2012

Reducing Readmissions: **Specific Tools** from Massachusetts STAAR Cross-Continuum Teams

MHA Massachusetts Hospital Association

The leading voice for hospitals.

Massachusetts Coalition for the Prevention of Medical Errors

Storybooks 2012 Hospital Tools
(Bolded tools are attached)

Baystate Franklin Medical Center
- CHF zone teaching tool
- Calendar to record daily weight
- Caring for Your Heart: Living Well with Heart Failure teaching booklet
- BFMC medication listing/side effects of common medications tool for nurses
- Risk stratification tool for determination of patients who are at high risk for readmission related to non-adherence to medication.

Baystate Medical Center
- Zone education
- Ask me 3 education tool

Beth Israel Deaconess Hospital- Milton
- Hospital purchased patient education software library

Beth Israel Deaconess Hospital- Needham
- **CHF Follow-up Call form (attachment #1)**

Cambridge Health Alliance
- **Readmission Root Cause Guide (attachment #2)**

Cape Cod Hospital
- "PCP Notification Form"
- Nurse to Nurse SNF Communication Worksheet and Audit tool
- Dovetail Referral Form
- Enhanced Reassessment Tool
- SNF Readmission Audit Tool and Report Template
- Teach Back – 5 Key Must Know Categories

Cooley Dickinson Hospital
- Medication Discrepancy Tool (Coleman)
- Personal Health Record (Coleman)
- Standardized Eclipsys documentation for high risk patients
  - ED high utilize plan
  - Complex care plan
  - Case Management Discharge Plan note
  - OASIS Data to measure improvement in management in oral medication and decrease in acute care hospitalization.
  - SNF post discharge feedback survey (how did the discharge go?)

Falmouth Hospital
- Nurse to nurse communication
- **PCP Discharge Notification Form (attachment #3)**
- **Discharge follow up phone call (attachment #4)**

Holyoke Medical Center
- **CHF Monitoring Tool for SNF (attachment #5)**
- **CHF Education Tool for SNF (attachment #6)**
- **MAR for the CHF Patient in a SNF (attachment #7)**

Lawrence General Hospital
- Script for warm handoffs

Massachusetts General Hospital
- **Wound Care Home Management Plan (patient education sheet) (attachment #8)**
- **MGH post-discharge medication reconciliation program worksheet (and script) (attachment #9)**
- **What to expect with VNA home care services (patient education sheet) (attachment #10)**

Merrimack Valley Hospital

- Hand off tool
- Interact / SBAR tool (hand off from SNF to acute)
- Total Revision of the Patient Admission packet to Patient Education Packet
- Pharmacy Discharge Counseling Brochure
- SNF Resource Guide

Milford Regional Medical Center

- **LACE (attachment #11)**
- **Teach back (attachment #12)**
- **Care Partner Brochure (attachment #13)**
- Community Resource Guide and Checklist
- 5 Steps to Wellness

Newton-Wellesley Hospital

- **Teach back – Medical and Surgery (attachment #14)**
- **Discharge phone call script (attachment #15)**

Northeast Health System

- **High Risk Readmission Criteria (attachment #16)**
- **Discharge Checklist (attachment #17)**
- **Mini cognitive assessment (attachment #18)**
- **Depression screening tool (attachment #19)**

Northshore Medical Center

- CHF discharge instructions
- Enhanced Risk Assessment Version 4

Norwood Hospital

- Enhanced Assessment Form
- Zone Trigger Tools

Saint Anne's Hospital

- **Discharge Checklist (attachment #20)**
- **iSBARt Bedside Report Guide & SBAR Poster (attachment #21)**
- Multidisciplinary Rounds Checklist

Saints Medical Center

- **Daily STAAR List (attachment #22)**
- **Teach Back (Heart Failure, Pneumonia) (attachment #23)**
- Risk Assessment Tool
- **Heart Failure Discharge to Home Care Pathway (attachment #24)**
- Discharge Instructions with scheduled follow-up appointment

South Shore Hospital

- **COPD Action Plan (attachment #25)**

Sturdy Memorial Hospital

- Patient Care Team data base

ATTACHMENT #1

Beth Israel Deaconess - Needham

CHF PATIENTS DISCHARGE FOLLOW-UP CALLS

BID Needham
CHF PATIENTS DISCHARGE FOLLOW-UP CALLS

PATIENT NAME----------TEL----------

D/C DATE----------FOLLOW-UP CALL DATE----------

1. **How are you managing?**

2. **Are you following your diet?**

    a. **Are you having any problems/questions about what to eat?**

3. **Are you taking any medications?**
    a. **Specifically, are you taking a "water"/fluid pill?**
    b. **Are you having any problems with your medicine?**

4. **Have you had any:**

    a. **Shortness of breath**
    b. **Swelling of your feet, ankles, hands or stomach**
    c. **Weight gain**
    d. **Feeling more tired, no energy**
    e. **Dry, hacky cough**
    f. **Feeling uneasy/just "not right"**
    g. **New or increased chest pain or pressure**

    h. **If yes (to any), what did you do?**

5. **Was a referral made for a Visiting Nurse to see you?**

    a. **If yes, has the nurse visited yet/when is that visit planned?**

    b. **Is the nurse reviewing your weight and discussing the signs/symptoms of CHF with you?**

6. **When do you have an appointment with your doctor?**

7. **Is there anything that you need assistance with right now?**

8. **Have you had any:**
    a. **Shortness of breath**
    b. **Swelling of your feet, ankles, hands or stomach**
    c. **Weight gain**
    d. **Feeling more tired, no energy**
    e. **Dry, hacky cough**
    f. **Feeling uneasy/ just "not right"**
    g. **New or increased chest pain or pressure**

    h. **If yes (to any), what did you do?**

9. **Is there anything that you need assistance with right now?**

ATTACHMENT #2

Cambridge Health Alliance

Readmission Root Cause Guide

Readmission Dictionary

Category

8/2/2011
Rev 1

Answers the question: What is the clinical reason for the Pt's return as it relates to the index visit diagnosis?

Please note that certain categories, New Diagnosis and Planned Surgery, allow for you to indicate that the return it not related to the index visit.

A	Progression of disease (Adherence)	The Pt's disease worsened even though he or she followed the suggested care plan as expected
B	Exacerbation of disease (Non-Adherence)	The Pt's disease worsened largely due to the Pt's inability or choice to not follow the suggested care plan
C	New diagnosis	The Pts condition is not directly related to the index visit diagnosis
D	Planned surgery	The visit was planned and is not related to the index visit diagnosis
E	Post-op/Post-Procedure complication	A surgery or procedure within the past 30 days led to complication
F	ETOH / Substance Abuse	Should only be used for Alcohol and Drug abuse and unrelated to other clinical conditions

Reason

Answers the question: What is the main cause for the Pt's clinical condition which prompted the return?

1	Preventive / Environmental	ETOH / Substance Abuse	An addiction to alcohol or other substances is hindering the Pt in his or her care plan
2		Failed outPatient treatment	Disease progression related to Non-adherence to plan of care.
3		Fall	Pt fell while not at the hospital
4		No visit by provider	Pt was not seen by a health care provider (VNA, physician, specialist, or other) as suggested on HCP
5		Readmitted before provider visit	Pt was not seen by a health care provider because he/she was readmitted before a scheduled appointment.
6		Unsupportive home environment	Pt has limited support or no family or care giver support. - Move to Pt Hospital Sub Category
7	Patient / Hospital	Behavioral health issues	Pt is candidate for psychiatric care, e.g.high utilizer, drug seeker, depression (Not the same as ETOH / Substance abuse)
8		Opt against recommended treatment	Pt opted against the suggested medication or treatment at the index visit for personal or religious reasons
9		Opt against recommended LOC	Pt opted against the recommended level of care (VNA, SNF, Rehab) at the index visit
10		Poor understanding of illness or HCP	The Pt did not follow the HCP or care for themselves appropriately due to a poor understanding
11	Disposition	Admitted to InPatient Hospice	To be used for Inpatient Hospice
12		Appropriate LOC not available	Pt and providers understand appropriate LOC, but no benefit ***(Please Detail)***
13		Appropriate LOC not identified	The pt would have benefited by being discharged to a higher level of care following the index visit
14		AMA / Eloped	The pt left the hospital AMA or Eloped during the index visit
15		Palliative Care Candidate	Pt is a candidate for palliative care but Pt decline during index admission
16		Patient was admitted from Medicine	Pt transferred to Psych from Medicine
17		Patient was admitted from Psych	Pt transferred to Medicine from Psych
18	Clinical	Medication	Pt did not take medication as prescribed or experienced a side effect ***(Please Detail)***
19		Change in Mental Status	A change in mental status contributed to the Pt's progression or is the reason for the return
20		Natural Cause Progression	Only to be used if the pt is adherent, no other preventive measures could have been taken, but the pt's disease still progressed ***(Please Detail)***
21	Other	Elective admission	A scheduled procedure or surgery unrelated to index visit *(To be used for Category: Planned Surgery.)*

Root Cause

Answers the question: What contributing factor(s) and / or underlying cause(s) led to the above reason for the readmission?

A	Preventive / Environmental	Home / family environment of substance abuse	Family or acquaintances compromising care plan due to substance abuse ***(Please Detail)***
B		Homeless or Inconsistent Shelter	Pt staying at shelters, or with friends / family
C		Limited or no Caregiver/Care Plan Partner	Ideally the Pt would have a family member or friend to help with care, but there is no one available
D		Medical equipment	Problem with equipment (e.g. O2 tank, insulin pump) allowed for exacerbation of condition or symptoms
E		No Community Health Visit	ASAP or similar visit, these were arranged but did not happen
F		No Follow-up Appointment Scheduled	During the index visit, a follow-up appointment with PCP or other was not scheduled
G		No insurance or inability to pay	Due to financial hardship, lack of qualification, legal status, financial limitation (includes self pay pts)
H		Patient did not fill Rx from index visit	Underlying issues such as transportation, poor understanding, finances ***(Please Detail)***
I		Transportation	Pt was unable to follow recommended care plan as a result of limited transportation, e.g. no ride to PCP visit
J		Weather	Poor weather conditions, extreme heat or cold contributed to readmission
K	Patient / Hospital	EOL Denial	Pt or family in stages of change (Kubler-Ross) unwilling to accept palliative / hospice care ***(Please Detail)***
L		Language Barrier	Pt experiences difficulty to understanding provider and/or HCP because English is not first language
M		Low Health Literacy	Pt experiences difficulty to understanding provider and/or HCP because of health terminology
N		Insufficient Patient Education	Pt did not receive sufficient education during index visit, e.g. nutrition, medication management
O		Patient Opt Against	Pt opts against recommended treatment, care plan, or disposition ***(Please Detail)***
P		Psychiatric and/or addictive issues	High utilizers, drug seekers
Q		Poor experience of care	Pt experienced poor service at index visit and left. Because pt did not receive treatment, disease progressed.
R		Patient substance abuse denial	Pt is in stages of change and not ready to seek treatment for alcohol or drug issues
S		Social Issues	Pt experiencing other social issues not captured by other definitions ***(Please Detail)***
T	Dispo	EOL	End of Life, for use for Hospice InPt Admissions
U	Clinical	Medication side effect - no rec	Side effect from medication could have been avoided through medication reconciliation or checking allergies
V		Medication side effect - unexpected	Pt experienced a side effect from medication that was new and unexpected
W		Natural progression of disease	No other reasons for progression but natural worsening

ATTACHMENT #3

Falmouth Hospital

PCP Discharge Notification Form

FALMOUTH HOSPITAL
Member Cape Cod Healthcare

PCP Discharge Notification Form

Patient stamp

To: Dr. _____

To: Fax #: _____

_____

From: _____
Unit / Phone Number

From: Fax #: _____

Date: _____ Time: _____ Number of Pages: _____
(Including this Form)

This notice is to inform you that your patient was discharged from Falmouth Hospital today.

Disposition:

- ☐ Home
- ☐ Home with Home Health_____
- ☐ Home Hospice_____
- ☐ Inpatient Hospice_____
- ☐ SNF _____
- ☐ Acute Rehab_____
- ☐ Acute Short Term Hospital
- ☐ LTAC _____
- ☐ Expired ☐ AMA
- ☐ Other _____

☐ Physician Referral Form

☐ Discharge Medication Sheet is attached

☐ The Discharge Summary is attached.

