St. Francis
Health Center

Sisters of Charity of Leavenworth Health System

Continuum of Care

Bridging the Gap between the Hospital and Nursing Home

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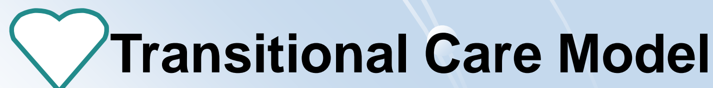
Objectives

- 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

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

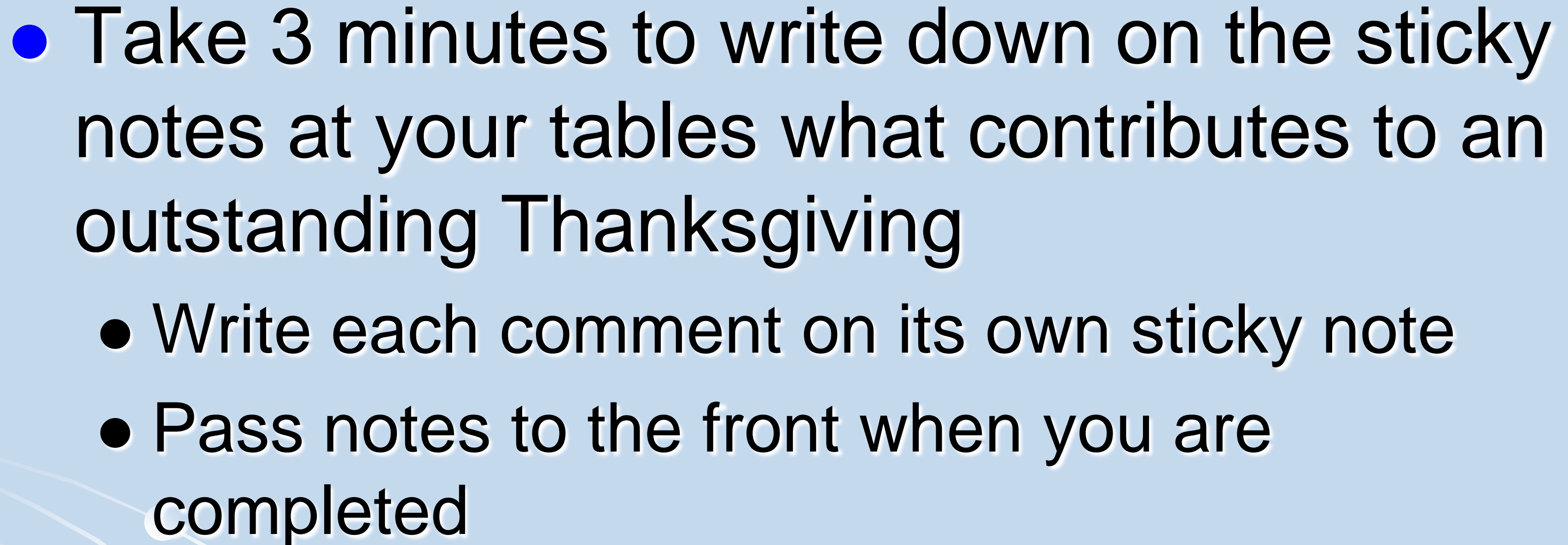
- "We are highly trained, highly motivated, hard working staff, with highly technical equipment where *the price of failure is expensive*"
  - *John Nance*

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”

