

Short title: Handover BP

1. Purpose

This review of PS53 has been undertaken because of the recognised and ongoing importance of effective clinical communication, which includes clinical handover, and noting that the previous review occurred in 2013. The National Safety and Quality Health Service (NSQHS) Standards include a *Communicating for Safety* standard which includes *Communication at clinical handover* and *Communication of critical information*.¹ Literature review (below) has highlighted the importance of effective clinical handover, and the value of the use of a structured tool. Although no specific tool is recommended in the literature, the principles of the 2010 Australian Commission on Safety and Quality in Health Care (ACSQHC) *OSSIE Guide to Clinical Handover Improvement for Clinician Leaders and Managers* ², which was a result of the *World Health Organization Patient Safety Initiative* remain valid.

The provision of anaesthesia, including deep sedation and regional anaesthesia, consists of a complex series of skills and functions that require the constant presence of the anaesthetist until appropriate handover to a healthcare professional, acting in their relevant scope of practice, following the end of the procedure. Similar handover requirements also apply after non-anaesthetic interventional procedures (eg CVAD insertion) and following procedures undertaken by interventional specialist pain medicine physicians (interventional SPMPs). During provision of anaesthesia, occasions may arise when the anaesthetist has a need to leave the operating room prior to completion of surgery and emergence from anaesthesia and effective and appropriate handover must occur on these occasions (see *PG18 Anaesthesia monitoring*).

2. Scope

This document covers:

- 2.1 General anaesthesia.
- 2.2 Sedation.
- 2.3 Major regional analgesia.
- 2.4 Interventional procedures performed by SPMPs.
- 2.5 Other situations which require the presence of an anaesthetist.

3. Issues

The risks associated with general anaesthesia, sedation and major regional analgesia require the constant presence of an anaesthetist to manage the clinical care of the patient in the context of the progress of the surgical procedure, as well as for the interpretation and response to clinical monitoring data.

There may be occasions when the anaesthetist may need to leave the operating theatre for a prolonged period or prior to the end of the surgical procedure. This will necessitate handover to another anaesthetist who will need to accept responsibility for ongoing management of the anaesthetic (*PG18 Anaesthesia monitoring*). It is recognised that clinical handover is likely beneficial if it mitigates against fatigue, but it has also been identified as a potentially high risk scenario for patient safety.²⁻⁴ To mitigate against the latter, relieving anaesthetists will need to satisfy themselves that they have sufficient understanding of the patient and their procedure, the anaesthetic technique being used, the drugs that have been administered, and the status and integrity of anaesthesia and monitoring equipment.

In exceptional circumstances, brief absences of the anaesthetist primarily responsible for managing the anaesthetic may be unavoidable. In such circumstances temporary delegation to a suitably trained and skilled healthcare practitioner who is deemed to be competent for the task (*PG18 Anaesthesia monitoring*) may occur.

The principles of handover apply to both intraoperative handover as above, as well as to postoperative handover to a ward or hospital unit-based care such as post anaesthesia care unit (PACU), high dependency unit (HDU), and intensive care unit (ICU). This also applies after an interventional procedure has been undertaken. The principles of handover also apply to any transfer of care including unplanned and intrahospital transfers.

4. Review process

This review was conducted as an Internal Review under the *CP24 Professional document process*, with oversight by the Safety and Quality Committee. The members are listed below and include consultation with the Faculty of Pain Medicine during development.

A literature review was also conducted, with the search strategy provided in Appendix 1.

