Example
Policies / Protocols Guidelines & Procedures

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Access to Geriatric Emergency Department Care from ED Triage

Our Academic Emergency Department has several unique areas, including a 20-bed observation unit, a 15-bed oncology unit, critical care bays, trauma bays, and a quick care or fast track area. All nurses and staff receive training to become better providers of care for our geriatric patients. Areas where we have focused our geriatric mission are the ED Observation Unit and our ED oncology unit. We also have developed a care continuum for our ED patients with specialized geriatric care on several admission teams (NICHE unit, Geriatric Trauma, and Geriatric Orthopedics).

ED Staffing:

a. ED nurses: All ED nurses undergo 2 hours of geriatric training with 1 hour of information about older adult physiology and 1 hour on specific hospital; protocols and screening tools.

b. Geriatric Consultation team: led by a board-certified geriatrician and includes geriatric NP, geriatric fellows, residents, and medical students. Available Monday –Saturday, business hours.

c. Physical therapy: We have 0.5FTE of a dedicated physical therapist in the ED as well as additional assistance from float PTs when there are further consults requested.

d. Occupational therapy: We have a dedicated occupational therapist assigned to the ED. These therapists work with many of our frail older adults and stroke patients. As this is an innovation, the therapists are currently assigned in 4 month blocks so that they become very comfortable with the ED patients and flow.

e. Case management: Our team consists of 6 full time nurse case managers for the ED and Observation Unit as well as a team with oncology care need specialization in the ED section.

f. Social work: Our team consists of 7 full time social workers for the ED and Observation Unit as well as a team with oncology care need specialization in the ED section.

g. Pharmacists: A team of 7 full time specialty practice pharmacists provides 19 hours/day of coverage in the ED.

ED care:

a. Triage Nurses: Triage nurses are experienced ED nurses. They will perform an initial assessment including vitals, document chief complaint, and the patient's Richmond Agitation Sedation Scale (RASS). A nonzero RASS has very good sensitivity and specificity for delirium (Han, AEM 2015). An older adult with a non-zero RASS should also have an ESI of 1 or 2. From our Jan 2018 data (most recent month available), a RASS was documented for 79.5% of ED patients. The nurse will then assign an ESI level and often will order initial diagnostic testing if there is an expected wait of over 30 minutes to get the patient to a bed.

b. Patient flow coordinators: These experienced ED nurses consider the patient flow through the entire ED and help assign patients to the correct area (Cancer ED, Arrival zone (fast track or minor complaints area), critical care bay, trauma bay, general bed, or Observation Unit). A patient with a non-zero RASS is at high risk of poor outcomes and prolonged length of stay and so will be placed in a non-

Obs bed unless no other bed is available. Otherwise, stable older adults without delirium and without active cancer (Cancer ED) will be prioritized for placement in the Observation Unit.

c. Geriatric Assessments: Multidisciplinary geriatric assessment is available to any ED patient and includes physical therapy, occupational therapy, speech therapy (also do cognitive assessments), case manager evaluations of home needs and resources, social work evaluations (mandatory if concern for abuse/neglect), medication review by pharmacy team, and geriatric consultation. Because these assessments are available during business hours only (other than social work which is available 24/7), patients in need of geriatric assessment are placed in the Observation Unit for continued medical care until the following morning. Our older adults have an average length of stay in Observation of 14.7 (±6.5) hours with a goal of <24 hours. A full Observation Unit does not preclude more patients being assigned to observation status and these teams can evaluate patients in any bed in the ED.

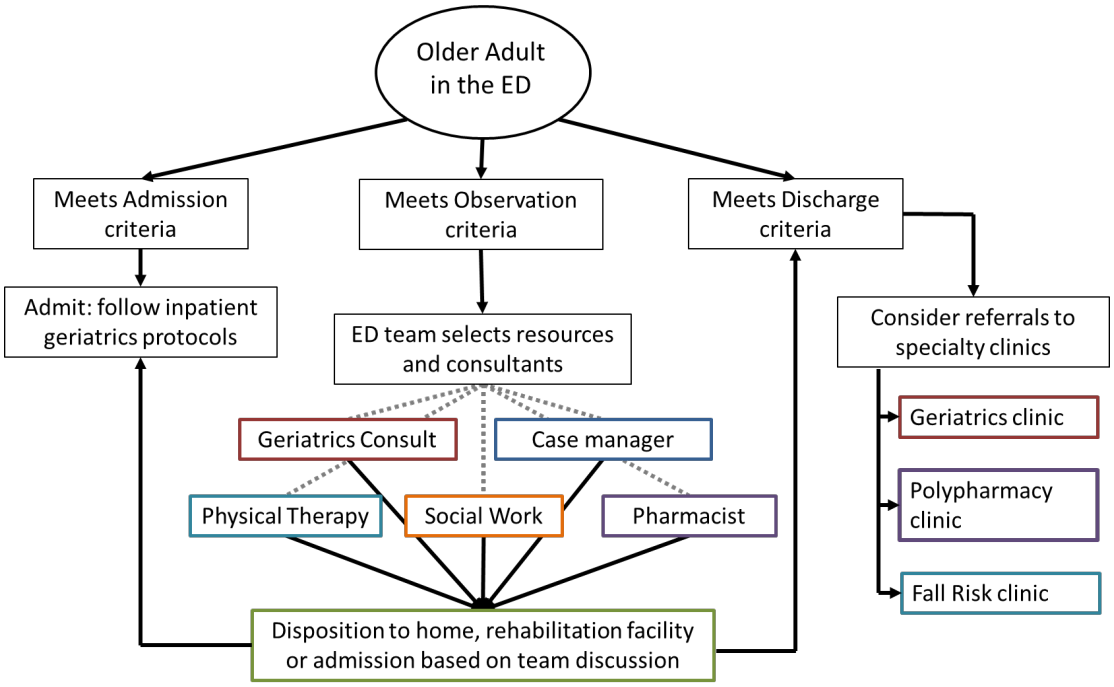


Figure 1: Flowsheet for care of older ED patients. Upon admission, patient to be assessed for appropriateness for the NICHE unit.

ED Observation Unit:

a. Description: The EDOU is a 20-bed unit dedicated to patients who require ED care and interventions that will require more than 4 hours. The unit is staffed by a group of 25 dedicated nurses with training in ED and Observation care. The staffing ratio is 5:1 in addition to a charge RN and two patient care associates. This unit is staffed 24 hours a day. There is a dedicated advanced practice provider 24/7 and ED attending dedicated coverage for 4-5 hours each morning for rounds. After that time period the Observation attending will see other ED patients in addition to the patients arriving in the Observation unit.

There are some rooms with doors, but the majority have curtains. This unit is the furthest away from the ambulance bay, waiting room, and critical care pods and so has the least amount of noise and foot traffic. It was remodeled in 2016 with new paint and flooring. There is a central nurses station that is easily accessible to all and a central food station with coffee, tea, water, and snacks. Unlike the rest of the ED, this unit also has full warm meal trays delivered from dietary for breakfast, lunch, and dinner. Mobility is encouraged.

b. Criteria: The Obs charge RN assess every patient who is registered at triage (this excludes traumas and stroke alert patients and medical resuscitations) for possible Obs Unit protocols. To be in the Observation area, a patient must be an ESI 2 or lower. We have 38 different protocols, including several that are geriatric specific or are commonly used for older adults: Fragility Fracture, Frailty, Transient Ischemic Attack or minor stroke symptoms, Congestive Heart Failure exacerbation, Vertigo, Trauma, AICD firing, Palpitations, Chest Pain, GI Bleed. Please see image of the Frailty orderset below. Any patient whose chief complaint is suggestive of need for one of these 38 defined protocols is preferentially pulled back to the Observation Area. The ED attending and resident will examine the patient per standard care and the ED workup is obtained in that area, including labs, CT scans, etc. If the patient requires observation care, an order will be placed (Place Patient in Observation) which is a change of status only. If a patient elsewhere in the ED is determined to require observation care, the same order will be placed and that patient will be physically transferred to the EDOU as soon as a room is available.

Exclusion criteria for the EDOU include intoxication, acute psychiatric disorder requiring a sitter (e.g., manic episode, suicidal ideation). If a patient is suffering from delirium, a sitter can be assigned to assist with reorientation, management, and safety.

c. Access to Geriatric Care: Observation nurses will perform geriatric assessments for all older adults in the ED Observation unit. This includes the Brief Delirium Triage Screen, 4 Stage Balance Test, and Identifying Seniors at Risk test. The Observation APP or resident caring for that patient will be informed of the results verbally and by their documentation in the medical record. These assessments are built into the EMR as nursing rounding notes. Evaluation by the multidisciplinary geriatric team will be ordered based on the following table:

Table 1: Geriatric Assessments used by the nursing teams and associated outcomes.

Assessment:		**Actions if assessment positive:**
Delirium Triage Screen	98% sensitive for ruling out delirium. Time: 10 seconds.	1. Physician administers CAM ICU or other assessment for delirium. If positive, Geriatrics consult ordered. 3. Delirium precautions.
4 Stage Balance Test	Balance test that improves identification of older adults in the ED at risk for fall. Time: 40 seconds	1. Fall precautions. 2. Physical therapy consult. 3. Case Manager home safety evaluation 4. Geriatrics consult.
ISAR	6 questions on ability to care for self, memory, and medication. Time: 90 seconds	1. Pharmacy consult if ≥5 medications. 2. Case management consult if score ≥2. 3. Geriatrics consult if score ≥2.

Comprehensive Cancer ED

a. Description: A 15 bed area of the ED devoted to patients with malignancies. Has 10 rooms with doors and several with private bathrooms. In addition, there are 5 rooms with curtains for quick assessments or treatments. This area also prioritizes patients with hematologic abnormalities such as sickle cell disease and bleeding diatheses. The cancer ED has its own ED nurses with additional training in oncology (e.g., accessing ports, treating chronic wounds from radiation).

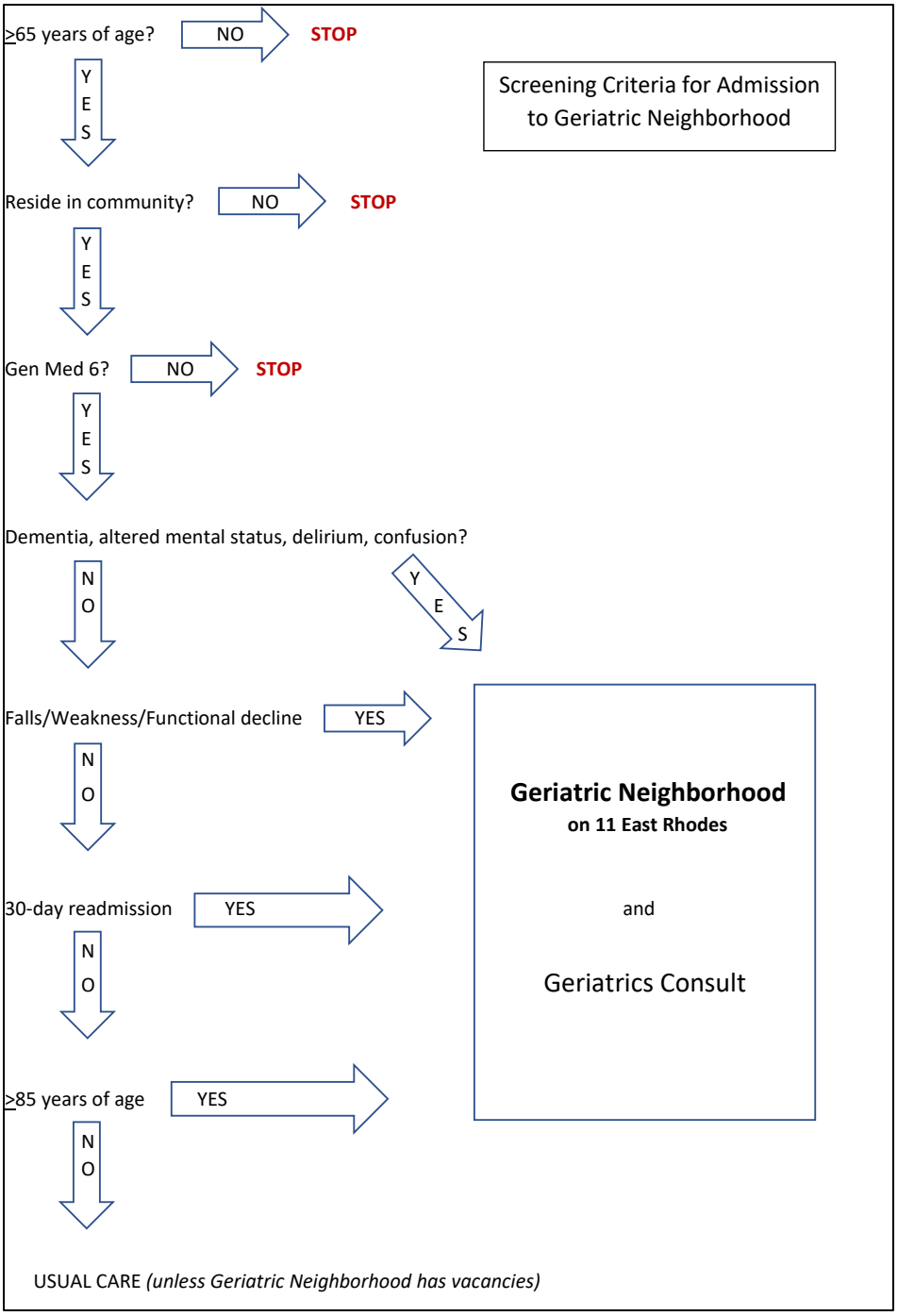
b. Criteria: Every patient who goes through triage is asked if they have active cancer or see a provider at the Comprehensive Cancer Center. The ED trackboard has a special marker to identify these patients and they are prioritized to the Cancer Center ED beds. These unit can take ESI 1 patients, however those with active resuscitations such as CPR are preferentially placed in the critical care pod.

