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Teaching Adult Learners Knowledge About Care Transition (TALK-ACT): A Quality Improvement Project to Promote Nursing Communication

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Teaching Adult Learners Knowledge About Care Transition (TALK-ACT): A Quality Improvement Project to Promote Nursing Communication

by

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Abstract

There is a growing incentive to recognize a way of improving the hospital discharge process to empower patients to succeed in care transition. Nurses play a crucial role in the prevention of hospital readmission by focusing on high-quality discharge instructions (Hesselink et al., 2014). When a patient is successful in self-care the improvement to the discharge process reduces unnecessary hospital readmissions (Roberts, Moore, & Jack, 2017). This doctoral project aimed to provide insight into a growing hospital discharge problem, the underlying causes, and an overview of results from a change in processes. Both communication and patient comprehension play significant roles in patients' transition to self-care and satisfaction scores (McIlvennan, Eapen, & Allen, 2015). The purpose of this process improvement project was to determine if the change in discharge instruction and education from the current process to that of teaching adult learners knowledge about care transition (TALK-ACT) would improve patient satisfaction, as evidenced by an increase in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores. The information was utilized to determine decisions for improvements in the current practice of patient discharge instructions, patient education, and follow-up guidelines to increase HCAHPS scores and prevent frequent readmissions.

Keywords: readmission, hospital discharge process, nurse-patient communication, patient education.

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v

Table of Contents

SECTION IX: UTILIZATION AND REPORTING OF RESULTS

List of Figures

List of Tables

SECTION I

Introduction

Improvement and continuation of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores are critical for the livelihood of hospital units and the organization's financial future. The current discharge process on the Intermediate Care Unit (IMCU) needed refinement to individualize and support the care transition of their patient population. The lack of adequate discharge teaching may stem from the nursing staff having multiple tasks, complacency, lack of time to educate, and decreasing communication skills (Bucknall, 2016). There is often an overwhelming 'task-related' daily routine, with patient care becoming an act of going through the motions or robotic; lost was the "Nightingale" passion for patient care (Selanders & Crane, 2012). A nurse has an obligation to the patient to ensure that education on medication, new procedures, or a disease process has occurred in order for the patient to maintain a balance of wellness once discharged home (Mabire, Dwyer, Garnier, & Pellet, 2017). However, the current discharge practice lacked disease-focused individualization and instructional communication, and patient care transition education had declined. The declining process was problematic for patient self-care and promoted patient dissatisfaction with nurses' communication skills and care transition domains for the HCAHPS scores.

According to the National Guidelines Clearinghouse (2015), a primary recommendation is for patient-centered care, communication and information sharing, involving the support and training of family caregivers, educating the patient on discharge instructions and education that is to their learning ability (p. 3). The suggestion

is also made for the use of health literacy and teach-back method used with the discharge process to ensure that the patients and family have an adequate understanding of discharge information (National Guideline Clearinghouse, 2015).

Background and Problem Recognition

Nurses are responsible for teaching patients about medication and their disease process and communicating that information to the rest of the care team. The information must be in a form the patient can understand. This process enables the patient to be more successful in the transition to self-care post-discharge (International Affairs and Best Practice Guidelines [ia BPG], 2016). In observation of the current discharge process, the discharge education and instruction taught to the patient for care transition had a communication gap. Patients were discharged home with insufficient planning, imperfect instructions, inadequate medication information, and lack of scheduled follow-up appointments from the healthcare team. There was poor communication between hospitalists, discharge nurses, and direct patient caregivers. Discharge instructions should include an interdisciplinary approach to continuity of care. A transition care plan that incorporates identification, planning, implementation, coordination, and evaluation of the disease processs helps patients take care of themselves at home without unnecessary readmission to the hospital (Lin, Cheng, Shih, Chu, & Tjung, 2012)

Identified Problem

Upon observation of nurses during the discharge process on the Intermediate Care Unit (IMCU) at a healthcare facility, it was evident that the process was not consistent. Patients were not getting the discharge education they needed. Patients, because of a lack

of knowledge, often did not ask questions or know where to begin with a question. Observation manifested the theory the nurses had worked so lean-staffed and had become so task-oriented that the patient communication had become a robotic routine. A large percentage of the time, a patient was discharged with a computer-generated handout or After Visit Summary (AVS), being left to fill in the gaps themselves.

The computer-generated AVS is a multi-page account of a patient's current health problems, instructions from health care providers on home care, follow up appointments and medications (if the current information has been input by a healthcare provider). It also includes directions for accessing a personal account online so that a patient may see lab results, follow up appointments, pay bills, etc. Without nursing intervention, it is just a lot of paper. Many persons served by this small rural hospital have reading disabilities, as well as difficulties navigating modern technology.

Several observations of the discharge process were conducted. One nurse, while in the room to discharge a patient home, took the patient's IV heplock out, and gave the patient a copy of the AVS, without explanation of discharge instructions. During a second observation a patient was discharged home with new blood pressure medication, and the patient did not receive written or verbal information about the new medication. The patient had questions about the medications, and the nurse stated: "well, your blood pressure was high on admission, so this new medication was prescribed to help bring it down." When the patient asked questions about side effects of the medications the nurse's reply was "when you pick your medication up at the pharmacy, you will get a handout with information about the medication based on what other medications you are taking." The nurse then left the room without telling the patient to discontinue her prior blood

pressure medication, which was the intention of the prescribing hospitalist. There was also no verbal instruction about a follow-up appointment. In a third observation a patient was discharged home with her daughter after a fall. The nurse gave the patient's daughter the AVS. When the patient's daughter asked questions about the discharge instructions, the nurse replied: "as much as she has been in the hospital she could probably tell me more about her medications than I can tell her." The nurse then left the room.

Nurses have a role in the care and education of their patients. This caring should involve sharing of information with the interdisciplinary team, utilizing a care plan that is individualized to patient and disease process and communicates that plan to the patient, caregiver, and family members. When discharging a patient home, the communication should be consistent with a reiteration of education received while in the hospital. The discharge education should be patient and family-centered to ensure that the patient has what they need to transition to home and be successful in the care-transition and avoid readmission ("AHRQ," 2015). Education provided by nurses has been found to improve patients' quality of life after hospitalization (Mehralian, Salehi, Moghaddasi, Amiri, & Rafiei, 2014). Hospital readmission and patient dissatisfaction are associated with unfavorable patient outcomes and high financial costs to patients and the hospital (McLlvennan et al., 2015). The Affordable Care Act (ACA) established the Hospital Readmission Reduction Program (HRRP) in 2012, which financially penalizes a hospital when a patient is readmitted within thirty days following discharge (McIlvennan et al., 2015).

At the beginning of this project, the facility had an increased readmission rate, especially on the IMCU. The readmission rate for the IMCU was 23%. The HCAHPS scores for the IMCU for overall rating of communication with nurses was 75.2%, discharge information was 76.8%, and care transition was at an all-time low of 39.3%. The increase in readmissions and low HCAHPS scores were believed to be due to the lack of clearly communicated discharge information. Figure 1 presents a comparison of the scores for IMCU and a surgical unit at the facility.
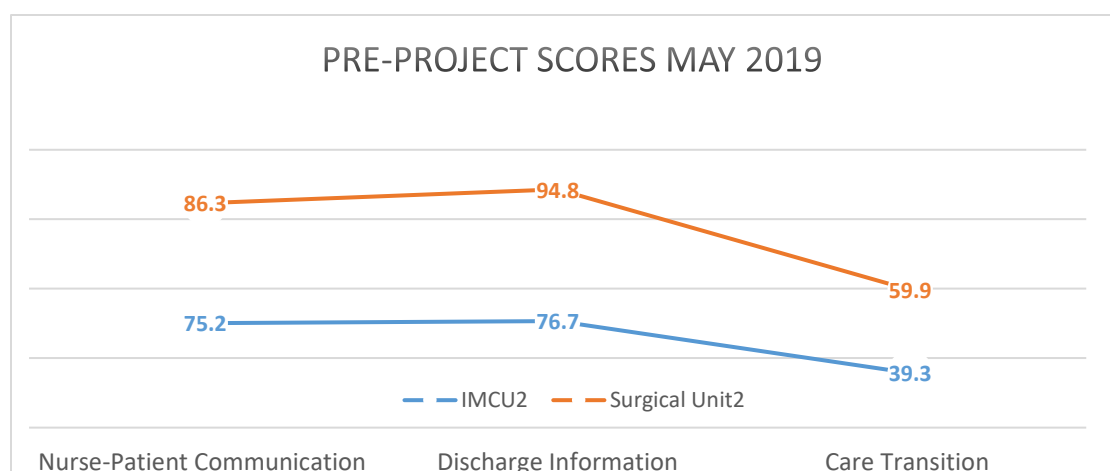
Figure 1. Pre-Project Comparison of HCAHPS Scores. Three domains scores before beginning the project. All domains are nurse-patient communication. The graph compares communication domain scores between the Medical and Surgical Units

Problem Statement

The nursing staff was not utilizing communication skills to provide adequate discharge instruction and education to patients to allow for the successful transition of care after discharge, therefore, contributing to patient readmission and low HCAHPS scores.

SECTION II

Needs Assessment

Literature Review for Best Practice

A literature review was conducted to determine best practice during discharge. Health Services Research (2014) recommends the use of protocols and check sheets during the discharge process to ensure patient comprehension (Hesselink et al., 2014). Protocols and policies have been shown to reduce patient harm through the improvement of standards and communication. The checklist ensures patient safety with information and procedures listed out, and the nursing staff checks off each task when it has been performed. A focused plan that is listed out for continuity of care helps to guarantee that the patient is getting the information or education that is needed for success in self-care. Other factors that have shown improvement in discharge teaching with the use of protocols and check sheets are patient safety, quality, cost containment and utilization, and morbidity and mortality rates (Hesselink et al., 2014).

The importance of individualization of practice with each patient is essential in every interaction. Standardization of practice is also an important goal because of the wide variation that exists in many areas of practice, including the medical industry (Hesselink et al., 2014). The intent and motivation for any protocol or checklist should be the improvement of patient safety and evidence-based practice management (Hesselink et al., 2014). Standardization of care using protocols and checklists for discharge promotes improvement in the quality of care, decrease in variations, reduction in cost, economic savings, and patient satisfaction (Hesselink et al., 2014).   It is best

practice for these protocols and checklists to be incorporated into the electronic medical record and to be accessible for the patients (Roberts et al., 2017).

According to Mcllvennan et al. (2015), to reduce readmissions to the hospital and incorporate ways to keep patients recovering at home, it is critical for patients to feel confident about self-care as they transition home. Patients' lack of confidence at the time of discharge is what prompted the introduction of the Hospital Readmission Reduction Program (HRRP), which focused on reducing readmissions to the hospital and incorporating ways to keep patients recovering in their homes. Along with the introduction of HRRP, the Affordable Care Act (ACA) was established as a way to protect the patient and Medicare from overpaying for disease process and treatment due to readmissions (Mcllvennan et al., 2015). The establishment of the new ACA program, 2012 placed a penalty on hospitals if discharged patients were readmitted in less than 30 days of discharge (Mcllvennan et al., 2015). The disease processes monitored at the beginning of the HRRP were acute myocardial infarction, heart failure, and pneumonia, with disease processes expanded in the following months (Mcllvennan et al., 2015).

Based on recommendations made by the administrators of the ACA program, the validation of risk-standardization processes were necessary and ongoing. However, the process may need some redesigning because of the current limitation in existing administrative data and concerns for coding manipulations (Mcllvennan et al., 2015). The current approach is forced to lump necessary and unnecessary readmissions together and rely on aggregate rates to reflect potentially preventable events (Mcllvennan et al., 2015).

Reformation of the current discharge process with a process improvement project would hopefully redesign how nurses on the IMCU could improve patient comprehension of discharge instructions and improve HCAHPS scores. Teaching adult learners knowledge about care transition (TALK-ACT) was developed.

TALK-ACT Discharge Process

TALK-ACT enlists the use of motivational interviewing and health literacy tools such as teach-back methods, Ask Me 3 clarification technique, and Medical "Plain Language" to improve discharge education. Motivation, as suggested by Lewis, Larson, and Korcuska (2017) is a prime focus to base practical discharge instructions, when talking with a patient about the importance of transition care at home (Lewis et al., 2017). The use of motivational interviewing (MI) combined with the use of goal attainment scaling (GAS) would help ensure patient compliance due to the clarification and understanding of the discharge plan (Lewis et al., 2017). MI is an evidence-based collaborative, goal-oriented style of counseling that focuses the client on personal reasons for wanting to improve their health. This style of preventive care has the potential to be a valuable clinical tool, especially when paired with GAS. Client-centered goals, monitored goal attainment, and providing feedback establishes positive outcomes with the disease and mental health conditions (Lewis et al., 2017). The use of health literacy standards such as teach-back helps to ensure the patient understands information taught. Ask Me 3 is a list of three questions that acts as a clarification tool. Patients can use it while in the hospital or take it to the follow-up visit with them. All four tools are noteworthy aspects and were incorporated into the plan to improve the discharge process.

