THE 20,000 DAYS CAMPAIGN

Health System Improvement Guide

TRANSITIONS OF CARE

Goal Discharge Date and POAC Facilitated Discharge

Version 1
December 2013

KO AWATEA
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

COUNTIES MANUKAU HEALTH

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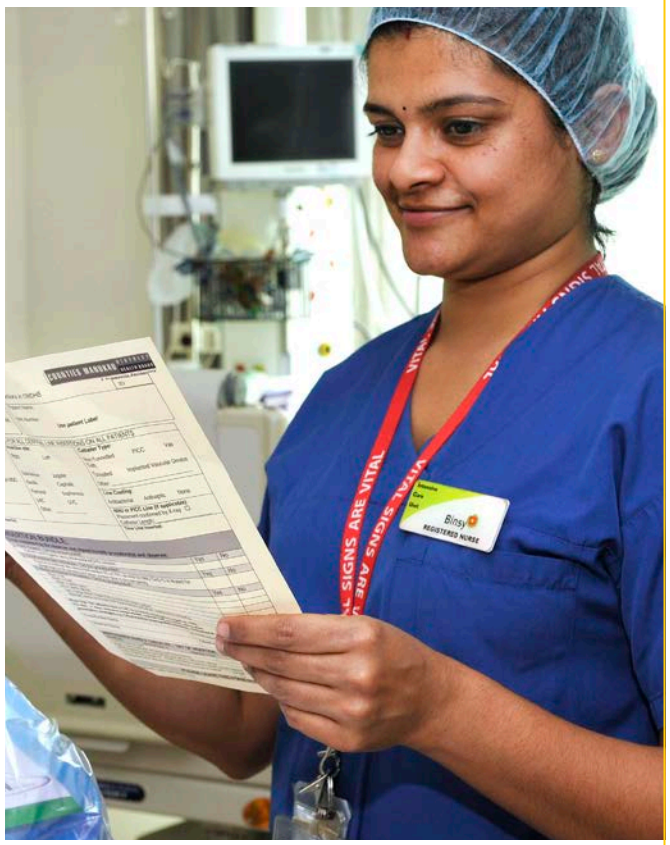


THE 20,000 DAYS CAMPAIGN

Our journey

Health systems worldwide are struggling with rising patient demand and Middlemore Hospital, which serves a growing and ageing population, is no exception. To meet the predicted 5.5% increase in bed days, we needed to save 20,000 days. Counties Manukau Health's 20,000 Days campaign aimed to do this by returning 20,000 well and healthy days to our community.

A whole-of-system approach brought together 13 collaborative teams to build on existing improvement work and deliver care in a different way. The 20,000 Days campaign launched in October 2011, and in May 2012 the collaborative teams came together, using the Institute for Healthcare Improvement's Breakthrough Series Collaborative Model for Achieving Breakthrough Improvement, to test a range of interventions.

By 1 July 2013 the campaign had achieved 23,060 days saved since June 2011, which is a reflection of the difference between the actual bed days used and the predicted growth.

Throughout our journey we also achieved many key successes and learned a lot about the essential collaborative components required to contribute to successful outcomes.

What worked well for our campaign?

- Alignment around a common goal
  - The campaign had a unifying goal to reduce demand on the hospital. This goal recognised we needed to do things differently and all the collaborative teams shared in this goal. In addition, each collaborative had specific aims and change ideas that would ultimately contribute to the overall campaign goal.

- Leadership and expert support for the collaborative teams
  - Geraint Martin, CEO Counties Manukau Health, as sponsor and Jonathon Gray, Director Ko Awatea, were involved throughout the campaign to ensure that the vision and milestones were met.
  - The Ko Awatea campaign team provided support via the campaign manager, campaign clinical lead, collaborative project managers, improvement advisors and a communications co-ordinator.
  - The campaign partnered with the Institute for Healthcare Improvement and Brandon Bennett, Senior Improvement Advisor at the Ko Awatea faculty, to provide continuous learning and guidance for the collaborative teams.

