Long Term TBI Clients: How Rehab Nurses Effectively Advocate Throughout Acute Care and Post Acute Care to Back Home Again

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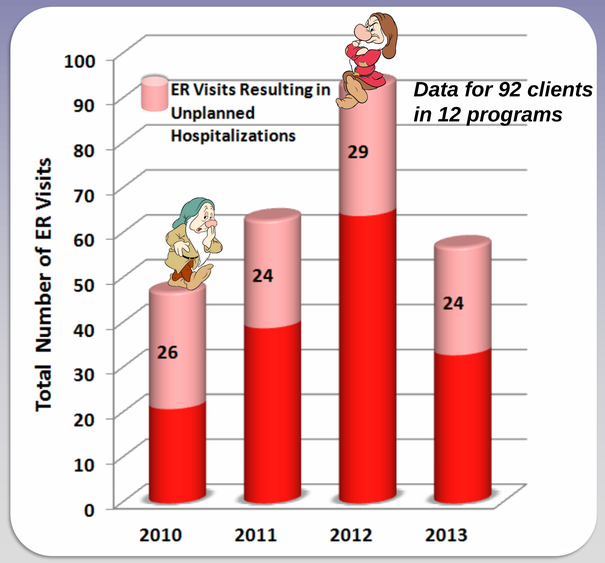
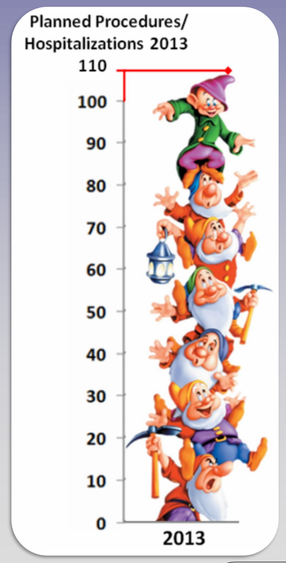
ReMeD

Introduction

Recent research shows client transitions between facilities are often ineffective/inefficient. (Camicia, et al, 2014). Transfers to Post-Acute Care settings are often based on factors not related to quality of care or outcomes—bed availability, insurance preferences, etc. The Association of Rehabilitation Nurses argues that rehabilitation nurses have the skills to ensure disabled patients get the "right care at the right time by the right provider" (Camicia, et al., 2014).

This long term residential brain injury program provides comprehensive care in small group homes and apartments in suburban Philadelphia. Clients range from 6 months to 40 years post-injury, and many are medically complex and fragile with multiple chronic illnesses. At-risk transitions to the Emergency Room, planned and unplanned hospitalizations, as well as outpatient procedures and surgeries increased significantly in recent years and have therefore been an area of increased focus. Early intervention combined with effective advocacy likely contributed to a decrease in ER visits in 2013.





TBI Patient Issues

- Acute medical problems
- Chronic medical issues
- Cognitive deficits
- Communication deficits/aphasias
- Behavioral deficits
- Mobility impairments
- Swallowing/dysphagia
- Safety/falls risks/elopement risk
- Function needed to return to residence

RN/RCM Advocacy

1. ***Communicate Medical/Special needs & Guardianship issues***- by phone or in person w/ER RN/Pre-op staff
2. ***Ongoing Communication & Medical Decision-making with Family/Guardian***
3. ***Contact Floor Nurse on Day of Admission***
   - Specific medical/mobility/behavioral/cognitive/ swallowing/safety and/or 1:1 needs
   - Medication reconciliation (JCAHO reg)
   - Behavioral approaches to improve compliance
4. ***Daily Contact with Floor Nurse***
   - Medical status: Vitals; Oxygen; Labs; Meds/tests; Behavior; Safety; Eating; Bowel & Bladder
   - Update from Hospitalist/Consultants; PT/OT/SLP
5. **Daily Contact with Discharge Planner**
   - Identify functional goals for safe discharge
   - Proper utilization of funds/insurance
   - Advocate for acute rehab/SNF/LTAC to optimize function; Attend care conferences
   - Coordinate continuum of care with ReMed Medical Director and team
6. ***Staff Visit 1-2x/daily***
   - Reorient; Decrease anxiety/Encourage cooperation; Model behavioral strategies; Distract w/recreational activities

Case Study- Fred

(36 yrs post)

Dx: Aspiration pneumonia /MRSA lung abscess

Acute care- 9 days
LTAC- 17 days

Case Study- Todd

(16 yrs post)

Dx: VP Shunt malfunction- Over 5 month period, repaired x 3 with multiple hospitalizations

1. Acute care- 10 days
   Acute rehab-4 days
2. Acute care- 18 days
   Acute Rehab- 24 days
3. Acute care- 13 days
   Acute Rehab-19 days

Same-Day Procedures

- Endoscopy/Colonoscopy
- Hand surgeries
- TURP
- Suprapubic tube
- Hysteroscopy/D&C/ Ablation
- Nuclear stress test
- Nerve stimulator
- Oral surgeries
- Lithotripsy
- Procedures on Coumadin

ER/Admissions

- Pneumonia
- UTI/Sepsis
- Cellulitis
- Falls/Fractures
- Seizures
- DVT/Greenfield filters
- Hysterectomy
- Cancer care
- Baclofen pump
- Chest pain/Stent
- Diabetic emergencies
- Spinal cord surgery

Conclusion

Rehabilitation nurses have been invaluable providing **ongoing and comprehensive advocacy** for their medically complex patients receiving care outside their TBI program. They are equally passionate about identifying and justifying **functional rehab goals** to ensure **safe return** to their program. **Continuity** of medical care across environments and **appropriate placement** to meet cognitive and/or behavioral needs hinges on **meaningful brain injury education** for all caregivers and **advocacy training** for **family and team members**.