

3 hospital admissions, 3 outcomes

By Pat M. Irwin, BA, CSA

“Goodbye, good luck!” As mother, adult daughter and tote bags toddled toward the elevator, two staff members exchanged glances. “Boomerang?” “Afraid so. She’ll be back!”

The terminology may differ, but every hospital unit knows them—the patients who are discharged but, despite everyone’s best efforts, are soon re-admitted with the same health issues, landing right back onto the ward. What causes the boomerang and how can it be prevented?

Mrs. Konkle’s case was complex. She had congestive heart failure causing breathing problems, edema and blistering of the feet and legs, and reduced mobility and stamina. This resulted in depression, lack of appetite and increased withdrawal from friends and social contact. She was admitted to hospital three times, each with very different circumstances, follow-up and outcomes. Let’s look at each admission in detail and see what we can learn.

Admission 1

Mrs. Konkle experienced shortness of breath on a Sunday night while at home alone. After a few hours she reluctantly called 911 and was taken to a busy emergency department. After a lot of confusing, repetitious questions and a very long wait, her immediate problem was addressed with medication. As soon as she was deemed stable she was sent home. She did not retain any information about what had happened or the need for follow-up. It was not until the following week that her family doctor, having received the hospital report, contacted her to make an appointment.

The outcome of this event was poor. Mrs. Konkle seemed to forget the episode, told none of her family or friends and made no adjustments to her daily routine. She continued living at risk, with no help for bathing,



shopping, housekeeping, meal preparation, medication or general health monitoring. Had she thought about supports at all, she would have dismissed any assistance as

being too expensive. Given her history of depression and withdrawal, she was unlikely to research the homecare services available in her community.

So what went wrong? It was no one’s specific fault. Mrs. Konkle’s experience was an everyday occurrence in a busy hospital where seniors with chest pain don’t rate highly at triage and a patient who seems stable is routinely sent home. Public education on resources, their availability and costs might have helped. So

would family assistance, oversight, intervention or assignment of a power of attorney for care. However, since Mrs. Konkle was mentally competent, the family was not required and friends weren’t justified in interfering.

Admission 2

When he finally saw her, Mrs. Konkle's family doctor was concerned and had her admitted. The hospital specialist ordered tests. Mrs. Konkle remained apathetic about her condition, had very little contact with the staff and did not ask questions or even seem to care about her outcome. Her immediate problems (breathing and blistered and seeping legs) were addressed, but no actual cure or long-term treatment plan was explained. Because her bed was in demand and she had been deemed an "alternate level of care," the hospital's policy meant she was discharged to recuperate in the community. She left for home with a referral from the social worker for an assessment when she returned home. This was when the staff members predicted her return.

The hospital had arranged transportation to Mrs. Konkle's house through a "Home at Last" program, which settled her in with basic groceries and comforts. Due to a backlog, however, the social services assessment did not occur for several days.



Although assistance with bathing, wound care and homemaking was gradually initiated, Mrs. Konkle was reluctant to eat or participate in her care. She was depressed and had a sense of hopelessness about her condition. She interpreted this as her "second failure" and was ashamed of not being able to care for herself, but was unwilling to be a part of her own recovery. The depression advanced to point where dementia was suspected and Mrs. Konkle's family doctor contacted her son in another city.

The learning here is to avoid making assumptions about the availability of publicly supplied resources. Delays or shortcomings should be expected and planned for. It would have been useful for

a family member or supervisory figure to have counselled Mrs. Konkle on potential delays. Help from friends or subsidized or private care could have been arranged until assistance from social services was in place. Ideally Mrs. Konkle should have been included in these plans, and prepared both mentally and emotionally for their rollout.

Admission 3

Two weeks later, Mrs. Konkle was once again sent to the emergency department by the wound care nurse, who also contacted her family doctor and son. Determined to find some answers, her son travelled in from out of town. He consulted the internet and hospital staff and located a care manager, whose advice was to set up a team meeting at the hospital. Questions were put to every team member about diet, therapy, lifestyle suggestions and prognosis. Mrs. Konkle's son insisted his mother attend the meeting and encouraged her to ask questions.