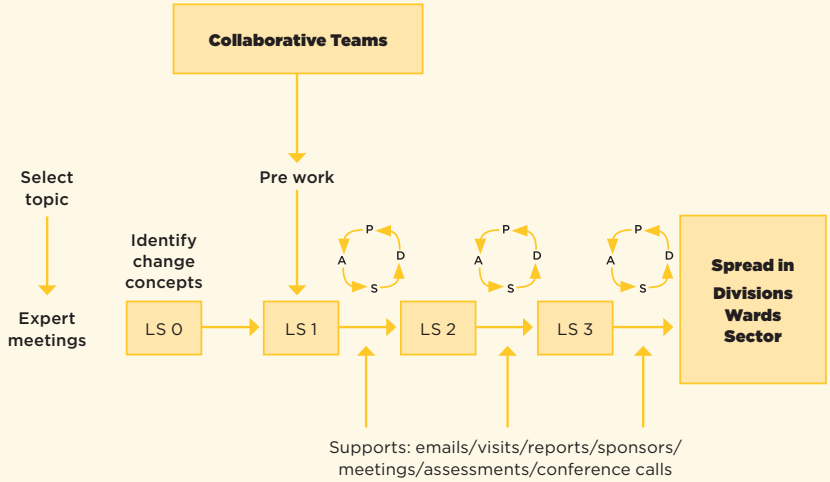
What the 20,000 Days campaign has built is a reusable network of skilled, passionate and committed health professionals who have the knowledge, skills and methodology to bring about sustainable change across the health sector.

Professor Jonathon Gray
Director, Ko Awatea

» Multi-professional teams working across the health sector
  › Collaborative teams included health professionals, managers, clinical leaders, project managers, improvement advisors, data analysts and community members.
  › Teams worked on projects across the sector, including primary care, secondary care and in the community.

» A structured series of milestones and activities
  › The Collaborative Model for Achieving Breakthrough Improvement (Figure 1) provided an ongoing series of structured activities to support the teams in their use of the methodology and to promote collaboration between the teams.
  › During the campaign there were a total of six days of learning sessions attended by 100–120 people. Significant expertise has been built up across the organisation in the improvement methodology.
  › The collaborative methodology has been proven to work extremely well as a structured way to implement evidence-based practice, and has been enhanced by using local knowledge and skills within the Counties Manukau context.

Figure 1: Collaborative Model for Achieving Breakthrough Improvement[1]



LS – Learning session

The Breakthrough Series:
Institute for Healthcare Improvement Collaborative Model for Achieving Breakthrough Improvement

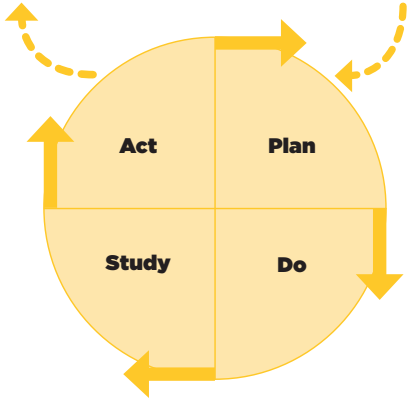
- The Model for Improvement
  - Each collaborative team applied the Model for Improvement (Figure 2).
  - Teams then tested their theory of change through Plan, Do, Study, Act (PDSA) learning cycles.
  - Teams tested many ideas, initially through small tests to gain confidence in their change ideas, then with larger scale tests, before moving to implement changes across the organisation or area of work.
  - Change packages are captured in the health system improvement guides, to be shared with other health service providers and support improvement initiatives beyond Counties Manukau Health.
  - Measures have been defined at both the 20,000 Days campaign level as well as for each of the collaboratives. The measures were analysed and displayed monthly on dashboards.
  - Each collaborative developed a driver diagram showing drivers of change. The driver diagram reflects the team's theories and ideas on the existing system and how it could be improved. This diagram was updated throughout the improvement journey based on lessons learned during the testing of ideas. Some of the ideas failed and were abandoned. Change ideas shown in the final driver diagram (p. 8) reflect successful ideas. These were tested using multiple PDSA cycles before implementation.

