Week 7: Discharge Analysis

Monday

Tuesday

A resident may discharge unexpectantly for a number of different reasons. It might seem like there was nothing that would have prevented an ED visit or hospitalization but often processes could have identified a problem before it resulted in discharge. Facilities must have processes in place for early identification of changes in condition and to communicate those changes to ensure timely interventions.

Assess your facilities communication processes. Do you have a huddle meeting with frontline staff to share and discuss important information? If not, consider using the HQIN Huddle Toolkit to implement huddles at start of shift and end of shift, quality improvement huddles, new resident huddles or "Everyone Stands Up Together" huddles where the daily standup meeting is conducted on the unit(s) with frontline staff.

Also, INTERACT® (Interventions to Reduce Acute Care Transfers) offers communication tools at no cost including Stop and Watch Early Warning Tool, SBAR (Situation, Background, Appearance and Review and Notify) and the Medication Reconciliation Worksheet.

Wednesday

Other adverse events should trigger the same evaluation as unplanned discharges. Reviewing adverse events helps to find opportunities for improvement that can prevent future ED visits or hospitalizations.

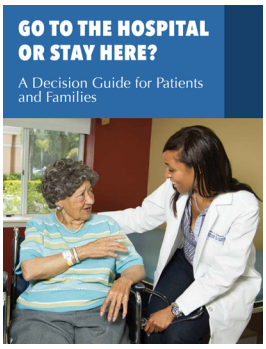
- When issues are identified or communicated, how are these issues reviewed?
- Are they reviewed at risk management meetings?

Discuss how possible opportunities are communicated to the risk management team. Use the EMR to help identify factors like changes in condition, falls, medication errors, etc. to include in risk management meetings.

Thursday

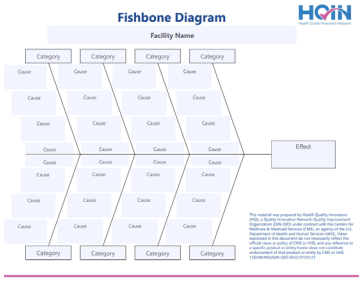
Residents and families play an important role in preventing ED visits and hospitalizations. Care planning and advanced care planning should be discussed with patients and families regularly. **Review CMS'** Go to the Hospital or Stay Here Decision Guide **for patients and families. Make use of the resource to assist patients and families to plan for future care.**

INTERACT® (Interventions to Reduce Acute Care Transfers) also offers care planning tools at no cost including the Advance Care Planning Communication Guide and Identifying Residents who may be Appropriate for Hospice or Palliative/ Comfort Care Order.



Choose your favorite resources as a team and make sure they are available to assist with care planning.

Friday



Sometimes the root cause of an adverse event is not immediately clear. Root cause analysis can help uncover the cause, and a fishbone diagram can assist with finding it. Fill out the problem (adverse event) at the head of the fish. As you brainstorm possible causes, group them into categories. Use these categories to identify areas where improvement would be beneficial.

When you have identified a problem and root cause, you will want to implement quality improvement interventions. Making changes to systems and procedures is sometimes necessary, but interventions that are not sustainable are unlikely to be effective. **Consider the problems and root causes you have noted this week.** Use the QAPI Sustainability Decision Guide to assist with choosing effective interventions.

INTERACT® Version 4.5 Tools For SNFs/ Nursing Homes also offers quality improvement resources including an Acute Care Transfer Log, Calculating Hospitalization Rates, Hospitalization Rate Tracking Tool, Quality Improvement Tool for Review of Acute Care Transfers and Quality Improvement Summary Worksheet.