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Quality Improvement, the New Catchphrase in Healthcare Systems

Numerous studies have shown that measuring and publicly reporting the performance of doctors, hospitals and other healthcare providers improves care.¹ This author believes that improvements are most likely to occur when the need for change is understood, measured, shared and publicly recognized.

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Nursing Homes

The Critical Link to Safe Transitions Home



Lumetra

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Implementing care transitions best practices in nursing homes is an effective strategy to avoid preventable re-hospitalizations, medical errors, and duplication of services.^{1,2} Care transitions are common and often poorly executed worsening patient health, burdening caregivers, and consuming additional health care costs.³⁻⁵ This article presents five care transitions best practices to smooth transfer from Skilled Nursing Facilities (SNF) to home with the objective of preventing costly re-hospitalizations.

Implementing Effective Care Transitions Best Practices Avoid Preventable Hospitalizations. Embarking on the journey to improve care transitions across the continuum of care in your community may seem like a daunting task. After all, the healthcare provider setting “silos” are alive and well and the barriers to improving care transitions are many. However, the implementation of evidence-based best practices of SNF

to home health care transitions is a solution to keep vulnerable people safe and avoid re-hospitalization.^{2, 3, 5}

Unsafe Care Transitions, Shocking Re-Hospitalization Statistics.

At present, most care transitions are dangerous, especially for frail elders with complex chronic conditions.^{6,7} Too often, care transitions are poorly executed, increasing healthcare costs, burdening caregivers, and worsening

patient health leading to complications resulting in readmission back into the acute care hospital setting.^{6,7} In fact, according to the Institute for Healthcare Improvement (IHI), there are about five million hospital readmissions every year, with approximately a third occurring within 90 days of discharge, of which 46% could be prevented.⁸

Unsafe Care Transitions Compromise Healthcare Quality. Many patients make multiple transitions across various settings and usually a SNF will make up at least two of a patient's transitions during a course of illness.^{7,9,10} Thus, SNFs serve as a critical link for frail elders. With each transition, the risks associated with poor care coordination and communication across settings increase.⁵ In many cases, patients and their family members are not prepared to cope, nor do they have the competence to navigate a fragmented healthcare system and advocate on their own behalf.^{6,7} Consequently, people are suffering from poor health outcomes.

Safer Care Transitions are Patient-Centered. At its core, a safe transition results from a patient-centered process.¹¹⁻¹⁴ Nursing home leaders can foster an effective process by embracing the patient, caregivers, and family members as partners of the care team.¹¹ They are to be empowered with education, decision-making and choices, including end-of-life care.^{1,9} In addition, care transitions should be provided in a manner compatible with the patient's cultural health beliefs, preferences, literacy level, practices, and preferred language.^{6,7,15}

Effective Care Transitions Best Practices

There are a number of evidence-based, pragmatic ways to ensure that patients remain safe when they are discharged home, which include: discharge planning, self-management, enhanced communications, medication reconciliation, and conducting a post discharge follow-up call.¹

1. Discharge Planning—Use Structured Instructions and Checklists.

We have all heard it many times before—begin discharge planning at admission.¹⁶ But rarely do we hear the specific evidence-based best practices for the SNF social worker. Listed below are key steps:

- **Promote Cultural and Linguistic Competency Support to Caregivers.** Assess the resident's family care giving capacity first and immediately begin preparing the family through culturally competent education and support.^{6,7} Family members need to understand that, in most cases, they will be providing 80% of their loved ones care when they are discharged home. Home modifications should be identified during the first few days within the SNF so that the construction is complete prior to discharge when possible.^{6,7}
- **Assess a Patient's Risk for Re-hospitalization.** Those most at risk of re-hospitalization are non-English speaking, low-income, isolated seniors with multiple

chronic conditions and some cognitive impairment.^{6,7} Thus, a foundational best practice is for SNF social workers to assess a patient's risk for re-hospitalization after discharge home at several stages during their stay in the SNF. SNF social workers should share the findings with the patient, their family, the attending physician, and the home healthcare agency. SNF social workers should use terminology that the home healthcare agency will clearly understand such as—"This patient is at high risk of re-hospitalization. Please consider frontloading your visits in order to keep her safe."

- **Know Local Community Resources.** Finally, all healthcare is local. The capacity of keeping frail elders safely at home varies from community to community. Therefore, SNF social workers should educate themselves about their local community resources in order to assist patients and their families as they navigate the entitlement maze. They should become an expert on their local resources and services such as Meals on Wheels, caregiver support groups, and other community-based organizations. Appropriate applications should be on hand in the social worker's office.

