Capstone Project Milestone 1:

Practice Issue and Evidence Summary Worksheets

**Student Name:** **Date:**

**Directions**

1. Refer to the guidelines for specific details on how to complete this assignment.
2. Type your answers directly into the worksheets below.
3. Submit to the Drop box by the end of Week 3, Sunday at 11:59 p.m. MT.
4. Post questions about this assignment to the Q & A Forum. You may also email questions to the instructor for a private response.

**Practice Issue Worksheet**

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| **List the topic and include the citation for the systematic review you have selected from our approved list (optional: an additional scholarly source of support):**Preventing 30-day hospital readmissions, of the congestive heart failure patient.Leppin, A. L., Gionfriddo, M. R., Kessler, M., Brito, J. P., Mair, F. S., Gallacher, K., & ... Montori, V. M. (2014). Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials. JAMA Internal Medicine, 174(7), 1095-1107. doi:10.1001/jamainternmed.2014.1608 |
| **What is the nursing practice issue you have identified related to the topic you have chosen?**Will initiating a patient care plan on heart failure education and providing a 48-hour post discharge follow up on a hospital cardiac unit; minimize the readmission rates of heart failure patients within 30 days?Congestive Heart failure patient’s accounts for one of the largest group of patients with frequent hospital readmission. Education both inpatient and outpatient can help minimize hospital readmission. Combining multiple teaching models has shown to be more effective in reducing the number of hospital readmissions.Hospital readmissions for Congestive heart failure create a huge impact on the healthcare system as well as on the patient. Finding ways to help reduce the rate of readmissions is important for the patient’s quality of life and also minimizing costs incurred to the hospitals. Readmissions within weeks after a congestive heart failure discharge are associated with negative patient outcomes, and increased hospital costs. Patients require knowledge and self care skills to manage this condition. Patients need the understanding of the basics of heart failure discharge instructions and if education is poor, that could potentially increase the rate of readmission.  |
| **Fully describe the scope of the practice issue:**20% of all Medicare covered patients are readmitted to the hospital within thirty days of discharge. These readmissions can cost the American public billions of dollars a year. Because the Affordable Care Act has implemented incentives to reduce readmission, it is important for our hospital to develop and implement practices to help prevent readmissionsEducation at discharge and throughout the hospital stay is a vital component of improving outcomes in heart failure patients. Patient and family education that involves a multidisciplinary team that emphasizes medication adherence, sodium and fluid restrictions, and recognizing signs and symptoms that indicate progression of disease may be as important as ensuring that patients are prescribed appropriate medical therapy and attend a follow up.In addition to verbal information, a combination of educational materials is used to enhance a patient’s ability to absorb information. Books, medication pamphlets, education print outs, teach back, follow up, and outpatient resources such as websites need to be used.  |
| **What is the practice area?**\_\_X\_ Clinical\_X\_\_ Education\_\_\_ Administration\_\_\_ Other (List):  |
| **How was the practice issue identified?** (check all that apply)\_\_\_ Safety/risk management concerns\_X\_\_ Unsatisfactory patient outcomes\_\_\_ Wide variations in practice\_X\_\_ Significant financial concerns | \_\_\_ Difference between hospital and community practice\_\_X\_ Clinical practice issue is a concern\_\_\_ Procedure or process is a time waster\_\_\_ Clinical practice issue has no scientific base\_\_ Other: |
