Reducing the Risk of Avoidable Resident Readmissions to an Acute Care Setting
Respectfully submitted by The Interdisciplinary Team of CNR a member of the Center Light Health System
Reducing Avoidable Readmissions
INTERACT New York: Key Initial Steps

- Every transfer is first referred to one of the Medical Directors = Gatekeepers/Consultants
  - Endorsed by HIC
  - Evening MDs
- Hypoglycemia Protocol
- Policy addressing GT dislodgment
- Administration of IV/IM Lasix for in-house treatment of CHF
- Send residents out for PICC line insertions so that IV Fluid and Antibiotics are administered more efficiently
Reduction in Hospitalization Rate: Top 3 Diagnosis

- Dislodged Peg: 36 in 2010, 0 in 2011 (100% decrease)
- Sepsis: 19 in 2010, 0 in 2011 (100% decrease)
- Hypertension: 22 in 2010, 7 in 2011 (68% decrease)
Reducing Avoidable Readmissions

- Communication training for the Interdisciplinary Team in the SBAR Format
  - Situation
  - Background
  - Assessment
  - Recommendation
- Developed a format to guide phone communication between disciplines
- *We Know You Care But Now You Have To Share*
  - Early recognition of a change in the resident
Reducing Avoidable Readmissions

- United Hospital Fund Initiative
  - We have adopted the *Teach Back Approach* to anchoring resident/family caregiver training
  - We have included Medication Reconciliation as our TC-QuIC Quality Management project following the *Plan Do Check Act* Model
    - Goal: reconcile medications from home with medications received during acute care admission; with medications ordered while at CNR within the first 7 days of admission
    - Success is directly related to the number of residents that actually bring in their meds from home
    - We needed to ensure that the message to bring in the meds from home started with the Admitting Department.
  - As another Interdisciplinary form of collaboration, we revised our *PRI Screening Top Sheet* to include a check off that indicated that this information was shared
Reducing Avoidable Readmissions

- Partnership with Methodist Hospital
  - Discharge information addressing medications was very difficult to interpret
  - We used 2 RNs to ensure accuracy and safety
  - We brought this issue to the Methodist Team and subsequently had a meeting with the entire Team including their IT people and fixed the problem
- Staff Education offered by Methodist Hospital to CNR Team
  - Signs, symptoms and management of CHF
Medication Safety

- In collaboration with the Medical Directors, policies were developed addressing:
  - Levothyroxine/Synthroid
  - Bisphosphonates
  - Vitamin C to ensure longer availability
- Administration Flow Sheets for
  - Anticonvulsants
  - Coumadin
- EMR addresses:
  - Transcription errors
  - Legibility
  - Signing for medication administration
Reducing Unnecessary Medications

- Ongoing collaboration with our Medical Attendings
- Utilize our SigmaCare Report feature to run reports on several resident monitors such as:
  - Blood Glucose
  - Blood Pressure
- Joined with the MDs to revisit insulin and anti-hypertensive medications
- In most cases we were able to make adjustments to medication regimen that reduced meds while maintaining clinical outcomes
Conversion from Human Insulin to Analog Insulin

- Pre-filled insulin syringe pens
- Allows users to set an accurate appropriate dose
- Does not require refrigeration
26 Residents with Gastrostomy Tubes qualified for the Protocol
4 Resident were below Ideal body weight = Not a Candidate for the Protocol
1 resident had no issues with constipation = Not broken, nothing to fix

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<th>Colace</th>
<th>Diocto</th>
<th>Lactulose</th>
<th>MOM</th>
<th>Docusate</th>
<th>Miralax</th>
<th>Fleet 3x week</th>
<th>SSE 3X week</th>
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Number of medications reduced = 39 meds x 2 to 3 doses a day
Number of procedures reduced = 12/week
## Fall Management: 10/2010 thru 10/2011

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<td>Assisted to floor by staff</td>
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<tr>
<td>Total</td>
<td>73</td>
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### Interventions:
- Heightened awareness/everyone’s responsibility
- Better pain assessment
- Better tools
- Better depth perception: Black toilet seats
- Invaluable Therapeutic Recreation support
Reducing Avoidable Readmissions
Sub Acute Care Training

- Eight week training program designed to anchor the knowledge base of the RNs;
  - 14 RN participants have successfully completed the program
  - The goal is to have each RN attend

- **Wound/Skin Management: STOP & WATCH**
  - **Nosocomial Pressure Ulcer Alert Form**
Reducing Avoidable Readmissions
Why Don’t We Do Our Own EKGs?
Prevention Of Nosocomial Urinary Tract Infections

- In the Past 18 Months
  - Improved documentation of UTI on admission
  - Evidence Based Practice: Administration of Vitamin C
- Going forward
  - New Adult Brief Products
Reducing Avoidable Readmissions

- **Advanced Care Program**
  - Partner with Managed Care companies to provide an *Alternative Care Setting* to acute care hospitals, utilizing our *Subacute Care Unit*
    - Direct admission from the community
    - Transfers from the ED
    - Intra-facility transfers to the Subacute Unit
  - Diagnoses that we can admit to the Advanced Care Program include:
    - Dehydration, pneumonia, cellulitis, pain management for those receiving palliative care