When discharge was suggested, another meeting was held. All options were discussed. It was decided to discharge Mrs. Konkle to a retirement home for a respite stay and care from the same wound care nurse. The son



alerted family friends to visit Mrs. Konkle and give moral support, but actual care was provided by retirement home staff. As Mrs. Konkle improved, a capacity assessment was performed. In fact, she did not have dementia; her poor health had mimicked many of the symptoms.

Mrs. K and her son discussed the possibility of her being incapable, made up powers of attorney and reviewed her will. They also thoroughly assessed her financial situation to determine the feasibility of moving to a retirement home. She confessed she had avoided tackling financial matters

since her husband died. It was a relief, she said, to now to have everything "sorted out and written down."

The elements of success

So, let's look at the elements of success that made this third visit to the hospital much more productive and how Mrs K's risk factors on discharge were reduced.

I have taken the elements that contributed to the positive outcomes of the third visit and turned them into a list of helpful tips for families faced with similar situations.

Choose an advocate:

- Approach family members or trusted friends to act as your partner, advocate and even power of attorney for care.
- Think about the commitment this might need.

Consider hiring a care manager for complex or time-consuming cases.

Get prepared:

- Set up a "grab-and go" page for the fridge door with your health-card number, regular medications, major health issues and contact information. This should be clearly labelled "in case of emergency."
- A similar page for your wallet is also helpful in an emergency.

Ask for information and help:

- Although medical staff are busy, they certainly want the best possible outcome

Using a visit to the emergency department to your advantage

It's important to understand how emergency departments are run, the alternatives and some tips for preventing a health crisis. Here are some guidelines:

Visiting the emergency department

Medical professionals advise a visit to the emergency department when any acute change occurs. In the case of an elderly person, this might include trouble breathing, a decline in cognition, a bad fall or perhaps excessive bleeding when taking blood-thinning medications such as aspirin.

Rather than driving yourself or a loved one, you may wish to call 911. The emergency medical services will arrive quickly and assess and stabilize the patient. They'll advise on whether a visit to the emergency department is required.

Triage

When patients enter the emergency department, they are seen by a triage nurse. This nurse determines

the urgency of their condition using a five-level assessment tool known as the Canadian Emergency Department Triage and Acuity Scale. For example, level 1 patients, who are in a critical unstable condition, such as cardiac arrest, must be seen immediately. Patients are therefore treated based on the acuity of their condition, not their arrival time or the fact that they arrived by ambulance.

Geriatric emergency nurses

A new innovation in many emergency departments is the geriatric emergency management (GEM) nurse. This is a practitioner who will make a full geriatric assessment, including of the patient's physical condition, cognitive level and home support. GEM nurses can diagnose, order tests and prescribe, working in consultation with a physician and the emergency team. Their goal is to treat seniors and to discharge them with a care plan that will ensure better long-term health to prevent future crisis visits.

Keeping track

Be sure information is collected, updated and accessible, including medications, pharmacy name, family doctor's name, medical history, valid health card (photo-ID health cards have expiry dates) and updated contact names and phone numbers. Attend medical appointments with your parent or family member, meet their doctors and learn about their medical conditions.



for their patients. Don't assume they know your concerns. Ask questions about your problem, follow-up instructions, available services and sources of assistance.

- Write down your questions with space for answers. This will help organize your thoughts and information.

Find and use the help in your community:

- Every community has a maze of public, subsidized and private assistance that can be daunting. Enlist the help of the Ministry of Health to understand and explore all your options.
- Consider services that require private payment.
- Review alternate funding sources such as Veterans Affairs, private insurance and workplace benefit plans.

Recognize the realities of community care resources:

- Publicly funded agencies are chronically overworked. Expect and plan for delays in services.
- Understand public agencies' procedures, wait times and constraints. Make your contacts allies, not an adversaries.

Create a transition plan:

- Examining the options and making a plan gives everyone a sense of order.
- In Mrs. Konkle's case, a sensible transition was a respite placement in a retirement home (This gave Mrs. K a full level of care, company, recreation, meals and ongoing support and monitoring.).

Manage expectations:

- All parties, including the patient, family, hospital care team, home caregivers or retirement home staff, are motivated to ensure the best outcome.
- Foster an atmosphere of open communication and mutual respect.

After three weeks, Mrs. Konkle's son said goodbye en-route to the airport. From the parking lot he could see his mother's profile outlined by her reading lamp as she tucked into a favourite Maeve Binchy novel. ●



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