Why the Wait?

Changing attitudes and culture to ensure timely discharge within older persons medicine.

Aim To decrease the avoidable harm experienced by older people waiting for discharge.

Background

The Royal Bournemouth Hospital is a 600 bed district general hospital serving a population of 550000 with an above average older population. Older people in hospital have increased risk of sarcopaenia, loss in confidence, depression, infections and death. There are an estimated 2.7 million occupied bed days per year in England by older patients who no longer need them[1]. In line with national best practice the trust has set targets regarding daily reviews and expediting patient flow. In the 6 months prior to the start of this project, repeated attempts to implement these recommendations were unsuccessful. Our initial staff surveys found that management believed the main issue to be "clinician non-compliance", whilst ward staff were found to be risk averse in making changes due to a perceived blame culture. Both groups passionately wanted to improve patient care yet there was a divide regarding the best approach. Around an agreed central aim, one geriatric ward sought to change their practices.

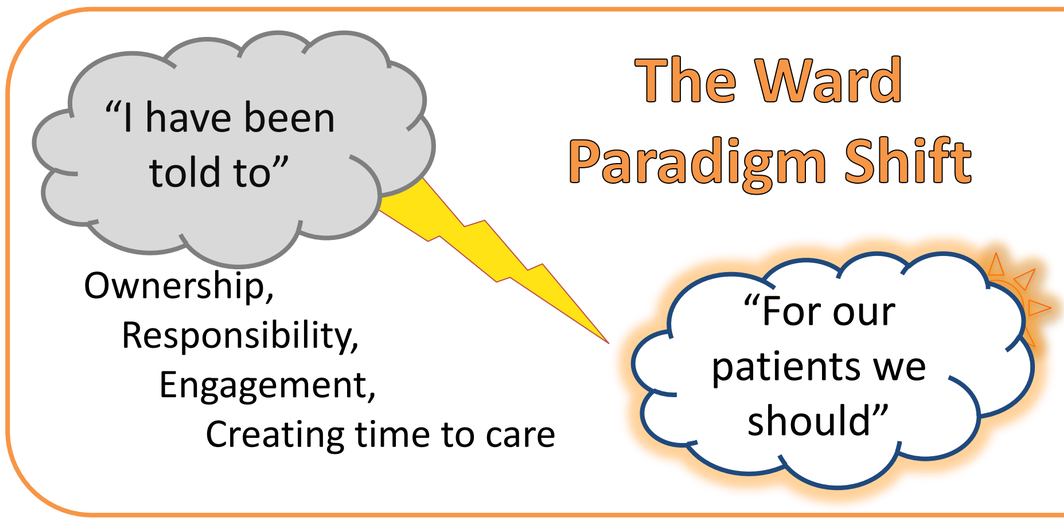
Strategy for Change

Between November 2015 and January 2016 an Occupational Therapist and myself critically observed the multidisciplinary team (MDT) working on an inpatient geriatrics ward. Regular meetings were held with ward staff as well as surveys being completed by staff and patients to help guide possible changes. The MDT was asked to conceive and develop their own changes based upon our observations, measures and feedback. Engagement was quickly established through integration into the MDT and use of patient narratives to establish validity and encourage self reflection. Outcome measures agreed were:

- To increase discharges to 16 per week by June 2016
- To increase proportion of discharges by midday to 33% by June 2016
- Increase patient and carer engagement and satisfaction
- Increased staff engagement and satisfaction

