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It's So Hard to Say Good-bye with DCI (Discharge Instructions)

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It's So Hard to Say Good-bye with DCI (Discharge Instructions)

Abstract & Introduction

Abstract

As a comprehensive stroke center, we strive to encompass the entire care continuum. This starts in the Emergency department and ends with return home. Recently, we have implemented a followup phone call process. Our call center nurses survey patients within 7 days of discharge. Within the survey, they inquire about: provider's appointments, prescription and therapy compliance, depression screening, and reinforcement of discharge instructions. Our review of patient data has also lead to Stroke Center RN interventions including: medication clarifications, depression identification and follow up appointments. It is through the eyes of our patients that we create simpler, specific discharge instructions. Our goal is to meet patient's and caregiver needs for adequate communication to enable smooth transitions after hospital discharge. An implementation of follow up phone call process has potential to reduce readmissions, discover depression after stroke and enable a more comprehensive patient experience.

Introduction

In 2012, The Joint Commission added multiple standards in the Disease-Specific Certification requirements that address the discharge process of stroke patients. In our journey for Comprehensive Stroke Center certification we needed to develop a process to monitor the percentage of stroke patients who receive a follow-up phone call within 7 days of discharge.

Learning Objectives

- Investigate specific deficits in current discharge instruction through a survey conducted within one week of discharge.
- Promote standard follow up phone call for stroke patients discharged to home or homecare from the hospital.
- Develop evaluation plan to capture data from survey results and initiate actions to ensure patients' compliance and safety.

Lynette Dondero, BSN, RN, MSPH and Claranne Mathiesen, MSN, RN, CNRN

Methods

The stroke center RN led a multidisciplinary team that included a call center RN, case manager, and unit staff to develop a standard survey to assess patient/caregiver follow through on discharge instructions. A pilot of the phone survey was revised to identify any stroke transition needs and included depression screening using the PHQ2 instrument. Ongoing review of survey results ensured capture used survey findings to improve patient post discharge experience and reduce early readmission.

Team Member Roles

Stroke Center RN:

- Identify stroke patients discharged to home/ home care
- Provide list to call center
- Triage call findings regarding d/c instructions, medication issues, followup appointments, followup positive depression
- Communicates potential patient needs or issues to neurologist and primary care provider
- Analyze findings

• Call Center RN:

- Call to patient/caregiver within 7 days of discharge
- Mail survey if unable to reach x 2 calls
- Assists with making post hospital appointments and referrals to community resources
- Refers to Stroke Center RN if PHQ 2 depression screen positive
- Reinforce stroke education and ensures caregiver materials provided
- Recruit patient / caregiver for stroke support group

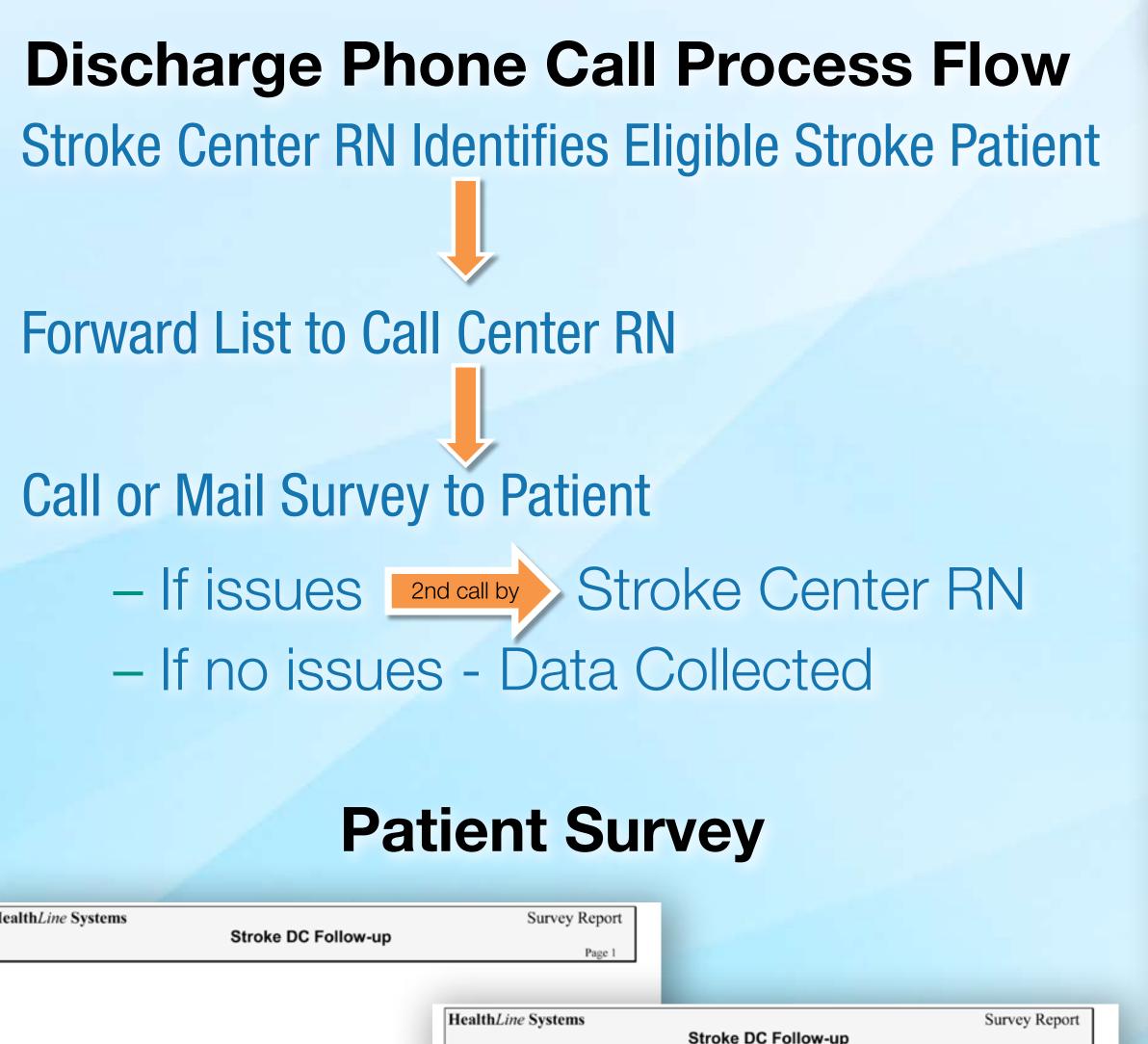
First Name: Last Name: Address: Phone number : If readmitted, what was your d Have you had to visit any hospita problems since your hospitalizati yes, how many times Were you readmitted to a hospi problems since your hospitaliza If yes, which hospital? Were you able to fill all prescrip If no, why? Were you discharged on a stroke p (Aspirin, Aggrenox, Plavix, Ticlid, P If 'Yes', which medication? Did the doctor tell you that you hav rate or atrial fibrillation?



