

Implementing the IDEAL Discharge

Step 2: Creating Your Implementation Strategy



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Implementation Step 2: AHRQ IDEAL Discharge Planning Implementation Handbook

Strategy 4: IDEAL Discharge Planning (Implementation Handbook)



Care Transitions from
Hospital to Home:
IDEAL Discharge Planning
Implementation Handbook

Goal Setting

- ✓ **Specific**
- ✓ **Measurable**
- ✓ **Attainable**
- ✓ **Relevant**
- ✓ **Time-based**

Examples:

- “Two units implemented the selected IDEAL Discharge Planning tools within six months.”
- “Have two tools from the AHRQ IDEAL Discharge implemented in three units within six months.”

Key Elements

1. Adapt for your facility

- Select specific elements
- Obtain input from clinicians, staff, patient and family advisors
- Clarify roles and responsibilities and approvals needed

2. Decide how to adopt in your facility











- Brand materials with your facility logo
- Identify key roles and responsibilities
- Determine if the selected tool will replace an existing tool or be integrated into current tools or processes

3. Plan clinical training

- Identify respected facilitators
- Identify patient and family advisors to help conduct or facilitate the training
- Determine the number and schedule of the trainings

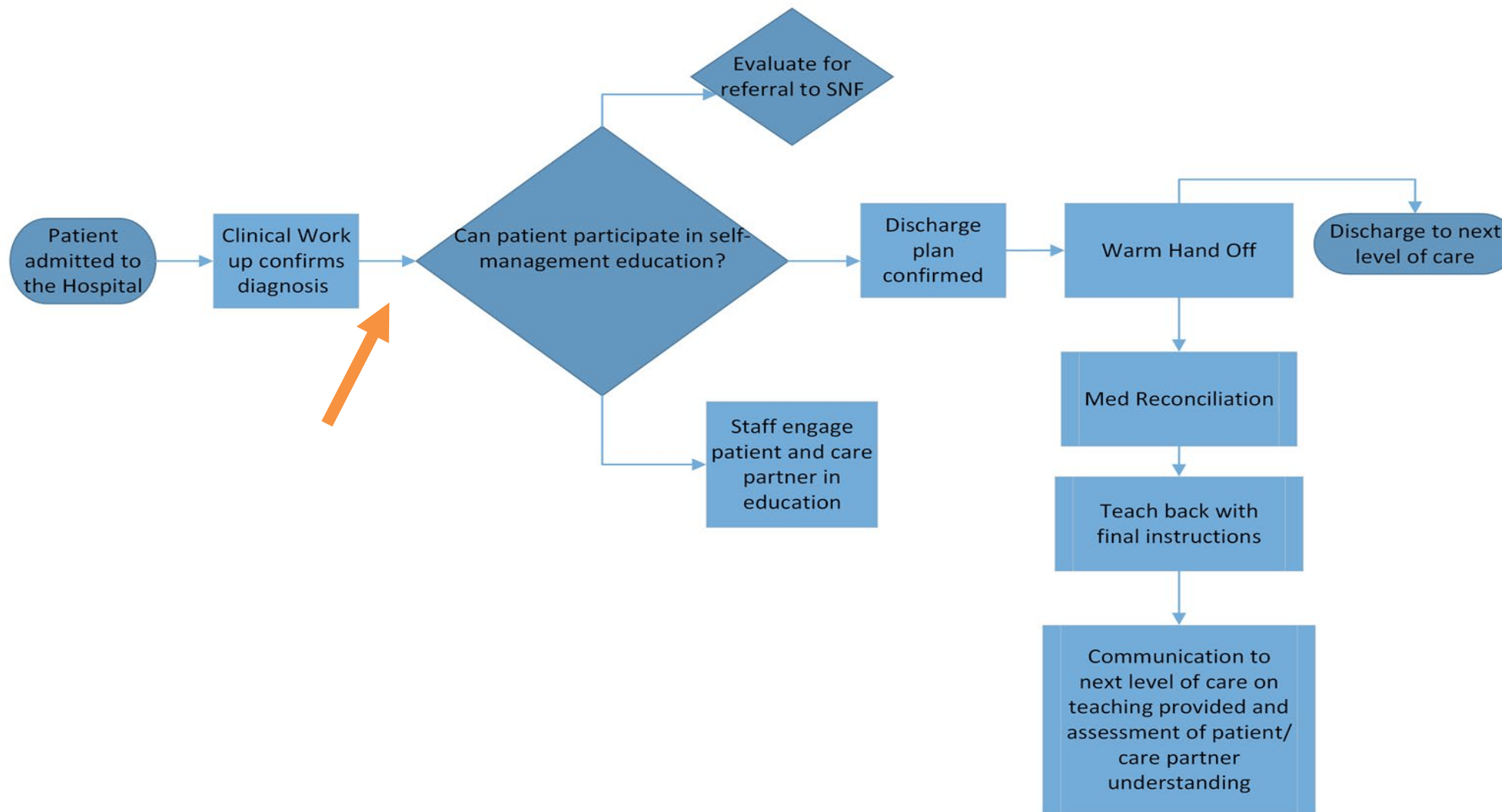
[AHRQ IDEAL Discharge Tools](#)

