Acute Medicine Services

Vickie Sullivan, ED Central Zone

Wanda Matthews, ED Western Zone

Madonna MacDonald, Sr. Director Acute Medicine, A- ED Eastern Zone

Victoria Sullivan
Operations Executive Director
Central Zone

- Graduated with Bachelor of Nursing from University of New Brunswick and holds a Masters of Health Studies from Athabasca University
- Holds a Canadian Nurses Association Specialty Certification in Oncology Nursing
- In November 2014, received Cancer Care Nova Scotia's Leadership Excellence Award

Leadership Experience

- Worked in various clinical settings across Canada, both as staff nurse and head nurse
- Manager for Nova Scotia Cancer Centre for 14 years
- Director of Capital Health Cancer Care Program for 9 years
- Director of VG Site for 4 years
- Assumed current role April 1, 2015

Hopes

- Understanding of each other's roles, services and realities.
- Build productive, collaborative relationships across the health system.
- Dialogue on improving experience of and transitions in care for individuals and their loved ones.
- Explore opportunities where we can work better together.

Presentation

- Overview of Acute Medicine with ACTIV admission criteria
- Patient Flow Data (NSHA)
- Realities
- Physician Coverage

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Key Contacts- Acute Medicine Services

Policy, Quality and Planning:

Dr. Amy Hendricks, Sr. Medical Director
Nicole Lukeman, Director Policy and Planning

Integration and Operations:

Eastern Zone: ED Vacant, Dr. Warren Wilkes, Dr. Paul MacDonald
Mark LeCouter, Mickey Daye, Angela MacArthur and Martha Cooper

Northern Zone: Cheryl Northcott, Dr. Nicole Boutilier, Dr. Raid Shaarbaff, Debbie Burris

Central Zone: Vickie Sullivan, Dr. Mark Taylor, Dr. Christine Short, Brian Butt, Heather Francis, Heather White, Roberta Duchene, Sherri Parker

Western Zone: Wanda Matthews, Dr. Alenia Kinsella (leaving June), Dr. Brian Moses, Vanessa Quigley

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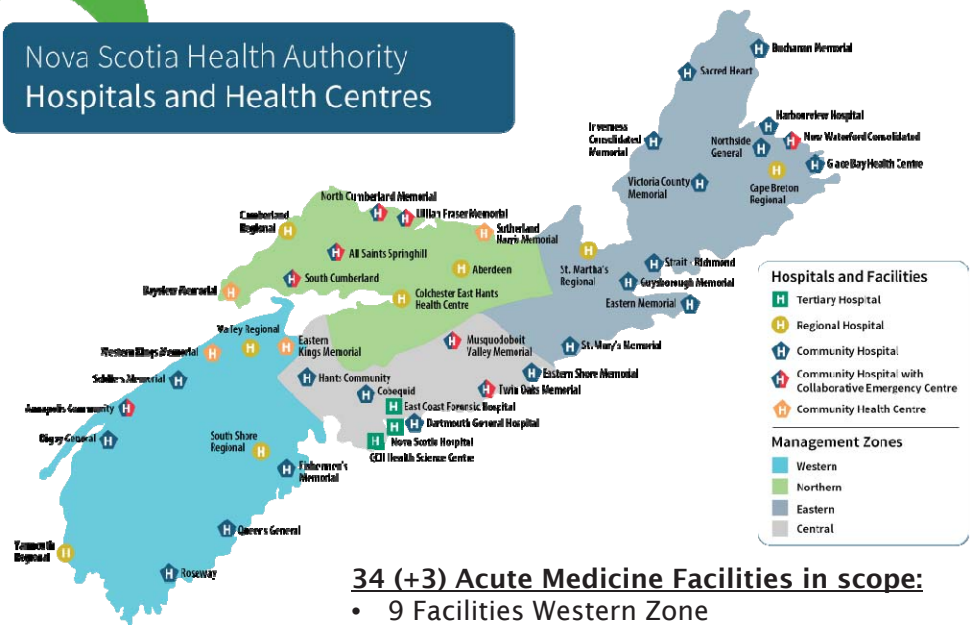
Nova Scotia Health Authority
Hospitals and Health Centres



34 (+3) Acute Medicine Facilities in scope:

- 9 Facilities Western Zone
- 5 Facilities Northern Zone (+2 RCU sites)
- 13 Facilities Eastern Zone (+1 RCU site)
- 7 Facilities Central Zone

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Overview Acute Medicine Services