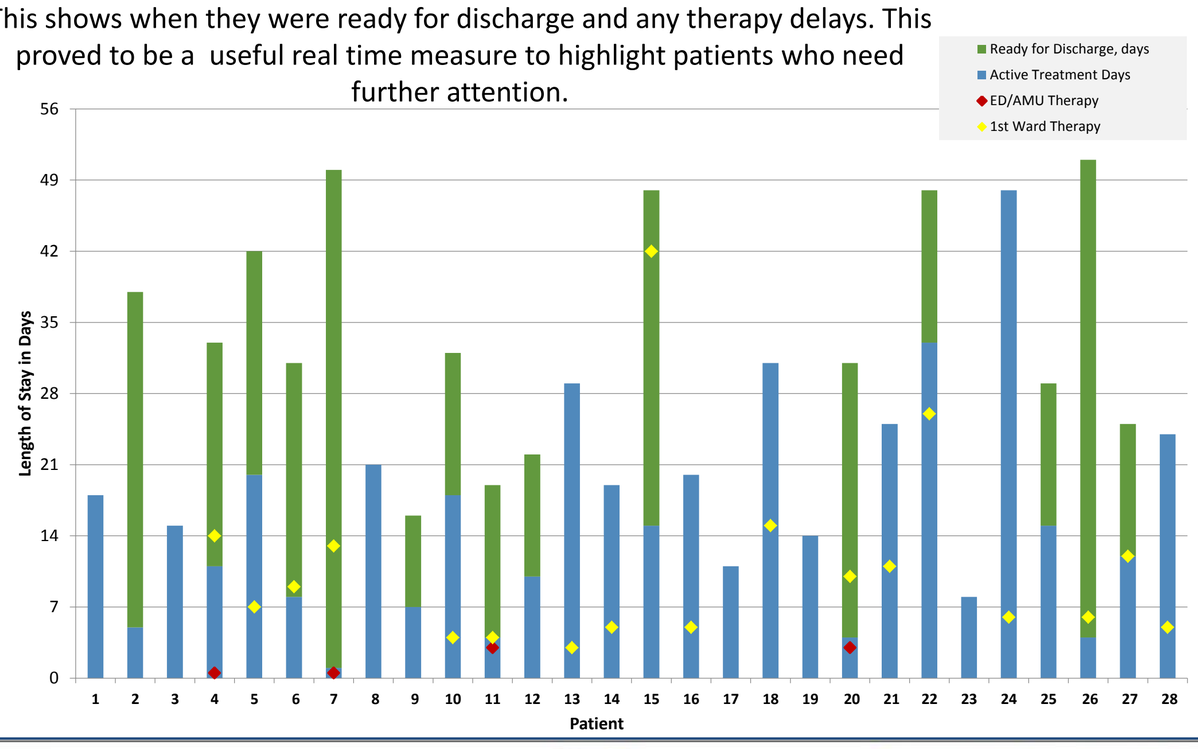
We completed successive PDSA (Plan-Do-Study-Act) cycles based on the processes of the MDT, such as duration, allocation and completion of tasks. We also measured these against our key outcome measures and the duration of stay for each patient from completion of medical intervention and rehabilitation therapy to discharge. We used a reduction in length of stay and decreased time waiting for discharge as a surrogate for decreased harm.

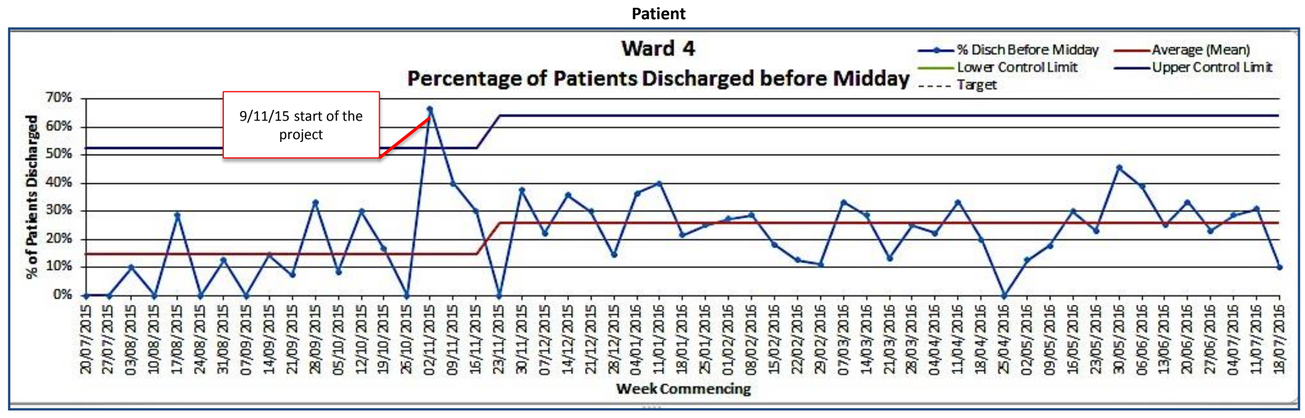
Discharges by midday have increased from 15% to 26% with a mean reduction in length of stay from 12.8 days to 10.7 (2.1 days). Although these measures were useful to focus attention on expediting patient flow, the most powerful measure was the delay between completion of clinical input and discharge date, i.e. the delay in discharge. Routine measures for this are now being instigated at a trust level. The reduction in length of stay has potential savings of 1302 bed days; this could allow an additional 120 patients to access the specialist elderly care services provided on this ward per year.



