Georgia Department of Public Health

Continuum of Care Communication: Transfer Form and Process

Presentation to: Hospitals, Long Term Acute Care and Long Term Care

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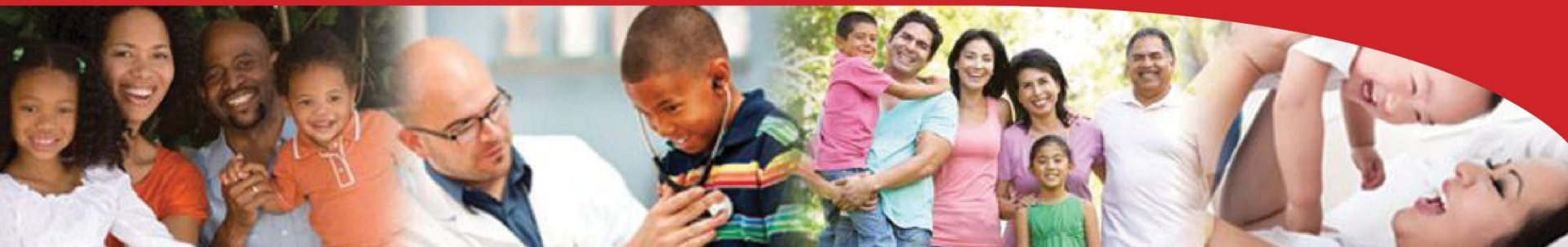
We Protect Lives.



Objectives

- Share transfer forms within community of practices
- Identify 4 infection control (IC) critical elements that need adding or revising
- Identify opportunities to improve IC communication
- Share collaboration highpoints with group

Getting Started

Co-Captain

- Volunteer or choose
  - Practice co-captain for each group
  - Co-captain will facilitate discussion and manage time
  - Share the highpoints of the discussion and the 4 critical elements identified by your practice group as missing are needs adding

Scribe

- Volunteer or choose
  - Scribe on flip chart in bullets
  - Highpoints of group discussion
  - 4 critical elements identified

Collaboration: 45 Minutes

Practice Group Collaboration

- Practice groups to include 1 hospital and their primary transfer partners per table
- Partners staff will assist with facilitation when needed
- Refer to presentations and identify critical elements that should be included in transfer communication process

Collaboration: 45 Minutes

Practice Group Collaboration

- Review each transfer partners current transfer form together
- Refer to and discuss the IC critical elements presented in the day's training sessions
- Consider how to use the PDSA model to make small changes to improve the IC transfer communication process
- Scribe capture work on flip chart: 4 critical areas your practice group agreed to work on, etc.

Collaboration Sharing : 20 Minutes

Practice Group Collaboration

- Co-captain to share the 4 critical areas your practice group agreed to work on within each individual organization
- Exchange contact information before leaving

Wrap-up

- Plan to attend April Webinar for training on transfer audit process

The Atlanta Regional CRE Continuum of Care Collaborative work is important to patients and their loved ones in the metro area.

Thank you!

Nursing Home to Hospital Transfer Form

INTERACT®
Version 3.0 Tool

Resident Name *(last, first, middle initial)* _____
Language: ☐ English ☐ Other _____ Resident is: ☐ SNF/rehab ☐ Long-term
Date Admitted *(most recent)* _____/_____/_____ DOB _____/_____/_____
Primary diagnosis(es) for admission _____

Sent To *(name of hospital)* _____
Date of transfer _____/_____/_____
Sent From *(name of nursing home)* _____ Unit _____

Contact Person _____
Relationship *(check all that apply)*
☐ Relative ☐ Health care proxy ☐ Guardian ☐ Other
Tel (_____) _____
Notified of transfer? ☐ Yes ☐ No
Aware of clinical situation? ☐ Yes ☐ No

Who to Call at the Nursing Home to Get Questions Answered
Name / Title _____
Tel (_____) _____

Primary Care Clinician in Nursing Home ☐ MD ☐ NP ☐ PA
Name _____
Tel (_____) _____

