Continuing Education

Promoting Quality Through Transitions of Care for Older Adults

Authored by: *Julie Savage Jones, EdD, MSN, RN, CNE and Arlene H. Morris, EdD, MSN, RN, CNE*

Disclosures: Neither the author or planning committee have any conflict of interest.

Target audience: All health care workers

Learning Outcome: The nurse will be able to explore the issues surrounding difficulties of promoting quality care during the transitions of care for older adults and state how to formulate best care for older adults during these transitions.

Contact Hours: 3.6 (ABN). Contact Hours are valid May 1, 2018 – April 30, 2020.

Fees: ASNA Member $ free Non Member $36.00 (Fees must be paid on line and the same time as the completing the evaluation.)

Accreditation: The Alabama Board of Nursing (Provider Number ABNP0002 – *Expires April 6, 2021)*

Instructions for Credit: Participants should read the learning outcome on line or printed out. After reading complete the post test at the end of the activity and compare your responses to the answers provided and review any incorrect response(s). Participants must complete the evaluation on line and submit the appropriate fee to receive continuing nursing education credit. The Certificate of Attendance will be generated after the evaluation has been completed. ASNA will report the contact hours to the Alabama Board of Nursing within 2 weeks of completion.

Introduction

Nurses are paid for their astute observations, skills and ability to identify and intervene to promote positive outcomes for patients in their care. The risk for negative outcomes is intensified with every transition to a different care provider or setting. This problem potentiates suffering of older adults and their families, while also dramatically increasing cost of care due to inaccurate or incomplete treatment.

Older adults comprise an increasing percent of the population in the United States as well as globally (World Health Organization, 2015; Center for Disease Control, 2013). Older adults are at risk for functional decline during both acute illness and progression of one or more chronic conditions. Many older adults live independently, with family members or friends, or in an assisted living facility (ALF). If supportive care is needed following hospitalization for an illness or injury, Medicare recipients can qualify for payment for rehabilitation in a skilled nursing facility (SNF) or in a long-term care (LTC) facility for 20 days post hospitalization without a copay and additional days with a copay (CMS, 2013). However, an older adult may prefer to receive rehabilitation nursing services and other therapies at home with family members or friends as partners in the recovery process. During every transition into and across any of these care settings, including home to the acute care facility, potential for problems increases without thorough communication and accurate assessments as foundation for meeting care needs.

Transitions of care (TOC) issues have been noted to be a problem impacting patient outcomes. According to the Centers for Medicare and Medicaid Services (CMS), improving transitions of care impacts quality of life and quality of care for older adults. The CMS (2018) noted many areas needing intervention, including:

> Preventing medical errors, identifying issues for early intervention, preventing unnecessary hospitalizations and readmissions, supporting consumers preferences and choices, and avoiding duplication of processes and efforts to more effectively utilize resources. (Para one)

Preventing 30-day readmissions is a quality measure associated with TOC. The Joint Commission (TJC, 2013) has addressed the issue of transitions of care, citing factors that may increase the risk of readmission, including

> diagnoses associated with high readmissions, co-morbidities, the need for numerous medications, a history of readmissions, psychosocial and emotional factors, such as issues relating to mental health, interpersonal relationships, or family matters, the lack of a family member, friend or other caregiver who could provide support or assist with care, older age, financial distress, and deficient living environment. (Page 3)

One of the areas TJC (2013) cited that could have a profound impact on TOC is:

> Two-way patient and family education – teaching the patient and family about their role and responsibility in managing a condition, while gaining an understanding of psychosocial issues affecting the patient and family. (Page 3)

The American Nurses Association (ANA) has identified several issues that could impact these problem-prone areas. The ANA initiatives, recommendations from the Agency for Healthcare Quality and Research (AHRQ), and from the Hartford Institute for Geriatric Nursing (HIGN) will be discussed in this paper.

Discharge Planning and Transitions of Care

Ideally, discharge planning should begin on the day of admission. Likewise, a patient being discharged from an acute care facility to a skilled care facility should have family present and involved in this stage of care for goals to be developed throughout care with the client and family an integral part of the process.

