Implementation of Standing Delegation Orders  
for Long Term Care Practice Call Center  
Reduces Number of Interruptions to Clinicians  
Seeing Patients in Long Term Care Facilities  

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Objective  
• Identify one process in developing standing delegated orders  
• Identify one result from implementing standing delegated orders

Background  
• Practice currently composed of 14 physicians, 19 nurse practitioners, 1 physician assistants & 1 CNS (providers) that see only long-term care patients (nursing homes and assisted livings)  
  74 Nursing Homes; 17 AL; 9 Hospices; Total of 39 Medical Directors of facilities & 8 Medical Directors of Hospice Companies. Approximately 5000 patients. Austin, Dallas, Houston, Kerrville, San Antonio  
• High volume of calls into call center with large number of calls transferred to providers in field that impacts time spent in facilities
Development of Standing Delegated Orders (SDOs)

- Task Force
- References
- Evaluation of Standing Delegation Orders

Task Force

- Representative from all areas
- Physicians
- Nurse Practitioners
- Director of Clinical Services (NP)
- Chief Operations Officer (RN)

References

- Hazzard’s Principles of Geriatric Medicine and Gerontology (5th and 6th edition)
- Texas Nurses’ Association Protocols for Long-term Care (2000)
- American Medical Director Association Clinical Practice Guidelines. (2007).
Evaluation of SDOs

- Review by all physicians
- Trial of coumadin SDO for 2 months

Review of Data

IRCC Average Calls October 2008
Results through March 2009

• The implementation of standing delegation orders used by RN staff showed that 40% of calls could be managed by the RNs using standing delegation orders, thus decreasing 40% of interruptions to clinicians working in facilities.

Future

• Potential for addition of SDOs
• New time changes with RN coverage
• Change in physician/NPP coverage in Houston and Central TX
• Task force review q 6 months or sooner if problem identified