Process for Resumption of Care Following Inpatient Facility Stay

This process takes place when the patient is returning home following an inpatient facility stay. The patient has been “on hold” status and remained open to homecare services during the inpatient facility stay. An inpatient facility includes a hospital, rehab facility, skilled nursing facility, nursing home or hospice.

1. The employee will make the Resumption of Care Assessment visit within 48 hours of the patient’s return home from an inpatient facility stay; within 48 hours of the referral or on the physician ordered ROC date.

2. Completion of the Resumption of Care Assessment is a two-step process:
   A. The employee will go to Care Pilot, Patient/Disc status and mark ROC.
   B. The employee will complete the ROC visit and Oasis Assessment.

3. Following the ROC visit:
   A. Call the physician office with an update, review the plan of care, the interventions initiated and receive any further orders.
   B. Call ROC report to nursing supervisor and to patient’s case manager on the day of the visit OR by Monday AM for weekend ROC’s. ROC report must include all disciplines ordered and frequency; any new diagnosis or exacerbations; POC synopsis items that will be included in the POC; and any new/changed treatments that are ordered.
   C. Make sure only current disciplines are referred in the Patient/Disc status.
   D. Complete ROC visit and submit through NDOC within 48 hours.
      *The Oasis Assessment, if applicable, should be placed on hold and marked “Ready for Coding” so QI can review.
      *The visit should be marked as complete.
   E. Write the Resumption of Care order to resume home health after hospitalization for the reasons patient was in hospital. Order must include any new diagnosis or exacerbations, new/changed treatments and disciplines ordered.
   F. Write frequency orders for all disciplines.
   G. Reconcile medications and update medication list noting any discontinued, new or changed medications.
   H. Update the Home Health Aide Assignment Sheet, if applicable, with any changes/additions and sign and date. Notify HHAide of changes and instruct HHAide to sign and date.

4. QI will review ROC assessments in date order. QI will add additional diagnosis and/or update current diagnosis if applicable. Any corrections/additions/clarifications needed will be entered by QI under Care Pilot activity area for patient. Corrections to be completed within 24 hours of notification by QI. Mark hold reason “RAC”.

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Orientation Manual
Procedure Form