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Approval: Julie Trpkovski - Vice President Medicine and Chief Nursing Executive 	**Date:** June 2, 2023

PURPOSE

The purpose of this policy is to provide health care providers (HCPs) with guidelines on a standardized, interactive process for transfer of accountability (TOA) to enhance patient safety and satisfaction at all care transition points throughout the patient journey.

POLICY STATEMENT

- Transfer of Accountability ensures that relevant patient information is exchanged whenever patients experience a change in HCP or a change in location (See Appendix A – How Information is Transferred at Patient Care Transitions).
- Information that is required to be shared at care transitions will be defined and standardized to ensure continuity of care.
- There are four main points of transition requiring TOA (admission, handover, transfer and discharge)

PROCEDURE

Special Instructions

- In line with best practices, this policy suggests using an SBARD (Situation, Background, Assessment, Recommendation, Decision) information transfer form or similar evidence-based structure to guide conversation/documentation during TOA to ensure that accurate and timely information is communicated between HCP's.
- SBARD components should include at miniumum (See Appendix B - Emergency Department Care Transitions)
  - The patient/resident full name and Medical Record Number (Hospital File Number)
  - Contact information for the sending and receiving health care providers
  - Reason for transfer

  - Safety concerns, need for additional precautions/Infection Prevention & Control (IP&C) status, and/or patient/resident risk factors
  - Patient/resident goals
  - Allergies, medications, diagnoses, test results, procedures, and advanced care planning wishes and decisions.
- Implementing the following actions supports a successful TOA:
  - Patients and families must be invited to participate in the information transfer process when possible, to be active partners in their care, giving them the opportunity to ask and respond to questions.
  - Patients and/or Substitute Decision Maker (SDM) will be informed of the upcoming change in location and the reason for the change in location.
  - If in-person TOA is not feasible, virtual conversations are recommended and documented in the patient's health record.
  - The transferring HCP must ensure all documentation is complete, accurate and up to date prior to patient transfer.
  - Both transferring and receiving HCP are required to sign the Information transfer form to validate the completion of the process.
  - The Information transfer form will become a permanent part of the patient's health record.

METHOD

A) **<u>Admission:</u>** The goal of TOA upon patient admission is to formally accept a patient to your area of care or service (i.e. ambulatory care/outpatients - intake, referral, inpatients - direct admission to HSN).

Direct Admission to HSN
• TOA may be a referral, telephone call and/or accompanying documentation from transferring facility/HCP • All patients admitted must have current electronic or paper documentation completed by the primary nurse regarding the patient's reason for visit
Intake/Referral to Ambulatory Care/Outpatient Services
• TOA will be a referral and will use a standardized process to triage and book the patient • Verify the reason for patient visit as part of patient registration

B) **<u>Handover:</u>** The goal of TOA at shift change handover is to communicate patient-specific information between two HCP's, same discipline or between multidisciplinary team members within a service while the patient location remains the same.

Handover on Inpatient Units
• All patients and/or SDM shall consent to their participation in handover (confirm if patient would like to be woken for handover) • Update the Whiteboard

- Handover shall occur verbally between the transferring and receiving HCP at the bedside using the unit's specific Information Transfer form.
- A safety check of the equipment/environment must occur for all patients during handover (i.e. HEAL – High Alert Medications, Equipment/Environment, Armband, Lines)

Special Circumstances:

- For Specialty Units (i.e. Mental Health and Addictions), handover MAY NOT occur at the bedside due to high risk population/sensitive content
- An environmental safety check will still occur with transferring and receiving HCP

Handover Ambulatory Care/Outpatient Services

- All patients and/or SDM shall consent to their participation in handover
- Handover shall occur verbally between the transferring and receiving HCP following unit specific standards and documented in the unit's Electronic Medical Record (EMR)
- A safety check of the equipment/environment must occur for all patients during handover

Intermittent Care during Break

- For intermittent care during break time or the need for the primary care nurse to step away,the most responsible nurse will provide a verbal report to the covering nurse with pertinent information to ensure safe care of the patient.
- Transfer of Information should include:
  - The patient's full name
  - Safety concerns, need for additional precautions/IPAC status, and/or patient risk factors
  - Patient goals
  - Allergies, medications, diagnoses, test results, procedures, and advanced care planning wishes and decisions.

