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Clinical Practice Guideline for Post Discharge Primary Care Follow-up Program for COPD

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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,
and that any and all revisions required by
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Abstract

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MS, Pace University 2006

BS, Pace University 2003

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Approximately 15.7 million individuals throughout the United States have been diagnosed with chronic obstructive lung disease (COPD), with 700,000 individuals hospitalized annually in the United States. An estimated one in five patients are readmitted within 30 days, raising the costs above $15 billion annually. The gap in practice was a lack of adequate clinical practice guidelines associated with discharge to primary care in this acute care facility. The purpose of this project was to use the expertise of the multidisciplinary team of pulmonologists, acute care nurse practitioners, respiratory therapists, and pharmacists to develop a clinical practice guideline using evidence-based literature and professional organization guidelines and recommendations. The guiding practice focused question was whether an interprofessional team can update COPD guidelines for post discharge care for the management of this high-risk population. The IOWA conceptual framework was used to direct the process. Key points that emerged from the literature were the importance of promoting self-management, and training on home care including medication compliance and standing orders for prescription refills and home oxygen therapy. The team advocated patient access to their health care team 24 hours a day through the telehealth platform. Consensus was documented with the AGREE II. The highest scores were rigor of development (92%) and scope and purpose (90%). Stakeholder involvement received the lowest score of 81%, reflecting lack of patient input. Upon execution, the guideline could improve nursing practice in the support of COPD patients and caregivers in the home environment and to improve health status and prevent readmissions of patients with COPD, promoting social change.

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Dedication

I would like to dedicate this capstone project to all individuals who assisted in its development, including my family, who motivated me to pursue learning boldly, and my project chairperson who gave me the basic insight required to undertake such an academic pursuit. Without the input of these stakeholders, this achievement would not have been probable, and I would not be pursuing a qualification in this aspect of healthcare.

Acknowledgment

First, I would like to acknowledge God Almighty for offering me the chance and drive to complete this project successfully. I expect that the project will positively impact individuals suffering from COPD as it has always been my goal to be of assistance to people in need.

Second, I would like to offer my sincere gratitude to my project chair Dr. Catherine Garner, throughout the project whose encouragement, mentorship, guidance, and support have offered me the necessary drive during these very challenging times to achieve all the stated goals successfully. I would also like to thank all the committee members who have assisted in one way or another at different project points. Third, I would like to sincerely thank all my family, friends and peers who have stood by me throughout the journey by offering their support in diverse aspects of the project.

Last, I would like to acknowledge myself for endurance throughout the project since it became very challenging at the end to accomplish what I had started due to the current global COVID-19 pandemic, but I encouraged myself with the words of Martin Luther King, who said, "The ultimate measure of a man is not where he stands in times of convenience and comfort, but where he stands during times of controversy and challenge."

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Section 1: Nature of the Project

Introduction

Chronic obstructive pulmonary syndrome is an inflammation of the lung resulting in airflow obstruction. The condition is one of the most prevalent in the United States and is the leading cause of mortality and morbidity. Prevalence of the condition in the United States can be associated with environmental risks or causes that place a significant percentage of the population at a high susceptibility of contracting the condition. Older adults have a heightened likelihood of contracting the disease, particularly following leaving occupations characterized by a high level of risk (Prudente et al., 2018). Approximately 15.7 million individuals throughout the United States have been diagnosed with the condition, with millions of others having a high probability of living with the disease unknowingly (Shah et al., 2016). One of the leading causes of the condition is associated with occupational exposure since research indicates that specific occupation groups have a higher likelihood of contracting the condition, specifically in service-related jobs. Even though remedial measures have been incorporated into managing the condition at its initial stages, reports indicate that readmission is one of the areas of failure in handling the disease, necessitating research to ascertain evidence-based practices to reduce the readmission rate. Statistics indicate that 10% to 20% of chronic obstructive pulmonary disease (COPD) patients are readmitted within the first 30 days following discharge, indicating the urgency of developing proper guidelines (Shah et al., 2016). Additional research indicates that patients readmitted following hospitalization due to the condition have a heightened risk of mortality and are typically associated with

worse outcomes due to admission-related factors. Several interventions have been advanced to reduce the readmission rate, but most of these have proven ineffective, necessitating further evidence-based practices to comprehensively and effectively address the state of affairs.

One of the key factors associated with readmission is that COPD progresses gradually. Hence, most people are unaware of its onset and the initial symptoms since they are diagnosed much later when the disease is already advanced. The outcome of this situation is that an excess of 800,000 individuals who are 40 years and older are admitted due to a primary COPD diagnosis (Bashir et al., 2016). Furthermore, an additional 3.8 million are admitted having a secondary diagnosis of the condition resulting in excess of $6 billion in direct care costs annually. The admissions cost is substantial such that in 2010, the costs rose to nearly $50 billion, with more than 70% of these being linked to excessive hospital stays and more than 30-day readmission rates (Press et al., 2019). Such statistics indicate an urgent need to address the ineffective approaches utilized to prevent readmission from diagnosis to practices within the healthcare facilities

In the healthcare setting, clinical practice guidelines ensure that all participants adhere to evidence-based proposals in offering care to patients. Existing COPD guidelines for follow-up are abundant, but there is an evident shortcoming concerning the effectiveness of these approaches and implementation, which is a potential contributing factor to heightened readmission rates. In this regard, there is a need to conduct research to present solutions aligned with evidence-based practices, ensuring that the involved healthcare personnel can reduce the admission rate. Such research can be centered on

ascertaining knowledge gaps and transforming them into the best available evidence to direct clinical practice guidelines theoretically and practically.

Problem Statement

COPD is one of the leading health challenges in the United States. Approximately 15.7 million individuals throughout the United States have been diagnosed with the condition, with millions of others having a high probability of living with the disease unknowingly (Shah et al., 2016). Statistics indicate that within the United States, more than 700,000 individuals are hospitalized annually, indicating the prevalence of the condition throughout the country (Spitzer et. al., 2019). Despite the relative success in handling the condition at first admission, the rate of hospital an estimated one in five COPD hospitalizations is readmitted within 30 days, raising the costs above $15 billion annually (MacIntyre, 2019). The costs associated with readmissions are projected to reach $32 billion annually, and it is estimated that by the year 2025, the economic burden of COPD readmission will be 50 billion annually, translating to an estimated average cost of $9,800 per patient annually (Portillo et al., 2018). The mortality rate associated with readmissions is high since it results in an estimated 55% of deaths, indicating the risk associated with patients being readmitted for the same condition. The seriousness of the issue is evidenced by the fact that the Centers for Medicare and Medicaid Services has incorporated penalties for healthcare facilities with an excess number of all-cause readmissions within the first 30 days of readmission (Stallings-Smith et al., 2019). The CMS ruling took effect in in 2015, and medical services offices recording readmission rates at an unreasonably high level experienced deficits of up to 3% of all the aggregate

Medicare repayment every year (Han et al., 2016). This policy modification has created new interest in estimating the risk level of readmissions due to COPD.

There are some shortcomings in the existing clinical guidelines on the management of COPD. Guidelines from the Global Initiative for Chronic Obstructive Lung Disease, (GOLD) are widely used among professionals to regulate the condition. However, despite the supposed comprehensiveness of such protocol, issues associated with exacerbation of the condition and rise in the readmission rates may indicate the ineffectiveness of the enshrined tenets (Mirza et al., 2018). Expert researchers have cited some shortcomings in such guidelines since, in most instances, the guidelines are not updated based on the current evidence-based practices; they are developed based on historical guidelines resulting in in-operability in the prevailing healthcare environment. The guidelines do not include resources for patient self-management. In this regard, to attain effectiveness in reducing hospital readmissions due to COPD, there is an urgent need to guarantee evidence-based practices are developed and that adherence to these guidelines is optimum. Advancing such guidelines will guarantee that there will be a reduction in the 30-day readmission rate that is currently at heightened levels exasperating the conditions and ultimate health outcomes for patients, specifically the mortality rate.

