Transfer of Clinical Information for Long-term Care

10.3.30PR

PROCEDURE

Procedures are a series of required steps to complete a task, activity or action

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Purpose:	To ensure timely, accurate and required information is communicated to, and received by, the new service provider at transfer and transition points.
Scope:	• Clinical Direct Staff including Allied Health, pharmacy, nursing, HCA • Physician/Nurse Practitioner • Clinical Support Staff: Nursing Unit Assistant • Long-term Care Island-Wide
Outcomes:	The Service Providers use a standardized process for timely transfer of information at both formal transfer and transition points that result in proper information transfer.

1.0 Equipment

- Discharge (Transfer) Checklist for Long-term Care
- ResidentLong-term Care 24 hour Unit Shift Report

2.0 Procedure

Procedure/Steps	Key Points
Before discharge to another facility or home with Services providers: RN/RPN/LPN completes the "Discharge (Transfer) Checklist for Long-term care" and ensures all appropriate documentation is ready to be sent to the new location (Service Provider).	Completion of the "Discharge (Transfer) Checklist for Long-term Care" is a standardized process to ensure that appropriate/accurate information is provided to the new service provider. There is also a specific checklist for respite resident.
Nursing Unit assistant (NUA) ensures that copies of all pertinent documentation/information are ready to be forwarded to the new location at the time of transfer.	
Before transfer to Emergency Department (ED): RN/RPN/LPN completes the "VIHA Resident ED Transfer Form".	Completion of the "Resident ED Transfer Form" is a standardized process to ensure that appropriate/accurate information is provided to Emergency Department at the time of transfer.
NUA ensures that copies of all pertinent documentation/information is ready to be forwarded to the Emergency Department (ED) at the time of transfer including Medical Orders for Scope of Treatment (MOST).	
If transfer to Emergency Department (ED) by ambulance: Provide the Ambulance Services with the following form: ○ Medical Orders for Scope of Treatment (MOST)	By default, Ambulance Services will perform CPR unless it is clearly stipulated that the resident/family does not wish CPR. If the resident/family wants to remain No-CPR, a physician's order is required. Any MOST designation other than C2 is sufficient for this purpose.

Procedure/Steps	Key Points
Documentation of the discussion/decision of CPR status is included in the Progress Notes under the Focus Word: "Legal".	If a resident wishes CPR, there is no need for a physician's order.
Transfer of information at Transition points: Each Service Provider is accountable to ensure that appropriate/accurate and timely information is shared to another Service Provider. The "Long-term Care 24 hour Unit Shift Report" is used to formally communicate resident's Service Plan (Care Plan) updated information.	The "ResidenLong-term Care 24 hour Unit Shift Report" is a standardized process to ensure that appropriate/ accurate and timely resident's information is shared between Service Providers (team) at shift change.
Resident/family are informed about the process related to transfer of clinical information specifically when transfer to another facility/home or transfer to the Emergency Department (ED).	

3.0 Definitions

Transfer of Clinical Information: The critical components of care are communicated to, and received by, the new provider at transfer and transition points.

Service Provider: Individuals or teams who work with residents to provide services; may also be referred to as provider, team, healthcare provider.

Service Plan: The documented plan that summarizes the goals, plan of intervention and evaluation process for each resident's service; may also be referred to as care plan, integrated service plan.

Transition points: Any point where the resident's integrated Service Plan or Care Plan is shared by different service providers. For example but not limited to:

- Between shifts of care providers
- Between disciplines within a team
- Between teams delivering the same intensity of care/service in a different setting

Discharge: A patient/client care transition may be classified as a discharge when the team prepares patient/client and their families for the transition to end of service or end of encounter.

4.0 Related Island Health Standards

9.6.1P Information Transfer at Care Transitions
16.1.3P Clinical Documentation Policy
9.3.2PR Transfer of a Patient/Client Procedure
9.3.3PR Discharge of a Patient/Client Procedure

5.0 References

Accreditation Canada (2015) Long-Term Care Services, Required Organizational Practice (ROP): 9.19