Optimizing Transitions and Acute Care Options: Making a difference in LTC

May 15, 2019

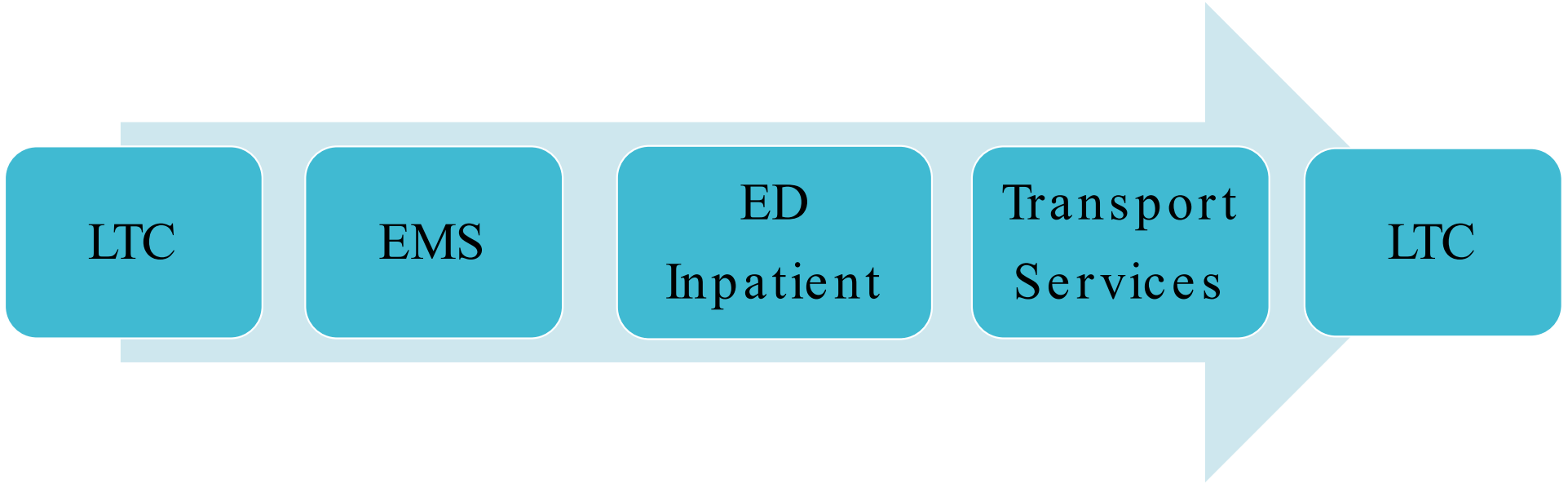
Kathryn May NP
The Ottawa Hospital: NP Led Outreach Team

Objectives:

- ✓ To review the evidence related to common issues affecting transitions between hospital and LTC setting
- ✓ To discuss strategies and opportunities to improve the quality of transitions
- ✓ To describe how a NP outreach program is enhancing acute care access and supporting transitions in care

