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Interdisciplinary Documentation and Communication Needs Assessment for
Emergency Department Transfers in Assisted Living Facilities

Dana Avist

Georgia State University

Abstract

Title: Interdisciplinary Documentation and Communication Needs Assessment for Emergency Department Transfers in Assisted Living Facilities

Purpose: The purpose of this quality improvement project was to examine communication and documentation practices among interdisciplinary providers of residents in Assisted Living Facilities (ALFs) who experience acute health changes that lead to emergency department (ED) transfers. The specific aim of this project was to map patterns of communication and documentation of acute health changes in residents of ALFs by interdisciplinary providers that result in ED visits to identify gaps in provider knowledge, practice and predictor variables.

Method: Retrospective chart reviews of three ALFs in a state in the southeast United States was conducted. Charts were randomly selected from facilities' lists of ED transfers over the last 24 months. An analysis of current practice and standard practice was done to identify specific areas for improvement. Upon completing the interviews, improvement plans for addressing the gaps using INTERACT[®] will be developed for each facility.

Results: A total of 61 charts were reviewed. Three main areas were identified: 1) incomplete documentation of acute health changes, 2) incomplete documentation of disposition following acute health changes, and 3) incomplete documentation of provider notification. All three facilities used an incident report form or electronic form which included nature of the acute health change, communication to provider and disposition of the resident. There was a significant deficiency in documentation and communication of acute health changes which led to ED transfers.

Conclusion: Direct care providers' deficiencies in documentation and communication regarding acute health changes of residents in ALFs may be a factor leading to avoidable ED transfers.

There are implications for a quality improvement program to address the documentation and communication gaps in ALFs regarding residents' acute health changes which leads to avoidable ED transfers.

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Background and Significance

People 65 years and older represent 14.5% of the population and are expected to grow to 21.7% of the population by 2040 (Administration on Aging, 2016). Based on current trends, it is estimated the 27 million people within this population group will be housed in assisted living facilities (ALFs) by the year 2050 (Dougherty et al., 2015). Assisted living facilities (ALFs) are living arrangements in which elderly people (many with dementia) are provided personal care services (PCS) and supervision to ensure safety (Bellantonio et al., 2008). The PCS include assistance with activities of daily living (ADL), coordination of medical care, meals, housekeeping and transportation (Bellantonio et al., 2008). The growth of this population is the most significant factor affecting the increase in ALFs (Dougherty et al., 2015). There are more than 835,000 Americans residing in assisted living facilities of which are 85 years or older, female and non-Hispanic white (National Center for Assisted Living (NCAL) 2016). These residents choose ALFs because they usually need assistance with only a few ADLs and do not require 24-7 skilled nursing care (NCAL, 2016).

Many of the residents of ALFs suffer from multiple medical conditions and require continuous medical care. Dementia is of particular concern because the decline in memory and other cognitive functions that characterizes this condition also leads to a loss of independent function that has a wide-ranging impact on patients, families and healthcare systems (Plassman et al., 2007). In 2001, it was estimated in the United States that 3.4 million people were affected with dementia, with a future increase greater than 10 million by 2040 (Koller & Byum, 2014). It is estimated that over 40% of ALF residents have Alzheimer's disease or other types of dementia (NCAL, 2016). This vulnerable and complex population is more likely to become acutely ill, present to the ED and require admission to the hospital for dementia related behaviors,

cardiovascular conditions, pulmonary conditions, and other comorbidities (Hullick et al., 2016).

The residents of ALFs rely upon the services of many interdisciplinary providers to assist with activities of daily living, health care, functional disabilities, medication administration, social problems and end-of-life conditions. It is important that the providers' communication and, documentation facilitate the achievement of optimal health outcomes for a population at higher risk for adverse events. Effective interdisciplinary collaboration may be the most effective means of reducing the occurrence of negative health outcomes in this population (Martin, Ummenhofer, Manser & Spirig, 2010). Deficiencies in collaboration and communication between healthcare professionals have a negative impact on the provision of healthcare and on patient outcomes (Martin, et al.), including emergency department (ED) transfers and avoidable hospitalizations from ALFs.

Problem Statement

Unlike skilled nursing facilities (SNFs), ALFs are without federal regulations and only held accountable to a variety of state regulations (Stefanacci & Haimowitz, 2014). Therefore, most of the ALFs do not have standard guidelines to follow regarding the assessment and evaluation of the residents and the appropriate steps to follow if ED transfer is necessary. Although, ALFs are not focused on health care delivery as SNFs, residents of ALFs encounter similar health issues to their peers in SNFs.