☐ The Discharge Summary is not completed at this time. Please access via Meditech

FOR PATIENTS DISCHARGED TO HOME ONLY

☐ *Appointment within 48-72 hrs.* ***Date & Time: _____/_____

Only for pts with: ☐ MI ☐ CHF ☐ Pneumonia ☐ COPD ☐ Readmission w/i 12 mos

***(*PCP offices – if date and time is blank please make appt and refax to*: _____)

COMMENTS:_____

_____

100 Ter Heun Drive
Falmouth, MA 02540
508-548-5300
www.capecodhealth.org

PLACE THIS FORM IN THE MEDICAL RECORD

ATTACHMENT #4

Falmouth Hospital

Discharge follow up phone call

Patient Label

Falmouth Hospital
Discharge Call-Back Form
(For home discharges only)

Discharge Date: _____ **Phone Number:** _____

Discharge Diagnosis: _____

Call-Back Date: _____ **Spoke to:**

Patient: _____
Family: _____
No Answer: _____
Left Message: _____

1. **Introduce yourself by name and your position, and tell the person the reason for your call: "We like to call our patients soon after discharge to see how they are doing."**

Suggested questions to ask:

1. **How are you feeling?** _____
2. **Do you have any questions regarding your discharge instructions? Yes _____ No_____**
3. **If yes, please document what they are, and what was told to the patient:** _____
   _____
   _____

Our goal is to ALWAYS provide excellent care: Were the people involved in your care professional, friendly and considerate of your needs? Yes_____ No _____

Is there anything we could have done better? _____
_____
_____

Comments: _____
_____
_____
_____

Nurse completing form: _____

ATTACHMENT #5

Holyoke Medical Center

CHF Monitoring Tool for SNF

Geriatric Authority of Holyoke

CHF MONITORING TOOL

	7:30am Weight	Swollen Feet	Shortness Of Breath	Fatigue /tired	Persistent Cough	Loss of Appetite	Rapid Heart Beat	Difficulty lying down or sleeping
Date:								
11-7	n/a							
7-3								
3-11	n/a							
Date:								
11-7	n/a							
7-3								
3-11	n/a							
Date:								
11-7	n/a							
7-3								
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Date:								
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7-3								
3-11	n/a							
Date:								
11-7	n/a							
7-3								
3-11	n/a							

ATTACHMENT #5

Holyoke Medical Center

CHF Education Tool for SNF

Geriatric Authority of Holyoke

CHF EDUCATION RECORD

Affix Resident Label Here

Provide education on each topic until the Resident and/or the Caregiver has demonstrated complete understanding.

Date	Topic	Description	Recipient	Method	Response	Signature
	Symptom Awareness					

Date	Topic	Description	Recipient	Method	Response	Signature
	Symptom Management					

Date	Topic	Description	Recipient	Method	Response	Signature
	Medications					

Date	Topic	Description	Recipient	Method	Response	Signature
	Weight					

Date	Topic	Description	Recipient	Method	Response	Signature
	Nutrition					

ATTACHMENT #7

Holyoke Medical Center

MAR for the CHF Patient in a SNF

FORM NO. 6900A (REV. 10/10)

PHYSICIAN'S ORDERS

INTERCHANGE IS ENCOURAGED UNLESS THE PRACTITIONER WRITES THE WORDS "NO SUBSTITUTION"

MEDICATION	HOUR	DATE	STAFF INITIALS AND TITLE	DATE
DIET: 2GM NA-LOW FAT	03/02/12 B L S			
INTAKE/OUTPUT INITIAL ~~[illegible]~~	03/02/12 11-7 7-3 3-11			
DAILY WEIGHT SAME TIME/SAME CLOTHING	03/02/12 7-3			
HEART FAILURE ZONE CHECK EVERY SHIFT G=GREEN Y=YELLOW R=RED	03/02/12 11-7 7-3 3-11			
VITAL SIGNS EVERY SHIFT X72 HOURS,THEN DAILY DOCUMENT IN NURSES NOTES	03/02/12			
O2 SAT DAILY ON ROOM AIR	03/02/12 3-11			
O2 AT _____ LITERS VIA NASAL CANNULA CONTINUOUS	03/02/12 11-7 7-3 3-11			
O2 SAT EVERY SHIFT ON O2	03/02/12 11-7 7-3 3-11			
NOTIFY MD FOR PARAMETERS OF YELLOW OR RED ZONE	03/02/12 11-7 7-3 3-11			

DESCRIPTION: PATIENTS IS AWARE OF AND IS AGREEABLE WITH THE STANDARD CARE PLAN FOR THIS RESIDENT THESE ORDERS ARE IN EFFECT FOR ONE YEAR UNLESS OTHERWISE DISCONTINUED OR LIMITED BY LAW ELECTRONIC ORDER IS EFFECT

36-60 (SINGLE USE) ORDER

PHYSICIAN: _____ DATE: _____

NURSE: _____ DATE: _____

PREFERRED PHARMACY SOLUTIONS

CHARTING FOR _____ THROUGH _____ MO. YR.

PHYSICIAN _____ TEL. NO. _____ MED. REC. NO. _____

ALT. PHY. _____ ALT. TEL. NO. _____ ADMS. DATE _____

ALLERGIES

DIAGNOSIS

RESIDENT CBF PROTOCOL SEX D/OB ROOM/BED PAGE 1

ATTACHMENT #8

Massachusetts General Hospital

Wound Care Home Management Plan
(Patient education sheet)

Wound Care Home Management Plan

- □ Sutures should be kept clean and dry.
- □ Try not to bump area.
- □ Do not trim or shorten the ends of your sutures or steri-strips.
- □ If they rub on your clothing, place a clean bandage between the sutures or steri-strips and your clothes.

Cleaning the wound: Use soap and water; and gently clean your wound if your caregiver tells you to.

What does your wound look like today?

▪ Clean, dry incision ▪ Staples or sutures intact, no pulling ▪ No drainage ▪ No redness ▪ No swelling ▪ No fever ▪ No change in pain at incision	**What you should do:** Continue with instructions	ALL CLEAR
▪ Pink around the edges of the incision ▪ Drainage from incision: clear/ or bloody tinged ▪ Increased swelling around the incision ▪ Staples or sutures pulling ▪ Low grade fever – less than 100 F ▪ Increase in pain at incision	**What you should do:** If you have VNA, please call the nurse. OR Call surgeon office for further instructions.	WARNING: SLOW DOWN
▪ Red around the edges of the incision ▪ Incision area warm to touch ▪ Increased swelling-inflammation ▪ Drainage from incision – yellow/green/bloody ▪ Fever of 100 F or higher ▪ Increased pain at incision	**What you should do:** Call your surgeon Name: _____ Contact Number: _____ _____	STOP: GET HELP

ATTACHMENT #9

Massachusetts General Hospital

MGH post-discharge medication reconciliation program worksheet and script

MGH RPh Educational Call to Optimize the Reconciliation of Discharge medications (RECORD) Program

Phone Script

May I speak to Ms./Mr. X,

Hello. My name is _____ and I am a pharmacist calling from Mass General Hospital. The reason why I am calling is because you were recently discharged from MGH Ellison 16 unit and we have a new pharmacy discharge service for that floor. I was wondering if you have a few minutes for me to go over the medications with you.

Have you met with your doctor or been seen by a nurse since being discharged?
Please let me know if you would rather I speak to a family member or a caregiver that helps you with your medications. I would be more than happy to wait if you want to get your medication bottles or medication list. Please feel free to ask me questions about your medications during our phone conversation.

If you don't mind I would like to work off of the hospital medication list because I want to make sure we focus on the new medications as well as any medication dose changes that occurred during the hospital stay. Please let me know if you are taking a medication in a different way.

1) Drug A (new medication):

What did they tell you this medication is for?
How are you taking this medication?

2) Drug B (dose change):

How are you taking this medication?
Did they explain the reason for the dose change?
Were you given a new prescription for the dose change?
If yes → did you fill and pick up the new prescription at the pharmacy

3) Drug C (home medication):

How are you taking this medication?

**If you have a minute I would like to ask you 3 simple questions. These questions will help us improve our discharge procedure. Your cooperation is greatly appreciated (see worksheet).

I will let your primary care physician know that we have spoken. If you have any questions or concerns please contact your doctor. Thank you for your time.**

MGH Post-discharge Medication Reconciliation Program Worksheet

1. Patient Name:
2. MRN: Last Location:
3. Discharge date:
4. Date of phone call: **Control Patient**: __ Did not call
5. High risk dx: **CHF DM COPD/Asthma PNA Renal Failure (acute or chronic) Anticoagulation UTI > 8 meds Others: _____**
6. Discharge summary available **Yes** **No**
7. Total number of attempts **1** **2** **3**
8. Unable to reach patient after 3 attempts or > 5 days post dc **Yes** **No**
9. Patient/caregiver declined service **Yes** **No**
10. Spoke with **Patient** **Other: _____**
11. Total time spent on phone **___ minutes**
12. Total number of discharge medications _____
13. Number of new medications added during this admission _____
14. Number of medications changed during this admission _____
15. Number of medications stopped during this admission _____

Pharmacist Assessment

16. Pharmacist identified medication- related issues, at risk for an adverse drug reaction (ADR) **Yes** **No** **N/A**
    a. Inappropriate medication dosage or selection by MD
    b. Dose adjustment or medication change needed due to ADR or renal function
    c. Lab results that posted after discharge that require a change in therapy
    d. Clinically significant drug-drug interactions (DDI)
    e. Discharge orders or instructions confusing or contradictory
    f. Patient misuse of medication or did not follow discharge instructions
    g. Medication list discrepancy found
    h. Other: _____
17. Pharmacist able to resolve MRP during phone call **Yes** **No** **N/A**
18. Urgent issues requiring a phone call / follow up **Yes** **No** **N/A**
19. Pharmacist made a non-medication related intervention **Yes** **No** **N/A**
20. RPh's impression on impact on quality of care **None** **Mild** **High**

Notes/Observations

_____
_____
_____
_____

Patient Questions:

21. Have you seen a visiting nurse or spoken to your doctor since dc **Yes** **No**
22. Do you have a Follow up appointment scheduled **Yes** **No**
23. Patient is aware to contact his physician if he experiences any problems **Yes** **No**
24. On a scale from 1-5 (1= poor; 5= excellent), how would you rate the discharge process? (*Ask for a reason if score is < **4***)

1 **2** **3** **4** **5**

ATTACHMENT #10

Massachusetts General Hospital

What to expect with VNA home care services (patient education sheet)

MASSACHUSETTS GENERAL HOSPITAL

What to Expect with Visiting Nurse Association (VNA) Homecare Services

Your doctor has ordered homecare services for when you leave the hospital. If you have any questions, please talk to your case manager or attending nurse.

What are homecare services? Why do I need them?
Homecare services are medical services provided to you at home through a licensed agency. Your doctor determined that you can leave the hospital, but still need skilled nursing care. Your doctor will work with the homecare team to decide what services you need.

Who will be coming to my home? How is the first visit set up?
You may see a: nurse; physical therapist; occupational therapist; speech therapist; social worker; or home health aide.

A registered nurse or physical therapist will make the first visit 1-2 days after you return home. The homecare agency will call you first to set up this visit. Please give your case manager or attending nurse your contact information and the best way to reach you so there is no delay in your care.

How often will I see a nurse or therapist? For how long?
Your doctor and homecare team will determine how often you need home visits.

You will have homecare services until you can safely manage your care, or until you can leave your home.

How will my doctor know what the homecare team is doing? Who manages my homecare?
A registered nurse or therapist manages your homecare. This homecare professional will tell your doctor about any changes in your medical condition and when homecare services end.

Will I receive a bill for homecare services?
Many private insurances, including Medicare, cover 100% of this service as long as you meet certain conditions. Some insurances may require a co- pay. If you don't know your homecare benefit, please call your insurance company.

This document has been reviewed for plain language by the staff of the Blum Center

ATTACHMENT #11

Milford Regional Medical Center

LACE

*Addressograph

Modified LACE Tool

L=Length of hospital stay
A=Acuity on admission
C=Comorbidity
E=Emergency dept. visits

Attribute	Value	Points	Score
Length of Stay (Prior Admit)	Less 1 day	0	
	1 day	1	
	2 days	2	
	3 days	3	
	4-6 days	4	
	7-13 days	5	
	14 or more days	6	
Acute Admission	Inpatient	3	
	Observation	0	
Comorbidity (Cumulative to a max of 6 pts)	No prior history	0	
	DM no complications, Cerebrovascular disease, Hx of MI, PVD, PUD	1	
	Mild liver disease, DM with end organ damage, CHF, COPD, Cancer, Leukemia, Lymphoma, any tumor, moderate to severe renal disease	2	
	Dementia or connective tissue disease	3	
	Moderate or severe liver disease or HIV infection	4	
	Metastatic cancer	6	
Emergency room visits during previous 6 months	0 visits	0	
	1 visits	1	
	2 visits	2	
	3 visits	3	
	4 or more visits	4	
	Take the sum of the points and enter the total → *If LACE score is 11 or greater, CM to send tool to agency/facility patient is referred to on discharge		

Agency/Facility faxed to:_____
Date:_____
CM:_____

ATTACHMENT #12

Milford Regional Medical Center

Teach Back

ADDRESSOGRAPH HERE:

HF Teachback
Trial Tool – 1/30/12

Opening Script: Question(s) to ask before doing the HF Teachback subject points:

1. ***Do you feel ready to learn what can be helpful for you to continue your recovery?***

   If 'yes' response, proceed with Teachback subject points.

