More of we, less of me?

Suzi Sharam- Dries
WoHP Lead
Dubbo Health Service - Dubbo Hospital

Introducing Suzie

Our Health District
Living Well Together

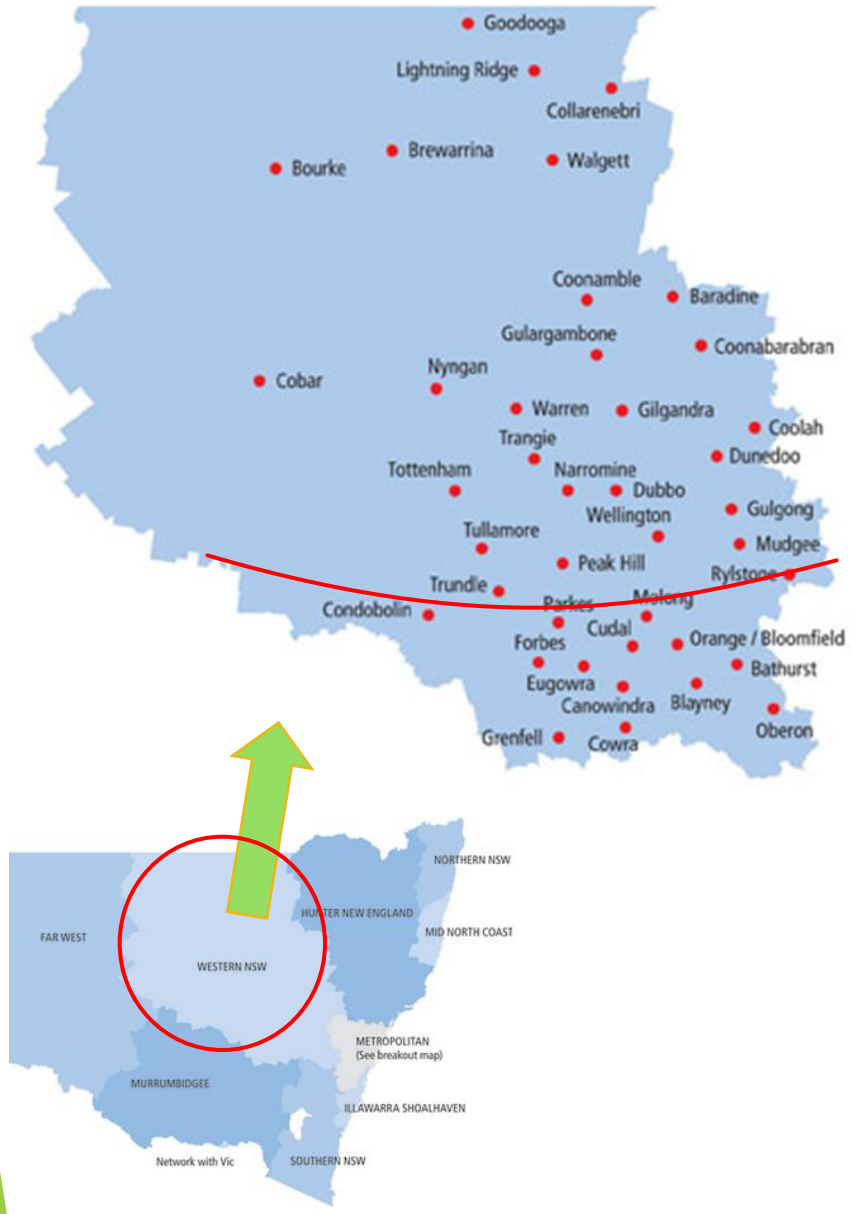
Dubbo Health Service

We are just across the other side of the blue mountains.

- It is the largest population centre in the Orana region, with a population of 42,108, and serves an estimated catchment of 130,000
- Dubbo has a large tourist market attracting over 400,000 visitors a year, many of whom are attracted to the world famous Taronga Western Plains Zoo. It is a major service centre for commercial, professional, medical, educational, retail, finance and agribusiness services for a huge area of inland NSW.
- It is located at the intersection of the Mitchell, Newell and Golden highways and is a major road and rail freight hub to other parts of New South Wales. It is linked by national highways north to Brisbane, south to Melbourne, east to Sydney and Newcastle, and west to Broken Hill and Adelaide.
- Trauma - farming, mining, industry, rail and road.

We live and work on Aboriginal Land and acknowledge the traditional owners of the land covering Western NSW Local Health District.

Servicing and Supporting 24 Facilities



Baradine Multi Purpose Service
Bourke Multi Purpose Service
Canowindra Soldiers Memorial Hospital
Cobar Health Service
Collarenebri Multi Purpose Service
Coonabarabran Health Service
Coonamble Multi Purpose Service
Dunedoo Multi Purpose Service
Gilgandra Multi Purpose Service
Goodooga Health Service
Gulargambone Multi Purpose Service
Gulgong Multi Purpose Service
Lightning Ridge Multi Purpose Service
Mudgee Health Service
Narromine Health Service
Nyngan Health Service
Peak Hill Health Service
Tottenham Multi Purpose Service
Trangie Multi Purpose Service
Trundle Multi Purpose Service
Tullamore Multi Purpose Service
Walgett Multi Purpose Service
Warren Multi Purpose Service
Wellington Health Service

We live and work on Aboriginal Land and acknowledge the traditional owners of the land covering Western NSW Local Health District.

What we wanted to Achieve

Goal: We wanted to develop key solutions to address the root cause of issues identified during diagnostic activities that would enable DHS to reach NEAT performance of 75% by 31 May 2014 and 83% by December 2014.

Plan: To improve the safety, quality and efficiency of patient care across the Emergency Department and ED accessible inpatient units including S Block, G Ward, ICU and Theatre.
To improve patient flow and access in the Emergency Department so that health service performance improves against access key performance indicators.

Our Message: We wanted our facility to be safer place for our Patients to come to, more efficient, with better use of our current resources and improve the outcomes for our patients and across the community

Our Health District
Living Well Together

How it was at DUBBO HEALTH SERVICE

Our Health District
Living Well Together

Dubbo Health Service Emergency Department Performance and Activity Indicators.

