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Enhancing Discharge Communication for Timely Patient Discharge:

A Quality Improvement Project

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Enhancing Discharge Communication for Timely Patient Discharge: A Quality Improvement Project

Section 1: Title and Abstract

A patient's timely discharge speaks volumes of a patient's quality of care. Discharging a patient from an acute care setting is complicated and quite challenging because of the involvement of the interdisciplinary team for comprehensive and patient-centered care to safely transition from hospital to the home or the community. A delay in discharge is a delay in patient care. A patient deemed appropriate for discharge but has discharge delays points to a system-level problem of ineffective communication and coordination between health team professionals and creates inefficiencies in acute bed usage and therefore, is a patient safety concern (Kochar, 2016; Rojas-Garcia et al., 2018). Poorly coordinated discharge preparation negatively impacts a patient's readiness to discharge, the quality of discharge teaching, and the assessment and identification of a patient's post-discharge needs that affect timely discharge and the overall quality outcomes of care (Opper, Beiler, Yakusheva, & Weiss, 2019). Discharge delays have been associated with a patient's decline in functional ability in performing activities of daily living (ADLs), frailty, increased age, complications, cognitive loss, dependency, and behavior issues (Everall et al., 2019). Valuable information is lost when the interdisciplinary team provides fragmented care.

Breaking the disciplinary silos of care that impacts safe, timely discharge calls for improved communication and coordination of a patient's discharge process. This Clinical Nurse Leader project aims to improve the timely discharge of patients getting discharged from the telemetry department of a moderately sized urban hospital within four hours of discharge orders by adapting estimated discharge date (EDD) on a patient's care board following admission to

identify the “who, what promptly, and when” of discharge. Current discharge practice in this microsystem is the daily triad rounding of a physician, discharge coordinator, and primary RN with the patient the day after admission. This practice, however, is getting missed half the time with only the physician rounding leaving behind the discharge planner or primary RN in the process and the EDD unidentified. With an organized, communicated and coordinated discharge plan, there is a potential of effecting timely discharge and address the delayed discharges negative implications of a patient’s hospital experience like reduced patient satisfaction, increased hospital costs, and decreased workflow efficiency and safety (Peltonen et al., 2015; Rojas-Garcia et al., 2018).

Section II: Introduction

All too often, the health care team’s variation in discharge process has implicated timely discharge resulting to issues like bed-block, workflow delay, errors in care, and decreased patient satisfaction (Chaboyer et al., 2011). The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), measures patient satisfaction by the quality of patient experience through survey following an inpatient stay (CMS.gov, 2017). In evaluating the baseline data of fifty-six total discharges in the telemetry department in two weeks, thirty-two discharges took more than four hours to discharge a patient due to the lack of interdisciplinary communication of a patient’s discharge needs. Reasons for delay were noted to be related to missed DME order, lack of transport arrangement, consults delay, patient’s readiness for discharge, and prolonged pharmacy fill for discharge medications.

Problem Description

Patient care processes related to discharge delays have often impacted patient transitions and interdepartmental transfers. The 24-bed telemetry department of an urban medical center is a

turbulent flow unit with multiple patient turnovers ranging from admissions to transfers and discharges. Patients in this microsystem are usually older adults with a primary diagnosis of sepsis, CHF, stroke, COPD/Asthma exacerbations, altered mental status, alcohol withdrawal, and acute renal failure. A review of the quality department's telemetry discharge monthly data report shows that only 30% of the total number of discharges happen on the dayshift. With the more significant volume of care transitions happening in the afternoon shift between the hours of 3-11pm (see Appendix C), feelings of frustrations and stress among hospital staff mounts up to free up beds and rush discharges that may potentially impact safe patient care and patient satisfaction.

To measure job satisfaction and nurses perceived productivity, the Practice Environment Scale of the Nursing Work Index (PES-NWI) three subscales was used (see Appendix L). A random survey of eleven-afternoon shift nurses show 41% of the nurses perceived there is inadequate leadership and support available; the workload is heavy, stressful, and poorly rewarded. Majority of the nurses (33%) feel there are insufficient staffing and not enough time to complete their work to their level of professional satisfaction. 46% rates satisfaction with the collegial nurse-physician relations. Rojas-Garcia et al., (2018) argues, discharge delay causes stress to hospital staff for several reasons: staff feels pressured and responsible for reducing the patient waiting list for an inpatient bed resulting to unsatisfactory patient care. Feelings of guilt and frustration, not being able to attend to other patients needs because of preoccupation to discharge patients to reduce delay. Also, some reported the adverse reaction of health staff blaming patients contributing to the delay aggravating a patient's adverse reaction to the length of the delay as well, and advertently effecting strained inter-professional relationships.

With the inconsistent and inefficient discharge process called triad rounding with the patient in the unit, there is a disconnect with discharge planning and agreement of a patient's

provisional discharge date. The lack of a standardized process of communication among care providers of a patient's discharge preparation has often delayed the progress of a patient's discharge and often results in poor patient satisfaction and ineffective discharge teaching. The telemetry's HCAHPS score of 82.8 in discharge composite in May (Appendix C, Table 2.1) is below the organizations' performance target of 86.8 providing evidence of patient's dissatisfaction of the hospital's discharge experience.

Available Knowledge

Timely hospital discharge affecting the throughput of patient flow is a problem of many hospitals worldwide. Often, releases are collectively held in the afternoon, causing significant overcrowding in the emergency department created by the mismatch between the demands and available beds for morning admissions and transfers (Mustafa & Mahgoub, 2016). Delayed discharges are costly for hospitals because it leads to an unexpected prolonged hospital stay and inappropriate bed usage that may compromise quality and cost-effectiveness of care (Ou et al., 2009). According to Rojas-Garcia et al., (2018) study, four types of costs are associated with delayed discharge, they are: (1) cost of inappropriate bed occupancy by patients medically fit for discharge, (2) cost related to delays where hospital admissions may occur but beds are still being used by those delayed, (3) cost for nursing employees to make discharge arrangements, and (4) administration cost associated with addressing discharge delays.

