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A Quality Improvement Initiative to Enhance Psychiatric Inpatient Satisfaction Scores Related to Discharge Using the AAMC S.M.A.R.T. Discharge Tool

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A DNP PROJECT

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Abstract

Background: The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires healthcare facilities to provide patients with information that integrates care goals and treatment preferences into discharge planning upon admission (Federalregister.gov, 2019). However, researchers highlighted that over half of psychiatric inpatients were discharged without comprehensive discharge planning (Smith et al., 2021). Additionally, approximately 40% of hospital-based acute care for psychiatric patients comprises adult emergency department visits within 30 days post-discharge, with readmission rates for schizophrenia being 10% higher than those for non-psychiatric conditions, leading to substantial financial burdens (Everett et al., 2022). Although research supports the benefits of standardized discharge protocols in enhancing patient care and satisfaction while reducing readmissions and financial burdens (Gowda et al., 2019; Owusu et al., 2022; Rodgers et al., 2022; St. John et al., 2020; Xiao et al., 2019), there is limited focus on discharge planning in psychiatric inpatient settings. Therefore, implementing a standardized discharge protocol in a psychiatric unit is critical to fill the gap.

Objectives: The purpose of this quality improvement project was to improve patient satisfaction by implementing the Anne Arundel Medical Center (AAMC) SMART discharge protocol within a psychiatric inpatient unit.

Methods: The quality improvement (QI) project was implemented in a 16-bed psychiatric unit in a 400-bed non-profit academic medical center. All nurses completed AAMC SMART discharge tool training by November 30th, 2023. During the implementation period, nurses ensured patients received the SMART journal worksheet and documented its provision under patient education in the Electrical, Process, Instrumentation, and Control Systems (EPIC) electronic health record (EHR) system within 24 hours of admission while maintaining ongoing monitoring and auditing. The AAMC SMART discharge tool comprised five components: symptoms, medications, appointments, results, and addressing patient questions and concerns

(IHI, 2023). Baseline data on patient experience, focusing on three discharge-related questions from the Press Ganey's Inpatient Behavioral Health (PGIBH) survey, were collected from August 1st to October 31st, 2023. Monthly data collection continued for implementation from December 1st, 2023, to February 29th, 2024. Patients who completed the survey three months before and after the implementation of the AAMC SMART discharge tool were included in the analysis. A chi-square test assessed the results between three specific discharge-related questions from the PGIBH survey before and after the implementation.

Results: Post-intervention, the completion rate for SMART education in EPIC rose from 1.86% to 91.39%. Despite this increase, patient satisfaction did not increase correspondingly. Post-intervention analysis of PGIBH survey results across various domains showed no significant enhancements in satisfaction: discharge overall ($\chi^2 = 1.326$, $p = 0.249$), understanding of discharge medication instructions ($\chi^2 = 0.412$, $p = 0.521$), information about care after discharge ($\chi^2 = 0.545$, $p = 0.460$), and discharge instructions for assistance ($\chi^2 = 0.586$, $p = 0.108$). However, there was an increase in top box scores for PGIBH surveys related to discharge, ranging from 0.8% to 7.25%, and average survey scores increased by 0.07 to 0.10 points when comparing December 2023 to February 2024 with December 2022 to February 2023. These findings suggest that implementing the SMART discharge protocol may have positively impacted patient experience.

Conclusions: The correlation between the discharge protocol and improving patient experience was inconclusive. Implementing the AAMC SMART discharge tool in the psychiatric inpatient unit did not improve patient discharge satisfaction scores despite an increased SMART completion rate. However, post-implementation survey top box scores related to discharge and average survey scores improved compared to the same months in the previous year. The lower patient experience score in the post-implementation period compared to pre-implementation months might be associated with a higher involuntary admission rate, a

younger population, more female participants, schizoaffective disorder, and severe depressive disorder with psychotic features. The post-implementation period had a 6.46% higher involuntary admission rate than the pre-implementation period, and the involuntary admission rate more than doubled between February 2024 and October 2023. The average length of stay for involuntarily admitted patients was one day longer during the post-implementation months compared to the pre-implementation months. Additionally, the previous year's data analysis showed that patient experience scores related to discharge were lower from December to February, with top box scores for three discharge questions being 3.43% to 17.6% lower than from August to October 2022. Notably, the top box score in October 2022 was more than twice as high as in February 2023. These results indicated that additional factors, not fully captured during the limited three-month monitoring period of the quality improvement project, may have influenced outcomes. With a post-intervention completion rate below 51%, potential nonresponse bias may have affected the results. Furthermore, data collected from a single site may not represent broader demographics and experiences. Further education, along with a higher completion rate of the PGIBH survey, an extended evaluation period of at least one year, and data gathered from multiple locations, is needed to gain deeper insights into the impact of SMART education on patient satisfaction. For sustainability, standardized discharge protocol should be incorporated into the continued training curriculum for all nurse staff, ensuring consistent discharge education that improves patient experience, lowers readmission rates, and reduces healthcare costs, as the literature supports.

Keywords: discharge planning, psychiatric inpatients, standardized discharge protocol, patient satisfaction

Introduction

Mental health patients often worry about life after discharging due to insufficient social support, community resources, and awareness to maintain medication adherence and comply with outpatient treatment (Gowda et al., 2019). Patients often felt overwhelmed and confused when receiving discharge instructions before leaving the unit, frequently due to an inability to manage information overload, limited cognitive capacity, and low health literacy (St. John et al., 2020). All patients would receive discharge education upon admission and participate in discharge planning throughout their stay to improve their understanding of self-management upon returning to their daily lives (St. John et al., 2020; Xiao et al., 2019).

The Doctor Nursing Practice (DNP) project was conducted at a 400-bed not-for-profit regional health system academic medical center in a metropolitan setting. The medical center was among the top three busiest hospitals in the region. This quality improvement project was implemented in an inpatient mental health unit with 16 private rooms. The inpatient unit was built and operated in the spring of 2020. The facility accepted voluntary and involuntary admissions of adults aged 18 and older. The unit delivered a transient psychiatric treatment program specializing in schizophrenia, bipolar disorder, depression, and anxiety. Additionally, the decision to select this site was influenced by the DNP student's employment as a staff nurse in the unit, ensuring familiarity with policies and facilitating efficient project monitoring and management.

The unit relied on the after-visit summary (AVS) provided just before discharge, which limited patient engagement and understanding of their medication and treatment plans. Researchers suggested that aligning standard discharge planning upon admission with treatment planning is crucial for improving hospital readmission rates and ensuring continuity of care (Thum et al., 2022). The quality improvement (QI) project implemented the Anne Arundel Medical Center (AAMC) SMART discharge protocol to address this issue, initially

identified by the Institute for Healthcare Improvement (IHI, 2023). The protocol consists of five essential elements: Signs, Medications, Appointments, Results, and Talk (IHI, 2023). Despite its widespread use across various medical units within our organization, the protocol had not been introduced in the psychiatric inpatient unit, and nurses required training.

The decision to adopt the AAMC SMART discharge tool was based on the organization's access to resources such as the AAMC SMART journal worksheet (Appendix E), SMART discharge protocol self-learning package (Appendix F) SMART discharge protocol PowerPoint (Appendix G), and SMART discharge frequently asked questions (FAQ) sheet (Appendix H). Additionally, SMART education had already been formulated and integrated into the organization's EPIC EHR system, with other medical units actively using the protocol. Unlike other medical units within the organization, the psychiatric inpatient unit did not have a specific requirement or training dedicated to discharge education. Therefore, the leadership team wondered whether implementing an evidence-based practice discharge protocol would enhance the discharge process and improve patient satisfaction scores in the unit.

While studies have demonstrated the effectiveness of implementing standard discharge protocols in improving patient satisfaction scores, research in psychiatric inpatient settings was limited. This emphasizes the need for rigorous quality improvement initiatives within psychiatric units. These initiatives are essential for gaining insights into how patient experiences during discharge influence outcomes and for establishing standardized discharge procedures. Ultimately, these efforts can significantly enhance the discharge process and play a pivotal role in reducing preventable readmissions and adverse events in psychiatric inpatient settings.

This quality improvement project aimed to improve the patient experience within a psychiatric inpatient unit by introducing comprehensive discharge planning via the AAMC

SMART discharge protocol. The DNP student developed a resource binder to educate patients on psychiatric medications, diagnoses, signs and symptoms, and available community resources. Furthermore, all nursing staff received training on utilizing the SMART discharge protocol and documenting education within the EPIC EHR system. All patients would receive education on utilizing SMART discharge journal worksheets upon admission and continuously throughout their stay until discharge.

Background and Significance

Individuals living with mental health illnesses experience numerous barriers due to the nature of the disease, poor insight, poor self-care, lack of transportation, limited support, and inadequate accessible resources (Gowda et al., 2019; St. John et al., 2020). Patients discharged from psychiatric inpatient units without comprehensive discharge instructions and planning had experienced increased adverse outcomes. These outcomes included an increased risk of hospital readmission, emergency visits, homelessness, encounters with law enforcement, and elevated mortality rates from various causes (Smith et al., 2021). Smith and his colleagues determined that over 54% of patients had not received comprehensive discharge planning, and more than 20% of patients did not have a follow-up care appointment before discharge. This analysis was based on 18,185 patients discharged from psychiatric inpatient units in New York state (Smith et al., 2021). Furthermore, mental health patients from minority backgrounds, homelessness, a history of schizophrenia, comorbid substance use disorder, or additional medical conditions, and those who had not received care within 30 days before admission stayed less than four days or longer than one month were less likely to receive discharge planning (Smith et al., 2021).

Patients readmitted to hospitals within 30 days of discharge from psychiatric inpatient units incur high healthcare costs and face adverse events due to insufficient discharge instructions. Researchers determined that more than 65% of psychiatric patients fail to attend

their initial outpatient appointment post-discharge, leading to a twofold increase in the likelihood of hospitalization within 12 months (Xiao et al., 2022). Moreover, psychiatric patients had shown a nonadherence rate to treatment between 40% and 60%, and poor communication between patients and healthcare professionals increased the nonadherence rate by 20% (Virgolesi et al., 2017). Within the first 30 days post-discharge, nearly 40% of hospital-based acute care for psychiatric patients involves adult emergency department (ED) visits (Everett et al., 2022). This rate is the highest among psychiatric patients across all age groups and income levels. In 2012, the readmission rates for patients with mood disorders and schizophrenia and psychoses were 12.6% and 18.6%, respectively, which is higher than the 8.7% rate for non-psychiatric conditions (Everett et al., 2022). The issue is compounded by the prevalence and cost of potentially preventable readmissions (PPRs). In California, Schmidt et al. (2018) identified 9.8% of 1.5 million ED visits and 33.6% of 1 million hospitalizations as psychiatric PPRs (Everett et al., 2022). Moreover, psychiatric PPRs in New York State's Medicaid program accounted for over $200 million, averaging more than $13,500 per patient (Everett et al., 2022).

Patients who had received adequate information and education about their disease and treatment were more likely to develop disease management skills and effectively manage their condition post-discharge (Virgolesi et al., 2017). Psychiatric patients satisfied with the information regarding their condition, signs and symptoms, and medications received in the hospital exhibited higher adherence to treatment post-discharge ($p = 0.008$) (Virgolesi et al., 2017). Furthermore, the IMPACT 2014 mandated hospitals to utilize discharge planning to provide adequate information to prepare patients for discharge, prevent adverse patient events, and reduce preventable readmission. Therefore, implementing a standard discharge planning tool was crucial for patients to engage in treatment and communicate effectively

with healthcare team members in a psychiatric inpatient acute setting, ensuring their long-term recovery.

Needs Assessment

The DNP implementation organization needs assessment is concluded using a needs assessment conducted on the psychiatric inpatient unit to evaluate its suitability for this QI project. The evaluation aimed to identify internal strengths and weaknesses and external opportunities and threats (SWOT). The SWOT Analysis Figure in Appendix C. The organization's vision is to dismantle health barriers and provide enhanced, high-quality care throughout the region. Implementing comprehensive discharge planning to minimize the obstacles for patients transitioning back to everyday lives aligns with the organization's values.

Due to several key factors, the 16-bed psychiatric inpatient unit presents an ideal setting for this quality improvement project. Firstly, it is affiliated with one of the region's leading teaching hospitals, boasting a highly motivated staff and a strong leadership team. The unit maintains a positive work environment that supports diversity and inclusiveness and contributes to high employee retention rates. Recent additions to the nursing staff further bolster the unit's capacity to provide care across all shifts. The unit's diverse, voluntary staff brings varied cultural backgrounds and experiences, fostering a collaborative environment conducive to achieving high-quality results. The nursing and medical leadership provide guidance, support, and motivation, driving a culture of growth and development while ensuring staff input and collaboration. Moreover, the organization offers valuable benefits and opportunities, including competitive salaries, health insurance, retirement plans, and professional development programs, fostering a supportive workplace culture where staff feel valued and respected. The physical environment of the unit further enhances patient care, with private, comfortable rooms and an excellent security team ensuring safety and comfort.

The organization consistently provides paid training and development opportunities for staff. Leveraging this existing framework can facilitate the implementation of the DNP project. By incorporating mental health specialty sessions tailored to the project's objectives, staff can build new skills and stay updated on best practices in discharge planning and patient education. Another opportunity stems from the unit's status as a new establishment, offering ample chance to develop tailored policies and procedures to address unique needs and challenges. The leadership team has identified a significant decrease in patient satisfaction scores related to discharge, and three of the top five patient concerns according to the third quarter 2023 patient experience e report relate to inadequate discharge instruction, highlighting the necessity for a standardized discharge education program or protocol. Other medical units within the organization have been using the AAMC SMART discharge tool since 2011. Discharge planning should commence upon admission, align with treatment planning, and notably affect hospital readmissions and continuity of care. However, the unit depended on the AVS given to patients just before their departure, restricting patient engagement and comprehension of their medication and treatment about discharge. While other units in the practice organization regularly utilized the AAMC SMART discharge planning protocol, the psychiatric inpatient unit had a SMART education completion rate of 1.86% during the pre-intervention period from August 1st to October 31st, 2023. This situation presents a valuable opportunity for the DNP student to address these challenges by implementing a standardized discharge education program or protocol within the unit. Additionally, opening additional positions presents a chance to bolster the unit's workforce and ensure staff receive adequate support. Allocating resources to hire additional staff dedicated to discharge planning and patient education can enhance the effectiveness of the implementation process. This can increase productivity, better patient outcomes, higher job satisfaction, and lower turnover rates. Moreover, opening more positions can provide

opportunities for career advancement and professional growth for existing employees within the unit.

Staff from different shifts may encounter challenges and exhibit varying attitudes toward change. Night, weekend, and holiday staff may perceive exclusion due to scheduling meetings and important events exclusively on weekdays during regular business hours. Moreover, limited resources during non-standard hours can engender safety concerns among patients and staff, potentially leading to burnout and reluctance to undertake additional tasks. Conversely, day shift nurses may be busy and occupied with numerous responsibilities, such as managing discharges, facilitating group sessions, supervising visitor interactions, admitting new patients, and executing new orders. These demanding tasks may make them hesitant to assume further responsibilities, such as implementing the discharge protocol. Complicating matters further is the unpredictable nature of the mental health patient population. Frequent encounters with high patient acuity levels are common in the unit, especially exacerbated by staffing shortages. These conditions pose safety risks and require nurses to dedicate considerable time and attention to fulfilling basic tasks and addressing patients' needs. When the unit experiences high acuity levels and staffing shortages, providers or leadership may find it challenging to address nurses' concerns, often due to the need to meet target census goals. Given the unit's recent establishment within the community, comprehensive discharge planning is indispensable. This circumstance presents an opportune moment to initiate a new project to enhance patient care within the unit. However, challenges persist, particularly concerning staff attitudes toward change. Overcoming these challenges, including addressing resistance to change and securing support from medical providers regarding patient acuity and admissions, will be essential for successfully implementing the discharge protocol and improving patient care outcomes.

Problem Statement

The absence of standardized protocols for initiating and maintaining discharge planning throughout a patient's stay in the unit posed a risk of inadequate comprehension of discharge education, including signs and symptoms, medications, appointments, and test results. This deficiency is evidenced by the declining and fluctuating patient satisfaction scores of three discharge-related questions in the PGIBH survey.

Purpose Statement

The primary purpose of this QI project was to determine if implementing the AAMC SMART discharge tool for evidence-based discharge planning positively influences patient satisfaction scores in a psychiatric inpatient unit, focusing on three discharge-related questions.

Aims and Objectives

Aim #1: Improving top box percent score related to three discharge questions in the PGIBH survey.

- Objective: Increase top box scores for all three discharge questions by 3% within three months of implementing the SMART intervention from baseline data, targeting achievement by February 29th, 2024.

Aim #2: Achieving a one hundred percent completion rate for SMART Education under patient education in EPIC.

- Objective: Ensure every nurse completes the SMART education training and quiz and signs off on the SMART Discharge Protocol Education Nurse Training Sign-Off Sheet (**Appendix K**) by November 30th, 2023.
- Objective: The DNP student ensured that each newly admitted patient's pre-made folder included the AAMC SMART journal worksheet.
- Objective: Ensure that each admitted nurse completes the SMART education under the patient education tab in EPIC within 24 hours.

- Objective: Ensure that all patients receive timely education on effectively using the SMART journal worksheet during admission by having the admitting nurse deliver a report to the incoming shift nurse if the SMART education is still pending finalization as planned.
- The DNP student and four other staff nurses in the unit conducted the Inpatient SMART Education Audit (**Appendix L**) daily to ensure that every patient receives AAMC SMART discharge journal worksheets and that SMART education under patient education in EPIC was completed.

Research Question

- Patient Population (P): Patients hospitalized in a psychiatric inpatient unit.
- Intervention (I): Implementation of the AAMC SMART discharge protocol.
- Comparison (C): Patient satisfaction scores before and three months after protocol implementation.
- Outcome (O): Improved patient satisfaction scores.
- Timeframe (T): Pre-implementation and three months post-implementation.

Is the AAMC SMART discharge tool effective in improving patient satisfaction scores related to three specific discharge questions, compared to pre-intervention baseline data and three months of post-intervention data from (PGIBH) survey?

What is the effect of the AAMC SMART discharge tool on the SMART Education completion rate under patient education in EPIC compared to the pre-intervention completion rate?

Hypothesis

The AAMC SMART discharge tool significantly improves patient satisfaction scores related to three specific discharge questions, compared to pre-intervention baseline data and three months of post-intervention data from the PGIBH survey.

Review of Literature

A literature review was conducted to synthesize the best evidence to support the effectiveness of implementing comprehensive discharge planning in a psychiatric inpatient unit to improve patient satisfaction scores. The initial review of the literature included research of PubMed, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and PsycInfo databases from 2013 to 2024. Research terms included (“Psychiatr*” OR “psychiatric department, hospital”[mesh]) AND (“discharge planning”[tiab] OR “patient discharge/standards”[mesh]) AND (“Patient satisfaction”[tiab] OR “patient satisfaction”[mesh]) in PubMed, or (“Psychiatr*”) AND (TI(“discharge planning”) OR AB(“discharge planning”)) AND (“Patient satisfaction”) in CINAHL and PsycINFO databases. Due to the lack of recent studies conducted in the psychiatric inpatient unit setting, most studies used to support this project were conducted in a non-psychiatric setting from citation searching.

Nine articles were appraised for level and quality using an appraisal tool from the Johns Hopkins Nursing Evidence-Based Practice Model (Dang & Dearholt, 2021). The nine articles included one Randomized Controlled Trial (RCT) (Gabriel et al., 2017), one systematic review of RCT (Gonçalves-Bradley et al., 2016), one pilot study (Patra et al., 2020), two quasi-experimental studies (Centrella-Nigro & Alexander., 2017; Waniga et al., 2016) three correlational studies (St John & Englund, 2020; Thum et al., 2022, Virgolesi, M. et al., 2017) and one retrospective cohort analysis (Smith et al., 2021). The articles are synthesized using an evidence table, which is in **Appendix N**.

Researchers from seven of the nine studies recommended the implementation of comprehensive discharge planning as a daily assessment tool starting from admission and throughout patients’ stay to enhance patient education about their health, medications, and treatment plan for a smooth transition into discharge and long-term recovery (Gabriel et al.,

2017; Gonçalves-Bradley et al., 2016; Patra et al., 2020; St John & Englund, 2020; Thum et al., 2022, Virgolesi, M. et al., 2017; Waniga et al., 2016). Researchers from six of those seven studies agreed on the positive association between patients who received comprehensive discharge planning before discharge with lower readmission rates, shorter lengths of hospital stay, higher adherence to continuous treatment, greater patient satisfaction regarding the speed of the discharge process and instruction for discharge, discharge readiness, the overall discharge process and transition of care (Gonçalves-Bradley et al., 2016; Patra et al., 2020; St John & Englund, 2020; Thum et al., 2022, Virgolesi, M. et al., 2017; Waniga et al., 2016). One group of investigators from the seven studies discovered insignificant differences in utilizing a discharge checklist. Gabriel et al. (2017) used daily discharge goals checklist as an intervention during interprofessional rounds within 24 hours of admission to determine if it is associated with reduced discharge times and improved patient satisfaction. The researchers found that discharge time was reduced, and overall patient satisfaction scores improved in the intervention group compared to the control group. However, the difference was not statistically significant ($p>0.05$) (Gabriel et al., 2017). The finding was unexpected, and the researchers believe that early discharge planning should associate with positive patient experiences, and satisfaction scores could be inaccurate due to patients' lack of attention to completing the survey at the time of discharge (Gabriel et al., 2017). Moreover, the researchers strongly recommended that nurses use a discharge checklist to prepare patients for discharge, especially patients with complicated discharge preparation needs (Gabriel et al., 2017).

Patra and his team members (2020) concluded that patient satisfaction significantly improved in postintervention groups compared to the preintervention group after one year of implementation. Society of Hospital Medicine PediBoost tool kit includes a discharge risk assessment checklist and IMPACT intervention elements (interdisciplinary family meeting,

medication review, patient education, appointment and communication, and teach-back method). There was a 3.7% increase in the speed of the discharge process (p=0.008), 8.9% increase in instructions for discharge (p<0.0001), 8.9% increase in discharge readiness (p<0.0001), 6.7 % increase in the overall discharge process (p<0.0001) (Patra et al., 2020). Moreover, the number of patients given handouts and scheduled follow-up visits before discharge significantly increased, 38.6 % (p< 0.0001) and 59.2% (p< 0.0001), respectively (Patra et al., 2020). Thum and other researchers from the study (2022) agreed with Patra that patient experience improved positively associated with implementing standardized discharge education. Patient satisfaction scores increased by 2.07% (p<0.0001) for the domains of care transitions and 2.74% in discharge information (p<0.0001) after one year of implementation (Thum et al., 2022). Furthermore, creating and implementing an informative patient-center tool to provide discharge instruction to patients before discharge was strongly associated with patient satisfaction scores increasing after one year of implementation (Waniga et al., 2016). After one year of implementation, patient satisfaction scores significantly increase, including 1.7% in discharge (p <0.01), 1.7% in extent felt ready for discharge (p=0.01), and 2.5% in discharge for homecare (p<0.01) (Waniga et al., 2016).

EBP Translation Model

The Johns Hopkins Nursing Evidence-Based Practice (JHEBP) was selected to guide the implementation of the SMART discharge protocol for this DNP project.