Consider the following scenario regarding transitions of care: Mr. Jones is an 86-year-old male with a history of mid-stage dementia and hypertension (treated with an antihypertensive). He was employed for decades as a popular math and history teacher, and was involved in his community through his church, school, and other volunteer organizations; currently his community involvement is limited to church attendance, eating at restaurants with family, and going for drives in the country. He infrequently initiates conversation, but responds to questions and requests, although answers may at times refer to a different situation than the one under discussion. He is usually pleasant and able to provide his self-care if prompted verbally and with needed objects in a slow, calm manner. Occasionally, he verbally recalls his military experiences, including combat episodes. He enjoys attending worship services and listening to music of various genres, including music from the 1950s.

He was recently admitted to an acute care facility from home, where he was cared for by his son and daughter-in-law. His daughter-in-law brought a notebook of his healthcare information, including an Allow Natural Death (AND) order signed by his attorney. His admitting diagnosis was dehydration and urinary tract infection. His family stated they had noticed some progressive weakening and slowing of his activities. Mr. Jones had limited verbal responses when questioned by the admitting registered nurse (RN) who was unfamiliar to him. The family was not with the patient on transfer from the hospital to the skilled nursing facility (SNF). The patient was transferred at 9 a.m. and the day shift hospital RN, who had just met him that day, called report to the day shift Licensed Practical Nurse (LPN) at the skilled care facility. The physician's discharge summary was sent to the admitting office.

The nursing report noted that the patient needs assistance with meals. No further information was provided. Family members spoke with the SNF admitting RN via phone. They informed the nurse that Mr. Jones had lost ten pounds in the last month. They said that he has always fed himself, but lately seems disinterested in his meals. Both of Mr. Jones caregivers work outside of the home. A private duty sitter cares for him during the day while they work. Mr. Jones was placed on a regular, no added salt diet with liquid nutritional supplements with meals. Additionally, Mr. Jones continued Bactrim DS for treatment of his urinary tract infection for seven more days. At the end of the first week at the SNF, when treatment team convened, Mr. Jones was noted to have lost seven additional pounds. When questioned about his food intake, the RN contacted the nursing assistant on day shift, who reported that he usually only drinks some of his liquid nutritional supplement at meal time.

This scenario includes preventable issues that, had they been addressed, could have had a positive impact on this client. From this case, it is apparent that Mr. Jones has a commonly occurring issue of forgetting how to carry out tasks. He appears to have forgotten how to use his eating utensils and this resulted in his weight loss and dehydration, causing further weakening and withdrawal. The potential for error was high in this case. Let's look at some of the issues involved in these transitions, including some methods to prevent or address them. Clearly, the family members caring for Mr. Jones did not have a clear understanding of the trajectory of dementia. There was also a breakdown in communication from home to hospital to SNF regarding the functional status of this resident. The following scenario shows how the same staff could have incorporated evidence-based assessment tools and interventions to improve the quality of care and outcomes to enable this older gentleman to return home to his family rather than rapidly decline.

During the transition of care scenario, the hospital RN, who just met the client on the day of discharge, called report to the SNF LPN. The family was not present for the transition at 9 a.m. to the SNF due to lack of being informed of the time the transfer would occur to enable taking a break from their work. Limited information regarding the patient's functional status was included in the transfer report. The hospital care team had not performed or included any kind of functional assessment on admission or during the client's stay. Had the hospital care team done these assessments on admission and every three days, this objective information could have been used to better structure care and could have been included in the discharge report. The Agency for Healthcare Research and Quality (AHRQ, 2017) provides an evidence-based system to improve quality and efficiency of healthcare through the TeamSTEPPS® communication tools (https://www.ahrq.gov/teamstepps). The hospital RN transferring care to the admitting RN at the SNF could have used the I-PASS-the BATON acronym to relay: **I**dentity of the nurse, **P**atient identifiers, **A**ssessment of the chief complaint, vital signs, symptoms and diagnosis, and the **S**ituation including current status and circumstances, and **S**afety needs such as critical lab values/reports, socioeconomic factors, allergies and alerts such as falls or isolation status. Further information includes **B**ackground of comorbidities, previous episodes, current medications and family history; **A**ctions that have been taken and are required (with rationale), **T**iming of urgency and prioritization of actions; **O**wnership of who is responsible (including family members); and anticipated **N**ext steps such as the plan or contingency plans for any anticipated changes.

