

The Consequences of Poor Communication During Transitions from Hospital to Skilled Nursing Facility: A Qualitative Study

Barbara J. King, PhD, RN,* Andrea L. Gilmore-Bykovskyi, MS, RN,*†‡ Rachel A. Roiland, PhD, RN,*§ Brock E. Polnaszek, BS,†‡ Barbara J. Bowers, PhD, RN,* and Amy J. H. Kind, MD, PhD†‡§

OBJECTIVES: To examine how skilled nursing facility (SNF) nurses transition the care of individuals admitted from hospitals, the barriers they experience, and the outcomes associated with variation in the quality of transitions.

DESIGN: Qualitative study using grounded dimensional analysis, focus groups, and in-depth interviews.

SETTING: Five Wisconsin SNFs.

PARTICIPANTS: Twenty-seven registered nurses.

MEASUREMENTS: Semistructured questions guided the focus group and individual interviews.

RESULTS: SNF nurses rely heavily on written hospital discharge communication to transition individuals into the SNF effectively. Nurses cited multiple inadequacies of hospital discharge information, including regular problems with medication orders (including the lack of opioid prescriptions for pain), little psychosocial or functional history, and inaccurate information regarding current health status. These communication inadequacies necessitated repeated telephone clarifications, created care delays (including delays in pain control), increased SNF staff stress, frustrated individuals and family members, contributed directly to negative SNF facility image, and increased risk of rehospitalization. SNF nurses identified a specific list of information and components that they need to facilitate a safe, high-quality transition.

CONCLUSION: Nurses note multiple deficiencies in hospital-to-SNF transitions, with poor quality discharge communication being identified as the major barrier to safe and effective transitions. This information should be used to refine and support the dissemination of evidence-based interventions that support transitions of care, including the Interventions to Reduce Acute Care Transfers program. *J Am Geriatr Soc* 61:1095–1102, 2013.

From the *School of Nursing, †Geriatric Division, School of Medicine and Public Health, ‡Health Innovation Program, University of Wisconsin at Madison, and §William S. Middleton Memorial Veterans Hospital Geriatric Research Education and Clinical Center, Madison, Wisconsin.

Address correspondence to Barbara J. King, School of Nursing, University of Wisconsin at Madison, H6/246 CSC, 600 Highland Avenue, Madison, WI 53792. E-mail: bjking2@wisc.edu

DOI: 10.1111/jgs.12328

Key words: care transitions; communication; hospital to skilled nursing facility

More than 5 million individuals transition from hospitals to skilled nursing facilities (SNFs) annually, and the nurses in these SNFs typically play the primary role in receiving and initiating these individuals' care.¹ Although hospital discharge processes and hospital discharge communications to primary care physicians have been well described,^{2,3} almost no prior work has been done on the nursing processes or on the SNF-based individual or system consequences of variation in transitional care quality. This is a critical oversight in the field of transitional care research, especially because discharge to a SNF is one of the strongest predictors of experiencing rehospitalization within 30 days.^{4,5} To design effective hospital-SNF transitional care interventions to reduce these rehospitalizations, the primary processes at the receiving end of these transitions must be better understood.

The objective of this study was to examine how SNF nurses transition the care of individuals admitted from hospitals, the barriers they experience, and the outcomes associated with variation in the quality of transitions. This was accomplished through a qualitative approach, which analyzed highly detailed information obtained in focus groups and interviews with practicing SNF nurses. This work suggests that high-quality, complete discharge communication is vital to safe and effective hospital-SNF transitions.

METHODS

Research Design

A qualitative study was conducted using grounded dimensional analysis (GDA), an alternative to grounded theory methodology.^{6–8} Both methodologies share a symbolic interactionist foundation, which focuses on exploring

social processes by understanding the actions of individuals in the context of social systems.⁶ GDA uses a systematic analytical process to generate knowledge about conditions associated with variation in individuals' socially constructed understandings and actions to identify consequences of these variations.^{7,9} GDA is not a consensus-building methodology, but rather focuses on the variation inherent in many real-world social processes, such as hospital–SNF transitions, during which clinical decision-making rarely follows a uniform pattern and may involve a wide variety of social and disciplinary groups (e.g., nursing, social work, medicine).

The end-product of GDA is a conceptual model capable of explaining the primary components of the social process of interest. In this study, this was the process SNF nurses engaged in when transitioning the care of individuals from hospitals. The conceptual model elucidates how the components relate to one another and whether certain conditions and outcomes are associated with variation in the process. To construct a conceptual model with sufficient detail to inform clinical practice, GDA dictates the use of in-depth interviews and observations to facilitate the linking of conditions and outcomes with processes.⁹

Setting and Participants

Between June 2011 and February 2012, data were collected from 27 registered nurses representing five SNFs in three Wisconsin counties. Facility characteristics are described in Table 1.

