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"All Set toGo Home":Improving Discharge Planning for Patient's SAfe and Timely Discharge

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Clinical Leadership Theme

The Clinical Nurse Leader (CNL) works on the project of discharge planning improvement process in the medical oncology and telemetry unit. The CNL is equipped with advanced clinical knowledge and competencies, with multifaceted roles to ensure that healthcare delivery is evidence-based and geared towards the most quality outcomes. For this reason, the CNL can display the quality assurance program to achieve the effectiveness of the patient's transitions between healthcare organizations, which provide for the continuation of safe, and quality care for patients in all settings (The Joint Commission, 2012). The CNL, can act as a lateral integration of care, works horizontally and collaboratively with other interdisciplinary teams to facilitate the delivery of safe, outcome-based practices from admission to treatment to discharge (White Paper on the Education and Role of the Clinical Nurse Leader, 2007). Other roles of the CNL throughout this project are the leader, educator, data analyst, and facilitator.

The project aims to improve the discharge planning of patients in Medical-Oncology/Telemetry unit at the county hospital in Northern California. The process begins with the patient's admission in the unit identifying the discharge destination, medical needs, education, resources and support post hospitalization through a discharge planning checklist. The process ends with the patients' discharge with an appropriate discharge disposition and equipped with necessary knowledge, skills, and resources to take care of his or her health condition at home or any other health care settings.

By working on the process, there is an expectation of a safe and timely discharge of patients. It is important to work on this process now to improve patient care, and efficiency, better care coordination, collaboration, and communication among health care professionals

involved in patients care, improved bed capacity, reduced readmission rates and costs, and improved patients and staff satisfaction.

Statement of the Problem

Studies have shown that patients admitted to the hospital, following adequate discharge planning experience high-quality of inpatient care and unnecessary readmission, which reduced costs (Wong et al., 2011). Patients at medical unit experience delays in discharge for several reasons, such as the need for durable medical equipment (DME), supplies, patient education, transportation, and medications. The Unit has no discharge coordinator. Nurses are responsible for the quality and safe discharge of patients from the acute setting to their discharge destination. Nurses' workload also delays discharges. Nurses prioritize patients with higher acuities than patients who are stable and ready for release. Discharge teachings are not the priority of the nurses. Patients are sent home without a clear understanding of their management and treatment which leads to unnecessary calls to the unit for clarification.

Patients experience a low quality of care, waiting for hours which makes them vulnerable to any harm such as falls, unnecessary stay and blocking the bed for acutely ill patients for admission. Discharges supposedly happened at 11:00 am but never realized. Most releases occur late in the afternoon. There are only 58 out of 137 (42%) releases happened by at least 2:00 pm in the month of February 2017. Professional Research Consultants (PRC) data regarding the percentage of patients describing the discharge process as "excellent" is only 31.38%. The quality initiative to improve the discharge process is critically important in this department. The CNL can implement a quality

assurance program to improve the discharge process by creating a standardized procedure, such as a checklist (Appendix A).

Project Overview

The goal of the project is to improve the discharge process with the implementation of the discharge planning checklist. One of the most critical components of the list are the patient education. Patient discharge education emphasizes tools, strategies, patient's readiness to learn and learning assessment from literacy, cognition, style, educational level, and family or social support.

The discharge process takes a “hospital village” which means team effort to improve each patient’s experience and satisfaction. It is a complicated process that requires coordination of the healthcare disciplines such as the medical team, therapists, care management team, pharmacists, nurses, and social workers. Thus, the discussion with the unit manager and shared leadership council for collaboration and engagement of nursing staff and other disciplines are necessary. Discharge checklist created as a guide for the nurses. Discharge champions of every shift will be identified and educated with the support from the unit’s nursing management and shared leadership council. The trained discharge champions will help the CNL educate, engage, and monitor the frontline nurses in this initiative.

