STANDARDS' COMPANION EXAMPLES

NATIONAL INSTITUTE *for* MEDICAL RESPITE CARE

Standard 1: Medical respite program provides safe and quality accommodations.

2023

Table of Contents

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INTERFAITH HOUSE

HEALTH SERVICES COLLABORATIVE PARTNERS

Heartland Health Outreach, PCC Wellness Center & Rush College of Nursing

Consent for Treatment and Record Review &
Acknowledgement of Privacy Policy

The Interfaith House Health Services Collaborative is dedicated to making sure that all residents of Interfaith House have the opportunity to access medical care by:

- Providing a primary care physician or nurse practitioner and offering preventive health services
- Helping residents get medicines
- Arranging follow-up care after leaving Interfaith House

To do this, we need your permission to provide you with medical treatment and to let us share information with the other people involved in your care. Please read the following statement and sign this form if you consent.

Consent & Acknowledgement

I agree to receive medical treatment from the Interfaith House Collaborative Health Partners. I consent to:

- Let clinic providers (doctors and nurse practitioners) look at all my Interfaith House records.
- Let Interfaith House non-medical staff review my clinic records.
- Let the clinic send my medical records to the medical provider I follow up with when I leave Interfaith House.
- Let the clinic release my information to insurers for billing purposes.
- Let the provider I follow up with share information about my medical status with the clinic.
- Have my records reviewed by the Chicago Department of Public Health, which helps to fund the clinic.

I have received the Health Services Collaborative Notice of Privacy Practices, which explains my rights to see and copy my records, decide who can receive any of my health information, and request that information in my chart be changed. I understand that I can change my mind about who gets to see my health information, although this will not affect health information that has already been shared with my consent. If I change my mind, I must let the Collaborative Health Partners know in writing.

Name of patient (printed)	Signature	Date

Name of Witness (printed)	Signature	Date

Revised March 2014

Medical Respite Guidelines for RNs and Providers on the Management of Patients Who Decline Recommended Care

Background: Patients have a right to determine whether or not they will agree to and comply with recommended care. This document is intended to provide RNs and Providers with guidance on how to optimize patient safety in these situations.

- If a patient declines medical recommendations:
  - A respite provider should meet to discuss this with the patient.
  - If a respite provider is not on-site, an RN should meet with the patient.
  - Respite RN may contact the on-call provider, if needed, for guidance on patient management.

- If a patient declines medical recommendations:

  - they should be apprised of the risks of declining the treatment.
  - The involved respite RN or provider should obtain confirmation of the patient's understanding of involved risks using the "teach-back" method.
  - If the patient's comprehension is limited, the respite RN should pass this information on to the provider on for the following day-shift (or contact the on-call provider if the recommendations are of an emergent nature) and document the information in a chart note.
  - If a provider is on-site, they should assess whether the patient has decisional capacity (see Table 1). The respite psychiatric provider can assist with assessment of decisional capacity, when needed. The decisional capacity assessment is to be documented in a chart note.

- **Table 1**, at the end of this document, offers guidance on the assessment of Decision-Making Capacity.

- If a patient is assessed to have decisional capacity and declines recommended treatment after receiving education on the associated risks:

  - the involved respite RN or provider should assess whether the patient can safely be managed in the respite setting (RN may consult covering provider as needed).
  - This assessment should take into account the absence of overnight medical staff for clinical monitoring of the patient.
  - This assessment should also take into account the clinical ramifications of the declined treatment.

- If it is determined that the patient can safely be managed in the respite setting, despite their declination of recommended care:

  - the patient should be asked to sign a "Refusal of Treatment" form (U2225)
  - a note should be entered summarizing the discussion and the patient's decision and signature of the form.

- If it is determined that the patient cannot be safely managed in the respite setting (they are or may become clinically unstable):

    - the provider or RN should refer the patient to the appropriate emergency department.
    - If the patient declines emergency department evaluation and it is deemed appropriate, the patient may be informed that they cannot remain at respite as they are beyond the program's scope of care.
    - Medics can be called to assess the patient and offer transport to the emergency department if the patient declines respite staff assistance with transfer to the emergency department.
    - Document information pertinent to the incident in the patient's record.

- If a patient is assessed to be clinically unsafe to remain at respite, they decline transport to the emergency department and choose to leave the program:

    - Offer pertinent information to the patient (e.g., ED options, community resources, crisis clinic telephone, walk-in visit options, list of upcoming appointments)
    - Within the boundaries of confidentiality, notify family, significant other(s), case managers and/or other members of the patient's care team to inform them of the patient's plan and discuss options to monitor and support the patient.
    - Document the circumstances under which the patient decided to leave, who was notified, that the patient was encouraged to seek emergency department evaluation and any other pertinent information.
    - Complete an incident Report on the Patient Safety Net

- If a patient is felt to be of immediate risk of self-harm or harm to others and is unwilling to have an emergency department evaluation, an MHP referral should be placed.

Table 1. Legally Relevant Criteria for Decision-Making Capacity and Approaches to Assessment of the Patient.

