Improving Management of Long Stay Patients

Engaging and supporting clinical teams

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Liverpool Hospital
SWSLHD
Overview

- Key principles
- What was the problem?
- Long Stay Project approach
- Results
- Sustainability
- Summary
Long Stay Patients

- Long stays are NOT always inappropriate but prolonged hospitalisation is associated with significant social, economic, physical and psychological burden.

- Effective care planning promoting patient and carer involvement is associated with lower LOS, better health outcomes, greater satisfaction and reduced risk of adverse incidents and complications.
Key Principles

- Culture of respect and empowerment
- Collaborative approach to solutions
- Respect and acknowledgement of professional roles, clinical expertise and responsibilities
- Valuing of patient and staff input across all disciplines
- Patient Safety focus – reducing risk of hospitalisation
- Patient and carer involvement
- Supportive monitoring processes
What was the problem?

- A systematic monitoring process was not in place.
- Early escalation of discharge planning issues and discharge barriers was not occurring.
- Executive involvement in care planning considered more likely to be punitive or counterproductive.
- Teams often felt ill equipped to identify solutions, adequately plan and resolve complex discharge issues without guidance and assistance.
- Limited team understanding of discharge options for complex discharges.
To reduce the total number of long stay patients (>30 days and >100 days) in ED accessible beds and long stay patient bed days by 20% within 6 months.
In May-June 2014 we identified a significant cluster of long stay patients in ED accessible beds at Liverpool Hospital:

- 70 patients with a LOS > 30 days
- 14 patients with a LOS > 100 days
- 4 patients with a LOS > 200 days
- Longest patient LOS > 450 days

LOS >30 day episodes in 2013-14 at Liverpool Hospital utilising 27,038 bed days*

*Data includes all patients with LOS>30 days in ED accessible beds only (excludes Mental Health, Neonatal ICU and Brain Injury Unit)
Diagnostics

**Case reviews** undertaken on 14 extreme long stay patients (>100 days) identified:

- 87% required input from > one team
- 28% had a supported management plan
- 93% team delays in escalation

**Other long stay factors were identified by:**

- Staff interviews - medical, nursing and allied staff
- Issues log following case reviews
- Case conferences and JBR visits
Potential Reasons for Long Stay Patients

Monitoring
- Lack of awareness
- Data Processes
- Ward Ownership of process
- LOS Committee
- Senior Clinician involvement
- Executive reports

Complexity
- Multiple team input
- Level of clinical experience in team
- Understanding of discharge options for complex discharges
- Senior Clinician involvement
- Clear planning responsibilities

Escalation
- Networks and contacts
- Discharge Barriers recognised
- Delays in identification
- Local system knowledge
- Multidisciplinary communication
- Ease of process / committees

Individual Factors
- Frustration
- Lack of urgency
- AMO variation

Long Stay Patient
Potential solutions

- Facilitate discharge for extreme long stay patients
- Long Stay Committee – single, consistent centralised monitoring process
- Process for active management of long stay patients at ward level
- Risk assessment and early identification
- Escalation process – encourage timely escalation of barriers to discharge
- Encourage communication and support – shared care
Potential solutions

- Ensure management plans are communicated to patient / carers eg. ISH
- Coordinate input for complex issues where appropriate eg. ADHC, Guardianship, Consults
- Develop culture and process with incentive to escalate early – backed up by triggers
- Senior nursing, medical and allied health input
- Encouragement of patient care teams
- Identification of and addressing of system issues
## Interventions – PDSA cycles

<table>
<thead>
<tr>
<th>PDSA 1:</th>
<th>Targeted Case Management (extreme LOS):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• MDT case management review for all current patients with LOS &gt;100 days</td>
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<tr>
<td></td>
<td>• Active support from Executive and clinical teams for complex discharges</td>
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<table>
<thead>
<tr>
<th>PDSA 2:</th>
<th>Introduction of Weekly Ward Reporting</th>
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<tbody>
<tr>
<td></td>
<td>• Long Stay Committee re-established to review LOS &gt;30 days weekly</td>
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<tr>
<td></td>
<td>• Reporting template for AMO/NUM to provide detail on management plans</td>
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<table>
<thead>
<tr>
<th>PDSA 3:</th>
<th>Appropriate Quality Care Plans:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• NUM and MDT education and feedback on patient management plans</td>
</tr>
<tr>
<td></td>
<td>• Ward visits support and enable teams to promote a culture of problem solving</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>PDSA 4:</th>
<th>Monitoring and escalation process</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• Monitoring tool to track LOS &gt;30 days and identify discharge barriers early</td>
</tr>
<tr>
<td></td>
<td>• Local ward escalation, bed meeting, DMU and committee processes</td>
</tr>
</tbody>
</table>
PDSA 1: Targeted Case Management

