Partnering for Patient Safety: A Clinical Nurse Specialist Intervention to Ease the Transfer from ICU

Presented to Dynamics of Critical Care 2010

Lyne St-Louis, MScN, CNCC(C) Clinical Nurse Specialist in Critical Care and Cardiac Surgery
Diane Brault, BScN, MEd
Clinical Nurse Specialist Medicine
Patient Safety and Quality Advisor

Hôpital général juif
Jewish General Hospital
Outline

• Background
• Literature Review
• Process
• Illustrative Cases
• Outcomes
• Conclusion
Background

• The Jewish General Hospital is a 637 bed University Teaching Hospital with numerous outpatients clinics. The JGH serves a multiethnic population that ranges in age from the neonate to the geriatric population.
Background

• The Intensive Care is a 20 bed unit, which receives pre-scheduled surgeries, admissions from the medical and surgical floors and the Emergency Department.
Background

• An average of 1000 patients are admitted each year.
• Admissions are divided as follows:
  • Cardiac Surgery: 50%
  • Other Surgery: 15%
  • Medicine (including oncology): 35%
Background

• The CNS Evaluation Process was developed based on several factors:
  – Increased complexity and acuity of patients’ health situations
  – Increased number of patients transferred from the ICU into the medical wards
  – Increased length of stay of post-ICU patients on medical wards
  – Increase in junior staff
  – Nurse to patient ratio
Literature Review:

- Impact of ICU Stay
  - Nature of Critical Illness
  - Mode of care in the ICU
- Impact of discharge from the ICU
  - Cognitive and physical impact
  - Patients and families can experience anxiety, panic attack; insecurity and non trust; depression.
Literature Review:
Problems associated with discharge from ICU

- Sick patient with physical impairment(s)
- Increased patient/nurse ratio
- Insufficient resources on receiving unit
- Poor communication
- Abrupt transfers – no preparation
- Off shift transfers
Literature Review:
Complications associated with ICU transfer

- Longer to achieve self care
- Increased number of adverse events
- Readmissions
- Increased rate of mortality
Literature Review: Solutions

• Many interventions have been proven effective in easing transfers from ICU, optimizing continuity of care, and preventing adverse events.

• Examples:
  – Planning discharge in advance
  – Identifying patients at risk
  – Discharging patients only during the day shift
  – Use of Intermediate Units
  – ICU transition nurse
  – ICU transition team
  – Clinic for post-ICU patients
The Clinical Nurse Specialist’s Role

• Goals:
  – Support the patient and family
  – Ensure continuity of care
  – Ensure support on receiving unit
  – Obtain positive outcomes
The Clinical Nurse Specialist’s Role

• Process:
  – Using a screening tool, the Clinical Nurse Specialist (CNS) assesses the medical and psychosocial needs of the patient, while considering the complexity of care required on the receiving units.
The Clinical Nurse Specialist’s Role

• Uses the McGill model of Nursing.
• Assesses patient/family needs.
• Assesses level of care needed in relation to level of care available on the receiving unit.
• Develops a plan in collaboration with the patient/family, the ICU and ward interdisciplinary team.
• Provides teaching as needed.
• Follows-up after transfer as needed.
Illustrative Case 1

• Mrs. X, a 67 year old female was admitted to the ICU because of respiratory failure, following a simple surgical procedure, resulting in a prolonged ICU stay. Once patient was deemed ready to be discharged from the ICU, the CNS was contacted.

• The initial assessment by the CNS of the patient’s health situation showed that she was an appropriate candidate for a transfer.

• The conversation with the husband revealed a high anxiety level.
Illustrative Case 1

• Issues for the patient and family:
  – Change of ICU medical team resulted in a different message.
  – Fear that complications would not be detected on the ward.
  – The husband felt his wife was not ready to be transferred out of the ICU.
• The CNS shared the husband’s concerns with the ICU team.
• Agreement made to keep the patient in ICU overnight and transfer her to the ward the following morning.
Illustrative Case 1

- The patient’s condition worsened overnight and required prompt interventions.
- The CNS’s intervention prevented an unsuccessful transfer and the resulting anxiety for the family.
- Within 48hrs, the patient recovered and was transferred successfully to the ward.
Illustrative Case 2

- Mr. X was a young healthy man with no PMH. He was admitted to the hospital because of decrease LOC.
- He was found to have a rare neurological disorder, leading to an 11 month ICU stay. He remained ventilator dependant at night.
- CNS was contacted one month before his discharge.
Illustrative Case 2

• Initial assessment was made with the interdisciplinary team and barriers for transfer were identified.
• Family was consulted soon after.
• Meeting with interdisciplinary team, admitting ward and family was held twice before ICU discharge.
• Patient was to be discharged to a rehabilitation center one month after ICU discharge.
Outcomes

- At the JGH over 150 patients transferred to the medical units are evaluated by the CNS per year.
- Among the patients deemed ready to be transferred out of the ICU, about 25% of patients are considered at high risk for complications upon their transfer.
- In these situations, the CNS partners with the healthcare providers on the implicated unit to develop the best possible care plan to meet the patient and family needs.
- This plan may consist of implementing temporary measures to support the transfer or, alternatively, postponing the transfer.
Conclusion

• A systematic evaluation of patients by the CNS, prior to their transfer to a ward, ensures a comprehensive patient care plan.

• Patients, families and staff members have verbalized that this safety initiative is helpful.
Questions ???

-THANK YOU !!!
References


References

References