UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Patient Transfer Process

One-Way Acute to Acute Transfers

EFFECTIVE FEBRUARY 4, 2019

Why transfer process is changing?

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- Barriers to notifications and coordination of patient transfers between facilities
  - *Example: missed handoff, delays in securing bed at receiving facility*
- Potential patient safety issues due to duplication or missed medication orders and delays in care
  - *Example: Patient received dose of vancomycin at HMH ED and received another dose once they arrived to UCMC in error, which caused renal failure.*

Effective **February 4, 2019**, a revised process will be implemented for all patient transfers

Updated Transfer Process

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Decision to Transfer

- Provider consults Specialist to determine appropriateness of transfer
- Provider utilizes Discharge Transfer order to streamline placement and coordination of transfer to UCMC

Coordination of Transfer

- Discharge Transfer Order triggers notification to Lab, Pharmacy and Patient Access
- Electronic Acute Care Transfer Form is initiated by provider
- Nursing prints, completes and obtains patient signature on new Acute Care Transfer Form

Physical Patient Transfer

- DocHalo messaging to improve communication and coordination of transfer

New Acute Transfer Form

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- Current Acute Care Transfer paper form is being replaced by new electronic Acute Care Transfer form in Meditech
- After provider completes form in Meditech, provider will verbally notify nursing to print it from report tab
- Nursing completes and obtains patient signature on new form as followed in current transfer process
- Make two copies of completed form; one for receiving facility and one for transfer log. Original remains in chart.

Old Acute Transfer Form

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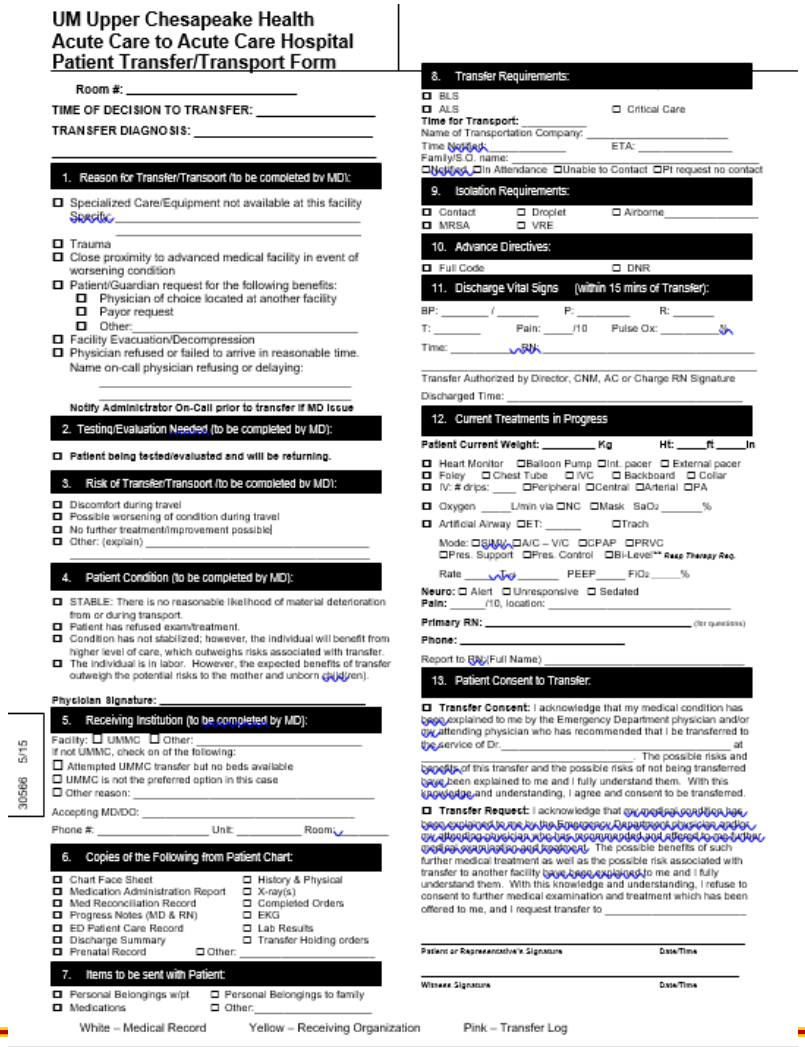
This form is now available electronically for
Acute To Acute transfers with an enhanced process for transfers!



