

Institution Name / Logo		<u>Intranet Reference / ID</u>
Department / Function: Nursing	Policy Number:	Policy Title: Interdepartmental Patient Transfer / Hand-off Policy
Effective Date:	Originator:	Approval:
Revision Date:		

POLICY

Patients are matched with the level and type of care and services within the hospital that are most appropriate to their assessed needs. When transferred within the hospital, appropriate communication between the transferring and receiving patient care areas is to occur.

PURPOSE

To ensure the accurate and efficient transfer of the patient to a nursing unit or procedure area that is best able to meet the patient and family's physical, psychological and emotional needs. The patient or patient's family or legal guardian are informed as early as possible as to the condition that may result in transfer to a procedural area, another organization or level of care, alternatives to transfer, if any, the basis for discharge, and the anticipated need for care post discharge.

RESPONSIBILITY

Attending physician, Registered Nurse, LPN

EQUIPMENT

Transfer Summary, ID Plate, patient chart, patient medications and transfer check list if applicable.

PROCEDURE

1. Obtain procedure name / type or transfer order from attending physician. If a nursing unit transfer is ordered, contact the Bed Board or Nursing Administrative Supervisor for bed availability on the specified nursing unit.
2. Inform the patient and the family of the transfer. The physician and the nurse will communicate this to the patient and the family.
3. Complete the scheduled medications and treatments due before procedure or transfer and document on the patient's chart.
4. Provide a report to receiving RN or procedural technician on the reason for transfer, referral, and discontinuation of service or discharge. Report any community referrals or resources provided to the patient, as appropriate, and provide report on the following:
 - a. Physical and psychosocial status.
 - b. A summary of care provided and progress towards goals.
 - c. The sending nurse completes the Transfer Summary Form as a tool for documenting report.

5. Transfer the patient (done by nurse or transporter) to the designated room according to the procedure or activity level of the patient.
6. Transfer the patient's personal belongings and medications to the nursing unit with the patient, when changing units and give the receiving RN the patient's belongings.
7. Assess the patient (by the receiving nurse) when changing units, and document in nurses notes.
8. Notify the patient's physician of room number, and notify the Bed Board or Nursing Administrative Supervisor to process the transfer in the computer when changing units. This will be the unit secretary's responsibility.
9. Notify housekeeping for cleaning of the bed when changing units.
10. Discharge acute care patients from acute care before admitting to the Inpatient Rehabilitation Center.
11. See attached guidelines regarding paperwork required for transferring / admitting patients to Inpatient Rehabilitation Care Unit.
12. See attached guidelines to facilitate the completion of the Transfer Summary Form.

Inpatient Rehabilitation Transfer / Admission Guidelines

The following is a listing of the required chart sections that must be copied and presented for Admission to Inpatient Rehab

- Current Orders
- H & P
- Advance Directives
- Consults
- Operative Notes
- Progress Notes (last 3 days)
- Labs and X-Rays
- EKG/ECHO Reports
- Nurses Notes (last 24 hours)
- Nursing Admission Database
- MARS (last 48 hours)
- PT/OT/ST notes

Guidelines for Completion of the Transfer Summary Form

The transferring nurse completes the Transfer Summary Form as a tool for documenting report and to ensure that all relevant information was relayed prior to transfer. Not all information identified on this form is applicable to every patient.

Only applicable sections of the form are to be completed. Completion of the Transfer Summary does not eliminate the need for a verbal report (so the receiving unit will be prepared to care for the patient on arrival to the unit and have an opportunity to ask and respond to questions).

Section 1

Complete for ALL transfers

Complete Section 1 ONLY for Post-Procedural Transfers

1. Enter the date and time of transfer.
2. Enter the location the patient is transferred from and the location the patient is transferred to (i.e. room number or procedural area).
3. Enter the patient's diagnosis and reason for transfer.
4. Enter all procedures and surgeries.
5. Enter the physicians currently involved in the patient's care.
6. Enter all relevant physical assessment data.
7. Enter any wounds and current status/treatment (dressings).
8. Enter IV medications/fluids, date IV inserted, size of the IV and the location.
9. Enter treatments to include oxygen, drains, NG's, and drains. Indicate if the patient has a Foley catheter and record the date inserted. Enter if the patient has voided, the time, and amount of voiding.
10. Assess and record the patient's pain level. Record the last pain medication amount, type and time along with any other PRN medications recently administered.
11. If the patient is on a antibiotic enter the type and the time last dose administered.
12. Enter current diet and/or tube feeding information. Document if the patient is experiencing nausea and vomiting.
13. Record any OTHER pertinent information on the line provided.
14. Check yes or no if belongings have been transferred, medication has been transferred, if the family was notified of the transfer and if the patient meets unit admission criteria.

