TRANSFER OF PATIENTS (EXTERNAL)

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Origin: NRSG
Authority: SM

SCOPE

All Patient Care Areas

PURPOSE

To provide guidelines for the transfer of patients into and out of the hospital and methods of transport.

TRANSFER IN/OUT

Patients will be accepted as transfers from other health care facilities and will be discharged and transferred to other facilities in accordance with State regulatory standards, payor consideration, and patient and/or family preference.

I. TRANSFER TO WAH

A. Acceptance Policy/Criteria For Transfer Of Acute Care Patients To Washington Adventist Hospital

1. Washington Adventist Hospital may accept inpatients referred by another institution for any specific procedure or treatment which is not available at the referring institution.

2. A physician's order is necessary to transfer a patient to Washington Adventist Hospital from another hospital. The physician must contact Bed Control and a reservation will be made for the patient. If more information is needed, Bed Control at Washington Adventist Hospital will contact Bed Control at the referring hospital. It is the responsibility of the referring hospital to reconfirm the availability of a bed on the day of transfer and to arrange transportation for the patient.

3. If a patient arrives without an acceptance from Bed Control and the Hospital is unable to accommodate the patient, the Administrator on Call is to be notified **PRIOR** to the return of the patient to the forwarding institution.

4. Guidelines for Admission/Transfer

   a. The Patient Access Department, in consultation with the admitting physician, shall evaluate the patient's need for specialized acute-care services and why the transfer/admission to Washington Adventist Hospital is necessary.

   b. If specialized services (such as radiation therapy) are required, it shall be determined whether or not the services can be provided on an outpatient basis, based upon the criteria established by the various third-party payors and the Maryland PRO as implemented by Washington Adventist Hospital through its pre-admission screening program.

   c. If the services must be provided on an inpatient basis, date of treatment must be determined so the patient can be admitted on the day treatment will begin.

d. If the patient is an inpatient at another facility and there is to be a time lapse before specialized treatment begins, WAH requests that the patient shall remain at that facility and be transferred only on the day treatment begins.

B. Transfer Protocol

Once the physician has notified the (Bed Control) of the request for admission, the following steps must be taken prior to the patient leaving the transferring hospital. [EMTALA]

1. Transferring Hospital

a. Once WAH Bed Control has made contact with the transferring facility, the following patient information is required:

1) Name
2) Date of Birth
3) Accepting physician
4) Insurance information
5) Diagnosis
6) Special care (Isolation, monitored bed, ICU)
7) Present bed assignment at transferring facility
8) Expected mode of transportation
9) Name of person calling, telephone number and department

b. Once transfer has been accepted, will call the Washington Adventist Hospital receiving unit/charge nurse or designee to give a patient report. [EMTALA]

c. Will transport the patient to Washington Adventist Hospital at the time agreed to by both hospitals. The transferring facility will call Washington Adventist Hospital's receiving unit if it has been longer than the agreed time, since report has been given <u>or</u> if the patient's status has changed.

d. Will send the following information/items with the patient:

1) Copy of medical record, and H&P
2) Current diagnostic studies (cinifilm, chest and other pertinent x-rays, CBC, BMP, ECG, UA, PT/PTT)
3) Medication Administration Record
4) Copy of Advance Directive

2. Washington Adventist Hospital will:

a. Return a call to the transferring hospital within 30 minutes to relate status of the transfer (except for emergents): **Note:** If bed availability is questionable, the Administrative Supervisor should be contacted before discussing with the transferring hospital. If the Administrative Supervisor will consult with the Administrator-on-Call if a bed is unavailable.

1) <u>Acceptance</u>

- For inpatient admission; or,
- For procedure only (which means patient will be the transferring hospital's responsibility for holding a bed at its facility and round-trip transportation for those returning patients).

2) Holding

- No bed available and will discuss the future possibility of bed availability.
- Need additional information to complete admission request; i.e., physician's order, insurance authorization, scheduling difficulties, etc. **Note:** If bed availability is questionable, the Administrator-On-Call should be contacted before discussing with the transferring hospital.

