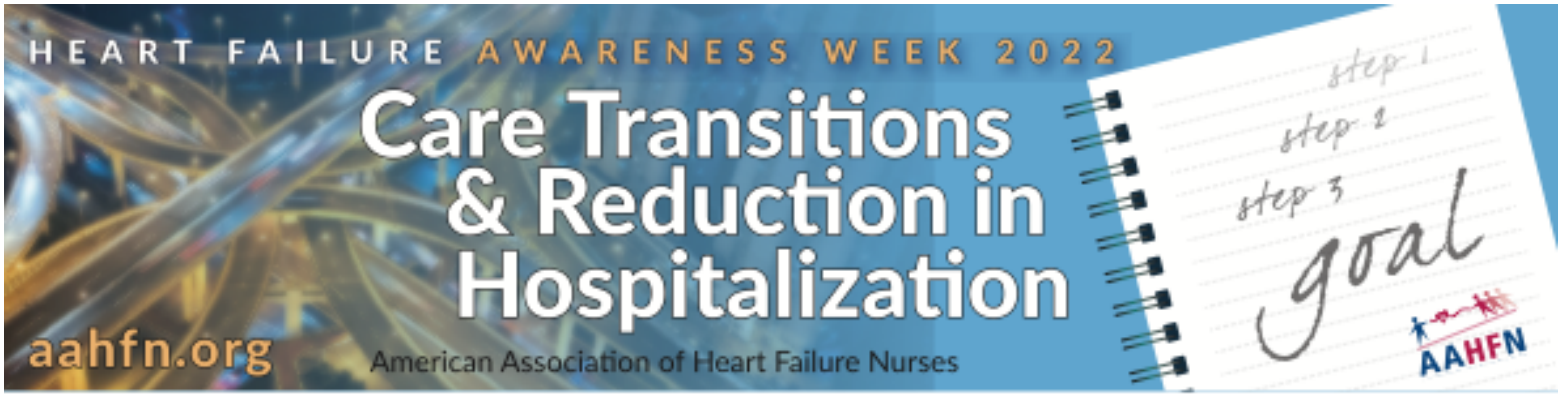


Supporting Care Transitions

Nurse Tip Sheet

Developed by AAHFN as a resource in supporting a safe care transition for the Heart Failure (HF) patient

Background:

A proactive system of care transition improves outcomes, decreases costs and length of stay and helps prevent patient decompensation and hospital readmission. Effective transitional care interventions enable nurses to identify potential gaps and barriers in the next care setting.

Transferring Care and Transitional Considerations:

Care transitions are optimized when nurses prepare patients and their caregivers for the next care setting and provide crucial information to the receiving providers. Effective transitional care requires actions designed to achieve continuity of care for HF patients.

Challenges During Care Transitions:

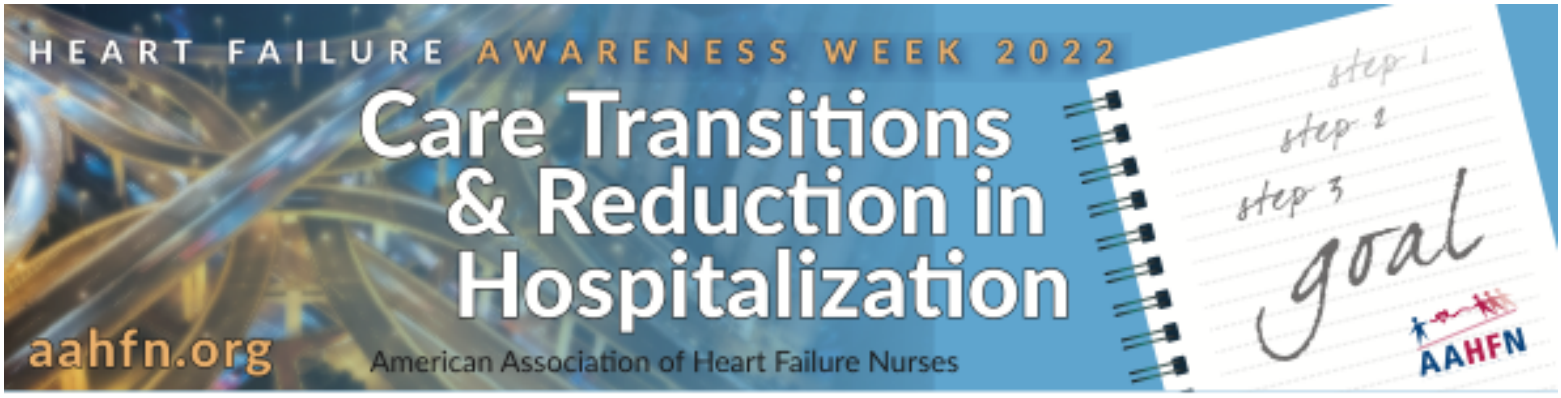
Heart Failure ranks among the most frequent diagnoses for all-cause readmission rates. Strategies that can help reduce hospital readmission and promote safe patient transfer from one level of care to another include:

- Strong community partnerships
- Multidisciplinary involvement
- Timely discharge summary completion
- Comprehensive medication reconciliation
- Identification of high-risk patients

Polypharmacy occurring during care transitions can place HF patients at high risk for adverse drug events and hospital readmissions. Medication reconciliation should occur at each patient transition point and change in care level and should include a review of medications.

Transitional Care Settings and Receiving Healthcare Providers:

- **Home with Self-Care/Family:** Primary Care, Cardiology Team and Care Transition Coach/Navigator
- **Home with Home Health Care:** Primary Care and/or Cardiology Team and Home Health Care Agency Director of Nursing and Skilled Service Providers (RN, PT, SW) and Care Transition Coach/Navigator
- **Skilled Nursing Facility (SNF):** Director of Nursing /RN at SNF receiving patient
- **Extended Care Facility (ECF):** Director of Nursing /RN at ECF receiving patient
- **Hospital/Long Term Acute Care Hospital (LTAC):** Nurse Manager/RN of Unit/Floor/Room of receiving hospital
- **Hospice Care (Life expectancy <6 months):** Primary Care and Hospice Agency Staff. Hospice care can be provided in the patient's home, nursing home/SNF/LTAC, a hospice facility, or specialty hospice units.



Communication among all involved providers is essential and should include:

- Patient's clinical data, events during hospitalization, and a care plan for the first 30 days after hospitalization
- Echocardiogram results and Diagnostics
- LVEF (MUGA, Cardiac Cath, Echocardiogram, Nuclear Scan)
- NYHA functional class
- Type of HF (HFpEF vs. HFrEF)
- Lab values (BUN, creatinine, potassium, sodium, glucose, and hematocrit)
- Physical exam findings
- Events during hospitalization
- Patient cognition (delirium or dementia)
- Family/patient decisions about treatment plan
- Follow-up laboratory tests
- Current medications including any recent changes to regimen
- Changes in clinical status including symptoms and physical findings
- Vital signs
- Discharge weight, target weight range (euvolemic/dry weight)
- Symptom management interventions that have been attempted
- Guideline Directed Medical Therapy
- Activity tolerance, exercise capacity, ADL's at time of transfer, and baseline function
- Contact information (family/next of kin, guardian, durable power of attorney)
- Code status
- Educational needs

Preventing Hospital Readmission – Provide Patients with the following:

- Recognizing personal HF symptoms and who to call with new or worsening symptoms
- Medication list (including how and when to take and what side effects to report)
- Weight log to record daily weights after transition (ensure patient has a scale)
- Low sodium diet (healthy meal alternatives when eating out, spices that add flavor, key food label information, daily sodium allowance)
- Activity recommendations
- Information on follow-up appointment (ideally within 7 days after hospital discharge)
- Key healthcare provider contact information
- Tips for addressing emotional health and coping skills
- Home care as appropriate and additional resources in the community
- Arrange a phone call to take place 24–72 hours after hospital discharge
- Discharge Education for HF Patients Going Home (*Heart Failure Passport to Self-Care*)
- Specific education about HF, recommended lifestyle modifications, and self-management strategies to facilitate self-care.
- Use the Teach-Back method to assess patient understanding
- Integrate Motivational Interviewing techniques with the Teach-Back method to facilitate patient engagement and accountability
  - **Please refer to the *Teach Back Method Videos* on the AAHFN Website to reference the Discharge Management video**