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Enhancing Transitional Care Outcomes For High-Risk Heart Failure Patients: A Liaison Nurse–Led Quality Improvement Initiative

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Abstract
Heart failure (HF) is a long-term illness that costs healthcare systems a lot of money because it leads to high rates of readmissions, treatment fragmentation, and bad outcomes. Liaison nurses are mostly responsible for making sure that care is passed on smoothly. There are still gaps in coordination, especially for patients who are at high risk of HF. This quality improvement (QI) program's goal is to make it easier for people from different fields to talk to each other. Also, a liaison nurse-led intervention should be put in place to make discharge processes more consistent and improve the flow of care. Using Lewin's Change Theory and the Model for Improvement. The main goals of the effort are to set up organized follow-up coordination after discharge, standardize communication channels, and plan discharge education. The clinical microsystem's baseline data showed that there was inconsistent follow-up within 7 days of discharge and a 28% readmission rate within 30 days. By using PDSA cycles and strategies that are backed by evidence. The initiative's goals are to cut down on remissions by 20% over six months and improve prompt follow-up by 85%. This study emphasized the implications for practice and leadership, alongside the problem's context and evidence synthesis. It also talked about how the intervention was designed, how possible it was, and what it meant. The program's main goals are to improve health quality and equity and to help nurses improve their liaison nursing skills.

Keywords: Heart failure, liaison nursing, transitions of care, quality improvement, care coordination.

Introduction

Purpose and Scope of the Review

This paper examines the challenges and possible solutions related to care coordination for high-risk heart failure patients transitioning from inpatient to outpatient treatment, with a focus on liaison nurse-led initiatives. They are particularly vulnerable to delayed follow-up, inadequate discharge planning, and disjointed communication, rendering effective transitions of care essential for this demographic. Most people agree that good transitional care must include better communication between different fields, standardized discharge education, and quick follow-up after discharge. Evidence-based coordination tools and well-organized follow-up procedures can help with patient self-management, continuity of care, and 30-day readmission rates. This analysis also stresses how important liaison nurses are for improving patient-centered outcomes, safety, and the quality of heart failure care transitions.

Patient Population

Adults at elevated risk for readmission resulting from heart failure constitute the demographic most affected by inadequate care transitions. Most of the people in this group are older adults who have been in the hospital a lot, take a lot of medications, don't get enough social support, and have a lot of other health problems at the same time. These patients are more likely to have complications and readmissions that could have been avoided because of how often care transitions are not smooth and discharge planning is not consistent. It is important to understand the many needs of this group of people when creating and evaluating transitional care programs (Pedersen et al., 2017).

Healthcare Professionals Involved

A multidisciplinary team, which may include cardiologists, bedside nurses, pharmacists, case managers, social workers, and liaison nurses, is usually in charge of coordinating the care of heart failure patients who are at high risk. Liaison nurses help with important parts of care coordination, such as planning for discharge, communicating between care settings, and following up after discharge. Social workers and case managers deal with things like social determinants of health, scheduling follow-ups, and making sure medications are correct. Pharmacists help with patient education and these other tasks. Primary care doctors and cardiologists work together on treatment plans and continuity of care so that patients can move smoothly and safely from the hospital to their homes (Sokos et al., 2023).

Care Processes

For high-risk heart failure patients, transitional care processes that are very important are interdisciplinary care planning, liaison nurse-led discharge coordination, and early identification of patients who are at a higher risk of readmission. Discharge planning usually includes standardized education, making sure that medications are correct, setting up organized communication with outpatient doctors, scheduling appointments before discharge, and following up after discharge to reinforce education and keep an eye on symptoms. Following these rules all the time helps keep care consistent and lowers the risk of readmissions that could have been avoided (Liu et al., 2023).

Patterns in Current Practice

Even though they are based on well-known best practices, the current patterns of care transition are not always the same. Follow-up appointments soon after discharge are often pushed back, communication between primary and specialized care providers is not always reliable, and education about discharge is often inconsistent. Also, different professions have different standards for documentation, which makes care transitions less smooth and makes it harder to share information. These differences make transitional care programs less effective, and they hurt patients who are at high risk of heart failure the most (Schnipper et al., 2019).

