Discharge Satisfaction Guaranteed

Discharge Information

HCAHPS Breakthrough Series

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Discharge Satisfaction Guaranteed

Discharge Information

How to prepare every patient for safe, continued recovery at home… every time!

Satisfactory Discharges Not Guaranteed: Patients Reported:

- They did **not understand** the discharge instructions
- Care instructions were **too general**
- **New prescriptions** posed special challenges
- **PCP's missing** from the picture
- Had only **limited support** at home
- Had **chronic** health condition, but they were **not educated** about it

-Robert Wood Johnson Foundation, February, 2013

Question:
"What kind of experience do you want for your patients, and how great do you want to be?"

When preparing patients for Discharge how many of you:

- Find it hard to bring importance to the task? (You've done this so many times)
- Identify who is responsible for the patient's care at home?
- Assure family is aware of safety concerns? (confusion, fall risk, allergic reactions, etc.)
- Identify time-critical actions? (Do they have a PCP to follow-up with? A CT scan to schedule in two weeks?)
- Just wish the Case Manager would do all this?

"Getting out of the hospital is a lot like resigning from a book club… You're not out of it until the computer says you're out of it." -Erma Bombeck, American Humorist

Discharge Questions and Why They Matter

HCAHPS Domain – Discharge Information
Survey Question #1: Help at Home

*During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether **you would have the help you needed when you left the hospital**?*

The 1st HCAHPS question is asking:
As hospital staff, do we feel assured that our patient is prepared to manage his/her care (with appropriate help) at home?

Survey Question #2: Written Counselling

*During this hospital stay, did you get information **in writing** about **what symptoms or health problems** to look out for after you left the hospital?*

The 2nd HCAHPS question is asking:
Was there written information and counselling given to the patient and family about future symptoms or health challenges that might arise?

Domain Leadership Owners:
Nursing Staff, Case Managers, and all team members engaged in assisting the Discharge process: from RN's to Transporters to Parking Attendants, starting with Admitting

Current National Threshold is;

(Rated a 4 – "Always"/50th Percentile)

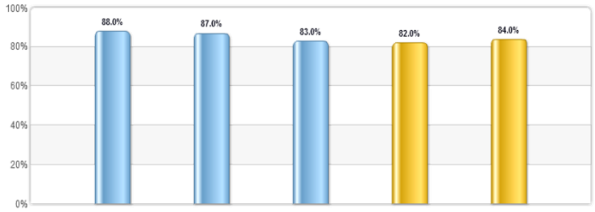
87%

What's Yours? _____%

Issues For the Family:

1. Pain and suffering (because patient lacks strategies for life after hospital)
2. Ne edless Stress (family not prepared to manage home care)
3. Unnecessary additional patient/family costs (time away from work to care for patient)
4. Patient/Family dissatisfaction (they feel lost or abandoned by hospital)

Discharge Information ratings are now public:



www.medicare.gov/care-compare

For Our Hospital:

5. Poor outcomes (longer recovery time)
6. Adverse events (effects 1 in 5 patients within three weeks)
7. Unnecessary readmissions. Cost: $26 billion per year (with 75% potentially avoidable)

Discharge Improvement Team *
The CNO to create a **Discharge Satisfaction Team** to continually improve skills and increase patient "going home" preparedness.

Team Charter
The Team maintains accountability for Discharge Best Practices

1. Learn to role-play discharge processes
2. Spread latest discharge information
3. Educate Managers to model and monitor behavior
4. Author a Master Discharge Checklist process
5. Create awareness around discharge skills
6. Improve inter-departmental collaboration and hand-offs
7. Monitor HCAHPS scores, and improve
8. Acknowledge and recognize progress

*For more information on the Discharge Improvement Team, please see page 10 of this guide.

