ASSISTED LIVING FACILITY AND HOSPITAL INTERFACE

Improving Care Transition Between Assisted Living Facilities and Hospitals

The purpose of this guide is to stress the importance of well-organized processes for transferring clients from assisted living facilities to and from hospital settings, including the emergency department.

WISCONSIN DEPARTMENT *of* HEALTH SERVICES

Division of Quality Assurance
Bureau of Assisted Living

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SECTION I: INTRODUCTION AND BACKGROUND

A report from the Centers for Health Care Research and Transformation states, "Poorly coordinated care transitions from the hospital to other care settings cost an estimated $12 billion to $44 billion per year." Not only do poor transitions create unnecessary health care costs, more importantly they often result in poor health outcomes. The most common adverse effects associated with poor transitions are injuries due to medication errors, complications from procedures, infections, and falls.

Over the years, the Bureau of Assisted Living has identified regulatory concerns that have contributed to difficult assisted living facility (ALF) to hospital transitions:

- Notification of transfer/hospitalization to the client's legal representative and physician
- Providing necessary information at the time of transfer to assure a safe, efficient transition (e.g., client's current medications, dietary, nursing, physical, and mental health needs, names of medical providers, POA/guardian, name and contact information of a preferred contact person who can provide additional information or updates)
- Failure to provide medication administration and clinical treatments appropriate to the client's needs
- Failure to communicate and/or provide services to manage the client's behaviors that may be harmful to themselves or others

The Department of Health Services (DHS), Division of Quality Assurance (DQA), Bureau of Assisted Living (BAL) convened a work group to develop guidelines and offer tools to support transitions in care between ALFs and hospitals/emergency departments. The project is inspired by the *Transitions for Assisted Living* (TAL) effort undertaken by ALF and hospital providers in Dane County under the direction of Dr. Maria Brenny-Fitzpatrick, UW Director of Transitional Care.

As the ALF transitions document is shared statewide, BAL anticipates it will become the basis for improved bidirectional communication between ALFs and hospitals/emergency departments (hereinafter referred to as "hospitals") for the benefit of the clients/residents/tenants/members (hereinafter referred to as "clients") served in assisted living settings. Additionally, standardization of transition in care coordination practices is critical since it integrates the different settings/ practitioners systems/practices in improving the health care outcomes of the client being served; increases community based providers understanding of the client's medical conditions and proposed treatments; decreases emergency department visits, decrease in hospitalizations, readmissions, and number of hospital days.

There are more than 4,000 ALFs serving an estimated 57,000 clients in Wisconsin. ALFs in the state of Wisconsin include adult family homes (AFHs); community-based residential facilities (CBRFs), and residential care apartment complexes (RCACs). Client groups served by these provider types include people with advanced age, dementia, intellectual disabilities, mental health diagnoses, physical disabilities, traumatic brain injury, alcohol and other drug abuse, correctional clients, and/or the terminally ill.

Aside from certain limitations imposed by Wisconsin state licensure or certification regulations, there is considerable variation in the type of care and/or service provided by ALFs across Wisconsin. Furthermore, there is little standardization among ALFs in how relevant and important information about the client is provided to a hospital at the time of transfer.

The *Transitions for Assisted Living* (TAL) project revealed numerous challenges to the effective bidirectional communication of client information at the time of transfer. Those challenges include, but are not limited to the rushed handoff of information (especially if the transfer is urgent), fragmented responsibility for the gathering of client information, lack of standard communication tools used across settings, low client/family engagement at the time of transfer, and multiple provider involvement throughout the transfer process.

Assisted living providers and representatives of emergency medical services (EMS) and hospitals participating in the TAL project spent considerable time focusing on the handoff of key client and ALF data and information. Their aim was to implement processes and tools that could be used during the transfer of clients to improve communication and quality of care. This was accomplished with the development of uniform communication tools that providers at all points of the transition now look for and rely on when the ALF client arrives at the hospital.

Stakeholders involved in the BAL's Assisted Living Transitions project believe the success of the TAL can be replicated if all ALFs and hospital systems across Wisconsin adopt the use of the communication tools included in this interface.

As noted above, there is wide variation among ALF providers in their ability to meet client needs following treatment in an emergency department or an inpatient hospital stay. **ALFs in Wisconsin are not required by code, and therefore hospitals should not assume an ALF will have a registered nurse(RN) or licensed practical nurse (LPN) on site or even available for consultation.**

BAL has witnessed the consequences of poor hospital/ALF communication in the form of re-hospitalizations, serious medication errors, lack of appropriate client monitoring, falls, and other unfortunate outcomes. Communication of key information about the ALF client from the hospital to the ALF prior to discharge is vitally important.

Participants in the BAL's Assisted Living Transitions project believe the successful return of a client to their ALF home depends on the following strategies:

- Working towards an established relationship with your local healthcare system through in-person meetings and discussions surrounding transitions between sites and the use of standardized tools
- Early and frequent telephone contact between the hospital/emergency department staff and ALF should the client be transferred out of your facility (calls initiated by both parties)
- Use of a standardized transfer packet and tools, such as the blue transfer packet described later in this document and/or INTERACT tools which contain the necessary information to safely and effectively care for the client

While this guideline is not a regulatory requirement, it is consistent with federal and state regulations. It is intended as a tool for quality improvement that providers can integrate into their policies, procedures, and clinical practice. The document is not a "blueprint" for providers but, rather, offers a framework to improve the transition of care between settings, encourage regulatory compliance, and improve client outcomes.

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SECTION II: ASSISTED LIVING FACILITY DEFINITIONS

A. Assisted Living Facilities

All assisted living facilities provide a living environment that is as home-like as possible and the least restrictive of each client's freedom. This environment is compatible with the client's need for care and services. Clients are encouraged to move toward functional independence in daily living or to continue functioning independently to the extent possible. Assisted living facilities operate in a manner that protects client rights, respects client privacy, enhances client self-reliance and supports client autonomy in decision-making, including the right to accept risk.

Services and capabilities vary from facility to facility depending upon the target groups serviced, the type of staffing employed and the experience of the facility and its staff. To fully understand the abilities and practices of a particular ALF it is recommended a discussion take place between the ALF and hospital staff about the ALFs ability to meet the clinical/medical needs of their clients.

While some ALFs do have licensed or certified nursing staff on site, it is important for hospitals to recognize there are no state requirements that any of the ALFs have a RN, LPN, and/or CNA on staff.

It is important for hospital staff to realize that a written practitioner’s order in the client's record for any prescription medications, over-the-counter medications, or dietary supplements administered to a client in an ALF is required. The administrative staff at the ALF is able to answer any questions related to this.

B. Residential Care Apartment Complex (RCAC)

Residential care apartment complexes (RCACs) are apartments that offer services to support independent older persons as they age.

