Reecha Madan
Geriatric Fellow
PGYIV
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IMPROVING NURSE TO NURSE COMMUNICATION DURING PATIENT TRANSFERS.

TEAM MEMBERS

- Dr. Reecha Madan MD Geriatric Fellow
- Dr. Rosina Finley MD, CMD
- Loren Fischer MS III
- Nursing
- DON

BACKGROUND

- Many healthcare providers have not practiced in the settings to which they are sending patients and are unfamiliar with care-delivery details of these settings, and may transfer patients inappropriately.
- Ineffective transitions lead to poor outcomes such as:

-inappropriate treatments
-delays in diagnosis
-severe adverse events
-patient complaints
-increased costs
-increased lengths of stay
-medication errors

BACKGROUND (CONT.)

- Monitoring and documenting the **mental status** of older patients transferred between providers or facilities is important because mental status change can be a sign of acute disease and mental status abnormalities necessitate specific approaches to care when the patient arrives at the facility.
- Not understanding the patient's **ADL limitations** while starting orders upon admission can lead to poor outcomes
- Sometimes **Foley's** get started and never stopped during admission in the hospital. The doctor in the nursing home does not see the patient right away may not know about the foley unless the nurse communicates that. Prolonged unnecessary use of the foley can lead to infection as well as prolong delirium.

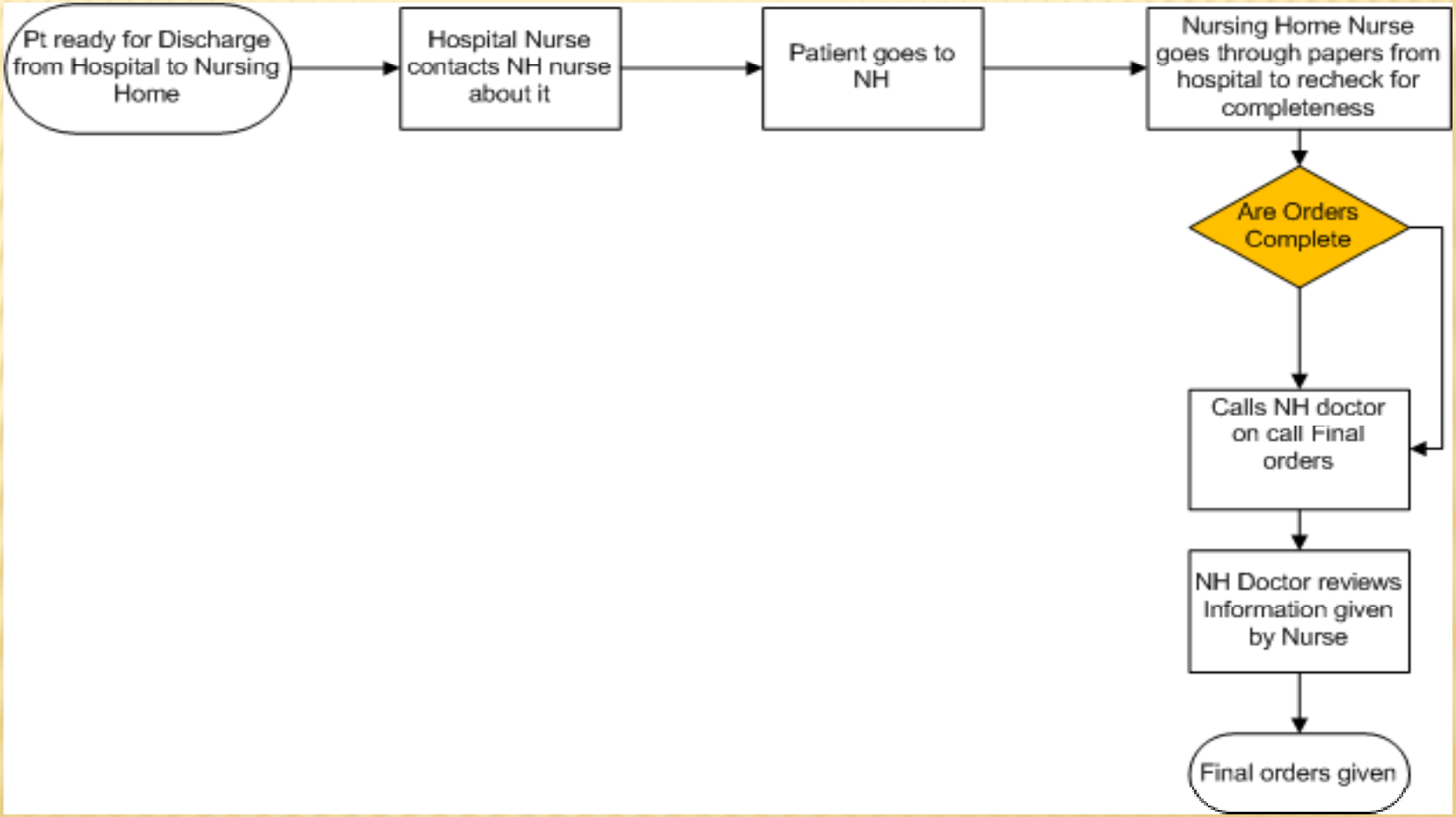
BACKGROUND (CONT.)

