



A project was undertaken to look at the improvement of patient flow in and out of ICU Southport campus.

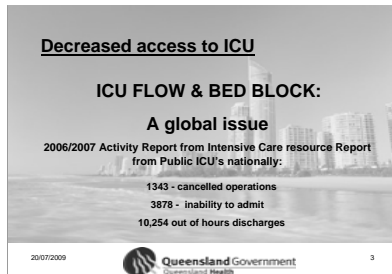
There were many issues identified which showed impedence to the patient flow . AND A NEED TO REVISE PATIENT TRANSFER PROCESS



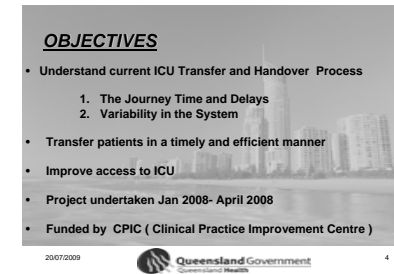
The Gold Coast hospital is a 650 bed tertiary hospital across two campuses - Robina and Southport.

Southport being the mother ship or larger facility covering a larger range of services. Population of 500,000.

Has level 3 ICU - 14 bed, currently only staff funded for 11 beds with approximately 1000 patients admitted each year. With 90% occupancy. Inability to admit and cancelled operations due to no bed in ICU.



ICU's are under resourced.



The object was to LOOK AT AND UNDERSTAND the current ICU transfer process, the **Journey Time and the delays** which were evident with the current system, and also looked at the **variables within the system** which were impeding flow in and out of ICU.


We needed to improve ICU patient transfer and patient handover in a more timely and efficient manner, which we felt would **Improve access to ICU**.

The project was undertaken in 2008. From recommendation from a study done by (Francis Lyn PhD candidate from Griffith University, 2007)

Data shows time frames 01/01/2007 to 30/09/07 and 01/01/2008 to 30/09/2008.

WHAT WAS IDENTIFIED

- **BED BLOCK**
 - Delays : Patient flow in and out of ICU
 - hospital discharge
 - portering
 - bed cleaning
 - poor understanding of patient flow
- **ICU DISCHARGE PROCESS**
 - Delay in notification to ICU by the Bed Manager of bed availability.
 - Lengthy ICU/ Ward handover
 - ICU Junior Medical staff not aware of transfer process policy

20/07/2009  5

We looked at Bed block and some of the issues around bed block which ultimately delays patient flow in and out of ICU. Bed block still exists and is a global issue, for many and varied reasons due to the culture of ICU and hospital occupancy and is in many cases unavoidable. However, the delay of discharge from ICU which impacted on access to ICU was of significance.

We identified that hospital discharge was delayed predominantly because of ineffective discharge planning from the medical division.

Porters are responsible for the movement of patients and bed cleaning services. They clean the beds the patients are to go into, so if there are delays with 1 or both of these services, this then delays ICU discharge.

ICU discharge process


There was a delay in notifications to the bed manager of beds required for patient transfers from ICU, which often did not occur until 0800 or later.

ICU to ward handover was also lengthy.

There was also a deficit in the ICU Junior medical staff knowledge of the discharge / transfer process because of very outdated orientation manual, which meant a time delay in preparing the patient for discharge from ICU. This oversight has been rectified with education and the recent revamp of the outdated medical staff orientation to ICU, which is now electronic (flash drive given to all new medical staff on rotation to ICU).

METHOD

- Appointment of change agent,
- Steering group - Ward Nurse Unit Managers (NUMS), ICU NUM and Medical Staff
- A multi-method approach was used:
 - action learning,
 - participant observation
 - systems thinking/lean thinking

20/07/2009  6

DATA COLLECTION

- Time of day discharged
- Percentage of discharges to specific wards
- Identified 3 key wards:
 - 38% Neurovascular
 - 16% Gastro intestinal
 - 11% Renal
- Process mapping – current state and collaborative development of desired future state

20/07/2009  7

We collected data at:

- time of day that discharges occurred, the majority being between 1200 – 1400
- the % of discharges to specific wards

3 key ward were identified

The remaining 40% of discharges are spread between 9 wards covering surgical/medical, ccu psychiatric unit and paediatrics. Through process mapping of our current state and collaboration with all stakeholders, we developed initiatives for our desired future state.

INTERVENTIONS

- Development of a generic standardised ICU/Ward transfer form.
- Posting of single point lesson

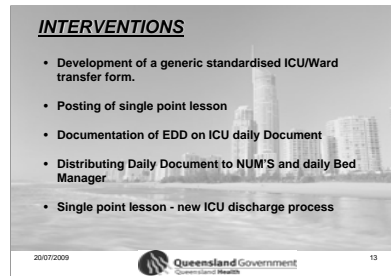
20/07/2009  8

Generic ICU/ WARD transfer form initial ICU /ward phone transfer handover communication summary . Full concise and succinct handover to be given to receiving ward at actual transfer.

Documentation of EDD on ICU daily Document which gives a forward view of possible transfers from ICU for the ward NUMs.

Distributing Daily Document to NUMs at 0730 am - this has allowed for pulling of patients by ward NUM early morning at times. **Posting of Single point Lesson** through ICU of ICU's Discharge Process.

