

CONFERENCE ABSTRACT

A daily multidisciplinary hospital discharge support meeting in an acute hospital: An evaluation of a quality improvement initiative to facilitate timely discharge & transfers of care

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Introduction: Timely identification of those with complex discharge needs (CDN) in hospital is important for good discharge practice. Our region developed a number of pathways to support those with CDN including rehabilitation of frail older patients; support for patients with dementia; enhanced short-term support at home by community intervention team; and a new 18-bedded transitional care unit. However, hospital audit documented delays identifying patients with CDN and poor recording of the predicted date of discharge (PDD). As a consequence there were opportunities for improved patient flow & discharge support missed.

Practice change implemented: We instigated a "discharge support meeting" daily between Monday & Friday in our hospital. The bed manager, discharge coordinators, clinical nurse specialist in gerontology and consultant in geriatric medicine are available to other teams at this meeting. A member of each medical and surgical team attends and shares the discharge plan for each of their patients. PDD are amended at the meeting.

Aim: Our aim is for more timely identification of patients with CDN throughout the hospital, thereby allowing those patients be matched to appropriate discharge support services and improve overall patient flow.

Targeted population and stakeholders: Those with CDN represent about 20% of discharges but account for over 50% of bed days. They have on-going health & social care needs, require multidisciplinary assessment, frequently require in-patient rehabilitation and regularly need support on discharge. The "discharge support meeting" helps make improving patient flow a hospital-wide endeavour.

Impact: The meeting commenced September 2016. Discharge bottlenecks are identified and acted upon at the meeting. Potential discharge supports are highlighted for individual patients early. Over 80% of doctors responding to our feedback survey find the meeting helpful. The accuracy of the PDD has increased significantly. There has been a 25% increase in consultations by geriatric medicine with a corresponding appropriate increase of both rehabilitation and transitional care bed use. Our hospital weekend discharges have increased

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to our highest levels. There is cultural change in relation to discharge planning needing active management.

Sustainability and transferability: The meeting is scheduled during patients' mealtime as clinical teams would be leaving the wards. Individual team member presents their patients and then can leave. Intermittent text messages remind teams about the meeting. On average ~45% of all teams attend daily. There were no additional resources required and this structure could be replicated in other hospitals.

Conclusions & discussion: Discharge planning is not always to the forefront of healthcare professionals looking after ill patients in hospital. This daily meeting has increased knowledge of discharge supports among doctors. Smooth patient flow depends on linking a defined population to appropriate capacity by means of an efficient process. Our daily "discharge support meeting" acts as the link in our hospital helping to identify those with CDN in a timely manner and drives efficiency in our discharge processes.

Lessons learned:

Managing patient flow is a complex task

A daily discharge support meeting involves knowledge and discharge processes

There were unexpected additional benefits of highlighting discharge bottlenecks

Keywords: complex discharge; frailty; patient flow