Highlighting the concern

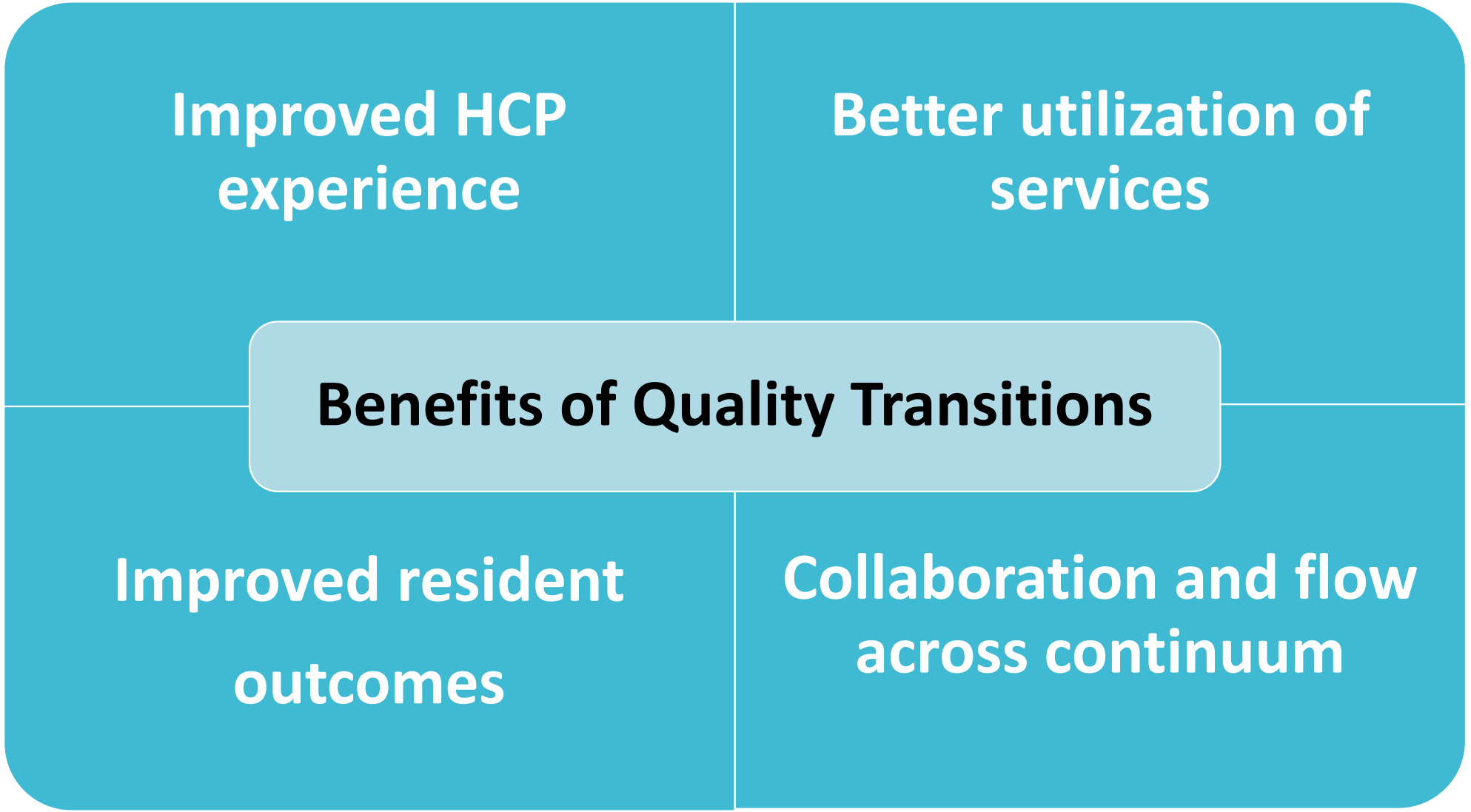
Case 1	Case 2	Case 3
▪ 88 yr F ▪ LTC to Hospital ▪ LTC/Hospital Record ▪ Consequences	▪ 78 yr M ▪ Hospital to LTC ▪ Discharge Record ▪ Consequences	▪ 86 yr F ▪ Hospital to Community ▪ Unknown ▪ Consequences



Poorly executed transitions in care

- Wrong treatment
- Severe adverse events
- Increased LOS
- Delay in diagnosis
- Patient complaints
- Increased costs

Coleman EA, Boult C. JAGS 2003


Improved HCP experience
Better utilization of services
Benefits of Quality Transitions
Improved resident outcomes
Collaboration and flow across continuum

Elements to Quality Transitions in Care

1. Medication management
2. Transition planning
3. Patient and family engagement/education
4. Information transfer
5. Follow-up care
6. HCP engagement
7. Shared accountability across providers and organizations

National Transitions of Care Coalition, 2014

LTC

ED

Inpatient

LTC

Assumptions: Stories we tell ourselves

“I figured LTC had the full capacity of the hospital and had no idea about staff ratio, physician presence and things like that”

“nurses have the same experience and skill set as the hospital and most things should be handled in the NH”

“I’ve seen a lot of people coming in with simple things like constipation, confusion and dehydration and I wonder ‘what is going on in LTC?”

“They are always delaying transfers back to LTC without a good reason”

“I don’t understand why residents are coming back with nothing done”

What makes a LTC resident unique?

- MIND
- MULTI-COMPLEXITY
- MEDICATIONS
- MOBILITY
- MATTERS MOST

Then	Now
▪ No BSO teams ▪ Limited mobile imaging ▪ Limited on site visits ▪ Custodial model of care ▪ LTC MDs replace Family MDs ▪ LTC isolation (silo)	▪ NPs on site ▪ Timely imaging (ultrasound) ▪ Econsult/on site consult ▪ EMAR ▪ BSO/ROH ▪ Focused education ▪ Surge learning ▪ Enhanced collaboration ▪ Guidelines ▪ Better access to equipment

To transfer or not to transfer …….

