Sturgeon Community Hospital (SCH): From the Emergency Department General Internal Medicine Consultation and Triage Service (GIM-ED) to the Hospital Medical Consult Service (HMCS) (PDSA #2)

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BACKGROUND

Background: Emergency Department (ED) crowding continues to be one of the major problems facing the Sturgeon Community Hospital (SCH). Data suggests that the sturgeon community hospital (SCH) has seen a remarkable increase in the number of ED visits from elderly patients with complex needs amounting 11.6% increase in the first 6 months of 2018. The SCH ED has seen as well a 16% increase in average EMS dispatches per month during 2018. Literature suggests that patients with more complex comorbidities are more likely to undergo multiple consultations and might stay longer in ED before a decision is made for admission or discharge from ED. In view of this increase in number of visits, we have seen a steady increase in the total ED waiting times especially for admitted patients (average of 38 hrs.) and heightened burdens on staffs to deliver the expected high quality care to their patients. Literature also suggests that when patients experience delays in treatment or are boarded in emergency rooms, outcomes are worse and costs are higher. The aim of this poster is to present the results of the second PDSA cycle (extended from March 5th to June 30th, 2018).

PROBLEM: Currently, within the SCH ED the medicine triage consultation (consult request to decision to admit) is delayed (out of the 2 hours AHS target) and patients are often not assigned to the most appropriate medical service team. Approximately ~2 hours/day a Medicine Physician is removed from the inpatient ward to perform ED consultations between the hours of 0700-1700. Delaying inpatient care and discharge processes. ED physicians faced with highly complex patients often debate which medical service should be consulted and batching of Medicine consultations requests result. All of the aforementioned, hinders the ED assessment timeframe, increases both workload and admitted patient boarding time in the ED.

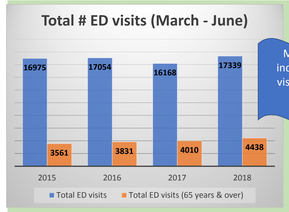
GOAL: Project aims to improve patient flow for medicine patients in the SCH ED by expediting medical consultation/disposition and allocation of admitted patients to the most appropriate medical service team.

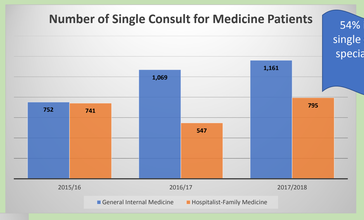
Goal statement: within 6 months develop an ED Medicine triage and consultation service with the primary objectives of reducing the **consult time** for medicine patients by **20%** as well as **20%** reduction in the **total ED length of stay** for admitted and discharged patients, 15% reduction in "Door to Doctor" timestamp and 15% reduction in "Doctor to consult" timestamp.

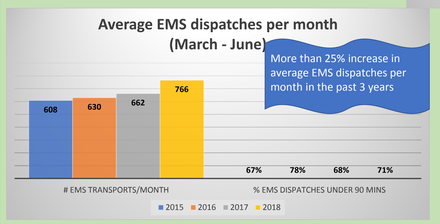
DO

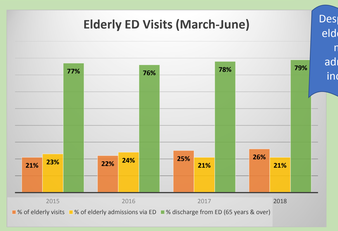
PDSA #1–Gap	PDSA #2 Describe the Test of Change (ToC)
Role confusion	Developed high level consult service algorithm
FM consult time increased and FM service felt they were losing contact with the ED	Developed criteria to support clear FM admissions (e.g. palliative, pain mgmt. and OCL).
HMCS service-7am to 5pm, Physicians often needed to stay later	HMCS service extended from 7am to 7pm
HMCS hand over to On-Call GIM physician at 5:00 pm	Handover is at 7pm
MRP confusion	Decrease ED physician handover-No morning sign over to HMCS. Service extension allowed for other physicians to join the service HMCS physician established as MRP from 7:00am to 7:00pm
Multiple orders and order confusion	Bridging orders written (allows for the patient to be moved to the unit) Clarified that the admitting GIM physician (HMCS) writes the orders
No Protective sleep time	Created protected sleep time from 0200-0700 am Extenders/House staff with clear role and responsibilities available to covers ED 2:00 am to 0700 as well as available daytime on weekends
SCH as a whole did not feel as they were part of the project. Therefore project speculation and negative assumptions increased	Developed a PDSA issue tracking meeting process (meet every 2 weeks; open to all SCH staff) with proper documentation and follow up of brought up issues.

