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Preparing Patients for Successful Transition to Rehabilitation: Preventing Readmissions

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Successfully transitioning a patient to acute rehabilitation is complicated for patients with multiple comorbidities or who may require a complex hospitalization. It is important that before patients are transitioned to the new setting they are prepared in a manner that ensures they will remain safe in the rehabilitation setting as their activity level increases. There are many challenges within this process, and any one or a combination of many of these could force the patient to return to the acute care hospital. This return penalizes the acute care hospital and is a setback that represents failure for the patient and the rehabilitation team. Some of the common challenges and preparation needed to prevent complications that may lead to readmission are listed below.

Activity Tolerance

Medicare and Medicaid and commercial insurance payers expect the patient to be able to perform 3 hours of therapy upon admission to rehabilitation. If the patient has not been getting out of bed to build activity tolerance during his or her hospitalization, the process of transferring onto the stretcher for transport to the rehabilitation setting may be enough to cause an increased heart rate, decreased oxygen saturation, and increased pain. The patient can decompensate enough from the transfer itself to require immediate return for a workup of a variety of complications such as pulmonary embolus, congestive heart failure, or a myocardial infarction. Encouraging the patient to sit up, transfer to a chair at bedside, and maximize participation with therapy prior to transfer will help the

patient tolerate the actual transition. After the patient arrives in rehabilitation, he or she will be more likely to successfully handle the demands of rehabilitation. The nurse in the acute care setting can coordinate efforts with therapy by communicating the patient's tolerance for certain activities and helping to improve activity around the therapy schedule.

Pain

Transitioning from intravenous (IV) pain medication is required before the patient is transferred to rehabilitation. IV pain medication is not appropriate in the rehabilitation setting because of its sedating effect and the fall risk that accompanies the medication. Longer acting oral or transdermal pain medication is necessary to allow activity while maintaining motivation and maximizing the patient's function. To ensure pain is successfully managed when the patient is transferred and performing therapy, it is recommended that he or she be placed on oral pain medication 2 days before leaving the acute care setting to make sure it is adequate. Patients may not experience the full intensity of their pain if they are inactive in bed. Attempting increased activity prior to transfer will demonstrate whether the patient's pain is properly managed.

Bowel

If the patient has had bowel surgery, a colostomy, or an ileus during their acute stay, ensure a bowel routine that will adequately demonstrate the patient has a functional bowel prior to transfer. Complications of a blockage or ongoing ileus will require transfer back to acute care for treatment and management. If the patient has had back surgery or has any

potential for spinal cord injury, severe constipation or loss of bowel control may indicate a complication that requires further diagnostics to properly manage.

Bladder

Many patients develop difficulty voiding after having an indwelling catheter. If the patient has a prior history of retention or inability to void, a consult with urology will help guide the plan of treatment. If not, the catheter may remain until the transfer or must be pulled in time to ensure the patient voids prior to leaving the acute care hospital. Scanning the bladder after voiding will determine if the patient is emptying fully. New incontinence may represent a urinary tract infection or a neurological change. Ensuring any newly developed clinical symptoms are evaluated by the proper specialty will help the rehabilitation team properly plan for managing a patient's bladder complications once he or she is in rehabilitation.

Nutrition and Hydration

A patient who is malnourished will not be able to perform successful rehabilitation. If the patient is unable to eat or drink adequately to sustain their daily requirements, they will need additional support during rehabilitation. Although there are many methods to accomplish this goal, many patients require time to ensure tolerance to enteral formulas. Fullness, diarrhea, and abdominal pain are signs that the patient is not tolerating tube feeding and, unless resolved, may require the patient's readmission for further management. In addition, a patient who can receive nothing by mouth must have a stable

PREPARING PATIENTS FOR SUCCESSFUL TRANSITION TO REHABILITATION: PREVENTING READMISSIONS

method of obtaining nutrition and hydration. Nasogastric tubes are not successful in rehabilitation because of the patient's expected activity level and the frustration and irritation the tube may cause while the patient is trying to regain a sense of normalcy. A properly functioning peg tube is usually the most appropriate long-term method for delivering nutrition during rehabilitation due to the ability to transition the patient to intermittent bolus feedings.

Respiratory

Patients often do not have high oxygen demands when they are immobile. Transferring to a chair can require a need for increased oxygen consumption. If the patient is already on oxygen at 3–4 liters at rest, he or she will likely be unable to maintain proper saturation with exercise. Building tolerance will be critical to allow the patient a successful transfer to rehabilitation. Shortness of breath and dyspnea on exertion represent potential complications, such as an embolus, that will need to be evaluated and treated in the acute care setting (unless it is known as a baseline prior to transfer and the patient is able to tolerate increasing activity). Patients

with tracheotomies will need to be able to tolerate increased activity while controlling secretions. If a patient requires frequent suctioning without activity, he or she is unlikely to tolerate the demands of therapy.

Skin Care and Pressure Sores

The patient will be expected to participate in therapy a minimum of 3 hours a day. Therefore, the patient should be able to apply pressure to applicable weight-bearing surface (sacral, feet) areas for sitting in a wheelchair or standing for ambulation during therapy. A patient should be free of wounds or have wounds that are stable enough to withstand rehabilitation unless he or she is being admitted for a wound management protocol.

Medical Stability

Tachycardia, hypoxia, leukocytosis, infections, and poorly healing wounds are all signs that the patient may have an underlying medical condition that will inhibit his or her inability to tolerate exercise. Collaborate with medical and therapy teams to ensure any new medical issues are reviewed and, if needed, treated to help ensure the patient will not need to return to acute care for management of the issues. If a patient has

a peripherally inserted central catheter or midline for ongoing blood work or the administration of IV antibiotics, ensure it is patent and remains intact for transfer. The need for access will likely continue in rehabilitation.

Patient and Family Expectations

One of the hardest parts of the rehabilitation process is being realistic about how much function a patient can or will get back. Some patients will make a full recovery and others will improve but require adaptations to enhance their functional or nonfunctional abilities. The patient and family (caregiver) may need to adjust their expectations and prepare to learn new ways of performing these activities of daily living skills. The patient and family (caregiver) should plan to become involved in some of the clinical and physical care processes during the rehabilitation stay. The therapeutic care participation process may involve all activities of daily living such as meals, grooming, dressing, bathing, toileting, transfers, and mobility. For that reason, a discussion with patients and their families to outline their perceived expectations and identify the primary caregiver is needed to ease transition between settings.

Do you have a transition success story or cautionary tale?

We would love to hear from you and feature your experience in a future newsletter.

Contact mbbenner@connect2amc.com with your ideas.