?

- NHs within 5min of ED have higher transfer rates
- The older you are the worse the hospital can be
- Residents hope they will not be hospitalized
- 30 day readmission rates are higher

Lemoyne et al. 2019, BMC Geriatrics; Grunier et al. 2018, BMC Geriatrics

One transition: Two perspectives

LTC to ED Transfer

Condition

- Injury related to falls
- Altered mental state
- Suspected infection

Reason

a) Medically indicated (acuity/CTAS)
b) LTC resources
c) Family request

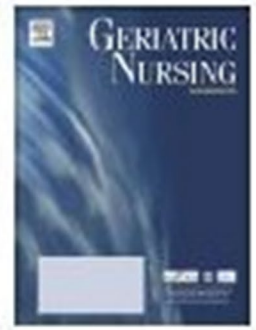
"I try to do the best I can but I need help to do my job"

Geriatric Nursing 35 (2014) 316–320

Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com



NGNA
National Gerontological
Nursing Association

NGNA Section

From nursing home to acute care: Signs, symptoms, and strategies used to prevent transfer

Alyce S. Ashcraft, PhD, RN, CNE, ANEF *, Donna C. Owen, PhD, RN, CNE

Texas Tech University Health Sciences Center, School of Nursing, 4601 4th Street, Lubbock, TX 79430, USA

JAMDA 17 (2016) 994–1005

JAMDA

journal homepage: www.jamda.com

Review Article

Decisions to Transfer Nursing Home Residents to Emergency Departments: A Scoping Review of Contributing Factors and Staff Perspectives

Lisa M. Trahan RN, BN [a], Jude A. Spiers RN, PhD [a], Greta G. Cummings RN, PhD, FAAN, FCAHS [b,*]

[a] Faculty of Nursing, University of Alberta, Level 3, Edmonton Clinic Health Academy, Edmonton, Alberta, Canada
[b] Faculty of Nursing, University of Alberta, Canada 5–110 Edmonton Clinic Health Academy, Edmonton, Alberta, Canada

Contributing factors (NH to ED)

1. Nursing
2. Physician/Nurse Practitioner
3. Facility/Resource
4. Residents/Family
5. Health System

Trahan, L.M. et al. 2016, JAMDA

“Common things are not necessarily common”

One transition: Two perspectives

Hospital to LTC Transfer

Condition

- Simple to complex
- Palliative to EOL
- Post operative

Reason

a) Further treatment not indicated
b) Interventions not in keeping with GoC
c) Family request

"What is the problem? Why are they sending?

The Consequences of Poor Communication During Transitions from Hospital to Skilled Nursing Facility: A Qualitative Study

Barbara J. King, PhD, RN, Andrea L. Gilmore-Bykovskyi, MS, RN,*†‡ Rachel A. Roiland, PhD, RN,*§ Brock E. Polnaszek, BS,†‡ Barbara J. Bowers, PhD, RN,* and Amy J. H. Kind, MD, PhD†‡§*

Qualitative Study: 27 RNs in 5 Skilled Nursing Facilities (SNF)

Results:
- Rely heavily on written discharge notes
- Cited multiple inadequacies of information
- Little psychosocial or functional history

Conclusion:
- Poor quality discharge communication is a major barrier to safe/effective transitions

Consequence of poor quality discharge communication

Resident and Family	Staff	Facility
▪ Care delays/under treatment ▪ Inappropriate care provided ▪ Dissatisfaction	▪ Increased stress and frustration ▪ Feeling inadequate ▪ Feeling unsafe “working blindly” ▪ Sense of guilt if care is associated with harm	▪ Additional costs in staff time, wasted resources ▪ Poor work satisfaction: high staff turnover ▪ Negative facility image

