

	POLICY AND PROCEDURE MANUAL	Policy Number
	PATIENT CARE POLICY: Hand-Off Communication	Effective Date: January 1, 2009

PURPOSE:

Patient information is in a standardized format to ensure that it is communicated comprehensively and accurately during transitions to different care settings or changes in care providers.

POLICY:

1. The DATA format is used to communicate patient-specific information when transferring a patient to a different care setting and/or to another care provider.
2. The language used is clear and objective. Terms or abbreviations that could be misinterpreted are avoided.
3. Sufficient time is allocated for the communication of patient information. Interruptions are minimized.
4. Hand-off communications are interactive, allowing the opportunity for questioning between the giver and receiver of information.
5. To assure accuracy and understanding, the receiver of information will repeat-back or read-back information, such as critical test results, for verification.
6. interruptions during hand-off communication will not be tolerated to decrease the possibilities of error or omission.

RESPONSIBILITY:

Nurses, physicians, and other staff who report clinical information during transitions of care are responsible for hand-off communication. The process does not extend to patient transporters, as they do not assume clinical responsibility for the care of the patient.

PROCEDURE:

1. Hand-off communication occurs when patients transition to different care settings or change providers of care. Examples of hand-off communications include, but are not limited to:
 - a. Nursing shift changes
 - b. Temporary change of provider, i.e., staff leaving the unit for a short time period
 - c. Physician transferring responsibility for a patient to another physician, either temporarily or permanently
 - d. Anesthesiologist hand-off of patient to the PACU nurse
 - e. Transfer to an ancillary service area for testing or treatment
 - f. Transfer from the ED to an inpatient care setting
 - g. Transfer to a different patient care area
 - h. Transfer to a different hospital, nursing home, home health, or other entity assuming care of the patient
 - i. Critical lab and radiology test results communicated to physician offices as part of a status report (For specific expectations concerning communication that is restricted to critical test results, please refer to policy # XXX, Critical Test Results.)
2. In preparation for the communication to the next caregiver, the communication sender reviews any needed information. This may include a need to reassess the patient. The patient's record is available during the hand-off.

3. Patient care providers use the standardized format of DATA: Demographics, Assessment, Treatment, and Action.
 - a. Demographics
 - i. Identify patient's name and room number and other relevant demographics
 - ii. History of current illness or reason for admission (including surgical procedures as applicable)
 - iii. Significant past history
 - iv. Allergies (if new)
 - b. Assessment
 - i. Pertinent normal and abnormal findings related to the reason for hospitalization or goals established
 - ii. Abnormal assessment findings
 - iii. Significant recent lab or test results (using read-back for any critical test results)
 - iv. Psychosocial issues (family dynamics and coping) pertinent to care during the next care cycle
 - v. Focus of patient/family education if a major aspect of care (diabetic teaching)
 - vi. Pain or discomfort, including any need for reassessment following recent intervention
 - vii. Functional assessment (if pertinent to care during the next treatment cycle, such as toileting for joint replacement patients)
 - viii. Nutritional assessment (if pertinent to care during the next treatment cycle, such as patients with poor intake and plan to consider supplementation)
 - ix. Resuscitation status if other than full code
 - c. Treatment
 - i. Surgeries or procedures anticipated
 - ii. Invasive lines and therapies
 - iii. Wound care and dressing changes
 - iv. Scheduled diagnostic testing
 - v. Care, treatment, services, and medications (required)
 - d. Action
 - i. Immediate plan for the next care cycle (pain management, ambulation, or antibiotic therapy)
 - ii. Discharge plan or anticipated discharge/transfer date
 - iii. To do list—i.e., give pneumococcal vaccine, complete smoking cessation counseling—for the next care cycle or beyond, as appropriate
 - iv. Consults pending
 - v. Follow-up items such as pending results that require communication to the physician
 - vi. Physician plan for care over next 24–48 hours (if known)
4. The receiver of the patient information will have the opportunity to review relevant historical data and treatment plans as needed.
5. If electronic transfer of patient information occurs (by computer or facsimile), a subsequent person-to-person communication (either by phone or in person) will follow to allow for questioning between the giver and receiver and to verify information by repeat-back or read-back.

References:

Joint Commission Perspectives on Patient Safety. *Strategies to improve hand-off communication: Implementing a process to resolve questions*, July 2005, Volume 5, Issue 7. Retrieved January 4, 2006.
 Joint Commission standards 2009