An Analysis of Nursing Home Transfers

N 599 Capstone project
Aspen University

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Name
Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Background</td>
<td>7</td>
</tr>
<tr>
<td>Literature search</td>
<td>11</td>
</tr>
<tr>
<td>Research question</td>
<td>17</td>
</tr>
<tr>
<td>Research design and methods</td>
<td>18</td>
</tr>
<tr>
<td>Results</td>
<td>20</td>
</tr>
<tr>
<td>Conclusions</td>
<td>24</td>
</tr>
<tr>
<td>Recommendations</td>
<td>27</td>
</tr>
<tr>
<td>Summary</td>
<td>28</td>
</tr>
<tr>
<td>References</td>
<td>30</td>
</tr>
<tr>
<td>Appendix A - Facility and Student Agreement</td>
<td>38</td>
</tr>
<tr>
<td>Appendix B - Resident Consent Form</td>
<td>39</td>
</tr>
<tr>
<td>Appendix C - Data Retrieval Form</td>
<td>40</td>
</tr>
</tbody>
</table>
Abstract

The transfer of nursing home residents to hospitals occurs daily across the county. The growing numbers of elderly makes this an important health concern facing American society. Various studies over the years have shown that the decision to transfer is very complicated and is affected by many different factors. Influencing factors discovered that the wishes of the resident, medical condition, financial status of the resident and nursing home, ethical issues and the beliefs of the nursing home physician and nursing staffs all affected the decision to transfer a nursing home resident to the hospital. Other studies discovered that residents did not always benefit by hospital interventions, as the family and resident expected. This study reviewed the reasons for hospital transfers for residents residing in a privately owned, skilled long-term care facility in X state. The quantitative study was conducted through a medical records review of the residents transferred to a hospital for a 12 month time frame. Findings of the medical record review demonstrated results consistent with other studies. While a physician may have recommended that a resident seek hospital treatment, the cases reviewed in this study identified that the residents and their families were the primary determining factor in the decision to transfer a nursing resident to a hospital.

The group of residents in this study were primarily female and over the age 80 years. The fact that many hospital transfers occurred soon after a resident was admitted to the facility was also validated in this study. While all residents in this sample had advance directives on file, most of these documents did not specify that the resident not be hospitalized. This report confirmed many findings previously published in other studies over the years.
Introduction

The increasing numbers of the elderly creates many issues that American society needs to address today and in the future. Ensuring that each elderly person receives assistance, as necessary, to lead a full and healthy life are very important concerns facing Americans. As the numbers of elderly increase rapidly due to baby boomers becoming senior citizens, these issues are going to gain more significance. In 2011, 20.6% of the U.S. population or 77 million baby boomers will begin to turn 65; at the same time, the old-old or those persons over 80 years of age will be the largest portion of the American population (Agency for Healthcare Research & Quality, 2002). The elderly reside in a variety of settings - single family homes, senior housing, with family members, and in long-term care settings. Most elderly persons who are healthy and not disabled live independently; while, those elderly persons who need assistance for their daily needs may reside permanently in residential settings or long-term care facilities, where this assistance is provided by paid caregivers. Nursing homes are the often the best setting for those elderly persons who require physical care 24 hours a day for dressing, bathing, toileting, eating and ambulation; and nursing care.

Long-term care is defined as extended assistance provided for chronically ill and disabled people; and skilled long-term care is care that is medically directed and monitoring by health care professionals, for which Medicare reimburses the facility (Shi & Singh, 2001). Medicare funds pay 14.9% and Medicaid funds support over half of all of persons residing in a nursing home (Gabrel, 2000). If the Medicare skilled criteria are met, these benefits can extend for 90 days of nursing home care, each year. A 3 day
hospital stay is required to qualify for Medicare skilled nursing home care and the resident needs to have Medicare days left.

Nursing home facilities work to ensure that each resident has a meaningful life in a setting that is as home-like as possible, while providing medical care and supervision. The goals for long-term care present conflicts for long-term care facilities. Facility administrators need to establish a balance between providing a safe environment, while at the same time providing each resident with opportunities for choice, control, and individuality (Kane & Kane, 2001). The staffing levels of professional nurses in a nursing home are not as high as that of a hospital; however, nursing homes have registered nurses on duty that perform assessments, administer medications, perform treatments, and interact with families and physicians, to name some of their many responsibilities.

Nursing home residents often become ill. In 1997, there were 1,465,000 nursing home residents and 2.1 million elderly nursing home discharges due to hospitalization and death in the United States (Gabrel, 2000). When a resident is observed to have a condition change, the nurse performs an assessment and makes a decision whether or not to notify the physician and the resident’s family or guardian. The most common symptoms that resulted in the transport of residents to a hospital emergency room were respiratory distress, altered mental status, gastrointestinal symptoms, and falls (Ackermann, Kemle, Vogel & Griffin, 1998). The changes in mental status could be deterioration in cognition or behavior of a resident and may be symptoms of an underlying serious medical condition (American Psychiatric Association, 2002). Hospital transfer of nursing home residents occur frequently and is concerning for all parties
involved. The transfer of nursing home residents can be very controversial and has been examined in the literature for years.