RCACs consist of five or more independent apartments, each of which has an individual, lockable entrance and exit; a kitchen, including a stove; individual bathroom, sleeping, and living areas; and, provide clients up to 28 total hours of service per week comprised of personal (activities of daily living), supportive (housekeeping), and non-licensed nursing services (medication administration) that are appropriate to the needs, abilities, and preferences of individual clients.

An RCAC does not include a nursing home or a community -based residential facility (CBRF), but may be physically part of a community that does have a nursing home or CBRF on site.

People living in RCACs are usually age 65 and older with an average age of 85+ years. Clients are generally independent, meaning they make their own decisions about the type and quantity of care they receive, but may also rely on family or others for support. In general, clients of RCACs are medically stable although they may be dealing with one or more chronic conditions. Some clients self-administer their own medications and make their own arrangements for medical care. In these cases, the client is responsible for managing his/her own healthcare and the RCAC staff may not have current information about health status.

Some RCACs have access to a RN who provides some oversight and performs certain services, but that does not mean the RN is in the facility on a daily or even weekly basis. In general, RCACs do not provide two-person transfers, use mechanical lifts, or monitor persons who present a wandering risk or who need dementia care. Some RCACs offer three meals per day/seven days per week, while others offer a more limited meal plan. RCACs can employ certified nursing assistants (CNAs) as

caregivers, but more often rely on personal care workers (PCWs) who are trained on the job to provide basic types of care (bathing, dressing, assistance with personal hygiene, etc.).

The RCAC code prohibits the new admission of persons who have an activated power of attorney for healthcare (HCPOA), are determined to be incompetent, or are incapable of recognizing danger, summoning assistance, expressing need, or making care decisions.

A residential care apartment complex may admit a person with an activated HCPOA, if the person being admitted shares an apartment with a competent spouse or other person who has legal responsibility for the individual. Facilities are permitted the option of retaining clients who become incompetent or incapable of recognizing danger, summoning assistance, expressing need, or making care decisions because familiar surroundings and routines are an important component of dementia care and in order to accommodate aging in place.

Because there is such wide variation in the style, type, and nature of RCACs, hospitals are encouraged to consult with local RCAC providers to determine the level of service they provide.

Should a RCAC client's condition significantly change due to an acute event or a hospitalization, it will be necessary for hospital staff to speak with the RCAC administration to clarify whether or not the facility can take the client back. This call should be made as early as possible so that arrangements can be made to either accommodate the client or to begin searching for alternate housing arrangements.

C. Community-Based Residential Facility (CBRF)

Community-based residential facilities offer a wide range of care, support, and services to people of advanced age and/or ten other client groups. Those client groups include:

- Dementia
- Developmental Disability
- Mental Health
- Physical Disability
- Traumatic Brain Injury
- AIDS
- Alcohol and Other Drug Abuse
- Correctional Clients
- Pregnancy
- Terminal Illness

While many CBRFs are stand-alone facilities, a growing number of CBRFs are corporately owned. Because of the diverse nature of the client groups served, hospitals are encouraged to consult with local CBRF providers to determine whether the level of service they provide coincides with the needs of the client.

CBRFs range in size from five to 100+ beds. Some CBRFs may have access to a RN and others may not. Hospital providers should review the CBRFs *Assisted Living Facility Capabilities* form (See Section VI: Resources.) to determine the specific services, staffing (clinical), and other capabilities of the CBRF. Staff persons working in CBRFs are required to complete state-approved training plus training for the client group they are serving. Those CBRFs that do not have access to a RN may be limited in their ability to serve clients returning from the hospital, if their clinical needs will require monitoring or oversight by a licensed nurse. It is imperative that hospital staff talk with CBRF leadership to discuss whether or not the facility is capable of taking the client back.

The availability of mechanical lifts varies from CBRF to CBRF and depends on the type of client being served. CBRFs that are more than one story may not have elevators. Depending on their licensing category, some CBRFs are prohibited from accepting non-ambulatory persons. CBRFs that serve persons with dementia may have wandering alert systems, but that may not be true for all facilities.

CBRFs provide care, treatment, and other services to five or more adults who need supportive or protective services or supervision because they cannot or do not wish to live independently, yet do not need the services of a skilled nursing facility. Licensed nurses are not required to be on site, but nursing services may be contracted to come into the CBRF.

CBRFs are limited to those who do not require care above intermediate nursing care or more than three hours of nursing care per week. Nursing care consists of nursing procedures, other than personal care, that a RN or LPN performs directly on or to a client.

CBRFs are licensed based on (1) size --- small (5-8 beds), medium (9-20 beds), and large (21 or more beds), and (2) class --- whether clients are ambulatory, semi-ambulatory, or non-ambulatory.

A CBRF may not admit or retain a person who is incapacitated unless the person has a health care agent under a valid and properly activated HCPOA or a court-appointed guardian. Depending on the client group, CBRFs may be serving persons who have a court-appointed guardian or an activated HCPOA.

If the client attends an off-site program (adult day service, sheltered workshop, etc.), the provider may want to work with them on providing appropriate information in the event of a medical emergency.

Should a CBRF client's condition significantly change due to an acute event or a hospitalization, it will be necessary for hospital staff to speak with the CBRF administration to clarify whether or not the facility can take the client back. This call should be made as early as possible so that arrangements can be made to either accommodate the client or to begin searching for alternate housing arrangements.

D. Adult Family Home (AFH)

Adult family homes of one-to-two beds are places in which the operator provides care, treatment, support, or services above the level of room and board for up to two adults. Services typically include supportive home care, personal care, and supervision. Services may also include transportation and recreational/social activities, behavior and social supports, daily living skills training, and transportation if provided by the operator or designee. It includes homes which are the primary domicile of the operator or homes which are controlled and operated by a third party that hires staff to provide support and services. Adult family home services also include coordination with other services received by the participant and providers, including health care, vocational, or day services. Services may also include provision of other waiver services as specified in the individual contract between a managed care organization (MCO) and the residential provider.

Adult family homes of three-to-four beds, licensed under DHS 88 of the Wisconsin Administrative Code, are where three or four adults who are not related to the licensee reside and where care, treatment, or services above the level of room and board are provided, which may include up to seven hours per week of nursing care per client. Services typically include supportive home care, personal care, and supervision. Other services provided may include behavior and social

support, daily living skills training, and transportation performed by the operator or designee of the operator.

In a state-licensed AFH, if a client is not able to walk; is able to walk only with difficulty; is able to walk only with the assistance of crutches, cane, or walker; or, is unable to easily negotiate stairs without assistance:

1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails.
2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a client not able to walk at all shall have a clear opening of at least 32 inches.
3. Toilet and bathing facilities used by a client not able to walk at all shall have enough space to provide a turning radius for the client's wheelchair and provide accessibility appropriate to the client's needs.
    a. Grab bars shall be provided for toilet and bath fixtures in those bathing and toilet facilities used by clients not able to walk at all or only with difficulty, or by other clients with physical limitations that make transferring difficult.
    b. If any client has either manual strength or dexterity limitations, the home shall have levered handles on all doors, bathroom water fixtures, and other devices normally used by that client if these can be replaced and if replacement is readily achievable.
    c. Any client who is unable to easily negotiate stairs without assistance shall have his or her bedroom, toilet and bathing facilities, and all common living areas on the first floor.

