BUILDING A STRONGER HOSPITAL-COMMUNITY INTERFACE

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ROYAL BRISBANE AND WOMEN'S HOSPITAL

The Royal Brisbane and Women's Hospital

- 986 bed tertiary referral teaching facility
- Major health specialities
- 7,834 staff
  - 3,478 nurses
  - 1,112 doctors
  - 937 allied health

Patient Flow Unit Principles

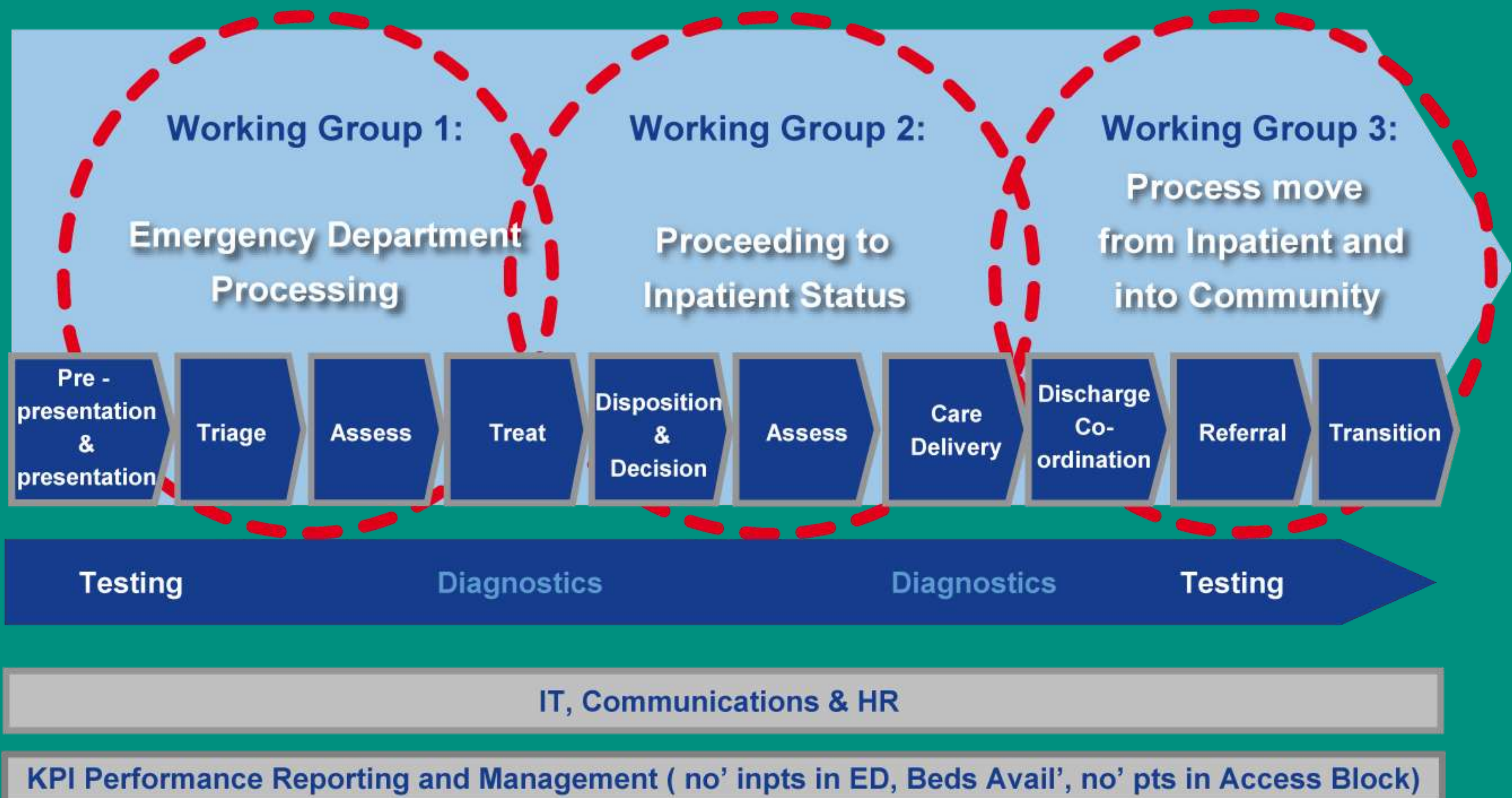
– Explore & implement innovation and improvement