C) **Transfer**: The goal of TOA on patient transfer is to communicate patient specific information when there is a change from one HCP to another and the location of the patient changes.

Transfers Within HSN: Amubulatory Care/Outpatient Services/Emergency Department ⟺ Inpatient Units

The transferring HCP will:

- Complete and sign the Generic Information Transfer at Care Transitions SBARD document
- For **Emergency Department** to Inpatient Unit: Fax the Information transfer form to the receiving unit prior to the transfer of the patient
- In certain circumstances (depending on patient presentation) provide a verbal report using the form as a guide, to the receiving unit HCP prior to the transfer of the patient
- Ensure that Information Transfer form accompanies patient to their destination
- Ensure that portering staff receives any personal belongings/medications that are with the patient

The receiving HCP will:

- Review and sign the Information Transfer form upon patient arrival and file in the patient's health record.

Temporary Transfers: Cardiodiagnostics (i.e. Angiogram, Percutaneous Coronary Intervention (PCI), Transcatheter Aortic Valve Implantation (TAVI), Pacemakers)

The transferring HCP will:

- Fill out the Cardiodiagnostic Transfer form ("Pre-Check Section) which will be placed on the front of the patient chart and will accompany the patient to their destination.
- In certain circumstances (depending on patient presentation),the transferring HCP will provide a verbal report using the form as a guide, to the receiving unit HCP prior to the transfer of the patient or accompany the patient for the procedure.
- Upon completion of the treatment/test/procedure the Cardiodiagnostic Transfer form ("Post-Check Section") will be filled out by the diagnostic/test/procedure HCP.
  Note if there are any significant changes in patient condition.

The receiving HCP will:

- Complete a visual check of the patient, check for orders and sign the completed Cardiodiagnostic Transfer Form.

Transfer to an External Partnering Healthcare Facility (Patient remains under HSN care)

The transferring HCP will:

- Complete and sign the PatientTransfer Record/Maternal Transfer Record prior to patient transfer
- Ensure that a copy of the Transfer Record accompanies the patient
- A copy of the signed Patient Transfer Record will be filed in the patient's health record
- The HCP will also give a verbal report to receiving most responsible HCP, guided by the Patient Transfer Record.

D) **Discharge:** The goal of TOA upon patient discharge from your area of care or service is to ensure that patients/ families are provided with follow-up information and an understanding of next steps. (e.g. Inter-facility, home, or to home with services, or from service):

Patient Discharge Home from Inpatient Unit / Emergency Department

- Complete a Discharge Instruction Record/Patient Discharge Instructions (Birthing Center)
- Ensure that the discharge record is reviewed and signed by the patient and/or SDM.
- Provide a signed copy of the discharge record to the patient/SDM and file a copy in the patient's health record.

Patient Discharge Home from Ambulatory Care/Outpatient Services

- Follow your service/care area-specific practices, and document any information provided to the patient/SDM
- Ask the patient and family if they have the information they require.
- Follow service level Standards to send information for ongoing services.

Patient Discharge to another Healthcare Facility

- Complete and sign the Patient Transfer Record prior to patient transfer
- Ensure that a copy of the Transfer Record accompanies the patient
- A copy of the signed Patient Transfer Record will be filed in the patient's health record
- The primary HCP will also give a verbal report to receiving most responsible HCP, guided by the Patient Transfer Record.
- A physician to physician telephone conversation will also occur

OTHER PROFESSION SPECIFIC TOA PRACTICES:

All health care professionals may use an Information transfer Tool as a template to guide their TOA, recognizing that each health care professional may have unique TOA practices.

Tools
All other documents and processes used at points of transfer must be in compliance with the core requirements of this policy. The content of the TOA tool may be adapted by other health care professionals to tailor their TOA discussion/clinical documentation.

