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Effective Postdischarge Communication from Nursing Staff to Mental Health Patients

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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
the review committee have been made.

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Walden University
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Abstract

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MS, Walden University, 2016

BS, Northeast Louisiana University, 1997

Submitted in Partial Fulfillment

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Abstract

Mental health patients have a history of decreased follow-up appointments, poor diet, and medication noncompliance after discharge from inpatient facilities in addition to multiple co-morbidities, making a return to the community difficult. The practice problem was an increase in hospital readmissions of mental health patients within 30 days postdischarge due to inadequate post-discharge education and follow-up communication. Using Rodgers's recovery on mental health theory and Revan's action learning theory, a staff education program was developed to educate 10 nursing staff and two social workers on how to effectively implement postdischarge communication at 3 days and 30 days after discharge from an inpatient mental health facility. The program included content on using a postdischarge communication algorithm and the brief psychiatric rating scale, which is used to rate patients' condition at the end of the contact. Pretests were administered before the education, and posttests were administered after the education to determine knowledge gain. The results showed an average of 82.75% knowledge gain using the knowledge gain formula. The pre-test mean score was 16.7 and the posttest mean score was 29 ($p < 0.00$). These results demonstrate the project positively impacts the staff's ability to teach patients how to adhere to their discharge plan, promoting social change. This patient population can positively grow and thrive in the community due to effective postdischarge communication.

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Dedication

I am dedicating this project to people who have impacted my life and helped me during this doctoral journey. To the memory of my son, Hunter Cole Garrison, who is no longer in this world, but he is my shining light when life gets dark. His spirit lives within me and encourages me to do better.

I am dedicating this project to my daughter, Hannah N' Cole Garrison, who lights the path for me daily. She is my gift from God that pushes me to develop a better version of myself every day.

I am dedicating this project to my parents, who have been my biggest cheerleaders. My parents are always available for my children and me, making it possible to pursue my dreams.

Kenneth (K-Rob) Robinson, I am dedicating this project to you. You are my forever best friend. Thank you for your endless love and support. Thank you for believing in me and for encouraging me to complete this project. I love you always.

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I want to thank my parents, brothers, and sister-in-law. Thank you for the continued support and motivation. The graduation is near! Hannah Garrison, you are next!

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Above all, I thank God for allowing me to make this journey. God gave me the strength and power to continue on this journey. Isaiah 40:29

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Section 1: Nature of the Project

Introduction

Mental health patients are members of a vulnerable population that must face many barriers to accessing health care. Additionally, mental health patients exhibited a decrease in follow-up care after discharge from inpatient facilities. The United States has over two million hospitalizations for mental illnesses each year. Only 36%–46% of this population received follow-up care 7 days post-discharge (National Committee for Quality Assurance, 2021). A strategic follow-up plan is needed because of worsening comorbidities and hospital readmission due to noncompliance. Inadequate postdischarge communication with mental health patients by the nursing staff increases hospital readmissions.

For this reason, an educational intervention was developed to promote a positive social change for this population. The mental health population is vulnerable, and the educational project promoted Walden University's definition of social change. Through the project, I deliberately created and applied new ideas and strategies, such as the postdischarge communication educational project, to empower the staff to aid patients to maintain a treatment program to maintain their dignity and self-worth (Walden University, 2021).

Follow-up discharge phone communication assists patient with any questions they may have after discharge and serves as a reminder to engage in self-care strategies. According to Maurad and Rennke (2012), if health care providers use an effective follow-up phone call program, providers can recognize postdischarge issues and use a network

of providers to intervene on behalf of the patient. Because of the increase in the staff's knowledge on adequate postdischarge education and communication with mental health patients, positive social change occurred within the community.

Problem Statement

I addressed the specific project problem through the study of the increase in hospital readmissions of mental health patients within 30 days post-discharge due to inadequate postdischarge education and follow-up communication. The readmission rate in the local clinical setting had doubled, with some patients readmitted within a week of discharge. These patients have complex comorbidities that warrant nursing care. According to the Centers for Medicare and Medicaid Services (2021), patients admitted to inpatient facilities have multiple comorbidities that affect their treatment and long-term outcomes. For these reasons, there was a need to address inadequate postdischarge education and follow-up communication. Addressing this problem was significant to nursing and nursing care because it advanced nurses' knowledge of postdischarge education and communication and assisted mental health patient in adhering to their treatment plan. This population is vulnerable and has decreased follow-up appointments, poor diets, and medication noncompliance after discharge from inpatient facilities. The poor discharge education and communication 3 days and 30 days postdischarge from an inpatient mental health facility results in hospital readmission within 30 days of discharge. According to New York Health and Hospitals (2017), improving the integration of follow-up care of mental health patients before 30 days postdischarge from

an inpatient facility can reduce inpatient readmissions and improve the quality of care delivered to the patients.

Purpose Statement

The purpose of this staff education project was to inform and educate the staff on how to effectively implement postdischarge communication 3 days after discharge from an inpatient mental health facility and 30 days after a patient is discharged from an inpatient mental health facility. The knowledge gap occurs when inappropriate planning or failure to educate the patient occurs. The practice focus question was: Will educating the nursing staff on postdischarge communications 3 days and 30 days postdischarge decrease hospital readmission of mental health patients from an inpatient mental health facility? With this project, I sought to address the gap in practice by implementing a staff education project that taught the staff how to educate and prepare patients to adhere to their discharge plans. Mental health professionals and social workers should be educated on how to teach patients strategies for self-monitoring, coping, and medication compliance before and after discharge from a mental health facility (Adnanes et al., 2020).

Nature of the Doctoral Project

When addressing the project question in this staff education project, the specific project design included the relationship of the value of postdischarge education and the dependent variable, which was decreases in hospital readmission. A pretest and posttest were administered to document the change in knowledge or knowledge gained. The project setting was a psychiatric mental health inpatient facility. Mental health patients

have complex diagnoses with multiple comorbidities. These complexities can result in noncompliance after discharge, no follow-up care, worsening signs and symptoms, and hospital readmissions. Addressing improper postdischarge education enables mental health patients to adjust to their normal way of living and bring awareness to the gaps in knowledge on patients with mental disabilities.