UM Upper Chesapeake Health
Acute Care to Acute Care Hospital
Patient Transfer/Transport Form

Room #: _____

TIME OF DECISION TO TRANSFER: _____

TRANSFER DIAGNOSIS: _____

1. Reason for Transfer/Transport (to be completed by MD):

- ☐ Specialized Care/Equipment not available at this facility
  Specify: _____
- ☐ Trauma
- ☐ Close proximity to advanced medical facility in event of worsening condition
- ☐ Patient/Guardian request for the following benefits:
  - ☐ Physician of choice located at another facility
  - ☐ Payor request
  - ☐ Other: _____
- ☐ Facility Evacuation/Decompression
- ☐ Physician refused or failed to arrive in reasonable time.
  Name on-call physician refusing or delaying:
  _____

Notify Administrator On-Call prior to transfer if MD issue

2. Testing/Evaluation Needed (to be completed by MD):

- ☐ Patient being tested/evaluated and will be returning.

3. Risk of Transfer/Transport (to be completed by MD):

- ☐ Discomfort during travel
- ☐ Possible worsening of condition during travel
- ☐ No further treatment/improvement possible
- ☐ Other: (explain) _____

4. Patient Condition (to be completed by MD):

- ☐ STABLE: There is no reasonable likelihood of material deterioration from or during transport.
- ☐ Patient has refused exam/treatment.
- ☐ Condition has not stabilized; however, the individual will benefit from higher level of care, which outweighs risks associated with transfer.
- ☐ The individual is in labor. However, the expected benefits of transfer outweigh the potential risks to the mother and unborn child(ren).

Physician Signature: _____

5. Receiving Institution (to be completed by MD):

Facility: ☐ UMMC ☐ Other: _____
If not UMMC, check on of the following:
☐ Attempted UMMC transfer but no beds available
☐ UMMC is not the preferred option in this case
☐ Other reason: _____

Accepting MD/DO: _____

Phone #: _____ Unit: _____ Room: _____

30566 5/15

6. Copies of the Following from Patient Chart:

- ☐ Chart Face Sheet
- ☐ Medication Administration Report
- ☐ Med Reconciliation Record
- ☐ Progress Notes (MD & RN)
- ☐ ED Patient Care Record
- ☐ Discharge Summary
- ☐ Prenatal Record
- ☐ History & Physical
- ☐ X-ray(s)
- ☐ Completed Orders
- ☐ EKG
- ☐ Lab Results
- ☐ Transfer Holding orders
- ☐ Other: _____

7. Items to be sent with Patient:

- ☐ Personal Belongings w/pt
- ☐ Medications
- ☐ Personal Belongings to family
- ☐ Other: _____

8. Transfer Requirements:

- ☐ BLS
- ☐ ALS
- ☐ Critical Care

Time for Transport: _____
Name of Transportation Company: _____
Time Notified: _____ ETA: _____
Family/S.O. name: _____
☐ In Attendance ☐ Unable to Contact ☐ Pt request no contact

9. Isolation Requirements:

- ☐ Contact
- ☐ Droplet
- ☐ Airborne _____
- ☐ MRSA
- ☐ VRE

10. Advance Directives:

- ☐ Full Code
- ☐ DNR

11. Discharge Vital Signs (within 15 mins of Transfer):

BP: _____ / _____ P: _____ R: _____
T: _____ Pain: _____/10 Pulse Ox: _____%
Time: _____ RN: _____

Transfer Authorized by Director, CNM, AC or Charge RN Signature

Discharged Time: _____

12. Current Treatments in Progress

Patient Current Weight: _____ Kg Ht: _____ft _____in

- ☐ Heart Monitor ☐ Balloon Pump ☐ Int. pacer ☐ External pacer
- ☐ Foley ☐ Chest Tube ☐ IVC ☐ Backboard ☐ Collar
- ☐ IV: # drips: ____ ☐ Peripheral ☐ Central ☐ Arterial ☐ PA
- ☐ Oxygen _____L/min via ☐ NC ☐ Mask SaO2 _____%
- ☐ Artificial Airway ☐ ET: _____ ☐ Trach

Mode: ☐ SIMV ☐ A/C – V/C ☐ CPAP ☐ PRVC
☐ Pres. Support ☐ Pres. Control ☐ Bi-Level** Resp Therapy Req.

