

Nursing Notes

BEST PRACTICE CONSIDERATIONS FOR DISCHARGE PLANNING

"Planning is bringing the future into the present so that you can do something about it now" Alan Lakein (time management expert)

The time to begin planning for the discharge of a consumer from the hospital starts at the time the person is admitted. As the population we serve ages, the likelihood that a consumer will experience a health-altering event increases. Many hospitalizations will result in the temporary or permanent alteration in the life and needs of the person. This alteration can trigger a need for change in the level and types of support the person receives. These changes are generally not accomplished overnight and often require planning and coordination.

To begin this process, it is important that the hospital is aware that the RN has an established relationship with the hospitalized person. Emergency demographic sheets should indicate the RN's name and contact information. The RN also has a responsibility to establish contact to ensure that the hospital has all pertinent medical information, current orders, and information about the person's current living situation.

Many times the nurse on the hospital unit will not discuss confidential health information as they are unaware of the RN's relationship with the person. If this is the case, contact should be made with the discharge planner. If problems continue to be encountered, it is recommended that the hospital risk manager be contacted to explain the situation and the relationship. Once communication is established, information about treatment and the anticipated date of discharge can be obtained. This information will allow the RN to use the nursing process and begin to assess what if any revisions need to be made to the current plan of care for the person. Time is often short for this planning process as persons are discharged as soon as possible.

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DISCHARGE PLANNING (continued)

The RN may feel especially stressed if this type of planning is left to be accomplished at the last minute and the outcome for the consumer may be less than desired when there is no time for thoughtful planning.

Best practice considerations for the RN during the revision of the health care plan may include the following:

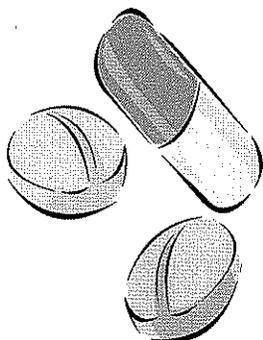
- Is this a temporary or permanent change of condition? Is the condition terminal?
- What are the nursing supports that need to be in place to meet the changed needs of the person (e.g., Increased RN time, LPN coverage for part/all of day)?
- What information needs to be conveyed to nursing staff and to non-licensed staff regarding the person's status and needs?
- What information needs to be reported to the RN On Call (agency or contracted) ?
- What new medications and treatments are likely to be prescribed?
- What additional supplies and/or equipment might be needed?(e.g., g or j tube supplies, dressings, catheters, Hoyer lift, etc.)
- What new responsibilities will need to be delegated?(e.g., administration of eye medications, g or j tube feedings, dressing changes, etc.)
- What training will staff and/or nursing staff require? (e.g., medication changes, training on delegated task, new guidelines for care, etc.)
- What is the time frame for getting training accomplished?
- Who else do I need to communicate information to?(e.g., guardian, family, team, PCP, etc.)?

Although the RN is responsible for the implementation of the nursing process and health care planning, the entire team supporting the person should be involved in updating the Level of Need tool and considering the revisions to the person's Individual Plan that are necessary to reflect the new needs of the person. This may require a meeting prior to discharge and/or a meeting at the time of discharge to consider the following:

- Are there other supports that will need to be in place either temporarily or permanently when the person returns (e.g., increased staffing or staff time, new or expanded ADL supports- hygiene, dressing, meal preparation, etc.),
- Are there other resources that will be needed (VNA, Hospice, PT, OT, SLP, Dietary)?
- Can the person safely be supported in their home? Does the person's present home meet the new accessibility needs of the person or are modifications or equipment needed (e.g., ramp, shower chair, safety bar in shower etc.)
- Does the person require short term rehabilitation in a skilled nursing facility?

The implementation of a thoughtful planning process allows for the best possible outcome for the consumer.

CONSIDERATIONS FOR INVESTIGATIONAL DRUGS



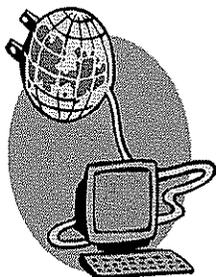
While the overwhelming majority of medication that is administered to consumers is approved by the Food and Drug Administration, there are occasions when consumers are prescribed medications that are considered to be investigational drugs. An Investigational drug is defined in the DDS medication administration regulations as "any medication which is being scientifically tested and clinically evaluated to determine its efficacy, safety, and side effects, and which has not yet received federal Food and Drug Administration approval".

When an investigational drug is proposed for use by a consumer who is residing in a residential setting, or is currently being administered to a consumer who will be moving from a family home into a residential setting there are several considerations that must be addressed:

- The DDS Institutional Review Board must review the proposed medication.
- The site where the person resides/will reside must have licensed nursing staff to administer this medication as per DDS Medication Regulations. A person who has been assessed by an RN to be capable of self-administration as per DDS Medication Administration Regulations, may self-administer this medication.
- A licensed prescriber must provide written orders for the administration of this medication. A licensed prescriber is defined as a physician or other health care practitioner with applicable statutory authority to prescribe medications in Connecticut.
- Occasionally, the administration of an investigational drug is recommended by a physician from another state who does not hold a license in CT. In this instance, the person's primary care provider may be willing to write the order for the administration of the medication.
- If the medication is not available in the United States, then the person's family will have to obtain it or have it sent to the site.