The staff of this SNF had recently adopted the GITT 2.0 toolkit, "a template and resources that can be adapted by any organization across the healthcare continuum interested in enhancing interprofessional education surrounding quality initiatives" for care to older adults, provided by the Hartford Institute for Geriatric Nursing, New York University (https://www.consultgeri.org). The admitting RN assessed Mr. Jones using the "Try This" series, available as an application for iPad,

Continuing Education continued on page 18

Continuing Education

continued from page 17

iPhones, or tablets. Assessment and intervention guides from this series had been downloaded to iPads for the interprofessional healthcare team. Furthermore, all staff in this facility had completed the eight-item competency checklist for care of adults 65 years+ (Hartford Institute for Geriatric Nursing, 2002).

Initially, the admitting nurse wished to differentiate changes of aging from dementia by asking the patient and family eight items from the AD8: The Washington University Dementia Screening Test (Galvin and Zweig, 2013). Mr. Jones scored six out of eight, indicating a significant impairment of cognition. The Katz Index of Activity of Daily Living (ADL) (Shelkey and Wallace, 2012) revealed three of the six areas needing assistance were feeding, bathing and dressing. The Lawton Instrumental Activities of Daily Living (IADL) scale (Graf, 2013) revealed that all eight areas needed assistance. The Fulmer SPICES overall assessment tool for older adults (Wallace and Fulmer, 2007) revealed there were no noted **S**leep disorders, some **P**roblems with eating and feeding, no **I**ncontinence, some **C**onfusion, no **E**vidence of falls, and no **S**kin breakdown.

Although several fall risk assessment scales exist, the RN used the Heinrich II Fall Risk Model (Heinrich, 2016) to evaluate Mr. Jones. Findings revealed that he was at risk of falling due to his increased weakness since being hospitalized. The LPN reported a near fall occurred when assisting him to the bathroom following lunch. This information prompted the RN to further evaluate for orthostatic hypotension at various times throughout the following day in order to promptly assess for potential etiology (Esstman, 2016). The LPN reported that Mr. Jones' standing blood pressure significantly dropped following each meal. The RN explained that blood diversion to the gastro-intestinal system for digestion could preclude sufficient flow to the brain upon standing. The care team used these findings to plan for post-prandial hypotensive episodes by encouraging toileting prior to each meal and sitting or reclining in a chair for at least 30 minutes after eating (Saccomano, 2017).

The admitting nurse used the seven-item Mini Nutritional Assessment (DiMaria-Ghalili and Amella, 2012) to obtain Mr. Jones' baseline status and make appropriate plans for Mr. Jones to have assistance with meals. This was communicated to the nursing assistants participating in his care. The treatment team RN used the Family Preference Index (Boltz, 2012) to ask the son and daughter-in-law their desires regarding participating in supportive care of Mr. Jones. They decided that in addition to the evening meal they would alternate coming at breakfast and lunch meals each day to be a familiar presence and to assist with intake. They were hopeful that Mr. Jones would return to the home they shared at completion of his rehabilitation stay. Following use of the Eating and Feeding Issues in Older Adults with Dementia: PART II Interventions (Amella and Lawrence, 2007), the plan of care was revised to include staff offering, and remaining to encourage intake of, water and various juices through the day, and liquid nutritional supplements and small finger-food snacks at mid-morning and mid-afternoon (rather than providing liquid nutritional supplements with meals), turning off the television (a potential distraction to eating), providing oral hygiene morning and evening, and assessing for pain.

