

Hospital to Long-Term Care Handoff Communication Form Guideline

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.

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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.

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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.

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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

Date: _____

Director of Nursing: _____

Form Reviewed and Approved

Date: _____

Director of Nursing: _____

Form Reviewed and Approved

Date: _____

Director of Nursing: _____

Form Reviewed and Approved.

Date: _____

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