2014 Gage Awards

Reference #	7489688
Status	Complete
Name of hospital or health system	University of New Mexico Hospitals
Name of project	The Effect of Self-care Nursing education on Outcomes of Patients with Heart Failure
CEO name	Mr. Steve McKernan
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
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Within which of the two categories does your application best align?	Quality

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	This is a quality improvement and research based intervention that involved nurse initiated self-care educational intervention for patients with heart failure. Over 7 million people in the U.S. are diagnosed with Heart Failure (HF) which costs over $40 billion.1 The majority of this cost is due to hospitalization readmissions of these chronically ill patients.2 If this does not change, hospitals will lose money with the changes with the Affordable Care Act being implemented in the next two years. Hospitals will not be reimbursed for patients readmitted within 30 days.3 Research reports that half of HF readmissions can be prevented with self-care education.4 Nurses have the responsibility to each patients' about their disease and self-care behaviors. At the University of New Mexico Hospitals, more than a 25% of the HF patients are re-hospitalized within 30 days and the nursing staff implemented a study to measure the effect of self-care education on re-admission rates of patients with heart failure. The hypothesis was that patients with heart failure who received nurse-taught self-care and telephone follow-up would have lower 30 day hospital readmissions than those who did not. Methods This was a IRB approved randomized control trial that enrolled 40 patients from the UNMH Cardiac Care Unit on 7S. The self-care intervention included giving them a scale and measuring their daily weight and daily education on low-salt diet, medications, activity level, disease process and a weekly telephone call for six months to reinforce the education and self-care behaviors. The control group received standard care. Results There 20 patients enrolled in each group with 25 male and 15 female and the largest comorbidity was hypertension (50%) and then diabetes (37%). The experimental group had 3 heart failure readmissions within 30 days and the control group had 2 readmissions. Thus the hypothesis was not supported. One of the explanations is that two patients in the experimental group were the cause of all the readmissions and once was an alcoholic who went on binges and drank a case of beer and the other patient had severe cardiac disease due to radiation to her heart as a child. These patients can be considered outliers and if they are taken out of the analysis, the hypothesis would be supported.

2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	This is a quality improvement/research project at the University of New Mexico Hospital that was conducted to improve the inpatient heart failure education and follow-up. The purpose was to increase the patient's knowledge and self-care behaviors of their heart failure and measure outcomes. This was a IRB approved randomized control trial that enrolled 40 patients from the UNMH Cardiac Care Unit on 7S. The self-care intervention included giving them a scale and measuring their daily weight and daily education on low-salt diet, medications, activity level, disease process and a weekly telephone call for six months to reinforce the education and self-care behaviors. The control group received standard care.
3. Describe the results of the project. What data was used to support improvement results?	The results included 20 patients enrolled in each group with 25 male and 15 female and the largest comorbidity was hypertension (50%) and then diabetes (37%). The experimental group had a significantly higher number of patients who attended the heart failure (HF) clinic than the control group. Other research findings report that patients with heart failure who follow-up at their HF clinic have fewer hospital admissions and are able to increase their self-care behaviors.
4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	As a result of the project, the cardiac nurses increased their knowledge and ability to educate patients on their heart failure disease and the education was standardized. Their documentation of the education and self-care behaviors was entered into the medical record and the experimental patients received weekly telephone calls for six months. The heart failure patients' self-care knowledge and behaviors were documented on a weekly basis. Yes, the project can be duplicated by other organizations and may result in fewer hospital readmissions as well as increased self-care behaviors in patients with heart failure
5. Describe how patients, families, and if appropriate, community was included in the work.	The patients were included in the work because they had to report their knowledge and self-care behaviors to the nurse on a daily basis while hospitalized. The patients and family members were engaged in learning about heart failure and knowing the daily weights, salt and fluid intake. They also took an interest in increasing their activities as tolerated as well as knowing about their disease process.
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