

Defining The Role Of The Nurse In Transitions Of Care Within A Comprehensive Stroke Center

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Defining the Role of the Nurse in Transitions of Care Within a Comprehensive Stroke Center

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Background / Purpose / Methods

Background

Transitions in care are a top priority for the US health care system as well as a core component of the CSC standards. Patients and caregivers are vulnerable due to poor communication and inadvertent information loss. Nurses play a key role in facilitating care from admission to discharge ensuring patients and caregivers successfully transition through a stroke health challenge. Impetus to examine hospital readmission rates has been heightened by public reporting and potential CMS financial penalties.

Purpose

The purpose of this presentation is to describe an interdisciplinary approach utilized in planning care transitions supporting successful discharge of patients. Our experience as a recently certified CSC identified opportunities for improvement as we examined stroke care transitions.

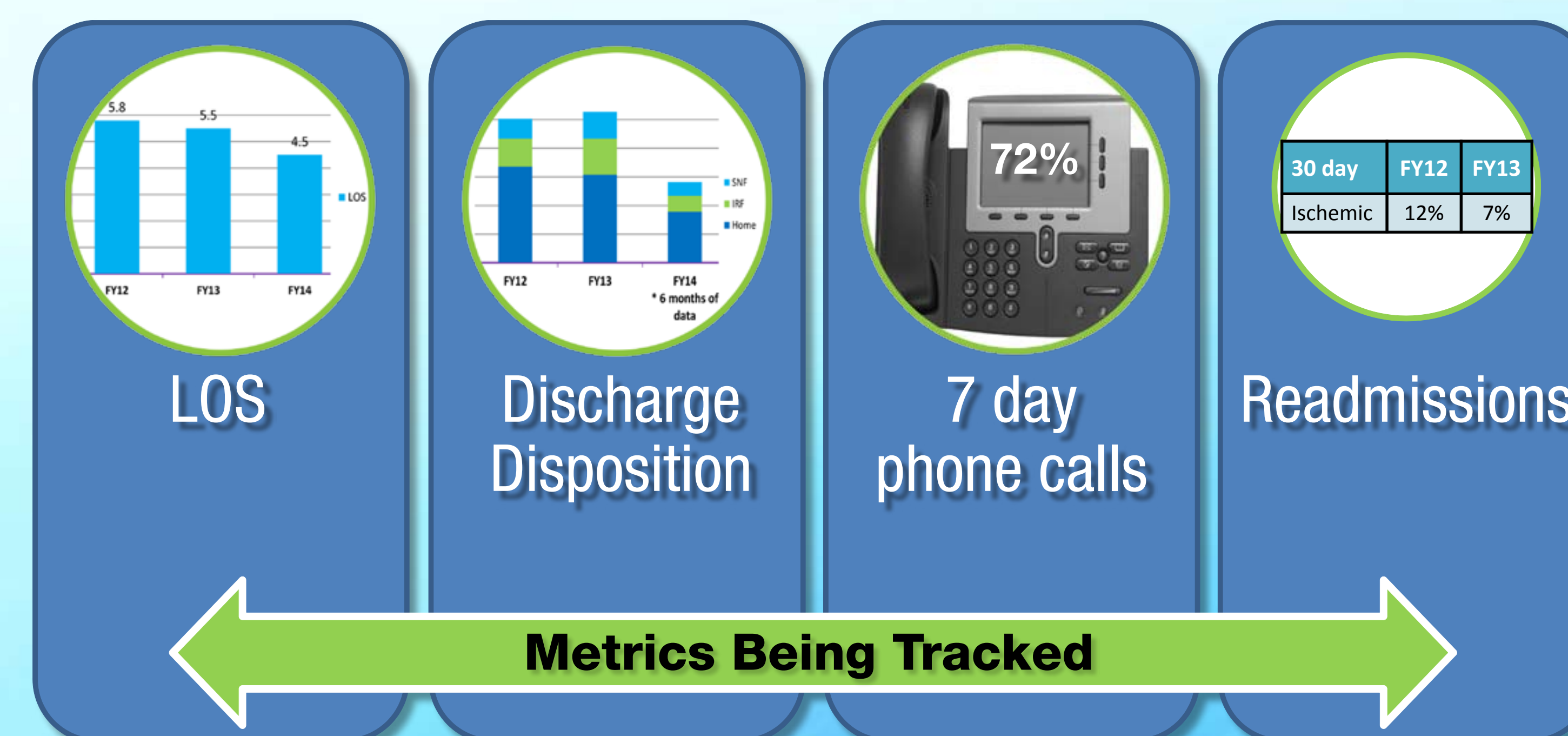
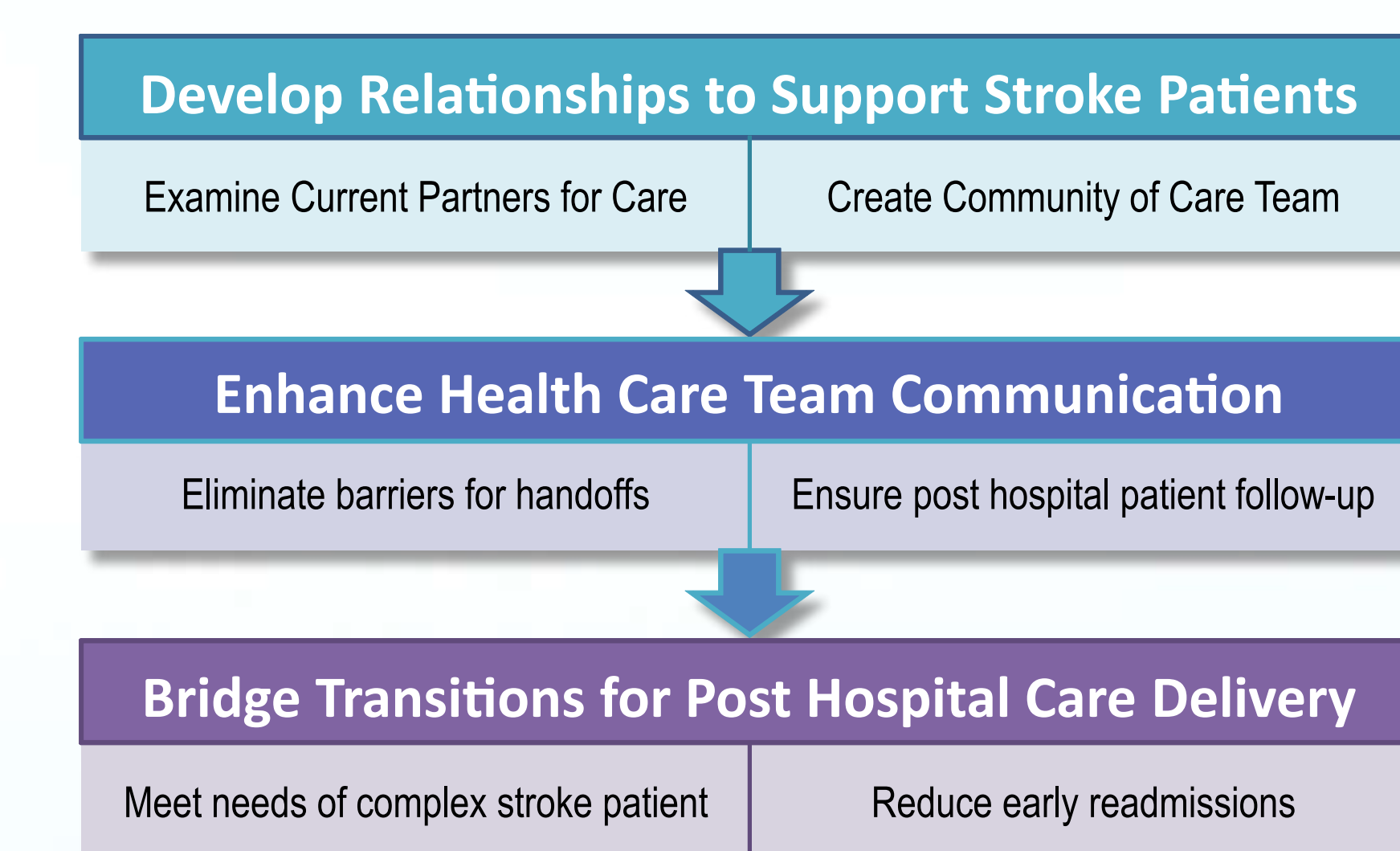
Methods

A Stroke Continuum Subgroup was formed including key stakeholders from partnering rehab facilities, inpatient rehab, home care, and stroke inpatient units with a specific focus to examine care transitions. Focused efforts evaluated resources provided for discharges with emphasis on patient and caregiver assessment, caregiver preparedness, and educational materials. Areas that were developed to support transitions included: development of standard resources to support caregivers including respite needs, daily discharge huddle to identify potential home needs and 7-day phone follow-up process. Metrics tracked and reported quarterly included length of stay, discharge disposition, number of patients reached with 7-day call, number of caregivers provided post-discharge educational materials and readmissions.