The JHEBP model provides comprehensive tools to guide the team in applying critical thinking to search, analyze, and apply the most current EBP evidence to support the project. The JHEBP model includes three essential components: inquiry, practice, and learning (Dang et al., 2021). The JHEBP model contains three processes, including practice question, evidence, and translation, which are divided into 20 steps (Dang et al., 2021). Each stage contains multiple steps that guide the users on effectively using the tools. The JHEBP

model is an inquiry-based learning framework and inquiry is the starting point of the process. The inquiry-learning framework provides a foundation that encourages users to take control of the process and to practice learning how to obtain new knowledge (Dang et al., 2021). Additionally, the JHEBP model encourages interdisciplinary team members to be autonomous according to their experiences and discover the most current, realizable, and relevant information (Dang et al., 2021).

The first phase is a critical phase to ensure the success of the project implementation and includes steps one to seven. This phase provides guidelines to develop a precise and meaningful question that is answerable and establishes an interprofessional team (Dang et al., 2021). The second phase of the process in the JHEBP model is evidence. This phase includes steps eight to twelve, which researchers follow to discover current studies conducted to answer the EBP questions and evaluate the level and quality of recourses (Dang et al., 2021). The last phase, practice, includes steps thirteen to twenty, which involves translating evidence into actual practice (Dang et al., 2021).

Process of Evidence-Based Practice Initiative

The first phase contains seven steps to develop a researchable EBP question and form a functional team (Dang et al., 2021).

Recruit an interprofessional team: The team will include mental health clinicians, pharmacists, nurses, social workers, and administrators.

Determine responsibility for project leadership: Recognized as a team leader with experience with EBP projects and excellent leadership style and skills. In this case, the DNP student would be the project leader and work closely with the unit educator and the program director, who would perform as the DNP student’s preceptor.

Schedule team meetings: Organize recurring meetings according to team members' availability and designate staff members to document discussion points and team decisions.

Develop a project proposal and timeline and coordinate essential tasks such as literature reviews and resource organization. The DNP student shared project updates and solicited feedback from unit staff during monthly meetings.

Clarify and describe the problem: Team members dedicate efforts to identify and articulate the disparity between existing evidence and the project's desired outcome. The DNP student interviewed providers, social workers, leadership, and primarily nursing staff to pinpoint the gap between evidence-based practices and the needs of the unit and patients.

Develop and refine the EBP question: The DNP student utilized the PICO framework to formulate an evidence-based practice (EBP) question. Refine the question after conducting research and reviewing evidence to ensure clarity and relevance to the project's objectives.

Determine the need for an EBP project: Limited studies have been conducted in psychiatric inpatient units regarding standardized discharge protocols and patient experience. Therefore, it is evident that an EBP project is necessary to address this gap in the literature.

Identify stakeholders: Utilize the stakeholder analysis tool to identify individuals and departments interested in or related to the project. Stakeholders for this project include project team members, all nursing staff in the unit, pharmacists, social workers, providers, unit and organizational administrators and leaders, patient experience specialists, and the quality improvement department.

The second phase of the JHNEBP model is to search, appraise, and synthesize the most current and presentable evidence to support the implementation of the project (Dang et al., 2021).

Conduct an internal and external search for evidence: Conduct both internal and external searches for evidence. For the external search, utilize hospital and school library resources to ensure a comprehensive and appropriate search. For the internal search, gather and

understand resources such as the current organization discharge policy, organization financial data, quality improvement data, patient and staff surveys, and satisfaction data.

Apprise the level of quality of each piece of evidence: Applying the JHNEBP Research and Non-research Evidence Appraisal Tools to evaluate the level and quality of any obtained evidence.

Summarize the individual evidence: The DNP student utilized the JHNEBP Evidence Summary Tool to organize and summarize all the appraised evidence individually.

Synthesize findings: Evaluate and synthesize findings by critically analyzing the evidence collected and incorporating insights from team members' experiences.

Develop best evidence recommendations: Recording the number of evidence sources and overall quality level on the JHNEBP Synthesis and Recommendation Tool.

The third phase of the JHNEBP model is practice, which involves translating evidence into actual practice (Dang et al., 2021).

Identify practice setting-specific recommendations: Discuss with organizational leaders and stakeholders to communicate practice setting, recommendations and gather feedback. Utilize the feasibility-fit-acceptability section of the Translation and Action Planning Tool to assess the project's potential success and address any concerns or barriers identified.

Create an action plan: Develop a standard procedure for the change project, create a detailed timeline for each implementation step, and collect valuable feedback from all stakeholders. The project timeline is in **Appendix M.**

Secure support and resources to implement the action plan: Secure support and resources for implementing the action plan by identifying and obtaining necessary resources, including financial support, human resources, and materials, to ensure the successful implementation of the project. Additionally, the DNP student submits a project proposal to the Nursing Research and EBP Council and the Clinical Quality Review Committee for Institutional Review Board

(IRB) approval. Furthermore, the DNP student communicates with the organization's patient experience specialist to coordinate data collection efforts. Additionally, the DNP student collaborated with the unit educator to develop EPIC documentation instructions, help with training, and conduct SMART education completion rate in EPIC. The DNP student invited four staff nurses to assist with daily audits to achieve a 100% completion rate for SMART education. The student also engages with organizational leadership to garner their support for the project, such as securing time to introduce the project and share progress during staff meetings.

Implement action plan: Provide verbal and written reports to all unit staff and stakeholders and create a method to answer questions. Introducing the project in monthly meetings.

If change is implemented, evaluate the outcome to determine whether improvement has been made: For this DNP project, the JHNEBP model offers the Translation and Action Planning Tool to assess the success of the implementation. This tool would evaluate whether the change has resulted in improvements as intended.

Report results to stakeholders: The DNP student reports results to organization leaders and other stakeholders by following the Stakeholder Analysis and Communication Tool and obtaining feedback to improve negative results. The DNP student shares findings with the DNP team members, the organization’s Nursing Research and EBP Council members, all nursing staff in the unit, including the unit education and preceptor, and other stakeholders.

Identify next steps: Analyze the outcomes from the three months of implementation, identify barriers that cause unfavorable outcomes, and find a solution to prevent similar mistakes in the future. Additionally, the DNP student recommended extending the implementation and data collection period to gather more comprehensive data and assess long-term effectiveness. Furthermore, the DNP student suggested that leadership consider integrating the project as a standard workflow in the unit and institutionalizing it as policy

and culture. This would ensure sustainability and continuous improvement in patient care practices.

Disseminate findings: The project's outcome was shared with the organization leader, unit staff, and other stakeholders. The DNP student shared finding with other units in the hospital or psychiatric inpatient units from other hospitals can consider implementing the SMART education program using the same structure and techniques. Moreover, consider publishing the project outcomes in professional journals or presentations at professional conferences. Furthermore, the project was accepted to present via a poster in a state university.

Methodology

Settings

The DNP project was conducted in a 16-bed psychiatric inpatient unit of a 400-bed, the third-busiest non-profit academic medical center in the United States, which offers acute inpatient mental health services through a short-term psychiatric treatment program to both voluntary and involuntary patients. The staffing ratio at this unit is one nurse for four to six patients on both day and night shifts. The organization sets the target for the overall patient satisfaction score based on the percentile selected, which is usually the 70th percentile. The organization set the goal of 73.87% to ensure their score would be better than 70% of similar hospitals.

Design

This quality improvement project involved the DNP student measuring and analyzing the impact of interventions by collecting and assessing trended data over time. The data consisted of top box percent scores from the PGIBH survey, tracked three months before and after implementing the AAMC SMART discharge tool for psychiatric inpatient admissions.

Study Population

The subject population comprised all patients aged 18 years and above admitted to the psychiatric inpatient unit and completed the PGIBH survey. All patients were encouraged to complete a PGIBH survey before discharge. Specifically, during the implementation phase, the subject population consisted of all patients discharged from the unit and completed the PGIBH survey from December 1st, 2023, to February 29th, 2024.

Subject Recruitment

The DNP student requested the organization's patient experience specialist to provide baseline data from August 1st, 2023, to October 31st, 2023, and monthly data throughout post-implementation from December 1st, 2023, to February 29th, 2024. The PGIBH survey data encompassed patient satisfaction metrics, including discharge question scores, percentile rankings, sample size, distribution of responses ranging from very poor to very good monthly, and demographic reports.

The unit educator conducted pre- and post-chart audits concerning SMART education using the organization's EPIC EHR system. She also double-checked SMART completion data for false positives and negatives. Subsequently, the findings were shared with the DNP student for data collection before implementation and monthly during post-implementation.

Ethical Consideration

As determined by the Clinical Quality Review Committee at the practice site, participating in the project posed a minimal risk. The project was deemed exempt from scrutiny and did not qualify as human subject research under 45 CFR 46.102. Consequently, it progressed as a quality improvement initiative with minimal potential for harm. The organization's Patient Experience Specialist provided the PGIBH survey data without personally identifiable information, aligning with HIPAA requirements and protecting patients' privacy. Moreover, all patient data entered by Statistical Package for the Social Sciences (SPSS) was de-identified and accessible solely to the project lead. The DNP student

ensured enhanced data security by storing it on a password-protected and encrypted computer, with no copies stored elsewhere. Additionally, summative data from this QI project was shared within the site and disseminated externally only with site permission. Before sharing the study's findings beyond the practice site, the DNP students had to obtain written approval for dissemination from the Chief Nursing Officer and Nursing Research EBP Council.

Costs and Compensation

The cost of the project was minimal. The DNP student prepared a resource book that included community resources and printed patient education information for common medications, signs, and symptoms of some common psychiatric diagnoses and coping techniques from the Neuroscience Education Institute, National Institute of Mental Health, and National Alliance on Mental Health. Nurses could make copies of medication and disease education sheets from the SMART resource binder. The organization had a printer and had to consider the cost of ink and paper. The DNP student worked with the unit educator to train all nurses, and current nurse staff provided patient education during the implementation. The unit educator and the patient experience specialist provided data to the DNP student without incurring extra costs from the organization. The DNP student collected and analyzed data without payment. The DNP project incurred no additional expenses for human resources, and the associated program costs were minimal.

Intervention

The Nursing Research and Evidence-Based Practice Council and the Clinical Quality Review Committee at the practice site reviewed the proposal, categorizing it as a quality improvement project, and approved it to commence on November 16th, 2023. The program was developed following an extensive literature review aimed at educating all nurses in the psychiatric inpatient unit to feel comfortable and confident in delivering discharge education

to admitted patients. The project sought to improve patient satisfaction by utilizing the AAMC SMART discharge journal worksheet and SMART resource binder, as evidenced by research findings (Strong & Bettin, 2015; Thum et al., 2022).

The AAMC SMART discharge tool was chosen because it was an evidence-based tool, already implemented in other medical units within the organization, with available resources for training. In 2011, Anne Arundel Medical Center in Annapolis, Maryland, was awarded the Picker Institute "Always Event" grant to develop the AAMC SMART discharge tool. Throughout their initiative, the AAMC SMART team utilized existing evidence and emphasized the importance and anticipated benefits of implementing the protocol for patients, families, and caregivers. The AAMC researchers also disseminated their findings widely and advocated for the protocol to be recognized as a national standard practice (IPFCC, 2023). Although the effectiveness of the AAMC SMART discharge tool has been demonstrated, limited studies were found, and no studies were conducted in a psychiatric inpatient unit setting. One study involving 67 surgical oncology patients who received SMART discharge education revealed that 44 (66%) patients responded to post-discharge calls and rated their readiness for discharge at 8.3 out of 10 (McLaughlin et al., 2019). Additionally, patient satisfaction related to discharge was reported at 87.5% (McLaughlin et al., 2019). Furthermore, staff observed improved discharge quality and enhanced interdisciplinary team effectiveness following the implementation of the SMART discharge protocol (McLaughlin et al., 2019).

The implementation team used the Plan-Do-Study-Act (PDSA) model to assess outcomes. Data collection for patient satisfaction scores and SMART education completion occurred throughout implementation. The DNP student facilitated open communication among staff and provided ongoing training to ensure proficiency in SMART education delivery. The method and analysis plan remained consistent throughout the process, with

baseline clinical data on patient satisfaction scores collected initially and re-collected over three months. Ongoing training and feedback sessions ensured discipline accountability and supported the project's success.

The pre-implementation phase was completed on November 30th, 2023, when all nurses in the psychiatric inpatient unit, regardless of employment status, completed the AAMC SMART education training and training sign-off sheet. Every nurse completed the SMART discharge protocol quiz **(Appendix I)** before receiving SMART discharge protocol education and one month after the training. All nurses in the psychiatric inpatient unit received training on the SMART discharge protocol and a SMART discharge protocol self-learning package.

The DNP student would track RN education completion rates and ensure all RNs receive the SMART discharge protocol training. The goal was to ensure that every nurse felt comfortable and confident in providing discharge planning using the SMART discharge protocol and the resource book. Furthermore, ongoing training will be provided to team members to ensure adequate education. The DNP student would work alongside the unit educator to provide additional one-on-one training sessions to nurses as needed. The goal is to ensure that every nurse feels comfortable and confident in delivering discharge planning using the SMART discharge protocol and the resource book.

The implementation period was from December 1st, 2023, to February 29th, 2024. Each new patient admission's pre-made folder contained the AAMC SMART journal worksheet. Nurses utilized the "SMART" section under patient education in EPIC by following the Instructions on How to Document SMART Education in EPIC **(Appendix I)**. Each admitted nurse ensured completion of SMART education within 24 hours under the patient education tab in EPIC, as per unit policy. If SMART education required finalization, the initial admitted nurse reported to the incoming shift nurse, ensuring prompt completion

during admission to guarantee patient understanding of the SMART journal worksheet. Nurses respected patients' rights to decline SMART education and revisited and offered the education when the patient was ready. The DNP student and four other staff nurses conducted daily audits to ensure every patient received AAMC SMART discharge journal worksheets and nurses completed SMART education in EPIC.

Patients received an educational information sheet from NEI with each new psychiatric medication and were instructed to place it in their discharge planning folders. If NEI's medication information sheet was unavailable, nurses provided education using EPIC medication education information. During nurse assessment sessions, the SMART discharge journal served as a patient discharge education tool, employing the teach-back method to ensure understanding and address questions and concerns. "SMART: Y N" was added to each patient's daily shift report sheet for communication among team members. Furthermore, nurses obtained outpatient appointment information one day before discharge and reviewed it with the patient if the information was available in EPIC. On the discharge day, nurses reviewed the patient's discharge folder and the AVS to ensure comprehensive discharge education before patient discharge.

Outcome Measurements

The effectiveness of the AAMC SMART discharge tool in improving patient satisfaction regarding discharge was assessed through pre- and post-intervention patient satisfaction scores, which were recorded in an Excel spreadsheet for comparison. The study focused on three discharge-related questions from the PGIBH survey, measuring the top box percent scores. Pre-intervention data were collected retrospectively for patients discharged from August 1st, 2023, to October 31st, 2023. This data included demographic information such as age, sex, and race. For post-intervention data, the DNP student requests the same information monthly data for December 2023, January, and February 2024.

The PGIBH survey served as the means to measure and analyze the alterations in patient experiences that resulted from introducing the protocol. The PGIBH survey, encompassing 26 standardized items across ten domains, captures various aspects of patient experience, including communication with nurses, care providers, and the treatment team, admission and discharge details, program activities, room and meals, and an overall program rating. This survey is a publicly reported tool and data collection method to evaluate patients' perceptions of their hospital experiences (Thum et al., 2022). The PGIBH survey top box presented scores as the percentage of questions or domains' responses with answers including very good, good, fair, poor, and very poor. A chi-square test assessed the relationship between the top box percent of three specific discharge-related questions from the PGIBH survey before and after the intervention. All analyses yielded a p-value of $< .05$, indicating substantial results.

The unit educator conducted pre and post-chart audits related to SMART education via the organization's EPIC electronic health record system and subsequently shared the findings with the DNP student for documentation. The Inpatient SMART Education Audit tool was created specifically to monitor and track the completion of SMART education sessions within the EPIC system. The Inpatient SMART Education Audit tool provides a structured framework for monitoring, ensuring consistent and effective implementation of the SMART education program. By establishing comprehensive measurement criteria, the tool enables impartial evaluation and timely identification of areas requiring improvement (Limb et al., 2017). Moreover, a Chi-Square test was used to evaluate the relationship between SMART education completion rates before and after implementation.

Software Utilized

The QI initiative data was collected using Excel spreadsheets with secured passwords and SPSS version 27 for management and analysis. The DNP student documented data

elements in both Excel and SPSS. Excel was primarily used for creating data graphs, while SPSS was utilized for statistical analyses such as obtaining descriptive statistics and conducting Chi-Square analyses. The DNP student managed data entry, ensuring its security by storing it on a password-protected and encrypted computer. No data was stored on any other hard drive or data location. **Table 2** contains a Data Coding Table for SMART Components for SPSS.

Data Entry Accuracy

The DNP student consistently reviewed and recorded real-time data during the intervention period, confirming its accuracy in Excel. Moreover, the unit educator double-checked all data to guarantee accuracy and precision. Both pre-intervention and post-intervention patient experience data and EPIC patient SMART education chart review details were compiled using a combination of Excel spreadsheets to store and analyze the data. The DNP student requested the monthly PGIBH survey report from the organization's Patient Experience Specialist, who managed patient experience data. The DNP student entered the number of patients who selected the “very good” option and the total number of patients who completed the survey in Excel for analysis. Moreover, three months of pre-intervention and three months of post-intervention top box percent (total top box/total surveys) were entered in Inpatient Behavioral Health Survey Domain Results with Statistical Analysis **(Table 5)**. Inpatient Patient Satisfaction Top Box Scores Pre- and Post-SMART protocol were documented in **Table 6**. Moreover, survey answers were documented in Survey Frequency Distribution Response Table **(Table 7)**, pre-and post-implementation survey score means **(Table 8)**, and monthly survey score means **(Table 9)** were used for data analysis. Furthermore, the same data from the same months from one year before were documented to analyze the impact of winter months or holiday season on patient satisfaction relate to discharge: Previous Year Top Box Scores **(Table 13),** Previous Year Monthly Survey

Frequency Distribution Response Table **(Table 14),** pre-and post-implementation survey score means **(Table 15)**, and monthly survey score means **(Table 16).**

The DNP student analyzed and inputted demographic characteristics for all patients who completed the PGIBH survey. Moreover, the unit educator conducted pre and post-chart audits related to SMART education via the organization's EPIC electronic health record system and subsequently shared the findings with the DNP student for documentation. The DNP student compared the SMART education completion data with the inpatient SMART education audit tool and documented the findings in SMART Education Monthly Completion Tracking in EPIC **(Table 3)**.

Project Timeline

The DNP project timeline, detailed in **Appendix M**, outlines the following phases:

- Phase I (January –May 2023): During this period, an organization needs assessment was conducted to pinpoint the focus of the DNP project. The standard discharge planning protocol was selected, and crucial meetings with stakeholders were held to establish a project team. Subsequently, the DNP proposal was submitted.
- Phase 2 (June – August 2023): This phase involved identifying a second project advisor, obtaining a letter of agreement from the project site, and securing practice site Institutional Review Board (IRB) approval.
- Phase 3 (September– November 2023): The project received approval from the Nursing Research and Evidence-Based Practice (EBP) Council and obtained practice site Institutional Review Board (IRB) approval. The project dates were finalized, and both the project team and unit staff were notified. All nurses completed SMART discharge protocol training by November 30th, 2023.

- Phase 4 (December 2023 - February 2024): The project was implemented from December 1st, 2023, to February 29th, 2024, followed by a comprehensive analysis of the results obtained.
- Phase 5 (March-May 2024): During the final phase, attention was directed toward evaluating the outcomes of the DNP project and disseminating the results to pertinent stakeholders, including the practice site and school.

Data Analysis

Characteristics of Participants and Predictors of Patient Satisfaction

All PGIBH Surveys completed by patients discharged from August 1st, 2023, to October 31st, 2023, and December 1st, 2023, to February 29th, 2024, were used for result analysis. In the pre-implementation period, 107 patients completed discharge overall, 104 patients completed question number one, and 104 answered questions two and three. In the pre-implementation period, 77 patients completed "discharge overall," 75 completed questions one and three, and 74 responded to question two. This information is available in **Table 5**: Inpatient Behavioral Health Survey Domain Results with Statistical Analysis.

Participants' characteristics, including age, sex, and race, and the statistical analysis were documented in both tables and charts. **Table 10** presents an analysis of participant age distribution. **Table 11** compares participant demographics by sex before and after SMART protocol implementation. **Table 12** compares participant demographics by race before and after the protocol. **Chart 10** visually represents statistical analysis related to participant age. **Chart 11** visually represented participant demographic distribution by sex, while **Chart 12** demonstrated the same for participant demographic distribution by race.

Before implementation, the patient's mean age ranged from 35.89 to 47.52 years compared to the mean age from 33.81 to 38.39 years, suggesting a change towards a slightly younger demographic after implementation. Notably, the mode, representing the most

common age, was higher pre-intervention, with August 2023 having a mode of 40.00. However, the mode consistently decreased post-intervention, with 18 years old being the most common age in January and February 2024 and 20 in December 2023. This indicates a significant shift towards younger patients following the implementation. Additionally, median ages ranged from 29.00 to 48.00 years before and from 30.00 to 35.50 years after the implementation, indicating a younger population post-intervention, with minor fluctuations. Furthermore, the standard deviation (SD) ranged from 15.44 to 19.11 before and from 15.08 to 16.79 after the intervention, implying consistent variability in patient ages regardless of the protocol implementation. However, the slight decrease in the SD post-intervention suggests a potential trend towards slightly less variability in patient ages. In other words, the patient samples were younger in the post-implementation period than before the implementation.

Understanding age distribution is crucial as it offers valuable insights into the patient population, aiding in identifying trends and patterns impacting healthcare delivery and outcomes. Assessing the effectiveness of the intervention and its impact on patient demographics allows healthcare providers to determine its efficacy. Additionally, researchers confirmed a strong correlation between higher satisfaction scores in healthcare services and older age (Adams et al., 2024; Berzina et al., 2021; Bird et al., 2020; Priebe et al., 2019; Molin et al., 2021). For instance, older patients exhibited significantly greater satisfaction with the meeting than younger patients (Mann-Whitney $U = 436.50$; $p = 0.013$) (Molin et al., 2020). Satisfaction scores related to discharge did not improve post-implementation of the SMART discharge protocol, possibly influenced by the younger demographic in the post-implementation period.

A higher rate of involuntary admissions may contribute to a lower patient experience score in the post-implementation period. Notably, younger patients in the unit demonstrate a higher rate of involuntary admissions, as depicted in **Chart 18**: Involuntary Admission Rate

by Age Bucket. Specifically, the involuntary admission rate for patients aged 18 to 30 was 8.8%, followed by 8.4% for those aged 31 to 50. However, this rate decreased to 3.3% for patients aged 51 to 64. The post-implementation period had a 6.46% higher involuntary admission rate than the pre-implementation period, presented in **Chart 14**: Monthly Involuntary Admission Rate. Moreover, the involuntary admission rate was more than double compared to February 2024 and October 2023, 38% and 17%, respectively. Woodward et al. (2017) confirmed that voluntarily admitted patients had a mean satisfaction score one point lower than involuntarily admitted patients, 6.52 and 7.58, respectively ($p < 0.0001$). Furthermore, patients who were admitted involuntarily were associated with a longer length of stay (LoS), as presented in **Chart 15**. The average length of stay for voluntarily admitted patients was similar, differing by 0.23 days. In contrast, the average length of stay differed by one day for involuntarily admitted patients.