- Boockvar et al (2004) found that a significant percent of ADEs(Adverse Drug Errors) occurred between **transfer from the hospital to nursing home** when a large percent of medications were discontinued or altered.
- ADE rate of 0.02-0.1 per 100 admissions (estimated that 42-51% are preventable).
- There have been other programs implemented (INTERACT) to address these problems, but
- No one intervention alone can fix this issue.

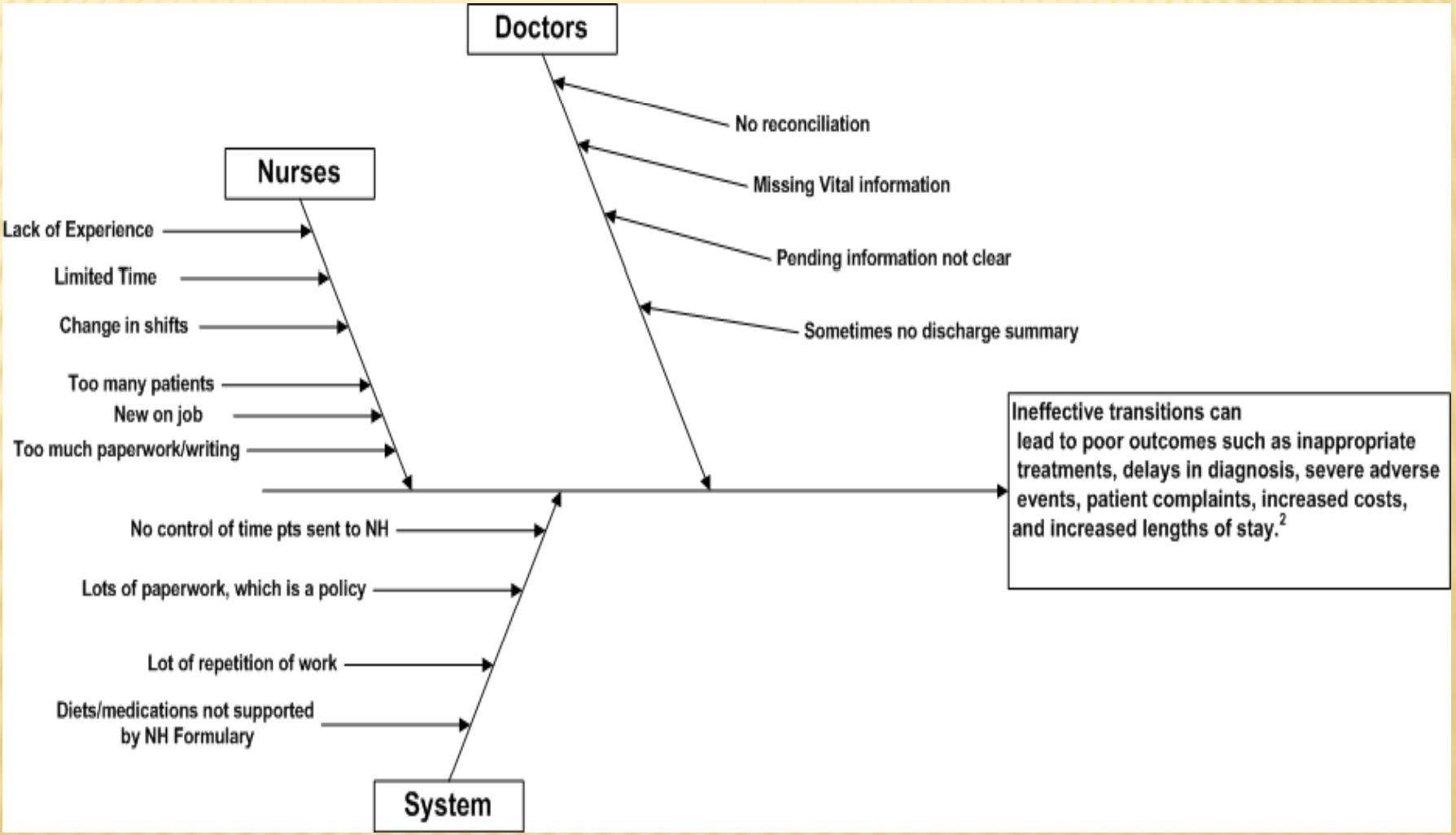
AIM STATEMENT

- The aim of this project is to implement a Nurse to Nurse communication tool to be used during transfer from hospital to nursing facility and have at least 60% increase in the collection of the 5 identified critical areas.
- A second aim was to add a medication reconciliation process to the tool to decrease ADE's.
- This is important to improve because as mentioned above it affects patient outcomes.

WORK PROCESS FLOWCHART



FISHBONE


Doctors
No reconciliation
Missing Vital information
Pending information not clear
Sometimes no discharge summary
Nurses
Lack of Experience
Limited Time
Change in shifts
Too many patients
New on job
Too much paperwork/writing
Ineffective transitions can lead to poor outcomes such as inappropriate treatments, delays in diagnosis, severe adverse events, patient complaints, increased costs, and increased lengths of stay.[2]
No control of time pts sent to NH
Lots of paperwork, which is a policy