Should an AFH client’s condition significantly change due to an acute event or a hospitalization, it will be necessary for hospital staff to speak with the AFH administration to clarify whether or not the facility can take the client back. This call should be made as early as possible so that arrangements can be made to either accommodate the client or to begin searching for alternate housing arrangements.

SECTION III: REGULTORY REFERENCES

Protocols and guidelines outlined in this document were developed with consideration for existing state and federal regulations.

Wisconsin State Statutes

- Chapter 50, Uniform Licensure
- Chapter 51, State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act
- Chapter 55, Protective Service System

Wisconsin Administrative Codes

- Chapter DHS 83, Community-Based Residential Facility
- Chapter DHS 88, Adult Family Homes
- Chapter DHS 89, Residential Care Apartment Complexes
- Chapter DHS 94, Patient Rights
- Chapter DHS 124, Hospital

Wisconsin Standards
Medicaid standards for 1-2 bed adult family homes

DQA Publications
P-01905, Physician Orders and Medications

DQA Assisted Living Medication Management Webpage
www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm

Federal Regulations
CFR 482 Code of Federal Regulations Hospital Conditions of Participation

Accreditation
Joint Commission Standards

Joint Commission Article
Transitions in Care: The need for a more effective approach to continuing patient care

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SECTION IV: ROLES AND RESPONSIBILITIES

In order to have a successful transition, it is necessary to identify and clarify the roles and responsibilities within each setting. It is recommended that ALFs have an emergency transfer packet on file for each individual client and all other pertinent information that would be important at the time of a client's transfer. (See Section VI: Resources.)

A. Assisted Living Facility

Transfer Out of Facility. It is the role of the ALF administrator, nurse, or designee to do the following after the decision has been made to transfer a client from the ALF to the hospital:

1. Contact EMS; provide facility location and client's name, age, reason for transfer, baseline cognitive, and functional status, as pertinent.
2. Ensure that the appropriate transfer documents are given directly to EMS with instructions to give the information directly to the hospital staff. It is important that the following documents be included: blue envelope containing copies of *ALF Client Face Sheet*, progress notes from past 48 hours, medication administration record (MAR), *Assisted Living Facility Capability* form, code status, HCPOA, and/or guardian HCPOA/guardian paperwork. (See Section VI: Resources for sample forms.)
3. Be sure client's assistive devices (hearing aids, glasses, etc.) accompany the client to the hospital. Ensure all assistive devices are labeled, as appropriate.
4. Contact the client's legal representative and family, as appropriate; update with current health condition and give reason for client transfer to hospital. Inform them which hospital the client has been transferred to and provide contact phone number of ALF, in case additional questions arise.
5. Call the hospital to notify them of transfer; provide client name, age, baseline cognitive and functional status, and reason for transfer. Provide name and phone number of ALF's preferred contact person.
6. Contact MCO within 24 hours or per their guidelines.

7. Contact primary care physician, as appropriate.

During Stay. It is the responsibility of the ALF administrator, nurse, or designee to do the following during the client's stay in the hospital if the decision is made to admit the client to the hospital:

1. Ensure that assistive and/or behavioral devices (hearing aids, walker, glasses, braces, weighted blanket, etc.) are with the client. If not, make arrangements for delivery to hospital.
2. The ALF's preferred contact person should make contact with the hospital discharge planner (case manager or social worker) as soon as possible to collaborate on the treatment and discharge plans.
   (a) Discuss medication regimen, sharing any specific client needs to ensure medications that have proven to be contraindicated are not ordered or that those medications which are effective are not adjusted. (Example: Ask provider not to alter Depakote for mood stabilization.)
   (b) Be sure to specify unique behavioral needs of the client (e.g., approach from left side, avoid touching right arm).
   (c) Maintain frequent contact with the discharge planner to assure your involvement in discharge planning. Clarify your facility and staff clinical capabilities as they relate to what the client might need post discharge. For frequent updates regarding discharge, refer to the blue envelope transfer label, *Client Transition from ALF to Hospital*. (See Section VI: Resources.)
   (d) Ask, "What is the expected day of discharge?"
   (e) Ask, "Have there been any medication changes?"
   (f) Ask, "Have there been any behavioral or health changes while in the hospital?"
   (g) Review your facility clinical capabilities as they relate to the ability to provide necessary clinical care. This includes clearly spelling out what services and treatments you can or cannot provide.
   (h) Clarify availability of assistant devices (walkers, canes, etc.) and how to obtain them if unavailable, as appropriate.
   (i) The facility must conduct a thorough assessment of the client's needs. After assessment, if the facility determines they cannot meet the client's need, the ALF should provide appropriate discharge notice to the client. The facility should work with client/responsible party/managed care organization/hospital to find a suitable living arrangement that can meet the client's needs. If a suitable living arrangement is not located prior to discharge, the facility should take client back with appropriate services in place. The facility would issue a 30-day discharge notice and continue to seek a suitable living arrangement.
3. Update client's legal representative and family, as appropriate.

Returning. It is the responsibility of the ALF administrator, nurse, or designee to do the following when the decision has been made to transfer the client from the hospital back to the ALF:

Prior to Discharge

1. Review medications (with hospital staff) and ensure prescriptions have been sent to the pharmacy.

2. Ensure needed durable medical equipment (DME) (walkers, wheelchairs, etc.) or other services (e.g., oxygen) are identified, orders are placed, and supplies are transferred so that they will be in place upon client arrival.
3. Coordinate transportation with hospital discharge planning staff.
4. Update plan of care at your facility.
5. Assure that your staff are oriented and/or trained for needed treatments.
6. Update client's legal representative and family, as appropriate.

Upon Return to ALF

1. Receive and review discharge summary.
2. Review rehabilitation and treatment needs (e.g., speech, occupational, and/or physical therapy).
3. Ensure the client attends post-discharge follow-up appointments as outlined in the client's discharge summary/orders sent by hospital.
4. Inform and educate your staff on necessary changes.

Post Discharge Appointments

1. Directions for date/time of post-discharge follow-up appointments may be found on hospital discharge paperwork.
2. If for some reason client is not able to attend this previously scheduled appointment, call the medical clinic as soon as possible and request to reschedule.
3. At time of appointment, send with the client a copy of the client's MAR, a copy of the discharge orders/discharge summary (if available), and a list of concerns or questions you and/or the client may have since time of discharge. Enclose private health information in a secure envelope.
4. Enclose instructions for clinic staff that you will need written orders for medication and/or treatment changes.
5. Provide clinic staff with a contact telephone number for you/facility leadership staff in case there are questions or new instructions.
6. Upon return from appointment, review all records with client/family, as soon as possible.

