Geriatric Nursing 35 (2014) 316–320

Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com

NGNA National Gerontological Nursing Association

NGNA Section

From nursing home to acute care: Signs, symptoms, and strategies used to prevent transfer

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Keywords:
Nursing home
Preventing transfer
Transfer signs and symptoms
Education in nursing homes

A B S T R A C T

Older adults are vulnerable to experiencing physiologic changes that may permanently decrease functional abilities when transferring from the nursing home (NH) to the acute care setting. Making the right decision about who and when to transfer from the nursing home (NH) to acute care is critical for optimizing quality care. The specific aims of this study were to identify the common signs and symptoms exhibited by NH residents at the time of transfer to acute care and to identify strategies used to prevent transfer of NH residents. Using survey methodology, this descriptive study found change in level of consciousness, chest pressure/tightness, shortness of breath, decreased oxygenation, and muscle or bone pain were the highest ranked signs/symptoms requiring action. Actions to prevent transfer focused on stabilizing resident conditions and included hydration, oxygen, antibiotics, medications, symptom management, and providing additional physical assistance. When transfer was warranted, actions concentrated on the practical tasks of getting the residents transferred.

Introduction

Nursing home (NH) residents enter NHs with health care issues that are typically not easily addressed at home. After settling into a stable pattern of care, they are managed with resources within the NH.[1] Changes in health status of older adult NH residents are expected. However, one of the most difficult treatment decisions for NH residents, their families, and health care providers is determining if transfer to the acute care environment for advanced treatment modalities is warranted. The decision to transfer can be influenced by many factors, including resident condition, treatment options in the NH (e.g. the presence of higher acuity skilled nursing beds), end-of-life decision-making, communication, staffing, and bureaucratic requirements.[2] The best outcomes occur when resident, family, and health care providers agree about the treatment decision with the greatest potential to yield the highest quality of life.

After transfer to the Emergency Department (ED), 41–52% of NH residents are admitted to the hospital, 42–54% return to the NH, and 1–5% of NH residents die in the ED.[3] Of the NH residents admitted to the hospital, 25% die during the first 24 h of admission and 50% die by day 5.[4] These statistics support the contention that NH resident hospitalization may be contrary to the provision of quality care. As hospital costs and charges are increasing, reimbursement is decreasing for admissions as well as readmissions.

Nurses are key decision makers in the NH setting of care, making judgments about whether and when to transfer residents to the acute care setting. These decisions are made based on recognizing and understanding the importance of changes in physical or mental status of residents and the impact of these changes on residents' quality of life. The specific aims of this study were (1) to identify common signs and symptoms exhibited by NH residents at the time of transfer to an acute care environment, and (2) to identify strategies used by geriatric health care providers (nurse practitioners [NP], physician assistants [PA], registered nurses [RN], licensed vocational nurses [LVN], and physicians) to prevent transfer of NH residents to an acute care environment.

The researchers gratefully acknowledge funding of this study from the Carillon Foundation.

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0197-4572/$ – see front matter © 2014 Mosby, Inc. All rights reserved.
http://dx.doi.org/10.1016/j.gerinurse.2014.06.007

Reasons for nursing home resident transfer

Specific clinical conditions in NH residents such as chronic heart failure, myocardial infarction, pneumonia, and urinary tract infections are positively associated with hospitalization.[5–9] Resident care practices, including physical restraints, the presence of pressure ulcers and feeding tubes, new medications, and catheter use are also associated with hospitalization.[8,10,11] As one might expect, past hospitalizations are also associated with future hospitalizations, with residents experiencing a greater risk for death in the hospital if transferred more than once in a six month period.[6,12] Conditions and resident care practices reflect disease processes and care requirements. They do not reflect the signs and symptoms recognized by nurses that prompt transfer leading to hospitalization. Initial recognition of important signs and symptoms, regardless of disease process or care requirements, has the potential for early treatment in the NH, thus preventing transfer.

