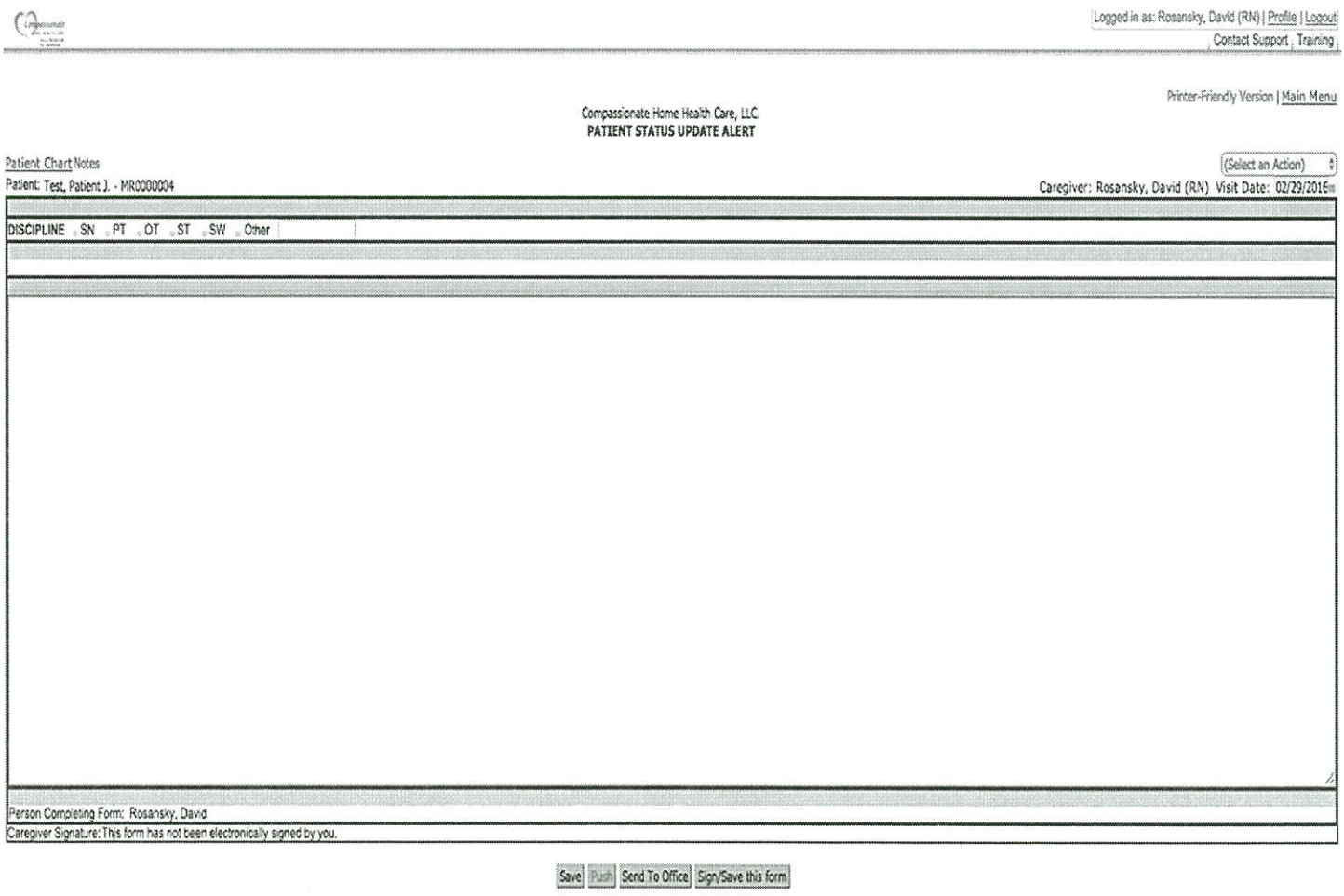
We have a new tool for Intra-team Communication in Devero