B. Hospital

Upon Arrival. At the time of arrival, hospital staff will do the following:

1. Triage/assess the client's medical needs.
2. Review the contents of the emergency transfer packet/blue envelope.
3. Choose to "treat and return" or "admit" and follow the corresponding steps indicated in the following table.

Treat and Return	Admit
1. Upon arrival, review transfer envelope and packet sent in with client. 2. Call/speak with ALF staff regarding any questions you might have. Telephone number to reach staff will be on the blue envelope sticker (if used). Prior to transfer back to facility, call ALF to notify of decision to return client to ALF, assure that the ALF has capabilities to care for the client and has access to necessary medication and treatments. 3. Coordinate transportation with ALF. 4. Send the emergency transfer packet (blue envelope) along with client back to ALF. 5. Contact client's legal representative and family, as appropriate.	1. Call ALF to notify of decision to admit client. (c) Provide diagnosis and reason for admission. (d) Send the emergency transfer packet (blue envelope) along with client to nursing unit. (e) Contact client's legal representative and family, as appropriate.

During Stay. It is the responsibility of the hospital discharge planning staff to do the following during an ALF client's stay in the hospital:

1. Review the *Assisted Living Facility Capability* form provided by ALF, if provided. (See Section VI: Resources.)
2. Identify ALF's preferred contact person.
3. Call the ALF to speak with the ALF preferred contact person to give frequent updates, discuss plan of hospital care, and to discuss post-discharge care needs as they relate to the facility capabilities and the ability for the facility to accept the client back. Inform the ALF of the client's status (admission or observation stay).

Transfer Out From Inpatient Unit. It is the responsibility of the hospital discharge planning staff to do the following when the decision has been made to transfer the client from the hospital back to the ALF:

1. Discharge planner calls the ALF's preferred contact person to notify of client's return and to assure that the facility has the capability to accept client. Use the blue envelope transfer label, *Client Transition from Hospital to ALF,* as a guide. (See Section VI: Resources.)
2. Notify legal representative and family of client's upcoming discharge.
3. Coordinate return transportation with ALF preferred contact person.
4. Inpatient nurse caring for the client calls the ALF's preferred contact person to give report. Refer to blue envelope transfer label, *Client Transition from Hospital to ALF* (Section VI: Resources).
5. Prepare discharge packet assuring that the discharge summary, signed medication prescriptions, signed prescription for DME orders, and signed ambulance transfer forms are present.
6. Ensure all client belongings are transported back to facility with client.

Transfer Out From Hospital: It is the responsibility of the hospital nurse to do the following when the decision has been made to return the client to the ALF:

1. Hospital nurse calls the ALF's preferred contact person to notify of client's return and to determine if ALF has the capability to accept client, using the *Assisted Living Facility Capability* form included in the blue envelope. (See Section VI: Resources.)
2. Notify client's family and/or legal representative of client's return to ALF.
3. Coordinate return transportation with ALF.
4. Prepare discharge packet assuring that the discharge summary, signed medication prescriptions, signed prescription for DME orders, and signed ambulance forms are present.
5. Ensure all client belongings are transported with the client.

C. Managed Care Organizations (MCOs)

For clients enrolled in Family Care or other Medicaid-funded service programs, the MCOs play a key role in providing and coordinating services for the client. MCOs operate the Family Care program and provide or coordinate services in the Family Care benefit package. Services are tailored to individual needs, circumstances, and preferences.

For an individual enrolled in the Family Care Program, an interdisciplinary team (IDT) composed of a nurse and a care manager are key partners in coordinating the client's care.

The IDT, ALF providers, and hospital staff should initiate communication with the MCO after a member's admission to a medical facility.

1. IDT should receive from the ALF medical reports and status updates regarding a client's condition.
2. For clients returning to a private home setting, the IDT works with hospital staff upon a client's discharge plan immediately after admission. This plan includes informing hospital staff about a client's baseline, history, recent medical or care issues, current services, and next steps. In cases where the client is returning to an ALF, the IDT will work with the ALF's staff to coordinate any care needs.
3. IDT coordinates planning with the client's current ALF or supportive home care providers to:
   (a) Determine if the client can return.
   (b) Look at increased services or an interim plan of care to support the client (e.g., home health care or a stay in a rehabilitation facility).
4. IDT will share their contracted provider list with hospital staff if the client will require a new provider or other services after discharge.
5. The MCO is the payer source for non-acute services; therefore, the IDT needs to work with the hospital to develop the discharge plan and to arrange services and authorizations.

D. Behavioral Health

Transitions in care and medical procedures often increase stress for anyone and this section addresses additional considerations for elderly people with dementia, individuals with a serious and persistent mental illness, an intellectual or developmental disability, substance use disorders, or any combination of these diagnoses or conditions. These individuals may present with complex or

challenging behaviors, different legal status, and specialized treatment needs, all of which furthers the importance of a good assessment and proactive planning to prevent a behavioral health crisis.

Engaging clients in a person-centered way to support their personal wellness goals and recovery is critical. Ask the person and those who support the person about approach strategies to help the person calm and de-escalate, or any specific triggers or risk factors to avoid. Help the person and their caregivers to identify their personal wellness resources and how treatment or aftercare may be coordinated to help the person develop an individualized plan.

Supporting people with behavioral health care and physical health care needs may require an integrated approach and special considerations. The legal status of the individual is important to include in their assessment and planning. Many individuals with behavioral health care needs may also have a behavior support plan (BSP), or summarized elements of an individualized behavior plan, that will be helpful to obtain in advance from their caregivers, guardian, or the client.

The BSP may include structured activities, assistive devices, a "pro re nata" (PRN, as needed) medication protocol, or even restrictive measures that are sometimes used to help the person remain safe. Developing or modifying the behavior plan, other safety protocols, or a crisis plan (as defined by DHS 34) that includes medical considerations, may also be important following treatment.

Proactive planning and multi-disciplinary teaming that includes the regular caregivers and county mental health professionals is an important consideration prior to admission, whenever possible or promptly after an unplanned admission. Promoting thoughtful planning utilizing county crisis resources is an important part of an integrated approach to behavioral and physical health care and may reduce the likelihood of law enforcement involvement, emergency detentions, or a transfer to a more restrictive environment. Acute care settings are often very short-term, so it is important to begin preparing for the client's return immediately following a crisis. Additional supports or environmental changes are sometimes needed to be added for a safe transition.

Arranging releases of information for mental health treatment records must be specific to each record and provider to allow teams to discuss needed treatment information and coordinate care between the hospitals and residential or other treatment providers. These releases of information may need to be obtained after admission to a hospital.

