The Best Practice Guide to Action presents an overview of a transfer process developed by the Missouri Department of Health and Senior Services Long-Term Care Best Practice Coalition in collaboration with hospitals and long-term care centers to improve continuity of care. This collaboration resulted in the determination of the essential information needed to be communicated and the development of a process and tools to improve handoff communication when transfers occur between hospitals and LTC centers.

This guide presents an overview of the recommended process, as well as a summary of the benefits health care facilities can receive by implementing this process. A CD with sample forms and guidelines, and implementation and training resources also is included for facilities to use for adapting to their individual needs and requirements.

**CD Contents**

**TOOLS**
- LTC Model Transfer Form
- LTC Model Transfer Form Guideline
- Hospital to LTC Model Transfer Form
- Hospital to LTC Model Transfer Form Guideline
- Emergency Department Model Transfer Form
- Emergency Department Model Transfer Form Guideline

**IMPLEMENTATION RESOURCES**
- Implementation Guide
- Hospital Invitation to LTC Centers
- Measurement Tools
- Hospital Staff Education PowerPoint
- LTC Staff Education PowerPoint
- FAQs
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Overview & Recommendations
Overview & Recommendations

WHAT IS THE CONTINUITY OF CARE PROJECT?

The Continuity of Care Transfer Project is a process to communicate timely, accurate and complete information when transferring patients and residents to and from hospital emergency departments, nursing units and long-term care communities. Its aim is to improve the quality, safety and continuity of care transitions between these care settings.

The coalition recognized delayed or incomplete communication adversely affected the quality and continuity of care, contributed to adverse events and increased health care costs. The committee appointed a Hospital/LTC Transfer Workgroup to develop interfacility transfer policies and model forms. The workgroup, facilitated by the Missouri Hospital Association, reviewed current literature, standards and regulations; conducted provider surveys; developed a recommended best practice; and drafted model forms and guidelines.

A survey of hospitals and LTC centers demonstrated a lack of timely and adequate information and numerous problems with the transfer process. The survey also showed that both hospitals and LTC communities were highly supportive of developing standardized forms and processes.

The process and forms developed were pilot tested by Boone Hospital Center in Columbia, Fayette Caring Center, Lake Regional Health System in Osage Beach, Laurie Care Center, Moberly Nursing and Rehabilitation, Osage Beach Health Center, The Bluffs in Columbia and Windsor Estates in Camdenton. Results of the pilot were shared with the coalition, and necessary modifications were made to the process and forms.

In May, the coalition endorsed the transfer process and data elements contained within the model forms as a best practice. It recommends all hospitals and LTC centers adopt a policy and process to ensure that the identified, essential data are communicated in a timely and accurate manner to receiving facilities when transferring patients and residents.

“Inaccurate information can occur in many ways, often putting a patient’s health in serious danger.”
— Carolyn M. Clancy, M.D., Agency for Healthcare Research and Quality
WHY SHOULD OUR ORGANIZATION PARTICIPATE?

ALL FACILITIES will benefit by improving the efficiency and effectiveness of transfers. Potential benefits include the following.

- decreased medical errors
- decreased duplication of tests
- decreased cost of care because of better utilization of services
- decreased staff time and frustration
- decreased readmissions
- reconciled medications and care
- increased patient/resident satisfaction
- reduced patient/resident complaints and litigation

HOSPITALS, and especially their emergency departments, are frequently operating at capacity, resulting in increased diversions and a reduction in elective procedures. They have a financial incentive to facilitate efficient, quality transfers and avoid unnecessary admissions and readmissions from long-term care centers.

SKILLED NURSING CENTERS may find the process improves the accuracy of the minimum data set assessment, aids in supporting the need for skilled care and enhances care planning.

ASSISTED LIVING AND RESIDENTIAL CARE CENTERS will benefit from improved quality and continuity of care for their residents.

PHYSICIANS who see residents after their discharge from the hospital often are not involved with their care during hospitalization, and hospital records often are not readily available after discharge. Emergency physicians often see residents without knowing the resident’s baseline status. The coalition’s recommended process will provide physicians with timely, complete information to effectively diagnose, treat and improve resident outcomes.

JOINT COMMISSION ACCREDITED FACILITIES adopting this process will meet the following national patient safety goals.

Goal 2 — improve the effectiveness of communication among caregivers. This requires organizations to implement a standardized approach to “handoff” communication, including an opportunity to ask and answer questions.

Goal 8 — accurately and completely reconcile medications across the continuum of care. This requires organizations to communicate a complete list of the patient/resident’s medications to the next provider when a transfer occurs.

“Patients who were recently discharged from the hospital and whose follow-up physician received their hospital discharge summary by the first follow-up visit were 25% less likely to be readmitted to the hospital.”

— Journal of General Medicine, 2002
The coalition’s recommendations for all hospital and long-term care centers are as follows.

- incorporate the recommended data elements into the forms used for transfers between LTC centers and hospitals
- adopt the continuity of care transfer process
- use the forms consistently and follow the recommended process

During the transfer process, the coalition recommends the following procedures for all hospitals and LTC centers.

- complete the appropriate transfer form
- fax the form to the receiving facility
- send a copy of the form and recommended patient records with emergency medical services or the patient/resident
- call the receiving facility to give a verbal report
- communicate key information with receiving physicians

Because of facility variance in medical record requirements, the coalition is not suggesting that all hospitals and LTC communities adopt the model forms and guidelines as presented. Rather, the coalition recommends that all facilities do the following.

- use the model forms and guidelines as written
- modify them to meet your institutional needs
- modify your existing forms to include the data elements included in the model forms

”Poor communication — poor information transfer or transfer of poor information — can cause a serious breakdown in the continuity of care, inappropriate treatment and potential harm to the patient/resident. Not only are transitions of care a point of vulnerability for patients but also an opportunity for providers to detect and correct errors.”

— U.S. Department of Defense: Healthcare Communications Toolkit to Improve Transitions in Care
WHAT IS THE RECOMMENDED PROCESS?

LONG-TERM CARE CENTERS
1. The form should be completed whenever a resident is transferred to a hospital for emergency evaluation or planned admission. Whenever possible, complete the form before the transfer and send a copy with EMS personnel or family, if applicable. In an emergency, it may be necessary to complete the form after the resident has left the facility.
2. Send the documents listed on the transfer form with EMS personnel or fax them to the receiving facility.
3. After the resident has been transported, fax the form to the receiving facility. If you are unsure of the receiving hospital, instruct EMS personnel to call the nursing facility when the destination is known and then fax the report.
4. Call the receiving facility and give a nurse-to-nurse report.
5. Place a copy of the transfer form in the resident’s chart.
4. A copy of the form and the records should be placed in a large envelope and addressed to the post-acute care facility. This envelope should be given to the person, family or EMS transporting the patient, with instructions to give to the receiving facility.
5. Place the original copy of the form in the patient’s medical record.
6. The ED physician should communicate key information with the LTC physician.

EMERGENCY DEPARTMENTS
1. Complete the handoff communication form before discharge.
2. Before discharge, fax the form to the receiving facility.
3. Call the receiving facility to give a nurse-to-nurse report.
4. Place a copy of the form and the records should be placed in a large envelope and addressed to the post-acute care facility. This envelope should be given to the person, family or EMS transporting the patient, with instructions to give to the receiving facility.
7. If new prescriptions are ordered, fax to the nursing home before noon on the transfer day to ensure no interruptions in the patient’s prescriptions.
8. Place the original copy of the form in the patient’s medical record.
9. The attending physician should communicate key information with the LTC physician.

HOSPITALS
1. Page 1 may be completed before discharge. Page 2 should be completed the day of discharge.
2. Page 3 is optional and may be used in place of the physician discharge orders and summary form normally used at discharge.
3. If applicable, a copy of the completed Page 1 and medical records necessary for acceptance should be faxed to the receiving facility before planned discharge.
4. Before the transfer, fax the handoff communication forms to the receiving facility.
5. Call the receiving facility to give a nurse-to-nurse report.
6. Copies of the forms and other discharge documents should be placed in a large envelope and addressed to the post-acute care facility. This envelope should be given to
Getting Started: Hospital Resources
HOW DO WE GET STARTED?

It is crucial to have leadership support and to identify a facility champion who will lead this initiative.

It also is important to assemble a team of key players to successfully design and implement this process. Team members may include discharge planners, MDS coordinators, social workers, patient safety and quality improvement staff, nursing directors, nursing staff, physicians, marketing and communications staff, information technology experts and unit clerks.

HOSPITALS AND LONG-TERM CARE CENTERS

Administrators and nursing directors should do the following.
- develop a specific action plan with staff input for the facility
- clarify key stakeholders and approval process
- obtain support and approval from the organization
- assemble a multi-disciplinary team
- design/analyze current transfer processes
- develop an implementation plan and time line
- consider available resources
  - Is a copier accessible to staff 24/7?
  - Should forms be triplicate to eliminate need to copy?
  - Is a fax machine able to handle receiving and sending large volumes?
  - Do we need to order larger envelopes for copied records?
- adopt or modify model transfer form and guidelines
- establish specific goals and benchmarks, such as usage and completion of forms, hospital readmissions or ED revisits
- create education plan for staff
- review and modify staff education materials in toolkit
- educate all staff on all shifts, including physicians
- monitor benchmarks (see sample measurement tools)
- celebrate successes and share results
- revise forms, guidelines and process based upon results and staff input
- evaluate the need for additional education or follow-up with specific staff

CONNECTING WITH LTC PROVIDERS

- invite LTC centers and EMS in your service area to participate in a communitywide project to improve the transfer process
- ask them to identify a project champion and key team members at their facilities
- host meetings to establish and promote communitywide transfer standards
- execute a communitywide plan
- review, evaluate and revise
- celebrate and share successes

Long-Term Care Best Practice Coalition Vision
— “consistently and accurately provide health care workers with basic health information when long-term care residents are transferred to and from hospitals and long-term care”
— Missouri Department of Health and Senior Services

VALUABLE RESOURCE

The BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions Resource Room provides a wealth of materials to help you optimize the discharge process at your institution. You can download the Care Transitions for Older Adults Implementation Guide at http://s200161356.onlinehome.us/PHP/CT/Implementation_Download.html
OVERVIEW OF PROBLEM

Insufficient communication between hospitals and long term care communities during care transfers...

