

**The Miriam Hospital
Administrative Manual**

**Subject: Electronic
Utilization of the
Continuity of Care Form**

File Under: MS-21 and IT-3

Issuing Department:

Clinical Informatics

Latest Revision Date:

Reviewed:

Original Procedure Date:

February 28, 2007

Page of 1 of 8

Approved By:

**Rebecca Burke RN
VP, Patient Care Services and CNO**

**Mary Kennedy RN
Director, Clinical Informatics**

PURPOSE: To provide guidelines for the use of electronic tools, the “Write Home Meds” list and the Continuity of Care (CoC) form, both of which will be available as menu items on LifeLinks/NurseLinks.

An electronic version of the CoC form has been approved by the Department of Health and replaces the paper version. This form will be available, and editable, throughout the patient’s hospital stay. The sections of the CoC form that are most pertinent for the patient are pulled together on a Patient Instruction Sheet that is printed for the patient at discharge. After discharge, the CoC will remain available through LifeLinks/NurseLinks for 14 days and a hard copy will be printed for the final chart.

The Continuity of Care form is to be used in conjunction with the Electronic Medication Reconciliation process.

POLICY: The Electronic CoC and medication reconciliation process will be completed on all patients admitted to TMH either under Observation or Inpatient Level of Care. This is initiated with the medication reconciliation process beginning at the moment a decision to admit a patient to the hospital is made (Refer to Policy & Procedure IT-2, “Electronic Medication Reconciliation”). Pages 1-4 of the CoC are reviewed, printed and provided to the patient and or next provider of care.

Definitions

CoC	Continuity of Care form
Write Home Meds	List of home medications recorded at admission, preadmission meds list
Discharge Instruction Sheet	CoC form pages 1 & 2, for LIP's
Discharge Referral Form	CoC form pages 3 & 4 for nursing and other disciplines
Patient Instruction Sheet	Simplified CoC to be given to patient at discharge; differs from CoC form printed for chart
Licensed Independent Practitioner (LIP)	Physician, NP, PA
Medication	Any prescription, over-the-counter (OTC) or sample medication, herbal product, vitamin, alternative remedy, respiratory-related drug (e.g., inhaler), diagnostic/contrast agent or blood derivative given within the past seven days

PROCEDURE

<u>Action</u>	<u>Responsibility</u>	<u>Special Notes</u>
<p><u>1. Medication Reconciliation</u></p> <ul style="list-style-type: none"> Per Hospital Policy & Procedure IT-2. 	RN/ Licensed Independent Practitioner	<ul style="list-style-type: none"> -Please review “Electronic Medication Reconciliation” P&P -The patients’ home med list, if entered completely it can be pulled forward to display on the CoC form, so it is essential to begin the medication reconciliation process upon admission.
<p><u>2. Preparing for Patient Discharge</u></p> <p>DISCHARGE INSTRUCTION SHEET: Physicians: (Pages 1 and 2 of online version)</p> <ul style="list-style-type: none"> Access the CoC using your LifeLinks password, clicking on the “Cont Care From” button found on the left menu option. Complete all boxes and fields of the “discharge instruction sheet”, There is a combination of fields automatically populated (that can be edited), free text fields and those not editable. 	<p>Licensed Independent Practitioner</p> <p>Licensed Independent Practitioner</p> <p>Licensed Independent Practitioner</p>	<ul style="list-style-type: none"> - Complete for all patient discharges (Inpatient and Observation Patients) Physicians are responsible for all fields of the Discharge Instruction Sheet, as appropriate. Items which are automatically populated on the form (and sources) <ul style="list-style-type: none"> - Patient Name and Address – from registration data - PCP – from registrations data - Allergies – from Lifetime Clinical

Action

Responsibility

Special Notes

Record (LCR)

- **Diagnosis** – from admissions registration data, which should be reviewed and updated at time of discharge

- **Surgical Procedures** – from iPATH

- **Medications** – from the pharmacy profile (active medications)

- **Home Medications prior to admission** – from Write Home Meds List

Non-editable fields; Demographic Information and Allergies

Allergies: If allergies need to be updated, this must be completed by updating POM first.

- **Page 1** : Review all editable fields: Licensed Independent Practitioner
 - Principle Dx
 - Surgery this Admission
 - Infections
 - Other Medical Problems
 - Diet
 - Condition at D/C
 - Physician Comments
 - New Prescriptions
 - Activity
 - Physician to follow after d/c
 - D/C Summary dictated by

- **NOTE: Principle Dx:** This field is automatically populated with admitting diagnosis, which is often not the discharging dx. Update accordingly.