| **Describe the rationale for your checked selections:**CHF is a common disease that can be difficult to manage; with poor patient outcomes. Since the implementation of the Affordable Care Act, hospitals lose reimbursement for extensive readmissions. If a hospital that makes $30,000,000 a year in Medicare reimbursement and 3% is taken off for extensive readmissions that is a $900,000 reduction in revenue for the hospital. Even without the decrease in reimbursement, poor patient outcomes are enough of an incentive to reevaluate our treatment plans and develop ways to help these patients. Hospitals need to focus on enhancing the effects of an education program, which includes: Education from admission to discharge, teach back, call back nurse, follow up, home health, community service resource, etc. We need to help patient's capacity for self-care in their transition from hospital to home. |
| What evidence must be gathered? (check all that apply)Studies regarding follow-up and education from a literature search will be helpful in deciding which interventions would be most effective. Knowledge about the Affordable Care Act and its requirements for reimbursement is another area that would be helpful in developing cost-effective interventions to prevent readmissions. A financial analysis would provide the evidence needed to know how the hospital’s reimbursement is paid and if there has been a decrease in reimbursement since the adoption of Affordable Care Act. The Hospital Readmission Reduction Program, in conjunction with the Affordable Care Act to monitor hospitals readmissions rates for myocardial infarctions, congestive heart failure, pneumonia and COPD, which were added in 2015. Hospital readmission rates are at a high; however, evidence about hospital strategies that are associated with lower readmission rates is limited. We would need to identify hospital strategies that were associated with lower readmission rates for patients with heart failure. We would need to distinguish which type of education is retained and keeps the patient compliant. What is the RN’s perception of patient discharge education and what are their practices.Is there a difference in the perception of heart failure discharge education of registered nurses employed in an acute care setting and those employed in a non-acute care setting? The studies I read showed that patient education and continuous post discharge follow-up interventions conducted by nurses could significantly reduce the rates of readmissions to the hospital or to the physicians' office. This aims at the permanent training, reinforcement, improvement and evaluation of self-care of the heart failure patient, which include weight monitoring, sodium and fluid restriction, physical activities, compliance of medications, monitoring of signs and symptoms of worsening and when to seek medical help. This will test nursing interventions with a direct effect on improved heart failure patient readmissions. As more is learned about the important effects of education and self- care on patients’ outcomes, the need to move away from the traditional view of patients as passive recipients of information is clear. Patients should be viewed as active partners in the management of their health. Cardiac nurses play a fundamental role in the  |
| \_\_X\_ Literature search\_X\_\_ Guidelines\_\_\_ Expert Opinion\_\_\_ Patient Preferences | \_X\_\_ Clinical Expertise\_\_X\_ Financial Analysis\_\_X\_ Standards (Regulatory, professional, community)\_\_\_ Other |
| **Describe the rationale for your checked selections:** Literature research will be collected to assess whether following up with patients should be implemented and whether or not it would be beneficial to the patient in preventing readmission. Clinical expertise will need to be assessed to determine whether staff doing the education is well educated and compliant in the teaching and able to answer any questions the patient may have. Clinicians must apply their expertise to assess the patient’s problem and should integrate effective interventions as evidenced by researchStandards; these include Federal, State, local and other regulatory frameworks that are necessary for the adoption of effective intervention strategies. The patient may need professional resources outside in the community, so getting information on local resources will Also be beneficial to inform the patient during the discharge and follow up. Financial analysis would provide the evidence needed to the hospital’s reimbursement |

