TRACER METHODOLOGY 101

Using Mock Tracers to Evaluate Care of Patients with Intellectual Disabilities, Part 2

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This is the second installment of a two-part series describing mock tracers performed in a major academic medical center in Chicago by hospital staff. This second installment of the series details how the hospital made improvements in pain assessment and management, the environment of care, transitions of care, and other key areas. The first installment appeared in the December 2015 issue of this newsletter. This second installment also includes a tool used by the organization during its mock tracers.

In addition to the identified strengths and gaps with care detailed in the first installment, the medical center also learned the following:.

Pain Assessment and Management

The majority of clinical staff could identify how they tailored pain assessments to meet the needs of patients. For example, the FACES scale, a behavioral pain assessment, was recognized in being a useful tool when caring for this patient population. Nurses reported that further modifications on how to assess pain often occurred if the caregiver was present. The nursing staff realized that caregiver knowledge about the patient could be crucial in addressing patient pain management needs. The electronic medical record (EMR) provides various pain assessment tools to choose, making it conducive for assessing pain in patients with intellectual disabilities (ID) and it allows ease of documentation of pain assessments and interventions.

Managing the Environment of Care

Managing the environment of care so that it is as conducive as possible for care is an issue identified by family members, caregivers, and hospital staff. Key issues that arise in the environment of care include addressing sensory needs, maintaining routines as much as possible, and addressing what patients find calming and/or anxiety producing or frightening. Besides breakdowns in communication during planned admissions, difficulty transmitting information
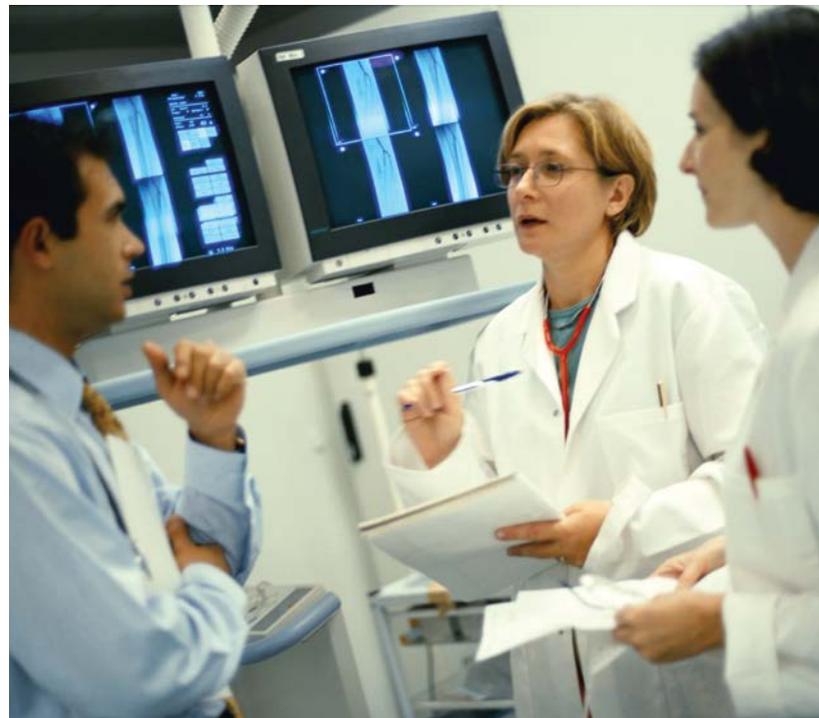
Careful coordination and communication during transitions of care helps to prevent patient harm.

about the patient's specialized needs within the chart was also noted during the tracer. The nurse on the unit had to verbally relay the information specific to that patient about necessary environmental alterations. This information was gathered through the nurse's own assessment, along with communication with the patient. However, within the EMR no designated place to document this type of information exists. Often, staff indicate this using progress notes.

Adjusting Care to Specific Needs

On one unit, the surveyors met with the tracer patient and a family member. The family member stated that the patient

was finally settled in a room and calm. A phlebotomist arrived to draw blood, and the patient was very afraid of blood draws. The patient noted having to insist on knowing the reason and found that although the test was standard for the age group for the draw, it was not connected to the reason for hospitalization. Consequently, the patient refused to have the blood drawn. The patient and family member expressed dissatisfaction that health care professionals do not always take into account individual patient needs for care.