Geriatric patients and patients with chronic medical conditions often encounter difficulties in accessing alternative or social care and requires more attention to execute timely discharge (Ou et al., 2009). Insufficient coordination and integration of home and community support care after discharge have resulted in hours, sometimes days in delayed discharges resulting to increased hospital costs and poor patient care outcomes implicating the adverse

effects on both the direct (through increased exposure to hospital-acquired infections) and indirect, secondary to the pressures for a quick bed turnover on staff (Bender & Holyoke, 2018; Gabriel et al., 2017; Hendy, Patel, Kordbacheh, Laskar, & Harbord, 2012; Rojas-Garcia et al., 2018).

Lennard (2014) study suggests vital to effective team collaboration and accommodation of patient issues is the adequate communication and information sharing of a patient's discharge needs. Poor health team communication of patient's pending discharge causes considerable delays because of lack of preparation or time to make post-discharge arrangements and the disadvantage of competing for workload demands (Opper, Beiler, Yakusheva, & Weiss, 2019). Several studies show, a shared situational awareness of a patient's readiness for discharge and the promotion and active engagement of interdisciplinary treatment team in discharge planning would help facilitate improved discharge practice and reduce hours of discharge delay (Chaboyer et al., 2011; Dainty & Elizabeth, 2009; Majeed et al., 2012; & Molla et al., 2018). Moreover, Dainty and Elizabeth (2009) study suggest, the close liaison by all stakeholders in setting patient goals and agreement of the estimated discharge date is crucial to an adequate discharge preparation.

Patients, nurses, and physicians have varying perspectives of discharge readiness, and poor agreement of anticipatory discharge date suggests lack of direct communication concerning the topic (Opper, Beiler, Yakusheva, & Weiss, 2019). While research shows interventions focused on improving discharge communication such as the use of visual prompts or checklist had some success, there needs to be further exploration concerning timing and content of the discharge process (Samuels-Kalow, Stack, & Porter, 2012).

It is crucial to address this issue now to improve enhanced communication and collaboration between caregivers in discharge planning for the potential benefit of reducing discharge delays and avoiding the direct and indirect implications of poor patient outcomes. By improving the health care team's communication of a patient's discharge preparations utilizing the patient's care board for timely recognition of discharge needs (e.g., DME, transport issues, appointment follow-ups, labs, medications, and others). This project aims to discuss the PICO question: adult telemetry patients (P), standardized use of care board as discharge tool (I), variations in discharge process (C), and timeliness of discharge within four hours of discharge orders (O).

Specific Project Aim

The goal of this project is to increase the telemetry department's patients discharge by two pm by at least 10% or higher in the next three months, from July 1 thru September 30, 2019.

Section III: Methods

Improving patient flow requires competent team communication and coordination. Identification of the barriers or its significant influences that causes delays in discharge may help direct efforts towards the improvement of timely discharge and avoidable prolonged hospital patient stay. Due to delayed discharges impacting care transitions and patient care, a microsystem needs assessments were performed to look for opportunities for improvement and growth (see Appendices B, F, G, N for SWOT analysis, driver diagram, fishbone diagram, and process map).

The goal is to improve interdisciplinary team communication of a patient's discharge, by including the EDD on a patient's care board. The EDD will enhance transparent and readily available items needed for discharge information for the sharing of tasks needed to achieve

timely discharge on that date. A team charter of informal frontline leaders, chief hospitalist, director of discharge planners, and unit's assistant nurse managers was gathered to establish the aim statement of the project, its timeline, and the measurements that will be used to track improvement and outcomes. A daily team review of a patient's care board will be conducted the morning after admission during triad rounding (MD, RN, and Discharge Planner) and every nursing shift handoff. A preliminary in-service of the small test of change will be shared among the nursing staff and other critical stakeholders like the hospitalists and discharge planners and regularly shared during shift huddles for a full week before implementation. A red, whiteboard marker pen was provided to each nursing staff and discharge planner during the week of staff education and was instructed to use the red marker to identify EDD on the right lower side of the patients' care board. Each triad rounding and nursing shift handoff, the identified EDD was used as a focal point of discussion. The unit's break relief nurse was tasked to do five daily random audits of patient's care board for the entirety of implementation to check for the written EDD in red. The critical stakeholders like the nursing staff were provided with a review of audit results daily during shift huddles to discuss for any feedback or concerns, while the chief hospitalist and the director of the discharge planners were given audits feedback weekly.

This author will use Kotter's eight-step change model (see Appendix K) for process improvement and will track progress through the quality department's telemetry discharge monthly data report. The discharge monthly data report is pulled from the electronic medical record (EMR) of the unit's daily discharges with information concerning the patient's name, medical record number, diagnosis, discharging unit, name of doctor discharging, date and time of discharge order, time of RN release of the discharge order, time of pharmacy fill, and time of patient release. The Kotter's 8-step process for leading a change theory would provide a

systematic approach in tackling a system change. The theory gives insight into what can drive people to accept change, work towards that change, and sustain the change (Kotter, 2012). The Kotter's eight-step leading change model will help create the stage of change environment and possibly the culture of how discharges are managed and viewed by the healthcare team.

Ethical Considerations

This project follows the ethical principles of respect for privacy and confidentiality. Any identifying patient discharge information has been kept private and confidential. Moreover, all possible measures have been taken to keep the discharge information protected from any potential damage or harm to the patients. The study and interventions implemented in this study have the patients' utmost best interest consistent with ANA's code of conduct for nurses, the obligation of non-maleficence to promote health and optimal patient care (ANA, 2015). The study has the approval and support of the organization's leadership. No conflict of interest declared.

Section IV: Results

Comparison between pre and post-intervention showed a marked improvement from the pre-average discharge time of 5.6 hours (n=336 in May and June) (Appendix D, Table 1.1) the time of discharge order entry to physical discharge, to post average discharge time of 3.5 hours (n=102, July 15-31) (Appendix E, Table 1.1). Moreover, the percentage of patients leaving the hospital on or before 2 pm increased from 31% to 38% (Appendix E, Table 1.2).

A self-developed audit tool (Appendix I, Table 1) was utilized to monitor daily team adherence of using the patient's care board in identifying EDD during triad rounding and RN-to-RN bedside shift handoff. A 75% compliance rate was noted from the daily five random checks of process measures, totaling 80 audits in 16 days.

