DEDER GENERAL HOSPITAL

Standard Operating Procedure (SOP) for Sustaining Improvement in Medical Ward Readmission Rates

BY: HSQU

July 2025

Deder, Eastern Ethiopia

SMT SOP APPROVAL

TITLE	**SOP for Prevention of Readmission** **Version: *DGH-SOP-MW-010***			
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REVIEW	**Review date: July 2026**			

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1.0 PURPOSE

To establish a standardized, multidisciplinary process for discharge planning, patient education, and post-discharge follow-up in the Medical Ward to sustain a readmission rate of <5%, improve continuity of care, and enhance patient outcomes and satisfaction.

2.0 SCOPE

This SOP applies to all healthcare providers involved in the care and discharge of patients in the Medical Ward at Deder General Hospital, including but not limited to: Medical Ward physicians, nurses, social workers, case managers, the Matron, and the quality improvement team.

3.0 DEFINITIONS

- **PDSA Cycle:** Plan-Do-Study-Act – a systematic method for testing and implementing changes on a small scale before full rollout to ensure effectiveness and sustainability.
- **Readmission Rate:** The percentage of patients who are admitted to the hospital again within 30 days of their initial discharge.
- **Multidisciplinary Team (MDT) Round:** A daily patient review involving physicians, nurses, and other relevant staff to discuss the patient's clinical status and plan for discharge.
- **Discharge Planning:** The process of preparing a patient for safe transition from hospital to home or another care setting, including medication reconciliation, follow-up appointments, and patient/caregiver education.
- **Focused Group Discussion (FGD):** A structured group session with patients and/or caregivers designed to educate them on self-care management, medication adherence, and warning signs requiring medical attention.

4.0 RESPONSIBILITIES

- **Medical Ward Director/Lead Physician:** Ultimately responsible for protocol adherence and PDSA implementation. Leads daily MDT rounds and monthly performance reviews. Ensures discharge plans are comprehensive and actionable.
- **Matron/Head Nurse:** Oversees nursing staff in implementing discharge education and follow-up call protocols. Manages training, documentation, and daily adherence to new processes. Co-leads the QI initiative.
- **Ward Nurses & Case Managers:** Responsible for conducting patient/caregiver education, facilitating FGDs, and making post-discharge follow-up calls. Document all interactions and patient understanding.
- **Social Workers:** Participate in MDT rounds to address social determinants of health that may impact readmission risk.
- **Quality Directorate (QI Team):** Conducts audits of discharge plans and follow-up logs, compiles monthly readmission data, facilitates feedback sessions, and manages PDSA cycle tracking.

5.0 IMPLEMENTATION APPROACH

All major changes to the readmission prevention process shall be implemented using the PDSA (Plan-Do-Study-Act) cycle methodology to ensure systematic testing and sustainable integration:

5.1 PDSA Cycle Framework

PLAN:

- Define objective, prediction, and measures for the change
- Identify team members, resources, and timeline
- Develop implementation plan with specific metrics

DO:

- Implement change on a small scale (pilot group)
- Collect data and document observations
- Train staff involved in the pilot

STUDY:

- Analyze results against predictions
- Identify successes, challenges, and unintended consequences
- Determine if change should be adopted, adapted, or abandoned

ACT:

- Implement successful changes widely
- Adjust approach based on lessons learned
- Standardize processes and update documentation

5.2 Implementation Checklist

Before full implementation of any change, the following must be completed:

- Change description and objectives defined
- Impact on key measures predicted
- Processes/products affected identified
- Documentation updates prepared
- Training materials and schedule developed
- Measurement and monitoring plan established
- PDSA cycle objectives defined

5.0 PROCEDURE

5.1 Discharge Planning During Multidisciplinary Team (MDT) Rounds

1. **Initiation:** Discharge planning begins on the day of admission or as soon as the patient's condition is stable enough to consider discharge.
2. **Daily Review:** During the daily MDT round, the team reviews each patient's progress and identifies potential barriers to discharge (e.g., pending tests, need for home care, medication access).
3. **Plan Development:** A clear, written discharge plan is created for each patient, including:
   - Final diagnosis and summary of hospital course.
   - Detailed medication list with instructions.
   - Follow-up appointment details (date, time, location).
   - Warning signs and symptoms requiring immediate return.
   - Contact information for the ward or primary care provider.
4. **Patient/Caregiver Education:** The primary nurse or case manager reviews the discharge plan with the patient and/or caregiver, ensuring understanding. This is documented in the patient's chart.