- The “Physician Comment Box” can be used to document review of the form with the patient, special instructions, activity modifications, etc.

- The name of the physician that last edited the form prior to printing will be entered by default into the Attending/Resident signature box (electronic signature). If the form is filled out by someone other than a Licensed Independent Practitioner (e.g., verbal orders for discharge), the individual completing the form will have to manually enter the ordering physician’s name

- The Licensed Independent Practitioner who dictates the discharge summary should type his/her name and the dictation job number in the “Discharge Summary Dictated by” field.

<u>Action</u>	<u>Responsibility</u>	<u>Special Notes</u>
<ul style="list-style-type: none"> Complete: <ul style="list-style-type: none"> - “Discharged to” - “Phone” - “Address” - “Referral to” - “Phone” - “Contact Person; - D/C’ing Facility” - “Phone/Beeper” 	Licensed Independent Practitioner/Case Manager	- Case Managers will enter appropriate Disposition codes for discharges going with services or to another facility. such as “Disposition Code” “ARS, ATE, ATB...”
<ul style="list-style-type: none"> Page 2: Complete free text fields and reconcile medications according to TMH P&P # _____ <ul style="list-style-type: none"> - Advance Directives - Immunizations - TB - Discharged to: - MRSA, VRE, C-diff - Info. Given to patient upon d/c (as appropriate) - Follow-up appointments - Call MD if: - Wound Instructions - Comments field - Medications 	Licensed Independent Practitioner	<p>-The form will not print unless all medications have “Yes” or “No” selected in the Continue After Discharge column and the meds are not identified as either “pre-admission” or “new”. However, the form can be saved to permit ongoing revisions during the patient’s stay.</p> <p>- If the medication list needs to be modified after being saved or printed, medications can still be added or repopulated from the active med list (click “update now” button at the top of the med list). Caution:: If you click to “Update Now” this will delete any free text medication entries one might have made.</p>
<ul style="list-style-type: none"> After adding or editing information, use the “save button” to save changes. 	Licensed Independent Practitioner	- Once the form has been saved or printed, editable boxes will not automatically update from their sources.
<ul style="list-style-type: none"> Final Review 	Licensed Independent Practitioner	- All editable items should be reviewed for accuracy prior to discharge.

PRINTING

RN

- We ask that the forms are **not** printed until all disciplines have an opportunity to complete their sections.

- The RN will print all pages of the CoC after he/she completes their section.

-A final chart copy will be available in

<u>Action</u>	<u>Responsibility</u>	<u>Special Notes</u>
<u>DISCHARGE REFERRAL FORM:</u> (pages 3 & 4)	RN	the MR and you will have an opportunity to go back into LifeLinks and print up to 14 days after discharge for your records.
Access the CoC using your NurseLinks password, clicking on the “Write Cont Care” button found on the left menu option.	Unit Secretary	- A fax copy of the CoC will be sent to the patients PCP upon the patients’ discharge.
<ul style="list-style-type: none"> • Physical and Functional Status – Nurse Form (Page 3) <ul style="list-style-type: none"> - Activities of Daily Living - Vital Signs - Mobility - Cognitive Status - Skin Integrity - Bowel and Bladder - Impairments 	RN	<ul style="list-style-type: none"> - Complete for all patient discharges (Inpatient and Observation Patients) - Portions of any form can be completed during the patient’s stay as appropriate. - Practitioners are strongly recommended to complete as much of the forms as possible prior to the day of discharge or transfer, but do not print the form until the day of discharge. - For check box items, click directly on the word or box. - For free text entries, click on the box to have the cursor appear
<ul style="list-style-type: none"> • Summary Notes – Specify Discipline (Page4) 	RN/Any additional Health Care Discipline	
1. Nursing Discharge Summary including final set of VS	RN	<ul style="list-style-type: none"> - When completed this can serve as your discharge note. - Date and Time a set of VS taken with 60 minutes of patient’s discharge.
2. Additional Discipline Documentation	Any Discipline	<ul style="list-style-type: none"> - Appropriately Identify the Discipline documenting <p>Caution: Do Not print any pages until you have updated/completed the Patient Instructions.</p>

Action
Patient Instruction Sheet:

Responsibility
 RN

Special Notes

- This form is what will be given to the patient upon discharge.

