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Improved Rehabilitation by Improving Discharge Processes to Decrease Readmissions

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Walden University
2018

Abstract

Improved Rehabilitation by Improving Discharge Processes to Decrease Readmissions

by

Deborah Walton

MSN, University of Phoenix, 2007

BSN, University of Phoenix, 2000

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2018

Abstract

Inadequate discharge planning for individuals with chronic illnesses or injuries is associated with increased readmissions to the hospital or rehabilitation facility where the original treatments were administered. To help ensure the recovery of discharged patients and avoid readmissions, discharge planners guide medication and care processes. The rate of readmissions was high in a stand-alone rehabilitation center due to ineffective discharge plans. Patients, family members, and caregivers lacked knowledge about medications, treatments, and self-care guidelines after the patient left the facility. The purpose of this project was to ascertain the impact of improved discharge processes using the (a) IDEAL Discharge Planning Overview, Process, and Checklist; (b) the teach-back Method training for discharge nurses; and (c) the Postdischarge Rehabilitation Services Follow-Up Tool incorporating telephone calls to all participants during Weeks 1, 2, and 4 postdischarge. Lewin's theory of planned change undergirded this project. According to Centers for Medicare and Medicaid Services data, the rate of readmissions among the 50 participants was 4.4%, compared with 6% (all-facility readmission rate) during the same quarter of the prior year. Findings from this project suggest that reductions in readmissions were associated with improvements in discharge planning, training of caregivers, and the use of national tools to standardize practices in reducing readmissions. The implication of this project for positive social change is that patient-centered inpatient rehabilitation care and patient-centered care following discharge may reduce readmissions, reduce costs, improve reimbursement, and reduce deterioration of patients' conditions postdischarge.

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Dedication

To Dr. John Ogundipe, Ph.D., M.D. for your dedication, commitment, and remarkable ability to inspire and support others who are aspiring to follow in your footsteps in helping and caring for persons who are less fortunate than we. Without your mentoring, education, and endorsement of the challenge of this evidence-base practice, scholarly work would not have been accomplished. I will forever be in your debt for such dedication to the completion of my Doctor of Nursing Practice.

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Section 1: Nature of the Project

Providing high-quality patient care is an effective way of reducing rehabilitation center readmissions among hospitalized patients (Hubbard & McNeil, 2012). Effective rehabilitation therapies are critical in the restoration of health in patients with chronic illnesses or injuries (Hubbard & McNeil, 2012). Discharge planning is another necessary step in reducing readmissions (Hager, 2010). With a shorter duration of hospital stay, discharged patients often require prolonged care after leaving the hospital (Popovic, 2000). Patients leave the hospital while still recovering and fragile underlining the need for purposeful and careful discharge planning.

Planning for care after hospitalization, therefore, is an essential part of overall patient care (Wells, LeClerc, Craig, Martin, & Marshall, 2016). Due to inadequate discharge planning, discharged patients often suffer further deterioration of their health condition. When the proper care has not been planned for a patient, the likelihood that the patient will be readmitted increases (Popovic, 2000).

Boutwell (2009) suggested that most of the adverse conditions witnessed after discharge are a result of (a) errors in medical prescriptions or their use and (b) failure by the relevant personnel to follow-up on an unresolved problem. Discharge planning helps discharged patients recover faster when patients and their caregivers are taught how to administer medications prescribed upon discharge (Forster, 2004).

Nurses are the health care practitioners entrusted with the task of ensuring that hospitalized patients receive appropriate and timely care. It is their responsibility to make sure that the caregivers who will be overseeing patients' care after discharge have

sufficient skills to enable patients to recover (Hager, 2010). Failure to maintain high-quality coordinated patient care skews the patient recovery process and leads to rehabilitation center readmissions (Hager, 2010) within 30 days of discharge. It is important that best practices and effective patient care models are adopted in rehabilitation facilities to decrease patient readmissions.

Problem Statement

The problem addressed in this Doctor of Nursing Practice (DNP) project was the lack of a systematic method for evaluating and preparing patients for discharge from a rehabilitation facility; it has led to high readmission rates and penalties from the Centers for Medicare and Medicaid Services (CMS). The current monthly readmission rate is between 15% and 20% of the discharged home patients, and the target facility wants to decrease the number of 30-day readmissions to 0%.

Rehabilitation centers provide an adequate environment for improving from exacerbations of chronic illnesses and injuries. Through rehabilitation, patients receive specialized care that helps enhance their recovery process (Hager, 2010). However, upon discharge, patients must continue receiving high-quality care until their ultimate recovery. Due to the medical technology improvements and other best practices, the quality of care provided to patients is usually high-level, leading to reduced days in the hospital. This move is economical for both patients and the hospital (Hager, 2010). But more attention should be paid to enhance the discharge process to reduce avoidable readmissions. As a result of increased post discharge 30-day readmissions to the facility

CMS has imposed a 0.73% reduction in hospital reimbursements for each avoidable hospital readmission (Rau, 2016).

To ensure the discharged patients' recovery, discharge planners must ensure that patients, family members, and other caregivers have the required knowledge about medications, other treatments, or care guidelines given to the patient and to the caregivers before leaving the hospital (Forster, 2003; Hubbard, 2012). If this teaching is not done, the discharged patients may be unable to continue their recovery process and caregivers may not able to help them abide by the medication prescriptions and treatment plans presented to them at discharge (Hager, 2010). This reality prompted the project to improve the discharge processes at the facility.

Purpose Statement

The purpose of this project is to determine if an improved discharge planning process starting at admission will provide patients and their caregivers with sufficient information and resources for their postdischarge transition and decrease the number of readmissions of patients within 30 days of discharge. The implementation of targeted discharge release plans just after patients are admitted is the best way to realize standardized care and a reduction in the incidence of hospital readmissions (Hager, 2010).

This project consisted of a formative evaluation of a pilot of the IDEAL materials (Agency for Healthcare Research and Quality [AHRQ], 2013) with patients and their families, and feedback through questionnaires about their understanding of medications

and necessary self-care after discharge. Based on this feedback, additional changes were recommended to enhance the current approach.

Nature of the Doctoral Project

This project's utilization of the IDEAL materials (AHRQ, 2013) assisted patients and their families in the understanding of medications and necessary self-care after discharge to prevent readmission to the hospital. Additional changes were recommended to the facility management after the pilot to enhance the discharge planning outcomes. Evidence used in the project and its evaluation was obtained from published articles, reports, and books accessible to the public. Permission to implement the project was sought from the Walden University Institutional Review Board (IRB). Nurses at a rehabilitation center received training on how to educate patients and caregivers through a Teach-back Method (see Appendix A). The project evaluation determined the effectiveness of the trialed discharge planning process initiatives. Fifty patients (see Appendix B) transitioning from the rehabilitation center to their homes or assisted living participated. Follow-up, consisting of three telephone calls over 1 month, was conducted to determine the number of discharges from the rehabilitation center and the number of readmissions (see Appendix C). These numbers were compared to data prior to the project implementation.

Significance of the Study

In the past, family members of discharged patients have complained about their inability to provide sufficient patient care after discharge (Hager, 2010). This dissatisfaction was prompted by their lack of knowledge on how best to care for the

patients at home. Patients have complained about their inability to read medical instructions, making it important that all postdischarge stakeholders receive specialized discharge education to help ensure that the patients recover fully (Forster, 2004).

Most of the patients admitted to rehabilitation centers are suffering from chronic illnesses that often require specialized high-quality care to boost recovery and reduce the rate of rehabilitation center readmissions (Hubbard, 2012). The cost of readmissions when treating chronic ailments is very high and can burden the families with financial difficulties, while also reducing the ability of rehabilitation centers to access reimbursements based on their rates of readmissions (Marek, 2010). This project may lead to mechanisms through which both the healthcare organizations and the patients gain financially. Using the discharge plans, patients and their community caregivers can receive standardized guidance on how to continue abiding by healthcare protocols and established medication regimens after discharge (Hager, 2010). Elaborating and communicating detailed release plans can guide the transition of patients from the rehabilitation center to the home in a more effective manner to ensure that safe and effective patient care continues.

Nurses may be able to instruct community caregivers on what they must do to help a patient fully recover (Hubbard & McNeil, 2012). Full patient recovery means no avoidable readmissions within 30 days after discharge. The project helped in patient satisfaction within 30 days after discharge having no readmissions. The project contributed to the enhancement of patient satisfaction related to the discharge process. Modern healthcare practices focus on the delivery of patient-centered care. When the

patients and families are not satisfied with the rehabilitation and discharge processes, lower satisfaction scores may affect financial reimbursement for the care provided.

This project led to enhancing the patient and caregivers' knowledge about the need to maintain care quality to help improve recovery and avoid unnecessary readmissions (Hubbard & McNeil, 2012). This project contributed to the implementation of best practices in health care improvement in the care of rehabilitation patients. The project provided information on the degree to which the development of effective discharge plans improved patient satisfaction scores.

<div align="center">**Summary**</div>

Patients with chronic ailments require a high-quality of care in the rehabilitation center setting and in their transition to the community or home setting. The medical requirements for patients suffering from chronic diseases are very specific prompting the need for enhanced vigilance of care. However, many patients and their caregivers have not been able to follow a specific care plan after discharge due to the lack of proper transition instructions from the rehabilitation centers, verification of the patient and caregivers' understanding, and commitment to the plan after discharge.

The specific discharge planning tools initiated during admissions can reduce instances of avoidable readmissions to the rehabilitation center. This project used a 30-day time frame to measure the readmission rate after discharge. In addition, a 30-day implementation of the new discharge planning process was used.

Section 2 will focus on the concepts, models, and theories that provided a rationale for this doctoral project. Terms will be defined and cited. Standard practices

will help validate the identified gaps in practice. Local background and context will be reported. Finally, the role of the DNP student will be addressed.

Section 2: Background and Context

The problem addressed in this project was the excessive and avoidable number of readmissions to the healthcare facility. Implementing better discharge processes would improve rehabilitation and decrease hospital readmissions. As stipulated in Section 1, the purpose of this project was two-fold: (a) to develop a new process for discharge assessment and planning and (b) compare preimplementation and postimplementation numbers to determine whether readmissions within 30 days had significantly declined after the implementation of the project.

Section 2 will address concepts, models, and theories that support the project and show how the intervention is relevant for nursing practices. A review of the literature will show the gaps in practice. The local background and the context of the problem will support the need for the practice changes.

