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Implementing the Fast Track Improvement Bundle: A Total Joint Replacement Quality

Improvement Project

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Abstract

The Fast Track program is a patient-centered and evidence-based intervention for post-surgical patients. It is widely used in many hospitals today because it has proven to promote early recovery, reduce postoperative complications, and decrease both length of stay and medical costs. Within a non-profit, Magnet community based hospital, the Fast Track program was implemented in April 2019. Currently, the success rate of the program is at 74%, which has warranted the initiation of a Quality Improvement (QI) project.

This project began with a microsystem assessment, root cause analysis (RCA), and strengths, weaknesses, opportunities, threats (SWOT) analysis. Four main barriers were identified as contributing factors to this program's lack of success. These barriers were as follows: 1) lack of a uniform location on the checklist to write the patient's discharge time and/or reasons they went "off-track," 2) lack of patient education on Fast Track criteria, 3) lack of nursing education on the program, 4) lack of preoperative education on patient's Fast Track status.

The recommended intervention is the Fast Track Improvement Bundle. This bundle includes an updated checklist requested by nurses, bedside patient checklist, talking points and in-service to educate nurses, and a Fast Track educational powerpoint slide to be utilized during the preoperative class. The future steps of this project include a formal implementation of the bundle and evaluation of its success. The expected result is >95% success rate of on-time Fast Track discharges.

Key words: early recovery after surgery (ERAS), fast track, checklists, patient involvement, preoperative education, nursing in-service, in-service education, hip and knee replacement, continuing education.

Introduction

In 1997, the idea of a Fast Track recovery program or “Enhanced Recovery After Surgery” (ERAS) was born. The term was coined by a Danish surgeon named Henrik Kehlet who found that a primary contributor to postoperative morbidity and mortality was organ function changes due to surgical stress. He hypothesized that a multimodal approach may ease this stress on the body and lead to reduced postoperative complications and deaths (Kehlet, 1997). This multimodal approach includes a variety of interventions such as early mobilization, physical therapy, effective pain management, and prevention of PONV (postoperative nausea and vomiting) (Kaye et al., 2019). Implementation of this Fast Track program has been associated with shorter hospital stays, lower hospital bills, decreased readmission rates, and an overall improved recovery (Kaye et al., 2019). Due to these benefits, the Fast Track program has been adopted and integrated into the postoperative care of many well-known hospitals today including the orthopedic unit, 4 Northwest Side 2 (4NW2), of a large, non-profit, Magnet hospital.

On April 2019, the Fast Track program began on 4NW2 for patients of elective total hip replacement (THR) and total knee replacement (TKR). Within this hospital, the surgeon pre-determines each patient’s Fast Track status depending on their past medical history, comorbidities, and overall ability to tolerate the process. If the patient is determined to be Fast Track, then this is established during a consultation among the patient, their family, and the interdisciplinary team (surgeons, nurse practitioners, physicians, orthopedic nurse navigator, etc.). Subsequently, the patient is educated on the Fast Track criteria that must be met prior to discharge home. Most importantly, they should be informed that being a Fast Track patient means that their goal is to be discharged on the same day of their surgery. Next, the patient is

connected with the orthopedic nurse navigator and strongly advised to attend a pre-operative class. After the surgery, the patient's care revolves around this Fast Track multimodal approach and they are safely discharged home after a set of standardized Fast Track criteria are met. If the patient does not meet these criteria by 23:59 on the day of their surgery, then they are considered "off-track" and are no longer treated as Fast Track patients.

In May 2019, 4NW2's Fast Track program underwent a QI project with the goal of overall improvement. This project discovered various barriers to the success of the Fast Track program. Most notably, the lack of a standardized, tangible criteria for nurses to follow was a formidable barrier to the success of the program. Therefore, the Total Joint Replacement (TJR) Fast Track Checklist was introduced in July 2019. This checklist provided nurses and staff with a uniform, standardized list of criteria that must be completed before the patient could be safely discharged home.

Problem Description

After the Fast Track Checklist was introduced, it was important that the success of the checklist be evaluated in the following months. This would allow for improvements to take place in order for it to become the most efficient process and lead to improved overall patient outcomes. Upon evaluation in September 2019, two months after the checklist was implemented, the Fast Track program was found to only have a 74% success rate. This rate was determined by unit metrics derived from the nurse manager of 4NW2 that showed whether or not assigned Fast-Track patients were discharged by 23:59 on the day of surgery. Not only is the success rate 74%, but the Off-Track discharges are also increasing (see Appendix D).

It became clear upon this evaluation that improvements needed to take place in the Fast Track process in order to increase these numbers. The current problem was determined based on data that was collected through a microsystem assessment. Following the assessment, a root cause analysis and SWOT analysis were performed to discover possible barriers in the current Fast Track process. Included in the root cause analysis was a collection of surveys filled out by the nurses and interviews with patients who were assigned Fast Track status.

The survey for the nurses sought to gain insight on nurse's opinions on the Fast Track process and any barriers they have experienced at the bedside. It was important to evaluate their feelings on this process because they are on the front line, carrying out the checklist in its entirety. Furthermore, studies have shown that patient involvement in care “creates trust between patients and healthcare professionals”; therefore, patient interviews were conducted in order to determine their level of understanding in their care (Ibrahim et al., 2019). During the interviews, patients were asked about the amount of preoperative education they received on the Fast Track process and whether or not they were aware of their goals for same day discharge.

After the full evaluation, four main barriers were found to be contributing to the lack of success in the current Fast Track process. The first barrier, discovered through our microsystem assessment and root cause analysis, was that there was no place on the Fast Track Checklist to record the time the patient was discharged and/or why the patient was not discharged by 23:59. This barrier led to a complete lack of data on why patients were not meeting the Fast Track criteria, when they were originally anticipated to meet it. In order for improvements to be made in the process as a whole, it is imperative that the nurses and nurse managers understand the reasons that are preventing on-time discharge.

The second barrier, discovered through interviewing the patients, was that patients were unaware of the Fast Track criteria they needed to meet in order to be discharged on time. In fact, 100% of patients interviewed could not list all the criteria they must meet for timely discharge. Through observation, some discrepancies were noted on the Fast Track education that each nurse provided to patients. This was alarming because in order for patients to be discharged on time, they must meet a strict criteria which includes factors that are highly dependent on the motivation of the patient, such as ambulation and tolerating food. If the patient is unaware of the factors that directly relate to their timely discharge, they may be less inclined or motivated to meet their discharge goals. This would ultimately lead to a delay in discharge.

The third barrier was that the nurses stated on the surveys that they would like more education on the Fast Track Checklist and process, including the proper terminology and guidelines to patient education. Furthermore, during the unit assessment, it was found that each nurse had noticeable discrepancies in the terminology they used when speaking to patients. This has largely contributed to the reason patients have gaps in their knowledge regarding the Fast Track process. Currently, there is no standardized education in place or formal set of directions they receive on the Fast Track program. The nurses simply rely on one another to answer questions about the process and terminology, which can easily lead to discrepancies and incorrect information.

Finally, the fourth barrier was that some patients did not know they were Fast Track prior to their surgery, and only found out when they saw a “Fast Track” sign attached to their hospital bed. Upon further investigation, it was discovered that the current powerpoint during the preoperative class for hip and knee joint replacement surgeries only vaguely mentions Fast Track one time. Evidently, without sufficient information on the program and knowledge of their Fast

Track status, patients will remain unaware of their discharge goals, be less motivated to accomplish these goals, and are less likely to be involved in their care.

