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An Educational Initiative to Prevent Unnecessary Hospitalization for Hospice Patients

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Walden University

College of Health Sciences

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Alkeisha Mims

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Walden University
2017

Abstract

An Educational Initiative to Prevent Unnecessary Hospitalization for Hospice Patients

by

Alkeisha Hill Mims

MS, University of Phoenix, 2010

BS, University of South Carolina, 1999

Project Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

January 2017

Abstract

Avoidable hospitalizations of hospice patients cost Medicare $3 billion a year. When hospice nurses are able to identify early signs and symptoms of acute illness and provide appropriate interventions to prevent such admissions, 20-60% of the hospitalizations are preventable. The practice problem addressed in this quality improvement doctor of nursing project was the 30% hospital admission rate of hospice patients as evidenced by chart review, admission data, and revocation data. The first purpose of the project was to identify evidence-based nursing care paths in the literature for the top 5 medical diagnoses related to avoidable hospital admissions. The second purpose was to develop an educational curriculum to educate the staff on the care paths with a pretest/posttest to assess knowledge gained from the education. Rosswurm and Larrabee's conceptual model was used to frame the project. Three content experts evaluated the curriculum plan using a 4 item dichotomous rating of 1 *(not met)* and 2 *(met).* An average score of 2 revealed that the curriculum content met the course objectives. Content experts validated each of the 16 pretest/posttest items using a Likert scale ranging from 1 (*not relevant*) to 4 (*highly relevant*). The content validation index score was .94, indicating that the pretest/posttest reflected the course objectives and content. Recommendations were made for structuring the pretest/posttest. The project promotes social change by assessing, intervening, and treating patients in the outpatient hospice setting to prevent avoidable hospitalizations, thus promoting patient well-being and fiscal responsibility of healthcare dollars.

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Dedication

I would like to dedicate this project to my grandmother Lillie Mae Hill who always inspired greatness from me. I would also like to dedicate this project to my parents Ricky and Leona Murray who have always encouraged the furtherance of my education, my dad, Aldophus Dennis who called me “doctor” as a young nurse from the beginning. My father and mother-in-law, The Honorable Henry J. Mims and Juliet Mims who have been great examples, and last but not least my husband Joey Mims and my two children, Jaeyden and Messiah Mims, whom I love.

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Section 1: Nature of the Project

Introduction

Nurses have the privilege and responsibility to provide care and comfort to patients during vulnerable and stressful times. Perhaps the most vulnerable time for patients and their families occurs as they prepare for the end of life. One approach during this time is to provide hospice care to patients with a life expectancy of six months or less. This care, which is provided by nursing case managers, often takes place in a Long Term Care Facility (LTCF) instead of a patient's home. In either location, the patient and nurse communication has been deemed key to the end of life transition (Olthuis, Dekkers, Leget, & Vogelaar, 2006).

While some hospitalizations for patients are necessary, when a hospice patient is admitted to the hospital related to the terminal illness, the cost of the admission is not covered by insurance (Teno, Plotzke, Gozalo, & Mor, 2014). Hospice care gives care of symptoms not curative care, whereas the hospital provides curative care, therefore the patient must be dropped from hospice care when changing from symptomatic treatment to curative treatment (Holmer, 2015). These types of potentially avoidable hospital admissions of patients are common, expensive, and are likely to result in complications (Centers for Medicare and Medicaid Services [CMS], 2010). Potentially avoidable hospitalizations have been reported to cost Medicare $3 billion (Walsh et al., 2012). The Affordable Care ACT (ACA) mandates that Medicare deny payment for avoidable hospitalizations and complications, and requires every hospital and long term health care facility to have Quality Assurance and Performance Improvement Programs (QAPI) in

place to improve patient care and decrease unnecessary hospitalizations (CMS, 2010). Therefore, the nurse case manager's role is to provide patient care and support the needs of the hospice patients through managed care provided in the LTHCF to prevent avoidable hospitalizations.

The importance of good communication during the patient's end of life experience is critical to the patient, caregiver, and nurse. The nurse must be able to obtain and address the patient needs with the comfort of discussing end of life symptoms of care to support the caregiver. The nurse must also be able to understand and assess terminal illness processes, elicit current emotional concerns, and respond to any signs or symptoms of distress the patient may be having in order to care for the patient and support the caregiver (Clayton, Carlisle, & Ellington (2014). Several researchers have demonstrated many of the hospitalizations that occur in LTCFs can be avoided with preventive care through nursing education related to symptoms and management (Intrator, Zinn, & Mor, 2004). Hospice case management nurses must be experienced and educated to provide care and maintain the patient's care in the home setting or nursing facility (McKinney, 2013).

The organization for which this project was developed is located in the southeastern section of the United States and has 106 hospice patients in 12 different LTCFs and patients homes. The organization found that hospital admissions were greater than 30% as evidenced by a review of patient electronic medical records and gathering data from admissions and patient revocations. Organization leadership provided education related to measures to prevent hospital admissions and encouraged better

communication between the case management nurses and the caregiver in the hospice setting in order to include the case manager as the first person to contact if symptoms occur. However, the organization continued to identify avoidable hospitalizations as an area in need of improvement.

One way to reduce the risks of avoidable hospitalizations is through educating case management nurses on developing confident relationships with patients and their caregiver. Confidence through education promotes confidence in calling the case management hospice nurse first for assessment rather than seeking emergency services (Zheng, Mukamel, Friedman, Caprio, & Temkin-Greener, 2015).

Researchers have suggested the nurse with optimal knowledge of hospice care can reduce risks of unnecessary hospitalization for patients (Zheng et al., 2015). The continuum of care for the hospice patient outside of the hospital is only cost-effective and beneficial to hospice and hospitals if the nurses who manage the patients' care are properly educated (McKinney, 2013). Therefore, case managers must be well educated in measures to prevent unnecessary costs, particularly those incurred through avoidable hospitalizations. The CMS funded the program INTERACT. These interventions included a set of four tools to assist the case management nurse with better communication, identification of signs and symptoms of changes, assessment, and evaluation (Ouslander et al., 2011). Two of these tools were incorporated into the algorithm of this project. The first is Care Paths which guides the nurse in decisions for patients as acute changes occur in the patient's condition. The tool is used to guide the nurse through assessment, implementation, and evaluation of the patient. The other

INTERACT tool is the communication tool situation, background, appearance, and review (SBAR) which is a critical thinking communication tool with organized progression notes about the patient that elicits clear and concise pertinent patient information between the hospice case manager and the LTCF nurse or patient home caregiver (Ouslander et al., 2011).

The SBAR tool was defined as follows:

- Situation**:** Change in the patient's condition to include signs and symptoms. An evaluation of the patient is done before seeking other healthcare assistance from consults.
- Background**:** A history to include the patient diagnoses and description of the issue.
- Appearance**:** Observation of what is seen.
- Review: Recommendations, interventions, and any notifications are all given.
- The combined care path tool provided the case manager with a visual guide to use with patients and the caregiver and the care paths systemic process was a major focus of this educational quality improvement project. This project will lead to social change by reducing hospital costs, providing end of life comfort as opposed to invasive measures, and help sustain the organization through optimal nurse case manager and care provider communication.

Background

According to the Center to Advance Palliative Care (CAPC), approximately 3 million patients will be living in LTCF in the United States in 2030 and 40% of the patients will die in the LTCF. Most of the patients will have chronic illnesses without long life expectancy (CAPC, 2008). Providing hospice care in a LTCF can improve patients' health states, decrease hospitalizations, and facilitate family members' positive perceptions of hospice care (Cimino & McPherson, 2014).

Avoidable hospitalizations and reduction rates can occur with initiatives in place for prevention. Researchers have indicated hospitalizations of LTCF patients are avoidable through better management of patient care in the outpatient setting through dissemination and implementation of interventions managing acute changes in patient status (Ouslander et al., 2011). Hospice is one of the key ways of caring for terminally ill patients and decreasing hospital utilization with continuum care using hospice as home hospital care (Flood, 2013). Nurses properly educated in early signs and symptoms intervention can treat patients with chronic illnesses in a more cost effective environment, rather than in the hospital setting, which will save money and decrease the risk of further complications (Kuo, Raji, & Goodwin, 2013). There are tools in the evidence-based literature which speak to helping the nurse case manager identify symptoms and management of those symptoms to prevent hospitalization. According to Segal, Rolline, Hodges, and Roozeboom (2014) avoidable hospitalizations were identified using logic and diagnosis codes and experts developed an algorithm focusing on conditions using

those codes to identify avoidable hospitalizations and symptoms which could be care without hospitalization.

Problem Statement

The practice problem addressed in this project was the 30% admission rate of hospice patients from the organization's LTCFs and private homes as evidenced by chart review, admission data, and revocation data. According to the evidence-based literature, 50% of the hospitalizations could have been avoided if hospice-nursing staff had increased knowledge related to early recognition of symptoms and appropriate interventions in order to avoid hospital admissions (Overland, 2014). A review of 200 hospitals in a study provided data that 69% of Medicare hospital admissions were avoidable (CMS, 2010). The avoidable hospitalizations were associated with increased cost to the facility because patients being admitted for inpatient care might have been candidates for care outside of the hospital if the nurses had taken a proactive approach to prevent the hospitalization from occurring. The results indicated early identification, assessment, and management of conditions before hospitalization was required based on quick interventions addressed by case management nurses (Ouslander et al., 2011).

Purpose

The first purpose of this DNP project was to identify evidence-based nursing care paths for the top five medical diagnoses related to avoidable hospital admissions of hospice patients. The second purpose was to develop an educational curriculum to educate the staff on the care paths with a pretest/posttest to assess knowledge gained from the education. Researchers have demonstrated that hospitalizations can be avoided if

nursing staff are educated and provided with tools to identify symptoms which might be cared for proactively thus preventing exacerbation requiring hospital admission (Ouslander et al., 2011). This project filled the gap between what is evident in the literature and the identified problem within the organization.

Goal and Outcomes

Goal

The goal of this DNP project was to educate hospice nurse case managers to facilitate avoiding preventable hospital admissions among hospice patients.

Outcomes

The outcomes completed at the end of this project include:

1. Literature Review (see Appendix B) was developed to analyze and synthesize the evidence-based literature. The literature reviewed was graded with permission using the John Hopkins Nursing Evidence-Based Practice (JHNEBP) Evidence Rating Scale (See Appendix C)
2. Evidence-Based Care Paths
3. Educational Curriculum Plan
4. Pretest/Posttest

Framework for the Project

Rosswurm and Larrabee Conceptual Model

Rosswurm and Larrabee's conceptual model was the framework used for the project to translate research into practice. The model guides the project through a

systematic process using six steps to implement change in practice (Rosswurm & Larrabee, 1999).

- Assess practice change and identification of the problem
- Link the project through identification of interventions, activities, and outcomes.
- Synthesize the scholarly literature to be used
- Design educational plan
- Implementation and evaluation of change
- Integration and management of change

OPTIMISTIC Model

The Optimistic model, used within the education curriculum, is meant to reduce avoidable hospitalizations. OPTIMISTIC is an acronym for

- Optimizing patient transfers
- Impacting medical quality
- Improving symptoms: Transforming institutional care

Education aimed at providing better care and communication between acute care and long-term facilities was the goal of the OPTIMISTIC model to prevent unnecessary transports to the acute care facility and decrease hospitalizations (Unroe et al., 2014).

Nature of the Project/Stakeholders

The initiative based on best practices from the literature. Step 1 of RLCM was identification of the problem and need for a practice change, which has been stated in this

section. Step 2 was identified in the outcomes of this section. Step 3, a review of the literature, was presented in Section 2. Step 4, designing the plan, was presented in Section 3, and Steps 5 and 6 will occur after my graduation from Walden University. This project was facilitated through an established team. Stakeholders in the organization find an interest in the patient outcomes and play a significant part of the planning stage (Hodges, 2011). The stakeholder team members for the QI initiative include myself as the leader, the chief operating officer, director of nursing, quality assurance nurse, team leaders, and social worker. The team guided the development of the project. The team provided ongoing evaluation and feedback related to development of the outcomes content experts on the team validated the curriculum, the care paths, and the items on the pretest/posttest and an expert in test design evaluated the pretest/posttest construction.

Definition of Terms

*Case management nurse***:** The registered nurse (RN) who manages plans coordinates and reviews the care services of the hospice patient (Offredy, Bunn, & Morgan, 2009).

End-of-life-care: Irreparable deterioration with a disease leading to death in six months or less (Hui et al., 2013).

Hospice: A community based type of palliative support individualized to support the patients and provide management of symptoms whether physical or psychosocial (Hui et al., 2013).

Palliative care: Managing patient care with terminal disease with symptom control for quality of the patient's life without curative possibilities (Hui et al, 2013).

Revocation: The beneficiary revokes the Medicare hospice benefit as a result of the patient no longer considered terminal, the patient dies, the patient can't be recertified or the patient face-to-face visit by the physician is not done in time (Centers for Medicare & Medicaid Services, 2015).

Symptom management: Treating symptoms of a disease to make the patient comfortable (Hui et al., 2013).

Assumptions

Assumptions for this DNP project included the following:

- Nurses wanted to provide the best care possible to prevent unnecessary hospitalization.
- Nurses would participate in the educational sessions.
- Nurses would apply their knowledge to specific situations involving hospice patients.

Families and caregivers would want to help facilitate the nursing staff care of the patient to help avoid unnecessary hospitalization. The scope of the project included all of the case management nurses from the hospice organization.

Limitations

A limitation was that the plan will not be implemented. Therefore any evaluation of implementation will occur after graduation.

Scope

The scope of the project included all of the case management nurses from the hospice organization.

Significance

Medicare and Medicaid charge hospitals penalties for unnecessary hospitalizations. The top penalty was the loss of Medicare reimbursement (Centers for Disease Control & Prevention [CDC], 2013). Hospitals cannot afford to lose money as a result of patients being admitted when the nurse manager at the LTCF could have prevented the admission. Nurse case managers are responsible for the coordination of and the care of the patients and having the knowledge to care for the patients and prevent unnecessary hospitalizations was beneficial and significant to improve the quality care of patients.

