Acute Care Taskforce

Workshop Report

Friday March 8, 2013

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Nigel outlined the Agency for Clinical Innovation's (ACIs) approach to developing innovations and it's link to the IHI triple aim – improving both patient outcomes and patient experience while providing value to the system (Figure 1). He also highlighted the role of the Clinical Program Design and Implementation team to support Local Health Districts to deliver projects.

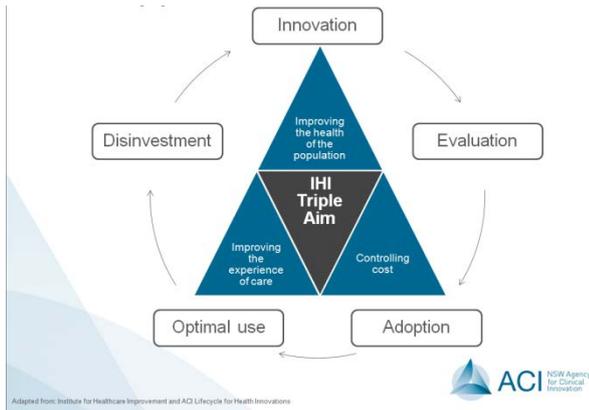**Figure 1:** IHI triple Aim and the ACI innovation cycle   **Figure 2:** Acute Care Taskforce – a statewide MDT approach

Nigel welcomed the new Acute Care Taskforce noting it's repositioning to a statewide focus with newly nominated teams from Local Health Districts and Specialty Networks (LHD/SNs) and increased consumer representation while maintaining links to the Ministry, Pillars and Primary Care (Figure 2).

Nigel introduced the proposed workplan for the Taskforce in 2013 outlining a focus on the medical inpatient journey (Figure 4). The elements presented were identified at a workshop with ACI Acute Medical Networks in November 2012.
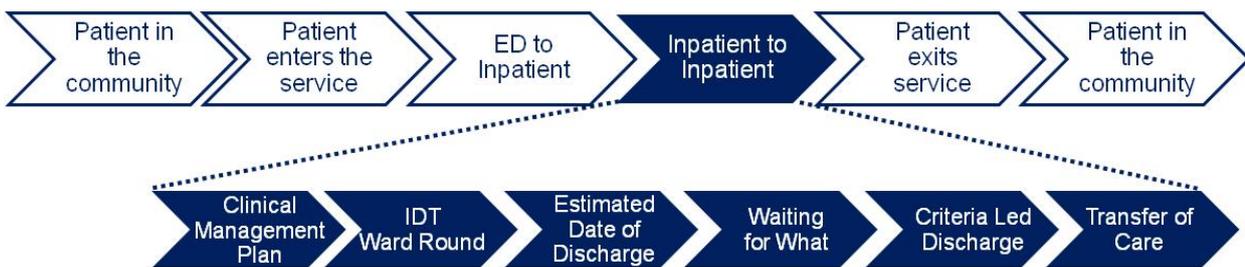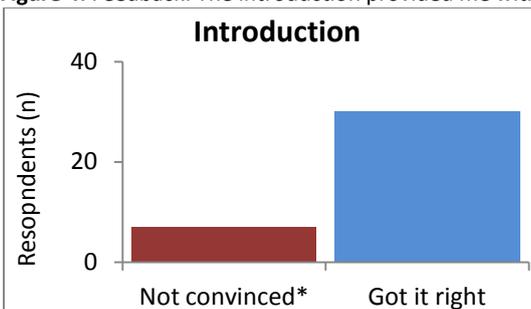
Figure 3: The Medical Inpatient Journey

Figure 4: Feedback: The introduction provided me with the appropriate background information

Tracey told us how she uses Clinical Management Plans in her daily practice as a Geriatrician.

