Continuum of Care
Bridging the Gap between the Hospital and Nursing Home

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Objectives

- Name key members involved in hospital/nursing home collaborative
- Identify crucial information and resources needed for a safe patient transfer between facilities
- Learn how to examine readmissions from a Nursing Home to identify potential performance improvement changes
- Understand how a partnership with a hospital affects nursing homes
Why are we here?

- Approximately 25% of Medicare skilled nursing facility (SNF) residents are readmitted to the hospital.\(^4\)

- Research shows that up to one-third of readmissions in patients with multiple medical problems could have been prevented with improved transitions of care.\(^5\)

- A recent survey by the Agency for Healthcare Research and Quality (AHRQ) on Patient Safety Culture found that 42% of hospitals surveyed reported the “things fall between the cracks when transferring patients from one unit to another.”\(^2\)
Programs on Safe Transfers

The Evercare Care Model

Transitional Care Model
Project Goals

- Develop a community partnership between the Health Center and each Nursing Home
- Assist in education of disease processes
- Reduce preventable readmissions to the hospital
- Improve communication and hand-off of care between facilities

  - Increase safety for our patients
Patient Safety

- “We are highly trained, highly motivated, hard working staff, with highly technical equipment where the price of failure is expensive”
- John Nance
Key Collaborative Members

**Hospital**
- Nursing Staff from medical unit
- Case Management/Social Work
- Hospitalist
- Emergency Department Staff
- Quality/Performance Improvement Specialist
- VP of Patient Care Services

**Nursing Home**
- Admission Coordinator
- Director of Admissions
- Director of Nursing
- Clinical Staff
- Social Worker
- Medical Director
We’re Here, Now What Do We Do?
Affinity Diagram

- Take 3 minutes to write down on the sticky notes at your tables what contributes to an outstanding Thanksgiving
  - Write each comment on its own sticky note
  - Pass notes to the front when you are completed
What do you need for a safe patient transfer?
“Baseline "need to know" information “
 “Info given on every patient admitted / transferred”
 “Communication on advance directives”
 “Resource for questions after transfer”

“Class 2 scripts for patient are present”
 “Current Med List”
 “Pain assessment & meds give before d/c”

 “Insurance cards sent with all patients”
 “Current chart sent with patient”
 “Forms signed on all transfers”
 “Care assessment completed prior to transfer”

“Patient/Family Education”
 “Why admission accepted/not accepted”
 “Family informed of discharge process”

“Patients admitted before 4 pm”
Transfer Communication

- Given on every patient admitted / transferred
  - Baseline "need to know" information
  - Communication on advance directives

Medication Reconciliation

- Class 2 scripts for patient are present
  - Current Med. List
  - Pain assessment & meds given before d/c

Chart

- Insurance cards sent with all patients
  - Current chart sent with patient
  - Forms signed on all transfers
  - Care assessment completed prior to transfer

Communication

- Patient/Family Education
  - Why Admission accepted/not accepted
  - Family informed of discharge process

Earlier Admits

- Patients admitted before 4 pm
Top Areas of Concern

- Medication Reconciliation
- Hand off communication
- Patient Chart
- Education/Resources
Hand-off Communication

- Standardized nursing transfer record used between the health center and area nursing facilities.
- **Hospital needs:**
  - Advanced Directives
  - Level of care (SNF, LTC, Assisted Living)
  - Activities of Daily Living
  - Diet, Consistency, Tube Feedings
  - Special Dressing Changes

- **Nursing Home Needs:**
  - What is the Plan of care
  - Tubes and Drains
  - Special Dressing Changes
  - Vaccinations
  - Pain Management
  - Pending Cultures/Labs
St. Francis Health Center
Topeka, KS

Hospital/NH Nursing Transfer Form

Primary Care Physician
Chief complaint
Allergies
Procedure(s)

