Establishing Collaboration between SNF and Hospice

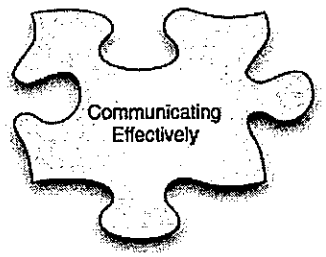
- **Communication is the key to a successful relationship with Hospice and SNF**
  - The more the communication the better!
- **Communication and Documentation are key to building working relationships with the SNFs!**

How do we communicate in the Facilities?

- Sign into visitor log upon arrival and exiting facility- all disciplines

- Upon arrival, introduce yourself to the floor nurse, charge nurse etc.- every discipline should be receiving a report before seeing a patient.

- At the end of the visit, circle back to the floor nurse regarding a plan, assessment, comfort medications, additional medications etc- report will vary depending on discipline.



How will we increase communication in the facilities? We have some new and exciting changes!

- After every visit, nurses, chaplains, and MSWs must ask to speak to the social worker, referral source, DON, resident care director etc. to discuss plan of care for the patient. If they are not available, please leave a note(Merrimack Valley Hospice/York Hospice) sorry I missed you card) that you were present and stopped by to see them. Visibility is the key to increase referrals!
- Every discipline should be writing in the communication book. Every patient should receive a book upon admission.
- Complete documentation log sheet after every visit- these sheets will be kept in a separate binder per facility unit. See log sheet for explanation. York office, all aides, volunteers and anyone without a printer at this time.

Merrimack Valley Hospice
360 Merrimack Street, Bldg 9, Lawrence, MA 01843
1-800-933-5593

The Leaders in Home Health and Hospice Care
Home Health VNA - Merrimack Valley Hospice - HomeCare, Inc.

Documentation Log

Patient Name_____

Date_____Time In/Out_____ NOTES:
Name: _____
Discipline: _____
Report given to:
POC Review: Y/N
Medication or POC changes? Y/N
If yes, describe in note

Date_____Time In/Out_____ NOTES:
Name: _____
Discipline: _____
Report given to:
POC Review: Y/N
Medication or POC changes? Y/N
If yes, describe in note

Date_____Time In/Out_____ NOTES:
Name: _____
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Report given to:
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Date_____Time In/Out_____ NOTES:
Name: _____
Discipline: _____
Report given to:
POC Review: Y/N
Medication or POC changes? Y/N
If yes, describe in note

How will we increase communication in the facilities? We have some new changes!

- All nurses, chaplains and social workers will now be calling DPOA/proxy after every visit. This is especially important at admission for introduction. If the DPOA/proxy is present at the visit, a call is not necessary. Please document the call in your notes. If a caregiver declines a phone call document in electronic record.

- Attendance at IDT/care coordination meetings at the facility are important! We will be implementing a care coordination minutes form to be completed by nurse or designee that will be completed at meeting. This new form increases collaboration with the facilities. See new form. One this form is completed(individual form for each pt), place in patient's chart or our binder.

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Care Coordination Meeting

Patient Name:_____
Date:_____ Start of Care:_____
Facility:_____

Facility Attendees:

Printed Name/ Title	Signature

Hospice Team (Merrimack Valley Hospice) Attendees:

Printed Name/ Title	Signature

Hospice DX:_____
DME:_____
Facility Update:_____
Pain/Symptoms:_____
Vitals:_____ PPS:_____
Skin:_____ Weight:_____
Facility Care Plan Reviewed:_____ Hospice:_____ Integrated:_____
POC Reviewed:_____

Visit Frequencies w/ Updates:

RNCM:_____
_____
Social Worker:_____
_____
Chaplain:_____
_____
Hospice Aide:_____
Volunteer:_____

Social Work
EOL Plans:
Funeral Home:
PT/Family Coping:

CHAPLAIN
Spiritual Needs:
Religious Preference:
Do they receive prayer?
Have they received SOS?

VOLUNTEER
How often:
Who:

Review of current SNF/ALF process

- Admission nurses: Speak to someone in the business office at time of admit. Complete VOR form and submit to business office. Please send an email to the liaison that this was completed. Liaison will follow up with business office that form was received.
- At SOC: admission nurses, meet patient/family, assessment, discuss plan, and place communication book in the room(explain pt/family purpose of book)
- All subsequent visits: Print completed note and place in hospice section of facility chart. (disciplines who have a printer). See instructions for printing notes. Documentation logs will be placed in a separate binder per unit for aides, York office, volunteers, and anyone without a printer.
- Case managers: After every recertification, a new plan for treatment should be printed and placed in hospice section of facility record. All medications should be reconciled and please make sure visits and orders match plan for treatment.

Summary of SNF/ALF initiative

- Documentation logs in hospice binder on nursing unit. (York office, aides, volunteers and anyone without a printer.)
- Mandatory phone calls by nurse, chaplain and social worker after every visit if proxy/DPOA not present.
- Every visit- follow up with DON, referral source, Social worker etc with plan of care- communicate that you were present and in their building.
- New care coordination forms implemented to increase collaboration and integrated plan of care.
- Random audits by management to ensure process completed.
- Contact will be made to the facility and family within 1 hour from receiving referral. Same day admissions.