Safe Care Transitions During COVID 19

Cohort 8 Session 12

February 19, 2021 11:00 AM

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Today's Agenda

Follow-up from Session II – Interprofessional Team Management and Monoclonal Antibody Treatment

Safe Care Transitions

Case Study and Break Out Rooms

Performance Improvement Discussion

Wrap-up and Poll

Questions & Answers







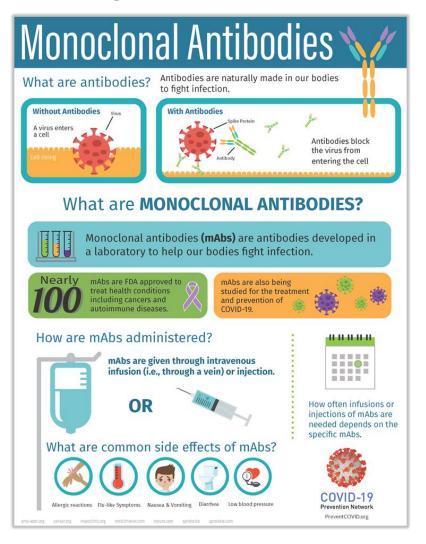






Session 11 Follow Up















Safe Care Transitions During COVID 19















Transition of Care Defined

- A transition of care is defined as the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
 - Center for Medicaid and Medicare Services

- Hospital to SNF
- SNF to Hospital
- SNF to Home
- SNF to SNF
- Between Units













DPH Regulations: Hospital to Nursing Home

- When a resident is transferred to a hospital for evaluation of any condition must accept the resident's return to the facility when the resident no longer requires hospital level of care.
- Shall not condition admission or return to the facility on COVID-19 testing or COVID-19 test results.
- If a test is not performed before discharge, facility should test the resident upon admission, if a test is available.
- Awaiting the test results should not delay discharge from the hospital to the long-term care
- Newly admitted or readmitted residents returning from any setting outside of the facility who are not recovered from COVID-19 within the previous six months
 - o should be quarantined in a private room or, if unavailable, placed in a room with another resident who is recovered (less than six months from infection), in a dedicated quarantine space
 - monitored for symptoms of COVID-19 for fourteen days after admission

DPH Admission Freezes

Does not apply to a resident transferred from the facility to a hospital or other healthcare facility.













CMS Regulations

Hospital to Nursing Home

- Can accept a resident diagnosed with COVID-19 and still under Transmission Based Precautions for COVID-19
- Should admit any individuals that they would normally admit to their facility
- If possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital.
- Quarantine I4 days with no symptoms

Nursing Home to Hospital

 Residents who require transfer to a hospital - facility alerts EMS and hospital of the resident's diagnosis (suspected or confirmed COVID-19) and precautions to be taken by transferring and receiving staff







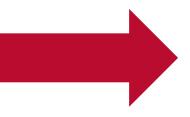






Care Transitions Programs and Toolkits

- BOOST (Hospital Based)
- ProjectRED (Hospital Based)
- INTERACT (Nursing Home Based)
- OPTIMISTIC (Nursing Home Based)
- RAFT (Nursing Home Based)



Effective Communication













Never More Important Than Right Now: Case Study

- Mr. Jones admitted to the facility in June 2020 with diagnosis of Stage 3 pressure ulcer, COPD, Major depressive disorder, Chronic Respiratory Failure, morbid obesity, osteoarthritis. He was admitted due to severe debility, requiring assistance with care needs, and was unable to get of bed by himself.
- Physician's order on 6/19/2020 for bilateral upper side rails on the bed and a side rail consent signed by resident on 6/29/20 to use bilateral upper side rails as an enabler and that side rails were recommended as part of the plan of care. Reassessment of use of side rails was completed on 12/10/20.
- Mr. Jones left the facility 12/25/20 on a social leave and upon his return was transferred to the quarantine unit.
- During personal care by the CNA on 12/28/20, resident attempted to roll onto his side in bed by throwing his leg over but because of weight, he lost control and fell of the bed. During the facility investigation, it was noted that resident's bed in the quarantine unit did not have bilateral upper side rails













Why Effective Communication During Care Transitions Matter

- Resident Outcomes
 - Hospital Admission or Readmission
 - Falls
 - Medication Errors
 - Delirium
- Facility Outcomes
 - Survey implications
 - Quality Measures
 - Health Care System partnerships













QI: Safe Care Transitions Process

Martha Hayward, IHI















Breakout Session: (15 minutes)

How Might We: Improve Communication When There Is A Care Transition During COVID 19?