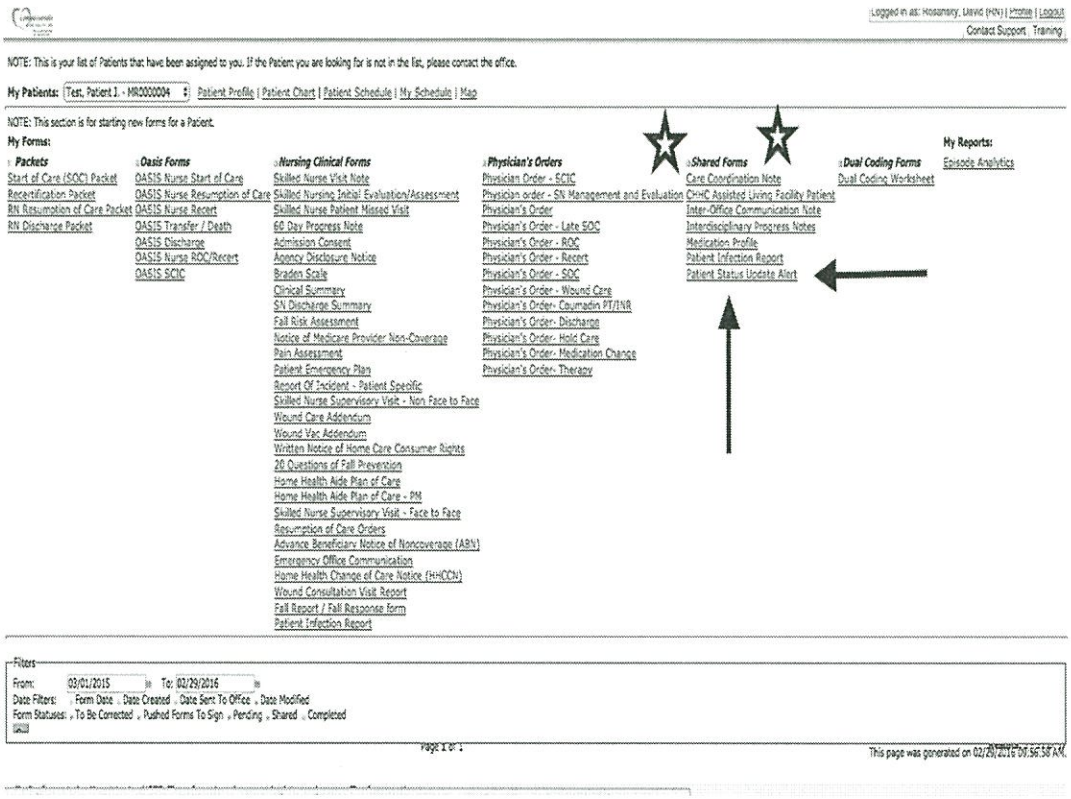
"Patient Status Update Alert"

"Go Live" is as soon as you feel comfortable using the tool. Hopefully this explanation will empower you to start using it this week. This tool is not limited to high-risk patients, but rather should be used on all patients, and used regularly.

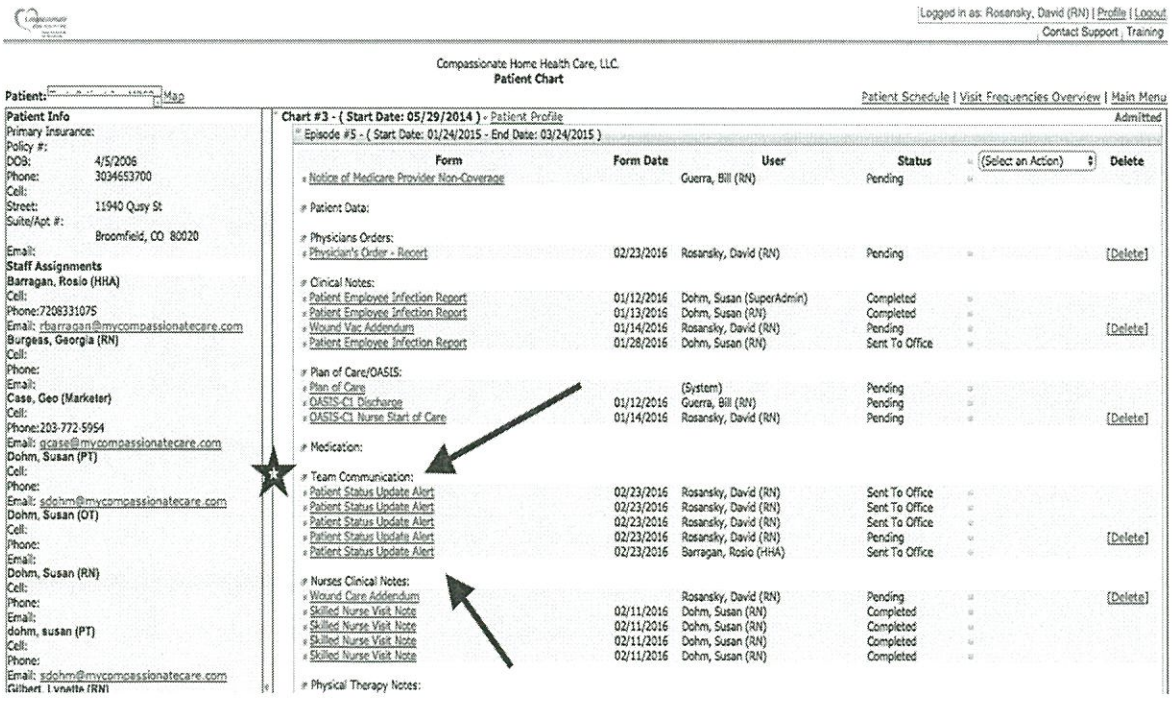
What: There is new form for communication amongst/between members of the interdisciplinary team. The form is called *Patient Status Update Alert.* This form, which will be referred to as ***PSUA***, does not replace the Care Coordination Note. Instead, it complements the CCN as a more practical **topically-oriented** tool, which can be created and distributed by any member of the team, from the Case Manager to the PTa and CNA.



