ED Transfer Communication

USING DATA TO DRIVE IMPROVEMENT!

EDTC-4: Medication information

June 16th 2016

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Agenda

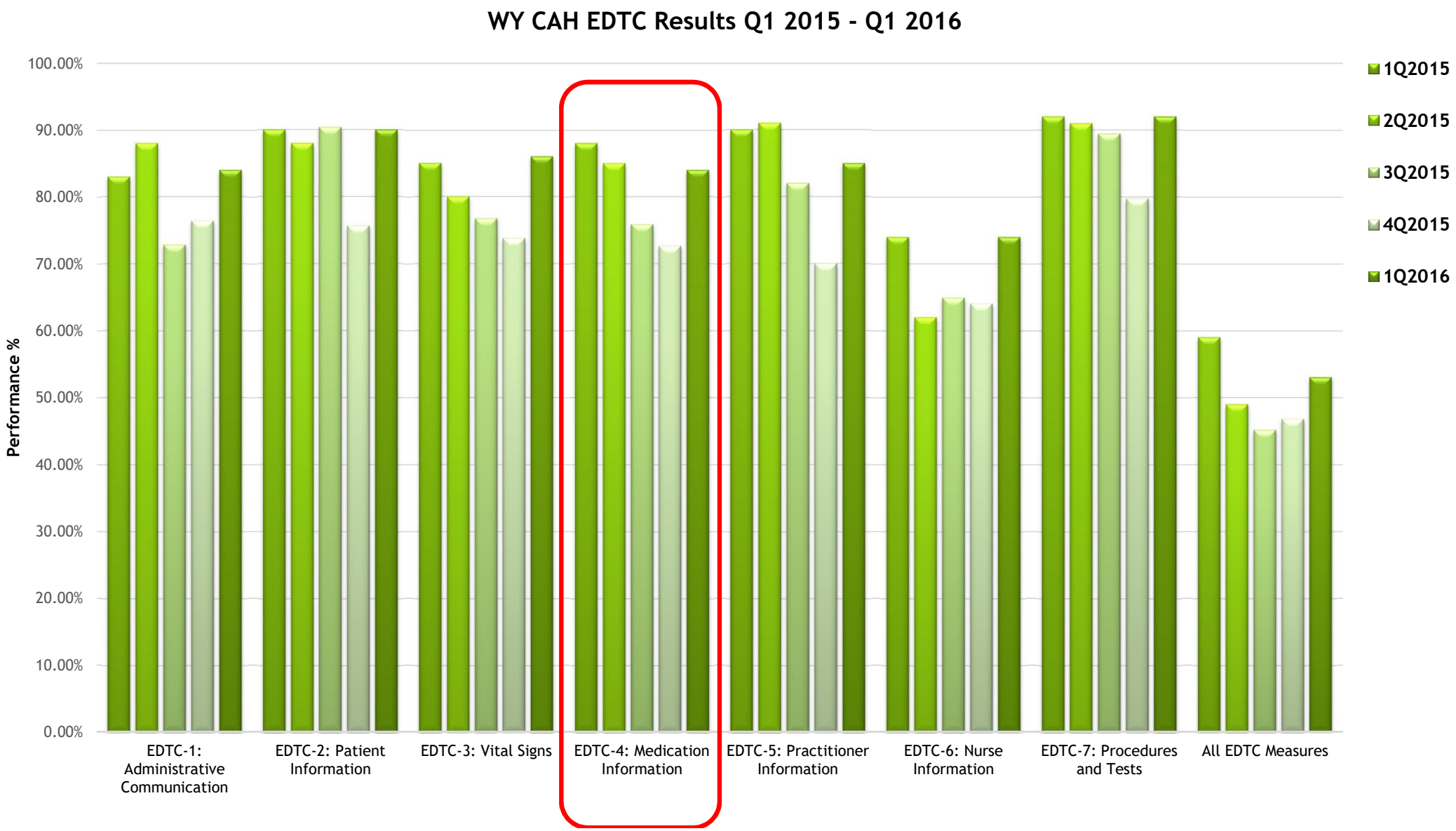
- EDTC–4 Measure Overview
- Review of Data Results – Discussion amongst CAHs
- Review of EDTC-4 Abstraction Guidelines *(If Necessary)*
  - *Roles and Responsibilities*
- Interpretation of EDTC-4 Reports (Q1 2016)
- Sharing of Best Practices
- Plan, Do, Study/Check, Act (PDSA/PDCA)
- Sample forms, checklists, fact sheets, etc.
- Additional resources

