

Week 2: Discussion | Evidence-Based Interventions to Address Gaps in Practice

In order to improve patient outcomes, it is necessary to take into account an evidence-based intervention that involves implementing a standardized interdisciplinary care protocol for the swing bed program in Critical Access Hospitals (CAHs) at Doctors Memorial Hospital. According to the findings of the literature search, this offers a successful DNP project that will raise the standard of the hospital's current swing bed program. According to the data, the swing bed program's implementation of a standardized interdisciplinary care protocol may contribute to increased hospital efficiency and better patient outcomes (Leung et al., 2020). By increasing the efficacy of its swing bed program, Doctors Memorial Hospital will incorporate steps to enhance the safety and quality of care. To guarantee that patients who fulfill the requirements for medical stability and rehabilitation move into the swing bed program, the suggested intervention will employ explicit admission criteria. A multidisciplinary team will also be involved in the intervention to create and carry out individualized care plans.

A swing bed is a section of an acute care hospital where patients are cared for by qualified nurses. Following surgery, a sickness, or an injury, this treatment gives patients more time to recuperate from medical or surgical interventions. In order to help swing bed patients become as independent as possible before being discharged, they have better access to high-quality nursing care and therapy. Leung et al.'s (2020) evidence-based study examined the use of swing beds for post-acute care in the population's health care transition. 2019 saw the implementation of this strategy at Ste. Genevieve County Memorial Hospital. The multidisciplinary team that managed each patient's care needs to enable a return to their previous level of functioning was the main focus of the quality improvement initiative. In order to determine readmission risk, the intervention entailed creating a quantitative high-risk screening tool for patients upon admission. Depending on skilled criteria, social need, and acuity, case management teams worked with transition patients, and high-risk patients were assigned to home referrals and received additional discharge community assistance. The findings indicated that the variance in the measure evidence for high-quality care has decreased. Compared to traditional standards, which had an average of 21% of patients encountering readmission, just 4% of patients under transitional care programs experienced readmission. Furthermore, research revealed that 75% of patients admitted to transitional care went home sooner, with patients being released in 10 days as opposed to the 3 weeks they had previously spent in regular care.

McGilton et al. (2021) looked into the use of programs for transitional care. Programs for transitional care were designed to enhance low-intensity restorative care for senior citizens who were at a high risk of experiencing a delayed release. Using the PRISMA-ScR checklist, a scoping review of evidence-based studies was carried out. According to the study's findings, patients admitted to TCPs had better treatment outcomes and shorter hospital stays.

Like Leung et al. (2020), McGilton et al. (2021) discovered that using transitional care programs improved outcomes and reduced length of stay. Han et al. (2022) looked at the impact of hospital stay duration on patient outcomes in another study. A single-center study with 32,270 participants examined the impact of a shorter hospital stay. The results showed that positive post-discharge outcomes, such as early readmission and mortality, were associated with short lengths