Improving Discharge Processes To Decrease Readmission Risk

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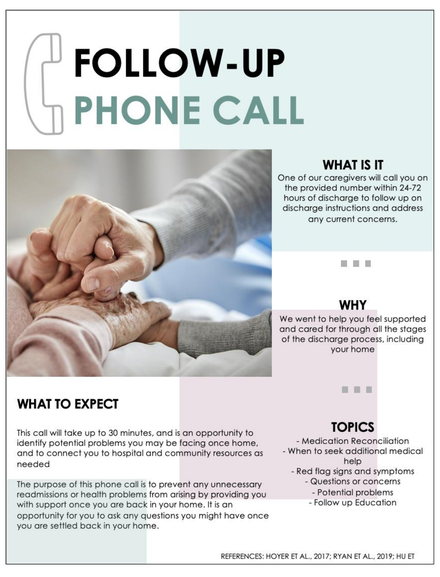
BACKGROUND

Preventable readmissions can occur due to a lack of patient education, preparation, and support and can be costly to hospitals and patients. However, early, individualized discharge planning and patient-specific education can improve preparedness to self-manage diseases at home and improve overall health outcomes. [1,3] This project aims to reduce readmission rates through optimal patient education, discharge planning, and support through the transition from hospital to home using a transition nurse coach.

The question asked in this study was: In patients recently discharged from acute care hospitals, how does increased discharge preparedness, education, and resources compared with current discharge protocols decrease readmissions within one month, three months, and six months?



METHODS

- The Iowa Revised Model guided the literature review to identify gaps in education and opportunities for improvement in current discharge processes.
- The 3 major themes identified through the literature review include early individualized discharge planning, caregiver involvement, and transitional care.
- Sub-themes included individual learning barriers, patient-specific education, transition coaches, interdisciplinary collaboration and community resources, and phone call follow-up.
- Key stakeholders for implementing the change process include registered nurses, transition coaches, social services, physical and occupational therapy, and nursing leadership.
- A readmission risk health needs assessment and template for determining transitional care services needed for patients were created to determine which transitional care services patients qualify for.
- An educational PowerPoint on the role of transition coaches for nurses and an informational handout for patients on the follow-up phone call was created to guide nurses stepping into these roles.
- Patients who receive a phone call follow-up or the support of a transition coach through their discharge are less likely to have an unexpected readmission.
- This project provides proper education and support for patients through the discharge process to decrease unnecessary readmissions. [2]

EVALUATION

- Success will be determined by comparing the readmission numbers from the pilot unit before implementation and compared to the numbers after.
- A 1% decrease in readmissions at the end of the quarter will indicate success for the first unit; this goal will be assessed after the first quarter to determine if it needs revision.
- Feedback and suggestions from floor staff on this unit will be used and reviewed; any adjustments to the project will be assessed and implemented as needed.
- Surveys will be emailed to patients to assess their satisfaction with the education and support they received. A mean satisfaction score of 4 is the goal for this project; there will also be a section to provide comments, opinions, and suggestions.
- Option to receive a follow-up call from the administrative team to further discuss their thoughts on the project.

REFERENCES

1. Hayajneh, A. A., Hweidi, I. M., & Abu Dieh, M. W. (2020). Nurses' knowledge, perception and practice toward discharge planning in Acute Care Settings: A systematic review. *Nursing Open*, *7*(5), 1313–1320. https://doi.org/10.1002/nop2.547
2. Hoyer, E. H., Brotman, D. J., Apfel, A., Leung, C., Boonyasai, R. T., Richardson, M., Lepley, D., & Deutschendorf, A. (2017). Improving outcomes after hospitalization: A prospective observational multicenter evaluation of Care Coordination Strategies for reducing 30-day readmissions to Maryland hospitals. *Journal of General Internal Medicine*, *33*(5), 621–627. https://doi.org/10.1007/s11606-017-4218-4
3. Kang, E., Gillespie, B. M., Tobiano, G., & Chaboyer, W. (2018). Discharge education delivered to general surgical patients in their management of Recovery Post Discharge: A systematic mixed studies review. *International Journal of Nursing Studies*, *87*, 1–13. https://doi.org/10.1016/j.ijnurstu.2018.07.004
4. Welch, S. R., Carruth, A. K., Wood, R., Bode, B., Babineaux-Jones, A., Mitchell, C., Burdett, G., Davis, B., & Ducombs, C. (2018). Improving care transitions. *JONA: The Journal of Nursing Administration*, *48*(12), 629–635. https://doi.org/10.1097/nna.0000000000000696
5. Upadhyay, S., Stephenson, A. L., & Smith, D. G. (2019). Readmission Rates and Their Impact on Hospital Financial Performance: A Study of Washington Hospitals. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, *56*, 004695801986038. https://doi.org/10.1177/0046958019860386

CONCLUSIONS

- This project can decrease costs for both patients and hospitals. [5]
- Implementing this project will increase support for discharging patients and improve patient satisfaction and outcomes by preventing unnecessary readmissions.
- RNs can experience greater job satisfaction by following and supporting their patients through their transition to home.
- The nursing profession aims to treat the whole person and help the patient develop self-management skills to improve their daily activities to positively impact their overall well-being. This project aligns with that goal. [4]