   If 'no' or 'unsure' response, then ask:

2. ***Is there something that may make it difficult for you to learn and follow through on your recovery?***

   OR: Is there something holding you back in your effort to succeed with your recovery?

   OR: What is the hardest thing that you may face going home?

   Based on response, make appropriate contacts/referrals. Reply genuinely with an affirming statement such as:

3. ***"I understand making changes is a difficult thing to do. I know that even small steps can be helpful and very important. The suggestions I have to share with you are meant to be just that, basic initial steps to help you succeed."***

   Then ask for their permission for you to share your five steps:

4. ***"Would you allow me to share with you the five steps that can help your recovery?"***

   If 'yes' response, proceed with Teachback subject points.

Closing Script:

If the patient has a Care Partner, conclude the patient's Teachback session by offering to contact the Care Partner:

5. ***"Can I have your permission to share these steps with your Care Partner?"***

5 Steps to Help Recovery (teachback content)

STEP	CONTENT	DATE & INITIALS RESPONSE: A = able to teachback B = needs reinforcement C = unable to teach COMMENTS	DATE & INITIALS RESPONSE: A , B or C COMMENTS	DATE & INITIALS RESPONSE: A , B or C COMMENTS	DATE & INITIALS Discharge Comments
WEIGHT	**Check weight daily, at same time, in same clothes.** **Record weight on log sheet or on calendar.** *Begin by having the patient chart his last few daily weights on the calendar or log book that he/she will take along & use.* **Avoid weight gain of 3 lbs in 24 hrs or 5 lbs in 1 week.**				
MEDICATIONS	**Take medications as ordered, especially your "water pill".** **Identify your "water pill" by name.** *Talk about what the patient could do if they need to be away from home at a time when they should be taking their water pill. (Many just "skip a day".)*				

STEP	CONTENT	DATE & INITIALS RESPONSE: A = able to teachback B = needs reinforcement C = unable to teach COMMENTS	DATE & INITIALS RESPONSE: A , B or C COMMENTS	DATE & INITIALS RESPONSE: A , B or C COMMENTS	DATE & INITIALS Discharge Comments
	Organize your daily pills with assistance if needed.				
FOODS	**Eat foods that are low in salt.** **Reduce sodium intake to 2000mg/day.** *RD consult will assist patient in setting individualized goals to achieve this.* *Talk about food choices; introduce label reading.* *Have the patient identify one food he/she likes that is high in salt and help him/her choose a low salt alternative.* *Elicit who is preparing/shopping for the patient's food.*				
CALL Your Care Provider	**Call your nurse or doctor if:** • your weight goes up more than 3 lbs in 24 hrs or 5 lbs in 1 week.				

STEP	CONTENT	DATE & INITIALS RESPONSE: A = able to teachback B = needs reinforcement C = unable to teach COMMENTS	DATE & INITIALS RESPONSE: A , B or C COMMENTS	DATE & INITIALS RESPONSE: A , B or C COMMENTS	DATE & INITIALS Discharge Comments
	• you have any swelling in your feet, ankles, hands or abdomen or if you are having trouble breathing.				
CALL 911	**Call 911 if:** • you are having any severe shortness of breath, or • you have chest pain that does not go away.				

ATTACHMENT #13

Milford Regional Medical Center

Care Partner Brochure

What is a Care Partner?

A Care Partner is one trusted family member or friend who is able to assist you during your hospitalization and after you are discharged.

Often someone is already helping with obtaining medications and preparing them, providing transportation to office visits and other appointments or with meal preparation.

Your Care Partner may be someone who lives with you in the same home, or someone who lives nearby.

Keeping your Care Partner informed about your health status, care needs and discharge plan makes the transition out of the hospital smoother.

Your Care Partner can also update your friends and family about you, if you wish. This helps to keep consistent information flowing, and minimizes calls to the floor.

Communicating with your Care Partner

During the hospital stay, various members of the team may want to speak with your Care Partner. This may occur at different times each day. To make this as easy as possible, we will ask you to provide more than one phone number (if appropriate) for your Care Partner, along with the times that they can be reached at this number.

Your Care Partner as a Member of the Team

We encourage you to share information with your Care Partner. If either of you has a question for a member of the medical team, write the question on the card titled, "Questions for My Healthcare Team".

The team will work to answer your questions, and to share them with you and your Care Partner.

For more involved questions, or to share information among the team, here are some ideas:

- Leave a note with information / questions on the chart, and ask for a phone call to discuss.
- Request a family meeting with the health care team to discuss complicated or difficult issues.
- Write questions about the discharge plan on the white board in the hospital room.

Phone number to the Unit:

_____

Making the Transition Home

All of the health care team members want to work towards the goal of making you well enough to leave the hospital.

In order to do that, we need to know what help you will have, and what additional help you may need once you leave.

Working with your Care Partner is one way to plan for the time when you will be relying on others to help you.

Important Information about the Care Partner

- A Care Partner is different than a health care agent (proxy). The agent can only make decisions when you are unable to do so. We encourage you to have both. They may be the same person or different people.
- The Care Partner cannot override your decisions. If you rely upon their help at home, including them in the plans being made for you after discharge assures the best possible plan will be developed.
- We will ask for a new Care Partner form to be completed with each admission, as it is possible that the information may change.

