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HSAG HEALTH SERVICES ADVISORY GROUP

Reducing Potentially Preventable Readmissions (PPRs)

Top Evidence-Based Strategies for Skilled Nursing Facilities (SNFs)

Referral

- Review referrals to determine if care needs can be met in your facility by:
  - Triaging referrals into high- medium- low-risk categories.
  - Having a clinical SNF staff member visit residents who are considered medium- to high-risk referrals to determine acuity, care, and equipment needs.
- Identify residents who are at high risk for readmissions and/or have documented multiple readmissions to determine if needs can be met.

Preadmission

- Use a consistent checklist to determine potential equipment needs or specialized service requirements, such as fall precautions, oxygen, continuous positive airway pressure (CPAP), wound vacuum, and continuous passive motion (CPM).
- Conduct a preadmission room huddle with admission nurse and nurse aide to determine that the room is set up with necessary equipment.
- Verify that required written prescriptions are completed and will accompany the resident on admission.
- Use a consistent process for a nurse-to-nurse report immediately prior to resident transfer from acute care for all admissions.
- Verify contact information from the discharging care provider point person in the event additional clarification is needed.
- Coordinate a handover clinical report from the hospitalist/physician to the SNF physician for high-risk residents.

Admission Process

- Provide the resident/resident's representative with a facility call nurse number or extension for notification of resident change in condition, similar to the process a rapid response team uses at the acute care level.
- Use a communication tool for a nurse-to-nurse shift change report that has consistent clinical information.
- Include resident or resident's representative in the medication reconciliation process by:
  - Requesting the resident or their representative bring in the resident's home medication list.
  - Initiating a process where at least two nurses review and verify medication orders and the transfer medication sheet.
  - Identifying/clarifying discrepancies, such as duplicate orders, dosages outside the recommended ranges, and/or unnecessary medications.
  - Clarifying lab orders for high-risk medications.
- Orient the resident and their representative to the unit with an explanation of the skill level and clinical services provided by the facility.
- Verify appropriate diagnosis or need for:
  - Foley catheter.
  - Antipsychotic medications.
  - Psychotropic medications.
- Complete a thorough head-to-toe assessment and initiate a treatment plan.

During SNF Stay

- Discuss discharge goals with the resident or resident’s representative and include those goals in the initial plan of care (POC) and subsequent reviews.
- Promote an interdisciplinary approach to the individualized POC and discharge plan, which includes nursing assistants, dietary staff, therapy staff, and other appropriate team members.
- Begin discharge education and support services needed for the resident to reach goals within 48 hours of resident admission.
- Ensure that the physician completes a physical exam within 48 hours of resident admission.
- Employ standardized documentation tools (e.g., Interact® tools), to identify early changes in condition and best clinical practice to reduce the risk of readmissions, such as:
  - Stop and Watch.
  - Situation, Background, Analysis Response (SBAR).
  - Clinical Pathways.
- Discuss advance care plan with resident/family.
  - Determine wishes/goals.
  - Provide education regarding palliative care and hospice, as appropriate.
  - Share resources, including:
    - Five Wishes—https://www.fivewishes.org/.
    - The Conversation Project—https://theconversationproject.org/.
- Promote consistent use of the warning/flags offered by electronic medical record (EMR) or facility software.
- Review therapy notes daily to identify those residents who have a noted decrease in therapy minutes or participation.
  - Assess for changes in medical condition.
  - Assess for changes in behavior.
- Engage and support development of daily huddles for residents with:
  - Changes in condition.
  - Recent or abnormal lab results.
  - Prescriptions for high-risk medications (opioids, blood thinners, diabetic agents).
  - High-risk diagnosis, such as sepsis, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).
  - Changes in therapy participation.
  - Increased complaints of pain.
  - Changes in behavior.
- Promote the use of resident/resident’s representative educational tools that assist in disease management.
  - Project RED®—Re-engineered Discharge
- Enforce nurse accountability for the use of evidenced-based clinical practices, such as:
  - Daily weights for residents with CHF.
    - Have any weight gain of two pounds or more in one day, or five pounds or more in one week reported to physician/cardiologist.
- Ensure medical directors/nurse practitioners conduct brief clinical review huddles with direct care givers to improve critical thinking skills regarding residents who are at high-risk for readmission.

