Effective Utilization of Nursing Students in a Nurse-led Heart Failure Transition of Care Clinic

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Introduction

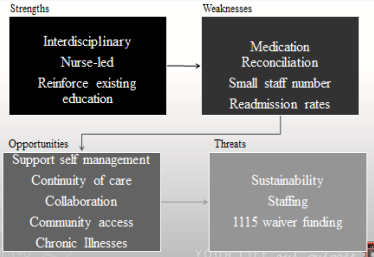
- Free standing nurse-led Heart Failure Clinic with association to a local hospital in Wise County Texas
- Program designed to provide follow up care to 60 days post discharge
- Focus on: education, health literacy, medication reconciliation, treatment and management of symptoms

Operational Plan-Student Services

wc.edu, 2016

- Students visit patients in pairs once a week for duration of their semester
- The students spend a minimum of forty five minutes in the home to a maximum of ninety minutes
- During the visit students reinforce education about the patient's diet, medication regimen, activity, and heart rate and blood pressure parameters
- After the visit is complete, the visit is documented and a verbal report is provided to the clinic staff

SWOT ANALYSIS



Resources

- Documents for recording patient information provided by Heart Failure 360 Program
- Locking document bags (6) at a cost of $15.00/each. Purchased by the 360 Clinic for document protection during travel to and from visits.
- Blood pressure cuff/scales/fluid container all provided by HF 360

Results- Patients

-Patients reported being extremely satisfied with the students

-Students helped me understand reading food labels, and importance of daily weights, when can they come back!"

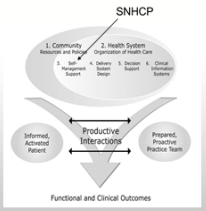
"The two student nurses helped my mom understand the importance of taking her medications correctly and at the right time each day. She was happy to have visitors that would help her understand more about her heart failure."

Plan

- Inclusion of 1115 waiver (currently in DY4)
- Gain alliance and partner with local hospital (completed 2012) DSRIP Program
- Provide a proposal with overall financial benefits clearly defined by avoiding readmission penalties (completed 2012)
- Support in the management cases of patients, recently discharged from the hospital with Heart Failure requiring time and resources that are not always easy to provide away from the hospital.
- Sustainability through SNHCP & community partners

Framework

- The Chronic Care Model
- Substantial portion of chronic care takes place outside of formal health delivery settings
- Patient self-management, delivery system design
- Analyzing key drivers of hospital readmissions, collaborative practices, identifying gaps in education



(ahrq.gov, 2015)

Value to the Healthcare System & Patient Population

- Interdisciplinary team involvement and interpersonal communication, medication reconciliation
- Involvement of pharmacists, and two-way patient and family education
- Involves teaching the patient and family about their role and responsibility in managing a condition
- Gaining an understanding of psychosocial issues affecting the patient and family

Results- Students

-Students reported this as a "great clinical experience,"

" Felt like we had some autonomy and spending time in the patient home was a great new experience."

-When asked if they would like to see this continue as a clinical opportunity in the future the students replied unanimously " Yes "

"Extremely satisfied with this experience and I felt like it increased my knowledge of transition of care"

Results

- Impacted the self management for these patients by providing reinforced education from the information they received in the hospital.
- Benefited the patients reporting practices, understanding good days and bad days, activity tolerance, diet modifications, and medication regimen
- Influenced the viability of the program
- 10 out of 10 students involved were very satisfied with the program

Operational Plan-Student Learning Objectives

- Health promotion, prevention of illness and injury, partnership, respect for diversity, advocacy and roles in Community/Public Health
- Communicate with community health clinic and interdisciplinary professionals in a community agency that serves a target population
- Integrate assessment findings, theory, and evidence-based research in the delivery of safe patient care in a selected target population.

wc.edu, 2016

Cost Benefit

- Utilizing students for home visits = no extra costs to the patient/healthcare system
- Only costs supplies (locking document bags) students use to conduct visits= minimal cost to clinic
- Serve a population with low income & insufficient access to care and education
- Identify the key drivers of readmissions for a healthcare system and its downstream providers=the first step towards implementing the appropriate interventions necessary for reducing readmissions

Evaluation Plan

- Measures-SON, clinic, hospital, and patient.
- Sources-program participants, student nurses, clinic, SON, and program documents.
- Descriptive analysis used to evaluate the program
- Implications- final meeting

Results-Clinic & Facility

- Clinic reported they were " very satisfied" with the student nurse home visits
- Also stated " the students reported back great information we were able to utilize for self management improvement faster than usual with our routine telephone calls."
- The facility received an update on this program and the readmission task force was " extremely satisfied" with the level of care provided to ensure the clinics sustainability.

Conclusion

- Implementing best practices of patient education, developing professional collaboration practices with schools of nursing, providing ongoing provision of care with students in the home
- Stakeholders for continued success -school of nursing, the healthcare system, clinic nursing employees, administrative staff from both the college and the system, students, & participants in the program.

Results-SON & Faculty

- The faculty with the SON were "very satisfied" with the students home visit clinical opportunity
- The SON was "highly likely" to utilize the home visits and the clinic for future clinical opportunities.
- The faculty and SON would like to see the clinical experiences begin as soon as possible, spring 2016

Conclusion

- Increased access to health care professionals
- Patient identified early attention to signs and symptoms
- Emphasis on barriers to compliance & coordination with other disciplines & agencies
- Impact of intensive patient & family education
- Program provides self-management tools at home for patients with heart failure