Lakeridge Health	**Transfer of Accountability – Policy and Procedures**	
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	Document Applies to: All Lakeridge Health Nurses	
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Introduction

Transfer of accountability (TOA) is an interactive and collaborative process of communicating the current and evolving care needs of a patient from one Health Care Provider (HCP) that is regulated and/or unregulated to another. TOA supports transparency in the continuity of the patient's/client's care as it establishes accountability for the care to be provided. A standard TOA approach is required to efficiently and effectively transfer relevant clinical information during transitions within or across settings, other health care organizations and/or providers.

The purpose of this policy is to:

- Standardize the processes for TOA across clinical programs
- Outline the information necessary to share during TOA to promote continuity of care and reduce the risk of harm
- Outline the accountabilities and expectations for completing TOA
- Specify details that must be included when providing TOA, including Transfer of Information (TOI) tools
- Outline documentation requirements

Policy

TOA will occur during transitions in care and under specific circumstances including:

- Admission
- Transfers
    - From one unit to another
    - From one service to another (e.g. to and from hemodialysis)
    - From one team to another (e.g. Critical Care Response Team)
- Before and after procedures (e.g. interventional radiology)
- Discharge (e.g. to another institution, community setting)
- Handover (e.g. shift to shift, break coverage)
- When there is a change in health status, condition or circumstances (e.g. new development in the patients care needs, risk of restraint use, falls risk)

- Time of a referral
- End of a service rotation

Core principles of providing TOA

- Patients/clients/essential partners-in-care (EPCs) and/or designates will be encouraged to participate in TOA whenever possible for the purpose of ensuring continuous, high-quality, and safe person-centred care (PCC).
- All privacy, security and legislative regulatory requirements must be followed when completing TOA. Refer to the *Personal Health Information Privacy and Protection Policy and Procedure.*
- The patients electronic health record (EHR) will be utilized to highlight current and accurate information about the patient status
- Tools such as the SBAR framework (Appendix A) and IPASSBATON (Appendix D) will be used to guide the TOA discussion and standardize how information is shared between HCPs.
- The use of abbreviations and medical terminology should be avoided whenever possible.

Methods of delivering TOA

Methods of providing TOA are tailored to suit different disciplines and specific circumstances, to ensure an efficient and effective transfer of relevant clinical information.

Methods can include in-person exchanges, phone communications, formal handoffs and written notes.

Verbal TOA

- Verbal TOA will be completed in-person, by telephone or electronic device (e.g. Rover)
- Verbal TOA will be conducted in a location that minimizes potential distractions while maintaining patient confidentiality
- For units that do not provide in-person TOA, an electronic device will be designated for the purpose of receiving/giving TOA
- HCPs will leverage the available summary overview report in the EHR to ensure the exchange of patient information is accurately communicated
- The sending and receiving HCP will provide opportunity for clarification as required

Mandatory in-person HCP accompaniment

- In person HCP accompaniment of the patient AND verbal TOA must be provided for the following circumstances
    - All **neonatal/paediatric patients** being admitted to paediatric inpatients units from LH Emergency Departments (EDs) and/or to Post-Anesthetic Care Units (PACU). **Exclusion**: Myringotomy and Tubes. Refer to the *Paediatric Inpatient Unit Admission and Transfer Guideline*.
    - All patients (inpatient and/or outpatients) that require a **higher level of care to Critical Care/ED** units require the HCP(s) accountable for the patient/client receiving care to accompany. Refer to the *CrCu Patient Care Standard for Transfer of Accountability.*
    - **Patients in the ED that are on a ventilator requiring transition to the Critical Care**:

        - The Critical Care HCP(s) will retrieve the patient in the ED, receive TOA and accompany the patient to the Critical Care.
    - In the event the receiving unit is unable to receive report within the 30 minutes of the bed being ready. **Note:** If there is a code/emergency situation that is greatly preventing timely patient transfer, discuss with the sending unit.

For disciplines who do not provide 24-hour care or who provide intermittent or consultative services (e.g. Dialysis, Interventional Radiology etc.):

- The transferring HCP will ensure that the patient information is current//updated in the patient's EHR per area processes (e.g., progress notes, navigators, flowsheets).
- The information will be reviewed by the on-coming/receiving HCP and with the patient/EPCs /delegate, as appropriate, to allow the opportunity to verify and add to the information.
- TOA will be provided verbally when able, and/or by reviewing the most recent progress note.