Milford Regional Medical Center

14 Prospect Street
Milford, MA. 01757
Tel: 508-473-1190
www. milfordregional.org

Milford Regional Medical Center

Care Partners

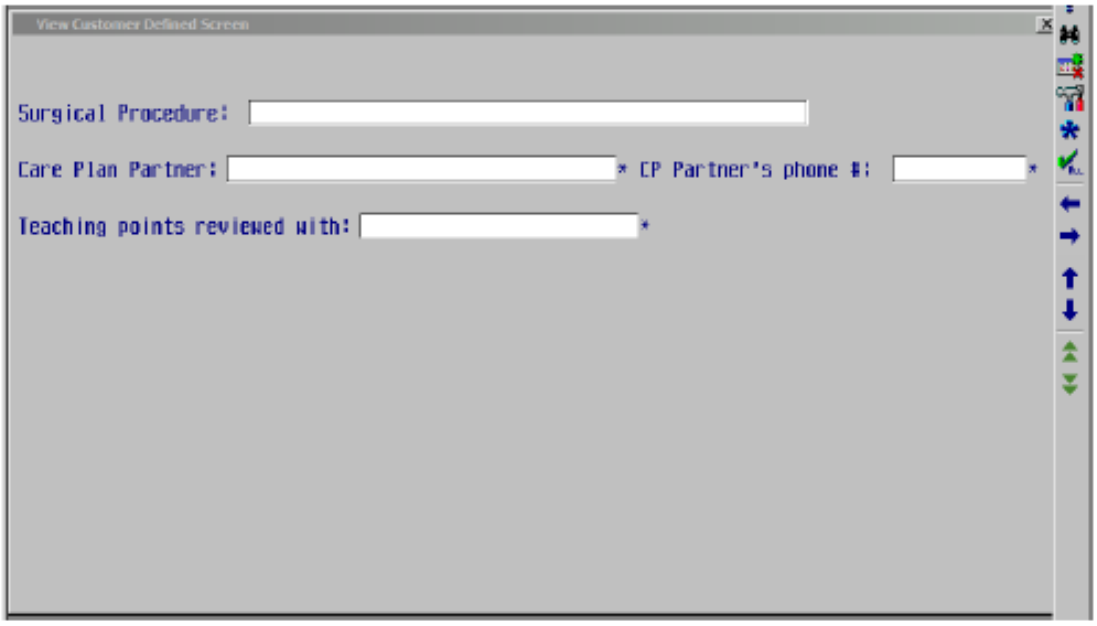
Dignity, Compassion & Respect

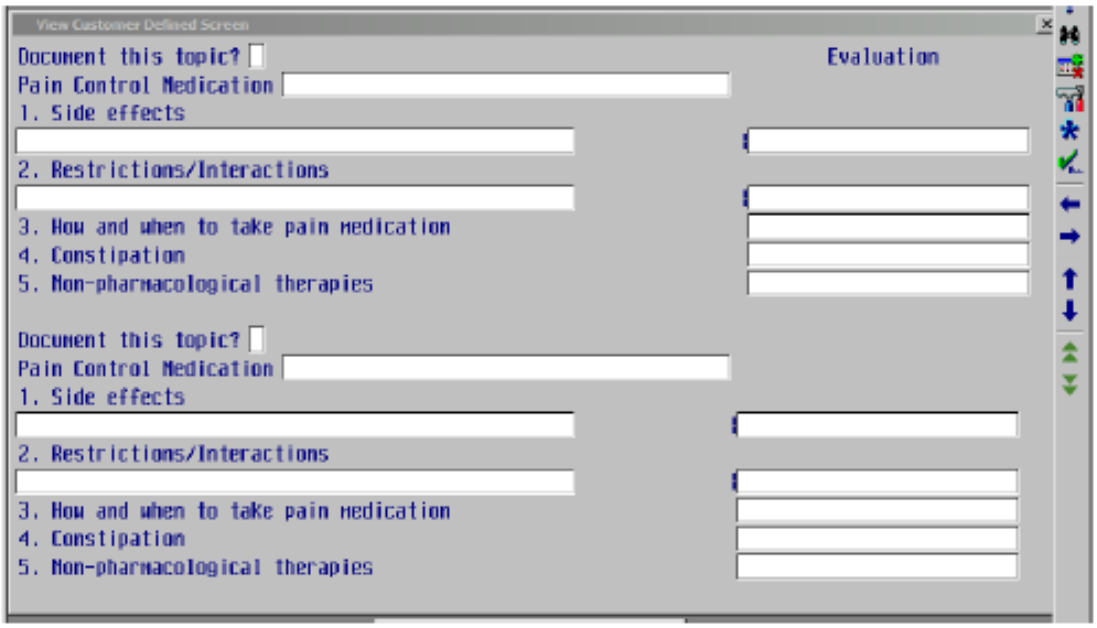
ATTACHMENT #14

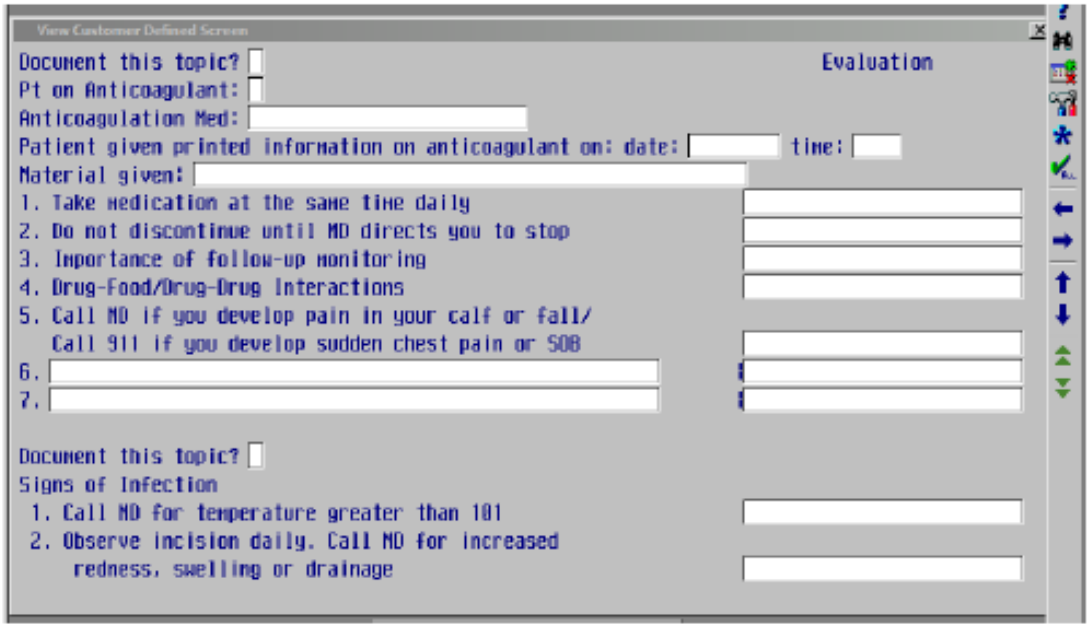
Newton -Wellesley Hospital

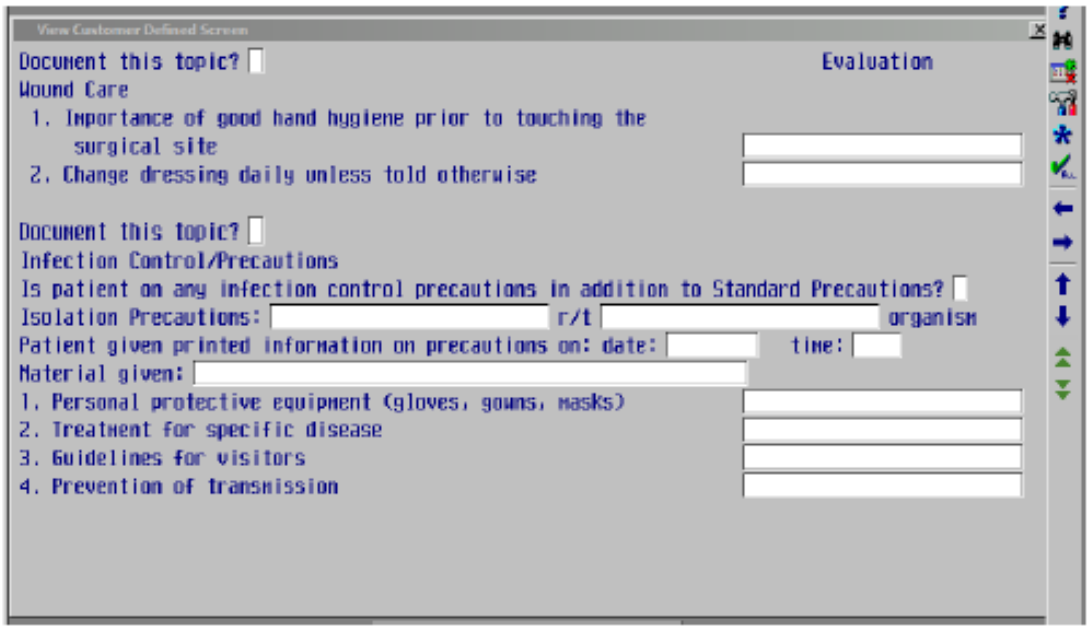
Teach back - Medical and Surgery

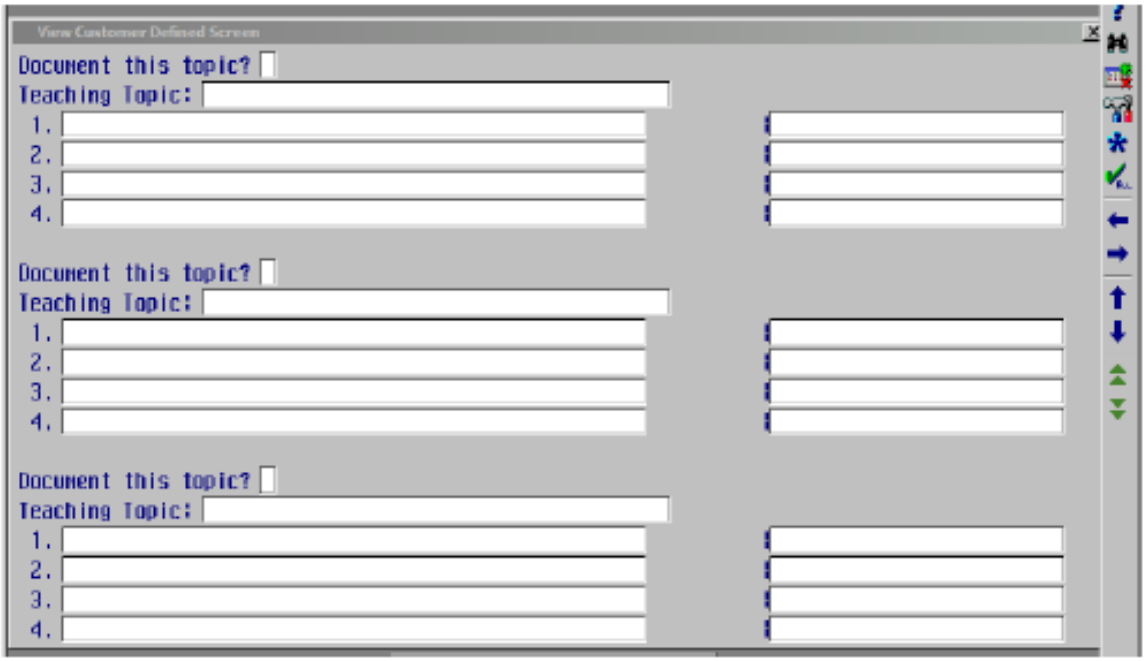
SURGICAL TEACH BACK





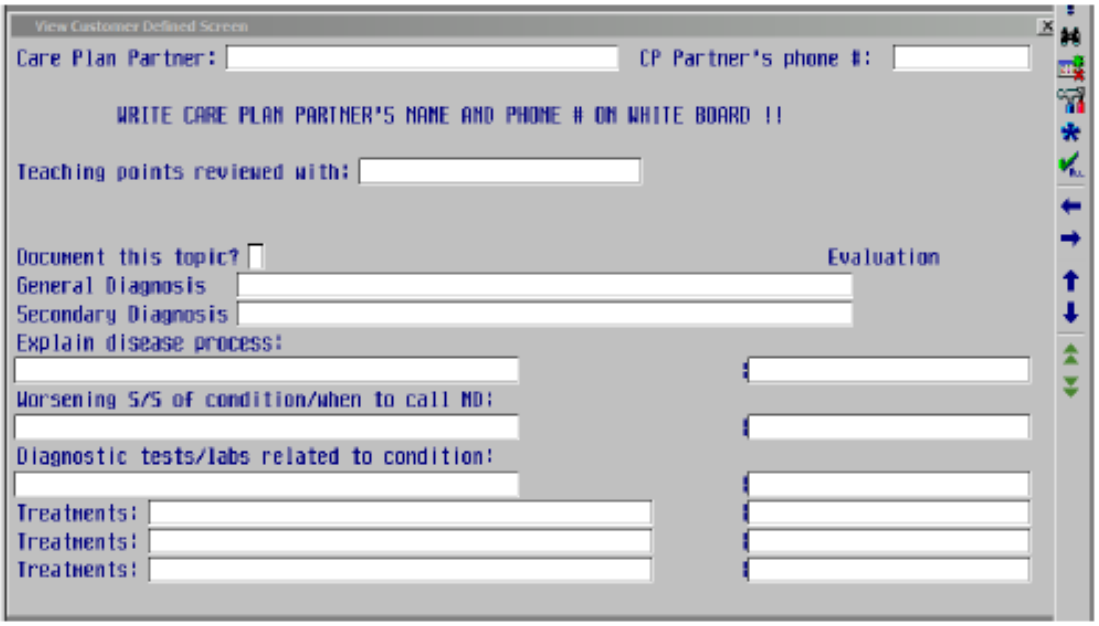

View Customer Defined Screen
Document this topic?
Evaluation
Pt on Anticoagulant:
Anticoagulation Med:
Patient given printed information on anticoagulant on: date: time:
Material given:
1. Take medication at the same time daily
2. Do not discontinue until MD directs you to stop
3. Importance of follow-up monitoring
4. Drug-Food/Drug-Drug Interactions
5. Call MD if you develop pain in your calf or fall/
Call 911 if you develop sudden chest pain or SOB
6.
7.
Document this topic?
Signs of Infection
1. Call MD for temperature greater than 101
2. Observe incision daily. Call MD for increased
redness, swelling or drainage

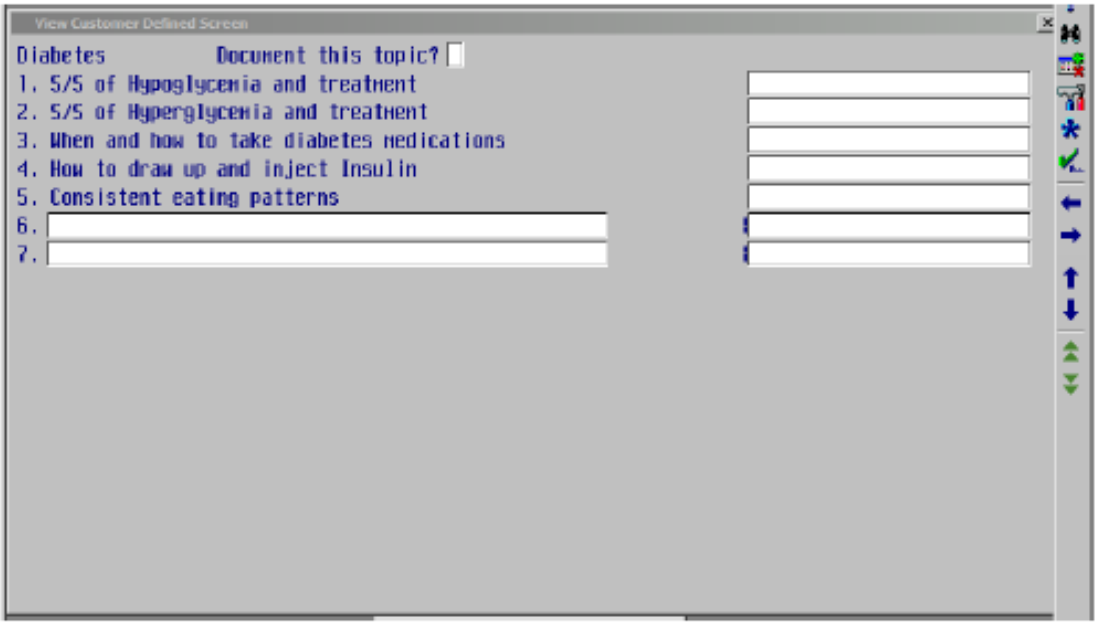

View Customer Defined Screen
Document this topic?
Evaluation
Wound Care
1. Importance of good hand hygiene prior to touching the
surgical site
2. Change dressing daily unless told otherwise
Document this topic?
Infection Control/Precautions
Is patient on any infection control precautions in addition to Standard Precautions?
Isolation Precautions:
r/t
organism
Patient given printed information on precautions on: date: time:
Material given:
1. Personal protective equipment (gloves, gowns, masks)
2. Treatment for specific disease
3. Guidelines for visitors
4. Prevention of transmission

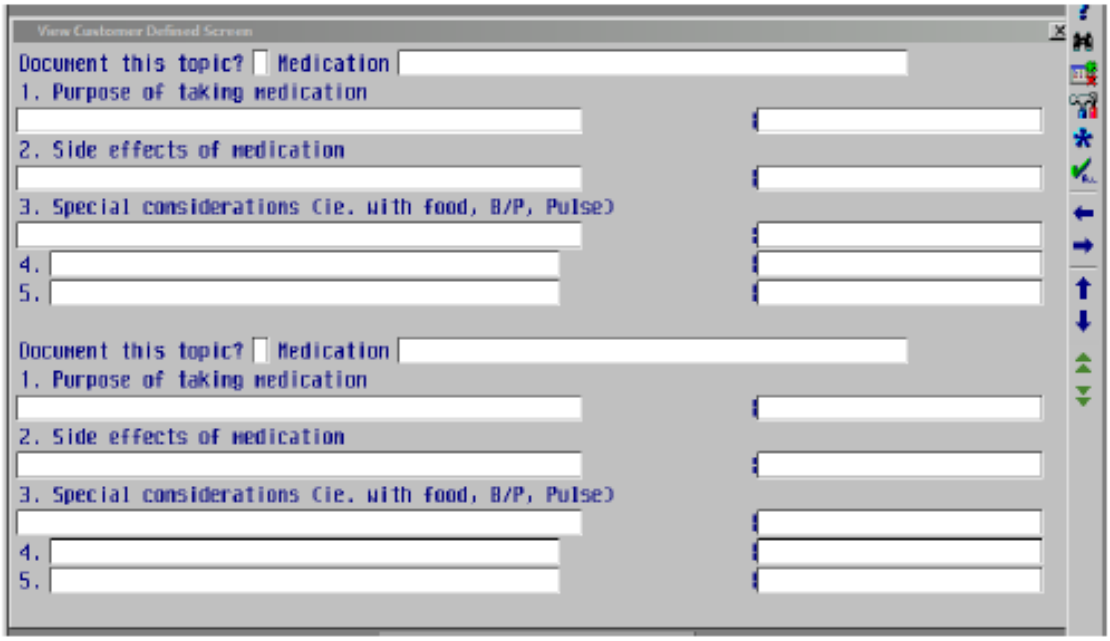

View Customer Defined Screen
Document this topic?
Teaching Topic:
1.
2.
3.
4.
Document this topic?
Teaching Topic:
1.
2.
3.
4.
Document this topic?
Teaching Topic:
1.
2.
3.
4.