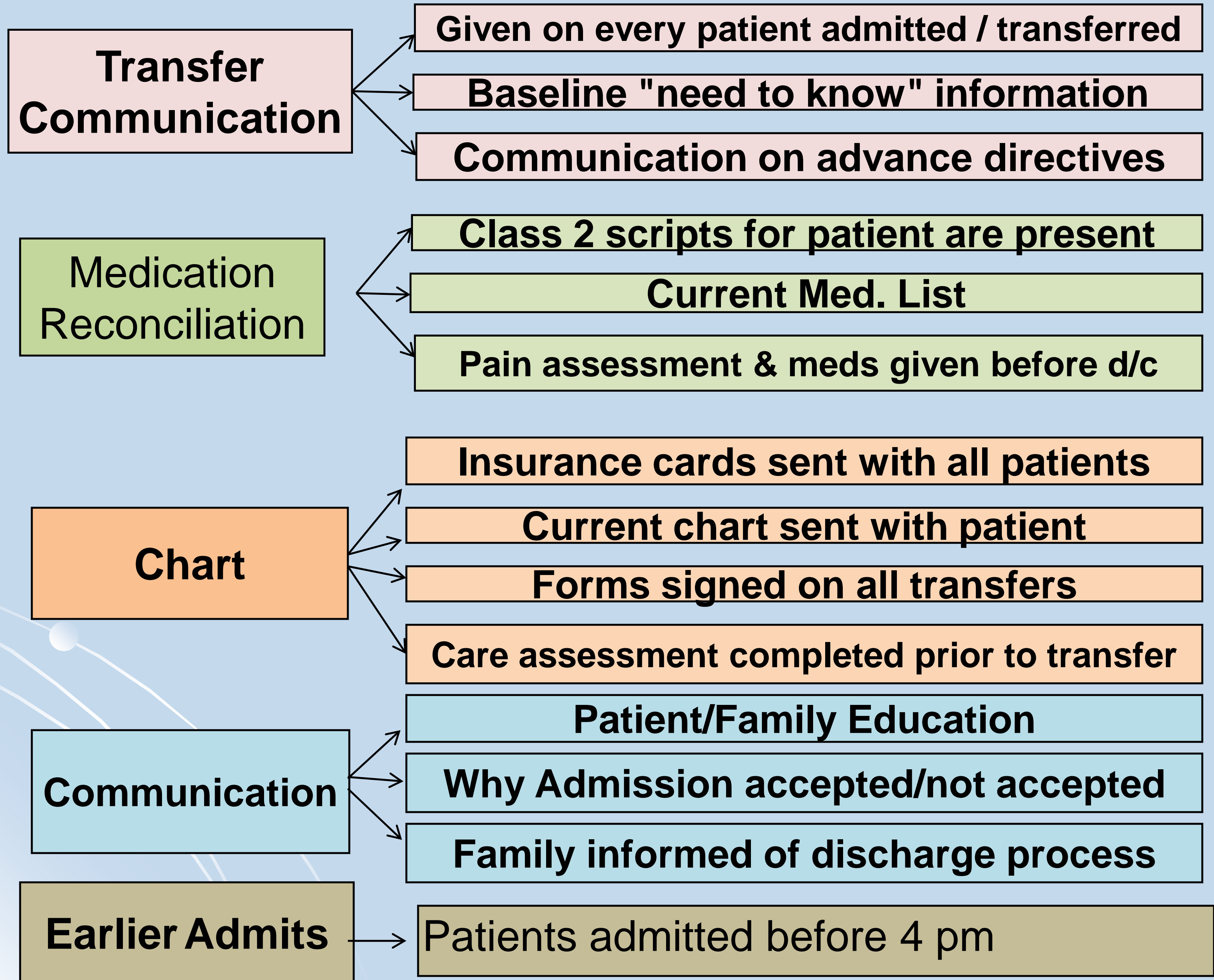
“Patient/Family Education”

“Care assessment completed prior to transfer”

“Why admission accepted/not accepted”

“Family informed of discharge process”

“Patients admitted before 4 pm”

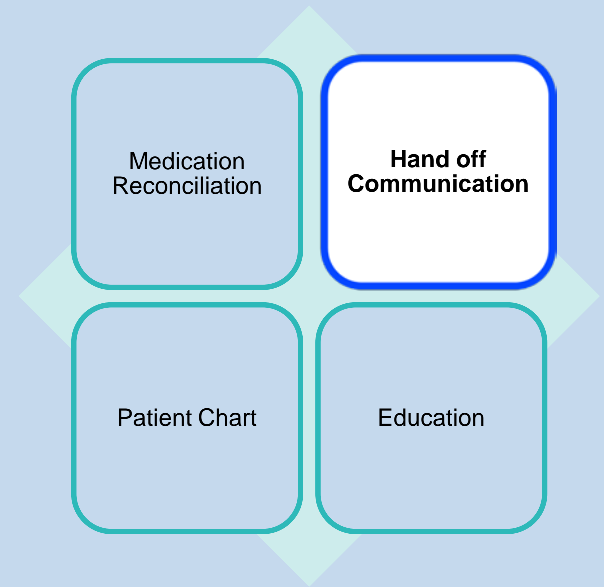

Transfer Communication
Given on every patient admitted / transferred
Baseline "need to know" information
Communication on advance directives
Medication Reconciliation
Class 2 scripts for patient are present
Current Med. List
Pain assessment & meds given before d/c
Chart
Insurance cards sent with all 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

