# **Standard Operating Procedure (SOP)**

## **Transfer of Important Patient Family or Visitor Information**

This SOP describes the process for the **transfer of important patient family or visitor information**, ensuring accurate and timely communication between healthcare providers, patients' families, and visitors. It includes procedures for collecting, verifying, and documenting relevant information, maintaining confidentiality and privacy, coordinating with appropriate departments, and ensuring that critical updates are conveyed effectively to support patient care and family engagement.

Version	Effective Date	Review Date	Approved by
1.0	YYYY-MM-DD	YYYY-MM-DD	[Name/Title]

## 1. Purpose

To define a standardized process for the transfer of important information involving patient families or visitors; ensuring accuracy, confidentiality, and effective communication among all parties involved.

## 2. Scope

This SOP applies to all clinical and administrative staff involved in the collection, documentation, and communication of information regarding patient families or visitors in the healthcare facility.

### 3. Responsibilities

- Healthcare Staff: Collect, verify, document, and communicate information as per protocol.
- Unit Managers/Supervisors: Ensure staff compliance and address process concerns.
- Patient Relations/Reception: Facilitate communication and direct queries as necessary.
- Information Technology: Maintain secure systems for documentation.

#### 4. Definitions

- Patient Family: Immediate relatives of the patient, as defined by the patient or legal documentation.
- Visitor: Any non-staff individual permitted to visit a patient.
- · Critical Information: Information that can impact patient care, safety, or engagement.

#### 5. Procedure

#### 1. Collection

- Obtain information from patient families/visitors during admissions, visits, or relevant interactions.
- Use approved forms/templates for documentation.
- o Collect only necessary and relevant information.

#### 2. Verification

- o Confirm identity of family members/visitors as required by policy.
- Verify contact information and relation to patient before recording.

#### 3. Documentation

- Record information in the patient's medical record or designated system as soon as possible.
- o Document date, time, source, and nature of the information.

#### 4. Confidentiality

- Ensure all documentation and communication follow privacy laws (e.g., HIPAA).
- Limit access to authorized personnel only.

## 5. Coordinating with Departments

- Notify relevant departments/teams (e.g., clinical care, patient relations) about critical updates.
- Use secure communication channels (e.g., encrypted email, secure messaging).

#### 6. Communication

- Relay critical information to appropriate staff during handovers and interdisciplinary meetings.
- Provide families/visitors with timely updates as appropriate and permitted.

### 7. Monitoring & Review

- Regularly audit transferred information for accuracy and compliance.
- Address discrepancies promptly with corrective action.

## 6. Confidentiality & Security

- All information must be handled in accordance with privacy regulations and facility policies.
  Breaches of confidentiality must be reported immediately as per protocol.

## 7. References

- Facility Privacy Policy
- Relevant National Privacy Regulations (e.g., HIPAA)
- Medical Record Management Guidelines

## 8. Revision History

Date	Version	Description of Change	Author
YYYY-MM-DD	1.0	Initial issue	[Author/Position]