

Acute Care Taskforce Workshop Report - Friday June 14

Co Chair Prof Jeremy Wilson welcomed the Taskforce to the second meeting. He highlighted the leadership role of this group and each member's importance in gathering and sharing information about *improving the medical inpatient journey*. Jeremy reiterated the role of nominated members with the following video: http://www.ted.com/talks/derek_sivers_how_to_start_a_movement.html.

Evidence Review

Kate Lloyd, Manager, Acute Care presented highlights from the evidence review commencing with communication/engagement and moving throughout the inpatient journey:

- Clinical Management Plans
- Ward Rounds
- Patient Flow
- Criteria Led Discharge
- Transfer of Care

And finishing with patient centred care.

The presentation can be found at: <http://www.aci.health.nsw.gov.au/networks/acute-care-taskforce/meetings>.

The Medical Inpatient Journey at Nepean

Anita Sharma, Geriatrician, Nepean Hospital presented the Medical Inpatient Journey at Nepean Hospital.

The presentation can be found at: <http://www.aci.health.nsw.gov.au/networks/acute-care-taskforce/meetings>.

A patient perspective

Jenni Brackenreg, Consumer Representative ACT presented a patient journey story that provided many issues for consideration. Jenni's presentation focused on improving communication:

- with patients and carers
- between health care teams
- between facilities

Jenni also shared a video from the Cleveland Clinic titled [Empathy: The Human Connection to Patient Care](#).

Patient Journey Boards

Three patient journey board presentations were made focusing on

- Huddle boards with bespoke magnets to document that inpatient journey visually (by Deb Stewart, Clinical Redesign Manager, NBHS HKHS and Sue Hair, Director Nursing and Midwifery, Manly Hospital)
- Huddle boards to document the inpatient journey visually and bedside boards to document patient care, patient and family questions and goals for the day (by Denise Harris, A/Director of Nursing and Midwifery, Northern NSW LHD).

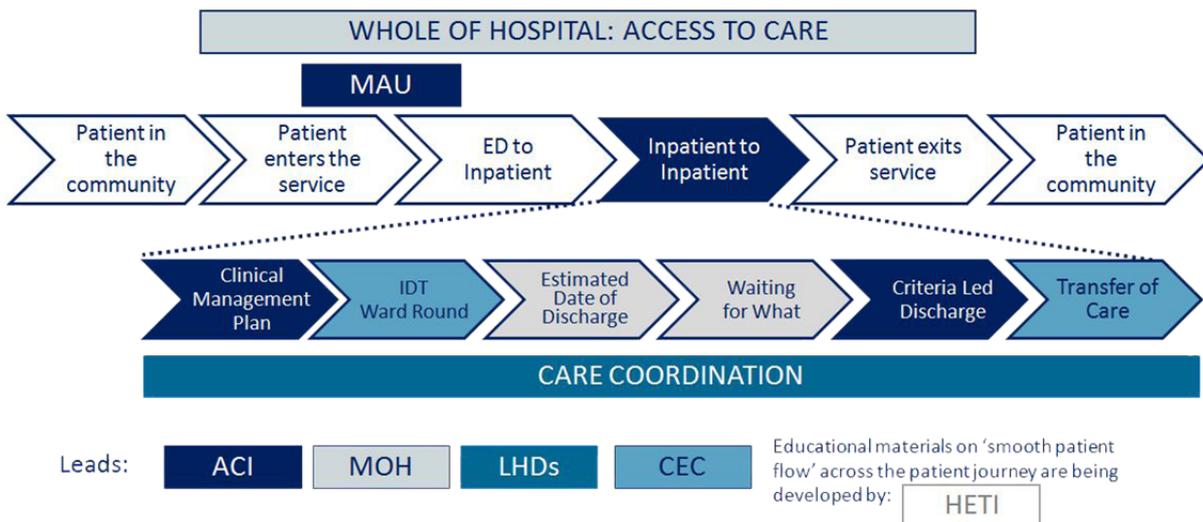
- Bedside boards to document patient care, patient and family questions and goals for the day in conjunction with a Structured Interdisciplinary Bedside Round (by Sue Patterson, Director of Nursing and Midwifery, Orange Health Service).