Tools for this strategy include --

1. IDEAL Discharge Planning Overview, Process, and Checklist -- Handout that gives an overview of the IDEAL Discharge Planning process and includes a checklist that could be completed for each patient.
[ [Microsoft Word version](#) - 720.52 KB ;  [PDF version](#) - 188.59 KB]
2. Be Prepared to Go Home Checklist and Booklet
 - a. Checklist highlights what the patient and family need to know before leaving the hospital and gives examples of questions they can ask. Note: The Word document uses hidden text. To see the text, go to Word Options, select Display, and choose the Hidden text box.
[ [Microsoft Word version](#) - 1.2 MB  [PDF version](#) - 159.66 KB]
 - b. Booklet contains the checklist plus additional space for writing information. Note: The Word document uses hidden text. To see the text, go to Word Options, select Display, and choose the Hidden text box.
[ [Microsoft Word version](#) - 511.84 KB  [PDF version](#) - 254.71 KB]
3. Improving Discharge Outcomes with Patients and Families -- Handout for clinicians that describes the new discharge planning process.
[ [Microsoft Word version](#) - 689.85 KB ;  [PDF version](#) - 104.82 KB]
4. Care Transitions from Hospital to Home: IDEAL Discharge Planning Training -- PowerPoint presentation to train clinicians and hospital staff to support the efforts of patient and family engagement related to discharge planning.
[ [Microsoft PowerPoint version](#) - 229.13 KB ;  [PDF version](#) - 218.92 KB]

Users can download materials in zipped format by selecting: <http://www.ahrq.gov/downloads/patfamilyengageguide/strategy4zipfiles.zip>; 14.24 MB.

Sample high level flow chart



IDEAL Discharge Planning Tools

Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist informs all clinicians about the new discharge planning process and keeps track of when tasks are accomplished.

