AHRQ's Safety Program for Nursing Homes: On-Time Preventable Hospital and Emergency Department Visits

Hospital Transfer Self-Assessment Worksheet

Purpose

The *Hospital Transfer Self-Assessment Worksheet* can help nursing home staff identify and review care that they provide that may lead to avoidable transfers to the hospital or emergency department. The worksheet addresses the following questions:

- Is the nursing home providing appropriate and timely responses to changes in health, or is the care insufficiently responsive, resulting in declines leading to hospitalization?
- Are some discharges preventable because the nursing home could have cared for the resident in the nursing home safely?
- Could residents with some adjustments to resources be treated in the nursing home safely?
- Does the nursing home identify who is at high risk for hospitalization?
- Do they provide preventive care to reduce the number of unnecessary hospitalizations?

Description

The assessment has four sections:

- Screening for hospitalization risk,
- Averting preventable transfers through symptom recognition,
- Communication practices, and
- Investigations or root cause analysis of preventable transfers.

Users and Potential Uses

The main user is the preventable nursing home transfers change team. The completed worksheet shows the nursing home's practices around screening for conditions and symptoms that may lead to a hospital or ED visit, communication about risk, and care planning and interventions to avert preventable transfers that the team can use to identify gaps in their clinical practice. A Facilitator guides these discussions and helps the staff identify how to use On-Time reports to fill in gaps in processes or to redesign or streamline processes.

This self-assessment tool is aimed at two types of nursing homes. First are nursing homes that are not using an electronic medical record (EMR) for preventable hospital and ED visits but have access to the *On-Time Preventable Hospital and ED Visits Risk Reports* from their health information technology vendor and have decided to use these reports to create electronic risk information to help avert preventable hospital and ED visits. Conducting the self-assessment tool is an important first step in implementing the reports into current workflow.

Second are nursing homes that lack access to On-Time in an EMR but want to understand their current practices and identify opportunities for improvement without using electronic records. This assessment should show how well the nursing home:

- Identifies hospitalization risk factors using information from multiple sources,
- Develops interventions specific to the risk factors to mitigate the risk,
- Communicates the intervention to all staff using multiple processes, and
- Investigates the root cause of hospital transfers to determine if any were preventable.

The worksheet covers the following:

- Section 1: Screening for Hospital Transfer Risk
- Section 2: Preventable Hospital and ED Visits - Prevention Plan
- Section 3: Communication Practices
- Section 4: Investigations/Root Cause Analysis of Potentially Preventable Acute Care Transfers

Section 1: Screening for Hospital Transfer Risk

1. Does your facility have a written policy and procedure for assessing residents at risk of hospital transfers? Yes ❑ No ❑ Not Sure ❑

   If no, skip to question 2.

   A. Does your policy and procedure on assessing risk for hospital transfers include the following items?

	Yes	No
Tools for resident evaluation (e.g., care paths)	❑	❑
Tools for communication with emergency medical service providers, physician, and hospital (e.g., SBAR)	❑	❑
Identification of factors that put a resident at risk for hospital/ED transfer	❑	❑

   B. What guidelines or evidence-based practice is your policy and procedure based on? Check all that apply.

   - ❑ INTERACT (Interventions to Reduce Acute Care Transfers)
   - ❑ RARE (Reducing Avoidable Readmissions Effectively)
   - ❑ Advancing Excellence
   - ❑ Project Boost
   - ❑ RED (Re-Engineered Discharge)
   - ❑ AMDA's Clinical Practice Guidelines for Transitions of Care in Long Term Care Continuum
   - ❑ None of the above
   - ❑ Other _____

   C. Does your policy and procedure include a provision for regular exchange of information with acute care providers? Yes ❑ No ❑

   If no, skip to Question 2.

   i. Warm handoffs (verbal report to triage nurse) Yes ❑ No ❑
   ii. Use of a standard interagency referral form Yes ❑ No ❑
   iii. Care transitions meetings Yes ❑ No ❑

2. Does your facility use a hospital transfer risk-factor screening tool? Yes ❑ No ❑

   If no, skip to Question 4.