Concepts, Models, and Theories

Change theories are very important in guiding the policies and processes for implementing various initiatives (Shirey, 2013). In this project, Lewin's theory of planned change (Lewin, 1997)—which incorporates three stages: unfreezing, moving, and refreezing—lends structure to the project. Unfreezing involves the identification of a problem to be addressed and the creation of an enabling environment through which proposed methods can work effectively to mitigate the problem. In this stage, guidelines are set through which issues are addressed, although the focus is on the provision of enabling environments that boost the applicability of the proposed measures to the problem (Dodge, 2014). The moving stage is a period of transition through which the

proposed measures and methods of addressing an identified problem are implemented in

an enabling environment. Teaching how to implement the proposed change is also

disseminated during the moving stage of Lewin's theory (Dodge, 2014). In the refreezing

stage, procedures are adopted and implemented to keep the newly identified and

implemented methods and measures in place (Zaccagnini & White, 2011). In this project,

the analysis of the need for change and the barriers envisioned in the implementation of

this project were evaluated in Lewin's unfreezing stage.

Based on Lewin's theoretical framework, the main analysis in the unfreezing

stage involved evaluation of the adverse events in the postdischarge period, the analysis

of the gaps in discharge training, and the examination of the level of preparedness of the

nurses to handle the discharge processes. The additional training of nurses, patients and

their families, and the implementation of quality improvement programs for practicing

nurses and other clinical support staff, are two of the most likely interventions to help

decrease avoidable patient readmissions. Evidence of improved patient outcomes from

similar interventions in the literature were a motivating factor for solving the readmission

problem in the rehabilitation center. The moving stage involved the use of a new

discharge planning questionnaire (see Appendix B) and the Teach-back Method (Maurer,

Dardess, Carman, Frazier, & Smeeding, 2012) (see Appendix C) to help enhance the

training of the discharge guidelines as outlined in the patients' discharge plans. The

Teach-back Method is used in the process of teaching patients and their caregivers how

best to follow the medication instructions upon discharge to avoid any instance of

avoidable readmission. Through the moving stage, the stakeholders were reminded of the

benefits of eliminating preventable healthcare readmissions. In the refreezing stage, all stakeholders were encouraged to embrace the guidelines of effective discharge plans and follow the Teach-back Method to help eliminate any incidences of avoidable hospital readmissions for at least 30 days after discharge.

Harrison (2002) stated that the growing number of readmissions has placed pressure on the resources of hospitals (see Table 1). The authors posited that there was a need for better management of chronic conditions as the patients make the transition to the community. Positive results have been reported from trials assessing improved hospital discharge practices and follow-up (Harrison, 2002). Low levels of knowledge may affect the quality of the transition experience (Schumacher, 1994). In older adults, hospital-based discharge intervention has traditionally overlooked the gaps in transitioning (Greysen, 2014). In a study by Plank (2012), three main themes were found during the transition period. (a) The patients and caregivers recently acquired responsibility for self-care, (b) the discharged patient's condition and (c) the amount of help the patients and caregivers needed. According to Plank (2012), it cannot be assumed that families can manage their new roles as caregivers.

Table 1

Most Frequent Report Problems Causing Readmission

Problem	Percent
Feeling unprepared for discharge	11.8
Difficulty performing activities of daily living	10.6
Trouble adhering to discharge medications	5.7
Difficulty accessing discharge medications	5.0
Lack of social support	4.7

Several care-transmission models have been established to help in the improvement of the discharge planning process (CMS, 2012). Subsequently, improvements and enhancements to the present discharge systems may help in the patient discharge from a rehabilitation center. Suitable and complete discharge preparation procedures can help ensure the patient's likelihood of appropriate post-discharge treatment (Greysen, 2014). However, there continued to be numerous inconsistencies in the discharge planning process, which created the rationale for this project. The necessary steps that the rehabilitation center needed to take to achieve this change were undertaken (Dodge, 2014). Additionally, outcomes were measured to ensure that the changes in the discharge process were effective.

Definition of Terms

Assisted living facility. A residential setting with 24-hour supervision. Residents require minimal assistance through accommodation of the aging process in the promotion of dignity, privacy, independence, and the safety of residence. (Hawes, Phillips, Rose, Holan, & Sherman, 2003)

Caregiver. The person caring for a patient after discharge (Hubbard & McNeil, 2012)

Discharge. The point at which a patient is released from the hospital either to a rehabilitation center where patients continue to recover after a hospital stay or returning home (Hager, 2010)

Readmission. The process of having patients return to the hospital after initial discharge (Hubbard & McNeil, 2012)

Rehospitalization. The process of having patients readmitted to the hospital soon after discharge (Boutwell & Hwu, 2009)

Recovery. The process of patients regaining their best possible health after receiving medical treatment (Boutwell & Hwu, 2009)

Rehabilitation. The treatment of persons with chronic illnesses or disabilities in medical facilities to improve their ability to conduct activities in daily living in their home setting (Hager, 2010)

Teamwork. The coordination of efforts from various professionals or participants to achieve set goals (Hubbard & McNeil, 2012)

Teach-back Method. A nurse's way of teaching healthcare services through clear communication for patient and caregiver understanding (Maurder, 2012)

Transition. The process through which a patient moves from one location to another. The transition is usually from a higher acuity setting to a less acute setting for recovery (Hubbard & McNeil, 2012)

Relevance to Nursing Practice

A proper discharge process is collaborative and a reflection of the care continuum that is necessary to provide positive heath outcomes after discharge. However, there are various barriers to administering appropriate rehabilitation discharges, which have led to increased and costly hospital readmissions (Cannaby, 2003). Care coordination among the rehabilitation centers, the health care providers, the patient and the caregiver(s) is necessary to ensure successful discharges. The current regulations and discharge policies are very broad, creating variations in practice. Over the past several years, significant advancements in the best practices relating to transitions of care have taken place, but no incentives for implementing them have been imposed. Some of the major issues in the discharge process are discussed below.

Local Background and Context

The rehabilitation facility has 170 beds and contracts with a local hospital for transitioning rehabilitation services for the patient into the community setting. This facility is part of a larger system. There are 220 locations with 11 hospitals in the state. The facility is a not-for-profit facility providing residencies and fellowships with over $14.3 million in services and donations. Thirty-seven to 40 nurses who work at this

location are employed full-time at the facility. The current readmission rate is 15% to 20% of patients monthly. The desired readmission rate is 0%.

Evidence has shown that patients encounter unnecessary harm and often struggle having their concerns heard (Ellis-Hill, 2009). As a result of increased technology and quality control issues, rehabilitation processes are not as effective as they should be. The cost of healthcare continues to rise as a result of frequent readmissions (Conroy, Dowsing, Reid, & Hsu, 2013). Seamless, intentional patient handovers and monitored transitions are necessary due to shorter rehabilitation stays, increased patient changes between departments and decreased health care provider work hours.

Continuity of care at the point of discharge from the rehabilitation center is critical to ensure high-quality patient care. In addition, the transition between reliable communication and cooperation between caregivers across departmental and organizational boundaries is paramount for improvement in the rehabilitation process. Incorrect or incomplete communication and information between providers more often than not leads to unplanned readmissions (Hansen et al., 2011). Various studies (Driscoll, 2000; Fisher et al., 1992) have identified the presence of discharge problems in the organizational, technical, linguistic and social context, but there lacks adequate evidence on what solutions need to be implemented. These problems include difficulties in changing care providers' behavior, the inability to change the practices in place, inadequate resources developed to aid in the evaluation of intervention impacts and the lack of systematic approaches to discharge problems into customizable solutions are a

few. These reasons, among others, warrant the need to examine the problem and find customizable solutions.

The process of providing discharge education to patients and their caregivers is essential in enhancing the patient's full recovery process once they leave the rehabilitation center premises. However, Dodge (2014) argued that for such a process to be effective, nurse-training institutions should first make it their priority to ensure that all graduate nurses are equipped with skills on how best to deliver discharge information to patients to help ensure there is no patient health deterioration after discharge. According to London (2004), nurse training on discharge planning should not be only theoretical in the classrooms but also practical to help enhance student nurses' skills about the post-discharge handling of patients, especially those suffering from chronic illnesses.

London (2004) also posited that nurses in the workforce seem overwhelmed with the task of providing discharge information to patients and their caregivers to help reduce instances of adverse events after discharge and, thus, much effort is needed in providing practical skills to nursing students and practicing nurses through real-world experiences. To help boost the competence of nurses in the rehabilitation center about patient discharge planning, Dodge (2014) proposed that nurses have quality improvement training to update and advance their skills. Adequate nurse training in discharge planning enhances the safety of the patients. Appropriate instructional information to patients and their caregivers upon discharge from rehabilitation centers reinforces the need for post-discharge self-care to reduce the risk for readmission (Dodge, 2014).

According to Hager (2014), discharge planning is a critical component for all discharge processes from various healthcare facilities, especially when handling patients with chronic ailments. Errors in medication, lack of follow-up, incomprehensible discharge information and infections are the leading causes of rehabilitation center readmissions soon after discharge (Forster, 2004). The transition process from the rehabilitation center to the community and family care is not judicious when discharge plans are not effective and, as a result, patients suffer from adverse effects leading to avoidable hospital readmissions. Hager (2014) noted that most patients who do not go through consistent and detailed discharge plans have difficulty in recalling the medication instructions and family members are often unprepared to provide sufficient care to chronic patients and feel incompetent to do so.

Care coordination among all relevant stakeholders is a significant step in the realization of reduced post-discharge adverse events that result in avoidable hospital readmissions. When the Teach-back Method (Maurer et al., 2012) is used by the discharge nurses are patient-friendly, the patients register high-satisfaction levels with the release process reducing the rates of avoidable rehabilitation center readmissions. Hager (2010) postulated that the discharge planning process is continually becoming more involved. To help mitigate any adverse effects of the process, nurses should devise innovative, effective, seamless, low-cost methods through which they can ensure patients will be safe in the post-discharge period (Hager, 2010). Hager (2010) further observed that the use of licensed personnel in providing release services to patients could help enhance accountability for the quality of discharge services provided to patients. Through

authorized personnel, Hager (2010) noted that assessments of patients' post-discharge

environments help ensure suitability for patient recovery.

