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Discharge Prospectus

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Discharge Prospectus

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Internship: Clinical Nurse Leader

NURS 653

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Discharge Prospectus

Clinical Leadership Theme

With implementing this Discharge Prospectus project, the 5 P's framework was utilized to provide a structured process to a microsystem for improvement on how to safely expedite discharges. When reviewing the 5 P's known as purpose, patients, professionals, processes, and patterns of this microsystem as an upcoming Clinical Nurse Leader (CNL), the role of outcomes manager and system analyst/risk anticipator became useful. These tools were beneficial in interpreting some of the processes and patterns that needed to be evaluated and improved upon throughout the discharge process. Using the outcomes manager tool, we compared data pre-and post of the project to help record and evaluate improvements made. By using the analyst/risk anticipator tool, this writer reviewed the current microsystem discharge process to help identify gaps and where improvements could be made.

After the assessment of this microsystems discharge process, a global aim statement was comprised which stated: We aim to improve the discharge process/timing by introducing multidisciplinary huddles in a medical surgical unit at the University of California Davis Medical Center (UCDMC). The process begins with physicians, nurses, discharge planners, dietary, physical therapy, and pharmacy rounding together during a daily huddle to identify needs of patients to transition home more efficiently. The process ends with patients being discharged by noon safely, and with the needs of patients being met. By working on the process, we expect to reduce the length of stay(LOS) and readmission rates for patients thereby increasing the flow of hospital operations, and providing safer transition of care/discharges for patients. It is important to work on this project now because the number of readmissions has increased, and patient delays in care are rising. For this aspiring CNL, the project helped to satisfy the leadership

competency of essential number one which includes the ability to "interpret patterns and trends in quantitative and qualitative data to evaluate outcomes of care within a microsystem and compare to other recognized benchmarks or outcomes" (American Association of Colleges of Nursing, 1998).

Statement of Problem

The purpose of this study is to streamline the discharge process so that the patients' needs are met and patients can transition home safely. Why is the discharge process key in the patient's overall outcomes and plan of care? According to Medicare (2016), the National rate of readmission after discharge from a hospital is about 15.6%. Tielbur et al. (2014), stated that "disjoined patient care is unfortunately a common and well-documented problem in health care systems resulting in inefficient utilization of resources as well as suboptimal patient care" (p. 36). One of the inefficiencies noted in a study done by Tielbur and colleagues, was that "inadequate communication" was a source of poor transition of out-patient care and care coordination.

In order to help increase communication and improve discharge transitions along with discharge timing, a multidisciplinary team huddle was formed. At UCDMC, a team has come together to introduce team huddles to address some issues with discharge for patients. Evidence has proven that huddles can improve care for patients and help organizations reduce system errors while improving overall experience for patient satisfaction.

Project Overview

In creating a huddle, our goal was to establish a team that fostered greater communication across disciplines that allowed for a patient's discharge plan to be discussed in detail. This would help identify discharge needs, and thereby improve the process of discharging a patient safely. A

huddle is comprised of physicians, nurses, case managers, and a pharmacy representative. A huddle would have multidisciplinary rounds on this specific medical-surgical unit each day and discuss the patient's condition, treatment plan for the day, potential discharge needs, risk for readmission, and anticipated discharge date. Discussing these items would help recognize needs and services required by patients while physicians prepare for writing orders by 10am the next day to plan for discharges by noon, thus improving the patients transition and hospitals need for beds. Some objectives such as communication have been improved between physicians and nurses. Increased communication has led to an increase in the number of early discharge orders done by 10am and patients discharged by noon. One university hospital states, "In addition to the immediate benefits of better coordination and smoother patient transitions, we believe the huddles also help to reduce unnecessary hospital days for our patients, ensure patients are aligned with the most appropriate post-discharge services based on their needs, and contribute to the lowering of readmission rates,"(States News, 2013). The changes made to implement huddle on the medical-surgical unit initiated ideas for a specific aim with discharge timing and readmission rate improvements. Based on the measurable outcome of discharge timing, a specific aim was created that stated: We aim to improve communication of care teams to include discharge plans through a huddle each day, and increase discharge timing by noon up to 30% from our original 23% starting January 2016 with improvement by January 2017. This relates to our original aim statement through the common goal of improving the discharge process and patient satisfaction while improving team collaboration. Another piece of team collaboration is to increase staff engagement in the discharge process. According to IHI, (2004) Huddles are a great communication tool to improve process and " enable the PDSA cycle while engaging staff participation". Discharging patients more efficiently leads to increased patient satisfaction of

both those patients discharging as well as those patients awaiting beds. Earlier discharges allow for more bed availability and thus increase hospital flow.

Rationale

A cause and effect diagram was used as an analysis tool to support our aim statement and provide more information related to the discharge process. A fishbone diagram (Appendix A) explores these specific cause and effects of discharge outcomes and how they are related to the unit's discharge process. The fishbone confirmed delays in discharge, and system faults that could be improved for the discharge process. Also, by mapping out the discharge routine starting with physicians down to the patient leaving the unit, we found that there was a need to restructure the way discharges occur in order to eliminate delays in discharge and improve patient satisfaction with discharges (Appendix B). The supporting data showed a lack of consistency in discharge planning with opportunities to improve on collaboration while improving coordination of care.

The discharge data (Appendix C) shows that patients are rarely discharged in a timely manner, and that physicians sometimes don't discharge until the end of the day due to routines and obstacles. The average time of day for discharge is anywhere between 12:30 pm-5pm which results in poor patient experience thereby decreasing bed availability within the hospital. With less than 20% of patients discharging before noon, there was much opportunity to improve. An assessment of strengths, weaknesses, opportunities and threats called a SWOT analysis (Appendix D) was created for developing strategies to deal with known forces, both internal and external, and to anticipate other actions during the implementation of the huddle. Some weaknesses identified in the SWOT were issues with cost, training, staff buy-in, and sustainability. A stakeholder analysis (Appendix E) was also formed so that the people involved

could be identified according to their impact on the project and the impact the action will have on those people working within the system. In this analysis, the bedside nurses at the huddle were the main individuals taking risks with low resources, and the executives who had high resources were just monitoring the progress of the project. This project could improve the hospitals ratings from the public if patient satisfaction scores increase and are reported. This increase in hospital ratings would show the need for this project and the continued sustainability of the project. The increased ratings would also increase stakeholder buy-in and executives would be more likely to support the future of the project. The success of this project will depend on the involvement from the multidisciplinary team and how well they can work together on patient discharges.

The discharge project focuses on a discharge huddle implementation and improving transitions of care and discharge timing to align with CMS standards for patient safety. According to AJC (2016), A lack of discharge planning and follow-up care leads to many unnecessary readmissions, resulting in more treatments, more tests, more time away from home and higher healthcare costs. CMS decreases payments to Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions, effective for discharges beginning on October 1, 2012 (CMS, 2016). With the introduction of a huddle as is key in this Discharge project, the likelihood for being discharged and being re-admitted is not likely since one of the goals of the huddle is to address all needs and barriers of patients. Timing is also important in discharge. Earlier discharges such as those before noon are preferable. In contrast, later half of the day discharges can have an affect on several elements such as: transportation pick-ups and traffic delays; medication and pharmacy closures; routines at home; and sleep patterns. These aspects can lead to re-admission which is why our huddle strives to have discharge orders in by 10 am.

The average readmission penalty is about $125,000 that is incurred to a hospital. With the cost for readmission and care of patient can grow rapidly thus increasing healthcare costs by billions of dollars. A cost analysis of the project was completed and showed that the cost of a daily huddle and supplies, along with wages of staff involved would potentially cost about $11,381.39 per year. If the penalty cost per year is subtracted from the huddle cost, the net savings for the hospital would potentially be: $125,000- $11, 381.39 equaling $124,618.61in savings (Appendix F).

After reviewing all the microsystem data sources and diagrams that show the need for improvement, this writer believes the discharge improvement project is well worth the time and energy of the staff and organization to continue climbing the improvement ramp to sustain the projects goals.

Methodology

This project contained both a pre-and post-quality intervention survey with goals outlined above. Outcomes were analyzed to assess whether this targeted intervention had any effects on quality and patient satisfaction. These outcomes include length of stay, 30-day readmission rate, and targeted domains of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, specifically Transitions of care and the Discharge domain. All measurements were based on a merger of Vizient case profile data with data from the hospital's electronic health records (EMR) system. The huddles were organized daily by the physician and charge nurse to meet after the physicians had time to round on patients and nurses could assess their patients progress. The huddles were equipped with a huddle checklist to ensure that the goals of the huddle remained intact and done in a timely manner-about 15 minutes each (Appendix G). During the huddle, patients were identified who were potential discharges for the

following day. The case manager, and nursing staff could then communicate the needs of the patient with the physician thus creating a smoother, expedited discharge the next day before noon. Evidence shows that early-in-day discharges of patients has been proposed as a means of helping to alleviate patient flow bottlenecks from the emergency department and potentially decrease patient length-of-stay (LOS) while also improving patient and staff satisfaction (Probasco et al., 2015, p. 197). The multidisciplinary team expected these huddles to increase staff engagement, collaboration, and improve patient satisfaction/discharge timing on the established pilot unit. Now that the huddles and some discharge times have been analyzed this year, the data shows we have not reached our goal yet. Our goal was to have 30% of our discharges by noon. Because we have less than our goal at 23%, there is a need to do another Plan, Do, Study, Act (PDSA) cycle to sustain discharge timing. With continuous focus group meetings, this writer decided to survey many nurses to find out what nurse obstacles are seen from the bedside as part of the next cycle to sustain early discharges (Appendix H). The survey results (Appendix H1-H5) showed that the physician orders were only received 10% of the time by 10am with the largest barrier to discharge being rides home at 52%. Many nurses also stated that early education with patients and increased communication between physician and patient would help expedite discharges earlier in the day. The last part of the survey showed that only 53% of nurses thought that discharges before noon occur about 25% of the time due to barriers previously stated. With this survey, an idea to implement a bedside poster (Appendix I) as a reminder about discharge needs for patients was created so that nurses and patients would be prompted early in addressing discharge needs. To expedite patient discharges so that patient's needs are met by noon, these poster reminders can help staff and patients to ask relevant questions for a safe and efficient discharge. Surveys will be conducted by staff again to see if

data proves that these posters helped sustain discharge times by noon. HCAHPS scores for the unit will be analyzed to determine if a safer, more efficient discharge for patients was revealed. This writer's predictions are positive with an expected increase in discharges by noon, and increased patient satisfaction scores with safe transition of care to home by this pilot unit.

