LEGACY HEALTH

PATIENT CARE
Procedure #: **900.4049**
Origination Date: **FEB 2007**
Last Revision Date: **JULY 2021**

SECTION: **Fundamental Procedures**
SUBJECT: **Care Transfer Communication Process**

FACILITY:

☒ Legacy Emanuel Hospital and Health Center (as applicable: ☐ LEMC only ☐ RCH only ☐ Unity only)
☒ Legacy Good Samaritan Medical Center
☒ Legacy Meridian Park Medical Center
☒ Legacy Mount Hood Medical Center
☒ Legacy Salmon Creek Medical Center
☒ Legacy Silverton Medical Center
☐ Administrative / System Support Services
☐ Legacy Medical Group
☐ Legacy Urgent Care
☐ Legacy Visiting Nurse Association (Hospice)
☐ Legacy Lab Services
☐ Legacy Research Institute
☐ Other:

POPULATION: ☒ **Adult** ☒ **Pediatric** ☒ **Neonate**
(Adult > 18 years of age; Pediatric 0-18 and adult patients under care of a pediatric specialty physician at RCH; Neonate 0-28 days and continued hospitalization in the NICU)

POLICY STATEMENT:
Verbal communication to include patient history, current status, and care needs will occur between clinical caregivers each time patient care is transferred (“handed off”) from one caregiver to another.

PURPOSE:
To describe a standardized process for providing accurate information about a patient's care, treatment and services, current condition and any recent or anticipated changes at the point of care transfer.

RESPONSIBILITIES:
Physicians
Advanced Practice Providers
Nurses
Allied Health Professionals

SUPPORTIVE DATA:

Communication breakdown between caregivers is a major concern in the delivery of safe patient care; evidence indicates that communication failure is frequently a contributing factor to sentinel events. The many distractions and frequent interruptions in the hospital environment pose a challenge to the quality of the hand off by increasing the possibility that information will not be conveyed or will be forgotten.

INSTRUCTIONS:
1. Care transfer communication will occur concurrent with the following:
    a. On admission
    b. With change of caregiver
        i. Change of shift
        ii.
        iii. Coverage by another nurse when leaving the unit for breaks and/or to transport of another patient off the unit
    c. When transferring patient to a different unit or level of care
    d. Inter-hospital transfer
    e. Prior to surgery, procedure, or diagnostic imaging
    f. After surgery or procedure
    g. Prior to hemodialysis with the Legacy RN and dialysis RN (refer to 900.1109 Adult Renal SOC and 900.3908 Hemodialysis)

h. Data collected by Licensed Practical Nurse (LPN) or Certified Nursing Assistant/Certified Health Technician (CHT) when reporting to the Registered Nurse (RN)
i. Change of physician coverage

2. Care transfer communication should occur verbally to allow an opportunity for the receiving caregiver to ask questions.

KEY POINT: *Ideally, communication should occur face-to-face. When this is not feasible, telephone communication is acceptable. Communication should occur in a location which provides for patient privacy protection, minimal interruptions, or distractions.*

KEY POINT: *The Ticket to Ride tool may be used to assist in communication about the patient when leaving the department for diagnostics or procedures and should be used for all transports not accompanied by an RN.*

3. Care providers should identify themselves, and their role or responsibility for the patient's care (e.g. attending physician, direct care nurse).

4. Content of the care transfer summary must be accurate, standardized, and consistent.

5. Information communicated should minimally include:
   a. Pertinent history, allergies, and code status
   b. Procedures, treatments, diagnostic tests (including results)
   c. Current condition, including isolation status for known or suspected communicable disease
   d. Patient safety risks
   e. Ongoing care needs

6. The process for care hand-off communication will follow the SBAR-Q process:

   a. **S = Situation:** Clearly and ***briefly*** define the situation.

   b. **B = Background**: Provide clear, relevant background information that relates to the situation

   c. **A = Assessment**: A statement of your professional conclusion.

   d. **R = Recommendation:** What do you need from this individual or what follow-up to the plan of care is recommended?

   e. **Q = Questions:** Provide an opportunity for questions. What questions do you have of me?

7. The assessment should be conducted in accordance with the assessment timeframe parameters and scope outlined in the applicable Standards of Care or based on patient condition.

8. To avoid lapses in communication secondary handoffs should be limited to urgent/emergency situations

DOCUMENTATION:

1. During face-to-face or telephone report, the patient's Electronic Health Record (E.H.R.) should be immediately available to both caregivers, if possible, to reference pertinent information.

2. Within the E.H.R. summary views are available to assist in accurate recall of key data. The Patient Care Snapshot, Patient Overview, Shift Change and IP Kardex provide view of relevant patient data to be included in the handoff.

3. A written care transfer summary in the health record may supplement the hand-off communication, but may not substitute for verbal exchange between caregivers. A written summary is not required.

Key Words: Communication, Care Transfer, Hand-off, SBARQ, Bedside Report

References:

The Joint Commission. (2017). Inadequate hand-off communication. *Sentinel Event Alert, Issue 58.* Retrieved from sea_58_hand_off_comms_9_6_17_final_(1).pdf (jointcommission.org)

Approval: CSR
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