Certain items will carry over to the Patient Instruction Sheet from pages 1 & 2 of the CoC.

- Review “Information Given to Patient on Discharge” section and add any additional checks as appropriate RN
- Add the “Time Last Given” and “Time Next Dose”. RN
- Clarify the frequency if not in a language a patient will understand (e.g. change “1XD” to “once a day”) RN
- Nurse Completing the form types his or her name in the box provided. RN

Caution: Do Not click on the “Update Now” button, this will delete any free text meds typed by the MD earlier and any “time last given” or “time next dose” entries made earlier

PRINTING OF CoC FORMS:

-All patients

- **Patients going home with or without services:** Print two copies of completed Patient Instruction Sheet, review with patient, and patient sign both copies. One copy goes to patient; one copy goes to medical record. RN
- **Patients going home with no services:** Print one copy of completed Discharge Instruction Sheet (CoC pages 1-2) and Discharge Referral form (CoC p 3 and 4)and place in the front of the patients MR. RN

- using Print button on form, not toolbar print icon

- using Print button on form, not toolbar print icon.

<u>Action</u>	<u>Responsibility</u>	<u>Special Notes</u>
<ul style="list-style-type: none"> • Patients go home with services: Print 2 copies of the completed Discharge Instruction Sheet (CoC pages 1-2) and Discharge Referral form (CoC p 3 and 4). One for the referring facility or agency, one for the medical record 	RN	- Using Print button on form, not toolbar print icon
<ul style="list-style-type: none"> • Fax completed pages 1-4 of the CoC and Patient Face Sheet to homecare agency identified on the CoC. 	Unit Secretary	- Case Manager will identify Agency and Fax number on “Pink Slips”
<ul style="list-style-type: none"> • Place pages 1-4 of CoC, patient face sheet and fax confirmation in Case Managers Box on the Unit. 	Unit Secretary	
<ul style="list-style-type: none"> • Patients go to a facility/Rehab: Print 3 copies of the completed Discharge Instruction Sheet (CoC pages 1-2) and Discharge Referral form (CoC p 3 and 4). One for the referring facility or agency, one for the medical record and one for the Case Management Box on the Unit. 	RN	
<ul style="list-style-type: none"> • Place pages 1-4 of CoC in envelope accompanying patient to the facility/rehab. 	Unit Secretary	- This is the envelope that the ambulance drivers take when picking up the patient.
<ul style="list-style-type: none"> • All Discharges: Fax pages 1-2 of the CoC to the PCP identified on page 1 “Physician who will follow patient after D/C. Use fax cover letter in accordance with HIPPA 	Unit Secretary	- You can look up any MD fax number in the Lifespan Intranet Phone book. If fax # is unavailable contact the PCP.

DOWNTIME

<ul style="list-style-type: none"> • When POM is down, and the Continuity of Care form cannot be accessed, go to the back up link on the intranet <ul style="list-style-type: none"> • Access the Downtime CoC LINK 	US/ RN	Go to the Intranet → Medical Tab → In the left hand column, under Clinical Systems Access, click on “Continuity of Care” form for
--	--------	---

<u>Action</u>	<u>Responsibility</u>	<u>Special Notes</u>
<ul style="list-style-type: none"> • Complete forms on line • If back-up link is not working, proceed to emergency back-up; 	US/RN	<p>downtime use;</p> <p>→ Click on Miriam Continuity of Care forms</p> <p>→ Log-in using your Siemens ID (Patient links or Nurselinks ID)</p> <p>→ Enter Patient Name, MRN to locate patient</p> <ul style="list-style-type: none"> • <p>Go to the Intranet</p> <p>→ Medical Tab</p> <p>→ In the left hand column, under Clinical Systems Access, click on “Continuity of Care” form for downtime use;</p> <p>→ Below the Miriam Continuity of Care forms;</p> <p>→ Read the last sentence and Click on “See Here” in small print and proceed to the next page</p> <p>→ Use one of these links to access the on-line Continuity of Care form</p> <ul style="list-style-type: none"> • Miriam Continuity of Care forms <ul style="list-style-type: none"> ○ Alternate Server 2 ○ Alternate Server 1
<p>Continuity of Care Form Emergency Back-up</p>		
<ul style="list-style-type: none"> • Complete forms on-line 	RN/MD	<p>→ Log-in using your Siemens ID (Patient links or Nurselinks ID)</p> <p>→ Enter Patient Name, MRN to locate patient</p>