Ultimately, careful planning and frequent communication among treatment professionals with the person and their support network will help to facilitate smooth transitions for people with behavioral health needs.

SECTION V: TRANSITION FROM/TO GUIDELINES

A. Hospital Checklist for ALF Clients Returning From a Hospital or Observation Stay

This checklist includes certain information that typically creates significant care or operational challenges for an ALF if not included in a verbal or written report given by hospital staff to the ALF ***before a client is discharged from an inpatient or observation stay***. It is **not** a checklist of the only information needed. Rather, it is intended to supplement any verbal or written report typically provided by the hospital to the ALF.

Depending on the clinical complexity of the client and the required post-discharge needs, the ALF may not be able to take the client back. Discharge planners and the ALF's preferred contact person should speak frequently about the client's care needs.

Medical Status

- Cardiac (hyper/hypo tension)
- Edema
- Pain
- Respiratory
  - Shortness of breath
  - Oxygen
  - BiPAP or CPAP

Cognitive Status

- Confusion (alert/oriented, intermittent confusion, usually confused)
- Decision making (independent, cueing needed, requires full staff support)
- Wandering
- Behaviors during cares or at other times during the visit/stay)
- Mental health concerns (depression, suicide watch)
- Has POA-HC been activated?
- 1:1 or direct supervision needed?

Ambulation

- Mobility (independent, stand-by assistance, hands-on assistance)
- Ability to walk up stairs (for a person returning to a setting where there is no elevator and living quarters are on the second floor)
- Gait and/or balance concerns
- Dizziness, vertigo
- Transfer status (independent, stand-by assistance, one-to-one assistance, two-to-one assistance, mechanical lift)
- Assistive devices (cane, walker, wheelchair)
- Falls

Therapy

- In hospital and/or therapy orders
- Physical therapy
- Occupational therapy
- Speech therapy

Treatments

- Wound care

Discharge Medications

- New medications
- Discontinued Medications
- Treatments
  - Nebulizer
  - Insulin
  - IV Medications

Infection Status

- Isolation status
- MRSA, C. Diff, VRE, Influenza, etc.

Continence

- Toileting assistance required
- Bowel, bladder incontinence
- Catheter
- Colostomy

ADL Assistance

- Bathing
- Dressing

Food and Nutrition

- Swallowing status
- Special medical diet
- Texture modified
- Fluid thickening
- Fluid restriction
- Tube feeding

Home Health Referral

- Orders sent to HH agency?
- HH RN services?
- HH therapy?

B. Hospital Checklist for ALF Clients Returning From Urgent Care or Hospital Visit

This checklist includes certain information that typically creates significant care or operational challenges for an ALF, if not included in a verbal or written report given by ED staff to the ALC ***before a client is discharged following treatment in an emergency department or urgent care clinic***. It is **not** a checklist of the only information needed. Rather, it is intended to supplement any verbal or written report typically provided by the hospital or urgent care clinic to the ALF.

There should be a conversation/documentation of what was done during the hospital or clinic stay, along with findings and clinical follow-up needed, including labs, diagnostics, etc.

Medical Status

- Pain
- Respiratory
  - Oxygen (Has ED made arrangements for oxygen with a supplier prior to dc from ED?)
  - Does ALF staff have training on how to administer Oxygen safely?

Cognitive Status

- Confusion (alert/oriented, intermittent confusion, usually confused)
- Behaviors during cares or at other times during the visit/stay)
- Has POA-HC been activated?
- 1:1 or direct supervision needed?

Ambulation

- Any changes in mobility (independent, stand-by assistance, hands-on assistance)

- Ability to walk up stairs (for a person returning to a setting where there is no elevator and living quarters are on the second floor)
- Transfer status (independent, stand-by assistance, one-to-one assistance, two-to-one assistance, mechanical lift)
- Orders for therapy (include prescription)

Discharge Medications

- New medications (include prescription)
- Discontinued medications
- Treatments
  - Nebulizer
  - Insulin

Infection Status

- Isolation status
- MRSA, C. Diff, VRE, Influenza, etc.

Food and Nutrition

- Swallowing status
- Special dietary needs, diets

Home Health Referral

- Orders sent to HH agency?
- HH RN services?
- HH therapy?

C. Suggested Scripting for Assisted Living Facility Staff

What could ALF staff say when hospital staff calls with information they are not authorized to receive/don't feel equipped to take the information?

> **Suggested:** "I'm sorry but I am not able to take this information. Please call the [name of ALF's preferred contact person] at [phone number]. May I have your name and phone number in case we need to reach you?"
>
> It is suggested that ALF staff be instructed to notify manager, or the ALF's preferred contact person, per facility guidelines within no more than15 minutes.

What could the ALF staff say when the ALF is unable to take the client back because the ALF is unable to meet the client's care needs or the ALF staff do not have the necessary skills to provide the required care? The following should come from the ALF's manager or preferred contact person:

> **Suggested:** "After hearing of the client's change in [health /care] requirements following [his / her] recent hospitalization and conducting an assessment of the client's need, we will be informing the client and [his / her] responsible party that we cannot meet the client's needs and will be issuing a discharge notice. We will work with the [client / responsible party / managed care organization / hospital] to locate a suitable living arrangement."

D. DQA Publication Physician Orders and Medications

ANALYSIS

- **Adult Day Care (ADC)**
  Standard I.F. (3)(a)
  A written order from the prescribing practitioner must be in the record.

- **Adult Family Homes (AFH)**
  Wis. Admin. Code § DHS 88.07(3)(d)
  Before a licensee or service provider dispenses or administers a prescription medication to a client, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances, and in what dosage the medication is to be administered.

- **Residential Care Apartment Complex (RCAC)**
  There are no regulations that specifically address physician orders for medications.

- **Community-Based Residential Facilities (CBRF)**
  Wis. Admin. Code § DHS 83.37(1)(a) Medications. (1) General requirements. (a) Practitioner's order.
  There shall be a written practitioner's order in the client's record for any prescription medication, over-the-counter medication, or dietary supplements administered to a client.

RESULT

A written practitioner order for specific medications can include the following:

- Written order mailed, faxed, or hand-delivered from the practitioner
- A MAR signed by the practitioner that is faxed, mailed, or hand-delivered
- A copy of a prescription that is faxed, mailed, or hand-delivered by the pharmacist (Pharmacists have specific regulations that allow providing a copy of a prescription to a client.)
- A MAR signed by the pharmacist based on prescription orders signed by physician that pharmacist has on file.
- An electronic order that is directly transmitted electronically to the facility's electronic health record (computer to computer transmission).
- A printed copy of the electronic order contained in the practitioner's electronic health record that indicates the practitioner electronically signed the order. This printed copy is provided directly to the facility from the provider.
- A printed copy of the electronic order from the pharmacy.
- The facility shall obtain one of the order types noted above within **two business days**. While waiting for an order, a facility can follow the instructions on the prescription label. This should happen only in situations where the pharmacy or physicians are unavailable to provide the written order.

