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Improving Care Experience of Total Joint Home Recovery Patients Through Nursing Education

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Abstract

Problem: At a Northern California hospital (NCH), there is a current effort to ensure the perioperative patients are satisfied with their care. These patients receive the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey after surgery. The scores regarding discharge process and patient knowledge over the last five quarters have fluctuated between the 10th percentile and the 36th percentile. NCH relies on patient satisfaction scores to better serve their members.

Context: NCH understands the higher the scores, the more members they will retain and the higher the overall income. Based on the low OAS CAHPS scores, an evidenced-based educational program to increase these scores was devised. This quality improvement program uses an educational program to teach the nurses in the post-anesthesia care unit (PACU) to use a perioperative experience booklet to educate total joint home recovery patients when they arrive at the hospital.

Intervention: The first interventions for this project are to use an educational program that teaches the PACU RNs how to place a 24-hour post-operative call. The second intervention is to teach PACU RN's how to use a perioperative experience booklet to educate patients during the preoperative phase of their care.

Measures: The goal of this quality improvement project is to increase the OAS CAHPS scores by the third phase of the project, which will start in December 2020. This quality improvement project will cover the first phase of the project. By educating the RNs to properly use the perioperative experiences booklet and place the 24-hour calls, patients should have an increase in their perceived care experience, which will impact the OAS CAHPS scores. By implementing this education with the nurses in the post-anesthesia unit, the leader hopes to see an increase in

confidence in the RNs' ability to perform these interventions. A survey was given to the RNs before and after the training. The survey was used to measure the difference in their confidence to perform this intervention. The results between the pre- and post-education surveys showed a marked difference in nurse confidence in delivering the post-operative call. The comments section displayed an increase in knowledge and understanding. RNs who took the post-education survey stated that they felt more comfortable in their abilities to implement the quality improvement.

Results: The RNs completed a survey before and after the training. The survey measured the difference in their confidence to perform this intervention. In the pre-education survey, 64% of the RNs felt they had little to no confidence in being able to teach total joint home recovery patients before surgery or place a 24-hour post-operative call. In the post-education survey, 57% of the nurses stated that they felt confident if using the perioperative experience booklet, and 100% of the nurses stated that they felt confident placing a 24-hour post-operative call. The results between the pre- and post-education surveys showed a marked difference in the nurse's confidence in delivering the post-operative call. The comments displayed an understanding of the goal of using the perioperative experience booklet and how to make the 24-hour post-operative call.

Conclusion: The education session showed it to be a positive tool to use to increase the nurse's knowledge of the interventions. Adequate nurse preparation to implement this intervention will increase the chance that this intervention achieves the goal of increasing the OAS CAHPS scores.

Section II: Introduction

Undergoing surgery can be a stressful and frightening experience for patients (C. Prothro, personal communication, February 17, 2019). Even those patients electing to have surgery can suffer from anxiety about the process before, during, and after surgery (Johansson et al., 2007). While having a knowledgeable healthcare team providing high-quality and safe care is essential, a Northern California hospital (NCH) believes that considering the patient's total care experience is a corequisite to the treatment paradigm (Roux, 2019).

In January 2020, the NCH national offices began offering training called "Care Experience Live" to all employees across the country. This training empowers employees to provide care to increase both the patient's and the public's perception of NCH and its affiliates as more trusted than other hospitals in the United States (Care Experience Live, 2020). NCH wants to increase authentic human connections through care experience. NCH strives to ensure that patients not only receive high-quality care but also perceive that they have received high-quality care (Smith, 2014).

To assess if this goal is being met, patients who receive care in the perioperative department at NCH are sent the Consumer Assessment of Health of Care Providers and Systems of Out-Patient and Ambulatory Surgery Survey (OAS CAHPS, see Appendix A). This survey is mailed after the patient has been home for two weeks. This survey asks them questions that detail their overall surgical experience (N. Rowe, personal communication, September 20, 2019). The OAS CAHPS provided the initial statistical data for this project. The OAS CAHPS metrics are driving this quality improvement project. The management team reviews the bimonthly results of the survey to see if the patient's needs and expectations were met.

Problem Description

NCH discharges approximately 45 post-surgery patients daily. Roughly, 10% of those patients can be classified as total joint home recovery (TJHR). Upon arriving in the perioperative department, the patients have approximately a one-hour wait before starting the surgical process. The same patients are discharged from the post-anesthesia care unit (PACU) or the ambulatory surgery unit to their home after they recover from anesthesia. Important communication, such as discharge instructions, medication administration instructions, pertinent numbers to call, and wound care, are discussed post-operatively. Physical therapists also work with patients before they discharge home. During the discharge process, 50% of patients are likely to forget the information that was verbally communicated or lose the educational material given to them (Madan & Tichansky, 2005). Forgetting this information can affect a patient's ability to care for themselves and decrease their feeling of support (Burch, 2012). When this happens, patients can become distrustful of the facility and the professionals caring for them (Burch, 2012). As a result, patients are not always able to comprehend the discharge information provided to them. Within the first 24-hours after discharge, issues regarding pain, nausea, and wound management are usually the first to arise (Clari et al., 2015). Therefore, during the 24-hour post-op timeframe, it is imperative that an intervention be made (Burch, 2012).

This quality improvement project will focus on TJHR patients. At NCH, the home recovery process was initiated approximately two years ago for all total joint patients (S. Islam, personal communication, November 8, 2019). The home recovery process discharges patients home the same day of surgery to recover, instead of a traditional two-night stay in the hospital. A two-night admission can cost NCH $10,000 to $20,000/night, depending on the case and treatment received (C. Prothro, personal communication, February 17, 2019). Patients recovering

in the home are less likely to acquire a hospital-related infection. These infections can incur costs to the hospital and the patient in the amount of $23,000/day (Schmier et al., 2016).

The OAS CAHPS is a reflection of the patient's perception of different stages of the patient's care (N. Rowe, personal communication, September 20, 2019). The December 2018 to March 2020 OAS CAHPS returned scores showed NCH patients scored the hospital in the 10th percentile in the discharge process and discharge information given to them (see Appendix B). NCH can improve the patient's perception positively through care experience initiatives to an expected 90% to 100% in these categories. The goal is to reach this by delivering registered nurse (RN) led pre-operative education and a 24-hour post-operative phone call and using a perioperative experience booklet (PEB) before surgery.

This quality improvement project will, in part, optimize the hour patients wait before the pre-operative process by presenting the patient with education during this time. The patients will be given a PEB, detailing information regarding pre-op/intra-op and post-op care (see Appendix C). The booklet will also outline aftercare pain management and wound management. This booklet will guide them through the surgical experience and be a reference for them after surgery, which can improve the care experience and surgical outcomes (Hansberry et al., 2014).

The quality improvement project's first intervention is a 24-hour post-operative call to TJHR patients. This call will allow the patient and the NCH staff to determine the patient's progress in the home and reinforce discharge material given to help increase care experience (Flanagan, 2009). Moreover, implementing a 24-hour post-operative call will support and strengthen the information received in the hospital. During this call, the patient will answer multiple questions related to care experience, pain, nausea, and vomiting (see Appendix D). These questions will obtain information on the care the patient received and will answer any

questions the patient may have. A designated RN will make the call. If there are questions the RN cannot answer or is out of the RN's scope of practice, the RN will refer the patient to the orthopedic physician assistant or the anesthesiologist covering the pain service.

On March 17, 2020, the California governor implemented guidelines for Californians to shelter in place (SIP) because of an international pandemic caused by SARS-CoV2 (California Department for Public Health, 2020). There were also guidelines placed on all healthcare facilities. These guidelines stated that all elective surgical cases could not be performed. This was to preserve personal protective equipment (PPE) and to reduce the potential for spreading the virus. This pandemic and the guidelines put in place put a 2.5-month halt on this project because there were no TJHR patients scheduled to undergo surgery. SARS-CoV2 interfered with the ability to teach nurses and to determine who would be working with this patient group. There was a directive from nursing executive leadership to halt all non-essential training and focus on preparing RNs within each department to be able to care for SARS-CoV2 patients and patients under investigation. Therefore, the timeline for this project was pushed back; thus, the project will be split into phases. The first phase will focus on educating the RNs on how the PEB should be used with our patients and how to perform the 24-hour post-operative call.

Available Knowledge

PICO Question

A PICO question (see Appendix E) can be a very useful tool to organize the approach to a quality improvement project such as this one (N. Taquino, personal communication, 2019). This project was guided by the PICO question as follows: (P) Do PACU RNs benefit from a (I) 2-hour education program taught by a CNL student, effectively increase their ability to teach total joint home recovery (TJHR) patients (C), as opposed to no education before a roll out of a pre-

operative teaching tool and a 24-hour post-operative call for TJHR patients. The original PICO question (not stated in this paper) was created before the COVID-19 pandemic. The way patients and surgeries were booked and performed changed drastically; therefore, this new PICO question was altered to align with those changes.

After the PICO question was created, using the Institute for Healthcare Improvement (IHI) microsystem assessment tool (see Appendix F), the writer was able to gather useful information. The microsystem assessment identified the need to increase care experience based on the results of the OAS CAHPS. Patients surveyed rated NCH's perioperative discharge process and their perceived care in the 10th percentile, the lowest possible score (see Appendix B). Although the OAS CAHPS scores are a representation of all surgical patients, the goal is to implement this quality improvement project as a small test of change. The ambition of this test is to increase the OAS CAHPS by at least 10% of the current numbers. The quality improvement project is based on the documented dissatisfaction that post-operative patients at NCH have outlined.

Patient and hospital staff relationships can significantly affect how patients view and validate their care (Gadalean et al., 2011). An international study performed in 2011, with a sample size of 106 participants, showed that staff who highlighted information, such as proper treatment, explanation of the procedure, and pain management, increased and influenced patient satisfaction (Gadalean et al., 2011).

Literature Review

A comprehensive search was completed using CINHAL, Joanna Briggs, PubMed, and Google scholar using the following terms in various combinations: *telephone, hospital, increase care experience, orthopedic, post-operative call, patient education, nurse education*. The search

retrieved approximately 750 different articles and books. The findings were narrowed down to 17 articles. Combing those varying in quality articles and subject matter expert opinions, the project lead created the PEB and RN education program and designed some of the post-operative call questions.

Rationale

NCH wants to be known as the most trusted name in healthcare (Care Experience Live, 2020). This goal is in line with the IHI's (2018) goals that identify the patient's experience as a high indicator that can affect patient satisfaction scores. After reviewing the OAS CAHPS, a quality gap was identified. At the time this was written, NCH scored in the 20th percentile on OAS CAHPS scores, when compared to other northern California hospitals. As stated earlier, NCH is striving to be the most trusted name in healthcare. This quality improvement project will attempt to address an aspect of this goal.

Conceptual Framework

The conceptual framework that will assist to guide the first phase of this project is Knowles' adult learning theory. This theory has principles and makes assumptions regarding adult learners that differ from child learners (Clapper, 2010):

1. Self-directed.
2. Past experience as a reservoir for guiding new learning.
3. Social roles can determine readiness to learn.
4. The knowledge should be applied to problem-centered learning.
5. Adult learners usually have internal motivation.
6. They need to know why something should be learned.

The conceptual framework will be important on two fronts. The first phase of the project is directed at training RNs to be prepared, self-directed educators to perioperative patients and using it as a guide for the education of our adult patients.

Theoretical Framework

Jean Watson's (2020) theory of human caring outlines 10 principles the nursing practice should be grounded in. Principle 7 and Principle 8 are the foundation for this quality improvement project (see Appendix G). These principles state that nurses, through transpersonal teaching, should and can create a feeling of safety and peace (Watson, 2020). By offering and explaining the care experience booklet, nurses engage in an experience where they can teach patients and learn from patients what their learning needs are to understand the surgery better. The PEB will be a reference that will guide patients through the surgical experience. The promotion of health is vital for patients to have a successful surgical recovery (Watson, 2020). As nurses and clinical nurse leaders, we must use all available resources to achieve optimal patient health.

The next central intervention is the 24-hour post-operative call. The 24-hour post-operative call will reinforce the information and education given to the patient while the patient was in the hospital. By using these two methods as part of the total care provided, we can increase the patient's chance of a successful recovery (Burch, 2012). The overall goal of this project is patient empowerment, which is the key to a successful surgical experience and recovery.

The project will be rolled out in three phases. The first phase will be educating the nurses. The second phase will be implementing the use of the PDB and the post-operative call by the

two co-leading RNs on the team. The third phase includes increasing the number of RNs who will be trained and making this project part of the orientation for new RNs.

Specific Aim

The specific aim of this project is to increase PACU RNs' knowledge and education so they can properly use the perioperative booklet and perform 24-hour post-operative calls to TJHR patients.

Section III: Methods

Context

This quality improvement project implementation will happen in the perioperative department of NHC. In this department, some RNs specialize in the pre-operative care of surgical patients and other RNs specialize in the recovery (recovery room nurses) of surgical patients. RNs who specialize in the care or the recovery of post-surgical patients are the primary target audience. The reason these post-surgical care nurses (recovery room) where chosen to be the implementers of this project is because of their critical care training, and although they specialize in post-surgical care, they routinely participate in pre-operative care of these patients. The post-surgical RNs also work closely with anesthesia providers and anesthetics and can communicate with the patients about this during the pre-surgical discussion and 24-hour post-operative call.

An informal survey was conducted during the week of April 19, 2020, at a recovery room nurses' huddle led by the unit's assistant nurse manager and project lead. During this huddle, the participants went through a SWOT analysis to understand better what the recovery room nurses thought of the project (see Appendix H). The initial reception of the described project was positively received. There were some minor questions from the RNs (see Appendix I).

Creating education to help retain RNs within hospital systems can be expensive to an organization (B. Williams, personal communication, January 16, 2020). The leader of this quality improvement project considered this factor when devising and implementing the plan. Training and ongoing cost for the RN to perform the duties of the project were taken into consideration. Calculations for the return on this initial investment were calculated (see Appendix J). The potential incurred costs if a patient is discharged home unprepared were considered (Sutton et al.,

2017).

The cost of patients going unprepared can be incurred when they develop a surgical site infection or return to the hospital, potentially incurring long-term care costs. These costs can vary from $10,000/night in the hospital to approximately $23,000/night in the hospital. The goal is that patients will be supported through this process and have the tools and support to care for themselves effectively in the home after surgery. This type of support can aid in reducing surgical infections and reducing readmissions (Hauk, 2018)

Intervention

A properly educated team is important for the successful implementation of a new intervention (Hawks, 1992). The intervention measured in the first stage of this quality improvement project will be the effectiveness of the training program to prepare the RNs to educate the patients using the PEB and making a 24-hour post-operative call. An educational handout or brochure can improve a patient's post procedure compliance and satisfaction (Sutton et al., 2017)

An online survey can be a valuable tool to collect data and to understand an RN's thoughts about their work environment and duties (Evans & Mathur, 2005). Using Survey Monkey, an online survey tool, a survey was administered to the peri-operative staff (PACU and ambulatory surgical unit [ASU]) to assess their ability to use the perioperative booklet to educate patients and to conduct a 24-hour post-operative call. The result showed that the majority of the RNs felt apprehensive about performing a 24-hour post-operative call and less so of using the PEB. A pre-education survey was given to the PACU RNs, with 25 of 34 nurses in the PACU responding (see Appendix K). The survey was conducted using five questions. These questions were designed to determine the current state of the PACU RNs and their ability to use the PEB

and to make the 24-hour post-operative call. In the questionnaire, 36% of the 25 nurses who responded stated they disagreed that they could educate the TJHR patients before they went into surgery. When the same RNs were asked if they could successfully perform a 24-hour post-operative call, 68% of the nurses stated that they could not or they were neutral about their ability to place that call. The comments from the RNs displayed that they were unaware they could be doing these two functions and felt other professionals of the care team should be preforming these functions. According to the Association for Perianesthesia Nurses (ASPAN, 2015), it is within the scope of practice of the PACU nurse to place post-operative calls. Not only is it within the scope of practice, but PACU nurses should strive for a standard of care that they are making post-operative calls (ASPAN, 2015)

With a small group of RNs who work in NCH's perioperative department, the leader of the quality improvement project created an education course (PowerPoint education tool) to conduct the first phase of the project (Appendix L). The specific intervention was comprised of a one-hour PowerPoint teaching session with a group of five nurses a day for 10 days. Unfortunately, classes were only held on five of those days because of unit RN shortages. These shortages made it impossible to hold the education session. At the end of the one-hour teaching session, the RNs had an additional hour to ask questions. The teaching session was led by an RN team member and the lead of the quality improvement project. The teaching session detailed the contents of the perioperative booklet and detailed the questions that would be asked when they place the 24-hour post-operative call. The session also reinforced perioperative skills and knowledge to better prepare the RNs to have these discussions with the patients. At the end of each teaching session, a post-education survey was administered to the PACU RNs (see Appendix M). To date, 23/23 RNs have completed this survey.

Study of the Intervention

Appropriate measurement strategies are useful when preforming a quality improvement project. This project is based on the evidence that performing a 24-hour post-operative call and using a pre-operative booklet will increase care experience. This project itself is a small test of change. Performing these two interventions on our TJHR patients should increase care experience and raise OAS CAHPS scores.

