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CAREGIVER TRAINING

A CLIENT CARE MODULE:

REDUCING & PREVENTING READMISSIONS TO THE HOSPITAL

...Developing top-notch caregivers, one inservice at a time.

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INSTRUCTIONS FOR THE SUPERVISOR

Step One:

- Make a copy of the Instructions for the Learner page. Return your original to the sheet protector. Add the following information to the copy:
    1. The name (or position) of the person to whom the aides should direct questions.
    2. The name (or position) of the person to whom the aides should turn in their quizzes.
    3. The date by which the quiz page should be turned in.
    4. The name (or position) of the person who will initial the aides' Inservice Club Membership Cards.
- Use this copy as your "master" as you make up the inservice packets.

Step Two:

- Have the following copied for each learner:
    1. The **Instructions for the Learner** page.
    2. The **10 Page** Inservice newsletter.
    3. OPTIONAL: Your workplace policy for providing a change-of-shift report.
    4. The **Quiz** page.

Step Three:

For Self-Study Use

- Distribute as desired—in employee mailboxes; folded in paychecks, etc.
- You may want to post the Quiz Answer Sheet in a prominent spot.

For Group Use

- Read over the Suggested Participatory Activities, the Suggested Teaching Tips and the Suggested Discussion Questions.
- Select the activities you want to use during your inservice hour.

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SUGGESTED PARTICIPATORY ACTIVITIES

ACTIVITY # 1: PREVENTING READMISSIONS CROSSWORD PUZZLE!

- Make enough copies of the "Preventing Readmissions Crossword Puzzle for each person in your group.
- Allow 5 to 10 minutes for participants to fill in their answers before revealing the answer key.
- If you are giving this topic as an independent learning module, consider adding copies of the puzzle to each learner's packet for an extra activity.

ACTIVITY #2: WHAT WOULD YOU DO?

- Use this activity to open the conversation on what to do in touchy situations when clients may be contributing to their own illness by failing to comply with doctors' orders. Read each of the statements, one at a time, to your group and ask "What would you do?"
- Remind the group there are no right or wrong answers. Encourage thoughtful exploration into helping clients make healthy choices.

What would you do if . . .

- You hear your client tell his doctor that he quit smoking, but you know it's not true.
- Your client tells you she is not going to take her medication anymore because it causes too many side effects and she doesn't think she needs it anyway.
- Your client refuses to go to his physical therapy appointments because he says he gets too sore.
- You client is depressed. You know that she may benefit from spending time with others and socializing, but every time you bring it up she refuses to discuss it with you.

ACTIVITY #3: NICE THINGS TO SAY—A TEAMBUILDING ACTIVITY!

Explain to the group that positive team relationships are crucial to working together and preventing unnecessary readmissions. Use this activity to promote positive feelings among your team members!

- Ask participants to stand in a circle. Have one person step into the middle of a circle.
- Ask the other participants to go one by one giving genuine compliments to the person in the middle of the circle. Everyone should be able to think of at least one warm and complimentary thing to say.
- Switch out the person in the middle until everyone has had a chance to hear the positive things their team members have to say about them.
- This activity will promote a positive energy amongst your team.
- When you are finished, ask the group how positivity may be a factor in reducing and preventing readmissions in clients.

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SUGGESTED TEACHING TIPS

TEACHING TIPS

- Make an overhead of the Quiz Answer Sheet and the crossword puzzle answer key.
- Take advantage of this inservice time to go over your workplace policies on giving and receiving change-of-shift reports.
- Take some time to allow participants to discuss their reaction to:
  - The "Connect It Now" box on page 4,
  - The "Think About It" box on page 6, and
  - The "Talk About It" box on page 8.
- If possible, begin to keep track of recently discharged clients. Provide some sort of reward, (like a $5 gift card to a local restaurant) to the Aides involved in the clients care when/if they make it to the 30 day mark without a readmission.
- In the Know has inservices on each of the most common medical conditions that increase the likelihood of hospital readmission. If your In the Know library includes these topics, consider offering them over the next five months to give your Aides a deeper understanding of these common illnesses.

RESOURCES

The following resources were used in developing this inservice. You might want to check them out for further information:

- The Official Medicare website at www.medicare.gov
- Centers for Medicaid and Medicare Services at www.cms.gov
- Agency for Healthcare Research and Quality at www.ahrq.gov
- The RAND Corporation at www.rand.org
- The Commonwealth Fund at www.commonwealthfund.org
- National Institute for Health www.ncbi.nlm.nih.go

More to Learn!