The RN used the five-item observational tool Assessing Pain in Persons with Dementia (Horgas, 2012) to determine that Mr. Jones had a frightened expression, and occasional short periods of hyperventilation. The RN used the Geriatric Depression Scale: Short Form (Greenberg, 2012) to determine that Mr. Jones was depressed. In addition to nursing interventions such as more frequent position changes and appropriate medication administration for pain, the family was consulted regarding measures to increase comfort in the unfamiliar environment. They brought a small audio player loaded with music that Mr. Jones had enjoyed, and a photo album which included pictures of family and friends throughout several decades.

Potential Barriers to Effective Transitions of Care

The fact has been established that rebound back into the hospital within 30 days of discharge is a negative outcome. This has implications for planning across transitions of care. Although nurses have knowledge, skills, and attitudes that can be used to identify transition of care issues and prevent negative patient outcomes, barriers impact their ability to function as change agents that promote such outcomes.

Safe Staffing

Unsafe staffing ratios potentially impact nurses' ability to have time to complete the assessment and planning necessary to promote positive outcomes. Nurses working in medical-surgical units in some hospitals are asked to care for up to six to seven patients, including older adults with multiple comorbid conditions. Nurses working in these facilities need to advocate for safer staffing ratios to facilitate better patient care outcomes. The American Nurses Association (ANA) is taking a lead role on this issue. The ANA (2015) collaborated with Avalere Health, LLC to develop a white paper, *Optimal Nurse Staffing to Improve Quality of Care and Patient Outcomes,* to address the growing problem of unsafe staffing and quality of patient care. This paper can be accessed at http://info.nursingworld.org/staffingwp/.

Nursing Process

Promoting better outcomes, such as decreased readmission rates, requires careful planning. Consider a geriatric client with dementia transitioning from care at home to care in the hospital setting for surgery or acute illness, and then to the skilled nursing facility. To plan effective care, the nurse must include detailed assessments that identify potential problems common for older adults. Due to the widespread problem of functional decline for older adults acutely ill, the nurse needs to assess the client's current functional status. The Katz Index of Activity of Daily Living (ADL) (Shelkey and Wallace, 2012) mentioned earlier is a tool that can be utilized in hospital and outpatient settings. Additionally, the older, acutely ill adult is at risk for delirium, particularly problematic with urinary tract and other infections. Specialized assessment tools can address common issues. The Mini-Cog™ (Doerflinger, 2013) or the Confusion Assessment Method (CAM, Inouye et al, 1990) can be used in inpatient, acute care settings to identify clients with delirium. There is also a CAM version for the intensive care unit. Nurses can make a positive impact on the outcomes for geriatric patients transitioning through various levels of care by routinely using evidence-based assessment tools to guide planning the client care. Licensed practical nurses can help facilitate the process by helping to collect data and reporting it promptly to the RN.

Nurses do not always feel empowered to complete assessments in addition to basic head to toe physical assessment taught in nursing school. However, nurses should integrate assessment tools to provide further objective assessment of geriatric clients and to facilitate communication in transitions of care. Utilizing specialized assessments tools can help identify issues that often impact geriatric clients and result in planning interventions to address common problems. Additionally, making the provider and other team members aware of such issues can be the start to promoting better outcomes for geriatric clients. Routine use of evidence-based assessment tools from the series *Try This: Best Practices in Nursing Care to Older Adults* (htpps://www.consultgeri.org) can be supported through narrative and video instructions on the website.

Family Involvement

Frail, vulnerable older adults need a family advocate with them during times of illness, and during transitions of care. Nurses need to involve family members in the care of patients, when this is possible. In American culture, children are considered vulnerable and require caregivers, especially when they are ill. However, when vulnerable, aging parents are hospitalized due to illness, the expectation that a family member will remain with them is not always a consideration. Nurses can do a better job of encouraging families to be involved, especially during transitions of care. Nurses have been designated as the most trusted profession by a Gallup poll for over a decade and are assumed to act in the best interest of patients and families. Knowing that involvement of patient and family in the process of transitions of care improves outcomes, nurses must incorporate and involve the patient and family in the plan of care throughout all stages.

