Guideline Title: Transfer of Accountability Guideline	Date Approved: January 31, 2024
Category: Professional Practice	Date of Next Revision: January 31, 2027

NSCRT TRANSFER OF ACCOUNTABILITY GUIDELINE

OVERVIEW OF THIS GUIDELINE

This Transfer of Accountability Guideline contains recommendations endorsed by the NSCRT. It is not meant to replace employer policies but rather to provide additional detail and enhance practice in the area. Members have a responsibility to familiarize themselves with all practice guidelines published by the College.

INTRODUCTION

Transfer of accountability is a standard of care and occurs when responsibility for patient care is handed over from one healthcare provider (HCP) to another HCP. Care transitions are a high-risk period for patient safety and quality of care. These transition points may occur between shifts, providers, and units or facilities.

The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or groups of patients, to another person or professional group may occur temporarily or permanently. Care Transitions are critical points in the care system during which communication and/or transfer of information is vulnerable.

PURPOSE

The transfer of accountability (TOA) aims to ensure continuity of care and the safety of patients during all transitions in care by collaborating and effectively communicating accurate, comprehensive, and relevant

information related to the current and evolving needs of the patient. Respiratory therapists are required to:

- Understand and have knowledge of legislation and policies that allow them to fulfill their roles and responsibilities to guide effective transitions.
- Communicate clearly and effectively information relevant to the care of the patient.
- Attempt to reduce the number of preventable adverse events relating to information sharing at transitions of care.

OCCASIONS WHERE TRANSFER OF ACCOUNTABILITY OCCURS

TOA can occur with the movement of patients between healthcare locations, providers, or different levels of care within the same location as their conditions and care needs change. They are points where patients experience a change in team membership and/or location: admission, handover, transfer, and discharge.

Examples include (but are not limited to):

- Episodic, e.g., lunch hour
- Shift to shift
- Provider to provider
- Between care areas, e.g., transport to diagnostic imaging
- Between units, e.g., within the same facility
- Between facilities
- Upon discharge (including to a community health partner)
-

INFORMATION RELAYED DURING TRANSITIONS

Patient-specific information relayed from one HCP to another (whether individual HCP or HCP team) to ensure continuity of care should include all relevant aspects of care required to maintain or improve the patient's cardiopulmonary status.

The information transferred at care transitions depends on the nature of the care transition and, at minimum, must include the patient's full name, reason for the transition, current patient status, and safety concerns.

Information transfer should be a face-to-face dialogue when possible, and patient information exchanged must be timely, specific, accurate, objective, and clinically relevant to the provision of safe care. The process must be standardized to ensure that the same degree of detail is provided in each instance. The use of standardized tools is encouraged. Documentation of the transfer should be recorded in the patient's healthcare record.

Consider what information should be included (this is not an exhaustive list and can be modified to distinct practice areas):

Shift to shift; provider to provider; between units; discharge to community health partner:

- Patient Specific Information:
    - full name and other identifiers (preferred name and pronouns), age, location, allergies, code status.
    - Safety concerns – falls, seizures, infectious disease measures, aggression.
    - Psycho-social – cultural, spiritual, psychological, language, special needs (patient and family), and SDM
- Diagnosis
- Relevant past medical history, brief narrative of the patient's hospital stay etc.
- Patient's current clinical condition - assessment, relevant vitals and concerns, relevant system concerns, e.g., NPO, volume status
- Specific respiratory report – airway (size, grade, strategy, and challenges of intubation), assessment findings, suction, medications, equipment in use and settings
- Critical lab values, relevant diagnostic tests, relevant medications
- Status of investigations/treatments
- Care Summary - patient's response to therapy, complications, and current prognosis.
- Current Goals of Care/Level of Intervention– delineate clear responsibilities for pending tasks/therapies; the currently anticipated clinical course; advise of patients requiring close

monitoring who have been assessed to be at risk of sudden and/or dangerous deteriorations; upcoming transports/transfers; discontinued treatments.

Between facilities; Discharge:

- In addition to the above, include a transfer note documented on the patient's health record. The transferring HCP ensures that the accepting HCP is aware of the transfer and receives verbal TOA.
- Contact Information should any questions arise.