PRINCIPLES / GOALS

- The medical record as the chief communication document
- Establish a system / process to improve documentation within the medical record and hence communication
- Good communication improves safety, satisfaction and efficiency
- The idea that an admission is a snapshot of care and must be appreciated as such
- "The more we know the less we need"

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WHAT TO DO

- Comprehensive assessment on admission
- Not a common pathway – individualised care plan
- BNW – Before, Now (active problem list), Why (diagnosis)
- Importance of documenting diagnosis and diff diagnosis
- Clear management plan – investigations, treatment, planned discussions, directions re review criteria
- Regular review of plan – results, what has worked and hasn't, what has been discussed and is yet to be discussed
- Summaries and suggestions for teams overnight and at weekends e.g. delirium, deteriorating or dying patient
- Acknowledge, Review, Refine

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CHALLENGES /SOLUTIONS

- Takes more time initially, new way of documenting especially on surgical wards
- Transparency – can be a challenge
- Importance of a format / guidelines– uniformity to improve familiarity e.g. EDS
- All units using the same approach
- Supported by senior clinicians expected part of ward round

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OUTCOMES

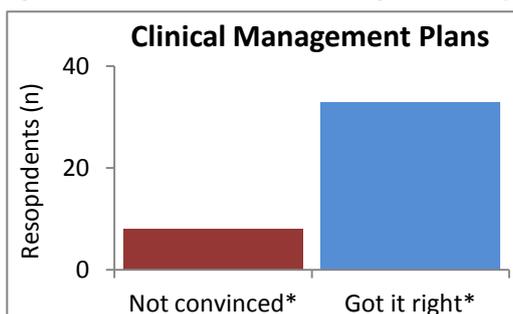|	
PATIENT	• less repetition of data • clear communication from staff re plan • SAFETY
STAFF	• avoids unnecessary testing • improves communication and time management • avoids duplication • improved job satisfaction
FACILITY	• patient and staff satisfaction • SAFETY • costs
EXTERNAL HEALTH PROVIDERS	• involved • improved data available for EDS

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As a Taskforce you told us that your workplaces do not currently have uniform use of Clinical Management Plans but some individual departments had pockets of excellence. These departments used the electronic system to write and share the plan.

To improve you asked for:

- structures to support consistent practice across disciplines across the state (e.g. use of ISBAR, standards). This should include the value of all contributions and the sharing of the plan across medicine, nursing and allied health.
- a proforma to be shared across the system (e.g. MDT assessment tools on admission).
- a sharing of pathways that are in place within the system.
- education within the orientation process on the use of clinical management plans.
- a standardised audit tool.
- education packages.
- a roadshow to share this practice with others.

Figure 5: Feedback: the Clinical Management Plan presentation was valuable in informing me about the Medical Inpatient Journey

*Using evaluation data Not convinced =1,2,3 Got it right=4,5

INTERDISCIPLINARY WARD ROUNDS – IN SAFE HANDS	A/PROF GABRIEL SHANNON, STAFF SPECIALIST PHYSICIAN, WNSWLHD

Gabriel presented the experience at Orange Hospital of implementing the CEC In Safe Hands program that has a strong focus on the Structured Interdisciplinary Ward Round or SIBR.

Principles/Goals

- **Aim:** To provide a platform for patient-centred care in an acute hospital setting based on teamwork and a daily interdisciplinary ward round

- **Goal:** Improved patient satisfaction
  Reduction in adverse events
  Improved staff satisfaction and retention
  Reduction in unexpected patient death

What we did/do?

- Combined two medical wards and nursing teams
- Changed from team based care to patient allocation
- Changed JMO rotations from team based to geographical [ward/unit] based
- Trained in and modelled interdisciplinary ward rounds [Structured Interdisciplinary Bedside Round]
- Changed Consultant model to one week blocks of acute medical service
- Established separate cardiology roster

Barriers/Enablers

- **Challenges:**
  Nursing team amalgamation and model of care
  Consultant buy-in
  JMO concerns [accreditation, training]
- **Solutions:**
  Discussion/demonstration/commitment
  Selling benefits to consultants
- **Enablers:**
  Executive buy-in/CEC support
  Leadership

What we learnt?

ORANGE HEALTH SERVICE 2012
Structured Interdisciplinary Bedside Rounds (SIBR)

As a Taskforce you told us that structured interdisciplinary beside rounds (SIBR) deliver:

- certainty to the patient.
- engagement across the multidisciplinary/interdisciplinary team that encourages teamwork.
- a structure that allows patient journeys to be predictable and consistent.
- care by the right person, at the right place, at the right time.
- a reduction in the safari ward round.

To deliver good ward rounds you told us your workplace needs:

- whole of organisation support with transformational leadership across each discipline, including VMO buy in (e.g. week on) and Locum involvement.
- availability of staff.
- a structured process with an agreed place and time.
- to provide the estimated date of discharge at the bed side.

