Quality: The Impact of Rehabilitation Nurses on Patient Outcomes

One prominent feature of the healthcare legislation that is quickly defining the future of rehabilitation in this country is quality. As rehabilitation nurses, we frequently define our own practice and our choice of practice settings in terms of having the opportunity to deliver high-quality care. Although quality is difficult to define, the Center for Medicare and Medicaid Services has now proposed a number of quality measures for rehabilitation hospitals that will be part of the future payment system. “Pay for performance” is no longer a distant possibility; it is a reality that has been mandated in the groundbreaking Affordable Care Act of 2010 (The Patient Protection and Affordable Care Act, 2010).

Quality measures can be positive or negative. A positive measure is the patient’s functional improvement from admission to discharge. A negative measure would be a fall, the development of a pressure ulcer, or a hospital readmission. Translating quality into metrics or numbers is no small task. Given the broad range of patients requiring rehabilitation care and services, their unpredictable and potentially worsening health status over time, and the broad variation of patient attributes, predicting outcomes is complicated. For example, a patient who refuses to comply with a turning schedule designed to help him or her avoid developing pressure ulcers may be negatively impacting their own recovery and may also be affecting the financial reimbursement that the hospital receives. We are often held accountable for outcomes; at the same time, we may not have any control over important variables such as patient compliance.

Rehabilitation nurses who practice across the continuum of care know firsthand that patients often move from one level of care to another, incurring complications that carry over to the next setting, whether that is at hospital or at home. How do we account for complications that originated in a previous setting but erupted on our watch? An unstageable pressure ulcer is one example of such an event. Nurses at every level of care are expected to conduct meticulous assessments upon admission that focus on identifying preexisting conditions. In the past, that has been important for internal quality tracking; however, in the very near future that activity could potentially determine the payment providers receive for the patient’s care. Although we have many regulations that focus on the continuum of care, such as medication reconciliation, this is still an awkward and often faulty process that may be wrought with missing information. Sharing information across the care continuum is a challenging prospect!

At the center of all of these challenges is nursing. The vast majority of proposed measures are “nurse sensitive” (Agency for Healthcare Research and Quality, 2009). What does this mean? They represent adverse events or complications that are heavily influenced if not controlled by the delivery of nursing care—shift to shift and day to day. Ironically, while nursing care is front and center in the debate about quality, we may often be missing from the table as experts grapple with how to define and measure these events or complications. Among the measures proposed in the 2012 rules for reporting for inpatient rehabilitation facilities in the Patient Protection and Affordable Care Act are catheter-associated urinary tract infections and pressure ulcers. The rehabilitation hospital industry is pushing for three other measures of quality to be considered in the final legislation, specifically falls, deep-vein thrombosis, and pain management. Although we all know that discharge to the community and hospital readmissions will be considered in future reimbursement regulations, there is still a great deal of debate about how to risk adjust these for patient attributes that may substantially impact a feasible community discharge, for example, patients on ventilators or patients who lived in a long-term-care setting prior to their hospitalization.

What does this mean for the rehabilitation nurse and for the field of rehabilitation nursing? First, our practice matters. We often forget the effect our practice has each and every day on patient outcomes. Rehabilitation nurses—whether case managers, direct care providers, or teachers and educators—are central to patient outcomes, either directly or indirectly. It cannot be overstated that one of the primary challenges we face is that care delivery is often in the hands of a group of nurses and a group of nursing assistive personnel, all of whom have a stake in the ultimate patient outcomes. If just one error occurs throughout this chain of care, that may...
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be all it takes for a patient to sustain a pressure ulcer or experience a fall. Now more than ever practice must be evidence based, and the delivery of care must include processes and fail safes that avert gaps in care to avoid potentially devastating effects on the patient. Pay for performance has brought quality to the forefront of the healthcare dialogue because it links a rehabilitation nurse’s paycheck to the delivery of nursing care (Bodrock & Mion, 2008). This new focus is an opportunity to take the specialty of rehabilitation nursing to new levels, and each of us has an important role to play in the world of healthcare reform.

References