- adversely affects the quality and continuity of care provided
- contributes to adverse events and increased health care costs

Presentation notes can be found on enclosed CD.
HISTORY OF THE PROJECT

- Best Practice Coalition identified the problems associated with transfers.
- Appointed workgroup to find solutions.
  - reviewed literature, standards and regulations
  - conducted hospital and LTC surveys
  - created a recommended transfer process, drafted model transfer forms and guidelines
- Conducted a pilot with hospitals and LTC centers
- Revised forms and process based on pilot
- Best Practice Coalition recommended the process and forms be adopted as a best practice

CONTINUITY OF CARE

Presentation notes can be found on enclosed CD.
HOSPITAL ADMINISTRATION PRESENTATION

BEST PRACTICE COALITION RECOMMENDATIONS

All hospitals and LTC centers should do the following.
- incorporate the recommended data elements into the forms used when transfers occur between LTC centers and hospitals
- adopt the continuity of care transfer process
- Use the forms consistently and follow the recommended process

THE CONTINUITY OF CARE TRANSFER PROCESS

All hospitals and LTC centers should do the following.
- complete the appropriate transfer form
- fax the form to the receiving facility
- send a copy of the form and recommended medical records with EMS or the family
- call the receiving facility to give verbal report

Presentation notes can be found on enclosed CD.
CASE DISCUSSIONS:
PROBLEMS WE FACE WHEN PATIENTS ARE TRANSFERRED

WHY SHOULD WE DO THIS?

- Improve quality, safety and continuity of care during care transitions
- Improve handoff communication and transfer of information
- Decrease medical errors
- Reduce the number of duplicated tests
- Decrease readmissions
- Increase patient satisfaction
- Reduce patient complaints and litigation
- Save staff time and frustration

Presentation notes can be found on enclosed CD.
WHY IS THIS IMPORTANT TO OUR HOSPITAL?

- NQF has proposed improved care transitions from one setting to another as one of its 2009 priority goals.
- CMS has made care transitions part of its 9th Scope of Work.
- Included in two of the Joint Commission National Patient Safety Goals
- New CMS Quality Measures focus on 30-day readmission rates.
- Addresses many of the hospital-acquired conditions for which CMS proposes to withhold payment

HOW DO WE GET STARTED?

- Identify a project champion and key players at your facility
- Establish goals and benchmarks
- Review current forms and processes
- Review project tools, forms and resources
- Adopt or modify transfer forms and guidelines
- Educate staff
- Do it!
- Review, evaluate and revise
- Celebrate and share successes

Presentation notes can be found on enclosed CD.
CONNECTING WITH LTC FACILITIES

- Extend invitation to participate in a communitywide project
- Ask them to identify a project champion and key players at their facilities
- Host meetings to establish and promote transfer standards
- Execute communitywide plan

MAKING CARING CONNECTIONS

...will make our residents and patients safer and make relationships between hospitals and nursing facilities stronger. Jeffrey A. Kerr, D.O., CMD

Presentation notes can be found on enclosed CD.
OVERVIEW OF PROBLEM

Insufficient communication between hospitals and long-term care communities during care transfers...

- adversely affects the quality and continuity of care provided
- contributes to adverse events and increased health care costs

Presentation notes can be found on enclosed CD.
HOSPITAL STAFF PRESENTATION

CASE DISCUSSIONS: PROBLEMS WE FACE WHEN TRANSFERS OCCUR

CONTINUITY OF CARE

Presentation notes can be found on enclosed CD.
BEST PRACTICE COALITION RECOMMENDATIONS

All hospitals and LTC centers should do the following.

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- Reduce the number of duplicated tests
- Decrease readmissions
- Increase patient satisfaction
- Reduce patient complaints and litigation
- Save staff time and frustration
- Meet Joint Commission Safety Goals

National Patient Safety Goal 2

National Patient Safety Goal 02.05.01
- Implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions.

The hospital’s process should include the following.
- Interactive communications that allow the opportunity for questioning between the giver and receiver of patient information
- Up-to-date information regarding the patient’s condition, care, treatment, medications, services and any recent or anticipated changes
- A method to verify the received information, including repeat-back
- An opportunity for the receiver to review relevant patient historical data, which may include previous care, treatment, and services

Presentation notes can be found on enclosed CD.
National Patient Safety Goal 8

Goal 8 - Accurately and completely reconcile medications across the continuum of care.
NPSG.08.02.01

- When a [patient] is referred to or transferred from one [organization] to another, the complete and reconciled list of medications is communicated to the next provider of service and the communication is documented.

Elements of Performance

- The patient’s most current reconciled medication list is communicated to the next provider of service, either within or outside the hospital. The communication between providers is documented.
- At the time of transfer, the transferring hospital informs the next provider of service how to obtain clarification on the list of reconciled medications.

LTC TRANSFER PROCESS

OVERVIEW

Population: All residents of skilled, intermediate, residential care and assisted living facilities transferring to a hospital

- Complete at time of emergency transfer or planned admission
- Send a copy of forms and records with EMS or family, fax forms to hospital and retain one copy for LTC record
- Give a nurse-to-nurse report to receiving hospital ED or unit

Presentation notes can be found on enclosed CD.
HOSPITAL STAFF PRESENTATION

ED TRANSFER PROCESS OVERVIEW

Population: All ED patients being transferred back to skilled, intermediate and assisted living facilities and other post-acute care facilities
- Complete form prior to discharge
- Fax copy to LTC facility
- Call LTC facility and arrange for discharge needs including resident’s need for new prescriptions and give a nurse-to-nurse report
- The ED physician should communicate key information to the LTC physician prior to discharge
- Send one copy of form with EMS or family
- Maintain copy for ED record

HOSPITAL TRANSFER PROCESS OVERVIEW

Population: Patients being transferred to skilled, intermediate and assisted living facilities and other post-acute care facilities
- Complete prior to discharge by nursing staff.
- Fax completed form to the receiving facility.
- Call receiving facility and give a nurse-to-nurse report.
- Give a copy of the form and other discharge documents to the persons (family or EMS) transporting the patient.
- Fax prior to noon on the day of transfer, if new prescriptions are ordered.
- Place the original copy of the form in the medical record.

Presentation notes can be found on enclosed CD.
HOSPITAL STAFF PRESENTATION

FORMS AND GUIDELINES

- Long-Term Care Handoff Communication Form
- Emergency Department to Long-Term Care Handoff Communication Form
- Hospital to Long-Term Care Handoff Communication Form

PERFORMANCE MEASUREMENT

- How we will measure the project’s success, effectiveness and performance
  - Performance Measurement Tools
  - Chart Reviews
  - Focus Groups

Presentation notes can be found on enclosed CD.
FREQUENTLY ASKED QUESTIONS

...will make our residents and patients safer and make relationships between hospitals and nursing facilities stronger.  

Jeffrey A. Kerr, D.O., CMD

Presentation notes can be found on enclosed CD.
PRE- AND POST-IMPLEMENTATION OF TRANSFER PROCESS
HOSPITAL EMPLOYEE SURVEY/FOCUS GROUP QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>*Disagree</th>
<th>*Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our ED/nursing unit receives transfer information and medical records from LTC facilities in a timely manner.</td>
<td></td>
<td></td>
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<tr>
<td>We rarely have to call the sending facility for additional information.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>We receive a nurse-to-nurse report when residents are sent to the ED/nursing unit.</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>We receive a list of the resident’s belongings that were sent with the patient.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident belongings are sent with the patient when discharged.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We give a nurse-to-nurse report when the resident is transferred back to the LTC center.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our physicians call the accepting or primary care provider to give a physician-to-physician report before a transfer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The final discharge summary is sent/faxed to the LTC facility within one week of discharge.</td>
<td></td>
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</tbody>
</table>

*Comments:*


* For disagree and strongly disagree areas, please explain/describe in the comments section.

**EMPLOYEE SURVEYS**
1. These questions can be used for pre-implementation of the new transfer process to determine baseline, assess the current process and identify strengths, weaknesses and barriers.
2. These questions can be used for post-implementation to measure the success of the new process against the baseline, assess the new process and identify areas for improvement and changes.

**FOCUS GROUPS**
1. They can be a combination of clinical, support and administrative personnel throughout your facility, including social workers, nurses, case managers, physicians, support staff and EMS personnel.
2. They can be used to measure the success of the project, identify strengths, weaknesses and barriers and identify champions and key players within your organization.
HOSPITAL PERIODIC PERFORMANCE REVIEW
OF LONG-TERM CARE TRANSFER PROCESS
(Complete for all transfers to LTC facilities.)