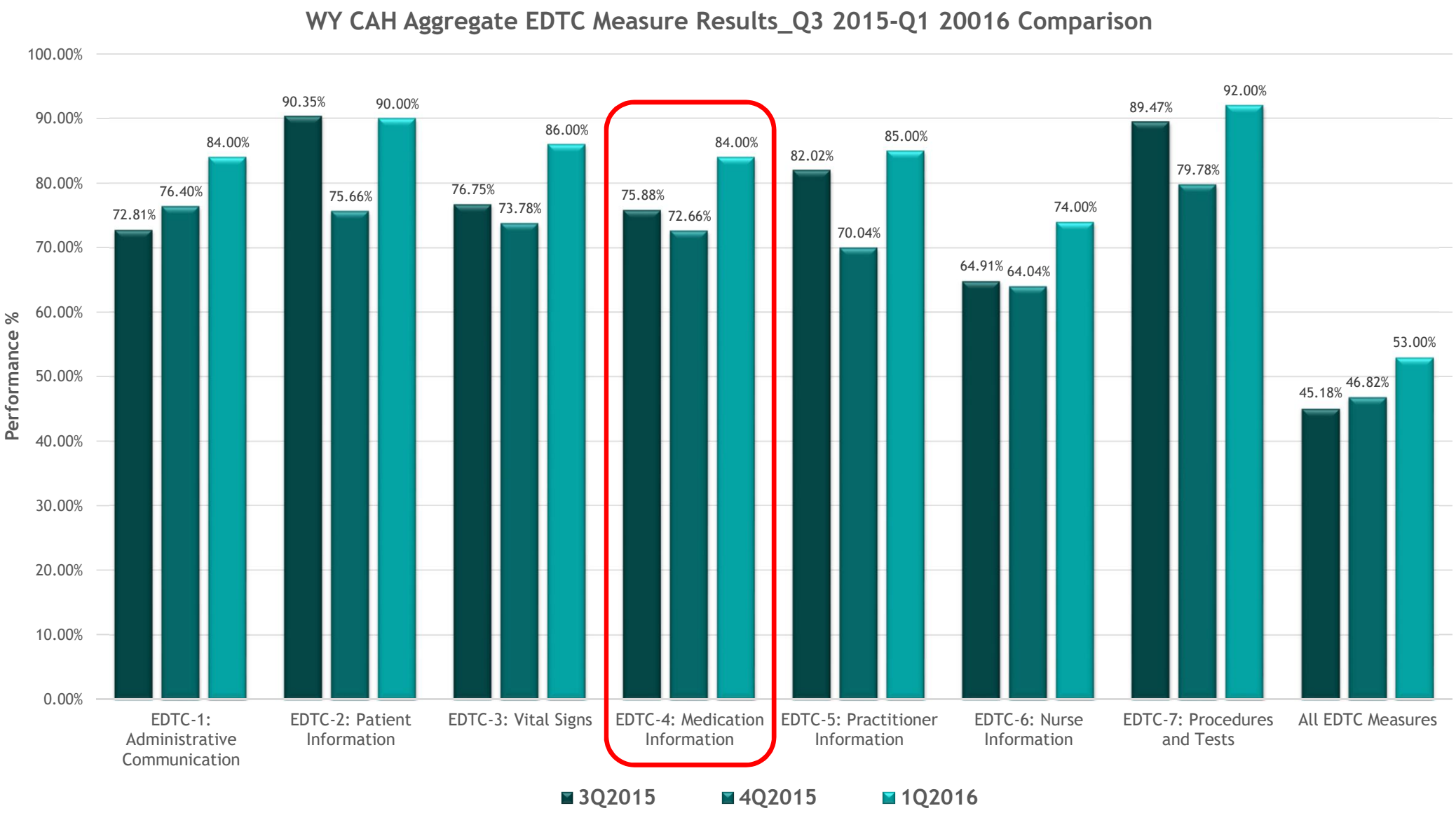
Measure Overview

ED Transfer Communication Measures

Category
Pre-Transfer Communication Information
Nurse communication with receiving hospital
Physician communication with receiving physician
Patient Identification
Name
Address
Age
Gender
Significant others contact information
Insurance
Vital Signs
Pulse
Respiratory Rate
Blood Pressure
Oxygen Saturation
Temperature
Glasgow score (trauma or neuro patients)

Medication-related Information
Medications Given
Allergies
Medications from home
Practitioner generated information (History and Physical)
Physical exam, history of current event, chronic conditions
Physician orders and plan
Nurse generated information
Nurse documentation includes:
Assessment/interventions/response
Impairments
Catheters
Immobilizations
Respiratory support
Oral limitations
Procedures and tests
Tests and procedures done
Tests and procedure results sent


WY CAH EDTC Results Q1 2015 - Q1 2016
Performance %
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
EDTC-1: Administrative Communication
EDTC-2: Patient Information
EDTC-3: Vital Signs
EDTC-4: Medication Information
EDTC-5: Practitioner Information
EDTC-6: Nurse Information
EDTC-7: Procedures and Tests
All EDTC Measures
1Q2015
2Q2015
3Q2015
4Q2015
1Q2016


WY CAH Aggregate EDTC Measure Results_Q3 2015-Q1 20016 Comparison
Performance %
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
72.81%
76.40%
84.00%
90.35%
75.66%
90.00%
76.75%
73.78%
86.00%
75.88%
72.66%
84.00%
82.02%
70.04%
85.00%
64.91%
64.04%
74.00%
89.47%
79.78%
92.00%
45.18%
46.82%
53.00%
EDTC-1: Administrative Communication
EDTC-2: Patient Information
EDTC-3: Vital Signs
EDTC-4: Medication Information
EDTC-5: Practitioner Information
EDTC-6: Nurse Information
EDTC-7: Procedures and Tests
All EDTC Measures
3Q2015
4Q2015
1Q2016

Review of Data Results: *Discussion amongst CAHs*

- *Insert notes form discussion here…*

Measure EDTC-SUB 4

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 4
Performance Measure Name: Medication Information
Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for medication information.
Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.
Type of Measure: Process
Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.

- Medications administered in ED
- Allergies
- Home medications

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 4

Numerator	# of patients who have a yes or NA for all measures: Medications administered in ED, allergies and home medications
Denominator	All transfers from ED to another health care facility

Medications Administered in ED

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the list of medication(s) administered or that no medications were administered in the ED was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the list of medications administered were sent to the receiving facility.
N (No) Select this option if there is no documentation that the list of medications administered were sent to the receiving facility.

Notes for Abstraction:

- If no medications were given during the ED visit, documentation must state that there were no medications given to select yes.
- Medication information documented anywhere in the ED record is acceptable.

Suggested Data Sources:

- Emergency Department record
- Medication Administration Record (MAR) if part of the ED documentation for the current encounter
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Allergies/Reactions

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's allergy history was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation the patient's allergy information was sent to the receiving facility.
N (No) Select this option if there is no documentation the patient's allergy information was sent to the receiving facility.

Notes for Abstraction:

- See inclusion guidelines for what should be contained in the allergy information.
- If documentation is sent that allergies are unknown, select yes.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:

- Food allergies/reactions
- Medication allergies/reactions
- Other allergies/reactions

Exclusion Guidelines for Abstraction:
None

Home Medications

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's medication history was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation medication history was sent to the receiving facility.
N (No) Select this option if there is no documentation medication history was sent to the receiving facility.

Notes for Abstraction:

- If documentation indicates patient is not on any home medications, select yes.
- If documentation is sent that home medications are unknown, select yes

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:

- Complimentary medications
- Over the counter (OTC) medications

Exclusion Guidelines for Abstraction:
None

Communication & Documentation

- Encourage healthcare professionals to take personal responsibility for the transfer of information about medicines.
- Provide a common data set for the improvement and development of organizational systems and processes to support the safe transfer of information about patients' medicines.
- Engage with patients to encourage them to take an active role in understanding their medicines to improve their safe management when they move between care providers and healthcare settings.