3. If yes, does the tool screen for any of the following?

	Yes	No
>1 hospitalization or ED visit in the past 3 months	❑	❑
>1 fall in the past 3 months	❑	❑
Active high-risk diagnoses (e.g., CHF, MI/angina, pneumonia/bronchitis, COPD, dehydration, UTI, infection, renal failure, diabetes, gastroenteritis)	❑	❑
Poor prognosis/end-stage disease	❑	❑
Lack of advance care planning	❑	❑
Lack of documented code status	❑	❑
Oxygen dependency	❑	❑
Confusion/mental status change	❑	❑
Any full thickness wound (e.g., pressure ulcers [Stage II or greater], surgical wound, stasis ulcer)	❑	❑
Polypharmacy (15 or more medications)	❑	❑
Presence of catheter or ostomy	❑	❑
Fall risk	❑	❑
ADL Late Loss score ≥ 12 based on RUG-III	❑	❑
Use of high-risk medications (anticoagulants, insulin, psychotropic medications, cardiac medications, etc.)	❑	❑
Other (specify):	❑	❑

4. Does your facility have a formal system for documenting a hospital transfer risk assessment on each resident?

   A. Long-term care residents Yes ❑ No ❑
   B. Short-term care residents Yes ❑ No ❑
   C. New admissions only Yes ❑ No ❑

5. When are residents screened for hospital transfer risk? Check all that apply.

   ❑ Upon admission/readmission
   ❑ Monthly
   ❑ Quarterly
   ❑ With a change in condition
   ❑ With each MDS assessment
   ❑ After every ED visit
   ❑ After every observation stay
   ❑ Annually
   ❑ Other (specify): _____

6. Who is responsible for completing the transfer risk assessment?

   - ❑ Admitting nurse
   - ❑ Charge/unit/floor nurse
   - ❑ Nurse manager
   - ❑ Nursing supervisor
   - ❑ Director of Nursing
   - ❑ Social Services
   - ❑ Other (specify): _____

7. Is the resident/family/caregiver involved in the risk assessment? Yes ❑ No ❑
8. If the resident is not currently at risk, is there a plan to rescreen at regular intervals? Yes ❑ No ❑
9. Do you screen residents with the following diagnoses for hospitalization risk?

   A. Congestive heart failure Yes ❑ No ❑
   B. Diabetes Yes ❑ No ❑
   C. Circulatory problems Yes ❑ No ❑
   D. COPD Yes ❑ No ❑
   E. Dementia Yes ❑ No ❑
   F. HIV/AIDS Yes ❑ No ❑
   G. Chest pain Yes ❑ No ❑
   H. Pneumonia or bronchitis Yes ❑ No ❑
   I. Dehydration Yes ❑ No ❑
   J. Renal failure Yes ❑ No ❑
   K. Chronic pressure ulcers Yes ❑ No ❑
   L. Recurrent UTI Yes ❑ No ❑
   M. Anemia Yes ❑ No ❑
   N. Fever Yes ❑ No ❑
   O. Sepsis or infection Yes ❑ No ❑
   P. Gastroenteritis Yes ❑ No ❑

Section 2: Preventable Hospital Transfer and ED Visits - Prevention Plan

For residents at risk:

1. Do you develop a care plan for residents *at risk* for hospital transfers? Yes ❑ No ❑

   If no, skip to Section 3.