Your staff may enjoy the following related In the Know inservices:

- Recognizing & Reporting Abnormal Observations
- Reporting and Documenting Client Care
- Working with Non-Compliant Clients
- Understanding CHF
- Understanding COPD
- Common Respiratory Conditions
- Working with the Mentally Ill
- Understanding Common GI Disorders
- Understanding Common Medications

If your In the Know library doesn't include these titles, they are available for purchase by calling our toll-free number:

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SUGGESTED DISCUSSION QUESTIONS

DISCUSSION QUESTION #1

- **Do you think that the efforts to reduce and prevent readmissions hurt or help patients? Why?**

  Answers will vary, but look for thoughtful answers that point in the direction of helping patients. Reducing and preventing admissions means the healthcare team works harder to help clients get healthier. It also means clients spend less time in the hospital. And as we all know, a hospital stay can put a sick or frail person at risk for nosocomial infections.

DISCUSSION QUESTION #2

- **Of all the issues that contribute to an increased risk of admission** (*medication, education, missed appointments, lack of social support, lack of primary care doctor, failure to make suggested lifestyle changes*) **what do you see most often in the clients for whom you provide care? And, what can be done to best help your specific client population?**

  Answers will vary based on the client population you serve. Look for thoughtful inquiry into what's really happening and encourage creative solutions. If a plausible solution to a real problem presents itself during this discussion, do what you can to make the changes proposed, then track the success of the change.

HERE ARE MORE QUESTIONS THAT MAY SPUR SOME INTERESTING DISCUSSION:

- Medicare was founded on a promise made to retired individuals that their healthcare needs will be covered at public expense. However, as the nation ages and the cost of medical care skyrockets, the public can not keep up with the demand. Do you think the promise of Medicare should continue to be true for all retirees? Or, do you think that retirees who can afford private insurance should be denied Medicare? Why or why not?
- Have you cared for clients who were readmitted to the hospital within 30 days? If so, what was the outcome? Looking back, do you think you could have helped keep the person out of the hospital?
- Do you think that most of the clients with whom you work understand what they need to do to get healthier (and stay out of the hospital)? Why or why not?

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REDUCING & PREVENTING READMISSIONS TO THE HOSPITAL

We hope you enjoy this inservice, prepared by registered nurses especially for caregivers like you!

Instructions for the Learner

If you are studying the inservice on your own, please do the following:

- Read through **all** the material. You may find it useful to have a highlighting marker nearby as you read. Highlight any information that is new to you or that you feel is especially important.
- If you have questions about anything you read, please ask your supervisor.
- Take the quiz. Think about each statement and pick the best answer.
- Check with your supervisor for the right answers. You need **8 correct** to pass!
- Print your name, write in the date, and then sign your name.
- Email In the Know at feedback@knowingmore.com with your comments and/or suggestions for improving this inservice.

THANK YOU!

After finishing this inservice, you will be able to:

Identify clients at increased risk for readmission within 30 days of discharge.

❖

List at least three ways that you can help clients 1) manage their medications and 2) keep appointments after a hospital discharge.

❖

Discuss the difference between symptoms that merit a call to the doctor versus those that require a trip to the ER.

❖

Develop a plan to improve change-of-shift reports for CNAs that reduces or prevents readmissions .

❖

Collaborate with the entire healthcare team to improve outcomes for clients at risk for readmission.

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Inside This Inservice:

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In accordance with industry standards, this inservice material expires on December 31, 2021. *After that date, you may purchase a current copy of the materials by calling 877-809-5515.*

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A Health Care Module:
Reducing & Preventing Readmissions to the Hospital

IS IT TIME TO FIRE YOUR MECHANIC?

If you went to a mechanic and paid $3000 to have your engine fixed, you'd be pretty mad if you had to go back to that mechanic two weeks later because the "fix" didn't work and now the problem is worse.

It's the same with hospital admissions. People go to the hospital to get fixed. No one wants to have to return because the fix "didn't take."

Unfortunately, the reality is that nearly ***one in five*** Medicare patients return to the hospital within 30 days of discharge . . . and Medicare is tired of footing the bill.

In the past, hospitals had no incentive to ensure patients got the care they needed once they left, and in fact they could actually benefit financially when patients didn't recover and needed to return for more treatment.

But, those days are over! More than 2,000 hospitals — including some nationally recognized ones — felt the first sweeping rounds of penalties in October 2012 because many of their patients were readmitted soon after discharge.

Together, these hospitals lost about $280 million in Medicare funds as a result of a new system that pays health care providers based on the **quality** of care they provide. That quality, for now, will be measured by the number of patients that need to be readmitted within 30 days of a discharge.

If you don't work in a hospital, you may be wondering what all this has to do with you. Well, preventing readmission doesn't end when a person leaves the hospital. In fact, that's often when it begins. When you receive a new discharge in your long term care facility or on your home health roster, you accept the responsibility to do everything you can to help that client follow discharge instructions, take their medications properly and to make and keep follow-up appointments.

Dropping the ball on just one of these crucial post-discharge activities can quickly, and sometimes unnecessarily, land clients right back in the hospital—whether they are on Medicare, have private insurance or no insurance at all.

