SOP Standardized Work

Job Name	Transfer of Accountability	Objective:	To ensure the TOA is completed and used when transferring care from one unit, campus, or facility to another.	Date: 8-May-16 Owner: Standard Unit

	Process Steps	Freq	Visual Aid
1	**Prior to transfer:**		
	To ensure safe patient transfer, determine if the patient's condition requires a nurse for escort (refer to policy)	always	
2	**"Sending" Nurse:**		
	a. Nurse: Stamp/attach patient addressograph/sticker on blank TOA form	always	
	b. Nurse: Complete the TOA before calling verbal report to receiving unit/nurse	always	
	c. Nurse: Vital signs are to be completed within 2 hours of transfer. If the patient's condition changes, it is important to reassess the patient prior to transfer document and communicate appropriately.	within 2 hours of transfer and when necessary	
	d. Nurse: Call receiving unit and ask for receiving /covering nurse where the patient will be assigned.	always	
	e. Nurse: Provide verbal report to receiving nurse by providing all the information as listed on the TOA. If the patient's condition changes after report has been called to the unit, call the unit back, speak to the receiving unit nurse and provide the update. Document appropriately in the TOA.	within 30 mins prior to transfer	
	f. Nurse: Record the time that report was called on page 1 and sign on page 2 of TOA sheet	always	
	g. Nurse: Complete the TOA Checklist (p. 2) before transferring patient	always	
	h. Nurse: Send completed TOA with patient chart to receiving unit/facility	always	
3	**"In Person hand off"**		
	a. For all in person patient hand-offs a single TOA may be used. Both nurses are to sign the TOA indicating they are in agreement that this document matches the patient they are sending/receiving.	always	
4	**Transferring patient between tests**		
	a. Any patient going for diagnostic test/ procedure, must return to the sending unit for assessment prior to transfer to the receiving unit. The TOA is to be completed once the patient is back from their diagnostic test /procedure. (to ensure patient is stable for transfer)	always	
5	**"Receiving" Nurse:**		
	a. Nurse: Record information on their own TOA as a work sheet (Receiving nurse to write or stamp "copy "on this form) while receiving verbal report from sending nurse, however it is not put in the chart (store in binder for clinical follow-up to be reviewed by CPM and to be discarded at CPM discretion)	within 30 min prior to transfer	
	b. Nurse: Ask for clarification or additional information, as needed	as needed	
	c. Nurse: Both sending and receiving nurse will " time out" to ensure page 2 is complete.	always	
	d. Nurse: **Upon arrival** 1. If patient's acuity doesn't reflect the information received prior to transfer escalate to Clinical Practice Manager/Operational Manager/After Hours Manager and ensure documentation is completed on patient health record. 2. If the TOA is accurate and complete sign on the original TOA at the bottom of the second page indicating that this document matches the patient (Receiving Nurse's Signature)	always	
	e. **Nurse**: If escalated, enter this as a patient safety error in RL6 with a severity code of "E"	as needed	
	f. Nurse: Use information on TOA to assist in completing Patient Summary Tool (If patient has been transferred within 30 minutes and staff are unable to complete the required tools in time for shift hand-off, use the Transfer of Accountability (TOA) located in patient chart, under the history tab as the first document, to provide the critical information during the shift change report)	as needed