– Collaboration & partnership – internal and external

– Provide resource support

– Maintain data integrity & monitoring

Patient Journey Across the Continuum of Care



Significant Patient Flow Initiatives

- Vascular Case Manager
- ED Falls Project
- Adults with Disabilities
- Weekend discharge services

Patient Flow Unit investigation

Aim to identify discharge delays & impact on LOS

Method:

- Chart Audits
- LOS data
- Clinical expert opinion

Results:

No real surprises – validated anecdotal reports.

The Vascular Problem

- More patients discharged from outlier wards than home vascular ward (552 vs 487)
- Patients discharged from outlier wards stayed on average 7 days longer than patients discharged from vascular wards.

Vascular Case Manager

Outcome: to trial a case manager role for outliers

Would a roving case manager position make a difference to the LOS and quality of care of vascular patients being managed in wards other than the vascular unit?

- Prescribed role developed.

Pre/post intervention study

- Overnight vascular patients
- 3 patient groups:
  - *Inliers* – entire stay in Home Ward
  - *Outlier* – External Wards only
  - *Multi Ward* – Home Ward and External Wards
- Time periods:
  - *Control* - 12 weeks in 2008
  - *Intervention groups* - total 21 weeks

Results:

- Statistically significant reduction in LOS of 3 days between inliers & outliers/multiwards (11.2 to 8.2)
- Nominal cost saving of $360K over 21 weeks
- High MDT satisfaction
- Improved patient satisfaction

….the role continues….

Falls in ED Project

Aim:

- Improve identification, screening, assessment & referral of patients presenting with a fall to ED and returning home to independent community living

  - *in partnership with primary care* -

Falls in ED Project

Method:

- Established hospital & community Steering Committee
- Developed KPIs meaningful to hospital & community
- Developed integrated referrals
- Education to hospital & community staff

Outcomes:

- 50% reduction in falls readmissions with associated cost savings
- Shared resources
- Timely response by community to all high risk fallers

Connecting
Healthcare
In
Communities

Primary Health Care
Partnership Councils

Adults with disabilities

- Issues with discharging this group
- Emotive and challenging for pts, clinicians and families
- Processes not understood, many people & agencies involved, lots of delays, lots of blame and cranky people.
- Patient Flow undertook initial investigation to understand the issue

What's the problem?