Based on the prevailing evidence on failure in overcoming readmission challenges, it is evident that there is a lack of consistency in healthcare personnel adhering to best practice recommendations associated with follow-up (Mirza et al., 2018). In essence, following the recovery of patients, health care personnel consider their duties

to be fulfilled and hence fail to follow up with the clients to ascertain lifestyle and occupation choices coupled with exposure to ascertained risk factors. Additionally, there is a failure to adhere to provided evidence-based interventions as outlined by GOLD guidelines, such as counseling on overcoming bad habits such as smoking, proper inhaler use, techniques, and referral to the relevant rehabilitation facilities that could enable patients to engage in healthier lifestyles (Grewe et al., 2020). Nonadherence to other guidelines such a self-management education and scheduling outpatient follow-up visits were also significant challenges associated with readmission rates necessitating extensive evaluation of these directives to address practical issues cited by healthcare personnel and patients that make it difficult to adhere to the proposals (Somani et. al., 2020). The prevailing gap in practice was associated with the absence of consistency concerning evidence-based guidelines since most of them were undermined by practical issues reported by healthcare personnel and patients.

Purpose Statement

The primary purpose of this quality improvement project was to advance critical practice guidelines with the input of experts in the distinct aspects of challenges in the prevailing setting concerning discharge follow-up of COPD patients. The guiding practice focused question was whether an interprofessional team could update COPD guidelines for post discharge care for the management of this high-risk population. My goal for the project was to guarantee that individuals who have recovered from their COPD hospitalization engage healthier lifestyles and are not subject to readmission since the pertinent evidence-based clinical practice guidelines have been suitably developed

and implemented to guarantee that discharge care is aligned with evidence-based research recommendations as well as the proposals of the relevant bodies. Existing statistics from the relevant data collection bodies indicate inconsistency in adhering to guidelines since they are not aligned with practical issues from a real-life perspective, hence exacerbating readmission rates. Occasional failures in follow-up specifically centered on directing patients toward the relevant supporting facilities and healthy lifestyle choices are some of the key issues that contributed to COPD exacerbation In this research, I addressed the factors leading to failures in follow-up care postdischarge and offered recommendations that the pertinent healthcare facilities can use. The gaps in the development of and adherence to guidelines are potentially the underlying factors of the increase in the readmission rates. An additional purpose of this research was to collect evidence on possible future issues associated with development and adherence of evidenced based clinical practice guidelines, hence offering guidelines to the healthcare facilities guaranteeing that they are adequately prepared to deal with the emerging issues.

Nature of Doctoral Project

The primary focus of this doctoral project was advancing a clinical practice guideline suitable to the issue of concern, specifically improving COPD patient discharge and reducing the ensuing rate of readmission. I used the Walden Manual for Clinical Practice Guideline Development in the doctoral project because of its comprehensiveness and effectiveness. Existing healthcare facilities encounter significant complications in managing readmissions, and hence there is a need to develop practical guidelines that can be used to regulate the high rates of readmission irrespective of the nature of the facility.

The conclusions of the doctoral project focused on healthcare facilities operating in regions characterized by middle-class families with populations exceeding 50 years of age as they were the population group with the most readmissions. While this demographic group was the focal point of the study, I incorporated other factors, including social-economic status, because existing research indicates adverse factors associated with the rise in COPD, necessitating a comprehensive approach to addressing them. I used the IOWA model of evidence-based practice to interpret the discoveries into clinical practice. The model fuses information-centered and issue-centered triggers for distinguishing proof of difficulties in clinical practice. Upon identifying the clinical challenge, I used suitable models to evaluate and appraise the quality of existing evidence, augmenting the identification of practice challenges and modeling subsequent solutions. Ultimately, the clinical practice challenge that I identified was the requirement of a solid clinical practice guideline that would guarantee effective discharge of COPD patients and suitable follow-up to reduce the readmission rate. The comprehensive care model can be incorporated in guaranteeing continuity in the care process following discharge since a lack of such a continuum significantly undermines the recovery of patients compelling them back into the hospital setting.

Significance

Existing evidence indicates a high rate of readmissions associated with COPD, ultimately leading to heightened mortality rates (Murray et al., 2021). Statistics indicate that one in five individuals suffering from COPD is admitted back to health care facilities within the first 30 days of discharge (Bashir et al., 2016). Additional projections indicate

that due to the progressive nature of the health condition, the frequency of these admissions will continue rising, necessitating the development of suitable strategies to prevent adverse outcomes (Ryrso et al., 2018). Most admissions could be averted by adopting suitable discharge guidelines that would include follow up on patients for a considerable time following discharge (Budde et al., 2018). However, there are still some prevailing gaps concerning proposed evidence-based interventions that should be used in such follow-up guidelines to guarantee comprehensive effectiveness.

Historically, ineffective tools have been used to appraise the prevailing guidelines, resulting in a failure upon adoption (Mehta et al., 2020). In this project, I incorporated the AGREE II model in appraising, identifying, and adopting the most effective interventions in enhancing care processes and gauging the appropriateness of evidence-based interventions in augmenting patient outcomes. Such assessment is significant for patients and providers because existing research points out that if patients have a comprehensive understanding of discharge instructions, they have a higher likelihood of not returning to the hospital since they have incorporated suitable remedial measures to avoid re-infection (Kobayashi, 2018). Furthermore, because the primary goal of the discharge follow-up is augmenting collaboration of care upon discharge, it presents a significant opportunity for boosting patient-provider information exchange while empowering patients to self-manage their conditions to avoid readmission.

Health care providers are facilitators of social change. The project will impact social change by enabling COPD patients to rapid access to PCP follow-up visits postdischarge. Clinical practice guidelines, including a patient/ family education

program, was developed to educate patients on self-management and reducing the risks of being readmitted into the hospital. The social change will be improved care coordination for COPD patients resulting in a better quality of life and decreased hospitalizations. The project supports Walden University's mission in promoting desirable social change in society.

Summary

Overall, the burden associated with COPD and readmission rates poses a significant challenge to the health care sector. Measures adopted to reduce the burden of COPD should incorporate evidence-based practice coupled with suitable assessment tools to guarantee that all dimensions of the challenge are addressed. Additionally, there is a need to constantly re-evaluate the prevailing guidelines to ascertain gaps and subsequently offer proposals to improve the clinical practice guidelines for discharge care planning of patients suffering from COPD. Cooperation between the involved stakeholders is quintessential in ensuring that the measures pursued are effectively achieved since all underlying components will support the larger goal of upholding COPD patient well-being following discharge. In this regard, establishing an interdisciplinary group is pivotal in ensuring that all aspects of the project are handled, including issues underscoring the high readmission rates.

Section 2: Background and Context

Introduction

Statistics on readmission of COPD indicate that approximately 30% of individuals return to the hospital following discharge (Goto et al., 2020). Owing to such high readmission levels, the quality of care offered to patients with COPD has been significantly affected necessitating re-evaluation of the procedures. Health organization bodies such as the Hospital Readmissions Reduction Program (HRRP) have endeavored to enhance the quality of care by analyzing hospitals that record high readmission rates and compelling such organizations to implement more effective health systems (Buhr et al., 2020). A review of the data from the hospital of interest indicates that effective practices for avoiding admissions were not adhered to, leading to higher readmission rates. Some of the disregarded practices included educating patients, linking patients with relevant support services, and recommending follow-up visits. For patients with COPD in the region and facilities of interest, there is a question about the possibility of a multidisciplinary approach to developing effective evidence-based practices per the AGREE II criteria for discharge. My primary goal for this evidence-based was the improvement of COPD patient care through the reduction of excessive hospital readmissions by developing suitable COPD clinical guidelines for discharge care planning. I aim to distinguish components of conceivable risk factors that may contribute to readmissions and offer evidence-based proof-based suggestions to the nursing field to overcome issues between existing practices and the general best proposals. In this section of the proposal, I will offer information concerning theories, models, and concepts

informing the project, enabling a comprehensive review of the relevance of the problem in nursing practice and the role that the pertinent stakeholders can play.