Criterion	Patient's Task	Physician's Assessment Approach	Questions for Clinical Assessment*	Comments
Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	Have you decided whether to follow your doctor's [or my] recommendation for treatment? Can you tell me what that decision is? [If no decision] What is making it hard for you to decide?	Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity
Understand the relevant information	Grasp the fundamental meaning of information communicated by physician	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor [or I] told you about: The problem with your health now The recommended treatment The possible benefits and risks (or discomforts) of the treatment Any alternative treatments and their risks and benefits The risks and benefits of no treatment	Information to be understood includes nature of patient's condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment) and their benefits and risks
Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	What do you believe is wrong with your health now? Do you believe that you need some kind of treatment? What is treatment likely to do for you? What makes you believe it will have that effect? What do you believe will happen if you are not treated? Why do you think your doctor has [or I have] recommended this treatment?	Courts have recognized that patients who do not acknowledge their illnesses (often referred to as "lack of insight") cannot make valid decisions about treatment Delusions or pathologic levels of distortion or denial are the most common causes of impairment
Reason about treatment options	Engage in a rational process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	How did you decide to accept or reject the recommended treatment? What makes [chosen option] better than [alternative option]?	This criterion focuses on the process by which a decision is reached, not the outcome of the patient's choice, since patients have the right to make "unreasonable" choices

* Questions are adapted from Grisso and Appelbaum.[31] Patients' responses to these questions need not be verbal.

Guidelines for found drugs and paraphernalia and exchanged items

Patients should be informed that drugs (including marijuana), drug paraphernalia or alcohol should be stored and kept out of sight on the unit. Patients who have drugs, alcohol or paraphernalia visible on the unit, but this is incidentally noticed and/or the patient is not appearing to be actively proceeding with use, are to be reminded that the substances/items need to be stored and kept out of sight at all times.

Open cans of alcohol, that cannot be closed, should be confiscated and dumped. Closed containers (including alcohol where a cap can be replaced) or closed containers with drugs or paraphernalia should be stored away by the patient.

Patients who have drugs or paraphernalia out in the unit that where it appears that purposeful on-site use is in process, should be given the choice of either going outside to use or storing paraphernalia in locker. After 9pm curfew the choices given to patient are to either go offsite for the night if they need to use or store paraphernalia in a locked box (provided by staff) in their locker. Patient can take lock box to MHP or RN next day to be opened.

Some examples of the appearance of on-site purposeful use include:

- Patient witnessed to be cooking drugs on the unit
- Patient with a loaded syringe in hand or next to them on the bed or bedside table
- Patient with a crack pipe and crack in their hands or on a bedside table in front of them, appearing to be preparing to use

Use of illegal substances on the unit, including alcohol and marijuana, is not an indication for discharge. If a patient is witnessed using substances on the unit this should be an opportunity for staff engagement around the substance use.

Patients using substances on-site will be reminded that all use is to occur off-site and all substances kept out of sight on the unit. Continued use onsite will put patient at jeopardy for discharge.

Possible Ideas for Engagement include:

- Highlighting that staff's goal is to ensure patient's respite stay is successful and avoid discharge due to continued substance use.
- Inquire about patient's goals for staying at Respite- How can staff assist in achieving patient's goals?
- Developing a plan with patient for safe drug use off unit and returning to respite for patient to be monitored by staff
- Behavioral Plan to address problematic behaviors around substance use or any problematic behaviors while under the influence
- Discussion of room change if patient's behavior is negatively impacting roommates
- Assess patient's readiness for change: are they open to methadone or suboxone? If so, making necessary referral and plan with patient how to manage use while waiting for treatment to start

Substance use on-site will be treated on a case by case basis. Engagement efforts or behavior plans will be communicated to all staff. Should a patient be discharge due to continued on-site use the patient will be discharged for 1 week, after which time they could be readmitted.

The ARNP will make the final decision on discharge during morning rounds, after reviewing the medical chart, arranging and arranging appropriate medical interventions, communication and follow-up and after consulting with the mental health team and other involved staff.

Patients witnessed to be exchanging items with others will generally have a behavioral plan put in place. If the behavior is recurrent, discharge for this behavior will be considered.

Prescribed scheduled medications found in possessions that patients leave behind at discharge should be disposed at the Harborview controlled substance disposal kiosk. An RN should count the number of scheduled medication pills, in the presence of a witness. The RN and witness should take the medications to the kiosk for disposal. The RN is to document a note including the type and quantity of medications disposed and who witnessed the count. The medication should be disposed of on the same day that it is found (including weekend days).

Drugs and paraphernalia found in abandoned possessions or discharged patient's rooms should be discarded. A description of the discarded items should be documented on the log sheet, along with a witness's name. Syringes containing material/substances are to be discarded in the needle disposal box in one of the clinic exam rooms.

Revised 11/2018

Illegal/Illicit Substances Found on Property Procedure

Policy

IPH recognizes that some guests use substances for various reasons. IPH is committed to providing a safe, non-judgmental environment where overall use or harm from use may be reduced through ongoing support and care.

Per IPH policy alcohol and illicit/illegal substances are not allowed on premise, including marijuana/K2 and prescription medications prescribed to someone other than the guest in possession. Anyone found to be in possession of alcohol or illegal substances will be asked to surrender the items to staff for safe disposal.

