Almost half of all surviving hospitalized patients experience a posthospital discharge associated medical error. Most discharge-associated errors are related to inaccurate or incomplete information regarding medications and/or diagnostic follow-up. Successful patient discharge depends on cross functional team work and redefined traditional roles and scope of responsibility. There was no electronic functionality within the existing hospital documentation system to facilitate a team-oriented and safe discharge process.

### Purpose

**Purpose:** Address barriers impacting the ability to effectively and accurately capture and communicate discharge-related information.

- **Objective 1:** Develop (design & build) an electronic transition of care document
- **Objective 2:** Educate the clinical workforce on how and why to use the transition of care document in their clinical workflows
- **Objective 3:** Implement the transition of care document

### Methods

**IRB Approval:** Not required

**Setting:** Not for profit healthcare system of 4 hospitals

Recipients of Care: Adult, non-perinatal discharge patients

### Objectives

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Steps</th>
</tr>
</thead>
</table>
| **Develop** | 1. Assembled a multidisciplinary team for design approval  
2. Determined “current state” clinical workflow through process mapping and direct observations  
3. Performed gap analysis between current and ideal states.  
4. Designed and built an evidence supported template that facilitates the ideal state discharge workflow |
| **Educate** | 1. Designed education and training materials  
2. Utilized formal classroom setting and project champions to teach new information  
3. Used multiple mechanisms for communication of new information |
| **Implement** | 1. Collaborated with Clinical Informatics and IT Applications to integrate the template into the EHR environment  
2. Worked together with Nursing, Pharmacy, Case Mgt, Medical Staff, Leadership, Revenue Cycle, and direct care staff to operationalize into clinical workflow |

### Evaluation

- The transition of care document was developed through the Discharge Redesign Core Team members and taskforces: Nursing, Medication Reconciliation, Physician Documentation and Post Acute Care

- Workforce learning was validated through improved overall utilization rate; currently above 50% with an error rate of <2%

- Implementation impacted the following clinical outcomes:
  - Patient satisfaction scores improved at 3 of the 4 facilities
  - Hospital system national percentile ranking improved 20 points
  - Readmission rates have not been impacted; further monitoring to determine long term impact will be conducted

### Conclusions

- An electronic structural foundation has created the means for the multidisciplinary care team to work on the discharge process in tandem

- Nursing functions related to discharging patients have been appropriately aligned in accordance with their scope of practice

- The transition of care document contains all essential discharge-related information in an easy to read and comprehensive format for patients and their providers

- Nursing practice is advanced with the addition of a discharge plan of care and nursing diagnosis

The unique contribution of nursing care is now clearly displayed to the healthcare team and the patient.

### References


### Acknowledgements

There were no conflicts of interests or external funding sources. Special thanks to the Clinical Informatics Department for the assistance with this project.