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VANTAGEPOINT®

VP 2016 ISSUE 1

Elderly Patients: Reduce Injury Risk by Enhancing Geriatric Care

As many as one in five Medicare patients sustains a healthcare-incurred injury.¹ In many of these cases, a single adverse event triggers a cascade of related injuries, leaving patients worse off than they were when admitted.² Hospitals can be especially risky environments for skilled care residents who present to acute care settings with compromised physical and emotional coping mechanisms, making them vulnerable to numerous hazards, including:

- Falls
- Hospital-acquired infections
- Adverse drug reactions
- Unintentional weight loss
- Dehydration and malnutrition
- Pressure injuries
- Delirium
- Functional decline
- Systems failure
- Anxiety and depression

¹ Hall, J. "20 Percent of Medicare Patients Harmed Due to Improper Care; Nursing Homes Among Areas Needing More Attention, Researcher Says." *McKnights*. Posted May 29, 2014.

² "Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries." Washington, D.C.: U.S. Department of Health and Human Services, Office of the Inspector General, report number OEI-06-09-00090, November 2010.

At a time of growing financial pressures, these adverse occurrences can have significant liability, reimbursement and reputational consequences for healthcare organizations.

To better protect older patients and avoid costly penalties for hospital-acquired conditions, industry leaders are reexamining the geriatric care model with an eye toward improving risk detection and management. Increasingly, hospitals are implementing innovative, evidence-based interventions, including dedicated geriatric units and emergency rooms, integrated geriatric treatment teams, and enhanced assessment tools to identify and document the risk of functional decline in older patients.

This edition of *Vantage Point*® presents claim data on the frequency, severity and financial impact of injuries to elderly inpatients, and suggests areas of geriatric care where healthcare leaders can most effectively focus their quality improvement efforts.

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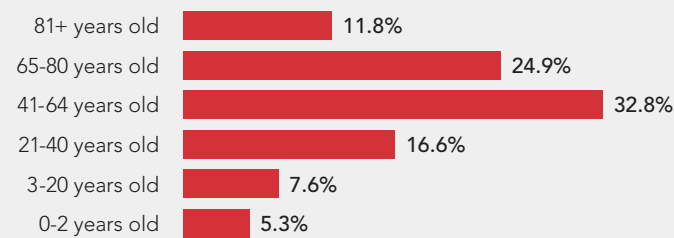
EXAMINING THE DATA

In the CNA [Hospital Professional Liability Claim Report 2015: Stepping up to Quality Healthcare and Patient Safety](#), almost 37 percent of the 591 closed claims involve injury to patients 65 years and older, with patients aged 65 to 80 comprising the second highest claimant age category. (See Figure 1.)

Falls, pressure injuries and medication errors are among the most frequent and serious injuries for older patients. Falls account for 9.9 percent of death-related claims (see Figure 2), with three of the reported deaths occurring on a geriatric behavioral health unit. Hospital-acquired pressure injuries contribute to the 23.6 percent of deaths attributed to overall improper care. Medication-induced fatalities are the third-highest category of death-related allegations, including medication errors that resulted in cardiopulmonary arrest.

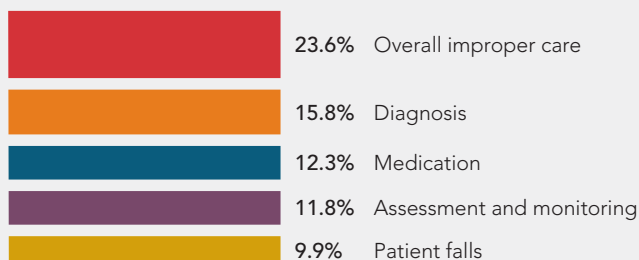
In addition to the very substantial human cost of these occurrences, related claims involving older patients can be quite expensive: CNA claim data indicate an average paid indemnity of \$152,911 for actions involving patients 65 to 80 years old and \$143,018 for patients 81 and older. Reducing these exposures should be a priority for every hospital. The [sidebar on page 6](#) contains a variety of clinical interventions designed to minimize the most frequent sources of loss associated with elderly patients.

Figure 1 – Frequency of Closed Claims by Claimant Age



* The graph excludes the 1 percent of claims with no age-related information.

Figure 2 – Most Frequent Death-related Closed Claims by Allegation



MITIGATING THE RISKS

At the root of most injuries involving geriatric patients is a care environment lacking the resources, expertise and processes necessary to meet their needs and address their vulnerabilities. The following initiatives are designed to help practitioners deliver high-quality care in specialized settings and foster a safety-focused atmosphere that minimizes the likelihood of harm:

Create specialized acute care units for elderly patients. Patient management on geriatric units has been shown to improve health outcomes and discharge disposition for patients 65 years and older. Specifically, Acute Care for the Elderly (ACE) units produce shorter hospital stays and associated cost savings. In a [study](#) by the University of California, San Francisco, ACE units helped decrease inpatient days from an average of 7.3 to 6.7 days, leading to a per-patient savings of \$974. These findings suggest that ACE units, if utilized on a nationwide basis, could reduce healthcare costs by as much as \$6 billion per year.

