

AHRQ's Safety Program for Nursing Homes: On-Time Preventable Hospital and Emergency Department Visits

Transfer Note and Intake Note

Transfer Notes and *Intake Notes* are not required, but the elements included in them must be in the nursing home's electronic medical record (EMR) to generate all components of the reports. Reports also require other elements from other data sources, including physician orders, medication records, Minimum Data Set (MDS) assessments, and nursing documentation.

Transfer Note

A transfer note is a written communication tool between the nursing home and the receiving facility—either hospital or ED. It provides a high-level summary of the reasons for transfer and what treatments (if any) were provided prior to transfer. The following data elements are suggested for capture in a consistent manner so that data can be used in reporting:

- Transfer date and time
- Transfer to location (hospital or ED)
- Reason for transfer (grouped according to symptom or condition: cardiac/circulatory/blood, respiratory symptoms, mental disorders/neurological/psychological, gastrointestinal/genitourinary, endocrine/nutritional/metabolic, wound and skin, fall-related and non-fall-related injury, musculoskeletal, other changes not specified elsewhere, or treatment not available at transferring facility)
- Treatments provided in the nursing home prior to transfer
- Providers who saw the resident within 24 hours of transfer
- Person authorizing the transfer to hospital or ED

Nursing homes will work with their EMR vendor to review and potentially modify the data elements listed in the *Transfer Note* to generate reports that meet the specific needs of the facility.

Sample Transfer Note

Resident Name:	Transfer Date: Transfer Time:	Transfer to: <input type="checkbox"/> Emergency Department <input type="checkbox"/> Hospital
<p>Reason for Transfer Out of Facility</p> <p>Cardiac/Circulatory/Blood</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> Coagulation defect <input type="checkbox"/> Chest pain/angina <input type="checkbox"/> Dizzy/lightheaded <input type="checkbox"/> Hypertension/uncontrolled HTN <input type="checkbox"/> Hypotension <input type="checkbox"/> Rule out congestive heart failure <input type="checkbox"/> Rule out DVT <p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormalities of breathing <input type="checkbox"/> COPD <input type="checkbox"/> Cough or wheezing <input type="checkbox"/> Hypoxia <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Rule out pneumonia <p>Mental Disorders/Neurological/Psych</p> <ul style="list-style-type: none"> <input type="checkbox"/> Change in mental status (e.g. agitation, anxiety, confusion) <input type="checkbox"/> Delirium <input type="checkbox"/> Depression <input type="checkbox"/> Dementia <input type="checkbox"/> Rule out CVA <input type="checkbox"/> Seizure/epilepsy/convulsion <input type="checkbox"/> Decline in cognitive function and awareness <input type="checkbox"/> Psychiatric (psychosis, suicidal) <p>Gastrointestinal/Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal/pelvic pain <input type="checkbox"/> Diarrhea/gastroenteritis <input type="checkbox"/> Dysphagia <input type="checkbox"/> GI bleed <input type="checkbox"/> G tube <input type="checkbox"/> Hematuria <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Renal failure <input type="checkbox"/> Rule out kidney or urinary tract infection <p>Endocrine/Nutritional/Metabolic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dehydration <input type="checkbox"/> Malnutrition <input type="checkbox"/> Uncontrolled diabetes <p>Wound & Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cellulitis <input type="checkbox"/> Edema <input type="checkbox"/> Infected wound or decubitus <input type="checkbox"/> Jaundice <input type="checkbox"/> Rash 	<p>Fall-Related Injury</p> <ul style="list-style-type: none"> <input type="checkbox"/> Major injury <input type="checkbox"/> Minor injury <p>Non-Fall-Related Injury</p> <ul style="list-style-type: none"> <input type="checkbox"/> Major injury <input type="checkbox"/> Minor injury <p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Joint pain/joint disorder <input type="checkbox"/> Weakness <p>Other Changes in Condition, Not Specified Elsewhere:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal lab results <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Fever/possible infection <input type="checkbox"/> Functional decline <input type="checkbox"/> Malaise/fatigue <input type="checkbox"/> Potential surgical complication <input type="checkbox"/> Poor intake or nutritional decline <input type="checkbox"/> Weight loss <p>Treatment Unavailable at Transferring Facility</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diagnostics: radiology, imaging <input type="checkbox"/> IV access/fluids <input type="checkbox"/> Transfusion <input type="checkbox"/> Catheter insertion/reinsertion <p>Treatments Prior to Transfer</p> <ul style="list-style-type: none"> <input type="checkbox"/> Labs <input type="checkbox"/> X ray <input type="checkbox"/> IV fluids <input type="checkbox"/> Subcutaneous fluids <input type="checkbox"/> NG tube <input type="checkbox"/> Oxygen <input type="checkbox"/> Respiratory treatment <input type="checkbox"/> Respiratory suctioning <input type="checkbox"/> Medication: IV <input type="checkbox"/> Medications: IM or SQ <input type="checkbox"/> Medications: PO <p>Seen by (Within 24 Hours of Transfer)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Primary Physician <input type="checkbox"/> Covering Physician <input type="checkbox"/> Consulting Physician <input type="checkbox"/> Nurse Practitioner or PA <input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Other <p><input type="checkbox"/> Transfer requested by resident/family</p> <p>Authorized by:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Resident's Primary Physician/Name_____ <input type="checkbox"/> Other Provider/Name_____ <input type="checkbox"/> Medical Director/Name_____ <input type="checkbox"/> Medicare Managed Care Organization <input type="checkbox"/> Outside Clinic or Service 	