CONTEXT





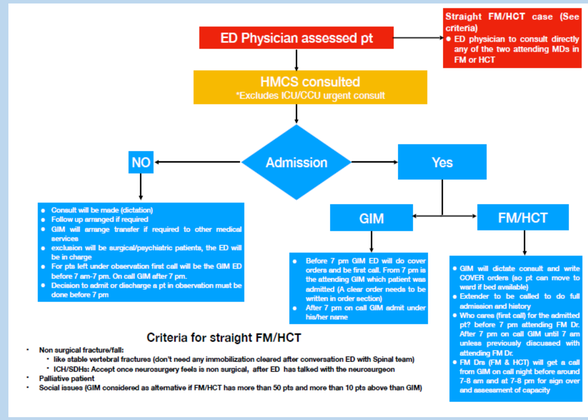




PLAN

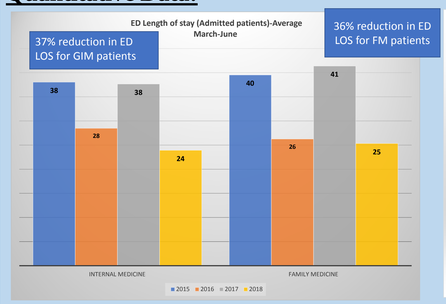
Based on the above, we developed a multifaceted medical consultation service (Hospital Medical Consult Service) and tested it through two PDSA cycles (PDSA #1: February 6 – April 30, 217 & PDSA #2: March 5 – June 30, 2018). Lessons learned from PDSA #1 were used to inform PDSA #2.

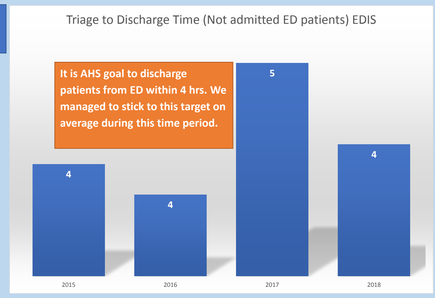
Hospital Medical Consult Service Algorithm*:

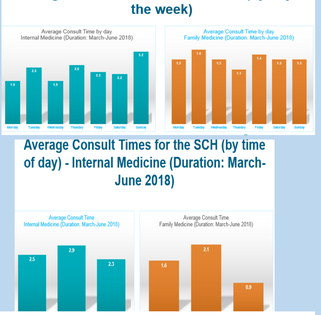


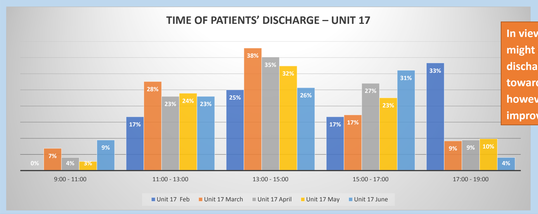
STUDY

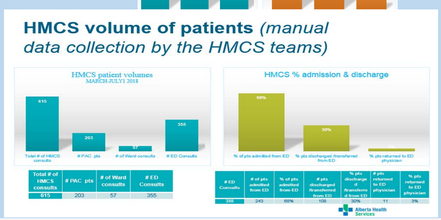
Quantitative Data:



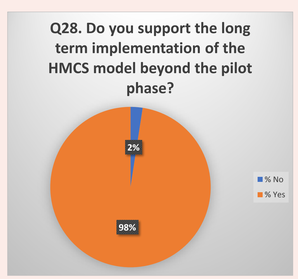


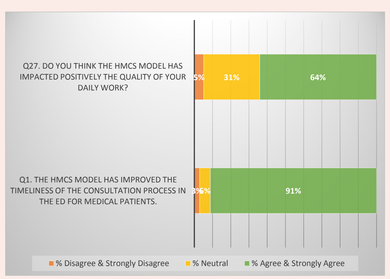


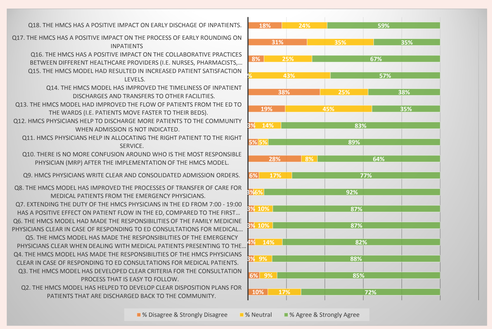




Qualitative Data:



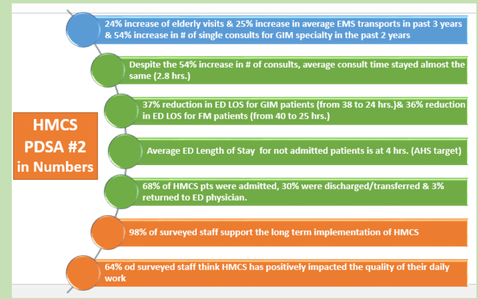




ACT

Reinforce Ownership, Measurement, & Continuous Improvement:

- HMCS has been continuing since the end of PDSA#2.
- SCH ED project team will continue to gather data to assess the impact of HMCS on the ED crowing problem during flu season and other parts of the year.
- Extend improvement efforts to early discharge of inpatients.
- Share learnings of PDSA#2 across the site/zone.
- Leaders to encourage adherence to the HMCS protocol.



SHARED LEARNINGS

Highlights of PDSA#2:

- Improved communication between ED, GIM & FM physicians.
- Improved joint care planning between ED & GIM physicians including clear disposition decision.
- Created an inclusive open forum for all staff to share their concerns/challenges in regards to the implementation of this project. We called it the "Brown bag lunch meeting" and it was held every other week with an open invitation.
- The physician leaders acted as champions for the implementation of HMCS and volunteered to educate & support others when needed to ensure proper compliance to the HMCS algorithm.

Opportunities for improvement identified throughout PDSA#2 include:

- Lack of consistency among the HMCS physicians.
- Lack of clarity about the most responsible physician (MRP) after 19:00 after decision is made to admit patients.
- Late discharges of inpatients.
- Limited number of GIM, FM/HCT Extenders.

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