ABSTRACT

A comprehensive approach to discharge planning involves (a) identifying and preparing for a patient’s anticipated healthcare needs, (b) implementing an effective care plan that meets the individual needs of the patient, (c) assessing and recommending plans of care from the interdisciplinary team members, (d) providing education and support to patient and caregiver(s), and (e) actively engaging the patient and caregiver(s) in the process. A patient-centered approach to the discharge process begins on the day of admission and continues throughout the course of hospitalisation. The Clinical Nurse Leader (CNL) provides expertise, leadership, guidance, and support for the improvement projects at the microsystem level. This CNL project involved the implementation of a discharge process to a 14-bed medical-surgical psychiatric unit for the elderly population at a Northern California Hospital. The goal was to provide a comprehensive approach to patient care that would improve patient outcomes and result in a favourable hospital experience for the patient and caregiver(s). This project called PaCeD (Patient-centered Discharge) was implemented on the unit as a performance improvement project. Patient satisfaction scores were evaluated before and after implementation of PaCeD. After implementation of PaCeD, there was significant increase in patient satisfaction scores by 14%. Patients reported increased satisfaction in their hospital experience and verbalised feeling more prepared for discharge. There were fiscal benefits to the organisation as no patients were readmitted to the hospital after participating in this project. PaCeD was therefore accepted and implemented as a standard practice of daily patient care to this microsystem.

INTRODUCTION

Advances in technology, expanded insurance coverage, and the ageing population have contributed to escalation of the United States (U.S.) healthcare spending. American healthcare continues to be one of the most expensive commodities in the US. As advancements in healthcare technology continue to evolve, patients will experience a longer lifespan. Research has found the elderly population to be one of the highest utilisers in the healthcare system. The elderly population identified as 65 years and older represented around 13% of the US population in 2002 but consumed 36% of total US personal healthcare expenses.

An identifiable cause that has led to increased readmission rates in the elderly population is lack of education and participation in their discharge planning process while in the hospital. A key initiative of the health care reform is to focus on the prevention of hospital readmission. Without a patient-centered approach to discharge, there is an increased likelihood of patients being re-admitted to the hospital setting due to poor adherence to their discharge plans.

After conducting needs for the assessment of the microsystem, it was evident that the current discharge process failed to put into practice a patient-centered approach that promoted positive patient outcomes. A microsystem analysis identified the following problems centered around the discharge process (a) patients and caregiver(s) verbalised disappointment about not being actively involved in their discharge plan, (b) lack of understanding regarding recommendations made...
by the interdisciplinary treatment team, and (c) failure to seek agreement with patients related to discharge goals.

This clearly reflected an opportunity and the need for an improvement project that would successfully meet the needs of this population and improve the patient’s hospital experience. Therefore, it was necessary to provide a comprehensive approach to meet the needs of this group, especially when they are hospitalised. A patient-centered discharge process called PaCeD was developed where emphasis was placed on the patient and caregiver(s) becoming active participants in his/her discharge process throughout the course of hospitalisation.

Foss and Askautrud examined the discharge process and found it to be a vulnerable portion of the patient’s hospital stay that necessitated a quality assessment and evaluation to help the patient manage outside of the hospital care setting. There are many facets to the discharge process such as identification of primary caregivers, exploration of options for home health nursing support, assessment of durable medical equipment, and patient understanding of instructions to facilitate adherence to plan upon discharge. Currently, discharge instruction and teaching are primarily conducted on the day of the patient’s discharge. It is, therefore, critical to begin discharge planning on the day the patient is admitted to the hospital to optimise results.

**MATERIALS AND METHODS**

The goal of this CNL was to provide a performance improvement project to this microsystem. Assessing the microsystem identified a need where improvements were needed to the current discharge process on the unit. This involved implementing a project where patients and caregiver(s) became active participants in their discharge process. This involved the CNL transitioning patients safely from the hospital setting to their home. The CNL was responsible for developing a PaCeD process that was comprehensive, agreeable to the patient, and caregiver(s), and supported a collaborative approach between patient, caregiver(s), and the interdisciplinary treatment team. This project was executed on an acute medical-surgical psychiatric unit for the elderly population. This is a voluntary unit where patients must have the capacity to sign themselves in and be willing participants of the inpatient programme. Individual and group therapy are provided to these patients where active participation is a major component of treatment. The programme is community-based so most activities are conducted in a common dayroom where all patients gather for meals and group therapy. There are no televisions in the room since the goal of the programme is community and social integration. The majority of the patients admitted to the unit are not only suffering from a major mood disorder but also several comorbidities that magnify their mood disorders. Such comorbidities include congestive heart failure, respiratory issues, diabetes, and failure to thrive. The average daily census on the unit ranges from 7 to 9 patients but has a capacity to house 14 patients. The average length of stay for these patients is about 14 days.

