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A Quality Improvement Transitional Care Intervention to facilitate the Reduction of Hospital Readmission among Older Adults admitted with Pneumonia.

Abstract

Pneumonia among older adults is a common cause for readmission and is a leading cause of death. The impact of high readmission rates on quality of care outcomes and financial implications makes it important for early identification of high-risk patients and implementing interventions to prevent subsequent readmissions. Hospital readmissions are influenced by inconsistencies and inadequacies observed in transitional care interventions. The key to reducing readmissions is ensuring continuity of care as patients' transition home from the inpatient setting. This gap in continuity further exacerbates the issues of patient management of medication regimens and follow-up with providers, coupled with ineffective symptom management. All three can result in deterioration and rehospitalization for the patient. This study determines the feasibility and effectiveness of implementing an evidence-based intervention focused on transitional care for patients and their family, regarding management of care at home following a hospitalization for pneumonia. Design: A pre- post study design was used in this quality improvement project. Methods: Questionnaire was administered to nurses working on the target unit following a structured education on the impact of readmission. A discharge checklist "Be Ready for Home" was implemented for patients based on inclusion criteria. Visits to the hospital within 30 days after discharge were assessed. Results: The pre-posttest scores showed higher levels of knowledge among nurses regarding impact of readmission. The compliance rate in

implementing the discharge checklist was 96.4%. Conclusion: Healthcare outcomes can be improved when appropriate, comprehensive transitional care interventions are utilized effectively by bedside nurses.

Key words: Hospital Readmission, Pneumonia, Older Adults, Transitional Care, Evidence based Practices