<table>
<thead>
<tr>
<th>TRANSFER OF INFORMATION REVIEW</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAS THE TRANSFER FORM COMPLETE?</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>WERE YOU ABLE TO GIVE A PHONE REPORT TO THE RECEIVING FACILITY?</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>DID YOU FAX THE TRANSFER FORM TO RECEIVING FACILITY?</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>WAS THE TRANSFER FORM SENT WITH THE PATIENT?</td>
<td>□ NO □ YES</td>
</tr>
<tr>
<td>WERE PERTINENT MEDICAL RECORDS SENT/FAXED?</td>
<td>□ FAXED □ WITH PATIENT □ NO</td>
</tr>
<tr>
<td>WAS THE HOSPITAL DISCHARGE MEDICATION LIST RECONCILED WITH THE LTC MEDICATION LIST AT DISCHARGE?</td>
<td>□ NO □ YES □ N/A</td>
</tr>
<tr>
<td>WAS THE HOSPITAL BELONGINGS LIST RECONCILED WITH THE LTC BELONGINGS LIST AT DISCHARGE?</td>
<td>□ NO □ YES □ N/A</td>
</tr>
</tbody>
</table>

*Comments:

INSTRUCTIONS
1. Performance reviews should be periodically done as random checks. Pick a random period of time (i.e., two weeks) when these forms are placed in every chart.
2. This form should be completed by nursing personnel in the ED or nursing unit at the time of discharge for every patient transferred to a LTC facility.
3. Compile results, look at noncompliance issues and analyze results.
4. Address staff members and/or LTC facilities, as needed, to either correct problems or seek feedback on the new process and forms.
HOSPITAL POST-DISCHARGE CHART REVIEW TOOL

INDICATOR | YES | NO | Comments
---|---|---|---
Was the LTC center transfer form placed in the patient’s medical record? |  |  |  
Was the hospital/ED transfer form placed in the patient’s medical record? |  |  |  
Were the forms complete? |  |  |  

INSTRUCTIONS
1. Submit a query to your facility’s information technology department for all patients transferred from the hospital to LTC centers.
2. Randomly select at least five to 10 medical records for your support staff/unit secretaries to review.
3. Support staff/unit secretaries should review the selected charts with this form to determine compliance with the recommended process.
4. Place a hash mark for each indicator in “yes” for compliance and “no” for noncompliance.
5. If the answer is “no,” please describe/explain in the comment section.
6. When chart reviews are completed, the tools should be given to your director/manager to compile the results.
MEMO

XXX, 2008

TO: Long-Term Care Administrator/Director of Nursing

FROM: (YOUR NAME)
(TITLE)

SUBJECT: Continuity of Care Transfer Project

The transfer of residents to and from long-term care centers and hospitals poses unique challenges and threats. Many of these transfers are unplanned. They result from unanticipated medical problems and occur during off hours, such as nights and weekends. They often involve staff and clinicians who do not know the resident and often occur so quickly that important information about the resident is not communicated accurately or in a timely manner. We would like to introduce you to a process that we believe will help improve quality, coordination and continuity of care when transferring residents between our facilities.

In May 2008, the Missouri Department of Health and Senior Services’ Long-Term Care Best Practice Coalition endorsed a transfer process known as the “Continuity of Care Transfer Project” as a best practice. The project is a recommended process to communicate timely, accurate and complete information when patients and residents are transferred to and from hospital emergency departments and nursing units and long-term care communities. Its goal is to improve the quality, safety and continuity of care transitions between these care settings.

Please join us and other LTC providers in our area for an information meeting on (TIME), (DATE), (LOCATION). This letter also has been sent to your (Director of Nursing/Administrator). Please RSVP to _____________ at _____________ by (DATE).

If you have any questions, please contact (NAME) at (PHONE). We look forward to working with you in creating a communitywide transfer process.
Getting Started: Long-Term Care Resources
Getting Started: LTC Resources

LTC ADMINISTRATION PRESENTATION

MAKING CARING CONNECTIONS: CONTINUITY OF CARE TRANSFER PROJECT
Management Presentation

LTC Facility
Presenter’s Name
Date

OVERVIEW OF PROBLEM

Insufficient communication between hospitals and long term care communities during care transfers...

- adversely affects the quality and continuity of care provided
- contributes to adverse events and increased health care costs

Presentation notes can be found on enclosed CD.
BEST PRACTICE GUIDE TO ACTION

HISTORY OF THE PROJECT

- Best Practice Coalition identified the problems associated with transfers.
- Appointed workgroup to find solutions.
  - reviewed literature, standards and regulations
  - conducted hospital and LTC surveys
  - created a recommended transfer process, drafted model transfer forms and guidelines.
- Conducted a pilot with hospitals and LTC centers
- Revised forms and process based on pilot
- Best Practice Coalition recommended the process and forms be adopted as a best practice

CONTINUITY OF CARE

Presentation notes can be found on enclosed CD.
BEST PRACTICE COALITION RECOMMENDATIONS

All hospitals and LTC centers should do the following.

- incorporate the recommended data elements into the forms used when transfers occur between LTC centers and hospitals
- adopt the continuity of care transfer process
- use the forms consistently and follow the recommended process.

THE CONTINUITY OF CARE TRANSFER PROCESS

All hospitals and LTC centers should do the following.

- complete the appropriate transfer form
- fax the form to the receiving facility
- send a copy of the form and recommended medical records with EMS or the family
- call the receiving facility to give verbal report

Presentation notes can be found on enclosed CD.
CASE DISCUSSIONS: PROBLEMS WE FACE WHEN RESIDENTS ARE TRANSFERRED

WHY SHOULD WE DO THIS?

- Improve quality, safety and continuity of care during care transitions
- Improve handoff communication and transfer of information
- Decrease medical errors
- Reduce the number of duplicated tests
- Decrease readmissions
- Increase resident satisfaction
- Reduce resident complaints and litigation
- Save staff time and frustration
- Meet Joint Commission Safety Goals

Presentation notes can be found on enclosed CD.
Continuity of Care Transfer Project

LTC ADMINISTRATION PRESENTATION

HOW DOES MY LTC CENTER GET STARTED?

- Identify a project champion and key players at your facility
- Establish goals and benchmarks
- Review current forms and processes
- Review project tools, forms and resources
- Adopt or modify transfer forms and guidelines
- Educate staff
- Do it!
- Review, evaluate and revise
- Celebrate and share successes

MAKING CARING CONNECTIONS

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LTC STAFF PRESENTATION

CASE DISCUSSIONS: PROBLEMS WE FACE WHEN TRANSFERS OCCUR

CONTINUITY OF CARE

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Population: All residents of skilled, intermediate, residential care and assisted living facilities transferring to a hospital

- Complete at time of emergency transfer or planned admission
- Send a copy of forms and records with EMS or family, fax forms to hospital and retain one copy for LTC record
- Give a nurse-to-nurse report to receiving hospital ED or unit
ED TRANSFER PROCESS

OVERVIEW

Population: All ED patients being transferred back to skilled, intermediate and assisted living facilities and other post-acute care facilities

- Complete form prior to discharge
- Fax copy to LTC facility
- Call LTC facility and arrange for discharge needs including resident’s need for new prescriptions and give a nurse-to-nurse report
- The ED physician should communicate key information to the LTC physician prior to discharge
- Send one copy of form with EMS or family
- Maintain copy for ED record

HOSPITAL TRANSFER PROCESS

OVERVIEW

Population: Patients being transferred to skilled, intermediate and assisted living facilities and other post-acute care facilities

- Complete prior to discharge by nursing staff.
- Fax completed form to the receiving facility.
- Call receiving facility and give a nurse-to-nurse report.
- Give a copy of the form and other discharge documents to the persons (family or EMS) transporting the patient.
- If new prescriptions are ordered, fax prior to noon on the day of transfer.
- Place the original copy of the form in the medical record.

Presentation notes can be found on enclosed CD.
LTC STAFF PRESENTATION

FORMS AND GUIDELINES

- Long-Term Care Handoff Communication Form
- Emergency Department to Long-Term Care Handoff Communication Form
- Hospital to Long-Term Care Handoff Communication Form

PERFORMANCE MEASUREMENT

- How we will measure the project’s success, effectiveness and performance
  - Performance Measurement Tools
  - Chart Reviews
  - Focus Groups

Presentation notes can be found on enclosed CD.
FREQUENTLY ASKED QUESTIONS

...will make our residents and patients safer and make relationships between hospitals and nursing facilities stronger.  Jeffrey A. Kerr, D.O., CMD

Presentation notes can be found on enclosed CD.
**PRE- AND POST-IMPLEMENTATION OF TRANSFER PROCESS**
**LONG-TERM CARE EMPLOYEE SURVEY/FOCUS GROUP QUESTIONS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>*Disagree</th>
<th>*Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our facility receives transfer information and medical records from hospitals in a timely manner.</td>
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<tr>
<td>We rarely have to call the sending hospital for additional information.</td>
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<tr>
<td>We receive a nurse-to-nurse report when residents are transferred to our facility.</td>
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<tr>
<td>Necessary information is communicated by the hospital in an easy to understand, friendly manner.</td>
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<tr>
<td>We receive a list of the resident’s belongings that were sent with the resident.</td>
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</tr>
<tr>
<td>We give a nurse-to-nurse report when the resident is transferred to the hospital.</td>
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<tr>
<td>Our physicians call the accepting or primary care provider to give a physician-to-physician report before a transfer.</td>
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<tr>
<td>We receive the final discharge summary from the hospital within one week of discharge.</td>
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<tr>
<td>We understand the resident’s discharge plan of care and new medication orders.</td>
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</tbody>
</table>

*Comments:*

* For disagree and strongly disagree areas, please explain/describe in the comments section.

**EMPLOYEE SURVEYS**
1. These questions can be used for pre-implementation of the new transfer process to determine baseline, assess the current process and identify strengths, weaknesses and barriers.
2. These questions can be used for post-implementation to measure the success of the new process against the baseline, assess the new process and identify areas for improvement and changes.

**FOCUS GROUPS**
1. They can be a combination of clinical, support and administrative personnel throughout your facility, including social workers, nurses, case managers, physicians and support staff.
2. They can be used to measure the success of the project, identify strengths, weaknesses and barriers and identify champions and key players within your organization.
LONG-TERM CARE PERIODIC PERFORMANCE REVIEW
OF HOSPITAL TRANSFER PROCESS

(Complete for all transfers to hospitals.)