SNFs have developed tools and resources to assist in the management of residents health care (Stefanacci & Haimowitz, 2014). One such tool is Interventions to Reduce Acute Care Transfers (INTERACT[®]). INTERACT[®] is a quality improvement program that focuses on the management of acute changes in residents' conditions. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities

(INTERACT II, 2014). INTERACT[®] tools for ALFs were developed to address the need of residents. INTERACT[®] has demonstrated strong reliability and validity with different SNFs (Ouslander et al., 2016, Handler et al., 2011, Rantz et al., 2017 and Tappen et al., 2014). The INTERACT[®] tools guide ALF staff of all skill levels in reporting and documenting changes in resident health status to reduce ED transfers (Eagleton, H. 2016, Ouslander et al., 2016 & Tappen et al., 2014)

Purpose of the Project

The purpose of this quality improvement DNP project was to examine communication and documentation practices among interdisciplinary providers of residents in ALFs who experience acute health changes that lead to ED transfers. The specific aim of this project will be to map patterns of communication and documentation of acute health changes in residents of ALFs by interdisciplinary providers that result in ED visits to identify gaps in provider knowledge, practice and predictor variables. The gaps will be addressed using the INTERACT[®] tool which has been validated by previous studies (Ouslander et al., 2016, Handler et al., 2011, Rantz et al., 2017 and Tappen et al., 2014).

PICO Question

Among interdisciplinary providers in ALFs does communication and documentation practices for acute health changes and subsequent acute care transfers align with INTERACT[®] guidelines?

Systematic Review of Literature

The literature search was conducted using the following databases: CINAHL, Medline and PubMed. The search strategy (Table 1) consisted of the following keywords: Emergency Department, transfers, avoidable hospitalizations, assisted living facilities, assisted living communities, interdisciplinary communication, interdisciplinary documentation, change in acute

health status, older adults and elderly. The search parameters were set to studies published in English between 2010 and 2017. The inclusion criteria consisted of the following: 65 years and older, emergency department transfers, interdisciplinary communication, interdisciplinary documentation, and residency in long term care facilities/communities. The exclusion criteria consisted of populations less than 65 years of age.

Table 1

Search Strategy

Search Keywords	Emergency department transfers, acute care transfers, avoidable hospitalizations, assisted living facilities, assisted living communities, interdisciplinary & interprofessional communication, interdisciplinary & interprofessional documentation, change in acute health status, dementia, older adults and elderly
Year/Language	2010-2017/English
Age of Subjects	65 and older
Search Engines	Google
Databases	CINAHL, Medline and PubMed
Professional Organizations	Alzheimer's Association http://www.alz.org/alzheimers Administration of Aging https://aoa.acl.gov
Other	Bibliographies

Table 2 gives a description of the total citations obtained using a combination of the search keywords and the respected databases from which the citations were obtained. Out of the 35 articles, 16 met the necessary inclusion criteria of 65 years and older, emergency department transfers, interdisciplinary communication, interdisciplinary documentation, and residency in long term care facilities/communities and were subsequently appraised using the GRADE criteria. Much of the literature reviewed support the effectiveness of communicating

and documenting acute health changes in the reduction of acute care transfers and hospitalizations. Ten of the articles were qualitative designs and 3 were RCTs. Of the 13 articles reviewed, only two specifically addressed ALFs. The others utilized SNFs.

Search Strategy

Search Keywords	Databases			
	CINAHL Citations	Medline Citations	PubMed Citations	Total Citations
Emergency department transfers/Acute care transfers	199/177	74/201	3,711/2,583	3,984/2,961
INTERACT Quality Improvement Program	5	5	86	
Avoidable hospitalizations	212	114	1,054	1,380
Assisted living facilities/communities	610	1,422	1545	3,577
Interdisciplinary communication	388	15,079	17,466	32,933
Interdisciplinary documentation	47	82	1,980	2,109
Change in acute health status	9	5	2,660	2,674
Elderly Dementia	1,572	4,241	84,119	89,932
Older adults	39,809	62,182	252,928	354,919
Elderly	71,611	220,358	3,071,254	3,363,223

Synthesis of the Evidence

A review of the literature supports that effective communication and documentation among interdisciplinary providers of health care and evidence-based guidelines to assess acute care changes will lead to a decrease in ED transfers and hospitalization (Hullick et al., 2015, Ouslander et al., 2016 & Stefanacci & Haimowitz, 2014).