Figure 2: Model for Improvement[2]

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Collaborative Teams

- Healthy Hearts
- Safer Medication Outcomes on Transfer Home (SMOOTH)
- Better Breathing
- Very High Intensity Users (VHIU)
- Transitions of Care
- Early Delirium Identification and Management
- Enhanced Recovery After Surgery (ERAS)
- Hip Fracture Care
- Skin Infection

For further information refer www.koawatea.co.nz

WHY DID WE NEED TO DO IT?

What was the problem?

Our health system delivers the care that patients need, but the timeframe in which it is delivered is often influenced by systemic factors.

The hospital discharge process is complex. Members of healthcare teams have other work priorities that compete with overseeing the discharge planning process. The acuity and care needs of other patients often take precedence over the discharge planning process for patients who are ready for discharge.

In addition, there are often communication and coordination problems around the care plan and likely discharge date. These problems can occur within multidisciplinary healthcare teams as well as between health professionals and patients and their families.

Achieving timely discharge for patients is challenging when referrals for new tests and procedures, service or speciality consultations are initiated in the afternoon at the conclusion of the daily ward rounds rather than in the morning during the ward round itself. This delay in initiating referrals unnecessarily extends the length of stay for some patients.

The benefits of change

Avoiding unnecessary delays to discharge is beneficial to patients, their families, and to the hospital facility in a number of ways:

» Patient satisfaction is increased through clear, defined expectations of care and more timely discharge.

» Disruption to family life is minimised, and family/whaanau are able to plan for transport arrangements and home support required after discharge.

» The risk of hospital-acquired infection and falls is reduced, as the risk of these is proportional to the length of stay.

» More timely discharges provide better patient flow and allow more efficient bed management.

I have found the GDD very helpful for patients that I am planning to see post discharge. It gives me an idea when they may go home and then I can look out for their discharge and make a home visit the following day.

District Nurse

WHAT WAS OUR AIM?

The optimum time for patient discharge is when the patient is medically safe to be at home and feels confident in their abilities, and when their ongoing needs and recovery can be equally well provided at home.

Our assumption

We worked on the assumption that we could improve the patient journey through our healthcare services with better understanding and communication of the patient's discharge date. This would allow patients, families and other services to plan for discharge in advance.

Our aim

Our aim was to improve the discharge process at Middlemore Hospital. Specifically, we aimed to:

» Increase the number of medical and surgical patients having a goal discharge date set on admission at Middlemore Hospital from zero to 100 per cent.

» Increase the number of referrals from Middlemore Hospital to the Primary Options for Acute Care (POAC) service. POAC facilitates early discharge by providing healthcare professionals with access to investigations, care and treatment for patients who can be safely managed in the community.

What did we do?

We focussed on active discharge management. The key to effective discharge planning is to work towards discharge from the time of admission. We developed a change package to support this, which included:

» The introduction of a goal discharge date.

» Effective means for communicating the goal discharge date to patients and their families.