Continuity of Care

In this case, the hospital RN called report to the RN at the SNF. The hospital nurse had never cared for the client before the day of discharge. This reflects several issues encountered in nursing related to continuity of care. Healthcare risks increase fragmentation and reduce quality without continuity of care. Ideally, a tentative plan for the approximate day of discharge should be determined at admission to acute care facilities. This information can be obtained from InterQual® (Change Healthcare, 2018) criteria, an evidenced-based clinical decision support system used for utilization review, and includes information such as average length of stay, based on diagnosis. Hospital case managers use these criteria to justify admission to an acute care facility. With proper planning and care coordination, discharge could be planned to allow a nurse with more complete knowledge regarding a client to call report to the admitting RN in a SNF. In addition to more familiarity with the patient, use of evidence-based communication tools for transfer of care increase both speed and quality of information communicated.

Regulations

In Alabama, LPNs can perform focused assessments, whereas comprehensive assessments are completed by an RN. However, SNFs are required to have a RN present for only 8 hours during the day shift. Therefore, most discharges to these facilities are carried out during the day shift hours. Individuals who transition from the acute care facility to the SNF often have multiple comorbid conditions. By the very nature of their general health condition, these clients are at risk for decline. Adding acute illness to this situation results in clients at elevated risk for rebound back to the hospital. Nevertheless, these clients are in an unfamiliar environment and potentially without family present. During the evening and night hours, care of these clients is overseen by LPNs, who are not allowed by state law to carry out a comprehensive health assessment. This presents a problem for less experienced LPNs. Ideally, an RN available within the facility at all hours of the day, every day of the week would provide a thorough assessment during changes in client condition, and address issues that would otherwise result in rebound back into the hospital. Readmissions within 30 days of discharge have implications for hospital reimbursements, possibly indicating quality of care issues.

Staffing Issues

According to Jones' (2016) research, new graduate LPNs encountered issues when transitioning to work in long term care environments. Two of the most stressful issues were managing death and dying of residents and intimidating and disruptive behaviors. In this study, LPNs did not feel prepared to deal with the difficulties associated these problems. Death is not usually an expectation in SNF, as people transition to these environments with the expectation to improve. However, clients in SNFs are often fragile and their health status is at risk for rapid or unexpected decline. Management of situations where the client's health status declines should be included in all levels of nursing education curriculum and as a competency evaluation during job orientation. A supportive environment, including availability of RN or advance practice nurse (APN) for more complex issues can help increase staff retention, thus reducing costs for the facility.

Another problem exists in healthcare environments that has a negative impact on client care. The Joint Commission (2008) referred to the problem as intimidating and disruptive behaviors. Jones (2016) found that new graduate LPNs transitioning to work in a LTC and SNF settings encountered these behavior from several disciplines of staff within the facilities or from client family members. This impacted their job satisfaction and could have resulted in negative client outcomes. These behaviors also negatively impact the teamwork needed to result in better client outcomes. The American Nurses Association (2015b) has a position statement and toolkit to help facilities address these behaviors in the workplace. Addressing incivility in healthcare will ultimately promote better outcomes for the clients, as well as satisfaction and retention of nurses. This is also an ethical issue that can be addressed by the ANA Code of Ethics.

The ANA (2015a) Code of Ethics speaks to the issue of incivility, indicating that the registered nurse is to "create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect" (ANA, 2015a, p. 4). Although this code applies to registered nurses, the ANA asserts that this issue is applicable to all healthcare workers and stakeholders, stating that "stakeholders who have a relationship with the worksite

also have a responsibility to address incivility, bullying, and workplace violence" (p. 1). In their position statement, *Incivility, Bullying, and Workplace Violence,* the ANA (2015b) asserted that nursing professionals will no longer tolerate these behaviors in nursing practice. Guidance is offered to identify and build a culture where this problem is not tolerated. The Center for American Nurses (CAN, 2008) also asserted that all healthcare organizations should adopt a zero-tolerance for lateral violence and bullying, emphasizing that organizations should adopt educational and behavioral interventions to help nurses deal with these behaviors.