   A. If yes, does your plan include:

      i. Standing daily weight orders for residents with CHF? Yes ❑ No ❑
      ii. Standing hypo/hyperglycemic orders for residents with diabetes? Yes ❑ No ❑
      iii. Standing rescue orders for residents with COPD? Yes ❑ No ❑
      iv. Standing orders for other diagnoses (specify) _____ Yes ❑ No ❑

2. Does your plan include interventions for treating in place? Yes ❑ No ❑
3. Does your plan include ongoing discussions about advance care planning with resident and/or family? Yes ❑ No ❑
4. Does your plan include interventions for code status? Yes ❑ No ❑
5. Does your plan include interventions for hospitalization transfer wishes (e.g., Do Not Hospitalize, Medical Orders for Life-Sustaining Treatment, Physician Orders for Life-Sustaining Treatment)? Yes ❑ No ❑
6. Is the plan readily accessible by all members of the interdisciplinary team? Yes ❑ No ❑
7. Does your plan include regular rescreening for hospitalization risk factors for residents currently at risk for hospitalization? Yes ❑ No ❑

Section 3: Communication Practices

1. This section of the assessment will help identify how your facility communicates the hospital prevention care plans to the interdisciplinary team. Please review the following list of meetings. For every meeting that occurs at your facility, indicate how often it occurs, who leads the meeting, and who attends.

Meeting	Hospital/ED Transfer Prevention Discussed (Yes/No)	Meeting Chair/Leader Name and Discipline	Staff Invited and in Attendance (A – Always, V- Varies as Needed)	Frequency of Meeting (Weekly, Biweekly, Monthly, Quarterly, Change in Condition, As Needed)
a. Daily morning meetings				
b. Report or brief with CNAs				
c. Report or brief with department heads				
d. Medical staff				
e. QAPI or Performance Improvement Plan meeting				
f. Care plan meeting				
g. MD/APRN rounds				
h. Report or brief with Dietary Department				
i. Report or brief with Social Services Department				
j. Report or brief with Therapy Department				
k. Report or brief with Other				

2. Training

Indicate the date of the most recent training.

Topic	Participants	Date
a. Standardized CHF education such as "Heart Talk"[1]	Nurses	
b. Standardized COPD education such as "Lung Talk"[2]	Nurses	
c. Warm handoffs[3]	Nurses	
d. Effective communication between nurse and providers (e.g., Use of SBAR, Chief Complaint [Context/Code Status], History, Assessment/Exam)	Nurses/MDs	
e. Reporting subtle changes in conditions	CNAs/Housekeeping/ Maintenance/Rehab/ Dietary	
f. Zones for residents with CHF/COPD to help self-manage[4]	Nurses/CNAs	
g. Care paths[5]	Nurses/MDs/CNAs	

3. Does your facility provide training to nursing/medical staff on how to accurately assess a change in condition that may put a resident at risk for hospitalization? Yes ❑ No ❑

   A. Does your facility provide education to certified nursing assistants regarding their role in identifying and reporting a change in resident condition? Yes ❑ No ❑

[1] Available at www.HeartTalk.org/.
[2] Available at www.LungTalk.org/.
[3] Available at http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/longtermcare/module6/igltccommunication.html#whathandoff.
[4] Available at http://www.pcpci.org/sites/default/files/resources/ExacerbationPlanProtcol-Combined.pdf.
[5] Available at https://interact2.net/tools_v4.html.

Section 4: Investigations/Root Cause Analysis of Potentially Preventable Acute Care Transfers

1. Do you investigate each hospital transfer to determine if the transfer could have been prevented with better preventive care during the resident's stay?

   Yes ❑ No❑ Not Sure ❑

   If No, Stop here.

   A. What guides your investigation? Check all that apply.

   - ❑ Organizational protocols/policy and procedures
   - ❑ Root Cause Analysis
   - ❑ INTERACT
   - ❑ Tree/Fishbone Diagrams
   - ❑ Others _____

   B. Who participates in the investigation? Check all that apply.

   - ❑ Director of Nursing/Assistant Director of Nursing
   - ❑ Nursing Supervisor
   - ❑ Administrator
   - ❑ Medical Director
   - ❑ Nurse managers/charge nurses
   - ❑ Social worker
   - ❑ Nursing assistants
   - ❑ Primary care provider/NP/PA
   - ❑ Other

2. How often does the team meet?

	Yes	No
a. Weekly	❑	❑
b. Monthly	❑	❑
c. Quarterly	❑	❑
d. Annually	❑	❑
e. After each transfer	❑	❑

