Discharge checklist and follow-up phone calls: the foundation to an effective discharge process

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Centura Health®

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DISCLOSURES

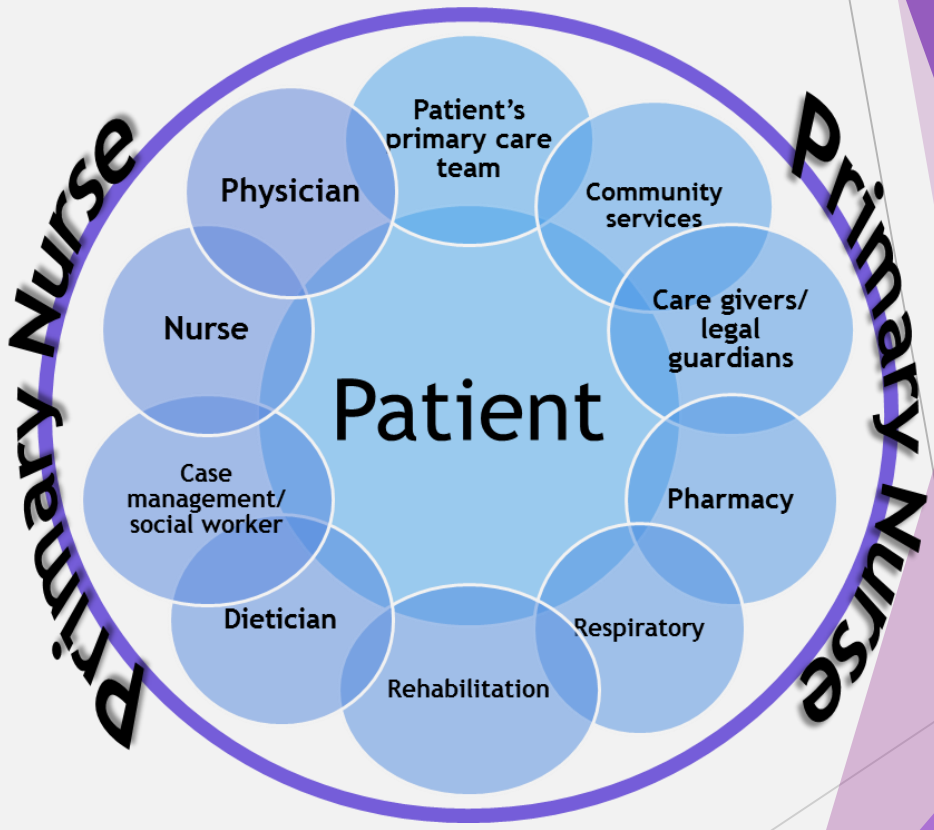
- Speakers have no conflicts of interest to disclose

OBJECTIVES

- At the end of this presentation the learner will be able to:
  - Utilize tools to promote the safe discharge and transition of patients to their next level of care
  - Implement a discharge process including:
    1. Discharge checklist
    2. Discharge follow-up phone calls
    3. Tools for monitoring the above

INTRODUCTION

- Discharging a hospitalized patient is a complex process that requires essential documentation and communications between multiple disciplines



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BACKGROUND

- Nearly 1 in 5 Medicare patients are readmitted related to the following contributing factors:
  - Delay in transfer of discharge summary
  - Test results unknown
  - No follow-up
  - Medications not being reconciled correctly (Jack et al., 2013).
- Hospitals are reimbursed for performance on quality measures – including readmissions (Centers for Medicare and Medicaid Services (CMS), 2015)
- With such complexity there are many opportunities for breakdowns in communication that can endanger patient safety and increase hospital readmissions (Jack, Paasch-Orlow, Mitchell, Forsythe, & Martin, 2013
- Hospitals must comply with the Colorado Patient Caregiver Designation Hospital Requirement & meet the CMS Discharge Planning Conditions of Participation (CoP)

