NAVIGATOR NOTES

Making Eldercare Easier

THE ELDERCARE NAVIGATOR

Checklist for Care Conference

(Example for Rehab Facility)

Care Conference for NAME OF ELDER. **Date of Care Conference**: xx/xx/xxxx

Attendees of Conference:

Name of Nurse:
Name of Physical Therapist (PT):
Name of Occupational Therapist (OT):
Name of Speech Therapist (ST):
Name of Social Worker:
Name of Family Members:
Name of Others:

Summary of current status: Elder arrived at rehab facility two days ago for condition XXX. Elder is fall risk so bed has been lowered to floor level. Special dietary needs are XXX, including acknowledgement of food allergies. Medications discussed and verified.

Goals for near term: Elder will have PT scheduled XXX. OT scheduled XXX. Social worker to evaluate return to previous residence or assist in locating appropriate facility.

Goals for long term: Elder will be able to walk unassisted with wheeled walker by time of discharge. Elder will be able to safely transfer on/off toilet and into/out of shower with standby assistance at minimum.

Notes:
(PT says this. OT says that. Nurse says this.) (Elder needs to eat more/do more XXX.) (Family member will discuss special needs with dietician.) (Concerns are this.)

Action Items for Staff:
1) PT will re-evaluate XXX.
2) Nurse will confirm change in meds with primary care doctor.

Action Items for Family/Elder:
1) Family will do personal laundry.
2) Elder will communicate more regularly about pain level.

Date of Next Meeting: xx/xx/xxxx

Another Solution from Navigator Notes

THE ELDERCARE NAVIGATOR

http://TheEldercareNavigator.com

Checklist for Care Conference

(Example for Assisted Living/Nursing Care Facility)

Care Conference for NAME OF ELDER. **Date of Care Conference**: xx/xx/xxxx

Attendees of Conference:

Name of Nurse:
Name of Aide or CAN:
Name of Activities Staff/Other Staff Member:
Name of Family Members:

Summary of current status: Elder arrived at asst lvg facility last week. Assessment upon arrival was XXX. Elder is fall risk so bed has been lowered to floor level at night. Special dietary needs are XXX, including acknowledgement of food allergies. Medications were discussed and verified. Patient's family will order meds from mail order Rx and coordinate with Nurse X on re-orders.

Goals for near term: Activities Director will work with Elder to introduce them to other residents and invite them to their favorite activities (XXX, XXX and XXX). Outpatient therapist will work (scheduled xx/wk) to strengthen Elder and minimize fall risk.

Goals for long term: Elder will be able to transfer safely in/out of bed and will no longer be a significant fall risk.

Notes:
(Nurse says this.)
(Elder needs to come more often to breakfast, do more XXX.)
(Family member, when visiting, will encourage Elder to participate in more activities.)
(Concerns are this.)

Action Items for Staff:
1) Nurse to make notes in chart about coordinating Rx orders with family.
2) Activities staff will invite Elder to do XXX and XXX.

Action Items for Family/Elder:
1) Family will introduce themselves to aides and staff.
2) Elder will attend XXX and try Activity XXX.

Date of Next Meeting: xx/xx/xxxx

Another Solution from Navigator Notes

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Checklist for Care Conference

(Example for Hospital)

Care Conference for NAME OF ELDER. **Date of Care Conference**: xx/xx/xxxx

Attendees of Conference:

Name of Nurse:
Name of Social Worker:
Name of Doctor or Hospitalist:
Name of Therapist:
Family Members:

Summary of current status: Elder was admitted 3 days ago for pneumonia and chest pain. Elder was initially in ICU but has since moved to regular care. Chest pain was diagnosed as associated with pneumonia. Nurse says current condition is XXX. Doctor would like to add Rx. Respiratory therapist sees improvement and is treating xx/day. High blood pressure condition is being treated. Family verified list of current meds and allergies.

Goals for near term: Next steps in treatment are XXX.

Goals for longer term: Anticipate discharge in XX days. Elder will likely need to go to rehab facility after discharge to build strength prior to returning to independent living. Social worker will begin working with family to identify rehab facilities.

Notes:
Doctor (Specialist) visits in early AM between hours of X and X. Nurse will make note for Dr. to call family member with update, if Dr. does not see family while examining Elder.

Doctor (Primary) has not yet been to see Elder, but Hospitalist is keeping Primary Dr. informed of treatment.

Respiratory therapist treats in AM around XX, and in PM around XX.
Nursing staff will call family if status changes. Family phone #s are on board in room.

Action Items for Staff:
1) Nurse to make notes in chart about Dr. updating family.
2) Social worker will have list of rehab facilities to family by XXX.

Action Items for Family/Elder:
1) Family will bring in toiletries for Elder.
2) Family will evaluate rehab facilities as soon as they receive list.

When Should We Meet Next? xx/xx/xxxx

Another Solution from Navigator Notes

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Instructions for Care Conference Notes

1) Make sure you set up a care conference as follows:
   - For rehab facility, set up in first week, then schedule one each week that your elder is in the rehab facility.
   - For a hospital, the care conference may be more informal as you meet with doctors, therapists and nurses when they are visiting your elder. However, you may request a care conference with the nursing staff or with the hospital social worker assigned to your elder.
   - For assisted living or nursing care, schedule a care conference in the first week after moving to the facility. Once a month after the initial conference – can be by phone but should have one in-person conference at least twice a year.

2) If representatives of each of the specialty areas listed above are not in attendance, make sure someone else from the facility reports on the missing specialty area.
3) Follow up on action items. Do not let any action items be forgotten. Ask attendees for the best way to communicate with them and who should be the point person inside the facility for follow-up.
4) If there are special dietary needs for your elder, ask the dietitian or food service representative to attend the conference.
5) If the conference is at a rehab facility, make sure you know the approximate date of discharge for your elder as they approach the end of their stay. Confirm that care will continue until discharge and what goals they believe will be met by the discharge date.

Discharge Appeals

A) Within 2 days of admission and prior to discharge from a hospital, the hospital will provide to your elder a notice called An Important Message from Medicare about Your Rights – or IM. The IM will have information on how to ask for a FAST APPEAL if you think your elder is being discharged too soon. A Fast Appeal must be requested by the day hospital discharge is scheduled.

B) Prior to discharge from a rehab facility, you will receive a Notice of Medicare Non-Coverage. This form tells you when Medicare will stop paying for care at that facility (essentially, it informs you of discharge date). If your elder continues to stay past that date, without appeal, your elder will be responsible for the charges. For a rehab facility, you'll need to file a Fast Appeal by no later than Noon of the first day AFTER you receive the "Notice of Medicare Non-Coverage".

C) If you need to appeal a discharge, you'll need to file a FAST APPEAL with the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in your area. To find their contact info, go to Medicare.gov/contacts. In the box, choose your state, then choose the BFCC-QIO from the options listed. Click on Find Contact Information. The BFCC-QIO organization in your area will be listed with a phone number and a link to their website.

Checklist for Care Conference

Care Conference for: _____ **Date of Care Conference**: _____

Attendees of Conference:

Nurse/Wellness Director: _____

Doctor/Hospitalist: _____

Therapists (Physical, Occupational, Speech): _____

Aide/CNA: _____

Social Worker/Activities Director: _____

Family Members: _____

Others: _____

Summary of current status:

Goals for near term:

Goals for long term:

Notes:

Action Items for Staff:

1)
2)

Action Items for Family/Elder

1)
2)

Date of Next Meeting: _____