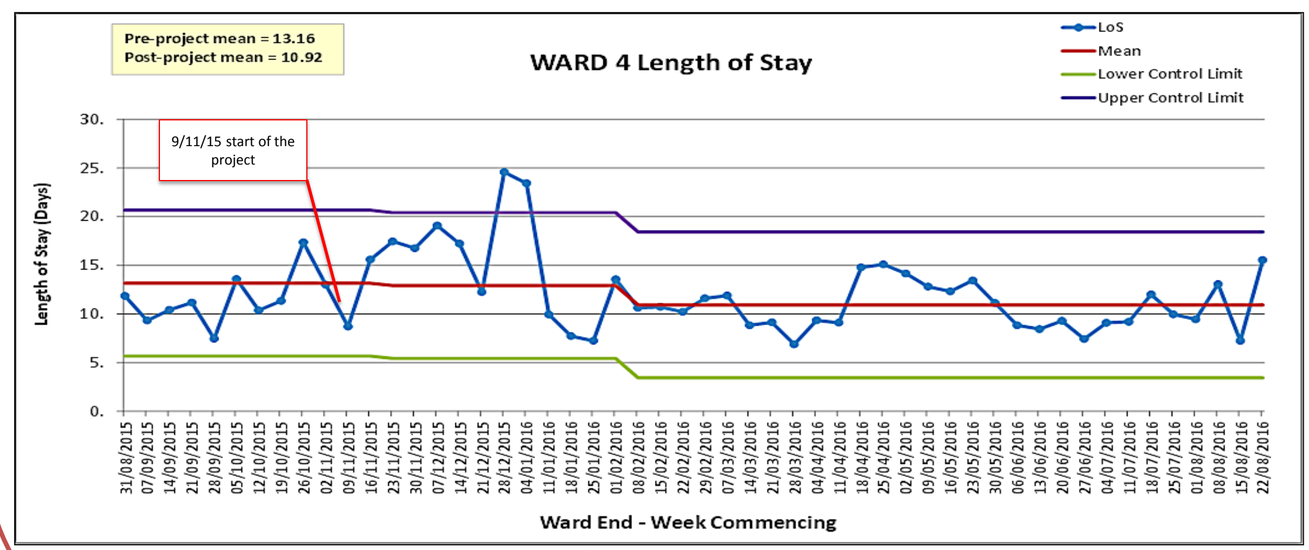
Outcomes

An example of a dashboard showing inpatient delays for all ward patients. This shows when they were ready for discharge and any therapy delays. This proved to be a useful real time measure to highlight patients who need further attention.





Run chart of patients discharged before midday. Patients discharged before midday allow better coordination with community services and facilitate better hospital bed management



Length of stay run chart.

Conclusions

Avoidable harm was minimised by highlighting internal delays and then reducing the unnecessary stay in hospital. Disappointingly we could not get individuals in the trust to agree one definition for expected date of discharge, which therefore remains variable depending upon ward and clinician. Additionally, agreement as to what constitutes a delay to discharge, and the reliable recording of an expected date of discharge is an continuing challenge.

Interestingly all methods suggested and then implemented by the ward to improve patient care and minimise unnecessary delays are accepted best practice and were similar to previous efforts and edicts from trust management. Collaborative changes are being continued and there is now an established working group of ward staff, directorate management and other stakeholders, notably local social services teams, to continue the improvement journey. As can be seen in the run charts, the improvements have been sustained and are on-going. Patient and carer surveys continue to be used to facilitate more focused patient centred care, which we are planning to expand further. Following success on this ward, the changes have spread to 2 surrounding wards with similar levels of success.

Fundamental to this project was giving ownership and responsibility for the change to the ward staff. Feedback on success energised ward staff and management teams to facilitate and expand good practice and novel ideas. We hope this provides a more robust and sustainable improvement than simply imposing new targets.

References: 1: Oliver D, Foot C, Humphries R. *Making our health and care systems fit for an ageing population*. London: The Kings Fund, 2014.

NHS Health Education England

Dr T Bartlett, Wessex QI Fellow and Geriatrics SpR

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust