The medical inpatient journey

### Key

- ACI=NSW Agency for Clinical Innovation
- CEC=NSW Clinical Excellence Commission
- HETI=NSW Health Education and Training Institute
- LHDs=NSW Local Health Districts and Speciality Networks
- MOH=NSW Ministry of Health
- IDT=Interdisciplinary
- HITH=Hospital in the Home
- MAU=Medical Assessment Unit

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**WHOLE OF HOSPITAL: ACCESS TO CARE**

- **MAU**
- **HITH**

Patient in the community → Patient enters the service → ED to Inpatient → Inpatient to Inpatient → Patient exits service → Patient in the community

**Clinical Management Plan** → **IDT Ward Round** → **Estimated Date of Discharge** → **Waiting for What** → **Criteria Led Discharge** → **Transfer of Care**

**CARE COORDINATION**

Leads: **ACI** → **MOH** → **LHDs** → **CEC**

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

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Patient Flow Systems

**PATIENT FLOW PORTAL** (Ministry of Health)
- Bed board: estimated date of discharge / waiting for what
- Predictive tool
- Dashboard

**STATUS:** IMPLEMENTED

- MAU reports
- Electronic Patient Journey Board

**STATUS:** USER TESTING

**SMOOTH PATIENT FLOW** (HETI)
Three stage blended learning program
1. Self-Directed Learning, Reading and Research.
2. eLearning module developed by HETI.
3. Continuous Improvement Activities

**STATUS:** READY FOR IMPLEMENTATION
Clinical Management Plan

The clinical management plan should articulate the:
1. patient’s goals
2. team’s agreed actions including responsibilities and timeframes

Supporting documents:
1. Daily plan (progress notes)
2. Problem Management Sheet
3. Weekend Handover

STANDARD 1: CONDUCT A SINGLE COMPREHENSIVE ASSESSMENT
- A complete assessment of the patient’s past and current physical, cognitive and social function
- The comprehensive assessment should be informed by other care providers and be contributed by the risk assessment, medication reconciliation and estimated date of discharge (EDD)

STANDARD 2: USE ISBAR TO DOCUMENT IN A CLEAR AND CONCISE MANNER
- Use the ISBAR structured approach to communication when documenting the clinical management plan

STANDARD 3: PLAN YOUR COMMUNICATION WITH PATIENTS, FAMILY/CARERS AND CARE PROVIDERS
- Develop and agree patient goals in partnership with patients and family/carers, including agreed actions, identified responsibilities and timeframes
- Gather information from other care providers outside the hospital e.g. General Practitioners or Residential Aged Care Facilities

STANDARD 4: RECOGNISE AND RESPOND TO DETERIORATING AND/OR DYING PATIENTS
- Document the deteriorating patient’s needs and the action that has been taken to escalate care
- Document existing advance care plans or initiate advance care planning discussions

STANDARD 5: REVIEW CLINICAL MANAGEMENT PLAN ACCORDING TO ONGOING NEEDS OF PATIENT
- Additional assessments may be necessary as a patient’s needs change; review existing information gathered to date
- Acknowledge the work of your colleagues when reviewing the clinical management plan as patient needs change. Know the plan, share the plan, action the plan

STANDARD 6: DEVELOP COMPREHENSIVE DISCHARGE PLAN
- The plan for discharge should commence on admission with an estimated date of discharge identified within 24 hours of admission
- Provide written evidence of the discharge plan
In Safe Hands aims to build and sustain **effective health care teams**. Structured Interdisciplinary Bedside Rounds (SIBR) is one component of the In Safe Hands program.

SIBR has been shown to:
> improve patient safety
> improve communication
> promote a patient centred approach to care
> develop and improve team structures

**Ward Rounds**

**STATUS: READY FOR IMPLEMENTATION**

30 teams currently implementing

Links to:
- Clinical Management Plan
- Criteria Led Discharge
- Transfer of Care
**Supporting documents:**
- CLD form
- Transfer of care checklist
- Policy/procedure
- Competency set
- Education/orientation slides
- Patient leaflet (in draft)
- Patient and Staff experience questions
- Audit form
- Implementation checklist

**Links to:**
- Clinical Management Plan
- Ward Rounds
- Transfer of Care
Transfer of Care

Safe Clinical Handover
A resource for transferring care from General Practice to Hospitals and Hospitals to General Practice

Electronic Discharge Summary (CEC/eHealth)
• Primary care consultation completed
• Hospital consultation in progress

STATUS: IN DEVELOPMENT
Implementation

Define the change
Build the agent capacity
Assess the climate
Generate sponsorship
Determine change approach

Prioritise action

Create culture fit

Develop culture fit

Develop reinforcement strategy

Build communication plan

Develop target readiness

Monitor
Plan
Implement
Hidden influencers

Who do you go to for advice and assistance at work?

- Internal to your organisation
- Internal to health
- External to health
Wrap up

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