Four papers specifically addressed ED/hospital transfers and INTERACT® (Hullick et al., 2015, Medicare.gov/Hospital Compare, 2016, Ouslander et al., 2016 & Stefanacci & Haimowitz, 2014). Avoidable hospitalization is currently a top priority in the health care sector and health care providers are being tasked with reducing visits for elderly adults entering the acute care system (Stefanacci & Haimowitz, 2014). The elderly population is at risk for frequent emergency department (ED) visits and hospitalizations due to acute health changes secondary to multiple comorbidities. Avoidable ED visits and hospitalizations among the elderly are a top

priority in the U.S. health care system (Stefanacci & Haimowitz, 2014). In October 2012, the Center for Medicare & Medicaid Services (CMS) implemented the Medicare Hospital Readmission Reduction Program (MHRRP) which reduces payments to hospitals for excessive readmissions (Department of Health and Human Services Centers for Medicare and Medicaid Services, 2016). For fiscal years 2013 and 2014, the MHRRP imposed a financial penalty on hospitals related to readmissions of Medicare patients ages 65 and older with diagnoses of acute myocardial infarction, heart failure, or pneumonia (Stefanacci & Haimowitz, 2014). In October 2014, the program expanded to include elective hip or knee replacement and chronic obstructive pulmonary disease (Stefanacci & Haimowitz, 2014). Because of the MHRRP, reimbursement has been provided to providers for transitional care which allows home visits to patients within thirty days of discharge from the hospital (Department of Health and Human Services Centers for Medicare and Medicaid Services, 2016). The aim of this process is to improve quality of care and lower costs.

In a randomized controlled trial (RCT) of the INTERACT[®] quality improvement program, it was concluded that the program improved care and prevention of unnecessary ED visits and hospital readmissions (Ouslander et al., 2016).

Five papers specifically addressed communication and documentation among interdisciplinary providers (Bellantonio et al., 2008, Karen & Andrew, 2013, Martin, et al., 2010, Lin, et al., 2012, and Shah, et al., 2010). In a RCT trial performed by Martin, Ummenhofer, Manser & Spirig, 2010, it was concluded that interdisciplinary collaboration shows promising results in relation to patient outcomes. Deficiencies in collaboration and communication between healthcare professionals have a negative impact on the provision of healthcare and on patient outcomes (Martin, et al., 2010). During a follow-up RCT, it was concluded that an

interdisciplinary team approach lowered ED visits and hospitalization among older adults with dementia in an ALF (Bellantonio, et al., 2008). The failure to effectively share ALF residents' information exposes them to a higher risk for poor outcomes and hospital readmissions (Shah, et al., 2010). A gap between evidence and practice was identified in current practice with respect to effective communication (Lin, et al., 2012). Karen and Andrew (2013) concluded that communication was important between health care providers.

The studies specific to the INTERACT quality improvement program supported that implementation of the program leads to a substantial decrease in ED transfers and hospitalizations, improve patient outcomes and providers process, including interdisciplinary communication (Ouslander et al., 2016, Handler et al., 2011, Rantz et al., 2017 and Tappen et al., 2014).

The overall level of evidence grade of the literature reviewed suggests a moderate recommendation with moderate quality evidence. There is sufficient evidence to support the DNP project. Performing a needs assessment of the communication & documentation of acute health changes among interdisciplinary providers in ALFs will facilitate the implementation of the INTERACT[®] program.

Conceptual Framework

W. Edwards Deming and Walter Shewhart's Plan-Do-Study-Act (PDSA) (Cleary, 2015) was used as the theoretical framework to guide the project. The PDSA is a structured approach to quality management and improvement. This process is used in healthcare settings to identify the needs of those for whom the design is being created and utilizes a team approach to ensure collaboration in the process (Cleary, 2015). Project implementation will be guided by the seven steps including knowing the customer (residents & interdisciplinary providers), collecting

data about the ways in which a process currently operates (communication and documentation of acute health changes) and analyzing that data using statistical methods (Cleary, 2015). The PDSA cycle involves thinking through a current situation thoroughly before beginning steps to improve it (Clearly, 2015). Therefore, a needs assessment is a necessary step.

