

## Davis Regional Medical Center

Title / Description: <b>“Hand-off” Communications</b>				Filing Number;
Effective Date: Dec. 1, 2005	Reviewed Date:	Revised Date:	Applies to: Hospital-wide	Approved by: MEC Nov 2005

### **POLICY:**

1. “Hand-off” communications will take place whenever there is a change in the patient’s/ client’s/resident’s caregivers. Caregivers include all clinical staff and physicians.
2. “Hand-off” communication shall include:
  - Accurate patient/client/resident information regarding care, treatment and services
  - Current patient’s/client’s/resident’s condition
  - Recent or anticipated changes in the patient’s/client’s/resident’s condition
3. All information will be presented in a clear, concise manner.
4. Healthcare professionals shall be allotted the time to “hand-off” patient communication and to ask and answer questions with minimal interruption. It is hoped that this will lessen the amount of information that might be forgotten or simply not conveyed.
5. Examples of patient/client/resident care transitions where “hand-off” communication will take place:
  - At the change of shift between nurses
    - Writing or tape recording report does not allow for questions; therefore, it is not acceptable for the “handing-off” of patient/client/resident information.
  - When a nurse leaves the unit for a period of time, such as lunch or to accompany a patient to another unit or diagnostic department
    - Temporary responsibility of the patients under the care of the departing nurse is given to another licensed nurse.
  - When a physician transfers complete responsibility for a patient/client/resident
  - When physicians are transferring on-call responsibilities
  - When physicians and nurses are transferring patients/clients/residents to another level of care
  - Anesthesiologist’s report to the PACU RN and/or to the unit RN

- Patient/client/resident transfer to another healthcare facility
- Critical Clinical Laboratory and Imaging/Radiology results sent/called to physicians' offices

### **PROCEDURE:**

1. Caregivers shall find a quiet area to give a verbal report (hand-off communications) to ensure accurate, clear and concise information is given with a minimum of interruptions.
2. Caregivers will give each other the opportunity to ask questions, answer questions and read-back or repeat-back information, as needed.
3. Information provided during hand-off communications will include at a minimum (this information will be discipline-specific):
  - Patient's/client's/resident's name and location
  - Patient's physician
  - Date of admission
  - Diagnosis
  - Summary of the patient's/client's/resident's current physical and mental health condition including:
    - Current medications and when they were last given
    - IVs present: heparin lock and/or IV solution, rate of infusion
    - Most recent vital signs
    - Input and output, when applicable
    - Oxygen, ventilator settings when applicable
    - Wound dressings, drains, etc.
    - Emotional status
    - Pain assessment and management
  - Allergies
  - Recent or anticipated changes in the patient's/client's/resident's condition
  - Pertinent past medical and surgical history

- The patient's/client's/resident's resuscitation status
- Results of recent Clinical Laboratory and diagnostic tests
- Patient/client/resident problem list
- Treatment, care and services that need to be completed (to-do list)
- Any other information which is important to the patient's/client's/resident's care