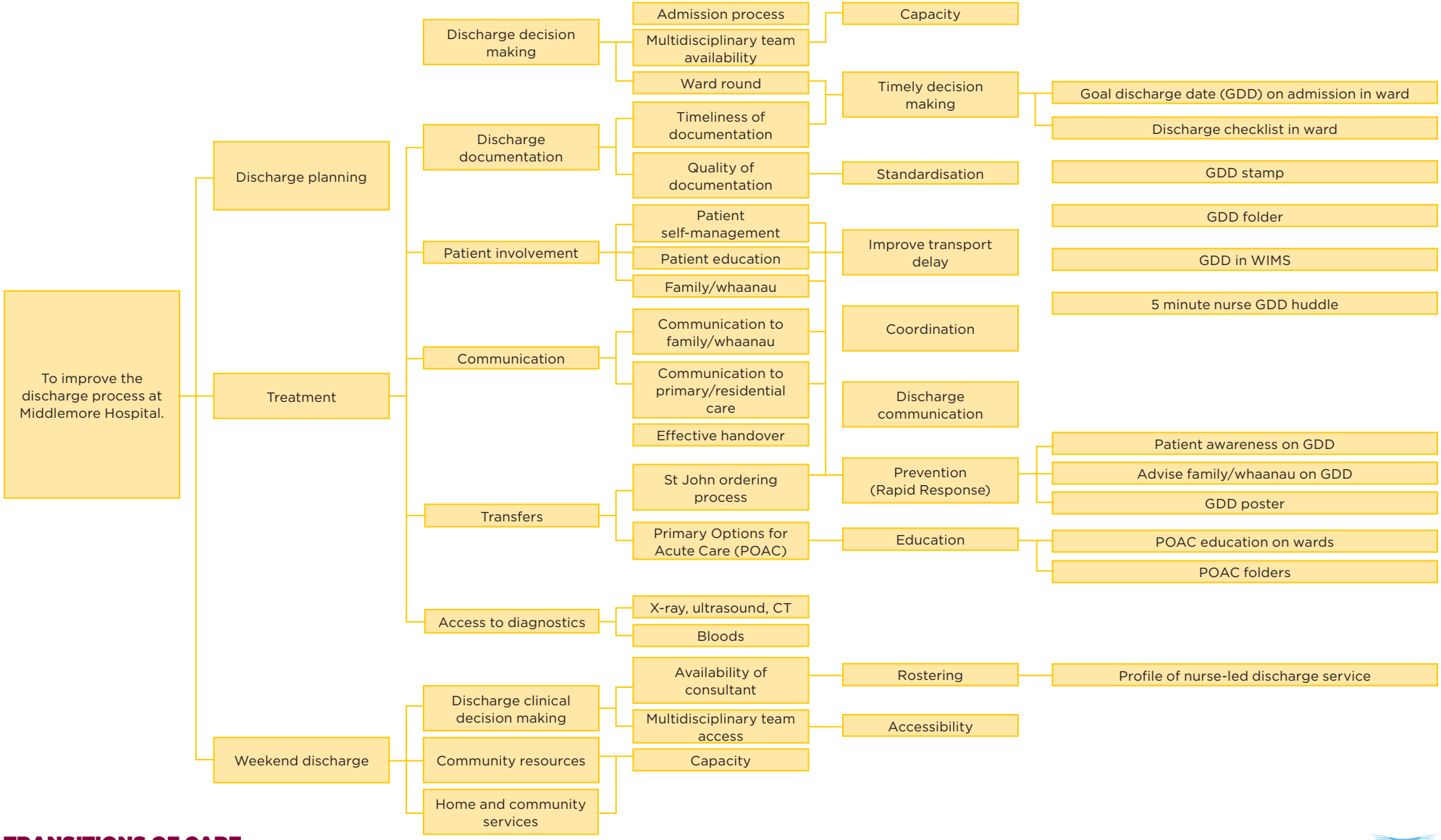
» The introduction of ward-round folders incorporating all necessary referral forms (for example, lab tests and radiology) to be completed during the ward round, thereby enhancing the timeliness of the referral process.

» Optimisation and raising awareness of the nurse-facilitated discharge process to improve the timeliness of discharge for patients with a weekend goal discharge date.

» Use of the Primary Options for Acute Care (POAC) service where appropriate to meet the goal discharge date seven days a week.

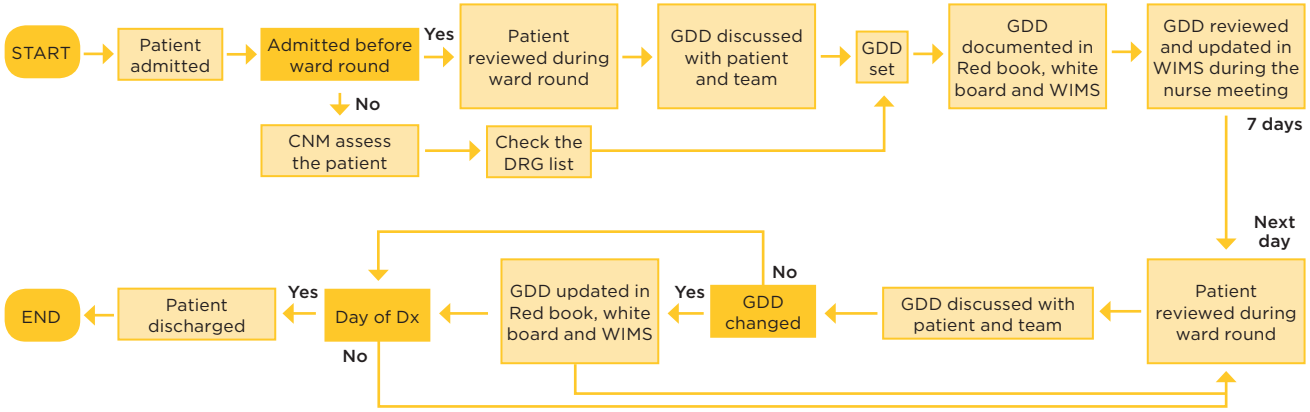
We frequently have a number of patients daily that we look up for the GDD on WIMS and try to plan for when they are expected to go home so that they do not get missed.
Clinical Nurse Coordinator, District Nursing