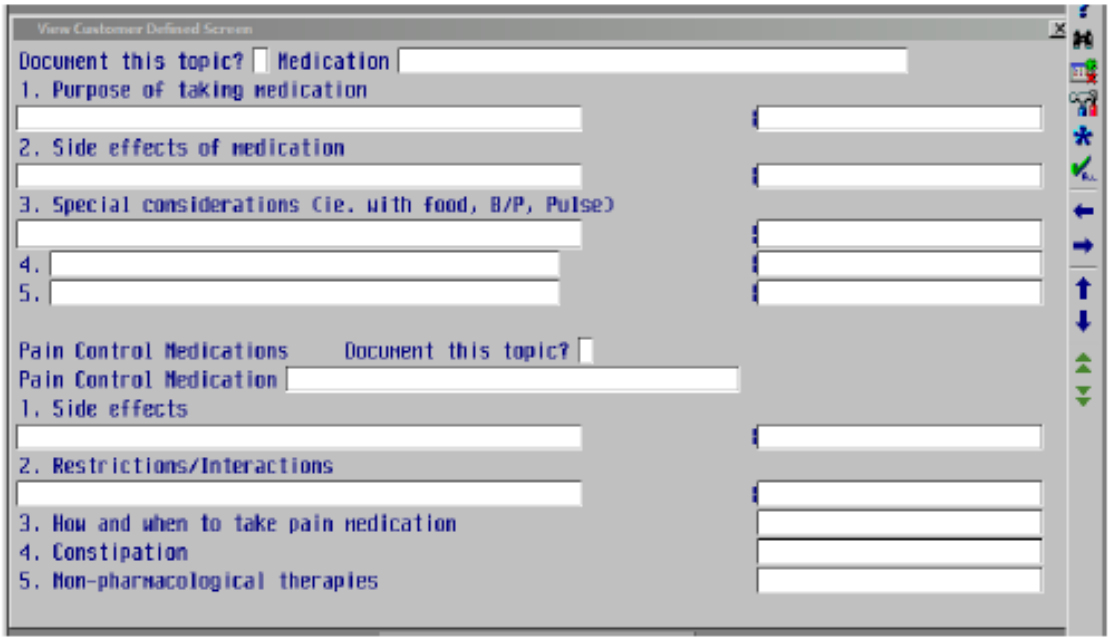

View Customer Defined Screen
Document this topic?
Teaching Topic:
1.
2.
3.
4.

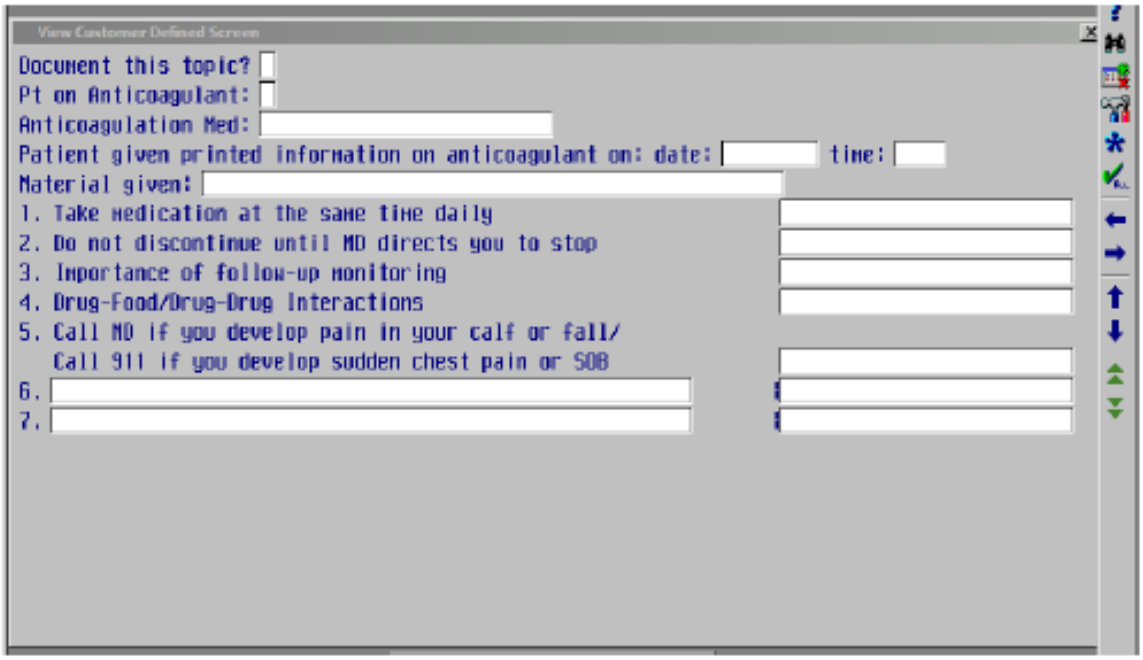
MEDICAL TEACH BACK

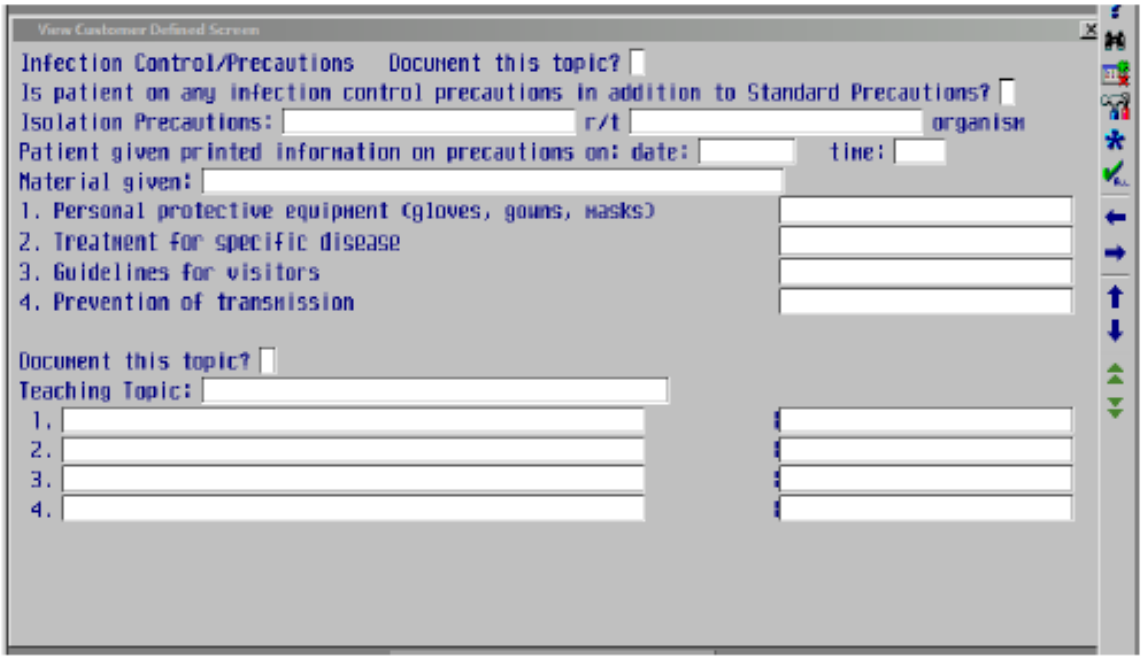


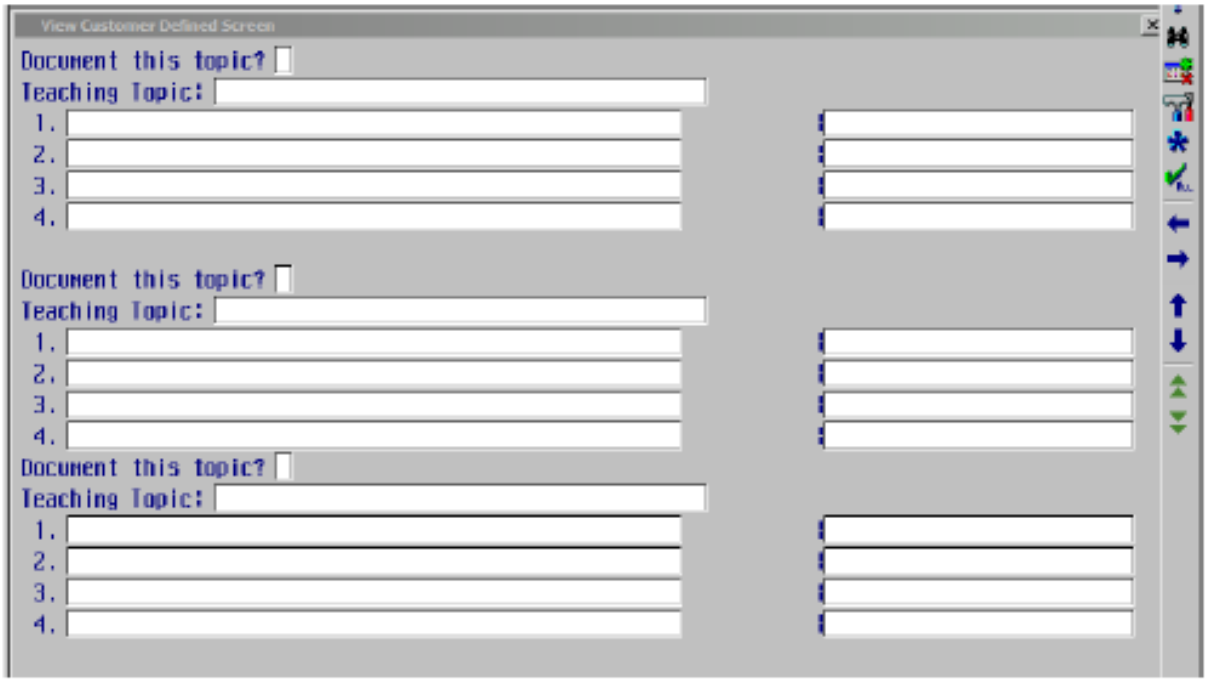



View Customer Defined Screen
Document this topic? Medication
1. Purpose of taking medication
2. Side effects of medication
3. Special considerations (ie. with food, B/P, Pulse)
4.
5.
Document this topic? Medication
1. Purpose of taking medication
2. Side effects of medication
3. Special considerations (ie. with food, B/P, Pulse)
4.
5.


View Customer Defined Screen
Document this topic? Medication
1. Purpose of taking medication
2. Side effects of medication
3. Special considerations (ie. with food, B/P, Pulse)
4.
5.
Pain Control Medications Document this topic?
Pain Control Medication
1. Side effects
2. Restrictions/Interactions
3. How and when to take pain medication
4. Constipation
5. Non-pharmacological therapies


View Customer Defined Screen
Document this topic?
Pt on Anticoagulant:
Anticoagulation Med:
Patient given printed information on anticoagulant on: date: time:
Material given:
1. Take medication at the same time daily
2. Do not discontinue until MD directs you to stop
3. Importance of follow-up monitoring
4. Drug-Food/Drug-Drug Interactions
5. Call MD if you develop pain in your calf or fall/
Call 911 if you develop sudden chest pain or SOB
6.
7.

