On-Call & Triage Nurse Call & Visit Management

Best Practice protocols and overview

Revised: 5/1/17
On-Call & Triage Nurse Practice Overview

- On-Call & Triage Nurse Roles
- Triage Urgent Support / Approval - Who to contact first and when
- Compare visits: On-Call vs RNCM
- On-Call Shift responsibilities
- Triage Shift responsibilities
- Triage Computer & Technical Setup
- Considering Visits by Location Type
- Prioritization and Resources
- Primary Documents & Orders
- Managing Level of Care Changes, Discharges & Relocations
- On-call & Triage documents & resources
- Abuse, Neglect, Safety & Elopement
“Never Never. Never Always.”

- Ali Hartman, Colorado Regional Director of Clinical Services

Each situation is unique and deserves a flexible and individualized approach.
On-Call & Triage Nurse Roles

- Visits & Triage management built upon Nursing skill and field assessment
- Job Description & Overview
  - Patient visit care manager based on clinical perspective
  - Collaborator and Customer Service Manager
  - Traits: flexibility, caring, adaptability, autonomy, diplomacy, teamwork
- Visits require: Critical Thinking & Utilizing Resources
  - Focus on independent decisions based on your clinical assessment in the field
  - Be Independent, but not alone - utilize resources as necessary: Triage, MD, Social Services, Administrator
- On-Call visits vs InterDisciplinary Team (IDT) care planning
  - Triage and On-call are responsible for timely stabilizing of acute and immediate patient conditions to allow time for primary IDT to develop longer-term care plan
Triage: Urgent Support / Approval Management

- **When to Contact On-call Medical Director (primary: DocHalo or Phone)**
  - On-call MD is the primary after-hours support Manager. When unsure of whether to contact MD or Administrator, start with Physician and collaborate for solution.
  - Clinical Needs: COC, medication, equipment decisions & support, death reporting/pronouncement as necessary
  - ER visit management and support, Level of Care changes
  - Meds & DME: receive urgent clinical orders for medications and out-of-cap equipment

- **When to Contact Supervisor / Administrator (primary: DocHalo or Phone)**
  - Staffing – critical needs for death visits, call-outs, and admissions
  - AGENCY REPORTING – Situation suggests need for immediate report or action (abuse, neglect, acute safety, elopement)
    - State Agencies - specific and urgent reporting timeframes, KEPRO and Medicare responses
  - Missed Visits - notify supervisor of missed visit (e.g. Fall visit) via email. Call facility directly if unable to make or complete a visit or if delayed.
  - Triage Communication disruption: phone lines, Internet, power. Utilize I.T. resources first, then contact Administrator if necessary.
  - EMERGENT non-formulary medication or non-cap equipment approval, after getting MD support for clinical need. Non-Urgent: Email supervisor for non-urgent medication or DME ordering follow up.
  - Admission – Urgent Admission or SOC approval when Intake hasn’t finished payor source review.

- **Additional communication - (contact parties directly via email)**
  - Clinical Director / Supervisor for non-urgent follow-up needs for primary team (RNCM, SW, SCC)
  - Pharmacy & DME approval: Urgent? Call MD. Non-urgent, email supervisor for approval & follow-up
Comparing On-Call & RNCM
Visit Management Goals

On-Call

- **Plan of Care**: Assess & investigate immediate needs. Focus on stabilizing patient symptoms and current situation, work to return towards baseline and/or help patient back towards original plan of care and home (if in E.R.).
- **Reporting**: Consider State agency reporting needs and timeframes. Collaborate with Triage.
- **Coordinate & Communicate**: immediate visit-related needs and update with: patient, family, facility, PCP & vendors (Pharmacy & DME)

RNCM

- **Plan of Care**: Long-term disease progression management, medication management, and multi-week care planning for decline, based on patient and family wishes.
- **Reporting**: Consider State agency reporting needs and timeframes. Collaborate with supervisor.
- **Coordinate & Communicate**: long-term POC with patient, family, facility, PCPs, MD, SS team, & vendors.
On-Call Nurse Shift Responsibilities & Time Management

- **Beginning of Shift Preparation**
  - Check email approx. ½ hour prior to shift, ensure phone and DocHalo turned on and available, dressed for visits

- **Visit Readiness**
  - Urgent call availability, supplies & proper transportation

- **Personal emergencies / Illness**
  - Notify Triage as soon as possible

- **Common Visit types**
  - Falls
  - Tuck-ins (relocations, ER return)
  - ER visits / Revocation
  - COC / Active patient
  - Admission / Assessment
  - Death
  - Wound Care