Lot of repetition of work
Diets/medications not supported by NH Formulary
System

PRE INTERVENTION DATA

- There was no standardized method or tool for taking report.
- Each nurse developed her/his own style.
- No systematic effort had been made to investigate the consequences of this.
- However, a small study had been done by chart audit to see if the recognized five critical areas were being addressed. The results confirmed that this was not occurring .
  - Orientation
  - ADL's
  - Foley
  - Continent
  - Skin Care

INTERVENTION: PHASE I

- A two-page Nurse to Nurse tool was introduced to the Long Term Care Facility (LTCF) staff to use during the phone call that is received from the acute care hospital prior to transfer of the patient. The site of the study is a dual certified facility with academic presence.
- A meeting was held to roll out the form and receive feedback from the nursing staff as well as the administrative staff.
- All the nurses were in-serviced through out all shifts. Morning phone calls were made to remind the nurses to use the form in all the transfers they accepted.

Nurse-Nurse Telephone Communication Tool

Date: . . . . . Unit: . . . . . Room: . . . . . .
V/S: T HR R B/P Ht: Wt:
O2 Sat: RA_____ On O2@ _____/_____
Home O2 Hemodialysis: Center: Days of wk:

Resident name: _____ **Sex:**__ male __ female

Age: . . . **Transferring facility:** . . . . . .