c. Access to Geriatric Care: Cancer nurses will perform geriatric assessments for all older adults in the unit. This includes the Brief Delirium Triage Screen, 4 Stage Balance Test, and Identifying Seniors at Risk test. Evaluation by the multidisciplinary geriatric team will be ordered based on the following table. As these patients tend to be very complex, they are typically admitted for these assessments although being a Cancer patient is not an exclusion criteria for the Observation Unit. Additionally, a specialized

team of oncology case managers and social workers assess each patient during their ED stay. They review home care needs, evaluate for caregiver stress, and offer assistance as needed. This team is available 24/7 and is stationed in the Cancer ED.

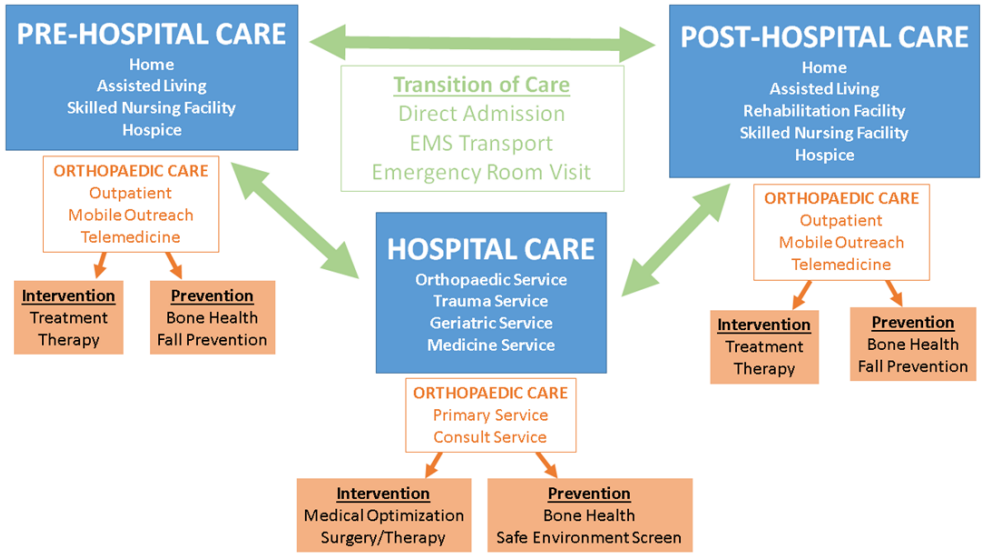
Specialized Admission teams:

a. NICHE Unit: XX achieved Nurses Improving Care for Health system Elders (NICHE) designation in September 2016. This designation demonstrates our medical center's commitment to provide exemplary care for adults age 65 years and older. To improve clinical outcomes by minimizing hospital-associated disability and geriatric syndromes, XX has created a Geriatric Neighborhood (GN) where vulnerable older adult patients are geographically clustered. This neighborhooding allows for consistent care from nursing staff who have attained Geriatric Resource Nurse (GRN) status by completing 20 hours of geriatric-specific nursing education. GRNs champion geriatric best care practices and protocols while role-modeling appropriate technical, problem-solving, decision-making, and communication skills. Staffed by an interprofessional team of experts, this renovated space includes environmental adaptations and a communal area for meals and activities. This Geriatric Activity Room (GAR) provides an open, well-lit space that promotes safety, functional abilities, and socialization. Additional key components of the neighborhood include an innovative nursing care delivery model, geriatric-specific nursing protocols, and an emphasis on patient mobility and function. Admission to the unit is determined by an algorithm (Figure 1).



b. Geriatric Orthopedic service: Hospital's Fragility Fracture Program is a national referral center, caring for the most complex patients and delivering excellent outcomes. It recently secured the highest-level premier certification from the International Geriatric Fracture Society (IGFS) for achieving high marks on key quality indicators, including swift time to surgery, low readmission and mortality rates, and thorough osteoporosis education. Hospital's interdisciplinary team evaluates for risk factors and seeks to prevent future fractures through follow up, such as bone density testing and visits to a bone-health clinic or high-risk osteoporosis clinic as needed. The team will see patients in the ED Observation Unit, where they can be assessed by orthopedics, PT, and endocrinology as part of the **Fragility Fracture protocol**. The orthopedic service also has partnerships with local rehabilitation and nursing facilities to provide orthopedic care on site at the facility. The mobile outreach program can check on patients recovering in their homes. The program also includes a geriatric NP who helps with care coordination and assessment on the orthopedic inpatient service. Any older adult with a fracture who is admitted or placed in the ED Observation Unit will be part of this extensive care coordination program (Figure 2).

Continuum of Care for Orthopaedic Patient



c. Geriatric Trauma service: The trauma service has a co-management model with the Geriatric consultation team for all injured older adults. This collaboration has been very successful and preliminary data was published last year. XX Hospital also has specific trauma leveling criteria that respects the different physiology of older adults (See attached Trauma Alert Criteria). Older adults with "minor" trauma such as isolated rib fractures or head trauma are often monitored for 12-24 hours in the ED Observation unit under our Observation Trauma protocol. Here they can be evaluated by PT, OT, case management team, and geriatrics if indicated.

Trauma Alert Criteria

Trauma is defined as any blunt, penetrating, burn, inhalation, or asphyxia/drowning injury

Category 1 Trauma Alert (Full Trauma Alert)*

- Hemodynamic instability
  - Pulse > 120
  - Systolic BP < 90mm Hg
  - Systolic BP < 100 mm Hg in **geriatric*** patient (* age ≥ 65 years)
- Respiratory distress, unstable airway
- Intubation on scene and Mechanical ventilation (Including inhalation injuries from referral centers)
- Altered level of consciousness due to trauma with a GCS < 8
- Penetrating wounds of the head, neck, torso or extremities proximal to elbow and knee
- Open or unstable pelvis fracture
- Transfer patients receiving blood products to maintain hemodynamic stability
- Judgment of the ED Physician to call or upgrade a trauma activation
- Tourniquet in place for hemorrhage control
- Evidence of paralysis to upper or lower extremities
- Traumatic amputation proximal to wrist or ankle
- Pulseless extremity

Category 2 Trauma Alert

- Patients at risk for significant injury based upon mechanism of injury but without the presence of any criteria for mandatory Category I Trauma alert
  - Ejection from automobile
  - Death in same passenger compartment
  - Extrication time > 20 minutes
  - Falls > 20 feet
  - **Geriatric** fall from any height including standing falls with evidence of TBI
  - Rollover
  - High speed auto crash
  - Auto-pedestrian/auto/bicycle injury with significant (>5mph) impact
  - Pedestrian thrown or run over
  - **Geriatric** pedestrian struck at any speed
  - Motorcycle crash > 20 mph or with separation of rider from bike
- Helicopter scene run (minimum of Category 2 alert)
- Near Drowning or asphyxiation with alteration of consciousness, respiratory distress or other symptoms
- Altered level of consciousness due to trauma with a GCS 9 – 13
- **Geriatric** trauma patient GCS ≤ 14 with a known or suspected TBI
- Open long bone fractures, multiple closed extremity fractures
- **Geriatric** trauma patient with fracture of one proximal long bone sustained in MVC
- Major burn
  - Greater than 20% TBSA
  - Any electrical burn (excluding minor flash burn)
  - Any other associated trauma
  - Upgrade to Level 1 activation if any level 1 criteria are met
- Judgment of the ED physician to call or upgrade a trauma activation

Policies / Protocols Guidelines & Procedures Example

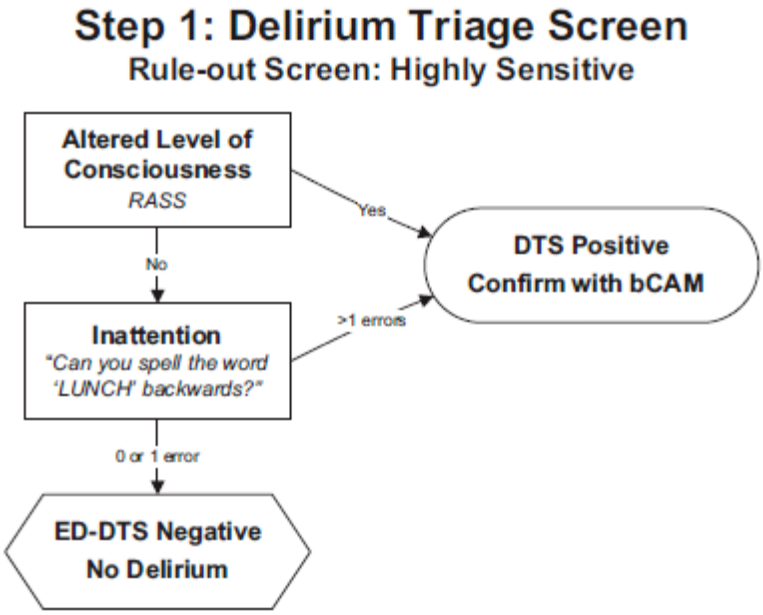
Emergency Department Delirium Screening Guidelines

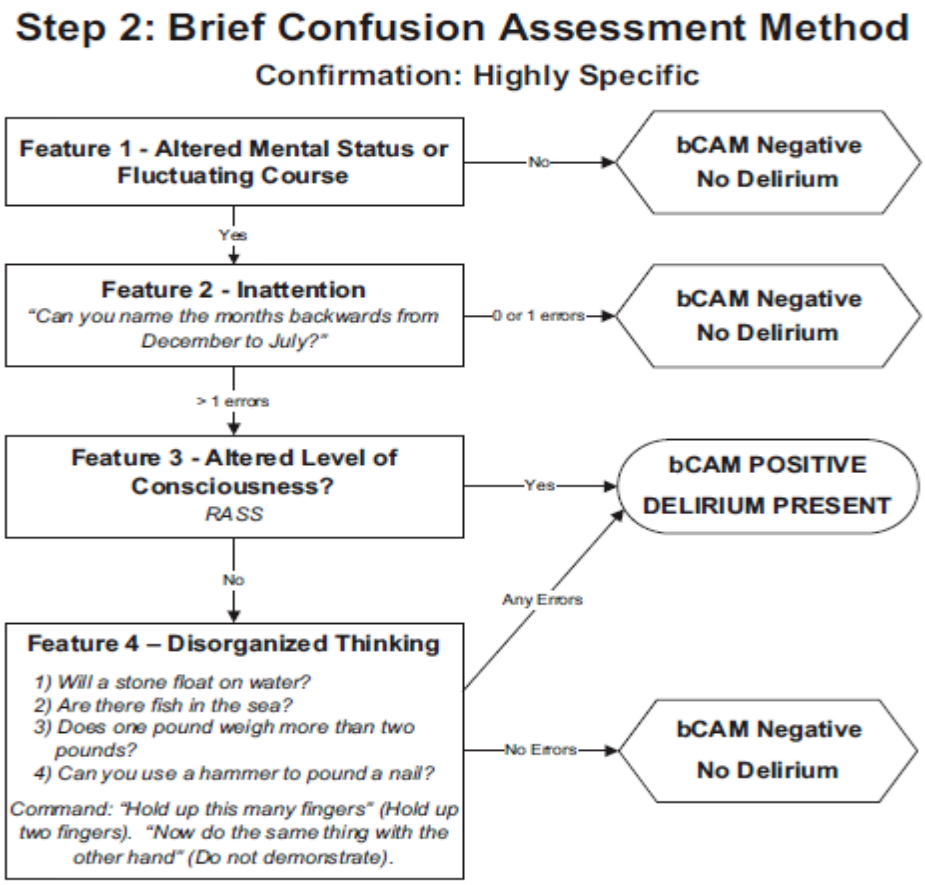
Policy: It is the policy of the Geriatric ED to comprehensively evaluate geriatric adults presenting with delirium, encephalopathy, or an altered mental status. Coordination of care, with special attention to directing interventions towards improving reversible causes and limiting factors that extend or cause delirium is the main goal.

