

Abstract

Problem Description

The problem is the risk of readmission in patients with congestive heart failure (CHF) within 30 days upon discharge from an acute care hospital in California.

Background

Readmission is a common problem that has equally attracted the attention of policymakers and researchers because it is a source of poor quality of care and an adjustable cause of high medical costs (Ziaieian & Fonarow, 2016). Congestive heart failure is the leading diagnosis for readmission followed by chronic obstructive pulmonary disease (COPD) and pneumonia. Implementing a follow-up discharge program for CHF patients is intervention aimed at reducing the risk of readmissions for such patients.

Method and Intervention

A discharge follow-up program was implemented for the staff that care for CHF patients at the project site. It included educating the registered nurses on discharge planning, who then educated their patients about the process of disease (CHF), signs and symptoms to report, diet, medication compliance. The registered nurses also completed a follow-up phone call one day after discharge (Chava et al., 2019). Date of previous discharge date and the readmission date was collected and reviewed. A chart review on previous admission and plan of care including discharge instructions was also collected and analyzed for clinical and statistical significance using descriptive statistics and a paired *t*-test.

Results

According to the project's findings of a decrease in the readmission rate. It was established that an implementation of a discharge follow-up program that included patient

education and a phone call follow-up resulted in a significant reduction in the rate of readmissions among patients with CHF.

Conclusions

Based on the project results, a follow-up discharge program should be implemented to reduce the readmission risk among patients with CHF. In this regard, there is a need to ensure nurses are well trained on discharge planning in tandem with project and the literature. The project is important to the practice site and systems at large as its findings could be used to facilitate the translation of knowledge to deliver the evidence-based intervention – discharge follow-up (Chava et al., 2019). The findings of this project could also be used to guide further research.

Keywords: discharge follow-up, congestive heart failure, hospital readmissions, reduce the risk of readmissions.