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**Improving Patient Safety during the Emergency Department Discharge Process with the
Use of Two Patient Identifiers**

by

Hannah English

Paper submitted in partial fulfillment of the
requirements for the degree of

Doctor of Nursing Practice

School of Nursing, University of Louisville

August 4, 2021



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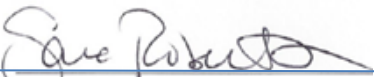
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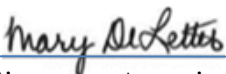
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Signature DNP Program Director

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Date

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Abstract

Nurses are not always confirming two patient identifiers while conducting a patient discharge, resulting in patient identification errors. This problem has been shown to significantly affect patient safety and satisfaction, decreasing both when errors are made. These errors also have heavy financial and legal consequences on the affected facility and on the discharging nurses, warranting a need for improvement. The purpose of this quality improvement project was to decrease patient-identification errors at discharge by increasing nurse use of two patient-identifiers through the implementation of an education program. This ten-week program involved education sessions that presented evidence-based material specifically focused on accurate and effective patient discharge, a pre/post-program survey measuring nurse attitude/perception and nurse comprehension/knowledge level, and a period of mentoring following the implementation period. The number of reported errors at discharge was evaluated before and after the program implementation to assess the effectiveness of the education. Nurse survey scores were evaluated both before and after education implementation to evaluate the effect that the education had on nurse attitude/perception and nurse comprehension/knowledge. There was no statistically significant increase in attitude/perception or comprehension/knowledge post-intervention; however, comprehension/knowledge was increased from a clinical standpoint. There was an 8.5% increase in comprehension/knowledge scores post-intervention and no identified patient-identification errors from January 2021 to the present. The intervention did not definitively prevent errors but was a factor that could have had an effect on these measurements. A patient identification-focused education program improves nurse comprehension/knowledge and accuracy of patient identification at discharge, leading to a reduced number of patient-ID errors and subsequent financial consequences.

Keywords: patient discharge, patient safety, satisfaction, quality improvement, discharge, education, survey, perception, comprehension, mentoring, nurse survey.

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Improving Patient Safety during the Emergency Department Discharge Process with the Use of Two Patient Identifiers

Using two patient identifiers prior to any and all nursing interventions is something that has been emphasized in the healthcare profession for years (Joint Commission, 2021). One type of nursing intervention, hospital discharge, is a process that takes place either when a patient is ready to leave the facility following treatment or the patient no longer requires in-patient care and can go home (Johns Hopkins Medicine, 2021). This process typically involves planning that may include patient teaching, providing prescriptions, and follow-up instructions, among other necessary actions and interventions. Discharge is a transition point that is susceptible to error (Drake et al., 2017, Joint Commission, 2021; Schulmeister, 2008; Suzuki et al., 2012). The Joint Commission has identified the improvement of the accuracy of patient identification by using at least two patient identifiers when providing care, treatment, and services as a major goal toward maintaining patient safety since 2003 (Joint Commission, 2021). Thus, ensuring the use of two patient identifiers during the nurse-led discharge process in the emergency department (ED) is a key component of providing safe, effective, and quality patient care.

Background of Problem and Significance

In the ED of a large hospital in a medium-sized Midwestern U.S. city, an opportunity for improving patient identification was brought to light. The problem is that nurses are not always confirming two patient identifiers during patient discharges. Lack of ID confirmation has resulted in some patients leaving the facility with another patient's printed information, discharge instructions, and/or prescriptions. This type of error falls under the category of a "patient identification error," also known as a "wrong-patient error," defined as "incorrectly matching a patient to appropriately intended interventions and communicating information about

the patient's identity accurately and reliably throughout the continuum of care" (ECRI Institute, 2016, p. 6). These printed materials contain protected healthcare information, including but not limited to the patient's medical record number (MRN), full name, birthdate, phone number, address, and educational health information related to the patient's problem list. Studies have shown that, in general, these patient identification errors occur more and more frequently in health care settings and are costing facilities both time and money while also decreasing patient satisfaction and patient safety (Byrne et al., 2017; Schulmeister, 2008; Stevens et al., 2019). When correct patient-identification is omitted from the nurse-led discharge, the occurrence of patient identification errors increases and results in negative safety outcomes for patients as well as subsequent penalties for the facility involved (Campbell et al., 2015; Schulmeister, 2008; Suzuki et al., 2012; Tilus, 2002). These errors and omissions can be due to a lack of communication and safety checks (Drake et al., 2017; Gao et al., 2018; Suzuki et al., 2012). Effective discharge planning, including correct patient identification, has been shown to save money by decreasing the need for return visits and related hospital stays (Gao et al., 2018; Suzuki et al., 2012; Tilus, 2002; Walter & Robb, 2019). The major factor in improving patient safety is the prevention of identification errors (Campbell et al., 2015; Schulmeister, 2008; Suzuki et al., 2012).

Available Knowledge and Current, Relevant Evidence

External Evidence

On a national level in 2020, the U.S. Department of Health and Human Services [HHS] reported that 26,530 complaints were filed regarding possible violations of The Health Insurance Portability and Accountability Act (HIPAA) and breaches of protected patient information (HHS, 2021b). Of those complaints, 872 were determined to be valid cases, were investigated,

and required corrective action (HHS, 2021b). When nurses fail to utilize two patient identifiers while providing care, wrong-patient errors are much more likely to occur (Campbell et al., 2015; Gao et al., 2018; Schulmeister, 2008). In Kentucky, 25% of cases were investigated and required corrective action, 70% of cases were resolved after intake and review, and 5% were investigated with no violation identified from 2003 to 2020 (HHS, 2021a). Currently, nurses are not ensuring accurate identification of patients during the discharge process on a consistent basis, resulting in compromised patient safety, higher potential for wrong-patient errors, and a greater likelihood of HIPAA violations. Nurses must verify two forms of identification to confirm a patient's identity during discharge teaching to ensure patient safety and decrease the potential for wrong-patient errors.

Internal Evidence

An informal needs assessment was performed at the facility over the course of several days. Meetings with the ED nurse manager, director, and educator resulted in several ideas being placed under consideration for the purpose of this project and resulted in the identification of areas in which the department needs quality improvement. Finally, a meeting with the hospital's nurse researcher produced the final topic for the Doctor of Nursing Practice (DNP) project. According to ED leadership staff and the nurse researcher, accurate, error-free patient discharge has been poor within the last year, with a marked increase in discharge errors recently reported. Examples of patient discharge errors include patients leaving the hospital with prescriptions that were written for another patient, patients being sent home with another patient's discharge instructions, and patients being sent to follow up at another facility out of town with the imaging disk containing another patient's imaging studies. The common denominator is that the errors have all occurred at discharge or could have been caught at discharge. The nurse researcher

asserted that if negligence is involved, some of these incidents may be dealt with on a legal level. During the meeting, she also stated that the common factor, after speaking with the staff members who were directly involved in the event, was that staff were not asking the most fundamental patient identification questions: “Can you please tell me your name?” and, “What is your birth date?” (T. Phillips, personal communication, September 2020).

Meetings with the nurse researcher and the ED management team revealed that, while there is generally a policy about patient care, there is currently not a standardized discharge process in place at this facility. Staff nurses in this ED indicate that the lack of a discharge process makes it even more difficult to efficiently conduct a discharge. With many different providers and nurses come many different ways for a discharge to occur. The ED management team constantly sends out emails to the ED staff nurses regarding this problem. Emails are received approximately every three to four weeks reminding staff to check patient identifiers because patients are being sent home with incorrect discharge paperwork and/or prescriptions. Despite these emails, errors are still being made.

Current Policy and Procedure

The current discharge policy in place at this facility originated in the middle of 1990 and was revised approximately four years ago. Specific policy wording indicates that patient identification should be performed by “all staff involved in patient care.” The policy’s purpose is to ensure all employees utilize the two patient identifiers when providing care, treatment, or services, and states that two patient-specific identifiers must be checked against the appropriate documents before administering patient care. The two patient identifiers approved for use are patient name and date of birth and can be checked by either the patient verbally providing the information or by the staff looking at the information on the patient’s armband.

The nurse researcher explained that this is a current, relevant issue within their system. The facility's director of compliance/HIPAA privacy provided data on instances related to the ED's release of patient records for both 2019 and 2020. This data reflects instances reported in the ED in which a patient's protected health information was disclosed to someone other than the patient. These instances occurred because of wrong-patient errors performed by staff. In 2019 there were six instances reported, and in 2020 there were seven reported. All the incidents reported and being investigated at this time could have been prevented at patient discharge if a staff member had asked for and confirmed two patient identifiers.

Problem Impact

Incorrect patient identification is the result of many different factors, one of which is inadequate staff training (Bittle et al., 2007; Byrne et al., 2017; Campbell et al., 2015; Grischott et al., 2018). This is relevant because accurate patient identification is an essential part of the discharge planning process (Joint Commission, 2021; Suzuki et al., 2012). Providing staff with discharge-related education has been shown to improve nurses' knowledge and nurses' attitudes towards the discharge planning process (Byrne et al., 2017; Campbell et al., 2015; Grischott et al., 2018; Suzuki et al., 2012). Attitude is defined in the context of healthcare as "a form of thought that is formed through experience and influences our behavior" (The Communication Institute for Online Scholarship [CIOS], n.d.). This means that attitudes are learned and can potentially be changed (CIOS, n.d.).

Incorrect identification can have a major impact on patients, as well as their families and the healthcare system as a whole. For example, cases of misidentification in a surgical setting have received increased media attention in recent years, with interventions like "time-outs," "pauses," and "surgical checklists" being implemented in hopes of reducing the number of

wrong-site and wrong-patient errors (Ambe et al., 2015). There are endless stories published describing patients who had the wrong leg amputated or the wrong organ removed because of a human error such as misidentification. Experiencing a wrong procedure can significantly and negatively impact the quality of life of a patient as well as that of their family. The healthcare system is affected as well in that changes are being made and safety protocols put in place to help prevent these errors (Ambe et al., 2015).

