Guide to Patient and Family Engagement

Care Transitions from Hospital to Home: IDEAL & SMART Discharge Planning

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The Wrong Way to Communicate Discharge Instructions

Before discussing best practices for reviewing discharge instructions with patients, let us review what patient discharge should NOT look like

CLIP1

- The nurse in this scene assumes the patient will be excited to go home and be very satisfied. However, the patient is unaware she is being released from the hospital and is unprepared.
- This creates a sense of dis-ease and discomfort because she does not know how she will get home, she may not feel medically ready to return home, and she isn't aware of how to best care for herself after leaving the security of the hospital

Risks at Discharge

- over 19% of patients discharged from a teaching hospital sustained an adverse event within two weeks of leaving the hospital.
- one-third were deemed preventable, and another one-third were found to be more severe than necessary. Medication-related events were the most common causes of adverse events.
- reported that 19.6% of 11,855 patients required re-hospitalization within 30 days. An additional 34% were readmitted inside of 90 days.
- the estimated cost to Medicare for the unplanned re-hospitalizations was as high as $17.4 billion annually.
- A significant number of patients have test and procedure results still pending at the time of discharge.

Best Practices

- A successfully planned and executed hospital discharge is critically important to a patient's continued recovery and fulfillment of post-discharge care.
- Patients must understand the medical or surgical reasons for their current admission and what transpired during the hospitalization.
- Patients must have a clear understanding of their medical conditions and what must be done to continue care as an outpatient.
- Patients must receive an explanation of potential warning signs and symptoms that could arise.
- Patients should be provided with a 24-hour phone number for emergencies.
- Patients should have the name of the provider responsible for their care after discharge (provide written name, address and phone number).

CLIP2

Teach-Back

- advised to not simply ask their patients
- patients will reply with a “YES” when, in fact, they don’t understand important directives interrelated to their successful healing and recovery.
- ask the patients to *explain back* the information
- patients are expected to clearly state the name of the providers who are responsible for their care upon discharge.
- teach-back method can be effectively used to insure a clear understanding of follow-up plans that were previously explained to the patient.

IDEAL Discharge Planning & SMART Discharge Method

Introduction

- Overview of the IDEAL Discharge Planning strategy-
- What are the IDEAL Discharge Planning tools?
- What is the IDEAL Discharge Planning process?
- What are the resources needed?

Rationale for the IDEAL Discharge Planning Strategy

- What is the evidence for improving discharge planning?
- What are the key challenges related to discharge?
- How to prevent adverse events after discharge
- How does the IDEAL Discharge Planning strategy improve the discharge process?
- How does engaging the patient and family differ from a typical discharge process?

Implementing the IDEAL Discharge Planning Strategy

Step 1: Form a multidisciplinary team to identify areas of improvement

- Engage patients and families and unit staff in the process: Establish a multidisciplinary team
- Assess family visitation policies
- Assess current views on the discharge process, including how patients and family members are engaged

- Recognize challenges in changing staff behavior-
- Set aims to improve discharge planning

Step 2: Decide on how to implement the IDEAL Discharge Planning strategy

- Decide on how to adapt the IDEAL Discharge Planning process for your hospital

Step 3: Implement and evaluate the IDEAL Discharge Planning strategy

- Inform staff of changes
- Train staff
- Distribute tools and incorporate key principles into practice
- Assess implementation intensely during the first month and periodically after that
- Get feedback from nurses, patients, and families
- Refine the process

GOALS

- The goal of the IDEAL Discharge Planning strategy is to engage patients and family members in the transition from hospital to home, with the goal of reducing adverse events and preventable readmissions.
- The IDEAL Discharge Planning strategy highlights the key elements of engaging the patient and family in discharge planning:

IDEAL

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

- Always include the patient and family in team meetings about discharge. Remember that discharge is not a one-time event but is a process that takes place throughout the hospital stay.
- Identify which family members or friends will provide care at home and include them in conversations.