The use of each was vital to the new proposal for discharge improvement and are explained in the following paragraphs.

Motivational Interviewing (MI)

Motivational interviewing is a process designed to help patients increase their internal motivation to accomplish goals related to self-care. It is becoming an essential clinical tool and has proven to be a valuable tool for counselors in a variety of settings, including but not limited to primary care, mental health, and acute care settings (Lewis et al., 2017). MI has four steps that include engaging, focusing, evoking, and planning.

- Step one: engaging, also known as the relational foundation step, is a client-centered step. This step is nondirectional and establishes the understanding stage of the client.

- Step two: focus or guide the client to a change in behavior and help the client identify a target area and facilitate the patient toward an area or place of importance or a reason to get better or to make a life change.

- Step three: evoking or drawing the client's intrinsic motivation toward an area of importance and helping the client get to an area of confidence with being at home and believing wellness is attainable.

- Step four: bridging the planning change and discharge processes. When the patient is to be discharged home, readiness can be determined by patient actions and the ability to demonstrate additional changes to their plan of care (Lewis et al., 2017).

With the use of the MI process, using the first three steps of engaging, focusing, and evoking builds confidence and readiness for behavior change and reasons for

improving the quality of health (Lewis et al., 2017). The first three steps should be introduced to the patient on admission in the way of honing in on what motivates the patient. MI technique gives the nursing staff an advantage at the time of discharge. The use of MI during the discharge planning process resulted in nurse tailored discharge planning, intended to motivate patient to succeed with the transition to home care, by emphasizing the importance of getting well and staying well. Step four planning involves communication between nurse and patient to develop a coherent discharge plan based on patient motivation and personal health goals. The nurse plays a crucial role in collaborating with the patient on "how to change and formulate a plan of action toward accomplishing the goals" (Lewis et al., 2017, pg. 198). Combining MI and an essential patient goal for transition care will motivate the patient to strive for wellness and adhere to the discharge plan.

Teach-Back Method

Studies have shown that 40-80% of the discharge information given to patients is forgotten immediately, and nearly half of the information retained is incorrect (Agency of Healthcare Research and Quality, 2015). Using clear communication is the foundation for patients to be able to understand and act on health information. The Agency for Healthcare Research and Quality (AHRQ) promotes patient and family-centered care with the Health Literacy Communication Tools such as Teach-Back and Ask Me 3.

Regardless of a patient's literacy level, it is crucial that the staff ensures patients understand and comprehend the given information. The teach-back method is a way of checking to understand, by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that the provider has explained

things in a manner which the patient understands. The related show-me method allows

staff to verify that patients can follow specific instructions (e.g., how to use an inhaler or

take diabetic medications). The teach-back method is a valuable tool for healthcare

providers to utilize with each patient (Agency of Healthcare Research and Quality, 2015).

These methods can help:

- Improve patient understanding and adherence

- Decrease canceled appointments and readmissions

- Improve patient satisfaction scores and outcomes

Ask Me 3

Ask Me 3 is a quick, easy, and effective tool designed to improve communication

between healthcare providers and patients. Patient education needs to be clear, concise,

yet thorough, and based on the understanding ability of the patient. Materials developed

that fit patient literacy and readability promote patient understanding. The leading health

literacy experts have produced the Ask Me 3 method as a way to promote three simple

but essential questions that patients should ask their providers in every healthcare

interaction. Providers should always encourage their patients to understand the answers

to:

- What is my main problem?

- What do I need to do?

- Why is it important to me to do this?

Along with encouraging patients to use the Ask Me 3 approach, simple

reassurance techniques increase patient comfort level to ask questions and participate in

their treatment plan after discharge from the hospital (Agency of Healthcare Research and Quality, 2015).

Medical "Plain Language"

Medical Plain Language is the term used in governmental writings in the 1950s when communicating with the public to make legislative policy easily understood when speaking to communities. ("U. S. Department of Health and Human Services: Office of Disease Prevention and Health Promotion," 2007). The most recent change in plain medical language took place in 1998; President Clinton issued a memorandum to the government to simplify governmental writing for public information as a way of sending a clear message to the public and improving communications regarding governmental issues of health care ("U. S. Department of Health and Human Services: Office of Disease Prevention and Health Promotion," 2007). Plain language communication of information saves time and effort, benefiting both the healthcare provider and patient. Plain language usage was intended to guide patients towards health maintenance. Plain language has no generally accepted definition, but most of the literature researched documents plain language as language the public can understand that meets readability guidelines.

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Literature Review of Discharge Process

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Loignon, Bedos, Sevigny, and Leduc (2009) compared effective discharge planning interventions in asthma patients discharged home after admission to acute care facilities with exacerbation of disease processes. The study used three types of teaching strategies to help participants stay healthy and out of the hospital. The three types of self-care strategies emerged as: (1) strategies focused on control systems; (2) strategies aimed

at preventing symptoms; and (3) strategies for coping with symptoms of the disease process and when to return to the doctor. Findings of the study showed that most of the problems for the discharged patients were things the patients had in their homes, personal habits, or their environments. The use of health literacy techniques and MI were instrumental in helping the researchers educate their patients on environmental changes, thus minimizing asthma attacks while staying well in their own homes (Loignon et al., 2009).

Mabire et al. (2017) performed a meta-analysis for effective nursing discharge planning interventions. Several models were looked at for best practice, patient safety, and patient discharge understanding. A systematic search was undertaken across 13 databases to retrieve published and unpublished studies in English between 2000-2015. In the recent decade, there has been a mountain of pressure to reduce the cost of health care and to have a leaner workforce. Despite all the changes in health care, the urgency of improved patient discharge care and treatment models would use less nursing staff, but still keep the patient safe after transition home (Mabire et al., 2017).

Two comprehensive discharge planning models were used in the study to see how the patients responded to each plan and if the changes to discharge planning made a difference (Mabire et al., 2017). The first model, care transition program, used a transition coach to coordinate patient discharge to home. The plan had four central pillars: (1) medication self-management; (2) a patient-centered record; (3) follow-up; and (4) attention to an indication of a worsening medical condition. With this program, interventions would vary with the different stages of hospitalization (Mabire et al., 2017). The second, the Transitional Care Model, outlined the discharge planning process

(including follow-up) for high-risk geriatric patients with chronic health conditions

(Mabire et al., 2017). This model incorporated several core elements, as represented in

Table 1.

Table 1

Transitional Care Core Elements

The use of a Multidisciplinary team made up of nursing and providers	Process
- Transitional care nurse - Advanced Practice Nurse - Gerontologist Nurse - In-hospital assessment coordinator - Providers	- Developed a discharge plan of care - Conducted early discharge preparation - Involved patient, caregiver, and family regarding the discharge process - Emphasized community care resources - Using effective communication skills - Complete predischarge assessment - Conduct a postdischarge follow up with every patient (Mabire et al., 2017).

Family and informal caregivers were encouraged to take part in patient care and

were given the opportunity to be present on the day of discharge, allowing the family and

informal caregivers to experience the educational process and receive the same

instructions (Mabire et al., 2017).

This study's emphasis and results on the importance of discharge instructions, is

in part the basis of TALK-ACT. The precise results were evidence that patient education

is a crucial component to improve the discharge planning process (Mabire et al., 2017).

The results showed that the most significant factor in readmission was the lack of

discharge interventions for transition care, effective team communication, and coordinating care occurrence descriptors. Important issues identified were the making of follow up appointments, follow up phone calls and the need for discharge instructions to be more individualized to the patient and their disease process (Mabire et al., 2017). Scant literature exists regarding the role of advanced practice nurses in transitional care. The opportunity to examine how the advanced practice nurse can contribute to new and innovative models of care to meet the needs of an aging population is a given. Recommendations are futuristic for the guidance of advanced nursing roles in the areas of aftercare, or transition care. In the emerging healthcare arena, this is a much-needed area of focus (Mabire et al., 2017).

A detailed, multifaceted process analysis study by Anthony et al. (2008), brought together an interdisciplinary team to provide a comprehensive individualized discharge plan. The success of the patient was significantly improved for transition care, keeping the patient well at home, and decreasing the incidence of readmission. Re-engineering the discharge process with patient and family involvement gave them a clear view of their roles and responsibilities in the wellness process. Patient education must start on admission and occur throughout the hospitalization process to assure that the patient understands the information. Sometimes it is easier to show a patient how to take care of themselves than to tell them; handouts with a list of discharge resources is an example of a way to achieve this. The study results showed that every discharge must have an individualized discharge plan that is comprehensive in scope and at a level of patient understanding. The instructions must address medications, therapies, diet, lifestyle modifications, and follow-up appointments (Anthony et al., 2008).

Population and Community Identification

The target population for this project included patients discharged from the IMCU. The IMCU nurses observed during the discharge instruction process were the basis for this project. HCAHPS scores were lower than the national average for the nursing communication domain and the care transition domain. Information about medication, discharge information, and information about transition care for this unit were areas of dissatisfaction for the patients. The observation results revealed that the staff nurses were not communicating the discharge instructions in a form that patients can understand. The nurses handed the discharge paperwork to the patient, asked if there were any questions, and then walked out of the room. The staff nurses were not following policy and guidelines for discharge teaching within this setting. The instructions should be clear with concise communication of discharge information, instructions should be explained verbally, and opportunity given for the patients to show their understanding by responding with return demonstration (Wake Forest Baptist Health Systems, "Current Facility Health Policies and Procedures," 2019).

The intervention for the project was to offer education for the nurses about how to teach adult learners. The class included role-playing and simulation activities and offered training on how to use teach-back, Ask Me 3, and motivational interviewing (AHRQ, 2015). Based on The Joint Commission (TJC) standards, patients have a right to understand their discharge instructions. Discharge instructions should be individualized and based on the patient disease process. The learning ability of each patient should be assessed while the nurse is taking the admission history (TJC, 2012).

Targeted Population

The target population was the IMCU nursing staff, the patients admitted and discharged from the IMCU, and their families. The data used to support the need for this discharge education project consisted of data collected during discharge observation and literature research for best practice of discharge procedures. Observations were made of the communication between the nurses and the patients at the time of discharge. Many inconsistencies were observed regarding discharge instructions given to patients. The other supporting factors were from three domains of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores: nursing communication, discharge instruction, and transition of care (http://www.pressganey.com/about/news/patinet-satisfaction-scores-optimizing-the-patient-and-clinician-experience/WMC). Each of the questions focused on nursing communication to prepare patients for the transition of care after discharge. Scores were low when compared to the national average and other inpatient units in the same facility. The questions and the results, at the time of this paper, are listed below and are found in the nursing communication domain of the Press Ganey Survey for HCAHPS Scores (http://www.pressganey.com/about/news/patinet-satisfaction-scores-optimizing-the-patient-and-clinician-experience/WMC):

- During the hospital stay, how often did nurses explain things in a way you could understand? Results were 69% compared to a national average of 81%.
- During this hospital stay, did you get information in writing about what symptoms of health problems to look for after you left the hospital? Results were 56% compared to a national average of 64%.

- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. Results were 80% compared to a national average of out of 86%.

- When I left the hospital, I clearly understood the purpose of taking each of my medications. Results were 38% compared to a national average of 51%.

The goal of this project was to improve scores for the nurse communication domains for IMCU on all questions, along with improving the nurses' communication skills for the IMCU. The aim of this project was to improve to the IMCU nurses' communication skills, improve the discharge process, equip the patient for transition care, improve the HCAHPS scores, and decrease readmissions. The administrative board and the quality improvement department agreed on the identified problem of poor communication during discharge instruction and education as stated on the patient comments via Press Ganey Patient Feedback section of the HCAHPS survey (http://www.pressganey.com/about/news/patinet-satisfaction-scores-optimizing-the-patient-and-clinician-experience/WMC).

There was a need for a quality improvement project to address the problem of communication. The Teaching Adult Learners Knowledge About Care Transition (TALK-ACT) project was developed as discharge improvement process that focused on education on communication, health literacy, teach-back, Ask Me 3, and motivational interviewing. It also emphasized quality time spent with the patients, allowing them to voice concerns and ask questions. Project implementation had the support of the administrative team. The focus of this project stemmed from a successful model for discharge that offers the patient the opportunity to participate in their discharge planning

and care and is supported by the Agency for Healthcare Research and Quality (AHRQ, 2015)

  The education consisted of a blended teaching method, with a PowerPoint presentation sent to the participants via e-mail followed by a face-to-face class for clarity. The Project Leader acknowledged that the IMCU staff might view this project as "just one more task to perform." To combat negativity, selected frontline staff and charge nurses were enlisted as project champions to promote positivity and help with the project. Unit Champions were available to answer questions and problem solve while showing support and positivity for TALK-ACT.   Unit Champions provided an important link between the project and the staff on the unit (AHRQ, 2019). The Project Leader collaborated with the champions as well as bedside staff through direct contact or e-mail for any issues that needed clarification. Weekly observation was planned and carried out during discharge instruction, patient admission learning assessments, weekly callbacks, and during new medication education as a method for monitoring improvement. The observations were documented on the TALK-ACT discharge observation tool designed by the Project Leader. As added monitoring of the discharge process, the Faith Health and Community Nurses educator followed patients after discharge, checking for confidence in care transition, and tracking readmissions. The outcome goal for the project was IMCU nursing staff would provide better discharge instruction, and the IMCU patient would gain a better understanding of their discharge information and be better prepared to manage their care and prevent readmission.

