**Hospital to Nursing Home Transition Process Checklist**

(To be completed by Nursing Home)

Patient ID #:

Hospital:

Nursing Home:

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**GOAL #1: Build and Strengthen Relationships Across Care Settings**

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| “Warm” Handoff (Hospital to Nursing Home) | Yes | No |
| Did hospital provider-to-NH provider communication occur within 24 hours of the patient being discharged from the hospital? |  |  |
| If YES, select communication mechanism:   * Phone call * Secure e-mail message (e.g., direct) * Other (please specify): | | |
| The following information was discussed during the “warm” handoff (Check all that apply):   * Overview of patient’s hospital course * Vital signs * Medication list (date and time the last dose was given; date and time the next dose is due; high-risk medications; medication allergies) * Advance directive(s) * Treatment plan * High-risk conditions * Relevant lab and diagnostic testing results, pending or outstanding tests * Behavioral issues or needs * Most recent communication with family or caregiver regarding patient’s care plan * Follow-up appointment that has been or needs to be made * Special care needs and equipment (e.g., wound care, dietary, catheters, PICC Lines) * Hospital follow-up contact information (e.g., PCP or hospitalist name and phone number; specialist name and phone number) * Other (please specify): | | |

**GOAL #2: Develop Standardized Processes for Communication and Information Transfer Between Facilities**

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| --- | --- | --- |
| Documentation Received |  |  |
| Please select the documentation that the nursing home received within 24 hours of discharge: | | |
| * Discharge Summary, Including: * Current Medication List * Advance Directives (e.g., MOLST) * Relevant Lab or Diagnostic Test Results * Other information to be customized by hospital-nursing home team | | |

|  |  |
| --- | --- |
| “Warm” Handoff (Hospital to Nursing Home) | 🗹 |
| Patient interviewed for “Best Possible Medication History” |  |
| Medication List reviewed for any changes |  |
| Medication regime reviewed for any changes in administration |  |
| Medication orders compared with medication list and regime |  |
| Provider-to-Provider communication and follow-up on medications |  |
| Discrepancies corrected, key changes highlighted |  |
| Patient interviewed for “Best Possible Medication History” |  |
| Medication List reviewed for any changes |  |

**GOAL #3: Incorporate Patients, Family Members, and Caregivers in the Transition Process**

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| --- | --- | --- |
| Goals of Care Discussion | Yes | No |
| Did a “goals of care” discussion with the patient occur upon arrival in nursing home? |  |  |
| Was a family member or caregiver included in the discussion? |  |  |