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

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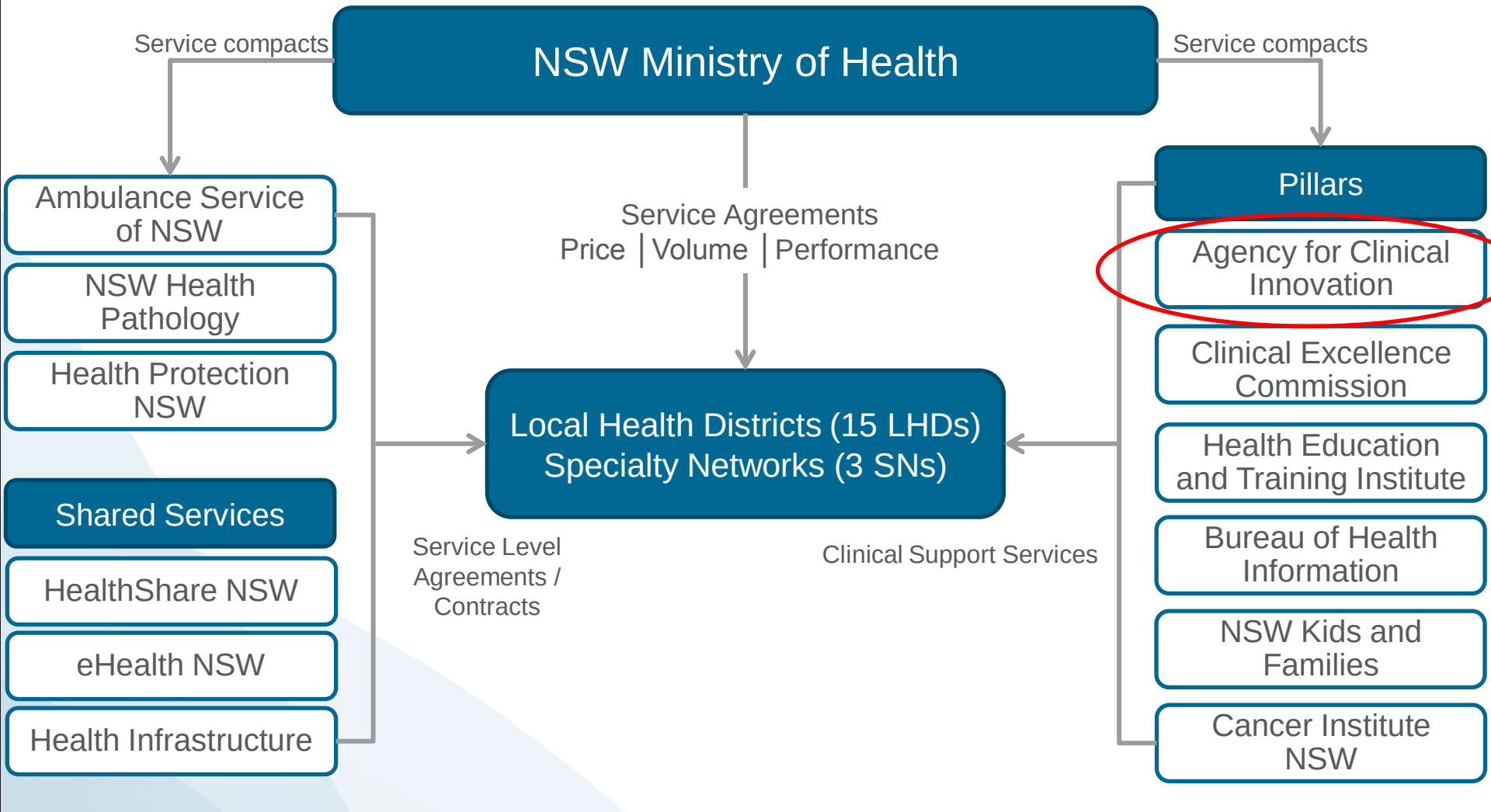
The ACI works closely with the NSW Ministry of Health, LHDs, other Pillars, Medicare Locals, Aboriginal Medical Services and other partners



The roles of the Clinical Excellence Commission and the Agency for Clinical Innovation provide many opportunities for collaboration