Admitting Diagnosis
Code Status:
Copy of Advance Directives: Yes No

Skilled, Sub-acute
Long Term Care
Residential/Assisted Living

VITAL SIGNS:
BP / Pulse RR Temperature SaO\textsubscript{2}% O\textsubscript{2} source
Weight BG Last BM date:

PAIN ASSESSMENT: Last Score Assessment Tool: 0-10 scale FACES Behavior

DIET: Low Concentrated Sweets No Concentrated Sweets
Consistency: Regular Thin Honey Nectar Pureed Soft Mechanical Soft

Tube Feeding:

MEDICATIONS: Whole Crushed Per Tube With Applesauce/Pudding
Anticoagulant Therapy: No Yes, Most recent INR:

ISOLATION: No Yes Location Type: Contact Airborne Droplet

ABNORMAL LABS:

COMPLICATIONS/ADVERSE EVENTS:

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>INDEPENDENT</th>
<th>ASSISTANCE</th>
<th>TOTAL ASSISTANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulation</td>
<td>Fall in last 3 months or in hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel/Bladder</td>
<td>Incontinent</td>
<td></td>
<td></td>
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<tr>
<td>Dressing</td>
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<td>Bathing</td>
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<td>Eating</td>
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<td>Hearing</td>
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</tbody>
</table>

Vision Normal Impaired Blind
Mental Status Alert Occ. Conf. Confused
Appetite Good Fair Poor
Behavior Cooperative Disruptive Combative
Withdrawn Oriented
Disabilities Contracture Paralysis Amputation
Social Activity Independent Encourage Individual

RESTRAINTS: Yes No Type: Behavioral Medical/Surgical Physician ordered, Reason:

TUBES/DRAINS: Foley – Size Date inserted Output PEG Other
Recent Foley, date removed: Voided since removal On dialysis, Can they sit up for tx?: Yes No

PERIPHERAL LINE: Size Site Date of insertion

Other Line:

EQUIPMENT: No Yes IV Infusion Pump Other
DRESSINGS: No Yes Location When changed last Drainage
Wounds: Location Type of Drsg When last changed Drainage

Other Nursing Care Needs:

ADDITIONAL: Meds given within last 2 hours
Pain Med – Last dose:
Immunizations: TB date: Influenza date: Pneumococcal date:
Nurse giving report Phone Number

Send form with patient
Hand-off Communication

- Emergency phone contact for nursing home caregivers with immediate questions on a recently transferred patient

For questions regarding patients recently discharged from SFHC Hospitalist group:

Monday-Friday during regular business hours call: 785-295-XXXX
Evenings after 4:30 pm & Nights and Weekends call: 785-295-XXXX

To ensure prompt service and response times, please have the patient’s account or medical record number available and if possible the discharging physician name.
Patient Chart

- Discharge Checklist
- Standardized chart copy process
- Pending Labs: Post-discharge forwarding process
  - Estimated 41% of inpatients are discharged with a test result pending. 2/3 of MDs are unaware of results.⁶
Transfer to Nursing Home Checklist
(SNF, LTC, Assisted Living, Independent Living)

Patients Going to **SNF or LTC**

Original sent with Patient:
- ☐ Transfer Referral Sheet (send original to NH, place copy on chart)
  - ☐ If patient discharging with BiPAP, ensure BiPAP settings are on order sheet
- ☐ Prescriptions (send original) Ensure Narcotics have prescription
- ☐ CARE assessment (provided by SW, if applicable)
- ☐ Nursing Transfer Report Sheet

Copies sent with Patient:
- ☐ Inpatient MROF & Printed copy of POC
- ☐ Lab Report
- ☐ Last day of vital signs
- ☐ X-Ray
- ☐ EKG (12-Lead)
- ☐ History and Physical
- ☐ Progress Notes (at least 3 days)
- ☐ Consults
- ☐ Rehab & Therapy
- ☐ OP Reports