Sponsors and Stakeholders

The members of this project team included the following:

- Chief Executive Officer (CEO)

- Chief Nursing Officer (CNO)

- Medical-Surgical Nurse Manager

- Nurse Manager for the Intermediate Care Unit (IMCU)

- Operating/Surgical services nurse educator

- Quality Improvement Manager

The following paragraphs explain why each of these members was chosen to be on the project team.

- The Chief Executive Officer is the co-chair of the readmission team, and has been instrumental in working with several groups on quality improvement projects. He was quick to offer any assistance needed with the change in process for the project, and his leadership was a great asset to this project.

- The CNO was chosen because of her experience with like projects and knowledge of successes and failures with other HCAHPS improvement projects. Both the CEO and CNO represented the administrative team for patient care and safety and supported the project.

- The Nurse Manager of the Medical-Surgical department participated in the project as a practice partner. The medical unit adjoins the IMCU. The practice partner was a doctorally prepared, medical-surgical unit manager with 30 years of experience at this hospital, 20 of those years being in nurse management. She led the largest group of nurses in the hospital and was acknowledged as a superior

leader by her staff. This manager had prior knowledge of working with the

HCAHPS scores and quality improvement projects, getting staff buy-in, and

added success in the improvement of her medical unit's scores.

- The nurse manager of IMCU served as another committee member and was

    instrumental in helping with the education of the IMCU staff as well as

    collaborating with the Unit Champions and Project Leader. She was an asset to

    this project because of prior experience and different roles within the facility.

    This manager had been in nursing for more than 30 years and in management for

    more than 20 years. Her role as both compliance and safety officer proved

    valuable for this project.

- The surgical services education nurse educator is a BSN-prepared nurse who had

    valuable knowledge and input from the bedside staff point of view. She could

    teach and persuade staff daily at the staff elbow of patient care. Forty plus years

    of varied nursing experience and staff acceptance as an educator who presents

    knowledge in an understandable format gave the project a positive advantage.

- The quality improvement manager was chosen due to her ability to provide

    statistics on inpatient satisfaction scores. She is a BSN prepared nurse who is

    currently pursuing a master's degree. She was instrumental in selecting the three

    problematic areas of the communication domains; nurse-patient communication,

    discharge instructions, and care transitions. Identification of the IMCU area was

    made possible by her knowledge of the HCAHPS score results.

Stakeholders in the project included the patients, healthcare facility, and the community

served by the facility.

Available Resources

Supplies and resources were already within the budget allowance of the education department of the project facility. The only cost, other than the nursing time, was a minimal cost for printing scenarios, performance checklists, rosters, surveys, and additional forms. The use of the printer in the education department was available for printing necessary forms at a minimal cost. The budgeted cost covered printing of paper forms and surveys.

The nursing staff was a listed resource for this project. Budgeted cost of hourly wages considered the extra time needed for learning sessions and modules. Management allowed extra staff time for learning sessions. Each learning session included a one-hour simulation that provided both interactions and role-plays to support the discharge process change. The simulation costs were computed based on hourly wage rates. Two education sessions were presented at an estimated cost of $25.00 per hour per nurse. Fifteen nurses attended the two sessions, making a total expenditure of $750.00. The cost of paper and printing presentation materials resulted in an expenditure of $90.00. Reinforcing TALK-ACT communication skills during a regular staff meeting resulted in no extra cost. Table 2 represents the identified cost analysis.

Table 2

Cost Analysis for TALK-ACT: A Quality Improvement Process

Identified plan	Learning sessions	Numbers to be trained	Projected Cost
Learning Sessions	• Two face-to-face sessions • Blended classroom modules combined with role-playing or simulations	15	$750.00
Reinforcing TALK-ACT skills during a regular scheduled IMCU staff meeting	• Reiterate and expand on prior education • How to educate adult learners about discharge instructions	15	0.00
Rekindle the needs for health literacy recognition, teach back, and the "Ask Me 3" skills	• Reiteration of communication skills, types, and how to improve communication	15	0.00
Communication Simulation Session	• This consisted of 2 learning sessions that combined with lecture	15	0.00
Cost of paper and course materials (handouts, forms, surveys, and test)	• For two training sessions	15	$90.00
		Total:	$840.00

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Desired and Expected Outcomes

The desired outcome of the project was for the IMCU nurses to take an active part

in the new process, and have the ability to practice individualized and effective patient

discharge education. Desired outcomes were based on the premise that learning is an

active process in which each has ultimate control over what was learned and how well it

is received. Self-concept, feeling of self-efficacy, and the ability of self-regulation were addressed, in hopes of improving knowledge acquisition andthe confidence to change feelings, thoughts, and behaviors. According to Butts and Rich (2018), adult learning theories suggest combining a formula of the learner's experience, learning process, and desired outcomes. This formula is a multidimensional approach to learning and represents the complexity involved in learning (p. 228).

Incorporating different types of communication, impressing upon patients the importance of medication compliance, adequate discharge education, and improving patients' care transition to home were goals anticipated at the end of project implementation. The ultimate project goal was a consistent patient discharge education process, staff communication sufficient for patient care transition, decreased patient readmission rate and HCAHPS score improvement.

SWOT Analysis

Strengths

The goals of the TALK-ACT project were to strengthen teamwork by facilitating handoff communication among staff, improving communication with the nurses, and improving the transitions of care by using the discharge flowsheet. The focus of the project was to equip the nurses with health literacy communication tools that could be utilized at every patient interaction. Emphasis on individualized patient discharge instructions, with a discharge plan begun on admission, would be enhanced by this process change, thus promoting patient confidence with care transition.

Weaknesses

Targeted weaknesses of the project were possible apathy of the patients and nurses and correctly identifying learning motivation for both. The current culture of beside care is predominantly task oriented and focuses on a daily routine schedule, leaving little time for patient education. Unidentified low literacy may exist due to lack of current communication skills for both patient population and nursing. Low literacy may be challenging to assess because it depends on the patient to honestly communicate their understanding. Admitting the inability to understand medical information could be an embarrassment to patients.

Opportunities

Changing the discharge process provides opportunities for staff collaboration. Allowing front line staff to contribute input which assists in tailoring patient education increases buy-in and assists in patient discharge planning. Empowering nurses to select process improvement and design changes increases project utilization and reiterates accountability of patient care transition. Improvement of HCAHPS scores and readmission rates from current trends would reflect project success.

Threats

Scheduling project learning sessions during the staffing crisis and the length of time needed to present information pose threats to attendance. Some nurses took offense to the suggested change, believing that patient discharge is done to the best of their ability. The ultimate threat to project success would be declining HCAHPS scores and an increase in patient readmissions. A SWOT analysis is presented in Figure 2.

Strengths
- Strengthen teamwork
- Improve nurse-patient communication skills
- Develop patient confidence in care transition

Weaknesses
- Apathy of the patients and nurses
- Motivation identification
- Time constraints
- Unidentified low literacy

TALK - ACT

Opportunities
- Increasing buy in from front line staff
- Nurse empowerment
- Reiteration of accountability
- Improve scores
- Reduce readmission rates

Threats
- Scheduling during staffing crisis
- Offending nurses
- Declining scores
- Increased patient readmission

Figure 2: SWOT Analysis as it relates to Teaching Adult Learners Knowledge About Care Transition (TALK-ACT)

The Scope of the Problem

As specified in The Essentials of Doctoral Education for Advanced Nursing Practice by the American Association of Colleges of Nursing [AACN], (2006), Essential two addresses the necessity for the doctoral-prepared nurse to evaluate care delivery systems. One will need to demonstrate advanced skills in clinical communication, navigation of the healthcare system, and the implementation of evidential findings by essentials two, three, and four. Essential one discusses the need to implement changes within the healthcare system through a theoretical framework (American Association of Colleges of Nursing, 2006). In an Intermediate Care unit, patients are often discharged home 48-hours after admission. Patients are too sick on admission to consider questions they need to ask. During discharge, they are given a significant amount of instruction

and are too overwhelmed to know what information is necessary for the transition.

The project proposed a change to the discharge process and the exchange of information between the nurse and the patient. The project reintroduced the idea of health literacy, Ask Me 3, motivational interviewing for self-care, and encouraged refining communication skills. The current discharge process involved the healthcare physicians adding discharge orders to unindividualized canned discharge instructions; this order is handed off to the discharge nurse, the nurse reviews the discharge orders, confirms them, and then prints a copy. The nurse then presents this discharge information to the patient with little thought to patient understanding or care transition. The electronic medical record (EMR) charting system has discharge patient education built into the documentation system with readability at a fifth-grade level; the nurse has the option to print discharge education from the system for discharge or other patient educational needs. However, the utilization of this process is not consistent, causing a gap in the discharge process. The communication between the care team is not patient-centered and does not support the patient with tools for a successful transition of care, as evidenced by the current HCAHPS scores and readmission rates. Improving nursing communications, improving HCAHPS scores, and decreasing readmission rates are project areas of focus. The discharge education and instruction, information about follow-up appointments, and symptom management are all areas that will benefit from this process change.

Seeking input from the frontline staff for process changes empowers them to personalize the discharge process change and contribute to the success of the project and support goal attainment. It is hoped that this will become a part of their daily routine instead of being viewed as an added task. The ultimate achievement of this project was

that the nurses would able to see the gaps in communication and discharge education

process and want to improve the process for the safety of their patients. An obstacle of

the project is time management by the floor nurses, the perception of the new process as

being just another task, and the support from the front line staff. A future

recommendations for this project would be that the communication skills and patient

education process be incorporated into the new hire orientation and become an annual

training for the nursing staff.

SECTION III

Goals, Objectives, and Mission Statement

According to Merriam-Webster, a goal is defined as the end towards which efforts are directed, and an idea that the future or the desired result a person or a group of people envision, plan, commits to achieve, or a process of identifying something that you want to accomplish and establishing measurable results within a timeframe (Merriam-Webster "Goal," 2018, para. 1).

Goals

The overall goal for this project was to improve the communication between the nurses and the patient for discharge instruction and care transition, thus improving HCAHPS scores and decreasing readmission rates. The two domains of nursing communication and transition care within the survey ask patients about discharge instruction and communication with nurses. These domains mainly focus on discharge planning, nursing communication, and the care transition readiness of the patient.

The Joint Commission (TJC) and the Agency for Healthcare Research and Quality (AHRQ) are concerned with the transition of the patient from hospital to home and nursing communication skills, primarily how they affect readmission rates due to the poor quality of discharge education ("TJC," 2012). When presenting this project to the facility administrative board, the board's primary concern was discharge education and nursing communications skills. This project took place on a regional hospital's busy cardiac step-down IMCU. An average of 62% of the facility discharges come from this unit.

Objectives

The objectives for this project were established using the acronym SMART. The objectives should be specific (S), measurable (M), attainable (A), realistic (R), and timely (T) (Zaccagnini & White, 2017). During the education sessions, the staff was given information about the HCAHPS scores and ways to improve communication with patients and family. Objectives were constructed for the discharge improvement process:

- Participants will be able to list two health literacy communication tools at the end of the education sessions.

- Participants will be able to seek patient information, using motivational interviewing techniques during nurse-patient interaction observation.

- Nurses will effectively demonstrate knowledge using the new discharge process, as evidenced by starting discharge education on admission.

- The patient will show understanding of discharge information, as evidenced by patient communication during the teach-back method.

- Nurse-patient communication will improve, as evidenced by the increase in HCAHPS scores.

- Patient confidence in care transition will be demonstrated by a decrease in readmission rates.

Mission Statement

This Doctor of Nursing (DNP) project mission statement was to communicate discharge information in an education style that patients will understand and is individualized to the patient and their disease process. Discharge education will reflect the education and experience that the nursing staff possesses. The nursing staff on the

Intermediate Care Unit will ensure that their patients are confident and have the skills needed to care for themselves during the care transition to home. The nurses and the care team will work together to ensure the patient can effectively and confidently transition home after discharge.

SECTION IV

Theoretical Underpinning

Being admitted to the Intermediate Care Unit with chest pain or having heart rate abnormalities is an overwhelming event. Nurses working in this unit are knowledgeable about these problems but did not always have time to spend with patients to explain their diagnoses. The project implemented a change to the current discharge process. The Project Leader planned to achieve a patient-centered discharge plan to include the patient, the family, and the caregivers in the discharge and to ensure a successful care transition. The theories that guided the process were chosen based on change and adult education theories, combined with a focus on patient care.

Theoretical Framework

There are many change theories and multiple nursing theories which could be chosen for this project. However, the theory selection had to match the plan and encompass the importance of the discharge process. Most changes in practice fail because nurses are not supported and empowered to adjust emotionally to new ways of working (Bowers, 2011). The two theories that guided and supported the project were Kirk Lewin's Change Theory and Malcolm Knowles' Theory of Andragogy.

