Skilled Nursing Facility (SNF)
Shared Best Practices to Reduce Potentially Preventable Readmissions (PPRs)

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 potential 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

Pre-Admission

- Use a consistent checklist to determine potential equipment needs or specialized service requirements, such as: fall precautions, oxygen, continuous positive airway pressure (CPAP)/ventilator, IV, wound vacuum/additional wound supplies/equipment, isolation precautions and specialized needs, such as bariatric lifts/bed; keep this consistent with your facility assessment
- Conduct a pre-admission room huddle with admission nurse and nurse aide to ensure the room is set up with necessary equipment
- Verify that required written prescriptions are complete and accurate, with indication for use, and will accompany the resident on admission
- Use a consistent process for 'nurse-to-nurse' report prior to resident transfer for all admissions, readmissions and Emergency Department (ED) visits, such as the INTERACT® Hospital to Post-Acute Care Transfer Form. (Located under the tab "Interact®Tools" > "Tools For Skilled Nursing")
- If the individual was hospitalized with an infectious illness, request additional details with the Inter-facility Infection Control Transfer Form https://www.cdc.gov/hai/pdfs/toolkits/Interfacility-IC-Transfer-Form-508.pdf
- 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 SNF physician for all residents

Admissions Process

- Provide a facility healthcare contact and phone number for the resident, or their representative, to call with questions or concerns about care and resident change in condition; preferably a case manager or charge nurse
- Utilize a communication tool for shift change report with consistent clinical and resident preference information. Shift change report should be conducted during paired walk-throughs
- Request the resident, or their representative, bring in the resident's home medication list and all home medications; once documented, send these medications with resident's representative
- Drug Regimen Review (DRR)-pharmacist review within 24hr; complete a DRR at admission to the SNF with timely follow-up from a physician for any medication issues identified
- Initiate a process where at least two nurses review and verify medication orders and the transfer medication sheet
- Complete a thorough head-to-toe assessment (include thorough skin assessment within 4 hrs of admission/readmission) and initiate a care plan
- Identify/clarify discrepancies, ie., duplicate orders, dosages outside recommended ranges, orders without indication or diagnosis and/or unnecessary medications

- Clarify lab orders for high-risk medications, such as blood thinners and diabetes medications: https://greatplainsqin.org/initiatives/medication-safety/
- Orient the resident and their representative to the unit with an explanation of the skill level and clinical services provided by the facility
- Verify need for and documentation of appropriate diagnosis related to:
  - ✓ Foley catheter
  - ✓ Opioid medications
  - ✓ Antimicrobial medications
  - ✓ Psychotropic (anti-psychotic) medications and all other medications

During SNF Stay

- Discuss discharge goals with the resident and/or the resident's representative; 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 within 48 hours of resident admission
- Ensure physician completes 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 the following Interact® tools, available at https://pathway-interact.com/ (Located under the tab "Interact(R) Tools" > "Tools For Skilled Nursing"):
  - ✓ Stop and Watch
  - ✓ Situation, Background, Assessment, Recommendation (SBAR)
  - ✓ Care Path
- Discuss advance care plan with resident/family
  - ✓ Explore wishes & identify goals
  - ✓ Provide education regarding palliative care and hospice, as appropriate
  - ✓ Share resources, including:
    - Serious Illness Conversation Guide: https://www.ariadnelabs.org/wp-content/uploads/sites/2/2015/08/Serious-Illness-Conversation-Guide- 5.22.15.pdf
    - Five Wishes: https://agingwithdignity.org/five-wishes/about-five-wishes
    - The Conversation Project: https://theconversationproject.org/
    - Caring Info:http://www.caringinfo.org/
  - ✓ Ensure the resident's wishes are care-planned and communicated with staff, family or representative and resident's physician
- Work with resident, resident's representative, consultant pharmacist and primary care provider to taper to eliminate any inappropriate or unnecessary medications that do not align with the resident's care goals. Consider nonpharmacological interventions.
  - ✓ Deprescribing.org
  - ✓ https://deprescribingresearch.org/
- Promote consistent use of the warning/flags offered by Electronic Medical Record (EMR) or facility software
- Assess for change in medical condition
- Engage and support development of daily huddles for residents with:

- ✓ Changes in condition
- ✓ Recent or abnormal lab results
- ✓ Prescriptions for high-risk medications (anti-psychotics, opioids, blood thinners, diabetic agents)
- ✓ High-risk diagnoses, such as sepsis, Chronic Obstructive Pulmonary Disease (COPD), and Congestive Heart Failure (CHF), pneumonia, dementia
- ✓ Changes in therapy minutes or participation
- ✓ Increased complaints of pain
- ✓ Changes in behavior