Summary

In Section 1 I provided an overview of the problem, the gap between the problem and the evidence in the literature, and the efforts to fill that gap. Using the RWLB model, I used a team approach for this DNP project. In Section 2 I reviewed the strategies used to search the literature on the major points of this paper, namely, the conceptual models used, and existing literature on hospice care and educating case managers to prevent hospitalizations.

Section 2: Literature Review

Introduction

The practice problem addressed in this project was the 30% admission rate of hospice patients from the organization's LTCFs as evidenced by chart review and admission and revocation data. The first purpose of this DNP project was to identify evidence-based nursing care paths for the top five medical diagnoses related to avoidable hospital admissions of hospice patients. The second purpose was to develop an educational curriculum to educate the staff on the care paths with a pretest/posttest to assess knowledge gained from the education. Management of hospice patients can usually be accomplished outside of the hospital through education and therefore decrease the number of hospital admissions as elderly patients are the largest part of the hospice population who continues to grow (Segal, Rollins, Hodges, & Roozeboom, 2014). Review of literature supported quality improvement through education to manage terminal diseases, proactive treatment, symptoms, and clinician expertise to decrease avoidable hospitalizations. The literature continued to refer to a decrease of cost saved from hospital admissions and the use of clinicians and research to prevent hospitalizations (Unroe et al., 2014).

In this section a scholarly review of the literature review presented and included the literature search strategy, the RLCM framework and the OPTIMISTIC model. In the last section I discussed how scholarship is applied in similar problems and how the project relates to the student's role.

Literature Search Strategy

An expansive literature review was conducted including the following databases: The Walden Library, MEDLINE, EBSCHO, ProQuest, PubMed, Cumulative Index to Nursing and Allied Health (CINAHL), google scholar, Greenville Technical College Library, Cochran and Ovid review. Keywords and phrases used were hospice saves money, caregiver hospice nurse relationships/communication, caregiver and avoidable hospitalizations, hospice patients, hospice, palliative care, palliative care nursing and hospitalizations, Unnecessary hospitalizations, preventable hospitalizations, potentially avoidable hospitalizations, avoidable hospitalizations, end of life care, nursing homes and avoidable hospitalizations, LTCF and unnecessary hospitalizations, Medicare cost for unnecessary hospitalizations, Medicare and Medicaid hospice patient cost, re-hospitalizations, potentially avoidable hospitalizations (PAH), complex care transitions, hospitalization challenges, hospice studies, unnecessary hospitalization studies, hospice live discharge studies, respite care, readmissions, quality of care, patient safety, and quality metrics. More than 32 hospice studies were identified with 20 studies related to the topic being selected. Studies used were the most recent information available to support the project. The studies were peer reviewed research articles and systematic reviews. The literature search was extended past five years to find adequate information to support the project.

Conceptual Model

Rosswurm and Larrabee Conceptual Model

The Rosswurm and Larrabee conceptual model provided a systematic process to translate evidence-based research into practice. The model supported clinical expertise and filling gaps in the practice setting decreasing gaps through research. The model guided the project through six steps that included the following:

- Step 1: Assessed change need in practice to develop an educational plan to prevent unnecessary hospitalization for hospice patients.
- Step 2: Linked the project through identification of interventions, activities, and outcomes.
- Step 3: Synthesized through the use of literature related to unnecessary hospitalizations to use the evidence for better patient outcomes
- Step 4: Designed the project through planning the process of implementing and defined the possible outcomes of the project.
- Step 5: Implement and Evaluate through translation of change to practice using the formative and summative evaluations and adopt the change in policy.
- Step 6: Integrate and Maintain through a presentation of the educational plan to the healthcare team and incorporating the plan into practice with continued monitoring of the patient outcomes to be completed after graduation.

A research project was coordinated by the American Stroke Association using a trauma center with 300 patient beds with participation of 49 patients diagnosed as stroke victims (Kavanaugh, Connolly, & Cohen, 2006). The project was guided using Rosswurm and Larrabee's systematic process to translate the research into practice. The projects purpose was to determine the difference outcomes for stroke victims before the patients received 9 months of evidence based care using a stroke treatment program. The results demonstrated patient improvement for the stroke population using the model. Stroke patients are a complicated population and the success of the model for the study is indicative the model will be a good fit for end of life improvement of care through educating nurses.

Rosswurm completed a study with interventions being tested to educate skills to common care givers of elderly patients. The findings of the study demonstated success with family care givers through training in person and through teleconference teaching (Rosswurm et al., 2002). Training family care givers of dependent elderly adults through onsite and telecommunication programs the project outcomes were successful in the project using the Rosswurm and Larrabee model. Another project conducted using the Rosswurm and Larrabee model the nurses used evidence based practice to integrate changes to include a path to expert nursing care (Reavy & Tavernier, 2008). The transition from theory to practice using models such as Rosswurm and Larrabee provided a sytematic process to guide the team through the design and implementation process. A group of four nursing staff members teamed with a nurse manager to participate and the clinical nurse specialist, nurse researcher and infection control nurse were experts used to

take the nurses through the education processes. The team of nurses with the experts held meetings to develop educational sessions to teach the entire nursing staff upon completion. The educational curriculum would include a power point presentation, posters as visuals and a detailed case study. A pilot study would be conducted and evaluation of the findings completed using a shot questionaire. The project results allowed the nurses to recognize following a model such as Rosswurm and Larrabee provided a systematic process of change in to practice in the clinical setting (Reavy & Tavernier, 2008). Another project was conducted in a setting with 208 beds at the facility, 15 operating rooms and a Level II emergency department. The project used Rosswurm and Larrabee's six steps to align evidence based practice and theory-driven care (Pipe, 2007). A different model was previously used but once multiple specialties and complex care was needed a literature search was completed to find a model to meet the organizations current needs. A survey was completed by nurses and the nurses needed inclusion of the chosen model to provide patient health and safety with a link to patient centered care. The literature search revealed a need for understanding the patient and early signs and directives of patients who may decline in care. The Rosswurm and Larrabee model was the best fit for the organization's current needs and used to implement a formal educational plan done in four interactive sessions focusing on detection of early patient signs, education, and patient research (Pipe, 2007). The model results included two major findings which included improvement of patient outcomes and improvement of quality of nursing care (Pipe, 2007). The quality of care on the hospitals score board has remained above the 90th percentile once nurses were able to

understand patient needs once the systematic model was adopted (Pipe, 2007). The Rosswurm and Larrabee model has had positive results used in projects to translate research into practice and the best choice for the DNP student's project.

The OPTIMISTIC Model

The OPTIMISTIC model provides information to guide the nurses through the process of quality improvement for the organization. The OPTIMISTIC model has three type of interventions nurse case managers need to be educated in and these include medical, transition, and hospice care. Training in these areas to coordinate and manage patient care by improving early recognition of the chronic disease symptoms to manage care and avoid being hospitalized (Unroe et al., 2014).

Medical care. Educate the nurse case managers to improve management through recognition of disease processes to prevent hospitalizing the patient. Care pathways and tools for improved communication to prevent development of symptoms to cause hospitalization. Signs and symptoms such as cognitive function, medication, fluctuation of weight, skin assessment, falls, and vaccines are all components. Tool guides to gather data about the patient and immediately begin to set goals for patient centered care are pertinent. The information is given to the nurse practitioner to assist with management of care (Unroe et al., 2014).

Transitional care. If the patient has to be transferred, standards of care must be met to make sure the hospitalization is not related to the disease process and the transfer is unavoidable. An Acute Care Transfer Tool is used to begin quality improvement to improve transfers and communication of patient care (Unroe et al., 2014).

Hospice care. Pain and symptom management is done in outpatient setting. A review of patient end of life wishes is always considered. Providing end of life care with symptom management is the goal of patient care during end of life (Unroe et al., 2014).

Existing Scholarship Review

Ouslander et al. (2011) examined 30 LTCF in three different states for two six month time periods. The purpose of the quality initiative was to reduce hospitalizations from nursing homes through education from an advanced practice nurse. A component of the project included the development of a practice tool to include the evidence-based care paths chosen for the students DNP project to be used to prevent avoidable hospitalizations. A total of 25 LTCF out of the 30 gave complete data to use for the project. Routine teleconferences were conducted by the advanced practice nurse and the nurses who engaged in learning during the process demonstrated a 23% decrease in patient hospitalizations. Experts answered questions to provide INTERACT tools. The INTERACT tools were used during the quality initiative to determine if unnecessary hospitalizations would decrease. The interventions were used to manage the patients before hospitalizations of the patients were required and results demonstrated a 23% reduction in hospital admissions thus supporting that educating the health care teams in the facilities were beneficial (Ouslander et al., 2011). Care paths tools were specific to the patient's condition, to provide a systematic process to proactively care for patients. The interventions provide steps to improve patient care including the early identification, assessment and the education of using the evidence-based care paths associated with the

five diagnoses of the project to manage the patients conditions to prevent avoidable hospitalization (Ouslader et al., 2011).

Results from one retrospective study determined 50% of LTCF patients' hospitalizations in the last year of life are unnecessary and cost Medicare 1 billion dollars (Xing, Mukamel, & Temkin-Greener, 2013). A national database accepted by Centers of Medicare and Medicaid Services was used to determine the patients who died in 2007, 65 years of age or older with chronic diseases. Early identification and higher skilled employees demonstrated better patient outcomes in the study to prevent unnecessary hospitalizations (Xing et al., 2013). The medical chart reviews within multiple studies examined identified pneumonia, CHF, and UTI's for 31-40% of avoidable hospitalizations. There was 16 condition grouped and identified in the study and five conditions were related to 80% of the unnecessary hospitalizations when compared in the different states (Xing et al., 2013). CHF, UTI and dehydration attributed to 40% of the hospitalizations and early intervention through education of management and early symptom detection using personalized treatment plans are effective to decrease hospitalization.

A cross-sectional prospective study was done using a Minimum Data Set (MDS) assessment, CMS records, online survey records and area file for the design. Facilities that had a training program educating health care workers had fewer hospitalizations (Intrator, Zinn, & Mor, 2004). The decreased hospitalizations were done through early identification of factors to prevent acute episodes before the patient was required to go into the hospital. Preventive care improves chances of avoiding unnecessary

hospitalizations. The study was the first to conclude education of nursing assistants and evaluation programs improved outcomes of patients in LTCF (2004).

A retrospective review of hospice patients' medical records to reduce the patients from going into a hospital setting was to determine the type of care the hospice patients were getting and the patients' goals for the services (Olsen, Bartlett, & Moynihan, 2010). The study was important to provide information about hospice patients going to emergency rooms for symptoms related to the terminal illness that could be avoided with plans to address the issues with the patient and family about anticipation of specific issues to decrease hospitalizations. Hospice specific issues using a care algorithm specific for the emergency department can be adopted to better manage cost and meet patient goals and education on end-of-life care is a necessity (Olsen et al., 2010). A retrospective cohort study measured hospitalizations and Medicare costs during a 6-month period, some Medicare costs were assessed for 48 months. The results of the study were LTCF were at 52% higher risk for unnecessary hospitalizations if the primary care provider could commit 85% or more time to patients in LTCF (Kuo et al., 2013).

Retrospective study of hospitalizations to measure avoidable hospitalizations using experts to identify certain issues related to certain conditions (Walsh et al., 2012). The conditions were determined by Diagnostic Related Groups (DRGs) and the results of 1 million hospitalizations greater than one-third of the patients from LTCF was hospitalized at least one time and 382,846 (39%) were unnecessary hospitalizations that were avoidable. The five conditions identified for hospitalizations across different epidemiological settings including CMS values of the patients included pneumonia,

congestive heart failure, COPD/asthma, dehydration and UTIs (Walsh et al., 2012). Walsh et al. (2012) concluded new initiatives are important and needed to prevent costly unwarranted hospitalizations to improve quality of care.

According to Lin, Levine, and Scanlon (2011) hospice benefits patients with end of life care and limits the patient's exposure to harmful risks in a hospital setting while healthcare cost are also decreased. The study of end of life care in hospitals in the United States was conducted using databases from 2000-2009 and reviewed hospital stays and hospice transfers. The results of the study provided information over a ten-year period with clinical and demographic characteristics demonstrating the use of hospice can affect cost and quality of care measures (Lin et al., 2011).

Background and Context

According to Flood (2013) the population of persons 65 or older in the US is 13% and the population is made up of 43% of the hospital stays. Cost complications, and increased deaths occur due to not recognizing patient symptoms of certain disease processes. Hospice care is for symptom management in the patient home or the LTCF to manage the patient in these settings to all the patients to die outside of the hospital. CMS and Joint Commission mandate quality care of the population of patients in order for the hospital to receive reimbursements and remain accredited. The Affordable Care Act provides incentives for hospitals to reduce unnecessary hospitalizations, improve the patients' healthcare outcomes, and prevent Medicare funds from being held. The goal is to apply evidence-based models of care to provide better patient outcomes and decrease the cost of healthcare (Flood, 2013).

According to research, interventions have been identified to improve inclusive geriatric care and prevent unnecessary hospitalization. Some of the identified interventions included Geriatric Resources for Assessment and Care of Elders (GRACE), caring for patients at home, Program for All-Inclusive Care for Elders (PACE), Interventions to Reduce Acute Care Transfers (INTERACT II), and end of life programs for patients with chronic or terminal diseases (Flood, 2013). Providing Hospice care with education to manage patient symptoms and provide care in the hospice setting reduces hospital cost, complications, and improve the symptoms of the patient to allow the patient to maintain end of life care in the outpatient hospice setting (Flood, 2013). Determining reasons hospice patients are hospitalized and decreasing the number of hospitalizations in the population through evidence-based research to provide better continuum of care is necessary to prevent avoidable hospitalizations.

Summary

The section demonstrated a review of scholarly literature with exploration of the importance of knowledge and education of nurses with understanding of disease processes that the project is founded on. The literature review included Rosswurm & Larrabee conceptual model, and the OPTIMISTIC models use to assist with decreasing patient hospitalizations that are unnecessary. In Section 3 I will provide the projects approach and methods for the educational plan to prevent avoidable hospitalizations through equipping the nursing staff with the ability to provide appropriate interventions

in the outpatient setting. The section will include the project team, ethical considerations, intervention plan, and implementation and evaluation plan.