DISCLAIMER/CAUTION: Fentanyl is a member of the class of drugs known as fentanyls, rapid-acting opioid (synthetic opiate) drugs and is 50-100 times more potent than morphine. Because of fentanyl's potency, health effects can occur at lower doses than with other drugs. For this reason, extra precautions should be taken to avoid exposure.
Fentanyl can be absorbed into the body via inhalation, oral exposure or ingestion, or skin contact. Do not touch your eyes, mouth, nose or any skin after touching any potentially contaminated surface. Wash skin thoroughly with cool water, and soap if available. **Do NOT use hand sanitizers as they may enhance absorption. If skin is exposed to fentanyl, wash with soap and waster as soon as possible and take measure to not touch your face, smoke, eat, or use the bathroom before washing.**

Procedure for found illegal/illicit substances on property:

When illicit/illegal substances and/or paraphernalia are found on site, immediately notify a coworker to assist with the two-person disposal procedure.

Always wear available PPE before handling/touching any found illicit/illegal substances on site. Full PPE kits are available including: gloves, masks, full body Tyvek suits, and goggles. Never handle unknown substances or paraphernalia without wearing gloves.

Place all substances and paraphernalia in the designated locked site and contact Albany Police Non-Emergency line for pick-up and disposal (518) 462-8013.

*Where each designated lock box/area site is for specific programs

Complete the Found Substances and Paraphernalia sign off sheet with two staff signatures located by the designated locked area.

Always complete an IPH Incident Report and ensure it is documented in the shift notes

Supervisor Procedures for Illegal/Illicit Substances Found on Property

If police do not come in a timely manner to remove locked substances that were found on site, Supervisors can destroy substances utilizing available Deterra Drug Deactivation System bags

Deterra Drug Deactivation Instructions:

- The Program Supervisor should always have a second staff member present with them when disposing of substances
- Tear open the pouch but do not remove the inner pods
- Please substances into the Deterra pouch
- Fill the pouch halfway with warm water and wait 30 seconds with pouch still open. Foaming may occur.
- After 30 seconds, seal the pouch tightly, gently shake, and dispose of pouch in areas away from client access.
- Both Supervisor and second staff member complete Sign Off sheet for Supervisor Deterra Drug Deactivation System
- Alert Operations Direct when stock of Deterra bags are running low

Medical Respite Weapons Policy

Policy Purpose

Staff guidance regarding presence of weapons in patient possession on Respite premises.

The respite program desires not to have to discharge patients for possession of weapons. If our up-front weapons screening process is thoroughly carried out, the risk of having to discharge patients for a weapons policy violation will be minimized.

Definitions

- Weapons Free Zone: No firearms or weapons are allowed on premises of Medical Respite
- Legal Weapons: Folding knives with a blade 3 ½ inches or shorter, tools, box cutters (Razor Knives), multi-tools, pepper spray, TASERs, legal firearms, or other items that can be perceived as dangerous and fall within State, City and HMC laws and/or policy.
- Illegal Weapons that are confiscated and cannot legally be returned: Any knife blade over 3 ½ inches (folded), fixed-bladed knife of any size including, hatchet, axe, straight-edged razor, or razor blade not in a package, dispenser, or shaving appliance, switchblade knife, throwing stars, metal knuckles of any variation.

Policy

I. Admission
   a. Referring facilities are to inform patients that Respite is a weapon free facility, firearms are not allowed on respite premises and that all other weapons will be locked up during their stay.
   b. Admission staff to emphasize to patients that all weapons will be turned in, including pocketknives and cooking knives, and any other items that that could be used as a weapon.
   c. HMC Security Services will review the belongings of all new patients upon admission as well as new belongings being brought into Respite during a patient's stay to evaluate and determine what would be considered appropriate and safe to be taken into and stored as safekeeping
   d. Weapons retained by HMC security will be logged with the patient's name and date. Patient will be given a property receipt to claim property upon discharge.
   e. Providers will inform patients of Respite's weapons policy during their initial patient intake visit.
   f. Assigned RN will reiterate the policy during the 1st RN visit after admission and ask the patient whether they have any weapons to turn in for safe keeping. The RN should document this conversation in the medical record.
   g. Assigned MHP will reiterate the policy during the psychosocial intake appointment and document in the medical record.

II. During stay
   a. Posters, summarizing the weapons policy and including photos of items considered to be weapons, will be posted in patient areas.
   b. Possession of weapons after the first post-admission nursing visit will lead to discharge from the program unless there are compelling extenuating circumstances that indicate an alternative decision.

c. If a patient is in possession of an item that might be used as a weapon but is not included in the list of designated weapons above, the respite team will navigate these situations on a case-by-case basis.
d. EVS will turn up the mattresses on a weekly basis (per EVS schedule). EVS should notify respite staff if they find a weapon during their cleaning process.
e. MHPs will meet with patients in their rooms weekly to encourage organization of possessions, discuss limitations to the number of possessions kept at respite and remind patients of the weapons policy.
f. Patients are not to be given their weapons when they leave respite premises, prior to program discharge.
g. If a patient is employed in work that requires use of tools, the tools could be checked out when the patient leaves for work and then checked in again after they return from work.
h. If a patient is noted to have a weapon during evening/night hours and they readily turn over the weapon to HMC Security Services, night staff can decide whether they feel comfortable asking the patient to leave for the night or whether, for the purposes of avoiding escalation, the patient should be allowed to stay in respite for the night.
i. Night staff should prioritize the avoidance of escalation when negotiating with a patient about possession of a weapon and allow daytime staff to follow-up with the patient discharge as needed.

