Inter-facility Transfer Narrative Help

T. Wagner –EMT-P

D. Yates – EMT-P

Overview

This Power point will assist in writing the narrative portion of transfer reports

This will include questions to ask yourself when writing the report and examples.

Follow protocol and CLEMC Narrative format

1.Where is the patient going, and Why?

Answers should include : What facility is the patient going to, and what is the reason the patient is going to this new facility.

Things to consider when answering this question

- Service not available at original facility (Be specific!)
- What service can the new facility provide that the originating facility cant?
- Discharge or Higher level of care?
- What type of facility is the new facility

Here are some sample reasons (this is not an all inclusive list)

- ✓ Long term acute care (antibiotic therapy, ICU/MICU care, cardiac monitoring, IV therapy or other post acute care monitoring)
- ✓ Long term assisted care by skilled facility or caregiver (Assistance with activies of daily living that patient cannot perform unassisted or safely unassisted
- ✓ Specialist care/ Specialist hospital
- ✓ Rehabilitation

Answering question #1 from one hospital to hospital

Going from “X” hospital to “y” hospital for - Specialist such as

- Neurologist/Nuerosurgeon
- Cardiologist/Cardiothoracic surgeon/Cath lab
- Pediatric specialist/ Pediatric surgeon/NICU capabilities
- OB/GYN specialist (or special ob/gyn procedure)
- ICU/IMU care after acute care
- Psychiatric services/inpatient psychiatric

Answering # 1 for a discharge to –Skilled nursing facility, Assisted care, Memory care , or home care provided by caregiver

Possible reasons why patient needs stretcher discharge

- Pt needs long term care due to Dementia/Alzhiemers/memory impairment
- Pt needs long term care due to age degeneration or debility secondary to physical or medical condition (BE specific on what that physical or medical condition may be)

Here is a Sample

Pt John doe is being transferred from St johns hospital to Houston Methodist –medical center campus for a Neurosurgeon that is unavailable. The patient was diagnosed with Sub arachnoid hemorrhage.

Pt Jane doe is being discharged to Happyland Skilled Nursing facility for long term day to day care for age degeneration and baseline AMS secondary to dementia.

2 Why does the patient need stretcher transport

(Be honest, provide accurate assessment) if patient does not need stretcher transport, document what you see

The reasons for transport should be checked off on CMN I CMN is required.

Refer to CMN for list of qualifying reasons. When writing your narrative, be detailed with your assessment findings

Example- The pt presents with Altered mental status , secondary to dementia. Pt also has right sided hemiparesis secondary to a CVA. Pt is a fall risk due to unsteady gait. Pt has poor trunk control due to right hemiplegia. Pt leans to right when sitting unassisted.

Your assessment needs to be consistent with what you document. If you document that the patient has current hemiparesis, but you state the patient ambulated to stretcher , you are documented an inconsistency.

Document what you SEE! Not what the staff says. Each patient should be assessed and reassessed.

Staff at a facility report your patient “had a stroke and only there left side works”

Does a patient have right sided deficit secondary to stroke if:

They are found sitting in a chair, are able to stand and walk to stretcher, can secured their own belts and give directions on how to get home?

Think about your patients condition when answering question # 2.

- They have baseline AMS. WHY? Why are they confused or altered? Is it due to TBI, or dementia
- Why are they weak or have poor trunk control? *Is it due to CVA with deficits, age degeneration, surgery, long term hospitalization , generalized weakness? Is it due to a medical condition such as rhabdomylosis*

Here are some examples of why patients need stretcher transport

- Poor Trunk control
- Poor safety awareness (Pt is Alert to person time and event, but doesn't know place, intermittent confusion, where pt. may forget they cant walk or drive)
- Altered mental status
- Suicidal/ flight risk
- Cannot regulate own o2 (physically or AMS)
- Special positioning requirements (such as angle restrictions, Ortho devices or contractures)
- Active isolation (MRSA, VRE, Psuedomonas C-diff ect.)
- Non weight bearing/non ambulatory

Question # 3. Why was the patient in the hospital?

In this, include what was done for them there

- Diagnosis
- Treatment provided by facility
- Tests performed (CT, MRI, blood work)
- Sign and symptoms they were admitted for. Are these resolved or active?

Question # 4 : What is the patient's PMH, MEDs and Allergies?

Refer to other sections of PCR if already documented.

Medication and medical HX should correspond.

EX-

Pt takes insulin- DX of DM

Pt takes metoprolol- DX of HTN

This information can be found in the patients packet or the patient's H&P. If pt is unable to provide there own hx, ask the staff your are receiving report from.

