

Gettin' them home

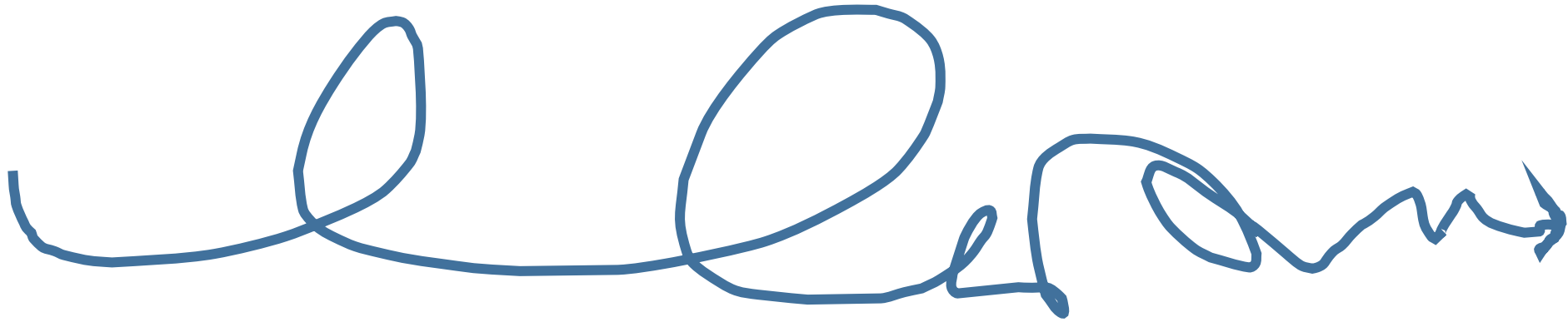
Ellie Borrell (RN)

Jenny Namkoong (RMO)





“DC”



“DC”



“DC”



“DC”



“DC”



“DC”





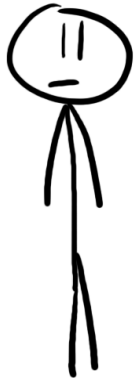
Forever waiting . . .





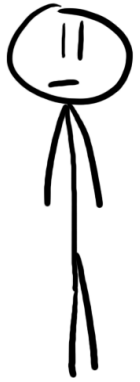
Forever waiting . . .





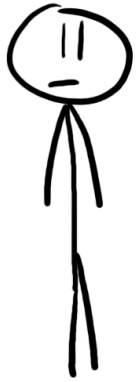
Forever waiting . . .





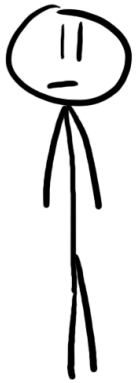
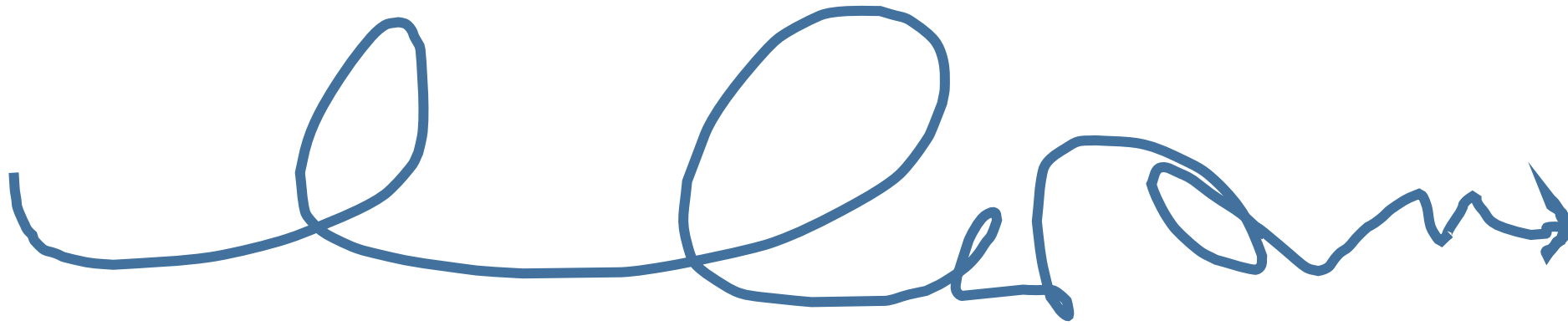
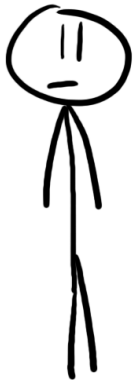
Forever waiting . . .