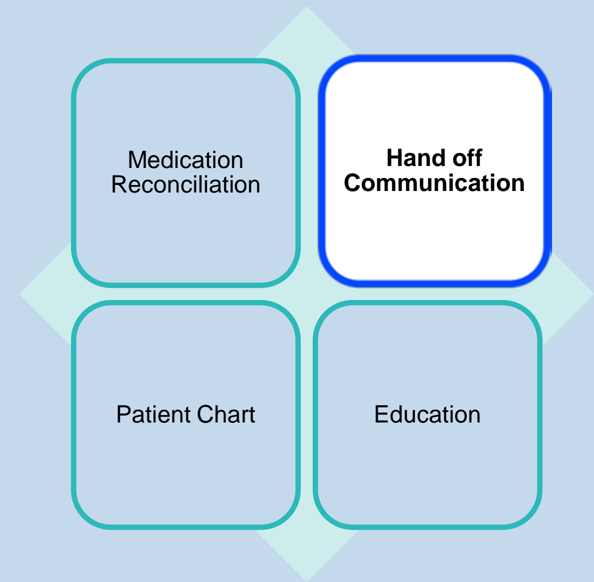
Hand-off Communication

- 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



Patient Sticker or
Patient Name:____________________
DOB:______________ M / F

St. Francis Health Center
Topeka, Ks

Hospital/NH Nursing Transfer Form

Transfer Date: ____________

Primary Care Physician__________________________ Admitting Diagnosis__________________________
Chief complaint____
Allergies__________________________ Code Status:____________ Copy of Advance Directives ❑Yes ❑No
Procedure(s)____
❑Skilled, Sub-acute ❑Long Term Care ❑Residential/Assisted Living

VITAL SIGNS:
BP________/________ Pulse________ RR________ Temperature ________ SaO_2 ______% O_2 source__________
Weight____________ BG____________ Last BM date:____________
PAIN ASSESSMENT: Last Score __________ Assessment Tool: ❑0-10scale ❑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:__________________________________ Culture Results sent with patient? ❑Yes ❑No
COMPLICATIONS/ADVERSE EVENTS: ____

ACTIVITY	INDEPENDENT	ASSISTANCE	TOTAL ASSISTANCE				
Ambulation ❑Fall in last 3 months or in hospital				**Vision**	Normal	Impaired	Blind
Bowel/Bladder ❑ Incontinent				**Mental Status**	Alert	Occ. Conf.	Confused
Dressing				**Appetite**	Good	Fair	Poor
Bathing				**Behavior**	Cooperative	Disruptive	Combative
Eating					Withdrawn	Oriented x __	
Speech	Normal	Impaired	Unable	**Disabilities**	Contracture	Paralysis	Amputation
Hearing	Normal	Impaired	Deaf	**Social Activity**	Independent	Encourage	Individual

RESTRAINTS: ❑Yes ❑No Type: ❑Behavioral ❑Medical/Surgical ❑Physician ordered, Reason ______________
SITTER NEEDED: ❑Yes ❑No 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:______________________________ Hard scripts sent for CII meds ❑Yes ❑No
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

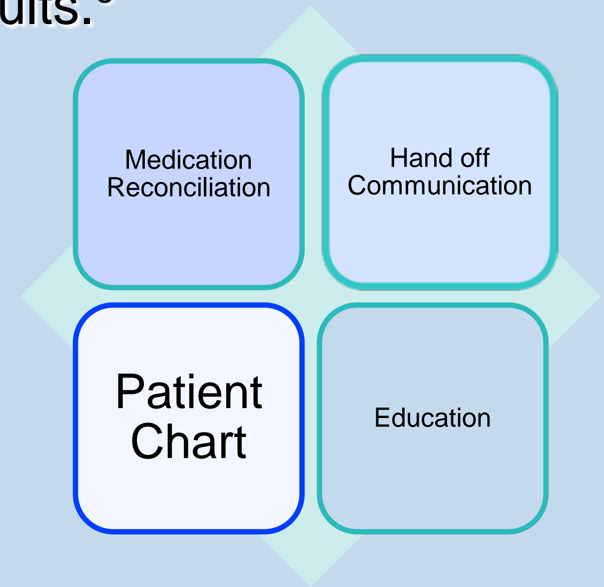
For questions regarding patients recently discharged from SFHC Hospitalist group:

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)

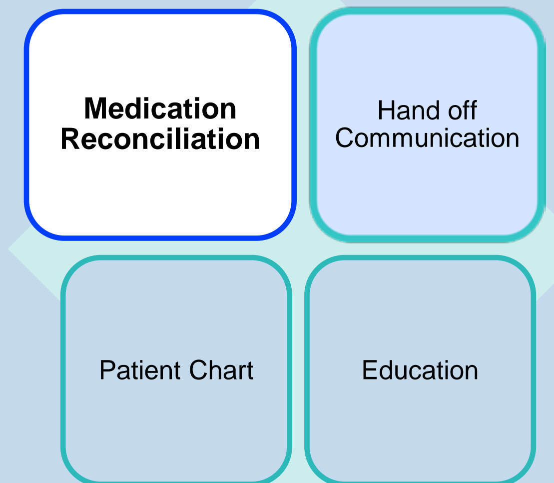
Patients Going to **Assisted** or **Independent Living**

❒ 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

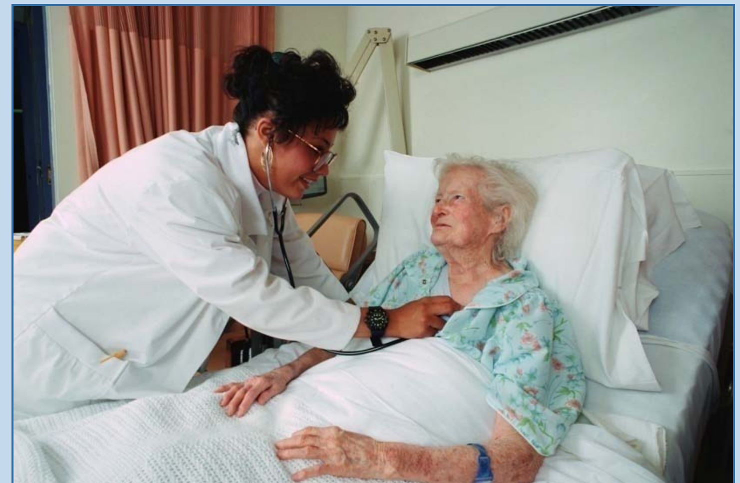


Data Reviewed

- 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 [1]