"the single biggest
problem in
communication is the
illusion that it
has taken place"
-George Bernard Shaw

Communication & Documentation

Four core principles for health care professionals:

1. Health care professionals transferring a patient should ensure that all necessary information about the patient's medicines is accurately recorded and transferred with the patient, and that responsibility for ongoing prescribing is clear.
2. When taking over the care of a patient, the healthcare professional responsible should check that information about the patient's medicines has been accurately received, recorded and acted upon.
3. Patients (or their parents, or advocates, or caregivers, etc.) should be encouraged to be active partners in managing their medicines when they move, and know in plain terms why, when and what medicines they are taking.
4. Information about patients' medicines should be communicated in a way which is timely, clear, unambiguous and legible; ideally generated and/or transferred electronically

Communication & Documentation

Three key responsibilities for organizations providing care:

1. Provider organizations must ensure that they have safe systems that define roles and responsibilities within the organization, and ensure that healthcare professionals are supported to transfer information about medicines accurately.
2. Systems should focus on improving patient safety and patient outcomes. Organizations should consistently monitor and audit how effectively they transfer information about medicines.
3. Good and poor practice in the transfer of medicines should be shared to improve systems and encourage a safety culture.

Everyone Plays a Role

Physician Responsibilities:

- Write complete transition orders, including medications according to the facility's Medication Reconciliation process.

Nurse Responsibilities:

- Discuss new medications ordered with the patient/family. Arrange to have medication prescriptions filled.
- Complete any required teaching for continued treatments and medication at home and document on a Discharge Instructions form.
- Assure medication reconciliation is complete

Patient Responsibilities:

- Play an active role in understanding their medicines to improve their safe management

Tips for Taking Medication History

Use a systematic approach

- For example, begin by asking about prescription medications, then over-the-counter products, and last vitamins/herbals/nutritional supplements—or develop and implement a standardized process workflow.

Engage patients

- Explain the importance of carrying an updated medication list to share with all healthcare providers.
- Explain the importance of obtaining a complete and accurate medication history.

Avoid yes/no questions

- Ask open-ended questions to solicit additional information.
- Review medical history – inquire about commonly prescribed medications for health conditions listed.

Tips for Taking Medication History

Consider all sources to obtain medication history and/or to clarify conflicting information, such as:

- Patient
- Patient's medication list – ask when the list was last updated
- Caregiver/family member
- Prior care provider
- Community pharmacy
- Physician(s)
- Past medical records

For each medication, record: name, strength, dose, route, frequency, and last dose taken.

- *Note any discrepancies in prescribed medications vs. what the patient reports he/she is actually taking.

ALLERGIES

- What medication allergies do you have?
- What type of bad reactions did you have?
- What other allergies do you have (such as food, latex, or environmental allergies)?

REVIEW OF COMMON HEALTH CONDITIONS/AILMENTS

- What medications do you take for:
  - Headaches? Seizures?
  - Sadness? Anxiety? Sleep?
  - Memory? Confusion?
  - Allergies? Your eyes?
  - Breathing? Inhalers?
  - Your heart? Blood pressure?
  - Blood thinners?
  - Diabetes? Thyroid?
  - Your stomach? Bowels?
  - Your bladder?
  - Your bones? Joints?
  - Pain? Fever?
  - Anything you put on your skin?

FOR MEDICATIONS/CONDITIONS WITH INCOMPLETE INFORMATION, CONSIDER:

- Who ordered the medication?
- What is the dose?
- When did you last take it?
- Where do you get your medications?
- Why do you take it?

OVER-THE-COUNTER MEDICATIONS

- What medicines do you take that you do not need a doctor's prescription to purchase?
- What do you take when you get constipation or diarrhea, heartburn, cough/cold, or headache? How often do you take it? How much?
- What do you take when you get sick? How often? How much?

SAMPLE Questions

SAMPLE Questions

PRESCRIPTIONS

- What pharmacy/pharmacies do you use?
- Are you taking any other medications prescribed by other healthcare professionals like your dentist, ophthalmologist, or chiropractor?
- What medications do you take every day? When do you take them?
- Are there any medications that you take only sometimes or when you need it? What are they? When do you take them?
- Have you used any patches?
- Have you had any injections given at a doctor's office or anywhere else?
- Has your doctor given you any sample drugs to take?

HERBAL/NATURAL SUPPLEMENTS

- What vitamins do you take?
- What herbal medications do you take?
- What natural supplements do you take?
- What supplements do you take to improve your diet?

MEDICATION CONCERNS

- Can you tell me about any missed doses in the past week?
- What problems or concerns do you have with your medications?
- What concerns do you have about side effects?
- Are there medications that you don't think are helping you?
- Are you having difficulty paying for your medications?

ED Transfer Comm. Data Collection Tool

EDTC Report Interpretation

Emergency Department Transfer Communication
Hospital Report

CMS Certified Number (CCN): 123456

Record List | Print Report | Main Page | Refresh Page

Measures	Data Elements	Q1 2016 1/1/2016 Records Reviewed (N) = 5	Q2 2016 4/1/2016 Records Reviewed (N) =	Q3 2016 7/1/2016 Records Reviewed (N) =	Q4 2016 10/1/2016 Records Reviewed (N) =
EDTC-1: Administrative Communication	Percentage of medical records that indicated the following occurred prior to patient departure from ED:				
	1. Healthcare Facility to Healthcare Facility Communication	100.00% (n=5)	N/A	N/A	N/A
	2. Physician to Physician Communication	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-1 Data Elements	100.00% (n=5)	N/A	N/A	N/A
EDTC - 2 Patient Information	Percentage of medical records that indicated the communication of following patient information within 60 minutes of patient's departure from ED:				
	1. Patient Name	100.00% (n=5)	N/A	N/A	N/A
	2. Patient Address	100.00% (n=5)	N/A	N/A	N/A
	3. Patient Age	100.00% (n=5)	N/A	N/A	N/A
	4. Patient Gender	100.00% (n=5)	N/A	N/A	N/A
	5. Patient Contact Information	100.00% (n=5)	N/A	N/A	N/A
	6. Patient Insurance Information	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-2 Data Elements	100.00% (n=5)	N/A	N/A	N/A
EDTC - 3 Vital Signs	Percentage of medical records that indicated the communication of following patient's vital signs information within 60 minutes of patient's departure from ED:				
	1. Pulse	100.00% (n=5)	N/A	N/A	N/A
	2. Respiratory Rate	100.00% (n=5)	N/A	N/A	N/A
	3. Blood Pressure	100.00% (n=5)	N/A	N/A	N/A
	4. Oxygen Saturation	100.00% (n=5)	N/A	N/A	N/A
	5. Temperature	100.00% (n=5)	N/A	N/A	N/A
	6. Neurological Assessment	100.00% (n=5)	N/A	N/A	N/A