During the two weeks the classes were held, meetings were conducted with specific team members to update them on progress of the classes. Although attempts were made, not all team members were available to meet. COVID-19 restrictions made planned meetings hard to achieve. Also because of elective surgery restrictions being lifted, it was difficult to acquire in-depth feedback from team members, as they were occupied with many meetings and this was not a priority.

Measures

The process measures for this project ensure that five nurses a day will be trained from May 29, 2020 until June 9, 2020. The leader and co-leader of this project will complete a daily tally to determine if this is being met. Using Survey Monkey, three to five individuals will take the post-education survey. The survey totals will be tallied at the end of each day.

Having at least 50% of the PACU staff go through the education program created is the outcome desired. This outcome will be measured by the class participation documentation on the sign-in sheet (see Appendix N). The secondary outcome is to see an improvement in the questions answered from the pre-education survey to the post-education survey. In the pre-education survey, the RNs where asked whether they understood the process of using the PEB

and placing the 24-hour post-operative call. Only 7.7%, or two respondents (nurses), said they understood how to implement these interventions. The ideal outcome would be after the education is complete, there will be an improvement in this number. After the education session, the RNs will need to complete a post-education survey and a return demonstration with acted out call. The return demonstration will be scored by the co-lead with a pass/fail. Once the booklet and 24-hour post-operative call is implemented, the patients will be given a satisfaction survey (see Appendix O).

Balancing measures for this project to date were related to the SARS-CoV-2 outbreak. When this project initially started, the goal was to place 10 calls per week from March 1, 2020 to May 17, 2020. Unfortunately, elective cases were cancelled. The RNs in the perioperative department were directed to retrain to become critical care RNs. The reason this training was conducted was to prepare for an event or a surge of patients with this virus. The leader of this quality improvement project was responsible for some of the teaching, so was unable to continue the project on the same timeline. Continued training for this project could have left the RNs with change fatigue because of all the new changes. Therefore, the balancing measure is that nurses participate, which will be measured by participation in the class.

Ethical Considerations

Whenever a quality improvement project is implemented and then studied for efficacy, it is essential to consider bias towards the participants of the study (Smith, 2014). Health literacy is also a consideration that will be afforded to the patients in the perioperative department. Patients who will receive the interventions will be English-speaking, as there is no consistent way that all languages can be accommodated currently. Not having access to current translation could place the RN performing the intervention in a position where they may convey information.

As this project is a quality improvement project, it was essential to ensure that all patients are treated equally and fairly. At no point were any experimental efforts made on the patients, nurses, or team of this quality improvement project. The University of San Francisco nursing faculty accepted the quality improvement project as such (see Appendix P).

Placing a 24-hour post-operative call is shown to be effective in reducing patient anxiety and questions about nausea, vomiting, and pain and will increase care experience (Clari et al., 2015). Furthermore, using the PEB reinforces the information that patients receive in their pre-surgery interview.

Outcome Measure Results

Fifty percent of the nurses in the PACU have attended the education session, and 50% of the RNs have currently been trained on how to place the post-operative call and use the PEB. The original outcome measure was to have 50% of the nurses trained with the PEB and to make the 24-hour post-operative call. A pre-education survey and a post-education survey were given to the RNs. There was a marked difference in the RNs' responses to the questions in the survey. The questions related to the confidence of the RN's ability to perform the interventions. In the pre-education survey, 64% of the RNs felt they had little to no confidence in being able to teach TJHR patients before surgery or place a 24-hour post-operative call.

The RNs were allowed to comment on their thoughts and feelings about this added workload. The comments were incorporated into the study phase of a plan-do-study-act (PDSA) cycle to change the education session (see Appendix P). The RNs were then given a post-education survey, and the results displayed a marked difference in their responses and understanding of how to use the perioperative experience booklet and 24-hour call with our patients (see Appendix R).

Summary

The progression of this quality improvement project was greatly affected by the SARS-CoV-2 pandemic of 2020. The pandemic affected the stakeholders buy-in into this project and their ability to support the leader of the project in the same fashion as they did before the pandemic hit (see Appendix S). There was also an inability to have the same level of scheduled meetings because of the social distancing recommendation from the Centers for Disease Control and Prevention (2020), which suggested limiting meetings to less than 10 people and physical distancing of six feet. The leader of the project was able to hold some meetings over Microsoft Teams application. The first phase of this project was the only phase before the end of the MSN program for which the leader was currently enrolled.

The quality improvement project was supported by the team members and the senior leadership, which was important to maintain momentum and overcome barriers. Some of the barriers were culture issues in the department. Theses culture issues had the potential to limit the leader's ability to successfully implement the intervention. The strong showing of support from the leadership team was instrumental to overcome this barrier.

At the beginning of this project, the leader of this quality improvement project believed that a 100% participation was possible. The changing environment of the PACU during the SARS-CoV-2 pandemic was a major setback, which is why only 50% of the RNs in the PACU went through the education program.

Looking forward, this project serves as a part of the long-range plan. As this project moves into the final stage, as previously described, the goal is to increase the cohort of patients involved. A general surgical PEB is being developed with RNs in the PACU. The two PACU RNs will create this booklet as a Staff Nurse III project. As part of their project, the RNs will

create a tool that will be used to teach all new hire RNs. As a means to further sustain this project until it needs to be updated, an RN leader currently in an earlier semester of graduate school at University of San Francisco will continue the quality improvement plan.

Conclusion

The education session showed it to be a positive tool to use to increase the nurse's knowledge of the interventions. Adequate nurse preparation to implement this intervention will increase the chance that this intervention achieves the goal of increasing the OAS CAHPS scores. The quality improvement project fulfills the first phase there may be some additional adjustments and interventions that may need to be added as the project continues.

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Section V: Appendices

Appendix A. OAS CAHPS Survey

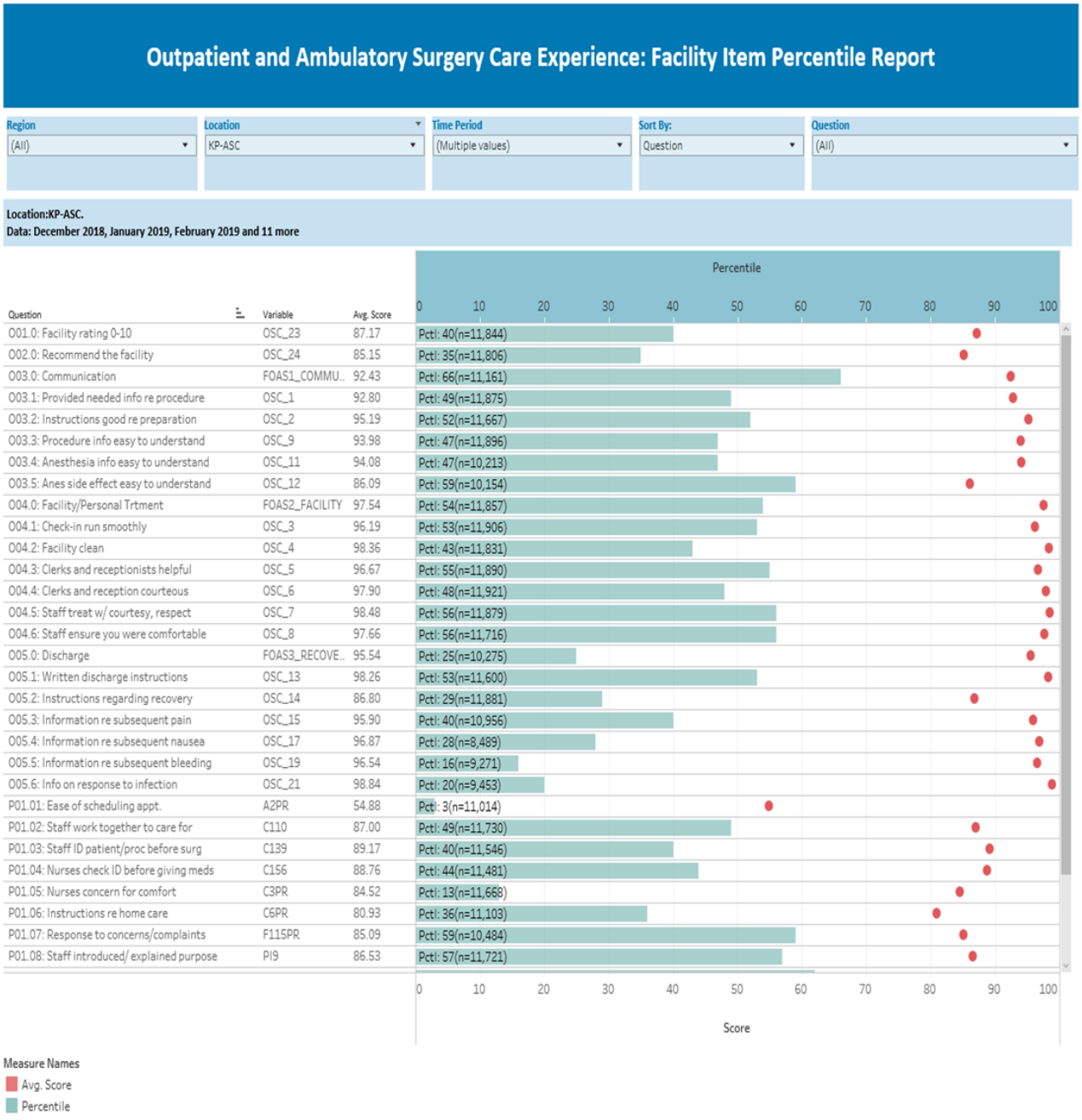
Outpatient and Ambulatory Surgery CAHPS® Survey

Protocols and Guidelines Manual

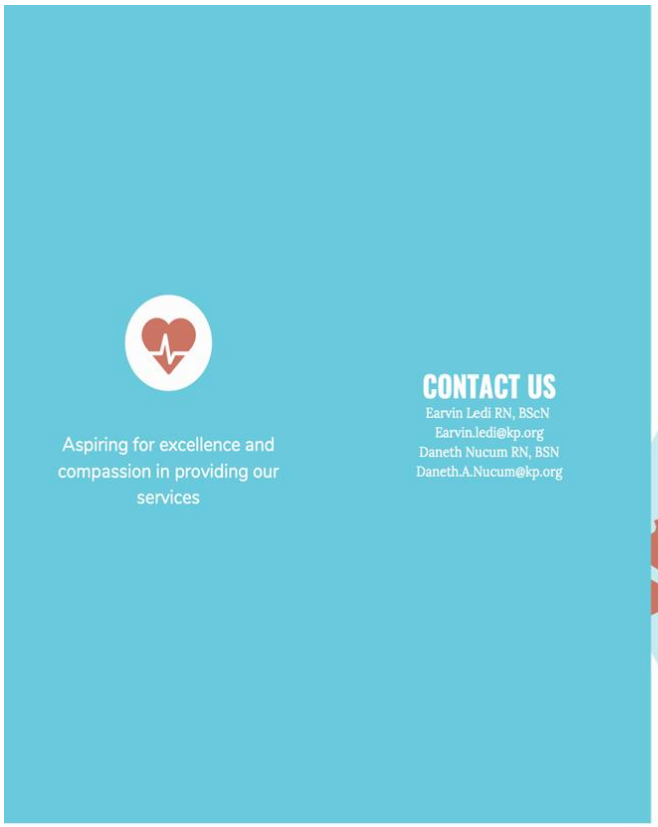
Version 4.0

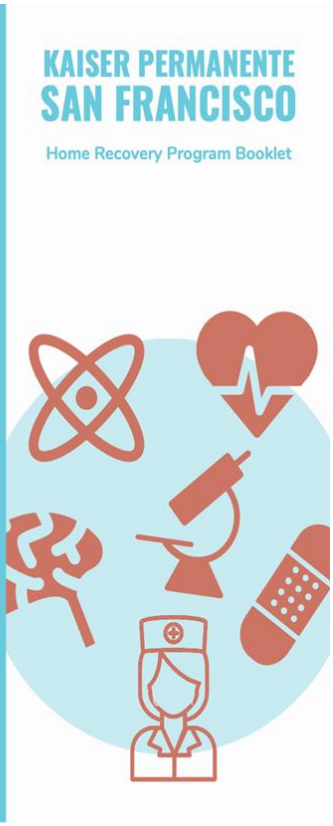
November 2019

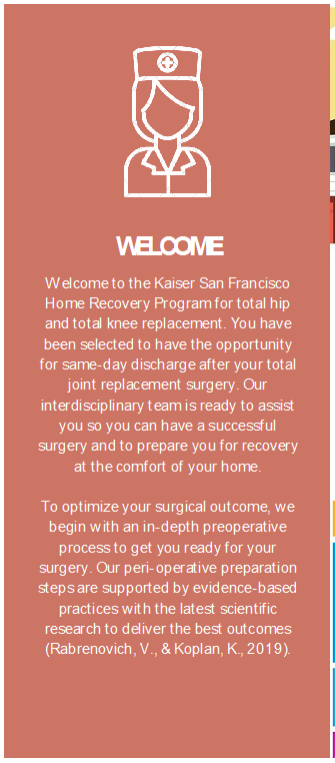
Appendix B. OAS CAHPS December 2018 to March 2020 Scores

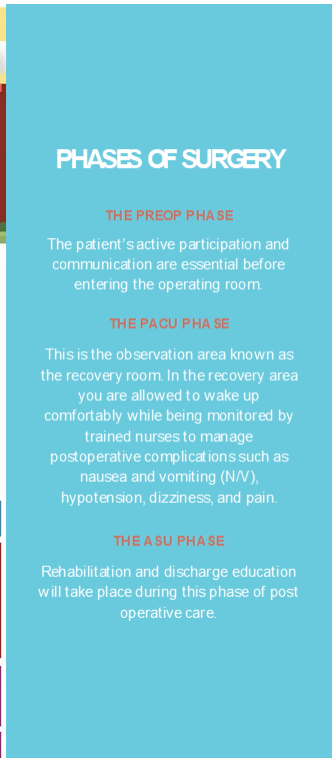


Appendix C. Peri-Operative Experience Booklet (TJHR Patients)









PREOP INTERVIEW

This is done to understand some information about you, so we can better plan and facilitate your discharge early. We will interview you about your readiness for home recovery. This includes equipment needs (walker or crutches), caretaker(s) that will participate and assist with home care and understanding your home environment status (number of stairs). After a few interview questions, we begin prepping you with evidence-based practice protocols for surgical site infection (SSI) prevention and Enhanced Recovery After Surgery (ERAS).

SSI PREVENTION ERAS PROTOCOLS

Patient Warming: Maintaining your core body temperature above 36C (96.8F) with our warming device has significantly reduced SSI. The body temperature will drop when you are receiving anesthesia, and hypothermia (low body temperature) is stressful to your body (Bu et al., 2019).

Assess the surgical site: hair clipping and wiping the skin with an antiseptic Chlorhexidine wipe has shown to reduce harmful bacterial load on the skin surface to prevent surgical infection.

SSI PREVENTION ERAS PROTOCOLS

Apply an Iodine solution into the nares of the nose to reduce potentially harmful bacteria that could lead to SSI (Sakr et al., 2018).

Provide multimodal pain management pre-opertively:
Tylenol (pain reliever)
Celebrex (anti-inflammatory)
Gabapentin (relax the peripheral nerves)
These medications have shown that preoperative pain is better managed and allows early participation with the Physical Therapy Team.

SSI PREVENTION ERAS PROTOCOL

THE PACU PHASE

Anesthetic pain management may begin after the anesthesia team has interviewed you. The anesthesia team will walk you through the pain management for your surgery. A tailored-patient participating in pain management either with a rapid-resolving spinal anesthetic pain management approach allows early mobilization and precise pain control before, during, and after surgery.

When all team members (surgeon, anesthesiologist/nurse anesthetist, and OR nurse) have met and answered all your concerns regarding your surgery, you will be transported into the operating room. Another safety measure that will take place is called a "time out" procedure; it allows your surgery team to pause and review all your accurate information before sedation and beginning surgery. Your surgery may take at least two hours long, and you will be waking up in the post anesthesia care unit (PACU) for observation. Your surgeon will then go over the surgery results with your family, friends, and/or caregiver(s).

WAKE UP AREA

Oral pain medication will be initiated if you have no N/V and are able to swallow pills before the rapid dissolving spinal anesthetic wears off. If you have a nerve catheter, also known as an On-Q pump medication for nerve block pain management, it will be activated on arrival to the PACU. The On-Q will last you multiple days after surgery and significantly reduce narcotic dependence.

Education regarding the On-Q pump will be given before discharge during the ASU phase. As soon as you are comfortable and able to do straight leg raises, the fluid challenge is prescribed. About 60-90 minutes after you arrive in the PACU, you should be able to dangle, maintain upright posture without N/V, excessive pain, hypotension and stable vital signs. Then you will be ready to transfer to the ASU to begin physical therapy and discharge.