**Evidence Summary Worksheet**

**Directions**: Please type your answers directly into the worksheet.

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| **Describe the practice problem in your own words with reference to the identified population, setting and magnitude of the problem in measurable terms:**Reducing hospital readmissions is a national focus for healthcare. Consequently, patient discharge education is increasingly important for improving clinical outcomes and reducing hospital costs. Hospital readmissions are widespread, costly, and often avoidable.Overall, hospital readmission is a challenge every institution faces. Even after you implement better processes to focus on decreasing your readmission rate, there will always be cases in which a patient must be readmitted. Unplanned hospital readmission, or a patient’s return to the hospital for the same or related issue is not only inconvenient for the patient; it also poses a significant concern for hospitals. The successful implementation of multiple interventions is essential to produce a significant reduction in heart failure readmissions. The majority of these interventions is “nurse-driven”, and can most efficaciously be implemented in structured nurse-led heart failure programs.  |
| **Type the complete APA reference for the systematic review article you chose from the list provided. It must be relevant to the practice issue you described above. Include the APA reference for any additional optional supplemental scholarly source related to the review you wish to use.**Leppin, A. L., Gionfriddo, M. R., Kessler, M., Brito, J. P., Mair, F. S., Gallacher, K., & ... Montori, V. M. (2014). Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials. JAMA Internal Medicine, 174(7), 1095-1107. doi:10.1001/jamainternmed.2014.1608 |
| **Identify the objectives of the article:**The objective of the article was to synthesize the evidence of the effectiveness of interventions to decrease early hospital readmissions and identify intervention features—including their impact on treatment burden and on patients’ capacity to enact post discharge self-care—that might explain their varying effects.**Provide a statement of the questions being addressed in the work and how these relate to your practice issue:**The high readmission rates experienced in the health-care system are generally attributed to inadequate skills for patients to administer self-care after discharge from hospitals. This is evidenced by the fact that approximately 20 percent of patients are readmitted to the hospital within 30 days after discharge. |
| **Summarize (in your own words) the interventions the author(s) suggest to improve patient outcomes.**The authors suggest that more effective interventions despite being complex are an important aspect of supporting patient capacity for self-care and should be adopted. Further, they claim that the efficiency of interventions tested recently is minimal. Interventions used to improve patient outcomes included in the discharge planning process: case management, telephone follow up, tele-monitoring, patient education, self management, medication intervention, home visits, scheduled follow ups, patient hotlines and streamlining. **Summarize the main findings by the authors of your systematic review including the strength of evidence for each main outcome. Consider the relevance to your project proposal for the Milestone 2 project paper**. **(If an optional supplemental source is also used, include a statement of relevance to it as well.)**OBJECTIVE is to synthesize the evidence of the efficacy of interventions to reduce early hospital readmissions and identify intervention features--including their impact on treatment burden and on patients' capacity to enact post discharge self-care--that might explain their varying effects.Addressing the early hospital readmission has been recognized and is a costly occurrence. Patients were discharged from hospital without social support and lack of education on how to care for their selves or diagnosis at home and are one of the factors that contribute to hospital readmission. If hospitals provide the supported intervention such as patient education, discharge planning (prepare for discharge), self-management, follow up, home visit, and community resource, this would enhance patients' capacity for self-care in their transition from home to hospital and in turn reduce the risk of early readmission. The findings also showed that the majority of the interventions tested were effective at reducing readmissions into the hospital. The interventions that supported the patient’s once returning home were most favorable. This is relevant to my project proposal because contacting a patient via phone allows the patient to be comfortable and independent. The author emphasized the risk of cause in unplanned readmission with or without hospital deaths at 30 days post discharge. The study selected randomized trials to assess the effect of interventions on the readmission within 30 days of discharge in adult patients hospitalized. The finding is if patients who receive follow up, and support on post discharge at home to patients and families related to diagnosis and treatment will reduce readmissions. Both clinician from hospital and primary care need to get involve in patients' care. The strength of evidence for main outcome is to provide support to patients, which can play an important role to reduce hospital readmission rates.  |
| **Outline evidence-based solutions that you will consider for your project**.Plan the research by meeting with the multidisciplinary team and to discuss what is trying to be implemented.* Engage co-workers to be involved
* Execute the research plan.
* Evaluate the outcome of readmissions.
* Address patient communication needs during discharge
* Engage patients and families in discharge planning and instruction
* Provide discharge instruction that meets patient needs
* Identify follow up providers that can meet patient needs

The follow-up phone call consists of five components:* Assessment of health status.
* Medication check.
* Clarification of follow up appointments.
* Post discharge home resources.
* Review of what to do if a health or medical problem arises (signs & symptoms).

 Evidence-based research has shown that programs that provide appropriate patient education; increases patient participation in his/her care, assists individuals in making informed decisions and increases patient adherence to treatment. Patient education needs to be individualized and based according to the individual’s needs and skills. Before establishing patient education it is important to keep in mind, the patient’s health literacy, their willingness in participating in their self-care and resources available. **Discuss any limitations to the studies that you believe impacts your ability to utilize the research in your project.** Patient and family education through out the hospital stay, through teach-back along with patient follow up, could be increasingly useful in heart failure education programs. However, significant barriers to patient self-care education are often present, such as cognitive impairment, and poor health literacy. Studies have demonstrated that we may not relay information to patients in a way they can understand. Instructions at discharge should be given in plain language, use verbal, audio, and visual instruction, be repeated by multiple providers (physician, nurse, dietician, physical therapy, and pharmacist, etc.), and be confirmed using a teach-back method where patients are asked to repeat back what they understand regarding their discharge instructions.  |