosure such as an intraoperative incident, the anaesthetists or interventional SPMP will arrange a suitable time to discuss this with the patient and their family/whanau where relevant.

6. Specific responsibilities

- 6.1 The anaesthetist is responsible for safe transport of the patient from the operating theatre or procedure room to the PACU, HDU or ICU.
 - 6.1.1 Safe transport may require administration of supplemental oxygen.
 - 6.1.2 The anaesthetist is responsible for selection and use of appropriate monitoring equipment for use during transport.
- 6.2 The anaesthetist or interventional SPMP must provide a formal handover to suitably trained and qualified staff in the PACU or ICU, with appropriate briefing on relevant aspects of the surgery or procedure, and anaesthetic technique. Handover of care:
 - 6.2.1 should ideally occur when the anaesthetist considers that the patient's condition is stable, particularly with regard to cardio-respiratory status.
 - 6.2.2 should be undertaken when there is sufficient focus with minimised interruptions and distraction.

- 6.2.3 should include instructions relating to specific relevant issues such as airways, throat packs, intravenous and intra-arterial devices, epidurals or drug infusions.
- 6.3 The anaesthetist will provide specific advice regarding:
 - 6.3.1 Identification of patient.
 - 6.3.2 The nature of the surgery and the type of anaesthetic.
 - 6.3.3 Relevant history, diagnosis, treatment and risks.
 - 6.3.4 Clinical observations and monitoring and reportable levels.
 - 6.3.5 Pain relief.
 - 6.3.6 Management of complications, particularly postoperative nausea and vomiting.
 - 6.3.7 Fluid therapy.
 - 6.3.8 Respiratory therapy.
 - 6.3.9 Any residual regional anaesthesia block.
 - 6.3.10 Discharge expectations from PACU.
 - 6.3.11 Ongoing care related to anaesthesia matters.
- 6.4 The anaesthetist must be readily available to deal with any unexpected problems or alternatively ensure that another nominated anaesthetist or other suitably qualified medical practitioner is available and has access to the necessary information about the patient. The information regarding who to contact and thresholds for notification or escalation of care must be clearly communicated and documented.
- 6.5 Other responsibilities of the anaesthetist or interventional SPMP are:
 - 6.5.1 To establish that the patient not be discharged from the recovery facility until discharge criteria are satisfied.
 - 6.5.2 To ensure that there are plans for adequate postoperative care of the patient after discharge from PACU.
 - 6.5.3 To provide advice to the primary care team after discharge of the patient from PACU.
 - 6.5.4 Where an interventional procedure has been performed by an SPMP, clear instructions should be provided to the patient and/or their carers regarding actions to be taken in the event of adverse events, or concerns of the same, occurring after discharge. This should include appropriate and accessible contact points for patients, particularly where such events may occur outside normal working hours. SPMP practice should follow Quality Statement 10 regarding Post-procedure care in PS11(PM).
 - 6.5.5 Where an interventional SPMP is not responsible for the patient's ongoing pain care, the SPMP must provide a documented handover to the treating doctor or team. This must include the indication and relevant procedural particulars, immediate outcome and complications, post-procedural risks and escalation advice, and the arrangements and responsible clinician for procedure-specific follow-up and outcome assessment.

Related ANZCA documents

PS04(A) Position statement on the post-anaesthesia care unit

PG06(A) Guideline on the anaesthetic record

PG15(POM) Guideline for the perioperative care of patients selected for day stay procedures

PG18 Guideline on monitoring during anaesthesia

PS11(PM) Procedures in pain medicine clinical care standard

This document is accompanied by a background paper (PS53BP) which provides more detailed information regarding the rationale and interpretation of the Position Statement.

References

1. Australian Commission on Safety and Quality in Health Care. OSSIE guide to clinical handover improvement Sydney2010. Available from: https://www.safetyandquality.gov.au/sites/default/files/2019-12/ossie_guide_to_clinical_handover_improvement.pdf. Accessed: 28 Aug 2026
2. National Safety and Quality Health Service (NSQHS). Communicating for Safety standard Australian Commission on Safety and Quality in Health Care; 2021. Available from: <https://www.safetyandquality.gov.au/national-standards/nsqhs-standards/communicating-safety-standard>. Accessed: 28 Aug 2026

Further reading

Australian Commission on Safety and Quality Health Care (ACSQHC). Implementation toolkit for clinical handover improvement. Sydney: ACSQHC, 2011. Available from: <https://www.safetyandquality.gov.au/sites/default/files/migrated/ImplementationToolkitforClinicalHandoverImprovement.pdf> Accessed 13 May 2024.

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