Grey Nuns Community Hospital (GNCH) General Internal Medicine-ED Triage Consultation Service

L. Chivers, P Barber,A. Brisebois, Department of Internal Medicine Physicians, Bed Management Team, Multidisciplinary Teams - Medicine, GNCH, and P. Mathura

Presentation PPT

DEFINE OPPORTUNITY

Background, Problem and Goal Statement: Within the Edmonton Zone(EZ), both Emergency Department (ED) patient flow and hospital wide patient flow have been a concern for several years. The rising EZ patient volume, subsequent rise in physician consult times and increased focus on physician wellness has prompted action to develop and trial a General Internal Medicine(GIM) ED service.

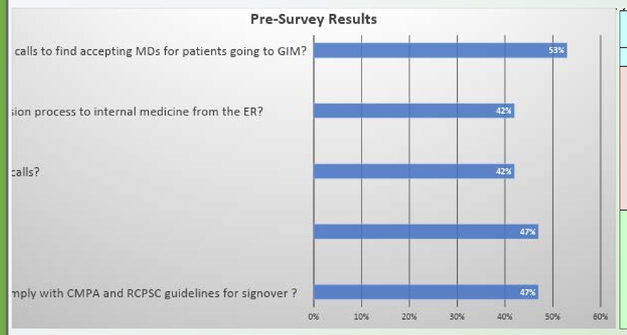
Problem Statement: The Grey Nuns Community Hospital (GNCH), with nearly 75,000 ED visits annually and the GIM physicians assigned to both the ward and ED consultation services; resulted in GIM physicians caring for both ward and ED patients at the same time. This has lead to GIM physicians working longer ward hours while consistently getting paged for ED consultation, multiple inter-ED physician handovers, poor GIM physician attendance to ward rapid rounds, increased ED consult, EIP, wait times, delayed discharges, and both poor patient and physician experience.

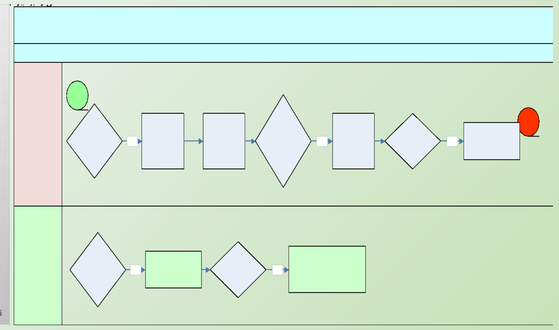
Goal Statement: Develop a GIM ED triage and consultation service to achieve the following:

1) 80% reduction of GIM ward physicians pulled away from the ward to attend a ED consultation
2) 80% increase in ward Physician rapid round attendance
3) 30% reduction from consult request to decision to admit closer to the 2h goal established by AHS
4) 30% reduction of Emergency inpatients(EIPs)

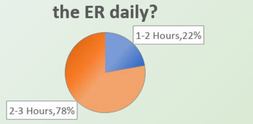
BUILD UNDERSTANDING

Process Assessment: Multiple physician engagement sessions with both medicine and emergency physicians were held, identifying current hurdles faced. EZ Benchmarking with Sturgeon Community Hospital and the University of Alberta Hospital along with a brief literature review provided background for GIM ED service development. The project team reviewed EDIS data, conducted a Gemba walk and a pre-survey. Key process issues identified include but are not limited to: GIM physician required to be in 2 places at once, increased inter-ED physician handovers, ED physician's waiting on GIM physician, poor rapid round attendance and patients are waiting either on the unit or in the ED to be seen by GIM.



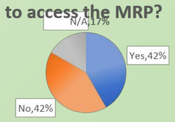


GIM Physicians: While on inpatient service how much time do you spend attending to the patients in the ER daily?



GIM Physicians: Do you feel that rapid rounds are supporting you in timely ward discharges?

Interdisciplinary Team: Do you face difficulties in patient care, due to localization issues and/or inability to access the MRP?



MANAGE CHANGE

Collaboration & Communication Strategies: GNCH operational and medical leaders support the project both locally and within the EZ. The project team included ***operational leader, medical leaders,* site utilization management*, multidisciplinary teams and support services.*** Consultation with UAH GIM ED project team and SCH ED project team provided insight, shared learning and increased EZ ED and GIM collaboration.

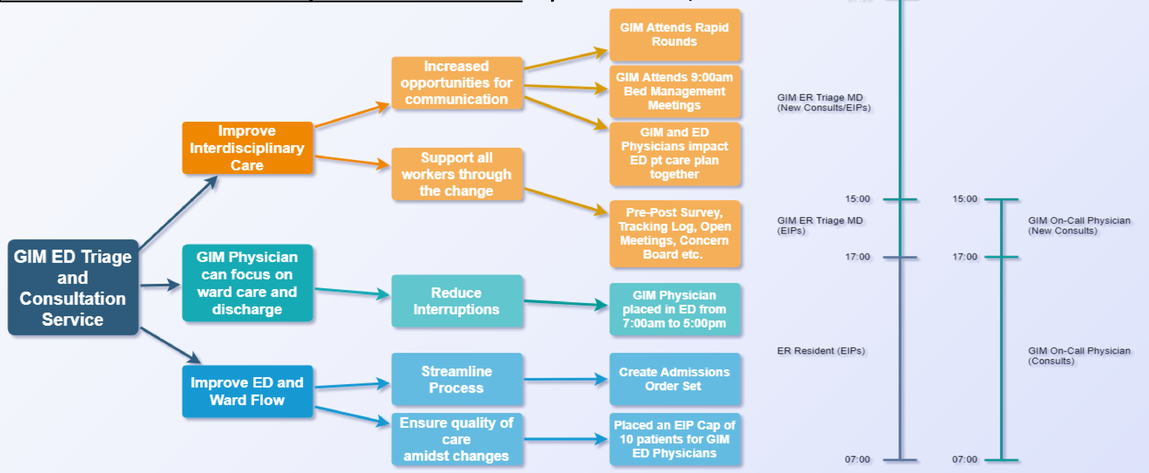
Communication Strategies:

The follow strategies were employed to support the GNCH team throughout QI intervention:

- Weekly open sessions held at lunch with all staff invited to voice concerns, allowing real time identification of issues and follow up determined
- Issues log created, allowing continual improvement within the PDSA and real time mitigation
- Concern book kept in the ED for real time tracking
- 9:00am bed management meetings involved more physicians (FM, GIM)
- A pre/post-survey was administered exploring staff priorities and how staff felt about the changes
- Communication to all staff focused on a *"Start with Why"* approach
- ADKAR model was applied, focus on increasing Awareness, Desire, Knowledge and Ability
- Engagement meetings and monthly physician check-ins were performed by site operational senior director
- Frontline project champions included both the site operational leader, bed management and the GIM medical leaders.

ACT TO IMPROVE

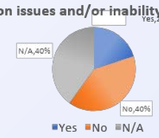
***Improvement Selection and Implementation Plan:* Sept 15 – Dec 15, 2018**



Schedule changes for PDSA #1

Post Survey: Changes made to improve patient care involving both GIM and ED departments.

Interdisciplinary Team: Do you face difficulties in patient care, due to localization issues and/or inability to access the MRP?



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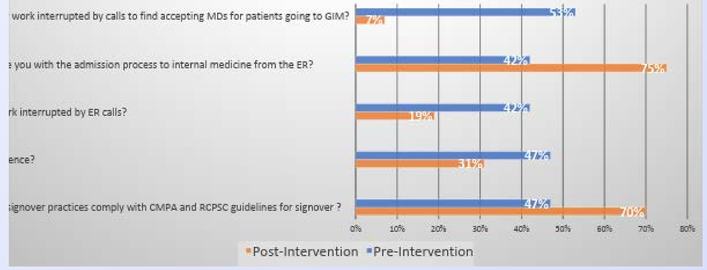
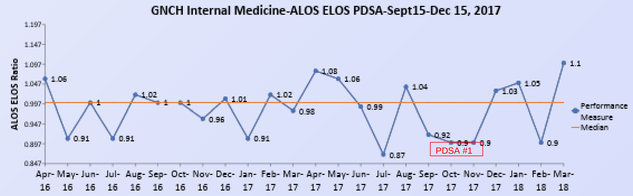
Consult time and EIP hours had minimal impact. This maybe due to the EIP cap of 10 patients. As the patient volumes were consistent. ALOS ELOS data indicates 3 data points maintained during the PDSA #1- possible start of a 'Shift' in the data

Pre to Post Intervention Comparison of Survey



GNCH Internal Medicine-ALOS ELOS PDSA-Sept15-Dec 15, 2017



SUSTAIN RESULTS

Reinforce Ownership, Measurement & Continuous Improvement: GNCH GIM ED service Project team will continue to address concerns that were identified to give rise to updates for PDSA #2. The project will continue exploring the cohorting of GIM patients on one ward along with developing a GIM ED service therefore improving interdisciplinary communication both on the ward and in the ED.

Arising PDSA Model #2 Potentials:

- Physician schedule will remain the same as PDSA #1, with a GIM ED Physician from 7:00am – 5:00pm
- A pharmacist will be added to the ED to complete all medication requisitions and alleviate some of the pressure of back-to-back consults
- Continual exploration of change management approaches to support all staff through the interventions
- Support the proportion of FM cases seen in the ED maintaining the FM and ED physician connection and to not disrupt FM patient flow
- Cohort a GIM ward- right bed for the GIM patient the first time; limit off service GIM patients
- GIM physicians attend ward rapid rounds and at Bed Management meetings (9:00am)
- Track the number of admission avoidance
- Review the cap of EIP's by benchmarking with other local hospitals therefore updating this intervention
- PDSA time frame recommendation of 6 months to view shifts in data are statistically significant

SHARE LEARNING

Lessons Learned:

- Separating out the GIM ward and GIM ED service has hospital wide flow benefits; however the GIM ED service is physically challenging therefore physician scheduling is critical to prevent burn out
- Consider how to best maintain quality trainee experience when implementing GIM ED service
- GIM ED service provides a predictable, standardized handover between ED & GIM physicians and strengthened this relationship
- Implementation of a standard admission order set supported streamlined admissions
- Cohorting GIM wards can further support hospital wide patient flow and allows higher acuity patients to gain access to beds in a more timely manner. Maintains the GIM physician on the ward with the care team with minimal disruptions/distractions.
- **Why this QI Change Matters:**
  - To Patients: Let's return them to their families sooner
  - To Alberta: Let's be leaders in challenging the status quo and improving how we deliver care
  - To the Healthcare System: Let's improve our ability to collaborate interdisciplinarily
- ***"This trial is a step in the right direction" – ER Physician***

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