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WHO GETS READMITTED TO THE HOSPITAL—AND WHY?

Ronald suffers from diabetes and high blood pressure. One day he seems to feel more tired than usual. He has no appetite and his daughter notices that he seems a little confused. His doctor sends him to the hospital to be ***admitted for tests***.

Rita suffers from COPD. Her immune system is weak and she is battling depression. She lives alone and does not have a primary care physician. She goes to the ER for a headache and is ***admitted for dehydration***.

After 3 days in the hospital. . .

Ronald *is discharged to home* with two new medications, a new diet plan and a follow-up visit scheduled with his primary care doctor.

Rita *is discharged to a Skilled Nursing Facility*. In addition to being dehydrated, doctors discovered she also had pneumonia.

Which of these two is more likely to be readmitted to the hospital in the next 30 days? Keep reading…!

Medical Conditions

The 5 most common medical conditions that increase the likelihood of hospital readmission are:

- Congestive Heart Failure (CHF).
- Pneumonia.
- Chronic Obstructive Pulmonary Disease (COPD).
- Mental illness.
- Gastrointestinal problems.

Other Risk Factors

A high rate of readmissions can also be related to:

- Polypharmacy, or taking ***more than 5*** prescribed medications.
- Lack of a primary care doctor.
- Lack of understanding of health conditions and care.
- Living alone and lack of social support.

Discharge Destination

Patients discharged to a Skilled Nursing Facility (SNF) are at risk for readmission because of:

- Poor communication.
- Mistakes in medication dosages.
- Inconsistent patient education.

Patients discharged to home are at risk when there are:

- Unclear medication instructions.
- Missing or confusing follow-up care instructions.
- Follow-up appointments not made, communicated or kept.
- Lack of family or social support.

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MINDING MEDICATIONS

A look back at the sidebar on page two should reveal a big, red, flashing neon arrow pointing to **MEDICATIONS**! *Polypharmacy* (taking more than 5 medications), *mistakes* in medication dosages and *unclear medication instructions* can all send a recently discharged client right back to the hospital.

SOME "BEST PRACTICES" YOU MAY SEE

Hospitals are working harder than ever to improve discharge teaching. Some hospitals will:

- Require the Registered Nurse to provide verbal and written instructions to clients prior to discharge regarding any new medications or changes to old medications.
- Send a pharmacist to the patient's room (or schedule a phone call) prior to discharge to teach clients about all of their medications.

If transferred to long term care, the receiving facility may:

- Review the client's list of medications upon admission. Call the doctor or pharmacist to clear up any confusing orders.
- Discuss all of the client's medications (new and old) with the client and his or her family so that everyone knows exactly what to expect.
- Require a "hand-off" meeting (usually by phone) between the discharge nurse at the hospital and the supervising nurse at the facility to discuss (among other things) the client's current medication orders.

If transferred home, the client may have been given:

- Verbal instructions by a discharge nurse that the client then had to repeat back in his or her own words to confirm understanding.
- Written instructions (including dose, frequency, side effects and a reason) for all medications the client is supposed to take.
- Medication dispensed by the hospital to take home. This gives the client time to get settled before having to go to the pharmacy to fill a new prescription.
- A follow-up call from a nurse or pharmacist 1 to 2 weeks after discharge to discuss medication doses, symptom improvement and side effects.

HOW YOU CAN HELP

- As a nursing assistant, you are probably not allowed to give medications. However, you are responsible for knowing your client's medical conditions, what medications they take and why, and any possible side effects.
- You spend the most time with the clients, so you will be the first person to notice and report right away if it seems your client's medications are not working, if there are any side effects, or if you think your client may not be taking medications properly.

WHAT EXCITES YOU?

TECHNOLOGY TO THE RESCUE!

Did you know that, on average, only 42% of patients are able to state their diagnosis when they are discharged, and only 37% are able to describe why they take the medications they do?

What if the answers to those questions were literally in the patient's pocket?

Everyone you meet has a smartphone these days, and seniors are no exception. Perhaps the time has come to start using smartphone apps to prevent readmissions.

Do a quick search today! You'll find plenty of apps (many free) that your tech savvy clients can use to help them learn more about their conditions, take meds on time and keep track of their doctor appointments!

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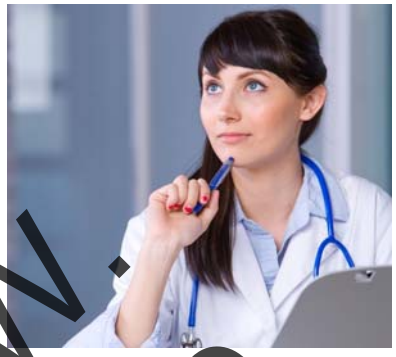
EDUCATION IMPROVES OUTCOMES



Readmission rates increase significantly when patients are unclear about what causes their illness, how they can prevent relapse and how to properly use recommended medical devices.