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PURPOSE

- Opportunities were identified to:
  - Improve process to promote safe discharge
  - Comply with Designation of Caregiver State of Colorado Law and CMS Conditions of Participation (CoP)
  - Clarify and set expectations for required activities and documentation at discharge
  - Follow-up with patients post discharge

SETTING

- Parker Adventist Hospital
- 170-bed Community Hospital
- Magnet Facility
- Implemented on Acute Care Units:
  - Med / Surg
  - Cardiac Med / Onc
  - Neuro / Joint / Spine
  - ICU
  - OB

DESIGN / METHODS

- Plan Do Study Act (PDSA) design:
  - Trial of discharge process checklist
  - A pilot project of RNs making follow-up discharge phone calls started on the cardiac / medical / oncology unit in April 2016
  - Patients discharged to home were called within 48 – 72 hours

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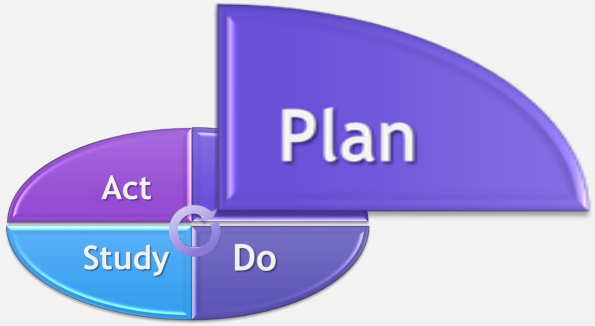
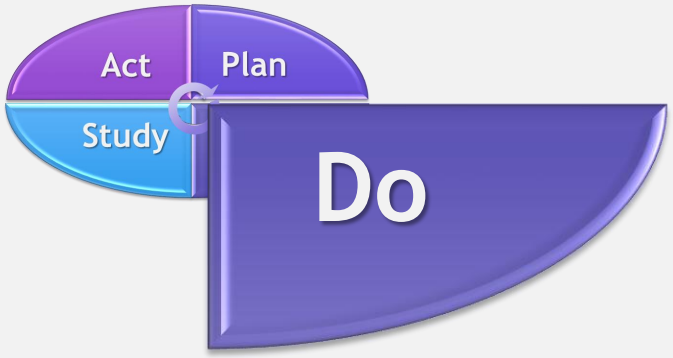
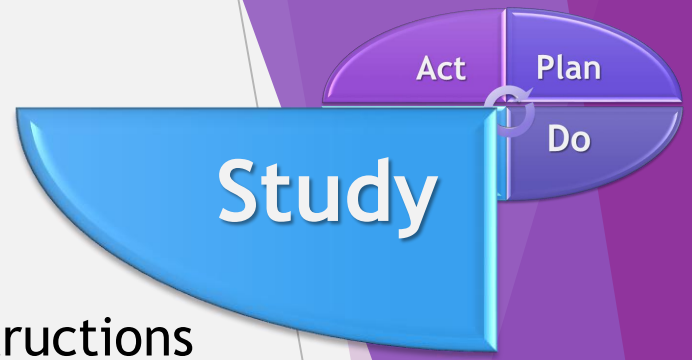


- The Discharge Process and Documentation Checklist was developed using evidenced-based components from AHRQ's RED Toolkit and included a team of the following:
  - Chief Nursing Officer
  - Directors
  - Managers
  - Case Management
  - Direct Patient Care RNs
- All inpatient RNs were provided with:
  - A list of responsibilities to discharge patients
  - Online and in-person training on using the Discharge Checklist



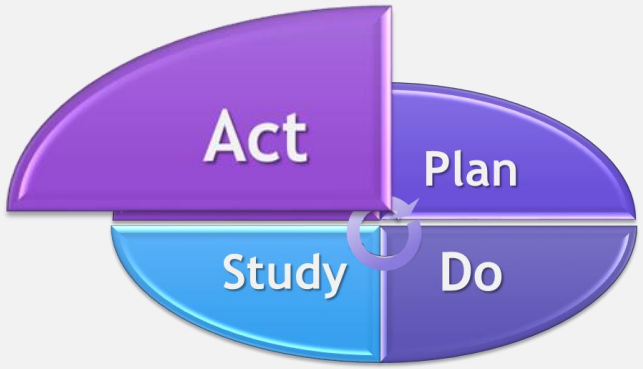
- Discharge Process and Documentation Checklist Education:
  - Train the Trainer
  - Inpatient nurses completed an online learning module
- Checklist implemented in all inpatient units
- The Discharge Checklist was incorporated into practice with concurrent monitoring by Assistant Nurse Manager (ANMs), unit charge RNs, resource nurses and super users
- An audit tool was created to monitor compliance of complete discharges and discharge checklists