Lewin's Change Theory

Lewin's Change Theory brings together multiple integrated elements that are business-focused but have a positive influence on patient care. Lewin, who was a social scientist, developed his Change Theory that focused on the changes in human behavior that come about due to changes in the forces or energies in the environment that surrounded them (Lewin, 1947). Changing the discharge education process is essential

for the patients to be successful with transitional self-care, thus helping them stay at home and decrease readmission rates. Health care has never been as much in a state of flux as it is today, and nursing needs to embrace this change and consider it necessary for the survival of patient self-efficacy and safety (Mitchell, 2013).

Change is inevitable, and health care is no exception. Using a change theory to help the nursing staff adapt to the changes in a smooth fashion happens with the appropriate selection of the correct theory. Lewin's Change Theory fit well with the proposed changes to the current discharge process. Lewin's Change Theory incorporates three stages to the change process: Unfreeze, Change, and Refreeze.

Stage 1: Unfreeze

This first stage of any change process is the most critical step. This step will identify the readiness of the staff to accept the change before the process starts. The transparency behind the current discharge process encouraged the nurses to embrace the TALK-ACT. Patients' statements on the Press Ganey Survey indicated they do not get enough discharge instruction at the time of discharge to safely take care of themselves at home, leading to hospital readmissions. During this stage, it is essential for the stakeholders, such as administrators and management, to give support to the Project Leader and the improvement plan. Staff motivation for change through education and encouragement was gained from leader support and interest.

Stage 2: Change

Stage 2, Change, was an essential part of the implantation of the TALK-ACT discharge process. The Project Leader worked side by side with the bedside nurses as a

mentor and remediated when needed. Necessary steps for modification of processes were

taken as the project expanded, with some of those practices listed below:

- Education was provided to help the staff adjust to the change that was

  taking place.

- Support was provided, especially if there was a transitional difficulty.

- Feedback to staff regarding the process results was provided and support

  given for the introduction of any new steps incorporated to improve

  operations. Feedback works both ways and transparency is a must,

  especially when introducing changes to procedures. Necessary

  adjustments and alterations to the process based on staff feedback were

  made and staff was involved in all decisions and change management

  (Lewin, 1947).

- Continued support for the staff was provided as a means of encouragement

  and frequent praise was given.

- Frontline staff was promoted as project champions to encourage their

  peers and to support the process change at a time when the Project Leader

  was not on site (AHRQ, 2019).

- There was open communication with staff, stakeholders, patients and

  management regarding the changes, including any project benefits or

  breakdown.

Stage 3: Refreezing

Stage 3, refreezing, was incorporated to provide stability by supporting changes

into habits and routines. Refreezing is a critical step in continued change until it becomes

routine. The Project Leader, unit manager, and the unit champions were accessible to

offer support and clarify any questions for the staff. This stage allowed staff time to

work through and clear up any doubts they may have related to the new process. Unit

Champions were also instrumental in:

- Acceptance and support to staff that allowed change to take place

- Acting as advocates during this process

- Reinforcing changes and reiterating the importance of patient discharge

  instruction (Bastable, 2019).

Most changes in practice fail because nurses are not supported and empowered to

adjust emotionally to new ways of working to bring about sustainable practice.

Adopting this change theory guideline enabled the whole team to embrace and sustain the

changes internally. An embraced change is one that is planned and implemented in a way

that responds sensitively to individuals' emotional reactions (Mitchell, 2013). Lewin's

Change Theory lends itself to healthcare practice – its three stages are comparable to the

processes of planning, implementing, and evaluating care.   Lewin proposed that bringing

about meaningful structured change meant supporting employees in psychologically

"unfreezing" from the point of comfort with the current state of affairs (Lewin, 1947). A

transition can then occur, as team members are encouraged to alter their values and

ideally gain ownership of the change, exploring the alternatives, and defining and

implementing solutions. "Refreezing" occurs once the change has become integral and

established (Bastable, 2019). The theoretical framework for process change using

Lewin's theory is illustrated in Figure 3.
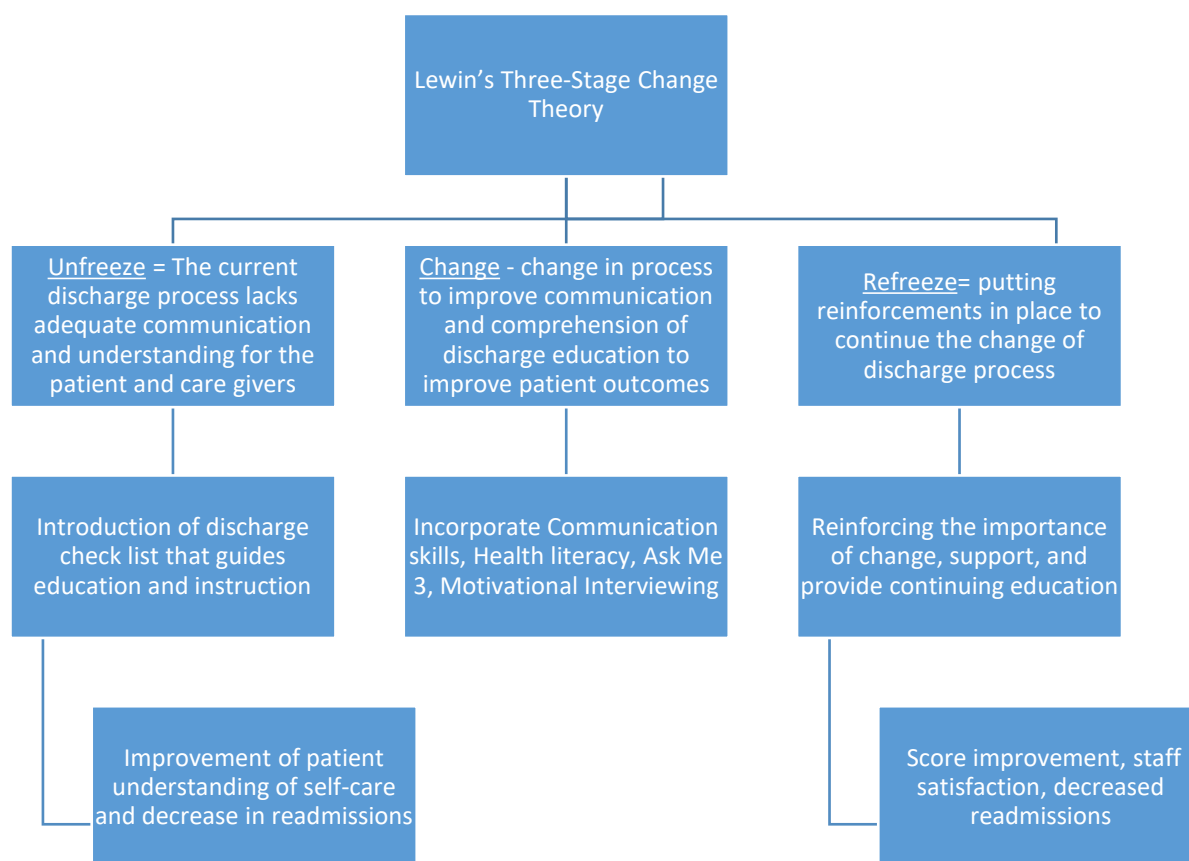
Figure 3: Lewin's Change Theory for TALK-ACT

Malcolm Knowles' Theory of Andragogy

Knowles' Theory of Andragogy focuses on the teaching or education of adult

patients. Nurses practice in a wide variety of settings, but all have one thing in common -

patients and the ability to teach disease processes and self-care to patients. Teaching

patients with instructions that they understand is critical in the care transition from

hospital to home with discharge planning (Candela, Piacentine, Bobay, & Weiss, 2018).

Day of discharge can be an overwhelming time for both patient and caregivers, which

causes an increase in stress. Andragogy, a theory of how adults learn, provides insight
into how to best work with patients to facilitate their learning to adjust to the care
transition from hospital to home (Knowles, 1984). Knowles' theory has a set of
assumptions that provide a guide for patient discharge planning, teaching, and patient
comprehension of that teaching. The Knowles' Assumptions focuses on five concepts to
assist with the education of adult learners:

1. Self-Concept: using adult valued autonomy to guide patient decisions
   about the learning process, which will help them with self-directed
   learning and encourage self-involved care.

2. Experience: using patient life experiences to guide the nurse's teaching
   method. These patient experiences will help nurses to individualize the
   discharge plan and influence patient readiness and motivation to learn and
   their learning style.

3. Readiness to learn: the patient accepts learning topics when these topics
   are perceived as vital to them at that time. Adult learners are pragmatic
   and learn on "a need to know" basis. They selectively engage in learning if
   they feel that it is essential to their immediate life or social role need.

4. Orientation to learning: adults learn based on the need to solve a problem
   or to improve a situation. The need for knowledge is for immediate
   potential or application for the direct result.

5. Motivation: patients are influenced by learning that matches an immediate
   internal goal or expectation rather than a goal imposed or set by others.
   When teaching a patient about care transition, the instructions should be

based on internal needs such as family, grandchildren, or pets at home to help motivate the learner to strive for wellness (Knowles, 1984). Process change using Knowles's theory is illustrated in Figure 4.

Knowles' Adult Learning Theory
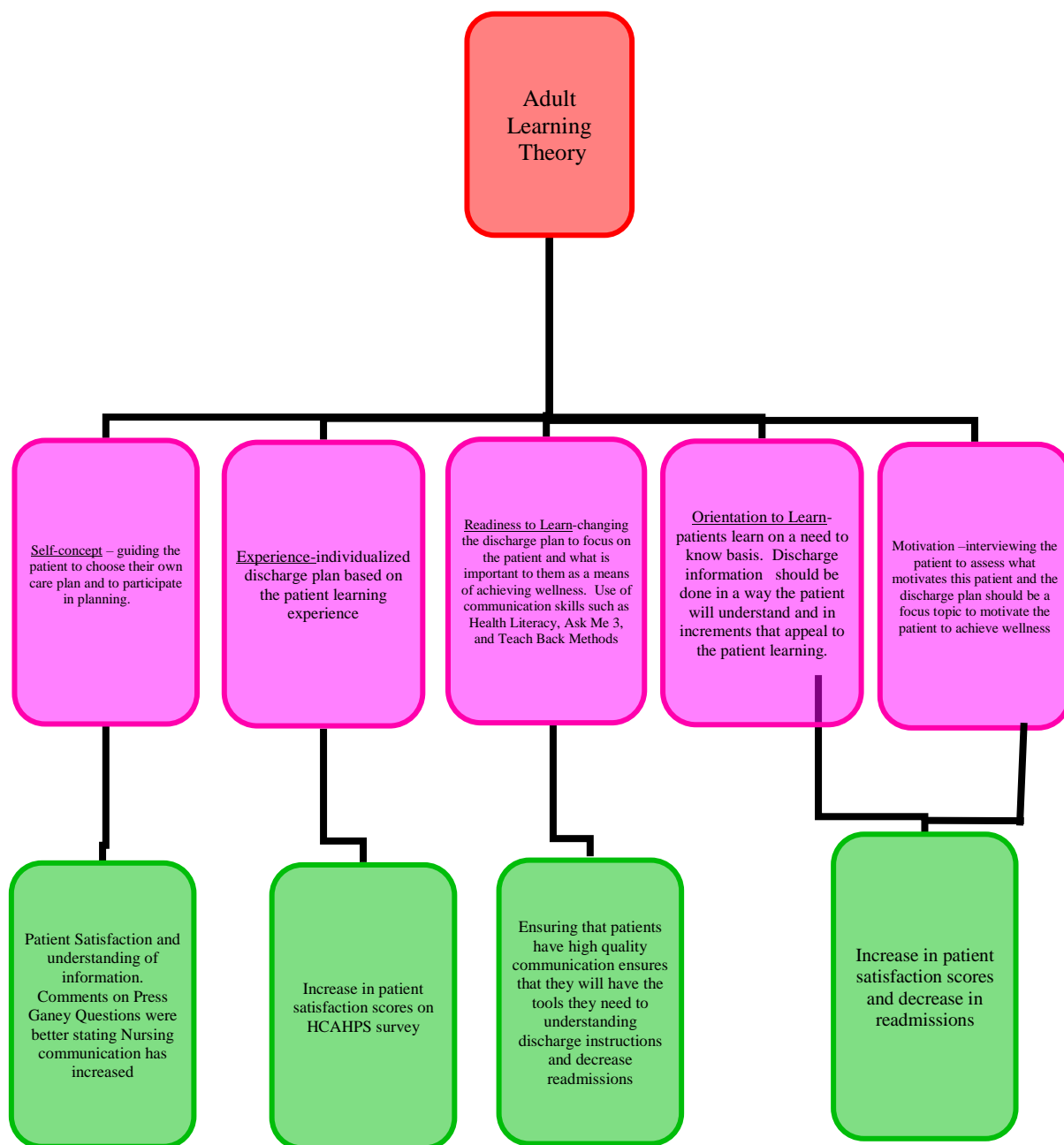
Figure 4: Knowles' Theoretical Framework for TALK-ACT

Process Change Patient Impact

According to the Centers for Medicare and Medicaid Services (CMS), nearly 20% of all Medicare patients are readmitted to the hospital within 30 days of discharge and 34% are readmitted within 90 days of discharge (Polster, 2015). Patient teaching must be understood as a process that involves taking the time to understand the patient's perspectives, concerns, health goals, and anything that may facilitate or hinder the ability to get to those goals such as their environment, health, and finances. Patient discharge education is an essential part of care transition; it requires an assessment that individualizes instruction and is tailored to the patient's preferences and learning style. Individualization is critical in planning the content to be taught, teaching approach, learner readiness, and the patient's support system (Candela et al., 2018).

