Five Things to Know About Transitional Patient Care

Changes in a patient's care settings represent challenging adjustments. Here are five key things providers should remember about patient care transitions to improve the quality of care delivered.

1. Critical patient information is often missing or incomplete.

Timeliness and accuracy of information are critical, yet it is well-documented that skilled nursing facilities often accept patients with diagnoses that are incomplete or missing. These facilities also have virtually no control on deciding what information is shared and often find themselves admitting patients lacking key personal information hindering their ability to fully understand the patients' status and individual needs. It isn't uncommon for a transferred patient to wait as long as eight to 12 hours to have their medication regimen restored, and it doesn't help that so many skilled nursing facilities rely on information and patient records systems that do not interface with those of hospitals and other clinicians like primary care physicians.

2. Communication is most critical during the first 24-48 hours.

All too often, what's not communicated leads to confusion. According to Minnesota-based nonprofit, Stratis Health, fragmented communication has been shown to lead to wasteful, often inappropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals. Additionally, caregivers may be so focused on getting a new patient settled that they do not adequately communicate with their friends and family as to their status and wellbeing. This leads to needless, emotionally fraught circumstances that only amplify the chaos.

3. Documentation can either save you or doom you.

Imagine accepting Mrs. Jones as your new resident only to discover that the originating hospital never told you she was on an important drug therapy before her broken hip landed her in the emergency room. Skilled nursing facilities are easily lulled into thinking they are not responsible for the reporting errors of originating hospitals, however all providers have a duty to demand missing and vital information and document the process thoroughly. This critical information includes, but is not limited to, a patient's complete medical history, assessments, medication treatment history and reconciliation history, and discharge documentation that tells the complete narrative about the patient before and during their hospital stay, according to Holly Harmon, senior director of clinical services at the American Health Care Association.

4. Mistakes during the discharge process can lead to problems down the road.

An admitted patient who goes without vital medications or has health issues that an incomplete discharge summary or continuity of care document failed to mention, could suffer a cascading series of adverse events that could lead to rehospitalization before or after discharge on the other end. If your facility remains vigilant during the hand-off and asks for any missing information at the point of triage, such mistakes may be avoided.

5. Engaging with discharge planners requires skill and an understanding of the rules.

For obvious reasons, skilled nursing facilities must tread lightly when communicating with discharge planners. In an ideal world, decisions about referrals must be made strictly and only with the patient's needs in mind. But that doesn't preclude your organization from being proactive. Done appropriately and well, such efforts can go far in ensuring a healthy, recurring patient referral base. Experts advise facilities to showcase what they do well while forming a joint hospital/skilled nursing facility identify a hospital's greatest needs and offer tangible ways to address them during the transition of care process.

Medication errors during transition of care can lead to dire consequences. Learn how PharMerica can streamline communication and improve quality of care during these critical handoffs.
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