FUTURE TRAINING OPPORTUNITIES

CT DDNA Annual Conference October 2009 Topic: Genetic Syndromes



Check out the DDS Mortality Review Report which can be found at: www.ct.gov/dds. Click on "Supports and Services" then click on "Health and Clinical Services" You will find this report and other nursing/ health related documents



Preparations That Can Be Delegated To Non-Certified, Non-licensed Staff

The use of any of the following products (or equivalent products) which are commonly prescribed on a long-term maintenance basis as part of the person's daily home care activities (bathing, tooth brushing, eating, etc.) may be utilized by non-certified, non-licensed staff **IF** the following conditions are met:

- The task is delegated by the supervising RN at the site (or LPN under the direction of that RN) and the delegation of this responsibility meets the requirements outlined in the Board of Examiners For Nurses Declaratory Ruling on Delegation including training, identified procedure, and reporting responsibilities, and oversight are met.
- The preparations to be delegated (excluding nutritional products) are stored in one of the following ways:
 - Locked areas that are separate from the medication storage areas
 - Non-certified staff are never permitted to access the medication cabinet and must be given the preparation by certified staff.
 - These items are not to be included on the Medication Administration Record/ Kardex. Licensed or certified staff should never be expected to document the use of these products unless they are the ones applying them.
 - Delegated non-licensed staff shall have a separate documentation format to record the use of such products (i.e., treatment sheet).

Section 1 of 2

Effective 7/1/09

Approved for Delegation	Exceptions/ Not approved for delegation
<p><u>Nutritional/ nutritional related products:</u></p> <ul style="list-style-type: none"> • Carnation Instant Breakfast • Ensure liquid, puddings • Protein power • Bran • Thickening agents 	<p>Products must be administered by mouth only, and not via a G or J tube.</p>
<p><u>Dental products:</u></p> <ul style="list-style-type: none"> • Gel-Kam or Prevident • Peridex • Toothpaste (Sensodyne, etc.) • Disclosing Solution • Mouth Rinses 	
<p><u>Topical Preparations:</u></p> <p>Lotions</p> <ul style="list-style-type: none"> • Products for dry skin (Vaseline Intensive Care, Eucerin, etc.) • Sunscreens <p>Creams/Ointments</p> <ul style="list-style-type: none"> • Products for maintenance of skin quality/ prevent breakdown (A&D ointment, Zinc oxide, etc.) • Products for dry skin (Eucerin Cream, etc.) <p>Shampoos</p> <ul style="list-style-type: none"> • Products for dandruff or dry scalp (T-gel shampoo, Tegrin, Head & Shoulders, etc.) <p>Powders</p> <ul style="list-style-type: none"> • Products to avoid chaffing (baby powder, Shower-to Shower, etc.) • Foot products to decrease odor and/or susceptibility to development of fungal infections <p>Deodorants prescription strength</p> <p>Sprays</p> <ul style="list-style-type: none"> • Products that protect skin/promote healing (Granulex spray) • Incontinence cleaners (Peri-Wash) 	<p>Lotions, creams, ointments, etc. including over the counter preparations which are prescribed to treat a particular acute condition or the exacerbation of a chronic condition including but not limited to: Calamine lotion, Hydrocortisone cream, Desenex ointment, Lotrimin cream/ powder/ spray, Kwell lotion/ shampoo</p> <p style="text-align: center;">PREPARATIONS THAT CAN BE DELEGATED TO NON-CERTIFIED, NON-LICENSED STAFF</p> <p style="text-align: center;">Section 2 of 2</p> <p>Effective 7/1/09</p>

CONNECTICUT HOSPICE

The Connecticut Hospice, Inc., the first Hospice in America, has been providing exceptional skilled care to patients, both at home and in the 52-bed Hospice and Palliative Care Hospital for nearly 35 years. The Mission of The Connecticut Hospice is to provide care to anyone who is in need of this level of care, regardless of ability to pay. Each patient is cared for in his/her own home environment for as long as the family or extended family wishes. If the situation requires the comforts and skills of the Hospice in-patient hospital, the individual is transferred seamlessly under one overall plan of care.

The Connecticut Hospice homecare and hospital program offers ALL patients, regardless of payment source the opportunity to receive all the complimentary therapies that are ordinarily given only under the Medicare Hospice Benefit. Patients admitted to The Connecticut Hospice transition programs may be those suffering from complications of complex and advanced disease (includes cancer and most other diseases), and are still receiving acute symptom relief regimens such as radiology, chemotherapy, or blood transfusions regardless of code status.