Quality and Safety Gap

There are still clear gaps in quality and safety when it comes to the transition of care for high-risk heart failure patients, even when liaison nurses are there. According to internal baseline data, the 30-day readmission rate was 28%, which is higher than the national average of about 21%. Also, only 60% of heart failure patients get the right discharge instructions, and only 52% of those at high risk have recorded follow-up within seven days of being released. These problems lead to unnecessary hospital readmissions, uncontrolled symptoms, medication errors, and poor treatment adherence. Overall, these results show how important it is to have a standardized, organized way to coordinate care led by liaison nurses in order to improve quality and patient safety (Feltner et al., 2014).

Stakeholder Considerations

Care coordination outcomes for high-risk heart failure patients affect many people, both directly and indirectly. This group includes cardiologists, primary care doctors, social workers, pharmacists, case managers, patients, and their caregivers. The hospital's administration, quality improvement teams, and IT staff also need to provide important things like governance, resources, and documentation infrastructure. To improve care coordination, make sure safe transitions, and cut down on readmissions that could have been avoided, it is important for different groups to work together well (Sokos et al., 2023).

Significance to Liaison Nursing Practice

The research that was looked at stresses how important liaison nursing is for helping high-risk heart failure patients move from one type of care to another. Liaison nurses are the best at coordinating communication between different disciplines, leading standardized discharge planning, and helping with follow-up care after discharge. By doing these things, liaison nurses make patients safer, help them manage their own care, and make sure that care continues. This review emphasizes the significance of evidence-based practice, enhances the competencies of core liaison nursing, and demonstrates how nurse-led coordination can elevate patient outcomes and system efficiency (Glogowska et al., 2015).

Literature review & evidence synthesis

Heart failure (HF) has several symptoms and possible causes. This makes it harder for nurses to care for teens and kids. Pediatric heart failure nurses do more than just care for patients at work. But they also teach and guide people who take care of others. Which is important for getting good results. The main goal of nursing care is to make sure that clinical results are the same in both inpatient and outpatient settings. By researching and putting into practice different ways to treat patients. Nurses possess the capacity to improve patients' lives, diminish their reliance on hospitals, and elevate their chances of survival (Hill et al., 2024).

Causes, and prevalence

Heart failure is a significant public health issue affecting 1%–3% of the global adult population, with approximately 6.7 million adults over 20 years old currently diagnosed. The condition arises from structural or functional heart abnormalities, severely impairing its ability to pump blood. Key causes include ischemic heart disease, myocardial infarction, hypertension leading to ventricular dysfunction, and various cardiomyopathies. Additional risk factors include obesity, chronic kidney disease, smoking, and age, often leading to a multifactorial presentation involving cardiovascular diseases and lifestyle influences (Golla and Shams., 2024).

Basic ideas in nursing theory

Nursing care for adults with heart failure is based on several theoretical frameworks that emphasize self-care, patient education, and holistic care. Orem’s Self-Care Deficit Theory underlines the nurse's role in assisting patients with medication adherence and daily self-monitoring, including weight tracking and dietary control. Adult learning theory suggests that effective education should be relevant and build on prior experiences. Additionally, the Chronic Care Model highlights the necessity of coordinated, interdisciplinary care and the active involvement of patients, aiming to improve outcomes in chronic conditions like heart failure. These frameworks collectively inform nursing interventions that facilitate effective care transitions and enhance self-management, ultimately reducing preventable hospital readmissions (Williams., 2015).

Nurses' evaluation for nurses

Nurses’ evaluation of adult patients with heart failure focuses on ongoing assessment of cardiovascular status, symptom severity, and functional capacity. Key elements include monitoring vital signs, fluid balance, weight changes, edema, dyspnea, fatigue, and response to therapy. As well as assessing comorbid conditions, medication adherence, and psychosocial factors. Continuous nursing assessment enables early identification of deterioration, supports timely interventions. Also promotes safe transitions of care (Fraser et al., 2024).

Nursing assessments

Nursing assessments for adult patients with heart failure focus on comprehensive evaluation of cardiovascular status, fluid balance, and functional capacity. Key components include monitoring vital signs, daily weight, intake and output, peripheral edema, lung sounds, dyspnea, fatigue, and oxygen saturation. As well as assessing response to medications. Nurses also evaluate comorbid conditions, medication adherence, nutritional status, psychosocial factors, and patients’ understanding of self-care. Ongoing assessment supports early detection of deterioration, timely intervention, and safe transitions of care (Ernstmeyer, and Christman., 2021).