I educated health care professionals on the following procedure: After a patient is discharged from the mental health facility, the health care professional contacts the discharged patient 3 days and 30 days after discharge. The health care professional completes a checklist of questions: Have you been able to get your medications? Are you taking your medications every day? Have you encountered any side effects? How do the medications make you feel? Are you having any problems with your living arrangements? Do you have any suicidal or homicidal ideations at this time? Do you have any questions or needs today? When asking these questions, the health care professionals use a postdischarge communication algorithm that guides them to complete the next action.

I educated the staff on using the Brief Psychiatric Rating Scale (BPRS) to rate a patient's condition at the end of each phone call. The team used 18 categories on the BPRS to assess patients over the phone using scores from 0–7. Zero is not evaluated, and seven is extremely severe (Bhandari, 2020). All scores were placed in the patients' discharge plan folders. The BPRS scores serve as a guideline of patients' condition. If the BPRS is severe, the health care professional notifies the physician. The scores give the doctors an indication of how the patient is affected by their condition (Bhandari, 2020).

The staff's understanding of discharge planning for mental health patients was assessed with a pretest. To determine if there had been a change in understanding of the discharge process and its importance in keeping mental health patients focused on following their treatment plan, a posttest was used.

Each patient had an individual electronic file. The staff electronically saved all notes on a patient's file. I educated the staff to save the data from the BPRS in the patient files. There is a legend at the top of the BPRS form. If the score is severe, the staff notify the on-call physician, and the health care professional follows given orders.

The staff were educated in small groups using a PowerPoint presentation describing the BPRS and the postdischarge communication algorithm. I gave a pretest before the presentation. After the presentation, I administered a posttest to evaluate the knowledge gained from the education. I determined the effectiveness of the project by using the value-gained formula. The pretest and posttest closed the knowledge gap in practice and indicated knowledge gained by the staff on postdischarge communication. This staff education project aimed to inform and educate the team on effectively implementing postdischarge communication. The postdischarge communication was administered 3 days after discharge from an inpatient mental health facility and again 30 days after a patient was discharged from an inpatient mental health facility.

Significance

The project is significant to all stakeholders and impacts them in a multitude of ways. Implementing postdischarge communication in mental health facilitates social change with all stakeholders. The stakeholders include nurses, physicians, pharmacists,

social workers, case managers, discharge planners, caregivers, coworkers, and the local community. The mental health population can positively grow and thrive in the community due to effective postdischarge communication. Because of the postdischarge communication at 3 days and 30 days postdischarge, mental health patients are able to maintain a continuity of care with their primary care provider. The nurses, physicians, social workers, case managers, and discharge planners can improve their interprofessional collaboration and enhance the transition of patient care.

This project closed the knowledge gap regarding the high readmission rate of mental health patients. Family members can be educated and equipped with the knowledge needed to understand discharge instructions and care for their mentally ill family member. Another important stakeholder is the pharmacist. Medication noncompliance is one of the primary reasons for hospital readmissions within 30 days of discharge from an inpatient mental health facility. The rates of medication noncompliance for mental health patients are between 40% and 65%, resulting in poor psychosocial outcomes, relapse of symptoms, and rehospitalizations (Semahegn et al., 2018). The pharmacist can electronically communicate with patients by sending reminders regarding the pickup of their medications or general medication information. The community benefits because, through adequate discharge communication, patients improve socially and integrate into the community. The project was essential to nursing practice because I directed health care professionals on how to provide a safe transition for mental health patients after being discharged from an inpatient mental health facility.

As a result of the education, the health care professionals know to use adequate discharge education and tools, such as follow-up phone calls, text messages, and video chats.

The results of this doctor of nursing practice (DNP) project can be useful in other studies. Iqbal et al. (2020) implemented postdischarge communication by nurses for heart failure patients. The results revealed that postdischarge communication improved the management of self-care by the patient. Pharmacists have been shown to have a significant impact on the transitioning of patients into their home environment. Phatak et al. (2016) studied the effect pharmacists have on the transition of care of discharged patients by implementing face-to-face medication reconciliation discharge phone calls 3, 14, and 30 days after being released from an inpatient facility. In a random control trial, Steinbeck et al. (2015) examined the transition in Type 1 diabetes mellitus pediatric patients to adulthood. The purpose of Steinbeck et al.'s study was to determine if postdischarge communication, which included a comprehensive transition program, would help patients with their transition to an adult diabetes service. The results showed the patients who participated in the comprehensive transition program increased retention in adult care; patients' follow-up HbgA1c appointments increased by 1.28% (Steinbeck et al., 2015).

Potential positive social change can arise by empowering stakeholders with knowledge on postdischarge education, which can allow patients to care for themselves and positively contribute to their social environment. This project supports the mission of Walden University to promote social change. By equipping the facility with the strategies and actions to promote the growth and dignity of mental health patients (Walden

University, 2020), this project advances social change within the organization, homes, and the community. Positive development among mental health patients can improve a community's success and decrease health care costs.

Summary

Educating the staff on postdischarge communication can have a significant impact on patient outcomes. Staff education improves interprofessional communication with all stakeholders and promotes organizational and social change. Adequate staff education can improve nurses' care coordination and can decrease hospital readmission of mental health patients from an inpatient mental health facility. Teaching professionals can increase collaboration among teams, support coordination of care, and improve organizational efficiency (Morley & Cashell, 2017). The overall goal was to educate the staff to deliver postdischarge information to patients. According to Morley and Cashell (2017), adequate staff education leads to a reduced length of hospital stay, improved medication compliance, and improved psychosocial management.

