# Improving Management of Long Stay Patients

## Engaging and supporting clinical teams

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# Overview

LIVERPOOL HOSPITAL

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

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# 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.

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# 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

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# 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

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# 2014 CEC CLP - Project Aim

*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.*

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# Diagnostics – size of the problem

- 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)

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# 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

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# 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
- Patient factors
- Clear planning responsibilities
- Senior Clinician involvement

**Individual Factors**
- Frustration
- Lack of urgency
- AMO variation

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

→ **Long Stay Patient**

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# 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

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# 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

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# Interventions – PDSA cycles

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

# PDSA 1: Targeted Case Management

Act

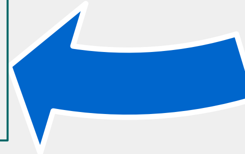
•Expand review LOS >30 days
•Define ward groups
•Ward driven process required

Plan

Identify patients LOS >100 days

Do

Facilitated MDT case management



Study

•Number discharged patients
•Discharge barriers (Issues Log)

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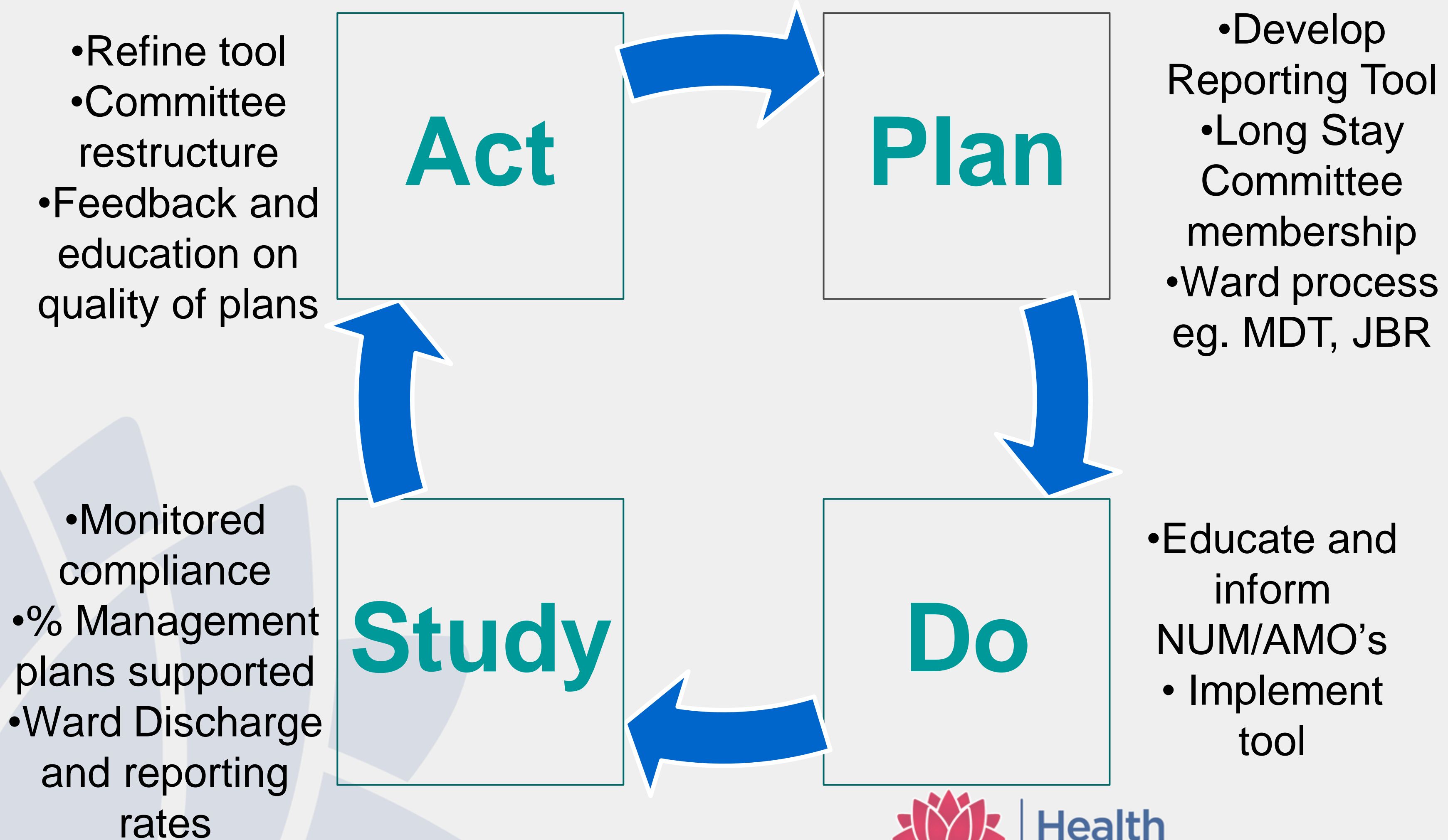
# PDSA 2: Weekly Ward Reporting

