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Health Care Providers' Use of Nudging with Families of Older Patients Making Discharge Decisions

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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MN, University of Toronto, 2003

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The health care system has focused on reducing costs associated with longer lengths of stay while facilitating safe and appropriate discharges. The purpose of this educational project was to increase awareness among health care providers regarding nudging and how it influences discharge planning decisions by patients and families. Enhancing health care providers' understanding of the impact of discharge communication may address the issue of alternate level of care (ALC). Transition theory was used to frame the project. Practice-focused questions addressed how the use of evidence-based case studies about nudging could improve discharge planning for patients in a large community hospital in Ontario, Canada, and the impact that nudging has on the ALC rate 3 months postimplementation. The project focused on enabling staff to self-identify instances of nudging, strategies, and messaging techniques to use during conversations about discharge planning. Of 48 nursing staff available, 22 participated in at least one of the three educational modules. Descriptive data showed that staff increased their awareness of nudging and developed new strategies to adapt their practice. Concurrent projects in the hospital to reduce the number of ALC patients in the organization may decrease the ALC rate. Through enhanced patterns of response, nurses promote positive social change by helping patients and families feel more confident in their decisions related to discharge and reducing overall cost to both the patient and the health care system.

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Dedication

This project is dedicated to my husband Paul and my sons Timothy and Alexander. If not for your support and patience, this project may not have come to fruition.

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I would like to thank both Dr. Rosalind Olade, who helped guide me on the first part of this journey. Your encouragement and support meant a lot in those early days. I would also like to thank Dr. Robert McWhirt, my committee chair, who kept me motivated to meet my goals in completing this project. A big thank you to Dr. Cheryl Holly, my committee member, who kept me on track with her feedback to make this project the best that it could be.

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Section 1: Nature of the Project

Caregiver burden can be a cause of delayed discharges; however, there is also the aspect of health care provider influences on the discharge planning process. Of interest are the processes of nudging and paternalism, which have become more prevalent in health care as providers seem to influence patients and families to make decisions in line with the thought processes of the health care team (Johnston, 2017). This is a clinical problem seen in alternate level of care (ALC) in Canada. The ALC designation occurs when a patient who is in an acute or postacute care bed no longer requires the level of services provided; this designation starts at the time that it is documented on the patient's chart and ends when they move to the discharge destination for which they have been waiting (Canadian Institute for Health Information, 2018). Higher ALC rates in acute care hospitals can lead to bed flow difficulties, meaning that emergency department patients may wait longer to get an inpatient bed and interventions to resolve their acute care issues may be delayed.

Patients often come into a hospital with premorbid frailty, and changes in health and illness make them more vulnerable (Kuluski, Im, & McGeown, 2017; Meleis, Sawyer, Im, Messias, & Schumacher, 2000) to changes in function, leading to a decision by their family that they cannot return to their previous living arrangement. McCloskey, Jarret, and Stewart (2015) found that most patients in their study were satisfied with the prehospitalization living situation despite safety issues, dependency level, and social isolation. Once these patients are admitted to the hospital, there can be a sudden shift of the families' opinions as to the need for placement in long-term care (nursing homes).

Being designated as ALC places these patients at risk for iatrogenic functional decline, delirium, falls, and infections as services such as physiotherapy are withdrawn so that the needs of the acute or postacute patient can be met (Kuluski et al., 2017). Enhancing health care providers' understanding of how they positively or negatively impact decision-making for families can lead to a more informed discussion to ensure that families can appreciate the options they have regarding discharge. Education on nudging, and how this can influence family discussions, may lead to improved insight for health care providers and create opportunities for them to reflect on their communication skills.

Problem Statement

In current health care systems, the focus has moved toward reducing costs associated with longer lengths of stays while ensuring patients are discharged in the safest and most appropriate manner (McCloskey et al., 2015). There has been an increased focus on the care transitions that occur between inpatient and outpatient settings, often resulting in longer length of stays in the hospital, which increases health-related costs (Lim, Doshi, Castasus, Lim, & Mamun, 2006). Older individuals are often considered to be major health care system users and have been labeled as bed blockers: those whose care needs could be better served in a setting other than acute care (Ronksley, et al., 2016; Victor, Healy, Thomas & Seargeant, 2000). In the Central East Local Health Integrated Network (CELHIN) in Ontario, the projected ALC rate for fiscal year 2018-2019 was 36.3%, which was an increase of 6.3% from fiscal year 2016-2017; this was prohibitive in the CELHIN meeting its 20% reduction of ALC target by 2019 (CELHIN, 2018).

Families have reported that it is important for the patient to be in a setting that better suits the patient's needs, as this allows for the patient to be able to focus on that which is important to them, such as personal space and social activity, things that are not available in the hospital setting (Kuluski et al., 2017). Patients and their families also carry significant guilt about occupying a bed in a hospital when their acute care needs have been resolved (McCloskey et al., 2015). The current project study was conducted to provide an educational approach to addressing the issue of ALC by increasing staff awareness of how their communication with patients and families can influence discharge planning decisions. This communication is particularly important for nurses, who are with patients and families more than any other health care provider due to the 24-hour nature of the role.

Purpose Statement

Understanding the barriers that families face in bringing the patient home may enable health care providers to be more aware of how they discuss alternatives to placement and ensure clarity of discussion. Often these discussions consist of suggesting discharge plans rather than exploring with the patient and family how they envision the support required to meet the patient's needs at home. The literature suggested that although health care teams may have discussed community support available, there may have been a lack of clear understanding of what was discussed, leading to the decision of long-term care placement (McCloskey et al., 2015). A clearer understanding of alternatives may assist families in making a more informed decision that meets the needs of the patient.

Due to a limited amount of literature on nudging and the influence health care providers have on discharge planning decisions, there is little knowledge of the patient's perspectives of how discharge conversations may or may not have influenced them. The literature suggested that many patients feel that the decision to go to long-term care is not made with them but rather for them (Kuluski et al., 2017). This is in keeping with the idea that health care providers direct discharge planning decisions rather than providing support to patients to age in place. The guiding practice-focused questions to address the identified nursing problem were as follows:

1. How does the use of evidence-based case studies about nudging help in educating interprofessional team members to reduce this behavior during discharge planning for patients in a large community hospital in Ontario?
2. What impact will the education of interprofessional team members about nudging have on the ALC rate in this community hospital after 3 months postimplementation?

Nature of the Doctoral Project

The aim of the doctoral project was to generate greater awareness among health care providers pertaining to the concept of nudging as it influences discharge planning decisions by patients and families. The setting for this project was a large community hospital in Toronto, Ontario. The hospital serves many older patients and their families from a diverse population. The project focused on discharge planning in the acute medicine units. In these units there is a significant challenge around discharge planning.