Where: The form is located under the Agent *Main Menu* for an individual patient. Under the header ***Shared Forms***, at the far right side of the Menu, you should see *"Patient Status Update Alert"* listed.



Where Continued: Within the patient's chart, the ***PSUA*** will appear under the header **Team Communication**. It will list as *Pending* until all clinicians who have received the form have commented on the form and signed it. Once completed, and sent to office, the form will list as *Sent to Office*, and then no longer be modifiable.



Who: The form is designed for use by any member of the care team. Any field clinician, no matter what their discipline, can create one of these ***PSUA*** forms. All team members will be held accountable to their contribution. ****At the **Admin level, we will be able to track when a form is created, who has received it, who has signed/acknowledged it and who has not.******

Hopefully, we will not have to provide too many reminders as the form itself, once pushed to a clinician, will sit in their **To Be Signed Box.**

Importantly, the person who initiates this form must be responsible for:

- **Creation** of the Form
- **Distribution** of the Form to appropriate members of the team using the **Push** function
- **Monitoring** for acknowledgement/signature of the Form by the other team members who received the ***PSUA***
- **Sending** the Completed Form to the Office

Why: As you are already aware, we have been focusing heavily on the role of adequate documentation regarding Intra-Team Communication. I think we can all agree that the ***Care Coordination Note*** is under-utilized, sometimes burdensome, requires an actual computer screen for optimal reading/review, and difficult to orient in a Topical fashion.

So, the amazing and persistent **Carla** reached out to **Devero** and worked diligently with their staff to create the ***PSUA*** tool. The aim of this tool is to provide you guys with a vehicle for communication that can be more functionally integrated into your normal workflow. It is crucial, I repeat **crucial** that any significant communication taking place between team members regarding your **patient** be documented in the patient's chart.

We understand that text-messages, phone calls, and email have become the norm for exchanging ideas, information, assessment findings, and updates. We are not asking you to stop that all together, for sometimes, it is the best option, especially for time-sensitive exchanges of information.

However, our goal is to have you guys shift a significant amount of that communication onto the *Patient Status Update Alert* Tool. This will ensure that in the event of an adverse patient outcome, early re-hospitalization, death-at-home, or other significant event →→→ anyone reviewing the patient's chart will be able to clearly identify how CHHC clinicians: ANTICIPATED, EVALUATED, INTERVENED AND COMMUNICATED about changes in a patient's plan of care, condition, caregiver/social situation, or presentation.

When: So, as stated earlier, the ***PSUA*** is not meant to replace the ***CCN*** entirely, rather the goal is for the new tool to serve as a **topical and direct clinician-to-clinician communication.** Here is a guidance list outlining when each form ***(CCN or PSUA)*** should be used.

