

PROCEDURE FOR: Hand Off Communication

- POLICY:**
1. ISBAR is the communication model utilized within JDH/UCHC.
 2. All inpatient admission and unit transfer handoffs by nurses will be communicated and documented using the Inpatient Transfer Handoff Communication Form (HCH-2080). Documentation using the Inpatient Transfer Handoff Communication Form is required following ISBAR communication for all inpatient admissions and unit transfer hand-off by nurses. This includes admission from all portals of entry including the ED, PACU, Outpatient Clinics, Cath Lab and transfers that occur from unit to unit (i.e., ICU to Med 4).
 3. ISBAR model communication is to be used when patient care is "handed-off" from one provider to another (i.e., nursing staff shift report) or from one department to another. ISBAR Inpatient Transfer Handoff Communication Form is not required for these handoffs.
 4. ISBAR model communication may also be used in non-clinical communications (such as emails, product information, educational updates and policy/procedure notifications) and with business and administrative communications at the discretion of the speaker initiating the communication.

DEFINITIONS: HAND-OFFS: The patient hand-off is a process when passing of patient-specific information occurs from one care-giver to another or from one department to another. A hand-off also includes transferring the responsibility of care from one care-giver to another. The opportunity to ask questions must be included as well as a verification of the information received.

ISBAR: ISBAR is an acronym that stands for Identification - Situation - Background - Assessment - Recommendation. It is an evidence based communication model that assists the speaker by providing a mental model or framework to organize and convey information.

PROCEDURE: Whether spoken or written, the process for using ISBAR communication will include the following steps:

I - Identification: Clearly identify yourself, your unit and the name of the patient and his/her date of birth you are calling about. Request the name of the person you are speaking to.

S - Situation and Safety Concerns: What is happening at the present time?

- Briefly state the problem: What it is, when it started and the severity of acuity of the issue
- State the chief complaint and diagnosis

B - Background: One only needs to convey information that is relevant to this issue. This section sets the context for what is being discussed. It should include recent medications/allergies/relevant history/code status. Be prepared and have this information ready.

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A - Assessment:

What is your assessment of the situation?

- Most recent or current vital signs (situation dependent)
- Skin assessment including wounds and decubitis if applicable
- Time of last antibiotic (if applicable)
- IV fluids, blood, NG tube
- Pain level and status. Time of last pain med, if applicable.

R - Recommendation:

What is your recommendation or what do you want to happen to the patient?

- Patient admitted to inpatient or observation status
- POE orders reviewed
- EKG's and rhythms
- Treatment
- X-rays or other diagnostic tests

REFERENCES: JCAHO National Patient Safety Goals

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 7/09

REVISION DATES: