

POLICY/PROCEDURE

SUBJECT/TITLE: “Hand-Off” Communication - Transferring Patients		
POLICY: Decisions to transfer a patient to another department, service, unit or facility are based on an assessment of the patient’s status or needs. A change in the patient’s condition, admission or discharge criteria, diagnostic or treatment orders may guide the transfer decision. It is the responsibility of the physician and hospital staff to ensure that patient services flow continuously and care is coordinated among practitioners when a transfer is needed. This is accomplished through the appropriate exchange of patient information and care needs. Communication between care sites must reflect this formal shift of responsibility.		
APPLICABLE TO: All Patient Areas		
APPROVED DATE: 5/97	EFFECTIVE DATE: 5/97, 12/08	REVISION/REVIEW DATE: 6/97, 4/00, 3/03, 5/05, 3/06, 7/08, 10/08, 12/08

PURPOSE:

To ensure coordination of care for the patient who is transferred:

- To any patient care area within the hospital,
- To any unit, treatment or clinical service,
- From one practitioner to another, and
- Outside the facility, as in discharge.
- For the purposes of this policy, a hand-off is defined as the provision of verbal and/or written information from one healthcare provider to another so that pertinent care, treatment or service needs as well as the patient’s current condition and any recent or anticipated changes are accurately communicated.

RESPONSIBILITIES:

Each patient care area and department is expected to communicate and arrange for any patient transfer to include:

- Appropriate actions taken to make transfer smooth,
- Communication of appropriate verbal and written information,
- Defining who takes responsibility for the patient during the transfer process,
- Completion of an initial assessment upon patient arrival from another facility or level of care, and
- Identifying what information is shared in documentation.
- Opportunity for questioning or clarification of patient information as necessary.

A. The hand-off communication between caregivers is driven by patient need and extent of transfer:

Situation	Process and Documentation
1. Transfers, external (nursing home, other hospital)	Use existing forms depending on the situation (STEMI, Intra-agency referral form, etc.); needs to be documented in Medical Record, supplementing form used. Transfer documentation to another facility will include but not limited to: <ol style="list-style-type: none"> The reason for transfer or discharge; The patient’s physical and psychological state; A summary of the care and services provided; Instructions and referral information provided to the patient and family.
2. Physician communication	Template: “Protocol for Communicating with Physicians” (not part of medical record); <i>Refer to “Physician Communication Protocol” Policy.</i>
3. Internal transport of patient (to another department)	Transport Passport (not part of Medical Record): <ol style="list-style-type: none"> Completed by caregiver when transport need is identified. Patient cannot be transported without a transport passport. Kept at nursing station on dedicated clipboard labeled “Transport Passports”. Transporter reviews before picking up patient. Form to accompany patient to all destinations. When transporter returns patient to unit, call light is activated and transporter remains in room until caregiver arrives. Transport passport is discarded in shredder bin. Patient’s return is documented in the medical record.
4. Shift reports	Template: worksheet (not part of Medical Record). Must include information about the patient’s status, immediate needs, plan of care, and progression in the plan.
5. Change in level of care to include but not limited to: <ul style="list-style-type: none"> • PACU to Inpatient Unit • ICU to M/S • M/S to ICU • Clinic to Inpatient Units • Clinic to ED • ED to all Units 	<ol style="list-style-type: none"> “Patient Transfer Summary” is completed and becomes part of the Medical Record. <ol style="list-style-type: none"> Transferring nurse completes and signs Patient Transfer Summary. The Summary reflects patient’s current status and background information and history pertinent to the patient’s situation. Patient Transfer Summary accompanies patient to receiving unit. Transferring nurse gives verbal report to receiving nurse either by phone or in person if transporting patient. The receiving nurse (if not patient’s primary caregiver) is responsible for communicating information received to patient’s primary caregiver. Receiving nurse signs Summary after review. <p style="text-align: center;">NOTE: Transfers to ICU are transported by patient’s nurse and Summary is received in person at time of transfer.</p> Surgical Services will utilize unit-specific nursing forms for completion of transfer summary. Patient will not be accepted to receiving unit until transfer summary is complete.

B. For details regarding transferring unstable patients or patients in labor refer to policy titled Emergency Transfers to Another Facility.