More than one patient is typically affected when wrong-patient errors occur (Emergency Care Research Institute [ECRI], 2016). For example, during discharge, when a patient goes home with someone else's discharge instructions and/or prescriptions, both patients are affected. With these incidents, neither patient receives their problem-focused, at-home care instructions or intended prescriptions for treatment (ECRI, 2016). These incidents pose serious health risks for both patients involved. For example, a patient needing an antihypertensive may not receive it, while the other patient may end up taking medication not prescribed for them, especially if this misidentification error is not stopped at the level of the pharmacy.

Significance of Problem

This problem is important because it has the potential to result in "adverse events" or "near misses" for patients. A near miss is an event that could've caused adverse outcomes for the patient but did not, while an adverse event does, in fact, cause an adverse outcome and/or patient injury (Agency for Healthcare Research and Quality [AHRQ], 2019). For example, a patient could have received an incorrect or unnecessary procedure based on a disk with imaging that isn't theirs, which could result in lawsuits and health problems for that patient. This problem is also a HIPAA violation that could cost the hospital money or even cause a nurse to lose their license (Kentucky Board of Nursing [KBN], 2021; U.S. Department of Health & Human

Services, 2013). Nurses in the ED need to be very intentional when discharging patients and make sure they're asking those two very important questions so that the patient can be correctly identified.

There are also major financial consequences for HIPAA violations and breaches of protected patient health information. Depending on the type and severity of the violation, the entity may have to pay a penalty of \$1,000-\$50,000 per incident up to \$1.5 million (HHS, 2013). These fines reflect a significant problem when it comes to patient privacy and protection of their information. It's safe to assume that most healthcare facilities would likely do whatever is necessary to keep these expensive incidents from occurring.

Target Population

The specific target population for this problem included the ED staff and charge nurses. These are nurses who work in the ED doing direct patient care and who conduct patient discharges from the ED several times per shift. They are at the forefront of this problem and are the biggest factors to either the success or failure of solving the problem. Adequate education and consistent reinforcement of the information provided are key aspects in assisting the target population to solve the problem. Since the focus is nurse-patient interactions and educating nurses accordingly, nurses were the main target population for this project. The specific inclusion criteria included: currently employed by this regional area hospital, currently worked (clocking hours) in the ED, involved in direct patient care, performed at least one discharge per shift, was 18 years of age or older, was English-speaking, and held the title of staff nurse and/or charge nurse. The specific exclusion criteria included: refusal to participate, did not work in the ED, and did not perform at least one discharge per shift.

Rationale

Patient identification errors at discharge are a significant problem that was identified through an informal needs assessment involving myself and other key stakeholders, as mentioned previously. A major driver of the nursing education quality improvement (QI) program is that inadequate staff education has been shown to contribute to patient identification errors (Bittle et al., 2007; Byrne et al., 2017; Campbell et al., 2015; Grischott et al., 2018). Therefore, providing staff with adequate and thorough education on the patient identification policy, especially during the discharge process, is an essential aspect of reducing patient identification errors at discharge. The goal of this educational project was to increase comprehension of these policies regarding how staff should correctly identify patients during any nursing task, as well as increase attitude/perception of the discharge process, which could potentially improve the accuracy of patient identification at discharge. The feasibility of this project was analyzed with the help of essential stakeholders for this particular facility. Informal interviews were conducted with multiple ED staff RNs regarding their perceived feasibility of the project. Each staff RN that was interviewed stated that they believed the project would be effective at improving patient identification during the discharge process.

Purpose and Specific Aims

The goal of this QI project is to decrease patient-identification errors at the time of discharge in the ED at the facility through education sessions for nurses that emphasize the use of two patient identifiers. These errors have led to patients receiving incorrect discharge instructions and prescriptions that are intended for another patient, which is considered a patient safety and privacy issue.

There were three specific, measurable objectives chosen for this QI project:

1. Within ten weeks, there will be a 90% increase in accuracy of patient identification at discharge measured by the number of reported patient-identification errors during discharge in the ED at this facility.
2. Within ten weeks, there will be an 80% increase in nurse comprehension of discharge expectations and the current discharge process in the ED at this facility measured by Tilus and Suzuki's survey questionnaires (Suzuki et al., 2012; Tilus, 2002).
3. Within ten weeks, there will be a 75% increase in nurse attitude toward discharge expectations and the current discharge process in the ED at this facility measured by Tilus and Suzuki's survey questionnaires (Suzuki et al., 2012; Tilus, 2002).

There were three outcome measures outlined by the Joint Commission that were chosen for this DNP project and include:

1. Improve the accuracy of patient identification (Joint Commission, 2021).
2. Improve the safety of using medications (Joint Commission, 2021).
3. Identify safety risks (Joint Commission, 2021).

These outcomes were chosen for this DNP project because there is currently a significant issue with nurses not confirming two patient identifiers when conducting discharges in the ED at this facility. Patients are also leaving this specific ED with incorrect medication prescriptions, which is a patient safety issue and a violation of the HIPAA law. Lastly, the current discharge process at the facility is causing patient safety concerns and places patient safety at risk. There is not currently a discharge-specific policy in place for staff to follow; however, there is a generalized policy on how staff should correctly identify patients during any nursing intervention or task. This includes a patient discharge. In this particular facility, identification errors are on the rise, and this has caused some concern among the stakeholders regarding patient safety.

Agency Goals and Principles

As a faith-based organization, the facility's mission is to exemplify God's love through the provision and coordination of patient care, all to improve community health. The vision is to meet the needs of patients in the community by being a leader in clinical excellence and compassionate care, all while promoting growth in the healthcare setting. The facility strives to achieve its mission and vision by incorporating core values and establishing a commitment to patients, employees, providers, and safety. They strive to develop their system further and become an exemplary example of what a healthcare system should be. They promise to provide the highest value care and optimal resources to the community through excellent clinical teams, as well as innovative programs. To advance the mission and vision of the facility, this facility will ensure financial commitment in areas needing updates or improvements as deemed necessary.

This DNP project is related to the agency goals in that it aimed to improve quality of patient care, thus providing patients with the highest value of care possible. It also promoted growth in the ED and highlighted the need for an updated and improved discharge policy. Ultimately this QI project will result in improved community healthcare through the incorporation of the facility's core values into the education sessions.

Description of the Environment (Setting)

The facility in which my DNP project has been conducted is a large area hospital and specifically took place in the ED.

People and Population

The hospital is a 373-bed, not-for-profit facility with a 31-bed ED and about 2,000 employees that provide care to around 200,000 patients each year. Within the hospital system,

there are nine hospitals that are located in a bi-state area. There are many people involved in the organization's everyday operations. Some of the people involved specifically in daily operations in the ED include the ED nurse director/manager, ED nurse educator, ED unit coordinator, charge nurses, staff nurses, respiratory therapists, phlebotomists, speech therapists, pharmacists, imaging technicians, physicians, advanced practice registered nurses, physician assistants, case managers, and patient care technicians. Shared governance and interprofessional collaboration are used by these staff members every day to achieve the set goals for the facility and the ED. Each staff member performs a particular job and contributes to the healthcare team for the benefit of the patients. The ED physicians and mid-level providers display interprofessional collaboration on each patient case, ensuring patient care is at the highest quality possible.

The key stakeholders involved in this project included the ED staff nurses, ED patients, ED nurse educator, ED nurse director/manager, ED unit coordinator, nurse researcher, director of compliance, and the chief nursing officer. Each of these stakeholders had a very important, specific role in making the project possible. I worked with each of them directly to carry out each phase of the project, including the initial facility approval, Institutional Review Board (IRB) approval, obtaining pertinent internal data, forming the education content, and implementing the sessions.

Facilitators of the project included the stakeholders that have been previously discussed, the DNP project committee, as well as the IRB. Some barriers for project implementation specific to this project site included staff turnover rates, environmental factors that threatened the daily operations of the ED, such as the current Coronavirus (COVID-19) pandemic, busy workdays that affected nurses' desire/ability to participate, and workflow disruptions that had potential to negatively impact nurses' attitudes towards the project.

Context and Performance

Performance metrics and overall standards of care for this ED were set by the Joint Commission standards of practice as well as the Centers for Medicare and Medicaid Services. Information and data indicating this facility's quality of care was publicly provided by Hospital Compare and included metrics such as patient experience, timely and effective care, complications, readmissions, and deaths, use of medical imaging, and payment and value of care. The timing and accuracy of ED discharges are tracked daily, with statistics displayed on the daily huddle board. The current goal is to have a given patient discharged within 30 minutes from the time the provider prints their discharge instructions. Another discharge goal is to ensure that discharge instructions and prescriptions are provided to the correct patient 100% of the time since this is a patient safety issue. At this time, there is a definite need for an improved discharge process and set policy at this facility. According to the ED leadership staff and the nurse researcher, performance in this area has been poor within the last year, with a marked increase in errors at discharge noted.

Ethics

The proposal for this project was submitted to the University of Louisville IRB (#21.0302) for approval upon review by the project committee, which included the project committee chair and co-chair. Additionally, the project proposal was submitted to the IRB of another hospital in this facility's system for approval (#XXX-21-1655). Approval through this system IRB is a process specific to this facility. Informal approval from this facility's chief nursing officer (CNO) was obtained on September 30, 2020, via email following several face-to-face conversations about the project. Formal, written approval from the CNO was obtained on January 26, 2021, via a signed letter.