Methodology

Design and Aims

Retrospective chart reviews in 3 Assisted Living Facilities (ALFs) in a state in the southeast United States was conducted to achieve the aim of this quality improvement project. The aim of this project was to assess current communication and documentation practices among interdisciplinary providers. An analysis of current practice and standard practice was done to identify specific areas for improvement. Upon completing the needs assessment, improvement plans for addressing the gaps using INTERACT[®] will be developed for each facility. The implementation of the improvement programs will be done at a later date and is outside of the proposed scope of the current project proposal.

Setting

The clinical settings for this project was three assisted living facilities. All facilities had a resident population of elderly men and women ages 65 and older.

Facility A had a resident population of 60 residents 65 years and older. The patient care staff consisted of certified nurse's assistants (CNAs) and sitters. Facility leadership consisted of the owner and two managers.

Facility B is a 30-bed memory care unit. The patient care staff consisted of LPNs, CNAs and sitters. Facility leadership consisted of an executive director and a wellness director who was an LPN.

Facility C had a resident population of 70 residents 65 years and older. The patient care staff consisted of CNAs and sitters. Facility leadership was comprised of an executive director and a wellness director who was an LPN. The LPN also provides direct patient care on occasion, however, she is primarily responsible for managing direct patient care staff.

All three facilities utilize the same mix of interdisciplinary providers. The type and extent of medical care in ALFs vary (Bellantonio et al., 2008). Medical providers, nurses/CNAs and administrative staff of ALFs are standard for all residents. An interdisciplinary team approach can improve communication and documentation among providers, therefore achieving desired outcomes (Martin, Ummenhofer, Manser & Spirig, 2010).

The interdisciplinary team of providers consisted of the following: nurse practitioners, physician assistants and/or physicians, registered nurses (RNs), LPNs, CNAs, sitters, executive directors, wellness care directors, managers, home health agencies, physical therapists, occupational therapists, speech therapists, hospice agencies and pharmacists

Assessment Procedures

Patients charts were reviewed. The review period was from December 2017 to January 2018. Twenty-six charts were reviewed in Facility A, 17 charts in Facility B and 18 charts in Facility C. Charts were randomly selected from facilities' lists of ED transfers over the last 12 months. The files were retrieved by the student primary investigator (PI) and reviewed on the premises of the facilities.

After selecting the files, a Data Extraction Tool (see Appendix A) was developed for this project and used to organize the data collected. The following information was collected from the files: date of ED transfer, reason for ED transfers, provider (physician, NP, physician assistant), gender, age, primary diagnoses, comorbidities, date acute health change documented,

date acute health change communicated to provider, additional communication of health changes, mode of communication (verbal or written), facility, race, and insurance provider.

If communication occurred more than once, the number of times was documented in parentheses next to the mode of communication.

Analysis

Descriptive analyses were used to analyze the data extracted from the Data Extraction Demographics Tool. The student PI was the only individual involved in the analysis process.

Table 1 provides a summary of the demographic data

Table 1: Demographics for Total Project Sample

Variable	Results
Date Range of Emergency Department (ED) Transfer	1/2016-1/2018
Reason for ED Transfer	Falls, Lacerations & Head injuries 2° to falls, Fractures, Contusions, Altered level of consciousness
Provider (Physician, NP, Physician Assistant)	70% NPs, 30% MDs
Gender	80% Female 20% Male
Age	73-98 years old
Primary Diagnoses	Dementia
Comorbidities	HTN, CV disease, diabetes, osteoporosis, arthritis
Shift when acute health change documented	90% 7-3 shift,
Shift when acute health change communicated to provider	90% 7-3 shift

Additional communication of health changes	Families were notified
Mode of communication <ul style="list-style-type: none"> ○ Verbal (phone and face to face) ○ Written (Notes in chart and communication log) 	Phone or Fax
Race	Majority Caucasian
Insurance	100% Medicare

Table 1: Demographics for Facility A

Variable	Results
Date Range of Emergency Department (ED) Transfer	1/2016-1/2018
Reason for ED Transfer	Falls, Lacerations & Head injuries 2° to falls, Fractures, Contusions, Altered level of consciousness
Provider (Physician, NP, Physician Assistant)	70% NPs, 30% MDs
Gender	80% Female 20% Male
Age	Range 73-98/Avg Age 87.6 SD 7.8
Primary Diagnoses	Dementia
Comorbidities	HTN, CV disease, diabetes, osteoporosis, arthritis
Shift when acute health change documented	7-3 54%; 3-11shift 38%; 11-7 8%
Shift when acute health change communicated to provider	7-3 42%; 3-11 4%; 11-7 4%
Additional communication of health changes	Families were notified
Mode of communication <ul style="list-style-type: none"> ○ Verbal (phone and face to face) 	Phone or Fax

○ Written (Notes in chart and communication log)	
Race	White 92%, Black 8%
Insurance	Medicare 64%, Aetna 28%, BCBS 8%, UHC 32%, Tricare 4%, Mutual of Omaha 4%; 35% have primary and secondary insurance. 65% have only primary insurance.

