Safe Hospitalization Discharge

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Agenda

- Safe hospitalization what is it?
- Negative outcomes
- Predictor of safe hospitalizations
- Key Mistake Rates and Statistics
- Important takeaways

What is a safe hospitalization discharge?

- Define in your own words and in less than two sentences what is a safe hospitalization discharge

What are the 4 components of safe hospital discharge?

1. Health care provider led discharge meeting discharge plan with clear written follow up care instructions, medication reconciliation, and right folks at the meeting
2. Patient centric discussion, social work led discharge planning, patient attendance at discharge meeting and patient and staff education
3. Attending physician led discharge meeting, a well written discharge planning, an ambulance ride back to the group home and the presence of the residence manager or DSP at the discharge meeting
4. Attending physician led discharge meeting, physician's presentation of follow up care to the team, patient attendance at discharge meeting and patient and staff education

What is the best predictor of a safe discharge?

1. Getting the right medical diagnoses
2. A top specialist leading the treatment plan in the area of concern that resulted in the hospitalization in the first place
3. A health care provider (MD, DO, NP, and PA) led discharge meeting with all appropriate stakeholders to include the patient, the patient's family, the health care staff from the group home and a person who knows the patient best
4. A discharge document that describes the care delivered at the hospital, patient's response to the care and a post discharge care plan

Key Mistake Rates and Statistics

1. Errors are particularly frequent during transitions of care (TOC) and are primarily related to medication management and communication breakdowns.

2. Medication Discrepancies: Estimates suggest that between 30% and 70% of patients have an error or unintentional change to their medicines when their care is transferred.

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Errors in Specific Settings:

1. Hospital to Skilled Nursing Facility (SNF): Nearly 70% of admissions to long-term care (LTC) facilities involve at least one medication discrepancy.
2. ICU to Non-ICU: A 2022 study found that over half of patients (58.15%) transferred from an ICU to a general ward had at least one medication error.
3. Hospital to Home/Community: A systematic review noted that up to half of adults discharged from the hospital to the community experience at least one medication error or unintentional discrepancy.

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Severity of Errors:

1. Approximately 40% of medication errors are attributed to inadequate medication reconciliation during handovers.
2. Up to 60% of medication discrepancies are classified as serious or life-threatening.
3. However, most errors often reach the patient but do not cause harm, although they require monitoring or intervention to preclude harm.
4. Adverse Drug Events (ADEs):Approximately 20% of transfer-related errors are believed to cause patient harm, and nearly 20% of adults discharged to the community suffer an ADE.
5. Communication Breakdown: An estimated 80% of serious medical errors involve miscommunication during patient transfers.

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Common Types and Causes of Errors

1. Mistakes often stem from systemic issues rather than individual negligence.

2. Common Errors: The most frequent issues include:
   - Omitted medications
   - Wrong dosage or frequency
   - Incorrect route of administration
   - Incomplete or omitted prescription drug records

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Risk Factors:

1. Transitions between different levels of care (e.g., ICU to general ward)
2. Polypharmacy (patients on multiple medications)
3. Lack of formal transfer policies or electronic health record interoperability
4. Specific medication classes, such as insulin, anticoagulants, and antibiotics, which are considered high-alert

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Key Take Aways

1. Safe hospital begins before the admission.
2. Educate parents of the risks if having them as the primary contact
3. Knowing the individual's baseline prior to admission
4. Having the nurse, the Director of Nursing written contact information, and the Director of Residential Services shared with the charge nurse
5. Secure the charge nurse's name and telephone number (know that charge nurses change)
6. Agency nurse visiting no later than 72 hours of admission
7. Determine the level of support needed during hospitalization given clinical profile presentation within 48 hours of admission

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Key Take Aways (Continued)

8. Advise the hospital early that you require a discharge meeting with medical personnel
9. Request all medical records early and often; get their release forms. Consider asking for the request in writing from your Director of Nursing or Director of Quality assurance with a copy to the family
10. Resist the temptation of wanting to take folks home as soon as possible as opposed to when the issue is resolved or hospitalization is no longer medically necessary or clinically indicated
11. Having a discharge meeting with medical professional (MD, DO, NP, PA)not social workers
12. Being clear as to the post care discharge instructions (not from social worker)

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Key Take Aways (Continued)

13. Pay close attention to what is said and crosscheck or triangulate against what is written
14. Securing follow up appointments before leaving the hospital, if possible
15. Securing discharge documents as it becomes a nightmare even 1 hour after you leave
16. Be clear about diagnoses (particularly new and additional ones) and treatment plan post discharge
17. Discharge documents must be reviewed by at least the agency nurse, nursing supervisor and Director of nursing
18. Determine what new (particularly physical or staffing) accommodations , if any, are needed upon discharge

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Key Take Aways (Continued)

19. Approval of the discharge by agency Chief Program Officer, Chief Operating Officer or Director of Residential Services or an appropriate senior leader
20. Ensure that prescription has been received by pharmacy and that it matches what is written on the discharge summary
21. If individual is not back to baseline, be clear what is the expected clinical trajectory given compliance with treatment
22. Within 24 hour of discharge agency clinical team meets to confirm what is known, come up with clear tasks, assigns owners to each task and target time for completion (suggest that a senior or executive staff is present)
23. Within one week, meet again to make sure to get a status update
24. At the one month mark, verify that every follow up is being worked on and that the case can be closed

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QUESTIONS