The presentations can be found at: <http://www.aci.health.nsw.gov.au/networks/acute-care-taskforce/meetings>.

Updates on Medical Inpatient Journey Project

The ACT focus is currently on improving the medical inpatient journey (Figure 1).

Figure 1: Improving the medical inpatient journey



Clinical Management Plans

Dr Tracy Brown, Geriatrician and lead of the clinical management plan working group (CMP WG) provided the ACT with an update on the CMP WG. Five high level principles have been suggested:

1. Partner with patients, family and carers
2. Structured Communications
3. Interdisciplinary Communications
4. Concise communications reviewed regularly
5. Link to primary health care plans

These principles are applied across two methodologies:

1. Acknowledge, Review, Refine (A.R.R.)
2. Before, Now, Why (B.N.W.)

Aligning with the evidence that recommends taking a more structured approach to communicating the three templates that have been suggested for use are:

1. Progress / Clinical Notes shared across the interdisciplinary team
2. Problem Sheets, particularly for weekend teams
3. Handover Notes

Action

Acute Care Taskforce members to contact Kate Lloyd 9464 4623 or kate.lloyd@aci.health.nsw.gov.au to discuss testing CMP tools. This work will occur between July and September.

Criteria Led Discharge

Grainne O'Loughlin, Director, Allied Health and criteria led discharge working group (CLD WG) member updated the ACT regarding the CLD outputs that include a:

- Framework (pathway)
- CLD form
- Revised Transfer of Care checklist

The CLD WG has adapted a draft five step process for CLD:

1. Interdisciplinary team (IDT) reviews patient and identifies eligibility for CLD.
2. Senior medical staff member signs off eligibility for CLD and assigns delegation to identified staff member.
3. IDT agrees on criteria for discharge; these may be a mix of medical, nursing, allied health and social criteria/milestones for the patient to meet/achieve. As part of this process the IDT agree on estimated date of discharge (EDD).
4. The estimated date of discharge (EDD) is reviewed on a daily basis.
5. Criteria/milestones are clearly documented on the CLD form in the patient record and linked to the inpatient management plan to ensure smooth transfer of care.

The CLD WG also adapted the Queensland Health protocol for a clinician who has the delegated authority to transfer care using CLD:

- An employee of NSW Health (not agency staff)
- Ability to assess and make critical decisions regarding discharge
- Have at least two years post registration clinical experience
- Be an Endorsed Midwife (for maternity/neonatal DRGs)
- Have the support of their line manager to confirm that
 - Their post is one of which they will have the need and opportunity to initiate and have the delegated authority to conduct CLD
 - Team protocols and patient criteria have been developed, agreed and are in operation
- They will have access to and support of the MDT clinical team
- Have completed three mentored CLDs
- Follow the discharge criteria when discharging patients on CLD

All presentations can be found at: <http://www.aci.health.nsw.gov.au/networks/acute-care-taskforce/meetings>.

Action

Acute Care Taskforce members to contact Kate Lloyd 9464 4623 or kate.lloyd@aci.health.nsw.gov.au to discuss testing CLD tools. This work will occur between July and September.

In Safe Hands

Wilson Yeung, Program Lead - In Safe Hands provided a program update for the rounding approach being developed by the Clinical Excellence Commission (CEC). Wilson linked the work of In Safe Hands to the NSW Ministry Whole of Hospital Program and the Patient Flow Portal. He informed members that the following wave 1 Whole of Hospital facilities (1-10) and five additional facilities (11-15) have been invited to take part in a residential to further explore In Safe Hands:

1. Nepean
2. POWH
3. RPA
4. RNSH
5. Coffs Harbour
6. Liverpool
7. Orange
8. Westmead
9. Gosford
10. Hornsby
11. St Vincent's
12. Mona Vale
13. Griffith
14. Dubbo
15. Bathurst

The residential will be focused on coaching and skilling up units to implement In Safe Hands and the structured interdisciplinary bedside round (SIBR).

