Healthcare and Nursing

[Name of the Writer]

[Name of the Institution]

**Healthcare Problem**

Heart failure readmission is one of the most critical problems that is faced by the United States. Research has highlighted that the treatment of heart problem is one of the most expensive and critical treatments, that is made more expensive because of the readmission of people who are suffering from heart disease. About half of the number of patients are readmitted in hospitals because of the same problem and so it is a serious problem that invites attention from doctors and nurses all around the globe. Under this problem, the role of patients and the hospital is questioned on the same board.

**Significance of problem**

Patient education to reduce readmittance of heart failure is a significant problem because about 25% of the patients are readmitted within 30 days of discharge from hospitals as a recovery sign for those problems. It is asserted that if people continue to be admitted with the same ratio, then there would be lesser chances of complete health recovery because medical tests should be effective enough to address heart failure from its core. Moreover, such strategies should be used that could help to cure this issue because the treatment for heart failure is very expensive. In the long run, this issue can even compromise the economy of the country.

**Current Practice**

In the present time, safety techniques like “Parent education at the time of discharge” and “healthcare management strategies” are used that can help to reduce the readmission of patients in hospitals. It is quoted that there are issues at both, patient as well as management end that causes the readmission of the patients. Usually, people have unsafe life practices; patients don’t obey the medical chart and the suggestions that are given to keep them safe from the consequences. So, special attention and instructions are given to the agents and their family members in order to make them aware of the safe practices that can help to curtail readmission in hospitals. Moreover, in a number of cases, the management of hospitals is found guilty, therefore, stress maintains healthy management of hospitals so as to avoid the readmission of patients within hospitals.

**Impact of the problem**

As the problem is multidimensional, it has multidimensional impacts. Taking into account the workplace culture, readmission of patient automaticity increases the number of absentees of the employee that make it hard for the employee to earn a living. Sometimes, the healthcare policies formulated by the workplace are also minimum because of continued health issues. The economy and the working of the company is also affected because it casts a negative impact on the working of the company as each employee plays a central role in making up the reputation of the company. It is also asserted that the other employees are also impacted because of a single employee, in terms of the policy framework, attitude towards workplace and the workload that is to be given to the other employee because of the absence of a single employee.

**Description of research articles**

Chamberlain, et al. (2017) conducted quantitative research so that they can determine the scale of readmission of the patient suffering from heart failure after they are discharged from the hospitals. It is asserted that about 5 million Americans suffer from Chronic Heart Failure, taking into account that the Medicare reimbursement for the impatient CHF has been recorded to be very high. It also promotes the establishment of certain strategies that can help to penalize the hospitals in which there are a great number of readmission of heart failure patients. Adhering to the current scrutiny of healthcare spending, a scale of RAHF was formulated that was used to predict the number of patients who are readmitted within the 30 days of discharge from the hospitals. It is found that there are some serious risks found associated with the patients as they are readmitted because by then, the problem has been maximized with other surrounding factors. As a result, the rescuer affirmed that individualized precautionary and preventive care strategies would be brought into practice so that the rate of readmission of patients can be reduced.

 Vera, et al. (2015) conducted a retrospective cohort study in order to analyze the readmission of the patient suffering from Chronic Heart Failure, adhering to the primary care organizational factors. After an in-depth analysis of the research material, the researcher found that the readmission of patients increasing over the course of time, it is one of the crucial points to address because it has the potential to question the life of patients as well as the overall framework of the progress of the country. The study found that the orientation of CHF care has specific pathways that can act as a basic tool to incorporate prime care level that is directly associated with lowering the readmission of patients in the hospitals. It is also concluded that the management of the primary care professional session after discharging patients can also be one of the major steps that can assert the management of the patient with Heart Failure.

**Description of non-research articles**

 According to the research that was conducted by Imperial College London and The British Heart Foundation, it is quoted that there are about 16% of the patients who actually die because of heart failure, taking into account that these patients die within last 28 days. It is found that the only way that can help to overcome this issue is to get clerk instructions from the doctors and take the symptoms of being well seriously. The study highlighted that there are a lot of patients who have been recovered because they took the symptoms seriously and consulted their doctors on time.

 According to the study conducted by Brent Walker, it is found that about $30.7 billion dollars are spent each year for the treatment of the patients who are suffering from different types of heart disease especially heart failure. The research study concluded that special attention should be given to the “Patient Education before and after discharge” because it is one of the ways that can help to overcome the problem. It was proposed because there is a lot of patients who die because of lack of education. The study also quoted that post-discharge appointments should be scheduled, because it will not only help the patient get clear and off the direct assistance but it will also help the patient learn what is required of him over the course of time.

**PICO Questions**

P: Which age group is the most effected population?

I: What are the possible healthcare intervention to treat the subject issue

C: What are the control measures that can help to reduce readmittance of the patient with chronic heart failure

O: What are the expected consequences of the preventive measures

“What are the possible healthcare interventions that can help to reduce the readmittance of patients with chronic heart failure of the patient of that most affected population.”.