SOME "BEST PRACTICES" YOU MAY SEE

Prior to discharge, some hospitals will:

- Provide verbal and/or written information to patients about their diagnosis in the individual's primary spoken language (English, Spanish, French, etc.).
- Show patients educational videos about their specific diagnosis and allow time for patients to ask the doctor or nurse questions prior to discharge.
- Provide a "patient-friendly" version of the care plan which describes interventions (what to do) and expected outcomes (what to expect).

If transferred to long term care, the receiving facility may:

- Meet with newly discharged clients and their family caregivers to discuss what they know and what they need to know about their care.
- Ask clients to describe, in their own words, what their diagnosis is, how to recover and/or how to prevent relapse. Clear up any misconceptions right away.

If transferred home, the client may have been given:

- Written and verbal instructions on proper self-care and disease management.
- A list of suggested resources for learning more about their condition, such as reputable websites, helpful books and disease specific community resources.

HOW YOU CAN HELP

- Ask your newly discharged clients if there is anything they want or need to know about their condition or their care that they don't already know . . . then help them find the answers they need.
- Clients with complex or multiple diseases may become confused or overwhelmed by their discharge instructions.

  For example: Mr. G was just discharged to home with a new diagnosis of Diabetes. He is also obese and sedentary. He was given instructions to check his blood glucose level before each meal and at bedtime, write down the results and then self-inject insulin on a sliding scale (based on the results). He was also given a new diet and an exercise plan to follow.

  Mr. G may need your help to break down the instructions into smaller, more manageable steps. You might suggest he spend the first week focusing on checking his blood sugar, documenting results and getting comfortable with self-injecting insulin. Then, the following week you can work on helping him understand his diet and exercise plan.

CONSIDER THIS

Why do you think some clients lack understanding of their diagnosis or admit that they don't know what to do to get better?

For some, it could be a **language barrier**.

For others, **education level** may be the problem.

Then there are those who are in **denial**.

And finally, there are those that **lack motivation** to take responsibility for their lives.

Think about a client you care for right now.

- Does he understand his diagnosis?
- Does she know what her medications are for?
- Is your client making doctor-recommended lifestyle changes?

If you answered "no" to any of these questions, think about some ways you can help educate and inspire your clients to take the next step in managing their own health.

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MAKING AND KEEPING APPOINTMENTS

Missed appointments can delay treatment or testing that may be critical to your client's health. Delays can lead to a decline in health status and a trip back to the hospital!

SOME "BEST PRACTICES" YOU MAY SEE

Prior to discharge, some hospitals will:

- Have the discharge nurse make post-discharge appointments with the patient's primary care doctor at a time that is convenient for the patient.
- Provide a written summary of any appointments made. The summary should include the date and time of the appointment, the reason for the visit, the name of the doctor or facility the appointment is with, the contact phone number and instructions for rescheduling, if needed.

If transferred to long term care, the receiving facility may:

- Maintain a system that tracks and reminds clients and key staff members of clients' appointments that take place outside of the facility
- Coordinate with family caregivers to take clients to post-discharge appointments, when appropriate. Place a reminder call to the family caregiver at least 24 hours in advance of the appointment.
- Arrange for safe and reliable transportation to and from appointments if no family members are available.

If transferred home, the client may have been given:

- Instructions to arrange a follow-up visit with his or her primary care physician within a certain timeframe.
- Reminder cards for follow-up appointments that were made prior to discharge.

HOW YOU CAN HELP

- Develop a system with your client for keeping track of appointments. This can be a calendar, appointment book, dry erase board, or any other system the client feels comfortable using.
- Go through appointment cards and put all the dates, times, and who the appointment is with on the calendar.

- Get your client into the habit of looking at the week ahead to plan in advance for appointments. Arrange transportation at least one week in advance.
- Encourage your clients to request appointment times when they know they will have the most energy. For example, if your client feels best just after lunch, recommend she schedule her appointments for this time of day.
- Stress the importance of cancelling and re-scheduling if your client is unable to make it to the scheduled appointment.

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SURROUNDING CLIENTS WITH SUPPORT

Whether patients are transferred to a long term care facility or go home after a hospital admission, it is well documented that lack of social support is one of the most important predictors of readmission. There are four common types of social support. They are:

Emotional support—This is when a person feels the empathy, concern, affection, love, trust, acceptance, intimacy, encouragement or caring of others. It helps a person feel valued.

Physical support—This support includes financial assistance, material goods or services.

Informational support—Information can be in the form of advice, guidance, or suggestions. It helps people make tough decisions and solve problems.

Companionship support—This type of support provides a sense of belonging and a shared experience.

SOME "BEST PRACTICES" YOU MAY SEE

Prior to discharge, some hospitals will:

- Arrange for a social worker to meet with the patient prior to discharge to help identify any family members or close friends for emotional support, programs where the patient can apply for financial support, and appropriate community resources that can provide informational and companionship support.