Section 3: Approach and Methods

Introduction

The first purpose of this DNP project was to identify evidence-based nursing care paths for the top five medical diagnoses related to avoidable hospital admissions of hospice patients. The second purpose was to develop an educational curriculum to educate the staff on the care paths with a pretest/posttest to assess knowledge gained from the education. This project was framed within the RLCM with Step 1, identification of the problem having been discussed in Section 1, Step 2 in the Literature Review, Section 2. This section covered the third and fourth step of the RLCM, designing the change, implementing, and evaluating the curriculum. Ethical considerations and the budget were also presented.

Approach and Methods

Using RLCM, the approach for this project was a team approach. I received approval to do the project from Walden IRB. The IRB approval number for this study is 09-19-16-0407942.

Activities of the Team

A synthesis of the literature was presented to the team using the Walden University Literature Review Matrix and graded using the Johns Hopkins Evidence-Based Practice Conceptual Model to produce the best quality information for the team to use. Permission to use the Johns Hopkins Nursing EBP grading scale was obtained from Johns Hopkins Medicine (2016).

I guided the design of the project with guidance from the team.

The main steps followed were listed below:

1. Used the literature review matrix to evaluate the process of change
2. An analysis and synthesis of the literature was completed with the matrix being reviewed by the team.
3. Content experts provided an evaluation of the curriculum and the pretest/posttest.
4. The project outcomes were approved by the team after content expert evaluations.

Stakeholders on the Team

Stakeholders in the organization had an interest in the patient outcomes and played a significant part of the planning stage (Hodges, 2011).The stakeholder team members for the QI initiative included the following:

- Leader: I facilitated as an educator throughout the QI initiative to present the evidence-based literature to support the knowledge gap and improve patient outcomes in the hospice setting.
- Chief operating officer: The executive director provided expertise while making sure evidence would translate into practice through support and recommendations for a successful project.
- Quality assurance nurse: Responsible for avoiding problems and assuring solutions for quality care was provided for the patients. Also the team made sure the nurses would remain compliant with all plans of action to be implemented.

- Team leaders: The organization had two and the teams leaders assisted to make sure nurses would be completing goals and these nurses understood the nurse's scope of practice. The job was to motivate and assist with the smooth transition of the QI changes.
- Social workers and chaplains: Manage the patient's psychosocial needs and collaborate with the case managers to give the patients the best possible care and supported the system of the project.

Population

The population included the content experts and the team members who provided the data for the project.

Ethical Considerations

The DNP project approval was obtained through submission of Walden University's Institutional Review Board (IRB). The IRB approval number for this study is 09-19-16-0407942.

Data Collection and Evaluation

Data collection consisted of provision of the three content experts with the educational tool to evaluate and provide a content evaluation of the curriculum. The evaluation form included four objectives related to the curriculum plan content and literature review to be evaluated by the content experts to determine the content would allow the learner to meet the learning objectives. The content experts had a copy of the literature review and care paths to determine whether the educational tool reflected the

literature and met the learning objectives. The content experts used a met not met evaluation scale with an area for comments regarding each of the four learning objectives. The content experts also completed a Likert-type scale of the pretest posttest, which was used as a descriptive analysis consisting of 16 test items using a scale of not relevant, somewhat relevant, relevant or very relevant to determine how well each test item represented the course objectives and reflected the course content of the project. A content validation index was also completed to determine the relevance of the pretest/posttest items. An assessment expert reviewed the construction of the test items as related to the literature and curriculum. An open-ended summative questionnaire was completed by the stakeholders related to the process of developing the project. The final product, and my leadership during the project development phase with comments shared about my behavior.

Summary

The evidence-based DNP QI project was to develop an educational plan to teach hospice-nursing staff to close the healthcare gap through knowledge and ultimately prevent patients from unnecessary hospitalization. The first purpose of this DNP project was to identify evidence-based nursing care paths for the top five medical diagnoses related to avoidable hospital admissions of hospice patients. The second purpose was to develop an educational curriculum to educate the staff on the care paths with a pretest/posttest to assess knowledge gained from the education. The plan includes key educational pieces to improve patient care through proactive interventions to care for hospice patients in the outpatient setting and maintain the care in the outpatient setting by

nitiating prompt care to prevent avoidable patient hospitalizations. Increased hospitalizations occur for hospice patients due to nurses not knowing how to communicate and manage patient care in the outpatient setting. Involving stakeholders throughout the development of the project was key to make sure the project was successful. The team was in place to equip nurses with knowledge and education to close gaps in the healthcare system and improving patient care in the hospice setting providing nurses with knowledge and measure the nurse's knowledge to proactively intervene with an understanding of patient signs and symptoms of the most common issues leading to hospitalization. In Section 4 I discuss the direction and target of the project to include the goals and objectives of the project with identification of the top five diagnosis and care paths related to avoidable hospitalizations, including the evaluation of the curriculum content, the curriculum matrix, pretest and posttest validation, and the summative evaluation findings of the project.

Section 4 included the use of the Rosswurm and Larrabee conceptual model, the optimistic model and how each model played a significant role to meet goals and outcomes of the quality initiative project. The methods of collection of the summative evaluations were examined and the outcomes of the evaluations were presented with content validation of the project outcomes. The section included implications, strengths and limitations of the project, and an analysis of self to complete Section 4.

Section 4: Discussion and Implications

Introduction

The purpose of this DNP project was to identify evidence-based care paths for the top five medical diagnoses related to avoidable admissions of hospice patients to the hospital, and to develop an educational curriculum for hospice nurse case managers to understand and incorporate the care paths in their practice to prevent such hospitalizations. The goal of this DNP project was to educate hospice nurse case managers with the hope of avoiding preventable hospital admissions among hospice patients.

The outcomes completed at the end of this project included:

- Outcome 1. Literature Review
- Outcome 2. Evidence-Based Care Paths
- Outcome 3. Educational Curriculum Plan
- Outcome 4. A Pretest/Posttest

In Section 4 I discussed the evaluation and findings, implications to include policy, practice research in practice, social change, strength and limitations, and an analysis of self.

Evaluation/Findings and Discussion

The evaluation findings of the project were supported through relevant evidence-based literature demonstrating hospitalizations can be avoidable through educating nursing staff with tools identifying symptoms. The literature was presented to the team

identifying the top five medical diagnoses related to avoidable admissions of hospice patients to the hospital through the development of an evidence-based curriculum and a pretest/posttest evaluation. The Rosswurm and Larrabee conceptual model six-step framework (see Appendix A) was used to guide the project through a systematic process to translate research into practice. The designed evidence-based practice curriculum plan designed using the team will be implemented after the DNP student graduates.

Expert Review, Evaluation, and Content Validation of the Project

The team reviewed the evidence-based literature. The literature identified the top five diagnoses related to avoidable admissions of hospice patients to the hospital. Three content experts were selected to evaluate the appropriateness of the educational curriculum plan, literature review matrix, and validate the pretest/posttest outcome products. The Florida Atlantic University evidence based care paths were found during the literature search for evidence-based literature to improve the patient care in the hospice setting and avoid potential hospitalizations. The four care paths chosen met the criteria needed to translate evidence into clinical practice at the bedside in the hospice setting for the top five medical diagnoses to prevent avoidable hospitalizations. The three content experts who evaluated curriculum and validated the pretest/posttest items were professors of nursing at a community college. They all serve on the curriculum committee with one evaluator being on the testing committee of the college. All three experts were Master's prepared. One evaluator was DNP, one a FNP and one PhD. After completing the project all of the team members completed a Summative Evaluation. The outcome findings are described below.

Outcome 1: Literature Review Matrix (see Appendix B)

Discussion. The results of the evidence-based literature were presented to the stakeholders on the team, the information was reviewed and the members were familiar with some of the literature regarding the project. The team was interested in seeing the curriculum plan and the care paths and was inquisitive about the five medical diagnoses linked to 80% of the avoidable hospitalizations. The John Hopkins Nursing Evidence-Based Practice (JHNEBP) Evidence Rating Scale (see Appendix C) was reviewed in the discussion as the tool to validate the content of the literature review matrix.

Evaluation. After presenting the literature review matrix to the team, the team agreed the evidence-based literature review was sufficient for the development of the quality initiative project and the JHNEBP evidence rating scale met the requirements to validate the researched literature. Based on the evaluation of the strength of the evidence the quality can be rated and determined to demonstrate high or good quality work (Newhouse, Dearholt, Poe, Pugh, & White, 2005).

Data. None

Recommendation. The team recommended approving the literature review matrix and the use of the 22 articles relating to symptom management and avoidable hospitalizations.

Outcome 2: Evidence-Based Care Paths (see Appendix D).

The team reviewed the articles on the top 5 medical diagnoses accounting for 80% of the avoidable hospitalizations (Segal, Rollins, Hodges, & Roozeboo, 2014), the CMS supported study demonstrated 50% of hospitalizations were avoidable through

management of the chronic disease (Unroe et al., 2014) while 78% of the patients hospitalizations were avoidable with the same repetitive top five medical diagnoses (Walshet al., 2012). The team was also able to review the evidence based literature supporting the education of nurses and the use of a systematic process use of care paths to provide direction to decrease a breakage of the continuum of care of hospice patients to be maintained in the hospice setting supported by Rosswurm and Larrabee Model for intervention training in person (Rosswurm & Larrabee et al., 2002). The team discussed the care paths used with permission obtained from Florida Atlantic University for the DNP student to use the developed care paths for this quality initiative project currently supported by CMS to bring about a systems change in healthcare (Unroe et al., 2014).

Evaluation. As the team leader I presented the literature review results and the team evaluated the care path tools and some of the team members had previously read the evidence of the success behind using the care path tools to identify and proactively treat hospice patients. The literature identified the top five diagnoses to treat and decrease avoidable hospitalizations through education of the case management nurses caring for the patients (Walsh et al., 2012). Several articles validated the use of the care paths for the project. The INTERACT II intervention which included the use of the care path tools evaluation and a pilot study for six months initiating the early interventions results was significant and encouraged future projects such as this one to improve patient care (Ouslander et al., 2011).

Recommendation. The team recommendation proposal to use the care paths as presented and approved the use of the care paths as a tool to provide a systematic process

of nursing care to assess and manage the care of the patients and to be implemented after the DNP student graduates.

Outcome 3: Educational Curriculum Plan (see Appendix E)

Discussion. A discussion with the team was based on the development of the curriculum which consisted of four objectives, an outline of the curriculum content, evidence, method of presenting and method of evaluation for the pretest and posttest items, and the grading of the evidence.

Evaluation. Three professors of nursing with clinical backgrounds who all have Master's prepared backgrounds in education and are either a DNP, PhD or Family Practitioner. All of the individuals are a part of the curriculum committee at a nursing college and one of the experts is part of the testing validation committee. The three experts completed an evaluation of the curriculum plan using the Content Expert Evaluation form (see Appendix F), the four objectives were evaluated numerically after choosing "not met=1 or met=2". Each expert received a packet that had no identifying information on the outside of the folders and the three folders were randomly given and the contents of each folder included a copy of the student's curriculum plan, the literature review matrix, and the pretest/posttest and the evaluators folders had numbers on the inside to identify an evaluator with a numerical one, two, or three. An evaluation of the content curriculum was done in comparison with the literature review matrix to determine all objectives were met.

Data. Average score = 2 = 2 (See Appendix G). Comments: **"**A strength of the SBAR section is the outline of when it should be used."

Outcome 4: Pretest/Posttest Content Expert Validation

Discussion. In order to validate the pretest/posttest items, the content experts were provided a copy of the Literature Review Matrix (see Appendix B), the Educational Curriculum Plan (see Appendix E), the Pretest/Posttest (see Appendix H), and the Pretest/Posttest Content Expert Validation (see Appendix I). An evaluation reliability analysis to evaluate and measure reliability of items was accomplished getting the test item total statistics and calculation of an index score (Polit, 2010).

Content validation. The content experts were able to validate16 pretest/posttest items using a four point Likert rating scale of "not relevant = 1, somewhat relevant = 2, relevant = 3 and very relevant = 4. Any score of 3 or 4 by an evaluator meaning relevant or highly relevant required taking the sum of the number of evaluators who determined the test was relevant and dividing that number by the total number of evaluators and getting the content evaluation index. The final content index validation score of all 16 test items were added together and divided by 16 to get the .94 validation score (See Appendix K).

Data. Content Validation Index = .94

Recommendations. Reviewer two commented the eligibility of the hospice patient was part of the problem but felt instead of testing on the eligibility the test item needed to be replaced with a question related to the avoidable admission rate for the facility. Recommendation is that the pretest/posttest is a good evaluation tool to determine the understanding of the curriculum objectives on the posttest and get an understanding of the nurses' knowledge before the educational curriculum is presented.

Summative Evaluation (see Appendix J)

After completion of the last team meeting a summative evaluation was left for each team member to take and complete the three part, open-ended seven item summative evaluation form. The directions were to complete the evaluation and anonymously place in the envelope left for interoffice mail for me to pick up the evaluations anonymously. Six questionnaires were completed and returned. The data revealed the following themes:

Team leader approach. The questionnaire first addressed my effectiveness in a team approach related to the meetings, communication and desired outcome and the team described the student as an "affiliative" leader. An affiliative leader was described as a team builder who placed together a team who was connected, the meetings were structured, peaceful, with cooperative people with positive attitudes and information was shared by the leader to solve issues throughout the project. The team noted the student as providing sufficient time for scheduled meetings, being organized and knowledgeable throughout the process of guiding the team using good communication skills both oral and written according to one team member. Another team member was complimentary on the professionalism and consideration of everyone's time throughout the process. Several team members acknowledged how being a part of a team to positively impact health care was appreciated to allow education to be given to their organization that would be expensive to get without the project and the only improvement noted was the time the process took for approval from IRB before the team could meet about the project because the organization was excited about the impact the educational curriculum plan and use of the care paths will make for their nursing case managers.

Project outcome products. The team felt the ability to review the literature and see the methods, results, interpretation and implications for future projects from the literature was evidence that demonstrated the effectiveness of the literature review matrix for the development of the project. Two of the team members expressed gratitude for me putting in the work and time to obtain the literature for review because working full time many of the nurse case managers and leaders do not have the time and sometimes the resources to gather the evidence-based literature demonstrating better patient outcomes.

