


GUAM MEMORIAL HOSPITAL AUTHORITY
NURSING SERVICES MANUAL

APPROVED BY:  Zennia Pecina, RN, MSN Associate Administrator of Nursing Services	RESPONSIBILITY: Nursing Services	EFFECTIVE DATE: October 24 2012	POLICY NO. 6301-II E-21	PAGE 1 of 4
TITLE: ADMISSION TO THE SKILL NURSING FACILITY (SNF) FROM THE ACUTE CARE FACILITY				
LAST REVIEWED/REVISED: 12/2015				
ENDORSED: NMC 11/2015; MEC 12/2015				

PURPOSE:

To relocate patients within the hospital to meet his/her needs and care for his/her present condition. When an inpatient medical condition level of care changes from an acute level to a Skilled Nursing level the attending physician can request for the patient to be evaluated for a Skilled Nursing Facility (SNF) level of care. This is not considered a transfer from GMH but a discharge from an acute unit to the Skilled Nursing Unit for admission.

POLICY:

I. CRITERIA FOR ADMISSION:

- A. Acute care patients must have been in the acute care facility at least three days (not including the discharge date), properly evaluated by their attending physician and their condition stabilized.
- B. Must be reviewed, and accepted by the Skilled Nursing Facility (SNF) Medical Director for admission to SNU, requires post-hospital care after a period of intensive hospital care, but no longer requires constant medical services.
- C. When the nursing care required by the patient is at a skilled service, required to prevent deterioration of their condition or to sustain their current capabilities, and to improve their potential for recovery.
- D. Need for Physical, Occupational, or Speech Therapy on a regular basis where the provision for these services if the patient was discharged home would not be as available
- E. The need of the patients requires other skilled services provided at SNU.

II. RESIDENTS MOST LIKELY TO BE ADMITTED TO SNF:

Post-acute care patients recovering from or requiring care for:

- A. Orthopedic Injuries;
- B. Cerebral Vascular Accidents;
- C. Myocardial Infarction;
- D. Lower Limb Amputations;
- E. Wound Care/Pressure Sore management, and/or Extensive Skin Graft management
- F. Trauma Cases;
- G. Intravenous (IV) Therapy, Antibiotics, or Total Parenteral Nutrition;
- H. Terminal Care for Intravenous pain management;

- I. Dialysis with Other Skilled Care Needs;
- J. Enteral Tube Feeding;
- K. Infectious Diseases requiring Skilled Care
- L. Skilled Care for a new tracheostomy;
- M. Family or home support care training.

III. ELIGIBILITY CRITERIA FOR SNU COVERAGE OF SERVICES (PAYMENT SOURCE)

1. FOR MEDICARE BENEFICIARIES

- A. Enrolled in the Medicare Program (Part A and Part B), and has Skilled Nursing days available;
- B. Medical Appropriateness Exception- An elapsed period of no more than 30 days is permitted for SNF admissions were the patient's condition make it medically inappropriate to begin an active course of treatment in at SNF within 30 days after hospital discharge, and it is medically predictable at the time of the hospital discharge that they will require covered care within a pre determinable time period;
- C. Attending Physician order for SNF admission;
- D. Requires skilled services by a Registered Nursing Staff or Skilled Rehabilitation Services on a daily basis;
- E. The SNF services are reasonable and necessary for the illness or injury;
- F. The medical need for daily skilled services which can be provided only as an inpatient at "SNF" (*from* the SNF manual issued by Medicare).

2. FOR OTHERS INSURANCE PROVIDERS

The criteria for coverage for non-Medicare patients is based upon the individual's extended/skilled care benefits. Family or patient needs to check with their insurance for covered benefits.

3. CLASSIFICATION OF PATIENTS

The SNF utilizes the RUG III Clinical Classification System to determine resident care needs. Residents/families or responsible representatives can obtain information about the Classification System from SNF Head Nurse or SNF Medical Director.

IV. PROCEDURE FOR ADMISSION:

- 1. Admission from an acute care unit of GMHA to SNF:
 - A. Attending physician shall request consultation from the SNF Medical Director.
 - B. The SNF Medical Director evaluates the patient and determines whether SNF admission criteria are met.
 - C. The SNF Medical Director uses the Request for Skilled Nursing Unit (SNU) Admission Form (**Attachment I**) to document findings and the determination for admission.