Nurses were recruited in coordination with each facility's Director of Nursing through announcements at facility staff meetings, distribution of flyers on-site, and e-mail announcements. In GDA, dimensions that are salient to the categories that emerge from the data exclusively determine subject characteristics. Therefore, this study did not systematically gather demographic characteristics on nurses. Interviews were conducted in a separate closed office space at the nurses' places of work or at the university to maintain privacy. No interviews occurred during paid work time. Each participant received an honorarium of \$30 per hour for interview participation. The University of Wisconsin-Madison institutional review board approved the study.

Data Collection and Analysis

In-depth interviews were conducted in focus groups ($n = 26$) or individually ($n = 1$). Interviews were audio-taped and transcribed verbatim. During GDA, data

collection and analysis are cyclic and concurrent. The research team analyzed data after each interview or focus group, and subsequent interview questions were developed. Concurrent data analysis also occurred during interviews through the modification of interview questions to maximize comparisons, an important analytical strategy of GDA. Analysis progressed through three phases: open coding, axial coding, and selective coding. Open coding involved line-by-line coding of data to examine how nurses understood hospital-to-SNF transitions, the actions they undertook as a result of their understandings, and whether conditions influenced their actions. Axial coding and selective coding developed the interrelationships between conditions and consequences associated with different components of the transition process. Throughout all phases of data collection and analysis, conceptual diagrams explicating the transition process underwent constant revision.

Analysis also occurred during interview sessions to facilitate ongoing constant comparative analysis, a fundamental analytical procedure of GDA.^{9,10} Constant comparative analysis involves the pursuit of variability and complexity in the social process and is often accomplished by exploring how nurses would respond to similar situations, provided different important variables. In this study, comparative analysis was accomplished by identifying nurses with relevant experience, constructing a social situation (the focus group) that allowed for dynamic comparisons between different social roles, probing for variations in experiences and events within single nurses, and modifying interview questions.

Several factors were considered in determining the appropriate sample size, including the extent of saturation in the core social process, and important data elements, including the scope, quality, and complexity of the data.¹¹ Data generated in this study were rich, descriptive, complex, and broad in scope. Methodological strategies undertaken to maintain rigor and ensure accuracy of the conceptual model included the use of a multidisciplinary research team, member checking, and maintenance of memos.

RESULTS

Overall Quality of Hospital-to-SNF Transitions

From the perspective of SNF nurses, difficult hospital-to-SNF transitions were the norm, and when asked to recall the details of a good transition, none were able to do so. Nurses noted multiple deficiencies, with poor-quality

Table 1. Participating Skilled Nursing Facility Characteristics

Facility	Ownership Type	Location	Continuing Care Retirement Community ^a	Resident Beds, n	Nurses per Facility, n
1	Nonprofit religious	Urban	Yes	140	6
2	Nonprofit religious	Rural	No	97	7
3	Nonprofit religious	Urban	Yes	42	1
4	Government	Rural	No	104	4
5	Nonprofit religious	Urban	No	184	9

^aAn institution that offers independent living and skilled nursing facilities that accommodate aging residents' needs.

discharge communication being identified as the major barrier to safe and effective transitions. To facilitate a safe transition, SNF nurses needed specific, up-to-date information, including descriptions of remarkable hospital events; written orders for medications, treatments, activity level, and diet; recent and pending laboratory test results; accurate descriptions of functional and cognitive status; and pertinent social information, such as preferences and unique needs. (See Table 2 for a comprehensive list.) Transition information came from three sources—the individual, the family, and the hospital—with written hospital discharge information serving as the primary source. This study focused primarily on the process SNF nurses used to implement the medical, rather than social, plan of care, although nurses described both as important.

Much of the information nurses needed from hospitals to design the medical plan of care was routinely missing or incomplete, conflicting, or discovered to be inaccurate upon the individual's arrival. As a result, nurses emphasized the importance of contact information of the discharging physician, nurses, and therapists, yet this information was rarely provided. Attempts to contact hospital staff for clarification were described as frustrating and time consuming, because hospital staff were often reluctant to reconcile discrepancies, could no longer access the individual's medical record, or were unable to locate a staff person with personal knowledge of the individual.

A conceptual model (Figure 1) was developed to illustrate the processes SNF nurses engage in when transitioning individuals from hospitals. The model describes how characteristics of hospital discharge information drove the transition process (seeking, reviewing, gathering, and reconciling information) and the consequences that missing or incomplete, conflicting, and inaccurate information had on care delivery and individual outcomes. In describing the transition process, nurses generally did not differentiate between returning SNF residents and residents who were new to the facility, but when nurses had longitudinal knowledge of a resident, they were sometimes able to identify inaccurate or missing information earlier in the transition process.