Code Status ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort Care Only ☐ Uncertain

Key Clinical Information
Reason(s) for transfer _____
Is the primary reason for transfer for diagnostic testing, not admission? ☐ No ☐ Yes Tests: _____
Relevant diagnoses ☐ CHF ☐ COPD ☐ CRF ☐ DM ☐ Ca *(active treatment)* ☐ Dementia ☐ Other _____
Vital Signs BP _____ HR _____ RR _____ Temp _____ O2 Sat _____ Time taken *(am/pm)* _____
Most recent pain level _____ (☐ N/A) Pain location: _____
Most recent pain med _____ Date given _____/_____/_____ Time *(am/pm)* _____

Usual Mental Status:
☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, but cannot follow simple instructions
☐ Not Alert

Usual Functional Status:
☐ Ambulates independently
☐ Ambulates with assistive device
☐ Ambulates only with human assistance
☐ Not ambulatory

Additional Clinical Information:
☐ SBAR Acute Change in Condition Note included
☐ Other clinical notes included
For residents with lacerations or wounds:
Date of last tetanus vaccination *(if known)* _____/_____/_____

Devices and Treatments
☐ O2 at _____ L/min by ☐ Nasal canula ☐ Mask (☐ Chronic ☐ New)
☐ Nebulizer therapy; (☐ Chronic ☐ New)
☐ CPAP ☐ BiPAP ☐ Pacemaker ☐ IV ☐ PICC line
☐ Bladder (Foley) Catheter (☐ Chronic ☐ New) ☐ Internal Defibrillator
☐ Enteral Feeding ☐ TPN ☐ Other _____

Isolation Precautions
☐ MRSA ☐ VRE
Site _____
☐ C. difficile ☐ Norovirus
☐ Respiratory virus or flu
☐ Other _____

Allergies
_____
_____
_____
_____
_____

Risk Alerts
☐ Anticoagulation ☐ Falls ☐ Pressure ulcer(s) ☐ Aspiration ☐ Seizures
☐ Harm to self or others ☐ Restraints ☐ Limited/non-weight bearing: (☐ Left ☐ Right)
☐ May attempt to exit ☐ Swallowing precautions ☐ Needs meds crushed
☐ Other _____

Personal Belongings Sent with Resident
☐ Eyeglasses ☐ Hearing Aid
☐ Dental Appliance ☐ Jewelry
☐ Other _____
_____

Nursing Home Would be able to Accept Resident Back Under the Following Conditions
☐ ER determines diagnoses, and treatment can be done in NH ☐ VS stabilized and follow up plan can be done in NH
☐ Other _____

Additional Transfer Information on a Second Page:
☐ Included ☐ Will be sent later

Form Completed By *(name/title)* _____ **Signature** _____
Report Called in By *(name/title)* _____
Report Called in To *(name/title)* _____ Date _____/_____/_____ Time *(am/pm)* _____

Nursing Home to Hospital Transfer Form *(additional information)*

INTERACT® Version 3.0 Tool

Not critical for Emergency Room evaluation; may be forwarded later if unable to complete at time of transfer.

RECEIVER: PLEASE ENSURE THIS INFORMATION IS DELIVERED TO THE NURSE RESPONSIBLE FOR THIS PATIENT

Resident Name *(last, first, middle initial)* _____

DOB _____/_____/_____ Date transferred to hospital _____/_____/_____

Contact at Nursing Home for Further Information

Name / Title _____

Tel (_____) _____

Social Worker

Name _____

Tel (_____) _____

Family and Other Social Issues *(include what hospital staff needs to know about family concerns)* _____

Behavioral Issues and Interventions

Primary Goals of Care at Time of Transfer

☐ Rehabilitation and/or Medical Therapy with intent of returning home

☐ Chronic long-term care

☐ Palliative or end-of-life care

☐ Receiving hospice care ☐ Other _____

Treatments and Frequency *(include special treatments such as dialysis, chemotherapy, transfusions, radiation, TPN)*