NOTE: MARs, printed electronic orders, and discharge summaries provided to the assisted living provider from the practitioner may not always be compliant for pharmacy prescription laws. For these

reasons, pharmacists will need to contact the practitioner to obtain legal orders. When contact is made between the pharmacist and the practitioner, in some cases, orders may be changed and this may cause delays in the medication being available. ALFs and pharmacists will need to communicate these changes and delays so that the ALF has the current orders and has direction to delay administration of the medication until available.

	CBRF	AFH	RCAC	ADC
Written Order Indicating Which Staff Can Administer	Silent	Yes	Silent	No No facility policy is required.
Written Order for Each Medication	Yes	Yes	Yes All prescription drugs require a physician order at a pharmacy.	Yes
Written Order for Each Medication when Client Self-Administers	Yes	No All prescription drugs require a physician order at a pharmacy.	No All prescription drugs require a physician order at a pharmacy.	No All prescription drugs require a physician order at a pharmacy.

SECTION VI: RESOURCES

The following section includes materials and resources developed by the organizations working on the Transitions for Assisted Living (TAL) project undertaken by ALF and hospital providers in Dane County under the direction of Dr. Maria Brenny-Fitzpatrick, UW Director of Transitional Care. These materials are offered as examples for other ALF and hospital providers to use as they work together to improve transitions of assisted living clients from their ALFs to the hospital and then back to the ALF.

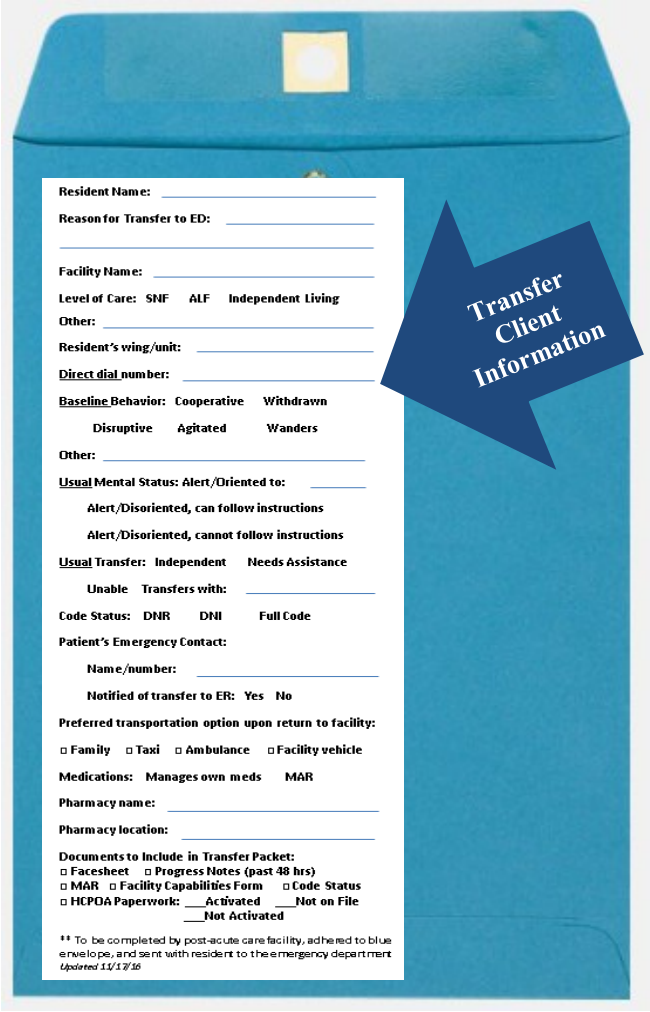
We are implementing a new standardized transfer process for clients transferring to hospitals for acute care.

What will be implemented?

- We will complete a standardized transfer label and share this information when giving the handoff phone report. This label and our handoff phone report will include important information for nurses and doctors at the receiving hospital; e.g., reason for transfer, level of care the client is being transferred from, direct dial number, and other pertinent information.
- A standard, blue, 9” x 11” envelope will be used to package the transfer documents and the completed transfer label will be adhered to the outside of the envelope.

What is the goal?

- To improve the quality and safety of client transfers.
- To improve communication between the facility and the receiving hospital.



Blue Transfer Envelope Process: Right Information Every Time

Assisted living facility staff (ALF) and local hospital leadership should meet to discuss the implementation of this process.

History

A focus group consisting of Dane County ALF staff, skilled nursing facility staff, University of Wisconsin emergency department (ED) staff, and emergency medical services (EMS) staff met over the course of a year with the goal of improving the quality and safety of client transitions to and from hospitals.

The teams identified key information that was needed to ensure that all caregivers had the information needed to safely care for clients at the time of transfer. It was decided to use a bright blue envelope so that the important documents would be easily identifiable.

Labels and envelopes are purchased by the ALFs and hospitals. Templates for the transfer labels (next page) are preprinted and attached to the blue envelope. Labels and envelopes can be ordered online or through your office supply store.

Process

There are two transfer labels—one for ALF use and one for the hospital staff to complete after the client has been seen in the hospital. The ALF transfer label, *Client Transition from Hospital to ALF*, is preprinted and attached to the front of the blue envelope. It is recommended that ALF staff have a blue envelope ready for each client to be kept on file and used at the time of transfer to the hospital. Much of the transfer label can be completed ahead of time, leaving just a few items to be completed at the time of transfer.

There is an item at the bottom of the ALF transfer label, "Documents to Include in Transfer Packet," listing which papers should be included inside the envelope at the time of transfer. ALF staff should hand the completed blue envelope directly to the EMS staff with instructions to give the envelope directly to the hospital staff. The ALF should also phone the hospital to notify them that the client is being transported to them via ambulance.

Participating hospitals should attach a completed hospital transfer label, *Client Transition from Hospital to ALF*, to the same blue envelope when the client returns to the facility after the hospital visit. The hospital staff should also call the ALF and give a verbal report prior to the client returning to the facility.

The blue envelope, along with any necessary prescriptions and papers, are then given directly to the EMS personnel to be given directly to the ALF staff.

IMPORTANT!

As the transfer packet has confidential health information on the transfer labels, the information must be protected. The blue transfer packet is intended to be handed directly from one caregiver to another to ensure proper handling of the information.

If there are concerns about the ability to protect confidential information, the labels can be attached to a blue sheet of paper and included in a sealed envelope to be given to the EMS and hospital staff. The same process should be used when the hospital returns the client to the ALF.

It is the responsibility of the receiving organization to properly destroy all hard copies of information when they are no longer needed.

Sample Transfer Label: "Client Transition from ALF to Hospital"

This label is to be completed by the assisted living facility staff, adhered to the blue transfer envelope, and sent with the client to the hospital.

