

Transitions of Care Checklist

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Use this handy checklist at admission, at transfer between units within the same facility, before discharge, and at the patient's first post-admission outpatient visit to help keep patients on track with their medications, and out of the hospital. Also, get our disease-specific resources, Transplant Medication Transitions of Care and Insulin Pump Use and Transitions of Care, for appropriate patients.

On Admission to an Acute Care Facility	
	• Get an accurate and complete med list, including OTCs and supplements.⁵ ○ Consider assigning dedicated persons to obtain medication histories.⁵ ○ Use multiple resources, including the patient, family, outpatient pharmacy, and primary care provider. In Canada, check PharmaNet (https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/pharmanet-bc-s-drug-information-network) for a record of every prescription dispensed in British Columbia community pharmacies.
	• Clarify confusing regimens, such as between immediate- and extended-release dosage forms (e.g., metoprolol 100 mg daily).
	• Ask about allergies, including associated reactions.⁵
	• Ensure a pharmacy team member reviews the list with the patient or caregiver before meds are ordered.²
	• Compare the patient's current med list to admission orders. Look for duplicates, omissions, unnecessary meds, inappropriate doses and dosage forms, and drug interactions. Ensure "as needed" home meds are not ordered scheduled in the hospital.
	• Look for problems with anti-infective, cardiovascular, central nervous system, endocrine, and hematologic meds.¹ The most problematic meds are oral antiplatelets, oral hypoglycemics, insulin, and warfarin.¹ Accidental overdose is the most common med-related reason for admission.¹
	• Look for potential administration problems (e.g., patient has an enteral tube and cannot take meds by mouth). Get oral tablets or capsules converted to other dosage forms, if appropriate. Ensure a pharmacist is consulted before crushing, splitting, or opening tablets or capsules.

Transfer Between Levels of Care Within an Acute Care Facility	
	• Compare the patient's current med regimen to transfer orders. Look for duplications, omissions, unnecessary meds (e.g., assess appropriateness continuing standing orders such as PPIs [stress ulcer prophylaxis] or antipsychotics [ICU delirium versus other indications], DVT prophylaxis), inappropriate doses and dosage forms, and drug interactions.
	• Look for problems with anti-infectives, diuretics, hematologic meds, electrolytes, and IV fluids, especially if transferring out of ICU. These meds are commonly associated with med errors when transferring out of the ICU.³
	• Were any home meds held on admission due to admission directly to the ICU (~60% of regularly scheduled meds are stopped when patients are admitted to the ICU)?⁴ Can consider incorporating a formal review of home meds for patients originally admitted to the ICU when transferring to the floor.
	• Watch for location-specific protocols (e.g., ICU or recovery room protocols), meds, drips (e.g., insulin, pressors), or infusion rates limited to use in certain areas. Check the MAR (not the label) to verify infusion rates, as rates can change after labels are printed. Ensure inappropriate meds are stopped or changed to align with the appropriate floor-specific protocol, med, or infusion rate.
	• Ensure doses are adjusted when necessary (e.g., changing kidney function, some IV to PO conversions [e.g., levothyroxine, furosemide]). Can consider incorporating a formal process to reassess doses on the floor for meds that were adjusted while in the ICU.
	• Look for potential administration problems (e.g., patient has an enteral tube, cannot take meds by mouth). Get oral tablets or capsules converted to other dosage forms, if appropriate. Do not crush, split, or open tablets or capsules before talking to the pharmacist. Or, adjust liquid meds back to home dosage forms, if enteral tubes have been removed.
	• Complete med reconciliations for ED boarder patients (admitted but waiting in the ED) and order home meds to help prevent delays in care and decrease the risk of missing orders. Consider developing protocols to facilitate these processes. ○ There are often orders for one-time doses (e.g., antibiotics) in the ED. Ensure subsequent doses are ordered and administered.
Patient Being Discharged to Home (Acute Care Considerations)	
	• Ensure patients/caregivers understand the home med regimen.
	• Identify expensive or prior authorization meds. Involve pharmacists and discharge planners to resolve problems before discharge.
	• Check for barriers to getting discharge meds (e.g., holiday, evening, or weekend discharge; transportation). ○ If your facility has delivery of discharge meds to the bedside with education, get this process started well in advance of discharge. ○ If the patient has prescription drug coverage, get this information so the patient does not pay out-of-pocket.
	• Use motivational interviewing and teach back to get patient/caregiver buy-in and to make sure instructions are understood.
	• Make sure patients/caregivers know how to use any prescribed injections (e.g., insulin, heparin) or devices (e.g., inhalers).
	• Use appropriate patient education handouts to help with discharge counseling.