Documentation

All HCP(s) will document in the patient's EHR that TOA has been given and received, including the names of each HCP.

- Documentation of TOA will confirm that the transfer of information has been communicated and the responsibility for the patient care has been transferred
- Both individuals involved in providing and receiving the TOA will complete the documentation
- Minimum Documentation requirements include:
    - The given name of the HCP receiving TOA, and
    - The given name of the HCP providing TOA.

Note: Physicians will find TOA in the "Handoff "tab of the patient's EHR and/or available "Summary Reports".

Allied Health team members who do not provide 24-hour care will refer to the *Transfer of Accountability Allied Health – Guideline*, and their program or practice setting specific process documents.

Patient, essential partners-in-care (EPCs), and/or designate participation in TOA

- Patients and/or EPCs will be involved in the TOA process whenever possible as this aids in active participation in care planning and treatment choices. Refer to the *Person-centered Decision-making - Patient Care Standard*
- Involving the patient/EPC/designate in the TOA process promotes an early introduction to the responsible health care team member and an opportunity for the patient/EPC/designate to understand and participate in the development and or adjustment of their plan of care.
- The patient/EPC/designate should be encouraged to ask questions and clarify information, as well as identify any patient specific goals/priorities, safety concerns or issues.

- Language and interpretation services may be required to ensure that vital information is accurately conveyed and understood by the patient/EPC.

- Information about unit-specific TOA processes including the approximate timing of TOA will be available to the patient and/or EPC in order to provide an opportunity for participation.

TOA criteria for all patient care units

- During TOA, critical pieces of information are communicated without exception. These include:
  - The patient's name,
  - The admitting diagnosis, and
  - The patients code status.
  - Standard requirements for what needs to be included in TOA are listed in Appendix E
- In addition to standard requirements, patient/unit-workflows and HCP scope of practice will influence what needs to be included in TOA specific care requirements, program (Exception: Break coverage).

It falls under the professional responsibility of HCP(s) to recognize instances where supplementary information might be vital. HCP(s) will provide this information as per their professional duties, and it will be communicated during TOA as needed, be it during shift-to-shift handovers or break coverage situations. Refer to Appendix E for some examples of additional information to be shared at the time of TOA.

Auditing/Evaluating TOA: Leadership Review Process

Evaluation mechanisms may include:

- Using an audit tool (e.g., direct observation or review of patient records) to measure compliance with standardized processes and the quality of information shared.
- Asking patients, EPCs and service providers if they received the information they needed.
- Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).
- Evaluate the effectiveness of transition planning on the patient, their EPCs before, during and after a transition.
- Evaluate the effectiveness of transition planning on the continuity of care.
- Evaluate the effectiveness of communication and information exchange between the patient, their EPCs and the healthcare team during care transition.

Definitions

Accountability: Each team member is accountable to the public and responsible for ensuring that their practice and conduct meets legislative requirements and the standards of the profession

Allied health: LH team members, including but not limited to, the following disciplines: Child and Youth Workers, Counselors, Registered Psychotherapists, Psychologists, Occupational Therapists, Physiotherapists, Recreational Therapists, Registered Dietitians, Occupational therapy assistant/Physiotherapy assistant Registered Respiratory Therapist, Social Workers, Speech Language Pathologists, Medical Radiation Technologists, Sonographers.

Bedside shift report: Face-to-face TOA that takes place at the patient's bedside and supports the patient's/ Substitute Decision Maker's (SDM)/EPCs participation including but not limited to: introduction of the oncoming nurse, verbal report and updating the whiteboard.

Care transitions: A significant point in a patient's healthcare, where information and care needs are transferred between HCPs or teams, due to a change in health status, care needs, healthcare providers or location (within, between or across settings).

Designate: A family member or essential partner-in-care (EPC) appointed by the patient (if the patient is mentally capable), or a patient's SDM if the patient is not mentally capable. The role of the Designate is to share and receive communication updates, with the healthcare team and other family members/EPC, as authorized by the patient/SDM, to support the patient's plan of care. The Designate will not act in the capacity of a Substitute Decision Maker (SDM), unless the Designate also happens to be the patient's SDM.