Nursing education and interventions

Nursing education and interventions for adult patients with heart failure focus on improving self-management, preventing symptom exacerbation, and promoting safe transitions of care. Core interventions involve individualized education on medication adherence, low-sodium diet, fluid management, daily weight monitoring, physical activity, and recognition of early warning signs. Nurses also perform medication reconciliation, reinforce education using teach-back methods, and coordinate follow-up care with interdisciplinary teams. Nurse-led interventions, involving discharge planning, telephonic follow-up, and care coordination. They have been shown to reduce readmissions and improve patient outcomes (Jaarsma et al., 2021).

Health and active participation in treatment

Health and active participation in treatment are essential components of effective heart failure management in adults. Patients are encouraged to take an active role in self-care by adhering to medications, monitoring daily weight and symptoms. Following dietary and fluid recommendations and attending scheduled follow-up visits. Nurses support patient engagement through education tailored to health literacy. Also, use of teach-back techniques, and involvement of caregivers when appropriate. Active patient participation enhances symptom recognition, treatment adherence, quality of life, and minimizes the risk of preventable hospital readmissions (Kitsiou et al., 2021).

Things that make healthcare less efficient

Several factors diminish the care efficiency for adults with heart failure (HF), including poor care coordination, inconsistent discharge education, limited health literacy, and inadequate provider communication. Patient barriers like medication nonadherence, cognitive impairment, anxiety, and insufficient social support complicate care further. System-level issues, such as time constraints and fragmented documentation, can lead to unmanaged symptoms, increased emergency visits, and hospital readmissions. Patients often face challenges with self-care due to low health literacy and mental health conditions, which negatively affect motivation and adherence to therapies. The progression of HF necessitates early discussions surrounding hospice and palliative care to improve quality of life. The 2022 AHA/ACC/HFSA guidelines advocate for the integration of palliative care in ongoing HF treatment, although hospice care remains underutilized among eligible patients (Sumaqa et al., 2023 and Biddle et al., 2020).

Thematic Synthesis

Theme 1: Evidence-Based Interventions to Improve Heart Failure Transitions

Research shows that planned discharge and transition therapies can greatly improve the outcomes of patients with heart failure. Telemonitoring, early outpatient follow-up within seven days, standardized release protocols, and nurse-led transitional care programs are all important steps. The plan also includes a full medication reconciliation. These evidence-based strategies that encourage continuity of treatment will lead to less clinical deterioration and fewer hospital readmissions (Schnipper et al., 2019).

Theme 2: Barriers and Facilitators to Effective Transitions

Some of the things that make it hard for people to transition to heart failure are inconsistent paperwork, low caregiver engagement, non-standardized practices, and poor communication between healthcare professionals. Digital tools that make communication and care coordination better, patient-centered education, and interdisciplinary team rounds are all examples of things that help. We need to deal with these issues if we want better patient outcomes and smoother transitions (Li et al., 2021).

Theme 3: Outcome Measures in Similar Initiatives

In previous quality improvement projects, people have often looked at things like 30-day readmission rates, how well patients kept their follow-up appointments, how much they knew about self-care, how often their prescriptions were wrong, and how happy patients were. These metrics help us choose the outcomes for the ongoing quality improvement project and give us a full picture of how well the shift worked (McCormack et al., 2013).

Theme 4: Sustainability and Long-Term Effectiveness

To make heart failure transitions better over time, it's important to include defined processes in regular workflows, keep an eye on performance, support leadership, and teach staff. The most important thing for these practices to work in the long run is to make them part of the company's culture and hold everyone accountable through regular reviews (Open Resources for Nursing., 2024).

Theoretical Framework and Quality Improvement Methodology

Quality Improvement Model: Model for Improvement

The Model for Improvement was chosen to guide this effort. This framework is based on three main ideas: figuring out the project's goal, setting success metrics, and making a list of possible course corrections. The model's iterative Plan-Do-Study-Act (PDSA) cycles make it possible to keep testing, improving, and optimizing interventions (Adams., 2018).

