Project Title

Facilitating Allied Health Discharges in Orthopaedic Patients

Project Lead and Members

Project lead: Matthew Neo

Project members: Lim Kian Chong, Cai Cong Cong, Zeng Hui Hui, Qiu Huaying, Abdul Rashid Jailani, Chee Thong Gan

Organisation(s) Involved

Ng Teng Fong General Hospital

Healthcare Family Group Involved in this Project

Allied Health, Medical

Applicable Specialty or Discipline

Orthopaedics, Physiotherapy, Occupational Therapy

Aims

To enhance current strategies and reduce the number of delayed discharges awaiting AHP review by 80% by April 2020.

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

i) ***Communication*** *is key (delayed discharges almost immediately reduced)*

ii) ***Teamwork*** *is needed to ensure timely discharges (HO and AHP feedback loop)*

iii) *Time will help* ***refine*** *the solution (each cycle took 1-2 months to refine)*

Conclusion

See poster appended/ below

Project Category

Care & Process Resign, Quality Improvement, Workflow Redesign, Clinical Practice Improvement, Value Based Care, Discharge Planning, Length of Stay, Productivity

Keywords

Delayed Discharge

Name and Email of Project Contact Person(s)

Name: Matthew Neo

Email: matthew_neo@nuhs.edu.sg

FACILITATING ALLIED HEALTH DISCHARGES IN ORTHOPAEDIC PATIENTS – A SIMPLE SOLUTION

MEMBERS: MATTHEW NEO, LIM KIAN CHONG, CAI CONG CONG, ZENG HUI HUI, QIU HUAYING, ABDUL RASHID JAILANI, CHEE THONG GAN

- ☐ SAFETY
- ☑ QUALITY
- ☑ PATIENT EXPERIENCE
- ☑ PRODUCTIVITY
- ☑ COST
- ☑ TEAMWORK
- ☑ COMMUNICATION

Define Problem, Set Aim

Problem/Opportunity for Improvement

From April to August 2019, patient discharges under the Orthopaedic Department were not meeting the morning discharge cut-off time of 1130hrs. Some identified reasons include requiring Allied Health (AHP) review such as Physiotherapy (PT) and/or Occupational Therapy (OT) and/or Medical Social Work (MSW) review prior to discharge. Such causes for delayed discharges are preventable.

The number of delayed cases after 5 months of data collection (April to August 2019) averaged at 13.2 cases per month that did not meet the discharge timing. This potentially results in increased waiting time for the patients as bed turnover speed was reduced especially in critical periods of high bed occupancy.

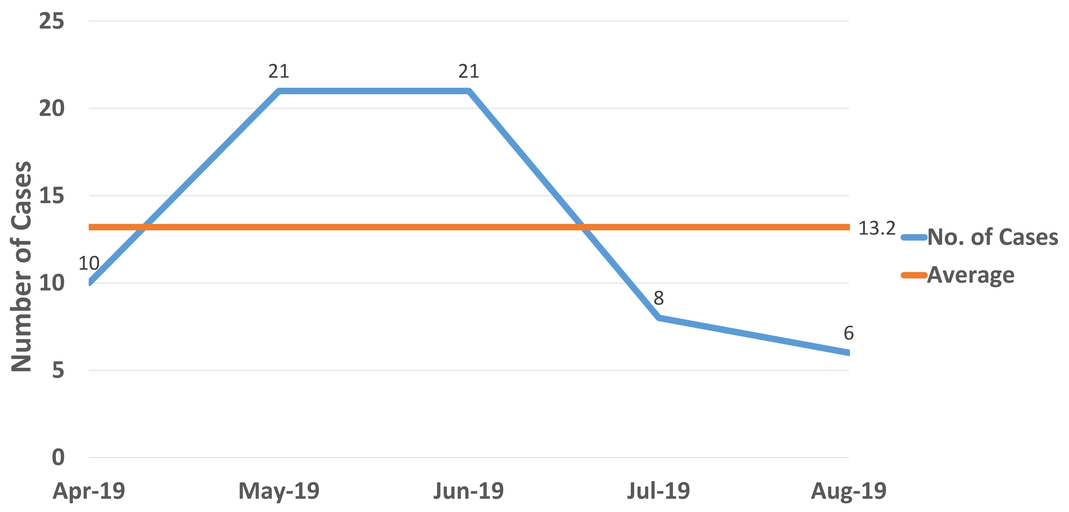
Aim

To enhance current strategies and reduce the number of delayed discharges awaiting AHP review by 80% by April 2020.