Teams; Rounds:

- Usually, a specific respiratory report – airway (size, grade), assessment findings, suction, medications, equipment in use and settings, patient's response to therapy, suggestions for future therapies

Episodic, e.g., lunch hour; transport to diagnostic imaging

- Determine what information should be included/documented for each instance.

USE OF STANDARDIZED TOOLS

Regardless of what approach is used for communicating during TOA, the process must be standardized to ensure that the same degree of detail is provided in each instance. Several communication methodology acronyms may be considered.

- **ISBARRD**: **I**dentify - **S**ituation – **B**ackground – **A**ssessment – **R**ecommendation – **R**epeat - **D**ocumentation.
  ISBARRD, or the shortened version SBARD, guides and facilitates the handover process and uses prompt questions in four areas to guide a conversation and ensure the efficient transfer of concise information:

  Identify – E.g., I am (RRT name), calling about (patient name)

  Situation - patient problems, symptoms, and stability, e.g. I am calling because (reason).

  Background - history of presentation and essential background information. E.g. John Smith was admitted yesterday with chest pain and heart failure.

  Assessment - impression and differential diagnosis. E.g. I have assessed the patient, and I am concerned because his condition is deteriorating. This could be the result of _____.

Recommendation - provide your recommendation for an action plan. E.g., I need you to come and see the patient in the next 15 minutes. Should I do anything in the meantime before you get here?

Repeat - the initiator of the communication should also get the receiver to repeat key information to ensure it has been understood.

Documentation - refer to NSCRT Documentation Guideline

- **ISTARTEND**: **I**ntroductions – **S**tory – **T**asks – **A**ssignment – **R**esources – **T**imely – **E**xiting - **N**ext - **D**ocument/Debrief. ISTARTEND is a tool to facilitate communications:

  Introductions - identify yourself and introduce the patient.

  Story - central, correct, complete.

  Tasks - treatment plan (what to do)

  Assignment - accomplish tasks and adjust as needed.

  Resources - what is required.

  Timely - updates as to the patient's condition - constantly evolving.

  Exiting - before leaving the patient, discuss…

  Next - responsibilities for pending tasks/therapies

  Document/Debrief - - refer to NSCRT Documentation Guideline

- **I-PASS**: **I**llness - **P**atient Summary - **A**ction - **S**ituation - **S**ynthesis

  Illness – includes severity, whether stable or unstable

  Patient Summary - events, current condition, treatment plan

  Action - what to do and timeline.

  Situation - awareness and contingency plan - know what's going on, plan for what might happen.

  Synthesis - by the receiver - receiver summarizes what was heard, asks questions and restates key action/to-do items, any further questions.

- **ATMISTAMBO:** **A** - Age, name, and date of birth
  T - Time of onset of symptoms; time of injury/illness
  M - Mechanism of injury; medical complaint/illness

I – Injuries/illness; exam findings
S - Signs- vitals, GCS
T - Treatment administered
A - Allergies
M - Medications
B - Background health history- including social, family, or other notable things
O - Other info, anything else of note that is relevant to the ongoing care of the patient.

YOUR ACCOUNTABILITIES

- Face-to-face verbal interactions whenever possible. Voice-recorded transfer of information is not best practice and should not be permitted. This type of communication is not acceptable due to the risk of violation of confidential health information, lack of opportunity to ask clarifying questions, and possible unclear audio recordings.
- If staff rely on previous progress notes and assessments when seeing a "new to them" patient and clarification is needed, it is the staff's responsibility to reach out to the previous clinicians.
- Both the transferring and accepting health care professionals (HCPs) are accountable for the exchange of patient information during care transitions. Minimize noise levels, interruptions, and distractions.

  The initiator of the communication should have the receiver repeat key information to ensure it has been understood and include opportunities to seek clarification and ask questions to avoid misunderstandings.

  The care provider receiving the information shall acknowledge each item with a response that indicates that the information has been transferred correctly and completely and ask the off-going care provider questions to clarify any information necessary to provide care.
- Perform a self-check – A sample of a helpful acronym for self-checking is **I'M SAFE**:

  Illness – which could affect performance.

  Medication – which could affect performance.

  Stress – was the shift hectic, personal issues.

  Alcohol – hungover, which could affect performance.

