Improving Discharge Procedures to Reduce Unnecessary Emergency Department Return Visits

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Unnecessary return visits to the emergency department are a problem for most healthcare facilities face across Florida and other states. Unnecessary return visits are indicators of poor care quality. Numerous studies have demonstrated emergency departments discharge procedures are a significant contributor to unnecessary return visits (Taylor, 2000). This issue creates gabs in continuity of care for patients resulting in an inadequate or incomplete emergency department discharge. The healthcare providers must realize that inadequate discharge negatively impacts patient compliance with care, treatments and follow-ups. Providing verbal and pre-formatted written discharge instructions to the patient does not guarantee that the patient understands information provided. The patient must understand the medical information given and participates in their care. The best way to achieve patient understanding is communicating, and reinforcing while acknowledging culture, belief and language barriers.

**Purpose**

The purpose of this project is to implement a discharge tool that will help healthcare providers to better communicate with patients and better achieve patient understanding. The proposed intervention is to implement a discharge checklist tool that enables patients to document their understanding of discharge instructions by marking and answering questions about the discharge instructions packet. The patient and the provider will document the exchange by both signing the discharge tool. The tool will remain in the patient’s medical records.

**Expected Outcomes**

After educating doctors, mid-levels providers and nurses on how to utilize the discharge tool they should be able to provide patients higher quality discharge instructions. Most importantly, once individuals have been educated on the appropriate way to discharge an ED patient, it can be assumed these patients will continue to seek care accordingly. The implementation of this tool is expected to achieve the following outcomes.

* Reduce or possibly eliminate unnecessary ED returns visits.
* Improve the ED quality of care.
* Improve patient satisfaction.
* Improve providers competence.

*Negative Outcome*

Negative outcomes can occur with the implementation of the discharge tool. The providers will need to take time to explain and make sure the patient understands discharge material. This can cause a delay in discharges that will lead to an increase in discharge time. The issue can be resolved by delegating certain discharge topics between doctors and nurses. For example the doctors will discuss diagnosis, test results and treatments with the patient, while nurses will discuss treatment side effects, follow-up care and reinforce all material given.

**Background**

Although hospitals have been striving to cut the cost, this goal has not been satisfactorily addressed because of the problem of unnecessary return visits to the ED. Most hospitals in the state of Florida have been concentrating on reducing 30-day readmission with a few activities and intercessions (Centers for Disease Control and Prevention, 2017). In Florida, it is estimated that 28% of the acute care visits and half of the hospital admissions emerge from the ED (Center for Disease Control and Prevention, 2017). The authorization of Patient Protection and Affordable Care Act 2010 has shown the requirement for coordinating patient care voice in structuring the conveyance of social insurance (Rising et al., 2014). The clarifications for patients to come back to the ED, the possibility of future return, and the recurrent unnecessary return visits can be obtained from administrative data. Some common factors have been associated with high rates of readmission of patients to ED. They include low follow up care and any language barrier that limits patients from understanding the discharge instructions. Other variables include old age, non-ambulatory status, and absence of family support.

These visits are not only cumbersome to the healthcare personnel, but also an important indicator of the quality of care. The EDs constantly face the issue of limited resources, high rates of patient admissions, aging population, and deficiency of human services suppliers. Majority of the ED have gotten amazingly overcrowded leading to long delays in care which contributes negatively to the patients' outcomes since they cannot be treated on time. Patients returning to the emergency department have medical issues that have either failed to go away or improve or have gotten worse. Being an important metric to measure the quality of healthcare, the problem of unnecessary return visits to the ED is very important to healthcare providers since it provides with essential information regarding their performance. A reduction in the rate of unnecessary return visits to the ED is a marker of high-quality care, while an increase in the rate signifies poor healthcare performance and poor patient outcomes.

**Advanced Practice Relationship**

The nurse practitioners possess a deep level of knowledge in health care that allows managing a broad spectrum of clinical problems that ends with positive outcomes. Nurses assume a key role in transforming care. They can offer cross cultural competencies and proficiency in care that leads to clear clarifications concerning patient discharge which involve the factors that emerge while patient is at home, and how to move toward circumstances that may force them to return to the ED (Rafnsson & Gunnarsdottir, 2010). This will help keep the patients from heading off to the ED once more. Moreover, nurse practitioner’s relationship with patients is built on working together to achieve a positive outcome which helps with care compliances. Nurse practitioners are proven to decrease patients ED visits, hospital admissions, and healthcare cost (Rushforth, 2015). The nurse practitioner can provide training that points towards upgrading the nurses and doctor roles that incorporates patient engagement.

**DNP Essentials**

This DNP Project is supported by the eight DNP Essentials. The essential I is the scientific underpinnings of this education which reflect the complexity of practice at the doctoral level and the rich heritage that is the conceptual foundation of nursing (AACN, 2006). The educational part of this project will assist healthcare providers to understand the patterning of human behavior in interaction with the environment in normal life events and critical life situations after being discharge from the ED. This will help improve science discipline by understanding the nature and significance of health and health care delivery phenomena. This essential also maintains that the extensive understanding of the nursing theory ensures that advanced nursing practice is built upon a solid foundation. Graduates can therefore integrate nursing practice with organizational or analytical sciences (AACN, 2006). These science-based concepts can therefore be used to improve the quality of healthcare.