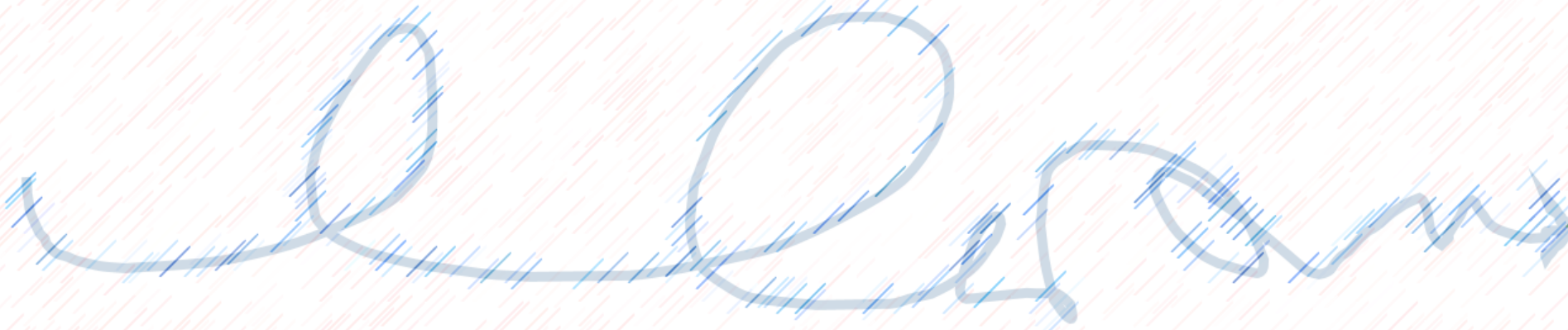
Forever waiting . . .



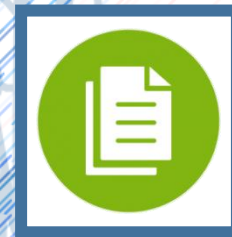
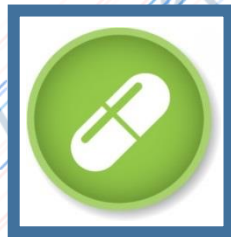


Forever waiting . . .





“DC”



Forever waiting . . .





Part 1: Early Patient Discharge

“DC”

“DC”



ED

“DC”