Client Transition from ALF to Hospital

Client Name: _____

Reason for Transfer to Hospital: _____

Facility Name: _____

Level of Care: ☐ SNF ☐ ALF ☐ Independent Living

☐ Other: _____

Client's Wing/Unit: _____

Direct Dial No.: _____

Baseline Behavior: ☐ Cooperative ☐ Withdrawn

☐ Disruptive ☐ Agitated ☐ Wanders

☐ Other: _____

Usual Mental Status:

☐ Alert / Oriented to: _____

☐ Alert / Disoriented; can follow instructions

☐ Alert / Disoriented; cannot follow instructions

Usual Transfer: ☐ Independent ☐ Needs Assistance

☐ Unable – Transfers with: _____

Code Status: ☐ DNR ☐ DNI ☐ Full Code

Client's Emergency Contact:

Name: _____

Phone No.: _____

Notified of Transfer to Hospital: ☐ Yes ☐ No

Preferred Transportation Option Upon Return to Facility:

☐ Family ☐ Taxi ☐ Ambulance ☐ Facility Vehicle

Medications: ☐ Manages own meds ☐ MAR

Pharmacy Name: _____

Pharmacy Location: _____

Documents to Include in Transfer Packet:

☐ *ALF Client Face Sheet* ☐ Progress Notes (past 48 hrs.)

☐ MAR ☐ *ALF Capability* Form ☐ Code Status

HCPOA Paperwork: ☐ Activated ☐ Not Activated

☐ Not on File

Client Transition from ALF to Hospital

Client Name: _____

Reason for Transfer to Hospital: _____

Facility Name: _____

Level of Care: ☐ SNF ☐ ALF ☐ Independent Living

☐ Other: _____

Client's Wing/Unit: _____

Direct Dial No.: _____

Baseline Behavior: ☐ Cooperative ☐ Withdrawn

☐ Disruptive ☐ Agitated ☐ Wanders

☐ Other: _____

Usual Mental Status:

☐ Alert / Oriented to: _____

☐ Alert / Disoriented; can follow instructions

☐ Alert / Disoriented; cannot follow instructions

Usual Transfer: ☐ Independent ☐ Needs Assistance

☐ Unable – Transfers with: _____

Code Status: ☐ DNR ☐ DNI ☐ Full Code

Client's Emergency Contact:

Name: _____

Phone No.: _____

Notified of Transfer to Hospital: ☐ Yes ☐ No

Preferred Transportation Option Upon Return to Facility:

☐ Family ☐ Taxi ☐ Ambulance ☐ Facility Vehicle

Medications: ☐ Manages own meds ☐ MAR

Pharmacy Name: _____

Pharmacy Location: _____

Documents to Include in Transfer Packet:

☐ *ALF Client Face Sheet* ☐ Progress Notes (past 48 hrs.)

☐ MAR ☐ *ALF Capability* Form ☐ Code Status

HCPOA Paperwork: ☐ Activated ☐ Not Activated

☐ Not on File

Sample Transfer Label: "Client Transition from Hospital to ALF"

This label is to be completed by the hospital nurse, adhered to the blue transfer envelope, and sent with the client to the next level of care.

Client Transition from Hospital to ALF

Admitting Client to Hospital Inpatient Unit

- ☐ Call facility to notify of decision to admit.
- ☐ Provide diagnosis and reason for admission.
- ☐ Send ALF admission "blue" packet to unit.
- ☐ Ensure belongings go with client to unit.

Discharging Client Back to Assisted Living Facility

- ☐ Call facility to notify of client's return.
- ☐ Call facility to determine if facility has capability to accept client back to facility (IV abx, dressing changes, etc.).
- ☐ HCPOA and/or family have been notified. ☐ N/A
- ☐ Exact location to transport client (building, wing, door, room number)

_____

- ☐ Preferred Method of Transport: _____
- ☐ Arrange transportation.
- ☐ Prepare discharge packet contents and send in blue envelope:
  - ☐ Hospital D/C Transfer (AVS) Report
  - ☐ Physician note (if available)
  - ☐ Signed medication prescriptions
  - ☐ Signed prescription for DME orders
  - ☐ Signed ambulance transfer form
- ☐ Ensure belongings return with client.

Client Transition from Hospital to ALF

Admitting Client to Hospital Inpatient Unit

- ☐ Call facility to notify of decision to admit.
- ☐ Provide diagnosis and reason for admission.
- ☐ Send ALF admission "blue" packet to unit.
- ☐ Ensure belongings go with client to unit.

Discharging Client Back to Assisted Living Facility

- ☐ Call facility to notify of client's return.
- ☐ Call facility to determine if facility has capability to accept client back to facility (IV abx, dressing changes, etc.).
- ☐ HCPOA and/or family have been notified. ☐ N/A
- ☐ Exact location to transport client (building, wing, door, room number)

_____

- ☐ Preferred Method of Transport: _____
- ☐ Arrange transportation.
- ☐ Prepare discharge packet contents and send in blue envelope:
  - ☐ Hospital D/C Transfer (AVS) Report
  - ☐ Physician note (if available)
  - ☐ Signed medication prescriptions
  - ☐ Signed prescription for DME orders
  - ☐ Signed ambulance transfer form
- ☐ Ensure belongings return with client.

Sample Form: "Assisted Living Facility Capability"

The *Assisted Living Facility Capability* form is utilized to make hospital staff fully aware of what a facility is able to provide to a client. Through clear distinction of abilities of the facility, such as consultations and clinical services, the hospital is able to determine if the assisted living facility can meet all of the required needs of the client. This form should always be included in the blue envelope.

ASSISTED LIVING FACILITY CAPABILITY

GENERAL INFORMATION

Name – Facility :	
Facility Address:	
Name – Preferred Contact Person:	Phone No.:
Facility Phone No.:	Facility Fax No.:
Name – Community Nurse:	
Name – Community Director:	
Minimum Lead Time Required for New Admission to Facility:	
Can admit on weekend or holiday? ☐ Yes ☐ No	

CLIENT POPULATION SERVED

☐ **Ambulatory:** Client must be able to walk without difficulty or help.

☐ **Non-ambulatory:** Client unable to walk, but who may be mobile with the help of a wheelchair or other mobility devices.

☐ **Semi-ambulatory:** Client must be able to walk with difficulty or only with the assistance of an aid such as crutches, cane, or walker.