Healthcare Team Member: A person who by education, training, certification, or licensure is qualified to and is engaged in providing health care to a patient.

Interfacility Discharge/transfer: The movement of a patient from one health care facility to another. This includes site to sire within Lakeridge Health.

Intrafacility Discharge/Transfer: The movement of a patient from one unit/department to another with the same Lakeridge Health Hospital site.

On-coming HCP: An individual who is at the start of their shift.

Off-going HCP: An individual who is at the end of their shift.

Person-centred approach (PCC): An approach in which patients are viewed as a whole persons; it is not merely about delivering services where the patient is located. The PCC approach involves advocacy, empowerment and respecting the patient's autonomy, voice, self-determination, and participation in care planning and collaborative decision making.

Regulated Healthcare Provider (RHCP): Member of staff or privileged staff who holds a professional designation and is a member of a prescribed college. For the purpose of this policy, these include:

- Registered Nurse
- Registered Practical Nurse
- Nurse Practitioner
- Registered Respiratory Therapist
- Physician
- Medical Radiation Technologist
- Sonographers

SBAR: The **S**ituation-**B**ackground-**A**ssessment-**R**ecommendation best practice communication methodology used at Lakeridge Health (LH) when communicating patient findings within the interprofessional team and particularly during bedside shift report.

Teach-back: Teach-back is a technique for health care providers to ensure that they have explained medical information clearly so that patients and their EPCs understand what is communicated to them.

Transfer of Accountability (TOA): refers to a reciprocal process of communicating "patient specific information from one clinician to another or from one healthcare team to another, for the purpose of ensuring the continuity and safety of the patient's care" (CNO, 2023). It includes transferring responsibility for some, or all aspects of a patient's care from one healthcare professional to another on a temporary or permanent basis. TOA is an Accreditation Canada Required Organizational Practice (ROP) and ensures effective transfer of patient information between care providers using a standard process and encourages the participation of the patients SDM/EPC.

Unregulated Health Care Provider (UHCP): refers to a healthcare provider who is not regulated under the *Regulated Health Professions Act* but who my provide health or other care to patients/residents/clients, including but not limited to Personal Support Worker (PSW), Clinical Extern, Physician Assistants

Procedures

Admission/Transfer TOA

1. TOA will be provided by the sending unit's HCP(s) to the receiving unit's HCP(s) within **thirty (30) minutes** of the bed being ready as designated in the EHR.
   Note: In some cases (e.g. transfer to another facility), TOA may be provided earlier than 30 minutes of the patient's expected time of arrival, if required.
2. The sending unit will either have a HCP(s), accompany the patient to the receiving unit to provide in-person verbal TOA and/or call the most responsible HCP(s), via telephone/electronic device (e.g., Rover).
   Note: Should the receiving unit be unable to accept TOA within the 30 minutes or in person due to extenuating circumstances on the unit this must be communicated to the sending unit and a time for TOA agreed upon. Instances where TOA must be extended beyond the 30 minutes will be reported to the respective unit leadership for debrief and follow up.
3. In instances where the primary HCP(s) is not able to receive TOA (e.g., deteriorating patient and break coverage), TOA will be received by an alternative HCP(s) on the receiving unit (e.g., unit coordinator, charge nurse, HCP providing break coverage).
4. The receiving unit HCP(s) will find the appropriate TOA information required in the "Summary tab" and/or "Summary Reports", located in the patient's EHR, and will collaborate with the sending HCP(s) as required (e.g., for clarification).
5. Any updates, changes, new orders, etc., that have occurred since the previous TOA communication and before the patient's expected time of arrival, **must** be communicated verbally, to the receiving units HCP(s), (i.e., additional TOA), before the patient's expected time of arrival.
6. Document completion of TOA in the EHR.

Shift-to-Shift and/or patient handover TOA

1. The primary HCP(s) caring for the patient(s) must remain on unit to provide TOA to the on-coming HCP.
2. If the HCP receiving the patient is unavailable at time of transfer (e.g. on break), then the HCP from the sending unit will provide TOA to an alternate HCP from the receiving unit.