Inadequate Standardized Assessment and Evaluation Tools for Continuum

Transition of Care

Currently, most institutions in the United States do not mandate the use of

standardized and comprehensive assessment tools to identify needs for a discharge. As a

result, there is no clear system in nursing practice to stratify and screen for patients with

higher readmission risks. The lack of an assessment tool contributes to the development

of an inefficient system where different tools are used to assess the needs of the patients

(Cannaby, 2003). In the Medicaid law (CMS, n.d.), conditions such as intellectual

disabilities, mental illnesses, and any related conditions have different protections that

mandate screening to ensure that patients are sent to the most integrated rehabilitation

centers. However, the screening tools fail to identify all the necessary information

required to construct a patient-centered discharge plan, which results in inconsistencies

and lack of sensitivity to patient needs.

Inadequate Patient Education

Patients and caregivers often report that they are isolated from the discharge

planning processes, while others are hesitant to ask for any clarifications when they fail

to understand some directions. The result is anxiety about the transition from a hospital

setting to the community setting (Weaver, 1998). Similarly, practicing nurses sometimes

assume that the patients or caregivers have all the required tools and information to carry

out the designated plan of care as they are not actively engaged and do not ask any

questions. Additionally, lengthy stays in the hospital sometimes lead to the development

of dependency, which inhibits patient education. Therefore, there is an apparent need for

patient education about post-discharge care as patients may experience confusion and

uncertainty about the kind of medications they need to take at home. The most common

source of confusion is caused by differences in pharmaceutical manufacturers as patients

may not understand why drugs look different and they may think they are completely

different medications. Most importantly, medication reconciliation safeguards against not

only possible hospital readmissions, but also the potentially harmful reactions to

improper medications (Smith, 2012).

Language Barriers

Another hindrance to an appropriate discharge process is caused by the language

barriers between the discharge planner and the patient or caregiver. The percentage of the

U.S. population speaking a language other than English at home was 21% in 2013

(Zeigler, 2014). As a result, miscommunications between the rehabilitation center's staff

and the patients with less English proficiency can lead to misdiagnoses causing mistakes,

which result in frequent hospital readmissions. Although current hospital regulations

mandate the presence of an interpreter for the patients who do not speak English, this

provision is not being strictly followed. Hospitals sometimes use bilingual noncertified

staff to provide translations. As a result, some important information necessary for the

patient to note may be lost during the translation process (Karliner, 2012).

Information and Fragmented Communication

The current process of discharge is fast and confusing for caregivers and patients, which leads to fragmented care and challenging transitions. In most cases, the release department is not notified of impending patient discharges until it is the day of the discharge or the day before the discharge. This limits the ability of staff to implement a discharge plan adequately. For a successful discharge process, timely notification to the accountable staff is critical. Timely reporting of discharge timelines would give the teams the appropriate time to assess the situation of the patients and caregivers, hence determining beforehand whether a comprehensive assessment is necessary (London, 2004). Additionally, one of the duties of the discharge department is to evaluate the kind of environment into which the patient is being discharged, which includes the assessment of the impact of the illness on daily living conditions, the availability of caregivers and physical hindrances such as access to bathrooms and stairs. For this reason, communication between multiple care providers both outside and within the acute care centers and the patients becomes vulnerable to assumptions and miscommunications (Drury, 2008). As a result, the lack of coordination leads to failure of the discharge plan.

Institutional Context

The project site was a for-profit healthcare and rehabilitation facility having 170 beds. The facility provides Medicare, Medicaid and private pay services. The average length of stay for the rehabilitation department is 4–6 weeks. The number of discharges per month averages from 50 to 70. The number of readmissions currently is 15% to 20%; however, the facility wants this reduced to 0%.

The demographics of the participants from the rehabilitation center used in the project were adult patients at least 18-years-old. Institutional factors related to the external push to ensure that quality care will be given to the patients to enhance positive outcomes and reduce cases of readmissions include the rehabilitation center's disbursements and funding, which will be determined by the cases of readmission within a period of 30 days. Payers, such as Medicare, have implemented limitations and reductions of payments to hospitals with excess readmissions emphasizing that facilities must develop stronger discharge processes in the promotion of the patient and caregivers' education and nursing efforts to promote quality discharge planning (Rau, 2016).

Federal and State Context

Due to landmark reports about the state of the United States health care system, various governmental groups, including the Institute of Medicine (IOM), have asked that significant resource commitments are directed toward improvement of health care quality (Leape & Berwick, 2005). To guarantee reduction of variation in the quality of care provided, increased implementation of quality improvement techniques in hospitals and clinics have been emphasized (Dodge, 2014). Additionally, national institutions have called for a greater accountability system that encourages achievement of the safety and quality in patient outcomes. State hospital review boards are enhanced by identifying the accountable parties, standardizing the contexts for which they are responsible and highlighting the procedures by which they are evaluated and held accountable. Numerous policies and organizations through the rehabilitation care system intertwine to create a medical accountability and safety system. Many of the national accountability

organizations include private sector accrediting bodies, licensing agencies, the CMS and individual credentialing and certification organizations (Rau, 2016). Healthcare facilities are also subjected to accountability requirements by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations and the Common Rule (CMS, 2012).

Role of Doctor of Nursing Practice Student

Students pursuing the DNP program aim to become more than licensed practitioners. They aspire to become politically savvy leaders and activists (AACN, 2006). The doctoral program teaches such students not only the importance and meaning of health advocacy and policy but also the skills that DNP graduates require to advance their personal practice and ensure the welfare of the patients they serve. The DNP project enables students to enhance their leadership skills and problem identification because the project helps in the development of the required advanced competencies to increase complex practices and faculty roles (AACN, 2006).

Over the recent past, studies conducted through Medicare and Medicaid payer sources have been conducted about the failing quality of hospital patient care, which resulted in an increase in frequent hospital readmissions. Given the nature of the current medical technological advancements, the reports on increased rehospitalization seemed illogical. As a result, I was motivated to develop my DNP project around the issue and found that the claim of increased readmissions was substantiated in the literature. I realized that the discharge process in rehabilitation centers was faulty, which led to inappropriate care transition for patients from hospitals to home care. Additionally, reports were available detailing this problem, but no reports were available suggesting

solutions. Therefore, this project will be a trial of a solution to the issue of inadequate discharge policies and processes to help in enhancing care quality provided by healthcare facilities and decreasing the costs associated with frequent readmissions.

I educated the staff by holding two Lunch & Learn conferences (30 days apart) within the facility on the project and desired outcomes. This educational session included unit managers, administrators, doctors, LPNs, RNs, discharge planners, NPs, and the admission coordinator. The Teach-back method was conducted and the required follow-up services were completed to prevent a 30-day avoidable readmission utilizing this EBP project. I participated in helping the nurses to assess their strengths and weaknesses.

I conducted calls to the patients during Week 1, Week 2, and Week 4 on the follow-up of services and collaborated with social worker and the physicians to get missing services in place for the patients. These included appointments, rehabilitation services, and medications, along with encouraging the patient to be compliant in attending all appointments.

Summary

It is clear from the reviewed literature presented in this section that there is a need to address the problem of frequent hospital readmissions within 30 days of discharge. The recommended solution to handle the issue is improved discharge processes to ensure smooth transitions of patients from the rehabilitation center to home care. For this to happen, educating the patients and their caregivers is paramount, including conducting an assessment to understand the environments into which they are being discharged.

Section 3 discusses how the literature review was conducted on the evaluation of discharge process best practices and patient awareness of the need for self-care.

Section 3: Collection and Analysis of Evidence

This project addressed the problems that arose from improper discharge processes that led to frequent hospital readmissions. Section 2 summarized the major problems of the current discharge process including language barriers, inadequate assessment tools, insufficient patient education, and insufficient information due to a fragmented communication process. This section will present the project method, techniques for analysis, and a detailed review of the evidence supporting the project.

Practice-Focused Questions

The main issue was the patient discharge process and the transition from hospital care to home. Formulating practice-focused questions to improve the discharge processes to prevent readmissions helped expand the review of information through the tools implemented within this EBP project. Use of practice-focused questions helps improve the discharge process by decreasing readmissions. The formulation of these questions also helps in sharing the needs for information in a clinical environment. Practice-focused questions must consist of four critical components. For this project they could be stated as:

Patient Problem

Although the patient problem is usually the diagnosis, it could also be a nondiagnostic problem. In this project, the problem was an inadequate assessment and planning for the discharge of patients from a rehabilitation center.

Patient Population

Patients admitted to a stand-alone rehabilitation center.

Comparison Intervention

The comparison intervention is the implementation.

Outcomes. The outcome of interest is whether the interventions implemented at the rehabilitation center reduced readmissions as reported by the CMS and analyzed using a *t* test statistic.

Sources of Evidence

There were two major sources of evidence for this project. The first was the literature; it establishes best practices for discharge assessment and planning. The second was the data generated by the project to determine the successfulness of the trial of the new discharge process.

Siegel's 2011 report, The National Association of Public Hospitals and Health Systems, noted a general concern about avoidable hospital readmissions around the world. The cost of avoidable hospital readmissions soon after discharge is high, both for the readmitted patient, who is demoralized, and for the healthcare facility: avoidable readmissions are very expensive to healthcare facilities, which should cover the unreimbursed costs of patients who are frequently readmitted to a healthcare facility. According to Siegel (2011), the main risk factors for the high rates of hospital readmissions are the low socio-economic status of patients, limited access to sustainable care, and lack of social support among the discharged patients. In the modern healthcare system, Siegel (2011) also noted that hospital readmissions are areas of major concern due to their direct association with quality issues.

The public's perception of high rehabilitation readmissions is poor quality care and service delivery, prompting hospital managers to engage all stakeholders in reducing the rates of avoidable hospital readmissions. Siegel (2011) suggested that a reduction of avoidable readmissions not only implies improved quality of care but also saves money on what could have been spent by the hospital and patients in meeting the readmission demands. The regulations penalizing healthcare facilities with high readmission rates while remunerating those with low rates of avoidable readmissions are considered important in helping achieve high-quality care to patients suffering from chronic ailments.

According to Armstrong (2009), nurses are the center of all hospital operations. Armstrong (2009) stated that nurses in the community are indispensable as they help in promoting public health, easing pain experienced by patients and educating the community on different healthcare issues to help achieve a better quality of life. Nurses have the capacity to serve at any healthcare facility in various capacities to help save lives, reduce suffering and save money. Armstrong (2009) noted that for nurses to be effective in delivering high-quality services and care to patients, their welfare and work environment should be highly prioritized by the relevant authorities. Maximum care from nurses comes when the nursing environments are staffed well with an appropriate skill-mix and manageable workloads to give them time to work innovatively to serve patients.

