



Position statement on the handover responsibilities of the anaesthetist

Background Paper

1. Needs analysis

The role of the anaesthetist in managing anaesthesia consists of a complex series of skills and functions that require the constant presence of the anaesthetist during anaesthesia. Occasions arise when the anaesthetist may need to leave the operating theatre prior to completion of surgery and emergence from anaesthesia, or leave the operating suite after the completion of surgery and termination of anaesthesia.

In both situations the accountability and responsibilities of the anaesthetist need to be clearly delineated to ensure safe progress of management and care of the patient. Likewise, the principles involved apply similarly whether the anaesthetist is handing over responsibility temporarily or permanently.

In 2010 the Australian Commission on Safety and Quality in Health Care (ACSQHC) published the OSSIE (Organisational leadership, Simple solution development, Stakeholder engagement, Implementation, Evaluation and management) *Guide to Clinical Handover Improvement for Clinician Leaders and Managers*¹, which was a result of the World Health Organization Patient Safety Initiative. The review and merging of *PS10* and *PS20* is in response to this federal initiative and is aimed at being compliant with the relevant aspects of the OSSIE guide.

2. Scope

This document covers:

- 2.1 General anaesthesia.
- 2.2 Sedation.
- 2.3 Major regional analgesia.

It is not intended to cover conscious sedation or procedures performed under local anaesthetic infiltration.

3. Issues

The risks associated with general anaesthesia, sedation and major regional analgesia require the constant and uninterrupted 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 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. It is recognised that clinical handover is a high risk scenario for patient safety.¹ Consequently, relieving anaesthetists will need to satisfy themselves that they have sufficient understanding of the patient, the anaesthetic technique being used, the drugs that have been administered, and the status and integrity of anaesthesia and monitoring equipment.

The primary anaesthetist must be satisfied that the relieving anaesthetist has the competencies and commitment necessary for the role.

The principles of handover apply to both intraoperative handover to another specialist 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).

The National Patient Safety Agency, in the United Kingdom, has defined clinical handover as “the 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”.^{2(p. 8)}

4. Discussion

The clinical handover may be divided into four stages¹:

- 4.1 Prepare for handover (HAND).
- 4.2 Organise handover (ME).
- 4.3 Provide environmental awareness (AN).
- 4.4 Individual patient handover (ISOBAR).

The first stage of clinical Handover 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 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. **N**otice 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 **I**dentification to ensure that the patient is correctly identified; communication regarding **S**ituation including current clinical status and patient centred care requirements; notification of the latest **O**bservations; provision of relevant **B**ackground and history; **A**ssessment and actions to establish an agreed management plan; and transfer of **R**esponsibility and risk management – **ISOBAR**.

5. Notes on the revision

- 5.1 The name of the document has been changed from *Guidelines on the handover of responsibility during an anaesthetic* to *Position statement on the handover responsibilities of the anaesthetist*. There are two parts to this change. Firstly, this document is now an amalgamation of *PS10* and *PS20*, which consequently requires deletion of the reference to “during an anaesthetic”. It now encompasses the anaesthetist’s responsibilities to all situations for handover. Secondly, as the evidence for clinical handover is poor (as stated in the OSSIE Guide) and the process of handover is procedural it may serve a more useful purpose as a “statement”.
- 5.2 The amalgamation of *PS10* and *PS20* seems reasonable given the considerable overlap of the functions contained within both documents.
- 5.3 Reference is made to the OSSIE Guide as well as other relevant ANZCA professional documents.

- 5.4 The reference to temporary and permanent relief has been deleted because the principles are the same and the only difference lies in the person to whom the patient handover is made.
- 5.5 The reference to “suitably trained and qualified staff” (see item 4.2) is intended as follows: “qualified” refers to the nursing degree; “trained” refers to PACU training, which may or may not have resulted in a formal qualification.

References

1. Australian Commission on Safety and Quality in Health Care. OSSIE guide to clinical handover improvement. Sydney: ACSQHC, 2010. From: <http://www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/ossie-guide/>. Accessed 1 November 2010.
2. The Australian Medical Association. Safe handover: safe patients: guidance on clinical handover for clinicians and managers. Kingston: AMA, 2006; p. 8. From: <http://ama.com.au/node/4064>. Accessed 1 November 2010.

Process of document review

The document development group comprised:

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Regional/national committees

Faculty of Pain Medicine Board

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PS53(A) was reviewed in 2013 after a pilot phase of two years. No significant amendments to the document were considered necessary at this time.

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