Table 18.
Analysis of Unplanned Hospital Transfers

Category Aspect of Care	**Avoidable**	**Possibly Avoidable**	**Unavoidable**
Recognition	• Examination and review by a nurse and/or practitioner was inadequate. • Patient had a condition or problem that was known or could have been anticipated. • Patient's condition was not significantly unstable (i.e., beyond the identified capacity of the facility to monitor and manage). • Attending or covering practitioner was not notified of condition change in a timely fashion. • Monitoring equipment was unavailable or malfunctioning.	• Nursing or practitioner assessment was suboptimal. • Staffing issues hindered ability to adequately monitor a somewhat unstable patient. • Patient's condition was mildly unstable.	• Patient's condition was too complex or unstable to be adequately managed in the facility.
Assessment	• Problem was characterized incorrectly or inadequately (e.g., patient described as unresponsive was little different than usual; nature, intensity and other specific features of chest pain were not defined). • Diagnostics were available in a timely fashion but were not used. • Diagnostics should have been available when needed, but were not. • Patient's condition change reflected a known or readily identifiable problem that should have been diagnosed at the time it occurred.	• Some diagnostics were available but their use was delayed. • Cause could not be immediately identified, but the patient's condition was sufficiently stable that more time could have been taken to perform the evaluation at the facility. • It is unclear whether the patient's condition change was related to a problem that was known or could have been anticipated.	• It was not feasible for the facility to obtain relevant diagnostics. • Symptoms were too obscure to be readily diagnosed or related to a known or potentially identifiable cause.
Treatment	• A condition change had been identified but was not addressed in a timely fashion. • Aggressive medical treatment was not indicated for the patient. • An available treatment was not used. • Caregiving staff did not recognize that the patient's condition, although not fully resolved, was stable or improving.	• Patient was not responding rapidly to treatment, but treatment had only been initiated within the previous 24 hours. • Patient was sent to the ER or the hospital but sent back to the facility within 48 hours.	• Treatment was too complex to be managed internally. • Patient's condition was worsening despite several days of treatment in the facility.
Ethical issues	• Patient's condition and prognosis were not discussed adequately or in a timely fashion. • Practitioner did not discuss with patient or family in a timely fashion whether hospitalization was a potentially beneficial treatment option.	• There had been insufficient time, or the family had not been readily available, to discuss ethical issues.	• Hospitalization had been selected as a desired option in the event of a condition that was too severe or unstable to be readily managed within the facility.

Table 18 continued			
Ethical issues continued	• Advance directives or other care instructions that indicated the patient should not be transferred to the hospital were unavailable or overlooked. • Treatment in the hospital was similar to the treatment the patient could have received at the facility.	•	•
Family issues	• Family was not adequately informed of the patient's condition or prognosis or of the facility's capacity to manage certain condition changes without a hospital transfer.	• Family demanded hospital transfer despite efforts to explain why it was not necessary.	• Conflict among relevant substitute decision makers about scope and aggressiveness of medical treatment could not readily be resolved.
Practitioner issues	• An attending or covering practitioner failed to respond in a timely fashion to notification of a condition change. • Upon responding, the practitioner insisted on transfer before discussing the case adequately with a nurse. • Wrong practitioner was notified of the condition change. • Attending practitioner could not be reached or had insufficient backup coverage to respond.	• Practitioner was adequately informed about the patient's condition but remained unsure of the seriousness or cause(s) of the situation and therefore was unable to readily initiate empirical treatment.	• Practitioner identified significant medical concerns about the patient that were beyond the scope of the facility's capabilities or required a higher level of monitoring or more complex treatment that the facility could readily provide.
Miscellaneous Facility Issues	• Relevant policy or procedure was unavailable or available but not used. • A procedure was not followed correctly. • Appropriate supervisory staff were not consulted as they should have been. • Pertinent documentation (e.g., previous hospital discharge information, diagnoses, family consents) was not on the patient's chart, not available, or not reviewed. • Facility has not adequately identified the degree to which it can monitor and manage medically unstable patients.	• Relevant policy or procedure did not adequately cover the situation. • Appropriate supervisory staff were consulted but were not sure what to do. • Some necessary care might have exceeded the scope of the facility's capabilities, staffing, equipment, and supplies.	• Required care would have exceeded the scope of the facility's capabilities, staffing, equipment and supplies.

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