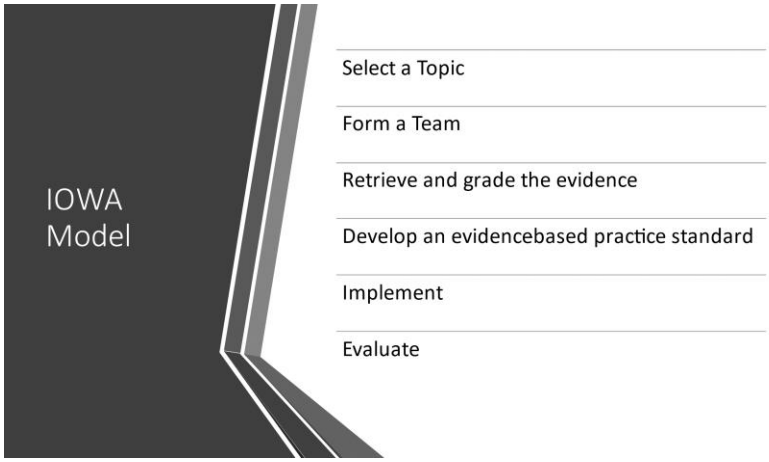
Concepts, Models, and Theories

IOWA Model

The IOWA model is used as a conceptual framework for developing clinical practice guidelines. Because the IOWA model accentuates team decision-making and evaluates the entirety of the healthcare system, it is a suitable model for projects involving multidisciplinary teams to advance clinical practice guidelines (Green, 2018).

Figure 1

IOWA Model



The IOWA model has been used for a long time and has proven to be effective. In 1994, Maria Titler developed the IOWA model (Buckwalter et al., 2017). She believed that it would guide nurses to use the best available evidence to enhance patient outcomes. Since it was developed, the model has been used extensively as a framework for addressing complications in translating research into best practice and the prevailing state

of affairs (Green, 2018). Nurses use the model to research the best possible alternatives and ultimately delineate a systematic approach of implementing the pertinent changes. Because the IOWA model applies an organizational approach to clinical decision-making, different stakeholders can evaluate the prevailing practices to enhance patient outcomes.

Chronic Care Model

The chronic care model is used as a suitable theoretical framework to improve the quality of this project. As delineated by GOLD, the guidelines consistently point to the fact that COPD can be treated and that by implementing a comprehensive approach, it can also be used to manage the burden of the disease (Sehl et al., 2017). Initially, the model was developed by a group of experts to improve the management of chronically ill patients (Raherison et al., 2018). Some of the most crucial components in the model are supportive information systems, planned interventions, self-management and health system support, and connections to community resources (Yeoh et al.,2018). By applying this model, it was possible to effectively develop a mechanism through which patients can be taken care of initially and subsequently guaranteeing that readmissions do not occur. Within the healthcare setting, reactive care for COPD exacerbations is considered a normal routine in which health care professionals have minimal interaction with patients suffering from the condition (Latreche et al.,2019). Owing to such a fragmented approach, COPD patients normally lack the required care beyond the hospital setting, which is a potential contributor to their increased readmission rates (Somani et al., 2020).

The incorporated framework approach, in this model is used to adjust the methodology of care from a responsive to a proactive methodology.

Clinical Practice Guideline Development

The development of quality guidelines in clinical practice is pivotal in offering nursing care of high quality. Clinical practice guidelines present systematic statements to assist patients and practitioners make appropriate decisions concerning suitable healthcare for clinical situations (Ryrso et al., 2018). Depending on the need to improve the quality of the prevailing evidence and recommendations, a multidisciplinary expert panel advances a new set of protocols to create more reliable guidelines (Ryrso et al., 2018). Contingent on the general classifications convened by the Institute of Medicine (IOM), clinical practice guidelines denote the statements, including recommendations, aimed at optimizing patient care informed by a systematic evidence review, and evaluates the advantages and drawdowns of alternative approaches to care.

Healthcare organizations ratify clinical practice guidelines to augment the quality of care offered to particular populations and avail consistent and well-formulated processes to bridge the gap between research studies, policy development, and best practice (Alam et al., 2020). The primary eight critical principles that underscore clinical practice guidelines include:

1. Defining suitable care based on the best available scientific evidence,
2. Diminishing preventable practice variations,
3. Availing a logical basis on which to make referrals,
4. Accentuating sustained educational practice,

5. Promotion of the efficient use of resources for the achievement of set goals,
6. Improving quality control such as auditing,
7. Recognizing the gaps in the present literature,
8. Offering suggestions on the suitable areas for research in the future (Alam et al., 2020).

Relevance to Nursing Practice

Transitioning patients with COPD from the healthcare to the home setting is a complex process for healthcare personnel because each discipline team typically operates autonomously in the discharge process (Sari Kundt et. al., 2018). Some suggestions to ease this transition include using discharge bundles as an effective mechanism for augmenting care processes, specifically since they consistently implement best practices (Dixon et al., 2020). The bundles include a small, direct set of evidence-based practices—typically five—that have proven effective in boosting outcomes for patients (Dixon et al.,2020). Using discharge care bundles to help multidisciplinary teams identify evidence-based intervention will boost patient outcomes (Lloyd & Garside, 2018). In the case of COPD, such an approach can prove effective because it guarantees that the rate of re-admission is significantly diminished. Systematic review indicates that using discharge bundles results in a significant decline in readmissions (Lloyd & Garside, 2018). Discharge care bundles offer standardized protocols that nurses can follow up on and guarantee effective delivery of care that will likely not lead to readmission. Additional research indicates that the bundles should be undertaken by incorporating the input of all

the participants in the remedial process to guarantee that the treatment pursued is effective (Lloyd & Garside,2018).

Similarly, recommended guidelines based on evidence-based research indicate that the combination of evidence-based interventions, including discharge care bundles, can significantly affect hospital readmission rates. Using proper inhaler techniques and scheduling outpatient coupled with follow-ups can be considered bundled care that can reduce the re-admission rate, thereby assisting hospital personnel (Johnson et al., 2020). Such an intervention approach ensures that patients are offered the appropriate care within the hospital setting to guarantee some degree of recovery, ensuring reduced readmission rates. However, in other cases the intervention is not useful and hence demands combination with other measures that have been proven to be effective from an evidence-based approach. Other components noted to be effective include pulmonary rehabilitation and smoking cessation (Cabrita et al., 2021). It is critical to guarantee that patients have critical comprehension of their discharge instructions, including the time for taking medication and scheduling follow-ups and the core components of the process for discharge planning. Patient understanding of the proper discharge instructions results in a reduction of readmission rates. Such a combination of proven, evidence-based practices will offer a suitable solution to the issues that underscore readmission.

The noted interventions offer a comprehensive approach empowered by interdisciplinary teams, reducing exacerbation of the disease and subsequent readmissions (Seckler et al., 2020). The training rule centered around using multidisciplinary groups to foster release packs to benefit organized systems of offering

satisfactory consideration to COPD patients. The development of a standardized process for patient discharge within the interdisciplinary team can significantly diminish gaps in healthcare and possibly diminish the readmission rates. In addition to this, the use of discharge bundles enables multidisciplinary teams to perform diverse measurable activities that can improve the care process. The bundles should be implemented to guarantee comprehensiveness in the recovery measures imposed in the recovery process. As a precaution, distinct bundles should be developed to guarantee that if one of the models fails, the rest can be adopted to offer alternate solutions for enactment and possible achievement of set objectives. The bundles should complement each other to prevent any incongruence between the measures pursued or the stakeholders to the project components.