  Fatigue – lack of sleep or excessive workload during the shift, which could affect performance.

Eating – if you have not eaten, which could affect performance.

Pertinent information from your self-check should be communicated to colleagues, as each item in the list can increase potential errors.

- You are required to be aware of and follow relevant employer policies, procedures, standards, and documents.
- Ensure patient privacy and confidentiality.
- Adhere to NSCRT Standards of Practice, Code of Ethics, and Documentation Guideline.
- TOA should be clearly documented in the patient's chart.
- If a healthcare provider refuses to engage in or acknowledge information during TOA, this must be documented, and the employer notified.

RECOMMENDED WORKPLACE PRACTICES

- Standardize practice and implement a strategy for collecting, documenting, and sharing information at care transitions. This can be done through policy, and implementation of working groups to review existing standards, challenges, and areas for improvement.
- Develop and implement tools and processes to ensure the complete transfer of standardized information during care transitions. (e.g., Shift Report Checklist posted at computer workstations, break rooms, etc.).
- Standardize orientation processes for all new employees and develop a method for identifying training needs in existing employees. Consider different learning styles when providing training (e.g.: giving information, modelling behaviour, providing feedback, and practicing skills). Emphasize that conducting shift reports can improve quality and safety.
- Maintain updated contact information for areas/facilities where TOA regularly occurs.

SPECIAL CONSIDERATIONS

- Unanticipated transfer - consider whether all relevant information is documented and initiate TOA communication to the receiving HCP as soon as possible.

- Documentation - Following information transfer, the transferring HCP hands over the patient's care, and the accepting HCP must sign the patient's health care record to complete the information transfer process.
- High risk care areas: The importance of effective information communication in intensive care units (ICUs) is twofold because ICU patients usually cannot participate in TOA activities and are very vulnerable to medical errors.
- Ensure privacy and confidentiality - Be cautious of to whom and where you provide personal health information about your patient(s). It is inappropriate to share information in an area not designed for TOA, such as hallways, crowded open areas, and/or in the presence of other patients, family, and healthcare providers other than those who legally need access to such information.

RELATED DOCUMENTS:

• NSCRT Standards of Practice Standards of Practice - Nova Scotia College of Respiratory Therapists (nscrt.com)

• NSCRT Code of Ethical and Professional Conduct
CODE_OF_ETHICAL_AND_PROFESSIONAL_CONDUCT.pdf (nscrt.com)

• NSCRT Documentation Guideline
https://www.nscrt.com/images/202002_Documentation_Guideline.pdf

• NSCRT Orientation Guideline Nova Scotia College of Respiratory Therapists (nscrt.com)

• Personal Health Information Act (PHIA) of Nova Scotia Personal Health Information Act | novascotia.ca

RESOURCES:

Alberta College of Paramedics. (2021). *Standards of Practice*. Standards of Practice (abparamedics.com)

Canadian Medical Protective Association (CMPA). (2021). *Transitions in Care: Handing over patient information to deliver safe care*. CMPA - Physician-Team | Transitions in care | CMPA Good practices (cmpa-acpm.ca)

College of Physicians and Surgeons of Nova Scotia. (2016). *Transfer of Care - Professional Standards Regarding Transfer of Care*. Transfer of Care - Standards & Guidelines College of Physicians &Surgeons of Nova Scotia (cpsns.ns.ca)

College of Respiratory Therapists of Ontario. (2014). *Transfer of Accountability Practice FAQs.* FAQ.Mar.2014.pdf (crto.on.ca)

HIPAA Journal. (n.d.). Communication Tools in Nursing. Retrieved October 1, 2023, from Communication Tools in Nursing (hipaajournal.com)

Nova Scotia Health. (2022). *Information Transfer at Care Transitions*. Information Transfer at Care Transitions - Policy - NSHA CL-SR-015 (nshealth.ca)

Registered Nurses' Association of Ontario. (2023). *Transitions in Care and Services Second Edition.* Transitions in Care and Services | RNAO.ca

IWK Health. (2023). *Clinical Handover: Information Transfer at Care Transitions*. TITLE: Policy Title (nshealth.ca)

Accreditation Canada 2020. Required Organizational Practices. Handbook 2020