Patient Being Discharged to Home (Acute Care Considerations), continued	
	• Educate patients about any new diagnoses they received during their admission.
	• Empower patients with customizable action plans.
	• Check for pending test results.
	• Make patients/caregivers aware of follow-up appointments and tests (and encourage keeping these).
	• Ensure patients/caregivers know what symptoms should prompt seeking medical attention, and who to contact if these occur.
	• Make sure new meds are continued upon discharge (e.g., heart failure meds, antiplatelets post-stent, controller inhaler), if appropriate.
	• Ensure chronic meds that were held during hospitalization are restarted (e.g., anticoagulants, diabetes meds), if appropriate.
	• A patient's med list should be shared with all of the patient's providers.
	• Ensure the patient has a follow-up appointment with their usual primary care provider.
	• Ensure explanation for any medication changes is in discharge summary, or in a separate summary.
	• Send discharge summary to primary care provider.
Patient Being Discharged to Home (Outpatient Pharmacy/Community Considerations)	
	• Use motivational interviewing and teach back to get patient/caregiver buy-in and to make sure instructions are understood.
	• Make sure patients/caregivers know how to use any prescribed injections (e.g., insulin, heparin) or devices (e.g., inhalers).
	• Clarify med instructions that aren't specific (e.g., "as directed" insulin prescriptions). Ensure there are stop dates for meds typically given as short courses (e.g., corticosteroids, antibiotics, pain meds). Instructions for meds being tapered or titrated should be specific.
	• Clarify liquid prescriptions written as "teaspoonful" or "tablespoonful"; use only mL. Give instructions for oral syringes or dosing cups.

Patient Being Discharged to Home (Outpatient Pharmacy/Community Considerations), continued	
	• Ensure meds switched at admission (due to formulary substitutions) are changed back to the patient's pre-admission med to avoid duplication or omissions. ○ Common formulary switches include ACEIs, ARBs, statins, and PPIs. ○ Liquid or short-acting formulations may need to be switched back to tablet, capsule, or long-acting formulations.
	• Look for new inpatient meds that may no longer be needed (e.g., PPI, H2-blocker, DVT prophylaxis). Get them stopped, if appropriate.
	• Look for interactions between current and discharge meds.
	• Ensure chronic meds that were held during hospitalization are restarted (e.g., anticoagulants, diabetes meds), if appropriate.
	• Look for opportunities to simplify drug regimens when possible (e.g., consider combination or extended-release products).
	• Ensure discontinued meds are taken off automatic refill programs. Encourage patients to discard meds they no longer take.
	• Help patients create an accurate med list and encourage patients to keep it up-to-date.
Patient Being Discharged to Long-Term Care Facility or Rehab Hospital	
	• Ensure accepting facility can meet the patient's medication needs (e.g., IV antibiotics, unusual or expensive meds).
	• Ensure meds switched at admission (due to formulary substitutions) are changed back to the patient's pre-admission med to avoid duplication or omission. ○ Common formulary switches include ACEIs, ARBs, statins, and PPIs. ○ Liquid or short-acting formulations may need to be switched back to tablet, capsule, or long-acting formulations.
	• Look for meds started in the hospital that are no longer needed (e.g., PPI, H2-blocker, DVT prophylaxis). Get them stopped, if appropriate.
	• Make sure new meds are continued upon discharge (e.g., heart failure meds, antiplatelets post-stent, controller inhaler), if appropriate.
	• Ensure chronic meds that were held during hospitalization are restarted (e.g., anticoagulants, diabetes meds), if appropriate.
	• Ensure chronic meds that the patient was on before hospitalization are still needed and will not result in duplication, drug interactions, or adverse events if restarted/continued.²

