Transfer of Care Between Agencies

POLICY

THE RULE

1. Medical Control comes from the receiving hospital whenever possible; if contact fails or the destination is unclear, Mercy Hospital ED — Springfield is the default
2. On scene, Medical Control authority rests with the Mercy paramedic on the responding ambulance (or the paramedic who assumes Medical Operations on multi-unit responses)
3. Care is never transferred without a face-to-face verbal report: history, current status, and treatments provided
4. Documentation transfers with the patient — EKGs, blood drawn for lab, patient information
5. On long transfers, if the patient deteriorates: divert to the closest appropriate hospital, establish Medical Control there, and update the original destination as soon as possible

WHY IT EXISTS

Policy 2-9 defines one flow for Medical Control and hand-off, so a patient is never 'between' providers with nobody owning their care

APPLIES WHEN

- Air ambulance: Mercy crews keep responsibility for the patient until the face-to-face report to the flight crew, and work together through the transition
- Transfer to another ground unit, including mechanical breakdown: face-to-face report, all information related — and when possible, the paramedic who started care rides in
- Multiple patient incidents: Mercy continues care until an incoming ambulance can accept it, with a full face-to-face report first

EXCEPTIONS & EDGE CASES

- Interfacility transfers: if the transferring physician arranged a specific destination, contact that physician or the receiving physician before diverting anywhere else

DOCUMENT IT

- Chart who received the patient, the report given, and the documentation transferred
- Record any diversion and when the original destination was updated

Take Home Message:

Care transfers face-to-face or it doesn't transfer: report, documents, and a named provider accepting the patient, every time.