Often these decisions result in long-term care placement, as patients and families are not able to afford the additional care required to keep the patient at home to age in place.

The CELHIN has established the strategic direction of reducing ALC rates across the region. The organization in which this project was conducted identified reduction of ALC rates as part of its quality improvement plan. Initial discussion with managers and directors at the study site indicated an interest in this project.

Evidence collected for this project included ALC data, discharge destination data, and staff attitudes toward the use of nudging through pre- and posttests. ALC is one of the indicators that are monitored as part of the Ministry of Health and Long-Term Care (and Local Integrated Health Network (LHIN) accountability agreements (CELHIN, 2014). These data are received monthly from regional reports to show the trends regarding ALC rates in the region. For discharge destinations, the information is captured by each hospital within the region, and these data are shared quarterly with the senior management, manager, and unit staff through the organization's Lean Six Sigma approach using Tier 1, 2, and 3 huddles.

To obtain the data regarding staff attitudes, a pre- and posttest was used to assess the health care providers' understanding about nudging. Teaching was done using a case study and reflection approach about nudging. Simulated discharge support meetings were facilitated for staff to practice their new knowledge and identify when old patterns of nudging behavior may reoccur.

Significance

Stakeholders in this project included patients, families, health care providers, hospital administration, and community health care providers. ALC designation impacts the care received, as active therapy may be stopped due to the need to focus on the acute patient, which in turn contributes to the functional decline further acquired in the hospital setting while waiting for a long-term care setting (Kuluski et al., 2017). Patients and their families also carry significant guilt about occupying a bed in the hospital when their acute care needs have been resolved (McCloskey et al., 2015). Knowing how to assist families in making discharge decisions may allow health care providers to explain the alternatives to long-term care more effectively, thereby reducing length of stay and ALC rates.

This doctoral project included a type of education for health care providers that had not been attempted. Usual practice in this organization is to place the pressures of discharge planning on the social workers, who then inform the rest of the health care team about what was discussed and the decisions that were made. However, by placing this onus on one group, there can be delays in discussions or a disconnect between what is said by the social workers and what is discussed with families by other health care team members. This can result in confusion for patients and families as they attempt to make difficult discharge decisions. This project can be expanded to other specialty areas in the organization, such as surgery, mental health, and the emergency department.

In the current health care environment in Ontario, the focus has become reducing length of stay and acute care admissions. The CELHIN tracks this as conservable days saved, and the goal for all acute and postacute health organizations is to reduce the

number of conservable days and the percentage of patients who are designated ALC (CEHLIN, 2018). Patients designated as ALC are charged a daily co-payment that is equivalent to the daily rate for a basic bed in long-term care, which can place a significant financial burden on them and their families (Kuluski et al., 2017). These costs are not limited to the co-payment, but also include parking fees, time away from work for family meetings, and fuel costs; these costs can be difficult for families with fewer financial resources, which is common in the catchment area of this organization (McCloskey et al., 2015). By improving communication among providers, patients, and families, some of these costs can be reduced through a shorter length of stay.

Summary

Barriers may be rooted in health care providers' approaches to holding crucial conversations around discharge planning. Facilitating a better understanding of health care providers' behavior regarding discharge discussions may allow for these providers to be more sensitive to the opinions of families in this process. Understanding the drivers behind the decision to place a person in long-term care from the hospital may provide better focus on what these issues are and how health care providers can reduce these barriers. The current project study may assist health care providers in recognizing caregiver burden and being cognizant of their role in discharge discussions.

In Section 2, the background of the issue is provided, including a discussion of the concepts of nudging and paternalism. There is also a discussion of the theoretical framework used for this project. Additionally, the relevance of this project to nursing practice and the local context are discussed.

Section 2: Background and Context

This project was designed to identify how health care providers may use nudging to direct families into making discharge decisions that providers feel are appropriate for the patient, rather than what the patient and family feel is best. The practice-focused questions that guided the study were the following:

1. How does the use of evidence-based case studies about nudging help in educating interprofessional team members to reduce this behavior during discharge planning for patients in a large community hospital in Ontario?
2. What impact will the education of interprofessional team members about nudging have on the ALC rate in this community hospital after 3 months postimplementation?

This section addresses the concepts of paternalism and nudging, and their influence on patients and families. I also discuss the transition theory that was used to frame this project. I review the relevance of this project to nursing practice and to the project site. Finally, I discuss my role in bridging the practice gap in practice.

Concepts, Models, and Theories

Caregiver burden can be a cause of delayed discharges. However, because the decision is often made to admit patients to long-term care settings from acute care, there is a question of health care providers' influences on the discharge planning process. Nudging and paternalism have become more prevalent in health care, influencing patients and families to make decisions in line with the thought processes of the health care team (Johnston, 2017).

Zomorodi and Foley (2009) defined *paternalism* as the meaningful enforcement of actions that may not be within the preferences of the patient under the guise of preventing harm and doing the best for that patient. In the case of discharge planning, paternalism may be as simple as the nurse suggesting to families that their loved ones cannot go home because they need 24-hour care. This would be considered benefit paternalism, which has the intent of creating a good outcome that may not have occurred without intervention (Zomorodi & Foley, 2009). Nys (2009) defined paternalism as the health care provider who intervenes without considering the autonomy of the patient, by performing the intervention without consent or because it is felt that the intervention will be beneficial to the patient. If the health care team presents as the only option for discharge is a long-term care facility without sharing the information of home supports available, this would be considered paternalistic.

Transition theory focuses on transitions from one health care setting to another (Geary & Schumacher, 2012). In transition theory (see Appendix A), there are four concepts: nature of transition, transition conditions, nursing therapeutics, and patterns of response (Weiss et al., 2007). Care transitions are affected by the nature of transitions, transition condition, and the pattern of response and can be related to developmental, situational, organizational, or health/illness factors (Geary & Schumacher, 2012). There are facilitators and barriers that may affect how transitions come about; for example, the family's knowledge about home supports could be a facilitator for discharge home, but knowledge of their limited income could be a barrier to going home as they will not be able to afford the home support required. Process and outcome indicators can also

overlap; feeling connected to family may have to align with making a new identity as a long-term care resident.

Nursing therapeutics affects all three of the components affecting care transitions: nature of transition, condition of transition, and pattern of response (Geary & Schumacher, 2012). How health care providers interact with their patients is based on the decision-making process; although the health care team may continue to work with a patient to reassess their ability to return home, the decision to initiate long-term care papers may have already been made. It is this through this feedback that the nurse can incorporate interventions such as continuous assessment role supplementation and healthy environment to best meet the needs of the patient and family during their care transition (Geary & Schumacher, 2012).