In the next chapter, I discuss concepts, models, and theories related to the doctoral project. I demonstrate how postdischarge communication is relevant to nursing practice. The local background and context are described to explain the evidence used to define the practice-focused question and the institutional context. Finally, I discuss the role of the DNP student, the relationship to the topic, and my motivation for the project.

Section 2: Background and Context

Introduction

Mental health patients require structure and consistency to return to healthy living. This staff education project followed a theoretical framework consistent with educating an adult learner who can assist patients in adjusting to life after inpatient hospitalization. This project shows relevance to nursing practice and how a DNP student can foster change within their local health care environment. In this project, I sought to answer this practice-focused question: Will educating nursing staff on postdischarge communications 3 days and 30 days postdischarge decrease hospital readmission of mental health patients from an inpatient mental health facility? According to Chen et al. (2020), when a patient is discharged from a psychiatric inpatient facility, they experience vulnerability due to the complexity of instructions, transitions between providers, and caregiver stress. The purpose of this staff education project was to inform and educate staff on how to effectively implement postdischarge communication 3 days after discharge from an inpatient mental health facility and 30 days after discharge.

In this chapter, I discuss how postdischarge communication is relevant to nursing practice. The local background and context help to explain the evidence used to define the practice-focused question and the institutional context. Finally, I discuss the role of the DNP student, the relationship to the topic, and my motivation for the project.

Concepts, Models, and Theories

The theories and concepts that ground this study include Rodgers's recovery in mental health theory and Revans's action learning theory. Rodgers's recovery in mental

illness attempts to bring a normal way of living to mentally ill patients after discharge. The theory is used to look beyond patients' signs and symptoms by including personal and spiritual growth and bringing clarity to the nursing care of mentally ill patients. Rodgers's (2000) recovery in mental health concept emphasizes life beyond illness without necessarily achieving the elimination of symptoms of the disease, reawakening hope and leading to a positive self and meaning through personal growth. Recovery in mental illness attempts to encourage a standard way of living among mentally ill patients after discharge. Rodgers (2000) used an evolutionary concept analysis to explain a humanist view of strategically planning for the care of a discharged mentally ill patient.

Rodgers's theory guides nurses to understand how to plan the care of mentally ill patients after discharge. Rodgers used six steps to teach nurses to develop knowledge in clinical practice. A brief overview included identifying the concept of interest, educating the staff to improve discharge education 3 days and 30 days postdischarge, resulting in decreased hospital readmission.

The setting was a 62-bed mental health facility that consisted of 10 nurses and five social workers. The first steps involved collecting and analyzing data. Data collection includes reviewing discharge instructions, analyzing them for completeness and specificity to patients, and identifying an exemplar. The exemplar services guide and assist with further development of discharge communication (Rodgers, 2000). The clinical organization does not use the evolutionary approach. The organization would benefit from the staff education project to help them understand the discharge process to assist mental health patients with following their treatment plan. Health care providers

became more involved in-patient care by advocating for optimal recovery for all patients based on how that is defined for each patient. To implement an effective project, the health care team must solve a problem within the facility. Implementing the discharge project using postdischarge communication three days and thirty days postdischarge helped to solve increased hospital readmission.

The action learning theory developed by Revans uses work-based problems to move forward through action and learning (Marquardt & Banks, 2010). I educated staff to address the increase in hospital readmissions using an algorithmic post discharge phone call. The action learning theory was effective for organizational problem-solving approaches. A brief overview of action learning reveals a continuous group-based process of learning and engagement (Masango-Muzindutsi et al., 2018). The action learning theory involves engaging staff in small groups about the intervention. I educated staff in small groups on steps in the discharge process that I developed.

The rationale for choosing the action learning theory and the recovery in mental health theory was the logical connection between the framework presented and the nature of the study. The alignment between the action learning theory and the recovery in mental illness concept can improve patient outcomes and decrease hospital readmission. Revans developed the action learning theory to support organizational development (Marquardt & Banks, 2010). The educational program was created by the project designer and included adaptations of several models. Teaching the staff how to improve the organizational workflow by having adequate post discharge communication assists

patients in returning to a normal state, thereby increasing medication and disease management compliance and decreasing hospital readmissions.

Relevance to Nursing Practice

Mental health patients have a history of decrease in follow-up appointments, poor diets, and medication noncompliance after discharge from inpatient facilities. Stentzel et al. (2015) studied postdischarge communication, such as telephone calls and text messages, regarding medication adherence. A randomized control trial was performed on patients with a range of mental health diagnoses (Stentzel et al., 2015). Telephone calls and short text messages were used to encourage medication adherence among patients from three psychiatric hospitals to emphasize the importance of follow-up phone calls after mental health patients are discharged from an inpatient facility (Stentzel et al., 2015). The intervention group received phone calls asking and answering questions related to their discharge every 2 weeks and weekly text messages over 6 months. The control group received routine discharge instructions and no communication afterward. The results showed an increased medication adherence among the intervention group (Stentzel et al., 2015).

Tyler et al. (2019) argued how ineffective communication and medication noncompliance can lead to hospital readmission and how patients can benefit from postdischarge communication. Tyler et al. revealed challenges that discharged patients experience, such as medication noncompliance and ineffective communication. Finally, Rosen et al. (2016) studied the effect of telephone care management on military veterans with posttraumatic stress disorder. The authors performed a randomized control trial to

examine how telephone care management could improve posttraumatic stress disorder in veterans. Some veterans were assigned the usual outpatient mental health treatment; others were given the standard outpatient mental health discharge treatment, plus a phone call twice a month (Rosen et al., 2016). Rosen et al. found that the effectiveness of telephone care management improved treatment adherence among the patient population.

The current state of nursing practice has resulted in increased hospital readmissions of the mental health and the need for a staff education project. One recommendation to improve the nursing practice was to educate the staff on the electronic tools used to communicate with the patients, such as smart apps. Vazquez et al. (2018) performed a randomized control trial on depressed caregivers. The authors studied using technology such as a smartphone app to give feedback during a conference call. The goal of the study was to increase program adherence for depressive caregivers. The study provided information on alternative formats to increase the accessibility of therapies and assessing a technique to improve compliance. The results showed that using the telephone and the app was essential to achieve commitment to postdischarge interventions.