NEAT	Total	Admitted	Non-Admitted
Target	71.0%	50.0%	82.0%
Mar-13	54.40%	22.70%	65.80%
	2428	639	1789
Oct-13	59.00%	21.80%	70.10%
	2384	547	1837

Suzie was worried – can we fix this …….together

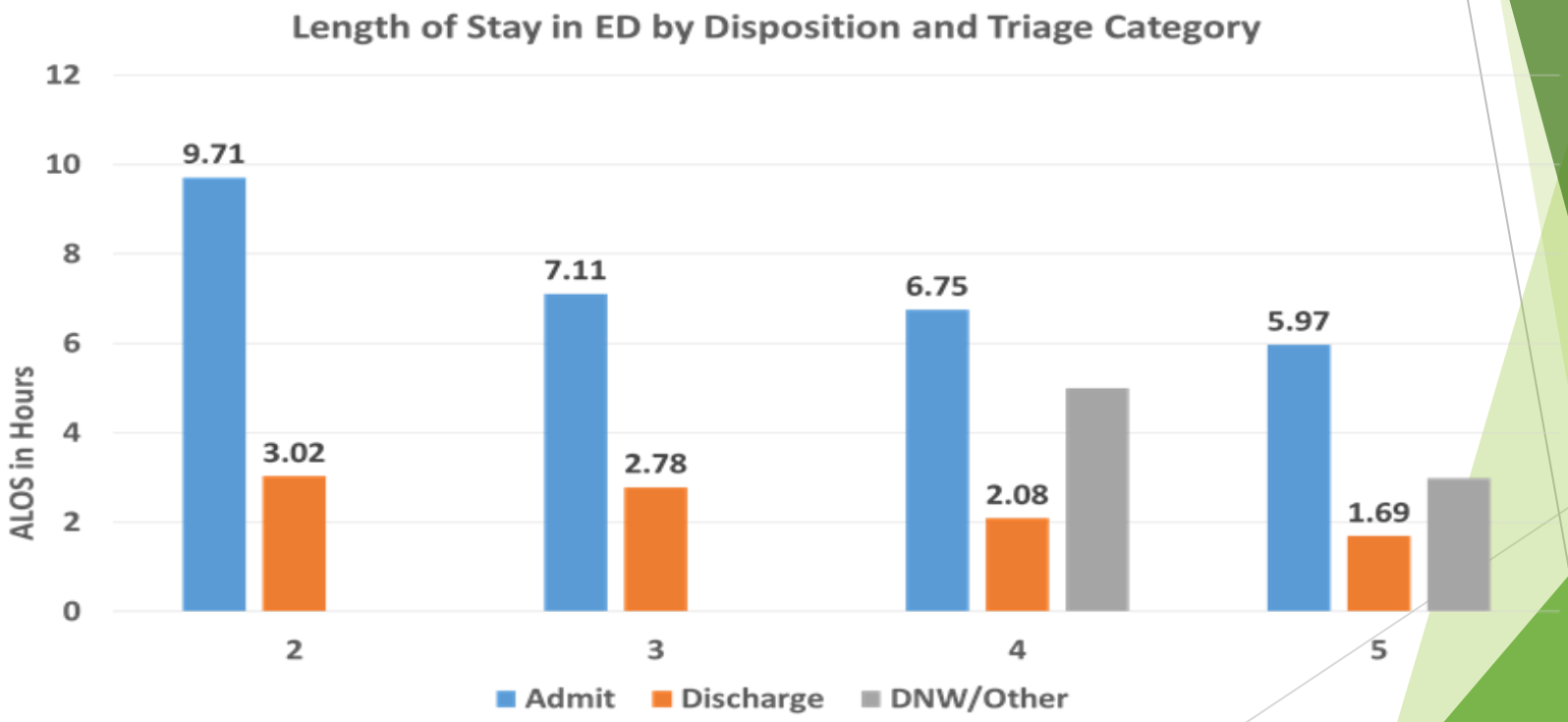
What did we do?

- Visited other sites, no need to reinvent the wheel – bend it a little to make it fit DHS.
  - Thank you Hornsby and RNSH
- We used the MOH WoHP WAISH and WOTTL studies.
  - Staff from our Executive Team were our observers and enabled them to have first hand experience of the barriers and culture that affected the flow of patients through DHS
  - There weren't too many surprises, but validation and evidence were a helpful in reinforcing the message that change was needed.
  - The message was Right care Right place Right time
- Listened to the MOH and our subject matter expert Louise Kershaw

Lets Analyse, evaluate and Plan

Analysed the results and brainstormed possible solutions and projects that we could introduce to drive change.

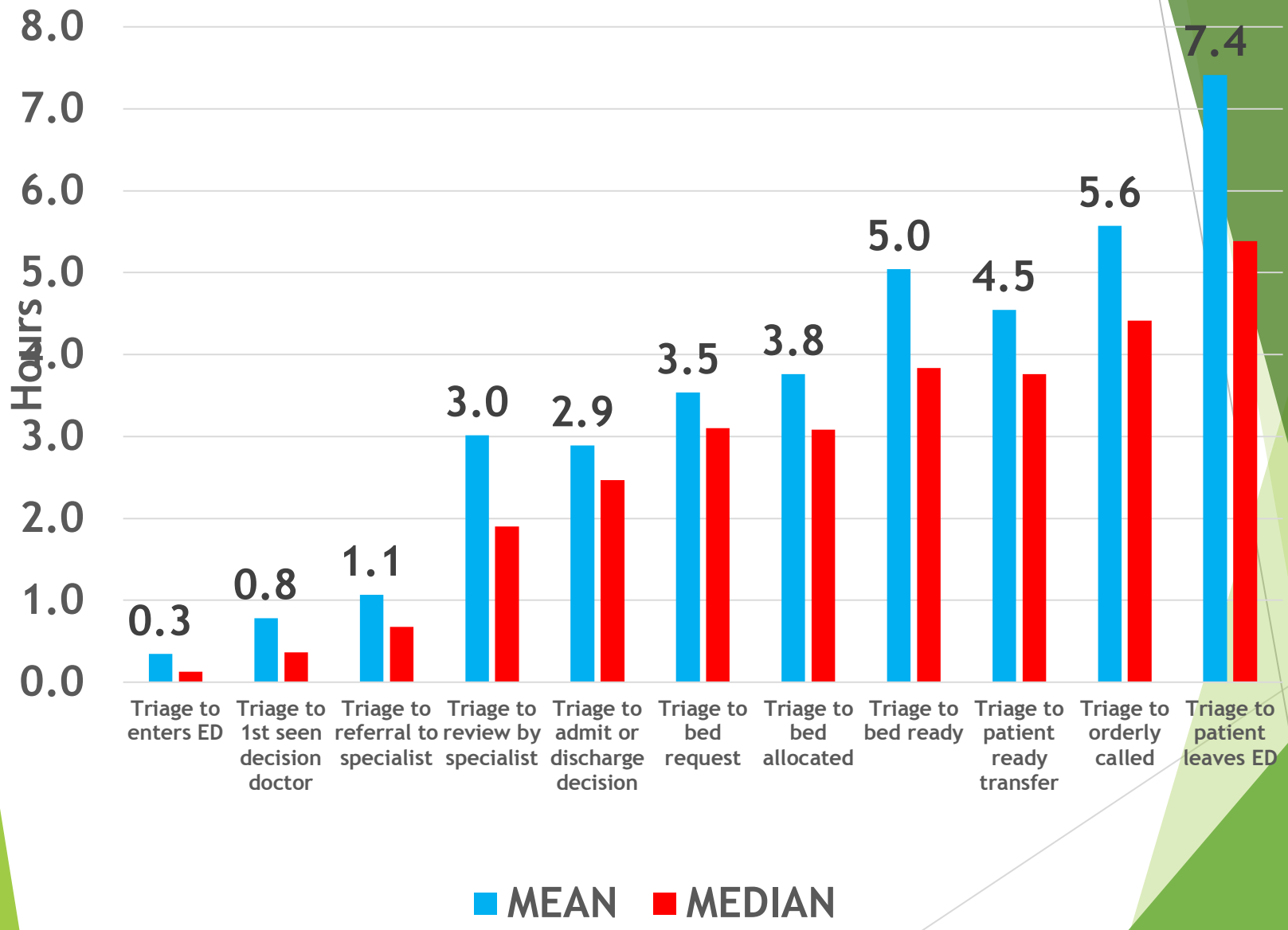
- 82% of patients presenting during the study period were followed in the ED Timeline study