Lippitt's Theory of Change was utilized to help make the changes tested in this project. In this theory, one person serves as a change agent, meaning that this person will be the key to success in their voice of change, in this project the change agent was this writer, an upcoming CNL. According to Harris, Roussel, and Thomas (2014), "having the right person as the voice of change and having support for the change further empowers the process". During the project, the seven stages of Lippitt's theory were considered as the process was implemented which are listed below:

1. Diagnose the problem and include those affected by change: This was done using the fishbone and team building process of the huddle project.
2. Assess the motivation for change in small groups to identify pros and cons of change: The team developed consisted of physicians, nurses, managers, and executives as well as a project manager.
3. Assess resources and motivation of people making change: This was done with a stakeholder analysis as provided in this document.
4. Choose elements for change and develop a timeline for the change: The Gantt timeline was created by staff to help keep project on time.
5. Choose who will lead the change and manage team dynamics and conflicts that arise: The chief physician was our lead in collaboration with this writer who was the voice for the nursing staff.

6. Maintain the change and revise procedures: This part was a group collaboration of efforts to help sustain this projects goals.
7. Terminate the helping relationship: This writer will soon give up her role as change agent once the culture of the unit has accepted this change.

The discharge huddle and posters have been generally accepted by many of the staff on the unit. Most of the staff are engaged and feel optimistic about the expected outcomes for the discharge plans. It is through this positive buy-in from staff that will make this project more successful as it becomes a part of the culture on the unit.

Data Source and Literature Review

With a focus on patient experience, quality, and safety; the department was tasked with completing a process improvement project to improve patient flow and address discharge processes. Shortly after initiation of the huddles, it was noted that on the unit, physician orders were meeting their goal (discharge order release time at 30% by 10 AM), but discharges by noon were not were not meeting the goal of 30%. Representatives of the huddle were brought together to discuss factors leading to delays in discharge, thus creating a survey to explore these delays. This provided insight into factors that most commonly led to delays in discharge. For example, patient rides home and ambulance transport were identified as barriers leading to delay in discharge. Thus, more focus was placed on this aspect of the checklist as the huddles continued to meet.

Through a PICO search statement, where the P stands for Patient population or Problem, “I” meaning Intervention, “C” stands for Comparison, “O” describes the Outcome, and “T” provides a Time frame, a question was formed to help conduct a literature review (Harris, Roussel, & Thomas, 2014). This writer’s PICO question stated: Regarding discharging patients,

does evidence support that a huddle/checklist and early discharge time help to eliminate discharge barriers compared with no use of any discharge tools or late discharges. To help answer this PICO question, this writer was able to find many articles and evidence on discharge huddles and some check-lists used in current practices but not much evidence on discharge times. Although the writer is still researching some aspects of the project, much evidence shows that discharges are more successful for patients when a checklist is used. The main search criteria used was "discharge" and "huddles." With this search, many articles arose with much evidence to support my project. One main piece of evidence was found in an Agency for Healthcare Research and Quality (AHRQ) (2016) article on discharges, this was very helpful in trying to create a checklist for discharge (Appendix J). Also, there was an article that gave some interventions that may improve the discharge process by the National Center for Biological Information (NCBI), it states how discharge summaries (DS) are important forms of communication between the physicians and team in patient care (Unnewehr, Schaaf, Marve, Fitch, & Friederiches, 2015). This is important because it shows how communication between the physician and the multidisciplinary team is key in streamlining discharge. According to HCPro (2014), patients often will spend hours waiting for necessary paperwork that has not been completed for discharge and create delays. This is important because it shows the consequence of not having adequate communication between the physician and the team and how this can delay discharge. By creating an early discharge program, this will improve patient flow and streamline the discharge process thus improving quality and performance.

Another article supported the barriers found in this project during the survey process and assessed the “patient’s readiness for discharge based on their perspective as a contributing factor in the discharge planning process” (Harrison, Greysen, Jacolbia, Nguyen, & Auerbach, 2016, p.

610). This is important because the patient themselves can be the barrier to discharge thus creating a delay, therefore identifying this barrier early is important so more communication can occur between physician and patient. To support the claims of patient safety through huddle initiatives, one article states that "huddle communication can be described as a briefing for collaborating, exchanging information, and bringing awareness to patient safety concerns as well as the need for leadership to support initiatives that improve patient safety" (Glymph et al., 2015, p. 183). This is important because this emphasizes the importance of huddle and the communication between members.

As the literature search continued, this writer stumbled upon a few articles that would provide my PICO with some positive research on transitions of care. According to Kasi et al., (2015), a systematic approach to hospital discharge improved medication reconciliation, supportive care, and follow-up appointments thus attending to transition needs. This article discussed huddle, methods, and checklist used to improve the transitions of care with many of their patients. And as quoted prior in this document, Tielbur et al., (2014) and her staff supports this project in many ways by documenting the multidisciplinary huddles as a system-wide initiative put into place with the use of technology for the future of healthcare. This article focused on LOS, efficiency, and the continuum of care to improve patient outcomes during a discharge huddle, it was a great reference for this document.

Timeline

To make a project successful, the pace of implementation and timing is a must to keep the project on track and reaching overall goals. A Gantt chart was created to see this project through the year and manage a schedule of activities to be completed during each phase of the project (Appendix K). The initiative was started on January 2016 and followed through a 9-

month intervention period up to date and will conclude at the beginning of the 2017 year in January. In the first three-month period, a project team was organized and identified inpatient discharge, with the average time of day for discharge orders anywhere from 12:30-5pm as an opportunity for improvement. The multidisciplinary team met to perform root cause analysis as to why discharge orders were not written by physicians early in the day and why discharges are delayed, and six main causes of delay were identified: 1) discharge process itself 2) Discharge equipment delays 3) Post-acute care need delays 4) upstream medication reconciliation not done 5) Barriers to MD seeing dischargeable patients prior to the DC order and 6) patients don't have rides home. The team found that hospitalists are required to complete many activities in the morning hours. These activities limit the time available to write discharge orders, and it was decided that the best way to enable orders to be written earlier is to conduct discharge planning huddles the previous afternoon. This would allow pre-discharge activities to be planned in advance. The huddles were organized and conducted by July 2016 with staff education, a checklist, and huddle timing. After July, another PDSA cycle was conducted, as discharge orders were noted to be timely, on or before 10am, while the nursing part of the discharge was still conducted after 12pm or later in the day. Hence, the development of the nursing survey and patient room posters were created as reminders to patients and staff of discharge needs and timing.

Now after three months, in late October, the evaluation of the room posters will take place by utilizing another survey to be completed by nursing and physicians about discharge huddle and interventions completed. At the beginning of the new year in January 2017, the final data will be compiled for a review of discharge timing, HCAHPS scores for the unit, and overall transitions of care by focusing on reported readmission rates.

Expected Results

Through this project, the fishbone, process mapping, and nursing surveys have shown that there are many issues within the discharge process. Many of these issues can be addressed through the multidisciplinary team huddles, awareness of the project goals, and active involvement from medical staff working together. The concept of early and safe discharges may sound easy to accomplish, but there are some factors that are not as easy to resolve. For example, there are some patients who may not want to leave the hospital when medically stable. Sometimes, these individuals are not ready for discharge and can make their stay longer and unnecessary, thus making this teams efforts very challenging. Aside from this challenge with the patients, this writer's expected results should be able to be obtained- the 30% of discharges accomplished by noon, HCAHPS scores improved over the year, with a reduction in readmission rate and LOS.

Some conclusions or theories that may develop from this project are that discharge huddles can improve patient outcomes through positive transitions of care. In addition, huddles should become a part of all organizations culture but individualized to meet the needs of patients on certain units throughout the hospital. I would strongly suggest a microsystem assessment of discharges, as evidence proves that more organizations need a new system to prevent readmissions with positive patient outcomes.

Nursing Relevance

Our present understanding of the discharge process is very simple minded and until this project pointed out some significant issues with this process, it was unclear on how to expedite discharges safely while considering the patients transition to home life after the hospital stay. The future of nursing will consist of more community health promotion and less hospital

admissions. Therefore, the discharge process will become more complex requiring more resources outpatient and my fear is that we may not have enough resources to meet the needs of people wanting to stay longer in their homes as they age. Another part of discharge planning that can be difficult is that there are not enough case managers to handle the large work load of the job. To provide a smooth transition to home, many aspects of the discharge rely on the discharge planner to accomplish in such a short timeframe. One other factor that plays a huge part in discharge planning is the lack of insurance coverage for many patients. If they do not have insurance to cover outpatient needs, the hospital pays a large sum to keep people inpatient if no insurance covers their needs. With this project, more issues can be identified and problem-solved with huddles, but some issues will remain as a healthcare system issue, which discharge planning will not be able to solve alone!

Summary Report

In this project, the writer organized a huddle multidisciplinary team to help identify discharge gaps and barriers. The designated huddle team would meet each day on this specific medical-surgical pilot unit each day to discuss the patient's condition, treatment plan for the day, potential discharge needs, risk for readmission, and anticipated discharge date. Discussing these items would help recognize needs and services required by patients while physicians prepare for writing orders by 10am the next day to plan for discharges by noon, thus improving the patients transition to home, hospitals need for beds, and overall patient satisfaction. Throughout the project, the writer performed a myriad of survey's and data review to identify if the aim goals were being met. Also, surveys were useful in identifying barriers to why discharges were not at goal. In the 9-months that the project has been going on, the rate of discharge is 23% which is below our goal of 30% of discharges before noon. However, the writer is optimistic results will

yield the end-goal of 30%. These are results that are to-date as the project itself does not come to a completion until January 2017. With reference to readmission rates, there has been essentially no change according to Hospital Compare (2016). Lastly, the patient satisfaction HCHAPS scores are improved by 3%. The writer learned that collaboration, teamwork, and effective communication is important to promote patient satisfaction and efficient transition home without readmission. These project results will be used to help roll out huddles on other floors, and to promote efficient discharges throughout the hospital. In the evaluations at the 9-month check-in, data showed that many of the unit staff have a higher level of staff engagement and awareness of potential discharge barriers. Unfortunately, our organization does not allow for interviewing specific patients involved in the project. However, the overall staff consensus is that patients felt "more prepared for discharge" and "listened to".

The aim of the project was to improve the discharge process/timing by introducing multidisciplinary huddles in a medical surgical unit at UCDMC. Reflecting on the aim, the writer feels that the goal was maintained. The population was the patients on the medical-surgical unit at UCDMC which included the physicians from the Hospitalist Service, the nursing staff, a pharmacy representative, and discharge planning.