Available Knowledge

Due to the 74% success rate of this program, the idea of the Fast Track Improvement Bundle was devised. This bundle would aim to incorporate interventions to educate nurses, increase patient involvement in the discharge process, and provide enhanced preoperative education. Before implementation of the bundle, evidence-based literature was researched in order to answer the following PICO question, “For Fast Track patients and their nurses on 4NW2 (P), what is the effect of implementing the Fast Track Improvement Bundle (I) in comparison to the results produced by current methods of nurse and patient education (C) on the percentage of same day discharge for Fast Track patients (O)?”

The databases utilized in this literature review included CINAHL Complete, Springer Nature Journals, Cochrane Clinical Answers, Cochrane Database of Systematic Reviews, and PubMed. The keywords used were early recovery after surgery (ERAS), fast track, checklists, patient involvement, preoperative education, nursing in-service, in-service education, hip and knee replacement, continuing education. The only articles that were considered were published after 2012 and from peer-reviewed journals. Out of 20 pieces of literature that were collected, 14 articles total were used in this review.

To understand the interventions needed for improvement, first and foremost, the evidence supporting the Fast Track process and the checklist method was reviewed. One of the first studies on the ERAS protocol or Fast Track program was on nine elderly, high-risk patients who underwent elective laparoscopic colonic surgery for neoplastic disease (Bardram, Funch-Jensen,

Jensen, Kehlet, & Crawford, 1995). In comparison to the extensive criteria on the current checklist on 4NW2, this early study utilized a more limited set of criteria which included the use of epidural analgesia, early ambulation, and early oral nutrition. As a result, the patients' hospital stays were reduced by two days and the patients remained without postoperative complications (nausea, vomiting, ileus), postoperative fatigue and functional impairment (Bardram et al., 1995). When the ERAS protocol was first introduced, it was commonly used for surgeries of the colon; however, evidence proves that the protocol has been highly effective for orthopedic surgeries as well. For total arthroplasty patients, recent studies reveal that the Fast Track program can decrease the length of a patient's hospital stay from 4-12 days to 1-3 days with no statistically significant increase in readmission rates (Kaye et al., 2019). With the number of knee and hip replacements rising each year (approximately 700,000 TKRs and 400,000 THRs) and accompanying increases in medical costs, these results hold promising outcomes for the future if implemented effectively (Scutti, 2018).

With the last QI project in May 2019, the use of a Fast Track checklist was introduced and is currently being used by 4NW2 nurses. Before this checklist was integrated on the unit, nurses would educate and care for the patient based on the individualized checklist they came up with in their minds. Evidently, this led to huge discrepancies in care. Upon reviewing the literature, it is clear that nursing checklists are an evidence-based practice and its use is correlated with a multitude of positive outcomes. In a peer-reviewed article from the *Western Journal of Nursing Research*, the use of a surgical safety checklist proved to decrease patient morbidity and mortality and improve safety measure compliance, teamwork and communication (Lyons & Popejoy, 2014). Additionally, the *Critical Care Nurse* released a peer-reviewed study

on the effects of implementing a checklist to guide nurses on the therapeutic hypothermia protocol after a cardiac arrest. Therapeutic hypothermia is an evidence-based practice, but was found to be under-utilized due to its complexity. However, after the implementation of a checklist, nurses unanimously supported the utility of it. They reported that the checklist significantly helped them organize care for a critically ill patient, remain on schedule and on task, guide their documentation, and ultimately complement their clinical decision making to prevent complications from therapeutic hypothermia (Ryan Avery, O'Brien, Daddio Pierce, & Gazarian, 2015). With undeniable outcomes for both the patient and the nurse, the use of a checklist is an intervention that is well supported and evidence-based.

Since the use of a Fast Track Checklist is evidenced-based and proven to be successful, three out of the four barriers for this Fast Track Improvement Bundle QI project are focused on aspects outside of the checklist. Only one out of the three established barriers were related to the checklist itself, which was the lack of a space for nurses to write down the patient's discharge time and/or why the patient was not sent home by 23:59. This was specifically requested by the nurses and the nurse managers on the unit when they were interviewed and asked about any components of the checklist they felt needed to be updated. Therefore, it became important to address in order for the unit to continue to track the barriers and success of the process as a whole.

The barriers that were identified revealed a need for patient involvement in care, in which evidenced based practices were pulled to determine the best route to approach this. Research shows that in orthopedic surgical cases, patients benefit by playing a more active role in their care. In a 2019 study done by Stålenhag and Sterner, the importance of nurses communicating the plan of care with the patient was examined. It was found that to enable patients to play an

active role in their recovery, it is necessary to establish routines in regards to nurse-patient communication that will allow for appropriate patient education, and therefore involvement. (Stålenhag & Sterner, 2019). The patient bedside checklist is a routine that will standardize nursing communication to the patients in terms of discharge goals.

Moreover, research on patient involvement in care emphasizes that it is a strong “tool if tailored for interaction and partnership, that leads to behaviour change within healthcare QI efforts.” (Bergerum, Thor, Josefsson, & Wolmesjö, 2019). Since the Fast Track Improvement Bundle is a healthcare QI project, it is imperative that interventions include patient involvement in their recovery. Additionally, having a checklist at the bedside would allow the family or caregiver of the patient to be educated on their loved one’s goals for discharge. It would give the patient and their caregiver something tangible to track their progress, and motivate them to accomplish the goals by the end of the day. A qualitative study done by Doekhie et al. in 2018 looked at various perspectives that professionals, informal caregivers, and patients have on the concept of patient’s involvement in care. It was found that patients are more likely to feel understood and involved when the full control of care is not solely in the professionals’ hands, but in their hands as well (Doekhie, Strating, Buljac-Samardzic, Bovenkamp, & Paauwe, 2018). By providing patients with the bedside checklist, they will less likely feel as though their recovery is out of their control. Additionally, this intervention allows patients to be well informed and more motivated on the measures needed for timely discharge.

Another barrier that must be addressed is the lack of education for nurses on the process as a whole. Literature on nursing education was researched, and available knowledge was found on the importance of nursing education. A literature review performed by *The Journal of Continuing Education in Nursing* explored the necessity and relevance of using the in-service

education model on nursing practice. It was noted that in today's constant evolving healthcare setting, performing an in-service is an appropriate model of education to meet nursing practice demands (Jackson, Jowsey, & Honey, 2019).

There are many studies within various healthcare settings that examine the effectiveness of in-service training. One such study was done in 2015 on a group of healthcare professionals who worked with critically ill neonates in developing countries. The study found that performing an in-service training course for these healthcare workers improved the care they were able to provide to the neonates (Opiyo & English, 2015). Another study related to nurses' knowledge and attitudes on pain management in postoperative patients found that continuing education with evidenced-based materials led to an improvement in the nurse's knowledge of pain (McNamara, Harmon, & Saunders, 2012). Since total hip and knee replacement patients fall under the postoperative category, and controlled pain is one of the discharge criteria for Fast Track, implementing an in-service and/or nursing educational tools will benefit both the nurses and patients on the unit.

Given the clear discrepancies in patient knowledge of the Fast Track program, literature on evidence-based patient education was reviewed. Research has shown there are many benefits that preoperative education can have. A systematic review done specifically on patients undergoing hip and knee joint replacement showed that adequate preoperative education reduced patient's anxiety regarding their operation and recovery (McDonald et al., 2015). This was especially found to be true of patients with a predisposition to anxiety and/or depression. Not only does proper preoperative education decrease anxiety, but additional studies have shown that it allows patients to have a better understanding of what the surgery and recovery process entails, as well as more realistic expectations (Edwards, Mears, & Lowry Barnes, 2017). Since Fast

Track patients play a huge role in completing their discharge criteria (e.g. ambulation, tolerating foods), reducing anxiety and providing proper education will likely increase their probability of going home on time.