PILLARS OF NSW HEALTH

Health Education and Training Institute

NSW Kids and Families

Cancer Institute NSW

Bureau of Health Information

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

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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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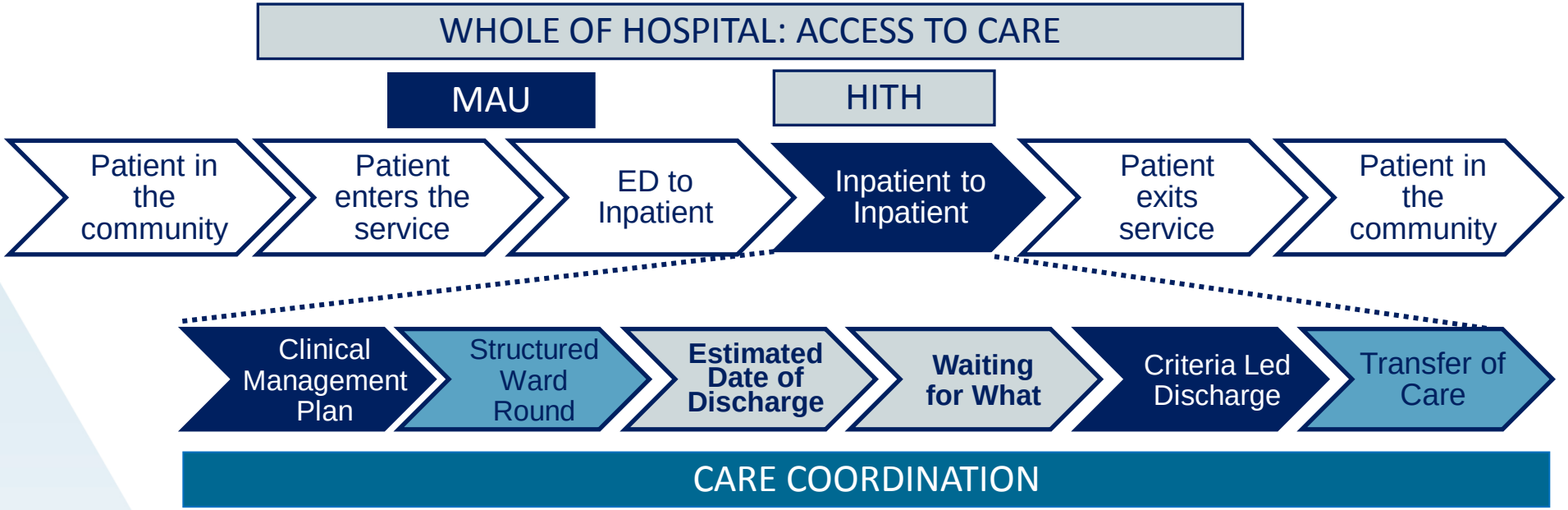
Improving the Medical Inpatient Journey



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

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

George Bernard Shaw

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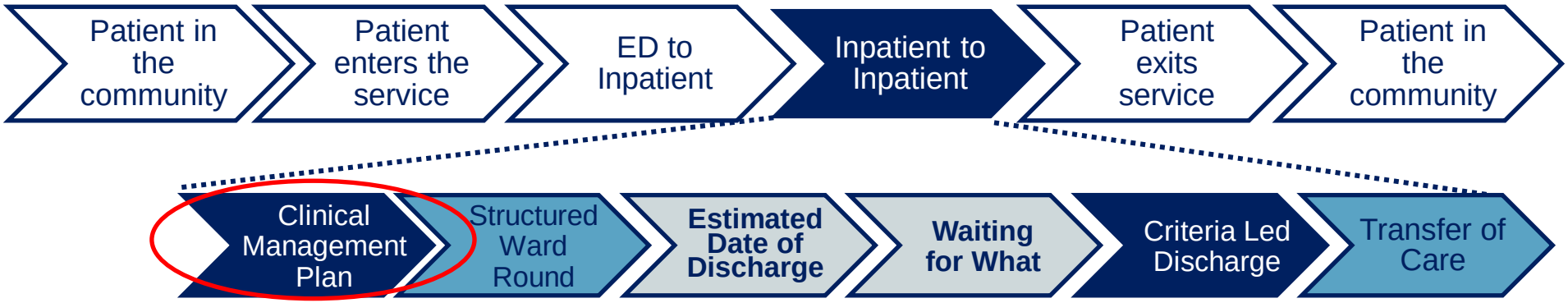
CLINICAL EXCELLENCE COMMISSION



