Creating a Culture of Patient Safety: Session 3

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Objectives

- Understand the importance of safe and seamless care transitions to decrease risk of re-hospitalization, post-discharge complications, and/or mortality
- Evaluate the seven elements essential for safe and seamless transitions as outlined by the National Transitions of Care Coalition (NTCC)
- Utilize tools to integrate patients, family members, and others into the client's plan of care and for transition readiness
- Compare facilitators and barriers within your organization related to care transitions and design ideas for future intervention

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Care Transitions

- Importance of harm area
  - Hospital re-admissions
  - Costs
  - Negative clinical outcomes
  - Preventable adverse events
- Evidence-based models of care transitions
  - Better Outcomes for Older Adults (BOOST)
  - Care Transitions Intervention (CTI)
  - Transitional Care Model (TCM)
- Examination of transitions from hospitals to ambulatory care clinics

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Care Transition Bundle Seven Essential Intervention Categories

1. Medications Management Services & Coordination
2. Transition Planning
3. Patient and Identified Family Caregiver Engagement & Education
4. Information Transfer
5. Follow-Up Care
6. Healthcare Provider Engagement & Shared Accountability Across the Healthcare Continuum
7. Physical Health, Mental Health, Social Determinants of Health Triune

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Medications Management Services & Coordination

- Assess patient's medication list and needs
- Assess Social Determinants of Health
- Provide the patient and the identified family caregiver education and counseling about medications
- Develop and implement a plan for medication management services as part of the plan of care
- Examples:

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Transition Planning

- Identify a practitioner to facilitate the transition plan
- Manage patients and their family identified caregivers' transition needs
- Use formal transition planning tools
- Complete a transition summary
- Develop and implement a plan for the use of medical devices and remote patient monitoring
- Examples:

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Patient and Identified Family Caregiver Engagement & Education

- Ensure patients and caregivers are knowledgeable about their condition and plan of care
- Communicate transition information in a patient centered format
- Develop patient's self-care management skills
- Facilitate patient engagement with technology
- Examples:

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Information Transfer

- Implement clear communication models
- Use of formal communication tool
- Clearly identify practitioners to facilitate timely transfer of essential information
- Examples:

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Follow-Up Care

- Ensure patients and caregivers have timely access to key healthcare providers after an episode of care
- Communicate with patients and caregivers and other providers post transition
- Examples:

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Healthcare Provider Engagement & Shared Accountability Across the Healthcare Continuum

- Convene the care team to establish processes that improve transitions and care coordination at each level of care
- Establish appropriate communication and networks with all levels of care
- Assume responsibility for the outcomes of the care transition process
- Examples:

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Physical Health, Mental Health, Social Determinants of Health Triune

- Ensure complete assessment of physical health, mental health, and SDOH
- Examples:

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Better Outcomes by Optimizing Safe Transitions (BOOST)

- Reduction of 30-day readmission rates
- Objective: Reduce readmission, enhance workflow, decrease medication errors
- BOOST Team members
- Clinical outcomes
- Process outcomes

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Care Transitions Intervention (CTI)

- Aims to improve continuity of care across care settings
- 4-week program
- Key components
  - Medication self-management
  - Dynamic patient-centered health record
  - Primary care and specialist follow up
  - Knowledge of red flags
- Clinical, process, and economic outcomes

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Transitional Care Model (TCM)

- Improve outcomes from hospital to home setting
- Empowers patients and caregivers to manage conditions
- Core components
- Clinical, process, and economic outcomes

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Plan of Care and Transition Engagement

- IDEAL Discharge Planning
- Patient and family/caregiver engagement
- Core concepts of patient and family centered care
  - Improved safety, outcomes, patient experience
- Discharge planning focus

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What is it like to be a patient at your facility?

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IDEAL Discharge Planning Tool

- Include the patient and family as full partners
- Discuss with the patient and family key areas to prevent problems at home
- Educate the patient and family throughout the stay
- Assess how well physicians and nurses explain diagnosis, condition, and next steps in care; utilize teach back method
- Listen to and honor the patient's goals, preferences, and concerns

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IDEAL Discharge Planning Tool

- Tasks:
  - Initial assessment
  - Daily duties
  - Prior to transition planning meeting
  - At transition meeting
  - Day of discharge

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IDEAL Discharge Planning Tool

- Benefits of using IDEAL
- Potential challenges
- Strategies for effective engagement

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De-identified Transition of Care Event

Case Information:
An eighty-year-old male patient was dismissed from the hospital several days after having had his right foot big toe amputated due to osteomyelitis. Two days later a home health RN found the patient had been experiencing nausea and vomiting since his dismissal from the hospital. A family member present during the home health visit reported he had developed mental disorientation since his return home.

The RN performing the home health visit discovered multiple medication bottles that were labeled with another patient's name. The patient reported that he had been taking meds from those bottles along with the meds labeled with his name since his return home.

The patient was readmitted to the hospital through the ED. He was an inpatient for six days because of an adverse reaction to the medications he had been taking which were not prescribed for him.

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Thoughts? How could this happen?

- Did this organization have a home medication policy and process?
- Was there a defined discharge process? Was it followed? If not, why?
- How prevalent is not using 2 patient identifiers when administering medications or performing lab tests and other procedures in your organization?
- Was this a HIPPA violation? If so, what are the next steps? If it is not, why not?

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RCA Findings for De-identified Event

- The medications given to the patient (Patient A) at his discharge were the home medications for the patient previously roomed in that room (Patient B).
- Both Patient A and Patient B had been assigned to several different hospital rooms during their inpatient stays.
- When the previous patient (Patient B) had been moved to a lower acuity location his home meds were not moved with him.
- At Patient B's hospital discharge it was recognized that his home meds were missing but since they could not be located Patient B was provided with two weeks of the missing home meds.
- Med reconciliation at discharge for Patient A did not occur or did not include medications recorded as home meds.
- Numerous RNs and Med Rec Techs physically handled Patient B's home medication bottles, and no one had looked at the label to verify the name of the patient for which they were prescribed.

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Clinical Vignette

- Patient is an 81-year-old male who is in your hospital due to an exacerbation of his congestive heart failure. The patient lives alone with adult children all living outside of the state. He has some neighbors that check on him periodically. Patient previously was independent with all ADLs and mobility tasks, but reports increased concerns with shortness of breath, oxygen tubing management, and fatigue during everyday tasks. You are conducting the discharge planning meeting with the patient.

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Reflection, Discussion, Q&A

What one thing did you learn?

How can you enhance your role with transition planning?

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References

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Post Session Zoom Survey

Please respond to the following statements whose responses are formatted with the Likert scale of strongly disagree to strongly agree.

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Thank You

"We yearn for frictionless, technological solutions. But people talking to people is still the way norms and standards change."

Atul Gawande, MD

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