LAC+USC MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

Subject:	Original Issue Date:	Policy #
HAND-OFF COMMUNICATION- PATIENT CARE REPORT	01/06	**706**
	Supersedes: 03/19	Effective Date: 04/23

Departments Consulted:	Reviewed & Approved by:	Approved by:
	Professional Practice Committee Nurse Executive Committee Attending Staff Association Executive Committee	(signature on file) Nancy Blake Chief Nursing Officer

PURPOSE:

To establish guidelines delineating a standardized approach by which nursing staff will provide "hand-off" communication among nursing caregivers.

POLICY:

Hand-off communication provides for the opportunity for discussion between one caregiver to another of patient information. A hand -off is a transfer and acceptance of patient care responsibility achieved through effective communication. Effective communication is a real- time process between sender nurse to receiver nurse of patient specific information for the purpose of ensuring the continuity and safety of the patients care.

PROCEDURE:

The nursing staff, who are relinquishing care of a patient (e.g., change of shift, transfer, emergency department (ED) to inpatient admission, OR/PAR, and diagnostic care areas/clinic) shall give a verbal hand-off report to the receiving nursing staff to ensure the continuity and safety of the patient's care. An opportunity to ask and respond to questions will be provided. When possible, the reporting nurse and the receiving nurse may open the chart to review the patient care and information during report.
The hand off verbal report will include but is not limited to the following information:

Emergency Department (ED) to Inpatient Unit and Inpatient Unit to Unit Transfer:

- Patient's name and preferred name
- MRN#
- Patient's primary provider or team
- Allergies
- Patient summary including reason for hospitalization/visit, hospital course, ongoing assessment, and plan of care
- Dated Vital signs
- Code status
- Special equipment needed to assume care for the patient i.e., ventilator, BiPap

- Independent double- checking Verification of High Alert medications* and ED/ICU continuous infusions:
  - Medication name
  - Concentration
  - Dosage
  - Pump settings on Guardrails
  - Tracing of invasive lines
- Medication list
- Dated laboratory tests, including pending results or orders, test/procedures or treatments,
- Additional information, as indicated;
  - Isolation precautions
  - Legal and/or Psychiatric holds
  - Suicide, violent behavior, sitter needs, and restraint use
  - Risk for falls
  - Pressure injuries
  - IV sites and gauge
  - Medication(s) given, and IVF(s) infusing

Temporary Responsibility for Staff Leaving the Unit for a Short Time

A nursing staff member, who is leaving the unit for a short period of time (e.g. on assigned breaks/lunch or while transporting another patient) will temporarily relinquish the care of their patient(s) by giving a verbal report of pertinent information to another licensed nursing staff member prior to leaving the unit. An opportunity to ask and respond to questions will be provided. The hand -off verbal report will include but is not limited to the following information:

- Patients name and preferred name
- MRN#
- Patient's primary Provider or team
- Allergies
- Patient summary including reason for hospitalization/visit, hospital course, ongoing assessment, and plan of care
- Medications given
- Recent or anticipated plan of care changes or important events, if applicable
- Dated laboratory tests, including pending results, test/procedures or treatments
- Any pertinent patient information for the purpose of ensuring the continuity and safety of the patient's care

Ambulatory Care Setting to Inpatient Unit

A nursing staff member, who is relinquishing care of a patient in the ambulatory care setting, shall give a report to the receiving nursing staff. An opportunity to ask and respond to questions will be provided.
The hand -off verbal report will include but is not limited to the following information:

- Patient's name and preferred name
- MRN#,
- Date of birth
- Location of patient
- Patient's admitting Provider or team
- Allergies
- Medication list
- Falls
- Isolation
- Legal and/or Psychiatric holds
- Patient summary including reason for hospitalization/visit, hospital course, ongoing assessment, and plan of care
- Dated Vital signs
- Dated laboratory tests, including pending results, diagnostic tests/procedures or treatments

Diagnostic Care Area to Inpatient Unit /Clinic

A staff member, who is relinquishing care of a patient in the diagnostic care setting, shall give a verbal report to the receiving nursing staff. An opportunity to ask and respond to questions will be provided.
The hand -off verbal report will include but is not limited to the following information:

- Patient's name and preferred name
- MRN#
- Date of birth
- Allergies
- Diagnostic test /procedure performed
- Anticipated interventions (post procedure care/assessment, if applicable)
- Medications given
- Current condition of patient (i.e. dated vital signs/pain score)
- Dated laboratory tests, including pending results, diagnostic tests/procedures or treatments
- Falls
- Isolation
- Legal and/or Psychiatric holds

RESPONSIBILITY:
Nursing Healthcare Providers

REFERENCES
The Joint Commission (2022). *Sentinel event alert 58: Inadequate hand-off communication*. https://www.jointcommission.org/assets/1/6/SEA_8_steps_hand_off
California Code of Regulations, Title 22, Section 70215
Joint Commission National Patient Safety Goals, 2017
LAC+USC Medical Center Nursing Policy, *"Transfers – Internal/External"*

REVISION DATES:
01/06, 02/08, 07/08. 08/09, 02/14, 3/15, 03/19, 04/23