Full Code: _____ **DNR:** _____ **MPOA/proxy:** _____

Acute Care Hospital(ACH) Dx: _____

Surgery:_____ **Date:** _____ **Wt. bearing status:**_____

Surgeon/Contact info:
ACH MD/Contact info: . . . . . .
PCP/Contact info:

Past Medical Hx: ___Dementia ___ CV ___ Dysphagia ___ AF ___ DM
Other:

_____

Mental Status: __alert __confused __forgetful

Oriented to: ___person ___place ___time ___situation

Activity: __amb __w/c __walker

Transferring: ____ self ___assist: 1____ or 2 persons ____ hoyer lift_____

___Enablers ___ Bed alarm ___ Low bed

ADL's: ___self ___assist ___total assist

Diet: _____ _____feeder _____assist

Fld Restriction: _____

Therapies: ___PT ___OT ___ST

Allergies:*_____
Medication: ___D/C sheet ____ACH MARS
Other med list: _____
_____

Antibiotics: _____ started _____stop _____labs Isolation: ___
For:_____
Anticoagulants: _____name _____stop date _____last dosed
PT/INR: Last_____ Next _____
Pending labs: _____Urine Cx _____Blood Cx
Other:_____
To be sent/ordered: _____
_____

Steroid: _____ started _____stop
Special Medication Notes: _____
_____
_____
_____

IV's: ____ Location: _____ Reason: _____
Hemodialysis: ____ Fistula: bruit/no bruit

Continent: __bowel __bladder

BRP: __self __assist __total assist

Pacemaker: __ Call MD if apical pulse check: below____ or above____

Foley: ____size: _____ **acute:** ____ **chronic:**____
Date inserted**:**_____ **reason:** _____

Last BM**:** _____

Skin: _____
Wound Care**:** _____
Designated wound care clinic: _____

Feeding tube: _____type ____PEG
Date inserted:_____
Formula: _____
rate: _____ gravity: ____bolus:____
amt: _____when:_____

Other comments:
_____

_____
_____

. . . . . .

Nurse giving report: **Phone:**

Nurse taking report:_____ **Phone:** _____

*Inadvertently omitted on revised tool

INTERVENTION: PHASE II

- Based on staff feedback, the tool was revised to add more check boxes and make it to fit on one page
- It was decided to include a section on medication reconciliation on the back side of the paper.

Nurse-Nurse Telephone Communication Tool

Name: _____ DOB: __/__/__ Sex: __M __F
Date:_____ Unit: _____ Room: _____
V/S: T____ HR ____R ____B/P ____ Ht: ____ Wt: ____
O2 Sat: RA_____ On O2@ _____/_____
Home O2___ Hemodialysis: Center: _____ Days of wk_____

Discharge Dx: __CHF __pneumonia __COPD exacerbation __hip fracture __UTI __sepsis __PE __knee replacement __GI problem __other:_____

PCP name: _____
Surgeon name: _____

PMH: __DM __CHF __chronic UTI's __A fib __COPD/Asthma __GERD __CKD __GI bleed __hypothyroidism __CAD __HTN __ dementia __lipid disorder __ depression __OA/osteoporosis __dysphagia __pacemaker __ other_____

Mental Status: __alert __confused __forgetful
Oriented to: ___person ___place __time __situation

Activity: __amb __w/c __walker __bed bound
Transferring: ___ self ___assist 1 __ assist 2 __hoyer lift
ADL's: __self __assist __total assist

Bladder: __continent __incontinent __foley, date inserted:_____
Bowel: __continent __incontinent Last BM: __/__/__

Diet: __regular __cardiac __low sodium __other_____
__feeder __assist
__PEG tube Date inserted_____

Fluid restriction: _____ **IV sites:** _____

Therapies: ___PT ___OT ___ST

Skin: _____

Code status: __DNR/DNI __Full code __unknown __do not hospitalize __hospice
Medical POA: _____

Pending labs: __urine cx __blood cx __other_____
To be sent: _____

Drug allergies: __NKDA __allergies to_____

MEDICATION RECONCILIATION (Please have a copy of the patients medication list from prior to transfer to compare to. At this point the accepting nurse please go over all of the resident's medications and see if they are still being continued. If they are not, or there are new medications or there are dose changes then please document in appropriate column below. If there no changes then no need to rewrite med.)