The basis for doing this specific project was that many nurses at UCDMC felt like discharges were being delayed. Secondly, bed availability has become increasingly limited. Some of the methods used throughout this project were the 5 P's, the Lippitt's Theory of Change, a combination of surveys and implementing change. I used many teaching aids which include: the fishbone diagram, SWOT analysis, stake holder analysis, and Gant Chart. All of which can be found in the appendix. The data collected were the discharges by noon times as well as the transitions of care data (Appendix L). In the beginning of the project, I predicted that

there would be an increase in the number of discharges before noon up to 30%. While discharges have not reached this percentage, the level of early discharges is steadily increasing. To sustain this project and plan, the writer suggests to continue to discharge huddles and PDSA cycles along with data collection for further improvement. Another way to sustain this project is to continue to show success through numbers such as in the form of patient satisfaction scores, publishing these and having the buy in from the executives so they see the need for the continuing of the project.

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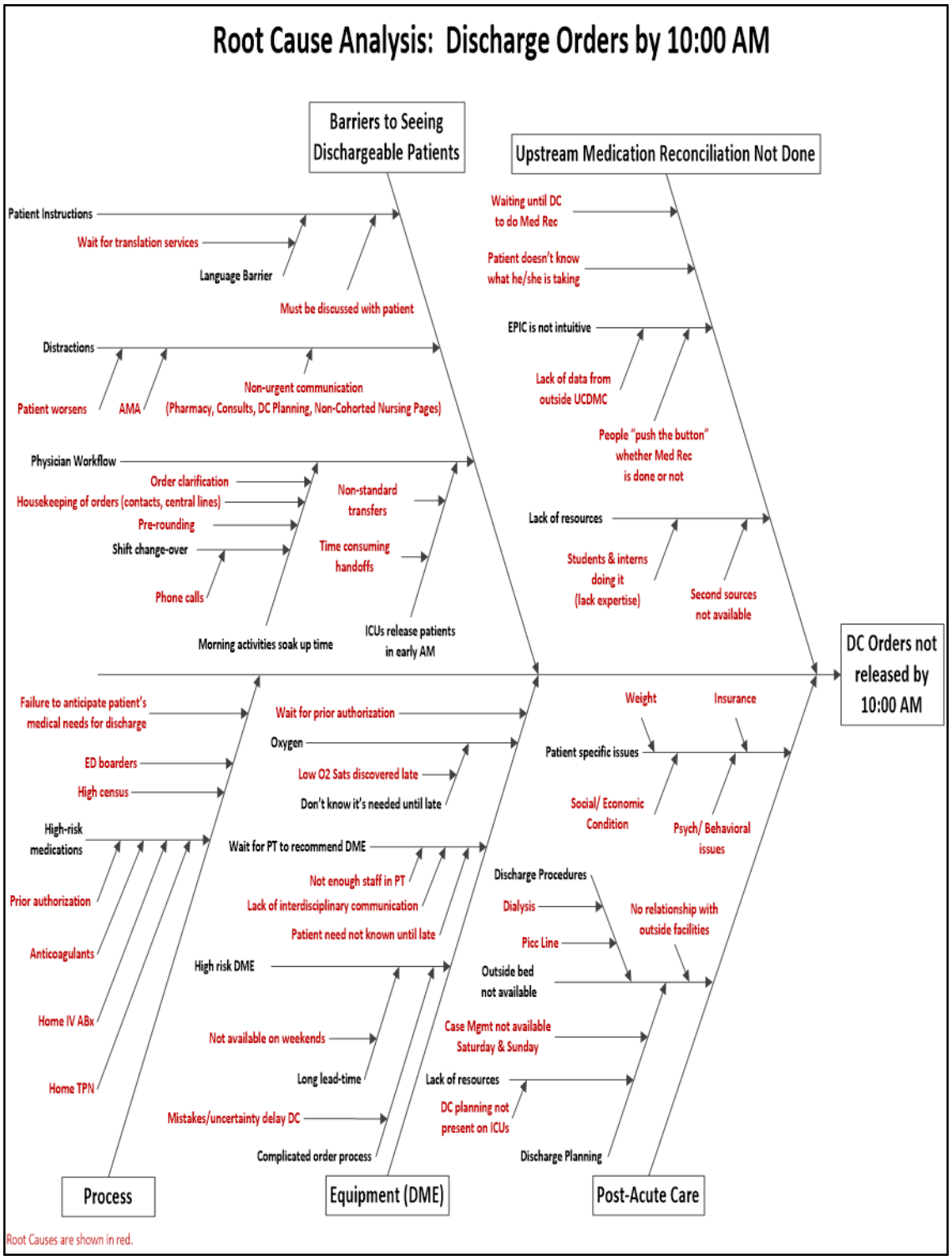
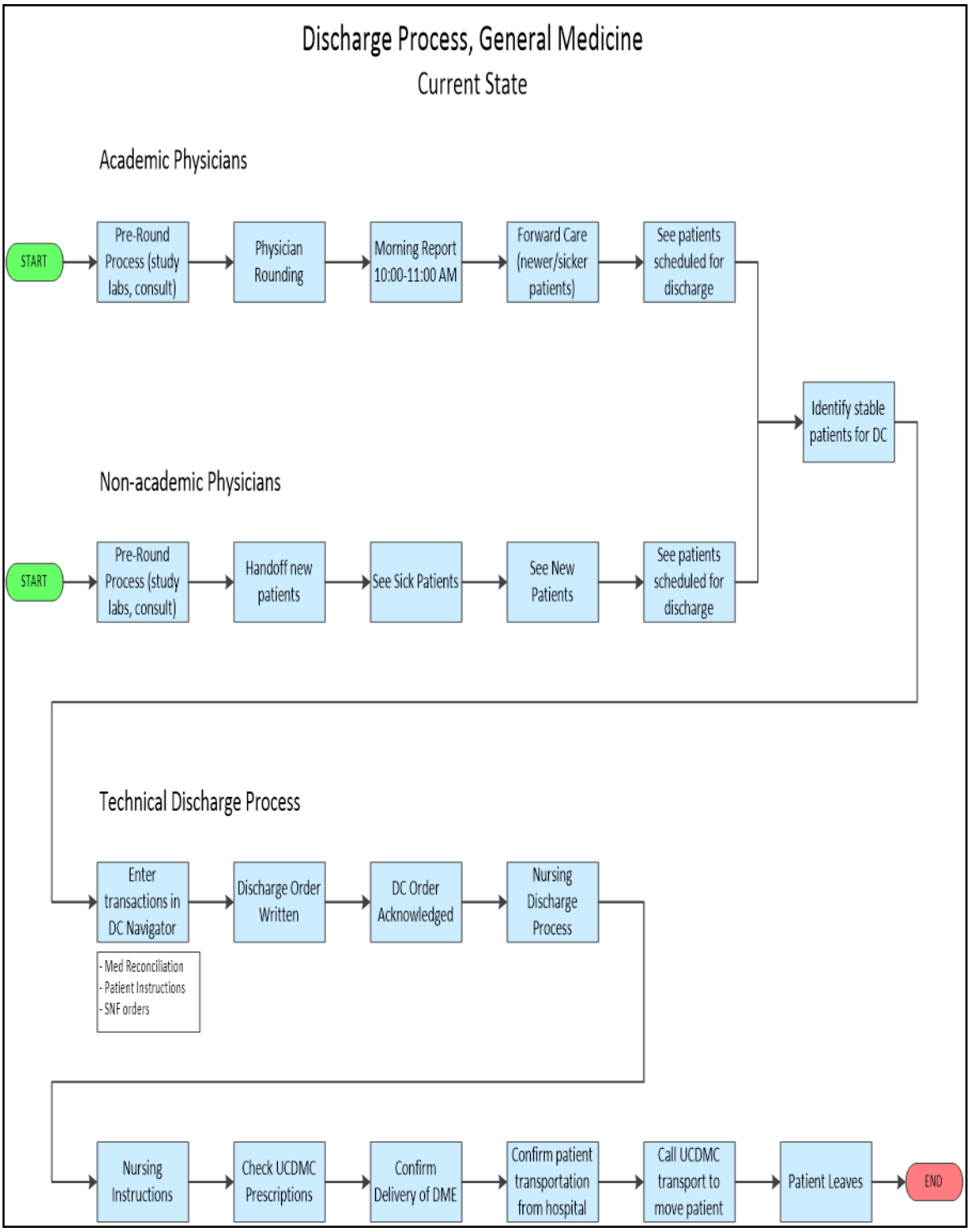
(Links to an external site.)