Additionally, a 2015 study published in the JBI Database Of Systematic Reviews And Implementation Reports found that proper education for orthopedic patients “has positive impacts upon patient satisfaction especially in managing pain” (Majid, Lee, & Plummer, 2015). Furthermore, literature by Edwards, Mears & Lowry Barnes reiterated this with their findings that preoperative education leads to improved postoperative pain control (2017). Since pain management is one of the criteria for timely discharge and research shows that preoperative education can aid in pain management, including additional materials for patient education, may have enormous benefits for Fast Track patients.

Rationale

The conceptual framework that was utilized to guide this Fast Track QI project was the Plan-Do-Study-Act (PDSA) model (Appendix A). The PDSA model is a well-known QI framework that can be applied to both the macrosystem and microsystem. For the purposes of this project, the microsystem of 4NW2 was the system of interest. A strength of the PDSA model is that it allows for potential interventions to be tested in a rapid and structured fashion (Nelson, Batalden, & Godfrey, 2007). It contains four total steps – plan, do, study, and act.

As a continuation of the previous QI team’s work on the creation and implementation (plan and do phases) of the checklist, this project began on the study and act phases of the PDSA model. During the study phase, the impact of the Fast Track checklist on the program and patient outcomes was analyzed closely. In response to the low success rate of the Fast Track program, even with the implementation of the checklist, modifications were made to the existing PDSA

model through the act phase. Once the previous QI team's PDSA cycle was completed, the modified cycle with new improvement goals was initiated to test and refine the best interventions for the Fast Track Improvement Bundle.

In the plan phase for each cycle, the PICO question guided the QI team in creating an appropriate objective. To achieve the objective, constant assessments of 4NW2 were carried out to determine the resources, barriers and factors within the microsystem. These assessments were performed utilizing various tools such as a root cause analysis (Appendix B) and a SWOT analysis (Appendix C). With each PDSA cycle, the goal was for each microsystem assessment to show positive improvements from the previous cycles. Furthermore, the planning phase also involved literature review and ample time to design a potential intervention.

In the do phase, the devised intervention was implemented. After implementation, the QI team diligently documented the successes, failures, problems, and observations (expected or unexpected) of the intervention. The next step of the PDSA cycle, the study phase, was when the QI team scrutinized the intervention, collected data and analyzed it. In this project, the quantitative data of interest was the percentage of same-day discharged Fast Track patients and the qualitative data consisted of the interviews of the nurses' and patients' experiences. At the end of the study phase, gaps, mistakes, and improvements in the interventions were highlighted.

Lastly, in the act phase, decisions were made regarding whether an intervention should be abandoned completely or modified. If modifications were necessary, then they would be made and the next PDSA cycle would begin. If the intervention was abandoned, then the next PDSA cycle would still continue, but with a new intervention. Ultimately, this framework gave

structure to the project and facilitated the refinement and creation of the Fast Track Improvement Bundle.

Aim

The aim of this Fast Track QI project is to increase the success of the Fast Track Checklist discharge process to greater than 95%. Therefore, the goal is to discharge almost all Fast Track hip and knee joint replacement patients by 23:59 on the day of their surgery. After having completed a full microsystem assessment and a root cause analysis on the current Fast Track process, the indicators for improvement became clear. To reach the goal of greater than a 95% success rate, the barriers to success needed to be addressed.

To overcome these four barriers to success, improvement measures must be created for each one. For example, to address the lack of a space on the checklist dedicated to discharge time and/or reason for unsuccessful timely discharge, the creation of an additional section on the checklist would provide valuable data for future QI remediations. For the lack of discharge related knowledge that patients present, an intervention to better educate patients must be put in place as to allow them to be more involved in their recovery. Due to the lack of education and discrepancies in terminology, an intervention must take place to provide the nurses with additional resources on the Fast Track program. Lastly, to ensure all patients are aware of their status as Fast Track prior to surgery, an intervention should be implemented in the preoperative class to better educate patients on the program. Through interdisciplinary collaboration and adherence to these new interventions, barriers will be overcome and an increase in Fast Track success will likely follow.

Context

To understand the microsystem of 4NW2, multiple tools and assessments were done to identify system patterns, barriers, and goals of the unit. The tools used to assess the microsystem were: Clinical microsystem assessment; root cause analysis; and (SWOT) analysis. A clinical microsystem assessment was conducted using the five P's method to follow the progress of the Fast Track program and the pieces of the microsystem that contribute to it (Appendix I). Since the start of the program in April 2019 until October 2019, there have been a total of 274 TJR surgeries with 84 of them being successfully discharged as a Fast Track patient. Most notably, upon review of the data it was clear that doctors were omitting the Fast Track label despite their qualifications to being a Fast Track patient. During the preoperative stage, the physician and staff must label the patient as Fast Track. Without this label, it is unclear to the multidisciplinary team if the patient is considered a Fast Track patient. One physician in particular is contributing to a total of 57% of the off track patients which can be a result of decadron dosing during surgery. Due to the lack of consistency in labeling, some patients that should have been labeled as Fast Track did not get labeled and was documented as same day discharge home or "SD HOME". Overall, the data could have reflected a higher success rate of the Fast Track program, but due to the inconsistency of labeling, the "SD HOME" data could not be considered under the success rate of the Fast Track program.

After evaluation in September 2019, the success rate of the Fast Track program was 74%. This may partly be due to the lack of preparation provided to nurses in combination with the patients' uncertainty of being discharged on the same day. Not all patients attended a preoperative class prior to surgery. Even though some patients may have felt comfortable and knowledgeable by not attending a class, however, some patients who may or may not have

attended that class expressed some anxiety about being discharged on the same day. Therefore, patient education heavily relied on the nurses assigned to these patients upon arrival to 4NW2. Upon reviewing the nurses survey, they had some concerns in regards to the program such as safety, adequate time, adequate resources, and structured education. It was evident that some nurses were very comfortable with taking care of postoperative and Fast Track patients. For some nurses, this was not the case, as they believed it was unsafe to discharge patients the same day of surgery because some patients have the tendency to deny numbness if the patient really wants to go home. This causes unsteady gait during physical therapy or ambulation to the restroom. One nurse stated that there is not enough time to complete all the tasks for a Fast Track patient. She stated “if there is more than one Fast Track patient, then Fast Track is overwhelming.” It’s also important to mention that most nurses requested more education because some of them did not attend the in-service provided by the last QI team.

Upon completing the clinical microsystem assessment, a root cause analysis was conducted, which can be found in Appendix B. Conducting a RCA assists in identifying risks within a system or process. Moreover, it can be utilized as a communication tool to share knowledge within the interdisciplinary team (Joint Commission, 2015). Through the clinical microsystem assessment, it was found that only 74% of Fast Track patients were being discharged by 23:59. Therefore, the RCA tool was utilized and revealed that the root causes were nurses, Fast Track program methods, other personnel, and the environment. Nurses were a root cause because there wasn’t a 100% buy in for the implementation of the program. Methods were a root cause because the implementation of the Fast Track program had areas of improvement that needed to be made. Other personnel was a root cause because the interdisciplinary team, patients, and caregivers all played a role in deterring the patient from being discharged by 23:59

on the same day of surgery. Lastly, the environment was a root cause because there were significant factors within the environment that was not set up for Fast Track program success.