You expressed concerns about:

- how to maintain the foundations that have been built by the *In Safe Hands* program
- the evidence: why do it this way?
- bed management and how you deal with medical outliers.
- the implication for billing and how you ward round with private patients.
- the workforce issues, particularly the staff/bed ratio for allied health.
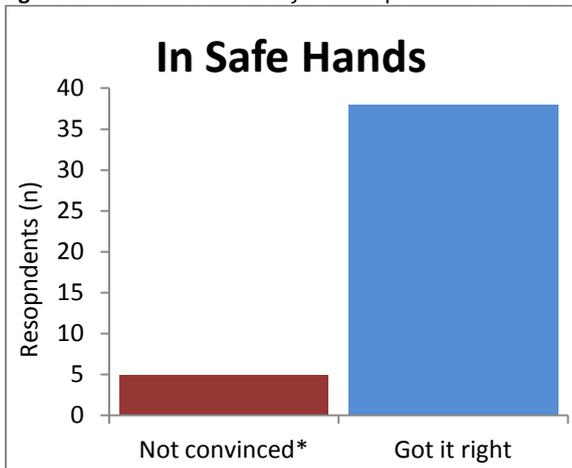
*Using evaluation data Not convinced =1,2,3 Got it right=4,5

- invisible barriers - need to explore.
- how to achieve the required big change e.g. lifestyle, timetable.
- how to deal with specific patient cohorts who may require different processes e.g. bariatric / dementia patients.
- if patient journey boards work (i.e. white board handover).
- how you get Medical involvement when you have a high locum population
- the Nursing culture challenge

You wanted to challenge the concept that the SIBR must be medical led but agreed that all relevant clinicians need to be present, including the consultant.

You asked us to focus on developing high performing clinical teams and build inter professional collaboration. Many of you indicated you would like to know more about implementing the *In Safe Hands* program and several recommended a state wide roll out.

Figure 6: Feedback: The *In Safe Hands* presentation was valuable in informing me about the Medical Inpatient Journey

PATIENT FLOW PORTAL	MELINDA PASCOE, PRINCIPAL POLICY NSW MINISTRY OF HEALTH

Background
- Developed in response to system requirements
- Real time information to support decision making
- Available at all NSW Public Hospitals
- Three modules:
  1. Bed Board
  2. Predictive Tool
  3. Executive Dashboard

Estimated Date of Discharge
- Established by the Interdisciplinary Team
- Clinical and patient centric
- Realistic
- Revised and updated during patient journey
- Driver of communication with patient and family/carer

Waiting for What
- Records "unreasonable" delays in the patient journey
- Delays may be during or at the end of the patient journey
- Can decrease delays and uncertainty about the next step
- Aggregated data can identify common delay causes

ESTIMATED DATE OF DISCHARGE	DEBBIE SCOTT, NURSE MANAGER, CCLHD ELLEN HARDCASTLE, PATIENT FLOW CO-ORDINATOR, CCLHD

Principles/Goals

Principles
- Compliance with MoH policy directive
- Patient centric
- Multidisciplinary engagement

Goals
- Enhanced care coordination
- Alignment of transfer of care coordination with EDD
- Standardised processes across LHD

What we did/do?
- Engagement of key stakeholders
- Daily reporting of EDDs by NUMs
- Utilising PFP - visual cues
- Demand Management Plans

Barriers/Enablers

Challenges
- Stakeholder engagement
- 24/7 processes
- EDD is not a stand alone tool.

Enablers
- Executive sponsorship
- Multi-disciplinary communication
- PFP visual cues

What we learnt?
- Patient awareness of transfer of care plans
- Second order change
- Sponsorship is key to a successful outcome
- Foundation for consistent practice

WAITING FOR WHAT?	TIM FREE, DIRECTOR CLINICAL OPERATIONS, CCLHD

VALUABLE - ????
POTENTIAL - YES
- As it stands its use is limited, but
  - Potential to reduce LOS
  - Potentially assist in resource allocation
  - Potential identification of roadblock individuals

Process Issues
- Limited information
- Relies upon staff dedication
- Who looks at the results
- Out of date information
- Only captures some patients
- Can it be relied upon

What Does It Need
- More automated populating of data
- Greater choice in drop down boxes
- Automatic assignment to areas needing to provide input/function
- Expanded reporting functions to assist decision making in resource allocation
- Clinician support

As a Taskforce you suggested that the Patient Flow Portal is currently being used well for:

- patient transfers.
- autogenerated estimated date of discharge (EDD) which allows the Nurse Unit/Flow Manager to identify patients who require a clinician defined EDD.
- prioritisation of patients.
- predictive functionality.
- identification of potential flow issues and options for remedial action.

