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Patient Flow

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Darlene LaRusic

Darlene LaRusic
Director, Patient Flow & Social Work
Eastern Zone

Registered Nurse:
- Graduate of VG Hospital, 1983
- Graduate of St. FX University, 1994
- Graduate of Critical Care Nursing Program, 1994

Received Emergency Nurse Certification:
- Canadian Nurses Association, 1998

Completed Nursing Leadership and Management Program:
- McMaster University, 2004

Clinical experience in emergency and critical care.

Leadership Experience:
- Nurse Manager, CBRH ED -2000
- Bed Utilization Nurse, CBRH – 2005
- Manager, Patient Flow & Social Work, CB Area – 2012
- Director, Patient Flow & Social Work, CB Area – 2014
- Director, Patient Flow & Social Work, Eastern Zone – 2016

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Service Area/Scope of Responsibilities

Overall accountability for patient flow and acute care social work services across all facilities within Eastern Zone:

- 13 Acute Care Facilities:
  - 2 Regional Hospitals
  - 3 Community Hospitals
  - 8 Rural Hospitals

- 834 Staffed & Funded Beds:
  - 410 Medical

Responsible for liaising with other programs within the zone, other zones, and across community sectors and agencies to facilitate the effective use of system resources and the smooth transfer of patients, clients, and residents between sites, organizations, and community programs.

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A day in the Life at Cape Breton Regional Hospital

- Over 20 admitted patients in ED with more admissions expected.
- Between 10 and 12 same day admission surgeries scheduled.
- 2 cardiac catheter patients returning from QEII.
- 2 patients to repatriate from across the province (closer to home).
- 1 patient to transfer out of palliative care unit to medical bed to accommodate new admission to palliative care from community.
- Call from cancer center with need to admit patient receiving chemo.
- Call from renal with need to admit patient who presented poorly for dialysis.
- Call from community hospital to transfer patient for internal medicine consult.
- Call from AP to advise that client from community needs to be taken to ED as can no longer be cared for safely at home.
- Call from nursing home to advise that client with responsive behaviors needs to be taken to ED as can no longer be cared for safely in facility.

AND

- Only 8 predicted medical/surgical discharges to start the day.

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Information Sources

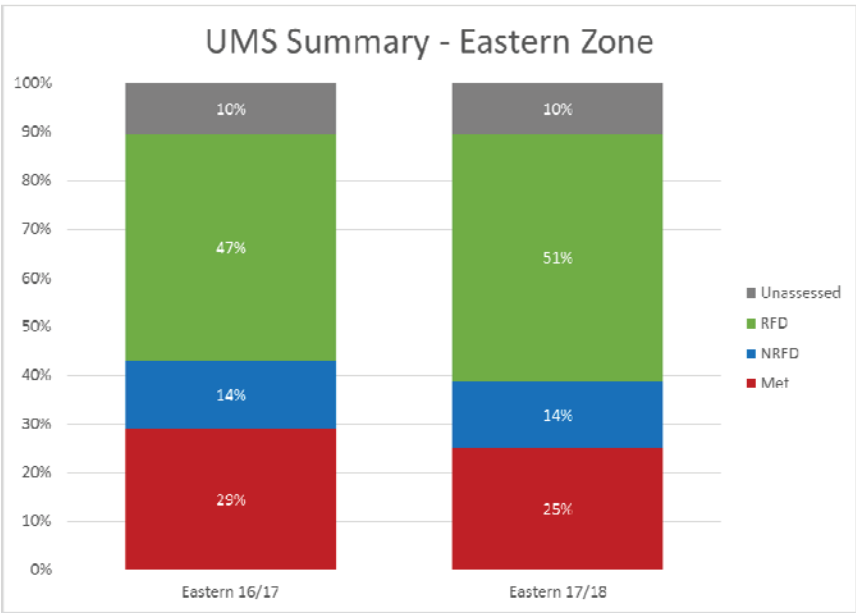
Patient Flow System:
- Appropriate for Service (MET/NOT-MET)
- Readiness for Discharge (RFD)
- Reasons preventing discharge (Organization / Community / Physician)

