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Implementing a Discharge Checklist in the Emergency Department

Angela Hahn MSN, RN, CEN and Rose Delarosa BSN, RN, CCRN

Background

The discharge process from the emergency department (ED) is a critical component to ensure favorable patient outcomes. If patients do not understand or know how to care for themselves after discharging from the ED, the result could be a worsening of their condition that could lead to a poor outcome including repeat ED visits and the need for hospitalization (Engel, et al., 2012). Additionally, patient satisfaction scores can be negatively impacted when discharge instructions are unclear or if the process does not cover essential information the patient needs to be successful at home care, and higher patient satisfaction with discharge communication has previously been correlated to better recall of care instructions (Press, 2012). A topic that is gaining a lot of attention is health literacy with the current literature revealing that more than 47% of the population have inadequate health literacy. This essentially means that they are lacking some comprehension into how to obtain health care or how to make necessary health care choices, and people with lower health literacy are linked to higher rates of ED utilization as well as poorer overall health (Buckley, et al., 2013).

Purpose

Because the Providence St. Vincent Medical Center (PSVMC) ED serves a large, diverse population, the assumption was made that the patient population could have the same problem with inadequate health literacy and the discharge process was targeted for improvement in an effort to improve patient comprehension of ED discharge instructions which would, in turn, decrease repeat ED visits and increase patient satisfaction. PICOT question: In adult, non-mental health emergency department patients, does the implementation of a discharge checklist tool designed to improve clear patient discharge teaching communication decrease the number of repeat visits over a thirty-day time frame?

Methods

This Evidence Based Practice Project included all non-mental health patients over the age of 18 that were discharged from the PSVMC ED from March 13, 2017 – May 12, 2017. This allowed for thirty days of baseline data (March 13 – April 11) prior to a two-week intervention trial period (April 12 – 26) and two weeks after the trial period (April 27 – May 12).

The intervention developed and implemented to improve the discharge process was an ED Discharge Checklist (see below) that covered the essential elements of a patient-centered discharge as guided by the literature that would be used by all staff nurses during the discharge process and sent home with the patient’s discharge instruction papers.

The metric to track repeat visits was the 72-hour hospital readmission rate, which has been long tracked as a determinant of a failure during the discharge process (Agency for Healthcare Research and Quality, 2014).

Patient satisfaction with the Press Ganey item “Information given about how to care for yourself at home”.

In order to determine if the staff nurses were using the discharge checklist, patients who were contacted for callbacks were asked whether or not they received the form.

Results

The data revealed no change in the number of adult, non-mental health readmissions within 72 hours of ED discharge: during the baseline 2 out of 7090 patients readmitted and during and after the trial 3 out of 7061 patients readmitted.

Patient satisfaction for information about how to care for yourself at home improved from the baseline (top box 63.2%) to the trial (65.8%) and the improvement was maintained after the trial (64.4%). Compared to all 2,099 EDs that use Press Ganey, the percentile improved from below average at baseline (48%) to above average (62%) during the trial and maintained above average (60%) after the trial.

Records for a total of 97 callbacks existed for a convenience sample of patients discharged during the trial period. Thirty-one were unable to be counted as the nurse making the call did not ask the patient if they received the discharge checklist. Twenty-four additional patients did not answer the call. Out of the 42 patients who were asked, 18 (43%) confirmed receiving the checklist.

Discussion/Conclusions

The discharge checklist led to improved patient satisfaction about receiving instructions about caring for themselves at home.

The short trial likely underestimates the impact of the discharge checklist because there was not sufficient time for all staff nurses to incorporate the checklist into their practice. A longer trial would result in highly reliable use of the checklist and likely further improve patient experience. Several staff nurses provided unsolicited feedback that the discharge checklist was more comprehensive than their previous discharge teaching, and presumably have made changes to their individual practice.

An important learning was about the challenge of tracking all repeat visits for 30 days as intended, so the 72-hour metric was used because it was more readily available.

Shortly after trial and post-trial period, an update to the electronic medical record (Epic) was made that changed the look of the printed patient discharge instructions. With these encouraging preliminary results and the Epic changes, it would be beneficial to re-implement the discharge checklist for a longer time period and monitor the impact to patient experience.

References