Hubbard and McNeil (2012) reported that the rate of hospital readmission in the United States is very high with statistics indicating that one in every five Medicare patients is readmitted within a period of 30 days after discharge. Hubbard and McNeil

(2012) observed that effective medical transitions from the care facilities to home were responsible for reducing instances of avoidable patient readmissions to healthcare facilities. CMS and other entities are among the leaders in advocating for high-quality discharge planning to help eliminate avoidable patient readmissions. According to Hubbard and McNeil (2012), regulatory bodies implemented penalties to help eliminate instances of avoidable hospital readmissions, prompting most healthcare facility administrators to devise effective ways to eliminate avoidable hospital readmissions with the same diagnosis soon after discharge.

Hospital readmissions are primarily due to the existence of adverse events, which are often related to medication use, making it crucial for hospitals to ensure that they develop effective discharge plans to avoid financial penalties for low-quality services due to high readmission rates (Hubbard & McNeil, 2012). The adoption of new models that comprehensively reconcile medications before discharge is the best method to counter the rising instances of avoidable patient readmissions due to ineffective discharge plans (Hubbard & McNeil, 2012). Appropriate discharge plans are the best method through which hospitals can provide effective transitional discharge care to help ensure that patients recover fully after a hospital discharge (Hubbard & McNeil, 2012). If hospital managers develop programs enhancing the patient's and family's understanding and use of medications, then the probability of reducing avoidable hospital readmissions is high (Siegel, 2011).

According to Gaynes (2015), the rate of hospital readmissions among patients suffering from psychiatric conditions is high and needs to be accorded with as much

focus as the readmissions of patients with chronic medical ailments. Many of the readmissions of persons suffering from psychiatric conditions occurs among persons with psychotic or depressive disorders (Gaynes, 2015). With high readmission rates noted in hospitals across the United States, Gaynes (2015) postulated that patient readmissions are a costly event that can result in the disruption of individuals and families in addition to demoralizing patients due to a sense of failure. Patients expect to recover from their conditions immediately after their discharge from healthcare facilities. When readmissions occur, patients feel overwhelmed by their diseases (Vincent & Coulter, 2002). In psychiatric cases, the main risk factors for readmission are the same factors contributing to the readmission of patients suffering from chronic medical illnesses. These risk factors include issues such as failure to adhere to medication guidelines, lack of comprehension of medication instructions and lack of proper postdischarge care due to ineffective discharge plans (Gaynes, 2015).

  To help reduce instances of hospital readmissions, hospital administrators should endeavor to institute appropriate techniques to help avoid adverse outcomes (Gaynes, 2015; Minnot, 2008; Benbassat & Taragin, 2000) suggested that healthcare organizations establish effective patient care programs to help boost psychiatric patient recovery. Secondly, the author argued that effective discharge plans can greatly help reduce instances of avoidable hospital readmissions as the plans can help disseminate all the necessary information to ensure that patients and their outpatient caregivers can adhere to and set up necessary community resources to support the medication guidelines.

Through effective discharge plans, nurses and other health care personnel can arrange to make follow-up calls to support the patients in adhering accurately to the set discharge plans, thereby mitigating avoidable patient readmissions. Nurses and clinicians can also visit patients regularly to help ensure a seamless patient recovery process (Gaynes, 2015). Additionally, they observed that hospital lengths of stay are decreasing as hospitals enhance efficiency and target hospital stays for cost savings, thereby increasing the discharge support needs of sicker patients.

Landers (2013) and Bradley, Sipsma, Horwitz, Curry, and Krumholz (2014) observed that homecare plays an important role in providing cost-effective and compassionate care to patients in the United States. Through the home health care system, Landers (2013) noted that nurses and physicians visit patients with chronic illnesses in their homes. Most of these visits are to the increasing population of the elderly in the United States.

Landers (2013) argued that the home health care system was started in the previous century to try to meet the health care needs of some groups of people who could not afford admissions to hospitals or rehabilitation centers. The home care system has gained popularity over time with several nursing organizations visiting patients in their homes to help provide and administer the required medications and treatments. With the modern regulations on accountability for patient healthcare conditions, physicians find it difficult to provide adequate care to home care patients due to the lack of important facilities only available in hospitals. However, Landers (2013) found that hospitals,

nurses, and physicians should attempt to find the most effective ways to provide

sufficient care to home care patients in a bid to provide value for society.

According to Landers (2013), much focus in the past century was put on care for

chronically ill patients with a target of mitigating avoidable readmissions for the same

diagnosis soon after discharge. Due to the overwhelming focus on the care for chronically

ill patients admitted to healthcare facilities over time, most researchers have skewed their

studies toward hospital-based care. Few made attempts to ascertain the feasibility of

providing patients with individual plans for home care. As a result, Landers (2013)

asserted that there exists insufficient research information about the care of chronically ill

patients at home, making it very challenging for policy makers to develop guidelines and

reimbursement schedules for home care. It is important that sufficient research on home

care is conducted to help develop guidelines for the home and community to promote the

most cost-effective care methods for patients suffering from various chronic illnesses.

Landers (2013) recognized the frailty of elderly patients suffering from chronic

illnesses who could not survive moving from their homes to healthcare facilities and

back, staying away from their close families, or enduring the process of readmissions. As

a result, the researchers recognized the home care system as the best means of providing

the necessary care to elderly patients suffering from chronic illnesses. Landers (2013)

suggested that effective transition plans be developed to guide the patient's change of

environment from hospitals and rehabilitation centers to their homes to help enhance the

care provided to patients after discharge. Transition discharge plans help provide

effective interventions through which the burdens and risks of readmissions soon after

discharge can be effectively countered. Effective transition plans are noted to improve the quality of life, enhance patient outcomes and prevent unnecessary hospital readmissions (Landers, 2013).

Boutwell and Hwu (2009), like other researchers, recognized the high rehospitalization incidences at hospitals and rehabilitation centers across the United States. According to the researchers, elderly persons were the most effected in the readmission cycle in which one in every five discharged patients was readmitted within 1 month after discharge. Boutwell and Hwu (2009) opined that most of the rehospitalization cases were avoidable had there been effective methods through which patient transition from healthcare facilities to home could be closely monitored. The researchers considered the failure to establish patient safety in an outpatient environment was a major reason behind their frequent readmissions.

Additionally, Boutwell and Hwu (2009) argued that the reduction in readmission cases is not only positive for the patients but also benefits all stakeholders including families and hospitals. Boutwell and Hwu (2009) proposed four measures to help mitigate avoidable hospital readmissions. These included (a) enhanced care and support during patient transitions upon discharge, (b) provision of improved patient education and self-management support, (c) use of multidisciplinary teams to help manage the patient conditions and (d) patient-centered planning at the end of life. Through these measures, Boutwell and Hwu (2009) recommended hospital and rehabilitation center readmissions within 30 days of discharge could be mitigated.

Project Method and Data Collection

The nurse managers were taught to use Teach-back Method (Maurer et al., 2012) and the IDEAL Discharge Planning Overview, Process, and Checklist by me. The IDEAL Tools that were initiated and piloted by the American Institute of Research (AIR) and funded by the AHRQ and the U.S Department of Health and Human Services, have been shown to be effective in patient and family engagement efforts. Each of the three nurse managers were trained on the IDEAL Discharge Planning Overview, Process, and Checklist (AHRQ, 2013) by the researcher through one session of training with the three nurse managers who in turn trained all the full-time nurses who were a part of the discharge planning team within their units in the clinical setting. The Teach-back Observation Tool was utilized by me to evaluate 10% of the trained nurse managers or nurses to determine their effectiveness of the Teach-back training method. The Teach-back Method Observation Tool was utilized in nurse education on Teach-back Method as outlined within the IDEAL Discharge Planning Overview, Process and Checklist (AHRQ, (2013). The Teach-back method as initiated by National Quality Forum (NQF), The Joint Commission (TCJ) and the American Medical Association (AMA) has been shown to be effective (Maurer et al., 2012). All nurses needed to pass the Teach-back Observation (Maurer et al., 2012) with a 100% score or were reeducated to meet the performance score; nurses unable to obtain 100% on the Teach-back Observation were removed from the discharge planning team. The effectiveness of the IDEAL Discharge Planning Overview, Process, and Checklist (AHRQ, 2013) tool was evaluated through its utilization within this project to decrease avoidable readmissions.

The organization tracks demographic data through the EHR EPIC system, including diagnoses of discharged patients and readmissions to hospitals. The process for data collection included use of the IDEAL Discharge Planning Overview, Process, and Checklist (see Appendix B). Telephone interviews conducted by the researcher were done during the post-discharge at Week 1, Week 2, and Week 4. The Week 4 telephone calls occurred approximately 30 days postdischarge and became the final postdischarge contact with the patients during the project. The discharge tool for telephone interviews was developed by the preceptor and me (see Appendix C). The development of the telephone interviews was the medical director's (preceptor) determination of the facility's needs in the promotion of health outcomes to prevent avoidable readmission. The preceptor guided me in designing the questions for the telephone questionnaire using the standards from the IDEAL Discharge Planning Overview, Process, and Checklist (AHRQ, 2013) in which all stakeholders were educated.

Analysis and Synthesis

The Admission Coordinator provided internal data from the facility system of the admissions, discharges, readmissions, and diagnoses. The data collection, which began immediately after a patient was admitted, were analyzed on the discharge date based on the interview responses of the project participants and after the 30-day follow-up observation period using the PostDischarge Rehabilitation Services Follow-Up tool (see Appendix C). The data from Appendix C were collected by the DNP student and analyzed using Excel. A *t* test statistic was used to determine if the reimplementation and postimplementation data were significantly different at a $p < .05$ level.

Comparison of the readmissions prior to the implementation of the nurse education and pilot discharge process to the readmissions after the nurse education and the pilot implementation of the improved discharge process was conducted using a *t* test statistic. The results are presented in the form of tables and graphs. The data from participants who wished to withdraw from the project had their responses to the discharge assessment deleted from the dataset. Participants who died before the completion of the project follow-up were not included in the analysis. All demographic information was collected within the facility internal database, and the Admission Coordinator provided me with all the demographic information and data required for analysis.

