NORTHERN HEALTH REGION

Care Transitions and Handover Guide

	Information required at all transitions
ALL AREAS Minimum information that must be provided by the sending HCP and available to the receiving area	• Client's full name and patient identifiers • Name and contact information for the sending healthcare provider • Reason for the transfer, referral, test or procedure • Safety concerns and or client risk factors (including infection control and prevention precautions) • Client's clinical status • Allergies • Clients goals and concerns • Action items for the receiving team
If client is at **risk of deterioration** also must include	• Level of urgency • Client's level of risk • Change in health status

Type of Transfer	**Additional Information Required**	**Tools to Support Information Transfer**	**Standard Operating Procedures**
Unit to Unit (intRA-facility) Transfer Between Acute Care Programs (i.e. Emergency to Medicine)	• name and contact information for the receiving HCP • Resuscitation code status / ACP / Health Care Directive • medications, • diagnosis, • test results, procedures • time of the report • fall risk including prevention strategies • contact information for alternate decision maker if required • pain management • skin assessment • vascular access • level of orientation or presence of delirium • mobility and transfer status	• Transfer of Accountability Record Form #: NHR_0134 • EDIS TOCE document • Verbal Handover: nurse to nurse • Verbal Handover: prescriber to prescriber	
Facility to Facility (intER-facility) Transfers	• MB Information Transfer Referral form all fields • The client's full name and Medical Record Number	• Manitoba Information Transfer Referral (MITR) Form (W-00147) and /or EDIS TOCE document	

Type of Transfer	Additional Information Required	Tools to Support Information Transfer	Standard Operating Procedures
	• Contact information for the sending and receiving healthcare providers • Reason for transfer • Safety concerns, need for additional precautions / Infection Prevention & Control (IP&C) status, and/or patient/resident risk factors • Patient/resident goals • Medications, diagnoses, test results, procedures, and advanced care planning wishes and decisions.	• Copy of relevant Health Record documents • Air Ambulance IFT Form #: NHR_0377 **Required:** • Verbal Handover: nurse to nurse • Verbal Handover: nurse to ERS and ERS to nurse • Verbal Handover: prescriber to prescriber	
Facility to Community Program on discharge home (i.e. Medicine to Home Care / Primary Care)	• Information will be dependent on the transfer and supported by the applicable referral or transfer form	• Referral form applicable to program area and/ or MITR form • Program Specific referral • EDIS discharge summary and / or EDIS TOCE document • Discharge Summary	
Community Program to Facility (i.e. Primary Care to Emergency Dept.)	• Information will be dependent on the transfer and supported by the applicable referral or transfer form	• Program specific referral • Primary Care Clinic to Emergency Dept form	
Program to Program (i.e. Primary Care to Home Care)	• Information will be dependent on the transfer and supported by the applicable referral or transfer form	• Referral form applicable to program area and/ or MITR form	
Handover: Shift to Shift	• Uncompleted tasks • Name and contact information for the MRP • Resuscitation code status / ACP / Health Care Directive • medications, • diagnosis, • test results, procedures	• Transfer of Accountability Record Form #: NHR_0134	

Type of Transfer	Additional Information Required	Tools to Support Information Transfer	Standard Operating Procedures
	• time of the report • fall risk including prevention strategies • contact information for alternate decision maker if required • pain management • skin assessment • vascular access • level of orientation or presence of delirium • bed mobility and transfer status		
Temporary movement with facility no nurse or paramedic escort (i.e. inpt. to diagnostics)	• Level of orientation / presence of delirium • Fall risk including prevention strategies • Bed mobility and transfer status	• If presence of high risk (e.g. high risk for falls, elopement, behaviour that puts self or others at risk) the nurse caring for the client should call the test or procedure area to provide a brief verbal update on the client, or accompany the client to the test or procedure if feasible.	

	Terms	Definitions/Possible information to include when transferring care
S	Patient Story/Summary	Summary of key events
	Reason for Transfer	Admission, increased level of care required
B	Primary Service	Example: Surgery, Pediatrics, Internal Medicine, etc. (who do you call when you have a concern)
	MRP	Most responsible provider (who to escalate concerns to)
	IPAC Status	IPAC screening tool completion, confirmation of ARO specimen collection, additional precautions and reasons
	Significant events in the last 24 hours	Safety events such as a fall, new delirium, etc.
	Patient and/or family goals and concerns	Person Centred Care Seeking voice of the patient: Ask first – right now/today, "what is important to you? What are your goals, concerns, worries, preferences or care needs?" Embed the voice of the patient. Share and act on what matters most. Inform and collaborate with the interprofessional team to follow through on goals that the patient identifies
A	Neurological	Alert and oriented to person, place and time, behaviour appropriate to situation
	Circulatory/ Cardiovascular	Venous thromboembolism prophylaxis, thromboembolic deterrent stockings, telemetry
	Respiratory	Smoking status, suctions, tracheostomy, chest tube
	Diet	Diet order (type/texture) enteral nutrition, total parenteral nutrition
	Gastrointestinal and Genitourinary	Method of urination and frequency, catheter type, continuous bladder irrigation, bladder scan, dialysis, last bowel movement, ostomy type
	Skin and Wound	Skin assessment, wound/drain care, hygienic care, mouth care
	Falls Risk	Falls risk assessment completed, risk identified as low, moderate or high
	Mobility	Mobility levels: A1 ambulates independently, A2 ambulates with assistance, B bed to chair transfers, C cannot stand to transfer, Activities of daily living
	High risk behaviour	Identified triggers for behaviours, use of observer, use of restraints, psychiatric forms
	Pain	Pain assessment, last pain medication, pain management modalities (eg. PCA, epidural etc.) pharmacological and non-pharmacological interventions in use
	Lines/tubes, drains/infusions	Peripheral vascular device, central venous access device
	Labs, tests, POCT, blood glucose	Lab work and tests completed, POCT schedule
R	Recommendations/ Follow-up	Outstanding or pending tests/procedures/medications due
	Anticipated changes/events	Possible events that could happen in the next 12 hours
	Plan of care	Anticipated next steps in patient's care (eg. discharge, rehab, etc.)