Question # 5- How was the patient found when you made contact?

Position & Level of Consciousness

Room or unit patient is located

active treatments? O2, Ventilator, Telememtry

Ex- John Doe was found sitting in hospital chair. Chair was leaned back with patients feet raised. Pt is located in Geriatric ACU unit Room 5. John doe has a suprapubic catheter in place. Pt has 02 via nasal cannula running, but nasal cannula was removed by patient. Pt was found sleeping but became alert to voice.

Question # 6 how did you move the patient

Did any incidents occur while moving patient?

- Was patient sheet transferred?
- Did patient ambulate
- Stand and pivot?
- 1, 2 or 3 or more person assist?

Question # 7, How was the patient positioned on the stretcher?

- Were all seatbelts secured
- Were both rails up?
- Incidents with loading or unloading patient?
- Semi fowlers, folwers, supine, lateral
- Pillow used for positioning?

Question # 8: What were your assessment findings

- Mental status
- ABC's
- Initial and destination v/s
- Head to toe assessment
- Continent, incontinent, diapered, foley? (condition, clean and dry? BM or wet? How did foley present? Urine color, urine clarity)
- Monitoring of equipment : IV (size and patency) PICC line, Dialysis port or shunt, PEG tube, trach, wound vac, ect
- Fluids or medications? Locked off for transport or drip?
- Recent IV narcotic admin? Dose and time?
- If on a vent or IV pump what are the setting? VTBI for pumps what it started at beginning of transport and what it ended at?
- 4 lead and 12 lead EKG, ETCO2, or other assessments.

Q 9 -What happened once you reached the destination?

- How was patient moved from stretcher to bed?
- Was patient moved to hospital bed, wheelchair or chair?
- What safey measures were in places? Are rails present and up? Are there safety mats present? Does patient have seatbelt or alarm on wheel chair?

- PLEASE be courteous and provide the patient with the call button and leave the bed in a safe position, lowest position if possible. Make sure devices are in reach. Walkers, canes, ect. And document what you did for the patient at destination.

Question # 10 Did you receive orders for treatment during transport?

- Does pt require treatment or intervention during transport?
- Who gave the orders or where did you obtain the orders?
- Continued care ? Such as IV or O2?
- Protocol, Pt specific or standing orders?

Question # 11 Who signed for the patient, and why?

Was the patient able to sign for themselves? If not why? AMS, physical impairment or other reason. Again be specific. “Pt Jane Doe was unable to sign due to sever contractures of upper extremities secondary to MS” Pt’s Husband signed for her with her verbal consent.

Did you obtain a facility signature? Who signed for receiving the patient, who was report given to what are there credentials? Was the person you gave report to at bedside? Ex – Report was given to RN JENNY. RN jenny signed for receiving patient, and was at pt bedside.

Signatures for AOB must be obtained by patient, patient representative or Facility

REVIEW TIME:

Examples

Kindred located on blossom is an LTAC- has ICU and rehab

Cornerstone is an LTAC and has ICU and rehab

Kindred located on medical center is a Rehab, not a SNF. It does not have ICU

Bay area Rehab (Post acute care) is a rehab hospital

Bellaire behavioral is a Psychiatric hospital, while

Bayshore is a hospital with a psychiatric unit

Quick facility Guide

Do you know what an LTAC is?

How about a SNF or Skilled Nursing facility?

What is rehab?

Assisted living, memory care and independent retirement living

- LTAC- Long term acute care- considered a hospital can have ICU, IMU, rehab capabilities. Staffed by RN'S and CAN's. *Requires MOT*
- SNF- Skilled nursing facility, Convalescent or Nursing home, These can also be rehabs or have rehab wings. but is not a rehab hospital. DOES NOT REQUIRE MOT
- Rehabilitation- Provides Physical, occupational or other therapy, is not a long term permanent living facility. It can be a Rehab hospital or rehab provided by SNF. REHAB HOSPITAL = MOT, SNF rehab No MOT
- Assisted living- Has an RN or Floor RN. Care is provided by caregivers or medication aides Not RN. May be CNA's but not always NO MOT
- Memory care- Alzheimer/dementia. Usually a locked wing or facility. Care provided by caregivers. RN is not always present especially after hours. NO MOT
- Independent retirement- medication aides are present and residents are provided some assistance. Resident is otherwise independent and there is no 24/hr supervision. Usually apartments NO MOT

Hope this was helpful
Thank you