The decision to hospitalize a nursing home resident is very complex and is affected by many factors. Among the influencing factors are the wishes of the family, the preferences of the physician and the facility, insurance coverage, and the presenting symptoms of the resident. The presence of advance directives or living wills indicate the resident or the guardian’s preferences for cardiopulmonary resuscitation, artificial feeding through feeding tubes, and may document the resident’s desire for hospitalization. The presence of explicit advance directives that indicates a resident’s preferences toward hospitalization has been proven to affect the decision to transfer a resident to a hospital (Pekmezaris, Breuer, Zaballero, Wolf-Klein, Jadoon, D’Olimpio, Guzik, Foley, Weiner, & Chan, 2004). Families are encouraged to discuss the wishes of their family member, before the elderly person is unable to make their wishes and preferences known.

In addition to affecting the resident and his family, the nursing home is affected by the hospital transfer of a resident. Ethical issues may arise when a resident with advanced dementia or Alzheimer’s disease becomes ill and the family wishes to continue life prolongation interventions; versus palliative or supportive care, which the facility believes is most appropriate (Lamberg, Person, Kiely, & Mitchell, 2005). In this type of case, the family’s wishes are honored and the resident will be transferred to the hospital; even though studies have shown little benefit for most nursing home residents that are hospitalized (Morrison & Sui, 2000).

This project includes many aspects affecting today’s health care environment and nursing. The use of critical thinking skills by practitioners is evident in the assessments,
communication, and interventions that are implemented to ensure the health and well
being of the geriatric population that resides in nursing homes. Quality concerns and risk
management issues are evident in the decisions that are made by the health care
practitioners and the facility. The maintenance of resident rights is intermingled with
medical decisions and the autonomy of each resident. The impact of health care financing
on long-term care is seen in the dependence of facilities on Medicaid and Medicare
payments and the possible affect this has on the decisions made to transfer nursing home
residents to the hospital when they become ill, and for testing and treatments.

The transfer of nursing home residents is problematic for facilities, residents, and
facilities. There are no regulations guiding the decision making process, except that the
resident be cared for according to his wishes, with respect, and kindness. The purpose of
this project is to analyze the hospital transfers of nursing home residents, to identify the
factors which influenced the decision making process, to review the effect of advance
directives, and to obtain information which may help improve the quality of nursing
home care. It is important to understand the factors that influence the decision to transfer
a nursing home resident to the hospital so that any inappropriate influences can be
recognized, and correction plans be suggested. This project also will determine if the
ongoing practice of transferring nursing home residents to a hospital is an evidence-based
practice.

Background

The number of senior citizens is increasing very quickly in the United States, as
baby boomers reach 65 years of age; due in part to the increasing longevity of Americans,
decreasing birth rates, and advances in medicine. The Administration on Aging reported
in 2000 that there were 24.5 million persons 65 years of age and older or 12.7% of the
U.S. population; and that by 2011, this number will reach 77 million (U.S. Department of
Health & Human Services, 2000). The growing senior population places many demands
upon family members, and society at large to ensure their health and well-being. Where
in past generations, extended families cared for their elderly family members; today’s
generation does not do so as often. It is not uncommon today, for baby boomers to be
caring for their elderly parents; with the increasing number of old-old persons. This group
of elderly is more apt to be frail, require more care, be medically unstable and require
care around the clock; the type of nursing and personal care, that is provided in a long-
term care facility. Overall, more women, widowed or never married persons were more
likely to receive care in a nursing home; 27% of the elderly aged 80 – 84 resided in a
nursing home, with this number expected to rise to 80% of those persons over 90 years of
age (Spector, Fleishman, Pezzin, & Spillman, 2001). The number of Americans afflicted
with Alzheimer’s disease is also increasing and 4.5 million Americans over the age 65
have been diagnosed with Alzheimer’s disease (Herber, Scherr, & Bienias, 2003).
Alzheimer’s disease and related dementias and chronic diseases that cause debilitation
also contribute to the increasing demand for long-term care services within the country
(Administration on Aging, 2003). This demand is slowly being met, however, ensuring
and maintaining the quality of these services is an ongoing concern.

The goals for long-term care present many challenges for nursing home
administrators; to create a balance between providing a safe environment, while at the
same time providing opportunities for resident to choose and control their environment,
to show their individuality (Kane & Kane, 2001). Nursing home environments are highly
regulated by federal and state agencies. Federal legislation has also affected how nursing homes manage their residents who become ill. The passage of the Omnibus Budget Reconciliation Act of 1987 resulted in significant changes in the nursing home environment and increased the demands on nursing homes for quality care, documentation, and monitoring of their residents (Spector, Fleishman, Pezzin, & Spillman, 2001). These regulations have increased the hours of nursing care; however, much of this increased nursing time is spent on the requirements of the regulations for computerized assessments and the completion of other forms and reports. These documents are directly related to the reimbursement rates that a facility receives and are considered very important.