The third tool to assess the microsystem was the SWOT analysis. The SWOT analysis utilized the data collected from the clinical microsystem assessment and categorized the data into the strengths, weaknesses, opportunities, and threats of the microsystem. The component of the SWOT analysis that led to the creation of the Fast Track Bundle was the weaknesses and opportunities of the microsystem. By reviewing the weaknesses and opportunities, the gaps in the microsystem became apparent and actions were made to close the gaps. By closing the gaps, the hope is to eliminate the threats to the microsystem such as delayed discharge and patient readmission. Moreover, by doing this and eliminating the threats to the microsystem, the implementation of the Fast Track Improvement Bundle could better support the strengths of the unit and lead to a higher percentage of Fast Track patients being discharged on time.

Intervention

With the information and data collected from the previous QI team in combination with the new data that was collected by the current QI team, the decision was to implement the Fast Track Improvement Bundle which includes four key interventions to the current Fast Track program. The first intervention and change that was made was to improve the current Fast Track Checklist by adding a criterion in the 'Patient ready for discharge' section where nurses can write down why a patient was not discharged the same day (Appendix J). This was a special request made by the orthopedic managers and nurses working with the checklist. For example, if a patient has not successfully voided within the criteria on the checklist, then the patient cannot be discharged. Therefore, the nurse would write down 'did not void' in the discharge section where it says 'if patient was not discharged, why?'. Keeping a record of this data is valuable

because it will provide insight as to why patients are not getting discharged the same day.

Furthermore, this data will facilitate further evaluations, improvements, and an overall increase in the Fast Track success rate.

The second intervention implemented was the creation of the Fast Track Discharge Readiness Checklist which is to be placed in the patient's room (Appendix H). During the interview with patients, it was acknowledged that 100% of them could not list the full criteria for same day discharge. Most patients were able to list four out of the eight criteria on the checklist. This indicated that even with the preoperative class and current state of bedside nursing education, most patients were not well informed with the discharge criteria. The checklist provided to patients at the bedside will be easy to read as they will be able to keep track of their progress and be more involved in their care. The bedside checklist has multiple benefits. First, it will serve as a reminder to nurses to educate their patients. Second, it standardizes patient education from nurse to nurse. Last, but not least, it promotes patient involvement in care, which is an evidence-based practice.

The third intervention that was created was the Fast Track Discharge Talking Points (Appendix F) that will be conveniently placed on the backside of the current checklist. These talking points will be presented at an in-service session with all the orthopedic nurses so that they will know how to use this tool for patient education. It will include the definition of Fast Track, criteria of the checklist for discharge, benefits of same day discharge and early ambulation, Fast Track qualifications, and other important terminologies. Nurses will be able to refer to these talking points if patients have questions or they can use it as a script while educating their patients. Even though the checklist itself is self-explanatory, nurses have missed key points during their discharge education which was seen during the time that was spent shadowing them.

Due to the patient complaints related to rushed discharge teaching and uneasiness in discharge, this was an important intervention for the safety of the Fast Track patients and the overall success of the program. When nurses are more educated, patient outcomes and care delivery are better. The talking points and in-service serves as key interventions because the literature and evidenced based practice supports its efficacy in quality patient care as mentioned previously.

Lastly, the fourth item of the Fast Track Improvement Bundle is the creation of a powerpoint slide that highlights the importance and requirements of being on the Fast Track program (Appendix G). This slide will be presented at the preoperative class taught every Tuesday by the orthopedic nurse navigator. The implementation of this change was created because the class only briefly mentions the Fast Track program. Understandably, this was due to the fact that the surgery and recovery is the same for all knee and hip replacement patients, regardless of Fast Track status or not. For these reasons, the management felt that it was redundant to schedule a separate preoperative class for Fast Track patients. However, after interviewing patients, it was evident that there was confusion on what the Fast Track program was and how they were chosen to be on this pathway. The powerpoint consists of one slide that highlights what it means being a Fast Track patient, criteria to qualify, evidence based safety, and requirements to be on same day discharge. It was created to be short, concise, and to the point so patients and the educator will not be overwhelmed with a plethora of information. As mentioned previously, evidence based practice reveals that proper preoperative education has many benefits such as reduced anxiety and more realistic expectations for patient's operation and recovery. Having reduced anxiety will help them partner with the nurse to accomplish their discharge goals as well.

Study of the Intervention

With the implementation of the Fast Track checklist back in early July 2019, the efficacy and current practice of utilizing the checklist on the unit needed to be evaluated. To fully comprehend whether the Fast Track checklist was supporting the needs of the microsystem, the “study” and “act” stages of the Plan-Do-Study-Act (PDSA) QI model was carried out. Upon obtaining the list of patients that underwent joint replacement surgery, there were two groups in particular that were of interest, those that were labeled as “Fast Track” and “Off Track”. Patients labeled as “Fast Track” indicated those that were discharged the same day of surgery. Patients labeled as “Off Track” indicated those that were originally labeled as “Fast Track” but didn’t meet the criteria for discharge and therefore were not able to be discharged the same day of surgery. Based on the data, the percentage of Fast Track patients being discharged on the same day of surgery was low. Therefore, in order to evaluate why the percentage was low, various tasks were conducted. First, a microsystems assessment was conducted. Through the conversations and anonymous surveys (Appendix E) completed by nurses, it was evident that there was very little staff nurse buy in for the implementation of the Fast Track program. The reason for this was variable from nurses feeling more comfortable with older practices to nurses feeling rushed when assigned a Fast Track patient. However, the most common theme across all nurses was that there wasn’t adequate training and education about the Fast Track program. Thus, the Fast Track Discharge Talking Points (Appendix F) was created to support nursing education and to serve as a reinforcement to the quality of education that nurses provide to patients during discharge.

Patients were also interviewed regarding their knowledge of the Fast Track program and what they understood about going home on the same day of their surgery. Some patients did not

know they were Fast Track status while others did. Some patients partially understood the goals they needed to meet to be discharged while others knew even less. To understand why the knowledge varied from patient to patient, the preoperative education class was evaluated. While reviewing the education patients received during this class, it appeared that there was very little Fast Track specific education and information provided to patients. Moreover, at the bedside, when patients were first brought over to the 4NW2 unit for recovery, the education that nurses provided varied with some being more thorough than others. Overall, it was evident that patient and nurse education was needed. There was a need to enhance pre- and post-operative education given to Fast Track patients so that they can be more aware of the goals that they must meet. Thus, an additional PowerPoint slide (Appendix G) for preoperative education and the Fast Track Discharge Readiness Checklist for postoperative education (Appendix H) were created.

Measures

Upon the implementation of the Fast Track Improvement Bundle, measuring the nurses' increase in knowledge of the program and comfort level with implementing the program on the unit will determine the success of the bundle. Furthermore, measuring the patients' increase in knowledge of the Fast Track program and understanding and retention of goals to meet prior to discharge will determine the success of the bundle. To assess for increased knowledge and comfort level from nurses, another survey will be conducted after having implemented the Fast Track Improvement Bundle for 3 months. The questions will address the difference in knowledge prior to and after attending an in-service as well as having access to the talking points at hand throughout the shift. To assess the increase in patients' understanding of the Fast Track program and retention of goals that need to be met prior to discharge, the patients will be asked to complete an evaluation at the end of the preoperative class and list their discharge goals. Upon

their arrival to the 4NW2 unit, patients will also be asked to verbally repeat the discharge goals without referencing the bedside checklist, but referring to it if needed. Patients will also be asked to respond to a question in a follow-up survey that addresses the education they received pre- and post- operation and whether or not this affected their perspective and comfort level as a Fast Track patient.