Several strategies have been used previously to address this gap in practice. Family involvement is one strategy that has been used in the past. Haselden (2019) studied how family involvement was significant to the patients' outcomes. The study emphasized how family contact and communication by the staff resulted in a positive discharge. When the family is involved with comprehensive discharge planning, patients comply with the discharge regimen and maintain their outpatient appointment. Another

strategy that has been previously used to address the nurses' lack of knowledge on how to implement discharge communication with mental health patients adequately is to incorporate teach-back with caregivers. The teach-back will involve discharge education and postdischarge phone calls to help the patient have an easier transition to home. The results showed that using different teaching components to caregivers regarding discharge instructions on follow-up appointments and medications improved patient care transitions improved the patient's transition to home. This evidence supports the project problem because staff education on postdischarge communication using teach-back provides a smooth transition to home and decreases hospital readmission.

This doctoral project advanced nursing knowledge in practice by directing health care professionals on how to provide postdischarge education to mental health patients adequately. The postdischarge communication resulted in a safe transition after discharge from the hospital using adequate discharge education and tools such as follow-up phone calls, text messages, and teleconferencing.

Local Background and Context

The local facility reported an increase in hospital readmission of mental health patients. However, the problem existed due to a decrease in interprofessional communication and inadequate postdischarge education. The psychiatric patients undergo the 'revolving door' phenomenon in which they are hospitalized, discharged, and are readmitted back to the hospital with similar symptoms (Adnanes et al., 2020). Educating the staff on implementing follow-up postdischarge communication with the mental health patients prevented the readmission cycle.

The institution serves a small community with a strategic plan to provide a continuum of care. Educating the nursing staff on implementing postdischarge communication with the patients three days and thirty days postdischarge allowed for a smooth continuum of care and help the patient return to normalcy. In 2021 the hospital readmission rate for geropsychiatric patients between the ages of 65 and 74 was 16% (United Health Foundation, 2021). Because of medication and appointment noncompliance and knowledge deficit, the patients are readmitted to the hospital with mental health diagnoses and other comorbidities. Because hospital readmissions indicate the quality of care that the hospital delivers, the state of Louisiana explored the causes of the readmissions. Confusion about medications, miscommunication by hospital staff of important information, and improper follow-up were significant causes of hospital readmissions (United Health Foundation, 2021). Teaching the staff how to implement the postdischarge communication three days and thirty days postdischarge allowed the team to help to meet any challenges and help them follow their treatment plan. Because of these facts, this doctoral project added value to the need to educate the staff on postdischarge communication.

Role of the DNP Student

I have worked in various positions in the psychiatric field of nursing for over twenty-two years. To further advance my knowledge in psychiatric nursing, I earned a psychology degree. I have seen patients with repeat admissions to a psychiatric facility or medical facilities throughout the years due to mental or medical defect exacerbations. Over the years, these patients have become known as ‘repeat offenders’ or ‘frequent

flyers. My role in the doctoral project was to educate and guide the nursing staff to successfully understanding how to implement postdischarge communication with mental health patients. My motivation for this doctoral project was to provide service to a vulnerable community. There was a gap in the project on postdischarge communication in mental health patients. There was a deficiency in the way nurses complete discharge education and follow-up care. My goal was to fill the gap in nursing knowledge of postdischarge communication and decrease hospital readmissions.

The apparent bias that I detected was my familiarity with the project and organization. The participants were observed hurrying through the pretest and posttest. The participants were allowed 30 minutes to complete testing to prevent procedural bias. Procedural bias occurs when too much pressure is placed on the participants, such as completing a test on their lunch break (Finch, 2017). Another bias would be only getting the viewpoint of the nurses. In mental health facilities, the care is interdisciplinary; therefore, the DNP student included the discharging staff to educate patients. If only one viewpoint is observed, the impartiality of the project is endangered (Finch, 2017).

Summary

Mental health patients are vulnerable populations that require strategic follow-up communication from the organizational staff to prevent hospital readmission. The organizational staff had a knowledge deficit on adequate postdischarge communication with mental health patients. Inadequate postdischarge practices causes risk for relapse and poor patient outcomes, leading to hospital readmissions (Chen et al., 2020). The staff knowledge deficit regarding postdischarge communication of the mental health patients

warranted a staff education project consisting of a pretest and posttest and tools for data collection.

There was a gap in the project on postdischarge communication in mental health patients. There was a deficiency in the way nurses complete discharge education and follow-up care, which increased hospital readmissions. The next chapter examined the practice focus questions and identified evidence that addressed the practice focus question. The next chapter also gives an overview of the evidence that was generated for the doctoral project. Finally, the data were analyzed and synthesized with an outline of the procedures used to ensure the integrity of the evidence used.

Section 3: Collection and Analysis of Evidence

Introduction

The specific project problem addressed through this study was inadequate postdischarge education and follow-up communication. After discharge from inpatient facilities, mental health patients experienced decreased follow-up appointments, poor diets, and medication noncompliance, resulting in hospital readmission. The purpose of this staff education project was to inform and educate the staff on how to implement postdischarge communication effectively at 3 days and 30 days after discharge from an inpatient mental health facility.

Increased hospital readmission of mental health patients can occur because of a decrease in interprofessional communication and inadequate postdischarge education. Educating organizational staff on adequate postdischarge follow-up communication is imperative for patient health outcomes. In 2021, the hospital readmission rate for geropsychiatric patients between the ages of 65 and 74 years was 16% (United Health Foundation, 2021). Teaching the staff how to implement postdischarge communication 3 days and 30 days postdischarge allows the team to help meet any challenges patients encounter within that time frame.

In this chapter, I examine the practice-focused question and identify sources of evidence that address the practice focus question. I give an overview of the evidence generated for the doctoral project. I analyze and synthesize the data with an outline of the procedures used to ensure the integrity of the evidence used in the project.