Emergency Department Indicators:
- Time to an Inpatient Bed (Target Within 8 Hours for 90% of Admitted Patients)
- ED Length of Stay (1,2,3 VS 4,5)

Patient Length of Stay in Hospital:
- Actual Length of Stay (ALOS)
- Expected Length of Stay (ELOS)

Clients Awaiting LTC Placement from Hospital

Number of SDAS Cases Cancelled due to Bed Availability



Common Myths

- Hospitals are the best place to get better
- Our built environment are appropriate for wandering patients or people with responsive behaviors
- People with dementia and responsive behaviours are appropriately cared for in mental health units
- Flow is a Monday –Friday 08:00-16:00 a day job
- Hospitals are well resourced to care for those who need sitters, need assistance with mobility and help with activities of daily living.
- Everyday spent in hospital is productive for the care of patients

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Our Realities

Increasingly demand out ways capacity and resources especially in regional/ tertiary centres.

One additional bed space can make a huge difference.

Delayed discharge at the smallest site can have a significant impact across the system of care in maintaining flow (flow in/ flow out (e.g.)Emergency Room overcapacity, EHS, Surgeries, patient outcomes.

Delays with inter-hospital transfers impacting access to critical and specialty care

Concern about provider burnout, high pressured workplace.

Patient experience is challenged (palliative experience in emergency, multiple moves for frail patients)

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The Challenges

Complex system/ continuum of care- communication, joint planning etc.

Population receiving care with increased aging, behavior challenge, complexity due to chronic illness, decreasing social supports

Hospitals serve as a social safety net

Absence of appropriate settings for care; expensive care setting that is not built or staffed appropriate. Cost of an Inpatient acute care bed at a Regional site $1450.00/day and at a Community site $835.00/day.

Ability to give right care to right patient at right time

Mobility-mobility-mobility….deconditioning

The Challenges

Within the Utilization Management system ALC is reported as four main barriers for discharge:

- Hospital Related reason: Processing Placement
- Hospital Related reason: Activation
- Community Related reason: Waiting Community
- Community Related reason: Social Issues
- No previous coordinating structure or service delivery model outside of geographic or zonal level
- Existing models of care not always a match for patient/population needs
- Unequitable distribution of resource exists. We need to understand our population and plan accordingly

The Opportunities

- Reciprocal trust; build collaborative partnership that are individual and family centred
- Understanding unique role of each service
- Timely access to preferred setting of care
- Streamlining processes to enable collaborative discharge planning and transitions in care
- Common language, data reporting

Our Offer

We want to work together for patient and families

Work to improve communication and collaboration

Engagement in discharge planning transitions in care

Our Ask

- Frailty informed care planning- work together so care happens in the right setting, circle of care and support in goals of care and earlier communication
- Who to call in other sectors
- Explore 7 days/week re-admissions to LTC
- Admissions within provincial policy timelines
- Consistent paper work/processes
- Common language e.g. placement process
- Elimination of home support waitlists
- Elimination of nursing capacity alerts

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The Opportunities

- Improved care/experience for patients/clients/residents, better outcomes
- Reductions in missed care, critical incidents and near misses
- Reductions in the time admitted patients spend in the Emergency Department
- Reductions in acute length of stay and Alternate Level of Care rates
- Reductions in transfers/moves of frail seniors
- Improved access to services across the health system
- Improved discharge planning processes

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Top Priorities for Collaboration & Change

- Circle of care and support engaged earlier in care planning for individuals with responsive behaviors.
- Promote Home First Philosophy – ensure home with supports explored before LTC
- Improve access to primary care for LTC residents
- Work to understand each others realities so we can work together to improve individual's experience in care
- Benefit and risk analysis for individuals within various levels of care prior to transition in care

Final Comments

When, how & where care is provided is often as important as what care is provided.

Timely access to appropriate care is fundamental to high quality care.

Key Contacts

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