Essential II is the organizational and systems leadership to improve quality and systems thinking meaning that doctoral level knowledge and skills in these areas are consistent with nursing and health care goals to eliminate health disparities and to promote patient safety and excellence in practice (AACN, 2006). This essential helps in transforming research into practice. The project is based on quality improvement by making changes to current discharge policies by providing the best practice to discharge a patient. This will improve patient outcomes after being out of the ED and prevent them from returning because they didn’t understand discharge/after care instructions.

Essential III states scholarship and research are the hallmarks of doctoral education (AACN, 2006). This essential mainly focuses on the complex issues that face modern health. It further focuses on the medical dilemmas that physicians face in patient care, as well as shaping the evidence-based initiatives in the agenda of healthcare. The project uses analytic methods to critically appraise existing policies and other evidence to determine and implement the best practice to discharge a patient from the ED.

Essential IV allows the DNP prepared nurse to design by selecting, utilizing, and evaluating the programs that monitors outcomes of care, care system, and quality improvement including consumer use of health care information system (AACN, 2006). This project contains a significant analysis that involved patient’s quality of care and the utilization of patient care technology. Findings represent an opportunity to evaluate the return visits to ED for inappropriate discharge.

Essential V refers to engagement with the policy development by identifying the problem and creating a healthcare system that meets the needs (AACN, 2006). This project helps the DNP prepared nurse to educate others such as policy makers regarding patient outcomes, policy change, and the correct way of discharging a patient from the ED. Additionally, would address and facilitate health care needs in acute care setting.

Essential VI states the importance of effective communication and collaborative skills in the development and implementation of practice models (AANC, 2006). The project demonstrates a collegiality within the community of knowledgeable people from different professions in health care system with endeavors to serve the population by utilizing healthcare resources.

Essential VII DNP prepared nurses is expected to evaluate care delivery models and the utilization of using concepts related to community, environment and occupational health, and cultural and socioeconomic dimensions of health (AACN, 2006). The project embraces the community to the extent of knowledge by supporting strategies directed to improve all dimensions of health. Additionally, supports the theoretical framework that is utilized to guide the project in the community as a whole.

Essential VIII the DNP prepared nurse is expected to design, implement, and evaluate therapeutic interventions based on nursing science and other sciences (AACN, 2006). This project focuses on the established strengths and knowledge of the NP by applying them to the ability of the researcher of effectively evaluate, teach and educate individuals on the correct alternative provision of health care. This Essential shows DNP prepared nurse ability to demonstrate advanced levels of clinical judgment such as systems thinking, accountability in designing, evaluating evidence-based care to improve patient outcomes.

**Population and Setting**

Florida’s Celebration community is populous, which makes it an ideal area to create and execute the intervention. The population for this DNP Project is located in an acute care hospital in rural Central Florida. They have varying cultural backgrounds, which are mainly determined by race. Local residents can be categorized into whites, African American, Hispanic, Asians, Native Americans, and people with a combination of two races. The culture of the target population impacts their health, beliefs about diseases and death, lifestyles as well as health promotion. The psychosocial dimensions include can be categorized into three. Medical dimensions relate to the type of treatment, the perception of suffering, and the clinical course. Psychological factors cover the disruption of life goals and the potential of adjusting life plans using coping strategies and emotional stability. The social factors comprise the availability of support from close associates such as friends, family, and co-workers.

**Project Alignment with Practice Site Mission and Goals**

The practice site for this project is a standalone emergency department in Polk County in the state of Florida. The facility is currently open twenty-four hour daily and staffed with healthcare professionals such as physicians, mid-levels providers, registered nurses and paramedics. Its mission and goals are closely aligned with the project objectives which include providing high quality care to patients, ensuring patient compliance with discharge instructions and patient satisfaction. Other goal aligned with project is safe transitions of care, that is essential in promoting better patient experiences, reducing costs, and enhancing the quality of outcomes. Unscheduled return visits to the emergency department reflects inadequate follow-up procedures or discharge practices. The goal of the project site is to eliminate indicators of poor-quality patient care and ensure that the facility enhances its provision of high-quality care by providing sufficient resources to the patients for them to be compliant with their care.

**Target Population**

The environmental factors for the target population are significant in influencing the quality of their health and defining the necessary preventive measures. It is estimated that 23% of all deaths in the world, as well as 26% of deaths in children below the age of 5, are contributed by environmental factors that can be prevented (Healthy People 2020, 2019). Some of the factors that impact the target population include climate change, exposure to toxins in food, water, air and soil, the contamination of their habitats, and occupational dangers.