Seeking, Reviewing, Gathering, and Reconciling Hospital Information

Initial steps in the transition process were seeking and reviewing medical information from the hospital. Upon an individual's arrival, SNF nurses often received "reams" of paper, commonly exceeding 80 pages. Although much of this information was not relevant to designing the individual's plan of care (e.g., surgical flow sheets), SNF nurses usually had no other resource available to search for needed information. Nurses described spending hours sifting through masses of records and sometimes through the entire printed electronic health record to piece together the hospital events. Variation in the amount, type, and order of written information that hospitals provided exacerbated the tediousness of this process.

In addition, nurses actively sought out information about prospective residents before their admission. This seeking was done to identify individuals with "red flags," which nurses defined as complex and demanding clinical

Table 2. Hospital Discharge Information that Skilled Nursing Facility Nurses Need to Develop and Implement a Safe Plan of Care

Contact information
Discharging unit and telephone number
Attending doctor and telephone number
Other providers who will manage specific conditions (e.g., infectious disease, anticoagulation) and contact information
Registered nurse who cared for individual and telephone number
Spouse or partner and telephone number
Family member(s) involved in care and telephone number
Power of attorney, if activated, and telephone number
Past medical history and hospital stay
Remarkable medical history
Remarkable events during hospital stay
Comorbidities
Code status
Medications
Discharge medication list
Drug name
Dose
Diagnosis and rationale for every medication
Start and stop dates and last dose administered
Opioid prescriptions (signed hard copy)
Significant medication changes
Change in psychiatric medications during stay
Change in opioid medication at discharge
Withdrawal of medication because of side effects
Allergies and intolerances
Medications
Food
Latex
Functional status
Ability to perform and assistance required for activities of daily living
Sensory aids (dentures, glasses, hearing aids)
Mobility status
Level of assistance needed
Equipment requirements
Fall risk
Psychosocial and behavioral concerns
Personal interests/communication preferences
Cognitive status
Behavioral symptoms related to dementia
Type and severity
Need for personal safety attendant during stay
Effective comforting and reorientation strategies
Treatments
Wound care
Dressing type
Dressing schedule
Peripherally inserted central catheter line care
Dressing type
Dressing schedule
Flushing schedule
Elimination status
Bladder or bowel incontinence and use of absorbent pads
Perineal skin concerns
Last bowel movement
Type and amount of medication administered for bowel-related problems before discharge
Use of indwelling urinary catheter and if and when discontinued
Nutritional status
Swallowing or feeding concerns
Special eating devices
Appetite

(Continued)

Table 2 (Contd.)

Weight
Dentures
Follow-up care
Scheduled appointments
Who
When
Where
Telephone number
Laboratory tests
Pending results
Follow-up laboratory tests that need to be done
Name and number of insurance policy

needs, such as mechanical ventilation, or challenging, dementia-related behavioral symptoms, which might make the individual not a safe fit for their facility. Nurses stated that, in their experience, red flags were often not communicated or that hospital staff underemphasized them because individuals with such flags were difficult to place.

Inadequacies in hospital discharge information prompted a cyclic process of gathering and reconciling additional information to implement a safe and appropriate plan of care. Gathering and reconciling involved returning to the written discharge information that the hospital sent or calling the primary care physician or a physician or nurse on the discharging hospital team. When called, primary care physicians were often unfamiliar with the individual's hospital stay and usually directed nurses back to hospital providers: "The primary states... 'I didn't know what happened at the hospital so I can't give you any orders... You need to call the hospitalist or whoever worked with them.'"

Reviewing written records often resulted in the discovery of additional information gaps and contradictions. These discoveries invariably led to additional information gathering to fill in the gaps and to reconcile conflicting information. As a result, the gathering and reconciling

process typically took hours on the day of admission, and discrepancies and questions were often not reconciled for several days.

Although nurses sometimes attempted to glean additional information by asking individuals and families, this approach was problematic for several reasons: individuals and families were often not sufficiently informed to contribute useful information; many individuals had dementia and were not able to provide information about their hospital stay or care needs; asking individuals and families to "fill in the gaps" created a poor first impression of SNF staff and the facility; and because medical orders are legally binding, a physician, nurse practitioner, or physician assistant must reconcile discrepancies within orders.

Nurses described instances in which they did not have the information they needed as "working blindly." Nurses also employed a strategy of "using caution" when care was perceived as potentially unsafe or informational sources appeared inaccurate. Nurses commonly discussed these situations as dangerous for individuals and staff, especially in the case of "aggressive" behavioral symptoms.