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

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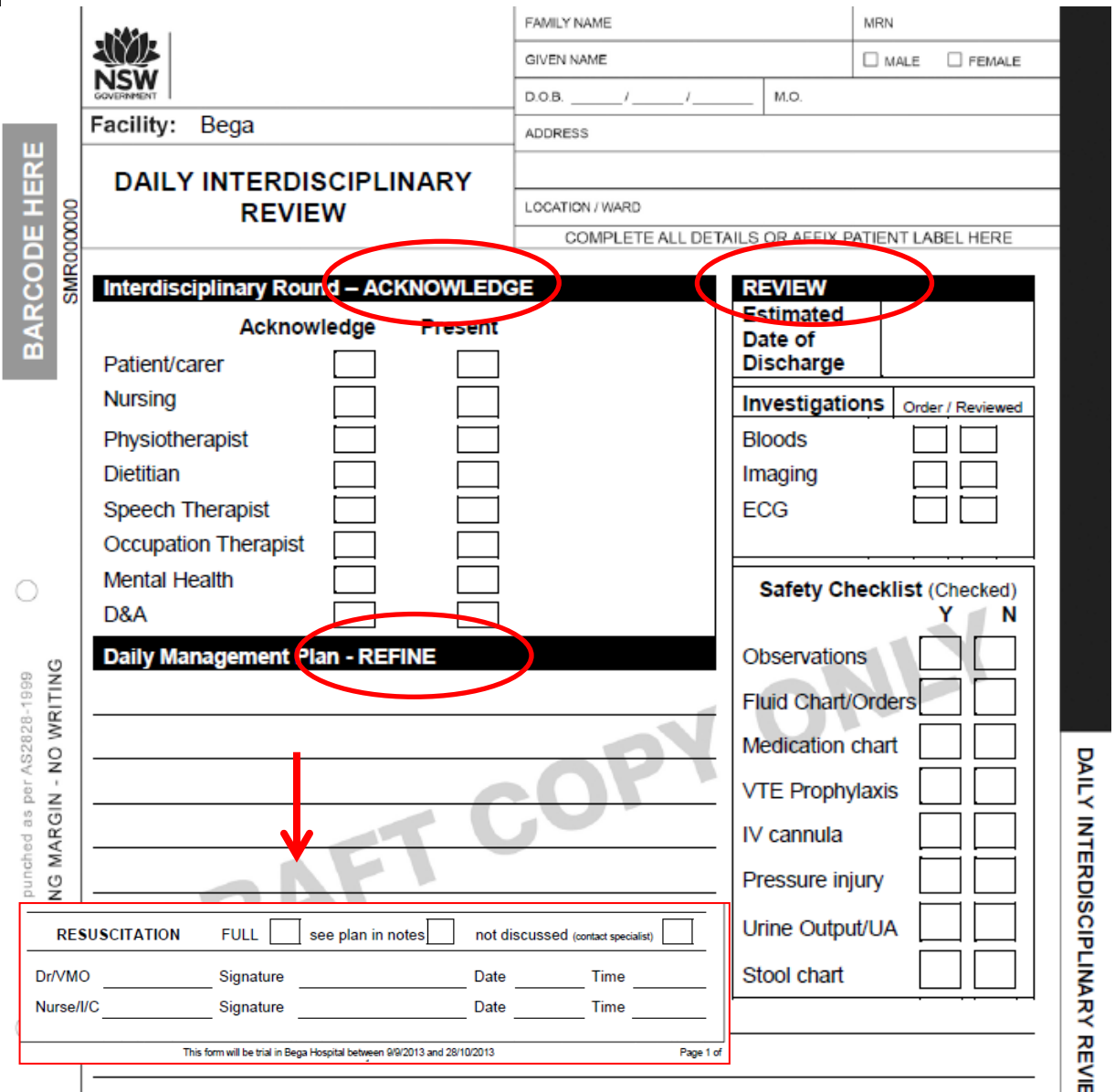
Documentation - Daily



- **A**cknowledge
- **R**eview
- **R**efine
- Plus **Progress Notes** for interdisciplinary documentation

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Documentation - Problems

NSW GOVERNMENT

Facility:

PROBLEM MANAGEMENT SHEET

GIVEN NAME ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DATE: _____

PRESENTING SYMPTOMS _____

PROVISIONAL DIAGNOSIS _____

Date	Problem/Diagnosis	Special Instructions/Investigation	Outcome	Initial

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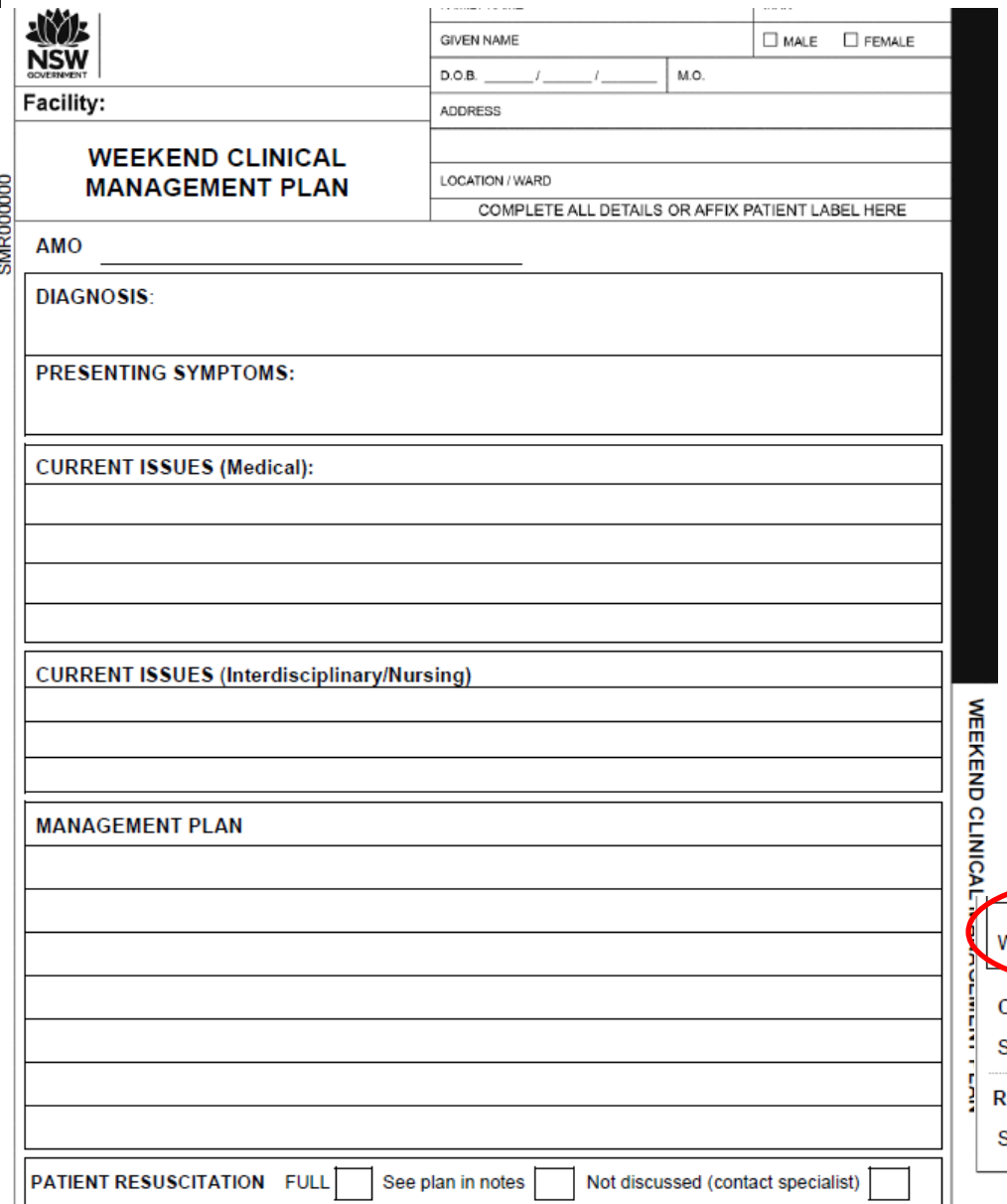
Documentation - Weekend

- Weekend handover
- **A**cknowledge
- **R**eview
- **R**efine



NSW GOVERNMENT

Facility:

WEEKEND CLINICAL MANAGEMENT PLAN

GIVEN NAME ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR000000

AMO _____

DIAGNOSIS:

PRESENTING SYMPTOMS:

CURRENT ISSUES (Medical):

CURRENT ISSUES (Interdisciplinary/Nursing)

MANAGEMENT PLAN

PATIENT RESUSCITATION FULL ☐ See plan in notes ☐ Not discussed (contact specialist) ☐

WEEKEND CLINICAL MANAGEMENT PLAN

WEEKEND CONTACT: _____ Mobile: _____

Completed by (Name) _____ Designation _____

Signature _____ Date _____ Time _____

Read/Acknowledged (Name) _____ Designation _____

Signature _____ Date _____ Time _____

This form is being tested in Bega Medical Ward between 09/09/2013 and 29/10/2013

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

George Bernard Shaw

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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

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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

