UNSAFE TRANSFER TO SKILLED NURSING FACILITIES

CASE DETAILS:

Patient #1: 50 y/o with spinal osteomyelitis and epidural abscess underwent spine surgery. Patient was discharged to SNF for a 4 week course of Vancomycin and Ceftriaxone. The discharge summary did not include a plan for vancomycin monitoring and the patient was readmitted to UCSF with new acute kidney injury attributed to supra-therapeutic levels of vancomycin.

Patient #2: A 60 y/o with paraplegia was admitted for surgical flap of a sacral pressure ulcer. Her 40 day hospital course was complicated by new pulmonary emboli. She was started on enoxaparin and transitioned to a stable, therapeutic, dose of warfarin. The patient was transferred to SNF for ongoing wound care, however warfarin was omitted from the discharge medication list and summary. The SNF MD noted the omission on day #6 and reinstated enoxaparin and warfarin.

ACTIONS TO IMPROVE SNF TRANSFER:

A Post-Acute Strategies team is building systems and collaborations to improve transitions for UCSF patients discharged to SNF. Highlights and best practices include:

- A dedicated group of hospitalists is now caring for UCSF patients at Kindred Lawton and Tunnel.
- Verbal MD to MD sign out is required for transfer to the Jewish Home, Laguna Honda, Kindred Lawton and Tunnel. Case Managers will provide contact information.
- Discharge summaries should include:
  - Accurate med list (med rec must be reviewed and discharge summary refreshed/updated on day of discharge)
  - Clear instructions for labs, monitoring of medication levels (e.g. vanco trough, INR), wound care, mobility restrictions
  - Documentation of code status and goals of care.
  - Follow up plans with PCP, surgeon, specialists
  - Contact information for UCSF provider for questions
- For patients on warfarin use “anticipate warfarin order” to prompt ordering at discharge.

Facts about Skilled Nursing Facilities

- 10% of adult discharges from UCSF go to a SNF or rehab facility
- Patients must have a skilled need to qualify for (and to remain at) a SNF. Skilled needs include:
  - Rehab (PT, OT or SLP)
  - Nursing (wound care or IV abx)
- Most patients discharged to a SF SNF from UCSF go to Jewish Home, Kindred Lawton, Kindred Tunnel and Laguna Honda.
- SNFs are highly regulated, particularly with respect to use of antipsychotic medications and POLST documentation.
- 30-50% of patients have a SNF LOS < 2 weeks
- At UCSF 30 day readmission rates from SNF are higher than readmission rates for other patients.

SAVE THE DATE

Patient Safety Grand Rounds
March 13, 2014; 12-1p
HSW 302 & MB site

Noted Speaker: John Nance JD
Topic: The Goal of Doing No Harm: Key Strategies for Getting to Zero

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Disclaimer: Clinical details of cases have been altered to protect patient & provider confidentiality.