Quality of Medical Information Sent from Hospitals

Missing and Incomplete Information

Basic information needed to transition individuals into SNFs was consistent across individuals and settings, yet such components (Table 2) were frequently absent in hospital discharge information. Missing or incomplete information resulted in care delays, which threatened individual safety and produced individual and family dissatisfaction with the transition process (Table 3).

Conflicting Information

SNF nurses regularly discovered conflicting information, especially in medication lists. Conflicting information was identified when discrepancies were noted within or

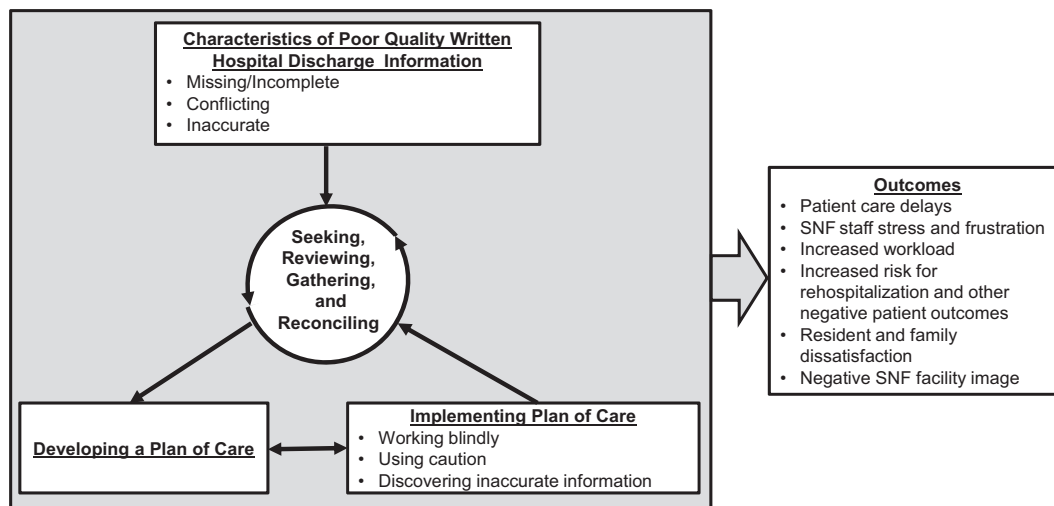


Figure 1. Conceptual model of the process and outcomes associated with transitions from hospital to skilled nursing facility (SNF). A conceptual model developed to illustrate the processes SNF nurses engage in when transitioning individuals from hospitals. The model describes how characteristics of hospital discharge information determine the transition process and the consequences that information has on care delivery and individual outcomes.

Table 3. Characteristics of Hospital Discharge Information

Category	Description	Examples	Quotations
Missing or incomplete	Necessary information that is omitted from discharge paperwork received by SNF nurses	No wound care instructions provided for postsurgical patient Medication orders missing important details No signed prescription for controlled substances, especially opioids No plans for medical follow-up	There was nothing about the femur fractures; we had no idea how, what, you know, if she was weight bearing or not weight bearing where-what we were supposed to be doing with them.
Conflicting	Discrepancies between written discharge documents	Multiple medication lists and order sets that vary in content	We have three discharge summaries with all these different medications list, it just like, how are we safely supposed to take care of this patient?
Inaccurate	Mismatch between the oral or written report of the individual's condition from hospital and the SNF nurses assessment of individual's clinical presentation	Mismatch between reported cognitive status and cognitive status Activity orders reflect a different level of assistance than needed by resident Resident presents as physiologically unstable	A lot of the times, we find when the person actually comes here they are a completely different picture than what we got in the pre-admission assessment.

SNF = skilled nursing facility.

between the following sources: discharge paperwork and orders, hospital records, initial telephone conversations, and preexisting medical orders.

Inaccurate Information

Inaccurate information was often in the form of a mismatch between the oral report of the individual's condition from hospital staff and the individual's status on arrival. Most inaccuracies were in cognitive (e.g., agitation, dementia) or physical or physiological (e.g., functional status, muscle weakness, low blood pressure, high pulse, fever) status.

Consequences of Poor-Quality Discharge Communication

Inadequate hospital discharge information and communication had a serious negative effect on individuals and families, SNF staff, and the SNF facility (Table 4).

Consequences for Individuals and Families

Missing or incomplete, conflicting, and inaccurate information produced significant care delays because of the time-consuming process of gathering and reconciling the information required to implement a safe plan of care. Limitations inherent in the SNF environment, such as the lack of an on-site pharmacy and the need to special order equipment (e.g., specialty bed) days in advance exacerbated these delays: "...we don't have a big central supply where we can just pick up the phone and say we need a bariatric bed... we have to rely on a rental company [causing] delays in care."