The HCP receiving TOA will be required to provide TOA to the patient's receiving HCP once they are available.

Off-Going HCP

When providing TOA to another care provider, the off-going HCP will, as applicable:

1. Perform primary assessments to ensure patient safety (i.e., **A**: airway, **B**: breathing, **C**: circulation, **D**: disability, **E**: exposure).
2. When conducting bedside TOA perform positive patient identification, utilizing the patients' armband. Refer to *Positive Patient Identification – Policy and Procedures*.
3. Receive verbal consent from the patient/EPC to perform TOA at the bedside, if applicable, and engage the patient/EPC, as appropriate, for participation in the TOA process.
4. Perform safety checks of the patient's environment (Appendix B).
5. Clarify any information necessary to provide care for the shift to the receiving HCP.
6. Discuss and review any events that will occur over the shift and indicate pertinent details to the patient, update patient whiteboard, etc.
7. Ensure that clinical documentation is up to date prior to beginning TOA with the receiving HCP. *Refer to the Patient Chart Check – Policy and Procedures.*
8. Answer any relevant questions the ongoing HCP may have about the patient plan of care, next steps etc.
9. Document that TOA was given, in the patient's EHR. An electronic signature will confirm that the transfer of information has been communicated effectively and responsibility for patient care has been transferred.

On-coming HCP

When receiving a patient from another HCP(s)/care provider on a temporary or permanent basis, the on-coming HCP(s) will:

1. Receive TOA and document that TOA was received, in the patient's EHR.
2. When conducting bedside TOA perform positive patient identification, refer to *Positive Patient Identification - Policy and Procedure*.
3. Introduce themselves, including designation, to the patient/EPC, delegate, as appropriate.
4. Perform primary assessments to ensure patient is safe (i.e., **A**: airway, **B**: breathing, **C**: circulation, **D**: disability, **E**: exposure).
5. Perform safety checks (Appendix B).
6. Discuss and review any events that will occur over the shift and indicate pertinent details to the patient/EPC/delegate, update patient whiteboard, and document as applicable.
7. Address any questions or concerns the patient/EPC/designate may have.
8. Ask any relevant questions to the off-coming HCP as needed.

Break Coverage TOA

1. Identify the Health Care Provider (HCP) going on break and the HCP(s) responsible for covering patient care during this period.
2. Access the patient's Electronic Health Record (EHR) system to review patient information.
3. Conduct a face-to-face TOA between the HCP going on break and the covering HCP(s).
4. Ensure both HCPs are at the same workstation to review the patient's EHR together.
5. Both the HCP going on break and the covering HCP(s) document in the patient's EHR that TOA was given and received.
6. Provide and receive all relevant patient information necessary for continuity of care as outlined in Appendix F.

7. Ensure mutual understanding and agreement between both HCPs regarding the patient's status, care plan, and any specific instructions.

Intrafacility Discharge/Transfer TOA

1. The sending HCP(s) will ensure documentation is up to date in the patient's EHR.
2. The HCP(s) providing TOA and the HCP(s) receiving TOA will review the patients' EHR at workstations in their own respective areas when TOA is being provided/received.
3. The sending HCP(s) will provide TOA supported by the use of the patient's EHR: "Summary Tab" and/or available "Summary Reports" and will include the Mandatory TOA criteria and any Additional TOA criteria, as required.
4. The sending units' HCP(s) will communicate with the patient/EPC, the rationale for the transfer, including transfer location, as applicable, and document in the patient's EHR, that TOA was provided to patient/EPC.
5. The sending and receiving HCP(s) will ensure all relevant safety checks have been performed (Appendix B), as appropriate.
6. Both HCP(s) will document in the patient's EHR, that TOA was given and received.
7. An electronic signature will confirm that the transfer of information has been communicated effectively and responsibility for patient care.

Patients in the Intraoperative Phase to Phase I Recovery (PACU) and/or Phase I Recovery to Phase II Recovery:

Pre-operative

1. The sending healthcare team member will ensure pre-operative documentation is completed in the patient's electronic health record, when an Operating Room (OR) procedure is ordered.
2. The pre-operative checklist under the "TOA report tab" will be reviewed during TOA. Care team members will review "TOA report" tab and will document TOA in the patient's health record at every point of care transition between perioperative phases under the "TOA Handoff" tab.