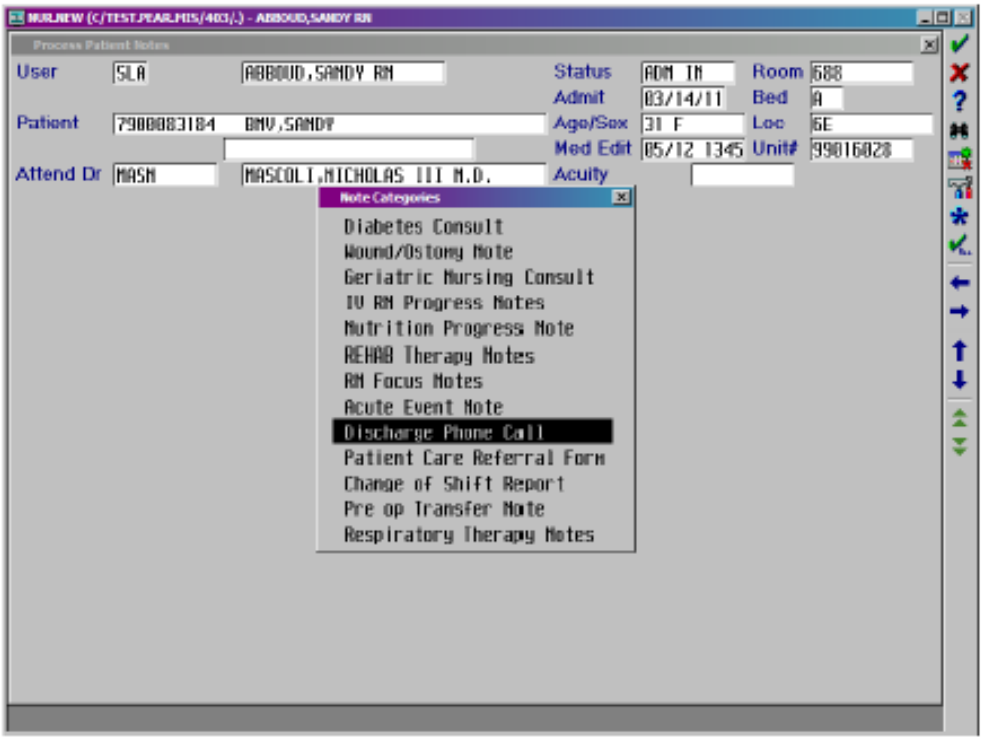

View Customer Defined Screen
Infection Control/Precautions Document this topic?
Is patient on any infection control precautions in addition to Standard Precautions?
Isolation Precautions: r/t organism
Patient given printed information on precautions on: date: time:
Material given:
1. Personal protective equipment (gloves, gowns, masks)
2. Treatment for specific disease
3. Guidelines for visitors
4. Prevention of transmission
Document this topic?
Teaching Topic:
1.
2.
3.
4.

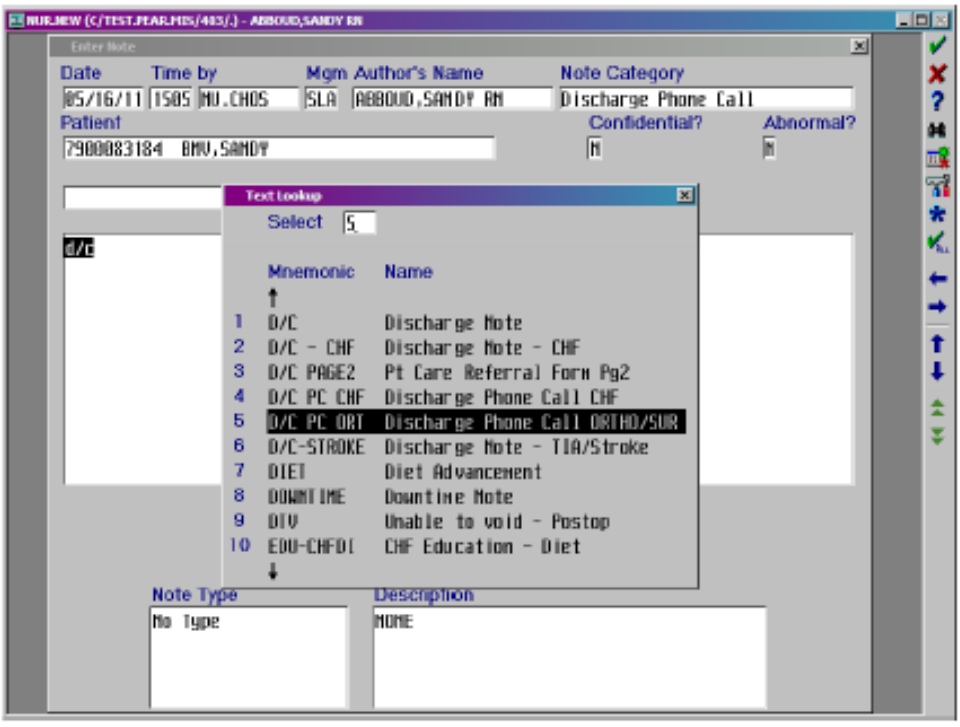

View Customer Defined Screen
Document this topic?
Teaching Topic:
1.
2.
3.
4.
Document this topic?
Teaching Topic:
1.
2.
3.
4.
Document this topic?
Teaching Topic:
1.
2.
3.
4.

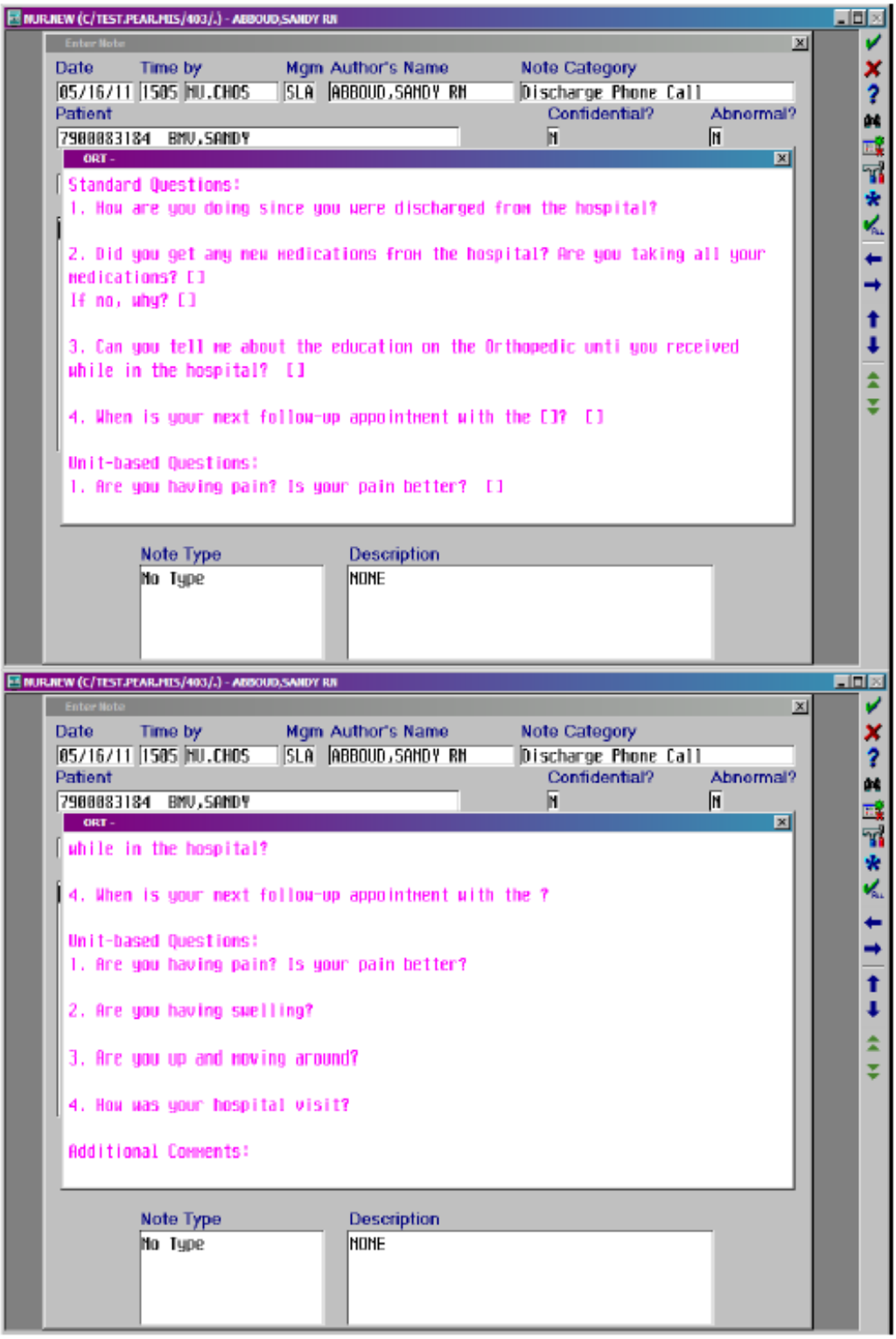
ATTACHMENT #15

Newton -Wellesley Hospital

Discharge phone call script


NURJNEW (C/TEST.PEARLMIS/403/.) - ABBOUD,SANDY RN
Process Patient Notes
User SLA ABBOUD,SANDY RN
Status ADM IN
Room 688
Admit 03/14/11
Bed A
Patient 7900083184 BMV,SANDY
Age/Sex 31 F
Loc 6E
Med Edit 05/12 1345
Unit# 99016020
Attend Dr MASN MASCOLI,NICHOLAS III M.D.
Acuity
Note Categories
Diabetes Consult
Wound/Ostomy Note
Geriatric Nursing Consult
IV RN Progress Notes
Nutrition Progress Note
REHAB Therapy Notes
RN Focus Notes
Acute Event Note
Discharge Phone Call
Patient Care Referral Form
Change of Shift Report
Pre op Transfer Note
Respiratory Therapy Notes


NURJNEW (C/TEST.PEARLMIS/403/.) - ABBOUD,SANDY RN
Enter Note
Date Time by Mgm Author's Name Note Category
05/16/11 1505 MU.CHOS SLA ABBOUD,SANDY RN Discharge Phone Call
Patient Confidential? Abnormal?
7900083184 BMV,SANDY N N
Text Lookup
Select 5
Mnemonic Name
1 D/C Discharge Note
2 D/C - CHF Discharge Note - CHF
3 D/C PAGE2 Pt Care Referral Form Pg2
4 D/C PC CHF Discharge Phone Call CHF
5 D/C PC ORT Discharge Phone Call ORTHO/SUR
6 D/C-STROKE Discharge Note - TIA/Stroke
7 DIET Diet Advancement
8 DOWNTIME Downtime Note
9 DTV Unable to void - Postop
10 EDU-CHFDI CHF Education - Diet
Note Type
No Type
Description
NONE


Enter Note
Date
Time by
Mgm
Author's Name
Note Category
05/16/11
1505
MV.CHOS
SLA
ABBOUD,SANDY RN
Discharge Phone Call
Patient
Confidential?
Abnormal?
7900883184 BMV,SANDY
N
N
ORT -
Standard Questions:
1. How are you doing since you were discharged from the hospital?
2. Did you get any new medications from the hospital? Are you taking all your medications? []
If no, why? []
3. Can you tell me about the education on the Orthopedic unti you received while in the hospital? []
4. When is your next follow-up appointment with the []? []
Unit-based Questions:
1. Are you having pain? Is your pain better? []
Note Type
No Type
Description
NONE
Enter Note
Date
Time by
Mgm
Author's Name
Note Category
05/16/11
1505
MV.CHOS
SLA
ABBOUD,SANDY RN
Discharge Phone Call
Patient
Confidential?
Abnormal?
7900883184 BMV,SANDY
N
N
ORT -
while in the hospital?
4. When is your next follow-up appointment with the ?
Unit-based Questions:
1. Are you having pain? Is your pain better?
2. Are you having swelling?
3. Are you up and moving around?
4. How was your hospital visit?
Additional Comments:
Note Type
No Type
Description
NONE

ATTACHMENT #16

Northeast Health System

High Risk for Readmission Criteria

NORTHEAST HOSPITAL CORPORATION

Title: High Risk Readmission Response

Date Effective:
Date Revised:
Date Reviewed:

Joint Commission Chapter: Provision of Care

I. Purpose or Intent

Identify the process for identification, planning and management of high risk readmissions

II. Policy or General Principles

A.. Patients will be identified upon admission as high re=isk readmitted patients.

B. Notification of admission will be sent to Nurse Manager of patient's unit, Case Manager, and Senior Health

C. High Risk Readmission Response Team will be assembled to review case after unit's next multidisciplinary rounds meeting.

III. Definitions

High Risk Readmission Criteria: Patient must have more than one.

- 75 years of age or older
- Readmission to hospital or previous Emergency Department visit in last 30 days
- History of falls
- Patient resident of long term care facility
- Current substance abuse
- Known financial hardship with medication procurement
- One or more of the following chronic diseases:
  - COPD
  - CHF
  - Chronic Renal Failure
  - Cancer
  - Dementia
  - Pneumonia

IV. Applies to RN, RT, CA, MD, PT, OT, Speech Therapy, Nutrition, SNF liason, Pharmacist, Home Care, Senior Care, members of health system team.