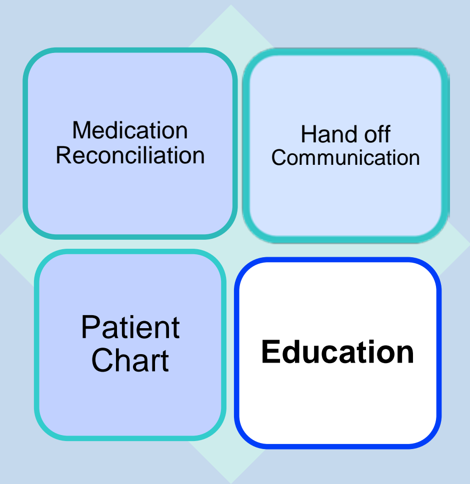
Top Diagnosis with Readmission

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



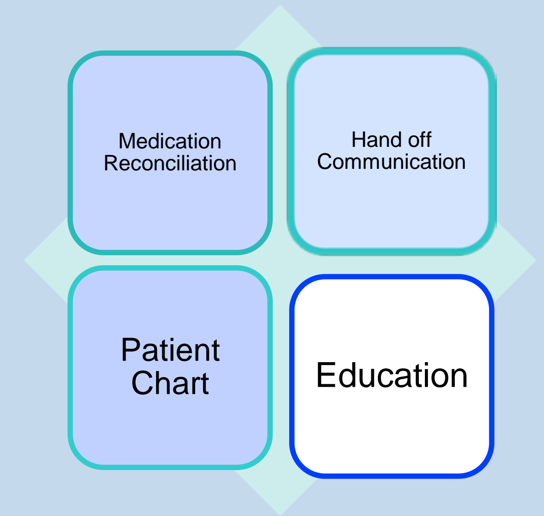
Education Resources

- 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



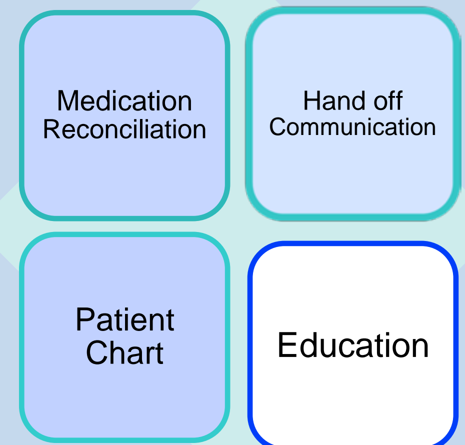
Education Resources

- 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: Its more than just fresh breath. Tips to preventing Respiratory infections and Pneumonia



Education Resources

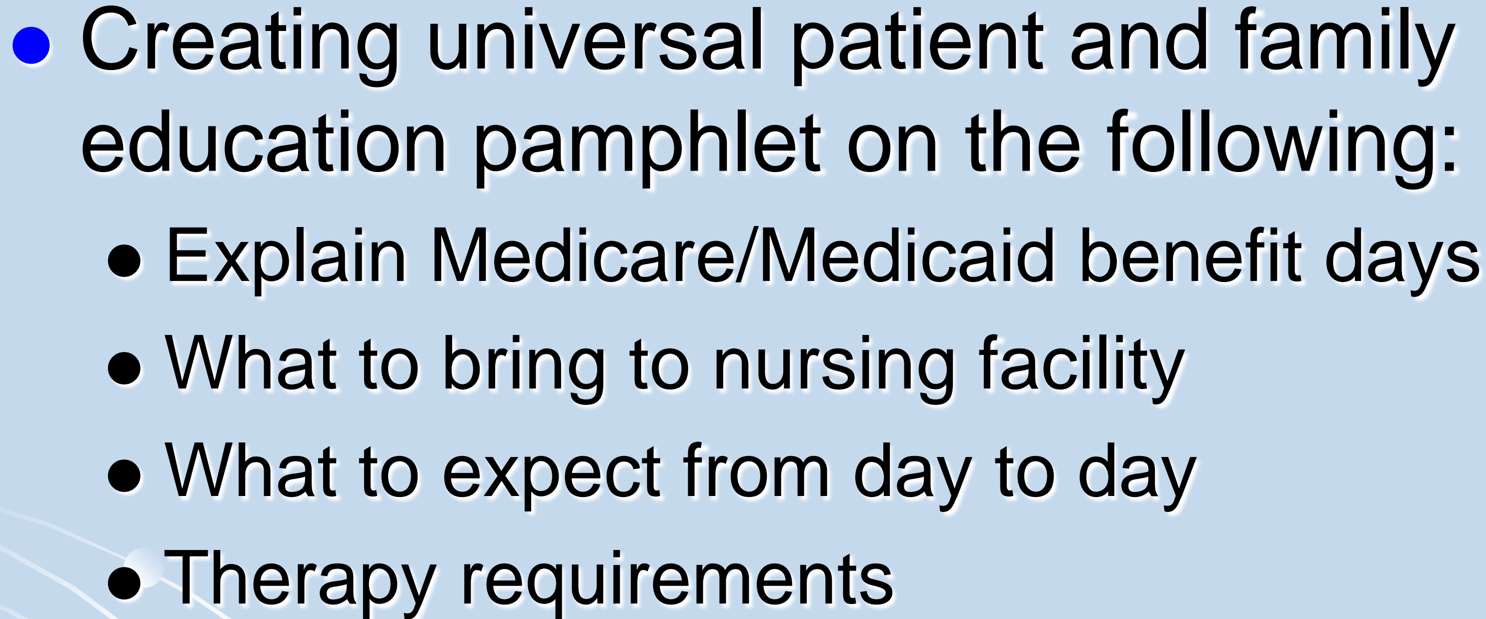
- Mobile Unit
  - Partnership with local university to offer additional resources to area nursing homes
    - Provide high-risk, low-volume drills using simulation scenarios including formal debriefing for the team
    - Provide the TeamSTEPPS™ communication program for the interdisciplinary team



