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

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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
Discharging a hospitalized patient is a complex process that requires essential documentation and communications between multiple disciplines.
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)
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
Parker Adventist Hospital
170-bed Community Hospital
Magnet Facility
Implemented on Acute Care Units:
- Med / Surg
- Cardiac Med / Onc
- Neuro / Joint / Spine
- ICU
- OB
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
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.
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
**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
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!

Keep up the great work!!!

Congratulation's!
### Discharge Process & Documentation Checklist

**Date:**
**Room #:**

Discharging to: □ SNF/Acute Rehab/Jail (please 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

- Vaccination complete?
- Vaccines offered & administered or refusal documented?
- Home Pharmacy Information present & correct? If not, add correct pharmacy.
- O2 assessment of post discharge orders completed and documented e.g., room air trial
- Verify O2 home setup 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
  - Goga 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, Foley, etc.) √
- Documented as removed or left in

**Wound Resolution Resolved**

- ***Safe Handover (click on "Report" button)*** Documents:
  - Name of receiving facility (including as ID)
  - 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)

- **C/IC & restrictions:** [if available] 
  - Follow up Provider
  - Home O2 Trip (√, Face-to-Face only by RT)

- **Wound care - document location & appearance & types of wounds/incisions e.g., puncture & drain sites**

- **For Home Disposition only - AVS Summary:** Educational handouts printed include:
  - Pt. diagnosis
  - New meds
  - Coumadin/K.Ca拮抗剂
  - 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 √ signed & paper signed? Verify DHCP √ 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"

**PICC Line Specific Instructions**

- PICC care set up through □ RMID □ PKR Infusion Center □ Home Health

- Don’t Q/C patient until:
  - a. RMID or PKR Infusion Center has set up an app’t tr 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 DOSE need to be listed on the discharge notes

### 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 handout, found under "Discharge Instructions/Attachments," then click on "Reference/Attachments."
- "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 off 5 boxes and “Reserve 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:

<table>
<thead>
<tr>
<th>Disposition</th>
<th>AVS to Home</th>
<th>Post-hospital DC Instructions</th>
<th>DC Transition Report</th>
<th>Call Report</th>
<th>New scripts</th>
<th>Narcotic scripts</th>
</tr>
</thead>
</table>
| Home, ALF - if pt. administers own meds
  *including pts living at home but who are driving themselves to Parker Valley Hosp* | X | | | | | |
| Home w/ HM | X | X | X | | | |
| SNF, LTACH, Jail, Hospice, Hosp, Psych, LTC, SNF, IRF, ALF - if ALF will administer meds Non-Centura Acute Care Hospitals | X | X | X | | | |
| Home w/ Hospice | X | X | | | | |
| Departing via ambulance to: | X | X | | | | (for ambulance)
  - Home w/ HM
  - Home w/Hospice
  - Parker Valley Hosp
  - Centura Acute Care (pts or Rehab status (LAA & PAM 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

### Average Number of Days from Discharge to Contact

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Call</td>
<td>4.81</td>
</tr>
<tr>
<td>2nd Call</td>
<td>6.72</td>
</tr>
<tr>
<td>3rd Call</td>
<td>7.54</td>
</tr>
</tbody>
</table>

### Top 10 Principal Diagnosis of Patients Contacted

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

### Breakdown of Calls Made

<table>
<thead>
<tr>
<th>Category</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Pts Contacted</td>
<td>991</td>
</tr>
<tr>
<td>Total Pts NOT Reached</td>
<td>496</td>
</tr>
<tr>
<td>Total Pts Called</td>
<td>1487</td>
</tr>
<tr>
<td>Phone Calls Made (1st, 2nd and 3rd)</td>
<td>1386</td>
</tr>
</tbody>
</table>
RESULTS

<table>
<thead>
<tr>
<th>Breakdown of Opportunities</th>
<th>Top 10 Interventions Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>No PCP F/U Appt. Made</td>
<td>Reinforced D/C Instructions</td>
</tr>
<tr>
<td>No Specialist F/U Appt. Made</td>
<td>Med Instructions Given</td>
</tr>
<tr>
<td>No Wound Site Documented</td>
<td>Instructed to Make F/U Appt. with Specialist</td>
</tr>
<tr>
<td>Scripts Not Filled/Picked Up</td>
<td>Other - See Comments</td>
</tr>
<tr>
<td>No PICC/IV Instructions</td>
<td>Instructed to Make F/U Appt. with PCP</td>
</tr>
<tr>
<td>No Wound/Incision Instructions</td>
<td>Med Instructions Given Reinforced D/C Instructions</td>
</tr>
<tr>
<td>No PCP F/U Appt. Made No Specialist F/U Appt. Made</td>
<td>Wound/Incision Instructions Given</td>
</tr>
<tr>
<td>No Wound Site Documented No Wound/Incision Instructions</td>
<td>Instructed to Make F/U Appt. with PCP Reinforced D/C Instructions</td>
</tr>
<tr>
<td>No Med H/O</td>
<td>Oxygen Teaching Given</td>
</tr>
<tr>
<td>No Education H/O</td>
<td>Gave PCP Information Med Instructions Given Reinforced D/C Ins</td>
</tr>
</tbody>
</table>

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
Contact Information

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QUESTIONS