Long-term care is very expensive for the elderly and persons with disabilities and their families as well as local, state, and federal governments. In 2006, the annual cost for a person in a nursing home in Michigan was $72,445 (American Association of Retired Persons, 2006). Some residents and families pay from private funds or long-term care insurance and some commercial insurance plans may assist in reimbursing for a resident’s nursing home stay. Residents become eligible for Medicaid; which will pay for nursing home stays, after their personal resources have been exhausted. Medicaid expenses accounted for 40% of the long-term care expenses which are paid for by Federal and State programs (Agency of Health Care Policy and Research, 2002); with this figure rising, as the numbers of elderly increases. Medicare payment for nursing home stays accounts for 30% of all residents (United States Department of Health & Human Services, 2001). Medicare will reimburse for skilled professional services - more intense
nurse monitoring; physical, occupational, or speech therapy; after a resident has had a 3 day hospital stay and is certified by the physician as needing this higher level of care.

The most common primary diagnosis categories for residents admitted to a nursing home was diseases of the circulatory system, followed by respiratory system problems and mental disorders; with over half of all residents being afflicted with arthritis and most needing assistance to perform their activities of daily living, such as bathing, toileting, and ambulation (United States Department of Health & Human Services, 2001). This vulnerable population is entitled to the best care that can be provided; however, the care should be the type of care that they desire, and be provided with humanity and dignity. The rights of each elderly person must be also upheld, as guaranteed by law.

The host facility for the project is a skilled long-term care facility located in a rural community in state. The facility is privately owned and operated as a for-profit entity. The facility is family focused and has an excellent reputation in the community for providing quality care and was citation free on their last state inspection. The nursing staff is very experienced and the facility enjoys longevity in their loyal staff. Nurses have an average of 10 years of long-term care experience and the nurse’s aides have an average of 5 years seniority with the facility. The nursing home has not experienced turnover that plagues some larger organizations. The owner of the facility is on site each day and is very involved in the operation of the nursing home; he also knows each resident and their families personally, and has proven to be a very compassionate and resourceful leader.
Literature search

A literature search yielded studies over the last 25 years and revealed that hospital transfers from long-term care facilities have occurred for years and have been studied from many different directions; each aspect contributing information to the understanding of the current situation. Medical, nursing, government, and association journals have studied the issue of residents being transferred from nursing homes to hospitals and provide their perspectives on this subject. The literature explained that the transfers occurred as a result of a multifaceted decision; which was influenced by the physician; the family and the resident; the facility and its capabilities; insurance coverage; and other subtle factors. In each situation, the factors may be different and often, several factors are involved.

Rarely in a nursing home was there a physician on-site daily. Some facilities have utilized nurse practitioners or physician assistants to supplement physician coverage and found that the access of residents to medical care was higher with the use of mid-level health care providers (Buckman, Murkofsky, O’Malley, Karon, Zimmerman, & Caudry, 2006). Several studies from 1998 to 2004 found that those facilities that utilized nurse practitioners or physician assistants had fewer hospitalizations of their nursing home residents (Ackerman & Kemle, 1998; Joseph & Boult, 1998; Kane, Keckhafer, Flood, Pershadsky & Siadaty, 2003; Intrator, Zinn, & Mor, 2004). The availability of diagnostic tools, such as radiology and laboratory services; and pharmaceuticals also affected the decision to hospitalize a nursing home resident (Carter, 2003). The geographic location of the nursing home affected the availability of these ancillary and support services.
When a resident was observed to have a condition change, the nurse performed an assessment and made a decision whether or not to notify the physician and the resident’s family or guardian. The purpose of hospitalization for nursing home residents was to improve their health, treat and alleviate symptoms, maintain or restore function (Buckman, et al, 2006). Procedures and tests may have also been performed, that could not be done at the nursing home or could not be done in a reasonable time frame. Changes in the cognition or behavior of a resident may be symptoms of an underlying serious medical condition and the physician was informed (American Psychiatric Association, 2002). Symptoms of delirium were identified as a frequent reason for hospitalization in a study reported by Levy, Eilertsen, Kramer, and Hutt in 2006. The most common symptoms that resulted in the transport of residents to a hospital emergency room were found to be respiratory distress, altered mental status, gastrointestinal symptoms, and falls (Ackermann, Kemle, Vogel, & Griffin, 1998). The old-old and persons diagnosed with Alzheimer’s disease or dementia were more apt to be physically frail and more prone to health problems which required hospitalization to treat; however, it was found that this group of elderly was least likely to benefit from hospitalization (Fried & Mor, 1997; Carter & Porell, 2005). Pneumonia occurred frequently in nursing home residents and was the leading cause of hospital transfers (Muder, Aghababian, Loeb, Solot, & Higbee, 2004; Zweig, Kruse, Binder, Szafara, & Mehr, 2004; Zarogiannis, Van der Steen, Helton, Fry, & Shay, 2006). The decision to hospitalize a nursing home resident was made based on the belief that the advantages of hospitalization, such as closer observation, greater access to diagnostic testing; outweighed the risk of adverse events, such as pressure ulcers, functional decline,
increased confusion (Bercovitz, Gruber-Baldini, Burton & Hebel, 2005). Physicians did not always explain the risks or side-effects of a hospitalization upon an elderly person, and the family members only expected benefits and improvement in a medical condition, precipitating the hospitalization.

