



PC.36.1.4 Urgency of consultation (24 hours for routine inpatient consults and one hour or less for emergency cases).

PC.36.1.5 Case summary.

PC.36.1.6 Rationale for consultation.

PC.36.2 The consulted physician indicates in writing:

PC.36.2.1 Date and time of consultation visit.

PC.36.2.2 Name and designation.

PC.36.2.3 Opinion and recommendations, including the need to transfer the patient under his name.

PC.36.3 The consulting physician approves and follows up the implementation of the plan of care as set by the consulted physician.

Standard Intent:

Patients who need opinion from another specialty, hospital must design an effective consultation process with a well design consultation request form that must be clearly and timely completed by both the consulting and the consulted physicians and include and name and time, the urgency of consultation, case summary, rationale for consultation and the opinion and recommendation and the need for transfer the patient under his care.

PC.37 Policy and procedure guides the transfer of patients between hospital units.

PC.37.1 The most responsible physician assesses the need for transfer and matches the condition of the patient with admission criteria of the unit.

PC.37.2 Verbal or written agreement as received from the receiving unit is documented in the patient's medical record, including the name of the receiving physician.

PC.37.3 The most responsible physician assesses the transfer requirements, both staff and equipment.

PC.37.4 Summary of the patient medical and nursing assessment findings including reason for transfer, diagnoses, clinical findings, and current medications is available in the patient's medical record before transfer.

PC.37.5 The physician and the nurse at the receiving unit assess the patient at arrival to ensure safe and smooth handover.

Standard Intent:

As patients move through the hospital from departments and services to another, many different health care practitioners may be involved in providing care. The continuity of care is enhanced when all patient-care providers have the information needed from the patient's current and past medical experiences to help in decision making. When multiple decision makers are providing care, the decision makers agree on the care and services to be provided. Indeed, hospital must develop a process of communication to facilitate smooth handover of patient care between hospital units. Both medical and

nursing staff must receive the patient from the transferring unit and re-assess the patient to ensure safe and smooth handover.

PC.38 The hospital has an efficient discharge process.

- PC.38.1 The patient and the family are involved in the discharge process with clear follow up instructions.
 - PC.38.2 Discharge is based on the patient's condition and relevant policies or criteria.
 - PC.38.3 Patients' needs after discharge are assessed as early in the care process as possible.
 - PC.38.4 The discharge process identifies the post-service needs and supports continuity of care after discharge.
 - PC.38.5 The post-service needs are communicated to relevant staff members.
 - PC.38.6 Staff members ensure coordination with various departments involved in the discharge process.
 - PC.38.7 Whenever required, staff members ensure coordination with outside organizations and post-service providers as appropriate to the patient's needs.
 - PC.38.8 Staff members ensure that all patients' needs are met prior to discharge.
 - PC.38.9 Policies and procedures guide the transfer of patients to other organizations.
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Standard Intent:

Discharging a patient to a health care practitioner outside the hospital, another care setting, home, or family is based on the patient's health status and need for continuing care or services. The patient's physician or individual responsible for his or her care must determine readiness for discharge based on the policies and relevant criteria or indications of referral and discharge established by the hospital. Criteria may also be used to indicate when a patient is ready for discharge. Continuing needs may mean referral to a medical specialist, rehabilitation therapist, or even preventive health needs coordinated in the home by the family. An organized process is required to ensure that any continuing needs are met by appropriate health care practitioners or outside organizations. The process includes referring patients to sources of care outside the region when required. When indicated, the hospital begins to plan for the continuing needs as early in the care process as possible. The family is included in the discharge planning process as appropriate to the patient and his or her needs.

PC.39 The hospital has a safe and efficient process for initiating transfer to other organizations.

- PC.39.1 Policy and procedure guides the transfer of patients to other organizations.
- PC.39.2 Transfer is based on the patient's health needs for continuing care and the resources available for both referring and receiving organizations.
- PC.39.3 The most responsible physician determines the need for transfer, the most suitable time for transfer, resources required during transfer, and whether the receiving organization can meet the patient's health and supportive needs.
- PC.39.4 There are written transfer criteria for staff to follow.