EDTC - 4 Medication Information	Percentage of medical records that indicated the communication of following patient's medication information within 60 minutes of patient's departure from ED:				
	1. Medication Given in ED	100.00% (n=5)	N/A	N/A	N/A
	2. Allergies/Reactions	20.00% (n=1)	N/A	N/A	N/A
	3. Medication History	40.00% (n=2)	N/A	N/A	N/A
	All EDTC-4 Data Elements	20.00% (n=1)	N/A	N/A	N/A
EDTC - 5: Physician or Practitioner Generated Information	Percentage of medical records that indicated the communication of following physician generated information within 60 minutes of patient's departure from ED:				
	1. History and Physical	100.00% (n=5)	N/A	N/A	N/A
	2. Reason for Transfer/Plan of Care	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-5 Data Elements	100.00% (n=5)	N/A	N/A	N/A
EDTC - 6 Nurse Generated Information	Percentage of medical records that indicated the communication of following nurse generated information within 60 minutes of patient's departure from ED:				
	1. Nursing Notes	100.00% (n=5)	N/A	N/A	N/A
	2. Sensory Status (formerly Impairments)	100.00% (n=5)	N/A	N/A	N/A
	3. Catheters/IV	100.00% (n=5)	N/A	N/A	N/A
	4. Immobilizations	100.00% (n=5)	N/A	N/A	N/A
	5. Respiratory Support	100.00% (n=5)	N/A	N/A	N/A
	6. Oral Restrictions	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-6 Data Elements	100.00% (n=5)	N/A	N/A	N/A
EDTC - 7 Procedures and Tests	Percentage of medical records that indicated the communication of following procedures and tests information within 60 minutes of patient's departure from ED:				
	1. Tests/Procedures Performed	100.00% (n=5)	N/A	N/A	N/A
	2. Tests/Procedures Results	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-7 Data Elements	100.00% (n=5)	N/A	N/A	N/A
All EDTC Measures	Percentage of medical records that indicated the communication of all necessary patient's data upon patient's departure from ED:				
	All EDTC Measures	20.00% (n=1)	N/A	N/A	N/A

High Performer
Sharing of Best Practices

Sharing of Best Practices

- RECOMMENDED TRANSITIONS OF CARE PRINCIPLES AND STANDARDS
- IMPROVE ACCOUNTABILTY
- IDENTIFY RESPONSIBILITY
- COORDINATE CARE
- INVOLVE FAMILY
- CLEARLY COMMUNICATE
- ASSURE TIMELINESS
- UTLIZE NATIONAL STANDARDS AND METRICS

1. TRANSFER FROM: _____

TRANSFER TO: _____

2. DATE OF TRANSFER: _____

TIME OF TRANSFER: _____ ☐AM/☐PM

3. PATIENT NAME: _____
Last *First Name and Nickname* *MI*

PATIENT DOB *(mm/dd/yyyy)*: _____ GENDER ☐M ☐F

4. LANGUAGE: ☐ English ☐ Other: _____

5. PHYSICIAN NAME _____ PHONE _____

6. CODE STATUS: ☐ DNR ☐ DNH ☐ DNI
☐ Out of Hospital DNR Attached

7. CONTACT PERSON _____ RELATIONSHIP _____

PHONE (Day) _____ (Night) _____ (Cell) _____

Check if Contact Person:
☐ Health Care Representative/Proxy ☐ Legal Guardian

NAME OF ☐ HEALTH CARE REPRESENTATIVE/PROXY
OR ☐ LEGAL GUARDIAN, IF NOT CONTACT PERSON: _____

PHONE (Day) _____ (Night) _____ (Cell) _____

8. REASONS FOR TRANSFER: *(Must include brief medical history and recent changes in physical function or cognition.)* _____

V/S: BP _____ P _____ R _____ T _____ PAIN: ☐None ☐Yes, Rating _____ Site _____ Treatment _____

