

TITLE: Hand-Off Communication	
FACILITY / DEPT / FUNCTION: St. Vincent's East	EFFECTIVE DATE: 01/06
DOCUMENT NUMBER: 6000-705	LAST REVIEW DATE: 2/08
ORIGINATION DATE: 01/06	LAST REVISION DATE: 2/08
APPROVAL DATE:	RETIREMENT DATE: N/A

SCOPE: All clinical departments of St. Vincent's East
PURPOSE: To provide accurate information about a patient's care, treatment/services, current condition, and any recent or anticipated changes. To provide a framework for effective communication among members of the health care team.
DEFINITIONS:
POLICY: Patient-care providers use a standardized approach: the Situation, Background, Assessment, and Recommendation (SBAR) technique, to communicate patient-specific information when transferring care of a patient between or among providers. SBAR is an effective communication technique for all members of the health care team.
PROCEDURE:

*The contents of this document rescind any previous document covering similar material.
The online version of this document is deemed current.*

1. Equipment/Supplies:

Patient chart

Any supplies or medications needed to provide continuity at the time of transfer.

2. Specific Information:

a. A standardized format for hand-off communications is required to be used in the interactions below. The SBAR format and technique is used when transferring care of and information about a patient during, but not limited to, the following exchanges of information:

- i. Nurse (RN) to RN change-of-shift reports, and when care is temporarily assigned to another RN on a short-term basis (e.g., coverage for breaks, off-unit for meetings).
- ii. Physicians transferring complete responsibility or on-call responsibility for a patient.
- iii. RN to physician, and vice versa.
- iv. Temporary responsibility for staff leaving the unit for a short time.
- v. Anesthesia provider to post-anesthesia care unit (PACU) nurse. (Will use REPORT format-see (e.) below)
- vi. RN and/or physician hand off from the Emergency Department (ED) to an inpatient unit.
- vii. Transfer to another hospital, nursing home, or home care agency.
- viii. When critical lab values and other critical diagnostic results are provided to a physician or physician's office staff.

SBAR may be used between and among all health care providers, and may be tailored for use in any exchange of information.

b. The SBAR format is a template for providing a standardized exchange of information.

- i. Sender begins by familiarizing themselves with appropriate patient information before initiating the SBAR communication.
- ii. S - Situation: Identify yourself, your position, the patient's name, and current situation. Describe what is going on with the patient.
- iii. B - Background: State the relevant history and physical (H&P), physical assessment pertinent to the problem, the treatment/clinical course summary, and any pertinent changes.

- iv. A - Assessment: Offer your conclusions about the present situation.
 - v. R - Recommendations: Explain what you think needs to be done, what the patient needs, and when.
 - vi. End with Questions: Verify any critical information received, review the history, seek clarification, ask questions, and read or repeat back critical test results.
- c. Person to person contact is preferred when transferring care. When this is not possible, it is acceptable to provide this information via phone, electronic messaging, hardcopy form, or fax. Follow up transfer of electronic information with person-to-person contact or telephone call, allowing for appropriate feedback and opportunity for questions. The SBAR format is followed and provisions are made for direct dialogue, including the opportunity to ask questions, between and among caregivers.
- d. When possible and appropriate, include the patient and family in the dialogue at the time of transfer. At a minimum, the transferring caregiver makes the patient/family aware of the hand-off and provides the name and title of the person or agency who will be assuming responsibility for their continued care.
- e. Pre procedural communication is accomplished using the pre-procedural checklist. Post-procedural hand-off is given utilizing the REPORT format.
- i. R-Reason for surgery/history
 - ii. E-Estimated blood loss and replacement/ cellsaver/ autotransfusion
 - iii. P-Patient name, age, allergies , procedure and surgeon, pain
 - iv. O-Output/ Intake/ Line/ Drains/ Packs/ Dressing
 - v. R-Results pending and/or critical labs/x-ray
 - vi. T-Treatments and To-Do, MD orders/Plan of Care

3. Documentation:

Formal documentation of the SBAR format is not necessary or required. All information relayed during the transfer process is already documented in the appropriate sections of the patient's medical record.

REFERENCES:

Institute for Healthcare Improvement. [SBAR Technique for Communication: A Situational Briefing Model.](#)

Joint Commission National Patient Safety Goals. [Goal 2E.](#) 2006.

Joint Commission Perspectives on Patient Safety. [The SBAR Technique: Improves Communication, Enhances Patient Safety.](#) February 2005. Volume 5, Issue 2.

ATTACHMENTS:

APPROVAL ROUTING

REVIEW HISTORY

REVISION HISTORY