Decreasing nursing home resident transfer

Studies have investigated the effect of licensed nurse staffing on transfer. Current regulations require nursing homes to provide a minimum of 8 h of RN and 24 h of RN or LVN coverage per day.[13] The minimum LVN staffing does not adequately support the knowledge required to care for NH residents with multiple disease processes that require coordinated, multifaceted management. Zhang et al[14] report a decline in NH staffing ratios and echoes our concern that resident needs are not adequately taken into consideration. Resident numbers continue to serve as the prime target for determining staffing levels. Nursing homes with higher ratios of RN to total nursing staff had lower risks of hospitalization.[15] In addition, a 10% increase in licensed nurse (RN and LVN/LPN) retention has resulted in a 0.2% lower rehospitalization rate.[16] Similarly for nurses' aides, higher Certified Nursing Assistant (CNA) to nurse ratios increased the odds of transfer,[15] and facilities spending a greater proportion of nursing expenses on LVNs/LPNs increased the odds of transfer.[5,6,10,17,18] Transfer also increases when there is lack of support to residents and their families about end-of-life care, lack of familiarity with residents by doctors covering nights and weekends, and perceived inadequate care by overburdened staff.[19–21] This supports the need for well educated geriatric health care providers to coordinate resident and family care in the NH environment.[22] Other strategies that decrease transfer include effective communication between nursing staff and physicians regarding resident conditions, the employment of NPs and PAs in the NH, provider access to resident medical history, laboratory results, and electrocardiograms, availability of treatment modalities such as intravenous therapy and respiratory therapy, and CNA training programs within the facility.[15,21,23,24] Decreasing transfer of NH residents requires discerning how residents may avoid transfer to an acute care environment for common problems that have the potential of being recognized and treated within the NH environment. Transfer is not the best option when care can be delivered in place. This study identifies common signs and symptoms exhibited by NH residents at the time of transfer to an acute care environment and strategies used by geriatric health care providers to prevent those transfers of NH residents.

Methods

Design

A descriptive survey design was used to identify common signs and symptoms exhibited by NH residents at the time of transfer to an acute care environment and to identify strategies used by NH health care providers to prevent transfer of NH residents.

Sample

Using a state listing of 1144 Texas nursing homes, Texas counties were divided into rural or urban with random selection of 50 rural nursing homes and 50 urban nursing homes for receipt of the survey. The decision to target rural and urban settings was done in order to best reflect the large geographical distribution of Texas NH residents. As defined by the United States Census Bureau, urban is "all territory, population, and housing units located within an urbanized area (total population of at least 50,000) or an urban cluster (total population of at least 2500)" having a core population density of at least 1000 people per square mile and a surrounding density of 500 people per square mile". Rural is defined as "all territory, population, and housing units located outside urbanized areas or urban clusters".[25,26] From the sampled nursing homes, data were solicited from NPs, PAs, and physicians who cared for residents in NHs, and from RNs and LVNs currently employed by the NHs. More than one health care provider from a single NH may have participated in the survey. A sample size of greater than 100 NH health care providers was targeted with this approach. Survey responses were anonymous and the NH associated with a given respondent was not tracked. Over 80% of the sample used the online survey rather than submitting a paper survey via the US mail.

Data collection

After Institutional Review Board approval, the Directors of Nurses (DONs) at the selected nursing homes were contacted by phone to inform them about the study. The DON of each selected NH was mailed a packet of study materials and asked to distribute the online survey instructions or hard copy surveys with stamped and addressed return envelopes to all NH health care providers. The final sample of 108 NH health care providers were either selected by their DON or they choose to participate after learning about the study and being given instructions to access the online or paper survey. If a participant chose not to answer a question, they were excluded from the analysis for that item.

Measurement

The investigator-developed survey consisted of eleven questions; the first seven were demographic and the last four directly addressed the specific aims of the study (Table 1). The primary investigator and two other researchers created the survey questions. Content experts were used to examine validity of the survey questions.[27] The questions were given to two RNs with over five years full-time experience working in long-term care and one NP with over ten years working with older adults and currently practicing as a primary care provider in an onsite clinic in a 120 bed NH. These content experts reviewed each question and provided comments on the relevance of the questions to their experience with the transfer of residents from the NH and suggested content that was not included in the initial set of survey questions. The online survey process was pilot tested with community members for readability and ease of use. Following subject responses in the pilot study, questions were reworded to better convey the intended meaning and reordered to create a better flow of response for participants.

In order to address Specific Aim 1, study participants were given a list of 11 common signs and symptoms generated from a retrospective chart review of NH residents.[1] Study participants were then asked to choose the five most frequent signs and symptoms they thought led to transfer of residents to acute care. Separately, study participants responded to an open-ended question about the types of signs and symptoms they thought indicated the need for transferring residents to the acute care setting. Specific Aim 2 was