Ethical Considerations

A potential ethical issue that can arise with the Fastrack Checklist is nonmaleficence. When nurses fail to properly educate on discharge teaching, it can potentially cause harm to the patient by causing hospital readmission and postoperative complications. Even though the goal of the checklist is to make sure the patient stays on track by avoiding harm and prolonging discharge, nurses can miss important instructions because the education process is not standardized. This can unintentionally harm the patient and cause them to feel uneasy about going home the same day of their surgery.

An observation that was made during rounding was that patients were only asked about symptoms they were experiencing, when they should have been fully educated about why certain criteria on the checklist needs to be met prior to being discharged. It seemed though that nurses were not educating patients about why the goals on the checklist needs to be accomplished before they can be discharged home. This was assumed because during patient interviews, patient were not able to recall all the goals for discharge. For example, patients were aware that their nausea must subside before being discharged, however not all patients knew why it was important. Patients should know the harm of nausea, and not only be asked whether or not they're nausea is controlled. Simply asking whether or not the patient is nauseous is not patient-centered. Based on the Enhance Recovery After Surgery protocol, “proactive management of

PONV is core to the patient returning to preprocedure health and activity” (American Association of Nurse Anesthetists, 2017). Patients should know the treatment that can be given when plagued with nausea such as adequate hydration and decreased use of opioids. Managing nausea will help decrease vomiting incidences which would cause more harm to the patient leading to major complications such as dehydration or stress on the incision site. According to the International Council of Nurses (ICN) Code of Ethics for Nurses, it states that “the nurse ensures that the individual receives accurate, sufficient and timely information in a culturally appropriate manner on which to base consent for care and related treatment” (2012). Based on this element, patients have the right to know everything in regards to their discharge and in a timely manner so they do not feel rushed or ill-prepared to go home.

Outcome Measure Results

Per hospital policy, an administrative panel must approve all new procedures and written materials prior to their implementation. Due to delays in this process, namely the inability to reach administrators when they were contacted, formal implementation of the bundle has yet to occur. However, the bundle was presented to the nurse navigator, who responded very positively and believes it will help meet the intended goal of an increased success rate.

Once the bundle has been implemented, evaluation and analysis of the results will occur continuously, with a formal evaluation at the three-month point. As previously discussed, nurses will receive a survey similar to the one they received during initial evaluation of the project (refer to Appendix E). Expected results include decreased safety concerns, increased comfort with time management and available resources, and increased understanding of the checklist.

Patient education will also be formally evaluated at the three-month point. Fast Track patients will be interviewed and asked to recite the aspects of the checklist required for

discharge, referring to the patient-friendly bedside Fast Track Discharge Readiness Checklist if necessary. Patients will also be asked to rate the quality and thoroughness of the education they received on the Fast Track process specifically, both pre- and post-operation. Expected patient results include being able to recite all aspects of the checklist and increased satisfaction on the education process, leading to better recovery and long-term patient outcomes.

Discussion

The total joint replacement fast track checklist as previously implemented showed great promise. Prior to the beginning of the project, no established guidelines were in place for nurses to track the progress of patients labeled for fast track discharge. After much analysis, a standardized, easy to follow checklist was created based on evidence-based research and introduced to the orthopedic floor nurses. The goals of this checklist were to improve adherence to the discharge guidelines and to ensure safe, high-quality postoperative assessment practices.

For several months following the introduction of the checklist, the overall success rate of the project showed significant room for improvement. Three quarters of patients labeled for the fast track program were discharged by the end of the day of surgery, so these patients certainly benefited. However, one quarter of fast track patients were not discharged within the specified time frame, so evaluation and further changes to the project targeted this population.

Thorough evaluation of potential causes of this low success rate included an RCA and a SWOT analysis, as well as assessments of the microsystem as a whole and its communication and culture. Nurses were provided with an anonymous survey where they were able to share their thoughts about the checklist as it stood at the time, and patients were interviewed about their experiences with the fast track process. Nurses caring for fast track and non-fast track patients were also shadowed, so that differences in care plans could be seen firsthand.

Through this analysis, a few gaps in the current system became apparent. First, most nurses received no education prior to the checklist's implementation on the floor. Many nurses admitted that they often did not know how to explain the fast track process to their patients or why same day discharge is beneficial, reducing checklist compliance. Second, patients were generally aware of their fast track status, but did not understand what that entailed. They were unable to assist in the process, because they did not know what factors were involved in meeting the discharge requirements.

Based on these discoveries, the fast track improvement bundle was initiated. The bundle includes nurse education in the form of an in-service for all current orthopedic nurses, and a talking points handout printed on the back of the checklist for them to refer to. The bundle also includes educational resources for patients, through a patient-friendly version of the checklist kept at the bedside and a more thorough introduction to the fast track process in the preoperative education Powerpoint slide. In addition to the bundle, the checklist itself was revised to include a section to explain why off-track patients did not meet the checklist goals. These interventions were designed to directly address the identified gaps and ultimately increase the overall success rate of the checklist.

The most valuable lesson learned is the need for constant evaluation, change, and re-evaluation. While the original checklist was strong in its foundations and implementation showed some level of success, further improvements will increase the level of success even more. Successful change was reflected in the results of the various analyses, as well as the nurse navigator's comments that they believe that fast track improvement bundle will increase adherence and understanding of the checklist.

Future steps include formal implementation of the bundle and evaluation of its success.

Conclusion

The overarching goal of this project was to determine the effect of implementing the Fast Track Improvement Bundle on the percentage of successful same day discharges for fast track patients and their bedside nurses in comparison with the percentage produced by current methods. The QI team attempted to meet this goal by implementing better education on the checklist. This education aims to improve the usefulness of the checklist by ensuring that patients and nurses understand what the checklist is, how it works, and why it is important. By doing so, adherence and buy-in will hopefully be increased, leading to more on-time discharges.

Sustainability of the project ultimately depends on the success of the Fast Track Improvement Bundle implementation. All aspects of the bundle have been thoroughly planned based on unit needs and evidence-based research, and introduced to unit management. However, implementation of the bundle interventions has not occurred. Future QI team members will need to officially implement the bundle and assess its effectiveness. Should delays in implementation occur, sustainability may be hindered.

If the bundle increases the fast track discharge success rate as intended, then this project has great potential for spread to other surgeries. More broadly, a successful checklist can be implemented for any number of processes throughout any health care system. This project exemplifies the power of streamlined, standardized visual aids in increasing nurse satisfaction, patient safety, and high-quality care overall.

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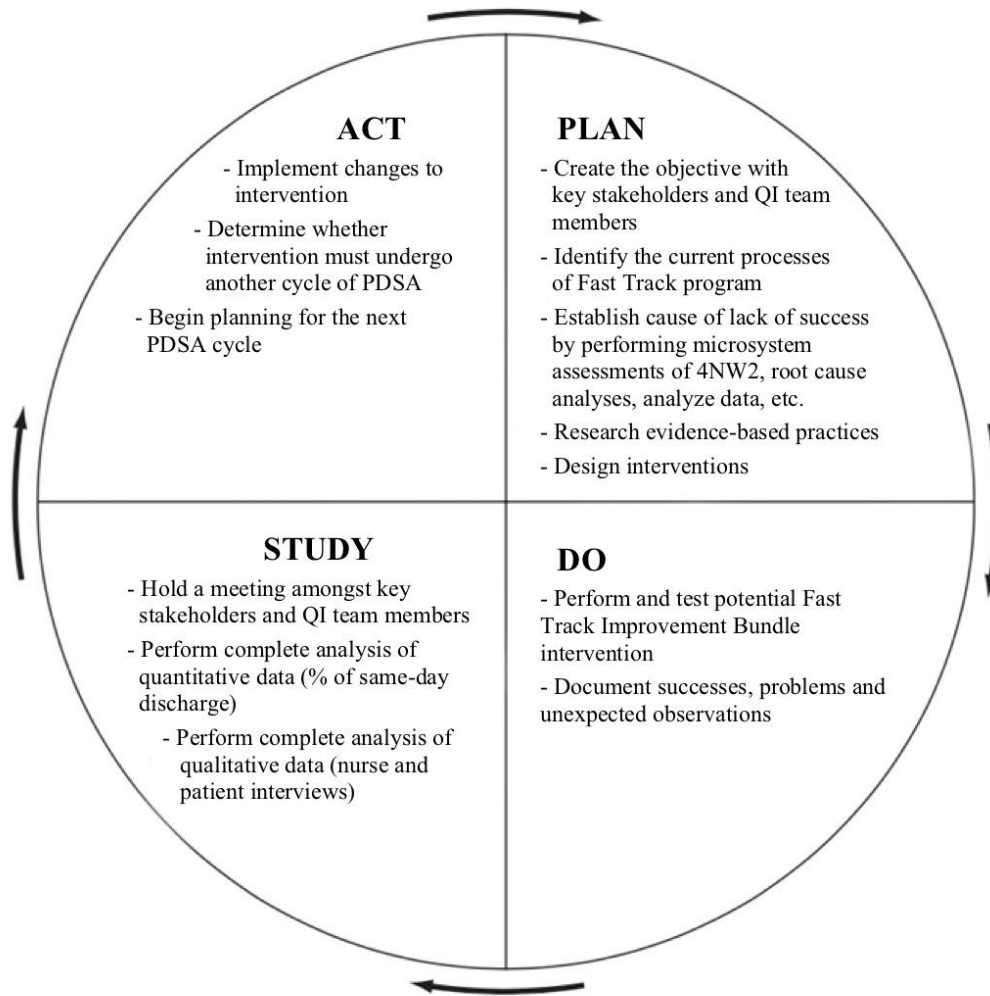
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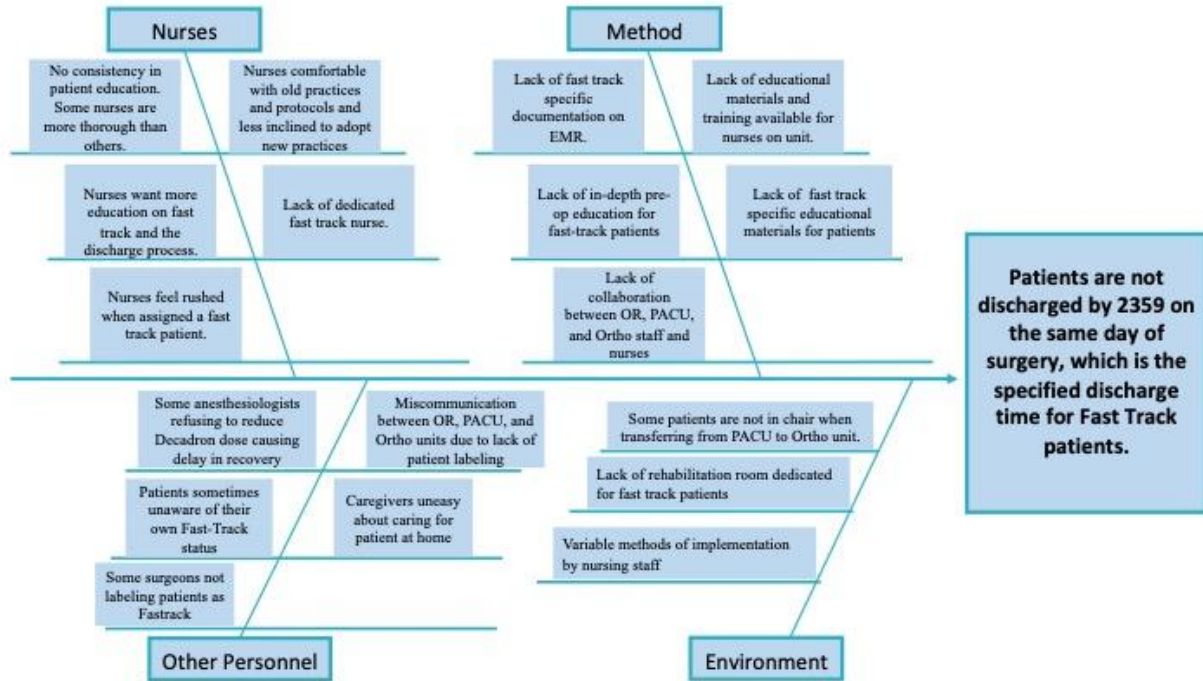
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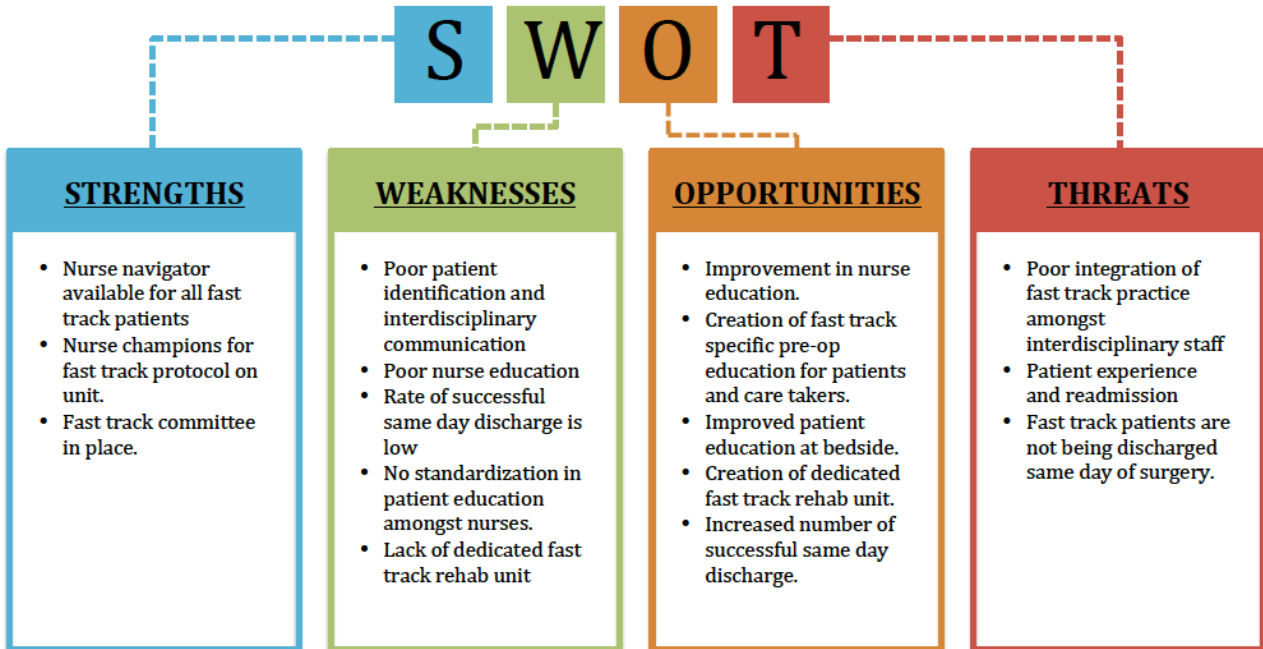
Appendix A
Plan-Do-Study-Act (PDSA) Framework