If transferred to long term care, the receiving facility may:

- Have regular support group meetings, a chaplain and/or volunteers that can help meet the social needs of a variety of individuals.

If transferred home, the client may have been assigned a home health caregiver:

- Home health caregivers support the social needs of clients who live alone or who live with other family members who are unable to meet the client's needs.

HOW YOU CAN HELP

- Speak to family members, if possible, about the importance of providing social support to your client.
- Contact a church group or other volunteer organization to make visits to your clients—especially the ones who are rarely visited by family members.
- If appropriate, volunteering can give your client a sense of purpose, connectedness and the satisfaction of helping others in need. Check out www.seniorcorps.org for volunteer opportunities all over the United States.

THINK ABOUT IT!

Think about a client you care for right now.

Do you think your client is getting the social support he or she needs?

❑ ***Yes*** ❑ ***No***

If you answered yes, list some examples of the social support you know your client receives.

_____

_____

_____

If you answered "No," what can you do to improve your client's social support?

_____

_____

_____

_____

_____

_____

Discuss your thoughts with your co-workers and supervisor and find out what they would do.

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SHOULD YOU CALL TO THE DOCTOR OR VISIT THE ER?

After being diagnosed and/or treated in the hospital for CHF, pneumonia, COPD, mental illness or gastrointestinal problems, some patients may be unclear on the difference between symptoms that require a call to the doctor versus a visit to the ER. Knowing the difference can prevent unnecessary readmissions!

Common Condition	Call the doctor (or nurse) to report . . .	Visit the ER for . . .
Congestive Heart Failure (CHF)	• Weight gain of more than 2 pounds in 1 day or 5 pounds in a week. (*If possible, daily weights should be checked in the morning after first urine and before any fluid intake.)* • More than usual swelling in the feet, ankles, or stomach region. *(Be sure the client is following any fluid restriction guidelines ordered by the doctor.)* • Increased urination at night. *(Clients with CHF will usually be on a diuretic or "water pill" that increases urine output.)*	• Struggling to breathe or unrelieved shortness of breath while at rest. • Chest pain. • New or worsening confusion or trouble thinking clearly. • Persistent palpitations (racing heart) • Lightheadedness that does not go away. • Passing out.
Pneumonia	• Breathing that seems too fast, painful, or difficult. *(Placing client in a sitting position, arms propped on a table, with shoulders relaxed and head slightly forward may help.)* • A cough that brings up blood. • Headaches or fever.	• Struggling to breathe after being moved to a sitting position, with arms propped on a table, shoulders relaxed and head slightly forward. • Dizziness or confusion. • Blue color around lips, fingers or toes.
COPD	• Coughing that brings up dark yellow, green, or bloody mucus. • Fever or chills. • The need to use inhaler more often than usual or more than prescribed. • New or worsening swelling in legs, ankles or abdomen.	• Chest pain or tightness not relieved by usual rest or medication. • Struggling to breathe. • Confusion or dizziness. • Feeling faint or passing out.
Mental Illness • Depression • Bipolar Disorder • Psychosis • Schizophrenia	• Medications don't seem to be helping. • Client experiences muscle spasms, stiffness, or trouble walking. *(These could be side effects of certain anti-psychotic medications.)* • New or worsening depression.	• Feeling like hurting or killing self or others. • Sudden onset of trouble breathing.
GI Problems • Diverticular disease • Colitis • Colorectal Cancer	• Sudden pain or cramping in abdomen or back. • Bleeding from rectum or bloody diarrhea. • Fever. • Unintentional weight loss. • Nausea or vomiting.	• Fever exceeds 101° F. • Nausea or vomiting persist for 24 hours. • Constipation or diarrhea that lasts for more than 48 hours. • Any redness, swelling, or foul-smelling drainage from incisions (or tubes).

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HELP CLIENTS MAKE LIFESTYLE CHANGES

SMOKING: Smoking is directly linked to the top 3 chronic illnesses that are most likely to lead to a hospital readmission: **heart disease, pneumonia** and **COPD**. If you provide care for clients with any of these conditions, it's likely you are providing care for a smoker (or former smoker).

If your client smokes, it's important to be both direct and supportive. Nicotine is a powerful drug that is highly addictive, and that makes quitting extremely difficult . . . but it's not impossible!

Encourage your client to speak to his doctor about medical interventions that can help. There are anti-smoking medications, like Zyban and Chantix. There are nicotine replacers, such as patches, gums and sprays. And there are non-medical solutions that include hypnosis, acupuncture and support groups.

There isn't one right answer for every smoker, but a great place to start, for is by calling the National North American Quitline. Quitlines are telephone-based tobacco cessation services available in all 50 U.S. states, 10 provinces and two territories in Canada, Mexico, Puerto Rico and Guam.