☐ Order message to Lab to send all pending labs to Nursing Home
  (List name of nursing home in order message)

Patients Going to **Assisted or Independent Living**

☐ Discharge Record (including follow-up appointment and medications)
☐ Complete Core Measure Education (CHF or Stroke)
Medication Reconciliation

- Class 2 narcotic lists placed on each discharging unit and given to hospitalist group
- Reminder added to the Nursing Transfer Record and Discharge Checklist
Data Reviewed

- Readmission Rate by Diagnosis
- Length of Stay for patients discharged to a SNF
- Length of Stay for patients readmitted from a SNF
- Days from Previous Admission
  - Readmissions within 0-10 days may link defects with hospital transitions
  - 7-14 days may be NH issue with processes
Top Diagnosis with Readmission

- Sepsis
- Heart Failure
- UTI
- Pneumonia/Respiratory Complications
Education Resources

- A focused discussion on diagnosis’ associated with readmission
- Review on consistency of care between facilities
- Share evidence based practice related to DRG
  - Provide patient education material to NH
- Identified needs from each facility
Education Resources

- Educational needs survey completed
- Clinician meeting every 2 months
  - The ABCs of CHF
  - Keep those Piggies at Home. A guide to the at-risk foot
  - Oral Care: It's more than just fresh breath. Tips to preventing Respiratory infections and Pneumonia
Education Resources

- Mobile Unit
  - Partnership with local university to offer additional resources to area nursing homes
    - Provide high-risk, low-volume drills using simulation scenarios including formal debriefing for the team
    - Provide the TeamSTEPPS™ communication program for the interdisciplinary team
Education Resources

- **Mobile Nurse Practitioner Clinic**
  - Potential to provide a once a month mobile clinic with a nurse practitioner and a variety of students from the university’s department of nursing and department of allied health.
  - Potential to provide a health fair for employees i.e. blood sugar screening, blood pressure screenings, cholesterol screenings, height/weight/BMI, and preventative education.
Patient Education

- Creating universal patient and family education pamphlet on the following:
  - Explain Medicare/Medicaid benefit days
  - What to bring to nursing facility
  - What to expect from day to day
  - Therapy requirements
Readmission

- Case studies on when a patient unexpectedly is readmitted from a nursing home
  - Focus on patients readmitted within 15 days of discharge
Readmission

- Items reviewed on readmission cases:
  - Was patient seen by physician prior to return?
  - Was there an ED visit(s)?
  - What was the functional status of patient at discharge for hospital?
  - Was plan of care clear?
  - Review chart for any documented reasons for readmission. Social condition contributing to readmission?
Readmission

- Interview patient, family, and nursing facility members about readmission:
  - How do you think patient became sick enough to return to the hospital?
  - Has anything gotten in the way of taking medications?
  - Describe typical meals last two weeks
Readmission

- Typical Failures:
  - Patient Assessment
    - Lack of understanding of patient’s physical and cognitive functional status
    - Failure to include patient and caregivers in planning
    - Failure to recognize worsening condition before discharge
  - Patient and caregiver education
    - Instructions confusing
    - Patient does not clarify lack of understanding
Readmission

● Typical Failures cont.: 
  ● Handover communication
    ● Medication discrepancies
    ● Inadequate discharge instructions
    ● No communication of discharge plan
    ● Functional status not communicated

● Failures following discharge
  ● DC instructions confusing
  ● F/U appointment too long after discharge
  ● Lack of plan for when symptoms worsen
Benefits for Nursing Facilities

- A forum to share needs and information
- Resource person to discuss issues
- Additional education and resources for nursing facility staff
Benefits for Nursing Facilities

- Improved communication
- Increased understanding of why delays in transfer occur from hospital
- Better understanding of data
- Increased understanding on hospital regulations
Success comes from doing common things uncommonly well.

- W. Clement Stone
Questions
References


3. INTERACT II website: www.iteract.geriu.org: see Toolkit