Solution Design Workshop

After listening to the presentations the ACT broke off into groups and moved around four stations: Clinical Management Plans, Ward Rounds (In Safe Hands), Patient Journey Boards and Criteria Led Discharge.

Clinical Management Plans (CMP)

In discussions the ACT identified important elements for CMP were:

- Maintaining a link to ISBAR and keeping the approach simple
- Emphasis on reaching audience needs
- General support for the use of the AR methodology, particularly for allied health
- Potential benefit for sharing documentation at change of shift

Factors that should be considered by the WG include:

- Understanding the approach used in Victoria
- Consider tertiary training
- Translation to eMR
- State wide adoption of principles / standardisation with senior support from all disciplines and link to other programs (e.g. ABF)
- The issue of senior leadership across disciplines that is needed to improve practice
- consider at both process and documentation

Actions

Kate Lloyd to liaise with the Victorian team regarding clinical management plans.

Kate Lloyd to organise eMR team to present at the next Acute Care Taskforce Executive to explore links to eMR work.

WG to work closely with HETI around an approach for education.

WG to complete documentation to support testing

Criteria Led Discharge

In discussions you identified the important elements for CLD were:

- Sustainability
- Dedicated and trained staff
- Link to specific pathways for identified for patient groups (DRGs)
- Incorporate into business meetings and planning days
- Culture of team

Factors that should be considered by the WG include:

- Identification of well-functioning teams for testing the concept
- Generic criteria e.g. Between the Flags (BTF), off oxygen
- Form completion rates – need consultants to be prompted, reminded
- Excluding CLD between midnight and 6 am
- Ensuring there is an opt out
- Content of training led by working group

Actions

WG to complete documentation to support testing.

WG to work closely with HETI around an approach for education.

Patient Journey Boards

Two main types of patient journey boards were discussed at the meeting. One type was a bedside patient journey board that details the patient goal for the day, health care team contacts and includes a space for patients and their families to write questions for the health care second. The second type was a 'huddle' board that is usually located in the ward and is a meeting place for the multidisciplinary team to conduct patient journey planning.

In discussions you identified the important elements for Patient Journey Boards (PJB) were:

- Inclusion of estimated date of discharge (EDD) and waiting for what
- That clinical care trumps privacy (boards have surname or first name but no diagnosis, although one site reported that no name was on the bedside board)
- having information all on one screen or "at a glance"

Factors that should be considered by the ACT include:

- Electronic Patient Journey Boards and linking with the NSW Ministry of Health Patient Flow Portal team. e.g. integrated with iPads/Tablets
- How to develop key stakeholder buy-in (medical)
- What are the business rules – e.g. rapid rounding with a huddle board
- A consideration to change who leads the round e.g. rotating leads
- Understanding what patients want to know

In the discussions some sites reported:

- initial resistance in publicising nursing VOIP phones → this is not the case now
- Resistance from JMOs in larger hospitals used JMO manager to encourage

In Safe Hands and the Structured Interdisciplinary Bedside Round (SIBR)

In discussions you identified the important elements for the SIBR were:

- Home based team model
- Agreed time for rounds
- Patient safety checklist
- Senior medical ownership
- Executive support

Participants were concerned about sustainability but felt that this work demonstrated teams were

- Taking a chance in a planned way to try something different
- Building a positive, collaborative culture
- Using a localised flexible approach to deliver an improvement to quality care