9. PRIMARY DIAGNOSIS _____ ☐ Pacemaker
☐ Internal Defib.

Secondary Diagnosis _____

Mental Health Diagnosis (if applicable) _____

10. RESTRAINTS: ☐No ☐Yes (describe) _____

11. RESPIRATORY NEEDS: ☐None ☐Oxygen-Device _____ Flow Rate _____

☐CPAP ☐BPAP ☐Trach ☐Vent ☐Related details attached ☐Other _____

12. ISOLATION/PRECAUTION: ☐None ☐MRSA ☐VRE ☐ESBL ☐C-Diff ☐ Other _____

Site _____ Comments _____ ☐Colonized

13. ALLERGIES: ☐None ☐Yes, List _____

14. SENSORY: Vision ☐Good ☐Poor ☐Blind ☐Glasses

Hearing ☐Good ☐Poor ☐Deaf Hearing Aid ☐Left ☐Right

Speech ☐Clear ☐Difficult ☐Aphasia

20. AT RISK ALERTS: ☐None

☐Falls ☐Pressure Ulcer ☐Aspiration

☐Wanders ☐Elopement ☐Seizure

Harm to: ☐N/A ☐Self ☐Others

Weight Bearing Status: ☐None

Left Leg: ☐Limited ☐Full

Right Leg: ☐Limited ☐Full

21. MENTAL STATUS: ☐Alert ☐Forgetful ☐Oriented

☐Unresponsive ☐Disoriented ☐Depressed

☐Other _____

22. ☐ PASRR LEVEL I COMPLETED

23. FUNCTION: Self With Help Not Able

Speech ☐Clear ☐Difficult ☐Aphasia

15. **SKIN CONDITION:** ☐No Wounds

☐YES, Pressure, Surgical, Vascular, Diabetic, Other ☐*See Attached TAR*

Type: ☐P ☐S ☐V ☐D ☐O

Site _____ Size _____ Stage *(Pressure)* _____ Comment _____

Type: ☐P ☐S ☐V ☐D ☐O

Site _____ Size _____ Stage *(Pressure)* _____ Comment _____

16. **DIET:** ☐Regular ☐Special (describe): _____

☐Tube feed ☐Mechanically altered diet ☐Thicken liquids

17. **IV ACCESS:** ☐None ☐PICC ☐Saline lock ☐IVAD ☐AV Shunt ☐Other: _____

18. **PERSONAL ITEMS SENT WITH PATIENT:** ☐None ☐Glasses ☐Walker ☐Cane

Hearing Aid: ☐Left ☐Right **Dentures:** ☐Upper/Partial ☐Lower/Partial ☐Other: _____

23. **FUNCTION:**

	Self	With Help	Not Able
Walk	☐	☐	☐
Transfer	☐	☐	☐
Toilet	☐	☐	☐
Feed	☐	☐	☐

24. **IMMUNIZATIONS/SCREENING:**

☐Flu Date: _____ ☐Tetanus Date: _____

☐Pneumo Date: _____ ☐PPD +/- Date: _____

☐Other: _____ Date: _____

25. **BOWEL:** ☐Continent ☐Incontinent Date last BM _____

Comments: _____

26. **BLADDER:** ☐Continent ☐Incontinent ☐Foley Catheter

Comments: _____

19. **ATTACHED DOCUMENTS:** *MUST ATTACH CURRENT MEDICATION INFORMATION* ☐Face Sheet ☐MAR ☐Medication Reconciliation ☐TAR ☐POS ☐Diagnostic Studies

☐Labs ☐Operative Report ☐Respiratory Care ☐Advance Directive ☐Code Status ☐Discharge Summary ☐PT Note ☐OT Note ☐ST Note ☐HX/PE

☐Other: _____

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27. **SENDING FACILITY CONTACT:** _____ Title _____ Unit _____ Phone _____

REC'G FACILITY CONTACT (if known): _____ Title _____ Unit _____ Phone _____

28. **FORM PREFILLED BY** (if applicable): _____ Title _____ Unit _____ Phone _____

29. **FORM COMPLETED BY:** _____ Title _____ Phone _____

Improvement Techniques

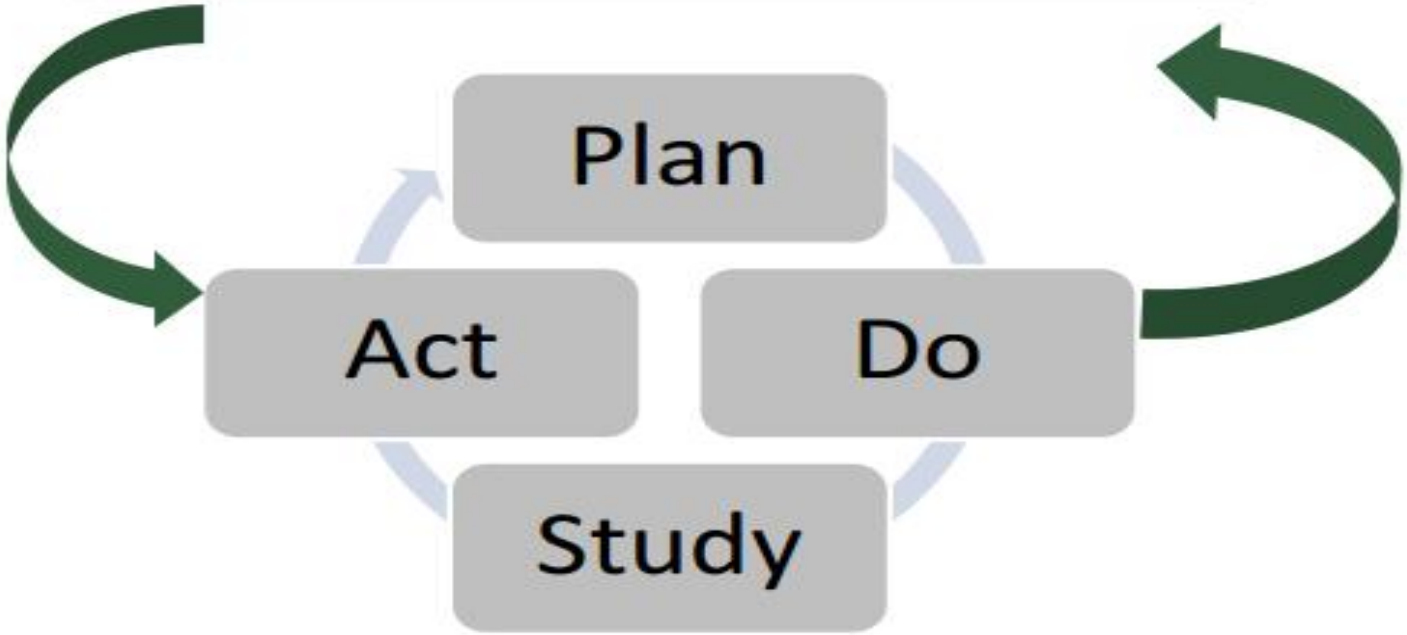
Principles of Improving:

- Know why you need to improve a system and/or process
- Have a way to obtain feedback to let you know if improvement is occurring
- Develop a change that you think will result in improvement
- Test a change before implementing
- Implement a change