REHABILITATION & DISCHARGE EDUCATION

A detailed report will be given to the ASU nurse to begin your rehabilitation process. Your caregiver will be invited to the bedside to receive the education along with you. A specialized Home Recovery team is ready to assist you in completing the rehabilitation and discharge planning. A discharge planner, physical therapist (PT), pain service anesthesiologist, and physician's assistant will be assigned to your case to evaluate your progress and provide education. The PT will evaluate your readiness to transfer, stand, ambulate, and manage stairs.

When will I go home?

Once you have completed the PT evaluation and have demonstrated safe mobility, your nurse will plan your discharge with the planner. You will have Home Health resources to assist you at home. The discharge nurse will educate you about the On-Q pump if you are going home with it.

The anesthesia department will call you the next day to ensure the pump is functioning properly. The physician's assistant will write your discharge medications, instructions, and the discharge planner will arrange a PT and Home Health nurse visit at your home base.

Our goal is to provide the most efficient and safe care for our patients and the community we serve.

The KP Home Recovery Program is eager to assist you and your caregiver(s) in promoting a safe and effective same-day total joint replacement surgery. Please communicate with us and ask all the questions you have so we can provide information to encourage a successful surgery and recovery.

KAISER PERMANENTE®

SURGICAL WOUND CARE

WASH YOUR HANDS WITH SOAP AND WATER BEFORE AND AFTER TOUCHING YOUR WOUND.

wound care.

- Your surgery site has a waterproof dressing which will be removed 7 days after surgery. You can shower with the waterproof dressing. However if you have a nerve catheter, please avoid showering or getting the dressing wet until it is removed (usually after 3 days).
- After the waterproof dressing is removed, you may shower. Gently pat the incision dry, DO NOT rub the wound with force.

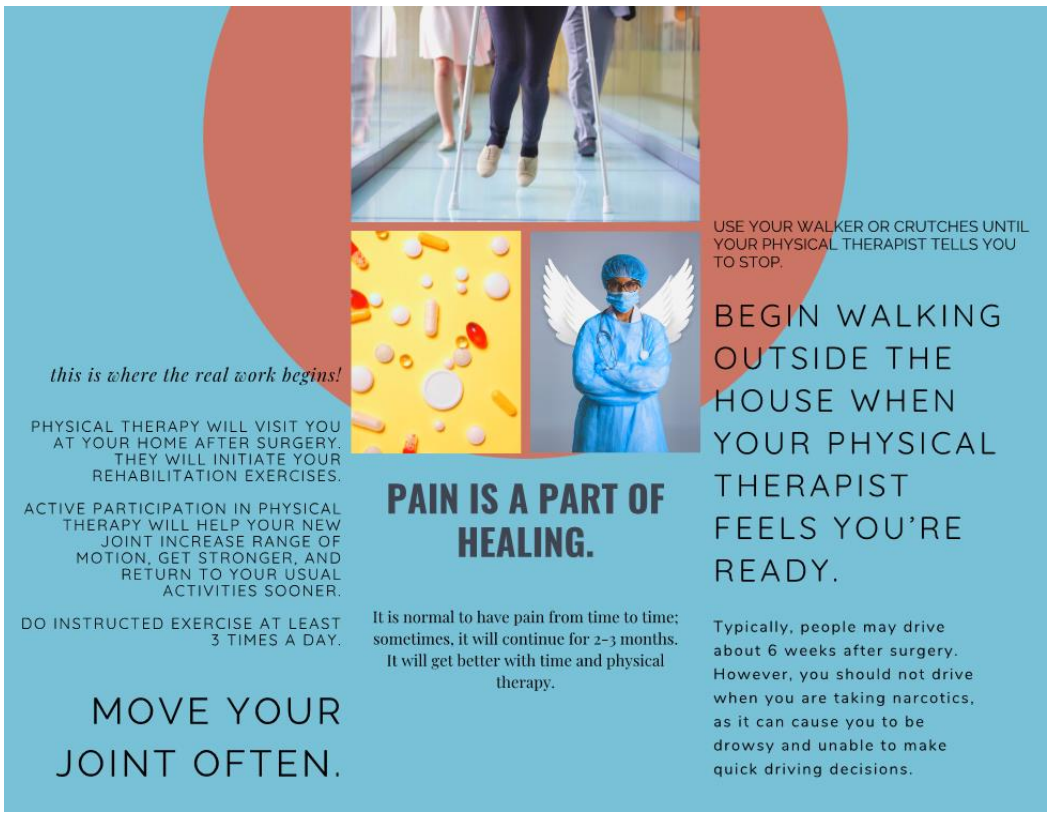
Contact us

Don't hesitate to call with any questions or concerns regarding your after care!

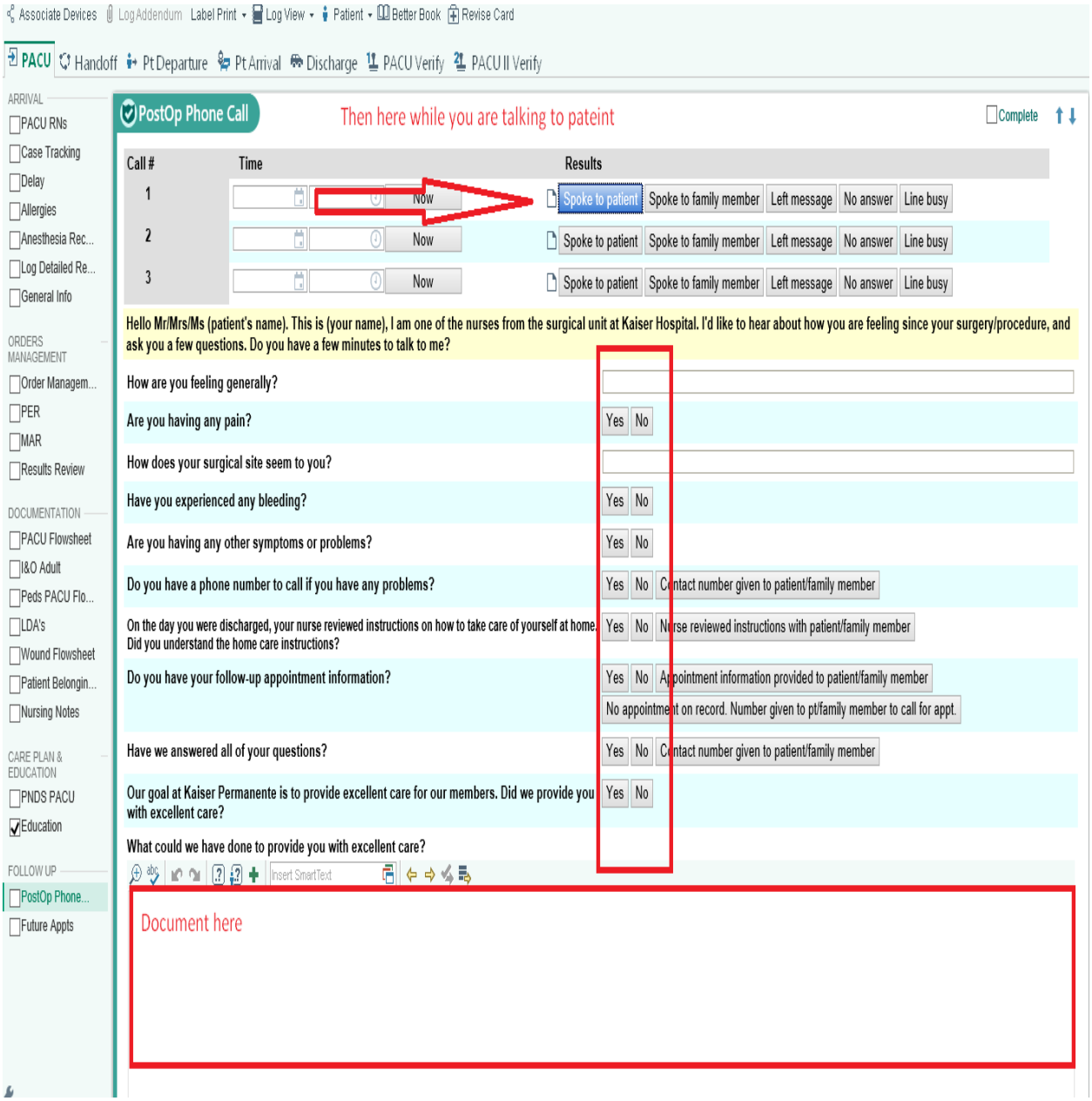
recovering at home

after total joint surgery

- If steristrips (surgical wound closure tape) have been placed, you will find it under the waterproof dressing. Keep the steristrips dry and intact, they will fall off on their own. DO NOT submerge or soak the incision in water (such as a bath or pool). This may cause incisional infection.
- It is normal to have swelling, bruising, or a change in skin color around the incision. Your incision may feel numb, and you may hear clicking or noises from your joint. Continue taking pain medications, and do your exercises, ice, and elevating your leg will help the healing process.
- If there are wound issues such as active bleeding, extensive drainage that saturate the entire dressing, and unusual redness/bruising contact the Orthopedic Care Team.



Appendix D. 24-Hour Post-Operative Questions to Ask patients



Appendix E. PICO Question

(P) Do PACU RN's benefit from a **(I)** 2 hours education program taught by a CNL student effectively increase their ability to teach total joint home recovery (TJHR) patients **(C)** as opposed to no education before a roll out of a pre-operative teaching tool and a 24-hour post-operative call for TJHR patients.

Appendix F. Microsystem Assessment Tool

CLINICAL MICROSYSTEM ASSESSMENT TOOL

Instructions: Each of the "success" characteristics (e.g., leadership) is followed by a series of three descriptions. For each characteristic, ***please check*** the description that ***best describes*** your current microsystem and the care it delivers *OR* use a microsystem you are *MOST* familiar with.

	Characteristic and Definition	Descriptions			
Leadership	**1. Leadership:** The role of leaders is to balance setting and reaching collective goals, and to empower individual autonomy and accountability, through building knowledge, respectful action, reviewing and reflecting.	☐ Leaders often tell me how to do my job and leave little room for innovation and autonomy. Overall, they don't foster a positive culture.	☐ Leaders struggle to find the right balance between reaching performance goals and supporting and empowering the staff.	☐ Leaders maintain constancy of purpose, establish clear goals and expectations, and foster a respectful positive culture. Leaders take time to build knowledge, review and reflect, and take action about microsystems and the larger organization.	☐ Can't Rate
Leadership	**2. Organizational Support:** The larger organization looks for ways to support the work of the microsystem and coordinate the hand-offs between microsystems.	☐ The larger organization isn't supportive in a way that provides recognition, information, and resources to enhance my work.	☐ The larger organization is inconsistent and unpredictable in providing the recognition, information and resources needed to enhance my work.	☐ The larger organization provides recognition, information, and resources that enhance my work and makes it easier for me to meet the needs of patients.	☐ Can't Rate
Staff	**3. Staff Focus:** There is selective hiring of the right kind of people. The orientation process is designed to fully integrate new staff into culture and work roles. Expectations of staff are high regarding performance, continuing education, professional growth, and networking.	☐ I am not made to feel like a valued member of the microsystem. My orientation was incomplete. My continuing education and professional growth needs are not being met.	☐ I feel like I am a valued member of the microsystem, but I don't think the microsystem is doing all that it could to support education and training of staff, workload, and professional growth.	☐ I am a valued member of the microsystem and what I say matters. This is evident through staffing, education and training, workload, and professional growth.	☐ Can't Rate
Staff	**4. Education and Training:** All clinical microsystems have responsibility for the ongoing education and training of staff and for aligning daily work roles with training competencies. Academic clinical microsystems have the additional responsibility of training students.	☐ Training is accomplished in disciplinary silos, e.g., nurses train nurses, physicians train residents, etc. The educational efforts are not aligned with the flow of patient care, so that education becomes an "add-on" to what we do.	☐ We recognize that our training could be different to reflect the needs of our microsystem, but we haven't made many changes yet. Some continuing education is available to everyone.	☐ There is a team approach to training, whether we are are training staff, nurses or students. Education and patient care are integrated into the flow of work in a way that benefits both from the available resources. Continuing education for all staff is recognized as vital to our continued success.	☐ Can't Rate
Staff	**5. Interdependence:** The interaction of staff is characterized by trust, collaboration, willingness to help each other, appreciation of complementary roles, respect and recognition that all contribute individually to a shared purpose.	☐ I work independently and I am responsible for my own part of the work. There is a lack of collaboration and a lack of appreciation for the importance of complementary roles.	☐ The care approach is interdisciplinary, but we are not always able to work together as an effective team.	☐ Care is provided by a interdisciplinary team characterized by trust, collaboration, appreciation of complementary roles, and a recognition that all contribute individually to a shared purpose.	☐ Can't Rate
Patients	**6. Patient Focus:** The primary concern is to meet all patient needs — caring, listening, educating, and responding to special requests, innovating to meet patient needs, and smooth service flow.	☐ Most of us, including our patients, would agree that we do not always provide patient centered care. We are not always clear about what patients want and need.	☐ We are actively working to provide patient centered care and we are making progress toward more effectively and consistently learning about and meeting patient needs.	☐ We are effective in learning about and meeting patient needs — caring, listening, educating, and responding to special requests, and smooth service flow.	☐ Can't Rate

Side A

Please continue on Side B

CLINICAL MICROSYSTEM ASSESSMENT TOOL

- CONTINUED -

	Characteristic and Definition		Descriptions			
Patients	**7. Community and Market Focus:** The microsystem is a resource for the community; the community is a resource to the microsystem; the microsystem establishes excellent and innovative relationships with the community.		☐ We focus on the patients who come to our unit. We haven't implemented any outreach programs in our community. Patients and their families often make their own connections to the community resources they need.	☐ We have tried a few outreach programs and have had some success, but it is not the norm for us to go out into the community or actively connect patients to the community resources that are available to them.	☐ We are doing everything we can to understand our community. We actively employ resources to help us work with the community. We add to the community and we draw on resources from the community to meet patient needs.	☐ Can't Rate
Performance	**8. Performance Results:** Performance focuses on patient outcomes, avoidable costs, streamlining delivery, using data feedback, promoting positive competition, and frank discussions about performance.		☐ We don't routinely collect data on the process or outcomes of the care we provide.	☐ We often collect data on the outcomes of the care we provide and on some processes of care.	☐ Outcomes (clinical, satisfaction, financial, technical, safety) are routinely measured, we feed data back to staff, and we make changes based on data.	☐ Can't Rate
	9. Process Improvement: An atmosphere for learning and redesign is supported by the continuous monitoring of care, use of benchmarking, frequent tests of change, and a staff that has been empowered to innovate.		☐ The resources required (in the form of training, financial support, and time) are rarely available to support improvement work. Any improvement activities we do are in addition to our daily work.	☐ Some resources are available to support improvement work, but we don't use them as often as we could. Change ideas are implemented without much discipline.	☐ There are ample resources to support continual improvement work. Studying, measuring and improving care in a scientific way are essential parts of our daily work.	☐ Can't Rate
Information and Information Technology	**10. Information and Information Technology:** Information is THE connector - staff to patients, staff to staff, needs with actions to meet needs. Technology facilitates effective communication and multiple formal and informal channels are used to keep everyone informed all the time, listen to everyone's ideas, and ensure that everyone is connected on important topics. *Given the complexity of information and the use of technology in the microsystem, assess your microsystem on the following three characteristics: (1) integration of information with patients, (2) integration of information with providers and staff, and (3) integration of information with technology.*	A. Integration of Information with Patients	☐ Patients have access to some standard information that is available to all patients.	☐ Patients have access to standard information that is available to all patients. We've started to think about how to improve the information they are given to better meet their needs.	☐ Patients have a variety of ways to get the information they need and it can be customized to meet their individual learning styles. We routinely ask patients for feedback about how to improve the information we give them.	☐ Can't Rate
		B. Integration of Information with Providers and Staff	☐ I am always tracking down the information I need to do my work.	☐ Most of the time I have the information I need, but sometimes essential information is missing and I have to track it down.	☐ The information I need to do my work is available when I need it.	☐ Can't Rate
		C. Integration of Information with Technology	☐ The technology I need to facilitate and enhance my work is either not available to me or it is available but not effective. The technology we currently have does not make my job easier.	☐ I have access to technology that will enhance my work, but it is not easy to use and seems to be cumbersome and time consuming.	☐ Technology facilitates a smooth linkage between information and patient care by providing timely, effective access to a rich information environment. The information environment has been designed to support the work of the clinical unit.	☐ Can't Rate

Side B

Appendix G. Jean Watson's Caring Science Theory

Watson Caring Science Institute

Core Concepts of Jean Watson's Theory of Human Caring/Caring Science

The Core Priniciples/Practices: Evolving From Carative to Caritas (Watson, 2008, p. 34)

- Practice of loving-kindness and equanimity
- Authentic presence: enabling deep belief of other (patient, colleague, family, etc.)
- Cultivation of one's own spiritual practice toward wholeness of mind/body/spirit—beyond ego
- "Being" the caring-healing environment
- Allowing miracles (openness to the unexpected and inexplicable life events)

Core Concepts of the Theory:

- **A relational caring for self and others** based on a moral/ethical/philosophical foundation of love and values

- **Transpersonal caring relationship** (going beyond ego to higher "spiritual" caring created by "Caring Moments")
  - ❖ Moral commitment to protect and enhance human dignity
  - ❖ Respect/"love" for the person—honoring his/her needs, wishes, routines, and rituals
  - ❖ Caring Consciousness of self as person/nurse and other as person—connection as human beings
  - ❖ Heart-centered/healing caring based on practicing and honoring wholeness of mind-body-spirit in self and each other
  - ❖ Inner harmony (equanimity)—maintaining balance
  - ❖ Intention of "doing" for another and "being" with another who is in need (**What** (skills) you do and **how** (caring conscious intention) you do it.)
  - ❖ "Authentic Presence" (honoring/connecting human to human)

- **Caring Occasion/Caring Moment:** Heart-centered Encounters with another person
  When two people, each with their own "phenomenal field"/background come together in a human-to-human transaction that is meaningful, authentic, intentional, honoring the person, and sharing human experience that expands each person's worldview and spirit leading to new discovery of self and other and new life possibilities.

