CHRISTUS Santa Rosa Health System

"Transitions"

Effectiveness of a Restorative Aide: Moving the Patient Across the Continuum of Care

Tonya Maunsell MSN, RN-BC, OCN and Imelda Sanchez MSN, RN
Christus Santa Rosa Medical Centre, San Antonio, TX

CHRISTUS. SANTA ROSA Health System

NICHE

Problem Statement

Functional decline is a typical occurrence for hospitalized older adults. By day two, functional decline is already starting to set in. This decline results in poor long-term outcomes and prevents patients from transitioning back "home".

Literature Review

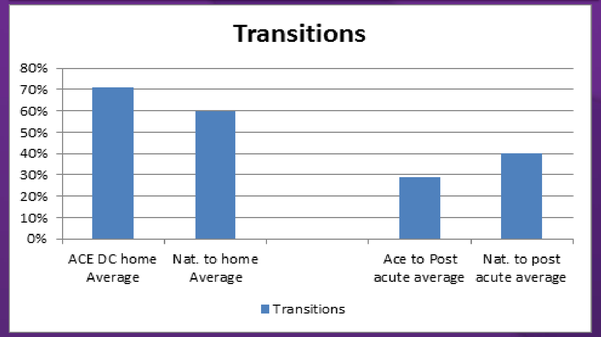
The elderly population, age 65 years and older, is growing at a significant rate. Currently there are an estimated 41.4 million older Americans in the United States. This number is expected to increase to 55 million by 2020 [2,3,4]. Hospitals typically focus on resolving the current admitting diagnosis, often overlooking the encouragement and improvement of function as a goal or outcome[3]. Thirty to sixty percent of older adults experience some level of functional decline during hospitalization [3,5,6]. As function is overlooked by the nurse, patient, and family, the patient continues to decline at a rapid rate. Up to a year after discharge, less than 50% of patients have returned to their pre-illness level of functioning [5,6]. Approximately 75% of patients ≥75 years old and functionally independent at admission are not functionally independent at discharge and **nearly 40% of Medicare beneficiaries are discharged to a post-acute setting** [7,8].

Your *health* care home *for life*.™

Interventions

1. Functional status is assessed early in the patient's admission.
2. Patient's are assembled in a community area for breakfast in a social setting.
3. Following breakfast, the restorative aide initiates a group activity designed to exercise large and small muscles (Family and visitors are encouraged to join in the activity).
4. After patients return to their room, one to one therapy is initiated. This activity focuses on each patient's specific needs.
5. Bedbound patients receive detailed range of motion exercises (both active and passive).

Average Length of Stay



Results

With collaboration of all interdisciplinaries, patients were kept active and moving to prevent functional decline. From April thru June, 2014, 71% of all patients admitted to the ACE unit were able to transition home with only 29% transitioning to a post acute setting. Compared to the national average for Medicare patients of ≤60% discharged home and ≥40% transitioning to a post acute setting.

Conclusion/Recommendations

The length of time an elderly patient remains in the hospital affects not only the financial reimbursement, but also the functional status of the patient. Decreasing the length of stay results in the ability to save an estimated $4971 per average patient admission. In an effort to prevent functional decline during hospitalization we recommend the following:

- ❖ *Implement the use of a Restorative Aide*
- ❖ *Assess the patient's functional status on admission and daily*
- ❖ *Ensure early mobilization*
- ❖ *Walk patients in the halls daily*
- ❖ *Get patients up to the chair for all meals*
- ❖ *Tailor activity to meet the patient's needs*
- ❖ *Promote socialization by encouraging patients to dine together as a group (unless contraindicated)*

As the duties of the registered nurse become more complex, we turn to the restorative aide with the tasks of spending more time with the patient and engaging them in social and physical activities. These activities help to keep the patient active, thus preventing functional decline. Not only does this help decrease the length of stay but it helps the patients maintain their mobility, independence, and the ability to be discharged *HOME.*

References

1. Hartford Institute for Geriatric Nursing, New York University, College of Nursing. Try This. Reducing Functional Decline in Older Adults during Hospitalization: A Best Practice Approach, 2012 (31).
2. Centers for Disease Control. United States Health Trend Tables 2012. http://www.cdc.gov/nchs/hus/contents2012.htm#094.
3. Boltz, M. Capezuti, E., Fulmer, T., and Zwicker, D. (2012). Evidence-Based Geriatric Nursing Protocols for Best Practice, 4th ed. Springer Publishing Co: New York, NY.
4. Administration on Aging. U.S. Department of Health and Human Services. A Profile of Older Americans. www.aoa.gov/aoaroot/aging_statistics/profile/.../2010profile.pdf.
5. Pfunter, A., Wier, L., and Steiner, C. (2013). Costs for Hospital Stays in the United States, 2010. Agency for Healthcare Research and Quality: Healthcare Cost and Utilization Project.
6. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (2008). Reducing Functional Decline in Hospitalized Elderly. www.ahrq.gov/qual/nurseshdbk.pdf.
7. The MERCK Manual Professional Edition. Hospital Care and the Elderly: Provision of care to the Elderly. Revised October 2013. http://www.merckmanuals.com/professional/geriatrics/provision_of_care_to_the_elderly.html
8. Mor, V., Intrator, O., Feng, Z., and Grabowski, D. The Revolving Door of Rehospitalization from Skilled Nursing Facilities. Health Affairs, 29, 1(2010): 57-64. doi: 10.1377/hlthaff.2009.0629.