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# Ward Reporting and Monitoring Tool (from PFP)

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

# 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)

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# LOS>30 day Patients Cumulative Bed days

| | Cumulative Beddays LOS>30 day Patients |
|---|---|
| PRE | 4328 |
| POST | 2536 |

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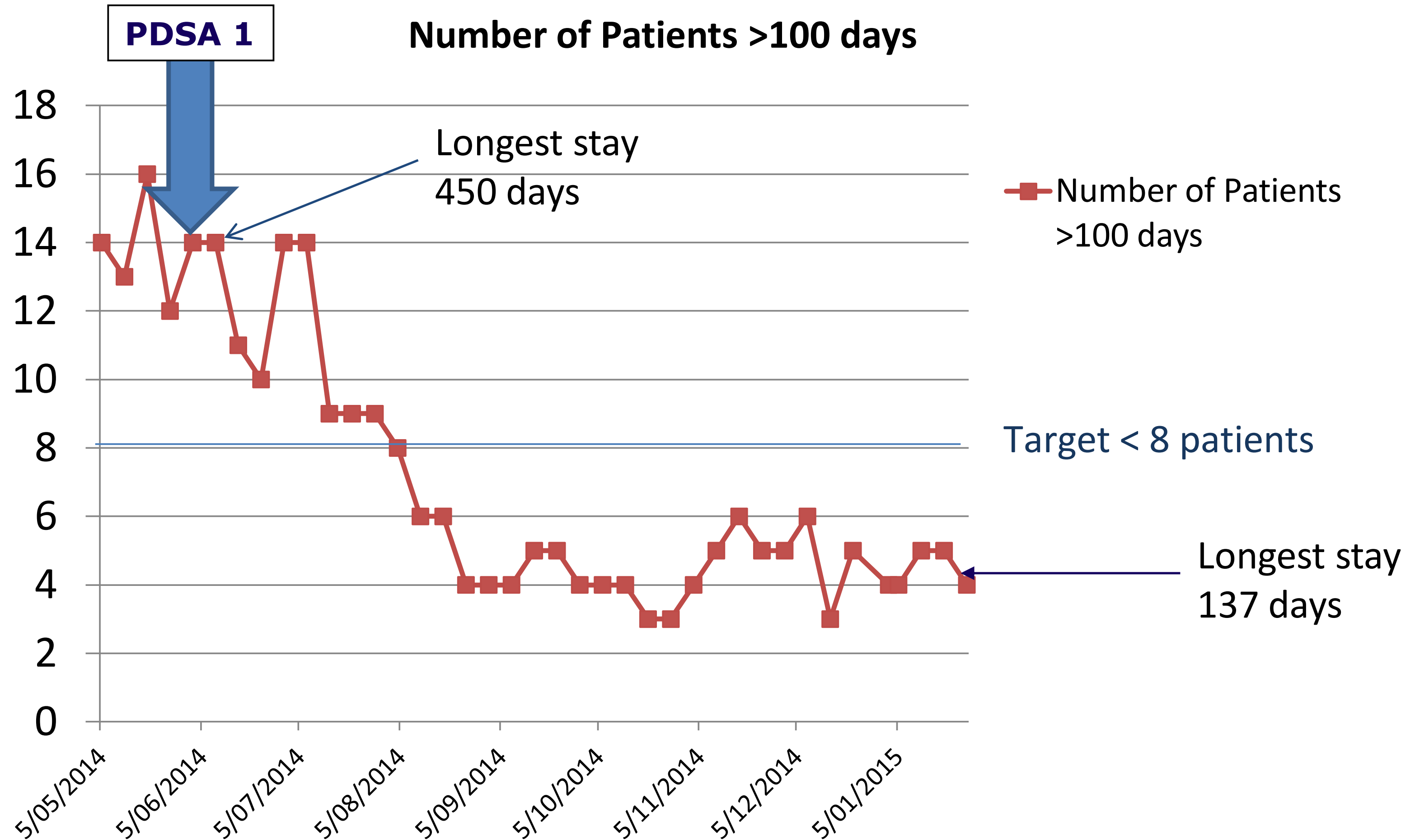
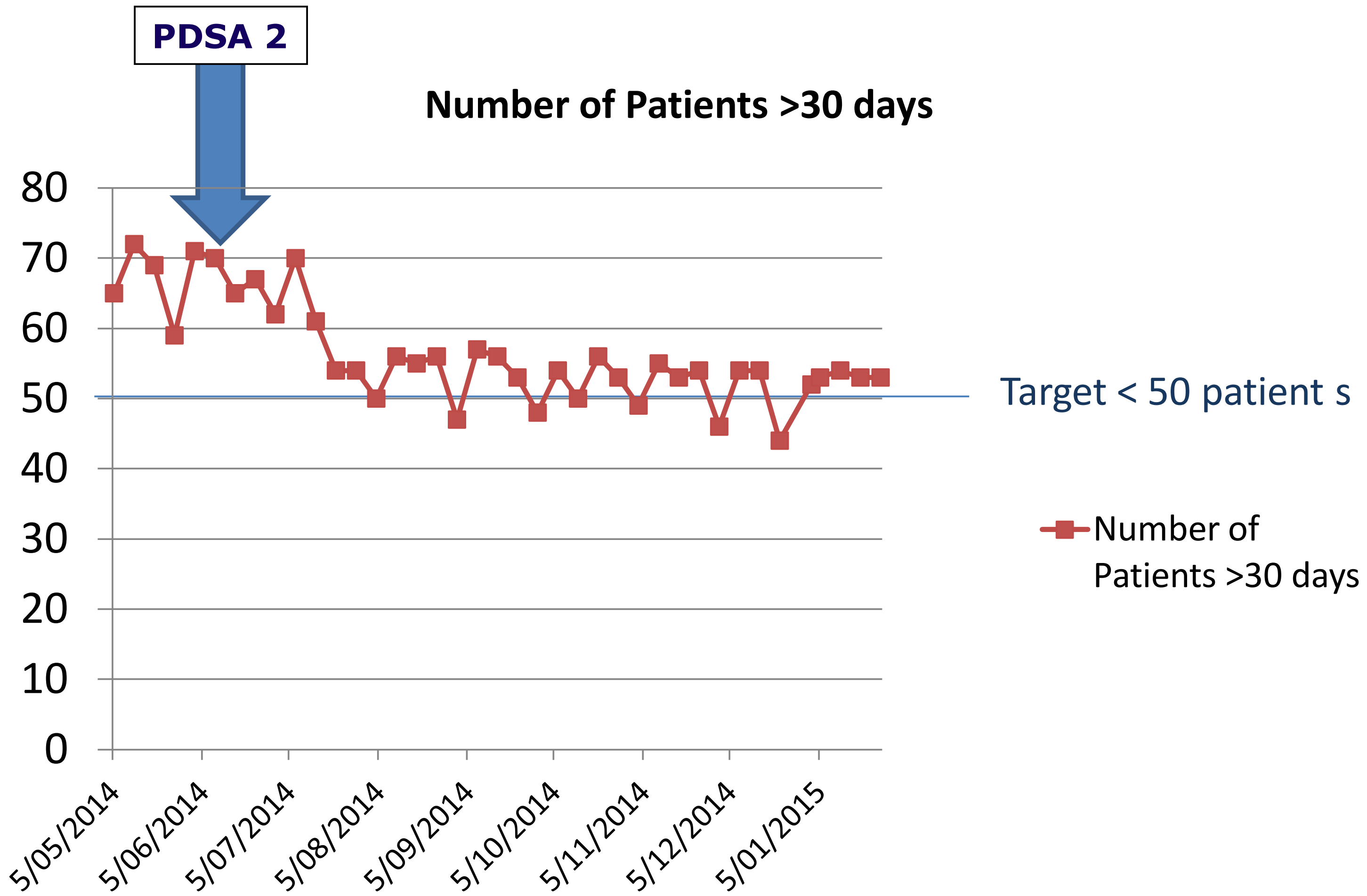
# Results: Targeted Long LOS Case Management