Rate _____ TV _____ PEEP _____ FiO2 _____%

Neuro: ☐ Alert ☐ Unresponsive ☐ Sedated
Pain: _____/10, location: _____

Primary RN: _____ (for questions)

Phone: _____

Report to RN (Full Name) _____

13. Patient Consent to Transfer:

☐ **Transfer Consent:** I acknowledge that my medical condition has been explained to me by the Emergency Department physician and/or my attending physician who has recommended that I be transferred to the service of Dr. _____ at _____. The possible risks and benefits of this transfer and the possible risks of not being transferred have been explained to me and I fully understand them. With this knowledge and understanding, I agree and consent to be transferred.

☐ **Transfer Request:** I acknowledge that my medical condition has been explained to me by the Emergency Department physician and/or my attending physician and has recommended that I be transferred to another facility. The possible benefits of such further medical treatment as well as the possible risk associated with transfer to another facility have been explained to me and I fully understand them. With this knowledge and understanding, I refuse to consent to further medical examination and treatment which has been offered to me, and I request transfer to _____

Patient or Representative's Signature Date/Time

Witness Signature Date/Time

White – Medical Record Yellow – Receiving Organization Pink – Transfer Log

New Acute Transfer Form

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Provider Completed in Meditech

University of Maryland
Upper Chesapeake Medical Ctr
500 Upper Chesapeake Dr.
Bel Air, MD 21014

Acute Care Hosp Transfer Form

Patient Name: Test,Rapposelli Karen **U334-1**

Date of Birth: 02/14/1974 **Account Number: MA0000060525**

Date of Admission: 06/25/18 **Record Number: M000000588**

Height: 5 ft 8 in **Weight:** 68.039kg **Code Status:** Attempt CPR

Time of Decision to Transfer: 16:11
Reason for Transfer: Specialized Care/Equipment not available at this facility
Specialized Equipment: Cardiac Cath
Patient being tested/evaluated and will be RETURNING: No
Risk of Transfer/Transport: Discomfort during travel, Possible worsening of condition during travel, No further treatment/improvement possible
Patient Condition: STABLE- Material deterioration during Transport not likely
Receiving Institution: UCMC
Other Facility Name: test
Why not University of MD Medical Center: UMMC is not the preferred option I this case
Accepting MD/DO: jokhadar
Phone Number: 888-888-8888

<Electronically signed by Angela C Wrzosek > 12/18/18 1612
12/18/18 1612

Patient Consent to Transfer:
[]Transfer Consent: I acknowledge that my medical condition has been explained to me by the Emergency Department physician and/or my attending physician who has recommended that I be transferred to the service of Dr._____ at _____. The possible risks and benefits of this transfer and the possible risks of not being transferred have been explained to me and I fully understand them. With this knowledge and understanding, I agree and consent to be transferred.

[]Transfer Request: I acknowledge that my medical condition has been explained to me by the Emergency Department physician and/or my attending physician who has recommended and offered to me further medical examination and treatment. The possible benefits of such further medical treatment as well as the Possible risk associated with transfer to another facility have been explained to me and I fully understand them. With this knowledge and understanding, I refuse to consent to further medical examination and treatment which has been offered to me, and I request transfer to _____.