- Promote the use of educational tools that assist in disease management
  - ✓ ®Project RED—Re-engineered Discharge: http://www.bu.edu/fammed/projectred/
  - ✓ Project BOOST: https://www.hospitalmedicine.org/clinical-topics/care-transitions/
- Enforce nurse accountability for the use of evidenced-based clinical practices; for example:
  - ✓ Daily weights for residents with CHF
  - ✓ Report to physician/cardiologist any weight gain of two pounds or more in one day, or five pounds or more in one week
- Ensure medical directors/ primary care providers conduct brief clinical review huddles with facility caregivers to improve critical thinking skills regarding residents who are at high-risk for readmission
- Collaborate with pharmacy staff to:
  - ✓ Ensure emergency medication box (E-box) has adequate medication supply
  - ✓ Include pharmacy consultant in inter-disciplinary team meetings
  - ✓ Facilitate ongoing drug regimen review with timely follow-up from a physician for any significant medication issues identified

Preparation for Transfer/Discharge

- Ensure the following are provided at time of transfer to ED from the SNF:
  - ✓ Nurse-to-nurse report hand-off with a standardized verbal communication tool, such as the Interact Nurse-to-nurse report hand-off with a standardized verbal communication tool, such as the INTERACT® tools available at https://pathway-interact.com/ (Located under the tab "Interact® Tools" > "Tools for Skilled Nursing")
    - SNF/NF – Hospital Transfer Form
    - Acute Care Transfer Document Checklist
      - ✓ Complete transfer form
      - ✓ Change in condition
      - ✓ Current medications
      - ✓ Medical management
      - ✓ Isolation precautions or MDRO status
      - ✓ Current treatment plan
      - ✓ Recommendations for ED
      - ✓ Documented readmissions within last 30 days

- Use teach-back methodology with resident education: https://greatplainsqin.org/initiatives/coordination-care/teach-back-training/
  - ✓ Document education provided, resident's understanding of education and areas in need of additional re-enforcement

- 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)
  - ✓ Chore services
- Facilitate exit meeting with the resident, and/or the resident's representative, and Inter-disciplinary Team (IDT) to discuss concerns/questions and identify any outstanding educational opportunities
- A family member/caregiver and a representative from next level of care, such as the home health nurse or hospice nurse, should be included
- Educate resident, and/or the resident's representative, about pharmacies that provide transitional care services and packaging assistance
- Arrange and schedule follow-up appointments for resident prior to discharge
  - ✓ Assist with transportation arrangements as necessary
- Complete a discharge summary and provide copies to primary care physician and resident/resident's representative
- Develop a consistent process for nurse-to-nurse report in real time for all transfers/discharges, including physician office, assisted living, home health and dialysis facility , such as the INTERACT(R) tools available at https://pathway-interact.com/ (Located under the tab "Interact(R) Tools" > "Tools For Skilled Nursing")
  - ✓ SNF/NF – Hospital Transfer Form
  - ✓ Acute Care Transfer Document Checklist
- Schedule follow-up calls with resident post-discharge, and when involved with care, the home health agency (on day 2, 7, 14, 28) to identify any changes in condition that require a readmission or ED visit
- Communication of SNF's level of service capabilities to ensure a smooth and safe transition back to the SNF setting such as the Interact® SNF/NF Capabilities List available at https://pathway-interact.com/ (Located under the tab "Interact(R) Tools" > " Tools For Skilled Nursing")

Education

- Incorporate clinical education in nurse orientation and periodically assess competency for:
  - ✓ Critical thinking
  - ✓ High-risk diagnoses
  - ✓ High-risk medications
  - ✓ Advance care planning
  - ✓ Dementia care
  - ✓ Employee Competency CMPRP Assessment Toolkit: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/CMPRP-Toolkit-1-Instruction-Manual.pdf
- Utilize expertise of contracted healthcare providers and available community/state resources to support additional staff education, including:
  - ✓ Medical Director
  - ✓ Nurse Practitioner
  - ✓ Respiratory Therapist

- ✓ Pharmacy Staff
- ✓ Therapist (PT/OT)
- ✓ Great Plains Quality Innovation Network
- ✓ Long-Term Care Ombudsman
- ✓ Alzheimer's Association

- Provide resources and 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
  - ✓ Fall prevention
  - ✓ Cough and deep breathing techniques
  - ✓ Catheter care
  - ✓ Identifying changes in resident's condition
  - ✓ Fluid intake
  - ✓ Proper body alignment and frequent position changes
  - ✓ Skin assessment and care
  - ✓ Restorative sleep https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment
  - ✓ Head to Toe Infection Prevention https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment

Resident Readmissions to Hospital (within 30 days of SNF Admission)

- All hospital readmissions within 30 days of SNF admission, necessitate that:
  - ✓ Complete an action plan based on chart audits, data, gaps, trends and drivers of readmission
  - ✓ SNF leadership meets with acute care providers and other members of the care community to partner in improving transitions of care in reducing preventable readmissions http://www.ihi.org/Topics/Readmissions/Pages/default.aspx
  - ✓ If a resident is readmitted to the hospital from the SNF within 30 days, the root cause of readmission should be completed within 48 hours, such as the Interact® RCA tool (Located under the tab "Interact(R) Tools" > "Tools For Skilled Nursing")

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