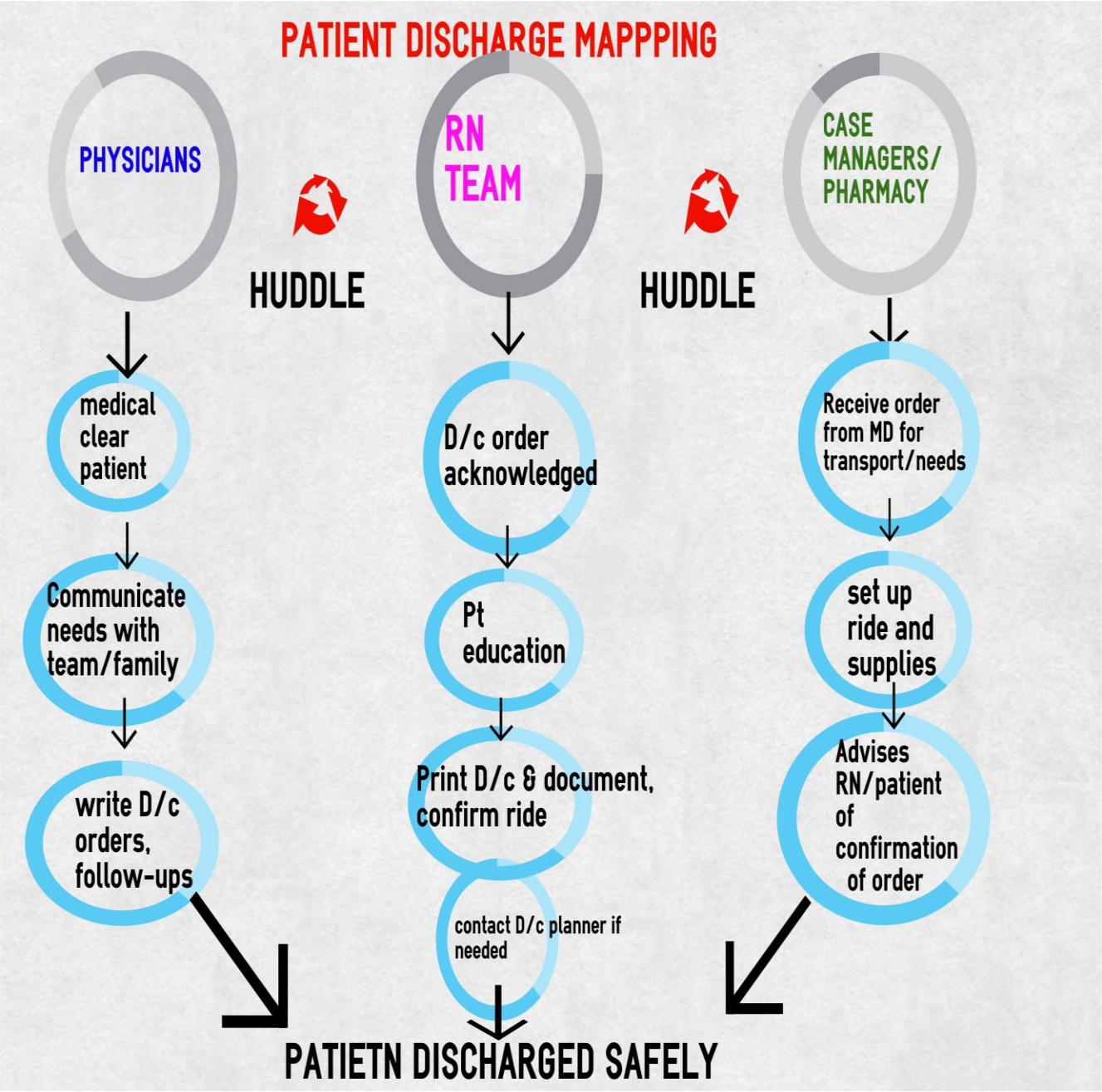
Appendix A


Root Cause Analysis: Discharge Orders by 10:00 AM
Barriers to Seeing Dischargeable Patients
Upstream Medication Reconciliation Not Done
DC Orders not released by 10:00 AM
Patient Instructions
Wait for translation services
Language Barrier
Must be discussed with patient
Distractions
Patient worsens
AMA
Non-urgent communication (Pharmacy, Consults, DC Planning, Non-Cohorted Nursing Pages)
Physician Workflow
Order clarification
Housekeeping of orders (contacts, central lines)
Pre-rounding
Shift change-over
Phone calls
Morning activities soak up time
Non-standard transfers
Time consuming handoffs
ICUs release patients in early AM
Waiting until DC to do Med Rec
Patient doesn't know what he/she is taking
EPIC is not intuitive
Lack of data from outside UCDMC
People "push the button" whether Med Rec is done or not
Lack of resources
Students & interns doing it (lack expertise)
Second sources not available
Failure to anticipate patient's medical needs for discharge
ED boarders
High census
High-risk medications
Prior authorization
Anticoagulants
Home IV ABx
Home TPN
Process
Wait for prior authorization
Oxygen
Low O2 Sats discovered late
Don't know it's needed until late
Wait for PT to recommend DME
Not enough staff in PT
Lack of interdisciplinary communication
Patient need not known until late
High risk DME
Not available on weekends
Long lead-time
Mistakes/uncertainty delay DC
Complicated order process
Equipment (DME)
Weight
Insurance
Patient specific issues
Social/ Economic Condition
Psych/ Behavioral issues
Discharge Procedures
Dialysis
Picc Line
Outside bed not available
No relationship with outside facilities
Case Mgmt not available Saturday & Sunday
Lack of resources
DC planning not present on ICUs
Discharge Planning
Post-Acute Care
Root Causes are shown in red.

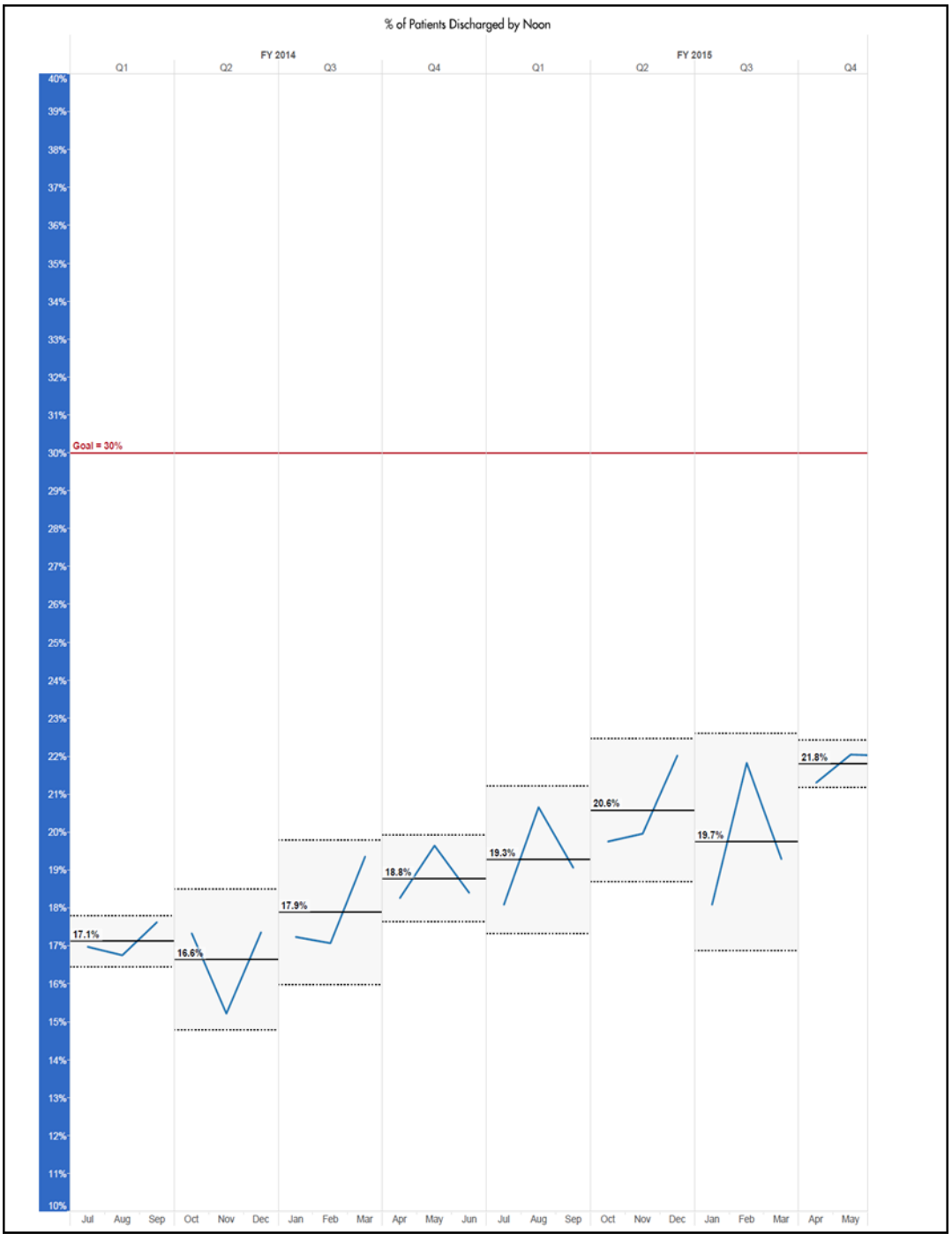
Appendix B


Discharge Process, General Medicine
Current State
Academic Physicians
START
Pre-Round Process (study labs, consult)
Physician Rounding
Morning Report 10:00-11:00 AM
Forward Care (newer/sicker patients)
See patients scheduled for discharge
Identify stable patients for DC
Non-academic Physicians
START
Pre-Round Process (study labs, consult)
Handoff new patients
See Sick Patients
See New Patients
See patients scheduled for discharge
Technical Discharge Process
Enter transactions in DC Navigator
- Med Reconciliation
- Patient Instructions
- SNF orders
Discharge Order Written
DC Order Acknowledged
Nursing Discharge Process
Nursing Instructions
Check UCDMC Prescriptions
Confirm Delivery of DME
Confirm patient transportation from hospital
Call UCDMC transport to move patient
Patient Leaves
END

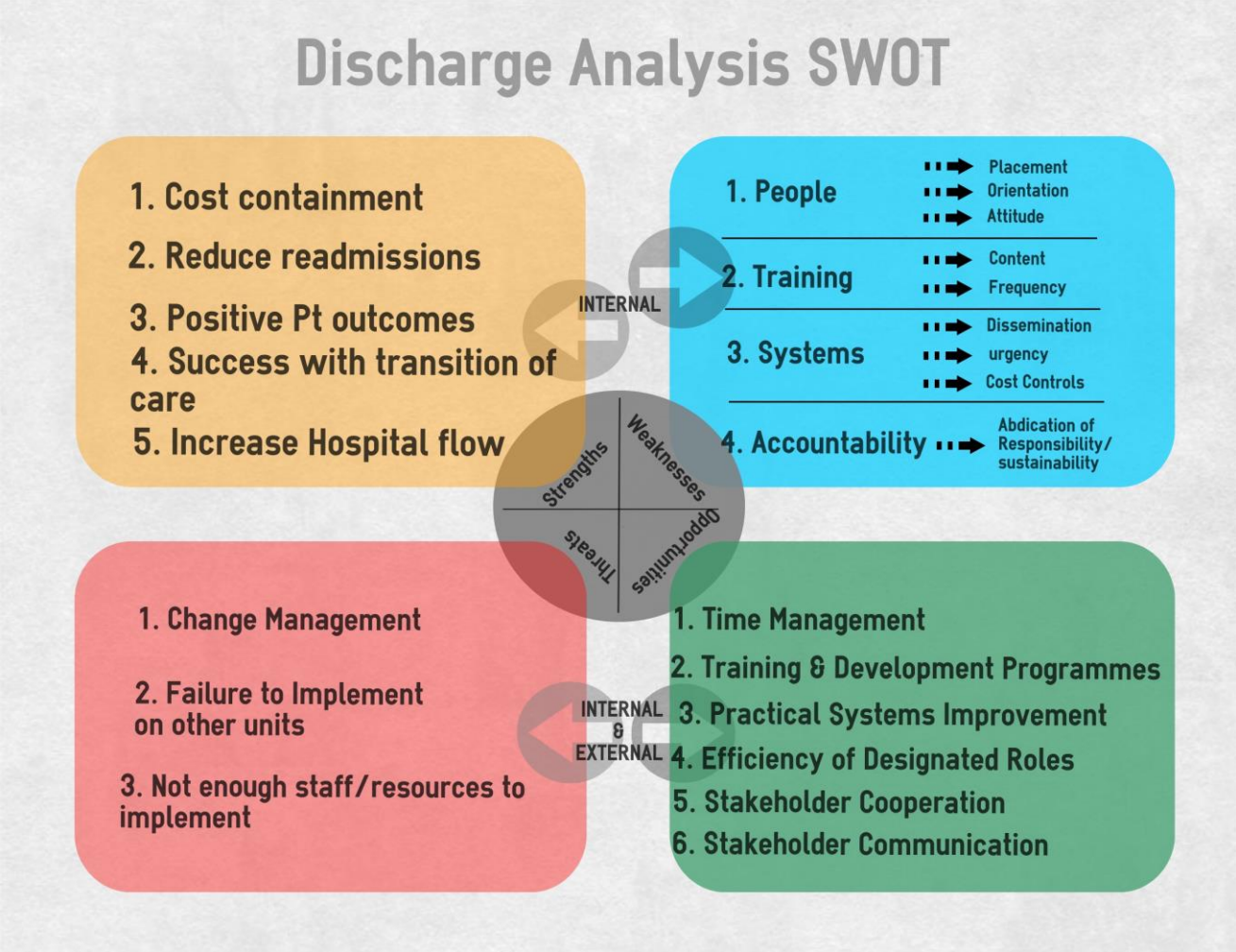
Appendix B


PATIENT DISCHARGE MAPPPING
PHYSICIANS
RN TEAM
CASE MANAGERS/ PHARMACY
HUDDLE
HUDDLE
medical clear patient
Communicate needs with team/family
write D/c orders, follow-ups
D/c order acknowledged
Pt education
Print D/c & document, confirm ride
contact D/c planner if needed
Receive order from MD for transport/needs
set up ride and supplies
Advises RN/patient of confirmation of order
PATIETN DISCHARGED SAFELY