Ethical Assurances

Four ethical considerations that needed to be addressed when designing research that includes human subjects include protection from harm, informed consent, confidentiality, and honesty with professionals. To ensure that these standards were met in this study, no data were collected and no contact was made with the target project population until approval was attained from the organization's IRB and the Walden University IRB. Participants received information related to the project type and purpose to decide whether to participate. Information was made known via written instructions and verbal instructions prior to project participation. In addition, participants were given information about who to contact with concerns or questions before, during, and after project participation.

Information was provided in an informed consent form. Having the informed consent form provided some protection for participants and reduced the risk of harm. The

consent form, included information on possible benefits and risks to participants, the process of the project, the limits of confidentiality, the right to stop or withdraw from the project without consequences, and project contact information. Participant confidentiality was protected in this project. The following are the systematic procedures that were followed to ensure that participant confidentiality and potential risks were reduced to a minimum. Any information collected was not included in the participant's identifying information. After a participant signed the informed consent form, his or her identifying information was no longer used. The participants were assigned a number that served as the participant's identification throughout the rest of the project. Once the number was assigned, the participant's name and personal information were no longer used, and the participant's information was no longer identifiable. All data are being securely stored for the required minimum of 5 years. All project findings are presented in an aggregate form, and no personal identifiers are attached. There were no participants under the age of 18 enrolled in this project.

　　　　If the patient stated a willingness to participate in the project, the project process was explained in the letter of introduction. Patients who were willing to participate in the project were provided with a date and time to meet with me to begin the process. I explained the informed consent form and provided potential participants time to read all forms and to formulate questions regarding the project before deciding if to participate. Participants received information related to the study type and purpose to decide whether to participate in the project. Information was fully explained through written and verbal instructions prior to project participation.

In addition, participants' concerns or questions were addressed at the introduction and information was provided on how and who to contact to ask the questions after they completed the introduction to the project. All Excel spreadsheets with patient names and identification were stored in a secure network directory. The only persons having access to the hard copy data, locked in the patient records room was me. The collected data were securely stored in a locked filing cabinet when not being used by the researcher. Data specific to a participant were destroyed if that participant completely and officially withdrew from the project. After use, all data will be destroyed in accordance with the guidelines provided by the IRB.

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Summary

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The rates of rehabilitation center and overall hospital readmissions, especially for patients suffering from chronic ailments, have been on the rise, prompting the implementation of severe penalties to healthcare providers and facilities failing to meet predetermined readmission caps. Most of the readmission cases have been attributed to lack of effective discharge plans through which the patients and their caregivers acquire a detailed understanding of their care and medication needs after discharge. It was, therefore, important that interventions based on the use of advanced discharge plans were instituted to help determine the impact of appropriate discharge planning in reducing and even eliminating instances of avoidable patient readmissions with the same diagnoses soon after discharge.

Through this project, the use of an improved discharge assessment and planning process was piloted to help determine its success in mitigating such avoidable patient

readmissions. Thus, this project assisted in the development of best practices and relevant policies to help guide the patient discharge process and mitigate instances of avoidable hospital readmissions.

Section 4 will address the findings and recommendations.

Section 4: Findings and Recommendations

Introduction

The number of patients who are readmitted within 30 days of initial discharge is relatively high nationally (Snow et al., 2009). This problem occurs due to lack of comprehensive discharge processes; patients are discharged without proper knowledge of how to take care of themselves, including how to take prescribed medications. Subsequently, these patients may be unable to maintain their health at home and are readmitted to the hospital. The expectation after hospitalization is that no discharged patient will be readmitted for at least 3 months. However, the rate of readmission within 30 days after discharge was high at the project rehabilitation center.

All nurses required adequate training on how to deliver discharge information to patients and families/caregivers efficiently and effectively. Discharge plan training was not limited to theoretical training in classrooms, but it was delivered in practice settings to equip nurses with the necessary skills on the best way to handle patients during the discharge process (Dodge 2014; London 2004). The gap in practice addressed in this project was the patient discharge process in the transition from rehabilitation hospital care to home.

The practice-based questions were formulated to facilitate expanding and reviewing information literacy and sharing the need for appropriate information transfer in a clinical setting. The question addressed by the project was: For patients admitted to a rehabilitation center, does use of the IDEAL Discharge Planning Tool, the Teach-back Method, and the Postdischarge Rehabilitation Services Follow-Up Tool, incorporating

telephone calls to all participants at Weeks 1, 2, and 4 postdischarge, result in decreased 30-day readmissions?

The purpose of this doctoral project was to improve the discharge process at the rehabilitation center in order to reduce the rate of patient readmissions within 30 days of initial discharge. The project facilitated identification of best practices and relevant policies to improve patient discharge process. The project consisted of a formative evaluation of the discharge process by implementing the IDEAL Discharge Planning Tool and by using the Teach-back Method with patients, families, and caregivers to determine if they understood the prescribed medications and necessary self-care management after discharge. The project also involved educating nurses about the effectiveness of the Teach-back method and how to use it in educating the patient, family, or caregivers. Furthermore, policy changes were made with the implementation of an improved discharge process to decrease readmissions after the initial discharge within 30 days for any diagnosis.

Evidence used in this project evaluation was obtained from articles, reports, and books accessible to the public. Permission to implement the project was obtained from the Walden University IRB (Approval No. 06-06-17-0332678). The nurses at the rehabilitation center received training on how to implement the new discharge planning process with patients, families, and caregivers and to use the Teach-back method. I conducted follow-up telephone calls using a discharge questionnaire with every patient transitioning from the rehabilitation center to the community (home, assisted living). The follow-up questionnaire (see Appendix C) contained items about compliance with

prescribed medications and treatment regimens and community health care follow-up services. The purpose of the telephone call was to determine the number of discharges from the rehabilitation center and the number of subsequent readmissions from the discharged group of patients within 30 days. The telephone calls also provided an opportunity to support patients/families as necessary.

Analytical Strategies Used

The planned change was based on Lewin's model of organizational planning. The intended change was to reduce 30-day readmissions to the facility after discharge through education and a 30-day follow-up. The project targeted avoidable readmissions in 50 patients discharged from the rehabilitation center because it was anticipated that such improvement would be an indication of enhanced quality of care and customer service. If successful, this initiative would also increase the reimbursements to the facility. As noted by Osulander and Berenson (2017), 23.5% of postacute admissions were readmitted to the hospital within 30 days with conditions that could have been treated outside the hospital setting.

The model was implemented in three stages. The first stage involved communicating with all the stakeholders. According to Batras, Duff, and Smith (2016), the first step of Lewin's model is the unfreezing stage, which entails open communication with stakeholders to create a sense of security and trust in all those involved in the planned change. In this case, lunch meetings were held with the discharge team, and I introduced the EBP practice process. Involving the key stakeholders was essential because it helped them understand the importance of the project (Johnson, 2017).

In the second phase of the project, I taught the nurses how to implement the Teach-back method. The follow-up telephone call was introduced to ensure health maintenance postdischarge (see Appendix C). If there were any problems or services not in place, the case was referred to the discharge planner. All calls were made by the DNP student with follow-up calls from the discharge planners (e.g., social services). In Lewin's model, the moving stage involves the actual implementation of the project (Batras et al., 2016; Borkowski, 2016). The team accepted and implemented the practice change processes enthusiastically. The training and education of the patients in preparation for discharge was performed and progress was made within the first 3 months after the initiation of the EBP change; all staff and team members participated and collaboratively shared interest in improving the discharge process.

The third and final phase in Lewin's model is the refreezing stage (Batras et al., 2016), which entails the process of freezing or refreezing the new practice. This stage leads to a period of stability and appraisal (Johnson, 2017). In this project, the final stage for establishing stability of the EBP change has yet to occur. Establishment of stability in the rehabilitation center was inconsistent because there was a nursing shortage and administration changes occurred within the facility. Although there were discharge planners and nurses still employed in the facility, they were removed or reassigned to other departments. Consequently, there was no consistency in who was accountable for implementing the discharge process and ensuring application of the education program. A nurse or a physician explained the discharge process and educated each patient upon

admission and throughout out their stay, but the staff inconsistently carried out the discharge process.

Evidence obtained through CMS provided the readmission data for the facility. To support patients postdischarge and prevent readmissions, I made three telephone follow-up calls (Harrison, 2002) to the discharged patients. Data were collected from these follow-up telephone calls regarding adherence to the discharge instructions on self-care management and prescribed medication. When problems were detected, I referred the case to Social Services for targeted follow-up calls to resolve any issues in services or resources reported from the calls.

The follow up telephone calls entailed a series of questions that confirmed patients' adherence to discharge instructions. During each telephone call, the patients confirmed if they (the patient and the nurse or physician) had reviewed medications prior to discharge. The patients also confirmed whether they had received their prescriptions from the facility. I also affirmed that patients had their medications at home, took the medications as scheduled, and whether they had someone to assist them in the home. Patients also confirmed if they understood the services they were to receive in the home and asked if they were given any doctor appointments before leaving the facility. Moreover, patients indicated if they went for scheduled appointments, had been back to the hospital with another problem and, where applicable, if they were receiving physical therapy and other ordered in-home services. Discharged patients also were asked about tests ordered by the physician, the test results, and timeliness of follow-up appointments and treatments after discharge. The results from the telephone calls are found in

Appendix C along with the data from CMS detailing hospital admissions and discharges from the facility (rehabilitation center) to evaluate postdischarge returns to the hospital within 30 days (Harrison, 2002).

I educated every patient and family at admission about the postdischarge 30-day follow-up telephone calls and the IDEAL Discharge Planning Process (see Appendix B), which included a discussion of the home environment and the promotion of safety, review of medications, and warning signs to indicate any postdischarge problems or complications.

CMS Data

Rehospitalization after admission, an outpatient ED visit, and successful discharge to the community were some of the quality measures (QMs) and quality indicators (QIs) used to evaluate the care quality in rehabilitation facilities. Since QMs/QIs are problem-based measures, the main goal was to score as low or as high as possible. For QM, a score of 20% was considered good but 90% was considered poor. Conversely, a score of 90% on QI was excellent, while a score of 20% was poor (Rantz, Flesner, & Zwygart-Stauffacher, 2010).