Researchers emphasized that LoS was the critical determinant impacting overall patient satisfaction, explaining around 65% of the total variability according to the mean decrease Gini measure (Haji et al., 2022). A shorter LoS significantly improves data clarity in decision tree node splits (Haji et al., 2022). According to the findings, involuntary extensions of LoS during the post-implementation phase may reduce patient experience scores. This could disrupt patients' expectations and comfort levels, resulting in dissatisfaction with their overall care experience.

Chart 11 presented the demographic distribution of participants by sex. In the pre-implementation phase, female participants outnumbered male participants by 10.62%, while in the post-implementation phase, this difference increased to 15.68%. Across five of the six months, the percentage of male patients consistently lagged that of females, a trend that continued during all three post-intervention periods. This consistent gender discrepancy suggests a persistent pattern rather than a temporary fluctuation. For example, in August

2023, female participants were 26.36% higher than males, 63.16%, and 36.84%, respectively. This trend persisted consistently throughout the observation period, with February 2024 displaying a similar pattern, where 60.87% were female compared to 39.13% male patients, indicating a considerable difference of 21.74%. However, October 2023 presented a deviation from this trend, with the percentage of female patients decreasing to 48.48% while the proportion of male patients increased to 51.52%. A possible gender bias should be considered.

In August, females outnumbered males by 26.36%, and question one, concerning understanding medication, had the lowest score at 52.63%. A similar pattern was noted in February, where the same question scored 64%, the second lowest compared, and females were 21.57% higher than males. Researchers confirmed that female patients consistently exhibited significantly lower satisfaction levels than men across categories and overall satisfaction (Ratner et al., 2018). Moreover, researchers concluded that male patients consistently rated slightly higher across all categories and provided better overall hospital ratings than female patients (Adams et al., 2024). However, Molin and colleagues (2020) found no significant gender-based difference in satisfaction scores, with men averaging 38.97 and women slightly lower at 36.32 ($p = 0.598$). Furthermore, research conducted by Bird et al. (2020) and Færden et al. (2020) confirmed these results, suggesting no significant gender disparities in satisfaction levels regarding psychiatric inpatient treatment.

The race demographic distribution is presented in **Chart 12**. The proportion of White/Caucasian patients remains relatively steady, ranging from 60.00% to 69.57%. On average, 22.08% of patients who complete the survey are African American. The percentage of Hispanic/Latino patients displays some variability, fluctuating between 11.43% and 4.35%, generally staying low. The “Other” category, which includes minority groups like Asian American, Native American/Indigenous, Middle Eastern, Biracial individuals, and

those who opt not to disclose their race, shows fluctuations, which increased to 21.05% in December 2023 compared to other months but generally remained low.

The data from August 2023 and September 2023 show similar demographic distributions: African American patients comprised 28.57% and 25.00%, respectively; White/Caucasian patients were 60.00% and 62.50%; Hispanic/Latino patients were 11.43% and 8.33%, and "Other" category was 0.00% and 4.17%. Despite these similarities, there was a notable difference in patient satisfaction scores, with a difference of over 20%. Specifically, the satisfaction score for Understanding Medication Instructions at Discharge was 52.63% in August 2023, contrasting with 85.71% in September 2023. Consequently, the result suggested no correlation between race and patient satisfaction scores. The findings were different from the outcomes of other studies. Research indicated that individuals from racial and ethnic minority groups, notably Black Americans, were disproportionately diagnosed with schizophrenia compared to White individuals (University of Pennsylvania, 2024). Olbert et al. (2018) concluded that Black Americans experienced a 2.5 times higher risk of being diagnosed with schizophrenia compared to Caucasian individuals. Additionally, Shea (2022) concluded that patients of color, especially those identifying as Black or other multiracial, had higher rates of involuntary admission. Furthermore, patients with psychosis and service user-related factors showed higher satisfaction levels when admitted voluntarily, contrasting with lower satisfaction scores for involuntarily admitted patients (Woodward et al., 2017).

Compared Patient Experience with Previous Data

The QI project was conducted during the winter and holiday seasons, from December 1st, 2023, to February 29th, 2024. The DNP student analyzed and compared patient experience data from August 1st, 2023, to February 29th, 2024, and from August 1st, 2022, to February 28th, 2023, to determine if seasonal variations impacted patient experience. The previous year's top box scores were documented in **Table 13, and Table 14** presented the

previous monthly survey frequency distribution response table. **Table 15 and Table 16** documented the last survey year's average score compared to August to October 2022 and December 2022 to February 2023 and the average monthly survey score. The same data were also illustrated in **Chart 7, Chart 8, Chart 9, and Chart 10.**

For patient satisfaction, top box scores related to three discharger questions were between 3.43% and 17.6% lower compared to August to October 2022 and December 2022 to February 2023, which were the same pre- and post-implementation months. October 2022 registered the highest scores for all three questions at 80%, 87.5%, and 87.5%, respectively, exceeding February 2023 by more than two-fold, where the scores were 43.33%, 40%, and 40% (**Chart 7)**. Compared to August to October 2022 and December 2022 to February 2023, the average survey scores experienced a decrease of 0.02 to 0.39 points (**Chart 8)**. In February 2023, the average survey score for all three discharge questions had the lowest points, with scores of 4.2, 4.2, and 4.1 out of 5 points, respectively (**Chart 9)**. On the other hand, patients' average survey scores related to the three discharge questions were 4.33, 4.88, and 4.88 in October 2022, which were 0.13 to 0.78 points higher compared to February 2023, the average survey score. Therefore, it is crucial to recognize that patient experience from December to February was lower compared to August to October. Researchers concluded that during the warmest and coldest months (June to August and December to February), there was a notable increase in ED visits and hospital admissions for severe mental illness,

Comparing December 2023 to February 2024 with October 2022 to February 2023, there was an increase in patient experience top box scores related to discharge, rising from 0.8% to 7.25%. Additionally, average survey scores increased from 0.07 to 0.17 points compared to the previous year's data. These findings suggest that implementing the SMART discharge protocol may have positively impacted patient experience.

Compared Patient Experience with monthly Top Primary Diagnoses

Understanding the monthly distribution of the top six primary diagnoses is crucial for comprehending patient experience scores. Researchers indicated that patients diagnosed with organic disorders exhibited significantly higher satisfaction levels than those diagnosed with schizophrenia spectrum disorders ($Z = 2.897$, $p = .038$). (Berzina et al., 2021). Moreover, Ratner et al. (2018) concluded that factors affecting psychiatric service satisfaction may encompass illness severity, symptoms, and psychosocial and personality traits. In the post-implementation period, schizoaffective disorder of the depressive type ranked as the fifth most prevalent diagnosis in December 2023 and among the top six diagnoses in February 2024. Additionally, in January 2024, major depressive disorder, recurrent, severe with psychotic features, was the second most common diagnosis. Notably, during the pre-implementation period, schizoaffective disorder did not rank among the top six primary diagnoses. The severity of the top six primary diagnoses during the post-implementation months indicates a potential contribution to lower patient experience scores.

The monthly top six primary diagnoses are demonstrated in Chart 16.

In August, the survey revealed relatively lower scores for all three discharge questions, with question one, regarding medication instruction related to discharge, receiving the lowest score of 52.3%. The low score might interfere with the top diagnoses. Among the top six diagnoses, 93% of patients were diagnosed with bipolar disorder or various levels of depressive disorder. In February 2024, the score for the first discharge question was the second lowest at 64%. This score might have been influenced by the prevalent diagnoses of depression and bipolar disorder, which accounted for 83% of all diagnoses.

January 2024 had the lowest top box score for questions two and three, 60.71 and 62.07, respectively. This could be attributed to the prevalence of major depressive disorder, recurrent, severe with psychotic features, which was the second most frequently diagnosed condition that month, affecting nearly 20% of the patients. Additionally, almost half of the

patients were diagnosed with various levels of depressive disorder. These findings indicate that patients with severe mental health conditions may have difficulty understanding or following discharge instructions, which could negatively impact their overall satisfaction with the discharge process (Berzina et al., 2021).

Results

A chi-square test was conducted to evaluate the project's success in achieving Objective 1, which aimed to improve patient experience related to discharge. This test assessed the relationship between the PGIBH survey top box percent scores for discharge before and after the intervention. Specifically, three questions related to discharge were analyzed using the chi-square (χ^2) statistic to compare expectations with actual outcomes. The results from the PGIBH survey indicated no significant improvements in patient satisfaction across several domains following the intervention. Post-intervention analysis of PGIBH survey results across various domains showed no significant enhancements in satisfaction: discharge overall ($\chi^2 = 1.326$, $p = 0.249$), understanding of discharge medication instructions ($\chi^2 = 0.412$, $p = 0.521$), information about care after discharge ($\chi^2 = 0.545$, $p = 0.460$), and discharge instructions for assistance ($\chi^2 = 0.586$, $p = 0.108$). These findings suggest that despite the notable increase in SMART education completion rates, the intervention did not significantly enhance patient satisfaction related to the discharge process. However, there was an increase in top box scores for PGIBH surveys related to discharge, ranging from 0.8% to 7.25%, and average survey scores increased by 0.07 to 0.17 points when comparing December 2023 to February 2024 with October 2022 to February 2023. These findings suggest that implementing the SMART discharge protocol may have positively impacted patient experience.

Statistical analysis, using the Chi-Square Test (X^2) and P-value, further validated the effectiveness of the implementation. A calculated Chi-Square test value of 250.15 and a *p*-

value <0.0001 showed a statistically significant difference in completion rates between SMART education's pre-implementation and post-implementation phases in EPIC **(Tablet 3)**. The implementation positively enhanced participant engagement and commitment, as demonstrated by the increase in completion rates from 1.86% pre-implementation to 91.39% post-implementation **(Chart 1)**. After implementing the QI project in the unit, the completion rate of SMART education within the EPIC framework. In the pre-intervention analysis involving 161 participants, three participants' charts indicated SMART completion in the unit. On the other hand, post-implementation, with a sample size of 151 participants, the number of individuals without SMART education under EPIC decreased to 1.86% (13) participants. In contrast, 91.39% (139) of participants' charts indicated SMART education after introducing the protocol.

Comments that relate to discharge were collected, and there were three positive, one negative, and one neutral comment:

1. Very helpful and educational. Willing to answer questions and be specific about the help I'm looking for.

2. I answer this survey before meeting my doctor and the social worker, but I have a pretty big amount of information.

3. The staff was thorough.

4. I even received a schedule & treatment sheet to use at home to help identify symptoms in the future.

5. I have not yet explained my mediation or plans.

Discussion

Despite an increase in the completion rate for SMART education in EPIC, from 1.86% to 91.39% compared to pre and post-implementation, patient satisfaction related to discharge did not improve. Although SMART Education effectively increased participant

engagement, it did not directly translate into improved patient perceptions of discharge-related factors. The study's evaluation of the correlation between SMART education and patient satisfaction, assessed through PGIBH surveys, encountered several limitations. Firstly, the post-implementation survey completion rate (Chart 13) was about 51% compared to 65% in pre-implementation. The low survey completion rate in post-implementation captured half of the patients' perspectives and experiences, raising concerns about nonresponse bias. Therefore, conducting a broader study with a higher survey completion rate is crucial for drawing more definitive conclusions about the relationship between SMART education and patient satisfaction. Second, the study relied on survey responses and omitted direct patient interviews. This methodological choice may represent the perspectives of some patients, as those satisfied with the discharge process or facing minimal issues might have been less motivated to participate, so sample bias must be considered. Consequently, there was a risk of bias in the collected data, potentially influencing the interpretation of patient satisfaction levels. Furthermore, this study's data collection was confined to essential demographic variables such as age, gender, and race. However, other significant factors were omitted, including education level, marital status, support systems, insurance coverage, housing status, and substance use. This absence makes it challenging to differentiate among patient groups accurately. Moreover, involuntary admissions were higher than pre-implementation with an increased length of stay, which may interfere with patient experience. Patients admitted involuntarily generally reported lower mean satisfaction scores than voluntarily admitted ones. For example, Woodward et al. (2017) emphasized a one-point discrepancy between involuntarily and voluntarily admitted patients. Additionally, the project was conducted in a single location, which may limit the applicability of the findings. This site's demographics, healthcare processes, and patient experiences may not represent other psychiatric inpatient units in different locations.

The survey's top box score, the percentage of patients who chose the "very good" option, was evaluated to determine the effectiveness of the QI project. However, the average survey scores may be more representative. For example, comparing the monthly top box score from August 2023 to September 2023 **(Chart 2)**, the top box score for question one was 52.63% in August 2023, which was 33.08% lower than in September 2023. The average score for question one between these two months was 0.35 points different **(Chart 5)**. Moreover, for question two, the top box score during pre-implementation was 6.06% higher than during post-implementation, 72.28%, and 66.22%, respectively **(Chart 3)**. However, the average score was 0.04 points lower in pre-implementation when comparing the average score of 4.56 and 4.52 out of 5 **(Chart 4)**. Furthermore, In October 2023, the top box score for question two was 70%, almost 10% higher than in January 2024. However, the average score in January 2024 was 0.02 points higher than in October 2023 (4.55 vs. 4.53). Additionally, in February 2024, the top box score for question two was 66.67%, 3.33% lower than in October 2023, while the average score was 0.07 points higher. Overall, the top box score between pre- and post-implementation surveys decreased by 4.48% to 6.06%. The average scores between pre- and post-implementation surveys were also reduced by 0.03, 0.08, and 0.11 points for all three discharge questions, indicating that patient satisfaction scores were similar before and after implementation.

Although the DNP project failed to enhance patient experience regarding discharge, it is crucial to acknowledge its limitations. These include a low survey completion rate, limited generalizability due to single-site implementation, and various factors impacting patient experience, such as legal admission status, length of stay, and diagnoses. Moreover, compared to the August to October survey, the top box and average scores were higher than in December to February in both years. Researchers confirmed that significant seasonal variations in mental health-related ED visits and hospital admissions for severe mental

illness, with increases during both the warmest (June to August) and coldest (December to February) months (Fraccalini et al., 2024). These increases are particularly noticeable among patients with conditions such as bipolar disorder, major depression, personality disorder, and schizophrenia (Fraccalini et al., 2024). The elevated involuntary admission rates and the prevalence of severe mental health illnesses during these periods are associated with lower patient experience scores (Berzina et al., 2021; Fraccalini et al., 2024; Rizavas et al., 2023).

A 12-month implementation time frame is needed to further understand the complex relationship between patient experience and the implementation of SMART Education, which underscores the need for a more extended study period. Even though the DNP project did not include data from March 2024, improvements in all three discharge-related questions were observed. For example, there was an 18% increase in understanding discharge medication instructions compared to February 2024 and a 30% increase compared to August 2023 **(Chart 17)**. This improvement emphasizes the positive impact of using SMART education, which will enhance patient care and improve patient experience in the long term.

Implications/Recommendations for Practice, Policy, Leadership and Quality/Safety

Implications for Practice

Implementing a standardized psychiatric discharge protocol can enhance the patient experience by empowering individuals to take control of their health, resulting in improved confidence and satisfaction with their care experience. Healthcare providers can effectively minimize the need for re-hospitalization and improve patient outcomes by ensuring that patients thoroughly understand their treatment plans and post-discharge instructions (Owusu et al., 2022). Implementing a standardized discharge protocol can lead to significant cost savings by preventing avoidable admissions and emergency visits, thereby reducing overall healthcare expenditures (Everett et al., 2022). Providing vulnerable populations with the necessary knowledge and resources to access appropriate healthcare services through

standardized discharge protocols can significantly reduce healthcare disparities (St John & Englund, 2020; Smith et al, 2021). Addressing mental health concerns through educational interventions and early intervention strategies incorporated into discharge planning can play a crucial role in reducing suicidal rates and promoting overall mental well-being in the community (Singh et al., 2022). Overall, adopting a standardized psychiatric discharge protocol enhances patient care and satisfaction and has broader implications for addressing societal challenges such as homelessness. This underscores the importance of integrating evidence-based practices into discharge processes to improve outcomes and support the holistic well-being of patients and communities.

Implications for Healthcare Policy

Collecting data over an extended period is imperative to endorse policy change effectively. Therefore, the DNP student advocated for leadership and staff nurses to sustain the implementation of the AAMC SMART discharge tool and collect data for at least 12 months. This prolonged timeframe will facilitate a comprehensive analysis of the protocol's impact on patient experience post-discharge, thereby accommodating valuable insights to guide future policy decisions. However, the organization's Nursing Research and EBP Council initially approved only a three-month data collection period for the DNP student. Given the significance of this project, it is crucial to emphasize to unit leaders the necessity of extending the data collection timeframe. The DNP student recommends proposing a new policy to continue practicing SMART education as part of the unit's standard protocol. This strategic approach will ensure the consistent implementation of evidence-based practices and contribute to sustained quality improvement initiatives within the organization.

Implications for Executive Leadership

Incorporate the SMART discharge protocol into strategic planning initiatives to prioritize patient-centered care and quality improvement efforts. Allocate resources for staff

training and protocol implementation to support the effective integration of SMART discharge practices. Lead the development of policies to mandate and sustain evidence-based practices such as SMART education, emphasizing ongoing education and protocol adherence. Promote a culture of continuous improvement and adoption of evidence-based practice within the organization, demonstrating leadership commitment and support for integrating the SMART discharge protocol. Further collaboration between executive leadership, clinical staff, and nursing councils is needed to ensure successful protocol implementation that aligns with organizational goals and objectives. Oversee the monitoring and evaluation of the SMART discharge protocol's effectiveness, utilizing regular assessment of outcomes and feedback mechanisms to drive improvements and ensure protocol sustainability. Consider extending the implementation of the SMART discharge protocol to another psychiatric inpatient unit on a different campus within the organization. Integrate the protocol into the unit's culture to enhance patient quality of care and improve the patient experience, supported by evidence-based studies demonstrating cost-effectiveness and quality improvement benefits.

Implications for Quality/Safety

Discharge planning should commence upon admission and persist throughout the patient's hospitalization to ensure their preparedness for discharge and recovery (St. John & Englund, 2020). Tools like the SMART discharge journal worksheet help patients address various aspects of their care, such as understanding their diagnosis, managing medications, scheduling follow-up appointments, improving their quality of life, and reducing caregiver burden. The SMART discharge protocol, supported by evidence-based practices, enhances healthcare quality and safety. Patients receiving comprehensive post-discharge instructions and follow-up care experience improved treatment adherence and fewer adverse events. Standardized discharge protocols facilitate smooth transitions between inpatient and

outpatient care, minimizing errors through clear patient instructions (St. John & Englund, 2020). Moreover, the SMART protocol enhances patient safety by providing detailed medication information, reorganizing the discharge process, reducing unnecessary readmissions, and optimizing resource allocation. Systematic implementation of the SMART protocol allows ongoing quality improvement efforts, empowering providers to enhance care delivery continually. Integrating evidence-based discharge practices into clinical workflows improves care coordination and patient satisfaction.

Conclusion

Implementing the AAMC SMART discharge tool in the psychiatric inpatient unit did not improve patient discharge satisfaction scores despite an increased SMART completion rate. However, post-implementation survey top box scores related to discharge and average survey scores improved compared to the same months in the previous year. The lower patient experience score in the post-implementation period compared to pre-implementation months might be associated with a higher involuntary admission rate, a younger population, more female participants, schizoaffective disorder, and severe depressive disorder with psychotic features. The post-implementation period had a 6.46% higher involuntary admission rate than the pre-implementation period, and the involuntary admission rate more than doubled between February 2024 and October 2023. The average length of stay for involuntarily admitted patients was one day longer during the post-implementation months compared to the pre-implementation months. Additionally, the previous year's data analysis showed that patient experience scores related to discharge were lower from December to February, with top box scores for three discharge questions being 3.43% to 17.6% lower than from August to October 2022. Notably, the top box score in October 2022 was more than twice as high as in February 2023. These results indicated that additional factors, not fully captured during the limited three-month monitoring period of the quality improvement project, may have

influenced outcomes. With a post-intervention completion rate below 51%, potential nonresponse bias may have affected the results. Additionally, data collected from a single site may not represent broader demographics and experiences. Further study of the low completion rate of the PGIBH survey should be addressed, the evaluation period should be extended to at least one year, and data from multiple locations should be collected. Further evaluation with a higher completion rate of the PGIBH survey, extending the evaluation period to at least one year, and gathering data from multiple locations are needed to gain deeper insights into the impact of SMART education on patient satisfaction. For sustainability, standardized discharge protocol should be incorporated into the continued training curriculum for all nurse staff, ensuring consistent discharge education that improves patient experience, lowers readmission rates, and reduces healthcare costs, as the literature supports.

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Appendix A

Table 1: Data Collection/Evaluation and Analysis Methods

Aim 1: Evaluate the effectiveness of the AAMC SMART discharge tool by conducting monthly comparisons of patient satisfaction rates before and after the intervention and aiming to improve overall patient discharge top box scores by 3% within three months of implementing the SMART intervention from baseline data by the end of February 29th, 2024.

Aims/Evaluation Questions	**Measure**	**Measure Type**	**Data Source**	**Sampling Method**	**Timing/Frequency**
Improved patient satisfaction with discharge including understand their medication instructions at discharge, information provided about their care after discharge and instruction on what to do if they need help after discharge. *Does use of the SMART Discharge Protocol improve patient's satisfaction & perceived understanding of discharge education/instructions/care after discharge?*	Patient satisfaction top box score related to discharge	Outcome	Patient discharge satisfaction data from the PGIBH survey	All patients discharge during the reporting period who answered at least one question in the "Discharge" section of the PGIBH survey	Monthly for three months following the SMART implementation The baseline data were compared for the three months preceding the pre-implementation period, spanning from August 1st to October 31st, 2023. Additionally, monthly data were collected for three months from December 1st, 2023, to February 29th, 2024.
Standard Measure?	Yes. The psychiatric inpatient unit uses the vendor Press Ganey's Inpatient Behavioral Health (PGIBH) survey and analyzes the service. The PGIBH survey is a standardized 26-item instrument and data collection methodology divided into ten domains. The DNP project will focus on discharge domains involving the measurement of three questions related to discharge, and the top box percent scores will be analyzed. The PGIBH survey top box presents scores as the percentage of questions or domains'				

	responses with answers including very good, good, fair, poor, and very poor.
Numerator	# of patients select the "very good" choice
Denominator or Population	Total # of patients discharged in monthly period completed PGIBH surveys
Exclusions	None
Calculation/Statistic(s)	Percentage/Proportion
Goal/Benchmark	Increase top box scores by 3% from baseline data

Aim 2: One hundred percent of patients in McNew will be provided SMART education and SMART education journal worksheets during their hospital stay. One hundred percent of patients' SMART education under the patient education tab in EPIC will complete their discharge from December 1st, 2023, to February 29th, 2024.

