IMPROVING NURSE TO NURSE COMMUNICATION DURING PATIENT TRANSFERS.
TEAM MEMBERS

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- Dr. Rosina Finley MD, CMD
- Loren Fischer MS III
- Nursing
- DON
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
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.
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

Pt ready for Discharge from Hospital to Nursing Home

Hospital Nurse contacts NH nurse about it

Patient goes to NH

Nursing Home Nurse goes through papers from hospital to recheck for completeness

Are Orders Complete

Calls NH doctor on call for final orders

NH Doctor reviews Information given by Nurse

Final orders given
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
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 throughout 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 H/P Ht: Wt: 
O2 Sat: RA ___ On O2(in): 
Home O2 Hemodialysis: Center: Days of wk:

Resident name: ____________________________  Sex: __ male __ female
Age: ______ Transferring facilty: ________ ________ ________ ________

Full Code: ______ DNR: ______ MPOA/proxy: ____________________________

Acute Care Hospital(ACH) Dx: ________________________________

Surgery: ______________ Date: __________ Wt. bearing status: ___________________

Surgeon/Contact info: 
ACH MD/Contact info: 
PCT/Contact info: 

Past Medical Hx: ____Dementia ____ CV ____ Dysphagia ____ AF ____ DM
Other: ___________________________________________________________________

<table>
<thead>
<tr>
<th>Mental Status:</th>
<th>__alert__confused__forgetful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oriented to:</td>
<td>__person__place__time__situation</td>
</tr>
<tr>
<td>Activity:</td>
<td>__amb__w/c__walker</td>
</tr>
<tr>
<td>Transferring:</td>
<td>__self__assist: 1 or 2 persons __hoyer lift __</td>
</tr>
<tr>
<td><strong>Enablers</strong></td>
<td><strong>Bed alarm</strong> __Low bed</td>
</tr>
<tr>
<td>ADL's:</td>
<td>__self__assist__total assist</td>
</tr>
<tr>
<td>Diet:</td>
<td>__feeder__assist</td>
</tr>
<tr>
<td>Fld Restriction:</td>
<td>_______________________</td>
</tr>
<tr>
<td>Therapies:</td>
<td>PT OT ST</td>
</tr>
</tbody>
</table>

Allergies:* 
Medication: __D/C sheet__ACH MARS
Other med list: ______________________________________________________________

Antibiotics: _______ started _______ stop
_____________ labs __________________ Isolation: __________________
For: __________________ name
Anticoagulants: ___________________ 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: ____________________________________________________
<table>
<thead>
<tr>
<th><strong>IV’s:</strong> Location:</th>
<th>Reason:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hemodialysis:</strong> Fistula:</td>
<td>bruit/no bruit</td>
</tr>
<tr>
<td>Continent:</td>
<td>bowel</td>
</tr>
<tr>
<td>BRP:</td>
<td>self</td>
</tr>
<tr>
<td><strong>Pacemaker:</strong></td>
<td>Call MD if apical pulse check: below</td>
</tr>
<tr>
<td><strong>Foley:</strong> size:</td>
<td>acute:</td>
</tr>
<tr>
<td>Date inserted:</td>
<td>reason:</td>
</tr>
<tr>
<td>Last BM:</td>
<td></td>
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<tr>
<td><strong>Skin:</strong></td>
<td></td>
</tr>
<tr>
<td>Wound Care:</td>
<td></td>
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<tr>
<td>Designated wound care clinic:</td>
<td></td>
</tr>
<tr>
<td><strong>Feeding tube:</strong></td>
<td>type</td>
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<tr>
<td>Date inserted:</td>
<td></td>
</tr>
<tr>
<td>Formula:</td>
<td></td>
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<td>rate:</td>
<td>gravity:</td>
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<td>amt:</td>
<td>when:</td>
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</table>

**Other comments:**

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**Nurse giving report:**

**Nurse taking report:**

*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: __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 __G I bleed __hypothyroidism __CAD __HTN __dementia __lipid disorder __depression __OA __osteoarthritis __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 patient's 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 are no changes then no need to rewrite med.)

### Discontinued medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>DX</th>
<th>Reason stopped</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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</tbody>
</table>

### New Medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>DX</th>
<th>Stop date</th>
<th>Last dose given</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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</table>

### Medications with dose changes:

<table>
<thead>
<tr>
<th>Name</th>
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<th>Route</th>
<th>Frequency</th>
<th>DX</th>
<th>Reason for change</th>
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<tr>
<td>1.</td>
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<td>2.</td>
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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

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Oct Wk 1</th>
<th>Oct Wk 2</th>
<th>Oct Wk 3</th>
<th>Oct Wk 4</th>
<th>May Wk 1</th>
<th>May Wk 2</th>
<th>May Wk 3</th>
<th>May Wk 4</th>
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<tbody>
<tr>
<td>LCL</td>
<td>0.236</td>
<td>0.300</td>
<td>0.236</td>
<td>0.300</td>
<td>0.236</td>
<td>0.300</td>
<td>0.236</td>
<td>0.300</td>
</tr>
<tr>
<td>CL</td>
<td>0.711</td>
<td>0.696</td>
<td>0.711</td>
<td>0.696</td>
<td>0.711</td>
<td>0.696</td>
<td>0.711</td>
<td>0.696</td>
</tr>
<tr>
<td>UCL</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
</tr>
</tbody>
</table>
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.
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.
PRIMARY DISCHARGE DIAGNOSIS (short statement)
Condition on Discharge: good

PENDING LABS, REPORTS:

Procedures / Surgeries performed:

ALLERGY:

Discharge Medication: (ONLY TAKE THESE MEDS)
Continued medications: Dose change: Reason:

New medications:

Discontinued medications:

Abnormal Labs / imaging for F/u:

Unresolved issues for F/u:

Other Diagnosis:

DNR (copy attached) FULL CODE

Discharge Instruction:

Narcotics prescription written

Signature: Espino, Oakes, Parker, Patel, Suh, Ye
Office: 315 N San Pedro, (210) 460-9881
Please Fax to 460-6088 if patient belongs to UT Geriatrics or to community PCP.
THANK YOU