In order to effectively implement this performance improvement project, it was necessary to have a theoretical framework that supported the integration of a PaCeD process. Lewin’s force-field model of change provided the framework for this CNL to utilise and oversee the process of change in the clinical microsystem. Lewin’s theory of change consists of three stages: unfreezing, moving, and refreezing. The success of each stage is essential for the process to move forward and change to occur.

During the unfreezing stage, the CNL prepared nurses and other members of the team regarding the new process to be implemented on the unit. Moving from unfreezing to the moving stage proved challenging as some nurses considered the new project additional work and did not understand the need for a new discharge process. The CNL provided evidence-based research to educate these nurses about the necessity of this performance improvement project. Key members of the team with strong leadership roles were sought out and encouraged to be active participants during the moving phase. They were given specific tasks to support the implementation of PaCeD. Once PaCeD was integrated into daily patient care, the phase of refreezing followed. During this phase, it was imperative for the CNL to provide ongoing support and encouragement to utilise PaCeD for every patient admitted on the unit. Lewin’s theory of change provided the framework that resulted in a formal process where PaCeD could be implemented and sustained on the unit.

In this microsystem, nurses are accountable for daily care plans. Daily care plans provide a problem list that nurses must address at least once a day. All interdisciplinary team members were encouraged to continually assess, review, and update each care plan for their patients. If there was a question of whether or not a patient and caregiver(s) would follow the plan of care, it was presented to all members of the team for recommendations. Patients and caregiver(s) were invited to interdisciplinary treatment team meetings and recommendations were shared. From there, an interactive process was initiated and care plans were revised according to the patient’s preference that reflected the updated discharge plan. Nurses were held accountable for daily documentation of the discharge plans of each patient. Inclusion of a daily discharge assessment and intervention on the problem list ensured a PaCeD approach throughout the course of hospitalisation occurred.

To monitor the success of this quality improvement project, the CNL led the movement of change using a transformation leadership approach. Patient satisfaction scores were evaluated to measure performance improvement methods initiated on the unit. Patient satisfaction scores were evaluated before and after implementation of this project. The CNL provided continued oversight, monitoring, and auditing for adherence to best practices through the PaCeD process.

**Cost Benefit Analysis**

A cost benefit analysis demonstrated financial savings with the implementation of PaCeD. According to Malcolm, readmissions are a major problem in the US healthcare system.
This is primarily due to a patient’s lack of knowledge about their disease process and the necessity of adherence to their treatment plans. Patients also do not understand the importance of following up with their primary care physicians. A comprehensive discharge process results in favourable outcomes to the patient care experience. When positive patient outcomes are achieved through an interactive discharge process, the potential for readmission back to the hospital setting is decreased. This reduction in recidivism improved hospital profitability.

Since the average length of stay is about 14 days, the daily cost to the hospital when a patient is readmitted averages $2,676.00. If a patient does not follow or understand his/her discharge plan, the potential for readmission to the hospital setting increases. Continued changes in reimbursement rates from insurance companies that are tied to patient outcomes can negatively impact the fiscal health of the organisation as a whole. When the patient is readmitted, this results in loss of revenue to the organisation each day the patient remains in the hospital due to noncompliance with discharge instructions. Patients that are actively involved in their discharge plans and understand the teaching and instructions provided to them results in more effective care transitions to their home setting.

Timeline and Schedule for Implementation
Data collection from current patient satisfaction scores was evaluated before the project was implemented to provide baseline data. After the project was implemented, patient satisfaction scores were compared against the original baseline data to measure improvements.

To support this change project, the CNL sought approval from the Unit Council Committee responsible for all performance improvement projects. Upon approval from unit council, the project was discussed with the nurse manager of the unit. It was also necessary to educate all other members of the healthcare team on project development, implementation, urgency, and necessity of this new process. These members include nurses, physicians, physical therapists, respiratory therapists, occupational therapists, pharmacists, social workers, dieticians, and other identified members of the team. At least three presentations were conducted to provide education on the project and ensure compliance of the PaCeD process.