- Group I: SNF to Hospital Transition
- Group 2: Hospital to SNF Transition
- Group 3: Unit to Unit Transition











Describing a Process

https://www.youtube.com/watch?v=Ct-IOOUqmyY













Breakout Session Activity

- Describe the process for information transfer between settings/units
 - High Level Flowchart
- Draft a safe care transition checklist
 - Be sure to include COVID specific information





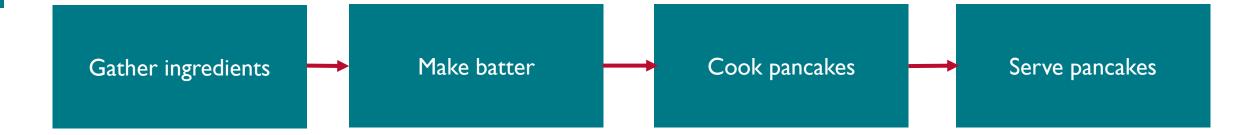








Make pancakes for breakfast



Who: Brian

When: Night before

Where: Kitchen

What: Flour, eggs, milk, yeast, salt, sugar, (spices), measuring

cups and spoons, bowls

How: Measure out

everything

Who: Brian

When: Night before

Where: Kitchen

What: Ingredients, mixing

bowl, whisk, fridge

How: Whisk dry ingredients,

add wet ingredients, rest

overnight in fridge

Who: Brian

When: Morning

Where: Kitchen

What: Batter, stove, nonstick pan, butter measuring cup +

pan, butter measuring cup

spoon, spatula, plate

How: Heat pan, add I tsp butter, add .25 cup batter.

Cook until both sides golden,

flipping once

Who: Brian

When: Morning

Where: Kitchen

What: Pancakes, maple syrup, butter, plates + utensils, coffee

How: Put pancake on plate, add butter and maple syrup

PRN













Safe transition from SNF to hospital



Who When Where What How Who: The patient,
MD/NP, Primary nurse
responsible for patient,
EMS
personnel/transferring
provider, responsible
person, emergency room
staff or unit staff at the
receiving facility, Social
worker, rehab team, case
manager if applicable.

When: prior to transfer, at the time of transfer

What: universal transfer form/and or SBAR, bed hold paperwork, Demographic face sheet, advance directives, orders, medication list (last administration), most recent labs/DX, copy of HCP/guardian, personal belongings (eye glasses, hearing aids, adaptive devices, phone), last meal, last BM/toileting.

Where: At the bedside, at nurses station, hospital.

How: Verbally, and through documentation







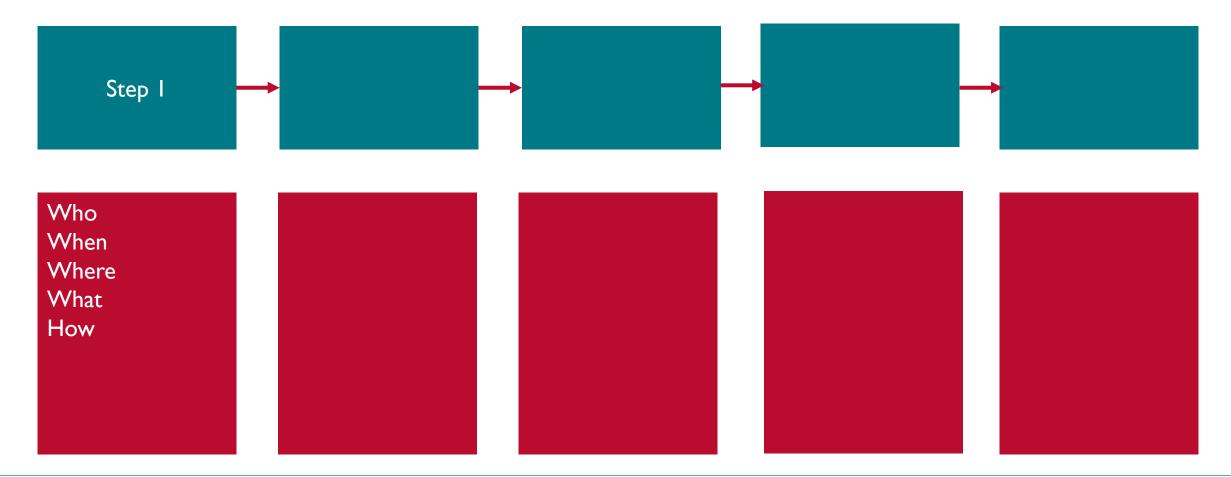








Safe transition from Hospital to SNF















Unit to Unit Transition (Group 3)

COVID-19 Test

Consent from Resident/HCP

Preparing the Resident Move

Communication

Who: Nursing When: Day of Resident Move Where: Resident

vvnere: Resident

Room

What: BinaxNOW

Rapid Test

How: CELEBRATE

the resident

graduation from

COVID Unit

Who: Social Services, Unit Manager When: 48 Hours Prior to Move (Try) Where: Resident Room and Health Care Proxy How: Phone call to HCP Who: Housekeeping,
Nursing, Maintenance
When: Prior or During
the Move
Where: New Room
Ready
What: Clean Room,
Resident Clothes and
Belonging, Moving of
Bed
How: 7-3 Shift to have
more support, after
lunch

Who: Social services, nursing, CNAs, Communication to the next shift/supervisor, kitchen/dietary, laundry When: Morning Meeting, Team Huddle What: Resident is a fall risk, resident preferences, behaviors, side rail assessment How: Nursing Communication, Texting, Emails













Report Out

How did you do?















What to expect next...

Next Session: February 26, 2021

Topics:

Session 13: Safe Visitation and Reopening

Tabitha Fineberg at Tabithafineberg@hsl.harvard.edu













Wrap Up and Poll

• Please watch your screen and respond to our 2 poll questions as they launch















Questions?