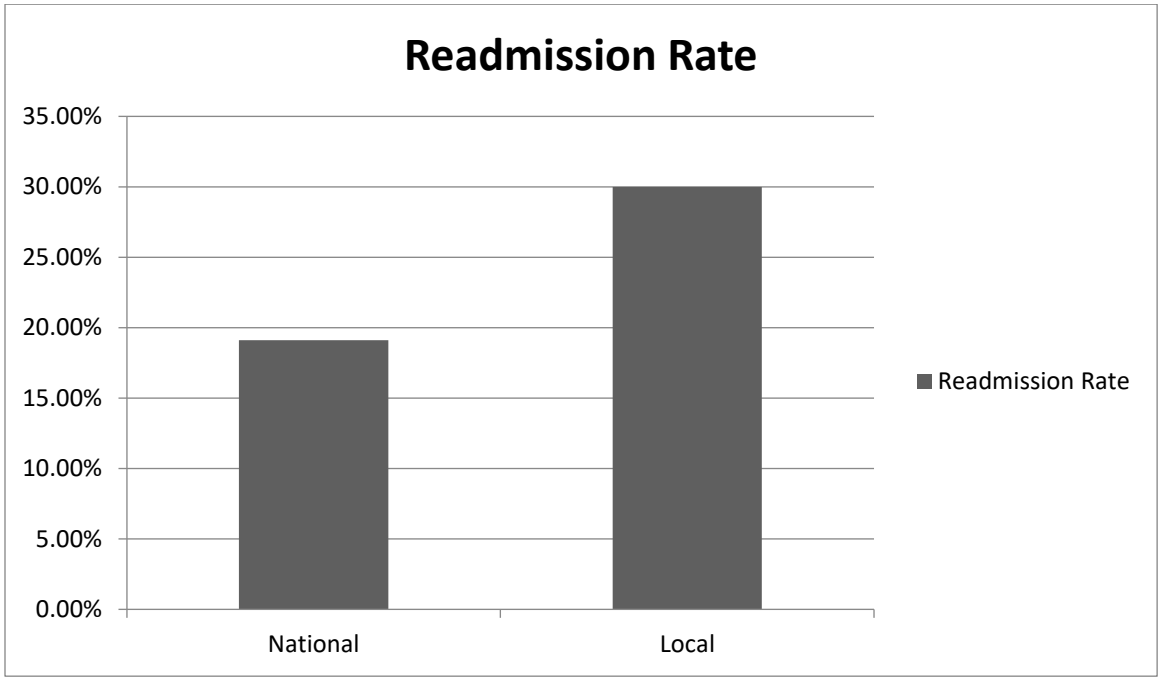
Local Background and Context

Within the local setting, in the Southeast region of the United States, the demand to reduce readmission rates is associated with the healthcare facility's accruing substantial fines and reductions in Medicare reimbursement due to high readmission rates. The readmission rate for patients suffering from COPD at the facility of interest was reported at 30%, significantly above the national average. Such a context demands that suitable measures be pursued to ensure that these rates are reduced to guarantee a healthy environment for patients, reducing readmission rates. The local participants should collaborate seamlessly with the relevant stakeholders and ensure that all COPD treatment dimensions are addressed. Ultimately, by addressing all the aspects

underscoring readmission, it will be possible to extend the 30-day window within which the highest readmission rate occurs.

Figure 2

Readmission Rate



While the maximization of monetary profits may be the primary motivation for practice change, there is a further drive to develop evidence-based practices to diminish COPD admissions. The project setting has multiple acute care facilities in the Southeast region of the United States, where the poverty rate is 15% higher than the national average of 13%. Based on the reviewed literature, there is a direct correlation between socioeconomic components, aging, and COPD occurrence (Liberman- Cribben et al., 2021). Based on the reports made for the healthcare facility, the institution reports a higher-than-average readmission rate compared to other healthcare facilities at its levels

of development and resources. The literature indicates that such a facility has incorporated some ineffective mechanisms of COPD treatment, resulting in heightened readmission levels, subsequently accruing substantial fines from the relevant health body.

Role of the DNP Student

My duty was to direct the advancement of an appropriate and important practice rule that is extensive. Based on the DNP essentials, the nurse should pursue leadership in leading professional teams to evaluate gaps in practice and then develop and enact evidence-based models to improve patient care. Additionally, I will function as an agent of change to improve processes of care that will comprehensively prepare COPD patients to be ready for discharge. Such components are progressively vital since gaps in preparation for discharge have a likelihood of raising 30-day readmissions. Assignments for the learners would incorporate receiving an orderly procedure in surveying readmission rates, framing an extensive group to handle every one of the issues, and working together with colleagues in recovering and reviewing proof for the improvement of clinical practice rules. Such rules are quintessential in maintaining nursing that is non-harmful and clinically capable. The essential inspiration is ensuring that COPD patients are exposed to powerful groundwork for reasonable release before progression to the home setting. The work of a COPD – competent nurse over the past few years has aided in noting provider-pertinent gaps in care quality associated with this population that could undermine the transition from the hospital setting to home. The process was undertaken professionally, adhering to the proposed guidelines to reduce the possibility of bias in data collection.

The DNP student will also implement an effective mechanism of guaranteeing that the project is operating based on the most recent trends. Students incorporate some vitality and modernity in the project since they can offer guidance on the most recent practices and research concepts in their interests. Additionally, by incorporating my input on some of the latest trends in COPD patient handling, the project will ensure that all its components and sections align with the prevailing environment adding to the relevance of the outcomes reached. DNP students can also use the project as a learning point to advance further research to assist the academic community.

Role of the Project Team

The task group will involve people adept in unique fields, including respiratory treatment, quality control, case boarding, and clinical care. Every medical care staff is fundamentally influenced by avoidable and unreasonable readmissions and consequently has a basic comprehension of their difficulties. Due to the COVID-19 restrictions, the weekly meetings will be conducted remotely using web-based platforms such as Zoom. The colleagues will assess the proposed guidelines and achieve consensus, using the AGREE II model. Case boarding and respiratory treatment are quintessential in determining the needs of the population.. the inclusion of the quality assurance will be vital in guaranteeing that the newly ratified guidelines adhered to the local population's needs, including from an ethical perspective.

Accountability is a critical component in undertaking projects, and hence there should be several stakeholders who can guarantee that each of the participants fulfills their roles as required. While the quality control manager is tasked with guaranteeing that

the output is optimum, there should be a mechanism of guaranteeing that each participant accomplishes their role. The project team will also function as a check mechanism to guarantee that the other team members adhere to the schedule and proposed measures are fulfilled in the long term. Ultimately, the project will be expedited, and the distinct roles fulfilled as delineated in the project schema. Everyone will be responsible for ascertaining that the roles are fulfilled collaboratively to achieve the general project objectives.

Summary

The central motivation behind fostering the guideline updates was to improve the care of COPD patients by applying evidence-based protocols for COPD patient discharge and transition management. The IOWA model enhanced the chronic care model by providing the framework to advance and implement evidence-based practice standards for discharging COPD patients. The AGREE II instrument was used as a structure for fostering the rule. The constant consideration model was utilized to ensure congruity of care after being released from the clinic setting. Following an evaluation by the team, suitable measures were pursued contingent on the guidance offered. Collaboration with the local community was a critical component in ensuring that the envisioned outcomes were not hampered by any possible resistance to change from the beneficiaries. In Section 3, I will review the process for collection and analysis of evidence.

Section 3: Collection and Analysis of Evidence

Introduction

The gap in practice that I addressed in this project is the absence of best practice guidelines for managing COPD patients postdischarge. This requires an interprofessional team to review current evidence and collaborate on a plan of action. The guiding question was whether an interprofessional team could develop COPD postdischarge guidelines for the management of this at-risk population. The use of a coordinated program and guidelines can improve the quality of life for COPD patients and their families and prevent untimely and costly hospital readmission (Braman, 2015). It is the core business of healthcare facilities to ensure appropriate patient treatment and improvement of health outcomes. In Section 3, I will offer information concerning the trajectory through which the multidisciplinary team will reach a consensus concerning the research proceedings and the sources of evidence and methods for collecting data.