Advance directives or living wills were requested of residents that were admitted to long-term care facilities. Advance directives are usually accompanied by designation of a durable power of attorney. In an advance directive a person indicated their wishes in the event that they could no longer make their own decisions (Kass-Bartelmes & Hughes, 2007). Advance directives usually indicate a resident’s preference for cardio-pulmonary resuscitation, intubation, artificial feeding, and sometimes hospitalization. A recent survey discovered that “directives to forgo hospitalization for U.S. nursing home residents with advanced dementia are uncommon and are associated with the organizational features of the facilities and the intensity of end-of-life care practiced in the region” (Mitchell, Teno, Intrator, Feng, & Mor, 2007, p. 432). It has been proven that advance directives that specified no hospitalization increased the numbers of residents dying in the nursing home, compared to expiring in a hospital setting (Pekmezaris, et al, 2004; Lamberg, Person, Kiely, & Mitchell, 2005). Advance directives ensured that a resident’s autonomy was maintained, even if they were incapacitated or afflicted with Alzheimer’s disease or other forms of dementia and unable to make their wishes known. This group of elderly often developed several other medical conditions and illnesses as their condition deteriorated and the aging process continued. Hospitalizations were not proven to benefit this population (Morrison & Sui, 2000). The decision making process of whether or to hospitalize a nursing home resident with dementia may also be an ethical
one. Families may not agree with supportive or palliative care recommended by the resident’s physician or nursing home staff; and may request that invasive and aggressive interventions associated with life prolongation be implemented (Luchins & Hanrahan, 1993). Some health care professionals argued for rationing of healthcare resources and using the resources and money for younger persons, who will benefit. Hospital care was more expensive than nursing home care and others argued that if there is not a proven benefit of the more expensive service, then the less costly type of care should be utilized (Dosa, 2005). A study of residents treated for congestive heart failure showed that the quality of care was higher in the nursing home than the hospital (Ahmed, Weaver, Allman, DeLong, & Aronow, 2002). Studies were not available that compared general medical care between long-term care and hospital settings. Nursing home staffs are specialists in geriatrics and hospital nurses do not always have this level of expertise; supporting the claim that many residents would improve as well if they were treated in the nursing home, versus an acute care hospital.

Studies examining the transfer of nursing home residents to the hospital showed that many of the residents were recent admissions to the nursing home and that 50% were receiving Medicare payment for their stay at the time of the transfer (Gabrel, 2000). Research showed that hospital transfers peaked 2 and 7 weeks after the resident was admitted to the facility (Boockvar, 2002; Carter, 2003). Those residents who died within a month of admission had more hospital transfers than those who died after a longer stay (Bercovitz, Gruber-Baldini, Burton, & Hebel, 2005). Hospital discharge planners are pressured to keep the hospital lengths-of-stay short to enhance the hospital’s bottom line, but this has resulted in skilled nursing home admissions of a higher acuity; in less stable
condition; and needing more medical and nursing care and resulting in more nursing home transfers.

Nursing home beds are paid for by private funds, commercial insurance policies, federal and state insurance plans, and often a combination of these sources. By 2004, Medicaid funds accounted for two-thirds of all days spent in nursing homes and half of all payments (Mor, Weiner, & Ouslander, 2004). Facilities, especially, in areas where the economy was poorer depended on Medicaid funding. Medicaid payment was significantly less than that of other sources and a relationship was reported between lower Medicaid payments and a higher hospital transfer rate of nursing home residents (Intrator & Mor, 2004). A study by Konetzka, Spector, and Shaffer (2004) found that for-profit nursing home chains had a higher transfer rates. Nursing home administrators are charged with maintaining the financial viability of their facility and this requires juggling and balancing quality care and fiscal responsibility. Physicians and nursing home administrators may encourage hospitalization of sicker residents to avoid allegations of neglect, keep expenses low, or receive deficiencies on a survey by the state agency that regulates their operation (Purdy, 2002). The practice of defensive medicine is commonplace, especially in the state of Michigan and the reimbursement from Medicaid is low.

While the factors described previously affected the decision to transfer a nursing home resident to the hospital, Buchman, et al (2006) determined that the most important factor in this decision was the resident’s preference for the hospital transfer; which should be specified in an advance directive and shared with the designated power of attorney or guardian. An earlier study stated that the family members or power of
attorneys for nursing home residents also preferred hospital type care when a resident became ill (Cogen, Patterson, Chavin, Cogen, Landberg, & Posner, 1992). It was easier for the family and the physician to transfer a resident to the hospital for evaluation, testing, and treatment; than to decide to leave the resident at the nursing home for supportive care. Suspected fractures of a bone were often an easy decision for a hospital transfer; however, abnormal laboratory tests were often a situation where hospital transfer could be avoided, with the same outcome for the resident.