The type, pattern, and properties of the transition are described in the discussion of the nature of the transition. Personal or environmental conditions can be facilitators or barriers to progressing the transition in a therapeutic manner. Nursing therapeutics focuses on promoting healthy transitions, which may be through education to implement new skills for families or supporting patients in adapting to the transition experience. Finally, the patterns of response focus on the patient feeling confident and competent in understanding their limitations, diagnosis, and treatment, and feeling connected with supportive people (Weiss et al., 2007).

In the case of the current practice problem, the transition would be from hospital to long-term care. In the current health care environment, which is focused on reducing acute care admissions and people remaining in acute care beds when their acute care

needs are resolved, the idea of focusing on a way to reduce issues with transitions from the hospital has become increasingly important (Geary & Schumacher, 2012). Health care workers must be aware not to discuss ALC in a way that could project blame on the family, but rather acknowledge the challenges in access to the care required in the community, both through home services and long-term care (McCloskey et al., 2015).

Relevance to Nursing Practice

There is limited literature on nudging and the influence health care providers have on discharge planning decisions, as evidenced by an initial literature review that indicated 11 articles and two systematic reviews by Goncalves-Bradley, Lannin, Clemson, Cameron, and Shepperd (2016) and Jacobson, Gomersall, Campbell, and Hughes (2015). Of the 11 articles reviewed, five focused on discharge delays (Dahl, Johnsen, Saetre, & Steinbekk, 2015; Denson, Winefield & Beibly, 2012; Goncalves-Bradley et al., 2016; Lim et al., 2006; and Victor et al., 2000). These articles focused on the health care setting's need to initiate care planning early to reduce length of stay, but none of them focused on the patient's perspectives of how the conversations may or may not have influenced them. The literature suggested that many patients feel that the decision to go to a long-term care facility is not made with them, but rather for them (Chidwick et al., 2017). This is gap in nursing practice, and this gap in decision-making process in discharging patients often leads to high ALC rates (Chidwick et al., 2017).

Higher rates of ALC mean that there is reduced patient flow from the emergency department to the units; this impacts funding based on emergency wait times. This reduction in funding also means that hospital budgets become tighter, which can result in

workforce reduction as a means of cost savings. Because nurses are a large percentage of health workers, reducing workforce often leads to the organization reviewing its staffing ratios of registered nurses, registered practical nurses, and personal support workers. Poorly planned workforce reductions can result in the loss of productivity and experience, with staff needing to assume the additional work left by the vacancies. This results in staff reporting feelings of overburden, mistrust, and fear that their positions are at risk (Palazzo, 2015).

Increased levels of stress and burnout related to heavy workloads have also led to lower levels of job satisfaction, which can further reduce the workforce as nurses leave the profession (Chau et al., 2015). Workforce reduction impacts health care providers in the ability to provide quality care due to increased workloads. Harmful consequences may occur to patients, staff, and the organization when downsizing plans are too aggressive (Palazzo, 2015). The level of patient safety and outcomes achieved are dependent on the quality of care provided, which is influenced by the number of nurses on the unit (Chau et al., 2015). This can result in poorer nurse-sensitive outcomes such as pressure injury rates, fall rates, and catheter-associated urinary tract infections (Chau et al., 2015). By showing health care providers the influence their conversations regarding discharge can have on their patients and families, providers may become more sensitive to supporting patients and families in the decision-making process.

Local Background and Context

There are 14 LHINS in Ontario, and currently the CELHIN rates 12th in ALC rates (Born & Sullivan, 2011). ALC is a designation that is used in Ontario hospitals for

patients who are admitted in an acute care bed, but no longer need the intensity of acute care services (Canadian Institute for Health Information, 2018). The criteria to be considered ALC include those patients who are stable, at low risk for rapid health decline, and not being considered for any additional diagnoses by the health care team (Canadian Institute for Health Information, 2018). Patients who are designated ALC are charged a daily co-payment as they wait; this can result in a significant financial burden to patients and their families, particularly if they are of a lower socioeconomic status (Kuluski et al., 2017). This financial burden is not limited to the co-payment fee; there are also the costs incurred by family members when they visit, such as fuel costs, parking expenses, and possible time away from work for family meetings (McCloskey et al., 2015). The study site organization has identified reducing ALC rates as part of its quality improvement plan, so the current project study was timely. Initial discussion with managers and directors at the study site indicated an interest in this project; the need will be to secure senior administration support to ensure momentum can be established. The organization determines its quality improvement plan by the direction of the CELHIN, and this plan cascades from the macro level to the micro level of the organization.

Role of the DNP Student

As a nurse practitioner who works in geriatrics within the organization, I have observed the increase in ALC rates over the past 10 years. When looking to address this issue, I took advantage of my experience of participating in family meetings and observing how health care providers have influenced decisions made during these meetings. To develop evidence-based practice projects, researchers should review the

literature to identify possible concepts and their definitions (Zaccagnini & White, 2014). Forsyth, Wright, Scherb and Gaspar (2010) stated that a review of the literature is a necessary component of any evidence-based project and requires a good understanding of research processes. The need to identify levels of evidence is also necessary in evidence-based projects so that the reader is aware that the best available evidence has been used (Forsyth et al., 2010). I was responsible for conducting this literature review to identify potential best practices that could be adapted to this project. Based on this review of best practice, I prepared an educational presentation using different modalities to best meet the needs of adult learners. These modalities consisted of didactic, case study, role playing, observation, and problem-based learning modules.

Summary

Using the transition theory to address how patients and families experience discharge planning discussions, the interprofessional health care team can be educated as to how their discussions can influence decisions. Using evidence-based case studies about nudging provides the opportunity for staff to learn using a problem-based learning modality that better addresses the principles of adult learning in which the learner's experience influences their willingness to adapt new ideas (Preeti, Ashish, & Shriram, 2013). As health care providers become more aware of how their communications about discharge planning impact the decisions made by patients and families, there may be a decrease in the number of patients waiting in the acute care hospital for long-term care. Section 3 includes an explanation of how evidence was collected and analyzed in the project study.

Section 3: Collection and Analysis of Evidence

The way that staff speak with patients and their families regarding discharge can be influenced by their beliefs as to what they feel is best for the patient. Staff may unintentionally nudge families into making decisions that are best aligned with the health care provider's beliefs rather than with what the patient and family feel is best for them. This project study was conducted to develop an interprofessional training package to enable staff to self-identify instances in which they may be using nudging, and to provide staff with strategies and messaging techniques to use during crucial conversations about discharge planning. The training package consisted of evidence-based case studies using a problem-based learning approach so that staff can use their experience to address the problems presented with my guidance as a facilitator to redirect when nudging becomes apparent. Following the case studies, the training package included mock discharge planning sessions to allow for reinforcement of the skills learned in a safe, nonjudgmental environment.