Patient Being Discharged to Long-Term Care Facility or Rehab Hospital, continued	
	• Clarify med instructions that aren't specific (e.g., “as directed” insulin prescriptions). Ensure there are stop dates for meds typically given as short courses (e.g., corticosteroids, antibiotics, pain meds). Instructions for meds being tapered or titrated should be specific.
	• Clarify liquid prescriptions written as “teaspoonful” or “tablespoonful”; use only mL.
	• Check for pending test results.
	• Make accepting facility aware of follow-up appointments and tests.
	• Ensure explanation for any medication changes is in the discharge summary, or in a separate summary.
	• Send discharge summary to the facility AND provider who will be following the patient.
Patient Being Admitted/Readmitted to Long-Term Care Facility	
	• Obtain discharge summary (if applicable).
	• Get an accurate and complete med list, including OTC drugs and supplements. Use multiple resources, including the patient, family, outpatient pharmacy, and primary care provider. In Canada, check PharmaNet (https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/pharmanet-bc-s-drug-information-network) for a record of every prescription dispensed in British Columbia community pharmacies.
	• Identify labs that were pending at discharge that need follow-up.
	• Call the inpatient prescriber to clarify discrepancies between the pre- and post-admission med lists that don't make sense.
	• Look for therapeutic duplications (e.g., due to formulary switches), or chronic meds that may have been held but not restarted.
	• Check for drug interactions, or meds started in the hospital that may cause problems for seniors (e.g., hypnotics, antipsychotics).
	• Clarify any med instructions that aren't specific (e.g., “as directed” insulin prescriptions). Ensure there are stop dates for meds typically given as short courses (e.g., corticosteroids, antibiotics, pain meds). Instructions for meds being tapered or titrated should be specific.

At/Before First Post-Admission Primary Care Visit	
	• Follow up with the patient by phone within two business days of discharge to: ○ ensure discharge instructions are being followed (e.g., antibiotics for pneumonia, prednisone for a COPD exacerbation). ○ make sure patients know what symptoms require medical attention (e.g., symptoms of worsening COPD, heart failure, or infection). ○ remind them of their follow-up appointment, or if not scheduled, schedule one within seven to 14 days of discharge. ○ ask the patient to bring any discharge materials from the hospital to the appointment. • In the US, get info on billing for these transitional care management services at https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf.
	• Obtain the most recent discharge summary before the patient visit. Review for pending labs, and order recommended follow-up tests, if needed.
	• Identify labs that were pending at discharge that need follow-up.
	• Call the inpatient prescriber to clarify discrepancies between the pre-and post-admission med lists that don't make sense.
	• Look for therapeutic duplications (e.g., due to formulary switches), meds started in the hospital that are no longer needed (e.g., stress ulcer prophylaxis), chronic meds that may have been held during hospitalization but not restarted, and chronic meds that are no longer needed or will result in duplication, drug interactions, or adverse events if restarted/continued.²
	• Ensure patients understand when to stop short-course therapy (e.g., corticosteroids, antibiotics, pain meds).
	• Ensure patients understand which meds they should change or stop. Encourage proper disposal of discontinued meds.
	• Use motivational interviewing and teach back to get patient/caregiver buy-in and to make sure instructions are understood.
	• Create an accurate med list. Verify doses and frequencies. Give patients the med list and encourage them to take it to all appointments.

Abbreviations: ACEI = angiotensin converting enzyme inhibitor; ARB = angiotensin receptor blocker; COPD = chronic obstructive pulmonary disease; DVT = deep vein thrombosis; ED = emergency department; ICU = intensive care unit; IV = intravenous; OTC = over-the-counter; PO = by mouth; PPI = proton pump inhibitor.

Users of this resource are cautioned to use their own professional judgment and consult any other necessary or appropriate sources prior to making clinical judgments based on the content of this document. Our editors have researched the information with input from experts, government agencies, and national organizations. Information and internet links in this article were current as of the date of publication.

Levels of Evidence

In accordance with our goal of providing Evidence-Based information, we are citing the **LEVEL OF EVIDENCE** for the clinical recommendations we publish.

Level	Definition	Study Quality
A	Good-quality patient-oriented evidence.*	1. High-quality randomized controlled trial (RCT) 2. Systematic review (SR)/Meta-analysis of RCTs with consistent findings 3. All-or-none study
B	Inconsistent or limited-quality patient-oriented evidence.*	1. Lower-quality RCT 2. SR/Meta-analysis with low-quality clinical trials or of studies with inconsistent findings

	3. Cohort study 4. Case control study
C	Consensus; usual practice; expert opinion; disease-oriented evidence (e.g., physiologic or surrogate endpoints); case series for studies of diagnosis, treatment, prevention, or screening.

***Outcomes that matter to patients** (e.g., morbidity, mortality, symptom improvement, quality of life).

[Adapted from Ebell MH, Siwek J, Weiss BD, et al. Strength of Recommendation Taxonomy (SORT): a patient-centered approach to grading evidence in the medical literature. *Am Fam Physician* 2004;69:548-56.

<https://www.aafp.org/pubs/afp/issues/2004/0201/p548.html>]

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