HOSPITAL TRANSFERS: PERSPECTIVES OF NURSING HOME RESIDENTS AND NURSES

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DEDICATION

This work is dedicated to my parents, Sejfo and Minka, who lost their lives during the Bosnian War in 1992. You believed in me and encouraged me to one day become "somebody." You have taught me about hard work, perseverance, and endurance. You have been through this journey with me every step of the way. I hope I made you proud!

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Alma Ahmetovic

HOSPITAL TRANSFERS: PERSPECTIVES OF NURSING HOME RESIDENTS AND NURSES

Between 1 million and 2.2 million nursing home residents are transferred to a hospital emergency department each year. These transfers are costly, have negative health outcomes, and can increase the morbidity and mortality of residents. Few studies, however, have provided in-depth descriptions of transfer experiences. The purpose of this study was to examine the transfer process between the nursing home and the hospital from the perspectives of nursing home residents and nurses, focusing on how decisions were made to transfer residents. Using a qualitative descriptive method, 22 participants (10 residents and 12 nurses) were recruited from four nursing homes located in rural Indiana. Purposive sampling, semi-structured interviews, and conventional content analysis were used to collect and analyze narratives obtained from residents and nurses about their experiences with a recent transfer and to develop four in-depth case descriptions of these transfers. The participants described four aspects of the transfer process: transfer decisions, transport experiences, hospital stays, and returns to the nursing home. The most common reason for transfers was an acute exacerbation of a chronic condition, and the decision to transfer was often made by a nurse. Most participants found aspects of the transfer, including their hospital stay, to be aversive or upsetting. The return to the nursing home was typically welcomed but often challenging due to problems with mobility, medication adjustments, and cognitive changes. Participants also provided several recommendations for avoiding potentially preventable transfers including adding “in-house” diagnostic testing and treatment equipment,

improving staff competencies in managing acute exacerbations, increasing staffing, improving communication among staff, and increasing staff familiarity with resident histories and preferences. The findings have several clinical and policy implications for preventing or decreasing the negative effects of hospital transfers.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

ACP	Advance Care Planning
AD	Advance Directives
AHRQ	Agency for Healthcare Research and Quality
AND	Allow Natural Death
ASN	Associated Science in Nursing
BIMS	Brief Interview for Mental Status
BSN	Bachelor of Science in Nursing
CPR	Cardio-Pulmonary Resuscitation
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
EOL	End-of-Life
DNH	Do-Not-Hospitalize
DNR	Do-Not-Resuscitate
DNAR	Do Not Attempt Resuscitation
HIPAA	Health Insurance Portability and Accountability Act
ICU	Intensive Care Unit
INTERACT	Interventions to Reduce Acute Care Transfers
IV	Intravenous
IoM	Institute of Medicine
LPN	Licensed Practical Nurse
MDS	Minimum Data Set
NICE	National Institute for Health and Clinical Excellence
NTOCC	National Transitions of Care Coalition
OPTIMISTIC	Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms: Transforming Institutional Care
PCC	Person- or Patient-Centered Care
PHI	Protected Health Information
POLST	Physicians Orders for Life-Sustaining Treatment
POST	Physician's Order for Scope of Treatment
QMA	Qualified Medication Aide
RN	Registered Nurse
SQ	Subcutaneous
WaPEF	Warwick Patient Experiences Framework

CHAPTER ONE-INTRODUCTION AND NATURE OF THE STUDY

This qualitative descriptive study examined the transfer process between the nursing home and the hospital from the perspectives of nursing home residents and nurses. The goals of this study were to gain a better understanding of nursing home residents' experiences during hospital transfers, their involvement in decision-making at the time of transfers, and nurses' perceptions of the hospital transfer process. Findings from this study may support the development of resident or person-centered approaches that can be used to manage hospital transfers. Exploring nurses' perceptions of the transfer process provide information about decision-making at the time of transfers and issues that arise during the transfer of residents to the hospital and upon their return to the nursing home. The involvement of residents in decision-making, improvements in advance care planning (ACP) programs, and implementation of person- or resident-centered care can improve the hospital transfer process. Increased collaboration between nursing homes and hospitals, improvements in staff education and training, and developments of effective relationships between residents, families, and staff can also create positive transfer experiences for nursing home residents and improve their quality of life.

Background and Significance

To "transfer" means "to move to a different place, region, or situation," while "transfer" (noun) is defined as "an act or process of moving someone or something from one place to of another" (Merriam-Webster.com). McGill (2002) defines a "transfer" as a sudden event where the patient is transferred between care settings. Transfers to the hospital are common for nursing home residents. Over 25 percent of residents 65 years or

older transfer to the hospital emergency department (ED) at least one time annually with many residents experiencing repeated visits (Pearson & Coburn, 2013). Researchers estimate that between 1 million and 2.2 million nursing home residents transfer to the hospital ED each year (Toles, Young, & Ouslander, 2013; Wang, Shah, Allman, & Kilgore, 2011). However, more than half of these ED visits do not lead to hospital admissions (Toles et al., 2013). One to five percent of nursing home residents who transfer to the ED die there during their ED visit, while 41-52% of residents who visit the ED get admitted to the hospital. Of the nursing home residents who get admitted to the hospital, 25% die during the first 24 hours of admission and 50% die by day 5 (Ashcraft & Owen, 2014). Mortality rates are high in this population even after discharge. Evidence suggests that about 50% of nursing home residents die within three months of hospital transfer and 12%-29% die within one month of leaving the hospital, rates much higher than the mortality rates of older adults admitted from the community (Dwyer, Gabbe, Stoelwinder, & Lowthian, 2014).

Hospitalizations are very expensive. Hospitalizations of nursing home residents cost Medicare about $14.3 billion per year (Department of Health and Human Services, 2013). One in four skilled residents are hospitalized within thirty days of admission at the cost of 4.3 billion dollars per year (Toles et al., 2013). Each hospital ED visit of a nursing home resident costs approximately $750 and an extra $490 for each ambulance transfer. The total cost of hospitalization can add up to about $6800 per each resident admitted to the hospital for care (Dwyer et al., 2014).

In addition to high costs, there are significant risks associated with the hospitalizations of nursing home residents. Older adults residing in nursing homes

typically have multiple, concurrent chronic conditions and continuing care needs requiring a variety of services. Residents' needs can often be met in the nursing home, but sometimes, they must be transferred to hospital settings for a higher level of medical services (McCloskey, 2011). The most common reasons that lead to transfers are fall and/or injuries including fractures, respiratory symptoms, gastrointestinal issues, central nervous system symptoms, and general deterioration (Kirsebom, Hedstrom, Wadensten, & Poder, 2013; Lemoyne, Herbots, De Blick, Remmen, Monsieurs, & Bogaert, 2019). When residents transfer to the hospital setting, they are exposed to severe breakdowns in the continuity of care and potential harm (Pearson & Coburn, 2013; Toles et al., 2013; Ashcraft & Owen, 2014). Nursing home residents admitted to the hospital experience higher rates of invasive interventions, delirium, pressure injuries, hospital-acquired infections, confusion, functional decline, and even death in comparison to older adults not living in the nursing homes (Baumgarten, Margolis, & Localio, 2006; Dwyer, Stoelwinder, Gabbe, & Lowthian, 2015; Han, Morandi, & Ely, 2009; Tappen, Elkins, Worch, & Weglinski, 2016).

Discontinuity of treatment or medication, miscommunication surrounding advance directives, immobility, and emotional distress are also recognized as serious risks of hospital transfers (Abrahamson, Bernard, Magnabosco, Nazir, & Unroe, 2016). Disruptions in care plans and deconditioning of residents can also occur during these transfers (Shanley, Whitmore, Conforti, Masso, Jayasinghe, & Griffiths, 2011). Hospital transfers can lead to more hospitalizations, increased lengths of hospital stays, care in higher-intensity settings, and patients' feelings of powerlessness (Olsen, Ostnor, Enmarker, & Hellzen, 2013). These transfers also have the potential to cause a

breakdown in the continuity of care, changes in the management of chronic conditions, repetition of diagnostic tests, and medical errors (Pedro, Teno, Mitchell, Skinner, Bynum, Tyler, & Mor, 2011).

ED transfers that do not result in a hospital admission also hold risks for the nursing home residents. Nursing home residents who visit the ED are at three times higher risk of acute infections than those who do not visit the ED (Quach, McArthur, McGeer, Lynne, Simor, Dionne, Lévesque, & Tremblay, 2012). The most common infections that are associated with the ED visits are gastrointestinal and respiratory tract infections (Dwyer et al., 2014). Also, residents with recurrent or recent transfers or hospitalizations show an increased number of resistant organisms (Dwyer et al., 2014). Nursing home residents who are admitted to the hospital within three days of symptoms of infections are more likely to develop pressure ulcers and die compared with those residents treated in the nursing home (Boockvar, Gruber-Baldini, & Burton, 2005). Nursing home residents are at the greatest risk of morbidity and mortality from communicable diseases acquired in the ED (Quach et al., 2012). Furthermore, if residents acquire infections during the ED visit, they may be a source of outbreak upon their return back to the nursing home (Quach et al., 2012). These outbreaks can increase workload and costs in the nursing homes (Quach et al., 2012).

In addition to the hospital-acquired infections, nursing home residents have a higher risk of developing hospital-acquired pressure ulcers, especially within the first two days of their hospital stay (Baumgarten et al., 2006). Baumgarten et al. (2006) have found that approximately 6.2% of nursing home residents develop a pressure ulcer within a couple of days of admission to the hospital. The study by Dwyer et al. (2014) have found

this number to be much higher, indicating that several residents have pressure ulcers upon admission and 19% develop new pressure ulcers in the hospital compared to 4.3% of older adults admitted from the community. Nursing home residents also experience longer ulcer healing times when compared with residents who do not experience transfers (Dwyer et al., 2014).

Risks with transferring physically frail and, in many cases, cognitively impaired older adults to the hospital are also very high (Trahan, Spiers, & Cummings, 2016). These transfers occur even though many common complications in nursing home residents with advanced dementia such as infections can be successfully treated in the nursing home with the same efficacy and at reduced costs (Givens Selby, Goldfeld, & Mitchell, 2012). About half of all ED visits of residents with advanced dementia are related to feeding tube complications (Givens et al., 2012). Older adults with dementia who are hospitalized are also at increased risks for intravenous (IV) line placements and restraints (Morrison & Siu, 2000). Hospital transfers may also occur in the final stages of a resident's life, even though more appropriate palliative care can be provided in the nursing home (Shanley et al., 2011). Approximately 25% of nursing home residents with advanced dementia experience a hospital transfer in the last six months of life (Givens et al., 2012). Even though comfort is the main goal of end-of-life (EOL) care for most residents with advanced dementia, about one in five of these residents experience a hospital transfer at the EOL (Pedro et al., 2011). These residents experience the trauma of the physical transfer, increased confusion due to unfamiliar settings and staff, the failure of the hospital staff to address their specific needs, such as assistance with feeding, and inability to communicate their goals of care (Pedro et al., 2011). The study by Unroe,

O'Kelly Phillips, Effler, Ersek, and Hickman (2019) found that nursing home residents with comfort measures orders still experience hospital transfers. Hospital transfers of residents on EOL care should not be happening unless they require the treatment to promote comfort that cannot be provided in the NH (Mitchell, Teno, Intrator, Feng, & Mor, 2007).

Hospital transfers are known to increase the risk of delirium (Fick, Agostini, & Inouye, 2002). Delirium is an acute, often reversible condition, that includes an alteration of consciousness, change in cognition, acute onset, fluctuating course, and reduced attention (Fick et al., 2002). Delirium has been associated with cognitive and functional decline, higher death rates, prolonged hospitalization, and greater hospital costs (Cole, 2004). Delirium also prolongs hospitalizations for older adults with dementia (Fick, Steis, Waller, & Inouye, 2013). Nursing home residents are more likely to present to the ED with delirium than the older adults from the community, because they have high risk factors for delirium and many use psychotropic medications routinely (Han et al., 2009). Dementia is the greatest risk factor for the development of delirium during hospitalization (Fick et al., 2013).

Statement of the Problem

Hospital transfers are costly, harmful, and significantly increase morbidity and mortality of nursing home residents. Despite these costs and risks, hospital transfers are a common occurrence for nursing home residents (Abrahamson et al., 2016; Ashcraft & Owen, 2014; Lamb, Tappen, Diaz, Herndon, Ouslander, 2011; Tappen, Worch, Elkins, Hain, Moffa, & Sullivan, 2014). Transfers are typically based on medical needs, but in many instances, transfers may be potentially avoidable (Lemoyne et al., 2019).

Decreasing transfers of nursing home residents to hospitals and EDs has been recognized as a focus of many national organizations such as Centers for Medicare and Medicaid Services (CMS), Agency for Healthcare Research and Quality (AHRQ), The Joint Commission, and National Transitions of Care Coalition (NTOCC).

This review will specifically focus on the decision-making process at the time of the transfer, residents' preferences regarding transfers, and their experiences and perceptions of the transfer process from the nursing home to the hospital and back to the nursing home. The review will also explore nurses' perceptions of the residents' transfer process. A review of the literature indicates that existing research on perceptions of transfers includes: a focus on residents' transfers and appropriateness of these transfers from the nursing home to the hospital; factors associated with decisions to transfer, resident, family, and staff preferences regarding these transfers; and nursing home nurses' perspectives about hospital transfers. Knowledge is limited concerning residents' actual experiences of the transfer process from the nursing home to the hospital and back to the nursing home, and residents' perceptions of the decision-making process and their involvement in decision-making at the time of the transfer. There is also a gap in the literature describing nurses' perceptions of the hospital transfer process of residents and their perceptions on issues that arise after the resident returns back to the nursing home. Gathering information into the residents' transfer experiences may lead to a positive influence on the residents' quality of life, resident satisfaction, and health outcomes. Knowing, valuing, and considering the residents' perceptions and experiences can assist healthcare providers in developing resident-centered approaches for the management of hospital transfers. Exploring nurses' perceptions of the residents' hospital transfer

process and their perceptions of issues that are identified after the resident returns to the nursing home can provide a better understanding of the circumstances surrounding transfers to complement resident perspectives and provide a more complete picture of the process.

Theoretical/Conceptual Framework

Hospital transfers are associated with significant risks for nursing home residents and are linked to adverse outcomes. Many studies examine the negative consequences of transfers of older adults to and from the hospital. The literature lacks information about the perceptions and experiences of nursing home residents and their involvement in the decision-making process at the time of transfer. Placing a focus on the resident experiences is consistent with a shift in the nursing home industry to elevate consideration of resident preferences.

This shift is in alignment with other industry trends. Over the past several years, the culture change movement has emerged in nursing homes. Person- or patient-centered care (PCC) has become a focal point in discussions about quality provision of health care. PCC is defined as providing the care that the person needs in the ways that he or she desires and at the time he or she desires (Davis, Schoenbaum, & Audet, 2005). Increasingly, patients want more information regarding their care, they want to be actively involved in their care, and they want to take part in treatment decisions about their care (Davis et al., 2005). The Institute of Medicine (IoM) defines PCC as the care provided in respectful and responsive ways in order to meet individual values, needs, and preferences and ensure that patient values guide all care decisions (IoM, 2001). In 1987, the Picker Institute and Harvard Medical School identified the eight principles of PCC to

better understand patient health care experiences (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993). The principles of PCC identified by Picker Institute are as follows: 1) Respect for patients' preferences, values, and expressed needs; 2) Coordination and integration of care and services; 3) Information, education, and communication; 4) Physical comfort; 5) Emotional support; 6) Involvement of family and close others; 7) Continuity and transition from hospital to home; and 8) Access to care and services (Gerteis et al., 1993). The practices related to these principles are conducive to positive patient experiences.

Culture change in the nursing home setting includes a transformation of care from the medical model to the holistic, comprehensive model (Abbott, Klumpp, Leser, Straker, Gannod, & Haitsma, 2018). The Pioneer Network, the national leader of the culture change, emphasizes the culture in which older adults' voices are heard and individual choices are respected (Pioneer Network, 2019). The goal of this organization is to change culture in nursing homes by promoting care that is managed by the individual who receives this care (Pioneer Network, 2019). PCC is a process that empowers older adults to maximize their relationships, capabilities, interests, and skills developed over their lifetime (Edvardsson, Varrailhon, & Edvardsson, 2014). PCC values relationship, choice, dignity, respect, self-determination, and purposeful living (Pioneer Network, 2019). This process includes nursing home residents' preferences for choices regarding daily routines and activities (Elliot, Cohen, Reed, Nolet, & Zimmerman, 2014) and helps them maintain their independence and a sense of autonomy (Bangerter, Heid, Abbott, & Van Haitsma, 2017). The focus of PCC is to encourage residents to use their voices to communicate their choices and preferences to their caregivers.

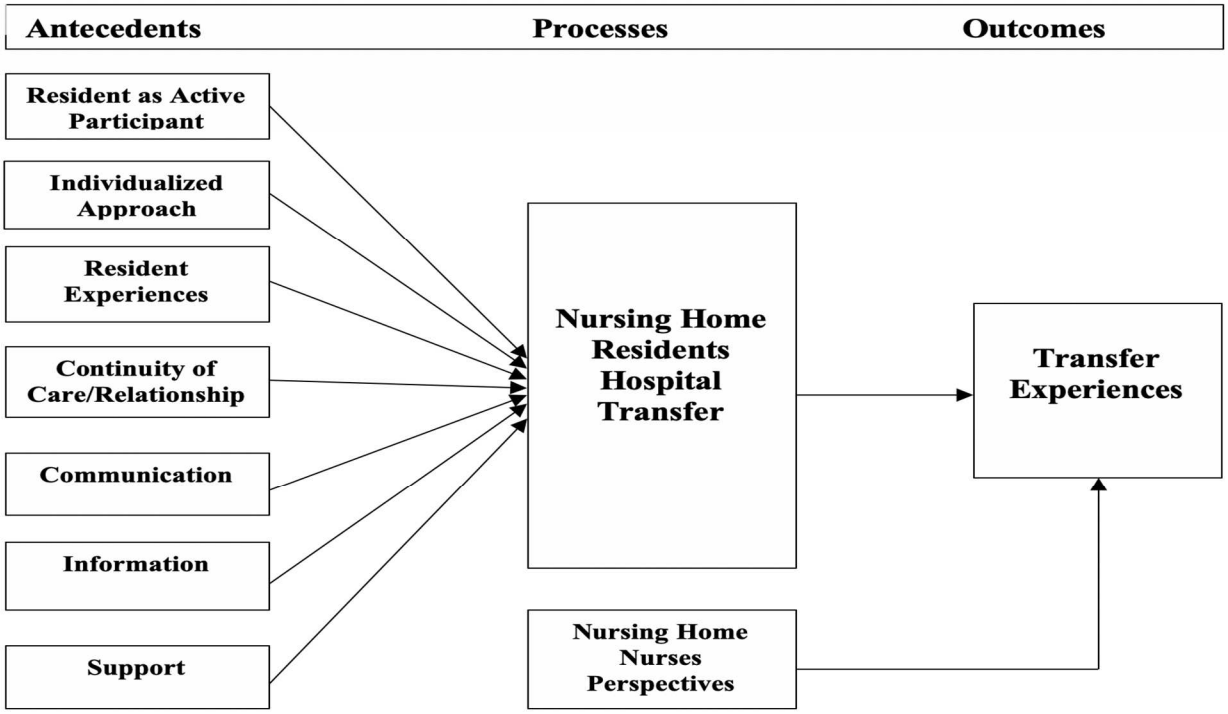
The Warwick Patient Experiences Framework (WaPEF) is a potentially useful framework for exploring nursing home residents' perspectives. It is focused on seven dimensions of patient experiences with descriptions of the content of each dimension: 1) patient as active participant; 2) responsiveness of services – an individualized approach; 3) lived experience; 4) continuity of care and relationships; 5) communication; 6) information; and 7) support (Staniszewska, Boardman, Gunn, Roberts, Clay, Seers, Brett, Avital, Bullock, & O'Flynn, 2014). The WaPEF was developed in the United Kingdom through a review of literature, selection of papers, and the development of themes and subthemes about patient experiences (Staniszewska et al., 2014). This framework has particular relevance to the experiences of nursing home residents with the transfer process, because it is developed based on themes extracted from the current literature that focused on patient experiences during ambulatory care and chronic conditions. The framework appears below in Figure 1.

The WaPEF framework builds on the Institute of Medicine (IoM) framework of patient-centered care. The IoM framework includes themes such as compassion, coordination, information and communication, physical comfort, emotional support, and involvement of family and friends (IoM, 2001). In addition to these themes, the WaPEF framework considers the active inclusion of patients in their care and advocates the importance of patients' lived experiences (Staniszewska et al., 2014). For this study, the WaPEF framework has been adapted to the context of nursing home resident transfers to the hospital. Based on the literature review and the WaPEF framework, a guiding conceptual framework was created in terms of antecedents, processes, and outcomes to

review nursing home residents' experiences during the transfer to the hospital and back to the nursing home.

Figure 1

A Guiding Conceptual Framework for the Study Based on the Warwick Patient Experiences Framework (2014)



The Patient Experiences Framework-Antecedents

Resident as an Active Participant

The antecedent, resident as an active participant, reflects the role patients play in their health care (Staniszewska et al., 2014). Toles et al. (2013) suggested that involving nursing home residents in discussions about their health care needs can result in safe and effective care transitions. However, in many instances, residents are either left out or remove themselves from these care discussions. They look up to others, close family, nurses, physicians, or friends, to make health care decisions for them (Tappen et al.,

2016). Active involvement of nursing home residents in health care decision-making may improve their satisfaction and health outcomes.

An Individualized Approach

Staniszewska et al. (2014) indicate the importance for health care providers to recognize and see the individual as a person within the healthcare system and to tailor care interventions to meet residents' needs, preferences, and values. Resident preferences are defined as statements made by individuals regarding their desirability of a range of health experiences, treatment options, or health status (Brennan & Strombom, 1998). These preferences are based on residents' cognition, experience, and reflection, and exist as the long-lasting effects of values (Brennan & Strombom, 1998). Knowing the resident and having information about who the resident is as a person including the resident's values, preferences, and needs, as well as being aware of resident's health history and current health status are crucial components on which health care providers base hospital transfer decisions (Robinson, Bottorff, Lilly, Reid, Abel, Lo, & Cummings, 2012).

Resident Lived Experiences

Resident experiences are defined as the sum of all interactions, shaped by an organization's culture, that influence patient perceptions, across all levels of care (The Beryl Institute, n.d.). Patient perceptions are described as individualized experiences recognized, understood, and remembered by patients (Wolf, Niederhouser, Marshburn, & LaVela, 2014). Every person experiences his or her condition in a unique way and these experiences are brought with the patient into the health care system (Staniszewska et al., 2014). Healthcare providers need to maximize patient experiences by making sure that they respect, communicate with, and coordinate patients' care to ensure their optimal

health outcomes (Stempniak, 2013). Listening to the lived experiences of nursing home residents and looking at the common themes in their experiences may reveal areas of concerns. It could provide the insights that may lead to the development of a structured, palliative, and holistic approach to nursing home care, decrease transfers to the hospital, and improve quality of life for this population.

Continuity of Care and Relationships

The antecedent, continuity of care and relationships, includes concepts such as contact with services, interpretation of symptoms, coordination, access, and availability of services, responsiveness of services, and feelings of abandonment (Staniszewska et al., 2014). Staniszewska et al. (2014) express the need for a patient to be known as a person rather than a number. In addition to the continuity of care, a relationship between a patient and the staff who are providing care to the patient is also very important. These relationships that are supported by trust, confidence, respect, and dignity alleviate concerns that may arise during care and in this case, during hospital transfers. A partnership of all people involved in decision-making is an essential component of these transfers.