The CNL led staff education include the discharge planning improvement process from the purpose, the implementation, and evaluation. Also, staff education covers how to use the discharge checklist with emphasis on patient education and how to implement in the daily workflows. The list is initiated upon patient’s admission by identifying their discharge needs. The checklist marked check for every list completed and updated every shift, and as needed so,

when the day the patient cleared for discharge needs such as medications, patient education, durable medical equipment, transportations, vaccines, and belongings are all prepared by healthcare professionals involved. The multidisciplinary rounds (MDR) color guide (Appendix B) utilized during MDR conferences for patient discharges will also be mentioned. The discharge color guide depicts green as cleared for release without needs; yellow means still has a condition to accomplish such as an echocardiogram; orange means 80% discharge the next day, red implies patient very acute not ready for release yet, and silver is a placement issue.

The CNL creation and implementation of a standardized tool, the discharge planning checklist for nurses for an effective transition of patients from the hospital to home and improve patient's health outcomes in both clinical and psychosocial aspect. The checklist will prevent process breakdown from nurses as a human factor with a heavy workload. Thus, patient and staff experience positive outcomes as revealed in the survey ratings.

Patients all set to go home are planned accordingly through the team efforts using the list will achieved the global aim of the project to improve patient discharge planning for a safe and timely discharge. The specific goals as well which are to increase the actual releases by 2 pm from 40% to 60%, increase the patients experience regarding discharge process from 30% to 50% and decrease readmission rate from 25% to 5% at the end of December 2017.

Rationale

The Affordable Care Act seeks to improve health care quality and reduce taxpayer costs by avoiding preventable mistakes and readmissions, rewarding excellence, and building on the health information technology infrastructure avoiding preventable mistakes and readmissions, rewarding excellence, and building on the health information technology infrastructure to ensure

health care quality (Centers for Medicare & Medicaid Services, 2014). Additionally, the Medicare Hospital Readmissions Reduction Program (HRRP) incentivizes hospitals to coordinate care efficiently and implement strategies to reduce readmissions. This program and microsystem assessment of fragmented system of our unit's discharge process (Appendices C, and D fishbone and SWOT analysis) led me to improve discharge planning for a safe and timely discharge that will eventually result to reduce readmission rates and costs and improve the patient care experience for reimbursement.

Direct costs involved in improving the discharge planning include the staff education and supplies (Appendix E for cost analysis). The total cost incurred of training all the nursing staff in the unit with the inclusion of the clinical nurse leader (CNL) who will oversee the business plan and improvement is $50,326.50. Staff education includes the two hours training for the nurses and half an hour for the nursing assistants. Supplies needed by the staff has an estimated cost of $300. The total cost for this project is $50,626.50 for the staff education and supplies needs. Estimated 10 patients for discharge per day with an hourly cost savings of $500 times one-hour timely discharge multiplied by the number of days about 270 (estimated nine months of implementation) will incur a savings of $1,350,00 for the hospital and appropriate release for the patient. The overall benefits of this project outweigh the negative cost. The conservation mentioned in this project is with the exclusion of the hospital cost saving from the readmission fine of about $10,000 to $14,000 per patient depending on patient's insurance and condition. As well as the cost savings of approximately $200,000 from achieving benchmark and 75th percentile of Hospital Consumer Assessment Patient Survey (HCAPS) dashboard.

Methodology

Graham, Gallagher, & Bothe (2012) points out that discharge planning commenced at admission by nurses, plays a key role in improving patient outcomes if they consistently comply and maintain effective discharge planning protocol. Greater incorporation of discharge planning activities into the nurses' daily practice occur if nurses are involved in the development and implementation of the discharge processes through education, training, and regular feedback (Graham et. al, 2012). Transformational leadership is one of the strategies that cause a valuable and positive change both the staff and the social structure. It depicts behaviors and attitudes of leaders who motivate staff to identify goals and work beyond high expectations to achieve good outcomes. The transformational leadership style applies to the discharge process improvement for it promotes innovations and improvements that aim to move the workplace into a high performing, proactive, efficient and effective one. The strategies of transformational leadership are to create a clear, shared vision and values of a new concept of change and explanation of how to attain these insights. The leaders act optimistically, leading by example, and empowering followers to achieve the vision (Stone, Russell, & Patterson, 2004).