Aims/Evaluation Questions	**Measure**	**Measure Type**	**Data Source**	**Sampling Method**	**Timing/Frequency**
Improve completeness of SMART Education during admission *Does the utilization of the SMART Education Discharge journal worksheet enhance the thoroughness of discharge education and instructions, as well as the preparedness of patients for post-discharge care?*	% of documented patients in the EMR with SMART Education	Process	EMR chart review	All patients discharged during the review period	Daily audited by using Inpatient SMART Education Audit tool for a duration of three months after the implementation rollout. Monthly for three months following the SMART implementation
Standard Measure?	Yes. Guidelines for the patient education process can be found in Unit Policies and Procedures. Every nurse completed the SMART education training and the SMART Discharge Protocol Education Nurse Training Sign-Off Sheet by November 30th, 2023. All nurses understood that every patient admitted to the unit would receive a SMART document journal worksheet and SMART education. SMART education under the patient education tab in EPIC must be completed within 24 hours of admission per unit policy. If the SMART education is not finalized as scheduled, provide a detailed report to the incoming shift nurse, and ensure prompt education completion during admission to guarantee that patients understand how to utilize the SMART journal worksheet effectively. The goal is to				

	empower patients to document their treatment throughout their stay, aiding their preparedness for discharge. Nurses understand that patients have the right to decline SMART education, and nurses are to revisit and offer the education when the patient is ready.
Numerator	# of patients with Yes SMART education in EPIC
Denominator or Population	Total # of patient discharged in monitoring period monthly
Exclusions	None
Calculation/Statistic(s)	Percentage/Proportion
Goal/Benchmark	100% of patients admitted in the unit with Yes SMART education

Table 2: Data Coding Table for SMART Components for SPSS

Data Element	Data Label	Data Type	Definition/Purpose	Data Values & Coding
Age	Age	Numeric, Continuous	Age in years	Actual Numeric Value
Gender	Current gender identity	Categorical	Self-identified gender from EHR	1, Male; 2, Female; 3, Non-binary; 4, Non-conforming; 5, Genderqueer
Sex	Sex	Categorical	Self-identified gender from EHR	1, Male; 2, Female;
Race	What category best desc race/ethnic	Categorical	Self-identified race from EHR	1, Africa American 2, Asian American; 3, Biracial 4, White/Caucasian; 5, Hispanic/Latino; 6, choose not to di
Shift	shift	Categorical	Nurse first shift	1, Day shift; 2, Night shift
Employment status	emploStat	Categorical	Nurse Employment status	1, full time; 2, Part time; 3, PRN
Admit Date	admitDate	Numeric, Continuous	Admit date from EHR	Date (D-M-Y) 08-01-2023 to 02-29-2024
Discharge Date	disDate	Numeric, Continuous	Discharge date from EHR	Date (D-M-Y) 08-01-2023 to 02-29-2024
Medication instructions	disMed	Categorical	comprehending the prescribed medication regimen upon leaving inpatient unit	1, Very poor; 2, poor; 3, fair; 4, good; 5, very good;

Aftercare information	Info re care after dis	Categorical	Information regarding care after discharge encompasses guidance and details	1, Very poor; 2, poor; 3, fair; 4, good; 5, very good;
Discharge instructions	disInstr	Categorical	Discharge instructions for seeking assistance outline guidance	1, Very poor; 2, poor; 3, fair; 4, good; 5, very good;
Discharge satisfaction	Pat disSatis	Categorical	Overall, I was satisfied with the discharge process.	1, Very poor; 2, poor; 3, fair; 4, good; 5, very good;
Suggestions	pat_suggestions	Text	Please share any additional comments or suggestions you may have about the discharge instructions, education or process.	Comments (describe good or bad experience)
SMART Education Completion	EduCom	Categorical	SMART Education completion tracking in EPIC	Yes SMART Education No SMART Education

Table 3: SMART Education Monthly Completion Rate Tracking in EPIC

Discharge Date	Yes SMART Education	No SMART Education	Complete Rate (%)	Note
08/01-8/31/2023	0	50	0%	A total of 14 patients indicated they received SMART education, but documentation occurred in other medical units, leading to a false positive rate of 100%.
09/01-09/30/2023	1	55	1.79%	A total of 16 patients indicated they received SMART education, but documentation occurred in other medical units, leading to a false positive rate of 98.21%.
10/01-10/31/2023	2	53	3.64%	A total of 11 patients indicated they received SMART education, but documentation occurred in other medical units, leading to a false positive rate of 96.36%.
12/01-2/31/2023	42	4	91.30%	Four patients refused SMART Education
01/01-01/31/2024	51	5	91.07%	Five patients declined SMART Education
02/01-02/29/2024	45	4	91.8%	Three patients declined, and documentation was inadvertently omitted for one patient by the RN.

Table 4: Pre-Post SMART Education Completion Rate with Data

Time/SMART	Pre-Implementation	Post-Intervention	Chi-Square	p	n
SMART Education Completion Rate	1.86% (3/161)	91.39% (138/151)	252.15	<0.0001[a]	312

Table 5: Inpatient Behavioral Health Survey Domain Results with Statistical Analysis

Domain and question	Pre-Implementation	Post-Implementation	Chi-Square	P	n
Discharge Overall	71.63% (74.5/104)	66.23% (51/77)	1.326	0.249	181
Understand discharge medication instructions	71.15% (74/104)	66.67% (50/75)	0.412	0.521	179
Information related care after discharge	72.28% (73/101)	66.22% (49/74)	0.545	0.460	175
Discharge instruction need help	71.29% (72/101)	65.33% (49/75)	0.586	0.108	176

[a]**p< .05 value used for significance.**

Table 6: Inpatient Satisfaction Top Box Scores Pre- and Post- SMART Protocol

Questions	Top Box (08/23)	n	Top Box (09/23)	n	Top Box (10/23)	n	Top Box (12/23)	n	Top Box (01/24)	n	Top Box (02/24)	n
Discharge Overall	60	38	82.86	35	72.53	31	68.18	22	63.53	29	67.12	26
Understand Medication instructions at discharge	52.63	38	85.7	35	77.42	31	68.18	22	67.86	28	64	25
Information about care after discharge	63.89	36	82.86	35	70	30	68.18	22	60.71	28	70.83	24
Instructions on what to do if need help after discharge	63.89	36	80	35	70	30	68.18	22	62.07	29	66.67	24

Table 7: Monthly Survey Frequency Distribution Response Table

Discharge Date	Questions	Very Poor n	Poor n	Fair n	Good n	Very Good n	Total n	Average
8/1/2023 - 8/31/2023	Understand disch med instructions	1	0	1	16	20	38	4.42
8/1/2023 - 8/31/2023	Info re care after discharge	1	0	3	9	23	36	4.47
8/1/2023 - 8/31/2023	Discharge instructions if need help	1	0	5	7	23	36	4.42
9/1/2023 - 9/30/2023	Understand disch med instructions	0	0	3	2	30	35	4.77
9/1/2023 - 9/30/2023	Info re care after discharge	0	0	5	1	29	35	4.69
9/1/2023 - 9/30/2023	Discharge instructions if need help	0	0	5	2	28	35	4.66
10/1/2023 - 10/31/2023	Understand disch med instructions	0	1	2	4	24	31	4.65
10/1/2023 - 10/31/2023	Info re care after discharge	0	1	3	5	21	30	4.53
10/1/2023 - 10/31/2023	Discharge instructions if need help	1	1	2	5	21	30	4.47
12/1/2023 - 12/31/2023	Understand disch med instructions	1	0	0	6	15	22	4.55
12/1/2023 - 12/31/2023	Info re care after discharge	1	0	0	6	15	22	4.55
12/1/2023 - 12/31/2023	Discharge instructions if need help	2	0	1	4	15	22	4.36
1/1/2024 - 1/31/2024	Understand disch med instructions	0	1	2	6	19	28	4.54
1/1/2024 - 1/31/2024	Info re care after discharge	0	1	3	7	17	28	4.43
1/1/2024 - 1/31/2024	Discharge instructions if need help	0	1	4	6	18	29	4.41
2/1/2024 - 2/29/2024	Understand disch med instructions	1	0	3	5	16	25	4.40
2/1/2024 - 2/29/2024	Info re care after discharge	0	0	3	4	17	24	4.58
2/1/2024 - 2/29/2024	Discharge instructions if need help	0	0	3	5	16	24	4.54

Table 8: Pre- and Post-Implementation Survey Score Means

Questions	Pre-Intervention	Post-Intervention
Understand disch med instructions	4.61	4.5
Info re care after discharge	4.56	4.52
Discharge instructions if need help	4.52	4.44

Table 9: Monthly Survey Score Means

Question/Score Means	Aug-23	Sep-23	Oct-23	Dec-23	Jan-24	Feb-24
Understand disch med instructions	4.42	4.77	4.65	4.55	4.54	4.40
Info re care after discharge	4.47	4.69	4.53	4.55	4.43	4.58
Discharge instructions if need help	4.42	4.66	4.47	4.36	4.41	4.54

Table 10: Age Distribution Analysis

Month	Mean	Mode	Median	SD
Aug-23	38.31	40.00	36.00	15.44
Sep-23	35.89	27.00	32.00	15.08
Oct-23	47.52	25.00	48.00	19.11
Dec-23	33.81	20.00	29.00	16.79
Jan-24	38.39	18.00	35.50	15.91
Feb-24	36.61	18.00	30.00	16.13

Table 11: Demographics Characteristics of Pre- and Post–SMART Protocol: Sex

Sex/Month	Aug-23	Sep-23	Oct-23	Dec-23	Jan-24	Feb-24	Total
Female	24	19	16	13	15	14	101
Male	14	16	17	9	13	9	78
Total	38	35	33	22	28	23	179
Female (%)	63.16%	54.29%	48.48%	59.09%	53.57%	60.87%	56.42%
Male (%)	36.84%	45.71%	51.52%	40.91%	46.43%	39.13%	43.58%

Table 12: Demographics Characteristics of Pre- and Post–SMART Protocol: Race

Race/Month	Aug-23	Sep-23	Oct-23	Dec-23	Jan-24	Feb-24	Total
African American	10	6	4	2	7	5	34
White/Caucasian	21	15	20	13	19	16	104
Hispanic/Latino	4	2	2	0	0	1	9
Other	0	1	1	4	0	1	7
Total	35	24	27	19	26	23	154
African American (%)	28.57%	25.00%	14.81%	10.53%	26.92%	21.74%	22.08%
White/Caucasian (%)	60.00%	62.50%	74.07%	68.42%	73.08%	69.57%	67.53%
Hispanic/Latino (%)	11.43%	8.33%	7.41%	0.00%	0.00%	4.35%	5.84%
Other (%)	0.00%	4.17%	3.70%	21.05%	0.00%	4.35%	4.55%

Table 13: Previous Year Top Box Scores

Questions	Top Box (08/22)	n	Top Box (09/22)	n	Top Box (10/22)	n	Top Box (12/22)	n	Top Box (01/23)	n	Top Box (02/23)	n
Discharge Overall	75	20	62.96	9	80	9	76.92	13	65.52	10	43.33	20
Understand Medication instructions at discharge	75	20	55.56	9	66.67	9	76.92	13	70	10	40	20
Information about care after discharge	75	20	66.67	9	87.5	8	76.92	13	60	10	40	20
Instructions on what to do if need help after discharge	75	20	66.67	9	87.5	8	76.92	13	66.67	9	43.33	20

Table 14: Previous Year Monthly Survey Frequency Distribution Response Table

Discharge Date	Questions	Very Poor n	Poor n	Fair n	Good n	Very Good n	Total n	Average
8/1/ - 8/31/2022	Understand disch med instructions	1	0	1	3	15	20	4.55
8/1/ - 8/31/2022	Info re care after discharge	1	0	1	3	15	20	4.55
8/1/ - 8/31/2022	Discharge instructions if need help	1	0	1	3	15	20	4.55
9/1/ - 9/30/2022	Understand disch med instructions	0	0	1	3	5	9	4.44
9/1/ - 9/30/2022	Info re care after discharge	0	0	2	1	6	9	4.44
9/1/ - 9/30/2022	Discharge instructions if need help	0	0	1	2	6	9	4.56
10/1 - 10/31/2022	Understand disch med instructions	0	0	1	2	6	9	4.33
10/1 - 10/31/2022	Info re care after discharge	0	0	0	1	7	8	4.88
10/1 - 10/31/2022	Discharge instructions if need help	0	0	0	1	7	8	4.88
12/1 - 12/31/2022	Understand disch med instructions	0	2	1	0	10	13	4.38
12/1 - 12/31/2022	Info re care after discharge	0	2	0	1	10	13	4.46
12/1 - 12/31/2022	Discharge instructions if need help	1	1	0	1	10	13	4.38
1/1 - 1/31/2023	Understand disch med instructions	0	0	0	3	7	10	4.7
1/1 - 1/31/2023	Info re care after discharge	0	0	0	4	6	10	4.6
1/1 - 1/31/2023	Discharge instructions if need help	0	0	1	2	6	9	4.33
2/1 - 2/28/2023	Understand disch med instructions	1	0	1	10	8	20	4.2
2/1 - 2/28/2023	Info re care after discharge	0	0	4	8	8	20	4.2
2/1 - 2/28/2023	Discharge instructions if need help	2	0	2	6	10	20	4.1

Table 15 : Previous Year Survey Score Means

Questions	August - October	December -February
Understand disch med instructions	4.44	4.43
Info re care after discharge	4.62	4.42
Discharge instructions if need help	4.66	4.27

Table 16: Previous Year Monthly Survey Means

Questions/Month	Aug-22	Sep-22	Oct-22	Dec-22	Jan-23	Feb-23
Understand disch med instructions	4.55	4.44	4.33	4.38	4.7	4.2
Info re care after discharge	4.55	4.44	4.88	4.46	4.6	4.2
Discharge instructions if need help	4.55	4.56	4.88	4.38	4.33	4.1

