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

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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 discharge. An implementation of follow up phone call process has potential to reduce readmissions, discover depression after discharge.

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.

Outcomes/Results & Implications

• 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 and making followup appointments. 11% of patients screened positive on PHQ2 depression screening 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.

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.

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