3. In the course of your investigation, what actions take place? Check all that apply.

   - ❑ Review of medical record for condition changes prior to transfer going back at least 14 days
   - ❑ Interview/discussion with charge nurse initiating the transfer for details on events leading up to the transfer
   - ❑ Interview/discussion with clinician authorizing transfer
   - ❑ Other (specify) _____

4. Does your team make a determination as to whether the hospital transfer was preventable? Yes ❑ No ❑

   A. If yes, does the multidisciplinary team evaluate the resident's care plan and implement new approaches to prevent recurrence? Yes ❑ No ❑
   B. How is the new plan to prevent future hospital transfers communicated to all staff? Check all that apply.

      - ❑ Shift report
      - ❑ Brief
      - ❑ Care plan meeting
      - ❑ Nursing staff meeting
      - ❑ Risk meeting
      - ❑ Department head meeting
      - ❑ Other (specify) _____

5. The investigation may reveal that a particular action should have been taken to address a condition change (e.g., increased fluids for suspected UTI, increased assistance with ambulation for new weakness, respiratory treatment for increased shortness of breath). How would you ascertain that an intervention had been identified as necessary but was not implemented?

   _____

   _____

6. Are there any particular barriers or challenges to investigating the root cause of preventable hospital transfers?

   _____

   _____

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Menu of Implementation Strategies

The Menu of Implementation Strategies lists potential ways facility teams may choose to integrate the preventable hospitalization/ED transfer reports into clinical practice. The menu provides possible uses for the reports with, in this case, a focus on averting preventable hospital and ED transfers.

Implementation strategies are developed to include multiple disciplines besides nursing, to promote the most effective use of the reports and improve communication across disciplines. Teams are encouraged to identify implementation strategies that may not be included on the list but are suited to integrate seamlessly into workflow at their facility.

The Preventable Hospital/ED Visits Menu of Implementation Strategies table below summarizes potential uses for each report, as described in each report section. See Tables 3, 5, 7, 9, and 11.

Preventable Hospital and ED Visits Menu of Implementation Strategies

	Existing	New
Transfer Risk Report – High Risk and Medium Risk		
1. Care plan meetings		
2. Dietary Department internal review		
3. Nurse shift change report		
4. Nursing leadership meeting		
5. Pharmacist medication review meeting		
6. Rehab Department internal review		
7. Weekly transfer risk meeting		
8. Weekly wound review meeting		
ED Treat and Release Report		
1. Care Plan Meetings		
2. Dietary Department internal review		
3. Nurse shift change report		
4. Nursing leadership meeting		
5. Pharmacist medication review meeting		
6. Rehab Department internal review		
7. Weekly transfer risk meeting		
8. Weekly wound review meeting		
Monthly Summary of Hospital Transfers by Facility or Unit Report		
1. Nursing leadership meeting		
2. Quality improvement review		
3. Root cause analysis for hospital admissions/ED visits		
Monthly Summary of Hospital Transfers by Provider		
1. Nursing leadership meeting		
2. Root cause analysis for hospital admissions/ED visits		
Key Metrics Trend Report		
1. Nursing leadership meeting		
2. Quality improvement review		
3. Root cause analysis for hospital admissions/ED visits		

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Implementation Steps and Timeline

The goal of the On-Time program is to incorporate the On-Time reports into day-to-day prevention activities and to ensure multidisciplinary input into clinical intervention decisions. The Implementation Steps document was created to help nursing homes understand the implementation steps for carrying out the program and the likely timeline to make the reports part of daily practice. It is intended to be used by the team champion and the Change Team members to help keep the effort on track and methodical.

Step 1: Agree To Use On-Time Preventable Hospital and ED Visits Reports

Nursing home leadership agrees to incorporate the On-Time reports into their workflow. Most facilities begin by implementing one report on one unit and then expand use to all units once the process of using the report is confirmed and effects on daily work, if any, are addressed and workflow redesigned as needed. Leadership agrees to identify a Change Team champion and establish a multidisciplinary Change Team to lead the project.

