Safe Care Transitions During COVID 19

Cohort 8 Session 12

February 19, 2021

11:00 AM

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AHRQ ECHO National Nursing Home COVID-19 Action Network

HEALTH SCIENCES | Project ECHO

AHRQ Agency for Healthcare Research and Quality

Institute for Healthcare Improvement | Massachusetts Senior Care Association

Hebrew SeniorLife | Harvard Medical School Affiliate

Today's Agenda

Follow-up from Session 11 – Interprofessional Team Management and Monoclonal Antibody Treatment

Safe Care Transitions

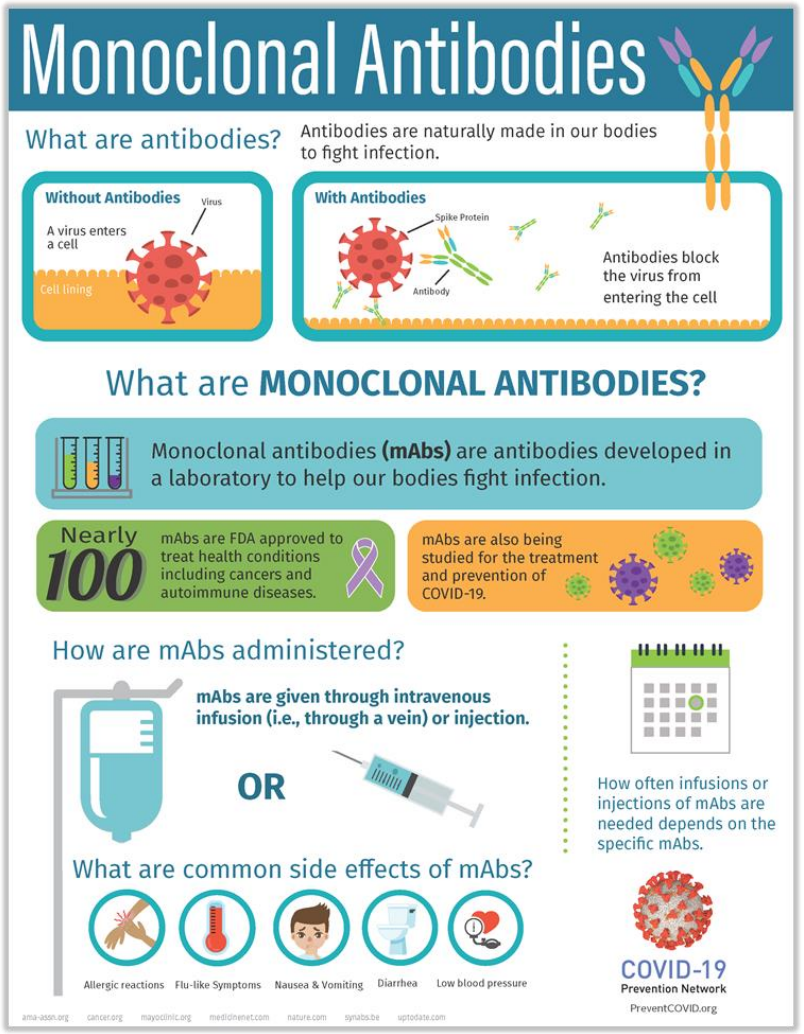
Case Study and Break Out Rooms

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
  - 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

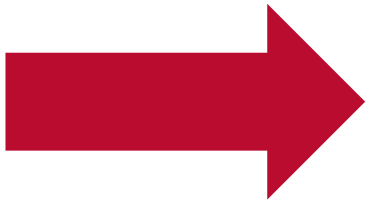
- Can accept a resident diagnosed with COVID-19 and still under Transmission Based Precautions for COVID-19
- Should admit any individuals that they would normally admit to their facility
- If possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital.
- Quarantine 14 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

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Breakout Session: (15 minutes)

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

- Group 1: SNF to Hospital Transition
- Group 2: Hospital to SNF Transition
- Group 3: Unit to Unit Transition

