Discharge by Noon

East 4: Accelerated Access Unit

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Introduction

Reducing patient length of stay (LOS) is an effective way to decrease hospital costs. The interdisciplinary discharge (d/c) process is complex; however, identifying causes to eliminate delayed discharge will improve financial stewardship. In addition, completing discharges sooner allows for more patients to be placed in beds and provided with inpatient care quicker, increasing overall quality and safety (El-Eid, G. R., et al., 2015). Therefore, decreasing patient discharge time should be a major goal in all inpatient areas.

Design/Sample

In East 4, RNs were educated and reminded to draw all AM labs as early as possible, if patient is planning to be discharged the next day. This reminder took place at pre-shift huddle, facilitated by Charge RN and Jessica Hori. Secondly, the East 4 HUSC, Veronica Galvin, will assist in picking up patient belongings prior to any discharge. Diana Kwong will be leading education of RN staff to inform Charge RN of patients in need of physical therapy (PT) evaluation before discharge. Ada Kwong will educate staff about identifying complicated discharges and notify Hospitalist RN, Trang Khuu, who can assist with discharges. Our evaluation strategy will consist of analyzing East 4 dashboard results for patients discharged by noon, with a goal of achieving a benchmark of 17% or greater.

Analysis

There is limited data collected regarding this research. The action plan outcomes were evaluated using patient care service dashboards. The patient experience HCAHPS score for discharges by noon as of March 29th is 14.7% with an average of 12% during this fiscal year. East 4 did not reach their goal. The entire hospital averaged 14%, therefore, East 4 is doing about the same as the entire hospital. However, compared to floors with similar patient acuity, East 4 falls behind the average. East 5 Neurology averaged 18%, Tower 8 Acute Care averaged 15.3%, and Davis 12 Surgical Specialties averaged 14%. In order to better understand the decline in discharges, an analysis of the amount of patients with orders by 10 AM was done. On average 39.5% of discharged patients had discharge orders by 10 AM. However, the research shows that the last discharge order on average was placed by noon. Therefore, patients would be unable to be discharged by noon with the last discharge order being filed by noon.

Results

Diagram 1 is the dashboard for percentage of patients d/c by noon on East 4. Discharge orders received by 10 AM for East 4 is on Diagram 2 and Diagram 3 shows the units East 4 was compared to in the analysis section. Please refer to the analysis section.

Diagram 1:

Diagram 2:

Diagram 3:
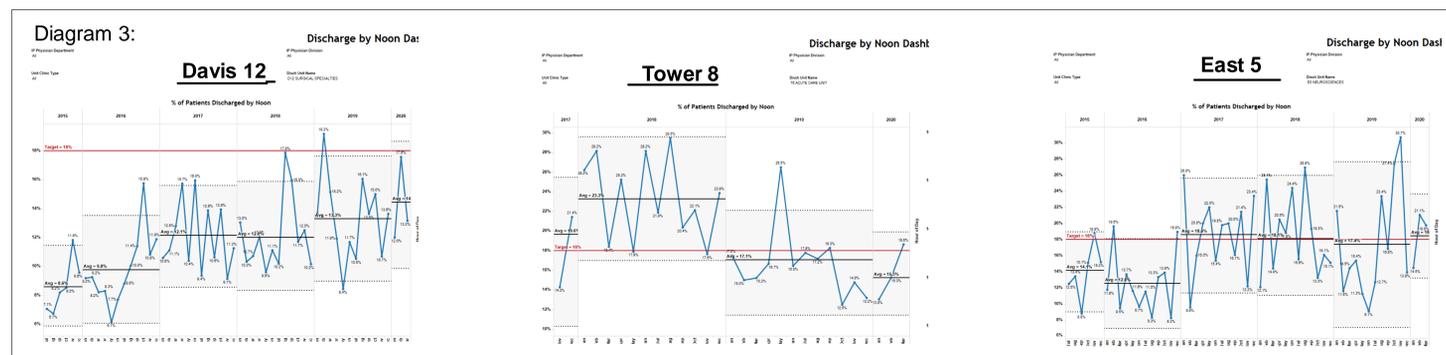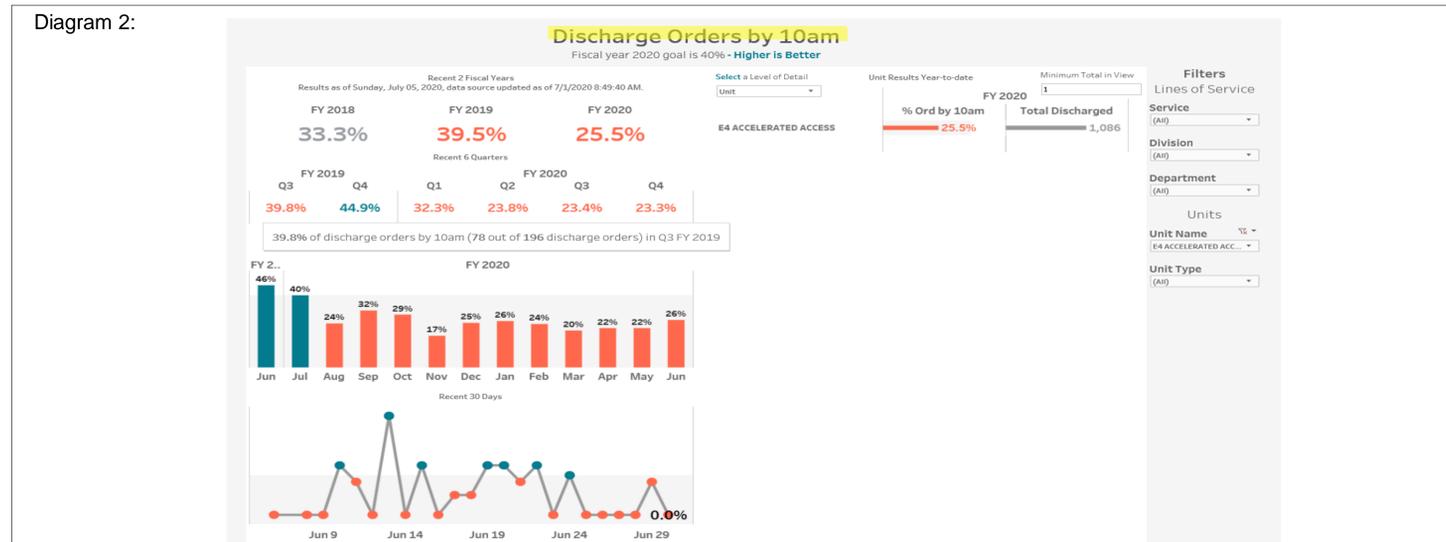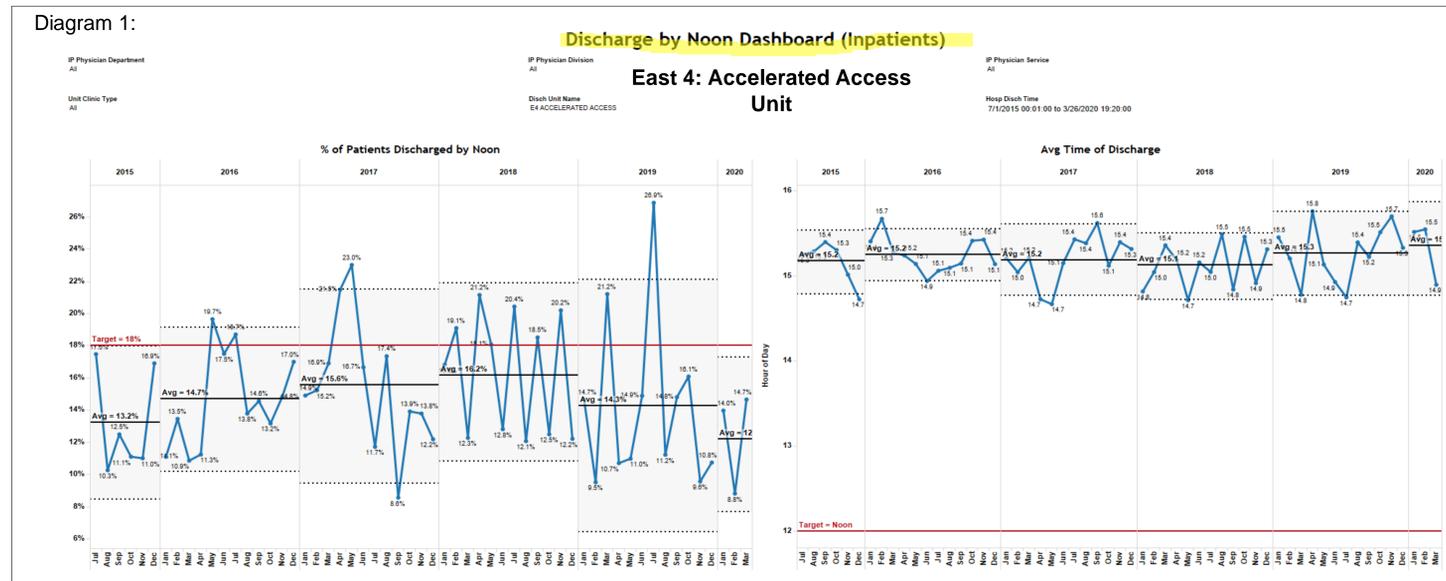
Summary

In summary, East 4's UBPC has made discharge by noon a priority to decrease patient LOS and more efficiently allocate beds for new patient turnover. Achieving this benchmark would decrease unit costs, while increasing quality and safety. We are using four action plans, targeting drawing AM labs on time, getting patient belongings/medications to bedside efficiently, prioritizing PT evaluations before discharge, and utilizing the discharge planning/Hospitalist RN more. As of now, we have not reached our goal of 17% discharged by noon (14.7% currently). However, we are continuing our efforts and action plans, while also analyzing other factors that could be slowing discharge efficiency, including discharge orders not being put in before the anticipated day of discharge. This project is still in progress and we will continue to analyze East 4 dashboard results as action plans are completed and amended over time.

Conclusions/Further Study

In conclusion, as the East 4 UBPC moves forward with this project, we will continue with our action plans, while also looking into alternative opportunities for improvement. A major obstacle we discovered to discharging by noon, was MD discharge orders not being submitted the day before or by early morning the anticipated day of discharge. We can look into educating RNs to take more initiative to remind MDs to put in orders the day before, but, unfortunately, this problem is difficult for RNs to directly impact. On the other hand, we anticipate brainstorming ways to analyze specific action plans individually, to find/eliminate barriers. For example, we can make a template to directly count how many AM labs were not drawn nights before anticipated discharge, or how many patients did not have belongings or medications brought to bedside by that morning. Analyzing any gaps in the plan and corresponding obstacles to completion will increase our success at carrying the action plans out fully, and, as a result, increase discharges by noon.

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