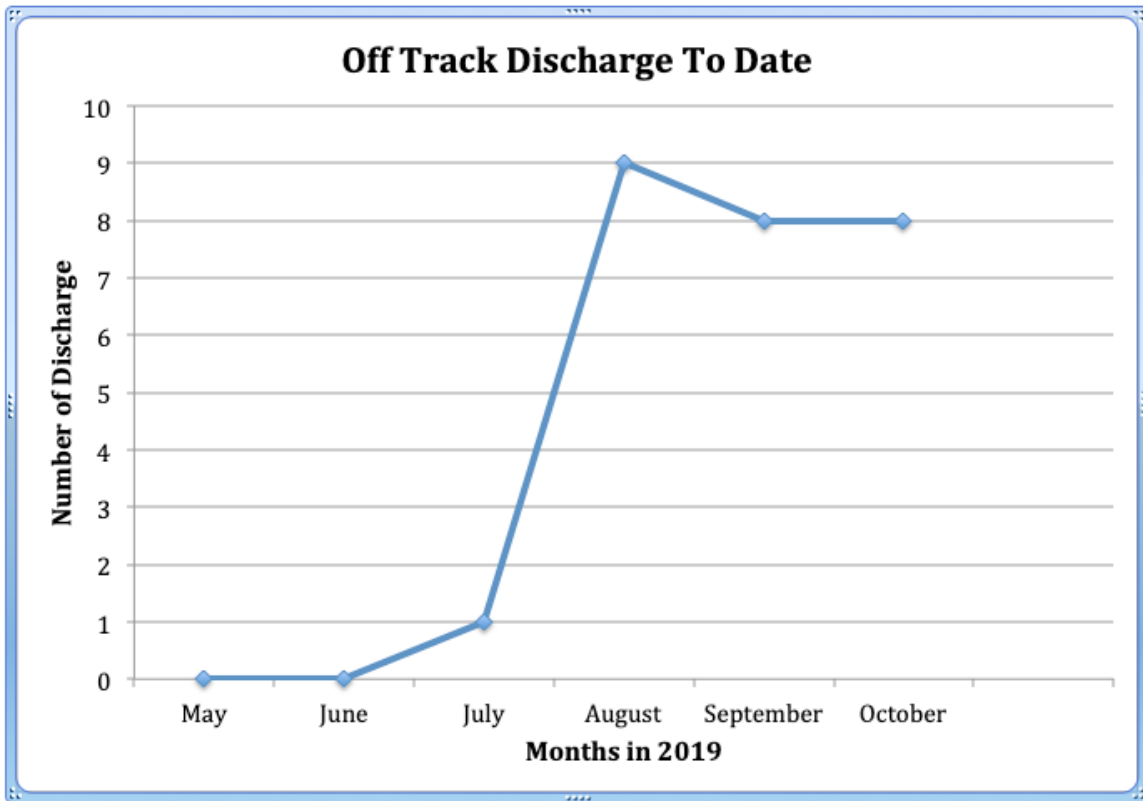
Appendix B
Root Cause Analysis: Fishbone Diagram



Appendix C
Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis



Appendix D
Off Track Discharge Data To Date for Total Joint Replacement on 4NW2



Appendix E
Nurse Survey

Fast Track Checklist Nurse Survey

1) Do you have any safety concerns related to the fast track checklists? Y/N

Comments (optional):

2) Do you feel that you have adequate time in your day to complete the fast track checklist? Y/N

Comments (optional):

3) Do you feel like you have adequate resources to discharge a fast track patient safely? Y/N

Comment (optional):

4) Did you receive any structured education on the new fast track checklist process? Y/N

Comments (optional):

5) What resources (if any) would you find helpful to aid in the fast track process?

In-service education

Fast track specific discharge instructions

Bedside checklist for patient to follow progress towards discharge (e.g. once your goals are checked off, you can go home)

Other:

Appendix F Nurse Education: “Talking Points”

Fast Track Discharge Talking Points

What is Fast Track?

- Hip or Knee replacement surgery where patient should be discharged by 2359 on day of surgery.
- Fast Track is supported by research and shown to:
 - Reduce postoperative complications (DVT, pulmonary embolism)
 - Reduce length of hospital stay and financial burden
 - Reduce readmission rate
 - Improve recovery time

When will I go home? - Provide the "Discharge Readiness Checklist." Tape on whiteboard.

- Doctor's discharge order
- Pain under control
- Successfully voided bladder
- Nausea under control
- Tolerated clear liquid diet to full liquid/solid diet
- Blood glucose <180, *except for diabetes mellitus patients*
- Tolerated ambulation and deemed safe by PT (including stairs training if appropriate)

What are the benefits to healing at home?

- Home is the safest healing environment for the patient.
- Evidence indicates that patients will develop earlier functional independence at home vs SNF.
- Infection risk in the days following surgery is lower at home than in any residential facility.

What are the benefits of same day ambulation?

- Early ambulation is the most important evidence-based strategy to reduce most post-operative complications following TJA.
- Evidence indicates mobility within hours from surgery improves 6 week functional ability.
- Reduces DVT risk, muscle atrophy, relieves pressure areas, stimulates ventilation, and restores proprioception.

How did I qualify for Fast Track?

Medical Criteria	Social Criteria
BMI < 40 Hg > 11 A1c < 7.5 ASA I-II	<ul style="list-style-type: none"> ● Connection with Navigator prior ● Independent in ADLs ● Patient engaged and expresses willingness ● Caregiver present for the first 48 hours ● Home Health (or OP therapy) in place before surgery

Terminology

- Enhanced recovery after surgery (ERAS) - Refers to protocols and pathways designed to achieve early recovery after surgical procedures; begins in the preoperative period and continues through discharge
- Patient reported outcomes (PRO) - Standardized questionnaires completed by patients and scored to indicate physical function impairments caused by an arthritic joint; collected in the surgeon's office prior to surgery and at 3 months and 12 months post to track improvement

Appendix G
Fast-Track Specific Preoperative Patient Education

FAST TRACK (SAME DAY) DISCHARGE

- Hip or knee replacement → discharged by 11:59pm on day of surgery.
- Must meet following criteria to qualify:
 - **MEDICAL:** BMI <40, Hemoglobin >11, HbA1c <7.5, ASA I-II
 - **SOCIAL:** connect with navigator before surgery, independent activities of daily living, be engaged and express willingness, caregiver present for 48 hours, home health or outpatient therapy in place prior to surgery
- Evidenced based safety of same-day discharge:
 - May reduce postoperative complications
 - Decreased length of stay & financial burden
 - Reduced readmission rates
 - Improved recovery time
- Requirements to be discharged same day:
 - Controlled pain
 - Successfully void bladder
 - Tolerating food (nausea control)
 - Blood sugar <180 (*except for diabetic patients*)
 - Return of leg sensation, walking, and clearance from PT/OT

Appendix H
Fast Track Discharge Readiness Checklist



Needs to have...