2. Upon approval of the admission to SNU, the Medical Director shall complete the following:
 - A. Provide the patient a copy of the patient information pamphlet;
 - B. Forward a duplicate copy of the Medical Director's Request for Skilled Nursing Unit (SNU) Admission Form (**Attachment I**) to the SNU unit;
3. The attending physician writes SNU admission orders. The admission orders should include the following criteria (if indicated):
 - A. Accuchecks should be limited to once or twice daily;
 - B. Recent Hemoglobin should not be less than 9 gm/dl. Hematocrit should not be less than 27%;
 - C. The patient should be afebrile at least 24 hours prior to admission;
 - D. PICC lines should be placed in patients who are admitted to SNU for long-term IV therapy;
 - E. No more than two IV antibiotics should be ordered;
 - F. Standing orders for Tylenol 500mg or 650mg every 4 hours for mild pain on pain scale of one to three or fever above 100.5;
 - G. Standing orders for Bowel Protocol;
 - H. Standing orders for Bladder Protocol;
 - I. Standing orders for renewal of medications every 30 days for long-term patients who stay over 30 days;
 - J. Standing orders for sliding scale for Regular Insulin coverage;
 - K. Standing orders for changing indwelling Foley catheters every 30 days and reassessment for possible removal if indicated;
 - L. Standing orders for labs to include (at a minimum) CBC and Chem 7 within a week of their admission and as needed. For patients that have wounds, Albumin levels should be ordered weekly;
4. The Charge Nurse of the transferring unit calls the SNU Charge Nurse for a bed assignment. The SNU charge nurse will assign the resident a bed that best meets their needs.
5. Required documents to be sent from the acute unit to SNU include:
 - A. Current Lab report/results such as CBC, Chemistry, Microbiology reports that were obtained during their acute admission, and other relevant laboratory studies;
 - B. Radiology reports, specifically chest x-ray reports;
 - C. Medication Administration Records (MARS) and parental therapy records;
 - D. PPD skin test results, Influenza and Pneumococcal immunizations, and any other relevant information or reports;
 - E. Copy of the History & Physical Report from the acute hospital admission;
 - F. Any other consultations;
 - G. Therapy evaluations;
 - H. Do Not Resuscitate (DNR) signed form if indicated.
6. Prior to SNU transfer, Patient Registration staff should obtain signatures on the SNU admission packet from the patient or their representative.
7. Once all the documentation is completed and room assigned, the transferring Charge Nurse will call SNU to give endorsement to the SNU's Charge Nurse.

8. FAX a copy of the SNU admission orders to pharmacy to prepare a 24 hour supply of medication.
9. The Utilization Review Coordinator conducts concurrent review every seven days to assure that criteria are being met for continued admission.

V. GENERAL INSTRUCTIONS FOR SNU TRANSFER:

- A. Once SNU medications are delivered to unit and endorsements are completed, the transferring Charge Nurse will notify the Nursing Supervisor to activate EVOC personnel;
- B. Safeguard patient's belongings and send with the patient or family;
- C. Transferring Charge Nurse will endorse to SNU Charge Nurse using the SBAR process.
- D. SNU Charge Nurse will place the accepted patient on a waiting list or in order of priority when there is no room available at SNU.

VI. ATTENDING PHYSICIAN RESPONSIBILITY:

- A. Complete Discharge Summary
- B. Attending Physician Orders which should include:
 1. Medications;
 2. Treatments;
 3. Rehabilitative therapies needed and special services ordered;
 4. Diet, fluid restrictions;
 5. Precautions relating to activities undertaken by the patient
 6. Activity level (ambulatory, wheelchair, etc.);
 7. Plans for continuing care and discharge plan from SNU

RELATED POLICIES:

Policy# 6301-II E-17 Transfer within Patient Care Unit, Nursing Services Manual

Policy# 6301-I E-3 Discharge of Patient from Hospital, Nursing Services Manual

Policy# 6580-B13 Transfer from SNU to Acute Care Facility, Skilled Nursing Facility Policy Manual

Policy # 6580-C-6 Transfer/Discharge Requirements, Skilled Nursing Facility Policy Manual

Policy# 6580-C8 Admission from Acute Care Facility to SNU, Skilled Nursing Facility Policy Manual

Policy # 6580-C9 Pre-Admission Screening of Mentally Ill Individual and Individual with Mental Retardation, Skilled Nursing Facility Policy Manual

Policy # A-PS300 SBAR Communication/Patient Hand-off Communication, Administrative Manual