Diet

Needs assistance with feeding? ☐ No ☐ Yes

Trouble swallowing? ☐ No ☐ Yes

Special consistency *(thickened liquids, crush meds, etc…)?* ☐ No ☐ Yes

Enteral tube feeding? ☐ No ☐ Yes *(formula/rate)* _____

Skin/Wound Care

Pressure Ulcers *(stage, location, appearance, treatments)*

Immunizations

Influenza:

Date _____/_____/_____

Pneumococcal:

Date _____/_____/_____

Physical Rehabilitation Therapy

Resident is receiving therapy with goal of returning home? ☐ No ☐ Yes

Physical Therapy: ☐ No ☐ Yes

Interventions _____

Occupational Therapy: ☐ No ☐ Yes

Interventions _____

Speech Therapy: ☐ No ☐ Yes

Interventions _____

ADLs Mark I = Independent D = Dependent A = Needs Assistance

Bathing _____ Dressing _____ Transfers _____

Toileting _____ Eating _____

☐ Can ambulate independently _____

☐ Assistive device *(if applicable)* _____

☐ Needs human assistance to ambulate _____

Impairments – General

☐ Cognitive ☐ Speech ☐ Hearing

☐ Vision ☐ Sensation

☐ Other _____

Impairments – Musculoskeletal

☐ Amputation ☐ Paralysis ☐ Contractures

☐ Other _____

Continence

☐ Bowel ☐ Bladder

Date of last BM _____/_____/_____

Additional Relevant Information _____

Form Completed By *(name/title)* _____

If this page sent after initial transfer: Date sent _____/_____/_____ Time *(am/pm)* _____

Signature _____

Resident/Patient Continuum of Care Transfer Form

Discharging Facility Name/Logo

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Patient Last Name:	Patient First Name:
Transfer to:	Attending Physician:
Reason for Transfer:	Date/Time:
❑ Attempted Treatment in SNF unsuccessful?	
❑ Please list ALLERGIES (meds, dyes, food): ❑ NKA	
Relative / Guardian Notified: Yes ❑ No ❑ Phone Number:	
Name of Relative Notified:	
Transfer Ambulance:	
VITAL SIGNS TAKEN Yes ❑ No ❑ Time Taken: AM ❑ PM ❑	
Respirations:	Blood glucose: Time:
O2 Sat:	VRE: Yes ❑ No ❑ Hx of ❑
Pulse:	MRSA: Yes ❑ No ❑ Hx of ❑
BP:	C. Diff: Yes ❑ No ❑ Hx of ❑
Temp:	**ANY** pending cultures? Yes ❑ No ❑
Height:	If Yes, what?
Weight: Lbs ❑ Kg ❑	MDRO?

ATTACHMENTS (Please check)

- ❑ Face Sheet
- ❑ History & Physical
- ❑ MD Orders
- ❑ MAR
- ❑ Wound Assessment & Tx Sheet
- ❑ Pertinent Labs
- ❑ Code Status
- ❑ MD Order Life Sustaining Tx
- ❑ X-rays
- ❑ Bed Hold Policy
- ❑ Other:
- ❑ Other:
- ❑ Other:

********** **YOUR SPECIAL ATTENTION PLEASE** **********

ISOLATION PRECAUTIONS? Yes ❑ No ❑ — **TYPE:** Contact ❑ Droplet ❑ Airborne ❑ Other: ❑