The study Highlighted:

- FirstNet entries were inconsistent in providing information concerning correct times
- Doctors assigning themselves, or not assigning themselves
- Triage was being delayed by having the MO in the same room
- What the clock watched to meet the KPI's - we were doing it, however not recording it correctly.
- The wards had no information as to what our ED activity was indicating and how to interpret this
- What the relationship was between ED admissions, transfer times and available ward beds.
- We weren't looking at capacity and would never have thought that our admissions were predictable

Admitted patient timeline



Qualitative observations

- High volumes of patients coming through triage and RAT early with very little going through to ED acute area – nothing going on in main are and JMOs in acute area underutilised
- Having triage and RAT together in same room delays the triage nurse. Up to 18 minutes delay on Sunday morning to start triage – RAT doctor takes longer to exam patient and order tests than it does to Triage. However good points of the current system is that patient only tells their story once to Tirage and RAT at the same time.
- Little sense of urgency
- No sense of the four hour timeframe
- Delays to inpatient team review
- Multiple communication delays and issues
  - ED to bed management
  - Ward to ED

CHANGES AT DUBBO HEALTH SERVICE

CHANGING WORKPLACE AND CULTURE

- Every patient belongs in Right place at the Right time, in order to receive the Right care – kept repeating the message into every conversation
- Everyone's time is precious - Everyone is important - the Patient and all members of the team
- Everyone is responsible
- We work as a Whole, not by department

Our Health District
Living Well Together

Strategies

- Redesign of the ED department and the Medical Model
- Bed Management – Daily then twice now covering the weekends.
- Ward Pull – using FirstNet Screen – Bed days/occupancy/staffing
- Patient Journey Board - White Board to Electronic
- Medical Plans
- Executive Rounding – Support, Escalation, Visibility.

Redesign of the ED department and the Medical Model

Whole Of Hospital Program

Care, Right Place, Right time for Dubbo and the Central West

Changes to the Emergency Department Model of Care

Why change?

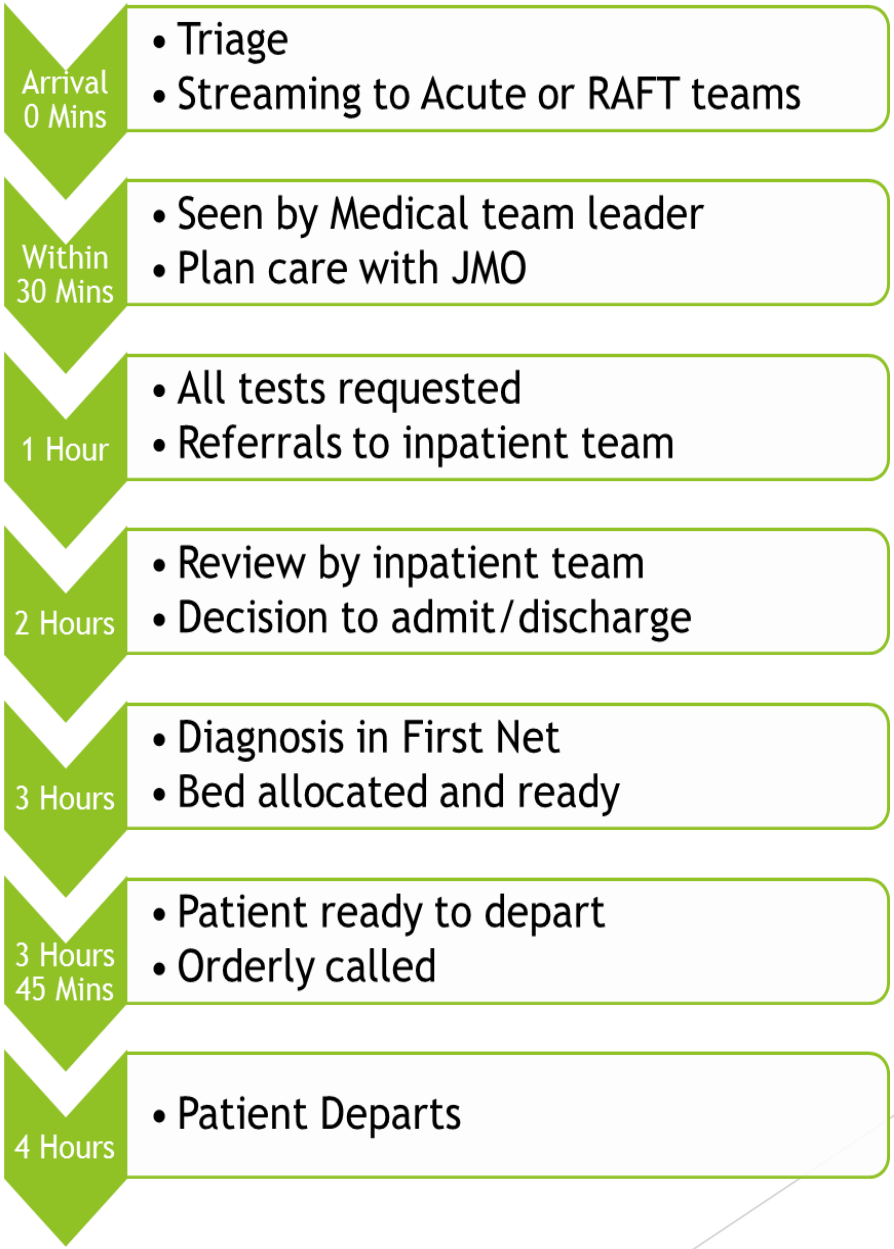
There is strong research evidence that patients have better health outcomes if ED access is improved.

ED overcrowding contributes to adverse outcomes and increased mortality - Sprivilus et al 2006, Richardson D 2001.

2012: Drs Geelhoed and de Klerk in MJA "mortality rate fell significantly by 13% (at 95% CI)". "Monthly mortality rates decreased significantly concurrently with decreased access block and an increased proportion of patients admitted in under 4 hours".