Unlike the traditional treatment model, in which an attending physician directs care and specialty providers are consulted as needed, ACE units are based upon interdisciplinary teams – comprising certified geriatricians, geriatric nurse practitioners, resource nurses and physician assistants – who promote a fully collaborative atmosphere. By integrating care management, pharmacy, physical and occupational therapy, social work, speech/language pathology and other disciplines, ACE units offer a more comprehensive plan of care for aging patients and help ensure prompt and appropriate intervention when needed.

In order to function most effectively, ACE units require that certain operational, technical and environmental features be in place, including the following:

- *Electronic health records* that facilitate information-sharing and prompt regular updates from care team members to outside providers.
- *Specialized assessment formats* designed to identify the unique needs of older patients.
- *Communication pathways* that relay team recommendations to primary care physicians, family members and others.
- *Daily team rounds* focusing on patient-centered rather than disease-centered care.
- *Care transition planning* that starts upon admission.
- *Environmental modifications* that promote safe mobility, cognitive stimulation and a homelike atmosphere.
- *State-of-the-art technology* to promote communication among patients, families and medical staff, including digital bedside communication boards and Skype-equipped conference rooms, which permit off-site participation in patient care discussions.
- *Support for those with vision or hearing challenges*, such as large-text clocks and telephone keypads, as well as pocket audio amplifiers.
- *Rooming-in programs for family members*, in order to allay patient anxiety and enable active participation by significant others in the recovery process.

To learn more about creating and sustaining ACE units, see Flood, K. and Allen, K. "[ACE Units Improve Complex Patient Management](#)" in *Today's Geriatric Medicine*, September/October 2013, volume 6:5, page 28.

Increase staff competency in regard to geriatric care. Over the past few decades, numerous geriatric nursing care models intended to prevent common complications in elderly hospitalized patients have emerged. The following models (among others) employ evidence-based, aging-sensitive practice parameters designed to promote interdisciplinary communication, targeted care planning and enhanced discharge management:

- [Geriatric Consultation Team](#)
- [Nurses Improving Care for Healthsystem Elders \(NICHE\)](#)
- [Geriatric Resource Nurse](#)
- [Hospital Elder Life Program \(HELP\)](#)

All of these approaches require significant contributions from nurses credentialed in geriatric care. The following websites contain a range of geriatric-specific clinical resources:

- [Nurses Improving Care for Healthsystem Elders \(NICHE\) Solutions Series](#)
- [ConsultGeri](#), a clinical resource website of The Hartford Institute for Geriatric Nursing
- [National Hartford Center of Gerontological Nursing Excellence](#), Community Resources

At the root of most injuries involving geriatric patients is a care environment lacking the resources, expertise and processes necessary to meet their needs and address their vulnerabilities.

Utilize dedicated emergency rooms as a gateway to readmissions.

Research shows that one quarter of skilled care residents are readmitted to the hospital within 30 days of discharge. According to a 2015 report in [Kaiser Health News](#), more than half of all hospitals are affected by the associated Medicare penalties, resulting in a combined annual loss of \$420 million. In addition to these fines, hospitals pay a staggering [\\$4.3 billion annually](#) in direct readmission costs.

In an effort to curb the rate of readmissions and contain unnecessary expenditures, more hospitals are opening specialty emergency rooms (ERs) designed to cater to older patients' non-urgent ailments. By permitting longer, more intense observation, geriatric ERs tend to produce fewer premature admissions. These specialty ERs typically share the following features:

- A *clinic-like setting* consisting of a relatively small number (usually six to eight) of both observational beds and examination rooms.
- A *specialized treatment team* of geriatric-certified caregivers.
- A *shared triage space*, where older patients undergo regular emergency department triage before admission to the geriatric ER.
- *Triage guidelines* for admission to the geriatric treatment area (e.g., patient is over 65; responds to name; was walking before the day of the ER visit; and is ranked three, four or five on an emergency severity index that ranges from one to five, with one being the sickest).
- *Telemedicine capabilities* that permit two-way video communication among ER physicians, aging services providers and residents, in order to facilitate prompt assessment. (To learn more about how a telemedical service can benefit both aging services settings and hospitals, see Seegert, L. "[How Nursing Facilities Use Telemedicine to Reduce Hospital Readmissions.](#)")
- A *modified clinical environment* designed to enhance elderly patient safety (e.g., nonskid floors, rails along walls, reclining chairs, thicker mattresses).
- *Touch-screen technologies*, such as "GeriPads," which permit patients to have a two-way video conversation with a nurse, or to request food, pain medication or assistance.