ALC data were provided by the CELHIN on a quarterly basis. A comparison of the ALC data from preimplementation to 3 months postimplementation was used. If the nudging behavior is addressed, there may be a decrease in the percentage of acute care patients who are designated ALC. Section 3 addresses the practice-focused questions, sources of evidence, and the analysis and synthesis plan.

Practice-Focused Questions

ALC rates were anticipated to increase by 6.3% in fiscal year 2018-2019 compared to fiscal year 2016-2017, which would prevent the CELHIN from meeting its

20% target of reduction of ALC by 2019 (CELHIN, 2018). Health care providers may influence patients and families in their discharge decision-making by nudging them toward decisions that align with the health care providers' perspective of what is best for the patient. The purpose of this project study was to provide evidence-based education to the interprofessional health care team regarding nudging and its impact on discharge disposition through problem-based learning using case studies and mock discharge meetings.

The guiding practice-focused questions to address the identified nursing problem were as follows:

1. How does the use of evidence-based case studies about nudging help in educating interprofessional team members to reduce this behavior during discharge planning for patients in a large community hospital in Ontario?
2. What impact will the education of interprofessional team members about nudging have on the ALC rate in this community hospital after 3 months postimplementation?

Postimplementation data may show that discharge planning discussions were viewed by families and patients as collaborative rather than directive.

Sources of Evidence

To implement this project, I reviewed the current ALC data to establish a baseline. ALC is one of the indicators that are monitored as part of the Ministry of Health and Long-Term Care and LHIN accountability agreements (CELHIN, 2014b). Data from regional reports are received monthly to show the trends regarding ALC rates in each

region. For discharge destinations, the information is captured by each hospital within the region. The data from the study site's hospital scorecard are shared quarterly with senior management, managers, and unit staff through the organization's business performance systems approach with Tier 1, 2, and 3 huddles. Tier 3 huddles are at the senior management level, while Tier 2 huddles are with the managers. Unit staff are provided this information during Tier 1 huddles and are tasked with addressing this issue more effectively in their area. By addressing ALC rates on the unit level, the organization hoped to show a reduction in the organization's rate, which would provide the evidence to the LHIN that the organization was better utilizing their acute beds. ALC rates are calculated by determining the number of new patients per month who receive the ALC designation.

A pilot unit for the educational rollout was determined in coordination with the medical program director and professional practice leader for social work, as they are the process owners for ALC reduction. This unit generated high ALC numbers to better determine the effectiveness of the educational intervention. The goal was to teach the interprofessional staff, hospitalists, and nursing staff, particularly those in charge nurse roles.

Case studies were developed in consultation with the professional practice leader for social work to ensure the accuracy and realism of the discharge issues presented. These case studies were presented in a working group format to stimulate discussion per the problem-based learning approach to enable staff to use their critical thinking and knowledge to support their learning. Simulated discharge meetings were held 1 month

after the case studies to allow for staff to reflect on their practice and apply the new knowledge in a safe, nonjudgmental setting. Three months after the completion of the training, ALC data were reviewed again to determine whether there had been any impact on the percentage of patients designated ALC.

Analysis and Synthesis

ALC data are collected by the organization by the entry of an ALC order into the electronic record. These data are collected by the social work department and discussed in weekly organizational discharge rounds. The purpose of the discussion is to ensure that all processes have been followed regarding placement applications and that alternatives to long-term care facility has been discussed. To review the percentage of patients designated ALC, descriptive analysis was used to identify monthly rate trends using SPSS software.

Diversion of ALC patients to their previous living arrangements is also likely to reduce ALC rates. These data are available monthly through discharge abstract data base reporting systems and were requested through the decision support department. Trends in discharge location were analyzed through the SPSS software.

Evidence of improved health care provider communication in terms of discharge planning would show a positive trend in patient satisfaction scores regarding awareness of discharge planning. This is an area in which the organization had received frequent feedback as an area for improvement. Patient satisfaction scores that are generated quarterly through NCR-Picker were reviewed preimplementation and 3 months postimplementation to assess trends.

Summary

Professional deliberation during the discharge planning process in making the decision for transition from the acute care setting has the potential to impact ALC rates and patient satisfaction. Educating staff to avoid nudging and to include the family and patient in this process as part of the evidence-based guideline may reduce the practice gap in this organization.

Section 4: Findings and Recommendations

The purpose of this educational project was to increase awareness among health care providers pertaining to the concept of nudging as it influences discharge planning decisions by patients and families. The following practice-focused questions guided the project:

1. How does the use of evidence-based case studies about nudging help in educating interprofessional team members to reduce this behavior during discharge planning for patients in a large community hospital in Ontario?
2. What impact will the education of interprofessional team members about nudging have on the ALC rate in this community hospital after 3 months postimplementation?

Section 4 includes a description of the setting of the educational pilot study, findings and implications of the educational program, recommendations, and strengths and limitations of the project.

Setting

The educational program was held in an acute medicine unit in a large community hospital in Ontario. ALC data and discharge destination data were reviewed for the 3 months preimplementation for the unit and 3 months postimplementation for the unit with unit leadership. Participants were asked to complete pre- and posttests to assess their knowledge of nudging prior to and following the education provided. The education was then provided using an in-time format to match the availability of the staff on the unit;

this meant that sessions were held in the afternoon, evening, and on weekends. Participation was voluntary, and demographic data were collected.

Demographics

The demographic analysis showed that of the 43 participants in the education program, 39 were nurses who worked on the unit while four were student nurses assigned to the unit. There were 19 (44.2%) registered nurses (RNs) and 20 (46.5%) registered practical nurses (RPNs), as shown in Table 1. The nurses from the unit had between less than 1 year and over 10 years of work experience in the organization; however, 21 (48.8%) of the staff participating in the education did not return the pretest while 31 (72.1%) did not submit the posttest (see Table 2). Although this was not as high a return as had been hoped, it is a fair representation of the staff who attended the education sessions and reflects the staff mix on the unit.