THE DRIVERS OF CHANGE



CHANGE PACKAGE – GOAL DISCHARGE DATE

Figure 3: Process map of setting and reviewing a goal discharge date



Why was the change needed?

Using a goal discharge date as a tool for improving communication in the multidisciplinary team and with patients and their families/whaanau assists in avoiding unnecessary delays in patient discharge. It also allows the healthcare team to prioritise their workload according to which patient's discharge is imminent.

How did we do it?

We developed a standardised process map for wards piloting the goal discharge date (GDD) based on the admitting nurse setting the patient GDD before having it confirmed or adjusted on the post-acute ward round (Figure 3). Where possible, the GDD was set by using historical data from the Diagnosis Related Group coding list on average lengths of stay for patients with the ten most common conditions. The GDD was then reviewed on the daily ward round by the ward team.

For some patients, a diagnosis by the medical team on the post-acute ward round was required before a best estimate for a discharge date could be given.

The GDD was entered into the electronic Ward Information Management System (WIMS) and written on the ward whiteboard, to be updated as required. This ensured that the entire multidisciplinary team working with a patient had access to the GDD.

An essential component for embedding the setting and review of a GDD for each patient into practice was weekly monitoring of the consistency of recording the GDD in WIMS, and auditing discharged patients as to their recorded GDD. Data gathered was discussed at weekly working group meetings to track the progress of implementation of the GDD on each ward.

CHANGE PACKAGE – GOAL DISCHARGE DATE

The things that helped

Afternoon coordinator

We used an afternoon coordinator on one of the wards to ensure that the goal discharge date was entered into WIMS and written and updated on the ward white board. This resulted in a marked improvement in electronic recording and updating of the GDD.

Five minute nurse GDD huddle

A quick nurse huddle at a computer following ward rounds ensured that the electronic GDD was updated in WIMS.

Patient GDD poster

Development of a poster (Figure 4) displayed on the wards for patients and staff helped to set expectations for the discharge process.

Engaging key staff

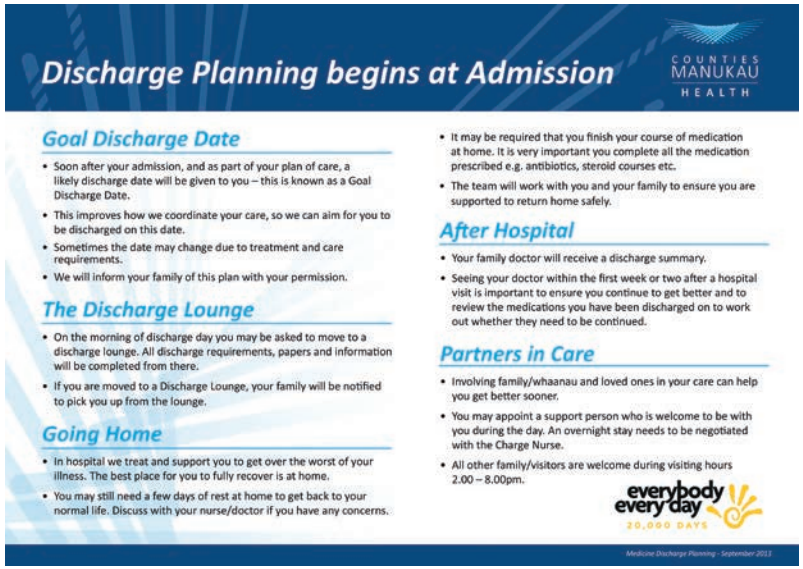
The successful implementation of the goal discharge date in the three medical wards we selected to pilot the GDD concept, and its subsequent spread to other medical wards, was directly attributable to the nurse manager Michele Carsons and charge nurse managers Janene Lawrence, Ruth Prakash and Brian Gabolinscy.