Despite the best interventions, some readmissions are inevitable for hospitals that serve a large population of elderly patients, especially those who present from aging care settings. When such transfers occur, hospitals are encouraged to initiate the transition process with aging care partners well in advance of discharge.

This practice facilitates the sharing of critical information, which in turn helps aging services settings provide residents with more appropriate care and may reduce future readmissions. For an overview of the transfer process, see the [sidebar on page 7](#), as well as *CareFully Speaking*® 2012–Issue 3, "[Transitioning Residents: Reduce Hospital Readmissions by Improving Information Flow, Standardizing Procedures.](#)"

Proactively assess the risk of functional decline in older patients.

The functional status of elderly patients, as measured by degree of impairment with activities of daily living, is a strong predictor of hospital length of stay, discharge destination, readmission rate and mortality. Therefore, any program designed to enhance clinical outcomes for older patients should include a protocol for early and accurate detection of those at greatest risk of decline.

The following standardized assessment formats (among others) can assist clinical staff in gauging functional decline:

- [Barthel Index of Activities of Daily Living](#)
- [Hospital Admission Risk Profile \(HARP\)](#)
- [Katz Index of Independence in Activities of Daily Living](#)
- [The Lawton Instrumental Activities of Daily Living Scale](#)
- [Triage Risk Screening Tool \(TRST\)](#)

The choice of assessment tool depends on ease of use, the nature of the patient population and compatibility with the hospital's care-planning process. Conversely, the most effective, risk-mitigating care plans are those that reflect ongoing monitoring, evaluation and documentation of patients' changing functional status and needs. Specifically, care plans should address the following areas, among others:

- *Chief findings* of baseline and ongoing functional assessments.
- *Need for daily rounds* with a multidisciplinary team.
- *Care measures designed to minimize the adverse effects of higher-risk procedures* – such as urinary catheterization and invasive diagnostic studies – and also of medications that may induce cognitive impairment.
- *Protocols aimed at improving self-care*, as well as continence, nutrition, mobility, sleep, skin care and cognition.
- *Training and reinforcement in the safe use of environmental enhancements*, including handrails, walkers, call buttons and elevated toilet seats.

For guidance in setting and achieving measurable goals for patients with identified levels of functional decline, see [“Reducing Functional Decline in Hospitalized Elderly.”](#) (Kleinpell, R. et al. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, Chapter 11. Rockville, MD: Agency for Healthcare Research and Quality, 2008.)

One of the key challenges for all hospitals is to provide a safe, therapeutically effective environment for elderly patients. The measures suggested here can serve as a useful first step in the process of evaluating and enhancing geriatric care, thereby reducing risk. To learn more about improving outcomes for aging patients, see [“Rapid Reengineering of Acute Medical Care for Medicare Beneficiaries: The Medicare Innovations Collaborative.”](#) an initiative designed to encourage hospitals and healthcare systems to adopt evidence-based models of geriatric care. (Leff, B. et al. *Health Affairs*, June 2012, volume 31:6, pages 1204-1215.)

The functional status of elderly patients, as measured by degree of impairment with activities of daily living, is a strong predictor of hospital length of stay, discharge destination, readmission rate and mortality.

QUICK LINKS

- [Hospital Readmissions](#), a resource website sponsored by the American Health Care Association.
- Karstetter, B. [“Reducing Readmission Rates from Skilled Nursing Centers.”](#) *Revera Health System’s Healthcare Update*, 2011.
- Resnick, B. [“Hospital Care and the Elderly.”](#) *Merck Manual*, October 2013.
- [“Retooling for an Aging America: Building the Health Care Workforce.”](#) A special report from the Institute of Medicine’s Committee on the Future Health Care Workforce for Older Americans, 2008.