5.2 Conducting Focused Group Discussions (FGDs) for Self-Care Education

1. **Scheduling:** FGDs are scheduled weekly for patients with chronic conditions (e.g., heart failure, COPD, diabetes) who are nearing discharge.
2. **Facilitation:** FGDs are led by a trained nurse educator or case manager using a standardized discussion guide covering disease management, medication adherence, diet, and activity.
3. **Environment:** Sessions are held in a private, comfortable setting (e.g., hospital conference room) to encourage open discussion.
4. **Documentation:** Attendance and key discussion points are recorded in the **FGD Log** (Annex 3).

5.3 Weekly Interdisciplinary Team Meetings for Readmitted Cases

1. **Frequency:** A dedicated meeting is held every **Monday** from 9:00 AM to 10:00 AM.
2. **Participants:** Medical Ward Director, Matron, QI Team representative, and staff involved in readmitted cases.
3. **Review Process:** Each readmission case from the previous week is reviewed to identify root causes and preventability.
4. **Action Plan:** Specific, actionable recommendations are developed to prevent similar readmissions.

5.5 Data Monitoring & Performance Review (Monthly)

1. The **QI Team** compiles data on the monthly readmission rate and process measure compliance (e.g., % of patients receiving follow-up calls, % of MDT rounds including discharge planning).
2. The **Medical Ward Director** leads a Monthly Performance Review Meeting with key stakeholders to:
    - Review the monthly readmission rate and trend against the <5% target.
    - Discuss findings from the weekly readmission case reviews.
    - Address systemic challenges (e.g., lack of community resources, staff training needs) and plan corrective actions.

6.0 DOCUMENTATION

- Discharge Planning Checklist (integrated into patient chart)
- FGD Attendance and Feedback Log (Annex 3)
- Weekly MDT Meeting Minutes for Readmitted Cases (Annex 3)
- Post-Discharge Follow-Up Call Log (Annex 3)
- Monthly QI Monitoring Report (Annex 4)
- Monthly Performance Review Meeting Minutes

7.0 REVIEW OF SOP

This SOP shall be reviewed **annually** by the Medical Ward Director, Matron, and Quality Directorate to ensure its ongoing effectiveness, relevance, and alignment with evolving best practices for care transitions.

8.0 SUSTAINABILITY & AUDIT

- **Annual SOP Review**
- **Quarterly Self-Audit** using the Sustainability Checklist
- **Ongoing PDSA Cycles** for process refinement
- **Monthly Performance Metrics** tracking against targets

ANNEX

Annex 1: Sustainability Checklist for Medical Ward Readmission QI Project

Domain	Checklist Item	Status (Yes/No/Partial)	PDSA Cycle Reference
Leadership & Commitment	Readmission rate is a standing agenda item in Medical Ward staff meetings		
Process Adherence	Discharge planning is initiated on admission and reviewed daily in MDT rounds for 100% of patients		
Process Adherence	FGDs for chronic disease patients are conducted weekly as scheduled		
Process Adherence	100% of discharged patients receive a follow-up call within 48-72 hours		
Resources	Standardized scripts and logs for FGDs and follow-up calls are available and used		
Monitoring & Evaluation	Weekly MDT meetings for readmitted cases are conducted and minutes documented		
Monitoring & Evaluation	Monthly readmission rate and process data are reviewed by the QI team		
PDSA Implementation	All process changes tested using PDSA methodology before full implementation		
Training & Competency	All staff trained on current procedures with competency assessments		
Patient Outcomes	Readmission rate is sustained at <5%		
Balancing Measure	Patient satisfaction with discharge process is monitored		

