Effective Utilization of Nursing Students in a Nurse-led Heart Failure Transition of Care Clinic

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Introduction

- Free standing nurse-led Heart Failure Clinic with association to a local hospital in Wise County, Texas
- Program designed to provide follow up care to 60 days post discharge
- Focus on education, health literacy, medication reconciliation, treatment and management of symptoms

Plan

- Inclusion of 1115 waiver (currently in DVM)
- Gain alliance and partner with local hospital (completed 2012) DVM Program
- Provide a proposal with overall financial benefit clearly defined by avoiding rehospitalization payments (completed 2012)
- Support in the management cases of patients, recently discharged from the hospital with Heart Failure ensuring time and resources that are not always easy to provide away from the hospital
- Sustainability through SNHCP & community partners

Operational Plan - Student Services

- Program helps CHF patients from hospital to home
- Bridging the gap
- CHF 360 program helps patients implement on their own
- Students visit patients in pain once a week for duration of their semester
- The student spend a minimum of four five minutes in the home to a maximum of thirty minutes
- During the visit, students reinforce education about the patient’s diet, medication regimen, activity, and heart rate and blood pressure parameters
- After the visit is complete, the visit is documented and a verbal report is provided to the clinical staff

Framework

- The Chronic Care Model
- Substantial portions of chronic care take place outside of formal health delivery settings
- Patient self-management, delivery system design
- Analyzing key drivers of hospital readmissions, collaborative practices, identifying gaps in education

Value to the Healthcare System & Patient Population

- Interdisciplinary team involvement and interpersonal communication, medication reconciliation
- Involvement of pharmacists, and two-way patient and family education
- Involves teaching the patient and family about their role and responsibility in managing a condition
- Gaining an understanding of psychosocial issues affecting the patient and family

Cost Benefit

- Health promotion, prevention of illness and injury, partnership respect for diversity, advocacy and roles in Community/Public Health
- Communicate with community health clinic and interdisciplinary professionals in the community agency that serves a target population

Evaluation Plan

- Measures SON, clinic, hospital, and patient
- Sources – program participants, student nurses, clinic, SON, and program documents
- Descriptive analysis used to evaluate the program
- Implications – final meeting

Resources

- Document the recording patient information provided by Heart Failure 360 Program
- Locking document bags (1) at a cost of $35.00 each
- Purchased for the 360 Chart for documentation purposes
- Cable ties to add to the bags

Results - Students

- Students reported as “very satisfied” with the student nurse visits
- Also stated “the students reported back great information we were able to utilize for self management improvement” more then usual with our routine telephone calls
- The facility received as update on this program and the readmissions trend for care “extremely satisfied” with the level of care provided to ensure the clinic sustainability

Conclusion

- Implemented best practice of patient education, developing professional collaborative practices with school of nursing, providing ongoing presence of our staff members in the clinic
- Stated the benefits included access of training, for the healthcare system, the nursing objectives, administration of those who live in the county, students, and participants in the program