Practice-Focused Questions

The essential practice centered inquiry for this task in norm and quality improvement was: Can a group of specialists adequately foster proof-based rules for clinical practice that cling to the AGREE II models for releasing patients experiencing COPD? While this functioned as the main question for the research, my goal was to diminish the rate of readmissions for individuals suffering from the condition by advancing and implementing acceptable practice guidelines for planning and execution aligned with the recommendations offered at a national level. Based on the collected evidence, it was clear that the acute care facility had a severe deficiency in a standard

process for discharging COPD patients, possibly underscoring the heightened readmission rates for this population group. The failure in the system can be traced to the lack of sufficient planning, specifically with regard ensuring a seamless transition to post-discharge follow-up care in the community and referring them to suitable facilities that can assist them in improving their future lifestyles as well as provide them with appropriate support systems. One fundamental measure that was absent was the lack of a clear self-medication regimen for COPD patients. Recommendations for smoking cessation, education on inhaler use techniques, and scheduling postdischarge follow-up visits have been overlooked in the guidelines for reducing readmissions (Murray et al., 2021). Fusion of normalized protocol, including usage of care groups, can ensure that basic mediations dependent on proof are not ignored during the release proceedings (Budde et al., 2018). Questions centered on why such aspects of care are disregarded will be quintessential in assisting the facility to improve its processes and guarantee that readmission levels are reduced. Additionally, questions centered on the possible implications of such high readmission rates on the facility will prove essential in creating urgency within the facility and prompt the individuals in charge to pursue appropriate measures.

Despite the lack of consensus concerning the interventions within a COPD bundle that attain the highest effectiveness, existing data implies that incorporating discharge bundles can minimize exacerbations, diminishing the probability of rehospitalization and augmenting the quality of life for the patients (Dixon et al., 2020). Questions around the ideal combination of bundles will be highlighted to ensure that bundles that are adopted

for this acute care facility are effective and would enhance patient outcomes. Bundle combinations that are ineffective in augmenting patient outcomes will be identified.

Eventually, it was important to suggest conversation starters: for instance, is the utilization of groups in the release arranging measure dependent on the requests of the customers ensured to offer a community and normalized approach, thus highlighting adherence to proposals for best practice? Additionally, it was important to consider the experts selected to develop the bundles and pose some questions. One of the possible queries was, how many individuals are required to be incorporated into the team to ensure that the developed proposals adhered to the AGREE II criteria for discharge of COPD patients hence guaranteeing that the outcomes are sufficiently potent in bridging the gap ascertained within the practice. Additionally, questions posed by the teams included what possible approaches could be used in creating the bundles such that all individuals are suitably catered for hence alleviating all concerns of possible readmission.

Sources of Evidence

Collection and analysis of evidence related to the healthcare sector is a complicated process necessitating extensive research to ascertain that the information retrieved is suitable to address the research question and primary topic. I only used reputable sources to establish credibility. I performed Literature searches using Walden library databases, Google Scholar, and the Cochrane database of systematic reviews. The Walden Library databases include ProQuest Nursing, Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, and Medline Simultaneous Search. The search queries or terms included *release anticipating COPD, GOLD rules, intense*

compounding of the ongoing obstructive illness, constant obstructive aspiratory infection, advantages of release arranging, clinical practice rules for COPD, care packs, and *COPD*. The websites of top public and worldwide general wellbeing associations were additionally investigated, including the Centers for Disease Control and Prevention (CDC), the Institute of Medicine (IOM), the Agency for Healthcare Research and Quality (AHRQ), and the World Health Organization. The GRADE (Grading of Recommendations Assessment Development and Evaluation) approach was employed to assess the quality of the articles selected and the significance of the recommendations. It was critical to use an approach verified scientifically when assessing the articles and recommendations to increase their significance and importance among the users of the findings. Research studies that use scientifically proven processes have been shown to have greater effectiveness in the market due to the fact that they are verified and can subsequently be beneficial in attaining the intended goals (Vasileiou et al., 2018). Specifically, 68 articles were reviewed for this research, while 58 articles were used for reference purposes, and an additional 10 were incorporated in the literature review. Collectively, these research articles underscored the aim of the project and hence shed light on the issue of COPD readmissions, ultimately assisting the team of experts in developing suitable guidelines to direct the remedial process.

Protection of Human Subjects

I adhered to the Walden DNP manual for Clinical Practice Guidelines because it offers a comprehensive approach to being a moral researcher. The manual has been subjected to numerous revisions to guarantee that it addresses all possible aspects of a

research proposal, specifically regarding the healthcare sector. There were no patients involved in the development process. All team members were employees of the healthcare facility and volunteers in the process, which the facility considers part of its Strategic Plan for Quality Improvement. I sought approval for the project from Walden University Institutional Review Board, (IRB).

Analysis and Synthesis

My primary goal for this evidence-based quality augmentation undertaking was to develop clinical practice guidelines for discharge care that would underscore best practice approaches in the effort to improve the readmissions rate in hospitals, boosting the quality of life for individuals suffering from COPD and improved care. I developed the initial draft of the guideline and shared them with the team via a teleconference. Each team member reviewed their own professional literature to add to the body of knowledge and made suggestions to improve the practice guideline. The document was housed in Google Documents, which allowed all team members to simultaneously add their comments. At the end of the first 2 to 3 weeks, depending on environmental circumstances, the team met again via Zoom and reviewed and revised until consensus was achieved. The team rated the guideline using the AGREE II tool. The final report to the hospital leadership included the names and roles of each of the team member but was omitted in the Walden manuscript. Once the hospital's senior leadership approved the guideline, the Google documents were downloaded from potential viewing and stored in the hospital's quality improvement archives.

In this project a multidisciplinary team-based approach was used for the synthesis of best available evidence in augmenting clinical practice guidelines. The multidisciplinary team also made recommendations for the implementation of evidence-based guidelines to bridge the gap ascertained in practice. The Scholarly articles presented in the research and the evidence collected significantly supported the role of the multidisciplinary team since the highest standards in the industry advised them and guaranteed that the subsequent proposals made were effective in their goals. Additionally, incorporating evidence ensured that the research is reliable hence garnering an audience with many people.

Summary

The number of COPD patients readmitted within 30 days of discharge is one of the critical challenges at one of the healthcare facilities. The absence of standardized approaches in discharging patients was one of the key issues noted by the team of experts, necessitating developing suitable strategies that would guarantee that patients are not admitted within a short timeframe after being released from healthcare facilities. The purpose of this project was to assemble a team of experts to achieve consensus on guidelines for the care of the COPD patients during the discharge and transition process. The ultimate implementation of this guideline may result in improved care for COPD patients and improve the use of healthcare resources.

Section 4: Findings and Recommendations

Introduction

The gap in practice that I addressed in this project is the absence of best practice guidelines for managing COPD patients post discharge. This required an interprofessional team to review current evidence and collaborate on a plan of action. The guiding question was whether an interprofessional team can develop COPD post discharge guidelines for the management of this at-risk population.

The scholarly project entailed incorporating the expertise of a multidisciplinary team in developing the protocol for hospital discharge, as well as the development of structured mechanism of caring for patients at home, including education on self-care management. The primary goal of clinical practice guidelines is to enhance patient outcomes and the quality of the care delivered to clients through incorporating evidence-based research (Shah et al., 2016). The development of a clinical practice guideline can potentially aid in bridging the gap between prevailing practices and evidence-based practice recommendations, diminish the heightened rate of admissions, and simultaneously boost the quality of life for individuals suffering from COPD.

