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# Nurse-Led Educational Program for Standardized Discharge Coordination

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# Walden University

College of Nursing

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Janet M. Foster

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and that any and all revisions required by
the review committee have been made.

Review Committee
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Walden University
2026

# Executive Summary: Executive Leadership System Improvement

# Nurse-Led Educational Program for Standardized Discharge Coordination

by

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Executive Summary Submitted in Fulfillment

of the Requirements for the Degree of

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**Introductory Summary**

Fragmented discharge processes increase the risk of missed follow-up, medication nonadherence, and avoidable 30-day psychiatric readmissions among individuals with serious mental illness (SMI). I conducted this Doctor of Nursing Practice project to address this practice gap by developing a standardized nurse-led educational framework to strengthen discharge coordination in an inpatient psychiatric setting. The practice-focused question examined whether a standardized nurse-led discharge coordination education framework would improve discharge coordination for adults with SMI transitioning from inpatient to outpatient psychiatric care compared with current non-standardized practices.

In a comprehensive literature search using the Johns Hopkins Model, I identified 15 peer-reviewed studies, including three Level I, five Level II, and seven Level III. Evidence supported nurse-led transitional care models, standardized discharge education, and structured follow-up as effective strategies for improving adherence, patient engagement, continuity of care, and post-discharge outcomes. Analytical strategies focused on developing executive-level deliverables, including standardized education materials, discharge coordination competencies, and documentation guidance.

Anticipated outcomes include improved continuity of care and greater consistency in discharge coordination. This project advances nursing practice by supporting organizational quality and safety priorities and contributes to positive social change, by promoting equitable access to culturally responsive discharge education for individuals with serious mental illness.

**Background**

Fragmented discharge coordination for adults with SMI remains a persistent challenge across behavioral health systems and is associated with missed outpatient follow-up, medication nonadherence, and increased risk of psychiatric readmissions (Velligan et al., 2017). Variability in nursing education, inconsistent discharge processes, and limited standardization contribute to communication breakdowns and unsafe transitions of care, creating patient safety concerns as well as financial, operational, and accreditation risks for healthcare organizations.

In this Doctor of Nursing Practice project, I focused on developing a standardized, nurse-led educational program to strengthen discharge coordination processes and address the identified practice gap. Internal organizational discharge data revealed variability in the completion and documentation of discharge education, inconsistent scheduling of outpatient follow-up appointments at discharge, and missed or delayed post-discharge contacts.

These internal findings align with national evidence indicating that 30-day psychiatric readmission rates for individuals with SMI often exceed 20%, with poor discharge coordination and follow-up identified as key contributors to failed transitions of care (Velligan et al., 2017). Community-level evidence further indicated ongoing access-to-care and continuity-of-care gaps among adults with SMI, underscoring the need to strengthen discharge coordination processes within behavioral health systems.

The evidence base supporting this initiative was established through a comprehensive literature review of CINAHL, PubMed, PsycINFO, and the Cochrane

Library. Nurse-led transitional care models, standardized discharge education, and structured follow-up processes have consistently demonstrated improved adherence, patient engagement, continuity of care, and post discharge outcomes (Sakashita et al., 2025). Educational interventions targeting nursing practice further improved staff knowledge and confidence and enhance the consistent application of evidence-based care coordination strategies (Mollon et al., 2012; Shiri et al., 2023).

This project aligns with the mission, vision, and values of the multisite outpatient healthcare organization, with integrated behavioral health services, by emphasizing patient-centered care, quality improvement, safety, collaboration, and equity. Organizational alignment is summarized in Figure 1.

**Figure 1**

*Organizational Alignment With Project Focus*

| Organizational element | Organizational focus | Project alignment |
|---|---|---|
| Mission | Deliver patient-centered, high-quality behavioral health services | Standardized nurse-led discharge education supports safe, consistent transitions of care |
| Vision | Improve outcomes and continuity for individuals with SMI | Strengthens discharge coordination to reduce readmissions |
| Values | Quality, safety, collaboration, equity | Supports evidence-based, equitable care coordination |

*Note.* SMI = serious mental illness.

## Project Development

Project development was informed by accreditation standards from the Joint Commission (2023) that emphasize effective discharge planning, continuity of care, staff competency, and quality improvement initiatives to support safe transitions of care. This project supports these standards by promoting standardized nurse education, clearly defined role expectations, and consistent discharge coordination processes aligned with evidence-based practice.