- **Multiple ways of knowing** (through science, art, aesthetic, ethical, intuitive, personal, cultural, spiritual)

- **Reflective/meditative approach** (increasing consciousness and presence to the humanism of self and other) (see Cara, C. (2003). *A Pragmatic View of Jean Watson's Caring Theory*, www.humancaring.org (under "continuing education)
  - ❖ Understanding self through reflection/meditation (journaling, the arts, meditation, etc.)
    - ○ What is the meaning of caring for the person/families/myself?
    - ○ How do I express my caring consciousness and commitment to my patients/clients? To colleagues? To the institution? To the community and larger world?
    - ○ How do I define self, nurse, person, environment, health/healing, and nursing?
    - ○ How do I make a difference in people's life and suffering?
    - ○ How do I increase the quality of people's healing and dying process?
    - ○ How can I be informed by the clinical caritas processes in my practice?
    - ○ How can I be inspired by Watson's caring theory in my practice?

- ❖ Understanding the patient/client/family as a person: Inviting story (Tell me about yourself, your life experiences, your feelings, your bodily sensations, your goals and expectations, your culture, etc., so I may honor you and your healing pathway.)
- ❖ Understanding the patient/client's health needs:
  - Tell me about your health? What is it like to be in your situation?
  - Tell me how you perceive yourself? What are your health priorities?
  - How do you envision your life?
  - What is the meaning of healing for you?

- **Caring is inclusive, circular, and expansive**: Caring for self, caring for each other, caring for patients/clients/families, caring for the environment/nature and the universe.

- **Caring changes self, others, and the culture of groups/environments**.

- **Watson's 10 Carative Factors redefined as Caritas Processes**: Guidelines for putting Love/Heart-Centered Caring practice into action:

1. Practicing loving-kindness and equanimity within context of caring consciousness.
2. Being authentically present and enabling, and sustaining the deep belief system and subjective life world of self and one-being cared for.
3. Cultivating one's own spiritual practices and transpersonal self, going beyond ego self.
4. Developing and sustaining a helping-trusting, authentic caring relationship.
5. Being present to, and supportive of the expression of positive and negative feelings.
6. Creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices.
7. Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within other's frame of reference.
8. Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.
9. Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind-body-spirit, wholeness in all aspects of care.
10. Opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being-cared for; "allowing and being open to miracles."

			healthy growth experiences; does not engage in unethical, illegal, safety-risk or seductive behavior. ❖ Allows others to choose best time to talk about their concern(s).
5	Promotion and acceptance of the expression of positive and negative feelings	Being present to, and supportive of the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared for **Wording of other systems using Watson's theory:** Promote and accept positive and negative feelings; authentically listen to another's story. Promote and accept the expression of positive and negative feelings. (HRC)	**I co-create caring relationships in caring environments to promote spiritual growth.** ❖ Creates/holds sacred space (safe place for unfolding and emerging.) ❖ Acknowledges healing as an inner journey. ❖ Allows for uncertainty and the unknown. ❖ Encourages narrative/storytelling as a way to express understanding. ❖ Allows for story to emerge, change, and grow. ❖ Encourages reflection of feelings and experiences. ❖ Offers blessings, prayer, and spiritual expression as appropriate. ❖ Helps others see some good aspects of their situation. ❖ Actively listens and lets the energy flow through one's self without being consumed by other's feelings. ❖ Accepts and helps others deal with their negative feelings.
6	Systematic use of the scientific problem-solving method of decision-making Refined in 1985: Systematic use of creative problem-solving caring process	Creatively using self and all ways of knowing as part of the caring processes; engaging in artistry of caring-healing practices. **Wording of other systems using Watson's theory:** Use creative scientific problem-solving methods for caring decision-making. Use creative problem-solving to meet the needs of others. (HRC)	**I exercise other-centered problem solving and scholarship in caring for this patient (other).** ❖ Integrates aesthetics, ethical, empirical, personal, and metaphysical ways of knowing with creative, imaginative, and critical thinking for full expression of caring arts and sciences. ❖ Acknowledges and integrates an awareness that the presence of oneself is an effective element of the plan of care for others. ❖ Uses self to create healing environments via: intentional touch; voice, authentic presence; movement; artistic expression; journaling; play-laughter-gaiety; spontaneity; music/sound; preparation; breathing; relaxation/imagery/ visualization; intentionality; appropriate eye contact; smiling/positive gestures; active listening; nature/light/sound/noise protection; etc..... ❖ Encourages others to ask questions. ❖ Helps others explore alternative ways, to find new meaning in their situations/life journeys in dealing with their health/self-health approaches.
7	Promotion of interpersonal teaching-	Engaging in genuine teaching-learning experiences that attend to unity of being and meaning,	**The co-created caring relationship promotes knowledge, growth, empowerment and healing processes and possibilities for patients (others) and for self.**

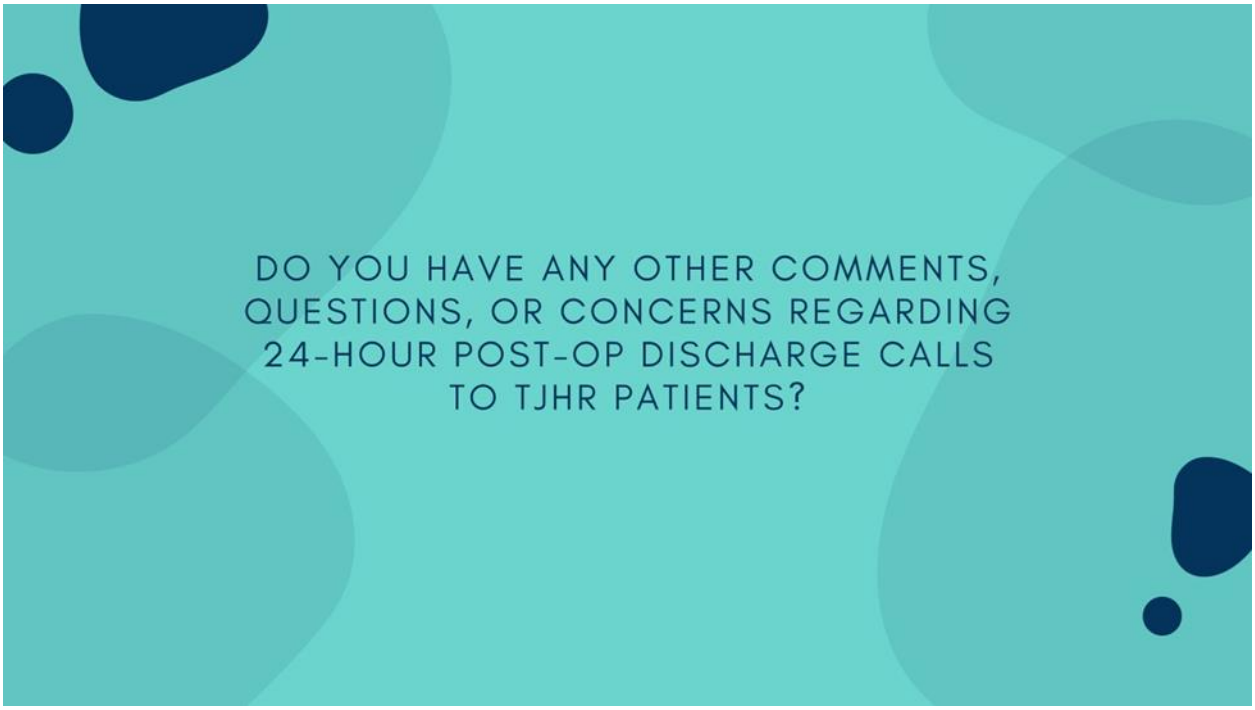
Watson Caring Science Institute

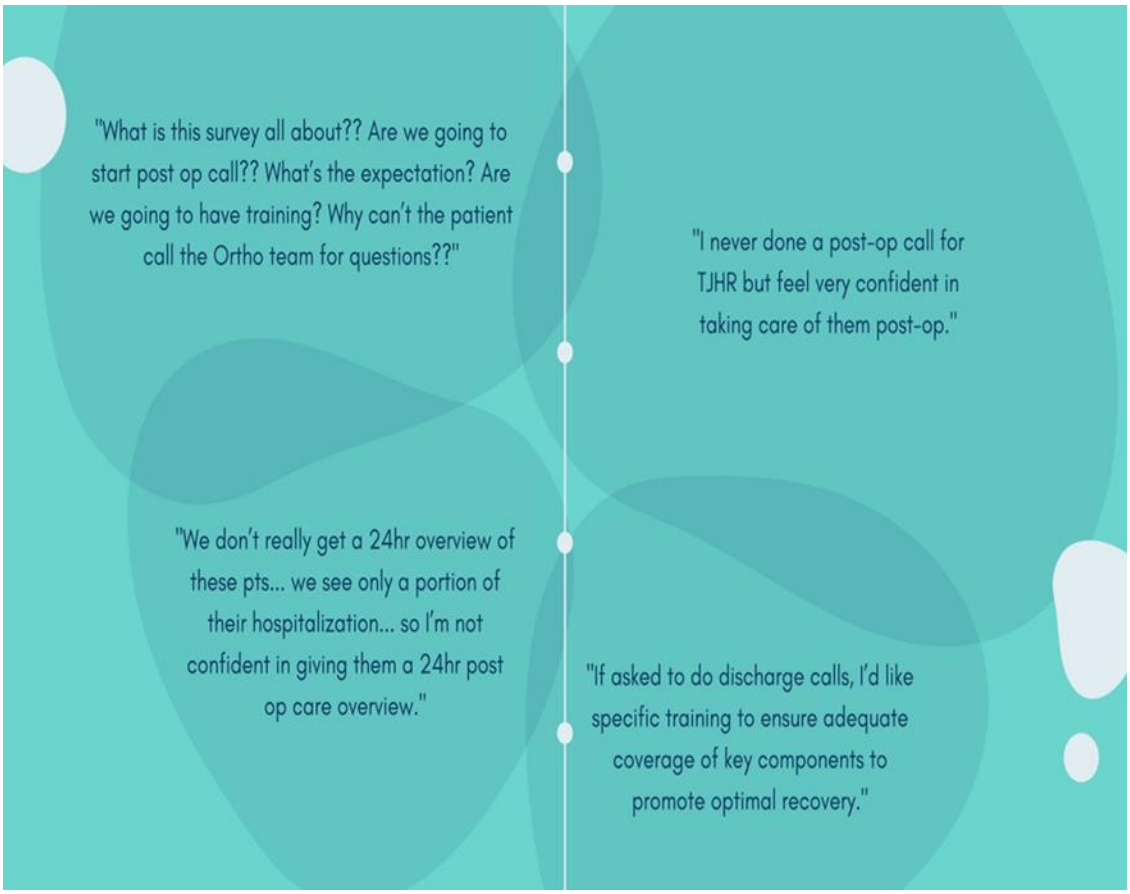
	learning. Refined in 1985: Promoting transpersonal teaching-learning	attempting to stay within another's frame of reference. **Wording of other systems using Watson's theory:** Share teaching and learning that addresses the individual needs, readiness, and learning styles. Perform teaching and learning that addresses individual needs and learning styles. (HRC)	❖ Actively listens with one's whole being to others telling their life experiences. ❖ Speaks calmly, quietly, and respectively to others, giving them full attention at the moment. ❖ Seeks first to learn from others, understand their worldview; then shares, coaches, and provides information, tools, and options to meet others' needs (works from others' frame of reference). ❖ Participates in collegial/collaborative co-creation. ❖ Accepts others as they are and where they are with their understanding, knowledge, readiness to learn. ❖ Helps others understand how they are thinking about their illness/health. ❖ Asks others what they know about their illness/health. ❖ Helps others formulate and give voice to questions and concerns to ask health care professionals.
8	Provision for a supportive, protective, and/or corrective mental, physical, sociocultural, and spiritual environment.	Creating healing environment at all levels (physical, non-physical, subtle environment of energy and consciousness), whereby wholeness, beauty, comfort, dignity, and peace are potentiated. **Wording of other systems using Watson's theory:** Create healing environment for the physical and spiritual self which respects human dignity. Create a healing environment for physical and spiritual needs. (HRC)	**By promoting the caring relationship I created space for this patient (other) to generate his/her own wholeness and healing.** ❖ Creates space for human connections to naturally occur. ❖ Participates in caring-healing consciousness. ❖ Creates caring intentions. ❖ Creates a healing environment attending to: • Nurse as environment • Other as unique person • Light • Art • Water • Noise • Cleanliness • Privacy • Nutrition • Beauty • Safety • Hand washing • Comfort measures • Others' times frames ❖ Others' routines and rituals ❖ Is available to others. ❖ Pays attention to others when they are talking. ❖ Anticipates others' needs
9	Assistance with gratification of human needs.	Reverently and respectfully assisting with basic needs, with an intentional caring consciousness, administering "human care essentials," which	**I was able to help meet the needs this patient (other) identified for him/herself.** ❖ Views others as integrated whole. ❖ Respects others' unique individual needs.