REVISIONS:

Attachment I

**REQUEST FOR SKILLED NURSING UNIT (SNU) ADMISSION
GUAM MEMORIAL HOSPITAL AUTHORITY**

DIAGNOSIS: Primary: _____
Secondary: _____

DOES THE PATIENT REQUIRE DAILY SERVICES THAT CAN ONLY BE PROVIDED ON AN IN-PATIENT SNU BASIS UNDER THE SUPERVISION OF A LICENSED NURSE OR THERAPIST? YES NO

REASON FOR SNU ADMISSION: (Select Category from SNU Pre-Admission Screening Form on Page 2)
 Rehabilitation Extensive Care Special Care Clinically complex Other _____

RECOVERY POTENTIAL: Excellent Fair Uncertain Nil

ESTIMATED LENGTH OF STAY: _____ weeks

SIGNATURE OF ATTENDING PHYSICIAN

DATE & TIME OF REQUEST

ACCEPT DEFER DENY

(Continued on back page)

SIGNATURE OF SNU MEDICAL DIRECTOR

DATE & TIME OF CONSULTATION

REQUEST FOR SNU ADMISSION
GUAM MEMORIAL HOSPITAL AUTHORITY
(page 1 of 4)
GMHA FORM #XXXXX REVIEWED: XXXXX
CREATED: 2/18/00 REVISED: 8/17/00

ADDRESSOGRAPH

**REQUEST FOR SKILLED NURSING UNIT (SNU) ADMISSION
GUAM MEMORIAL HOSPITAL AUTHORITY**

[Empty rectangular box for medical notes or consultation details]

ACCEPT DEFER DENY

SIGNATURE OF SNU MEDICAL DIRECTOR

DATE & TIME OF CONSULTATION

REQUEST FOR SNU ADMISSION
GUAM MEMORIAL HOSPITAL AUTHORITY
(page 2 of 4)
GMHA FORM # XXXXX REVIEWED: XXXXX
CREATED: 2/18/00 REVISED: 8/17/00

ADDRESSOGRAPH

**REQUEST FOR SKILLED NURSING UNIT (SNU) ADMISSION
GUAM MEMORIAL HOSPITAL AUTHORITY**

REFERRING AREA: Medical-Surgical Surgical
 Medical Telemetry Pediatrics ICU/CCU

REHABILITATION CATEGORY

- | | |
|--|---------------------------------|
| 1. Does the patient have a diagnosis that will benefit from one or more rehab disciplines? (If yes, MAKE NOT IN HOSPITAL CHART REQUESTING REHAP THERAPY (PT, OT, and/or ST) TO EVALUATE AND RECOMMEND CARE PLAN. | 1. <input type="checkbox"/> Yes |
| 2. Has patient had Rehab Evaluation and is PT, OT and/or ST recommended? | 2. <input type="checkbox"/> Yes |
| 3. Will the patient have a physician's order for this therapy? | 3. <input type="checkbox"/> Yes |

EXTENSIVE CARE CATEGORY

In the last 14 days, has the patient received:

- | | |
|--------------------------------|---------------------------------|
| 1. IV Medication | 1. <input type="checkbox"/> Yes |
| 2. Suctioning | 2. <input type="checkbox"/> Yes |
| 3. Tracheostomy Care | 3. <input type="checkbox"/> Yes |
| 4. Ventilator/Respiratory Care | 4. <input type="checkbox"/> Yes |

In the last 7 days, has the patient received:

- | | |
|---------------------------|---------------------------------|
| 1. IV/Parenteral Feedings | 1. <input type="checkbox"/> Yes |
|---------------------------|---------------------------------|

SPECIAL CARE CATEGORY

Does the patient currently have:

- | | |
|---|---------------------------------|
| 1. Surgical wounds or open lesions with one of the following: wound care or skin care treatments, or foot dressing or special applications, ointments or medications. | 1. <input type="checkbox"/> Yes |
| 2. A stage 3 or 4 pressure ulcer or 2 ulcers (any type) across all Stages. | 2. <input type="checkbox"/> Yes |
| 3. Fever with dehydration, pneumonia, or vomiting, or weight loss or tube feeding. | 3. <input type="checkbox"/> Yes |
| 4. A feeding tube (NG/PEG). | 4. <input type="checkbox"/> Yes |

In the last 7 days or since admission if less than 7 days in the facility:

- | | |
|------------------------|---|
| 1. Respiratory Therapy | 1. <input type="checkbox"/> Yes Most recent date received: |
|------------------------|---|

In the last 14 days did the patient have:

- | | |
|----------------------|---------------------------------|
| 1. Dialysis | 1. <input type="checkbox"/> Yes |
| 2. Radiation Therapy | 2. <input type="checkbox"/> Yes |
| 3. Chemotherapy | 3. <input type="checkbox"/> Yes |

SNU PRE-ADMISSION SCREENING FORM
 GUAM MEMORIAL HOSPITAL AUTHORITY
 (page 3 of 4)
 GMHA FORM # XXXXX REVIEWED: XXXXX
 CREATED: 2/22/00 REVISED: 8/17/00

ADDRESSOGRAPH

**REQUEST FOR SKILLED NURSING UNIT (SNU) ADMISSION
GUAM MEMORIAL HOSPITAL AUTHORITY**

CLINICALLY COMPLEX CATEGORY

Does the patient currently have:

- | | |
|--|---------------------------------|
| 1. Hemiplegia | 1. <input type="checkbox"/> Yes |
| 2. Coma | 2. <input type="checkbox"/> Yes |
| 3. Dehydration | 3. <input type="checkbox"/> Yes |
| 4. Pneumonia | 4. <input type="checkbox"/> Yes |
| 5. Septicemia | 5. <input type="checkbox"/> Yes |
| 6. Burns | 6. <input type="checkbox"/> Yes |
| 7. Internal Bleeding | 7. <input type="checkbox"/> Yes |
| 8. Tube Feeding | 8. <input type="checkbox"/> Yes |
| 9. Diabetes with daily injections and 2 days of Physician order changes? | 9. <input type="checkbox"/> Yes |

In the last 14 days, did the patient receive

- | | |
|---|---------------------------------|
| 1. Oxygen Therapy | 1. <input type="checkbox"/> Yes |
| 2. Chemotherapy | 2. <input type="checkbox"/> Yes |
| 3. Transfusions | 3. <input type="checkbox"/> Yes |
| 4. Dialysis | 4. <input type="checkbox"/> Yes |
| 5. In the first week will the resident be medically unstable enough to require physician's examination and/or changes (at least 2 instances). | 5. <input type="checkbox"/> Yes |

ADDITIONAL INFORMATION

- | | |
|------------------------------------|---------------------------------|
| 1. Behavior problems | 1. <input type="checkbox"/> Yes |
| 2. Restraints used | 2. <input type="checkbox"/> Yes |
| 3. Hemoglobin greater than 9 gms | 3. <input type="checkbox"/> Yes |
| 4. Nutritional Supplements Needed: | 4. <input type="checkbox"/> Yes |
| 5. Recent Surgeries | 5. <input type="checkbox"/> Yes |

NOTES

SNU PRE-ADMISSION SCREENING FORM
GUAM MEMORIAL HOSPITAL AUTHORITY
(page 4 of 4)
GMHA FORM # XXXXX REVIEWED: XXXXX
CREATED: 2/22/00 REVISED: 5/16/00