- **Communication with Triage**
  - Availability & general Location
  - Arrival & Departure times
  - Visits requiring additional collaboration, safety concerns, ER visit management
  - Social Services needs
  - LOC changes / Revocation
  - Unable to complete visits (car problems, illness, emergency, safety, etc.)
  - Additional charting time or other needs

- **Visit Communication Needs**
  - Patient / Family
  - Facility
  - Updating PCPs and care partners
  - Vendors – Pharmacy & DME
  - Triage & Supervisors
Triage Nurse Shift Responsibilities & Time Management

- **Beginning of shift preparation**
  - Computer open, phone lines transferred, HC1 access set up and logged in

- **Communication with On-Call**
  - On-call nurse locations
  - Upcoming visit: Patient name & contact information, nature of visit request
  - Check-in with On-Call nurse if no contact in expected time period
  - Requests requiring additional collaboration
  - LOC potential changes

- **Personal emergencies**
  - Communicate with Supervisor or Administrator

- **Managing CNA & On-Call illness calls**
  - CNA? Forward notification to CNA mgmt team; On-Call? email Administrator

- **Urgent Reporting Needs**
  - Medical Director on call is primary contact
  - Contact Administrator as necessary

- **Social Services needs**
  - Pt / Family / facility support
  - Death visit support / funeral home arrangements
  - Emergent LOC change needs / transport
  - Requests for 11th hour Volunteers

- **Triage Log**
  - Primary vehicle for alerting care team (RNCM, SW, SCC, CNA)
  - Include short object review of call and contact/time details and whether on-call assigned to visit

- **HC1 updates**
  - Telephone Progress Notes: record pertinent details of contact
  - Discharging patients: Update records at midnight
  - Relocation & Revocation: update records/addresses at time of relocation or revocation

- **End of Shift reports**
  - Send triage report via email to each office DON
  - Send On-Call Nurse relief needs to day supervisors and affected primary team (RN, SW, SCC)
Computer & HC1 -
- Reliable Internet and backup wireless Internet MiFi JetPack
- Microsoft Outlook email access - Review and create on-call & triage reports
- HealthCareFirst (HC1) access - Ensure access obtained in HC1 for both Hospice & Palliative Care for appropriate offices. Note: Colorado has 4 offices to access

Phone - Cell phone and Avaya phone for Triage-specific nurses
- DocHalo access (via phone and DocHalo.com website)
- Transfer instructions for call forwarding of main number between cell phones and Avaya office phones
- Voicemail access

Support: I.T., Phone & Computer use - understand Internet tunneling process and support system for Avaya phone system, IT phone and email numbers

Primary contact information - on-call nurse & SS team, supervisor, administrator

Updated patient and employee rosters with contact information

Orders - C2, Comfort Kit, TO/VO

Triage Report template to fill in during shift and email end-of-shift

E-mail lists: triage, on-call, new referral (intake)

Fax access for incoming Suncrest line and ability to send faxes
Considering Visits by Location

Communities & Facilities (ILF, ALF, Memory Care, SNF)

- Setting, understanding and managing expectations and competing loyalties.
  - Consider Relationship Triad (facility-patient, patient-hospice, and hospice-facility)
  - Are we collaborating? Negotiating? Facilitating?
  - Determine appropriate staff to report findings to
- Clinical management of condition / symptoms
- Orders & Medications:
  - Use PCP/Attending for pt mgmt., updates and orders
  - PRNs, writing facility-specific orders, comfort kits, Haldol, facility-preferred Pharmacy vendors
- DME (Durable Medical Equipment): Facility preferences & restrictions (e.g. O2)
  - Non-cap item approval
  - Facility DME restrictions
- “Restraints” – understanding facility policies about what is and is not considered a restraint

Independent Home Patients & Families

- Structure: Nurse as person of authority and trust, ensure use of appropriate provider for orders and management
- Communication more direct, also requires collaboration, negotiation and facilitation
- Involve attending provider for patient management, updates and orders
- Order management for home patients: comfort kits preferred, education regarding administration and med management
- Nurse and Patient Safety, & PPE (Personal Protective Equipment)
- DME management / approval
- Pharmacy management / approval
Prioritization & Resources