King, B. et al, 2013, JAGS

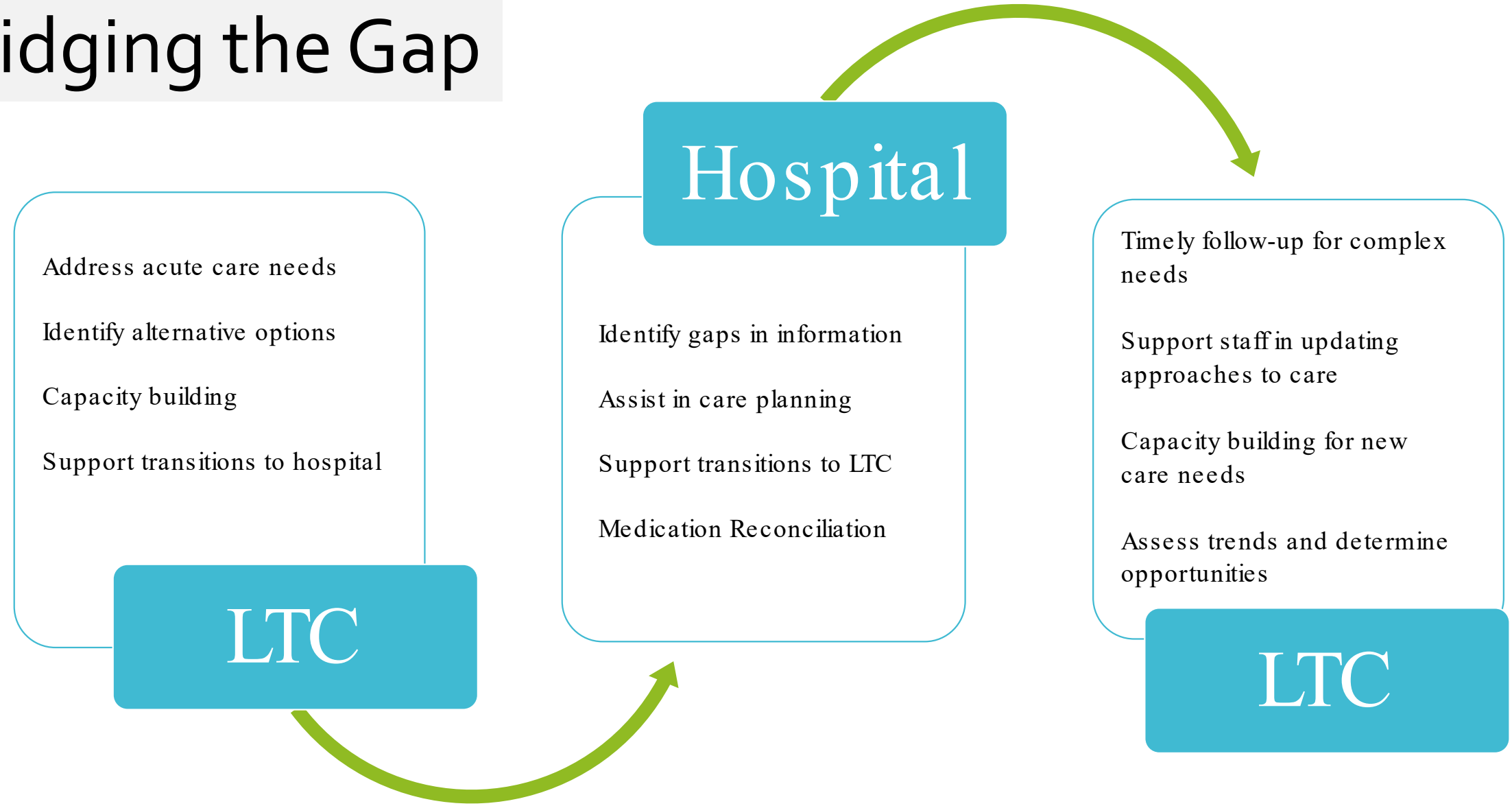
Process recommendations

- Hospitals communicate discharge plans > 24hrs
- Discharge early in the day
- Communicate changes to the plan of care
- Provider to provider communication prior to discharge
- Immediate access to HCPs with UTD knowledge
- Focused, current, complete medical information
- What about a nursing discharge summary?
- Send prescriptions prior

