Improving the Discharge Experience for Trauma Program Patients and Families

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Background

- Sunnybrook has Canada's largest regional trauma centre – 1374 patients seen in 2015 with 664 of admitted patients discharged directly home
- Gap in the C5 trauma ward's practice with limited written discharge education provided to patients and their families going home
- Literature supports proper discharge protocols to reduce readmissions[2], decrease patient and caregiver stress[4] and increase patient and family satisfaction[1]
- Best practices for discharge education include:

- Discharge Planning is one of Sunnybrook's Best Practices and the Trauma Program Strategic Plan involves making improvements in transitions from acute care trauma

Objectives

Within the six months of the Fellowship program, I set out to create, implement, and evaluate new discharge education handouts for trauma program patients (and their families) being discharged home to:

1. Increase staff satisfaction with the handouts
2. Track staff usage of the handouts
3. Seek out the patient and family experience of the handouts

Improvement

Phase 1 – Needs Assessment

- Inventory of current discharge materials and processes at Sunnybrook and other trauma hospitals
- Focus groups and survey with C5 staff
- Follow up phone calls with previously discharged patients and families

Phase 2 – Development

- Five new discharge handouts:

1. **Getting Ready for Going Home from C5**
2. **How to Use and Take Care of Your Aspen Collar**
3. **Wound Care at Home**
4. **Your Mobility At Home**
5. **Financial, Community, Care, and Mental Health Help**

- Handouts were created by C5 staff with feedback from other C5 staff, physicians, former patients and families
- Group and individual education sessions to C5 staff and physicians about new handouts and discharge process

Phase 3 – Implementation

- Six week discharge handouts' trial
- Tracking method used to document patients, handouts provided and staff members involved
- Follow up phone calls with patients and families within 1-2 weeks from discharge home
- Staff follow up survey

Results

February 1 to March 14, 2016 trial (6 weeks)

- **53** patients discharged directly home
- **87%** of these patients received one or more discharge handouts
- **30** follow up phone calls with patients

C5 Group Education Sessions' Attendance

Profession	# Attendees
Nurses	24
Allied Health	10
Students	5
Unspecified	2

C5 Staff Implementation Involvement

Profession	# Staff
Nurses	22
Allied Health	8
Students	1

Patient/Family Impact

Qualitative feedback from follow up phone calls with patients and families:

Common Threads

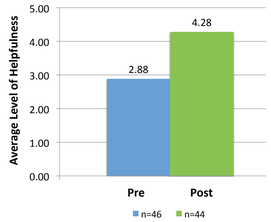
- Easy to understand, very helpful information
- Verbal teaching is just as important (to supplement the written education)
- Family (caregiver) involvement is key

Quotes:

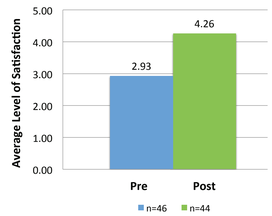
> *"It brought me comfort just to have the handouts in case I needed them."*
>
> *"I have the Aspen collar handout right next to me when I'm changing [his] collar."*
>
> *"I didn't read them since the nurse already told me what I needed to know."*

Staff Impact

Staff Perception of Discharge Materials' Helpfulness



Staff Satisfaction with Discharge Materials



Quotes:

> *"It's a great help that patients have written material to reinforce and complement our teaching!"*
>
> *"I feel my patients are more prepared for discharge now."*

Sustainability Plan

- Provide updates and reminders at C5 unit staff meetings
- Regular meetings with C5 Practice Council and C5 Discharge Champions
- Bi-annual evaluation of discharge handouts' content and process
- Discharge handouts to be part of new staff orientation

Potential Next Steps and Recommendations

- Finalize content, format and process of providing handouts
- Apply for Patient and Family Education Print Material Grant
- Upload handouts onto Sunnybrook Trauma Program website
- Expand handouts' usage to other relevant units and populations
- Supplement discharge handouts with "teach-back method"

References

1. Cain, C.H., Neuwirth, E., Bellows, J., Zuber, C., and Green, J. (2012). Patient experiences of transitioning from hospital to home: An ethnographic quality improvement project. Journal of Hospital Medicine, 7(5), 382-387.
2. Enhancing the continuum of care: Report of the avoidable hospitalization advisory panel. (2011, November). Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/en/common/ministry/publications/reports/baker_2011/baker_2011.pdf
3. Friedemann-Sanchez, G., Griffin, J. M., Rettmann, N. A., Rittman, M, and Partin, M. R. (2008). Communicating information to families of polytrauma patients: A narrative literature review. Rehabilitation Nursing, 33(5), 206-213.
4. Griffin, J. M., Friedemann-Sanchez, G., Hall, C., Phelan, S., and van Ryn, M. (2009). Families of patients with polytrauma: Understanding the evidence and charting a new research agenda. Journal of Rehabilitation Research and Development, 46(6), 870-892.
5. Kripalani, S., Jackson, A. T., Schnipper, J. L., & Coleman, E. A. (2007). Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalists. Journal of Hospital Medicine, 2(5), 314-323.

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