

SECTION B: THE NURSING PROCESS
CHAPTER 8: TRANSFER, ESCORT AND DISCHARGE

POLICY AND PROCEDURE 8.1: PATIENT TRANSFER

Standard of Practice:

Nursing staff will prepare the patient for the transfer.
The Registered Nurse will assess the patient prior to and following transfer.

Standards of Care:

The patient can expect to receive an assessment prior to and following transfer to ensure continuity of care.

Policy:

The patient will be assessed and care needs identified before transfer.
The patient will be reassessed and continuing care provided following transfer.
The patient will be oriented to the new unit of care.

Procedure:

I. Transfer Process and Documentation - Transferring Unit

- *Ensure documentation (Progress Notes, Medication Administration Record [MAR] and the Nursing Plan of Care) are updated and signed per relevant policies, prior to transferring the patient.
- Discuss transfer with patient and address concerns.
- *Assess patient and document findings in *Section I: Transferring RN Assessment Section* of the *Nursing Transfer Reassessment* form (WFH-254).
- *Denote psychiatric status, current mental status, risk concerns, behavioral functioning, level of observation, and high alert medication considerations and/or medications which require increased monitoring.
- Denote medical status by updating all current medical problems. Take vital signs and record in the transfer progress note. If there are any abnormalities in the vital signs, notify the medical provider prior to transfer. Denote any pending lab work, and review laboratory values as appropriate to ensure continuity of care.
 - See also WFH operational policy Section 1 Policy 5 and Procedure 5.14 Transfer Between Divisions
- *Assure *Patient Scheduled Medical Appointment* form (WFH-545) is updated.
- *Denote General overview including diet/hydration concerns, sleep patterns, elimination, personal hygiene and level of functioning.

- Update clothing/personal property record, obtain patient signature of receipt, and notify supervisor of any discrepancies.
- *Provide a Verbal Hand Off and coordinate transfer time with Receiving Registered Nurse.
- *Document clinical summary of Verbal Hand Off in Integrated Progress Notes.
- Coordinate transfer time with Whiting Agency Policy if to/from the Whiting Services.
- Send clothing and personal property, Medical Record, MAR, Treatment Record, Patient Specific
- Medications and Addressograph with the patient.
- Document transfer time and location in the Integrated Progress Notes.
- Accompany patient to receiving unit and introduce patient to staff.
- Review patient's record and belongings with receiving staff.
- Record transfer in Unit Census Book and on Daily Report.
- Notify Dietary Department of the transfer.

II. Transfer Process and Documentation - Receiving Unit

- Document patient arrival and response to transfer in the Integrated Progress Notes of the patient's medical record.
- Record transfer in Unit Census Book and on Daily Report.
- For transfers within/from Whiting Services, return ID cards to Whiting Agency Police.
- *Notify medical provider, give them the patient profile, and obtain new orders.
- *Review the *Nursing Transfer Reassessment* and complete *Section II*, the *Receiving RN Section* of the *Nursing Transfer Reassessment* by the end of shift. Indicate concurrence with the Transferring RN's findings and comment on changes on the form and in the Integrated Progress Notes by the end of the shift.
- *Ensure pending lab work, consultations, tests and medical appointments are arranged.
- *Update Nursing Plan of Care, MAR and Treatment Record.
- Integrated Progress Note documentation requirements are treated as a new admission:

daily for seven days, weekly for eight weeks, and monthly thereafter.

- *Provide patient clinical summary at Inter-Shift report.

*** RN Responsibility**