RESCUERS – Reduce Elective Surgery Cancellations Utilising Existing and Realigning Services.

Facility: Northern Beaches (Manly and Mona Vale) and Hornsby Hospitals.

B Friend NM Mona Vale Hospital, H Liddle NUM Manly Hospital, M Rose NM Hornsby Hospital

Case for change

The Directors of Nursing and Midwifery of Manly, Mona Vale and Hornsby required a more predictable and balanced number of elective surgical admissions to aid with bed management. The variable bed availability was also resulting in an increasing incidence of “no bed” cancellations for elective surgical patients and the resultant risk of not meeting surgical waitlist targets. (NEST).

Goal

Equitable, timely access to a surgical journey of co-ordinated care + informed preparation, for all stages, resulting in best patient outcomes and most efficient use of resources.

Objectives

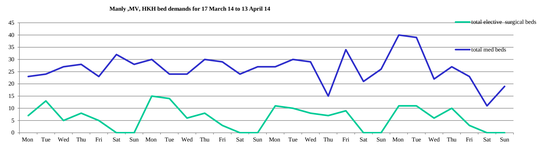
1. Reduce the number of elective surgical cancellations due to no post-operative bed by 50% on each site by 31 December 2014

2. To increase the percentage of surgical patients treated as Day Only admissions to 80% of all elective surgical patients by 30 June 2015.

Method

A review of elective surgery cancellations for 2013 found that 32% were due to “no post-operative bed”.

A review of elective surgery bed demands showed a range between 4 – 17 per day. Graphing the results showed a Monday, Tuesday peak each week with a tapering on Thursday, Friday.

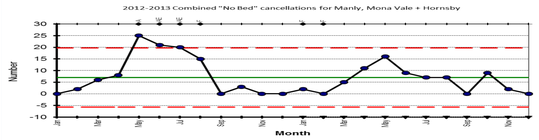


An analysis of the hospital surgical beds showed that up to one third to one half could be occupied by medical patients. This blocked the beds for elective surgical use.

Interviews with cancelled patients found the disruption to family and work plans, disappointment and impact of the lengthened wait led to significant dissatisfaction with the hospital.

Diagnostics

1. An inconsistent request for admission (RFA) process with 50% of waitlist managed by the relevant surgeon rather than the hospital.
2. Seasonal variation of elective surgical bed availability due to medical bed needs in the winter months.



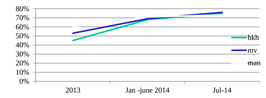
3. Suitable procedures were not being allocated to Day Only bed classifications – often based on traditional treatment modalities of some surgeons.
4. Some Day Only patients were unable to be discharged on the same day due to pain and vomiting issues or delayed discharge due to need for medical review prior to discharge.
5. Patient education and expectations were not adequately addressed prior to admission.

Planning and implementing solutions

1. Weekly “theatre bookings” meeting with theatre manager, wait list co-ordinator, nurse screener and patient flow co-ordinator at each hospital to review all elective surgery bookings for 4 weeks prior to surgery date.
2. Standardise the Referral for Admission information required and ensure it is provided.
3. Scheduling of theatre lists to improved patient throughput
4. Criteria led discharge for Day Surgery patients to be developed by a collaboration of day surgery staff, surgeons and anaesthetists to minimise discharge delays.
5. Clinical pathways to be developed by a collaboration of surgeons, surgical nurses, physiotherapists and divisional manager sponsor for primary hip, knee and thyroid surgeries to ensure consistent management practices.
6. Theatre template review by surgical clinical director, anaesthetics director, divisional manager and theatre manager to better distribute elective surgical overnight bed needs.
7. Quarantine surgical beds for elective surgical patients.

Results

1. Weekly “theatre bookings” meeting held with elective surgical admissions limited to set daily limits. Bed classifications are checked and changed to Day Only if suitable and with consultation with the requesting surgeon. List length is checked and the surgeon is advised if lists are over or under booked. Patients are placed on standby rather than cancelled and this has resulted in improved usage of available beds and less “no bed “ cancellations.
2. No bed cancellations have changed from 65 in 2013 to 36 until 30 Oct in 2014.
3. There has been an increase in the types of procedures that can be treated as Day Only patients. Many minimally invasive parathyroid, anterior cruciate ligament repairs, adenotonsillectomy, laparoscopic cholecystectomy and hernia repairs have all moved to Day Only procedures with the aid of multidisciplinary working parties or surgeon initiatives.



4. Consultation with other Local Health Districts to gain further ideas on management of suitable day only procedures and waiting list management.
5. Criteria led discharge parameters introduced to Day Surgery Ward.
6. Clinical pathways for total hip and knee procedures and for thyroid surgery are in development. A consistent pathway will then be introduced for all three sites.
7. Each site has identified their individual template change needs to even out the elective surgery beds demand. These changes are continuing.
8. Request for Admission (RFA) minimum data set education completed and incomplete RFA’s are returned for correction before the patient is entered onto the hospital wait list.

SITE	Mandatory DATA	% complete	Waitlist within 3 days Receipt date	% complete
Manly	34/34	100%	34/34	100%
Mona Vale	40/40	100%	39/40	97.5%
Hornsby	50/50	100%	49/50	98%

Sustaining change

Cancellation reasons will be monitored monthly as part of the theatre monthly activity / KPI report.

RFA content will be audited monthly for 6 months and reported to the Perioperative Management Committee.

The weekly Theatre list meeting has now become routine and will continue with positive feedback received from the participants. There has been an improvement in list management and improved proactive management of list issues.

Day Surgery treatment modalities are monitored by the weekly theatre list meeting to ensure that change is sustained.

Criteria led discharge from Day Ward embedded.

Many timetable changes are now embedded but there is continual review for further improvements .

Ongoing review for the quarantining of surgical beds.

Conclusion

The value of analysing the data and finding the root cause of an issues is invaluable in any planned change.

The generosity of nursing and support staff, surgeons and anaesthetists and their willingness to change their approach has made progress in the project possible. We have also learnt the importance of sponsor support and assistance to maximise the effectiveness of the project.

Any theatre unit can improve their percentage of Day Only treated patients examining their casemix and working collaboratively with surgeons and anaesthetists to move appropriate patients and procedures to be done as day only. Even more traditional surgeons can be encouraged to change to better service their patients.

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Contact

Bronwyn.Friend@health.nsw.gov.au 02 9998 0213

Heather.Liddle@health.nsw.gov.au 02 9976 9751

Mary.Rose@health.nsw.gov.au 02 9477 9135