2. Involve Residents and Family Caregivers in Care Transitions.

Social issues dominate the barriers to

improving care transitions. On the social side, the solution relies heavily on the patient and their primary caregiver—usually a family member.^{3, 6, 7} The SNF to home transition is fragile. To safely transfer a patient home from the SNF and avoid re-hospitalization, patients and their family caregivers must be educated and prepared to:^{6, 7}

- Use a personal health record,
- Complete advanced directives,
- Arm themselves with checklists and medication regimes before physician office visits, and
- Learn to manage complex health conditions.

For many family members, it is the first time they have assumed a caregiver role.^{6, 7}

Listed below are key skills to consider:

- **Prepare Patients and Family Caregivers for Safe Care Transitions.** Educate residents and family caregivers with appropriate discharge information, treatment regimens, and follow-up appointments.¹⁷
- **Develop Patients and Caregivers with Self-Management Skills.** Self-management strategies prepare patients and their caregivers to assert a more active role in managing their care.^{1, 18} Educate patients with key discharge information and focus on increasing self-confidence. In a study, residents that underwent care transition interventions reported greater self-efficacy in obtaining key information for managing their condition,

communicating with healthcare providers, and understanding their medications.¹

- **Educate Patients and Their Family Caregiver in Using a Personal Health Record.** Provide and educate your patients and caregivers to keep-up-to-date and share with healthcare providers a patient-centered health record with key healthcare information including a complete list of medications and allergies, chronic illnesses, “red flags,” advance care directives, and contact information.^{1, 16, 19}

3. Improve Provider Communications and Standardize Handoffs Tools.

Enhanced communications among healthcare providers using standardized handoff protocols improve healthcare quality and patient safety.

- **Standardize Handoffs and Promote a Safe Handoff Culture in Your Community.** Effective transitions involve standardized written and verbal instructions to pass information to the next provider.^{20, 21} Implement a standardized approach to handoff instructions including an opportunity to ask and respond to questions.^{20, 21} Information includes administrative data, patient background, up-to-date clinical information, current conditions, a to-do list and contingency plans.^{6, 7, 20}
- **Increase Communication Between the Sending and Receiving Providers.** Interdisciplinary team

interventions such as having SNF social workers, case management, multidisciplinary healthcare team coordination, and planning for community-level health referrals improve patient health and satisfaction.^{6, 7, 22} Enhanced communication among healthcare providers ensures that comprehensive clinical information is passed from one provider into the next point of contact.

4. Promote Medication Reconciliation Review at Admission and Discharge

Medication review is an effective way to intercept unsafe medications. Medication reconciliation helps to avoid errors of transcription, duplication of therapy, and drug-related interactions. The medication reconciliation process has three major steps:

- **Verification**—collection of medication history
- **Clarification**—checking appropriate medications and doses
- **Reconciliation**—documentation of changes in the orders.
- **Medication Problems Are Major Contributor Factors for Hospital Re-admission.** If there is one single, overriding key to a safe discharge process, that key is medication reconciliation. In laymen’s terms, medication reconciliation means the discharging facility ensures that the patient, the home caregiver and every medical provider has a final, correct, legible, understandable, “take only these”

list of medications that includes not only prescription, but non-prescription drugs, as well.²³⁻²⁵

Medications are a significant proportion of elder illness and hospital admissions with 10-30% of hospital admits in elders found to be drug-related.^{26, 27} Likewise, re-admissions to the hospital have a sizable medication related source. One study found that about 20% of re-admissions to the hospital in a geriatric population were drug-related, and more telling, that 76% could have been prevented with proper medication use.²⁸ Proper medication use saves hospitalizations, patient injury, and deaths.^{25,29}

• **Medication Changes in SNF Are Common and Contribute to Hospital Readmission.** The typical elder facing SNF discharge has been hospitalized with an acute event, precipitating a drug regimen change. If those medications were again modified during the SNF stay, it is unlikely that the elder returns home on the same medication list that was in effect before hospitalization. In addition, it is likely that even the same medications have a different trade or generic name. There is a strong urge to resume the prior drugs rather than spend significant sums on new ones when the patient feels better. It is a small wonder that medication discrepancies exist.

Little work is available for SNF discharge medication problems, but a study indicated a 14.1%

medication discrepancy rate in elders after hospital discharge, and that those patients with a medication issues were more than twice as likely to be re-admitted within 30 days.²⁹ It strains belief to assume SNF discharge efforts are anything but similar.