The 30-day readmission rate is one of the four basic metrics developed by CMS as quality measures for rehabilitation facilities. Readmission rates receive the most attention because of the financial penalties associated with them, but they are a component of the overall hospitalization rate. These rates are calculated by pinpointing individual residents admitted to the facility after an inpatient hospital stay during a given duration (Florida Atlantic University, 2014).

Emergency room visits are the measure of ED visits that do not result in readmission or an observational stay. These visits are quality indicators because they cause discomfort and risk of adverse events for patients. They are expensive and cause unnecessary anxiety for the residents and families members. Furthermore, they create considerable work for the staff in the rehabilitation facility. Therefore, lower rates of ED visits are an indication of high care quality (Florida Atlantic University, 2014).

Preimplementation Data

The preimplementation data for 2016 on short-stay patients were obtained from CMS. Before the project implementation, the percentage of patients who reported improved ability to move around at discharge was 76.6%, but for patients who were rehospitalized, the percentage was only 17.7%. The percentage of residents who had an outpatient ED visit was 9.9%. Fifty-five percent (55.2%) of the rehabilitation patients were discharged successfully to the community as determined by lack of 30-day readmissions.

Postimplementation Data

Fifty rehabilitation center patients were followed through an attempt to reduce the avoidable 30-day readmission rate to the facility or a hospital within this time frame. The discharge team of 28 members included nurses, social workers, and administrative staff. The team was educated on the Teach-back method. The purpose of the EBP project was to reduce the avoidable readmission of patients (n = 50) to the rehabilitation section of the facility within 30 days after the initial discharge. Hospital readmissions from

rehabilitation facilities occur, but patients and providers consider avoidable readmissions as an indicator of deficit in quality and value (Vasilevskis et al., 2017).

Hospitals that normally discharge a high number of patients into rehabilitation facilities have high rates of readmission. Therefore, many patients in rehabilitation facilities are at high risk for readmission because of their multiple comorbidities. However, previous research (Vasilevskis et al., 2017) indicated that 23% to 60% of patient returns to hospitals from rehabilitation facilities are related to conditions that can be managed outside a hospital setting. Furthermore, Vasilevskis et al. (2017) established that a significant percentage of hospital readmissions are preventable through improved communication between staff and patients.

Patient Demographic Characteristics

The project participants were admitted between May 2017 and August 2017 and discharged between May and September the same year. The youngest participant was 31 years old while the oldest participant was 98 years old. Table 1 shows the age distribution of the participants. Most of the participants were over the age of 51. The modal age range was 71 to 80 with 19 participants; only one participant was in the age range of 31 to 40 (Table 2).

Table 2

Age Distribution

Age Group	31-40	41-50	51-60	61-70	71-80	81-90	91-100
No. of Participants	1	0	9	10	19	9	2

Gender distribution. There was an unequal distribution by gender because a significant number of participants who were discharged during the project implementation were female. Only 18 of the participants were male (Table 3).

Table 3

Gender Distribution

Gender	No. of Participants
Female	32 (64%)
Male	18 (36%)

Race distribution. The ethnicity categories identified in the demographic data obtained from the facility were Blacks, Whites, Others, and not available (N/A). A significant number of participants were either Black or White. The categories of Others and N/A were the minority of participants as indicated in Table 4.

Table 4

Race Distribution

Race	No. of Participants
Blacks	22 (44%)
Whites	20 (40%)
Others	3 (10%)
N/A	5 (6%)

Reasons for admission. Participants were admitted with various chronic illnesses and injuries. Reasons for admission included coronary artery disease (CAD), chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes complications (DC), hemiplegia (H), head injury (HI), rehabilitation after orthopedic surgery (OS), pneumonia (P), renal disorder (RD), and stroke (S) (Table 5).

Table 5

Reason for Admission

Condition	No. of participants
CAD	4
CHF	10
COPD	6
DC	2
H	4
HI	7
OS	3
P	3
RD	4
S	7

The project focused on short-stay patient participants who resided in the facility for a period of less than 100 days. Some patients were discharged within 24 hours due to insurance payer issues while the longest stay was 87 days. Notably, 12 participants were discharged within 10 days after admission, eight within 20 days, 12 within 30 days, and 18 participants stayed in the facility for a period of more than 30 days. The majority of participants stayed in the facility for period of less than 30 days after their initial admission.

For the 50 patients, 21 Teach-back forms were used by the discharge team (which included an educator and evaluator) and returned. These forms were used to determine the performance of the Teach-back method during the patient discharge education process. Therefore, the return rate was 42% on the Teach-back forms; no form was returned for 58% of the patients. All 21 Teach-back forms demonstrated 100% compliance and effectiveness of teaching the patient because none of the patients who received Teach-back were readmitted into the facility. During the discharge process, all of the participants received their prescriptions. The highest number of prescriptions was 30, while the lowest number was zero.

After discharge, I attempted 30-day follow-up telephone calls on all 50 participating discharged patients in the first, third, and fourth weeks after the discharge date. Thirty-three follow-up telephone calls were completed. These patient participants answered their telephones and participated in the data collection and follow-up call at all three (the first, third, and fourth week) follow-ups. Seventeen follow-ups were incomplete because of various reasons. Two of the participants died during this 30-day period, while the remaining 15 participants were unreachable (because of telephone disconnection or failure to answer the telephone). During the follow-up telephone calls, 33 participants expressed gratitude and reported high patient satisfaction.

Data Comparison

The rate of hospital readmission 30-days postdischarge and the successful discharge of residents into the community were the only variables analyzed because of their relevance to the practice-focused question and the purpose of the doctoral project.

As indicated earlier in Figure 2, the CMS 2017 report showed that 55.2% of short-stay residents were discharged into the community successfully with no readmissions to the hospital within 30 days of discharge the previous year (2016). In 2017, there were only three participants who were readmitted to the hospital within 30 days of initial discharge. One participant who died after readmission was included in the calculation of the readmission rate during the project; it was important to include these data for clarification purposes.

Of the 50 participants successfully discharged from the hospital, only three were readmitted into the hospital from home. Two participants who were readmitted to hospital from home died. Other factors that influenced the transition results included (1) transfer to long-term care, (2) transfer to another facility, and (3) transfer from the facility to a hospital.

Because this project compared the successful discharge of residents to the community, all those who were readmitted, regardless of whether it was from the facility to the hospital or from home to the hospital, were included. Therefore, out of the 50 patients discharged from the facility, 44 were successfully integrated into the community, six patients were readmitted, died, were transferred to another facility, or committed to long-term care. Therefore, the percentage of participants who were successfully discharged into the community after the project implementation was 88% of the 50 patients included in this EBP project.

The rate of hospital readmissions within 30 days of initial discharge for the rehabilitation center, according to the CMS 2017 report, was 17.7% in 2016. In 2017,

there were three patients readmitted into the hospital setting after discharge home within the 3 months of this EBP project. The rate of readmission was calculated by dividing the number of discharged patients (excluding the two patients who died during the project) with the number of readmitted patients and multiplying by 100. The rate of hospital readmission during this EBP project was 4.4% of the study participants as three patients were readmitted into the hospital from the home within the period of this EBP project. The results of this project are not comparable to the CMS data of the previous year (17.7%). The readmission rate for the 2017 quarter in which this project was conducted was 4.4%, while the same quarter 2016 readmission rate was 6%. However, the decrease in the readmission rate during this EBP practice project may have resulted from facility admissions being halted by the State; therefore, the decrease in readmissions seen during the quarter of this EBP project should be interpreted with caution.

Discussion

The overall performance by the rehabilitation center was above average compared to national quality measurement and indicator score benchmarks. The benchmark measure of quality was at least 50%, while the indicator scores were below 20%. Quality measurements and indicators reflect the quality of individual nursing home (Rantz et al., 2010).

The 2016 readmission rate (17.7%) within 30 days after discharge was a comparatively high score. Hospital readmission is a major concern because of the associated costs that could possibly have been avoided through improved discharge processes. Furthermore, there are financial penalties for hospitals and rehabilitation

facilities if the readmission occurs within 30 days (Neuman, Wirtalla, & Werner, 2014). Therefore, skilled rehabilitation facilities are using the Interventions to Reduce Acute Care Transfers INTERACT tool to conduct a root cause analysis to identify areas that need improvement to enhance care and reduce the prevalence of potentially avoidable readmissions within 30 days (Florida Atlantic University, 2014; Neuman et al., 2014). Previous research has shown that there are some interventions that can reduce readmission rates within 30 days of discharge. Kripalani, Theobald, Ancti, and Vasilevskis (2014) stated that a patient needs assessment, patient education, medication reconciliation, organizing timely appointments, and telephone follow-ups after discharge interventions reduced readmissions. These interventions at the project site reduced the rate of readmission within 30 days postdischarge for patients discharged to home from the project rehabilitation facility (Kripalani et al., 2014).

The success of the program can be attributed to the multiple-component interventions that were implemented. According to Kripalani et al. (2014), the impact of interventions on the readmission rate is related to the number of components affected. Therefore, it is highly unlikely that a single-component intervention can reduce readmissions significantly. In this project, several interventions were implemented through a process that started upon patient admission. The multiple-component interventions included Teach-back, use of IDEAL, and telephone follow-ups. These components provided more comprehensive care by enhancing communications, improving training to managing medical conditions, and promoting thorough care planning.

Successful reduction of readmission rates is an indication of care quality in health care institutions. CMS has established a 30-day readmission after discharge from inpatient rehabilitation facilities as a national quality indicator (Ottenbacher et al., 2014). The quality rating for the rehabilitation center is high, despite the fact that most of the participants were at a high readmission risk. Ramey et al. (2016) stated that older and sicker patients are at a higher risk of readmission. More than half of the participants were older than 71 years of age, making the risk of readmission higher.

Unanticipated Limitations and their Potential Impact on the Findings

Implementing evidence-based practices in health care settings can be a challenge because of barriers that hinder the implementation processes. Previous research has indicated that lack of time, lack of power to change practice, organizational cultures encouraging the status quo, misconception about EBP, lack of mentorship, lack of administrative support, inadequate resources, and unclear work expectations are some of the challenges that hinder successful implementation of evidence-based practice (Kyalo, 2015). Lack of time is the most common barrier encountered by nurses who are employing evidence-based practice (Brown, Wickline, Ecoff, & Glaser, 2009).

