A strategy to reduce readmissions: *Improving the inpatient experience*

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Overview

- The NSW Health system
- Readmission drivers
- Clinical management plan
- Structured ward rounds at the bedside
- Smooth patient flow – early decision making
- Criteria Led Discharge
- Transfer of care
The ACI works closely with the NSW Ministry of Health, LHDs, other Pillars, Medicare Locals, Aboriginal Medical Services and other partners.
The roles of the Clinical Excellence Commission and the Agency for Clinical Innovation provide many opportunities for collaboration.

**PILLARS OF NSW HEALTH**

**Agency for Clinical Innovation**
- Focus: best practice, evidence based **models of care**
- engage clinicians, consumers and managers
- promote system-wide innovation to improve care
- design new models of care
- implement new models of care

**Clinical Excellence Commission**
- Focus: best practice, evidence based **quality and safety**
- engage clinicians, consumers and managers
- provide system-wide clinical governance leadership
- design improvements to clinical quality and safety
- review and respond to adverse clinical events

**Additional Institutions**
- Health Education and Training Institute
- NSW Kids and Families
- Cancer Institute NSW
- Bureau of Health Information
Readmissions

Drivers
- Older patients, with co-morbidities and greater requirements for social care on discharge [1]

Solutions
- Before hospital admission
- During hospital admission
- After hospital admission

1. Shalchi, Z; Saso, S; Li, HK; Rowlandson, E; Tennant, RC (2009). Factors influencing hospital readmission rates after acute medical treatment Clinical Medicine, Journal of the Royal College of Physicians, 9: 5:426-430(5)
Readmissions

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- Older patients
- Co-morbidities
- Greater requirements for social care [1]

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Improving the Medical Inpatient Journey

**WHOLE OF HOSPITAL: ACCESS TO CARE**

Patient enters the service → ED to Inpatient → Inpatient to Inpatient → Patient exits service → Patient in the community

- **MAU**
- **HITH**

**CARE COORDINATION**

- Clinical Management Plan
- Structured Ward Round
- Estimated Date of Discharge
- Waiting for What
- Criteria Led Discharge
- Transfer of Care

Leads: ACI, MOH, LHDs, CEC

Educational materials on ‘smooth patient flow’ across the patient journey are being developed by: HETI

**Key**
- ACI=NSW Agency for Clinical Innovation
- CEC=NSW Clinical Excellence Commission
- HETI=NSW Health Education and Training Institute
- LHDs=NSW Local Health Districts and Speciality Networks
- MOH=NSW Ministry of Health

HITH=Hospital in the Home
MAU=Medical Assessment Unit
The single biggest problem in communication is the illusion that it has taken place.

George Bernard Shaw
Know the Plan. Share the Plan. Action the Plan.

1. Single comprehensive assessment
2. Partner with patients, family and carers
3. Multidisciplinary team documentation
4. Structured approach
5. Confirm, don’t repeat
6. Link to Primary Health Care plans
# Documentation - Daily

- **Acknowledge**
- **Review**
- **Refine**
- Plus **Progress Notes** for interdisciplinary documentation

## Daily Interdisciplinary Review

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<thead>
<tr>
<th>Interdisciplinary Round</th>
<th>Acknowledge</th>
<th>Present</th>
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<tbody>
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<td>D&amp;A</td>
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## Daily Management Plan

- **REFINE**

## Resuscitation

- **FULL**
- **see plan in notes**
- **not discussed (consult specialist)**

<table>
<thead>
<tr>
<th>Dr/HMO</th>
<th>Signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse/IC</td>
<td>Signature</td>
<td>Date</td>
<td>Time</td>
</tr>
</tbody>
</table>

This form will be trialled in Bega Hospital between 19/9/2013 and 20/10/2013.
Documentation - Problems

PROBLEM MANAGEMENT SHEET

Facility:

GIVEN NAME

D.O.B. _____ / _____ / _____

M.O.