PATIENT LABEL HERE

Transferring Unit:
Nurse/CNA Signature:
Date: ____________  Time: ____________

TRANSFER OF INFORMATION REVIEW

<table>
<thead>
<tr>
<th>Item</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAS THE TRANSFER FORM COMPLETE?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WERE YOU ABLE TO GIVE A PHONE REPORT TO THE RECEIVING HOSPITAL?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DID YOU FAX THE TRANSFER FORM TO THE HOSPITAL?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAS THE TRANSFER FORM SENT WITH THE RESIDENT?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DID YOU SEND THE MOST CURRENT MEDICATION ADMINISTRATION RECORD?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAS THE RESIDENT'S PHYSICIAN NOTIFIED OF THE TRANSFER?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAS THE RESIDENT'S FAMILY NOTIFIED OF THE TRANSFER?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WERE PERTINENT MEDICAL RECORDS SENT/FAXED?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS

INSTRUCTIONS
1. Performance reviews should be periodically done as random checks. Pick a random period of time (i.e. four weeks) when these forms are placed in every resident’s chart.
2. This form should be completed by nursing personnel whenever a resident is transferred to a hospital.
3. Compile results, look at noncompliance issues and analyze results.
4. Address staff members, as needed, to either correct problems or seek feedback on the new process and forms.
Forms & Guidelines
**HOSPITAL TO LONG-TERM CARE HANDBOFF COMMUNICATION — Page 1 of 3**

To [ ] SNF [ ] ICF [ ] RCF/ALF [ ] Swing Bed [ ] Rehab [ ] LTCH [ ] Group Home [ ] Other

<table>
<thead>
<tr>
<th>Hospital</th>
<th>LTC Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Unit</td>
<td>Accepting Physician/PCP</td>
</tr>
<tr>
<td>Unit Phone</td>
<td>Unit Fax</td>
</tr>
<tr>
<td>Phone Number</td>
<td>Fax Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admission Date</th>
<th>/ /</th>
<th>Reason for hospitalization</th>
<th>Discharge Date</th>
<th>/ /</th>
</tr>
</thead>
</table>

**ALLERGIES**

- [ ] Durable Power of Attorney for Health Care [ ] Guardian
- [ ] Name [ ] Phone
- [ ] Advance Directives [ ] Yes [ ] No
- [ ] Capable of making own decisions [ ] Yes [ ] No
- [ ] Health Care Decision Maker or Local Contact Notified of Transfer
- [ ] Name [ ] Phone

Admissions to Other Hospitals/Facilities in Past Month [ ] Yes [ ] No

**CHECK ALL THAT APPLY**

**Mental Status**
- [ ] Alert [ ] Oriented [ ] Non-Verbal [ ] Unresponsive [ ] Confused [ ] Uncooperative [ ] Disruptive [ ] Withdrawn [ ] Depressed

**Impairments**
- [ ] None
- [ ] Mental (describe) [ ] Speech (describe) [ ] Hearing (describe) [ ] Vision (describe) [ ] Sensation (describe)

**Disabilities**
- [ ] None
- [ ] Amputation (describe) [ ] Prosthesis (describe) [ ] Contracture (describe) [ ] Paralysis (describe)

**Fall In Hospital**
- [ ] Yes [ ] No (describe)

**Infection**
- [ ] Active MRSA [ ] Colonized MRSA [ ] C. difficile Positive [ ] Diarrhea Present [ ] UTI [ ] TB [ ] Wound Site [ ] Other [ ] Not Applicable

**Bowel**
- [ ] Continent [ ] Incontinent [ ] Ostomy Type [ ] Changed [ ] / [ ] / [ ] Last BM [ ] / [ ] / [ ]

**Bladder**
- [ ] Continent [ ] Incontinent [ ] Catheter/Urostomy/Type [ ] Inserted/Changed [ ] / [ ] / [ ] DC'd [ ] / [ ] / [ ]

**IV**
- [ ] None [ ] IV Access Type [ ] Location [ ] Inserted [ ] / [ ] / [ ] Dsg. Changed [ ] / [ ] / [ ]

**Assisted Devices**
- [ ] None [ ] Cane [ ] Walker [ ] Wheelchair [ ] Crutches [ ] Other

**Appetite/Nutrition**
- [ ] Good [ ] Fair [ ] Poor [ ] Feeding Tube Type [ ] Inserted/Changed [ ] / [ ] / [ ]

**Safety Concerns**
- [ ] None [ ] Aspiration [ ] Skin Breakdown [ ] Seizures [ ] Isolation [ ] Wander/Elope [ ] High Risk for Falls

**Immunizations In Hospital**
- [ ] None [ ] Influenza [ ] Pneumonia [ ] Tetanus [ ] TB Skin Test

**Treatment Received Within Last 14 Days**

- [ ] Chemotherapy
- [ ] Radiation
- [ ] Oxygen therapy
- [ ] Suctioning
- [ ] Tracheotomy care
- [ ] Ventilator
- [ ] IV medications
- [ ] Transfusions
- [ ] Dialysis
- [ ] Isolation for active infectious disease
- [ ] BiPap/CPAP
- [ ] Hospice care
- [ ] None of the above treatments or procedures received

*Only complete for patients transferring to skilled nursing level of care. If dates are not recorded, the last 14 days of nurse notes and MARS must be sent to SN facility.

**Activities of Daily Living**

<table>
<thead>
<tr>
<th>Independent</th>
<th>Needs Help</th>
<th>Unable To Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Toileting</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Turning</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Bathing</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Dressing</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Feeding</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Transferring</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**Place patient label here or complete**

- **Patient Name**
- **Date of Birth**
- **Medical Record or SS #**

Place hospital logo here

- [ ] Patient Name
- [ ] Date of Birth
- [ ] Medical Record or SS #
This page intentionally left blank.
The following items are required to be sent with ALL patients on day of discharge to any post acute care facility.

<table>
<thead>
<tr>
<th>Form</th>
<th>Content Needed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face Sheet</td>
<td>With payer sources</td>
<td></td>
</tr>
<tr>
<td>Medication Administration Record</td>
<td>Send most current and complete MAR which includes IV IM and PO medications and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>flushes, blood transfusions and chemotherapy. If patient is transferring to SNF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>care and treatment dates not recorded on page 2, send last 14 days of MAR.</td>
<td></td>
</tr>
<tr>
<td>H&amp;P</td>
<td>If older than 30 days, have physician review/update/sign/date</td>
<td></td>
</tr>
<tr>
<td>Physician Discharge Summary (official)</td>
<td>If not checked as sent, Medical Records should send a copy to the receiving</td>
<td></td>
</tr>
<tr>
<td></td>
<td>facility when completed. <strong>Note to receiving facility:</strong> If a Physician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discharge Summary is not received within 7 days or to receive additional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>patient records, a request for information from the medical records</td>
<td></td>
</tr>
<tr>
<td></td>
<td>department should be faxed to (FAX NUMBER).</td>
<td></td>
</tr>
<tr>
<td>Nursing Assessment/Nurses Notes</td>
<td>Send last 2 days if patient is transferring to SNF care and treatment dates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>not recorded on page 2, send last 14 days of nurses notes.</td>
<td></td>
</tr>
<tr>
<td>Consult Reports</td>
<td>A copy of each consult</td>
<td></td>
</tr>
<tr>
<td>Discharge Medication Reconciliation Record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Directive/DPOA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This Form</td>
<td>Fax to facility prior to discharge</td>
<td></td>
</tr>
</tbody>
</table>

Based on post acute care facility requirements, the following may or may not need to be sent.

<table>
<thead>
<tr>
<th>Form</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Notes</td>
<td>The last 3 days</td>
</tr>
<tr>
<td>PT/OT/ST/Wound Therapy</td>
<td>Include the evaluation and notes from the last week</td>
</tr>
<tr>
<td>Physician Progress Notes</td>
<td>Last 4 days</td>
</tr>
<tr>
<td>Pertinent Laboratory Results</td>
<td>Include most recent UA, C&amp;Ss, CBC, glucose, electrolytes, and</td>
</tr>
<tr>
<td></td>
<td>labs used in dosing meds (ie. Theophylline, Dilantin levels,</td>
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<tr>
<td></td>
<td>INRs etc.)</td>
</tr>
<tr>
<td>Pertinent Radiology/Special Studies Reports</td>
<td>Include swallowing studies, MRIs, CT Scans, ultrasounds, EKG,</td>
</tr>
<tr>
<td></td>
<td>stress test, echo</td>
</tr>
<tr>
<td>Operative Reports</td>
<td>For all major surgeries</td>
</tr>
<tr>
<td>Preadmission Screening and Annual</td>
<td>Complete screening for patients who are suspected of having</td>
</tr>
<tr>
<td>Resident Review (PASARR) if applicable</td>
<td>mental illness (MI), mental retardation (MR), and/or related</td>
</tr>
<tr>
<td></td>
<td>conditions and who are going to a Medicaid-certified LTC</td>
</tr>
<tr>
<td></td>
<td>facilities.</td>
</tr>
</tbody>
</table>

### Skin and Body Assessment

- Skin Intact
- Skin Not Intact—Identify each non-intact area and drain with a number and describe site and care below.

1. **#1 Site**
   - Care
   - 

2. **#2 Site**
   - Care
   - 

3. **#3 Site**
   - Care
   - 

4. **#4 Site**
   - Care
   - 

### Pain Assessment

- None
- Acute
- Chronic
- Intermittent
- Sharp
- Dull
- Other

- Location________________
- Intensity (1-10)_____  
- Time of last pain med

### DISCHARGE INFORMATION

- Have you addressed discharge planning needs and transportation?  
  - Yes
  - No
- Have you addressed with the LTC facility, the resident’s need for NEW prescriptions until LTC pharmacy services are available?  
  - Yes
  - No
  - NA
- Current Vital Signs
  - BP ____________
  - Temperature ____________
  - Pulse ____________
  - R ____________
  - Pulse Ox ____________
  - Time ____________

- Discharge Date __/__/__
- Discharge Time ____________
- Transported by
  - EMS
  - Family
  - LTC Facility

- Verbal Report Given By (print name/title) ____________
- Given To ____________
- Time ____________

- **Note to LTC:** Patient care questions call ____________
- Request for additional medical records call ____________

### BE longings SENT WITH PATIENT

- Eyeglasses/Contacts
- Dentures/Partial Plates
- Upper
- Lower
- Both
- Hearing Aid(s)
- Right
- Left
- Jewelry (list)
- Cane
- Walker
- Splints
- Brace Type
- Wound Vac

### FORM COMPLETED BY

Place hospital logo here

**PLACE PATIENT LABEL HERE OR COMPLETE**

- Patient Name ____________
- Date of Birth ____________
- Medical Record or SS # ____________
This page intentionally left blank.
**Primary and Secondary Diagnoses**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Present on admission to hospital</th>
<th>Procedures/Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
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</table>

**Discharge Medications**

Dose/Frequency/Route (prescription must be written for Schedule II controlled substances.)