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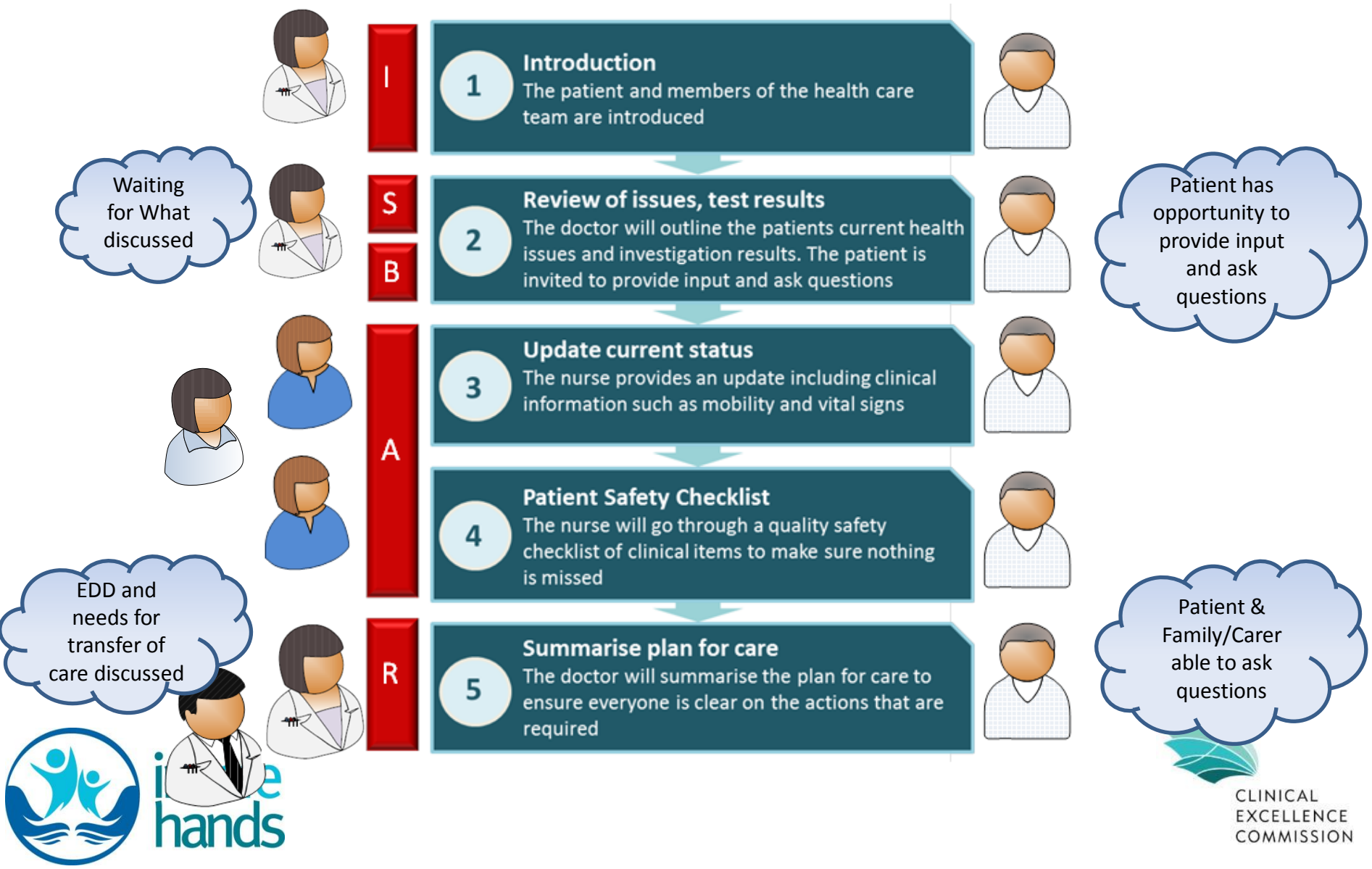
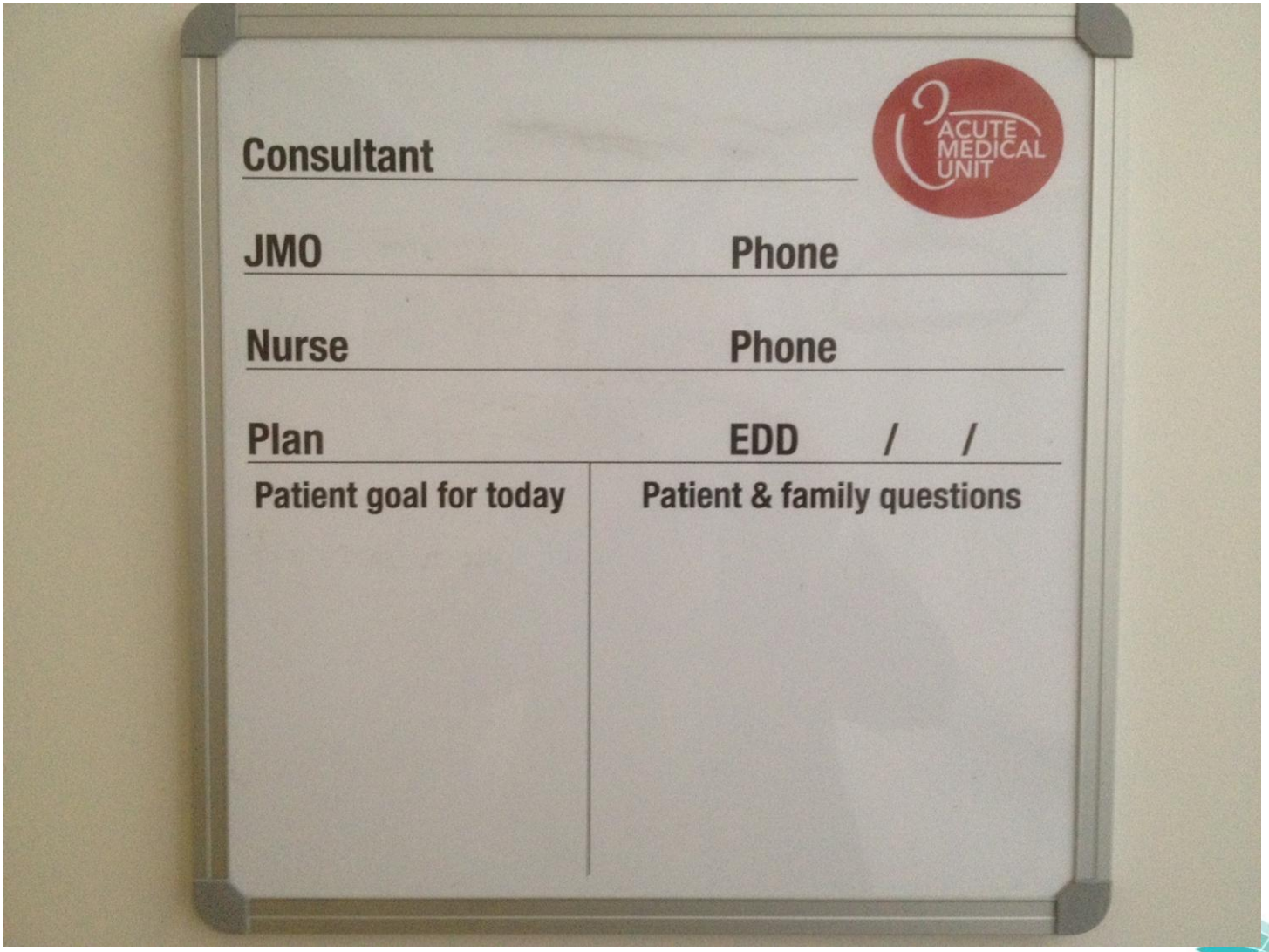
Round Communication Structure