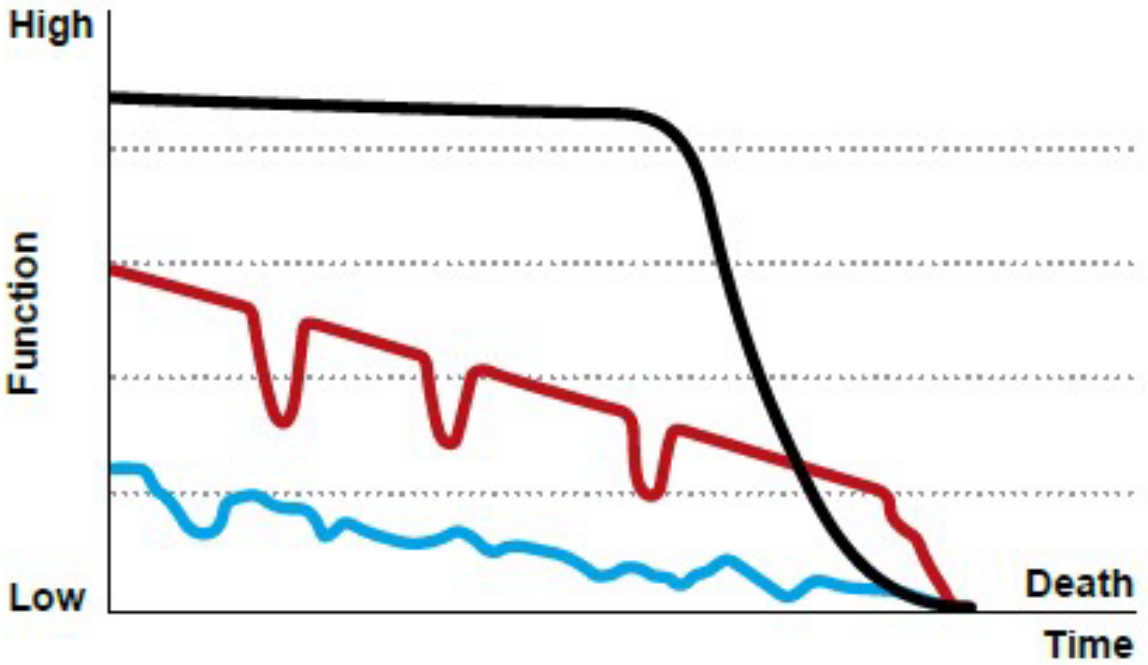
NP Outreach Team

- Provide acute, episodic care
- Prevent ED transfers
- Support safe transitions
- Capacity building initiatives
- Support palliative approaches to care

Bridging the Gap



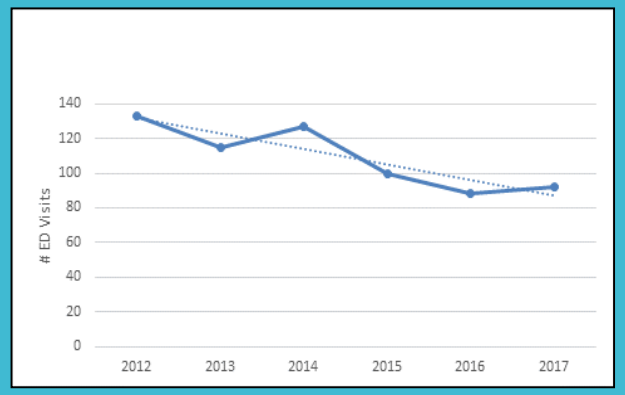
Trajectory of Illness



Source: Murray, S.A. et al[1]

- Cancer (n=5)
- Organ failure (n=6)
- Physical and cognitive frailty (n=7)
- Other (n=2)

