BryanLGH MEDICAL CENTER
PROCEDURE

TRANSPORTING PATIENTS WITHIN THE MEDICAL CENTER

PC.A.66

Date Originated: September 17, 2001
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PURPOSE

To establish care guidelines and provide comparable care for all patients being transported within each site of the Medical Center, e.g., between nursing units, between nursing units and other hospital departments.

INTRODUCTION

I. This procedure applies to all patients in the Medical Center.
II. This procedure does not include transportation between East and West Campus sites. Refer to procedure, #PC.A.141, Transfer of Patients Between BryanLGH East and West Sites.

SCOPE

I. All patient care staff is responsible for adhering to guidelines in this procedure.
II. An RN will assess and determine the transport needs of the patient.

EQUIPMENT/SUPPLIES/RESOURCES

I. Medical Center Procedure, #PC.A.141, Transfer of Patients Between BryanLGH East and West Sites
II. Medical Center Procedure, #PC.A.140, Report
III. Medical Center Procedure, #PC.A.124, Cardiac Monitoring
IV. Medical Center Procedure, # PC.A.191A, Oxygen Therapy, Addendum A – “Transporting Patients Receiving Continuous Oxygen or Ventilatory Support – In House” (of the Oxygen Therapy procedure, PC.A.191)
V. Medical Center Procedure, #PC.A.53, Suicide Prevention
VI. Medical Center Procedure, #RI.A.17, Elopement Precaution (Unauthorized Departure)
VII. Medical Center Procedure, #PC.A.145, Identification of Patient
IX. Patient Sign Out Sheet (Form #784)
X. Ticket to Ride Form #M47
XI. Ticket to Ride Rehab Form #M96
XII. Instructions for Completing Ticket to Ride Form – Addendum A
XIII. Sample Ticket to Ride Form M47 Completion – Addendum B

STEPS

I. RN will assess the patient to determine transport needs and appropriate transportation.

II. At time of transport, RN will verify the original order requisition to assure appropriate transport needs. Changes in oxygenation or pressure will warrant licensed nurse or LRCP to accompany.

III. Ticket to Ride (Form #M47) will be utilized any time a patient leaves the unit for a procedure or test.
   A. Exception: Ticket to Ride Rehab Form #M96 will be utilized any time patient leaves the Rehab unit for a procedure or test.
   B. See Addendum A for instructions on completing the ticket to ride form.

IV. Refer to procedure, #PC.A.124, Cardiac Monitoring, as needed.

V. Refer to Addendum A of the procedure, Oxygen Therapy, #PC.A.191 “Transporting Patients Receiving Continuous Oxygen Or Ventilatory Support In-House”, as needed (Addendum A is located in the Oxygen Therapy procedure, PC.A.191).

VI. Refer to procedure, #PC.A.53, Suicide Prevention, as needed.

VII. Refer to procedure, #RI.A.17, Elopement Precaution (Unauthorized Departure), as needed.

VIII. Transport Guidelines:
   A. **The process for transport of a patient with oxygen is the licensed nurse or licensed respiratory care practitioner (LRCP) will disconnect the oxygen from the wall and reconnect to the portable cylinder.** Any person may then wheel/push the patient to the area of testing. When the patient is in the testing area, they should remain on the portable cylinder. The person in charge of the test should monitor the psi on the cylinder. When it reads 500 psi, the person doing the test should make a call to the nursing contact person to arrange for cylinder change. In situations where the procedure may last longer than amount of gas in the cylinder, a licensed nurse or LRCP must transition from cylinder to wall source.

   **Note:** If a patient safety concern or change in condition is assessed concerning transport of the patient, the concern should be addressed before transport. Notify the charge person, Manager or Administrative Supervisor to assist, if needed.

   B. **Minimal Care:**
      1. Can be transported by a RN, LPN, Respiratory Therapist, transporter, technologist, or volunteer.
2. Indicates that the patient requires minimal attention to their needs while in transport. Patient may be on home oxygen. No acute changes in mental status in last 24 hours. No increase in oxygen needs in past 8 hours.
3. Patients are at low risk for injury or deterioration of condition.
4. There may be tubes, intravenous infusions, etc., in place that require no intervention while off the unit.
5. Patient is not an identified suicide or elopement risk.
6. If patient is on telemetry monitoring, CMU must be alerted that the patient is off the unit and the patient’s destination.
7. If a continuous pulse oximeter is in place, the transporter must be a licensed nurse and/or Respiratory Therapist.

C. Moderate Care: (Progressive or General Care)
1. Indicates the patient requires moderate care from the person transporting the patient while patient is off the unit.
2. Can be transported by a RN, LPN, or LRCP. If patient requires moderate care transporting by RN or LPN, nurse-to-nurse report is required prior to leaving patient.
3. Patient has a moderate risk for injury or deterioration of condition during transport.
4. There may be tubes, intravenous infusions, etc., in place that require close observation or possible interventions while off the unit. Patient may be on cardio/vaso-active drips requiring titration, if titration is not increasing.
5. If patient is on telemetry monitoring, CMU must be alerted that the patient is off the unit and the patient’s destination. (CMU cannot monitor in MRI).
6. If a portable cardiac monitor is in place, the transporter must be a RN with appropriate competencies.
7. If a continuous pulse oximeter is in place, the transporter must be a RN and/or Respiratory Therapist.