Table 1

Demographic Data

Variable	Number	Percentage
Designation		
RN	19	44.2%
RPN	20	46.5%
RN student	4	9.3%

Table 2

Pre- and Posttest Years of Experience

Years of Experience	Pretest	Posttest	Pretest	Posttest
Less than 1 year	9	2	20.9%	4.7%
1-2 years	2	6	4.7%	13.9%
3-4 years	1	1	2.3%	2.3%
5-10 years	2	1	4.7%	2.3%
10+ years	8	2	18.6%	4.7%
No response	21	31	48.8%	72.1%

Data Collection

Staff were invited to complete the pre- and posttest either on paper or online using Microsoft Forms without identifying information to maintain anonymity. The pretest (see Appendix B) consisted of nine items that focused on demographics such as length of time at the organization, current job role, knowledge of discharge planning, and knowledge of nudging. Paper forms were left on the unit in the nursing staff room with a collection envelope to return them. The online forms were submitted directly to Microsoft Forms, which collated the data. There was no opportunity to identify the participants.

The first pretests were sent in early April 2019. Due to low responses, the pretests were sent out again in early May, early June, and mid-June until the liberal conditions for response based on sample size of 35% was met (see Nulty, 2008). The total number of pretests received was 22 out of 48, a return rate of 45.8%, which exceeded the liberal conditions of response target of 35% (see Nulty, 2008).

The education sessions were designed based on the pretest responses and delivered in a just-in-time format to be cost neutral due to budgetary limitations that prohibited pulling staff from the unit for an off-unit in-service (see Appendix C). The

lesson plan was developed using Kolb's experiential learning theory as it allowed for a structure to the education while considering the learning cycle (see Healey & Jenkins, 2000). Just-in-time learning is designed to provide education at the time and place most convenient for staff, not the provider (Cho & Schmelzer, 2000). The advantage of just-in-time learning is that it allows for the education to include multiple modalities for shorter periods of time.

The first block of education sessions, which explained the concepts of nudging and included examples, was a 20-minute didactic in response to the pretest that showed only 15.6% of staff who responded were familiar with this term. Fourteen sessions were offered at various times throughout the week, of which six were canceled because of conflicts on the unit. These conflicts included unanticipated staffing shortages, high patient acuity that prevented staff from participating, and other urgent education sessions that were required by the organization. Education sessions for the current project started in August and ran until a minimum of 50% of the staff had attended. Total staff attending the first session was 25 out of 43 (58.1%) nursing staff; none of the interprofessional team attended. This could have been due to improved availability of nursing staff for sessions that were made available at 10:00 p.m. and on weekends, when interprofessional staff were not available. Participant attendance ranged from one to seven staff per session.

The second group of sessions consisted of a 20-minute problem-based learning module to build on the understanding of the first module and pull in staff experience and knowledge. Problem-based learning allows staff to integrate new knowledge into practice

through guided discussions about realistic case studies (Agussalim, Setyosari, Kamdi, & Dasna, 2019). There were two case studies available that were alternated between groups of staff randomly. These cases were first vetted through the professional practice leaders for social work and physiotherapy/occupational therapy for their appropriateness. The cases had been used for other education related to discharge planning and had been found to be realistic regarding the types of issues that the organization faces on a regular basis. Nine sessions were offered at various times throughout the week, and three were canceled due to unanticipated staff shortages. These sessions were held in September and ran until a minimum of 50% of the staff had attended. The total number of nursing staff attending the second session was 26 out of 43 (60.5%). Participant attendance ranged from three to seven staff per session.

The final group of sessions, which was originally slated to be a simulated discharge meeting, was switched to a discharge video from the United Hospital Fund (2012) in response to staff wanting the option to be able to view this on their own or in a group setting. This video was vetted through the professional practice leaders for social work and physiotherapy/occupational therapy for content. One professional practice leader expressed concern that the video could be construed as a caricature of what could happen on a unit with a very dysfunctional team, but that the video could work if the intention was to highlight things that could be done wrong. Initial response by the nursing staff was that the video was very realistic to a case currently on the unit. There were 11 20-minute sessions offered, of which four were canceled because there was unanticipated staff shortages or high patient acuity on the unit. These sessions were held in November

and ran until a minimum of 50% of the staff had attended. A total of 24 out of 43 (55.8%) nursing staff attended the final sessions. Staff participants ranged from one to six staff per session.

The posttest (see Appendix D) included the same nine questions from the pretest and an additional question to address the synthesis component outlined in Bloom's taxonomy. The first posttests were sent out at the start of December 2019. Due to low response rate by the initial deadline, they were sent out again at the end of December 2019. Weekly reminders were sent through January 31. There were no paper copies returned despite staff requests to have these available. The final number of posttests received was 12 out of 48 (25%). Key questions that were reviewed to determine the direction of the education sessions were as follows: (3A) Do you feel that health care providers have a responsibility to direct discharge discussions? (3B) Do you feel that patients and families have all the information required to make safe discharge decisions? (3C) Have you ever had a family want to pursue a long-term care application because they were told by a health care professional that they should? (4A) Have you heard of the term nudging? and (5A) Do you feel that health care providers use nudging to influence discharge decisions? The responses to these questions were used to develop the didactic presentation, particularly because only 22.7% of respondents had heard of the term nudging (see Table 3). I determined that the didactic was necessary to start the educational series because the case studies and discharge discussion video would have little meaning if the staff were unable to identify what nudging meant.

Table 3

Pretest Responses

Question	Yes (%)	No (%)	Not sure (%)
3A	17 (77.3%)	0 (0%)	5 (22.7%)
3B	9 (40.9)	9 (40.9%)	4 (18.2%)
3C	11(50.0%)	11 (50.0%)	0 (0%)
4A	5 (22.7%)	17 (77.3%)	0 (0%)
5A	7 (31.8%)	2 (9.0%)	13 (59.1%)

The response rate for the pretest was 45.8%.

Findings and Implications

Of the 43-nursing staff, 11 (25.6%) attended all three sessions, 10 (23.3%) attended two sessions, and 22 (51.2%) attended only one session (see Table 4). Staff gave positive verbal feedback following each session. Of particular interest were some of the responses regarding the problem-based learning modules, which warrant further study. Comments made about fear of providing the wrong information or overstepping professional boundaries affirmed the idea that nurses sometimes feel restricted in their ability to influence outcomes related to discharge. Nurses reported that they should not overstep in providing information due to a fear of not knowing the correct information or because they do not want to upset the team member whose role they feel it is to supply information. In keeping with the findings of Zaforteza, Gastaldo, de Pedro, Sanchez-Cuenca, and Lastara (2005), those who control the information control the power in the staff's opinion. If the information is related to social supports, only the social worker can provide it; if the information is related to medical follow-up, only the physician can provide it. According to Zarfortez et al., this is a long-standing norm in health care, so it

was not surprising that this behavior was observed during the education provided in the current project.

