THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Nursing Service Guidelines
General

Title: **HANDOFF COMMUNICATION**

Responsibility: The trained and competent Registered Nurse (RN)

Purpose of Guidelines: To provide a framework for nursing clinical handover at UTMC.

Procedure:

Direct patient care handover (inpatient areas):

- In inpatient areas handoff occurs every day at the time of the shift change over/ start of shift.
- Handoff should occur by each patients' bedside. If not appropriate, it should occur outside the patient room
- Patients are encouraged to participate in handoff and should be aware of the plan of care for the next shift.
- 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
- All nurses providing handoff should do so in the SBAR format (utilizing the handover report from our patient handoff tool link).
- Patient identification is to be incorporated as per the patient id procedure
- Clinical alerts need to be included i.e. allergies, infection control precautions
- Patient communication boards will be updated

Short break handover (inpatient areas):

- Occurs between the nurse responsible for the patient and the nurse who is assuming responsibility for the patient
- Comprises of a short verbal handover focusing on the greatest risk for patient

Long break handover or Patient/Nurse reallocation during shift:

- Occurs between the nurse responsible for the patient and the nurse who is assuming responsibility for the patient.
- Comprises of a verbal handover in SBAR format – ID of patient, current situation and any risks or recommendations for break interval

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

- All patients transferred out of the unit to another clinical area require handover to be documented in the EMR
- Documentation of transfer time indicating a transfer of professional care needs to be recorded in the patient's care plan
- For inpatients being transferred within inpatient units, clinical handover is required from the bedside nurse to the receiving nurse. This handover is to be documented in the EMR

- Handover should include communication regarding infectious risk and precautions.
- 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 handover to a receiving nurse or qualified health professional.
- 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 handoff from the bedside nurse may be conducted over the phone to the receiving nurse and documented in the EMR
- The receiving staff member will then assume responsibility and accountability for the patient.
- 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 handover given.

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