Table 1: Demographics for Facility B

Variable	Results
Date Range of Emergency Department (ED) Transfer	1/2016-1/2018
Reason for ED Transfer	Falls, Lacerations & Head injuries 2° to falls, Fractures, Contusions, Altered level of consciousness
Provider (Physician, NP, Physician Assistant)	NP 43%, MDs 57%
Gender	Female 64%, Male 46%
Age	Range 73-98/Avg Age 85.7 SD 5.27
Primary Diagnoses	Dementia
Comorbidities	HTN, CV disease, diabetes, osteoporosis, arthritis
Shift when acute health change documented	7-3 53%; 3-11 12%; 11-7 35%
Shift when acute health change communicated to provider	7-3 59%; 3-11 18%; 11-7 18%

Additional communication of health changes	Families were notified
Mode of communication <ul style="list-style-type: none"> ○ Verbal (phone and face to face) ○ Written (Notes in chart and communication log) 	Phone or Fax
Race	Majority Caucasian
Insurance	100% Traditional Medicare or Medicare replacement plan. Name of insurance plan not recorded on form.

Table 1: Demographics for Facility C

Variable	Results
Date Range of Emergency Department (ED) Transfer	1/2016-1/2018
Reason for ED Transfer	Falls, Lacerations & Head injuries 2° to falls, Fractures, Contusions, Altered level of consciousness
Provider (Physician, NP, Physician Assistant)	70% NPs, 30% MDs
Gender	Female 75% Male 25%
Age	Range 65-98; Avg Age 82.3, SD 8.8
Primary Diagnoses	Dementia
Comorbidities	HTN, CV disease, diabetes, osteoporosis, arthritis
Shift when acute health change documented	7-3 44%; 3-11 44%; 11-7 39%
Shift when acute health change communicated to provider	7-3 23%; 3-11 6%; 11-7 6%

Additional communication of health changes	Families were notified
Mode of communication <ul style="list-style-type: none"> ○ Verbal (phone and face to face) ○ Written (Notes in chart and communication log) 	Phone or Fax
Race	Majority Caucasian
Insurance	100% Traditional Medicare or Medicare replacement plan. Name of insurance plan not recorded on form.

Results

The three main areas identified were incomplete documentation of acute health changes, incomplete documentation of disposition following acute health changes, and incomplete documentation of provider notification. All three facilities used an incident report form or electronic which included nature of the acute health change, communication to provider and disposition of the resident.

A total of 26 charts were reviewed at facility A. Seventy three percent of the charts reviewed had incomplete documentation of the incident report forms for hospital transfer. Fifty percent of the charts did not include provider notification or disposition of the resident. Twenty three percent of the charts provided provider notification but no disposition information. Only 27% of the charts were 100% compliant and reported both provider notification and resident disposition. Disposition of residents to the ED following an acute health change was documented only one time.

Table 3 below depicts notification/communication to provider of acute health changes and documentation of the resident disposition per work shift for facility A.

Table 2

	7-3 Shift (14 charts)	3-11 Shift (10 charts)	11-7 Shift (2 charts)
Provider Notified of acute health changes	78%	10%	50%
Disposition of resident documented	50%	None	None

Sixteen charts were reviewed at Facility B. The facility utilized an electronic documentation system which they identified as an “incident log”. The system identifies acute health changes and disposition according to severity codes. The severity codes and descriptions, along with the number of charts identified per code are depicted in Table 3. Facility B had a 100% rate of complete documentation of the incident report log and patient disposition. There was a 99% rate of provider notification of acute health changes to the provider. There was a total of 13 residents transferred to the ED. Nine residents were assessed in the ED and returned to the facility. Four residents were admitted to the hospital. Three residents were treated on an outpatient basis.

Table 3

Severity Code	Code Description	Number of Charts Reviewed
Severity Code 1	No Apparent Harm/Injury	
Severity Code 2	Harm/Injury without Outside Treatment and/or Observation	1
Severity Code 3	Harm/Injury with Outside Treatment (e.g. urgent care, EMT, doctor’s office)	2
Severity Code 4	Harm/Injury with ER Treatment/Assessment	9
Severity Code 5	Harm/Injury with Admission to Hospital	4

Table 5 below identifies notification/communication to provider of acute health changes and documentation of the resident disposition per work shift for facility B.