Monitoring
The effectiveness of information transfer will be evaluated and improvements will be made based on feedback received. Evaluation mechanisms may include:

- Using an audit tool (i.e. direct observation or review of patient's health record) to measure compliance with standardized processes and the quality of information transfer.
  - Conduct weekly audits (10/week) of the process using the Information Transfer audit tool found under the Accreditation HUB tab: Required Organizational Practices (ROPs)/ ROP Resources and Materials/ ROP: Information Transfer at Care Transitions/Year 2023
  - Click here for Audit Tool
  - *With 8 weeks of consistently meeting all targets, follow the same data collection process auditing monthly (10 /month).
- Post results on the Quality Board.
- Asking clients, families, and service providers if they received the information they needed (i.e. Through patient satisfaction surveys).
- Evaluating safety incidents related to information transfer (i.e. Critical Event process and Patient Relations complaints).

EDUCATION AND TRAINING

Definitions

1. SBARD: An acronym for **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, and **D**ecision. It is a technique used to facilitate prompt and appropriate communication, to assist healthcare professional to communicate effectively with one another, and for important information to be transferred accurately.

2. Transfer of Accountability: The process of transferring patient-specific information from one healthcare provider to the next, at every transition point, to ensure continuity and safe patient care.

3. HEAL: A safety check to improve patient safety and quality outcomes, and to reduce patient harm and eliminate medical errors. HEAL stands for **H**igh alert medications, **E**quipment/environment, **A**rmband and **L**ines.

4. HCP is the abbreviation for Health Care Provider and is defined as a person who by education, training, certification, or licensure is qualified to and is engaged in providing health care to a patient/healthcare consumer. Includes medical staff, nursing, and allied health.

References and Related Documents

Accreditation Canada. 2018. Required Organizational Practices Handbook, For on-site surveys starting January 2019.

Alvarado K. et al. 2006. Transfer of Accountability: Transforming Shift Handover to Enhance Patient Safety. *Healthcare Quarterly.* 9*:* 75-79*.*

College of Nurses of Ontario. 2002. Practice Standard: *Professional Standards, Revised 2002.*

Health Research & Educational Trust. 2013. *Checklists to improve patient safety*. Chicago: IL. Illinois. Health Research & Educational Trust. Accessed at www.hpoe.org.

Registered Nurses' Association of Ontario (March 2014). Clinical Best Practice Guidelines: *Care Transitions.* Retrieved from https://rnao.ca/sites/rnao-ca/files/Care_Transitions_BPG.pdf

Queensway Carleton Hospital: Nursing Policy and Procedure(2018) *Transfer of Accountability for Nursing*

Sunnybrook Health Sciences Centre: Transfer of Accountability Policy (2021)

Halton Healthcare: Transfer of Accountability Policy (2019)

SBARD documents:

Health Sciences North/Horizon Sante Nord: Generic Information Transfer at Care Transitions

Health Sciences North/Horizon Sante Nord: Emergency Department Care Transitions

Health Sciences North/Horizon Sante Nord: Psychiatry Information Transfer at Care Transitions

Health Sciences North/Horizon Sante Nord: CAMHP Information Transfer at Care Transitions

Health Sciences North/Horizon Sante Nord: CMU Daily Rounding Checklist: CMU – Information Transfer – Shift to Shift Handover

Health Sciences North/Horizon Sante Nord: Critical Care – *InformationTransfer – Shift to Shift Handover*