SECTION V

Work Planning

Executive Summary of TALK-ACT

According to the Centers for Medicare and Medicaid Services (CMS), nearly 20%

of all Medicare patients are readmitted to the hospital within 30 days of discharge; 34%

are readmitted within 90 days of discharge. ("Centers for Medicare and Medicaid,"

2017). However, 75% of the readmissions could be prevented with better transitional

care education and support (Common Health Community Digital Magazine, [CHDM],

2015). Readmissions and patient transition care outcomes are linked to poor

understanding and comprehension of the discharge plan, lack of education, no follow-up

appointment initiated for the patient, and little or no care transition support at home

(Centers for Disease Control [CDC], 2013). HCAHPS nursing domain scores for nurse-

patient communication was 49.6 % based on 503 surveys returned for 2018, with a goal

of 85%. Transition of care was at 47.9% out of a goal of 86% (Press Ganey Score

Summary Wilkes, 2019).

Before this practice improvement project, the discharge process was not

individualized, and instructions were hard for patients to understand and contributed to

poor transition care as evidenced by the decreased HCAHPS scores for discharge

instructions, transition care, and nurse communication. The discharge instructions given

to the patients previously were canned discharge instructions written with a focus on the

disease process instead of a holistic approach. Discharge instruction lacked

individualization and left gaps in care transition, with little or no communication with the

patient or family. Centers for Medicare and Medicaid and The Joint Commission expect

nurses and providers to discharge patients home with proper education and a discharge plan that is personalized and addresses modifiable factors that cause an increase readmission including (1) insufficient understanding of discharge instructions and education, (2) inadequate follow-up appointments, (3) lack of individualized discharge plans, and (4) inadequate post-discharge care transition support (Polster, 2015).

A landmark report released by The Centers for Disease Control (2013), highlights the need for a focused discharge plan that is more patient-centered and individualized to the patient's disease process (CDC, 2013). Patient-centered care is defined as providing care that is respectful and responsive to the individual patient and providing a plan that references patient needs, values, and ensuring that the patient has a valuable guide that helps the patient with clear clinical decisions (NEJM Catalyst, 2017). Based on satisfaction scores, the prior discharge process allowed the nurse to miss valuable teaching opportunities with patients due to task-oriented patient care workload. The proposed change for the discharge process incorporated a discharge flowsheet. The TALK-ACT discharge flow sheet listed the discharge instruction tasks in three sections. Studies have shown that having a task or steps listed on a checklist helped the nursing staff stay on track with patient teaching (Roberts et al., 2017). This discharge flow sheet begins patient discharge education on the day of admission; this type of patient education ensured that the patient was not overwhelmed with information on the day of discharge. This process facilitated a change in the way the nurse prepared the patient for discharge due to discharge instructions being taught in frequent short sessions and starting them on the day of admission. Nurses were encouraged to never miss a teaching moment with their patients.

Successful discharge teaching should start as soon as possible on admission and continue throughout the patient stay. At the time of discharge the patient is preoccupied and overwhelmed and has more difficulty understanding the discharge plan ("Institute for Healthcare Improvement (IHI)," 2017). The proposed discharge plan contained four evidence-based approaches to patient-centered discharge planning. These four evidence-based patient approaches have been shown to help with patient and family engagement, combat low literacy, and promote understanding. Health Literacy tools such as Teach Back and Ask Me 3, motivational interviewing (MI), and plain language communication for discharge instruction should be incorporated into all discharge planning (Polster, 2015). These changes to discharge instructions can make a distinct contribution to empowering patients to meet their care transition goals (Polster, 2015). A problematic discharge process, low satisfaction scores, and an increased readmission rate provided an excellent opportunity for the introduction of a new discharge process. The new discharge process is more patient-centered and individualized. TALK-ACT has an educational base that is guided by the theoretical framework of Malcolm Knowles known as andragogy. Andragogy, a theory of how adults learn, provides insight into ways to best incorporate patient-centered teaching and facilitate learning (Knowles, 1984). Andragogy uses a set of assumptions that offers a guide to planning patient teaching focused on adult patients and family members. Because adults need to know the reasons for learning, an effective patient educator explains the reasons for teaching specific skills (Peterson, 2019). Knowles' theory postulates adults learn by doing. Useful discharge instructions focus on tasks that adults can perform, rather than on memorization of canned content. Because adults are problem-solvers and learn best when the subject is of immediate use, effective

instruction involved the learner in solving real-life problems. When the patient is engaged in the discharge plan, they have helped to tailor the discharge plan to what they perceive as essential to their quality of life, thus motivating wellness.

Using the TALK-ACT Plan

TALK-ACT is a plan that consists of four areas of communication to individualize discharge planning: (1) the health literacy tools teach-back and Ask Me 3, (2) motivational interviewing, (3), plain language - both written and verbal, and (4) TALK-ACT discharge flow sheet. TALK-ACT is a patient-centered discharge process that ensures patients receive an individualized discharge plan that involves the participation of the patient and family. Nursing staff improved nurse-patient communication as well as the communication between the nursing staff with the use of the TALK-ACT discharge flowsheet. The checklist permitted the nurse to focus on the patient's educational needs. By using the TALK-ACT flowsheet, each time the nurse completed an education topic, it was checked off. Communication is essential for patient transition success and understanding of discharge instructions (Roberts et al., 2017).

Teach-Back and Ask Me 3

Teach-back is a method to question the patient about instructions by getting them to teach back to the nurse the information on the patient discharge plan. An excellent example of teach-back is with the teaching of discharge medication when the patient can repeat back to the nurse what was taught to them. The nurse can validate this by conveying to the patient "You have been taught a lot of information about your discharge medications. Can you tell me how you will take your Lasix when you get home?" If the

information is given back to the nurse correctly is an indication that the patient understood the teaching (AHRQ, 2015).

Not only is the understanding of information critical, but the patient should also be encouraged to ask questions about issues that they do not understand. The communication tool Ask Me 3 note page is a place to write these questions. Questions could be written down for the nursing staff or the provider on return appointments. Nursing can offer patients an Ask Me 3 note page with an explanation of the three questions: "What is my problem?", "What can I do about this problem?" and "Why would that be important to me?" An explanation should encourage the patients to write down any and all questions about treatment, medications, recovery, or clarifications (AHRQ, 2015). Ask Me 3 is a way to get the patient involved in their care plan by empowering them to ask questions (AHRQ, 2015).

Motivational Interviewing

Another change incorporated motivational interviewing (MI). MI, when used on patient admission, can help the nurse to identify what motivates the patient to achieve wellness. MI is a client-centered teaching style for eliciting behavior change by helping the clients to explore and resolve ambivalence (Motivational Interviewing, "Psychology Today," 2019). MI is a more focused and goal-directed teaching process for discharge planning designed to help the patient achieve wellness through a positive self-drive. MI usually happens on admission but can be combined with patient care tasks and discharge planning. The nurse needs to be comfortable with their own emotions to be able to teach patients disease-specific education and encourage lifestyle changes that could help improve the disease processes. Motivational interviewing helps the nurse to identify

reasons for the patient to achieve good health. Focusing on that motivation is important

when designing a discharge plan that can improve care transition (Droppa & Lee, 2014).

Plain Language

Plain language with both written and verbal communication enhances

understanding for both patient and family. Plain language is a process of giving

education and instruction to patients using "living room language" or "everyday

language." Trading medical terms and phrases for a more comprehensible form of

instruction ensures that patients have an opportunity to understand. Plain language

facilitates clear and concise health instruction that proves to be of key importance with

care transition. Clear and easy to understand discharge planning and instruction in a form

that the patients understand is mandated by The Joint Commission, American Nurses

Association, and the North Carolina Board of Nursing (Roberts et al., 2017). The Centers

for Disease Control and Prevention published a plain language thesaurus for the medical

community to use to promote patient understanding of disease process and discharge

instruction ("Centers for Disease Control and Prevention: National Centers for Health

Marketing (CDC)," 2009). When patients and families are more engaged, the plan of care

is more likely to be carried out.   Patient advocacy and knowledge assessment can be

learned through plain language and instructions are in a form that the patient can

understand (Ahmad, Hugtenburg, Welschen, Dekker, & Nijpels, 2009). The ongoing

collaboration of the patient, family, and nursing staff is critical and extends the

opportunity for shared decision making between patients and family members, with all

parties having adequate information and time to make informed decisions (CHDM 2015).

TALK-ACT Discharge Flowsheet

The flowsheet received push back at first, because the nurses in the IMCU felt they gave adequate patient care. Observation showed nursing care was adequate, but the education and communication needed development. Implementation of the TALK-ACT flowsheet improved the flow of information immediately. The flowsheet was designed by the Project Leader and divided discharge instruction into three different sections: on admission, inpatient stay, and discharge day. This design provided the nurse with the opportunity to give short, frequent educations sessions. The flowsheet should be perceived as a prompt or a guide to ensure that no patient teaching moments were missed. The flowsheet proved to be a positive addition to the discharge process. One nurse wrote: "the flow sheet is like a grocery list; everything is listed for you and helps to organize patient care and education." As a way to help the patient with questions, the patient is also given an Ask Me 3 form. During discharge instruction, it should be reiterated to the patient to continue to write questions on this form and take it to the follow-up visit for clarification of any questions about a disease process or discharge instructions, using this as another step to facilitate communication and improve transition care (AHRQ, 2015).

Evaluation Process

Outcome assessment metrics, including readmission rates for patients within 30 days of discharge, should be monitored to determine education program success. Patient satisfaction scores for printed discharge instructions may also reflect a practice change with the assessment of the scores. Ultimately, the assessment and evaluation of the patient's new knowledge and skills was the primary goal of education. The post-

discharge phone calls process continued during the TALK-ACT project. These calls took place within 24 hours of discharge to evaluate the comprehension of the discharge plan.

A phone call may reveal that the patient needs additional support at home. After the second week of implementation, the questions for clarity were fewer than those at the beginning of the project. Patients were given the Ask Me 3 forms to write down any questions that they may have. The patient was instructed to take this form with them to the first follow-up visit and to write down any questions that they may have about their disease process. This promoted further education and clarity. TALK-ACT's goal was to improve discharge transition through the improvement of the nurse to patient communication by including the patient and family into the discharge planning. If the discharge transition is improved, the readmission rates will decrease, both of which would contribute to the improvement of satisfaction scores. The evidence of improved satisfaction came after the first two weeks of project implementation. The TALK-ACT discharge improvement process uses communication and management tools and Figure 5 represents the work breakdown structure diagram.
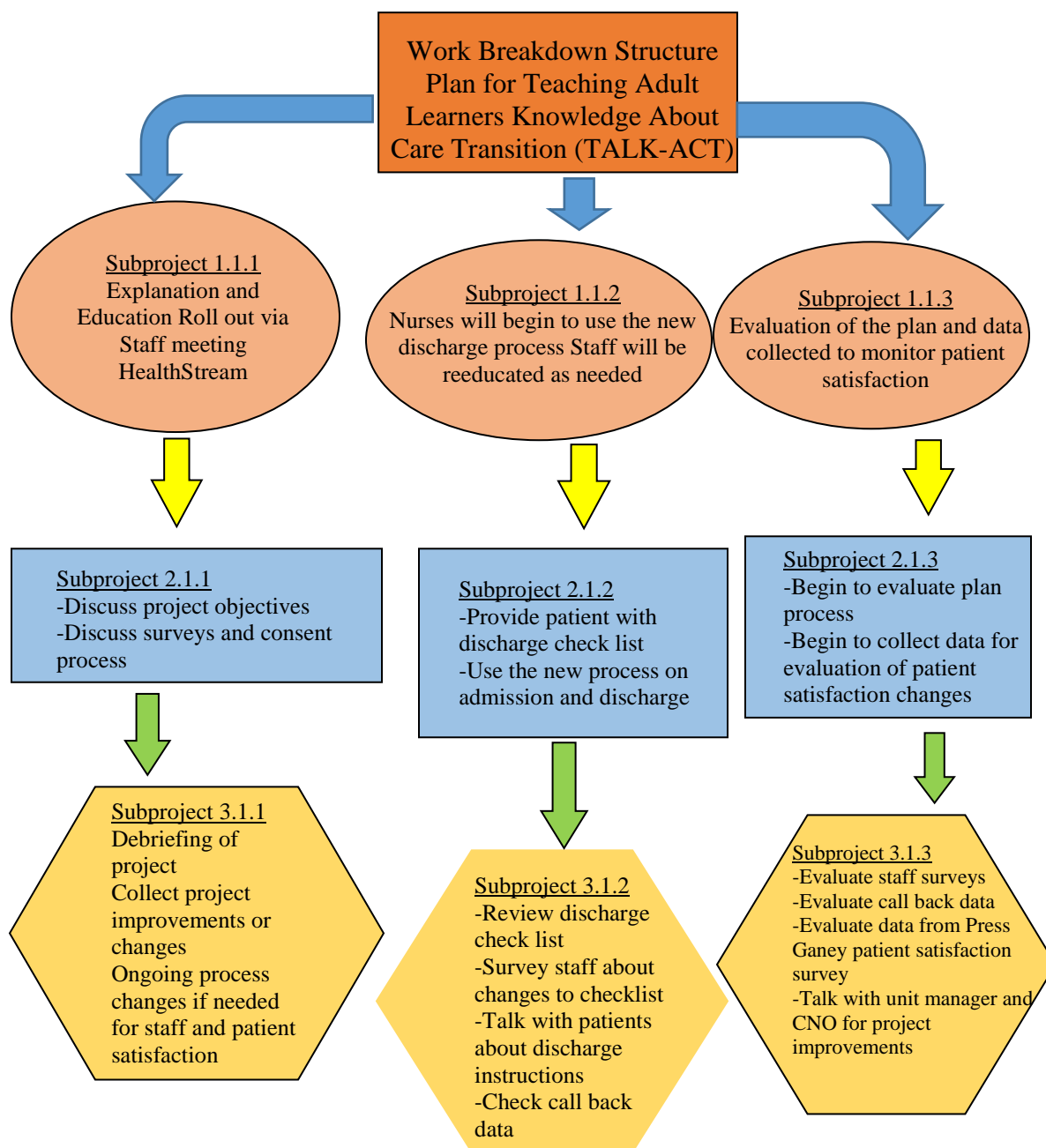
Figure 5: Project Management Tools: Work Breakdown Structure Diagram