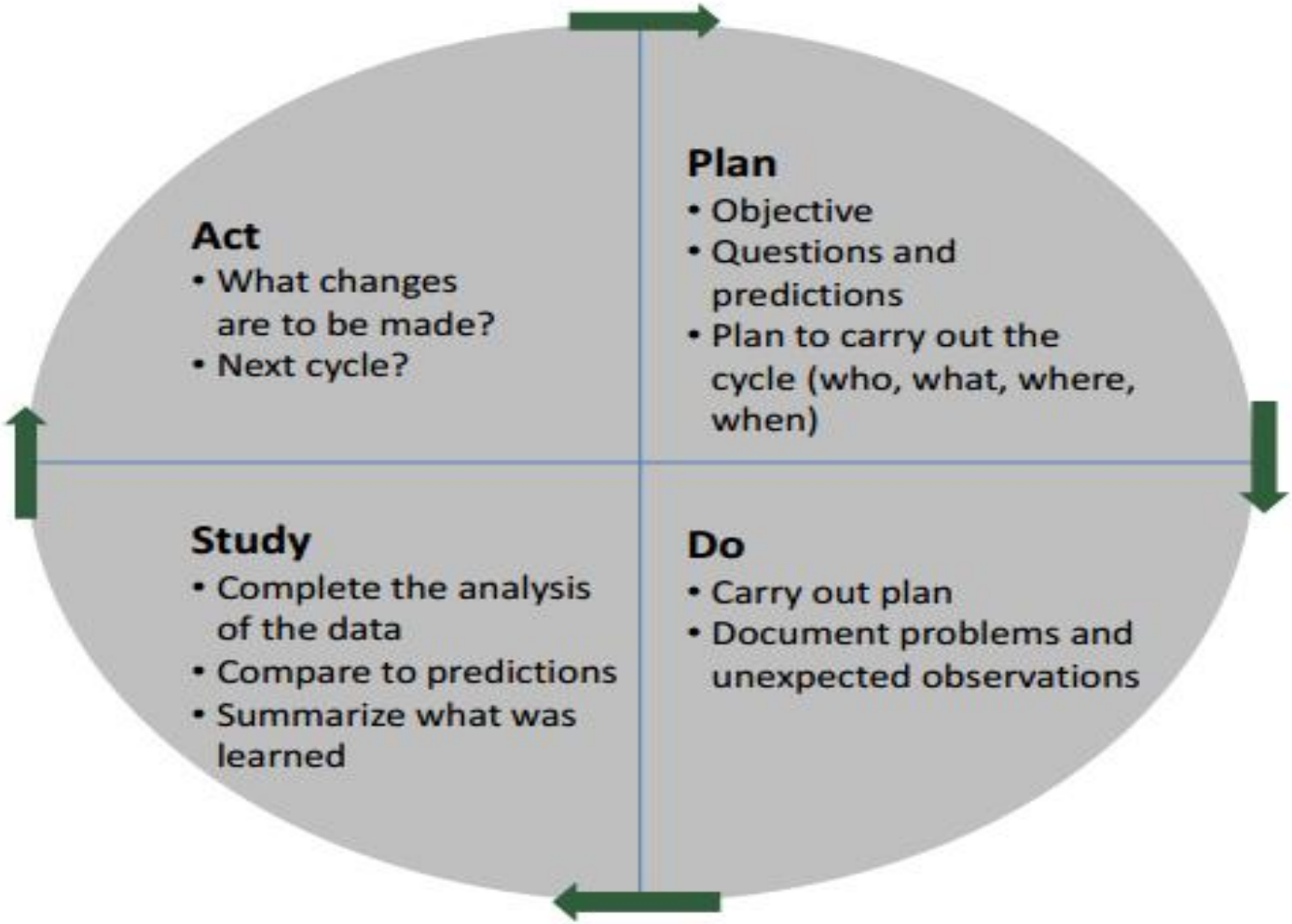
What are we trying to accomplish?

How will we know that change is an improvement?

What change can we make that will result in improvement?



PLAN-DO-STUDY-ACT



Show Sample
Medication Transfer Sheet(s)

Bring this form with you and show it to your prescriber or MTM provider any time you have a doctor's appointment you have to go to the hospital, and whenever you have a new prescription filled at your pharmacy.

Patient Name: _____

Date of Birth: ___/__/_____ **Date Form Updated:** ___/___/____

mm/dd/yyyy mm/dd/yyyy

Allergies / Reaction: _____

_____

Medications:

	Start Date / Stop Date	Name of Medicine	Tablet Strength	How to Use / When to Use	What is this Medicine for?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Patient Medication, Vitamin and Supplement Log

for (name) _____

Include prescription medications, over-the-counter medications, vitamins and herbal supplements

Pharmacy Name: _____ Phone: _____ Pharmacy Cross Streets: _____

Mail Order Pharmacy Name: _____ Mail Order ID #: _____

Start Date	Name of Medicine Brand Name/Generic Name	Dose (mg, units)	# taken per day	When do you take it? Morning/night, after meals	With food? Y or N	What's it for? Purpose	Size/color/ shape	Prescribed by Provider's name	Local Pharm or Mail order	Important Comments (danger signs, side effects, interactions)

Please bring this updated form with you to all of your medical office visits. If your medicines change, please tell your medical provider.
Check the detailed drug sheets provided by the pharmacy with each medication, or talk to your doctor about possible side effects, danger signs and interactions.

Allergies to: _____

Other Medical Providers that you are seeing (please include dentist and eye doctor):

Last Seen	Provider name	Specialty	Problem they are treating	Comments

Sample Checklist

While some aspects of emergency department transfer communication may be unique, many of the communication concepts and ideas that have been developed for transitions of care or handoffs between settings along the continuum of care also apply. Below is a series of sample checklists that can be used, adapted, or provide suggestions on how to meet your hospital's and community's unique needs.

- **Safer Handoff: Patient Handoff Checklist**. *Emergency Nurses Association (ENA)*. Developed to highlight information that should be transferred to and from emergency departments and Long Term Care facilities/agencies.
- **Transfer Checklist and Feedback Form**. *Northeast Health Care Quality Foundation*. Checklist and feedback form for interfacility transfers. Allows receiving facility to provide feedback and suggestions if information was not received or is incomplete.
- **Acute Care Transfer Document Checklist**. *Interact*. *Florida Atlantic University*. Designed for long term care facilities to ensure appropriate documentation is sent with a resident to the Emergency Department. Could be adapted to address communication from the emergency department to other settings of care.