ADDRESSOGRAPH

**ADMITTING SKILLED NURSING UNIT (SNU) PHYSICIAN ORDERS
GUAM MEMORIAL HOSPITAL AUTHORITY (page 1)**

DIAGNOSIS: Primary: _____ Secondary: _____	
PATIENT INFORMED OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO CODE STATUS: <input type="checkbox"/> FULL CODE <input type="checkbox"/> NO CODE <input type="checkbox"/> UNDECIDED	
DIET: <input type="checkbox"/> REGULAR <input type="checkbox"/> SPECIAL (Specify on Physician's Order sheet) FAMILY MAY BRING IN FOOD: <input type="checkbox"/> YES <input type="checkbox"/> NO ACTIVITY: <input type="checkbox"/> Un-restricted <input type="checkbox"/> SPECIAL (Specify on Physician's Order sheet) VITAL SIGNS: <input type="checkbox"/> ROUTINE <input type="checkbox"/> SPECIAL (Specify on Physician's Order sheet) ALLERGIES: <input type="checkbox"/> NO <input type="checkbox"/> YES	
REHAB EVALUATION: PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH/LANGUAGE THERAPY REHAB POTENTIAL:	<input type="checkbox"/> FULL EVALUATION & TREATMENT AS RECOMMENDED <input type="checkbox"/> EVALUATION ONLY (FOR NEED OF INTERVENTION) <input type="checkbox"/> FULL EVALUATION & TREATMENT AS RECOMMENDED <input type="checkbox"/> EVALUATION ONLY (FOR NEED OF INTERVENTION) <input type="checkbox"/> FULL EVALUATION & TREATMENT AS RECOMMENDED <input type="checkbox"/> EVALUATION ONLY (FOR NEED OF INTERVENTION) <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> NIL
PRESSURE SORE PROTOCOL <input type="checkbox"/> YES <input type="checkbox"/> NO BOWEL CARE PER SNU PROTOCOL <input type="checkbox"/> YES <input type="checkbox"/> NO DENTAL CONSULT IF NEEDED <input type="checkbox"/> YES <input type="checkbox"/> NO PODIATRY CONSULT IF NEEDED <input type="checkbox"/> YES <input type="checkbox"/> NO RECENT CHEST X-RAY NEGATIVE FOR TB <input type="checkbox"/> YES <input type="checkbox"/> NO DATE: _____ LABORATORY TESTS REQUIRED <input type="checkbox"/> YES <input type="checkbox"/> NO (Specify indication and application on Physician's order sheet)	
EXPECTED LENGTH OF STAY IN SNF: _____ WEEKS	
PHYSICIAN'S SIGNATURE: _____ DATE: _____	

SNU PHYSICIAN'S ORDER FORM
 GUAM MEMORIAL HOSPITAL AUTHORITY
 (page 1 of 2)
 GMHA FORM # XXXXX REVIEWED: XXXXX
 CREATED: 2/19/00 REVISED: 5/16/00

ADDRESSOGRAPH

**ADMITTING SKILLED NURSING UNIT (SNU) PHYSICIAN ORDERS
 GUAM MEMORIAL HOSPITAL AUTHORITY (page 2)**

ALL ORDERS MUST BE WRITTEN WITH A BALL POINT PEN AND INCLUDE DATE, TIME, AND PHYSICIAN'S SIGNATURE

PLEASE MATCH MEDICATION ORDERS WITH DIAGNOSIS AND SPECIFY INDICATION FOR PRN ORDERS

CAN SNU PHYSICIAN-DIRECTOR COUNTERSIGN AND WRITE ORDERS?
 YES NO

CAN GENERIC SUBSTITUTES BE USED?
 YES NO

DATE	TIME	PHYSICIAN'S ORDER	DATE/TIME

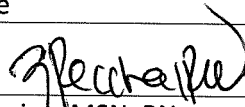
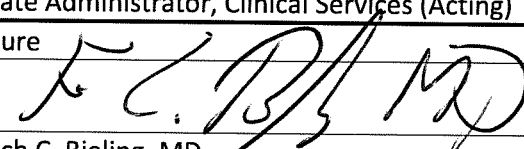
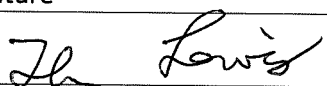
SNU PHYSICIAN'S ORDER FORM (page 2 of 2)
 GUAM MEMORIAL HOSPITAL AUTHORITY
 GMHA FORM # XXXXX REVIEWED: XXXXX
 CREATED: 2/19/00 REVISED: 5/16/00

ADDRESSOGRAPH

GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledged that they have reviewed and approved the following:

<input type="checkbox"/>	Bylaws	Submitted by Department/Committee: Nursing Management
<input type="checkbox"/>	Rules and Regulations	Policy No.: 6301-II-E-21
<input checked="" type="checkbox"/>	Policies & Procedures -Renewed	Title: ADMISSION TO THE SKILLED NURSING FACILITY FROM ACUTE CARE FACILITY

Reviewed/Endorsed	Date	Signature
	11/23/2015	
Title	Zennia Pecina, MSN, RN Associate Administrator, Clinical Services (Acting)	
Reviewed/Endorsed	Date	Signature
	12-23-15	
Title	Friedrich C. Bieling, MD Medical Executive Committee, President	
Reviewed/Endorsed	Date	Signature
	12.28.15	
Title	Theodore Lewis, MBA Executive Management Committee, Chairperson	
Reviewed/Endorsed	Date	Signature
		•
Title		
Reviewed/Endorsed	Date	Signature
Title		
Reviewed/Endorsed	Date	Signature
Title		
Reviewed/Endorsed	Date	Signature
Title		

*Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer