Great Plains
Regional Medical Center

GREAT PLAINS REGIONAL MEDICAL CENTER
601 WEST LEOTA STREET
NORTH PLATTE, NEBRASKA

Contact Name: Laura Ryan

Email Address: ryanl@gprmc.com

Phone Number: 308 696 8300

Fax Number: 308 696 7453

Submission Date: September 23, 2010

Topic: Discharge Flow Process Improvement

Category of criteria: Process Management/Organizational Performance Results

OVERVIEW

A great deal of attention has been focused on the delivery of health care services as a competitive advantage to any organization, specifically hospitals. The need to maintain customer loyalty and the expectation of quality services have increased dramatically over the last few years given new technology and customer choice. Great Plains Regional Medical Center (GPRMC) is a 116 bed acute care hospital located in North Platte, Nebraska. Our mission is to provide the kind of health care we would want for our families, in partnership with those we serve. Our vision is to become the regional health care destination for West Central Nebraska. All 850 + employees are dedicated to provide health care that is safe, timely, efficient, equitable, and patient centered. GPRMC is committed to improving patient processes for increased patient satisfaction and safety measures following the direction of our mission and vision. The GPRMC Board of Directors provides the resources and expects leadership to utilize an effective performance improvement program to achieve the mission of the medical center. The mission and vision, along with the strategic plan provide focus and give direction for the performance improvement activities.

Hospital leadership determined one of the performance improvement projects for 2010 would be the 'discharge flow process.' The rationale for selecting this project was twofold – 1) patient satisfaction surveys identified an opportunity to improve and 2) literature showed that 'discharge' can be an untimely and unsafe experience for patients. We determined it was important to improve communication and teamwork around the patient discharge process. Data was collected which showed it took, on average, nearly four hours from the time the discharge order was received until the patient left the building. The data also showed patients were being discharged any time, day or night. The team determined that streamlining the process of

discharge would not only result in improved patient and physician satisfaction but also shorten length of stay and increase the safety of the patient being discharged.

In today's competitive health care marketplace, we are required to be proactive in managing shrinking resources more efficiently while continuing to provide quality care and ensuring patient satisfaction with our services. Patients choose where they receive health care and it is our goal to give them every reason to want to choose GPRMC. As the final step in the hospital experience, the discharge process is the pinnacle of the entire hospital stay. Even if every other realm of the patient's stay is satisfactory, a slow, frustrating discharge process likely will result in a low satisfaction rating by the patient/family. The new and improved 'discharge flow process' improvement project developed at GPRMC demonstrates a proactive approach in managing our resources more efficiently while providing quality, timely care and ensuring patient safety and satisfaction with our services.

Inpatient discharges in 2009 totaled 4,786. The process of discharge begins at admission with case management developing a discharge plan within the first 24 hours and ends with a successful discharge and documentation completed in the electronic record. Throughout the patients hospitalization, the case manager works in conjunction with the patient/family, care providers and external organizations to coordinate appropriate departure to a location where the patient will be cared for. The performance improvement (PI) team quickly recognized that discharge is a process and not an isolated event. Our objective was to expedite the discharge process by establishing a framework of an integrated multidisciplinary team, working to manage all aspects of the discharge process within an effective and efficient system. The PI team determined its aim was to "expedite the inpatient discharge process to under two hours following

written order by the physician." Baseline data showed that the average time from physician order to patient discharged was 3 hours and 53 minutes.

METHOD

The Hospital Quality Committee chartered the "Discharge Flow Process performance improvement team in April of 2009. The project was chartered at the request of administration due to patient feedback on the patient satisfaction survey and physician feedback about the length of time that it took for the patient to be dismissed after being told they could go home. A multidisciplinary team was led by the Director of Case Management and the team members consisted of nursing administration, respiratory services, unit registered nurses, charge care coordinators, nurse managers, unit secretaries, the hospitalist coordinator and case managers. Ad Hoc members included physicians and the Chief Operations Officer. The Vice President of Medical Affairs was the physician champion. The Vice President of Nursing was the Senior Leadership champion.