In the surgical service, the introduction of the GDD was championed by the surgical services patient flow coordinator, Clivena Ngatai.

The evidence that supports what we did

The concept of setting goal discharge dates has been validated with proven results by various international agencies, including the National Health Service (NHS), the Institute for Healthcare Improvement (IHI) and the Clinical Advisory Board.[3-6]

Figure 4: Patient GDD poster



Ward whiteboard

CHANGE PACKAGE – PRIMARY OPTIONS FOR ACUTE CARE

Primary Options for Acute Care (POAC) is a service that facilitates early discharge by providing healthcare professionals with access to investigations, care and treatment for patients who can be safely managed in the community. It is a solution offered by primary care to assist in managing the acute demand for hospital beds in Counties Manukau Health. A range of community diagnostic, therapeutic and logistic services are available, including:

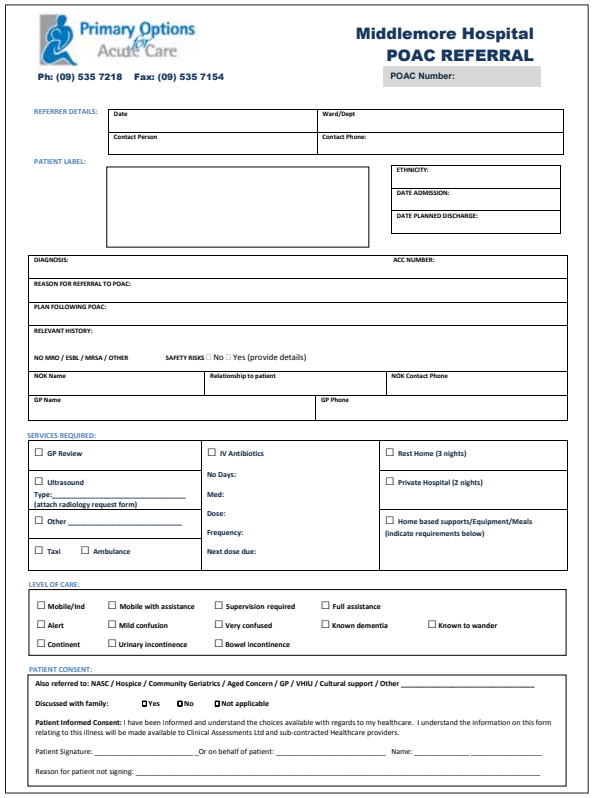
- Diagnostic procedures, e.g. x-ray, ultrasound and CT
- Extended services within the GP's surgery or in an accident and medical centre
- GP or nurse home visits
- Home nursing, home help, Meals on Wheels (a home meal delivery service) and equipment hire
- Intravenous therapy (antibiotics/fluids)
- Transport to and from primary care locations
- Rest home or private hospital care
- Early discharge from hospital into the community

What we did differently

We initiated staff education to increase knowledge of the availability of POAC services. This included:

- Making information about POAC available on the nursing station
- Provision of training on POAC referral criteria
- Running awareness sessions on the role of POAC in patient care
- Charge nurses acting as POAC champions for the ward

Figure 5: POAC referral form



Primary Options for Acute Care

Middlemore Hospital
POAC REFERRAL

Ph: (09) 535 7218 Fax: (09) 535 7154

POAC Number:

REFERRER DETAILS: Date | Ward/Dept | Contact Person | Contact Phone:

PATIENT LABEL: ETHNICITY: | DATE ADMISSION: | DATE PLANNED DISCHARGE:

DIAGNOSIS: ACC NUMBER:

REASON FOR REFERRAL TO POAC:

PLAN FOLLOWING POAC:

RELEVANT HISTORY:

NO MRO / ESBL / MRSA / OTHER SAFETY RISKS ☐ No ☐ Yes (provide details)