NP Outcomes



2010 to 2019

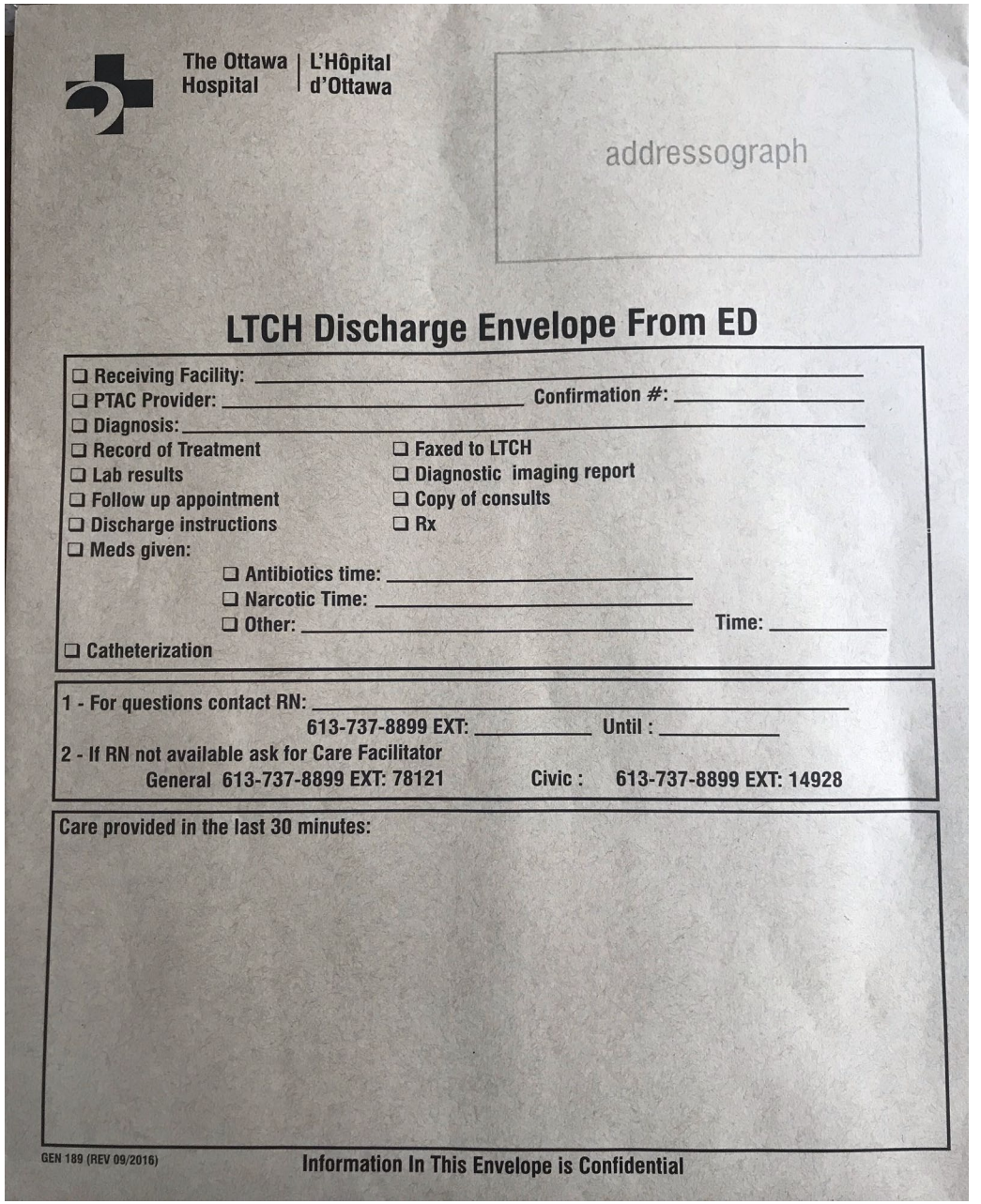
Encounters:	9333
ED Diversion:	90 – 94%
Admission rate:	60+%
Qualitative Piece:	

Annual Reports of the RGPEO/TOH NLOT Data Collection

Highlighting the progress

Case 1	Case 2	Case 3
▪ 72 yr M ▪ LTC to Hospital ▪ Urethral Stricture ▪ Specific request ▪ Outcome	▪ 70 yr M ▪ Hospital to LTC ▪ Metastatic disease ▪ Collaboration ▪ Outcome	▪ 74 yr F ▪ Frequent Hospital Visits ▪ Pulmonary HTN ▪ HCPs collaboration ▪ Outcome

Commitment to Change



The Ottawa Hospital | L'Hôpital d'Ottawa

addressograph

LTCH Discharge Envelope From ED

- ❑ Receiving Facility: _____
- ❑ PTAC Provider: _____ Confirmation #: _____
- ❑ Diagnosis: _____
- ❑ Record of Treatment
- ❑ Lab results
- ❑ Follow up appointment
- ❑ Discharge instructions
- ❑ Meds given:
- ❑ Faxed to LTCH
- ❑ Diagnostic imaging report
- ❑ Copy of consults
- ❑ Rx
  - ❑ Antibiotics time: _____
  - ❑ Narcotic Time: _____
  - ❑ Other: _____ Time: _____
- ❑ Catheterization

1 - For questions contact RN: _____
613-737-8899 EXT: _____ Until : _____
2 - If RN not available ask for Care Facilitator
General 613-737-8899 EXT: 78121 Civic : 613-737-8899 EXT: 14928

Care provided in the last 30 minutes:

GEN 189 (REV 09/2016)

Information In This Envelope is Confidential


Dank U
Merci
mahalo
Grazie
Thank you
mauruuru
Dziękuję
Děkuju
danke