Essential Interventions to Prevent Common Injuries in Elderly Patients

INJURY CATEGORY	CLINICAL INTERVENTIONS
Adverse medication errors	<ul style="list-style-type: none"> ■ <i>Implement safeguards against polypharmacy</i> by performing a documented review of all clinical indications for medications. ■ <i>Combat potential drug toxicity</i> by adjusting doses based on comorbidities as well as age, and by measuring serum drug levels and creatinine clearance for renally excreted drugs when doses are adjusted. ■ <i>Avoid contraindicated drugs</i> by adopting computerized physician order entry systems equipped with physician-support software. ■ <i>Prevent medication errors</i> by utilizing bar-code technology at the point of dispensing.
Falls	<ul style="list-style-type: none"> ■ <i>Conduct and document a falls risk assessment upon admission and on a quarterly basis thereafter</i>, as well as after a fall and any change in condition. ■ <i>Utilize ergonomic aids</i>, such as mechanical lifts and height-adjustable beds, to assist in transferring patients at risk for falls. ■ <i>Limit use of physical restraints and psychoactive pharmacotherapy</i>, adhering always to institutional policies and relevant regulations.
Functional decline	<ul style="list-style-type: none"> ■ <i>Conduct a geriatric functional decline risk assessment</i> and document the findings. ■ <i>Formulate effective strategies to increase mobility</i>, such as structured exercise programs, walking sessions and resistance strength training. ■ <i>Avoid inappropriate transfers</i> by identifying early in the hospitalization any need for rehabilitative and post-hospital care. ■ <i>Conduct ongoing assessment of cognitive status changes</i> and address chronic or episodic confusion and delirium within written care plans.
Hospital-acquired infections	<ul style="list-style-type: none"> ■ <i>Strictly adhere to respiratory etiquette</i> and ensure that visitors are aware of the protocol through signage and written material. ■ <i>Follow aspiration precautions</i> and document compliance in the patient health record. ■ <i>Minimize antibiotic resistance</i> by avoiding broad-spectrum therapies. ■ <i>Monitor the duration and continued appropriateness of catheters</i> and other indwelling instruments, a leading cause of inpatient infection.
Pressure injuries	<ul style="list-style-type: none"> ■ <i>Conduct and document a skin assessment upon admission</i> and create a plan for prevention of skin breakdown. ■ <i>Address toileting needs</i> and management of urinary and/or fecal incontinence within written care plans. ■ <i>Have dietary services perform a nutritional assessment upon admission</i>, and develop dietary recommendations to enhance nutrition and hydration during the hospital stay. ■ <i>Include a schedule for patient mobility within written care plans</i>, as well as a routine for turning bedridden patients. ■ <i>Utilize specialty mattresses</i> for patients at higher risk of developing pressure injuries.

Transitional Care Readiness

PATIENT IDENTIFICATION

- Patients are assessed upon admission, and those who may benefit from the transitional care model are identified.
- Criteria for inclusion are documented in the patient's health information record, including:
 - Age (e.g., 80 or older)
 - Documented functional deficits
 - Cognitive disability
 - Polypharmacy (e.g., six or more medications)
 - Comorbidities (e.g., four or more chronic conditions)
 - Hospitalizations (e.g., two or more in past six months)
 - History of noncompliance with stated plan of care
 - Inadequate social/family support

COMMUNICATION PATHWAYS

- An established protocol outlines the ongoing exchange of transitional care information between hospital staff and the patient, family members, primary care providers, aging services settings and/or other caregivers.
- There is a two-way flow of information, with all parties having the opportunity to ask questions, provide clarification and offer feedback in regard to diagnosis, treatment, hospitalizations and consultations.

CASE MANAGEMENT

- A dedicated transition coordinator facilitates communication between providers and settings, including discussions concerning diagnosis, plan of care, transition timeline and pending discharge status.
- If discharged home, the patient's primary care provider is prominently identified in the health record, and a follow-up visit is scheduled.
- In the event of transfer to an aging services setting, a verbal confirmation of the pending move is secured from facility administrators 24 hours prior to transfer, and family members and the patient's physician are notified of the pending transfer.

FAMILY INVOLVEMENT

- Family resource needs and health literacy levels are assessed and mutually acceptable goals regarding the patient's transition are established and documented.
- Family members are promptly notified in writing of any change in functional status or signs that the patient's physical and/or psychological condition may be worsening.

MEDICATION MANAGEMENT

- A written medication reconciliation report (which includes over-the-counter products and supplements) is prepared and shared with the patient and family members, as well as primary care and aging services providers.
- The risk of polypharmacy is assessed, and if indicated, written warnings are conveyed to the patient, family members and providers.
- Prior to discharge home, the patient is taught a practical system for managing medications and asked to demonstrate proficiency in monitoring drug intake.

DISCHARGE PROCESS

- To enhance process consistency, a uniform discharge checklist or transition tool is utilized, which includes the following elements, among others:
 - Written discharge summary and orders
 - Medication list (including last dose taken and stop dates)
 - Pending test results
 - Follow-up appointment(s)
 - Hospital contact information
- Discharge-related information is shared with the patient's family, physician and aging services provider within 24 hours of the transition. These messages are communicated electronically, when possible.

POST-DISCHARGE ACCOUNTABILITY

- Contact is made with the patient and/or aging services setting within 24 hours following the discharge or transfer, in order to monitor the patient's condition and reinforce the transition plan.
- Responsibility for the patient is transferred to a receiving provider, who confirms acceptance of and agreement with the transition plan. This confirmation is documented in the healthcare record.

CNA Risk Control Services

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