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Quality Improvement Activity: Being sent home too early.

A 35-year-old male come in to have a prostatectomy. A nurse receives hand off from a PACU nurse who informs her he has maxed out on pain medication. He has an indwelling catheter that he will be sent home with. The nurse also informs her that the doctor wants the patient to go home today. She lets her know that the patients pain has not been managed and the patient is nervous to go home with a catheter. The nurse looks at the doctors requirements for the patient to go home and sees the only requirement is for the patient to be able to sit up. The nurse knows that since COVID a lot of the doctors are trying to make more space in the hospital and that major surgeries like this one were being sent home when in the past they would be admitted in the hospital for recovery. The nurse waits thirty minutes and gets the patient up and standing she waits another ten minutes to see how the patient tolerated getting up. The patient asked the nurse if the pain medication they receive at home be just as good as the pain medication they have been giving him in his IVs? The patient has been receiving fentanyl through their IV access but will be sent home with acetaminophen/hydrocodone. The nurse informs him that the pain medicine he is receiving right now is a stronger version than the one he will be sent home with. She asks him on a scale of 0-10 how would he describe his pain at the moment? She had just given his IV pain medication about fifteen minutes prior. The patient says it is a 3/10. The patient is sent home with pain medication. The patient goes home and is in an unbearable amount of pain. The patient's wife calls the physician's office and informs him that the patient is in an extreme amount of pain and his blood pressure has increased since coming home to 140/90. She lets him know that he has a fever of 102F and there has not been any urine drainage into the Foley catheter since they came home. The doctor tells the wife to bring her husband back to the hospital. He is readmitted and evaluated his blood pressure is 160/95, temperature of 102F, pulse 102, and respiration of 22. He is admitted to the hospital and IV access is placed and IV pain medication is restarted and about thirty minutes after his vitals were stabilized and his pain was a 4/10. Since the patient left and had to be readmitted the hospital does not get paid for the readmission and loses money.

Describes the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In the scenario above, patient's care is not centered around the patient it is centered around just getting the patient home that day. The patient was clearly showing signs of pain and should not have been sent home when pain was expected to be more than what the patient could manage on their own. The nurse just went by the criteria that the doctor set due to the doctors changing the requirement due to COVID and making more room in the hospital. This has become more common since COVID patients being sent home after major surgeries that would usually require hospital admission due to our lack of bed capacity. This puts our patients at risk for infections, readmission, pain and could result in a death of a patient if bleeding had occurred.

What circumstances led to the occurrence?

I believe the circumstance that led to this occurrence were actually two thing the nurse not using her. own critical judgement to advocate for the patient also her lack of teaching to the patient and family. Also, the physician was not worried about the patient at hand but more concerned about taking up space in the hospital. Yes, COVID was a massive thing and we had to make sacrifices to make room to take care of everyone, but I believe that does not mean we should not give quality care that we have strived to do. Every patient matters and should be given the same care.

In what way could you measure the frequency of the occurrence?

I believe the way to measure these occurrences is analyzing readmission and seeing how many of them could have been prevented. Doing this, we can see the need for better patient education or a need for better patient care during the initial hospitalization so that there is no need for readmission. Not all readmission is due to problems that could have been prevented. If a patient leaves the hospital after surgery and is in a car accident due to a drunk driver. That is something we could not have prevented but if the patient went home without proper education on how to care for their incision and it gets infected, and they are readmitted that is something as a nurse we could have prevented. If we can go through readmissions and see how many could have been prevented, then we would see the frequency of being sent home too early without proper education or care could cause readmission to the hospital.

What evidence based idea do you have for implementing interventions to address the problem?

A good evidence-based idea to address the problem would be better patient education. If our patients have to have major surgeries, we should never lie to them and tell them they will not be in pain when we know they will be. We should be the ones to tell them yes, it is going to hurt but I am going to do everything I can to keep the pain tolerable and low as possible. A lot of times I have seen doctors come in before procedures and really sugarcoat what is about to happen and the patient has no idea what to really expect or what's about to happen. Then they come to post op in so much pain and distress. I believe being up front with them will help them prepare better for recovery. Also, when we discharge them let them know you're going to have some pain and discomfort or even depending on their surgery bleeding. It is normal cause if we do not educate them, they will come back because they do not know it is a normal post op effect. Another intervention that could address the problem is a better discharge protocol. Yes, I know doctors set the protocol for discharge, but nurses should be better educated on risk factors that could cause readmission from being sent home early. I think if we cover all the risks like pain management, bleeding, voiding before discharge, ambulating and education it is shown there is less readmission from early discharge. Nurses must listen to what doctors say but that does not mean they do not have a voice to advocate for the patients that what we are here for. The patient cannot see something is wrong so it's up to us to point out what we think should happen; at least we know we tried everything we could for our patient.

How will you measure the efficacy of the intervention?
Just like when we measured the occurrence of this problem we go back and compare every month or couple months and see if there is lower readmission from early discharge. That is the best way to see if our interventions are working, let the statistics show it. It is also a way to encourage nurses to keep it up if they set goals to make it go down then they will improve and try to produce new interventions to make the improvements. Change takes everyone to make it happen so it's our responsibility to make sure we are doing our part so that our patients do not have to suffer.