In this project, the unexpected limitations were related to the facility management and nursing changes. The nurse turnover significantly influenced the results during the initial stages of the project implementation. There was no consistency during the implementation of the EBP intervention because of the changes in nurse assignments. Due to the high inconsistency, most staff nurses resorted to the previous known patterns and discharge practices. Brown et al. (2009) stated that task-based practice is a significant

barrier to successful EBP implementation. Staff inconsistency encouraged task-based practice because there were no staff specifically assigned to the EBP education procedure. The staff who were assigned to the process resorted back to their task-based practice because of the inconvenience and unfamiliarity with the new practice. It was easier to follow the old procedure instead of adopting the new process (Johnson, 2017). However, returning to the established patterns of discharge impacted the quality of care.

The rehabilitation facility underwent significant changes and restructuring because of nursing shortages. There was not adequate time to implement the new intervention (Brown et al., 2009). The nurses who were initially trained on the EBP were transferred to the rehabilitation department during the restructuring. Despite the inconsistency, this restructuring had a positive outcome because nurses were able to provide improved care in this department. Conversely, nurses who replaced the trained nurses were not equipped to implement the EBP because they had not received training on the Teach-back method.

The unit managers, who were trained on EBP and the Teach-back method, were not always available to help the untrained nurses with the discharge processes when the trained nurses who were part of the Teach-back discharge team were unavailable. The major setback that significantly impacted the outcomes of the Teach-back process was the resignation of two primary nurses from the facility. These two primary nurses were the most knowledgeable and skilled in the Teach-back method process. Therefore, implementing the Teach-back method was the most challenging part of the project due to lack of consistent staff who had adequate knowledge and expertise with this intervention.

This lack of consistency in staffing and loss of knowledge and expertise may have impacted the education process with the patients.

I spent time with the patients in the facility. Observations of nurse and patient interactions were made during the admission and discharge processes. I also met with each patient and all caregivers who were present at the time of the admission. The nurses or social worker prepared patients and caregivers for the discharge, reminded them of the prescribed medications and self-care management using the Teach-back method, and discussed the follow-up telephone calls that they would receive. I observed these interactions as I wanted to ensure that the patients were ready for discharge to home and were prepared adequately to continue the prescribed self-care management in the home. This discharge education was also delivered to the caregivers who were available during the discharge process.

Implications Resulting from the Findings

The nursing shortage was a significant challenge at the rehabilitation center and it was a major barrier in the project implementation. The problem of a nursing shortage is universal, affecting health care systems across the globe. One way the rehabilitation facility can address the nurse shortage problem is by creating an environment that can cultivate and support a competent and confident nursing staff. Research showed that administrative interventions focusing on improving the quality of practice environment, maintenance of adequate staffing levels (Twigg & McCullough, 2014), and improved quality of practice are more effective in retaining staff than increasing recruitment or remuneration.

Nurse retention is crucial in any health organization because a nursing shortage within any facility leads to poor job satisfaction, unfavorable patient outcomes, and effects the long-term relationship of nurses within the work environment (Twigg & McCullough, 2014). Therefore, it is paramount for health care institutions to establish ways of increasing their staff retention because health care facilities that have adequate staffing and a positive practice environment have demonstrated favorable patient outcomes and have satisfied nurses. Factors that motivate nurses to remain in a facility include supportive staff, supportive management, good physical environment, and job satisfaction. A positive practice environment impacts a nurse's ability to practice professionally and provide safe quality care (Twigg & McCullough, 2014).

CMS five-star initiatives have promoted improved discharge processes to the community from hospitals and rehabilitation facilities, thereby reducing 30-day readmissions to the hospital. CMS developed its Five-Star Quality Rating System to help patients, their families, and caregivers compare rehabilitation facilities. Facilities with five stars are considered to have advanced quality care, while facilities with one star are considered below average (Castle & Ferguson, 2010).

Reduced readmission rates have potential implications for positive social change because they promote better health outcomes and alleviate pain and suffering. Hospital readmissions have a negative impact on society because they increase the duration of suffering for the hospitalized patients, impede patient productivity, and put patients at risk for further medical complications. Furthermore, rehospitalizations cause discomfort

and anxiety for the family and caregivers. Therefore, low rates of hospital readmissions have a positive social outcome, leading to better health outcomes (Kripalani et al., 2014).

Collaborative and improved communication in discharge planning promotes improved patient outcomes. The education of all team members on the discharge process that starts at admission to the facility enhances patients' health outcomes. Patients' safety is improved when there is an effective collaboration of nurses and patients during the discharge process. A proper discharge process allows patients to take their medications effectively and practice self-care that promotes their health. Therefore, education on the proper discharge process, efficient patient education, and proper discharge planning that focuses on the specific needs of patients and families can promote patient health outcomes by eliminating chances of readmission within 30-days postdischarge (Kripalani et al., 2014).

Recommendations

There was need to improve staff education on the appropriate discharge process at the project site. The IDEAL Discharge Planning Overview, Process, and Checklist; the Teach-back method of patient education; and the Postdischarge Rehabilitation Services Follow-Up Tool incorporating telephone calls to all participants during Weeks 1, 2, and 4 postdischarge were effective evidence-based strategies for improving patients' outcomes. In order to avoid reverting to the regular discharging processes, it will be important to educate all the nurses about the importance of the interventions and also train them on how to use the tools to ensure patients understand and can carry out discharge instructions. The facility management might consider implementing a new policy

regarding training all nurses on patient-centered discharge instructions and processes.

This policy could make it possible that the constant nurse rotation across various

departments will not affect the discharge process because all nurses will have knowledge

related to use the discharge tools.

Regarding the nurse shortage, the institution can work toward creating a positive

practice environment. The center can create such an environment by increasing nurse

participation in the rehabilitation affairs. The facility can empower nurse-friendly work

structures, offer additional staff support, and provide opportunities and resources for

nurses to grow, so that there will be a higher retention of nurses who might have left the

facility to explore other growth opportunities.

In addition, the facility needs to promote interdisciplinary collaboration between

health care professionals. Physicians and nurses could participate in ongoing education

together to create a positive environment for practice. The facility also needs to have

adequate staffing and resources to reduce the work load of the current staff.

Plans to Extend the Project Beyond the DNP Doctoral Project

Given the cautiously positive trend in the quarter of this project, there is a plan to

extend the interventions beyond the DNP doctoral project. I intend to return to the facility

and review the outcomes of this project over time. I will also discuss the effectiveness of

the Teach-back method with the nursing staff. I will encourage the discharge team to

enhance their staff training procedures to ensure that all nurses are adequately prepared to

implement the project interventions to prevent avoidable 30-day readmissions. The team

will also be urged to continue the 30-day follow-up telephone calls to patients after

discharge address problems and to ensure that patients adhere to the discharge

instructions, and, subsequently, reduce avoidable readmissions.

Strengths and Limitations of the Project

The strength of this project was the implementation of improved patient education

through use of the IDEAL tool, the Postdischarge Rehabilitation Services Follow-Up

Tool, and the Teach-back method (see Appendix A). The Teach-back method, in

particular, can be used to ensure the patients' understanding of their care and provided

them with the help necessary to address and resolve any concerns relating to medications,

follow-up healthcare provider services, and health concerns during recovery at home. The

Teach-back method and follow-up telephone calls improved the patients' satisfaction

with their care. Patients expressed gratitude for the follow-up telephone calls, and there

was a 70% satisfaction improvement within a period of 5 months after the intervention.

Consistency in conducting the follow-up telephone calls to all discharged patients is

urged to ensure compliance with postdischarge regimens for the patients at home and to

prevent avoidable readmissions.

However, a nursing shortage and high turnover were major limitations in this

project. These limitations resulted in a restriction in the admissions to the facility.

Admissions were delayed for 90 days because of complaints about services. My progress

in obtaining adequate data in a timely manner was affected. Also, related to the nurse

staffing issues, the project relied heavily on my dedication of time and determination to

continue the project without placing an extra burden on the facility. I was only able to

collect and assess data for 50 participants during the time frame of the DNP project.

These efforts, however, demonstrated to the facility administrators that the discharge management changes could be successful and contributed to plans for project sustainability after the DNP project ended.

Finally, I recommend that any future organizational change projects use Lewin's change process to promote consistency in implementation methods. Understanding of organizational dynamics and processes of organizational change are paramount for the development and successful implementation of evidence-based practices (Batras et al., 2016).

Section 5 provides an overview of the study. Section 5 also discusses implications for nurses, nurse manages, patients, family members of patients, and DNP students. Recommendations for future research are included.

Section 5: Future Plan

The aim of this doctoral project was to enhance the discharge process at an inpatient rehabilitation center to reduce the rate of patient readmissions within 30 days of initial discharge. To achieve this objective, I facilitated the implementation of best practices and urged relevant policies to improve patient discharge processes.

I will revisit the facility to review the project outcomes with the nursing staff and team members and emphasize how the project can improve overall patient satisfaction, promote long-term results, and enhance facility reimbursements. The outcomes of this EBP project will be presented to the team during a lunch meeting. The team will learn that effective communication and collaborative efforts across all management team members will promote an effective discharge process to reduce the number of avoidable readmissions. I also plan to participate in a poster board session at a national conference. This project paper will be published in ProQuest at the end of my doctoral program.

Analysis of Self

I hope that I have influenced the teams and individual persons that I have worked with on this project to improve the field of nursing and promote DNP practice for future practitioners. I also hope that I have played a role in improving the quality of services at the rehabilitation center through effective communication and collaborative work to facilitate effective long-lasting recovery for the patients in their homes or communities. My goal was to have impacted people's lives whether patients, staff, or administrators within the facility with this EBP project. I hope I have had a positive influence on their

professionalism, attitudes, and effective communication through my building of lasting relationships within this facility and my bonding with team members.

I could have done better. During the nursing turnover, I could have been more active in the training of the new nurses and managers during this EBP change process. However, due to the constraints on my time, the education and follow-up of the discharged patients was a priority and prevented my further involvement in the education of new nurses employed by the facility.

The education of the nurse unit managers, social workers, and the administrator did not change during this EBP project. The continuity of the administrative staff led to the successful trends seen after this EBP change project. The main quality leaders were able to enforce the EBP project goal of educating the patient and caregivers on the need for continued follow-up care upon discharge to promote care in the home, thereby preventing avoidable readmissions to the facility. Professionally, this EBP project has enlightened me on the need to strive constantly to improve quality through EBP and engage and promote involvement within the team environment to improve patient outcomes.

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Always Use Teach-back!