SECTION VI

Project Evaluation Proposal

For the most part, discharge from an acute care hospital stay is routine and uneventful if the patient has adequate discharge education. However, for a percentage of patients, discharge from acute care requires careful planning to ensure continuity of care (Roberts et al., 2017). Transition care, especially in the older population who have complex medical needs, requires more instruction and support. The Project Leader intentionally designed the TALK-ACT process to focus on individualizing the patient discharge education to ensure that the patient has a comprehension of valuable information for care transition success.

The essential elements for discharge planning are: (a) communication, (b) coordination, (c) education, (d) patient participation, and (e) collaboration between medical personnel (Mintz-Binder, 2019). Outcome measures of successful discharge planning include patient satisfaction and quality of life. Smooth and efficient coordination of this process reduces stress and anxiety for all the participants involved, especially the patient and their family. Improvement of the current discharge process was the reason for creating TALK-ACT.

The project outcomes that guided the TALK-ACT discharge process improvement included:

- The use of MI for patient discharge, as evidenced by the specific information obtained on patient history to create an individualized discharge plan.
- Nurses will voice the knowledge of using small teaching sessions to improve patient comprehension.

- Improved communication between nurses and patients, especially with discharge instructions, as evidenced by the improvement of HCAHPS nursing communication scores

- Improved communication between nurses and patients, as evidenced by the patient recall of discharge medication teaching.

- Nurses demonstrate proper use of MI as a way of encouraging patients to achieve wellness, as evidenced by the discharge plan for care transition.

- Nurses will use health literacy and the teach-back method with every patient every time as evidenced by results from observation using the TALK-ACT observation tool.

- Development of patient knowledge and confidence in discharge information as evidenced by a decrease in readmission rates.

- Nurses can incorporate the new discharge method and use new ways of communication in their daily practice as measured by observation at the time of discharge.

- Improved nursing and patient communication as evidenced by a decrease in readmission rates and improvement in nursing communication scores.

- Nurses will improve their communication skills with the patient as evidenced by the increase in the scores for nursing communication.

- A noticeable change in process upon observation of the nursing staff during discharging of the patients.

- Improvement in scores for nursing communication and transition of care domains as evidenced by the rise in the satisfaction scores.

Patient understanding of discharge instructions, patient comfort, success with care transition, frontline staff buy-in, improvement of patient scores for communication, and decreased readmissions rates are all reasons for a change in the discharge process. The project phases were incorporated into a timeline which indicated the desired outcome and reflected the communication process goals for care transition.

Participatory Models Education

Project implementation consisted of PowerPoint education for the development of a process using health literacy tools, motivational interviewing, and plain language. The PowerPoint presentation was e-mailed to the IMCU staff members. The presentation lasted 60-minutes and was for staff viewing prior to coming to an education session. The participants were asked to attend a training class that included a reiteration of the PowerPoint education combined with skills portion for communication role-play simulations. The simulation lab allowed the staff to participate in the use of communication skills to recognize low literacy, using Teach Back and Ask Me 3, and simulation using MI.

The participants were asked to participate in the scenarios involving problematic situations that interfered with patient understanding or communication. The task was for the staff to format the discharge instructions in a manner that would promote patient understanding. At the end of the learning session, the TALK-ACT discharge flowsheet was introduced, and the Project Leader provided an explanation of how and when to use the checklist communication tool.

Implementation of Plan

Participants were informed of the purpose and methods for the discharge change as well as the desired outcome of improving care transition, increasing the HCAHPS scores and decreasing readmissions. Informed consent forms were given to the nurses with the explanation of the discharge improvement process. Staff was given ample time for questions. The staff was notified that evaluations for the education sessions were entirely voluntary. At the end of the education sessions evaluations were given out, with instructions to leave them on the table upside down as they left the meetings. The participating nurses were asked to start implementing the process change immediately after the education sessions.

Process Observation

The staff was instructed to start the process with all newly admitted patients immediately following the learning sessions. The implemented process included the following:

- Upon admission, the patient will be issued a discharge checklist. The checklist will be maintained on the patient clipboard and kept at the nursing desk; this checklist will not be a part of the final chart.

- The patient will have information on admitting diagnosis explained to them on admission to assure that the patient has adequate knowledge of admission diagnosis.

- For clarity of the patient questions, the nurse will also offer the patients a note sheet with Ask Me 3 questions on it and explain the process for the user of this note sheet.

- Each time the nurse enters the patient's room to perform tasks, the patient's discharge checklist will be reviewed, and teaching checked off when education is done.

- When it is time for the patient to be discharged to home, the nurse will come in and do the discharge instructions, paying close attention to the information specifics, motivational interviewing, and communication skills about discharge care transition.

- At the end of the discharge instruction period, information on the checklist will be reiterated to ensure patient understanding.

- The teach-back method will be used to check for the recall of information with the patient, especially for discharge medications.

- All discharged patients will receive a 24-hour follow-up phone call to check for clarity of the discharge instructions, questions about medications, or follow up appointments.

Project Evaluation Plan

This project utilized evidence-based practice with a focus on increasing discharge understanding. The ultimate goal was to improve care transition and show a decrease in readmission rates and an increase in patient HCAHPS satisfaction scores. Use of pre- and post-evaluation tools for the project and the visual observation evaluation tool for discharge instructions will help the Project Leader and the rest of the committee evaluate and measure the outcomes for the new TALK-ACT discharge process. Another evaluation review will be from data collected from the patient satisfaction scores through surveys scores and patient comments made during discharge phone calls. Evaluation of

readmission rates is based on hospital readmission within 30 days of discharge. The IMCU is a 15-bed unit that has multiple discharges, mostly with patients that are 50 years of age or older.

The evaluation plan included the use of observation of process change, identifying interventions that worked, what the HCAHPS scores mean, usefulness of the process change, participants' perception of the changes, and analyzing the failures and successes of the project implementation (Zaccagnini & White, 2017). The project was introduced as a quality improvement project using best practices to improve the current discharge process. Project outcomes were measured using the HCAHPS survey scores, observation of the discharge process, readmission rates, and staff satisfaction on evaluations pre- and post-project implementation. Staff outcomes were measured utilizing the staff perception of the discharge process and successful incorporation of the new process. HCAHPS survey data was assessed with a focus on communication scores for the nursing domain and transition of care domain ("Hospital Consumer Assessment of Healthcare Providers Communication (HCAHP) Scores," 2019). The HCAHPS survey has been found to be reliable and valid.

SECTION VII

Implementation

Discharge is a time of stress for patients and family caregivers due to the massive amount of discharge information that is given to them. The transition from nursing care to self-care can further increase that stress for patients and their families (Lin et al., 2012). Nurses practice in a wide variety of settings, but all settings have one thing in common; understanding through education (Droppa & Lee, 2014). It is crucial that nurses understand the importance of individualized instruction and the role they play in this process.

Problem Recognition

The purpose of this quality improvement project was to develop a discharge process to improve nurse and patient communication, improve discharge education, and empower patients through information leading to successful care transition. The prior discharge process lacked individualization and effective communication of the discharge plan, leading to a lack of understanding of discharge instructions. The lack of knowledge of self-care measures often results in hospital readmission within 30 days of discharge. Ineffective communication during the discharge education process is reflected in low patient satisfaction scores for nursing communication and transition care readiness on the HCAHPS survey questions. Studies have shown that 40-80% of the discharge information given to patients is forgotten immediately, and nearly half of the information retained is incorrect (National Guideline Clearinghouse, 2015). Clear communication is the foundation for patients to be able to understand and act on health information. Literature supports the use of communication tools to improve patient discharge

instructions as well as to improve patient outcomes and prevent readmissions within 30-days of discharge (McIlvennan et al., 2015).

Project Team Building

Staff buy-in for the new discharge process was essential for the sustainability of the project. Resistance and negativity were both met in the beginning from already overworked staff. Staff were frustrated with the introduction of a new process and were resistant to learning a new way to do discharges. The implementation was viewed as just another task to add to their already overloaded work schedules. When nurses view their job as task-oriented, then patient care becomes a process of going through the motions or a robotic activity and nurse-patient communication decreases (Smith, 2018). Prior to the implementation, Unit Champions were sought as a means to keep the staff positive about the changes and to increase buy-in and cooperation (AHRQ, 2019). These champions consisted of leading frontline staff such as charge nurses and resource nurses who were given talking notes and words of encouragement for use when speaking and answering questions for the staff. Unit Champions were positive, upbeat, and encouraging to the staff concerning the new process. The champions encouraged the staff about the transition to the new process and created positivity, which encouraged staff and presented this as a process improvement instead of a task.

The TALK-ACT champions were able to identify areas where clarification in process steps was needed, especially with individualizing the discharge plan to each patient. The change in the process of discharge showed improvement in nurses' workflow by creating a better method of discharge information and how that information was given to patients. Once the value of the process change was revealed, the attitude

towards using TALK-ACT changed. The change proposed that discharge planning and

education happened with every patient encounter starting with patient admission. The

TALK-ACT discharge process helped with the flow because the patient's questions were

answered each time information was relayed. The IMCU nurses used the discharge

flowsheet to guide the individualization of discharge processes. Each time a nurse

performed patient teaching, it was documented on the flow sheet. Individualizing patient

discharge information improved the discharge flow and improved nurse-patient

interactions and communication. Each patient interaction was used as "teaching

moments" and time for patient questions and clarification of information. The TALK-

ACT implementation process is illustrated in Figure 6.

tions

Current Discharge process

Education Sessions

Implementation

TALK-ACT

Observation and skills reinforced

Process improvement Improved scores and Reduction of Readmission Rate
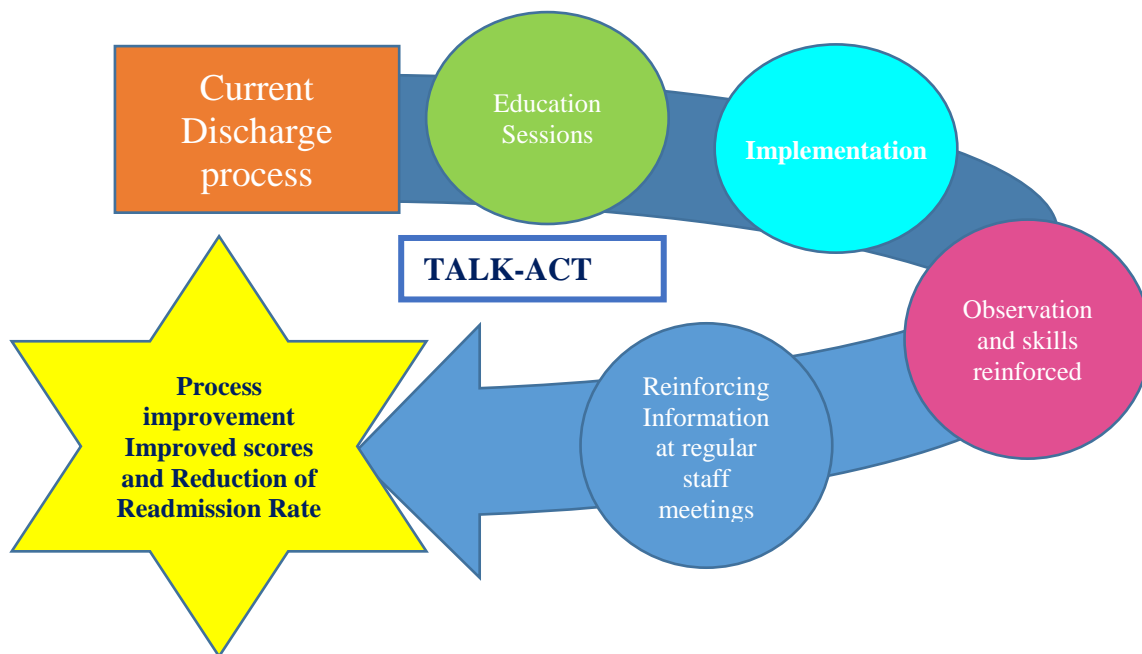
Reinforcing Information at regular staff meetings

Figure 6: TALK-ACT Implementation Process

Institutional Review Board Process

The project proposal was approved by both the University and facility Institutional Review Boards (IRB) in December of 2018. Once both entities had approved the project, staff education began, and the project was implemented immediately after the completion of the education.

