



Spring 1068 Training

Health Care Referral & Follow-Up

ADULT CARE LICENSURE SECTION

DIVISION OF HEALTH SERVICE REGULATION

Training Objectives:

- the knowledge of the rules pertaining to health care
- observation, interview, and record review to assess the quality of health care services provided to residents
- effective interventions to improve the quality of health care services.

10A NCAC 13F/G .0902(b)

Health Care

- The facility shall assure referral and follow up to meet the routine and acute health care needs of residents



Routine Health Care Needs

Lab work

**Medical
appointments**

**Referrals to
mental health,
PT, OT, podiatry**



Key Focus Points:

- **Were there any changes in behavior, status, symptoms, or condition identified and communicated with staff and appropriate health care providers?**
- **Were incidents and refusals investigated to identify patterns and safety or health risks? Were health care providers notified?**
- **Did residents attend health care appointments as ordered?**
- **Were provider orders implemented timely and as ordered?**

Observations

- Observe for implementation of any orders related to safety interventions
- Examples include but are not limited to compliance with use of chair alarms, blood sugar checks, TED hose, blood pressure checks, toileting schedules, dressing changes, etc.
- Meals for appropriate diets are served
- Medication on hand—note dispense date, original dispense quantity and quantity currently on hand
- Observe for change in condition, wounds/dressings, behaviors, other safety/supervision needs, etc.

Record Reviews

- **FL-2:** orders for vital signs, medication, diet, any special wound/dressings orders, toileting program orders
- **Physician Orders:** same as FL-2 orders to include physician orders for medications, treatments (dressing changes, CPAP, etc.), special services (PT, OT, home health etc.), interventions (chair alarms, specialty bed, special diabetic shoes, increased supervision, etc.), resident condition orders (blood pressure, heart rate, blood sugars, labs, etc.) **BE SURE TO NOTE ANY PARAMETERS FOR NOTIFICATION SUCH AS FOR HIGH AND LOW BLOOD SUGAR OR BLOOD PRESSURE READINGS:** referrals to specialty care (podiatry, dental care, etc.), dietary orders, any other orders such as personal care and supervision
- Review hospital discharge documents and orders for all of the above be sure to look for follow up orders or appointments

Record Reviews Continued

- Home health orders/Hospice orders and notes
- Mental health provider notes to include orders for safety, medication, lab, & follow-up care
- Activities of Daily Living (ADL), bathing/shower, &/or skin assessment sheets
- Progress notes—note refusals, changes in condition, timeline, etc.
- Notifications to HC providers (order sheets, faxes, etc.)
- Medication Administration Records (MAR)/ Treatment Administration Records (TAR) for medications, treatments, vital signs

- What was the process or policy that was supposed to be followed for order implementation and referral?
- What was the process (if any) to track orders and communicate the orders to staff?
- What were the staffs' responsibilities related to orders?
- What happened that resulted in the lack of HC implementation?
- What was done to address? (if any)
- What was the change in condition?
- What were the staffs' responsibilities related to change in resident's condition or status?

Interviews

WHAT?

- What was the expectation of the provider who wrote the order(s) relative to notification, refusals, notification of change in condition, implementation of orders as written, timeline of referral and implementing orders, and for referral for specialty, change in status, and or emergent care, etc. ?
- What was the expectation of facility management related HC referrals, change in status, implementation of orders as written and timeline of referral and order implementation?
- What was the outcome to the resident?

Interviews

WHAT?

- Who was responsible to implement the order(s)? Faxed to pharmacy? Document on medication administration record?
- Who was supposed to be notified of any problems?
- Who was notified? Was there coordination of care between primary care physician and any specialists?
- Who first noticed the change in residents status or condition?
- Who was responsible for communicating orders to all staff providing care?
- Who was responsible for assuring policy and procedure was followed? Was there any monitoring in place by management or administrator?

Interviews

WHO?

- When was the order implemented?
- When was notification completed?
Was it timely?
- When was change in resident's condition first noticed?
- When was medical attention provided? When was the resident sent to hospital or evaluated by provider? Were there any delays?
- When was the provider notified? (if applicable)

Interviews

WHEN?

- How would facility receive new orders and be made aware of the new orders?
- How were staff trained to respond for HC status changes, emergencies, implementation of orders, etc.?
- How often were residents monitored?
- How were orders communicated with staff?
- How often (if ever) were chart audits done or orders verified to assure implementation and nothing was missed?
- How were problems with orders communicated amongst staff and with the providers?

Interviews

HOW?

- Why was the established procedure or policy not followed?
- Why was the medical provider not notified?
- Why was the resident not provided medical care or evaluated by a medical professional?
- Why was there a delay in the resident receiving care or being evaluated?
- Why were new orders not completed as ordered or never implemented?

Interviews

WHY?

- **Quality Assurance is an ongoing self-survey process that evaluates the care and services you deliver to residents every day.**
- **Who is better equipped to survey your building than YOU?**

What is Quality Assurance?

Quality Assurance Monitoring Health Care

- **Record Review**
 - What have you read?
- **Interview**
- **Observation:**
 - What have you seen?
 - What have you heard?
- **Analysis?**
 - Is there a problem?
 - What is causing the problem?

Quality Assurance Systems

- Random review of residents' records
 - Recent hospitalizations, MD appointments
- Random and unannounced observations of medication passes, finger stick blood sugar check, pulse check, (Rotate shift & medication aides)
- Routine review of medication administration records

Conclusion

An effective QA system assures safety and enables accountability

Use your available resources

Be sure to ask questions!!!

Resources

- Adult Care Licensure Section
 - 919-855-3765
- DHSR.AdultCare.Questions@dhhs.nc.gov