NURSING SERVICE GUIDELINES
GENERAL

Guideline: **Handoff Communication**

Policy Number Superseded:

Responsibility: The trained and competent Registered Nurse (RN)

Purpose of Guidelines: To provide a framework for nursing clinical hand-over at UTMC.

Effective Date:
April 2025

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March 21, 2018

Procedure:

(A) Direct patient care handover (inpatient areas).

(1) In inpatient areas, handoff occurs every day at the time of the shift change-over/start of shift.
(2) Handoff should occur by each patient's bedside. If not appropriate, it should occur outside the patient's room.
(3) Patients are encouraged to participate in hand-off and should be aware of the plan of care for the next shift.
(4) Occurs between the staff member that holds responsibility for care and the staff member who will be assuming responsibility for the care of the patient.
(5) All nurses providing hand-off should do so in the SBAR format.
(6) Patient identification is to be incorporated as per the patient ID procedure.
(7) Clinical alerts need to be included i.e., allergies, infection control precautions.
(8) Patient communication boards will be updated.

(B) Short break handover (inpatient areas).

(1) Occurs between the nurse responsible for the patient and the nurse who is assuming responsibility for the patient.

(2) Comprised of a short verbal hand-over focusing on the greatest risk for the patient.

(C) Long break handover or patient/nurse reallocation during shift.

(1) Occurs between the nurse responsible for the patient and the nurse who is assuming responsibility for the patient.
(2) Comprised of a verbal hand-over in SBAR format – ID of patient, current situation and any risks or recommendations for break interval.

(D) Transfer of patient to another clinical area (for procedure, treatment of transfer).

(1) All patients transferred out of the unit to another clinical area require hand-over to be documented in the EMR.
(2) Documentation of transfer time indicating a transfer of professional care needs to be recorded in the patient's care plan.
(3) For inpatients being transferred within inpatient units, clinical hand-over is required from the bedside nurse to the receiving nurse.
(4) Hand-over should include communication regarding infectious risk and precautions.
(5) If the patient is unstable, requires clinical observations of less than 4 hourly, or has fluids or blood product transfusion running, the nurse must escort the patient and hand-over to a receiving nurse or qualified health professional.
(6) If the patient is assessed as stable, predictable and has no fluids or blood product transfusion running and does not require frequent clinical observations (4 hours or longer) to be performed, the patient may be transported and hand-off from the bedside nurse may be conducted over the phone to the receiving nurse and documented in the EMR.
(7) The receiving staff member will then assume responsibility and accountability for the patient.
(8) When a non-admitted/Ambulatory Care patient is being transferred to another clinical area, the nurse transferring care should contact the relevant clinical area to ensure patient is expected and hand-over given.

Approved by:
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