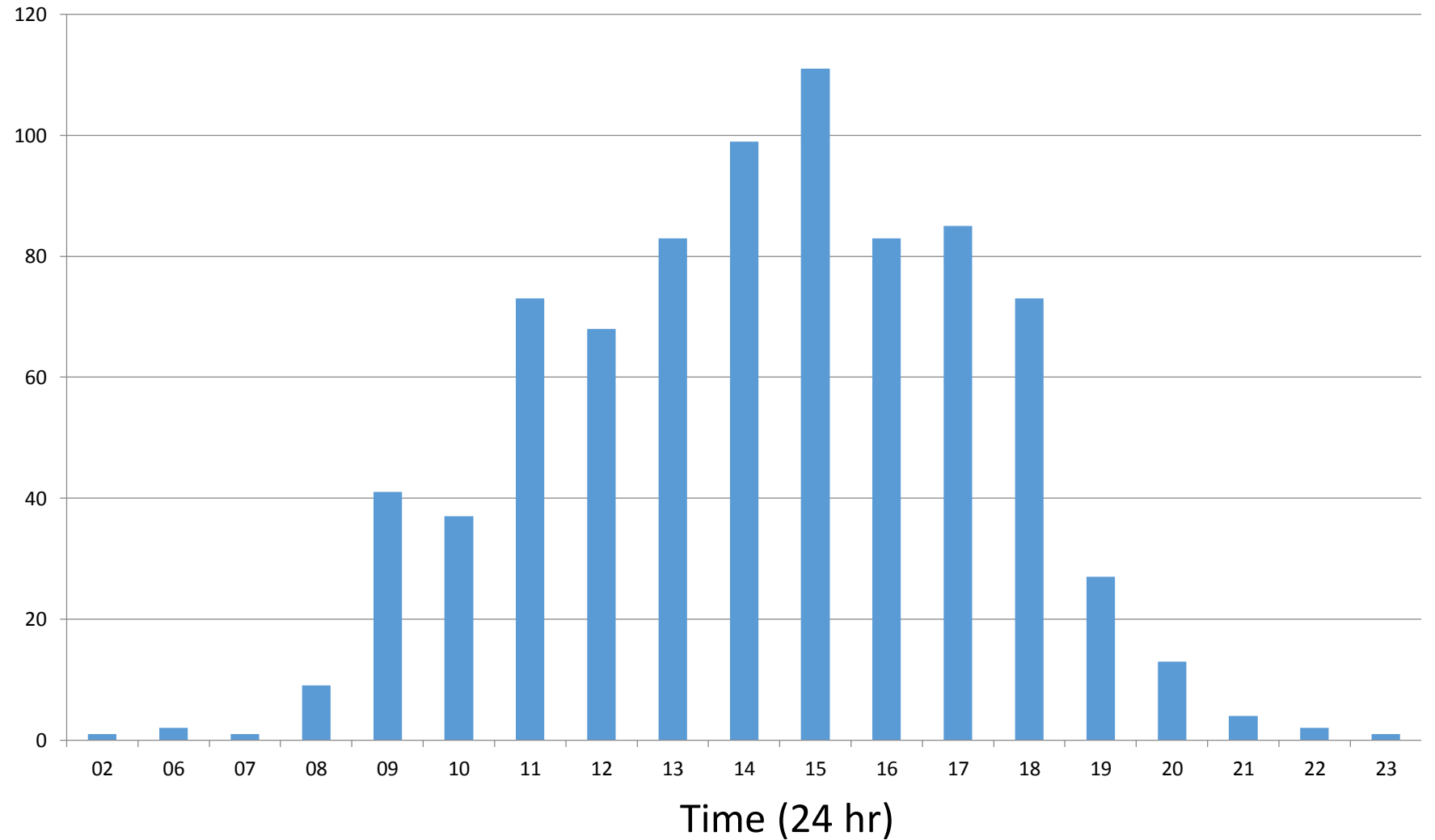
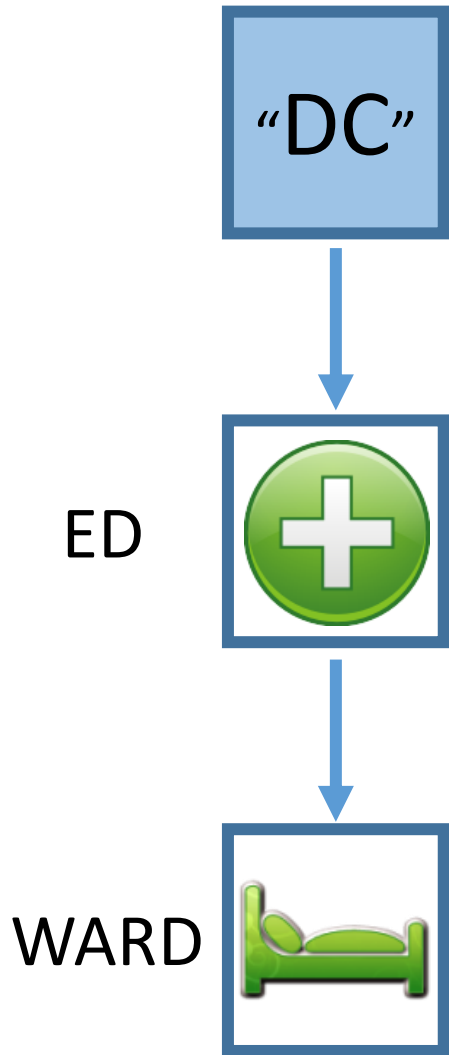
ED

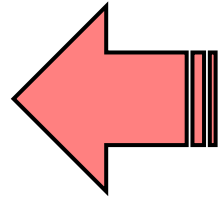


WARD



