

How nurses can help reduce hospital readmissions

Learn how to help mitigate readmission risk starting from the time of admission.

By Joan M. Nelson, DNP, RN, ANP-BC, and Laura Rosenthal, DNP, RN, ACNP-BC

For too many patients, the hospital door is a revolving one. About 20% of Medicare patients leave the hospital only to be readmitted within 30 days. Failure to create standard discharge processes, adequately prepare patients and family caregivers for discharge, educate patients about medications, and communicate effectively with postdischarge providers contribute to preventable readmissions. The Hospital Readmission Reduction Program (part of the Affordable Care Act) reduces payments to hospitals with high readmissions rates within 30 days of discharge.

Through efficient coordination, communication, planning, and education, nurses and nurse case managers (NCMs) can play a pivotal role in reducing readmissions. Starting at admission, we can mitigate readmission risk at multiple points during the pre-discharge and postdischarge periods by:

- appropriately determining the patient's readiness for discharge
- compiling a comprehensive and accurate discharge summary
- helping to determine an appropriate postdischarge care setting
- coordinating care with multiple settings and providers

- involving the patient and family caregivers in the plan of care
- conducting postdischarge follow-up phone calls.

Nursing interventions on admission

Project BOOST® (Better Outcomes by Optimizing Safe Transitions) recommends interventions begin at admission. To help identify concerns that may warrant additional interventions during the patient's hospital stay, be sure to evaluate key psychosocial issues, including cognitive status, substance abuse or dependence, abuse or neglect, and documentation of advanced care planning. Communicate areas of concern to the NCM for potential interventions and referral to appropriate resources and referrals.

The General Assessment of Preparedness (GAP) tool helps nurses and NCMs with early patient evaluation. This simple checklist, which various healthcare team members can complete, addresses potential logistical and psychosocial issues. To learn more about GAP, visit www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality_Innovation/Implementation_Toolkit/Boost/BOOST_Intervention/BOOST_Tools.aspx.

Nursing interventions throughout the stay

It's crucial to identify who will provide care for the patient after discharge and to involve this person in discharge planning. To increase the chance that family caregivers will be involved in planning, write the name of the postdischarge caregiver on the whiteboard in the patient's room. Preparing the patient and home caregiver for discharge throughout the hospital stay can ease information overload and confusion during the discharge process. Readmission rates decline when patients and family caregivers participate in discharge planning as active care team members. (See *IDEAL discharge planning method*.)

Nursing interventions during discharge

Many studies link readmissions with lack of prompt follow-up by primary care providers (PCPs) or other healthcare professionals. Ideally, patients should have a follow-up appointment within 48 hours to 7 days after discharge. NCMs may use the following strategies to increase the chance of successful follow-up:

- Develop scheduling agreements with local clinics, such as system-affiliated ambulatory care clinics.

- Create processes for assigning patients to a PCP if they don't have one.
- Educate patients and home caregivers about the importance of timely and appropriate follow-up.
- Identify and address barriers that contribute to cancelled healthcare appointments.
- Give the patient and family caregivers the discharging unit's phone number so they can call with questions or concerns.

Communication

During this critical transition time, clear communication must occur among PCPs, home healthcare agencies, long-term care facilities, and other facilities. Nurses and NCMs can assist in gathering written chart information as well as giving verbal report to the caregiver who's receiving the patient.

The National Transitions of Care Coalition encourages use of a standardized universal transfer tool to promote transfer of necessary patient information during care transitions. The Reducing Avoidable Readmissions Effectively Campaign provides transition information templates in its Safe Transitions of Care Toolkit, which includes checklists for important patient information. Available at www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/readmissions-safe-transitions-of-care, this tool can be faxed to the receiving facility and reviewed before the patient-report phone call and patient transfer occur.

IDEAL discharge planning method

The Agency for Healthcare Research and Quality has developed a guideline and toolkit to help nurses and other clinicians involve patients in discharge planning. Using the acronym "IDEAL," this guide encourages nurses to use the following strategies with patients and family caregivers.

