Team Name: Information Transfer Working Group Team Lead: Executive Director - West Approved by: Executive Director - West	Reference Number: CLI.4110.PL.010 Program Area: Across Care Areas Policy Section: General
Issue Date: June 20, 2018 Review Date: Revision Date: March 20, 2020	Subject: Information Transfer at Care Transition

Use of pre-printed documents: Users are to refer to the electronic version of this document located on the Southern Health-Santé Sud Health Provider Site to ensure the most current document is consulted.

POLICY SUBJECT:
Information Transfer at Care Transition

PURPOSE:
The purpose of this policy is outline minimal requirements for information transfer at care transitions within clinical programs to support client safety and continuity of care.

BOARD POLICY REFERENCE:
Executive Limitations (EL-01) Global Executive Restraint & Risk Management
Executive Limitations (EL-02) Treatment of clients

POLICY:
Each program's Information Transfer at Care Transition policy outlines processes specific to the Program's and client's needs. Standardized documentation tools and processes for information transfer at care transitions are utilized within each respective program.

In compliance with the Brian Sinclair inquest recommendation #1, communicating that a client is under a Committeeship, such as Public Guardian and Trustee of Manitoba, must be highlighted within Information Transfer at Care Transition between all program areas, service and health providers, including Fee for Service Physicians. This includes flagging the client's health record and communicating Committeeship in recognition of the risks inherent for the client's vulnerability and the complexities within the health system and a shared responsibility for ensuring safe care for the client. See Policy Public Guardian and Trustee of Manitoba Committeeship (CLI.4110.PL.020).

Providers derive knowledge from scientific sources and professional experiences. The culmination of knowledge gained from these sources results in a provider's foresight, intuition

and gut sense that guides continued critical thinking and decision-making around what to be worried about, what could go wrong, and what to look out for. This is a critical component within Information Transfer at Care Transition.

The SBAR-Clinical (CLI.4110.PL.010.FORM.01) is a tool that asks for articulating the situation, background, assessment and recommendations to capture critical and relevant information as a standardized approach for information transfer at care transition. The SBAR clinical may be used to support information transfer by communicating pertinent verbal or written information within a standardized approach. Programs are provided the opportunity to tailor the SBAR-Clinical with prompts or triggers that serve to ensure that communication of information includes minimally required information within the assessment section however information is not to be removed from the standardized SBAR-Clinical. i.e. adding "'Fetal Heart Rate ___" to the obstetrical SBAR-Clinical within the assessment section.

Documented Information Transfer at Care Transition involving admission, transfer or discharge to other units, program or services is required and included as a component of the health record.

Clients and families are supported during care transitions by being provided information that they need to support and be involved in their care.

Information shared aligns with the Personal Health Information Act and Southern Health-Santé Sud Policies and Procedures.

Programs conduct regular audits, at minimum bi-annuallly, retrospective or observational

DEFINITIONS:

Care transition: Any point in care when one care provider is transitioning care responsibility to another care provider e.g. admission, transfer, discharge and handover.

Client: Any individual recipient of healthcare services including patients and residents.

Handover: Information transfer from one provider to another provider assuming responsibility of care, within the same care location and includes but is not limitted to: transferring responsibility of care between shifts, or shorter periods of time such as breaks or change in care assignments.

Health Care Provider: All individuals who provide direct or indirect care as a result of their position and role in client care.

Information transfer: Communication at care transitions of pertinent information relevant to the care of the client to assist the receiving provider to immediately identify and prioritize ongoing care needs and monitoring requirements.

SBAR: acronym for Situation, Background, Assessment, Recommendation(s). A tool to organize pertinent findings, verbally or in writing to support Information Transfer at Care Transition, referral or consultation with another health care provider ie: nurse to physician.

IMPORTANT POINTS TO CONSIDER:

- Information Transfer supports safe care by providing information reflective of critical inquiry, emphasizing critical thinking and clinical judgment, informed by the condition and care needs of the client.
- Information Transfer includes involving and informing the client, family and/or designate in care and providing them information that they need to support and guide their care.

PROCEDURE

Refer to the program specific Policies or Standard Guidelines for respective processes:

Acute Care

- Information Transfer at Care Transition–Acute Care (CLI.4510.PL.005)

Emergency Medical Services

- Information Transfer at Care Transition-Emergency Medical Services (CLI.5310.PL.016)

Home Care

- Information Transfer at Care Transition–Home Care (CLI.5415.PL.001)

Interfacility Transfer

- Information Transfer at Care Transtition-Interfacillity Transfer (CLI.4110.PL.007)

Mental Health

- Information Transfer at Care Transition–Mental Health (CLI.5610.PL.003)

Obstetrics

- Routine Care of the Labouring Patient (CLI.5810.SG.003)

Personal Care Home

- Information Transfer at Care Transition–Personal Care Home (CLI.6410.PL.003)

Primary Care

- Information Transfer in Primary Health Care (CLI.6110.PL.001

SUPPORTING DOCUMENTS:

CLI.4110.PL.010.FORM.01 SBAR–Clinical

REFERENCES:

CLI.4510.PL.005	Information Transfer at Care Transition–Acute Care
CLI.5310.PL.016	Information Transfer at Care Transition–Emergency Medical Services
CLI.5415.PL.001	Information Transfer at Care Transition–Home Care
CLI.5610.PL.003	Information Transfer at Care Transition–Mental Health
CLI.5810.SG.003	Routine Care of the Labouring Patient
CLI.6410.PL.003	Information Transfer at Care Transition–Personal Care Home
CLI.6110.PL.001	Information Transfer at Care Transition–Primary Health Care
CLI.4110.PL.007	Information Transfer at Care Transition–Interfacility Transfer
CLI.4110.PL.020	Public Guardian and Trustee of Manitoba Committeeship