While the intent of hospitalization for nursing home residents was to improve their health, alleviate symptoms, maintain or restore function (Buckman, et al, 2006); in many cases, residents were also “exposed to iatrogenic disease and social and psychological harm” (Intrator, Gragowski, Zinn, Schleinitz, Feng, Miller & Mor, 2007, p. 1670). Many residents who were transferred to a hospital emergency room were considered problem patients and required more resources in the hospital (McCloskey & Vanden Hoonaaard, 2007). In many cases, residents developed complications while in the hospital (Malone & Danto-Nocton, 2004); suffered functional decline, disorientation, and confusion (Buchanan, et al, 2006); and often experienced an increased incidence of incontinence, pressure ulcers, and nutritional deficit (Panke & Volicer, 2002). Nursing home staffs, who are accustomed to the resident’s normal habits, are often able to prevent the functional decline that is often seen when the nursing home resident was hospitalized.

The elderly who reside in nursing homes are a vulnerable population that may not be able to make their own needs and preferences known and depend on others to ensure their well-being. As the literature demonstrated there are several factors that may affect each case. The choice to transfer a nursing home resident to a hospital may be influenced
by many factors. This complex decision may be different in each situation, even for the same resident.

*Research question*

With the increasing number of elder and old-old persons, the number of hospital transfers of nursing home residents will rise. This is a problem that will impact the residents, their families, nursing homes, and the entire nation. The financial impact to individuals and the nation are also significant. There are also ethical issues that society and physicians will be forced to address. The reasons why some nursing home residents are transferred to the hospital; while other residents are treated at the nursing home is a very complex issue. The literature indicated that the decision to hospitalize a nursing home resident is influenced by many different factors and not simply the physician’s decision. “The decision to hospitalize involves an inexact process that considers the patient’s medical needs, rights, and probable outcomes, as well as the limitations of care inside the nursing home and outside social pressures, such as family wishes and financial cost” (Cohen-Mansfield & Lipson, 2006, p. 64). The transfer is influenced by many factors, in addition to the presenting symptoms of the resident. The research hypothesis under investigation in this study is that: Other factors, rather than the resident’s medical condition, affect the hospital transfer decision of persons residing in a nursing home. This project will review the conditions surrounding the transfer of residents residing in a privately owned skilled long-term care facility in state for a period of 12 months.
Research format and design

The purpose of this project is to identify the factors that contribute to the decision to transfer a nursing home resident to the hospital. It is believed that factors other than the resident’s medical condition influence the transfer decision. To test this hypothesis, a retrospective medical record review will be conducted at a privately owned skilled long-term care facility in state of the residents transferred from the facility to a hospital during the past 12 months. This review and analysis will not be an experimental exercise.

An agreement between the facility administrator (Appendix A) and the student will be obtained for the purposes of completing this project. A list of discharges for this time period will be provided by the host facility’s business office. The residents discharged from the facility will be identified from the list with the assistance of the admission coordinator. Letters will be mailed to the durable powers of attorney or guardians of these residents by the facility administrator, to obtain permission for participation in the project (Appendix B).

A list of useful data points to retrieve from the medical records has been prepared (Appendix C). This information will provide background information on the residents - medical record number, age, sex, date of admission to the nursing home, admitting diagnosis, advance directives, type of insurance; as well as facts regarding the hospital transfer - date and time of the hospital transfer, symptoms or reason for the transfer, name of the hospital transferred to, date of last physician examination; and if appropriate, date of readmission to the nursing home, hospital length of stay, reason for the hospitalization (diagnosis on hospital transfer form), and if the resident was eligible for Medicare upon return from the hospital. The diagnosis will be recorded by systems and the reasons for
the hospital transfers will be categorized by general groupings – family/resident request, physician order, facility request, and other reasons. The medical record review will start on a specific resident, as the permission slips are received from the resident’s power of attorney.

Several steps were taken to ensure confidentiality of the resident’s information; the resident list was retained by the facility, no resident identifying information was recorded on the data retrieval form (no names or medical record numbers). Upon completion of the medical record review, the list was returned to the business office. The data retrieval forms were retained at the facility, until completion of the medical record review; they were transported to a secure area in the student’s residence and shredded upon completion of the tabulation process of the study.

Tabulation of the data was performed to obtain information on the demographic aspects of the resident population transferred to the hospital, the total number of transfers to the hospital in the 12 month time period, the number of residents transferred, the numbers with the specific diagnosis, the reasons for transfers, the time of day the transfers occurred, the length of time from admission to transfer, the length of stay at the hospital, the hospitals used, the presence of advance directives, the presence of do-not hospitalize directives, the number of residents with Medicare and Medicaid, and the time interval from physician’s last visit to the hospital transfers.

This project was designed to search for relationships that influenced the hospital transfer of nursing home residents at the host facility. The results of the tabulation will be compared to the findings from other research and analyzed for trends and any other important details. Internal validity was maintained by ensuring that only those residents
that were listed on the census log as being transferred were used in the medical record review; to prevent selection bias. Only the information included in the medical record was recorded on the data retrieval forms to avoid any experimenter influence, which could have affected the validity of the project. Only those data points that were selected to be included in the analysis were analyzed, to prevent any negative affects from measurement methods.