Establish Measures

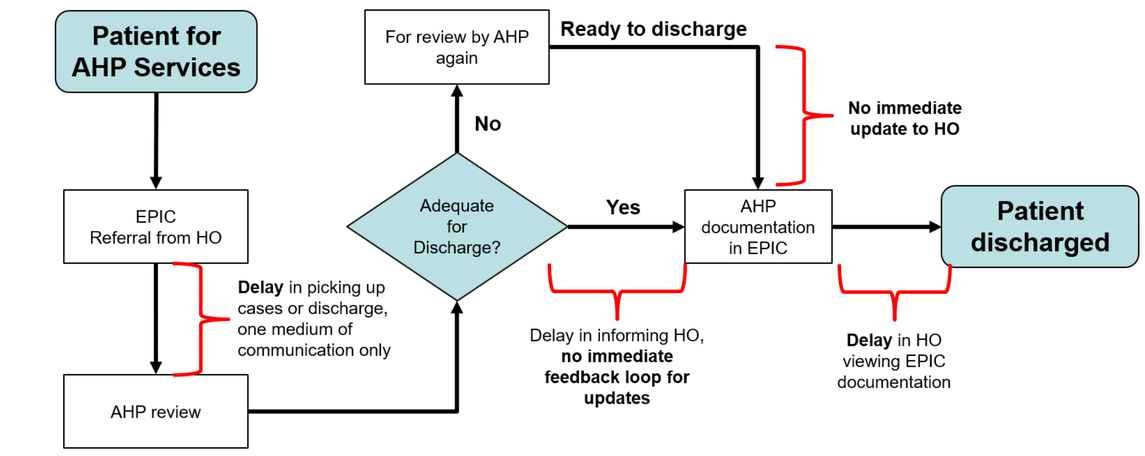
What was your performance before interventions?

An average of 13.2 cases per month were awaiting discharge after PT/OT/MSW review for the period of April to August 2019

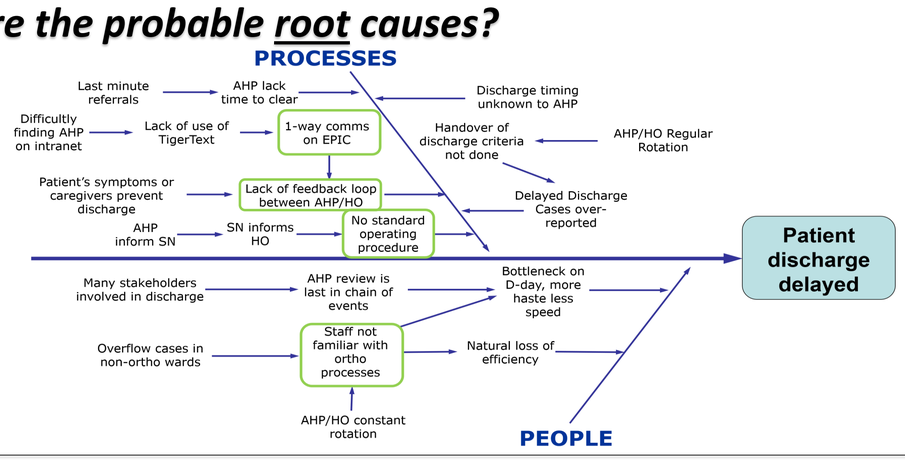


Analyse Problem

What is your process before interventions?



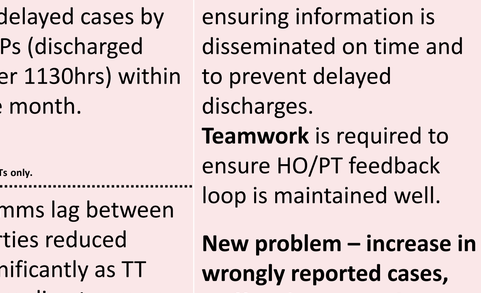
What are the probable root causes?



Select Changes

What are all the probable solutions? Which ones are selected for testing?