Conceptual Framework

The conceptual framework for this quality improvement DNP project was the Institute for Healthcare Improvement's [IHI] Model for Improvement with the incorporation of a Plan-Do-Study-Act (PDSA) cycle to test the change. This framework involved three crucial, fundamental questions as well as four steps in a PDSA cycle: plan, do, study, and act (IHI, 2021). It has been used as the fundamental conceptual framework in several evidence-based studies to date (Gao et al., 2018; Newnham et al., 2017; Stevens et al., 2019). This particular framework improves processes with a simple, straightforward, step-by-step approach to achieving quality improvement of processes (Hall, 2019). The Model for Improvement was an excellent framework to use for my DNP project because I aimed to improve the current ED discharge process.

Fundamental Questions

The Model for Improvement starts by asking three questions: "What are we trying to accomplish?" "How will we know that a change is an improvement?" and "What change can we make that will result in improvement?" (IHI, 2021). This DNP project will accomplish the improvement of the current ED discharge process at this facility within ten weeks. This change was an improvement based on both quantitative and qualitative data, which included the number of patient-identification errors at discharge and the level of nurse attitude/perception and comprehension before and after the education sessions. The specific change resulting in improvement was the premise of the DNP project itself, which was a live educational session for ED staff involved in patient discharges.

PDSA Cycle

The PDSA cycle portion of the framework demonstrated how a particular change could be tested in the form of "action-oriented learning" (IHI, 2021). The first step was to plan the

initiative and develop it by choosing the PDSA team and the specific improvement initiative (Hall, 2019). The DNP project improvement initiative was selected as stated above, and the team was assembled based on who could provide adequate resources and best aid in the process change. The next step was to try it out and implement the initiative with the help of the PDSA team (Hall, 2019). This testing was accomplished by carrying out the initiative, which was the education intervention. This part of the PDSA cycle also included regularly discussing the Specific, Measurable, Attainable, Realistic, and Trackable (SMART) goals that were set as a sort of motivation for change (Hall, 2019). A SMART goal or objective is an approach used in QI initiatives to “help the team stay focused and efficient through impactful goal setting” (Hall, 2019, p. 5). Next, analysis of the results occurred by measuring them against the outcome measures and project aims that were set by the team at the beginning (Hall, 2019). This was done using quantitative and qualitative data from staff questionnaires, as well as from tallying the number of patient-identification errors committed at discharge, both before and after the live educational sessions took place. Lastly, the results allowed for process adjustment and brought about the improvement of the current process (Hall, 2019). The PDSA cycle was continuous and is something that will constantly be incorporated into process change based on the data for outcomes (Hall, 2019).

Program (Intervention)

The program for this quality improvement project was adapted from two evidence-based studies, with permission from the authors granted (Suzuki et al., 2012; Tilus, 2002). This program involved a series of 20-minute education, lecture-style sessions administered by me and included evidence-based content presented through a PowerPoint slide show. Each staff nurse attended one session but was allowed to attend more than one if they so desired. Attendance was

considered voluntary. Multiple sessions were held to accommodate nurse schedules. Pedagogical approaches were used in creating content for the sessions, while mentoring was also a strategy used. Pedagogy is a method of teaching that involves joining with others, being concerned with, and taking steps to help where there is a need, and helping people reflect, commit, and act (Smith, 2021). Mentoring was used as positive reinforcement for participants following the education sessions, allowing for any questions to be answered by mentors in real-time. These mentors included the DNP project leader as well as members of the ED leadership team and the ED charge nurses. Mentors answered staff questions about the discharge process expectations, referred staff to posted flyers for reference, and reinforced the material learned during the education sessions. Specifically, content included lecture bursts, narrative pedagogy, and case exemplars. During education sessions, several evidence-based topics surrounding effective discharge were discussed, including an explanation of current policies and procedures regarding expectations for the current discharge process in the ED, correct identification of patients during discharge by using two open-ended verification questions approved by the site, the importance and effect of accurate patient discharge, and the difference between understanding the principles of an accurate discharge as well as the importance of integrating these principles into practice (Suzuki et al., 2012; Walter & Robb, 2019). Following the sessions, an open discussion took place in which staff discussed both barriers and means of overcoming barriers, as well as discussed case exemplars in order to raise awareness of the appropriate discharge process. Some current, relevant data in the form of a handout was provided to staff in an effort to highlight the problem at this facility (Appendix A). Flyers were posted in various locations of the ED to provide a quick reference reminder of discharge expectations, with mentors (myself, charge RNs, and the ED leadership team) available to answer staff questions in real-time (Appendix A).

Literature Review

The use of accurate, high-quality discharge is an essential patient-safety practice that is highlighted by The Joint Commission. They have determined that the failure to identify patients consistently and correctly is at the forefront of the problem (Joint Commission, 2021). A literature search was conducted to locate articles supporting a quality improvement initiative focused on improving the discharge process. Several articles were reviewed; those articles that were most relevant to the DNP project were then screened further based on relevance to this project. Databases used for this search included PubMed, Google Scholar, and the Agency for Healthcare Research and Quality (AHRQ).

Search Terms

PubMed and Medical Subject Headings (MeSH) Database. The PubMed/MeSH database was searched using: (("Health Services"[Mesh]) AND ("Health Services/nursing"[Mesh] OR "Health Services/organization and administration"[Mesh] OR "Health Services/standards"[Mesh] OR "Health Services/trends"[Mesh])) AND "Patient Discharge/standards"[Mesh]; (("Health Services"[Mesh]) AND ("Health Services/nursing"[Mesh] OR "Health Services/organization and administration"[Mesh] OR "Health Services/standards"[Mesh] OR "Health Services/trends"[Mesh])) AND "Patient Discharge/standards"[Mesh] AND emergency; (("Health Services"[Mesh]) AND ("Health Services/nursing"[Mesh] OR "Health Services/organization and administration"[Mesh] OR "Health Services/standards"[Mesh] OR "Health Services/trends"[Mesh])) AND "Patient Discharge/standards"[Mesh] AND emergency NOT admission AND "care transition"; and (("Health Services"[Mesh]) AND ("Health Services/nursing"[Mesh] OR "Health Services/organization and administration"[Mesh] OR "Health Services/standards"[Mesh] OR

"Health Services/trends"[Mesh])) AND "Patient Discharge/standards"[Mesh] AND emergency room AND safety AND protocol. Keyword search terms included: "health services"; "health services/nursing"; "health services/trends"; "patient discharge/standards"; "health services/organization and administration"; "health services/standards"; "emergencies"; "safety"; and "emergency service, hospital".

Google Scholar. The Google Scholar database was initially searched using the following search terms: ED discharge OR ER discharge AND department AND protocol AND "patient safety."

The Agency for Healthcare Research and Quality. The AHRQ database was searched using the "advanced search" feature for "discharge process."

Evidence Hierarchy Model

The evidence hierarchy model used to identify the strength of evidence for each article considered for the literature review was the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Model. This model helped determine the quality and strength of the evidence presented in a given body of work by providing criteria that allow an academic professional to categorize the evidence (Johns Hopkins University School of Nursing, 2017). Appendix B and Appendix C include brief tables that organize the strength of evidence of the literature based on this model from highest to lowest.

Summary and Synthesis of Evidence

The body of evidence pertaining to the problem with ED discharges has grown over the last five years and continues to grow with many articles and studies from 2020. The literature supported the use of a systematic discharge process and encouraged a patient-centered approach to discharge planning (Campbell et al., 2015; Grischott et al., 2018; Newnham et al., 2017). A

focus on the improvement of patient safety and nurse satisfaction was evident throughout the articles as well (Newnham et al., 2017; Stevens et al., 2019). The literature pointed out barriers to a successful discharge process as well as methodologies that have helped form the framework for the final DNP project (Gao et al., 2018; Newnham et al., 2017; Stevens et al., 2019). This included the use of the PDSA framework with subsequent PDSA cycles.

There were four common concepts present throughout the literature: discharge planning/process; safety at discharge; nurse satisfaction and attitude; and nurse knowledge/comprehension.

Discharge Planning/Process

In searching for evidence to provide support for programs that aim to improve the overall discharge process, several articles that provide conceptual frameworks and models for care were found. Reviewing evidence that focuses on discharge communication programs preferred by staff and patients was essential and ensured the discharge information itself was patient-centered (Grishott et al., 2018; Newnham et al., 2017). Successful and patient-preferred discharge communication practices that have been shown to improve patient outcomes include IT-based communication methods such as websites, audio-visuals, video-conferencing, and computer-generated discharge instructions (Newnham et al., 2017). However, a single communication format is most likely not going to work for all patient scenarios. Instead, patient communication formats should vary and be patient-specific (Newnham et al., 2017; Stevens et al., 2019). There is room for further research in determining the best mode of communication (verbal vs. written) for providing patient discharge instructions that ensure patient understanding and compliance (Stevens et al., 2019). The literature also highlighted the importance of having a standardized

discharge process in place for employees to follow because it has been proven to improve patient outcomes (Campbell et al., 2015; Grischott et al., 2018; Newnham et al., 2017).

During the discharge process, ensuring that both the provider (advanced practice nurse, physician's assistant, or physician) and the patient are equally and actively involved is critical (Grischott et al., 2018; Schulmeister, 2008). This interactive process includes reviewing new medications with the patient as well as discussing any changes to the medication list (Byrne et al., 2017; Grischott et al., 2018). In most cases, the discharge nurse is responsible for going through all discharge information with the patient, including any medication changes; however, best practice would ideally involve two nurses confirming correct assembly of discharge prescriptions (Byrne et al., 2017).

Current evidence suggests that inadequate discharge planning and ineffective patient verification can occur with interdisciplinary miscommunication, a lack of knowledge, busy nursing work schedules, workflow disruptions, the use of confirmation-based questions, low adherence to organizational policies, variability among staff on how to verify a patient, insufficient staff training, and information gaps. (Campbell et al., 2015; Drake et al., 2017; Suzuki et al., 2012). Other factors that pose challenges in ensuring safe discharge are the complexity of the patient population, dynamic team structures, and high rates of discharge (Drake et al., 2017). Using open-ended questions in an established, standardized patient identification process has been shown to increase accuracy of patient verification and should therefore be implemented (Campbell et al., 2015).

Research recommends that when printing out medication prescriptions at discharge with patient information, nurses should double-check to ensure that the correct patient information is present on the prescriptions before giving them to that patient (Schulmeister, 2008). This

information should match the name and birth date of the patient that the nurse is attempting to discharge. In an effort to prevent errors, nurses should not print discharge information for several patients at the same time as this creates a potential for papers to be mixed and the information to go home with the wrong patient (Schulmeister, 2008).

Safety at Discharge

Patient safety at discharge is a priority among healthcare institutions by Joint Commission standards (Joint Commission, 2021). To facilitate patient safety at discharge, nurses and prescribing physicians should discuss medication lists with patients at the time of discharge (Byrne et al., 2017; Grischott et al., 2018). Errors may also be reduced by providing staff training sessions to increase compliance with the appropriate discharge procedure, which will improve patient safety by increasing the accuracy of patient identification at discharge (Byrne et al., 2017; Gao et al., 2018). It has been found that a large percentage of patients actually express safety concerns before their discharge, which, if identified and corrected, can improve patient outcomes (Drake et al., 2017).

Evidence suggests that the use of open-ended versus confirmation-based verification questions decreases the potential for errors to occur (Campbell et al., 2015). Confirmation-based questions are those that can be answered by a simple “yes” or “no” and can lead to incorrect answers should the patient not be able to fully hear or understand the question (Campbell et al., 2015). Open-ended questions, however, require an answer other than “yes” or “no” and force the patient to provide their own authentic response (Campbell et al., 2015).

Incorrect patient identification is, of course, a significant safety issue. One of the many factors identified in the literature that results in incorrect patient identification is inadequate staff training on best practices, which, if addressed and improved, will increase patient safety (Bittle

et al., 2007; Campbell et al., 2015). Discharging nurses should allow patients (those that are able) to have an active role in the identification process by encouraging them to answer only with their name and birthday when asked but also show their armband if needed (Schulmeister, 2008). This allows patients to be our partners in safety when it comes to the discharge process (Schulmeister, 2008).

Barriers to practice improvement safety initiatives have been identified in the literature and include human behavior and habits being hard to change, time pressures, distractions, and complacency, all of which can prompt nurses to accidentally omit verification of patient identity at discharge (Schulmeister, 2008). Nurses may be tempted to rely solely on their memory of facial recognition or familiarity of their patients rather than appropriate identifiers, which should never be done (Schulmeister, 2008).

Nurse Satisfaction and Attitude

Ensuring information is presented in the patient and provider's preferred format has been shown to improve both nurse and provider satisfaction (Newnham et al., 2017). It is also important to remember that discharge instructions should be personalized and easily accessible (Newnham et al., 2017). Patient satisfaction can be improved by utilizing methods that they prefer as well as by using high-quality verbal communication (Newnham et al., 2017; Stevens et al., 2019).

Research shows that practical staff training through continued education improves support for discharge planning from co-workers, and therefore improves discharging nurses' attitudes toward the task (Suzuki et al., 2012). Educational sessions have been shown not only to improve nurse knowledge and practice but also to improve their confidence level (Walter & Robb, 2019). Implementing nurse-led educational sessions with the use of mentoring fosters a

supportive learning environment as well as a feeling of empowerment and confidence among staff nurses (Walter & Robb, 2019). The use of pedagogy helps to elicit emotional interest in presentation information as well as encourages nurse reflection on professional practice regarding the impact of best practice on patient outcomes (Walter & Robb, 2019). It can be used to create content for education sessions, including lecture bursts, narrative pedagogy, and case exemplars (Walter & Robb, 2019).

Nurse Knowledge/Comprehension

To improve patient comprehension of discharge information, discharging nurses need to make sure their instructions are specific and in the format preferred by the patient (Newnham et al., 2017). To accomplish patient comprehension during discharge as well as to increase nurse accuracy and maximize the quality of discharge, nurses need adequate training on the proper way to conduct a discharge (Byrne et al., 2017; Campbell et al., 2015; Grischott et al., 2018). The integration of staff training sessions has been shown to improve staff discharge procedure compliance and accuracy (Byrne et al., 2017; Grischott et al., 2018). In order to improve nurse accuracy and the overall effectiveness of the program, these educational sessions should take nurse learning preferences into consideration and highlight current procedures in place at the facility, as well as the correct way to verify identification, the importance of correct identification, and the ability to identify gaps in the system when errors do occur (Campbell et al., 2015; Roberts et al., 2018).

Educational sessions led by ancillary staff (physicians and pharmacists) supported the successful implementation of discharge procedures and improved accuracy among staff as well (Byrne et al., 2017; Grischott et al., 2018). Involving other relevant staff such as physicians and pharmacists in the educational process carries a huge advantage. The use of a multidisciplinary

team such as this provides the opportunity for expert collaboration as well as the chance to clear up any difficult questions about prescriptions or other pertinent discharge information (Byrne et al., 2017; Grischott et al., 2018; Suzuki et al., 2012). Additionally, discharging nurses can enhance patient learning as well as the overall patient experience by providing instructions in the format preferred by the patient, whether that is verbal, face-to-face, print-out, telecommunication-related, or website-based (Newnham et al., 2017).

Nurse accuracy of patient identification and overall patient safety should be promoted by encouraging the reporting of all misidentification errors because this can help capture further opportunities for improvement (Campbell et al., 2015). Studies show that a comprehensive approach to nurse education leads to improved nurse knowledge levels (Suzuki et al., 2012). This comprehensive approach includes ensuring the distribution of materials about the discharge process, as well as supportive information on scholarly websites and related literature at education sessions (Suzuki et al., 2012).

Research has shown that the implementation of a 30-minute educational session followed by four weeks of mentoring increases nurse knowledge and understanding, as well as empowers nurses to integrate the content into daily patient care (Walter & Robb, 2019). Placing posters in an area where nurses on the unit can view them for reference has been shown to be a good strategy for reinforcing content learned during the educational session and encouraging accuracy (Walter & Robb, 2019). Thirty-minute education sessions consisted of PowerPoint presentations that discussed central tenants of patient-specific and family-centered care, barriers and strategies for overcoming barriers, and the impact that family-centered care has on the patient and family's perception (Walter & Robb, 2019). By encouraging participants to have an open discussion with the project manager regarding perceived obstacles and select case exemplars, awareness of the

current issue can be increased (Walter & Robb, 2019). Staff nurses benefit from having someone available to answer their questions in real-time on the unit when needed, as it has shown to increase accuracy and compliance (Walter & Robb, 2019).

Analysis of Synthesis

Some common themes across the evidence include the supported use of patient-centered discharge instructions as well as adequate patient teaching at discharge with a patient-preferred method (Byrne et al., 2017; Gao et al., 2018; Grischott et al., 2018; Newnham et al., 2017; Stevens et al., 2019). Interactive discharge involving the patient, the provider, and the discharging nurse is essential to a safe discharge in which the patient fully understands their instructions and medications (Byrne et al., 2017; Gao et al., 2018; Grischott et al., 2018). Ensuring that correct patient instructions and medication prescriptions are sent with the right patient is key to providing a safe discharge and ensuring patient satisfaction (Byrne et al., 2017; Gao et al., 2018; Grischott et al., 2018).

One point that was consistently and repeatedly stated about the problem across articles and studies was the definite need for intervention. There were many different types of programs found throughout the literature search, all aiming to improve the quality of the discharge and decrease discharge errors. The literature supports the use of nurse-preferred learning methods when educating on a tool to be used in an education program (Campbell et al., 2015; Roberts et al., 2018). A few of the articles noted that there is still so much unknown about what exactly a high-quality discharge entails and what methods are consistently successful in improving that quality (Newnham et al., 2017; Stevens et al., 2019). More research is needed to determine the exact formula for success. The perfect method for high-quality discharge can be complicated, as much of a patient's discharge should be individualized and specific to that patient.

Literature Gaps and Inconsistencies

A significant gap in the problem of decreasing discharge errors is identifying the source of these errors. Studies indicate the problem is varied and dependent upon the study setting. Each facility has its own policies and protocols, as well as its own processes for conducting discharges. This makes it difficult to pinpoint at which point in the discharge process errors most likely occur. Not having a universal, standardized discharge process that is recommended makes education on this subject very difficult as well. The fact that most “good catches” and discharge errors are self-reported is an apparent hindrance to the improvement of the process. This means that it is hard to get an accurate quantitative reflection of the actual number of errors made. However, this gap further solidifies the need for quality improvement initiatives in this particular area across the board. The literature is also lacking in research on the discharge process, specifically in the ED. The implementation of this project helped fill this identified gap at this specific facility.

Relevance to Program

The evidence generated from the studies found during the literature search formed the foundation and structure for this project, which included an educational session for ED nurses at the facility. The educational intervention was created using this evidence; survey questions were adapted from these studies, with permission, in an effort to assess nurse attitude and perception as well as nurse knowledge and comprehension of the discharge process. Accuracy of patient identification was also assessed both before and after education.

Methods

Design/Procedures (Implementation)

ED nurses were offered the opportunity to take the pre-survey prior to the educational intervention. ED nurses, as identified by inclusion criteria, were emailed a survey request, as well as verbally invited to take the survey. Following the pre-survey, there were four educational sessions held per week from which staff could choose. One session each week was held during night shift hours and allowed for maximum night shift nurse participation. The other three weekly sessions were held on day shift. Some of the day shift sessions were intentionally held close to shift change in an effort to include any night shift staff that had not had the opportunity to participate. The implementation period was a four-week period in which four sessions a week were offered. This allowed for 16 total sessions for staff to choose from. The initial implementation period was planned for six weeks; however, each staff nurse had attended at least one education session by the end of the fourth week; thus, the implementation period ended at that time. Nurses were then invited verbally and by email to take the post-survey.

Informing staff and other stakeholders of the project involved sending a formal email to each potential participant briefly describing the project in general, the purpose and aims, as well as the planned program. Participants included all ED staff nurses, as they all elected to participate. Participation in both the education sessions and the pre- and post-surveys was completely voluntary. Informed consent was obtained prior to both the pre- and post-survey using a preamble of consent in which the participant consented to be in the study by agreeing to take the survey.

The accuracy of data was assessed by having participants directly enter data into the Research Electronic Data Capture (REDCap) form. The completeness of data was assessed by

the DNP project leader, who assessed participant responses in REDCap to ensure that all surveys had been completed appropriately and adequately. Through a unique identifier, Statistical Package for Social Sciences (SPSS) matched the participants' pre- and post-surveys. Survey participants were coached to choose their own unique identifier, such as the last four digits of their driver's license number, and not to share that identifier. To maintain the security of data and participant confidentiality, a password-protected laptop was used to access, analyze, and store data; the facility's HIPAA policy and procedures were followed throughout the process. There were no incentives provided to ensure staff adherence to the education program.

Data Collection

The data collection and statistical analysis process for this DNP project involved the use of the software program SPSS, as well as REDCap. SPSS is a validated program that allows the user to input statistical data and organize these data professionally, safely, and effectively (International Business Machines [IBM], 2021). It is often used by nursing professionals for the purpose of collecting, organizing, and analyzing data to use in QI projects such as this one, as well as research studies (IBM, 2021). The plan for the maintenance and security of data also involved the use of the SPSS software as well as storage on a password-protected laptop. Data were collected and managed using REDCap electronic data capture tools hosted by the University of Louisville. It was used to build and administer the nurse surveys for nurse attitude/perception as well as nurse comprehension and knowledge. REDCap is a password-protected, secure, web-based software platform designed to support data capture for projects such as this one (Harris et al., 2009; Harris et al., 2019). It provides users with an intuitive interface for validated data capture, audit trails for tracking data manipulation and export procedure, automated export procedures for seamless data downloads to common statistical

packages, and procedures for data integration and interoperability with external sources (Harris et al., 2009; Harris et al., 2019).

Financial Needs

The expected financial needs for this project included the author's personal time, staff nurse time, ED leadership team time, cost for printed handouts, cost for printed flyers, cost for stickers indicating nurse verification of patient identifiers, and unit secretary time spent applying the stickers to the discharge form. The QI education sessions were free to the project site. No funding or grants were received. There were no identified costs to adapt and use the tools from the two articles in which the surveys were shaped after.

Measurement

The basic project design was adapted from evidence found in two articles (Suzuki et al., 2012; Tilus, 2002). It included a nurse pre-program survey, education sessions, and a nurse post-program survey. Outcomes for this QI project were measured using a self-administered nurse pre- and post-survey using REDCap and reported data from the compliance department showing the reported number of identification errors at discharge during the four weeks following the end of the implementation period. The implementation and evaluation period took a total of ten weeks, with four weeks of education implementation followed by three weeks of evaluation and mentoring through positive reinforcement for staff. The program started with a two-week pre-intervention period in which the participants were allowed time to take the pre-survey and ended with a one-week post-intervention period in which the participants were allowed time to take the post-survey. The data were evaluated both before and after the education period of the project. The nurse pre-survey was intended to be completed prior to the start of the first education session held, and the post-survey to be completed after week nine once the education sessions concluded

and three weeks of mentoring was allowed. This helped determine the level of impact that the education had on the outcomes. The aim of this project's program was to increase nurse perception and attitude, increase nurse knowledge and comprehension of the current process, and increase nurses' accuracy of patient identification by decreasing the number of reported patient identification errors at discharge. Reliability within the project sample was not directly evaluated due to the way that the survey instrument was adapted. The adaptation and subsequent creation of the instrument used in the project involved taking questions from two different, valid and reliable survey instruments and merging them together to create an instrument relevant to this project's aims. Demographic data measured included participant age, gender, years of nursing experience, and education level, all of which were asked at the beginning of each survey completed and is present in Appendix D.

Outcome Measures

Nurses' accuracy of patient identification was measured by the number of errors reported at discharge. This data was provided by the facility's compliance department with permission from the facility. Nurse attitude/perception and nurse comprehension/knowledge was measured using a Likert scale and survey questions from two peer-reviewed research articles that were found during the literature review with the authors' permission (Suzuki et al., 2012; Tilus, 2002). Four questions were created by me with the help of the nurse researcher and added to the pre- and post-survey questionnaires that assessed nurse comprehension/knowledge. Two of these questions were site-specific, meaning they assessed the nurse's comprehension/ knowledge of the project site's discharge expectations.

Instruments

A pre- and post-survey was adapted using two instruments from reliable sources in literature to measure nurse attitude/perception and nurse comprehension/knowledge (Suzuki et al., 2012; Tilus, 2002). Permission for use in this QI project was formally granted by the authors. Suzuki et al. (2012) created, implemented, and analyzed a survey instrument to determine changes in attitude toward discharge planning as well as participants' perception of factors relating to discharge planning such as barriers, facilitators, interest in discharge planning, communication, and support from co-workers. The study falls under Johns Hopkins level II evidence with grade B quality, which means the study is of good quality. The instrument's validity and reliability were checked by the facility's staff and its discharge planning researcher, as well as through principal component analysis (Suzuki et al., 2012). This instrument was chosen because it measured a significant improvement in attitude and nurses' ability to recognize discharge needs as well as supported discharge planning (Suzuki et al., 2012). Tilus (2002) adapted, implemented, and analyzed a survey instrument to determine nurses' current levels of knowledge and perception of collaborative discharge planning. Validity and reliability were tested using Cronbach's alpha coefficient and were determined to range from 0.65 to 0.97 (Tilus, 2002). The study falls under John Hopkins level III evidence with grade B quality, which means it is of good quality. This instrument was chosen because it showed that participants had a favorable and/or knowledgeable perception of discharge planning (Tilus, 2002).

Nurse Attitude/Perception. Both the pre- and post-surveys included statements used to specifically assess nurse attitude/perception and nurses' perceptions of discharge planning collaboration and communication (Suzuki et al., 2012; Tilus, 2002). Each of the statements was ranked using a Likert scale: 1 "disagree," 2 "somewhat disagree," 3 "uncertain," 4 "somewhat

agree,” and 5 “agree” (Tilus, 2002). Higher scores reflected better attitudes and overall perception (Suzuki et al., 2012; Tilus, 2002). Questions 1-17 were taken from Suzuki’s and Tilus’s instruments and assessed nurse attitude/perception of discharge planning collaboration and communication (Tilus, 2002). Scoring occurred by performing a Wilcoxon signed-ranks test, assessing the *p*-value, and calculating the *z*-score. A *z*-score indicates whether there is any difference between two sets of scores, and the *p*-value indicates whether the difference is statistically significant. If the difference between the scores is statistically significant, an effect size is calculated (Cohen’s *d*) to assess whether the difference between two groups is small, medium, or large. However, since the results were not statistically significant, effect size was not calculated. Descriptive statistics including min, max, and mean scores were also obtained and compared pre- and post-intervention for each question. The specific questions included in the survey are presented in Appendix E.

Nurse Comprehension/Knowledge. To assess nurse comprehension of the knowledge provided by the educational intervention, the pre- and post-surveys included one multiple choice question (number 18) from Tilus that assessed the level of nurse knowledge (Tilus, 2002). Additionally, four questions (questions 19-22) were created by the project leader with input from the facility’s nurse researcher. Scoring occurred by averaging the pre- and post-survey scores and assessing change between pre- and post-survey averages. Individually, survey questions were also analyzed using sum scores analysis and compared pre- and post-intervention. The specific questions included in the survey are present in Appendix F.

Measurement of Patient-Identification Errors. The addition of one statement to the current discharge checklist form at the project site was discussed and formally approved by key stakeholders. This statement was in the form of a sticker and was included at the top of the

discharge checklist form. It was a tool used to assess nurses' use of two-patient identifiers at discharge, as well as the effectiveness of the education program. It also promoted compliance with the material presented in the education sessions. The statement read: "I have verified the patient's name and date of birth." The discharging nurse checked the box, indicating that they have verified two identifiers prior to discharging the patient. The nurse and patient then signed the form as they usually do, indicating that the current policy had been followed. In the event that a patient-identification error occurred during the project timeline, the project team would have audited charts to investigate if the checkbox was completed by the nurse in an effort to identify how the error occurred. The number of errors was measured using compliance reports provided by the project site's director of compliance/HIPAA privacy from the calendar years 2019-2021.

Evaluation (Analysis Plan)

Data analysis was carried out using SPSS software version 27.0. To evaluate the effectiveness of the QI project, quantitative data analysis was performed. Descriptive analysis was performed on participant demographic data, including mean, median, and frequency. The original plan was to complete a paired t-test on the sample; however, due to a low sample size of paired responses ($N=9$), a Wilcoxon signed-rank test was performed to compare pre- and post-survey scores. This non-parametric test was also chosen because it can be used to compare two groups that are matched. The Wilcoxon signed-rank test is appropriate to use in the case that two different instruments are adapted to create a final survey instrument, which occurred in this project. The number of reported patient identification errors at discharge prior to program initiation was compared to the number of reported errors following program implementation. Both surveys included a short demographic section containing questions about age, gender, years

of nursing experience, and level of education. These demographic data were analyzed following the implementation period. Matching of the pre/post-surveys was done using SPSS. Participants used their self-assigned, individualized identifiers on the surveys. This helped ensure accuracy of data. The process component was affected by participant retention and attrition rates, as well as other barriers and facilitators.