IDEAL

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

- 1.Describe what life at home will be like
- 2.Review medications
- 3.Highlight warning signs and problems
- 4.Explain test results
- 5.Make followup appointments

- 1.Describe what life at home will be like. Include home environment, support needed, what the patient can or cannot eat, and activities to do or avoid.
- 2.Review medications. Use a reconciled medication list to discuss the purpose of each medicine, how much to take , how to take it, and potential side effects.
- 3.Highlight warning signs and problems. Identify warning signs or potential problems. Write down the name and contact information of someone to call if there is a problem.
- 4.Explain test results. Explain test results to the patient and family. If test results are not available at discharge, let the patient and family know when they should hear about results and identify who they should call if they have not heard the results by that date.
- 5.Make follow up appointments. Offer to make follow up appointments for the patient. Make sure that the patient and family know what follow up is needed.

IDEAL

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.

- Getting all the information about a condition and next steps on the day of discharge can be overwhelming. Discharge planning should be an ongoing process throughout the stay, not a one-time event. During the hospital stay, you can:
- •Elicit patient and family goals at admission and note progress toward those goals each day
- •Involve the patient and family in nurse bedside shift report or bedside rounds
- •Share a written list of medicines every morning
- •Go over medicines at each administration: What it is for, how to take it, and possible side effects
- •Encourage the patient and family to take part in care practices to support their competence and confidence in caregiving at home

IDEAL

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.

- **•Provide information to the patient in small chunks and repeat key pieces of information throughout the hospital stay**
- **•Ask the patient and family to repeat what you said back to you in their own words to be sure that you explained things well**

IDEAL

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

- •Invite the patient and family to use the white board in the room to write questions or concerns
- •Ask open-ended questions to elicit questions and concerns
- •Use the Be Prepared to Go Home Checklist and Booklet (Tools 2a and2b) to make sure the patient and family feel prepared to go home
- •Schedule at least one meeting specific to discharge planning with the patient and family caregivers

What are the IDEAL Discharge Planning tools?

Tool1: IDEAL Discharge Planning Overview, Process, and Checklist

Use this tool to :

Inform clinicians about the new discharge planning process and keep track of when tasks are accomplished

- **Used by clinicians, this handout gives an overview of the IDEAL Discharge Planning process and includes a checklist that could be completed for each patient.**
- **Format: 2-page overview, 2-page process steps, 2-page checklist**

Tool2: Be Prepared to Go Home Checklist and Booklet

Use this tool to:

Identify and discuss the patient and family's questions and concerns about going home

- **Given to patients soon after admission, the checklist highlights what the patient and family need to know before leaving the hospital and gives examples of questions they can ask. The booklet companion piece contains the checklist plus additional space for writing information.**
- **Format: Tri-fold checklist, 14-page booklet. The electronic version of the tri-fold checklist provides information about how to fold the brochure by indicating the front and back covers.**

Tool3: Improving Discharge Outcomes with Patients and Families

Use this tool to:

- Inform physicians of the IDEAL Discharge Planning process
- Given to physicians, this handout describes the new discharge planning process. A verbal description should also accompany the distribution of the handout at a staff meeting or other venue.
- Format: 1-page handout

Tool4: Care Transitions from Hospital to Home: IDEAL Discharge Planning Training

- Prepare clinicians and hospital staff to support the efforts of patient and family engagement related to discharge planning.
- This training is for any staff involved in the discharge process : Physicians, nurses, discharge planners, social workers, and pharmacists.
- Format: PowerPoint presentation and talking points

What is the IDEAL Discharge Planning process?

The IDEAL Discharge Planning strategy focuses on engaging the patient and family in the discharge process from the hospital to home. You can incorporate elements of the IDEAL Discharge Planning process into your current discharge process. This process incorporates the IDEAL elements from admission to discharge and includes at least one meeting between the patient, family, and discharge planner to specifically address the patient's and family's questions and concerns.