The estimated demographic descriptors of the population are 49.1% male and 50.9% female and a median age of 35 for both genders. The population has an average family size of 3.14. The health literacy of the target population varies significantly according to race. For example, 14% of the whites are proficiency in health literacy; the rate literacy rate for Hispanics is 4%, with that of the African American being only 2% (Rikard et al., 2016). The intermediate literacy rate for the three races is 58%, 31%, and 41 %, respectively. The proficiency level implies that individuals can clear read, write, understand, and solve problems. The intermediate level suggests that people can experience a problem, such as solving problems. Health literacy has direct impacts on health outcomes. Literate people have better outcomes than illiterate ones. In 2016, the life expectancy of the target population was 78.8 (Rikard et al., 2016). Diabetes and stroke caused 21.3 and 37.6% of all deaths in this population. The adults that smoke cigarette makes 15.1% of the entire population. It is further estimated that 21.8% of the people visit the emergency room at least once a year.

**Key Stakeholders**

The key stakeholders in this project are the physicians, nurses, home care providers, managers, and prehospital care personnel, as well as the insurance companies who pay for the patients’ medical care. The emergency department stakeholders primarily focus on the several indicators focus mainly on their capacity to provide quality care. For emergency departments to effectively respond to patient care needs, the stakeholders must step in to ensure the current environment of health care delivery, enabling the ED to adjust changing models of care delivery; hence creating a controlled process that enhances the achievement of goals and efficiencies of the healthcare facility.

**Benefit of Project**

The major benefits of this project to clinical practice is to ensures improvement of the quality of care, patient satisfaction, discharge process and follow-up care, as well as significantly reducing the overall cost of patient care. According to Lee et al (2015) a study done by Dr. Sabbatini and colleagues, it was determined that patients who unnecessary return to ED for further treatment have longer lengths of stay and increased costs during the repeat hospital admissions compared to those who do not return to the emergency department. A greater understanding of the essentials of this project will be beneficial to physicians, nurses and other healthcare practitioners and improve their clinical practice; hence enhancing the overall patient care and outcomes, preventing unnecessary return visits to the emergency department.

**Needs Assessment**

The volume of patients’ received in the ED from December, 2019 to March, 2020 ranges anywhere from 72 to 98 patients per day, with 35% of these patients returning back to the ED because they did not obtained instructions for follow up, unexplained diagnoses, and not given test results so they can provide to their primary care provider for continuity of care. This issue has caused primary care providers to referred patients back to ED for further treatments or follow-up care. From that 35% of unnecessary return visits, 12% ends up being admitted to the hospital due to the failure to complete treatment and to the lack of instructions in care after they had been discharged from the ED. There are several information gaps which occur due to the unavailability of patient information that were previously collected by physicians. Information gaps were present in around one-third of the visits to the emergency department. These gaps meant that physicians were not able to provide high quality care to patients upon their first visit, increasing the chances of unnecessary return visit to the emergency department (Hayward et al., 2018).

Return visits to the ED are presently a metric of the adequacy of ED discharge activities. The short returns to the ED are constantly monitored with metrics. This metric mirrors the ED quality, particularly in situations where patients need re-hospitalization. Nonetheless, there issues embracing unnecessary return visits as proportions of value since it is unsure and connected with unpredictable results. The ED offers care for a blend of the patient population. A considerable number of patients are released home after treatment without appropriate education related to follow-up care. This analysis distinguished the issue in relation with adult population in the ED. This investigation recognizes the challenges that address the difficulties related with unnecessary return visits. The doctors in the ED must realize how to adjust expected hospitalization benefits against costs related with hospital stay and clinical vulnerability when settling on choices concerning patient hospitalization.

**Literature Review**

A literature search conducted in the current body of research for this topic. This included online library search of peer reviewed evidence-based articles, site library, and journals. The identified documents were reviewed and collected as part of evidence. References listed of each document for the identification of relevant publications. The research conducted online for the purpose of this investigation were reliable sources such as Cochrane library, MEDLINE, and CINAHL. The irrelevant articles were limited by using accurate terms.

The key words utilized for the search of this project were the following: return visits in the emergency department, discharge process in the emergency department, emergency department overcrowding, quality of care in the emergency department, correct way to discharge a patient from the emergency department, return visits to the emergency department costs, emergency department discharge policies, high quality discharge, best discharge process in the emergency department, improve emergency department discharge process.

**Literature Synthesis**

Return visits to emergency departments in medical facilities are one of the most common challenges facing organizations. The emergence of these trends has adverse effects on the provision of care services. Particularly, the unnecessary returns visits stretch the resources of the organizations in such a manner that they have adverse effects on the quality of care being provided to patients. The purpose of this section is to provide a review of the literature regarding the concept of unnecessary return visits of patients to ED and the extent to which they affect the quality of care in medical facilities.