Despite this you reported that the Patient Flow Portal was not being used consistently to its full potential and therefore the complete benefits were not being realised

You wanted support on:

- how to implement and get a broader range of staff to use the portal daily and look at the data.
- improving medical staff engagement to increase usage.
- identifying who is using the information and how they are using it.
- tackling the challenge of DONs being responsible for patient flow while not being professionally and operationally responsible for clinical networks.

To make improvements we need to:

- expand the reporting functions.
- develop a framework to support wards not using the bed portal to begin using it.
- expand the 'wait' reasons.
- provide training and education for a broader range of users.
- provide the EDD at the bedside on a whiteboard.
- develop cross functional collaboration, leadership and governance at the local level.
- extend bed portal for HITH services. This will show access and promote option of care.
- develop stronger local governance and more effective leadership as we know what patients are waiting for but we cannot resolve e.g. Nursing home beds, ACAT assessments, guardianship boards.

The Ministry of Health informed us that incremental improvements are planned with two new releases later this year - they are looking for more feedback on what the tool can provide to assist LHD/SNs. A further document will follow based on the issues raised.

Figure 7: Feedback: The presentations were valuable in informing me about the Medical Inpatient Journey

Apologies to the ACT and Tim Free W4W was mistakenly left off the evaluation sheet.
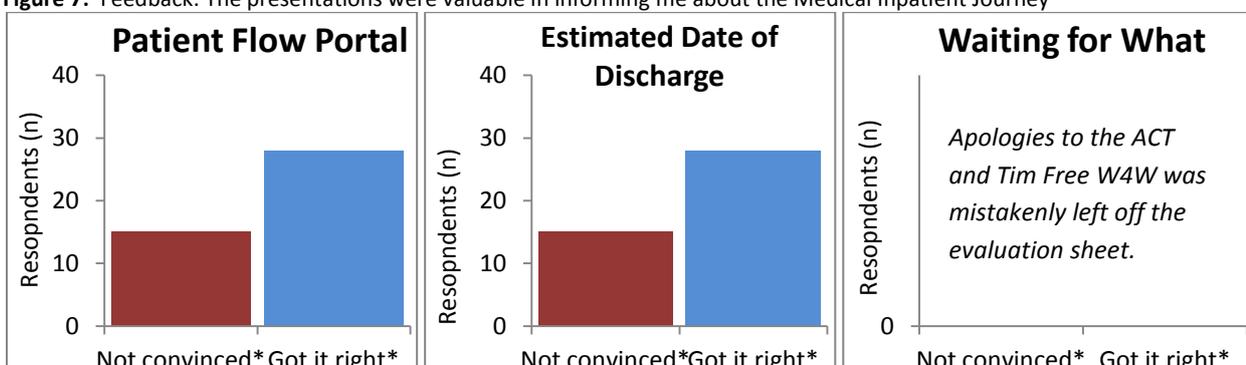
Ellin presented on the experience of developing Criteria Led Discharge (CLD) for Gynaecology and Obstetrics in Manchester, UK.

Principles/Goals

- To look at how Gynaecology and Obstetrics could manage better. Obstetrics requirement to manage a rapid increasing number of births and Gynaecology to manage costs within the department
- Reduce variation in Length of Stay across the same conditions or procedures with a speciality
- Benchmarked against peer hospitals in England our LOS looked long –were we being inefficient or were we special?
- Look at how the specialities could save money in very financially constrained environment. To save money needed to reduce bed numbers in Gynaecology

What did we do?

- Clinical collaboration, clinical collaboration, clinical collaboration
- Meeting of all clinicians in speciality agreed principles standard LOS for each procedure or admission condition. THIS IS HARD so many variables!
- Agreed identified medics and nurses to work on care pathway documents
- Agreed key principles patients must be seen by consultant post surgery
- Agree criteria for each condition on the care pathway document
- Performance management system for LOS weekly meeting

Barriers and Solutions

- Different medical working patterns, simple timetabling affects discharge, information given to patients managing expectations from beginning.
- Confidence required in system so that there was not a 'lack of control' for medical staff. Fear of being 'left to it' from nursing staff.
- The 'who does what'
- Requirement for consensus –majority rule/best practice
- **Solutions**
- Care pathway documents developed in a multi disciplinary team
- Take time for the dialogue
- Determination to make improvements in our effectiveness –clinical leadership
- Ensure document meets any standards already in place for discharge Royal Colleges, Anaesthetists, Nursing etc
- Performance management

What we achieved?