Appendix B

Chart 1: SMART Completion Rate Pre-Post SMART Protocol

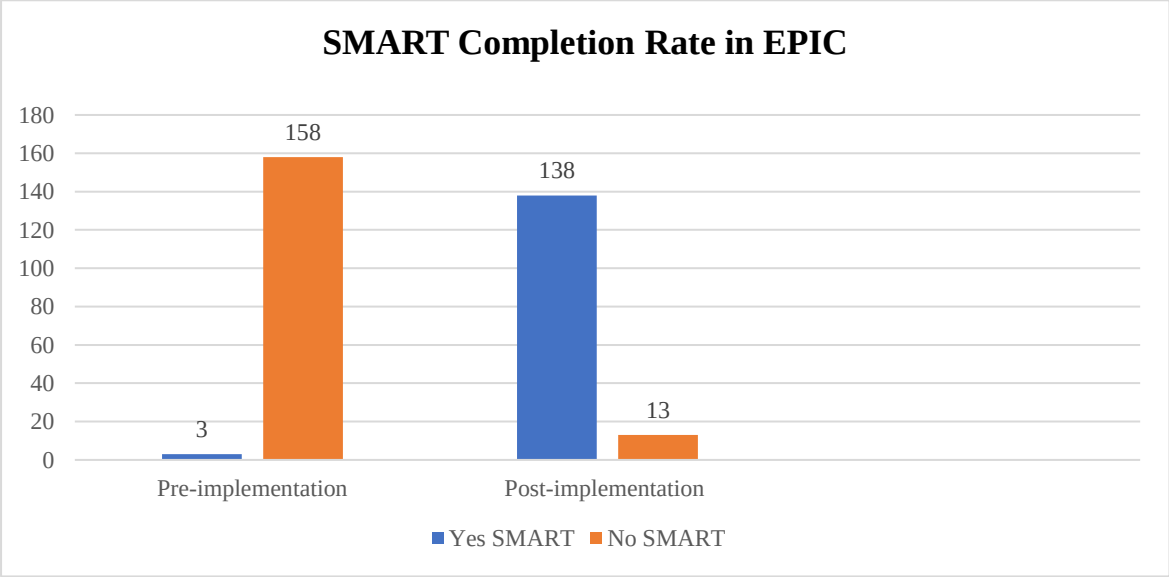


Chart 2: Inpatient Behavioral Health Survey Monthly Top Box Scores

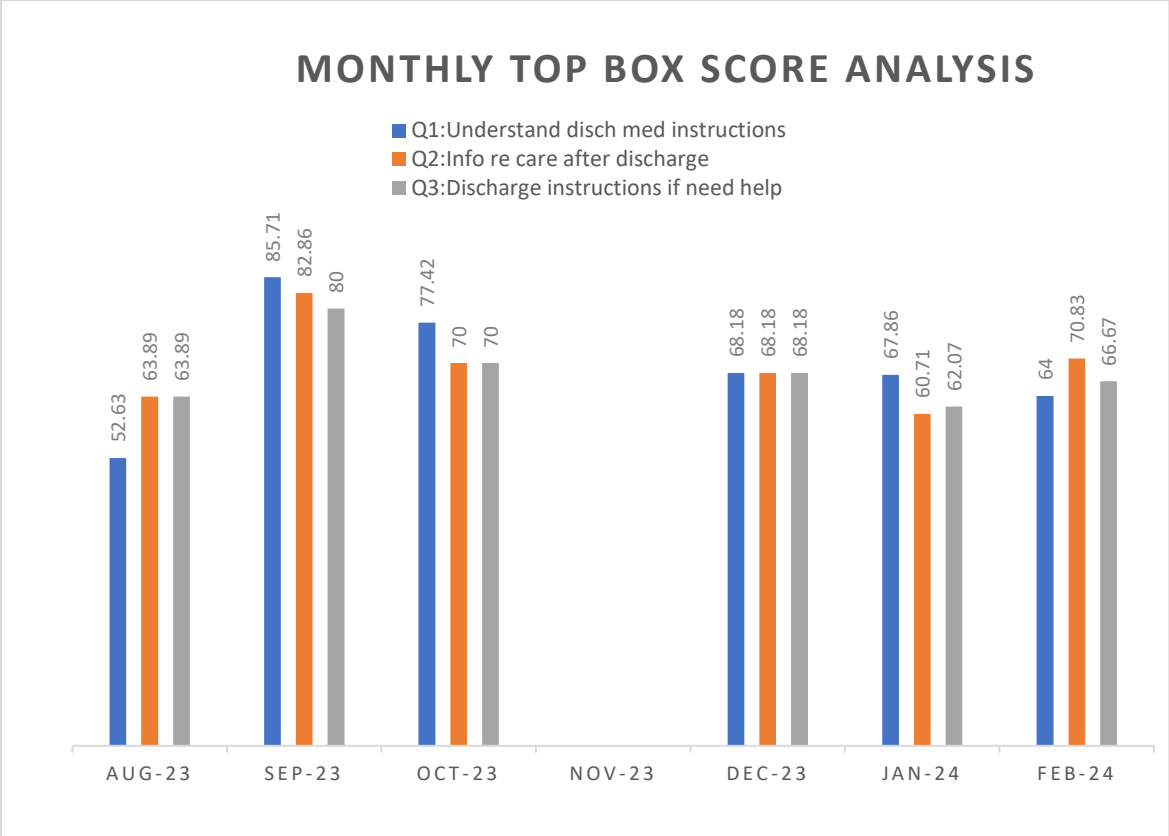


Chart 3: Pre and Post-Implementation Top Box Scores

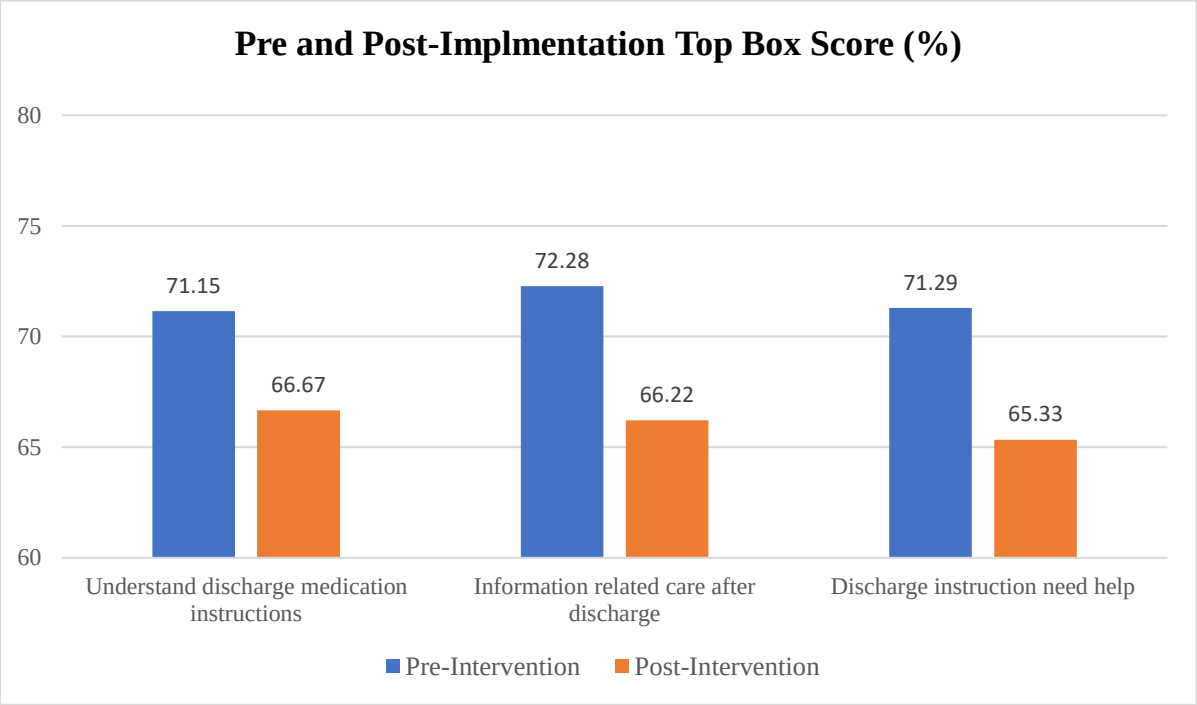


Chart 4: Pre- and Post-Implementation Survey Score Means

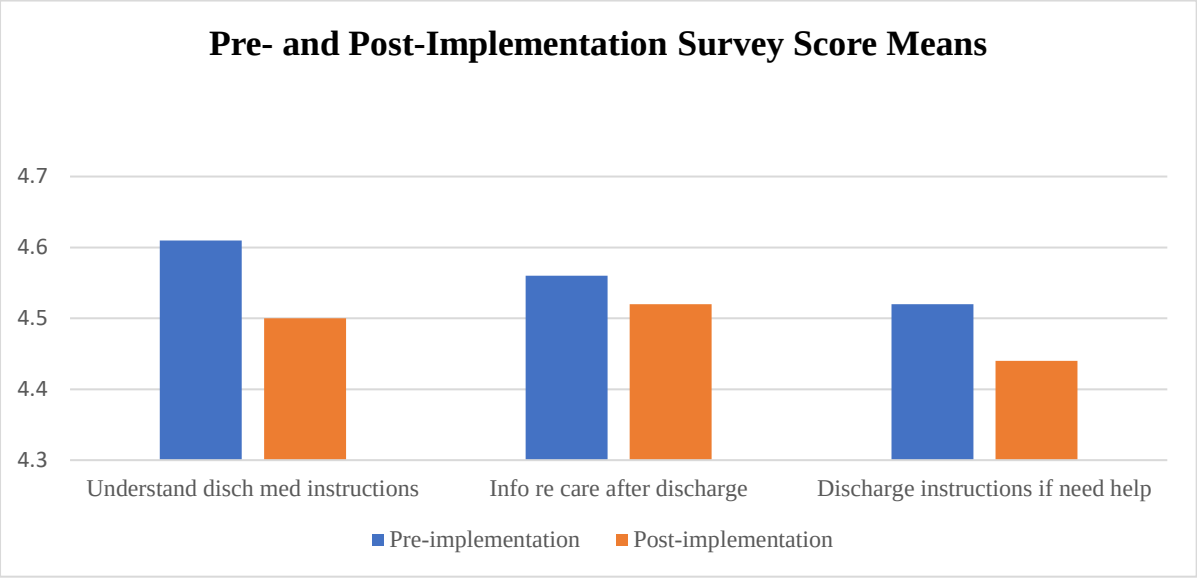


Chart 5: Monthly Survey Score Means

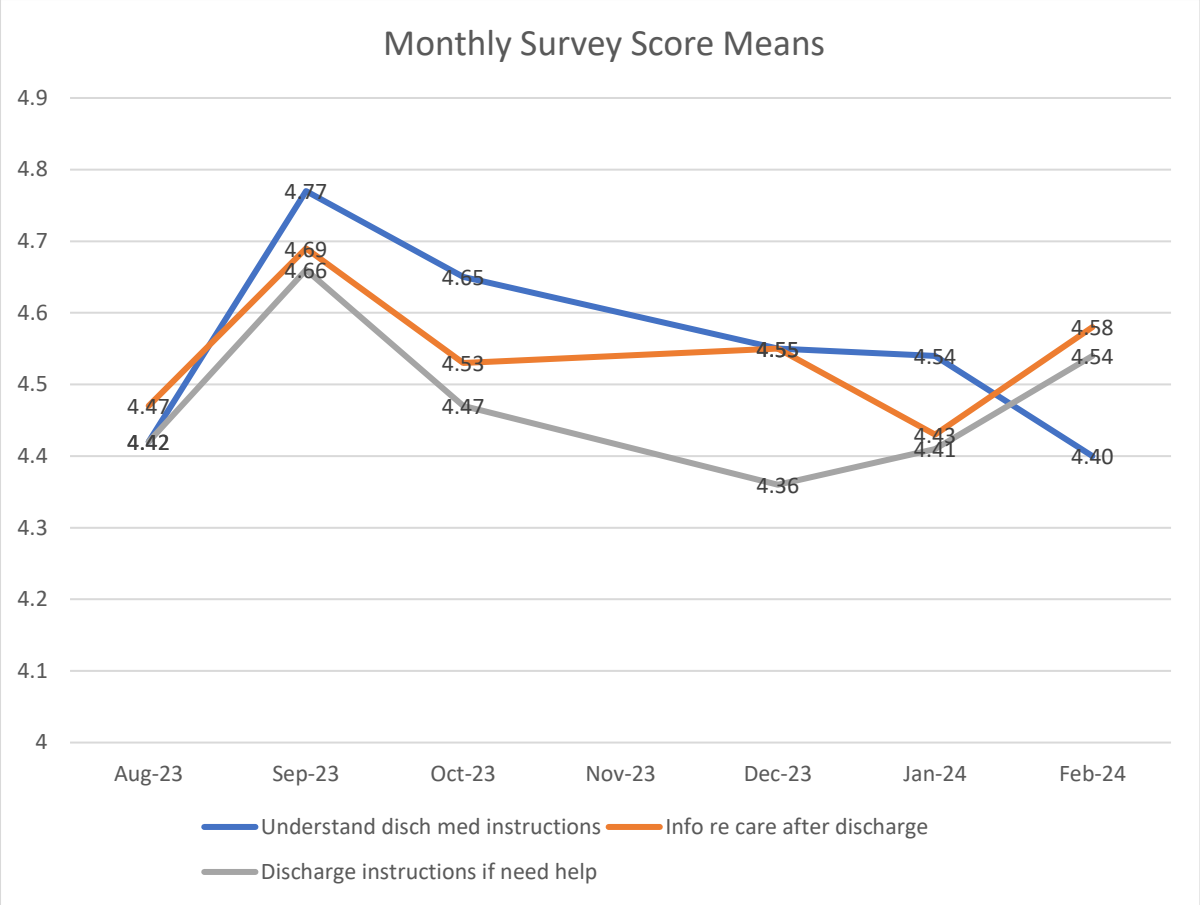


Chart 6: Previous Years Monthly Top Box Scores

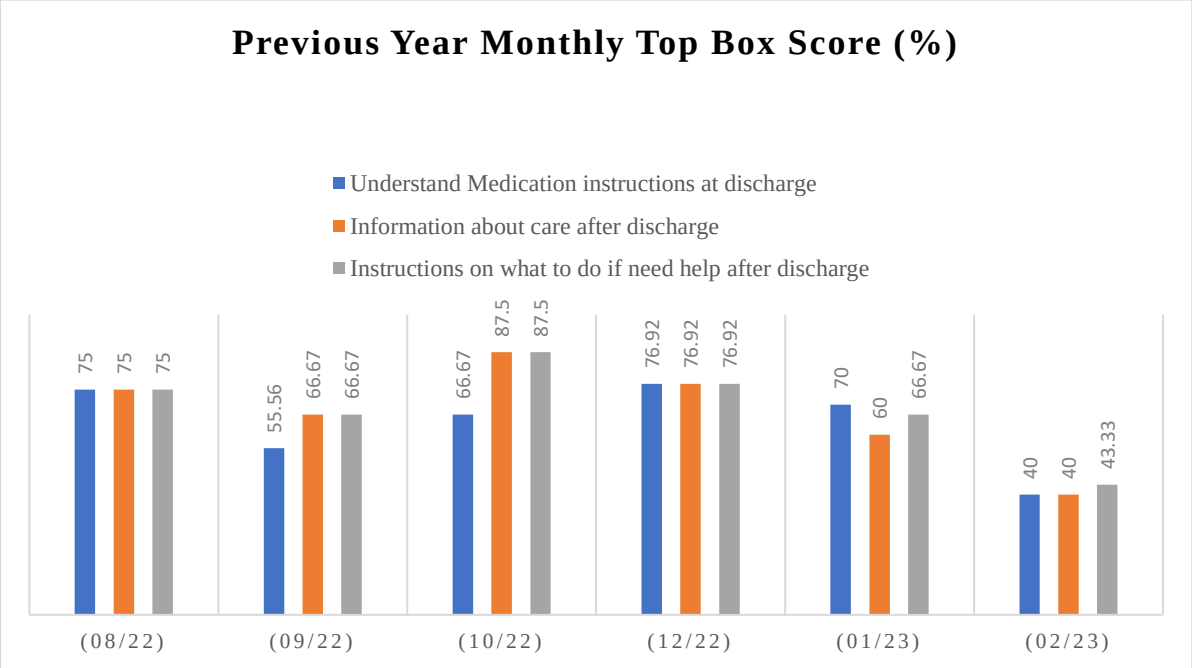


Chart 7: Previous Years Top Box Scores

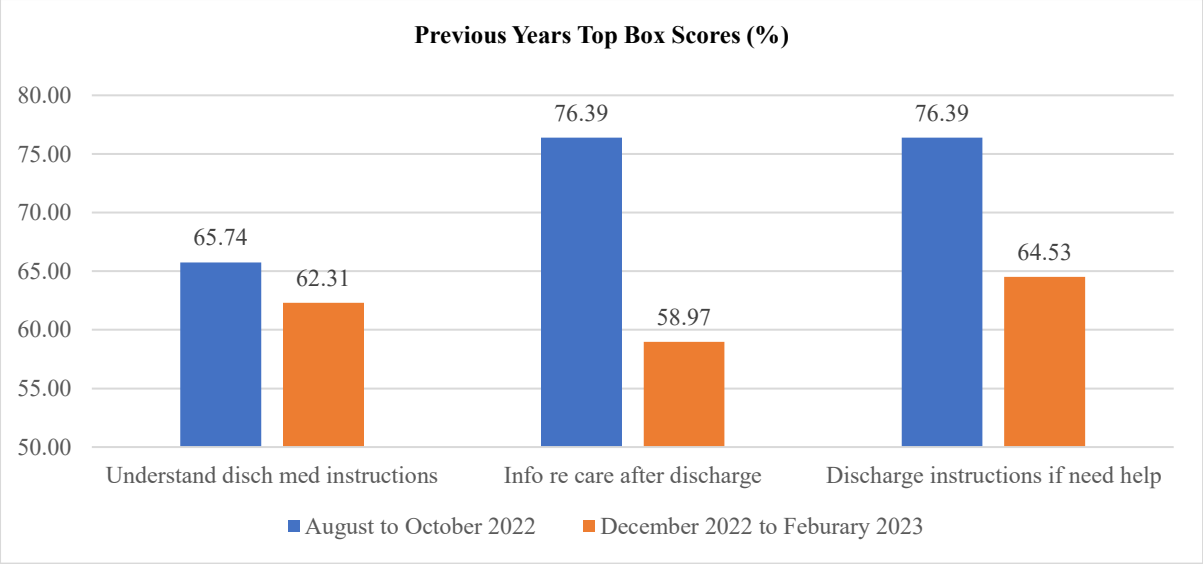


Chart 8: Previous Yea Survey Score Means

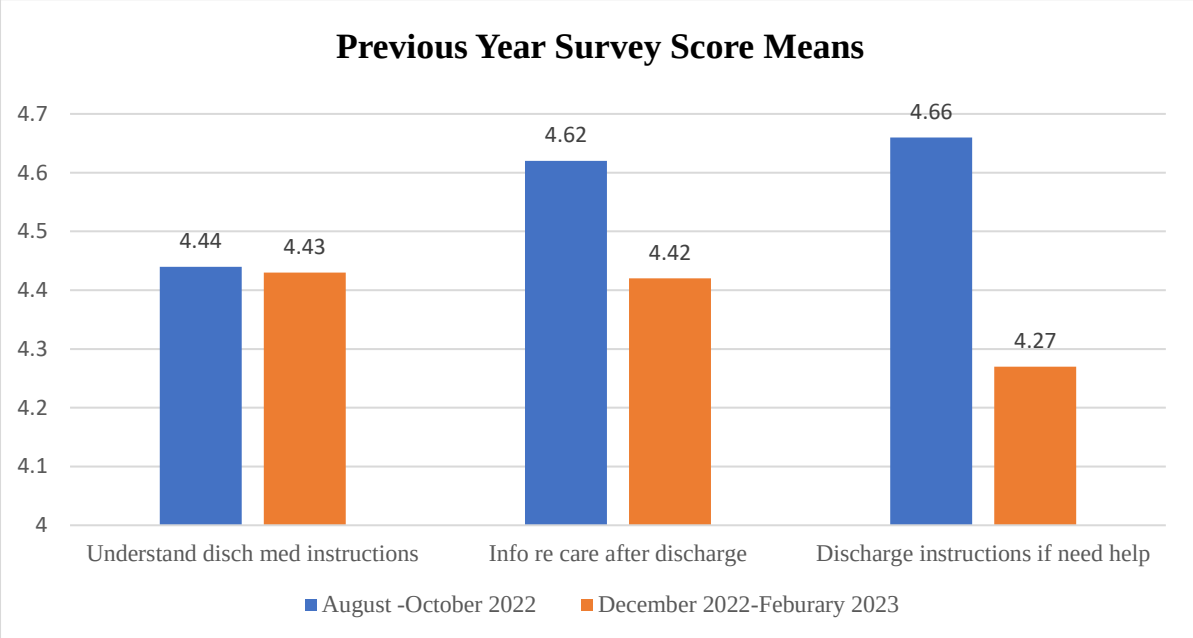


Chart 9: Previous Year Monthly Survey Score Means

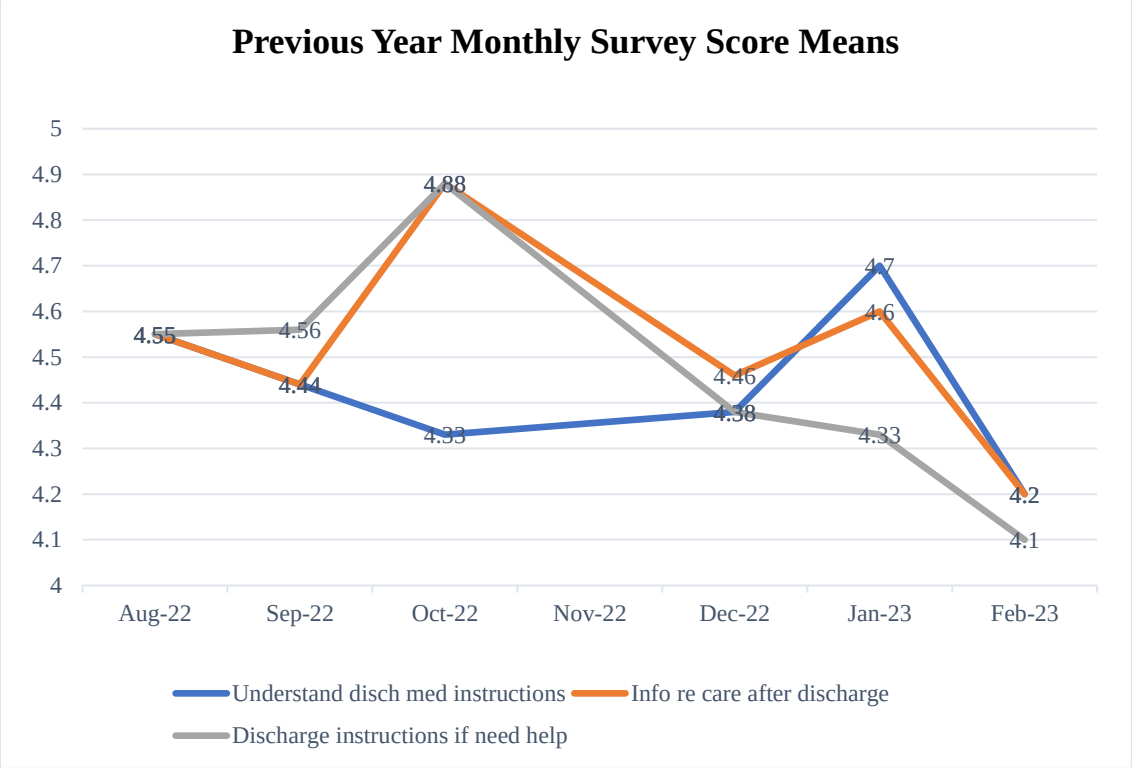


Chart 10: Age Statistical Analysis

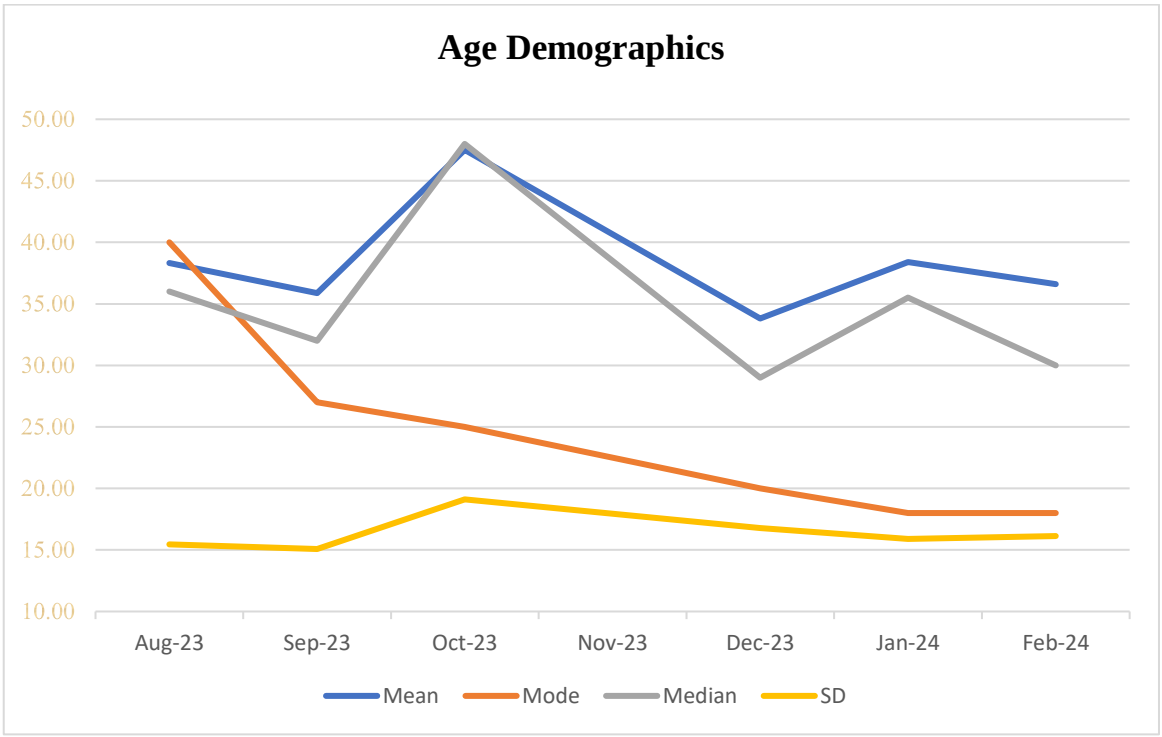


Chart 11: Sex Demographic Distribution

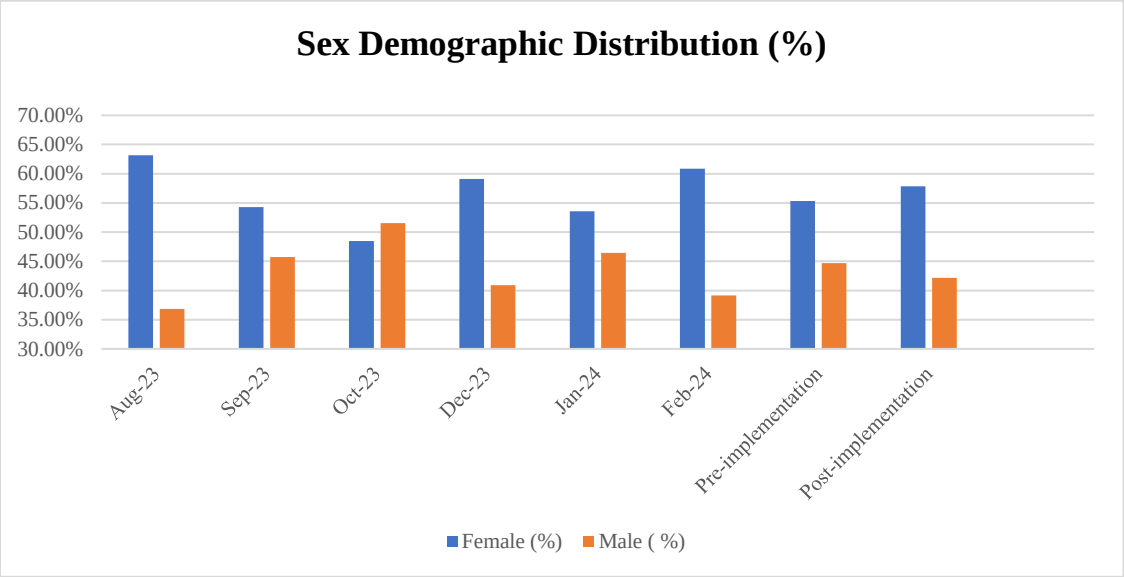


Chart 12: Sex Demographic Distribution

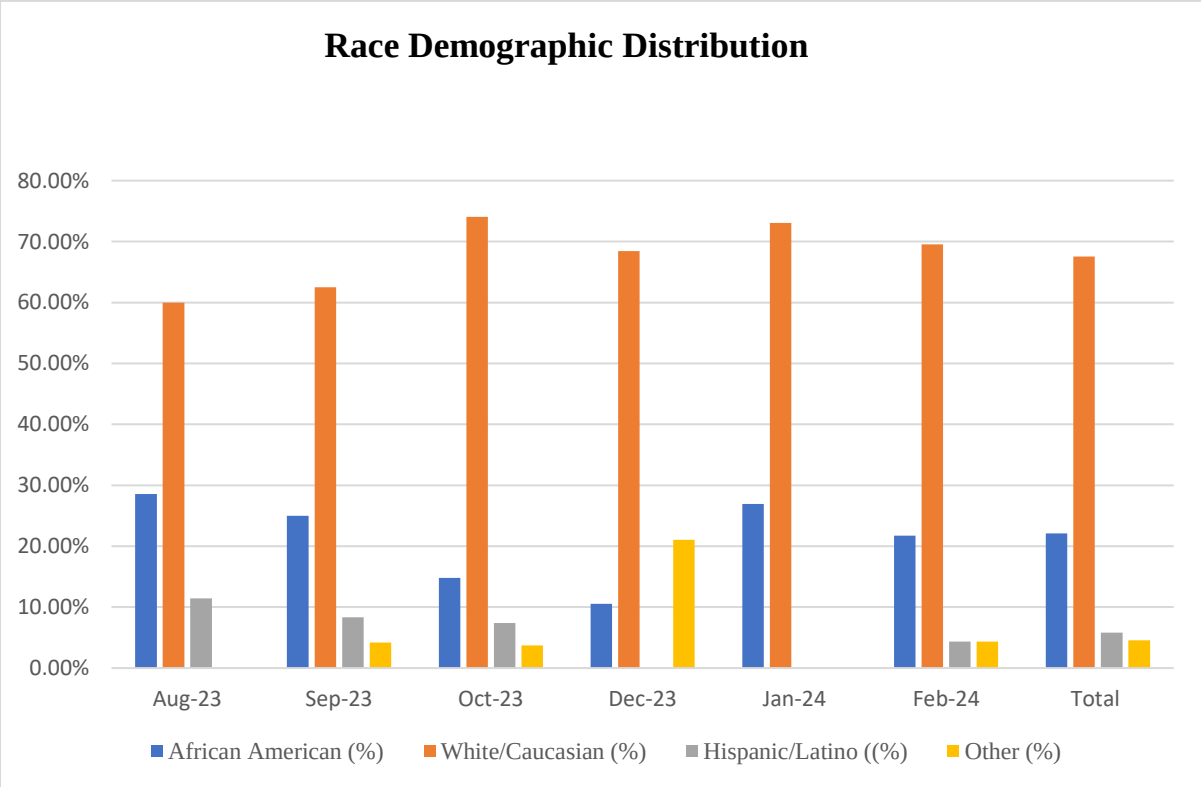


Chart 13: Inpatient Behavioral Health Survey Completion Rate

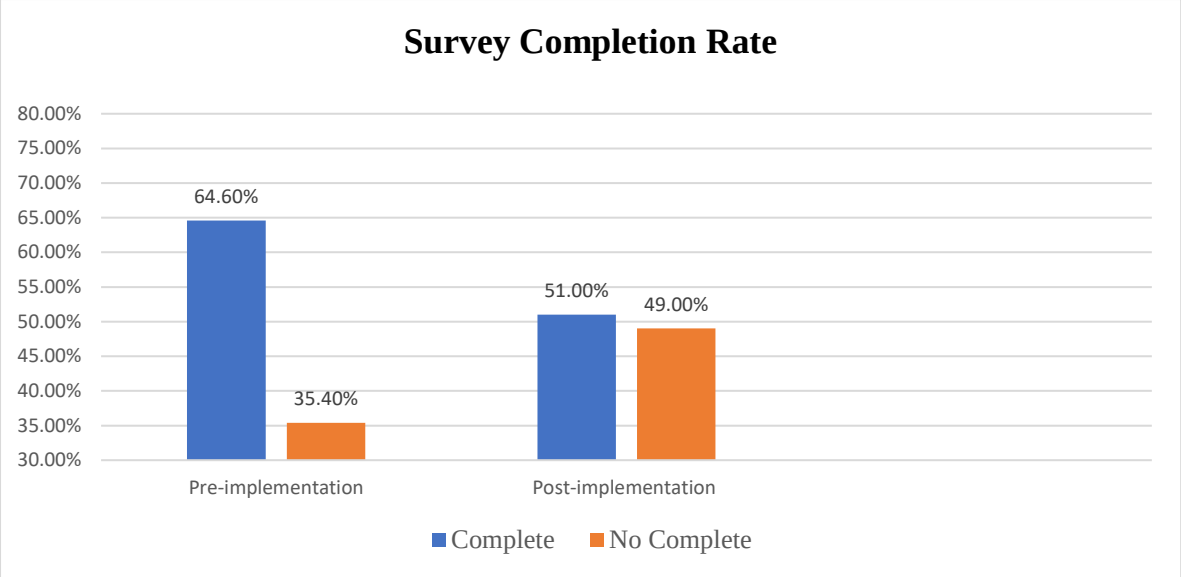


Chart 14: Monthly Involuntary Admission Rate

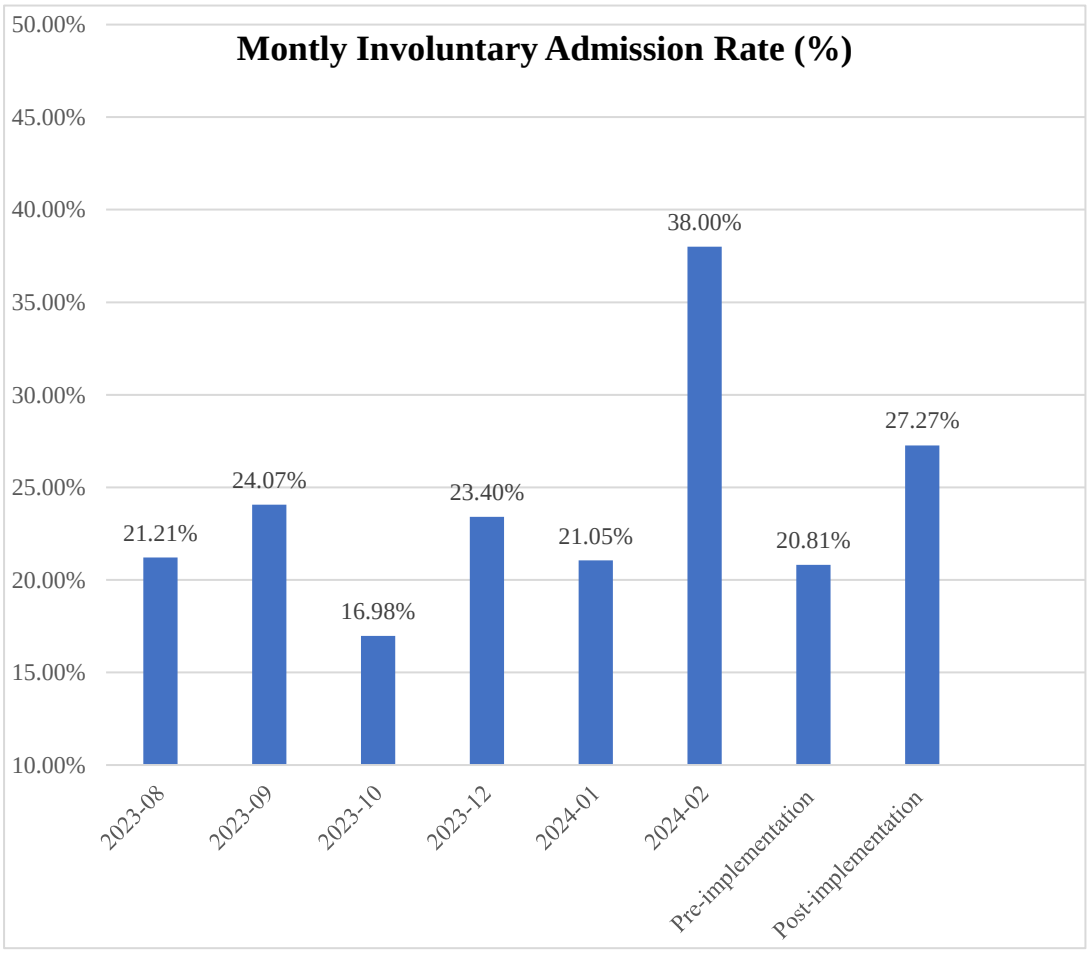
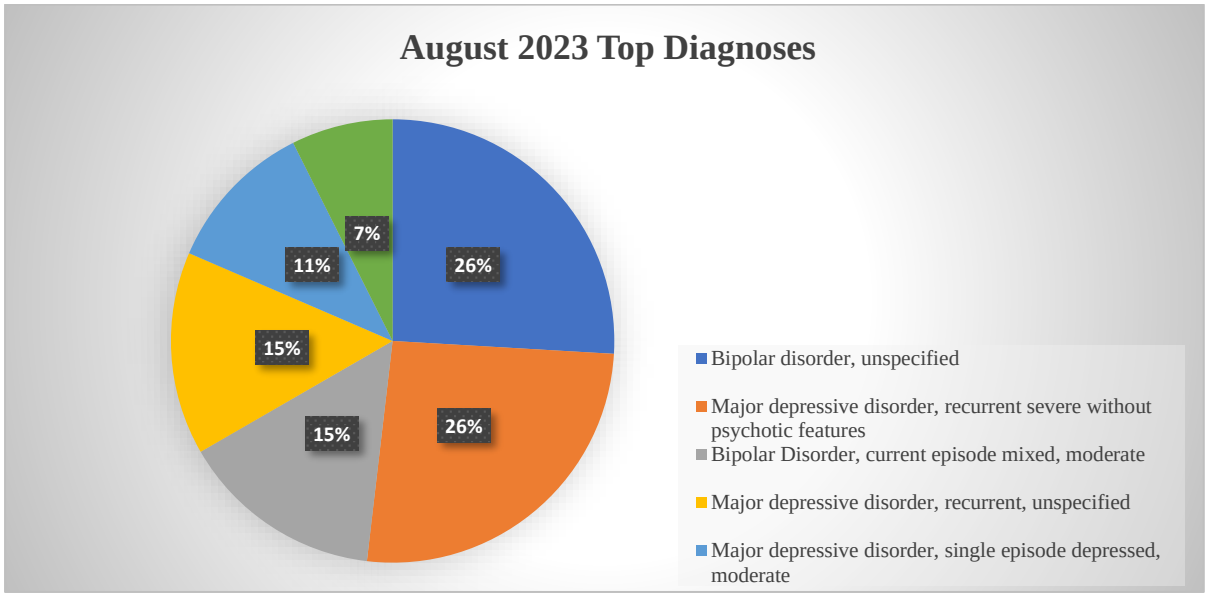
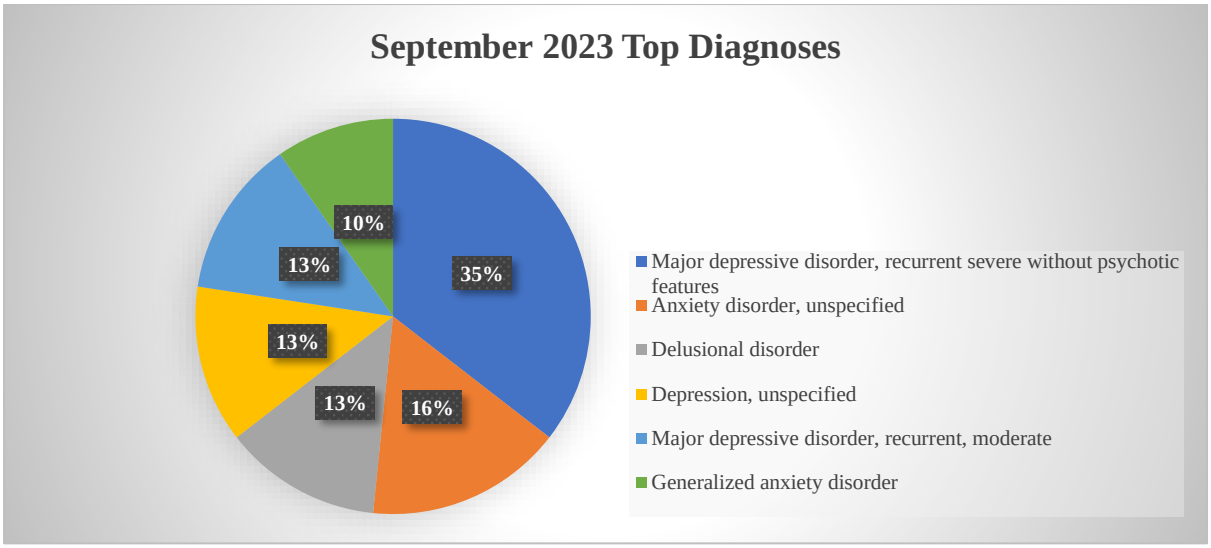
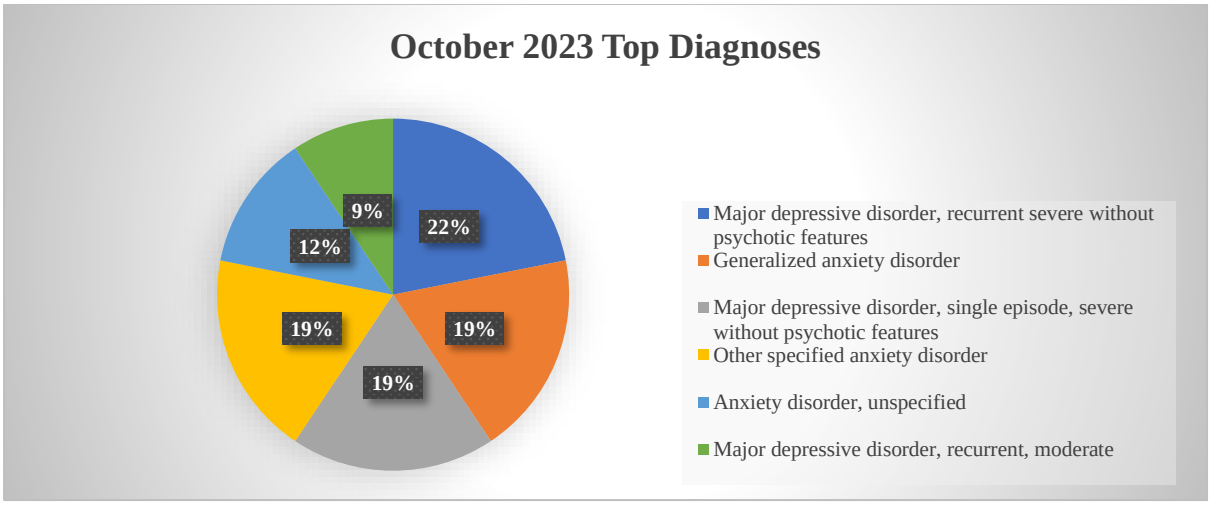


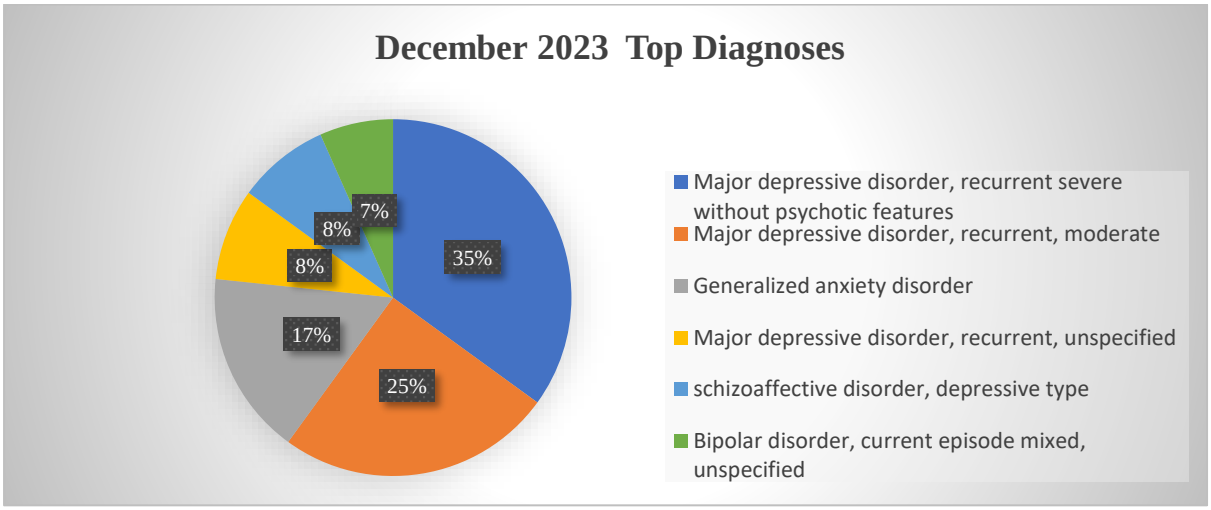
Chart 15: Monthly Length of Stay

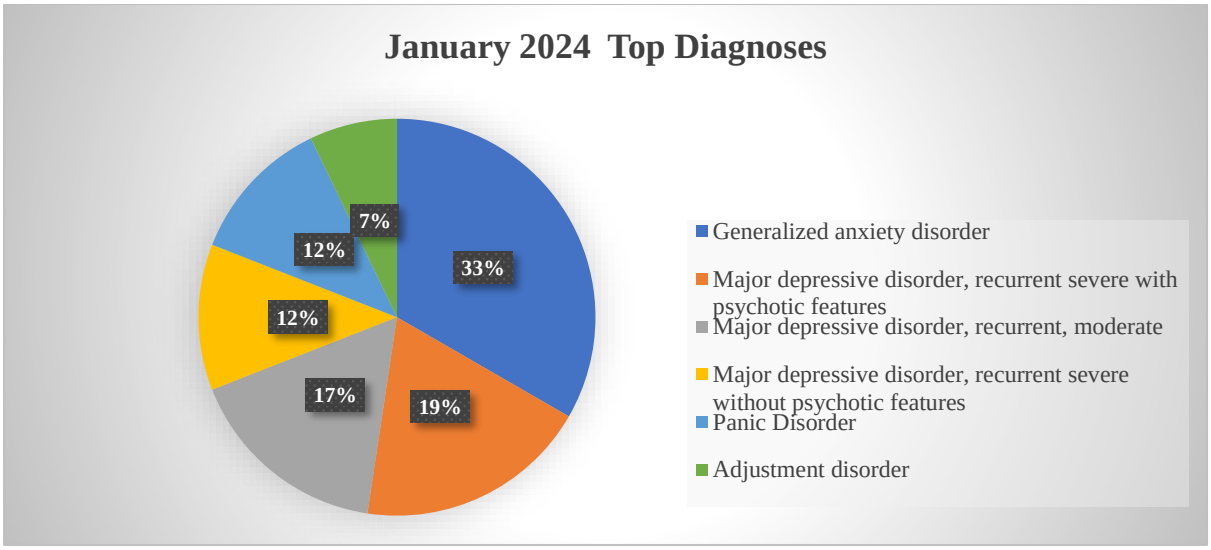
Chart 16: Monthly Top Six Primary Diagnoses




September 2023 Top Diagnoses
35%
16%
13%
13%
13%
10%
Major depressive disorder, recurrent severe without psychotic features
Anxiety disorder, unspecified
Delusional disorder
Depression, unspecified
Major depressive disorder, recurrent, moderate
Generalized anxiety disorder


October 2023 Top Diagnoses
22%
19%
19%
19%
12%
9%
Major depressive disorder, recurrent severe without psychotic features
Generalized anxiety disorder
Major depressive disorder, single episode, severe without psychotic features
Other specified anxiety disorder
Anxiety disorder, unspecified
Major depressive disorder, recurrent, moderate


December 2023 Top Diagnoses
35%
25%
17%
8%
8%
7%
Major depressive disorder, recurrent severe without psychotic features
Major depressive disorder, recurrent, moderate
Generalized anxiety disorder
Major depressive disorder, recurrent, unspecified
schizoaffective disorder, depressive type
Bipolar disorder, current episode mixed, unspecified


January 2024 Top Diagnoses
33%
19%
17%
12%
12%
7%
Generalized anxiety disorder
Major depressive disorder, recurrent severe with psychotic features
Major depressive disorder, recurrent, moderate
Major depressive disorder, recurrent severe without psychotic features
Panic Disorder
Adjustment disorder

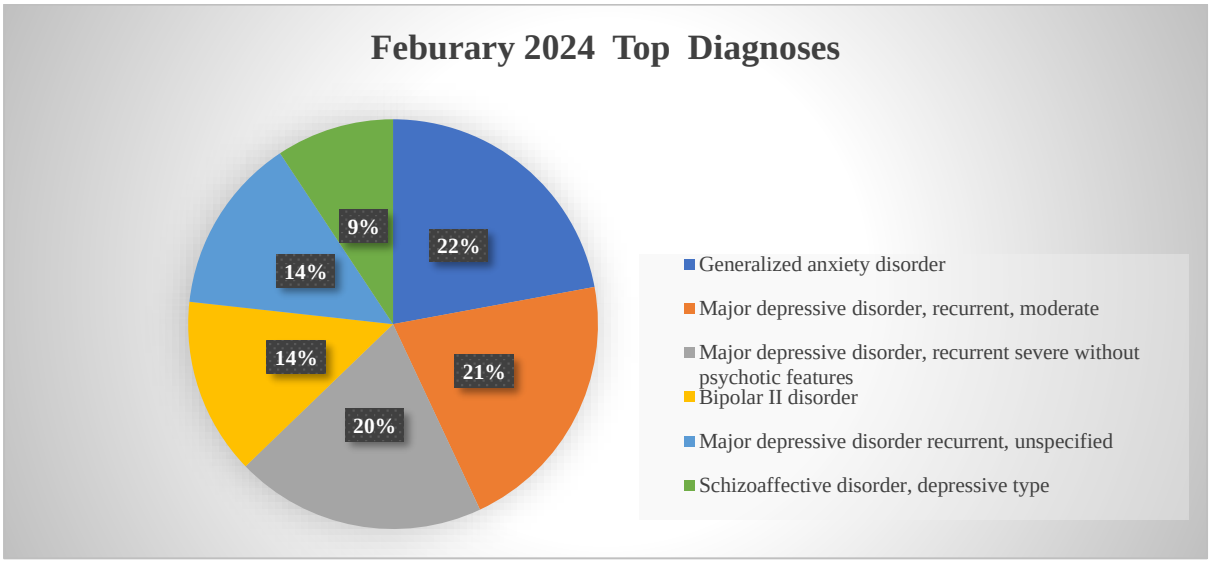

Feburary 2024 Top Diagnoses
22%
21%
20%
14%
14%
9%
Generalized anxiety disorder
Major depressive disorder, recurrent, moderate
Major depressive disorder, recurrent severe without psychotic features
Bipolar II disorder
Major depressive disorder recurrent, unspecified
Schizoaffective disorder, depressive type

Chart 17: Understand Medication Instructions in March 2024

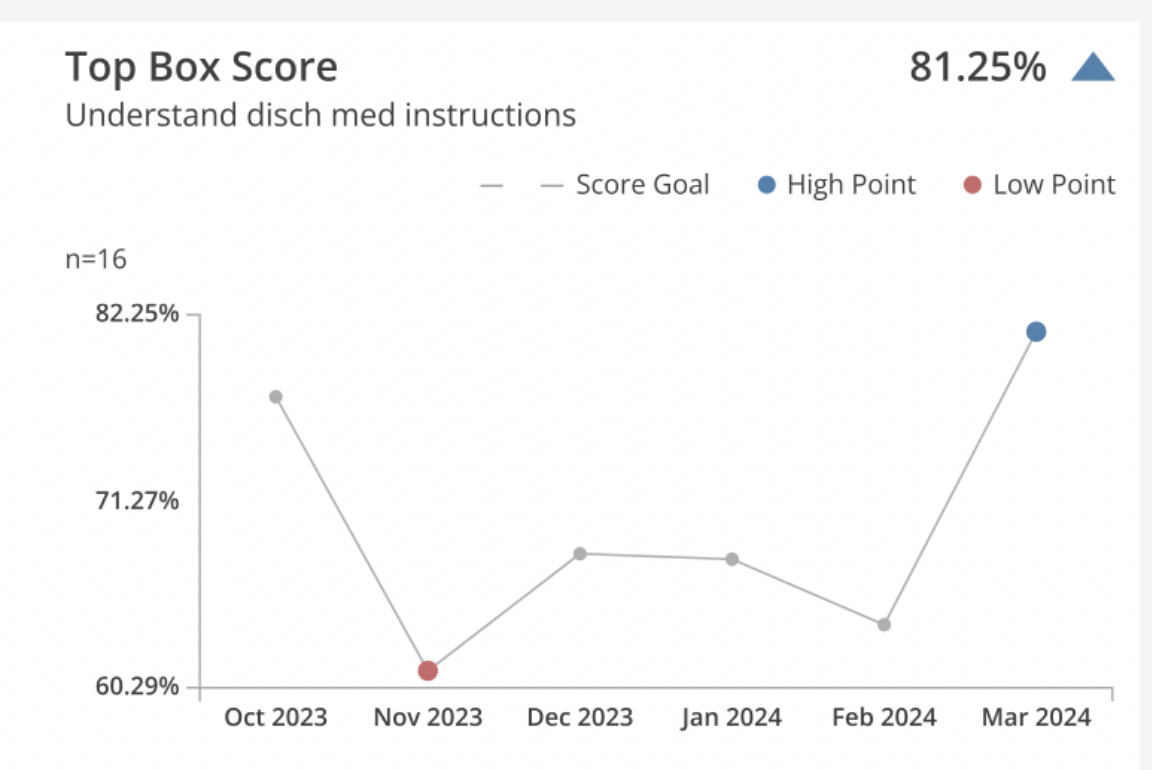
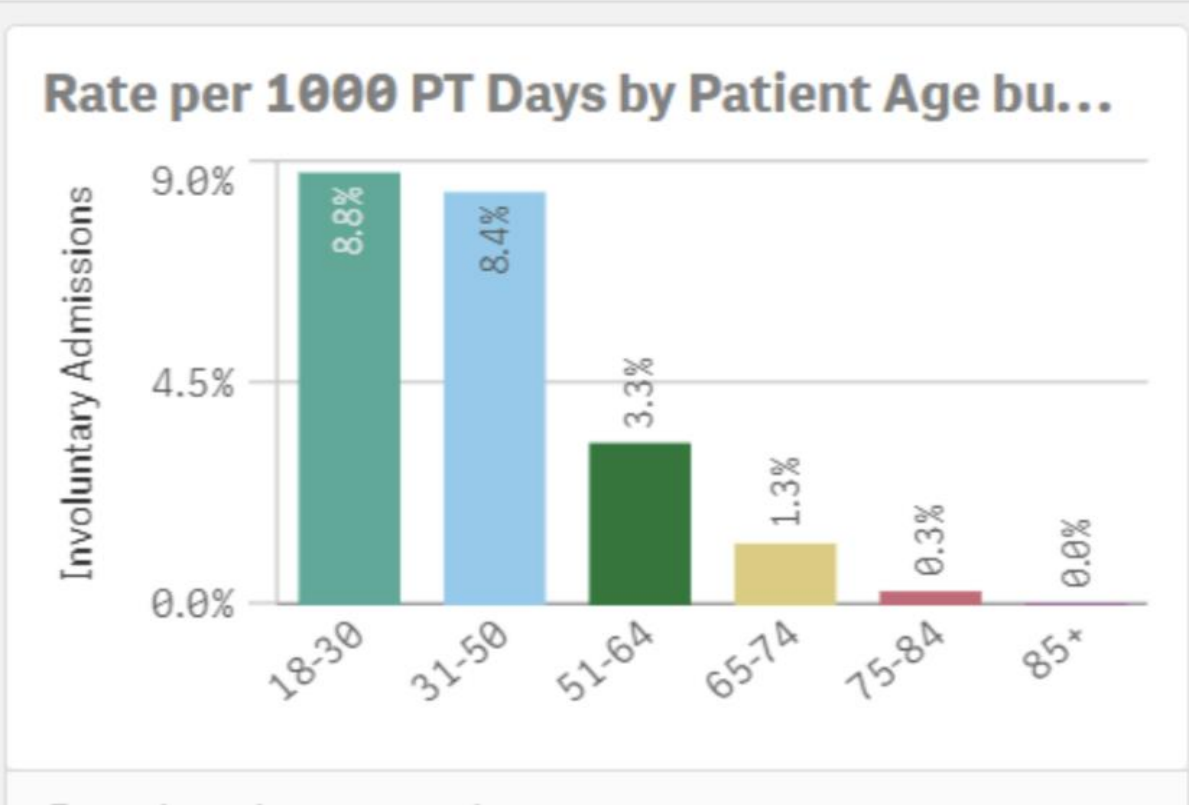


Chart 18: Involuntary Admission by Age Bucket



Appendix C

SWOT Analysis Figure

Internal Origin {Attributes of the organization}	Helpful To achieving the objective	Harmful To achieving the objective
	Strengths • Staff are highly motivated and committed to making a positive impact in the mental health community • Strong leadership team with an excellent leadership style • A positive and productive work environment with a share governing culture • Competitive salaries and comprehensive benefits • Strong teamwork and collaboration • Brand-new building designed to prioritize safety and aesthetics • Strong support from the security team	**Weaknesses** • Inconsistent allocation of resources exists between day and night shifts, as well as among weekday and weekend staff • Limited support for staff during night shifts and weekends: absence of regular medical and psychiatric providers, social workers, pharmacists, and leadership on-site during after-hours and weekends. • Being distant from the main campus leads to a disconnect from its resources, such as the flow nurse, especially when facing short staff. • Small unit with limited staff backup • Absence of standardized discharge planning

External Origin {Attributes of the organization}	Helpful To achieving the objective	Harmful To achieving the objective
	Opportunities • The Comprehensive access to resources due to affiliation with the third largest teaching hospital • Unit initiatives that offer growth opportunities and potential for policy development • Plans to hire additional positions, including filling nurse vacancies and adding more CBT nurses for backup, to bolster staff support and ensure resource adequacy • Leadership and staff are committed to advocating for high-quality patient care and preparing for Joint Commission accreditation • The need for a standardized discharge protocol to facilitate successful patient transitions and enhance patient satisfaction	**Threats** • Uncertainty regarding the patient's acuity combined with staffing shortages • Limited availability of support and resources during weekends and after hours may curtail patient education time and impede the implementation process • Providers dismiss nurses' concerns about patient acuity, staff shortage and admission volumes due to the necessity to maintain census • Uncertainty about staff cooperation and their readiness to support the project's implementation • The uninsured population in the community presents a financial burden and an unpredictable variable impacting project implementation

Appendix D

Press Ganey's Inpatient Behavioral Health (PGIBH) Survey

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS

1. Date of admission:
   ☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)
2. Date of discharge:
   ☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)
3. Admitted through an Emergency Department ..... ○ Yes ○ No
4. Referred by your physician ..... ○ Yes ○ No
5. Did someone give you information about the Patients Bill of Rights? ..... ○ Yes ○ No
6. Patient's sex ..... ○ Male ○ Female
7. Patient's age ..... ☐☐☐
8. Who is completing this survey? **(select one only)**
   - ○ Patient
   - ○ Friend
   - ○ Legal Guardian
   - ○ Spouse
   - ○ Family Member
   - ○ Other _____ (specify)
9. Reason for choosing this hospital
   - ○ Psychiatrist Recommended
   - ○ Physician Recommended
   - ○ Insurance Required
   - ○ Friend Recommended
   - ○ Internet Search
   - ○ Hospital Reputation

INSTRUCTIONS: Please rate the services you received from our facility. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely. Example: ●

ADMISSION

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Courtesy of staff during admission	○	○	○	○	○

Comments (describe good or bad experience):_____

YOUR CARE

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Staff's concern for your privacy	○	○	○	○	○

YOUR CARE (...continued)	very poor 1	poor 2	fair 3	good 4	very good 5
2. How well the staff showed concern for your emotional needs	○	○	○	○	○
3. Your feeling of safety on the unit	○	○	○	○	○
4. Staff's efforts to include you in decisions about your care	○	○	○	○	○

Comments (describe good or bad experience):_____

ROOM	very poor 1	poor 2	fair 3	good 4	very good 5
1. Daily cleaning of your room	○	○	○	○	○
2. Courtesy of the person who cleaned your room	○	○	○	○	○

Comments (describe good or bad experience):_____

NURSES	very poor 1	poor 2	fair 3	good 4	very good 5
1. Courtesy and respect of the nurses	○	○	○	○	○
2. Helpfulness of the nurses	○	○	○	○	○
3. Nurses' promptness in responding to your requests	○	○	○	○	○

Comments (describe good or bad experience):_____

CARE PROVIDERS	very poor 1	poor 2	fair 3	good 4	very good 5
YOUR CARE PROVIDERS ARE THE PEOPLE WHO ADDRESSED YOUR MEDICAL NEEDS INCLUDING ANY PRESCRIPTIONS FOR MEDICATIONS. YOUR CARE PROVIDERS MAY HAVE BEEN PSYCHIATRISTS, MEDICAL DOCTORS, PHYSICIAN ASSISTANTS (PAs), OR NURSE PRACTITIONERS (NPs). PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THESE HEALTH CARE PROVIDERS IN MIND.					
1. Courtesy and respect of the care providers	○	○	○	○	○
2. Helpfulness of time spent with the care providers	○	○	○	○	○
3. Information provided by the care providers about your condition	○	○	○	○	○

Comments (describe good or bad experience):_____

OTHER MEMBERS OF THE TREATMENT TEAM	very poor 1	poor 2	fair 3	good 4	very good 5
1. Courtesy and respect of the counselor/case manager/social worker	○	○	○	○	○
2. Helpfulness of time spent with counselor/case manager/social worker	○	○	○	○	○

OTHER MEMBERS OF THE TREATMENT TEAM (...continued)	very poor 1	poor 2	fair 3	good 4	very good 5
3. Courtesy and respect of technicians/treatment assistants	○	○	○	○	○

Comments (describe good or bad experience):_____

_____

_____

PROGRAM ACTIVITIES	very poor 1	poor 2	fair 3	good 4	very good 5
1. Helpfulness of group sessions	○	○	○	○	○
2. Helpfulness of social/recreational activities	○	○	○	○	○

Comments (describe good or bad experience):_____

_____

_____

MEALS	very poor 1	poor 2	fair 3	good 4	very good 5
1. Quality of the food	○	○	○	○	○
2. Quantity of the food	○	○	○	○	○

Comments (describe good or bad experience):_____

_____

_____

DISCHARGE	very poor 1	poor 2	fair 3	good 4	very good 5
1. Understanding of your medication instructions at discharge	○	○	○	○	○
2. Information provided about your care after discharge	○	○	○	○	○
3. Instructions on what to do if you need help after discharge (when to seek help, whom to call, etc.)	○	○	○	○	○

Comments (describe good or bad experience):_____

_____

_____

OVERALL ASSESSMENT	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the staff worked together to care for you	○	○	○	○	○
2. Overall rating of care given at this facility	○	○	○	○	○
3. Likelihood of your recommending this facility to others	○	○	○	○	○

Comments (describe good or bad experience):_____

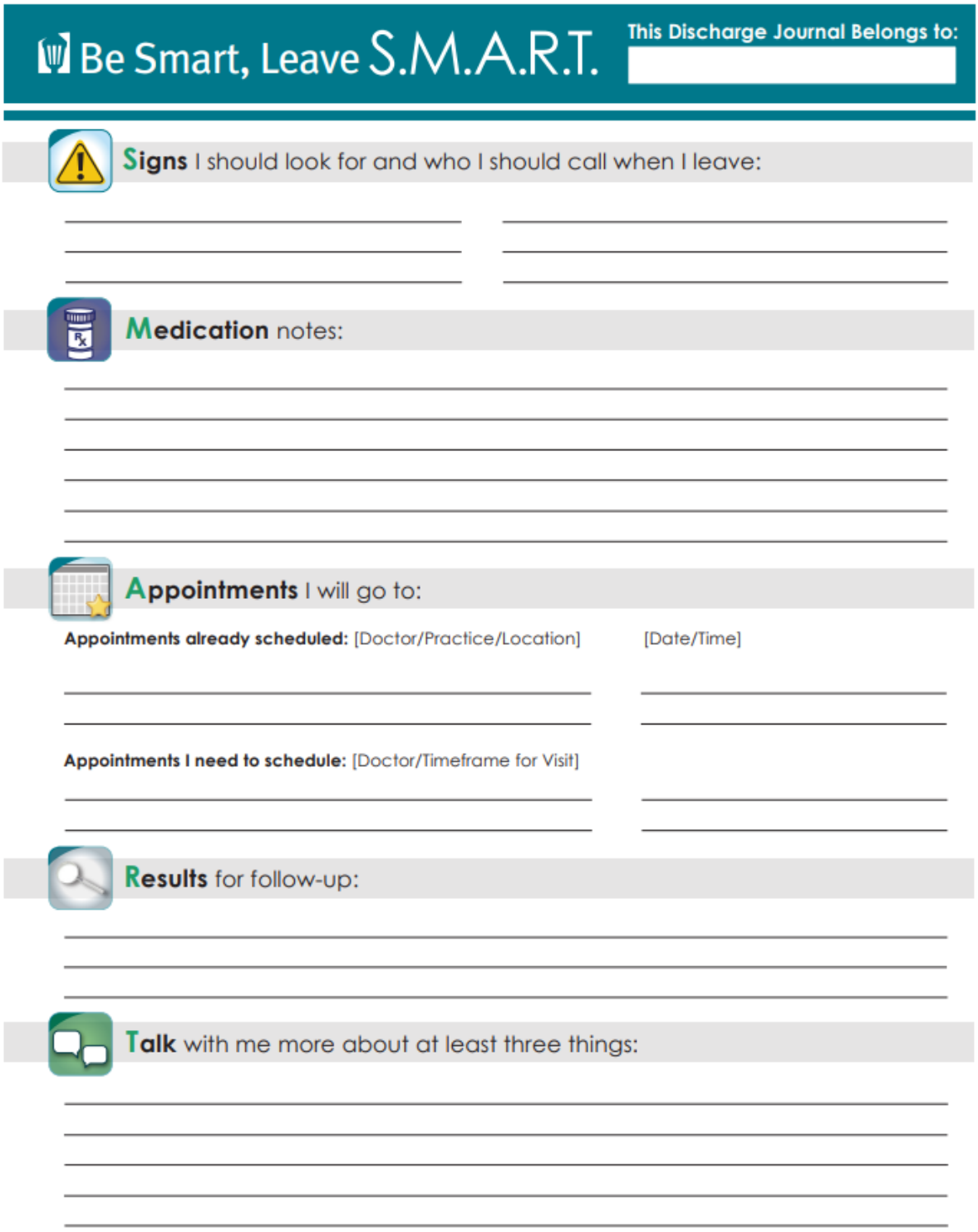
_____

_____

Patient's Name: (optional)_____

Appendix E

AAMC SMART Discharge Journal Worksheet



Be Smart, Leave S.M.A.R.T.

This Discharge Journal Belongs to:

Signs I should look for and who I should call when I leave:

Medication notes:

Appointments I will go to:

Appointments already scheduled: [Doctor/Practice/Location] [Date/Time]

Appointments I need to schedule: [Doctor/Timeframe for Visit]

Results for follow-up:

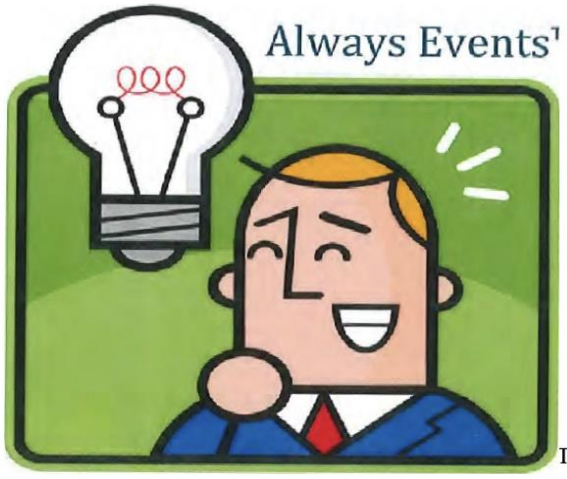
Talk with me more about at least three things:

Appendix F

SAMRT Discharge Protocol Self-Learning Packet

SMART Discharge Protocol

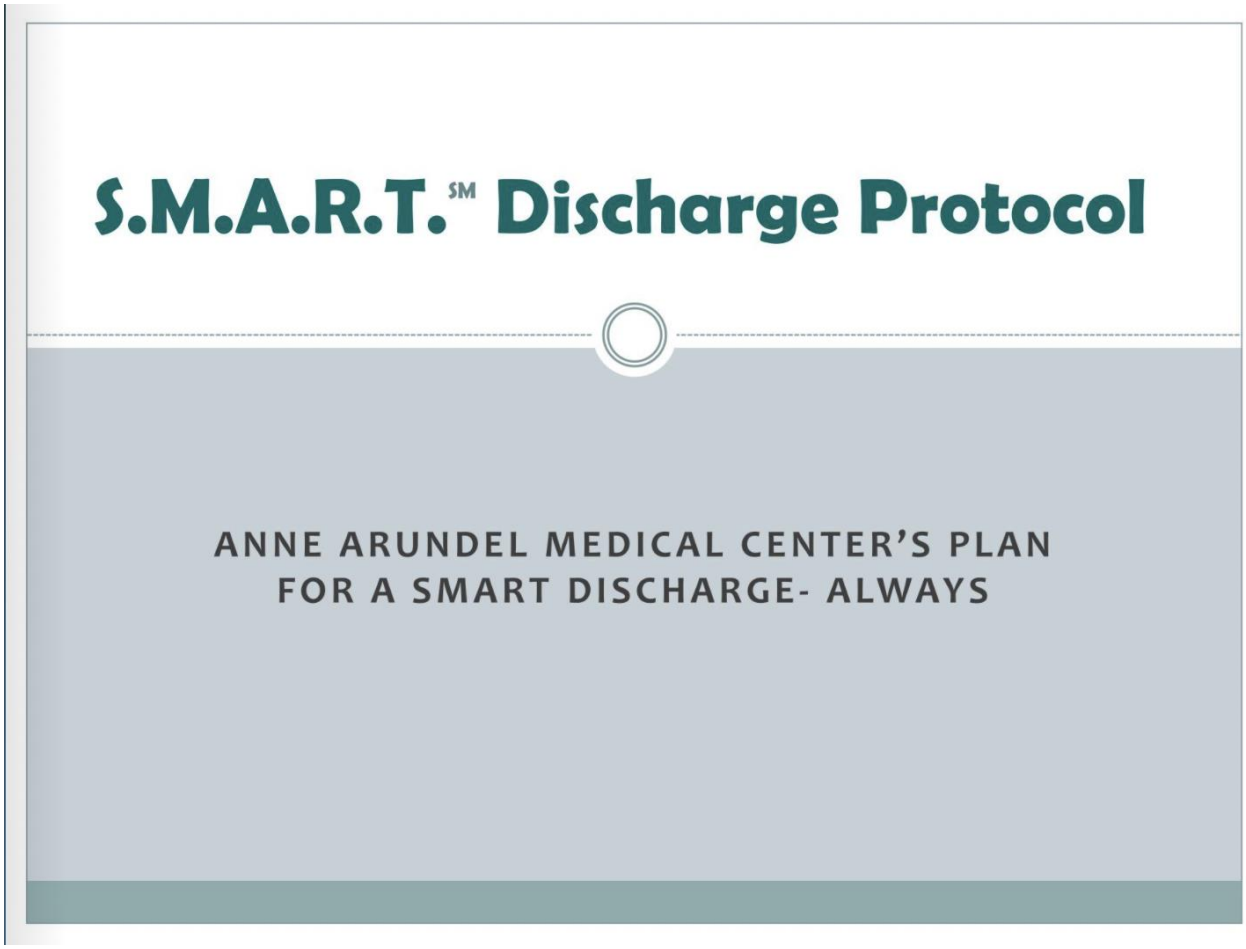
Self-Learning Packet



Name: _____

Appendix G

SAMRT Discharge Protocol PowerPoint



Appendix H

SMART Discharge Protocol FAQs

S.M.A.R.T. FAQs

1. **Who fills out the "Be Smart, Leave SMART" worksheet?**
   Primarily, patients and families. However, nurses, doctors, case managers and other care team providers are welcome to use this tool as well. It is simply a communication tool that can be used as a "memory" jogger or "notes to myself" for patients and their families.

2. **Who is responsible for talking with the patient about Signs, Medications, Appointments, Results, and Talk?**
   ALL care team providers should be discussing these issues with the patient throughout their hospital stay.

3. **When is the SMART worksheet filled out and discussed?**
   This worksheet is given upon admission, used and discussed daily throughout the hospital stay and then reviewed again immediately prior to discharge.

4. **What if the patient or family is unwilling/unable to fill out the worksheet?**
   The premise of patient –and family-centered care is to give patients and families helpful tools to enhance their experience of care. If the patient or family does NOT want to use the tool or does not find it helpful, a nurse can offer to write things down, but leave open the possibility of the patient declining this help.

5. **What if the patient or family uses up all of the space? Where can I find a new one?**
   Patients and Families can have as many of these worksheets as they want/need. Extras can be found in a folder in each alcove.

6. **What if the patient or family doesn't speak English?**
   If SMART discharge protocol is adopted housewide, a Spanish version will be created. Until that time, patients and families can still receive the SMART worksheet to use with the MARTI translation system or an interpreter.

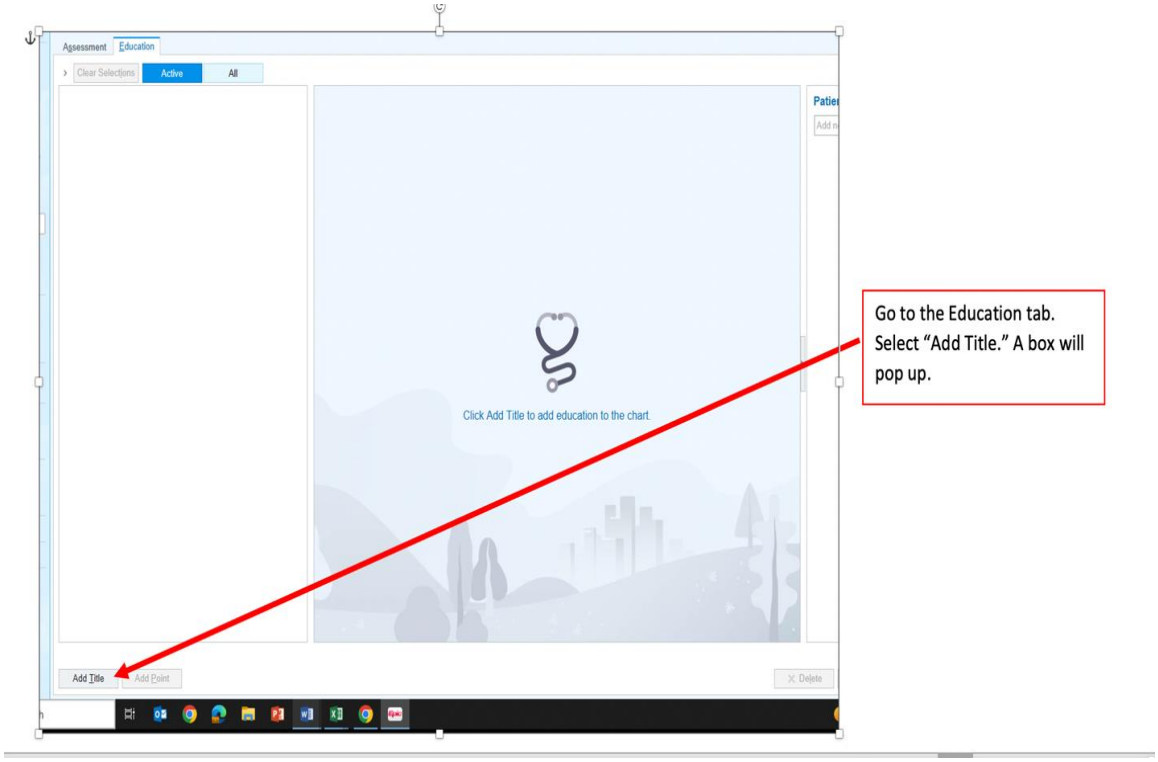
7. **Do I have to ask the patient if I can have the carbon copy for data collection purposes upon discharge?**
   Yes. Explain why you want this information, but the patient does have the right to refuse.

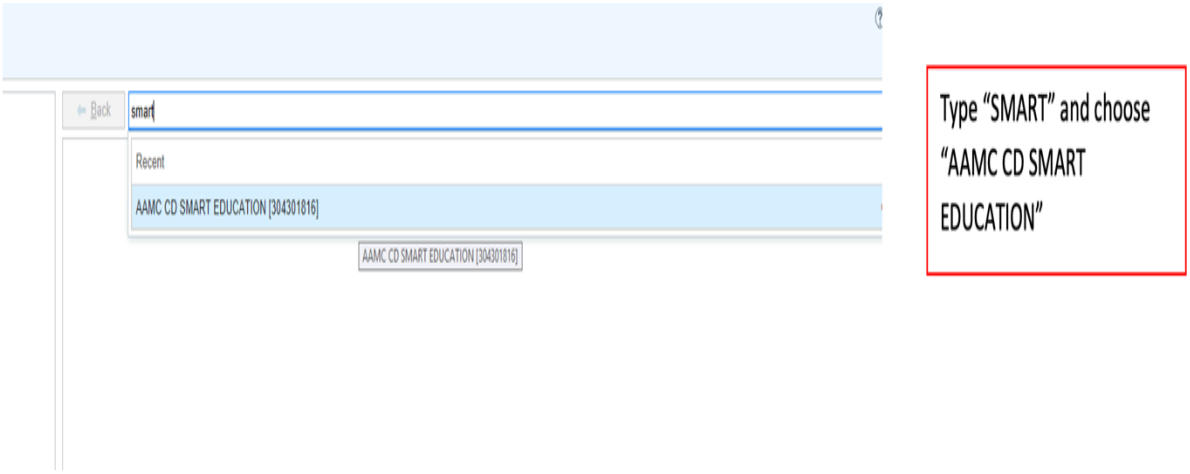
8. **What do I do with the carbon copy once a patient is discharged?**
   Place completed forms with the discharge instructions in the patient's chart. If the patient did not complete a form, please write the reason why on a blank form and place in chart. ALL discharged patients must have a form turned in. (Whoever breaks the chart down will put the worksheet in the "SMART" basket on the unit.)