**Evidence Matrix**

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| --- | --- | --- | --- | --- | --- | --- |
| **Author Names** | **Journal Names**  | **Research Design** | **Sample Size**  | **Outcome Variables**  | **Quality** | **Results** |
| Chamberlain, R. S., Sond, J., Mahendraraj, K., Lau, C. S. and Siracuse, B. L. | International Journal of General Medicine | Quantitative Research  | Data from State Inpatient Database | CHF readmission investigated in smaller scale clinical trials. | A | demographic and clinical factors risk stratification models such as the RAHF scale should be used to reducing overall health care expenditures of readmittance. |
| Avaldi, V. M., Lenzi, J., Castaldini, I., Urbinati, S., Di Pasquale, G., Morini, M., Protonotari, A., Maggioni, A. P. and Fantini, M. P. | Journal of Public Health  | Regression Analysis | elderly residents in the Local Health Authority of Bologna (Northern Italy) discharged with a diagnosis of HF from January to December 2010 | patient lifestyle behaviors (smoking, diet, and physical activity) | A | It is suggested that the engagement of primary care professionals starting from the early post-discharge period may be relevant in the management of patients with HF. |
| Howie-Esquivel, J., Carroll, M., Brinker, E., Kao, H., Pantilat, S., Rago, K. and De Marco, T. | Journal of Cardiac Research  | prospective cohort design with a historical comparison group | Consecutive patients who were 65 years and older, admitted to the cardiology and medical services and had a primary or secondary diagnosis of HF. | Group baseline characteristics such as (19% usual care vs. 12% for the intervention respectively (P = 0.003) | A | A very high cost is associated with the readmission of patients.  |
| Pacho, C., Domingo, M., Núñez, R., Lupón, J., Moliner, P., de Antonio, M., González, B., Santesmases, J., Vela, E., Tor, J. and Bayes-Genis, A. | *Revista Española De Cardiología (English Edition)*,  | Qualitative Research  | STOP-HF-Clinic Referral Area (∼250000 people) with that of the rest of the Catalan Health Service (CatSalut) (∼7.5 million people) | 518 consecutive patients were included (age, 82 years; Barthel score, 70; Charlson index, 5.6, CORE-HF 30-day readmission risk, 26.5%) | A | The STOP-HF-Clinic, an approach that could be promptly implemented elsewhere, is a valuable intervention for reducing the global burden of early readmissions among elder and vulnerable patients with HF. |
| Kociol, MD; Eric D. Peterson, MD, MPH; Bradley G. Hammill, MS; Kathryn E. Flynn, PhD; Paul A. Heidenreich, MD; Ileana L. Piña, MD, MPH; Barbara L. Lytle, MS; Nancy M. Albert, RN, PhD; Lesley H. Curtis, PhD; Gregg C. Fonarow, MD; Adrian F. Hernandez, MD, MHS | Aha Journals | Qualitative Research  | GWTG-HF registry | a semi-structured focus group, with 3 sites identified as leading performers on the basis of 30-day readmission data among GWTG-HF participating centers. | A | Hospitals’ use of inpatient care processes, discharge processes, and quality improvement methodologies for patients hospitalized with heart failure varies widely. |

**Recommended Practice Change**

It is recommended that patients should be taught about safety measures that can help them to stay healthy. The patient study was used to address the issue of readmittance of patients. (Pacho, et al. 2017). Financial penalty assessment is used to reduce the risk of readmittance of patients (Kripalani, et al. 2014). Care domains and patient education were used to analyze the readmittance of the patients (Kociol, et al. 2017). RAHF scale was used to learn about the techniques of readmittance for the patients (Chamberlain, et al. 2018). Organizational factors were used to study the prevention strategies for reducing the readmittance of patients (Avaldi, et al. 2015). Teaching patients was used as a preventive measure that can help to reduce the readmittance of the patients (Howie-Esquivel, et al. 2015).

**Key Stakeholders**

There are several key stakeholders that are directly or indirectly associated with the issue. The major stakeholders are, management staff of the hospitals, Head nurse and family of the patients. Head nurse will ensure the provision of the required services, management staff will collaborate with the family so that required aims can be achieved.

**Barriers**

One of the major barriers in addressing the issue is education. Lack of education and lack of training and instructions from the doctors and the nurses is one of the significant barriers in bringing about the required change. Sometimes, there is a very bleak and insufficient approach because of the workload of nurses which lead to the sufferings of the patients.

**Strategies for Barriers**

Training is one of the strategies that can be used to address the barrier because nurses should be trained in such a way that they can help to train patient during his stay or visit to the hospital

Public awareness is another way that can help to overcome the barriers of education because if the issue goes public, then there would be more stress towards the undertaking of the issue leading to a safe and healthy lifestyle.

**Indicators for Measuring Outcomes**

There are several indicators that can be used to address the issue. The number of readmittance of the patients is one of the indicators that would act as a tool to measure if the set outcomes are achieved or not.

**References**

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