Patient Flow

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Kate Melvin
Central Zone Director, Patient Flow

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Director, Patient Flow
Central Zone

Registered Nurse – Dalhousie BScN graduate, 2004

Obtained an MBA from Dalhousie University, 2008

Clinical nursing experience in medical intermediate care and emergency; completed the Emergency Nursing Program in 2006.

Leadership Experience:

- QEII Bed Manager and Nursing Administrative Coordinator
- Health Services Manager, General Surgery inpatient unit, QEII Endoscopy services and Enterostomal Therapy services
- Director of Patient Flow, Central Zone

Our Population includes:

Central Zone
- 423,163 for Primary and Secondary Care

Nova Scotia
- 921,725 for Tertiary & Quaternary Care

Atlantic Canada
- Specialized Tertiary & Quaternary Care
  - Blood & Marrow Transplant
  - Multi Organ Transplant

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Service Area/Scope of Responsibilities

- Supports safe, quality people centred care by facilitating effective and timely patient flow across the system, appropriate bed management/utilization, and discharge facilitation within the central zone
- CZ total bed capacity = 1,339 beds
  - **863** Acute Care; **67** Rehab; **31** Transitional/Alternate Level of Care; **175** Veterans; **171** Mental Health; **31** Long Term Care and **1** Respite
- Central Zone 2017/18
  - 188,618 Emergency Department visits 2017/18
  - 28,052 surgeries at the QEII/5,097 surgeries at DGH

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A day in the Life of Flow Team

- On any given day, our bed managers:
  - admissions holding overnight in the EDs
  - changing admission status where patient may now require ICU/IMCU
  - the discharge they were banking on has just revealed that he is the primary caregiver for his ill spouse and will require increased supports prior to going home
  - the ED phones to let them know that a patient presenting to the department will need Adult Protection and once accepted will need to be moved to an appropriate location to wait for a bed in the community
  - a day patient in the OR now requires admission to hospital in a monitored bed
  - a clinic phones to request a bed for a patient who can no longer manage their condition at home and must be admitted today
  - a call from PEI to let you know that a patient has an ischemic limb and requires urgent intervention, they must come today to the HI.
  - Valley Regional phones to report they have a patient actively having a heart attack, the needed medications have been started and they are already enroute to Halifax and the cath lab.

Information Sources

Patient Rounds

- Number of Admits in ED
- Number of Surgeries scheduled/number on the waitlist
- Number of other admits (at home waiting/out of Zone/out of Province etc.)

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

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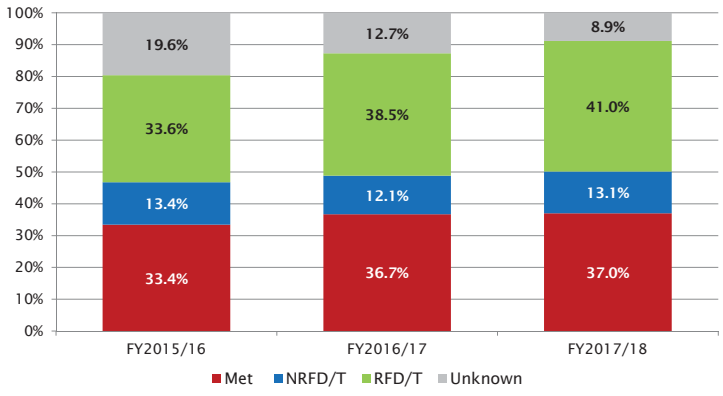
Utilization Management System (UMS) Data
NSHA Central - Met, Not-Met and Unknown Days

All Sites - Medical/Surgical Units
(Excludes IMCUs and 9 Lane)



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Definitions:

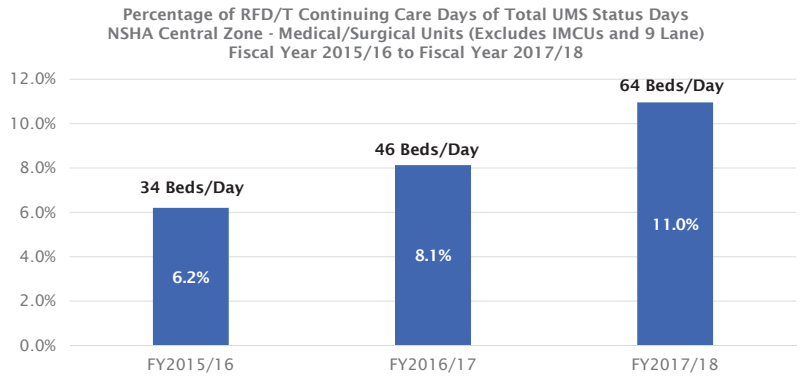
Met: Service intensity appropriate for patient's care needs.

Not-Met NRFD/T (Not Ready For Discharge/ Transition): Service intensity different than care needs (not appropriate), but patient not yet clinically stable.

Not-Met RFD/T (Ready For Discharge/Transition): Service intensity different than care needs (not appropriate) and patient clinically stable.

Unknown: Days that were not assessed.

Utilization Management System (UMS)
RFD/T Days for Continuing Care



Includes *Processing Placement – Referral to Continuing Care (*Adult Protection, Home Care, Home Nursing Care, LTC, Other*); Waiting Community – Challenging Behaviours* (LTC Bed, Home Care, Residential Care Facility); *Waiting Community – Continuing Care* (Equipment, Equipment Bariatric, Home O2 Set-up, Home Nursing, Home Support, Home Safety Assessment, LTC Assessment, Needs Exceed Available Resources-Requires 24hr Care, Palliative Care, Self Managed Care, Service Closed – Identify, Other); and, *Waiting Community – Waiting Bed* (LTC, Needs Exceed Defined Care Levels/Chronic Ventilator, Residential Care Facility.)

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Common Myths

- Hospitals are the best place to get better
- The hospital unit environments are appropriate for wandering patients or people with responsive behaviors
- People with dementia and responsive behaviors 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

- Demand exceeds capacity and resources especially in regional/ tertiary centres.
- One additional bed space can make a huge difference.
- Delayed discharge(s) at the smallest site can have a significant impact across the system of care in maintaining flow (flow in/ flow out i.e., Emergency Department overcrowding, EHS, Surgeries, patient outcomes.
- Delays with inter-hospital transfers impacting access to critical and specialty care
- Concern about provider burnout in a high pressured workplace.
- Patient experience is impacted (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: inpatient acute care bed - regional site - $1450.00/day; Community site - $835.00/day
- Ability to give right care to right patient at right time
- Mobility-mobility-mobility… deconditioning
- Utilization Management - four main barriers for discharge: Processing Placement; Hospital Activation; Waiting Community and Social Issues

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Our Ask

- Frailty informed care planning- work together so care happens in the right setting, circle of care
- Earlier communication and intervention; perhaps transfers can be avoided
- 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/ data reporting
- Elimination of home support waitlists
- Elimination of nursing capacity alerts

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The Opportunities

- Improved care experience for individuals with better outcomes
- Reductions in missed care, critical incidents and near misses
- Reductions in time admitted patients wait in Emergency Departments
- Reductions in acute length of stay and Alternate Level of Care rates
- Reductions in transfers/moves of frail seniors
- Timely access to appropriate care setting
- Improved access to services across the health system
- Improved collaborative transitions in care and discharge planning

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Top Priorities for Collaboration & Change

- Collaborative person-centred care planning for individuals with responsive behaviors
- Home First Philosophy – home with supports explored before LTC
- Improve access to primary care for LTC residents
- Understand each others realities

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 Patient Flow Contacts

- Kate Melvin – Director Patient Flow, Central Zone
  - 902-473-2261
- Administrative Patient Flow Managers QEII
  - 902-473-5693
- Bed Manager DGH
  - 902-460-4126
- Bed Manager Mental Health
  - 902-473-2548
- Cardiology Bed Manager (Provincial Program)
  - 902-473-6571
- Central Zone after hours (nights/weekends/holidays)
  - 902-473-7793 or through locating (902-473-2220: pager 2607)