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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

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CLINICAL EXCELLENCE COMMISSION

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**

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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!)*

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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

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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

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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

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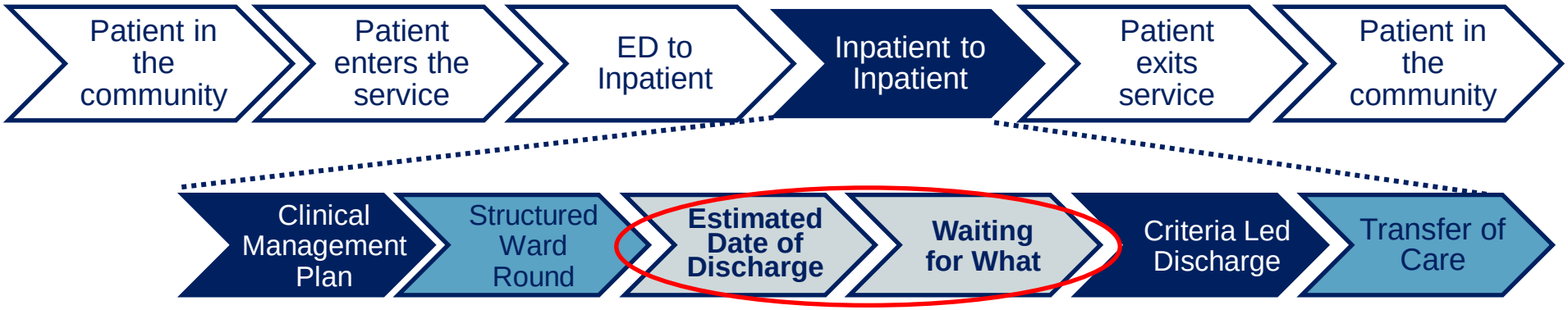
CLINICAL EXCELLENCE COMMISSION



