Abstract

Potentially preventable early rehospitalization is a significant problem for patients, hospitals, and skilled nursing facilities (SNFs). Fragmentation of care increases the vulnerability of frail elderly SNF patients, contributing to the problem of rehospitalization. The Transition of Care Model (TCM) provided the theoretical framework for this DNP quality improvement project that used an evidence-based protocol to systematically coordinate, implement, and evaluate the transition of care when patients are discharged from hospitals to SNFs. Project objectives were to implement and evaluate an educational program for RNs to identify SNF patients at risk for rehospitalization; determine if the implementation of an assessment tool for change of condition decreases rehospitalization rates of high-risk SNF patients; and maintain APN provider compliance in following SNF admission protocol. Despite the lack of significant findings for the educational intervention, the project results supported the use of an evidence-based SNF protocol using LACE score and an assessment of patient's risk of rehospitalization. The results also supported the use of the INTERACT Stop and Watch tool and LACE scoring tool for enhancing staff nurses' awareness of patients at high risk for rehospitalization as well as staff nurses' timely reporting of patients' change in condition to the APN provider.