Protocol for Pneumonia



Hospital Discharge Internal Process/Protocol for Pneumonia

The following steps should be taken when a resident comes to The Cottages from the hospital for this diagnosis.

Day 1:	
	Set up outside services (ex. Home health) – where applicable
	Review Fall Risk Assessment and or complete one
	Schedule a follow up Dr. Appt.
	Ensure we have resident's medication set up in Bluestep and that we have the medications
	available
	Inquire to see if a breathing treatment should be performed if one has not been ordered
	Coordinate with our nurse to have an assessment performed same day
	Perform frequent checks and vitals every shift x 7 days to include BP, Pulse, Resp., and Temp.
	Monitor oxygen stats. on the MAR q shift (if under 90 notify RN)
	Take daily weight measurement for entire 30days (notify RN if resident gains or loses 2 lbs.)
	Ask about Diuretics to help avoid fluid retention
	Set up a Temporary Care Plan
	Monitor frequent fluids & diet
	Check for edema daily and remind staff to assist in elevating residents' feet - Staff need to be
	delegated on what to report to the nurse in relationship to edema, urine, and hydration
Day 7:	
	Have our nurse perform a follow up review of O2, weight, medications, nutrition log & make
	comprehensive notes
	Continue therapies – review home health/hospice agency notes and follow up as needed
	Add progress notes based on current progress and condition
Day 14:	
	Inquire to see if the doctor would like to have a chest x-ray performed
	Check and record vitals in Bluestep (BP, Pulse, Resp., Temp, and weight)
П	Obtain orders for the lab to ensure there is not infection (ensure doctor's order is in place)
	Have our nurse perform a face to face nurse visit with comprehensive notes and add follow up
	notes
	Administrator - Send a note to our resident's doctor and family to let them know how their
	doing (email, fax, or phone)
	Incorporate the Temporary Care Plan into the Service Plan
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Day 2	l:	
	Check and record vitals in Bluestep (BP, Pulse, Resp., Temp, and weight)	
	Have our nurse evaluate resident's condition, add follow up notes and notify administrator of	
	progress.	
	☐ Administrator contacts the doctor and discuss progress	
	Administrator - Make progress notes about residents' overall condition, activity level, mood state and appetite and verify the nurse has read the notes	
Day 28:		
	Check and record vitals in Bluestep (BP, Pulse, Resp., Temp, and weight)	
	Have nurse and administrator review fall risk assessment	
	Review resident's Service Care Plan for areas that need modified, review LOCA and submit changes to accounting	
Day 30:		
	Close out the BounceBack form in Bluestep to determine whether our resident was able to stay	
	at The Cottages or went back to the hospital	
	Inquire about hospice if appropriate	
	Follow up with resident's doctor and discharge planner on status of our resident	
	 Send handwritten personalized card 	
	☐ Email completed Protocol form to the Director of Operations and CMO (<i>Protocol forms</i>	
	are on E-binder)	
	☐ Send medication review fax to Dr.	

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