**Causes of Unnecessary ED Return Visit**

Kuan (2009) explains that one of the causes of unnecessary return visits to emergency departments is the failure to give adequate instructions to the patients or their guardians at the point of discharge. The author says that before patients are discharged from medical facilities, there is a need to make sure that they have sufficient information that they will rely on during their recovery. However, in many instances, the medical care providers fail, out of human error, to give adequate instructions to the patients. In these instances, mistakes occur, and these mistakes may have adverse effects on the recovery of the patients. Most importantly, the failure to give adequate instructions may lead to the patients making mistakes that may have huge effects on their recovery. Kuan (2009) says that in his investigation, many of the returning patients complain of the initial issues that they had initially. The implication of this is that from the time of discharge and return home; there must have been a mistake that the patient or their handlers made.

Kuan also makes an interesting observation about the cause of a high rate of unnecessary returns visits to emergency departments. In his study, Kuan mentions that the levels of congestion in many emergency departments have contributed significantly to the high levels of returns visits due to poor quality of discharge. The author contends that congestions in emergency departments in hospitals lead to under-treatment of patients in the emergency departments, and this compromises the quality of healthcare being provided in the medical facilities. Thus, when patens return to the emergency department, part of the reason for their return is poor treatment at the initial presentation.

Van der Linden et al. (2015) stated that the nature of the initial complication plays an important role in determining whether a patient will make return visits to the hospital. For instance, the paper says that patients with abdominal pains or urinary problems are likely to make to return to the hospital for further medical attention. It is also evident from the analysis of Van der Linden et al. (2015) that the timing of the initial presentation also plays a role in the determination of whether or not a patient will return to the hospital. For example, in their studies, the researchers found that a significant majority of the patients who made the returns were those who initially presented their cases at night. The implication of this fact is that patients are presented to emergency departments at night; there is a high chance that mistakes may happen with their treatment and discharges, and that is likely to have adverse effects on the quality of treatment. Thus, when an organization is exploring various ways to reduce the rates of returns visits to medical facilities after being attended to in the emergency departments, it is necessary to make a consideration of the quality of medical care being provided in the night shifts. Besides, it would be necessary for a healthcare facility to take stock of the most common causes of returns and make necessary changes that would address the challenges.

**Impacts of Unnecessary ED Return Visits**

Unnecessary return visits can have tremendous effects on hospitals emergency department. There is a need to carry out an assessment of the extent to which this problem is capable of affecting hospitals so that it may be easy to come up with appropriate policies for healthcare organizations. Trivedy and Cook (2015) indicate that return visit is capable of putting a hospital's reputation at risk of being questioned. When it appears that there are very many return visits to hospitals, it creates a leeway for many people to start questioning the quality of healthcare in the organizations. Hospitals depend significantly on their reputation to attract clients. A hospital will only get clients when it has a good reputation in the industry. Therefore, when it appears that there are many patients who return to receive further treatment, there is a chance that it may have effects on the public perception of the organization.

Sauvin et al. (2013), on the other hand, says that return visits to emergency departments are a threat to the resources of an organization. In many cases, treatments in emergency departments consume tremendous resources, and that makes them very expensive. For instance, the authors mention that emergency surgeries are very expensive, and that means for every single return, there is a double amount of resources being spent on one medical problem. Such resources could have been used to address other challenges within the organization. At a time when costs of medical resources are on the rise, many facilities are looking for strategies to reduce the costs of medical equipment; there is a need to make sure that there is optimum utilization of resources. The occurrence of high levels of returns to emergency departments means there is avoidable utilization of resources. Such resources could not be spent in the event where they were not spent.

**Reducing Rates of Unnecessary ED Return Visits**

In the face of the impacts that return visits are capable of having on an organization and its resources, there is a need to take active actions that would reduce the trends. Reversing the trends will not only improve resource utilization but also protect the reputation of an organization. In Jimenez et al. (2017) suggestted that the ability of a medical facility to offer high-quality care is capable of having a tremendous impact on the rates of unnecessary returns. In the event where an organization offers high-quality care services, some of the recurring complications will not recur since they would have been addressed comprehensively. In this regard, the paper says that the most important thing is for medical organizations to improve the quality of care services that they offer.

Chan et al. (2016) indicate that keeping communication with patients even after they have been discharged from hospitals is likely to have a significant contribution to the recovery of patients. Since some returns are occasioned by the failure of patients to follow instructions on what they need to do post-discharge from the facilities, consistent communication with the patient is likely to prevent the mistakes from happening. It is, therefore, necessary for hospitals to make sure that they have adequate plans to make sure there will be effective communication with the patients when they leave the premises of the hospital.

**Theoretical Framework**

A theoretical framework plays an important role in the development of an objective and academic piece of work for this project. The theoretical framework is critical in providing the philosophical, epistemological, methodological, and analytical foundations to the study. The development of a theoretical framework was critical to the successful complete of this study. The Andersen framework of health utilization is the framework that has been selected for the execution of the study. The Andersen framework of health utilization is a model of healthcare that has been used to analyze and explain the factors that influence the ability of people to access healthcare services (Heider et al., 2014). The utilization of this model will make it possible to understand the unique traits of communities and the extent to which these unique traits may influence healthcare behaviors. (Andersen Framework model see Appendix Figure 1).