Teach-back Observation Tool

Care Team Member: _____ Date: _____

Observer: _____ Time: _____

Did the care team member...	Yes	No	N/A	Comments
Use a caring tone of voice and attitude?				
Display comfortable body language, make eye contact, and sit down?				
Use plain language?				
Ask the patient to explain in their own words what they were told to do about: • Signs and symptoms they should call the doctor for? • Key medicines? • Critical self-care activities? • Follow-up appointments?				
Use non-shaming, open-ended questions?				
Avoid asking questions that can be answered with a yes or no?				
Take responsibility for making sure they were clear?				
Explain and check again if the patient is unable to use teach-back?				
Use reader-friendly print materials to support learning?				
Document use of and patient's response to teach-back?				
Include family members/caregivers if they were present?				

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Appendix A: Teach-back Observation Tool

Teach-back Observation Tool continued

Notes: _____

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Note: (Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/professionals/quality-patient-safety/quality-

Appendix B: IDEAL Discharge Planning Overview, Process and Checkout

IDEAL Discharge Planning Overview, Process, and Checklist

Evidence for engaging patients and families in discharge planning

Nearly 20 percent of patients experience an adverse event within 30 days of discharge.[1,2] Research shows that three-quarters of these could have been prevented or ameliorated.[1] Common post-discharge complications include adverse drug events, hospital-acquired infections, and procedural complications.[1] Many of these complications can be attributed to discharge planning problems, such as:

- Changes or discrepancies in medications before and after discharge[3,4]
- Inadequate preparation for patient and family related to medications, danger signs, or lifestyle changes[3,4,5]
- Disconnect between clinician information-giving and patient understanding[3]
- Discontinuity between inpatient and outpatient providers[3]

Involving the patient and family in discharge planning can improve patient outcomes, reduce unplanned readmissions, and increase patient satisfaction.[6,7]

More and more, hospitals are focusing on transitions in care as a way to improve hospital quality and safety. As one indicator of this, the Centers for Medicare and Medicaid Services implemented new guidelines in 2012 that reduce payment to hospitals exceeding their expected readmission rates.

To improve quality and reduce preventable readmissions, [insert hospital name] will use the Agency for Healthcare Research and Quality's Care Transitions from Hospital to Home: IDEAL Discharge Planning tools to engage patients and families in preparing for discharge to home.

Key elements of IDEAL Discharge Planning

Include the patient and family as full partners in the discharge planning process.

Discuss with the patient and family five key areas to prevent problems at home:
1. Describe what life at home will be like
2. Review medications
3. Highlight warning signs and problems
4. Explain test results
5. Make followup appointments

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps throughout the hospital stay.

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.

Listen to and honor the patient's and family's goals, preferences, observations, and concerns.

This process will include at least one meeting to discuss concerns and questions with the patient, family of their choice, and [identify staff].

What does this mean for clinicians?

We expect all clinicians to:
- Incorporate the IDEAL discharge elements in their work
- Make themselves available to the [identify staff] who will work closely with the patient and family
- Take part in trainings on the process

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How do you implement IDEAL Discharge Planning?

Each part of IDEAL Discharge Planning has multiple components:

Include the patient and family as full partners in the discharge planning process.

- Always include the patient and family in team meetings about discharge. Remember that discharge is not a one-time event but a process that takes place throughout the hospital stay.
- Identify which family or friends will provide care at home and include them in conversations.

Discuss with the patient and family five key areas to prevent problems at home.

1. Describe what life at home will be like. Include the home environment, support needed, what the patient can or cannot eat, and activities to do or avoid.
2. Review medications. Use a reconciled medication list to discuss the purpose of each medicine, how much to take, how to take it, and potential side effects.
3. Highlight warning signs and problems. Identify warning signs or potential problems. Write down the name and contact information of someone to call if there is a problem.
4. Explain test results. Explain test results to the patient and family. If test results are not available at discharge, let the patient and family know when they should get the results and identify who they should call if they have not gotten results by that date.
5. Make followup appointments. Offer to make followup appointments for the patient. Make sure that the patient and family know what followup is needed.

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps at every opportunity throughout the hospital stay.

Getting all the information on the day of discharge can be overwhelming. Discharge planning should be an ongoing process throughout the stay, not a one-time event. You can:

- Elicit patient and family goals at admission and note progress toward those goals each day
- Involve the patient and family in bedside shift report or bedside rounds
- Share a written list of medicines every morning
- Go over medicines at each administration: What it is for, how much to take, how to take it, and side effects
- Encourage the patient and family to take part in care practices to support their competence and confidence in caregiving at home

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.

- Provide information to the patient and family in small chunks and repeat key pieces of information throughout the hospital stay
- Ask the patient and family to repeat what you said back to you in their own words to be sure that you explained things well

Listen to and honor the patient and family's goals, preferences, observations, and concerns.

- Invite the patient and family to use the white board in their room to write questions or concerns
- Ask open-ended questions to elicit questions and concerns.
- Use Be Prepared to Go Home Checklist and Booklet (Tools 2a and 2b) to make sure the patient and family feel prepared to go home
- Schedule at least one meeting specific to discharge planning with the patient and family caregivers

IDEAL Discharge Planning Process

The elements of the *IDEAL Discharge Planning* process are incorporated into our current discharge. The information below describes key elements of the IDEAL discharge from admission to discharge to home. Note that this process includes at least one meeting between the patient, family, and discharge planner to help the patient and family feel prepared to go home.

Initial nursing assessment

❑ **Identify the caregiver who will be at home along with potential back-ups.** These are the individuals who need to understand instructions for care at home. Do not assume that family in the hospital will be caregivers at home.

❑ **Let the patient and family know that they can use the white board in the room to write questions or concerns.**

❑ **Elicit the patient and family's goals for when and how they leave the hospital,** as appropriate. With input from their doctor, work with the patient and family to set realistic goals for their hospital stay.

❑ **Inform the patient and family about steps in progress toward discharge.** For common procedures, create a patient handout, white board, or poster that identifies the road map to get home. This road map may include things like "I can feed myself" or "I can walk 20 steps."

Daily

❑ **Educate the patient and family about the patient's condition at every opportunity,** such as nurse bedside shift report, rounds, vital status check, nurse calls, and other opportunities that present themselves. Use teach back.
Who: *All clinical staff*

❑ **Explain medicines to the patient and family (for example, print out a list every morning) and at any time medicine is administered.** Explain what each medicine is for, describe potential side effects, and make sure the patient knows about any changes in the medicines they are taking. Use teach back.
Who: *All clinical staff*

❑ **Discuss the patient, family, and clinician goals and progress toward discharge.** Once goals are set at admission, revisit these goals to make sure the patient and family understand how they are progressing toward discharge.
Who: *All clinical staff*

❑ **Involve the patient and family in care practices to improve confidence in caretaking after discharge.** Examples of care practices could include changing the wound dressing, helping the patient with feeding or going to the bathroom, or assisting with rehabilitation exercises.
Who: *All clinical staff*

IDEAL Discharge Planning Checklist

Fill in, initial, and date next to each task as completed.

Patient Name: _____

Initial Nursing Assessment	Prior to Discharge Planning Meeting	During Discharge Planning Meeting	Day of Discharge
_____ Identified the caregiver at home and backups	_____ Distributed checklist and booklet to patient and family with explanation	_____ Discussed patient questions	**Medication**
_____ Told patient and family about white board	_____ Scheduled discharge planning meeting	_____ Discussed family questions	_____ Reconciled medication list
_____ Elicited patient and family goals for hospital stay	Scheduled for	_____ Reviewed discharge instructions as needed	_____ Reviewed medication list with patient and family and used teach back
_____ Informed patient and family about steps to discharge	_____ / _____ / _____ at	_____ Used Teach Back	**Appointments and contact information**
	_____ [time]	_____ Offered to schedule followup appointments with providers. Preferred dates / times for:	_____ Scheduled followup appointments:
		PCP:	1) With _____ on ____ / _____ / _____ at _____ [time]
		Other:	2) With _____ on ____ / _____ / _____ at _____ [time]
			_____ Arranged any home care needed
			_____ Wrote down and gave appointments to the patient and family
			_____ Wrote down and gave contact information for followup person after discharge

IDEAL Discharge Planning Daily Checklist

Fill in, initial, and date next to each task as completed.

Patient Name:_____

Day 1	Day 2	Day 3	Day 4
_____Educated patient and family about condition and used teach back	_____Educated patient and family about condition and used teach back	_____Educated patient and family about condition and used teach back	_____Educated patient and family about condition and used teach back
_____Discussed progress toward patient, family, and clinician goals	_____Discussed progress toward patient, family, and clinician goals	_____Discussed progress toward patient, family, and clinician goals	_____Discussed progress toward patient, family, and clinician goals
_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other	_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other	_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other	_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other
_____Involved patient and family in care practices, such as:	_____Involved patient and family in care practices, such as:	_____Involved patient and family in care practices, such as:	_____Involved patient and family in care practices, such as:

Notes

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Appendix C: Post-Discharge Rehabilitation Services Follow-up

Patient #   Admission Diagnosis

                                                                       Discharge Diagnosis

Date of Admission   Date of Discharge

Initial Call (Week 1) Date: Follow-up Call (Week 3) Date:

Final Call (Week 4) Date:

Follow-up	es	o	Comments
1. Did the nurse review your medications with you prior to your discharge?			
2. Did you receive your prescriptions from the facility?			
3. Did you get your RX filled timely upon leaving the facility?			
4. Do you have your Medications in the home to take as scheduled?			
5. Do you have someone to help you at home (if applicable)?			
6. Do you understand what services you are to receive in the home?			
7. Were you given appointments to the doctor prior to leaving the facility?			
8. Did you go on the appointment made for you prior to leaving the facility?			
9. Have you been back to the hospital?			
10. Have you been back to the hospital for another problem?			
11. Are your receiving your physical therapy (if applicable)?			

Appendix D: Data Abstraction Form

Patient Number _____

Age

_____

Sex

Male_____   Female _____

Ethnicity

African   White_____   Hispanic_____   Asian_____   Other_____
American_____

Discharge Destination

				Long Term
Home	Home with	Assisted Living	Care	
Alone_____	Caregiver_____	Facility_____		Facility_____

Education Level

			Advanced
< High	High	College_____	Degree_____
School _____	School_____		

Number of Medications

Primary Diagnosis