**INTRODUCTION**

Background:
- The quality of hospital-to-home discharge transitions is a critical issue affecting the United States health system. More than 20% of parents report problems in the transition of care from hospital to home (Auger et al., 2014).
- Discharge planning is mandated by federal legislation and includes strategies such as: assessment of barriers to discharge, making decisions regarding post-hospitalization care, engagement of family in communication, provision of supplies for home care, and completing procedures such as scheduling follow-up appointments (Gonzalves-Bradley et al., 2016).
- Discharge readiness is the ability to understand and execute the intended discharge care plan and is more likely when parents believe their child is prepared for home care and have the supplies for home care, and completing procedures such as assessment of barriers to discharge, making decisions regarding post-hospitalization care, and engaging in family in communication, provision of supplies for home care, and completing procedures such as scheduling follow-up appointments (Gonzalves-Bradley et al., 2016).
- Total estimated annual costs of 30-day preventable readmission rates for pediatric hospitals are $353 million, or 27.3% of all-cause readmission costs, thus accounting for 4.6% of the total costs for all pediatric hospitalizations (Gay et al., 2015).

**PICOT QUESTION & OBJECTIVES**

**PICOT Question:**
To pediatric patients (P), how does a family-centered discharge transition planning process (I), compared to the usual discharge process (C), affect family readiness for discharge (O) within two months of implementation?

**Objectives:**
1. There will be a 10% increase in family perception of readiness for discharge (O) within two months of implementation (I).
2. There will be a 10% increase in documentation of daily review of the discharge plan with family.

**RESULTS**

**Demographics**
- **Age:** Mean age of 8.23 years (SD = 1.2) for time point 1 and 8.92 years (SD = 0.70) for the time point 2 group which was not statistically significant between groups, t(39) = 5.6, p = .05, 95% CI [-3.16, 1.78].
- **Length of Stay (LOS):** There was a decrease in mean length of stay of 5.5 days (SD = 12.2) from time point 1 to 2.3 days for time point 2 (SD = 2) but was not statistically significant, t(38) = 12.2, p = .01, 95% CI [-3.6, 7.25], d = .4.
- **Specialty Service:** General Surgery (47%, n = 38), followed by ENT (17.5%, n = 14), Orthopedics (10%, n = 8), and EMU/Neurology (7.5%, n = 6). There was no statistically significant difference between the two groups, χ² (8) = 7.32, p = .19.

**CONCLUSIONS**

- **Overall Readiness:**
  - Parents in both time points 1 (100%, n = 38) and 2 (100%, n = 53) indicated that overall, they personally felt ready to take their child home.
  - There was no statistically significant difference found in overall readiness between the two groups, χ² (1) = 7.1, p = .40.
- **Individual Item Significance:** Of the 24 items included in the RHDS scale, two items were statistically significant, and both had moderate clinical significance:
  - **Lower stress at time of discharge:** t(87) = −1.47, p = .06, 95% CI [-2.35, .01], d = .6
  - **Confidence in ability to cope with demands at home:** t(88) = −2.00, p = .06, 95% CI [-.86, .25], d = .6.
- **Subscapes:** There was no statistically significant difference in all 5 subscales. There was small clinical significance in increased parent personal status, knowledge, coping, and expected support.

**ACKNOWLEDGEMENTS**

The project director would like to thank her doctoral committee chair, Dr. Jan Sherman, PhD, RN, NNP-BC; members: Dr. Umeaka Jefferson, PhD, RNC-LRN; Debra Quackenbush, MS, RN, CPS; the nursing staff of Children’s Hospital Colorado’s SMSC department for their time and insight; and the Sinclair School of Nursing for helping make this project a reality.

**REFERENCES**


**SINCLAIR SCHOOL OF NURSING**

University of Missouri- Sinclair School of Nursing