The emergency department will limit the use of chemical and physical restraints to only those situations in which they are absolutely necessary. Appropriate use of medications and alternative safety measures will be maximized to manage the agitated geriatric patient.

Procedure: Validated screening tools will be used to identify patients presenting with dementia and delirium. The assessment for delirium will use a two-step process conducted by the ED physician.

- Step 1 is the highly sensitive delirium triage screen.
- Step 2 is the highly specific Brief Confusion Assessment Method





As mental status changes can wax and wane, delirium screening is reevaluated on a regular basis.

Upon diagnosis of an acute delirium, attention is paid to underlying causes including, but not limited to:

- Infections
- UTI, pneumonia most commonly
- Medications
- Anti-cholinergic medications
- Sedative/hypnotics
- Narcotics
- Any new medication, especially if multiple medications have been recently added
- Electrolyte imbalances
- Alcohol/drug use or withdrawal
- New focal neurologic findings should guide an evaluation for stroke syndromes

Any geriatric patient being admitted to the hospital, regardless of primary diagnosis, should be evaluated for the presence/absence of the following risk factors for the development of a delirium while hospitalized:

- Decreased vision or hearing
- Decreased cognitive ability
- Severe illness
- Dehydration/pre-renal azotemia

Reference:

2013. American College of Emergency Physicians, The American Geriatrics Society, Emergency Nurses Association, and the Society for Academic Emergency Medicine. The Geriatric Emergency Department Guidelines

Policies / Protocols Guidelines & Procedures Examples

Standardized Dementia Screening Protocol

The ED utilizes the Ottawa 3DY tool to screen for dementia:

Ottawa 3DY Questions	Correct	Incorrect
What is the date?	1	0
What day of the week is it?	1	0
Spell "WORLD" backwards: DLROW	1	0
What year is it?	1	0
TOTAL: Score of 4: No cognitive impairment Score < 4: Cognitive impairment; go to STEP 2.		

Step 1: Is there previous medical history of cognitive impairment?

- Yes: Go to Step 2.
- No: Proceed with Ottawa 3DY Questions (1 point for each correct; 0 points for incorrect).

Step 2: Are there behavioral changes (aggression, wandering, yelling)?

- Yes - Initiate Social Work/Case Management consult to discuss access to resources with patient's family.
    - Follow up with possible consult to geriatric psychiatry or geriatrics.
- No - Follow up with PCP, who can decide to initiate referral.

Please see the following screen shot of our EMR.

Policies / Protocols Guidelines & Procedures Example

Protocol for Standardized Assessment of Function and Functional Decline

The ED shall screen patients that meet Geriatric criteria with ISAR

- If 2 or more positive in the 6 questions a Social Work/Case Management consult to discuss access to resources with patient's family

ISAR
1) Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?
2) Since the illness or injury that brought you to the Emergency, have you needed more help than usual to take care of yourself?
3) Have you been hospitalized for one or more nights during the past six months (excluding a stay in the Emergency Department)?
4) In general, is your sight good?
5) In general, do you have serious problems with your memory?
6) Do you take more than three different medications every day?

See the following screen shot in our EMR

Policies / Protocols Guidelines & Procedures Example

Geriatric Emergency Department Protocol/Guideline on Falls in Older Adults

Background: Over half of fallen older patients present to the emergency department for care without disclosing the fact that they sustained a fall. However falls are a sentinel of potential functional decline and define an older adult at high risk for morbidity and mortality. We recognize that it is important to identify older adults with falls. To provide optimal care for our older population we screen all older adults for the existence of fall. We have also developed specific ED falls assessments, interventions, and referrals.

This protocol/guideline goes beyond to the XXXXX Hospital policy on preventing new falls in the hospital setting for older adults. Rather we intend to promote optimal patient safety and preserve function in fallen older patients to limit future falls, morbidity and mortality. This Geriatric Emergency Department Protocol/Guideline is intended to supplement any existing hospital policy, thereby providing additional guidance for fallen older adults in the ED setting.

How is this policy disseminated to EM nurses and physicians?

If EMR reminder, consider including screenshots of the falls protocol reminder.

Procedure:

- All older adults will be screened for occurrence of fall related to the current emergency department visit.
- Patients who screen positively for fall will be evaluated in the ED for both medical cause of the fall and injury resulting from the fall.
- Connection with either inpatient or outpatient care specifically addressing safety in the prevention of future falls and maintenance of function will be made as appropriate.

Fall assessment:

- Screening for falls
  Patients will be asked if *this ED visit* is the result of a fall
  Positive falls screening will be evident to emergency providers in real time as follows: A or B

- Protection from falls in the hospital setting

Protection from fall in the ED/hospital setting will occur as follows: A or B
Examples: Use bed alarm, or non-restraint roll belt
Ensure frequent toileting
Bedrails will be up unless required down for patient care

Clinical interventions:

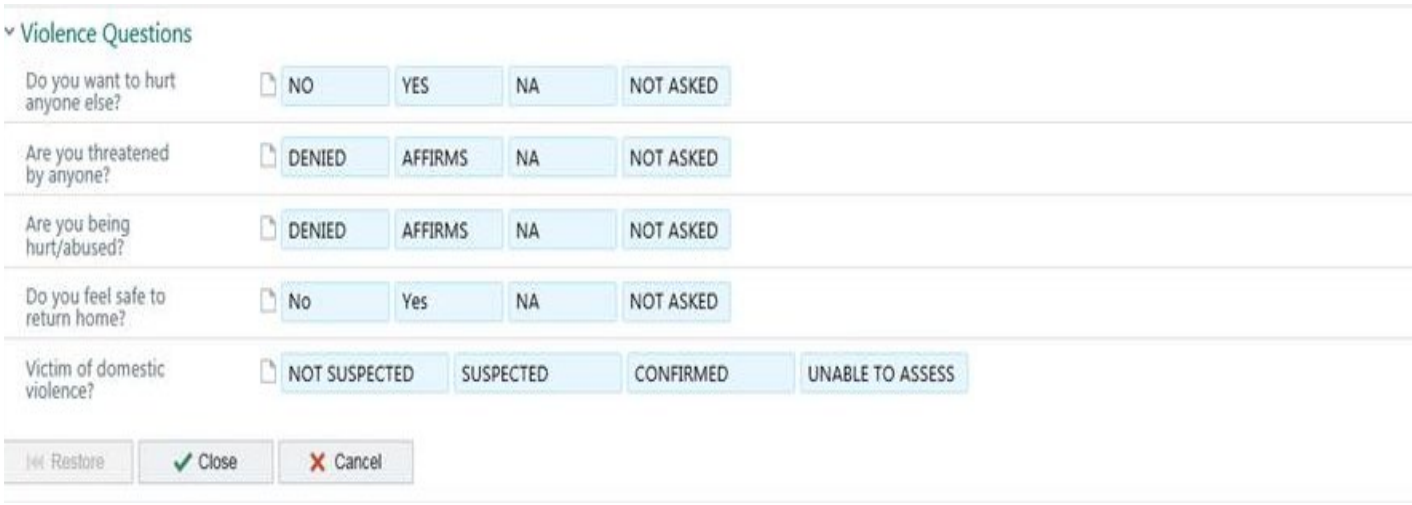
- Assess for medical acute medical conditions or deterioration of chronic medical issues that could have resulted in this fall.
- Assess for existing geriatric syndromes.
- Assess for any trauma as the result of the fall.
- Assess for associated hemorrhage in any fall patient taking anticoagulant medication.
- If possible, a gait assessment will be performed in ambulatory patients as follows: A or B Example: a TUG test will be performed and recorded during the ED visit.
- Abnormal gait assessment is defined as X and will be addressed by Y.
- Discharged patients, who are ambulatory, will be referred to physical therapy or PCP for attention to home safety, mobility, balance, strength and fall prevention.
- Admitted patients who are ambulatory, will have a request for physical therapy assessment as appropriate.

Hospital's Fall Prevention Policy may also be included with application.

Policies / Protocols Guidelines & Procedures Examples

Protocol for Identification of Elder Abuse

- All identified geriatrics patient populations will have a screening questions specific to elder abuse that is done during their initial triage or shortly after arriving to the ED
- For patients who are suspected of suffering from elder abuse or neglect but are unable to provide a response are immediately referred to the on duty social worker



Any positive answers will be referred to attending physician and if appropriate, he or she will initiate a social worker consultation.

Policies / Protocols Guidelines & Procedures Examples

Protocol for Medication Reconciliation with Pharmacist

Hospital-wide Policy	**Title:** Medication Reconciliation
Issuing Department: Pharmacy	

I. Purpose

To accurately and completely reconcile patient medications across the continuum of care and to prevent medication errors.

II. Scope

All Tufts Medical Center prescribers and pharmacists who are involved in providing care to inpatients or outpatients

III. Policy

Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. Medication reconciliation should be performed for every patient with a unique encounter, invasive procedure, or a transition in care in which medication management is clinically relevant. Transitions in care include changes in setting, service, practitioner or level of care.

IV. Procedure

The medication reconciliation process consists of five steps:
1) Develop a list of all current medications regardless of prescriber
2) Develop a list of medications to be prescribed
3) Compare the medications on the two lists
4) Make clinical decisions based on the comparison
5) Communicate the new list to appropriate caregivers and to the patient.

XX Medical Center care providers will make a good faith and reasonable effort to generate a complete and accurate medication list, including the medication name, dose, route and frequency. If after a reasonable effort, a provider in a procedural area is unable to obtain the medication dose, route and frequency, obtaining the medication name is sufficient to ensure safe care is provided for the patient. At a minimum, a good faith

effort includes asking the patient what medications they take and documenting that information.

Medication information is usually obtained from the patient or guardian, but when their ability to provide a complete and accurate list of medications is in doubt, additional sources should be consulted, if possible, recognizing that some of these sources may at times have out-of-date information. Additional sources include:

- The patient's family
- The patient's primary care providers
- Hospital records
- Skilled Nursing Facilities' documents
- The patient's pharmacies

Only a prescriber or pharmacist can make clinical decisions on the patient's medication list and verify the complete medication reconciliation, however collection of the patient's current medication list may be delegated to clinical support staff.

When a discrepancy such as medication omission, duplication, dosing errors, or drug interactions is detected during the reconciliation process, the discrepancy is investigated and corrected. At a minimum, the provider will review the med list, update the medications they manage, and note any identified discrepancies with any other medications they do not prescribe. The Tufts provider will then make a reasonable effort to notify the responsible prescriber of patient non-adherence with high-risk medications, such as anticoagulants, opioids (patients on a pain management contract), antipsychotics, immunosuppressants, or anti-seizure medications.

When an inpatient is discharged or transferred to another facility, the clinician who completes discharge orders reconciles the discharge medications with the patient's preadmission medication list. Upon discharge, the patient or their caregiver will be given written information about the medications the patient should be taking at discharge and advised of the importance of medication adherence.

The patient and, as appropriate, their caregiver will be given a copy of their updated list of medications by the prescriber or his/her designee and a copy will be sent to the known next provider of service (PCP, referring physician or facility). A copy of the discharge medications will be retained in the patient's medical record.