Staff Notification Process

An introductory email that briefly explained the project was sent to the IMCU staff via hospital email. Also contained in the notification e-mail was a PowerPoint presentation for the TALK-ACT discharge process for the staff to view prior to coming to the classes. This was meant to familiarize the staff with the information prior to coming to the classes. All IMCU registered nurses providing direct patient care were required to participate in educational sessions for the TALK-ACT discharge process.

Staff Education

After notification by e-mail, the staff education was presented during two staff meetings. The TALK-ACT project was presented as a quality improvement project which focused on the implementation of a new discharge process designed to improve communication and patient education, resulting in successful care transition. The Project Leader reviewed the informed consent with the nurses at the beginning of class. All IMCU nurses were required to participate in the educational session and the TALK-ACT process was mandatory for this unit.

The education sessions consisted of a PowerPoint presentation, and simulation of communication skills conducted by the Project Leader. Included was an introduction to the TALK-ACT discharge flowsheet (discharge teaching checklist) designed by the

Project Leader to help with simplifying the discharge process for patients and nurses. Copies of the discharge flow sheet were given to the staff, with a thorough explanation of how to use the flowsheet to complement the discharge planning process. Handouts were given to the participants that contained information about the communication techniques, and some scripted conversation starters that could be used. Following the PowerPoint presentation and TALK-ACT review, the nurses completed a written test related to knowledge of communication skills and literacy. The test was then reviewed with the participants.

Following the review, the nurses participated in simulations designed to improve the use of communication skills. The skills simulations were presented in the form of role-playing and scenarios illustrating correct and incorrect communication techniques. During simulations, the nurses were given case studies using various communication skills and literacy methods. The new checklist for the discharge process was reviewed and discussed. Two nurses were not able to attend the education session, and both nurses received a one-on-one education session by the Project Leader upon their return to work.

<div align="center">**Staff Evaluation**</div>

Following the skills simulations, the nurses were asked to complete the TALK-ACT evaluation survey voluntarily. Completion of the learning session evaluation was anonymous, and it could be filled out or turned in blank. The nurses were asked to submit the evaluations by putting them in a basket placed on the table near the door. The Project Leader handed out the evaluation to the nurses and left the room. The Project Leader returned to the room after 10-minutes to collect the evaluations. Completed evaluations were placed in a locked filing cabinet in the Project Leader's office.

Project Threats and Barriers

According to Zaccagnini and White (2017), threats can be divided into two

categories, those that can be predicted and those that cannot. Some threats to the project

are listed below with an explanation of how they were overcome.

- Delayed IRB approval- The IRB process is a complicated process, and the

  timeline for project implementation had to be revised.

- Project approval by two entities- after receiving approval from the University the

  IRB application had to be submitted to the Project Leader's facility for approval.

  Once approved at the facility, it was returned to the University for a second

  approval.

- Lean staffing situation due to employee turnover- following collaboration with

  administration for project implementation on the IMCU, there was employee

  turnover. Initially there were 21 nurses on this unit, and at project

  implementation, there were only 15 RN staff members.

- Delays of education due to nursing staff on medical leave- once the education had

  begun, two nurses did not receive an education due to medical leave. Those

  nurses had to have a one-on-one education session.

Implementation

After completion of the educational sessions for all nurses, TALK-ACT was

implemented. The Project Leader stayed on the unit for four days during implementation

to be available for any questions or clarification. Nurses were randomly observed using

the TALK-ACT observation tool during the four-week process. The Project Leader

designed this tool as a means of evaluating the effectiveness of the discharge checklist

and communication skills through observation of nurses during discharges. Table 3

contains observation results and comments. Observation results will help to identify any

changes in the process flow that need to be made or any other information that needs to

be incorporated. Some additional education was needed for missed information or for the

proper use of the discharge flowsheet. All nurses were observed at least once as they

completed the discharge process with a patient. Following the observation, the Project

Leader met with the nurse to discuss processes and any strengths and opportunities for

improvement. The Project Leader does not currently supervise or have any evaluative

responsibilities for these participants.

Table 3

TALK-ACT Discharge Practice Observation Tool Results

Did the care team member to…	Yes	No	N/A	Comments
Use a caring tone of voice and attitude?	7	0	0	
Display comfortable body language, make eye contact, and sit down to talk with the patient?	5	2	0	Two nurses did not sit down to talk with the patient, acted hurriedly
Use clear, straightforward, plain language?	7	0		
Ask the patient to explain in their own words what they were told to do about: Signs and symptoms they should call the doctor for? Key Medicines? Follow-up appointments?	4	3	0	The nurses had completely changed their approach towards the patient and how they used understandable information
Use non-shaming, open-ended questions?	7	0	0	
Take responsibility for making sure they were clear with their teaching?	7	0	0	
Explain and check again if the patient is unable to use teach-back?	5	2	0	Some nurses were great about this, but 2 of them did not use teach-back
Use reader-friendly, individualized materials to support learning and transition care?	7	0	0	
Document use of, and patient's response to teach-back?	7	0	0	
Include patient and family-centered care with discharge instructions?	6	1	0	One nurse did not wait for the patient's daughter to come.

TALK-ACT Project End

After 30 days of implementation of the TALK-ACT discharge process, a second

evaluation was sent to the IMCU nursing staff via their e-mail. Nurses were asked to

print the survey, fill it out, and place the completed survey in a sealed envelope and

return it to a box in the IMCU nursing supervisor's office. The nurse manager returned

the completed evaluations to the Project Leader once they were all collected. The nurses

were instructed that no identifying information should be placed on the evaluations and

that completion of the evaluation was voluntary. The purpose of this survey was to

evaluate the nurses' perceptions of project effectiveness, their recommendations for

process changes, and to determine nursing concerns about the HCAHPS scores.

HCAHPS scores were tracked for the IMCU after 15 days of implementation and

again after 30 days. Communication scores had improved for all three domains: nurse

communication, discharge instructions, and transition care. The scores will continue to

be tracked. Readmission rates will also be tracked following the implementation of the

new discharge process.

Project Continuation

Tracking for an extended period of time was beyond the time limit of this project,

but changes in both HCAHPS scores and readmission rates will continue to be monitored

in order to evaluate the impact of the new discharge process.

Project Changes

At project completion, the evaluation of the new discharge process was more

positive, especially when nurses were notified of the slight improvement of the HCAHPS

scores. A suggestion for project improvement was the recommendation for a devoted

nurse educator for the IMCU to ensure that education is consistent for all discharged patients. Another change that the Project Leader would suggest is to change the education presentation into a module that could be assigned to the staff in the facility education system. The system allows the building of custom evaluations that are completed immediately after education. Additional educational sessions would be beneficial to allow greater discussion and practice time.

SECTION VIII

Interpretation of the Data

For this project, data collection included evaluation of the new discharge process by the IMCU staff, evaluation of current practice and learning sessions, evaluation of HCAHPS scores, and readmission rates.

Staff Evaluations

The evaluations are based on a Likert scale using five categories of scoring, including strongly agree, agree, neutral, disagree, and strongly disagree. Evaluation data were collected on two separate occasions. A total of 28 evaluations were received at two different periods of the project. Both evaluations are listed below with details.

The first evaluation was from the TALK-ACT leaning sessions. The staff education was presented in 60-minute learning sessions that combined a PowerPoint presentation, simulation, and scenarios, and ended up with role play. The nurses were asked to evaluate current practice and the education process; evaluations were left in a basket by the door as the IMCU nurses left the education session. Seventeen nurses participated in TALK-ACT implementation and evaluation. The evaluation consisted of 15 questions. Fourteen were based on the Likert scoring, and the last question allowed staff to write in comments. The results of this evaluation are presented in Table 4.

Table 4

TALK-ACT Project Education Evaluation

TALK-ACT End of Project Evaluation	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. In my opinion it will be beneficial to receive annual Health Literacy education.	35.29%	29.41%	35.29%	0.00%	0.00%
2. I frequently use the Health Literacy process when I am teaching patients or discharging them home	23.53%	29.41%	41.18%	5.88%	0.00%
3. I need access to training materials and classes for Health Literacy and Communication skills to improve patient satisfaction scores.	17.65%	35.29%	29.41%	11.76%	5.88%
4. The Health Literacy test refreshed my memory about the Health Literacy.	29.41%	64.71%	5.88%	0.00%	0.00%
5. When I am discharging a patient home, I give discharge instructions in a clear and concise manner, and I make sure that my patients understand what I am teaching by using the Teach Back method.	23.52%	52.94%	23.53%	0.00%	0.00%
6. My current practice ensures that patients understand the use of discharge medications and schedule for follow-up appointments.	29.41%	58.82%	11.76%	0.00%	0.00%
7. Nursing is a position of caring, but I don't have time to show my patients I have a caring attitude because I have too many tasks to communicate education adequately.	35.29%	35.29%	5.88%	17.65%	5.88%
8. I like the idea of patient and family-centered care, especially for discharge instructions and education.	29.41%	64.71%	5.88%	0.00%	0.00%
9. It concerns me that the patients are not satisfied with my unit's communication skills.	29.41%	52.94%	11.76%	5.88%	0.00%
10. I am familiar with Teach Back, Ask Me 3, and Motivational Interviewing techniques.	25.00%	62.50%	12.50%	0.00%	0.00%
11. I can communicate important discharge information to my patients without problems.	23.53%	52.94%	23.53%	0.00%	0.00%
12. My communication skills are adequate for patient understanding.	23.53%	58.82%	17.65%	0.00%	0.00%
13. I currently use the Teach-Back Method to make sure my patients understand the route and dosage of their discharge medications.	17.65%	52.94%	23.43%	5.88%	0.00%
14. I currently take every teachable moment to make sure my patients understand their disease process and treatment.	23.53%	58.82%	17.65%	0.00%	0.00%
15. Please add any information that you feel needs to be a part of the patient discharge information, or any process improvements you feel should be added to this project. Please use the back of this form if necessary.	Multiple comments were made on this question; the repeated statement was for a full-time education nurse for the unit.				

Note: Evaluation results based on 17 staff evaluations returned

A second evaluation was conducted 30 days after implementation of the new discharge process. The evaluation was e-mailed to the staff. Participation in the evaluation process was anonymous and voluntary. Eleven surveys were received from the IMCU nursing staff. Two of the nursing staff were on medical leave, and others declined to fill the evaluation out. The evaluation had a total of 14 questions; 12 questions utilized a Likert scale format to obtain information concerning the TALK-ACT project improvement of discharge instructions, project implementation, and patient satisfaction. Questions 13 and 14 were open-ended questions and allowed the staff to list any changes that would improve the TALK-ACT process, list any strengths or weaknesses of the project, or what they would add to make patient discharge better. All nursing staff improved in their discharge education process and were surprised by the scores increasing. Some of the comments made on the TALK-ACT education evaluation were "great job"; "make classes later for night shift"; "we need a discharge educator, so education is consistent"; "this is a great program, but I am already doing this"; "in my opinion we are doing our job so why change it"; "great presentation"; "we need an education nurse that would visit and speak with patients"; and another suggestion for a discharge education nurse. Results from this evaluation are presented in Table 5.

Table 5

TALK-ACT Project End Evaluation

	Staff post evaluation for TALK-ACT Discharge Process	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	The TALK-ACT project improved Nurse / Patient communication.	58.33%	33.33%	8.33%	0.00%	0.00%
2	I will continue to use the TALK-ACT process when discharging a patient.	58.33	33.33%	8.33%	0.00%	0.00%
3	Training for communication skills: Health Literacy, Motivational Interviewing, and the TALK-ACT process should be done annually	33.33%	41.67%	16.67%	8.33%	0.00%
4	When discharge instructions are individualized, it helps the patient to understand.	66.67%	33.33%	0.00%	0,00%	0.00%
5	It is a patient's right to have discharge instructions in a form that they understand.	58.33%	41.67%	0.00%	0.00%	0.00%
6	This project has caused a change to my current discharge practice.	58.33%	33.33%	8.33%	0.00%	0.00%
7	Nursing is a caring profession, but I do not have time to show my patients I have a caring attitude because I have other patients to take care of.	16.67%	25.00%	8.33%	16.67%	33.33%
8	This project has helped my communication with my patients.	50.00%	41.67%	8.33	0.00%	0.00%
9	I have been able to use what I have learned on my job.	58.33%	33.33%	8.33%	0.00%	0.00%
10	Overall, I feel that this was a necessary practice improvement.	41.67%	50.00%	8.33%	0.00%	0.00%
11	I am concerned about my patients' satisfaction.	66.67%	33.33%	0.00%	0.00%	0.00%
12	In my opinion, the Project Leader was knowledgeable about the discharge and TALK-ACT processes	83.33%	16.67%	0.00%	0.00%	0.00%
13	Please list any changes that would improve the TALK-ACT process. Please use the back of this form as needed.					
14	Please list any strengths or weaknesses of the project. Please use the back of this form as needed.					