Enthusiasm was created by the CNL about the improvement project to get buy-in from all members of the team. Getting buy-in was a crucial element to the success and continuity of this project. Key staff members with leadership abilities were identified and given specific tasks to support the implementation of this project. By increasing key members of the team to be part of the change process, this increases acceptance of the new discharge process and its implementation.

Once a thorough discharge assessment was conducted as part of the patient’s admission process, a patient-centered care plan was created from this assessment. All interdisciplinary team members responsible for patient care were held accountable for addressing these daily care plans. PaCeD was included as part of the problem list on the care plans of each patient.

Throughout the development and implementation of this performance improvement project, the CNL provided guidance to implement the project into daily patient care. This included overseeing the admission process and ensuring a discharge assessment was done. It was also necessary for the CNL to monitor daily patient care plans to ensure an interactive process between the patient and healthcare team members occurred. The CNL provided oversight and support to ensure that the project moved forward according to scheduled timelines.

RESULTS

Pre-intervention Satisfaction Scores
Baseline data was gathered prior to implementation of PaCeD. Three specific areas of the discharge process were identified as essential areas to accurately gauge measurement scores for patient satisfaction prior to project implementation. A sample of 12 patients was reviewed and results from these patient satisfaction scores showed a 77% satisfaction rate in the area of discharge. The common identified theme requiring attention among these patients was readiness for discharge and instructions for caring themselves at home. As this organisation has applied for magnet recognition, this was clearly an area where improvement was needed. With new incentive programmes being introduced frequently to our healthcare system, patient satisfaction scores are crucial areas that must be addressed by the organisation. Hospitals must shine and excel in areas of patient satisfaction in order to survive and remain competitive.

Post-intervention Satisfaction Scores
After the implementation of PaCeD, there was an overall improvement in patient satisfaction scores from pre-implementation of the project (see appendix A for breakdown of patient satisfaction scores). Scores increased by 14% with the implementation of PaCeD from 77% to 91%. There was significant improvement in the area of readiness for discharge and instructions for caring for themselves at home. An increased level of preparedness on the part of the patient and caregiver(s) was reported. Patients became partners in their daily plans of care. There was increased satisfaction from patients collaborating with the members of the healthcare team. It is also important to mention there were no readmissions to the hospital setting for patients that participated in this project.

DISCUSSION
For this performance improvement project, there was an overall increase in patient satisfaction scores in the area of discharge. PaCeD was initiated from the beginning of each patient’s admission to the unit. During the admission
process, patients and any present caregiver(s) were invited and encouraged to actively participate in the discharge process. This involved a comprehensive assessment of discharge needs at the time of admission. By identifying the discharge needs of the patient, a PaCeD care plan could then be created with the patient’s individual needs in mind. Identifying PaCeD as a problem list on individual care plans served as a reminder for all interdisciplinary team members to address them daily. The CNL-led project was supported by assigning specific tasks to champion nurses that would help facilitate this new process. From these care plans, interdisciplinary team members were able to successfully organise and implement a discharge plan that met the needs of the patient. Through continual patient and interdisciplinary team interaction, PaCeD was implemented throughout the course of the patient’s hospitalisation. Nurses were excited about the new project as they witnessed their patients become more engaged and become active participants in their discharge process. Patients reported feeling more prepared, expressed a positive hospital experience upon discharge, and recidivism did not occur with patients who participated in PaCeD.

**CONCLUSION**

The purpose of this project was to implement a performance improvement process to the current discharge process that was in place in this microsystem. The goal was to provide an interactive process for patients and caregiver(s) to become active participants in their discharge process. A comprehensive approach in the area of discharge was developed and integrated into daily patient care. All aspects of the patient’s needs were identified using a PaCeD approach. Implementation of PaCeD included a thorough assessment at the time of admission in the following areas: discharge education needs, resources for home, assessment of durable medical equipment, and home health services. This also involved establishing a trusting and supportive environment for patients to feel comfortable expressing their needs in preparation for discharge. Nurses are trusted healthcare professionals who provide a holistic approach to nursing care. By implementing PaCeD, the nurse continues to advocate patient’s safety, support patient’s independence, increase revenue to the organisation through decreased readmission rates, and support the profession of nursing practice.

**REFERENCES**

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