CONNECTICUT VALLEY HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION I:	**PATIENT FOCUSED FUNCTIONS**
CHAPTER 2:	**PROVISION OF CARE, TREATMENT & SERVICES**
PROCEDURE 2.53:	**INTERNAL PATIENT TRANSFERS**
REVISED:	*NEW* 10/29/18
APPROVED:	11/8/18

Purpose: To provide clinical staff with health information upon transfer of the patient from one Unit/Division to another Unit/Division within Connecticut Valley Hospital.

Scope: All Clinical Staff; Health Information Management

Policy: When patients are transferred to another Unit/Division, clinical information is provided to the (receiving) Treatment Team to insure continuity of patient care.

Procedure:

MEDICAL RECORD:

1. The patient's active medical record is delivered by clinical staff accompanying the patient to the new unit.
2. Overflow archived portions of the medical record and any previous records are delivered to the HIM office in the building the patient is transferred to if applicable.

REQUIRED DOCUMENTS AND TIMEFRAMES FOR COMPLETION:

1. Nursing Transfer Reassessment CVH-254:
   Completed by the RN transferring the patient/receiving the patient
2. Transfer Progress Notes:
   Transfer note must be written before the patient is transferred to the new Unit/Division and no earlier than 1 business day prior to transfer.
3. Acceptance Progress Note: Upon receipt of the patient
4. Immediate Plan of Care: Upon receipt of the patient

CONTENT OF PROGRESS NOTE DOCUMENTATION:

Psychiatrist Transfer Note

1. Identification and Demographics:
   a. Patient's name
   a. Age
   b. Gender
   c. Race
   d. Language preference
   e. Date of admission to CVH
   f. Date admitted to the transferring unit
2. Current active Behavioral diagnoses under treatment

3. Current Psychiatric Medications, include
    a. target symptoms
    b. effectiveness
4. Reason(s) for transfer of the patient to a new unit/program
5. Summary of relevant treatment interventions received while on the transferring unit relevant to transfer.
6. Current active risk issues include
    a. Violence
    b. Suicide risk
    c. AWOL risk
    d. Level of cooperation anticipated
    e. Patient's view of the transfer
    f. Level of functioning
    g. Special needs
    h. Level of staff intervention
    i. Recommended initial observation level
7. Condition of the patient on transfer
8. Evidence of education and support provided to the patient

Ambulatory Care Services Clinician Transfer Note

1. Current active Medical diagnoses under treatment
2. Current Medications
3. Course of treatment
4. Medical condition on transfer

Nursing Transfer Note

1. Nursing sends the patients' Kardex
2. Current level of observation
3. Current active psychiatric nursing care issues
4. Current active medical nursing care issues
5. Scheduled appointments (laboratory tests, x-rays, consultations, etc.) within the next 24 hours of transfer
6. Condition of patient on transfer

Social Work Transfer Note

1. Current active social work issues
2. Scheduled appointments, visits and/or court appearances
3. Current active discharge planning issues

DOCUMENTATION REQUIREMENTS OF RECEIVING UNIT

1. Each Prescriber (Psychiatrist and Ambulatory Care Services clinician or the On-Call

Physician) reviews and signs the Pyxis Patient Profile sent by the transferring Unit/Division prior to writing medication orders. This meets the criteria for Medication Reconciliation.

2. Brief Acceptance Progress Note and Immediate Plan of Care by the receiving:
   a. Psychiatrist
   b. Ambulatory Care Services Clinician
   c. Nurse
3. Treatment Plan Review to be completed within 7 days of the transfer.