- [ ] See Medication Reconciliation Record or Discharge Medication List

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose/Frequency/Route</th>
<th>Prescription</th>
<th>Written/Called</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Labs**

- [ ] INR Frequency
- [ ] TB Test
- [ ] Blood glucose test Frequency
- [ ] Sliding Scale Insulin

**Respiratory Care**

- [ ] Oxygen at ___ L/M per __
- [ ] CPAP
- [ ] BiPAP
- [ ] Trach
- [ ] Nebulizer Treatments

<table>
<thead>
<tr>
<th>Ventilator Type</th>
<th>T.Vol.</th>
<th>PEEP</th>
<th>PCO2</th>
<th>SIMV</th>
<th>Other</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Activity**

- [ ] No Restrictions
- [ ] Up with Assist
- [ ] Bed Rest
- [ ] HOB Up 30°
- [ ] WB as Tolerated
- [ ] Toe-Touch WB on _______ leg
- [ ] Non-WB

**Durable Medical Equipment**

**Code Status**

- [ ] DNR
- [ ] Resuscitate

**Rehab Potential**

- [ ] Good
- [ ] Fair
- [ ] Poor

**Evaluate and Treat**

- [ ] PT
- [ ] OT
- [ ] ST

**Diet**

- [ ] Regular
- [ ] Cardiac
- [ ] low cholesterol
- [ ] low sodium
- [ ] low fat
- [ ] ADA _______ calories

- [ ] Tube Feedings
- [ ] Supplements
- [ ] Weigh Daily

**Follow up appointments**

**Treatment/Dressing Changes/Other Orders**

**Place hospital logo here**

**PLACE PATIENT LABEL HERE OR COMPLETE**

Patient Name _________________________________________

Date of Birth _________________________________________

Medical Record or SS # _________________________________

45
This page intentionally left blank.
Purpose
- ensure continuity of care and improve handoff communication
- provide the LTC staff and attending physician with information on the diagnosis, procedures and treatments provided during hospitalization, new physician orders, discharge instructions and the patient’s physical and mental status at discharge
- ensure that medication reconciliation is completed
- ensure that belongings brought with the patient are sent with the patient at discharge
- facilitate an efficient, safe transfer

Responsibility
Nursing staff is responsible for Pages 1 and 2. If used, Page 3 may be completed by the physician or nursing staff under the physician’s direction. The nurse is required to sign Page 2, and the physician is required to sign Page 3.

Patient Population
Patients being transferred to skilled nursing units and facilities, intermediate facilities and assisted living communities, residential care communities and other LTC facilities, such as LTC hospitals, rehabilitation units and hospitals.

Placement of Form
After copying and sending the forms to the LTC centers, the original completed forms should be placed in the patient’s medical record, along with the discharge instructions.

General Instructions
1. Page 1 may be completed before discharge. If needed, Page 1 should be updated and Page 2 should be completed the day of discharge.
2. Page 3 is optional and may be used in place of the physician discharge orders and summary form normally used at discharge.
3. If applicable, a copy of the completed Page 1 and medical records necessary to determine acceptance should be faxed to the receiving LTC center before the date of discharge. The social worker or discharge planner should determine the accepting physician or primary care provider and that the provider is aware of the transfer.
4. Before transfer, fax the forms and call the receiving LTC community to give a nurse-to-nurse report. Assisted living/residential care communities may not be required to have a licensed nurse on site 24/7. A hospital nurse may give the report to a certified medication technician or certified nursing assistant. When giving the report, determine who is receiving the information and communicate at the level of the staff member’s expertise.
5. The attending physician while in the hospital should call the patient’s primary care physician or the accepting physician at the LTC facility.
6. On the day of the patient’s discharge, copies of the forms and other discharge documents should be placed in a large envelope and addressed to the LTC center. This envelope should be given to the person (family or EMS) transporting the patient, with instructions to give the envelope to the receiving LTC facility.
7. If new prescriptions are ordered, fax this to the nursing home as early in the day as possible, preferably before noon, to allow time for prescriptions to be delivered and to ensure no interruptions in medications.
8. Place the original copy of the form in the patient’s medical record.

continued
Hospital to Long-Term Care Handoff Communication Form Guideline

Page 1 - Instructions for Completion

1. Check the appropriate box to indicate the type of LTC facility the patient is entering.
2. Enter the name, address and phone number or affix label(s) with contact information for the sending hospital and the receiving facility.
3. At the bottom of the form, affix patient label or document the patient’s name, birth date and medical record or Social Security number.
4. Record admission date, reason for hospitalization and discharge date.
5. Enter all allergies and drug reactions, including food, drug and environmental sources such as latex allergy. If these are listed on the medication administration record, write “See MAR.”
6. If applicable, enter the patient’s durable power of attorney for health care or legal guardian’s name and phone number.
7. Enter the patient’s primary health care decision maker’s name, phone number and if notified of transfer.
8. Indicate if the patient has an advance directive and if they are able to make their own decisions.
9. Indicate if the patient speaks English. If not, specify the language spoken.
10. Under “Literacy/Religious Concerns,” list important concerns, such as inability to read or write, Jehovah’s Witness, etc.
11. If the patient was admitted to other hospitals or facilities in the past month, list the facilities’ names and the dates.
12. Under the “CHECK ALL THAT APPLY” section, check all applicable boxes and describe or supply dates or additional information when indicated.
   a. Under “Infection Control,” indicate date and result of last tuberculin skin test. If the resident has an active methicillin resistant Staphylococcus aureus (MRSA) or vancomycin resistant enterococcus (VRE) infection or is colonized with MRSA or VRE, check the applicable boxes and list site(s). Indicate if the patient had a Clostridium difficile infection while hospitalized and if the infection is still active or has been treated and resolved.
   b. Under “Bowel,” specify type of ostomy such as ileostomy, urostomy, colostomy etc., if applicable. Record date of last bowel movement.
   c. Under “Bladder,” mark if the patient had a catheter or urostomy tube while hospitalized, the date inserted or changed and, if applicable, the date discontinued.
   d. Under “IV,” indicate whether or not the patient has IV access and, if applicable, the type of access, location, date inserted and the date the dressing was changed.
   e. Under “Appetite/Nutrition,” if patient has a feeding tube, record the type of tube (dobhoff, PEG) and the date it was inserted or changed.
   f. Under “Immunizations,” ONLY indicate dates of immunizations administered during the patient’s hospitalization.
13. The “Treatment Received Within Last 14 Days” section, is designed to assist skilled nursing units and facilities in completing the minimum data set. Only record the dates the listed treatments were last administered if the patient is transferring to a skilled nursing bed, unit or facility. Hospitals with electronic medical records may be able to generate a report with this information. If the dates are not recorded, the last 14 days of the nurse’s notes and MARs must be sent. Indicate this by writing “See Nurse’s Notes and MARs” in this section.
14. For each activity listed under “Activities of Daily Living,” check if the patient is able to perform the activity listed independently, with assistance or is unable to do the activity with assistance.
Hospital to Long-Term Care Handoff Communication Form Guideline

Page 2 - Instructions for Completion
The patient’s name, birth date, Social Security number and the LTC center name also must be entered on Page 2 because the two pages may be separated during a transfer or fax.

Records to Be Sent with Patient or Faxed to Receiving Facility
The top nine documents listed on Page 2 of the form should be sent with each patient discharged to any LTC center. Depending on LTC center requirements, the remaining seven items may be sent. Document dates when forms are sent or faxed to eliminate sending duplicate copies. Avoid sending multiple documents by fax because many fax machines at LTC facilities can only accept a limited number of pages. If a patient is transferring to a SNF and if treatment dates are not recorded on Page 2, send the last 14 days of nurse’s notes and medication administration records.

Skin and Pain Assessment
1. Under “Skin and Body Assessment,” indicate if skin is intact. If not, use numbers to identify on the body diagram all drains, abrasions, bruises, skin tears and decubitus ulcers. Describe condition in the space provided. Use the nurse’s notes if additional space is needed.
2. Under “Pain Assessment,” indicate type, location, intensity of pain and the time the last pain medication was administered.

Discharge Information
1. Indicate if you addressed the patient’s discharge needs and transportation with the LTC community.
2. Because LTC facilities have special requirements and arrangements for resident’s medications, indicate if you addressed the resident’s need and availability of NEW critical medications, such as antibiotics and pain medications with the LTC community. Fax new prescriptions as early in the day as possible, preferably before noon, to allow time for prescriptions to be delivered and to ensure no interruptions in medications.
3. Record the patient’s most recent vital signs and time assessed.
4. Record the discharge date, time and mode of transportation.
5. Document that the receiving LTC community was called, as well as the date, time and the name and title of the individuals giving and receiving the report.
6. Record phone numbers for the LTC facility to call for patient care questions and medical record requests.

Belongings Sent with Patient
1. Document the aids and appliances sent with the patient. It is not necessary to document clothing and other personal items.
2. Reconcile this list with the belonging list on the admission or LTC transfer form.

Signature
The nurse completing the form should sign and date it, with the time also noted.
Page 3 - Instructions for Completion

Page 3 is optional and may be deleted if the physician uses the physician discharge order and summary normally used when patients are discharged.