5. Discussion

The United Kingdom National Institute for Health and Care Excellence has defined clinical handover as “Handover is the system by which the responsibility for immediate and/[or] ongoing care is transferred between healthcare professions.”⁵

Evidence supports structured handover processes. A standardised, team-based approach to OR-to-PACU handovers in a paediatric hospital was shown to increase the quantity of patient information transferred, without increasing the handoff duration.⁶ In adults, a checklist-based handover process in a single center decreased hypoxic events in PACU and handovers were less frequently interrupted.⁷ A systematic review which included intraoperative and postoperative handovers concluded that a tailored, site-specific approach may be more effective in achieving sustainable practice that improved clinical outcomes than the specific intervention strategy used.⁸ This was consistent with another systematic review, noting that the Situation, Background, Assessment, Recommendation (SBAR) tool, and SBAR variants, were found to be most commonly used in the perioperative environment.⁹

An example of a structured aid based on SBAR follows as a four stage process^{2, 10}:

- 5.1 Prepare for handover (HAND).
- 5.2 Organise handover (ME).
- 5.3 Provide environmental awareness (AN).
- 5.4 Individual patient handover (ISOBAR).

The first stage of clinical **H**andover is to prepare for it by ensuring that appropriate staff is available to be **A**llocated (for example, consultant vs. trainee); participants, time and venue are **N**ominated (for example, theatre, PACU, HDU, ICU); and that the handover is **D**ocumented (in the anaesthesia or patient record) - **HAND**.

The next step is to organise the handover by **M**aking sure that all relevant participants are present (anaesthetist, intensivist, nursing staff as relevant), and **E**nsuring that leadership is provided during handover (that is, the clinician accepting responsibility and accountability) - **ME**.

The third stage of clinical handover is to provide environmental awareness through **A**lerts to attention and safety, or special patient needs or risks including environmental concerns such as adequacy of facilities.

Notice of patient and staff movements also needs to be highlighted to ensure that beds (PACU, HDU or ICU) and staff are available – **AN**.

Finally, the individual patient handover requires **Identification** to ensure that the patient is correctly identified; communication regarding **Situation** including current clinical status and patient centred care requirements; notification of the latest **Observations**; provision of relevant **Background** and history; **Assessment** and actions to establish an agreed management plan; and transfer of **Responsibility** and risk management – **ISOBAR**.

The handover needs to be adaptable to the clinical context as determined by patient complexity, clinical setting and risk. Urgent tasks need to be completed before information transfer. Education in communication and teamwork are important elements in ensuring safe handovers.¹ Employers may facilitate training and assessment in handover and communication skills.

References

1. 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
2. Australian Commission on Safety and Quality in Health Care. OSSIE guide to clinical handover improvement Sydney 2010. Available from: https://www.safetyandquality.gov.au/sites/default/files/2019-12/ossie_guide_to_clinical_handover_improvement.pdf. Accessed: 28 Aug 2026
3. Zou C, Chen H, Zhang W. Does intraoperative anesthesia handovers associated with adverse outcomes? A systematic review and meta-analysis. *Frontiers in Medicine*. 2026;13:1815524.
4. Jones PM, Cherry RA, Allen BN, Jenkyn KMB, Shariff SZ, Flier S, et al. Association Between Handover of Anesthesia Care and Adverse Postoperative Outcomes Among Patients Undergoing Major Surgery. *JAMA*. 2018;319(2):143–53.
5. National Institute for Health and Care Excellence (UK). Chapter 32 Structured patient handovers 2018. Available from: <https://www.nice.org.uk/guidance/ng94/evidence/32structured-patient-handovers-pdf-172397464671>. Accessed: 28 Aug 2026
6. Caruso TJ, Marquez JLS, Gipp MS, Kelleher SP, Sharek PJ. Standardized ICU to OR handoff increases communication without delaying surgery. *International Journal of Health Care Quality Assurance*. 2017;30(4):304–11.
7. Jaulin F, Lopes T, Martin F. Standardised handover process with checklist improves quality and safety of care in the postanesthesia care unit: the Postanaesthesia Team Handover trial. *British Journal of Anaesthesia*. 2021;127(6):962–70.
8. Duffy CC, Lepore G, Bass GA, Abraham J. A Systematic Review of Postoperative Care Transition Interventions: Examining the Implementation of Handoff Protocols and Checklists. *Anesthesia & Analgesia*. 2025;141(6):1237–44.
9. Patel SM, Fuller S, Michael MM, O'Hagan EC, Lazzara EH, Riesenber LA. Handoff Mnemonics Used in Perioperative Handoff Intervention Studies: A Systematic Review. *Anesthesia & Analgesia*. 2025;141(3):468–81.
10. Australian Medical Association. Safe handover: safe patients: guidance on clinical handover for clinicians and managers 2006. Available from: https://ama.com.au/sites/default/files/documents/Clinical_Handover_0.pdf. Accessed: 28 Aug 2026