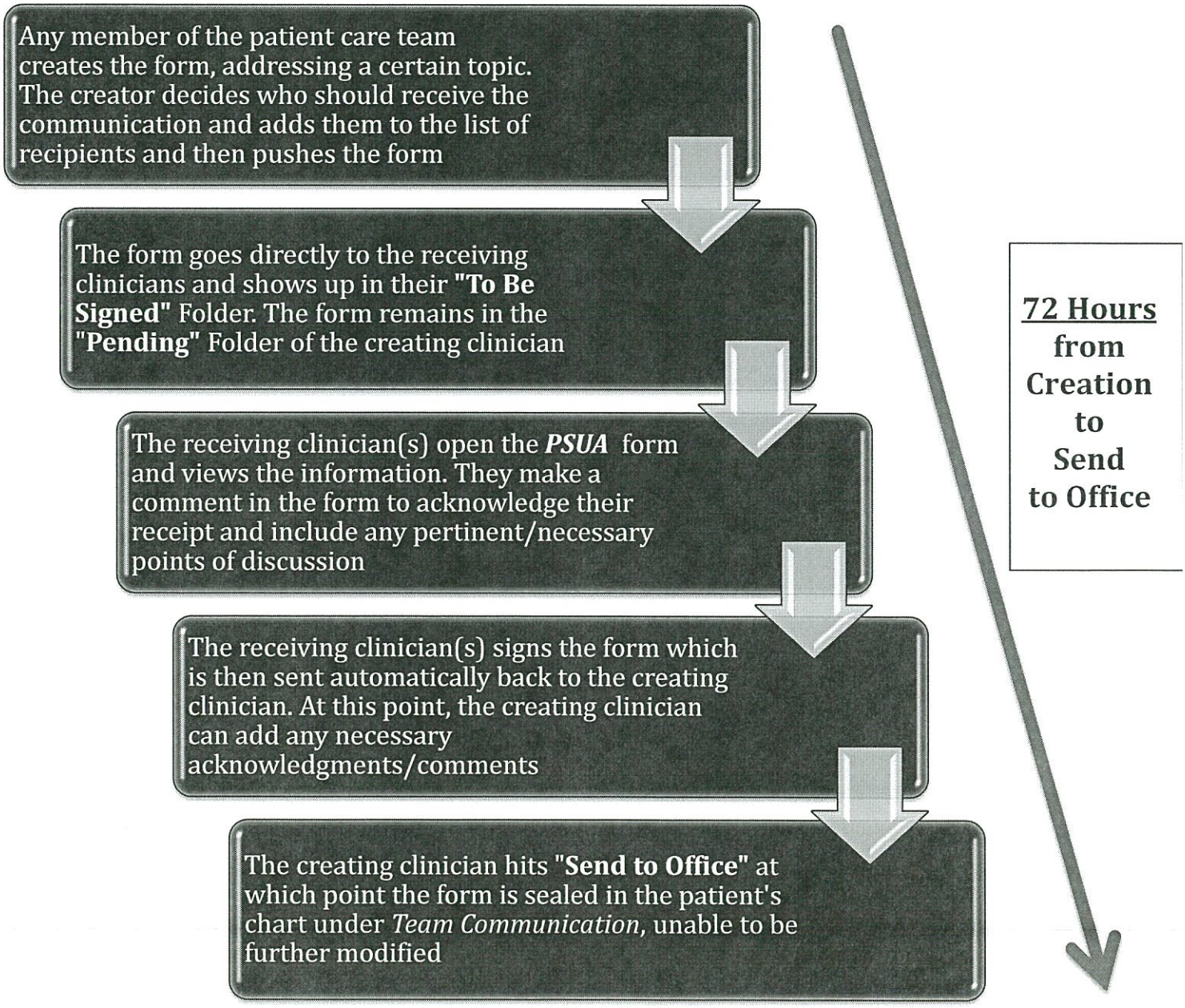
This list is by no means **comprehensive**, but hopefully covers useful examples. Furthermore, communicating something on the ***PSUA*** does not take the place of expected documentation: **(Fall Report, Med Profile, Infection Report, Physicians Order, etc..)** Nor does this form replace the need for you to **contact the Physician as appropriate in the event of an acute change in patient status.**