# Results: Ward Reporting and LOS Committee



# 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

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# 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

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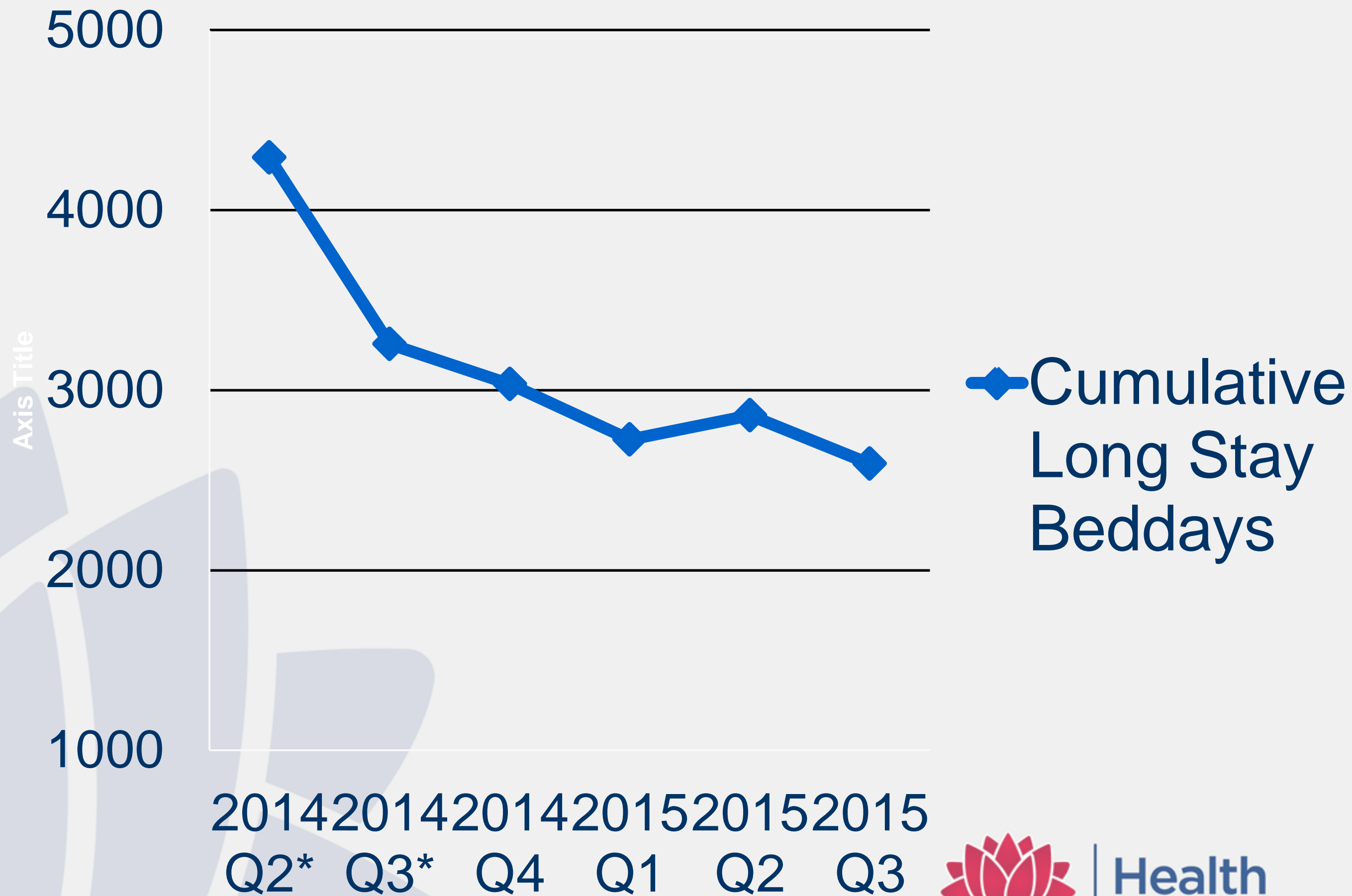
# 2014/15 Cumulative Beddays (>28/ >30 days*)

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# Liverpool Hospital Length of Stay