ACEP Geriatric Emergency Department Accreditation

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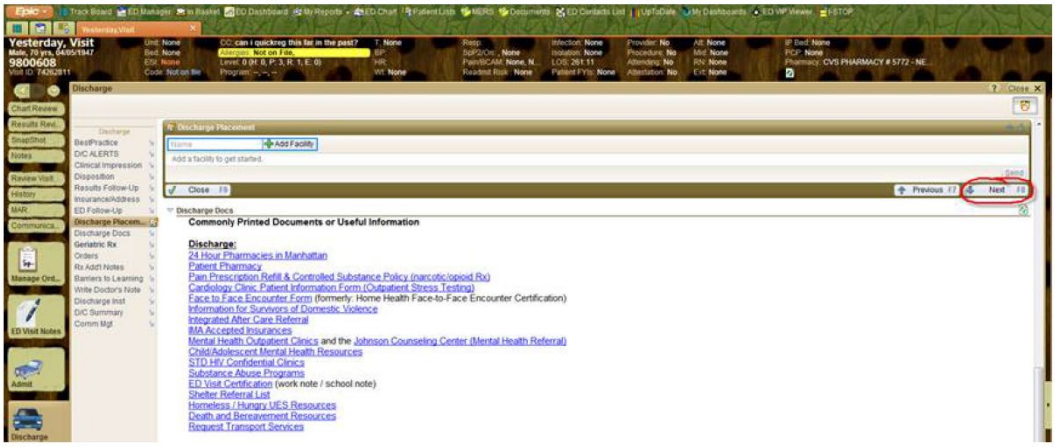
Potential Inappropriate Medication

Please use the new EPIC Geriatric Rx discharge order set for all patients 65 and older.
It will help you safely discharge older adults by avoiding potentially inappropriate medications (PIMS).

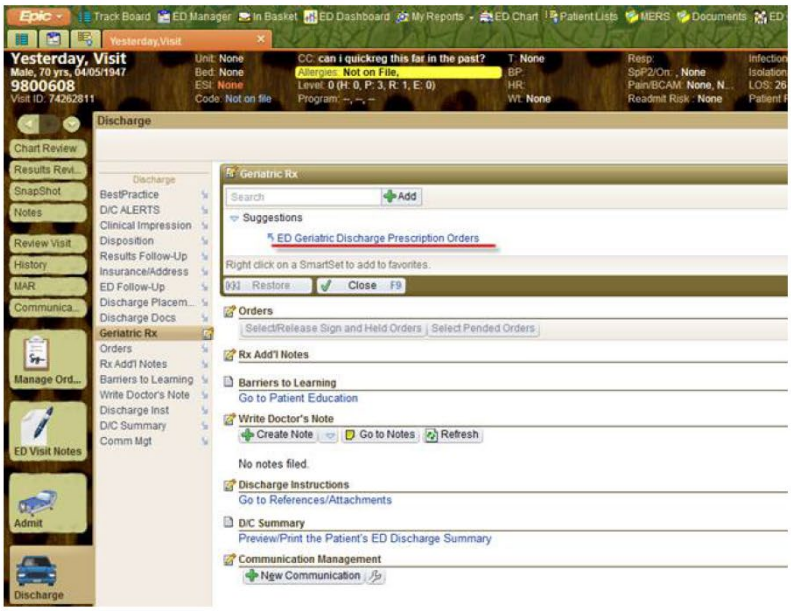
The Geriatric Rx order set can be found in EPIC here:

ED Geriatric Discharge Prescription Order Set

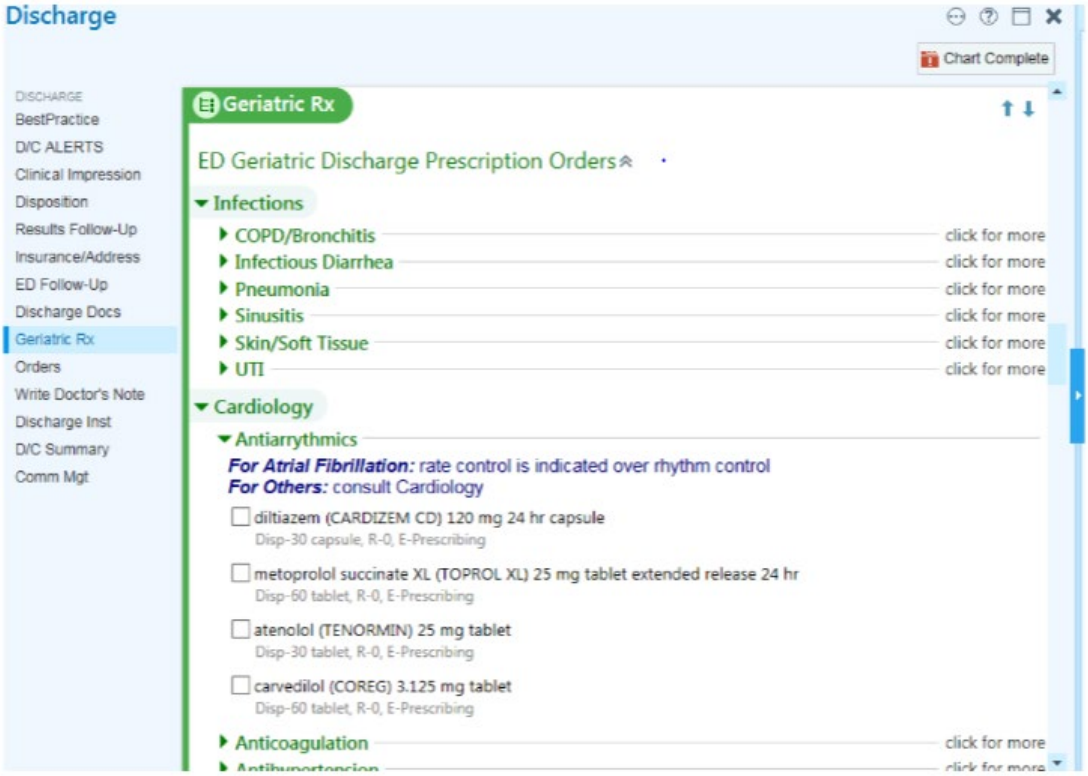
For geriatric patients in the Emergency Room, the Discharge activity will have a new navigator, Geriatric Rx.



Following the standard discharge navigator, selecting Next from the Discharge Placement navigator will take you to the Geriatric Rx navigator



The Geriatric Rx navigator displays the suggested order set ED Geriatric Discharge Prescription Orders. Click on the order set hyperlink and start placing prescription orders.



The Geriatric Rx order set is part of the EQUIPPED Project, a multi-site process improvement project. It is based on the evidence-based Beers Criteria/ List of PIMS (potentially inappropriate medications) - these are medications for which risk usually outweighs benefit for older patients.

Our goal is to reduce our current rate of PIMS discharge prescriptions.

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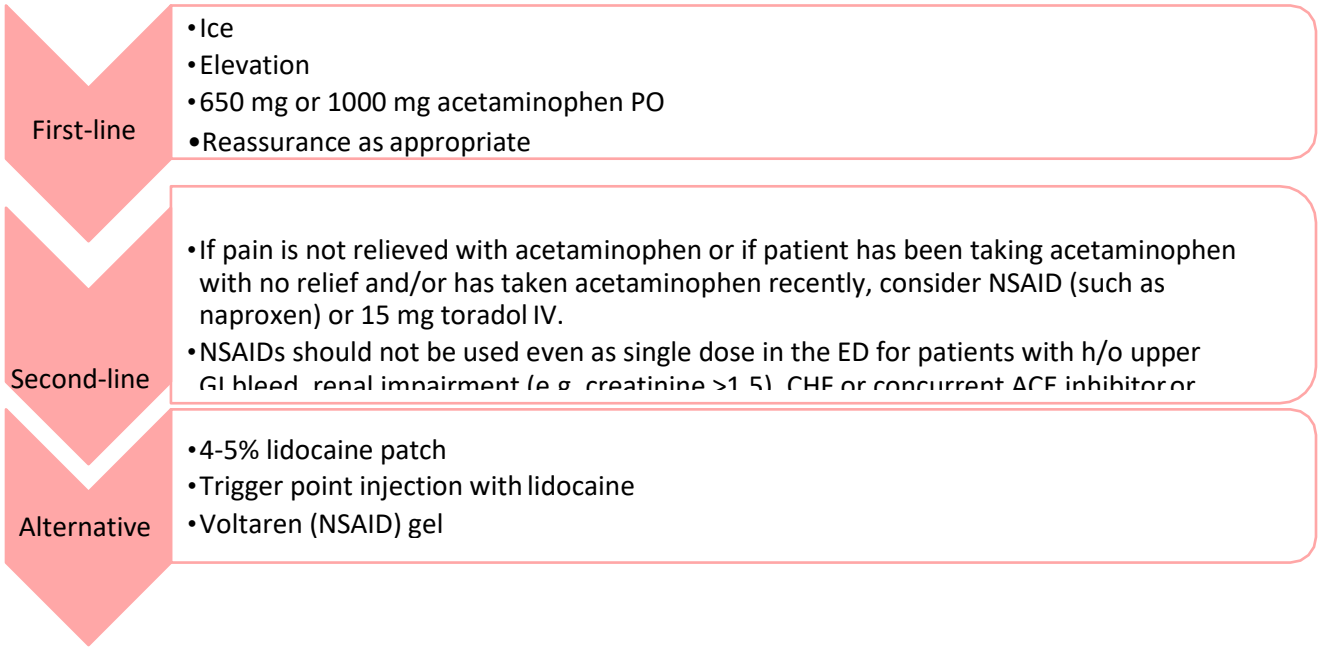
Acute Pain Management in Older Adults

I. Description

Pain medications can have significant side effects in older adults, as well as potential interactions with other medications. These guidelines serve as a suggestion for possible medications that can be used in older adults in an attempt to minimize side effect risk, while still managing pain. As with all medication selections, it is important to weight the individual risks and benefits.

II. Protocol/Guideline Procedure



For severe pain in the ED:

- Toradol IV (if no NSAID contraindication - see above).
- Acetaminophen PO (if okay to give meds PO).

Second

- 2-8 mg morphine IV (1-4mg if frail) with dosing and repeat dosing based on patient weight, expected tolerance, and pain severity.
- Oxycodone 2.5-5mg Oral
- Femoral nerve block in patients with hip fracture who do not respond well to initial opioid dose.
- 0.15 mg/kg ketamine IV can be considered, and caution should be given in patients with known CAD due to potential tachycardia

Discharging Patients

Non-pharmacologic

- Discuss with patient the importance of physical activity, mobilization of injured area, physical therapy, sleep, and reducing social stressors.
- Emphasize that the above behavioral activities are safer and have a bigger effect on long-term outcomes than pharmacologic therapies.
- Include family or caregivers in treatment plan.
- Encourage continuity of care with PCP.

Pharmacologic

- 650 mg acetaminophen PO TID
- 500 mg naproxen twice a day or 400-600 mg ibuprofen TID (naproxen is preferred for patients with h/o CAD due to lower risk of CV events). Educate to stop medication if patient develops stomach pain. Again, avoid in patients with contra-indications to NSAIDs, the very old or frail, and those on ACEI/ARB medications, as it can precipitate acute renal failure.
- Topicals such as lidocaine patch 4-5% applied once daily for 12 hours, or voltaren gel applied three to four times a day to the painful area.
- Neurontin is an effective medication in older adults and is quite safe, but the dosing needs to start low and increase incrementally. This is best for pain conditions that are likely to be chronic and for neuropathic pain (e.g. diabetic neuropathy, herpetic neuralgia), but is not limited to these conditions.
- Consider PRN opioids such as oral morphine, hydrocodone, oxycodone. Emphasize that each of these medications can be addictive and should only be used if needed for pain treatment. Discuss prevention of constipation and falls if opioids are given. Prescribe low doses and explain that they should only be used as needed for breakthrough pain. Also prescribe peri-colace (combination colace/senna) to prevent constipation.

It is important to communicate the need for follow up with their regular physician for reassessment of their pain and pain management. Additional, multi-disciplinary pain management and improvements in function may be achieved through physical therapy, exercise, or follow-up with a specialty clinic such as the spine clinic for back pain, or with PMR.

III. Dissemination and Implementation

This guideline will be disseminated to the nurses, physicians, and APPs. In addition, it will be emailed out at regular intervals as part of the “daily dose” administrative reminders email series to the physicians. Recommendations and references/resources for further reading or education regarding pain management in older adults will also be sent to the physicians.

Policies / Protocols Guidelines & Procedures Examples

Accessing Palliative Care Consultation

Palliative care cases are brought to the Nurse Navigator. The Geriatric-Palliative Nurse Navigator is responsible for evaluating and referring patients as necessary.

- Assess patient's performance status using the ECOG and Karnofsky Scales.
- Determine Health Care Proxy
- Obtain goals of care through a family meeting. Provide and assess patient/family education on disease processes, diagnosis, and prognosis in patients with potential life limiting diseases.
- Provide support and assess patient/family desires for end of life
    - Advanced Directive /POLST? Yes: copy present, will be brought in, exists in prior record, other; No: discussed with patient, completed in ED
    - Determine Health Care Proxy
- Determine whether patient is Hospice appropriate
- If patient is to be admitted, then arrange a consult for inpatient palliative care
- If patient can be discharged on home hospice, arrange with case management and in-house hospice agency
- If at end of life, ensure that LSMA protocol is carried out by staff

LSMA Protocol

Purpose: To provide the patient and their family with dignity and respect at the patient's end of life. This will be provided through a peaceful and caring environment, with excellent medical and nursing care.