Transfer Checklist and Feedback

Sending Facility:_____ Receiving Facility: _____

Person & Phone Number of Receiving Facility Requesting Info: _____

Patient's Name_____ Date: __/__/__ Time: _ _:_ _ (military)

☐ **All** information necessary to treat the patient was **received**.
☐ The following information necessary to treat the patient was **not received or was incomplete**:

☐ Face sheet with demographic and insurance information	☐ Discharge Summary or discharge paperwork
☐ Medication list missing ☐ Medication list incomplete, missing: _____	☐ Treatment orders (wound care, nursing care, OT/PT/Speech therapy, lab orders)
☐ Reason for transfer	☐ H & P or Medical History
☐ Face to Face	☐ Verbal Report or Nurse to Nurse Report
☐ Advance Directives and/or Code Status	☐ Inadequate supplies for care
☐ Safety Concerns/Special Treatments:	☐ Other:

Please fax form **within 1 business day** to:
1. Contact person listed below *and*
2. NHCQF Fax

Form received on: ____/____/____ To be completed and resent **ONLY** if all information was not received.
RESPONSE: The following is now in place to prevent these deficiencies from occurring with future referrals:

_____
_____
_____
_____
_____
_____
_____

Person completing form: _____

*Please fax form **within 5 days** to Contact Person at Receiving Facility **and** NHCQF Contact*

Resident Name _____

Facility Name _____ **Tel** _____

Copies of Documents Sent with Resident *(check all that apply)*

Documents Recommended to Accompany Resident

_____ Resident Transfer Form

_____ Face Sheet

_____ Current Medication List or Current MAR

_____ SBAR and/or other Change in Condition Progress Note *(if completed)*

_____ Advance Directives *(Durable Power of Attorney for Health Care, Living Will)*

_____ Advance Care Orders *(POLST, MOLST, POST, others)*

Send These Documents *if indicated*:

_____ Most Recent History and Physical

_____ Recent Hospital Discharge Summary

_____ Recent MD/NP/PA and Specialist Orders

_____ Flow Sheets *(e.g. diabetic, wound care)*

_____ Relevant Lab Results *(from the last 1-3 months)*

_____ Relevant X-Rays and other Diagnostic Test Results

_____ Nursing Home Capabilities Checklist *(if not already at hospital)*

Emergency Department:

Please ensure that these documents are forwarded to the hospital unit if this resident is admitted. Thank you.

Sample Transfer Forms

Transfer forms are another tool used to improve transfer communications. In some states, minimum data standards have been set for all care transitions/transfers. Examples of what is required within the standard data sets established for all care transitions include:

- Principle diagnosis and problem list
- Reconciled medication list including over the counter/herbals, allergies and drug interactions
- Clearly identified medical home/transferring coordinating physician/provider/institution and their contact information
- Patient's cognitive status
- Test results/pending results ▫ Pertinent discharge instructions
- Follow up appointments
- Prognosis and goals of care
- Advance directives, power of attorney, consent
- Preferences, priorities, goals and values, including care limiting treatment orders (e.g., DNR) or other end-of-life or palliative care plans

Sample Transfer Forms

In addition, the "ideal" transfer record would also include:

- Emergency plan and contact number and person, Treatment and diagnostic plan, Planned interventions, durable medical equipment, wound care, etc., Assessment of caregiver status, and Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transitions record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive

Following are sample transfer forms that can be adapted to meet your hospital emergency department and community needs, including:

- **Safer Handoff: Patient Handoff/Transfer Form**. *Emergency Nurses Association (ENA)*. ★
- **Universal Transfer Form.** *New Jersey Department of Health*.
- **Interact Hospital to Post Acute Care Transfer Form**. *Florida Atlantic University*. Designed for acute care discharges to post-acute facilities. Could be adapted for emergency department use.
- **Model Transfer Form: Nursing Facility to Emergency Department/Hospital**. *Virginia Department of Health*. Designed for nursing facility use, could be adapted or used as a tool with local nursing home partners.

Miscellaneous Reminders

- Next Q2 2016 EDTC Data Submission Deadline is July 31st 2016
- NEW! Quality Improvement Matters (QIM) website www.wyqim.com
- Quality Improvement Matters Newsletter: June version to go out the 17th
- MBQIP Deadline Reminders:
  - Q1 2016 Outpatient Core Measures (AMI, CP, PM) due August 1st 2016
  - Q1 2016 Inpatient Core Measures (IMM-2) due August 15th 2016
  - Q1 2016 Inpatient & Outpatient Population & Sampling due August 1st 2016

THANK YOU!

Questions ? ? ?

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Review EHR Medication Profile Sample

Individual's Name: Mary Active
Time Zone: US/Arizona

Current Medication List

Jump to: Home Medication | Medication Review | Medication Reconciliation

Medication Name	Dose	Form	Route	Frequency	Begin Date	End Date
ACETAMINOPHEN-OCD #4 TABLET	500.0	Tablet	Oral (mouth)	2 X DAILY	12/01/2011	
AQUA GLYCOLIC FACE CREAM		Creams	Topical		12/01/2011	

This button will open the Medication History form for the Individual.

Add Medication

Home Medication

Jump to: Current Medication | Medication Review | Medication Reconciliation

Medication Name	Dose	Form	Route	Frequency	Begin Date	End Date
ACETAMINOPHEN-OCD #4 TABLET	500.0	Tablet	Oral (mouth)	2 X DAILY	12/01/2011	
AQUA GLYCOLIC FACE CREAM		Creams	Topical		12/01/2011	

Clicking on this button will take the user to the Home Medication area in the Medication History form.

Add Home Medication

Recent Medication Review List

Jump to: Current Medication | Home Medication | Medication Reconciliation

File	Valid (From-To)	Comment	Reviewer (Physician)	Created By
Medication for Review.pdf (8KB)	12/01/2011-12/05/2011			Ray Helper, Direct Support Professional on 12/05/2011

Users can review the medications of the Individual by clicking here.

Add Medication Review

Medication Reconciliation List

Jump to: Current Medication | Home Medication | Medication Review

Reconciliation Type	Reconciled By	Reconciliation Date	Active (From - To)	Comment	Reference Medication
Admission	Ray Helper, Direct Support Professional	12/04/2011	12/01/2011 - 12/05/2011		

Medication Reconciliation for the Individual can be added from here.