GPRMC utilized the FOCUS (PDSA) model for improvement. The PDSA worksheet with task, responsible person, and timeline are provided in the support documentation.

The customers and suppliers of the process are identified below:

Customers:	**Suppliers:**
Patients	Physicians
Patient family or caregiver	Nursing Staff
Physicians	Case Management
Nursing staff	Volunteers
Long term facilities	Environmental Services Staff
Home care services	House Supervisors
	Unit Secretaries
	Dietary
	Pharmacy
	Durable medical equipment vendor
	Ancillary Services

The first step was a comprehensive review of the entire in-patient discharge process. The team identified that a new discharge protocol process was the key. The discharge process flow chart (see support documentation) was created. The following interventions were implemented:

(1) Chart racks were placed and chart dials were utilized on each unit to prioritize physician orders including stat, discharge and routine orders.

(2) A Stop Sign (see support documentation) was implemented on each unit to remind the nurse to stop at the nurse's station when discharging the patient. The nurse notifies the unit secretary to discharge the patient from the computer.

(3) The projected discharge date, time and destination are posted on the facility boards (a component of the clinical software system located in the nurse's station) and the communication board in the patient's room. Projected discharge date is obtained from the physician upon admission and updated during physician rounds.

(4) Case management attends the 7 am hospitalist's report and the 9:30 am bed huddle with house supervisor, charge care coordinators, pharmacy, environmental services and nutrition services, nursing administration, and hospitalist coordinator to identify and evaluate discharges.

(5) Phone calls are placed to case management and charge nurses after bed huddle to notify them of patient discharges.

(6) Daily interdisciplinary team meetings are held to discuss discharge plans including patient and family circumstance impacting the discharge.

(7) Daily afternoon communication occurs with the charge care coordinators and pharmacists regarding anticipated next-day discharges.

(8) The night shift nurse leader prepares the discharge paperwork for physician review and completion during early-morning rounding.

(9) The physician writes a discharge order and instructions and uses the dial to set the priority. The chart is then placed in the discharge chart rack.

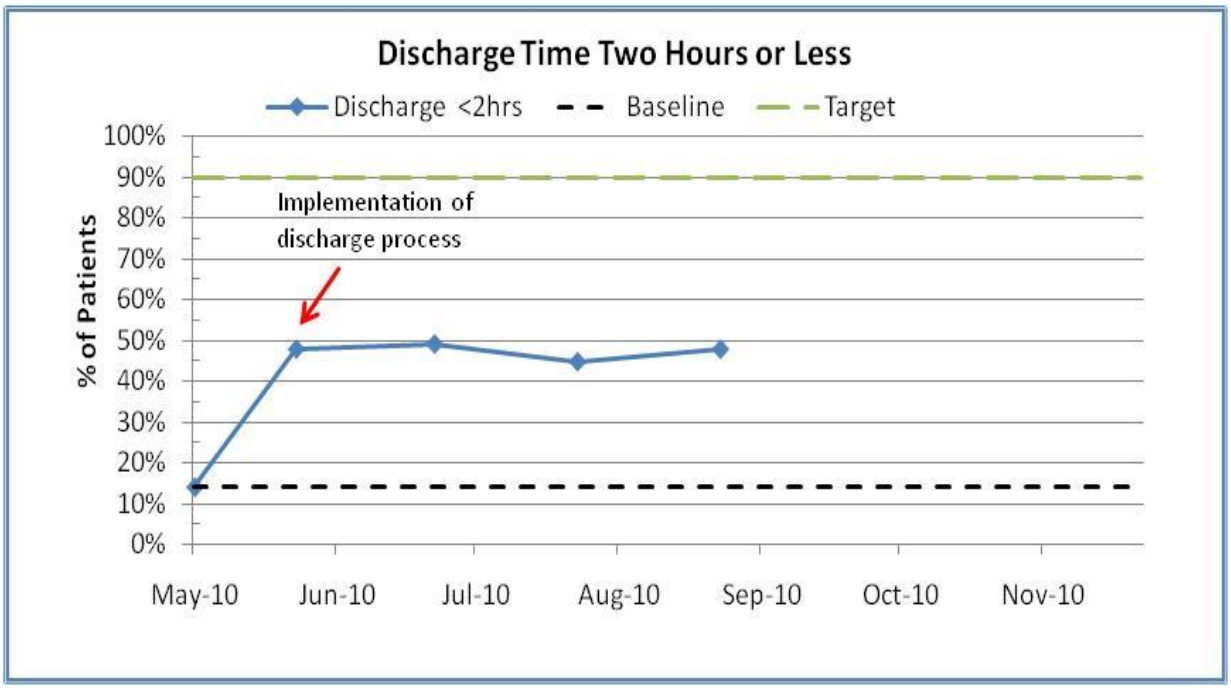
(10) The unit secretary notifies the patient's caseload RN of discharge orders immediately following the receipt of the written discharge order.

A critical step in the success of the project was to provide education to the interdisciplinary team on the new discharge flow process. Nursing education was completed on individual nursing units with 90% attendance. Learning opportunities were maximized by utilizing breakfast and lunch sessions for one week to facilitate attendance from both night and day shifts. Education was extended to the patients through a letter (see support documentation) placed in the admission packet which explained GPRMC's new discharge process. The process was rolled out on May 17, 2010. GPRMC recognizes that prioritizing and moving discharge times toward earlier hours of the day can pay large dividends in patient flow throughout the hospital. Timely discharges from medical surgical beds facilitate patient flow in and out of specialty care units including ICU and ED.

RESULTS

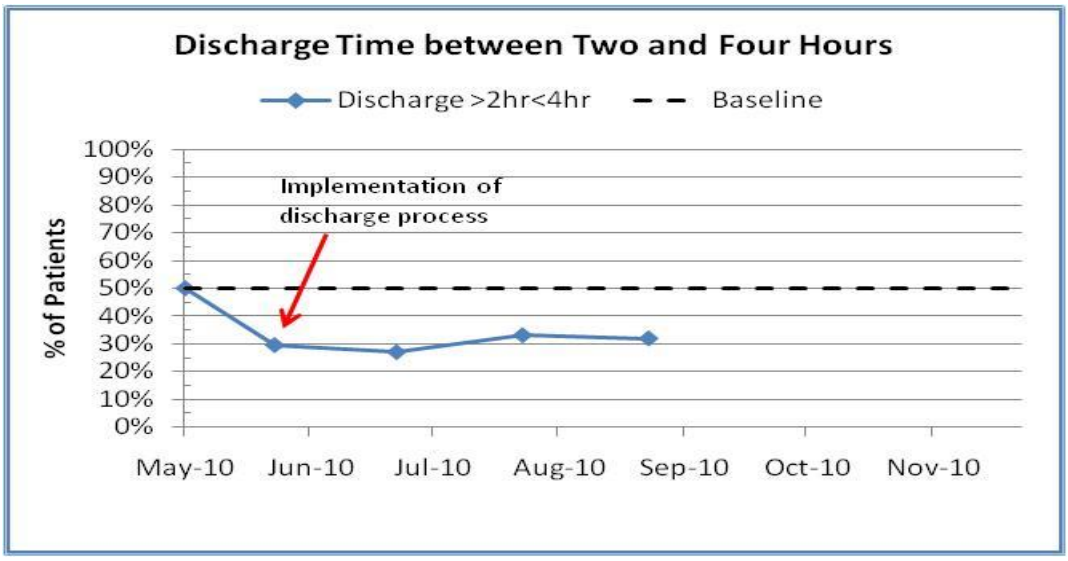
Outcome Measure:

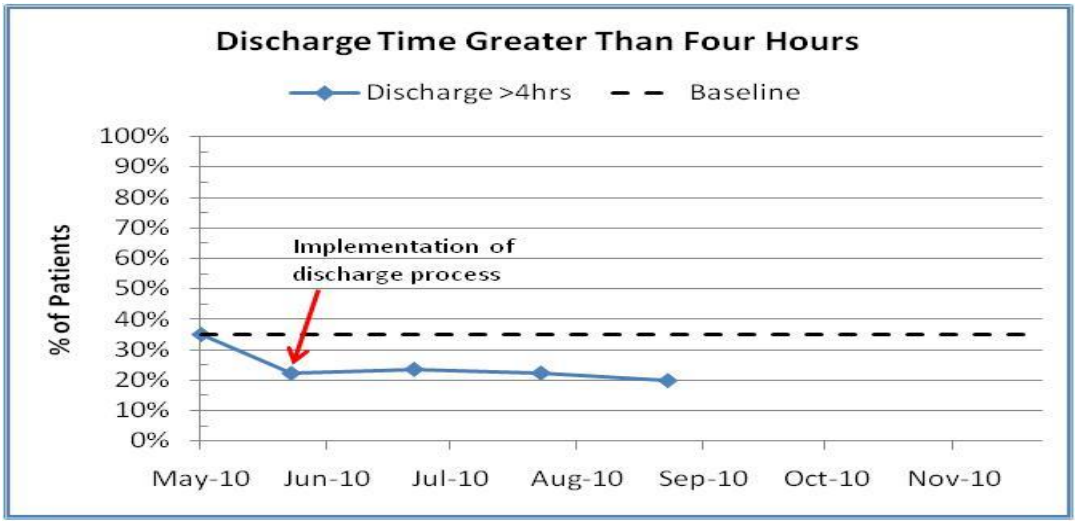
Percent of discharges that were completed within 2 hours



Higher than baseline is better

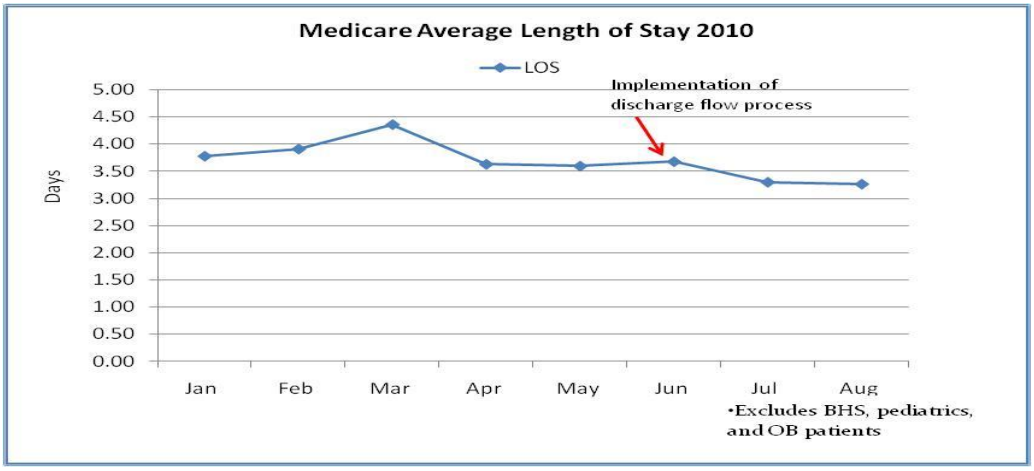
Analysis: The percentage of patients who are discharged within 2 hours of the discharge order being written improved to 48%. The target is 90%. September data is through September 15, 2010.





Lower than baseline is better

Analysis: The percent of patients discharged between 2 and 4 hours after the physician order decreased to 31%. The percent of patient discharged greater than 4 hours after the physician order decreased to 22%. The September data is through September 15, 2010.



Lower is better

There was a reduction in length of stay for Medicare patients from 4.36 days in March 2010 to 3.27 days in August of 2010. The reduction in the length of stay has a positive financial impact for the patient and the hospital. Costs that cannot be quantified are decreased dietary and pharmacy utilization, staffing efficiency, as well as increased availability of beds for patient placement.

An unexpected benefit was an increase in physician satisfaction with case management/discharge planning with ratings going from 87.5% to 93.9%. The National Research Corporation database average is 91%.

See supporting documentation for additional data collection.

LESSONS LEARNED

The lessons learned from the implementation include:

In order for the process change to be successful, the patient's family must be included and committed to meeting the discharge date and time. Transportation is usually the biggest issue with some patients not having a ride home until after 5 pm when their family can get off work.

Enhanced communication is the key. Utilizing the method of practice for patient coordinated care, the charge care coordinator facilitates the timely discharge once the order is received. The unit nursing staff and case management must know who is being discharged early in the day to facilitate and must have a commitment to make it happen.

Ambulant self-caring patients need to be able to be discharged on weekends. This frees up beds for emergency admissions over the weekend and expedites patient flow. This has been accomplished by ensuring coverage by case management seven days a week.

The discharge process does not occur only Monday through Friday. Nursing facilities need to be able to accept patients on Saturday and Sunday. Weekend admissions have been achieved through positive communication with the nursing facilities with the implementation of a monthly nursing facility breakfast led by case management

Daily bed huddles to promote communication across the multi-disciplinary team have increased awareness of the patient's progress towards a satisfactory discharge.

With data collection, it was discovered that approximately 50% of the discharge orders were not present or lacked a date and or time and subsequently had to be excluded. Physician education as well as re-enforcement from the Vice President of Medical Affairs has been completed to improve discharge order compliance. The team theorizes the number of timely discharges will increase as compliance with a written discharge order improves.

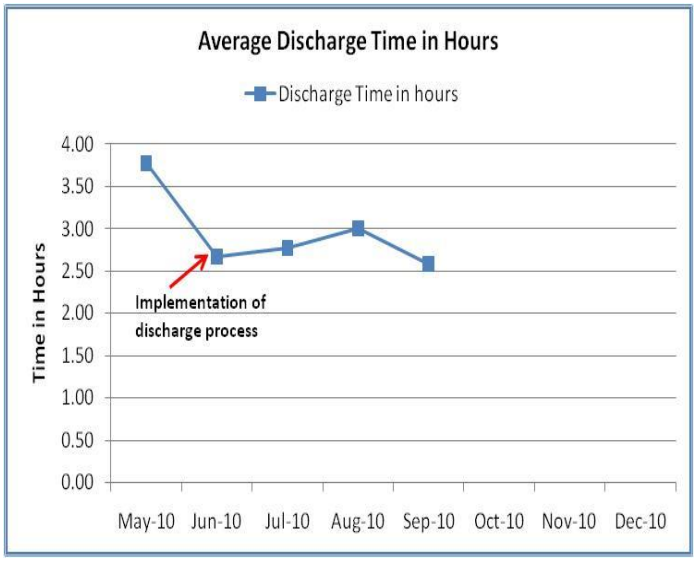
Reflecting on the implementation of the process, a small trial group versus the house-wide rollout would have made implementation easier. The education of nursing staff was successful because the information was taken to the nurses instead of taking them off the floor and away from patients to attend a meeting. Significant changes in the discharge process were made within six weeks of formation of the team.

The next steps for the team include:

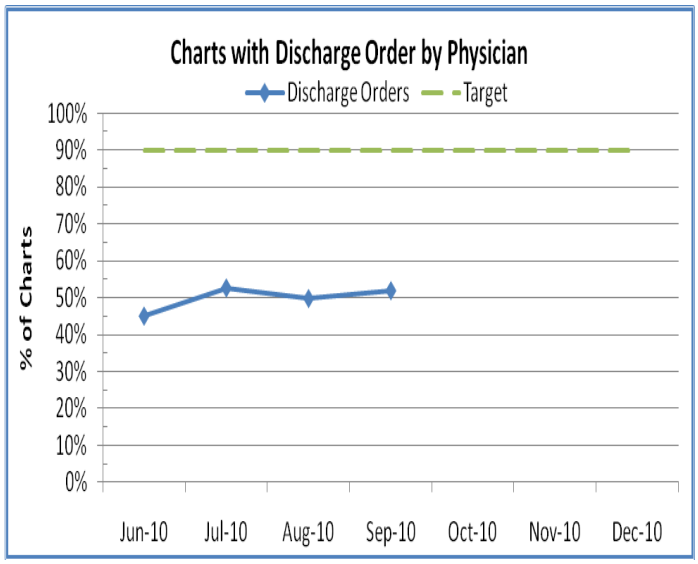
- Reeducate and reinforce the discharge flow process with new physicians and staffing changeover
- The discharge flow process education will be added to the new physician and hospital department specific orientation
- Ongoing monitoring and improvement of process with just in time training by case management and charge care coordinator as needed
- Improve the process for obtaining the projected discharge date
- Consider slotted discharge date and time
- Consider a discharge lounge for patients who have been discharged but are not immediately able to leave the facility

SUPPORTING DOCUMENTATION:

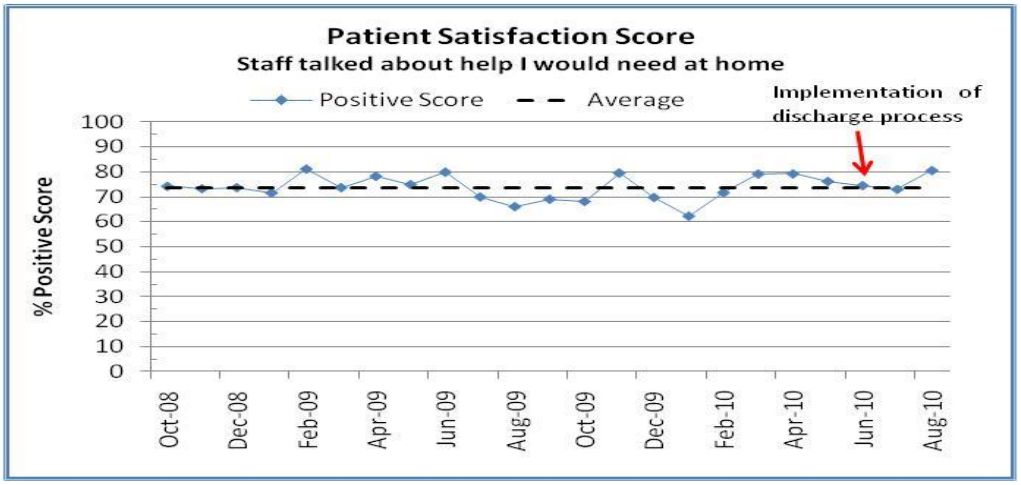
Additional Data Collection



Analysis: The average discharge time has decreased by more than one hour with the implementation of the process improvement.



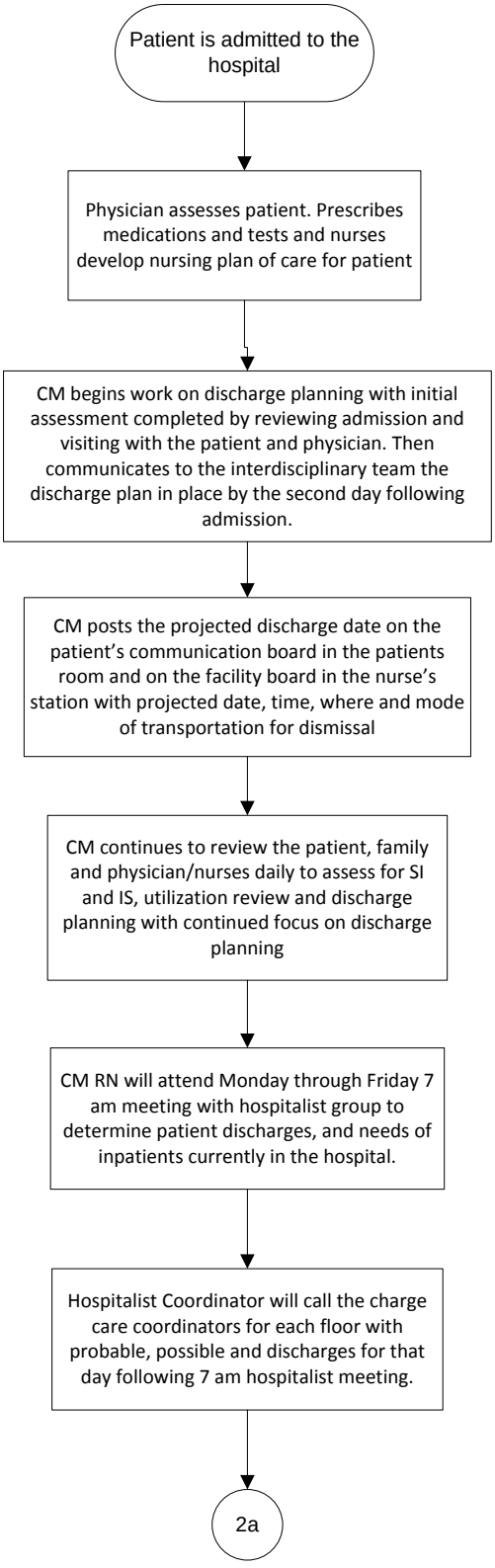
Analysis: Early data on the number of charts with a discharge order by the physician. September data is through September 15, 2010.