Role as a Team Leader. The questionnaire asked a set of questions to include how I as the student leader assisted the team to meet project goals, how support was given to the team in meetings for project goals, and areas of improvement for myself. The team all offered positive feedback dealing with my leadership reflecting affiliative leadership traits. They felt I made everyone feel a part of the project and important for the success of the project and continued to provide compliments on the organizations leadership and ability to maintain a positive atmosphere for employees to want to provide the best services for the organization. They felt I was very organized and task oriented when meeting goals and supporting the team as well to maintain the goal of completing the project goals using evidence-based literature as a focus of the project working for the organization. Participation was not a problem with the leaders and building the team connectedness was not a challenge as stated by three of the team members because solutions to gaps that needed to be filled to improve patient care in the outpatient setting was what the organization was looking for. The suggestion of several of the team members to improve was for the leader to not be limited to the teaching arena at the

college she works for but to consider being a consultant as a clinical expert at the bedside. The team members were unanimous in the decision to approve the project and shared the readiness of the organization to implement the education of the nurse case managers and use the curriculum for all new hires to be educated using this curriculum plan to impact healthcare needs.

Implications

The literature continues to indicate hospitalizations of LTCF patients are avoidable through better management of patient care in the outpatient setting through dissemination and implementation of interventions managing acute changes in patient status (Ouslander et al., 2011). The implications for this project are related to policy, practice, and social change. The implications of this project educating the nurse case managers through proactive interventions and using systematic processes the usage of the care paths will equip the nurse case managers to know symptoms to begin to quickly identify and care for these patients in the hospice setting quicker and prevent avoidable hospitalizations. The projects implications are not only beneficial to the organization but to any outpatient setting agency who cares for patients and need the knowledge to prevent avoidable hospitalizations and maintain patient care in the outpatient settings.

Policy

A policy will be developed and included for the nurses to use the care paths and follow the systematic process to improve patient practices and care.

Practice

Nurses play an important role as doctor's peers to share in patient care needs to identify issues early and assist with proper care management to promote better patient outcomes. Nurse must understand the roles and responsibilities which can be unclear which is similar to general practitioners (McInnes, Peters, Bonney, & Halcomb, 2015). Nursing clinicians can review the findings of this project to improve practice not only in hospice care settings but in any area of nursing care delivered outside of the hospital acute care setting. This project ensures the use of early interventions using care paths as a tool to assist the nurses with his or her role or next step in the patients care to provide better care outcomes and fewer incidences of hospitalizations through improvement in the system of care being delivered to patients.

Research

The goal of this DNP project is to educate hospice case managers with the hope of avoiding preventable hospital admissions among hospice patients. Using evidence-based clinical pathways used as research for other organizations with improvement of patient care will assist with development, implementation, utilization, and ongoing evaluation to ensure improved patient outcomes and assist with expensive healthcare cost (Gurzick & Kesten, 2010). Continuing to use evidence-based literature to review care paths and other tools to guide patient care will improve the patient's quality of care and decrease the patients cost of care with interventions in place from evidence to provide these patients with the best possible care. Although the nurses are equipped with laptops these nurses have day to day increased patient loads and caring for these patients the nurse case

managers do not have much time to review evidence-based literature. I have been able to review the evidence-based literature for the organization to provide evidence-based research to improve the patient care through an education curriculum.

Social Change

The organization wants to equip nurses with knowledge and education to close gaps in the healthcare system and improve patient care in the hospice setting. Providing nurses with knowledge and measuring the nurse's knowledge to proactively intervene with an understanding of patient signs and symptoms of the most common issues leading to hospitalization is key to transform the continuity of care of the hospice patients in the hospice setting and therefore prevent avoidable hospitalizations.

Strengths and Limitations

The strength of the DNP project was the ability to bring evidence-based literature into an organization with identification of evidence-based care paths with permission from Florida Atlantic University to provide interventions for the top five medical diagnoses related to avoidable admissions of hospice patients to the hospital. The care paths have already provided improvement in other organizations who used the care paths in researched projects. The development of the educational curriculum using care paths already demonstrating significant improvement of care in other organizations adds to the furtherance of continued projects improving patient care through nurse education. The greatest strength of the project was having a team who was excited about improving patient care through my project. Limitations of the project included: The plan will not be implemented; therefore any evaluation of implementation will occur after graduation.

Another limitation of the project was the length of time and process for IRB approval which caused me as the leader to have to be proactive in reminding the team of the upcoming meetings that would take place after approval of the project by IRB. An acute care representative was not a part of the team was also a limitation of the project. Although plans are made to prepare for resistance change always brings about some sort of resistance which can affect the time prepared to implement the project after graduation.

Analysis of Self

The below listed sections will discuss my views of myself related to the development of the DNP project.

Scholar

The DNP project has transformed me into a scholar who is able to retrieve evidence-based literature to research the needs related to an issue and to design and proceed to positively impact change and improvement of patient care. The project has caused several organizations to communicate interest in my education curriculum and after graduation would like me to get involved to implement the educational curriculum to their nurse case managers and nurses in the LTCF's. As an educator who works to develop the novice nurse the learning experience has provided me with continued knowledge to improve practices and educate developing nurses to provide the best patient care at the bedside through the use of evidence-based practice. As a scholar I will provide future nurses with a foundation of using evidence-based literature to not only improve

patient care but to provide new nurses with a better understanding of the importance of using evidence supporting better patient outcomes.

Practitioner

As an educator as the role of a DNP nurse is to bring evidence based practice as an expert in the field of nursing that will provide the students with knowledge to provide better quality care in nursing. Nurses are patient advocates, the goal is to care for the patients providing safe, and effective care that can be received by teaching concepts and best practices that has been researched and acknowledged as evidence based practice for better patient outcomes. Prevention of nosocomial infections, falls prevention, and decreased cost are all areas that the DNP prepared nurse can use to provide better patient care to patients at the bedside. The DNP prepared nurse can assist faculty and educate faculty on new insights that can be used to adapt into curriculum using Boyer's framework to maintain non-biased balance (Thoun, 2009).

The DNP project that I am completing is evidence-based-practice based on recommendations of literature of the importance of educating nurses. The organizational heads based on evidence-based practice will adopt the educational curriculum as a policy. This policy will include care paths that gives directions to the nurses about the chain of command to follow when medical diagnoses that cause the most avoidable hospitalizations in the acute care setting are proactively cared for to prevent lags of time being wasted that are important to increase better patient outcomes. As the practitioner my role is important to continue to promote the use of evidence to improve the quality of

care provided. The information may be published to assist patients nationwide to prevent avoidable hospitalizations.

Project Developer

The development of the DNP project has been both challenging and awarding throughout the completion of the project. In the beginning before starting the program leadership was an area I felt I was strong in but going through the program I have developed into a true leader who was able to identify issues, create and develop a team and guide the team throughout the process of the development of the DNP project. As the project developer the student has transformed into a true leader and expert clinician at the bedside to change healthcare with better patient care and outcomes through the use of evidence-based practices.

Professional Development

The entire process of the development of the DNP project has positively challenged the student and caused the student to transform into a leader who is effective, goal oriented, inclusive of all participants and efficient in moving others through knowledge and motivation to translate evidence into practice to meet the DNP program outcomes.

Summary

The goal of this DNP project was to identify evidence-based care paths for the top five medical diagnoses related to avoidable admissions of hospice patients to the hospital, and to develop an educational curriculum for hospice nurse case managers to understand

and incorporate the care paths in their practice to prevent such hospitalizations. Achievement of educating the hospice nurse case managers provides the hope of avoiding preventable hospital admissions among hospice patients. Section 5 will convey the abstract for a PowerPoint presentation designed to display the project for a larger arena of nurses to view.

Section 5: Scholarly Project Dissemination

Poster Presentation

The scholarly project dissemination of a poster aligns with the guidelines of The National Hospice and Palliative Care (NHPC) annual conference. The poster presentation consists of evidence accepted in the medical profession and I included the purpose, background, methods, DNP project design, data collection, implications for evidence based practice and results of the development of an educational initiative to prevent unnecessary hospitalization for hospice. The poster abstract requirements were to describe the project with measurable learning objectives. The poster provides a visual summary of the student's scholarly work to present and share the outcomes to audiences of the importance of nursing education through the use of an educational curriculum and the use of care paths as a systematic tool to improve patient care and avoid unnecessary hospitalizations of hospice patients.

Purpose

The purpose of this DNP project was to identify evidence-based care paths for the top five medical diagnoses related to avoidable admissions of hospice patients to the hospital, and to develop an educational curriculum for hospice nurse case managers to understand and incorporate the care paths in their practice to prevent such hospitalizations. The literature demonstrated that hospitalizations can be avoided if nursing staff are educated and provided with tools to identify symptoms which might be cared for proactively thus preventing exacerbation requiring hospital admission

(Ouslander et al., 2011). This project filled the gap between what was evident in the literature and the identified problem within the organization.

Background/Significance

The practice problem addressed in this quality initiative project is the 30% admission rate of hospice patients from the organization's long-term healthcare facilities (LTCFs) and private homes as evidenced by chart review and admission and revocation data. According to the evidence-based literature, 50% of the hospitalizations could have been avoided if hospice-nursing staff had increased knowledge related to early recognition of symptoms and appropriate interventions in order to avoid hospital admissions (Overland, 2014). A review of 200 hospitals in a study provided data that 69% of Medicare hospital admissions were avoidable (CMS, 2010). The avoidable hospitalizations were associated with increased cost to the facility since patients being admitted for inpatient care might have been candidates for care outside of the hospital if the nurses had taken a proactive approach to prevent the hospitalization from occurring. The results indicated early identification, assessment, and management of conditions before hospitalization is required based on quick interventions addressed by case management nurses (Ouslander et al., 2011).

Method

A synthesis of the literature was presented to the team using the Walden University Literature Review Matrix and graded using the Johns Hopkins Evidence-Based Practice Conceptual Model to produce the best quality information for the team to use.

I guided the design of the project with guidance from the team using the Rosswurm & Larrabee Model to structure the DNP project. The key stakeholders were used to evaluate the process of change. An analysis and synthesis of the literature was completed and the matrix was reviewed by the team. Content experts provided an evaluation of the curriculum using the content expert evaluation form and validated the pretest/posttest using the pretest/posttest content expert validation form. The project outcomes were approved by the team after the completion and review of the content expert evaluations with the team.

Results

Three experts evaluated the curriculum plan using the Content Expert Evaluation form and the four objectives were evaluated comparing the curriculum content with the literature review matrix and all of the objectives were met according to the evaluation. The pretest/posttest content validation of the 16 items to be used to test the nurse case managers' knowledge before and after the presentation of the curriculum plan initiative content validation index was 1.00 and the pretest/posttest received a .94 validation index score from the three expert evaluators. The .94 index score validated the use of the pretest/posttest as an accurate tool to measure the knowledge of the nurse case managers. A summative evaluation was completed by each individual on the team after the project was completed to receive feedback about the project as the project developed. The team stated eagerness to compare the care paths with the previous use of no systematic approach to patient care of hospice patients after the student graduates and the curriculum is implemented to work proactively to decrease avoidable admissions for the top five

medical diagnosis causing patient admissions with care paths to direct nursing into a new translation of patient care at the bedside to ultimately change the care of hospice patients.

Conclusion

End of life care is eventually the fate of everyone who lives with a terminal disease. The responsibility to provide comfort to patients during this most vulnerable time of life has been awarded to nurses. Hospice care is provided by nursing case managers to care for the patient in hospice in the patient's home or in a Long Term Care Facility (LTCF). Wherever the chosen transition of the patient's end of life care will take place the goal is for the nurse case manager to maintain the patient's care in the hospice setting. Avoidable hospitalizations continue to be expensive and the ACA mandates changes to prevent these hospitalizations. The top five avoidable medical diagnosis that make up 80% of these hospitalizations can be avoided through the use of care paths as a systematic process of changing the patient outcomes. The development of an educational curriculum plan to initiate use of the care paths developed using literature from the evidence-based matrix identify implementation of educating the nurse case managers to improve patient management and care.

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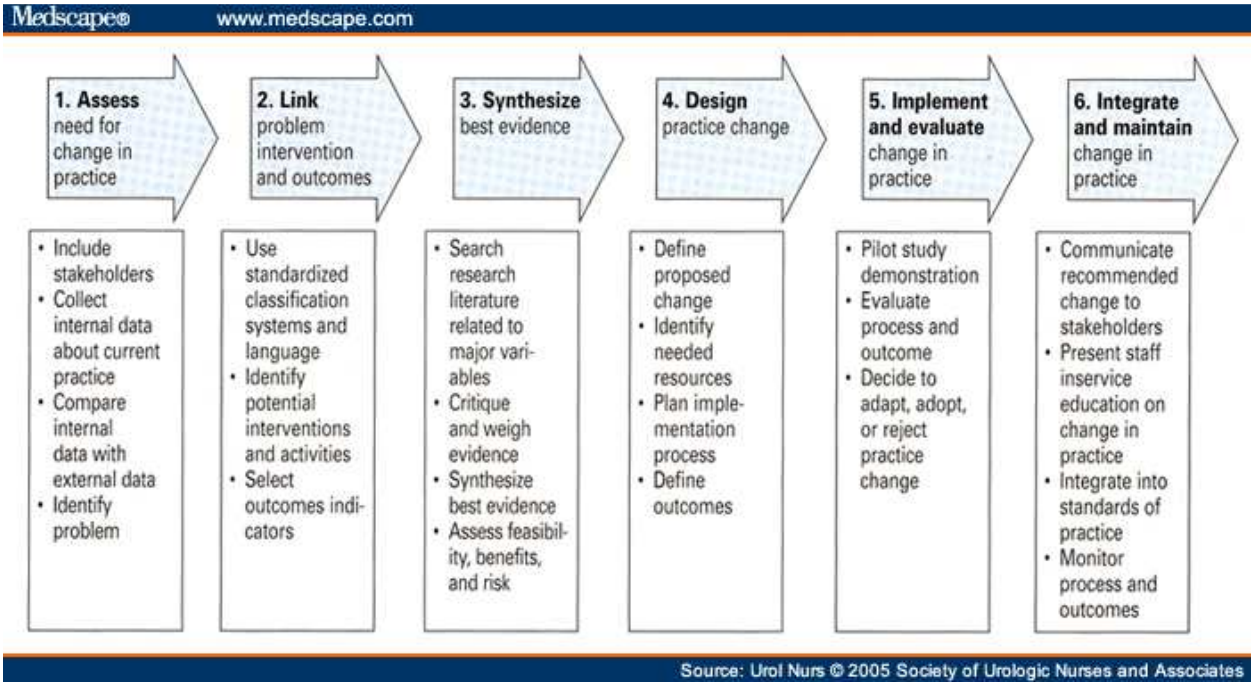
Appendix A: The Rosswurm and Larrabee Model