Communication

Communication needs to be two-way communication and include shared decision-making (Staniszewska et al., 2014). Also, the physical environment and the number of people present at the time communication occurs, play a role in enabling effective exchange of information and allowing patients to ask questions and provide answers (Staniszewska et al., 2014). Poor communication among stakeholders involved in the transfer process negatively affects the quality of care of nursing home residents

involved in transfers to the hospital (Murray & Laditka, 2010). Also, a lack of communication about the baseline cognitive function of nursing home residents can present another challenge during the transfer process (Murray & Laditka, 2010). Hendricks Smalbrugge, Hertogh, and van der Steen (2016) recommend having discussions with residents and their family members about the most common health problems such as pneumonia, urinary tract infections, and congestive heart failure. These discussions can help residents and families better prepare for the future and can help prevent hospital transfers (Hendricks et al., 2016).

Information

Information sharing is also an important concept in nursing home residents' hospital transfer process. Residents need information about advance directives, do-not-hospitalize orders, and Physicians Orders for Life-Sustaining Treatment (POLST), as well as information about their conditions, options, and treatments. This information needs to be tailored to suit the individual (Staniszewska et al., 2014). Information also needs to be in an accessible format such as written information, pictures, symbols, large print, Braille, and different languages (National Institute for Health and Care Excellence (NICE), 2012). Lack of providing key information about the risks, benefits, and alternatives in the context of reflection on goals and values and lack of understanding of clinical complications related to chronic conditions can lead to resident and family decisions to transfer from nursing homes to hospitals. Information sharing between health care settings also affects the hospital transfer process. During the transfers of residents, important information is often not communicated to the ED. Specific information missing during transfers are the reason for transfer, the baseline cognitive function and

communication ability, vital signs, advance directives, medication, activities of daily living, and mobility (Cwinn, Forster, Cwinn, Hebert, Calder, & Stiell, 2009). Ideally, the ED should receive information about the resident's medical history, medications, baseline conditions, and nursing home contact information upon admission (Murray & Laditka, 2010). After discharge, the nursing home should receive information about the resident's ED diagnosis, treatment received, results of diagnostic tests, and recommendations for treatment and follow up (Murray & Laditka, 2010). Emergency Medical Services (EMS) and EDs depend on nursing home staff and family to provide them the critical information about the resident, including knowledge about the resident as a person (Robinson et al., 2012).

Support

Patients have different preferences for support such as support for individual coping strategies, family and friends support, support for education, responsiveness of healthcare providers to individual support needs, need for emotional support and need for hope, role of advocacy, and not wanting to be a burden (Staniszewska et al., 2014). A better understanding of nursing home residents' experiences and a thoughtful dialog between healthcare providers, residents, and families can lead to the development of a more holistic and supportive care system in nursing homes that can see a resident as a whole person with a story, rather than see a resident through an acute and medical lens.

The Patient Experiences Framework-Processes

Nursing Home Residents' Hospital Transfer

A transfer is defined as the movement of a resident between one certified facility and another certified facility with the expectations that the resident will return to the

original facility (CMS, 2017). Transfers between these facilities are not "one size fits all" (Golden & Shier, 2013). Nursing home residents present diverse populations with different cultures, conditions, needs, and preferences. In order to meet residents' needs and preferences, hospital transfers must be individualized and person-centered. Nursing home residents must also be included in decision-making at the time of the transfers to ensure that their wishes regarding hospital transfers are honored (Ashcraft & Owen, 2014). Coordination of services, communication, information sharing, and support are also important components of the transfer process.

Nursing home residents who experience exacerbations of chronic health conditions or acute illnesses, usually transfer to the hospital for management of these conditions. Nursing homes can provide daily care required by residents. However, when a change in health condition or a fall occurs, nursing homes may no longer be able to meet residents' needs and residents may need to be transferred to the ED for further treatment (McCloskey, 2011). Transfers between nursing homes and EDs can be complex, because the staff in EDs bases their care on the treatment of medical diagnosis, while nursing homes focus on a supportive care for residents (McCloskey, 2011). Research also suggests that older adults receive suboptimal care during these transfers (Coleman, 2003).

Nursing Home Nurses' Perspectives

Nurses play a vital role in the transfers of nursing home residents to the hospital. Nursing home nurses ultimately make decisions about whether and when to transfer residents to the hospital (Ashcraft & Owen, 2014). They make these decisions based on changes in resident's health conditions and the impact these changes have on resident's

quality of life (Ashcraft & Owen, 2014). Often, nurses decide on a hospital transfer, because they see the transfer as necessary for resident's well-being. Once they make their decision, nurses contact the physician or nurse practitioner for the order to transfer the resident. However, nurses have negative perceptions of how residents are being treated in the hospital (O'Neill, Parkinson, Dwyer, & Reid-Searl, 2015). Nurses do not believe that nursing home residents are treated the same as younger patients in the hospital. They also report residents returning from the hospital to the nursing home with newly developed pressure injuries and medication issues (O'Neill et al., 2015). Gathering data from the nurses will provide a more of comprehensive 'story' of the hospital transfer experience of nursing home residents.

The Patient Experiences Framework-Outcomes

Transfer Experiences

Patient experiences are described as patients' self-reports of their experiences during the hospitalization including interactions with staff, information sharing, involvement in decisions, and support for self-care (Hewitson, Skew, Graham, Jenkinson, & Coulter, 2014). Nursing home residents' hospital transfer experiences may be stressful and cause anxiety, because of unfamiliar environment, unknown staff, and possibilities of invasive testing (Givens et al., 2012). Enhancing patient experiences can be accomplished by creating a patient-centered culture and engaging patients in their health care (Stempniak, 2013). Mitchell, Laurens, Weigel, … Li, Williams, and Jack, (2018) depict positive and negative experiences that occur during transfers of patients across healthcare settings. The positive experiences are characterized by continuity in care, caring attitudes, and accountability in the healthcare system. These positive patients' experiences can lead

to patient satisfaction, caregiver self-confidence, and better adherence to care plans. The poor experiences during transfers involve health care professionals who are not committed to their patients, which results in feelings of fearfulness and abandonment among patients (Mitchell et al., 2018). These negative experiences cause the development of anxiety, confusion, and mistrust in patients and lead to inefficient care delivery and slower recovery (Mitchell et al., 2018). Hewitson et al. (2014) indicated that patients with multiple chronic conditions are less likely to report positive experiences with hospitalizations than patients with single conditions.

Summary

This study provides an opportunity to learn about resident experiences during the transfer process between the nursing home and the hospital and discover their perceptions about the transfer experiences. The study also focuses on nursing home nurses who have experienced the process of transferring a resident to the hospital or readmitting the resident back to the nursing home. The results of this study contribute new knowledge for (a) understanding the hospital transfer process from the nursing home residents' perspectives, (b) recognizing the importance of residents' involvement in the transfer process, (c) developing residents' person-centered care goals based on their values, needs, and preferences, and (d) understanding the nursing home nurses' perceptions of the hospital transfer process. The results of this study provide a better understanding of resident-centered hospital transfers.

Research Aims

A qualitative descriptive study of nursing home residents and nurses was designed to address the following aims:

Specific Aim 1: Describe nursing home residents' perceptions of the decision-making process at the time of the transfer and their involvement in the decision;

Specific Aim 2: Describe residents' experiences and perceptions of the transfer process from the nursing home to the hospital and back to the nursing home;

Specific Aim 3: Describe nurses' perceptions of the transfer process of nursing home residents to the hospital including perceptions of the residents' decision-making process at the time of transfers;

Specific Aim 4: Describe nurses' perceptions of the issues that arise after the resident returns back to the nursing home.

CHAPTER TWO-REVIEW OF THE LITERATURE

This chapter provides an overview of the hospital transfers of nursing home residents, the residents' decision-making process at the time of the transfer, and their experiences and perceptions of the transfer process from the nursing home to the hospital and back to the nursing home. The review also explores nursing home nurses' perceptions of the transfer process.

Overview of The Hospital Transfer Process

Hospital transfers are common occurrences for nursing home residents. Each year 1 in 4 nursing home residents experience a transfer to the hospital (Robinson et al., 2012). According to Arendts and Howard (2010), about 60% of these residents are admitted to the hospital for further treatment, while Ashcraft and Owen (2014) estimate these numbers around 41-52%. Nursing home residents are transferred to the hospital with expectations that these transfers will lead to better clinical outcomes and increased quality of life (Arendts, Quine, & Howard, 2013). Transfers of nursing home residents to the hospital can be a positive process that allows for the treatment of acute illness. However, in many instances, the risks of hospital transfers outweigh the benefits. Evidence suggests hospital transfers of nursing home residents result in serious complications such as delirium, confusion, agitation, falls, nosocomial infections, decline in function, and pressure ulcers, discontinuity of treatment or medication, miscommunication surrounding advance directives, immobility, restraint use, emotional distress, and even death (Murray & Laditka, 2010; Palan Lopez, Mitchell, & Givens, 2017; Tappen et al., 2014; Terrell & Miller, 2011). Hospital transfers can result in serious complications, poorer health outcomes, decline, and excessive costs (Ouslander et al.,

2009; Palan Lopez et al., 2017; Terrell & Miller, 2011). Hospital transfers significantly increase morbidity and mortality of nursing home residents, because of the loss of functional abilities and emotional distress (Trahan et al., 2016). Many hospital transfers of residents can be avoided with appropriate care being given in the nursing home (Morphet, Innes, Griffiths, Crawford, & Williams, 2015).

About 25% of nursing home residents with advanced dementia are hospitalized in the last six months of life (Lamberg, Person, Kiely, & Mitchell, 2005). Hospital transfers of nursing home residents with dementia can cause unnecessary suffering and increased financial costs (Palan Lopez et al., 2017). Hospital transfers are difficult for nursing home residents with dementia, because they increase the risk of aggressive treatments such as feeding tube insertions and intensive care unit (ICU) admissions (Teno, Mitchell, Skinner, et al., 2009; Fulton, Gozalo, Mitchell, Mor, & Teno, 2014). Research suggests that nursing home residents with advanced dementia who reside in the regions of the United States that have higher rates of hospital transfers and are at higher risks for a feeding tube insertion (Teno et al., 2009). More than one-third of nursing home residents are hospitalized in the last 30 days of life (Cohen, Knobf, & Freid, 2017), and residents with advanced cognitive and severe functional impairment have increased rates of the ICU use in the last 30 days of life (Fulton et al., 2014).

Residents are often transferred to the hospital for conditions that can be managed in the nursing home such as congestive heart failure, pneumonia, urinary tract infections, chronic obstructive pulmonary disease/asthma, pressure ulcers/cellulitis, and dehydration (CMS, 2014; Walsh, Wiener, Haber, Bragg, Freiman, & Ouslander, 2012; Unroe, Fowler, Carnahan, Holtz, Hickman, Effler, . . . Sachs, 2018). The Interventions to Reduce Acute

Care Transfers (INTERACT) program have provided training, tools, and resources to assist nursing home staff in identifying, assessing, and communicating changes in residents' conditions, so that their care can be provided in the nursing home (Ouslander et al., 2011). In addition to promoting early recognition of health condition changes, communication between nursing home staff, healthcare providers, and hospital staff, and management of selected chronic conditions in the nursing home, the INTERACT program also have focused on the advance directive's conversations between nursing home staff, residents, and families prior to their condition changes (Ouslander et al., 2011). Researchers have found that when nursing homes adopt the INTERACT program, they experience lower rates of hospitalizations (Tena-Nelson, Santos, Weingast, Amrhein, Ouslander, & Bookvar, 2012).

In 2012, the CMS launched the initiative to reduce avoidable hospitalizations of long stay residents in seven different states (Ingber, Feng, Khatutsky, Wang, Bercaw, Zheng, ... & Segelman, 2017). One of these projects, Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms: Transforming Institutional Care (OPTIMISTIC) project, was a 2-phase project funded by the CMS in attempts to reduce potentially avoidable hospitalizations and provide resources and education to the participating nursing homes in Indiana (Unroe et al., 2018). The OPTIMISTIC model focused on improving medical care, enhancing transitional care, and supporting palliative care in order to reduce avoidable hospitalizations (Ersek, Hickman, Thomas, Bernard, & Unroe, 2017). The goal was to reduce hospitalizations of nursing home residents by managing six common clinical conditions: pneumonia, urinary tract infection, skin infection, heart failure, chronic obstructive pulmonary disease or asthma, and dehydration

in nursing homes (Unroe et al., 2018). Forty participating nursing homes were able to access some new revenue to help them improve resources to manage residents experiencing acute condition changes "in-house" (Unroe et al., 2018). The OPTIMISTIC project was successful in reducing potentially avoidable hospitalizations (Ingber et al., 2017). Reducing these hospitalizations helped lower the cost for Medicare and Medicaid and improved the quality of care and quality of life for residents (Ingber et al., 2017).

Transfers of nursing home residents to the hospital are also very expensive costing Medicare about $14.3 billion per year (Department of Health and Human Services, 2013). One in four skilled residents are hospitalized within thirty days of admission at the cost of 4.3 billion dollars per year (Toles et al., 2013). Financial costs associated with hospital transfers of nursing home residents include Medicare reimbursements for hospital stays, physician services during these stays, and applicable copayments (Department of Health and Human Services, 2013). There are also strong financial incentives and medical-legal pressures to transfer residents between the hospital and nursing home (Mor, Intrator, Feng, & Grabowski, 2010). On the other hand, nursing homes are financially disincentivized to provide high-cost medical care to residents (Golden, Ortiz, & Wan, 2013).

In addition to health and financial implications, hospital transfers are burdensome and stressful for nursing home residents. In many cases, hospital transfers do not change the course of an illness or improve the quality of life of nursing home residents, but rather result in harmful risks and distress for residents (Cohen et al., 2017). Hospitalized residents frequently receive inappropriate interventions to prolong their life, even though they benefit more from a palliative approach to care, and many die alone in the hospital,

in unfamiliar surroundings, being cared for by strangers (Lamberg, Person, Kiely, & Mitchell, 2005; Waird & Crisp, 2015). Evidence suggests hospital transfers can be prevented when appropriate care is provided in the nursing home and when residents' preferences and goals regarding transfers to the hospital are well known and documented (LaMantia, Scheunemann, Viera, Busby-Whitehead, & Hanson, 2010).

Factors Contributing to Transfers of Nursing Home Residents to the Hospital

Multiple factors including lack of resident and family education about advance care planning (ACP), negative perceptions of nursing home skills and resources, difficult resident and family relationship with nursing home staff, and poor communication among stakeholders involved in the transfer process may contribute to the decisions to transfer residents to the hospital. A common perception is that nursing homes do not have the service and care capacity to provide needed medical care.

Inadequate Use of Advance Care Planning (ACP)

Advance Care Planning

Advance Care Planning (ACP) is the process of learning and making decisions about healthcare and medical treatment, considering these decisions in advance of the acute health event, and ensuring that others are aware of these decisions and preferences (National Institute on Aging (NIA), 2018). ACP involves having a plan in place to ensure that the health treatment a nursing home resident receives is in accordance with his or her preferences and values. Evidence suggests nursing home residents should be involved in making their preferences and values known (Shanley et al., 2011). ACP can help reduce pain and suffering, improve quality of life, and provide a better understanding of decision-making processes involving individuals and their families (Centers for Disease

Control and Prevention (CDC), n.d.). ACP provides more precise guidelines and directions to nursing home staff about decisions surrounding hospital transfers (Shanley et al., 2011) and is also the first step in decreasing hospital transfers for nursing home residents with dementia (Palan Lopez et al., 2017). There are a variety of ACP tools that are used to document nursing home residents' preferences regarding their care and hospital transfers including advance directives, code status orders, do-not-hospitalize orders, and Physicians Orders for Life-Sustaining Treatment (POLST).

Advance Directives. Advance Directives (ADs) inclusive of a living will and durable power of attorney for healthcare or surrogate appointment is a legal document that communicate nursing home residents' preferences about the who and what regarding their care (NIA, 2018). Moreover, a living will is a written document that lists certain emergency situations such as cardiac and respiratory arrest, and the individual preferences of what to do in these situations (NIA, 2018). A durable power of attorney for healthcare is a legal document naming a healthcare proxy, which is an individual who will be responsible for making decisions when the patient is unable to do so (NIA, 2018). This individual must be familiar with the nursing home resident's preferences and values.

Code Status Orders. Another common component in ACP are code status orders, Do-Not-Resuscitate (DNR) or Full code status orders, and are included in the nursing home residents' medical records. A DNR order also known as DNAR (do not attempt resuscitation) or an AND (allow natural death) order is defined as an order that alerts nursing home staff that nursing home resident does not want them to try to resuscitate him or her upon cardiac or respiratory arrest (NIA, 2018). A full code order allows for all life-saving interventions such as chest compressions, electric shock, and

intubation to be attempted in order to get the heart started (Lam, 2019). Evidence about the risks and benefits of cardio-pulmonary resuscitation (CPR) suggests that after cardiac arrest the 30-day survival among nursing home residents is 1.7% and one-year survival is 1.2% (Ellis, 2018). Research suggests that this low survival rate among nursing home residents is due to the older age and higher comorbidities (Ellis, 2018). Older adults and people with multiple chronic conditions have the lowest rates for success following the life-saving interventions (Lam, 2019).

DNH Orders. The do-not-hospitalize (DNH) order indicates that the nursing home residents' or their healthcare proxies' preferences is to avoid hospitalization (Dobalian, 2004) resulting in a reduction in hospital transfers (Givens et al., 2012). Furthermore, nursing home residents with DNH orders also have fewer hospitalizations when nearing the end of life (Dobalian, 2004; Givens et al., 2012). Evidence suggests only 7% of nursing home residents have a DNH order in place (Gozalo, Teno, Mitchell, Skinner, Bynum, Tyler, & Mor, 2011), and those do fail to provide clear guidance for the nursing home staff regarding hospitalizations, but rather serve as a warning to discuss hospital transfers with the resident and family (Cohen et al., 2017).

POLST. The Physician Orders for Life-Sustaining Treatment (POLST) is an ACP documentation form that includes medical orders reflecting nursing home residents' preferences about CPR status, medical interventions including hospitalization, antibiotics, and artificial nutrition (Hickman, Nelson, Perrin, Moss, Hammes, & Tolle, 2010). The POLST form is also used to communicate nursing home residents' preferences related to their treatment wishes. This form is specifically designed for patients with chronic conditions and frailty (Hickman et al., 2010). The POLST form can help initiate and

guide discussions with patients regarding their treatment decisions (Hickman, Keevern, & Hammes, 2015). The form also transfers between nursing homes and hospitals and can be useful in improving communication between care settings (Hickman et al., 2015). Implementation of POLST with nursing home residents can prevent unnecessary treatments and acknowledge residents' preferences for EOL care (Hickman et al., 2015). The Indiana version of POLST form is called POST form, which stands for Physician's Order for Scope of Treatment.

The ACP tools, such as ADs, code status orders, DNH, and POLST orders, can help prevent the transfer of residents from the nursing home to the hospital in situations where residents prefer not to transfer. Evidence suggests that ACP implementation leads to a decrease in emergency visits and hospital admissions (Waird & Crisp, 2015). Nursing home residents with ADs and DNH orders are less likely to be hospitalized when compared to residents who do not have these orders in place (Murray & Laditka, 2010; Givens et al., 2012; Palan Lopez et al., 2017). Despite this evidence, many nursing home residents do not have documentation about resident's preferences and values in place (Ouslander, Naharci, Engstrom, Shutes, Wolf, Alpert, Rojido, Tappen, & Newman, 2016; Tappen et al., 2014). There have also been situations where ADs are in place for nursing home residents, but they are not being followed at the time of hospital transfer (Lamb et al., 2011). Also, in some situations, healthcare providers and nursing home staff fail to involve residents and families in ACP discussions regarding hospital transfers (Tappen et al., 2014). Providing residents and families with the information they need to base their decisions may help them make informed choices regarding hospital transfers (Abrahamson et al., 2016).

Lack of resident and family education about ACP, palliative/comfort care, and hospice benefits has been identified as one of the significant factors influencing resident and family decisions to transfer to the hospital for treatment (Laging, Ford, Bauer, & Nay, 2015; Tappen et al., 2014; Trahan et al., 2016; Shanley et al., 2011). Nursing home residents and families lack adequate information from physicians and accurate understanding of the clinical course and possible complications of chronic health conditions like advanced dementia (Mitchel, Teno, Kiely, Shaffer, Jones, Prigerson, . . . Hamel, 2009) has been identified as a factor influencing hospital transfers. Evidence suggests 18% of family members report that they received information about the prognosis from a physician and only 33% state that a physician educated them about the clinical complications and expectations (Mitchel et al., 2009). Research supports that healthcare providers and nursing home staff need to educate residents and families and involve them in ACP discussions (Shanley et al., 2011). Residents and families also need to be educated about circumstances under which transfers from nursing homes to hospitals for treatment are justified (Tappen et al., 2014).

Negative Perceptions of Nursing Home Skills and Resources

Another factor influencing decision-making for hospital transfers is the perception that nursing homes do not have the service and care capacity to provide necessary or adequate medical care (Abrahamson et al., 2016; Arendts, Popescu, Howting, Quine, & Howard, 2015). Residents and families describe hospitals with a sense of safety, trust, and as institutions that improve clinical outcomes and quality of life for nursing home residents (Arendts et al., 2015; Laging et al., 2015; Robinson et al., 2012) and nursing home care as limited due to a lack of timely diagnostic tests, the inability of nursing

home staff to quickly recognize changes in condition, and avoiding weekend transfers (Abrahamson et al., 2016). Families of nursing home residents believe that the nursing home staff are trained to do aged care, but not acute, sick care (Arendts et al., 2015), and that they lack skills in noticing the resident's condition changes (Abrahamson et al., 2016; O'Connell, Hawkins, Considine, & Au, 2013). The lack of availability of staff, medical services, and equipment in the nursing homes contributes to hospital transfers (Arendts et al., 2015). Also, not having a physician available to visit residents in nursing homes when they experience change in condition and not being able to provide timely medical services in nursing homes, are contributing factors to their decisions to transfer residents to the hospital (Abrahamson et al., 2016; Arendts et al., 2015; O'Connell et al., 2013).

Difficult Relationships with Staff

Resident and family relationships and nurses' knowledge and trust with the nursing home residents are factors that influence resident and family decisions to transfer from the nursing home to the hospital (Abrahamson et al., 2016; Jablonski, Utz, Steeves, & Gray, 2007). An effective family-provider relationship allows for negotiations of decisions surrounding hospital transfers (Robinson et al., 2012). For example, in situations where family members observe nursing home staff treating their relatives with compassion, dignity, and respect results in a sense of trust, confidence, and admiration (Robinson et al., 2012; Tappen et al., 2016). Furthermore, patients report having poor experiences during transfers when their physicians and nurses lack compassion and empathy. Patients want to "feel cared for and cared about" by their physicians and nurses and have healthcare professionals who are committed to their recovery and well-being,

provide care to them (Mitchell et al., 2018). However, more often, patients find their care being delivered without care and compassion, causing mistrust and causing families to become advocates for patients (Mitchell et al., 2018).

