Heart Failure Discharge Preparation: Utilizing the Bedside Nurse to Help Decrease Readmission Rates

Our Lady of the Lake Heart Center
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Objectives

1. Articulate the steps in successful heart failure patient/family education to decrease readmission
2. Increase patient satisfaction related to readiness for discharge following an admission for heart failure

Background

• The prevention and effective treatment of heart failure (HF) is a high profile public health need with national and world wide implications.
• Reports from the American Heart Association (AHA) estimate that more than 5.5 million Americans have been diagnosed with HF, and there are more than 550,000 newly diagnosed cases each year.

Background

• Among Medicare beneficiaries, HF is the leading cause of hospitalization and readmission in 2007 at a cost of more than $33 billion.
• National data reveal that within 3-6 months post discharge, 29-47% of patients are readmitted with HF symptoms.
• Recent recommendations from the Payment Advisory Committee (PAC) to Congress are to reduce or possibly deny payment for all cause readmission following HF admission.

Heart Failure Workgroup

• In May 2008, Rachel Tidwell, Divisional Director of Cardiovascular Systems at OLOL commissioned a multidisciplinary workforce to assess our current HF treatment regimen, rate of admission, length of stay, readmission rate due to HF, all cause readmission rates and patient follow-up post discharge.

HF Workgroup

• The project team consist of:
  – Divisional Director of the CVS at OLOL HC
  – Divisional Director of the Emergency Services
  – Physician Champions from Cardiology, Hospital Medicine, Medical Staff Office
  – Clinical Nurse Specialist-Medicine, Cardiovascular Services
  – Quality Outcomes Coordinators
  – Medical Management Consultant
HF Workgroup
• Pharmacists
• Cardiovascular Nurse Managers
• Cardiovascular RN Team Members
• Cardiovascular CNS Educator
• Health Information Management and Coding Specialists

Process Development
1. Designation of a primary unit for HF admissions (Cardiology 3)
2. Design an arsenal of discharge tools that complimented one another and filled all gaps in the current discharge process
3. Develop a flow chart of the current processes and one for best practice process

Process Preparation and Implementation
• Team input and education in use of all tools
• Team education packet developed
• Cardiovascular Nurse Educators utilized for team development for all new and existing team members
• Computer based learning tools available

Educational Tool
The following items were discussed daily with the patient and/or family members:
– Medications
– Activity
– Diet
– Worsening Symptoms (Daily Weights)
– Follow up
– Home needs
– Avoid
– Are you ready?

Educational Tool
• The yellow light: signified the patient had some understanding, but needed more information about how to care for self at home.
• The red light: meant the patient had multiple questions and needed better understanding of the medical needs or condition
• The green light: meant the patient fully understood and had no questions about self-management at home.
Educational Tool

- Scripting was developed to assist the bedside nurse in educating the patient.
- For example: Is there any reason you will not be able to start taking your prescribed medications as soon as you get home?
- Do you have a scale at home so you can weigh yourself everyday?
- Season your food with herbs instead of salt

Complimentary Tools

- Fight Against Heart Failure Handbook
  1) Medical Contacts
  2) Common Symptoms
  3) Limit Intake of Sodium
  4) Limit Cholesterol and Fat
  5) Exercise
  6) Medication and Treatment Options
  7) Calendar
  8) HF Symptom Awareness and Action Plan

Additional Resources

Discharge Callback Protocol

- All patients discharged with HF received follow up phone calls to proactively address issues related to daily weights, medication compliance, worsening signs and symptoms, and follow-up appointments with physicians.
- The calls are initiated by the Customer Service Representatives.
- Patients with any concerns receive follow-up call from RN

Outcomes

1. Callback compliance protocol is 100%.
2. HF Readmission rate decreased from 38 patients (19.7%) to 32 patients (16.6%) in the initial five months of process implementation
3. Patient Satisfaction Scores on Cardiology 3 regarding instructions for care at home increased from a mean score of 83.7 in the 2nd annual quarter to 88.6 in the 4th annual quarter.

Next Steps

1. Re-evaluate volume of HF admissions and current space
2. Create an electronic task as a reminder for HF Discharge Readiness Patient Education daily
3. Implement processes on other units with HF admissions.
4. Continue to review processes from Inpatient to home and beyond to ensure continuity.
Q/A