Table 4

Staff Attendance by Designation

	Session 1	Session 2	Session 3	All 3 sessions
RN	13	10	12	5
RPN	11	13	12	8
Student	1	3	0	0
Total staff	25	26	24	13

During the pretest, only four of the 22 respondents (18.2%) attempted to answer the question "what is nudging?" Only two themes were evident in the pretest: influencing and providing information. Under the influencing theme, responses included phrases such as "influencing decision making," "influencing behavior," and "influencing family members." Under the providing information theme, there was only one response that suggested that "input and information is provided during unit rounds to pave the way for a healthy discharge plan."

For the posttest, 10 of the 12 respondents (83.3%) were able to respond to the question "what is nudging?" Two additional themes emerged: insinuation and persuasion (see Table 5). This suggests that participants may have been better able to identify the negative aspects of nudging despite having been provided positive examples during the education. In the original theme of influencing, responses included terms such as "guiding decision making," and "using indirect suggestions." In the original theme of providing information, the phrase "using professional knowledge to assist families" was

evident. Under the new theme of insinuation, nudging was identified as “inadvertently insinuating,” “powerfully suggesting,” and “comments that subtly indicate.”

When asked to describe how nudging can be used to influence discharge decisions, 11 (50%) of the pretest participants were unable to answer, while only two (16.7%) of the posttest group were unable to respond. Of the responses collected for this question, there were four themes identified: influence, respect, nurses’ preference, and information. Under the influence theme, comments included “being careful of what we say and how it’s said,” “conversation can be taken out of context,” “old age elderly who live alone,” “sometimes it can be done hastily,” and “undermining diagnosis so the patient won’t think it’s serious.” Under the respect theme, comments included “respecting abilities and decisions,” “explaining to families,” presenting choices,” “sharing patient and family concerns,” and “decreasing family anxiety.” In the nurses’ preference theme, there was only one comment that suggested “putting a better light on the options you prefer.” The information theme included “encourage use of available resources,” “health care providers can teach patients and families,” “descriptions of other options,” and “possible alternative solutions.”

As part of the evaluation of the learning, staff were asked the additional question of what they would do differently in their practice based on the education provided. Of the 12 respondents, four (33.3%) responded they would not change their practice. Of the remaining eight responses, four themes emerged: information, discussions, advocacy, and awareness. Responses related to information included a suggestion to provide an information sheet on discharge for those new to community services. Responses related

to discussions included comments such as listening to the concerns of the patient and their families and reviewing informal support systems prior to discussing discharge plans. Respondents who planned to be more of an advocate wanted to encourage families to express how they truly felt about discharge proposals, encourage additional discussions and alternatives, and proactively collaborate with the health care team. Two staff identified the need to be more aware of the language used around workload and avoiding making judgmental comments to families about the care load of the patient.

Table 5

Posttest Results

Question	Yes (%)	No (%)	Unsure (%)
3A	11 (91.7%)	0 (0%)	1 (8.3%)
3B	5 (41.7%)	7 (58.3%)	0 (0%)
3C	6 (50.0%)	6 (50.0%)	0 (0%)
4A	8 (66.7%)	4 (33.3%)	0 (0%)
5A	9 (75.0%)	0 (0%)	3 (25.0%)

Discharge destinations between preproject and postproject showed some variation. Before this project was conducted, 64% of patients returned home or home with support. In the three months following the project, 68.5% patients returned home or home with support. Where there was a difference between those discharged to residential care/group homes/supportive housing; 11.8% were discharged to these locations prior to the project while only 1.3% were discharged to these locations following the project (see Table 6). The education may have influenced the number of patients becoming ALC, but it must be recognized that other organizational efforts put in place during the current project, such as discharge rounds, improved access to transitional care in another

organization, and the promotion of enhanced short-term community supports offered by our community partners may have also contributed to the decline in numbers seen.

Table 6

Discharge Destination

Discharge Destination	Pretest	Posttest
Home with support	32.9 % (109/331)	33.1% (102/308
Private home	31.1% (103/331)	35.4% (109/308)
Inpatient care	9.1% (30/331)	13% (40/308)
Residential care	10.3% (34/331)	1.3% (4/308)
Group/supportive housing	1.5% (5/331)	0% (0/308)
Against medical advice	1.2% (4/331)	0% (0/308)
Expired	10.9% (36/331)	0% (0/308)

ALC data before the project began showed the pilot unit had an average ALC rate of 24.5%. The average ALC data for three months following the completion of the education sessions showed 22.7% (see Figure 1). This showed a downward trend for ALC numbers. While this trend cannot be attributed solely to this project because of numerous organizational initiatives implemented to address ALC globally, the combined results of all initiatives did result in positive outcomes.

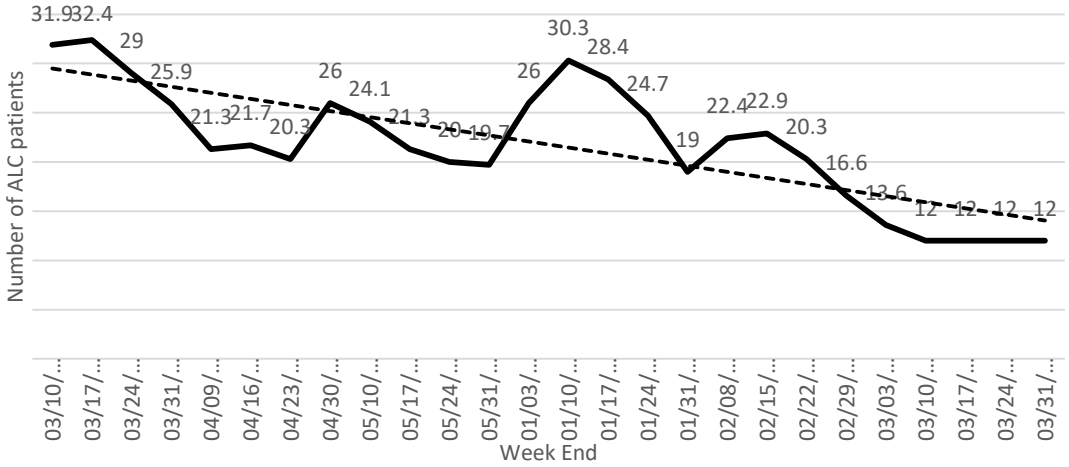

Figure 1. Number of ALC patients per week.

Patient satisfaction scores were captured for the entire organization as part of the strategic plan monitoring, therefore only one question from the NCR Picker survey for medicine inpatients was used: “Did you receive enough information from the hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?” (SHN, 2019). The baseline for this data in fiscal year 2018-2019 was 74.6%, with a target of 80.7% (SHN, 2019). In September 2019, this score was 75.0% (SHN 2019). By November 2019, this has increased to 76.7% (SHN, 2019). The patient satisfaction for the organization improved by 2.1% from baseline. This cannot be attributed solely to this project as the data were not specific to the pilot unit, nor is there satisfaction data specific to the pilot unit available at this time. Overall results, however, are encouraging.

