

# Transfer of Higher-Acuity Patients



**SITUATION:** Throughout the medical continuum, inadequate handoff communication is recognized as a potential risk to patients. With higher-acuity patients, transfers are more complex and more susceptible to communication lapses. Thus, transferring higher-acuity patients between hospitals puts them at higher risk of adverse events and mortality.<sup>1</sup>



**BACKGROUND:** Transfer documentation is frequently absent or incomplete, which increases the likelihood of adverse events occurring within 24 hours of patient arrival. Completing proper transfer documentation reduces duplication of work when treating the patient and is associated with a reduction in adverse events and patient mortality.<sup>2</sup>



**ASSESSMENT:** At minimum, a hospital's transfer information should include:

- Patient name, DOB, patient type (e.g., adult, pediatric, OB, behavioral health)
- Patient medications (and their availability)
- Medical equipment necessary for a safe patient transfer (e.g., IV, BiPAP)
- Patient's special communication needs (e.g., deafness or a language barrier)
- Method of transfer to accepting facility and contact information for that facility
- Patient's emergency contact, legal guardian, or other key family member(s)
- Documentation of person responsible for security of patient's personal belongings

## RECOMMENDATIONS

Evaluate your handoff communication process and ensure that it includes all information essential for safe patient transfers. Use a tool such as ASHRM's High Acuity Patient External Transfer Handoff Guidance document (<https://www.ashrm.org/high-acuity-patient-external-transfer-handoff-guidance-tool>) to assist in your review process. When appropriate, this transfer tool should accompany the patient at the time of transfer and also be faxed to the accepting facility. Compliance with all related policies, procedures, and regulations (such as EMTALA) should be documented as required.

<sup>1</sup> *J Crit Care.* 2016;36:240-245. doi:10.1016/j.jccr.2016.08.006

<sup>2</sup> *J Crit Care.* 2016;36:240-245. doi:10.1016/j.jccr.2016.08.006