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Dissemination Project/Deliverable
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Re-submit Assignment

EVIDENCE BASED GUIDELIES FOR DIABETES MANAGEMENT TO REDUCE READMISSION RATES

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BACKGROUND

Hospital readmission rates is healthcare measure in diabetes patients

- It is also a financial burden for both the patient and hospital.
- Patients with low socioeconomic background are mostly affected.
- Poor diabetes management at home leads to frequent readmissions
- The high rates of readmission comes with financial implications.
- Healthcare organizations can be proactive in managing diabetic patients to avoid unnecessary readmission and improve patient outcomes.

PURPOSE AND OBJECTIVES

Implement a set of guidelines for home health nurses to use when managing diabetic patients to reduce risk of readmission within 30 days.

By using a collaborative interdisciplinary approach, the home health nurse can evaluate and mange diabetic patients effectively at home.

Home health nurses to perform detail assessment to include psychosocial needs and initiate appropriate referrals.

Timely and efficient communication with patient's primary care physician and the inter-disciplinary team can help avoid unnecessary return to the hospital.

Evidence based research shows that diabetic patients discharged home with comprehensive follow-up program are less likely to readmit within 30 days.

PROJECT DESIGN AND METHODS

Diabetes is a complex medical condition that requires continuous follow up after discharge from hospital. Individuals with socio-economic barriers are mostly affected, therefore nurses can take initiative in implementing evidence based practice to make meaningful change.

A quality improvement project to improve outcomes on diabetes patients and avoid readmissions.

New plan of care guidelines was designed for home health nurses to use a decision tool to manage care. Nurses were required to make initial visit for patient assessment within 24 hours patients' arrival to home. Also, increased nursing visit form once a week to twice a week for first three weeks.

Nurses were also require to complete comprehensive assessment with attention to psychosocial needs especially on elderly patient living alone with no primary caregiver.

Theoretical Framework applied was the Lewin's change theory to implement a change process for the nurses with the new plan of care. This allow to unfreeze previous practice and help structure new plan.

The Plan, Do, Study, Act (PDSA) model was used to implement the change.
Home health nurses were trained on new diabetes guidelines. Training includes pre and post training survey questionnaires to assess nurses' knowledge levels.
Retrospective chart audits of similar patient was completed and compared to post-implementation results.

Stakeholders involved were home health agency administrator, frontline nurses, discharge planners, social workers and physicians.

Intervention timeline for project for was divided into pre implementation, implementation phase and post implementation. The actual implementation phase was 4 weeks, with a total of 26 patients enrolled.

Significance of nursing implications – care coordination post discharge from hospital is necessary to reduce readmission rates. Home health nurses can bridge the gap in care transitions and improve patient outcomes. nurses can educate patients on self-management at home and empower lifestyle changes to promote disease management.

Barriers identified include financial implication form insurance payors due to increased nursing visits with possible denial of non-payment and nurses complains to increased workload due to longer duration at patients visits and increased documentation times.

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RESULTS

Results were based on analysis of the outcomes from pre and post implementation chart audits, nurses knowledge assessment and patient outcomes.

Post training knowledge level assessments of nurses showed improved scores from pre-training assessments.

At least 2 patients avoided unnecessary readmission with 3 days due to timely nursing assessment and intervention to address issues.

Based on the chart audits, reasons for readmission are mostly due to psychosocial issues and multiple comorbid conditions.

Patients non-compliance to treatment was not excluded, therefore, nurses must educate patients on importance of treatment compliance.

CONCLUSIONS

According to evidence based research and project results, the answer to the project question is yes, implementing an evidence based guidelines for home health nurses to efficiently manage diabetic patients can reduce readmission risk by 10%.

BIBLIOGRAPHY

Susie Akrong
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Nice work Sussie.
Your poster looks great!
Dr. Peckham

Samantha Peckham , Jun 27 at 4:19pm

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