



CREATING A CULTURE OF QUALITY

Care Transitions Project

The poster will demonstrate care transitions forms developed during the project to improve communication between hospitals and dialysis facilities. It will also include Change Concepts to improve communication. Obtaining access hospital's computer system was considered a best practice by Network staff.

Organization Name: The Renal Network, Inc.

Authors: Raynel Wilson, Quality Improvement Director

Objective, Purpose & Goals: Obtaining information from hospitals in a timely manner after patients are discharged and return to outpatient dialysis has always been a major area of concern for providers. Improving this process requires effective communication between the dialysis unit and the hospital to ensure safe patient hand-offs. Improving communication between the dialysis center and hospital regarding patient information is critical to avoid complications while the patient is hospitalized and is essential for patient safety. For the purposes of this project, the focus was on the communication process between hospitals and outpatient dialysis facilities.

Goal: The primary goal of the project was the development and use of a care transitions form as well as the development of a sound process for communication, data collection & reporting. By the end of the project at least 50% of participating facilities were expected to have implemented the use of a Hospital to Dialysis Unit Transfer Summary to improve communication (care transitions) and safe handoffs.

Intervention: A Focus Group of dialysis facilities were selected to participate in the project consisting of representatives from 30 facilities across Networks 4, 9 & 10, hospital representatives of their choosing, and QIO personnel. The group utilized their knowledge and expertise to identify barriers to communication and recommend improved processes.

The Focus Group developed two model transfer forms for the exchange of information between the dialysis facility and hospital upon admission and between the hospital and dialysis facility at discharge. These forms could potentially be used between dialysis facilities and other healthcare facilities in the future.

Process: Network Quality Improvement staff members developed items for use in the project: 1) A care transitions form, 2) an Excel data collection form, 3) an environmental scan to determine surveillance practices, and 4) a letter of invite for Focus Group facilities. Focus Group members were scanned for their process and queried on effective and ineffective processes.

Evaluation: By sharing their knowledge and processes with the Network, the Focus Group helped to develop a list of Change Concepts for Care Transitions. The Network identified the use of the hospital computer system to obtain information on hospitalized patients as a best practice. Other practices that improved care transitions included communication with the nephrology office; using a care transition liaison staff member to communicate information on hospitalized patients; using a care transitions form to share information; obtaining discharge summaries from the hospital; and telephoning hospital personnel to obtain patient information.

Conclusions and Recommendations: By the end of the project 100% of the Focus Group facilities had adopted some form of a care transitions process. Network staff concluded that gaining access to the hospital computer system was the best method to obtaining information on hospitalized patients. Relying on the transmission of verbal or written communication was less effective. Assisting facility management in obtaining access to their hospitals computer system will be a goal for the future.