Practice-Focused Question

The local problem was the increase in hospital admission rates among mental health patients. In this project, I sought to answer the clinical question: Will educating nursing staff on postdischarge communications 3 days and 30 days postdischarge decrease hospital readmission of mental health patients from an inpatient mental health facility? The gap in practice was identified as inadequate postdischarge follow-up care by organizational staff. I implemented a staff education project to advance staff knowledge of implementing postdischarge follow-up communication 3 days and 30 days postdischarge. Because the staff education project was aimed at informing and educating the team, the project was aligned with the practice-focused question. The staff understood how to implement postdischarge communication effectively 3 days and 30 days after a patient is discharged from an inpatient mental health facility.

In this chapter, I address the practice-focused questions and sources of evidence. I address evidence generated for the doctoral project, including a detailed description of how evidence was collected. I also discuss the analysis and synthesis of the evidence, including the software used.

Sources of Evidence

The sources of evidence relied on to address the practice-focused question were the data points from the pretest and posttest. The pretest and posttest determine the knowledge gained by the staff from the education project (Shivaraju et al., 2017). The pretest and posttest were administered using a Likert scale. According to Brigham and Women's Hospital (n.d.), a project designer can use the following calculation to

determine the knowledge gained by the staff: (postlearning score minus prelearning score / maximum score minus prelearning score) X 100. A high posttest score indicates knowledge gained by the team. A high posttest score shows that educating the staff on implementing postdischarge communication 3 days and 30 days after a patient has been discharged from an inpatient mental health facility could lead to decreased hospital readmissions.

Administering and analyzing the pretest and posttest revealed that the knowledge gained from the staff education project advanced the staff's skills, knowledge, and clinical practice. Also, these tools adequately taught the team how to implement postdischarge communication 3 days and 30 days after discharge, which can result in a decrease in hospital readmission. Using a pretest and posttest allows the staff to be actively involved with the educational process and enables them to demonstrate their knowledge gained (Shivaraju, 2017).

Evidence Generated for the Doctoral Project

The clinical facility was an inpatient psychiatric mental health facility. The mental health patients had multiple hospital readmissions, some within a week of discharge. The problem was inadequate postdischarge follow-up education by the organizational staff, leading to increasing hospital readmissions. Due to the increased readmission rates and the knowledge gap in postdischarge communication, I educated the team on adequate postdischarge education of mental health patients.

I educated 10 nurses and two social workers on implementing postdischarge education for the discharged mental health patients. A small number of participants were

selected to correlate with the action learning theory. Revans developed the action learning theory to support organizational development (Bowerman, 2018). The action learning theory emphasizes organizing small group teachings to promote engagement of all participants. Teaching the staff how to improve the organizational workflow to include adequate postdischarge communication assists the patients in returning to a normal state, thereby increasing medication and disease management compliance and decreasing hospital readmission. These participants were relevant to the practice-focused question because teaching them how to implement the postdischarge communication 3 days and 30 days postdischarge allowed the staff to change the discharge process. Increasing the staff's knowledge in the discharge process further assisted the mental health patients with following their treatment program.

The staff were educated by a PowerPoint presentation in small groups. A pretest was given to the team before the educational project. I informed the staff on using a template of questions that correlated with the postdischarge communication algorithm and the BPRS. After the education presentation, the team completed a posttest to determine if there was a change in the understanding of the discharge process and its importance in keeping mental health patients focused on following their treatment plan. I made modifications to the pretest and posttest by adding a Likert scale. Shivaraju et al. (2020) emphasized the importance of using a pretest and posttest in behavioral modification to measure change and assess the impact of an intervention.

According to Bhandari (2020), the BPRS can rate a patient's condition at the end of each phone call. I made no modifications to this BPRS. Eighteen categories are used

with scores ranging 0–7, and seven is the severest score. The BPRS gave the doctors an indication of how the patient's condition affects them (Bhandari, 2020). The BPRS proven to be reliable and a valid tool to evaluate changes in psychiatric patients. According to Yee et al. (2017), the BPRS has been a valid and reliable instrument in many languages.

The postdischarge communication algorithm was used to guide the phone interviewer through postdischarge communication. The algorithm used during postdischarge communication helps guide the interviewer during contact with the patient. The algorithm helps show the interviewer the right resources for the patient. I modified the algorithm for follow-up questions for the next postdischarge communication contact. Schyltebraukes et al. (2020) used an algorithm to identify patients at psychiatric risk discharged from an emergency department. The results showed external validity accuracy to discriminate posttraumatic stress disorder risk (Schyltebraukes et al., 2020). This project algorithm supports and validates the use of postdischarge communication for mental health patients.

Another tool I used to educate the staff was a postdischarge communication script. The script allows the interviewer to gain information for the BPRS and questions for the post discharge algorithm, which fill the gap in staff knowledge to assist the patient in adhering to the treatment plan. I developed this tool to correlate with the most common problems most mental health patients encounter medications, follow-up appointments, discharge instructions, pending test results, aftercare plans, home services, and any symptoms of patients' disorders' exacerbations. Other health care professionals can use

the tool to establish the validity of the discharge communication script on a different population of patients.

The DNP student worked closely with the staff at the clinical facility to build trust and maintain a working relationship with the team. One of the recruitment strategies that the DNP student used was to recruit within the organization. Another strategy used by the DNP student was the distribution of flyers and printed material, an easy and cost-effective method for recruiting participants (The Regents of the University of California, 2021). These methods allowed for voluntary participants. The measures ensured the participants' ethical protection, including not adding the participant's name or any other identifiable information to the pretest and posttest. All information was stored in the Excel program was locked and password encrypted. The DNP student ensured ethical protection because participation in the project was voluntary. Also, all participants were educated that they could withdraw from the project at any time. The participants were informed of freedom of withdrawal verbally and in writing. Walden University's IRB role ensured that all of the DNP student's data on this project complied with the university's ethical standards (Walden University, 2021). The DNP student ensured that all rights and autonomy of the participants are honored.