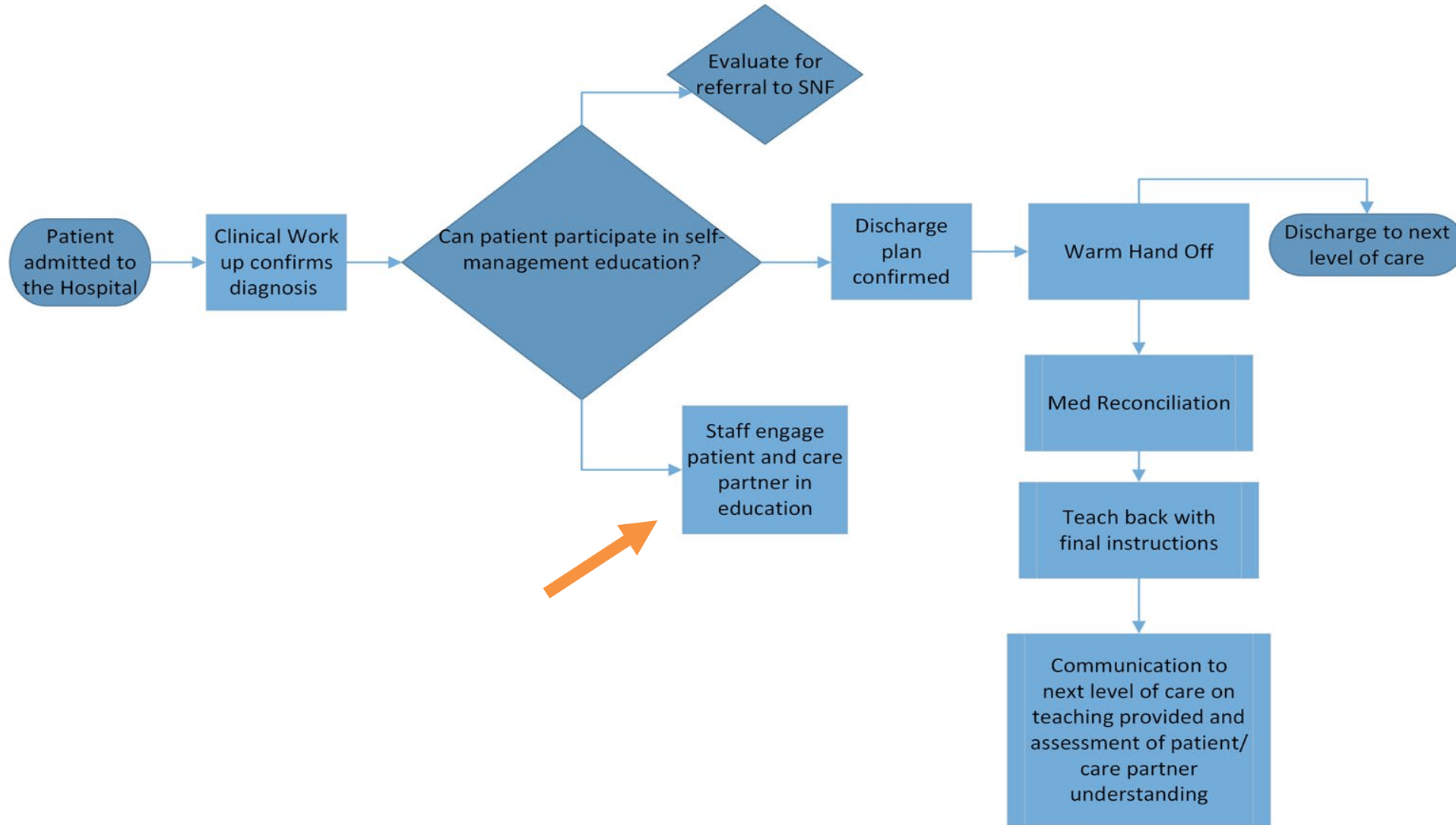
IDEAL Discharge Planning Checklist

Fill in, initial, and date next to each task as completed.

Patient Name: _____

Initial Nursing Assessment	Prior to Discharge Planning Meeting	During Discharge Planning Meeting	Day of Discharge
<p>_____ Identified the caregiver at home and backups</p> <p>_____ Told patient and family about white board</p> <p>_____ Elicited patient and family goals for hospital stay</p> <p>_____ Informed patient and family about steps to discharge</p>	<p>_____ Distributed checklist and booklet to patient and family with explanation</p> <p>_____ Scheduled discharge planning meeting</p> <p>Scheduled for _____ / ____ / _____ at _____ [time]</p>	<p>_____ Discussed patient questions</p> <p>_____ Discussed family questions</p> <p>_____ Reviewed discharge instructions as needed</p> <p>_____ Used Teach Back</p> <p>_____ Offered to schedule followup appointments with providers. Preferred dates / times for: _____</p> <p>PCP: _____</p> <p>Other: _____</p>	<p>Medication</p> <p>_____ Reconciled medication list</p> <p>_____ Reviewed medication list with patient and family and used teach back</p> <p>Appointments and contact information</p> <p>_____ Scheduled followup appointments:</p> <p>1) With _____ on _____ / ____ / ____ at _____ [time]</p> <p>2) With _____ on _____ / ____ / ____ at _____ [time]</p> <p>_____ Arranged any home care needed</p> <p>_____ Wrote down and gave appointments to the patient and family</p> <p>_____ Wrote down and gave contact information for followup person after discharge</p>

Sample high level flow chart



IDEAL Discharge Planning Tools

I know about other help I need at home.

You may need other help at home. Or, you may be fine on your own. We will set up nursing care, therapy, or other help if you need it. Family or friends can also help. Ask your doctor or nurse how others can help you recover.