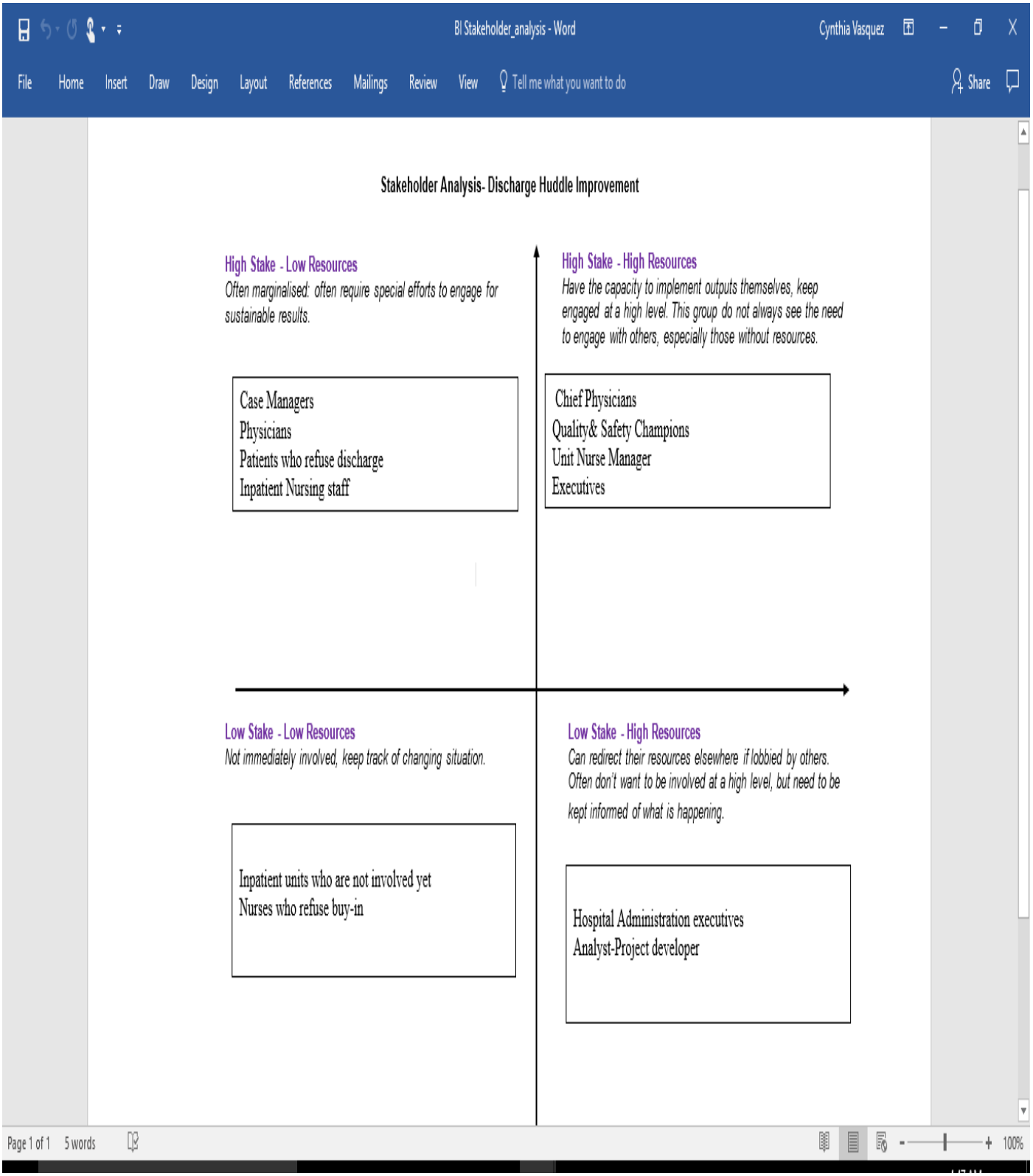
Appendix C


% of Patients Discharged by Noon
FY 2014
FY 2015
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Goal = 30%
17.1%
16.6%
17.9%
18.8%
19.3%
20.6%
19.7%
21.8%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May

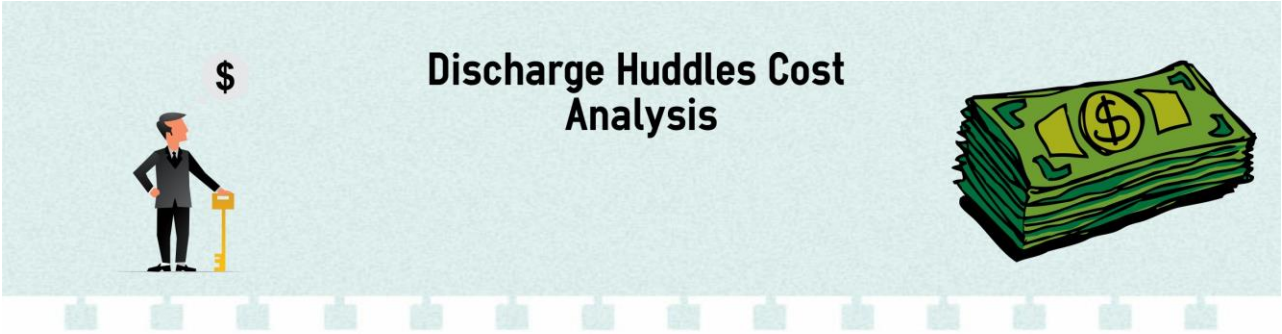
Appendix D


Discharge Analysis SWOT
1. Cost containment
2. Reduce readmissions
3. Positive Pt outcomes
4. Success with transition of care
5. Increase Hospital flow
INTERNAL
1. People
Placement
Orientation
Attitude
2. Training
Content
Frequency
3. Systems
Dissemination
urgency
Cost Controls
4. Accountability
Abdication of Responsibility/ sustainability
Strengths
Weaknesses
Threats
Opportunities
1. Change Management
2. Failure to Implement on other units
3. Not enough staff/resources to implement
INTERNAL & EXTERNAL
1. Time Management
2. Training & Development Programmes
3. Practical Systems Improvement
4. Efficiency of Designated Roles
5. Stakeholder Cooperation
6. Stakeholder Communication

Appendix E


BI Stakeholder_analysis - Word
Cynthia Vasquez
File Home Insert Draw Design Layout References Mailings Review View Tell me what you want to do
Share
Stakeholder Analysis- Discharge Huddle Improvement
High Stake - Low Resources
Often marginalised: often require special efforts to engage for sustainable results.
Case Managers
Physicians
Patients who refuse discharge
Inpatient Nursing staff
High Stake - High Resources
Have the capacity to implement outputs themselves, keep engaged at a high level. This group do not always see the need to engage with others, especially those without resources.
Chief Physicians
Quality& Safety Champions
Unit Nurse Manager
Executives
Low Stake - Low Resources
Not immediately involved, keep track of changing situation.
Inpatient units who are not involved yet
Nurses who refuse buy-in
Low Stake - High Resources
Can redirect their resources elsewhere if lobbied by others. Often don't want to be involved at a high level, but need to be kept informed of what is happening.
Hospital Administration executives
Analyst-Project developer
Page 1 of 1 5 words
100%

Appendix F



Budget cost: Huddles last about 15-30 min per day with all staff:
Md: $117/hr
Dietician: $31/hr
Rn: $56/hr
Pharmacy: $57/hr
case manger: $50/hr
PT: $45/hr

Total: $356/hr divided by 2(30min)= $178 per huddle or $89 per huddle a day
Cost for huddle check list $20/mo and posters 15 rooms x $5= $75 total= $95 /mo or $3.39 per day.
Rn project time for data collection and implementation: 200hr x $56=$11,200

Total: 11,381.39 (BLS, 2016)

Savings for readmissions: the average readmission penalty is about $125,000. The CMS is also to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012 (CMS, 2016).