In a homecare setting, care is provided under the direction of the patient's community physician. If it is appropriate, the Connecticut Hospice physician may make a home visit and collaborate with the person's community physician. In the Hospice and Palliative Care Hospital, the nurse works under the direction of the hospice-trained physicians. Wherever the person is located, the goal is the same-- relief for patients/families suffering from complex irreversible illness through competent and compassionate care.

The Connecticut Hospice considers the patient and family as one unit to whom care will be provided. Persons who have been residing in a group home or other supervised living situation where staff, nurses, and others have been providing care to the person are viewed as the person's extended family and therefore support and education is provided to them as well as the patient.

Hospice nurses develop plans of care that are unique to each individual patient/family unit. These plans are based on the collaborative input of the Hospice Interdisciplinary Team. This Team consists of nurses, physicians, pharmacists, and social workers. Art Therapy and Complementary Therapies including bereavement, pastoral, volunteer, physical therapy (and speech and occupational therapies as needed) is available as well as home health aides. The care provided by Hospice incorporates the use of the most up-to-date technologies and clinical practice strategies to support the needs of the person and their family/staff. Additionally but of equal importance is Hospice's mission to teach, train and participate in various research projects to further the understanding, access and training of hospice care principles and concepts.

The in-patient hospital is located in Branford, CT and receives referral from physicians and

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CONNECTICUT HOSPICE (continued)

hospitals throughout the state. Homecare offices are located in Farmington, Wallingford, Shelton and Norwalk in addition to the Branford office. Through these offices the coverage area is extensive reaching from north of Hartford down to lower Fairfield county and east to the Connecticut River and west to Danbury.

Hospice offers a number of programs to support persons with terminal or irreversible illness.

- Patients admitted to the Connecticut Hospice transition programs may be those persons suffering from complications resulting from complex and advanced illness including cancer and most other diseases. Persons may be eligible if they are still be receiving acute symptom relief regimens such as radiology, chemotherapy, or blood transfusions regardless of code status.
- The CanSupport program is for the person who is homebound and has a skilled nursing need.
- The Open Hospice program allows care to be provided to a person with an irreversible illness who chooses to receive active treatment.
- The Medicare Hospice Benefit is for persons with a prognosis of six months or less. This benefit may be extended.

Hospice care should be considered for consumers who may benefit from the programs mentioned above.

For specific information on the availability of services, contact Patty Magrath, Admissions Office Supervisor, at 203-315-7546 or 203-315-7450.



The Trouble With Muffins

Many people enjoy a muffin with their coffee in the morning. However for people who are endentulous and/or have an identified swallowing risk, muffins can be dangerous. It has been recently noticed that muffins and for that matter any baked good could place a person at significant risk for injury, aspiration or even death. Therefore, muffins and other similar food items should be addressed by the appropriate Dysphagia practitioner when the person is evaluated and guidelines are specified as per the DDS Health Standard # 07-1

Contact Information Changes Effective 7/1/09



Many familiar faces at DDS, will be departing as of June 30th. New faces will be replacing them. Here is the updated contact information



Central Office

DOREEN MCGRATH, Acting DDS Director of Health and Clinical Services:
Doreen.McGrath@ct.gov or 860-418-6083

VAL VUJS, Med Certification Coordinator: Valerie.vujs@ct.gov or 860-418-6135

North Region

VALENCIA BAGBY-YOUNG, Director of Health Services:
Valencia.Bagby-Young@ct.gov or 860-263-2545

PATRICIA LILLEY, Nurse Consultant, Liaison to Private Sector:
Patricia.Lilley@ct.gov or 860-263-2530

KAREN STEBBINS, Nurse Consultant, Liaison to Private Sector:
Karen.Stebbins@ct.gov or 860-263-2453

West Region

GARY DURANTE, Director of Health Services: Gary.Durante@ct.gov or 203- 806-8751

JANETTE STEWARD, Nurse Consultant, Liaison to Private Sector:
Janette.Steward@ct.gov or 203-806-8725

South Region

BETTY ZOUBEK, Director of Health Services: Betty.Zoubek@ct.gov or 860-859-5504

FRANCES PARK, Nurse Consultant, Liaison to Private Sector: Frances.Park@ct.gov or 860-859-5489

CELESTE FASSBENDER, Nurse Consultant, Liaison to Private Sector:
Celeste.Fassbender@ct.gov or 203-294-5089

SOMETIMES OUR DIRECTIONS ARE NOT AS CLEAR AS WE THINK THEY ARE

The patient's condition did not improve as it should have after taking the medication for two weeks. When questioned the patient was adamant that he had followed the Doctor's directions so he was asked to demonstrate exactly what he was doing.

After receiving a glass of water, the patient took out a packet of waxed paper and opened it very carefully to reveal a wrinkled and faded piece of paper that was the original prescription. The patient proceeded to put the paper in the water and then drink the water. He then carefully refolded and rewrapped the prescription in the waxed paper. He looked at the doctor and said "See Doc, I am doing exactly what you told me to do: Take this in a glass of water twice a day"