Partnerships in Transitions: Acute Care to Skilled Nursing Facility

Mae L. Dizon, DNP, RN, NP, ANP-BC, Ruth Zaltsmann, MS, RN, and Cheryl Reinking, MS, RN, NEA-BC

ABSTRACT

Purpose/Objectives: Older adults, in particular those discharged to skilled nursing facilities (SNFs), are at high risk for readmission. As part of a multifaceted approach to reduce readmissions, a community hospital initiated a 3-prong approach (Collaboration, Communication, and Competency) and partnered with regional SNFs.

Primary Practice Settings: El Camino Hospital, an independent, locally owned, not-for-profit district, acute care hospital in Northern California, and 11 participating SNFs in the same region.

Findings/Conclusions: Collaboration: The combined leadership team developed a case report form and instituted regular reviews of 7-day readmissions. Communication: Standardized form for transferring patients to SNFs, form for transfer from SNF to emergency department, and consent form to enable SNFs to administer antipsychotic medications were developed. Regular phone and video conferencing between clinicians at the hospital and receiving SNF were instituted. Competency: Educational series to recognize and intervene to prevent readmission, and mutual exchange of best practices among hospital and SNF staff, were instituted.

Implications for Case Management Practice: Initiating collaboration with the SNFs is imperative in the changing health care landscape. Because of the complexity of the problem, acute care facilities and SNFs need to create a partnership to ensure smooth patient transition. Communication between care settings is essential in achieving optimum patient outcomes.

Key words: partnerships, skilled nursing facilities, transitions of care

Older adults confront significant challenges as they transition from hospital to home and other care settings. Because of multiple comorbidities and complex inpatient stays, this segment of the population often faces the need for readmission. The landmark study of Jencks, Williams, and Coleman (2009) highlighted the need to focus on avoiding these readmissions when they found that nearly one in five Medicare patients were readmitted within 30 days of discharge and 34% within 90 days from 2003 to 2004. These unplanned readmissions in 2004 had an estimated cost of $17.4 billion. A 2011 study further supported these findings with Medicare beneficiaries having an overall higher readmission rate compared with those with private insurance, 17.2% and 8.7%, respectively (Hines, Barrett, Jiang, & Steiner, 2014).

Furthermore, older adults discharged to skilled nursing facilities (SNFs) have higher rates of unplanned readmissions (Mor, Intrator, Feng, & Grabowski, 2010). Between 2000 and 2006, the readmission rate from SNFs has grown significantly to 29%, and more specifically, in 2006 with nearly 25% of Medicare beneficiaries readmitting back to the hospital within 30 days of discharge (Mor et al., 2010). In California, the 30-day Medicare readmission rate from SNFs was 20.8% and in Santa Clara County it was 18.7% in 2013 (Health Services Advisory Group, 2013). While these vulnerable older patients are more likely to have additional medical problems, the unplanned readmissions in a short period after discharge warranted a review to help identify and reduce avoidable readmissions.

With the assistance of a planning grant from the Gordon and Betty Moore Foundation, the acute care setting’s executive and clinical staff in 2010 evaluated patient readmissions from SNFs to help identify common characteristics of patients at highest risk for readmission. Among the findings of this comprehensive review was the critical need to ensure a smooth transition to a SNF, to provide caregivers the information necessary to care for patients, and to

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facilitate communication between the SNF and the acute care facility. This work was part of a comprehensive effort to reduce readmissions hospital-wide and among patients identified as being at high risk for an unplanned readmission (Reinking & Dizon, 2016). The purpose of this article was to describe the efforts and results of the work to address this need among patients discharged to SNFs.

METHODS

Setting

The acute care setting was an independent, locally owned, not-for-profit district, acute care hospital in Northern California, serving residents of Silicon Valley, consisting of two campuses with 441 beds. Its mission is to be an innovative, publically accountable, comprehensive health care organization.

Eleven SNFs, identified as admitting the highest volume of discharges from the hospital, agreed to participate in the efforts to address readmissions with a bed capacity ranging from 30 to 170.