C. Procedures for external transfer may also be found in the policy titled “Discharge Planning”.

D. Forms are available on the Intranet under Forms: Nursing.

TRANSPORT PASSPORT (Not part of Medical Record)

(Patient Sticker)

Date: _____ DESTINATION: Diag Imaging _____

ALLERGIES? NO YES (See Chart for Allergies)

CODE STATUS (check one): Full DNR

ISOLATION: NO YES

LOC:

O2: NO YES

Contact

Alert & Oriented

Confused/Forgetful Amount _____

Respiratory

Dementia

Agitated

Route _____

Protective

Combative

Lethargic

Unresponsive

FALL RISK: NO YES

ACTIVITY LEVEL: Independent Assisted (Type) _____

Narcotics/Sedation/Antiemetic Given/Time: _____

Special Needs: _____

PRIMARY CARE GIVER: _____ CONTACT #: _____

Pertinent info to report to caregiver: _____

* Call light activated upon return to room

TRANSPORT PASSPORT (Not part of Medical Record)

(Patient Sticker)

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ACTIVITY LEVEL: Independent Assisted (Type) _____

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Special Needs: _____

PRIMARY CARE GIVER: _____ CONTACT #: _____

Pertinent info to report to caregiver: _____

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PATIENT TRANSFER SUMMARY

Transfer From: _____ To: _____ Date: _____	
SITUATION: DNR: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Diagnosis/hx present illness: _____ _____ _____	PRECAUTIONS: Falls Risk: <input type="checkbox"/> No <input type="checkbox"/> Yes Interventions: <input type="checkbox"/> Sitter <input type="checkbox"/> Bed Alarm Isolation: <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ Restraints: <input type="checkbox"/> No <input type="checkbox"/> Yes
VS: T _____ P _____ R _____ BP _____ SPO ₂ _____	
Surgical Procedure: _____	
Anesthesia: <input type="checkbox"/> General <input type="checkbox"/> Spinal <input type="checkbox"/> Block <input type="checkbox"/> Local <input type="checkbox"/> Other _____ EBL _____	
VENT SETTINGS: FIO ₂ _____ vT _____ PEEP _____ Last ABG: pH _____ PCO ₂ _____ PO ₂ _____ Other _____	
Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes _____	
Pertinent History/Abnormal Findings: _____ _____ _____	
Family Notified: <input type="checkbox"/> No <input type="checkbox"/> Yes Comments: _____	
CURRENT STATUS:	
NEURO: <input type="checkbox"/> A&O <input type="checkbox"/> Confused <input type="checkbox"/> Agitated <input type="checkbox"/> Combative <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive	
PULM: <input type="checkbox"/> NA <input type="checkbox"/> Clear <input type="checkbox"/> Labored <input type="checkbox"/> Non-Labored	<input type="checkbox"/> Rhonchi/Rales <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bil <input type="checkbox"/> Wheezing <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bil <input type="checkbox"/> Diminished <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bil O ₂ _____ l/m via _____
CV: <input type="checkbox"/> NA <input type="checkbox"/> Pulses Palpable <input type="checkbox"/> Peripheral Edema <input type="checkbox"/> Cyanosis <input type="checkbox"/> Telemetry: <input type="checkbox"/> No <input type="checkbox"/> Yes Rhythm _____	
GI/ABD: <input type="checkbox"/> NA <input type="checkbox"/> Soft <input type="checkbox"/> Bowel Sounds: <input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Last BM _____ <input type="checkbox"/> Distended <input type="checkbox"/> Obese <input type="checkbox"/> Tender <input type="checkbox"/> Non-tender <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> NPO	
GU: <input type="checkbox"/> NA <input type="checkbox"/> Voiding Foley/Size _____ Output _____ Color _____	
SKIN: <input type="checkbox"/> NA Dressings: _____ Surgical/Wound Site: _____ Drains/Tubes: _____ Chest tube: _____ Splints: _____ Other: _____	
MEDICATIONS: <input type="checkbox"/> None <input type="checkbox"/> Meds Given: _____ Last Abx/Time: _____ IV Site: Peripheral _____ Central Line: _____ PICC: _____ IV Solution _____ ml/hr Blood _____ ml/hr Amount Infused _____ <input type="checkbox"/> PCA Medication _____ rate _____	
PAIN SCALE @ this time: _____ Location: _____ Last sedative/narcotic given: _____	
VALUABLES/BELONGINGS: <input type="checkbox"/> With Pt <input type="checkbox"/> With Family <input type="checkbox"/> Brought to Room #: _____ Other _____	
Review Pending Orders, Results, Interventions:	
_____ _____ _____ _____	

Signature of Sending Nurse

Time

Ext.

Signature of Nurse Receiving Report

Time



Patient Label