Stroke Care Continuum Stakeholders



Benefits of Collaboration



Review & Evaluate Joint Commission Standards

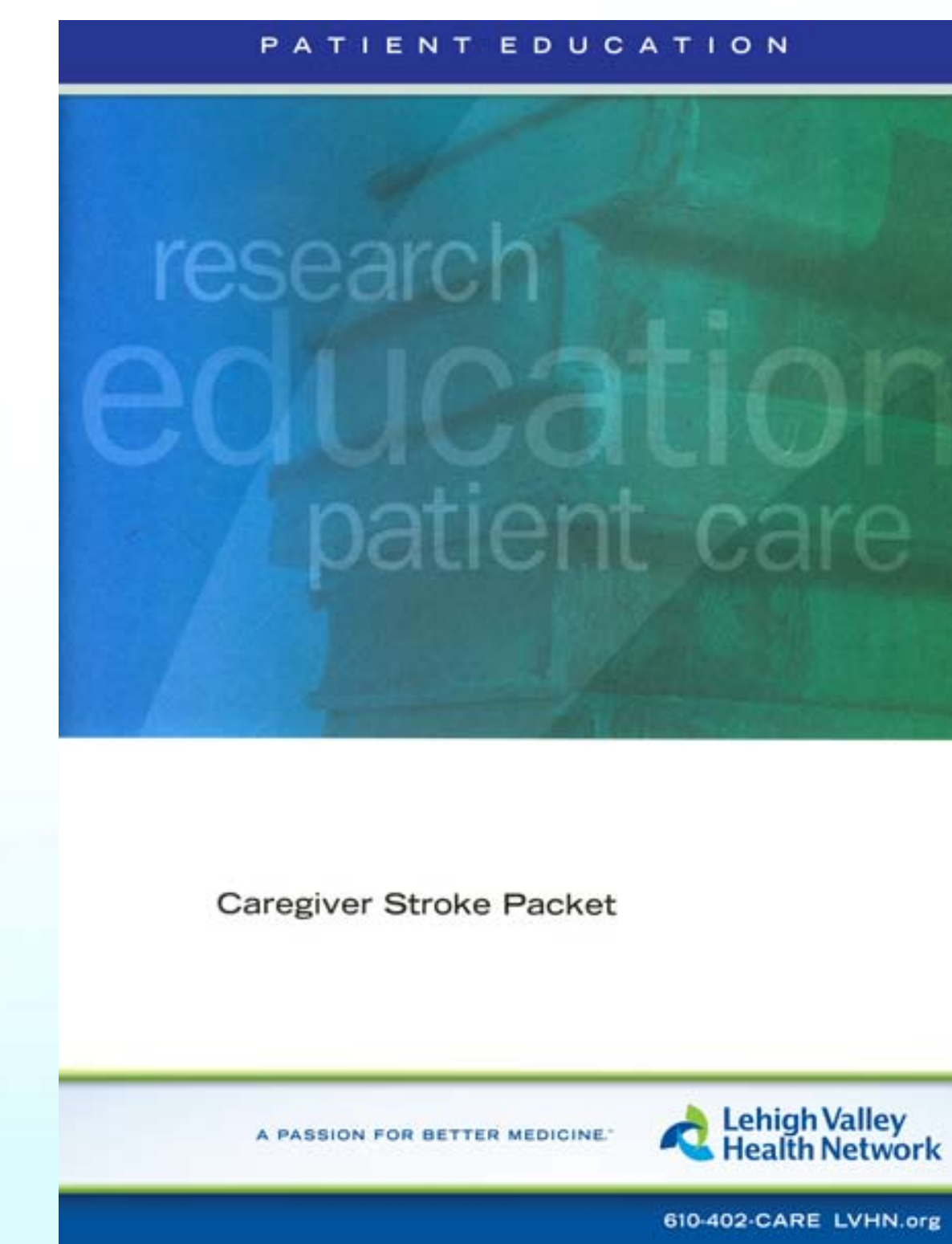
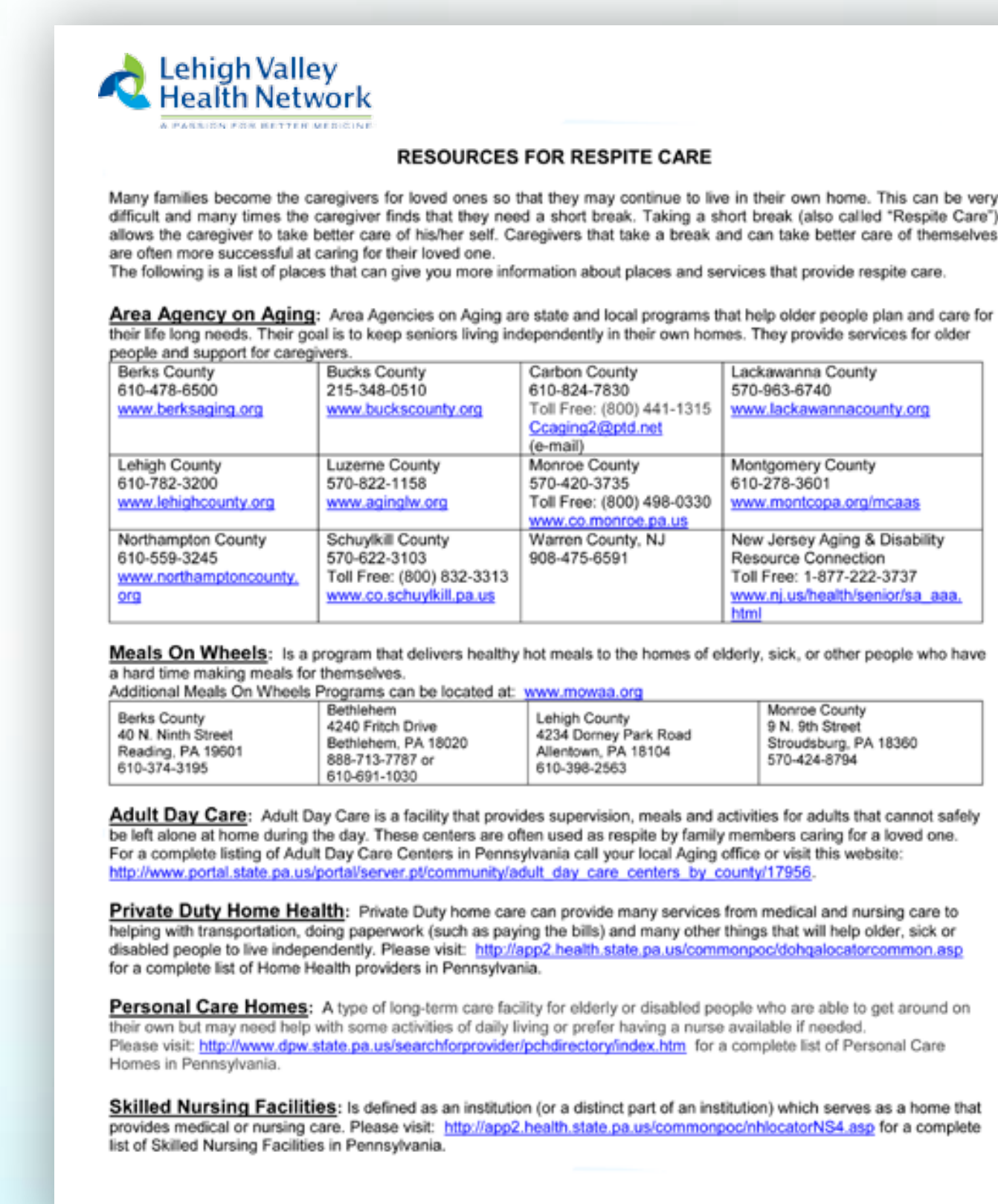
- Patient and caregiver needs
- Transition communications needs
- Collaborative care planning to meet needs of complex stroke patients
- 7 day phone follow-up post discharge
- Delineate responsibilities within stroke stakeholder team