Sample

On the basis of the analysis of readmissions, patients who were readmitted to the hospital within 7 days of discharge were a primary focus, as we assumed that this was the population with the potential for the greatest impact in reducing readmissions. The findings of Ouslander, Diaz, Hain, and Tappen (2011) reported that 33% of readmissions to a community hospital in Florida from SNFs occurred within 7 days of discharge supported this assumption. We also, however, examined patients who were readmitted within 30 days of discharge. The hospital’s 7-day unplanned readmission rate for fiscal year 2012 (June 2011–June 2012) among Medicare patients discharged to SNFs was 4.87%, while the 30-day unplanned Medicare readmission rate was 15.36%.

Procedures

In June 2011, clinical leaders from the hospital and the 11 SNFs developed a close collaborative relationship, which was a challenge for health care facilities operating under different management systems. Initial discussion in the monthly meetings focused on the needs identified by the hospital and SNFs, and the combined leadership team developed mutual patient-centered goals to improve quality of care. The team divided the work into 3 areas of focus—collaboration, communication, and competency—and, for each, identified problem areas, objectives to address them, and action items necessary to achieve the established goals.

RESULTS

Collaboration

The leadership team recognized that hospitals and SNFs traditionally have not collaborated to improve the overall transition of patients. The relationship between the two entities has typically focused on marketing and availability of beds and not on quality of care. Most SNFs often see themselves as competitors, not as collaborators to improve patient outcomes. The group agreed that stronger relationships between the hospital and SNFs could improve the patients’ transition, improve outcomes, and reduce the need for unplanned readmissions (Rahman, Foster, Grabowski, Zinn, & Mor, 2013).

The team set the objective of reviewing every unplanned 7-day readmission in an open forum during the monthly meetings, to identify trends and action items. The reviews were based on an evaluation of the circumstances of the readmission, conducted jointly by the hospital’s nurse practitioner and SNF clinical staff, using a standard case review form developed by the team (Appendix A). To prepare for the case study discussion during the open forum, the hospital’s nurse practitioner spoke privately with the staff at the treating SNF. To preserve patient privacy, the open forum discussions were conducted without patient-identifying information. Reviews were based on an evaluation of the circumstances of the readmission pertaining strictly to clinical information. The reviews helped identify gaps in care for both the acute care setting and SNFs, as well as opportunities for improvement. These reviews proved to be a valuable tool in improving patient outcomes and reducing readmissions.

The leadership team recognized that hospitals and SNFs traditionally have not collaborated to improve the overall transition of patients. The relationship between the two entities has typically focused on marketing and availability of beds, and not on quality of care. Most SNFs often see themselves as competitors, not as collaborators to improve patient outcomes. The group agreed that stronger relationships between the hospital and SNFs could improve the patients’ transition, improve outcomes, and reduce the need for unplanned readmissions.
learning forum for both care settings, which resulted in improved delivery of care and patient outcomes.

**Communication**

Open communication and strong relationships between acute care and SNFs have been associated with better patient outcomes (Rahman et al., 2013). Acute care facilities who own a SNF often have the upper hand with regard to reducing avoidable readmissions since information sharing has already been established, thus reducing the possibility of errors that occur during transfer (Rahman et al., 2013). One of the main barriers to a successful transition is the lack of information provided to SNFs that will enable them to properly care for these patients (Butcher, 2013).

**Case study 1**

In 2012, a patient was readmitted from a SNF shortly after discharge because of behavioral problems. A root-cause analysis conducted with the SNF determined that the patient had been started on an antipsychotic medication in the hospital but was unable to receive this medication because of strict state regulation requiring SNFs to obtain a separate consent form prior to administration. When the patient’s behavior became unsafe and with the SNF’s inability to contact family, the patient was transferred back to the hospital.

The hospital was not consistent in providing SNFs the correct information; therefore, the first objective of the hospital-SNF partnership was the creation of a number of standardized forms for transferring patients, both to and from the hospital. A hospital to SNF checklist (Appendix B) and SNF to emergency department checklist (Appendix C) were created. In part because of readmission exemplified by the case described earlier, a consent form for antipsychotic medications to be administered in SNFs was initiated in the acute care setting and was valid for the first 72 hours of the SNF stay (Appendix D).

