Transfer of Accountability-Interdepartmental Patient Transfers

Background:
Transfer of Accountability using the Situation Background, Assessment, Recommendation (SBAR) methodology is a formal process that occurs when transferring patients from one department to another.

The purpose of transfer of accountability during interdepartmental patient transfers is to ensure vital information concerning the patient's background information, current care plan, and future treatment goals are communicated from one department to another. Transfer of accountability and communication among care providers enhances teamwork, promotes patient safety and decreases the risk of error.

POLICY:
Pembroke Regional Hospital (PRH) utilizes a modified version of the SBAR methodology during interdepartmental patient transfers.

Utilization of the Interdepartmental Patient Transfer Communication Tool (formatted as SBAR) occurs with all unit to unit patient transfers and consists of comprehensive, accurate verbal exchanges of patient care information among nursing team members with an opportunity for clarification and verification of information.

PROCEDURE:
1. Once it has been determined that a patient has been assigned a bed in a department other than the patient's current location and the patient is ready for transfer the most responsible nurse:
   - Calls the receiving unit to ensure the receiving nurse is available to accept the patient.
   - Asks the receiving nurse if he/she is available to transfer the patient – if the receiving nurse is unavailable, the most responsible nurse from the originating unit will be required to transfer the patient.

2. At the time of patient transfer, the **Transferring nurse** and the **Receiving nurse** utilize the Interdepartmental Patient Transfer Communication Tool to assist in the provision of verbal face to face patient report.

   In exceptional circumstances when the **Transferring nurse and the Receiving nurse are not** able to do a verbal face to face patient report:
   - **Another nurse** transfers the patient.
   - The **Transferring nurse** on the unit calls to the Receiving nurse and gives telephone report using SBAR tool and signs SBAR tool.
   - The **Receiving nurse** signs the SBAR tool when the patient arrives (See links to view "*Interdepartmental Patient Transfer Communication Tool*" form).

Utilizing the Interdepartmental Patient Transfer Communication Tool
- Two patient identifiers are used to ensure the identity of the patient being transferred is accurate and confirmed (See links to view "Patient Identification" policy).

- The transferring nurse and the receiving nurse follow the sequence of the Interdepartmental Patient Transfer Communication Tool during the provision of verbal report.
- The date and time of information exchange is recorded on the top of the Interdepartmental Patient Transfer Communication Tool.
- Commencing with **S- Situation** the transferring and receiving nurse discuss the patient situation and complete the **Situation** section of the Interdepartmental Patient Transfer Communication Tool.
- The **B- Background** information section is discussed outlining allergies, medications, patient belongings and abnormal diagnostics. Exchanged information is documented in the Background section of the tool.
- Sequentially, the **A-Assessment** section focuses on the current assessment of the patient prior to transfer. The assessment information is discussed and accurately documented according to the legend depicted on the tool.
- Lastly the **R-Recommendation** section is discussed and any patient treatment recommendations pertaining to the patient care plan are communicated and documented in the R-Recommendation section.
- Upon completion of the Interdepartmental Patient Transfer Communication Tool the receiving nurse has an opportunity to ask any questions necessary to assume and meet the needs of the patient's care.

DOCUMENTATION:

Documentation on the Interdepartmental Patient Transfer Communication Tool is essential to ensure the information has been provided and exchanged. The methods of documentation include:

- Complete the blanks where applicable.
- Boxes- Checkmarks are used to indicate discussion has occurred and blank boxes denote the topic has not been discussed.
- In the Assessment section of the tool checkmarks denote normal findings, star or asterisk denote abnormal assessment findings and no mark indicates does not apply or not discussed.

At the bottom of the Interdepartmental Patient Transfer Communication Tool the transferring nurse and the receiving nurse sign the document along with the respective units. Interdepartmental Patient Transfer Communication Tool is retained on the patient chart as part of the patient record.

REFERENCES:

Leonard G. Kaiser Permanente of Colorado. SBAR Technique for Communication: A Situational Briefing Model. http://www.ihi.org/ihi Retrieved February 2009.

Mascioli S, Laskowski-Jones L, Urban S, Moran, S. Improving Handoff Communication. Nursing 2009. February (52-54).

Hamilton Health Sciences, Clinical Manual. HHS Transfer of Accountability (TOA) at Change of Shift Protocol. 2006-06-22.