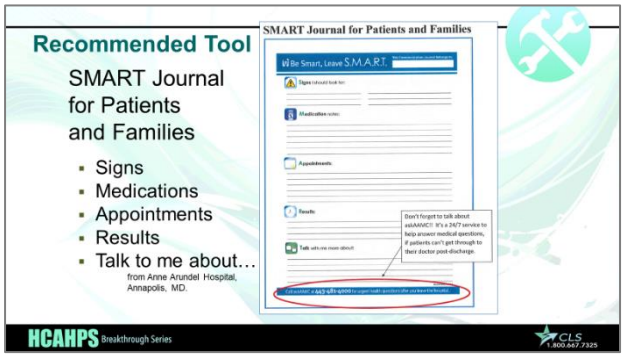
Discharge Starts at Admitting

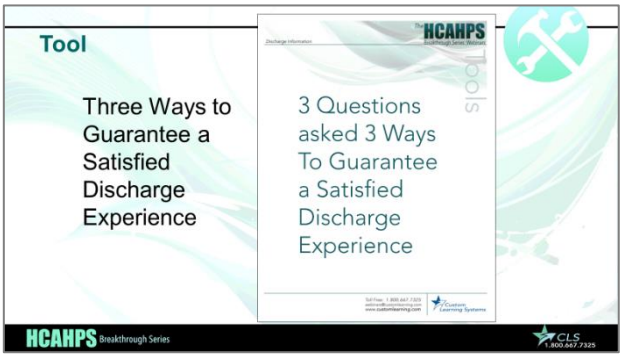
It All Starts at Admitting

- We believe that "discharge information" is not something that happens at the end of a stay
- It's an on-going process… and it all starts at Admitting!

A Great Admitting Staff

- Informs the patient that a well-planned discharge is a hospital priority. "We'll start preparing / educating you to go home long before we say 'good-bye…'"
- Engages active participation of patient & family as partners with clinical staff
- Documents patient's functional status:
  – risk at home?
- Introduces Discharge Coordinator
- "Manages Up" the nursing staff





Three Critical Statements to Guide You:

1. *"We'll make sure you have family or a friend who'll look after you every day when you come home. Do you have someone to do that?"*
2. *"We'll tell you everything you need to know about any new medications you'll continue to take after your stay with us."*
3. *"And we'll send you home with a packet of written information, everything you need to know about your safe healing at home"*

Discharge Coaching - Daily

Question:
On a daily basis, how are you preparing patients for going home?

"The more patients are involved in their care, the higher is their adherence to the treatment, and their satisfaction with their care and outcome." -Rydeman & Tornkvist, 2010

Every day of the hospital stay, teach Patients and families essential home-care skills:

- Guidelines for proper medication & diet.
- Techniques for changing dressings, wound-care hygiene.
- A variety of pain-control strategies.
- Are coached to ask questions of bedside caregivers.

Education for life-at-home is on-going. Coach daily about possible new, lifestyle changes at home. Examples:

- **Coach** adjustments needed to manage new health realities, make new lifestyle decisions.
- **Remind** patient he/she will move from a **hospital cocoon** – where everything's done for him – to home, where a certain degree of independence is required for healthy recovery.

Everyone's Challenge: To make education for post-discharge life part of your daily routine.

When teaching aftercare strategies:

- Eliminate distractions
  - Close the room's doors.
  - Draw curtains for privacy if necessary.
- Make giving information a **Very Big Deal.**
- If it looks/sounds routine and unimportant – your teaching won't sink in.

Keep it Simple:

- Sit close to the patient. Make good eye contact.
- Avoid unnecessary medical jargon, wordy explanations.
- Be sure instructions are clear and easy to understand.
- Use an interpreter when necessary. Have communication devices for the hearing and visually impaired.

Beware of information overload!

- Limit number of topics for education.
  - *"Information in small bites beats a big banquet of facts"*
- Best strategy: Start the education process in advance of discharge, not last-minute.
- Overload results in **poor retention.**

Discharge Coaching – Day Prior

Question:
"If you're not certain they're ready to pack, ask your patient to teach back!"-Brian Lee, CSP

Please Answer These Questions:

1. How do you check for a patient's *"independence readiness*"?
2. How do you provide a needed *"independence awareness heads-up"* for the patient and their family?

The Pre-Discharge Checklist

- ❑ 1. Supply patient/family with **list of post-hospital care services.**
  Also: Where to access home health equipment and supplies.
- ❑ 2. Wisely counsel patients/family again (and again) about **new lifestyle changes at home**, along with possible adjustments necessary to manage new health realities.
- ❑ 3. Give written home-care instructions to patient in a well-organized packet (with a brightly-colored, can't-lose-it cover), in multiple languages.
- ❑ 4. Review the 6 critical pieces to remove the root cause of adverse events with the patient and caregiver:

- ❑ Who to contact if questions or problems arise.
- ❑ Signs/symptoms of recurring poor health to watch for.
- ❑ Medications – and how to safely take them.
- ❑ Safe and effective management of pain.
- ❑ How to perform self-care.
- ❑ Possible exploration of end-of-life options.
  -Hospice services to help patients manage care at home, rather than return to hospital

Discharge Coaching – Going Home Day

"When the student is ready, the teacher will appear."– anonymous

Checklist at Discharge:

- ❑ Co-ordinate/arrange all discharge elements with Case Worker.
- ❑ Check all initial go-home prescriptions filled.
- ❑ Alert/book transporter. They'll double-check patients have all the information they need before they leave.
- ❑ Inform patient/family they'll receive a follow-up call at home within 48 hours.

Revisit the medication safety points:
Your focus: Convey a clear understanding of all medications to be taken, including:

- ❑ **New** medications.
- ❑ **Continuing** medications.
- ❑ Previously **discontinued** home medications that *are* to be resumed.
- ❑ And which previously discontinued home medications are **not to be resumed.**

The **Discharge Coordinator** avoids delays by ensuring:

- ❑ Medication reconciliation done; go-home Rx's filled.
- ❑ Final test results available from Lab.
- ❑ Next appointment with PT, OT, etc. are booked.

Three Critical Questions to Ask:

1. *"Just so I'm clear, **who'll be your daily caregiver** at home?"*
2. *"Now help me be sure you're okay with your new medicines"*
   - *"You're going home with ____ new medications."*
   - *"Here's the **pop quiz**: Can you tell me the **name of each**?"*
   - *"What is **each one for?**" "And what **side effects** you need to be aware of?"*
     "Great! You've got it!"
3. *"Have you looked at the **discharge packet of written instructions** you're taking home?"*
   - *"What section do you think will **be most helpful** to you…?"*

Post Discharge Phone Calls

Question:
What do **you see** as the **benefits** of a Post Discharge Phone Call?

The benefit is the process:

- Establish **protocols** for the follow-up call. Check for: Wellness - Safety - Service - *And any questions?*
- Harvest patient satisfaction comments, complaints and share immediately with relevant staff
- Systematically use 'lessons learned' from post-discharge calls to improve caring service to patients
- Quickly provide Service Recovery as needed

Who should make the Post Discharge Phone Call?

- Ideally, call should come from a nurse who cared for the patient.
- When that isn't possible, call must come from someone who can answer questions about medications and health concerns.
- Or a call center.
- Or a hospital volunteer (must be trained/skilled at answering patient questions).

Call within 48 hours:

Make calls from private location. Have at hand:

- The patient's chart/discharge information
- Resources to answer questions re: medications and health conditions
- Resources to answer questions about out-of-hospital services

Essential elements of an effective post-discharge call:

- Identify yourself.
- Explain why you are calling.
- Ask about safety, care, and comfort.
- Check for follow-up MD & other appointments.
- Assess satisfaction with service during stay using the "Three Thoughtful Questions."
- Express thanks.

Be sure to spend extra time with patients:

- With cognitive impairments.
- The elderly.
- Social issues: A history of abuse, neglect, no known social support, or patients who live alone.
- Poor nutritional status.
- Financial issues.
- **Listen carefully for challenges needing help**

Three Critical Questions to Ask:

4. *"Just so I'm clear, **who is your daily caregiver** at home?"*
5. *"Now help me be sure you're okay with your new medicines"*
   - *"You went home with ____ new medications."*
   - *"Here's the **pop quiz**: Can you tell me the **name of each**?"*
   - *"What is **each one for?**" "And what **side effects** you need to be aware of?"*
6. *"Have you looked at the **discharge packet of written instructions** you took home?"*
   - *"What section do you think will **be most helpful** to you…?"*

Discharge Packet

Question:
How can you help your patient avoid being overwhelmed with so much important information at the time of discharge?
Answer: The Organized Discharge Packet

An invaluable Discharge Packet to accompany patient home should include:

- Education handouts.
- Hospital contact info.
- A medication list including potential side effects.
- A follow-up appointment schedule.