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

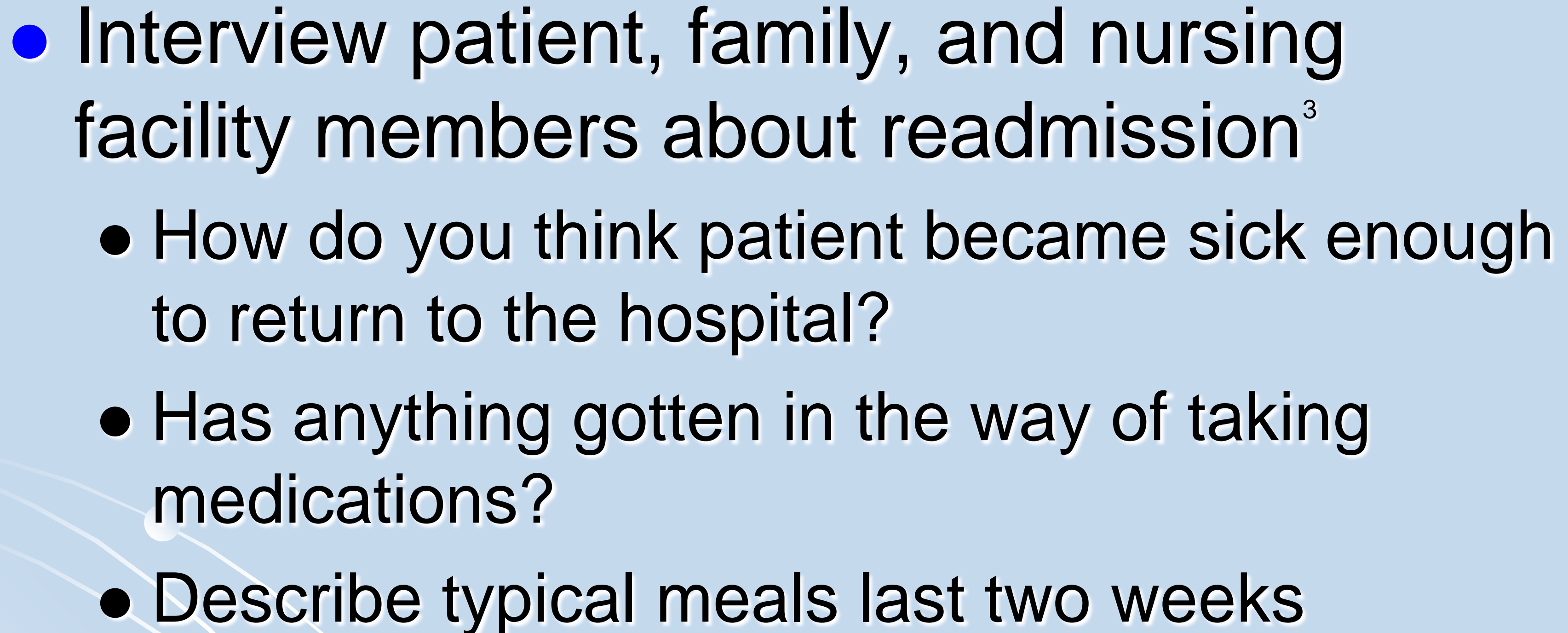
Readmission

- 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[3]:
  - 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



Readmission

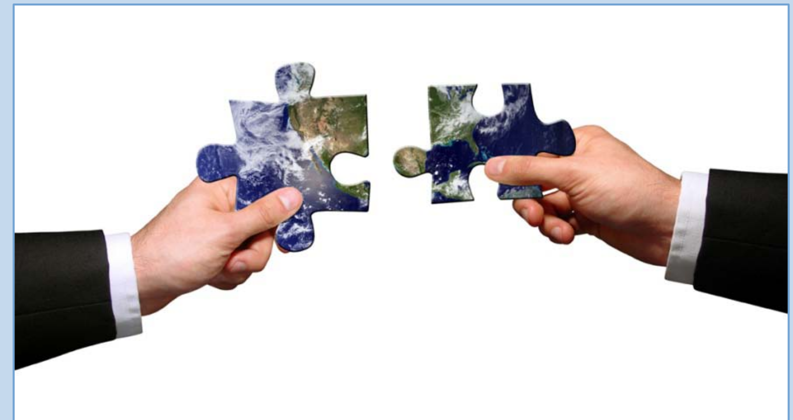
- Typical Failures[7]:
  - Patient Assessment
    - Lack of understanding of patient's physical and cognitive functional status
    - Failure to include patient and caregivers in planning
    - Failure to recognize worsening condition before discharge
  - Patient and caregiver education
    - Instructions confusing
    - Patient does not clarify lack of understanding