Appendix B:Literature Review Matrix

Literature Review Matrix

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Grading the Evidence
Flood (2013)	Transitional Care Model Level 1 RCT	Hospice care is for symptom management in patient home or LTCF managing the patient in the setting quality care in the setting with interventions through educating the nurses decrease unnecessary hospitalizations	Nurse management interventions using evidence based algorithms as a tool Intervention to Reduce Acute Care Transfers (INTERACT II) of care for better patient outcomes.	The results of the study identified the demand for specialized needs of patients with a terminal or chronic illness for more palliative	Cost complications and increased deaths occur due to not recognizing patient signs and symptoms of certain disease processed. Application of evidence-based models of care to provide better patient outcomes and decrease cost of healthcare Use of INTERACT II tools and nurse education for end of life programs important for management of chronic or terminal diseases.	Level I

Intrator, Zinn, & Mor, 2004	Management Intervention	Prevention of acute symptoms from chronic conditions causing hospitalization through management.	Cross-sectional prospective study that used Minimum Data Set Assessments (MDS), CMS claims and records, Online Survey Certification Automated Records, and Area Resource File	The study results identified preventive therapy training for nursing aide program and NP/PA were all identified in decreasing patient hospitalization rates.	Providing preventive therapy, programs to train and reduce hospitalization through education. Education included early identification of factors to prevent episodes before patient required hospitalization.	Level III
Kavanaugh , Connolly, & Cohen, 2006	Rosswurm and Larrabee Model systematic process	The project was guided using Rosswurm & Larrabee systematic process to translate the research into practice. The projects purpose was to determine the difference outcomes for stroke victims.	300 patient beds with participation of 49 patients diagnosed as stroke victims. The project was guided using Rosswurm & Larrabee systematic process to translate the research into practice. The projects purpose was to determine the difference outcomes for	The results demonstrated patient improvement for the stroke population using the model.	Stroke patients are a complicated population and the success of the model for the study is indicative the model will be a good fit for end of life improvement of care through educating nurses	Level I

			stroke victims before the patients received 9 months of evidence based care using a stroke treatment program.			
Kuo, Raji, & Goodwin, 2013	Cohort Study	Assess preventable hospitalizations of Long Term Care patients and clinical effort.	Retrospective Cohort Study viewed patient care over 6 to 48 month timeframe MDS data patients 12,249 Medicare beneficiaries in 1,094 Texas NHs.	12,249 patients examined provider effort and outcomes 70% had physician, 25% advanced practice nurse, 5% physician assistant. Patients 52 % increased risk with <5% clinical effort and patient with 85% physician effort had lower hospitalizations by 1/3.	Provider's clinical effort to patient care plays a role in patient hospitalization in the study.	Level III

Lin, Levine, and Scanlon (2011	A 10 year national Sample used from a random sample of hospitals	United States hospitalizations hospice transfers and discharges to hospice care	Data National Inpatient Sample (NIS) from 2000-2009Random sample of hospitals	Discharges to hospitals /year increased from 27,912 to 420,882 in 2009	Hospital discharges to hospice care has increased past ten years. End of life care in the US positively impact cost of healthcare and quality measures of care. Ten year period of time done with results demonstrating the use of hospice can affect cost and quality of care measures.	Level III
Author/ Date	Theoretical/Conceptual Framework	Research Question(s) Hypotheses	Methodology	Analysis & Results	Conclusions	Grading the Evidence
Hurley, Strumpf, Barg, & Ersek, 2014	Ethnographic methods	What are the transitions between home and inpatient hospice?	11 month timeframe gathered data from hospice agency in northeast. Collection took place using	Triggers identified, signals identified causing advanced needs for patient care. Actions taken to	Different approach to care planning, awareness of the complex needs of the patient by the hospice team and minimizing	Level I

			observations totaling 18 and 38 interviews with the patients that were semi-structured with patient, caregivers, hospice interdisciplinary team (IDT)	respond to the triggers and signals in the hospice setting. Issues not being able to be cared for in home were transferred to inpatient hospice setting.	transitions allowed continuum of hospice care in the hospice setting.	
McKinney, 2013	Data review health alliance plan	New Models of care changes to align with IOM for nursing care to shift focus to chronic or advanced diseases	Data used from 2007 with home support, cost savings, cost analysis conducted. Two insurers used data for potential saving in cost using the pilot model.	Promising results of hospice use using home support model demonstrated 30% to 36% savings.	Advanced planning and management of patient care allowed quality targets to be met, cost savings, and better managed care programs.	Level III
Olsen, Bartlett, & Moynihan, 2010	Retrospective Review	Hospitalization and characteristics of care received by hospice patients in the hospital	263 Medical record used from human subjects excluding anyone under 18 years old. Review of test, treatment and patient goals of the patients.	17% of the 263 patients hospitalized in the hospital in 2007 and 42% of those died in the hospital. Length of stay was approximately 4	Hospice patient hospitalizations are expensive and most care was low or moderate needs. Improvement comes through communication of the patients needed	Level III

				days with estimated $9,000 per patient stay.	goals and symptoms prevention	
Ouslander et al (2010)	Descriptive Theory	Avoidable hospitalizations of Nursing Home Residents Was the hospitalization avoidable?	Quality Initiative Data from Minimum Data Sets (MDS) and Medicare date reviewed and obtained from all of the Nursing homes in the state of Georgia over 15 months. Experts used to review records and develop tools for intervention.	200 hospitalizations/ 134(67%) rated possibly avoidable. Clinicians' inability to assess the acute changes patients were having. Not getting lab test quickly and giving IV fluids.	Better patient care. Communication tools for nurses, increase attention to issues to decrease need for outside care. Good nursing home care important to improve patient care and avoid hospitalizations that are unnecessary.	Level IV
Ouslander et al (2011)	Descriptive Theory	"Is the hospital the lowest level of care where the resident's needs could be safely met?"	INTERACT II intervention conducted as quality improvement project. Leadership of nursing homes. Includes a set of tools and ways to initiate early interventions	30 nursing homes took part in the project. Nursing homes (10 each) from three states. Of the 30 nursing homes 25 and the population of each about 166 participants. A	The 23% reductions of hospitalizations were significant and encouraging for future projects. Results determined 50% of LTCF hospitalizations were unnecessary. The results were	Level I

			evaluation 25 nursing homes in three states over a six month period. Pilot test, focus groups and interviews.	six month intervention period and hospitalization rates. The Interact II intervention and tools. Reduction of hospitalization self-reported from the nursing homes with 17 to 24% decrease.	the INTERACT II tools and interventions are important for nursing to improve patient care.	
Ouslander et al (2012)	Descriptive Theory	How to define preventable hospitalizations?	The researchers reviewed two systematic reviews used for Centers for Medicare and Medicaid Services (CMS) and Agency for Healthcare Research and Quality. Search for any quality measures to identify preventable hospitalizations	250 measures defined. Measures suggested failures in the care of the patients before hospitalized. All identified measures were diagnoses.	Major contributions come with identification and development of interventions to decrease preventable hospitalizations. Reducing preventable hospitalizations needed to improve patient health and reduce cost to the patients.	Level IV

Overland, 2014	Retrospective Review	Does hospice used decrease hospitalization and decrease patient cost?	The study was done accessing data from 40,000 Medicare patients who were diagnosed with cancer and who died in 2011	The study revealed a link between using hospice care vs not using hospice care and patients who receive hospice care had decreased results of hospitalization and cost of care when compared to those who died without hospice care.	A contribution of being under hospice care is insurance companies save money by decreasing the number of hospitalizations required when treated by case management nurses in the hospice setting.	Level III
Pipe, 2007	Theory of Human Caring	Does nursing theory and evidence based practice to optimize patient outcomes?	The study was conducted in a setting with 208 beds at the facility, 15 operating rooms and a Level II emergency department. The project used Rosswurm and Larrabee's six steps to align evidence based	The literature search revealed a need for understanding the patient and early signs and directives of patients who may decline in care. The Rosswurm and Larrabee model was the best fit	The quality of care on the hospitals score board has remained above the 90th percentile once nurses were able to understand patient needs once the systematic model was adopted (Pipe, 2007). The Rosswurm and Larrabee model	Level I

			practice and theory-driven care (Pipe, 2007). A different model was previously used but once multiple specialties and complex care was needed a literature search was completedto find a model to meet the organizations current needs. A survey was completed by nurses and the nurses needed inclusion of the chosen model to provide patient health and safety with a link to patient centered care.	for the organizations current needs and used to implement a formal educational plan done in four interactive sessions focusing on detection of early patient signs, education, and patient research (Pipe, 2007). The model results included two major findings which included improvement of patient outcomes and improvement of quality of nursing care (Pipe, 2007).	has had positive results used in projects to translate research into practice and the best choice for the DNP student's project.	
Reavy & Tavernier,	Evidence-Based	Rosswurm & Larrabee	A group of four nursing staff	The project results allowed	Training family care givers of	Level I

2008	Practice Stetler Model	model used for translation of evidence into practice for nursing staff to go through the design and implementatio n process.	members teamed with a nurse manager to participate and the clinical nurse specialist, nurse researcher and infection control nurse were experts used to take the nurses through the education processes. The team of nurses with the experts held meetings to develop educational sessions to teach the entire nursing staff upon completion. The educational curriculum would include a power point presentation, posters as visuals and a detailed case study. A pilot	the nurses to recognize following a model such as Rosswurm and Larrabee provided a systematic process of change in to practice in the clinical setting. The focus is on nurses and their involvement with implementing and use of evidence-based practice in patient care.	dependent elderly adults through on-site and telecommunication programs the project outcomes were successful in the project using the Rosswurm and Larrabee model. Another project conducted using the Rosswurm and Larrabee model the nurses used evidence based practice to integrate changes to include a path to expert nursing care	

			study would be conducted and evaluation of the findings completed using a shot questionaire.			
Rosswurm & Larrabee, 1999	Rosswurm & Larrabee Model	A model to guide nurses using a systematic process for evidence-based practice changes in to practice.	Medline a systematic review, and CINAHL internet search on evidence based nursing clinical expertise and quality improvement	The model is a guide for nurses using a systematic process for evidence based practice changes in to practice.	Nurses can't continue to rely on clinical experience and the Rosswurm & Larrabee model serves as a tool to translate evidence into practice.	Level IV
Rosswurm & Larrabee, 2002	Rosswurm & Larrabee Model	Following the Rosswurm & Larrabee Model for systematic process to translate evidence	Rosswurm completed a study with interventions being tested to educate skills to common care givers of elderly patients.	The findings of the study demonstated success with family care givers through training in person and through teleconference teaching.	Training family care givers of dependent elderly adults through on-site and telecommunication programs the project outcomes were successful in the project using the Rosswurm and Larrabee model.	Level IV
Segal, Rollins,	Descriptive Theory	Examination of avoidable	The use of Diagnosis codes by	26 % hospitalizations	90% of the LTCF patients with	Level III

Hodges, & Roozeboom, 2014		hospitalizations	experts using data from Chronic Conditions Data Warehouse. The participants were Medicare and Medicaid beneficiaries. The participants had to benefit eligible for at least one month and the time period was 2007 to 2009. Algorithm developed by experts and paid for by CMS to decrease hospitalizations.	were avoidable. Avoidable hospitalizations in institutions accounted for 45%. Five conditions responsible for the 80% of avoidable hospitalizations.	avoidable hospitalization rates were 690 per 1,000 person-years. Benefit recipients enrolled in Medicaid home and community services rate 210 per 1,000 person-years. Medicare home health beneficiaries rate 300 per 1,000 person years. The avoidable hospitalizations for community beneficiaries rate was 65 per 1,000 years.	
Shier, Ginsburg, Volland, & Golden, 2013	Patient Centered Care and education	Hospice improves patient quality of care through reducing symptom distress reducing	Longitudinal survey given to adults >50 years old. Interviews every two years. Sample selection participants who died 2002-2008	Subjects mean age at the time of death was 83. Decrease in hospital stay was 9 and this was those enrolled 53-105 days	Formalized partnerships with hospital programs and community hospice programs to promote patient centered care and education will	Level III

		hospital service needs.	age 65>. Medicare A and B coverage a year before death with no managed care. Sample 3,069 total. Measured periods of hospice enrollment before death 53-105days, 15-30 days, 8-14 days, and 1-7 days. Totaled Medicare money spending from enrollment to death. Retrospective study completion.	prior to dying. 1-7 days, decrease in ICU. Overall the patients enrolled 53-105 days saw more readmissions in hospitalization.	benefit the value of patient care given.	
Unroe et al., 2014	Clinical demonstration project	Can use of new model decrease hospitalizations and bring about a systems change?	19 LTCF participating in Nurse at the participating facilities provided direct support to LTCF patients. 50% of hospitalizations avoidable through management of chronic diseases.	A change in the definition of the health care workers clinical roles and the staff who were trained to fill the roles, Strategies were developed to integrate in the nursing facility culture,	Improvement of patient care must come from collaboration of the researcher and the clinician according to the article.	Level I