**The Rationale for the Choice of the Conceptual Framework**

 The choice of a conceptual framework aligns with the nature of the project. There various features of Andersen framework of health utilization that make it suitable for this project. The model describes the environmental, population characteristics, health behavior, and outcomes that influence the access to healthcare by people (Heider et al., 2014). In the present research, it is evident that the primary focus is to examine rates of unnecessary returns visits to emergency department. The examination of the reasons of unnecessary returns visits will make it imperative to look at some of the characteristics addressed by the Andersen framework of health utilization. For example, the aspect of healthcare outcomes when it comes to patient satisfaction and the nature of the populations will make it relevant to use the model. An analysis of the nature of the population and the healthcare outcomes in the emergency departments will make the application of this conceptual framework suitable for the study. Moreover, the component population characteristics is divided in three elements: predisposing characteristics, enabling resources, and need (Andersen, 1995).

 Predisposing characteristics are the socio-cultural characteristics of individuals which exist before the illness and encompass social structure, health beliefs, and demographics (Andersen & Newman, 2005). The social structure includes education, occupation, ethnicity, social networks, interactions, and culture. Meanwhile, health beliefs are defined as attitudes, values, and knowledge of disease processes and the health care system by individuals. Demographics include age and gender.

 Enabling resources is the accessibility of those resources by the community. These include income, transportation, health insurance, and a primary source for health care (Anderson, 1995). Moreover, the community reflects the available health resources for facility space, wait times, and adequate staffing levels.

 Lastly, the need aspect of the model includes functional and health problems that generate the need for health care services and is divided into two aspects: perceived need and evaluated need (Andersen, 1995). Perceived need in this framework explains how people see self-general health and functional state which includes the experience of symptoms such as illness, pain, wellbeing and whether their problems to be of sufficient importance to seek professional help. On the other hand, evaluated need represents the decision of the health care provider that will act as the source of care fulfilling patient health care need (Andersen, 2008).

**Relationship of the Theory/Framework**

 The primary way in which the theoretical framework may be helpful in the DNP project is its contribution to the development of approaches that may be used to improve the quality of healthcare services in emergence departments. Through this model, it will become possible to have an understanding of the nature of the challenges facing the department. Such knowledge will be helpful in the determination of quality improvement strategies.

**Identify Change Theory**

 The Andersen framework of health utilization examines the history of a population or a medical care facility. The understanding of history makes it possible to develop suitable interventions for challenges facing patients and the hospital. The Andersen framework of health utilization makes it possible to understand the implications of discharging patients before giving them adequate care services. Additionally, explores quality of care through outcomes and patient satisfaction. The framework will make it possible to create a connection between quality of healthcare services in the emergency departments and the rates of unnecessary returns visits.

**Project Implementation Plan**

**Preparation**

This intervention would take effect with proper ED discharge training. The doctors, mid-levels and nurses will be briefly educated on appropriate discharge procedures before starting with the discharge checklist tool intervention. The training will be guided by researcher and consists in introducing a discharge checklist tool and how to use it appropriately when discharging a patient from the ED. The doctors, mid-levels providers and nurses will participate in this training. A pretest will be given just to have an idea on how each healthcare provider takes care of a discharge. Additionally, a post test will be provided at the end of the training. The checklist tool will assure that patients understood all information provided and resources were given before being released from the emergency department. The patient and healthcare provider will need to sign affirming discharge instructions were cleared and patient is ready for check out. This tool will be place in patient’s medical records. The expected outcome and evaluation of this activity is to ensure that healthcare providers have necessary tools to discharge a patient appropriately from the emergency department by providing high quality of care. The effectiveness of this intervention will be manifested in the improvement of service delivery. The strategy is expected to reduce unnecessary return visits to ED and improvement of the patient outcome. (Discharge tool see Appendix Figure 2).

**Protection of Human Subjects**

Protection to all participants is maintained throughout the project since no information that identify participants would be needed for the completion of this project. Upon project proposal approval an application will be submitted to the IRB for approval.

**Project Budget**

 The project cost for now is $455.48. This reflects the costs of printing material that will be provided during the preparation of training. Additionally, the costs of printer ink for the utilization of practice site printer for making copies of discharge tool, questionnaire, pretest and post test and surveys. These costs will be covered by researcher since it will be reimbursed by practice site scholarship that was requested on January 15, 2020 and was approved January 31, 2020.

**Implementation**

The proposed intervention will start by utilizing the expertise of nurses in minimizing overcrowding in the ED. These professionals are at an ideal position of reducing the congestion because they are in direct contact with patients. They have specialized tasks, that provides opportunity to better communicate with patients. The problem of the patients to understand discharge instructions can be addressed adequately by doctors but nurses have more time to handle better situation (Sayah et al., 2014). They handle all the necessary procedures of ensuring that patients are discharged from the hospital, which includes all the paperwork that needs to be illustrated to the patients, their caregivers, or family members. Nurses can take this opportunity to explain in detail all the questions that the patients of caregivers ask and even asking them questions to ensure that they understand the provided information in detail. Nurses are in better positions of discussing in detail all the concerns of the patients as well as their illnesses. The participation of all nurses employed in practice site is required for the completion of the project. Additionally, doctors and mid-levels providers are invited but not require due to their busy agenda, but information will be provided to medical director via email for sharing. The participants identification is not currently needed for project, but an attending/participation list will be provided by administration for them to keep.