Patient Status Update Alert (PSUA): Used to document Dynamic Information, which may have a direct impact on one or more members of the care team. Used to notify your team members of new/significant developments	**Care Coordination Note (CCN): Used to document Static Information or individual clinician-provider/caregiver/family discussions that Do Not Largely Impact the other Team Members**
ADL Scoring Discussion	Referral/ F2F Information
Discovery of a New Wound	Notes about obtaining/awaiting paperwork (H&P, Med List etc..)
Abnormal Vital Signs	SOC, RCT, ROC Summary
Addition of a New Medication	Therapy Eval Summary: Plan of Care, Frequency/Duration and Documentation of MD Clarification Order Obtained
Discontinuation of an Existing Medication	Nurse Eval Summary
Patient and/or caregiver reports Problems with Medication (adverse reaction, new allergy, etc..)	Conversations with PCP or other Providers (Pharmacist/Dietician/Wound Care Specialist) regarding general information: new orders, special requests, faxes going or incoming
Change in Medication Dosage	Caregiver Information: special contact #s, best time to call, who to call for what
Changes in Mental or Physical Presentation via *assessment findings*	Discussions between CHHC clinicians and Caregivers/Family ((*Information may be cut and pasted from this into a* ***PSUA****) and pushed to team members whom this information may directly impact*
Changes in the Plan of Care (Skilled Focus, Frequency, Duration, etc..)	Documentation of your efforts to contact PCP or other providers and the follow-up, if received
Concern regarding patient living/social situation; Discussion with MSW	Patient/Family Conference Discussion Notes (*Information may be cut and pasted from this into a* ***PSUA****) and pushed to any team members who were not present.*
Abnormal or Unusual findings of any kind	Notification regarding upload of Medication Discrepancy Form by QA RNs
Request for another discipline to assess a certain change/finding and then provide their feedback	Any communication with the CHHC Office Staff
High Risk Patients: Within 48 hours of open, note goes out all disciplines highlighting the	Addition of Other Disciplines

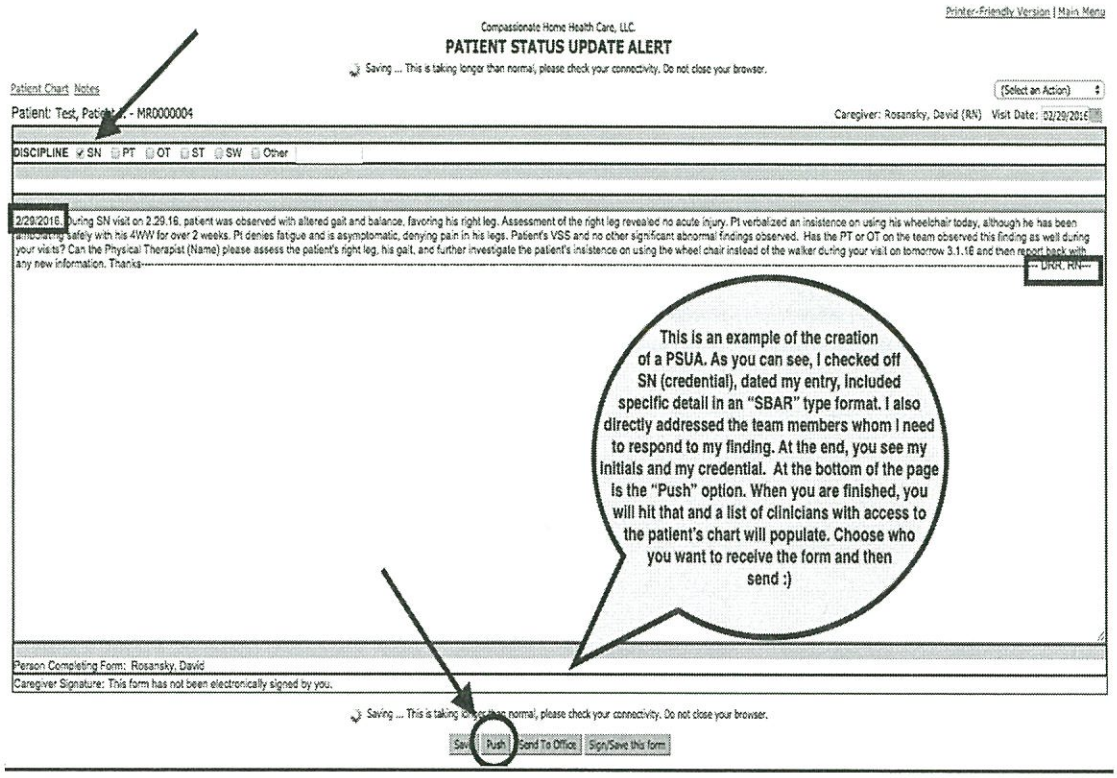
biggest areas of focus/concern	
Notifying Team Members of a Fall	Discipline Specific Discharge

How: The workflow for the ***PSUA*** may seem confusing at first, but we believe/hope that once you start to incorporate the ***PSUA*** into your charting, the process will be easy.