Implications

The goal for this QI project was to improve the discharge process and patient safety by educating nurses on the need for using two patient identifiers during discharge.

This project required approximately 20 hours of staff time for 41 RNs to attend the 20-minute education session and to complete a pre- and post-survey. The education sessions were attended when the staff member was scheduled and present for a paid workday. Feasibility has been determined by informal interviews with stakeholders that included feedback from staff RNs in the ED. Education sessions were held in the main nurses' station in a one-on-one fashion to ensure that each team member had an opportunity to participate without having to leave their assigned patient care area. If any participant was pulled away or missed portions of the session, the DNP project leader followed up with and updated that participant on the content they missed at a more convenient time. This is the current practice in this ED, and the ED nurse educator frequently provides education for staff in this manner.

Results

Findings

Forty-one ($N=41$) ED nurses (35 females and 6 males) participated in the project, received the education intervention, and received a three-week mentoring period. There were 23 pre-intervention survey responses and 15 post-intervention survey responses, for a 56% pre-

survey participation rate and a 37% post-survey participation rate. Data from these surveys were cleaned, coded, and merged using SPSS software. The pre- and post-survey responses were matched using the participants' self-assigned unique identifiers. As a result, the sample size included nine ($N=9$, 22%) respondents' matched data pairs that were able to be used for statistical analysis. More surveys were not matched because not all nurses completed the surveys, some nurses only completed one survey (only the pre or only the post), and some nurses used a different unique identifier for the post-survey than their original number for the pre-survey. If the survey responses were unable to be matched, they were not included in the final sample. One major reason for nurses not completing the surveys, in general, could have been the fact that the survey link was shared with potential participants via their work emails, which are only able to be accessed while at work. In order for a participant to complete the survey at home, they would have had to forward the email link to their personal email. Additional steps would have had to be included to have access to it at home that many could not or did not take. Additionally, busy workdays and workflow disruptions could have also contributed to the reason surveys were not completed by all nurses, as they did not have the time at work to complete them.

Descriptive Statistics

Demographic data was collected for each participant via the pre/post-survey. Frequency analysis tests were performed on the sample ($N=9$) and revealed that most respondents were between the ages of 34-41 (44%), female (89%), had less than five years of nursing experience (44%), and held a BSN degree (67%). Further information can be found in Table 1.

Baseline ED demographic data was provided by the unit coordinator and included statistics on staff gender and education level. Of the 41 ED RNs, 85% are female, with 23%

being male. 34% of nurses in the ED have an ADN, 63% have a BSN, and 3% have an MSN.

The project sample was highly representative of the ED nurse population, as both were majority female and holding a BSN degree.

Nurse Attitude/Perception

A Wilcoxon signed-rank test was performed and showed that a four-week patient identification-focused education intervention did not elicit a statistically significant change in nurse attitude/perception or comprehension/knowledge post-intervention ($p>0.05$). The p -value proved to be greater than 0.05 for every question; however, questions six and eight were close to statistical significance: $p=0.063$ and 0.084 , respectively (Table 2). Question six read, “It is the nurse’s role/responsibility to initiate discharge planning.” Question eight read, “I worry about the individual patient’s life after hospital discharge.” Descriptive statistics (Table 3) revealed that for most questions, the mean pre-intervention score was fairly high, leaving little room for improved scores post-intervention.

Nurse Comprehension/Knowledge

Sum scores analysis revealed that five respondents’ comprehension/knowledge scores increased from the pre-survey to the post-survey by 20%, while two respondents had decreased scores and two respondents’ scores were unchanged (Table 4). Overall, mean scores were improved from 77.8 pre-intervention to 84.4 post-intervention, resulting in an 8.5% increase in scores post-intervention.

Accuracy of Patient Identification

While there were six patient identification errors reported in the 2019 calendar year and seven errors reported in the 2020 calendar year (13 total), there were no identified patient identification errors for the 2021 calendar year from January to the present. This data was

provided by the project site's director of compliance/HIPAA privacy. No patient charts were audited during the project timeline; therefore, the number of errors for this calendar year is based on reported errors only.

Barriers and Facilitators

Barriers that interacted with the intervention included perceived workflow disruptions and busy workdays, both of which may have stopped nurses from taking the survey. Management emphasis on reducing patient identification errors at discharge and management implementation of a new pilot process that included having the discharging nurse highlight the patient's name on each individual page of the discharge paperwork and signing their initials on the top of each page as well contributed to the lowered error rate beyond this project. This new pilot process was implemented by the ED management team approximately six months before the start of the implementation period of this project. There were instances in which participants were required to step away from education to respond to patient and provider requests as well as staff requests for assistance with daily tasks. This caused disruptions in the flow of the education delivery and required participants to return and make up the information they missed. All of these factors more than likely played a part in the zero error rate beyond the effect of this specific DNP project. Despite some of these barriers, the project itself had no modifications or changes.

Facilitators included ED management and CNO support for this project, consistent and positive support from the facility's nurse researcher, unlimited access to nursing staff involved in this project, and nursing staff that supported this project. Staff and management were fully supportive of finding solutions to this vexing problem.

Discussion

Summary

When nurses do not confirm two patient identifiers during discharge, the potential for patient identification errors significantly increases. This increases the chance that patients will be discharged with incorrect paperwork resulting in HIPAA violations, fines, and decreased patient safety and satisfaction (Byrne et al., 2017; Campbell et al., 2015; HHS, 2013; Schulmeister, 2008; Stevens et al., 2019; Suzuki et al., 2012; Tilus, 2002). The first project aim was met, as there were no identified patient errors for the 2021 calendar year (January to present). The second aim was not met, as there was only an 8.5% increase in mean scores post-intervention. The final aim was not met, as there was no statistically significant increase in post-survey scores on any question.

Interpretation

The intervention did not definitively prevent patient identification errors alone, as there were other factors that contributed to this outcome that were outside of the actual project. The intervention could have been responsible, in part, for no errors in the 2021 calendar year. There also could have been no reported errors due to management's emphasis on the issue during this time introducing historical bias, or the fact that the staff knew that the project was occurring, which could have introduced observer bias. Comprehension/knowledge was increased post-intervention by 8.5%, reflecting higher levels of knowledge about the discharge process post-intervention. Our initial aim of achieving an 80% increase in comprehension/knowledge post-intervention was likely too high and should have been lower, as many of the participants' pre-survey scores revealed that they perceived their initial comprehension/knowledge to be already fairly high. The intervention did not increase attitude/perception toward discharge expectations,

as there was no statistically significant increase in the post-surveys; however, it is not clinically insignificant that patient identification errors were decreased overall, and comprehension/knowledge levels did increase post-intervention.

Mentoring

The mentoring style used during the mentoring period was passive, meaning that participants were required to come to the project team if they needed help or if they had any questions regarding the education of discharge expectations. An active style would have required the project team to frequently reach out to participants to reinforce the education material. This passive mentoring approach could have affected nurse attitude/perception as well as comprehension/knowledge, causing lower post-survey scores. A more active approach to mentoring could have possibly improved post-survey scores; however, the literature is silent on the benefits of active versus passive mentoring. Better mentoring practices for education is a gap that has been identified in the literature as a result of this project. The effects of active versus passive mentoring should be explored in the future.

Scoring

The survey instrument was an adapted version of two independent instruments by two different authors without specific scoring instructions available from the authors, which had an effect on the validity and reliability of the project survey instrument. The lack of scoring information could have affected the survey scores. The instrument developed for this project was likely not a completely accurate measure of comprehension/knowledge and attitude/perception.

Nurse Attitude/Perception

The Wilcoxon signed-ranks test revealed that the null hypothesis, that there would be no statistically significant difference in attitude/perception pre-intervention to post-intervention, was

accepted. The p -value was noted to be >0.05 for each question, meaning the results were not statistically significant; however, questions six and eight were very close to being statistically significant. This was probably due to the fact that the intervention clearly laid out what a nurse's role/responsibility is in initiating the discharge process (question six) and encouraged participants to engage in active conversation about how the discharge process affects their attitude/perception (question eight).

The results of the Wilcoxon signed-ranks tests and the mean score for each question indicate that many of the participants scored themselves high on the pre-survey, leaving little room for improvement on the post-survey (Table 3). It is also possible that the need for nurse education was overestimated, meaning staff perceived themselves to be adequately educated on the discharge process prior to the intervention. This is evident by the fact that the majority of participants noted no change in their attitude/perception post-intervention for every question except question eight, in which five participants had a higher post-intervention attitude. Question eight asked whether staff felt they were trying not to overlook signs indicating risk after discharge. The majority of participants' attitude/perception improved on this question post-intervention; however, it was not statistically significant.