Findings and Implications

I conducted literature searches using the following databases: ProQuest Nursing, CINAHL, Cochrane, PubMed, Medline, and Google Scholar. Additionally, I sought evidence from some of the leading public health organizations including Centers for Disease control (CDC), Institute of Medicine (IOM), Agency for Healthcare Research and Quality (AHRQ), and the World Health Organization (WHO), These organizations

have the most accurate data concerning COPD patients as well as suitable actions for addressing heightened readmission rates. I summarized this information in an evidence table, and used it to develop the first draft of the proposed guidelines.

The panel included representatives from the project site: the quality management department, readmission coordinator, lead hospitalist, the chief nursing officer, and the local medical physicians and nurse practitioners treating COPD patients. The chief nursing officer assisted in selecting the panel because he was aware of the demands of the project as well as the individuals that could expedite the achievement of the objectives. Meetings were held via videoconferencing due to the COVID-19 pandemic and varying schedules of each participant. Each panelist was offered a disclosure form from Walden university's DNP clinical practice guideline manual to guarantee that they were fully aware of their purpose in the study and how the information would be used.

The draft guidelines were in a Google Doc format, which allowed those with access to comment on and edit a single document. This avoided the use of versioning of documents. Each panelist was offered 7 days to appraise the guidelines and offer feedback. By offering this online flexibility, each panelist could take their time appraising all the components and giving appropriate feedback. Five of the six appraisers presented their feedback within the allotted time frame, but one took a longer period because they needed to fully understand the components and guarantee that their feedback was accurate and productive in improving the guideline.

Once comments were received, I revised the guidelines to incorporate the various points of view. The feedback offered by the experts was critical in reaching the defined

goals since they are a clear depiction of individual perceptions on the quality of the guidelines, compelling modification if necessary. Once all the comments were incorporated and the group members indicating agreement, they were asked to rate the guidelines using the AGREE II instrument. Video instructions were provided via the AGREE website.

The data collection instrument has 23 items organized into three distinct domains to appraise the quality level of the defined practice guidelines. Each question in the instrument utilizes a 7-point Likert scale measuring the extent to which a recommended guideline should be used, with 1 being *strongly disagree* and 7 *strongly agree*. The six primary domains incorporated include applicability, development rigor, scope and purpose, editorial independence, clarity of presentation, and stakeholder involvement. The instrument incorporates two final general assessment components rating if the guideline quality is suitable for use. In the following sections, I will provide a brief description of the results extracted from the evaluation by the experts , with each of the tables displaying the feedback.

Domain 1: Scope and Purpose

The purpose and scope of developing the clinical practice guidelines were assessed based in domain one within the AGREE II instrument. The experts offered a summative score of 90% for the domain, implying a consensus that the defined objectives of the practice guidelines were achieved. One of the panelists indicated that it is critical to expand one of the age groups in the target population to incorporate children since they also have COPD complications due to asthma and chronic lung infections.

Table 1

Scope and Purpose

	Item 1	Item 2	Item 3	Total
Appraiser 1	6	6	6	18
Appraiser 2	6	7	7	20
Appraiser 3	6	6	6	18
Appraiser 4	7	7	7	21
Appraiser 5	6	7	6	19
Total	31	33	32	96

Domain 2: Stakeholder Involvement

Domain 2 assessed the involvement of stakeholders in the development of the guideline and appraised whether the views of the target users and the preferences of the population were factored in. The general score for the domain was at 81%, implying a consensus concerning the involvement of stakeholders. Compared to other domains, this domain was characterized by the lowest scores, with one panelist scoring items at 4, 5, and 6 lower than the other panelists. He commented that patient input could not be located within the guidelines; this was beyond the scope of the DNP project.

Domain 3: Rigor of Development

Domain 3 of the AGREE II instrument contains eight questions addressing the systematic approaches used in gathering and synthesizing the best available evidence to

formulate guideline recommendations. The general score for the domain was at 92%, with each of the panelists offering scores for the items within this domain between 6 and 7. High scores implied that the team of experts agreed that these guidelines were developed incorporating extensive research and that minimum modifications were required based on the prevailing standards. One of the appraisers noted that the document offered a clear outline of the search methods utilized to systematically review the literature on the topic hence boosting the reliability and validity of the findings.

Domain 5: Applicability

The fifth domain within the instrument was associated with the applicability of the guidelines relative to the hindrances and expeditors with implementation. The domain attained 83% agreement, implying a consensus concerning the application of the guideline from a practical perspective. However, one of the panelists posed a question on how the issue of referring homeless patients to pulmonary rehabilitation can be rectified. The recommendations based on evidence-based research for the project were general, and not designed to address this type of issue. However, this recommendation recommending linking up with the relevant individuals with expertise in homeless patients hence broadening the scope of the project without investing additional resources.

Domain 4: Clarity of Presentation

Domain 4 is concerned with presentation clarity and contains three aspects specifically related to format, structure, and terminology used in the guideline. The score achieved within this domain was 83%, implying that the guideline was easily understandable. One of the panelists stated that the recommendations were clear and

offered sufficient details, while another indicated a requirement to number the recommendations based on priority. The primary purpose of the guideline was to offer evidence-based recommendations at an equal level of importance, guaranteeing the general quality of the guidelines.

Table 2

Stakeholder Involvement

	Item 4	Item 5	Item 6	Total
Appraiser 1	6	6	6	18
Appraiser 2	2	4	6	12
Appraiser 3	7	5	7	19
Appraiser 4	7	7	7	21
Appraiser 5	6	6	7	18
Total 3	28	27	33	88

Domain 6: Editorial Independence

The sixth domain in the instruments evaluated the editorial independence with a specific focus on the competing interests and any biases associated with recommendations. The domain achieved 93% agreement and did not receive any negative suggestions or comments. Such a high score indicates a sense of independence on the implementation of the document, hence verifying that bias did not factor into the accuracy of the findings.

Overall Guideline Assessment

The cumulative quality score of the clinical practice guideline was 80%, with three experts recommending the guideline should be released without any changes while additional areas such as the homeless were explored. After meeting with the individual experts to review the comments made and feedback the guidelines were prepared for submission to the executive committee at the site for approval. While names will be used to establish credibility in the hospital environment, no names are included in the Walden manuscript.

Table 3

Overall Guideline Assessment

	The overall quality of guideline
Appraiser 1	6
Appraiser 2	6
Appraiser 3	6
Appraiser 4	5
Appraiser 5	6
Total	29/30

Implications for Individuals, Communities, Institutions, and Systems

A comprehensive discharge process and a reduction in the readmission rate of COPD may yield better outcomes for individuals. With the implementation of the

proposed guidelines, individuals and caregivers could benefit significantly by being empowered to engage in self-care management and decision-making. Health and wellbeing are critical components in an individual's life since it enables them to conduct their day-to-day activities leading to greater productivity. It is important to note that individuals face significant problems regarding readmission since many of them lack the finances or insurance to be admitted into the facilities for a lengthy period.

Currently, the healthcare setting is experiencing a considerable rise in hospitalizations and placing significant strain on the available resources. A reduction in the rates of readmission linked to COPD can lead to greater financial stability and the use of scarce resources for increased demand caused by the COVID-19 pandemic. The system will need to invest in modifying the electronic medical record and in providing telehealth services, but the cost-benefit should have a positive outcome.

Nursing can benefit from the use of evidence-base practice to improve their own clinical practice and make a difference in the lives of COPD patients and their caregivers. COPD is a terminal condition which generally has a lengthy course, necessitating medication and oxygen management. Being able to educate and to manage patient symptomatic outbreaks of coughing and shortness of breath via telehealth expands the practice of nursing by offering more holistic care. Should the use of this guideline be successful in improving patient well-being and reducing readmissions, it can be shared with other healthcare organizations. The follow-up evaluation can add to the nursing body of knowledge in evidence-based practice.