7B Time of Discharge (28 Dec '15 – 27 June '16)





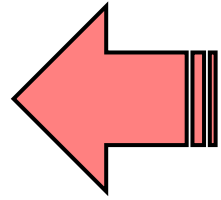
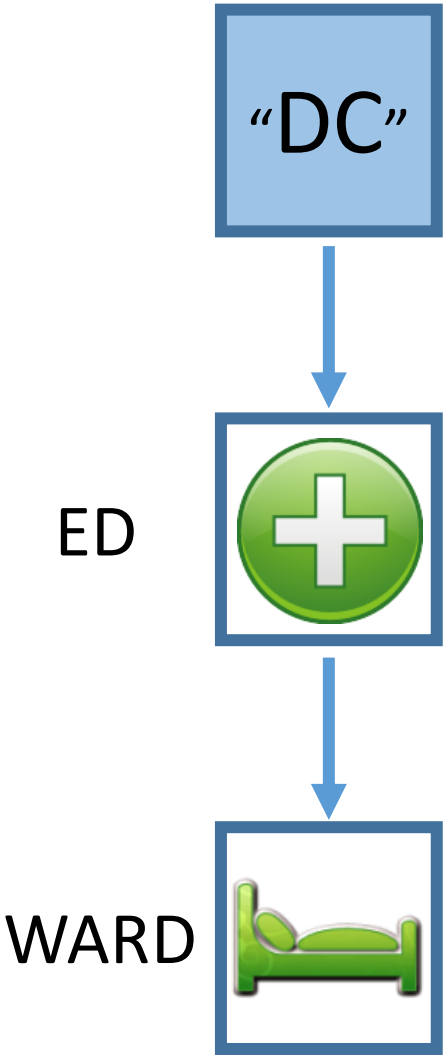
AIM: Early Discharge

