IDEAL Discharge Planning Overview, Process, and Checklist

Evidence for engaging patients and families in discharge planning

Nearly 20 percent of patients experience an adverse event within 30 days of discharge.[1,2] Research shows that three-quarters of these could have been prevented or ameliorated.[1] Common post-discharge complications include adverse drug events, hospital-acquired infections, and procedural complications.[1] Many of these complications can be attributed to discharge planning problems, such as:

- Changes or discrepancies in medications before and after discharge[3,4]
- Inadequate preparation for patient and family related to medications, danger signs, or lifestyle changes[3,4,5]
- Disconnect between clinician information-giving and patient understanding[3]
- Discontinuity between inpatient and outpatient providers[3]

Involving the patient and family in discharge planning can improve patient outcomes, reduce unplanned readmissions, and increase patient satisfaction.[6,7]

More and more, hospitals are focusing on transitions in care as a way to improve hospital quality and safety. As one indicator of this, the Centers for Medicare and Medicaid Services implemented new guidelines in 2012 that reduce payment to hospitals exceeding their expected readmission rates.

To improve quality and reduce preventable readmissions, [insert hospital name] will use the Agency for Healthcare Research and Quality's Care Transitions from Hospital to Home: IDEAL Discharge Planning tools to engage patients and families in preparing for discharge to home.

Key elements of IDEAL Discharge Planning

Include the patient and family as full partners in the discharge planning process.

Discuss with the patient and family five key areas to prevent problems at home:

1. Describe what life at home will be like
2. Review medications
3. Highlight warning signs and problems
4. Explain test results
5. Make followup appointments

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps throughout the hospital stay.

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.

Listen to and honor the patient's and family's goals, preferences, observations, and concerns.

This process will include at least one meeting to discuss concerns and questions with the patient, family of their choice, and [identify staff].

What does this mean for clinicians?

We expect all clinicians to:

- Incorporate the IDEAL discharge elements in their work
- Make themselves available to the [identify staff] who will work closely with the patient and family
- Take part in trainings on the process

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How do you implement IDEAL Discharge Planning?

Each part of IDEAL Discharge Planning has multiple components:

Include the patient and family as full partners in the discharge planning process.

- Always include the patient and family in team meetings about discharge. Remember that discharge is not a one-time event but a process that takes place throughout the hospital stay.
- Identify which family or friends will provide care at home and include them in conversations.

Discuss with the patient and family five key areas to prevent problems at home.

1. Describe what life at home will be like. Include the home environment, support needed, what the patient can or cannot eat, and activities to do or avoid.
2. Review medications. Use a reconciled medication list to discuss the purpose of each medicine, how much to take, how to take it, and potential side effects.
3. Highlight warning signs and problems. Identify warning signs or potential problems. Write down the name and contact information of someone to call if there is a problem.
4. Explain test results. Explain test results to the patient and family. If test results are not available at discharge, let the patient and family know when they should get the results and identify who they should call if they have not gotten results by that date.
5. Make followup appointments. Offer to make followup appointments for the patient. Make sure that the patient and family know what followup is needed.

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps at every opportunity throughout the hospital stay.

Getting all the information on the day of discharge can be overwhelming. Discharge planning should be an ongoing process throughout the stay, not a one-time event. You can:

- Elicit patient and family goals at admission and note progress toward those goals each day
- Involve the patient and family in bedside shift report or bedside rounds
- Share a written list of medicines every morning
- Go over medicines at each administration: What it is for, how much to take, how to take it, and side effects
- Encourage the patient and family to take part in care practices to support their competence and confidence in caregiving at home

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.

- Provide information to the patient and family in small chunks and repeat key pieces of information throughout the hospital stay
- Ask the patient and family to repeat what you said back to you in their own words to be sure that you explained things well

Listen to and honor the patient and family's goals, preferences, observations, and concerns.

- Invite the patient and family to use the white board in their room to write questions or concerns
- Ask open-ended questions to elicit questions and concerns.
- Use Be Prepared to Go Home Checklist and Booklet (Tools 2a and 2b) to make sure the patient and family feel prepared to go home
- Schedule at least one meeting specific to discharge planning with the patient and family caregivers

IDEAL Discharge Planning Process

The elements of the *IDEAL Discharge Planning* process are incorporated into our current discharge. The information below describes key elements of the IDEAL discharge from admission to discharge to home. Note that this process includes at least one meeting between the patient, family, and discharge planner to help the patient and family feel prepared to go home.

Initial nursing assessment

- ❑ **Identify the caregiver who will be at home along with potential back-ups.** These are the individuals who need to understand instructions for care at home. Do not assume that family in the hospital will be caregivers at home.
- ❑ **Let the patient and family know that they can use the white board in the room to write questions or concerns.**
- ❑ **Elicit the patient and family's goals for when and how they leave the hospital,** as appropriate. With input from their doctor, work with the patient and family to set realistic goals for their hospital stay.
- ❑ **Inform the patient and family about steps in progress toward discharge.** For common procedures, create a patient handout, white board, or poster that identifies the road map to get home. This road map may include things like "I can feed myself" or "I can walk 20 steps."