Dubbo Hospital Emergency Department performs poorly compared to peer hospitals for key ED safety and quality indicators. 2012/13 NEAT (admit/discharge and depart ED in 4 hours) = 58.7%. Target 2013/14= 75%

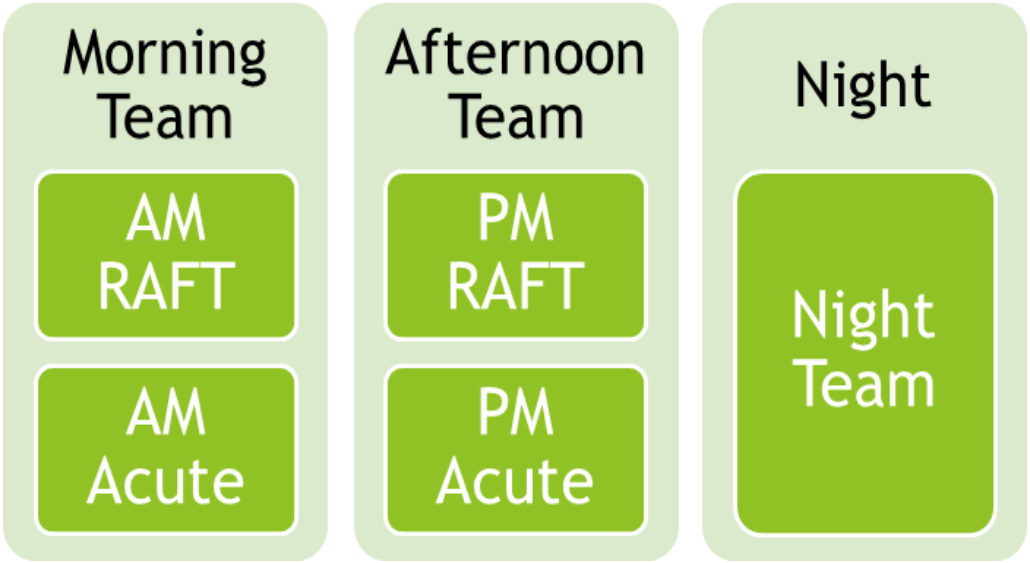
Time Activities to complete - FN



The medical model consists of medical teams with each team led by a senior medical staff member (ED consultant, registrar or CMO) and operating across a 24 hour period. All medical staff will be assigned to a team during their shift in the ED.

The two AM and two PM teams will also work together under the direction of the ED consultant in charge to ensure the safety and quality of care and respond to peaks in demand.

The ED Consultant in charge will lead the department overall and will retain a pivotal role in providing advice and guidance to junior staff.



RAFT is a dedicated area in the ED to treat ambulant, non-complex (single system problem) patients who can be discharged within < 2 hours. Triage streams patients into the RAFT using a pre-determined inclusion/exclusion fast track criterion. Patients triaged to RAFT will include:-

- Patients presenting for review, primary care or GP type presentations
- Ambulant patients with simple single system problems without complex co-morbidities.
- Ambulant psychiatric patients.
- Patients with minor orthopaedic injuries that may be managed in an arm chair

ED Medical & Nursing Model Changes

- NUM 1 Role Change to Floor Coordinator
- Team Based care with increase in junior medical staff Supervision and teaching
- Early assessment by a Senior ED Doctor
- Patient streaming to Resuscitation, Acute or Fast Track
- A senior Ed Doctor will be responsible for and have governance over all ED patients.

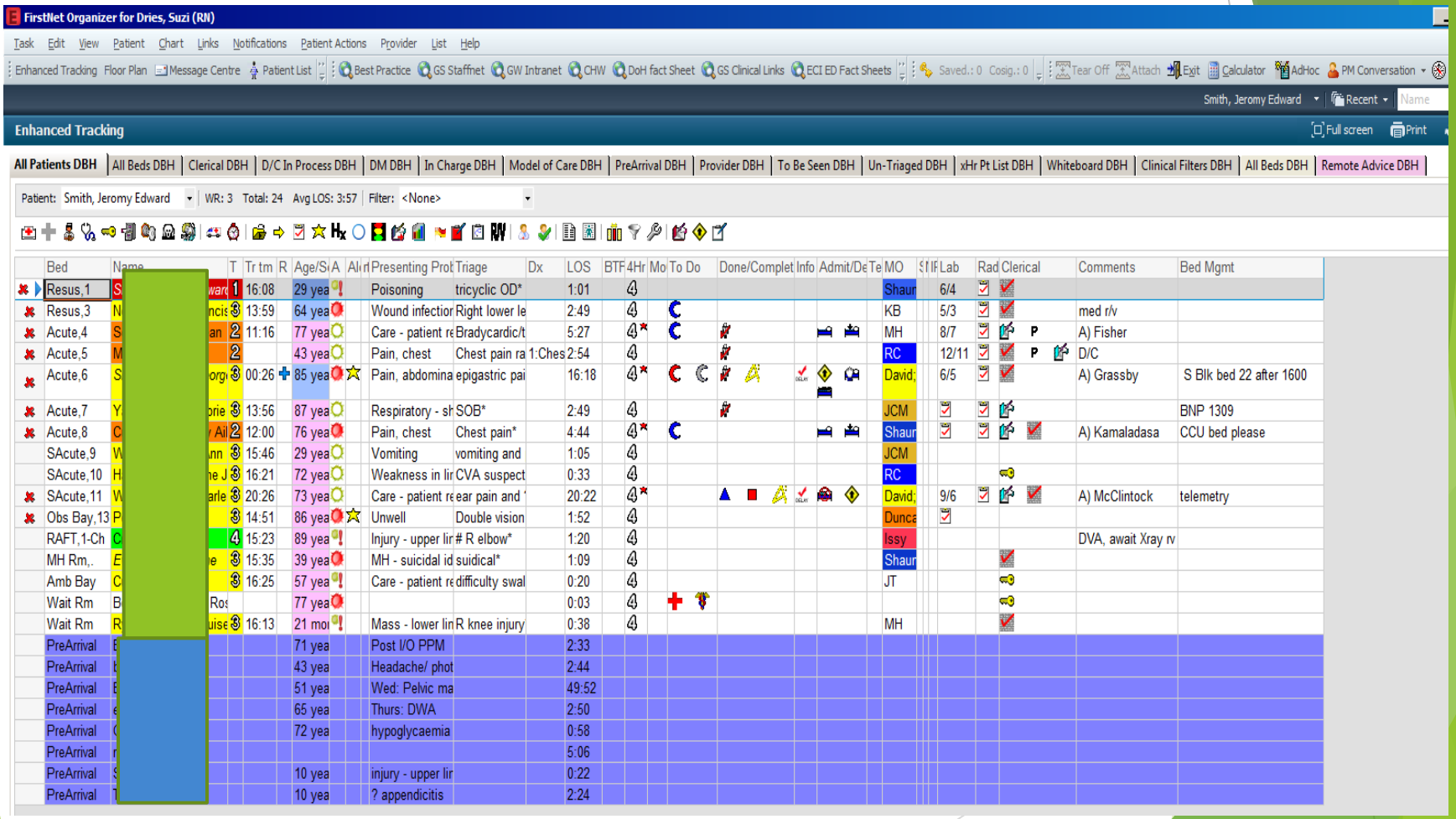
We developed the board to suit the Changing parameters

Bed Management – Daily then twice now covering the weekends.