NOK Name | Relationship to patient | NOK Contact Phone

GP Name | GP Phone

SERVICES REQUIRED:

☐ GP Review
☐ Ultrasound Type:_____ (attach radiology request form)
☐ Other _____
☐ Taxi ☐ Ambulance
☐ IV Antibiotics
No Days:
Med:
Dose:
Frequency:
Next dose due:
☐ Rest Home (3 nights)
☐ Private Hospital (2 nights)
☐ Home based supports/Equipment/Meals (indicate requirements below)

LEVEL OF CARE:

☐ Mobile/Ind ☐ Mobile with assistance ☐ Supervision required ☐ Full assistance
☐ Alert ☐ Mild confusion ☐ Very confused ☐ Known dementia ☐ Known to wander
☐ Continent ☐ Urinary incontinence ☐ Bowel incontinence

PATIENT CONSENT:

Also referred to: NASC / Hospice / Community Geriatrics / Aged Concern / GP / VHIU / Cultural support / Other _____

Discussed with family: ☐ Yes ☐ No ☐ Not applicable

Patient Informed Consent: I have been informed and understand the choices available with regards to my healthcare. I understand the information on this form relating to this illness will be made available to Clinical Assessments Ltd and sub-contracted Healthcare providers.

Patient Signature: _____ Or on behalf of patient: _____ Name: _____

Reason for patient not signing: _____

We can use the GDD to coordinate and plan with all keyworkers involved in the patient's care, to provide a timely follow-up when the patient is discharged into the community.

We can inform the ward staff of potential risks if for example community services are unable to provide appropriate support on the planned date for discharge. Alternatives can be considered (eg POAC) and an unnecessary readmission may be prevented.

Clinical Nurse Coordinator
Very High Intensity User Team

CHANGE PACKAGE – WARD ROUND FOLDERS

We introduced 70 referral and discharge folders containing all the necessary referral forms for tests, procedures, services or speciality consultations for use on ward rounds.

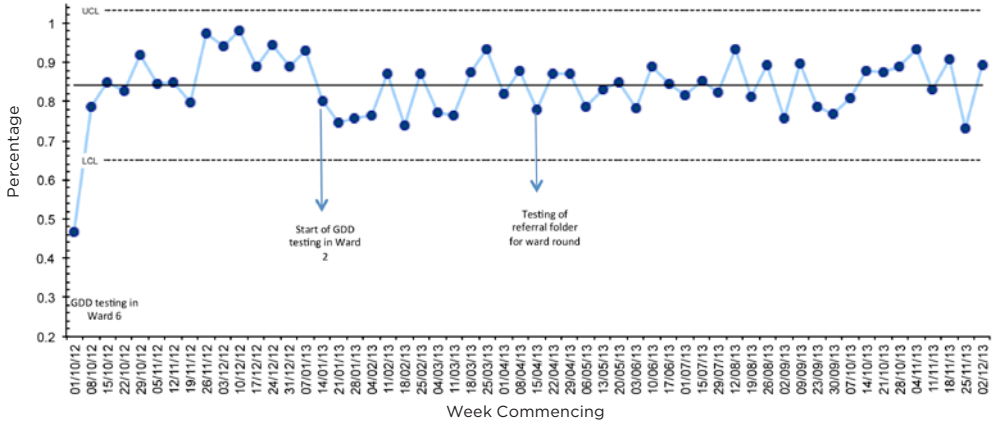
The folder allowed referrals to be made in the morning during the ward round rather than after ward rounds had been completed. This enabled referrals to be processed earlier and reduced 'double handling', resulting in a more timely referral process.

Instigating the referral process during ward rounds also had the added benefit of improving the level of engagement with the patient (and their family/whaanau, if present) by managing their length of stay expectations in a more transparent manner and enhancing communication in relation to their plan of care and treatment

Having a GDD for patients has been very helpful to facilitate a smooth transition of care for patients returning home and requiring specialist home health care services. It has provided an opportunity where planning can be coordinated, especially for patients with complex wounds or needs before discharge to ensure that patients will be supported in a safe and timely manner when returning home.