To facilitate communication further, a second objective involved incorporating transitions work in the role of the nurse practitioner (NP). At the time of discharge, the NP called the receiving SNF to give report for high-risk patients. In 2014, responsibility for the communication directly to the SNF clinical staff was transferred to the bedside nurse, who had current and detailed knowledge of the patient. A detailed phone list was prepared identifying the appropriate staff and phone numbers to contact, to facilitate a smooth phone handoff between the care settings. This practice has been incorporated into the bedside nurses’ workflow for all SNF-bound patients and not just for high-risk patients, with the nurse practitioner making a follow-up phone call 24–48 hr after transfer. Since April 2012, more than 2,500 follow-up phone calls have been made by the NP. A major trend identified during the phone calls was the need to address palliative and end-of-life care. Patient information such as discharge orders and plans of care were discussed. In addition, this provided the SNF staff an opportunity to ask questions. The collaboration resulted in agreements to update or change the care plan as needed.

A third objective involved enhanced communication by video conferencing. The hospital acquired telepresence units that allowed for advanced video conferencing with the SNFs. Initially, one SNF with a high volume of the hospital’s patient discharges was identified for implementation of this initiative. Since then, two other facilities were added. Weekly telepresence meetings have allowed secured communication of patient information between care settings through clear interactions among care providers, thus saving time and eliminating location barriers. These meetings are scheduled during the SNF’s multidisciplinary rounds allowing for attendance by physicians, director of nursing, administration, rehabilitation staff, social work, and dietary personnel. This “virtual” environment helps create a respectful and mutually trusting relationship between the teams at each facility.

**Case study 2**

Prior to the project, end-of-life care was not fully addressed in either care setting. After the project was implemented, both the case reviews and the follow-up phone calls revealed that majority of the patients readmitted back to the hospital were hospice or palliative care appropriate. Close communication between caregivers proved to be an invaluable piece in reducing avoidable readmissions. Unwarranted readmissions were then averted because of the collaboration, extensive discussion, and consistent messaging that occurred in the inpatient setting, which were then continued at the SNFs regarding end of life. More
importantly, these patients received the most appropriate level of care and improved quality of life through competent and compassionate end-of-life care.

**Competency**

The initial leadership team meetings identified a need for education in some critical areas of clinical care. The participating SNFs verbalized the need to educate their staff on the common conditions and symptoms that can lead to a readmission. Ouslander et al. (2010) reported that acute changes in patients at SNFs can often be managed effectively at their present setting, supporting the enhancement of clinical care in the SNF. This relationship between competency and readmission rate was explored in a study of patients with heart failure (HF). Researchers showed that staff education led to effective disease management and ensured that evidence-based care was delivered, which could eventually lead to lower readmission rates (Boxer et al., 2012). To help determine the objectives and focus areas for an education program, a needs assessment survey was completed by the clinical SNF staff in 2012. The primary need identified was early recognition and intervention in the SNF to prevent the need for readmission. This led to the creation of an educational series for the SNF nurses with 1-hr classes given by various specialties. Continuing education credits were offered to the attendants for a small fee. Topics included aspiration pneumonia, pressure ulcers, stroke, and heart failure. Likewise, during the monthly meetings, clinicians from SNFs were encouraged to share their best practices through presentations and demonstrations to help other facilities and the hospital staff have a better understanding of their scope of work. In addition, outside presenters were invited to discuss new ventures and policies that affected both hospital and SNF care.

**Discussion**

The comprehensive multidisciplinary work conducted between the hospital and participating SNFs resulted in the development and standardization of forms across the different facilities participating in the project. The forms are the physical results of many hours of collaboration and agreement on critical information needed for the smooth transition, whether from hospital to SNF or from SNF to hospital. The work also enabled the linking of facilities for ongoing communication on best practices to improve patient care, regardless of the setting. Recent changes in regulations, such as those related to opioid use, demonstrate the importance of having established collaborations across facilities that can efficiently and effectively implement important changes in practice. Stronger relationships have resulted in better communication, mutual respect, and a comfort level between personnel in our acute care hospital and SNFs.

This collaboration has resulted in a sense of shared accountability, ease in communication with known contacts in each site, communication based on the concept of teamwork to find a solution versus a feeling of blame, easier placement of complex patients, and common, shared goals for care for these patients, including palliative and end-of-life care and involvement of families.