Strengths and Limitations

The use of varying educational approaches was a strength in this project as the learning needs of the staff could be better addressed. Nurses are adult learners. It is

necessary to consider learning styles and life experiences when developing education so that nurses can develop a better understanding of why the education is required (Conner, Richardson, & Murphy, 2018). The use of case studies and video critique allowed the staff different opportunities to apply the didactic component of the teaching in identifying incidents of nudging, strategies to prevent nudging, and alternatives to placement for discharge planning. This allowed for the application of evidence-based practice (Conner, et al., 2018). The use of didactic sessions, case studies and video critique addressed the learning categories of visual learning using video, auditory learning through didactic sessions, and kinesthetic learning using case studies. Reading/writing learning was utilized throughout by the provision of hand outs for staff to review later (Sanchez & Cooknell, 2017). One of the potential weaknesses was that the education provided in the visual learning met the needs of a staff member who does better with kinesthetic version, however it is hoped that the material was still found to be engaging regardless of the learning technique employed.

Just-in-time learning strategies better met the staff's availability for education, as it is considered to be a means to provide education that is relevant to staff at the time it is required (Jamu, Lowi-Jones, & Mitchell, 2016). However, it also prolonged the length of time it took to achieve a 50% attendance for each module because of uncontrollable issues such as staffing shortages and increased patient acuity. Providing the education on the unit, considered to be place-based learning, can also affect how the staff respond to the teaching provided, as the location of education can be a trigger for how staff learn (Zamfir, 2019). Teaching on the unit can make education session feel rushed; there is

competition with nursing tasks such as medication administration and with call bells ringing; this increased the risk that the learning was not well absorbed, but given a cursory amount of attention to simply get through the education.

Recommendations

To spread this education on nudging, it would be ideal to have a designated four-hour session away from the unit where more time can be spent in holding discussion regarding the education. For example, it is preferred to have two groups work on different case studies and present back to each other to generate further ideas and discussion regarding strategies to avoid nudging. This would prevent the competition of call bells and nursing tasks that created a need for shortened sessions. This would require the securement of funding to cover the staff both for the education and backfill to ensure the unit has adequate coverage for patient care. While it would be ideal to have this education as part of the organization's general orientation, it may not be plausible at this time as the process is currently being reorganized. Instead, the education could be integrated into the unit orientation to introduce these concepts to new staff.

Interprofessional team involvement in these sessions would bring a different worldview to the discussions held, increasing the understanding of each other's roles. Discharge planning involves all health care professionals, and by working together through case studies and video critique, the communication between these professions can be improved as well as further enhancing clinical thinking skills by hearing a different perspective to the issues that present themselves during the discharge planning process (Smith, Keiser, Turkelson, Yorke, Sachs, & Berg, 2018).

Ongoing discussions in unit huddles on a monthly basis would allow for monitoring of the maintenance of the new behaviors. These huddles are attended by nursing and the interprofessional team.

Summary

The purpose of this educational project was to increase staff awareness of nudging as it influences discharge planning decisions by patients and families. Of the 48-nursing staff available, 22 participated in at least one of the three educational modules. Data were analyzed using SPSS. Staff demonstrated increased awareness of nudging and developed new strategies on how to adapt their practice. Concurrent projects in the hospital to reduce the number of ALC patients in the organization prevents a definitive statement that the education impacted the ALC rate. In the next chapter, a proposed sustainability plan will be shared as well as a reflection of self and final summary.

Section 5: Dissemination Plan

ALC rates have become a significant barrier to acute care services across the CELHIN. Health care professionals have a role in reducing these rates, which can be achieved by knowing the impact their discussions have on patients and families making discharge decisions. Section 5 includes a self-analysis, the proposed dissemination and sustainability plan for the study site institution, and a summary.

Analysis of Self

Completing a DNP project can be difficult in an acute care setting due to the competing priorities found daily on the unit. These priorities can be impacted by staffing levels, patient acuity, and other hospital-focused improvement initiatives deemed necessary by senior management. During the current project, there were several times when the scheduled education session had to be postponed despite confirming it with the unit management because an organizational priority had taken its place. Because the nurse practitioners are separate from the educator group, there is not always an awareness of what these organizational priorities are because they are not shared among these professional groups. This conflict delayed completion of each education module. This was frustrating at times because effort had been made through email and telephone discussions to clear the day and time of the sessions with the educator and unit manager.

Another difficulty was the pervasive “it’s not my role” attitude of the unit staff regarding discharge planning. Nursing staff voiced the concern that they did not want “to overstep” the roles of other interprofessional staff; however, what they did not appreciate was that they have these discussions informally with their patients and families every

day. Nurses understand that they are one of the only professions that are on the unit 24 hours per day, but they do not understand that they may influence decisions of patients and families through these informal discussions. A significant amount of discussion was required to review how nurses can impact these discharge discussions, but a few of the staff may not have evolved in their thinking regarding their role in these discussions. The education project indicated some growth in the staff's beliefs about their role in discharge planning as seen in the posttest results. Further research on staff's attitudes toward discharge planning would be warranted to clarify the barriers surrounding discharge.

Dissemination and Sustainability Plan

A summary will be provided to the medicine clinical services group and the social work group during their monthly meeting. Initially only one medicine unit was used for the project setting and was identified because it had the largest number of ALC patients. Next steps would include presenting this project to the remaining medicine units because this is where the highest number of ALC patients are generated in the organization.

With additional discussion, the information obtained through this project may be integrated into the discharge planning portion of the organization's staff orientation using the materials developed. The material may need to be adapted to align with the current orientation format; however, this is achievable by reducing some of the didactic material and transferring it to the case study or video analysis portions of the presentations. This project may raise awareness among staff regarding the use of nudging and their conversations with patients. An abstract will be submitted to the Gerontological Advanced Practice Nurses Association's annual conference to reach a large audience of

nurse practitioners working in a variety of health care settings. An abstract will also be submitted to the regional geriatric conference in Ontario.

