NURS-FPX4030 Assessment 3

PICO(T) Questions and an Evidence-Based Approach

Nurse-Led Transitional Care for Adults With Heart Failure

Author	FlexPath Assignment Help
Course	NURS-FPX4030: Making Evidence-Based Decisions
Assessment	Assessment 3
Publication date	August 6, 2026
Website	FlexPathAssignmentHelp.com
Canonical page	https://flexpathassignmenthelp.com/nurs-fpx4030-assessment-3-pico-t-questions-and-an-evidence-based-approach-sample

Primary keyword: NURS-FPX4030 Assessment 3 PICO(T) Questions and an Evidence-Based Approach

Related keywords: PICOT question, heart failure readmission, transitional care, teach-back, medication reconciliation, nurse follow-up, evidence synthesis

Using a PICO(T) Framework to Improve Heart-Failure Transitions

Adults hospitalized with heart failure face a vulnerable transition after discharge. They may leave with new medications, complex self-care expectations, unresolved social barriers, and limited understanding of when symptoms require help. A focused PICO(T) question helps a nurse convert this broad problem into searchable concepts and evaluate whether a specific intervention is likely to improve a measurable outcome. This paper develops a question about nurse-led transitional care, describes the evidence-search process, evaluates relevant sources, and proposes an evidence-based answer.

Practice Problem and PICO(T) Question

The practice problem is preventable readmission within 30 days after a hospitalization for heart failure. Readmission may result from disease severity, but gaps in medication reconciliation, patient education, symptom monitoring, follow-up, transportation, cost, and communication also contribute. The selected intervention is a nurse-led transitional-care bundle that begins before discharge and continues through the first month at home.

> **PICO(T) question:** In adults hospitalized with heart failure (P), does a nurse-led transitional-care bundle that includes medication reconciliation, teach-back education, scheduled follow-up within seven days, and telephone monitoring (I), compared with usual discharge instructions (C), reduce all-cause and heart-failure-related readmissions (O) during the first 30 days after discharge (T)?

Element	Definition in this question	Rationale
P - Patient/problem	Adults discharged after hospitalization for heart failure	Identifies a population at high risk during the hospital-to-home transition.
I - Intervention	Nurse-led bundle: medication reconciliation, teach-back, written action plan, seven-day follow-up, and post-discharge calls	Combines education, monitoring, coordination, and early response rather than relying on a single handout.
C - Comparison	Usual discharge process or standard instructions without the defined bundle	Provides a realistic comparator for determining whether structured nursing actions add value.
O - Outcome	30-day all-cause and heart-failure-related readmission; secondary outcomes include self-care and follow-up completion	Uses patient and organizational outcomes that can be measured consistently.
T - Time	Thirty days after discharge	Matches the highest-risk early transition and common quality-monitoring period.

Evidence Search Strategy

CINAHL Complete and PubMed/MEDLINE were selected as the primary databases because the question includes both nursing-delivery interventions and medical outcomes. Cochrane Library was used to identify systematic reviews, and professional guideline sources were searched for current management recommendations. The main concepts were heart failure, transitional care, nurse-led care, discharge education, teach-back, medication reconciliation, telephone follow-up, and readmission.

A sample PubMed search was: (Heart Failure[MeSH] OR heart failure) AND (Transitional Care OR nurse-led OR discharge education OR telephone follow-up) AND (Patient Readmission[MeSH] OR readmission) AND (randomized OR systematic review OR meta-analysis). The search was limited mainly to English-language publications from 2021 through 2026 and supplemented with current professional guidelines. Sources were retained when they addressed adults with heart failure, a nursing or multidisciplinary transition, and readmission, utilization, self-care, or follow-up outcomes.

Findings From the Evidence

Nurse-Led Transitional Care

Li et al. (2021) pooled randomized controlled trials of nurse-led transitional-care interventions for patients with heart failure. The review found a 29% reduction in heart-failure-specific readmission risk, with a pooled risk ratio of 0.71. Common intervention components included structured telephone support, case management, education, counseling, close monitoring, and extended follow-up. This evidence directly addresses the PICO(T) question because it compares nurse-led transition models with usual care and evaluates healthcare utilization.

The review also shows why the intervention should be treated as a bundle. Individual studies used different combinations, durations, and intensities. It would be inaccurate to claim that a telephone call alone produces the pooled effect. The more defensible interpretation is that continuity, repeated contact, education, and early problem-solving work together. Local implementation should therefore define the minimum bundle and monitor fidelity.

Guideline-Directed and Patient-Centered Care

The 2022 AHA/ACC/HFSA guideline supports multidisciplinary, patient-centered heart-failure management and provides the clinical foundation for safe transition planning (Heidenreich et al., 2022). A discharge intervention cannot compensate for incomplete medication review or a treatment plan that does not reflect current evidence. The nurse-led bundle should therefore verify medication access and

understanding, communicate unresolved clinical concerns, and reinforce rather than independently alter the prescribed plan.

The 2023 ESC focused update demonstrates the need to check for new evidence that changes treatment recommendations (European Society of Cardiology, 2023). This matters to the nursing question because patient teaching must match the current therapeutic plan. The nurse's role includes recognizing adverse effects, checking adherence and barriers, monitoring symptoms, and escalating concerns to the prescribing clinician.

Self-Care Education and Monitoring

Jaarsma et al. (2021) describe heart-failure self-care as maintenance, monitoring, and management. Maintenance includes taking medication and following individualized lifestyle advice; monitoring includes attention to weight and symptoms; management includes responding appropriately to deterioration. This framework supports teach-back and a written action plan because education should not stop at providing facts. The patient must know what to do when symptoms change.