Step 2: Contact Vendor

The Change Team champion or information technology (IT) representative contacts the facility's electronic medical record (EMR) vendor to confirm that *On-Time Preventable Hospital and ED Visits* reports and the data elements included in Intake Notes and Transfer Notes are in the system. He or she takes appropriate steps at the facility to provide frontline staff with access to the reports.

Step 3: Identify Multidisciplinary Team Members To Serve as the Change Team

The Change Team consists of a Change Team champion, nurse managers from each nursing unit, quality improvement coordinator, and nursing assistants. The champion advocates and supports the project and ensures project activities are sustained during turnover of key staff. Nursing leadership may assume this role or delegate responsibility.

Two team leaders co-facilitate project activities; one is a nurse and the second can be from nursing or another discipline. Team leaders share responsibilities to coordinate and implement activities and coordinate calls with an On-Time Facilitator. The director of nursing determines his or her level of involvement.

In some facilities, the director of nursing participates actively as a member of the Change Team. In other facilities, he or she may serve more of a consultative role. Ad hoc team members include the staff educator, medical director, pharmacist, nurse practitioner, and rehabilitation staff.

Step 4: Introduce On-Time Preventable Hospital and ED Visits Reports

On-Time Facilitator provides technical assistance via an initial telephone consultation to confirm EMR capabilities and readiness to start On-Time, to discuss immediate next steps regarding IT, and to guide staff through the introductory material as needed. The Facilitator answers questions

and confirms that the facility team members understand how to access reports and tools and establishes the process for working together.

Step 5: Review Reports

The team reviews reports with Facilitator to understand content and potential use of reports.

Step 6: Complete Self-Assessment

The team completes the On-Time Self-Assessment Worksheet that identifies current processes at the facility to identify risk factors for preventable hospital and ED transfers and develop interventions to mitigate the risk, as well as communication processes. The review includes identification of team meetings, huddles, and other communication structures in place, ways risk information is transmitted to clinical staff, and ways care plans are updated and interventions determined. The Facilitator guides the team to identify gaps and begin to think about ways On-Time reports could be used to prevent hospital and ED transfers.

Step 7: Pilot a Report With Data

The On-Time Facilitator assists the team in using one of the reports. The team should decide which report they will use first and then review the material for that report and generate it for one nursing unit. The Facilitator works with the team to understand the first report and answers questions, as needed.

Step 8: Validate Data

This step helps the team gain confidence in the validity of the data in the reports. The team discusses residents populated on the report to ensure that data on the report agree with staff knowledge of residents' health and risks. Staff may choose to go back to the medical record to confirm if data on the report are consistent with other clinical findings.

In completing this task, the team may identify problems in, for example, nursing assistant documentation incompleteness and may find it necessary to reeducate nursing assistants to improve report validity. In addition, a Facilitator may help to clarify any normal but potentially confusing data situations and how to interpret them. Each report the team uses should go through this process so the team is confident in the information being produced on the reports.

Step 9: Agree To Use Core Reports/Implementation Strategies

With the Facilitator, the Change Team uses the Preventable Hospital and ED Visits Menu of Implementation Strategies to determine which reports will be especially helpful to them considering the results of their Hospital Transfer Self-Assessment Worksheet. The Facilitator describes the strategies and helps the team determine which reports may help them given the findings from the self-assessment (Step 6). The team can use one report more than one way and in multiple meetings.

Step 10: Create Report/Meeting Strategies

Strategies are based on self-assessment identification of pre-On-Time communication and care plan meetings/huddles and the Menu of Implementation Strategies. Some new huddles and other meetings may be created and meetings may be altered to accommodate report discussion. The

team reviews the Menu of Implementation Strategies for each On-Time report and discusses options for using the reports within current communication structures. The team considers meetings, huddles, care plan, or other existing meetings where a report would enhance the current process to identify risk and coordinate care across disciplines.

