



# Discharge Facilitation: An Innovative PNP Role

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## ABSTRACT

Efficient and safe transition from the hospital to the community setting remains a priority in health care. Providers face mounting pressure of both timely discharges and minimizing readmissions, because these factor have an impact on provider reimbursement. Traditionally in academic medical centers, rotating teams of resident physicians have been responsible for discharging inpatients. The acute care pediatric nurse practitioner (PNP), when discharging patients, may arrange follow-up care, prescribe medications, and sign discharge orders, as the resident physician does. Additionally, the PNP is positioned to provide continuity of care and provide detailed discharge teaching and care coordination. The goal of this article is to review the literature pertaining to the nurse practitioner role in discharge facilitation and describe the creation and impact of an innovative nurse practitioner discharge coordinator role at a large urban pediatric medical center where improved discharge times were achieved. *J Pediatr Health Care.* (2016) 30, 499-505.

## KEY WORDS

Discharge, throughput, transition, pediatric nurse practitioner

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The efficient and safe transition of patient care from the inpatient setting to the community setting has always been a priority in health care, and nurse practitioners (NPs) are well positioned to support this care transition. Nomenclature describes this process of transition from the emergency department (ED) or inpatient unit to the community as "patient throughput." Nurses and physicians frequently encounter throughput bottlenecks during high census periods, when EDs fill with patients awaiting admission while those pending discharge remain on inpatient units. It has been established that care transitions such as discharge are vulnerable times for patient safety (Harlan et al., 2010; Snow et al., 2009). Traditionally, medical residents have been responsible for writing discharge orders and working with nursing case managers and nursing staff to coordinate referrals and other aspects of discharge. However, medical residents have competing demands of admitting patients and addressing other urgent patient care issues, and discharges may not be viewed as a high-priority task. Thus, throughput may suffer as discharges are delayed. An NP in the medical unit whose primary focus is to facilitate discharges can serve a valuable role.

In our large urban pediatric medical center, we established a discharge coordination role for a pediatric nurse practitioner (PNP) to address this issue of discharge throughput bottleneck. This article describes the creation of the role and a review of the literature pertaining to patient throughput and discharge. Evaluation data on how the PNP discharge coordinator role has influenced throughput and efficiency is summarized. Moreover, similar initiatives with a focus on expediting hospital discharge have helped improve patient and family satisfaction and support patient safety and quality (Finn et al., 2011; Haan et al., 2007; Holland et al., 2015; Jack et al., 2009; Jarrett & Emmett, 2009; Kravet, Levine, Rubin, & Wright, 2007; Petitgout, 2015).

## REVIEW OF THE LITERATURE

The roles of advanced practice registered nurses (APRNs) and NPs in particular are flexible and

continually expanding. Practical experiences and research have demonstrated that NPs in acute care roles offer widespread benefits to patients, including continuity of care and reduced length of stay (Hauck, 2009; Hittle & Tilford, 2010). Some studies have shown higher rates of documentation accuracy among APRNs compared with physicians (Bradford, Camacho-Carr, & Lydon-Rochelle, 2007).

Holland and colleagues (2015) purport that pediatric hospital discharges involve unique challenges not typically present in adult discharges, including limited disposition options, more limited home care agencies and supplies, family and school environment considerations, and developmental concerns. In an evaluation of hospital discharge in a pediatric hospital, Harlan and colleagues (2010) identified areas in which transition of care from the inpatient to primary care setting may be improved. The authors concluded that the discharge process and documentation may encompass delays and errors, placing patients at risk for adverse events. They identified quality improvement strategies to support an improved discharge process, including earlier identification of the primary care provider (PCP), use of an electronic discharge order form, and better communication with the PCP at the time of discharge via e-faxing. Using a prospective, cross-sectional study design, 2,530 hospitalist patient discharges over 34 weeks were divided into preintervention, intervention (new discharge process), and postintervention weeks (Harlan et al., 2010). Adjusting the process to include auto-faxing of discharge notes to PCPs significantly improved the amount and timeliness of postdischarge communication. However, this study looked solely at automating one segment of the discharge process. The authors note that the rates of PCPs receiving the faxes and other elements of discharge such as medication adherence or follow-up with PCPs were not assessed. It is likely that although electronic medical records and automated interventions have the potential to improve documentation accuracy and timeliness of document sharing, multiple aspects of ensuring a safe and efficient discharge home require clinical judgment.

In a feasibility study of the Early Screen for Discharge Planning–Child Version (ESDP-C), the use of this decision support tool in the pediatric acute care setting was evaluated (Holland et al., 2015). The tool was used by a clinical nurse specialist (CNS) to screen patients on the day after admission; data were compared with data for patients who received standard care prior to use of the tool, consisting of the hospital's multidisciplinary discharge planning rounds. The authors found that for the patients who were screened soon after admission and found to need discharge planning assistance, the CNS was alerted to the patient's discharge needs sooner. A statistically significant decrease in length of stay (LOS) occurred after implementation of

the ESDP-C, although the small sample size ( $n = 197$  patient stays reviewed prior to implementation, compared with  $n = 103$  after implementation) is a study limitation (Holland et al., 2015). The role of the CNS did not include directing the patient plan of care, such as signing discharge orders or writing prescriptions. In another example of the nurse discharge coordinator role, a quality improvement analysis was conducted regarding the creation of a unit-based discharge coordinator in a pediatric acute care setting (Petitgout, 2015). In this role, the CNS functioned as discharge planning support, identifying discharge needs earlier in the hospital course and ensuring that patients received appropriate supplies and education. The author found that patient satisfaction scores improved, LOS was decreased, and the role was well integrated into unit staffing (Petitgout, 2015).

### ROLE EVOLUTION OF THE DISCHARGE NURSE PRACTITIONER

A distinct role to support patient throughput has previously been examined (Blankenship & Winslow, 2003; Gould, 2011; Webster, Connolly, Paton, & Corry, 2011). Blankenship and Winslow (2003) outlined the creation of the “admission-discharge-teaching nurse,” which involved having nurses available to spend time in this dedicated role on the often lengthy process of admission and discharge tasks and teaching, so bedside nurses were able to spend time on inpatient assignments. The role resulted in improved documentation of admission assessment, documentation of patient education, work satisfaction, and a sense of decreased burden reported by staff nurses. However, this role was limited to staff nurses who were unable to prescribe medications and therapies often needed for patients upon discharge and who were unable to sign orders for discharge.

Webster and colleagues (2011) conducted a randomized controlled trial (RCT) of a nurse-initiated discharge protocol in a 23-hour surgical unit that allowed for hospital discharge without physician review. Results revealed that more patients in the intervention group were discharged by 9 AM, with no difference between the two groups in total LOS or in patient satisfaction. Gould (2011) describes an RCT evaluating nursing intervention to support early discharge of adult patients who had undergone a procedure in the interventional cardiology unit. The intervention consisted of written discharge materials, including medication instructions, and telephone follow-up within 24 hours by an expert cardiovascular RN. Other than the intervention group reporting a higher level of understanding of the chronic nature of their cardiovascular disease, no significant differences were found between the two groups with regard to medication adherence, accessing urgent care after discharge, or patient satisfaction (Gould, 2011). It is possible that the intervention did not go far enough and that provision of written discharge

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