It is difficult to quantify the effect these collaborative efforts had on reducing morbidity and complications after the transfer. This project was part of a broader effort to reduce readmissions hospital-wide, and statistically significant reductions were achieved, in the hospital overall and among those identified as being at high risk (Reinking & Dizon, 2016). Furthermore, evaluation of this collaboration on reduced or delayed readmissions and costs was beyond the scope of this article. Although financial data were not collected, these efforts align with current value-based purchasing initiatives. The project served as an initial step for process development, relationship building, and improvement of workflow and communication between the acute care and postacute care settings. This work is key in moving toward efforts to meet the CMS’ target of 50% of payments being tied to quality and value by the end of 2018. We believe that these strategies have improved patient and clinical staff experiences from both settings during care transition.

The innovation of this project lies not only in its multidisciplinary, but also in its multisite approach, involving and engaging both front-line staff and executive support and shared decision-making among facilities. Readmissions are multifactorial and may not always be preventable among older, complex patients. The use of standard methods for evaluating and tracking patients and communication as they move from one setting to another allows care to be seamless and patient-centered, not hampered by institutional differences. Future work in the link between hospitals and SNFs should build on this work, to include physician-to-physician handoff and collaboration with home health agencies to ensure seamless transition as the patient moves through the continuum of care. In addition, more work needs to include the use of diagnosis-specific standardized care.
protocols at the SNF to reduce variability and improve patient care.

**Acknowledgments**

The authors thank the following funding received for this work:

1. Gordon and Betty Moore Foundation: Betty Irene Moore Nursing Initiative. Avoiding Readmissions Through Collaboration Planning Grant 2010: This was a planning grant meant to support hospitals that demonstrated interest in reducing readmissions by 30% by 2013 for both 30- and 90-days. Grantees were supported by an improvement advisor who assisted each hospital in the development of the plan.

2. Gordon and Betty Moore Foundation: Betty Irene Moore Nursing Initiative. Improving Transitions of Care for High Risk Patients: This grant supported El Camino Hospital to implement a transitional care program for patients at high risk of hospital readmission. The goal of the program was to achieve and sustain a 30% reduction in the 30-day and a 15% reduction in the 90-day all-cause readmission rates for these high-risk patients.

3. Gordon and Betty Moore Foundation: Betty Irene Moore Nursing Initiative. Spotlight on Success Grant Program: The Spotlight on Success Grant Program’s main objective was to support individuals and organizations in their effort to disseminate their approach, results, and learning from their Nursing Initiative projects to regional/national audiences. The ultimate goal was to share best practices and learning opportunities with the hope that it can be replicated elsewhere.

**References**


**Mae L. Dizon, DNP, RN, NP, ANP-BC**, is an adult nurse practitioner who has mainly focused on geriatrics. She is the nurse practitioner and coordinator for El Camino Hospital’s NICHE (Nurses Improving Care for Healthsystem Elders) Program that aims to improve the care provided to older adults. In addition to this, Mae has been integral in the implementation of the Transitions of Care Program, concentrating on reducing avoidable readmissions for skilled nursing facilities.

**Ruth Zaltsmann, MS, RN**, was an emergency department nurse before joining El Camino Hospital as a program manager to develop, implement, and manage the Transitions of Care Program. In addition, Ruth has spoken at many conferences and webinars focused on hospital transitions work, preventing readmissions, collaborative work within the health care environment, and Medicare’s Bundle Payment Care Improvement Initiative (BPCI). Ruth currently serves as a BPCI Clinical Program Manager for Dignity Health and provides consulting services on the topic of health care changes to hospitals and physician groups in San Francisco, CA.

**Cheryl Reinking, MS, RN, NEA-BC**, is currently the Chief Nursing Officer at El Camino Hospital in Mountain View, CA. Cheryl oversees 24 nursing departments as well as laboratory, pharmacy, respiratory care, and clinical nutrition. Cheryl has been in this role since 2013. Cheryl has served El Camino Hospital for the past 20 years in multiple roles including Vice Chief of Clinical Operations, Director, and Manager. In addition, Cheryl is a member of the Magnet committee, which was instrumental in assisting the hospital in achieving Magnet status in 2005, 2010, and a third designation on 2013. Cheryl was recipient of the Silicon Valley Women of Influence Award in 2013.
### APPENDIX A