Preparation for Transfer/Discharge

- Use teach-back methodology with resident education for both primary and secondary diagnosis.
- Follow up with documentation of resident's ability to participate in the teach-back methodology.
  - Document areas of outstanding educational opportunities, as well as what has already been covered.
- Schedule therapy services for a home visit to evaluate home and/or make recommendations for additional safety needs, as appropriate.
- Assist and provide information to the resident and/or their representative regarding available post-discharge community services based on resident goals and needs, such as:
  - Transportation services.
  - Equipment needs (durable medical equipment).
  - Medication management (availability, medication cost, alternatives, and education).
  - Special dietary needs (availability, cost, alternatives, and education).
- Facilitate a resident/resident's representative and interdisciplinary team (IDT) exit meeting to discuss any concerns/questions and identify any outstanding educational opportunities.
  - A family member/caregiver and a representative from next level of care (LOC), such as the home health nurse or hospice nurse, should be included.
- Educate resident/caregiver about pharmacies that provide transitional care services and compliance packaging assistance.
- Arrange and schedule follow-up appointments for residents prior to discharge.
  - Assist with transportation arrangements, as necessary.
- Complete a discharge summary and provide copies to the primary care physician and resident/resident's representative.
- Develop a consistent process for nurse-to-nurse reports in real time for all transfers/discharges, including physician office and dialysis facility.
- Schedule follow-up calls with the resident post-discharge and, when involved with care, the home health agency on days 5, 14, and 28 to identify any changes in condition that require a readmission to the SNF LOC.
- Ensure the following are provided at time of transfer to emergency department (ED) from the SNF:
  - Nurse-to-nurse report hand-off with a standardized verbal communication tool.
  - Completed a transfer form, such as the Interact tool.
  - Adequate information to ensure the emergency physician has a thorough understanding of the resident's:
    - Change in condition.
    - Current medications.
    - Medical management.
    - Current treatment plan.
    - Recommendations for ED.
    - Documented readmissions within last 30 days.
  - Communication of the SNF's level of service capabilities to ensure a smooth and safe transition back to the SNF setting.

Education

- Incorporate clinical education in nurse orientation and periodically assess competency for:
  - Critical thinking.
  - High-risk diagnosis.
  - High-risk medications.
  - Advance care planning.
  - Dementia care.
- Use expertise of contracted healthcare providers to support additional staff education, including:
  - Medical director.
  - Nurse practitioner.
  - Respiratory therapist.
  - Pharmacy staff.
  - Therapist.
- Provide resources and education/training that will support additional services, such as IV therapy and specialized units.
- Set up clinical skills practice labs for nursing staff.
- Train and educate key staff on all shifts to promote a peer-to-peer approach to training.
- Educate and empower nursing assistants to provide best-practice preventative measures, such as:
  - Ambulation programs.
  - Cough and deep breathing techniques.
  - Catheter care and maintenance.
  - Identifying changes in resident's condition.
  - Monitoring fluid intake.
  - Proper body alignment and frequent position changes.

Resident Readmission to Hospital (Within 30 Day of SNF Admission)

- All hospital readmissions within 30 days of SNF admission, necessitate that:
  - An action plan based on chart audits, data, gaps, trends, and drivers of readmissions be completed.
  - SNF leadership meet with acute care providers to partner in improving transitions of care in reducing preventable readmissions.
- Additionally, if a resident is readmitted to the hospital within 7 days of a SNF admission, a 7-day huddle to evaluate the root cause of readmission must be completed within 48 hours.

Sources:

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