			Use of INTERACT tools and interventions	communication with multiple stakeholders, and data collection. "The OPTIMISTIC RN and NP roles are unique in long-term care. Feedback from staff and facility leadership helped show that clinical skills and ability to deliver education were just pieces of the puzzle."		
Walsh, Wiener, Haber, Bragg, Freiman, & Ouslander (2012)	Retrospective Study of hospitalizations	Examine amount of hospitalizations, cost, and associations of the hospitalizations.	Nursing facilities, Medicare and Medicaid services stays of Home and community based services such as hospice with waiver programs in 2005.	Greater than one-third of the population went to the hospital at least one time which gave a total of 1 million hospitalizations. The DRG admission for 382, 846 which	Five conditions identified for hospitalizations using Diagnostic Related Groups (DRGs) results of 1 million hospitalizations >1/3 from LTCF avoidable. Top 5 included	Level III

				was 39% of the admissions were identified as avoidable. Five conditions pneumonia, CHF, UTI, dehydration, and COPD/asthma were identified as potentially avoidable for 78% of the patients. The total Medicare cost totaled $3 billion.	pneumonia, congestive heart failure, COPD/asthma, dehydration and Urinary Tract Infections. Conclusion necessitates the need for new initiatives to prevent avoidable hospitalizations and improve quality of care.	
Xing, Mukamel, and Temkin-Greener (2013)	Retrospective study	Examine the incidence of endo of life and association of nursing facility characteristics and facility level quality measures and variations of the cost and	Long term care nursing home residents who died in 2007 were used in the study. A quality measurement was constructed for avoidable hospitalizations using PAH (O) and the expected risk-	50% of the hospital admissions for the nursing facility residents were avoidable conditions and the cost was $1 billion to Medicare. Five conditions were responsible for	Retrospective study determined 50% of LTCF hospitalizations unnecessary. Early identification and higher skilled employees demonstrated better patient outcomes in the study.	Level III

		potentially avoidable hospitalizations (PAH).	adjusted rate (E) and a logistic regression model to determine the association of the facility characteristics and reason for higher than expected avoidable hospital admissions. PAH (O-E> 0). Any quality measure > 0 indicated worse than average patient quality.	80% of the hospitalizations. Pneumonia, CHF, UTI, dehydration, and falls/trauma. The nursing homes with better skilled nursing staff had the greatest performance.		
Zheng, Mukamel, Friedman, Caprio, &Temkin-Greener, 2015	Retrospective Analysis Instrumental Variable method	Using hospice care does it decrease the hospitalizations?	Medicare Beneficiary File, Inpatient and Hospice Claims, Minimum Data Set Version 2.0, Provider of Services File, and Area Resource File. Retrospective analysis of long-stay residents who died between2005-	Results demonstrated over a 30day period 37.63% of patients without hospice service were hospitalized and 23.18% of patients with hospice services were hospitalized.	Increased facility level hospice care reduces patient hospitalizations and the cost-effectiveness of hospice care	Level III

			2007. 505,851of the patients were not under hospice care (67.66%) 241,790 hospice enrolled in hospice (32.34%) 14,030 residents were in the study from nationwide facilities. Nursing home distance and hospice facility distances were used as the instrumental variables.			

Appendix C: John Hopkins Evidence-Based Practice Nursing Rating Scale

JHNEBP Evidence Rating Scales

Strength of the Evidence	
Level I	Experimental study/randomized controlled trial (RCT) or meta analysis of RCT
Level II	Quasi-experimental study
Level III	Non-experimental study, qualitative study, or meta-synthesis.
Level IV	Opinion of nationally recognized experts based on research evidence or expert consensus panel (systematic review, clinical practice guidelines)
Level V	Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience)

Quality of the Evidence		
A High	Research	consistent results with sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.
	Summative reviews	well-defined, reproducible search strategies; consistent results with sufficient numbers of well defined studies; criteria-based evaluation of overall scientific strength and quality of included studies; definitive conclusions.
	Organizational	well-defined methods using a rigorous approach; consistent results with sufficient sample size; use of reliable **and** valid measures
	Expert Opinion	expertise is clearly evident
B Good	Research	reasonably consistent results, sufficient sample size, some control, with fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence
	Summative reviews	reasonably thorough and appropriate search; reasonably consistent results with sufficient numbers of well defined studies; evaluation of strengths and limitations of included studies; fairly definitive conclusions.
	Organizational	Well-defined methods; reasonably consistent results with sufficient numbers; use of **reliable and valid** measures; reasonably consistent recommendations
	Expert Opinion	expertise appears to be credible.
C Low quality or major flaws	Research	little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn
	Summative reviews	undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results; conclusions cannot be drawn
	Organizational	Undefined, or poorly defined methods; insufficient sample size; inconsistent results; undefined, poorly defined or measures that lack adequate reliability or validity
	Expert Opinion	expertise is not discernable or is dubious.

**A study rated an A would be of high quality, whereas, a study rated a C would have major flaws that raise serious questions about the believability of the findings and should be automatically eliminated from consideration.*

Newhouse R, Dearholt S, Poe S, Pugh LC, White K. The Johns Hopkins Nursing Evidence-based Practice Rating Scale. 2005. Baltimore, MD, The Johns Hopkins Hospital; Johns Hopkins University School of Nursing.

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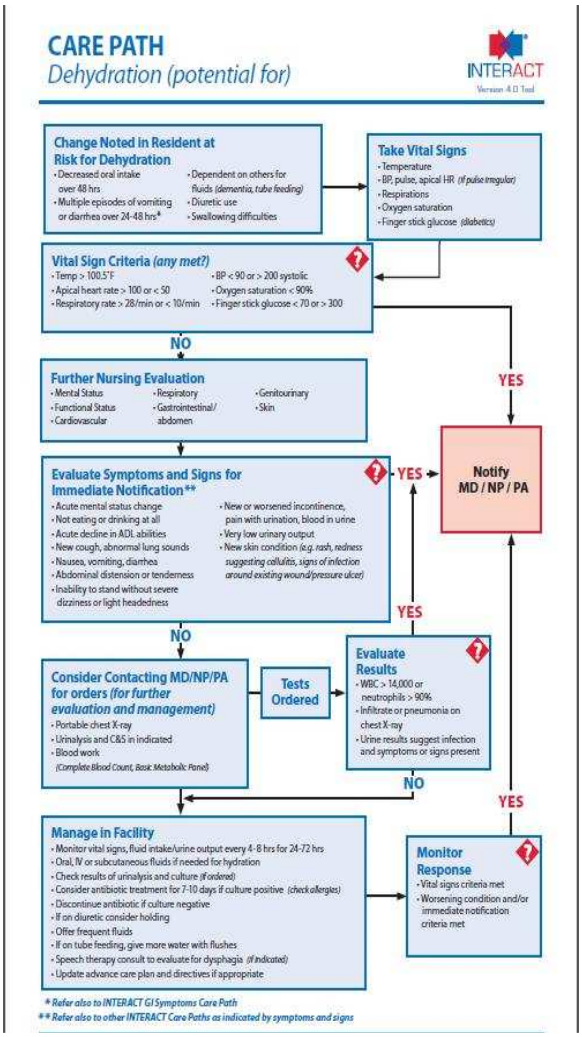
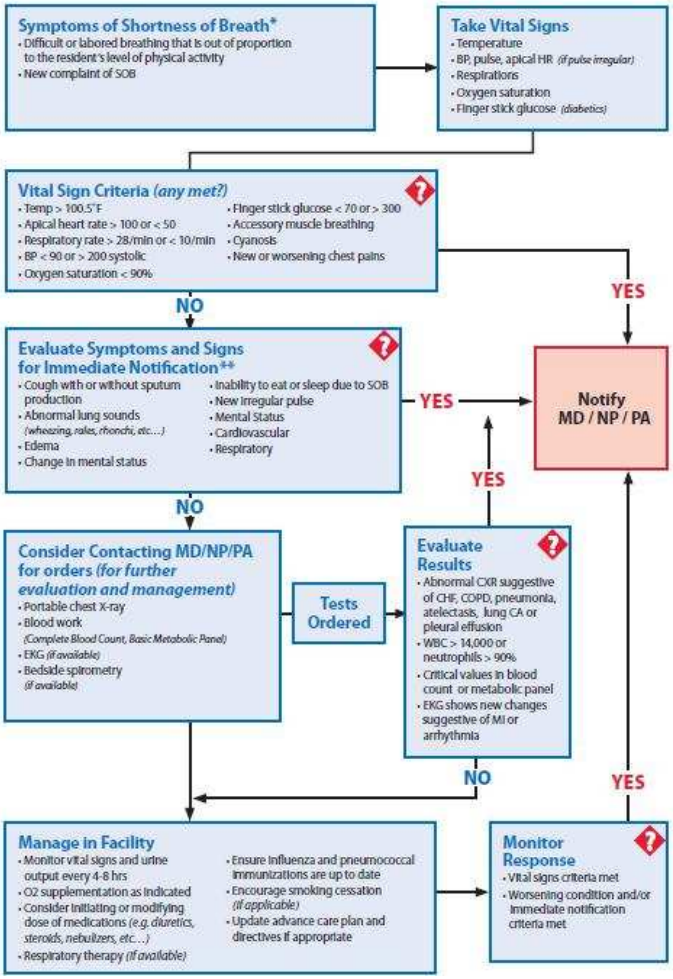
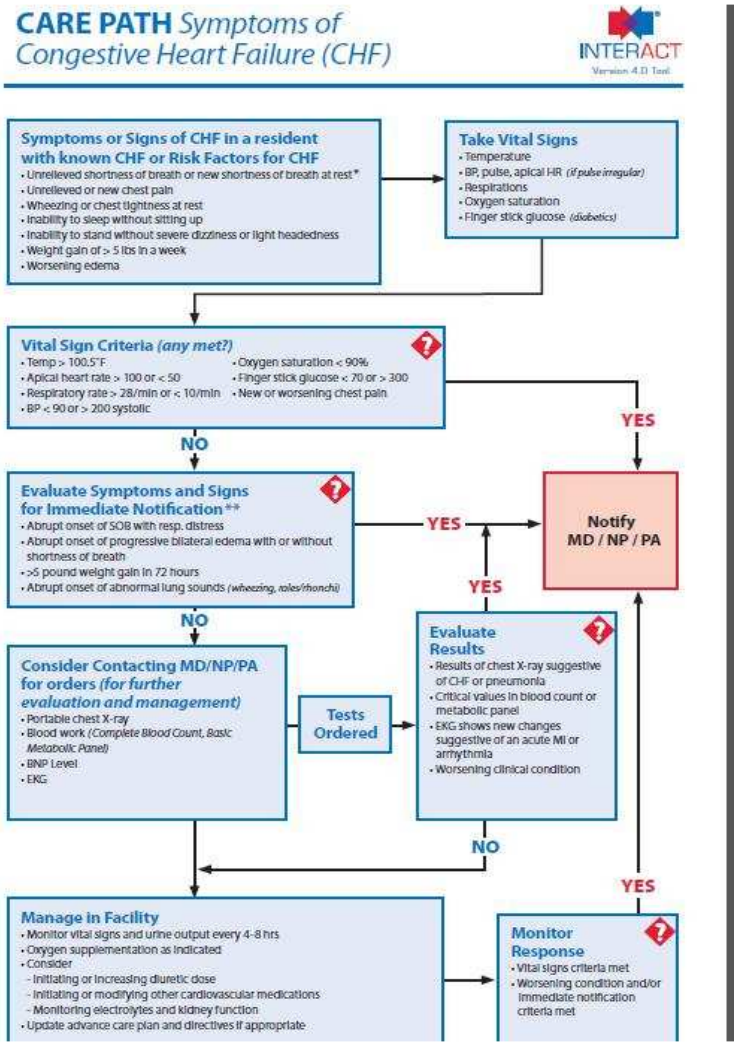
Appendix D: Care Paths