ED

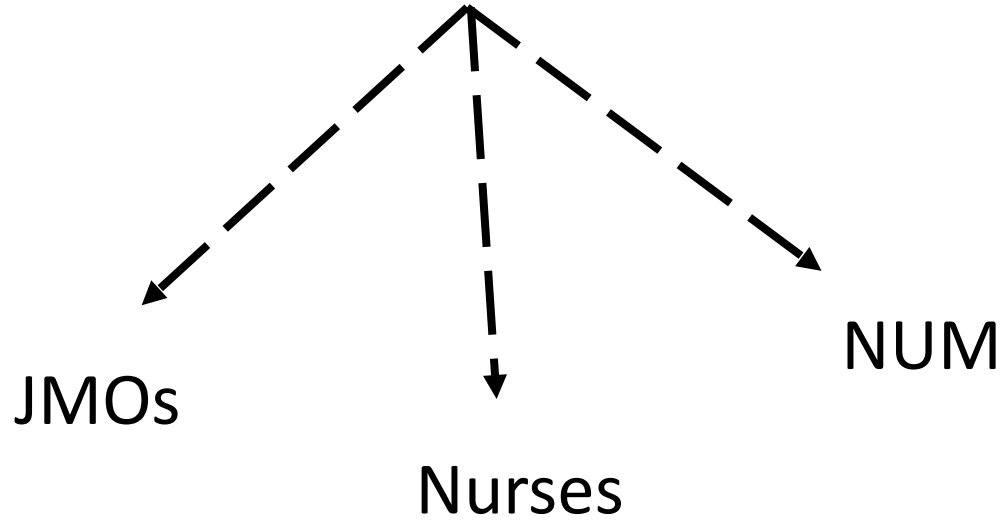


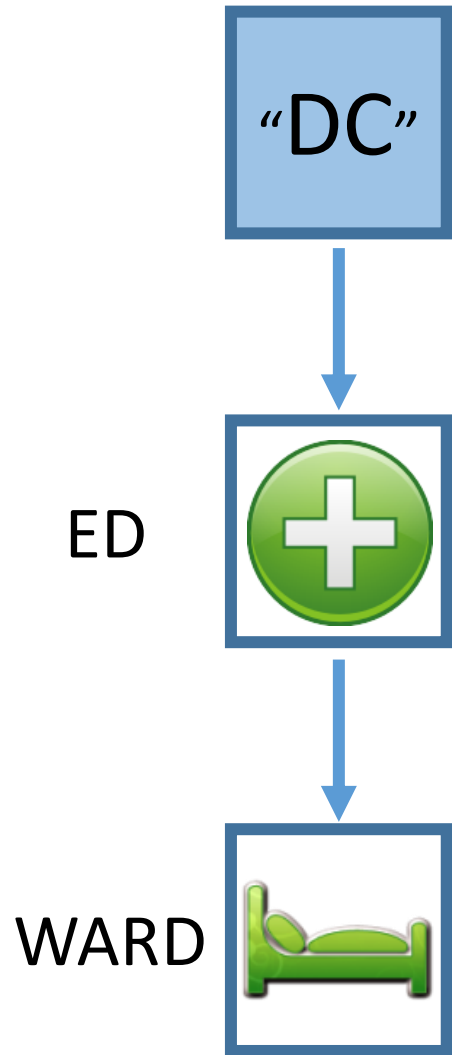
WARD





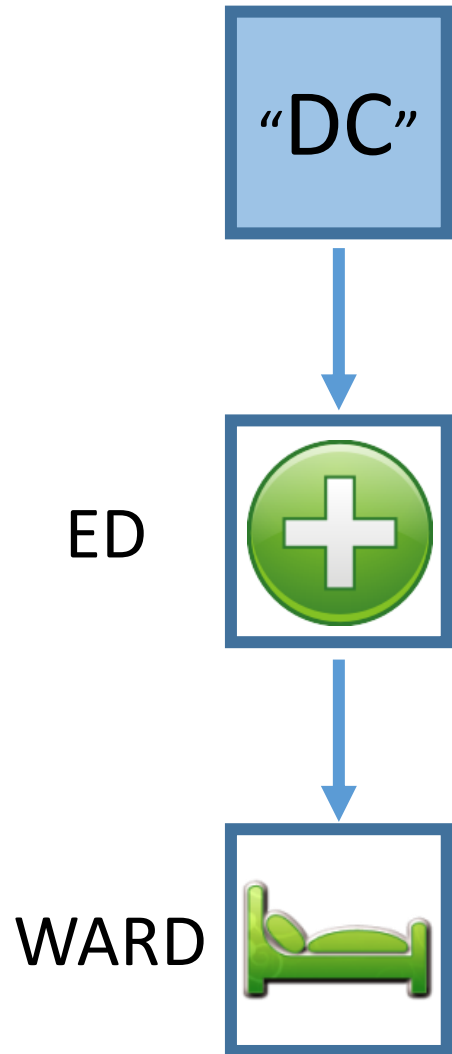
AIM: Early Discharge





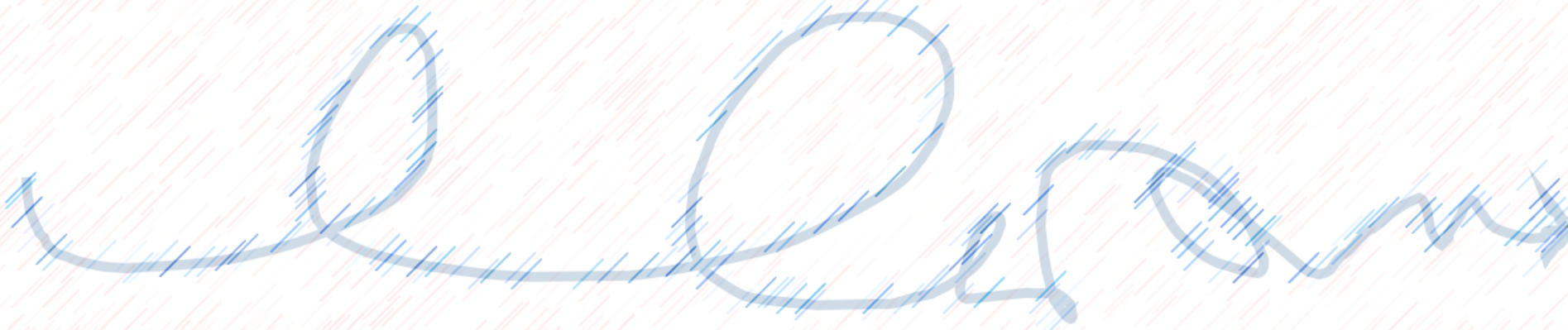
Results

- EDD accuracy: 55% → 90%
- 7B pt: 1.5hrs less in ED
- Discharge time 4 hrs earlier

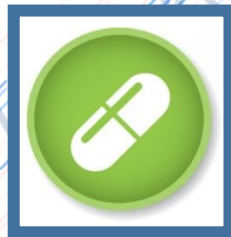


What this project adds

- Current literature: vague
- Adding to the literature
 - Specific times of DC
 - EDD accuracy
 - ❖ Specific pt outcomes measured:
 - Readmissions
 - Complications
 - In ED (long wait)
 - On Ward (late admission)



“DC”



Forever waiting . . .