Ask:

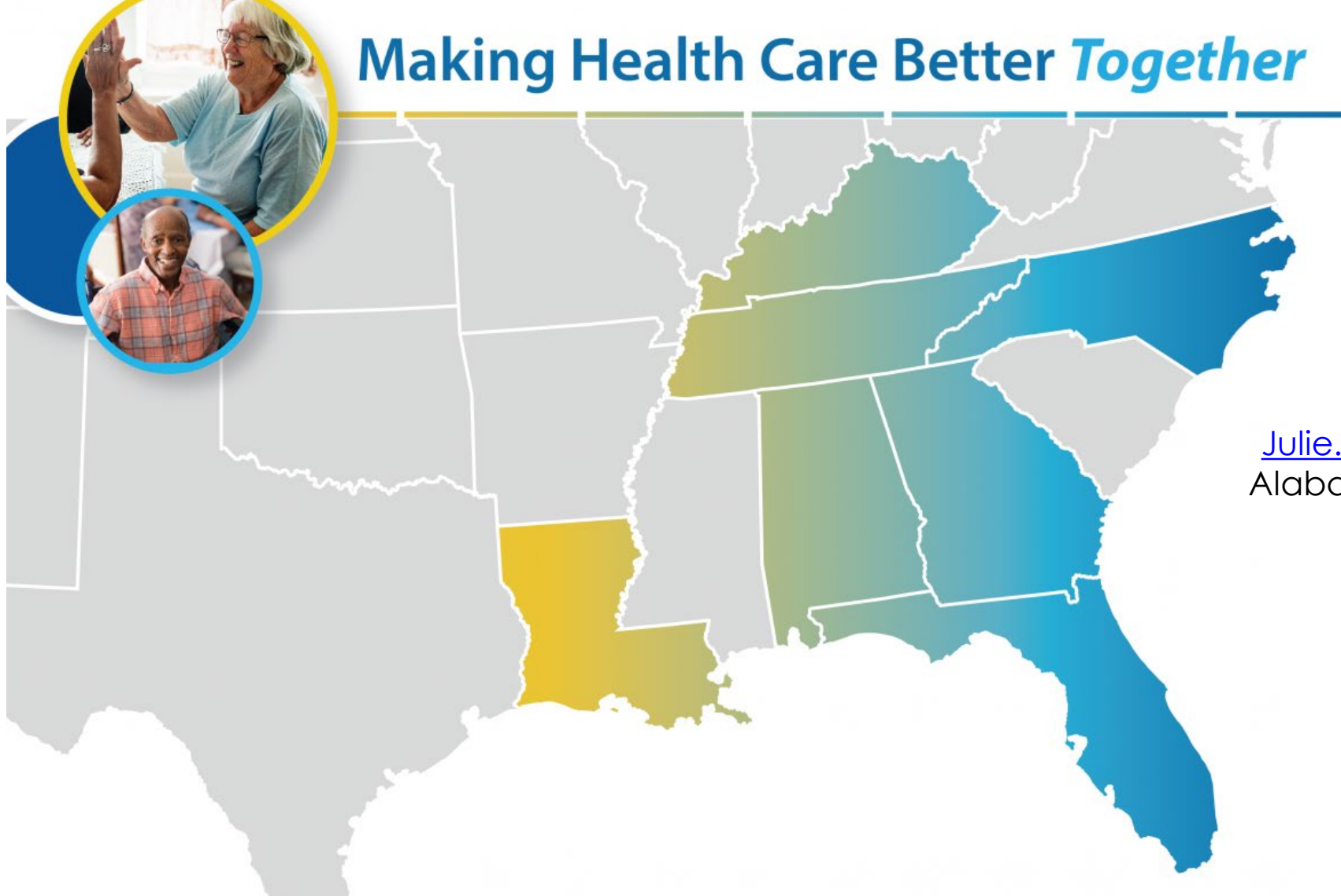
- When I get home, what kind of help or care will I need? Should someone be with me all the time?
- Will I need nursing care for taking my medicines or taking care of cuts or wounds? For how long? Who pays for it?
- Will I need physical or occupational therapy for help with exercises or relearning how to do things? For how long? Who pays for it?
- Will I need help with eating, bathing, or going to the bathroom? For how long? Who pays for it?
- Will I need any equipment, such as crutches or oxygen? Where do I get it? Who pays for it? How do I use it?
- How can friends or family members help me at home?

Use this space to write any information you need:

Tool 2a and 2b: Be Prepared to Go Home Checklist and Booklet are companion pieces that help the patient and family identify questions and concerns about going home.



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