1. The patient’s name, birth date, Social Security number and the LTC community name also must be entered on Page 3 because the three pages may be separated during a transfer or fax.

2. Record all Primary and Secondary Diagnoses. Each physician should specify if the condition was or was not present on admission or if unable to determine at this time. POA determination is required under Medicare to determine reimbursement.

3. Record all major procedures and treatments performed while the patient was hospitalized.

4. Record Discharge Medications NOTE: If a medication reconciliation record or discharge medication list was used to reconcile and/or order all discharge medications, check “See Medication Reconciliation Record or Discharge Medication List.”
   a. Record all discharge medications, dose, frequency and route, date and time the next dose is due, and check box to indicate if a prescription was written or called. If additional space is needed for medications, use a physician order form.
   b. Whenever possible, new orders for prescriptions should be faxed to the nursing LTC community before noon on the day of discharge to ensure that the patient will have the necessary and appropriately packaged medications.
   c. Written prescriptions are required for Schedule II controlled substances.

5. Record all physician orders for labs, respiratory care, activity, durable medical equipment, code status, diet, treatments and dressing changes. Any skin care reported under skin and body assessment does not have to be repeated.

6. List any follow-up appointments. Indicate the provider and where the appointment was or should be made.

7. The physician should certify the patient is stable for transfer, the type of the LTC center for transfer and that diagnoses and procedures are accurate and complete.

8. A space is provided for physicians to document if they will follow the patient in the post-acute care facility. If not, the physicians will indicate that the accepting physician or primary care physician was called.

Form Reviewed and Approved
Director of Nursing: ____________________________ Date: ________________

Form Reviewed and Approved
Director of Nursing: ____________________________ Date: ________________
EMERGENCY DEPARTMENT TO LONG-TERM CARE HANDOFF COMMUNICATION

To  □ SNF □ ICF □ RCF/ALF □ Swing Bed □ Rehab □ LTCH □ Group Home □ Other

Records sent with patient or faxed to receiving facility

- □ Face Sheet
- □ Medication Reconciliation Record
- □ Physician and Nurses Notes
- □ This Form
- □ Lab/Radiology/Special Studies Reports if available
- □ Other

Belongings sent with patient

- □ Eyeglasses/Contacts
- □ Dentures/Partial Plates
- □ Upper
- □ Lower
- □ Both
- □ Hearing Aid(s) □ L □ R
- □ Brace □ Wound Vac □ None
- □ Cane □ Walker □ Splints
- □ Jewelry (list)

Physician orders and follow-up appointments

- □ See Medication Reconciliation Record
- □ See Physician Order Sheet

ED diagnosis/primary findings/treatments

New/changed medication

<table>
<thead>
<tr>
<th>New/changed medication</th>
<th>Dose/frequency/route</th>
<th>First dose given</th>
<th>Next dose due</th>
<th>Prescription written</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ No □ Yes</td>
<td>Date/<em><strong>/</strong></em> Time</td>
<td>□ No □ Yes</td>
</tr>
</tbody>
</table>

Follow up labs/tests/physician appointments

- Labs/tests pending □ Yes □ No
- Tests pending ____________________________ If yes, call __________________ for report.

Diet

- □ Resume diet
- □ Resume activity

Additional orders

Discharge information

- Have you addressed discharge planning needs and transportation? □ Yes □ No
- Any change in skin condition from LTC transfer form? □ Yes □ No □ NA
- If yes, describe in nurses notes.
- Have you addressed with the LTC facility, the resident’s need for new prescriptions until LTC pharmacy services are available? □ Yes □ No □ NA

Current vital signs

- BP_________ T _______ P_______ R_______ Pulse Ox_________ Time_________

- This patient is stable for transfer and has no emergency medical condition.

- (The EMTALA form must also be completed if the patient is transferring to the same or a higher level of care.)

ED discharge date /__/__/__ ED discharge time transportation mode

Verbal report given by (print name/title)

Verbal report received by (print name/title) time report called

Notes

- Notes to LTC Patient questions call ____________________________ Requests for additional medical records call ________________
- Attending physician/PCP called ____________________________ Time ________________

Physician’s signature ____________________________ Time ________________

Nurse’s signature ____________________________ Time ________________

Place hospital logo here

Place patient label here or complete

Patient name ____________________________

Date of birth ____________________________

Medical record or SS # ____________________________
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Emergency Department to Long-Term Care Handoff Communication Form Guideline

Purpose
- provide the long-term care center and patient’s attending physician with information on diagnosis, procedures and treatments, new physician orders and discharge instructions
- ensure continuity of care and improve handoff communication
- ensure that medication reconciliation is complete
- facilitate an efficient, safe transfer
- ensure belongings brought with the patient are sent with the patient at discharge

Responsibility
nursing staff and the ED physician responsible for the patient’s care

Patient Population
ED patients who will be discharged to skilled, intermediate and assisted living/residential care communities and other LTC centers, such as LTC hospitals, rehabilitation units and hospitals

Placement of Form
The completed form should be part of the patient’s ED record.

General Instructions
1. Complete the handoff communication form before discharge.
2. Before discharge, fax the form and call the receiving LTC center to give a nurse-to-nurse report. Assisted living/residential care communities may not be required to have a licensed nurse on site 24/7. An ED nurse may give the report to a certified medication technician or certified nursing assistant. When giving the report, determine who is receiving the information and communicate at the level of the expertise.
3. The ED physician also should call the patient’s primary care or attending physician at the LTC center.
4. A copy of the form and the records should be placed in a large envelope and addressed to the LTC community. This envelope should be given to the person (family or EMS) transporting the patient, with instructions for giving the envelope to the receiving LTC center.
5. Place the original copy of the form in the patient’s medical record.

Instructions for Completion

LTC Information
1. Check the appropriate box to indicate the type of LTC center the patient is entering.
2. Enter the name, address, phone and fax number or affix label(s) with contact information of the sending hospital and the receiving LTC center.

Patient Information
At the bottom of the form, affix patient label or document the patient’s name, birth date and medical record or Social Security number.

Records Sent with Patient or Faxed to LTC Center
1. Document the copies of records that were sent with the patient to the LTC center.
   a. face sheet
   b. record of medications/IVs administered in the ED or the ED treatment record
   c. discharge medication reconciliation record used to reconcile new medication orders with the resident’s medication record
   d. handoff communication form (fax before giving verbal report)
   e. reports or results of lab, radiology or special studies performed in the ED, nurse’s and physician’s notes, nursing discharge instructions and any physician orders not recorded on the handoff communication form

continued  53
Emergency Department to Long-Term Care Handoff Communication Form Guideline

2. If Schedule II controlled substances are ordered, a prescription must be written.

Belongings Sent with Patient
1. Document the aids and appliances sent with the patient at discharge. It is not necessary to document clothing and other personal items.
2. Reconcile this list with the belonging list on the LTC transfer form.

Physician Orders and Follow-Up Appointments
1. Record the patient’s new diagnosis and any procedures and treatments performed during the ED visit.
2. If a separate physician order sheet was used and a medication reconciliation record was completed, the remainder of this section may be left blank.
3. If a separate physician order sheet is not used, do the following.
   a. Record any new medications or changes in patient’s current medications, along with dose, frequency and route.
   b. For new medications, indicate if the first dose was given, when next dose is due and if a prescription was written.
   c. Reconcile LTC medications by using the medication reconciliation record.
   d. Record follow-up labs/tests and physician appointments, diet, activity and any additional orders or restrictions.
   e. Indicate and list if there are any pending labs or tests. Give a number for the LTC center to call to retrieve results.

Discharge Information
1. Indicate if you addressed the patient’s discharge needs and transportation with the LTC center.
2. If there are any changes in skin condition from the LTC transfer form, check “yes” and describe in the nurse’s notes.
3. Because LTC centers have special requirements and arrangements for resident’s medications, indicate if you addressed the resident’s need and availability of NEW critical medications, such as antibiotics and pain medications, with the LTC facility.
4. Record the patient’s most recent vital signs and time assessed.
5. Mark the box indicating that the patient is stable for transfer and no emergency medical condition exists. (The EMTALA form also must be completed if the patient is transferring to a facility with the same or higher level of care.)
6. Record the discharge date, time and mode of transportation.
7. Document that the receiving facility was called, as well as the date, time and the name and title of the individuals giving and receiving the report.
8. Record any additional notes pertinent to the transfer in the space provided for notes.
9. Provide phone numbers for the LTC center to call for patient care questions and requests for additional medical records.
10. Document that the attending or primary care physician was called by the ED physician. If you are unable to reach the physician, note the unavailability and the date and time the attempt was made.

Signatures
If a physician uses a handoff communication form for physician orders, both the physician and nurse are required to sign and record the date and time.