Part 2: Decreasing Medication Error

Admission
Med List



Admission
Med List



Prescription



Admission
Med List



Prescription



Discharge
Med List



Admission
Med List



Prescription



Discharge
Med List



14%



Admission
Med List



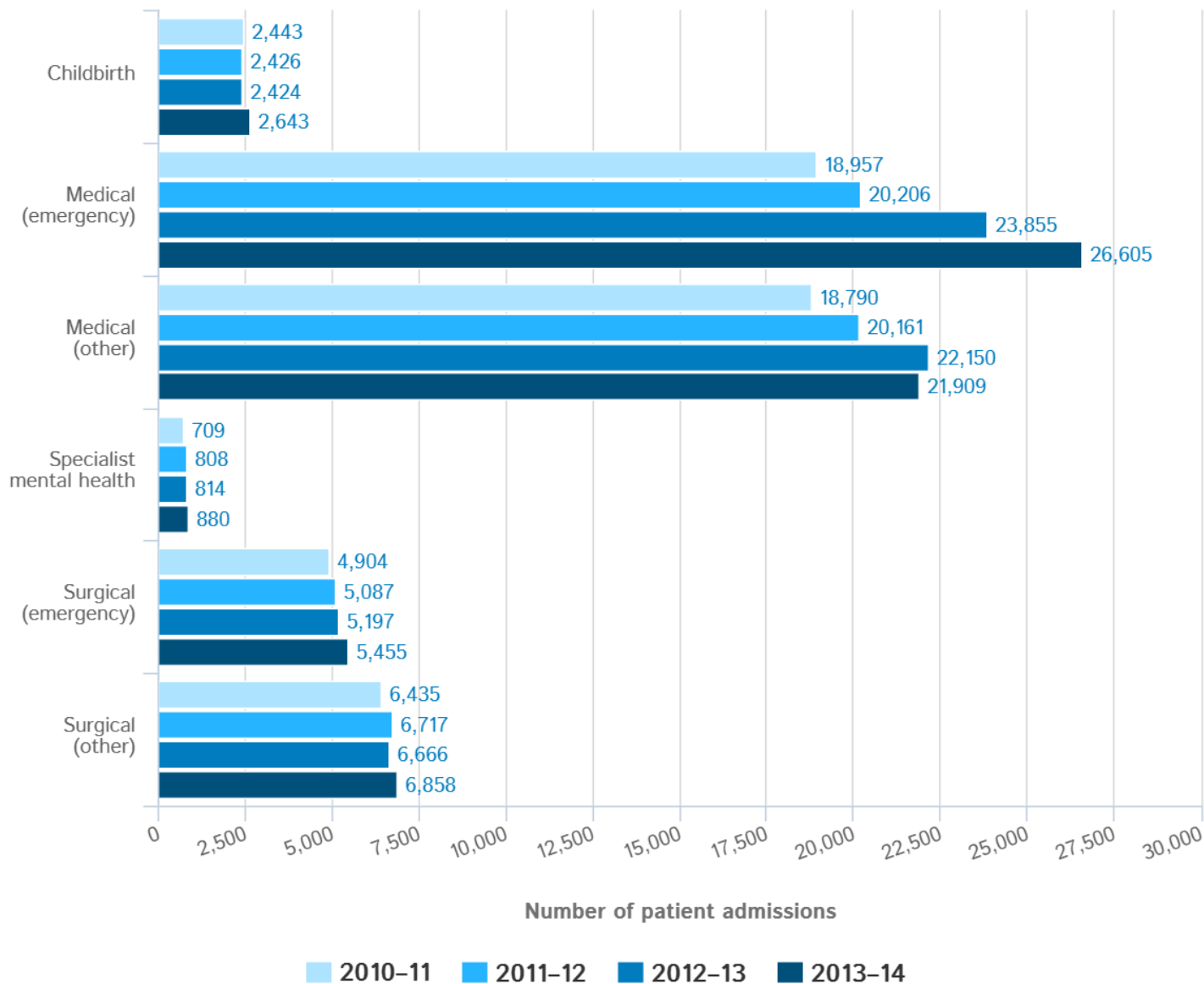
Prescription



Discharge
Med List



Patient admissions to Royal North Shore Hospital, 2010 to 2014



Admission
Med List



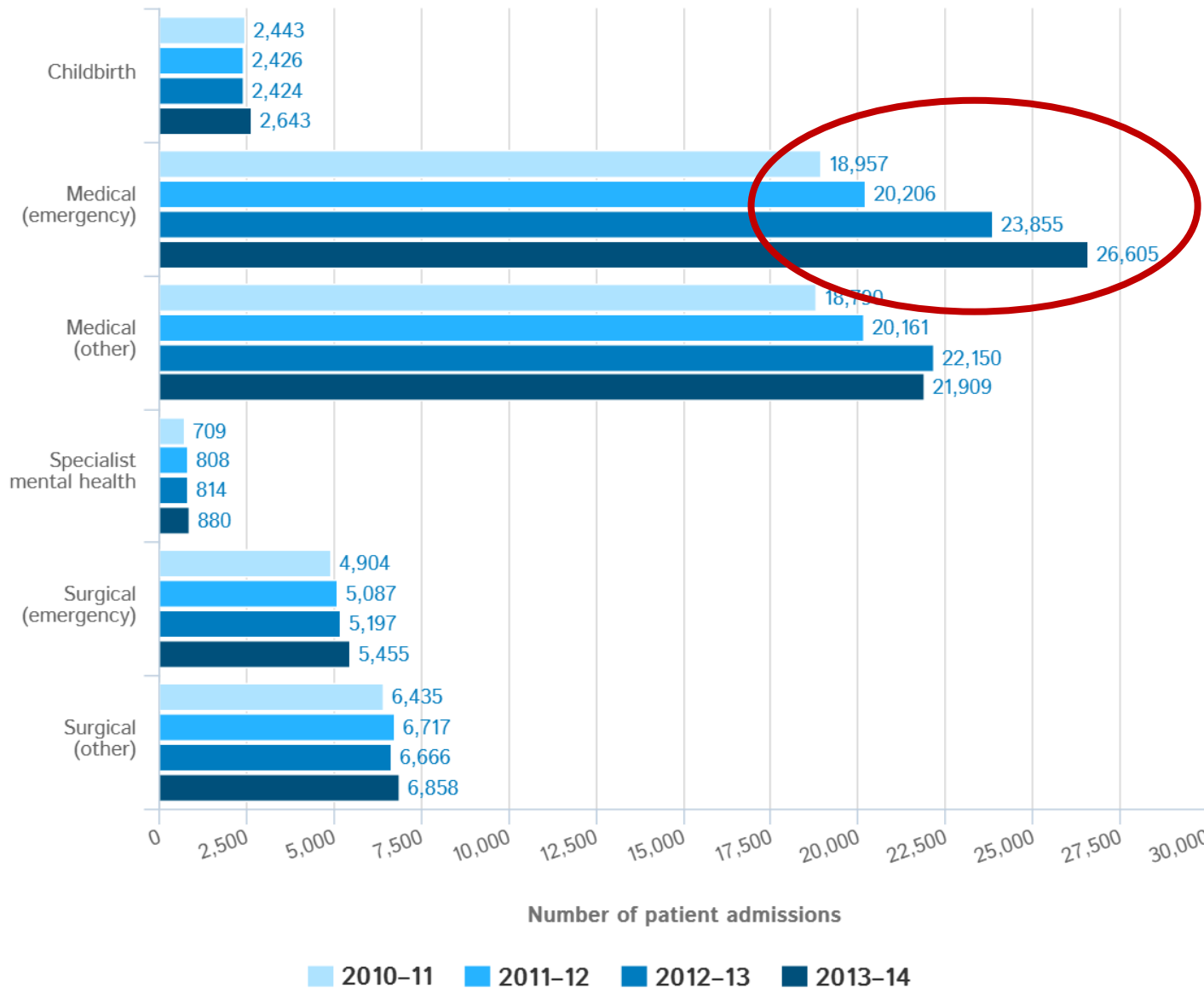
Prescription



Discharge
Med List



Patient admissions to Royal North Shore Hospital, 2010 to 2014



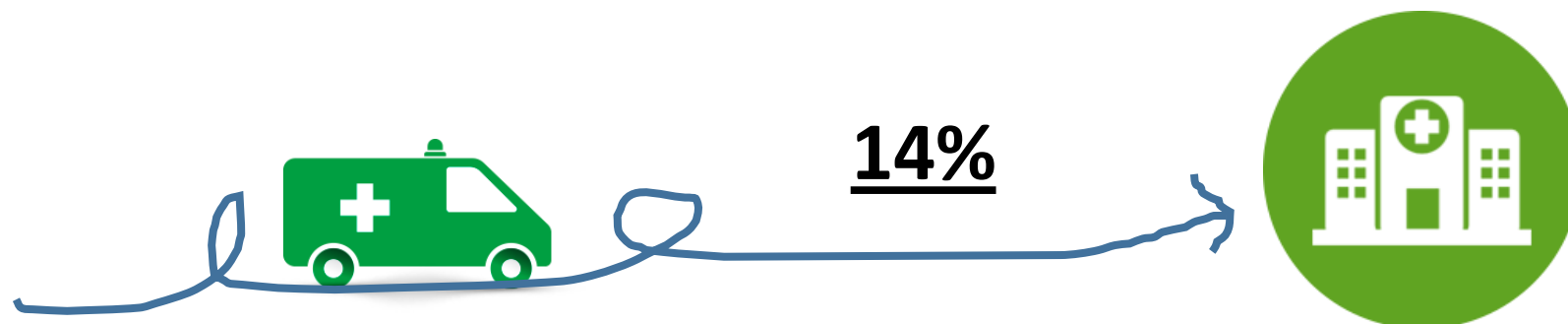
Admission
Med List



Prescription



Discharge
Med List



- Baseline statistics:
 - **60% error (15% significant)**
- Pharmacist Review:
 - 60% increase in accuracy
 - 50% decrease in rehospitalisation

