Referral To and Discharge From Acute Care Facilities

Guideline: Pertinent health and functional status information about people being transferred to acute care facilities should be documented in a complete, concise, and readily accessible manner. The person should be transported in a safe and efficient way.

DEFINITION:

Primary care providers: Physicians, nurse practitioners, and physician assistants who provide primary care services and are authorized to prescribe medications and treatments for people on their assigned caseloads.

RATIONALE:

1. All information relating to the acute episode should be made available to the receiving facility to ensure immediate and appropriate follow-up care.
2. Pertinent background information regarding the person's ongoing health status is essential for evaluating the need to modify the existing medical regime in relation to acute problems.
3. Information about the person's functional level, problem behaviors, and personal preferences is needed so that health care can be provided in a manner that is least disruptive to the person's lifestyle and conducive to a return to optimal health status.

EXPECTED OUTCOMES:

1. Accurate and complete information needed to provide safe and competent care should accompany a person who is transferred to an acute care facility.
2. Appropriate and knowledgeable staff should accompany the person to the acute care facility.
3. The type of transportation to and from the acute care facility should be determined based on the condition of the person.
4. Adaptive equipment and/or assistive technologies that will be needed during the stay at the acute care facility should accompany the person at the time of transfer or soon thereafter.
5. Receiving facilities should receive advance notice if pressure-reducing/relieving equipment is required to be in place at the time of transfer.
6. There should be ongoing regular contact between the designated professional at the Regional Center/residential facility and the contact person at the acute care facility to monitor the person's status and to facilitate discharge planning. A summary of contacts made should be documented per facility policy.
7. A transfer summary sheet from the acute care facility should be sent with the person returning to the Regional Center/residential facility. The transfer summary should include information about the treatment given at the acute care facility and recommendations for follow-up care.

GENERAL GUIDELINES

Transfer to Acute Care Facility

1. **Decision and Order to Transfer**
   a. The transfer will be at the direction of a primary care provider. In case of a life threatening emergency and the primary care provider cannot be reached, the nurse can decide to transfer the person immediately.

Decision and Order to Transfer cont'd

b. The primary care provider should contact the receiving facility to provide a medical overview of the reason for transfer prior to the person's arrival at the receiving facility.

2. Documentation

Documentation accompanying the person (or sent immediately following transport) should include at least the following:

a. Demographic Data:
   1. Name (include the name the person responds to)
   2. Date of Birth
   3. Contact Person
      a. Primary care provider and phone number
      b. 24 hour phone number for patient care questions
      c. Correspondent's name, relationship, and phone number
   4. Financial Information (Medicare, Medicaid)

b. Relevant Medical/Nursing Status:
   1. Problem List
   2. Chief complaint
   3. History of present illness
   4. Current medications and treatments
   5. Diet: type, consistency and special mealtime requirements or techniques. Include dining cards with pictures and directions, if available.
   6. Special concerns including changes in past 72 hours
   7. Seizures (type and frequency)
   8. Injuries in past 72 hours
   9. Baseline information:
      a. Allergies
      b. Height and Weight
      c. Immunizations
      d. Vital signs
      e. Hepatitis B status
      f. Tuberculosis status
      g. Other communicable disease status
      h. Other infectious conditions, e.g., multiple drug resistant organisms, HIV
   10. Prostheses such as dentures, corrective lens, hearing aid, artificial limb(s), shunt, pacemaker, and other assistive technologies or equipment. (Appropriate equipment should be sent along at time of transfer.)
   12. Recent and pertinent lab and x-ray findings
   13. Concerns related to intake, output, or weight loss

c. Functional Levels:
   1. Communication Skills: Verbal and non-verbal
   2. Significant behaviors that may affect treatment including pica
   3. Mobility Status
   4. Hearing and vision status

Documentation cont'd

5. Level of independent functioning
    a. Eating skills
    b. Requirements for special equipment and/or positioning
    c. Sleep/rest
    d. Hygiene/grooming
    e. Toileting
6. Special interests or past times
7. Supervision requirement

d. Nursing Assessment:
    1. Vital signs (temperature, pulse, respirations and blood pressure)
    2. Pulse oximeter reading if respiratory distress is evident and in other circumstances as indicated
    3. Full body systems review unless affected system is apparent

3. Transportation

The type of transportation provided should be appropriate to the condition of the individual.

a. Persons in a supine position may not be transported by facility transportation.
b. Forms required by EMS must be completed prior to transport by EMS.

4. Staff Accompanying the Individual

Appropriate staff knowledgeable of the patient's condition should accompany the person to the acute care facility, whenever possible. In emergency situations, it is preferable that this person be a nurse.

5. Notification of Family of Transfer

a. The professional staff member coordinating the transfer should notify the family regarding the transfer.
b. The professional staff should keep family members informed of the person's condition, as necessary.

6. Notification of the Interdisciplinary Team of Transfer

A called team meeting will be held to provide the IDT with information about the transfer.

7. Communication with Acute Care Facility

a. There should be regular, ongoing contact with staff caring for the patient in the acute care facility.
b. The designated professional at the Regional Center will be in regular contact with the hospital staff and maintain a log of the patient's status.
c. Appropriate Regional Center/residential facility staff should be notified as discharge plans are developed so that preparations can be made for the person's return to the Regional Center.

8. Extended leave from the Regional Center/Residential Facility

Individuals whose leave from the Regional Center/Residential Facility exceeds ten (10) days must be administratively discharged for the ICF/IID. This can be accomplished with a Called Team Meeting.

Readmission to Regional Center/Residential Facility from Acute Care Facility

1. Regional Center/residential facility medical and nursing staff should be notified prior to the discharge and the recommendations made by the acute care facility for follow-up care.
2. Regional Center/residential facility nursing staff should request specific information about current medications and treatments.
3. A transfer/discharge summary from the acute care hospital should accompany the person back to the facility. This summary should include any treatments provided at the acute care facility and any orders for the primary care provider to review. If the transfer summary or full discharge summary is not received in a timely manner, the primary care provider should follow-up.
4. A called team meeting will be held when the person is readmitted to the Regional Center to develop a current plan of care.
5. For those individuals who are administratively discharged due to a hospital stay of 10 days or more, all ICFs/IID admission requirements should be followed.
6. A nursing assessment should be completed and documented immediately upon return from the acute care facility.
7. The person should be assessed by the attending or on-call primary care provider upon return to the Regional Center/residential facility.
8. In some instances, immediate readmission to the Regional Center/residential facility may not be possible due to the complexity of follow-up care needed. The hospital discharge planner and appropriate staff from the Regional Center/residential facility will develop an interim plan for care until readmission is possible.