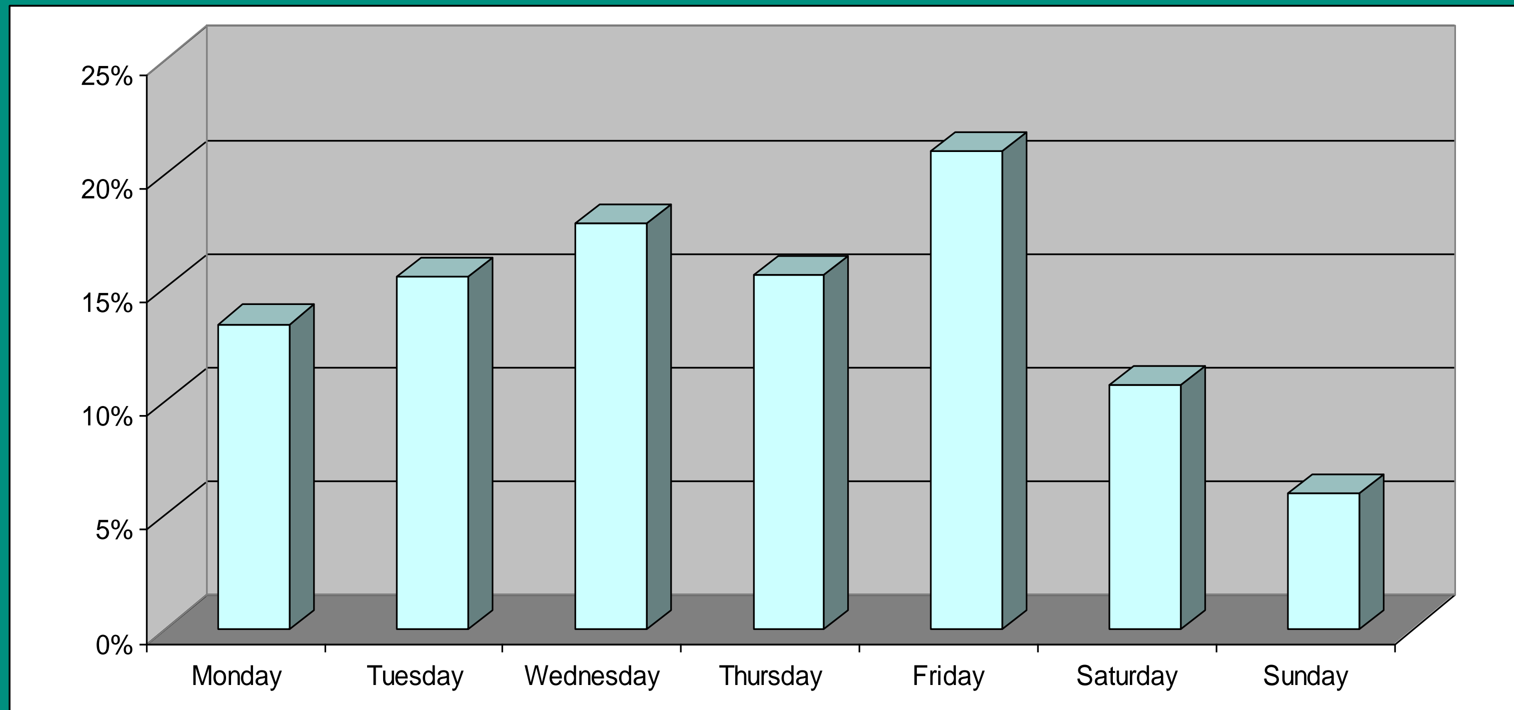
- 9 patients currently in hospital waiting for discharge care and 5 who are acute but will require discharge assistance.
- Since we have been collecting data:
  - Average age – 48 years (range 19-92)
  - 14% already a disability services client
  - Average NON-ACUTE LOS 102 days

Collaborating with disability sector and ACAT for 18 months.

- Achievements
  - An agreed process of referral & assessment between sectors
  - An inpatient management pathway
  - Case management role
  - A centralised and single point of contact
  - KPIs and regular reporting
  - Local level access for escalation

Weekend Discharge Services

The Problem…



Would a Discharge Service on the weekend help the problem?

Objectives:

- Increase patient discharges on weekends to reduce weekday peaks
- Identify issues and barriers to weekend discharge

- Implemented discharge service for a 20 week trial
- Voluntary rostering with existing experienced staff
- Advertised service, case-finding strategies, KPIs established

Outcomes:

- No difference in % discharges at weekend
- Major reasons pts couldn’t be discharged on weekends
  - No allied health service for final inpatient assessment & clearance
  - Access to transport
  - Delays with diagnostic services

Recommendations:

- Implement discreet MD discharge team esp nurse, social worker, and OT
- More criteria-led discharge protocols
- Pre-arranged transport services
- Maintain discharge planning focus across the weekend hours with **use of EDD**, standardised discharge **risk screening**, increased **education of staff** in simple discharge planning.

In summary, what is working at RBWH?

- Our whole of organisation approach to patient flow
- High level governance and accountability
- Our partnership & collaboration with the community sector
- Our use of data to support change
- Our willingness to test and try ideas