The change model, transformational leadership, will be utilized in the medical setting. The application of transformational leadership is to challenge and change the current state of the unit's system of discharge. The charismatic, transformational leader lead by example, inspires and motivates staff to share responsibility and decision-making to make innovations and improvements. Transformational leadership will also expand and raise the interests of the staff involved in the process, promote awareness and acceptance of the goals, vision, and mission of the team, and can assure that staff sees beyond their self-interest for the greatness of the team.

Both the leader and the team will build a trusting collaboration with common goals and shared value to achieve change.

The clinical nurse leaders (CNLs) are facilitators for change, driven by a strong sense of vision for the common good of the stakeholders involved. They also possess characteristics of transformational leaders such as good communicator, team player and with inspiring and trustworthy traits. An inspirational leader is committed to shared vision and challenges the staff to strive to succeed and maintain the image. Trust is crucial in every working relationship that promotes confidence among staff. A good communicator shows respect of what others might say by listening attentively and giving others the likelihood to air out their views and opinions. Stakeholders engaged in any potential change promote teamwork and collaboration. The CNL who exhibit these qualities will work alongside the dedicated healthcare team members to create positive energy and culture to achieve and maintain their desired goal. Transformational leadership style will then bring forth reflections and guidelines to assist the CNL and stakeholders with a better-coordinated discharge process.

The CNL role as a leader and educator in the microsystem instill confidence, motivation, and a sense of purpose among the staff to make change happen. A highly functioning and well-prepared team supported by the CNL can provide valuable services to meet the departmental objectives of meeting patients needs for an efficient transition. Thus, transformational leadership, facilitated by the CNL will sustain the greater good and supportive work environment.

The expected outcome of change measured through the result of patient's survey from the Professional Research Consultants describing the discharge process as excellent. The unit also has the list of patients release on each shift with the actual time the doctor wrote the discharge

order, and the real time the patient left the unit. The list will show if we meet the expected actual number of discharges by 2pm.

The data collection will also be from the Quality Improvement (QI) monthly reports of the discharge rates, discharge patient survey. The data collection will be reviewed and monitored monthly to compare improvement in the implementation of the MDR at the bedside with the use of standard discharge planning checklist. Additional data from the organization patient turn over report will be collected and review monthly to monitor the readmission rate and the timely discharge rates.

The reliability and validity of the survey and data controlled well because it is an outside survey company (Professional Research Consultants) that gathers the patients or participants answers during the survey and are being submitted to the QI Director monthly. The EPIC consultant will be compiling the data from the chart reviews of the department patients discharges with the time the discharge ordered, the actual time of discharge and readmissions rates which also submitted to the QI Director and the Unit Managers. All these data will show if the project reaches the expected outcomes of change.

The CNL will also be able to identify changes from the staff. The team is more empowered to improve the discharge process by using the checklist consistently and efficiently. The CNL working with the team members create a real culture and positive energy that lead to higher level of staff satisfaction due to a sense of empowerment and a greater degree of autonomy (Martin, McCormack, Fitzsimons, & Spirig, 2014).

Data Source/Literature Review

The PICO statement leads me to furnish a wide variety of literature and peer review articles to choose from to support the discharge process improvement. The search modified to the last five years and emphasize on patient discharge education for better health outcomes provide an adequate number of evidence-based articles to work on to accomplish this project. Patients at medical oncology and telemetry unit is the focus of the project. The intervention emphasizes on staff education and support through a standardized discharge procedure such as discharge planning checklist with emphasis on patient discharge instructions and resources. The comparison was related to unsafe and delayed discharge of patients; low staff, and patient satisfaction rating. The ultimate outcome is safe and timely discharge; improve patient and staff satisfaction and reduce costs.

A research study by Renke & Ranjit (2015), showed several effective transitional care strategies successfully utilized in different patient populations and health care settings, but there is minimal information provided on cost, resources, and efforts to ensure continuity. Project Better Outcomes for Older Adults Through Safe Transition, (Project BOOST) developed a toolkit that includes interventions such as “risk assessment, medication reconciliation, a checklist, and a multidisciplinary team-based approach” (Rennke & Ranjit, 2015). In this study, the use of universal patient discharge checklist was successfully implemented in different hospital settings in the United States. The checklist tool was answerable by yes or no with space for staff to initial, after the task completed.