- We started with showing we could predict the Ed admissions on any given day – on an average.
- Established business rules for what was expected from ED and the wards
- Looked at our capacity
- Alternatives to inpatient carte
- Transfer barriers

- Used the study change practise – no holding of beds
- Why was the bed empty
  - DOSA/Theatre
  - Reason not identifiable
  - Discharge destination
  - Medical Plans –
  - Coordination
  - Collaborative Care

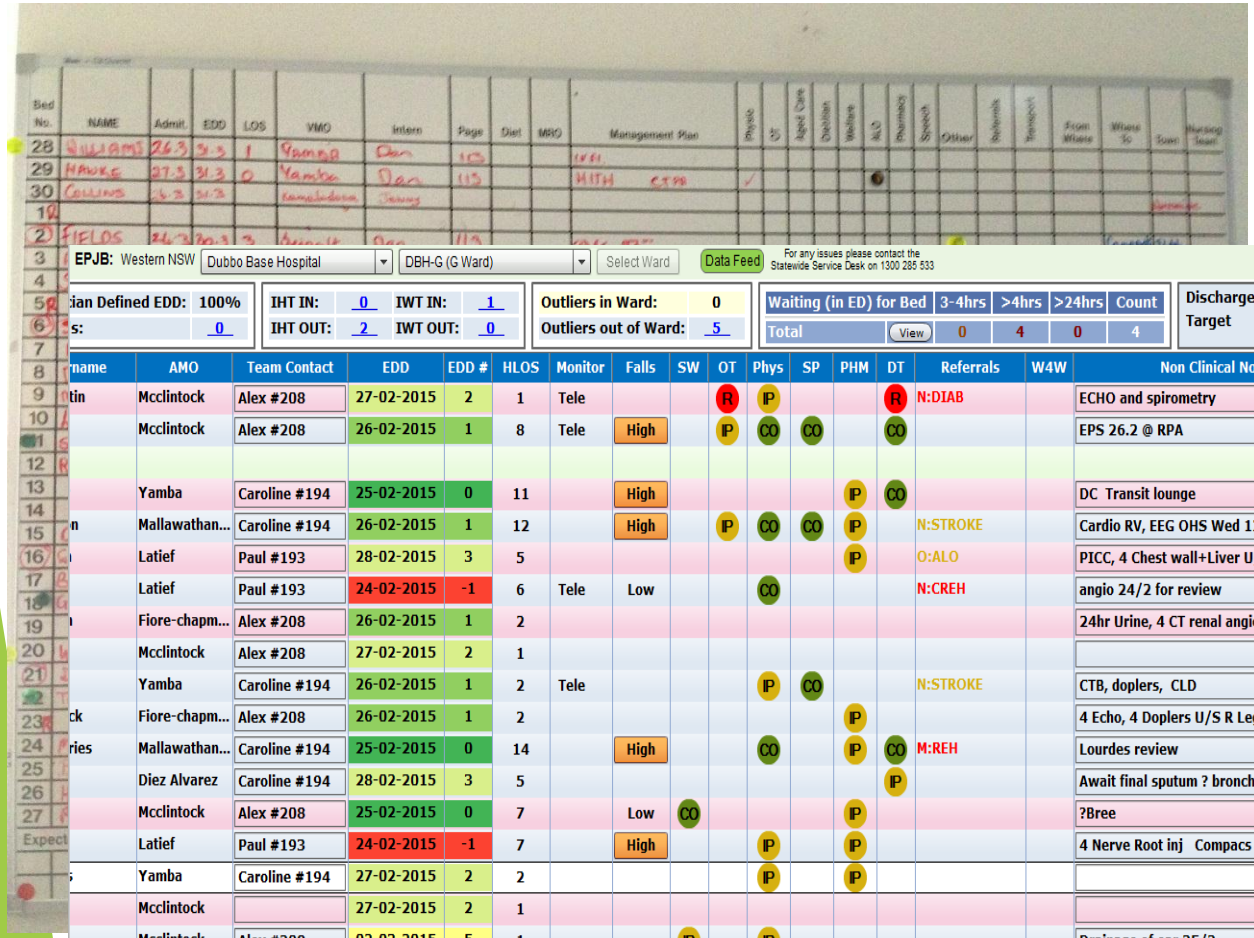
Ward Pull – using FirstNet Screen – Bed days/occupancy/staffing



Ward Pull

- Resisted by staff on the wards due to anecdotal fear
- More Patients = more work
- Change in priority and ownership
- Everyone working together
- Reinforcement from Executive and AHNM
- Agenda for ward meetings
- Developed business rules – Posters where they sit

Patient Journey Board - White Board to Electronic



EPJB: Western NSW | Dubbo Base Hospital | DBH-G (G Ward) | Select Ward | Data Feed | For any issues please contact the Statewide Service Desk on 1300 285 533

ian Defined EDD: 100% | s: 0 | IHT IN: 0 | IHT OUT: 2 | IWT IN: 1 | IWT OUT: 0 | Outliers in Ward: 0 | Outliers out of Ward: 5

Waiting (in ED) for Bed	3-4hrs	>4hrs	>24hrs	Count
Total (View)	0	4	0	4

Discharge Target | Last Refreshed: 25-02-2015 17:05

name	AMO	Team Contact	EDD	EDD #	HLOS	Monitor	Falls	SW	OT	Phys	SP	PHM	DT	Referrals	W4W	Non Clinical Notes	Disch To	IHT	G2G	Nurse
tin	Mcclintock	Alex #208	27-02-2015	2	1	Tele			R	IP			R	N:DIAB		ECHO and spirometry				Patrica
	Mcclintock	Alex #208	26-02-2015	1	8	Tele	High		IP	CO	CO		CO			EPS 26.2 @ RPA		R		Patrica
	Yamba	Caroline #194	25-02-2015	0	11		High					IP	CO			DC Transit lounge	Home			Patrica
n	Mallawathan...	Caroline #194	26-02-2015	1	12		High		IP	CO	CO	IP		N:STROKE		Cardio RV, EEG OHS Wed 12:45				Jo
	Latief	Paul #193	28-02-2015	3	5							IP		O:ALO		PICC, 4 Chest wall+Liver U/S, 4 Gastro/He		E		Jo
	Latief	Paul #193	24-02-2015	-1	6	Tele	Low			CO				N:CREH		angio 24/2 for review				Jo
	Fiore-chapm...	Alex #208	26-02-2015	1	2											24hr Urine, 4 CT renal angiogram Wed 09:0				Jo
	Mcclintock	Alex #208	27-02-2015	2	1															
	Yamba	Caroline #194	26-02-2015	1	2	Tele				IP	CO			N:STROKE		CTB, doplers, CLD				Hannah
ck	Fiore-chapm...	Alex #208	26-02-2015	1	2							IP				4 Echo, 4 Doplers U/S R Leg, 4 MRI - then L				Hannah
ries	Mallawathan...	Caroline #194	25-02-2015	0	14		High			CO		IP	CO	M:REH		Lourdes review				Hannah
	Diez Alvarez	Caroline #194	28-02-2015	3	5								IP			Await final sputum ? bronch				Bec
	Mcclintock	Alex #208	25-02-2015	0	7		Low	CO				IP				?Bree				Bec
	Latief	Paul #193	24-02-2015	-1	7		High			IP		IP				4 Nerve Root inj Compacs on D/C				Siji
	Yamba	Caroline #194	27-02-2015	2	2					IP		IP								Siji
	Mcclintock		27-02-2015	2	1															
	Mcclintock	Alex #208	02-03-2015	5	1			IP		IP						Drainage of ear 25/2				Siji
el	Moreton	Alex #208	25-02-2015	0	8		High	IP		CO		IP				For Lourdes referal, chemo, CT abdo/pelvis				Bec
	Mcclintock	Alex #208	27-02-2015	2	1											Continue antibiotics				stephanie
	Stanton	Jennifer #204	27-02-2015	2	1															

Executive Rounding – Support, Escalation, Visibility.