Annex 2: Readmission Prevention Process Audit Tool

Month of: _____ **Auditor:** _____ **Sample Size:** _____ discharged patients

Patient ID	Discharge Plan in MDT Round? (Y/N)	FGD Attended (If applicable)? (Y/N)	Follow-Up Call Made? (Y/N)	Call Within 72h? (Y/N)	PDSA Compliance? (Y/N)	Overall Compliant? (Y/N)
% Compliance	_____%	_____%	_____%	_____%	_____%	_____%

Annex 3: Weekly MDT Meeting & FGD Log

1. Weekly MDT Meeting for Readmitted Cases

Date: _____ **Facilitator:** _____ **Attendees:** _____

Cases Reviewed:

- **Patient ID:** _____ | **Reason for Readmission:** _____ | **Preventable? (Y/N):** _____ | **Action Taken:** _____

Action Plan from Meeting:

Action Item	Responsible Person	Deadline	PDSA Cycle Reference

2. FGD Log

Date of FGD: _____ **Topic:** _____ **Facilitator:** _____

Attendees (Patient IDs or Names): _____

Key Discussion Points & Feedback:

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Annex 4: QI Team Monitoring Tool

Department: Medical Ward (MW) **Project:** Sustaining Readmission Rate Reduction

Reporting Month: _____ **Prepared by:** _____ **Reviewed by:** _____

1. Key Performance Indicators (KPIs)

Indicator	Definition	Target	Current Month	Status	PDSA Impact
Readmission Rate	% of patients readmitted within 30 days of discharge	<5%	_____%		
Discharge Plan Compliance	% of patients with documented, comprehensive discharge plan initiated in MDT rounds	100%	_____%		
Follow-Up Call Rate	% of discharged patients receiving a follow-up call within 72 hours	100%	_____%		
FGD Participation Rate	% of eligible chronic disease patients attending an FGD before discharge	>80%	_____%		
PDSA Implementation Rate	% of process changes implemented using PDSA methodology	100%	_____%		

2. Process Monitoring

Activity	Planned Frequency	Actual Conducted	% Achieved	PDSA Cycle	Remarks
Daily MDT Rounds w/ Discharge Planning	Daily	_____ days	_____%		
Weekly FGDs	1 per week	_____	_____%		
Weekly Readmission Case Reviews	1 per week	_____	_____%		
Monthly Review Meetings	1 per month	_____	_____%		
PDSA Cycle Completions	As needed	_____	_____%		

3. Challenges Identified

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4. Corrective Actions & Recommendations

Issue Identified	Corrective Action	Responsible Person	Timeline	PDSA Cycle	Status

5. Summary & Way Forward

Overall Compliance Status This Month: _____

Next Steps / Priority Actions:

Annex 5: PDSA Cycle Implementation Worksheet

Change to be Implemented: _____

Implementation Dates: From _____ to _____

Team Members: _____

PDSA Cycle Plan

Cycle Phase	Activities	Responsible	Timeline	Measures
PLAN	Define objective, predictions, and plan			
DO	Implement on small scale, collect data			
STUDY	Analyze results vs. predictions			
ACT	Adopt, adapt, or abandon change			

Implementation Checklist

Area	Item	Status	Comments
Change Definition	Change description and objectives defined		

	Impact on key measures predicted		
	Processes/products affected identified		
Documentation	Materials/forms defined		
	Procedure defined		
	Equipment defined		
Training	Training procedure defined		
	Training resources allocated		
	Training schedule complete		
Measurement	New measurements defined		
	Measurement procedures defined		
	Responsibilities assigned		

Predicted Impact on Key Measures

Measure	Current Performance	Predicted After Change	Actual After Change
1.			
2.			
3.			

PDSA Cycle Log

Date	Cycle Phase	Activities Completed	Observations	Lessons Learned