Providing a Safe Hospital Admission and Discharge for an Older Adult—Transitional Care

TRANSITIONAL CARE is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. This ACE card illustrates the opportunities for improvement in transitions of care that occur with residents of assisted living.

MRS. CERONE, AN 80-YEAR OLD FEMALE RESIDENT has had a cough with a poor appetite for 3 days. The resident and her family are concerned with the disruption in her daily activities and wonder whether she requires hospitalization. After careful evaluation, you determine that the resident should be admitted to the local hospital. How can you ensure that her hospital admission and return home are as safe as possible? You review a pocket ACE Card as a checklist.

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Providing a Safe Hospital Admission for an Older Adult

Acute Care for the Elderly (ACE) Program
Aurora Sinai Medical Center/UW School of Medicine & Public Health

- Check on medication allergies.
- Define if patient has an advance directive. Determine the code status.
- If a urinary catheters is in place:
  - Question if it is new (placed in ER) or chronic.
  - Question if the patients needs the urinary catheter. If not, order to remove it.
- If a patient is on oxygen, how often do you want pulse ox readings?
- If patient is confused, determine their baseline.
  - Not every confused patient has dementia. Many may have delirium. Identifying new onset delirium should lead to an assessment of an underlying cause.
- Be sure you know what medications patient was on prior to admission.
  - Check old records on computerized record.
  - Check with nursing home because med sheets do not always include recent changes.
  - Check with patient's pharmacy.
- Order a physical/occupational therapy assessment of the patient if they: have fallen, require an assist device, or have had a decline in their functional status.
- Communicate with admitting RN so s/he knows the plan.
- Do **not** order bedrest unless absolutely necessary (unstable patient). If you **do** order bedrest, re-evaluate daily and change ASAP.
- Anticipate where the patient will go after hospitalization and begin working towards that goal!

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Providing a Safe Hospital Discharge for an Older Adult

1. Assure patient preferences are taken into account in deciding the health care needs at discharge.
2. Discuss with patient's nurse – make sure there are no other needs s/he has identified.
3. Be sure to consider need for home care services.
4. Dictate a summary at the time of hospital discharge for each patient.
   - Include an accurate medication list.
   - Include information regarding the patient's functional status/cognition at baseline and at transfer.
   - Provide description of overall goals of care.
5. Assess for special equipment at home: commode, assist device, etc.
6. If on O_2 in hospital, be sure to assess the need on discharge.
7. **Be sure medication list on discharge is correct.**
   - Provide patient with **written** direction/list.
   - Pay extra attention to reconcile the medications from before hospitalization with the medications at the time of discharge.
   - Be sure patient has prescriptions for new medications.
8. Be sure there are adequate plans for the follow-up studies and appointments.
9. Give instructions regarding symptoms to watch for and contact name/number to call.

References: Lyons WL, Coleman EA. Transitional care in Duthie EH, Katz PR, Malone ML ed. Practice of Geriatrics – 4th ed. Elsevier

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This ACE (Acute Care for the Elderly) Card™ on *Providing a Safe Hospital Admission and Discharge for an Older Adult—Transitional Care* was developed by Dr. Michael Malone at Aurora Health Care in Milwaukee, WI. These geriatric care reminder cards will be published in *ALC* as resources to help clinicians manage common conditions that plague elderly patients. The complete series of cards can be ordered from Dr. Malone at Michael.Malone.MD@aurora.org. ALC

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