During the first month of the study period in June, an unforeseen closure of the telemetry unit halted the progress of the intervention. Low patient census prompted the closure to merge with another cardiac monitoring unit on the second floor. The untimely closure, merger of the two units, and unpredictability of reopening the telemetry unit caused the targeted evaluation time to have shorter two weeks duration. The unintended consequence of the merger increased the proposed budget for education (Appendix J), an addition of one-week of training to accommodate for the 105 second-floor nurses. Consequently, decreasing the cost savings of the project.

Section V: Discussion

Key findings of this project are the marked improvement of timeliness of discharge in meeting the goal to physically discharge the patient within four hours of a written discharge order as evidenced by the quality department's data report of telemetry's average time of discharges in the two-weeks of intervention. Integral drivers to a redesigned health communication process of timeliness of discharge are the participation and buy-in of critical stakeholders like the physicians and nurses. The 7% increase of 2 pm discharges suggests that if more than 75% of staff adheres and participate with the redesigned discharge process, a higher percentage of 2 pm discharges would likely happen.

One lesson learned is not to dictate another profession's workflow. The initial plan, do, study, act (PDSA) cycle was to get the physicians to write their discharge orders by 11 am. This process did not go well with the physicians and created a conflict within the team. The physicians would not commit their discharge priorities to the telemetry unit because of a higher order of priority set on the medical-surgical floor twice the size of the telemetry microsystem. With the primary process metric of the discharge order, entry time to physical discharge

challenged, this author looked for other intervention opportunities to promote timely discharge. According to Molla et al. (2018) study, focusing on the physician's discharge order entry time alone undermines effective discharge planning and may not result in the actual physical emptying of beds. Without the comprehensive, structured approach of staff engagement, quality improvement framework, and systems-level approaches, improvements to the timeliness of discharge may not be achievable.

The second lesson learned was the realization that the late entry of a physician's discharge order may not be the real cause of discharge delays. An attitude of blame would have caused enhanced team communication to fail. Eliminating the preconceived notion of blaming another professions' discharge process is probably what made the change successful.

Despite the challenge of temporary closure and relocation of the telemetry unit, a formalized effort to improve existing processes has helped the early discharge initiative to move forward from its original state and integrate the new staff's involvement in the process. With limited time allocation for this study and the unplanned merger of the two units, the results may not accurately reflect the study intervention of the project. The HCAHPS quarterly scores of patient experience on discharge, however, will be a considerable measure to validate the success and sustainability of the project (Appendix C, 2.1, &2.2).

Conclusion

This study supports a significant improvement with the telemetry patients' release time and earlier discharge time compared to its pre-intervention data. The study provided an essential insight that timely discharge can happen with enhanced health team communication, coupled with a structured discharge process. The study also showed despite its limited evaluation time, the simple inclusion, identification, and discussion of a patient's estimated date of discharge on

the patient's care board with team rounding and nursing handoff, improved timeliness of discharge process. The regular use of this discharge communication process has the potential to significantly impact patient and staff satisfaction, as well as contribute to cost savings to the organization (see Appendix J). Further research is suggested to strengthen the results of the project and assess its more prolonged impact without the demographic variations and time constraint factor encountered in this study.

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Appendix A

Evaluation Table

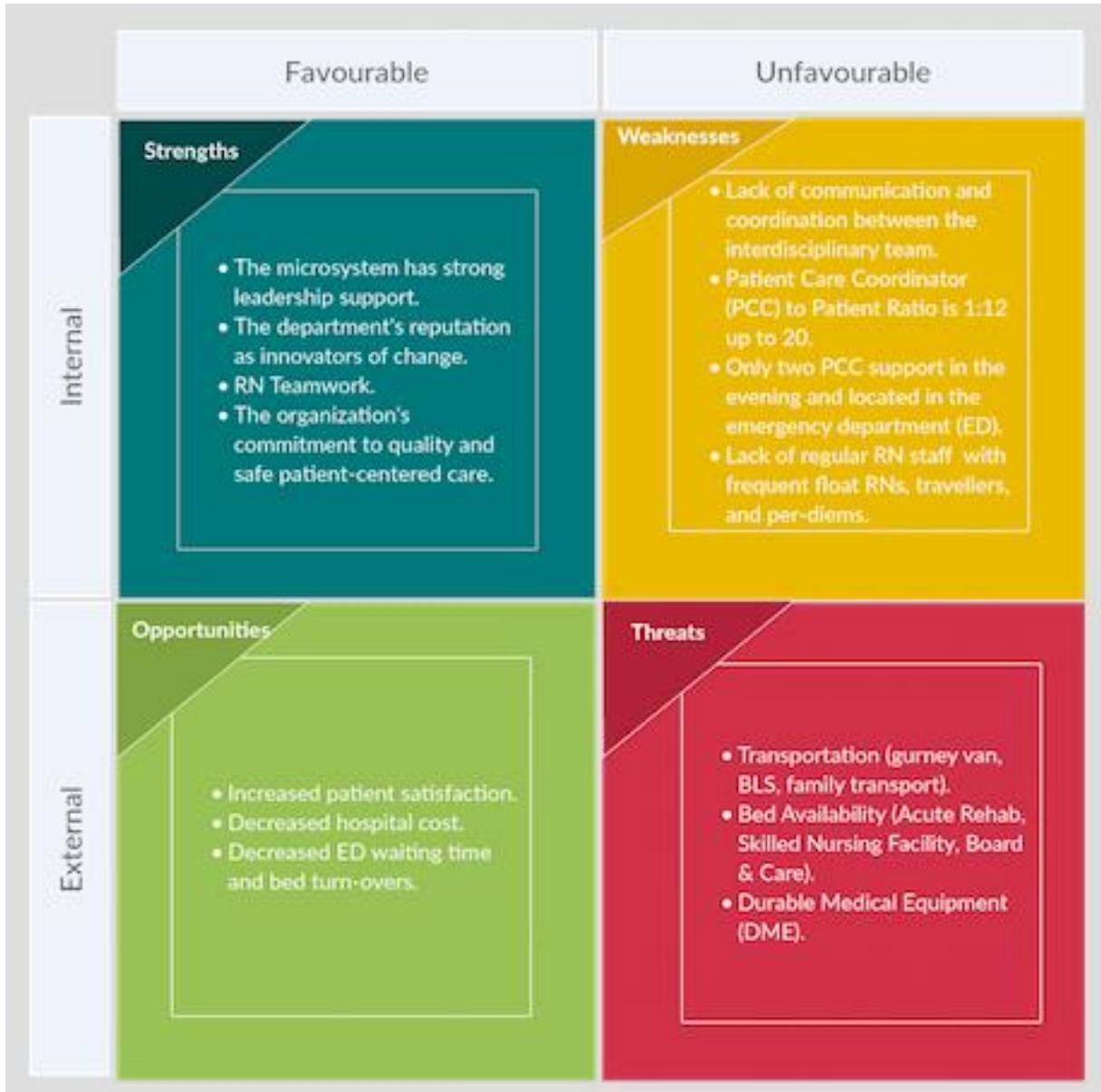
Citation	Theoretical/ Conceptual Framework	Sample	Methods	Measures	Results	Strengths/ Limitations	Discussion
Lennard (2012)	Lean thinking	Total number of staff members unspecified. Setting in an 18-bedded mixed sex adult acute mental health inpatient ward	The adoption of the Productive Ward, Patient Status at a glance (PSAG) board Purpose: Immediate visual information of timely throughput of patients from hospital to home to include estimated discharge date (EDD).	Self-developed audits	Improved communication between teams and more timely discharge of patients.	This is a performance improvement project.	A holistic view that identifies prompt accommodation of issues has the potential to enable order and consistent transition from hospital to home.
Molla et al. (2018)	Lean Six Sigma	Two medical/surgical units at UC Davis Medical Center, each consists of 35 medical	Quasi-experimental	Logistic regression for adjusted odds ratio estimate of binary variables with 95% confidence interval	Significant improvements in time of written discharge orders and patients physical discharge by noon.	Focus of the study was only on medicine patients with nonteaching hospitalist service. Interventions were dependent on	A structured framework with staff and physician engagement is integral to a successful and sustainable early discharge initiative.

