2/22/2016

Quality Focus: Staff Education Regarding High Risk Protocol: Distributed in All Staff Email: Crumbs Newsletter

High Risk Patients: Reviewing Four Crucial Components of the Plan of Care

I know it may seem like I am touching on the same issues from February Case Conference, but as we move forward, we must continue to remain vigilant about how we construct our approach to ***High Risk Patients***. Moreover, two of the points I will review in this brief were not given much spotlight during the prior Case Study.

Bill and I will be making some changes to the High Risk Protocol Checklist in the coming week or two and Bill will be sending out some educational review of the **High Risk Protocol for CHHC**. In the meantime, I just wanted to review these **Four Crucial Components** that deserve thoughtful attention when developing the Plan of Care for ***High Risk Patients***:

******MOST IMPORTANT THING TO REMEMBER:******

******IF THE FOLLOWING COMPONENTS ARE NOT INVOLVED IN THE PATIENT'S PLAN OF CARE, IT IS VITAL THAT AN EXPLANATION AS TO " WHY NOT" IS DOCUMENTED IN ADEQUATE DETAIL IN THE CARE COORDINATION NOTE******

1. **Front Loading:**
    a. Skilled Nursing Visits are to be **frontloaded**, perhaps daily for a short time, depending on symptom severity. Regardless, there should be a **Minimum of 3-5 Visits/ Week** in the **First 2 Weeks,** until patient is stable. CNA Visits may also be frontloaded and then tapered down.

2. **MSW Order:**
    a. An **order** for **MSW to Evaluate and Treat** has at least been **Addressed** and if necessary, implemented in a **timely** fashion.

3. **Discharge Before 30 Days:**
    a. Our goal is to keep patients on service for at least **the first 30 Days (post Hospital Discharge).** The High Risk Protocol necessitates that we do everything in our power to keep patients out of the hospital for the first **30 Days.**
    b. ****However, please be mindful that we will never keep a patient on service unnecessarily nor will we object to pt/family preference for early discharge.**** **It is though, our responsibility, to help patients and family understand the role of CHHC in helping to keep the patient from Re-hospitalization.**

4. **Care Coordination Note Use:**
    a. As discussed in detail during both the North and South February Case Conferences, it is absolutely expected that all communication regarding **changes in patient presentation or condition** be **communicated** amongst the **Interdisciplinary Team, ALF Staff, Family, Caregivers, and, if necessary, the Physician.*** Subsequently, it is vital that these exchanges are documented in the Care Coordination Note***