Net benefits: $125,000- 11, 381.39= $ 124,618.61

Appendix G

Implementation Checklists

MULTIDISCIPLINARY HUDDLE CHECK LIST:

1. **Physician anticipate the patient to be medically cleared for discharge:**

   - ☐ **Today**
   - ☐ **Tomorrow**
   - ☐ **In 1-2 days**
   - ☐ **In 3-5 days**
   - ☐ **In > 5 days**

2. **Discharge barriers:**

   - ☐ **None**
   - ☐ **Medications (prior authorization, etc.)**
   - ☐ **Placement**
   - ☐ **DME**
   - ☐ **Home IV antibiotics, TPN or home O2**
   - ☐ **Psycho-social issues**
   - ☐ **Transportation**
   - ☐ **Pain**

3. **Choosing wisely / Restful Night's Sleep**

   - ☐ **Frequency of vitals check**
   - ☐ **Appropriateness of labs**
   - ☐ **Medication times at night**

Appendix H

RN Discharge Survey

1. *How often do you receive D/c orders by 10am?*

_____ *All the time* _____*10% of the time*

_____ *50% of the time* _____ *Never*

_____*25% of the time*

2. *What would you say is the largest barrier to discharges?*

____*equipment needs (w/c, BSC, Walkers, etc)*

____*Medication Needs (pharmacy, transition of care, orders, etc)*

____*Rides (no ride, waiting for ride, transport not on time)*

____*Other- state why:*_____

3. *Do you feel all aspects of discharge are addressed by the time the patient is ready to leave hospital? If not what can we do to help?*

4. *What can nurses do to expedite discharge?*

5. *How often do you discharge your patient by noon?*

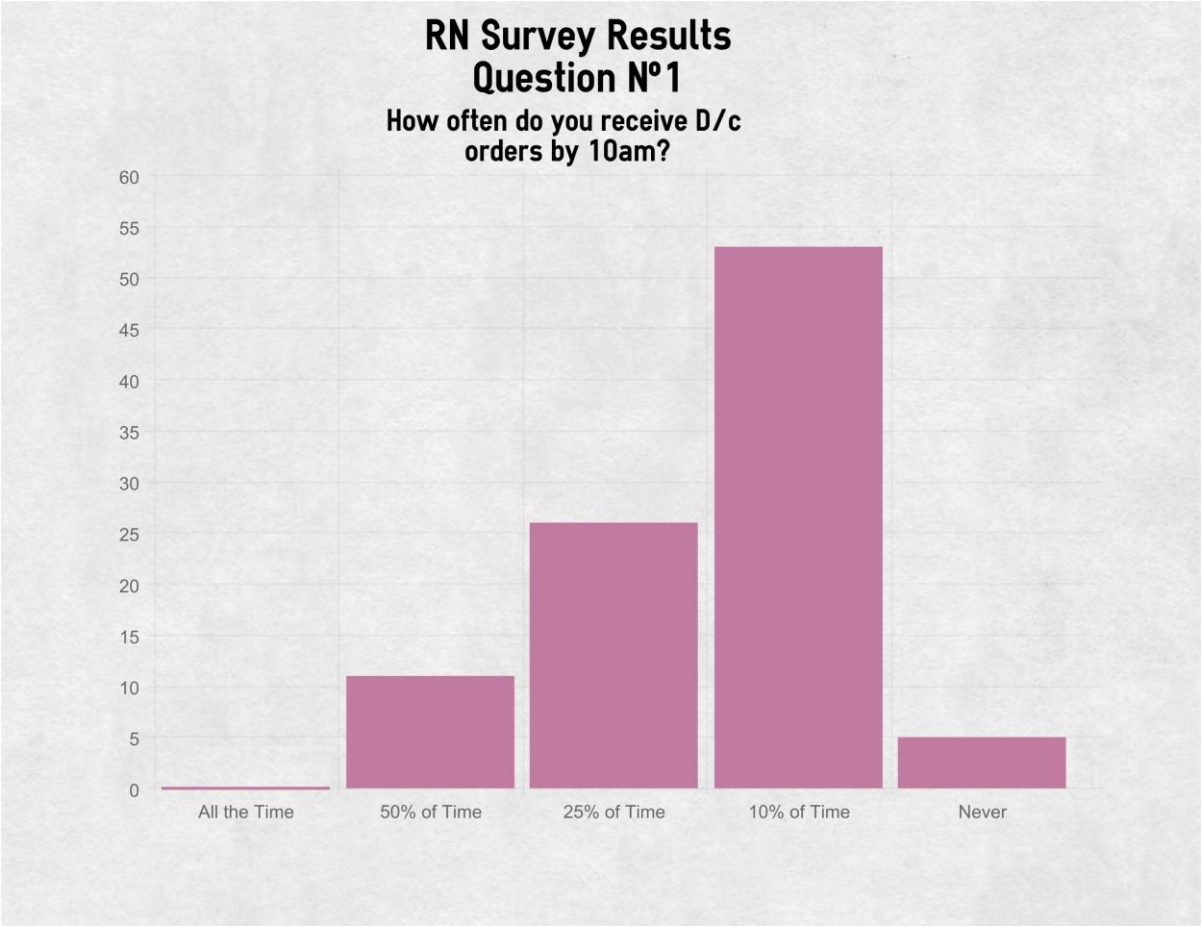
_____ *All the time* _____*Never*

_____ *50% of the time*

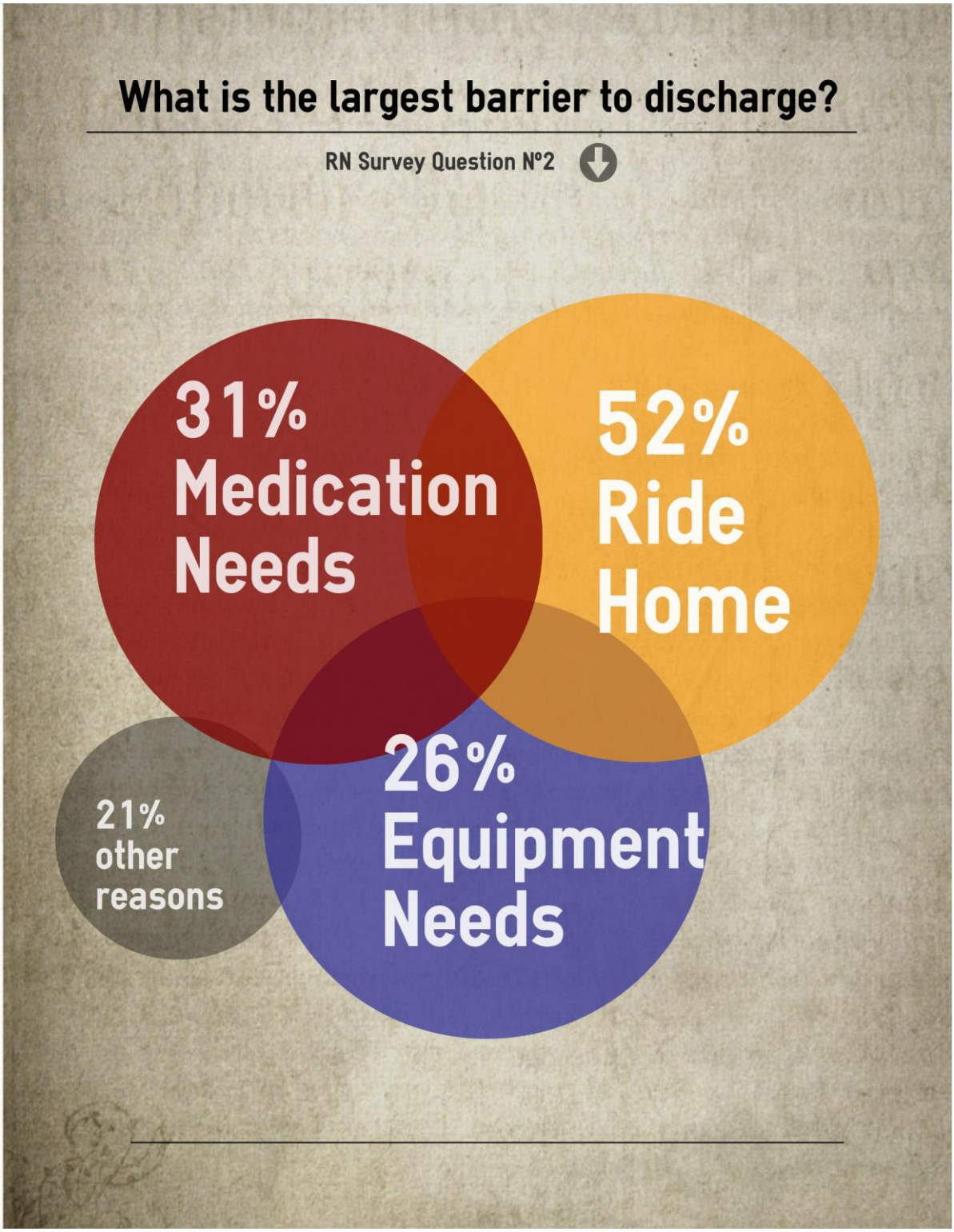
_____*25% of the time*

_____*10% of the time*

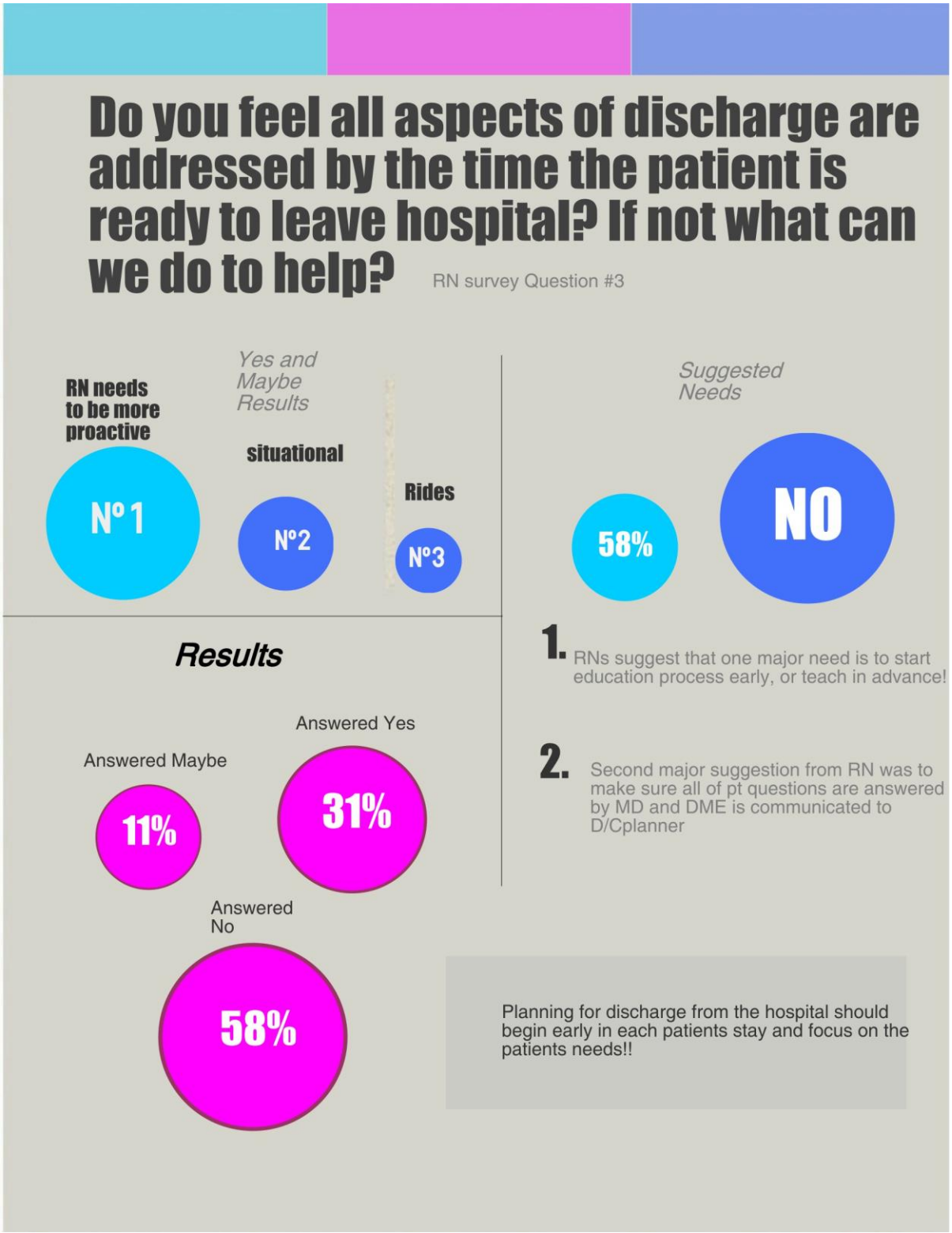
Appendix H-1


RN Survey Results
Question Nº1
How often do you receive D/c orders by 10am?
60
55
50
45
40
35
30
25
20
15
10
5
0
All the Time
50% of Time
25% of Time
10% of Time
Never

