

Patient Centered Care Narratives in Healthcare Transitions

From “Successful Handoffs for Touchdowns in Transitions of Care”

Sepsis Awareness Month

Overview

The purpose of this activity is to listen to a non-fiction narrative about care and to identify improvement opportunities. Mrs. Anderson’s narrative is from the caregiver’s perspective referencing hospital readmissions. Prior to reading, consider your experiences, attitudes and beliefs that may influence your thoughts. How might your perceptions differ from another professional’s perceptions? Consider the need for inter-disciplinary reviews of the narratives. While reading the narratives aloud, listen and keep notes on themes and opportunities that you hear. The focus of analysis is to listen and consider the multiple factors that affect care and the contextual opportunities to improve resources for staff, patients and caregivers. Consider the biological, psychological, and social needs of the participants.

Consider the following:

- What went well for the patients & caregivers?
- What systems improvement have you already made that would prevent these omissions in care?
- Were there patient, caregiver, or staff needs or expectations that were unmet?
- Did you hear any omissions in care that affected the trajectory of illness?
- Did you hear any individual or system opportunities suggested?

We hope this activity fosters conversation while listening to care recipients’ experiences as they travel across the healthcare continuum.

Thank you for your interest in improving care transitions and identifying sepsis -- please contact us with questions!

Rebecca Hancock

rhancock@IHAconnect.org

Karin Kennedy

kkennedy@IHAconnect.org

Mrs. Anderson's Readmission & Sepsis

This story is written by a daughter of an elderly woman, Mrs. Anderson, who lived alone since the early 1990s. The patient, Mrs. Anderson, was known to take her medications faithfully, as prescribed by her physician, but was stubborn and avoided medical tests that could lead to surgery or an extended illness. She would regularly tell her physician, family, friends and neighbors, "I'm fine," when others, including her daughter, who provided increasingly more caregiver support over the past two years knew differently.

Her physician, Dr. Thurber, did an excellent job managing her care and keeping Mrs. Anderson at home. However, since mid-September of 2016, Mrs. Anderson's health was declining, and she was seeing her doctor more frequently. For the past two years, her daughter never missed her mom's doctor visits. Her daughter was actively engaged and knew everything about her mom's health conditions. Dr. Thurber knew her patient wanted to avoid being hospitalized, however, her congestive heart failure, atrial fibrillation and COPD conditions were not improving after several weeks of close monitoring. As a result, Mrs. Anderson was admitted to the hospital mid-October 2016. After six days in the hospital, Mrs. Anderson was released to a skilled rehab facility for a short-term stay. The goal was for Mrs. Anderson to return home.

Mrs. Anderson's daughter shares with us today, her story and details of their journey:

My mom's scheduled discharge was set for Tuesday. After being in the hospital for six days and being transferred to three hospital rooms, she was ready to leave. But, before she could leave, she needed to address one issue – her magnesium was low. My brothers and I waited as our mom was given magnesium through an IV. Late in the afternoon, we were still waiting to leave the hospital. Being an engaged daughter and wanting to make sure my mom's transition was as smooth as possible, I approached the nurses' station and asked if we could go over the discharge instructions. A few questions running through my mind included: Did they have her primary care physician listed as following her at the nursing home?

- Were there any signs or symptoms that I needed to watch for?
- Were there any high-risk medications?
- Could we review her medication list?
- When were follow-up appointments?
- Is there anything else that we needed to know about my mom's condition or anything we needed to do to finalize before leaving the hospital?
- What was the treatment plan for her hospital-acquired pressure ulcer? The sore was identified on Saturday afternoon and, as of Tuesday, no treatment had been given.

The response from the nurse made my jaw drop. The nurse looked at me and said, "I don't have to go over anything with you." I thought I had misunderstood her, so I replied, "I don't

understand. I have questions about mother's discharge plan?" The nurse held up a folder and said, "I have communicated to the nursing home and everything about your mother is in the folder. I don't have to review it with you and your mother." Wow! And, that was the end of it until we got ready to leave the hospital and the same nurse asked, "Where's your mom's portable oxygen tank?" No one had told us that we needed to bring her portable oxygen tank. So, I left the hospital, traveled to her house and got it. Finally, at 8:30 p.m., we arrived at the skilled nursing facility.

In the days to come, we learned that there was no mention of her pressure sore in the records sent from the hospital. She was being followed by the skilled nursing facility physician until a nurse questioned why I was asking about my mom's primary care physician, Dr. Thurber, being notified about her constipation. I learned about physician appointments that required transportation on the day of the appointment. She was diagnosed with a UTI and had a fall. For 24 days, I watched my mom decline and become more and more confused and agitated. We were told she was depressed. There may be some truth to that, however, I kept trying to tell individuals, "This is not my mother; something else is wrong." Her fluids continued to be restricted due to the congestive heart failure, and because my mom followed the fluid restriction orders, she was drinking very little. I asked the question, "Shouldn't we be tracking a minimum amount of fluid?" On day 24, she was transferred back the hospital with an adverse drug reaction, possible pneumonia and mild dehydration. As the ER physician asked questions, I learned that there were signs and symptoms that could have been recognized sooner. Unfortunately, this information was not communicated to us.

My mom's roller coaster ride continued through November and into December. She was hospitalized a third time and to be keep this story short, we'll skip those details. After the third hospitalization, the physicians had a conference and decided that they would let my mom into the inpatient rehab program even though she didn't technically meet the full criteria. They wanted to monitor her, let her have rehab and continue to adjust her medications. We were extremely grateful for this opportunity. It was an outstanding experience. She showed progress and her COPD, heart failure and atrial fibrillation were under control. She was progressing with rehab and becoming stronger. On the final day of rehab, my mom left the hospital, smiled and said, "Cha-Ching, I'm out of here." We left and drove to an extended care facility, where my mom was eager to continue physical and occupational therapy. We arrived and the nurse did her initial assessment. She said that the medications were ordered and knew that my mom needed her evening medications immediately. An hour went by; two hours went by, and then there was shift change. The night nurse explained there was an issue and her medicines didn't get ordered. We waited and waited. We were told the medications would arrive by 1 a.m. from Indianapolis. Missing not only her evening medications, but also her bedtime medications was horrible. My mom's heart rate went up to 188, and she was having trouble breathing without her scheduled

breathing treatments. She became very anxious. I tried not to show it, but I too was very anxious and frankly angry.

Everything corrected at the hospital seem to unravel within hours. At 3:30 a.m., the nurse arrived with my mom's medications. The medications came in bottles from the CVS at 9th and Poplar St. in Terre Haute. I was so confused. I asked, "I thought the medications were being delivered from Indianapolis." I was wrong. In fact, someone from Indianapolis drove to Terre Haute, got the medications from CVS and delivered them. I couldn't believe it. We had been waiting for a driver from Indianapolis, and I was told that it must be done this way because of the pharmacy contract. To this day, I am still perplexed about this inefficiency, which in my mind is poor quality of care.

Three days after leaving the hospital rehab unit, my mom, unfortunately, was transferred back to the hospital. The diagnosis, we learned in the ER, was sepsis. Four days after leaving the rehab unit, she was placed into hospice care. And, seven days after leaving the rehab unit saying, "Ch-Ching, I'm out of here," she passed away.