Potential Implications for Social Change

Social change refers to modifying mechanisms within a social structure characterized by variations in value systems, social organizations, rules, behaviors, and cultural symbols (Adloff and Neckel, 2019). A key component in understanding social order recognizes that while it is acknowledged as an ongoing societal phenomenon, diverse forms of social change are evident, including the process of change within the social structure that maintains the framework, (Adloff & Neckel, 2019). The implementation of these guidelines has the potential to improve discharge care and management of the COPD patient at home. Empowering patient self-management can assist patients and caregivers in feeling more in control during this lengthy terminal disease. Better self-care can decrease costly and traumatic readmissions and help patients have a better quality of life.

Recommendations

One of the recommendations is integrating the evidence-based recommendations from the guideline into the electronic health record of the site as a standardized order set. The standardized order sets, also termed standardized protocols, have the primary purpose of improving compliance with the recommendations for care processes (Mirza et al., 2018). The second recommendation would entail incorporating some of the key points in a checklist during the multidisciplinary team sessions. The multidisciplinary teams can combine efforts and collaborate in patient care, assisting the team in identifying some of the critical steps to be handled before discharge. One of the fundamental recommendations concerns the management of symptoms within the home

setting. In most instances, individuals experience worsening conditions within the home setting since they lack the relevant knowledge and resources to manage some of the simple symptoms that may arise. Management of symptoms within the home setting has been proposed as one of the critical approaches that can be incorporated in the reduction of hospitalizations. When individuals are trained on the proper approach to managing their situations at home, they can prevent an exacerbation of the situation since they will undertake the preliminary measures to ensure that the conditions are mitigated. Prompt mitigation of symptoms has been proven to prevent individuals from seeking admission into hospital facilities. Any additional support required in home management can be conducted through mobile applications, particularly telemedicine.

Telemedicine is a leading recommendation since it incorporates electronic information and telecommunication technology so that patients do not have to visit the healthcare centers. Telemedicine can assist them by offering medical care remotely via the available technologies. The digital options utilized include smartphones and computers to offer clients the relevant support remotely. Telemedicine assists the pertinent stakeholders in assessing whether clients require treatment in person hence reducing the likelihood of admission. In most instances, the client issues can be handled in the home setting under the appropriate direction. Patients merely need to forward their issues to the relevant health personnel to receive the direction or guidance they require. Clients can be directed on the suitable approach of undertaking their treatment within the home setting to prevent exasperation of their conditions to the extent of necessitating admission. The pertinent stakeholders can develop an application of their own to

guarantee that the components are most suited for the dependents' needs. The elements or the functionalities incorporated should guarantee that the likelihood of patients being readmitted is significantly reduced. At a certain level of utilization, the application should also incorporate the perspective of them clients in order to guarantee that evidence-based practices are incorporated. Some of the current telemedicine applications incorporated fail to consider the perspective of the clients hence leading to inefficiency (Shah et al., 2018).

Home oxygen is another therapy provided for COPD that can function as a significant step in reducing readmission rates. When an individual suffers from the chronic obstructive pulmonary disorder, it becomes significantly complicated to breathe. Home oxygen typically gives individuals extra oxygen to simplify breathing and ensure they remain more active. Multiple approaches are utilized in offering supplementary oxygen, including tubes and face masks. A key recommendation is that the healthcare personnel should guarantee that they offer clients multiple options from which they can select to ensure that all patients have the necessary support in alignment with their financial capacity.

Community stakeholders such as the American Lung Association can purchase the necessary equipment and rent them out to the individuals in need since they can offer them better rates compared to profit-making entities that may seek to inflate the prices. The relevant guidance needs to be offered to prevent hazards in the home setting. Although the support may be critical for the survival of the patients, the other family members and professionals within the home setting can also present significant hazards

such as smoking. Short lessons should be offered incorporating both clients and their family members to ensure that they are all operating based on the prescribed standards, specifically concerning reducing the number of risks within their home environment. Oxygen is highly flammable, and hence a key component of the guidelines should be centered on safe storage and utilization of the equipment. Routine replacement orders can ensure that the home supply remains consistent.

Contributions of the Doctoral Project Team

The project team was comprised of an expert panel from the diverse disciplines and administrative sectors to guarantee that all aspects of the problem were addressed. In collaboration with the lead researcher, the chief medical officer, the case management coordinator, and the chief nursing officer assumed leadership roles. Each of the members who took part in the project possessed extensive comprehension for COPD and the factors involved with readmissions. The team had previously conducted meetings on multiple occasions to identify clinical gaps in the care that could aggravate readmission rates.

Due to the recurring waves of the COVID-19 pandemic, there was a reduced attendance in the meetings to review the literature. The AGREE II scoring instrument was utilized in critically appraising the guideline by the team of experts. The chief nursing officer and chief medical officer will secure administrative support to spearhead the change initiative and gain the support of subordinates within the facility. Additionally, there is a need to gain the support of clinical personnel in the project site to adopt suitable strategies that would specifically resolve the acknowledged challenges.

Strengths and Limitations of the Project

Discharge of COPD patients from the hospital setting to the home setting is a complex maneuver involving a multidisciplinary team of experts. One of the fundamental strong points of the scholarly project was collaborating with individuals with expertise in diverse fields to develop appropriate clinical practice guidelines. The group sought a standardized methodology that can be adopted to diminish practice inconsistency. Incorporating a multidisciplinary team of experts made it possible to give the guidelines credibility, an important step to guaranteeing widespread adoption.

A key limitation associated with the project is that the practice guidelines were developed particularly for COPD patients, and hence the results may not be generalized to patients with other conditions. For instance, pneumonia and heart failure are the most challenging cases affecting hospital settings, necessitating the development of appropriate remedial measures. Another weakness in the project is that the panel members are primarily clinical and administrative personnel who had limited time for participating in a comprehensive and systematic literature search. Such comprehensive engagement in literature reviews is essential in guaranteeing that the approaches selected are associated with clearly defined evidence-based practices. In the future, the most suitable strategy would entail developing guidelines that can be utilized for any readmission-related infections hence addressing a wide variety of diseases. This project was applicable to this specific site, so may not be generalizable to other settings.

Section 5: Dissemination Plan

Nurse-led scholarship should be shared with medical experts to bolster the quality and individual outcomes and facilitate clinical scholarship. The first approach is by presenting a policy proposal to the local site medical executive committee for approval as a clinical standard of care to patients suffering from COPD. The approved guidelines are also posted on the intranet operated by the hospital, making them readily accessible to staff members. The acute care facility is part of a larger health system which holds annual research and informatics conferences in which clinicians offer evidence-based initiatives for improving performance and using technological standards for the augmentation of patient care at the point of contact. The recommendation to incorporate these clinical practice guidelines into the facility's systems guarantees that the project can be presented during the annual general meeting.

The third methodology that can be used in disseminating the guideline is using the corporate quality improvement committee within the organization to release the findings for the project across the health system. In essence, this committee accentuates the best practices and sustained improvement through communicating best practices via organizational communication methods published quarterly to 50 campuses. In addition to this, the quality improvement committee releases information on new practices to workers, partners, and contractors through the systems available within the facility's intranet. External dissemination is also an option in the project since the research will continuously seek opportunities to publish the research in interdisciplinary journals as well as presenting the content at nursing conferences.

Analysis of Self

The DNP scholarly project has offered me multiple opportunities for growth and self-discovery. This project augmented my leadership skills by establishing an evidenced -based practice change that can impact the entire facility. As a writer, the project has offered me the opportunity to understand the dynamics of content presentation primarily by using medical terminology to guarantee that the material is beneficial to both experts and novices. Throughout the presentation, it has been possible to ascertain the proper approach of delivering scientific content utilizing the pertinent framework and structure. Some of the challenges entailed filling all aspects of the structure or fields since they were substantially expansive. However, the examples given were significant in filling all the parts seamlessly. The examples offered also enabled me to perform effective review literature to determine the suitability of presenting ideas and concepts aligned with the research methodology and the stated objectives.