Establishing trust between residents, families, and staff starts soon after the admission of the resident to the nursing home. Conversations are initiated in either formal family meetings or during informal conversations and focus on establishing trust between the nursing home staff and families (Palan Lopez et al., 2017). Nursing home nurses report the most challenging part of resident admission is having conversations with the family regarding EOL care and death (Palan Lopez et al., 2017). Nursing home staff must take time to explain to residents and families what acute changes in a health condition can be expected to occur based on the residents' diagnoses, and to describe the risks associated with hospital transfers, so that residents and families can be prepared for when the actual acute event happens. At the time of the acute condition change, staff and families should respond to the change based on the early discussions and make decisions to either have care provided in nursing home or transfer resident to the hospital (Palan Lopez et al., 2017). Nursing home staff can demonstrate respect for residents by treating them with respect, dignity, kindness, compassion, and honesty, by respecting their confidentiality, and by involving them in discussions about their care (NICE, 2012).

Poor Communication

Poor Communication Occurs During Hospital Transfers

The IoM (2001) has identified safety as one of the four care dimensions fundamental to providing person-centered care. Medication errors, communication challenges, and cognitive and mental status communication needs are recognized as a

part of the IOM dimension of safety (Murray & Laditka, 2010). Communication is identified as the most frequently reported barrier to effective hospital transfer (Shah, Burack, & Boockvar, 2010). Poor communication among stakeholders involved in the hospital transfer process including nursing home staff, physicians, ED, and EMS personnel, can negatively affect the quality of care of residents involved in these transfers (Terrell & Miller, 2006). Lack of communication about the baseline cognitive function of residents who are transferred from nursing homes to the hospital presents another challenge during the transfer process (Murray & Laditka, 2010). Sixty-two percent of nursing home residents with moderate to severe dementia have no information about their cognitive and mental status included in the hospital transfer records (Bookvar, Fridman, & Marturano, 2005). Also, EOL communication that lacks care coordination, plan of care evaluations, and discussions about the EOL and hospitalization goals can result in multiple transfers of nursing home residents to the hospital (Cheng, Tororezos, Zorowitz, Novotny, Dubin, & Maurer, 2006).

Communication Regarding Medication

About 20 percent of nursing home residents who have changes in medications during the hospital transfer process are at risk for adverse medication events (Boockvar, Fishman, Kyriacou, Monias, Gavi, & Cortes, 2004). Even though these medication changes occur in the hospital, most of the adverse events happen in the nursing home after residents return from the hospital (Bookvar et al., 2004). These adverse events related to poor communication impact quality of care of NH residents (Bookvar et al., 2004). Nursing home nurses report issues such as missing or inaccurate medications, lack of valuable information about care provided in the hospital, discharge notes from the

physician, and laboratory records with residents' medications, upon the resident's return to the nursing home following hospitalization (Kirsebom et al., 2013). Evidence suggests that improving communication and coordination between hospital and nursing home and implementation of pharmacy consultations can ensure safety of residents who are being transferred between these settings (LaMantia et al., 2010).

Communication Between Nursing Homes and EDs/Hospitals

Communication between the nursing home and the hospital is a concern of family members involved in the hospital transfer decisions of residents (Abrahamson et al., 2016). Family members describe this communication as "poor and disjointed" (Abrahamson et al., 2016). Communication difficulties between nursing homes and EDs result from poor documentation, lack of telephone access, and person-to-person handover (O'Connell et al., 2013). Poor communication and lack of understanding of ED and hospital procedures among nursing home staff can also lead to hospital transfers and overnight hospitalization of nursing home residents (Mercer & Robinson, 2008).

The partnership between the hospital and nursing homes is essential during the transfer process. The focus of this partnership should be on collaboration, communication, and competencies in these care settings (Dizon, Zaltsmann, & Reinking, 2017). Open communication and strong relationships between hospitals and nursing homes leadership teams can improve residents' transfers, provide better outcomes, and reduce readmissions (Rahman, Foster, Grabowski, Zinn, & Mor, 2013). Increased collaboration among nurses in both of these settings can help them understand each other's work situation better (Kirsebom et al., 2013). The hospital can also provide a competency education to the nursing home staff with topics such as aspiration

pneumonia, pressure ulcers, stroke, and heart failure (Dizon et al., 2017). This education can help the nursing home staff recognize changes in condition early and implement interventions to prevent hospital transfers. The nursing home staff can also share best practices with the hospital staff, so that they can have a better understanding of the work nursing home nurses do (Dizon et al., 2017). Improving and understanding the communication between nursing homes and EDs can potentially decrease hospital transfers (Murray & Laditka, 2010).

Transfer of Records. A transfer of the nursing home resident' records to and from the hospital is a vital part of communication that occurs during the transfer process. Accurate medication lists and ADs are vital information that needs to be communicated during hospital transfers (LaMantia et al., 2010). Terrell and Miller (2006) suggest that, in order to improve communication, the ED should receive information about the resident's medical history, medications, baseline conditions, and nursing home contact information. The nursing home should receive information about the resident's ED diagnosis, treatment received, diagnostic test results, and recommendations for treatment and follow up (Terrell & Miller, 2006). Also, establishing communication between sending and receiving clinicians can be beneficial in ensuring continuity of care (LaMantia et al., 2010). Another important part of communication that occurs during the transfer of records process is the use of electronic health records **(**EHRs). EHRs are used to communicate and provide high-quality care to nursing home residents during their hospital transfers and ED visits (Vest, Jung, Wiley, Kooreman, Pettit, & Unruh, 2019). However, most of the EHRs used in nursing homes do not have full capabilities to electronically share patient's information across different providers and care settings

(Vest et al., 2019). In order to improve care for residents experiencing hospital transfers, nursing homes will have to fully integrate their EHRs (Vest et al., 2019).

Decisions to Transfer to the Hospital

Decisions to transfer nursing home residents to the hospital are often based on acute symptoms (Hallgren, Ernsth Bravell, Dahl Aslan, & Josephson, 2015). However, many nursing home residents suggest that they have not even thought about whether they would want to transfer to the hospital if they experience health condition changes (Tappen et al., 2014). In contrast, about 50% of families and nursing home staff indicated that they have thought about these transfers following residents' health condition changes (Tappen et., 2014). In many instances, residents are not empowered or capable of making decisions regarding their health condition changes (Arendts et al., 2013). Shared decision-making can assist with the complex decision-making processes and can add to the empowerment of older adults (Lally & Tullo, 2012). Elements of shared decision-making include decision clarification and availability of options, communication of the risks and benefits, exploration of the patient's values and preferences, and determination about which decision is the best match. When these elements are incorporated into a clinical practice, they allow patients to discuss available options, collaborate with their physician and family members, and make an informed and appropriate choice (Lally & Tullo, 2012).

Family Involvement in Decision-Making

Families strongly influence decisions to transfer nursing home residents to the hospital (Palan Lopez et al., 2017; Tappen et al., 2014). Family members request hospital transfers even in situations where residents are receiving palliative care in the nursing

homes (Tappen et al., 2014). In some instances, family members instruct residents not to make decisions to transfer to the hospital without consulting with them first (Robinson et al., 2012). Family members often feel guilt and distress about the resident's health decline, especially when a condition is perceived as potentially life-threatening, strongly influencing a decision to transfer the resident to the hospital (Arendts et al., 2015). Having family members who are poorly educated about the resident's prognosis and treatment options available in nursing homes, also results in these family members insisting on a hospital transfer of their loved one (Tappen et al., 2014).

Resident's Involvement in Decision-Making

Nursing home residents are not always involved in decisions regarding hospital transfers (Arendts et al., 2015). Residents may not be involved because they are too unwell, hence the transfer. Residents report that usually someone else makes transfer decisions for them. They are also often left under the impression that they must transfer to the hospital for further care (Arendts et al., 2015). The federal guidelines from the State Operations Manual (2017) for nursing homes suggest that residents and their family representatives must be allowed to participate in their care planning process and to be included in decisions regarding their care, treatment, and/or interventions (CMS, 2017). The guidelines also recommend that a resident with impaired ability to make decisions about care and treatment, or a resident who has been deemed incompetent by a court, must still, "to the practicable extent," be kept informed and be consulted on personal preferences (CMS, 2017). About 39% of residents believe that they should be fully

involved in decisions regarding transfers to the hospital, while only 12% of family members and 12% of staff believe that residents should be involved in these decisions (Tappen et al., 2014).

When compared to all stakeholders involved in the decision-making process regarding hospital transfers, nursing home residents are least likely to be active participants (Arendts et al., 2015). In about 60% of transfers, residents report that the decision to transfer to the hospital is made by someone at the nursing home (Jacobsen, Schnelle, Saraf, Long, Vasilevskis, Kripalani, & Simmons, 2017). In only 15.4% of hospital transfer cases, residents insist on hospital transfers (Jacobsen et al., 2017). Nursing home nurses believe that residents should be involved in decisions regarding transfers to the hospital; however, at the time of the actual transfer they fail to involve residents (McCloskey, 2011). Furthermore, nursing home nurses confirm that in many instances, they persuade residents to transfer to the hospital when their condition changes (McCloskey, 2011). Older people have preferences regarding their decision-making and the extent of their involvement depends on how comfortable they are with the process (Lally & Tullo, 2012). Discussions about the extent of the involvement in decision-making and risks and benefits of treatment options are more likely to lead to patients' participation in decision-making (Lally & Tullo, 2012). The involvement of a resident in decision-making can help clarify the resident's values and preferences and encourage a resident's engagement in this process.

In general, research suggests that older people prefer to be informed of the decisions regarding their health options and they wish to take an active role in decision-making (Deber, Kraetschmer, & Irvine, 1996). When patients are involved and satisfied

with decision-making, they are more likely to follow the prescribed treatment options (Pipe, Conner, Dansky, Schraeder, & Caruso, 2005). The barriers to older adults' involvement in decision-making are the commitment to social norms that support passive patient role, sensory and cognitive changes that may affect decision-making, and potential ageism from the healthcare team (Pipe et al., 2005). In order to decrease these barriers, healthcare providers need to spend more time and effort when communicating with older adults about procedures and treatment goals, so that they can feel engaged and participate in the decision-making process (Pipe et al., 2005). There is always the potential for difficulty in communicating with older patients due to their hearing or vision impairments. Using videos, audio tapes, and written information can significantly improve this communication and ensure that patients have a full understanding of their treatment options (Pipe et al., 2005).

Active engagement of patients in health care decision-making also improves their satisfaction and health outcomes (Satin, Swenson, & Stovitz, 2017). Active engagement of patients in the decision-making process can be accomplished by the use of pictograph decision aids to discuss a patient's health condition, possible treatments, and outcomes, clarification and understanding of patient's preferences regarding to treatment options, and choice of plan of care related to patient goals (Satin et al., 2017). A decision-making model developed by Elwyn, Frosch, Thomson, Joseph-Williams, Lloyd, Kinnersley, … Barry (2012) describes a solution on incorporating shared decision-making into clinical practice. This model is based on three steps: 1) choice talk; 2) option talk; and 3) decision talk and is used to guide physicians to help them involve patients in decision-making (Elwyn et al., 2012). The choice talk can be initiated either by the patient or his/her

physician and it includes making sure that patients know that there is a choice about their treatments. This step can be done via email, letter, telephone, or in person. The option talk includes providing education regarding a list of options, discussing the pros and cons of each option, exploring patient's preferences, and offering patient decision support. The final step, decision talk, focuses on the patient's preferences and decision-making. This model encourages patients to convey their preferences during the decision-making process (Elwyn et al., 2012).

Modes of Decision-Making at the Time of Condition Changes

There are multiple models to describe the process of decision-making concerning ED/hospital transfers from nursing homes, including Tappen and Jablonski (Tappen et al., 2016; Jablonski et al., 2007). While the Tappen model accounts for three modes of decision-making in the context of hospital transfers including deliberation, emotion-based, and delegation or trusting specific others process (Tappen et al., 2016), the Jablonski model recognizes three themes such as consensus, conflict, and cogency, which is defined as persuading others in order to reach consensus (Jablonski et al., 2007). Both models recognize the need for better understanding of how decisions to transfer are made, weigh the pros and cons of the choices, and achieve consensus regarding transfer decisions. Participants use their perspectives to resolve conflicts and achieve consensus in transfer decisions (Jablonski et al., 2007). These models also acknowledge the need to include all participants in decision-making and encourage them to share their perspectives (Tappen et al., 2016; Jablonski et al., 2007). Family members are more likely to use the deliberative mode, seeking information and weighing the risks and benefits, while nursing home residents are more likely to trust others to make the decision

(Tappen et al., 2016). Nursing home residents and family members who do not trust nursing home staff to provide adequate care are more likely to decide on a hospital transfer. On the other hand, residents who have bad experiences during hospitalization or hear of others who experience negative outcomes during their hospital stay, are likely to insist on staying in the nursing home (Tappen et al., 2016).

Resident-Centered Approach to Hospital Transfers

While research indicates that the decision-making process during the hospital transfers is of significant importance, person or resident-centered approach to these transfers is also a priority nationally. The IoM (2001) identified person- or patient-centered care (PCC) as one of the six aims focused on improving health care in the 21st century. Patient-centered care includes care that is compassionate, empathetic, and responsive to the preferences, needs, and values of the patient. The IoM (2001) also suggest that patients should be informed and involved in decisions regarding their care. In order to reach this improvement aim, care should be individualized to meet patients' needs and values and patients should be provided with the necessary information and opportunity to be involved in making their own health care decisions (IoM, 2001). Resident or person-centered care is focused on knowledge and respect in regard to the diversity, values, choices, and needs of nursing home residents (Murray & Laditka, 2010). There is increasing recognition that nursing home residents' values and preferences need to be considered when decisions are being made regarding their transfers to the hospital (Murray & Laditka, 2010). Patient preferences that are clearly documented are a crucial factor in decision-making (McDermott, Coppin, Little, & Leydon, 2012) and in the hospital transfer decision (Murray & Laditka, 2010).

The CMS guidelines and current trends in nursing homes focus on resident-centered care. In fact, the federal government made recent changes to the Minimum Data Set (MDS) a set of the assessment and health status screening tools used for all residents living in nursing homes (CMS, 2018). The most significant changes are noted in the direct resident interviews. Several MDS 3.0 sections such as mood, pain, and preferences, now require direct interview of the resident in order to obtain this information. The goal of these interviews is to increase resident's voice in the MDS assessments. The focus is on improving resident input, improving accuracy and reliability, increasing efficiency, and improving staff satisfaction (CMS, 2018). Completing the interviews with nursing home residents requires nursing home staff to involve residents in their care considerations and preferences, which can enhance resident-centered care. With the recognition of resident-centered care, nursing home residents are encouraged to engage in discussions regarding their decisions, plan of care, and preference for hospital transfers. Nursing home residents' involvement and input can ultimately lead to improving their care and quality of life.

Family members need to consider residents' preferences when making transfer decisions for nursing home residents. This is especially important for residents who are unable to make their own decisions (CMS, 2017). Many times, the resident and family transfer preferences are based on the severity of the change in the resident's condition. In order for a successful hospital transfer to occur, nursing home residents' transfers must be person-centered and tailored based on their values, needs, preferences, and cognitive and functional abilities (Robinson et al., 2012). By having a knowledge of what is a baseline for residents including their behaviors, symptoms, and co-morbidities, nursing home staff

can improve resident-centered care related to hospital transfers (Robinson et al., 2012). An individual needs to be seen as a person within the healthcare system and that healthcare needs to recognize and tailor services based on an individual needs, preferences, and values (Staniszewska et al., 2014). Nurses often describe knowing the patient as having in-depth knowledge of the patient's patterns of responses and knowing the patient as a person (Tanner, Benner, Chesla, & Gordon, 1993). Knowing the patient allows nurses to advocate for patients' best interests, personalize their care, and empower them to have a voice (Tanner et al., 1993). Nursing home staff knowledge about residents and their family's needs and preferences as well as being aware of resident's health history and current health status, influences decisions to transfer nursing home residents to hospitals for treatment of chronic conditions (Robinson, et al., 2012; Tappen et al., 2014; Trahan et al., 2016). Discussions with residents and families about their health history, needs, and preferences should occur soon after the admission to the nursing home, so that the nursing home staff can provide individualized care and meet resident's needs (Robinson et al., 2012).

Nursing Home Resident Experiences with Hospital Transfers

Defining Patient Experiences

Patients' experiences are defined as direct, personal observations of their healthcare (Bowling, Rowe, Lambert, Waddington, Mahtani, Kenten, Howe, & Francis, 2012). Patients care experiences should include respect, partnership, shared decision-making, well-coordinated transitions, and efficiency (Institute for Healthcare Improvement, n.d.). Robison (2010) suggested that the ideal patient's experience is created by meeting four basic emotional needs: confidence, integrity, pride, and passion.

Patients need to be respected, communicated with, and have their care coordinated to ensure optimal health outcomes (Stempniak, 2013).

Positive and negative experiences occur during transfers of patients across healthcare settings. The positive experiences are characterized by continuity in care, caring attitudes, and accountability in the healthcare system (Mitchell et al., 2018). These positive patients' experiences can lead to patient satisfaction, caregiver self-confidence, and better adherence to care plans. The poor experiences during transfers involve health care professionals who are not committed to their patients, which results in feelings of fearfulness and abandonment among patients. These negative experiences cause the development of anxiety, confusion, and mistrust in patients and lead to inefficient care delivery and slower recovery (Mitchell et al., 2018).

Several transition care models focus on older adults' experiences, engagement, preferences, and decision-making during their hospital to home transitions (Coleman, Perry, Chalmers, & Min, 2006; Naylor, 2004; Altfeld, 2012; Williams & Coleman, 2009; Project RED, 2012). Coleman et al. (2006) have conducted several studies with chronically ill patients to explore care transitions through different healthcare settings using a transition coach program to help educate patients on how to manage their health and to communicate successfully with the healthcare system. The main goal of this program is to encourage patients to take on an active role during care transfers as their involvement leads to the reduced number of hospital readmissions. This goal is accomplished through the care coordination and continuity of medical health records across settings and a series of follow up visits and calls by a transition coach. The transition coach program consists of medication assistance and self-management, a

patient-centered transfer, timely follow up with primary or specialty care, and any signs and symptoms that can indicate worsening of health conditions (Coleman et al., 2006). Although this model is focused on transfers from the hospital to home, several elements have relevance for hospital transfers of nursing home residents including the focus on care coordination and information transfer as well as the focus on patients (Cwinn et al., 2009; Murray & Laditka, 2010; Staniszewska et al., 2014).

The Warwick Patient Experiences Framework (WaPEF) was developed to describe patient experiences in cardiovascular disease, diabetes, and cancer (Staniszewska et al., 2014), but it has not been used to study the transfer process of nursing home residents to the hospital. However, this framework has particular relevance to the experiences of nursing home residents during the hospital transfer process, because it is developed based on themes extracted from the current literature that focused on patient experiences. The WaPEF was developed in the United Kingdom through the findings of a scoping study (Staniszewska, Boardman, Gunn, Roberts, Clay, Seers, Brett, Avital, Bullock, & O'Flynn, 2011). The IoM framework was used as a starting point for the analysis of themes and subthemes identified in the scoping study. The IoM framework themes include compassion, coordination, information and communication, physical comfort, emotional support, and involvement of family and friends (Staniszewska et al., 2014). The WaPEF builds on the IoM framework by providing a narrative commentary to explain how the IoM themes develop in the WaPEF. The biggest difference between the IoM framework and the WaPEF is that the WaPEF framework considers an active inclusion of patients in their care and advocates the importance of patients' lived experiences (Staniszewska et al., 2014).

The WaPEF is a potentially useful framework for exploring nursing home residents' perspectives. It is focused on seven dimensions of patient experiences with descriptions of the content of each dimension – 1) patient as active participant; 2) responsiveness of services – an individualized approach; 3) lived experience; 4) continuity of care and relationships; 5) communication; 6) information; and 7) support (Staniszewska et al., 2014). These dimensions are used to support and inform the National Institute for Health and Clinical Excellence (NICE) patient experiences guidelines in the UK. The focus of the NICE guidelines is on enhancing the quality of life for people with chronic conditions, ensuring that people have positive care experiences, and treating people in a safe environment and protecting them from avoidable harm (NICE, 2012).

Research on Resident Experiences During Hospital Transfers

Hospital transfers present difficult experiences for nursing home residents (Arendts et al., 2015; Palan Lopez et al., 2017). Residents experience harm as they move between hospitals and nursing homes settings. Transfers that are not managed well can cause residents to experience emotional distress, medication errors, and worsening conditions. During hospital transfers, nursing home residents also display confusion, disorientation, and anxiety in the unfamiliar environment (Palan Lopez et al., 2017). Management of these behaviors is difficult for hospital staff as they are unfamiliar with the specific needs of the individual. Nursing home residents also experience disempowerment in decision-making during the hospital transfer process (Arendts et al., 2015). In most cases, nursing home residents are not consulted about the hospital transfer.

Furthermore, even in situations where nursing home residents make decisions not to transfer to the hospital, their decisions may still get overridden by staff (Arendts et al., 2015).

An Australian researcher team has explored perspectives of nursing home residents, families, and staff regarding the decision-making process during the hospital transfers (Arendts et al., 2015). Nursing home residents describe feelings of resignation and security associated with decisions to transfer to EDs. They also report experiencing a sense of reassurance, safety, and necessity with ED transfers (Arendts et al., 2015). Even though nursing home residents describe the ED environment as chaotic and busy, they still report feelings of security in the ED. Nursing home residents feel secure in the ED, because of having several ED staff around and available to help them in case their condition deteriorates. Some nursing home residents believe that hospital transfers and ED care are necessary for their health. They appreciate the care they receive in the ED, even when this care does not meet their needs and preferences (Arendts et al., 2015).

On the other hand, Carusone and colleagues (Carusone, Loeb, & Lohfeld, 2006) have explored the views of nursing home residents and their families regarding hospital transfers for treatment of pneumonia. The researchers have found that comfort and individualized care are the most important for residents and their families (Carusone et al., 2006). Residents and families prefer that care and treatment for pneumonia be provided in the nursing homes instead of the hospital (Carusone et al., 2006).

Nursing Home Nurses' Perspectives About Transfers from Nursing Homes to the Hospital

Nurses play a key role when a nursing home resident's health condition changes and a transfer to the hospital is being considered and their perspective is therefore important (Arendts et al., 2015; Lagging et al., 2015; O'Connell et al., 2013; O'Neill et al., 2015; Shanley et al., 2011; & Tsai et al., 2016). McCloskey (2011) has found that nursing home nurses display different attitudes in regard to hospital transfers of nursing home residents. Some nurses are quick in making decisions to transfer residents, while others opt for monitoring residents for several shifts and days before making decisions to transfer (McCloskey, 2011). However, nursing home nurses themselves are unsure about their roles and responsibilities when needing to transfer a resident to the hospital. Nurses are still somewhat unsure when care should be provided in nursing homes and at what point transfer to the hospital is absolutely necessary. They find it difficult to make decisions regarding whether or not residents need to be transferred to the hospital (Kirsebom et al., 2012). When making transfer decisions, nurses do consider the potential distress of the unfamiliar environment and staff who do not know residents' preferences (Laging et al., 2015). In addition to the lack of roles and responsibilities for nursing home nurses in the decision-making process, nurses also report several other factors that contribute to hospital transfers including limited access to services and resources, limited skills and confidence, and challenges advocating for the resident (Laging et al., 2015).

Nurses understand that hospital transfers are difficult for nursing home residents and that many variables need to be considered at the time of the transfers. These variables are acuteness of the condition, legal considerations, family input, physician's directives,

and medical support (O'Neill et al., 2015). Nurses fear criticism if they do not transfer residents to the hospital and they worry about being sued for their transfer decisions (O'Neill et al., 2015; Shanley et al., 2011). Nurses report immediately transferring any resident requiring resuscitation, because they do not want to get sued for keeping the resident in the nursing home (O'Neill et al., 2015). They also worry about how other healthcare professionals view them and their transfer decisions (O'Neill et al., 2015) and in many situations, they prefer to have a second opinion regarding their decisions (Carusone et al., 2006). However, nursing home nurses report feeling more confident in making transfer decisions when there is some type of plan and interventions in places such as ACP/ADs, medical care plan, or informal plan of care or agreement (O'Neill et al., 2015; Shanley et al., 2011).