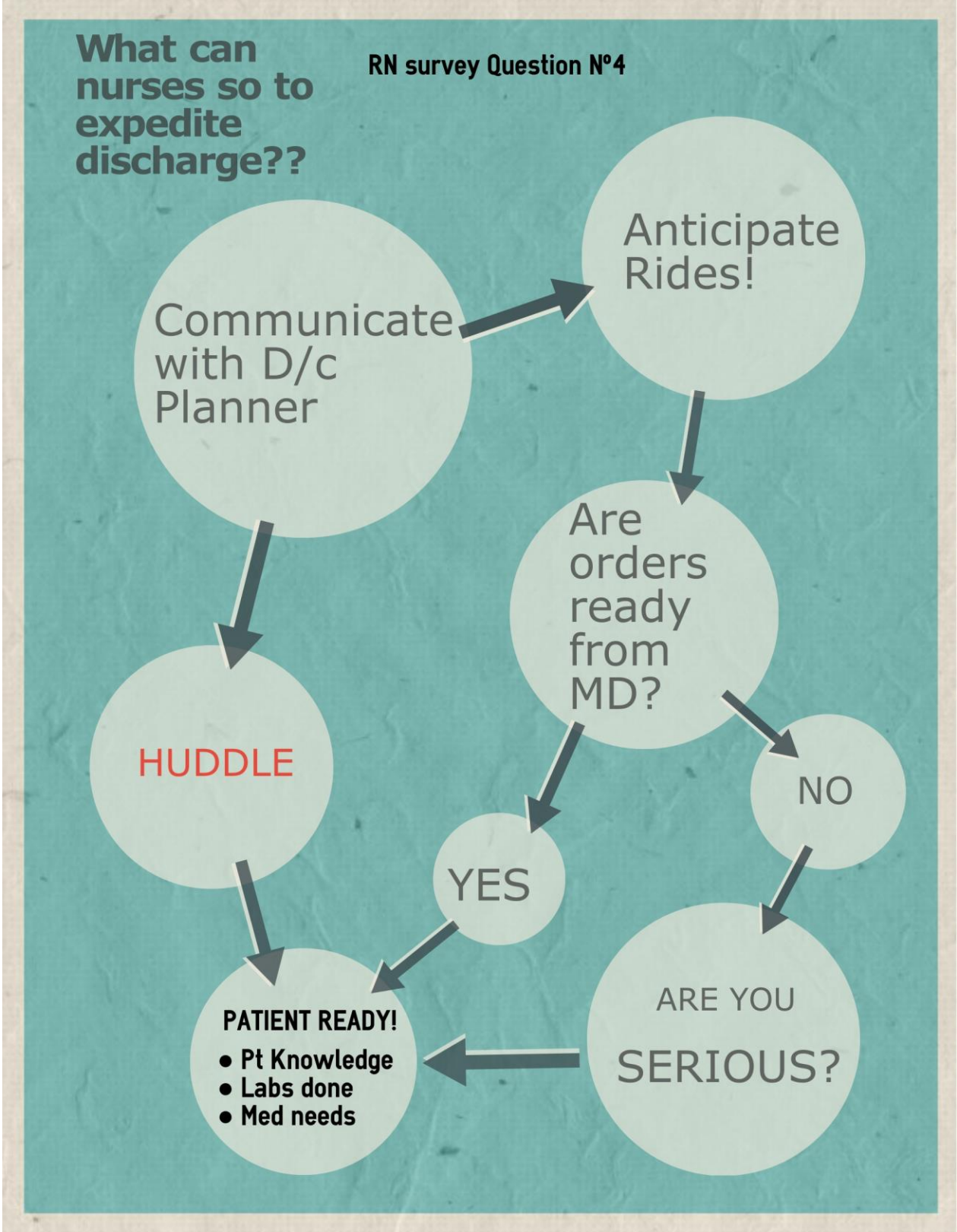
Appendix H-2


What is the largest barrier to discharge?
RN Survey Question N°2
31% Medication Needs
52% Ride Home
26% Equipment Needs
21% other reasons

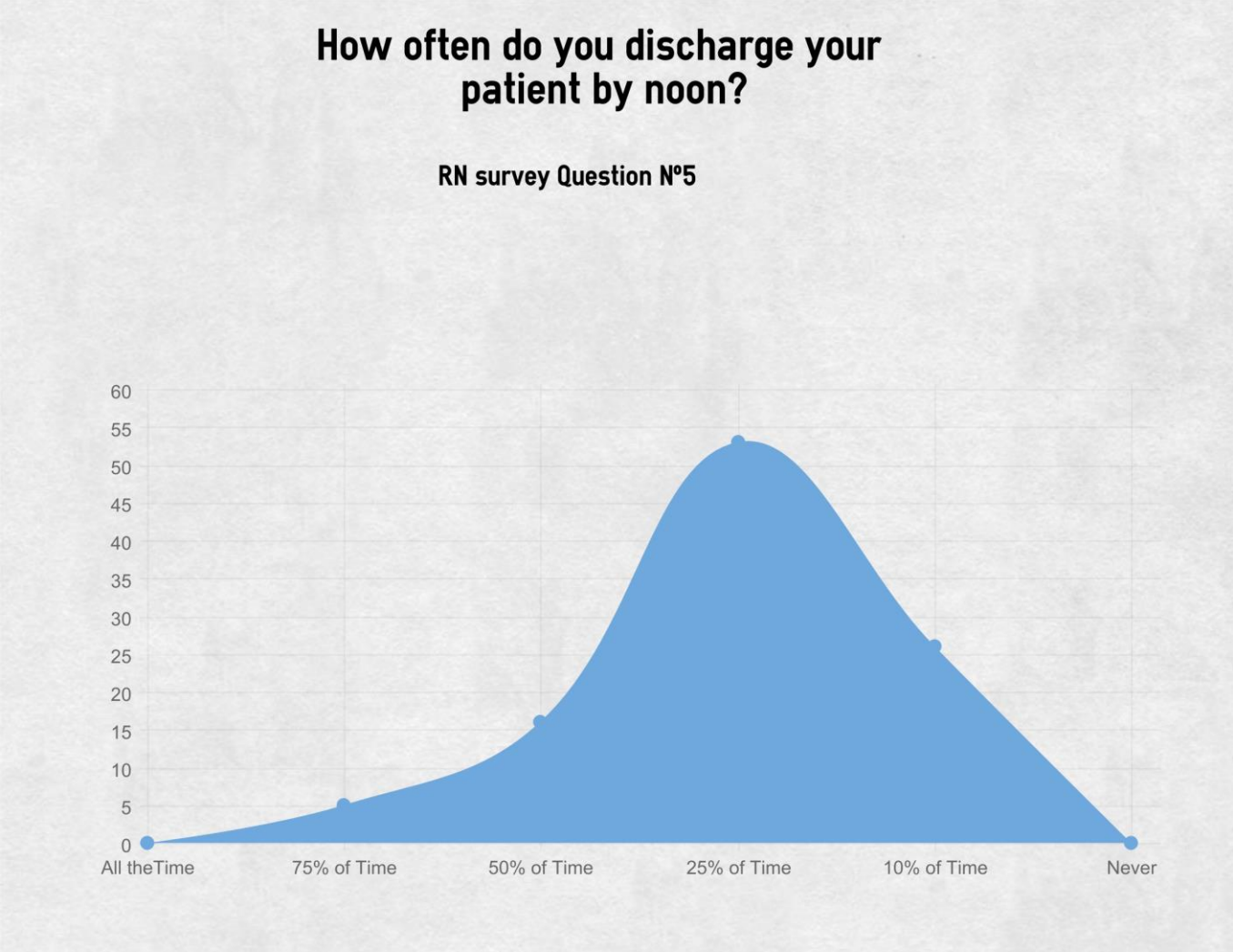
Appendix H-3


Do you feel all aspects of discharge are addressed by the time the patient is ready to leave hospital? If not what can we do to help?
RN survey Question #3
Yes and Maybe Results
RN needs to be more proactive
Nº 1
situational
Nº2
Rides
Nº3
Suggested Needs
58%
NO
Results
Answered Yes
Answered Maybe
11%
31%
Answered No
58%
1. RNs suggest that one major need is to start education process early, or teach in advance!
2. Second major suggestion from RN was to make sure all of pt questions are answered by MD and DME is communicated to D/Cplanner
Planning for discharge from the hospital should begin early in each patients stay and focus on the patients needs!!

Appendix H-4


What can nurses so to expedite discharge??
RN survey Question N°4
Anticipate Rides!
Communicate with D/c Planner
Are orders ready from MD?
HUDDLE
NO
YES
ARE YOU SERIOUS?
PATIENT READY!
• Pt Knowledge
• Labs done
• Med needs

Appendix H-5


How often do you discharge your patient by noon?
RN survey Question N°5
60
55
50
45
40
35
30
25
20
15
10
5
0
All theTime
75% of Time
50% of Time
25% of Time
10% of Time
Never

Appendix I

ARE YOU DISCHARGING SOON???

H **How are you getting home, Do you have a ride?**

O **Ongoing care/ follow-ups scheduled?**

M **Medication education/ordered/co-pay?**

E **Equipment needs/support at home?**

By answering these questions your transition to home will be more successful for you! If you have any questions please ask your nurse or discharge planner.

All discharges are expected by 12 noon!