- Approximately 40,000 discharges from inpatient acute medicine services in fiscal 2016-17.
  - Through 4 management zones over 34 facilities NSHA wide
  - From 4 bed rural community units to regional hospital medicine and mixed medicine/surgical units, to tertiary/quaternary specialty/academic medicine units
  - Approximately 17 m over budget
- Existing models of care and our buildings are not always a match for patient/population needs.
  - High levels of complex chronic care, frailty, and geriatrics
  - No standard model of care delivery for nursing, allied health, and physician care. Issues with orphan patients, the impact of vacancies, cross coverage of sites, and novice staff
  - Mobility gaps leading to deconditioning; falls as a high trend in patient safety incidents
  - Variation in process, procedures, tools and approaches to patient care
- Access and Flow issues internal and external to the medicine portfolio reflected in data including occupancy rates, ED admits, and length of stay indicators

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Admission Criteria Acute Medicine
Adult Medical/Surgical Criteria Set(ACTIV)

In the Medworxx UM "ACTIV" Criteria Set the patient is "Met" for acute care admission if they meet parameters specific to :

- Airway
- Close Observation/Protection
- Tubes/Traction
- Injection/IV
- Vital Signs

Met, Not Met, Ready for Discharge (Acuity)

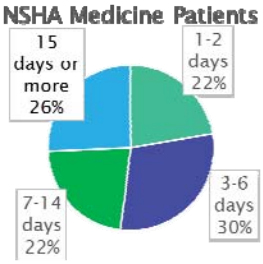
On average, 50% of assessed days in the medicine service are Ready for Discharge.

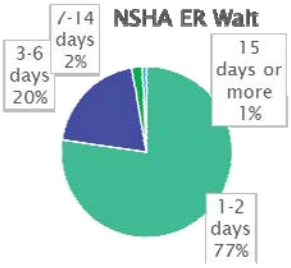
- As a zone, WZ has the highest average RFD days,
- The individual sites with the highest % are in EZ.

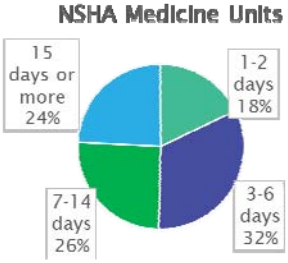
Overall, approximately 25% of assessed days meet *acute medicine criteria*.

- Within tertiary and regional hospitals MET rates range from 20-35%
- Rural and community hospitals are 0-20% MET days.
- Lowest average is in WZ.
- CZ has the highest percentage of met days.

Length of Stay







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Does the Resource Meet the Patient Need?

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Realities

- Over capacity in medicine units at most regional hospitals results in longer emergency department waits; many patients are held in emergency rooms as admissions because no inpatients available.
- Patients have told us discharge planning and preparation needs to improve.
- Patient population changing; treatment and care advances so more can happen out of inpatient setting.
- No standard approaches or expectations to patient flow processes in medicine units; practices and processes are not always consistent, and not always completed "with intention"
- Fifty- Ninety percent of nursing staff may be within first two years of practice
- Retention of staff; aging infrastructure; increasing cost of supplies, medication, equipment; advancements in technology (OPOR, OMNICELL, Point of Care)
- Challenges with physician coverage models, physician engagement tends to be more consistent within the Central Zone

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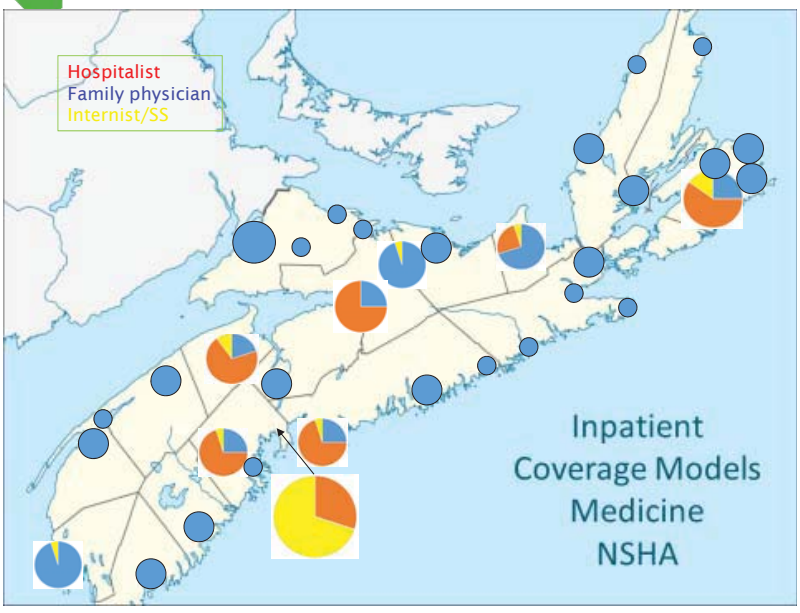