Intake Note

The *Intake Note* is written to capture information in a standardized way about the hospital or ED visit upon return to the nursing home, to use it in reporting, and to facilitate improved monitoring and management of resident care. The *Intake Note* is a mechanism to capture more details about the resident's care across settings than is currently available. The *Intake Note* is completed for each resident returning from a hospital admission, ED visit, or observation visit.

- Admit date and time
- Admit to unit (long-term care, subacute or rehab)
- Intake type (ED visit, observation stay, or hospital admission)
- Hospital length of stay or hospital admission date
- Treatment received in the ED, if returning from ED
- Discharge diagnosis from hospital (principal diagnosis and secondary diagnoses)
- Surgical procedures received in the hospital, if applicable

Sample Intake Note

Resident Name:	Admit Date: Admit Time:	Admit to: <input type="checkbox"/> Long Term Care <input type="checkbox"/> Subacute or Rehab	
Intake Type: <input type="checkbox"/> ED Visit <input type="checkbox"/> Observation Stay <input type="checkbox"/> Hospital Admit (Enter one of the following) <input type="checkbox"/> Hospital Admission Date OR <input type="checkbox"/> Hospital LOS	<i>If admitted from one of the following, do not complete this form:</i> <input type="checkbox"/> Long-Term Care Facility <input type="checkbox"/> Assisted Living <input type="checkbox"/> Home		
Treatments Received in the ED/HOSP	ED Discharge/Hospital Discharge Diagnoses: Primary & Secondary (Indicate principal or secondary if more than one hospital discharge diagnosis.)		
Catheter Insertion/Reinsertion <input type="checkbox"/> Foley <input type="checkbox"/> Ostomy <input type="checkbox"/> PEG <input type="checkbox"/> Suprapubic Diagnostics <input type="checkbox"/> EKG <input type="checkbox"/> CT scan <input type="checkbox"/> Doppler studies <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> X rays <input type="checkbox"/> Other IV Access/Insertion and Fluids <input type="checkbox"/> PICC <input type="checkbox"/> Central <input type="checkbox"/> Peripheral <input type="checkbox"/> IV fluids Labs Obtained <input type="checkbox"/> Electrolytes <input type="checkbox"/> Cardiac workup <input type="checkbox"/> CBC <input type="checkbox"/> Blood cultures <input type="checkbox"/> Other Medications <input type="checkbox"/> Oral <input type="checkbox"/> IM or IV <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Observation only Respiratory <input type="checkbox"/> Oxygen therapy <input type="checkbox"/> Respiratory treatment <input type="checkbox"/> Suctioning <input type="checkbox"/> Transfusion <input type="checkbox"/> Other _____ Surgical Procedure During Hospital Stay? <input type="checkbox"/> Abdominal <input type="checkbox"/> Cardiac <input type="checkbox"/> Hip fracture <input type="checkbox"/> Other fracture <input type="checkbox"/> Joint replacement <input type="checkbox"/> Other major surgery, not listed above	<input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Acute MI <input type="checkbox"/> Cellulitis <input type="checkbox"/> CHF <input type="checkbox"/> Circulatory problems <input type="checkbox"/> COPD <input type="checkbox"/> CVA <input type="checkbox"/> Dehydration <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Dysrhythmias <input type="checkbox"/> Electrolyte imbalance <input type="checkbox"/> Fever <input type="checkbox"/> Fall - injury <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Genitourinary problems <input type="checkbox"/> GI bleed <input type="checkbox"/> Hypotension <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperglycemia <input type="checkbox"/> Kidney infection <input type="checkbox"/> Medication reaction <input type="checkbox"/> Mental status change <input type="checkbox"/> Mental disorder/psychosis <input type="checkbox"/> Neoplasm <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pressure ulcer <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Respiratory, other nonpneumonia <input type="checkbox"/> Renal disease <input type="checkbox"/> Seizure <input type="checkbox"/> Sepsis/urosepsis <input type="checkbox"/> Surgical complications or infection <input type="checkbox"/> Syncope <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> Other _____	Principal	Secondary