Protocol for Post Rehab Fracture

Hospital Discharge Internal Process/Protocol for Post Rehab Fracture *(Urinary Tract Infection)*

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

Day 1:

- ☐ As soon as resident is admitted to *the hospital*, the administrator will contact the hospital discharge planner on a weekly basis
- ☐ Once the resident goes into *rehab*, the administrator will establish weekly contact with the case manager
- ☐ Approximately one week before resident returns, the administrator will conduct an onsite assessment
- ☐ Set up therapy services with an outside agency 3-5 days before the resident returns
- ☐ 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
- ☐ Coordinate with our nurse to have an assessment performed upon return (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 weekly, or more often if needed, weight measurement for entire 30 days (notify RN if resident gains or loses 2 lbs.)
- ☐ Set up a regular fluid intake schedule - Monitor frequent fluids & diet
- ☐ Set up a Temporary Care Plan
- ☐ 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
    - ☐ Ask the therapist to provide daily recommendations
- ☐ Add progress notes based on current progress and condition

Protocol for Post Rehab Fracture

Day 14:

- Check and record vitals in Bluestep (BP, Pulse, Resp., Temp and Weight)
- During the second week 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

Day 21:

- 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 (*Protocol forms are on E-binder*)
    - Send medication review fax to Dr.