Patients will be moved to room 50 or 51 if the following criteria are met:

- Patient and/or family have a consult with the palliative care team or ED physician
- Patient and/or family agrees to hospice admission
- Patient and/or family is aware the patient will expire in a short time frame

The patient will reside in one of these rooms until a hospice bed is available or patient expires.

<u>If a patient meets the above criteria, the nurse is to open a room immediately and accept the patient regardless of which ED physician is assigned to them.</u>

When a patient is assigned to an LSMA room, the following should be performed ASAP:

- Unnecessary medical equipment removed from room (rolling cabinets, biohazard receptacle, etc.)
- Extra chairs provided for family/friends
- Lighting dimmed to family's desired setting
- TV channel should be placed on 54, the serenity channel
- Allow additional family at bedside – as long as it does not interfere with patient care
- Call for clergy, if desired by family
- Provide comfort care for family as well as patient (tissues, food/fluids, etc.)
- If a patient liaison is present, inform them to provide additional time for the family
- Be observant of the noise level at the nurse's station

Additional care that will be needed:

- Turn patient q2h – as indicated
- Oral care q2h - as indicated
- Discontinue vital signs
- Discontinue cardiac monitoring
- Discontinue labs and radiological studies
- Foley catheter as needed for urinary retention
- Consider discontinuing IV fluids or titrating down – prevent edema and congestion
- Rounding q30 minutes
- Avoid suctioning when possible

Please allow family to enter and leave through outpatient registration entrance.

Please ensure that you assess for the following:

1. Pain and Dyspnea
    - Consider Morphine IV drip or Morphine IV bolus – document a reason for each bolus or titration
2. Nausea/Vomiting
    - Consider Zofran IV and/or Prochlorperazine PR
3. Anxiety/Agitation/Depression
    - Consider Lorazepam IV or PO
4. Delirium
    - Consider Haldol 0.5-1 mg IM
5. Terminal Congestion/Death Rattle
    - Consider Atropine 1% Ophth solution: 2 drops SL q6h or Scopalomine patch 1.5mg
    - Consider Artificial Tears 2 drops OU q2h as may be needed

ECOG Performance Status

ECOG	Description
0	Fully active, able to carry on all pre-disease performance without restriction.
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.
4	Completely disabled. Cannot carry on selfcare. Totally confined to bed or chair

Karnofsky Performance Status Scale

Karnofsky Performance Status Scale

Able to carry on normal activity and to work; no special care needed.	100	Normal with no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs and symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or do active work.
	60	Requires occasional assistance, but able to care for most of his/her personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death is not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

Figure 2. The Karnofsky Scale, introduced in 1948, was among the first scales developed to assess a patient's performance on a regular basis.

Policies / Protocols Guidelines & Procedures Example

Geriatric Psychiatric Care Guideline

I. Description

This procedure describes how physicians at can access psychiatric care for geriatric patients in general, as well as specifically the geriatric psychiatry service.

II. Rationale

Psychiatrists are not available in person in the hospital or ED, however, patients may present with acute psychiatric concerns. This procedure describes how we can access consultation with a psychiatrist, and, if needed, transfer the patient specifically for geriatric psychiatry specialty care to the Medical Center.

III. Policy/Procedure For patients requiring a Psychiatric emergency department consult:

- For behavioral health patients, assess for safety and need for psychiatric consultation.
- If the patient meets criteria, page the Psychiatry Emergency Service (PES) pager during hours when they are in the hospital.
- The patient will be held until tele-psych consult is available.
    - The PES team will give an estimate of timeline when consulted. The patient will be evaluated in the queue with Med Center patients.
    - During hours when the PES team is not available (on the overnight), the providers will initiate the consult at 9am. The overnight attending will need to relay a need for PES consult to the 7am-3pm attending who will call the PES consult.
- Based upon the results of the PES assessment, a disposition for the patient will be facilitated. If needing transport, see below.
- IVC Process
    - For those patients who need an IVC, proceed with completion of the paperwork and magistrate process. Patients who have an IVC can be transported with the assistance of Hospital Police.
    - If you feel that a patient needs psychiatric evaluation, but do not need to initiate an IVC (the patient wishes transport to the Medical Center on a voluntary basis), you can arrange for transport via AirCare. Patients who are non-IVC can be transported, with their agreement, by Air Care with Hospital Security in the vehicle for the sole purpose of preventing harm to Air Care staff during transport. These patients should only be transported with their voluntary consent – if the patient is unwilling to go voluntarily and the provider is not comfortable allowing them to leave, the only other option is to initiate the IVC process. Hospital security cannot detain a non-IVC patient against their will. At no time can we advise or otherwise communicate to the non-IVC patient that they cannot leave the hospital, nor can we transport them against their will.
- Hospital Police assistance with voluntary psychiatric patients is not mandated but if medical staff feels there may be a safety issue a Security Officer may assist with the transport.
- If the patient requires specifically geriatric psychiatry specialty care, the usual process for transportation from the ED to the medical center should be followed. Once the patient is in

the Medical Center, the PES team can be called to perform an evaluation and facilitate admission to the geriatric psychiatry service.

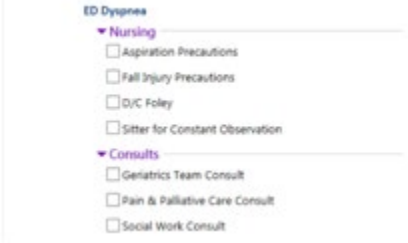
Policies / Protocols Guidelines & Procedures Examples

Development & Implementation of at Least Three Order Sets for Common Geriatric ED Presentation

- In addition to Geriatric Nursing and Consultation specific sections, we have created a "Quicklist" order of common geriatric weight-based dosing to be utilized as a prompt to standardize care in the ED
- Furthermore, a new NPO order for the geriatric population will be used to allow renewed focus on maintaining patients on NPO status
    - 

1. Syncope
    a. Standard ED syncope evaluation in addition to

2. Dyspnea
    a. Standard ED syncope evaluation in addition to



3. Delirium


Order Sets
Clear All Orders
HOSP: Elderly Delirium Orders Manage My Version
- Milliman Guidelines weblink
Elderly Delirium Orders
Labs
BMP
BNP
Hepatic Function Profile
Ammonia Level
CBC w/ Diff and Platelet Ct
Vitamin B12/Folate Levels
Urinalysis Reflex to C & S
Urine Drug Screen, #2 (Medical)
TSH Reflex to Free T4
ABG
Calcium, Ionized
Blood Culture x2
Glucose Meter
ONCE, STAT
Blood Culture x2
Glucose Meter
ONCE, STAT
Lumbar Puncture
Studies
EKG, 12 Lead
CXR
MRI - Brain Stroke Protocol Panel
CT - Brain
EEG Routine
Medications
Haldol 0.5 mg PO
Haldol 0.5 mg IM
Haldol 0.5 mg IV
Nursing
Aspiration Precautions
Fall Injury Precautions
Seizure Precautions
D/C Foley
Sitter for Constant Observation
Consults
Neurology Consult
Geriatrics Team Consult
Consult to Behavior Health Services (MCLT/Psychiatry CL)
Ad-hoc Orders
Search
You can search for an order by typing in the header of this section.
Close
Previous
Next

Policies / Protocols Guidelines & Procedures Example

Guideline for Use of Urinary Catheters for Older Patients

Background:
CAUTIs (Catheter associated urinary tract infections) are the most common hospital-associated infections and 70-80 percent of these infections are attributable to an indwelling urethral catheter. [1] Catheter use is also associated with negative outcomes other than infection, including mechanical trauma, immobility and sepsis. The length of time that a catheter is in place contributes to infection. so limiting catheter use and duration are important to preventing infection.[2] A urinary catheter should only be inserted when medically necessary due to the potential risk of infection.

Purpose: This guideline follows the recommendations of the CDC and the XXX Health System policy on Urinary Catheters

Indication: Indication for placement of indwelling Urinary Catheter in the ED includes the following, and an active order for catheter placement from a physician/NP/PA is required:

- Urinary retention/obstruction
- Critically ill patient or trauma patient requiring close monitoring of output
- Stage III or stage IV pressure ulcer or wound with urinary incontinence
- Patient with hematuria requiring continuous bladder irrigation
- Neurogenic bladder
- Emergent surgical candidate
- Patient receiving palliative care if indicated
- Additional documentation by LIP/PA required for other indications

Procedure: follow procedure noted in AHS policy

Alternatives to urinary catheter: Consider use of external catheter (condom catheter for men, external female urinary collection system for women) for patients with limited mobility, unmanageable urinary frequency or incontinence with need for strict measurement of output.

Dissemination: This policy is emailed out monthly as part of the "Daily Dose" of best practices. It is also available for reference 24/7 within the hospital/ emergency department intranet.

References:

1. Weber DJ, et al: Incidence of catheter-associated and non-catheter-associated urinary tract infections in a healthcare system. *InfectionControl and Hospital Epidemiology.* 2011 August;32(8):822-823
2. Centers for Disease Control and Prevention (CDC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Guidelines for the prevention of catheter associated urinary tract infections. (2009).

Policies / Protocols Guidelines & Procedures Examples

NPO Designation

POLICIES:

Diets are ordered through the electronic medical record or in writing by the responsible physician prior to the service of the diet.

PROCEDURE:

Physician

- **Writes/enters diet order** in medical record/information system.
- Uses **terminology** under "How to Order the Diet" heading of the facility approved addendum to the diet manual.
- Rewrites entire diet order when any component of a **combination diet** is revised.
- Writes a diet order for "NPO" when a patient is not allowed oral intake.
- Writes new diet order to resume oral intake for **patients who have been NPO.**
- Orders **"tube feeding"** and specifies the formula, rate, strength and hours over which the feeding will be given. Orders amount of free water flush. Orders any oral diet to accompany tube feeding (i.e. clear liquid).
- Specify total milliliters (ml) for **fluid restriction**, and whether fluid restriction applies to liquids taken by mouth only or to liquids taken by mouth plus I.V.

DIET ORDERS (Continued)

- Specifies **kosher** food in addition to diet order when appropriate. Kosher

food also served at patient request.

- Contacts Clinical Nutrition Manager for approval of any **diet not in diet manual.**

- Notes any food allergies or sensitivities.

Clinical Nutrition Manager/Designee:

- Arranges for a Diet Census Report to be printed at set times. At a minimum, the report includes the patient's name, diet order, the second identifier (usually birthdate), food allergies, and any additional notes needed to provide the diet as the physician intends.

- Approves any ordered diets and/or special diets that are not in diet manual.

- Interprets diet orders that are inconsistent with the diets listed in the diet manual addendum. Provides a reference for use by Food/Nutrition.

- Interprets orders for tube feedings and nutritional products not on the formulary. Provides a reference for use by Food/Nutrition.

- If information about between meal feedings is not included on the Diet Census Report, establishes a system to maintain this information.

Food/Nutrition:

- Keeps the most current copy of the Diet Census Report readily available for reference. Updates the information on the report, as changes are made, until the next report prints.

- Uses the information on the Diet Census report to manage the accuracy of the menu for each patient.

- Accommodates special diets and altered diet schedules.

- Contacts nursing to determine Nursing/Food & Nutrition split of fluid allotment for fluid restricted diets.

- Serves meals/snacks after receipt of a written order via the hospital information system. Verbal orders are not accepted.

Nursing:

- Notifies Food/Nutrition of the action to be taken.

DIET ORDERS (Continued)

IN THE EVENT OF PHYSICIAN ORDER FOR	REQUEST FROM FOOD/NUTRITION AS APPROPRIATE
Test/Therapies	"First Out"/"Early
Isolation	"Isolation"
Suicide Precautions	"Plastic Utensils" "No Knives"
Fluid Restriction	Fluid allotment from Food/Nutrition: ml of total. **
Discontinuation of orders, e.g., Fluid Restriction	D/C Fluid Restriction

Other trays must be held in kitchen, since there are not adequate food-holding facilities on the floor.

