Criteria Led Discharge - Improving Patient Flow, Discharge Planning And Experience In An Acute Medical Ward in Ireland

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Improving patient flow, reducing Average Length of stay and readmissions to hospital are key objective of the HSE, National Acute Medicine Programme, and Department of Health.

Devolving discharge to competent members of the Multidisciplinary team is a nationally agreed target for acute hospitals. It was hypothesized that Criteria Led Discharge (CLD) - a tool to support safe, timely and effective discharge may be a suitable discharge planning tool to support devolving of the discharge process by competent interdisciplinary team members in Irish hospitals. Planning and testing in one diagnostic group – COPD began in February 2016. If successfully tested it will be adopted as an alternative Model of discharge planning for Acute Hospital Services in Ireland.

The Aims of the improvement programme are:

- To improve patient flow and experience by including 100% of COPD patients admitted under one Consultant on Medical One ward on the CLD pathway by July 2016.
- To reduce AVLOS for COPD patients to < 6 days
- Reduce readmissions within 30 days of discharge by 50%
- Achieve Home by 11am for 90% of CLD patients
- Achieve increased patient and staff satisfaction with discharge planning

Method & Process Change

- Hospital Governance, Interdisciplinary (hospital & community) steering group, planning and testing team established.
- Pareto analysis of ward admissions. COPD identified as lost cohort (most common cause of medical admission and higher AVLOS than other diagnostic related groups).
- Driver Diagram February 2016. (Diagram 1)

Between Feb 16 and May 16th 2016

- PDSAs and Resources (Diagram 2). Staff preparation and competency development programme (x 2); Staff FAQ sheet (x 2); Staff Inhaler technique refreshers (x 3). Patient information (x 1 and ongoing); Patient Management and crisis management (x1). CIT Home follow up (x 1 Plan Programme) staff board developed.
- Patient reported experience (PREM), and Patient Reported Outcome of Care (PROM), Real Data. Real People Toolkit (Consumers Health Forum Australia utilised following PDSAs (x1)).
- Data measures: Numbers staff trained, self rating's of competency; No. patients included on CLD: Home by 11am (target 90%); AVLOS: Balancing measures: removal from pathway and reasons; Readmissions within 30 days of discharge; No. referred to community resources.

Key Reference Materials


Results

Conclusions

Engaging all members of the team is critical to creating ownership as is responding to specific learning needs to increase confidence in competence.

Qualitative data from staff and patients aids learning and identification of change packages.

Too few data points to draw any conclusions of improvement yet.

Next steps

- Ongoing collection of data
- Develop standard operating process (SOP) for CLD
- Introduce Documented Patient Self Management Plan,
- Introduction of CIT and Pulmonary Rehabilitation programme referral
- Measure Staff Experience and re-evaluate self rated measures of CLD competency
- Patient Wheel (PROM and PREM) story collection
- Develop National Guidance Document and Tool Kit

Key Learning Points

- Critical success factors:
  - Governance support and stakeholder engagement
  - Education and programme visibility
  - Team learning from PDSAs
  - Data, and mode of presentation to demonstrate impact and outcomes
  - Supporting teams in developing QI capacity
  - Supporting at a distance is difficult but builds relationships
  - Clinical and cultural fit

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