Change Theory: Lewin's Change Theory

Lewin's transformation Theory is another way to manage changes in an organization. The unfreezing stage creates urgency by showing care gaps using baseline performance data. During the transition phase, workflows are organized and standardized tools are put in place. To keep things going, successful methods should be used every day during the refreezing stage (Majka., 2024).

Application to the Initiative

These frameworks can help with the implementation, evaluation, and long-term planning of the quality improvement initiative's changes. They work together to provide a structured, data-driven approach. This program's goal is to cut readmissions within 30 days by 20% and raise the percentage of patients who complete their seven-day follow-up visits after being discharged to 85% within six months. To reach these goals, a care coordination plan led by a liaison nurse will be put into place (Elsener et al., 2023).

Intervention Description

The intervention is made up of many parts that work together. The standardized heart failure discharge checklist that liaison nurses will give patients will include a review of medications, warning signs of symptoms, daily weight checks, and dietary advice. An SBAR-formatted structured interdisciplinary communication pathway is being made to help with safe handoffs and automatically let primary care doctors and heart failure clinics know. As part of the follow-up scheduling process before release, liaison nurses will check on transportation needs and set up appointments for seven days. Within 48 hours of release, a phone call will also be made to check on symptoms, reinforce instructions, and make sure that prescription drugs are available (Abd Elaty et al., 2021).

Implementation Plan

The first month is for training staff and finishing the tools. The second month is for pilot testing using an initial PDSA cycle. The third and fourth months are for full implementation, and the fifth and sixth months are for review and improvement. Liaison nurses will lead the project, with help from pharmacists who will check medications, case managers and social workers who will handle logistics, and IT professionals who will make templates for documentation. Weekly team huddles, monthly meetings to improve quality, and leadership briefings will all help keep everyone up to date. The training sessions will cover things like how to consistently educate patients, how to use SBAR communication, and how to set up follow-up protocols (Abuzied et al., 2023).

Outcome Measures

The percentage of patients who get the standardized discharge checklist and the percentage of patients who have their follow-up visits scheduled before they leave will both be looked at as process measures. Outcomes will be measured by how many patients were readmitted within 30 days, how many follow-up visits were completed within seven days, and how well patients said they understood heart failure care. We will keep an eye on things like how much work staff has to do and how long it takes to teach people about discharge to make sure that changes don't have any unexpected effects (Patra et al., 2020).

Risk Assessment and Mitigation

There are many risks, such as patients not following through, paperwork that isn't reliable, time limits, and staff resistance. Specialized training, support from upper management, easier-to-use resources, standardized electronic health record (EHR) forms, personalized patient education, and caregiver involvement are all ways to lower risks (Holmes et al., 2021).

Feasibility and Sustainability Analysis

Feasibility

The program is possible because it uses current staff and moves around the time of the liaison nurse as needed. Low budgets are mostly needed for training, printing, and updating IT templates. The organization is ready because lowering readmissions is one of its top priorities. Leadership involvement and clear protocols are important factors that help, while competing goals and workflow interruptions are potential barriers (Cruz., 2020).

Sustainability

The initiative will be more likely to last if it is linked to existing hospital heart failure management programs, heart failure outcomes are checked every three months, competency-based training is given once a year, and the discharge checklist and SBAR tools are added to the electronic health record. This effort improves clinical practice by making transitions safer for patients, encouraging them to participate, and making sure they get the same level of care throughout. Using systems thinking and working with people from different fields are signs of good leadership. This makes liaison nurses better at transitional care. The program helps patients who are at risk get the follow-up care they need, which is a step toward health equity. Standardized discharge paths are being worked on, and they fit with the national goal of lowering the number of people who have to go back to the hospital for heart failure (Xu et al., 2023).

Conclusion

Heart failure is still hard and complicated. To avoid problems and having to go back to the hospital, treatment needs to be organized and focused on the patient. Liaison nurses are an important part of this quality improvement project because they standardize discharge procedures, improve communication between different departments, and make sure that high-risk heart failure patients get timely follow-up care after they leave the hospital. All of these things make the transitions of care stronger. By fixing the problems that already exist with quality and safety. The suggested approach could help improve patient involvement, self-management, and clinical results. By using these evidence-based principles in everyday work, you can constantly improve quality, safety, and efficiency. Even while it stresses how important liaison nursing is in modern heart failure treatment.

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