NICHE Hospitals report

Best Practice Conducted in NICHE Hospitals: **Transitions**

The NICHE Hospitals Reports are published to identify the positive outcomes and innovative initiatives experienced at NICHE designated facilities in their care of older adult patients.

Quality Improvement Projects:

NICHE Site: Dartmouth-Hitchcock Medical Center. Realizing the geriatric population in Medical Specialties at their facility represented their core consumers, Dartmouth-Hitchcock needed to commit to meet the unique care needs of this group as well as provide support for patients transtioning to home.

A multidisciplinary team implemented a number of initiatives to help transform the culture of geriatric care and achieve the greatest potential for the older adult patients and their families. These initiatives included:

- Creation of a Geriatric Nurse Coordinator position in the medical specialty line
- Formation of a geriatric steering committee
- Home transition bags
- Follow-up phone calls
- Use of local and national resources, including…
  - NICHE designation
  - Dartmouth Centers for Health and Aging partnership
  - Clinical Microsystems quality improvement processes

Specific action steps involved an “Ask the Nurse” community education program and ongoing internet-based staff education efforts. A Geriatric Resource Nurse and a Geriatric Patient Care Tech were also added to the staff.

Results:
The units that implemented the Elder Care initiatives demonstrated a 19% improvement in functional status, a 6-36% lower rate of delirium compared to pre-intervention rates and finally a reduction in the Pressure Ulcer rate from 6% to 2%.[1]

NICHE Site: Mount Sinai Hospital, Toronto, Ontario, Canada. Mount Sinai Hospital determined that front-line staff members lacked the proper education and knowledge to identify and manage geriatric issues. The specialized needs of older adult patients were a challenge to meet in the Emergency Department (ED) model of care, which focused on addressing a single, acute medical issue.

The hospital created two advanced practice nursing roles to optimize outcomes for their older adult population: the Geriatric Emergency Management (GEM) Nurse and the Inpatient Geriatrics APN. The GEM Nurses provided targeted geriatric assessment and intervention for older adult patients (ages 65+) in the ED. At-risk patients are identified through the Triage Risk Factor Screening Tool (TRFST) and the Identification of Seniors at Risk (ISAR) tool.

GEM Nurse program interventions included:
- Support for staff to implement geriatric care strategies in the ED
- Linkage to community support services
- Referral for specialized geriatric services
- Liaison with family physician

Inpatient Geriatric APN interventions included:
- Follow-up on issues identified by GEM nurses when patients admitted to hospital
- Develop interdisciplinary treatment and management plans
- Education and support for staff to implement geriatric care strategies

Results: A total of 2134 patients were assessed by the GEM Nurses, with 69.7% of these patients being discharged at the end of their ED visit. The GEM nurses initiated linkages to specialized geriatric services for 34.7% of patients, and initiated community support services referrals for 34.2% of patients. Through linkage of 334 high-risk admitted patients to the Inpatient Geriatrics APN, these patients' needs were identified early during their inpatient stay, resulting in the timely development of care plans and initiation of needed referrals.[2]

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NICHE Site: Saint Mary's Health Care. Traditionally, patients will move 3-6 times during a hospital stay to receive the level of care needed to meet their acuity level which can cause missed or delayed treatments, medication errors, patient falls and result in contact with as many as 100 healthcare providers. By incorporating an evidence-based acuity adaptable care delivery model, hospitals can reduce the amount of transfers, decrease length of stay and improve patient satisfaction.

The Acuity Adaptable Care Delivery Model:
- Places the patient on a unit with varied levels of acuity
- Nurses are able to alter the level of care based on the acuity of a patient without moving the patient to another unit
- Allows for the care of patients from general med/surg to intermediate and from intermediate to intensive care levels

Results: The use of the model can positively impact patient, physician, and nurse satisfaction, decrease patient anxiety, and reduce mortality, complications, LOS and hospital costs. Implementation of the model at Saint Mary's Health Care reduced transfer of patients to a higher level of care by 35% and improved patient satisfaction scores by 9%.[3]

NICHE Site: St. Mary Mercy Hospital. This hospital identified that a significant percentage of older adults residing in senior facilities were being transported to the ED without essential documentation for emergency decisions, diagnosis and discharge disposition. Also, the ED staff was unfamiliar with the levels of care provided at each senior facility. A breach in communication at the transfer of care can increase risk of harmful effects and predispose the patient to lower quality care, unnecessary tests, increased length of stay, and over use of resources.