Wu et al. (2024) reviewed nurse-led heart-failure clinics and found that these services commonly combine assessment, self-management education, counseling, follow-up, case management, and multidisciplinary support. The review supports the feasibility of nurse-led follow-up but also reports variation in models and outcomes. That variation is a limitation and a reason to specify team roles, training, escalation pathways, and outcome measures before implementation.

Evidence-Based Answer to the PICO(T) Question

The available evidence supports implementing the nurse-led transitional-care bundle rather than relying on usual discharge instructions alone. The strongest direct evidence is the randomized-trial meta-analysis, while guidelines and self-care recommendations explain what the bundle should reinforce. A reasonable minimum intervention is:

- Medication reconciliation before discharge, including indication, dose, timing, access, and a plan for adverse effects or uncertainty.
- Teach-back education on heart failure, daily weight and symptom monitoring, individualized diet and fluid guidance, activity, and when to seek help.
- A simple written action plan using green, yellow, and red symptom zones and contact information.
- A follow-up appointment scheduled before discharge, preferably within seven days for a high-risk patient.
- A nurse telephone call within 48 to 72 hours and additional calls based on risk during the first 30 days.

- Closed-loop communication with the prescriber, pharmacist, case manager, and primary or cardiology team when a problem is identified.

The primary outcome should be 30-day all-cause and heart-failure-related readmission. Process measures should include completed medication reconciliation, documented teach-back, scheduled and completed seven-day follow-up, successful post-discharge contact, and escalation response time. Balancing measures should include nurse workload, duplicated calls, patient burden, and avoidable emergency referrals. These measures show whether the bundle was delivered and whether improvement created unintended problems.

Limitations and Clinical Judgment

The evidence does not establish one universally optimal bundle. Trials vary in setting, patient severity, intervention duration, staffing, and usual care. Readmission is also influenced by socioeconomic conditions, comorbidities, health-system access, and the patient's goals. Therefore, the evidence supports the direction of practice but not a rigid one-size-fits-all protocol. Nurses must adapt communication to culture, language, cognition, hearing, digital access, caregiver support, and health literacy. Urgent symptoms require immediate clinical evaluation rather than continued remote coaching.

Conclusion

The PICO(T) framework produced a focused, answerable question about adults transitioning home after heart-failure hospitalization. Current evidence supports a structured nurse-led bundle that integrates medication reconciliation, teach-back, an action plan, early follow-up, and telephone monitoring. Compared with usual discharge instructions, this approach is expected to reduce heart-failure-related readmissions and strengthen self-care, although local implementation and patient factors will influence outcomes. The best practice is to combine guideline-directed clinical management with a reproducible nursing transition process and ongoing measurement.

References

European Society of Cardiology. (2023). 2023 focused update of the 2021 ESC guidelines for the diagnosis and treatment of acute and chronic heart failure. European Heart Journal, 44(37), 3627-3639. https://doi.org/10.1093/eurheartj/ehad195

Heidenreich, P. A., Bozkurt, B., Aguilar, D., Allen, L. A., Byun, J. J., Colvin, M. M., Deswal, A., Drazner, M. H., Dunlay, S. M., Evers, L. R., Fang, J. C., Fedson, S. E., Fonarow, G. C., Hayek, S. S., Hernandez, A. F., Khazanie, P., Kittleson, M. M., Lee, C. S., Link, M. S., ... Yancy, C. W.

(2022). 2022 AHA/ACC/HFSA guideline for the management of heart failure. Circulation, 145(18), e895-e1032. https://doi.org/10.1161/CIR.0000000000001063

Jaarsma, T., Hill, L., Bayes-Genis, A., Brunner-La Rocca, H.-P., Castiello, T., Celutkiene, J., Marques-Sule, E., Plymen, C. M., Piper, S. E., Riegel, B., Rutten, F. H., Ben Gal, T., Bauersachs, J., Coats, A. J. S., Chioncel, O., Lopatin, Y., Lund, L. H., Lainscak, M., Moura, B., ... Stromberg, A. (2021). Self-care of heart failure patients: Practical management recommendations from the Heart Failure Association of the European Society of Cardiology. European Journal of Heart Failure, 23(1), 157-174. https://doi.org/10.1002/ejhf.2008

Li, M., Li, Y., Meng, Q., Li, Y., Tian, X., Liu, R., & Fang, J. (2021). Effects of nurse-led transitional care interventions for patients with heart failure on healthcare utilization: A meta-analysis of randomized controlled trials. PLOS ONE, 16(12), e0261300. https://doi.org/10.1371/journal.pone.0261300

Wu, X., Li, Z., Tian, Q., & Ji, S. (2024). Effectiveness of nurse-led heart failure clinic: A systematic review. International Journal of Nursing Sciences, 11(3), 315-329. https://doi.org/10.1016/j.ijnss.2024.04.001

Appendix A: Assessment Coverage Map

The table shows where the sample visibly addresses the central requirements commonly associated with this NURS-FPX4030 assessment. The current scoring guide remains the controlling source.

Assessment requirement	Location in sample
Define a practice issue or diagnosis and explain the PICO(T) approach.	Practice Problem and PICO(T) Question
Develop a complete PICO(T) question.	Highlighted PICO(T) question and element table
Identify relevant sources and explain the search strategy.	Evidence Search Strategy
Evaluate evidence that helps answer the question.	Findings From the Evidence
Explain the answer, application, and limitations.	Evidence-Based Answer and Limitations