Add Reconciliation

Comment

Necessary comments can be added in here!

To view the PDF, click on the Display PDF link.

Display PDF

<< Back | Cancel | Save

Medication Profile

Individual's Name: Andrew Jackson
Time Zone: US/Eastern

Active Medication List

Jump to: Historical Medication | Medication Review | Medication Reconciliation

Medication Name	Dose	Form	Route	Frequency	Begin Date	End Date
LIQUID CALCIUM 600-VIT D CAP	400.0	Capsules	Oral (mouth)		11/01/2012	11/22/2012
PARA-TIME 150 MG CAPSULE SA					11/01/2012	

All active medications and medications with current date as an end date are listed under this section

Add Medication

Home Medication

Medication Name	Dose	Form	Route	Frequency	Begin Date	End Date
LIQUID CALCIUM 600-VIT D CAP	400.0	Capsules	Oral (mouth)		11/01/2012	11/22/2012

Add Home Medication

All discontinued and inactive medications appear under this section

Historical Medication List

Jump to: Active Medication | Medication Review | Medication Reconciliation

Medication Name	Home Medication	Dose	Form	Frequency	Begin Date	End Date	Status
TYLENOL COLD M-S NIGHTTIME LIQ	No	4.0	Liquid		11/01/2012	11/17/2012	Approved
ACETAMINOPHEN PM TABLET	No	250.0	Tablet	2 X DAILY	11/01/2012		Discontinued

Section 2 - Medication History Information

Drug Lookup

Drug Name: Search

Medication Name:* ASPIR-TRIN EC 325 MG TABLET Drug Details

Medication Category: General Medication

Medication Subcategory: Allergy/Cold/ENT

Prescription Over the Counter

Dose: 325.0

Total Dose: 325.0

Measurement Unit: mg

Total Count: 1.0

Form: Tablet

If Other:

Route: Oral (mouth)

If Other:

Medication Type: Scheduled (Medication)

Frequency:

Medication Schedules

2 Time(s) Every Tuesday Starting from: 05/02/2011

- Please Select -
Every
Every Other
As

Schedule

11:30 am

11:30 pm

Add Another Schedule Row

Allergy Profile of Mary Active, 000001

Created By: Ray Helper, Direct Support Professional on 06/16/2011 03:10 AM
Last Updated By: Ray Helper, Direct Support Professional on 06/20/2011 07:36 AM
Time Zone: US/Eastern
Update History (4)

Allergy Profile

NOTE: Highlighted allergies represent manual entries, these will not be considered for Drug-Allergy interaction.

Active Allergies Hide

Allergy	Type	Severity	Reaction	Identification Date	Added By
Acid Green 50	Food Allergy	Severe	Rashes are found all over the body.	06/01/2011	Ray Helper
Acid Mantle	Drug Allergy	Moderate	Rashes are found over the body.	06/01/2011	Ray Helper
Nut Allergy	Food Allergy	Mild	Irritation occurs.	06/01/2011	Ray Helper

Inactive Allergies Show

Deleted Allergies Show

Comment

Items that cause Allergy to Mary should not be provided to her.

Back | Add Allergy Information | Save

Review recommended core content of "records for medicines" when Patients transfer care Providers

Additional Resources

(i.e. Nurse to Nurse Communication & Care Transitions)

- **Appropriate Interhospital Patient Transfer**. *American College of Emergency Physicians*. This website includes policy statements and principles regarding patient transfers.
- **Care Transitions Program**. *Dr. Eric Coleman*. This website includes tools and resources to support care transitions, including those with Spanish and Russian translations.
- **Care Transitions: Strengthening Communication, Improving Outcomes**. *Oregon Patient Safety Commission*. Retrieved January 1, 2014. This website discusses care transitions between various health care settings and presents tools and resources to support improvements.
- **Got Transition.** *Center for Health Care Transition Improvement*. This toolkit focuses specifically on transitions related to young adults and children with special needs. It includes policies and procedures, action plans, and checklists.
- **Critical Care in the Emergency Department: Patient Transfer**. *Emergency Medical Journal*, January 2007, "This article reviews current recommendations for the transfer of critically ill patients, with a particular focus on pre-transfer stabilization, hazards during transport and the personnel, equipment and communications necessary throughout the transfer process."
- **Care Transitions Toolkit**. *Colorado Foundation for Medical Care*. This website includes a set of tools that supports organizations in beginning a quality improvement project through a series of steps such as root cause analysis, interventions, and measurement. The tool can be adapted and applied for most quality/process improvement needs. There are both online and PDF versions of the tool.
- **Transfer of Patient Care Between EMS Providers and Receiving Facilities.** *American College of Emergency Physicians*. This website includes policy statements and principles regarding patient transfers.

- **Implementation Guide to Improve Care Transitions**. *Project BOOST: Better Outcomes for Older Adults Through Safe Transitions, Society of Hospital Medicine*, retrieved January 19, 2014. "This guide is designed to facilitate the implementation, evaluation and maintenance of the BOOST toolkit and its adaptations. In addition to presenting BOOST interventions, the guide is filled with additional resources to manage, organize and document the efforts of your team."
- **Improving Nurse to Nurse Communication During Patient Transfers.** Reecha Madden, June 2012. This Powerpoint presentation describes the outcomes of the implementation of nurse to nurse communication tools.
- **INTERACT (Interventions to Reduce Acute Care Transfers).** This website includes tools and resources targeted at reducing transfers to hospitals, including care transitions between care settings, such as long term care, home health, and acute care.
- **National Transitions of Care Coalition Toolbox**. This website includes a series of tools, resources, and links to websites to support care transitions.
- **New Performance Improvement Coordinator Education.** *Montana Rural Healthcare Performance Improvement Network*. "This resource is specifically designed to provide new quality professionals with basic education about quality management and the tools used in implementing an effective, organization-wide quality program. The resources are designed for individual educational purposes as well as for the education and training of facility staff in the basic principles of quality management."
- **Patient Safety and Quality: An Evidenced-Based Handbook for Nurses.** *Agency for Healthcare Research and Policy*, April 2008. This handbook describes the handoff process in various care settings and presents strategies to improve handoff communications.