Note: Evaluation results based on 11 staff evaluation returned post-project period

Patient Satisfaction Scores

The project was implemented as a quality improvement project to improve the discharge process and patient satisfaction scores from three communication domains of the HCAHPS survey: nurse communication, discharge instruction, and care transition. These scores were monitored before, during, and after the project implementation and are shown in Figure 7. The scores will continue to be tracked.
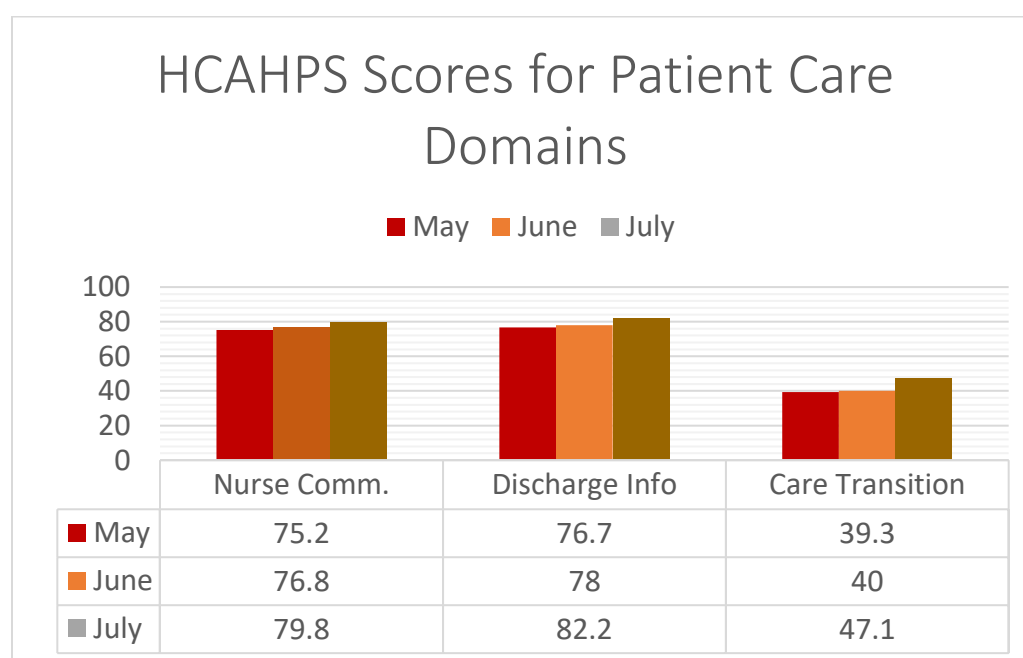

HCAHPS Scores for Patient Care Domains			
	Nurse Comm.	Discharge Info	Care Transition
May	75.2	76.7	39.3
June	76.8	78	40
July	79.8	82.2	47.1

Figure 7: HCAHPS Scores for Nursing Communication

Readmission Rate

The baseline readmission rate was based on patients discharged from the IMCU during the month of May. Out of 48 patients discharged from this unit, 11 were readmitted to the hospital within 30 days, resulting in the readmission rate for IMCU at 23% for the month of May, 2019. It is the goal of TALK-ACT to improve discharge

instructions to decrease readmission rates. Reporting and evaluation of readmission rates was beyond the timeline of project completion. Readmission rates will be tracked to determine the effectiveness of the process change and to identify any needed process changes. Readmission rate for May 2019 is shown in Figure 8.
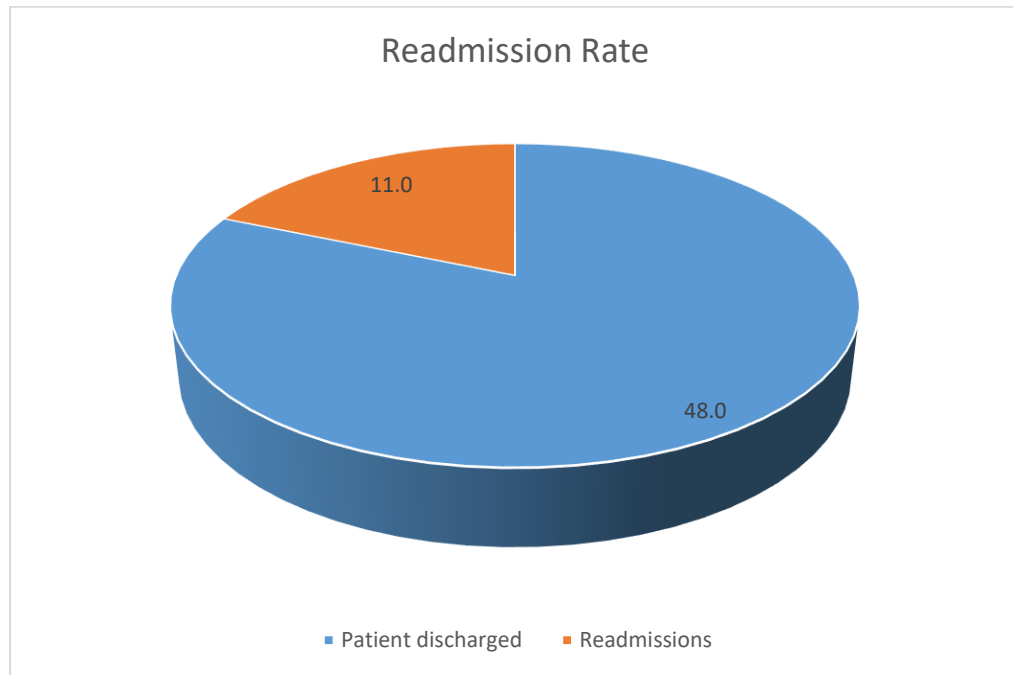

Figure 8: Readmission Rate for May 2019

SECTION IX

Utilization and Reporting of Results

The TALK-ACT project was proposed as a means to improve the discharge

process. Discharged patients are isolated at home without support, providers, nurses, or

nursing assistants to help with their care, and often do not have the knowledge or

resources to care for themselves at home. The discharge process is an appropriate means

to influence a patient to achieve wellness and to make small lifestyle changes to prevent

health hazards. The project focused on the improvement of patient discharge to increase

confidence with the care transition. The goal of this project was to improve nursing

communication, especially with discharge instructions and planning for care transition.

Summarizing the Problem

When discharging a patient home, nursing communication should be a reiteration

of what was learned while in the hospital. It is crucial that discharge education be patient

and family-centered and in a form that the patient can understand in order to ensure a safe

and successful care transition and prevent readmission ("AHRQ," 2015). Hospital

readmission and patient dissatisfaction are associated with unfavorable patient outcomes.

Readmissions, due to a lack of discharge communication, create high financial costs to

patients and the hospital (McIlvennan et al., 2015). Individualized discharge planning

instruction provided by nurses has been found to improve the patient's quality of life after

hospitalization (Mehralian et al., 2014).

The project sought to improve communication as shown in the HCAHPS domains

of nurse communication, discharge instructions, and transition of care. The Project

Leader observed the nurses during discharge instruction and viewed comments from

patients from prior HCAHPS surveys about the discharge process. The TALK-ACT discharge project was created to improve nursing communication and the discharge process for patients.

TALK-ACT Summary

A total of 17 nurses in the IMCU attended the education sessions for TALK-ACT. During the sessions, methods to improve communication were discussed and practiced. The education introduced the TALK-ACT discharge flowsheet, which emphasized that discharge education starts on the day of admission. Also introduced with explanation was the Ask Me 3 form that contained the three questions: (1) what is my problem, (2) what do I need to do about it, and (3) why is that important to me. The nurses were to give the Ask Me 3 form to the patients on admission. The nurses were to instruct the patients to write down any information they did not understand during their hospital stay or for their follow-up appointment.

Following the education sessions, the staff completed an evaluation form. The evaluation contained 15 questions, with 14 in a Likert format and one open-ended question with a comment area. Results from the TALK-ACT education session evaluation are listed in Table 4.

The TALK-ACT discharge process was implemented immediately after the education sessions with the incorporation of the discharge flowsheet. The Project Leader was on the unit to be accessible to the staff for questions or clarification of information. Observations were made of the nursing staff during the discharge process with feedback given to staff regarding the process.

At the end of the project, nurses were given another evaluation form. The findings were supportive of the TALK-ACT discharge process. Results from the TALK-ACT end evaluation are listed in Table 5.

Interpretation of Findings

The discharge improvement project outcomes were positive. The HCAHPS scores increased in all domains. Scores indicated the project had a positive impact on communication and discharge instruction.

Project Impact

The TALK-ACT quality improvement discharge process utilized communication strategies such as health literacy, teach-back, Ask Me 3, motivational interviewing, and the TALK-ACT flow sheet. After the learning sessions the Project Leader observed nurses' interactions with patients during the discharge process and evaluated the process using an observation tool. Overall, nurses were utilizing the communication skills discussed in the learning sessions. The Press Ganey Satisfaction scores (HCAHPS) increased following project implementation. According to the Press Ganey Score Summary Wilkes (2019), all three domains showed improvement after implementation. Nursing communication results pre-project was 75.2%, and post-project was 79.8%; an increase of 4.6 %. The transition of care pre-project was 39.3% and post-project the score was 47.1%, an improvement of 7.8 %. The domain for discharge information pre-project was 76.7% and post-project was 82.2 %, a total increase of 5.5%. Continued monitoring of the results will better illustrate the impact of the project.

TALK-ACT Sustainability

The TALK-ACT discharge process focused on a change in the current process with the introduction of a discharge flowsheet that encouraged starting discharge teaching on admission. Future sustainability will result from continued observation of the discharge process on the unit by the Project Leader and nurse manager. Project Leader rounding on the floor will reinforce the use of TALK-ACT and will give staff the opportunity to ask questions and make suggestions for improvement. The discharge process is a culture change and should be practiced until it becomes the routine of the staff to start discharge education on admission.

Future Recommendations

Literature supports that a change in discharge instructions can improve patients' comprehension of information (Waniga, Gerke, & Shoemaker, 2016). Future recommendations are to continue the use of the TALK-ACT process and introduce it to the other inpatient units. Learning sessions on communication strategies and the discharge process should be incorporated into the new hire orientation and also become an annual training for the nursing staff. The improvement of the communications scores on HCAHPS surveys supports the use of TALK-ACT and the discharge flowsheet for future discharges. Observation of the discharge process and monitoring of HCAHPS scores will be continued. Readmission rates will be monitored.

TALK-ACT Lessons Learned

With the implementation of TALK-ACT, there were some lessons learned from the staff and the patients:

- Staff education needed to be in a two-part session. There was too much information to be reviewed in one session.

- More time was needed to educate the staff for process change.

- Lack of staff engagement was a problem in the beginning, but once the project got started, staff got excited about the results.

- Project Leader's presence on the floor for the entirety of the project would have provided continuous feedback from the staff and change could have immediately been implemented.

- Monitoring needed to be in place to ensure that the discharge education started at the time of patient admission.

- Assigning a discharge educator to each floor would ensure that patient education is consistent.

- Research is needed on what additional care transition measures should be implemented and the impact readmissions rates.

- Observation of the discharge process showed gaps in the consistency of discharge instructions and education. More observation needs to be done to instill culture change.

Project Limitations

The project was implemented on only one unit, and the unit was experiencing staff turnover. The results of the HCAHPS scores were based on a four week time period. The communication scores did improve, but continued monitoring will be needed to see the trending results for HCAHPS scores and readmission rates.

Plan for Dissemination

Since there were only four weeks to monitor the effects of the TALK-ACT project, monitoring of the data results by the Project Leader and Nurse Manager will continue. Future plans for dissemination of the project will be the expansion of the TALK-ACT discharge process to other inpatient units within the facility and presentation to the facility administration and board members. Project findings may be disseminated through future poster and podium presentations or publication in a nursing journal.

Conclusions

TALK-ACT outcomes were positive due to improvement in communication domain scores on the HCAHPS. Not only did the communication quality change for the nurse to the patient but also nurse to provider and nurse to nurse. During observations, nurses' communication improved, as evidenced by patients' teach-back demonstrations of information understanding. The two takeaways for nurses as a result of TALK-ACT project implementation are never miss a patient education moment, and incorporate a human caring side to discharge when relaying information to the patient or family member. If the project implementation changes one patient's outcome, the project has done what it was designed to do.

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