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

1. Patient Flow Portal (http://www.health.nsw.gov.au/pfs)
2. HETI module in development

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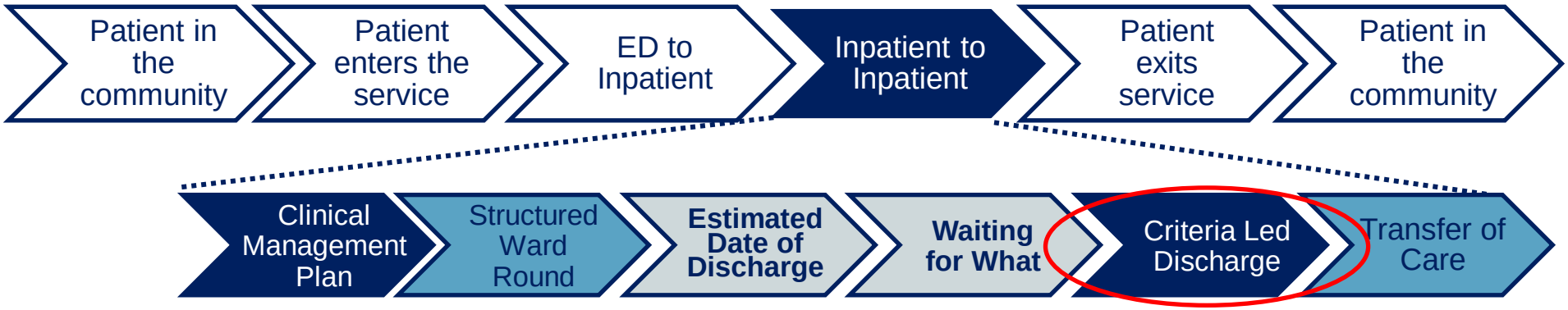

Optimal time for discharge:

- 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

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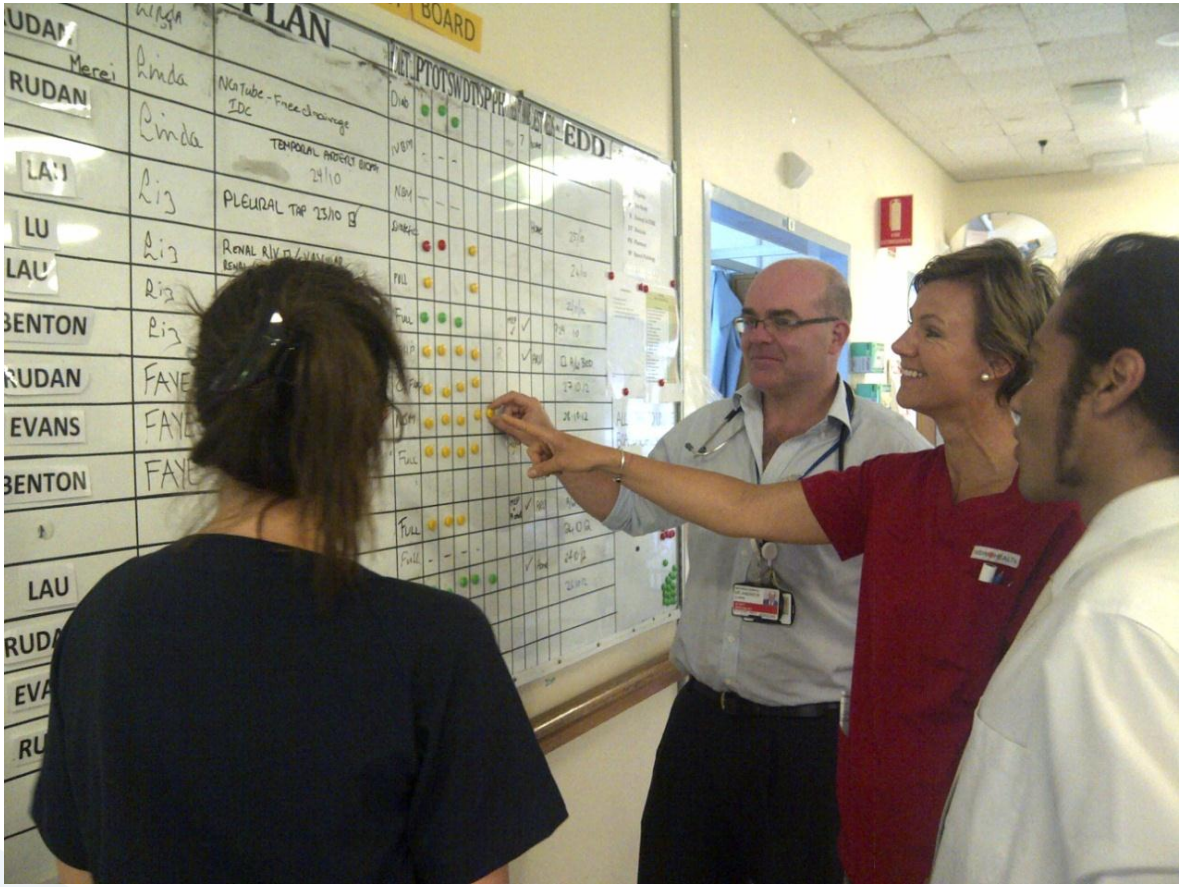
Rapid Round / Patient Journey Board



