Geriatric High Risk Rounding

Situation:

- Geriatric Nurse Specialty Team in place
- Consult within 24 hours of admission to provide care team with risk picture of patient:
    - Risk for hospital acquired adverse events and poor outcomes
    - Risk for care transition issues/ readmission
    - Risk of poor quality and safety in the continuum beyond the inpatient stay
- Focus on evidence based practices
- Bedside staff resistant to following recommendations

Background:

- Level 1 Trauma Center: staff very prideful- difficulty sharing ownership of patients
- Geriatric Nurse Specialty Team in place for 3 years prior to this rounding
    - Communicated and documented recommendations to bedside nursing and case management
    - Recommendations largely not followed or acknowledged
- Noted need for change in workflow/ re-branding of geriatric specialty team- researched different rounding concepts, styles, methods, and risk tools

Action:

- Established rounding process- patient centered model, rounds happening at the bedside and including the patient
- Our format was risk, recommendation, rationale, recommendation
- Encourage discussion to happen at the evidence level
- Removed from high risk status if condition changed such that high risk no longer present OR if recommendations are being followed even if patient remains in a high risk situation
- Emailed managers about good catches, high levels of engagement, and particularly good staff with rounding processes
- Entered adverse reactions/ outcomes from not initiating recommendation in our incident reporting system and also emailed managers about those cases as well

Results:

- 1st discovery- medication reconciliation, helped hospital identify larger issues with this process, initiating med techs due to discovery
- Fewer in restraints, out of restraints quickly now if initiated
- Initiating home behavior meds/removing behavior meds for delirium when appropriate more often
- Mobility still a challenge!

Sample of Recommendations associated to Risk:

See high risk rounding note template

Geriatric Nurse Specialist High Risk Rounding Note

Problem list

Today (patient name) is at high risk for {debility, deconditioning, delirium, falls, readmission} because ***.

This team recommends { seek IV discontinuation/ saline lock, seek telemetry discontinuation, no bedpans, remove indwelling catheter at first possibillity, toileting schedule/ timed toileting, sitting on edge of bed for all meals, up in chair for all meals, wash up/ ADLs in chair, wash up/ ADLs in the bathroom, walk to bathroom for toileting, walk in hall (minimum 50 ft, minimum 100 ft, minimum 200 ft, lap around unit) at least 3 times per day, advance levels through Hurley's Progressive Mobility Protocol, use chair alarm when in chair, use bed exit alarm 24/7} to promote activity level that will lower risk for decline, deconditioning, fall with injury.

This team recommends {use hearing aid, use glasses or visual aids, encourage care partner/ family member to spend time at bedside and stay the night if possible, place orientation sign at bedside and/ or doorway, avoid transfer or relocation between sunset and 0800, orient toward daytime and nighttime- open blinds during the day and close them at night, reorient to time, date, surroundings, and situation as necessary and at least every shift} to lower risk for delirium.

This team recommends {offer warm drink/ warm milk at hour of sleep, offer relaxation channel at hour of sleep, quiet time/ low stimulation/ limit noise, lower lights in room and hallways at hour of sleep, offer roommate headphones at hour of sleep, avoid unnecessary interruptions to sleep, initiate out of bed/ rest schedule to promote ability to rest at night, bring favorite pillow/ blanket/ comfort item from home} to allow for best possible sleep while hospitalized thereby decreasing both risk for delay in discharge and delirium.

This team recommends {that restraints be removed at first possible opportunity, seek IV discontinuation/ saline lock, seek telemetry discontinuation, implement toileting schedule/ timed toileting, assess for pain, assess for hunger/ provide food regularly, assess for thirst/ provide sips of fluid with each hourly round, use bed alarm 24/7, use chair alarm when in chair, use hearing aid, use glasses or visual aids, have patient spend time at nursing station with staff, encourage care partner/ family member to spend time at bedside and stay the night if possible, place orientation sign at bedside, cover abdominal tubes with binder, cover IV sites with burn netting, advance through Hurley's Progressive Mobility Protocol, offer diversional activities, use spiritual care support} to reduce need for restraints thereby lowering risk for delay in discharge.

This team recommends { assess for hunger/ provide food regularly, assess for thirst/ provide sips of fluid with each hourly round, sitting on edge of bed for all meals, up in chair for all meals, use glasses or visual aids, encourage care partner/ family member to spend time at bedside and stay the night if possible,

assess for pain, set up tray/ open packages/ cut food into bites, feed patient- food and drink} to promote good nutrition and hydration thereby lowering risk for delay in discharge.

Please provide education with return demonstration/ teachback to ensure understanding re: ***

{Referral, communication} made to case management/ social work re: {discharge plan, promoting discharge, concerns related to discharge plan, ambulatory referrals to (wound care, for equipment, pulmonary rehab, cardiac rehab, outpatient therapy/ rehab, diabetes center, VAAA transition program, caregiver role strain, inability or lack of adherence related to home medication needs, noted or verbalized transportation barriers, limited or lack of resources, limited or lack of support systems, possible need for in-home services, frequent admission to hospital setting/ inability to remain in a community setting}