ACCREDITATION

Required Organizational Practice (ROP) of the Month

INFORMATION TRANSFER AT CARE TRANSITIONS

- The **Information Transfer at Care Transitions** is a **Required Organizational Practice (ROP)** that states information relevant to the care of the patient, client, or resident is **communicated effectively during care transitions**.
- Care transitions include when a patient, client, or resident experiences a change in team or location, such as **admission, handover, transfer, or discharge.**
- Effective communication must include an accurate and timely exchange of information that minimizes misunderstanding.

AT HEALTH PEI:

- **SBAR (*Situation, Background, Assessment, Recommendation*)** is a widely accepted communication tool for sharing information during care transitions.
- The information shared varies by transition, but at minimum, typically includes the patient, client, or residents' full name and identifiers, contact information for responsible providers, reason for transition, safety concerns, and goals.
- Additional relevant information may include allergies, medications, diagnoses, test results, procedures, and advance care directives.
- During care transitions, patients, clients, residents and their partners-in-care receive the information necessary to make informed decisions about their care.
- Information shared at care transitions must be documented.
- It is recommended for programs/areas to complete audits of the information shared at care transitions, to identify strengths and areas for improvement.

Questions Surveyors May Ask Staff:

What tools or strategies do you use to ensure timely and accurate transfer of information at care transitions?

Where do you document the information shared at care transitions?

How are patients, clients, residents and partners-in-care involved in sharing information at care transitions?

How does your area evaluate the information being shared at care transitions?

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