- Identify patients LOS >100 days
- Facilitated MDT case management

**Plan**
- Expand review LOS >30 days
- Define ward groups
- Ward driven process required

**Do**
- Number discharged patients
- Discharge barriers (Issues Log)

**Act**
- Expand review LOS >30 days
- Define ward groups
- Ward driven process required

**Study**
- Number discharged patients
- Discharge barriers (Issues Log)
PDSA 2: Weekly Ward Reporting

- **Plan**
  - Develop Reporting Tool
  - Long Stay Committee membership
  - Ward process eg. MDT, JBR

- **Do**
  - Educate and inform NUM/AMO’s
  - Implement tool

- **Act**
  - Refine tool
  - Committee restructure
  - Feedback and education on quality of plans

- **Study**
  - Monitored compliance
  - % Management plans supported
  - Ward Discharge and reporting rates
<table>
<thead>
<tr>
<th>HLOS</th>
<th>Ward Code</th>
<th>WLOS</th>
<th>Surname</th>
<th>First Name</th>
<th>Medical Officer</th>
<th>Specialty</th>
<th>EDD</th>
<th>Age</th>
<th>Admission Reason</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>95</td>
<td>3BCB</td>
<td>39</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 1</td>
<td>Surgery-general</td>
<td>06/02/2015</td>
<td>68 yrs</td>
<td>Falls</td>
<td>Complicated by congestive cardiac failure. Aim to discharge by 30/1/15</td>
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<tr>
<td>95</td>
<td>CB4B</td>
<td>73</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 2</td>
<td>Vascular Surgery</td>
<td>06/02/2015</td>
<td>80 yrs</td>
<td>Stumo Debridement</td>
<td>Patient for discharge to N/Home 28/1/15</td>
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<tr>
<td>91</td>
<td>CB5D</td>
<td>62</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 3</td>
<td>Surgery-general</td>
<td>20/02/2015</td>
<td>46 yrs</td>
<td>Trauma - multiple injuries</td>
<td>Awaiting Guardianship Hearing Date.</td>
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<tr>
<td>87</td>
<td>CB4D</td>
<td>67</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 4</td>
<td>Renal</td>
<td>06/02/2015</td>
<td>88 yrs</td>
<td>Pain, abdominal</td>
<td>Awaiting Chest Bx results. Repeat MRU next week.</td>
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<tr>
<td>82</td>
<td>4ANS</td>
<td>48</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 5</td>
<td>Neurology</td>
<td>30/01/2015</td>
<td>47 yrs</td>
<td>Care - patient review</td>
<td>Patient discharged 27/1/15</td>
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<tr>
<td>78</td>
<td>CB4B</td>
<td>77</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 6</td>
<td>Vascular Surgery</td>
<td>26/01/2015</td>
<td>64 yrs</td>
<td>ISCHAIEMIC TOE</td>
<td>Ongoing Sepsis. Investigations continue for Erdheim Chester Syndrome</td>
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<tr>
<td>77</td>
<td>CB5F</td>
<td>61</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 8</td>
<td>Neurosurgery</td>
<td>13/02/2015</td>
<td>35 yrs</td>
<td>Injury - head</td>
<td>Under Mental Health Act. Requires ongoing care. Allied health review. IVAB's</td>
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<tr>
<td>61</td>
<td>CB5B</td>
<td>40</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 10</td>
<td>Geriatric Medicine</td>
<td>29/01/2015</td>
<td>90 yrs</td>
<td>Falls</td>
<td>Developed R) sided weakness + septic screening</td>
</tr>
<tr>
<td>60</td>
<td>CB4B</td>
<td>60</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 11</td>
<td>Vascular Surgery</td>
<td>27/01/2015</td>
<td>89 yrs</td>
<td>Necrotic Toes</td>
<td>Awaiting housing</td>
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<tr>
<td>31</td>
<td>CB4E ComMed</td>
<td>26</td>
<td>Brown</td>
<td>Colour</td>
<td>Doctor 12</td>
<td>Radiation Oncology</td>
<td>22/01/2015</td>
<td>68 yrs</td>
<td>Unwell</td>
<td>await cranioplasty TBA with Dr 12</td>
</tr>
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Results