Discontinued medications:

Name	Dose	Route	Frequency	DX	Reason stopped
1.					
2.					
3.					
4.					
5.					

New Medications:

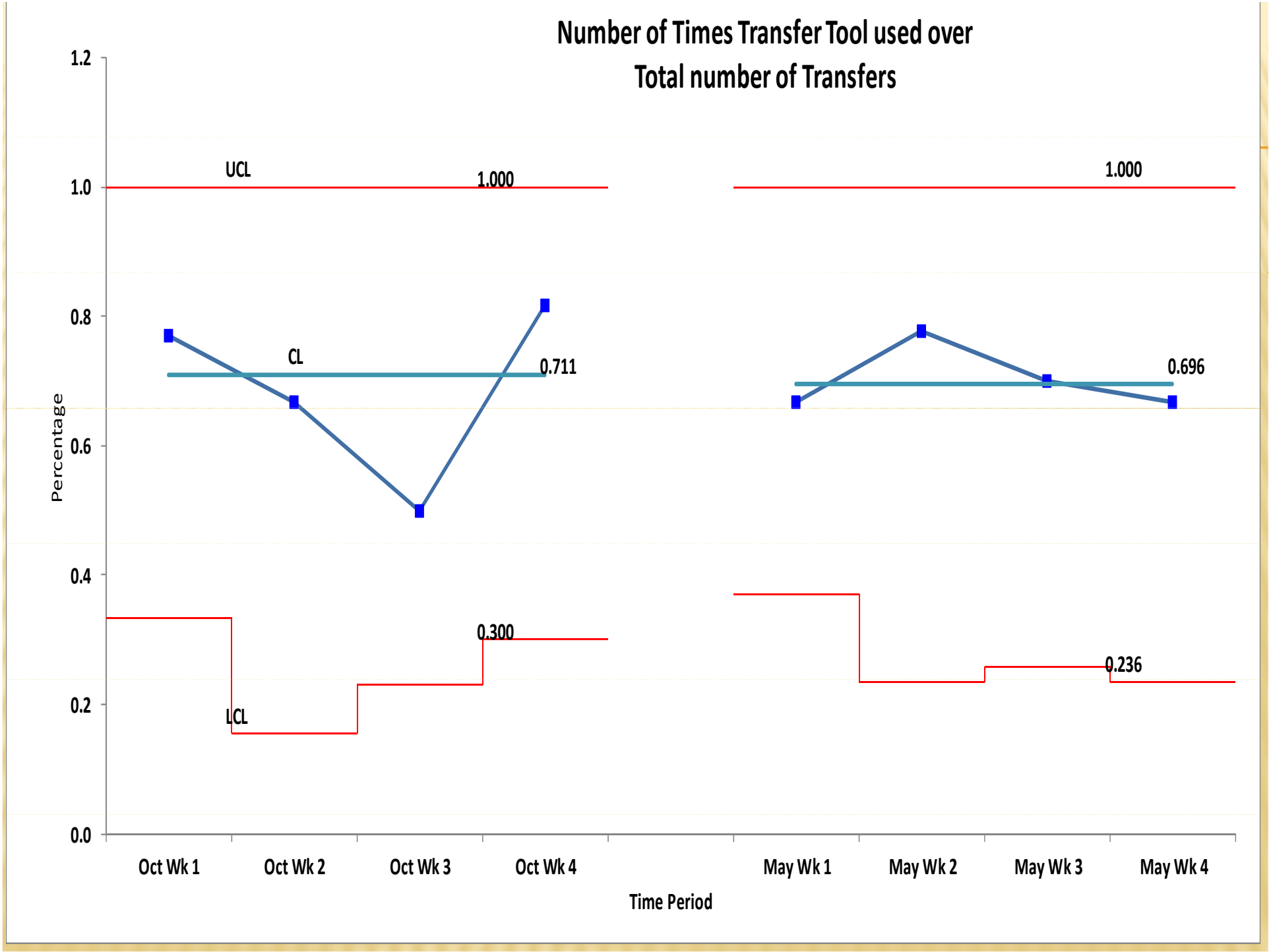
Name	Dose	Route	Frequency	DX	Stop date	Last dose given
1.						
2.						
3.						
4.						
5.						