Admission
Med List



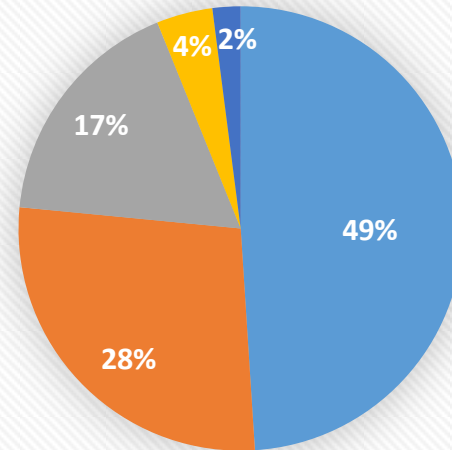
Prescription



Discharge
Med List



Medication Discrepancy Classification



■ Drug omitted
■ Unnecessary drug
■ Drug allergy issue
■ Incorrect dose
■ Highly specialised drug issue

Data from NSW Tertiary Hospital in focus for this project (Levy, 2015)

Drug Incident Severity Assessment Code

Minor errors

1. Insignificant: Incident is likely to have little or no effect on the patient.
2. Minor: Incident is likely to lead to an increase in level of care e.g. review, investigations, or referral to another clinician.

Serious errors

3. Moderate: Incident is likely to lead to permanent reduction in bodily functioning, increased length of stay, surgical intervention.
4. Major: Incident is likely to lead to a major permanent loss of function.
5. Serious: Incident is likely to lead to death.

(Westbrook, Li et al. 2015)

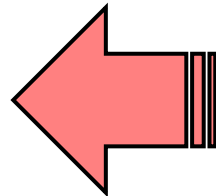
Admission
Med List



Prescription



Discharge
Med List



AIM: Accurate Discharge Med List

Autoalert to GP

Autofax to local pharmacist

Alerts for Do Not Use Abbreviations

Electronic Medication Reconciliation

Alerts for duplicates / odd dosing

Database sharing

Pharmacist counselling for high risk meds/patients

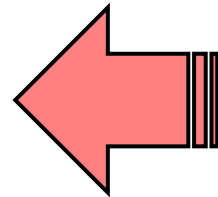
Admission
Med List



Prescription



Discharge
Med List



AIM: Accurate Discharge Med List

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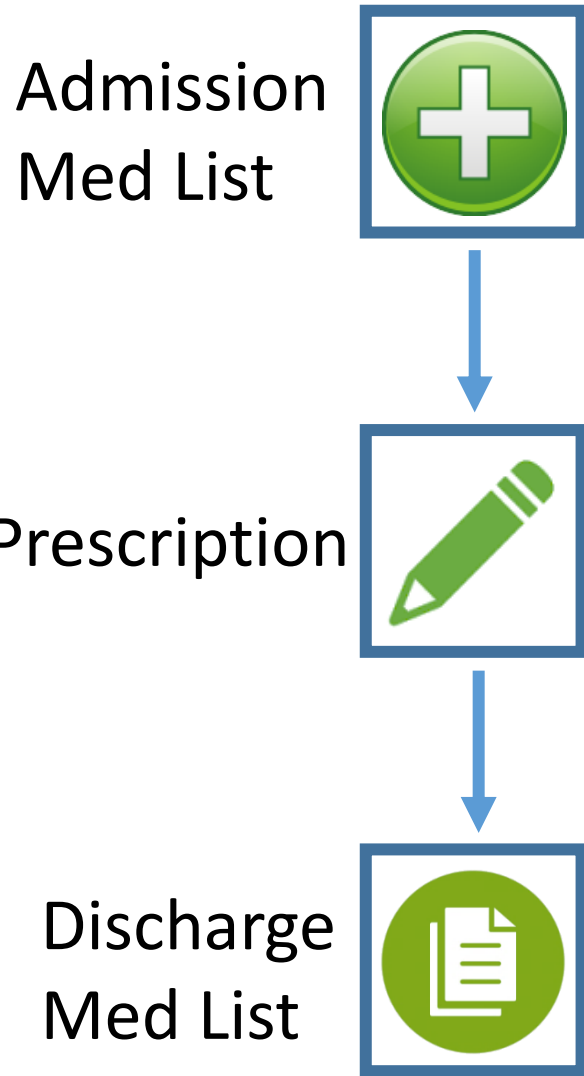
Alerts for Do Not Use Abbreviations

Electronic Medication Reconciliation

Alerts for duplicates / odd dosing

Database sharing

Pharmacist counselling for high risk meds/patients



Results

- Preliminary: “downwards trend”
- Measurements:
 - Accuracy of discharge medications
 - Comparison
 - Real patient outcomes
 - Readmissions
 - Complications

Learnings

- Different focus of staff (JMOs/RNs/Pharmacists)
- Embedded organisational culture
 - “It’s not my role/problem”
 - → Taking ownership (through responsibility)
- Leadership matters
- Grassroots focus



Where to from here

- Solid Evidence
 - 30day Readmission Rates
 - Late Discharge
 - Medication Error





"DC"

