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### Figure List

### References

- 1. Jabre, P., Belpomme, V., Azoulay, E., Jacob, L., Bertrand, L., Lapostolle, F.,...Tazarourte, K. (2013). Family presence during cardiopulmonary resuscitation. The New England Journal of Medicine, 368, 1008-18. doi:10.1056/NEJMoa1203366
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### Figure List

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College of Nursing & Health Sciences

# Discharge Handoff to the Nursing Homes

Kelly Henry, Taylor Legg, Amanda Mixer, & Maranda Neisen NSG 405: Senior Leadership Change Project, Spring 2017

### Assessment

- Improve handoff communication between
- and nursing homes No consistent discharge report between hospital Blessing Hospital (BH) to area nursing homes

### terature Review:

- Nursing homes rely on hospital discharge communication to transition patients effectively<sup>3</sup>
- barrier to safe and effective transition<sup>2</sup> Nurses note poor discharge communication as
- risk of transmitting inaccurate and incomplete Implementing a communication tool reduces the
- Discharge summaries lack essential information<sup>4</sup>

# Attitudes Beliefs and Knowledge:

- Handoff report impacts patient outcomes
- "When doing handoff report to the nursing homes some general background information." – Angie B. example last bowel movement, current vitals, and information that I feel is the best at that time, for there is no standard protocol, I give the

# Assessment Continued

- Nursing Staff/Management/Leadership BH Sepsis Committee
- (within 30 days) High rate of readmitted nursing home patients
- Centers for Medicare and Medicaid Services reimbursement

### Restraining Forces:

ime management

### Resistance to culture change

### Change Agent Strategies Planning

- Normative-reeducative
- Rational-empirical

### Short Term Goals:

nursing homes Educate staff on effective communication to the

### \_ong Term Goals:

- nursing home when discharging Better communication between hospital and
- Implement discharge handoff into Electronic Decrease nursing home readmission rates

### Medical Record (EMR)

Evaluation Plan:

Performance Excellence Consultant Monitor the readmission statistics with

# **Implementation**

# Interviewed nursing staff/care manager on

- 2 South
- Educated nursing staff on medical surgical floor

### Evaluation

### Strategies to Hardwire Change

educators collaboration with Associate CNOs and BH implement change project as nurse residents, in Project members will continue working to

# Evaluate Effectiveness of Change:

- Develop EMR parameter
- Monitor the readmission statistics

### Summary

- What Did We Learn:
- Time management is important Importance of effective communication

# What Would We Do Differently:

- Start project earlier
- Meet with nursing administration earlier Utilize all available resources

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- Hohman, C., Haefelint, N., Klotz, J. M., Freidank, A., & Radziwill, R. (2014). Providing systematic detailed information on medication upon hospital discharge as an important step towards improved transitional care. *Journal* doi:doi.org/10.1111/jcpt.12140 of Clinical Pharmacy and Therapeutics, 39, 286-291.
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