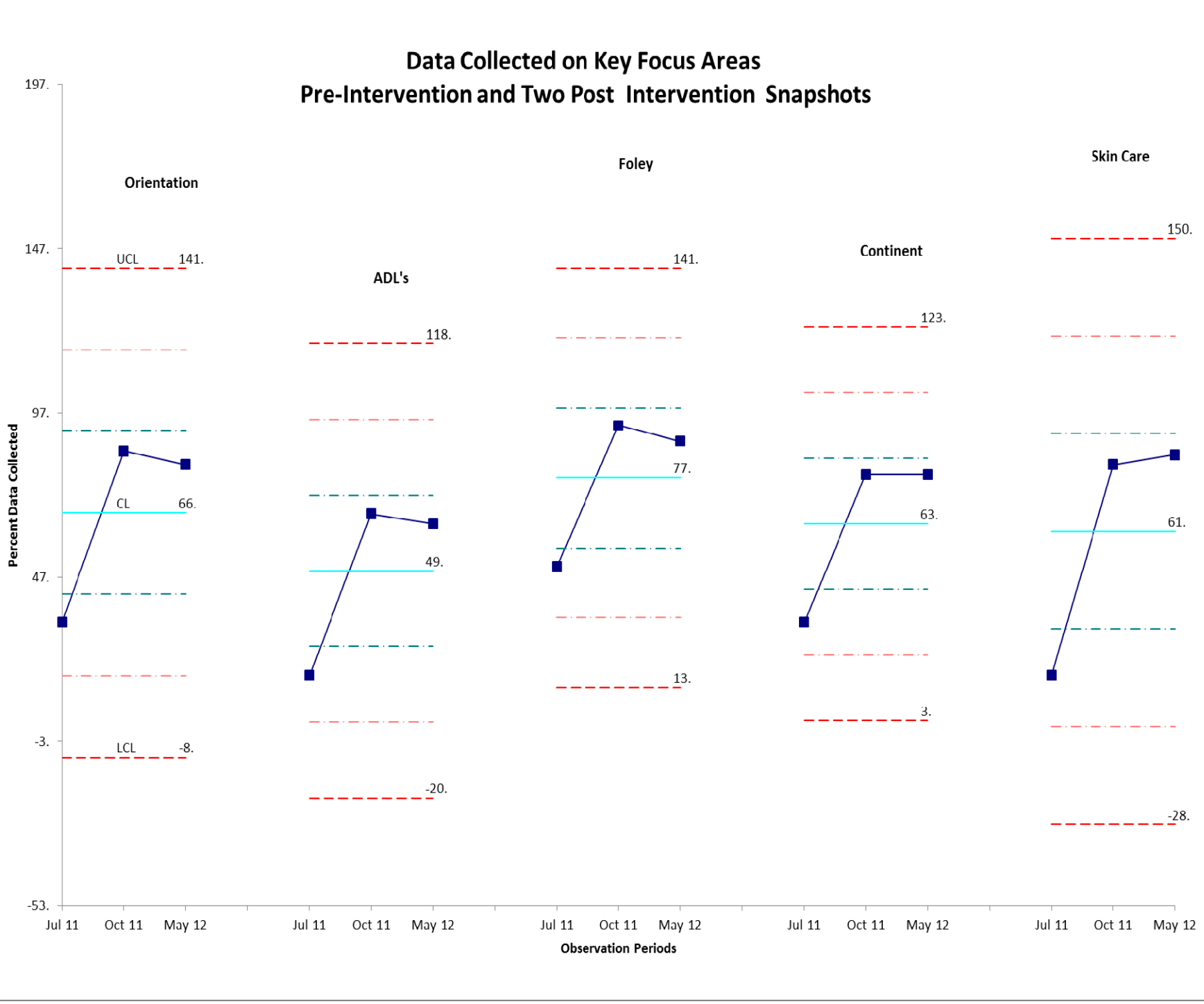
Medications with dose changes:

Name	New Dose	Route	Frequency	DX	Reason for change
1.					
2.					
3.					
4.					
5.					