**Nursing records fluid division in nursing information system

Volunteer Engagement

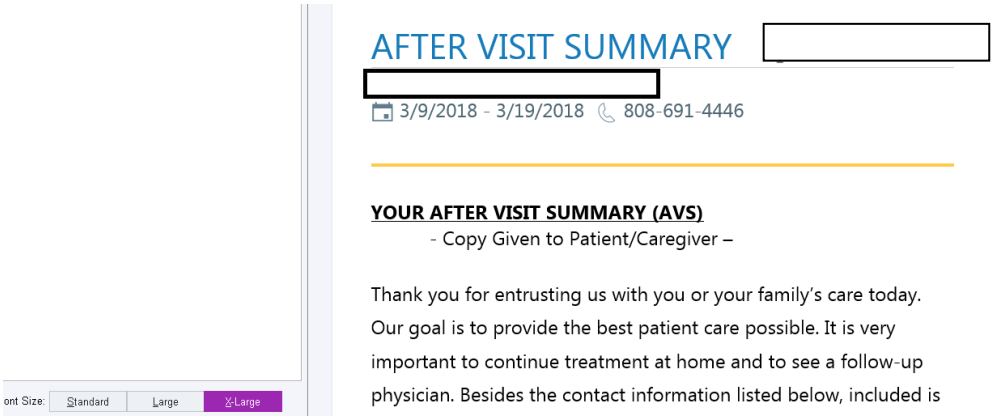
The GEDA allows us to provide a perfect blend of impactful work in the ED and meaningful patient experience.

- Volunteers are typically present in the ED for 4-6 hours a day
- At the top of the hour the volunteer(s) checks with the charge nurse to see which geriatric patients require comfort rounding
- We will focus on those 75 years or older and designated as an admission (typically 1-2 patients at any given time), if none than any 75+ patient
- The support will include distributing reading material to patient or reading to patient, holding conversation with the patient, offering and providing comfort such as blanket/pillows
- The volunteer will spend at least 30 minutes with the patient unless the patient prefers to be left alone
- The volunteer will communicate with the ED tech or RN any needs or questions the patient or family has

Policies / Protocols Guidelines & Procedures Examples

Protocol to Standardize Discharge Protocol for Patients Discharged; Addressing Age Specific Communication Needs

- The ED shall provide individualized discharge instructions for geriatric patients, with special consideration age-specific communication which includes
    - Large font for discharge instructions
    - Utilizing hearing assist devices, and language assistance per policy 610-18-118-A (Language Assistance Policy).



Protocol for PCP Notification

Every ED patient is asked who their primary care physician is upon registration. That information is listed under the PCP tab. At discharge, a written notification is sent to the PCP either through EPIC inbox or by mail. This is done automatically.

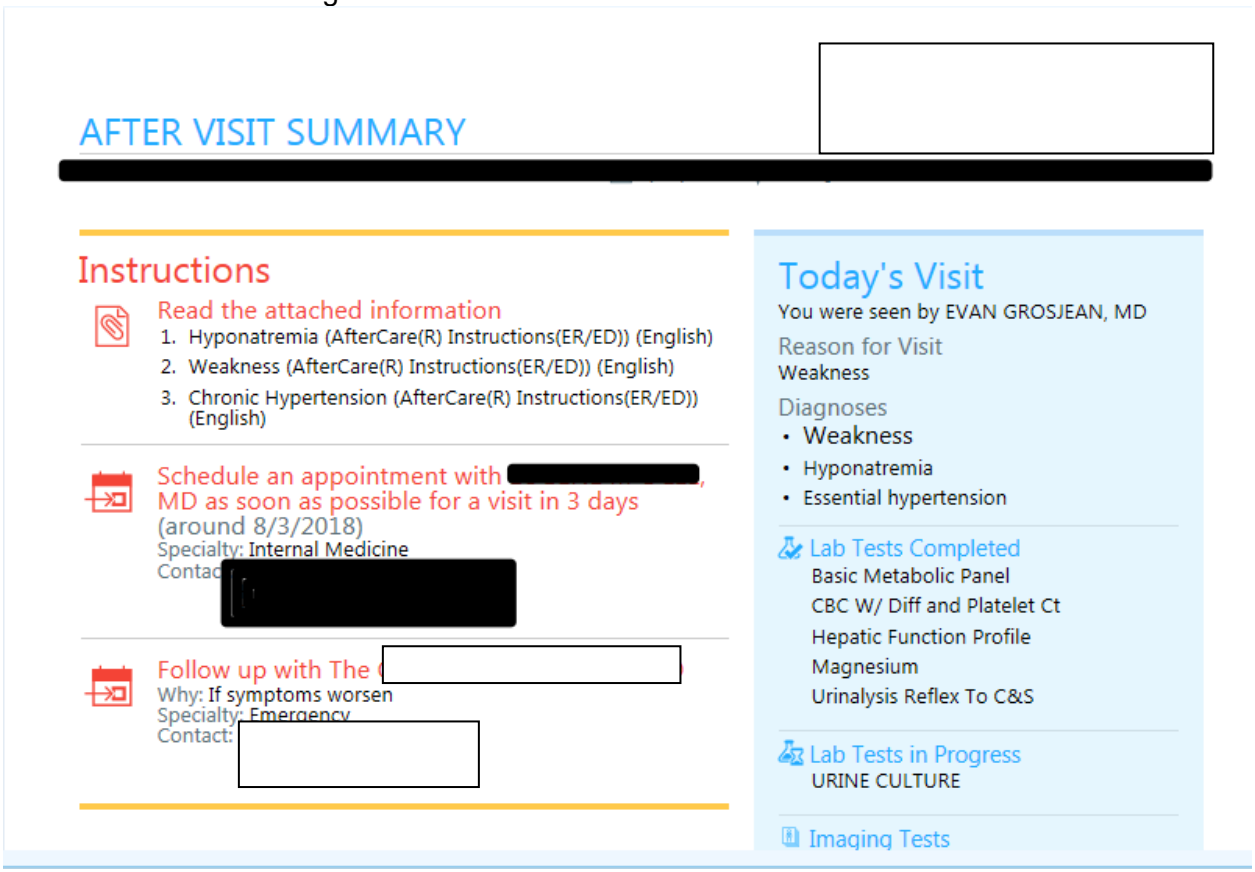
Adherence to PCP Notification

As this system is automated, there is no way (short of calling the PCP) to ascertain if they received notification. We will consider compliance as: documentation of a PCP or of patient being provided assistance in how to obtain a PCP.

Policies / Protocols Guidelines & Procedures Examples

Protocol to Address Transition of Care to Residential Care

- Discharge instruction and after visit summary is printed and shows test results, diagnosis for visits, and treatment to be continued or discontinued
- Nursing staff in the ER are also required to sign out to nursing staff in nursing facilities via phone regarding workup and treatments that were performed in the ER
- If the PCP listed is the nursing home physician they will receive an automated fax summary of care at time of discharge



AFTER VISIT SUMMARY

[redacted]

Instructions

Read the attached information

1. Hyponatremia (AfterCare(R) Instructions(ER/ED)) (English)
2. Weakness (AfterCare(R) Instructions(ER/ED)) (English)
3. Chronic Hypertension (AfterCare(R) Instructions(ER/ED)) (English)

Schedule an appointment with [redacted], MD as soon as possible for a visit in 3 days (around 8/3/2018)
Specialty: Internal Medicine
Contac[redacted]

Follow up with The [redacted]
Why: If symptoms worsen
Specialty: Emergency
Contact: [redacted]

Today's Visit

You were seen by EVAN GROSJEAN, MD

Reason for Visit
Weakness

Diagnoses
- Weakness
- Hyponatremia
- Essential hypertension

Lab Tests Completed
Basic Metabolic Panel
CBC W/ Diff and Platelet Ct
Hepatic Function Profile
Magnesium
Urinalysis Reflex To C&S

Lab Tests in Progress
URINE CULTURE

Imaging Tests

Policies / Protocols Guidelines & Procedures Examples

Protocol to Minimize use of Physical Restraints

Background: Older patients may be more prone to issues of delirium, altered mental status, depression and dementia. The ED is an unfamiliar environment and older patients may be very afraid. Providing reassurance and modifying the environment may help to reduce the need for restraints. If physical restraints are used for geriatric patients, they should only be used as a last resort, in the least-restrictive manner, and for the shortest possible time.

This protocol/guideline conforms to the XXXXX Hospital policy on physical restraints, which is in compliance with the Joint Commission and XX state Department of Health. The goal of XXXX Hospital is to preserve the rights, dignity and safety of our patients by utilizing nonphysical interventions wherever possible and to minimize the use of restraints when they become necessary to ensure the immediate physical safety of the patient or staff member. This Geriatric Emergency Department Protocol/Guideline is intended to supplement the hospital policy, providing additional guidance for older adults in the ED setting.

Procedure:

- Restraints may not be used as part of a falls prevention program
- Restraints may not be used because of patient/family request
- Appropriate use of alternatives to physical restraints should be implemented prior to the use of physical restraints

Alternatives for physical restraints:

- Modifying the Environment
  - Call bell within reach
  - Maintain quiet, dark environment at night as possible
  - Promote mobilization during day time hours
  - If possible, have patient out of bed in recliner during the day
  - Use bed alarm if patient is a falls risk, or non-restraint roll belt
  - Ensure patient has access to hearing device and/or glasses as needed
  - Ensure patient has access to dentures as needed
- Psychological interventions
  - Engage patient in conversation (use volunteers if available)
  - Maintain non-threatening body language and tone of voice; keep your hands in sight when possible, avoiding gestures or rapid movements that may be misinterpreted as aggressive
  - Talk clearly, slowly repetitively
  - Use interpreters if difficulty with comprehension of the language
  - Provide explanations of procedures to decrease fear and anxiety
  - Promote family presence at bedside
  - Use relaxation techniques: back rub, massage, healing touch with patient permission
  - Use music therapy via headphones or through TV channel

- Try distraction techniques such as use of activity belt or art project if appropriate

- Clinical interventions
  - Assess and treat pain
  - Minimize bothersome stimuli
  - Cover tubes, catheters with gown, or wrap IV in gauze
  - Remove catheters and drains as soon as possible
  - Ensure frequent toileting
  - Change position frequently
  - Ensure patient has regular mealtimes, assist with feeding if necessary, and check if patient hungry

Use of a trained companion/sitter

In the event that a patient is at danger from self-harm they may need to be placed under supervision in the ED zone designated for patients requiring watch or under 1:1 supervision of a specially trained sitter.

A trained sitter may also be required for those patients where other alternatives have been tried without success and patient is at danger from falling due to agitation or confusion.

Policies / Protocols Guidelines & Procedures Example

Referral to Geriatrics Specialty Clinic and REACH Home Visit

Geriatrics Specialty Clinic

I. Description

This guideline describes the referral process for patients from the ED to the geriatrics specialty outpatient clinic. The outpatient clinic provides primary or consultative care by physicians, nurses, social workers, and pharmacists who have specific expertise in geriatrics, geriatric medication management, and geriatric syndromes.

II. Rationale

Many older adult patients have complex care needs that involve geriatric syndromes such as frequent falls, polypharmacy, recurrent UTIs, delirium, and dementia, among others. These syndromes can be difficult to address in the ED and will often benefit from holistic outpatient evaluation and management including care from a geriatrics-trained internal or family medicine physician as well as a geriatrics-trained pharmacist. Patients who have visits to the ED and who have complex care needs or geriatric syndromes can be referred to the geriatrics specialty clinic at the discretion of the treating ED physician or APP. There is no age cutoff below or above which the referral can be used. The geriatrics clinic can serve as a primary care source, but patients can also continue to see their regular primary care physician and visit the geriatrics clinic as a specialty, or consultant service. A referral can be placed for patients who are admitted as well as those who are discharged.