Information Management

Staff reported that information on the presence of ID was sometimes in the history and physical notes of the EMR, sometimes with diagnoses information on the fact sheet, and sometimes progress notes. Information on guardianship was difficult to find (again in various locations) in the EMR outside of the perioperative locations. Not only was locating guardianship more of a challenge, but so was locating and using the specialized care plan.

Transitions of Care

The points of transitions and transfers between units were also assessed during the mock tracers. A gap was noted with handoff report, particularly information regarding an individual's disability or conditions. Although the report included going over the patient's problem list, including the diagnoses of ID, it was at times only discussed during report and not documented, leading to miscommunication with families and/or asking questions that were rightly perceived as having been asked before.

Lack of Specialized Equipment

The availability of specialized resources was limited; some resources, such as weighted blankets, were for children younger than 18 years old. A special case had to be made for adults. A nurse reported that one patient became very agitated and difficult to calm down after admission, and it became difficult for nurses to perform the necessary tasks. This patient ultimately required different techniques and tools in order to allow for de-stimulation. The nursing staff had to help calm the patient through trying to decrease stimulation, moving the patient to a quieter room, and attempting to obtain specialized tools from child-life services, but ultimately had to medicate the patient in order to perform the necessary assessments.

Discharge Planning

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On one unit, the nurse stated that they provide the information based on the caregiver's or family's discretion on who should receive the discharge instructions. If a residential facility is noted, the nurse would call to provide the discharge information, along with any pertinent information regarding that patient, with documentation in the discharge note. This is not the only location in which such information can be found, and there is not a designated format in the EMR for a note to follow regarding to whom and how the discharge information was given. It is crucial that discharge information be relayed to someone responsible for its carry-through. Proper interdisciplinary collaboration may enhance the gathering of this information and help to bridge the gap between acute care and the environment to which the patient is being discharged.

Recommended Improvements

Based on the mock tracers, the student, staff, and faculty surveyors made the following recommendations:

1. Create formal drop-down questions to ask in pre-admission interviews of patients with ID, with questions on sensory challenges, particular routines, and particular fears in order to facilitate safe, thorough, and patient-centered care.
2. Nursing standards of patient care (care plans) for patients with ID, available at this facility, have such drop-down questions.
3. Make it easier to access "care plans," with preference for automatic population of specialized care plans in the EMR depending on patient profiles.
4. Update the EMR so that staff can easily obtain information about caregiver/guardianship.
5. Thorough and easier methodology for documentation of discharge instructions, including documentation of the recipient
6. Collaborate with community agencies in order to increase communication to achieve better patient outcomes.

The last recommendation is to create a stronger relationship and have better collaboration with community agencies from which patients are regularly admitted. By doing so, this would increase the communication about the patient between the facility and the health care staff at the hospital. The facility would know what crucial information is important to relay during an evaluation or when an admission assessment is conducted even if the staff may not ask for it at that time. In addition, it could also lead to improved outcomes upon discharge if that pertinent information could be relayed to the most appropriate individuals at a community agency. TS

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Mock Tracer Tool

This tool for conducting mock tracers was developed and used by the Rush Medical Center mock tracer team. A printout of this worksheet was used to take notes and write down responses while conducting the mock tracer. Information gathered during the nurse interview and the patient chart review can be recorded in a document such as this during the performance of the tracer. An electronic copy was created and sent to nursing leaders following the completion of the mock tracer.

Tracer Team Members: _____

Tracer Patient Initials: _____   Patient Diagnosis (if applicable): _____

Unit or Department Where Tracer Was Conducted: _____   Date: _____

TRACER QUESTIONS	Comments or Notes
1. How do you determine if a patient has an intellectual disability? Where is the information documented in the EMR?	
2. How do you determine if a patient with an intellectual disability has a guardian? Where is this information documented in the EMR?	
3. Describe how you assess for and treat pain in patients with an intellectual disability. Where is this documented in the EMR?	
4. Describe how you assess for any changes needed in the environment to facilitate care. Where is this documented in the EMR?	
5. If a patient is agitated or aggressive, how do you assess his or her needs? How do you manage the situation? Where is this information documented in the EMR?	
6. Describe how you assess and address discharge needs of patients with intellectual disabilities. Where is this information documented in the EMR?	