Form Reviewed and Approved
Director of Nursing: _____________________________ Date: ________________

Form Reviewed and Approved
Director of Nursing: _____________________________ Date: ________________
# Skin and Body Assessment

<table>
<thead>
<tr>
<th>Site</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>#3</td>
<td></td>
</tr>
</tbody>
</table>

# Reason for Transfer
- Altered Mental Status
- Shortness of Breath
- Hyponatremia
- Fever
- Chest Pain
- Abdominal Pain
- Weakness
- Other
- Injury/Fall (Describe)

# Code Status
- See DNR Form
- Full
- Limited
- DNR

# Allergies
- No Known Allergies
- See MAR

# Code Status
- See DNR Form
- Full
- Limited
- DNR

# Allergies
- No Known Allergies
- See MAR

# Chronic Conditions
- See Diagnosis Sheet

# Infections
- MRSA Site
- VRE Site
- C. difficile
- UTI
- Other

# Implants
- See MAR

# Mental Status
- Alert
- Oriented
- Non-Verbal
- Unresponsive
- Confused
- Uncooperative
- Disruptive
- Withdrawn
- Depressed

# Impairments
- Mental (describe)
- Speech (describe)
- Hearing (describe)
- Vision (describe)
- Sensation (describe)

# Disabilities
- Amputation (describe)
- Prosthesis (describe)
- Contracture (describe)
- Paralysis (describe)

# Mobility
- No Mobility Aids
- Cane
- Walker
- W/C
- Bed Bound
- No Weight Bearing
- Partial Weight Bearing

# Elimination
- Incontinence
- Constipation
- Diarrhea

# Last Vital Signs
- Time
- BP
- T
- P
- R
- Pulse Ox

# Transfer Date
- / / Date
- Time

# Facility Transferred To
- Transfer Date
- Transfer Time

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This page intentionally left blank.
Long-Term Care Handoff Communication Form Guideline

**Purpose**
- consistently and accurately provide EMS, emergency department and hospital staff with important information about nursing center residents
- ensure continuity of care and improve handoff communication
- facilitate an efficient, safe transfer
- ensure that a resident’s aids and appliances sent during the transfer are returned upon the resident’s return to the LTC facility
- provide immediate baseline information to health care and emergency personnel in the event of an evacuation of nursing facility residents
- provide temporary staff with baseline information about residents

**Responsibility**
- nursing staff

**Resident Population**
- all residents of skilled, intermediate and assisted living centers

**Placement of Form**
When the transfer form is completed, a copy should be placed in the resident’s chart because it provides documentation of the transfer.

**General Instructions**
1. The form should be completed whenever a resident is transferred to a hospital for emergency evaluation or planned admission. Whenever possible, complete the form before transfer and send a copy with EMS personnel or family. In an emergency, it may be necessary to complete the form after the resident has left the facility.
2. Send the documents listed on the transfer form with EMS personnel or fax to the receiving hospital.
3. After the resident has been transported, fax the form to the receiving hospital. If you are unsure of the receiving hospital, instruct EMS personnel to call the nursing center when the destination is known and then fax the report.
4. Call the receiving hospital to give a nurse-to-nurse report.
5. Place a copy of the LTC transfer form in the resident’s chart.

**Instructions for Completion**
1. Enter the center’s name, address, phone and fax number or affix label with contact information.
2. Record the resident’s attending physician and phone number. This should be the physician responsible for the resident’s care in an intermediate or skilled facility or the assisted living resident’s primary care physician. Check the “Notified” box to indicate that the physician was notified of the transfer.
3. Document the resident’s name, birth date, sex and Social Security number.
4. Enter the reason(s) for the transfer and the date and time of onset of the illness or injury.
5. Enter whether the resident is a full, limited or a do-not-resuscitate under “Code Status.” Another option is to mark the “See DNR Form” box if a form was included with the records sent with the resident.
6. Enter all allergies and drug reactions, including food, drug and environmental sources such as latex allergy. If allergies are listed on the MAR to be sent with the resident, check “See MAR.”
7. If applicable, enter the resident’s durable power of attorney for health care or legal guardian’s name and phone number.

*continued*
Long-Term Care Handoff Communication Form Guideline

8. Enter the resident’s primary health care decision maker’s name, phone number and if notified of transfer.
9. Indicate if the resident has an advance directive and if he or she is able to make their own decisions.
10. Indicate if the resident speaks English. If not, specify the language spoken.
11. Under “Literacy/Religious Concerns,” list important concerns, such as inability to read or write, Jehovah’s Witness, etc.
12. List any previous admissions to hospitals or other LTC centers in the past month.
13. List the resident’s primary diagnoses and chronic conditions.
14. Under “Immunizations” indicate date (month/year) of immunizations administered in past year.
15. Under “CHECK ALL THAT APPLY,” check all applicable boxes and describe or supply dates or additional information when indicated.
   a. Under “Impairments and Disabilities,” mark all that apply. Briefly describe the impairment or disability.
   b. Under “Falls in Last 30 Days,” list date(s) and whether an injury occurred.
   c. Under “Infection,” indicate if the resident has an active infection or is colonized with methicillin resistant Staphylococcus aureus (MRSA) or vancomycin resistant enterococcus (VRE) and list site(s).
      Indicate if the patient has Clostridium difficile or a urinary tract infection.
   d. Under “Elimination,” mark if resident had a urinary catheter in the past month, the date inserted or changed and, if applicable, the date discontinued.
16. Check all records sent with resident and fax all requested records, if necessary.
17. Document aids and appliances sent with the resident. It is not necessary to document clothing and other personal items.
18. Under “Skin and Body Assessment,” indicate if skin is intact. If not, use numbers to identify all abrasions, bruises, skin tears and decubitus ulcers on the body diagram. Describe site and care conditions in space provided. Include wound vac settings, if applicable.
19. Indicate transfer date and time, hospital and mode of transportation.
20. Record most recent vital signs, height and weight.
21. Document that the receiving hospital was called, as well as the date, time and name and title of the individuals giving and receiving the report.
22. The person completing the form should sign and date the form.

Records to Be Sent with Resident or Faxed to Receiving Facility
1. face sheet
2. medication administration record that is currently in use, with recorded time of most recent doses
3. most recent complete nursing assessment. This provides a baseline for the hospital to identify normal functional and mental status of the patient.
4. most recent LTC history and physical or, if unavailable, a copy of the hospital admission history and physical
5. most recent physician orders; pertinent lab reports, especially PT/INR levels and drug levels; radiology reports and, if available, advance directive, durable power of attorney for health care and Do Not Resuscitate documentation

Form Reviewed and Approved
Director of Nursing: __________________________ Date: ______________

Form Reviewed and Approved
Director of Nursing: __________________________ Date: ______________
Frequently Asked Questions
Frequently Asked Questions

**ALL**

1. **The transfer form and process are designed for what types of transfers?**
   For hospitals, the forms are designed to be used whenever a patient is transferred to any post-acute care setting, with special emphasis on skilled nursing and assisted living communities. For LTC centers, this form has been designed so that you have the ability to use the form for transfers to hospitals and other LTC centers.

2. **Is our facility required to adopt the continuity of care transfer process and forms?**
   No, you are not required to adopt the exact process and forms. However, we do recommend that all hospitals and LTC centers adopt a process and forms to ensure that the identified, essential data are communicated in a timely and accurate manner to receiving facilities when transferring patients and residents. Because of facility variance in medical record requirements, the coalition is not suggesting that all hospitals and LTC communities adopt the model forms and guidelines as presented. Rather, the coalition recommends that all facilities modify them to meet their institutional needs.

3. **What can we do proactively to ensure success of the continuity of care transfer process?**
   You may want to consider pulling together focus groups before implementation to evaluate the current transfer process and forms and the proposed process and forms to identify strengths, weaknesses and barriers. Consider doing a “Failure Mode and Effects” analysis to evaluate the new process before implementation to detect possible failures, assess the effect on existing processes and prevent project failure by addressing identified issues and correcting them proactively.

4. **How can I measure the effectiveness and efficiency of this project/process?**
   You may use your organization’s performance measurement tools or you may use or modify the measurement tools in the “Getting Started: Resources” section. You also may want to consider evaluating outcome measures, such as readmission within 30 days or transfers back to ED within one week.

5. **What if certain belongings were checked but not sent with the patient/resident?**
   First, check with EMS personnel or the family and ask if they have the missing items. If they are unable to locate them, call the sending facility about the missing items. Document on the form that those belongings were not received.

6. **What if EMS or families neglect or forget to bring the forms and medical records with the patient/resident?**
   First, ask EMS personnel or the family if they have the forms and the records. Often, they simply forget or do not know they are to give them to the receiving facility. If the forms were not sent with EMS personnel or the family, please refer to question 10.

ED/HOSPITAL

7. **How do we handle calls from LTC centers to the ED or nursing unit when the person who took care of the resident is not available?**
   If the chart is still present in the unit or department, you should be able to answer most questions. If the chart has been sent to medical records, contact medical records (or house supervisors after hours) to retrieve the medical record for the ED or unit staff to review and answer questions. If the LTC center is requesting additional medical records, instruct them to call medical records during normal business hours to request the additional medical records.

8. **If the nurse-to-nurse report did not or cannot happen, is a faxed report adequate?**
   The Joint Commission requires all accredited facilities to have a handoff communication process, which includes an opportunity to offer questions and answers from the receiver to the sender. If a verbal report is not possible, indicate on the faxed transfer form that the receiving facility should call (provide telephone number) as soon as possible. You also can ask EMS personnel or the family transporting the resident to request that the receiving facility call as soon as possible.

9. **What if there is no nurse available for giving a report?**
   Assisted living and residential care facilities may not be required to have a licensed nurse on site 24/7. In those cases, it is acceptable to give the report to a
certified medication technician or certified nursing assistant. Be sure to determine who is receiving the information and communicate at the level of the staff member’s expertise.

10. What should we do if we receive a resident from a LTC center without a transfer form or with an incomplete or inaccurate form?
There are several reasons why the sending facility may not have completed the form. The LTC center may not be aware or may have chosen not to participate in the project or they were unable, unwilling or simply forgot to complete the form.

If no form was received, you should call the sending facility and ask them to complete the transfer form. If they are unaware of the transfer form, fax them a copy and ask them to complete and fax it to you. If the form received is incomplete or inaccurate, ask them the necessary questions or to clarify any answers during the verbal report. You also may want to notify the appropriate person (your director or the project champion) or record the non-compliance on a tracking tool.

11. Why do we have to address the resident’s need for new prescriptions with the LTC center until pharmacy services are available?
LTC communities have unique requirements and arrangements with LTC pharmacy services for residents’ medications. New orders for critical medications, such as antibiotics and pain medicine, may not be available for several hours or until the next day. It may be necessary to send enough doses of critical medications to meet the resident’s needs during this time. State hospital licensure regulations permit the hospital to dispense medications when prescription services from a pharmacy are not reasonably available. (See hospital licensure rule CSR 19 30-20.100)

12. What role does the patient and their family play in this recommendation?
In the ED, verify with the patient and family the accuracy and completeness of the information provided, especially in the areas of advance directives and medication reconciliation.