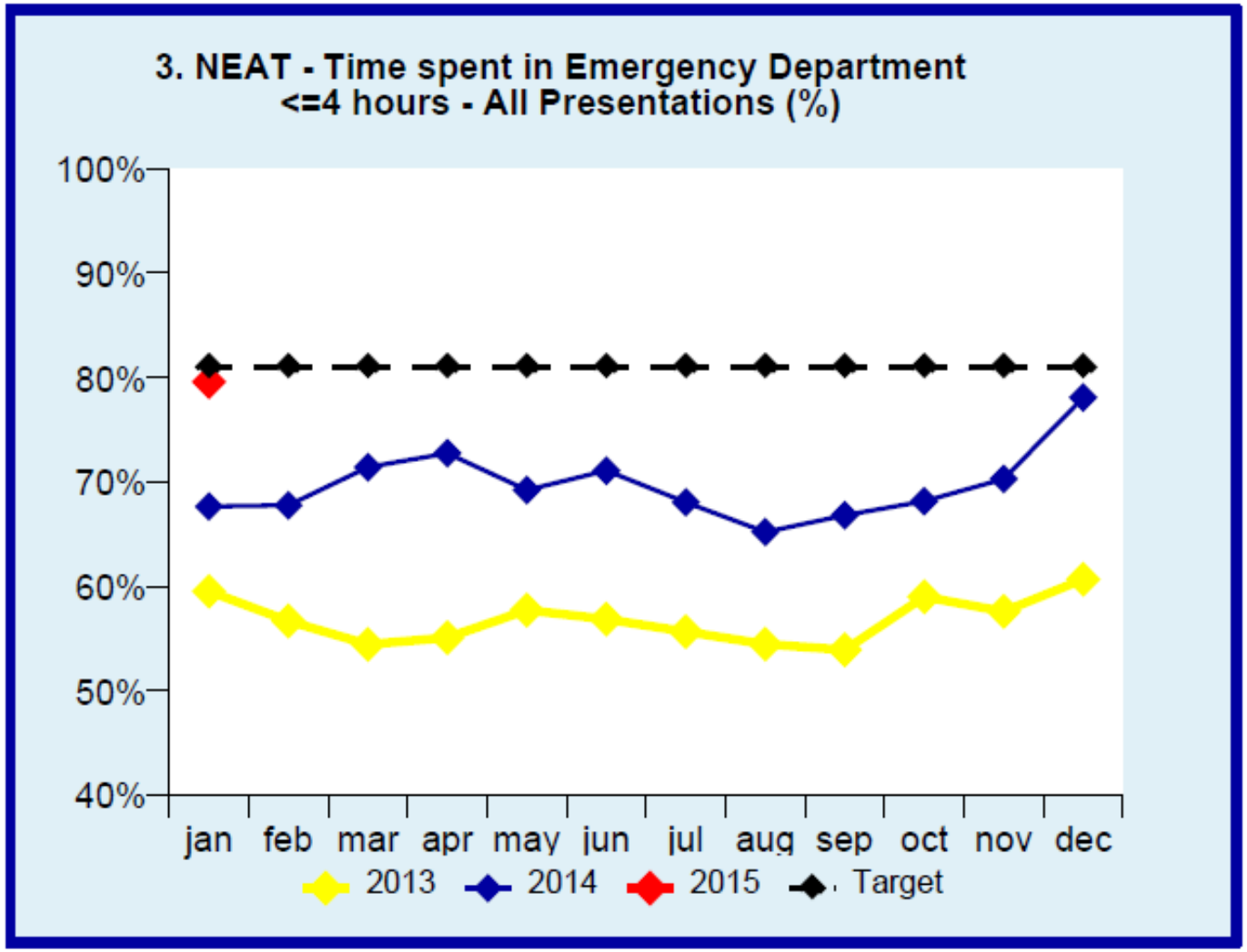
- Established a Roster to suit the Schedule
- Monitoring the WFW's
- Attend the Bed management Meeting in am
- Leave with a goal -= increase capacity through action
- Drives process change
- Mentors new managers
- Staff appreciate the presence
- Reinforces the message
- Communication in the ward
- Opportunity to focus on other messages – safety, falls
- We are a team

RESULTS AT DUBBO HEALTH SERVICE

Our Health District
Living Well Together

Where are we now?

	NEAT - All					NEAT Admitted					NEAT NonAdmitted				
Target	81%					50%					82%				
Week	3 weeks previous	2 weeks previous	week previous	Reporting Week	4 week trend	3 weeks previous	2 weeks previous	week previous	Reporting Week	4 week trend	3 weeks previous	2 weeks previous	week previous	Reporting Week	4 week trend
LHD Result	83.2%	87.0%	81.4%	81.2%	→	42.2%	56.8%	45.0%	39.4%	↓	889.6%	92.0%	88.4%	88.3%	→
NEAT	2185	2252	2252	2236		149	208	200	158		2273	2044	2052	2078	
Presentations	2626	2588	2765	2754		353	366	444	401		2273	222	2321	2353	
Dubbo	74.3%	81.4%	67.5%	70.9%	↓	31.3%	50.5%	31.7%	28.3%	↓	83.9%	88.6%	79.4%	80.6%	↓
NEAT	390	395	376	431		30	46	44	32		360	349	332	399	
Presentations	525	485	557	608		96	91	139	113		429	394	418	495	