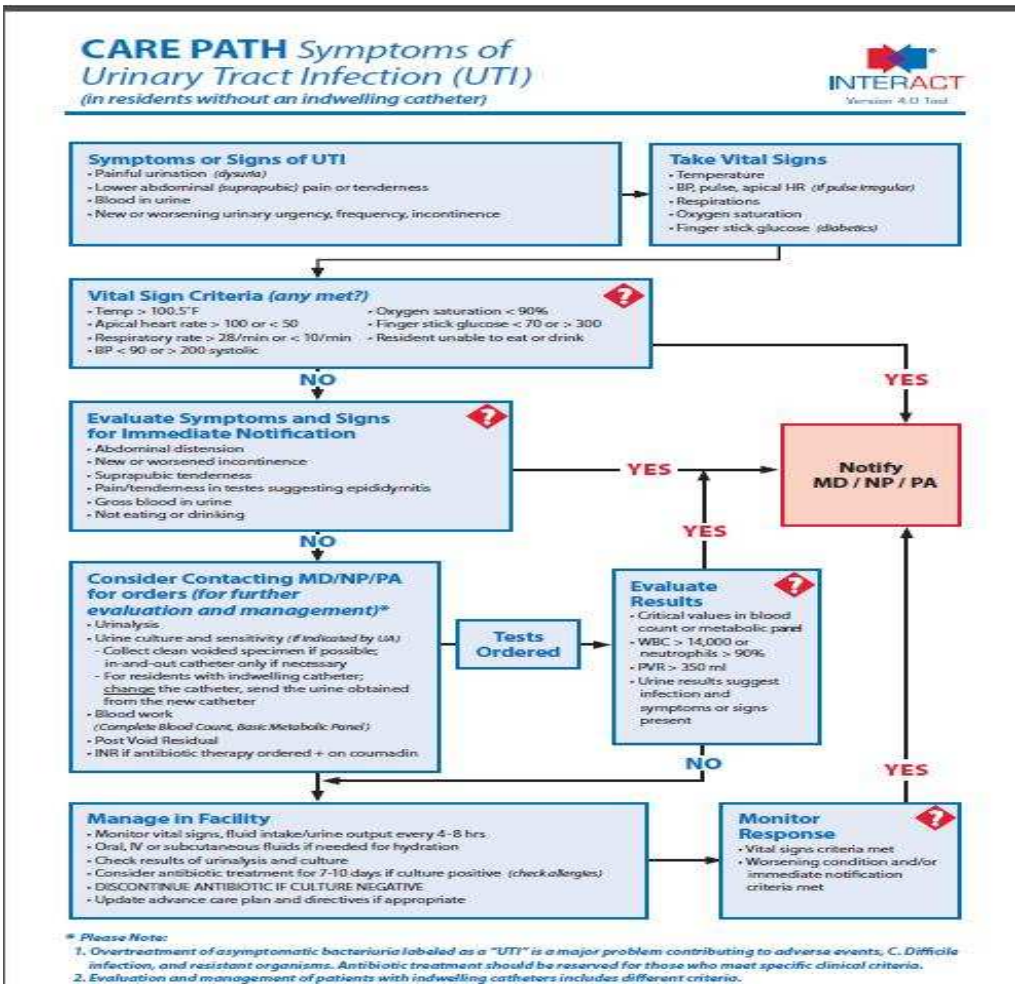


CARE PATH *Symptoms of Shortness of Breath (SOB)*

INTERACT Version 4.0 Tool




CARE PATH Symptoms of Congestive Heart Failure (CHF)
INTERACT
Version 4.0 Tool
Symptoms or Signs of CHF in a resident with known CHF or Risk Factors for CHF
• Unrelieved shortness of breath or new shortness of breath at rest*
• Unrelieved or new chest pain
• Wheezing or chest tightness at rest
• Inability to sleep without sitting up
• Inability to stand without severe dizziness or light headedness
• Weight gain of > 5 lbs in a week
• Worsening edema
Take Vital Signs
• Temperature
• BP, pulse, apical HR (if pulse irregular)
• Respirations
• Oxygen saturation
• Finger stick glucose (diabetics)
Vital Sign Criteria (any met?)
• Temp > 100.5°F
• Apical heart rate > 100 or < 50
• Respiratory rate > 28/min or < 10/min
• BP < 90 or > 200 systolic
• Oxygen saturation < 90%
• Finger stick glucose < 70 or > 300
• New or worsening chest pain
YES
NO
Evaluate Symptoms and Signs for Immediate Notification**
• Abrupt onset of SOB with resp. distress
• Abrupt onset of progressive bilateral edema with or without shortness of breath
• >5 pound weight gain in 72 hours
• Abrupt onset of abnormal lung sounds (wheezing, rales/rhonchi)
YES
Notify MD / NP / PA
YES
NO
Consider Contacting MD/NP/PA for orders (for further evaluation and management)
• Portable chest X-ray
• Blood work (Complete Blood Count, Basic Metabolic Panel)
• BNP Level
• EKG
Tests Ordered
Evaluate Results
• Results of chest X-ray suggestive of CHF or pneumonia
• Critical values in blood count or metabolic panel
• EKG shows new changes suggestive of an acute MI or arrhythmia
• Worsening clinical condition
NO
YES
Manage in Facility
• Monitor vital signs and urine output every 4-8 hrs
• Oxygen supplementation as indicated
• Consider
– Initiating or increasing diuretic dose
– Initiating or modifying other cardiovascular medications
– Monitoring electrolytes and kidney function
• Update advance care plan and directives if appropriate
Monitor Response
• Vital signs criteria met
• Worsening condition and/or immediate notification criteria met


CARE PATH Symptoms of Urinary Tract Infection (UTI)
(in residents without an indwelling catheter)
INTERACT
Version 4.0 Tool
Symptoms or Signs of UTI
- Painful urination (dysuria)
- Lower abdominal (suprapubic) pain or tenderness
- Blood in urine
- New or worsening urinary urgency, frequency, incontinence
Take Vital Signs
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)
Vital Sign Criteria (any met?)
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300
- Resident unable to eat or drink
NO
YES
Evaluate Symptoms and Signs for Immediate Notification
- Abdominal distension
- New or worsened incontinence
- Suprapubic tenderness
- Pain/tenderness in testes suggesting epididymitis
- Gross blood in urine
- Not eating or drinking
YES
Notify MD / NP / PA
NO
YES
Consider Contacting MD/NP/PA for orders (for further evaluation and management)*
- Urinalysis
- Urine culture and sensitivity (if indicated by UA)
- Collect clean voided specimen if possible; in-and-out catheter only if necessary
- For residents with indwelling catheter; change the catheter, send the urine obtained from the new catheter
- Blood work (Complete Blood Count, Basic Metabolic Panel)
- Post Void Residual
- INR if antibiotic therapy ordered + on coumadin
Tests Ordered
Evaluate Results
- Critical values in blood count or metabolic panel
- WBC > 14,000 or neutrophils > 90%
- PVR > 350 ml
- Urine results suggest infection and symptoms or signs present
NO
YES
Manage in Facility
- Monitor vital signs, fluid intake/urine output every 4-8 hrs
- Oral, IV or subcutaneous fluids if needed for hydration
- Check results of urinalysis and culture
- Consider antibiotic treatment for 7-10 days if culture positive (check allergies)
- DISCONTINUE ANTIBIOTIC IF CULTURE NEGATIVE
- Update advance care plan and directives if appropriate
Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met
* Please Note:
1. Overtreatment of asymptomatic bacteriuria labeled as a "UTI" is a major problem contributing to adverse events, C. Difficile infection, and resistant organisms. Antibiotic treatment should be reserved for those who meet specific clinical criteria.
2. Evaluation and management of patients with indwelling catheters includes different criteria.

Appendix E: Curriculum Plan

Education Initiative to Prevent Unnecessary Hospitalization for Hospice
By
Alkeisha Hill Mims, RN, MSN, MHA/Ed

Problem: The problem identified for this quality improvement DNP project is the 30% admission rate of hospice patients from the organization's long-term healthcare facilities (LTHCFs) and private homes as evidenced by chart reviews and admission and revocation data.

Purpose: The purpose of this DNP project is to identify evidence-based care paths for the top five medical diagnoses related to avoidable admissions of hospice patients to the hospital, and to develop an educational curriculum for hospice nurse case managers to understand and incorporate the care paths in their practice to prevent such hospitalizations.

Goal: The goal of this DNP project is to educate hospice nurse case managers with the hope of avoiding preventable hospital admissions among hospice patients.

Objectives	Content Outline	Evidence	Method of Presenting	Method of Evaluation P/P Item
I. Discuss the purpose of hospice patient care and the services provided.	**Introduction** **I. Project Significance** **a. Hospice Care criteria patient centered care** 1. Planning	Centers for Medicare and Medicaid Services (CMS)	Oral Presentation and Power Point	Post Test 1,2,4, 9

	2. Delivery 3. Evaluation 4. Medicare and Medicaid charge hospitals penalties 5. Readmissions within 30 days 6. Medicare payment reductions 7. Emergency Department awareness of symptoms 8. Money lost as a result of patients being admitted when avoidable admission a. **Assist with containing cost through use of professional healthcare interdisciplinary team.** b. **Nurse case managers are responsible for the coordination of care and includes:** **1. The role of the case management team is:** a. Medical Directors- Medical Director and Nurse Practitioner work with the patient's personal Care Practitioner to provide the patient with symptom care and comfort care b. Case Management Nurse-Manages the patient's daily care	Data National Inpatient Sample (NIS) Quality Initiative Data from Minimum Data Sets (MDS) Lin, R. Y., Levine, R. J., & Scanlon, B. C., 2011 Overland, 2014 Kavanaugh, Connolly, & Cohen, 2006 Kuo, Raji, & Goodwin, 2013 McKinney, 2013 Pipe, 2007 Reavy & Tavernier, 2008 Rosswurm & Larrabee, 1999	Group Discussion Poster	

	to include coordination of the patient's physical care while monitoring the patient's symptoms of the terminal disease. The nurse sets up medications, supplies, and medical equipment and provides education to the patient and the family about the terminal disease, what to expect and how to provide the best patient care. c. CNA-Certified Nursing Assistant (CNA) assists with the patient's personal care to include bathing, meals and exercise. The CNA assists with bed changes, laundry, errands and other light duties to directly support the patient. d. Social Worker-Provides patient's and their family with emotional support and counseling for transition through the end-of-life. Assess the patient and family for signs of distress and address the patients psychological, social and resource needs. e. Chaplain-Provides the spiritual and emotional support for the patients and their families. f. Volunteers-Provide the support and companionship through	Rosswurm & Larrabee, 2002		

	visits, calling, cards, reading to patients and writing letters. 1. Manage all of the patient's care needs as the providers a. Relate to the terminal disease b. Relate to the prognosis of the disease. c. Treat patient's in a comfortable setting wherever he or she lives **2.** The team treats symptoms a. Physically b. Spiritually d. Meets needs and wants of patient and family 3. Patient care Hospice services are available to anyone who meets criteria and continued eligibility. 1. Routine care 2. Continuous home care 3. Inpatient respite care 4. General inpatient care 5. Nursing home resident hospice services 6. Supplemental services of support 7. Pain management 8. End of life care e. Medicare Hospice Benefit if eligible for Part A of Medicare 1. Diagnosis of two physicians **2.** 6 months or less to live.			

	f. The role of the care giver 1. Assist to develop plan of care a. Nurse Case Manager assists with the role he or she is able to provide and which resources will be needed to provide patient care in the home or Long Term Care Facility (LTCF). 2. Responsibilities a. Individualized plan designed and detailed about the roles and responsibilities of the care giver and the nurse manager. 3. Communication between caregiver and nurse case manager a. Identify the key role of the case manager to the care giver about the role of the nurse case manager and everyone on the team as listed above with resources for the patient in the community to try to prevent avoidable hospitalizations and maintain care in the outpatient setting. b. Patient important numbers to contact hospice 24 hours 7 days a week and information about the plan of care in a designated area the family can find quickly before panicking and calling emergency care. **II. Educational Initiatives – see individual care path** a. Discuss risk factors for avoidable hospitalization to make sure patient has a list of S/SX related to the terminal illness			

	Ex. to include CHF b. Refer to S/SX noted during assessment c. Care path for patient care to be maintained in the hospice patients living setting. d. Discuss importance of communication refer to SBAR **III. Framework/Models** **a. Six Steps Rosswurm & Larrabee Conceptual Model of Evidence-Base Practice** • Assess practice change and identification of the problem. During the assessment of the practice change and identification of the need to develop a nurse case management educational plan to prevent unnecessary hospitalization for hospice patients. Stakeholders are included and collection of data is gathered to compare the			

	organization's data with researched data to not only identify the problem but to identify interventions and positive outcomes. • Identify the best evidence through research. Using the matrix to develop an educational plan for nurse case managers. • Synthesize the scholarly literature related to unnecessary hospitalizations to use the evidence for better patient outcomes. • Design educational plan through the process of implementing and define the outcomes of the project. • Implementation and evaluation of change to practice using the formative and summative evaluations and adopt the change.			

	• Integrate and Maintain through a presentation of the educational plan to the healthcare team and incorporating the plan into practice with continued monitoring of the patient outcomes. **a. Lewin's Change Model** 1. Unfreeze-Identify leaders within the organization to assist with changes in healthcare to promote the transition of changes and provide understanding to the nurses about the importance of change of care. 2. Transition- Educate the nurse case management team on changes needed to begin to improve patient care and practices. Once educated continue to review data to determine if the education and change of practice improved			

	patient care and practices. 3. Freeze-Practice patient care interventions for better outcomes and make the practices apart of daily patient care to continue to improve care and outcomes of care in the hospice setting. **b. Optimistic Model** 1. **Medical Care.** Educate the nurse case managers to improve management through recognition of disease processes to prevent hospitalizing the patient. Care pathways and tools for improved communication to prevent development of symptoms to cause hospitalization. Signs and symptoms such as cognitive function, medication, fluctuation of weight, skin			

	assessment, falls and vaccines are all components. Tool guides to gather data about the patient and immediately begin to set goals for patient centered care are pertinent. The information is given to the nurse practitioner to assist with management of care (Unroe et al., 2014). 2. **Transitional Care.** If the patient has to be transferred standards of care must be met to make sure the hospitalization is not related to the disease processes and is unavoidable. An Acute Care Transfer Tool used to begin quality improvement to improve transfers and communication of patient care (Unroe et al., 2014). 3. **Hospice Care.** Pain and symptom management will be done in outpatient setting. A review of patient end of life wishes is always considered. Providing end of life			

	care with symptom management is the goal of patient care during end of life (Unroe et al., 2014). **A. Background** a. Introduction of avoidable hospital admissions According to the Center to Advance Palliative Care (CAPC), approximately three million patients will be living in LTCF in the United States in 2030 b. 40% of the patients will die in the LTCF. c. Most of the patients will have chronic illnesses without long life expectancy (CAPC, 2008). d. Providing hospice care in a LTCF can improve patients' health states, decrease hospitalizations, and facilitate family members' positive perceptions of hospice care (Cimino & McPherson, 2014).			

II. Identify the physical and psychological signs and symptoms of patients who are transitioning at the end of life.	a. Identify signs and symptoms related to terminal illness – covered in care paths 1. Early sign and symptom recognition 2. Notifications of patient changes of status a. Case Management Nurse 3. Proactive interventions of care (Refer to Care Paths) b. Hospice care in LTCF 1. Responsibility of the Nurse Case Manager a. To manage the patient's care and be called for any issues that may occur and seem urgent	Hurley, S., Strumpf, N., Barg, F. K., & Ersek, M., 2014 Shier, G., Ginsburg, M., Howell, J., Volland, P., & Golden, R., 2013	Oral Presentation and Power Point Case Study	Post Test 3,8, 13

	Example: Decrease oxygen saturation < 90% and Nurse Case Manager will work with the practitioner to provide supplemental oxygen and maintain oxygen saturation 90% or greater in the facility. An on call case manager is always available. 2. Role of the primary nurse a. Using the case manager and the rest of the hospice team to manage the patients comfort and symptoms throughout the rest of the patient's end of life care. b. Understand we support the primary nurse from medical to nursing care with spiritual or emotional support and the commitment of			

	providing the best comfort and symptom care during end of life. c. Identify with the care paths and become proactive with seeking nurse case management for patient care. 3. Collaboration of the two for prevention of hospitalizations 4. Initiatives to prevent unnecessary hospitalizations **B. Who plays a role in psychological care?** a. Social worker and Chaplin services 1. Role of Social Worker 2. Role of Chaplin b. Case management of all signs and symptoms 1. Role of the unlicensed health professional (CNA)			

	and the importance of communicating any signs or symptoms noted during the visit when bathing or completing any of the duties as a CNA that may seem to be a concern. Ex. If a patient complains of pain to a CNA the role as the unlicensed professional is to direct the complaints to the case management nurse who can assess and manage the patient's pain. (Sometimes the clarification of communication of things seen and told by a patient can be early warning signs to prevention of further complications of patient care).			
III. Classify nursing management for hospice patients using care paths	**C. Top Five Reasons for Hospice Unnecessary Hospitalizations**	Flood, K. L. 2013 Nurse management interventions using	Oral Presentation and Power	5, 6, 11,12, 14, 15, 16

to prevent unnecessary hospitalizations.	a. Pneumonia Care Path 1. Symptoms of the disease as on Care Path A. See Shortness of Breath Care Path b. COPD/ Asthma Care Path 1. Symptoms of the disease a. See Shortness of Breath Care Path c. Dehydration Care Path 1. Symptoms of the disease a. See Dehydration Care Path d. Urinary Tract Infection (UTI) Care Path 1. Symptoms of the disease a. See Urinary Tract Infection Care Path 2. Congestive Heart Failure Care Path and algorithm 1. Symptoms of the disease	evidence based algorithms as a tool Intervention to Reduce Acute Care Transfers (INTERACT II) of care for better patient outcomes. Kuo, Y., Raji, M. A., & Goodwin, 2013 Olsen, M. L., Bartlett, A. L., & Moynihan, T. J., 2010 Segal , Rollins, Hodges, & Roozeboom, 2014 Walsh, Wiener, Haber, Bragg, Freiman, & Ouslander, 2012 Unroe et al., 2014 Xing, Mukamel, and Temkin-Greener, 2013 Zheng, Mukamel, Friedman, Caprio, & Temkin-Greener, 2015	Point Algorithm	

	a. See CHF Care Path **D. Management of Patient Care Using the Care Paths (See Appendix D)** **1. CHF** **2. Dehydration** **3. UTI** **4. Shortness of Breath**			
			Poster	

