

# Transitional Surgery Center: Reducing 30-day Hospital Readmissions

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## ABSTRACT

In 2013 and 2014, an urban medical center had an overall surgical 30-day readmission rate of 17%. A team of nurse practitioners, nurses, and physicians collaborated to reduce this rate. To accomplish this, they addressed 3 areas of focus: patient education, discharge readiness, and early intervention. The team implemented an evidence-based discharge readiness tool, established a postdischarge communication process, and used a transitional surgery center where patients could be seen urgently. After this pilot program, the rate of readmissions for surgery was reduced from 17.2% in 2014 to 15.3% in 2015.

**Keywords:** discharge readiness, postdischarge communication, readmission prevention, surgery, transitional care

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Nurse practitioners (NPs) are affected by issues pertaining to hospital cost and revenue. As members of the inpatient care team, NPs have a critical role in reducing hospital cost. In Maryland, the Health Services Cost Review Commission defines potentially avoidable utilization as “hospital care that is unplanned and can be prevented through improved care, care coordination, or effective community based care or care cost increases that result from a potentially preventable complication occurring in a hospital.”<sup>1</sup> Potentially avoidable utilization includes 30-day all-cause, all-hospital, inpatient readmissions within the state as well as emergency department or observation revisits within 30 days of an inpatient admission.<sup>1</sup> Readmissions after surgery are often related to complications that develop after discharge from the hospital.<sup>2</sup> By leading the transition of surgical patients from hospital to home, NPs have the opportunity to reduce readmissions.

One urban academic medical center had a surgical readmission rate of 17% in both 2013 and 2014. To tackle these elevated rates, inpatient surgical NPs and nursing leaders established a team to identify ways to reduce surgical readmissions. In this institution, the surgical NPs were primarily inpatient based and worked alongside the surgical team, consisting of fellows, residents, and the attending surgeons. The primary role of the NP was to work with patients and

the multidisciplinary team toward safe and effective discharge in addition to inpatient management. Discharge decisions were ultimately made by the attending surgeon.

A transitional surgery center (TSC) was created in order to provide more support to patients after discharge. The TSC started in February 2015 as a collaborative effort among the surgical NPs, inpatient nursing, and ambulatory nursing to reduce surgical readmissions through discharge readiness assessments, telephone triage by the TSC nurses, and face-to-face NP evaluations. The TSC initiative aimed to improve both preoperative and discharge patient education, improve postdischarge communication, and decrease 30-day readmissions.

Baseline readmission data showed that surgical oncology and vascular surgery had the highest readmission rates at 18.6% and 22.7%, respectively. For this reason, the team started the TSC with these 2 services. Key stakeholders were assembled, including other surgical NPs, surgeons, residents, and both inpatient and ambulatory nurses, and established 3 areas of focus: patient education, discharge readiness, and early intervention.

## PATIENT EDUCATION

Preoperative education has been a staple in many surgical specialties including orthopedics and cardiac

surgery. Studies show education started at the preoperative appointment, in both written and verbal formats, helps to ease patient anxiety, improve outcomes and patient satisfaction, and decrease length of stay.<sup>3-7</sup> Written and verbal instructions are crucial because patients forget 40% to 80% of medical information provided to them immediately after hearing it.<sup>8</sup> The *what to expect* aspect is especially important to patients and their families.<sup>3</sup> When there is a lack of appropriate written discharge instructions, patients are at an increased risk for complications and readmissions.<sup>8</sup> Therefore, patient education was a priority for decreasing readmission risk.

The NPs created procedure-specific education for patients at the preoperative visit. This evidence-based education included information about the surgery and what to expect while in the hospital and at home. Education also included what is expected of the patient, information about pain control, incentive spirometry, and diet. In addition, the NPs developed new discharge instructions based on the specific procedures. Pieper et al<sup>9</sup> described that postoperative patients have 3 critical areas of information needs: pain management, incision/wound care, and activity guidelines. This critical information, as well as the reasons to contact the surgeon's office, is thoroughly discussed in the patient's discharge instructions. These new instructions are easy to read and use as little medical jargon as possible.<sup>10</sup>

### DISCHARGE READINESS

To determine if surgical patients were ready for discharge, the team examined the most common reasons for surgical readmissions. Kassin et al<sup>11</sup> found that the 3 primary reasons for surgical readmissions were gastrointestinal problems (27.6%), surgical site infections (22.1%), and malnutrition (10.4%). Parker and Griffith<sup>12</sup> developed a postoperative discharge readiness tool for Medicare patients in their institution to help the clinical teams address any barriers to discharge. This screening tool is a 13-point assessment performed by the bedside nurse before discharge. The team instituted this tool on the inpatient floor to help ensure that patients were ready for discharge before leaving the hospital. In the TSC program, the nurse completed the assessment 1 day before the anticipated discharge date and

contacted the NP with any scores that could herald a delay. In addition, the teams participated in daily multidisciplinary rounds at set times with the discharge coordinator, charge nurse, case manager, and registered dietician. In these rounds, the team discussed daily patient plans and discharge planning to ensure that patients had all available resources to fulfill their needs at discharge, including educational resources, home care, and rehabilitation placement. The case managers communicated with the patients and their families regarding any discharge needs so that patients and families are familiar with what to expect.

### EARLY INTERVENTION

To examine the variables that contributed to readmission, the team evaluated the timing of readmissions within the 30-day window. In this review, the team determined that the majority of patients returned to the hospital within the first 14 days after discharge (surgical oncology 74% and vascular surgery 83%). The timing of readmissions was especially enlightening, considering that most patients did not follow up with their surgeons for 2 weeks after discharge. Because of the high number of patients readmitted during that 2-week period, it was evident to the team that early communication with the patient and intervention when necessary could be successful in reducing readmissions.

In February 2015, the TSC nurses initiated post-discharge phone calls to all patients discharged from surgical oncology, and vascular surgery was added in March 2015. The TSC nurses made initial contact within 72 hours of discharge from the hospital. They used a telephone assessment tool implementing Briggs telephone triage protocols.<sup>13,14</sup> If the nurse determined that the patient was doing well, the patient received a second follow-up phone call between postdischarge days 8 and 10 to ensure that the patient continued to recover appropriately. If, during the call, the nurse determined that the patient had a question or concern, the nurse notified the NP who covered that patient during hospitalization. The NP contacted the patient, triaged the issue, and determined whether a face-to-face evaluation was necessary. If a face-to-face evaluation was required, the NP instructed the patient to come to the TSC

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