The findings from the medical record reviews were tabulated and analyzed; and compared to other research. The results of this process were used to develop conclusions and recommendations for the nursing home facility administrator.

Results

The list of residents discharged by the facility identified 44 transfers to a hospital for the year of August 1, 2006 through July 31, 2007. The transfers affected 29 residents. Letters requesting permission for participation in the study were mailed to the guardians or powers-of-attorney listed in the facility’s records by the facility’s administrator. Of the letters mailed, consent was obtained from 27 family members. For the 2 family members that did not respond to the facility’s request, the residents had expired.

The study reviewed 40 hospital transfers for 27 residents for this time period. The range of hospital transfers for a resident was 1 to 4; with 18 residents transferred to a hospital once for 66.7%; 6 residents were transferred twice; 2 residents were transferred 3 times; and 1 resident was transferred 4 times. The time frame from admission to the hospital transfer ranged from 8 days to 1002 days; with 12 transfers occurring less that 12 days from admission, 19 transfers less than 90 days from admission; and 9 transfers occurred after the resident had been at the facility for over 1 year.
### Transfers of Nursing home residents

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<th>Length of time</th>
<th># of residents</th>
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<td>Adm. to 12 days</td>
<td>12 residents</td>
</tr>
<tr>
<td>&lt; than 90 days from admission</td>
<td>19 residents</td>
</tr>
<tr>
<td>Over 1 year</td>
<td>9 residents</td>
</tr>
<tr>
<td>Total # of transfers</td>
<td>40</td>
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Demographics of the resident group revealed that 88.9% of those residents transferred to a hospital were female and the average age was for this group was 86.5 years. Each resident in the study was eligible for Medicare; and 21 or 77.8% were receiving Medicaid insurance to cover their nursing home stay, at the time of discharge from the facility. Advance directives were present for all residents and 1 resident had a do not hospitalize statement. It was noted upon review of the medical records, 3 residents who had several hospital transfers had their advance directives changed after their last hospital visit, to a do not hospitalize request.

Analysis of the diagnosis of the residents revealed that all residents had a cardiac related diagnosis; 93% had some type of mental illness; 89% had an Alzheimer’s disease or dementia diagnosis; and 82% had a diagnosis of nutritional deficit. Other diagnosis listed less frequently for those nursing home residents transferred to a hospital were endocrine and orthopedic related at 70% each; respiratory related diagnosis were seen in 67% of the residents; and 63% of the residents in the group had a gastro-intestinal type diagnosis. Infectious diseases were identified in 41% of the residents; nervous disease disorders were found in 30%; renal disease in 22%; and fluid imbalances and non categorized disorders were listed in 19% of the residents of this group.
The medical record of each resident’s transfer to a hospital was reviewed for the date of the last physician visit. The time from the visit to the hospital transfer ranged from zero to 18 days; with the most common time frame being 5 days from the physician’s visit as documented in the physician’s progress records, to the date of the hospital transfer.

Of the 40 nursing home resident transfers to the hospital, 50% of the transfers occurred on the day shift (0630 – 1500 hrs) and 50% occurred on the afternoon shift (1430 – 2300 hrs). There were many different medical related reasons for the hospital transfers of the nursing home residents documented in the medical records. The most common reason (39%) for the hospital transfers was categorized as a mental status change, delirium or lethargy of the resident; 16% of the transfers were for symptoms of respiratory distress; 14% of the residents transferred to the hospital were for reasons related to cardiac diagnosis – chest pain, low blood pressure or low pulse. Three residents were transferred to a hospital as a result of a fall, 3 for findings of positive laboratory or radiology tests that resulted in the need for hospitalization for treatment of the results,
infections that did not improve caused 3 hospital transfers; and 2 transfers were for mental health reasons – attempted suicide and combative behavior.

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<th>Reasons for hospital transfer</th>
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<td>Mental status change</td>
<td>39%</td>
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<td>Respiratory distress</td>
<td>16%</td>
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<tr>
<td>Cardiac complaints</td>
<td>14%</td>
</tr>
<tr>
<td>Falls</td>
<td>8%</td>
</tr>
<tr>
<td>+ lab/x-ray results</td>
<td>8%</td>
</tr>
<tr>
<td>Nonimproving conditions</td>
<td>10%</td>
</tr>
<tr>
<td>Mental illness</td>
<td>5%</td>
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</table>

Seventy-three percent (73%) of the transfer decisions were made by the family or durable power of attorney for the resident and the remaining 27% of the hospital transfers of the residents occurred as a result of a physician’s order.

The most common type (40%) of nursing home readmission diagnosis were infectious disease related – sepsis, urinary tract infection, pneumonia, and osteomyelitis. Electrolyte imbalance was identified in 13% of the residents readmitted to the nursing home; and 13% of the residents had a cardiac related diagnosis. Various other diagnoses were listed upon the hospital discharge records. Almost half (47%) of the hospitalized residents received intravenous antibiotics and 8 residents (21%) received a surgical procedure – surgery, PICC insertion. Residents were hospitalized for less than 24 hours to 41 days; with most staying 3 to 7 days at the hospital. Of those residents transferred to a hospital, 95% were readmitted to the facility. The 2 residents that did not return to the facility, expired at the hospital. Of those residents readmitted to the facility, 92% were eligible for Medicare.