• **Use the Facility Consultant Pharmacist to Review Discharge Medication Lists.**^{13, 30, 31} Consider having drug regimens faxed to the attending physician the day prior to discharge for approval, or calling the physician to confirm discharge medications just as the facility confirms phone medication orders. Fax or e-mail the discharge medication list to the patient's primary care physician, but also to all specialty physicians likely to see the patient post-discharge. Many of the specialists may see the patient before the primary physician (who in some cases may not even know the patient is in the SNF). Also, it is recommended to utilize the SNF Medical Director in situations where the confirmation of drug therapy is problematic.

While any discharge, especially when a frail elder is involved, is the equivalent of "running with scissors," discharges that do not practice good medication reconciliation are "running with scissors blindfolded." An accident is certain, only the extent of the preventable injury is in question.

5. Conducting a Post-Discharge Follow-up Call

Last on the list of strategies to help keep people safe after their discharge is for SNF social workers to conduct a post-discharge follow-up call 24-48 hours after the patient's departure.^{10, 22, 32, 33} During the call, the SNF social worker should speak to both the caregiver and the patient and:

- Inquire about the visit from the home health nurse.
- Reinforce their adherence to medications and treatments.
- Reinforce the need for follow-up visits with physicians and specialists.
- Ensure that the supplemental resources have started (i.e., Meals on Wheels).

Summary

Having the critical link in planning discharge to the home requires five key points:

1. **Discharge Planning Begins Upon Admission, If Not Sooner.** The care of vulnerable elders demands that the SNF "plan for the unplanned." Discovering a frail elder being discharged is the caregiver for an even frailer spouse, or disabled child, redefines what level of function the patient about to be discharged must attain. Finding that the elder has no transportation to necessary medical follow-up, funds for medications, or finding someone to provide care for them at home upon the day of discharge, have the potential to negate the good care provided in the SNF which places the facility in a precarious situation clinically and legally.

2. Involve the Patient and Caregiver in the Beginning.

Empower patients and family caregivers with skills, tools, and self-confidence to follow treatment recommendations, recognize “red flags,” follow-up with the care team, share a personal health record, and take a more active role in managing their care. Train patients and caregivers on warning symptoms and adverse events. Educate patients and caregivers about warning symptoms, signs, and adverse reactions that may indicate that their condition has worsened. Provide contact information in the event that this occurs.²

3. Improve Communications Among Providers Using Structured Communications Tools.

Transfer complete clinical information to the next point.² Standardized written and verbal instructions to pass information to the next healthcare provider. Collaborate with members of the care team across settings to formulate a common care plan.

4. Medication Reconciliation is the Single, Overriding key to a Safe Discharge Home.

Use all your available resources to insure each patient goes home with a final, correct, legible, understandable, “take only these” list of medications that includes not only prescription, but non-prescription drugs, as well. Educate patients and caregivers to use and bring a personal health record to the next care team visit.

5. A Post-Discharge Call Demonstrates Your Competence

and Your Caring. The discharge process presents patient and family with information overload; so much said with many words that are foreign to the listener and at a time of marked stress. The reminder that the home health nurse should have been by to see them, reinforcing the new medication list, to follow-up with their physician, or for additional treatments is essential. Expected resources such as Meals on Wheels, support groups, and community-based organizations are essential to a successful handoff of care.

These five keys can be performed by every SNF. We can do no less for our vulnerable elders.

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EMS Rounds

**Joy Peters, RN, MICN, Paramedic Liaison Nurse
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On December 15, 2007, Arrowhead Regional Medical Center (ARMC) received a call from Victorville, Medic Ambulance 713 for a 9 year old male with a complete "AIRWAY OBSTRUCTION." The child had agonal respirations at a rate of 6/minute. The patient's torso and the lower extremities were cyanotic and the Glasgow Coma Scale (GCS) was 3. The pupils were 6 centimeters and non reactive. The patient's history included an ETOH baby with cerebral palsy. The child's baseline Glasgow was 6.

While in route to Victor Valley Hospital, the Paramedic from Medic Ambulance 713, visualized the foreign

body with direct Laryngoscope and removed a piece of peanut butter and jelly sandwich with a Magill forcep.

Following the removal of the foreign body, the skin color improved and the pupils were reacting to light. The child's Glasgow Coma Score improved to baseline and breath sounds indicated wheezing. When the patient arrived at Desert Valley Hospital, an x-ray of chest was done which was normal and patient was discharged home

the same day.

I want to extend my congratulations to the Emergency Medical Services team on Medic Ambulance 713 for their life saving efforts in managing this difficult situation.