#### I. Patient Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code Status on 1st Admission</th>
<th>Skilled Nursing Facility</th>
<th>Date of Discharge</th>
<th>Date of Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Days Between Discharge &amp; Readmission</th>
<th>□ 0-3 days</th>
<th>□ 4-7 days</th>
</tr>
</thead>
</table>

#### II. El Camino Hospital Patient Visit Information

Primary Diagnosis on Discharge: 

- CHF
- COPD
- Dehydration
- Possible Fracture
- MI
- Hypo/Hyperglycemia
- Change in Mental Status
- Pneumonia
- UTI/Urosepsis
- Other: 

Medical/Surgical History: 

Attending on 1st Admission: ____________________________  Unit: ________  Length of Stay: ________

Consults: 

Was this readmission related to the previous admission? □ Yes  □ No

Was the patient appropriate for the selected skilled nursing facility? □ Yes  □ No

Was a clear discharge plan documented? □ Yes  □ No

Was discharge plan communicated to patient/significant other? □ Yes  □ No

Was provider discharge instructions complete? (wound care orders, continuation/discontinuation of meds) □ Yes  □ No

Impression: 

#### III. Skilled Nursing Facility Resident Visit Information

Reason for transfer: 

Date the change in condition first noticed: _______________

Date change reported to primary caregiver: _______________  Response time of primary caregiver: _______________

Describe the change in the resident’s condition. Check all that apply:

<table>
<thead>
<tr>
<th>Change In:</th>
<th>New Condition:</th>
<th>New Symptom/Sign:</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>appetite</td>
<td>bleeding</td>
<td>change in mental status</td>
<td>abnormal lab</td>
</tr>
<tr>
<td>mental status</td>
<td>difficulty breathing</td>
<td>Heart Failure</td>
<td>abnormal vital signs</td>
</tr>
<tr>
<td>functionality</td>
<td>constipation</td>
<td>dehydration</td>
<td>family concern</td>
</tr>
<tr>
<td>skin/wound</td>
<td>diarrhea</td>
<td>fever</td>
<td></td>
</tr>
<tr>
<td>fall</td>
<td>pain</td>
<td>respiratory infection</td>
<td></td>
</tr>
<tr>
<td>pain</td>
<td>other</td>
<td>urinary tract infection</td>
<td></td>
</tr>
</tbody>
</table>
Describe symptom, sign, or change in condition that led to the transfer:

Evaluation Conducted in Skilled Nursing Facility
Check all that apply:
Medical Evaluation: Intervention:
telephone report ☐ bloodwork ☐ new medication ☐
MD On-site Visit ☐ Urinalysis/Culture ☐ other ☐
NP/PA On-site Visit ☐ X-Ray ☐

Describe interventions performed to manage resident prior to hospital transfer:

Was patient status discussed: (i.e. DNR, DNH, palliative or hospice care)? ☐ Yes ☐ No

IV. Areas for Improvement
El Camino Hospital:
☐ Patient should have been more stable prior discharge
☐ Patient did not meet the level of care that the facility could provide
☐ Discharge plan should have been communicated better to the patient and/or significant other
☐ The “Skilled Nursing Facility Checklist” needed to be completed
☐ Other: _______________________

Skilled Nursing Facility:
☐ Earlier identification and management regarding the change in status should have occurred
☐ Transfer could have been avoided if the provider was available or returned call earlier
☐ Additional information could have been communicated to the care provider in order to make a better determination for interventions
☐ Discussion about goals of care/advance directive should have been discussed with the patient
☐ Other: _______________________

V. Action Plan for Both Institutions Avoid Readmission

<table>
<thead>
<tr>
<th>El Camino Hospital:</th>
<th>Skilled Nursing Facility:</th>
</tr>
</thead>
</table>

El Camino Hospital Representative: ____________________________ Date: ____________
Skilled Nursing Facility Representative: ______________________ Date: ____________
Name of Skilled Nursing Facility: ____________________________
#APPENDIX B