_____ _____
Patient or Representative's Signature Date/Time Witness Signature Date/Time

Page: 1 of 2

Nursing to Complete & Patient Sign

Acute Care Hosp Transfer Form
Test,Rapposelli Karen **MA0000060525**

Copies of the Following from Patient Chart:
[]Chart Face Sheet []History & Physical []Medication Administration Report
[]X-ray(s)
[]Med Reconciliation Record []Completed Orders []Progress Notes (MD & RN)
[]EKG
[]ED Patient Care Record []Lab Results []Discharge Summary
[]Transfer Holding orders []Prenatal Record []Other: _____

Items to be sent with Patient:
[]Personal Belongings w/pt []Medications []Personal Belongings to Family []Other:_____

Transfer Requirements:
[]BLS []ALS []Critical Care
Time for Transport:_____ Name of Transportation Company: _____
Time Notified:_____ ETA:_____
Family/S.O. name: _____
[]Notified []In Attendance []Unable to Contact []Pt request no contact

Isolation Requirements:
[]Contact []Droplet []Airborne_____ []MRSA []VRE

Discharge Vital Signs (within 15 mins of Transfer):
BP:____/____ P:____ R:____ T:____ Pain:___/10 Pulse Ox:____%
Time:_____ RN:_____

_____
Transfer Authorized by Director, CNM, AC or Charge RN Signature
Discharged Time:_____

Current Treatment in Progress:
[]Heart Monitor []Balloon Pump []Int. pacer []External pacer []Foley
[]Chest Tube []IVC []Backboard []Collar
[]IV: # drips:____ []Peripheral []Central []Arterial []PA
[]Oxygen _____L/min via []NC []Mask SaO2 _____%
[]Artificial Airway []ET: _____ []Trach
Mode: []SIMV []A/C - V/C []CPAP []PRVC []Pres. Support []Pres. Control
[]Bi-Level** ***Resp Therapy Req.*** Rate _____ Tvol _____ PEEP_____ FiO2 _____%

Neuro: []Alert []Unresponsive []Sedated **Pain:** ___/10, location: _____
Primary RN: _____ (for questions) **Phone:** _____

Report to RN:(Full Name) _____

Original - Medical Record Copy1 - Receiving Organization Copy2 - Transfer Log

Rept: 1218-0005
Conf: Y

Page: 2 of 2

After nurse obtains patient signature, make two copies of form

Transfers Between UCH Facilities

University of Maryland Upper Chesapeake Health

- ***ONLY*** when transferring **between UCH facilities**; use the DocHalo messaging system as noted below:
  - Discharging unit sends DocHalo message to "HMH to UCMC Transfers" group when patient has left unit OR the transfer has been cancelled
  - Receiving unit sends DocHalo message to Attending Provider when patient has arrived to unit
  - Receiving unit calls Patient Access to change patient status to "REG"
  - Responsible Party:
    - Unit Secretary or Primary Nurse

What is changing for providers?