VACCINATION HISTORY	**SKIN OR PRESSURE ULCER CONCERNS**
Pneumococcal Vaccine: Yes ❑ DATE: Refused ❑	**HIGH risk for skin breakdown**PLEASE TURN**** Yes ❑ No ❑
Flu Vaccine: Yes ❑ DATE: Refused ❑	Current Skin Breakdown: Yes ❑ No ❑
Tetanus: Yes ❑ DATE: Refused ❑	Most Recent Treatment Time: AM ❑ PM ❑
TB Skin Test: Negative ❑ Positive ❑ DATE:	Please Treat at (time): AM ❑ PM ❑
OR Chest X-ray ❑ Result Date: Comments:	Treat with (product name): To (what area):
MEDICATION INFORMATION	**SAFETY CONCERNS**
Meds Given: Whole ❑ Crushed ❑	History of Falls Yes ❑ No ❑ / Risk for Falls Yes ❑ No ❑
Prefers meds with:	Behavior Issues Yes ❑ No ❑ / Explain:
Pain Meds in past 24 hours Yes ❑ No ❑	RESTRAINT Use: Yes ❑ No ❑
Level on **Pain Scale** at time of transfer : (Please circle level) **1 2 3 4 5 6 7 8 9 10**	Type of Restraint Used: When Used:
DIET & FEEDING	**ELIMINATION**
Current Diet:	Bladder Incontinence ❑ / DATE of UTI (within 14 days):
Needs Assistance ❑ / Feeds Self ❑ / Feeding Tube ❑	Catheter: Yes ❑ No ❑ / Date Inserted or Last Changed:
Thickened Liquid ❑ Consistency?	Bowel Incontinence: Yes ❑ No ❑ / Colostomy: Yes ❑ No ❑
Supplement ❑ If so, name:	Date of Last BM:
IMPAIRMENTS/DISABILITIES: (Please check all that apply)	**PATIENT EQUIPMENT/BELONGINGS: (Check all sent with resident)**
Speech ❑ Contractures ❑ Mental Confusion ❑ Vision ❑ Hearing ❑ Amputation ❑ Paralysis ❑ Language Barrier ❑	None ❑ Right Hearing Aid ❑ Left Hearing Aid ❑ Glasses ❑ Upper Denture ❑ Lower Denture ❑
COMMENTS:	Jewelry ❑ Please list:
Report Called to:	Other (i.e., prosthesis):

Nurse Name (Print):	Nurse Signature:	Phone #:	Date/Time:

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Inter-facility Infection Control Transfer Form

This form must be filled out for transfer to accepting facility with information communicated prior to or with transfer

Please attach copies of latest culture reports with susceptibilities if available

Sending Healthcare Facility:

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number
		___/____/_____	

Name/Address of Sending Facility	Sending Unit	Sending Facility phone

Sending Facility Contacts	NAME	PHONE	E-mail
Case Manager/Admin/SW			
Infection Prevention			

Is the patient currently in isolation? □ NO □ YES

Type of Isolation (check all that apply) □ Contact □ Droplet □ Airborne □ Other:

_____

Does patient currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	**Colonization or history** *Check if YES*	**Active infection on Treatment** *Check if YES*
Methicillin-resistant Staphylococcus aureus (MRSA)		
Vancomycin-resistant Enterococcus (VRE)		
Clostridium difficile		
Acinetobacter, multidrug-resistant*		
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL)*		
Carbapenemase resistant Enterobacteriaceae (CRE)*		
Other:		

Does the patient/resident currently have any of the following?

☐ Cough or requires suctioning
☐ Diarrhea
☐ Vomiting
☐ Incontinent of urine or stool
☐ Open wounds or wounds requiring dressing change
☐ Drainage (source)_____
☐ Central line/PICC (Approx. date inserted ___/___/_____)
☐ Hemodialysis catheter
☐ Urinary catheter (Approx. date inserted ___/___/_____)
☐ Suprapubic catheter
☐ Percutaneous gastrostomy tube
☐ Tracheostomy

Is the patient/resident currently on antibiotics? □ NO □ YES:

Antibiotic and dose	**Treatment for:**	**Start date**	**Anticipated stop date**

Vaccine	**Date administered (If known)**	**Lot and Brand (If known)**	**Year administered (If exact date not known)**	**Does Patient self report receiving vaccine?**	
Influenza (seasonal)				o yes	o no
Pneumococcal				o yes	o no
Other:_____				o yes	o no

Printed Name of Person completing form	**Signature**	**Date**	**If information communicated prior to transfer: Name and phone of individual at receiving facility**