Transferring patients between facilities and the ED

By Cathy Sendecki

Some time ago, ENA appointed a committee to come up with a comprehensive process to improve the transfer of nursing home (NH) residents to and from the ED. As the NENA representative, I participated in a number of conference calls with colleagues in the U.S. Several Canadian nurses with an interest in improving the care of seniors sent sample forms.

Some I spoke with were less enthusiastic—"Why are you doing this again? I developed a form 10 years ago," and a non-nursing friend said bluntly, "How hard can it be?"

In our discussions some facts became very clear—in some small centres, a good process already exists. The staff may work together at times, the clients have been known in the community as they have aged, and communication is effective. While not directly transferable to urban settings, some aspects can be adopted. Some areas had developed successful measures that could easily be added to existing processes—dentures, hearing aids, glasses in a fanny pack, and a checklist for other items such as mobility aids.

But we had not developed the definitive transfer process and I observed at work the continuing conflicts: calls from the director of a facility to complain that we had "just sent them back without any documentation", and comments from ED nurses, physicians and paramedics criticizing a lack of information from "The Home." Clearly, most staff in both areas care about good care for these patients, but experience ongoing frustration.

Why?

Another perspective is outlined in *A Conceptual Framework for Understanding Interorganizational Relationships Between Nursing Homes and Emergency Departments: Examples from the Canadian Setting* by Rose McCloskey et al., www.sage publications.com, Policy, Politics and Nursing Practice, Nov. 2009, 10, 285–294.

Since 1960, the question of how to improve transfers between hospital and NH has been considered. This article outlines some aspects of the interorganizational relationships. How the staffs at ED and long-term care facilities view the work they do, the mandate of their organization, their perceptions of their counterparts, and their expectations of the other institution may all contribute to less than optimal communication and outcomes. The extent to which the ED staff view older adults in the health care system as potential "bed blockers" or perceive that "what you see is all they've got" (to quote Geriatrician Dr. Duncan Robertson) in terms of potential improvement and ongoing quality of life can also affect the decisions made to investigate and treat. Do we discount the intrinsic value of seniors due to our ageism?

Clearly there is more to a successful transfer than forms and official process.

Some tips from the geriatric emergency nurse perspective

- Have information in the ED available about local "nursing homes" and the services provided. The continuum from independent living in a seniors' building through residential or complex care is immense. A summary will help to clarify what care can be provided after discharge, and give direction as to how we can support the patient in the transition back to the facility.
- Communication: if more information is needed, call the staff. Ask to have any missing documentation faxed so you know how their meds have changed recently. Call before sending the resident back to deal with any questions. Can they obtain a new medication in time for the next dose? Would it help if we fax the prescription so it can be delivered? Or have the EP phone the pharmacy directly?
- When completing the transfer form back to the facility, include what investigations turned out negative. Copies of the results may be appreciated for follow-up with the GP within the next few days. We know we don't send someone back without doing ANYTHING, but we often don't clarify that we did—a CXR and blood work to R/O pneumonia or ACS with negative results.
- Be very clear about any change in medications—what did we give? When? What is the new prescription? Is anything to be discontinued? Keep a copy on the chart.
- What follow-up is needed? Under what circumstances is a return visit to the ED needed?

These measures add a little to the time needed to care for our patients, but they save time later and enhance future dealings with the staff of that facility. They will certainly contribute to improved care of our seniors.

About the author

Cathy Sendecki has worked in Burnaby Hospital ED since 1987. As Educator, in 2005 she worked with the Clinical Nurse Specialist for Acute Care of Older Adults to improve the care of seniors in the ED. What started as a three-month project by an ED nurse who did not see great areas for improvement, became a full-time position that continues to be fascinating and challenging. She appreciates the opportunity to assess patients with a geriatric and emergency "lens" to assist the emergency team to provide the best care to those seniors with complex presentations.