- Significant reduction in LOS for Gynaecology meant that the service had 2 wards one 26 beds and one 24 beds with all but 10 bed closing Fri-Mon. The 24 bed ward became a day case facility.
- Patients with shorter length of stay have reduced risk of hospital acquired infection, better mobility and fewer post operative complications. Ease for carers and families with less time spent having to travel to and from hospital.
- Outcome for maternity services was that it enabled the team to manage without closing for capacity reasons for 6 months post changes
- The changes to ward configuration saved approximately 3500 bed days per year and made £350,000 savings in nursing costs.
- Increased efficiency of services against the same income.

As a Taskforce you told us that you supported the use of CLD. You expressed concerns about:

- certain patient groups or complexity levels (e.g. palliative care).
- how to generate buy-in.
- how to challenge history - nurse initiated discharge has a perceived negativity and thus failed.
- the variation in JMOs skills.
- how to write this expectation into VMO/consultant performance agreements and position descriptions.
- how to manage VMOs/consultants who don't get a payment unless they eyeball the patient and discharge them.
- how acceptance of the philosophy is dependent on acceptance of medical teams.

In order to develop CLD in your workplace you asked us to:

- develop a physical assessment workbook, competency and assessment process to ensure health professionals have the skills to assess a patient is ready for discharge.
- provide a way to share care pathways across LHD/SNs.
- be clear about who is responsible for the checklist or certain bits of the checklist.
- target easier groups first e.g. short stay patients, standard clinical condition pathways.
- develop standards for implementation across the hospitals/LHDs for consistency of expectation.
- enable medical staff to sign off on the criteria and health professionals add criteria if relevant.
- ensure the form includes a space to complete why patients are not going home on standard criteria.
- to consult widely, obtain executive support and senior buy-in, particularly with medical staff.
- listen to medical staff concerns and solve issues for them.

You suggested we could:

- incorporate CLD with the ward round (e.g. with the SIBR in *In Safe Hands*).
- pilot/test in a part of the hospital.

*Using evaluation data Not convinced =1,2,3 Got it right=4,5

- learn some lessons from the private hospital sector.
- roadshow successful sites via ACI with key clinicians.
- use Australian and International success stories.
- use whiteboards and other existing systems.

You gave examples of areas where this has been working e.g. Ken Peacock has examples of paperwork, tried in MAU 7 days per week.

Figure 8: Feedback: The Criteria Led Discharge presentation was valuable in informing me about the Medical Inpatient Journey
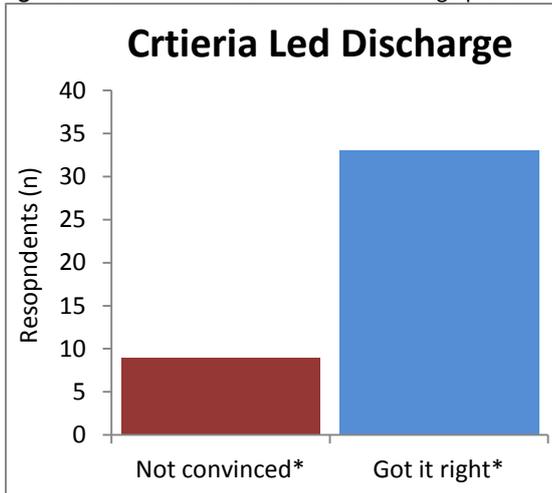
Principles/Goals

Severe Chronic Disease Management (Connecting Care) eligible patients
- Optimise experience of patients and carers accessing services/emergency

- Increase transmission of health information between GPs and acute health sector

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What we did (GP/hospital)?

- Clinical Redesign - Diagnostics Analysis :
- 1)Large gap in Communication at weekends
- 2) Identification of GP was not always performed (difficult to locate on eMR if it was available) 20% missing/unknown
- 3) Need for clearer information sharing– management/treatment plans
- 4) Need for communication paths for frail complex patient cohort

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Barriers/Enablers

- Fragmented clinical records – not easily shared electronically with primary care
- Solutions – Improved Docmail (automatic letter to GPs – admission, discharge, deceased), Clear treatment/transfer letters to GPs, MedicAlert bracelet trial, Relaunch GP Hotline in ED
- Steering Committee and engaged execs a key driver and enabler

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What we learnt?