IV. Analyze the needs of caregivers and nurses who care for hospice patients and include better communication through the use of the	**E. SBAR Communication tool Importance** 1. The effect of using a communication tool a. Causes a patient evaluation	Intrator, O., Zinn, J. & Mor, V., (2004) Centers for Medicare and Medicaid Services (CMS) Ouslander et al (2010)	Role play Questions and Answers Handout	7, 10

SBAR tool for critical care thinking to improve accuracy exchanges of patient information.	b. Ensures assessment of patient vital signs and head to toe assessment of the patient c. Causes a review of all labs, medication, pertinent patient history d. Causes the use of the Care Path if applicable 2. When to use SBAR a. Before calling the health care practitioners b. Before transferring a patient c. Before calling for emergency care d. To provide SBAR communication between LTCFN and case managers e. To gain patient care improvements through effective communication	Ouslander et al (2011) Ouslander et al (2012)		

	f. INTERACT V4 SBAR_Communication_Form Dec 10.pdf http://interact2.net/docs/INTERACT%20Version%204.0%20Tools/INTERACT%20V4%20SBAR_Communication_Form%20Dec%2010.pdf			

Appendix F: Content Expert Evaluation of the Curriculum Plan

Title of Project: Education Initiative to Prevent Unnecessary Hospitalization for Hospice

Student: Alkeisha Mims

Date: **Number of Reviewer:**

Products for review: Curriculum Plan with Complete Curriculum Content, Literature review Matrix

Instructions Please review each objective related to the curriculum plan, content and matrix. The answer will be a "Met" or "Not Met" with comments if there is a problem understanding the content or if the content does not speak to the objective.

At the conclusion of this educational session the learner will be able to:

Objective 1: Discuss the purpose of hospice patient care and the services provided.

Met____ Not Met____

Comments:

Objective 2: Identify the physical and psychological signs and symptoms of patients who are transitioning at the end of life.

Met____ Not Met____

Comments:

Objective 3: Classify nursing management for hospice patients using a care path to prevent unnecessary hospitalizations.

Met____ Not Met____

Comments:

Objective 4: Analyze the needs of caregivers and nurses who care for hospice patients and include better communication through the use of the SBAR tool for critical care thinking to improve accuracy exchanges of patient information.

.

Met____ Not Met____

Comment:

Appendix G: Content Expert Evaluation of Curriculum Plan Summary

Content Expert Evaluation of Curriculum Plan Summary
Not Met = 1 Met - 2

Objective Number	Evaluator 1	Evaluator 2	Evaluator 3	Content Evaluation Index
1	2	2	2	2
2	2	2	2	2
3	2	2	2	2
4	2	2	2	2

Comments: A strength noted by content expert 2 was dealing with the SBAR section of the outline of usage

Appendix H: Pretest/Posttest

Education Initiative to Prevent Unnecessary Hospitalization for Hospice

Test Item #

1. **A person with a life expectancy of _____ months or less is eligible for hospice.**

   a. 1
   b. 6
   c. 12
   d. none of the above

2. **Hospice provides care to manage _____ and _____ connected to the patient's terminal disease.**
   a. curing, medicine
   b. healing, a cure
   c. pain, symptoms
   d. none of the above

3. **A hospice patient is dehydrated with symptoms that include vomiting and diarrhea, the patient has vital signs within normal limits according to the signs and symptoms the algorithm instructs the nurses to evaluate:**
   a. mental status
   b. respiratory
   c. cardiovascular
   d. all of the above

4. **A person who has end of life symptoms time of death can be expected to occur**
   a. within the hour
   b. within the day
   c. within the week
   d. at a different time in each individual

5. **A _____is a tool to use and intervene proactively when caring for patients during end of life care to improve better patient outcomes and decrease unnecessary hospitalizations.**

a. care path
b. treatment
c. communication form
d. none of the above

6. **List the top five reasons for unnecessary patient hospitalizations of hospice patients below.**
   a. Pneumonia
   b. Chronic Obstructive Pulmonary Disease (COPD)/Asthma
   c. Congestive Heart Failure (CHF)
   d. Dehydration
   e. Urinary Tract Infection (UTI)

7. **What is the acronym for the critical thinking communication tool to improve accuracy of patient information with organized progression notes about the patient that elicits clear and concise pertinent patient information between the hospice case manager and the LTCF nurse or patient home caregiver?**

   a. STAR b. SBAR c. SCAR d. SART

8. **A person who generally is sharp and does not have any signs or symptoms of confusion but suddenly become confused and start displaying continued episodes of forgetfulness should first be assessed for:**

   a. infection
   b. dementia
   c. Alzheimer ‘s
   d. headache

9. **The Rosswurm and Larrabee model goes through how many steps to assist with translation of evidence into practice?**
   a. 4
   b. 3
   c. 8
   d. 6

10. **The Long Term Care Facility Nurse (LTCFN) or patient home caregiver should understand the importance of communication with the nurse case manager to allow the nurse case manager to:**

    a. provide curative care
    b. provide comfort care
    c. allow a hospital transfer
    d. both b and c

11. **Providing hospice care to a patient using an algorithm as a care path and a critical thinking tool for communication about the patient and the needs of the patient can decrease the number of unnecessary hospitalizations and allow patient treatment to be maintained in the hospice setting by using proactive interventions of care.**

    a. true
    b. false

12. **A care path is designed to assist the case management nurse to evaluate, treat, manage, and monitor the patient symptoms being experienced.**
    a. true
    b. false

13. When evaluating Shortness of Breath (SOB) the patient could potentially be treated and managed in the facility without being transferred to the hospital.

a. true
b. false

14. Management of a Urinary Tract Infection (UTI) in a facility or home include all of the following except:

a. monitor patient vital signs
b. monitor fluid intake/urine output q 24 hours
c. consider antibiotic treatment for 7-10 days
d. check urinalysis and culture results

15. A person with Congestive Heart Failure (CHF) complaining of inability to sleep without sitting up and wheezing or chest tightness at rest as the nurse what should you do first:

a. call for emergency care
b. take patient vital signs
c. notify the doctor or nurse practitioner
d. do nothing patient is in hospice

16. What are some nursing evaluations a nurse needs to assess for when assessing a dehydrated patient?

a. mental status/functional status
b. skin
c. genitourinary
d. all of the above

Answers- Highlighted in yellow

Appendix I: Pretest/Posttest Content Expert Validation

Date: **Student Name: Alkeisha H. Mims**

Reviewer's Number:

Packet: Curriculum Plan, Pretest/Posttest, Complete Curriculum

INSTRUCTIONS: **Please check each item to see if the question is representative of the course objective and the correct answer is reflected in the course content.**

Test Item #

1. **A person with a life expectancy of _____ months or less is eligible for hospice.**

   a. 1
   b. 6
   c. 12
   d. none of the above

   Not Relevant __ Somewhat Relevant__ Relevant__ Very Relevant__

   Comments:

2. **Hospice provides care to manage _____ and _____ connected to the patient's terminal disease.**
   e. curing , medicine
   f. healing , a cure
   g. pain, symptoms
   h. none of the above

   Not Relevant__ Somewhat Relevant__ Relevant__ Very Relevant__
   Comments:
3. **A hospice patient is dehydrated with symptoms that include vomiting and diarrhea, the patient has vital signs within normal limits according to the signs and symptoms the algorithm instructs the nurses to evaluate:**
   e. mental status

f. respiratory
g. cardiovascular
h. all of the above

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__

Comments:

4. **A person who has end of life symptoms time of death can be expected to occur**
   e. within the hour
   f. within the day
   g. within the week
   h. at a different time in each individual

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__
Comments:

5. **A _____is a tool to use and intervene proactively when caring for patients during end of life care to improve better patient outcomes and decrease unnecessary hospitalizations.**

   e. care path
   f. treatment
   g. communication form
   h. none of the above

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__
Comments:

6. **List the top five reasons for unnecessary patient hospitalizations of hospice patients below.**
   a. Pneumonia
   b. Chronic Obstructive Pulmonary Disease (COPD)/Asthma
   c. Congestive Heart Failure (CHF)
   d. Dehydration
   e. Urinary Tract Infection (UTI)

Not Relevant__ Somewhat Relevant__ Relevant__ Very Relevant__
Comments:

7. **What is the acronym for the critical thinking communication tool to improve accuracy of patient information with organized progression notes about the patient that elicits clear and concise pertinent patient information between the hospice case manager and the LTCF nurse or patient home caregiver?**

   a. STAR b. SBAR c. SCAR d. SART

   Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__
   Comments:

8. **A person who generally is sharp and does not have any signs or symptoms of confusion but suddenly become confused and start displaying continued episodes of forgetfulness should first be assessed for:**

   a. infection
   b. dementia
   c. Alzheimer ‘s
   d. headache

   Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__
   Comments:

9. **The Rosswurm and Larrabee model goes through how many steps to assist with translation of evidence into practice?**
   a. 4
   b. 3
   c. 8
   d. 6

   Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__
   Comments:

10. The Long Term Care Facility Nurse (LTCFN) or patient home caregiver should understand the importance of communication with the nurse case manager to allow the nurse case manager to:

a. provide curative care
b. provide comfort care
c. allow a hospital transfer
d. both b and c

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__
Comments:

11. Providing hospice care to a patient using an algorithm as a care path and a critical thinking tool for communication about the patient and the needs of the patient can decrease the number of unnecessary hospitalizations and allow patient treatment to be maintained in the hospice setting by using proactive interventions of care.

a. true
b. false

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__
Comments:

12. A care path is designed to assist the case management nurse to evaluate, treat, manage, and monitor the patient symptoms being experienced.

a. true
b. false

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__

Comments:

13. When evaluating Shortness of Breath (SOB) the patient could potentially be treated and managed in the facility without being transferred to the hospital.

a. true
b. false

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__

Comments:

14. Management of a Urinary Tract Infection (UTI) in a facility or home include all of the following except:

a. monitor patient vital signs
b. monitor fluid intake/urine output q 24 hours
c. consider antibiotic treatment for 7-10 days
d. check urinalysis and culture results

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__

Comments:

15. A person with Congestive Heart Failure (CHF) complaining of inability to sleep without sitting up and wheezing or chest tightness at rest as the nurse what should you do first:

a. call for emergency care
b. take patient vital signs
c. notify the doctor or nurse practitioner
d. do nothing patient is in hospice

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__

Comments:

16. What are some nursing evaluations a nurse needs to assess for when assessing a dehydrated patient?

a. mental status/functional status
b. skin

c. genitourinary
d. all of the above

Not Relevant__ Somewhat Relevant__ Relevant___ Very Relevant__

Comments:

Answers- Highlighted in yellow

Appendix J: Summative Evaluation

Education Initiative to Prevent Unnecessary Hospitalization for Hospice

Project Title: Summative Evaluation Stakeholders/Committee Members
Student: Alkeisha H. Mims
Thank you for completing the Summative evaluation on my project. Please complete and send anonymously via interoffice mail

A. This project was a team approach with the student as the team leader.

1. Please describe the effectiveness (or not) of this project as a team approach related to meetings, communication, and desired outcomes etc.

2. How do you feel about your involvement as a stakeholder/committee member?

3. What aspects of the committee process would you like to see improved?

B. There were outcome products involved in this project that included: Curriculum matrix of evidenced literature, John Hopkins Nursing Evidence –Based Practice (JHNEBP) Evidence Rating Scale, Curriculum Plan, care paths, and pretest/posttest

1. Describe your involvement in participating in the development/approval of the products.

2. Share how you might have liked to have participated in another way in development/approval of the products.

C. The role of the student was to be the team leader.

1. As a team leader how did the student direct the team to meet the project goals?

2. How did the leader support the team members in meeting the project goals?

D. Please offer suggestions for improvement.

Appendix K: Content Expert Content Validation Index Score Summary

Content Validation Index Score by Content Experts

Not Relevant = 1, Somewhat Relevant = 2, Relevant = 3, Very Relevant = 4

Test Item	Evaluator 1 Score	Evaluator 2 Score	Evaluator 3 Score	Content Evaluation Index
1	4	2	4	.67
2	4	3	4	1
3	4	4	4	1
4	4	2	4	.67
5	4	4	4	1
6	4	4	4	1
7	4	4	4	1
8	4	4	4	1
9	4	1	4	.67
	4	4	4	1

10				
11	4	4	4	1
12	4	4	4	1
13	4	4	4	1
14	4	4	4	1
15	4	4	4	1
16	4	4	4	1
Total score				15.01

Content Validation Score: 94

Recommendations:

Evaluator 1: Recommendation is to use the pretest /posttest as an evaluation tool of the nurse's understanding and know the objectives that may require remediation.

Evaluator 1 and 3: Recommendation was to require the pretest/posttest scores be kept on file as part of the nurse's permanent record identified in the policy with at least a 90% pass rate on the posttest.

Evaluator 2: One comment was eligibility of the hospice patient was part of the problem but felt instead of testing on the eligibility to replace this question with a question related to the avoidable admission rate for the facility. Restated the use of SBAR communication is a great asset to the content outline and highly recommends SBAR. The final recommendation is that the pretest/posttest is a good evaluation tool to determine the understanding of the curriculum objectives on the posttest and get an understanding of the nurses' knowledge before the educational curriculum is presented.