Findings Relating to Current Literature

Previous studies have highlighted the importance of using a standardized discharge process to improve patient outcomes, which was a focus of this project (Campbell et al., 2015; Grischott et al., 2018; Newnham et al., 2017). We found that, like other studies, by emphasizing the importance of using a standardized, patient-centered process to nursing staff, we could improve patient outcomes related to safety and satisfaction by decreasing the number of identified errors at discharge (Newnham et al., 2017; Stevens et al., 2019). During this project,

nurses were required to review patient medication information and new prescriptions with patients when providing their discharge instructions, as this is current process at the site and is best practice to lower patient misidentification (Byrne et al., 2017; Grischott et al., 2018; Schulmeister, 2008). When nurses provide patients with medication education at discharge, the number of good catches tends to increase, and errors, such as wrong prescriptions or medication education paperwork, are caught before they can negatively impact the patient. As with other studies, asking program participants open-ended questions during the intervention seemed to help with overall comprehension of the discharge process, providing an opportunity for feedback and learning reinforcement, which probably resulted in no identified errors for the 2021 calendar year (Campbell et al., 2015). The project findings support the current evidence in the literature, which suggests that busy work schedules, workflow disruptions, low adherence to organizational policies, insufficient training, information gaps, and variability among staff are all barriers in the success of accurate patient identification, as many of these factors were found to be barriers to the project as well (Campbell et al., 2015; Drake et al., 2017; Suzuki et al., 2012).

There were no additional or unanticipated costs during this project. Additionally, the project (despite multiple delays beyond the control of this author and as described above) saw no trade-offs as it was implemented and measured as planned.

Limitations

A major limitation of this QI project was the low number of paired samples ($N=9$). Reasons for this limitation were identified and discussed previously; future projects would need to ensure that staff knew the necessity of taking both the pre- and the post-survey (not just one) and of providing an easier-to-remember survey ID (unique identifier) to provide for both pre- and post-surveys.

Types of Bias

There were a few types of bias identified as likely being present during the project that includes: voluntary response bias, observation bias, and historical bias. Voluntary response bias resulted from recruits being able to choose to participate in the project and respond to the surveys. Providing an incentive that would encourage participants to take both surveys may encourage participants to take both surveys in the future. Observer bias was likely introduced, as staff were aware that the project was taking place and were also aware that management was introducing solutions to halt this problem. Participants could have altered their survey responses or not answered honestly as a result of knowing how important this issue is to patient safety and to management. In contrast, this type of bias could also have contributed to there being no reported errors for the 2021 calendar year because they knew they were being observed and would therefore take extra steps to ensure they did not commit errors. Historical bias was also potentially introduced as the ED management/leadership team heavily emphasized the problem during the project timeline and during the intervention period in particular. This could have resulted in participants being overwhelmed by the emphasis on the issue, contributing to the attrition rate and overall participation in the survey. Conversely, this bias could be responsible, in part, for there being no reported patient identification errors for the 2021 calendar year.

Response/Attrition Rate

Another limitation of the project included staff turnover rates, as it is common for the ED to have a high nurse turnover rate. This could have affected the attrition and overall survey response rate. Busy workdays and workflow disruptions could have had an effect on recruits' motivation to participate, as the ED was frequently busy on days education was delivered, and participation required a certain degree of disruption in workflow to participate. COVID-19 limited how the education could be provided. In accordance with the project site's temporarily

revised education policy, the education intervention was to be provided individually to participants instead of in a group setting in a quiet, secluded conference room, for instance.

Matching

Each participant assigned themselves a unique identifier to input into the REDCap surveys in an effort to help in the matching of the participants' pre- and post-surveys. The participants were coached to use the last four digits of their driver's license number; however, since participants could self-assign their identifier, many of the participants chose a random four-digit number. There were several cases in which participants expressed that they could not remember their identifying number and therefore came up with a different one when answering the post-survey. There were also cases of participants who only responded to one of the surveys but not both. These factors contributed to the attrition rate in that many of the surveys were unable to be successfully matched into pairs, resulting in a small sample size.

Checkbox Sticker

I was unable to oversee the daily use of the checkbox stickers as I was not present at the project site every day. I did, however, educate both of the unit secretaries on the correct use of the stickers as well as their purpose. Because this project was a quality improvement project that was not built as a research project and because the project was specific to the project site, the results are not completely generalizable to other areas or facilities.

Internal Validity and Reliability

Finally, internal validity and reliability analysis was unable to be performed on the survey instrument as it was adapted and merged using two other instruments. There were specific questions, which were relevant to the project aims chosen from Suzuki's and Tilus's questionnaires incorporated into the final version of the survey instrument. Not all of the

questions presented by Tilus and Suzuki were included. For instance, Suzuki included questions about home care and the discharge process related to that type of setting, which was inappropriate for the purpose of this project, and those questions were not used. Reliability and validity were unable to be determined as a result.

Conclusions

This project was useful in identifying barriers to nursing education as well as helpful in identifying how education can improve patient outcomes. Sustainability could be achieved if the responsibility was given to the unit's nurse educator, who could provide follow through with education, mentorship, and evaluation using the PDSA model. Education is an ongoing process that involves continuously incorporating best practice; thus, this education intervention could be administered to staff on a regular basis, improving outcomes. There is potential for spread to other contexts; however, adjustments would need to be made in order to fit that site's specific discharge requirements and expectations. Management support of the project goals may also improve outcomes and should therefore be valued and sought.

In future projects, options for 100% participation in the educational intervention should be investigated and explored. Options for valid and reliable tools measuring attitudes/perceptions of the discharge process should be investigated as well. Assessing whether patient satisfaction with the discharge process is tied to quality survey scores is also worth exploring in the future. Better mentoring practices for education should be explored in future projects as well.

A patient-identification-focused education program improves nurse comprehension/knowledge and accuracy of patient identification at discharge, leading to a reduced number of patient-ID errors and subsequent financial consequences. Accurate patient identification at discharge is crucial in preventing errors that could cause the right patient to

receive the wrong discharge information and plays an essential role in decreasing errors and increasing patient satisfaction. This begins with ensuring the use of two patient identifiers to correctly identify our patients.

Dissemination

Dissemination of the DNP project involved a virtual, oral proposal presentation, a live poster presentation, and a plan to submit this project and its results for publication. Vetting of the project dissemination was conducted by the project committee representing the University of Louisville and the facility's leadership team. Dissemination of this project was cleared with the local agency before presentation and possible publication. The name of the facility was not identified for any formal publication, during the oral defense, or during the poster presentation. The results of the project were shared with the facility's ED leadership team, the CNO, and the nurse researcher.

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Table 1
Demographic Statistics from Data Analysis (N=9)

Gender	n (%)
Female	8 (88.9%)
Male	1 (11.1%)
Age Group	
18-25	2 (22.2%)
26-33	2 (22.2%)
34-41	4 (44.4%)
50-65+	1 (11.1%)
Years of Nursing Experience	
<5	4 (44.4%)
5-10	1 (11.1%)
11-15	3 (33.3%)

16-20+	1 (11.1%)
Education Level	
ADN	3 (33.3%)
BSN	6 (66.7%)

Table 2**Attitude/Perception Analysis from Wilcoxon Signed-Ranks Test**

Survey Question #	Z	Asymp. Sig (p-value)
1	-1.414	0.157
2	0.000	1.000
3	-0.707	0.480
4	-0.577	0.564
5	0.000	1.000
6	-1.857	0.063
7	0.000	1.000
8	-1.730	0.084
9	-1.000	0.317
10	0.000	1.000
11	-1.282	0.200
12	-1.633	0.102
13	-0.577	0.564

14	-0.577	0.564
15	-0.577	0.564
16	-1.134	0.257
17	-1.414	0.157

Table 3**Descriptive Statistics for Attitude/Perception Questions**

Question	Minimum	Maximum	Mean
1 (pre)	4	5	4.78
1 (post)	4	5	4.56
2 (pre)	4	5	4.67
2 (post)	4	5	4.67
3 (pre)	1	5	3.89
3 (post)	2	5	4.11
4 (pre)	2	5	3.89
4 (post)	2	5	3.78
5 (pre)	4	5	4.56
5 (post)	4	5	4.56
6 (pre)	2	5	3.22
6 (post)	2	5	3.89
7 (pre)	2	5	4.11

7 (post)	2	5	4.22
8 (pre)	2	5	3.44
8 (post)	3	5	4.11
9 (pre)	4	5	4.78
9 (post)	4	5	4.67
10 (pre)	4	5	4.56
10 (post)	4	5	4.56
11 (pre)	2	5	3.67
11 (post)	1	5	2.89
12 (pre)	3	5	4.22
12 (post)	2	5	3.67
13 (pre)	3	5	4.33
13 (post)	3	5	4.22
14 (pre)	3	5	4.33
14 (post)	3	5	4.22
15 (pre)	4	5	4.67

15 (post)	4	5	4.78
16 (pre)	3	5	4.11
16 (post)	3	5	4.44
17 (pre)	4	5	4.44
17 (post)	3	5	4.22

Table 4
Comprehension/Knowledge Sum Scores Test

Respondent	Pre	Post	Increase Vs. Decrease
1	0.4 = 40%	0.6 = 60%	Increase
2	1.0 = 100%	0.8 = 80%	Decrease
3	0.6 = 60%	0.8 = 80%	Increase
4	0.8 = 80%	1.0 = 100%	Increase
5	1.0 = 100%	0.8 = 80%	Decrease
6	0.8 = 80%	1.0 = 100%	Increase
7	1.0 = 100%	1.0 = 100%	Same
8	0.8 = 80%	1.0 = 100%	Increase
9	0.6 = 60%	0.6 = 60%	Same

Appendix A

Flyer/Handout

- ❖ **Review** each page of the discharge packet prior to entering the room, checking the name & then check the box
- ❖ **Confirm** your patient's identity at bedside with two identifiers (name & date of birth)
- ❖ **Ask** verbally or check the patient's armband
- ❖ **Ensure** the discharge packet you have belongs to that patient & sign after the discharge is performed

- ❖ **Remember..**
- ❖ Collaborate with your team! Get the info you need
- ❖ Discuss your discharges openly
- ❖ Have a positive attitude

Discharge planning is teaching done regarding diet, medications, activity, wound care, and follow-up.

Discharge planning is a process that begins with early assessment of anticipated patient care needs.

The nurse initiates the patient discharge and ensures that both the patient and the family understand the discharge plan.