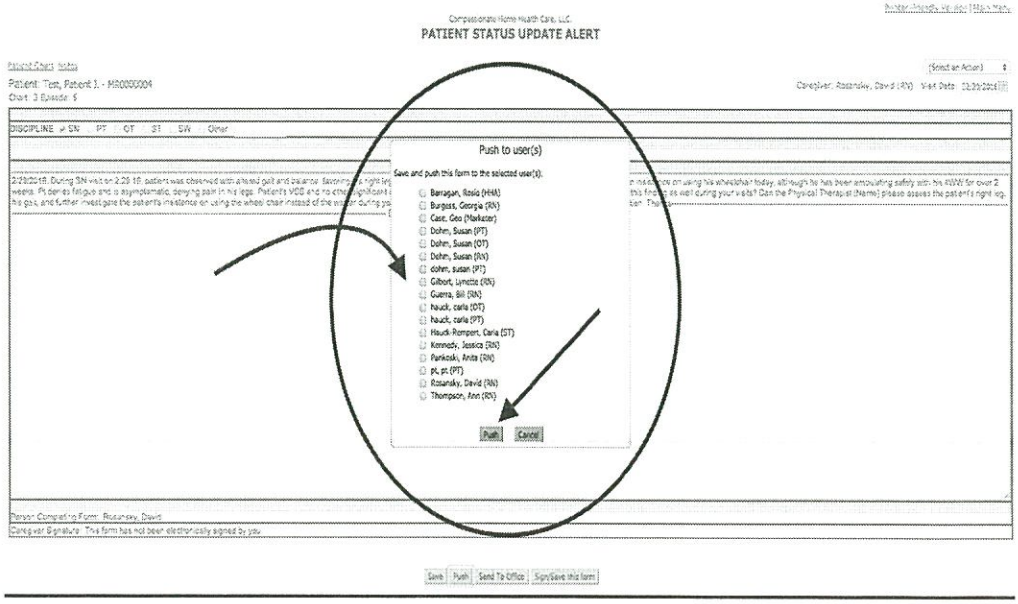
Patient Status Update Alert
Intra-Team Workflow:



Example: Creating a new PSUA and Pushing it off to other Clinicians



Once you hit PUSH, you will see this window: Please just check the boxes next to the name of the clinicians whom you would like to receive the *PSUA* form and then click PUSH again in that window.



The rest is easy: Everyone here knows how to view their "To Be Signed Folder," open a document, add an entry, and then sign the document. For the creators, once you notice that everyone involved has made an entry and signed the form, go back into the form (which is sitting in your "Pending Folder,") add an entry if needed, then hit "Send to Office" and you're DONE.

What are the Caveats?

The ***PSUA*** is not perfect; please take note of the following:

- The ***PSUA*** cannot be "pushed" by anyone except the clinician who created the form
- This means the discussion is more linear than circular. If the creating clinician wants to continue the conversation, they can push the ***PSUA*** back out prior to sending it to the office. **Or, if a member of the team wants to edit/modify/or add more to their comment, they can call the creator clinician and ask them to push the *PSUA* back, as long as it has not been sent to office. The other team-members can then add to the *PSUA and sign it again.***
- Otherwise, once all requested team members have commented and signed the form, they are no longer able to access the ***PSUA***
- It will likely become quite common to see a number of these forms, perhaps in excess of 10 ***PSUAs***, created and listed in the patient's chart by end of episode, especially for a complex patient
- The clinician who creates the form must remember to check their pending box regularly to monitor whether the form has been commented on and is ready to be sent to office
- Team members receiving the form must prioritize addressing the issue at hand (as this is one of the main purposes of the ***PSUA***), so that the creating clinician can get acknowledgement and/or resolution and then send the form to the office in a timely manner
- A new ***PSUA*** form will have to be developed if there is further follow-up or communication needed once the form has been submitted to the office

Entries in the Patient Status Update Alert Form are expected to Mirror the Format of those Entries in the CCN

Entries are to Include:

- Date
- Identification of yourself and your Credential
- Directly address other disciplines/clinicians
- Detailed explanation of the topic at hand