## YTD comparison 2013-15* Excluding MH

| Weekly Average LOS (excl MH) | Jan - July 2013 | Jan - July 2014 | Jan - July 2015 |
|---|---|---|---|
| MEAN (days)* | 5.80 | 5.78 | 5.58 |
| No. weeks ALOS > 6.0 days (High) | 10 | 8 | 2 |
| No. weeks ALOS < 5.4 days (Low) | 7 | 4 | 9 |

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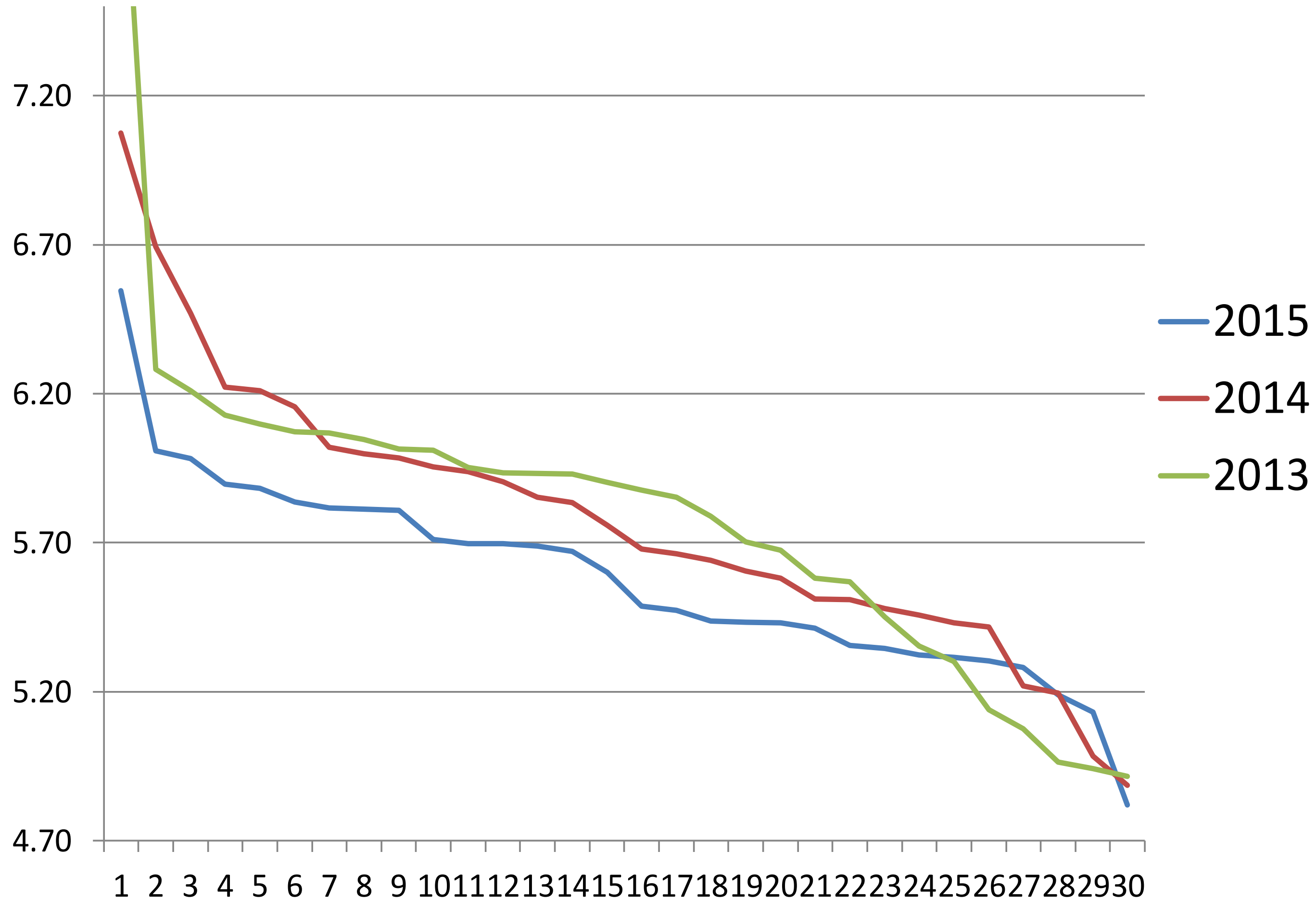
# Weekly ALOS: 1 Jan- 31 July 2013-2015

*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

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# 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

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# 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

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# Questions?

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