

Nursing Home Best Practices to Reduce Preventable Readmissions

This resource brings together a collection of best practices gathered to help nursing homes reduce preventable hospital readmissions. It offers practical ideas to strengthen care, communication, and transitions so residents feel supported throughout their stay.

Preadmission

- Have a nurse or team member with clinical experience review each referral to confirm the facility can safely meet the resident's care needs based on the facility assessment.
- Review medication orders in advance and coordinate with the pharmacy to ensure medications needed are available upon arrival, such as pain medications, for timely administration and symptom management.
- Use a checklist to identify needed equipment, supplies, and other services before admission, which may need to be obtained from different vendors, such as wound vacuum-assisted closure (VAC) devices, intravenous (IV) infusion pumps, total parenteral nutrition (TPN) equipment, continuous positive airway pressure (CPAP) machines, or bi-level positive airway pressure (BiPAP) machines.
- Hold a preadmission room huddle with the receiving admission nurse and nurse aide to confirm the room is ready.
- Confirm that required discharge instructions or written prescriptions are complete and will arrive prior to or with the resident.
- Complete a nurse-to-nurse report with the hospital nurse before the resident transfers to the nursing home.
- Verify the contact information for the hospital point person in case follow-up questions are needed.

Admission Process

- Orient the resident and caregiver to the facility's clinical services and level of care within 24 hours of admission.
 - Share the INTERACT Tool (log-in required; <https://pathway-interact.com/>): Resident/Family Tool: Deciding About Going to the Hospital.
 - Share the HSAG's [What to Do When You're Admitted to a Nursing Home](#) flyer.
 - Use the HSAG [Resident and Family Conversation Guide: In-House Treatment vs. Hospital Transfer](#) tool.
- Provide the resident and caregiver with a direct nursing contact number to report concerns.
- Verify the appropriate diagnosis or clinical need for all medications and durable medical equipment (DME) indicated on the discharge instructions, including oxygen, enteral feeding, and foley catheters.
- Obtain consent to treat and consent for medication as indicated to include psychotropic medication, opioid medication, and any other medication per the facility's policy.
- Complete a head-to-toe assessment and start the treatment plan following the facility's policy and procedures.
- Medication Safety
 - Ask the resident or caregiver for the resident's home medication list and reconcile it with the current medication list to ensure there were no omissions as per the drug regimen review (DRR) process.
 - Have two nurses review and verify the medication orders and the transfer medication sheet.
 - Clarify medication discrepancies (i.e., duplicate orders, incorrect doses, unnecessary medications).
 - Clarify lab orders for high-risk medications.
 - Notify the physician promptly of any identified discrepancies following the facility DRR policies and procedures.

During Nursing Home Stay

- During the first care plan meeting, discuss discharge goals and reinforce the facility's clinical services.
 - The baseline care plan needs to be developed within 48 hours.
 - At a minimum, include initial goals based on admission orders, physician orders, dietary needs, therapy services, social services, and Preadmission Screening and Resident Review (PASRR), if applicable.
- Begin discharge education and needed support services upon admission to the facility and include them in the baseline care plan.
- Ensure the physician completes each resident's physical exam within 48 hours of admission or per the facility's policy.
- Use standardized tools, such as INTERACT tools, for nurse-to-nurse shift change reports, to improve communication with physicians and the care team, and to identify changes in resident condition early:
 - Stop and Watch Early Warning Tool
 - Situation, Background, Appearance, Review and Notify (SBAR) Communication Form
 - Care Paths
 - Acute Change in Condition File Cards
- Use facility electronic medical record (EMR) alerts or reports to develop a robust daily clinical review of all high-risk residents and follow up, as appropriate.
- Conduct shift-to-shift huddles with nursing and ancillary staff to communicate resident information, such as new care plan interventions, safety risks, and changes in condition.
- Work with pharmacy staff to ensure the emergency medication box (E-box) has necessary medications and supplies.
- Discuss advance care planning, wishes, and goals with the resident and caregiver, as appropriate.
 - Use INTERACT Advance Care Planning Communication Guide.
 - Share resources, including [Five Wishes](#) and [The Conversation Project](#).
- Use HSAG's [Resident and Caregiver Education Tools](#) and [Zone Tools](#) to support disease management.

Preparation for Transfer/Discharge

- Hold a discharge meeting with the resident, caregiver, Interdisciplinary Team (IDT), and a representative from the next level of care (i.e., home health, hospice) to address questions, needs, and concerns.
- Ensure DME is delivered prior to transfer to the next level of care to avoid delay in care.
- Use teach-back and return demonstration when providing education about the resident's care needs, medications, and discharge plan in the resident's preferred language and in a manner the resident understands.
- Schedule a home visit, as appropriate, to evaluate the home environment and recommend safety modifications.
- Arrange follow-up appointments before discharge and assist with setting up transportation, as needed.
- Complete the discharge summary and provide copies to the primary care physician, resident, and caregiver.
- Schedule post-discharge follow-up calls with the resident, and the home health agency if involved, on days 5, 14, and 28 to identify changes in condition that may require readmission to the nursing home.
- When transferring a resident to the emergency department (ED), provide:
 - Nurse-to-nurse report using a standardized verbal communication tool.
 - Completed transfer form with key clinical information, including:
 - Reason for transfer/change in condition.
 - Current medications and treatment plan.
 - Requested ED evaluation or recommendations.
 - Readmission history within the past 30 days.
 - Information about the nursing home's capabilities to safely care for the resident if he or she returns.

Staff Education

- Include readmission reduction topics in nurse orientation and ongoing staff training, such as high-risk conditions, high-risk medications, advance care planning, dementia care, and early identification of changes in condition.
- Use clinical leaders and contracted providers to support staff education, such as the medical director, nurse practitioner, pharmacy staff, therapists, respiratory therapy staff, and hospital leadership.
- Train key staff on all shifts to support peer-to-peer education and prevention practices.
- Set up clinical skills practice labs for nursing staff.

After a Resident is Readmitted to the Hospital

- Use HSAG's [Quality Assurance and Performance Improvement \(QAPI\) Tools](#), including the [Just-Do-It Handout](#) and [Performance Improvement Project \(PIP\) Playbook Tools](#), to understand why residents are being readmitted, identify practical solutions, and test changes.
- Use the [INTERACT Quality Improvement Tools](#) to complete a thorough root cause analysis for residents readmitted to the hospital and review findings at monthly QAPI meetings.
 - INTERACT Quality Improvement Tool for Review of Acute Care Transfers
 - INTERACT Quality Improvement Summary–Worksheet
 - INTERACT Hospitalization Rate Tracking Tool
- Meet with hospital leadership to review readmission trends, identify transition gaps, and improve communication between the hospital and nursing home.
- Conduct monthly meetings with nursing leadership, and include physicians, to review all return-to-acute transfers, identify contributing factors through root cause analysis, evaluate the effectiveness of current interventions, and implement improvements to prevent potentially avoidable hospital readmissions.

[Interventions to Reduce Acute Care Transfers \(INTERACT\)](#) tools can be accessed by creating a free account at pathway-interact.com.