

## **Older Adults Transitions between Health Care Settings Study Guide**

### **Concept-Based Learning Activity -CBLA**

*(Developed by Tadesse, R., RN, MS, PMHNP, Winter, 2007)*

**Definition:** Transitions between care settings are often times of physical and emotional vulnerability for older adults. Communication between health care providers and coordination of care can avert or alleviate some of the problems that may otherwise occur. In facilities with more than one unit, the transition between units or levels of care also needs careful coordination.

#### **Learning Activities:**

1. Identify various living arrangements (at least 5) for older adults.
2. Consider the functional abilities that an older adult needs to meet in order to live in the settings you identified.
3. Identify changes in function or chronic illness(es) that may precipitate a transition from one setting to another.
4. Find and evaluate discharge transition forms and evaluate them for usefulness for older adults.
5. Identify strategies that might be used of older adults between a long-term care setting to a hospital or another health care setting.

#### **NURS 221/321 Course Outcomes:**

- #4. Identify and use community resources to provide support for client and family care giving.
- #5. Communicate, as appropriate, with all agencies involved in patient care to assure continuity of care across settings (i.e retirement homes, assisted care living, skilled nursing home, specialty units such as dementia units, hospitals)
- #6. Negotiate with others to develop or modify client care
- #7. Analyze impact of health care delivery system issue, policy and financing on individual and family

#### **Brief Description of CBLA:** This CBLA is composed of four parts:

- (1) Assessment of overall community living arrangements for older adults and their families (caregivers) focusing on the individual chronic illness(es) and functional abilities.
- (2) Consider eligibility for a community-based living arrangement (focus on the individual older adult chronic illness(es), functional abilities, financial status and health care insurance).
- (3) Identify issues related to transition from one community-based living arrangements to another (focus on what caused the need to transition and effect of relocating to the individual older adult and family (caregiver).
- (4) Create a tool for communicating information about the older adult chronic illness(es), usual functional abilities and other things that you think will be helpful when he or she will be transferred to a different unit or to a hospital (focus on best outcome for the older adult and family; the tool can be a fanny pack (refer to Cortes, Wexler & Fitzpatrick (2004) article) or a revised discharge transition form used by the facility).

**Student Evaluation:**

1. Completion of Relocating issues and the role of the LTC staff nurse Form which includes:
  - a. Assessment of currently used discharge transition form in the LTC
  - b. Identifying strength and improvements that could be made to the current discharge transition form being used by the facility
  - c. Participation in discussion of transitioning issues focusing on management of chronic illnesses and maintaining functional abilities
  - d. Thoughtful reflection of relocation issues keeping the older adult and their family as well as the challenges of managing chronic illness(es) in mind
2. Presentation of a discharge transition form (could be a new form or an updated/revised current discharge transition form).

**Readings:** [Other than textbook to be posted on sakai under LTC clinical readings, articles also could be accessed by connecting to OHSU data base and e-journal.]

1. Cortes, T.A., Wexler, S., & Fitzpatrick, J.J. (2004). The transition between hospitals and nursing homes: Improving nurse to nurse communication. *Journal of Gerontological Nursing*, 30(6), 10-15.
2. Gladden J.C. (2000). Information exchange: Critical connections to older adult decision-making during health care transitions. *Geriatric Nursing*, 21(4), 213-218.
3. Gracheck, M.K. (2000). Joint commission accreditation: A framework for coordinating care for older adults. *Geriatrics Nursing*, 21(6), 326-327.
4. Lee DT, Woo J, Mackenzie AE. (2002). A review of older people's experiences with residential care placement. *Journal of Advanced Nursing*, 37(1), 19-27.
5. Shearer, N.B. (2002). Endnotes: Loss of power within the nursing home zone. *Journal of Gerontological Nursing*, 28(11), 54-56

\*\*\*Check the Hartford Institute for Geriatric Nursing, College of Nursing, New York University website and click on ***try this*** to access tools used to assess functional various kinds of functional abilities.

\*\*\*Listen to Mrs. Morton's Multiple Transitions, narrated by Linda Felver, Ph.D., RN. This true story involves six health care setting transitions for a 92-year-old woman in less than 2 months. If you prefer, you can read a transcript of the story.

**Some considerations when identifying transitional issues and concerns and creating a tool to help the older adult and family in safe transitions:**

- Relocating to a new environment could be very stressful and create many problems to the older adult and family (or caregiver).
- Clear communicating baseline as well as current health status and functional abilities is important.
- As a LTC nurse, you could play a critical role and make great impact on maintaining functional abilities and reduce stress to the older adult and their family (or caregiver) during transition time.
- *Be creative and think outside of the box when creating a tool that could be used by LTC staff nurses to promote safe transition.*

**Relocating issues and the role of the LTC staff nurse  
Older Adults Transitions between Health Care Settings – CBLA**

**Student:** \_\_\_\_\_ **Name of Facility:** \_\_\_\_\_

Describe how a staff nurse communicates with other nurse or healthcare provider when a resident transfers to another unit within the facility and/or to a hospital. [Is there a discharge transition form that is being used to promote continuity of care? Who is responsible for filling this form? Summarize what the form does and does not include]

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**1) Background:**

- a. Describe your understanding and knowledge of the effects of transitioning when an older person transfers due to chronic illness exacerbations, a decline in function or other reasons between health care settings.

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- b. What are the potential effects of transitioning to the older adult and their family (or caregivers)?

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- c. What information do you think need to be communicated to another provider when an older person transfers to another place during the transition process? Give rationale for each reason.

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- b. Describe the negotiations that took place between the discharge planner and each of these persons (if pertinent):
- the older adult
  - the family caregiver
  - a home care agency
  - the care setting to which the older adult transitioned

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- c. For each of the above, include how the process occurred and what problems arose by answering the following questions:

- 1) How smoothly did the process work to obtain the needed resources to match the intensity of the older adult's care needs?

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- 2) Describe the circumstances for which the older adult needs this level of care (e.g., change in functional status, rehabilitation, no available family caregiver).

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3) Evaluate the outcome for its success in meeting the care needs of this older adult. What would you have done differently to obtain a satisfactory outcome?

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d) In general what did you notice about how this information of an older adult communicated during transitions to different health care settings? How well do these systems function during weekends or holidays?

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e) What changes did you notice that should be made to the current practice?

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f) How could you work within the system to improve the transition process for the older adults and their families (or caregivers)?

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g) From your perspective, what are the two most important lessons you learned from the discharge case you observed or Mrs. Morton story?

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h) If you had been a family member of the person you watched being discharged or Mrs. Morton, what might you have done differently? Assume that you could not have traveled to be here in person.

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i) Which of the six organization-focused functions of the joint commission standards (see Grachek's article) apply to the case you followed or to Mrs. Morton's story?

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k) Use the following functional assessment screening tool to note and determine the older adult functional ability upon transition to a different health care setting.

<b>Functional Assessment Screening Tool for Older Adults</b> <i>(Developed by C. Van Son for the Older Adult Focus Project, OHSU School of Nursing.)</i>	
<b>Target Area</b>	<b>Screening</b>
<b>Vision</b>	Test each eye with screening card. Ask date of last eye exam.
<b>Hearing</b>	Whispered voice screening. Check for cerumen.
<b>Arms</b> Assesses ability to care	Touch palms to back of head. Pick up a small object. Reach up above head.

for hair, dress, and get items off shelves.	Touch hands behind waist.
<b>Legs</b>  Assesses fall risk, ability to dress, and wash feet.	Get Up and Go Test. Sitting: Touch foot with opposite hand.
<b>Oral</b>	Ask date of last dental appointment. <b>Ask:</b> "Do you have any trouble eating or swallowing?"
<b>Nutrition</b>	Height and weight. Nutrition screen: Quadruple A's of Nutrition or "DETERMINE"
<b>Elimination</b>	"DRIP" assessment <b>Ask:</b> "Do you ever lose urine or stool before you get to the toilet?"
<b>Cognitive Function</b>	Mini Mental State Exam (MMSE) Geriatric Depression Scale (GDS) or Cornell Scale for Depression in Dementia
<b>ADL-IADL</b>  Activities of Daily Living  Independent Activities of Daily Living	<b>Ask:</b> "Do you need help with ..."  <ul style="list-style-type: none"> <li>• Bathing</li> <li>• Ambulation</li> <li>• Transfers</li> <li>• Toileting</li> <li>• Eating</li> <li>• Dressing</li> <li>• Shopping</li> <li>• Telephone</li> <li>• Transportation/Driving</li> <li>• Housework/Laundry</li> <li>• Meal preparation /Cooking</li> <li>• Managing money</li> <li>• Managing medications</li> </ul>
<b>Home Environment</b>	<b>Ask:</b> "Have you had trouble with stairs or falls inside or outside your home?"
<b>Social Support</b>	<b>Ask:</b> "Whom would you call in case of an illness or emergency?"
<b>Chronic Pain</b>	<b>Ask:</b> " Do you experience pain that prevents you from doing certain activities?"
<b>Medication</b>	<b>Ask:</b> " What medications, vitamins, supplements, and remedies do you take?" "What do you take them for?" "Do you have any trouble taking them?"