- Phase I Revisions:
  - Write out any abbreviations physicians placed in discharge instructions
  - Tip added on where to document home oxygen
  - Space was created to list findings, feedback, and barriers encountered
- Phase II Revisions:
  - A new EMR go-live created need to update the checklist to match
- Phase III Revisions:
  - Incorporation of nursing feedback
  - Updated to match the flow within discharge process navigator in new EMR

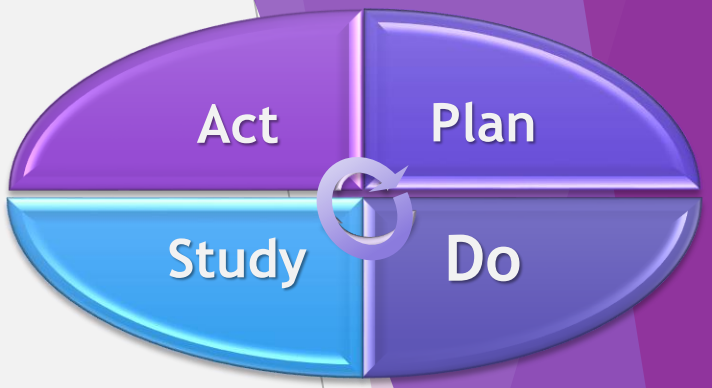
The checklist was decreased from three pages to one double sided copy!!

(The back page contained references, tips and hints, and space to identify barriers encountered)



- The Discharge Process and Documentation Checklist was rapid cycled six times to adequately meet its purpose
- The checklist is still in use today and work continues to be done to improve upon the checklist
- Education on checklist built into RN orientation
- Focus Study created in Midas that attaches directly to the patient record and allows discharge nurses to track follow-up

DESIGN / METHODS



- Plan Do Study Act (PDSA) design:
  - Plan:
    - Developed follow-up phone call questions and methodology to capture collected information (Midas)
  - Do:
    - Discharge resource RN initiated pilot project to call cardiac medical oncology patients beginning in May 2016
  - Study:
    - Process worked well, very positive patient feedback
    - Process changed made based on information gained
    - Phone calls expanded to other discharging units
  - Act:
    - Sustained follow-up calls
    - Enhancements to DC process continue

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DISCHARGE FOLLOW-UP PHONE CALLS

Patients discharged to home called within 48 to 72 hours following discharge

- Script was created
- Data collected to track and trend patient needs and feedback that included:
  - How the patient was feeling including symptoms related to their admit / discharge diagnosis
  - Medications
    - Whether prescriptions are filled
    - Questions about the medication
    - Whether the medications match the discharge instructions
    - Review of high risk medications (i.e. blood thinners)
    - For patients discharged with lines / tubes – review of care for these items
  - Whether patient has made their follow-up appointments
  - Review of available transportation to appointments
  - Additional questions for patients with a diagnosis of heart failure:
    - Questions about daily weights / blood pressure and the opportunity to speak with a heart failure clinical nurse specialist
  - Additional questions for surgical patients:
    - Prescriptions filled
    - Status of incision/wound
    - Follow-up regarding surgery

Discharge Audit Phone Calls

Initial Call Date: 10/18/2017

Second Call Date:

Third Call Date:

Able to Contact? (•) Yes ( ) No

Discharge Deficiencies:

Intervention Done:

Duration of Call (in minutes):

Dispatch information given? ( ) Yes ( ) No

Was the patient readmitted since their last discharge? ( ) Yes ( ) No

Readmission date:

ED Visit since their last discharge? ( ) Yes ( ) No ( ) Unknown (•) <blank>

Return ED Visit Date:

Saved Admission/Readmission? ( ) Yes ( ) No

Was this a Bariatric Patient? ( ) Yes ( ) No

Was this an AMI Patient? ( ) Yes ( ) No

Was this a Stroke Patient? ( ) Yes ( ) No

Was this a Heart Failure Patient? ( ) Yes ( ) No

Was this a Saved ER Vist? ( ) Yes ( ) No

Was this patient admitted because of COPD Exacerbation? ( ) Yes ( ) No

Was this a Pneumonia Patient? ( ) Yes ( ) No

Was this patient seen by discpatch health? ( ) Yes ( ) No

Comments:

Midas Focus Study

Recognition

Frequent Communication

Reply Reply All Forward IM

Storie, Stephanie /CE PKR Medical/Surgical; + 4

FW: Readmissions by Discharging Unit through December DOWN...

Dear Team,

I want to congratulate you all for your dedicated, hard work with the Discharge Checklist Process!!! Your persistence in providing patients with the proper discharge care, education, and instructions has greatly paid off as evidenced by the decrease in readmission rates!

Average readmission rate for the three acute care units from January to October was **5.5%**

- November was **3.2%** - 41.8% decrease
- December was **2.4%** - 56.36% decrease

You are truly doing what is best for our patients and making an incredible difference!

Reply Reply All Forward IM

Storie, Stephanie /CE Parker Cardiac/Stroke; + 1 12/28/2016

Discharge process audits through 12-25 - 12-28

Dear Team,

I am pleased to tell you all there were ZERO fallouts from the discharges audit 12/25-12/28!!! Congratulations to you all for your hard work and dedication!!!

Keep up the great work!!!

Discharge Process & Documentation Checklist

Date: _____ **Room #:**_____ **Discharging to:** ☐ SNF/Acute Rehab/Jail (place patient label here)
Discharging Doctor:_____
Discharging RN *(print name)*: _____ **Charge/Resource RN Name:**_____

INSTRUCTIONS: Write all pt. instructions at 5th grade level and avoid using medical abbreviations. Discharging RN is responsible to complete each section of the checklist. Prior to discharging the patient, hand checklist to the Charge Nurse/Resource RN so they can verify all bolded sections.