MEASURES

- Following implementation of the tool, measures were taken at two time periods to track usage.
- All transfers done at these two time periods were reviewed to see if the tool was completed and if the five critical areas were addressed.
- Results indicated that the tool was being used and, compared to the study done previously, the five critical areas were being addressed.


Number of Times Transfer Tool used over
Total number of Transfers
1.2
1.0
0.8
0.6
0.4
0.2
0.0
Percentage
UCL
1.000
1.000
CL
0.711
0.696
0.300
0.236
LCL
Oct Wk 1
Oct Wk 2
Oct Wk 3
Oct Wk 4
May Wk 1
May Wk 2
May Wk 3
May Wk 4
Time Period


Data Collected on Key Focus Areas
Pre-Intervention and Two Post Intervention Snapshots
Orientation
ADL's
Foley
Continent
Skin Care
Percent Data Collected
197.
147.
97.
47.
-3.
-53.
UCL
141.
CL
66.
LCL
-8.
118.
49.
-20.
141.
77.
13.
123.
63.
3.
150.
61.
-28.
Jul 11
Oct 11
May 12
Observation Periods

MEDICATION RECONCILIATION

Unfortunately, the medication reconciliation section was not well received by the staff and not completed.

In October, only 10 out of 46 forms had the med rec section completed

In May, none of the 38 transfers had the med rec section completed.

LESSON LEARNED

- There has to be buy-in:
  - the nurses did not buy into the med rec process.
  - the nurses had not been involved in designing the med rec process and tool
  - the nurses felt that it took too much time.

FUTURE DIRECTIONS

- The hospital-based Acute Care of Elderly Unit (ACE) staff use our tool while giving ACE Unit/LTCF nursing report so both ACE unit and LTCF nurses would be using the same tool making things much more efficient.
- The ACE unit is also changing their discharge form to match the way our medication reconciliation was done to draw attention to the appropriate use of the medication reconciliation section as well as to help the physicians in medication management.

UT Medicine-CHRISTUS Santa Rosa Geriatrics
Discharge Orders (v7)

Date: //
Time:

Admit Date: //
D/C Date: //

PRIMARY DISCHARGE DIAGNOSES (short statement):

Condition on Discharge: good

PATIENT TO BE DISCHARGED TODAY X

Pending Labs, Reports: _____

Procedures / Surgeries performed:

Allergy: ☐ NKDA ☐ PCN ☐ SULFA

Abnormal Labs/imaging for F/u

Unresolved issues for F/u:

Other Diagnosis

☐ DNR (copy attached) ☐ FULL CODE

Discharge Instructions:

Discharge Medication: (ONLY TAKE THESE MEDS)

Continued medications: Dose change: Reason:

New medications:

Discontinued medications:

Home Health Agency
Diet ADA diet
PT ☐ OT ☐ Speech ☐
PCP Contacted: _____

DISPOSITION: ☐ Home ☐ AFVI ☐ AFVII ☐ PLW
☐ Buena Vida ☐ Grayson ☐ MSM Other:
_____
☐ Follow up appointments needed:
with Dr. _____ Date _____
with Dr. _____ Date _____

Narcotics prescription written ☐

Patient label:

Signature_____ Resident's name: _____
Espino Oakes Parker Patel Suh Ye Resident's Pager: _____
Office: 315 N San Saba, (210) 450-9881
Please Fax to 450-8088 if patient belongs to UT Geriatrics or to community PCP.

THANK YOU