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Addressing the Gap in Discharge Planning from a Skilled Nursing Facility

Yaqui Del Rio

University of St. Augustine for Health Sciences, y.delrio@usa.edu

Amy Lyons-Brown

University of St. Augustine for Health Sciences, alyons-brown@usa.edu

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Addressing the Gap in Discharge Planning from a Skilled Nursing Facility

Yaqui Del Rio, OTS, Amy Lyons-Brown, OTD, OTR/L



UNIVERSITY of ST. AUGUSTINE
for HEALTH SCIENCES

BACKGROUND

- Effective discharge planning is one of the most critical stages of rehabilitation impacting the standard of inpatient care and readmissions (Harding et al., 2022).
- Patients and caregivers encounter significant challenges during the transition home, with reported instances of unmet discharge needs (Toles et al., 2022).
- During the transition from a SNF to home, individuals encounter a critical period marked by the challenges of adapting to new environments, routines, and potential limitations, as highlighted by Schreiner & Daly, (2018).
- Patient Driven Payment Model (PDPM) implemented an adjustment factor that reduces daily payments by 2% every 6 days if the SNF stay exceeds 20 days (Zhang et al., 2022).

PROBLEM

The absence of a comprehensive discharge plan in a skilled nursing facility hinders patient readiness for a successful discharge, increasing the risk for poor patient outcomes and readmissions.

PURPOSE

- The purpose of this project was to aid the discharge planning process to increase patient readiness for discharge by
- Creating and implementing a comprehensive evaluation of the patient's readiness for discharge.
 - Identify areas where patients lack confidence to increase patient outcomes.

This project does not involve human subjects and does not require IRB approval

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METHODS

Literature Review:

- Poor Discharge Planning
- Readmissions
- Health Literacy

Needs Assessment:

- Interview the rehabilitation team, director of rehabilitation, social service director, and patients to identify facility needs.

Questionnaire

- How confident are you in meal preparation and maintaining proper nutrition, including adherence to dietary restrictions and nutritional guidelines?
- How confident are you in managing your medications and adhering to prescribed medication regimens, including proper dosage, timing, and adherence to instructions?
- How confident are you in accurately monitoring your vital signs, such as blood pressure, heart rate, and temperature?
- How confident are you in recognizing and responding to changes in your health condition(s)?

Product Evaluation:

- Adjust based on pertinent professional's feedback.
- Readminister assessment tool.
- Knowledge check and skill carry over with patients.

PRODUCT DEVELOPMENT

Occupational Therapy Home Discharge Confidence Assessment Tool

- Purpose:** evaluate a patient's readiness for discharge based on their confidence levels.
- Area of Assessment:** Activities of Daily Living (ADL's), Meal Preparation and Health Management
- Assessment Type:** Self Report
- Population:** Non-Specific Patient Population
- Diagnosis/ Conditions:** Any
- Age range:** 18 and older
- Key Descriptions:**
 - ✓ Administered verbally or self-administered.
 - ✓ Identifies specific areas where the patient lacks confidence.
 - ✓ Items are on a four-point scale that ranges from 1(Not at all confident) to 4(Extremely confident).
 - ✓ Total score ranging from 0-100.

III. Health Management:

Symptom and Condition Management, Health Indicators

- Confidence in recognizing and managing symptoms related to their condition(s): $\frac{__}{4}$
- Confidence in understanding symptoms progression and when to seek medical advice: $\frac{__}{4}$

DELIVERABLES

Levels of Care for Loved Ones



Interventions on Increasing Discharge Confidence



DISCUSSION

- The product evaluates several critical aspects for a successful discharge.
- The tool assesses areas impacting patient outcomes and readmission rates.
- Fills a gap in comprehensive assessments currently unavailable.
- Identifies needs for training, education, or adaptations.

NEXT STEPS

- Create a suitable environment in an inpatient setting for patients to carry out occupations.
- Create an assessment instrument based on patient performance.
- Publish the tool to improve discharge readiness in the healthcare field.

REFERENCES