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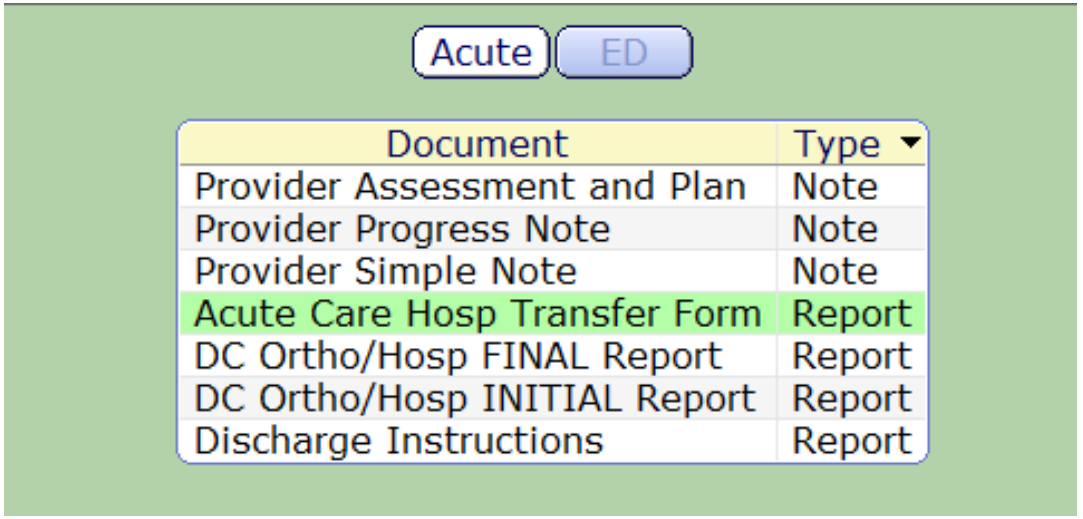
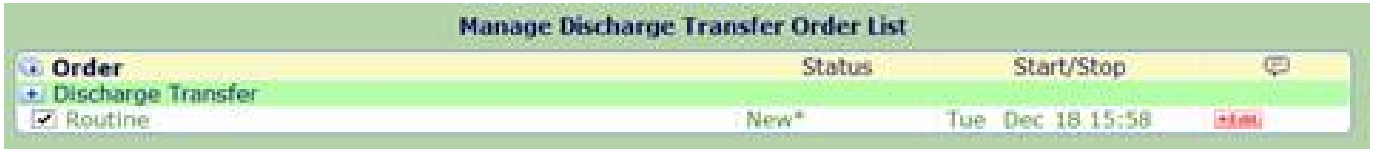
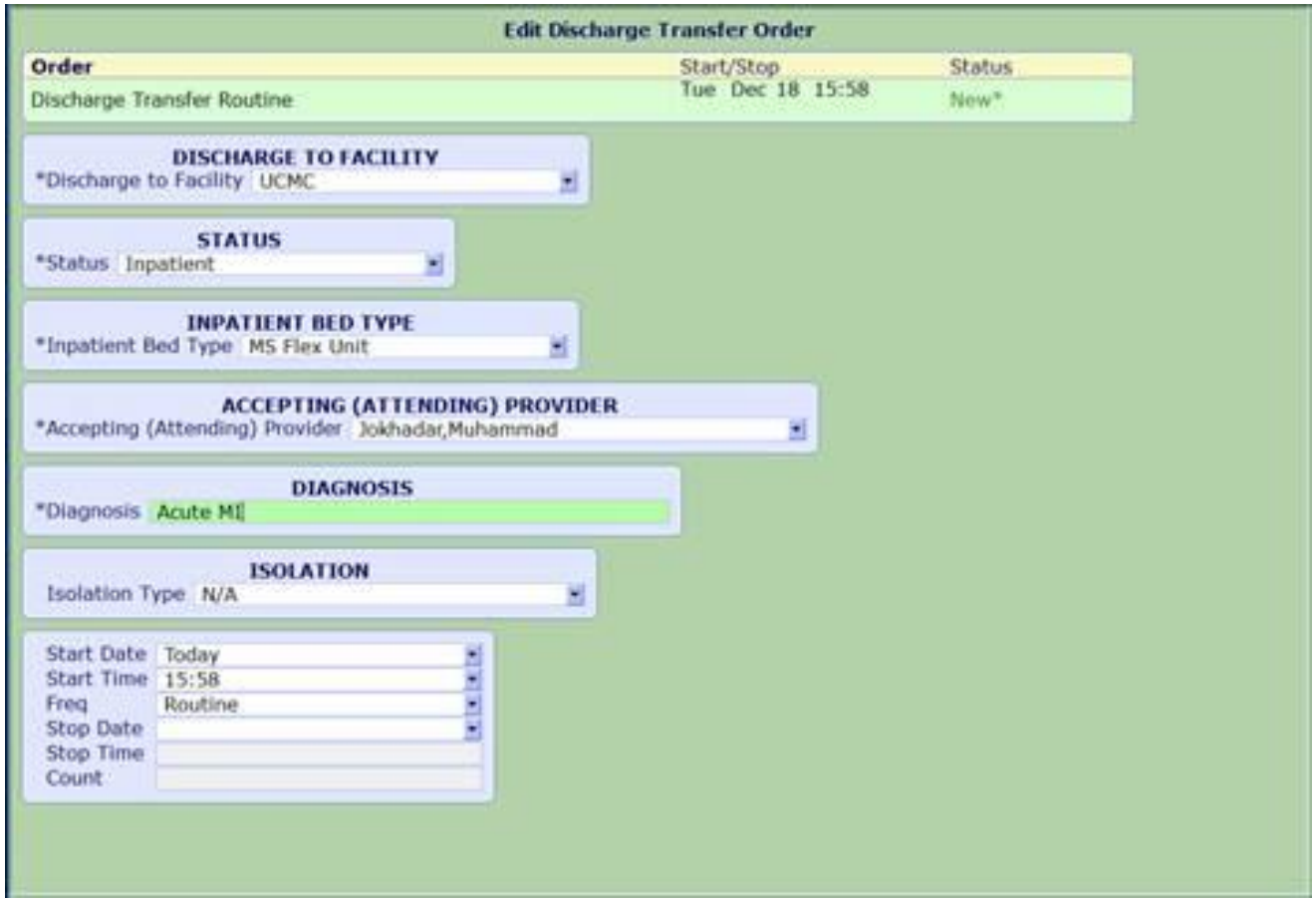
Discharging Provider:

1. Go to “Document” tab
2. Find “Acute Care Hospital Transfer Form”
3. Complete Discharge Transfer Order (continue or omit orders)
4. Complete Transfer Form
   - Transfer Diagnosis
   - Reason for Transfer
   - Etc.
5. Save



Discharge Transfer Order





Acute Transfer Form

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Test,DischargeTransfer12 HA0000033555 H0(
45 F 04/27/1973 E(
DIS IN CDUHMH CDU351-2 Allergy/Adv: gentamicin

Acute Care Hosp Transfer Form N

Internal UM UCH Transfer			
Required for ALL one-way UM UCH inter-facility transfers			
✓ **Time of Decision to Transfer**			
Time of Decision to Transfer	13:37	Comment:	
Transfer Diagnosis			
<Select Problem>			
Reason for Transfer/Transport			
*Reason for Transfer	Specialized Care/Equipment not available at this facili ... Trauma Close proximity to adv medical facility in event of wor ...	Patient/Guardian request for benefits: Facility Evacuation/Decompression Physician refused or failed to arrive in a reasonable t ...	
Specialized Equipment			
Requested Benefits	Physician of choice located at another facility Payor request	Other	
Name of Physician refusing or delaying			
Testing/Evaluation needed			
Patient being tested/evaluated and will be RETURNING	Yes No		
Risk of Transfer/Transport N			
*Risk of Transfer/Transport N	Discomfort during travel Possible worsening of condition during travel	No further treatment/improvement possible Other	
Patient Condition			
*Patient Condition	STABLE- Material deterioration during Transport not lik ... Patient has refused exam/treatment	Pt will benefit from higher level of care; outweighs ri ... Pt in labor;transfer offset of potential risks of mom & ...	
Receiving Institution			
Receiving Institution	UCMC HMH	University of MD Medical Center Other Facility	
Other Facility Name			
Why not University of MD Medical Center	Attempted UMMC transfer but no beds available UMMC is not the preferred option I this case	Other	
Accepting MD/DO			
Phone Number			