Some indications for which to consider referral:

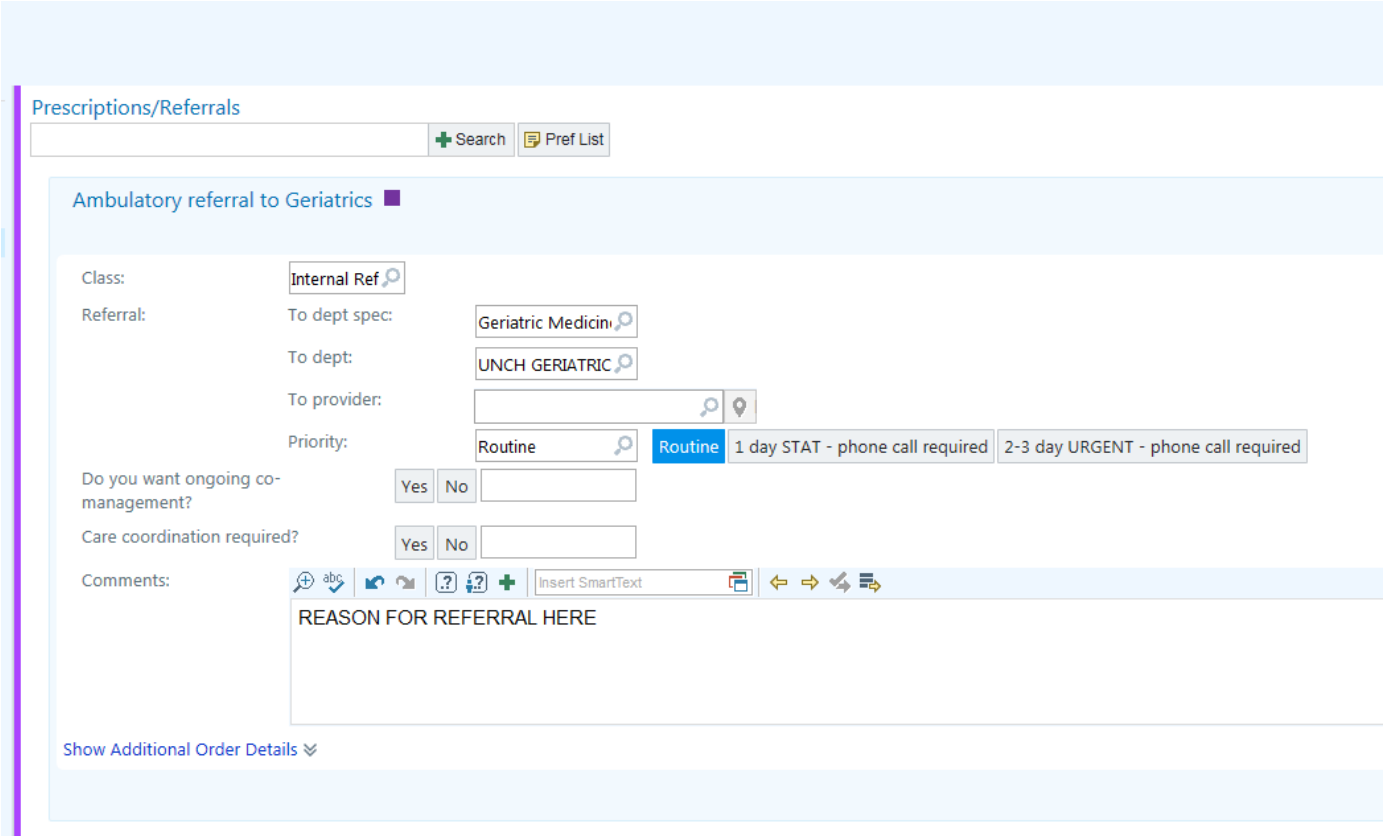
- Complex medical co-morbidities that lead to ED visits
- Polypharmacy, particularly if causing side effects or leading to ED visits
- Recurrent ED visits or hospitalizations
- Poor management of chronic medical conditions
- Apparent caregiver of family stress, lack of understanding, poor medical literacy, or lack of resources that has not been adequately addressed by existing healthcare contacts
- Need for goals of care conversations
- Poorly controlled symptoms that could benefit from palliative care expertise
- Failure to thrive
- Recurrent falls or gait instability
- Delirium
- Dementia associated with symptoms that prompt ED visits
- Lack of access to regular primary care
- Frequent visits for concerns that could potentially be managed in the outpatient setting, but poor

access to care.

- Need for social work or case management that is not available at their regular

III. Protocol/Guideline Procedure

For patients who are identified in the ED as potentially benefitting from referral to the geriatrics specialty clinic, in the discharge section under “orders” type in referral to geriatrics. Make sure that the referral to department and specialty are selected and insert a reason for the referral.



Please discuss the referral with the patient and/or family members to alert them that they will receive a call to schedule an appointment, and the reason you are referring them for additional geriatrics expertise.

IV. Dissemination and Implementation

The protocol here will be disseminated to the physicians and APPs and will be emailed out at regular intervals on the “daily dose” administrative email reminders.

Geriatrics Specialty Clinic

I. Description

This guideline describes the referral process from the ED to the REACH home visit program. The outpatient clinic provides primary or consultative care by physicians, nurses, and pharmacists with specific expertise in geriatrics, geriatric medication management, and geriatric syndromes.

II. Rationale

Older adults frequently have medical needs that cannot be fully met during an Emergency Department (ED) visit. For example, patients may have difficulty obtaining or understanding their medications, which can lead to recurrent visits for medication complications. Patients may also have multiple ED visits for frequent falls. While the ED physicians can treat injuries sustained during a fall, they cannot adequately assess the home environment or other factors that may contribute to the falls. Other patients may require home health, home physical therapy, home meal services, or transportation to medical visits all of which cannot easily be coordinated in the ED.

The REACH program provides one-time or ongoing physician home visits to assess and intervene in many of the concerns listed above. The physicians, NPs, pharmacists, and social workers in this program can provide multi-disciplinary care that goes beyond the capabilities of the ED. They are able to meet the patient in their home, thereby reaching patients whose care is limited by a lack of transportation. They perform a comprehensive evaluation of the patient, their living environment, social support, medications, and level of cognitive function, in addition to the medical history and physical exam. They are able to coordinate many home services, including medication delivery and organization to help prevent medication errors. They are able to coordinate home physical therapy or home health nursing and can provide additional physician or NP visits on an ongoing basis if needed. They can also help with non-medical needs such as meal delivery. REACH program physicians also address advance directives with each patient. All of these services could help provide a smoother transition of care from the ED or the hospital back to home, and could help prevent readmission or return to the ED.

The potential indications for referral to the REACH program include the indications for referral to the geriatrics specialty clinic, as well as the need for a home safety evaluation, coordination of home services, and limited transportation. Formal eligibility criteria also include:

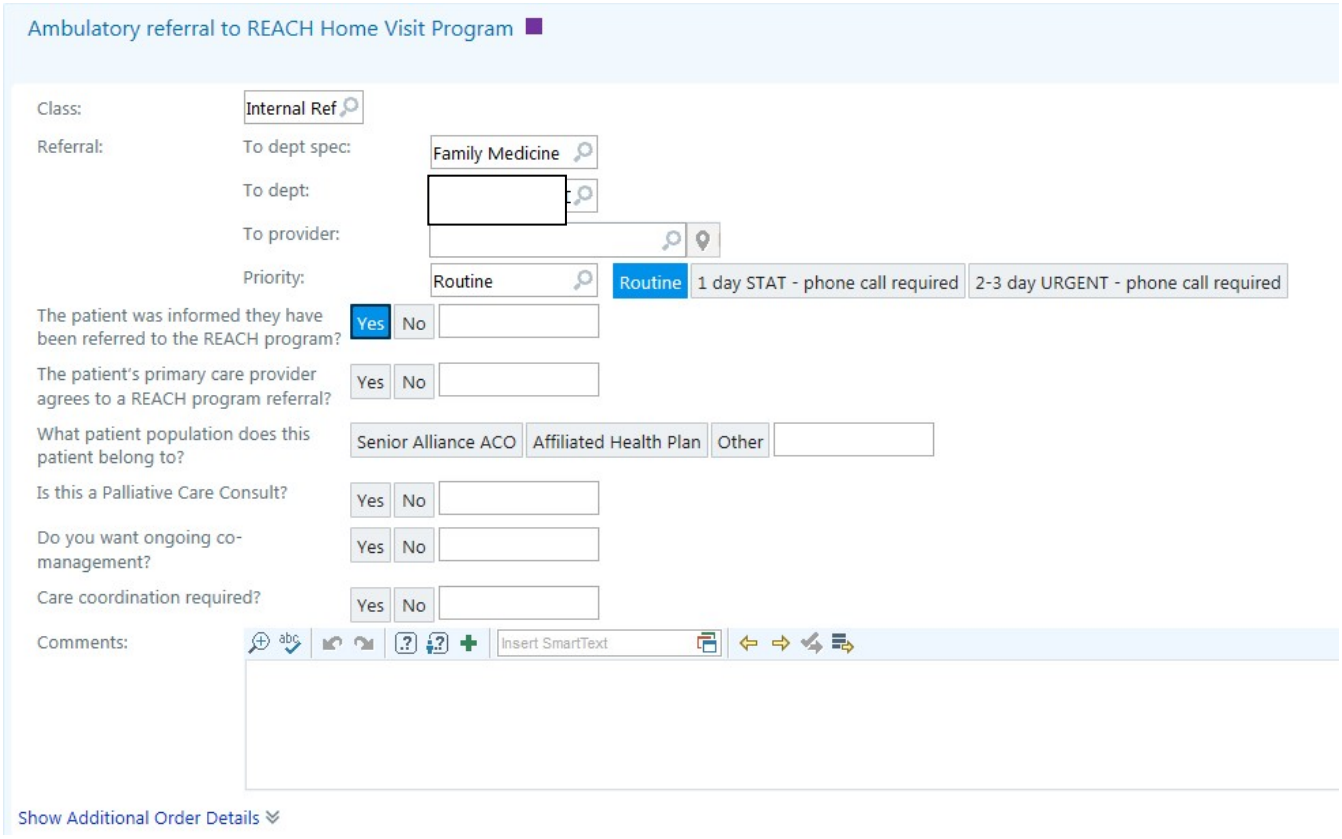
- 2 or more chronic conditions
- Need assistance with 2 or more functional dependencies
- Had 1 non-elective admission with the last 12 months
- Receive acute or sub-acute rehab in past 12 months
- Live in a 25-mile radius of the medical center

III. Protocol/Guideline Procedure

For patients who are identified in the ED as potentially benefitting from referral to the REACH home visit program, you can refer them as follows:

- Obtain permission/consent from patient
- Obtain permission/consent from PCP

- Ensure the patient lives within 25mi of the Medical Center
- Place order for referral to REACH.



Please discuss the referral with the patient and/or family members to alert them that they will receive a call to schedule an appointment, and the reason you are referring them for the home visit.

IV. Dissemination and Implementation

The protocol here will be disseminated to the physicians and APPs and will be emailed out at regular intervals on the "daily dose" administrative email reminders.

Policies / Protocols Guidelines & Procedures Examples

Patient Care: Discharge Planning Services – Home Health Skilled Services Referrals

Example 1:

POLICY:

Referrals to a certified home health agency can be made by any profession of the health team. This policy refers only to referrals made by the social worker.

Referrals to a Joint Commission or CHAPP accredited certified nursing agency will be made on all patients in need of skilled nursing services who meet eligibility requirements. The Department of Social Work Services maintains a list of certified home health agencies participating in the greater New York area that is available to be given to patients. The preferred provider relationship with Visiting Nurse Service of New York [VNSNY] is disclosed on this listing. Social workers provide choice in referrals for certified home health. A list of referral choices of certified agencies is offered and made available to patients and families.

PROCEDURE:

1. Referral is discussed with patient/family and approval obtained to make the referral. This is documented in the medical record. The social worker provides a list of agencies that serve the geographically requested location and are in network with the patient's insurance. If patient/family has a preference for a particular nursing agency, the social worker will make a referral to that agency, if appropriate.

2. If patient/family does not have a preference for a nursing agency, the social worker will discuss options and make a referral to VNSNY for an assessment of patient need and service eligibility after agreement of patient/family. Our preferred provider relationship with VNSNY is disclosed.

3. If VNSNY is unable to service the patient, for example due to catchment area, managed care limitations etc., the social worker will discuss with patient/family and make a referral to another agency.

4. The social worker coordinates completion of the Home Health Service Request form for those patients not being referred to VNS NY and faxes it to the appropriate agency. The social worker telephones the certified agency to confirm receipt and verify the initial visit date upon patient's discharge. Outcome of telephone contact with referral agency is documented in the medical record.

5. The social worker is responsible for obtaining physician documentation to meet the Face to Face requirements.

6. A copy of the Home Health Service Request Form (utilized with adult population only) is maintained in the medical record.

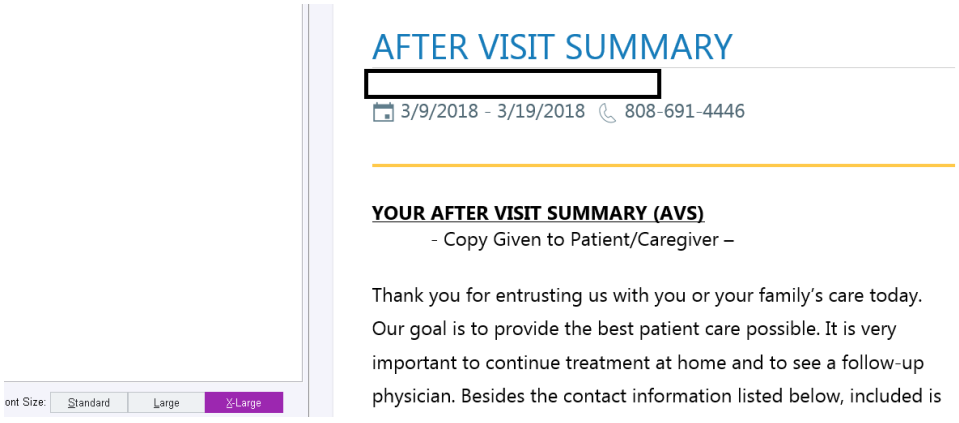
7. For inpatients, copies of these forms go in the hard copy chart on the unit which will later be scanned into EPIC.