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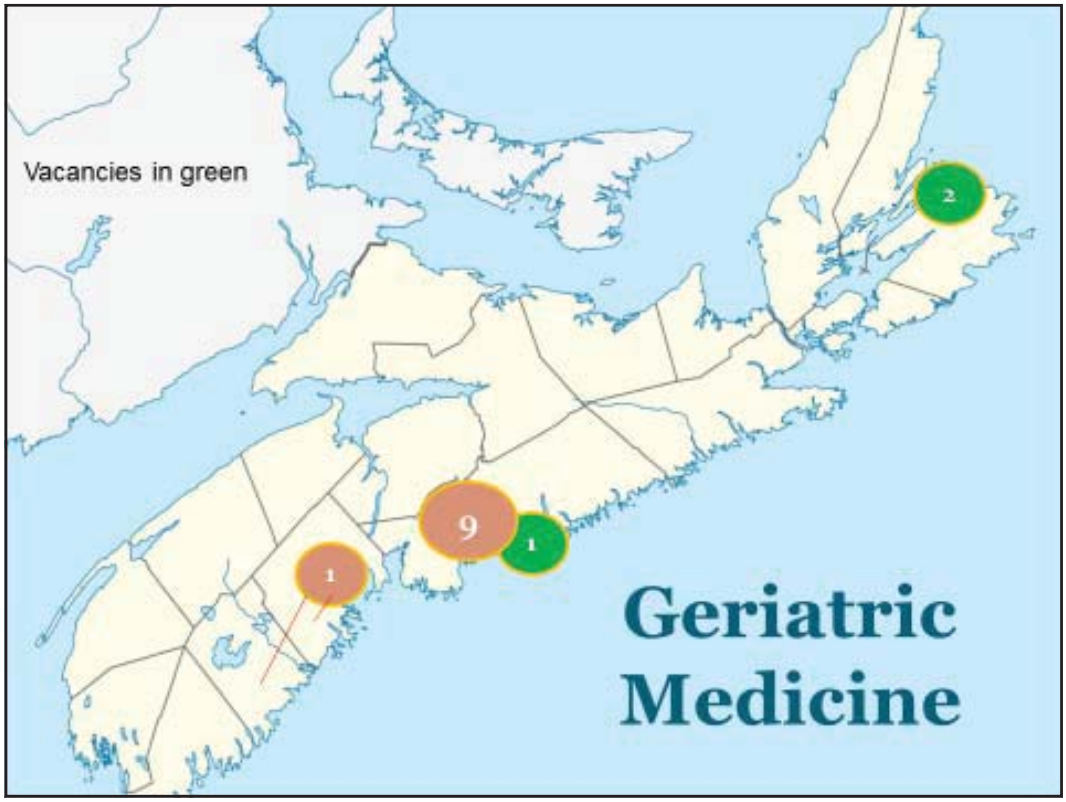

Patient Satisfaction Survey Results 2016/17

Table 1. Patient Experience Survey Results by Dimension, for Acute Inpatient Program Area

Dimensions	% Positive*
Overall Rating of the Hospital	87.0%
Hospital Environment	86.3%
Sharing Information, Communication and Education	80.7%
Services Received from Healthcare Professionals	91.9%
Respecting your Values, Needs and Preferences	93.7%

Highest rated survey questions:

- Doctors (97.1%) and nurses (96.6%) treated me with courtesy and respect.
- My/my family diversity was respected and valued (96.9%)

Lowest rated survey questions:

Did you get the information regarding symptoms/problems to look out for post-hospitalization? (66.0%)

- Before new medications, were side effects described in a way you could understand? (72.1%)
- Were supports you required post-hospitalization discussed with you by the team? (81.5%)

The Opportunities

- Re-design –model of care framework informed by population needs and promising practice
- NSHA Patient Flow and Length of Stay action plan
- Practice development with frailty informed care and responsive behavior; partnership with researchers, with NGOs
- Collaborative planning earlier in care experience, transitional care, Home First
- Investments in Primary Health Care, Continuing Care
- Evidence informed practice- technologies, treatment and care advances mean innovative ways to deliver care in places people call home

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