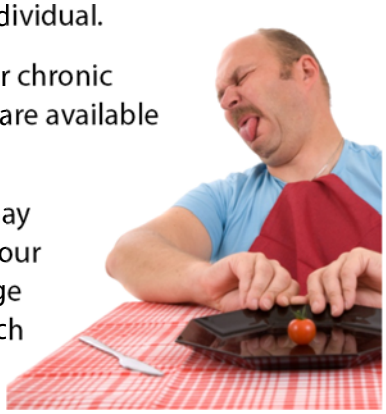
Help your client find your state's Quitline number at www.naquitline.org or call the national number at **1-800-QUIT-NOW** to be routed to your local line.

OBESITY: It is estimated that 1 out of every 3 Americans is obese. Obesity is considered a "gateway" disease. That means it contributes to other diseases. Currently, obesity is linked to heart disease, cancer, respiratory diseases, Type 2 diabetes, high cholesterol, sleep apnea, liver and gallbladder disease, osteoarthritis, dementia and Alzheimer's Disease.

Like smoking, there is no one-size-fits-all approach to treating obesity. Treatment may include diet, exercise and behavioral modification, as well as drug therapies and surgery for some individuals.

Encourage your clients to speak to their doctor about the best way to lose weight. Weight loss routines for obese clients must be designed specifically for the age and chronic illnesses faced by each individual.

Treat your clients' weight like another part of their chronic illness, ***not a character flaw***. Let them know you are available to support them in their weight loss journey.



Help your client understand that improvement may mean changing a lifetime of eating habits. Help your client make small changes at first. Trying to change everything at once usually results in failure—which can spiral into guilt and more weight gain.

TALK ABOUT IT!

WHO'S TALKING NOW?

There was a time when doctors would avoid talking to their patients about the dangers of smoking.

- Some said they were just too uncomfortable bringing it up.
- Others were afraid of offending patients, and thus losing their business.
- And a final group thought it didn't matter because no one was listening anyway.

Fortunately, things are changing. Doctors now speak with smokers at every visit and offer ways to help them quit. And, guess what? Smokers are listening!

Are you uncomfortable speaking with clients about quitting smoking?

Ask your supervisor today for some resources that can help you help clients make better health choices!

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FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. One in five Medicare patients return to the hospital within 30 days of discharge—and Medicare will no longer foot the bill.
2. Certain medical conditions, like CHF, COPD and pneumonia increase the likelihood of hospital readmission.
3. Other risk factors, such as polypharmacy, lack of primary care doctor, lack of understanding of health conditions, and a lack of social support also increase the odds that a person will be readmitted within 30 days of discharge.
4. Preventing readmission doesn't end when a person leaves the hospital. In fact, that's often when it begins.
5. Preventing readmissions to the hospital is a *team effort*. One person, or even one group of people, cannot do it all.

IMPROVE CHANGE-OF-SHIFT REPORTS

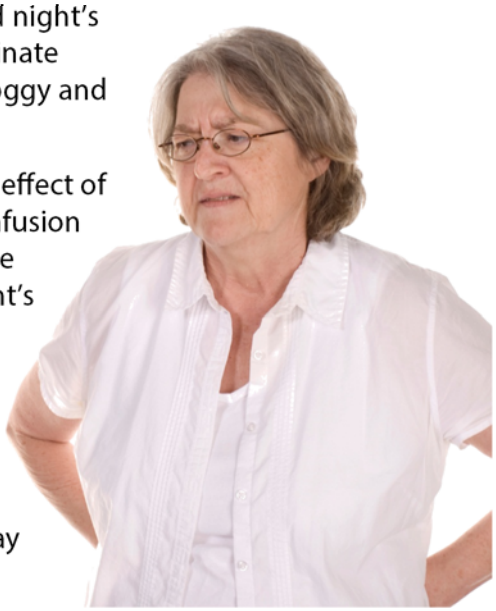
Whether you work in a facility, caring for dozens of clients, or in home care with just one client, the change-of-shift report is one of the most important ways you can help clients prevent unnecessary readmissions.

You may be thinking, "I'm *just* a nursing assistant, we don't do a change-of-shift report." Or, "That's something the nurses do and *we* are not included." Well, if that's the case for your workplace, it's time to make some changes.

If your team does not routinely share a shift report between nursing assistants, it's time to consider adding the practice. It doesn't have to take a long time. Just a few minutes is all it takes to share important and abnormal information. **For example:**

- When giving a shift report, focus on things that have changed during your shift and anything that might affect the way the next shift gives care.
- Pay particular attention to the health status of clients who have been discharged from the hospital within the last 30 days. Be prepared to report more details about these clients when your shift is over, and be ready to ask more questions about these clients as your shift begins.
- If possible, request to be present during the nurses change-of-shift report. You will learn about your clients in much greater detail, which can improve the care the entire team is able to provide.
- **Carry your brain in your pocket!** If you care for many clients during a given shift, don't try to rely on your memory to report all those details to the next shift. Instead, carry a piece of paper or a small note pad in your pocket and take notes as you go along!