III. Discharge
a. Legal weapons can be returned to patients at the time of discharge: It is the patient's responsibility to maintain their receipt and to claim their property upon discharge, unless specifically arranged otherwise by Respite staff
b. Illegal weapons will not be returned to patients: The patient will be informed of the confiscation prior to Security Services taking possession of that item. The patient has the right to remove the item(s) from campus and relocate the item(s) at their own risk
c. If a patient is exhibiting behavioral problems at the time of discharge, their weapons should not be returned to them.

IV. Weapons Storage
a. Security will manage and store weapons in a locked cabinet.
b. All safekeeping property items left behind and unclaimed by patients will be destroyed after 2 days of being discharged from Respite.

(Revised 08/2022)

Medical Respite

RN Protocol for Over-Sedated Patients

Department: Medical Respite
Effective Date: July 2019
Revision Dates:

POLICY PURPOSE

To describe Registered Nurse (RN) actions when Medical Respite patients are found over-sedated.

DEFINITIONS

- Naloxone (e.g. brand name Narcan) is a medication which reverses opioid drug overdose by temporarily blocking the drug effects.

- Opioid Emergency occurs when an excessive quantity of a recreational or prescribed opioid drug prevents an individual from responding appropriately to their environment. It is a medical emergency that includes symptoms such as:
    - Unconsciousness/Unresponsiveness
    - Severe sleepiness
    - Slowed heartbeat
    - Difficulty breathing (or slowed breathing)
    - Snoring or gurgling sound
    - Difficulty walking or talking
    - Pale or blue skin, feels cold
    - Pinpoint pupils or eyes rolled back

POLICY

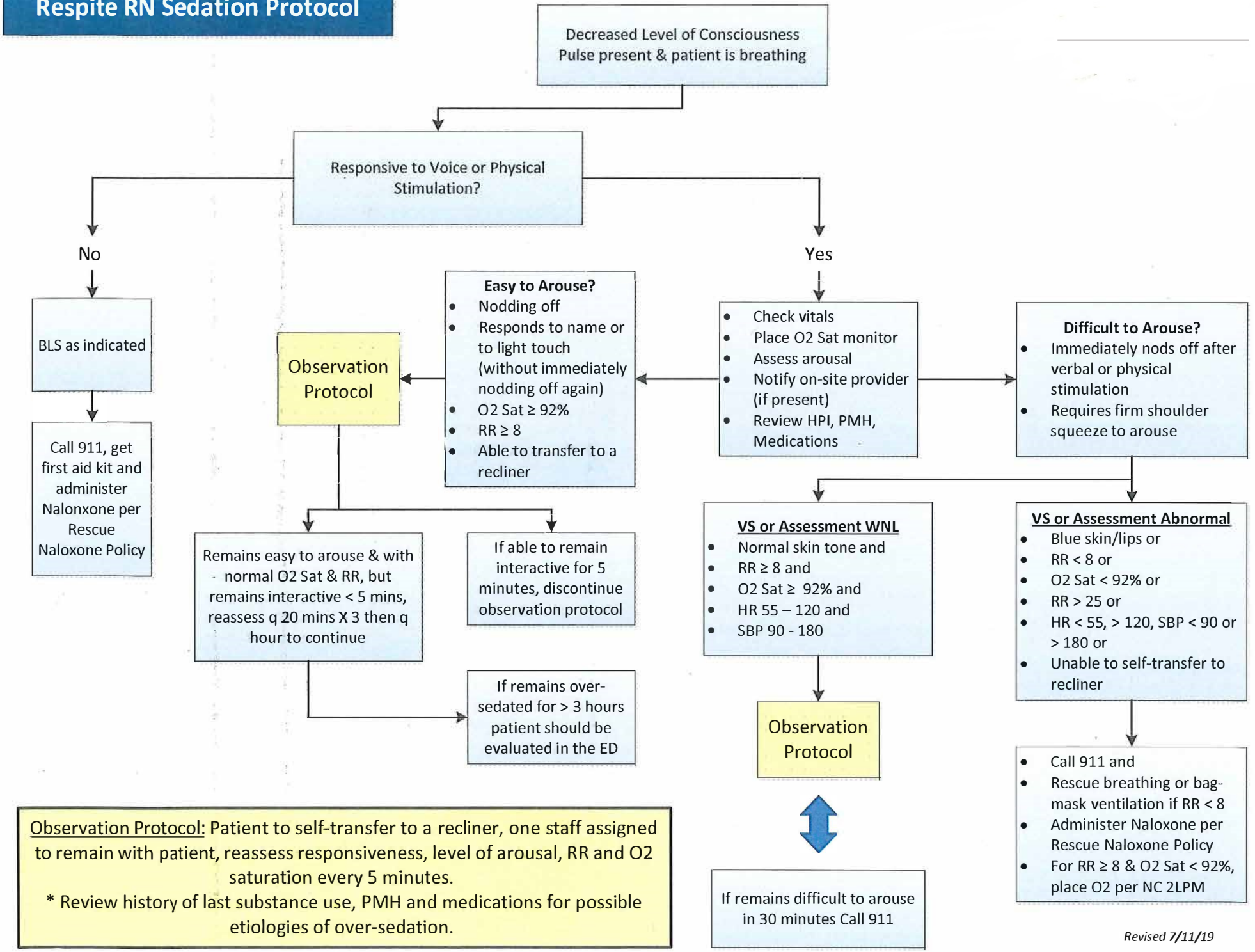
- Registered Nurses (RNs) at Medical Respite who encounter over-sedated patients should utilize the Sedation Protocol Algorithm (attachment) for this opioid emergency.