D. Maximum Care: (PCU/ICU status)
1. Indicates the patient has a high risk for injury or deterioration in condition during transport.
2. When defined as Maximum Care, must be transported by a PCU/ICU/PACU RN, Invasive Cardiology RN, anesthesia provider, or PALS trained RN for the pediatric patient (16 years of age or younger), or a NRP RN for neonatal patients. A Respiratory Therapist must accompany all invasive or non-invasive mechanically ventilated patients on transports unless the patient is already accompanied by an anesthesia provider. A Respiratory Therapist must accompany all neonates on Comfort Flow™ and adults on high oxygen flows.
3. An ICU/PCU/PACU RN or anesthesia provider and Respiratory Therapist will be responsible for transport of invasive mechanical ventilation patients and will determine, based on patient needs,
whether both the RN and the Respiratory Therapist must stay with patient to monitor patient in the ancillary department. Therapists must assure stability on vent prior to leaving the patient in the area.

4. If a portable cardiac monitor is in place, the transporter must be an RN with appropriate competencies.

5. If a continuous pulse oximeter is in place, the transporter must be an RN and/or Respiratory Therapist.

E. Patients with 1:1 Supervision: (including Mental Health Services patients)
1. Includes patients requiring direct observation.
2. The staff member (may be MH tech) assigned to provide continuous observation of the high risk Mental Health patient (suicide precautions or high risk for elopement) will accompany the high risk Mental Health patient and continue to provide continuous observation while the patient is away from the Mental Health unit.
   a. On other inpatient areas, staff member (may be nursing tech) assigned 1:1 observation care will accompany the patient.

F. Mental Health Services
1. The patient not identified suicide or elopement risk will be considered minimal care. Can be transported by RN, LPN, technician, transporter or volunteer.
2. Patient is at low to moderate risk for suicide (Suicide Observation in place) or elopement (Elopement Precautions in place) can be transported by RN, LPN, technician or transporter.
   a. The patients' precaution level will be noted in the comment section of the requisition
   b. The RN assigned to the patient will notify the transporter to stay with the patient continuously until that responsibility can be turned over to the staff in the department where the patient is going who will then assume care for the patient.
   c. Report will be called to the testing/treatment areas staff and recorded in the CARE notes.
   d. The testing/treatment area will document that continuous observation was provided in the progress notes of the patient’s chart and will instruct the transporter taking the patient back to the unit to stay with the patient continuously.

3. Patients at high risk for suicide or elopement see step VII.E.

VIII. Interdepartmental Communication (Hand-Off Communication):
A. Report Guidelines:
1. Refer to procedure, #PC.A.140, Report.
2. Refer to procedure, Identification of Patient, PC.A.145.
3. The primary care RN or designee will provide a patient report to the receiving staff/RN, if a possible intervention(s) is required while off the unit.
4. All patients are to be transported with chart and contents of clipboard which is divided for easy reference in the front of the
chart.

a. Contents of the clipboard include:
   1) MAR
   2) Anticoagulant Record
   3) Pain Flow Record
   4) Diabetic Worksheet
   5) Nursing Care Flow Record(s)
   6) Any other pertinent documentation

5. Transporters will collaborate with the primary care nurse to ensure a safe transport as follows:
   a. Upon arriving on the unit, the transporter will present the Ticket to Ride with date and procedure to be completed. Patient sticker is applied in unit. Transporter will collaborate with RN with “Ticket to Ride” information. “Ticket to Ride” will be a part of the permanent record and be filed under Patient Care Notes section of the medical record.
   b. All transport personnel will sign the patient off/on the unit using the Patient Sign Out Sheet (Form #784).
   c. Patient identification should be completed per procedure #PC.A.145, Identification of Patient.
   d. Nurses, Respiratory Therapists or RT/RN students under supervision will connect or disconnect oxygen from source or change liter flow on oxygen tanks.

6. Recheck connections and trace all patient tubes and catheters to their sources upon patient’s arrival to a new setting or service as part of the hand-off process.

IX. Telemetry Guidelines:
A. To ensure a seamless, safe system for transport and comparable care for the telemetry patient, all Central Monitoring Unit operational guidelines must be followed. Refer to procedure, PC.A.124, Cardiac Monitoring.
   1. When a patient on Telemetry is transported to another area for test or treatment, the primary care RN must call the Central Monitoring Unit (CMU) to give the CMU information as to which area the patient is being transported.
   2. On return of patient from transport off the unit, the primary care RN must call the CMU to report that the patient is back on the unit.

B. Transfer of patient to a different patient care area.
   1. When a patient is being transferred to a different patient care area within the Medical Center, it is the responsibility of the RN receiving the patient to make sure the monitoring equipment is at the bedside to ensure continuous cardiac monitoring.
   2. It is the responsibility of the transferring RN to ensure the cardiac telemetry monitor is placed on the patient and working properly through communication with the Central Monitoring Unit before leaving the area.

X. Emergency Transport

Procedure # PC.A.66
A. In the case of emergency transport (e.g., cardiac alert) the completion of the ticket to ride may be bypassed when the safety of the patient may be compromised with the delay. The form should note Emergency Transport occurred.

REFERENCES

Briefings on JCAHO. October 2005. Four tips to meet JCAHO hand off goal. pgs 9 -10.
Joint Commission National Patient Safety Goals.
Meghan Dierks, MD, MS. Patient handoff must be more than a formality. Handoff information should cover past, future. Health Risk Management, August 2005. pgs 93-94.

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KEYWORDS

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SIGNATURES (Signature Sheet on File)

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