3) Denial

- No bed available or possibility of availability. **Note:** If bed availability is questionable, the Administrator-On-Call should be contacted before discussing with the transferring hospital.
- Inappropriate transfer
- Unscheduled procedure (except for emergent)
- Insurance denial (except for emergent)

d. Will continue to follow up with holding status request until resolved.

II. TRANSFER TO OTHER FACILITIES

A. Whenever a patient is to be transferred to another health care facility, it shall remain the responsibility of Washington Adventist Hospital to ensure continuity of care until the transfer has been accomplished by arrival at facility or a transport team from a specialty referral center accepts responsibility for care of the patient.

B. The transfer of a patient to another acute care hospital will be initiated by the physician, who will:
1. Determine and indicate the reason for the transfer.
2. Determine the mode of transport and the need for medical personnel to accompany the patient.
3. Establish contact with the accepting physician.
4. Inform the patient, or someone acting on his behalf, of the risks/ benefits of the proposed transfer, and any reasonable alternatives.
5. Obtain consent for transfer/transport, as appropriate. [For patients presenting emergently to the Emergency or Labor & Delivery Departments and immediately requiring transfer to another hospital following stabilization, appropriate consent must be documented. See ED/MCH Patient Transfer/Transport to Another Facility form.]

C. The transfer of a patient to a non-acute care facility will be initiated by Case Management as part of the discharge planning process.

D. The physician will dictate or write a transfer summary prior to patient transfer (not needed if the patient is going for testing or treatment and returning to WAH). Note: Completion of the ED/MCH Patient Transfer/Transport to Another Facility form is sufficient for patients who have presented emergently as described in II.B.5.

E. The nurse, case management, and/or Utilization Management Coordinator in collaboration, based on the patient's needs will contact the receiving facility's Admitting Office to confirm acceptance of the patient prior to making transportation arrangements. After confirmation, case management or the nurse will communicate this information to the patient or family based on the needs of the patient.

F. The appropriate transfer documents will be processed under the direction of the nurse. The transfer documents will include the following information, as appropriate to the care, treatment, and services

provided: reason for transfer, the patient's physical and psychosocial status, any community referrals, and a summary of the care, treatment, and services provided and progress toward goals.

1. ED/MCH Patient Transfer/Transport form, as appropriate (see II.B.5).
2. Discharge Instructions (except ED/MCH emergent transfers)
3. Copy of the medical record:
   a. Inpatients: Previous 24 hours nurses notes or equivalent summary, current MAR, previous 72 hours progress notes, previous 72 hours therapy notes (e.g. PT, OT, Speech), do not resuscitate order sheet (if present), admission H&P, physician transfer/discharge summary, recent diagnostics (e.g. labs, chest x-ray, ECHO, EKG, MRI, CT), dialysis treatment records (last 3 treatments), recent OR notes, initial consultation notes if recent, advance directive (if present), and any other document requested.
   b. ED/MCH emergent transfers: available and pertinent medical records
   c. An electronic discharge transmission is completed by the case management department.

G. Copies of the transfer documents will be secured in an envelope and sent with the patient. The original medical record is never to leave the Hospital. For transfers to an equal or higher level of care, the nurse will telephone report to the receiving unit prior to the patient leaving WAH.

H. At the time of transfer, the nurse responsible will review the patient's current status and the most recent nursing assessment documented, and update as appropriate.

I. All patients who are transferred for a higher level of care, shall be accompanied by the appropriate health care provider, who will be responsible for the administration of continued patient care enroute to the receiving facility. The physician shall determine the mode of transport, personnel to accompany patient, and necessary equipment. All emergency transfers using EMS transportation must be in cooperation with EMS procedures.

J. All patients who are transferred (discharged) from Washington Adventist Hospital to Adventist Rehabilitation (Unit 5200) will be transported via stretcher. Transporters are required to wait at the unit coordinator's desk at AHRM when delivering a patient until nursing staff arrives to assist transporter to take the patient to their assigned room.