Here's an example scenario: Ms. J. was recently discharged from the hospital with a diagnosis of congestive heart failure. She is adjusting to being on a diuretic (water pill) and didn't get a good night's sleep because of the frequent urge to urinate during the night. The next day she is groggy and a little confused due to the lack of sleep.



More frequent urination is a normal side effect of diuretic therapy, but grogginess and confusion are not. Without the information from the outgoing shift that Ms. J. had a poor night's sleep, the day shift may see the grogginess and confusion as a sign that her heart condition is worsening.

The lack of information about the poor night's sleep could lead to a call to the doctor or a return to the hospital that may have easily been avoided.

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FINAL TIPS

- Preventing readmissions to the hospital is a ***team effort***. One person, or even one group of people cannot do it all.
- Preventing readmission starts the moment a person is admitted to the hospital. Hospital staff do everything they can to educate clients about their conditions, teach them what to do to stay healthy after discharge and set up community resources to support clients along the way. But, preventing readmission doesn't end with the hospital staff.
- Clients can be discharged from hospitals into the care of a skilled nursing facility, rehabilitation center, assisted living or to home health caregivers. When the care is handed off from the hospital, the responsibility to prevent readmission lies with the ***new*** care team.
- There has to be a plan, good communication and accountability from the staff at the hospital, the nursing home and/or the home health agency, and no one is exempt from responsibility. Every discipline is involved, from physicians, nurses, and social workers to case managers, therapists, and nursing assistants just like you.
- Nursing Assistants like you are ***vital*** to preventing readmissions because you are the main link between the client and the rest of the team. You spend the most time with the client. You are in the best position to observe changes in symptoms, side effects of medications, and non-compliance with medications, therapies or suggested lifestyle changes.
- You are probably the first person the client will talk to if he or she is having trouble understanding doctors' orders. You are the one that helps coordinate follow-up visits to doctors. You are the cheerleader that can make all the difference when it comes to making difficult lifestyle changes.
- Regardless of how, when or in what setting you interact with clients, you are an important part of the solution. The bottom line is that you, along with your team CAN reduce and prevent unnecessary readmissions with all of your clients.
- ***Start today!*** By making just a few adjustments to your typical routine you can shine a brighter spotlight on those recently discharged clients who are the most vulnerable and at risk for an unnecessary and costly readmission.

WHAT I KNOW NOW!

Now that you've read this inservice on preventing readmissions, jot down a couple of things you learned that you didn't know before.

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A Health Care Module:
Reducing & Preventing Readmissions to the Hospital

EMPLOYEE NAME
(Please print):

_____

DATE: _____

- ***I understand the information presented in this inservice.***
- ***I have completed this inservice and answered at least eight of the test questions correctly.***

EMPLOYEE SIGNATURE:

_____

SUPERVISOR SIGNATURE:

_____

Inservice Credit:	
☐ Self Study	1 hour
☐ Group Study	1 hour

File completed test in employee's personnel file.

Each In the Know PDF course includes a 10 question post test.

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PREVENTING READMISSIONS CROSSWORD PUZZLE

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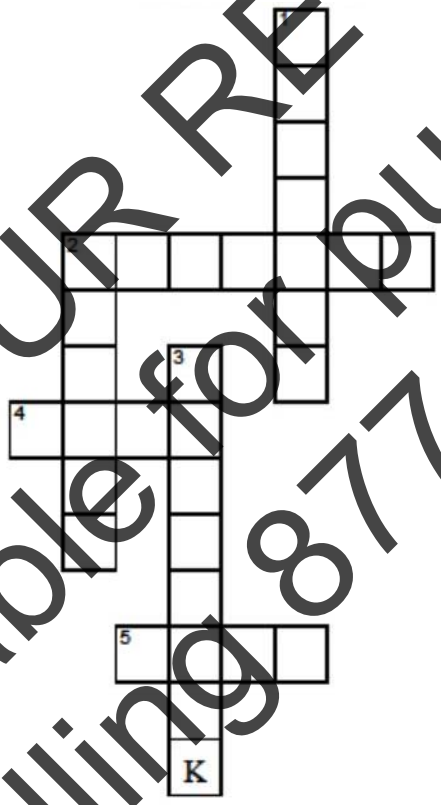

Across:

2. Helping someone quit this can ease symptoms of heart disease, pneumonia and COPD.
4. Polypharmacy is taking more than ____ medications at once.
5. A lung disease that often leads to re-admission.

Down:

1. If the person's primary language is Spanish, in what language should discharge instructions be provided?
2. A person who lives alone may lack _____ support.
3. It takes this to prevent unnecessary re-admissions.

