

The Utilization of Discharge Phone Calls to Facilitate Transition from Hospital to Home

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Introduction & Purpose

- Older adults are the overwhelmingly majority of hospitalized patients and are the most complicated patients to care for in the acute care setting.
- They suffer from complex medical problems, take multiple medications, are susceptible to iatrogenic events and can experience prolonged hospital stays.
- The complexity of the older adult's care doesn't end upon discharge from the hospital.
- A well thought out discharge plan, supported by nursing, can provide for a more optimal transition home and potentially prevent re-admission to the hospital.



Discharge Phone Call Intervention

- The unit clinical assistant maintains a daily paper log of patients who are discharged from the Acute Care of the Elderly (ACE) unit. The paper log is then transcribed into an Excel spreadsheet.
- The dayroom RN will review patient's discharge instructions on the EMR prior to calling the patient to help focus/individualize the phone call.
- The dayroom RN will attempt to contact the patient on day #3 post-discharge to ascertain specific information regarding the patient's understanding of their discharge instructions.
- The information from the discharge phone call is entered into the Excel spreadsheet and the data is tabulated quarterly.
- The data is reviewed and shared at both the unit and hospital level.

Results

The results verified:

1. Ace unit readmissions within 30 days have decreased 3.3%
2. 95.8% patient's had their prescriptions filled
3. 79.8% patient's scheduled their follow-up physician visit
4. 98.8% patient's were knowledgeable about when to seek medical care
5. Overwhelmingly, the patient's reported they were pleased to receive a follow-up phone call

Implications for Nursing Practice

- Hospital readmission rates for the population aged 65 yrs. and older within 30 days of a hospital discharge are scrutinized closely due to changes in Medicare health care policy.
- Registered nurses have the ability to decrease hospital readmission rates by communicating with our older adults to ensure they understand and are following their discharge plan.

