**Nursing Home to Hospital ED Transfer Process Checklist**

Patient ID #:

Nursing Home:

Hospital:

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

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| “Warm” Handoff (Nursing Home to ED) | Yes | No |
| Did a provider-to-provider phone call occur within 24 hours of the patient being transferred to the hospital? |  |  |
| 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):
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**GOAL #2: Develop Standardized Processes for Communication and Information Transfer Between Facilities**

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| Documentation Received by Hospital During Transfer to ED | Complete | Incomplete |
| Please select the documentation received by the hospital from the nursing home within 24 hours of discharge and whether documentation was complete: |
| Transfer Form |  |  |
| Current Medication List |  |  |
| Advance Directives (e.g., MOLST) |  |  |
| Other (please specify):  |  |  |
| Medication Reconcilation Checklist (To be completed upon every transition by receiving facility) | 🗹 |
| 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 |  |

**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? |  |  |