Goals of Team

- Improve care coordination across disciplines and settings
- Share evidence-based practices
- Promote staff education
- Strengthen and standardize communication hand-offs
- Share data collected on processes and outcomes

Projects Completed

- Standardize Transfer Checklist and RN-RN Report at receiving facility
- Staff exchanges - RN Immersion Project
- Improve access to EMR for referral facilities to facilitate continuity of care
- Share department specific stroke performance improvement projects (fever, UTI, mobilization, DVT, Neuroimaging)
- Develop and implement Caregiver Educational Packet
- Develop and implement Respite Information Sheet
- Develop and implement 7-day phone follow-up
- Educational Outreach areas and post hospital care settings



Results

Developing interdisciplinary relationships promoted improvements in communication that directly led to improved patient transitions related to follow up care, medication reconciliation and sharing of clinical information to promote continuity of care. At one year out we are capturing 72% of patients discharged home with a structured post-discharge phone call which continues to identify opportunities to assist with scheduling follow up care, support early recognition of post stroke depression and ensure caregivers utilize respite resources. Our 30 day readmission rates in our ischemic stroke patients decreased to 7%, an overall 5% reduction from previous year.

Conclusion

Assessment of patient and caregiver needs after discharge can be difficult and requires a coordinated multidisciplinary effort with multi-prong interventions. Development of a Stroke Care Continuum team allowed the CNS and Stroke Director to work with both inpatient and outpatient stakeholders.



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