Training /education was undertaken to ICU and ward nursing Staff on the new transfer and hand over process.



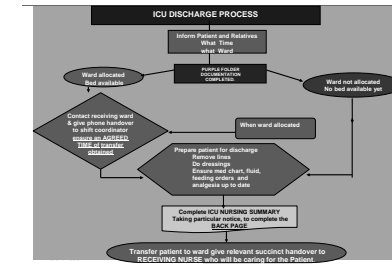
Generic ICU/ WARD transfer form initial ICU /ward phone transfer handover communication summary . Full concise and succinct hand over to be given to receiving ward

Documentation of EDD on ICU daily Document which gives a forward view of possible transfers from ICU for the ward NUMS

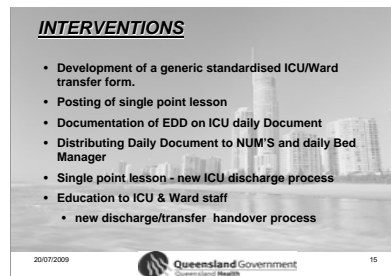
Distributing Daily Document to NUMS at 0730 am this has allowed for pulling of patients by ward NUM early morning at times

Posting of Single point Lesson through ICU of ICU's Discharge Process.

Training /education was undertaken to ICU and ward nursing Staff on the new transfer and hand over process



Single point lesson posters throughout ICU - Nursing staff would see at a glance as to the discharge process to be followed by ICU nursing staff.



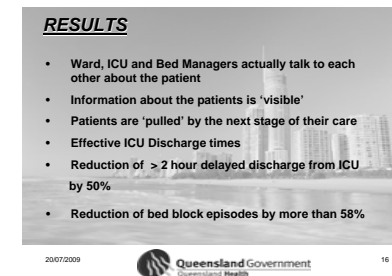
Generic ICU/ WARD transfer form initial ICU /ward phone transfer handover communication summary . Full concise and succinct hand over to be given to receiving ward

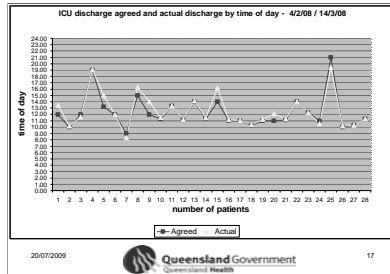
Documentation of EDD on ICU daily Document which gives a forward view of possible transfers from ICU for the ward NUMS

Distributing Daily Document to NUMS at 0730 am - this has allowed for pulling of patients by ward NUM early morning at times (the ICU daily document in its entirety had been being sent to bed manager for extended period of time)

Posting of Single point Lesson through ICU of ICU's Discharge Process.

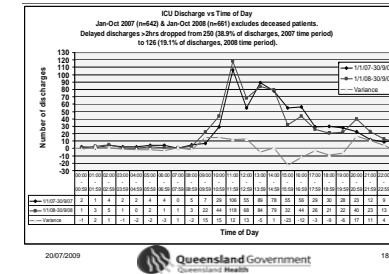
Training /education was undertaken to ICU and ward nursing Staff on the new transfer and hand over process



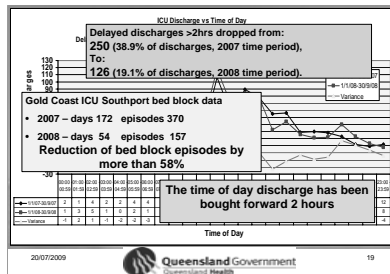


We monitored/tracked the actual and mutually agreed time and actual time of discharge between ICU – ward.

This proved to be aligned in most discharges – IN these patients tracked there is little delay, small delays are attributed to travel time, extended, related to portage delays and on occasions patients requiring radiological examination prior to being sent to receiving ward.



As can be seen we have managed to increase the number of patients transferred between 0900 & 1100 from the 2007 data, however there is an increase between 1300- 1500 and for 2000 - 2200 hours. Looking at the admissions and discharges for these time frames is not clear as to why this still occurs, this will need further investigation.



Complimentary GCHSD initiatives

- Introduction of Home wards
- Estimated Date of discharge (EDD) on patient's admission to hospital with daily update
- Introduction of morning bed and staff management meeting
- Implementation of 'Stay in the bed' strategy when patient transferred

2007/2009 Queensland Government Queensland Health

WHAT WAS LEARNT

- ICU patient access relies on valued discharge/handover processes between ICU and ward.
- Discharge needs to be :
 - patient focused
 - simple
 - of value
 - standardised
 - followed by ICU and ward staff.
- Timely effective discharge and handover maximises resource and improves patient flow in and out of ICU.
- Change has to be sustainable

20/07/2009  21

Acknowledgements

Thank you to The CULT Team
Lynn Massey & Helen O'Flanagan
Julie Creamer ICU Data Manager
and
to the ICU and Ward Nursing staff of the
Gold Coast Hospital
for their cooperation and support.

20/07/2009  22

Thank You

Questions

20/07/2009  23

GOLD COAST HOSPITAL
SOUTHPORT CAMPUS

20/07/2009  24