Monash Health: Design of new pathway to improve access to subacute services direct from Emergency Department

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Introduction

• Context: This project was undertaken in the Monash Medical Centre (MMC) Emergency Department (ED) (Clayton, Victoria) and the Kingston Centre, a stand-alone subacute facility (Cheltenham, Victoria) (figure 1).

• Problem: Access to subacute services for some patients was not timely due to the lack of a direct pathway between MMC ED and Kingston Centre.

• Aim: To design and trial a patient-centred pathway which aims to avoid acute admissions when they are not necessary and multiple ward transfers (figure 2) to improve access to subacute beds.

• Right care, right place, at the right time.

• Previous observational studies indicate direct admission to subacute care from ED can be feasible, safe, and acceptable for selected patient cohorts.1,2

Methods

• Intervention: The new pathway was co-designed by multidisciplinary teams ensuring perspectives of ED staff and subacute staff were captured and mutual goals were met. Figure 3 shows the process design brainstorming session in action.

• Methods: Historic data review, benchmarking with other services, screening current ED arrivals, root cause analysis and process mapping (figure 4) were used to develop the model and test feasibility. Once developed, the new pathway was trialled for a 3 week period.

Effects of changes

During the 3 week trial:

• On average 3 patients per week directly accessed subacute services from ED (table 1) and avoided unnecessary acute admission(s).

• Improved knowledge of services/resources at geographically distanced sites.

• Collaborative teamwork supported the referral and acceptance process.

• Triage to subacute provided responsive care and early discharge planning.

Table 1. Suitable patient cohorts and number of direct transfers during trial

<table>
<thead>
<tr>
<th>Patient cohorts</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>TOTAL suitable patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients with injuries who would normally function independently at home – no surgery required</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2. Patients requiring geriatric evaluation because of increasing difficulty managing at home</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>3. Patients with recurrent falls with no underlying medical condition, but require admission</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. Patients requiring stabilisation of chronic medical conditions who are not acutely unwell</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5. Well patient of sick carer needing hospitalisation when respite bed not available for them</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>6. Patients with minor medical problems who need short term treatment away from home</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

TOTAL suitable patients 1 2 6 9

Lessons learnt

1. After hours (post 7pm transfer) creates settling issues in aged patients
2. Delays do impact viable transfer within time window e.g. delay in ambulance arrival or diagnostic results
3. New direct pathway increased assessment workload
4. Existing allied health resources at receiving site stretched due to extensive care plan assessment now required as a result of direct transfer from ED
5. Stretched resources due to flex up of beds and limited resource increase during trial.
6. Flex of beds to increase bed capacity required additional night nurse staff for nurse patient ratios

Message for others

• Teams with differing care focuses located at different hospital sites can partner successfully to ensure patients receive responsive, appropriate care.

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References:
1. Halpert, Pearson, Rape. Direct Admission to an Extended-Care Facility from the Emergency Department. Effective Clinical Practice. 1998; 2, 7-14