8. For outpatients, all forms should be processed in the same manner as any other documents that need to be scanned into the Electronic Medical Record. If a practice area does not have an already established process for this, the social worker should contact their direct supervisor.

Example 2:

Protocol to standardize discharge protocol for patients discharged home that addresses age specific communication needs

- The ED shall provide individualized discharge instructions for geriatric patients, with special consideration age-specific communication which includes
    - Large font for discharge instructions
    - Utilizing hearing assist devices, and language assistance per policy 610-18-118-A (Language Assistance Policy).



Access to Transportation Service for Return to Residence

- The ED staff shall coordinate transport for patient to return home as requested
- The ED staff shall contact ED Social Work who is available 24 hours every day or Case Management to coordinate transport that are able to coordinate with existing contracts with medical transportation which include:
    - Self-pay or family
    - Insurance covered
    - Care facility provided
    - Out of pocket by the hospital as charity

Pathway to Short or Long-Term Rehab or Extended Care Facility placement from the ED OBS

Patients who require short or long-term placement from the ED can sometimes be placed from our Observation Unit. These patients will require evaluation by PT or documentation of need for skilled nursing. The patient must be discussed with the ED Observation Unit case manager who will first check the guidelines for that patient's insurance.

Patients who have Managed Medicaid or Medicare plans and do not have a recent qualifying inpatient stay should be admitted for care and placement. Also, certain dates/times are more difficult to arrange placement for patients (holidays, weekends). Our team works with the patient and family or caregivers to find an acceptable safe place close to home. The team has lists of long term care units that have secure units for patients with Alzheimer's, behavioral health units, and other special accommodations. If openings are available, we have also successfully placed patients in our Inpatient Rehabilitation Facility. Place a consult to the PM&R resident for assessment for placement in inpatient rehabilitation (IP CONSULT TO PM&R) and page the resident on that this patient would take priority over inpatients for evaluation.

Insurance Plans	Example of plans	Precert or approval	Length of precert/approval process
Traditional Medicare	Straight Medicare	Requires 3 day overnight stay if no qualifying admission within last 30 days	
Private Company Medicare plans	Aetna, Anthem, UCH, Humana, etc.	Precert required from insurance, approval required from PASRR	May take up to 1-2 business days (no weekend precerts)
State Medicaid	Straight Medicaid	Approval required from LOC/PASRR	Potential for same day placement
Managed Medicaid	Caresource, Molina, Paramount Community, Buckeye Community Health Plan, Aetna My Care, UCH Community, etc.	Precert from insurance, approval required from LOC/PASRR	May take up to 1-2 business days (no weekend precerts)
Private Insurance	Health Plan, UHC, Aetna, Anthem, Medical Mutual, etc.	Precert required from insurance, approval required from PASRR	May take up to 1-2 business days (no weekend precerts)
VA Insurance	Tri-Care, VA	Contact VA Liaison for placement	Per liaison

1. PT/OT evaluation (definitely PT)
2. Review recommendations from PT/OT
3. Patient choice of ECF
    a. Provide list to patient of ECFs
4. Referral sent to multiple ECFs for consideration
5. Review insurance
6. Every Emergency Department patient placement requires a completed 9 page "PASRR" (Preadmission Screening and Resident Review) for placement, which is also included with the approval process (completed by the ED SW)
    a. **NOTE: If a patient has mental health or substance abuse issues, they may "trip the PASRR," which triggers a second level review. It can take days to weeks for this review to occur.**

- **Medicare** is a federal health insurance program for people who are 65 or older, and certain younger people with disabilities
    b. **Traditional Medicare** – review for qualifying admission last 30 days, if not, will require 3 day overnight qualifying stay
    c. **Private company Medicare contract plans** - (Aetna, Anthem, UCH, Humana, etc.) precert required
        i. Precert and approval required (<u>may</u> take up to 1-2 business days)
- **Medicaid** (straight Medicaid)
    a. Medicaid patients require "level of care" form with 9-page PASRR and submitted to XXXX for approval
    b. Potential for same day placement
- **Managed Medicaid** (Caresource, Molina, Paramount Community, Buckeye Community Health Plan, Aetna My Care, UCH Community, etc.)
    a. Medicaid patients require "level of care" form with the 9-page PASRR
        i. Precert and approval required (may take up to 1-2 day business days)
- **Private Insurance plans** (Health Plan, UHC, Aetna, Anthem, Medical Mutual, etc.)
        i. Precert and approval required (<u>may</u> take up to 1-2 business days)
- **VA Insurance –** Contact VA Liaison

Approval must come from PASRR, and/or Level of Care (if applicable), and precert from insurance. ECF has to accept patient medically and financially

Policies / Protocols Guidelines & Procedures Examples

Access to an Outreach Program Providing Home Assessment of Function and Safety

Our ED Case Management team assists with home safety assessments and referrals. We have active relationships with several nonprofit community resources and for-profit home health care agencies. The patient is assessed for their needs and educated about options that service his or her geographic area. All of County is covered by the Central Area Agency on Aging which offers Senior Options Services (see below). Two local agencies that are very responsive to our requests for home assessments. Finally, attached is a list of centers that provide Adult Day Care services.

Protocol:

ED Case Management team will meet with patient and discuss options for home health care agencies and home safety assessments. PT and OT are recommended consultants as they can provide excellent initial assessments of the patient's functional status and home health needs. Case manager will coordinate referral with the chosen agency.

Adherence:

If PT or OT assessments indicate home health or safety needs, case manager will document a discussion with patient and family and either assist with referral or recommend admission if unable to coordinate outpatient resources for safe discharge.

Numerator (documentation of a needs assessment (PT, OT, and/or case management) and plan to address any care needs)

Denominator (all older patients in the Observation unit)

Senior Options Services

Service	Description
Information and Advocacy	Resource information on community-based services for older adults is furnished to the public.
Case Management	Ongoing assessment and interaction with older adults is conducted to insure the adequacy and quality of community- based services.
Homemaker Services	To enable older adults to achieve and maintain a clean, safe and healthy environment, assistance is provided with light housecleaning and laundry.
Personal Care	Older adults are aided in the performance of necessary activities, such as, personal hygiene, grooming, foot care and moving about the home.
Adult Day Service	Community-based programs designed to meet the needs of functionally impaired adults in a protective setting are available. Program components include health services, personal care, meals, activities and transportation. Some programs include social work services and rehabilitation therapies.
Home-Delivered Meals	Well-balanced meals are delivered to the older adult's home to promote adequate nutrition. Hot noon meals are available

	Monday through Friday. A cold evening meal and/or weekend meals may also be provided.
Caregiver Relief (Respite Care)	Trained individuals are available to help with the care of older adults who need 24-hour supervision. This provides caregivers an opportunity to enjoy personal time without worry.
Medical Transportation	Transportation to medical facilities is available for older adults. Wheelchair transportation is available, and one escort may ride with each participant.
Emergency Response Systems	A system designed to monitor an older adult's safety at home and provide access to emergency services through electronic communication devices is available.
Minor Home Repair	A variety of repairs can be performed on an older adult's home to improve independence and safety.

Paramedicine Programs

- Upper Arlington Community Program
- Mifflin Township
- Truro Township
- Whitehall Fire Department
- Hamilton Township
- Jefferson Township
- Delecare
- Columbus Division of Fire
- West Licking Fire Department
- Violet Township

Adult Day Centers

Facility	*Address*	*City*	*Zip*	*County*	*Phone*	*Cost*	*Services*	*Transportation*	*Hours*
Almost Family	2100 Bethel Rd.					$60/ day	Bath included	$12.00 one way $22.00 round trip	M -Sat: 7:00a-5:30p
Alzheimer's Assoc	3380 Tremont Rd.								
Columbus Adult Day Ctr	1415 E. Dublin Granville								
Columbus West Park	2137 Clime Rd.					$45/day	Bath $15	$15 one way, $25.00 round trip	M-F: 6:30a-6p
Enrichment Center	2120 E. Fifth Ave.			$44 >4 hours		$22 <4 hours	No Bathing	Round trip included	M-F: 8a-4:30p
Forest Hills Center	2841 E. Dublin Granville		(614) 891-1111						
Grace Kindig	440 Industrial Mile Rd.			$45.75 >5 hours		$27.75 <5 hours	Bath $15	$37.10 round trip	M-F: 6:30a-5:30p
Heritage Day Center	4550 Heaton Rd.			M-F: 7:30a-5:30p; Sat: 8:30a-4p					
Heritage Day Center	3341 E. Livingston Ave.		$50/ day	$12.50 one-way		M-F: 7:30a-5:30p			
Isabelle Ridgway	1520 Hawthorne Ave.								
John J. Gerlach Ctr	3724 Olentangy River Rd.		$47-$53				Bath $14, beauty shop, podiatry, dentistry, some lab-work	$10 one way within 10-mile radius	M-F: 6:30a - 6p
Life Center	20 S. Third St.		$41/day	M-F: 6:30a-5:30p					
Life Center	2225-LC S.R. 256		$41/day	M-F: 6:30a-5:30p; Sat. 9a-5p					
Perkins Adult Day Care	3425 Refugee Rd.								

Settlement Houses Senior Services

1. **Community Resource Center Food Pantry**

Did you know that the City has the largest percentage of people 65 years of age or older?
We value all that Seniors offer as members of our community and so we provide a myriad of services to help seniors remain independent and safe in their homes. We serve more than 400 Seniors each year. *Services Include:*

- Individual case work with assistance accessing community resources and benefit programs and removal of barriers to healthcare
- Transportation to the grocery and medical appointments
- social outings and recreation
- Personal Finance Management assisting with budgeting, bill pay, debt reduction, financial organization

2. **Community House**

Our program provides comprehensive services to senior citizens in the community and outlying areas:

Services Include:

- Advocacy
- Supportive Services
  (home visitation and linkage with community resources)
- Socialization and Recreational Activities
- Workshops and Seminars
- Neighborhood Health Center On-Site
- Meal site for LifeCare Alliance

3. **Community House**

Senior Citizens Outreach Services include:

- Case Management Services
- Grocery Trips
- Socialization Outings

4. **Central Community House**

Senior Program – Those aged 60 or older, may access assistance with basic needs, linkage/referrals to resources and an array of activities and educational workshops designed specifically for older adults. Weekly lunch, games, crafts, exercise and more are available (subject to change). Call for details. This program is funded by County Senior Options.

Food and Nutrition Programs– Those enrolled in CCH programs find help in ensuring families don't go hungry through take-home groceries, afterschool/summer meals and other programs. Community dinners and celebrations with free meals are often offered throughout the year.

Policies / Protocols Guidelines & Procedures Examples

Community Paramedicine Referrals

EXAMPLE County has 22 different EMS agencies that operate within its borders. The area closest to Hospital is serviced by EXAMPLE City, who offer extensive community paramedic services.

Community Program

a. Description: This paramedic program (called CARES) does home safety assessments including evaluations for fall risks, assists with coordinating medical care, and assists with connecting residents at need to community programs. To qualify for the program the patient must be a resident of EXAMPLE. The community also has a Kind call system, where residents receive a phone call up to daily checking in them and their needs.

b. Criteria: EXAMPLE resident being discharged from the ED who agrees to an in home follow up visit.

c. Protocol: To schedule a visit with the CARES team, the ED Case manager will place a call or email.

Other Community Paramedic Programs:

Protocol:

A pamphlet of community paramedic services and ways to contact them is being created. This must be approved by the agencies involved and approved by hospital. A packet of resources for geriatric patients including this pamphlet on paramedic services, a description of the hospital specialty clinics for geriatric assessment, and a document on local resources for EXAMPLE County residents will be available in the ED Case Management room. This will be given to every older adult in the Observation Unit. The case management team is available to assist with any questions and in helping to make referrals.

By hospital policy, we are not allowed to release any patient information to these agencies without confirming with the patient first that he or she would like this service. Therefore, automatic referrals or referral lists of ED patients cannot be given to these agencies.

Adherence:

Case management notes will document that the geriatric resources packet is given to the patient.

Numerator (adult >65 in the Observation Unit who receives a geriatric packet)

Denominator (all older adults in the Observation Unit.)