Table 3. *Treatment of Acutely Sick Patients*

- *Pedialyte 400cc PO Q shift for 48 to 72 hours (patients on Hemodialysis should not receive more than about 600 to 700cc per day).*
- *Patients should be placed on clear liquid diets until they have been free of symptoms for 24 hours.*
- *Hold all laxatives.*
- *If alternative causes of diarrhea are suspected e.g. C.Difficile, then these should be investigated and treated according to the etiology.*
- *Careful monitoring of clinical status for pre-renal azotemia and biochemical monitoring of BUN and Cr.*
- *If diarrhea is worsening despite Pedialyte and other measures indicated then IV fluids should be started.*

The Medical Director educated staff of each unit on spread control and treatment measures. Department heads (Nursing, Housekeeping, Rehab, Dietary and Social Services) were informed daily by email on new cases including unit location of the new cases. Stool specimen was collected by nursing and was sent for laboratory RTPCR for confirmation of Noro diagnosis.
Results: 360 patients were exposed to the outbreak at the SNF – 33 patients met the case definition (2 or more episodes of loose stools in 24 hours with or without vomiting and abdominal pain). The units with the highest attack rates of illness were predictably the units with the most dementia patients.
Conclusion/Discussion: Norwalk gastroenteritis has a significant impact medically and financially on SNFs in the US and worldwide. Our low attack rate and improved clinical outcomes was instituted by a proactive interdisciplinary team approach to prevention of spread and treatment. By improved clinical outcomes, I mean low rate of hospitalization and reduced duration of symptoms. Also we had no mortality. This was partly due to the **innovative** and **early** use of ORS (Pedialyte, Abbott Laboratories, North Chicago, IL) to prevent potential dehydration and subsequent multi organ failure.
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Improving the Quality of Information sent to Primary Care Physicians for Patients Discharged from Nursing Facilities

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Introduction/Objective: As part of an assessment of documentation in transitions of care, we identified that none of the nursing facilities (NF) where our group is on staff had a formal process for a discharge communication (DC) to the primary care provider (PCP).
Design/Methodology: The six providers in our geriatric group developed a standardized single page summary to be sent to the PCP at discharge. This form included Patient name and Date of birth, NF where the patient received care and discharge destination, functional and cognitive status, Home Health Agency and contact numbers, details of admission diagnoses and course in the NF, other medical diagnoses, medication list, any follow up laboratory or radiology testing and follow up appointments. Approval had to be given by each NF to allow the DC form to be used and placed on the NF chart. The form was completed by the discharging provider, and faxed to the PCP and our office for tracking. PCP office is called by staff to ascertain if form was received, and if not, form is re-faxed. Comments made by PCP office were also logged.
Results: During the initial pilot period of 8 weeks, 75 DC forms were faxed to PCP office. Of these, 30/75 (40%) needed to be re-faxed. 3/75 (4%) PCP offices never responded back as to whether DC form was received despite multiple calls. Multiple process issues were identified. Many PCPs were incorrectly identified in our provider registry and phone and fax numbers were also wrong. Many PCP offices asked for the DC to be re-faxed, mostly as they were not sure if they had received it or not. As a measure of provider compliance, we compared discharge billing codes for patients with forms sent. 77% of patients with a 315/316 code on a bill had a DC form. 10 additional DC forms were sent for whom no bill with a discharge code was made out. One NF was slow to give approval for the form, and so the physician at that NF could not use the form for 6 weeks out of the 8 week pilot period. Providers found some difficulties with the process- obtaining information about the Home Health Agency and accurate functional status, and contact numbers for the PCP office were the most troublesome. One provider photocopied prescriptions given to the patient instead of listing the medications, and these were illegible when received by the PCP. In some cases the handwriting on the DC form was hard to read.
Conclusion/Discussion: One NF adopted the DC form for all short term discharges, though it will be completed by a case manager and nurse rather than providers. Four revisions were made to the form during the pilot period- the space for narrative for the NF stay was enlarged and space for addition of cognitive testing scores was added. We found numbered spaces for diagnoses and medication to be too short to write some data and so this was changed to free text space. We also plan to include code status and allergies on a next updated version. To evaluate the usefulness of the content of the DC form, we plan to survey PCP offices
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Leadership Collaborative Education Intervention to Enhance the Quality of End-of-Life Care in Nursing Homes: The IMPRESS Project

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Introduction/Objective: Although deaths in nursing homes are increasing, end-of-life (EOL) care has been found to be poorest in nursing homes compared to other sites. Our objective was to engage the leadership of nursing homes in a collaborative fashion to enhance implementation of quality EOL care.
Design/Methodology: IMPRESS (IMproving PRofessional Education and Sustaining Support) is a quality improvement intervention of EOL care in 5 community nursing homes in Honolulu, Hawaii. Nursing home leaders, including Directors of Nursing, charge nurses, social workers and administrators (n=18), participated in quarterly collaborative sessions for 1 year. Each session provided education on evidence-based strategies to improve EOL care in nursing homes. Participants shared experiences in open discussions. Pre and post session feedback forms rating the effectiveness of the educational intervention were completed by 12 participants (67%) using a 1 to 4 point scale (higher scores were better). Paired t-tests compared implementation of strategies for quality EOL care before and after the collaborative sessions.
Results: There were significant improvements in all 8 areas assessed (overall score mean change 0.93, $p<0.0001$). Specifically, there were improvements in identifying patients with limited life expectancy (mean change 1.25, $p<0.0001$), effective Advance Directive discussions (mean change 0.91, $p=0.002$), reviewing EOL care policies (mean change 1.08, $p=0.0006$), reviewing EOL forms (mean change 0.75, $p=0.002$), effective communication with physicians and nurses (mean change 1.17, $p<0.0001$), facilitating provision of respectful death (mean change 1.0, $p<0.0001$), communication with hospice and palliative care providers (mean change 0.75, $p=0.006$), and incorporating EOL care questions into patient/family satisfaction surveys (mean change 0.5, $p=0.05$). Common barriers to EOL care before collaborative sessions included lack of time (50%), lack of knowledge (33%) and other higher priorities (25%). After the collaborative sessions, all barriers decreased.
Conclusion/Discussion: Collaborative education of the nursing home leadership on EOL care was successful in enhancing implementation of effective strategies and reducing barriers. The long-term impact of this project on quality of EOL care in nursing homes is yet to be determined.
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Management of Phantom Limb Pain with Methadone in the Long Term Care Setting

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