Root Cause		Potential Solutions
Lack of comms/ feedback loop	1	Communicate through chat group – TigerText (TT). All parties are easily contactable without need to keep "searching on intranet" or wait for EPIC notes
	2	Early identification of discharge cases as D-1
	3	Early referral (during rounds)
Lack of knowledge/ teamwork	4	Regular education to new AHPs and HOs as staff constantly have rotations to standardize and handover definition of discharge timing.
	5	Orientation to new AHPs on discharge timings
Lack of standard operating procedure	6	Chat group created – to ensure overflow Ortho cases are picked up by AHP

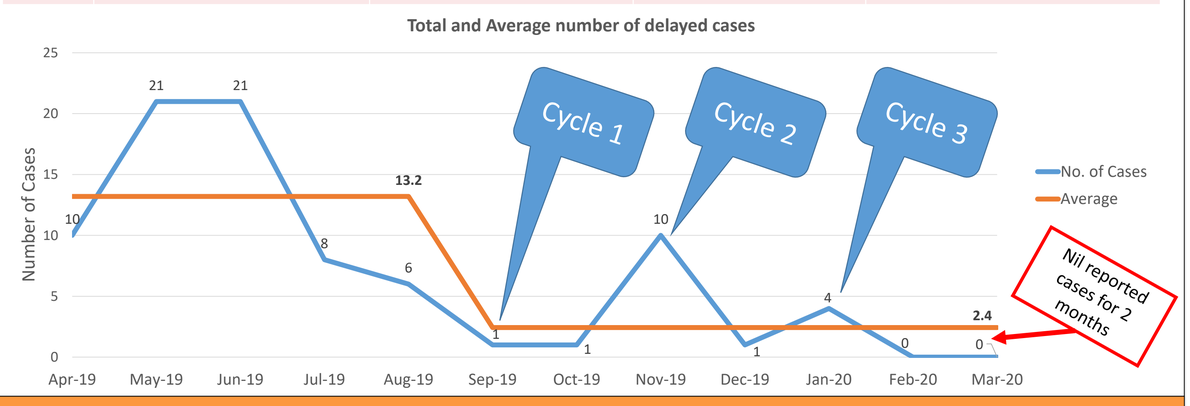


Test & Implement Changes

How do we pilot the changes? What are the initial results?

CYCLE	PLAN	DO	STUDY	ACT
1	Identify the HOs of the different orthopaedic teams involved in discharge planning in each rotation. Then add HOs/PTs* to chat group.	TT group created in September 2019. All HOs and Ortho PTs added to group in v1.0.	Reduction in number of delayed cases by AHPs (discharged after 1130hrs) within the month.	**Communication** is vital in ensuring information is disseminated on time and to prevent delayed discharges. **Teamwork** is required to ensure HO/PT feedback loop is maintained well. **New problem – increase in wrongly reported cases, staff undergo rotations. Modify idea (Cycle 2)**
	Target comms delay and increase comms options (not just EPIC only).	Direct and immediate feedback to HOs on discharge status through TT.	Comms lag between parties reduced significantly as TT more direct comms route than EPIC.	
2	**Problem**: Over-reporting. Plan: Educate on criteria of late discharges to HO at each rotation after sudden spike (8/10 cases wrongly reported).	Ortho PT lead (Matthew) regularly educates HOs and staff on TT chat group and proper reporting.	Maintenance of low numbers of wrongly reported cases. Education improves proper reporting of cases.	**Education** is required to standardize the cases being reported and minimize mistaken reporting of late discharges. **New problem – more than one AHP involved in discharge. Modify idea (Cycle 3)**
	Staff to auto-populate when rotating out of discipline.	Each rotation, HOs rotating out will add in their "successor" before leaving TT chat group.	TT group kept current with auto-population of members.	
3	**Problem**: Many stakeholders in discharge **Plan**: OT and other relevant AHPs added to TT chat group v2.0.	HOs able to comms directly with OTs, no need PT to relay information. All stakeholders are team members	Maintenance of low number of cases. AHPs involved in discharge can pick up cases more quickly.	Direct **comms** is preferred where possible. Increased **teamwork** (adding relevant AHPs) results in timely discharges. **Plan adopted.**

*Although PT/OT/MSW cases were identified, the main bulk came from PT and hence the first cycle of the group consisted of PTs only.



Spread Changes, Learning Points

What are/were the strategies to spread change after implementation?

After implementation, the strategies include having the relevant stakeholders be added to the group chat. We are intending to spread the changes to other patient populations such as the Day Surgery or Day Surgery (23 hours) cases where delayed discharges are common as well, and we hope to have similar findings in the future.

What are the key learnings from this project?

*i) **Communication** is key (delayed discharges almost immediately reduced)*
*ii) **Teamwork** is needed to ensure timely discharges (HO and AHP feedback loop)*
*iii) Time will help **refine** the solution (each cycle took 1-2 months to refine)*

Ng Teng Fong General Hospital

Jurong Community Hospital