Source Manly Hospital:
Sue Hair: Director of Nursing and Midwifery, Manly Hospital
Deb Stewart Manger Clinical Redesign, Northern Beaches and Hornsby Ku-ring-gai Health Services

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Source: Sue Hair: Director of Nursing and Midwifery, Manly Hospital and Deb Stewart Manger 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:_____

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CLD Form – PART B

PART B: Specific patient interdisciplinary team (IDT) discharge criteria (to be completed by IDT)

IDT agreed specific milestones	Name	Designation	Contact
1.			
2.			
3.			
4.			
5.			

Responsible person:_____

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CLD Form – PART C

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

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:_____

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In collaboration with

gp General Practice NSW

Safe Clinical Handover

A resource for transferring care from General Practice to Hospitals and Hospitals to General Practice

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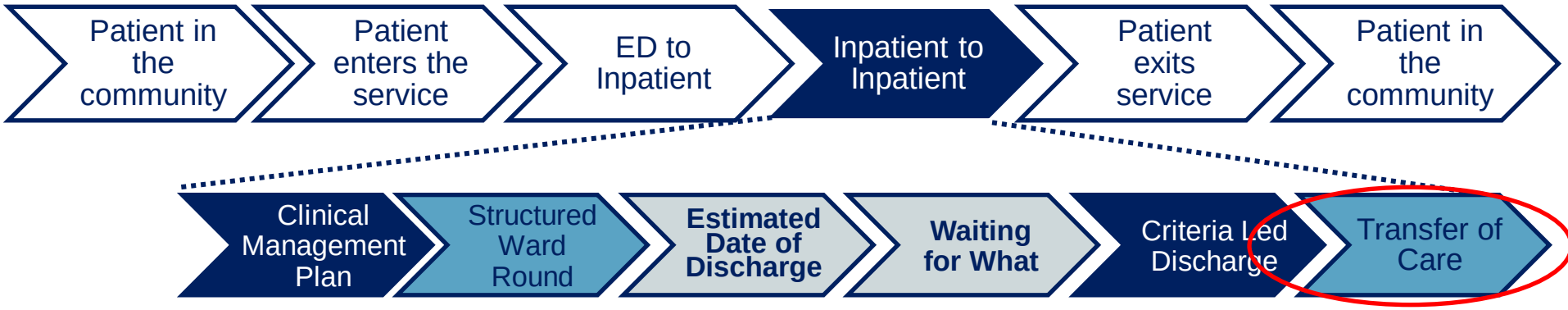

1. The patient, their family and carer is involved.
2. Clear, succinct communication.
3. Medication reconciliation should occur at every transition of care.
4. A patient, their family and carer must leave the hospital with their discharge communications.
5. Infrastructure to enable GPs to have access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

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Questions & Contacts

Contact me for Clinical Management Plans/ Criteria Led Discharge
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W: http://www.aci.health.nsw.gov.au/networks/acute-care-taskforce

Whole of Hospital Program
NSW Ministry of Health, System Relationships and Framework Branch
Luke Worth, Director | Systems Relationship Branch C
T 02 9391 9538 **|** E: LWORT@doh.health.nsw.gov.au | W: http://www.health.nsw.gov.au/wohp/Pages/default.aspx

Patient Flow Portal
NSW Ministry of Health
T: 02 9424 5924 | E: patientflow@moh.health.nsw.gov.au
W: http://www.health.nsw.gov.au/pfs/Pages/pfp.aspx

Patient Flow (Education)
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Rhonda Loftus, Whole of Hospital Program Lead (HETI)
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In Safe Hands (Ward Rounds)
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W: http://www.cec.health.nsw.gov.au/programs/in-safe-hands

Transfer of Care
Clinical Excellence Commission
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T: 9269 5578 E: Tracy.Clarke@cec.health.nsw.gov.au
W: http://www.archi.net.au/resources/safety/clinical/nsw-handover

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