The medical records of those residents transferred to the hospital contained detailed documentation of a resident’s condition leading to the transfer, communication
with the physician and family. Copies of the hospital transfer forms were also present, as well as the hospital discharge notes; which contained the data necessary to complete this study.

The nursing home facility and staff was very accommodating and cooperative during the process of obtaining the consents and reviewing the medical records. All of the persons approached were very helpful and professional. The administrator hoped to learn information that would improve the quality of care provided to the residents residing in his facility and improve the financial status, as well.

**Conclusions**

The findings from this study are similar to those results of other studies that have been performed over the years. Clinical and non-clinical factors influenced the decisions to transfer a nursing home resident to the hospital, as discovered by Buchanan, Murkofsky, O’Malley, Karon, Zimmerman, Caudry, and Marcantonio in 2006. In this study, the decision to transfer the resident to the hospital was made solely by the physician, based entirely on the clinical presentation of the resident. However, the majority of the final decisions was made by the durable power of attorney/guardian or responsible family member and was similar to the statements in the advance directives. The assumption can be made that the advance directives are representative of the beliefs of the residents, when they were competent to share their desires. Buchanan, et al. in 2006, also determined that the factor most high-ranking in the hospitalization decision was resident’s preference for hospitalization. Cogen, et al. (1992) established that surrogate decision makers (durable powers of attorney, guardians, and family members)
prefer hospitalization for treatment of acute illness, even when the resident had advanced dementia; this was also seen in the medical record review of this study.

The influence of the nursing staff on physician decision making for hospital transfers of nursing home residents is significant at this facility. Nurses communicated symptoms and assessments to physicians, usually by telephone. Similar conclusions were reached by Carter (2003); “the level of discretion in the nursing home in initiation physician care may reflect broader institutional policies, levels of experience and skill among nursing personnel, and availability of in-house resources (p.1203). The physicians rely on the evaluation of the nursing home nursing staff and respond to the tone of the conversation. The nurses know the residents normal behavior and are able to recognize changes and concerns.

While this state’s Medicaid rates are some of the lowest in the country, the study does not show any relationship to the transfer of nursing home residents to the hospital, as previous studies declared (Intrator & Mor, 2004; Mor, Weiner, & Ouslander, 2004). The private ownership of the facility did not appear to affect the transfer decisions, as implied in the studies by Carter and Porell (2003) and Konetzka, Spector and Shaffer (2004). Findings of this study in regard to these opinions may be limited, due to the use of the medical record solely for retrieval of data. This type of information would rarely be documented in this context.

There were not any other factors influencing the transfer decisions identified from the medical record reviews at the facility. Decisions were based on the resident’s condition and apparent medical needs; this was a similar finding in the study by Buchanan, Murkofsky, O’Malley, Karon, Zimmerman, Caudry, & Marcantonio (2006).
The most common time from admission to hospital transfer was within the first 90 days of admission was also supported by studies by Boockvar (2002) and another by Carter (2003). The proposed reasons for this occurrence were instability of overall health and less familiarity of the nursing home staff with the resident.

Mental status changes were the most common reason for hospitalization of this group of nursing home residents, also seen in the 2006 study by Levy, Eilertsen, Kramer and Hutt. The average age of the group studied was 86.5 years, which qualifies the group as old-old; and 89% of the residents had a diagnosis of dementia or Alzheimer’s disease. Studies supported the fact that the group of old-old is frailer and has more illnesses and hospitalizations (Lamberg, Person, Kiely, & Mitchell, 2005).

The results of this analysis of the study findings are valid. Internal validity was ensured by the use of only information documented in the medical record of each resident transferred to the hospital. The research is also, externally valid because of the similarity of the results to other studies. The other studies support the results of this analysis. This study found that the resident and his family made the decision for hospital transfer for treatment in 73% of the cases reviewed. Generalizability was achieved; this study could be applied to other nursing home populations.

Limitations of the findings should be considered, due to the small sample size; however, they appear to be representative of the previous studies at larger centers. The possibility of other factors influencing the transfer decision cannot be excluded, just because they are not documented in the medical records. Other methods of retrieving this information would be necessary and were not included in the planning of this study. How others factors may have influenced the family and physician decision’s cannot be entirely
disregarded. As other researchers stated, the decision is complex and the reasons intertwined in the family’s history; beliefs and values; the facility’s culture; the preferences of the physicians and staff; and the facts surrounding each individual case. As all people are different, so are their opinions and each situation and case.