Include

Include the patient as a full partner in discharge planning, bedside rounds, and shift reports. Review medications daily and at each dose administration. Have at least one meeting specific to discharge planning at least 1 or 2 days before discharge. During this meeting, you can use the "Be Prepared to Go Home Checklist," available at www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_2a_IDEAL_Checklist_508.pdf.

Discuss

Focus on these five key areas to prevent problems at home:

- Describe life at home after discharge, including home safety, dietary changes, activity restrictions, and support services.
- Review medications using a reconciled medication list.
- Review red flags for changes in the patient's condition and action plans. Ensure that the patient has a contact phone number to call with questions or if his or her condition changes.
- Review test results, including pending results, and explain how to access this information.
- Highlight required follow-up appointments and provide assistance in making them, if needed.

Educate

Using plain language, educate the patient and family about the patient's condition, discharge process, and next steps on an ongoing basis throughout the hospital stay.

Assess

Assess the quality and effectiveness of healthcare professionals' explanations of the patient's diagnosis, condition, and next steps in care. Also assess how often healthcare professionals use teach-back techniques.

Listen

Listen to and honor the goals, preferences, observations, and concerns of the patient and family caregivers. Provide a whiteboard or other area for the patient and family to write questions as they arise. Elicit the patient's goals for the hospital stay.

For more information on IDEAL discharge planning, visit www.ahrq.gov/professionals/systems/hospital/red/toolkit.

Postdischarge nursing interventions

The period immediately after discharge is a vulnerable time for patients—one in which rapid changes can occur. Following up with patients and home caregivers soon after discharge can

decrease confusion and reinforce follow-up plans. Common topics to discuss during the first postdischarge phone call include medications and pending services or appointments. Healthcare providers should inform patients about the purpose of the call.

INTERACT tools

The Interventions to Reduce Acute Care Transfers (INTERACT) program includes the following tools that nurses and nursing assistants can use in long-term care and assisted living facilities:

- advanced care planning tools
- medication reconciliation worksheet
- decision-support tools related to specific presenting signs and symptoms aimed at guiding appropriate information gathering and providing criteria for calling a nurse practitioner (NP) or physician
- communication tools that support staff can use to notify nurses of changes in the patient's condition, including a progress note/change-in-condition template for documentation and communication by nurses to NPs or physicians and a documentation template used to communicate essential information to the acute-care facility in case the patient requires transfer to that setting
- quality-improvement tools that promote consistent incorporation of these tools and standards into daily practice.

To access these tools, visit <https://interact2.net/>.

Training nurses or NCMs to make these calls using a script and an electronic documentation template can help ensure important issues are covered and documented in the medical record.

Discharge to a setting other than home

When a patient is discharged to a setting other than the home, nurses and NCMs can play a crucial role in preventing transfer back to the hospital. Interventions to Reduce Acute Care Transfers (INTERACT) is a quality-improvement program that provides an evidence-based guide, web-based educational materials, and tools designed to reduce transfers (including readmissions) from long-term care and assisted living settings to acute-care hospitals. INTERACT can improve patient safety and satisfaction and reduce readmissions through early identification and evaluation of changes in the patient's condition, optimal documentation and communication about these changes, and management of the patient's condi-

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tion in a way that's consistent with the patient's and family's wishes. (See *INTERACT tools*.)

Halting the readmission cycle

Hospital readmissions are costly to patients and healthcare facilities. Nurses and NCMs are natural communicators and educators, putting them in an excellent position to help prevent readmissions at multiple points—from admission through discharge and beyond. Becoming familiar with and using easily accessible, evidence-based resources and tools can help nurses and NCMs manage patient transitions optimally and consistently.

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The authors work at the University of Colorado College of Nursing in Aurora. Joan M. Nelson is an associate professor and Laura Rosenthal is an assistant professor.