Emergency Department Visit Toolkit
For Long-term Care Facilities

This toolkit provides an overview of a quality improvement process to reduce the frequency of outpatient emergency department (ED) visits of short stay nursing home residents. As part of a QAPI Performance Improvement Project, this toolkit provides your team with actionable steps to decrease the number of hospital transfers of short stay residents.

Area for Improvement ⟹ Decrease number of outpatient ED visits of short stay residents

Along with hospital readmissions and successful discharges to the community, the number of outpatient ED visits in short stay residents are key short stay quality measures. Reducing the number of unnecessary hospital transfers is a national priority because ED transfers can result in unnecessary diagnostic tests and interventions, adverse events, increased health care expenditures, and physical and emotional discomfort for both residents and their families. It is estimated that approximately 25% of transfers from the nursing home to the hospital are potentially avoidable.

Root Cause Analysis ⟹ Review and select which factors apply

RCA Process: Review 10% of your short stay resident transfers for the last 6 months or at a minimum 10 charts to determine the reasons for transfer and if the transfer could have been avoided. For more on avoidable hospital transfers, read the article, Root Cause Analyses of Transfers of Skilled Nursing Facility Patients to Acute Hospitals: Lessons Learned for Reducing Unnecessary Hospitalizations by Joseph Ouslander.

Common reasons for transfer:

1. Inadequate communication during hand-offs from hospital to nursing home
2. Lack of awareness of nursing home capabilities by hospital discharge staff
3. Early change in resident's condition unrecognized and unreported by frontline nursing staff
4. Multiple signs and symptoms without specific clinical diagnosis and effective management
5. Lack of resources necessary to manage the resident's condition
6. Inadequate communication between nursing staff and primary care provider
7. No in-person assessment by healthcare provider; nighttime transfer
8. Family insistence and preferences
9. Family calling 911 without facility input
10. Inadequate advance care directives
11. Infection; potential sepsis
12. Inadequate post fall assessment

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Set a Goal ⟶ Develop a specific, measurable, relevant, and time-bound goal

SMART Goal Example: (1) Reduce the number of transfers of short stay residents to the ED by 25% by December 31, 2021.

Strategies for Improvement ⟶ Analyze barriers discovered during RCA and select which strategies best address them

Challenges	Strategies
SECTION 1: Inadequate communication during hand-offs from hospital to NH; hospital unaware of NH capabilities	• Conduct QI meetings with hospital clinical leadership for RCA to determine challenges and reasons for transfer back to hospital. Implement strategies to address hospital transfers during the first week after nursing home admission. • Conduct "warm handoffs" with direct nurse to nurse and physician to physician communication via telephone. • Provide hospital with INTERACT Nursing Home Capacity List so that discharge staff are familiar with what tests and procedures facility can perform.
SECTION 2: Failure of frontline nursing staff to detect and report early changes in resident's condition	• AMDA's Transitions of Care in the Long-term Care Continuum Guidelines • AMDA's Acute Change in Condition Guidelines • Train staff in the use of INTERACT Change in Condition cards to report changes in resident status early. • Develop evidence-based protocols that enable nurses to respond appropriately to change in condition. Use the INTERACT guidelines. • Examine how residents with changing status are monitored, and how that information is communicated to medical providers in real time.
Section 3: Multiple signs and symptoms without clinical diagnosis and effective management; lack of resources to manage resident's condition	• Train nursing staff in structured evaluation, documentation, and communication of clinical signs and symptoms such as abnormal vital signs, altered mental status, shortness of breath, pain, functional decline, behavioral symptoms, fever, and unresponsiveness. Provide tools such as the INTERACT SBAR for COPD, CHF, and pneumonia. Use the AMDA tool, Know It All Before You Call and related decision-support tools. • Provide evidence-based order sets that address the most common symptoms and signs associated with transfers. This includes UTIs, pneumonia, CHF, and COPD.

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SECTION 4: Inadequate communication between nursing staff and physician	• Train nurses on structured evaluations, documentation, and communication strategies such as using the INTERACT SBAR so that off-site clinicians can make informed choices about transfers. • Utilize telehealth to improve off site resident assessment by primary care providers. CMS Telehealth and Telemedicine Toolkit. • Trial use of an admissions nurse or advance practice nurse who can assist in making informed choices about new admissions as well as hospital transfers. • Use the AMDA tool, Know It All before You Call.
Section 5: Family insistence and preferences; inadequate or missing advance care planning	• Use the decision guide, *Go to the Hospital or Stay Here?* when working with families prior to admission to determine preferences and to answer questions about hospital transfers. • Use the INTERACT advance care planning tools to determine family and resident needs and preferences. • Use the AMDA advance care planning resource series including pocket cards. • Educate families about the risks associated with hospital transfers and the capabilities of the nursing home.
Section 6: Infections; potential sepsis	• Use the UTI Toolkit for Long-term Care Facilities to access evidence-based strategies for the prevention and management of UTIs. • Use the Sepsis Toolkit for Skilled Nursing and Long-term Care. • Use this Screening Tool for Sepsis. • Use HQIN's brochure to educate families about sepsis.
Section 7: Inadequate post fall or injury assessment	• Use the post fall criteria in AHRQ's On Time Falls Prevention. • Read Chapter 2 of AHRQ's Falls Toolkit for a comprehensive response to falls. • Use this Falls Protocol.

Measure Your Success ⟹ Collect and analyze data for specific measures

Measurement is an important component of a performance improvement program which helps to identify areas of low performance and target future interventions. Both outcome measures and process measures should be part of the measurement process. In this instance, an outcome measure may be the number of transfers of short stay residents to the ED per month.

Process measures are in response to the findings of root cause analysis and therefore are specific to each facility. They must be measurable either through audits or observation. Examples of process measures include:

1. Number of times an SBAR tool is used by nursing staff to communicate a change in condition to the primary care provider and the number of times the involved resident was transferred versus being managed in the nursing home.
2. Number of times frontline staff use a change in condition card each shift and which of the residents were the subject of the card who were later transferred.

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Celebrate Success ⟹ Express gratitude and appreciation when goals are met

Use a graph to illustrate monthly ED visits of short stay residents. Display the graph so that staff are aware of trends. Highlight residents who were not transferred and instead were managed in the nursing homes to avoid unnecessary tests and emotional distress. Ensure that staff realize the many benefits to residents and families when an unnecessary hospital transfer is prevented.

Celebrate when staff make progress towards the goals of increasing activities and resident engagement. Utilize incentives, pizza parties, posters, raffles, small gift cards, and other rewards for excellence. Ensure that leadership demonstrates gratitude and encouragement during and following your campaign.

Collaborate with hospital leadership to congratulate discharge staff and others when avoidable transfers to the ED are reduced. Share the success!