- Improved information available frail people – through Medicalert, printed summaries
- Docmail improved – SESLHD and ISLHD
Information faxed/encrypted via ARGUS
- Improved relations with GPs – ED Hotline, Docmail
- Prepared way for Connecting Care program – energy and knowledge

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As a Taskforce you told us that Handover needs:
- to be a habit like clockwork in your daily practice.
- to have commitment from senior leadership.
- to have adequate training.
- to be delivered in multiple modes: verbal, written, online (all three not only one method).

You told us that you were concerned:
- that CERNER currently only allows for a discharge summary to one person.
- about the sustainability of new initiatives in handover.
- about the lack of electronic access to patient records for non hospital staff.
- regarding poor communication skills in the system, education is required.
- about how person dependent the successful projects are.
- about the lack of appropriate communication between multidisciplinary team (MDT).
- the lack of robust processes for after hours and public holidays.
- about the accuracy of information in discharge communications, particularly to GPs.

You suggested we should focus on:
- garnering Executive support for handover.
- the technical capability - developing a universal eMR across the whole system (ED, ambulance, GP, hospital, primary health care).
- view access to eMR for primary care.
- providing financial support for handover, including seed funding to collaborative projects e.g. MLs/Acute/Community.
- education and training for consistent communications across the MDT.

Figure 9: Feedback: The Handover presentation was valuable in informing me about the Medical Inpatient Journey
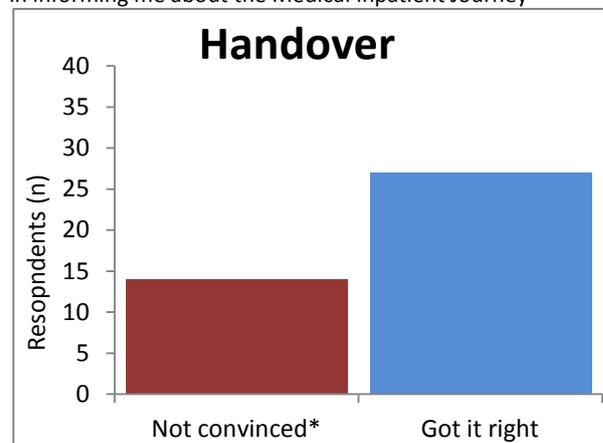
*Using evaluation data Not convinced =1,2,3 Got it right=4,5

MISSING ELEMENTS

As a Taskforce you told us that the following elements were missing from the current thinking:

- Home wards.
- Home residents.
- Appropriate streaming.
- Alternatives to admission.

The focus for 2013 is specifically on delivering improvements across the medical inpatient journey. These elements will form part of the longer term workplan for the Taskforce.

OUTCOME MEASURES

As a Taskforce you told us that we should consider including the following outcome measures:

- SLA with inpatient teams to accept care
- Data that indicates if the EDD is improving patient outcomes?
  - Length of stay
  - Lowering complaints
  - Lowering complications
  - Lowering aggression

CHANGES THAT I WOULD MAKE IN MY LHD/SN NOW

As a Taskforce you told us that you would make the following changes immediately:

- Common element, 'person centred care'.
- Have more evidence based conversations.
- Develop a shared language to improve buy-in and bring about a shared vision and culture.
- Conduct education sessions on improving the medical inpatient journey.
- Nurses to be able to set own ratios for patient care.
- Stronger accountability, performance consequences, incentive budgeting through monthly performance meetings.
- Ensure that Clinical Staff Councils are mixed/multidisciplinary.
- Make high level choices - power of clinical council.
- Clinician empowerment - have a say, have input, use ideas.
- Allow innovation to be heard from the floor, bottom up.
- Develop data
  - KPIs in Medical staff constraints
  - KPIs in ward rounds
  - KPIs in length of stay
- Recognising all tribes need to give something up to truly deliver a patient centred model.
- Confront the fallacy of terminal uniqueness and realise we are all inside the same tent.