Section 2

Complete Section 1 & 2 for all patients transferring from any Medical / Surgical or Critical Care departments.

1. Enter assessment information on GI system.
2. Enter cardiac assessment information.
3. Record other pertinent information such as Code Status, Infection/Isolation, Abnormal labs or labs pending, fall risk information, restraint information.
4. Record the primary patient goal(s).

Section 3

Complete Section 1, 2, and 3 for all patients transferring from any Critical Care area.

1. Enter telemetry information along with patient's current rhythm.
2. Enter if patient has a pacemaker.
3. Enter information on DVT precautions.
4. Provide a summary of the Critical Care course.

Section 4:

Complete Section 4 for all patient transfers.

1. Document how the patient is to be transferred and who accompanied the patient after all pertinent sections of the Transfer Summary have been completed.
2. Check the correct box for opportunity to ask and respond to questions.
3. Document the signature of the transferring nurse and date/time.
4. Document the signature of the receiving nurse/procedural technician and date/time.

Refer to Sample Interdepartmental Transfer Summary Form on the following page.

Interdepartmental Transfer / Hand-off Summary

Date: _____ Time: _____ Transferred From: _____ To: _____
Diagnosis: _____
Reason for Transfer: _____

Section I: Complete for All Transfers (Complete Section I ONLY for POST-PROCEDURAL Transfers)

Procedures/Surgeries/Dates _____
Physicians: _____ / _____ / _____
Patient Assessment:
BP _____ Pulse _____ Respirations _____ Temperature _____ Allergies: _____
Orientation: Alert _____ Other _____
Lungs: Clear Rales Rhonchi Wheeze Other _____ Oxygen ___ L/min via _____ Sat _____ %
Dressings: _____ N/A
Drains (Jackson Pratt, NGs, chest tubes) _____ N/A
Foley Yes No Date inserted: _____ Voided: Yes Time/Amount _____ No
Pain Rating : _____ Type, amount and time of last pain medication: _____ N/A
Sedation: Med _____ Total amount _____ Last dose _____ N/A
Antibiotic (Include type and last dose administered) _____ N/A
IV: Date inserted _____ Size _____ Location _____
Fluid: _____
GI: Diet _____ Nausea or Vomiting Yes No
Other: _____
Special Concerns:
Belongings Transferred Yes No NA Medication Transferred Yes No NA
Family Updated/Aware of Transfer Yes No NA Other _____

Section II: Complete Section I & II for all patients transferring from any Med/Surg or Critical Care departments

GI: Bowel Sounds Normal Absent Hypoactive Hyperactive
Last BM _____
Cardiac: Pulse present R radial L radial R DP L DP Repeating Labs DC'ed
Other: Code Status _____ Transfer orders written / re-written
Infection/Isolation: _____
Abnormal labs or labs pending: _____
High Risk for Falls ? Yes No Use of Restraints? Yes Type: _____ No
Primary Patient Goal (s): _____

Section III. Complete Section I, II, and III for all patients transferring from any Critical Care Area

Telemetry: Yes No Rhythm: _____
Pacemaker: Yes Type: _____ No Repeating Labs DC'ed
DVT Precautions: Yes No Transfer orders written / re-written
Summary of Critical Care Course: _____

Section IV. Complete for all transfers & hand-offs

Transferred via: _____ Accompanied By: _____
Transferring Nurse, Receiving Nurse/Technician, and Patient have had an opportunity to ask and respond to questions:
 Yes No
Questions: _____

Signature of Transferring Nurse / Technician _____ Date/Time _____
Signature of Receiving Nurse / Technician _____ Date/Time _____