NSHA Interdisciplinary Clinical
IWK Clinical
POLICY

Title:	Admission, Transfer and Discharge by Nurse Practitioners	Number:	**NSHA** CL-AP-075 **IWK** 634
Sponsor:	**NSHA** Senior Director, Interprofessional Practice and Learning **IWK** Director, Interprofessional Practice and Learning	Page:	1 of 6
Approved by:	**NSHA** VP Research, Innovation and Discovery, Chief Nurse Executive **IWK** Policy and Practice Committee	Approval Date: Effective Date:	January 9, 2024 January 23, 2024
Applies to:	Nurse Practitioners (NPs)		

PURPOSE

This policy supports the process of patient admission, transfer, and discharge by nurse practitioners (NPs) within hospitals, long term care (LTC), and other community health care settings within Nova Scotia.

Note: This policy supersedes any former District Health Authority policy that outlines the process of patient admission, transfer and/or discharge as being completed only by physicians.

POLICY STATEMENTS

1. To implement NP admitting, and to create a pro-active role integration and transition to practice plan, each site/care team lead must consult/collaborate with the:
   - Interprofessional Practice and Learning (IPPL)-NP team at Nova Scotia Health, or
   - Director of Interprofessional Practice and Learning at IWK
2. The NP is authorized to admit patients to a hospital setting when **confirmed** to be within the NP's scope of employment.
3. The NP must practice:
   - In alignment with the Nurse Practitioner Standards of Practice.

- In alignment with the Nurse Practitioner Client Admission and Discharge from Hospital Settings Guideline.
- In collaboration with the patient, Essential Care Partners, and the interdisciplinary team.

4. The NP is authorized to admit patients to hospitals, long term care (LTC), and other community health care settings within Nova Scotia:
   - To a service, team, or a specific physician/NP who accepts the accountability as most responsible health care provider (MRHCP), or
   - To serve as MRHCP.

   4.1. The admitting NP is accountable to write admission and treatment orders prior to, or at the time of admission.

5. The NP is authorized to transfer, accept transfer of, or discharge patients:
   - As MRHCP in hospitals, LTC and other community health care settings, or
   - With the authorization of the MRHCP.

NP as MRHCP

6. The NP must be:
   - Clearly identified in the patient's health care record as MRHCP.
   - Following acceptance of the patient from the transferring MRHCP/Designate, notified of all patients for whom they are accountable, regardless of patient location.
7. The NP must ensure that the patient is assessed within 24 hours of admission or accepting transfer of the patient, and thereafter as per facility/unit-specific procedure unless the patient's condition warrants assessment sooner.
8. The NP has the ultimate responsibility to:
   - Prescribe medication and treatments,
   - Monitor health status and treatment outcomes,
   - Order, interpret and follow up diagnostic tests,
   - Collaborate with members of the interprofessional care team (as appropriate),
   - Consult with, or Refer to the most appropriate health care professional when the patient's health care needs extend beyond the NP's Individual or regulated scope of practice, and
   - Support team-based care and discharge planning.
9. The NP is accountable for the patient's care until they arrange transfer of care or arrange coverage in consultation with another MRHCP/Designate, service, and/or manager.
10. The NP/NP manager must develop, in consultation with the physician/NP team members, a plan for coverage for scheduled and unexpected NP absences.

Transfer of Care

11. When an in-patient transfer of care is deemed appropriate by the MRHCP:
    - The NP must confirm and document the service/MRHCP acceptance of the transfer on the patient's health record.
      - □ This information may be documented in the transfer orders.
    - The NP transferring the patient must write transfer orders.
12. When acceptance of an in-patient transfer is deemed appropriate by the MRHCP, the NP must ensure transfer orders are continued or modified as needed, within the following timeframes:
    - Acute care: Within 24 hours or per facility/unit-specific procedure.
    - LTC and other community health care settings: As per facility/unit-specific procedure.

Discharge

13. When an in-patient discharge is deemed appropriate by the MRHCP, the NP discharging the patient is accountable to complete a discharge summary in the patient's health record noting:
    - The patient's health status at discharge, and
    - The follow up plan.

REFERENCES

Barron, A. & White, P. A. (2009). Consultation. In A. Hamric, J. Spross, & C. Hanson (Eds.). *Advanced practice nursing: An integrative approach* (pp. 191-216). St. Louis: Saunders Elsevier

Healthcare Excellence Canada. (2021). *Policy guidance for the reintegration of caregivers as essential care partners. Executive summary and report*. https://www.healthcareexcellence.ca/media/4btksgep/202110_policyguidance_en.pdf

Nova Scotia College of Nursing. (2019). *Nurse practitioner standards of practice*. https://cdn3.nscn.ca/sites/default/files/documents/resources/NP_Standards_of_Practice.pdf

Nova Scotia College of Nursing. (2022). *Nurse practitioner client admission and discharge from hospital settings. Practice guideline.* https://cdn3.nscn.ca/sites/default/files/documents/resources/NP_Client_Admission_Discharge_Hospital.pdf

RELATED DOCUMENTS

Policies

Information Transfer at Care Transitions - CL-SR-015

Clinical Handover: Information Transfer at Care Transitions – IWK 770

Minimum Documentation Standards for Health Care Providers – IWK 1003.0

Other

Documentation for Nurses

Appendices

Appendix A: Definitions

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Collaboration	Working together with one or more members of the health care team, each of whom makes a unique contribution toward achieving a common goal. Collaboration requires effective communication among members of the health care team and a clear understanding of the roles of the individuals involved.
Consult/Consultation	A request for advice on the care of the patient from another health professional. The consultant may or may not see the patient directly. The responsibility for clinical outcomes remains with the consultee who is free to accept or reject the advice of the consultant.
Designate	A health care provider authorized by licensure/scope to accept accountability for aspects of care designated by the MRHCP
Essential Care Partner	Essential Care Partners provide physical, psychological and emotional support, as deemed important by the patient. This care can include support in decision making, care coordination and continuity of care. Essential Care Partners are chosen by the patient or Delegate/Substitute Decision Maker (SDM). This person might be a patient's family member, extended family, partner, friend, advocate, guardian, and other people in the patient's support network. Each patient or Delegate/Substitute Decision Maker has the right to choose who is an Essential Care Partner and can change this choice at any time.
Most Responsible Health Care Provider (MRHCP)	The physician or nurse practitioner who has responsibility for directing and coordinating the care and management of an individual patient at a specific point in time.
Refer/Referral	An explicit request for another health professional/service to become involved in the care of a patient. Accountability for clinical outcomes is negotiated between the health professionals involved. .

POLICIES BEING REPLACED

NSHA CL-AP-002 Nurse Practitioner Discharge

VERSION HISTORY

Version:	Effective:	Approved by:	What's changed:
Original	2024-01-23	**NSHA** VP Research, Innovation and Discovery and Chief Nurse Executive **IWK** Policy and Practice Committee	N/A