PROCEDURE

- RN should initiate Respite RN Sedation Protocol if patient presents with decreased level of consciousness, pulse present and patient is breathing.
- Patients being monitored on the over-sedation protocol should self-transfer to a recliner chair that is placed in a readily visible location. One staff should be assigned to remain with the patient.

- If there are greater than 2 over-sedated patients requiring RN protocol monitoring, the patient(s) determined to be the most over-sedated should be referred to the ED.
- MHS or Medical Assistant (MA) staff may collect vital signs and report these to an RN. Responsiveness and level of arousal is to be assessed by RN staff.
- A note detailing the over-sedation event, vital signs and O2 saturations should be charted in ORCA and forwarded to Medical Respite providers.
- If an over-sedated patient is enrolled in a methadone maintenance program, the over-sedation documentation should be faxed to the appropriate methadone program facility.

Respite RN Sedation Protocol



Observation Protocol: Patient to self-transfer to a recliner, one staff assigned to remain with patient, reassess responsiveness, level of arousal, RR and O2 saturation every 5 minutes.

* Review history of last substance use, PMH and medications for possible etiologies of over-sedation.

Revised 7/11/19

Medical Respite Program Discharge Guideline

The medical respite program is considered to be an acute care setting for patients who have daily nursing needs. The program serves the entire homeless population in (redacted) County and has a responsibility to utilize the limited available beds for those patients with the greatest need for medical care. Patients should generally be discharged from respite on the date that their acute medical issue is stable and they no longer have daily nursing needs (though weekend discharge dates are avoided when indicated). Allowing patients to remain in medical respite past their date of healing can cause problems including:

- Preventing access to respite's medical and social services for other patients who have an acute care need but can't remain in the hospital.
- Extending lengths of stay for inpatients waiting for respite beds. Each extra day in the hospital costs at least $2000.
- Billing MCO's for respite level care

Medical respite routinely connects patients with primary care providers and outside supportive services for continued follow up. Additionally, a number of emergency shelters offer weekday RN care for more minor medical issues and offer bunks and on-site meals for patients with limited weight bearing or other mobility limitations. Our team is responsible for making "warm hand-offs" to clinical staff who will continue to provide care and services to our patients after discharge. Our outreach MHP staff can assist patients with post-respite transitions. Respite patients should generally not remain in respite for the purposes of attending outpatient appointments if they don't have active nursing.

If a patient has been in respite for a 3-month period of time without resolution of their acute process, they generally should be discharged from respite with a plan for outpatient follow up. A wound that has not resolved within a 3-month period of time, even if it is slowly progressing in terms of healing, should be transitioned to outpatient wound care. There are rare circumstances for which medical respite would extend a patient's care beyond 3 months. I patients who are receiving support for cancer treatment or palliative care have care needs that exceed 3 months, their stay may be extended for up to 6 months.

It is the responsibility of the medical providers at respite to determine the discharge date for respite patients. Providers utilize their clinical assessments, input from medical and mental health staff and medical data to determine whether a patient is sufficiently stable and safe to leave respite. Providers are responsible for setting discharge dates and writing discharge orders. This decision also requires consideration of medical issues unrelated to the primary reason the patient has received care in respite. Respite medical providers are to determine whether patients are in need of discharge to the emergency department and would contact follow-up providers as indicated. Discharge summaries are to be forwarded to primary care providers (and specialist providers, when indicated).

Patients must have a provider review and provider discharge decision prior to being discharged from respite. Respite providers should review clinical information on every patient prior to making a discharge decision.

Administrative Discharges:

Administrative discharges are sometimes indicated for policy violations or for patients who have been absent from the unit or missing nursing care visits. If a patient should be considered for administrative discharge, a medical respite provider would review the case with the team, review the status of the patient's medical issues and determine a discharge decision. For administrative discharges, the provider would write a brief administrative discharge note to include indication for discharge, decision of discharge, disposition (ED vs shelter, etc.), follow-up medical needs and plans for care. This note is to be forwarded to a patient's primary care provider.

If a patient is felt not to be appropriate to remain on the unit when no provider is on-site, the patient should be asked to leave the unit and return at noon the following day. The oncoming provider would gather information about the incident, review pertinent clinical information, determine appropriate disposition and make a discharge decision. If a patient is felt to be unsafe to return to respite premises after being asked to leave the unit, the ARNP would review the case, write a discharge order and administrative discharge note and follow-up on any outstanding medical issues. In some circumstances, a violation of respite policies, such as on-site drug use, might not result in immediate discharge from the program, if there is a clinical indication to keep the patient in respite. If there is not provider coverage when an administrative discharge decision is needed, staff could contact the Medical Director to discuss the case or contact the on-call AMC provider. If the patient is deemed safe to remain on the unit, at the discretion of on-site staff, the decision could be deferred until an on-site provider is scheduled to be at respite.

