Unplanned 28 Day Readmission to Wollongong Hospital

Prepared by Fiona Coventry
Whole of Health Program Lead
LHD/Facility5 February 2016

What was the problem we wanted to address?

Wollongong Hospital had one highest Unplanned 28 day readmission in the State.
(Health Round Table Data)

NSW GOVERNMENT Health

What was the Goal?

- To reduce the readmission rate at TWH
- Identify any trends/ themes to the admissions that had occurred over the passed 6 months.
- Develop Action plans for the multiple Admission within six months eg: COPD, heart failure patients.
- To help reduce bed block and improve Patient flow throughout TWH.

What we did

* Run daily report through the Bed Board portal and reviewing all unplanned 28 Day readmissions to TWH

* Entered all information into a spreadsheet, Gathered data and statistics to reduce unplanned admissions

* Education to all staff on the importance of community referrals and follow up appointments.

What we did

- Identified if the admission is related
- Medical discharge summary Audit on a monthly bases. – System issues.
- Developed a chronic and complex patient care working party
- Developed an Ideal patient discharge working party.
- Carried out patient surveys (health round table)

* Ensure a comprehensive Case management plan for all COPD and heart failure patients are in place or develop one with CNC and admitting teams.

* Increased MDT rounds per week on most wards.

* Clinical Psychologist appointed on Monday/ Tuesday each week to construct and individualised action Plan for COPD patient (coping and anxiety strategies)

* Medical Administration Officer involvement with complex cases.

How did we do it?

- Monthly meetings
- Being available and visible to Medical Teams and ward staff
- Family Conferences
- Audits
- Patients surveys

What are the outcomes?

- Very slow improvement but continuing to improve.
- Increased compliance with Discharge summaries. Still investigating eMR system
- Action plans implemented in ED (has proven to reduce the unplanned admissions)
- Medical team are more accountable for the Medical Discharge Summaries and Action Plans for Chronic conditions.
- Increased communication with Families regarding End of life plans (In ED /prior to discharge /outpatients clinics)

What were the challenges?

1. Lack of comprehensive case management
2. Poor compliance with Medical Discharge Summaries
3. Gap between referrals and follow ups appointments
4. Poor discharge preparation
5. Prevention of multiple readmissions in relation disease progression
6. Medical Engagement