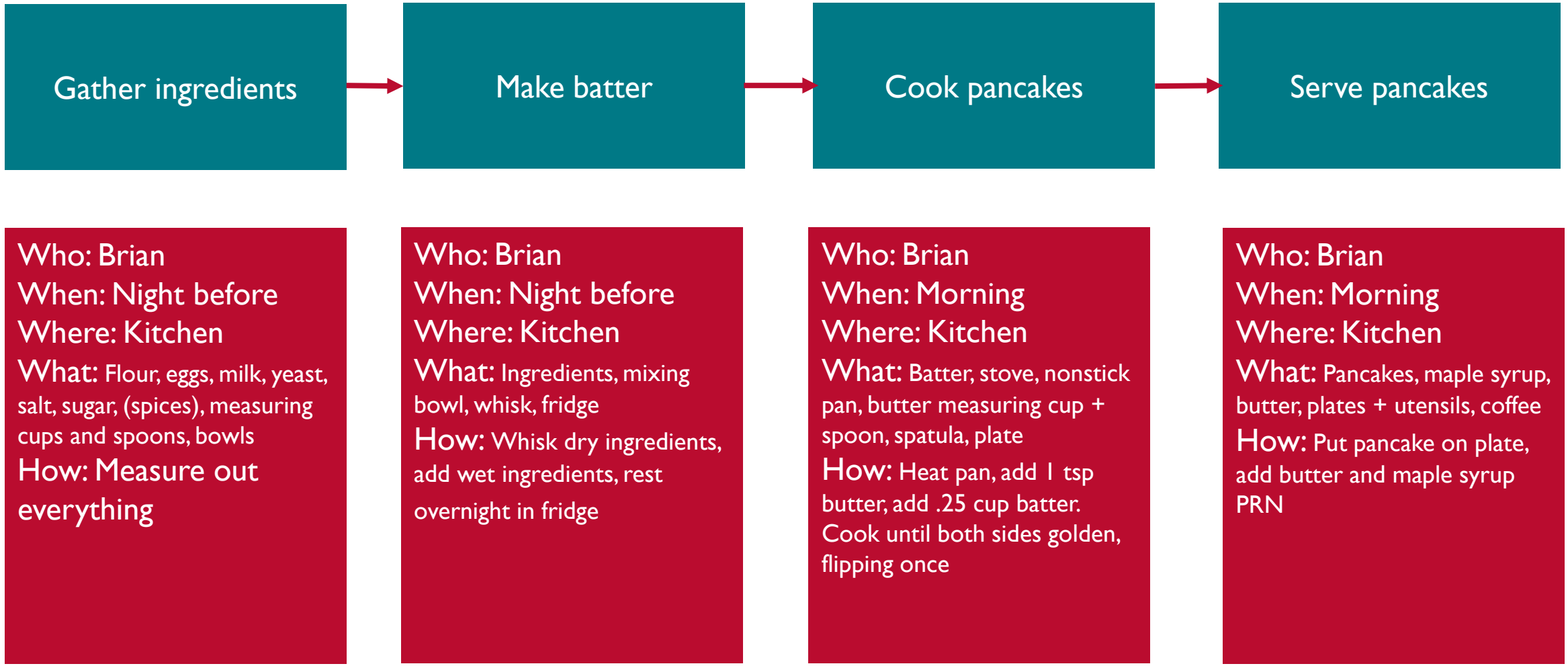
Describing a Process

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

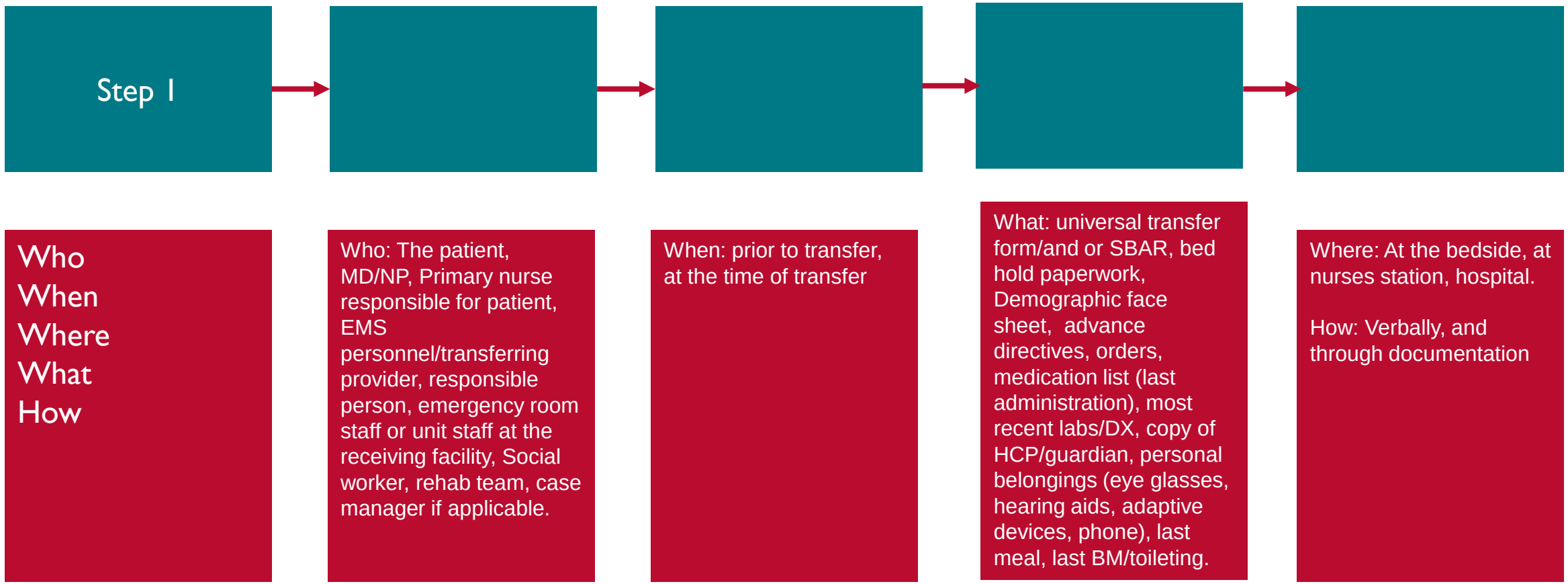
Breakout Session Activity

- 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

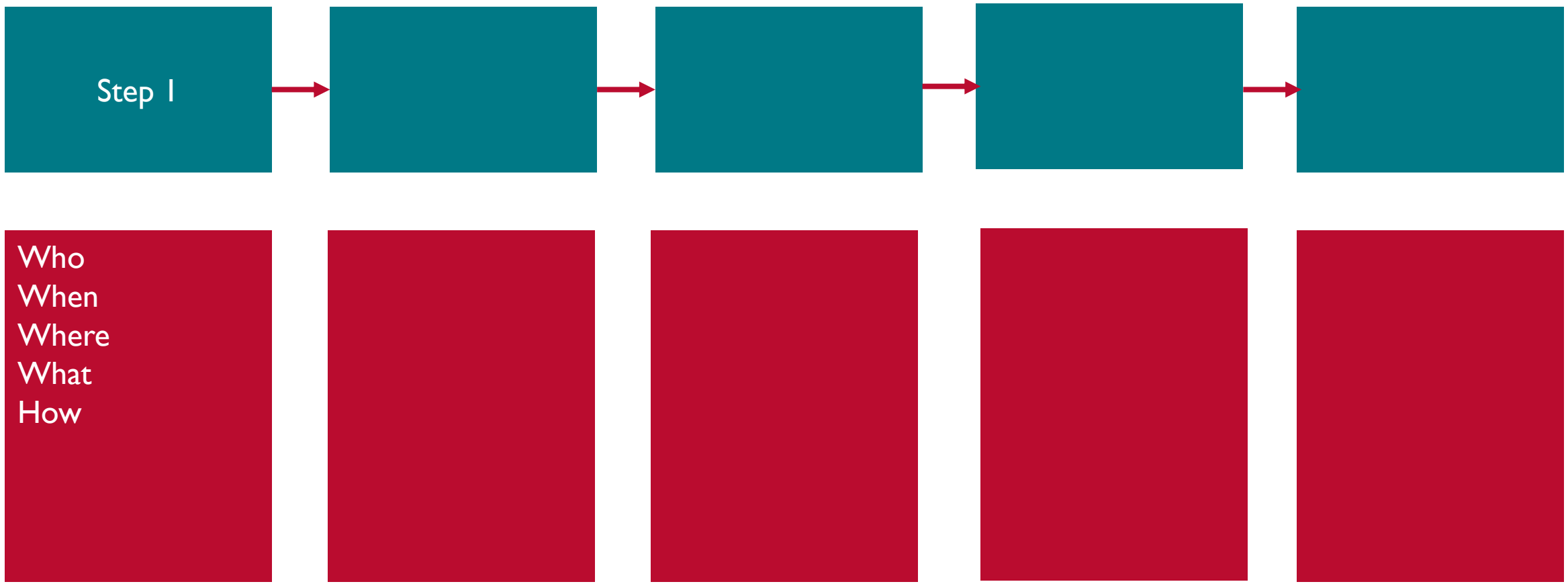
Make pancakes for breakfast



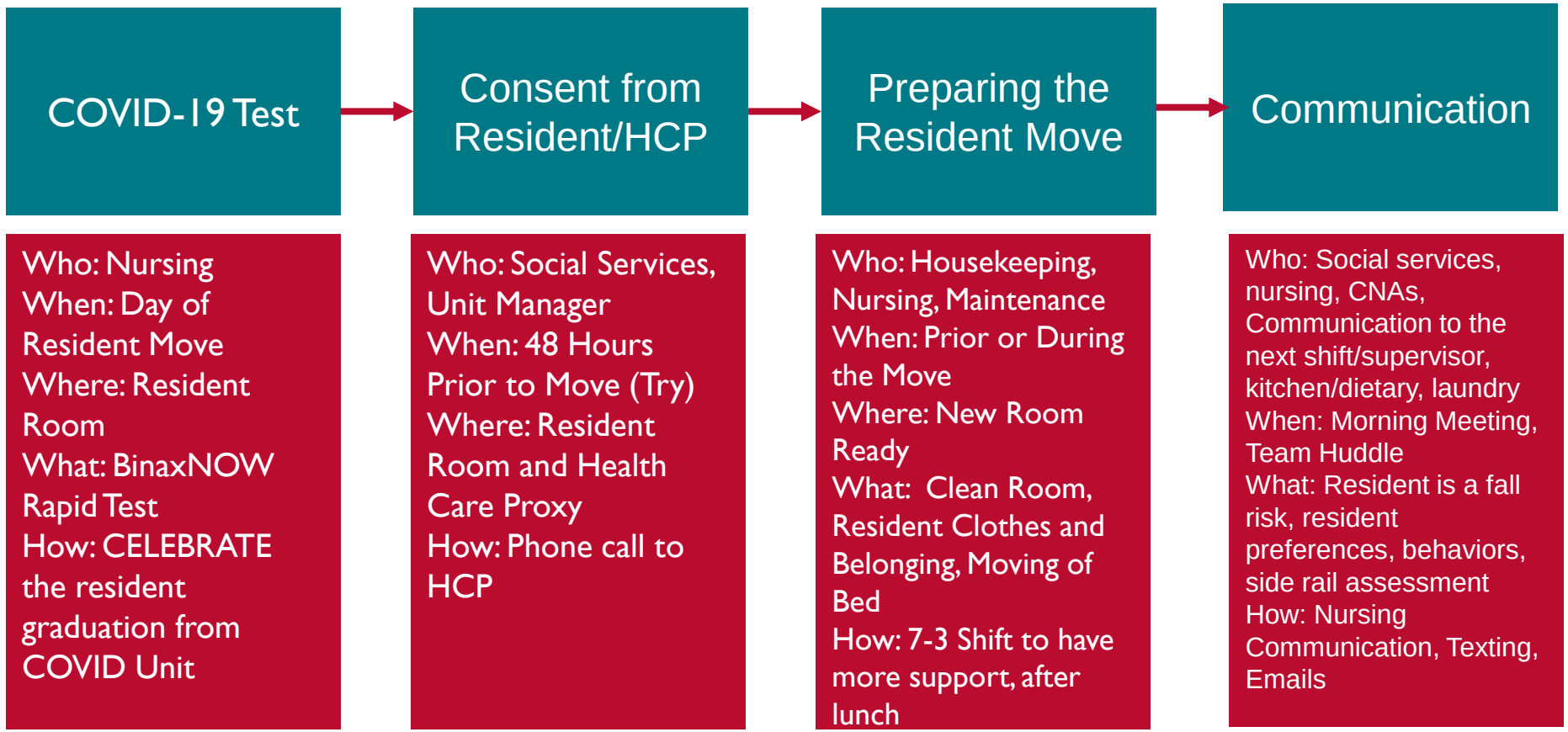
Safe transition from SNF to hospital



Safe transition from Hospital to SNF



Unit to Unit Transition (Group 3)



Report Out

- How did you do?

What to expect next…

Next Session: **February 26, 2021**

Topics:

- Session 13: Safe Visitation and Reopening

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Wrap Up and Poll

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

Questions?