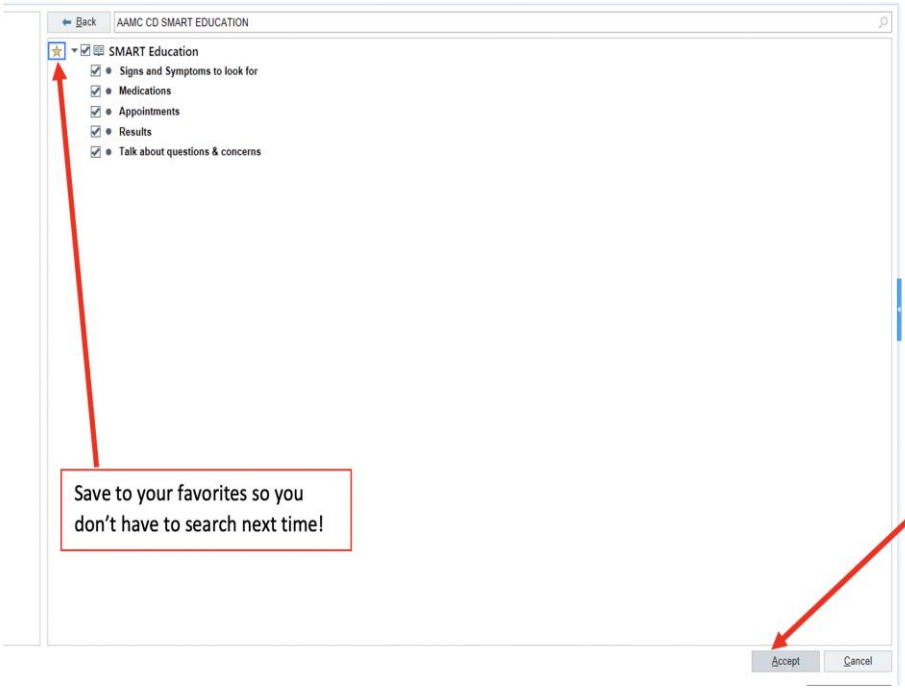
9. **What about patients going to rehab- do they still get a worksheet?**
   Yes. Patients and families can still write questions throughout their stay on the worksheet.

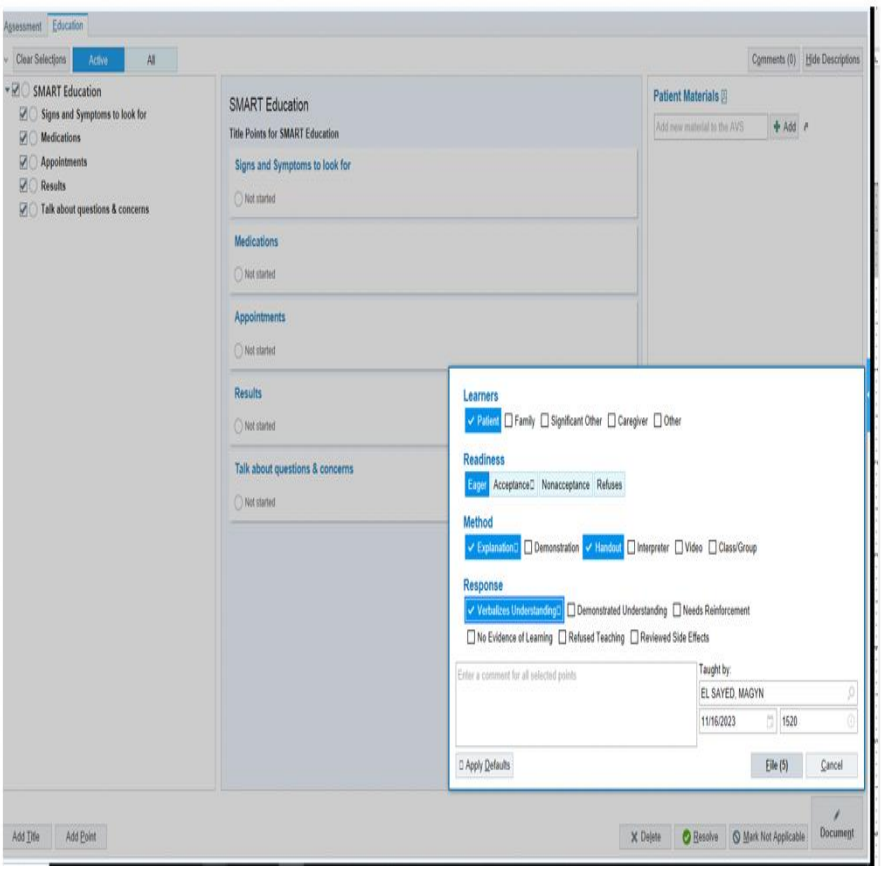
Appendix I

Instructions on How to Document SMART Education in EPIC






Back
AAMC CD SMART EDUCATION
SMART Education
Signs and Symptoms to look for
Medications
Appointments
Results
Talk about questions & concerns
Save to your favorites so you don't have to search next time!
Select all options then "Accept."
Accept
Cancel


Assessment
Education
Clear Selections
Active
All
Comments (0)
Hide Descriptions
SMART Education
Signs and Symptoms to look for
Medications
Appointments
Results
Talk about questions & concerns
SMART Education
Title Points for SMART Education
Signs and Symptoms to look for
Not started
Medications
Not started
Appointments
Not started
Results
Not started
Talk about questions & concerns
Not started
Patient Materials
Add new material to the AVS
Add
Learners
Patient
Family
Significant Other
Caregiver
Other
Readiness
Eager
Acceptance
Nonacceptance
Refuses
Method
Explanation
Demonstration
Handout
Interpreter
Video
Class/Group
Response
Verbalizes Understanding
Demonstrated Understanding
Needs Reinforcement
No Evidence of Learning
Refused Teaching
Reviewed Side Effects
Enter a comment for all selected points
Taught by:
EL SAYED, MAGYN
11/16/2023
1520
Apply Defaults
File (5)
Cancel
Add Title
Add Point
Delete
Resolve
Mark Not Applicable
Document
Document as you usually would for educating patients.

Appendix J

SMART Discharge Protocol Quiz (Pre-implementation and 1 month post-implementation)

1. What does SMART stand for?
    a. Signs, Meals, Appointments, Results, Talk
    b. Situation, Medications, Appointments, Results, Talk
    c. Symptoms, Medications, Appointments, Results, Talk
    d. Symptoms, Medications, Assessment, Results, Talk

2. T or F SMART Journal will replace AVS instructions.

3. Where can you find the SMART Recourse Binder with extra copies of AAMC SMART discharge journal worksheet?
    a. Ms. Cindy's office b. Bookshelf at the Nurse station c. The med. Room

4. When a patient receives AAMC SMART discharge journal worksheet and instruction
    a. On admission
    b. When the patient receives a new medication
    c. On the last day of hospital admission

5. Why do hospitals measure patient satisfaction?
    a. To better understand the patient's experience
    b. To better understand the provider's experience
    c. To change patient behavior

6. Which of the following is not a barrier to patient preparation for discharge?
    a. Patient health illiteracy
    b. Lack of structure in educational materials
    c. Standard educational tools and processes

7. Patient understanding of health management at discharge is important because it:
    a. Reflects on the hospital's staffing
    b. Impacts the patient's recovery and well-being
    c. Eliminates provider discharge follow-up

8. Who should receive SMART topic education?
    a. Voluntary b. Every patient c. Involuntary patient

9. Where can you document when you complete a shift assessment using SMART?
    a. EPIC shift assessment flowsheet b. Shift report sheet in the nursing shift report binder

10. Where should you document SMART Education?
    a. EPIC patient education b. EPIC shift assessment flowsheet

Appendix K

SMART Discharge Protocol Education Nurse Training Sign-Off Sheet

I verify that I have been trained to use the AAMC SMART discharge protocol. I understand I must provide new patients with a SMART discharge worksheet journal sheet upon admission and complete the "SMART" section under patient education in the EPIC. I understand how to use SMART language during daily interactions and document it in the daily report sheet. I know that I need to check the after-visit summary (AVS) in each shift and discuss outpatient appointments with patients using the SMART discharge protocol. I will review the AVS with patients using all five key components of SMART. I understand where the SMART discharge worksheet journal sheets and SMART patient education resource binder are located and how to use the resources.

Nurse's name	**Signature**	**Date**

Appendix L

Inpatient SMART Education Audit

Date of Audit	Patient Name	Admission date	Received SMART Discharge Worksheet	SMART Education complete in EPIC	Nurse Completing Audit	Notes

*****Please correct incomplete items**

Appendix M

DNP Project Timeline

Tasks	Timeline									
	August	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Introduce Project in Monthly Staff Meeting										
DNP Project Accepted by Nursing Research and EBP Council										
IRB Approval GWU and Practice Site										
Analyze the three months baseline data from the PGIBH survey regarding the top box percent score associated to discharge										
Pre-implementation Nursing Training										
SMART Education implemented documentation in EPIC and SMART resource binder utilization										

Tasks	Timeline									
	Sept		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Reinforcement of education, support from leadership, and collection of feedback										
Share the progress of SMART Education implementation with peers during staff meetings and gather suggestions and feedback										
Collect monthly post-implementation data on SMART Education Completion and Patient Satisfaction Scores concerning Discharge, followed by data analysis										
Evaluation of DNP project outcomes and dissemination of project results										
Further dissemination of results through posters and plans for sustainability										

Appendix N

Evidence Table

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
1	Centrella-Nigro & Alexander. (2017). Using the Teach-Back Method in Patient Education to Improve Patient Satisfaction.	A quasi-experimental design	A 361-bed community Magnet-designated hospital in northern New Jersey. Intervention group: n=23, all the permanently assigned nurses on the designated nursing unit Control group: n=30, from a similar medical unit	Nurses in the intervention group receive a 1-hour teaching session including lecture, role-play, discussion and videos, and then take a test one month after the training.	The *t* testes score for knowledge of teach-back shows a significant improvement after nurses in the intervention group received teach-back training. Nurses in the interventional group reported knowledge scores are associated with a significant improvement (p=0.002). Patient satisfaction score relates to the question "Tell me what new medicine was for" significantly improved	Quantitative analysis was used for multiple-choice answers and qualitative thematic analysis was used on the open-ended questions. Using paired *t* test to analyze the difference between before and after intervention score by using SPSS version 18	A small sample size may not represent the general population. The study was conducted in a non-psychiatric inpatient setting that may not represent the general population.	Level II Grade B	The teach-back method is an effective technique for patient education to improve patient outcomes that may lead to increased patient satisfaction.

					(*p*=0.025) during first three months of teach back was implemented.	software.			
2	Gabriel et al. (2017). Use of a daily discharge goals checklist for timely discharge and patient satisfaction.	A posttest randomized controlled design	A 26-bed medical oncology and hematology inpatient unit in a 511-bed academic medical center in the southeastern United States. Adult patient age 19 or older no cognitive impairment and stay at least three days in an inpatient medical unit. N=65 Early discharge planning: n=36, 55.6% female Usual discharge planning: n=29,	Using daily discharge goals checklist within 24 hours admission during interprofessional rounds. Documenting the discharge time order and the time patient left the unit. Using a 24-items Quality of Discharge Teaching Scale to	No. Patient satisfaction scores were higher in the intervention group, but the improvement was insignificant compared to the control group (p>0.05). The finding was unexpected, and the authors believe that early discharge planning should associate with positive patient experiences and that patients may need more attention on survey completion at discharge.	Using descriptive statistics to summarize data. Using Chi-square analysis to conclude differences for insignificant data between two groups. Using the Kaplan-Meier log-rank test to test for the difference in time to discharge between groups. Using Independent Student's t-test to	The similarity between the intervention group and the control group in a study could be attributed to the small number of patients who experienced significant delays in discharge, despite being medically cleared for discharge.	Level I Grade B	A discharge checklist can aid in preparing patients for their discharge, which can be used as a systematic tool, guaranteeing that all essential tasks and considerations are accounted for

			80% female	evaluate patient education received before discharge.		evaluate patient satisfaction scores.			before a patient's discharge.
3	Gonçalves-Bradley et al. (2016). Discharge planning from hospital.	Systematic review of Randomized Controlled Trials	N=11,964 participants from 30 trials: 21 trials recruited older adults with a medical condition, five studies combine medical and surgical condition, one trials from a psychiatric hospital, one from both meatal health and medical hospitals, two trials included patient admitted due to a fall.	Developing a discharge plan based on patient's needs before their discharge based on four steps: pre-admission assessment, case finding on admission, inpatient assessment and preparation of an individualized	Yes. Six of 30 studies report data for patient experience and indicate that discharge planning is possibly positively associated with satisfaction for patients and healthcare professionals. The evidence must be more substantial due to the inconsistent patient satisfaction measurement in different studies. Two trials include participants with a medical condition who reports	Measure outcomes: unscheduled readmission within three months of discharge from the hospital, hospital length of stay, satisfaction, and costs.	The research could be outdated due to being completed in 2016, and the newest study was conducted in 2014. Twelve trials did not report adequate distribution concealment. One pilot trials present a high risk of bias for the outcome	Level I Grade A	Patients received individualized discharge plans associated with lower readmission rates, shorter lengths of hospital stay, and higher patient satisfaction.

				discharge plan and essential documentation of the discharge process. Control group: no individualized discharge plan	increased patient satisfaction with participants' perceptions of continuity of care, non-financial access to medical care, hospital care, hospital discharge, and home recovery. Two studies evaluating pharmacy discharge plans report two different results: one trial report no different findings in both groups, one report that patient satisfaction scores are the same in both groups and one report improves information exchange in discharge. One study concluded that 40 participants admitted to general medical units reported increased satisfaction		readmission.		

					with discharge planning, with 27% higher in the intervention group (p<0.001).				
4	Patra et al. (2020). Improving Discharge Outcomes by Using a Standardized Risk Assessment and Intervention Tool Facilitated by Advanced Pediatric Providers.	1 year pre- and post-intervention pilot study	Children's hospital pediatric ward in a rural academic center in West Virginia. All patients who admitted aged 0-21 years. 1321 pre-intervention group 1413 patients post-intervention group.	Using Society of Hospital Medicine PediBoost tool kit include discharge risk assessment checklist and IMPACT intervention elements (interdisciplinary family meeting, medication review, patient education, appointment and	Yes. Patient satisfaction presented a significant increase in the postintervention group compared to the preintervention group: Speed of discharge process: 3.7% (p=0.008), instructions for discharge: 8.9% (p<0.0001), discharge readiness: 8.9% (p<0.0001), overall discharge process: 6.7 % (p<0.0001). There is no statistically decreased in 7-day readmissions: 0.6% (p= 0.305).	Process measures: percentage of discharge patients with post-discharge phone calls, use of electronic hangouts, percentage of discharge patients with a follow-up appointment scheduled before discharge, risk assessment checklist adherence. Outcome measures:	Limited to the pediatric patient population, single institutions may not represent another age group of the population or other institutions nationwide. Not all IMPACT interventional items consistently provide to all patients. Press Ganey patient	Level I Grade B	Using a standardized risk assessment and intervention tool is associated with a significant increase in patient satisfaction regarding the speed of the discharge process

				comm unicati on and teach-back metho d).	The number of patients given handouts and scheduled follow-up visits before discharge significantly increased: 38.6 % (p< 0.0001) and 59.2% (p< 0.0001).	patient satisfacti on and readmiss ion rate Balancin g measure : lengthy stay	satisfac tion surveys only represe nt about 40% of hospital s in the United States.		and instr uctio n for disc harg e, disc harg e readi ness, and the over all disc harg e proc ess.
5	Smith et al. (2021). Factors Associate d With Discharg e Planning Practices for Patients Receivin g Inpatient Psychiatr ic Care.	Retro specti ve cohor t analy sis	From 2012 to 2013 New York State Medicaid claims database: 18,185 patients ages<65 years were treated in psychiatri c inpatient unit and discharge home or the communit y.	NA	Yes. The study confirmed that more than 54% of patients discharged from a psychiatric inpatient unit did not receive a comprehensi ve discharge planning, and more than 20% did not have a scheduled appointment to connect with an outpatient y provider before discharge for follow-up care.	Using Odds ratios (ORs) with 99% confiden ce intervals (CIs) to analyze each characte ristic. Using logistic regressi on analyses to calculate adjusted PRs (AORs) Using average marginal	Due to the nature of the study, potentia l informa tion bias could occur related to the consiste ncy of the dischar ge plannin g practice variable s. Unmea sured confou nding	Lev el IV Gra de A	The auth ors conc lude d that patie nts disc harg ed from a psyc hiatr ic inpat ient unit with out com preh ensi ve disc harg e

					Mental health patients who are homeless, comorbid with substance use disorder and other medical conditions, and did not see an outpatient provider prior to the admission stay less than four days or longer than one month and are more likely to be discharged without receiving discharge planning.	effects (AMEs) as a quantity of an outcome on the probability scale.	factors may cause insufficient implications regarding connection. The Medicaid claims data was from ten years ago, and the finding may not present the current situation. The data was limited in New York State and may not represent the population nationwide.		planning might face a higher risk of experiencing various adverse outcomes, including readmission, homelessness, violent behavior, involvement with law enforcement, and mortality.
6	St John & Englund (2020).	None experimental	Two 30-bed medical-surgical	Nurses in the interventional	Yes. Approximately 90% of	Three-question survey that	The sample sizes of the	Level III	It is vital to prep

	Improving patient discharge education through daily educational bursts: a pilot study.	descriptive correlational design	floors at a moderate-size hospital in Northeastern Wisconsin. Interventional group: N=41 of 104 patients Controlled group: N=35 of 70 patients	group receive education on teach-back method and how to provide education bursts for discharge teaching and provide at least 10-15 minutes patient education cover one of the four predetermine discharge topics: medication, general follow-up appointment schedule, signs and	patients in the intervention group received daily education documentation on at least one of the topics, compared to 22% of patients in the control group who received the daily educational bursts. The patient satisfaction survey represents a significant difference in the mean score for the intervention group compared to the control group's first question, "Did your nurses help you to feel confident in your ability to care for yourself at home" (p= 0.026) and second question, "did the nurse break up your teaching into	selected from Quality of Discharge Teaching Scale. Using a 11-Point Likert Scare to score each question.	intervention and control groups are small, increasing a type II error risk with low statistical power. The study was conducted in a sole location from one moderately sized urban hospital. Participants may not represent the general population due to more than 90% of patients in both groups being	Grade B	are nurse training and resources for patient education to improve discharge education and confidence in post-discharge self-care management abilities.

				symptoms of compilation and when to contact a medical provider, and any specific prescribed diet/activity/self-care regimen. Nurses in control group did not receive education related to teach-back method or education bursts.	small amounts to help you learn? (p<0.000). However, no statistical significance was found between the intervention and control groups in the third question, "Did you like the way your nurses taught you about how to care for yourself at home" (p= 0.275).		white or Caucasian and 76% in the interventional unit being 50 or older, and 90% in the control unit.		
7	Thum, et al. (2022). Improving the discharge experienc	Quantitative Correlational	A total of 957 beds combined a large academic tertiary care	Development of a computer-based video	Yes. Patient satisfaction scores increased by 2.07%	Using the Hospital Consumer Assessment of	The discharge folder was derived by a	Level III Grade A	Implementing a standardized

	e of hospital patients through standard tools and methods of education.	Research	center and its smaller academic community hospital. Care transitions: n=36,642 Preintervention total surveys: n=21,984 Postintervention total surveys: n=14,657 Discharge information: n=22,140 Preintervention total surveys: n=13266 Postintervention total surveys: n=8,874	training program to instruct nurses about effective patient teaching, implementation of a discharge folder presented to every patient on admission by their nurse, redesign of provider workflows and the output of the discharge instruction or "AVS" to ensure appropriate information	(p<0.0001) for the domains of Care Transitions and 2.74% in discharge information (p<0.0001) after one year of implementation.	Healthcare Provider And Systems (HCAHPS) survey to measure patient satisfaction before and after the implementation. Using the Kruskal-Wallis test to determine the difference in Press Gamey percentile ranked before and after the intervention.	third party which affected its accessibility initially. The folder was available in English only, and the patient speaking other languages may not be beneficial.		discharge process to provide patient education positively impacts patient satisfaction scores.

				was provided to the patient.					
8	Virgolesi, M. et al. (2017). The effectiveness of a nursing discharge programme to improve medication adherence and patient satisfaction in the psychiatric intensive care unit.	Prospective correlational design	Setting: psychiatric intensive care unit in Italy. N= 156 participants and 135 complete baseline data, average aged 33 years, and 57% of the samples was female.	Nurse staff provide discharge information to patient during stay and within 7-10 days after discharge	Yes. Patients who satisfy with the information about their health and the medications that they received in the hospital are associated with higher adherence to treatment after discharge ($p = 0.008$).	The Morisky Medication Adherence Scale, the Satisfaction with Information about Medicine Scale, and the General Satisfaction Questionnaire.	The sample size is small due to specific inclusion criteria. The study lacked a case-control comparison.	Level II Grade B	Nurses received 10 hours of orientation in the most frequent themes related to prescribed medications.
9	Waniga et al. (2016). The impact of revised discharge instructions on patient satisfaction.	Quasi-experimental study	A 180-bed community-based hospital in Massachusetts. Sample size between 1,600-1,900 September 2011 to September 2012 overall rating of care	Creating and implementing a transition record, which is an informative patient-center tool used to provide discha	Yes. After one year of implementation, patient satisfaction scores significant increase including: Discharge overall (83.0% vs 84.7%, $p<0.01$) Extent felt ready for	Using basic statistical comparison models include: *t* test and analysis of variance	There are other interventions to improve patient satisfaction that coincide when revised discharge instructions were	Level III Grade B	The study concluded that the modified discharge instruction was positively asso

			given: n= 1,559. September 2012 to September 2013 overall rating of care given: n= 1819	rge instruction to patient before discharge	discharge (84.9 % vs 86.6%, *p*=0.01) Discharge for homecare (85.3% vs 87.8%, *p*<0.01)		implemented. Most of the high-risk population speak only Spanish. Only 30% of patients complete the survey. Single-site study at a community hospital in Massachusetts.		ciated with an increased patient satisfaction score. The new discharge process demands slightly more time from nurses and physicians than their regular workflows.

This assignment is used during the DNP Project Planning Course to evaluate the Table of Evidence. It is adapted from Dearholt, S. & Dang, D. (2021). *Johns Hopkins Nursing Evidence-Based Practice Model and Guidelines*. Indianapolis, IN: Sigma Theta Tau International, Chapters 5,6,7, Appendices D, E, F, and G. Refer to the text for expanded explanation.