##Skilled Nursing Interfacility Transfer Report

<table>
<thead>
<tr>
<th>AS Initials</th>
<th>Primary RN Initials</th>
<th>Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Skilled Nursing Interfacility Transfer (computer generated: 1 copy to SNF, 1 copy to patient/family)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advanced Directive / POLST (if available)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Triplicate prescriptions for narcotics (if appropriate)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AS Initials</th>
<th>Primary RN Initials</th>
<th>Printouts from ECHO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2 Facesheets (one for receiving facility / one for transport team)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medications given in the last 24 hours and last 7 days (including immunizations)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lab results (ancillary, pathology labs reports)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OT / PT / Speech evaluations (including swallow evaluation if done)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wound care notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MD’s Dictated Transfer Summary (1 copy to SNF, 1 copy to patient/family)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AS Initials</th>
<th>Primary RN Initials</th>
<th>Copy from Chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Copy of H&amp;P (including consultations)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doctor’s progress notes from the last 7 days (handwritten or EMR copy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EKG copy with dictation (if appropriate)</td>
</tr>
</tbody>
</table>

##NURSING EVALUATION

**Baseline Status**
- [] Verbal
- [] Non-Verbal
- Alert & Oriented: [ ] 1 [ ] 2 [ ] 3 [ ] 4
- Confused
- Wanderer
- Aggressive
- Withdrawn

**Allergies**
- [ ] PICC line
- [ ] wound vac
- [ ] urinary catheter
- [ ] colostomy
- [ ] tube feeding
- [ ] other: [ ]

**Pre-existing Medical Devices**
- [ ] bed bound
- [ ] wheelchair
- [ ] walker
- [ ] cane
- [ ] ambulatory with assist
- [ ] independently without assist

**Isolation**
- [ ] MRSA
- [ ] VRE
- [ ] ESBL
- [ ] C-DIFF
- [ ] other:

**Functional Status**

<table>
<thead>
<tr>
<th>Feeding</th>
<th>Self</th>
<th>Set up</th>
<th>Assist</th>
<th>Total care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>Self</td>
<td>Assist</td>
<td>Total care</td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td>Self</td>
<td>Assist</td>
<td>Total care</td>
<td></td>
</tr>
</tbody>
</table>

**Primary Language:** [ ]

**Ambulation Status**
- [ ] Vision: [ ] Good [ ] Fair [ ] Poor
- [ ] Glasses Hearing: [ ]
- [ ] Good
- [ ] Fair
- [ ] Poor
- [ ] Hearing Aid
- [ ] Dentures: [ ] Upper [ ] Lower

**Last Antibiotic(s) Given**

<table>
<thead>
<tr>
<th>Names:</th>
<th>Date/Time:</th>
</tr>
</thead>
</table>

**Immunizations**

- [ ] Pneumococcal [ ] Yes, Date: [ ]
- [ ] No [ ] Unknown [ ] Declined
- [ ] Influenza [ ] Yes, Date: [ ]
- [ ] No [ ] Unknown [ ] Declined

**Skin Condition**

<table>
<thead>
<tr>
<th>Names:</th>
<th>Date/Time:</th>
</tr>
</thead>
</table>

**Last Bowel Movement**

<table>
<thead>
<tr>
<th>Names:</th>
<th>Date/Time:</th>
</tr>
</thead>
</table>

**Last Anti-psychotic Given**

- (i.e. Haldol, risperidone, olanzapine )
- If new medication, ensure MD completion of anti-psychotic consent.
- Date/Time:

- [] Transportation form signed by MD present if required

---

### Sending RN:

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Sign Name</th>
<th>Date</th>
<th>Time</th>
<th>Unit</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

*SNF checklist – updated 3/11/14  GOLDENROD – SNF  CANARY - CHART*

---

*Please send original with patient, copy remains on chart*
### APPENDIX C

**Skilled Nursing Facility → Emergency Department Checklist**

**Reason for Transport:**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Code Status (circle one)</th>
<th>Conservator Yes / No Name and Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Full Code DNR Comfort Care</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DNR with active care</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skilled Nursing Facility Name</th>
<th>Sending Staff Name</th>
<th>DIRECT Phone # for clinical questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Staff Initial**

- Documents
  - POLST / Advance Directive / Durable Power of Attorney (front of paperwork)
  - Patient Facesheet (2nd)
  - Medication List / Med Kardex (3rd)
  - Pertinent / Recent Labs
  - Physician Consults and Progress Notes, Nursing Notes (most recent)