Perioperative

1. Pre-operative phase to Intraoperative (OR) involves an electronic TOA review; if patient requires a higher level of care, verbal TOA is required.

Intraoperative phase (OR) to Post-Anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)

1. In-person accompaniment and verbal TOA is required. OR RN accompanies the patient and anesthesia care provider to the receiving care unit and provide the receiving unit nurse with a care transition. For Mandatory/Additional TOA Criteria specific to this program/area Refer to Appendix E.

Phase I Recovery (PACU) to Phase II Recovery (Day Surgery)

2. Verbal TOA is required. Phase I to Critical Care in-person accompaniment verbal TOA is required. For Mandatory/Additional TOA Criteria specific to this program/area Refer to Appendix E.

Interfacility Discharge/Transfer TOA

1. Communicate with the patient and/or EPC the rationale for the transfer, including transfer location, as applicable, and document this in the patient's HER.
2. Ensure that clinical documentation is up to date prior to beginning TOA with the external organization.

3. Provide verbal-telephone TOA to the HCP(s) of the receiving organization following the same process as within organization. Refer to Appendix E for mandatory/additional TOA criteria.
4. Fax or send (in compliance with privacy standards) with the patient, any required documentation to the receiving organization, at the request of the receiving organization (i.e., external organization does not have access to the patient's EHR, as per facility requirements).
5. Document in the patients' EHR, that TOA was given/received by indicating the name of the individual that completed TOA.

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Appendices

Appendix A
SBAR

S	Situation: Clearly & Briefly identify the situation, include positive patient identifiers; **what is going on**
B	Background: Provide relevant facts & background information (e.g., reason for admission/diagnosis, vital signs, pain level); **what is/has happened**
A	Assessments: Assessment, findings, overall impressions of the situation; **what you think is happening**
R	Recommendations: What is required to do, urgency, actions needed to be taken, clarify actions, **what you want/need to be done**

Appendix B
TOA Safety Checklist

Safety checks, including but not limited to:

- Visual inspection of the patient ((i.e., **A**: airway, **B**: breathing, **C**: circulation, **D**: disability, **E**: exposure).
- Confirm the patient's armband is on, allergies and/or alerts, and appropriate identifiers are in place (e.g., high risk for falls)
- Perform positive patient identification as per the *Positive Patient Identification - Policy and Procedure*, utilizing the patient's armband
- Review allergies
- Assess and treat for pain
- Assess for orthostatic hypotension, as appropriate (e.g., risk of dehydration, post dialysis, etc.). Refer to the *Orthostatic Hypotension (Adult 18 Years of Age and Older) – Patient Care Standard*.
- Ensure equipment is functional and in place (e.g., bed alarms, call bell, Vacuum Assisted Closure (V.A.C.) dressing)
- Ensure the patients' room is free of clutter
- Required screenings have been completed, an/or other preventative strategies have been implemented (e.g., falls risk, Braden scale, Cognitive Assessment Method (CAM))
- As applicable assess the appropriateness of the urinary catheters, and as per protocol
- Advise the patient to utilize call bell as required
- Ensure correct intravenous solution/medications are infusing at the prescribed rate
- Inspect the infusion site for complications (e.g., Peripheral Venous Access Device (PVAD), Central Venous Access Device (CVAD))
- Oxygen and suction equipment are set up and functional (as applicable)
- Lines, tubes, and drains are in place and functional (e.g., draining well, infusing well)
- Inspect and assess site(s)/dressings (e.g., wound, PVAD, CVAD)
- Ensure bed is in lowest position or most appropriate height for the patient (ideally so that the patient's feet can touch the floor)
- Ensure appropriate number of bed rails are in use
- Call bell, bedside table, sensory devices (e.g., eye glasses, hearing aids), mobility devices, and personal belonging (e.g., cell phone) are functional and within reach of the patient
- Follow *Least Restraints Prevention, Administration and Management - Policy and Procedure*
- Review all required shifts documentation, new orders and/or outstanding tasks (e.g., new medication orders). *Refer to the Patient Chart Checks – Policy and Procedures*