Appendix J

Huddle Nursing Checklist

The following checklist is designed as an example of items to be considered by nursing staff. This checklist should start on admission and includes items that will help to facilitate discharges in a timely manner in conjunction with the huddles. This program can only be successful through our nurse's efforts at the bedside and charge nurses support.

NURSING DISCHARGE CONSIDERATIONS:

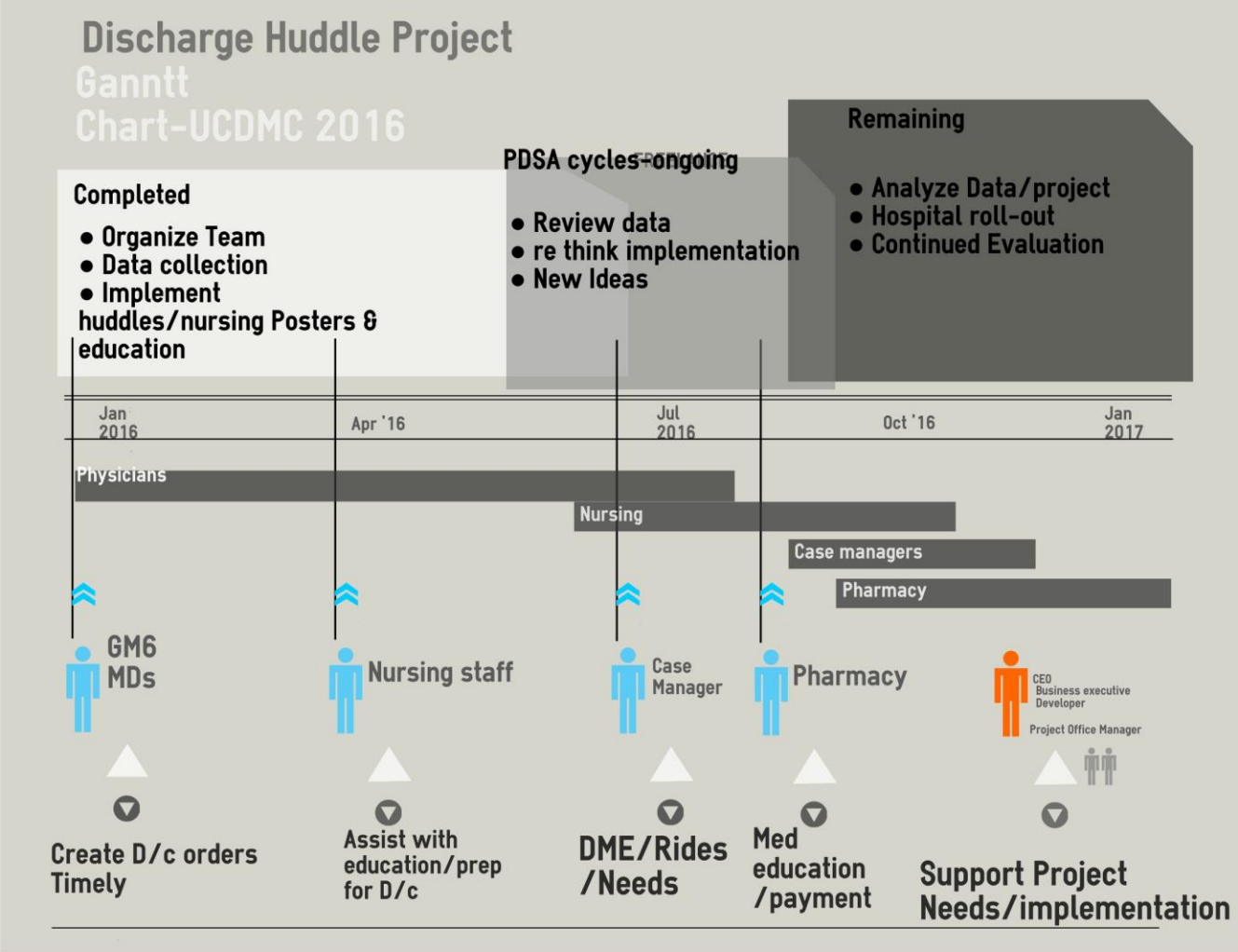
- ☐ Arrange time for education sessions based on learning assessment prior to d/c day
- ☐ Meet with your nursing team frequently to insure labs, procedures, and orders are completed on time
- ☐ Determine discharge needs early (day before, early in the am) such as: rides, medication, transition of care pharm, discharge planner, PT/OT etc
- ☐ Discuss the plan with patient and family so that all questions are answered prior to d/c, make them feel comfortable/safe about discharge
- ☐ Consider the flow of the hospital –RN supervisor communication, bed control, etc. Be proactive in discharging out of unit manager, and admitting patients.
- ☐ Create a positive relationship with MD, and nurses to encourage discharges to be complete in a timely manner.

COMMUNICATION WITH THE NURSES:

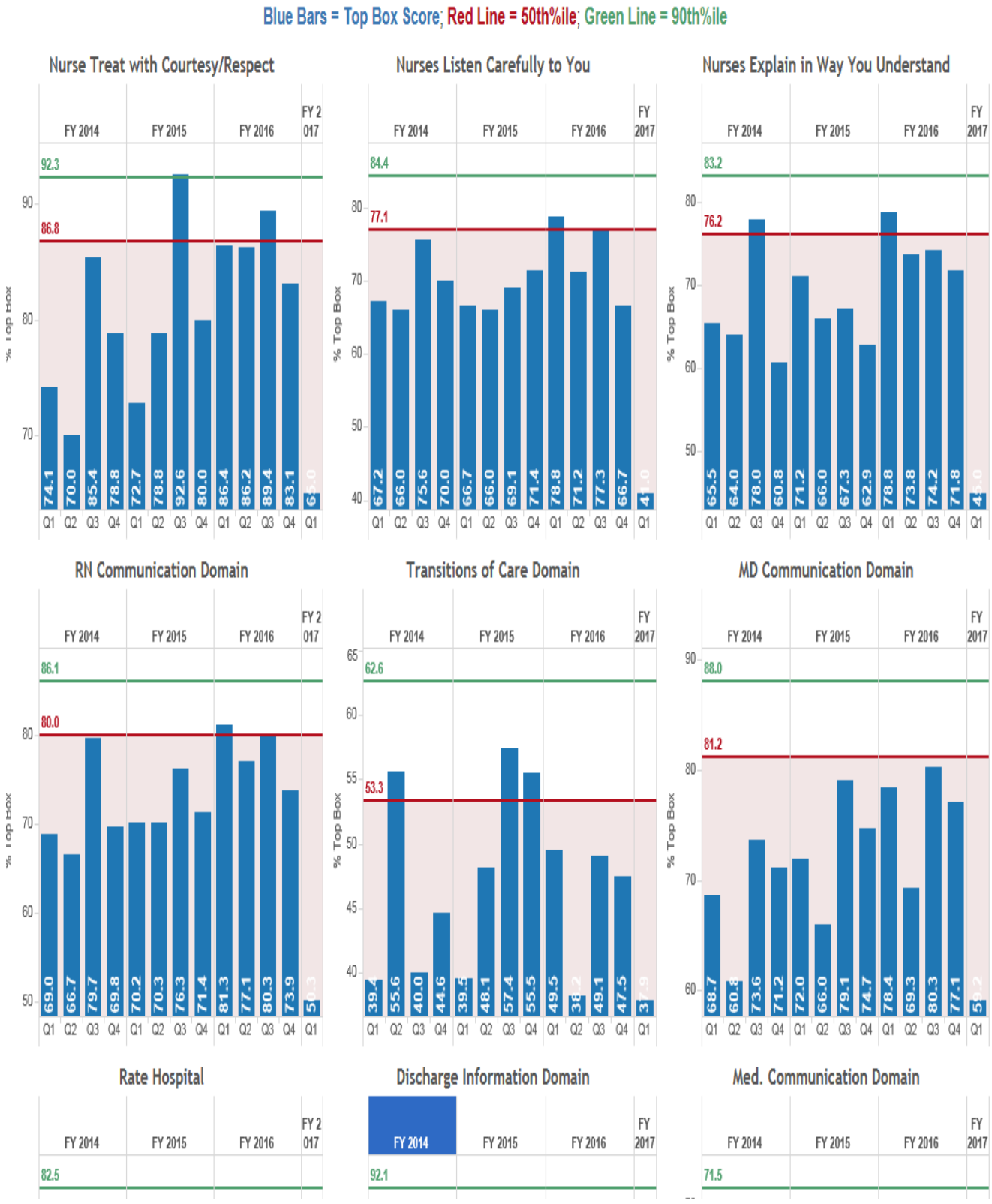
No one like to get new patients but consider the patient and their needs such as:

- Getting home early before dark
- Picking up medications before next dose is due
- Home needs prior to closing time of businesses

Appendix K


Discharge Huddle Project
Ganntt
Chart-UCDMC 2016
Completed
• Organize Team
• Data collection
• Implement huddles/nursing Posters & education
PDSA cycles-ongoing
• Review data
• re think implementation
• New Ideas
Remaining
• Analyze Data/project
• Hospital roll-out
• Continued Evaluation
Jan 2016
Apr '16
Jul 2016
Oct '16
Jan 2017
Physicians
Nursing
Case managers
Pharmacy
GM6 MDs
Nursing staff
Case Manager
Pharmacy
CEO
Business executive Developer
Project Office Manager
Create D/c orders Timely
Assist with education/prep for D/c
DME/Rides /Needs
Med education /payment
Support Project Needs/implementation

Appendix L


Blue Bars = Top Box Score; Red Line = 50th%ile; Green Line = 90th%ile
Nurse Treat with Courtesy/Respect
92.3
86.8
74.1 70.0 85.4 78.8 72.7 78.8 92.6 80.0 86.4 86.2 89.4 83.1
Nurses Listen Carefully to You
84.4
77.1
67.2 66.0 75.6 70.0 66.7 66.0 69.1 71.4 78.8 71.2 77.3 66.7
Nurses Explain in Way You Understand
83.2
76.2
65.5 64.0 78.0 60.8 71.2 66.0 67.3 62.9 78.8 73.8 74.2 71.8
RN Communication Domain
86.1
80.0
69.0 66.7 79.7 69.8 70.2 70.3 76.3 71.4 81.3 77.1 80.3 73.9
Transitions of Care Domain
62.6
53.3
55.6 40.0 44.6 48.1 57.4 55.5 49.5 49.1 47.5
MD Communication Domain
88.0
81.2
68.7 73.6 71.2 72.0 66.0 79.1 74.7 78.4 69.3 80.3 77.1
Rate Hospital
82.5
Discharge Information Domain
92.1
Med. Communication Domain
71.5
FY 2014
FY 2015
FY 2016
FY 2017
% Top Box