V. This policy and procedure stands alone

VI. Procedure

A. Admitting Nurse completes Admission Assessment

1. Last discharge date/ED visit are electronically pulled to appear
2. Age of patient is electronically identified
3. Residence is identified as SNF
4. Medication from home list is entered
5. Patients states yes to financial hardship for obtaining medications at home
6. Fall risk is identified
7. Previous medical history has high risk criteria as drop down choices

B. Electronic alert prints to unit's case Managers and Nurse Managers printer based on "yes" to above criteria, also prints to Senior Care's Northeast Link.

C. Email/page alert goes to entire High Risk Response Team core members. Addition members are invited to attend huddle based on patients need.
   1. HRRT meets after care rounds of unit.

D. HRRT review case for:
   1. Medication reconciliation history: time of last admission and discharge, entry to hospital upon this admission
   2. Did PCP appointment occur since discharge
   3. Significant change in nutrition, living situation
   4. New medications from BEERS or STOPP list

E. Identification of cause of readmission may necessitate interview of family and/or patient.
F. New plan of care and discharge plan will be formulated.
G. Upon discharge the patient will receive:
   1. Active medication reconciliation with next level of care provider, example pharmacist at hospital conducts reconciliation review with SNF caregiver or home care nurse upon 1st home visit.
   2. Warm handoff will be provided by nursing to next level of care
   3. PCP appointment will be made for within 1 week of discharge and confirmed with family.
   4. Patient will receive teachback for disease management, provided with "zone" discharge tool and information of status provided to next caregiver.
   5. Summary of readmission reduction plan given to patient and next level of care.

VII. Documentation

A. Medication Reconciliation List
B. Teachback tool
C. Page 1, 2, 3 and discharge documentation tool
D. Zone discharge tool
.

VIII. Orientation / Training

Unit-based orientation upon hire and policy change.

IX. Monitoring

X. References

XI. Storage, Retention and Destruction

A. All policies are able to be retrieved upon request. Policies are stored in MCN Policy Manager and in paper format.
B. This policy will be reviewed at least every three years
C. Previous versions of this policy are archived in MCN Policy Manager. Policies in paper format are retained for 7 years, or 9 years if related to obstetric and newborn care.

ATTACHMENT #17

Northeast Health System

Discharge Checklist

High Risk for Readmission Pilot Checklist:

Discharge preparation:

- ❑ Patient/family has been involved in decisions about what will take place after leaving the facility
- ❑ Patient/family understands where pt. is going after leaving the facility, and what will happen once they arrive
- ❑ Patient/family has the name and phone number of a person they should contact if a problem arises during the transfer
- ❑ Patient/family understands what their medications are, how to obtain them, and how to take them.
- ❑ Patient/Family understands the potential side effects of their medications and whom they should call if they experience them
- ❑ Patient/family understand what symptoms they need to watch out for and whom to call should they notice them
- ❑ Patient/family understands how to keep their health problems from becoming worse
- ❑ The doctor or nurse has answered my most important questions prior to leaving the facility
- ❑ My family or someone close to me knows that I am coming home and what I will need once I leave the facility
- ❑ If I am going directly home, I have scheduled a follow-up appointment with my doctor and I have transportation to this appointment

- ❑ Case Manager and RN admission assessment printed for review

- ❑ Mini-cognitive assessment done with patient. Result:_____

- ❑ Depressive screening done with patient (combined question score of 3 or more=at risk) ☐

- ❑ Zone teaching for **CHF COPD Pneumonia (NA)** reinforced with patient (circle one)

- ❑ PCP appointment made

- ❑ Polypharmacy assessed/pharmacy consult requested

- ❑ Discharge phone call 2-3 days post discharge:

ATTACHMENT #18

Northeast Health System

Mini Cognitive Assessment

The Mini-Cog Assessment Instrument for Dementia

The Mini-Cog assessment instrument combines an uncued 3-item recall test with a clock-drawing test (CDT). The Mini-Cog can be administered in about 3 minutes, requires no special equipment, and is relatively uninfluenced by level of education or language variations.

Administration

The test is administered as follows:

1. Instruct the patient to listen carefully to and remember 3 unrelated words and then to repeat the words.

2. Instruct the patient to draw the face of a clock, either on a blank sheet of paper, or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time, such as 11:20. These instructions can be repeated, but no additional instructions should be given. Give the patient as much time as needed to complete the task. The CDT serves as the recall distractor.

3. Ask the patient to repeat the 3 previously presented word.

Scoring

Give 1 point for each recalled word after the CDT distractor. Score 1–3.

A score of O indicates positive screen for dementia.

A score of 1 or 2 with an abnormal CDT indicates positive screen for dementia.

A score of 1 or 2 with a normal CDT indicates negative screen for dementia.

A score of 3 indicates negative screen for dementia.

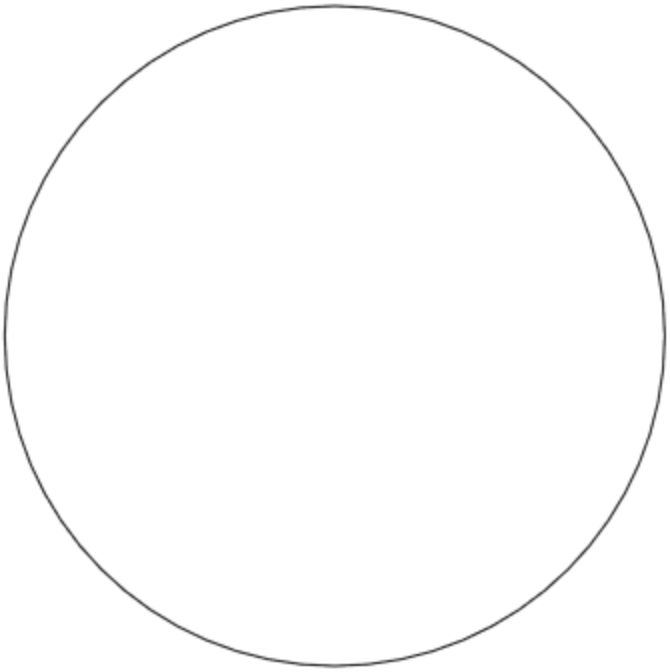
The CDT is considered normal if all numbers are present in the correct sequence and position, and the hands readably display the requested time.Source: Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The mini-cog: a cognitive "vital signs" measure for dementia screening in multi-lingual elderly. *Int J Geriatr Psychiatry* 2000; 15(11): 1021–1027.

CLOCK DRAW TEST

Patient name_____
Patient ID #_____
Date__/__/__

1) Inside the circle, please draw the hours of a clock as they normally appear

2) Place the hands of the clock to represent the time: "ten minutes after eleven o'clock"



Reproduced from: ***The Clock Drawing Test*** in: Palmer RM, Meldon SW. Acute Care. In: Principles of Geriatric Medicine and Gerontology, 5th edition, 2003. Eds. Hazzard WR et al. McGraw-Hill Pub. pp 157-168. Inouye SK. Delirium in hospitalized older patients. Clin Geriatr Med 1998; 14:745-764

ATTACHMENT #19

Northeast Health System

Depression Screening

The Patient Health Questionnaire-2 (PHQ-2) - Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish final a diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Clinical Utility

Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

Scoring

A PHQ-2 score ranges from 0-6. The authors[1] identified a PHQ-2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

Psychometric Properties[1]

Major Depressive Disorder (7% prevalence)				Any Depressive Disorder (18% prevalence)			
PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)	PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)
1	97.6	59.2	15.4	1	90.6	65.4	36.9
2	92.7	73.7	21.1	2	82.1	80.4	48.3
3	**82.9**	**90.0**	**38.4**	**3**	**62.3**	**95.4**	**75.0**
4	73.2	93.3	45.5	4	50.9	97.9	81.2
5	53.7	96.8	56.4	5	31.1	98.7	84.6
6	26.8	99.4	78.6	6	12.3	99.8	92.9

** Because the PPV varies with the prevalence of depression, the PPV will be higher in settings with a higher prevalence of depression and lower in settings with a lower prevalence.*

1. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. Medical Care 2003, (41) 1284-1294.

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

ATTACHMENT #20

Saint Anne's Hospital

Discharge Checklist

High Risk for Readmission Pilot Checklist:

Discharge preparation:

- ❑ Patient/family has been involved in decisions about what will take place after leaving the facility
- ❑ Patient/family understands where pt. is going after leaving the facility, and what will happen once they arrive
- ❑ Patient/family has the name and phone number of a person they should contact if a problem arises during the transfer
- ❑ Patient/family understands what their medications are, how to obtain them, and how to take them.
- ❑ Patient/Family understands the potential side effects of their medications and whom they should call if they experience them
- ❑ Patient/family understand what symptoms they need to watch out for and whom to call should they notice them
- ❑ Patient/family understands how to keep their health problems from becoming worse
- ❑ The doctor or nurse has answered my most important questions prior to leaving the facility
- ❑ My family or someone close to me knows that I am coming home and what I will need once I leave the facility
- ❑ If I am going directly home, I have scheduled a follow-up appointment with my doctor and I have transportation to this appointment

- ❑ Case Manager and RN admission assessment printed for review

- ❑ Mini-cognitive assessment done with patient. Result:_____

- ❑ Depressive screening done with patient (combined question score of 3 or more=at risk) ☐

- ❑ Zone teaching for **CHF COPD Pneumonia (NA)** reinforced with patient (circle one)

- ❑ PCP appointment made

- ❑ Polypharmacy assessed/pharmacy consult requested

- ❑ Discharge phone call 2-3 days post discharge:

ATTACHMENT #21

Saint Anne's Hospital

iSBARt Bedside Report Guide & SBAR Poster

Saint Anne's Hospital
A STEWARD FAMILY HOSPITAL

Steward

iSBARt Bedside Report

State your purpose: "Shift change/Handoff report"
Educate patient/family if necessary
Obtain permission from patient

	Report in order:	Meditech screens to view:
i	**identify yourself & patient** Give Your Name & Title Check Two Patient Identifiers Introduce the next care giver Fill out white board	• Status Board
S	**Situation** Attending MD Gender Age Code Status Precautions/Isolation Consults Allergies Admitting Diagnosis Chief Complaint	• Chart Header • Review Visit • Summary
B	**Background** Medical History Procedures/Treatments Scheduled tasks	• New Results • Clinical Panels • Past Medical History
A	**Assessment** Head to Toe Assessment Report all abnormal findings Show on patient	• Clinical Panels • 24hr Clinical Snapshot
R	**Recommendation** Plan of care Protocols Core Measures STAT meds given Vaccine status Specimens due Provider Med Rec completed	• Status Board
t	**thank you**	• Review orders & charting

Questions?

Communication Tool: When the condition of your patient changes, use iSBARt!

i — identify yourself

- full name
- title
- location (if not reporting in person)

S — Situation

- Patient Identification
  - Name & Date of Birth
- Pertinent Need-to-Know Information
  - Gender, Age & Advance Directives (code status)
- Why they are here
  - Admitting Diagnosis
- The reason why you are reporting

B — Background

- Pertinent History
- Pertinent Procedures done or Treatments given
- What orders you've been following

A — Assessment (RN, LPN)

- Pertinent Assessment Data
- Report by exception
  (give only abnormal or pertinent findings)
- Be accurate!
  (use actual numbers & medical terms)

Acknowledge (CNA, CNT)

- Abnormal Data
- Issues with the Patient
- Changes you've noticed

R — Recommendation

- Your recommendations for how this patient should be cared for
- What you need in order to care for this patient
  (be direct and to the point)

t — thank you

- Show your appreciation for your team members.
- This is a good time to ask if they have any questions!

Use iSBARt for every communication about patients

Evidence shows that it is what's best for our patients!