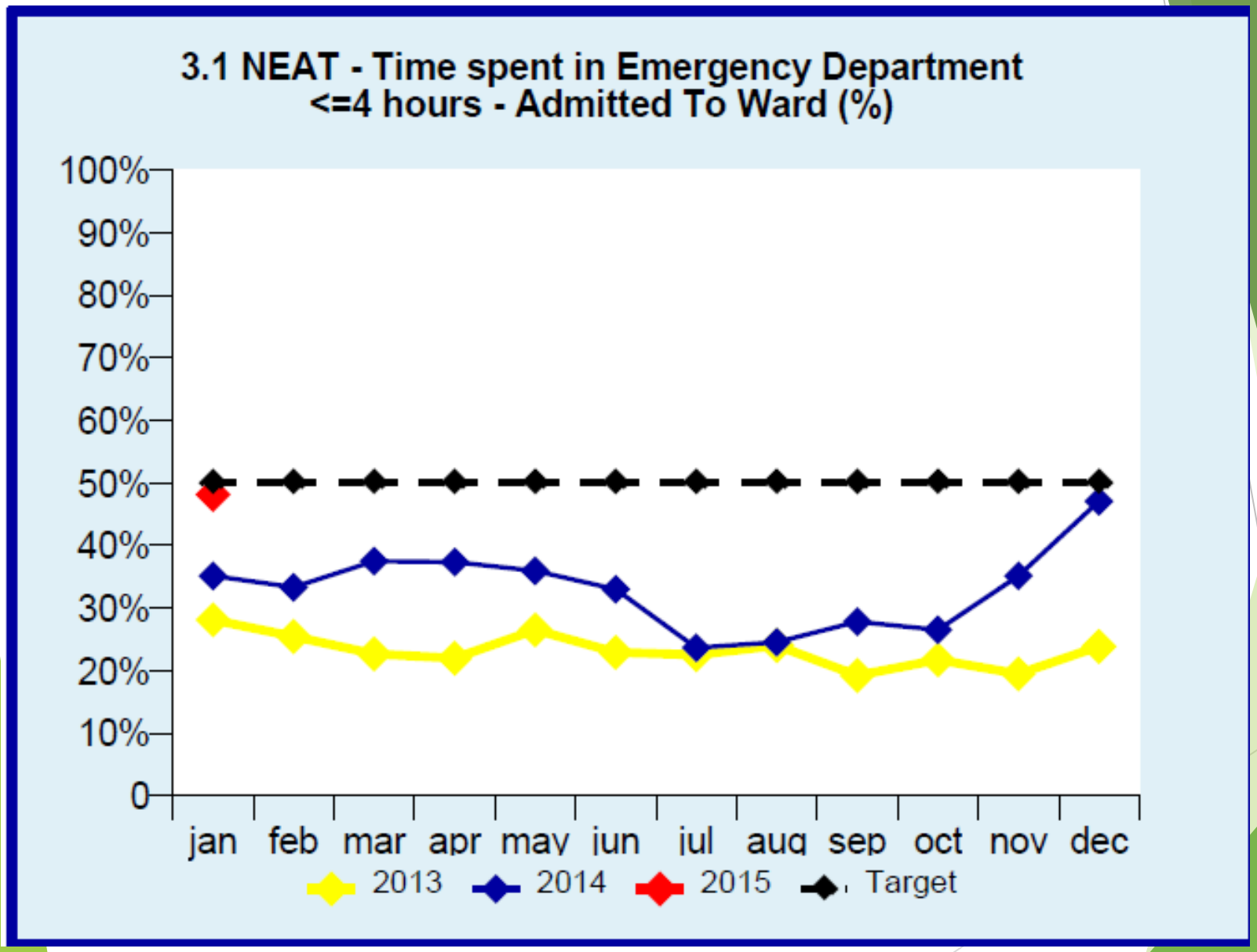

3. NEAT - Time spent in Emergency Department
<=4 hours - All Presentations (%)
100%
90%
80%
70%
60%
50%
40%
jan
feb
mar
apr
may
jun
jul
aug
sep
oct
nov
dec
2013
2014
2015
Target