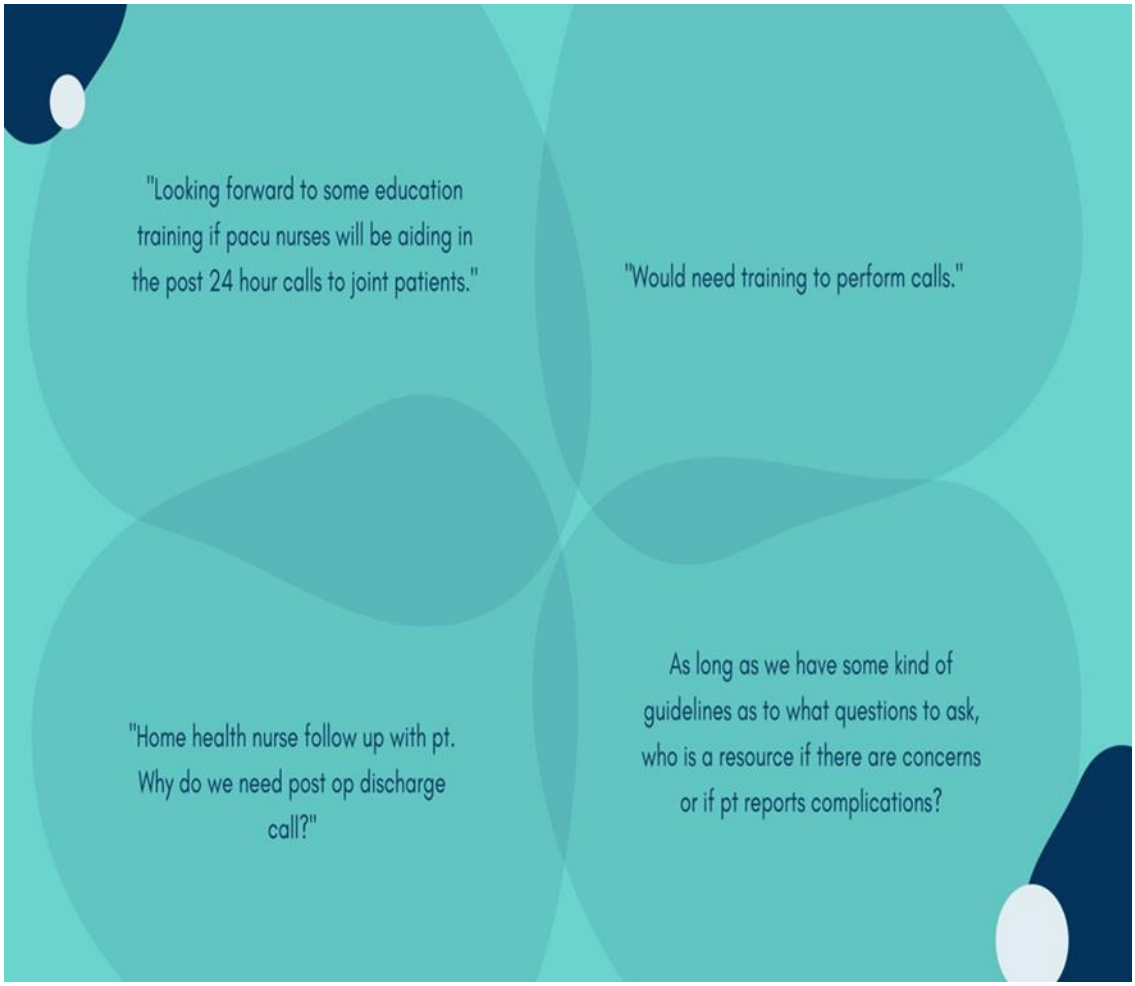
Appendix H. SWOT Analysis

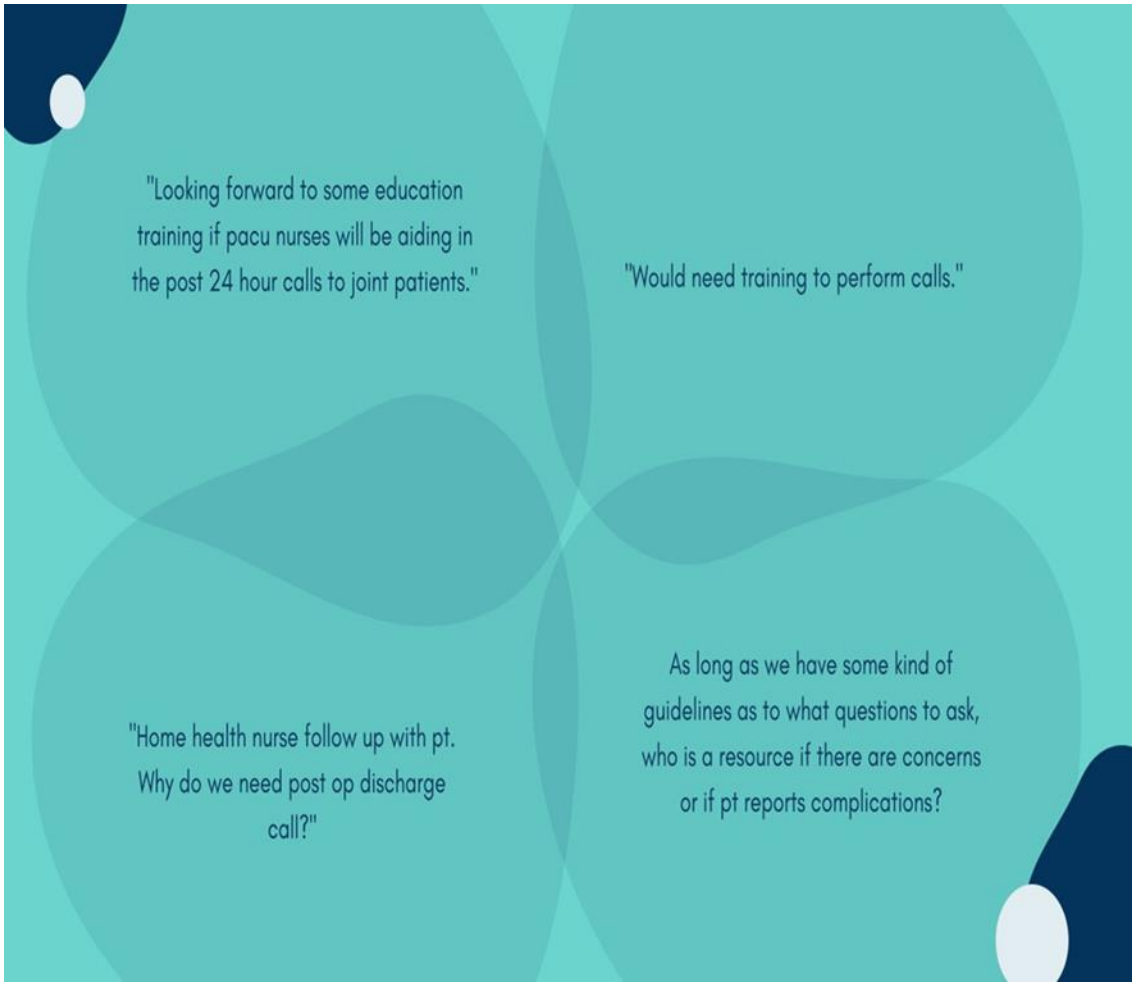
Strengths	Weakness	Opportunities	Threats
Increase patient access to education and knowledge	Continual department operational changes may affect how we engage patients	Increase OAS Scores	RN refusing to participate in the quality improvement project
Long term reduction in costs by empowering patients to be prepared for home recover	In ability to effectively translate per-operative experiences booklet to other languages.	Increase RN involvement of total care of TJHR patients	
increased patient engagement		Improve PACU RNs understanding of OAS CAHPS scores and how they affect the medical center	

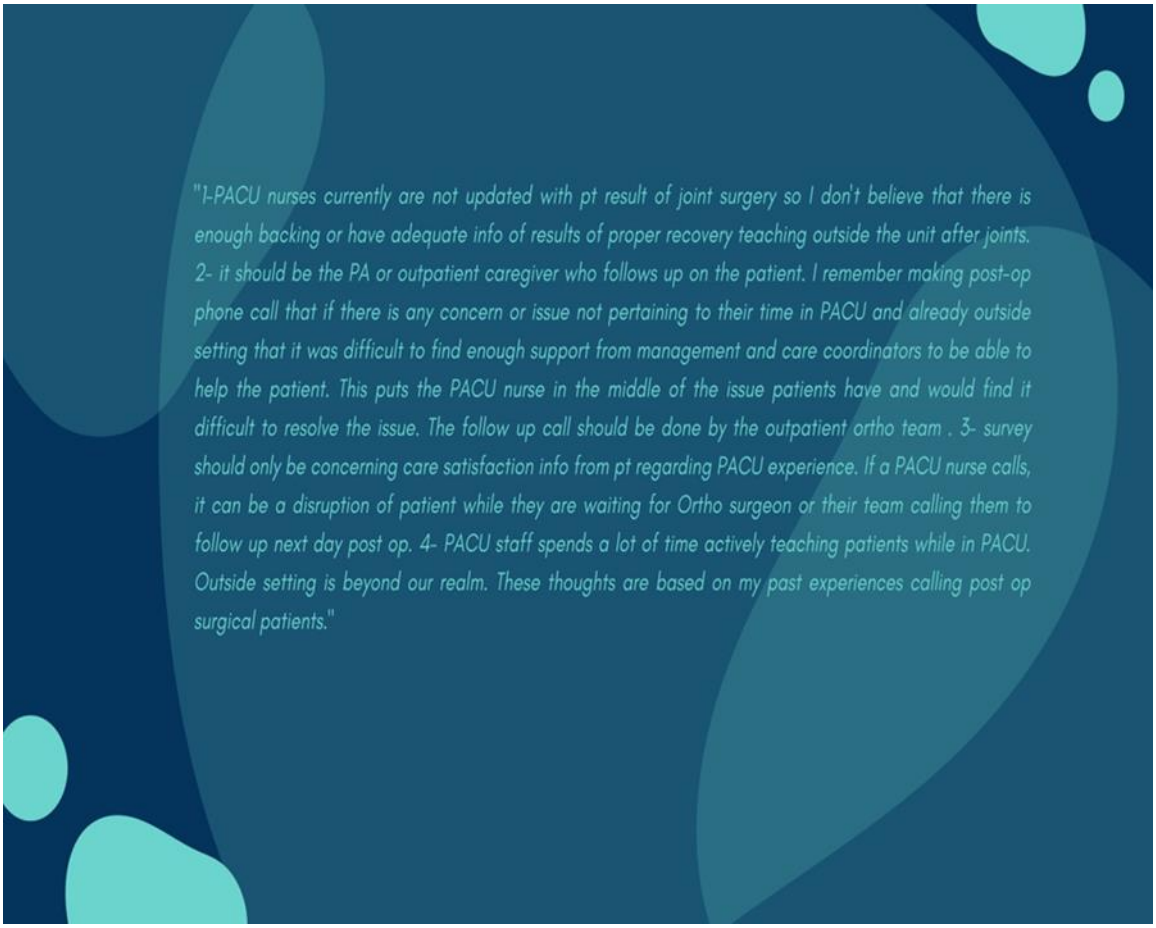
Appendix I. Pre-Education RN Survey Comments











Appendix J. Return on Investment

Expenditures

Initial Investment

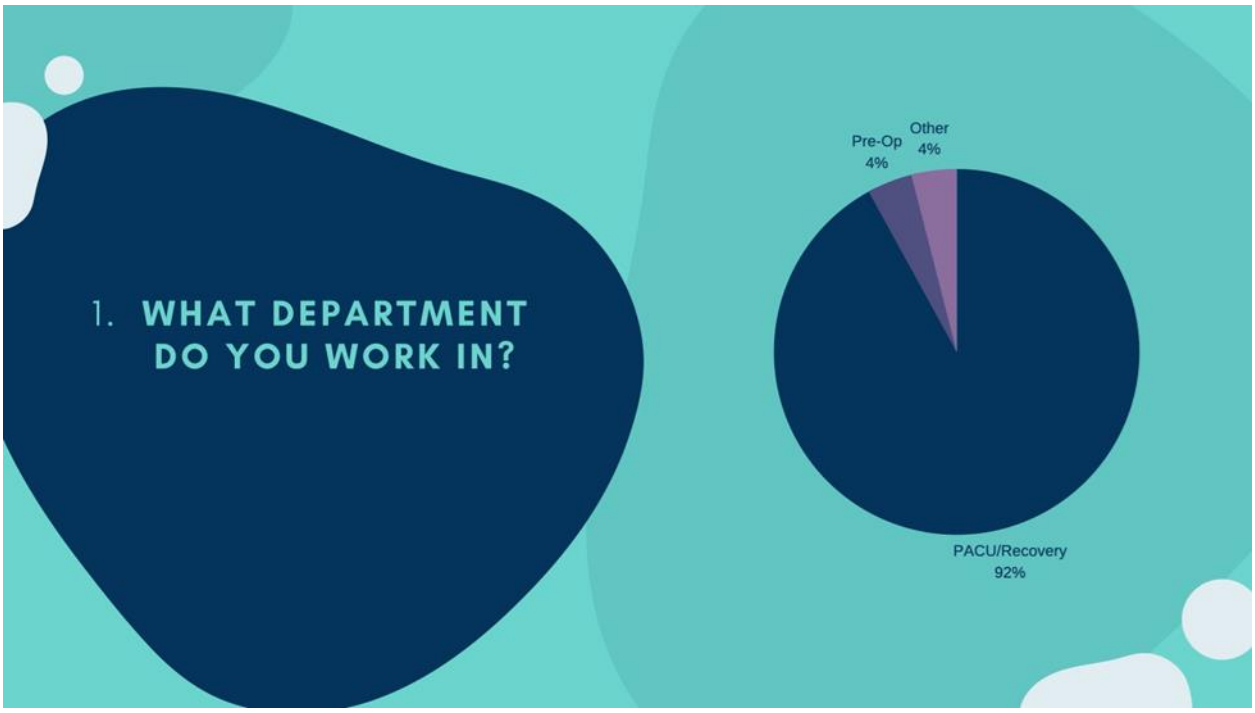
Training for 23 RNs for 2 hours X $85/hour = $3,910
+
Training for the additional 20 RNs (yet to be spent) 2 Hours X $85/hour = $3,400
+
1 week of on the job training for 2 RNs to become the trainers at $85/hour = $6,800
+
1 Year of a full-time RN X $85/hour = $176,800
+
Phone service = $473

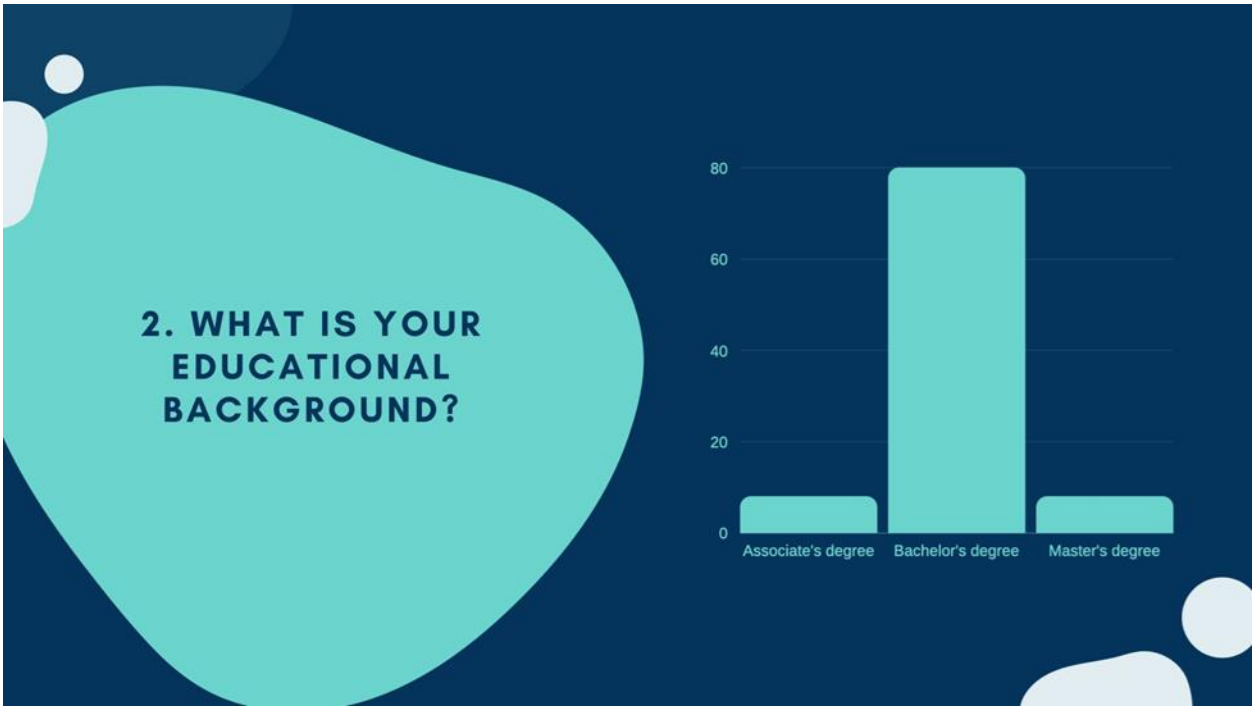
Total first year expense = $190,900

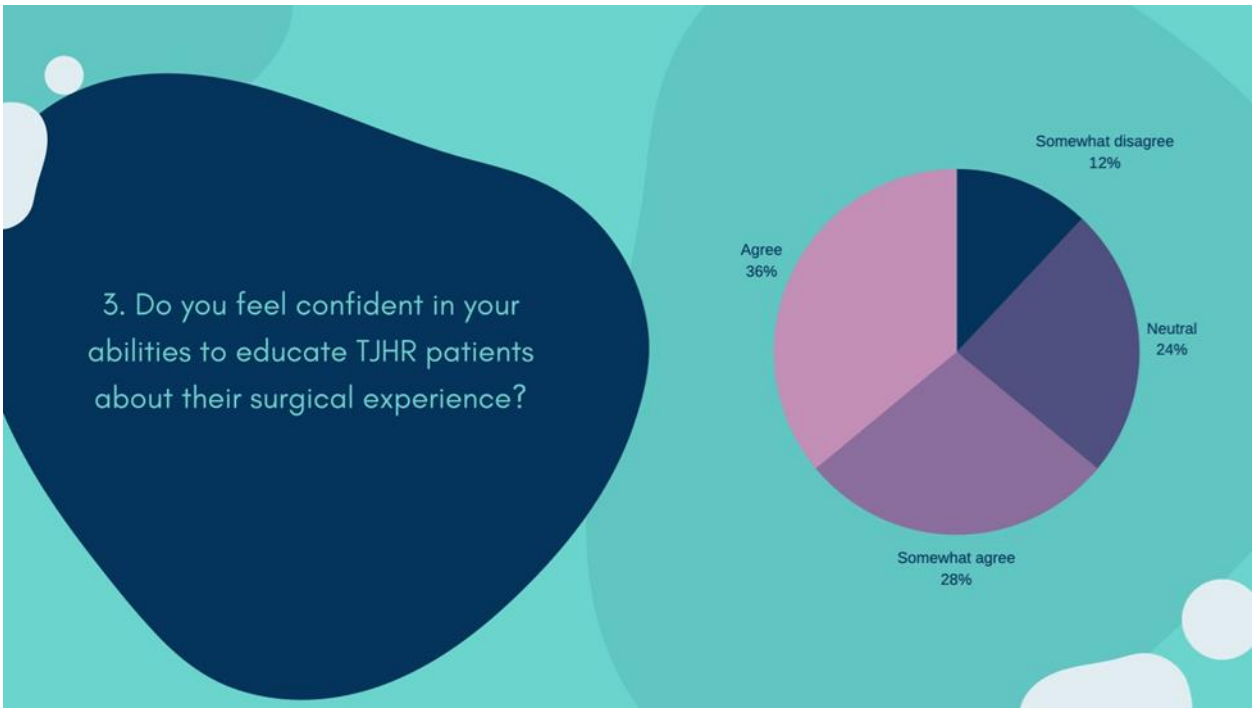
Approximately 10% of total joints surgical cases return to care. If 10% of the total number of cases performed (Total joints) return to the hospital for care for approximately 2 day visit would equal 1.4 million if all of their cases were critical care treatment and 630,000 if they were basic cases.