Nurses noted that missing or incomplete or inaccurate information on activity level or orthopedic device care produced delays that put individuals at risk of mobility problems and rehospitalization. Nurses described several occurrences in which bed rest was enforced purely because of missing activity orders because they did not know whether the individual should ambulate. In one example, an individual who had bilateral lower extremity casts was left in bed for 1 week as the SNF nurses repeatedly

requested and waited for clarification of physical activity orders and cast care.

A common and problematic care delay that nurses cited was the lack of signed, hard-copy opioid prescriptions, which are legally required to dispense controlled substances. It often took hours to obtain opioid prescription orders. Delays in pain treatment sometimes resulted in severe pain, especially for individuals who did not receive a scheduled pain medication before leaving the hospital.

Another common challenge was the discovery of conflicting medication orders upon the individual's arrival. Nurses sometimes received facsimiled discharge orders before admission to prepare for the transition, but many medications changed immediately before discharge, and these changes were not communicated before transferring the individual. Because many SNFs did not have an on-site pharmacy, the new medications and treatments were often not readily available, resulting in additional treatment delays. This was particularly problematic for late-in-the-day or weekend transfers because fewer resources were available.

Care delays and implementation of an inappropriate plan of care resulting from inaccurate information produced significant individual and family dissatisfaction and made the SNF facility appear unorganized and ill equipped to care for individuals. This experience produced substantial stress and frustration in SNF nurses.

Consequences for SNF Staff and Facility

Nurses described feeling overwhelmed by the constant need to gather and reconcile information received from hospitals. This process is cyclical, inefficient, and extremely time-consuming. SNF nurses had little ability to influence what they perceived to be the primary driver of this process—inadequate discharge communication. Nurses described feeling that attempts to "demand" that hospitals supply discharge orders early in the day and communicate changes would not be productive and feared that hospitals would refer fewer individuals to the facility: "We used to demand... the discharge summaries from the hospitals the night before. And now hospitals are saying,

Table 4. Consequences of Poor-Quality Discharge Communication for Individuals and Families, Staff, and the Skilled Nursing Facility

Group	Consequences	Example	Quotation
Individual and family	Care delays resulting from gathering, reconciling process and “working blindly” Dissatisfaction with care quality and transition Inappropriate care delivery Greater rehospitalization risk Greater risk of being untreated or undertreated for pain at time of transition Individual safety compromised	Providing treatments such as wound care without specific orders Delaying pain medications for several hours because of lack of signed opioid prescription Not having necessary equipment for individual care on admission Inappropriate care delivered leading to medication errors	We didn’t know what her mobility...and we didn’t know if she was weight bearing... so we left her in bed, for probably a week.
SNF staff	Increased work, stress, frustration, feelings of inadequacy Feeling unsafe in care delivery while “working blindly” Feelings of guilt associated with individual harm Additional work effort	Delivering care “blindly” while missing crucial information such as medication and activity orders Unsuccessful attempts to clarify orders with multiple providers over the course of hours to days Feeling guilt as a result of individual harm because of missing information regarding aggressive behavior	And as nurses, you just feel like you’re just asked to take care of this person with blinders on. I had to talk to like three people just to find out who the doctor was... Well then I called that office, he wasn’t in. Nobody at the office could help me; it was like a week before we got some good information.
Facility	Additional costs in staff time Additional costs due to wasted resources Poor work satisfaction, which may contribute to high turnover rates Individual and family dissatisfaction with care, perpetuating a negative facility image	Paying a pharmacist overtime to drive from their home to fill an opioid prescription after hours Ordering medications for an individual that are later discontinued without notification before transfer Family feel that facility is unorganized and ill-equipped	It sends a terrible message to the patient and their family that we are ill prepared or that we are not capable of handling the acuity.

‘No, we refuse to do that. They’ll come when we want them to come.’”

This process produced stress and frustration within other departments, such as physical therapy, because these groups also relied on timely and accurate discharge information to implement their care plans. SNF nurses assumed the primary responsibility and workload for obtaining, reviewing, and reconciling all necessary information and for relaying the information to appropriate departments. This work spread across shifts as information needs were sequentially passed on while waiting for a clarifying call from the hospital or primary care provider to be returned.

Constant shifting of care strategies and the high level of vigilance that unclear care needs necessitate produced workflow disruptions and inefficiencies. The unresponsiveness, and sometimes hostile responses, from hospital staff exacerbated these frustrations. Nurses described hospital staff as often abandoning responsibility for discharged individuals regardless of the urgency of the nurse’s concern. Nurses commonly described calling multiple providers and “begging” for clarifications for discharge orders, which contributed to SNF nurses’ feelings of inadequacy.