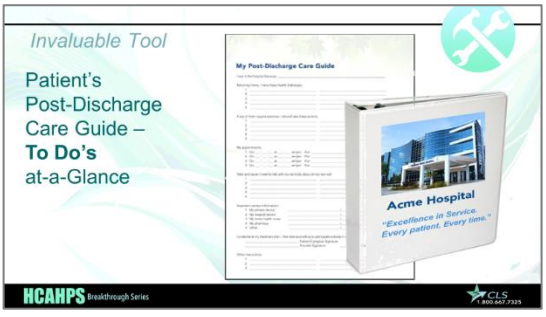
*"Don't make your discharge packet valuable, make it **invaluable!**"*-Brian Lee, CSP

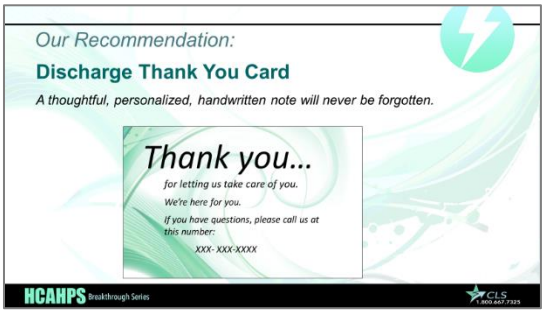
My Challenge

1. Present your Discharge Packet to Grade 7 to 9 classroom, and ask for feedback
2. Have your Family and Patient Advisory Council review your Discharge Packet and give you feedback

The Discharge Packet: W*ritten words the patient takes home*:

- Lists are helpful.
- Sentences are kept simple and short.
- Highlight important elements in bold type.
- Print is large enough for easy reading.
- Avoid using all capital letters and italics.
- Avoid jargon, tech words, & medical abbreviations





Your Hospital Discharge Document should contain a line or two which says:

- "I've been given instructions on all my medications and understand how to take them."
- "I also understand my responsibilities for my aftercare."

Patient or caregiver are asked to initial these lines to indicate their preparedness for home

Discharge Sentence Starters

To make sure the patient understands their medications and self-care at home.
Question:
What would be the value of using **key words at key times**? We call them:

- Empathizers, or
- Sentence Starters, or
- Conversation Starters, or
- Talking Points

A "Sentence Starter" Is…
an easy way to communicate to your patients, in a positive way, so that they can better understand and accept new and important information.

Would you agree that ..
It's crucial we get it right when communicating with your patient about their discharge education?

Teach Back:

- *"So that I'm sure you know how to change your dressing… (take your medications, monitor your blood pressure, etc.)"*
- *"Will you please show me how you'd remove and replace your dressing?"* ***Or:***
- *"Explain what the two medications are for, and when you'll take them, and what to do if you miss a dose?"* ***Or:***
- *"How will you apply your blood pressure cuff?"*

Utilize Take-Home Discharge Information Packet
How will you review the take-home information packet? Here's how:

Put the Packet in their hands

- *"We've put a good deal of thought into this packet. It contains the names, numbers and e-mail addresses of everyone you'll need to contact if you have questions or need help."*
- *"It's divided into five sections."*
- *"Let me show you how they're arranged and what's in each one."*

***Question**:*
How will you manage unrealistic expectations about recovery at home?
(Including responses to questions the patient may be reluctant to ask?)

Coaching Our Concerns

- *"What else do you need in order to feel safe during your recovery at home?"*
- *"I've had many patients who worry about _____. Do you have any of the same concerns? I'm happy to share what I know!"*
- *"Frequently, when going home, patients ask me about _____. How can I be of help to you in that area?"*

Attitude is everything!
Encourage a positive outlook and promote patient's sense of being in control.

Ego-Boosting Encouragement

- *"It won't be long before you'll…"*
- *"People like you don't usually take any longer than they need… in order to…"*
- *"Slow but sure is often best, as you continue your recovery…"*

Two Questions:

- Which conversation-starters do **you** want to put to work as soon as possible?
- What other **"words that work"** are you successfully using, that you could share with team members?

The Accountability First Step:

Who **W**ill do **W**hat by **W**hen & **H**ow?

What's the BEST idea you've heard on this webinar?

- _____
- _____
- _____

How **soon** will you put it/them to use?

_____

_____

Discharge Improvement Team

Discharge is a Team Activity!(no Lone Rangers allowed)

The Power of the Team
Especially with a complex discharge, you'll want a **multi-disciplinary** group to plan a streamlined exit in advance

Discharge Satisfaction Team Stakeholders…
Would include reps from:

- Administration (as Exec Sponsor)
- Key MD's involved in the discharge process
- Clinical nursing staff
- Social Workers, Case Managers, Geriatricians
- Pharmacists
- ED
- Medical Records Dep't
- Nutrition / Dietary
- Home Health
- Call Center

Discharge Satisfaction Team Mission:
To continuously improve the process of prepare every patient for a safe, continued recovery at home, and improve HACHPS scores.