Therefore, the potential for savings is from $439,000 - $1.209 million.

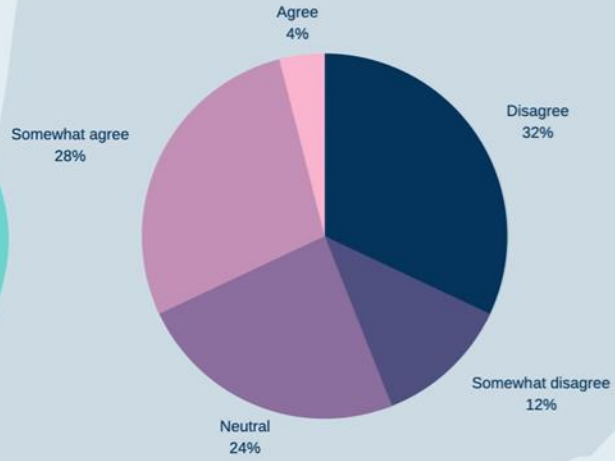
Appendix K. Pre-Education Survey Given to PACU RNs



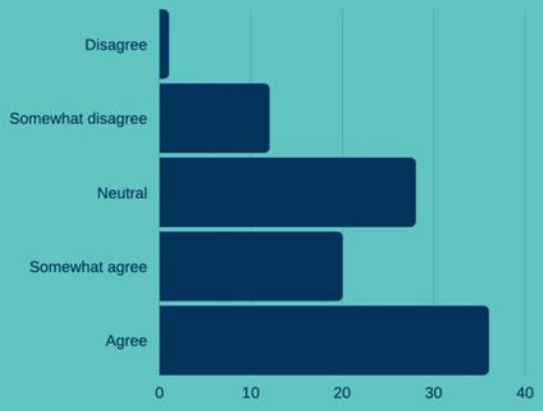




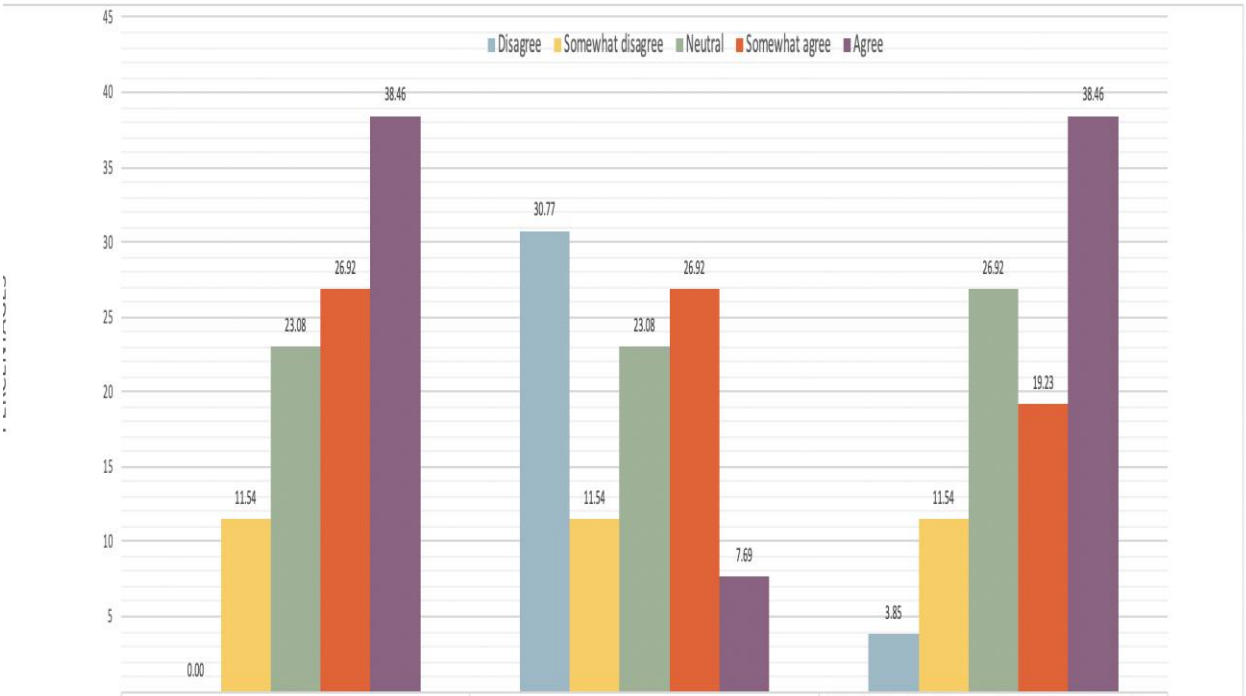
4. Do you feel adequately prepared to perform a 24-hour post-op discharge call to TJHR patients?



5. Without looking at Kaiser analytic data, do you feel that Kaiser members who have undergone total joint surgery perceive that they received excellent care?

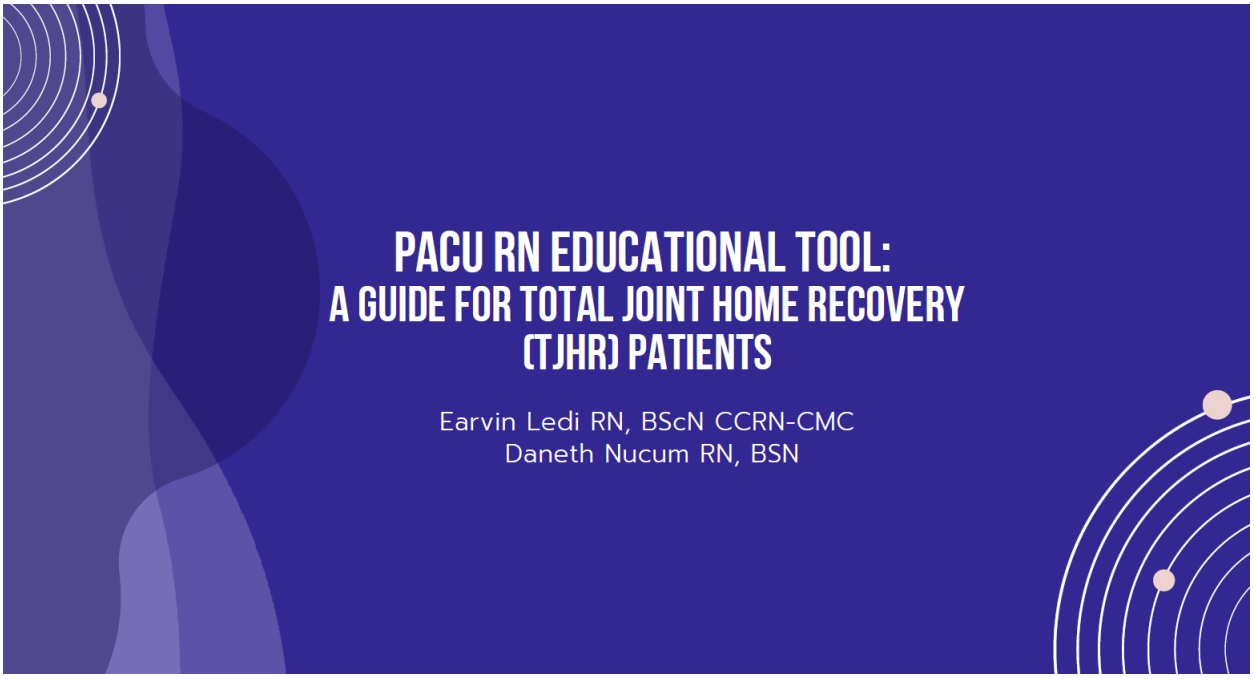


Pre education Survey: RN Readiness for 24-Hour Post-Op Total Joint Home Recovery (TJHR) Discharge Call



	Q3: Do you feel confident in your abilities to educate TJHR patients about their surgical experience?	Q4: Do you feel adequately prepared to perform a 24-hour post-op discharge call to TJHR patients?	Q5: Without looking at Kaiser analytic data, do you feel that Kaiser members who have undergone total joint surgery perceive that they received excellent care?
Disagree	0.00	30.77	3.85
Somewhat disagree	11.54	11.54	11.54
Neutral	23.08	23.08	26.92
Somewhat agree	26.92	26.92	19.23
Agree	38.46	7.69	38.46

Appendix L. Education Course



OUR GOAL IS TO INCREASE CARE EXPERIENCE AT KAISER SF THROUGH THE EDUCATIONAL SUPPORT OF TJHR PATIENTS

By improving patients' perception of quality care through proper and thorough education and follow-up, we could enhance their experience.

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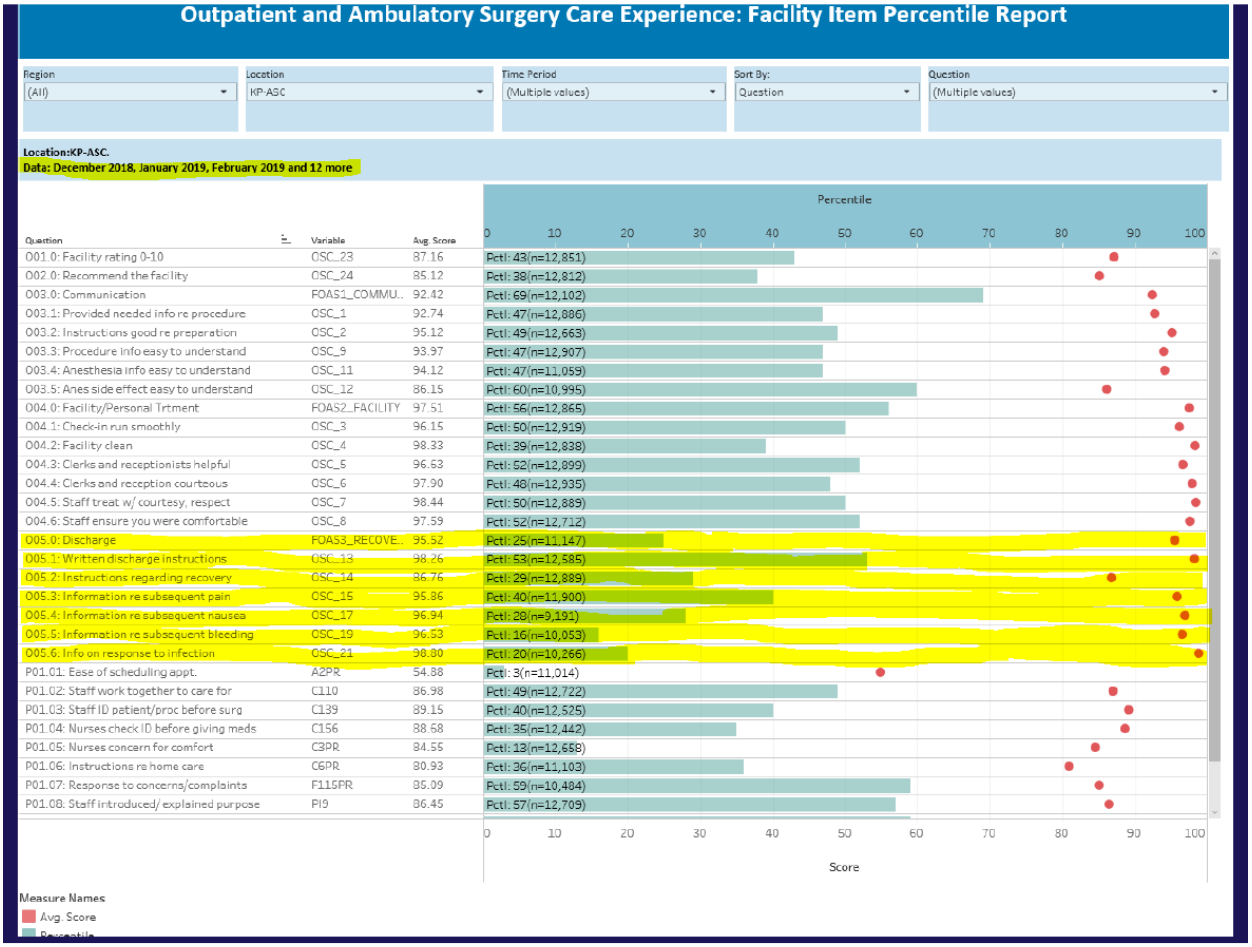
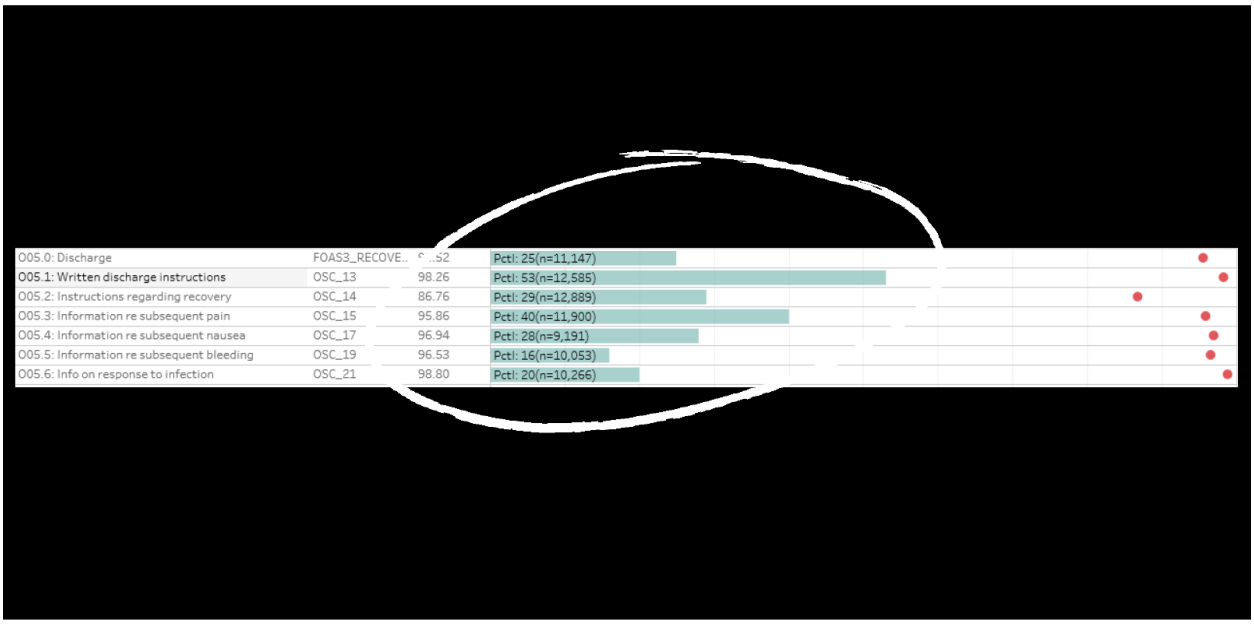
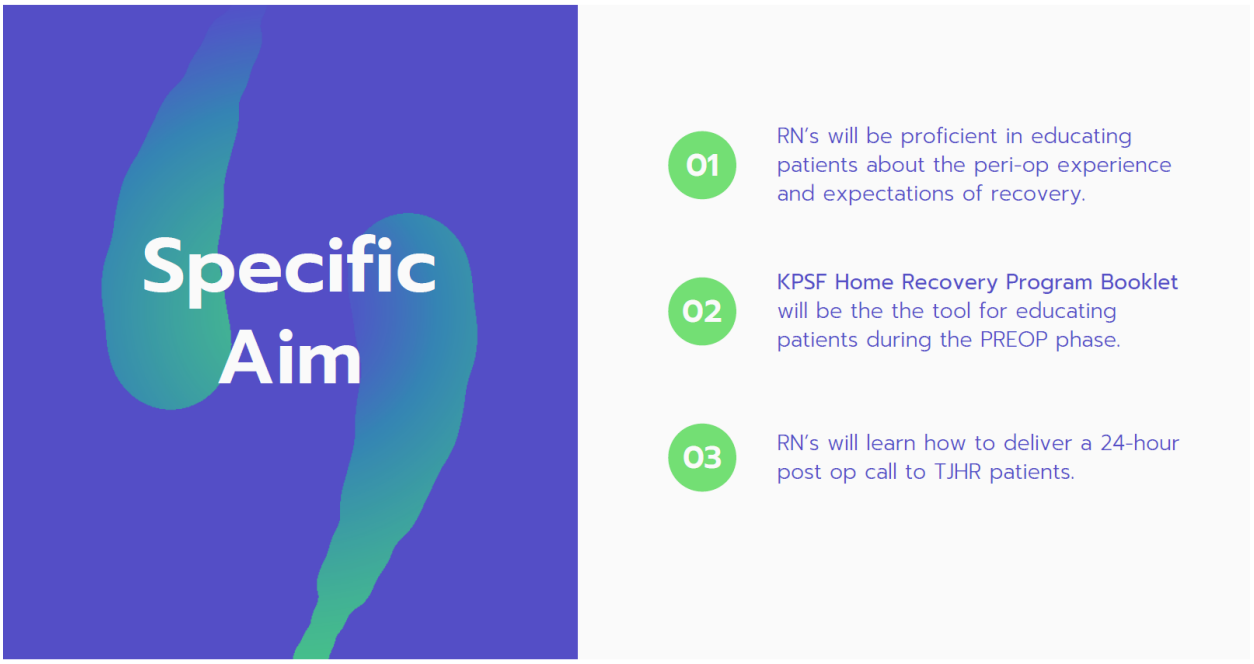
By improving patients' perception of quality care through proper and thorough education and follow-up, we could enhance their experience.

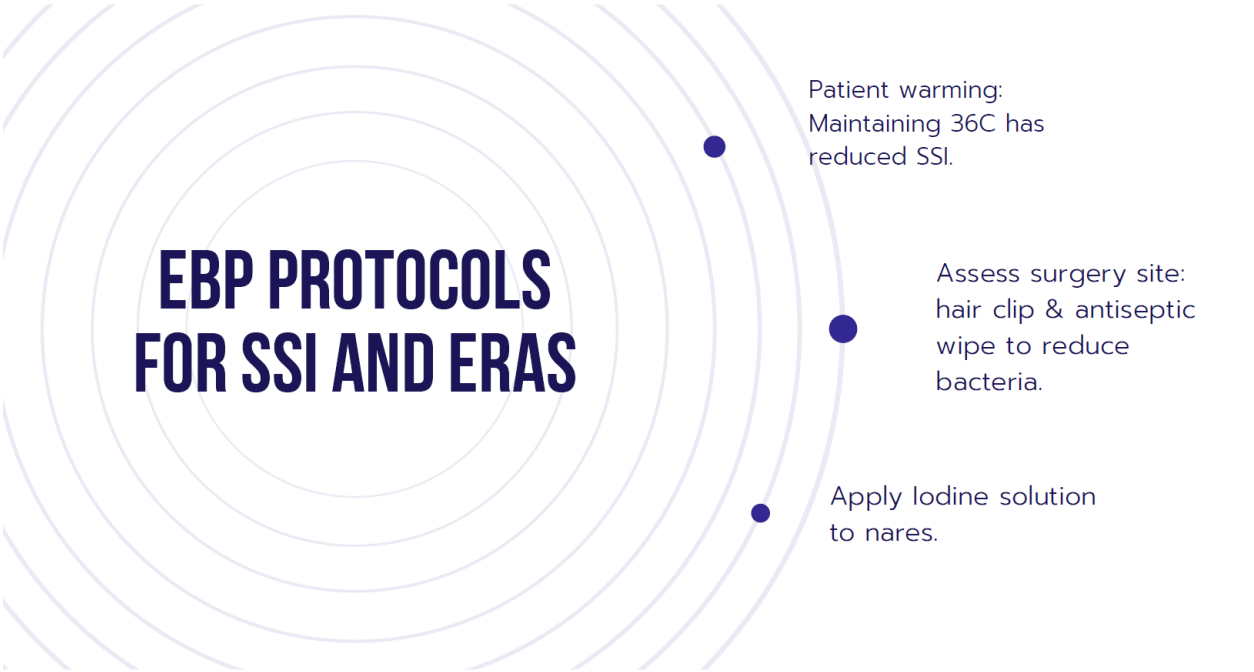
BACKGROUND

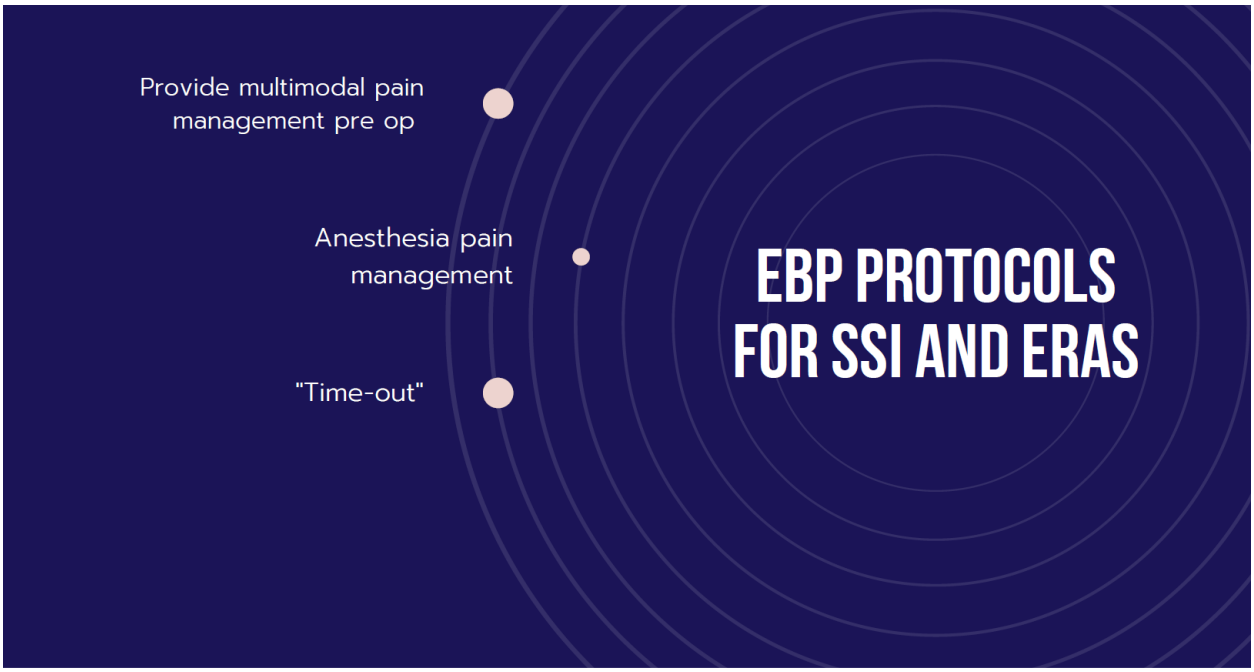
- Outpatient and Ambulatory Surgery Survey Hospital Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) reported care experience scores related to the discharge process over the last 2 years.
- Kaiser SF peri-op department has had scores in the 10th percentile that have dropped to the lowest possible scores (Roux, 2019).
- Patients' responses detailed not knowing what to do if they develop pain post op at home.

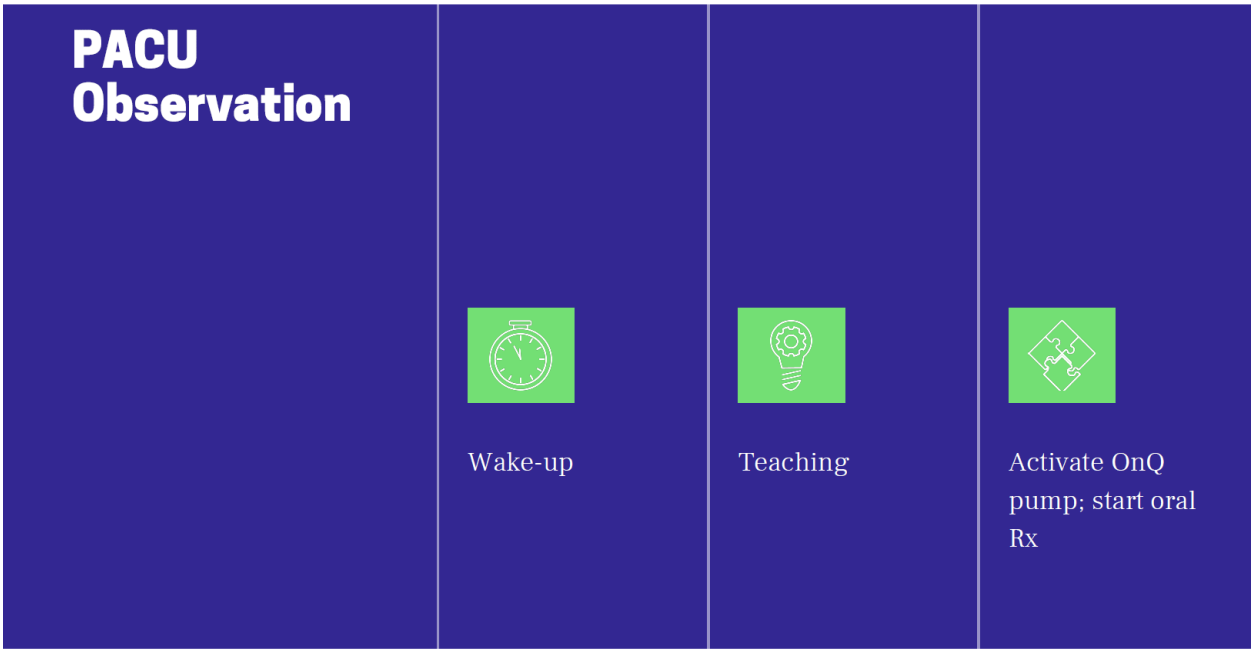


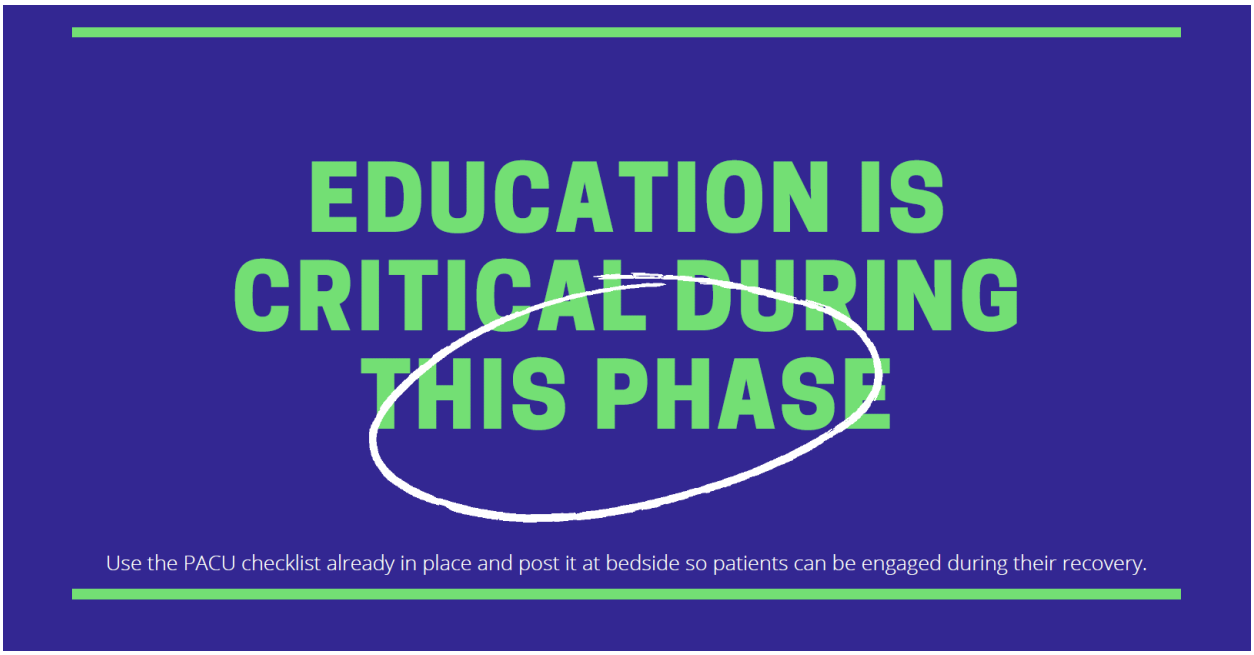












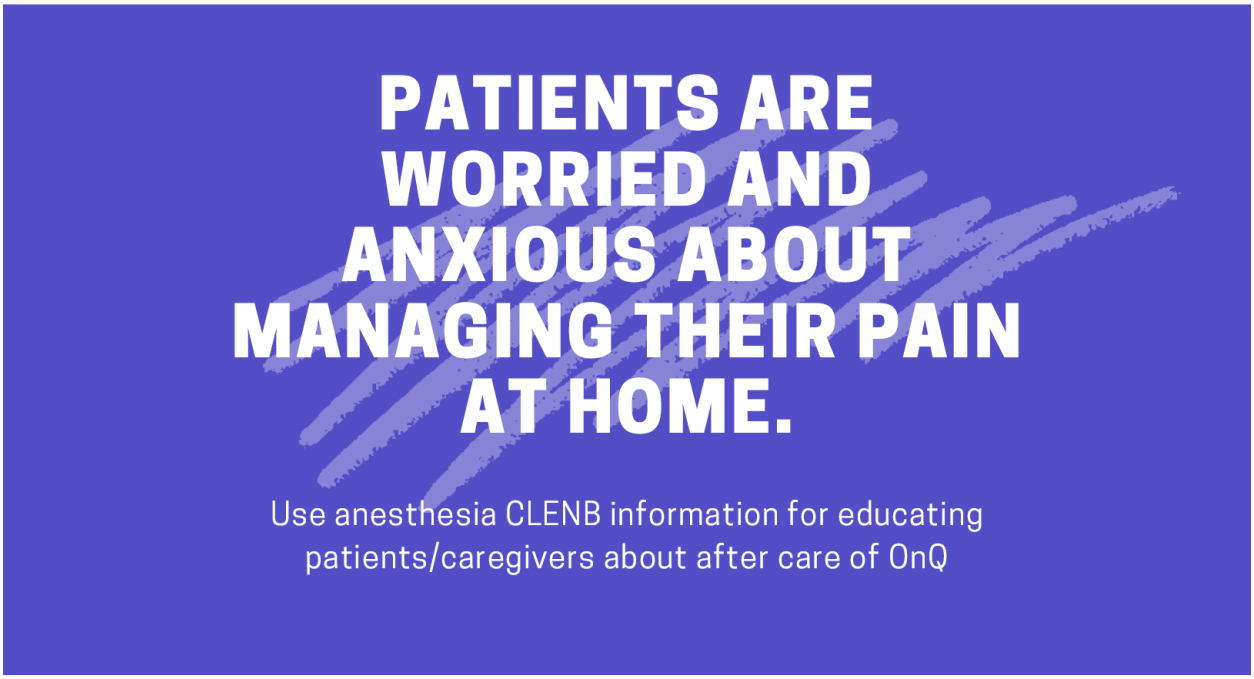
ASU PHASE

Rehabilitation and discharge education is the focus during this phase.

- Report to ASU RN; tasks completed v. uncompleted
- PA, PT, and Anesthesia should all be on the same page
- PT to evaluate patient for readiness to demonstrate safe mobility.

PHYSICIAN'S ASSISTANT RESPONSIBILITIES

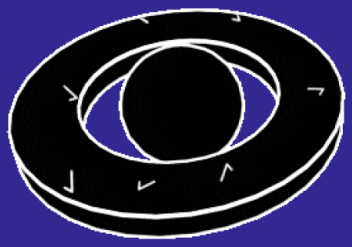
- Arranging home health resources
- Equipment needs
- Evaluate readiness for same day discharge
- D/c orders, pain Rx, other interventions



WOUND CARE

DRESSING	SHOWERING	STERI-STRIPS	SKIN
A waterproof dressing is covering the incision (removed in 7 days)	After waterproof dressing is removed, it is okay to shower; pat dry to keep intact. DO NOT SUBMERGE in water.	Leave until it falls off on its own.	Normal amount of swelling, pain, bruising, change in skin color, clicking in joint, numbness.

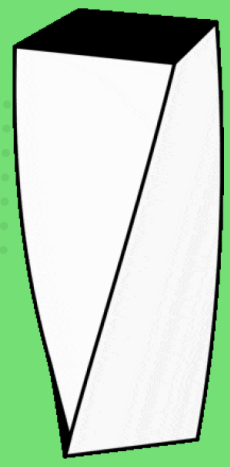
Be Active at Home



1. Ask for help when moving around
2. MOVE JOINT OFTEN
3. Work with PT at home

Be Active at Home

- Use equipment until told when to stop
- Manage pain around-the-clock
- Don't drive while on narcotics



The OnQ pump is new to patients. Ease discomfort by teaching them about it.

Although anesthesia discusses the benefits of the onQ pump, reinforce how it helps minimize use of narcotics and speed up recovery.

Good luck.

We hope you'll use these tips to educate our patients to ensure a safe and engaging surgical experience!

Appendix M. Post-Education Survey Questions

Have you read the KPSF Home Recovery Program Booklet in its entirety and attended the class?