Most nursing home nurses believe that residents receive the best care in the nursing home where they reside (Arendts et al., 2015). However, at times nurses make decisions to transfer residents to the ED due to a lack of resources in the nursing home and professional burden related to trying to take care of a resident with a condition change and several other residents (Arendts et al., 2015). Some nursing home nurses perceive the ED as a place that provides safety net services for residents, because EDs have a physician available at all times, especially during holidays (Arendts et al., 2015). Physicians who provide care in nursing homes are sometimes difficult to contact, because they are not available and not on call at all times. In many situations, nursing home nurses end up calling ED physicians for orders and further directions related to hospital transfers (O'Connell et al., 2013). Inaccessibility to physicians leads to the transfer of nursing home residents to the hospital (McCloskey, 2011). In addition to physicians,

having resources such as timely access to radiology and laboratory results and electrocardiograms (ECGs) allows nurses to provide adequate care to residents in nursing homes (O'Neill et al., 2015).

From nursing home nurses' perspectives, clinical knowledge, skills and resources, including staffing and support, are important considerations regarding possible transfers (Laging et al., 2015; O'Neill et al., 2015; Shanley et al., 2011). Many nurses report that they lack confidence in their assessment skills and judgement (Laging et al., 2015). Nursing home nurses depend on certified nursing assistants (CNAs) to report residents' condition changes to them (Laging et al., 2015). Nursing home nurses need to have the knowledge to recognize early symptoms of health condition changes and assess and manage mental and physiological changes of their residents. They also need to have a verbal and written communication training to ensure effective information exchange between nursing homes and hospitals or EDs and with families and physicians (O'Neill et al., 2015).

Nursing Home Nurses' Perspectives-Family in Power

Once nurses determine that the transfer to the hospital is imminent, they communicate with family members, physicians, and ED staff. Nurses report that, if they have familiar and trusting relationships with family and other healthcare professionals, their viewpoints are considered at the time transfer decisions are being made (Hov, Athlin, & Hedelin, 2009). Nurses describe family members as the ones in a position of power at the time of transfers (O'Neill et al., 2015). A transfer to the hospital may be delayed if family members want to come to the nursing home and see the resident themselves to make sure he or she actually needs to be transferred (Tsai et al., 2016). A

lack of family involvement in the resident's transfer is due to the inability of nurses to reach the family, inability to promptly come to the ED, and their differences in opinions about medical decisions (Tsai et al., 2016). Nursing home nurses report that at times, family members devalue their decisions to transfer a resident to the ED, because they do not expect a resident's condition to change fast (Tsai et al., 2016).

Nursing Home Nurses' Negative Perceptions of Residents' Experiences with Hospital Transfers

Many nursing home nurses do not believe that residents are treated the same way as younger adults in the hospital (Kirsebom et al., 2012; O'Neill et al., 2015). Nurses also indicate that they are aware that residents may not be treated right away or aggressively by the ED staff, because other patients may require immediate services (Tsai et al., 2016). Nurses base these perceptions on their own experiences when sending residents to the hospital and residents returning to the nursing home from the hospital with newly developed pressure injuries and medication issues (O'Neill et al., 2015). On the other hand, ED staff devalue nursing home nurses' care quality and roles, because of a lack of understanding about nursing home care by the ED staff and stereotypes about nursing homes (Tsai et al., 2016). Negative interactions with paramedics and ED staff contribute to nurses' perceptions surrounding hospital transfers (O'Neill et al., 2015).

Summary

The goal of this study is to gain a better understanding of a transfer process of residents from nursing homes to the hospital. Understanding the experiences and perspectives of residents during the hospital transfers, their involvement in decision making at the time of transfers, providing resident-centered care during transfers, and

nursing home nurses' perspectives on hospital transfers can lead to improvements in these processes and ultimately help achieve truly person-centered care. Nursing home to hospital transfers are complex and present difficult experiences for nursing home residents. Nursing home residents and their families together account for approximately one-third of hospital transfer decisions. Even though residents believe that they need to be involved in the hospital transfer decisions, nursing home staff and families do not always find their involvement necessary. Including the nursing home resident in decision-making can help clarify resident's values, preferences, and goals and encourage a resident's engagement in this process. A resident's active engagement in healthcare decision-making can improve their satisfaction and health outcomes. Also, nursing home nurses and family members need to have a knowledge of residents' preferences, values, needs, and cognitive and functional abilities. By knowing what a baseline for residents is including their behaviors, symptoms, and co-morbidities, nurses can improve resident-centered care and experiences related to hospital transfers. Discussions with the nurses, residents, and families should happen soon after the admission to the nursing home. These team discussions allow nurses to implement resident-centered care based on the resident's health history, needs, and preferences. This same resident-centered approach to care can be taken during the nursing home residents' transfers to the hospital.

Many factors influence decisions to transfer nursing home residents to the hospital or ED. These factors include a lack of resident and family understanding about ACP, resident and family perceptions of nursing home care and service capacity, resident and family relationship with staff, and communication. Participation of nursing home staff, families, and residents in the care planning process can improve factors influencing

decisions to transfer residents to the hospital by building trust in nursing care and improving communication among all stakeholders. Also, discussions about ACP must be conducted among all stakeholders upon admission to the nursing home, quarterly, and with any changes in health conditions. ACP tools put in place prior to the hospital transfers can ensure that a resident-centered approach is taken during these transfers.

Nursing home nurses are identified as key participants in the transfer process of residents between nursing homes and hospitals. Nurses believe that residents receive the best care in the nursing home where they live. Nurses also suggest that they do not trust that nursing home residents are treated the same way as younger people in the ED. Nursing home nurses need to understand their own responsibilities, improve resident, family, and physician communication, and become more decisive and confident during this transfer process. Learning more about the nursing home nurses' perspectives on issues that arise after the resident returns back to the nursing home can improve the transfer process.

Conclusion

Information about residents' involvement and experiences during transfers from nursing homes to the hospital may lead to changes in how transfers occur, resulting in improvements in the residents' quality of life, resident satisfaction, and health outcomes. Also, knowing, valuing, and considering the residents' perceptions and experiences can assist nursing home staff in developing resident-centered approaches for the management of hospital transfers. Exploring nurses' perceptions of the transfer process and their perceptions of issues that are identified after the resident returns to the nursing home can provide a better understanding of the circumstances surrounding transfers. This

qualitative study of the resident and nurse perceptions of the transfer process is designed to describe the decision-making process at the time of the hospital transfer, the involvement of residents in the transfer decisions, and their experiences of the transfer process, as well as the issues that arise after the resident returns back to the nursing home.

CHAPTER THREE-METHODS

This chapter describes the methods that were used to explore nursing home residents' decision-making process at the time of the hospital transfer, their preferences regarding transfers, residents' experiences and perceptions of the hospital transfer, and nursing home nurses' perceptions of the transfer process of residents and issues that arise upon their return to the nursing home.

Design

Qualitative descriptive methods were used in this study to address the study aims. The goal of qualitative description is to produce a comprehensive and straightforward summary of a phenomenon as described by relevant stakeholders (Sandelowski, 2000). Qualitative description is a type of naturalistic inquiry that that allows a researcher to understand events in persons' everyday lives from their own perspectives (Bradshaw, Atkinson, & Doody, 2017). The approach does not yield a highly abstract or conceptual rendering of data as do other methods such as grounded theory or phenomenology, but rather uses a low-interpretive analysis to construct a clear and useful account of the participants' actions and views related to a phenomenon of interest (Sandelowski, 2000). Purposive sampling, semi-structured interviews, and content analysis are procedures commonly used in this method to identify persons who can speak to the phenomenon of interest, collect texts in their own words, and summarize the texts in ways that provide pragmatic answers to questions relevant to practice and policy (Bradshaw et al., 2017; Sandelowski, 2000). The qualitative descriptive approach was appropriate for this study as the goal was to produce a straightforward description of hospital transfers from the

perspectives of nursing home residents and nurses and to summarize their views on preventing transfers that may be unnecessary.

Study Aims

Qualitative descriptive methods were used to address the following specific aims:
Specific Aim 1: Describe nursing home residents' perceptions of the decision-making process at the time of the transfer and their involvement in the decision;
Specific Aim 2: Describe residents' experiences and perceptions of the transfer process from the nursing home to the hospital and back to the nursing home;
Specific Aim 3: Describe nurses' perceptions of the transfer process of nursing home residents to the hospital including perceptions of the residents' decision-making process at the time of transfers;
Specific Aim 4: Describe nurses' perceptions of the issues that arise after the resident returns back to the nursing home.

Addressing these aims ensures information that can provide the foundation for the development of interventions or strategies to improve the transfer experiences of nursing home residents or prevent transfers that may be avoidable. The transfer process includes all actions and interactions from the time a change in residents' health status is observed and transfers are considered until residents return and reacclimate to the nursing home.

Settings

The study was conducted in four nursing homes located in northeast Indiana between August 2020 and May 2021, a timeframe that overlapped the COVID-19 pandemic. All four nursing homes used in this study were not-for-profit continuing care retirement communities and were located in small communities in rural areas. The

nursing homes selected for inclusion represented a convenience sample as they were selected based on the researcher's prior relationships with the facilities and ease of access for data collection. All four nursing homes had a 5-star overall rating by the CMS meaning that they are considered to have above average quality (CMS, 2019). Table 1 below contains an overview of facility characteristics including location, profit status, bed size, and CMS Star Rating.

Table 1

Participating Nursing Homes

Name of the Nursing Home	Location	Profit Status	Bed Size	Star Rating
ID #1	Rural Indiana	Not-for-profit corporation	128 bed healthcare center	*5-star overall rating (top 20% of NHs in Indiana) -5-star Health Inspection -5-star Quality Measures -5-star Nursing Staffing
ID #2	Rural Indiana	Part of Critical Care Hospital	143 bed healthcare center	*5-star overall rating -5-star Health Inspections -2-star Quality Measures -3-star Nursing Staffing
ID#3	Rural Indiana	Not-for profit	86 bed healthcare center	*5-star overall rating -5-star Health Inspections -5-star Quality Measures -4-star Nursing Staffing
ID #4	Rural Indiana	Not-for profit corporation	183 bed healthcare center	*5-star overall rating -3-star Health Inspections -5-star Quality Measures -4-star Nursing Staffing

Sample

The study population included nursing home residents in the targeted nursing homes and nurses who had experienced a hospital transfer. Both groups were targeted so that the experience of transfers could be described from both groups' perspectives. Participants were recruited using purposive sampling. Purposive sampling is a sampling technique in which the researcher relies on his or her own judgment and targets a population whose characteristics meet the needs of the study aims (Dudovskiy, 2017).

Eligibility Criteria

Residents

Inclusion criteria for nursing home residents included the following: 1) has a chronic condition(s); 2) has experienced a transfer to the hospital in the last month; 3) is willing and able to participate in the study; 4) has a Brief Interview for Mental Status (BIMS) score of 13-15 (cognitively intact) or BIMS score of 8-12 (moderate cognitive impairment); and 5) are able to recall events and experiences surrounding the hospital transfer. Having at least one chronic condition was an inclusion criteria as this circumstance predisposed residents to frequent hospital transfers for the management of these health conditions. Both short and long stay nursing home residents were included in this study. Exclusion criteria for residents included the following: 1) BIMS score less than 8 (severe cognitive impairment); 2) experienced hospital or ED transfers more than a month ago; and 3) unable to recall events regarding the hospital transfer.

Nurses

Inclusion criteria for nursing home nurses included the following: 1) English-speaking; 2) Registered Nurses (RNs) and Licensed Practical Nurses (LPNs); 3) currently

working in the nursing home; and 4) involved in one or more transfers of residents to the hospital and/or back to the nursing home within the last month.

Targeted Sample Size

The sample size in qualitative descriptive research is not determined a priori but is estimated based on the amount of information needed to answer the study aims (Bradshaw et al., 2017). However, a sample size between 10 and 20 participants per stakeholder group is common in qualitative descriptive studies (Kim, Sefcik, & Bradway, 2017). Because the aims focused on a circumscribed event (e.g., hospital transfers) and relied on straightforward descriptions of the event, 15 to 20 residents and 15 to 20 nurses were targeted for the study.

Study Procedures

Facility Engagement

The researcher contacted the executive directors and/or administrators (hereafter referred to as managers) at the four nursing homes via email to ask for permission to collect data in each facility. The researcher briefly explained the project, stressing that participation in this study was voluntary and that refusals were honored. All managers agreed to study participation and identified a contact person with whom the researcher should correspond. The contact persons were charge nurses on dayshift. The researcher then met with the contact persons to explain the study. The researcher obtained permission to complete in-person interviews with about 4-5 nursing home residents and 4-5 nursing home nurses in each facility and to access the nursing home residents' electronic medical records (EMR). Each participating nursing home was assigned a unique identification number (ID#).

Participant Recruitment

Residents

The contact persons at each facility identified residents for potential study participation. The researcher reviewed their medical records to ensure they met study criteria. The contact persons confirmed that the residents were well enough to be interviewed and the interview would not interfere with their care routine. The contact person introduced the researcher to the residents and assessed whether they were open to learning about the study. The contact person explained that the researcher was a doctoral student from Indiana University and asked if the residents would be willing to meet in a private room to learn more about the study. If they agreed, the contact person transported them to a private room where the researcher conducted the interview.

Nurses

The managers also identified nurses who had recently participated in transferring a resident to the ED/hospital and/or readmitting a resident back to the nursing home after an ED visit or hospital stay. The researcher approached eligible nurses in the nursing home settings and briefly explained the study to them. For those who expressed interest in participating, the researcher explained the study further and arranged an interview for those who agreed to participate. The researcher interviewed nurses involved in transfers even if the resident involved was unable/unwilling to participate.

Data Collection

Medical Records Data

Data were extracted from participating residents' charts to verify eligibility and to document events surrounding the participants' recent hospital transfers. Information that

was extracted that included the following: most recent quarterly or annual CMS Minimum Data Set (MDS) assessment, medical diagnosis, and documentation regarding recent transfers. Nurses' notes and MDS assessments were reviewed to ensure that residents experienced a transfer from the nursing home to the hospital and back to the nursing home within the last month. Dates of these transfers were obtained. Monthly logs kept by the facilities confirmed dates of transfers. Resident demographic information such as admission date, race and ethnicity, educational history, marital status, and presence of advance directives were also extracted from the resident's medical record.

Residents' recent scores from the Brief Interview for Mental Status (BIMS) were also extracted from their medical records. The BIMS is a required screening tool in nursing homes used to assess resident's cognitive status (Heerema, 2019) and was used to determine participant eligibility. The test is administered quarterly or with a change in condition and indicates level of cognitive impairment. The BIMS tests attention, orientation, and short-term memory. Scores indicate the following: 13 to 15 – cognitively intact, 8 to 12 – moderately impaired, and 0 to 7 -- severe impairment (Heerema, 2019).

Interview Guides

Development. Interview questions were developed to guide data collection (see Appendix A and Appendix B). The development of the interview guides was informed by The Warwick Patient Experiences Framework by Staniszewska et al. (2014). This framework focused on seven dimensions of patient experiences. These dimensions were as follows: 1) patient as active participant; 2) responsiveness of services – an individualized approach; 3) lived experience; 4) continuity of care and relationships; 5) communication; 6) information; and 7) support (Staniszewska et al., 2014).

An interview guide created by Locke, Wyrick Spirduso, and Silverman (2014) and a questionnaire created by Tappen et al. (2014) were used to guide the formatting and content of the interview guide. Locke et al. (2014) starts the interview process by informing the participants about the purpose of the study, discussing how their confidentiality is protected, alerting them to the recording of the interviews, and sharing the background of the interviewer (Locke et al., 2014). The Tappen et al. (2014) questionnaire was developed to ask residents who have not experienced a hospital transfer about a hypothetical transfer situation, including reasons for potentially avoidable hospitalizations. This questionnaire included questions regarding preferences for hospital transfers and involvement in decision-making (Tappen et al., 2014).

Residents' Interview Guide. The participating residents' interview guide (see Appendix A) began with the broad data generating questions "Please tell me about the time when you got sick and had to go to the hospital," and "Please tell me everything you remember about this hospital transfer experience." Other items queried how the decision was made that they would be transferred, their role in that decision, their experience being transported to the hospital, their experiences in the hospital, and their return to the nursing home. Questions about how long they had lived in the nursing home, how many times they had been to the hospital since moving to the nursing home, and if their family was involved in their care were also included.

Nurses' Interview Guide. The nurses' interview guides (see Appendix B) also started with the broad data generating questions including "Please tell me about the recent experience you had with transferring a resident to the hospital or readmitting the resident back to the nursing home," and "Please describe the events that led to this

hospital transfer." Other items queried their roles in the transfer decisions, their perceptions of the residents' transfer to the hospital, and issues that arose after the resident returned. Questions about how long they had worked in the nursing home, what their educational background was, and how many times they had been involved in the transfer of resident to the hospital and back to the nursing home were also included.

Participant Consents and Interviews

Residents. The interviews with resident participants were conducted in person in the private area of the nursing home where residents lived. Prior to the interview, the researcher provided a copy of the consent document to the residents and read it aloud, focusing on important points. The residents were informed of the purpose of the study and their role in the study. All study procedures were explained, and residents were encouraged to ask questions. Residents were instructed that they were free to withdraw from the study at any time (see Appendix C and Appendix D). After the residents signed the document, they received a copy, and another was placed in their medical records. Prior to turning the digital recorder, the researcher obtained verbal permission to audio-record the interviews. Interviews were conducted and guided by the questions described above. If a participating resident appeared fatigued or was unable to stay focused, the interview was interrupted by breaks and in some instances divided in two sessions. At the end of the interview, they were provided with the name of the researcher so that they could contact her with any questions they might have related to their participation. The interviews were digitally recorded and transcribed by a professional transcriptionist.

Nurses. The interviews with nurse participants were conducted in person in the private area of the nursing home where nurses worked. Prior to the interview, the

researcher explained the study in greater detail. A waiver of written informed consent had been obtained for the nurses. They were informed of the purpose of the study and their role in the study. All study procedures were explained, and nurses were encouraged to ask questions. They were informed that they were free to withdraw from the study at any time (see Appendix E). The administration had the researcher's email and phone number in case they had any further questions or concerns. Prior to turning the digital recorder, the researcher obtained verbal permission to audio-record the interviews. Interviews were conducted and were guided by the questions described above. The interviews were digitally recorded and transcribed by a professional transcriptionist.

Data Management

The digitally recorded interviews were sent to and returned from a professional transcriptionist by a secure file transfer process. All recordings and transcriptions were stored in a password protected folder in Box Health, which was a university-maintained file server approved for storing protected health information (PHI) data as regulated by the Health Insurance Portability and Accountability Act (HIPAA). All digital recordings were erased from the recording equipment. Identifying information was removed during transcription, and the researcher verified the removal of identifiable information and accuracy of the transcriptions. The codes and names of participants were maintained in a separate secured file and destroyed at the end of data collection.

Data Analysis

Data were analyzed with conventional content analysis (Hsieh & Shannon, 2005). This inductive approach is used when the goal is to describe a phenomenon by allowing analytic structures such as codes and categories to be derived from the data without

imposing preconceived theory or research findings (Hsieh & Shannon, 2005). The data set for the content analysis was all relevant data provided in the participants' narratives. The data from the participating nurses and residents were analyzed side-by-side to allow integration of both perspectives in the findings. However, data from each group were tracked to ensure the contributions made by each group were clearly attributed to the correct group. The content analysis was carried out in six steps as described by Miles, Huberman, and Saldaña (2014).

Step One-Review of Transcripts

All transcripts were read several times by the researcher to gain an appreciation of the participants' narratives in their entirety. The researcher wrote a brief summary of the stories of transfers within each transcript and summarized other main thoughts expressed by the participants. The researcher's initial impressions of the interviews were noted in memos and shared with the committee members.

Step Two-Extraction of Text Units

The researcher highlighted all narrative text that addressed the study aims. This text was divided into text units, which are segments of text (e.g., words, phrases, sentences) that reflect a discrete point.

Step Three-Coding

The researcher coded all relevant text units with a brief phrase that captured the essence of each. Miles et al. (2014) defined the codes as "tags or labels for assigning units of meaning to the descriptive or inferential information compiled during the study" (p. 56). A dissertation committee member verified that the codes aptly described the meaning of the text units.

Step Four-Creating Data Display Tables

The researcher developed a series of data display tables as described by Miles et al. (2014). The first table organized all relevant codes. Each row represented a participant (indicated by the assigned case number) and each column represented a major topic discussed by the participants. The topics aligned with the interview questions and were primarily related to the process of transfer or recommendations about preventing potentially preventable transfers. Codes were placed in the appropriate cells. For example, one of major topics was how transfer decisions were made. Therefore, codes attributable to participant 001 related to transfer decisions were placed in the corresponding cell (001 X transfer decision).

Step Five-Categorization

For each topic, the researcher grouped similar codes in each column into categories. The categories were discussed with the committee member and modified through a review of the transcript data and discussion and consensus. Through the use of additional data display tables, the categories were then subdivided further. For example, one major category related to the transfer decision was *the roles of people involved in transfer decisions* and this category was further sub-divided into nurses, providers, family members, and residents. The topics, categories, and subcategories were then placed in logical order to present the findings. For example, the transfer process was described by placing the categories in the order events would naturally occur (e.g., documentation and awareness of residents' goals of care regarding transfers, reasons for transfers decisions, the roles of people involved in transfer decisions, facility factors that influenced transfers, and so on).

Step Six-Narrative Summary

Once the data had been organized as described above, the researcher wrote a narrative summary of the findings structured according to how the main topics, the categories, and sub-categories had been ordered. Verbatim quotes were inserted to support the findings as presented in the summary. The dissertation committee chair and another committee member reviewed the findings to ensure they well represented the participants narratives.

Based on these findings, the researcher chose the narratives of four participants to develop into case summaries. Cases were chosen because the participants had provided robust data about the transfer process and each exemplified a variety of the findings presented in the narrative summaries. The descriptions of the cases were structured to align with the findings related to the transfer process.

Evaluative Framework

An evaluative framework discussed by Miles et al. (2014) was used to guide activities to enhance the quality of study findings. The framework includes five standards: Confirmability, dependability, credibility, transferability, and utilization. For each criteria, Miles et al. (2014) outlined several study procedures that can be used to address each standard.

Confirmability

Confirmability is the "relative neutrality and reasonable freedom from unacknowledged researcher biases" (Miles et al., 2014, p. 311). Several procedures were used to enhance the confirmability of the study findings. The researcher provided an explicit and detailed description of the study methods and procedures and followed the

procedures with fidelity or documented the rationale for any deviations. The researcher kept all original memos, transcripts, coding documents, and data displays, and these detailed records serve as the study's audit trail. All analytic decisions are evident in a series of data display tables, and all conclusions are clearly linked to the data.

The researcher was aware of her potential personal biases due to her administrative and clinical positions in nursing home settings and discussed these biases regularly with her committee members. The positionality of the researcher was also examined when the study was designed because she worked as a health facility administrator in one of the nursing homes where data were to be collected. She completed a few interviews with the residents with whom she had no direct contact but did not interview any nurses. This decision was made because she had authority over these nurses, and this may have influenced their responses or made them uncomfortable. Once she left this nursing home, she conducted interviews with nurses as she no longer had authority over them. These issues were discussed with her research advisors.