Appendix C

Transfer of Accountability (TOA) Checklist

The information provided below does not address the mandatory transfer of accountability requirements specific to programs/areas. For a more comprehensive understanding of these particular details, I recommend referring to Appendix E

Transfer of Accountability (TOA) Checklist

Reminder: Positive Patient Identification ✔

Minimum Requirements for TOA (for all health care team members)	**Completed**
Reason for Admission	
Relevant Diagnosis	
Safety Risks and Preventative Measures (e.g.: Infection Prevention and Control, Falls Risk status, Cognitive Status, Behavioural Risk)	
Code Status	
Adverse/Allergic Reactions	
Significant Assessment Findings	
Outstanding Orders and Tasks	

TOA for admissions/transfers will be provided within 30 minutes of the patient arriving on the receiving unit.

The names of both health care team members providing or receiving TOA are documented in the Clinical Information System (CIS).

If transfer is an emergent transfer, documentation will be updated 30 minutes, post TOA

Additional information may be provided at TOA (as per professional responsibilities of health care team members)	**Completed**
Functional Status	
Care Plan with Identified Goals	
Information and Education for the Patient/Substitute Decision Maker (SDM) and/or Designate	
Discharge Plan and/or Follow up Requirement if applicable	
Update provided to Patient/SDM/and or Designate of any changes in location or plan of care	

Appendix D

IPASS BATON

To guide the discussion regardless of the patient care unit, all RHCP and/or HCP may use the following **IPASS BATON** acronym (i.e., content) when providing TOA:

Introduce	Introduce yourself and your role to the patient/family/SDM
Patient	Identifiers, age, gender, location
Assessment	Present chief complaint, vital signs, symptoms, and diagnosis
Situation	Level of acuity, code status, recent changes, responses to treatments
Safety	Critical lab values/reports, socioeconomic factors, allergies, alerts
Background	Co-morbidities, previous episodes, current medications, family history
Actions	What actions were taken or are required? Provide brief rationale
Timing	Level of urgency, explicit timing and prioritization of actions
Ownership	Who is responsible (nurse, doctor, team)
Next	What is expected to happen next? Anticipated changes? Are there contingency plans? What is the plan?

Appendix E
Mandatory and Additional TOA Criteria

Mandatory Criteria	**Additional Criteria (required as applicable)**
Patient's full name	Cardiac rhythm and interpretations
Reason for admission/transition	Legal status (e.g., capacity, form 1 status)
Relevant diagnosis, and pertinent history	Functional status
Known surgeries, treatments, or procedures (e.g., hemodialysis Mon-Wed-Fri)	Height and weight if not available in EHR (e.g., pre- and post-dialysis weight)
Most responsible Practitioner (MRP)	Care plan and identified goals
Code status	Information/education provided to the patient/partner-in-care/designate
Allergies and reactions/sensitivities (e.g., anaphylaxis)	Discharge plan, consultations and/or follow-up, as required
Isolation status/precautions and rationale	Partner-in-care/delegate, concerns and any update(s) provided to patient/partner-in-care (e.g., changes in location or plan of care)
Relevant investigations and results (e.g., glucometer results, laboratory results)	Patient belongings and safety devices (e.g., glasses, dentures, walker, cane)
System assessment • Vitals including deteriorating index status, • Pain, • Neurological, • Respiratory, • Cardiovascular, • Gastrointestinal, • Genitourinary, • Musculoskeletal, • Skin/wounds, • Mobility stage, • Mental health/psychosocial	Best possible medication history/medications
Outstanding orders, medications, and tasks (e.g., diagnostic tests, last dose of blood thinners)	Consultations (e.g., CCAC, specialist, social work)
Significant physical assessment findings (e.g., wounds, packing, intravenous, blood products, urinary catheter, chest tube, acute delirium)	
High-risk flags and prevention strategies (e.g., Braden, falls, workplace advisory)	
Relevant significant events (e.g., intraoperative complications, blood loss, hypotension, febrile)	
Safety Checks: Appendix B	