- 1. Doctor's order
- 2. Pain managed
- 3. Tolerated clear liquid diet to full liquid diet
- 4. Managed nausea
- 5. Urinated
- 6. Blood sugar less than 180 (except for those who have diabetes)
- 7. Physical therapy completed
- 8. Occupational therapy completed (if needed)

**ONCE YOU HAVE BEEN CHECKED OFF OF
EVERYTHING ABOVE, YOU CAN GO HOME!**

HAPPY RECOVERY!

Appendix I
Clinical Microsystem Assessment-5 P's

Purpose

To create an efficient and safe Total Joint Replacement Fast Track Checklist for patients to be discharged the same day on the Orthopedic Unit at a large community based hospital. The mission of the hospital is to provide compassionate, reliable and safe care and to continually implement quality initiatives that ensure our patients receive the absolute best care.

Patients

- Target population age distribution: 50-84 years old
- Average Time of discharge: 07:26-21:01
- As of October 2019, since the start of the TJR Fast Track Program: 274 total TJRs, 113 Fast Track patients, 84 successful Fast Track, 30 Off Track, 24 Same Day Discharge patients (considered Fast Track, but not labeled as Fast Track),

Professionals

- Orthopedic Surgeons: Dr. Joseph Mayo III, Dr. Shawn Solhpour, Dr. Kiarash (Kevin) Khajavi, Dr. Stewart L Shanfield, Dr. Bob Yin, Dr. Karen Evensen
- Orthopedic Unit Manager: Tamara Nunley, RN
- Orthopedic Nurse Navigator: Lisa Marie Giambalvo, RN
- Orthopedic Nurses
- Physical Therapists
- Occupational Therapists

Process

Patient process for a total joint replacement surgery:

- Schedule surgery (determine if patient meets criteria for Fast Track)-->Attend preoperational class (led by Lisa Marie every Tuesday)àHave surgery-->Recovery in PACU-->Transfer to Orthopedic Floor (start checklist and education)-->Discharge same day if requirements for checklist all met

Pattern: Measuring Team Performance + Patient Outcomes

Measure	Current	Target
Success Fast Track discharge:	74%	>95%

Appendix J Updated Fast Track Checklist

Total Joint Replacement Fast Track Checklist - Patient must be discharged by 2359 on day of surgery

Patient labeled as Fast Track on the surgery scheduled _____ (Surgeon name) DATE: _____

Documentation
<input type="checkbox"/> Leave the Standard of Care that was added (Peri-procedure) <input type="checkbox"/> Add the Total Joint Care Plan
Pain Management
<input type="checkbox"/> Patient states pain is controlled or If patient states pain: <input type="checkbox"/> pain med given → <input type="checkbox"/> reevaluate in 30 mins → <input type="checkbox"/> patient states pain is controlled
Oxygen
<input type="checkbox"/> 2L NC for 4 hours
PT Clearance
<input type="checkbox"/> PT cleared or If not cleared: <input type="checkbox"/> reevaluate patient in 1-2 hours → <input type="checkbox"/> PT cleared
OT Clearance *only for posterior lateral hip replacements • Physical Therapy will assist in determining if OT is needed. Collaborate with them to determine the plan.
<input type="checkbox"/> N/A or <input type="checkbox"/> OT cleared or If not cleared: <input type="checkbox"/> reevaluate patient in 1-2 hours → <input type="checkbox"/> OF cleared
Blood Sugar *initial check must occur 4 hours after the 1st check in PACU
<input type="checkbox"/> < 180 mg/dL x 2 (first reading) _____ @ _____ (second reading) _____ @ _____ or If patient has a history of Diabetes Mellitus: <input type="checkbox"/> give insulin per ACHS sliding scale or If > 180 mg/dL and no history of Diabetes Mellitus PATIENT NO LONGER QUALIFIES FOR FAST TRACK <input type="checkbox"/> give insulin per non-diabetic insulin sliding scale and call attending surgeon to inform them of result.
Diet
<input type="checkbox"/> Successful advancement from clear liquid diet to full liquid/solid diet without N/V or If N/V: <input type="checkbox"/> give antiemetic → <input type="checkbox"/> reevaluate patient in 30 mins → <input type="checkbox"/> N/V controlled
Voiding
<input type="checkbox"/> <6 hours and successful voiding or If >6 hours: <input type="checkbox"/> bladder scan → if > 300 ml: <input type="checkbox"/> catheterize patient → <input type="checkbox"/> reevaluate in 4 hours or If >6 hours: <input type="checkbox"/> bladder scan → if < 300 ml: give patient PO fluids and/or IV fluids per attending surgeon → <input type="checkbox"/> reevaluate in 4 hours or If >6 hours and successful voiding: <input type="checkbox"/> no catheterization needed
Case management collaboration *contact Lisa Marie @ (714) 853-4909 (cell)
<input type="checkbox"/> DME or <input type="checkbox"/> N/A <input type="checkbox"/> Home health orders or <input type="checkbox"/> N/A
Discharge Paperwork
<input type="checkbox"/> Patient education complete
<input type="checkbox"/> Patient ready for discharge @ _____ (time). If patient was not discharged, why? _____

THIS CHECKLIST IS NOT PART OF THE MEDICAL RECORD. PLEASE GIVE TO 4NW2 COORDINATOR



Appendix K Orthopedic Unit Updated Fast Track Education Inservice

Group Introductions

- We are MSN-CNL students from the University of San Francisco on the Orange County campus implementing a quality improvement project to improve the Total Joint Replacement Fast Track Project of the Orthopedic floor. The previous cohort came in to create and implement the checklist that is now used for the Fast Track program. We are here to share some results with you in regards to the progress of the program and also new interventions that can be used to further educate patients and keep them safe.

Hand out update checklist with “talking points” and In-room Patient Checklist

Share data from the start of Fast Track program until October 2019

- As of September 2019, the success rate for Fast Track patients was 74%. Meaning 74% of patients on Fast Track did not return back to the hospital or experience some type of complication. 26% unsuccessful rate was due to lack of standardized education given by nurses, lack of comprehension of the Fast Track program by patients, and complications during recovery that required them to stay longer in the hospital.

Updated Checklist

- We were told that if a patient was no longer on Fast Track anymore, there was no area on the current checklist where they can write why they were Off Tracked. Therefore, we updated the checklist and added an area near the Discharge section where you now can add why they were not discharged the same day.

“Talking Points”

- After conducting the previous survey, it was stated that more education should be given on the Fast Track Checklist and process, including the terminology and the education that should be provided to the patients.
- We came up with “talking points” that will be on the back of the checklist for easy access that will help you further educate your patients, using the correct terminology and explaining the correct process. This will help standardize the education given to every patient.

In-room Patient Checklist

- Another barrier that we found was that some patients did not even know they were Fast Track prior to their surgery, and only found out when they saw a “Fast Track” sign attached to their hospital bed. Patients were also unaware of the criteria they needed to meet in order to be discharged on time if they were a Fast Track assigned patient. They could not list all the Fast Track criteria they needed to meet for timely discharge.
- That is why an In-room Patient Checklist was created so that the patient can follow the plan of care leading up to discharge. The checklist is easy to read and follow. Nurses just have to check off the In-room Patient Checklist once a criterion has been met. This will also remind nurses to educate patients on each criterion and allow patients to ask questions.

Conclusion

- Moving forward, the next cohort from USF will be taking over the project to further assess, analyze, and evaluate the checklist and other interventions implemented to make the Fast Track program successful
- Please let Lisa Marie know of any of your concerns, questions, comments and we’ll be sure to adjust and make improvements on the program.
- We thank you again for your time and attention during our presentation. If there are any questions, we’ll take them at this time.