Yes	N/A	Prior to discharge:
		☐ Vaccine screening complete? ☐ Vaccines offered & administered or refusal documented?
		Home Pharmacy Information is present & correct? If not, add correct pharmacy.
		O2 assessment of post discharge oxygen needs completed and documented e.g., *room air trial*
		Verify home oxygen set up by RT in Miscellaneous Orders ☐ paperwork signed & in chart
		☐ Physician Discharge order complete ☐ MD post hospital discharge order present for SNF/HHC Discharge orders to include whether to keep or discontinue items below: ☐ Port (access or deaccess) ☐ PICC ☐ Peripheral IV ☐ On Q Pump ☐ Foley ☐ Drains
		Pt Legal Representative/ Designated Caregiver **☐ notified of d/c plan within 24 hours prior to patient leaving hospital** **☐ notification documented under Transition Readiness in the Discharge Navigator**
		☐ Communication Needs Documented ☐ Belongings & home meds returned to pt. & documented
		Devices (*IVs, drains. Foleys, etc.*) ☐ Documented as removed or left in
		Wound Resolution Resolved
		****Safe Handover** (click on "Report" button)- **Document:** ☐ Name of receiving facility (including jail) ☐ Name of RN receiving report ☐ Summary of topics covered
		Medication Details: document **general indication** for meds & when **next doses due** on all meds
		ALL types of discharge orders include & address: (*If order not present, call physician for telephone orders*) **☐ Activity & restrictions ☐ Diet ☐ Follow up Provider ☐ Home O2 Eval (Face-to-Face is done by RT)**
		**Wound care - document location & appearance of & types of wound/incisions *e.g., puncture & drain sites*
		For Home Disposition Only - AVS Summary: Educational handouts printed include: ☐ Pt. diagnosis ☐ New meds ☐ Coumadin/Vit K (if given Coumadin) ☐ Wound care ☐ Drain mgmt. ☐ IV lines ☐ Oxygen
		Prescriptions printed with correct patient name? Verify in AVS: ☐ E-scripts ☐ paper scripts
		***Patient &/or designated caregiver education documented under Transition Readiness:** **☐ Accurate Teach Back documented AFTER education provided to pt &/or caregiver** **☐ Education Resolved**
		Care Plan: all problems must be documented as "adequate for discharge"
		Patient discharge instructions ☐ e-signed ☐ paper signed? *Verify →Media → AVS Summary report*
		In "AVS Given to," document the individual(s) who received the printed AVS *e.g., spouse, ambulance, etc.*
		Nursing Note: Use for any final documentation regarding discharge if needed.
		Core Measures Checklist completed ☐ CVA ☐ CHF ☐ Refer to DVT/VTE Algorithm **Make sure core measures are documented under "Education" with accurate teach back** *(if needed)*
		Discharge VS measured within 30 minutes of pt. departure and documented in "Vital Signs"
Yes	**N/A**	**PICC Line Specific Instructions**
		PICC care set up through ☐ RMID ☐ PKR Infusion Center ☐ Home Health Don't D/C patient until: a. RMID or PKR Infusion Center has set up an appt. with pt. b. Home Health arrangements have been made for IV home infusion c. DO NOT SEND patients home with IV antibiotic paper prescriptions. *The name and the dose of the IV antibiotic DOES need to be listed on the discharge med list!*

Discharge Tips:

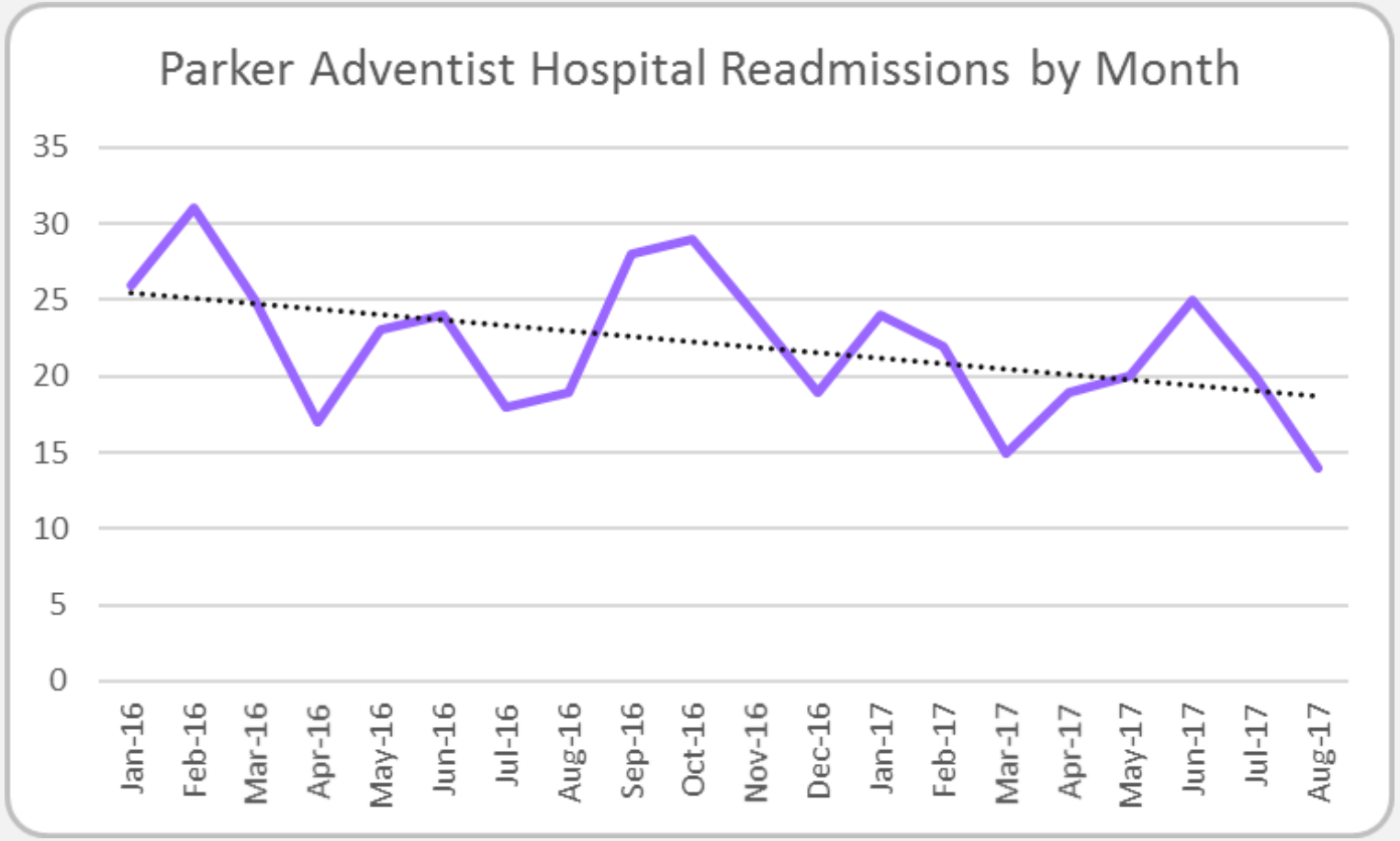
☐ Verify diet, activity and follow-up instructions are present, or get telephone order from MD. It is ok for RN to enter information per MD telephone order into approved header if MD has not addressed.
☐ Attach Diagnosis/Medications handouts, found under "Discharge Instructions/Attachments," then click on "Reference/Attachments."
☐ **"Miscellaneous orders" Document wound/Incision/Foley/PICC/On Q pump care instructions here. Wounds/Incision: Describe location & condition of wound; spell out instructions in text box.
☐ "Discharge Instructions" - note any further instructions, (ex. when to call the MD).
☐Print the AVS, review with Pt/family member/designated caregiver/legal guardian.
☐*Document in Discharge Navigator under "Transitions Readiness" that the legal Guardian and if patient has a Designated Caregiver have been made aware of Pt being discharged. **The patient's guardian MUST be notified PRIOR to any discharge or transfer to a facility – before the patient physically leaves our hospital property.** Document all attempts made to contact legal guardian and designated caregiver.
☐ ONLY *Document teach back after teach back has been completed. File education; click all 5 boxes and "Resolve for discharge"*

M1 transfers:
☐ Original M1 ☐ Original patient's rights ☐Personal belongings returned from security
☐ DC Transition Report

Required Items for Discharge to Various Discharge Dispositions:

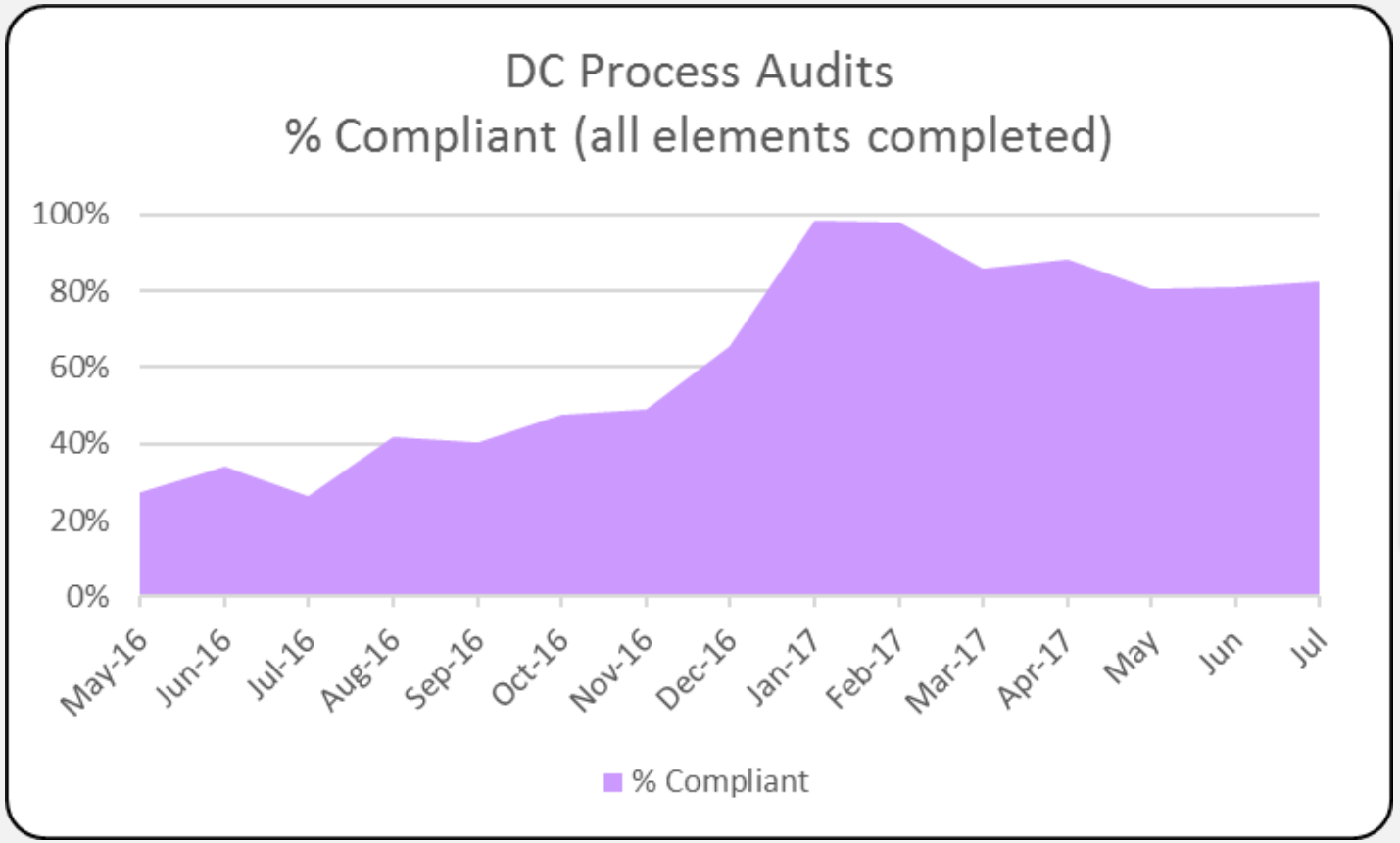
Disposition	AVS to Home	Post-hospital DC Instructions	DC Transition Report	Call Report	New scripts	Narcotic scripts
Home, ALF - if pt. administers own meds *including pts d/c'd to home but who are driving themselves to Parker Valley Hope	X				X	
Home w/ HH	X	X			X	
SNF, LTACH, Jail, Inpt Hospice, Inpt Psych, LTC, NH, IRF, ALF - if ALF will administer pt's meds		X	X	X	*DC to Jail only	X
Non-Centura Acute Care Hospitals			X	X		
Home w/ Hospice	X	X			X	
Departing via ambulance to: • **Home w/ HH** • **Home w/Hospice** • **Parker Valley Hope**	X	X	X (for ambulance)		X	
Centura Acute Care Inpt or Rehab status (LAH & PAH only)		X *Can also send DC Summary if available*		X		

RESULTS



13.1% decrease in readmissions from January to August compared to the same time frame in 2016.