III. TRANSPORT

Selection of the appropriate method of transportation shall be based upon the medical condition of the patient, in conjunction with consideration of the cost to the institution or patient. The most appropriate method is to be selected from:

- Private car
- Taxicab
- Wheelchair van
- Ambulance (BLS, ALS)
- EMS
- Helicopter

Arrangements for transfer of inpatients to another facility will be made by the Case Management. When the case management department is closed, a case manager can be reached by pager via the hospital operator for transfer support and information. When case management is unavailable, nursing will make transportation arrangements - the Administrative Supervisor may be contacted to assist in selecting and approving the mode of transfer. All helicopter transports into the facility are to be coordinated by the nursing supervisor. If the patient is to be transported via helicopter from the ED, the charge nurse/ED physician will coordinate the transfer arrarngements.

The cost of transportation will be the financial responsibility of the patient when such transfers are for personal or physician preference. Case management can be consulted to assist with this process.

A. Public/Private Transportation

1. Patients may be transported by car or taxi to a non-acute care facility when such transportation is appropriate to the medical condition of the patient and when accompanied by a responsible adult.

B. Commercial Ambulance

1. AHC has contracted with a private ambulance company for BLS and ALS transportation. Contact information can be obtained from case management or the Administrative Supervisor.

   a. The appropriate type of ambulance will be selected based on patient needs based on CMS guidelines:

      1) BLS (basic life support) ambulance transportation is appropriate for patients:

         a) Not on a cardiac monitor
         b) If the patient is on their own ventilator, and it is patient controlled, or someone who is familiar with the ventilator is in the ambulance with the patient (i.e. family member, aid, nurse).
         c) Receiving Crystalloid IV solutions (Lactated Ringer's, 2.5%-10.0% dextrose in water, 0.25%-0.9% saline solution), potassium chloride added to any of the allowed crystalloid solutions not to exceed 20 milliequivalents per liter, or TPN administered without an infusion pump and via a peripheral limb vein.
         d) Receiving patient-controlled medications or IV solutions.

      2) ALS (advanced life support) ambulance transportation is appropriate for patients:

         a) Needing cardiac monitoring
         b) Requiring ALS interventions
         c) Receiving IV solutions by central line, or IV pump, containing medications or other additives not permitted for BLS transport.

2. A Physician's Certification Statement form must be completed and provided to the crew upon their arrival.

3. A Registered Nurse must accompany the patient if:
   a. The patient is receiving continuous infusions other than those permitted by BLS transport and Integrilin, Lidocaine, Dopamine, Heparin or Morphine.
   b. Patient requires skilled nursing assessment and intervention such as deep suctioning.
   c. The patient is being transported for testing and requires nursing care at the testing site.

4. When a Registered Nurse must accompany the patient, the ambulance service can often provide a nurse for the transport, typically Monday through Friday, 0630 to 1830, by prior arrangement. Washington Adventist Hospital must provide the nurse if the patient is being transported for testing, and return to the hospital is likely. Note: for critically ill patients, in the absence of a physician during transport, the Registered Nurse must have documented expertise and competency in the skills appropriate to the patient population, in the specialized technical life-saving procedures, and training specific to interagency transport. A critically ill patient is characterized by the presence of, or being at high risk for developing, life threatening problems.

5. All equipment needs for the patient during transport will be determined and communicated to the ambulance company. The ambulance service is normally equipped with a portable cardiac monitor/defibrillator (the company should be notified if external pacing is desirable), oxygen, and emergency equipment and supplies. The company will provide a portable ventilator when requested, however, the patient may be transported with a hospital provided ventilator if the accompanying practitioner so desires.

6. Written physician orders for emergency treatment must accompany the patient. The form provided by the contracted provider may be used, or written physician's orders addressing emergency treatment, photocopied from the patient's chart, are acceptable if the physician or nurse do not wish to use the form.