Reed (2010) presented a quality research study in England in a rural health setting about discharge checklist implementation to improve the quality and consistency of discharges. Most reasons for delayed discharges were identified such as diagnostic and lab results, transportation,

medication provision, and coordination. The checklist developed and implemented to reduce unnecessary delays. It was first trialed to about 21 members of staff and 23 patients. Then, to the entire ward after staff felt that the tool meant for their purpose. Modifications were made in the checklist during trials of implementation. Staff also face challenges despite acceptance and support from the multidisciplinary team and executive staff. The test change measured through the percentage of patients who experienced delayed discharges and data plotted on a run graph and shows a meaningful reduction of delays. The other measure was the percentage of the length of stay of patients and showed the mean length of stay lowered by 0.86 days (Reed, 2010).

Goncalves-Bradley, Lannin, Clemson, Cameron, and Shepperd (2016) presented a randomized controlled trial of 30 inpatients. Participants were randomly selected. A sample size of 21 participants with a medical condition was chosen, five participants with a blend of both medical and surgical conditions, one recruited from a psychiatric hospital, one from both a psychiatric and a general hospital, two other participants admitted to the hospital following a fall. The hospital length of stay and readmissions were reduced for members admitted to the acute setting with medical diagnosis and provided with effective discharge planning. The study adopted a statistical analysis based on the intention-to-treat principle, and mean differences for data using fixed-effect meta-analysis (Goncalves-Bradley, et al., 2016). The outcome of this study showed that an individualized discharge plan reduced “the risk of readmission to the hospital at three months follow-up for older people with a medical condition and increased patient and staff satisfaction” (Goncalves-Bradley et al., 2016).

Waniga, Gerke, Shoemaker, Bourgoine, and Eamrond (2016) described in detailed the improved discharge instructions in an acute care setting. Written information and explaining the plan of care including management of any symptoms, follow-up recommendations, and use of

medications and treatments improve patients' ability to understand and adhere with the given discharge instructions. Ensuring nursing staff education play a crucial part in providing well-described discharge instructions to improve the perception of care by patients and consequently improve patient satisfaction.

Timeline

The timeline of the project began in February 2017 (Appendix F for Gantt chart) with a thorough assessment of the microsystem. The focus of discharge planning improvement identified from the microsystem assessment, current evidenced-based clinical practices initiated the research in March 2017 to support the project. April 2017 list down possible interventions to improve discharge planning such as multidisciplinary rounds (MDR) conferences, and nurse's utilization of the discharge planning checklist developed in May 2017. The project provided the opportunity for the CNL to conduct various meetings and discussion with the unit manager, shared leadership council and other health care disciplines involved in discharge planning to gain support, approval, communication, collaboration, and teamwork in June to July 2017. In August 2017, the discharge champions identified and educated about the discharge process supporting purpose, implementation, and evaluation. The education covers how to use the discharge checklist with emphasis on patient education and how to implement in the daily workflows. The trained discharge champions will help the CNL to reach out all the nursing staff to have mandatory classes for this quality initiative. The nursing staff were invited to attend the 2-hour class to incorporate the quality improvement measures in the discharge process. Further follow-up with the stakeholders, staff educators, and principal sponsors of the project gained buy in and approval of the CNL project. The implementation kicks off was completed October 2017. Poster board was visible in the unit with balloons to increase

awareness that the project is currently in full swing. Flyers and tip sheets tucked in the bulletin boards and in mailboxes to advertise the change to improve discharge planning. In the following period from October to December 2017, continuation of the implementation and evaluation of the project, to support and guide the frontline nurses through this change.

Expected Results

The expected results are to have a safe and timely discharge of our patients. This is evident by the increase of actual discharges at 2 pm from 40% to 60%, increase patient satisfaction describing discharge process as excellent from 30% to 50% and reduce readmission rate from 25% to 5%. The realization of these expected results is through the stakeholder's compliance and consistent engagement and involvement in the discharge process with the support and guidance of the CNL, who act as a leader and educator in the microsystem.

Nursing Relevance

Improving the patient's discharge planning by implementing the use of a checklist has numerous significance for the nursing profession. This initiative allows the clinical nurses to be more responsible and accountable for the quality, safe, and timely discharge of patients from the acute setting to the discharge destination. The Joint Commission (TJC) determined that ineffective transitions of care exist. TJC identifies root causes of transitions of care issues include accountability, communication breakdown, and patient education (TJC, 2012). In conclusion, promoting effective discharge planning requires compliance and consistent engagement, communication, and collaboration of an active multidisciplinary team.

Summary Report

The aim of the project is to improve the patient's discharge planning by implementing the discharge planning checklist within the medical-oncology and telemetry unit. The specific goals are to increase the actual releases by 2 pm from 40% to 60%, increase the patients experience regarding discharge process from 30% to 50% and decrease readmission rate from 25% to 5% at the end of December 2017.

The site of the CNL project is at the 56-bed unit that specializes oncology, telemetry, human immunodeficiency virus (HIV) / acquired immunodeficiency syndrome (AIDS), continuous ambulatory peritoneal dialysis (CAPD), palliative and comfort care, and incarcerated patients.

Improving the discharge planning is critically necessary in the microsystem as the assessment revealed a very unsatisfactory staff and patient's survey rating of the discharge. To achieve the goal, the CNL created the discharge planning checklist, identify discharge champions every shift, staff education and support in the implementation of the quality improvement.

Doing small tests of change and including key stakeholders was instrumental. The interventions for improvement was propelled towards the frontline staff through the efforts of the discharge champions led by the CNL. Patient's discharge planning is now one of the priorities of the staff for patient's safety. The department achieved the culture of safety in patient's care. The percentage of the readmission rate and actual discharges from the QI will prove it's worth as well as the result of the patient's survey rating.

The medical unit effective patient's discharge planning will be sustained through the commitment of the healthcare providers involved. The CNL as a team leader,

educator, data analyst, and advocate has helped the various patient population improved the quality and safe transitions. The department will then take the ownership of keeping the patients' safe during transitions of care.

Reference

Center for Medicare and Medicaid Services (2014). Retrieved from: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/downloads/HospiceFace-to-FaceGuidance.pdf

Graham, G., Gallagher, R., & Bothe, J. (2012). Nurses' discharge planning and risk assessment: Behaviors, understanding and barriers. *Journal of Clinical Nursing, 22 2338-2346*

Goncalves-Bradley, D. et al., (2016). *Discharge planning from the hospital*. Retrieved from http://www.cochrane.org/CD000313/EPOC_discharge –planning-hospital

Martin, J., McCormack, B., Fitzsimons, D., & Spirig, R. (2014). The importance of inspiring a shared vision. *International Practice Development Journal, 4*(2), 1-15.

Reed, Julie (2010). Implementing a discharge checklist to improve the quality and consistency of discharges for patients from hospital. Retrieved from http://www.salzburgglobal.org/fileadmin/user_upload/documents/2010-2019/2016/ses

Reinke, Stephanie, and Ranji, Sumant, (2015). Neurohospitalist: Transitional Care Strategies from Hospital to Home. Retrieved from https://www.ncb.nlm.nih.gov/pmc/articles/PMC4272352

Stone AG, Russell RF, Patterson K (2004). Transformational vs. servant leadership: a difference in leader focus. *Leadership Organization Journal*.

The Joint Commission. (2012). Hot Topics in Health Care. Transitions of Care: The need for a more effective approach to continuing patient care. Retrieved from www.jointcommission.org/toc.aspx

Waniga, H., Gerke, T., Shoemaker, A., Bourgoine, D., & Eamrond, P. (2016). The impact of

revised discharge instructions on patient satisfaction. *Journal of Patient Experience, 3*(3), 64-68.

