Improving Patient Discharge from PICU

PIER Conference - 2017

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Background

• PICU team day Summer 2016

• It was felt too many patients were being discharged at sub-optimal times...
  1. Patient Safety
  2. Patient Experience
  3. Efficiency

• Staff felt motivated to improve the experience for patients, their families and staff
What did we want to achieve (aim)?

For 50% of patients discharged from PICU to be discharged between the hours of 8am – 3pm

Timeline: 6 months

With further target to increase this to 75% by 1 year
What was our baseline?

Number of Patients Discharged to Each Ward: Jan – Mar 2017

Total = 237

- **E1**: Discharged inside 8-3: 50, Discharged outside 8-3: 100
- **G2N**: Discharged inside 8-3: 10, Discharged outside 8-3: 5
- **G3**: Discharged inside 8-3: 5, Discharged outside 8-3: 10
- **G4N**: Discharged inside 8-3: 5, Discharged outside 8-3: 5
- **G4S**: Discharged inside 8-3: 5, Discharged outside 8-3: 5
- **HDU**: Discharged inside 8-3: 5, Discharged outside 8-3: 5
- **PMU**: Discharged inside 8-3: 5, Discharged outside 8-3: 5
- **NNU**: Discharged inside 8-3: 5, Discharged outside 8-3: 5
- **Other Hospital**: Discharged inside 8-3: 5, Discharged outside 8-3: 5

Total Discharged inside 8-3: 200, Total Discharged outside 8-3: 37.
How will we know a change is an improvement?

Percentage of patients discharged between 8.00am to 3.00pm: January – March 2017 (Baseline)

Median = 43 %
## Summary of 4 Patient Journeys

<table>
<thead>
<tr>
<th>Patient</th>
<th>Discharge ward</th>
<th>Discharge time</th>
<th>Delays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>E1</td>
<td>1.20pm</td>
<td>n/a</td>
</tr>
<tr>
<td>2</td>
<td>G2N</td>
<td>8.00pm</td>
<td>Bed no longer available as deterioration in ward patient</td>
</tr>
<tr>
<td>3</td>
<td>G4S</td>
<td>8.00pm</td>
<td>Cubical requested but not actually required, ward unaware of patient</td>
</tr>
<tr>
<td>4</td>
<td>E1</td>
<td>2.00pm</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Communication a key theme
What did we learn?

• **Process map**
  - Bed availability problem
  - Communication links particularly to bed manager & ward staff

• **Patient journeys**
  - Excessive bleeping of bed manager
  - Communication breakdown between PICU & wards
  - Exact reason(s) for delayed discharge unclear – further info collected...

• **Further Information**
  – Was the patient actually ‘ready’ for discharge
    • Total medical discharge plan completed → YES
  – Reasons for delays (2 week coded system)
    • No actual bed available
    • Beds waiting to be cleaned by SERCO...
• Exploring SERCO cleaning process
  – Escalated findings to clinical director for child health & support services care group manager
  – Identified opportunity to review prioritisation process
  – Contact made with SERCO management team to explore & address this
  – Teletracking system in design – allows job prioritisation

• This is not just a PICU/paediatric issue...

Improvement here has potential positive implications for the whole trust!
Percentage of patients discharged between 8.00am to 3.00pm: January – Sept 2017
Lessons learnt

1. Engage with and utilise experience of all staff members

2. Robust process map focuses efforts for improvement

3. Start small think BIG!
   - If you find a golden nugget dig deeper and you might find a pot of gold!!
Thank You’s & Questions

Special thanks to Kate Pryde, Lorraine Major and Kim Sykes for their continued QI support.