Dependability

Dependability is reflected in findings that are "consistent, reasonably stable over time and across researchers and methods" (Miles et al., 2014, p. 312). Dependability was enhanced through frequent and regular peer debriefing. The researcher met regularly with her committee members who read all transcripts, reviewed all codes, helped form categories, and reviewed the narrative summaries of the findings. Committee members also ensured that study procedures were followed consistently. All analytic and methodological decisions were made through discussion and consensus with committee members and documented in the audit trial.

Credibility

Credibility is defined as "truth value" of the study findings (Miles et al., 2014, p. 312). Credibility is reflected in study findings that make sense and are true to the data. Several procedures were used to enhance the credibility of the study. Semi-structured interview guides based on the study purpose were used to collect rich and meaningful data from both participating nurses and residents. The interview guides were reviewed and approved by the researcher's committee members. The researcher was well familiar with the study population, which created a shared understanding of the topics discussed in the interview. The findings are detailed, remain close to the participants words, and are well supported by verbatim quotes. The contributions of both participating nurses and residents are clearly indicated but merged to provide a comprehensive description of transfer processes from both points of view. The four case studies also contribute to the credibility of the findings by providing detailed and clear depictions of the transfer processes as outlined in the findings.

Transferability

Transferability is the ability to "transfer study findings to other populations or contexts" (Miles et al., 2014, p. 314). The researcher describes the sample and institutions where data were collected fully, which allows readers to determine if the findings are applicable to their own settings or contexts or their own populations of interest. Information provided about study participants includes gender, race, ethnicity, age, marital status, highest level of education, BIMS score, code status, POST form, family lives nearby, and transfer involvement. Information about the nursing home settings included location, profit status, bed size, and quality star ratings.

Utilization

Utilization is the ability for researchers and consumers to use the study findings and for the findings to lead to "positive and constructive actions" (Miles et al., 2014, p. 315). The study findings are written using clear and straightforward language that is accessible to the nursing home nurses, residents, families, and other researchers conducting studies in nursing homes. The findings provide practical and actionable information that can be used to develop practices that will improve the process of nursing home to hospital transfers and prevent transfers that are potentially preventable.

Human Subjects Protection

Throughout the study, procedures were taken to protect the rights of the study participants. Before recruitment, IUPUI Internal Review Board (IRB) approval was obtained. Throughout the study, participant information was protected in accordance with the Health Insurance Portability and Accountability Act (HIPAA). As described above, consent procedures ensured that participants were fully informed about study procedures, risks and benefits, and protections for confidentiality. They were informed that participation was voluntary, and they could stop at any time.

The study involved no more than minimal risk to participants. The potential risk was the possibility of a loss of confidentiality. Procedures taken to protect against the risk of a loss of confidentiality including the storage of data (medical record data, interview recordings, transcriptions) on a secure file storage platform and the use of a secure file transfer process, removing identifying information from participant data, and deleting identifying information when date were collected. Participant data were identified using a

unique identification number assigned to each participant at the time of enrollment. All paper-based study materials were stored in a locked file cabinet in the locked office.

The study participation may or may not have directly benefited study participants. Participation may have provided residents with insights into their experiences with hospital transfers, increased their awareness of the decisions that were made at the time of the transfers, and allowed them an opportunity to discuss their preferences related to transfers. Similarly, participation may have provided nurses with a better understanding of the transfer process and risks involved.

CHAPTER FOUR-FINDINGS

Introduction

This chapter presents the study findings. The results of the qualitative analysis are divided into two main sections. The first section is a description of the process of transfers from the nursing home to the hospital (hereafter referred to "transfers"). The second section is a description of the participants' recommendations regarding preventing potentially preventable transfers. The chapter concludes with a brief summary of the findings.

Sample Description

Ten residents and 12 nurses from the four participating nursing homes participated in the study between August 2020 and May 2021. The personal and health characteristics of the participants are described below.

Participating Residents

Ten residents participated in the study. Half (50%) were women, and all were white. They ranged in age from 80 to 100 (mean age = 89). Half (50%) completed high school and half (50%) had college degrees. Most (70%) had family members living nearby. Sixty percent (60%) had experienced multiple transfers to the hospital during their life, while 40% had experienced only one or two transfers. Seventy percent had advance directives in place with "do not resuscitate" orders, and 30% had a "full resuscitation" order. Only 10% had a POST form in place. BIMS scores ranged between 14 and 15 (out of 15 total) indicating that all were cognitively intact at the time of the interview. Table F-1 summarizes the additional characteristics of the resident sample (see Appendix F).

Participating Nurses

Twelve nurses participated in the study. All were women, and all were white. They were between the ages of 29 and 59 years, with an average age of 42 years. They had between 2 and 28 years of experience in the nursing field. Eight of the nurse participants had Associated Science in Nursing degree (ASN), three were Licensed Practical Nurses (LPN), and one had a Bachelor of Science in Nursing (BSN). Most of the nurse participants were involved in several transfers during their nursing careers except for one nurse who had transferred a resident only one time. Table G-1 summarizes the demographic characteristics of the nurse sample (see Appendix G).

Description of Interviews

The resident interviews were conducted in person in the private area of the nursing home where the residents lived. The interviews lasted between 30 and 50 minutes, with an average of 40 minutes. In response to interview questions, many participating residents readily provided detailed descriptions of their experiences with transfers, whereas some discussed transfers in general terms and had to be prompted to describe their recent transfer. While several were very talkative and eager to share their thoughts and experiences, a few answered the questions very briefly and had to be encouraged to provide more explanation about the events surrounding transfers. Many discussed other topics such as their families, their overall health, and their nursing home experiences but were able to be redirected back to the topic of their transfer. Most were able to recall their transports to the hospital, their hospital stays, and their returns to the nursing home. Due to condition changes, however, a few had a difficult time recalling some details about the transfer itself or the first few days in the hospital.

The interviews with nurse participants were conducted in person in the private area of the nursing home where nurses worked. The interviews lasted between 25 and 45 minutes, with an average of 35 minutes. Most provided detailed descriptions of their experiences with resident transfers. Some discussed their thoughts about transfers in general terms and had to be prompted to describe a specific transfer in which they had been involved. While several were very talkative and willing to share their thoughts about resident transfers, a few answered the interview questions very briefly and had to be encouraged to provide more explanation about the events surrounding transfers.

Findings

All codes drawn from the participating nurses and residents related to hospital transfers were placed on data display tables and summarized as described in Chapter 3. The codes were divided into two main topics: (1) the transfer process as experienced by participating nurses and residents and (2) participant recommendations for preventing potentially preventable transfers. The findings as related to these two topics are summarized below with supporting evidence and verbatim quotes from the participant transcripts. The summaries indicate which findings are based on information provided by the participating nurses and which findings are based on information provided by the participating residents. In addition, four case summaries are presented to demonstrate the transfer process in its entirety from the decision to transfer to the residents' return to the nursing home.

The Transfer Process

All the participating nurses and residents described at least one transfer. The participating nurses described one or more transfers they had been involved in, and the

participating residents described the transfers they had experienced themselves. Four aspects of the transfer process were extracted from the codes: (1) transfer decisions; (2) the transport experience; (3) the residents' hospital stay; and (4) the residents' return to the nursing home.

Transfer Decisions

Participating nurses and residents described how transfer decisions were made from their perspective. Descriptions of the transfer decisions including the following elements: (1) documentation and awareness of resident goals of care regarding transfers; (2) reasons for transfer decisions; (3) the roles of people involved in transfer decisions; (4) facility factors that influenced transfer decisions; and (5) resident responses to transfer decisions.

Documentation and Awareness of Resident Goals of Care Regarding Transfers

The participating nurses indicated that most of the time, residents' preferences about being transferred to the hospital were not documented in their records nor discussed with them or their families ahead of time. The participating nurse said, "We never really talked about her preferences on going to the hospital" (#412). When preferences were documented, it typically specified that the residents wished for comfort care at the nursing home rather than being transferred to a hospital, except in the case of an acute injuries such as a fracture. However, this documentation in the residents' records did not influence transfer decisions because in each of the situations described by participating nurses, the residents had an acute injury and needed immediate care. A few participating nurses were aware of residents' preferences regarding transfers due to "impromptu" conversations with families, but these conversations were not documented

in the residents' records. One family member brought in a POST form that specified a preference to avoid hospitalization after the resident was hospitalized. The participating nurse said, "We [nurses] knew that she [the resident] just wanted more comfort care at that point than to keep getting sent to the hospital and having labs drawn and trying to prolong life when it [transfer] was just causing her more harm than good" (#404).

Reasons for Transfers Decisions

Participating nurses and residents indicated that the reasons for the hospital transfers were most often acute exacerbations of symptoms related to the residents' chronic or serious conditions. The chronic or serious conditions that led to the transfers were urinary retention, COVID-19, congestive heart failure, stroke, cellulitis, rectal bleeding, vomiting, pancreatic cancer, and urinary tract infection (UTI). The symptoms related to these conditions were abdominal pain (reported by 1 participating nurse, 1 participating resident), respiratory distress (reported by 1 participating nurse, 1 participating resident), edema and weight gain (reported by 1 participating nurse), cognitive changes (reported by 3 participating nurses), leg pain (reported by 1 participating resident), rectal bleeding (reported by 1 participating nurse, 2 participating residents), vomiting (reported by 1 participating resident), chest heaviness (reported by 1 participating resident), and altered mental status (reported by 1 participating resident). The participating nurses and residents implied to each of these symptoms as the cause of a hospital transfer. Other reasons for transfers not tied directly to chronic or serious conditions included falls (reported by 4 participating nurses, 1 participating resident), choking (reported by 1 participating nurse), and receiving the wrong medication (reported by 1 participating resident).

The Roles of People Involved in Transfer Decisions

Participating nurses and residents indicated that four kinds of persons were involved in making transfer decisions: direct care nurses, medical providers (nurse practitioners and physicians), residents, and family members. References to nurses included nurses providing direct care and references to providers included nurse practitioners and physicians responsible for treatment decisions. These persons were involved in the transfer decisions in several ways: driving the decision, providing input into the decision, accepting the decision, and authorizing the decision. In some instances, at least one of these individuals was not included in the decision-making. The ways in which each of the four groups were involved in the decision-making are described below.

Nurses' Role in Transfer Decisions. Participating nurses and residents indicated that nurses at the nursing homes were often involved in transfer decisions. Participants described how nurses either drove the transfer decisions or provided input into them.

Driving the Decision. Participating nurses and residents described several instances in which a nurse drove the decision to transfer a resident; that is, a nurse was the one who actually "made the call." Most often, nurses completed an assessment, decided if the residents' condition warranted evaluation or care in the hospital, and notified the provider to request a formal order to transfer. The participating nurse said, "I thought that she [the resident] was no longer suitable to be within the nursing home and needed more care than we could give her. I called the doctor and he agreed" (#404). A few participating nurses indicated that they had to "push" the provider to agree to the transfer. One nurse stated, "Nurses influence every transfer decision a little" (#405).

Providing Input into the Decision. A few participating nurses indicated nurses were involved in the transfer decision by helping another nurse with an assessment and "weighing in" about whether a transfer was necessary. One participating nurse described an instance in which another nurse helped the participant lift a patient who had fallen and the two discussed the need for transfer. The participating nurse said, "We felt like it was in his [the resident's] best interest to send him" (#408).

Providers' Role in Transfer Decisions. Participating nurses and residents indicated that providers were often involved in transfer decisions. Participants described how the providers either drove or authorized the transfer decision.

Driving the Decision. Participating nurses and residents described some instances in which a provider rather than a nurse drove a decision to transfer the resident. The participating nurses indicated that some providers "made the call" based on their assessment of a resident or on specific test results. Some participating residents attributed "the call" to their provider rather than a nurse. The participating resident said, "I just knew I needed help and I knew Dr. L. [physician] knew what he was doing, and he insisted that I needed at least two IVs [intravenous infusions] and then they [providers] could put me on the oral medication" (#104). In some instances, participating nurses provided assessment information, but providers "ultimately" made the transfer decision and gave a formal order. The participating nurse explained, "I spoke with the nurse practitioner through the [communication system] and then she agreed to transfer. She made the decision. I just provided her with everything I saw" (#411).

Authorizing the Decision. Several participating nurses indicated that while nurses actually "made the call" to transfer a resident, typically providers were then consulted

and provided transfer orders. The participating nurses pointed out that often providers just confirmed the nurses' decisions. For example, in some instances, "on-call providers" did not know the residents and provided transfer orders primarily at the nurses' request.

Residents' Role in Transfer Decisions. Both participating nurses and residents indicated that the residents were involved in transfer decisions in a variety of ways. The residents drove the decision, accepted the decision, or were excluded from the decision.

Driving the Decision. Participating nurses and residents described two instances in which residents drove the decision for their transfer to the hospital. These residents determined themselves that they needed immediate attention and wished to be seen by a physician in the hospital right away and insisted on a transfer. The participating resident insisted on going to the hospital and said, "I was hurting bladder wise. I was hurting. So, I just said, 'We got to do something about this. Something needs to be done here'" (#109).

Agreeing with the Decision. Several participating nurses and residents indicated that residents were often informed of and then agreed to a decision to transfer them to the hospital. A few participating residents indicated that they trusted nurses and providers to make transfer decisions for them and were especially amenable to transfers if a family member expressed the belief the transfer was necessary. The participating nurse said, "I told him [resident] I was going to go call the daughter and see what the daughter wanted done and the daughter wanted him to go and as soon as I told him that, then he agreed to it [the transfer]…" (#403).

Not Being Included in the Decision. Some participating nurses indicated that residents were at times not included in the transfer decisions. These residents were not

asked to "weigh in" on the decision to transfer due to their confusion, other cognitive changes, or rapidly deteriorating health. The participating nurse said, "[The] resident was alert and talkative, but not making complete thoughts. And so, he could not make a decision on his own to transfer" (#411). Some participating residents agreed that they were excluded from the transfer decision due to their health status. The participating resident said, "I wasn't aware of all of that [decision to transfer] at the time. I knew something was going on…. I didn't fully understand what was going on…" (#110). A few participating residents were troubled that they had not been involved in the transfer decision. The participating resident said, "Someone here [nursing home] made a call [the transfer]. I never was consulted on it. I had no input on it…. If I would have been making the choice, I would not have gone [to the hospital]…everybody makes the decisions for you" (#103).

Family Members' Role in Transfer Decisions. Participating nurses and residents indicated that family members were involved to varying degrees in transfer decisions. Participants described how family members drove the transfer decision, accepted the decision made by nursing home staff, or were not involved in the decision at all.

Driving the Decision. Participating nurses and residents indicated that in some instances a family member drove the decision to transfer a resident. In these instances, a family member decided the resident "needed more done" than the nursing home could provide and insisted on the transfer. The participating resident said, "He [son] insisted that I go [to the hospital] right away. I knew it [transfer] was important because I was oozing blood" (#102). In some instances, participating nurses did not necessarily agree

with the family member's decision but facilitated a transfer, nonetheless. The participating nurse said, "This [transfer] was more like the family pretty well insisting. So, I mean, when that happens all we [nurses] can do really is contact the doctor or the NP [nurse practitioner]. I mean, at that point, even the NP said, okay, send her" (#407).

Accepting the Decision. Several participating nurses indicated most often family members accepted the transfer decision made by staff when informed of the nursing home residents' condition. The participating nurses typically notified family members after the transfer decision had been made to ensure they knew of and agreed with the transfer decision. The participating nurse said, "I [nurse] called the son and I told him what was going on. And he said, 'Okay, well, what do you need from me?' And I said, 'If you could communicate with your other siblings and let them know what's going on'" (#408).

Not Being Included in the Decision. A few participating nurses and residents indicated that some family members were not aware of or involved in the transfer decision when it was made. A few participating nurses did not notify family members until a resident was already "sent out" if the situation was emergent, or if the family was well known to staff. In one instance, a resident's son was initially not pleased with the hospital transfer but accepted it after speaking to the provider. In most instances, however, family members supported the transfer decision even if they were notified after the transfer occurred. A few participating residents were transferred during the night and their family members were not notified until the next morning. The participating resident said, "I was the only one there [nursing home] at midnight. She [wife] would have been sleeping. I doubt if they [nurses] could have gotten ahold of her even" (#103).

Facility Factors That Influenced Transfers

Participating nurses and residents also pointed to factors within their facilities that possibly influenced why residents were transferred (i.e., "sent out") rather than treated at the nursing home (i.e., "kept in house"). These factors included inability to receive diagnostic or laboratory results in the timely fashion, inability to manage complications, unavailability of specialists or physicians, and staffing shortages.

Inability to Obtain Diagnostic or Laboratory Results in Timely Fashion. Several participating nurses indicated that transfer decisions were prompted by the need for timely imaging or laboratory results. Although her facility had the capacity to do "in-house" X-rays, the participating nurse explained, "We [nursing home nurses] sometimes have to send them [residents] to the hospital for X-rays. Just if it's something that needs to be done right away, we can get it [results] back quicker" (#404). Some residents were "sent out" to the hospital following a fall, because they were in pain and needed an X-ray done "right away" to check for fractures. One participating nurse initiated the transfer of a resident because she hoped the resident would get a blood transfusion in the ED faster than she would if the nurse participant "followed protocol" and scheduled an outpatient transfusion.

Inability to Manage Potential Complications. Some participating nurses transferred residents for procedures, evaluations, or monitoring that could be done in the nursing home, but the participating nurses felt the residents would be "safer" in the hospital if complications arose. One participating nurse, for example, transferred a resident who had aspirated food and another participating nurse transferred a resident for

a catheter insertion. In both instances, the participating nurses were concerned that problems might arise that the nursing home staff would not be able to "handle."

Unavailability of Specialists or Physicians. Several participating nurses indicated that they transferred the residents because they needed to be seen by a physician or specialist, and such a provider was not available in the nursing home but would be available in the ED. The participating nurse said, "…They [hospital] had a doctor right there to read the results [of lab tests]. They [hospital staff] were able to help her [the resident] a lot quicker than we would have been able to here at the nursing home" (#404). A few participating nurses transferred residents who were experiencing stroke-like symptoms so they could be evaluated by an ED physician "right away." One participating nurse transferred a resident to the ED so she would been seen by an orthopedic specialist in a timely manner.

Staffing Shortages. Several participating nurses indicated that transfer occurred because their facilities did not have enough staff to provide services "in-house." One participating nurse "sent out" a resident who had fallen because it was the night shift, and there were not enough staff available to lift the resident back to bed because of her size. The participating nurse was unable to assess the extent of the resident's injuries as she laid on the floor (#409). A participating resident indicated that she was "sent out" because she required close monitoring following the medication error as there was not enough staff in the nursing home to ensure this monitoring was being done.

Resident Responses to Transfer Decisions

Participating residents and nurses described a variety of ways in which residents responded to the decision to transfer them to the hospital. Several participating residents

had welcomed the transfer. They were "glad" to be "sent out" to have their conditions monitored and especially to have their pain managed if they had sustained a fracture. These participants were relieved by the transfer.

Conversely, both participating residents and nurses described how some residents had a negative response to being transferred. Some participating residents "kept telling" the staff that they "felt fine" and did not need to go to the hospital and were disturbed when staff did not abide by their wishes and "sent them out" anyways. One participating resident initially refused a transfer because she feared hospital staff would perform invasive procedures that she did not want. Participating nurses and residents revealed that some residents who either were not involved in the transfer decision or had resisted the transfer were distressed when they were told of the transfer. A few participating nurses described how residents became upset, tearful, anxious, and confused when informed they were to be transferred. The participating nurse stated,

> She's [the resident] so confused. Like you would tell her, like I told her she was going to go in [hospital] and she said, 'okay.' And then as she was going out the door, she's like, 'Aren't you guys coming with me?' I said, 'No, you'll come back,' and she said, 'Oh, okay. Save my bed for me.' She was just so confused (#409).

Transport Experiences

Participating nurses and residents described the process by which residents were transported to the hospital. Descriptions of transport experiences included how nurses prepared for the transports and how residents experienced the transports.

Nurses' Preparations for Transport

Several participating nurses indicated that preparing for a resident's transport could be arduous. Some found that completing the paperwork required for transport could

take significant time as they needed to complete a long list of items for a "transport packet," which was particularly problematic in emergent situations. Participating nurses sometimes spent so much time with paperwork that they felt they neglected residents who were experiencing acute condition changes and awaiting transport. A few participating nurses found that electronic medical records slowed the process of preparation for transport as it was difficult to locate residents' medical records. A few participating nurses were frustrated because they questioned whether the hospital staff even looked at the paperwork they sent with residents. The participating nurse said,

> I [nurse] don't even know if the hospital opens up some of those packets. I think we've had several incidences where the hospital will call and say, 'Well, we've lost it [paperwork]….' You wonder if they [hospital staff] ever even opened it [paperwork] up. I just know from working on a med surg floor…those nursing home packets would literally just like sit on the shelf and collect dust while they [residents] were there. Like they rarely got looked at and there's so much valuable information in there about that resident and their condition. It takes a good chunk of time to prepare those and make copies and get everything that you try to equip them [hospital staff] with the information they're going to need for that resident. And if you feel like they don't even look at it, it's kind of a slap in the face (#410).

Residents' Transport Experiences

Participating residents described their experiences being transported to the hospital. Most indicated that they were transferred by EMS transport and were placed on a cot in the transport vehicle. Some had no memory of the transport due to their acute condition changes, and others had only vague memories of the transport.

Several participating residents described the transport as a positive experience. They appreciated that EMS staff explained the transfer process, monitored the resident's condition, and conversed with them during the entire ride. One participating resident said his transport experience was positive because he was familiar with EMS and knew what

to expect during the transport. Another participating resident, who was transported by the facility van, appreciated that the driver accompanied her into the ED as this made her feel secure.

Several participating residents found the transport to be a negative experience. They described a transport process as being "loaded up," "strapped in a wheelchair," "placed on the little buggy" and "handed over" to the hospital staff. A few experienced pain and discomfort during the transport and some found the transport experience to be frightening. One participating resident recalled being transported by "the two men in dark clothes" and did not know "what was going on" (#108). A few participating residents had troublesome transport experiences. The participating resident was dropped at the curbside/ambulance entrance and left alone by the facility van driver. She said, "It [being dropped off] wasn't a very usual thing to do, I guess, but she's [the driver] the one that let me out at the door and said, 'You check in at the desk and do your thing,' and I really did feel abandoned" (#101).

Resident Experiences in the Hospital

The participating nurses and residents indicated that 12 residents who were transferred were admitted to the hospital, while 6 residents were evaluated in the ED and sent back to the nursing home. Some hospital stays often lasted just a day or so as treatments begun in the hospital could be completed in the nursing home. Stays in the ED typically lasted between three and four hours. Participating residents described their experiences during the hospital stay. For the most part, the participating residents experienced their hospital stay as stressful or unpleasant and a couple indicated they would refuse to go back. Descriptions of hospital stays included the following

experiences: (1) difficult procedures; (2) medication concerns; (3) poor communication with staff; (4) frequent moves; (5) lack of attention from staff; (6) disturbed rest and sleep; (7) emotional distress; and (8) positive hospital stays.

Difficult Procedures

Several participating residents described having a variety of procedures including diagnostic tests, IV infusions, blood transfusions, fracture care, and blood draws. Most found these procedures to be painful, stressful, or bothersome. For example, several had blood draws that were completed every few hours, which was tiring. The participating resident said, "They would test all kind of things, all time day and night" (#102). A few compared the blood draws to "being stabbed." Others reported bruising from blood draws and IV insertions. Some found monitoring equipment to be burdensome. One participating resident said, "There were times I had to ring for a nurse to get untangled [from cardiac monitoring equipment]. Eight to ten wires, if you're on a cardiac, is not unusual" (#110).