Print Outs to Patient Access & Pharmacy

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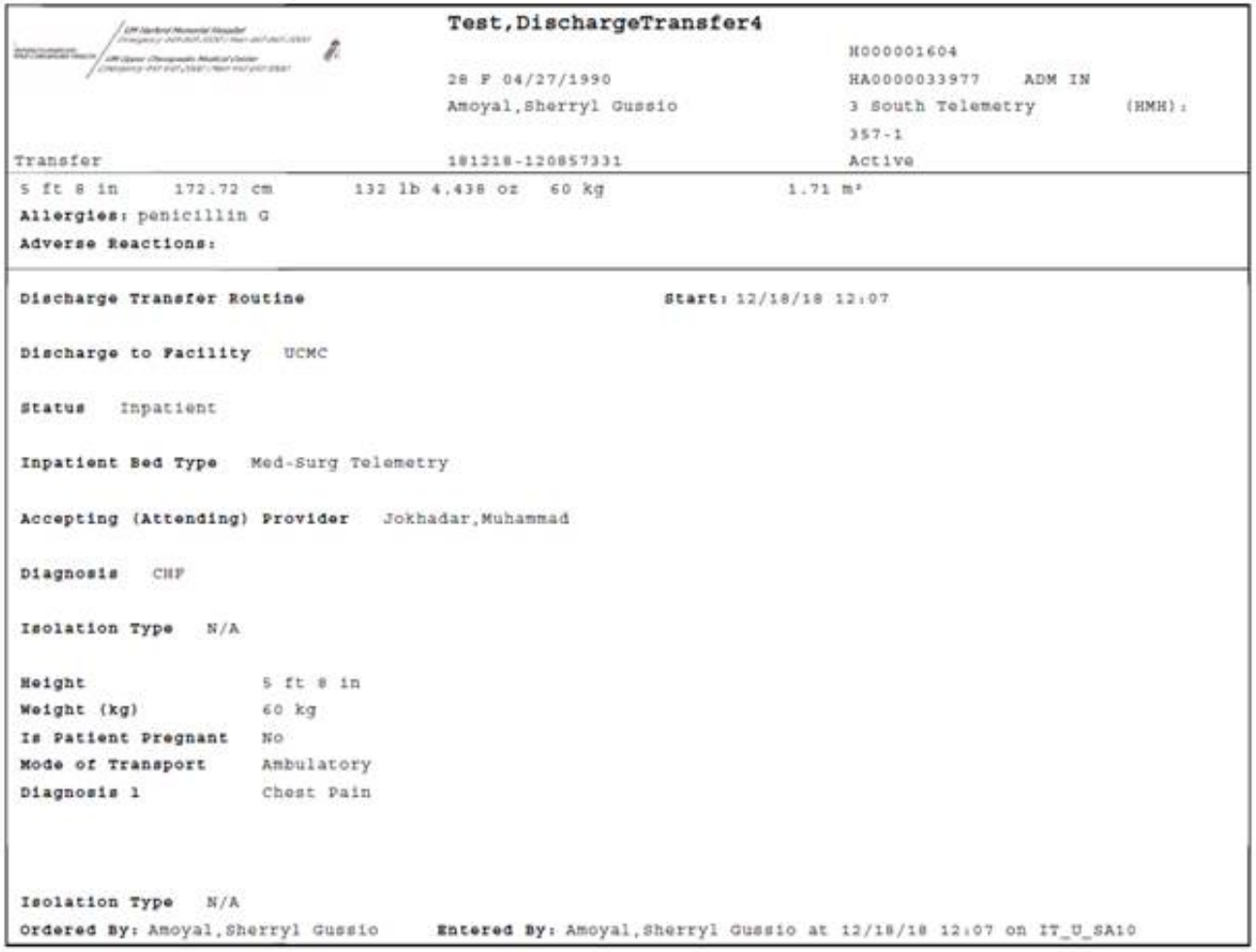
Pharmacy, Patient Access and Lab will receive report to pre-register patient and add patient to Pharmacy list to screen for duplicate orders



Test,DischargeTransfer4

M000001604
28 F 04/27/1990 HA0000033977 ADM IN
Amoyal,Sherryl Gussio 3 South Telemetry (HMH):
357-1
Transfer 181218-120857331 Active

5 ft 8 in 172.72 cm 132 lb 4.438 oz 60 kg 1.71 m²
Allergies: penicillin G
Adverse Reactions:

Discharge Transfer Routine **Start:** 12/18/18 12:07

Discharge to Facility UCMC

Status Inpatient

Inpatient Bed Type Med-Surg Telemetry

Accepting (Attending) Provider Jokhadar,Muhammad

Diagnosis CHF

Isolation Type N/A

Height	5 ft 8 in
Weight (kg)	60 kg
Is Patient Pregnant	No
Mode of Transport	Ambulatory
Diagnosis 1	Chest Pain

Isolation Type N/A
Ordered By: Amoyal,Sherryl Gussio **Entered By:** Amoyal,Sherryl Gussio at 12/18/18 12:07 on IT_U_SA10

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Thank you for completing this presentation!

Please be sure to complete the next component of this course in UMMS U.