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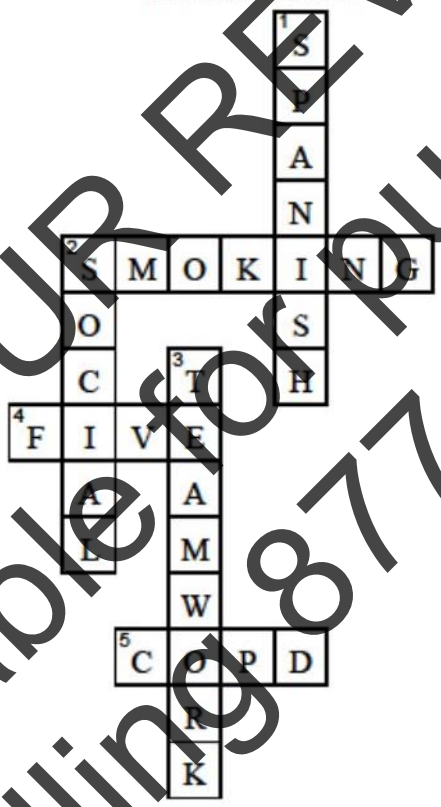
CROSSWORD PUZZLE ANSWER KEY



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EVALUATION

Employee Name_____

Date_____ ❑ **Self-Study Inservice** ❑ **Group-Study Inservice**

1. Put a checkmark in the box that best describes how you feel about each learning objective.

LEARNING OBJECTIVE	I am able to do this.	I might be able to do this.	I can't do this.	I'm not sure.
Identify clients at increased risk for readmission within 30 days of discharge.				
List at least three ways that you can help clients 1) manage their medications and 2) keep appointments after a hospital discharge.				
Discuss the difference between symptoms that merit a call to the doctor versus those that require a trip to the ER.				
Develop a plan to improve change-of-shift reports for CNAs that reduces or prevents readmissions.				
Collaborate with the entire healthcare team to improve outcomes for clients at risk for readmission.				

2. Did you learn anything new that will help you in your job? ❑ **Yes** ❑ **No**

If yes, please explain:_____

_____

_____

3. If you have questions about the inservice information that did not get answered, note them here:

_____

_____

4. Other comments? _____

_____

_____

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Certificate of Completion

This certifies that

_____

CNA Certificate Number (if applicable) _____

has successfully completed one hour of continuing education entitled

Preventing Readmission to the Hospital

on this day

_____

Each In the Know inservice provides one hour of continuing education credit.

Florida: In the Know CE Provider #: 50-16953; Topic Approval Code 20-511071

Washington: DSHS Approval Code CE134854

This certificate should be retained by the certified nursing assistant for a period of four years after the course has been completed.

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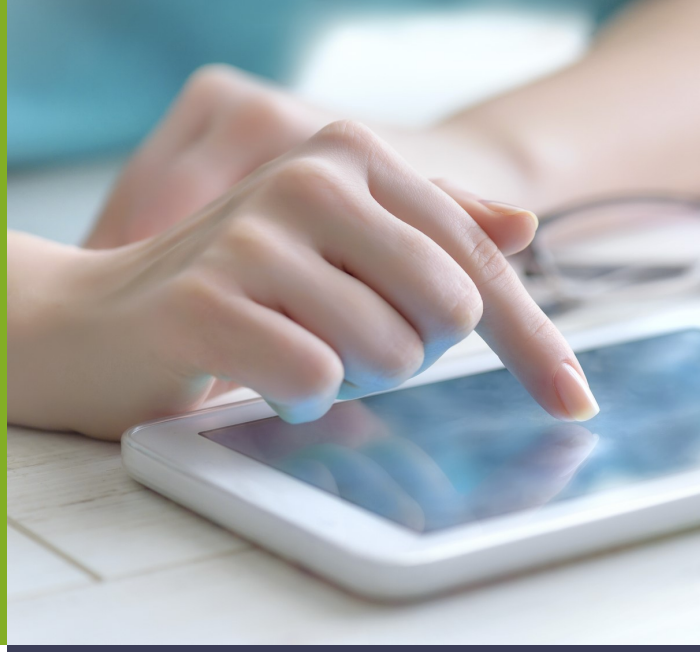

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SAMPLE SAVINGS

12 LEARNER COURSES
12 INSTRUCTOR PACKETS
12 HOURS OF CREDIT

for each of your caregivers!

$950
annually

...a savings of 20%!

Save Money with BLENDED LEARNING!

A blended learning plan is a strategy that uses a combination of traditional classroom training with online learning. The mix, or "blend" of training strategies is where the magic happens!

There's no doubt that online learning has revolutionized caregiver training. It's *convenient*, *easy*, *interactive* and *engaging*. It makes tracking and reporting a breeze for compliance.

But in healthcare, there will always be a time when instructor-led, classroom training is an absolute must. **A Blended Learning Plan is the solution!**

Contact Us for a Quote!