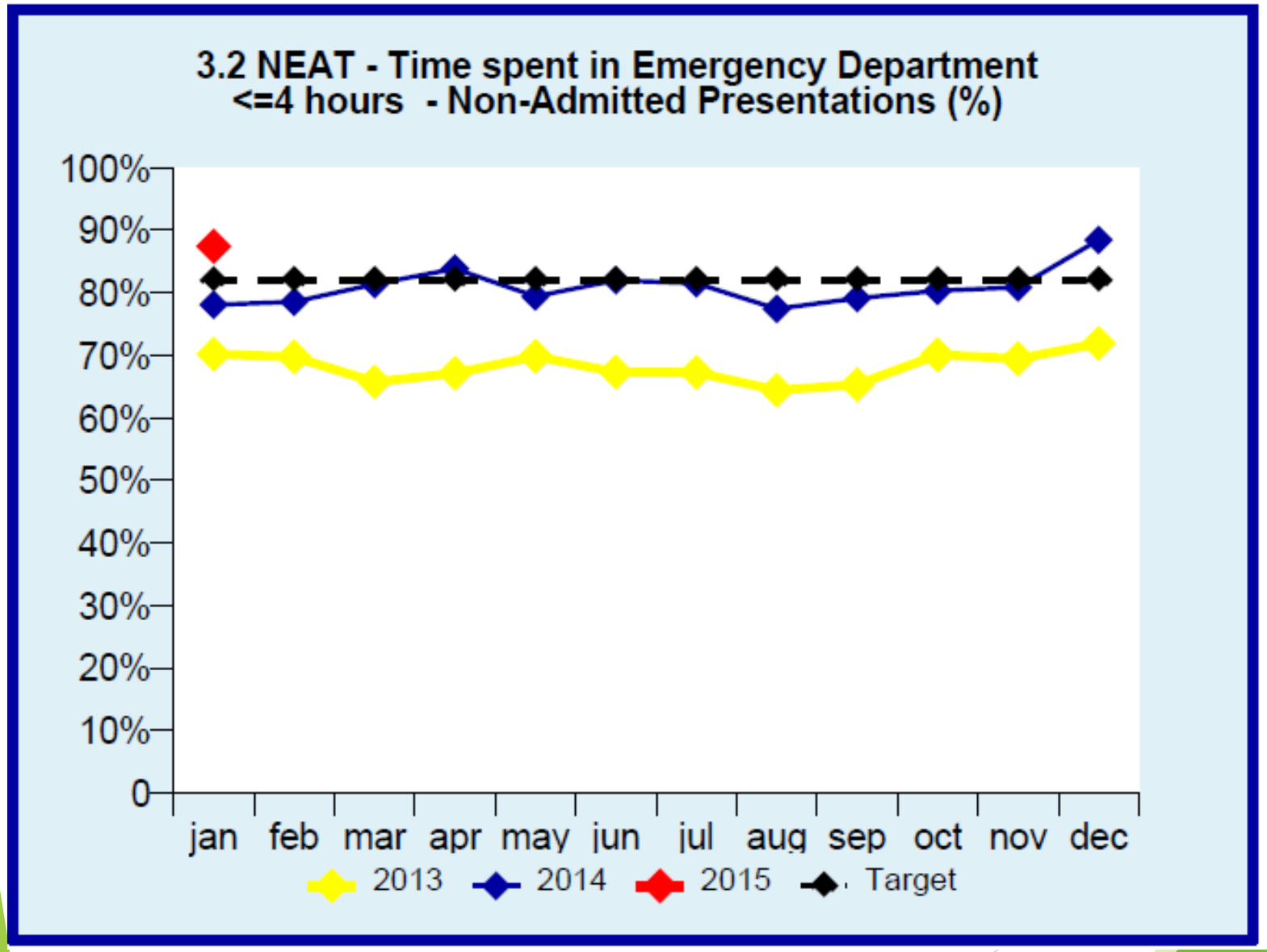
Dubbo Health Service, Dubbo Hospital

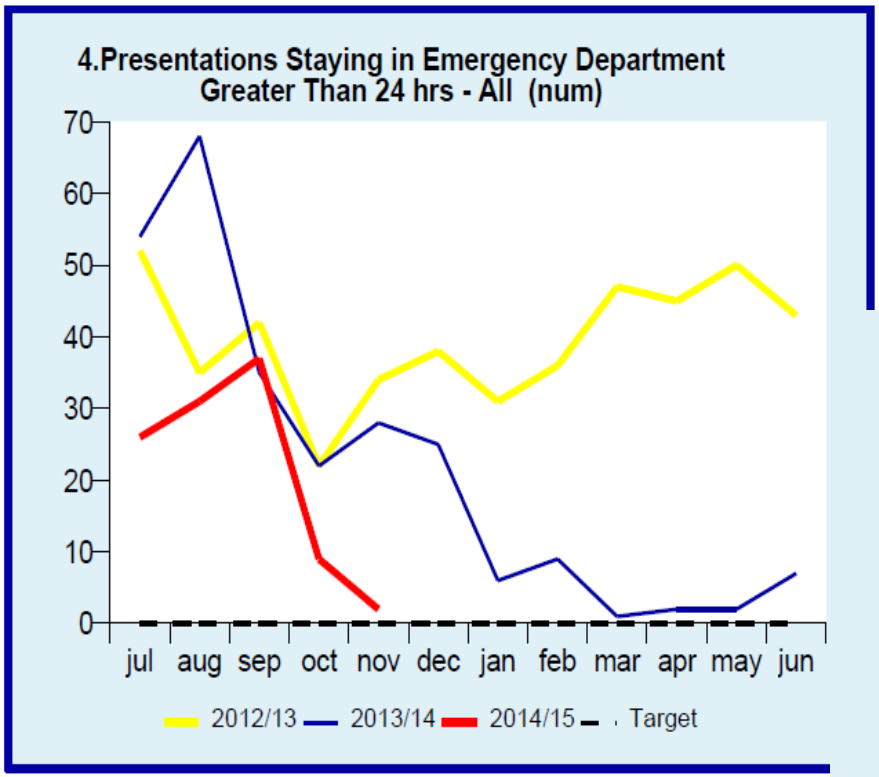
June 2013	
YTD Triage Performance	
Triage 1	100 % (100%)
Triage 2	86% (80%)
Triage 3	64% (75%)
Triage 4	73% (70%)
Triage 5	93% (70%)

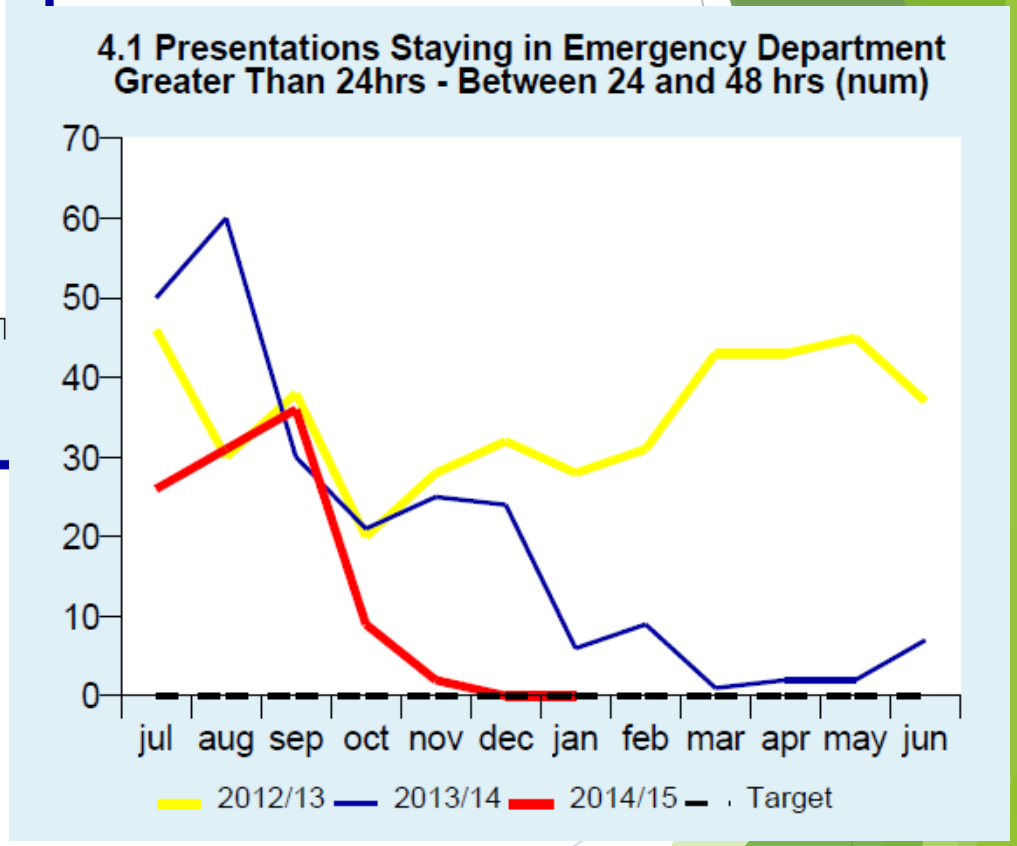
Last week in 2014	
Triage Performance	
Triage 1	100 % (100%)
Triage 2	94.4% (80%)
Triage 3	76% (75%)
Triage 4	87.9% (70%)
Triage 5	94.7%(70%)

Our Health District
Living Well Together


3.1 NEAT - Time spent in Emergency Department
<=4 hours - Admitted To Ward (%)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0
jan
feb
mar
apr
may
jun
jul
aug
sep
oct
nov
dec
2013
2014
2015
Target


3.2 NEAT - Time spent in Emergency Department
<=4 hours - Non-Admitted Presentations (%)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0
jan
feb
mar
apr
may
jun
jul
aug
sep
oct
nov
dec
2013
2014
2015
Target

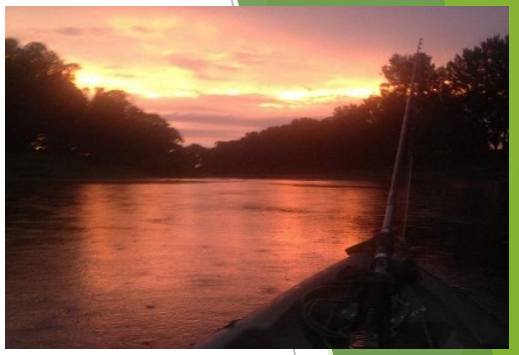

4.Presentations Staying in Emergency Department
Greater Than 24 hrs - All (num)
70
60
50
40
30
20
10
0
jul aug sep oct nov dec jan feb mar apr may jun
2012/13 2013/14 2014/15 Target


4.1 Presentations Staying in Emergency Department
Greater Than 24hrs - Between 24 and 48 hrs (num)
70
60
50
40
30
20
10
0
jul aug sep oct nov dec jan feb mar apr may jun
2012/13 2013/14 2014/15 Target

What didn’t work as well as we expected

Inter-Hospital Transfers	Patient Flow Unit assists by facilitating of transfers - escalate to sector manager when required Transfers to Rehabilitation Facility	Initial improvements from Lourdes have been slow. SLA in process of Development	Sector transfers hope to be improved with the roll out of eMR across the district and improved use of the PFP
Transit Lounge	Improve number of patients transferred by Pulling pats to lounge and Wards planning for next day discharges	Staff attend Bed management meetings, however MO’s not finished discharge process and block P\t. transfers.	Educate new staff to the process for planning for EDD.
Patient Huddles	Multi-disciplinary Team Huddles daily at PJB	Culture of separate forums continues – duplication of work	Working parties to be developed as part of EPJB roll out
Medical Officer involvement in Program	What is WoHP – What does it mean for my patient’s	Need to try new strategies	Culture change to: How can I assist

CONSOLIDATE



And Progress to Whole of Community program

- Re examine the Timelines in ED and the WAISH for inpatients

- Projects focussing on Patient Pathway's by Diagnosis –
  - Oncology
  - Palliative
  - Connecting Care
  - Mental Health

- Criteria led Discharge

Our Health District
Living Well Together

Our new Facility for our team We, no longer just me.

Part of a Thriving Community