**Data Collection**

Data collection will play an important role in the accurate determination of the most relevant approaches to use in addressing the needs of the facility. Then the accuracy of data will make it possible to develop the most suitable approaches to solve the challenges facing society. One of the approaches that is used in data collection is a questionnaire. The questionnaire will be provided to patients who are leaving the hospital, the medical and non-medical staff of at the facility. Specifically, the open-ended questionnaire will be used to enable then individuals to provide all the necessary information that may be useful in making decisions concerning the hospital. An open-ended questionnaire is advantageous in the sense that it is possible for a respondent to provide additional information that was not sought in the questionnaires (Saris & Gallhofer, 2014). Besides, personal attendance to the facility and witnessing the activities at the facility will make it possible to have a personal interaction with the environment and make observations that will improve the quality of decision-making (Terrell, 2012).

There are specific activities that have been carried out for the project implementation. The following is a description of some of the activities that have to be implemented in the project implementation plan. (Questionnaire tool see Appendix Figure 3)

* Interviewed the doctors, mid-levels providers and nurses in the emergency department regarding the situation. The interview with these groups has shed more light on the activities taking place in the emergency departments.
* Clinical Practice at the emergency department which was observed how medical care services are provided. This has made it possible to have an in-depth understanding of some of the challenges that this facility encounters on daily basis and to make comparisons.
* Identified some of the issues that may be contributing to returns visits among patients.
* List possible causes of action.
* Settle one course of action and develop a framework to address it.

*Pretest for providers*

* Identify the correct way to discharge a patient from the emergency department.
* What educational material the discharge instructions should contain?
* Did you provide educational material to patient? What method should be use?

*Posttest for providers*

* What is the appropriate way to discharge a patient?
* What educational material you should provide to the patient?
* What is the appropriate way to educate patients?
* What boxes you should checkoff on the discharge tool?
* How do you know if patient understood and received all the material needed on discharge?

**Project Timeline**

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| --- | --- |
| **EVENT** | **TIMELINE (2020)** |
| After data collection will start with discharge procedure training of existing employees. Introduction of discharge checklist tool.  | April-May |
| Evaluation of effectiveness of discharge procedures with new tool. | May-June |
| Revaluating of organizational policies and practicesDischarge policy changes. | June-July |
| Impact analysis, Introduction of necessary changes after impact analysis. | August |

**Data Analysis**

The data analysis is taken from the answers provided by ED employees questionnaire which was evident of avoidable mistakes that some of the staff members commit during discharge process. One of the possible reasons is the failure of the organization to train employees and enhance their skills continually in discharging patients from ED. The implementation strategy will be a classroom presentation and training of the appropriate ways for discharging patients and how to utilize the new discharge checklist tool. A pre-test and post-test will be provided in order to validate employees learning and understanding of the material given. Most importantly, employees at the facility need to be trained on then-emerging medical practices. From the interaction with the employees, it is notable that a significant number of the employees, especially the medical staff, are not conversant with the prevailing medical practices. Intensive training can concentrate on improving the role of doctors, nurses and incorporating patient engagement. The efforts can guarantee that patients don't go to the emergency department again because discharge instructions were not provided the correct way, or no one took the time to make sure that patient understood entirely after care.

**Project Evaluation**

The expected outcome and evaluation of the discharge tool will be determined by the extent to which the patients understand the instructions. The effectiveness of this intervention will be manifested in the improvement of service delivery. The strategy is expected to reduce the overcrowding at the emergency department due to unnecessary return visits and improvement of patient outcome. Additionally, nurses are they key for this tool since they are in direct contact with patients. The issue of the patients to comprehend release guidelines can be tended effectively by nurses (Sayah et al., 2014). They handle all the vital techniques of guaranteeing that patients are released from the hospitals, which incorporates all the desk work that should be shown to the patients and family members. Nurses can grasp this opportunity to clarify in detail every one of the inquiries that patients or family members have by asking them questions to guarantee they understand the information given. Nurses are in a better position to partake in clarifying the concerns of the patients as well as their diseases. This intervention can guarantee that patients are compliance with their care by following discharge instructions and maintain a strategic distance from unnecessary visits to the ED. It should be fortified with legitimate ED training on discharge tool and patient management to reduce future unnecessary returns. Intensive training can improve the role of nurses and incorporating patient engagement. These efforts can guarantee that providing a high-quality discharge process, it initiates the preparations for patients to return home and can properly manage their recovery without having the necessity of returning to the ED, thus reducing overcrowded.