The DNP project also offered significant insight into leadership. As a nurse leader, it will be expected that an individual will espouse all the traits of an effective leader in all activities within healthcare. DNP-prepared nurses have a responsibility to ensure a culture of safety (AACN, 2006). Throughout the project, leadership skills were enhanced using an evidence-based approach that could impact the entire organization. Leadership skills are an indispensable component of organizational culture as it contribute to ascertaining gaps in care and incorporating evidence-based methodologies in enhancing quality initiatives. Being a leader in my project entailed coordinating activities among the involved stakeholders. Such an experience introduced me to how to

exercise control and guarantee that all stakeholders fulfill their duties satisfactorily. The project enhanced my understanding of the curricula and core competencies underscored by the DNP essentials. By using knowledge gleaned from the sciences I was able to translate and use this knowledge to benefit patients by address a gap in practice (AACN, 2006; DNP Essential 1 and VII).The project has offered me expertise in collaborating with professionals, a multidisciplinary team, (DNP Essential VI), and clients to guarantee that a central point is established that will underscore the effective delivery of healthcare and improve population health (DNP Essential VII). However, it was significantly challenging to determine the suitable means of guaranteeing that professionals and clients collaborated seamlessly.

Summary

The doctoral project is part of the commitment of the hospital in improvement processes of care through scientific evidence for the delivery of effective, safe, patient-centered and timely care within the community it operates. This DNP project addressed one of the significant gaps noted in clinical practice which was the shortcoming in transition of COPD patients from the hospital setting to their natural environment as possibly contributing to excessive rates of readmission. As a result of this project, an evidence-based clinical practice guideline informed by a team of interdisciplinary experts was advanced in order to address the gap noted and significantly reduce the rate of readmission. Developing a COPD clinical practice guideline embodies one of the effective approaches of decreasing excessive rates of readmissions while simultaneously boosting the quality of care delivered to patients. Additionally, it also provides nurses

with consistent and structured methodologies of bridging the gap between the prevailing discharge approaches and the recommendations for best practices underscored by evidenced-based findings. In this research, I focused on defining the suitable recommendations for discharging patients, future research and projects should incorporate proposals for infection-specific and evidence-based clinical practice guidelines enhancing quality of care delivered to patients coupled with informing clinical decisions.

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Appendix A: Literature Review Matrix

Reference	Purpose	Study Design	Data Collection/Outcome Measures	Findings/ Conclusions	Grade
The global initiative for chronic obstructive lung diseases [GOLD] (2020)	The central focus is offering experts in the healthcare sector the relevant guidance concerning diagnosing, managing, and preventing COPD	The primary study design adopted is systematic reviews of RCTs	The approach selected was the grading system which essentially measures the effectiveness of diagnostic assessment and management of stable and unstable COPD	Ultimately, there is a strong degree of support for pulmonary rehab, self-education, support for chronic care management, and addressing anxiety disorders and depression.	A
Adloff, F., & Neckel, S. (2019). Futures of sustainability as modernization, transformation, and Control: A Conceptual Framework.	The primary purpose of the article is ascertaining elements of social order through evaluating modernization, the associated transformation, and the control mechanisms existent in society	The study design utilized in the research is exploratory and meta-analysis to determine the content presented in existing studies. Such a design guarantees that all possible arguments on the topic	Data is collected from the existing studies as opposed to performing primary research. After the data is collected, the studies are compared to determine the similarity and differences, ultimately improving the outcomes.	The findings and conclusions from the research indicate a significant relationship between transformation and control concerning social order. Social order is an outcome of transformation to societal	B

		are comprehensively addressed.		revolutions concerning multiple dimensions.	
Bashir, B., Schneider, D., Naglak, M., Churilla, T., & Adelsberger, M. (2016). Evaluation of prediction strategy and care coordination for COPD readmissions.	The primary purpose of the article is to determine the factors influencing the probability of readmission for COPD patients and the implications of post-hospital care coordination. The study capitalizes on a tool that predicts 30-day readmission for general medicine patients.	The study design utilized in this case is a case-control in which the predictors were analyzed using multivariable logistic regression for a sample group of 461 patients. Care coordination entailed telephone conversations in which discharge instructions are reviewed, emphasizing medical adherence. Follow-up appointments were made, including emergency	Data collection was primary since patients indicating a high probability of admission at discharge were accorded care in July of 2013. Subsequently, tests were conducted to establish an association between readmission and care receipt.	The results indicate that the rate of COPD readmission was initially 16.5% but was reduced to 14.3% after the proposed measures were adopted. The conclusions are a positive indication that post-hospital care coordination for care transition between hospital and the community embodies a critical set of factors impacting the rates of readmission	A

		backup plans.			
Grewe, F., Sievi, N., Bradicich, M., Roeder, M., Brack, T., & Brutsche, M. et al. (2020). Compliance of pharmacotherapy with GOLD guidelines: A longitudinal study in patients with COPD.	The study's primary purpose is evaluating clinical implementation of pharmacotherapy recommendations concerning COPD contingent on the gold guidelines. The authors seek to determine the effectiveness of the implementation and possible implications for care delivery and clients.	The study design is a sub-analysis of a prospective non-interventional cohort study.	Data was collected by performing follow-up visits to facilities for seven years. In each visit, data were collected concerning compliance with the proposed pharmacotherapy based on the gold guidelines. A comparison was performed to determine whether concordant variations in the prescribed dosage accompanied the GOLD stages or standards. The data was collected from a sample group of 305 patients.	The results indicated that in 59.1 percent of the visits made, prescriptions were in alignment with the pertinent gold guidelines. Patients suffering from extreme COPD were highly likely to receive pharmacotherapy in alignment with guidelines. A conclusion can be made that adherence to COPD pharmacotherapy with the GOLD guidelines was sub-optimal, particularly in groups at a lower risk.	A

Han, M., Martinez, C., Au, D., Bourbeau, J., Boyd, C., & Branson, R. et al. (2016). Meeting the challenge of COPD care delivery in the USA: A multiprovider perspective.	The research's primary purpose is to summarize expert opinions from multiple stakeholders concerning the barriers to care delivery and present possible remedies. Understanding the hindrances will be possible to develop the pertinent remedies that will ensure better outcomes for COPD patients.	The study design is primarily exploratory since it seeks to evaluate the outcomes of existing studies in explaining the challenges of delivering COPD. Reviewing the pertinent literature will indicate an extensive scope of evidence for the challenges.	Based on the results, some recurring themes include poor implementation of guidelines and undermined access of patients to key treatments, including drugs and pulmonary rehabilitation. The conclusions also make the recommendation that financial incentives might be vital in boosting the rate of engagement between healthcare systems and providers	Data collection is from a secondary perspective since no interviews or surveys are administered to gather the required data. Such an approach is utilized to acquire as many data points as possible	
Portillo, E., Wilcox, A., Seckel, E., Margolis, A., Montgomery, J., & Balasubramanian, P. et al. (2018).	The primary purpose of the article is assessing the likelihood of reducing COPD readmission rates by	The study design utilized is primarily observational since the veterans receiving the care are offered the	The participants were scheduled for an inter-professional postdischarge follow-up visit in which the pertinent	The results indicated that patients who followed through with the recommendations for COPD	B

Reducing COPD readmission rates: Using a COPD care service during care transitions.	utilizing care services in the process of transition. The research delineates that one of the key reasons for readmission is a poor transition from the hospital to the community exasperating the risk of falling ill. The researchers, therefore, seek to incorporate interprofessional care to improve health outcomes through communication and teamwork.	intervention at the clinical site. However, the process is purely from an observational perspective instead of researchers altering the valuables. The nurse manager engaged in conversations with the patients through the phone and offered the pertinent services.	data was collected. The follow-up was performed within 30 days of discharge.	discharge had a 0% readmission rate. A conclusion was made that the COPD care service significantly enhanced patient access and reduced the rate of COPD admission within the intervention group.	