Readmission

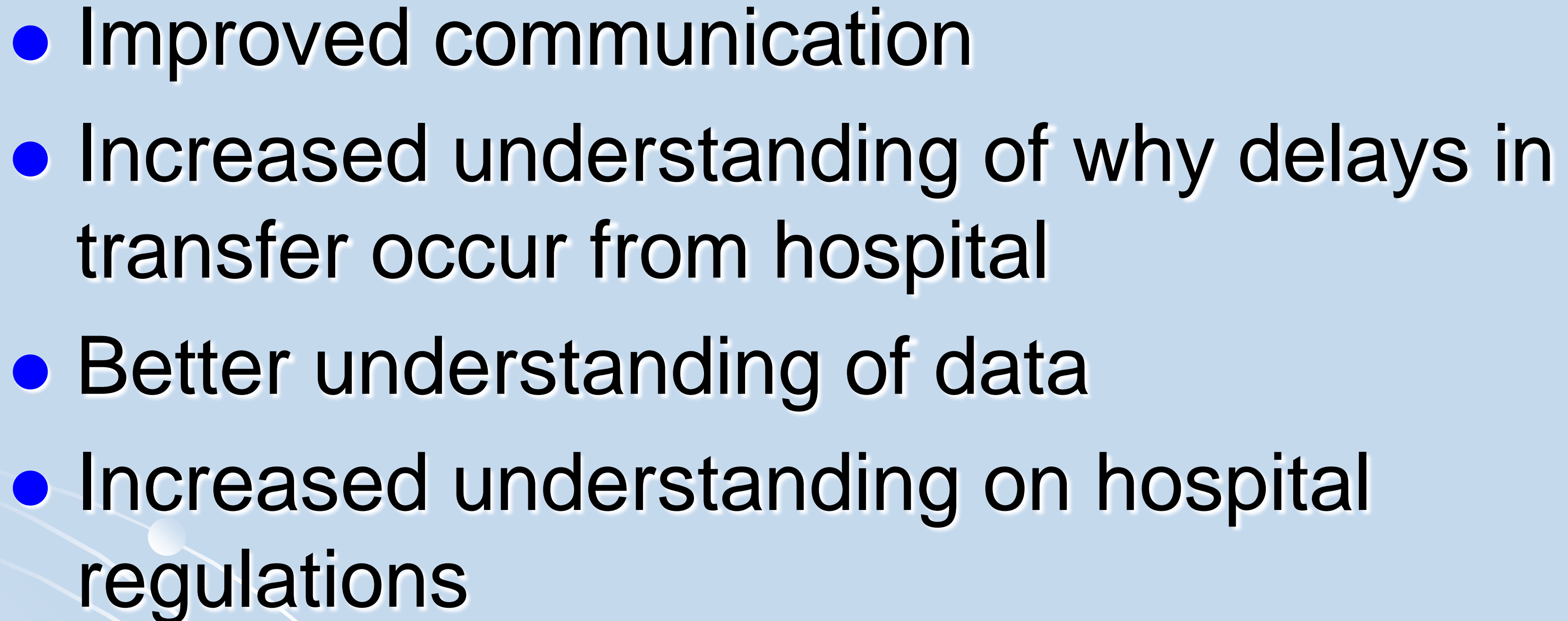
- Typical Failures cont.[7]:
  - Handover communication
    - Medication discrepancies
    - Inadequate discharge instructions
    - No communication of discharge plan
    - Functional status not communicated
  - Failures following discharge
    - DC instructions confusing
    - F/U appointment too long after discharge
    - Lack of plan for when 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



Success comes from doing common things uncommonly well.

Questions

References

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