2018

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

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CentraCare St. Cloud Hospital

MAGNET RECOGNIZED

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 the 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:

Include the patient and family as full partners in the discharge planning process

Discuss with the patient and family five key areas to prevent problems at home:

1. Describe what life at home will be like-section in binder
2. Review medications
3. Highlight warning signs and problems-in binder and on AVS
4. Explain test results
5. Make follow-up appointments

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps at every opportunity throughout the hospital stay

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.

Listen to and honor the patient and family's goals, preferences, observations, and concerns.

Team Members

Colleen Porwoll, BSN, RN, ONC – Core Charge RN
Mollie Greener, RN, ONC – Charge Support RN
Jill Lageson, BSN, RN, ONC – Core Charge RN
Katie Theis, BSN, RN, ONC – Clinical RN
Kathy Wilson, LPN – Clinical LPN
Renita Weeks, BSN, RN, ONC – Total Joint Program Resource RN/Champion & Clinical RN
Sadie Seezs, BSN, RN, ONC – Educator
Lisa Meyer, BSN, RN – Director
Naomi Schneider, MBA, BSN, RN, ONC – Section Director
Sally Blair – Lead Health Unit Coordinator
Joseph Nessler, MD, St. Cloud Orthopedics

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EBP Practice Change

~ Hospital stay work flow ~

Day of Admission

Identify caregiver and Include in conversations:
- Plan (LOS)
- Education
- Set 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

Daily

Educate on the discharge process and what is to be expected:
- Review plan with patient and their caregiver

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
  - PT/OT/Speech

Discuss transportation

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

Update discharge checklist in discharge navigator

Day before Discharge/ Transition of Care

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

Identify discharge plan:
- Set time
- Finalize transportation
- Communicate plan with providers

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

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
- All of treatment team needs to sign off

Confirm all test results have been received, communicated and appropriate action taken

Provide (AVS) written discharge instructions and education to patient with their caregiver using the Teach Back method:
- Listen to their questions, concerns and feelings
- Review and confirm appointments
- Review medication list

Complete discharge checklist in discharge navigator

~ Using Teach Back Method Throughout ~

I.D.E.A.L

This logo for the project represents a home which has a different meaning for each individual. Home is defined to where one lives (facility, family member or friends house, apartment, shelter, etc). Its everyone's end goal to eventually get to a place that they call "home"

Transition Plan

Date: Time:

Location: Transport:

Support Person:

Equipment: Prescriptions:

Layout of all the dry erase board in all patient's room
Random audits on completion of the boards by team increased by 30%.
These are filled out and updated daily by ALL staff.

Pre/Post Measures

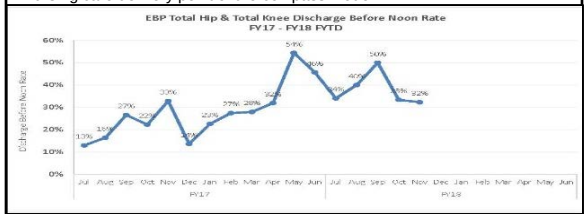
Outcomes -

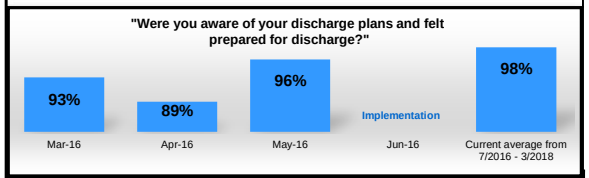
All disciplines (nursing, physicians, therapies, care management, etc) were educated on the model, the logo and the transition board in May 2016.

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.





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