Medication Concerns

Several participating residents indicated that they had their medications "mixed up" while in the hospital. A couple felt they were given a wrong medication, given a medication that has been adjusted or discontinued at the nursing home, or not given medications they believed they should have received. One participating resident described an incident in which a hospital nurse insisted on giving the resident an insulin injection despite him telling her he had never received insulin before (#103). The participating resident said that he refused the injection, and the hospital nurse admitted later that she made a mistake.

Poor Communication with Staff

Some participating residents were troubled by poor communication with hospital staff. They saw a physician or a hospitalist during their hospital stay, but the visits were brief, and they were unable to ask questions. The participating resident said,

> She [physician] came in and evidently her phone rang, and she said that 'I got a telephone call.' I don't know. She didn't say very much to me at all. And she said, 'I've got a telephone call. It's probably Doctor L [the resident's physician],' and she went outside the door, and she never came back (#104).

Another participating resident was unsure what tests were done and was disturbed that he was not told the results of an X-ray that was ordered to check for broken ribs received during CPR (#102). Some participating residents felt troubled communication caused tension between them and the staff. One participating resident reported that the hospital nurses did not like her because she "complained about things" (#104).

Frequent Moves

Several participating residents were confused and upset by frequent moves during their hospital stay. Some were moved from room to room, from floor to floor, or even from one hospital to another. Several found not having their families present in the hospital due to COVID-19 pandemic visitor restrictions made these moves even more stressful because family members could not explain "what was happening" during the move or advocate for the residents if they were confused or unsettled by the move.

Lack of Attention

Some participating residents felt that hospital staff were not attentive to them. One participating resident said,

> They [nurses] put me in a different room. And they just put me there and I think forgot I was there half the time. I called to use the little potty, I couldn't get anybody to come. I don't know where everybody was…. I couldn't get anybody

> to come and help me. I had, I ended up having to go. I never done that before. I had to go, I couldn't stand it any longer (#108).

A few participating residents were kept in the ED for several hours, and one resident attributed this wait to the ED physician's reluctance to admit her to the hospital.

Disturbed Rest and Sleep

Several participating residents indicated that they were unable to get much rest during their hospital stay. They were kept awake because staff was always in their room checking on them, monitoring their vital signs, and performing treatments and blood draws, or administering medications. Some participating residents got to sleep only to be awoken a short time later. The participating resident stated, "You don't get much rest. By the time you get to sleep, you're woken up again" (#102). A few participating residents were kept awake by noise at the nurses' station. As a result of the interruptions, the participating residents took "catnaps" during the day. Moreover, several participating residents found the hospital beds were so narrow and uncomfortable that they did not get any rest. One referred to the hospital beds as "glorified gurneys" (#104).

Emotional Distress

A few participating residents revealed that their hospital stay caused emotional distress or was disorienting. One participating resident felt anxious, tense, and "in agony" while in the hospital and said he could not wait to return back "home" (#109). Another participating resident indicated she started "seeing things," "getting mixed up," and having things appear as "weird and strange" (#108).

Positive Hospital Experiences

While most participating residents described their hospital stay as stressful, some had positive experiences. A few felt that hospital staff were "nice" and "good" to them.

The participating resident said, “I’m impressed with the nurses that were there. They were kind and they were always so willing…. They were very caring…” (#101). A few participating residents also pointed out that the staff monitored them closely, especially while they spent time in the intensive care unit. Several participating residents were seen by the physician daily while in the hospital. A few participating residents felt that the food was “decent,” and the hospital environment was very “clean.” One participating resident was “glad” she got admitted to the hospital as she believed her care there exceeded the nursing home care (#101).

Residents’ Experiences Returning to Nursing Home

Participating nurses and residents described residents’ experiences returning home from the hospital. Most participating residents indicated that they were glad to return “home” and reported sleeping and eating better when they returned to the nursing home. However, both participating residents and nurses described several challenges that arose following transition back to the nursing home. Descriptions of challenges included: (1) mobility problems; (2) medication adjustments; (3) unmet personal needs; (4) discontinuity of care; and (5) cognitive changes.

Mobility Problems

Several participating residents indicated that they experienced mobility issues and weakness upon return from the hospital to the nursing home. They described needing physical therapy to regain their strength, having to use a walker to help with ambulation, or requiring motorized carts or “scooters” to get around the nursing home. Several participating nurses also indicated that many residents returned back from the hospital with mobility and weakness issues. The participating nurses indicated that in some

instances these issues were due to on-going recovery from fractures, but in some cases, it was iatrogenic as residents spent most of their time lying in bed while in the hospital and needed therapy services to get them back to their baseline mobility. One participating nurse indicated that it often took some time for residents to regain mobility, and some residents never completely recovered the mobility they had before the transfer.

Those participating residents who were receiving physical therapy upon return to the nursing home reported mixed benefits. A few indicated that their rehabilitation was slow because their therapy was limited by COVID-19 restrictions. The participating resident said, "I'm quarantined here for 14 days. Can't go out in the hallway. I'd love to go out in the hallway and walk, but I can't do that, but I'm doing well" (#102). One participating resident said he did not want physical therapy and was annoyed that he was "pushed" to walk. Another participating resident felt she was working toward her mobility goals and credited her progress with being familiar and having good communication with the therapy services staff.

Medication Adjustments

Several participating residents indicated they had problems with medications after returning to the nursing home. Some were concerned that their medications were not ordered or administered in a timely manner, which caused setbacks in their progress. One said that the rehabilitation nurse was unable to find out who the physician was that ordered one of the resident's medications, so the nurse was unable to fill the prescription. However, some participating residents pointed out that medication issues were often resolved within a few days.

Several participating nurses also discussed problems with residents' medications after they returned to the nursing home. The participating nurses had difficulty getting medication orders in a timely manner from the hospital following the residents' return – a process referred to by one participating nurse as "pulling teeth to get all orders." The participating nurses found that medications were frequently changed, discontinued, or withheld while residents were in the hospital and discharge medication orders often needed to be clarified by nursing home providers. The participating nurse said,

> Sometimes they get rid of meds that they've [residents] been on for years and years and years and they are reliant on them [medications] and they're used to taking them and they still want to continue taking them…. We're [nurses] almost always calling the NP [nurse practitioner] to get clarification orders and then of course, unless that NP has access to that hospital's medical records, most of the time they're just shooting in the dark and guessing on what to order… (#410)

Moreover, a few participating nurses were unable to get approvals from providers needed to order narcotics for returning residents, which required residents to wait days for these medications. One participating nurse said that nurses sometimes did not have adequate time to set up medications and equipment for returning residents because they were often "sent back" to the nursing home without much warning. The participating nurses also pointed out that some residents did not get their psychiatric medications while in the hospital and thus exhibited behaviors such as calling out and yelling upon return.

Unmet Personal Care Needs

Several participating nurses indicated that residents sometimes were returned to the nursing home with unmet personal care needs. The participating nurses found that some residents had not been shaved, had their teeth brushed or hair washed, or showered for several days while in the hospital. The participating nurse said, "I don't feel the personal care, the hygiene is as good. It's almost like they don't get cleaned up at all.

Like their hair is always greasy…. It's like you just want to throw them in the shower" (#409). Moreover, the participating nurses were troubled that some residents returned from the hospital with pressure injuries, skin breakdowns, and dressings embedded in their skin. A few participating nurses found that residents were returned with unnecessary catheters and IVs still in place.

Discontinuity of Care

A few participating residents described situations in which there was discontinuity of care between the hospital and the nursing home. Upon return, some indicated they expected to be seen by the physician right away, but this did not occur. One participating resident was told by nursing home staff that "this is not a hospital but a nursing home" (#101). Another had some tests postponed because costs were covered in the hospital but not in the nursing home.

Several participating nurses discussed continuity problems between the nursing home and the hospital for returning residents as well. They felt that communication between the hospital and nursing home staff at the time of residents' return was problematic. The participating nurses indicated that hospital nurses were "supposed to call" nursing home nurses with a report on returning residents and while some of these reports were thorough and helpful, others were poorly done, delayed, or not conveyed at all. A few participating nurses were troubled that important information about advance directives and code status was not provided by hospital staff, leaving nursing home staff to clarify this information with their providers. One participating nurse was concerned that nursing home staff often did not get reports on nursing home residents' behaviors during their hospital stay (#405).

Cognitive Changes

A few participating nurses indicated that some residents exhibited cognitive changes when they returned to the nursing home. The participating nurses found that residents who had dementia in particular became confused when transferred back to the nursing home. The participating nurse stated,

> It [transfer] can be very, almost traumatic. That's why I think a lot of families do decide let's just keep them [residents] here. And especially with the dementia, because we've seen a lot of residents that we 'send out' and I mean, they come back and I feel like sometimes they're almost worse as far as their memory, as far as behaviors. We've seen a lot of that and even the hospital, when they call to report that they're [residents] coming back will tell us we had to put an alarm on them. They were so confused. It [transfer] just magnifies everything!… It's just a lot for the elderly…period (#407)

Case Studies

The following four case studies are presented to represent the transfer process as a whole. The cases were chosen to further exemplify important findings. Some specific details not germane to the narratives are removed to ensure that identity of the participants is not revealed. The residents are referred to as Resident 1, Resident 2, Resident 3, and Resident 4.

Resident 1

Resident 1 is an 84-year-old male resident who lives in the assisted living of the facility. He is widowed. His three children live close by and are involved in the decisions about his care. He has advance directives in place with a full code status order but no POST form or documentation of transfer preferences in his medical records. He has experienced several transfers in the past. Information about his transfer was provided by both himself and a nurse participant.

Transfer Decision. Resident 1 was transferred to the hospital due to abdominal pain and urinary retention. He was complaining of severe pain in his stomach and inability to sit. He was the driver of the transfer decision. He demanded to be "sent out" as he did not believe that the nursing home staff were able to manage his condition. He called his daughter and said, "I'm going to tell them here that I want to go to the ER..." She accepted his decision to be transferred.

The director of nursing (the nurse participant) facilitated the transfer. She was familiar with Resident 1's preferences and goals of care regarding code status and knew the family well. However, she believed that the nursing home could provide the care Resident 1 needed and thus felt "silly" and "embarrassed" for transferring him to the hospital. She believed the hospital already "looked down upon" nursing homes and an unnecessary transfer would "make things worse." She also believed that transfers were not beneficial to most residents. She said, "Transfers completely threw them [residents] out of their environment and confused them and almost made matters worse." She advised Resident 1 that the nursing home could provide "in-house" interventions, but he still insisted on the transfer. He said, "I was hurting bladder-wise. I was hurting. So, I just said, 'We got to do something about this. Something needs to be done here.'" The director of nursing notified the provider and obtained the formal transfer order.

Transport Experience. The director of nursing prepared the required paperwork. She complained that collecting the paperwork prior to transport took a long time to complete and delayed the transfer process. Resident 1 requested to be transported by ambulance as he felt unable to sit in the car. He described the ride as "bumpy" and "uncomfortable."

Experiences in the Hospital. Resident 1 spent a couple of hours in the ED and had a urinary catheter inserted. He felt mentally relieved and fortunate to be taken care of in the ED. He was impressed with the staff and service at the hospital and begged the hospital to keep him overnight.

Experiences Returning to the Nursing Home. Resident 1 returned to the nursing home with his family in their car. He had been given a diagnosis of urinary retention. In addition to a catheter being inserted, he had been given a follow-up appointment with a urologist. The nursing home staff provided instructions to the resident to perform catheter care himself. The resident had the catheter removed a couple of weeks later.

Resident 2

Resident 2 is a 90-year-old female resident who recently moved to the healthcare center from her independent living apartment. She has been experiencing gradual decline in her health condition, so she made a decision to transfer to the area of the facility where she could receive more care. She is widowed. She requires supervision with all her care needs and is independent with decision-making. She has advance directives in place with a no code status. Resident 2 does not have a POST form and she has no documented preferences regarding transfer order. Her two daughters live about two hours from the nursing home, but they visit her often. Resident 2 has experienced only two transfers in the past. Information about her most recent transfer was provided by both herself and a nurse participant.

Transfer Decision. Resident 2 was transferred to the hospital as she had gastrointestinal bleeding and needed a blood transfusion. She had experienced bleeding

for a week prior to transfer. She was monitored by providers and had frequent blood work done. On the day of the transfer, the registered nurse (participating nurse) observed that Resident 2 was pale, weak, and had difficulty transferring. The registered nurse drove the decision to transfer because she thought Resident 2 required a blood transfusion.

The registered nurse informed the provider of the Resident 2's condition and received an order to repeat the blood work. The registered nurse drew the blood and took it to the hospital herself to obtain the results fast. The results indicated Resident 2 needed a blood transfusion. Normal protocol would have been for Resident 2 to get the transfusion through outpatient services, but the registered nurse believed Resident 2 could get it immediately if she was sent to the ED. The registered nurse notified the on-call provider who gave a transfer order. The registered nurse notified the family who approved of the decision. The registered nurse explained to Resident 2 that she needed to go to the hospital to receive blood. Resident 2 initially refused the transfer because she was worried that the hospital staff would perform invasive procedures but agreed to the transfer after talking to the nurse. Resident 2 hoped that the hospital would find the reason for her bleeding.

Transport Experience. The registered nurse completed the paperwork, called the EMS, and sent a report to the hospital. She felt the transfer was not an emergency, so she took time to prepare the paperwork. Resident 2 recalled that she did not have time to get ready for the transport as "two men in dark uniforms" came and took her to the hospital right away. Resident 2 found the transport experience to be frightening.

Experiences in the Hospital. Resident 2 was hospitalized for three days and had a negative experience in the hospital. She experienced an incident in which nurses

"forgot" about her. She called out to them because she needed to use the bathroom, but no one came, and she urinated on herself. She said, "They [hospital staff] just did not care." Resident 2 also recalled experiencing discomfort as she was repeatedly "stuck by a needle." At one point, she thought she was seeing things as everything seemed "strange and weird."

Experiences Returning to the Nursing Home. Resident 2 was glad to be back "home." She said, "After being at that hospital for a few days, I was kind of glad to get back here [nursing home]. To tell you the truth, I don't know what it was. I thought going to the hospital would help out." She felt the hospital experience was frightening and unhelpful. At the time of the interview, she remained unsure about the cause of bleeding because no one discussed it with her. Resident 2 did not want to go back to the hospital "ever again."

Resident 3

Resident 3 is a 92-year-old male resident who was in the skilled nursing rehab unit following a recent hospitalization and gall bladder surgery. He is married and lives home with his wife. His two daughters live close by and assist him when he needs help. Resident 3 functions independently only requiring supervision with some of the daily tasks. He was receiving therapy to regain his strength so he could return home safely. He has advance directives in place with a no code status order but no POST form or documentation of transfer preferences in his medical record. Resident 3 has experienced four transfers in the last three months. Information about his most recent transfer was provided by Resident 3 himself.

Transfer Decision. Resident 3 was transferred to the hospital after the vomiting episodes that, in his opinion, were caused by eating a hotdog and having difficulty chewing his food. He has had similar issues in the past - always after eating hotdogs.

Resident 3 was unhappy that he was not involved in the transfer decision. He was unsure of who made the decision, but he believed it was the nurses and EMS. He said, "Someone here [nursing home] made a call [the transfer]. I never was consulted on it. I had no input on it…. If I would have been making the choice, I would not have gone [to the hospital]…. Everybody makes the decisions for you." He told the staff that he did not need to go to the hospital but felt no one would listen. He kept telling them that he "did not feel bad." His wife was not informed of his transfer because it happened late at night and happened quickly.

Transport Experience. Resident 3 was transported to the hospital by the ambulance. He felt that the transfer was uneventful. He referred to the ambulance transport as a "little horse drawn buggy." During the transfer, he had an IV inserted in each arm.

Experiences in the Hospital. Resident 3 spent four days in the hospital. For the first three days he could have nothing by mouth, even water, but was then given a liquid diet. He was unable to sleep and rest while in the hospital as he found the beds to be uncomfortable. He felt he lost strength in the hospital because he spent most of the time lying in bed on his back. His room was moved several times.

Experiences Returning to the Nursing Home. Resident 3 pointed out that he received a good meal upon the return to the nursing home. He continued to work in therapy, got stronger, and was eventually discharged back home.

Resident 4

Resident 4 is an 86-year-old female resident who lives in the healthcare center. She is widowed. Her daughter and granddaughter live one hour away. She is dependent on staff to provide personal care and relies on her family to make decisions for her. She has advance directives with a no code status order but no POST form or documentation of preferences regarding transfer in her medical record. Resident 4 has experienced several transfers in the past. Information about her transfer was provided by the nurse participant only.

Transfer Decision. Resident 4 was transferred to the hospital with symptoms of increased edema and weight gain indicating congestive heart failure (CHF). She also had a diagnosis of dementia. Oral medication for CHF was initiated in the nursing home, and the resident was improving slowly. The family had attempted to take Resident 4 to a follow-up eye appointment in their care. However, when she was unable to transfer to the car, the family requested she be "sent out" for an evaluation.

Resident 4's daughter and granddaughter insisted on transfer. The registered nurse (nurse participant) facilitated the transfer. She notified the provider who wrote a transfer order. The provider was familiar with Resident 4 and had treated her for CHF. The registered nurse said, "We don't argue when family insists on transfer. We just do it [transfer]." Resident 4 was unable to participate in the decision-making as she was confused but agreed to the transfer when the registered nurse told her that her daughter wanted her "to go." The nurse was not in total agreement with the transfer. She said, "Most families are open-minded and have [the] resident's best interest in mind, but some can't let go and want to keep doing everything."

Transport Experience. The registered nurse prepared the paperwork. Resident 4 was very upset and crying when the ambulance came to transport her. She told the nurse to "just pray for me." The registered nurse pointed out that a transfer can be traumatic and upsetting for the residents as "it magnifies everything." She also said, "Transfer…it is just a lot for the elderly. Period…. Think about the impact on residents."

Experiences Returning to the Nursing Home. The registered nurse explained that Resident 4 returned to the nursing home after a few days later with hospice services in place. She passed away a couple of weeks later.

Recommendations To Prevent Potentially Preventable Transfers

After the participating nurses and residents described specific transfer experiences, they were asked to provide recommendations for avoiding potentially preventable hospital transfers. The recommendations were related to (1) nursing home resources; (2) nurse and staff competencies; (3) staffing; (4) communication between providers and nurses; and (5) staff familiarity with resident histories. Many of these recommendations were based on the experiences described above by the participants.

Nursing Home Resources

Participating nurses recommended "in-house" nursing home resources that could prevent potentially preventable transfers. These resources included: (1) laboratory tests ("labs"); (2) X-rays; (3) intravenous lines ("IVs"); and (4) other diagnostic equipment.

Labs

Several participating nurses indicated that having lab facilities "on-site" could avoid some transfers. They indicated that lab results can help determine a course of action and thus might indicate a transfer was unnecessary. Moreover, they suggested

nursing homes should be able to do "stat" or urgent labs as well as routine labs. A few stressed that nurses should not be required to "run" products to the hospital for analysis or wait for long periods of time to receive lab results. The participating nurse stated, "It does take a little bit of time to get the results back because after we draw it [blood] we have to make sure somebody can take it over to them [the lab at the hospital]…and then even though they could have the results done, it usually takes the nurse calling them and asking them to send it to us before we always have it back" (#404).

X-rays

Many participating nurses indicated that having convenient access to diagnostic imaging equipment could prevent some transfers. They argued that having good X-ray equipment readily available could allow providers to keep residents "in-house" instead of sending them to the hospital when X-rays are needed. The participating nurses suggested that if imaging results are delayed or inadequate, transfers are more likely. One participating nurse indicated that mobile X-rays equipment needs to be available in the healthcare centers and all areas of a facility (i.e., assisted, residential, independent living areas).

Intravenous Infusions

Several participating nurses suggested that being able to do intravenous (IV) infusions for hydration or administration of antibiotic medication in nursing homes could prevent some transfers. They acknowledged the cost of maintaining IV pumps on site but felt that nursing homes should keep these pumps on hand and have them readily available. They pointed out that if the pumps had to be delivered from the suppliers, infusions could be delayed, and residents' conditions could deteriorate leading to a

transfer. The participating nurses also pointed out that suppliers need to ensure that pumps work correctly. A few participating nurses recommended having IV equipment on hand that do not require pumps. The participating nurses also indicated that physicians should not be hesitant to order IVs in nursing homes. The participating nurse said, "If we need to start [a resident] on an IV, we can do that…but some of the doctors are a little bit hesitant because we're not acute care hospital…so when it comes to that type of thing [IVs] they feel more comfortable sending them [residents] to the hospital" (#407).

Other Equipment

Several participating nurses recommended having other types of equipment available so that residents could be cared for at the facilities rather than transferred to the hospital. They suggested that nursing homes keep bladder scanners to check for urinary retention, and oxygen therapy, emergency inhalers, and nebulizers for respiratory therapy on hand. They also recommended that instant finger check machines to measure Coumadin [medication] levels, emergency kits/medication to start medication "stat," and subcutaneous (SQ) hydration (hypodermoclysis) should be available "in-house."

Nursing and Staff Competencies

Several participating nurses and one participating resident indicated that providing more education for nurses on how to assess acute changes in residents' chronic conditions could prevent some transfers. The participating nurses suggested that improving assessment skills would allow nurses to recognize early signs of acute condition changes. The participating nurses also indicated that providing additional training for nurses on certain procedural or technical skills could keep more nursing home residents "in-house."

Assessment Skills Education

Many participating nurses indicated that providing education for nurses on how to accurately assess signs and symptoms of acute exacerbations of common chronic conditions could prevent some transfers. These participants pointed out that nurses need to have good assessment skills and be attuned to acute changes in residents' status. A few participating nurses suggested educational programs should include how to communicate the results of assessments to providers and families in a calm and professional manner so these persons do not insist on a transfer that might not be necessary. The participating nurse stated,

> Instead of just calling the families and saying to them, 'This happened, their [the residents'] blood pressure is this, they've got this going on'…. I think if you explain in a way that doesn't sound so maybe scary or critical…it's just the approach, cause if it sounds life-threatening or scary to them [families], they're automatically going to say, 'Send them [residents] out.' But if you can say, 'So I called the NP [nurse practitioner] and this is what we can do here…' (#410)

One participating nurse suggested staff education should focus on the use of critical pathways or guides for specific chronic conditions so nurses could recognize acute changes, notify a provider, and initiate treatment in a timely manner - thereby keeping the resident "in-house." The participating resident also indicated that nurses need training in assessment skills. She said, "When you have sick people, you need good nurses…. You need someone with training that can complete their assessments" (#101).

Procedural Skills Training

Several participating nurses indicated that providing training for nurses on a variety of procedural or "hands-on" skills could help them better manage residents' chronic conditions and thus avoid transfers. The participating nurses pointed out that if nurses had strong skills in starting and monitoring IVs, managing SQ hydration, drawing

blood, doing nebulizer treatments, and using other equipment, they could do these procedures at the nursing homes. The participating nurses noted that sometimes residents are transferred just to have one of these procedures done. Some participating nurses recommended that nursing organizations provide special certifications for blood drawing and starting and monitoring IVs for nursing home staff. A few participating nurses stressed that skills training should focus on applied practice to build nurses' confidence. One participating nurse suggested that more experienced nurses should help novice nurses enhance these critical skills.