SNF nurses indicated that individuals and family members interpret the consequences of poor quality discharge information as evidence that SNF staff “don’t know what they are doing.” Continually revising the plan of care or being unable to respond to individual needs in a timely manner undermined the trust and confidence of individuals and families. This added to the stress and workload of all SNF staff, who then had to work even harder to reestablish trust and rapport with individuals and families.

Suggestions for Improving Transitions

SNF nurses had several suggestions for improving transitions. First, they stated that hospitals need to communicate medical information at least 24 hours before SNF admission to ensure that needed medications and special equipment are available. Any changes to the plan also need to be communicated immediately after the change is made. Second, SNF nurses wanted to have immediate access to a prescribing provider with up-to-date knowledge of the individual as the individual is admitted to the SNF. Ideally, this provider would be able to clarify missing, inaccurate, or conflicting information. Nurses from one participating SNF stated that their local community hospital provided telephone access directly to the discharging hospitalist physician for 24 hours after discharge and that this arrangement greatly expedited the communication and clarification process. Finally, SNF nurses highlighted the need for more-focused, standardized, complete communication of medical information, as outlined in Table 2.

DISCUSSION

This study represents the first in-depth examination of SNF nurses’ work processes, perceived barriers, and outcomes associated with variation in the quality of hospital-to-SNF transitions. Nurses described numerous safety concerns, inefficiencies, and adverse individual and staff outcomes that commonly result from hospital-to-SNF transitions, with poor-quality discharge communication identified as the major barrier to safe and effective transitions.

The information nurses received from hospitals was virtually always described as being inadequate because of missing or incomplete, conflicting, and inaccurate information. Poor-quality discharge communication produced a cyclical, inefficient process of gathering and reconciling information. These attempts often took the form of repeated calls back to discharging hospitals; were time-consuming; led to delays in care, individual and family dissatisfaction, greater rehospitalization risk, and greater staff stress and frustration; and perpetuated a negative SNF facility image. Occasionally, poor-quality discharge information led directly to inappropriate care, which compromised individual safety.

A lack of transitional care training among health professionals might contribute to poor-quality discharge communication and, to some extent, might explain the limited responsiveness SNF nurses receive in attempts to reconcile inadequate information. Accreditation guidelines for physician and nursing training programs are vague in terms of the type or extent of transitional care training that they must provide.^{12–14} Considering the lack of focus in these guidelines, it is likely that nation-wide transitional care training is variable, and crucial topics, such as understanding the needs and resource limitations of nonhospital settings, may not be consistently addressed. A review of curricular interventions focused on transitional care found that only 32% included “introduction to care settings” as a learning objective,¹⁵ suggesting that more-detailed accreditation guidelines are needed to ensure that a minimum level of transitional care training and experience is included in all health professional training programs.

These findings also suggest that poor-quality discharge communication might be directly related to individual outcomes such as rehospitalization. Discharge summaries are the primary (and sometimes only) document accompanying individuals between care facilities and are the regular source of SNF admission orders.^{2,16–19} The frequent omission of recommended components in discharge summaries found in prior research is consistent with the findings of this qualitative study.^{2,20,21}

Although it is clear from this study that an overwhelming amount of written discharge data interferes with effective communication, SNF nurses felt that a minimum standard set of components (Table 2) would be necessary to ensure high-quality individual safety and care for newly admitted SNF residents. Hospital providers may view the SNF nurses’ requested component list as overly extensive or burdensome, but these discharge communications can dictate SNF care for up to 30 days for some individuals, especially those who do not see a prescribing provider until their 30-day Medicare SNF benefit recertification,²¹ so their quality and completeness is critical. Also, with the advent of new electronic medical record capabilities and the restructuring of health systems to focus on episodic care and population health (e.g., accountable care organizations), innovative technologies and programs may soon be available to ease this burden on the discharging hospital provider while generating higher-quality discharge communication that takes the needs of the end-user (e.g., SNF nurse) into account. The requested content list provided here can be used in the design of such innovative programs.