FACILITY

☐ Mechanical Lifts Used

☐ Dementia Unit

☐ Contracted with Family Care / Managed Care Organization

Name: _____

☐ Assessment required for admission / readmission

☐ Face-to-face

☐ Remote (phone consult / document review)

☐ Clinical Monitoring

☐ Frequent Vital Signs

☐ Daily Weights

☐ Accu-Cheks for Glucose

☐ INR

☐ Fluid Restriction Monitoring

CONSULTATION AVAILABLE ON-SITE TO CLIENT				
☐ Audiology	☐ Hearing Aide Care	☐ Podiatry	☐ Registered Dietician	☐ Vision Care
☐ Dental Care	☐ Hospice	☐ Psychiatry	☐ Respiratory Care	☐ Wound Care

CLINICAL SERVICES

☐ Licensed Nurse on Site (RN or LPN) – ☐ PT ☐ FT ☐ Phone Consultation ☐ None

☐ Oxygen Therapies – ☐ CPAP ☐ BiPap ☐ Oxygen ☐ None

☐ Able to Accommodate – ☐ Walker ☐ Wheelchair ☐ Mechanical Lift ☐ 2-Person Transfer ☐ None

☐ Transportation to/from Hospital – ☐ Facility ☐ Third-Party Vendor – Preferred Vendor: _____

☐ Respite Care – Minimum Stay of _____ Days

☐ Home Health Care Available per Third-Party Vendor

☐ Hospice Available per Third-Party Vendor

☐ Physician Services per Visiting Physician Services

☐ Private Duty Nurses per Family Private Pay

☐ Bariatric Services – Comment:

☐ Special Medical Diets

☐ Texture Modified Diets

☐ Fluid Thickening Ability

☐ Fluid Restriction Monitoring

☐ Catheter Care

☐ Suprapubic Catheter Care

☐ Colostomy Care

☐ Tube Feeding

☐ Insulin

☐ Sliding Scale Insulin

☐ IV Medication Therapies

☐ IV Site Care

CALL FACILITY ASAP IF OUR CLIENT HAS:

☐ Change in medications prior to returning to facility (There is no pharmacy on site.)

☐ Change in mobility status

☐ Change in mental status

☐ Newly placed IV or dialysis port that will remain upon discharge

☐ New wound or wound care needs

Sample Form: "Assisted Living Facility Client Face Sheet"

This document is offered as an **example** of a typical face sheet that could be used by ALFs to record key information about their clients. A copy of the client's face sheet would be included in the blue envelope when a transfer occurs. ALFs are welcome to modify this example, as needed.

ASSISTED LIVING FACILITY CLIENT FACE SHEET					
GENERAL					
Name – Client:		DOB:		DOA:	Age:
Address:				Phone:	
Medicaid #:		Medicare #:		Affective Date:	
Medicare Part D Provider and No.:				SSN:	
Gender:	Race:	Height:	Weight:	Hair Color:	Eye Color:
DIAGNOSIS					
	Axis I:				
	Axis II:				
	Axis III:				
	Allergies:				
Behavior plan needed? ☐ Y ☐ N	Consent for psych meds needed? ☐ Y ☐ N			Health log updated? ☐ Y ☐ N	
GUARDIAN, RESPONSIBLE COUNTY, CARE MANAGER, PAYEE					
Name - Guardian:				Phone:	
Responsible County:	My Choice Care Manager:			Phone:	
Payee:				Phone:	
CONTACT INFORMATION					
Contacts	**Name**	**Address**		**Phone**	
Emergency Contact					
Primary Care Physician					
Hospital					
Pharmacist					
Dentist					
Eye					
Psychiatrist					
Podiatrist					
Vocational Provider					
Transportation Provider					

INTERACT Tools

INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in client condition. It includes clinical and educational tools and strategies for use in practice in long-term care facilities. To access these tools, see http://www.pathway-interact.com/interact-tools/ . There are numerous user-friendly tools for both assisted living facility and hospital utilization. The following is an example of an INTERACT tool.

Assisted Living to Hospital Transfer Data List

INTERACT Assisted Living V 1.0 Tool

This list is intended to provide guidance on key data elements critical for safe and effective care at the time of transition to an acute care hospital. It is not intended to be comprehensive. The INTERACT **Assisted Living – Hospital Transfer Form** illustrates an example of how these data can be formatted so that the data are readily accessible for receiving clinicians.

Information to be Sent Immediately at the Time of Transfer

Contact Information
- ☐ Resident name
- ☐ DOB
- ☐ Language
- ☐ Date of admission

Type of stay
- ☐ Assisted Living Facility

- ☐ Primary diagnosis for admission

Facility Information
- ☐ Name of hospital sent to
- ☐ Date of transfer

Assisted Living Facility Information
- ☐ Contact person at Assisted Living Facility
- ☐ Phone number

Contact Person Information

Relationship
- ☐ Relative
- ☐ Health care proxy
- ☐ Guardian

- ☐ Contact number

Primary Care Clinician in Assisted Living Facility
- ☐ Name
- ☐ Contact number

Code status
- ☐ Full Code
- ☐ DNR (Do Not Resuscitate)
- ☐ DNI (Do Not Intubate)
- ☐ DNH (Do Not Hospitalize)
- ☐ Comfort Care Only
- ☐ Uncertain

Key Clinical Information
- ☐ Reason for Transfer

Primary reason for transfer diagnostic testing only:
- ☐ Yes
- ☐ No

Relevant Diagnoses
- ☐ CHF
- ☐ COPD
- ☐ CRF
- ☐ DM
- ☐ Ca *(active treatment)*
- ☐ Dementia
- ☐ Other

Vital Signs
- ☐ BP
- ☐ HR
- ☐ RR
- ☐ Temperature
- ☐ Most recent pain level
  - ☐ Pain location
- ☐ Most recent pain med
  - ☐ Date given
  - ☐ Time given

Usual Mental Status
- ☐ Alert, oriented, follows instructions
- ☐ Alert, disoriented, but can follow simple instructions
- ☐ Alert, disoriented, 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 for Assisted Living Facility Note included
- ☐ Other clinical notes included
- ☐ Date of last tetanus *(for residents with lacerations/wounds)*

Devices and Treatments
- ☐ Oxygen
  - ☐ Liters per minute
- ☐ Nasal cannula
- ☐ Mask
  - ☐ Chronic
  - ☐ New
- ☐ Nebulizer Therapy
  - ☐ Chronic
  - ☐ New
- ☐ CPAP
- ☐ BiPAP
- ☐ Pacemaker
- ☐ Bladder (Foley) Catheter
  - ☐ Chronic
  - ☐ New
- ☐ Internal Defibrillator
- ☐ Enteral Feeding
- ☐ Other

Isolation Precautions
- ☐ MRSA
  - ☐ Site
- ☐ VRE
  - ☐ Site
- ☐ C. difficile
- ☐ Norovirus
- ☐ Respiratory virus/flu
- ☐ Other

Allergies
- ☐ Yes
- ☐ No

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

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

Form Completed By
- ☐ Name
- ☐ Title
- ☐ Signature

Report Called By
- ☐ Name
- ☐ Title

Report Called To
- ☐ Name
- ☐ Title
- ☐ Date
- ☐ Time