RAVEN Reduce AVoidable Hospitalizations using Evidence-based interventions for Nursing facilities in Pennsylvania

Communication → Process → Documentation

What helped RAVEN succeed?

Facilities that have had the most success decreasing hospitalizations, improving resident outcomes and improving revenue, throughout this Initiative in Pennsylvania, were able to implement a best practice model using three principles: communication, documentation, and process.

How were best practices implemented?

Most facilities did not create something new or novel. Many of these principles were already in practice in their facility. Most facilities simply reviewed and/or fine-tuned their processes to create an efficient and effective best practice to identify, treat, and manage changes in condition.

Communication: Everyone needs to know who, why, what, when, and how

- Provide the medical director, NHA, DON, ADON, RNAC, business office, admissions, social work, activities, and nursing managers with education and tools explaining the process from start to finish. This can be a conference type education using facility forms, facility specific electronic communication tools and hardcopy materials, and/or corporate SharePoint.
- Give a clear message to management on the outcome goal and the job duty of participation.
- Educate all nursing staff (CNAs, LPNs, RNs) on the same goals and expectations.
- Hold staff accountable to participate.
- Put tools in place:
    - Label charts
    - Flag electronic records
    - Color clipboards or binders to communicate the need for alert or high-level
    - Verbal scripts for nursing staff for notifying practitioners
    - Create documentation templates
    - Provide SBAR, change in condition notes, and INTERACT tools electronically or in hardcopy
- Education continues through annual skills fairs, competency training, and new hire orientation.

Process: How to identify and track changes in condition

- Nursing identification process:
  - When alerted, identify the change in condition through the nurse assessment
  - Document the assessment using a communication tool
  - Notify a supervisor/manager and practitioner
  - Obtain and initiate monitoring and treatment orders
  - Communicate change in condition on 24hr report
  - Document monitoring and treatment of change in condition until resolved
- Facility tracking process:
  - Utilize Stand Up, 24hr update, or Daily Facility Census meetings
  - Review census
  - Review discharges
  - Review referrals
  - Review skilled Part A and skilled Part B
  - Having nursing leadership review changes in condition.
  - Report those residents reviewed to appropriate supervisor/unit manager for follow up of practitioner notification, nursing assessment, and alert nursing to need for daily assessment and documentation.
  - Track those residents until the change in condition resolves.
  - Ask:
    - Was the practitioner notified and diagnosis made?
    - Is there nursing documentation to support assessment, monitoring, and treatment of change in condition?
    - Is the continued change in condition being notified to the practitioner if the resident not responding to treatment?

Documentation: What is needed?

- Change in condition assessments and notes, SBAR, and INTERACT tools.
- Daily nursing documentation that supports assessment, monitoring, and treatment of the change in condition identified until change in condition is resolved.
- Documentation and assessment specific to the system affected (neurologic, cardiovascular, musculoskeletal, pulmonary, genito-urinary, skin, etc.)
- Practitioner documentation with diagnosis of change in condition

What are the benefits?

Implementing a whole house process for identification of change in condition will benefit your residents and your facility by decreasing hospitalizations, improving outcomes and improving revenue by reducing the cost of hospitalization and limiting fines imposed by hospitalization.