Transitioning Patients From Hospital to Hospital: What You Need to Know

Howard Utra RN, BSN, CWCN
Wound Care Nurse
St Joseph Outpatient Wound Center

Patients with wounds are often transferred from hospital to hospital, nationally and internationally, for a variety of medical reasons. During this transition, the care team which consists of patients, doctors, nurses, case managers, and social workers face many challenges that can all be avoided. According to the American Hospital Directory website, there are 31,787,121 yearly patient discharges from non-federal hospitals in the USA based on each hospital's most recent Medicare cost reports.[1] Many of these patients have either acute or chronic wounds that require specialized attention. Rarely do these patients have knowledge about their specific treatment plan nor the significance of how important it is to continue the treatment that they are receiving. Although it is very important to involve patients in their care, often they either do not understand the treatment plan or they are too overwhelmed and afraid to face the situation. Therefore, the care plan for these patients and their wounds must be communicated from one care team to another care team as patients transition from acute care to home care and from hospital to hospital. Furthermore, this information must be communicated in a simple but detailed approach to ensure a smooth transition to enable adequate wound healing.

Although every wound is different, each of them follows simple principles and guidelines. For example, a highly exudative wound may require a dressing that provides absorption, a dry wound may need hydration unless that is contraindicated for the patient, and a painful wound may need a non-adherent dressing or hydrogel.[1] If we, as practitioners, follow our experience, along with other best practices for wound care, and properly document information, we will be able to transfer patients efficiently from facility to facility without delayed care. This communication may translate into patient compliance which may lead to improved patient outcomes and

higher patient satisfaction and quality of life. In our center's experience and in my personal observation, the main factors that cause delays in care during a patient transfer include; insurance authorization, poor communication among facilities, and lack of education. For example, patients with surgical wounds or with heavy exudative wounds are often treated with negative pressure wound therapy (NPWT) for the healing of their wounds. When this patient population is transferred out of the hospital setting, several important details should be considered during this transition:

1. What manufacturer does the other hospital use for negative pressure wound therapy?
2. How long will it take to transfer the patient? Is the transfer local, national, or international?
3. What are the possible challenges that this patient can encounter during this transfer?

Although KCI is one of the leaders in the negative pressure wound therapy marketplace, not all hospitals and care facilities may use their equipment and disposables. If the patient's current treatment is not well communicated or understood between the hospitals and other care facilities prior to transportation arrangements being made, the patient will need a modification of his/her treatment plan before transfer. For example, if a patient is being treated with an NPWT dressing such as the V.A.C. VERAFLO CLEANSE™ Dressing, it is critical to communicate this to the receiving hospital or care facility because the other facility will need to have this product available to continue the prescribed treatment plan or stop NPWT treatment and implement another treatment plan.

Additionally, when a patient is being transferred to a facility, the travel time should be considered. A common mistake that I have seen in my years of practice is to send a patient who is on NPWT, with a dressing that has been applied but that is not connected to negative pressure. A NPWT dressing without negative pressure needs to be changed within two hours, and if this is not done it could cause wound deterioration and infection. Therefore, it is important to know when the therapy unit was disconnected.

In my experience, when patients have deep surgical wounds or heavy exudative wounds, it is better to pack the wound with a calcium alginate-like dressing such as the SILVERCEL™ NON-ADHERENT Antimicrobial Alginate Dressing and cover the wound with foam dressings or absorbent dressings. The reason for choosing this silver based and high absorbent dressing is driven by the anticipation of challenges in transferring patients like delays in transportation, delays in having a room ready for the patient at the receiving facility, lack of proper communication regarding the location of the wound, and/or a change in patient's status.

If the patient's condition deteriorates during transportation, a properly dressed wound would be one less thing for clinicians to have to deal with and address. Therefore, if the wound has been dressed with a dressing that can manage the wound for a potentially extended period of time, the wound would likely not further deteriorate even if other more pressing and emergent health concerns were to manifest.

Another key to facilitating and optimizing facility-to-facility transfers is the need for clear and detailed documentation, especially for high-risk patients, specifically those with many comorbidities and with wounds at risk of deterioration. Documentation sent along with the patient's electronic medical record (EMR) is a great tool to measure the wound status before departure and upon arrival at the receiving facility. By taking this small proactive measure, facilities can help eliminate inefficiencies and potential problems associated with litigation in the case of adverse outcomes.

Wounds with tunnels and undermining tend to suffer clinical deterioration during transfer due to poor communication between the sending facility and the receiving facility. A good way to manage this potential hurdle is for the sending facility to write on the dressing itself how many pieces of packing were applied and where. Naturally, this information must be documented on the chart or EMR and also provided in the course of the patient hand-off.

A lot of staff nurses avoid performing a full body skin check upon discharge due to the fact that it is time consuming, but this extra step can avoid a lot of confusion and will assist with a smooth transfer. Also, by addressing and assessing the skin before discharge, we can prevent pressure ulcers during transportation. Missing a pressure ulcer during the initial assessment can result in confusion down the road for all members of the care team.

When transferring a patient out of state or to another country, it is important to arrange for the patient to have the proper support surface for the

long(er) journey. In my experience, patients with poor perfusion are at a high risk of developing a pressure ulcer very quickly and are also at risk of accelerated wound deterioration. When a patient with negative pressure is being transferred to another country, the use of a negative pressure pump can be challenging. However, using non-powered technology like the SNAP™ Therapy System can help eliminate those challenges. In these scenarios, even if we need to use more than one dressing, the process can be faster and less expensive as our experience has shown that shortening a patients' length-of-stay by a few days in hospital, can lead to thousands of dollars of savings to the overall system.

In conclusion, my strongest recommendations for an effective transfer among and between facilities are:

- Communicate,
- Anticipate,
- Be practical, and
- Document

If you communicate the status of the patient's wound, the location, and the type of dressings applied, the receiving facility will be prepared, and, in all likelihood, the patient's wound will not deteriorate. Try to anticipate delays in transportation, potential for miscommunication, and possible scenarios that are out of your hands. Being practical or thinking outside the box are helpful tools when dealing with obstacles that cause delays.

Finally, DOCUMENT!!! Proper documentation is always beneficial to the patient as well as to you and the facility where you work. There is no such thing as over-documentation. Also, remember that a picture is worth a thousand words. Taking a picture might be an extra step, but a picture may capture details about the wound that you might forget to mention or that you may not be able to effectively convey to a receiving facility.

I hope that you are able to incorporate my tips and advice into your day-to-day case management for wound care patients.

REFERENCES:

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2. Sanger PC, Hartzler A, Han SM, et al. Patient Perspectives on Post-Discharge Surgical Site Infections: Towards a Patient-Centered Mobile Health Solution. PLoS ONE. 2014;9(12). doi:10.1371/journal.pone.0114016.

HOWARD UTRA RN, BSN, CWCN

Howard graduated from the Emory University WOCN program and earned board certification in wound care. He advanced his wound care career at Florida Hospital Tampa where he ran the inpatient wound care program and assisted with the education of resident nurses, critical care nurses, and students from other universities such as USF and UT. Howard is currently a regional clinic specialist at Acelity.