Evidence Review

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Evidence Review

- Literature Review: N=88,849
  - Yes: N=2,564
  - No: N=86,285
- Initial title review: N=293
  - Yes
  - No: N=2,271
- Abstract Review
  - Yes
  - No: N=99
- Additional Papers: N=222
  - Yes: N=18
  - No: N=99
- Paper review
  - Yes: N=61
  - No: N=161

ACI NSW Agency for Clinical Innovation
Overview

WHOLE OF HOSPITAL: ACCESS TO CARE

MAU

Patient in
the
community

Patient enters
the
service

ED to
Inpatient

Inpatient to
Inpatient

Patient exits
service

Patient in
the
community

Clinical Management Plan

Daily Ward Round

Estimated Date of Discharge

Waiting for What

Criteria Led Discharge

Transfer of Care

CARE COORDINATION

Educational materials on ‘smooth patient flow’ across the patient journey are being developed by:

HETI

ACI

NSW Agency for Clinical Innovation

Leads:

ACI

MOH

LHDs

CEC
Communication/Engagement

Communication
- critically important to provide safe and effective care\(^1,2\)
- significant barrier is the structure and geographic spread of team\(^3\)
- Collaboration/teamwork are associated with better patient outcomes\(^4\)

Engagement
- poor work climates ➔ ↓ patient experience\(^5\)
- Employee engagement ➔ ↑ patient satisfaction, ↓ patient mortality, ↓ infection rates\(^6\)
Clinical Management Plans

- Document with efficiency
- Document verbal communications
- **Electronic / Hybrid notes**
  - Medical clinicians (electronic notes) – Patients (paper)
  - Copying in the eMR is common – risk of errors

- **Improving documentation**
  - Standardising: ↑documentation, knowledge and satisfaction
  - Checklists: ↓length of stay, ↑medication compliance
  - Clinical pathways
  - Evidence based medicine workshops
Ward Rounds

Benefits of IDT ward rounds
- ↓mortality\textsuperscript{17}
- ↓Length of stay / ↑discharges\textsuperscript{18-20}
- ↑collaboration\textsuperscript{10,18,21,22}

Type
- Bedside rounds are preferable\textsuperscript{28,30-32}, JMOs report a preference for conference room questions\textsuperscript{31}
- Rounding staff should avoid jargon\textsuperscript{28}
- Board rounds\textsuperscript{29}

Timing
- Bedside rounds take 20% longer than traditional rounds but ultimately save time\textsuperscript{30}
12 minutes per patient (8-24 minutes)\textsuperscript{33}, another study found 7.5 min (3-16 min)\textsuperscript{27}

Improving
- Variability in review of medication charts\textsuperscript{23}, can be reduced through a standardised checklist\textsuperscript{24}
- Collaboration through all IDT sharing at bedside\textsuperscript{25}
- Junior medical officers requested that rounds feature teaching the management of patients\textsuperscript{26}
- A more structured approach to communication would benefit patients\textsuperscript{27}
Patient Flow

- Establish realistic estimated date of discharge (EDD) at admission\textsuperscript{34}
- EDD updated throughout journey\textsuperscript{34}
- Commence discharge planning within 24 hours of admission\textsuperscript{34,35}
- Implement separate streams for emergency and elective surgery\textsuperscript{34}
- Ensure patients are seen by a senior clinician\textsuperscript{34}
- Complex discharges: confirm discharge date 2-3 days in advance\textsuperscript{34}
- Communicate to all involved in a patient’s discharge\textsuperscript{34}, particularly patients\textsuperscript{36}
- Support patients to leave the ward as early in the day as possible\textsuperscript{34}
Criteria Led Discharge

*Criteria Led Discharge involves the identification of a patient who is signed off by a senior medical clinician as eligible for hospital discharge under agreed criteria without final medical review.*

**CLD has been found to:**
- reduce length of stay\(^{37,38}\)
- increase the percentage of discharges that occur before admissions arrive\(^{37,39}\)
- increase weekend discharges\(^{37}\)
- increase patient and staff satisfaction\(^{37}\)
- improve quality of discharge planning, resulting in improved patient care\(^{37}\)
- have no discernable impact on patient readmission rates\(^{37}\)

**CLD should**
- 1. be integrated with and not separate from the usual discharge process
- 2. be conducted with a review of the whole discharge process.
- 3. include outcome measures (e.g. use and accuracy of EDD, last medical review, time of actual discharge)\(^{40}\)
Transfer of Care

Clinical handover or transfer of care is the: …transfer of professional responsibility and accountability for some or all aspects of care for a patient… to another person or professional group on a temporary or permanent basis

- Interventions are multi-component
- Health professionals have differing expectations
- Introducing a multidisciplinary care coordination team reduced hospital admission rates and improved stakeholder satisfaction
- Transfer of care checklist increased staff satisfaction
Transfer of Care

Recommendations for General Practice to Hospital (bi-directional)

1. Clear, succinct communication is essential for safe transfers of care. Clinical judgement will be required to determine the appropriate method.

2. A patient must leave the hospital with a copy of discharge communications.

3. GPs access to electronic patient results in the hospital.

4. Medication reconciliation should occur at every transition of care.

5. The patient, their family and carer must be involved as a partner.
Patient Centered Care

3 tenets:
1. The needs of the patient come first\textsuperscript{49}
2. Nothing about me without me\textsuperscript{14, 33, 49-51, 53, 54}
3. Every patient is the only patient\textsuperscript{49}

Important features:
- Empowerment\textsuperscript{52-54}
- Shared decision making\textsuperscript{52}
- Partnership \textsuperscript{52}, being heard\textsuperscript{58}
- Verbal communication, including between inpatient and outpatient providers\textsuperscript{57}
- Information about lifestyle changes\textsuperscript{57}
References


References


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