WHAT WE WILL DO BEFORE JUNE 2013

1. Conduct an evidence review of the suggested elements of the medical inpatient journey.
2. Convene two working groups for Clinical Management Plans and Criteria Led Discharge. Each working group will meet at least once before June 2013.
3. Work with the Clinical Excellence Commission on the implementation of Ward Rounds and Handover.
4. Work directly with the Ministry of Health to provide feedback on the Patient Flow Portal, including Estimated Date of Discharge and Waiting for What. Including connecting LHD/SNs teams who wish to have additional training from the Patient Flow Portal Team.
5. Partner with up to two LHD/SNs on a medical inpatient journey Redesign School project.
6. Ensure you are adequately prepared for the June 2013 workshop.

WHAT YOU CAN DO BEFORE JUNE 2013

1. Continue discussions with your colleagues in your LHD/SN about improving the medical inpatient journey (consult, consult, consult!).
2. Share your examples of good practice with kate.lloyd@aci.health.nsw.gov.au.
3. Share peer reviewed journal papers with kate.lloyd@aci.health.nsw.gov.au .
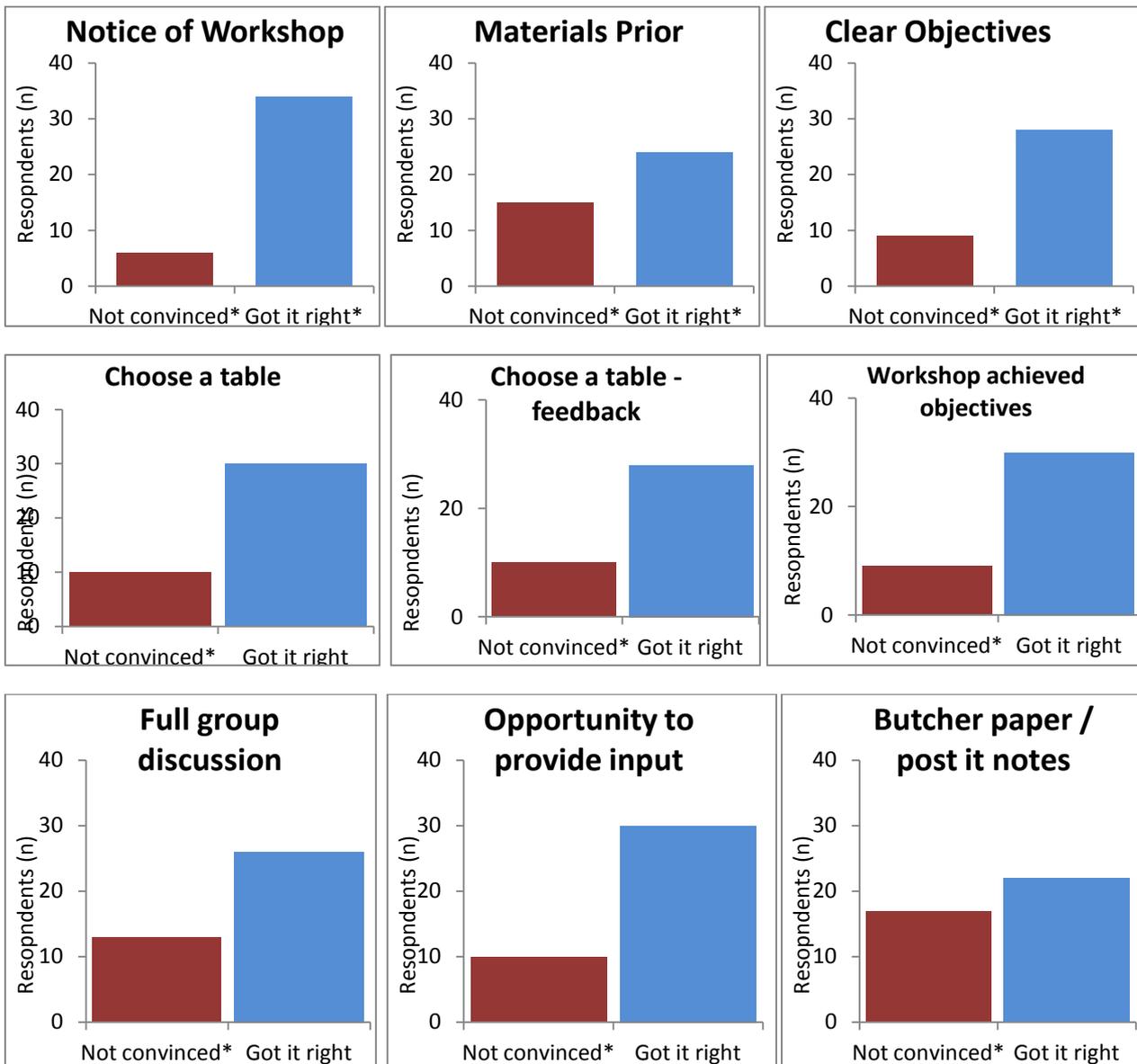4. Join a working group (Clinical Management Plan or Criteria Led Discharge) before April 5.