Feedback

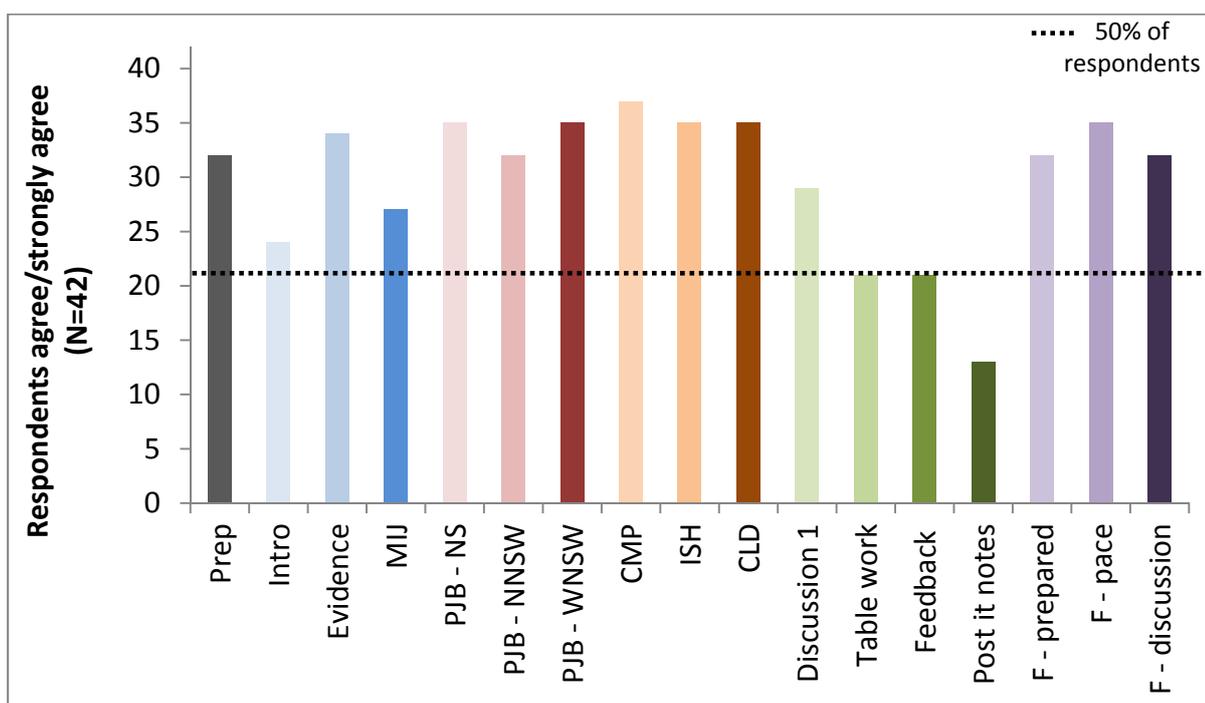
As a group you agreed to be ‘evangelists’ and review own local approaches to improving the medical inpatient journey. One group suggested it would focus on seven day per week thinking. You suggested that you could bring local teams together to ‘fire up’ interest with a focus on team unity. You agreed that you will always make the patient the focus.

You requested support from Pillar agencies and Ministry of Health to:

- Continue to bring people together, in particular through senior clinical and Executive engagement
- Provide the evidence base, including local data
- Provide team building activities and infrastructure
- Provide implementation support
- Create opportunities for LHD/SNs to examine resources to allow staff to concentrate on change processes
- Provide follow up on this meeting

Responses to the presentations were generally positive (Figure 2). Additional work on the discussion sessions, particularly the table work will need to occur ahead of the next ACT meeting.

Figure 2 Acute Care Taskforce – Respondents who agree/strongly agree that the session was valuable



Some specific comments are included below:

- Presentations not long enough at 10 mins / loved the short sharp presentations.
- Not enough time for questions / the walkaround sessions could have been longer too / allow more time for debate and discussion / more interaction, early on.
- I really enjoyed the patient perspective presentation.
- Assist us to develop an action plan.
- Consider inviting Chief Executive’s and Directors of Operations to attend.
- Good to hear implementation of same idea in different locations and to hear practical applications
- Journey board outcomes can be achieved a number of ways / electronic is the way to go.