- 70% decrease in LOS >100 days patients (14 to 4)
- 29% decrease in LOS >30 days patients (70 to 50)
- 82% management plans supported (up from 28%)
- Cumulative LOS >30 bed days reduced by 41% from 4328 to 2536 days (Target <3000)
LOS>30 day Patients Cumulative Bed days

PRE  |  POST
-----|-------
4328 | 2536

Cumulative Beddays LOS>30 day Patients

NSW Government
South Western Sydney Local Health District
Results: Targeted Long LOS Case Management

Number of Patients >100 days

- Longest stay: 450 days
- Target: < 8 patients
- Longest stay: 137 days

PDSA 1
Results: Ward Reporting and LOS Committee

PDSA 2

Number of Patients >30 days

Target < 50 patients

Number of Patients >30 days

2015 - Sustaining Improvement

- Strong monitoring - weekly reporting, DMU and Long Stay Committee oversight
- Refined monitoring tool better utilising Patient Flow Portal (PFP) in 2015
- Introduction of targets for long stay patient numbers >14, >28 and >99 days
- Issues log - early identification and escalation of discharge barriers
Sustaining Improvement (cont)

- Increased specialty team led processes with accountability and data transparency
- Incorporating discharge risk stratification plans into ward process (WOHP)
- Ongoing team education and encouragement of early escalation
- Team feedback on care management plans at electronic JBR, MDT meetings
2014/15 Cumulative Beddays (>28/ >30 days*)

Axis Title

Cumulative Long Stay Beddays

2014/15 Cumulative Beddays (>28/ >30 days*)

Q2* Q3* Q4 Q1 Q2 Q3

Axis Title
Liverpool Hospital Length of Stay

YTD comparison 2013-15* Excluding MH

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<tr>
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<tr>
<td>MEAN (days)*</td>
<td>5.80</td>
<td>5.78</td>
<td>5.58</td>
</tr>
<tr>
<td>No. weeks ALOS &gt; 6.0 days (High)</td>
<td>10</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>No. weeks ALOS &lt; 5.4 days (Low)</td>
<td>7</td>
<td>4</td>
<td>9</td>
</tr>
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Weekly ALOS: 1 Jan- 31 July 2013-2015
*Data points sorted highest to lowest; Excludes MH
LOS Committee Issues Log

Build intelligence on discharge barriers, examples include:

- Subacute Rehabilitation Access (Dialysis/MRO’s/Traches)
- Guardianship and ADHC Processes
- Patient / Carer involvement in care plans
- Shared care for Surgical Patients eg. Orthogeriatric models
- Mental Health and Socioeconomic Factors eg housing
- End of life care - futility / community expectation
- Ward Communication – consistent messaging, MO/NUM leave
Practical tips

- **Consistency** - Regular structured review of management plans with team feedback
- **Value teams** - rapidly prioritise issues when escalated and provide coordinated effective response
- **Include multi-disciplinary team** that actively engages staff
- **Co-opt other key providers** as required to troubleshoot complex patient care issues and support care planning
- **Use existing monitoring tools** eg. NSW Patient Flow Portal
- **Identify local issues** eg. early rehabilitation for surgical patients, RACF placement
Summary

- Clinician engagement is critical
- Build credibility and stronger partnerships over time
- Be constructive in problem-solving
- Support, respect and empower ward based team decision making to address discharge barriers
- Promote and focus on ultimate goal - better care and better patient outcomes
- Specialist multidisciplinary teams have responsibility for patient management plans
Questions?

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