

## Summary of Notes from Hospitals and Nursing Homes at October 5, 2011 Meeting

1. Hospital – SNF transfers
  - a. Improve protocol
    - i. Double check transfer orders
    - ii. Fax prescriptions, orders and information in advance/as soon as possible
      1. Medical Records
      2. Narcotics—hard prescriptions
    - iii. Streamline discharge orders/med sheets
    - iv. Hospital sealing envelope to ensure scripts get to SNF
    - v. Need diagnosis for each med
    - vi. Duplication of discharge orders—need one accurate set sent
    - vii. Verbal Reports (sending or receiving)
    - viii. Standardization of communication (i.e., Code Status)
      1. Checklist for transfers—standardized form to ER
      2. Checklist of documents from hospital (bright yellow colored envelopes for discharge documents)
    - ix. Revisit transfer forms
    - x. Identifying OOS vs. IP 3 day stay patients
    - xi. PASSAR signed
    - xii. Discharge/Admit before 5 pm
2. What's needed
  - a. Pyxis (Med Machine)
  - b. Access to medical records
  - c. Electronic Record access
3. Open communication:
  - a. Communication with physicians of what can be done in the nursing home before sending the patient to the hospital
  - b. Communication between hospital discharge planners and the NFs (a Clinical Nurse Liaison)
  - c. clarify orders
  - d. discharge times—be honest
  - e. contact social workers/charge nurse @ Memorial
  - f. Flu and Pneumonia vaccine
  - g. PAS
4. Improve Collaboration
  - a. Collaborative meetings with hospitals and LTC providers
    - i. SNF to come to in-servicing meetings @ hospital
    - ii. Include physician in collaborative meetings (i.e., Medical Director and ER)
  - b. Key people meet (hospital, SNFs, Level of Care, REAL Services)—use models that are working elsewhere
  - c. Key Contacts—updated and provided to admissions and social work staff

- d. Open Forum—Hospital /Admissions Coordinator/DON/Administrator/REAL Services
- e. Keep hospital informed on Medical Director
- f. Include Mental Health providers and REAL Services (PASSAR, Ombudsmen, etc.)
- g. Partner for education
- h. Regular meetings between hospital and facilities (small groups)
- i. Having a regular “go-to” person at each facility for questions
- j. Collaborative meeting quarterly
- k. Meetings between physicians (Medical Directors, Attendings, Hospitalists) to discuss direct admissions vs. ER
- l. Heart Failure Nurse Practitioner from hospital to complete “home visits” to individuals in NFs if ordered by physician

5. Education

- a. Greater education of LTC nurses regarding ER need for information
- b. Increase education on Medicare eligibility
- c. Understanding financial concerns for both hospitals and NFs
- d. Understanding hospital stays (inpatient admissions vs. observation)

6. Notes

- a. Last minute discharges on evenings and weekends are challenging
- b. Readmissions within 30 days
- c. Nurses asking Dr’s what measures can be taken @ NF to reduce number of hospital transfers
- d. What to expect in ECF: staffing ratios; encourage tours; therapy minutes