**Formative Evaluation**

The project is on course with data collection and intervention ideas. Formative evaluation is an important assessment of the project that helps to identify the progress and effectiveness of the implementation plan. Some of the approaches with which formative evaluation will be conducted in this project include:

* Generation of possible intervention ideas.
* Testing of ideas and concepts.
* Seeking early response, a determining general acceptance of the interventions.
* Opening communication channels to get the perspective of people in the process of implementing the interventions.

**Summative Evaluation**

The evaluation primary objective is to measure the success of project implementation. By conducting a summative evaluation, it becomes possible to know if the project has achieved its goals. The following are some of the ways through which the summative evaluation will be done in the project;

* Evaluate if the project has been completed within the planned timelines.
* Evaluation of questionnaires, pretest, posttest and surveys.
* Evaluate the responses of the targeted audiences to determine if it achieves the intended goals.
* Evaluate the outcome if there is any meaningful change.

**Project Sustainability**

There is a need to evaluate the suitability of data collection instruments. The plan is to evaluate if employees are adapted to new changes with discharge process and evaluation of unnecessary return visit outcomes. This will help to determinate if the project was successful and sustainable. The next step is to make changes in the current discharge policy by adding discharge checklist tool in the policy. This step will assure that project will sustain, and all employees will be required to discharge patients appropriately.

**Conclusion**

The purpose of this project is the implementation of a clinical intervention to ensure a reduction of unnecessary return visits to the emergency department. The problem is the healthcare providers are not providing high quality of discharge instructions to patients and it reflects as a poor quality of care. The findings in this project indicates that patients are returning to the ED unnecessarily due to the lack of resources provided by health care providers upon discharge. These providers are not explaining diagnosis entirely, treatment options, side effects and follow-up care resources to patients. On the other hand, many patients do not understand medical terminology and further education such as reinforcing is needed, others is language barrier issue because translation takes a lot of time. Many healthcare providers in the ED are in a fast pace and time is not enough for explanations which have led to poor quality of care. The issue is causing patients to return to ED due to poor outcomes in patient care. At the moment, it is evident several challenges are making it possible for many healthcare facilities to realize increased cases of unnecessary return visits. The purpose of this project is to addressed these issues by training healthcare providers on appropriate ways to discharge patients and also the implementation of a discharge checklist tool that will ensure that patients receive discharge instructions in their preferred language with all resources needed well explained in simple vocabulary to help patient to understand after care plan or treatments. This project will improve the quality of care and will reduce unnecessary return visits to the emergency department.