Staffing

Some participating nurses indicated that having adequate staffing in nursing homes could prevent some transfers. They suggested that having more licensed nurses (RNs and LPNs), qualified medication aides (QMAs), and certified nursing aides (CNAs) would improve call light response times and ensure that room checks are done frequently. The participating nurses indicated that increased staff presence could prevent some incidents that frequently lead to transfers – such as resident falls and missed condition changes. The participating nurse said,

> So, nobody is doing room checks.... I'm not saying that it [room check] would have prevented it [fall], but maybe they [staff] could have found him [resident] sooner because no one really knows how long he was laying there…. We need more staffing because a lot of times we are "sending" them [residents] in for a fracture…if we had more staffing then we could have more eyes on the resident (#408).

A few participating nurses also recommended having more staffing on the night shift so residents could be checked on frequently and changes would be noticed timely.

Several participating nurses indicated that having more providers "in-house"

could also prevent some transfers. The participating nurses suggested having providers immediately available would allow for timely intervention when problems arise without having to wait for a response from "on-call" providers. Moreover, participating nurses explained that "on-call" providers are not often familiar with residents and are thus more likely to "send them out" when they experience acute changes. Some participating nurses also pointed out that "in-house" providers could contribute to quality improvement initiatives that could improve processes within the nursing home that might lead to fewer transfers.

Communication

Some participating nurses indicated that timely communication between providers and nurses could prevent some transfers. The participating nurses indicated that when providers, especially physicians, are slow to respond to calls or texts from nurses about emergent problems or concerning changes in the residents' condition, the residents will more likely be transferred because the problem will worsen due to the delay. The participating nurse said,

> She [resident] was experiencing signs and symptoms of stroke…. I notified the doctor… the doctor did not respond right away, which is normal…he doesn't usually…. So I talked to the family and told them what is going on…asked them [family] if they wanted me to wait until the doctor responded. They asked my opinion on whether she needed to be sent out…. And I said, yes, because obviously with the stroke, if they get to the hospital soon enough, they can get tPA [tissue plasminogen activator intravenous medication] and it will be better…. (#412)

A few participating nurses recommended that nursing homes have some type of software in place to ensure timely communication between providers and nurses. One participating nurse suggested providers be provided a nursing home capabilities list so they are aware of what services nursing homes can provide "in-house."

Staff Familiarity with Resident Histories

Some participating residents indicated that transfers might be prevented if nurses were more familiar with residents. They indicated that nurses should have more awareness of the background and history of all residents. The participating residents suggested that nurses should become familiar with the persons for whom they provide care to by asking them about their medical conditions and getting more information about their history. The participating resident said,

> A lot of times the nurses or staff or whoever don't have enough background…. One time I was in [hospital] they [physicians] wanted to give me a heart specialist and I said why? I've got my own [heart specialist]. He's been treating me for four or five years. This guy [new heart specialist] has three or four days…he doesn't know any of the past, but that's why they need a little more background on some of the patients…. (#103)

A few participating nurses pointed out that nurses who have worked in a nursing home for a long time know their residents well. These nurses can therefore recognize immediately when residents experience acute changes and can thus intervene in a timely manner. One participating nurse suggested that reviewing the information noted in the residents' care plans could help nurses understand their history and background and make a better decision about whether a transfer is necessary.

Summary of Findings

Twelve participating nurses and 10 participating residents described multiple incidents of transfers of nursing home residents to hospital emergency departments. Transfers were not generally informed by documentation or prior knowledge of the residents' transfer preferences. Most residents were transferred due to an exacerbation of a chronic condition. The decision to transfer involved interactions among nurses, providers, family members, and residents. One person, typically the nurse who provided

daily care for the resident, drove the decision, but decisions could be driven by providers or in, a few cases, by family members or residents. Other persons provided input into the decision (e.g., other nurses), authorized the decisions (e.g., providers), or accepted the decisions (e.g., family members, residents). At times, residents and their family members were not included in the decision-making. Transfer decisions could be influenced by the inability of the nursing home to complete diagnostic and laboratory tests, concerns about managing potential complications in the facility, unavailability of specialists or physicians on-site, and staff shortages. Regarding the transfer process, participating nurses spoke mostly about feeling burdened by the amount of paperwork required for transfers. While some participating residents found being transported as positive or uneventful, several found it to be frightening and troublesome.

Similarly, while some participating residents found the hospital stay to be positive, most found the stay to be distressing or disorienting as they experienced bothersome or painful procedures, lack of attention from staff, frequent moves, unmet personal care needs, and poor eating and sleeping. Upon return to the nursing home, some residents felt "happy to be home" but some struggled with mobility problems, problems with their medication regimes, and cognitive changes. Participating nurses were concern about discontinuity of care especially regarding receiving information about residents' follow-up care.

Four case studies provided examples of diverse transfer experiences and highlighted some of the issues revealed in the participants' narratives. Who "drove" the decision in each of the cases varied. In one case, the resident drove the decision, in two cases the nurse drove the decision, and in one case the family members drove the

decision. In each case, however, the decision to transfer involved series of interactions between the nurse, the provider, the resident, and/or a family member. In one case, the resident was troubled that he was not involved in the decision and his wishes were not respected. While the resident who spent short time in the ED found the hospital experience to be helpful, two of the residents who were admitted to the hospital found to experience to be unpleasant or distressing. One resident died shortly after returning home from the hospital.

The participating nurses provided several recommendations regarding what could be done to prevent potentially preventable transfers. The participating nurses and residents suggested that having greater resources in the nursing home might help staff avoid resident transfers. They remarked that having equipment for IV administration, lab services, and imaging that was readily available in all areas of the facility would allow staff to better meet more residents' needs at the facility. They also recommended more assessment and procedural skills training for staff so they would be better prepared to deal with more complex situations at the facility. In addition, they felt that having more providers on site, more staff to provide care and monitoring, better communication among staff, and retention of staff familiar with the histories and preferences of residents would all help prevent potentially preventable transfers.

CHAPTER FIVE-CONCLUSION

The purpose of this qualitative study was to examine the processes by which nursing home residents were transferred from the nursing home to the hospital from the perspectives of nursing home residents and nurses. The study also examined the participants' recommendations for preventing transfers when possible. This chapter will summarize the study findings, place the findings in the context of relevant literature, outline the study limitations, provide suggestions for future research, and discuss practice and policy implications.

Summary of Findings

The study findings provide a description of the transfer process as experienced by the participating nurses and residents and their recommendations for preventing potentially preventable transfers. Reasons for transfers to the hospital most often included acute exacerbation of symptoms related to the residents' chronic or serious conditions. In several cases, the decision to transfer a resident was driven by a nurse, although, in a few instances, the decision was attributed to the provider, family member, or resident. In some instances, residents and family members were not involved in the decision-making process. Some transfer decisions were made because the nursing home could not complete diagnostic and laboratory tests in a timely fashion, nursing home staff felt they might not be able to manage potential complications "in-house," specialists or physicians were not available on-site, and too few staff were available to monitor and manage the resident's emerging symptoms.

After the transfer decision was made, the transfer process included the transport to the hospital, the hospital stay, and the return to the nursing home. Many participating

residents found the transfer and hospital stay to be an aversive and even frightening experience, while a few found it to be positive or at least uneventful. The challenges residents experienced in the hospital included difficult procedures, disturbed sleep, medication concerns, frequent moves, and problematic interactions with staff. Most participating residents were pleased to return back to the nursing home, but this return often included challenges with mobility, medication issues, continuity of care, and cognitive changes. As reflected in the four case studies, the transfer experience was unique for each of the participating residents, but all involved some challenges.

The participating nurses and residents provided several recommendations for preventing transfers when possible. These recommendations included more on-site lab, diagnostic imagining, and IV capabilities; more education and training for nursing home staff to manage acute changes in chronic conditions; enhanced staffing; improved communication between providers and nurses; and greater staff familiarity with resident histories and preferences.

Findings in the Context of Prior Literature

Transfer Decisions

One of the main findings of the study was that nurses who provided direct care to residents were most often the "drivers" of the transfer decisions, and only in a few cases did providers, family members, or residents "drive" the transfers. This finding is consistent with the findings of a study by Ashcraft and Owen (2014). These authors reported that nursing home nurses made decisions about whether and when to transfer residents to the hospital and made these decisions based on changes in health conditions of the residents and the impact these changes had on their quality of life. As in the current

study, the findings of the Ashcraft and Owen (2014) study revealed that after the decision to transfer was made, the nurse contacted providers with updates, obtained the formal order for transfer, and communicated with families to make them aware of the transfer decisions.

Resident Preferences Regarding Transfers

Our study findings indicated inadequate use of advance care planning (ACP) in identifying goals of care and transfer preferences. Most of the participating residents did not have their preferences regarding transfers documented in their medical records and could not recall discussions about their preferences with families or nursing home staff. Participating nurses in our study mentioned some "impromptu" conversations about transfers, but the review of medical records did not reflect these conversations. Our finding that ACP did not occur is consistent with the findings of studies by Ouslander et al. (2016) and Tappen et al. (2014). These studies revealed that many nursing home residents did not have documentation in place about their preferences regarding transfers and this information can help prevent unnecessary transfers. For example, a study by Shanley et al. (2011) found that ACP provides guidelines to the nursing home staff about decisions surrounding transfers and can decrease transfers for residents with dementia. A study by LaMantia et al. (2010) also found that transfers can be prevented when residents' preferences and goals regarding transfers are well-known and documented.

Several tools have been developed to increase ACP and some of these included discussions about transfers. The INTERACT program have focused on the management of acute changes in resident condition (Ouslander et al., 2011). The program contains several tools that provide guidance to support the ACP conversations between nursing

home staff, residents, and families prior to resident condition changes (Ouslander et al., 2011). Nursing homes that implemented the INTERACT program have experienced reduction of hospitalizations of nursing home residents (Ouslander, Bonner, Herndon, & Shutes, 2014). In addition, the POLST form is specifically designed for patients with chronic conditions and used to communicate nursing home residents' preferences related to their treatment wishes (Hickman et al., 2010). Implementation of the POLST form can prevent unnecessary treatments and acknowledge residents' preferences for EOL care (Hickman et al., 2015). The POLST form can also help initiate and guide discussions with residents regarding their treatment decisions (Hickman et al., 2015). Despite the known benefits of the POLST form in guiding ACP discussions regarding residents' treatment decisions and preferences related to their treatment wishes, the nursing homes that participated in our study did not use the INTERACT tools and only one resident in our study had a POLST form in place. While it is unclear if the use of any of these tools would have prevented the transfers that were highlighted in the study, it is possible that the tools would have provoked discussions about the participating residents' preferences regarding transfers.

Resident's Role in the Transfer Decisions

Many organizations emphasize person-centered care which encourages residents to use their voices to communicate their individualized care preferences to the staff and be actively involved in their care decisions (Pioneer Network, 2019). Even though experts advocate that patients should be involved in the decision-making process (Staniszewska et al., 2014; Toles et al., 2013; Tappen et al., 2016; Coleman et al., 2006), most of the residents in our study reported that they were not actively involved in the

transfer decisions. Several were experiencing acute condition changes or cognitive dysfunction and thus the decision was made by others. This finding is consistent with prior studies that revealed nursing home residents are often not actively involved in the decision-making process. For example, Arendts et al. (2015) found that residents are the least likely of all stakeholders to be active participants in most transfer decisions, and Jacobsen et al. (2017) found that most of the transfer decisions are made by someone other than a resident.

While several participating residents in the current study were not able to make transfer decisions because of their health status, a few were functioning well cognitively and were actively involved in other care decisions and yet nonetheless were not included in the transfer decision. These findings are consistent with the findings of a study by McCloskey (2011) that revealed that nursing home nurses believe that residents should be involved in the transfer decisions but often fail to involve them when transfer decisions are made or persuade them to transfer if they are reluctant. Similarly, Arendts et al. (2015) found that residents' decisions not to transfer are often overridden by staff, because they believe that the transfer is in the best interest for the resident.

Family Involvement in the Transfer Decisions

In the current study, participating nurses reported that most often family members accepted and supported the transfer decisions made by nurses, providers, or residents, and in only a few cases had an active role in the decision. This finding contradicts findings from some previous research. For example, studies by Palan et al. (2017) and Tappen et al. (2014) found that families often insisted on transferring a resident when residents needed palliative care or were experiencing potentially life-threatening situations and

when treatment options available in the nursing home had not been clearly communicated to families. Similarly, a study by O'Neill et al. (2015) found that nurses perceived that family members had control over the transfers and often delayed the transfer process. In addition, the study by Tappen et al. (2014) found that family members who were poorly educated about the resident's prognosis and treatment options available in the nursing home, were more likely to insist on a hospital transfer.

Hospitalizations and Burdensome Interventions

Our study found that most residents had negative experiences during the transfer process. Several of our participating residents reported painful or bothersome procedures, disturbed sleep, medication concerns, poor communication with staff, and emotional distress during their hospital stay. Participating residents described their experiences during hospitalizations as stressful and disorienting. Previous studies have indicated that nursing home residents' transfer experiences may be stressful and cause anxiety, because of an unfamiliar environment, unknown staff, and possibilities of invasive testing (Givens et al., 2012; Mitchell et al., 2018). In addition, Mitchel et al. (2018) suggested that these negative experiences can cause mistrust in patients and can lead to inefficient care delivery and slower recovery (Mitchell et al., 2018). Our study extends these findings by describing the transfer experiences from the residents' own perspectives.

A few of our participating residents indicated that they found some of the treatments they received in the hospital to be burdensome. Previous studies have indicated that hospital transfers often entailed aggressive treatments and can result in serious complications, decreases in functional mobility, emotional distress, and increased rates of morbidity and mortality (Murray & Laditka, 2010; Palan et al., 2017; Trahan et

al., 2016). This finding is consistent with evidence that suggests that nursing home residents admitted to the hospital experience serious complications such as delirium, confusion, agitation, falls, nosocomial infections, decline in function, and pressure ulcers, discontinuity of treatment or medication, miscommunication surrounding advance directives, immobility, restraint use, emotional distress, and even death (Murray & Laditka, 2010; Palan Lopez, Mitchell, & Givens, 2017; Tappen et al., 2014; Terrell & Miller, 2011).

Although none of our participants reported that they received aggressive treatments to extend their lives, other literature suggests this can be highly problematic. The studies by Lamberg et al. (2005) and Waird and Crisp (2015) found that hospitalized nursing home residents received inappropriate interventions to prolong their life, even though palliative approaches to care were available, and many residents died alone in the hospital, in unfamiliar surroundings, being cared for by strangers.

A few residents in our study reported feelings of fearfulness and abandonment during the transfer. They recalled feeling fearful while being transported by strangers and not knowing what was going on at the time. In most instances, participating residents were alone in the hospital without family or nursing home staff support and they felt that hospital staff were not attentive to them. This is consistent with the study by Mitchell et al. (2018) where patients reported poor experiences during transfers and the same feelings of fearfulness and abandonment. In addition, some residents in our study reported frequent moves within the hospital. This finding is consistent with the study by Naylor et al. (2008), which acknowledged these frequent transitions within the hospital and indicated that these moves can be detrimental to the health of older adults. Our study

extends these findings by describing the transfer experiences from the residents' own perspectives and provides rich descriptions of a wide variety of adversities and complications that can accompany a hospital transfer.

Return Back to the Nursing Home

Our study findings indicate that residents reported that they were glad to return "home" and reported sleeping and eating better when they returned to the nursing home. In addition, our study findings indicated that residents experienced several challenges following transition back to the nursing home such as mobility problems, medication adjustments, unmet personal needs, discontinuity of care, and cognitive changes. These findings are consistent with prior research which found that residents return to the nursing home from the hospital with newly developed pressure injuries and medication issues (O'Neill et al., 2015). Our study findings extend these findings by describing the additional challenges noted upon residents' return to the nursing home as well as the positive aspects of readmission.

Nursing Home Resources

The current study findings also revealed institutional factors that influenced transfers. Our findings suggest that transfers can occur if facilities do not have the capacity to manage acute exacerbations of chronic conditions. Similar to our findings, other studies found that the nursing homes often lacked capacity to assess and manage residents on-site due to resource or staff limitations (Abrahamson et al., 2016; Arendts et al., 2015). Facility-level interventions such as OPTIMISTIC and INTERACT that focus on managing residents with chronic conditions "in-house" may help address these institutional factors by providing the nursing home staff with tools, resources, and

training to improve communication, enhance skills, improve familiarity with residents' preferences, and become more comfortable with the ACP and EOL care discussions (Ersek et al., 2017; Ouslander et al., 2011). Our study extended these findings by asking participating nurses and residents what they believed could be done and what tools and resources do they need to prevent transfers that might not be necessary.

A Unique Contribution of the Current Study

While several of our findings thus resonate with prior literature, the current study will make a unique contribution to the literature because it is one of the only studies that describes the entire transfer process from both nurse and resident perspectives. By merging these two points of view in a subset of cases, we were able to provide a more nuanced description of each aspect of the process. The current study is also one of the only studies to provide case studies that reflect unique transfer experiences described from the emergence of the acute changes in the conditions that resulted in the transfer to the residents' adjustment back in the facility.

Limitations

The findings of the study should be considered in the context of several limitations. Ten residents and 12 nurses discussed experiences with transfers from their perspectives. In only four cases was the same transfer described by a participating nurse and resident. Family members were not included in this study. Therefore, most of the transfers were described by one person who described the actions of the other persons involved in the transfers. The descriptions of the transfers were thus primarily from one viewpoint, and it is thus possible that other persons would have differing perspectives on the transfers.

In addition, some participating residents were not able to provide robust narratives about their transfer experiences. The interviews were completed one to three weeks following their return from the hospital, and some were unable to recall the events surrounding the transfer due to their health status at the time of the transfer. Several provided only brief answers to the interview questions and needed a fair amount of prompting to describe the transfer. Others frequently drifted off track and talked about their lives, their families, and other topics unrelated to this study. Several advised the interviewer to talk to their spouses and/or family members who could better describe what exactly happened at the time of the transfer. Despite these limitations, all participating residents provided some information that made important contributions to the study findings.

The study settings limit to some extent the transferability of the findings. All four nursing home facilities were located rural northeast Indiana, and thus findings might not be completely transferable to facilities in different geographical areas or in more urban areas. Moreover, all the facilities were in very good standing with all state and federal regulators, and it is possible that the transfer process may differ in less highly rated nursing homes that likely have fewer resources, less established procedures related to transfers, and possibly higher staff turnover rates. The sample was primarily Caucasian race, so we cannot make any claims about how other races/ethnicities would respond to transfers.

Finally, the researcher's position in one of the participating nursing homes might have influenced the participants' responses. As discussed earlier, during part of the study the researcher held a managerial position in one of the facilities. Although the possibility

that this would introduce bias was discussed by the research team and it was decided that the researcher would not interview nurses over whom she had authority, her administrative position might still have predisposed participants to respond in certain ways. Some participants might have been more reticent to discuss problematic aspects of the transfer experiences, while others may have been more forthcoming about problematic aspects of the transfer experiences as they might have seen the researcher as someone who could address their concerns. Nonetheless, all participants provided rich data about both positive and negative aspects of the transfer experience, and the researchers familiarity with the settings and participants seemed to facilitate in-depth discussions of the transfer experiences.

Data collection took place during the COVID-19 pandemic. Only one interview was completed with the resident who tested positive for COVID-19 and was transferred to the hospital due to respiratory symptoms. The COVID-19 pandemic delayed the data collection but did not otherwise influence the conduct of the study nor did it appear as a theme in participants' interviews.

Suggestions for Future Research

To address these limitations and to further understand the experiences of nursing home transfers, several recommendations for future research are proposed. Future studies should include the perspectives of multiple stakeholders in the transfer process, including providers and family members, so that a variety of viewpoints can be considered. Studies might also include hospital personnel who receive transferred residents in the ED or who provide care for residents while in the hospital. Moreover, studies should be conducted in a variety of types of facilities in different geographical locations so that the influence of

institutional factors on the transfer process can be better understood. Further studies should employ several interviewers who have
no connections to the nursing homes that serve as the settings for the studies. Studies might also include more racially diverse population to determine how other races/ethnicities respond to transfers.

Many organizations such as CMS and Pioneer Network advocate active involvement of nursing home residents in the decision-making process as would be consistent with the principles of person-centered care. Our study, like others, found that residents were often not involved in the transfer decisions. Future research could focus on the development of strategies that promote more active involvement of residents in transfer decisions to evaluate the effect of involvement on resident outcomes.

Additional studies are also needed to determine if the institutional factors identified in this study as influencing transfer decisions, such as availability of on-site diagnostic capabilities or staffing levels, do in fact influence transfers. For example, research could be designated to assess what measures institutions might adopt to reduce preventable transfers in the most effective and cost-effective ways.

Practice and Policy Implications

The findings point to several practice and policy implications. Nursing home staff should implement ACP practices in their facilities, which can include discussions about potential complications of the residents' condition that may necessitate transfers. Staff should consider providing information to residents and family members about when and how hospital transfers occur so they will be prepared if the need should arise. Staff should also include information about the common risks of transfers as these risks have

now been well-identified by research. These discussions can then elicit the residents' and family members' preferences regarding transfers under a variety of circumstances. These ACP discussions should be held well before a transfer is needed and should be documented in the resident's medical record (Hickman et al., 2015; Ouslander et al., 2011). As soon as residents exhibit health changes that might call for a transfer, all stakeholders, if possible and appropriate, should be involved in the decision to transfer. Nursing homes should also consider implementing tools such as the INTERACT tools and the POLST form to help them manage acute changes in resident condition "in-house."

The findings also suggest that nursing home administrators might assess how resources and staff availability in their institutions contribute to preventable transfers. For example, if being able to complete certain diagnostic and laboratory tests "in-house" or having providers more available on-site could prevent transfers, making these changes could serve as cost-effective ways of reducing transfers and thus avoiding negative effects associated with transfers. Similarly, providing education and skills training for staff in assessing and managing acute exacerbations of chronic conditions might effectively reduce transfers (Ingber et al., 2017; Ouslander et al., 2016). Funding more initiatives at the state or federal level to provide facilities with the resources they need to improve their capacity to manage acute conditions and thereby decrease transfers may be needed.

Because the findings of the study indicate that the "paperwork" required for transfers was so burdensome for nurses and communication between nursing home and hospital staff was often problematic, procedures that streamline the transfer processes and

enhance continuity of care are advised. Procedures that could facilitate the sharing of information both during the residents' transfer to the hospital and during their return to the nursing home could likely decrease some negative transfer experiences for both residents and healthcare personnel and improve resident outcomes.

Conclusion

The findings of the study revealed that the processes by which nursing home residents are transferred to the hospital were complex and often aversive for residents. Our findings were consistent with prior research that demonstrated that decisions to transfer are typically driven by nurses, and residents and families are often not actively involved. The study findings indicate that institutional factors such as inadequate on-site diagnostic testing capabilities and limited staffing could account for preventable transfers. The main limitations of the study were that most transfers were described from one person's perspective, some residents provided sparse descriptions of the transfers, and the facilities were all located in one geographical area. Future studies on nursing home transfers should include a larger and more diverse group of institutions and stakeholders and focus on factors that contribute to transfers that could be prevented. Nursing homes should continue to ensure that residents' voices are present at the time of a hospital transfer so that residents' values, goals, and preferences are considered before transfer decisions are made.

APPENDICES

Appendix A

Section II: Semi-Structured Interview Questions for Nursing Home Residents

A. Background and Preparation

Thank you for your willingness to share your thoughts and experiences. First, before we get started, I would like to hear more about you, your family, and your stay here at (name of nursing home).

Tell me about yourself.
Tell me about your family….
Tell me about your stay at [name of nursing home).

On last *Saturday* you were taken by *ambulance to the (XXX) hospital* emergency room… and I would like to know more about this experience. *Tell me more about it…*

If resident is unable to recall this transfer experience, the interaction will be terminated here.

