MAXABILITIES OF YORK COUNTY

PROCEDURE TITLE: Post Acute Medical Care Evaluation & Follow Up Protocol
APPLICABILITY: MaxAbilities Staff
EFFECTIVE DATE: June 27, 2007
PROCEDURE REVISIONS: September 24, 2026
January 17, 2018
January 19, 2011
March 4, 2009
August 5, 2008
November 16, 2007
REFERENCE: OIDD (Office of Intellectual & Developmental Disabilities) Residential Licensing Standards
MaxAbilities Procedure: Medical Emergency

PROCEDURE PURPOSE: Ensuring appropriate follow-up to any acute or chronic health issues is vital to the ongoing care of a resident supported by MaxAbilities. The procedure outlines the steps to take to ensure effective and efficient resident care following visits to a physician or a hospital for acute or chronic health conditions.

1. " Acute" is defined as treatment sought for a brief and severe condition. Acute visits are not planned in advance but are in response to a sudden change in condition. Examples of acute issues include but are not limited to: sinus infection, urinary tract infection, flu, accidents that result in fractures, falls with injury. An acute visit would include an appointment made less than 24 hours prior to a clinic visit for a specific condition similar to those note above.
2. "Chronic" conditions are defined as previously diagnosed conditions characterized by longer duration, usually greater than a year and usually have less intense or severe symptoms. Examples of chronic issues include but are not limited to: gout flair-ups, asthma of COPD exacerbation, congestive heart failure symptoms.

INITIAL NOTIFICATION PROCESS- UNPLANNED MEDICAL VISIT:

1. For all emergencies call 911 first, then call appropriate staff
2. When a resident is in need of an unplanned visit to a hospital or urgent care facility, care is the first priority. Notification must be made to appropriate management staff once the emergency care has been initiated.
3. Residential staff are to take the MaxAbilities Hospitalization Form for any Emergency Room visit- in the event the resident needs to be admitted. Upon any hospital admission, this form is to be completed and forwarded along with any discharge orders to pertinent management staff.
4. Residential staff are to notify the nurse within one hour following completion of an unplanned medical visit (hospital or Urgent Care). If the visit was a hospitalization, staff are to obtain a written copy of the discharge summary and any medical orders before leaving the hospital.

5. Residential staff are to document the name of the nurse providing discharge instruction, attending physician, specific discharge instructions, and date/time of discharge on the THERAP GER (General Event Report).
6. Staff are to notify the residential House Manager of any new physician's orders and forward those orders to Tarrytown Pharmacy for completion if not completed by hospital staff. Inform the Manager a GER has been completed for review.

MANAGEMENT STAFF FOLLOW-UP RESPONSIBILITIES:

HOUSE MANAGER RESPONSIBILITIES:

1. The House Manager is to provide notification that an unplanned medical visit took place by phone to the Residential Coordinator within one hour of the event. If the Coordinator cannot be reached, they are to contact the on-call Administrator to provide the contact. That person is responsible to contact additional staff members for initial notification.
2. Ensure that any pharmacy orders have been received by Tarrytown Pharmacy and arrange for receipt of the medication.
3. Communicate with staff members of the home discharge instructions and any medication changes. This communication should be both verbal and written on the program shift log. Additionally, a notation should be made on THERAP as a T-Log.
4. Ensure staff are following all discharge orders effectively and report to the agency nurse if unable to do so or if the treatment is not resulting in improved resident condition.
5. Fax or email a copy of the hospital discharge summary immediately upon receipt to the Residential Coordinator, Residential Director, VP-Operations, and Lead Community Nurse Coordinator (LCNC) upon receipt.

NURSING RESPONSIBILITIES:

1. For any unplanned medical visit, a post-acute medical care evaluation form (*Attachment A*) is required to be completed within 24-36 hours to verify all discharge orders have been initiated, medications received and the resident's condition is not worsening. The nurse is responsible to initiate this documentation.
2. The nurse will prepare the post-acute form with pertinent discharge information to include verification of the date and time of any agency- initiated, self-initiated, or family-initiated unplanned medical visits.
3. The form is to be e-mailed to the Residential Coordinator and Cc'd to the House Manager, Residential Director and VP-Operations, as soon as it is completed. It is required to be completed before the 24–36-hour visual check window begins.
4. If the resident has had a hospitalization following the unplanned medical visit, the nurse is to completed the post-acute medical form visual resident check within the 24–26-hour visitation window to ensure medical continuity.

COORDINATOR/ADMINISTRATOR RESPONSIBILITIES:

1. Upon receipt of the medical discharge summary, the Coordinator will ensure that the nurse has received the report and that the post-acute report is being initiated.

2. The Coordinator will do a visual check of the resident and complete the post-acute medical care evaluation form between 24-26 hours.
    - NOTE: If the Coordinator has not received the post-acute medical care form from the nurse and the 24-hour visual observation window has arrived, the Coordinator will complete the required visual observation and complete the post-acute medical care form.
    - Following completion of the visual check and initiation of the post-acute medical care form, the Coordinator will notify the Residential Director that the form was not received by nursing staff. The Residential Director will notify the VP-Operations for needed follow-up.
3. If during the visual observation, the resident's condition is not determined to be improving, phone contact must be made to both the LCNC and the CEO to notify of the lack of improvement and to receive additional follow-up instruction. This contact is to be documented on the post-acute medical care form.
4. Immediately upon completion of the 24–26-hour visual observation and completion of the post-acute medical care form, the Coordinator will attach the hospitalization checklist, completed GER, and discharge summary to the form and submit that to the Lead Community Nurse Coordinator. This distribution is to be completed no later than the next business day.

LEAD COMMUNITY NURSE COORDINATOR RESPONSIBILITIES:

1. The LCNC will monitor the post-acute process for all residents who are taken for unplanned medical visits. In the event a nurse is not available to assist in the process of post-acute medical form completion, the LCNC will assume this responsibility.
2. The LCNC will be available to receive the completed post-acute medical care forms, review them for completeness and route them for review by the Residential Director, VP-Operations and CEO. Routing of completed post-acute packets will be completed within one week of the completion of the unplanned medical visit.
3. The LCNC will receive fully routed post-acute medical packets and will ensure all required documentation tracking of the visit is completed. They will ensure all forms contained in the post-acute packet have been uploaded to the THERAP resident file by residential staff.

RESIDENTIAL DIRECTOR RESPONSIBILITIES:

1. The Residential Director will monitor all incidents requiring post-acute medical care form implantation. If paperwork is not initiated from nursing staff according to required timeframes, the Residential Director will assist the Coordinator in getting needed forms to complete the required post-acute documentation by making contact with the LCNC.
2. If the 24-36 hour required visual observation of the resident is not completed, the Residential Director will follow-up with the appropriate Residential Coordinator.

STAFF TRAINING: Staff training on the requirements of the post-acute medical care form will be provided during the OJT (on the job training) process. Documentation of this training will be maintained in the employee's personnel file.