The Agency for Healthcare Research and Quality (2018) also developed TeamSTEPPS® 2.0 for Long-Term Care. This evidence-based teamwork system is designed to improve quality, safety, and efficiency of healthcare, including a curriculum guide with videos to facilitate better communication and teamwork. Additionally, a slide presentation provides an overview of the program for leaders. The framework for this model of care provides key principles of teamwork, communication, leadership, situation monitoring, and mutual support (AHRQ, 2018).

As nurses and other healthcare providers on the team age themselves, we must consider what type of care will be provided when we are the recipients and how will that influence quality of life for each of us. By providing standardized objective information, nurses' assessments can prompt action by other healthcare team members. These best practices can help reduce length of stay and hospital readmissions that impact us all as citizens and healthcare providers. Further indications may also be implicated for staff patient ratio. Additionally, creating a culture that supports collaboration and teamwork and does not tolerate intimidating and disruptive behaviors will result in better client outcomes. If this is not being done in the current environment, nurses must help change the paradigm.

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Continuing Education Questions:

Compare your response(s) to the correct answers following the questions:

1. The Joint Commission specified which of the following risks for readmission? (select all that apply)
   a. Family or other caregiver support
   b. Financial distress
   c. Older age
   d. Psychosocial and emotional factors

2. Which of the following does The Joint Commission recommend to reduce errors associated with Transfer of Care (TOC)?
   a. Care maps that specify assessments and interventions for each day of hospitalization
   b. Rapid discharge from acute care facilities to rehabilitation settings of care
   c. Two–way patient and family education that allows healthcare team members to gain understanding of related issues.
   d. Written discharge instructions

3. What communication tool is suggested by the Agency for Healthcare Research and Quality (AHRQ) to promote communication at transitions of care?
   a. ADESCC
   b. CUS
   c. I-PASS-the-BATON
   d. SBAR

4. In this scenario, which assessment tool revealed problems with eating and feeding and some confusion?
   a. Fulmer SPICES
   b. Heinrich II Fall Risk
   c. Katz Index of Activity of Daily Living
   d. Lawton Instrumental Activities of Daily Living

5. In this scenario, which assessment tool was used to assess pain?
   a. Assessing Pain in Persons with Dementia
   b. Mini-Cog
   c. Mini-mental Status Exam
   d. Numeric pain rating scale

6. In this scenario, which assessment tool was used to determine family involvement in care?
   a. Family Preference Index
   b. No assessment of family involvement was made
   c. Observation of who was present
   d. Question and answer session

7. Which nurse licensure is required for comprehensive patient assessments in Alabama?
   a. Patient care technician certification
   b. Licensed practical nurse
   c. Registered nurse
   d. Advance Practice Nurse

8. Which barriers to quality care was identified by Jones' (2016) research of new graduate LPNs in Alabama? (select all that apply)
   a. High patient to nurse staffing ratios
   b. Intense and strenuous work required for patient care
   c. Intimidating and disruptive behaviors (incivility)
   d. Managing situations of death and dying of patients

9. Which professional organization has developed a toolkit to address behaviors such as bullying and incivility in the workplace?
   a. Agency for Healthcare Quality and Research (2018)
   b. American Nurses Association (2015)
   c. Centers for Medicare and Medicaid Services (2018)
   d. Hartford Institute for Geriatric Nursing at New York University College of Nursing

10. Which of the following has been found to improve quality outcomes and reduce rates of health decline or readmission of older adults? (select all that apply)
    a. Creating a workplace culture that supports collaboration and teamwork
    b. Including management of issues related to death and dying in all nursing curricula
    c. Use of evidence-based assessment tools to provide care for all patients
    d. Zero-tolerance of bullying, intimidating and disruptive behaviors

Correct Responses

1. B, C, D
2. C
3. C
4. A
5. A
6. A
7. C
8. C, D
9. B
10. A, B, C, D