B. Decision to Transfer

Thank you for sharing with me thus far. It is greatly appreciated, as we move forward, I want to remind you that we are especially interested in your thoughts and experiences with the process of making decisions about transferring NH residents to the hospital. We realize that much thought and deliberation go into these decisions and we are trying to deepen our understand. So, I have some questions about how the decision was made that you would go to the hospital.

Could you tell me about when you first realized you might be going to the hospital?
*Tell me how it was decided that you would go to the hospital. (*That should get you who made the decision but if it doesn't you can probe directly*)*

Who made the decision for you to go to the hospital…?
How did you feel about the decision to go to the hospital?
Were you able to weigh in on the decision? Tell me about it.
Did anyone else weigh in on the decision, like your family members? If so, how so?
What were you told about going to the hospital?
What were you told about your condition that caused you to go the hospital?
Tell me about conversations you had with others about you going to the hospital.

C. Transfer Experience

Thank you again for sharing your thoughts and experiences about the decision to transfer. Next we would like to transition into the resident transfer experience.

We are interested in better understanding what it is like for nursing home residents to be transferred to the hospital, so I have a few questions about the transfer (the time you were taken by the ambulance to the hospital).
Tell me about when you were taken to (XXX) hospital last (Saturday) by the ambulance?
Tell me what you remember about the ride in the ambulance?
Who else was there? Was anyone from you family present?
What were you thinking about?

D. Hospitalization Experience

Thank you for providing such helpful insight so far. We are also interested in what your time was like *at (XXX) hospital* after you went there last (*Saturday*)?

Tell me about your experience in the hospital.
What sort of treatment did you receive? Was it helpful to you?
What was your stay like?

Were you able to get some sleep? Why/why not?
Were you comfortable? Why/why not?

E. Back-Home Reflection

Thank you for sharing your thoughts and experiences about your transfer and hospitalization experiences. We are nearing the end of our interview, but I do have one more area to explore. Do you need a break before we continue? The next area we would like to learn more about is your experience when you returned from the hospital back to the nursing home.

What was the experience like for you when you were transferred back to the nursing home?

Now that you are back at [name of facility] *what do you think about the decision for you to go to hospital?*

We want to help doctors and nurses make good decisions about whether nursing home residents should go to the hospital or stay in the nursing home when they have a medical concern such as your [condition]. Because you have just had an experience being sent to the hospital, we would appreciate your thoughts on this. From your point of view, what should *doctors and nurses keep in mind when deciding to send a resident to the hospital or deciding to keep them in the nursing home and take care of [condition] there? What advice might you give them?*

F. Closing

Thank you so much for sharing your experience with me today.

Do you have any questions for me?
Is there anything you would like to add?

Appendix B

Section II: Semi-Structured Interview Questions for Nurses

A. Background and Preparation

First, I would like to ask you a few questions about your personal background.

Please tell me a little bit about yourself. Age; Gender;
Education background? highest degree obtained;
Shift scheduled to work (days, nights, weekday, weekend);
How long have you worked here? Years of experience in nursing home setting;
How many times have you been involved in transfers of nursing home residents to the hospital?

I am going to ask you some questions about the recent transfer of (name of the resident) to the (XXX) Hospital last (Saturday…). I would like to know more about this experience.

B. Decision to Transfer

We are particularly interested in how decisions are made to send nursing home residents to the hospital as we realize a lot goes into these decisions. So, I have some questions about how the decision was made to transfer the (resident) to the (XXX) hospital.

Please describe the events that led to the hospital transfer of the resident.
Tell me how it was decided that resident would go to the hospital.

Who made the decision for resident to go to the hospital…?
How did you weigh in on the decision?
What influenced how you weighed in on the decision?
Did anyone else weigh in on the decision, like resident's family members or other staff members? If so, how so?
Did [resident] weighed in on the decision about the transfer? How so?
Tell me what information [resident] was given about the transfer?
Looking back, was there any other information that [resident] might have been given about the transfer to help [him/her] choose whether to go to the hospital or stay at the nursing home?
Looking back, how did you feel about the decision to transfer [resident] to the hospital?

C. Resident Preferences

We are also interested in learning more about how well nursing staff know their residents and their care preferences.

Please tell me how well you knew (resident) at the time [he/she] was transferred to (XXX) hospital?
What did you know about [resident's] goals of care?
What did you know about [resident's] preferences regarding hospital transfer?
What did you know about [resident's] advance directives and POST form (if available) at the time of the transfer?

D. Transfer Experience

We are interested in better understanding what it is like for nursing home residents to be transferred to the hospital, so I have a few questions about the transfer.

Tell me how the transfer to the hospital was coordinated with the hospital staff.
(If the same nurse was involved in transfer to the hospital and back to the nursing home ask the following question)
Tell me how the return to the nursing home was coordinated with the hospital staff.

E. Return from the Hospital Issues (Interviewer will ask these questions E only if the same nurse is readmitting resident back to the nursing home OR if the nurse is only being interviewed about the resident's return back to the nursing home)

F.

We would like to learn more about any issues that nursing staff noticed after (resident) returned from the hospital.

Please tell me if you noticed any issues with (resident) upon his/her return to the nursing home from (XXX) hospital?
At the time of (resident's) return, did you receive all information regarding his/her care from (XXX) hospital? Please explain.
How did (XXX) hospital communicate (resident's) goals of hospitalization and his/her advance directives with you at the time of (resident's) return?
Do you believe that (resident) received the care he/she needed while at XXX hospital? Why or why not?

G. Nursing Home Resources

We would like to learn more about availability of nursing home resources at the time of (resident) transfer to (XXX) hospital.

What resources do you wish you had? What if anything would have made it easier?
Tell me whether you believe that the nursing home staff could have provided needed care to the resident or was the transfer to the hospital necessary for the resident's well-being.

We think that it might be possible to treat conditions such as x, y, and z at the nursing home to save the negative consequences of transfers and are therefore interested in understanding what nurses might need to do this and I would like your opinion on this.

What resources would you need to treat {conditions x, y, and z] at the nursing home?
What competencies would nurses need to treat [conditions x, y, and z] at the nursing home?
If our goal is to keep residents at the nursing home, if possible and advisable, what would you recommend that nursing home administrators/director of nursing provide to staff to support that goal?

H. Closing

Thank you so much for sharing your experience with me today.

Do you have any questions for me?
Is there anything you would like to share with other nurses involved in hospital transfers of nursing home residents?

Appendix C

INDIANA UNIVERSITY AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION FOR RESEARCH

You have the right to decide who may review or use your Protected Health Information ("PHI"). The type of PHI that may be used is described below. When you consider taking part in a research study, you must give permission for your PHI to be released from your doctors, clinics, and hospitals to the research team, for the specific purpose of this research study.

This authorization relates to the following study

TITLE OF THE RESEARCH Hospital Transfers: Perspectives of Nursing Home Residents and Nurses
IRB PROTOCOL # #2003586527

PRINCIPAL INVESTIGATOR (in charge of Research Team) Susan Hickman PhD SPONSOR #

NAME OF RESEARCH PARTICIPANT **BIRTHDATE**

STREET ADDRESS **CITY, STATE & ZIP CODE**

What information will be used for research purposes? This form is to allow the release of your health information to be used for the research described above. Your health information includes information that can identify you. For example, it can include your name, address, phone number, birthday and medical record number.

This permission is for health care provided to you: Medical records of NH residents will be reviewed to determine whether he/she meets the study inclusion criteria. Medical records reviews will only apply to residents and not nurses. The only time PHI will be accessed for the purposes of this research is the time right before the interview is conducted so that the researcher can ensure that NH resident meets the eligibility criteria. Demographics such as admit date, race and ethnicity, educational history, marital status, proximity of the family members, and presence of advance directives will be obtained from the NH contact.

I understand the information listed below will be released and used for this research study:

- Information provided by you
- Medical diagnosis/chronic condition
- Recent hospital/ED transfer dates (within the last 30 days)
- Demographics provided by the NH contact (admit date, race and ethnicity, educational history, marital status, proximity of the family members, and presence of advance directives)
- Other: Brief Interview for Mental Status (BIMS) – researcher will not administer this test, she will just review the results of this test in the resident's medical record.

In the event of an adverse event, such as injury related to the research, other records may be accessed for the purposes of your treatment and/or for reporting purposes. This may include records from other health care providers from which you have received medical care, but who are not specifically listed in this Authorization.

Specific authorizations: I understand that this release also pertains to records concerning hospitalization or treatment that may include the categories listed below. I have the right to specifically request that records **NOT** be released from my health care providers to the Research Team. However, I understand that if I limit access to any of the records listed below, I **will still** be able to participate in this research study. Check limitations, if any, below:

- ☐ Mental health records
- ☐ Psychotherapy Notes
- ☐ HIV (AIDS)
- ☐ Other:
- ☐ Sexually transmitted diseases
- ☐ Alcohol / Substance abuse
- ☐ Sickle Cell Anemia

Who will be allowed to release this information?

I authorize the following persons, groups or organizations to disclose the information described in this Release of Information/Authorization for the above referenced research study:

- Indiana University
- Other: Participating Nursing Homes

Who can access your PHI for the study? The people and entities listed above may share my PHI (or the PHI of the individual(s) whom I have the authority to represent), with the following persons or groups for the research study:

- The researchers and research staff conducting the study
- The Institutional Review Boards (IRB) that review the study
- Indiana University
- US or foreign governments or agencies as required by law

Expiration date of the authorization: This authorization is valid until the research ends and required monitoring of the study has been completed.

Efforts will be made to ensure that your PHI will not be shared with other people outside of the research study. However, your PHI may be disclosed to others as required by law and/or to individuals or organizations that oversee the conduct of research studies, and these individuals or organizations may not be held to the same legal privacy standards as are doctors and hospitals. Thus, the Research Team cannot guarantee absolute confidentiality and privacy.

I have the right:

1. To refuse to sign this form. Not signing the form will not affect my regular health care including treatment, payment, or enrollment in a health plan or eligibility for health care benefits. However, not signing the form will prevent me from participating in the research study above.

2. To review and obtain a copy of my personal health information collected during the study. However, it may be important to the success and integrity of the study that persons who participate in the study not be given access until the study is complete. The Principal Investigator has discretion to refuse to grant access to this information if it will affect the integrity of the study data during the course of the study. Therefore, my request for information may be delayed until the study is complete.

3. To cancel this release of information/authorization at any time. If I choose to cancel this release of information/authorization, I must notify the Principal Investigator for this study **in writing** - Susan Hickman PhD at hickman@iu.edu. However, even if I cancel this release of information/authorization, the research team, research sponsor(s) and/or the research organizations may still use information about me that was collected as part of the research project between the date I signed the current form and the date I cancel the authorization. This is to protect the quality of the research results. I understand that canceling this authorization may end my participation in this study.

4. To receive a copy of this form.

I have had the opportunity to review and ask questions regarding this release of information/authorization form. By signing this release of information/authorization, I am confirming that it reflects my wishes.

Printed name of Individual/Legal Representative

Signature of Individual/Legal Representative Date

*If signed by a legal representative; state the relationship and identify below the authority to act on behalf of the individual's behalf.

***Individual is:** ☐ a Minor ☐ Incompetent ☐ Disabled ☐ Deceased

***Legal Authority:**

☐ Custodial Parent
☐ Executor of Estate of the Deceased
☐ Authorized Legal Representative
☐ Legal Guardian
☐ Power of Attorney Healthcare
☐ Other:

Appendix D

Indiana University Study Information Sheet For Residents

Hospital Transfers: Perspectives of Nursing Home Residents and Nurses

You are invited to participate in a research study, because you recently became sick and had to go to the hospital/emergency department. The study is being conducted by Alma Ahmetovic, a doctoral student at Indiana University School of Nursing, with Professor Susan Hickman. This study information sheet is designed to help you decide whether you want to participate. Please read this sheet, and ask any questions you have, before agreeing to be in the study.

STUDY PURPOSE

The purpose of this study is to learn more about your recent experience when you got sick and had to go to the hospital for treatment and your involvement in decisions to go to the hospital. I am interested in learning about your unique perspective. Please know that there are no right or wrong responses. If you agree to participate, you will be one of the 30 participants taking part in this study.

PROCEDURES FOR THE STUDY

If you agree to be in the study, you will be asked to participate in an in-person interview (30-45 minutes) about your demographics, your experience with going to the hospital, your involvement in the decisions to go to the hospital, you preferences about going to the hospital, and your family support. We will complete this interview in a private setting here in the nursing home. The interview will be recorded. I will also review your chart in order to ensure that you have a chronic condition, that you recently went to the hospital with dates of the transfer, and that you have recently completed a screen of your cognitive status. I will also ask nursing management for the information such as admit date, race and ethnicity, educational history, marital status, proximity of the family members, and advance directives. I will not access this information in your chart.

RISKS AND BENEFITS

The risks of participating in this research study are minimal. You may feel uncomfortable answering the questions. You do not need to answer every question. You can decide to skip a question, ask me to clarify a question, or help me develop a better question. There is a risk of possible loss of confidentiality. There are protection measures in place to protect your information.

Your decision to participate will not in any way influence the care you receive here in the nursing home.

You may not receive any benefit from taking part in this study. However, I hope what we learn will be helpful to nursing home staff and researchers in the future. Your participation may provide insights into your experiences when going to the hospital and

increase your awareness of the decisions that are being made at that time. The study may also increase understanding of your preferences, relationships, support, and information that is being shared during the hospital transfers.

CONFIDENTIALITY
Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. No information which could identify you will be shared in this study. As a student researcher, I will write about what you tell me. I will never use your name, but I might quote some things you say in my study. We will keep your information in locked cabinet in a private office or in a password protected electronic files.

I will only take notes occasionally. I will digitally record our conversation with your permission, and I will have the interview transcribed by a professional transcriptionist. The only people that will listen to this recording will be me and a professional transcriptionist. This person is contracted to only listen and transcribed our recorded conversation word for word. The digital recordings will be destroyed after data analysis is complete.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the Indiana University Institutional Review Board or its designees, and any state or federal agencies who may need to access your medical and/or research records (as allowed by law).

PAYMENT
There will be no payment for participation in this study.

COST
There is no cost to you for taking part in this study.

VOLUNTARY NATURE OF STUDY
Participation in this study is voluntary. You may choose not to take part, not answer questions, and leave the study at any time. Leaving the study will not result in any penalty and will not affect your current or future relations with Indiana University.

CONTACTS FOR QUESTIONS AND PROBLEMS
For questions about the study, contact student researcher Alma Ahmetovic (mobile number) or Dr. Susan Hickman (office number). For questions about your rights as a research participant, to discuss problems, complaints, or concerns about a research study, or to obtain information or to offer input, please contact the IU Human Subjects Office at 800-696-2949 or at irb@iu.edu.

Appendix E

Indiana University Study Information Sheet For Nurses

Hospital Transfers: Perspectives of Nursing Home Residents and Nurses

You are invited to participate in a research study, because you were involved in a recent transfer of a nursing home resident to the hospital/emergency department. The study is being conducted by Alma Ahmetovic, a doctoral student at Indiana University School of Nursing, with Professor Susan Hickman. This study information sheet is designed to help you decide whether you want to participate. Please read this sheet, and ask any questions you have, before agreeing to be in the study.

STUDY PURPOSE
The purpose of this study is to learn more about your recent experience when you transferred a nursing home resident to the hospital for treatment and your involvement in the transfer process. You were selected as a possible participant because you were recently involved in the transfer of a resident. If you agree to participate, you will be one of the 30 participants taking part in this study.

PROCEDURES FOR THE STUDY
If you agree to be in the study, you will be asked to participate in an in-person interview (30-45 minutes) about your demographics, your experience with transferring a nursing home resident to the hospital, your involvement in the transfer process, perceptions of the residents' decision-making process at the time of transfers, and your perspectives on issues that arise after resident returns back to the nursing home. Please know that there are no right or wrong responses. We will complete this interview in a private setting in the nursing home or by phone given COVID-19 visitation restrictions. The interview will be recorded.

RISKS AND BENEFITS
The risks of participating in this research study are minimal. You may feel uncomfortable answering the questions. You do not need to answer every question. You can decide to skip a question, ask me to clarify a question, or help me develop a better question. There is a risk of possible loss of confidentiality. There are protection measures in place to protect your information.

You may not receive any benefit from taking part in this study. However, I hope what we learn will be helpful to nursing home staff and researchers in the future. Your participation may provide nursing home nurses with a better understanding of the transfer process and risks that are involved with each nursing home resident transfer to the hospital and back to the facility. Participation may also help nurses become more aware of the events and decisions surrounding transfers and increase their understanding of residents' experiences throughout the entire transfer process.

CONFIDENTIALITY
All research includes at least a small risk of loss of confidentiality. Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and databases in which results may be stored. As a student researcher, I will write about what you tell me. I will never use your name, but I might quote some things you say in my study. We will keep your information in locked cabinet in a private office or in a password protected electronic files.

I will only take notes occasionally. I will digitally record our conversation with your permission, and I will have the interview transcribed by a professional transcriptionist. The only people that will listen to this recording will be me and a professional transcriptionist. This person is contracted to only listen and transcribe our recorded conversation word for word. The digital recordings will be destroyed after data analysis is complete.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the Indiana University Institutional Review Board or its designees, and any state or federal agencies who may need to access your medical and/or research records (as allowed by law).

VOLUNTARY NATURE OF STUDY
Participation in this study is voluntary. You may choose not to take part, not answer questions, and leave the study at any time. Leaving the study will not result in any penalty and will not affect your current or future relations with Indiana University.

PAYMENT
There will be no payment for participation in this study.

COST
There is no cost to you for taking part in this study.

CONTACTS FOR QUESTIONS AND PROBLEMS
For questions about the study, contact student researcher Alma Ahmetovic (mobile number) or email or Susan Hickman, PhD email. For questions about your rights as a research participant, to discuss problems, complaints, or concerns about a research study, or to obtain information or to offer input, please contact the IU Human Subjects Office at 800-696-2949 or at irb@iu.edu.

Protocol 2003586527 IRB Approve

Appendix F

Participating Residents' Characteristics

Table F-1	Number of Resident Participants n (%) N=10
Gender	
Male	5 (50%)
Female	5 (50%)
Race	
White/Caucasian	10 (100%)
Black/African American	
Native American	
Ethnicity	
Hispanic	
Non-Hispanic	10 (100%)
Age in years	
70-79 years	0 (0%)
80-89 years	4 (40%)
90-99 years	5 (50%)
100+ years	1 (10%)
Marital status	
Married	4 (40%)
Widowed	6 (60%)
Highest level of education	
High School Diploma	5 (50%)
Some college/vocational	4 (40%)
Bachelor's Degree	0 (0%)
Master's degree	1 (10%)
BIMS score	
0-7 severe impairment	
8-12 moderate impairment	
13-15 intact cognition	10 (100%)
Code status	
Full code	3 (30%)
No code	7 (70%)
POST form	
Yes	1 (10%)
No	9 (90%)
Family lives nearby	
Yes	7 (70%)
No	3 (30%)
Transfer involvement	
1-2 transfers	4 (40%)
3-5 transfers	0 (0%)
5-10 transfers	0 (0%)
10+ transfers	6 (60%)

Appendix G

Participating Nurses' Characteristics

Table G-1	Number of Nurse Participants n (%) N=12
Gender	
Male	0 (zero)
Female	12 (100%)
Race	
White/Caucasian	12 (100%)
Black/African American	
Native American	
Ethnicity	
Hispanic	
Non-Hispanic	12 (100%)
Age in years	
≤ 50	9 (75%)
≥ 50	3 (25%)
Highest level of education	
Licensed practical nurse/LPN	3 (25%)
Associate of science in nursing/ASN	8 (67%)
Bachelor of science in nursing/BSN	1 (9%)
Shift worked	
First shift	9 (75%)
Second shift	2 (17%)
Third shift	1 (8%)
Years of nursing experience	
1-5 years	1 (8%)
5-10 years	4 (33%)
10-20 years	5 (42%)
20+ years	2 (17%)
Transfer involvement	
1-5 transfers	1 (8%)
5-10 transfers	0 (0%)
10+ transfers	11 (92%)

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CURRICULUM VITAE

Alma Ahmetovic

License

State of Indiana
Registered Nurse
Health Facility Administrator

Education

PhD: 2022
Indiana University
IUPUI
Indianapolis, IN

MSN: 2016
Leadership Track
Ball State University
Muncie, IN

BSN: 2014
Ball State University
Muncie, IN

ASN: 2005
Ivy Tech State College
Marion, IN

LPN: 2003
Ivy Tech State College
Fort Wayne, IN

Professional Experience

Adams Woodcrest Retirement Community, Decatur, Indiana
Executive Director/Health Facility Administrator, December 2021-Present
Oversight of the entire community/all levels of care

Adams Health Network, Decatur, Indiana
Associate Clinical Director, February 2021-December 2021
Quality Improvement Projects

Swiss Village Retirement Community
VP of Healthcare Services/Health Facility Administrator, September 2015-2021
Managed all departments within healthcare

Swiss Village Retirement Community
VP of Healthcare Services/Director of Healthcare Services, May 2013-2021
Managed all departments within healthcare

Swiss Village Retirement Community
Director of Nursing, July 2012-2013
Directed the nursing care program

Swiss Village Retirement Community
Registered Nurse/Unit Manager, May 2005-2012
Managed healthcare unit on day shift

Swiss Village Retirement Community
Licensed Practical Nurse, May 2003-2005
Provided care to residents on night shift

Swiss Village Retirement Community
Qualified Medical Assistant, February 2002-2003
Administered medication to residents on evening shift

Swiss Village Retirement Community
Certified Nursing Assistant, August 1997-2002
Provided care to residents on evening shift

Certifications

American Heart Association
Basic Life Support (BLS) Provider

National Alliance of Wound Care and Ostomy
Wound Care Certification

Indiana State Department of Health
Infection Preventionist

Indiana State Department of Health
Certified Nursing Assistant Instructor

Professional Honors and Awards

The Luella McWhirter Internship/Fellowship, October 2020

Frank and Robin Newhouse Scholarship, August 2020

Jonas Nurse Scholar, Scholarship Award 2018-2020

Indiana Organization of Nurse Executives (IONE) Scholarship, October 2016

LeadingAge Indiana, Linda Woolley Excellence in Nursing Leadership Award, July 2016

National Association of Long Term Care Administrator Boards, Indiana, 2015

National Alliance of Wound Care and Ostomy, 2011, 2016

Professional Organization Memberships

Jonas Nurse Scholar, 2018-2020

National Association of Long-Term Care Administrator Boards, 2015-Present

Indiana Healthcare Association, 2021-Present

LeadingAge Indiana, 2015-2021

Continuing Education

American Healthcare Association Annual Conference
Washington DC, Fall 2021

Indiana Healthcare Association Spring and Fall Conferences
Indianapolis, IN

Post-Acute Care Conference, University of Colorado
Denver, CO, April 2019

LeadingAge National Conference
Philadelphia, PA, October 2018

Nursing Home Research Conference, International Working Group
St. Louis, MO, October 2017

Pioneer Network Annual Conference
Chicago, IL, September 2017

LeadingAge Indiana Spring and Fall Conferences
Indianapolis, IN

LeadingAge Quarterly Compliance Conferences
Indianapolis, IN

Presentations

July 2020: Presented on the topic of the Outdoor and Indoor Family Visitation Practices at Swiss Village during the 20-minute national webinar by Institute of Healthcare Improvement – COVID-19 Rapid Response Network.

August 2017: Presented on the topic of The First 72: Post-Acute Care Onboarding & Hospitality during the 3.5-hour, half-day intensive session at the 2017 Pioneer Network Annual Conference in Schaumburg, IL.