Analysis: The March through August scores are at or above the GPRMC average score. The increase of the score in the February- March time frame is attributed to case management changing their practice to seeing all patients instead of just high risk patients. The discharge process change occurred mid May.

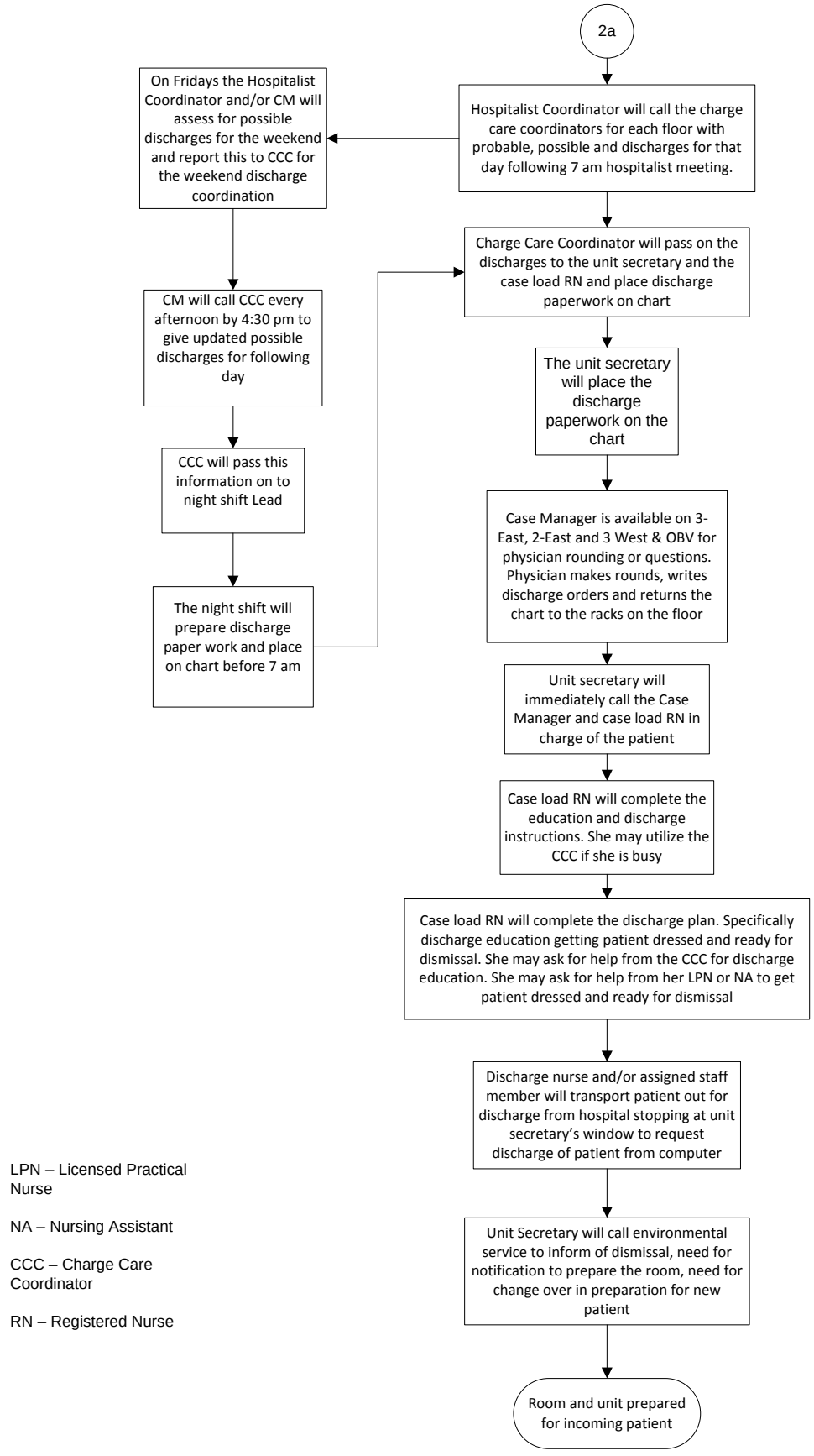
DATA COLLECTION CHARTS

Patient Discharge Process Chart



KEY:
SI = Severity of Illness
IS = Intensity of Service
CM = Case Management

PATIENT DISCHARGE PROCESS FLOWCHART



LPN – Licensed Practical Nurse

NA – Nursing Assistant

CCC – Charge Care Coordinator

RN – Registered Nurse

PATIENT DISCHARGE PROCESS FLOWCHART

Signage developed and placed at the elevators to remind staff to notify the unit secretary that the patient was leaving the nursing area.

Plan-Do-Study-Act (PDSA) Worksheet for Testing Changes

Describe the first (or next) test of change-	**Person Responsible**	**When to be done**
• Review and plan to add patient dismissal process to the educational binder.	Traci Hoatson	5/17/10
• Review the process dials on the charts.	Karen Ochs	4/14/10
• Implement the dials for red being stat orders, yellow –to be reviewed by primary nurse, green to be discharged today and black-no changes.	Roseanne Trumbull	5/17/10
• Chart Racks for OB GYN	Jessamine Baker	4/14/10
• Educate the CCC's to 3-West and 2-East on 4/15/10	Barb & Traci	4/15/10
• Education of nursing staff	Barb, Traci, nurse managers	5/8/10
• Educate physicians on the discharge flow process	Case Management	5/17/10
• Communicate to nurses and unit secretaries the STOP FOR CHECK OUT before leaving hospital	Traci Hoatson	4/14/10
• Chart racks for 2-East and 3-West	Sandra Pelas	5/14/10
• Review discharge out of computer and access educational training for unit secretaries	Barb Chamberlain	5/3/10
• Provide the case management schedule and hours/phone # to Barb Chamberlain for education to unit secretaries	Barb Eshleman	4/14/10