References:

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First Name:				
Last Name:				
Address:				
Phone number :				
If readmitted, what was your diagnosis?				
n readmitted, what was your diagnosis?				
		If no, why not?		
Have you had to visit any hospital with neurological				
problems since your hospitalization?		Did the dectors tell you that you have	high chologioral or	
If yes, how many times		Did the doctors tell you that you have high cholesterol or hyperlipidemia?		
ir yes, now many unles				
		If yes, are you on a medication to treat	t this?	
Were you readmitted to a hospital with neurological				
problems since your hospitalization?		If yes, which medication?		
If yes, which hospital?		in yos, which medication:		
, yoo,				
		If no, why not?		
Were you able to fill all prescriptions given at discharge?		Did the doctor refer you to have rehab after discharge (outpatient physical therapy, occupational therapy or speech therapy)?		
If no, why?				
Mana and Manhamatic and a second s		Did you go?		
Were you discharged on a stroke prevention medication (Aspirin, Aggrenox, Plavix, Ticlid, Pradaxa, Xarelto or				
Coumadin)?	HealthLine S	vstems	Surve	y Report
If 'Yes', which medication?	incurrent since 5		C Follow-up	Jucpon
		Sticke	o i onon-up	Page 3
If no, why?				
in no, why?				
	_			
If 'Other', describe:				
Did the doctor tell you that you have an irregular heart rate or atrial fibrillation?	Did you receiv	Did you receive the caregiver resource packet at discharge?		
	discharge?			
	_			
If yes, are you on a medication to treat this?	Are you or you	r caregiver interested in information for		
	Care Transitio	s? (Such as home safety assessment, n Coach, Meals on Wheels, transportation-		
Which medication?	Metroplus, Agency for Aging)			
	Would you and	your caregiver be interested in	If yes please include your email address	
	participating in	a Stroke support group (Brain Warriors)		
	that meets the October 2012)	third Monday of the month (starting in		
		r an you name the 5 signs of a stroke?		
	in summary, c	an you name the 5 signs of a stroke?		
	Over the past	2 weeks, how often have you been	0 – Not at all	
	bothered by th	e following problems:-Little interest or	1 – Several Days	
	pleasure in do	ing things (Circle One)	2 - More Than Half the Days	
			3 – Nearly Everyday	
	Additional Con	amente		
	Additional Con	11101113		

Outcomes/Results & Implications

- and making followup appointments. 11% of patients

Implications for Practice

- Often patients do not fully understanding Discharge Instructions and have questions post hospitalization.
- In the first week after a hospitalization, patients and caregivers are often overwhelmed and appreciate assistance in navigating outpatient care.
- Screening for depression can help identify patients at risk and expedite appropriate evaluation.
- Extending the role of the Stroke Center RN bridges the critical period before patients are seen by primary care provider.
- Partnership between the acute care team and the Call home.
- with readmission.

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A PASSION FOR BETTER MEDICINE."

• From Sept 2012 to Aug 2013, 413 eligible patients were identified with 66% participating in our survey process. 90% of patients reported compliance with filling prescriptions screened positive on PHQ2 depression screen prompting further assessment and referral for evaluation by provider.

• Commonly noted by Call Center RN's were questions related to discharge instructions, medication reconciliation and timeliness of scheduling outpatient appointments. Use of the Call Center RN provided immediate access to provider scheduling and referral to health management resources.

Center RN has developed stronger processes to support transitions after hospitalization in patients discharged to

Future work is needed to correlate impact of phone followup





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