**Pertinent Information regarding Patient**

<table>
<thead>
<tr>
<th>Isolation (circle all that apply)</th>
<th>Skin Body Assessments Pressure Ulcers Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>none MRSA, VRE, ESBL, C-DIFF, TB</td>
<td>(mark diagram)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Baseline Status (circle all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal, Non-Verbal, Alert &amp; Oriented x 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulation Status (circle all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed bound, wheelchair, walker, cane, Independently without assist</td>
</tr>
</tbody>
</table>

**Type of Diet:**

**Pre-existing Medical Devices (circle all that apply)**
- PICC line, wound vac, urinary catheter, tube feeding
- other:

**Immunizations (circle all that apply)**
- Pneumococcal Yes, Date: ___________ No, Unknown, Declined
- Influenza Yes, Date: ___________ No, Unknown, Declined

**Primary MD:** ___________________ **Phone #: __________________**

**Comments:**

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SNF → ED revision 9/3/13
APPENDIX D

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY
2500 Grant Road, Mountain View, CA 94040-4378

Patient Consent for Use of Antipsychotic Medication – Patients Discharging to SNF Only

This is to affirm that the physician has recommended that I be treated with an antipsychotic medication after I am discharged from the hospital. To make an informed decision, I have been provided with sufficient information by the physician. This information includes the following:

1. The nature and seriousness of my mental condition
2. The reason(s) for the medication
3. Name, type, frequency, amount and method of dispensing the medication and the probable length of time that the medication will be taken
4. The likelihood of improvement with or without the medication
5. The nature, degree, duration and the probability of the side effects and interactions of other medications
6. The reasonable alternative treatment

Medications (Name, Schedule, Dosage Range and Route of Delivery)

By my signature I acknowledge:

1. That the medications set forth above have been adequately explained by my treating physician and that I have received all information that I desire concerning such medications
2. I am aware of the meaning of the above information
3. That I authorize and consent to the administration of such medications
4. I am aware that I have the right to refuse each antipsychotic medication either now or in the future except in medical emergencies

Patient/ Durable Power of Attorney – Print Name

Date

Time

Patient/ Durable of Power Attorney – Sign Name

Physician Name – Print

Date

Time

Physician Name – Sign Name

This consent form is valid through 72 hours post discharge

Form 6858 Rev. 05/13

WHITE - PATIENT CANARY - CHART PINK - SKILLED FACILITY
Instructions:

- Read the article. The test for this CE activity can only be taken online at www.nursingcenter.com/ce/PCM. Tests can no longer be mailed or faxed.
- You will need to create (it's free!) and login to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Williams & Wilkins online CE activities for you.
- There is only one correct answer for each question. A passing score for this test is 13 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Williams & Wilkins: 1-800-787-8985.

Continuing Education Information for Certified Case Managers:
This Continuing Education (CE) activity is provided by Lippincott Williams & Wilkins and has been preapproved by the Commission for Case Manager Certification (CCMC) for 1.0 clock hours. This CE is approved for meeting the requirements for certification renewal.

Registration Deadline: July 1, 2018

Continuing Education Information for Certified Professionals in Healthcare Quality (CPHQ):
This continuing education (CE) activity is provided by Lippincott Williams & Wilkins and has been approved by the National Association for Healthcare Quality (NAHQ) for 1.0 CE Hours. CPHQ CE Hours are based on a 60-minute hour. This CE is approved for meeting requirements for certification renewal.

This CPHQ CE activity expires on July 1, 2018.

Continuing Education Information for Nurses:
Lippincott Williams & Wilkins, publisher of Professional Case Management journal, will award 1.0 contact hours for this continuing nursing education activity.
LWW is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 1749. LWW is also an approved provider by the District of Columbia, Georgia, and Florida CE Broker #50-1223.
Your certificate is valid in all states.
The ANCC’s accreditation status of Lippincott Williams & Wilkins Department of Continuing Education refers only to its continuing nursing educational activities and does not imply Commission on Accreditation approval or endorsement of any commercial product.

Registration Deadline for Nurses: August 31, 2019

Disclosure Statement:
The authors and planners have disclosed that they have no financial relationship related to this article.

Payment and Discounts:
- The registration fee for this test is $12.95
- CMSA members can save 25% on all CE activities from Professional Case Management! Contact your CMSA representative to obtain the discount code to use when payment for the CE is requested.

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