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I.D.E.A.L. Transition Plan

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I.D.E.A.L. Transition Plan
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Purpose Statement
The purpose of this evidence based practice project is to increase the number of discharges prior to noon by using the IDEAL discharge planning tool with noncomplex total joint replacement patients and maintaining score of discharge phone call follow up: “Were you aware of your discharge plans and felt prepared?”

Synthesis of Evidence

IDEAL MODEL - Discharge from hospital to home requires the successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions. Engaging patients and families in the discharge planning process helps make this transition in care safe and effective. Transitions From Hospital to Home: IDEAL Discharge Planning highlights the key elements of engaging the patient and family in discharge planning:

1. Describe what life at home will be like
2. Educate the patient and family in plain language about the patient’s condition, and next steps in the patient's care to the patient and family
3. Highlight warning signs and challenges
4. Explain test results
5. Make follow-up appointments

EBP Practice Change

Day of Admission

Identify caregiver and include in conversations:
- Plan (LOS)
- Education
- Discharge goals
- Discharge process

Teach and complete My Care Board

Verify preferred pharmacy

Discuss five key areas of home life prior to admission:
- Describe what home life would be like
- Review PTA meds
- Highlight warning signs and challenges
- Explain plan and test results
- Appointments

Day before Discharge/Transition of Care

Obtain discharge orders from provider if possible
- Make follow-up appointment

Assess readiness for discharge and identify the barriers:
- Daily progress
- Goals

Communicate plan:
- My Care Board
- Care Team
- Communication
- Care Plan

Consider resources:
- Care management
- Dieticians
- DM educator
- Therapies

Discuss transportation

Assess diagnoses and the need for home requirements:
- Dressing changes
- Injections
- Wound care
- Drains, etc.

Update discharge checklist in discharge navigator

Day of Discharge/Transition of Care

Obtain discharge orders if not already completed day before
- Check completion and pending criteria

Identify discharge plan:
- Set time
- Finalize transportation

Communicate plan with providers

Consider home equipment and medications:
- Order oxygen tolerance test or wear if possible
- DME orders

Prescriptions

Update discharge checklist in discharge navigator

Pre/Post Measures

Outcomes - All disciplines (nursing, physicians, therapies, care management, etc) were educated on the model, the logo and the transition board in May 2016. After implementation of IDEAL discharge planning process in June 2016 on the Bone and Joint Unit, responses to the post-discharge phone call question, “Were you aware of your discharge plans and felt prepared for discharge?” continually increased to an average of 98% while the percentage of discharges before noon also increased from 13% to a high of 54% with an average of 32%.

The IDEAL model trial then spread to Medical/Oncology Unit and Family Birthing Center with their success, this model has been implemented to all the inpatient units on January 1, 2018. The project resulted in the addition of IDEAL principles to the patient outcome standards. Additionally, the nursing care delivery policy was updated November 2016 with an increase focus on discharge planning. A “Be Prepared to Leave Checklist” was created and handed out to patients on admission. The professional practice model was updated January 2017 addressing IDEAL principles of proactive discharge planning within the nursing care delivery point of the compass model.

References


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