RESULTS



- Nursing documentation compliance increased dramatically since training
- Overall compliance several months later, continues to be over 80%

From May 2016 to July 2017 almost 2500 patients were contacted

RESULTS

Breakdown of Calls Made	
Total Pts Contacted	991
Total Pts NOT Reached	496
Total Pts Called	1487
Phone Calls Made (1st, 2nd and 3rd)	1386

Average Number of Days from Discharge to Contact	
1st Call	4.81
2nd Call	6.72
3rd Call	7.54

Top 10 Principal Diagnosis of Patients Contacted		
	N	% of Grand Total
Morbid (severe) obesity due to excess calories	92	9.28%
Sepsis, unspecified organism	54	5.45%
Other chest pain	33	3.33%
Chest pain, unspecified	30	3.03%
Syncope and collapse	21	2.12%
Unspecified acute appendicitis	16	1.61%
Pneumonia, unspecified organism	15	1.51%
Calculus of GB w acute and chronic cholecyst w/o obstruction	15	1.51%
Other pulmonary embolism without acute cor pulmonale	14	1.41%
Non-ST elevation (NSTEMI) myocardial infarction	12	1.21%

RESULTS

Breakdown of Opportunities	
No PCP F/U Appt. Made	50
No Specialist F/U Appt. Made	23
No Wound Site Documented	9
Scripts Not Filled/Picked Up	9
No PICC/IV Instructions	8
No Wound/Incision Instructions	6
No PCP F/U Appt. MadeNo Specialist F/U Appt. Made	6
No Wound Site DocumentedNo Wound/Incision Instructions	5
No Med H/O	4
No Education H/O	3

Top 10 Interventions Done	
Reinforced D/C Instructions	148
Med Instructions Given	48
Instructed to Make F/U Appt. with Specialist	41
Other - See Comments	39
Instructed to Make F/U Appt. with PCP	23
Med Instructions GivenReinforced D/C Instructions	22
Wound/Incision Instructions Given	14
Instructed to Make F/U Appt. with PCPReinforced D/C Instructio	7
Oxygen Teaching Given	6
Gave PCP InformationMed Instructions GivenReinforced D/C Ins	5

Discharge Opportunities:

- 828 (83.5%) patients did not have any discharge deficiencies
- 163 (16.5%) patients had discharge deficiencies

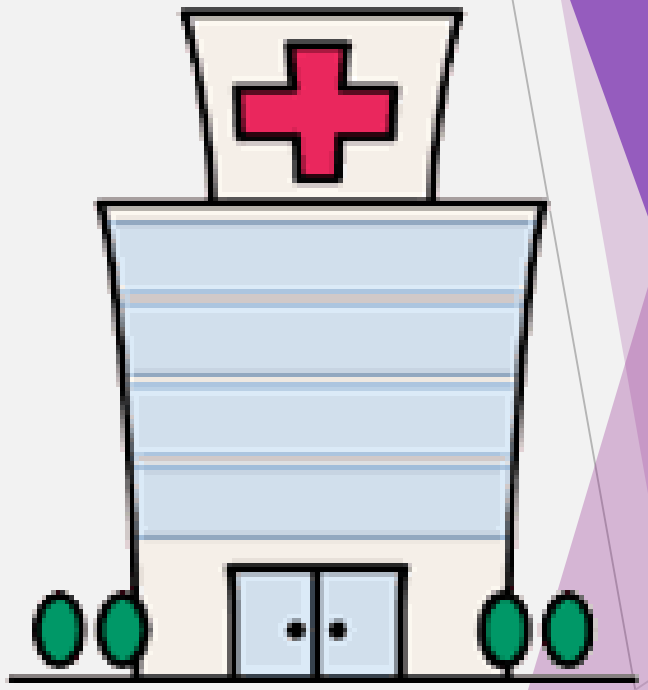
Interventions Done:

- 413 (41.6%) did not have any interventions
- 578 (58.4%) did have interventions

RESULTS

Patient contact facts:

- Average number of minutes / call: 5.48 minutes
- Range: 1 minute to 30 minutes
- Mode: 2 minutes (20.94%); 3 minutes (22.51%)
- 3.95% (n=37) were given Dispatch Health contact information
- 1.09% (n=10) of patients contacted were readmitted
- 4.16% (n=39) of patients had an ED visit
- < 1% (n=3) were saved from being readmitted



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