Summary

The development of an education program to increase awareness among health care providers regarding the concept of nudging as it influences discharge planning decisions by patients and families was meant to improve the communication between nurses and patients. A future project could address staff's perception of their role in discharge planning. The attitude of "it's not my role" may prove to be a barrier in discussions held with patients and families in off hours when the rest of the interprofessional team is not available. The anticipated outcome is that staff would increase their knowledge of nudging and be able to identify possible incidents of nudging as well as how to avoid nudging. Increasing the nursing staff's ability to identify possible nudging and how to avoid it may enable them to provide appropriate information on discharge supports and options with less risk of influencing the decisions made by patients and their families. This aligns with the transition theory in minimizing barriers that can negatively impact nursing therapeutics or transition conditions. By enhancing the patient and family patterns of response in a positive manner that does not include nudging, nurses can help patients and families feel more confident in the decisions they have made related to discharge.

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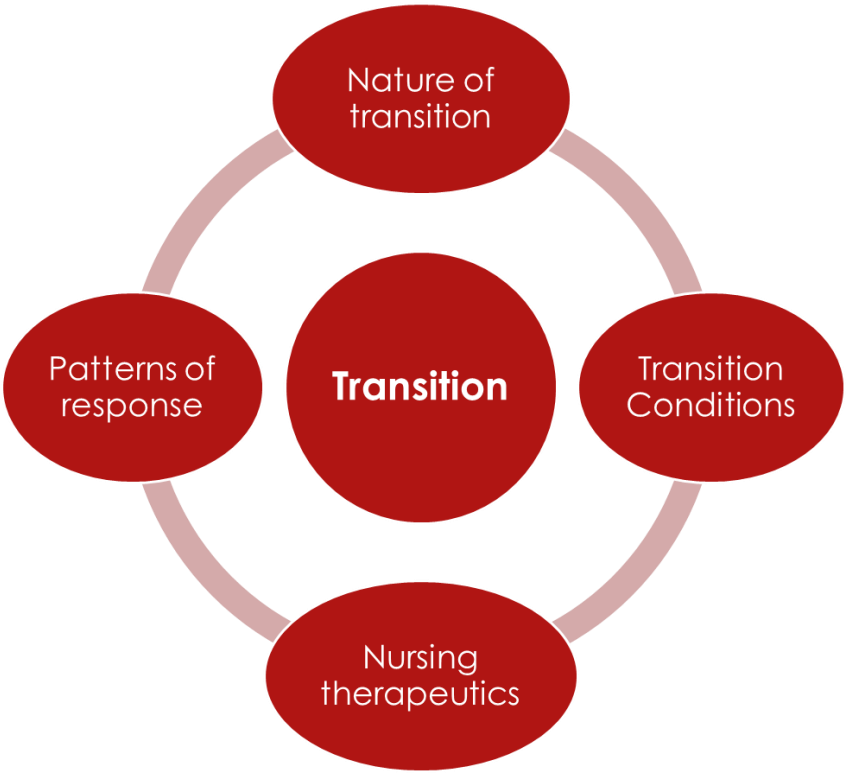
Appendix A: Concept Map of Transition Theory



Appendix B: Pretest

Demographics

1. Please list how long you have worked at the (organization name):

☐ Less than one year ☐ 1-2 years

☐ 3-4 years ☐ 5-10 years

☐ 10+ years

2. Your current job role: ☐ Nursing ☐ Physician ☐ Allied Health

3. Discharge Information

a. Do you feel that healthcare providers have a responsibility to direct discharge discussions? ☐ Yes ☐ No ☐ Not Sure

b. Do you feel that patients and families have all of the information that they need to make safe discharge decisions? ☐ Yes ☐ No ☐ Not Sure

c. Have you ever had a family tell you that they want to pursue long term care placement because a health care professional told them that they should? ☐ Yes ☐ No

4. Nudging

a. Have you ever heard of the term nudging in health care? ☐ Yes ☐ No

b. If yes, can you please describe what nudging is:

5. a. Do you feel that health care workers use nudging to influence discharge decisions? ☐ Yes ☐ No ☐ Not sure

b. Please describe how nudging can be used to influence discharge decisions:

Appendix C: Lesson Plan

Course: Nudging	Announcements/Reminders: This is for the inter-professional teams on the pilot unit
Teaching Aids: Problem Based Learning using case studies, Video, Handouts	
Instructional Objectives: (Knowledge, Comprehension or Application Levels of Bloom's Taxonomy) Participants will discuss their current knowledge of nudging and how it can influence discharge decisions (Cognitive—Remembering factual knowledge) Participants will apply their knowledge of nudging to case studies (Cognitive—Application of procedural knowledge) Participants will apply their knowledge of nudging to a video discharge demonstration and identify potential episodes of nudging (Cognitive—Application of procedural knowledge) Participants will revise their practice regarding nudging reflection of their learning (Affective -- Internalizing Values) Learning Cycle: Concrete Experience (CE), Reflective Observation (RO), Abstract Conceptualization (AC), Active Experimentation (AE)	
Motivator: Think of how the language you use with patients and their families may influence their decision making regarding care and discharge	
Pretest: To be completed prior to initiation of learning sessions	

Minutes	Lrng. Cycle	Instructor's Activities	Student Activities	Evaluation	Resources
Session 1: 20 minutes	CE	Review nudging 1. What is nudging 2. Why we need to understand nudging 3. Examples of nudging 4. How does nudging impact care decisions	Didactic discussion	Formative—did they understand the expectations	Discussion hand out
Session 2: 20 minutes	AC	Case study review	Problem based learning review of case studies	Diagnostic—determine what is has been learned from didactic	Case studies
Sessions 3: 20 minutes	AE	Discharge video analysis	Problem based learning review of video using previously obtained knowledge	Summative—how are they applying the knowledge	Video and reflection questions
Assessment	RO	Post-test		Summative—how are they applying the knowledge	Post-test

Appendix D: Posttest

Demographics

1. Please list how long you have worked at the (organization name):

☐ Less than one year ☐ 1-2 years

☐ 3-4 years ☐ 5-10 years

☐ 10+ years

2. Your current job role: ☐ Nursing ☐ Physician ☐ Allied Health

3. Discharge Information

a. Do you feel that healthcare providers have a responsibility to direct discharge discussions? ☐ Yes ☐ No ☐ Not Sure

b. Do you feel that patients and families have all of the information that they need to make safe discharge decisions? ☐ Yes ☐ No ☐ Not Sure

c. Have you ever had a family tell you that they want to pursue long term care placement because a health care professional told them that they should? ☐ Yes ☐ No

4. Nudging

a. Have you ever heard of the term nudging in health care? ☐ Yes ☐ No

b. If yes, can you please describe what nudging is:

(Please turn over to continue)

5. a. Do you feel that health care workers use nudging to influence discharge decisions? ☐ Yes ☐ No ☐ Not sure

b. Please describe how nudging can be used to influence discharge decisions:

6. Based on the knowledge you have gained during the education on nudging, is there anything you would do differently in your practice?