Analysis and Synthesis

The DNP student used an Excel spreadsheet to record, track, organize, and analyze the pretest and posttest. The DNP graduate only scored the pretest and posttest. The DNP student entered the scores on the spreadsheet. To protect the anonymity of the staff, the pretest and posttest did not require the participants' names or any identifiable

information. The DNP student saved all information on the DNP student's computer with a secure password.

The pretest and posttest scores were checked and rechecked to ensure the integrity of the data. Another procedure used was to ensure the integrity of the data is to submit the information for peer review. An outlier can indicate that the project had errors in calculation, recording, or measurements (Allen, 2018). Another challenge that interferes with the integrity of the evidence is missing data. The missing data will occur if participants drop out of the project or if the data is lost (Kwak & Kim, 2017). The graduate student had an alternate participant available to replace a participant if there was a dropout.

The analysis procedure used in the doctoral project to address the practice-focused questions was a calculation of the knowledge gain by the staff. The pretest and posttest provided a means to assess the knowledge gained by the team. The results of the pretest and posttest showed that the project positively impacted the staff's ability to teach patients how to adhere to their discharge plan, resulting in no hospital readmission during the time period of the project. The knowledge gain formula, Post-learning Score minus Pre-learning Score / Maximum Score minus Pre-learning Score, analyzed the knowledge gained by the staff and addressed the practice-focused question.

Summary

This chapter identified the practice-focused question and clarified its purpose. This chapter also demonstrated how the purpose was in alignment with the practice-focused question. The sources of evidence were reviewed in this chapter. All evidence

was generated for the doctoral project. The project participants were educated on selection procedures and how the DNP student protected the participants' rights. The chapter also reviewed the tools that were used for data collection. To address the local problem of increased hospital readmissions in mental health patients, the graduate DNP implemented a staff education project to advance staff knowledge on implementing postdischarge follow-up communication three days and thirty days postdischarge. Finally, the DNP student explained the recording, tracking, analyzing, and analytical procedure utilized.

The above information indicated that the staff education project was ready for implementation. This chapter discussed how the project promoted positive social change. The next chapter discusses the findings and implications, and recommendations.

Section 4: Findings and Recommendations

Introduction

The readmission rate in the local clinical setting had doubled, with some patients being readmitted within a week of discharge. The specific problem I sought to address through this study was the increase in hospital readmissions of mental health patients within 30 days postdischarge to inadequate postdischarge education and follow-up communication. The gap in knowledge and practice was inappropriate discharge planning or failure to educate the patient to prevent hospital readmission adequately. The purpose of this staff education project was to inform and educate the staff on how to effectively implement postdischarge communication 3 days and 30 days after a patient is discharged from an inpatient mental health facility. The staff education project sought to answer the question: Will educating the nursing staff on postdischarge communications 3 days and 30 days postdischarge decrease hospital readmission of mental health patients from an inpatient mental health facility?

The staff was educated in small groups using a PowerPoint presentation that describes the BPRS and the postdischarge communication algorithm. I gave a pretest before the presentation. After the presentation, I administered a posttest to evaluate the knowledge gained from the education. I determined the effectiveness of the project by using the value gained formula, comparing the pretest and posttest values. The staff was educated to implement the postdischarge communication 3 days and 30 days after a patient has been discharged from an inpatient mental health facility. The pretest and posttest were administered using a Likert Scale. Names were omitted from the test to

protect confidentiality. The staff used numbers to match the pretest and posttest. The knowledge gained by the staff was determined using a knowledge gain formula. All project information was stored and calculated using MS Excel.

Findings and Implications

The findings that resulted from analysis and synthesis of the evidence show no new patient readmissions during the period of the project. Ten nurses and two social workers were educated on postdischarge communication. Since there have not been any new readmissions, there is a probable correlation with educating the staff on postdischarge education 3 days and 30 days postdischarge and reduced hospital readmissions, but more time is needed for data collection. The results show an average of 82.75% knowledge gain using the knowledge gain formula (Table 1). The results of the learning gain formula demonstrate meaningful learning within the organization (Brigham Health, n.d.). There was a significant change in pretest and posttest scores, showing the pretest mean of 16.7 and the posttest mean of 29. The p value was < 0.000, indicating a significant difference between pretest and posttest scores, thus a significant knowledge gain among the nursing staff.

The DNP project had limitations that impact the findings. One of the limitations of the study was the frequent change in staffing and management; delivering consistent training to a fluctuating staff is a challenge. The organizational change had an impact on the ability to provide consistent training and engage the learners. Another limitation was the timing of the study. Because the facility was experiencing organizational turmoil, the data collection process took longer than projected.

The implications resulting from the findings increased a nursing staff's knowledge that improved continuity of patient care. The findings assisted the patients in having a better understanding of the discharge process to decrease hospital readmissions. The findings from this study enabled the staff to help the patients to become a productive part of the community. The communities will be positively affected by citizens that will be productive in the workforce. The institutions will prosper from the impact of nursing education. The DNP project will have a significant effect on social change. The DNP project will use technology to guide the staff and patients to learn new ways to grow and shape the world (Walden University, 2021).

Table 1

Pretest/Posttest: Effectiveness of Postdischarge Communication by a Nursing Staff With Mental Health Patients

Staff	Pretest	Posttest	Knowledge gain
Staff 1	9	29	95%
Staff 2	17	29	92%
Staff 3	21	28	77%
Staff 4	20	28	80%
Staff 5	9	29	95%
Staff 6	21	30	100%
Staff 7	18	29	92%
Staff 8	20	25	50%
Staff 9	24	28	67%
Staff 10	12	2	72%
Staff 11	17	28	85%
Staff 12	14	28	88%
Mean	16.8	28	82.75%

Recommendations

The recommendations from this DNP project included the adoption of this evidence-based project into the organization's educational plan to close the gap in

practice. All staff was encouraged to implement the postdischarge algorithm (Appendix B). Also, the Brief Psychiatric Rating Scale will be implemented by the organization (Appendix C). The postdischarge communication script will also be used along with the postdischarge communication algorithm to collect data (Appendix D). It is recommended that the organization include these recommendations in a new policy for postdischarge communication.