St. Mary's STARForUM (Safe Transition of all Residents For You & Me) program included the following improvements in practice: bi-directional flow of current and accurate health information, creation of forms to share information and development of information on the levels of care at the different facilities.

Results: Prior to STARForUM, a 20-chart review showed omission of clinical elements from documents that were sent with the older adult to the ER. One year later the group's intervention of focused strategies to improve transitions of care in both directions, the inclusion of clinical elements (medication list, time of last dose, code status, baseline cognition and baseline functional status) markedly increased compared to the non-participating STARForUM facilities. A convenience sample of 43 patient care transfer documents indicated there was a significant change in the total number of elements in the STARForUM facility group compared to the non-STARForUM group p=0.000.[4]

NICHE Site: Aurora Health Care. Aurora Health Care hospitals were experiencing a high rate of readmissions from skilled nursing facilities.

2010 Readmission Data (age 65+)
- Total inpatients discharged to skilled nursing facility: 3,449
- Acute readmissions within 30 Days: 642
- Readmission rate: 18.6%

A quality improvement project was launched to reduce avoidable hospital readmissions from skilled nursing facilities.

Program Scope:
- Hospital discharge summary reviews
- Vitals
- Cognitive assessment
- Medication reconciliation
- Follow-up on any orders
- Functional status, falls risk
- Family meetings
- Advance Directives

Results: The "Transitions from ACE" model reduced skilled nursing facilities patient readmissions by 7.9% and 10.4% at each of the two participating hospitals. Hospital cost avoidance totaled $49,011 (smaller Aurora hospital) and $258,580 (larger Aurora hospital).[5]

References

1. No. 22 NICHE Solutions: Integrating Geriatrics with Patient & Family Centered Care on Medical Specialties. Justin Montgomery, ARNP, MSN, Geriatric Nurse Coordinator, Dartmouth-Hitchcock Medical Center Lebanon, New Hampshire.
2. No. 24 NICHE Solutions: Supporting Hospitalized Frail Seniors from Ed to Home. Nana Asomaning, RN(EC), MN, GNC(C), NP-adult; Carla Loftus, RN, MN, GNC(C); & Rebecca Ramsden, RN(EC), MN, GNC(C), NP-adult, Mount Sinai Hospital, Toronto, Ontario, Canada.
3. No. 29 NICHE Solutions: Acuity Adaptable Care Delivery Model. Kristy Todd, MSN, FNP-BC, RN-BC, Clinical Nurse Specialist, Saint Mary's Health Care, Grand Rapids, Michigan.
4. No. 33 NICHE Solutions: STARForUM: Crossing the Quality Chasm in Care Transition. Kathy Dattolo, LMSW, Senior ER Social Worker & J. Michelle Moccia, MSN, ANP-BC, CCRN, Program Director, Senior ER, St. Mary Mercy Hospital, Livonia, Michigan.
5. No. 37 NICHE Solutions: Transitions from Ace - Reducing 30-Day Hospital Readmission in Nursing Home Patients Using an Advanced Practice Nurse Model. Patti Pagel, MSN, RN, GCNS-BC, Aurora Health Care, Milwaukee, Wisconsin.

About NICHE

NICHE (Nurses Improving Care for Healthsystem Elders) is an international program designed to help improve the care of older adults. The vision of NICHE is for all patients 65-and-over to be given sensitive and exemplary care. The mission of NICHE is to provide principles and tools to stimulate a change in the culture of healthcare facilities to achieve patient-centered care for older adults. NICHE, based at the NYU College of Nursing, has hospitals and healthcare facilities from the U.S., Canada, Bermuda and Singapore in the network. For more information visit www.nicheprogram.org.

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