**Recommendations**

The literature makes several suggestions that would affect the decisions to transfer nursing home residents to the hospital for treatment of acute illnesses. The presence of advance directives is positive; however, it is difficult to determine the understanding of the resident and family, when the directives were determined. Several sources recommend that an education process be provided, prior to the signing of such important legal documents. A physician, nurse, or social worker, can assist the patient and family through the process of planning for their future health care needs; this is especially important when dementia is involved and the benefits of many treatment choices involve discomfort and have few benefits to the resident (Bottrell, O’Sullivan, Robbins, Mitty, & Mezey, 2001; Panke & Volicer, 2002). The family should be educated into the risks of treatment choices and encouraged to use this information when determining the best course of action for future forms of treatment. Many physicians would recommend palliative care as a more compassionate choice; however, the primary physician should have a discussion with the family regarding quality of care, values and choices (Katz, Walke, Suri, Bellin, & Jacobs, 2001). Studies reported in 2004 and 2007 demonstrated that the presence of explicit advance directives, prohibiting the use of artificial feeding and hospitalization, resulted in more deaths in the nursing home, than the hospital (Pekmezaris, et al, 2004; Mitchell, et al, 2007). An understanding of the
disease process and expectations will assist the family in realistically knowing what types of illnesses can be treated and those treatments that could increase the resident’s pain and cause emotional and physical suffering.

Another recommendation for the host facility would be to alter the method that medical services are provided. Other literature pointed out that the daily presence of a physician or mid-level health care providers decreased the number of hospital transfers of nursing home residents (Ackermann & Kemle, 1998; Joseph & Boult, 1998; Intrator, Zinn, & Mor, 2004). The mid-level provider could be a physician assistant or nurse practitioner. An experiment by Kane, Keckhafer, Flood, Bershadsky & Siadaty (2003) demonstrated that nurse practitioners managing a group of residents “prevented the occurrence of some hospitalizable events, but its major effect was allowing cases to be managed more cost-effectively” (p. 1430). From a cost standpoint to society and the government, the decreasing number of hospital transfers lowers the expense; however, to the facility, fewer Medicare days, lowers their revenues and abilities to improve their facilities, hire staff, and pay other expenses.

**Summary**

As the numbers of elderly residing in nursing homes rises, the issues surrounding quality of care increase. The transfer of residents from nursing homes may improve the medical conditions of the resident; however, studies have shown that this care can often be provided in the long-term care setting and that there may be many adverse side-effects as a result of the hospital stay. The presence of advance directives indicated the resident’s preference for hospitalization. Each decision to transfer a nursing home resident to the
hospital is affected by many factors; however, as the findings of this analysis revealed, the primary determinant of the transfer decision was the resident and his family.
References


Boockvar, K. (2001, Nov-Dec). Development of definitions for acute illness in nursing home residents based on chart-recorded physical exam findings. *Journal of the American Medical Directors Association, 2*(6), 279.


Appendix A

Letter of Agreement

Between: Facility Name and student’s name RN.

The purpose of this agreement is for the completion of the Capstone Project for student’s name Master of Science in Nursing program. The project will review medical records of those residents transferred to the hospital; identify the reasons and conditions surrounding the hospital transfer; analyze the findings, and develop conclusions.

Facility Name agrees to be the host facility for the project; student’s name agrees to ensure the confidentiality of all information and to perform this investigation in a professional manner; keeping the facility administrator updated on the project progress.

________________________________    ________
Nursing Home Administrator
Facility Name

________________________________    ________
Student

Date

Date
August 9, 2007

Dear Family member/Guardian

X Facility has agreed to participate in a research study conducted by one of our nurses, name, as part of her Master in Nursing program. This project will review the hospital transfers of nursing home residents. To obtain the needed information, a review of your loved one’s chart is necessary. We are asking that you complete the bottom of this form and return it to us in the self-addressed stamped envelope granting your permission or declining participation in the study.

The information retrieved is solely for the purposes of the student’s project; no personal information will be shared or identified in the final report. Confidentiality will be maintained at all times.

If you have any questions or concerns, please feel free to contact me at ________.

Sincerely

Facility Administrator

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I give my consent for _________________________________ (Resident’s name) to be included in this project. I understand that all information will be held in strictest confidence.

__________________________________   ____________
Signature of POA/Guardian    Date

------------------------------------------------------------------------------------------------------------

I do not consent to having my loved one ______________________ (Resident’s name) included in the project.
Appendix C

Data retrieval form

Age _____     Sex - M F

Date of admission ___________     Insurance - Caid Care Other

Advance directives - Y N     Do not hospitalize directive - Y N

Admission diagnosis:
   Alzheimer’s disease/dementia ______
   Cardiac/circulatory (hypertension, etc) ________
   Endocrine ______
   Fluid balance alteration ______
   Gastro/intestinal ______
   Infectious process ______
   Mental illness/depression ______
   Nutritional deficit _____
   Orthopedic _________
   Renal/Urinary _________
   Respiratory ______
   Other _______________________

Date of last doctor visit __________

Date of hospital transfer _______  time _____  Hospital - _____________

Reason/symptoms - fall _____; lab/xray result _____; med related ________
Change in consciousness/delirium _________; chest pain _____________;
Respiratory distress ______; elevated temp __________;
other____________________________________________________________

Family request_____  Dr order ______  Facility request______
Other ________________________________

Readmit to facility- Y N     Medicare – Y N     LOS_____hosp

Return diagnosis __________________________________________