Strengths and Limitations of the Project

This project had several strengths and limitations. First, this evidence-based project was both sustainable and transferrable. It was easy to implement and was cost-effective for all stakeholders involved. The stakeholders were easily engaged with the implementation of the project, which was beneficial for the organization's growth.

One of the observed limitations was that it was difficult to confirm if the staff had completed all follow-up discharge communication three days and thirty days postdischarge with every patient. Another limitation was that some of the staff had difficulty using the BPRS. Many staff members reported that the BPRS was awkward to use and too time-consuming. Because this project has transferability, many other disease processes such as congestive heart failure and diabetes will benefit from implementing this postdischarge communication project within their organization.

Section 5: Dissemination Plan

The plan to disseminate this work to the project site institution involves the staff and stakeholders. The work will be distributed into the community by educating the local hospitals and physician offices regarding outpatient education and referral resources. Introducing a community link team is a successful intervention that can decrease the length of hospital readmissions (Tyler et al., 2019). This DNP project is sustainable and transferrable. This evidence-based project can be used across health care practices. The publication of this evidence-based project will demonstrate the need to adopt this work in the health care setting.

Analysis of Self

As a practitioner, my role in this project is passionate, with a drive to educate other health care professionals to improve patient mental and physical health. According to the American Association of Colleges of Nursing (2006), the DNP Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking emphasizes the importance of the DNP graduate practice to include focusing on the needs of a panel of patients, a target population, a set of population, or a broad community. I have demonstrated my ability to focus on the mental health population, which has a positive impact on the community.

The project has increased my knowledge as a scholar in applying evidence-based practice in the clinical setting. The application of DNP Essential III, Clinical Scholarship and Analytical Methods for Evidence-Based Practice, is heavily involved in this DNP project. I successfully educated the organizational staff on a postdischarge education plan

for mental health patients. This education plan was implemented by the staff 3 days and 30 days postdischarge. I applied knowledge to solve the practice problem of inadequate postdischarge education resulting in an increase in hospital readmissions. DNP Essential III emphasis integrating knowledge across disciplines to solve practice problems to improve health outcomes (AACN, 2006).

Technology was used within the facility to improve patient outcomes. The staff was educated on different electronic communication tools that can be used for patient communication postdischarge. DNP Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care includes using technology to monitor outcomes of care and also the consumer use of the technology (AACN, 2006). Because of this project, I successfully implemented a plan that includes the use of technology for health care providers and patients, which can result in an improvement of patient care.

Lastly, this project has given me experience in project development, implementation, and dissemination. DNP Essential VIII: Advanced Nursing Practice involves designing, implementing, and evaluating interventions based on science. My role in this project allowed me to assess the impact of inadequate discharge education by a nursing staff and implement a project that ultimately improves outcomes for mental health patients.

Summary

This postdischarge communication project identified a knowledge gap of the staff with the discharge education in a mental health facility. The evidence-based project

educated the staff on implementing the various forms of postdischarge communication interventions. These interventions promoted safety, medication compliance and ultimately decrease hospital readmission. The mental health population positively grew and thrive in the community due to effective postdischarge communication. The successful implementation of this education project taught the organizational staff to guide the mental health patients to a healthy transition after discharge and decrease hospital readmission. From the stated intervention, there has not been any patient readmissions. This suggest that the project may influence the hospital readmission rate, but more time is needed for data collection. The completion of this project addressed the question: will educating the nursing staff on postdischarge communication three days and thirty days postdischarge decrease hospital readmission of mental health patients from an inpatient mental health facility. The staff demonstrated an increase in knowledge according to the results from the knowledge gain formula, but more time is needed to gather data to further answer the stated question.

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Appendix A: Pretest/Posttest

Number: _____

Date: _____

PRE/POST-TEST: Effectiveness of Post Discharge Communication by a Nursing Staff with Mental Health Patients

Strongly Disagree (SD), Disagree (D), Undecided (U), Agree (A), Strongly Agree (SA)

	SD	D	U	A	SA
As a healthcare provider, I understand my role in post-discharge communication with mental health patients.	1	2	3	4	5
I am familiar with the BPRS.	1	2	3	4	5
I understand how to use the post-discharge communication algorithm.	1	2	3	4	5
I understand the time frame when the discharged patients are the most vulnerable and will require post-discharge communication.	1	2	3	4	5
I am familiar with the post-discharge communication script	1	2	3	4	5
I understand how to effectively implement post-discharge communication in 3 days and 30 days after a patient has been discharged from an inpatient mental health facility.	1	2	3	4	5