		and surgical beds. A total of 4,134 patients from July 2015-February 2016.		(CI) and linear regression for length of stay (LOS) index with a estimate coefficient of 95% CI.		geographic cohorts of physicians to a specific unit.	
Opper, Beiler, Yakusheva, & Weiss (2019)	Melei's Transitions Theory	Health team members (n=105, {pre}, n=95 {post}) from two surgical units of a 536-bed academic medical center in the midwestern United States. Patients discharge experience (n=413 {pre}, n=191 {post})		Logistic regression of readmissions with a matched pre-and post intervention sample. Chi square and t tests for unadjusted pre-and post interventions comparison.	Minimal change in interprofessional communication and collaboration and patients' discharge experience. Decreased readmissions from 28% to 12% (p<.001). Decreased ED visits from 4.4% to 1.5%.	Lack of contemporaneous control group. Only two nursing units tested in a large academic medical center.	There is evidence to link daily interprofessional team bedside rounding and bedside shift report improves the healthteam's discharge communication and reduce patient readmissions.
Everall et al. (2019)	Levac's Methodological Framework	Seven articles included in the scoping review.	PRISMA-ScR guidelines by Tricco and colleagues	Not applicable	Five overarching themes to patient/care giver delayed discharge experience namely: overall	Overall lack of hospital staff's physical and emotional health support to patient/caregivers during discharge	Few studies are available related to patient and caregiver experience of discharge hospital delay.

					uncertainty , impact of hospital staff and physical environme nt, cognitive and physical impairment , lack of participatio n in decision making and the need for advocacy, and the initial disbelief and reluctant acceptance of the situation.	delay.	
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Appendix B