Table 4

	7-3 Shift (9 charts)	3-11 Shift (2 charts)	11-7 Shift (5 charts)
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Provider Notified of acute health changes	100%	99%	100%
Disposition of resident documented	100%	100%	100%

Eighteen charts were reviewed at Facility C. Seventy-five percent of the incident reports were incomplete. Sixty-five percent of the incident report forms did not include documentation of residents' disposition following an acute health change or notification of the provider. Although Facility C incident reports were incomplete, the PI could obtain ED transfers from the narrative notes. There was a total of 24 ED transfers, 10 of which was the same resident.

Table 5 identifies notification/communication to provider of acute health changes and documentation of the resident disposition per work shift for facility C.

Table 5

	7-3 Shift	3-11 Shift	11-7 Shift
Provider Notified of acute health changes	75%	50%	10%
Disposition of resident documented	75%	50%	10%

Discussion

Unexpected findings such as incomplete incident reports and not documenting or communicating to the provider resulted in difficulty identifying the number of ED visits or hospitalizations. It was discovered that many of the caregivers documented communication to the provider but in fact a call and/or fax was not received on the provider's end.

All three facilities utilize unlicensed personnel to complete the incident reports. Certified nurse assistants (CNAs) and proxy care givers were the direct health care providers to the assisted living facility (ALF) residents. Facility B utilize a licensed practical nurse (LPN) to oversee the unlicensed personnel. Facility B also use an electronic system of reporting. Facility

B's documentation and communication far exceeded the other facilities. Although facility B received nearly 100% compliance, communication to the provider hours later was a common occurrence.

Although facility C was not compliant in completing the required incident report forms, there were documented notes in a narrative format regarding the nature of the acute health change and disposition of the resident. Facility C also had a high turnover rate of administrative staff which may have affected the inconsistency of completing incident reports.

There were patterns noted among the work shifts. The 7 a.m.-3 p.m. shift was most successful in documentation and communication of acute health changes followed by the 3 p.m.-11 p.m. shift. The 11 p.m.-7 a.m. shift had the poorest documentation and communication of acute health changes.

The project included only three ALFs, therefore the results may be limited regarding generalizability. Another limitation was the lack of assessing other ALFs with licensed personnel. As previously mentioned, the facility with an LPN far exceeded the facilities with unlicensed personnel. There were less ED transfers in Facility B due to better documentation and communication practices.

The project findings support the need for improvement of documentation and communication among healthcare providers in ALFs. The gaps identified in documentation and communication can be addressed by the implementation of Interventions to Reduce Acute Care Transfers (INTERACT®). As discussed in section 1, INTERACT® is a quality improvement program that focuses on the management of acute changes in residents' conditions. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities (INTERACT II, 2014). The INTERACT® tools guide ALF staff of all skill levels in reporting and documenting changes in resident health status to reduce ED transfers (Eagleton, H.

2016, Ouslander et al., 2014 & Tappen et al., 2014).

The implementation strategy for each facility will be the same. An interdisciplinary team will be selected for initial training of INTERACT® to lead the implementation process. This team will consist of an administrator/manager, nurse practitioner, nurse (where applicable), and CNA. The interdisciplinary team will be trained by the nurse practitioner who will oversee the implementation process of the quality improvement program INTERACT®.

Implications

Direct care providers' deficiencies in documentation and communication regarding acute health changes of residents in ALFs may be a factor leading to avoidable ED transfers. There are implications for a quality improvement program to address the documentation and communication gaps in ALFs regarding residents' acute health changes which leads to avoidable ED transfers. The doctor of nursing practice (DNP) advanced practice registered nurse (APRN) is prepared to implement quality improvement programs in ALFs to educate facility leadership, direct caregivers and other interdisciplinary providers on the importance of timely documentation communication to reduce the incidence of ED transfers.

Conclusion

Implementation of the INTERACT® quality improvement program will promote timely documentation and communication of acute health changes that lead to ED transfers within ALFs. Further studies are recommended following the implementation of INTERACT® to explore improvement in documentation and communication among ALF direct caregivers. The use of electronic systems should be explored by ALFs with the possibility of integrating INTERACT®. This would improve communication and documentation among interdisciplinary providers as well as patient outcome.

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