Unit 9 Assignment Introduction

One of the times when there is the high risk of miscommunication is during “patient hand-off” among patient providers like nurse practitioners, as they give report among and between other healthcare providers in multiple healthcare and treatment settings.

Think of yourself as the nurse practitioner helping a patient transition from one healthcare treatment setting to another. There are essential elements of effective care transitions vital to ensuring quality in transitions of frail elderly in healthcare transitions that NPs need to know about and implement to ensure safe patient care transitions.

The average annual incidence of care transitions of frail elderly patients from nursing homes to emergency departments ranges on average from 23- 60% in adult patients in the United States who are 65 years of age and above.

Advancing age and acute and chronic disease states complicate care and often results in fragmented care and adverse patient outcomes.

The NP plays a major role in making certain healthcare transitions are smooth, uncomplicated and that the receiving health care provider has critical information to provide optimal care to the frail elderly.

Essential elements of effective and timely care transitions vital to quality patient outcomes include provider verbal and written communications regarding the patient and poorly executed transitions can result in adverse events or suboptimal patient outcomes.

There is no excuse for not meeting the standards of care because a patient is a frail elderly patient. The NP must be accountable to meet standards of care and be certain to advocate on behalf of the frail elderly patient when the patient cannot act on his or her own behalf. Frail elderly patients are not to be forgotten or disregarded because “they are old so it does not matter.”

There are standards of care that include required data to be shared and communicated between the sending and receiving healthcare facility.

There are minimal data sets that should be part of the transition record or discharge summary including but not limited to:

- principal diagnosis
- active problem list
- name and contact information of the transferring healthcare provider
- patient’s cognitive and functional status
- current medication list
- any pending diagnostic test or laboratory tests