Great Plains
Regional Medical Center

Returning Home

Here at Great Plains Regional Medical Center (GPRMC) we know how important it is to you to return home as quickly as possible. Our goal is to provide you with the best possible care while hospitalized, being West Central Nebraska's Regional Health Care Destination.
Discharge planning begins when you are admitted. We want to make sure you will be able to care for yourself or that we make alternative arrangements including home health, physical therapy, and transportation to assist in your recovery. A case manager will be in contact with you by your second hospital day. The Charge Care Coordinator (CCC) is a charge nurse on each unit who focuses on positive patient outcomes. The CCC rounds on patients daily and helps you progress through your plan of care. Please tell the CCC if you have any care concerns.
To make your return to home timely after your physician discharges you we have established the following goals.

1. Families are asked to pick up loved ones by 11 am the day of discharge or make other arrangements with case management.
2. The nurses will have your paper work ready within 2 hours after the physician writes the order for discharge.
3. You will receive written information regarding medication changes that were made during your hospitalization and a current list of prescribed medications with doses and times will be sent home with you.
4. You will be provided with education materials regarding your diagnosis and treatment plan.
5. Follow-up appointments will your physicians will be made and listed on discharge papers.
6. It is very important you keep your appointments for any lab or diagnostic tests ordered by your physician for your safety. The requested tests will be listed on your discharge instructions.

Thank you for choosing GPRMC as your health care destination. We appreciate your trust in us and want to assist you in making a seamless transition returning home.