Improving discharge times through data and engagement

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Multidisciplinary Team
Baseline data

Discharges by hour of day

Defining our problem

**Problem:**  
Timely admission of patients to Ward 7B was hindered by discharges occurring late in the day

**Aim:**  
To discharge 50% of Ward 7B patients by midday by 31 July 2014
Defining our problem

Inclusion criteria:
• All patients discharged from Ward 7B

Exclusion criteria:
• Intra-hospital transfers
• Deaths
• Medical short stay patients

Methodology

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Plan

Act

Study

Do
Reduce delays to discharge (discharge 50% of 7B patients by 12 midday by July 31, 2014)

Discharge Planning

Communication

Hospital after hours services

**SECONDARY DRIVERS**

- A Completion of Discharge Documentation
- B Allied health input for discharge
- C Roles and responsibilities for discharge tasks
- D Completion of med switch discharge plan

**SECONDARY DRIVERS**

- A MDT planning meeting
- B Prioritisation of ward round

**SECONDARY DRIVERS**

- A Discharge Lounge opening hours
- B JMO coverage for PM/nights/24/7
- C Pharmacy capacity after 5pm and weekends
- D Allied health cover pm and weekends

Baseline data
Baseline Data

Multidisciplinary Team
Patient Journey Board

10:00
10:30
11:00
11:30
12:00
12:30
13:00
13:30
14:00
14:30
15:00
15:30
16:00
16:30
17:00

Ward 7B
Median discharge time

New patient journey
Board Morning planning Afternoon round Quarantined JMO time

Implementation of the 6 Ps
Education only 6 Ps Check list

Workshops/coaching

New JMO rotation
No Discharge Liaison Nurse
Significant variation in the distribution of discharge times by MAPU consultant. Why?

Conclusion: There was no evidence to suggest that earlier discharge times lead to an increased length of stay.
Coordinating of Care group

- **Key Learnings**
  - Multidisciplinary team
  - Senior Physician leader and followers
  - Owning your data
  - Data interrogation
  - PDSA cycles and Driver Diagrams
  - Understood our microsystem
Key Learnings

Success

what people think it looks like

what it really looks like

Canberra Hospital
Eureka! An evaluation culture has finally been grown in the lab!

Now if only we could figure out how to grow it in the real world.

Hey look, these guys are forming a subcommittee! No, wait, they’re just disputing the results.

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Tack

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