A number of existing interventions to improve care transitions could help to address this communication

problem. Many of these transitional care interventions use nurse practitioners to bridge the gap between care settings soon after hospital discharge,^{22,23} but these programs are not available in many areas and often exclude individuals with dementia, an important SNF population. There is work being done at the national level to standardize information sharing across health systems, including the Continuity of Care Document,²⁴ but the currently proposed document omits many of the informational components that SNF nurses deemed to be critical and leaves problems of communication timing and clarification unaddressed. The Institute for Healthcare Improvement and others have made important recommendations for improving care transitions,²⁵ including direct nurse-to-nurse communication (“warm handoff”), but according to the SNF nurses in this study, the quality and content of these handoffs is often poor. The Interventions to Reduce Acute Care Transfers (INTERACT) program²⁶ is a nursing home-based intervention that shows considerable promise for addressing this intersetting communication problem, especially if the program were more widely disseminated. The most recent version of INTERACT includes multiple tools to help improve collaboration between hospitals and nursing homes, and the information offered in this article may inform further evolution of the program. The SNF nurses in this study offered a number of interventions that they thought would be helpful, but more work is needed to design, refine, and disseminate nursing home-focused transitional care interventions. With the advent of payment penalties for hospitals with higher-than-average recidivism rates, there may be additional incentives for hospital systems to engage in partnerships with SNFs to improve the quality of transitional care.

This study has several limitations. The sample represents nurses working in geographically similar areas with a limited number of hospitals. Although these hospitals represent a variety of urban, rural, academic and community practice settings, they may not be representative of all hospitals nationwide. Furthermore, this study did not include for-profit nursing homes. Negative outcomes that the nurses described may be exaggerated in for-profit sites, which generally have lower staffing ratios.²⁷ This study examined transitions to SNFs only, and findings may not be generalizable to individuals discharged to inpatient rehabilitation or other outpatient settings. No demographic information was collected on participating nurses, which limits the ability to interpret whether differences in work process might be related to educational training and background or past work experiences. Because no direct participant observation took place, it is impossible to affirm, with certainty, how often nurses encounter deficiencies in the quality of information and how they respond to those situations. Future studies in this area are needed.

CONCLUSION

Nurses noted multiple deficiencies in hospital-to-SNF transitions, with poor-quality discharge communication being identified as the major barrier to safe and effective transitions. This information should be used to refine and support the dissemination of evidence-based interventions that support transitions of care, including INTERACT.

Future research is needed to quantify the effect of poor discharge communication on individual outcomes.

ACKNOWLEDGMENTS

The findings of this study have been selected for poster presentation at the annual meetings of the American Geriatrics Society, the Gerontological Society of America, and the Midwest Nursing Research Society. The authors would like to acknowledge Peggy Munson for institutional review board assistance, Melissa Hovanes for project management and support, and Kristen Pecanac for assistance with data analysis. The authors have obtained written consent from all contributors who are not authors and are named in this section.

Conflict of Interest: The editor in chief has reviewed the conflict of interest checklist provided by the authors and has determined that the authors have no financial or any other kind of personal conflicts with this paper.

This project was supported by the National Institute on Aging Paul B. Beeson Patient-Oriented Research Career Development Award (K23AG034551, PI, Kind), in partnership with the American Federation for Aging Research, the John A. Hartford Foundation, the Atlantic Philanthropies, and the Starr Foundation and the Madison VA Geriatric Research, Education and Clinical Center (GRECC-Manuscript 2013–05). Roiland and Gilmore-Bykovskiy received support from the John A. Hartford Foundation Building Academic Geriatric Nursing Capacity Program. Roiland's contributions were supported by an F31 National Research Service Award from the National Institute of Nursing Research (F31NR013097–01). Additional support was provided by the University of Wisconsin School of Medicine and Public Health's Health Innovation Program; the Community-Academic Partnerships core of the University of Wisconsin Institute for Clinical and Translational Research; and the Clinical and Translational Science Award program of the National Center for Research Resources, National Institutes of Health (1UL1RR025011). The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

Author Contributions: King: design; acquisition, analysis, and interpretation of data; drafting the article; final approval of the version to be published. Gilmore-Bykovskiy: design, analysis and interpretation of data, drafting and critical revision of the article, final approval of the version to be published. Roiland: acquisition, analysis, and interpretation of data; drafting of the article; final approval of the version to be published. Polnaszek: acquisition and interpretation of data, critical revision of the article, final approval of the version to be published. Bowers: design, analysis and interpretation of data, critical revision of the article, approval of final version to be published. Kind: conception; design, analysis, and interpretation of data; drafting and critical revision of the article; final approval of the version to be published.

Sponsor's Role: None.

