# COMMUNICATION BETWEEN CAREGIVERS - HAND-OFF

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| **Authoring Department:** | **Environment of Care – Risk Management** |
| **Primary Department:** | **Entire Southwest Health Organization - Patient / Resident Safety** |

**PURPOSE:**

The purpose of hand-off communication is to enhance the safety of patients by providing accurate information about a patient's treatment and services, current condition, and any recent or anticipated changes.

**POLICY**:

Hand-off communication uses a standardized method to maximize the effectiveness of the care that is provided to our patients throughout the facility. Hand-Off should be accurate, current, and thorough.

**DEFINITIONS:**

• **SBARQ Format:** The SBARQ format is a template for providing a standardized exchange of information. This format includes the following elements:

o **S**ituation: Reason the hand-off is occurring

o **B**ackground: Reason for hospitalization, relevant history, summary of treatment/clinical course

o **A**ssessment: Pertinent physical assessment data, any pertinent changes in patient status

o **R**ecommendations: Needs the patient may have off of the unit or during the receiver's care

o **Q**uestions: Allow time for clarifying questions

**RESPONSIBILITY:**

All staff who are directly involved with the care of patients at Southwest Health in which care of the patient may be transferred permanently or temporarily to another are responsible for complying with the hand-off policy. Hand-offs may include, but are not limited to:

- Nursing shift changes,
- Physicians transferring complete responsibility for a patient,
- Physicians transferring on-call responsibility,
- Temporary responsibility for staff leaving the unit for a short time, such as for Radiology Procedure

- CRNA report to post-anesthesia recovery room nurse,
- Nursing and physician hand off from any SH facility service to other unit or facility, such as the emergency department to Radiology or inpatient unit, other hospitals, nursing homes, home health care, etc.

**PROCEDURE:**

1) Hand-off reports are given person to person, defined as either face to face or via phone, at the time of transfer. Hand-offs should also be done in front of the patient, whenever possible.

2) All Hand-offs will include:

   a. Up-to-date information regarding the patient's care, treatment and services, condition and any recent or anticipated changes.

   b. Interactive communications allowing for the opportunity for questioning between the giver and receiver of patient information.

   c. A process for verification of the received information, including repeat-back or read-back, as appropriate.

   d. An opportunity for the receiver of the hand off to review relevant patient historical data, which may include previous care, treatment and services.

   e. Interruptions during hand offs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

3) Patient Hand Off will be located in the patient's medical record and should be completed for all hand offs except shift to shift nursing and physician to physician hand offs.