At this time, the team identifies potentially new processes that may be developed to use the reports. Teams pilot reports and incorporate report discussion into existing meetings or new meetings. Changes in requirements to attend meetings may be needed to increase the number of disciplines and nursing assistants providing input and to change communication networks to improve risk identification.

The Facilitator helps the team initiate the first report meeting strategy. The team makes sure it understands the criteria for identifying residents profiled on the report, knows the definitions of risk factors that are profiled, and receives advice on how to structure existing meetings or create new meetings to best incorporate report discussions. Advice includes who should attend the meeting, what their roles are, who is responsible for the reports, and who will lead the discussion.

Step 11: Pilot All Report/Meeting Strategies in One Unit

The team discusses implementation issues with the Facilitator after piloting report/meeting strategies. This process is iterative, so it should be repeated until the process is smooth and effective.

Step 12: Ensure Implementation Strategies Are Carried Out

Once a new report is incorporated into a meeting, the champion decides on role changes for staff to ensure the report is used at designated meetings with appropriate multidisciplinary team input. It is important for the champion to have supervisory responsibility so these changes can be informed and enforced.

Step 13: Develop Plan and Implement New Strategies in All Units

The training and implementation planning process for integrating reports in one unit should take approximately 3 to 4 months once the facility has confirmed that the *On-Time Preventable Hospital and ED Visits* reports are available and staff have been granted access to view and print the reports (Steps 3-12). The timeline depends on leadership commitment, stability of staff, how familiar the facility is with using computerized reports, and quality improvement (QI) experience of staff.

Implementing on all units is likely to add another 3 months. The Facilitator will help the team during the next 3 months to problem solve implementation issues until all reports and all units are implementing the reports as planned and the team becomes more independent.

Step 14: Monitor Facility Implementation Progress Monthly

After about 6 months, the Facilitator's role is to check in to identify obstacles that could occur and to troubleshoot issues such as turnover of key staff, computer glitches, and implementation issues as needed. The expectation is that reports will be used on a weekly basis except for meetings that occur less frequently (e.g., monthly).

Step 15: Review Hospital and ED Transfer Rates

The Facilitator works with the team to generate On-Time Monthly Summary of Preventable Hospital and ED Visits Report that identifies hospital/ED transfer rates to provide feedback to the Change Team and support reporting requirements.

Step 16: Sustain the Effort

After 9 months, the nursing home Change Team develops a plan for incorporating implementation strategies for report use into facility policies and procedures. The plan includes incorporating educational in-service for new hires and training material for temporary employees. The facility needs to establish a permanent champion for this QI effort and champions on units.

Likely champions for each nursing unit are the nurse managers, with backup support by the QI staff, who may be assigned to conduct periodic monitoring of implementation strategies that ensure they are sustained. It is suggested that on a weekly basis, the director of nursing ensures that On-Time process improvements are carried out on each nursing unit and holds each nurse manager accountable.

Approximate Timeline

Implementation Steps	Estimated Duration/Time From Implementation
1. Agree To Use On-Time Preventable Hospital and ED Visits Reports	
2. Contact Vendor	Start time is after confirmation of access to reports for frontline staff
3. Identify Multidisciplinary Team Members To Serve as the Change Team	Within 2 weeks
4. Introduce On-Time Preventable Hospital and ED Visits Reports	1st month
5. Review Reports	1st month
6. Complete Self-Assessment	1st month
7. Pilot a Report With Data	2nd month
8. Validate Data	2nd month
9. Agree To Use Reports/Implementation Strategies	2nd month
10. Create Report/Meeting Strategies	2nd month
11. Pilot All Report/Meeting Strategies in One Unit	2nd month
12. Ensure Implementation Strategies Are Carried Out	3rd month–4th month (some facilities implement in all units simultaneously)
13. Develop Plan and Implement New Strategies in All Units	4th month-6th month
14. Monitor Facility Implementation Progress Monthly	6th month-9th month
15. Review Hospital and ED Transfer Rates	As required
16. Sustain the Effort	End of 9th month–12th month