SWOT Analysis



Appendix C

Table 1.1

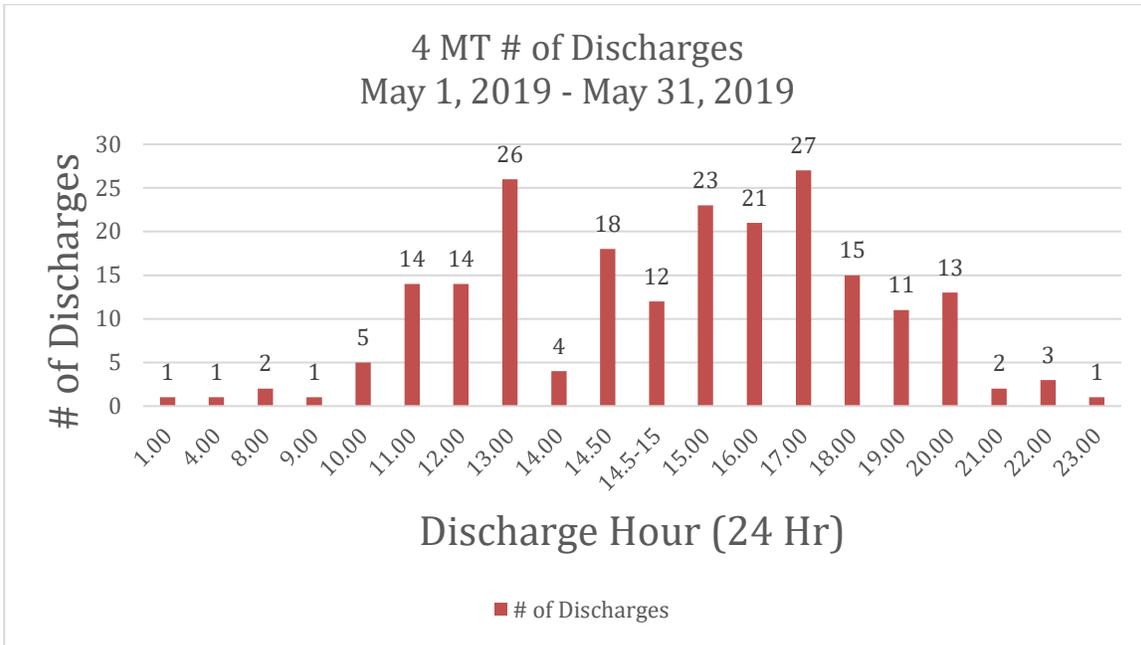


Table 1.2

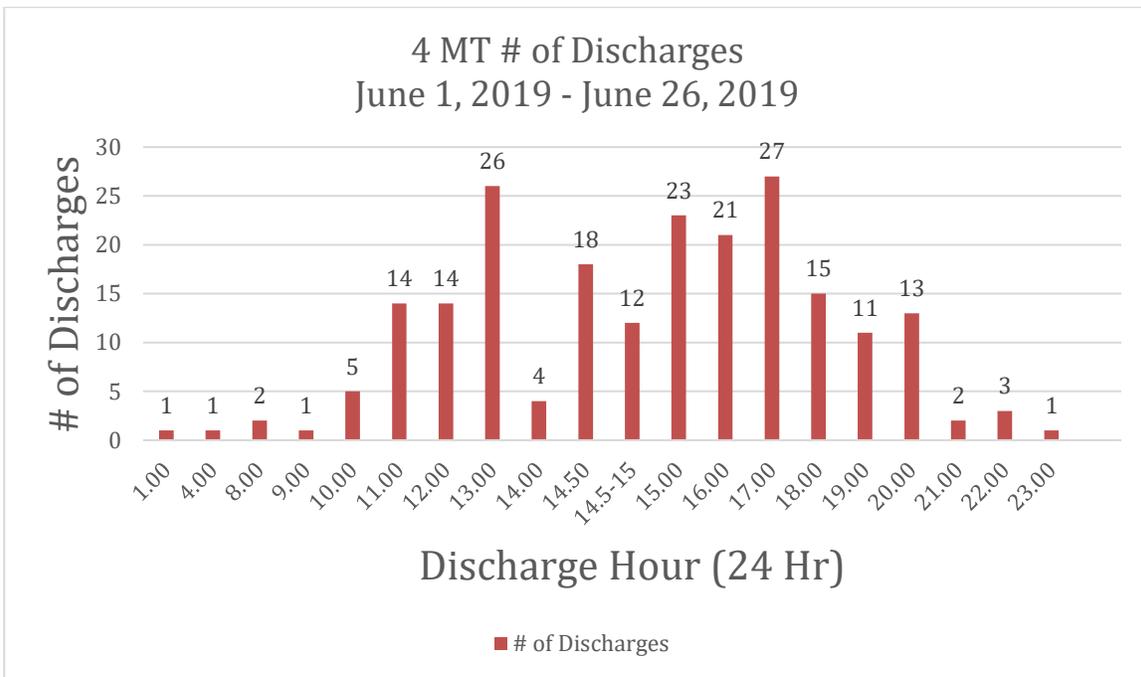


Table 2.1

Antioch - 4 Med/Tele

Data As Of: 7/31/2019

Performance Period: Oct'18 - Sep'19

CARE EXPERIENCE - Linear Mean	Baseline	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
		Close	Open						
HCAHPS: Discharge Info.	87.2	80.1	94.1	93.1	80.0	83.9	79.2	86.7	82.8
<i>Talked About Help You Would Need</i>	85.8	82.4	88.2	93.3	85.0	77.8	75.0	86.7	83.3
<i>Received Info Regarding Symptoms</i>	88.6	77.8	100.0	92.9	75.0	90.0	83.3	86.7	82.4
HCAHPS: Care Transitions	80.0	81.9	81.3	80.8	77.8	83.7	78.6	79.8	80.1

Above Stretch
Between Target & Stretch
Below Target

Table 2.2

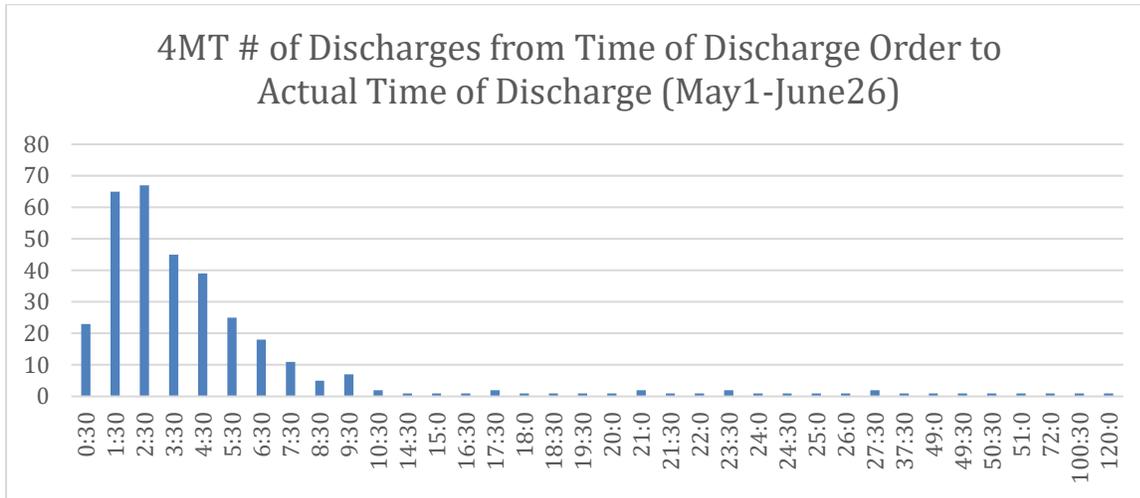
Q4 2018 CMS Cut Points

CARE EXPERIENCE - STAR Rating	Baseline	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
		Close	Open	Open						
HCAHPS: Discharge Info.	3	1	5	5	1	2	1	3	2	4
HCAHPS: Care Transitions	3	3	3	3	2	4	2	3	3	3