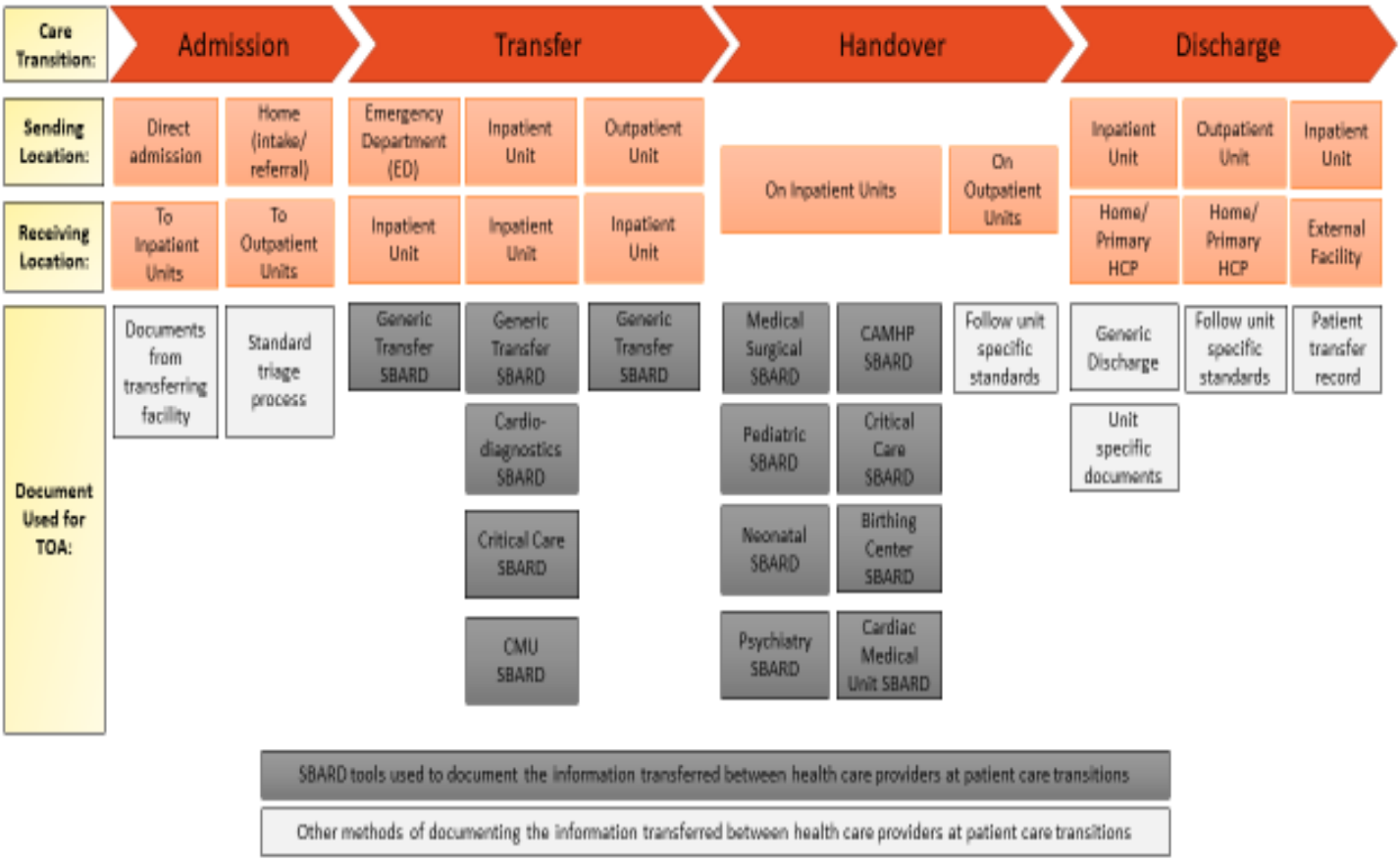
Health Sciences North/Horizon Sante Nord: Neonatal/Pediatric Information Transfer at Care Transitions:
The one on line still says bedside reporting

Health Sciences North/Horizon Sante Nord: Intrapartum/Postpartum Information Transfer at Care Transitions:

Health Sciences North/Horizon Sante Nord: Cardiodiagnostics: Information Transfer at Care Transitions

Appendix A:

How Information is Transferred at Patient Care Transitions:



Appendix B – Emergency Department Care Transitions

Health Sciences North/Horizon Santé Nord
Emergency Department Care Transitions

Date: _____ Time:_____

From: ❒ ZONE ❒ SHIFT _____ To: ❒ ZONE ❒ SHIFT ❒ IP BED #_____

Bolded items must be completed

S – Situation

Admission Date: _____ Reason for current visit (key events):_____
Diagnosis:_____
_____
MRP: _____ **IPAC:** ❒ Routine ❒ Contact ❒ Droplet ❒AGMP
Consulting Physician: _____ ❒ Other:_____
Allergies: ❒ NKA ❒ Yes _____
Goals of Care (Code status/Advance directives): **UPDATED:** ❒ Meditech ❒ Whiteboard
❒ Full Code ❒ DNR ❒ Other:_____ **COVID STATUS:** ❒ **Positive** ❒ **Negative** ❒ **Pending**

B – Background

Past Medical History: ❒ Angina/CAD ❒ CVA ❒ Drug/ETOH abuse ❒ Seizure
❒ None ❒ Cancer ❒ Dementia ❒ Hyper/hypotension ❒ Smoker
❒Asthma ❒ HF ❒ Diabetes ❒ Kidney Disease ❒ Other: _____
❒ COPD ❒ Hepatitis ❒ Mental Health Illness _____
Previous surgeries/procedures/injuries: _____
❒ Pressure Ulcer Risk ❒ VTE Prophylaxis _____ ❒ Social concerns:_____
❒ High risk hazardous drug: _____ Last given: _____
❒ Family aware of transfer Belongings: ❒ None ❒ Sent home ❒ With Patient: # Bags:

A – Assessment

VS Time: _____T: _____ HR:_____ R:_____ BP: ____/____ SpO_2:____ FiO_2 _____

Activity: ❒ AAT ❒ CBR ❒ BRP Level: _____ ❒ Assistance: _____ ❒ Transfer aids: _____	Neuro: ❒ Alert ❒ Oriented GCS: _____ ❒ Confused acute/chronic ❒ Agitation _____	Respiratory: ❒ Room Air ❒ O_2 @__ NP/Face mask ❒ BiPap ❒ CPAP Resp Effort ❒ Normal ❒ Laboured
Musculoskeletal: Weakness: _____ Numbness: _____ Skin Integrity:	Cardiovascular: Rhythm_____ ❒ Telemetry: _____ Pulses: _____ ❒ Edema:	Breath sounds: ❒ Clear ❒ Diminished ❒ Wheezing ❒ Crackles Cough: ❒ Non/Productive
Gastrointestinal: ❒ NPO ❒ Diet Order_____ **Abd appearance** ❒ Normal ❒ Firm	IV Therapy: ❒ No ❒SL ❒ PIV ___❒ CVAD _____ Sol'n_____	Tubes/Drains/Dressings:_____ **Fluid balance** IN OUT
Genitourinary: ❒ Voiding ❒ Foley _____ ❒ Incontinent ❒ Dialysis Clear/Cloudy/Yellow/Amber	Pain Level: _____ Location: _____ Medication: _____ PRN last dose:	Pertinent diagnostic/lab values
Mental Health: Admission Status: ❒ Formed **Restraints:** ❒ Physical ❒ Chemical ❒Environmental	Sedatives: ❒ Yes ❒ No Medication: _____ PRN last given:_____ CIWA next check:	Seen by Crisis: ❒ Yes ❒ No **VAT: time** _____ **Score**_____

R – Recommendations

Specimens needed: ❒ Stool ❒ Urine ❒ Sputum **Tests needed:** ❒ **N/A**

Recommendations/follow up ❒ **N/A** ❒ _____ ❒ _____ ❒ _____	Anticipated changes/events:_____ Plan of Care: EDD_____ ❒ UNK ❒ Home ❒ Repatriation ❒

Notes:_____

D – Decision

Health Care Provider Contact Information (Print Name/Signature)			**ZONE**	**Ext #**
SAFETY: ❒ Armband present ❒ AOB ❒ BPMH Complete ❒ Fall Risk ❒ Environment ❒Call bell				
Transferring				
Receiving				
SAFETY: ❒ Armband present ❒ AOB ❒ BPMH Complete ❒ Fall Risk ❒ Environment ❒Call bell				
Transferring				
Receiving				

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