REFERENCES

- Mor V, Intrator O, Feng Z et al. The revolving door of rehospitalization from skilled nursing facilities. *Health Aff* 2010;29:57–64.
- Kripalani S, LeFevre F, Phillips CO et al. Deficits in communication and information transfer between hospital-based and primary care physicians: Implications for patient safety and continuity of care. *J Am Med Assoc* 2007;297:831–841.
- Schoenborn NL, Arbaje AI, Eubank KJ et al. Clinician roles and responsibilities during care transitions of older adults. *J Am Geriatr Soc* 2013;61:231–236.
- Kind AJ, Smith MA, Frytak JR et al. Bouncing back: Patterns and predictors of complicated transitions 30 days after hospitalization for acute ischemic stroke. *J Am Geriatr Soc* 2007;55:365–373.
- Kind AJ, Smith MA, Liou JI et al. The price of bouncing back: One-year mortality and payments for acute stroke patients with 30-day bounce-backs. *J Am Geriatr Soc* 2008;56:999–1005.
- Bowers B, Schatzman L. Dimensional analysis. In: Morse J, Stern P, Corbin J et al., editors. *Developing Grounded Theory: The Second Generation*. Walnut Creek, CA: Left Coast Press, 2009, pp 86–125.
- Kools S, McCarthy M, Durham R et al. Dimensional analysis: Broadening the conception of grounded theory. *Qual Health Res* 1996;6:312–330.
- Schatzman L. *Dimensional Analysis: Notes on an Alternative Approach to Grounding of Theory in Qualitative Research*. New York: Aldine de Gruyter, 1991.
- Caron C, Bowers B. *Methods and Application of Dimensional Analysis: A Contribution to Concept and Knowledge Development in Nursing*. Philadelphia: W.B. Saunders Co., 2000.
- Strauss AL. *Qualitative Analysis for Social Scientists*. Cambridge, UK: Cambridge University Press, 1987.
- Morse J. Determining sample size. *Qual Health Res* 2000;10:3–5.
- Liaison Committee on Medical Education. Function and structure of a medical school: Standards for accrediting of medical education programs leading to the M.D. degree [on-line]. Available at <http://www.lcme.org/standard.htm> Accessed October 9, 2012.
- American Association of Colleges of Nursing. The essentials of baccalaureate education for professional nursing practice. Available at <http://www.aacn.nche.edu/education-resources/baccessential08.pdf> Accessed October 9, 2012.
- Accreditation Council for Graduate Medical Education. Common program requirements [on-line]. Available at <http://www.acgme-nas.org/assets/pdf/CPR-Categorization-TCC.pdf> Accessed October 9, 2012.
- Buchanan IM, Besdine RW. A systematic review of curricular interventions teaching transitional care to physicians-in-training and physicians. *Acad Med* 2011;86:628–639.
- Kind A, Anderson P, Hind J et al. Omission of dysphagia therapies in hospital discharge communications. *Dysphagia* 2011;26:49–61.
- Kind A, Smith M. Documentation of Mandated Discharge Summary Components in Transitions from Acute to Sub-Acute Care. *AHRQ Patient Safety: New Directions and Alternative Approaches*. Rockville, MD: Agency for Healthcare Research and Quality, 2008, pp 179–188.
- Kind AJ, Thorpe CT, Sattin JA et al. Provider characteristics, clinical-work processes and their relationship to discharge summary quality for sub-acute care patients. *J Gen Intern Med* 2012;27:78–84.
- Walz SE, Smith M, Cox E et al. Pending laboratory tests and the hospital discharge summary in patients discharged to sub-acute care. *J Gen Intern Med* 2011;26:393–398.
- National Archives and Records Administration. *Public Health—Requirements for States and Long Term Care Facilities*, 42 CFR 483. Washington, DC: U.S. Government Printing Office, 2012.
- Dimant J. Roles and responsibilities of attending physicians in skilled nursing facilities. *J Am Med Dir Assoc* 2003;4:231–243.
- Naylor MD, Brooten D, Campbell R et al. Comprehensive discharge planning and home follow-up of hospitalized elders: A randomized clinical trial. *JAMA* 1999;281:613–620.
- Coleman EA, Smith JD, Frank JC et al. Preparing patients and caregivers to participate in care delivered across settings: The Care Transitions Intervention. *J Am Geriatr Soc* 2004;52:1817–1825.
- Agency for Healthcare Research and Quality. Prospects for care coordination measurement using electronic data sources: Challenges of measuring care coordination using electronic data and recommendations to address those challenges [on-line]. Available at <http://www.ahrq.gov/qual/prospect-scare/prospects1.htm> Accessed January 4, 2013.
- Herndon L, Bones C, Kurapati S et al. *How-To Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement, 2012.
- Florida Atlantic University. Interventions to reduce acute care transfers [on-line]. Available at <https://www.interact2.net> Accessed February 5, 2013.
- Harrington C, Olney B, Carrillo H et al. Nurse staffing and deficiencies in the largest for-profit nursing home chains and chains owned by private equity companies. *Health Serv Res* 2012;47:106–128.