- Clinically: Nurses triage the “ABCs”
- Triage: Nurses prioritize visits and resources
- Visit & Call Priorities to consider
  - Death
  - COC / Active patient med review
  - Falls with injuries
  - Admission / Assessment (urgent need?)
  - Falls without stated injuries
  - Wound care
  - Check-in visits
  - Supply runs

- Determining specific patient teams
  - Patient roster, HC1, CNA schedules

- Outreach options
  - Phone
  - In-person family and facility
  - Fax or eFax
  - E-mail
  - DocHalo. NOTE: Do NOT use regular texting programs

- Vendors: Pharmacist, DME Company
- PCP offices
# Primary Documents & Orders

<table>
<thead>
<tr>
<th>On-Call</th>
<th>Triage</th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PRN Visit Note</td>
<td>• Telephone Progress Note</td>
<td>• Case Communication</td>
</tr>
<tr>
<td>• Fall Risk Screening (Multi-Factor) for any fall visit</td>
<td>• PRN Visit order</td>
<td>• HACPB</td>
</tr>
<tr>
<td>• Case Communication</td>
<td>• Medication order</td>
<td>• INA</td>
</tr>
<tr>
<td>• HACPB</td>
<td>• Documents related to appeals request from KEPRO / Medicare / State</td>
<td>• IPOC or RPOC</td>
</tr>
<tr>
<td>• Death Visit Note</td>
<td>• Wound Orders</td>
<td>• IDTPOC</td>
</tr>
<tr>
<td>• PRN Visit Order</td>
<td></td>
<td>• Braden Scale, Fall Risk Screening (multi-factor), Palliative Performance Scale</td>
</tr>
<tr>
<td>• Death Visit Order</td>
<td></td>
<td>• Initial Visit Order</td>
</tr>
<tr>
<td>• Death Order (Pronouncement)</td>
<td></td>
<td>• Email admission to Allusers</td>
</tr>
<tr>
<td>• Medication Order</td>
<td></td>
<td>• Email admit/assess case communication to New Referrals</td>
</tr>
<tr>
<td>• Wound Orders</td>
<td></td>
<td>• Medication orders</td>
</tr>
</tbody>
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Managing Level of Care Changes & Revocations

- **4 Medicare Hospice levels of Care**
  - Routine Care (95-98% of the care we provide)
  - Respite Care (temporary relocation up to 5 nights at SNF, used for unpaid caregiver burnout and support). Use triage and SS team for support setting up this LOC. Suncrest covers room and board in SNF for Respite level of care.
  - Continuous Care (**in-home** acute crisis management, 8 hours per day or greater). Chart in HC1 PRN Progress Note - may be a single note updated hourly.
  - General Inpatient care (Relocation to SNF for skilled nurse symptom mgmt.). Use triage and SS team for support setting up this LOC. Suncrest covers room and board in SNF for Respite level of care.

- **When to consider changes to Level of Care**
  - Collaborative process including On-Call, Triage, SS Team and on-call Medical Director
  - **Death Discharge:** Breathe, it’s not an emergency! Vitals ceased, PCP or MD Pronouncement, coroner release, mortuary notification/transfer, reportable events
  - **Live Discharge:** Revocation, Discharge/Graduation, Discharge for cause, Transfer
  - **Updating HC1:** Revocations, Live Discharge after midnight and relocations
On-Call Documents & Written Resources

- Hospice “Legals”
- Change of attending form
- Medication paper orders
  - (C2, Comfort Kit, TO/VO)
- Incident Reports (Falls, med errors, etc.)
- Advanced Directives awareness
  - MOST (on hand)
  - MDPOA
  - Proxy
- Nurse Business Cards

- PTHandbook (in Admission packet)
- Hospice QuickFlips spiral guide
- Gone from My Sight blue booklet
- Admission packets (blue folder)
- Continuous Care packets (red fldr)
- “Sorry we missed you” notepads
- Patient Visit logs (Green folder)
- PPS/FAST and Hospice Eligibility
  - 8.5x11 laminated card (also online at http://geriatrics.uthscsa.edu/tools/Hospice_eligibility_card_Ross_and_Sanchez_Reilly_2008.pdf)
Abuse, Neglect, Elopement & Safety

- Managing safety concerns
  - Safety for team and patient
    - Acute safety response
  - Reportable occurrences
    - Abuse
    - Neglect
    - Medication diversion
    - Elopement
  - How and when to communicate and help manage concerns
  - Reporting timeframes (as short as 24 hours!)
  - On-call & Triage nurses not directly responsible for making decision to report, but are responsible for identifying and communicating potential concerns and supporting investigation.