Total _____

Appendix B: Post Discharge Communication Script

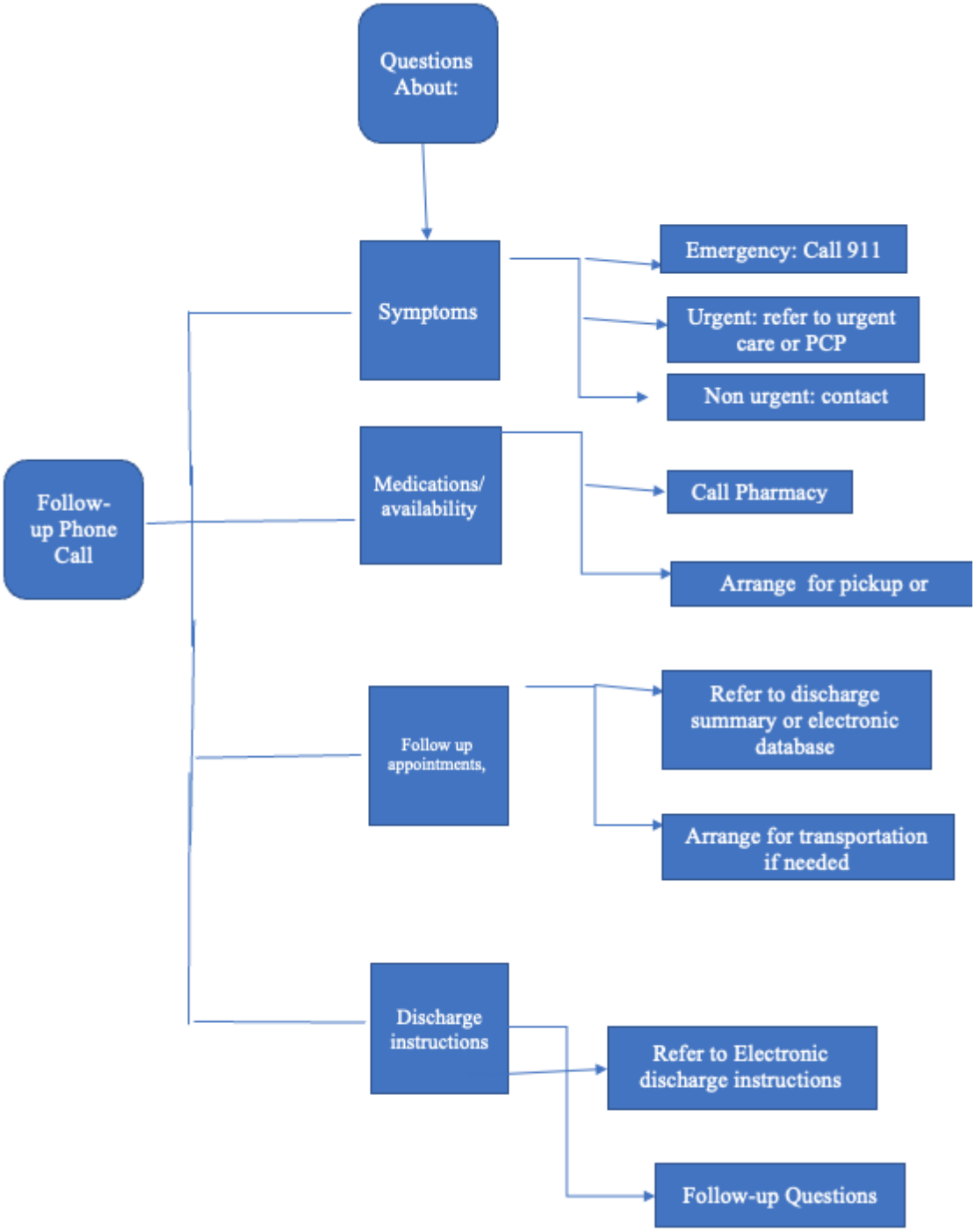
- Symptoms
  Hello Mr. Smith. My name is Nurse_____. How are you today? Are you having any problems today? Do you have suicidal or homicidal ideations at this time? (The healthcare provider will assess orientation and refer to the Post Discharge Follow-up Phone Call Algorithm for further direction)

- Medications/Availability
  Today is day three since you were discharged from the hospital. Have you been able to get your medications? Are you taking your pills every day? Are you having any side effects from the medications? (The healthcare provider will refer to the Post Discharge Follow-Up Phone Call Algorithm for further direction)

- Follow-up Appointment
  Your next follow-up appointment is scheduled for _____, 2021. Do you foresee any problems attending your appointment? (The healthcare provider will refer to the Post Discharge Follow-Up Phone Call Algorithm for further direction)

- Discharge Instructions
  Do you have any questions about your discharge instructions? (The healthcare provider will refer to the Post Discharge Follow-Up Phone Call Algorithm for further direction)

Appendix C: Post Discharge Follow-Up Phone Call Algorithm



Appendix D: Brief Psychiatric Rating Scale

Patient Name: _____ Today's Date: _____

Please enter the score for the term that best describes the patient's condition.

0 = Not assessed, 1 = Not present, 2 = Very mild, 3 = Mild, 4 = Moderate, 5 = Moderately severe, 6 = Severe, 7 = Extremely severe

Score	
	1. SOMATIC CONCERN Preoccupation with physical health, fear of physical illness, hypochondriasis.
	2. ANXIETY Worry, fear, over-concern for present or future, uneasiness.
	3. EMOTIONAL WITHDRAWAL Lack of spontaneous interaction, isolation deficiency in relating to others.
	4. CONCEPTUAL DISORGANIZATION Thought processes confused, disconnected, disorganized, disrupted.
	5. GUILT FEELINGS Self-blame, shame, remorse for past behavior.
	6. TENSION Physical and motor manifestations of nervousness, over-activation.
	7. MANNERISMS AND POSTURING Peculiar, bizarre, unnatural motor behavior (not including tic).
	8. GRANDIOSITY Exaggerated self-opinion, arrogance, conviction of unusual power or abilities.
	9. DEPRESSIVE MOOD Sorrow, sadness, despondency, pessimism.
	10. HOSTILITY Animosity, contempt, belligerence, disdain for others.
	11. SUSPICIOUSNESS Mistrust, belief others harbor malicious or discriminatory intent.
	12. HALLUCINATORY BEHAVIOR Perceptions without normal external stimulus correspondence.
	13. MOTOR RETARDATION Slowed, weakened movements or speech, reduced body tone.
	14. UNCOOPERATIVENESS Resistance, guardedness, rejection of authority.
	15. UNUSUAL THOUGHT CONTENT Unusual, odd, strange, bizarre thought content.

16. BLUNTED AFFECT
Reduced emotional tone, reduction in formal intensity of feelings, flatness.

17. EXCITEMENT
Heightened emotional tone, agitation, increased reactivity

18. DISORIENTATION
Confusion or lack of proper association for person, place or time.

Total Score