Uncertainty and unplanned hospital readmissions among older adults - exploring a concept in context

Emma Pascale Blakey[1] & Dr. Helen Walthall[1 2]

1. Oxford Institute of Nursing, Midwifery & Allied Health Research

2. Department of Nursing, Faculty of Health & Life Sciences, Oxford Brookes University

Oxford Institute of Nursing, Midwifery & Allied Health Research

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Knowledge

Planning

Ability

Penrod J (2001) Refinement of the concept of uncertainty *Journal of Advanced Nursing* **34** (2) 238 - 245
Horwitz L I (2017) Self-care after hospital discharge: knowledge is not enough *BMJ Quality and Safety* doi:10.1136/bmjqs-2015-005187

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Discussion questions:

1. How would you assess someone's ability to self-care?

2. How are you making this judgement?

3. In light of today's discussion, imagine we have identified an older person who is at risk of being readmitted – can we do anything about this? If so, what?

Points raised during the ViPER discussion on 16/04/2018

Context:

Unplanned readmissions to hospital among older people. What can we do as part of our nursing care to reduce these readmissions. Could exploring these questions about self-care give us some ideas on how we can improve the nursing care we provide?

Points raised during the ViPER discussion on 16/04/2018

How would you assess someone's ability to self-care?

- What is their baseline? As assessed by a healthcare professional supervising & encouraging patients in a hospital setting.
- What are their own aims and objectives?
- What is their own perspective on their ADLs?
- Technique to assess could include asking them to teach you about their medication.
- What is their knowledge base?
- Co-production of care
- How to assess self-care in their own home? Arrange an OT visit? Use simulation?
- What is their support network like?
- How can safety be managed?
- What is their context like? Bio-psycho-socio-environmental…
- Having an intelligent conversation with them

Points raised during the ViPER discussion on 16/04/2018

2. How are you making this judgement?

- What tools do we have to make this judgement as it appears acute settings are not using them (though they are being used in community settings)?
- Community or care home representatives coming into the acute setting to help with assessment. Integrated care with integrated acute and community trusts.
- The InREACH approach (tool)
- Discharge to assess
- Communication with family important, include family / carers in conversations & decision making.
- An assessment tool could also
- Also need to assess physical assessment & people's mini mental state score, physical parameters etc.
- We have heard of Medically Fit for Discharge what about Nurse Fit for Discharge? Or just Fit for Discharge? Or even the idea of manageability and safe discharge vs being medically fit for discharge.
- Instead of self-care should consider their ability to manage, they can come up with their own solutions

Points raised during the ViPER discussion on 16/04/2018

3. In light of today's discussion, imagine we have identified an older person who is at risk of being readmitted – can we do anything about this? If so, what?

- What about timings? We should be considering safe discharge on admission.
- Assessment for care bundles from time of admission.
- Nursing and nurse led role in using the right tool on admission that incorporates holistic assessment & involves family, carers…
- Use the Comprehensive Geriatric Assessment in an acute setting?
- Risk assessment
- Integration of care

Thank you all for engaging so enthusiastically and helping to make this such an interesting ViPER.

If you would like to continue this discussion please do get in touch:

15128144@brookes.ac.uk and hewalthall@brookes.ac.uk

@pascale_blakey and @hewalthall