White Paper on the Education and Role of the Clinical Nurse Leader. (2007). American Association of Colleges of Nursing. Washington, DC. Retrieved from http://www.aacn.nche.edu/publications/white-papers/ClinicalNurseLeader.pdf

Wong, E.L., Yam, C.H., Cheung, A.W., Leung, M.C., Chan, F.W., Wong, F.Y., & Yeoh, E. K. (2011). Barriers to effective discharge planning: a qualitative study investigating the perspectives of frontline healthcare professionals. *BMC Health Services Research, 11*, 242. http://doi.org/10.1186/1472-6963-11-422

Appendix A

Discharge Planning Checklist

Expected Date of Discharge:

Discharge Disposition: (Circle one)

Home, Respite, SNF, Board and Care, Residential Facility, & Correctional Facility

Transportation:

Family/Friend, Ambulance, Taxi, Bus Token

Medical:

Lab results, Echo, Attending MD clearance, Discharge Summary per MD

DME:

Walker/Cane/Wheelchair, Splints/Diabetic Shoes, Home Oxygen

Vaccinations:

Pneumonia, Influenza (Mar-Oct)

Consults:

Wound, PT/OT, Case Manager, Social Worker

Belongings:

Safe, Inpatient pharmacy meds, excuse letter if needed

Medications:

TOC pharmacy, Medication Reconciliation, Paper prescription/triplicate for narcotics, outside pharmacy

Discharge Education:

Drain care, wound dressing, appointment, dietary instructions, injection teaching, catheter care, disease specific

Discharge order written (date & time)

Actual patient discharge (date & time)

Comments:

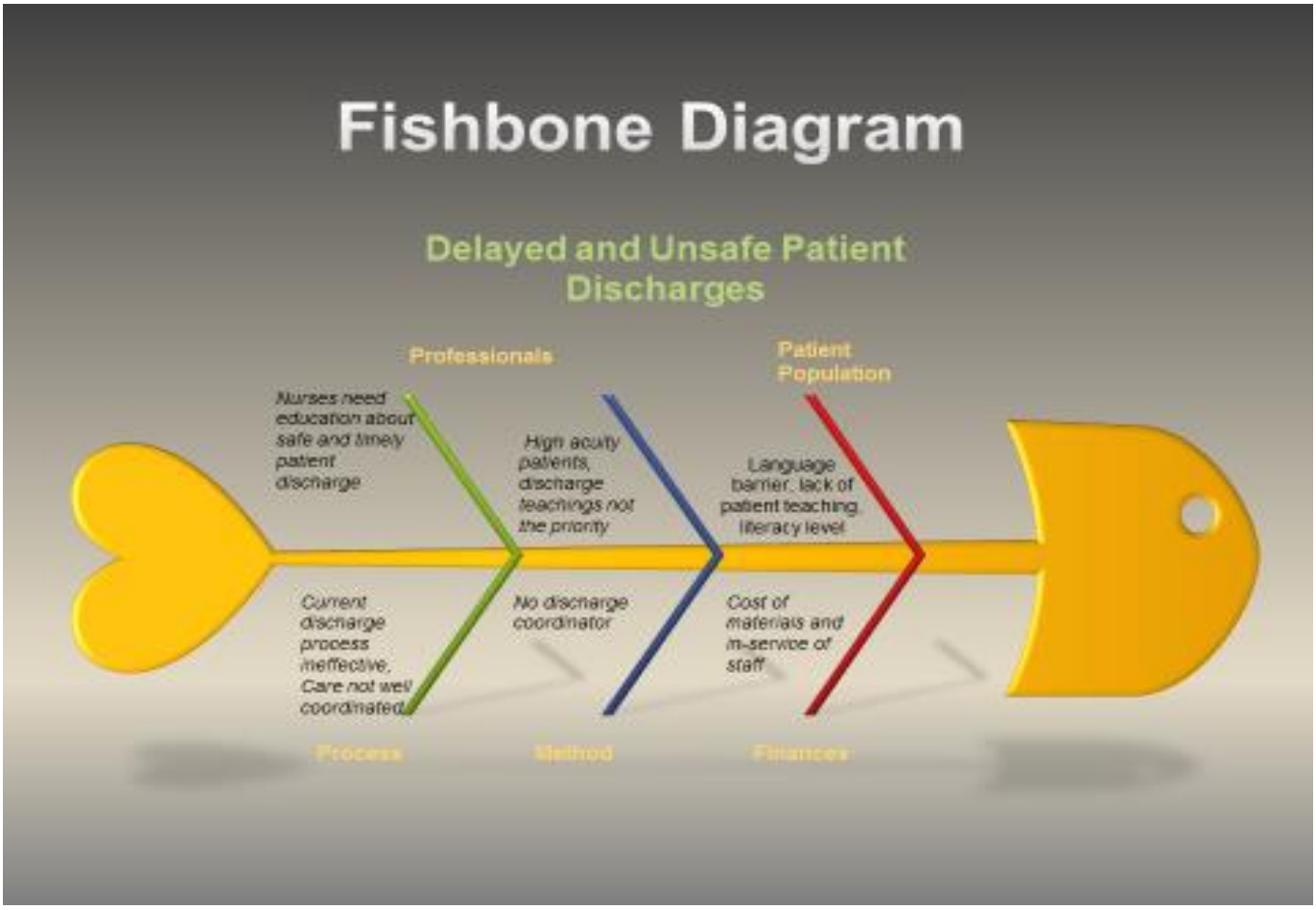
Patient's Name: **MRN:**

Appendix B

MDR COLOR GUIDE
(Discharge Status)

Green 	Patient is ready/cleared to go home today.
Yellow 	Patient maybe going home today with conditions.
Orange 	Patient has 80% chance of going home tomorrow.
Red 	Patient is acute, not ready for discharge.
Silver 	Patient has chronic placement issue.

Appendix C


Fishbone Diagram
Delayed and Unsafe Patient Discharges
Professionals
Patient Population
Nurses need education about safe and timely patient discharge
High acuity patients, discharge teachings not the priority
Language barrier, lack of patient teaching, literacy level
Current discharge process ineffective. Care not well coordinated
No discharge coordinator
Cost of materials and in-service of staff
Process
Method
Finances

Appendix D

SWOT ANALYSIS

STRENGTHS **S** • Management & educators support • CNL support • Teamwork and collaboration of health care disciplines • Committed staff • Data obtained to improve the discharge process	**WEAKNESSES** **W** • Staff resistance to change • Patient cognitive deficits and lack support system • Patient behavior – uncooperative/non-compliance • Staff inundated with paper
OPPORTUNITIES **O** • Improvement in standardizing discharge process through a checklist • Increase in discharge time • Operational efficiency of bed flow • decrease readmission rates • increase patient and family satisfaction in discharge process • decrease length of stay • increase staff satisfaction through a standardized & team effort process	**THREATS** **T** • Lack of time allocated for education and training • Time away from direct patient care • Staff unreceptive to change and education • Loss of reimbursement over low rating of patient satisfaction of the discharge process

APPENDIX E

Cost Analysis

Improving discharge time in medical-surgical, oncology, and telemetry unit cost analysis							
Staffing needs	# of Staff	Hours	Total Hours	Hourly Rate	Hourly Salary	Benefits	Total Salary
CNL role	1	267	267	($ 80.00)	($ 21,360.00)	1.4	($ 29,904.00)
Nurses	120	2	240	($ 60.00)	($ 14,400.00)	1.4	$20,160.00
CNAs	15	0.5	7.5	($ 25.00)	($ 187.50)	1.4	$262.50
Total Staff Costs							$50,326.50
Supplies							$300.00
							$50,626.50
Savings	savings	# Of Pts.	Hourly Cost	Hour Reduced	# of Days*		
		10	$500)	1	270		$1,350,000)
Cost Savings							$1,299,373.50

Appendix F

Gantt chart

	2017							
Description of the process	**Feb**	**Mar - May**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Responsible person**
ID Problem								CNL
Measure Problem								CNL
Engage stakeholders								CNL Discharge champions All stakeholders
Implement the proposed project								CNL Discharge champions All stakeholders
Evaluation								CNL Discharge champions