

NURS-FPX4905 Assessment 4 Intervention Proposal

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NURS-FPX4905: BSN Capstone Project

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Month, Year

Intervention Proposal

The intervention proposal translates analysis and evidence into a concrete plan for addressing a healthcare problem. By detailing the intervention, its implementation, and its evaluation, the proposal provides a roadmap for improving outcomes. This paper proposes an evidence-based intervention to reduce heart failure hospital readmissions, detailing the intervention, its implementation, and the plan for evaluating its effectiveness in the practicum setting.

Overview of the Proposed Intervention

The proposed intervention is a comprehensive transitional care program for patients with heart failure. The program includes structured discharge education, medication reconciliation, scheduled follow-up contact, and remote monitoring of symptoms. The goal is to bridge the gap between hospital discharge and home management, reducing preventable readmissions.

This intervention is grounded in strong evidence demonstrating that transitional care reduces readmissions and improves outcomes for heart failure patients (Van Spall et al., 2017). By addressing the gaps in care transitions that drive readmissions, the transitional care program targets the root causes of the problem. This evidence-based foundation supports the intervention's potential effectiveness.

The intervention is designed to be comprehensive, addressing the multiple factors that contribute to readmissions. By combining education, medication management, follow-up, and monitoring, the program provides comprehensive support during the vulnerable period following discharge. This comprehensive approach is essential to addressing the complex, multifactorial problem of heart failure readmissions.

Implementation Plan

Implementation involves several components. Before discharge, nurses provide structured education on medications, diet, symptom monitoring, and when to seek care, using the teach-back method to confirm understanding. This education prepares patients to manage their condition at home and to recognize warning signs that require attention.

Medication reconciliation ensures an accurate, understood medication regimen, reducing the risk of medication-related problems that can lead to readmission. After discharge, patients receive scheduled follow-up calls and, where available, remote monitoring of weight and symptoms to detect early signs of deterioration. This ongoing contact enables timely intervention before the patient's condition worsens.

Implementation requires staff training, coordination among the interdisciplinary team, and integration with existing workflows. A clear timeline, defined roles, and stakeholder engagement support successful implementation. By planning implementation carefully and engaging stakeholders, the intervention can be integrated effectively into the practicum setting and sustained over time.

Evaluation Plan

Evaluating the intervention's effectiveness is essential. The primary outcome measure is the 30-day readmission rate for heart failure patients, compared before and after implementation. This measure directly assesses whether the intervention achieves its goal of reducing readmissions. Tracking readmission rates provides clear evidence of the intervention's impact.

Secondary measures include patient adherence, patient satisfaction, and the effectiveness of patient education. These measures provide additional insight into how the intervention is working and where it might be improved. Data will be collected systematically and analyzed to assess the intervention's impact, ensuring that the evaluation is rigorous and informative.

Regular evaluation allows for refinement of the intervention and provides evidence of its value to stakeholders. By evaluating the intervention and refining it based on the results, the care team can improve its effectiveness over time. Engaging patients and staff in evaluation ensures the intervention remains responsive and effective, supporting its ongoing success.

Anticipated Outcomes

The intervention is expected to reduce heart failure readmissions by improving patients' ability to manage their condition at home and enabling early detection of deterioration. By addressing the gaps in care transitions and providing ongoing support, the intervention targets the factors that drive readmissions. The anticipated reduction in readmissions would improve patient outcomes and reduce costs.

Anticipated benefits include improved patient outcomes, enhanced patient satisfaction, and reduced costs associated with readmissions. These benefits align with the goals of value-based care and quality improvement, making the intervention valuable to patients, the organization, and the healthcare system. By achieving these benefits, the intervention can make a meaningful contribution to improving care for patients with heart failure.

By demonstrating these benefits, the intervention can build support for sustained implementation and potential expansion. Evidence of the intervention's effectiveness can justify its continuation and its application to other settings or populations. This potential for sustained

impact and expansion enhances the value of the intervention and its contribution to improving care.

Stakeholder Engagement

Successful implementation of the intervention depends on engaging key stakeholders. These stakeholders include nurses, physicians, pharmacists, case managers, patients, and organizational leaders, each of whom has a role in the success of the transitional care program. Engaging stakeholders early and throughout the process builds the support and collaboration needed for effective implementation.

Stakeholder engagement involves communicating the rationale and benefits of the intervention, soliciting input, and addressing concerns. By involving stakeholders in the design and implementation of the intervention, the project can benefit from their expertise and build their commitment to the effort. This collaborative approach increases the likelihood that the intervention will be implemented effectively and sustained over time.

Engaging patients and families as stakeholders is particularly important. Patients and families are central to the success of the transitional care program, as their understanding and participation are essential to managing the condition at home. By engaging patients and families and respecting their perspectives, the intervention can be designed to meet their needs and to support their active participation in care.

Conclusion

This intervention proposal presents a comprehensive transitional care program to reduce heart failure readmissions, detailing its implementation and evaluation. Grounded in strong

evidence, the intervention addresses the gaps in care transitions and self-management that drive readmissions. The comprehensive, evidence-based approach targets the root causes of the problem.

By implementing and evaluating this evidence-based intervention, the capstone project aims to improve outcomes for heart failure patients and demonstrate the value of effective transitional care. The proposed intervention provides a concrete, actionable plan for addressing heart failure readmissions, reflecting the application of evidence and the principles of quality improvement. Through this intervention, the capstone project can make a meaningful contribution to improving care for patients with heart failure.

References

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