5 Star
4 Star
3 Star
2 Star
1 Star

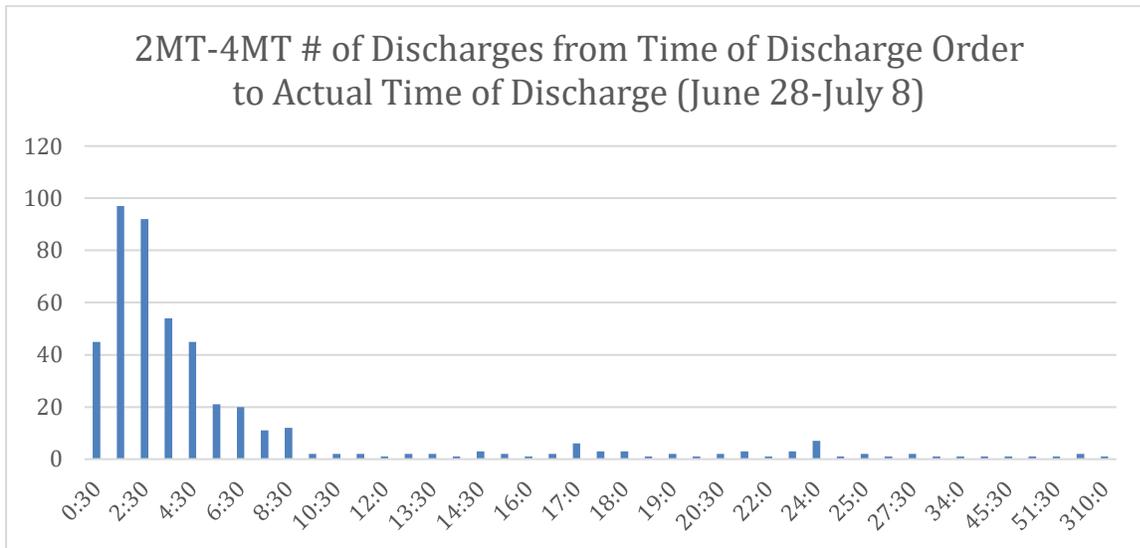
Appendix D

Table 1.1



Average Time (Minutes) 341.5595
 Average Time (Hours) 5.692659

Table 1.2



Average Time (Minutes) 368.0841
 Average Time (Hours) 6.134734

Appendix E

Table 1.1

2 M/T # of Discharges
July 15 - July 31, 2019

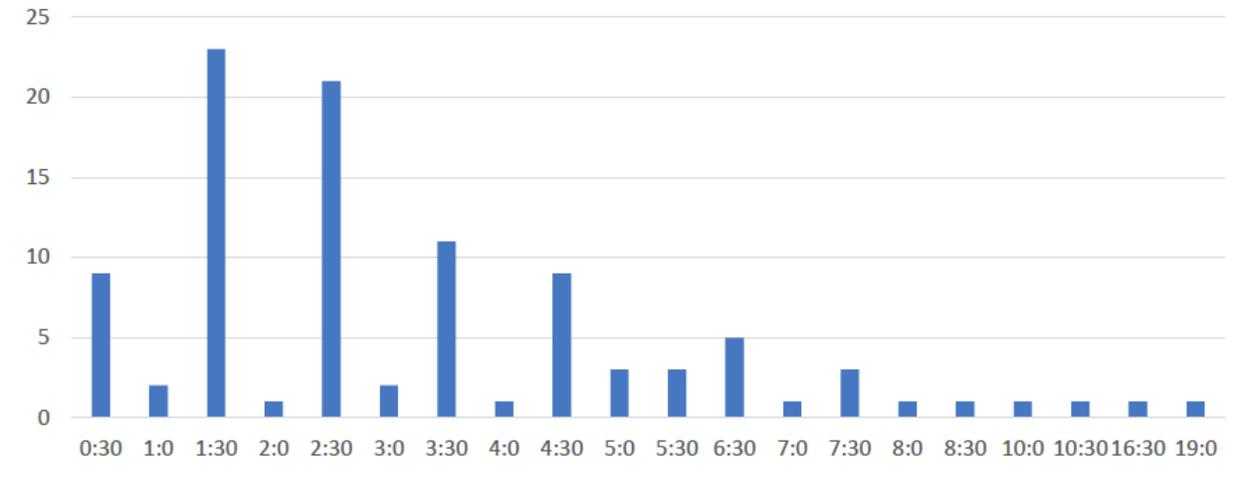
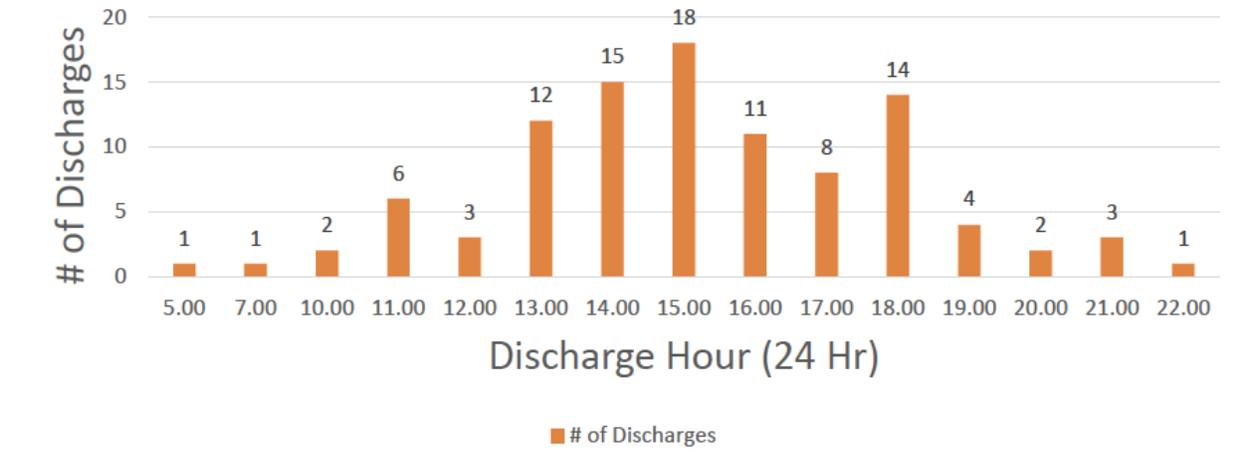