Key Points:

- Patients should, generally, be discharged from respite on the day their acute medical issue resolves or is stable and they are not in need of daily RN care
- The broader HCHN programs can follow up with outstanding patient needs when patients are ready for respite discharge
- Not every respite policy violation will automatically result in immediate discharge (including drug use on-site)
- Medical respite providers must review clinical information on each patient prior to making a discharge decision
- The discharge decision is to be made by an on-site or covering provider and the patient should not be discharged from the program prior to a provider case review and provider discharge decision

- If patients are felt to be unsafe or inappropriate to remain on the unit, they should be asked to leave and the case then reviewed with the covering provider

Client Name: _____ DOB _____ Bed _____

I give permission for COTS Recuperative Care (RC) staff to assist me with medication management as they and my health care provider(s) deem necessary.

I understand that "medication management" may include: (*please initial each line*)

_____ RC staff physically handing me the medication bottle and reading the directions to me

_____ RC staff reminding me of when to take my medications (verbal or written)

_____ RC staff supervising me while I take my medications

_____ RC staff keeping a log of when I take my medications (at provider's request)

_____ RC staff locking up medications in the file cabinet to protect them from theft

_____ RC staff accepting my prescription deliveries to Mary Isaak Center

_____ RC staff communicating with the pharmacy and/or my health care provider(s)

_____ RC staff picking up my prescription(s)and/or OTC medications

_____ Signing each time RC staff picks up and delivers my prescriptions

_____ Signing each time RC staff assists me with medication management

Please Note:

1) COTS/RC staff is not responsible for paying prescription co-pays

2) COTS is not liable for clients' mismanagement of their medications. CLIENTS ARE RESPONSIBLE FOR OBTAINING AND TAKING THEIR MEDICATIONS AS PRESCRIBED.

3) These medication management services are available only for the duration of my stay in the Recuperative Care program.

4) The above services are voluntary. I may decline any or all these services at any time.

Client Signature_____ Date _____

Staff Signature_____ Date _____

Date:

Patient Name:

DOB:

Re: Verifying need for assistance with medication management

Please allow COTS Staff to assist this patient with medication management while residing at the Mary Isaak Center facility. This patient does not have the capacity to manage their own medications safely.

Notes about specific medications or services needed: _____
_____
_____
_____

Thank you,

_X_____

Provider Name & Title:

Provider/ Facility Contact Phone:

Name of Facility:

Address of Facility:

Please return this signed medication management verification letter to:

Email: recuperativecare@cots.org OR Fax: (707) 776-4771

Recuperative Care Medication Log

Client's Full Name: _____ DOB: _____ Bed #: _____

Date	Time	Medication Name(s) & Dosage(s)	RC Staff initials	Client Initials	Misc. Notes

Over-the-Counter (OTC) Medication Policy

Over-the-counter (OTC) drug products are non-prescription medications that are safe and effective for use by the general public without seeking treatment by a healthcare professional. Available medications include pain relievers, cough suppressants, and gastrointestinal relief. The purpose of administration of OTC medications is to provide guests of IPH with safe and affordable access to these medications, while alternate treatment or medical care is being sought.

- OTC medications will be available to guests 24 hours a day and provided in areas of regular medication management. Medications are always kept locked up in medication cabinets within areas designated only for staff access.
- Guest's signature is required each time and OTC medication is provided in one of the IPH programs. A copy of this agreement is always available to you, at your request.
- IPH Staff must be informed by guest if any existing allergies or reactions have been experienced to the requested medication. It is not the responsibility of staff to be aware of known drug allergies for a particular guest.
- If symptoms continue to occur or multiple requests are made for OTC medication, guest must utilize their Case Manager for assistance in seeking long-term care with their symptoms or illness. This may include correspondence with medical providers, pharmacy, or other coordination services.
- IPH Staff reserve the right to deny requests for OTC medications. If multiple requests are made for OTC medication without seeking assistance of other medical management, a guest can be denied when requesting medications not directly prescribed to them.
- All regulations and instructions for OTC medications must be followed, and will be supervised by IPH Staff. For example; Tylenol/Acetaminophen is instructed to only take 2 tablets every 4-6 hours as needed. If a guests requests Tylenol at 9:00 am, it cannot be requested again until after 1:00pm (4 hours later). This also applies to quantity, as only the exact dose amount can be provided. Staff reserve the right to decline requests for medications based on these instructions for dosing and time frames.

By signing below, you acknowledge that you have received and understand the information stated above.

Guest Name	Signature	Date
Staff Name	Staff Signature	Date

Emergency Guide:

Know Where to Go

When an emergency strikes, make sure you know where to go for care. This checklist is a quick guide for common emergencies. If the situation is life threatening, call 911 or go to the emergency room.

PRIMARY OR URGENT CARE	VIRTUAL URGENT CARE	EMERGENCY ROOM	
✕		✕	**Abdominal pain** If pain is severe, go to the ER.
		✕	**Allergic reaction that causes difficulty swallowing** (or call 911)
✕	✕		**Animal or insect bites**
✕			**Asthma attack (mild)**
		✕	**Asthma attack (severe)** (or call 911)
✕		✕	**Broken bone** If skin is punctured, go to the ER or call 911
✕		✕	**Burns** If severe, go to the ER.
		✕	**Chest pain (severe)** (or call 911)
✕		✕	**Concussion** If loss of consciousness, go to the ER.
✕			**Coughs**
✕			**Depression/Anxiety/Grief** Huntsman Mental Health Institute crisis hotline: 1-800-273-8255
✕	✕	✕	**Diarrhea, Nausea, Vomiting** If vomiting blood, go to the ER.
	✕	✕	**Dizziness** If you are over the age of 65, go to the ER.
✕	✕	✕	**Eye irritation or redness** For penetrating or foreign body, go to the ER.

