Long-Term Care Facilities—Just the Facts: Part Two

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Sam, an 87-year-old man, has been sent to the emergency department after a fall while playing tennis. Even though he did not sustain any fractures, he has strained his hip, knee, and wrist. Unfortunately, attempts to discharge Sam back to his apartment are looking risky. Sam lives in the independent section of a Continuing Care Retirement Community. Included in his activities of daily living (ADLs) is preparing breakfast and lunch in his own apartment, monitoring his blood sugar daily, and taking his prescribed medications. Because one meal a day is included in his monthly fee, he enjoys meeting with his friends over the evening meal in the facility's dining room. In an attempt to "road test" Sam and ensure he could safely go home, he was medicated with an oral narcotic pain medication, which made him very drowsy. Even with medication, he is unable to get out of bed without the help of 2 people, and then he has great difficulty bearing weight to walk on the injured leg. He is unable to use crutches or a walker because of the wrist injury. This combination of injuries and drowsiness from the medication puts Sam at risk for another fall. The concern is that if he goes home and is unable to get out of bed, he could experience pressure sores, continence problems, dehydration, and lack of nourishment and would be unable to take his medication. Sam's normal activity related to self-care also would most likely suffer. Depression, deep vein thrombosis, and pulmonary embolism could also occur. It is suggested to Sam that he be admitted for observation care, but he is against this idea because the cost most likely would not be covered by his insurance plan and he believes he pays enough at his long-term care (LTC) facility that they should provide this care. In this situation, Medicare coverage for Sam's hospital stay would require a 3-day qualifying hospital stay, which the ED physician cannot justify. What can the emergency nurse do to ensure a safe discharge and decrease the chances that Sam will end up back in the emergency department as the result of this, or an additional, injury?

In the first part of this two-part article, "Long-Term Care Facilities—Just the Facts: Part One," a description of LTC facilities and levels of care was provided.[1] Briefly, LTC facilities provide several types and levels of care. Some provide total care, including that of a registered nurse (RN) 24 hours a day/7 days a week; some provide nursing assistants with an on-call RN; and some provide care similar to the type of care that Sam, our patient, is receiving. Some facilities require the patient to be even more independent, with the care only being "emergent"—that is, if a resident calls for emergency assistance, someone on site will call 911 and come to the resident's aid. Some LTC facilities can manage intravenous therapy, ventilators, feeding tubes, and postoperative patients during recovery. Furthermore, some facilities provide only one type and level of care, whereas others offer a variety of options, with opportunities for the patient to move along the continuum of care as needed.

Based on what Sam is saying, it appears that he might be able to receive a higher level of care at his LTC facility. Should it be up to Sam to arrange for this care on his own? What if a patient lives in his or her own home, or lives in a facility that does not offer a continuum of care, or lives in a facility with a continuum of care but that currently does not have a bed available at the level of care the patient now requires? Does this increase in level of care require a physician's order? What can the emergency nurse do to make Sam's discharge safe and ensure that he does not sustain another injury or problem that requires a return visit to the emergency department?

This last question is very important, because geriatric admissions and readmissions have been the focus of the Centers for Disease Control and Prevention and other organizations since the institution of the Affordable Care Act. In 2009, it was reported that unplanned readmissions to the hospital cost Medicare $17.5 billion. If a hospital has

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an excess of readmission rates of Medicare patients, they can be penalized,[2,3] and thus many hospitals are working to develop processes that will lead to safer discharges for geriatric patients and decrease readmissions.[4,5]

What Does This Mean to the Emergency Nurse?

"Over the last 5 decades, quality emergency care has become synonymous with speed. Overcrowding has become a significant problem, with doctors and nurses having to work as quickly as possible simply to see all the patients. Unfortunately, when it comes to geriatric patients, it is nearly impossible to work quickly."[6] Older adults often have a list of chronic diseases and medications. It takes time to sort these out, especially if the patient has difficulty recalling this information—one of the adverse effects of aging. The older adult's baseline hearing and vision deficits, combined with his or her feeling of being rushed because of the overwhelming atmosphere of the emergency department, create significant challenges for the patient and the health care team as they try to ascertain the patient's history and symptoms. As the patient is being discharged, the ED staff not only needs to address the plan of care for the actual illness or injury that brought the patient to the emergency department but also incorporate the new treatments into the patient's underlying conditions and medications. A lot of information is needed to ensure that the older adult is being discharged to a safe and appropriate location. (See Table.)

The question, "What level of care does the patient need?" is important. To answer this question, the ED staff will not only need to thoroughly assess the presenting problem but also identify other comorbidities or issues that could have an impact on the patient's outcome, including the ability to take care of himself or herself and an assessment of available assistance at the place he or she is sent upon discharge. This process takes time and resources. Taking the necessary time and using a variety of resources to find an appropriate placement will ensure best patient outcomes and decrease the chance that the patient will return to the emergency department in poorer condition.

One of the resources that can be used is prehospital personnel. For example, when an older adult arrives by ambulance, ask the crew about the patient's living conditions. Take the time to listen and learn if they noted adequate food, temperature control, or unsafe living conditions. Did family or care providers seem appropriately caring and concerned? Did pre-hospital personnel make other observations that raised red flags?

A second resource is the ED staff, who do what they can to decrease the overwhelming nature of the ED environment. To meet the needs of the rapidly growing older population in the United States, about 50 medical centers have incorporated changes to "geriatricize" their emergency departments.[7] Some examples include hiring providers trained in caring for older patients, administering quick but effective screening tests for dementia and other cognitive impairments, and installing nonslip flooring, hand railings, and higher toilets to decrease the risk of falls, as well as more sound-absorbing materials to dampen noise levels. Staff members are trained to recognize the physiologic and psychological needs of older adults, as well as to complete screening related to the ability to sit up in bed, feed oneself, get out of bed, go to the toilet, dress, and ambulate independently. Staff members also determine whether assistive devices are needed and what treatments are required, which helps create a profile regarding how much care and the level of care the patient will need. When ADL information such as this is available and incorporated into the plan for discharge, the patient will most likely be sent to the appropriate location for continued care.

Staff members are also trained to be more attuned to social factors that can affect care for elderly persons, such as

TABLE
Typical information needed to determine level of care for safe discharge.

- Emergency department phone and fax numbers
- Primary diagnosis
- Secondary diagnosis
- Condition on discharge—including patient's mental status
- Prognosis and goals of care
- Advanced directive status—next of kin/power of attorney for health care
- Orders for care—including new/changes in medications/devices/oxygen/intravenous access
- Pertinent discharge instructions
- Medication reconciliation form
- Allergies
- Diet/weight-bearing status/activity level
- Special treatments: feeding tube/catheters/blood glucose monitoring/oxygen/etc
- Therapy needed—physical/occupational/respiratory
- Follow-up appointments
- Physician ordering and physician who will be following up on patient after ED visit
- Note on family involvement/contact