Department of Nursing & Patient Care Services

SUBJECT: Hand-Off Communication of Patient Information

EFFECTIVE DATE: 12/2008  REVIEWED DATE: 4/14, 8/17
REVISED DATE: 8/17

I. Policy:

A. To ensure the appropriate continuity of patient care, healthcare providers will communicate to one another pertinent patient information about patient’s care, treatment and services, current condition and any recent or anticipated change whenever patient moves from one level of care to another, from one unit to another unit and/or to and from a unit to a diagnostic or treatment area.

Hand-off communication may also include communication of critical laboratory and radiology results.

Definition:
A “hand-off” communication is a simultaneous, interactive process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity of patient care and safety.

B. During a hand-off, care providers should have the opportunity to ask and respond to questions. Hand-off communication should include at a minimum:
1. Diagnoses and current condition of the patient.
2. Recent changes in patient condition including diagnostic and laboratory tests/results or treatment plan.
3. Anticipated changes in patient condition or treatment plan.
4. What to watch for in the next interval of time.

II. Responsibility:

A. Care givers including laboratory and diagnostic personnel will communicate pertinent information at patient “hand-off”.

B. The primary disciplines involved in hand-off communication include but are not limited to nursing and medical staff. Other personnel involved in hand-off communication are indirect care givers such as the laboratory staff, radiologists, respiratory care, transport etc.
III. **Procedure:**
   A. Hand-off situations include but are not limited to the following:
      1. Nursing shift change
      2. Temporary responsibility for staff leaving the unit for a short time
      3. Anesthesiologist or circulation nurse reports to PACU nurse
      4. Transfer in level of care (e.g., Emergency Department to an Inpatient unit)
      5. Transfer between inpatient units
      6. Transfer to different providers or service of care
      7. Transfer to and from diagnostic or treatment area.
      8. Transfer to another facility (e.g., another hospital, nursing home, home care, or ambulatory care setting)
      9. Critical laboratory or radiology results

   B. Hand-off communication should include at a minimum:
      1. Diagnoses and current condition of the patient
      2. Recent changes in condition or treatment
      3. What to watch for in the current plan of care.

   C. Written information sources:
      1. Transfers between units require a written transfer note/summary
      2. Upon discharge from inpatient services, a written discharge summary and discharge instruction are completed in EPIC and printed.
      3. Communication of critical test values follow the write-down-read back procedure

   D. There must be an opportunity to ask and answer questions for the purpose of obtaining accurate and adequate patient information.

IV. **Reference:**
   JCAHO 2017 Hospital Accreditation Standards