PRIMARY OR URGENT CARE	VIRTUAL URGENT CARE	EMERGENCY ROOM	
✕	✕	✕	**Fever** If very young infant or adult has fever of 105-plus degrees, go to the ER.
✕	✕	✕	**Headache** If severe, go to the ER.
✕	✕	✕	**Minor wounds/laceration** If uncontrolled bleeding, go to the ER.
✕			**Newborn** Follow-up, jaundice, feeding difficulties, rash or congestion.
CALL 911			**Numbness in arm or leg, difficulty speaking, face drooping**
✕		✕	**Pregnant + minor symptoms** If you have bleeding or abdominal pain, go to the ER.
✕	✕	✕	**Rashes**
		✕	**Seizure (without an epilepsy diagnosis)**
✕	✕		**Sinus pain**
✕		✕	**Shortness of breath** If severe, go to the ER or call 911.
✕	✕		**Sore Throat** If child, go to urgent care.
✕			**Sprained ankle**
✕	✕		**Urinary tract/bladder infections**

CARE CLOSE TO HOME

To find a U of U Health facility near you, visit ***healthcare.utah.edu/locations***.

URGENT CARE, EMERGENCY ROOM OR DOCTOR'S OFFICE?

More than 10 percent of all emergency room visits could have been better addressed in either an urgent care facility or a doctor's office. If you're suddenly faced with symptoms of an illness or injury, how can you determine which facility is most appropriate for your condition? This comparison between urgent care clinics, your primary doctor's office and the emergency room helps you decide where to go when you need medical help.

Conditions Treated

Primary Care Physician

- Treats most conditions listed under urgent care
- Annual physical exams
- Non-urgent specialist referrals
- Overall wellness
- Management of chronic diseases, such as: diabetes, arthritis, hypertension, etc.
- Vaccinations

Urgent Care

- Abdominal pain
- Allergies
- Animal bites
- Asthma
- Cold
- Coughs
- Conjunctivitis (Pink eye)
- Cuts
- Dehydration
- Diarrhea
- Ear infections
- Fever
- Flu
- Headaches
- Minor burns
- Minor head injuries
- Minor infections
- Nose bleeds
- Rash & skin irritations
- Respiratory infections
- Shortness of breath
- Simple fractures & sprains
- Sinus infections
- Sore throat
- Sports injuries
- Sports physicals
- Urinary tract infections
- Vomiting
- Work injuries

Emergency Care

- Any severe/life threatening conditions
- Acute changes in vision
- Chest pain
- Confusion/ disorientation
- Coughing blood
- Loss of consciousness
- Overdoses
- Seizures
- Severe abdominal pain
- Severe allergic reactions
- Severe burns
- Shortness of breath
- Snake bites
- Stroke
- Trauma
- Uncontrolled bleeding

Hours of Operation

Primary Care Physician

Typical business hours:
8 a.m. to 5 p.m.
Monday through Friday
(with select locations offering extended hours Monday - Saturday)

Urgent Care

Extended hours:
8 a.m. to 9 p.m.
7 Days a Week

Open on holidays
(with modified hours)

Emergency Care

Open 24 hours a day,
7 Days a Week

Open all holidays

Wait Time

Primary Care Physician

Shortest wait time on average, with an appointment.

Urgent Care

Wait times vary but typically much shorter then ER wait time.
Online Check-in available at most Urgent Care locations.
Wait where you choose until your appointment time.

Emergency Care

Wait time can vary but typically longer wait time than urgent care especially during flu season. Shortest wait times for life threatening conditions

Note: Wait times between ERs can vary significantly

Out-of-Pocket Cost

Primary Care Physician

Lowest co-pay on average of three options

Urgent Care

Lower co-pay than Emergency Care, higher than Primary Care

Emergency Care

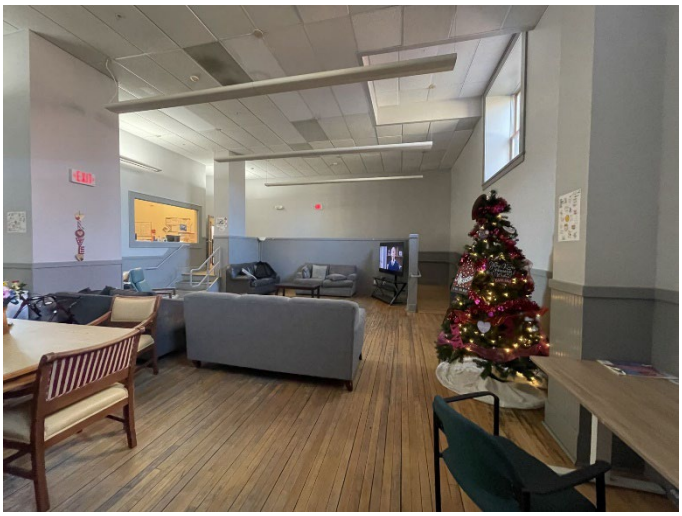
Higher co-pay than Urgent Care

Co-pays vary based on your insurance plan.