TIMELINE

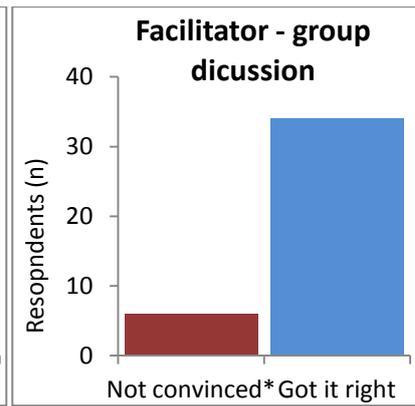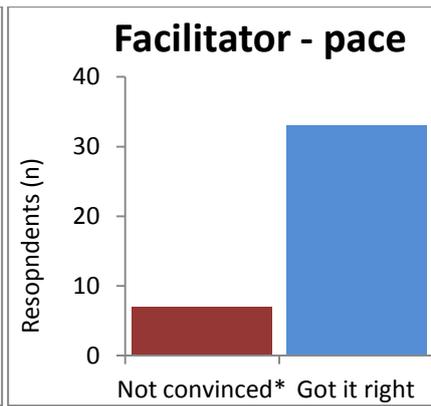**Figure 10:** 2013: A timeline for the Acute Care Taskforce

	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Acute Care Taskforce -Executive		12 14:00-16:00	10 14:00-16:00		12 14:00-16:00	12 14:00-16:00		11 14:00-16:00	8 14:00-16:00	
Acute Care Taskforce	8 12:30-16:30			14 12:00-16:30			13 12:00-16:30			13 12:00-16:30
Evidence review										
Clinical Mgmt Plan WG		15 14:00-16:00	2 9:30-11:30							
Criteria Led Discharge WG		18 9:30-11:30	2 14:30-16:30							
Evidence presented				14						
High level model developed										
High level implementation strategy developed										
High level model presented							13			
High level implementation strategy presented							13			
Implementation/roadshows										
Implementation feedback										13

As a Taskforce **you told us** we could be better at preparing you for the meeting and that you didn't get adequate opportunity to use the butcher paper / post in notes around the room. Some of you would have liked more opportunities to share with the larger group. You also told us that it would be a good idea to record the presentations and upload them onto the ACI website. These are all comments we will take on board in preparing for June. The majority of you wanted to stay at a half day Friday PM meeting.

Notice of Workshop — Respondents (n): Not convinced* ≈ 6, Got it right* ≈ 34

Materials Prior — Respondents (n): Not convinced* ≈ 15, Got it right* ≈ 24

Clear Objectives — Respondents (n): Not convinced* ≈ 9, Got it right* ≈ 28

Choose a table — Respondents (n): Not convinced* ≈ 10, Got it right ≈ 30

Choose a table - feedback — Respondents (n): Not convinced* ≈ 10, Got it right ≈ 28

Workshop achieved objectives — Respondents (n): Not convinced* ≈ 9, Got it right ≈ 30

Full group discussion — Respondents (n): Not convinced* ≈ 13, Got it right ≈ 26

Opportunity to provide input — Respondents (n): Not convinced* ≈ 10, Got it right ≈ 30

Butcher paper / post it notes — Respondents (n): Not convinced* ≈ 17, Got it right ≈ 22

*Using evaluation data Not convinced =1,2,3 Got it right=4,5

Facilitator - prepared

Facilitator - pace

Facilitator - group dicussion

The best day for meetings in the future is:					
	M	**T**	**W**	**T**	**F**
Half day (AM)	4	3	2	2	4
Half day (PM)	9	7	7	6	15
Full day	1	1	3	1	3

*Using evaluation data Not convinced =1,2,3 Got it right=4,5