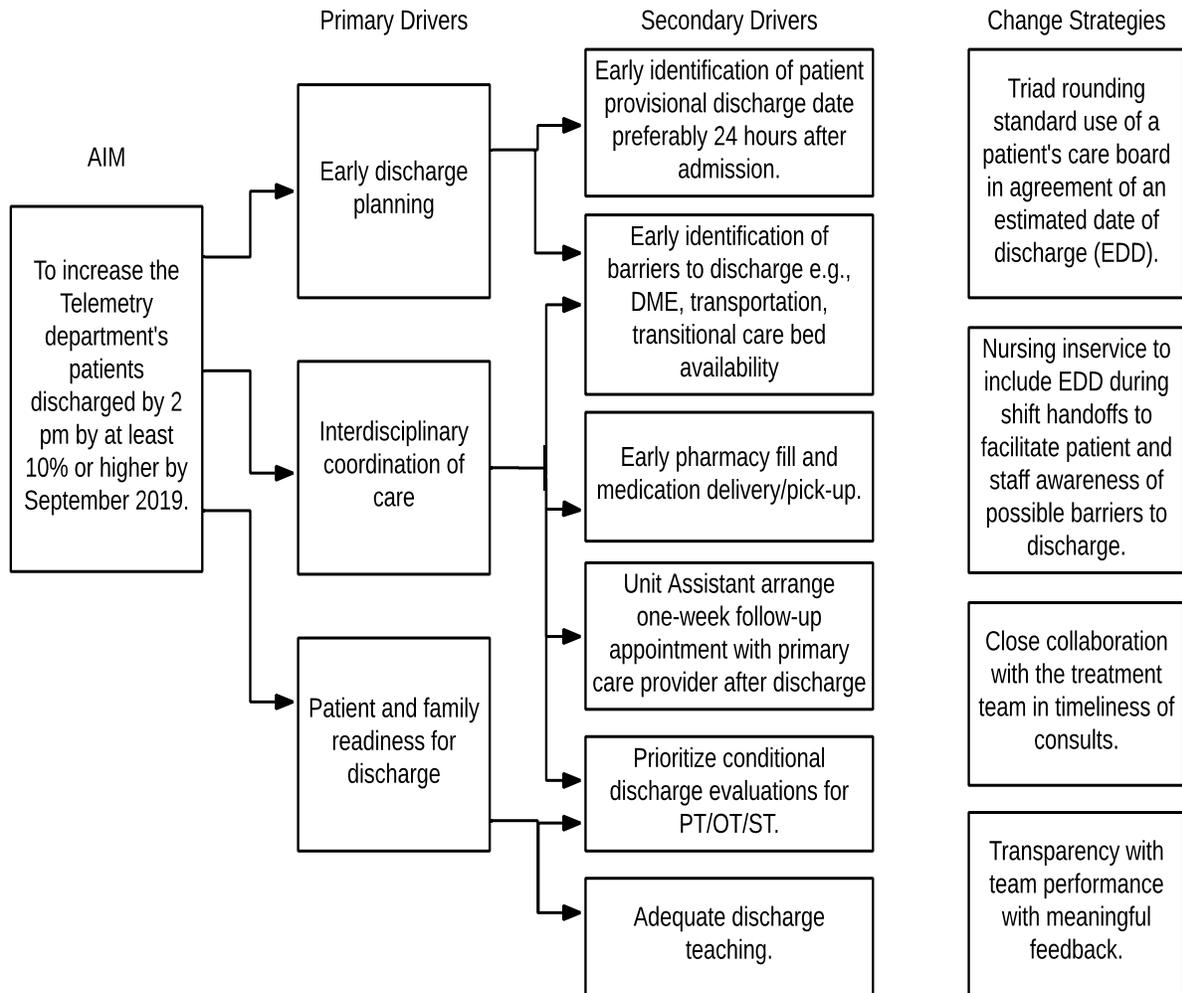
Table 1.2

2 M/T # of Discharges
July 15 - July 31, 2019



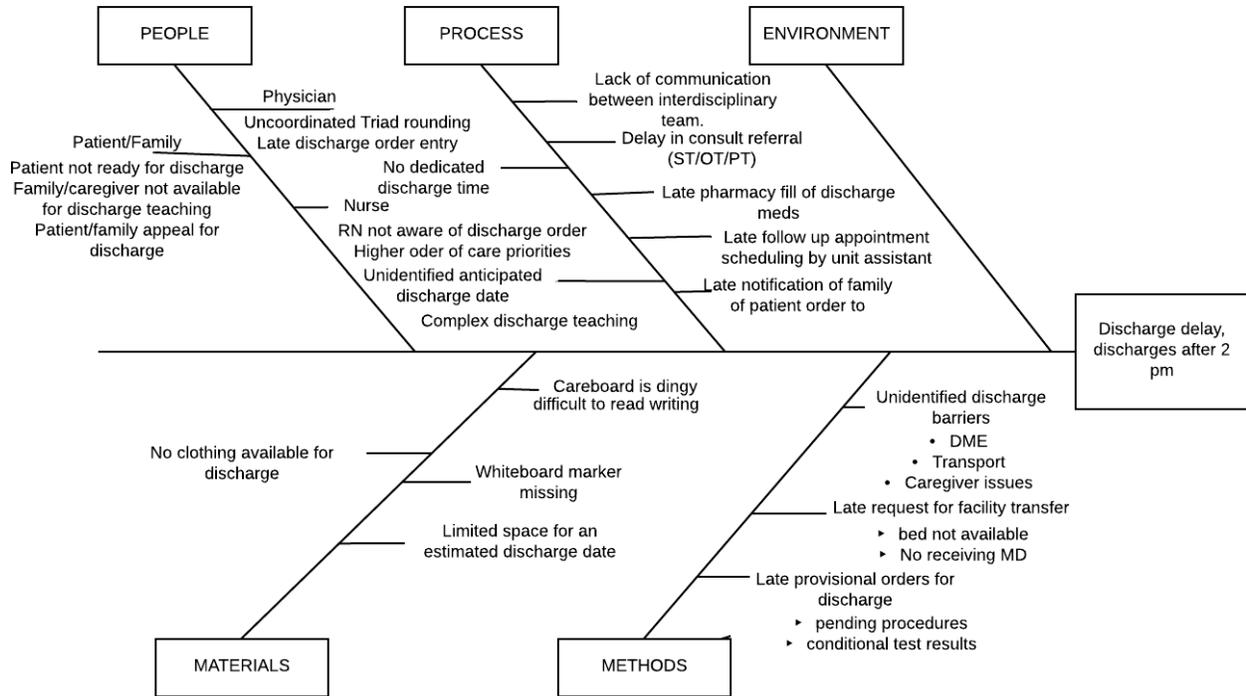
Appendix F

Driver Diagram



Appendix G

Fish Bone Diagram



Appendix I

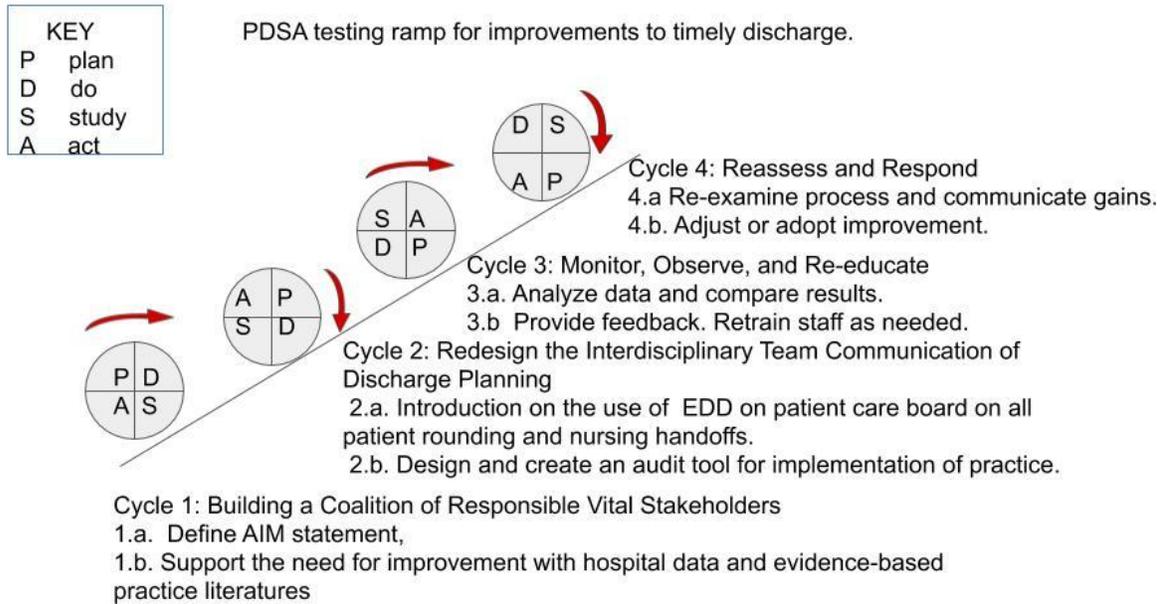


Table 1. Telemetry Audit Tool for Discharge Communication Improvement Project

Patient Room #	Daily Triad Rounding Observed (Yes/No)	RN to RN Bedside Shift Handoff (Yes/No)	Care Board Updated with Estimated Date of Discharge (Yes/No)

Appendix J

Budget

	Actual Annual Spending	Proposed Annual Spending	Annual Savings
Expenses			
Hospital Cost	\$1,752,000.00	\$1,314,000.00	\$438,000.00
RN Labor Cost	\$3,504,000.00	\$2,803,000.00	\$700,800.00
Training Cost	\$0.00	\$42,690.00	-42,690.00
Refresher Training Cost	\$0.00	\$42,690.00	-\$42,690.00
TOTAL SAVINGS	\$5,256,000.00	\$4,202,380.00	\$1,053,420.00

*Proposed budget will save 1RN/shift = 3 RNs/day

** Patient Average LOS will decrease from 4 days to 3 days

Cost Benefit Analysis

Particulars	Number of Staff	Training/Implementation Hours	Hourly Rate	Total Cost
CNL	1	480	\$74.00	\$35,520.00
Registered Nurses	112	0.5 (30 minutes)	\$120.00 (max. average rate to incl. OT & contractual differentials	\$6,720.00
Materials				\$450.00
6 mos. Refresher- Training Cost:				\$42,690.00
Total Project Cost:				\$85,380.00

Average Daily Census (ADC)	RN Per Patient Ratio	Every 4 Patient Discharged = 1RN	Ave. Hourly Rate	24 Hours Savings	Annual Savings
16	1:4		\$80	\$1,920	\$700,800.00
Average Length of Stay (LOS)	Cost of Telemetry Patient Per Day	Number of Patients	Number of Days		
4	\$1,200	1	365		\$438,000.00
Cost Savings					\$1,138,800.00

Cost Savings - Total Cost	\$1,138,800.00 - \$85,380.00
Total Annual Savings	\$ 1,053,420.00

Appendix K

Kotters 8-Steps Change Model

"Kotters Eight Steps of Change"



■ Kotter, John P. and Cohen, Dan S. The Heart of Change. Boston: Harvard Business School Press

Appendix L

Practice Environment Scale of the Nursing Work Index (PES-NWI)

Manager Ability, Leadership and Support of Nurses Subscale (5 items)				
	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
A nurse manager who is a good manager and leader				
A nurse manager who backs up the nursing staff in decision-making, even if the conflict is with the physician				
Supervisors use mistakes as learning opportunities, not criticism				
A supervisory staff that is supportive of the nurses				
Praise and recognition for a job well done				
Staffing and Resource Adequacy Subscale (4 items)				
	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
Enough staff to get the work done				
Enough registered nurses to provide quality patient care				
Adequate support services allow me to spend time with my patients				
Enough time and opportunities to discuss patient care problems with other nurses				
Collegial Nurse-Physician Relationships Subscale (3 items)				
	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
A lot of teamwork between nurses and physicians				
Physicians and nurses have good working relationships				
Collaboration (joint practice) between nurses and physicians				

Appendix M

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT**CHECKLIST ***

Instructions: Answer YES or NO to each of the following statements:

Project Title: Delay Discharges Implications on Patient Care and Well-Being	YES	NO
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	X	
The specific aim is to improve performance on a specific service or program and is a part of usual care . ALL participants will receive standard of care.	X	
The project is NOT designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does NOT follow a protocol that overrides clinical decision-making.	X	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.	X	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	X	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	X	
The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	X	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	X	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <i>“This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.”</i>	X	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does **NOT** meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files. If the answer to **ANY** of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

Appendix N
Process Map