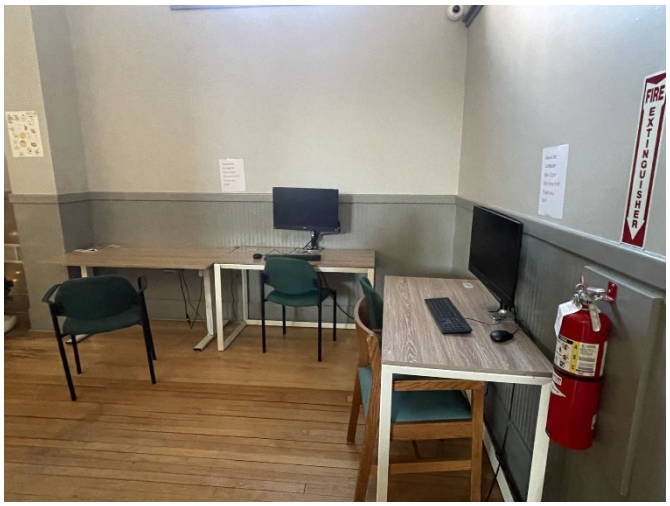
Lovitt & Touché
Marsh & McLennan Agency LLC

Interfaith Partnership for the Homeless (IPH) - Albany, New York
Site Photos

IPH bathroom



IPH community room



IPH computer area

IPH client storage

IPH living space

IPH elevator

IPH laundry facility

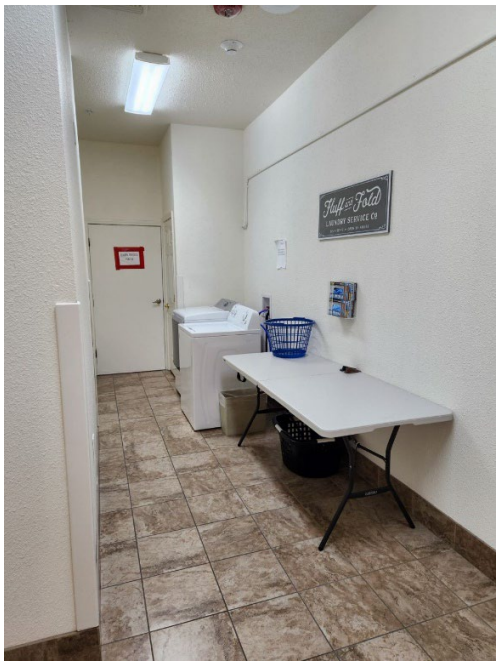
IPH kitchen

Colorado Coalition for the Homeless Medical Respite Program – Denver, Colorado
Site photo

Commercial kitchen

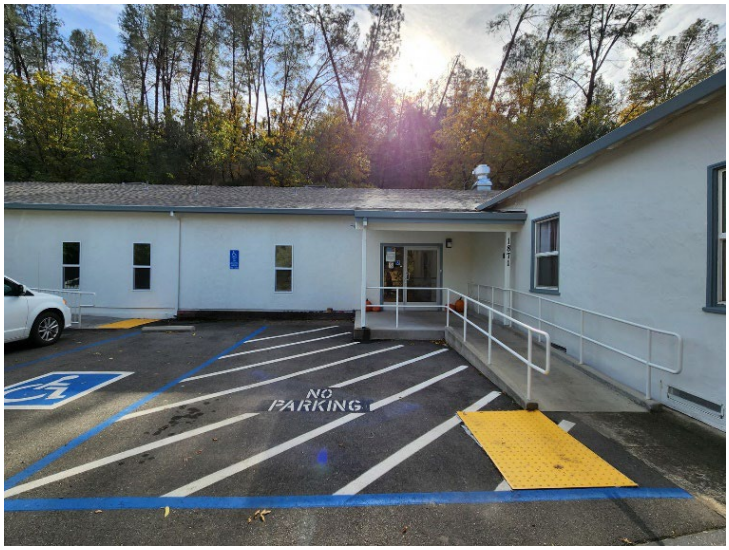
Shasta Community HOPE Medical Respite – Redding, California
Site Photos

HOPE kitchen



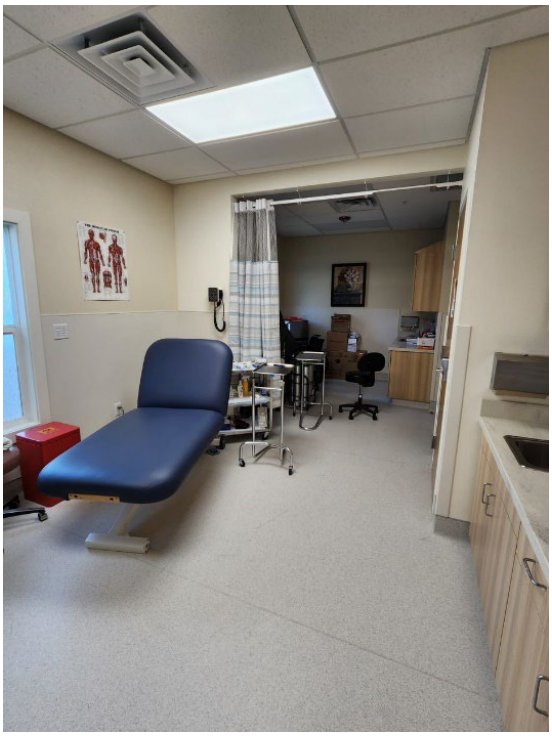
HOPE laundry facility

HOPE community room



HOPE medical respite facility

HOPE living space



HOPE clinical space