C. Helicopter Transport

1. When a non-combative, critically ill or injured patient requires immediate medical, obstetrical, pediatric, or surgical services that can best be provided by a specialty referral center, such services are to be provided as promptly as possible. The patient's attending or hospital based physician will decide if the patient warrants helicopter transportation to accomplish a prompt transfer. The following guidelines are specific to:

   a. Transferring critically ill or injured patients expeditiously from Washington Adventist Hospital to a specialty referral center by helicopter when deemed necessary by the attending or Hospital based physician.

   b. Coordinating incoming helicopter transported patients.

2. Nursing Responsibilities Outgoing Transports

   a. When the physician orders a helicopter transfer to a specialty referral center:

      1) The sending unit will:

         a) notify the unit Nurse Director/Manager or Administrative Supervisor.

         b) call the report directly to the receiving unit.

         c) document information on the patient's medical record, including the name of the hospital agent (Admission Office/Administration) at the specialty referral center who has accepted the patient (that hospital agent does **NOT** include the accepting physician).

      2) The Nurse Manager/Director or Administrative Supervisor will assist with transportation arrangements.

      3) The Nursing Supervisor will contact the specialty referral center for flight information if the referral center is dispatching the flight, or Medstar (1-800-824-6814) to dispatch a helicopter. Information provided to Medstar will include patient name, age, weight, diagnosis, in-flight interventions necessary, destination, and landing zone. The Washington Adventist Hospital landing zone is the roof helipad. The Nursing Supervisor will also obtain the estimated time of arrival of the helicopter.

4) The helicopter transport team will respond directly to the unit to prepare the patient for transport and receive report.

a. All incoming and outgoing helicopter transports are coordinated by the Nursing Supervisor.

3. Nursing Responsibilities Incoming Transports

a. All incoming transports are coordinated by the Nursing Supervisor.

b. When a physician requests a patient be transported to Washington Adventist Hospital, the sending physician/hospital is referred to the Nursing Supervisor (301-891-7600) to coordinate the flight arrangements.

c. The Nursing Supervisor confirms transfer with Washington Adventist Hospital Admitting.

d. The Nursing Supervisor requests the following information in brief from the sending facility: patient name, age, weight, diagnosis, location, and in-flight interventions anticipated.

e. The Nursing Supervisor calls Medstar (1-800-824-6814) for flight request.

f. The Nursing Supervisor directs the sending facility to call report directly to the receiving unit.

g. The Nursing Supervisor will inform the, Emergency Department Charge Nurse of an estimated time of arrival (ETA) and designated unit/bed assignment from the helicopter service. The Flight Alert Response is activated when the incoming flight is within 15 minutes of arrival time to the facility (refer to Safety Policy "Helicopter Safety" #3870). A nurse from the Emergency Department, a Respiratory Technician, and a member of the security team will meet the helicopter on the pad.

h. The helicopter team delivers the patient to the receiving unit and gives report directly to the receiving nurse.

TRANSFER OF PATIENT CARE FROM ONE PHYSICIAN TO ANOTHER

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SCOPE

All Patient Care Areas

PURPOSE

To establish the protocol to be followed when a physician transfers the care of a patient to another physician.

POLICY

When a physician transfers the care of a patient to another physician, the following protocol shall be followed:

A. Physician Request

1. The physician transferring the care will write an order on the chart stating specifically which physician will be assuming care of the patient. The physician assuming care will be notified prior to the written order (by the physician) transferring the care.

2. The Admitting Office is notified by computer of the physician change.

3. A face sheet, patient ID label, and ID band with new attending physician's name will be sent by the Admitting Office to be placed on the patient's chart.

4. The unit secretary or nurse will then change the physician's name on the chart, MAR, and replace patient's ID band.

B. Patient/Family Request

1. If a patient, or the relative of an incompetent patient who is not responsive, requests a change of physician, the responsibility to arrange the change rests with the patient and/or family.

2. The Patient Relations Department is available to assist with this request.