In the hospital, you can use the transfer form as an adjunct to the information provided by the family when completing the admission assessment.

13. Is it okay to fax a copy of all the required medical records to the LTC facility?
Most fax machines at LTC facility’s can only accept a limited number of pages. We recommend only faxing the transfer form and medication orders with the resident.

14. Why is it important for the ED physician to call the LTC resident’s physician before transferring the patient back to the LTC facility?
Most ED physicians have never practiced in an LTC setting and may be unfamiliar with the capacity of these settings to provide the necessary care. For example, many LTC settings do not have the nursing capability to administer IV fluids or antibiotics or a facility may not have the sufficient staff to closely monitor the resident. Residents of assisted living facilities often have a primary care physician who is not affiliated with the assisted living facility and therefore would be unaware of the resident’s condition.

15. What if the ED physician is unable to reach the resident’s physician before transfer?
In the space provided, note the unavailability and the date and time the attempt was made.

16. What if there is not enough space to record all of the medications?
You only need to record new or changed medications. If more space is needed, you may use a physician order sheet. Be sure to indicate if the first dose was already given and the date and time that the next dose is due.

17. Do we have to complete the physician orders and follow-up appointments?
If your facility uses a separate physician order sheet and/or medication reconciliation record, check the “see physician order sheet” and/or “see medication reconciliation record” boxes and leave this section blank.

18. What if there is not enough room to record the ED findings or additional orders?
Use a separate order sheet or progress notes and indicate on the form that you have done so.
19. What facilities should I expect to send the transfer forms?  
Because this is a voluntary project, you should only expect the transfer form from those LTC centers that are participating in the project. (Refer to question 10.)

20. What LTC Centers should we contact?  
At first, you may want to focus on the LTC facilities, including nursing homes and assisted and residential living centers, with the most ED and hospital transfers. Begin to reach out to others as experience is gained. If your hospital is in a service area that includes other hospitals, you may want to collaborate on reaching out to the LTC centers together. It may be helpful to include your EMS providers in the discussion of this project.

21. Why is it important for the attending physician or hospitalist to call the LTC resident’s physician or the accepting physician before transferring a patient to an LTC facility?  
Many physicians have never practiced in an LTC setting and may be unfamiliar with the capacity of these settings to provide the necessary care. Therefore, they may transfer inappropriately or too soon. For example, many LTC settings do not have the nursing capability to administer IV fluids or antibiotics, or a facility may not have the sufficient staff to closely monitor the resident. Residents of assisted living facilities often have a primary care physician who is not affiliated with the assisted living facility and therefore would be unaware of the resident’s condition.

22. How does the attending physician know who is the accepting physician in the LTC facility?  
The hospital’s social worker or discharge planner should determine the accepting physician and necessary contact information when arrangements are made with the LTC center for transfer. This person will enter the information on Page 1 of the transfer forms.

23. What if the attending physician is unable to reach the resident’s physician before transfer?  
In the space provided, note the unavailability and the date and time the attempt was made.

24. The guidelines recommend that prescriptions be faxed to the receiving LTC center by noon of the day of transfer. Why is this necessary? What if you are unable to meet the noon deadline?  
LTC centers obtain their resident medications from special LTC prescription services. In most circumstances, all medications must be in unit dose form. LTC centers only keep a limited supply of emergency drugs on site. Many of these LTC pharmacies are not located in the same area as the LTC center, and filled prescriptions are sent by couriers. If prescriptions are not faxed or sent by noon of the day of discharge, the resident may not receive the necessary medications, such as pain medications and antibiotics in a timely manner. (Refer to question 10.)

25. Do we have to use the physician discharge and summary sheet?  
This page is optional because many hospitals use the same discharge summary sheet for all patients. You may want to incorporate some of the recommended data elements into the form you currently use.

26. Why do you recommend coding whether or not a diagnosis was present on admission on Page 3?  
Hospitals are required to code and report whether or not a primary or secondary diagnosis was or was not POA on all Medicare inpatients in acute care hospitals. Many other payers also are beginning to require the POA indicator code. For Medicare discharges occurring on or after October 1, 2008, acute care hospitals will not receive additional payment for some hospital-acquired conditions. POA depends on accurate physician documentation that the condition was POA. The space provided on Page 3 gives physicians one last opportunity to consider if a condition was POA and makes it easier for coders to identify these conditions.

27. Do we have to complete the discharge medication section if we use a separate medication order sheet or reconciliation record?  
If your facility uses a separate medication order sheet and/or medication reconciliation record, check the appropriate boxes and leave this section blank.
28. What if there is not enough room to record all of the medications?
Use a separate order sheet and indicate on the form that you have done so.

29. On Page 1 of the hospital transfer form do we have to look up all of the treatments listed in the last 14 days?
This section is designed to assist skilled nursing units and facilities in completing the minimum data set as required by Medicare and to reduce the hundreds of pages the LTC centers were previously required to copy and send. If a treatment was administered in the last 14 days, record the last day that a treatment was given. For example, if a patient had been on the ventilator and received a blood transfusion 18 days ago and received oxygen and IV medications yesterday, only check the oxygen and IV medication boxes and record yesterday’s date. If your hospital has electronic medical records, your information technology department may be able to create a report that provides the last date a treatment was given. If you opt to copy and send the last 14 days of MARs and nurse’s notes instead of completing this section, write “see MARs and nurse’s notes” in this section.

30. What if an LTC center insists that we continue to copy and send all 14 days of MARs and nurse’s notes on the entire chart?
The state MDS coordinators and the Department of Health and Senior Services’ LTC section reviewed the process and the forms and agreed that a hospital completing this section meets the requirements for documentation for the MDS. After discharge, they may request additional forms and documents from medical records, but these may be subject to medical record copying fees. This could decrease the number of medical records requested.

31. Where can we get extra assistance with the forms, guidelines and process?
For LTC centers, your greatest asset will be communicating with key contacts at your local hospital. They should be able to help and assist you. If they are unable or unwilling, please contact your LTC association or the Missouri Hospital Association.

32. What if I don’t know the answer to a specific question on the form? (For example, admissions to other hospitals in the last month or immunizations.)
You may write “unknown” in the space provided.

33. What do you mean by “send the most recent complete nursing assessment?”
This is the last nursing assessment completed by a licensed nurse in your facility. These may be done monthly, quarterly or annually, depending on the type of facility. This is not the MDS. A nursing assessment provides a baseline for the hospital to compare the resident’s current condition.

34. What if the patient is being transferred emergently and I do not have time to complete the form?
After the patient has been transferred by EMS, complete the form and fax to the receiving facility.

35. If we have questions, concerns or need additional information after a resident is discharged from the ED, who should we call?
First, review the transfer form and the medical records that were sent with the resident. If you still have questions, call the hospital ED or inpatient unit. The medical record may have already been sent to the medical records department, and the unit may have to retrieve the record and return your call to answer your questions. If the ED or nursing unit is unable to answer your questions, call and speak with the house supervisor. If you are requesting additional medical records, call the medical records department during normal business hours.

36. What if I receive a resident and the transfer form but have not received a call from the receiving facility?
Call the hospital and ask to speak with the person listed on the transfer form.

37. What if I don’t know to which hospital the EMS is transporting the resident?
Ask the EMS personnel to call you when they know the hospital to which the resident will be transferred.
REFERENCES


“The problem of inadequate information transfer between long-term care facilities and hospital and vice versa has created barriers to effective, efficient and safe patient care. It is my hope we can work together to disseminate this information to all health care facilities in Missouri and make information transfer problems go away. Our residents will be safer, and relationships between hospitals and nursing facilities will be stronger.”

– Jeffrey A. Kerr, D.O., CMD
ACKNOWLEDGEMENTS

The Long-Term Care Best Practice Coalition would like to acknowledge the support given to this project by the following organizations.

Boone Hospital Center  Missouri Association of Nursing Home Administrators
Fayette Caring Center  Missouri Center for Patient Safety
Lake Regional Health System  Missouri Department of Health and Senior Services
Laurie Care Center  Missouri Health Care Association
Missouri Assisted Living Association  Missouri Hospital Association
Missouri Association of Homes for the Aging  Missouri League for Nursing
Missouri Association of LTC Physicians  Missouri Nursing Home Ombudsman

Moberly Nursing and Rehabilitation
Osage Beach Health Care Center
Primaris
The Bluffs
University of Missouri Center for Bioethics
University of Missouri Sinclair School of Nursing
Windsor Estates

The Missouri Hospital Association would like to acknowledge the time and efforts of the transfer workgroup who contributed their time and talents to develop the tools and resources used in this guide.

Heather Arnold  Charolette Hallmark  Don Reynolds
Cindy Baird  Elaine Hobein  Jesse Roberts, M.D.
David Brunworth, M.D.  Kerri Hock  Christy Robertson
Debra Cheshier  Patricia Kapser  William Rosen, M.D.
Denise Clemonds  Jeffrey Kerr, D.O.  Michael Roth
Lisa Coots  Stephanie Long  Tawney Sandifer
David Cravens, M.D.  Lana Martin  Carol Scott
Charles Crecelius, M.D.  Sally McKee  Sharon Thomas
Thomas Dahlberg, M.D.  James McMillen, M.D.  Susan Tonarely
Jon Dolan  Becky Miller  Jennifer Wankum
Natalie Fieleke  Patti Muxlow  Alison Williams
Deborah Finley  Amy Nichols  Shelly Williamson
Sharon Ford  Sam Plaster  Cindy Wrigley
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SPONSORS

Thank you to the following organizations that provided financial support for this toolkit.

Missouri Hospital Association
Missouri Department of Health and Senior Services
Missouri Association of Homes for the Aging
Missouri Health Care Association
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