IMPROVING PATIENT SAFETY DURING
THE EMERGENCY DEPARTMENT

DISCHARGE PROCESS

WITH THE USE OF TWO
PATIENT IDENTIFIERS

QUICK REFERENCE GUIDE

Appendix B

Strength of Evidence I

Study Design	Meta Analysis	Systematic Review	Randomized Controlled Trial	Experimental Study	Clinical Practice Guideline	Observational Study/Quality Improvement	Descriptive/Exploratory Study
Level of Evidence Scale	(Highest) ←-----→ (Lowest)						
Evaluation Method Level (Johns Hopkins)	I	I	I	II	IV	V	V
Rigor		A	A	B		B	C
Article		Newnham et al.	Grischott et al.	Byrne et al.		Gao et al.	Stevens et al.
Strengths & Weaknesses of Study/Study Design		<p>Strengths: -Sample size of 30 articles were reviewed. -5 different databases used/searched. -Inclusion & exclusion criteria discussed. -Provides good evidence on communication preferences.</p>	<p>Strengths: -Large sample size. -Primary outcomes thoroughly discussed. -Study design is flexible.</p> <p>Weaknesses: -Sample only included pts 60+ yrs old that were</p>	<p>Strengths: -The number of assembled discharge prescriptions to be audited was equivalent to the number of discharges. -Unit nurses were not informed that the audit was taking place</p>		<p>Strengths: -Model for Improvement framework used -Good catches were identified -Good sample size -Stakeholders discussed -Stakeholders involved in creating checklist</p>	<p>Strengths: -Face to face interviews with clinicians. -Identified 5 key themes. -Sample included a good mixture of different types of clinicians. -Limitations and bias were addressed and discussed.</p> <p>Weaknesses:</p>

		<p>-Methods and search terms addressed. -PRISMA chart included.</p> <p>Weaknesses: -Variability in research design, populations, types of interventions and time-points of the studies reviewed (impeded the synthesis of their findings). -Studies reviewed were conducted in 10 countries with different national health systems (may make comparison difficult). -Generalization possibly restricted.</p>	<p>considered multimorbid. -The contamination between clusters within the same hospital cannot be fully excluded.</p>	<p>(to ensure no change in routine practice). -Pharmacists did not collect audit data (to avoid bias). -Pharmacists performed accuracy checks to identify errors. -Medication errors were clearly defined.</p> <p>Weaknesses: -Conducted on 2 units, but at the same facility. -Only conducted over a 2-week period. -Small sample size (56 discharge prescriptions).</p>		<p>-Outliers addressed</p> <p>Weaknesses: -No biases or weaknesses were addressed -No discussion of rigor -Study took place on one general medical unit at a single institution (limited generalizability) -Part of the checklist open to interpretation</p>	<p>-Conducted in one district Tasmanian hospital (may cause problems with generalizability). -Small sample size (100 pts). -Study only involved self-reported perceptions by ED fast-track non-urgent pts (findings may not be generalizable). -Possible sample bias. -Convenience self-selection sampling method. -No randomization. -Data collection relied on pts' self-report and recall of their ED experiences which may not reflect actual ED practice or behavior. -Recall was not rigorously tested. -ED observations were not undertaken to corroborate pt recall. -No statistical analysis of the tool's validity or reliability was undertaken.</p>
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Appendix C

Strength of Evidence II

Study Design	Quasi-Experimental	Non-experimental, Qualitative	Observational, Qualitative	Non-experimental, Qualitative	Literature Review	Quality Improvement	Quality Improvement
Level of Evidence Scale	(Highest) ←-----→ (Lowest)						
Evaluation Method Level (Johns Hopkins)	II	III	III	III	V	V	V
Rigor	B	A	B	B	A	A	A
Article	Suzuki et al., 2012	Roberts et al., 2018	Campbell et al., 2015	Tilus, 2002	Schulmeister, 2008	Walter & Robb, 2019	Drake et al., 2017
Strengths & Weaknesses of Study/Study Design	<p>Strengths: -Good sample size (256 RNs). -Quasi-experimental design. -Intervention & control group.</p> <p>Weaknesses: -Groups not randomized. -Increased risk for bias due to</p>	<p>Strengths: -Assessed RTL of nurses (not many of these studies). -Correlation between female RNs and those of PRN status having a higher level of self-directed RTL. -Examined RN's actual retention and</p>	<p>Strengths: -Recent (less than 5yrs old). -Provided recommendations for improved practice. -Audit tool was developed. -Observational qualitative design.</p> <p>Weaknesses:</p>	<p>Strengths: -Good sample size (12 hospitals in both rural and metropolitan areas).</p> <p>Weaknesses: - Convenience sampling. -Didn't acknowledge</p>	<p>Strengths: -Literature review. -Sited many reputable, primary sources. -Clear conclusions drawn from findings.</p> <p>Weaknesses: -Greater than 5yrs old.</p>	<p>Strengths: -Formal quality improvement. -Clear aims. -Consistent results. -Literature review. -Implications for practice.</p> <p>Weaknesses: -Times constraint (implementation</p>	<p>Strengths: -PDSA cycles used. -Process improvement design. -Good sample size (1,064 checklists audited). -Clear aims/objectives. -Literature review with search terms. -Consistent results.</p> <p>Weaknesses:</p>

	<p>units having differing degrees of interest, participation, & understanding.</p> <ul style="list-style-type: none"> -Frequency & content was not standardized; the schedule differed based on the unit. -Evaluation was done by self-reports, which RNs could under or over-report. -Some RNs were unable to attend, so dose of intervention was not assured. -Greater than 5yrs old. 	<p>application through chart reviews.</p> <p>Weaknesses:</p> <ul style="list-style-type: none"> -More BSN-prepared RNs in this setting compared to the national average, which could have skewed results. -Bias may have come from those that agreed to complete the SDLR-A questionnaire, resulting in higher RTL levels. -Study was conducted in a single facility, limiting the generalizability. -Small sample size (69). 	<p>-No limitations acknowledged.</p>	<p>any limitations</p>		<p>timeline was 8wks).</p> <ul style="list-style-type: none"> -Didn't afford the opportunity to assess knowledge retention later than 4 weeks post-intervention. 	<ul style="list-style-type: none"> -No clear definition of what constitutes a safety issue, which hindered communication. -Using AMDC may have identified more safety issues than were formally recorded.
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Appendix D

Demographic Survey Questions

Indicate your age group:

- a. 18-25
- b. 26-33
- c. 34-41
- d. 42-49
- e. 50-57
- f. 58-65
- g. >65

To which gender do you most identify?

- a. Male
- b. Female
- c. Transgender male
- d. Transgender female
- e. Gender Variant/Non-Conforming
- f. Prefer Not to Answer

How many years of nursing experience do you have?

- a. <5 years
- b. 5-10 years
- c. 11-15 years
- d. 16-20 years
- e. >20 years

What is your highest achieved level of nursing education?

- a. ADN
- b. BSN
- c. MSN
- d. DNP

Appendix E

Attitude/Perception Survey Questions

Rank the following statements on the Likert Scale provided:

	1 = Disagree	2 = Somewhat Disagree	3 = Uncertain	4 = Somewhat Agree	5 = Agree
1. I worry about the individual patient's life after hospital discharge (Tilus, 2002)					
2. I am willing to cooperate with other professionals while conducting discharge planning (Tilus, 2002)					
3. I am willing to take part in the training on discharge planning being conducted within and outside of the hospital (Tilus, 2002)					
4. Discharge planning is a usual					

topic among co-workers (Tilus, 2002)					
5. Co-workers try to tackle discharge planning positively throughout the whole unit (Tilus, 2002)					
6. I can get advice on discharge planning from my co-workers (Tilus, 2002)					
7. Co-workers are willing to collaborate on discharge planning together (Tilus, 2002)					
8. I am trying not to overlook signs indicating risk after discharge (Suzuki et al., 2012)					
9. I am striving to get information on social resources necessary for					

discharge planning (Suzuki et al., 2012)					
10. Co-workers understand everyday tasks for discharge planning (Suzuki et al., 2012)					
11. It is easy for me to talk openly with other nurses on this unit (Suzuki et al., 2012)					
12. Physicians are readily available for consultation regarding patients' discharge plans (Suzuki et al., 2012)					
13. Social workers provide information about the discharge plans of patients when I need it (Suzuki et al., 2012)					
14. Nurses have been adequately trained to be effective discharge					

planners (Suzuki et al., 2012)					
15. Nurses and physicians on this unit work hard to arrive at the best possible solution (Suzuki et al., 2012)					
16. It is the nurse's role/responsibility to initiate discharge planning (Suzuki et al., 2012)					
17. It is the nurse's role/responsibility to determine patient/family understanding of the discharge plan (Suzuki et al., 2012)					

Appendix F

Comprehension/Knowledge Survey Questions

18. Discharge planning is: (select all that apply) (Tilus, 2002)

Focused only on the physical care needs of the patient.

Teaching done regarding diet, medications, activity, wound care, and follow-up.

A process that begins with early assessment of anticipated patient care needs.

Limited to concerns about the physical transfer of the patient.

19. What are the two patient-specific identifiers that have been approved for use at this facility?

Name and date of birth

20. What is the appropriate method for confirming a patient's identifiers prior to discharge? (select all that apply)

Verbally ask the patient.

Looking at the patient's room number.

Checking the patient's armband.

21. It is considered a HIPAA law violation when a patient is sent home with discharge paperwork that have another patient's name on them.

True or False.

22. Which of the following are possible consequences that could result in the event that a nurse does not confirm at least two patient identifiers at the time of discharge? (select all that apply)

The patient goes home with incorrect discharge paperwork.

The facility is fined.

The nurse has their license suspended or revoked.