DATE:

PRESENTING SYMPTOMS

PROVISIONAL DIAGNOSIS

<table>
<thead>
<tr>
<th>Date</th>
<th>Problem/Diagnosis</th>
<th>Special Instructions/Investigation</th>
<th>Outcome</th>
<th>Initial</th>
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</thead>
</table>

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

ACI NSW Agency for Clinical Innovation

DRAFT COPY ONLY
### Documentation - Weekend

- Weekend handover
- Acknowledge
- Review
- Refine

**Weekend Clinical Management Plan**

<table>
<thead>
<tr>
<th>AMO</th>
<th>__________________________</th>
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</thead>
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**Diagnosis:**

**Presenting Symptoms:**

**Current Issues (Medical):**

**Current Issues (Interdisciplinary/Nursing):**

**Management Plan:**

**Weekend Contact:**

<table>
<thead>
<tr>
<th>Completed by (Name)</th>
<th>Designation</th>
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<td>Date</td>
</tr>
</tbody>
</table>

**Read/Acknowledged (Name):**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

This form is being tested in Bega Medical Ward between 02/06/2013 and 20/10/2013

Page 1 of 1
The single biggest problem in communication is the illusion that it has taken place.

George Bernard Shaw
Evidence from Root Cause Analysis Reports

Universal Root Causes

• **Communication** - poor communication of essential information between healthcare providers and with patients and their families

• **Teamwork and coordination of care** – poor teamwork, care planning and delivery in a fragmented system of care
In Safe Hands Program

Through Structured Team Rounds:

• Enhance teamwork and communication
• Improve patient safety
• Engage and involve the patient and family/carer at all times
• Bring everyone together to the point of care to make key decisions
Round Communication Structure

1. Introduction
   The patient and members of the health care team are introduced

2. Review of issues, test results
   The doctor will outline the patient's current health issues and investigation results. The patient is invited to provide input and ask questions

3. Update current status
   The nurse provides an update including clinical information such as mobility and vital signs

4. Patient Safety Checklist
   The nurse will go through a quality safety checklist of clinical items to make sure nothing is missed

5. Summarise plan for care
   The doctor will summarise the plan for care to ensure everyone is clear on the actions that are required

Patient has opportunity to provide input and ask questions

Patient & Family/Carer able to ask questions

Waiting for What discussed

EDD and needs for transfer of care discussed
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<tbody>
<tr>
<td>JMO</td>
<td>Phone</td>
</tr>
<tr>
<td>Nurse</td>
<td>Phone</td>
</tr>
<tr>
<td>Plan</td>
<td>EDD</td>
</tr>
<tr>
<td>Patient goal for today</td>
<td>Patient &amp; family questions</td>
</tr>
</tbody>
</table>
So what’s different?

• **Patient** is an active participant
• Happens regularly at the **same time**
• Discussion is **brief** (around 5 minutes)
• Detailed discussion (or further examination/assessment) by specific health care team members occur after the Structured Team Round
So what’s different?

• **Family and carers** encouraged to be part of the Structured Team Round

• The patient’s **goal of the day and care plan** is understood by everyone

• Patient, family/carer has an opportunity to **ask any questions**
Benefits of Structured Team Rounds

• Occurs at the agreed scheduled time
• Patient and their family/carer know when the team will be coming
• Patients encouraged to write down any questions for the team before the Round
• Clear plan for transfer of care communicated to everyone on the team *(patient is part of the team!)*
Benefits of SIBR

• Very good feedback from patients and carers
• Enthusiastic adoption by medical, nursing and allied health teams
• Time efficient
• Staff satisfaction
• Enhances teamwork and communication
Benefits for the patient

• **Involvement**: being a part of the team
• **Empowerment**: having more say
• **Confidence**: talking the same language
• **Certainty**: knowing what to expect
Early Evaluation

Improvements in:

• Patient safety
• Care coordination
• Clinical outcomes
• Patient flow (e.g. weekend discharges) & length of stay
• Staff satisfaction
• Patient and family/carer satisfaction
Smooth Patient Flow

1. Patient flow = everyone’s business
2. Navigator roles
3. Analyse EDD, waiting for what and multiple ward moves
4. Use predictive tool and dashboard

Tools

2. HETI module in development
Optimal time for discharge:

- is when the patient is medically ready to go home; and
- carers are confident to care for the patient at home

**Tools**

- Huddle white board / electronic journey board
- CLD form / transfer of care checklist
- CLD draft protocol
- CLD competency set
- Orientation/training slides
Rapid Round / Patient Journey Board
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<th>Pager #</th>
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<th>Allied Health</th>
<th>Management Plan</th>
<th>Best</th>
<th>Where From</th>
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</table>

Source: Sue Hair: Director of Nursing and Midwifery, Manly Hospital and Deb Stewart Manager Clinical Redesign, Northern Beaches and Hornsby Ku-ring-gai Health Services
CLD Form – PART A

GP ________________________ GP PHONE ______________________ DATE OF ADMISSION __________

This form is to be completed for every patient

PART A: MEDICAL REVIEW (to be completed by Consultant or Medical Fellow)

Diagnosis: ____________________________________________________________

Expected Date of Discharge

☐ I agree for this patient to be discharged once the milestones in part B and C are met.

☐ Please do not discharge until medical team review for the following reason(s):

______________________________________________________________

Consultant/Fellow Name: _________________________________________________

Signature: ___________________________________________________________ Date: ________________ Time: __________
### CLD Form – PART B

<table>
<thead>
<tr>
<th>IDT agreed specific milestones</th>
<th>Name</th>
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<tr>
<td>5.</td>
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**Responsible person:** __________________________________________
CLD Form – PART C

<table>
<thead>
<tr>
<th>PART C: PATIENT CRITERIA</th>
<th>Y/N</th>
<th>Name</th>
<th>Signature</th>
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</thead>
<tbody>
<tr>
<td>All observations Between the Flags within the last 24 hours or within the documented Altered Calling Criteria for this patient</td>
<td></td>
<td></td>
<td>If No refer to senior medical clinician</td>
</tr>
<tr>
<td>Transfer of care checklist completed</td>
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</table>

Reason patient not discharged using Criteria Led Discharge protocol:

I confirm that the criteria I parts B and C have been met and are achieved:

Name: ___________________________ Designation: ___________________________

Signature: ______________________ Date: ____________ Time: ____________
Safe Clinical Handover

A resource for transferring care from General Practice to Hospitals and Hospitals to General Practice
1. The patient, their family and carer is involved.
2. Clear, succinct communication.
3. Medication reconciliation should occur at every transition of care.
4. A patient, their family and carer must leave the hospital with their discharge communications.
5. Infrastructure to enable GPs to have access to electronic patient results in the hospital.
Questions & Contacts

Contact me for Clinical Management Plans/ Criteria Led Discharge
Kate Lloyd, Manager, Acute Care
T: 02 9464 4623 / 0467 603 578 | E: Kate.Lloyd@aci.health.nsw.gov.au

Whole of Hospital Program
NSW Ministry of Health, System Relationships and Framework Branch
Luke Worth, Director | Systems Relationship Branch C

Patient Flow Portal
NSW Ministry of Health
T: 02 9424 5924 | E: patientflow@moh.health.nsw.gov.au

Patient Flow (Education)
Health Education and Training Institute
Rhonda Loftus, Whole of Hospital Program Lead (HETI)
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Clinical Excellence Commission
Wilson Yeung, Program Lead – In Safe Hands
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Transfer of Care
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Tracy Clarke, Clinical Nurse Lead – In Safe Hands
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W: http://www.archi.net.au/resources/safety/clinical/nsw-handover