ATTACHMENT #22

Saints Medical Center

Daily STAAR List

STAAR - CURRENT IN-PATIENTS

04/12/12

Name	Acct #	Unit #	Admitted	Location	Last Disc
		HEART FAILURE			
Mr. Smith	57575757	566555	03/28/12	IMC 309-2	None
Mrs. Peabody	57575758	566556	04/09/12	IMC 308-1	01/26/12
Col. Mustard	57575760	566558	04/03/12	ICU 355	01/26/12
Ms. Peacock	57575761	566559	04/10/12	ICU 356	04/06/12
Mr. Redford	57575763	566561	**04/11/12**	**3E 333-2**	**03/27/12**
Ms. Sinclair	57575765	566563	04/09/12	4A 403-2	03/06/12
		PNEUMONIA			
Mr. Willis	45454455	989889	04/11/12	3E 330-1	10/17/11
Ms. Carey	45454456	989890	04/10/12	3E 322-2	None
Mr. Betts	45454458	989892	047/07/12	ICU 351	04/04/12
Mr. Jaems	45454460	989894	04/11/12	4A 412-2	03/23/12
Ms. White	45454462	989896	04/10/12	5P 514	11/23/11
		STROKE			
Ms. Potter	65656565	878787	04/04/12	4A 403-1	
Mr. Truman	65656567	878789	04/11/12	3E 322-1	
Ms. Horace	65656568	878790	4/4/12	3E 334-1	
Ms. Balboa	65656570	878792	04/10/12	IMC 309-1	
Mr. Connor	65656571	878793	04/10/12	IMC 303-1	
Ms. Thomas	65656572	878794	04/11/12	IMC 315-1	

TOTAL: 11

** **Indicates re-adm within 30 days**

***Not real patient data. Names and numbers have been changed!!!!

ATTACHMENT #23

Saints Medical Center

Teach Back
Pneumonia and Heart Failure

Saints Medical Center

Patient Label

HEART FAILURE TEACHING, DAILY WEIGHT AND DISCHARGE INSTRUCTIONS

Date/Weight	Date/Weight	Date/Weight	Date/Weight
ex: 7/8/2011 165 lbs.			

Primary Learner - *circle one*: Patient / Family Member / Other: _____

Patient received "Heart Failure" teaching packet: (date)_____

Teaching Key:
A- Able to teach back
B - Needs Reinforcement
C - Unable to teach

You should be able to answer the following questions:	Date/Grade	Date/Grade	Date/Grade	Date/Grade
What is the name of your water or fluid pill?	*ex: 7/8/2011 B*			
What weight gain should you report to your doctor?	*B*			
What foods should you avoid?	*A*			
Do you know what symptoms to report to your doctor?	*B*			
RN Signature:	*Jane Doe, RN*			

You are aware that to maintain optimal health you will need to:

- **Weigh yourself daily and record**
- **Stop Smoking**
- **Take medications as prescribed**
- **Follow diet as ordered, avoid table salt and items with high salt content**
- **Increase activity to baseline and continue to perform activities as tolerated**

My scheduled doctor's appointment is: (date) _____

This information has been discussed with me, I understand it and have received materials.

(Patient Signature) (Date) (Nurse's Signature)

Original form to be given to patient, Nurse to make copy of signed form and place in medical record

Saints Medical Center

Patient Label

PNEUMONIA TEACHING AND DISCHARGE INSTRUCTIONS

Primary Learner - *circle one*: Patient / Family Member / Other: _____

Teaching Key:
A- Able to teach back
B - Needs Reinforcement
C - Unable to teach

You should be able to answer the following questions:	Date/Key Code	Date/Key Code	Date/Key Code	Date/Key Code
What is the name of the antibiotic you are taking for pneumonia?				
What antibiotic medication side effects would cause you to call your doctor? (rash, diarrhea, nausea, vomiting)				
When should you stop taking your antibiotic as the doctor orders? (when the prescription is finished)				
After completing your antibiotic treatment, what symptoms should you report to your doctor? (chills, fever, shortness of breath, change in sputum/mucous, increased weakness, prolonged cough)				
RN Initials:				

You are aware that to maintain optimal health you will need to:

- **Take your antibiotic as directed**
- **Stop Smoking - call 1-800-NO-BUTTS (1-800-662-8887)**
- **Balance increased activity with rest**
- **Attend your scheduled follow-up doctor's appointment**

My scheduled doctor's appointment is: (date) _____

This information has been discussed with me, I understand it and have received materials.

(Patient Signature) (Nurse's Signature) (Date/Time)

Original form to be given to patient, Nurse to make copy of signed form and place in medical record

ATTACHMENT #24

Saints Medical Center

Heart Failure Discharge to Home Care Pathway

Saints Medical Center

HEART FAILURE – DISCHARGE TO HOME CARE

CORE CONCEPTS – SAINTS MEDICAL CENTER TRANSITION CARE

Effective Home Care is essential for reducing unplanned heart failure (HF) admissions and maximizing positive patient outcomes.

CORE ELEMENTS OF EFFECTIVE HOME CARE INCLUDE

- Initial visit must occur within 24 hours.
- Early home care intervention must occur often (at least 3-4 times a week for the first 2 weeks, then at least 2-3 times for weeks 2-4) and may be transitioned to fewer visits as the patient and caregiver becomes comfortable with managing heart failure.
- The telemonitoring program extends the ability to help patients manage their own care.
- Early referral to Elder Services for Transition Coaching and/or other community resources.

PRIOR TO DISCHARGE

FOLLOW UP CARE RESOURCES

- Primary care physician (PCP) contact information for urgent and routine heart failure care will be identified;
- Patient and/or caregiver will be given SMC HF discharge folder including HF ZONES. This is to be used as primary educational material.
- First post discharge PCP appointment will be scheduled (goal: for within 5 days of discharge)

POST DISCHARGE HOME CARE

ASSESSMENT

AT EVERY VISIT ASSESS

- Patient pulse and blood pressure (include orthostatic signs)
- Daily weight and confirm presence of scale; obtain baseline weight
- Auscultate lungs for increasing crackles
- Examine extremities for edema
- Evaluate psychosocial needs including patient anxiety
- Evaluate for signs of neglect or abuse; initiate community services referral if signs of inadequate support, abuse, neglect
- Note caregiver stress or decompensation
- Assess medication adherence/compliance
- Assess dietary habits, sodium intake

NOTIFY PCP

- Pulse – new onset irregularity
- Blood pressure – symptomatic hypotension
- Weight gain – 2 to 3 pounds in 2 to 3 days or 5 pounds in one week
- Weight loss – 3 to 5 lbs below baseline (dry) weight
- Increase lung crackles
- Increased edema combined with weight gain and worsening symptoms
- Patient anxiety or caregiver stress/decompensation

COMMUNICATION

- Home Health Nursing staff will be available 24/7 for follow-up calls from PCP.

Saints Medical Center

HEART FAILURE – DISCHARGE TO HOME CARE

Within 24 hours of discharge – VISIT ONE

NURSING CARE

- Full assessment (see above)
- Review emergency contacts and guidelines with patient; make certain patient/Care Giver (CG) understands when to call Home Health, PCP or 911
- Reinforce and Post HF ZONES
- Confirm that patient and individual who performs cooking and shopping is able to accurately determine sodium content and portion size
- Introduce Telemonitoring Program
- Assess need for OT/PT and initiate order request if needed
- Ensure patient has scheduled follow-up appointment with PCP and transportation

WEIGHT MONITORING

- Evaluate scale for ease of patient use (including readout) and accuracy
- Instruct patient regarding significance of weight gain in heart failure

MEDICATION REVIEW:

- Determine patient's ability to prepare and take all prescribed oral medications
- Initiate medication reconciliation and prioritize for high risk medications. Clarify discrepancies with PCP.
- Screen for expired medications and OTC medications that should be avoided
- Pre-fill medication cassette, as necessary
- Assess patient and caregiver understanding of medications
- Provide medication education.

Within first week post discharge – VISITS TWO THROUGH FIVE

NURSING CARE - 3-4 VISITS THIS WEEK

- Full assessment (see 1st page)
- Install and train in use of Telemonitoring
- Instruct awareness of what symptoms weight gain may cause
- Promote progressive activity.
- Initiate early stage OT/PT as necessary.
- Assess need for on-going Elder Services and transition coaching

MANAGING EMERGENCY AND PROVIDER CONTACTS

- Assist/instruct patient in notifying PCP of problems: assess comfort level at reporting on their own as per HF ZONES
- Use "Teach Back" with patients for making calls; to assess their knowledge of whom to call
- Review emergency contacts and guidelines; make certain patient/caregiver understands when to call Home Health, PCP or 911

MEDICATION MANAGEMENT

- Complete medication reconciliation
- Using "Teach Back" method, explain medication doses, time to be taken, purpose (including heart failure specific indications) and side effects
- If needed, teach patient/caregiver to fill medication cassette
- Assess medication compliance and understanding; help patient notify PCP of problems.

FOOD MANAGEMENT

- Review with patient and caregiver education materials on high sodium foods
- Review normal eating habits and, using examples from patient's kitchen cabinets if appropriate, make suggestions for low sodium substitutions
- Evaluate for Nutritional Consult

OCCUPATIONAL AND/OR PHYSICAL THERAPY – 1-3 VISITS THIS WEEK

- Review emergency contacts and guidelines; make certain patient/caregiver understands when to call Home Health, PCP or 911
- Instruct energy conservation principles
- Assess understanding and compliance of diet and low sodium foods

WEEKS TWO THROUGH FOUR

NURSING CARE

- Visit 2-3 times per week
- Full assessment (see 1st page)
- Assess proper utilization of Telemonitoring
- Assess understanding of disease processes, implication of weight gain and role of sodium in diet; provide additional instruction and education as needed
- Assess medication compliance and put in place changes and/or additional education as needed.

OCCUPATIONAL AND/OR PHYSICAL THERAPY CARE

- Visit 1-3 times per week
- Instruct energy and conservation principles

CONTINUE THROUGH DISCHARGE

NURSING CARE

- Visit as needed
- Full assessment (see 1st page)
- Assess proper utilization of Telemonitoring
- Assess understanding of disease processes, implication of weight gain and role of sodium in diet; provide additional instruction and education as needed
- Assess medication compliance and put in place changes and/or additional education as needed

OCCUPATIONAL AND/OR PHYSICAL THERAPY CARE

- Visit as scheduled
- Instruct energy conservation principles

WEEK PRIOR TO DISCHARGE FROM HOME CARE SERVICES

- Transition patient to using home assessment equipment: scale, blood pressure cuff, calibrate Telemonitor to home scale, if applicable
- Confirm on-going Elder Services or community resources are in place if needed
- Notify PCP that home care services are concluding
- Confirm patient has scheduled appointment with PCP and transportation, as necessary.
- Evaluate for appropriateness and initiate, as necessary, Cardiac Rehabilitation and/or Chronic Disease Self-Management Program.

ATTACHMENT #25

South Shore Hospital

COPD Action Plan

COPD Action Plan

Physician	Physician's Phone #

The colors of a traffic light will help manage your COPD:

Green Zone: Use daily medicines

If you have *all* of these:

- Breathing is good
- Clear – white phlegm
- Sleep through the night
- Can work and play

Use This Daily Controller Medicine:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For symptoms with exercise, activity:		

Caution Zone : Add additional medicines

If you have *any* of these:

- Short of breath
- Wheezing or coughing more than usual
- Unexplained changes in your weight
- Changes in your phlegm (thicker, color, amount)
- More tired and can not do your usual activities
- Increased anxiety
- A temperature

Continue With Green Zone Medicine and Add:

CALL YOUR HEALTHCARE PROFESSIONAL (Physician ,Case Manager, VNA)

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

DANGER Zone

If you have *any* of these symptoms:

- Severe shortness of breath (You feel like you cannot breathe or catch your breath while resting)
- Chest pain
- Feel faint
- More sleepy and have difficulty staying awake
- Feel confused
- Bluish color to your lips or nails

Call 911
or
Go to the Hospital Emergency Room

Get help from a healthcare professional now! Do not be afraid of causing a fuss. It's important! Go directly to the emergency room or Call 911. DO NOT WAIT.

COPD Action Plan

Name	Date

Chronic Obstructive Pulmonary Disease (COPD) definition:

COPD is a chronic and progressive disease that causes difficulty breathing and cannot be completely changed by medications. COPD can lead to blockage of airflow out of the lungs which results in shortness of breath (SOB) especially when active.

Breathing Techniques:

- ❑ Pursed lip breathing; practice daily
- ❑ Coughing
- ❑ Deep breathing

Medications:

- ❑ Take medication as prescribed
- ❑ Take medications consistently
- ❑ Learn to use inhaled medications properly

Triggers:

- ❑ Smoking including 2nd & 3rd hand smoke
- ❑ Allergens/environmental
- ❑ Cold/Humid weather

Energy Conservation:

- ❑ Plan, Pace, Prioritize
- ❑ Rest
- ❑ Spread out activity

Diet:

- ❑ Drink fluids
- ❑ Balanced diet
- ❑ Small frequent balanced meals

0xygen (O2) and Safety:

- ❑ Do not use petroleum jelly
- ❑ Do not smoke
- ❑ Caution with equipment & tubing

professional's instruction.

Developed by Cross Continuum Team- June 2011