Daily

- ❑ **Educate the patient and family about the patient's condition at every opportunity**, such as nurse bedside shift report, rounds, vital status check, nurse calls, and other opportunities that present themselves. Use teach back.
  Who: *All clinical staff*
- ❑ **Explain medicines to the patient and family (for example, print out a list every morning) and at any time medicine is administered.** Explain what each medicine is for, describe potential side effects, and make sure the patient knows about any changes in the medicines they are taking. Use teach back.
  Who: *All clinical staff*
- ❑ **Discuss the patient, family, and clinician goals and progress toward discharge.** Once goals are set at admission, revisit these goals to make sure the patient and family understand how they are progressing toward discharge.
  Who: *All clinical staff*
- ❑ **Involve the patient and family in care practices to improve confidence in caretaking after discharge.** Examples of care practices could include changing the wound dressing, helping the patient with feeding or going to the bathroom, or assisting with rehabilitation exercises.
  Who: *All clinical staff*

Prior to discharge planning meeting

When: *1 to 2 days before discharge planning meeting. For short stays, this meeting may occur at admission.*

- ❑ **Give the patient and family Tools 2a and 2b: Be Prepared to Go Home Checklist and Booklet.**
  Who: *Hospital to identify staff person to distribute, for example a nurse, patient advocate, or discharge planner.*

- ❑ **Schedule discharge planning meeting with the patient, family, and hospital staff.**
  Who: *Hospital to identify staff person to distribute, for example a nurse, patient advocate, or discharge planner.*

Discharge planning meeting

When: *1 to 2 days before discharge, earlier for more extended stays in the hospital*

- ❑ **Use the Tools 2a and 2b: Be Prepared to Go Home Checklist and Booklet as a starting point to discuss questions, needs, and concerns going home.**
  - If the patient or family did not read or fill out the checklist, review it verbally. Make sure to ask if they have questions or concerns other than those listed. You can start the dialogue by asking, "*What will being back home look like for you?*"
  - Repeat the patient's concerns in your own words to make sure you understand.
  - Use teach back to check if the patient understands the information given.
  - If another clinician is needed to address concerns (e.g., pharmacist, doctor, or nurse), arrange for this conversation.

  Who: *Hospital to identify staff to be involved in meeting, for example the nurse, doctor, patient advocate, discharge planner, or a combination. Patient identifies if family or friends need to be involved.*

- ❑ **Offer to make followup appointments. Ask if the patient has a preferred day or time and if the patient can get to the appointment.**
  Who: *Hospital to identify staff person to do, such as a patient advocate or discharge planner.*

Day of discharge

- ❑ **Review a reconciled medication list with the patient and family. Go over the list of current medicines. Use teach back (ask them to repeat what the medicine is, when to take it, and how to take it).** Make sure that patients have an easy-to-read, printed medication list to take home.
  Who: *Hospital to identify staff person to review the medication list with patient and family. Because this involves medications, we assume it would be a clinician — nurse, doctor, or pharmacist.*

- ❑ **Give the patient and family the patient's followup appointment times** and include the provider name, time, and location of appointments in writing.
  Who: *Staff who scheduled appointment.*

- ❑ **Give the patient and family the name, position, and phone number of the person to contact if there is a problem after discharge.** Make sure the contact person is aware of the patient's condition and situation (e.g., if the primary care physician is the contact person, make sure the primary care physician has a copy of the discharge summary on the day of discharge).
  Who: *Hospital to identify staff person to write contact information, for example a nurse, patient advocate, or discharge planner.*

IDEAL Discharge Planning Checklist

Fill in, initial, and date next to each task as completed.

Patient Name: _____

Initial Nursing Assessment	Prior to Discharge Planning Meeting	During Discharge Planning Meeting	Day of Discharge
_____Identified the caregiver at home and backups _____Told patient and family about white board _____Elicited patient and family goals for hospital stay _____Informed patient and family about steps to discharge	_____Distributed checklist and booklet to patient and family with explanation _____Scheduled discharge planning meeting Scheduled for _____/ ___ / _____at _____ [time]	_____Discussed patient questions _____Discussed family questions _____Reviewed discharge instructions as needed _____Used Teach Back _____Offered to schedule followup appointments with providers. Preferred dates / times for: PCP: Other:	**Medication** _____Reconciled medication list _____Reviewed medication list with patient and family and used teach back **Appointments and contact information** _____Scheduled followup appointments: 1) With _____ on _____ / _____ / _____at_____ [time] 2) With _____ on _____ / _____ / _____at _____ [time] _____Arranged any home care needed _____Wrote down and gave appointments to the patient and family _____Wrote down and gave contact information for followup person after discharge

IDEAL Discharge Planning Daily Checklist

Fill in, initial, and date next to each task as completed.

Patient Name: _____

Day 1	Day 2	Day 3	Day 4
_____Educated patient and family about condition and used teach back	_____Educated patient and family about condition and used teach back	_____Educated patient and family about condition and used teach back	_____Educated patient and family about condition and used teach back
_____Discussed progress toward patient, family, and clinician goals	_____Discussed progress toward patient, family, and clinician goals	_____Discussed progress toward patient, family, and clinician goals	_____Discussed progress toward patient, family, and clinician goals
_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other	_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other	_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other	_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other
_____Involved patient and family in care practices, such as:	_____Involved patient and family in care practices, such as:	_____Involved patient and family in care practices, such as:	_____Involved patient and family in care practices, such as:
Notes			

References

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