The Case

Helen is a 79-year-old woman who lives with her husband in their home. She received a kidney transplant 7 years ago, for which she now takes immunosuppressants and steroids. She also takes more than a dozen medications daily for her multiple illnesses, which include essential hypertension and pulmonary hypertension.

Gait instability and falls have produced several fractures. She continues to drive (much to the dismay of her family) and acts as caregiver for her 80-year-old husband, Jim, who is legally blind from macular degeneration and suffering from early cognitive deficits.

Recently, Helen and Jim both developed a flulike illness, and as a result ate and drank little, resulting in dehydration and weakness. Helen fell on the way to the bathroom and could not get up. Jim fell in his attempts to get his wife up, and then was unable to get up himself. He remained at Helen’s side but without calling for help. The next day, when Helen and Jim did not answer the phone a neighbor checked on them and found both on the bedroom floor. Upon arrival at the emergency department, Jim was noted to be dehydrated. After intravenous fluids, Jim was pronounced as “fine” and was discharged to the care of local family. Helen was diagnosed with congestive heart failure, pneumonia, and dehydration and then admitted to the hospital. Additional findings included delirium and elevated blood glucose, requiring multiple blood tests and insulin administration. Although Helen’s condition improved and she gained strength, she was not able to walk safely.

At 11:00 a.m. on the fourth day of Helen’s hospitalization, someone appeared to tell her she would be discharged at “2 or 3 p.m. today,” the major reason being that she was not making progress in therapy. This was the first indication that discharge was being considered. Helen had received no explanation for her elevated blood glucose except that now she was “a diabetic.” She had received no training in checking her blood glucose or administering insulin at home.

Although the worst of her delirium had resolved, her memory was still suspect.

Multiple frenzied phone calls to a son in California (a geriatric physician) and local family resulted in a decision that Helen could not return home safely. The family’s refusal to allow her to be discharged home resulted in the hospital producing a list of long-term care facilities. With a recommendation from a physician friend of the son, Helen transferred that day for “rehabilitation” under her son’s care of the physician friend. Evaluation at the nursing home revealed that Helen could not walk because of pain in her foot. An x-ray revealed two foot fractures suffered in the initial fall at home.

Helen’s husband was cared for, at home, by an informal committee of friends, neighbors, and family members who took care of housekeeping, food, and safety. Someone drove him to the nursing facility daily, as absences from Helen were unsettling for him.

Helen’s elevated blood glucose proved to be reactive hyperglycemia from a combination of stress, infection, and steroids, which resolved as she improved.

Discussion

Those of us in medicine recognize the hospital as familiar territory. To us, the distances between attending physicians, dietitian, nurse, nurse’s aide, hospitalist, consultant doctor, social worker, and other members of the care team is obvious. More importantly, we understand the essential role each team member plays. To Helen, hospital procedures and the roles of the various members of the health care team were a puzzle.

In the world in which she grew up, all doctors were men and all nurses were women. They were the only people in the hospital who wore white. In that era, patients did what the doctor said without question. Her frame of reference in today’s world was not only out of touch, but in dangerous territory.

The physicians engaged in her care included cardiologists, pulmonologists, nephrologists, and hospitalists. As all these physicians belonged to group practices, she rarely saw the same one twice. Helen did tell “the doctor” about her foot pain. Unfortunately, the main in the white coat was the physical therapy aide walking her. When he said she should let the doctor know about her foot pain, she thought she had. Even if Helen had realized her mistake, would she know which doctor to notify?

Her painful foot caused Helen to perform poorly in therapy, and the missed communication prevented the pain from being addressed. When Helen’s lack of goal attainment in therapy was documented and the discharge planner was made aware, discharge ensued within 24 hours.

Discharge planning must always consider the environmental challenges a patient will face in a discharge location and whether the person will be safe there. In this case, patient-centered care would have included ensuring Helen’s ability to monitor her blood sugars along with the skills to draw and administer insulin (if the diagnosis of diabetes had been accurate).

Helen, for all her frailty, was still the caretaker of a husband with dementia and blindness. A return to that responsibility with her medical issues, would have guaranteed a hospital readmission (or two) in short order.

Takeaways

▶ Discussions between team members would have notified the physician of a therapy concern and initiated an investigation of the source. The therapy aide never reported the painful foot.

▶ True interdisciplinary rounds occur when all care disciplines are represented, all team members are present, and the focus is what the patient needs to reach safe discharge – rather than discharge within a specific timeframe.

▶ Always consider what scenario the patient may be entering from your care site. Helen was a caretaker. Investigation of the home environment, focusing on any mismatches between the patient capabilities and what is required for safety in the home is a key component in the transition conversation.

▶ Although consistently high blood sugars were noted by the nurses and insulin was administered per sliding scale, no diabetic teaching was provided or dietary instruction provided.

▶ Elderly hospital patients do not know the difference between hospital care professionals. Nursing homes may consider using the hospital glossary as a template for a long-term care version.

▶ The passive acceptance of “do what the doctor says” ingrained into this age group is in addition to elders’ tendency to ask few questions.

Helen and Jim’s interaction with the medical system ended up in their being able to resume their prior lifestyle rather than follow the disastrous trajectory so often seen. This was not the result of a supportive, patient-centered process. Instead, it was the product of a son who was a geriatrician with connections in the community and an activated, loving, and local family. Few elders experiencing problematic transitions are this fortunate. The transition process must be constructed to protect those without such a support system.

About This New Column

This is the first installment of Dr. James Lett II’s new column on making hospital and home transitions safer for nursing home residents and saner for long-term care professionals.

In every quarterly column, he will present a difficult care-transition case – what many CARING FOR THE AGES readers will recognize as a too-common “horror story” – and suggest how to avoid problems.

A recent study published in the New England Journal of Medicine found that one in five patients near the end of life and with advanced cognitive and functional impairment is subjected to a “burden-some” and possibly unnecessary transition of care, such as being moved from a nursing home to a hospital. In our February issue, CARING FOR THE AGES reported on the study, “The transfer itself can be traumatic for these easily confused and physically frail patients, and it opens the door to fragmen-

tation of care and medical errors.”

Dr. Lett is a recognized expert on how to avoid such consequences for long-term care residents. He regularly offers training on the topic at AMDA conferences, as he will next month in Baltimore at AMDA’s Advanced Curriculum on Medical Infection in Long Term Care.