Mandatory and Additional TOA Criteria – Program/Area Specific

Program/Area	Relevant Information
Intraoperative phase (OR) to Post-Anesthesia Care Unit (PACU) or Intensive Care Unit (ICU)	• Patient age/gender • Pre-operative diagnosis • Surgical procedure performed • Allergies • Pertinent medical history/co-morbidities • Isolation required • Sensory impairment • Family location and valuable depositions (patient's belongings) • Religious/spiritual/culture needs • Interpreter required • Musculoskeletal restrictions • Skin integrity • Intraoperative complications • Loose/capped teeth (dentures) • Intake and output (blood loss) • Foley/NG tube/drains • Packing • Medication given intraoperatively (excluding anesthesia care providers' medications) • Specific care required immediately or soon • Outstanding labs or X-ray • Available blood products for the patient- # units
Phase I to in patient unit	• Type of surgery and time spent in the OR, • Type of intraprocedural sedation, • Type of pain control: PCA, Epidural, Nerve block, • Level of consciousness, • Sensory (dermatomes), • RASS, • POSS • Bromage score
Labour and Delivery to Post-Partum	• Gestation • Gravida/para • Group B streptococcus (GBS) status and related medications • Pregnancy related/maternal health issues • Baby delivery: date, time, method (e.g., forceps, vacuum) • Sex and birth weight • Head circumference protocol • Last time baby fed and preferred feeding method • Hypoglycemia risk • Mom and baby output status (e.g., bowel movement and voiding) • Fundus firm and location • Better Outcomes, and Registry Network (BORN) submitted

Labour and Delivery/Post-Partum to NICU	• Gestational and corrected gestational age • GBS status and related medications, • pregnancy related/maternal health issues • Baby delivery: date, time, method (e.g., forceps, vacuum) • Sex • Birthweight and current weight • Feeding method and last feed • Reason for admission to NICU • Social considerations (e.g., family involvement)
Interventional Radiology	• NPO status including time enteral feeds held • Intravenous access • Required bloodwork results • Anticoagulants held as per *Anticoagulation Guidelines-Diagnostic Imaging* • Patient able to consent or SDM contact available • Isolation requirements • Patient cooperative for procedure • Mobility status • Code status

Appendix F

Break Coverage TOA

Program	Relevant Information (required but not limited to)
General (Relevant to inpatient and outpatient care areas)	• Patient's full name • Reason for admission/transition • Relevant diagnosis, investigations, and results as appropriate • Most Responsible Practitioner (MRP) • Safety checks (Appendix B) and preventative measures (e.g., falls risk, behavioural risk) • Code status • Isolation status • Significant adverse/allergic reactions • Significant physical assessment findings (e.g., vitals, wounds, intravenous, blood products, urinary catheter, acute delirium) • Outstanding orders and tasks
Surgical inpatient unit	• Type of surgery and time in the OR, • Type of intraprocedural sedation, • Type of pain control: PCA, epidural, Nerve block • Level of consciousness • Sensory (dermatomes) • RASS • POSS • Bromage score
Labour and Delivery	• Gestation • Gravida/Para • Pregnancy/maternal health related issues • GBS status and related medication dose • Medications • Membrane status • Fetal health surveillance • Recent cervical exam • Oxytocin and rate • Epidural • Planned feeding method
Post-Partum	• Gestation • Gravida/Para • GBS status and related medications, • Baby delivery: time, date, method (e.g., forceps, vacuum) • Sex • Birthweight • Last time baby fed and preferred feeding method • Hypoglycemia risk • Head circumference protocol • Last void and bowel movement for baby • Voids for mother

NICU	• Gestation and corrected gestational age, • Baby delivery: date, time, method (e.g., forceps, vacuum) • Sex • Birthweight and current weight • Feeding method and last feed • Reason for admission to NICU • Outstanding orders, medications, and tasks • Social considerations (e.g., family involvement) • Significant physical assessment findings
Inpatient Mental Health (Exclusion: Outpatient Mental Health Units)	• Status of the Mental Health • Act Form (e.g., form 1, form 3, voluntary), and expiration • Elopement risk • Violence and safety • Substance use and or any withdrawal protocols in use • Suicide Risk • Usual symptoms of physicalhealth, mood, behaviour, thought process, motor activity • Restraint use, type (chemical, physical, seclusion), and status (time in restraint and when last removed)