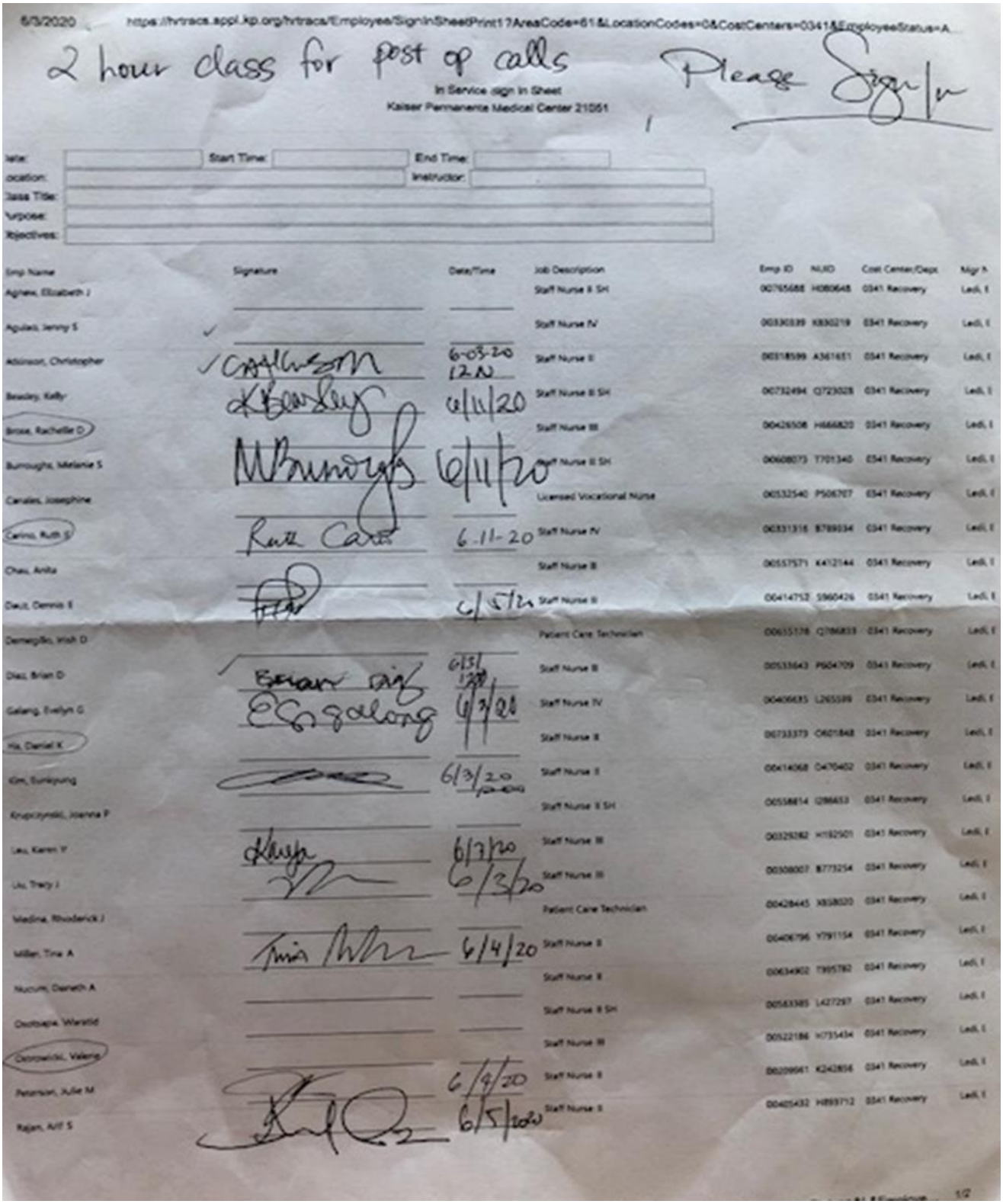
Has the post-op call questionnaire been explained to you by the project lead?

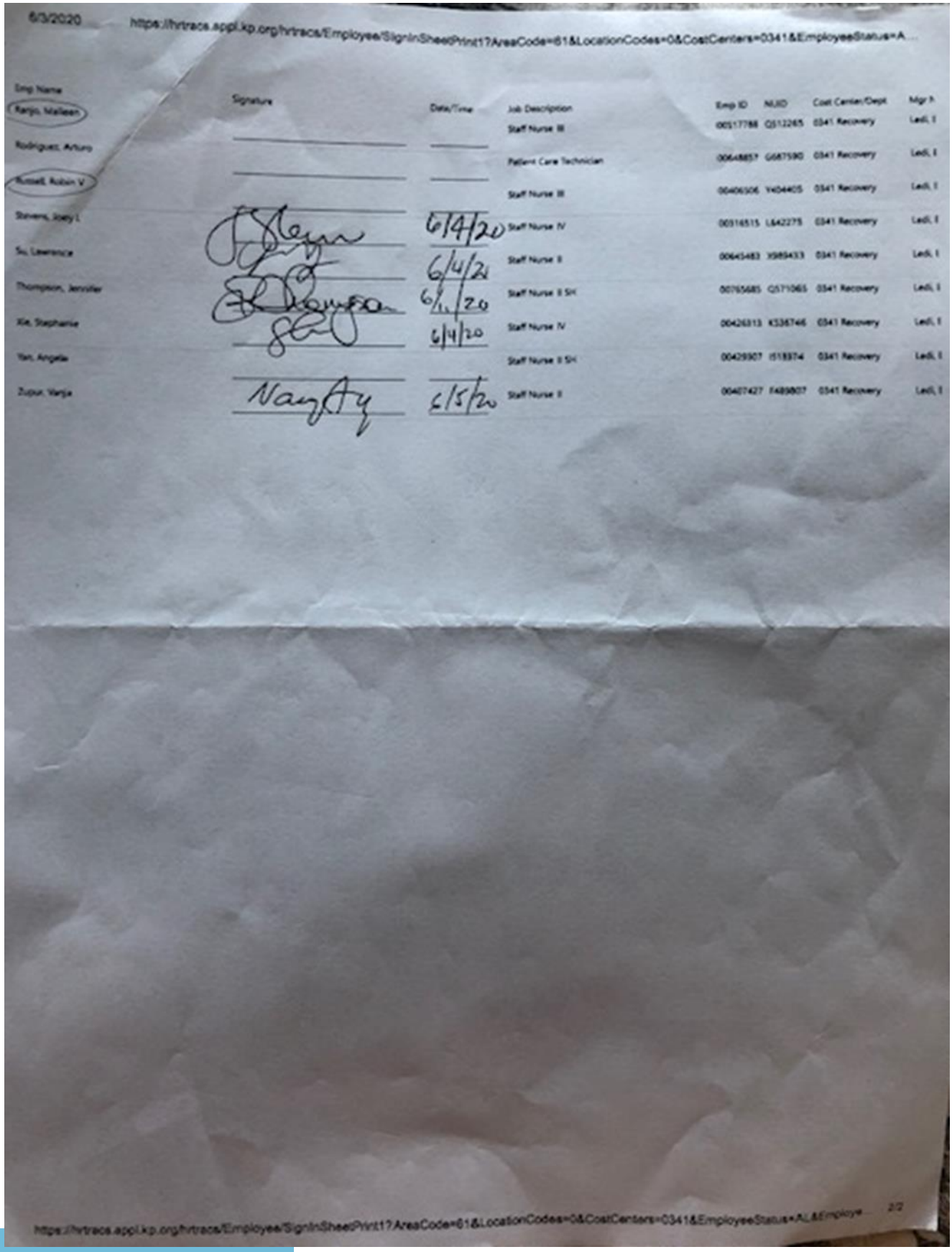
Have the 24-Hour post-op call questions and escalation process been explained to you?

How would you rate the overall training from numbers 1-5?

Do you feel prepared to use the KPSF Home Recovery Program Booklet to educate patients?

Appendix N. Sign-in Sheet





Appendix O. Post-Op Patient Satisfaction Survey

Outpatient and Ambulatory Surgery CAHPS® Survey

Protocols and Guidelines Manual

Version 4.0

November 2019

Appendix P. Statement of Non-Research Determination

Student Name: Earvin Ledi

Title of Project: To increase PACU RN's knowledge about factors that will be used to increase the care experience of TJHR patients at Kaiser SF.

Brief Description of Project:

A) Aim Statement: To increase PACU RN's knowledge about factors that will be used to increase the care experience of TJHR patients at Kaiser SF.

B) Description of Intervention: To teach PACU RN's how to deliver 24 hour postoperative calls and to educate total joint home recovery patients how to care for themselves post operatively.

C) How will this intervention change practice? These two interventions are aimed at increasing the care experience of this group of patients

D) Outcome measurements: The RN's that are being trained will have a greater understanding of how to increase care experience using these two interventions.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:
(http://answers.hhs.gov/ohrp/categories/1569)

X This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**X**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**X**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**X**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	**X**	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**X**	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	**X**	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**X**	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	**X**	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	**X**	

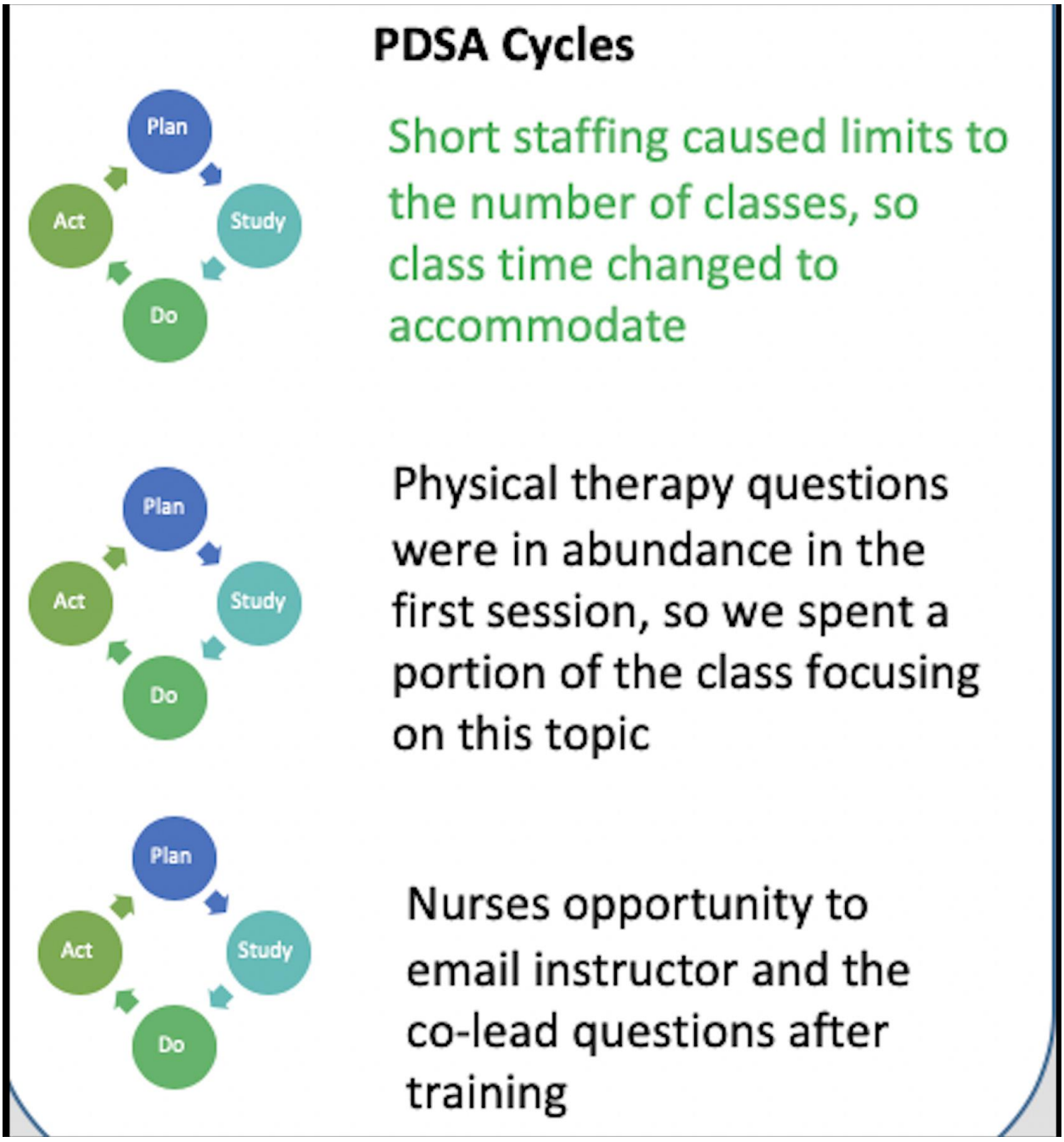
ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

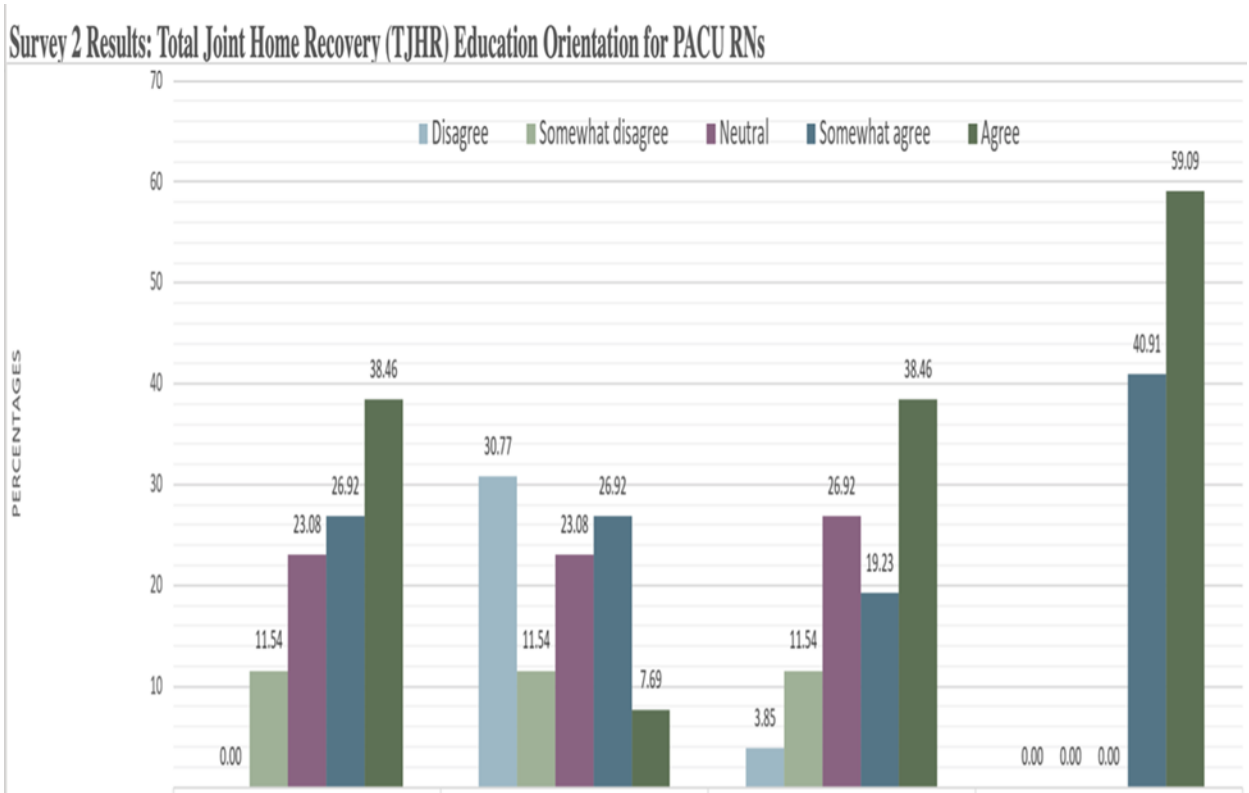
STUDENT NAME (Please print):
EARVIN
LEDI_____
Signature of Student: ___EARVIN LEDI (electronic signature on 4/12/2020_____DATE_4/12/2020_____

SUPERVISING FACULTY MEMBER NAME (Please print):
_____
Signature of Supervising Faculty Member __Dr. Nancy Taquino_____DATE_____

Appendix Q. PDSA Cycle



Appendix R. Post-Education Nurse Survey



	Q4: Have the 24 Hour post op call questions and escalation process been explained to you?	Q5: How would you rate the overall training from numbers 1-5.	Q6: Do you feel prepared to use the KPSF Home Recovery Program Booklet to educate patients?	Q7: Do you feel prepared to perform a 24 hour post op call to TJHR patients?
Disagree	0.00	30.77	3.85	0.00
Somewhat disagree	11.54	11.54	11.54	0.00
Neutral	23.08	23.08	26.92	0.00
Somewhat agree	26.92	26.92	19.23	40.91
Agree	38.46	7.69	38.46	59.09

Appendix S. Stakeholder Analysis

Stakeholders	Interest or requirement in the program	What the program needs from the stakeholder	Perceived attitudes and risks	Actions to take
Physicians / Advance Practice RN's	Long-term reduction in readmission rates Increase bonus' Less time calling the patients	Full buy in	There may be varying concerns for important information that should be conveyed to the patients	Maintain Communication and educational partnership with implementation team
Registered Nurses	-Increase patient satisfaction scores. Increase involvement with patient care and discharge outcomes	Some recommendations	Increased workload	Maintain knowledge Seek answers about implementation
Nursing and Hospital Administrators	-Increase patient care experience and OASCAHPS scores	Full buy in	ROI Encourages QI leader to report out monthly ROI Monitor readmission rates and care experience	Provide support in form of education and leadership
Orthopedic Surgeons and PA's	Increase care experience and OAS CAHPS scores Less time calling the patients	Full buy in	There may be varying concerns for important information that should be conveyed to the patients	Maintain Communication and educational partnership with implementation team

Adapted from (Pangilinan 2018)