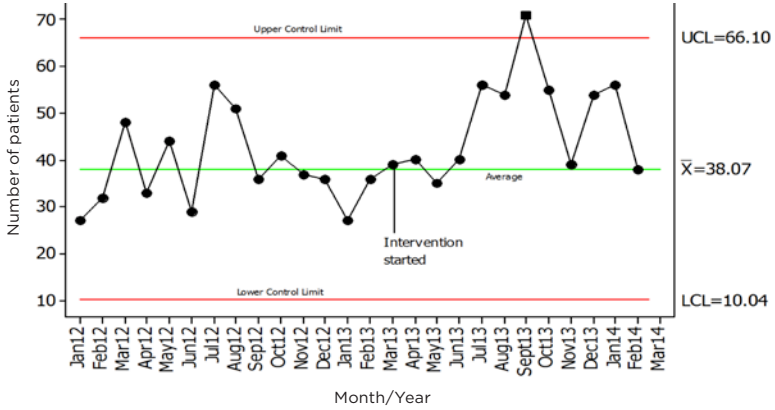
Liaison Nurse, Home Health Care

Figure 6: Percentage of patients with goal discharge date



The process for establishing the goal discharge date (GDD) was tested in Ward 6. Initially, only 45% of patients had a GDD set. This increased to 80% after testing, refinement and scaling up of the GDD allocation process. As confidence in the process increased, GDD allocation was extended into further wards. Since then, the team have consistently set GDD for 84% of patients.

Figure 7: Total number of patients referred to Primary Options for Acute Care per month from Middlemore



The total number of patients referred to POAC shows a shift indicating an increase since the beginning of the intervention. This has a direct impact on bed capacity.

STAFF AND PATIENT FEEDBACK

Patient feedback

We interviewed a patient who was part of the goal discharge date project about his experience. The following is an account of our conversation:

Was it helpful having a goal discharge date?

Yes, it was a good idea. It gave me something to work towards.

Did it work for you?

Yes. Even though we missed the date by one day, it was still good to have a goal. It was explained the date wasn't a 'definite' and that it could change if clinically indicated.

Did your family/whaanau feel included in the goal discharge date?

It was good for my partner to know when to expect I would be coming home – it gave her the opportunity to prepare and plan for my discharge. It meant I knew when the process I was in would end. While I was very impressed with the care I received, it was good to know when this would be over.

Would you recommend we continue to use goal discharge dates?

Yes, I would recommend that it continue. Even though it's not a definite, it gives you an end point to focus on, a date to work towards.

That staff do, and want to do, a good job is not in doubt, but at times patients wait for us to do just this. These waits are not always clinically necessary. This has been the focus of the Transitions of Care group, and especially with embedding the goal discharge date. It provides a stake in the sand that allows services to rally around in making sure patients receive all the care that they need, without unnecessary waits for services.

Clinical Lead – Transitions of Care Group
Director Allied Health, Counties Manukau Health

For patients admitted to hospital that are already known by the Home Health Care service, having a goal discharge date helps ensure the patient receives follow-up care in a timely manner after being discharged. We can plan the next visit according to the goal discharge date and, when supported by a referral update, the continuum of care for the patient is smooth and ongoing.

Clinical Nurse Coordinator
District Nursing

REFERENCES

1. Institute for Healthcare Improvement. The breakthrough series: IHI's collaborative model for achieving breakthrough improvement. IHI Innovation Series white paper. Boston: The Institute; 2003.

2. Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The improvement guide: A practical approach to enhancing organizational performance. 2nd ed. San Francisco: Jossey-Bass; 2009.

3. Department of Health. Achieving timely 'simple' discharge from hospital: A toolkit for the multidisciplinary team. London: The Department; 2004.

4. Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. How-to guide: Improving transitions from the hospital to post-acute care settings to reduce avoidable rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; 2011.

5. Clinical Advisory Board. Next generation capacity management, Volume 2: Best practices for collaborating to drive toward discharge. Washington, DC: The Advisory Board Company; 2009.

6. Tell W. Clockwork efficiency: Creating capacity by avoiding discharge delays. 2012 Australasia Clinical Operations Board Summit; 2012 Nov 7; Wellington, New Zealand. Washington, DC: The Advisory Board Company; 2012.

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everybody every day
20,000 DAYS

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