Re-engineered Hospital Discharge Program (RED)

MacKenzie Bammer, Hayley Carlson, Morgan Roberts, Moriah Wittenberg
Michelle Van Wyhe, DNP, ARNP-BC
Department of Nursing, Northwestern College

Introduction

Between September 2020 and November 2020, an extensive literature review was done to determine how discharge education among medical-surgical patients can be improved. Results showed that there should be an introduction of discharge education from the start of a patient's admission. Further, there needs to be greater understanding of specific roles within discharge and utilization of discharge material so as to improve patient satisfaction and self- perceived readiness for discharge. All efforts need to be placed to ensure that patients receive the best quality care and are not readmitted within 30 days of discharge.

Clinical Question

What method of education among patients being discharged from the hospital is most useful in preventing readmission?

Project Integration

Population: General patients within the medical-surgical unit

Impact on Population:

- Patients receive the optimal discharge education and are able to retain information
- Health outcomes of patients are improved faster
- Patient and families are more integrated in patient's care
- Decreased costs due to decreased readmissions
- Increased patient satisfaction in hospital performance and discharge

Results

- The results from the research is that through the Re-engineered Discharge (RED) process, the flow of communication among staff members is improved and patients are better able to retain their discharge education from the start of admission
- A health educator role provides consistent patient education and coordination with an interdisciplinary team approach
- An After-Hospital Care Plan helps reiterate education after patient's stay at hospital
- Post-discharge phone calls are proved to be effective in helping reinforce the patient's discharge plan, follow-up appointments and medications
- Overall, there are decreased readmission rates and decrease hospital costs per patient

Statistics

- Project RED
  - decrease by 30% of patient readmissions within 30 days of discharge (Jack et al., 2009)
  - Saved $412 per patient discharged (Jack et al., 2009)
- Interdisciplinary approach:
  - Decrease from 17.8% to 12.3% of patient readmissions (Aniemeke, 2017)
  - This approach saved $67,804 within 6 weeks (Lingle, 2013)
- Follow-up phone assessments
  - Only 5% of patients readmitted within 30 days who fully participated in follow-up phone calls (Olsen et al., 2016)
  - Unreached patients were 2x more likely to be readmitted (Olsen et al., 2016)

Proposed Interventions

Patient's admission: discharge education begins right away

- Patient's history and assessment gathered
- Ascertain for language assistance
- Medication reconciliation
- Assess for need of Home Health Care after discharge

Nurse receives patient

- Nursing assessment and social services assessment
- Patient's plan of care begins, referrals initiated
- After-Hospital Care plan

Patient education process

- Written educational material provided
- Reassessment of referrals
- Discharge planning meeting

At discharge

- Medication reconciliation
- AHCP completed and given to patient
- Transition of discharge summary to PCP before discharge
- 48-96 hour post-hospital discharge phone call received

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