- Complete Evaluation Form to receive : **Discharge Information – Team Charter**

Team DO IT Plan

☐ 1. Place the sharing of "**Inspiring Stories**" on all staff, leadership, and Board meeting agendas.

☐ 2. Engage everyone in authoring a unit-based team **Mission Statement**.

☐ 3. Champion daily patient "**chat time**." A good conversation-starter:
"What can you tell me about yourself that isn't on your chart?"

☐ 4. Standardize the use of "A.I.D.E.T." or "S.E.R.V.E." through:
- ☐ "Bite-sized" – 30 minute "**Learn and Role-Play**" labs.
- ☐ Managers **model and mentor** for consistent use
- ☐ Appoint a "**Standing Team**" to consistently promote, acknowledge / reinforce these communication behaviors.
- ☐ Request the **"S.E.R.V.E." mini-poster** on this webinar evaluation form. Make copies and post for staff to use.

☐ 5. Appoint a **Bedside Reporting Team** to continuously improve continuity of care and patient engagement.

☐ 6. Make certain you have updated your **Care-Boards** to:
- ☐ Include and insure everyone asks and uses it as a part of the patient care plan.

☐ 7. Review the Patient Room Tool list for immediate improvement opportunities:
- ☐ Care Board
- ☐ Staff Photographs and "Scrubs" Board
- ☐ Wong-Baker "Faces" Chart
- ☐ Chair
- ☐ Access to Translator
- ☐ Notepad and Pen
- ☐ Hands-Free, Voice-Controlled, Wireless, Wearable, Communication Device

☐ 8. Decide which additional nurse and support staff you want to take these webinars, especially to focus on:
- ☐ Staff Communication Skills
- ☐ Staff Conversation Starters

☐ 9. Model and champion the use of "**Three Thoughtful Questions**" at every opportunity.
- ☐ **Listening**: At the Beginning of the Shift; *"What would good care mean for your today?" "If there was one thing you would like to make a priority today, what would it be?"*
- ☐ **Empathy**: During Hourly Rounding or use SERVE; *"Do you have any questions before I go?" "Is there anything else I can do for you? I have the time…"*
- ☐ **Educate**: A the end of the shift/Bedside report; *"How did we do on achieving today's goals?" "What made today good for you?"* and *"What could we do to make tomorrow even better?*

☐ 10. Place the minutes from this **"DO IT Plan" debrief** on nursing leadership meeting agenda, until you achieve your patient experience goals, and practices are hardwired.

☐ 11. Request a **One Hour Nursing Leadership Coaching Call** with Brian Lee or David Dworski, to break through barriers you've encountered with implementation.

☐ 12. Register every Nurse Leader for this webinar series, to ensure they receive the notices, Learning Guides, and Tools directly to their inbox. Set a goal for who should take the final series test to become recognized as a "**Certified HCAHPS Practicing Professional**." (CHPP)

Participant Satisfaction Report **PLEASE PRINT**

HCAHPS Breakthrough Leadership Series

This Evaluation Page can be accessed online: Click Here to complete online.
Or, Email/Fax this form: webinars@customlearning.com / 403-228-6776

You've just heard from me, now I'd like to hear from you. Evaluation is the "genius" of growth and we sincerely value your contribution to this learning experience. Thank you.

We **totally employ** about #_____ full and part time staff, at _____ facilities.

1. **For me, the most valuable idea I learned and intend to use is**:_____

   _____

   _____

2. **What I would tell others about the quality of the speakers and value of the content**: _____

   _____

   _____

   _____ O.K. to quote me: YES NO

3. **Presentation improvements I would suggest**:_____

   _____

   _____

4. **On a scale of 1 - 5, this presentation:** (Met My Expectations) 5 4 3 2 1 (Did Not)

5. ***Featured Implementation Tool:***

   Yes A. *3 Questions asked* and *Discharge Information – Team Charter* **Tools**

   Yes B. Interested in Scheduling Our **Team Coaching Call**

6. **P.S. – My Best Tip**: _____

   _____

   _____ ❑ More on Reverse

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