What to do?	Who does it?
At initial nursing assessment	
•Identify the caregiver who will be at home with the patient	**Bedside nurse**
•Let the patient and family know that they can use the white board in the room to write questions or concerns.	**Bedside nurse**
•Elicit the patient and family's goals for the hospital stay	**Bedside nurse**
•Inform the patient and family about steps toward discharge	**Bedside nurse**

What to do?	Who does it?
Daily activities	
•Educate the patient and family about the patient's condition at every opportunity and use teach back	**All clinical staff**
•Explain medicines to the patient and family and use teach back	**All clinical staff**
•Discuss progress toward goals	**All clinical staff**
•Involve the patient and family in care practices	**All clinical staff**

What to do?	Who does it?
Prior to discharge planning meeting (1 to 2 days before discharge planning meeting; for short stays, this may occur at admission)	
•Give Be Prepared to Go Home Checklist and Booklet (Tools 2a and 2b) to the patient and family	**Hospital identifies one person: Nurse, patient advocate, or discharge planner**
•Schedule discharge planning meeting with the patient, family, and hospital staff	**Hospital identifies one person: Nurse, patient advocate, or discharge planner**

What to do?	Who does it?
Discharge planning meeting (1 to 2 days before discharge or earlier for more extended stays in the hospital)	
•Use the Be Prepared to Go Home Checklist and Booklet Tools 2a and2b) as a starting point for (discussion on questions, needs, and concerns about going home	**Hospital identifies one person or a combination: Nurse, physician, patient, advocate discharge planner**
•Offer to make follow up appointment(s) and ask if the patient has a preferred day and time and if they can get to the appointment	**Hospital identifies one person or a combination: Nurse, patient advocate , discharge planner**

What to do?	Who does it?
Day of discharge	
•Review a reconciled medication list with the patient and family	**Hospital identifies one person: Nurse, physician, or pharmacist**
•Give the patient and family their follow up appointments, if applicable , and include provider name, time, and location of appointments	**Staff who scheduled appointments**
•Give the patient and family the name, position, and phone number of the person to contact if there is a problem after discharge	**Hospital identifies one person: Nurse, patient advocate, or discharge planner**

What are the resources needed?

- Staffing.
- Costs.

Rationale for the IDEAL Discharge Planning Strategy

- Patient and family engagement creates an environment where patients, families, clinicians, and hospital staff all work together as partners to improve the quality and safety of hospital care. Patient and family engagement encompasses **behaviors** by patients, family members, clinicians, and hospital staff, as well as the **organizational policies and procedures** that support these behaviors.

For discharge to be most effective, communication between clinicians, the patient, and family needs to happen throughout the hospital stay. Education and learning is a two-way path:

- The patient and family need to learn from clinicians about the condition and next steps.
- Clinicians need to learn from the patient and family about their home situation (both what help and support they can count on and the barriers they may face in taking care of themselves) and to learn what questions they have after they get home. Clinicians also need to make sure that patients and amily members *really* understand the next steps in their care.

What is the evidence for improving discharge planning?

- **A focus on improving clinical quality and patient care** with the belief that reductions in readmissions will naturally occur as a result of these improvement efforts.
- **Attention to discharge planning from the first day of patients**' stay, typically within 8 hours of admission. This includes staff assessment of patients' risk factors, needs, available resources, knowledge of disease, and family support.
- **Care coordination after discharge**. hospitals scheduled followup appointments for most of their patients prior to discharge.
- **Empowering patients through educational activities throughout the stay** to help patients understand their conditions; manage their diet, activities, medications, and care regimens; and know when to seek care.

What are the key challenges related to discharge?

- Discontinuity between inpatient and outpatient providers
- Changes or discrepancies in medication lists before and after a hospital stay.
- Inadequate preparation for discharge.
- Disconnect between provider information-giving and patient understanding.
- Burden of care assumed by patients and families after discharge.

Recognize challenges in changing staff behavior

- Clinicians and hospital staff may feel that they already engage the patient and family in discharge planning or may not know how to incorporate new communication approaches into their care
- Staff have inadequate time to prepare the patient and family for discharge.
- Negotiating interactions with family members can be sensitive.
- Staff may fear change.

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THANK YOU