Stakeholder involvement was incorporated throughout project development to ensure feasibility, leadership support, and alignment with organizational priorities. Key stakeholders included nursing leadership, frontline nursing staff, quality improvement personnel, informatics support staff, and executive leadership. I developed a formal team charter outlining stakeholder roles, responsibilities, communication processes, and decision-making authority to guide stakeholder collaboration and engagement throughout project development.

A logic model framework guided project development by explicitly linking the identified practice problem to leadership-driven educational interventions and anticipated outcomes. The logic model illustrates how nursing and case-management expertise, leadership engagement, and information technology resources support educational development activities, resulting in standardized training materials and documentation tools that position the organization for future implementation. The logic model framework for change is summarized in Figure 2.

**Figure 2**

*Logic Model Framework for Change*

| Inputs | Activities | Outputs | Short-term outcomes | Long-term outcomes |
|---|---|---|---|---|
| Nursing and case-management expertise | Literature review, curriculum development | Education modules, competency tools | Staff readiness and role clarity | Reduced psychiatric readmissions |
| Leadership and QI engagement | Content validation, workflow alignment | Standardized discharge protocol | Leadership alignment | Sustainable coordination practices |
| IT and education resources | EHR templates, documentation aids | Standardized tools | Improved workflow consistency | System-level integration |

*Note.* QI = quality improvement; IT = information technology; EHR = electronic health record.

The project emphasized the use of existing organizational infrastructure rather than the acquisition of new technology. Current electronic health record functionality and established educational platforms supported the delivery of nurse education and competency validation. No new software systems or supply chain resources were required. Training strategies included asynchronous online modules and live or recorded in-service education integrated into existing workflows to minimize disruption to clinical operations (see Mollon et al., 2012).

This initiative was classified as a quality improvement and educational project and did not require Institutional Review Board approval. Ethical considerations included adherence to organizational policies, protection of patient confidentiality, and compliance with applicable regulatory requirements. No additional regulatory, legal, or union approvals were required. Potential risks included staff time demands and change fatigue; however, these were mitigated through leadership engagement and phased integration of training into existing workflows.

I developed an implementation plan outlining role accountability, key activities, and timeline sequencing to support the future adoption of standardized discharge coordination practices. Goals included preparing nursing staff through standardized discharge coordination education, defining discharge coordination competencies, standardizing documentation processes, and supporting consistent outpatient follow-up scheduling at discharge. I also developed a draft budget and a return-on-investment analysis to assess projected implementation costs and anticipated financial implications of the proposed nurse-led educational program.

## Results

If implemented, the standardized nurse-led educational program and discharge coordination framework are expected to improve continuity of care for adults with SMI. Anticipated outcomes include improved nurse competency and confidence, increased adherence to outpatient follow-up, enhanced medication management, and reduced 30-day psychiatric readmissions (see Sakashita et al., 2025).

The detailed implementation plan included clearly defined goals, objectives, responsible parties, deliverables, and timelines to guide future adoption of standardized discharge coordination practices. I developed a draft budget and a return-on-investment analysis to examine projected implementation costs and anticipated financial implications of the proposed educational program. I also developed an evaluation plan using a mixed-methods approach that outlined formative measures to assess staff education completion, discharge-coordination competency validation, and adherence to standardized documentation practices, as well as summative measures to evaluate 30-day psychiatric readmission rates and outpatient follow-up appointment adherence following implementation.

## Conclusions

With this Doctor of Nursing Practice project, I provided executive leadership with an evidence-informed, nurse-led framework to address system-level gaps in psychiatric discharge coordination for adults with SMI. By focusing on standardized education, leadership planning, and evaluation readiness, the project positions the organization for future implementation to improve continuity of care, reduce avoidable psychiatric readmissions, strengthen accreditation readiness, and support sustainable system-level improvement (see The Joint Commission, 2023).

The project advances nursing practice through enhanced role clarity, accountability, and leadership in discharge coordination and quality improvement. The project also contributes to positive social change and supports diversity, equity, and

inclusion by promoting equitable access to follow-up care and reducing disparities experienced by individuals with SMI during transitions of care (see Shiri et al., 2023).

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