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Appendix

**Levels of Evidence**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title** | **Author(s)** | **Year** | **Type of Article** | **Grade** | **Summary** |
| Centers for Disease Control and Prevention | Emergency department visits | 2017 | Short report | 1 | Discusses a wide range of emergency issues in many health facilities. |
| Trends in emergency department use by rural and urban populations in the United State | Ericksen & Kocher | 2019 | Original Research | 1 | The paper takes a look at the trends in America’s emergency departments with a keen interest in quality indicators. |
| Environmental health | Healthy People 2020 | 2019 | Short Report | 1 | The paper looks at the environmental factors that influence the health of individuals. |
| Examining health literacy disparities in the United State: A third look at the National Assessment of Adult Literacy (NAAL) | Rikard et al. | 2016 | Original Research | 1 | The paper summarizes health literacy in the United States. It is concerned with the manner in which health literacy impacts health choices. |
| Return visits to the emergency department: The patient perspective | Rising et al. | 2014 | Original Research | 2 | The paper summarizes the perspectives of patients on the reasons for return visits to emergency departments. |
| Minimizing ED waiting times and improving patient flow and experience of care | Sayah et al. | 2014 | Original Research | 1 | The paper examines the ways of minimizing waiting time in emergency departments and to improve experience of care. |
| Revisiting the behavioral model and access to medical care: Does it matter? | Andersen | 1995 | Original Research | 2 | The paper looks at the behavioral models applied in healthcare and the extent to which it influences the quality of care. |
| National health surveys and the behavioral model of health services use. Med Care | Andersen | 2008 | Original Research | 2 | The paper also looks at various health behavioral models and the extent to which they impact access to health services. |
| Societal and individual determinants of medical care utilization in the United States | Andersen & Newman | 2005 | Original Research | 2 | The paper discusses the societal and individual factors that determine the utilization of care services in the country. |
| Characteristics of patients who made a return visit within 72 hours to the emergency department of a Singapore tertiary hospital | Chan et al. | 2016 | Original Research | 2 | The paper looks at the different human or personal characteristics of the individuals who returned to emergency departments for treatment. |
| Health care costs in the elderly in Germany: an analysis applying Andersen’s behavioral model of health care utilization | Heider et al. | 2014 | Original Research | 2 | The paper looks at the impact of healthcare costs on the access to quality healthcare. |
| Which unscheduled return visits indicate a quality-of-care issue? | Jiménez-Puente et al. | 2017 | Original Research | 2 | The paper holds that there are certain unscheduled returns to hospitals that are due to quality challenges in the provision of healthcare systems. |
| Emergency unscheduled returns: can we do better? | Kuan | 2009 | Original Research | 2 | The paper looks at the contributing factors to unscheduled emergency returns with a specific interest on the best ways to improve the outcome of medical care. |
| Psychosocial factors influencing non-urgent use of the emergency room: a review of the literature and recommendations for research and improved service delivery | Padgett & Brodsky | 1992 | Original Research | 2 | The paper hold that there are psychological rather than medical purposes that made many people to seek to use emergency departments. |
| Correction: unscheduled return visits to the emergency department: consequences for triage | Sauvin et al. | 2013 | Original research | 2 | The paper highlights the challenge and consequences associated with unscheduled returns to emergency departments. |
| Unscheduled return visits (URV) in adults to the emergency department (ED): a rapid evidence assessment policy review | Trivedy & Cooke | 2016 | Review article | 4 | The paper reviews a wide range of policy documents concerning emergency management to determine where there are gaps and make necessary adjustments. |
| Unscheduled return visits to a Dutch inner-city emergency department | Van der Linden et al. | 2014 | Original Research | 2 | The study examines the most prominent causes of unscheduled returns to emergency departments in Dutch inner-city. |
| Emergency department crowding: time for interventions and policy evaluations | Boyle et al. | 2012 | Original Research | 2 | The paper looks at crowding in emergency departments and the extent to which it contributes to unscheduled returns to the departments. |
| Google Flu Trends: correlation with emergency department influenza rates and crowding metrics | Dugas et al. | 2012 | Original Research | 2 | The paper looks at flu outbreaks and their contribution to congestion in the emergency departments. |
| Inter-rater agreement of emergency nurses and physicians in Emergency Severity Index (ESI) triage. Emergency | Esmaikian et al.  | 2014 | Original Research | 2 | The paper evaluates the contribution of the efficiency of nurse and other care providers to effective provision of care emergency departments. |
| Unscheduled return visits to the emergency department: the impact of language | Gallagher et al.  | 2013 | Original Research | 2 |  The paper evaluates the impact of language use on the effective delivery of care emergency departments. |
| Patient autonomy in chronic care: solving a paradox | Reach | 2014 | Original Research | 2 | The paper hold that different patient characteristics can contribute to the effectiveness of healthcare in emergency departments. |
| Adherence, shared decision-making, and patient autonomy | Sandman et al.  | 2012 | Original Research | 2 | The paper looks at the triple factors of Adherence, shared decision-making, and patient autonomy and their impact on the provision of care in emergency departments. |
| Design, evaluation, and analysis of questionnaires for survey research | Saris & Gallhofer | 2014 | Original Research | 2 | The paper evaluates the effectiveness of various data collection methods including questionnaires in survey research. |
| US emergency department visits for outpatient adverse drug events | Shehab et al.  | 2016 | Review article | 1 | The paper analyzes the policies of the United States emergency department in addressing adverse drug events for outpatient patients. |
| Effect of emergency department crowding on outcomes of admitted patients | Sun et al.  | 2013 | Original Research | 2 | The paper also looks at the issue of crowding in emergency departments and its contribution to patient outcomes |
| Mixed-methods research methodologies | Terrell | 2012 | Review article | 1 | The paper evaluates the application of mixed methodologies of research in different circumstances. |

Figure 1. Andersen framework of health utilization



Figure 2. Discharge checklist tool

|  |  |
| --- | --- |
| **EMERGENCY DEPARTMENT PATIENT DISCHARGE CHECKLIST**

|  |
| --- |
| Patient Label |

Hospital Logo |
| **DISCHARGE CHECKLIST** | **ANSWERS** | **COMMENTS** |
| Language of preference  | Spanish |  |
| Certified interpreter present | Yes | C.P #1234 |
| Education given: Verbal, Written, Video | Verbal and Written |  |
| Diagnosis | Hypertension |  |
| Prescriptions given | Yes | Beta Blockers |
| Prescriptions instructions explained | Yes | Side effects |
| Test results given: verbal, copies | copies | Explained |
| Follow up care with specialists or PCP given | Yes | Dr. John Doe Cardiologist  |
| Care notes given and discussed | Yes | Monitor B/P, HTN diets  |
| Hospital property returned | Yes | Gown, blankets |
| Presense of next of kin | No | No companion |
| Discharge instructions understood | Yes |  |
| Addional instructions material provided | No |  |
| **PATIENT SIGNATURE** | Joe Doe |  |
| **DISCHAGE NURSE SIGNATURE** | CPales MSN ARNP |  |
| **DISCHARGE DOCTOR SIGNATURE** | John Doe MD |  |

Figure 3. Questionnaire for patients upon discharge

|  |  |
| --- | --- |
| **QUESTION** | **COMMENT** |
| What is your preferred language? |  |
| What language was utilized? |  |
| Did you receive discharge instructions? |  |
| Did facility provide interpreter? |  |
| What material was discussed? |  |
| What method was utilized? |  |
| Who discussed discharge instructions? |  |
| Overall are you satisfied with this visit? |  |
| General comments |  |