Process of document review

The 2026 Internal Review Group comprised:

Dr Michelle Mulligan, Director of Professional Affairs, Professional Documents

Prof David A Scott, Director of Professional Affairs, Professional Documents

Dr Dilip Kapur, Director of Professional Affairs, Faculty of Pain Medicine (for consultation)

Vanessa Hille, Policy Officer, Professional Documents

The 2013 document development group comprised:

Associate Professor David A Scott, FANZCA, FFPMANZCA, Councillor

Professor Paul Myles, FANZCA, Quality and Safety Committee member

Dr Peter Roessler, FANZCA, Director of Professional Affairs (Professional Documents)

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the college's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the college website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

While ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Promulgated: 2011
Reviewed: 2013, 2026
Current document: Oct 2026
Links reviewed: Oct 2026

© Copyright 2026 – Australian and New Zealand College of Anaesthetists. All rights reserved.

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from ANZCA. Requests and inquiries concerning reproduction and rights should be addressed to the Chief Executive Officer, Australian and New Zealand College of Anaesthetists, 630 St Kilda Road, Melbourne, Victoria 3004, Australia. Email: ceoanzca@anzca.edu.au

ANZCA website: www.anzca.edu.au

Appendix 1: Key search terms

Search strategy (Medline)

#	Searches	Results
1	exp Patient Handoff/	1862
2	exp Patient Discharge Summaries/	366
3	hand-over*.ti,ab,kf.	1447
4	handover*.ti,ab,kf.	2929
5	handoff*.ti,ab,kf.	2345
6	hand-off*.ti,ab,kf.	744
7	1 or 2 or 3 or 4 or 5 or 6	7762
8	exp Anesthetists/	6130
9	exp Anesthesiologists/	2548
10	exp Anesthesia/	218547
11	exp "Anesthesia and Analgesia"/	268424
12	exp Anesthesia Recovery Period/	6095
13	exp Anesthesia Department, Hospital/	1117
14	exp Anesthesiology/	34601
15	exp Deep Sedation/	1709
16	exp Procedural Sedation/	11805
17	exp Perioperative Care/ or exp Perioperative Period/	275871
18	exp Perioperative Medicine/	197
19	exp Perioperative Care/	168544
20	exp Perioperative Period/	114329
21	an?esth*.ti,ab,kf.	481357
22	analges*.ti,ab,kf.	178646
23	sedat*.ti,ab,kf.	82989
24	perioperat*.ti,ab,kf.	167970

25	peri-operat*.ti,ab,kf.	11336
26	8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25	1078830
27	7 and 26	605
28	limit 27 to yr="2013 -Current"	492
29	limit 28 to english language	465
30	from 29 keep 9-10, 12-14, 17, 19, 23-25, 34...	166
31	limit 7 to yr="2013 -Current"	6063
32	limit 31 to english language	5900
33	limit 32 to (meta analysis or randomized controlled trial or "systematic review")	218
34	33 not 29	192
35	from 34 keep 17-18, 20-21, 26-27, 29, 40, 46...	26
36	exp Australia/ or exp Oceania/ or exp New Zealand/	257109
37	(Austral* or New-Zealand* or Aotearoa).ti,ab,kf.	276738
38	36 or 37	377371
39	7 and 38	356
40	limit 39 to yr="2013 -Current"	262
41	limit 40 to english language	262
42	41 not 29	245
43	42 not 34	241
44	from 43 keep 6, 44, 65, 73, 117, 120...	15
45	limit 7 to yr="2013 -Current"	6063
46	limit 45 to english language	5900
47	limit 46 to guideline	3
48	from 47 keep 2	1
49	30 or 35 or 44 or 48	207