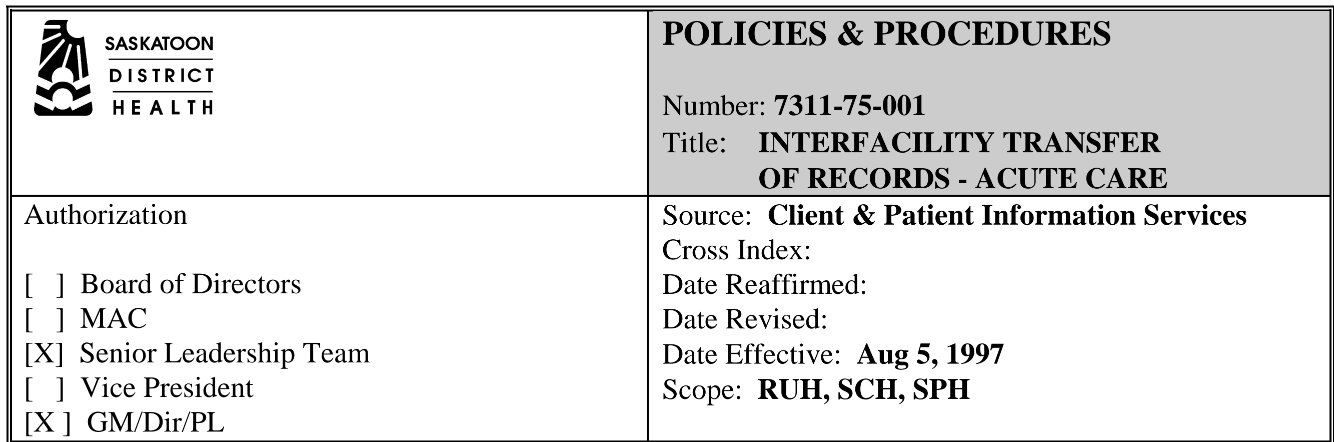

SASKATOON DISTRICT HEALTH	**POLICIES & PROCEDURES** Number: **7311-75-001** Title: **INTERFACILITY TRANSFER OF RECORDS - ACUTE CARE**
Authorization [ ] Board of Directors [ ] MAC [X] Senior Leadership Team [ ] Vice President [X] GM/Dir/PL	Source: **Client & Patient Information Services** Cross Index: Date Reaffirmed: Date Revised: Date Effective: **Aug 5, 1997** Scope: **RUH, SCH, SPH**

1. POLICY

1.1 Upon transfer of a patient between SCH, RUH or SPH pertinent information regarding the patient's current episode of care shall accompany the patient.

1.2 Original documents shall be sent to another acute care site only when it is not possible or practical to make photocopies of the records.

1.3 Only original documents of the current episode of care are to be sent. Original historical records will remain on site. Copies of historical records are available as required for continuity of care.

1.4 The Health Record division will monitor the movement of these records; returning the appropriate documents to the originating acute care site.

2. PURPOSE

2.1 To allow information pertinent to the patient visit be available for services or continuing care at another acute care site.

2.2 To reduce duplication of documentation and diagnostic investigations for a continuing episode of care.

2.3 To continue to fall within legal framework of *The Hospital Standards Act* and affiliate agreements for maintenance and custodial responsibilities of patient record.

3. PROCEDURE

3.1. Sending Site:

3.1.1 Documents in the Nursing Progress Notes that the chart is being sent with the patient.

3.1.2 Place the records in a sealed envelope; clearly mark the envelope with the patient's name.

3.1.3 Deliver the envelope to the receiving nursing station or instruct attendants to do so if using ambulance or Tri-Hospital Patient Transfer Services.

3.1.4 Depending on the site, enter the appropriate discharge code in the ADT system or relay information to Patient Registration/Admitting.

3.1.5 Follow the same procedure if the patient is subsequently transferred to a third SDH acute care site without being discharged home.

3.2. Receiving Site: Nursing

3.2.1 Keep the sending site's record in a secure area in the nursing station.

3.2.2 Do not write on sending site's documents. The history & physical and nursing database do not need to be repeated and can be copied from sending site documents.

3.2.3 Upon discharge of the patient, included the sending site record with the current chart.

3.3 Health Records

3.3.1 Log and track the movement of patient records. Ensure that any entry errors in the ADT system are corrected.

3.3.2 Upon discharge or upon request from the sending site, return records and documents in a sealed envelope via Tri-Hospital Courier; use Priority Post in Emergency situations.

3.3.3 On a regular basis, review the log of records that have not been returned; identify those that were sent more than one week ago. Contact Health Records at the receiving site and arrange to have the charts returned.