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Case for change

90 Royal North Shore Hospital (RNSH) surgical inpatients per day experienced a HAC in 2021/22, with RNSH having the highest number of surgical complications per 10,000 episodes of care compared to Australian peer comparators in 2022. Despite knowing that complications post-surgery are the third leading cause of death in the developed world (ANZCA Perioperative Care Fact Sheet, 2023), there is very little optimisation of patients pre-operatively to ensure that they are adequately prepared for surgery and recovery. As one RNSH anaesthetist said, "we are doing the bare minimum so that patients aren't cancelled, rather than optimising them to be the best they can be for surgery".

Complications arising after surgery are the third leading cause of death in the developed world.
(ANZCA Perioperative Care Fact Sheet, 2023)

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Perioperative optimisation pathways reduce hospital length of stay by up to 3.7 days and reduce post operative complications by up to 80%.
(Centre for Perioperative Care, UK, 2020)

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Goal

To achieve integrated and streamlined care for patients on their preoperative journey by April 2024, ensuring every patient is appropriately assessed and prepared for surgery, receiving quality preoperative care to achieve the best surgical and health outcomes.

Objectives

1. Ensure patients receive personalised perioperative care and self-management support that suits their needs and risks by increasing the portion of Category 2 and 3 elective surgical patients offered an "optimisation pathway" within 14 days of being placed on the surgical waitlist from 0% to 100% by April 2024
2. Increase preadmission touch points on surgical perioperative journey by:
   a) Increasing the percentage of audio-visual appointments from 4% - 14% by April 2024
   b) Reduce number of patients requiring face-face PAC appointment from 43% to less than 30% where clinically appropriate by April 2024
3. Ensure patients receive access to timely care by:
   a) Reducing number of days patient spends on NRFC list from 90 days to 60 days
   b) Increasing portion of patients with a documented NRFC plan and documented follow up outcomes on eMR from 0% to 100% by April 2024
4. Reduce avoidable day of surgery (DOS) cancellations due to patient reasons from 2.4% (22/23 FY) to 1.5% by April 2024 (Ministry target <2%)

Diagnostics

The team undertook extensive diagnostics to ensure that they fully considered issues from multiple perspectives. This included process mapping with key staff, 49 patient surveys, 47 staff surveys, a range of staff interviews across administration, nursing, medical and allied health disciplines, five patient interviews, three interviews with peer comparator hospitals, eight patient tag-alongs, a staff focus group with 15 attendees, quantitative data analysis and a record audit.

Solutions

14 key themes were identified from the diagnostics, including the lack of surgical team buy in to the preadmission process, the single source of RFA screening and the resulting poor coordination of care experienced by patients. It was shown that patients were booked to PAC with insufficient time to allow optimisation, and that referrals to NSLHD PAC model of care did not meet criteria. The PAC appointment itself was inefficient in the workflow and use of clinic time, with patients waiting up to four hours for their appointment. There was also little to no data capturing or monitoring. The setting of the clinic also decreased efficiency, with only a very small amount of telehealth being completed.

Results

Solution stream one: Preoperative Optimisation pathway

Problem statement: There is no current optimisation pathway for patients on the elective surgery waitlist beyond those identified as frail by the Clinical Perioperative Coordinator. Patients are booked to attend PAC on average 10 days prior to their surgery (cat 3).

Progress

- $80,000 approved funding for digital pathway for 18 months
- Clinical led working group to implement pathway. Meeting weekly
- Approx 'go live' for surgical category 3 patients mid-May 24
- Optimisation pathway developed including prehab and community services led by perioperative team

Solution stream two: Relocation of PAC

Problem statement: The shared location of PAC within the Ambulatory Care Centre has led to delays in assessments and interventions being performed (cannot see stretchered patients). The distance between PAC and the surgical services (booking unit, nurse screener) means more limited communication, reduced collaboration and an inability to review non-ambulant patients.

Progress

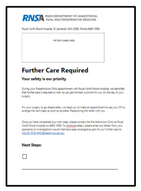
- Space identified, collocated in the Short Stay Surgical Unit
- Existing meeting room identified for PAC telehealth
- Reallocation of PAC nursing and admin FTE to SSSU cost centre and line management to assist in building a skilled pool of perioperative clinicians
- Consumer walk through and feedback on proposed space and flow

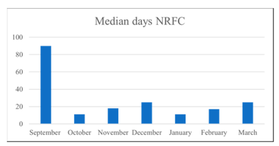
Solution stream three: Not Ready for Care process

Problem statement: Challenges with case coordination and inconsistent documentation of the care plan for patients made Not Ready For Care (NRFC). No one is identified as responsible for coordinating the NRFC clinically unfit patient cohort in the current model of care document.

Progress

- Embedded new workflow
- Digitised process with 100% of documented follow up online
- Reduced average days spent on NRFC waitlist from 90 to 18 days



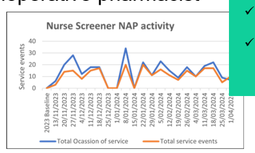


Solution stream four: Governance and PAC performance

Problem statement: No clear governance or current measures on PAC performance/KPIs. NAPing along the preoperative pathway isn't accurate and therefore missed opportunity for revenue generation.

Progress

- PAC governance realigned to the Perioperative Medicine Service
- Agreed suit of KPIs that define what success look like in delivering PAC
- Embedded NAPing process has generated approx.$46,000 in NWAU since being implemented 6 months prior. The project team has proposed that the funding be reinvested back into service to fund perioperative pharmacist



- ✓ Nurse screener NAP process embedded
- ✓ Approximately $46,00 in NWAU generated since implementation in Nov 23

Sustaining change

The project team has provided handover to the Division of Surgery and Anaesthesia (DoSA) regarding each solution stream and the proposed requirements of the solutions ongoing.

The implementation of the perioperative pathway with Personify Care has been handed over to the Clinical Perioperative Coordinator (CPC) and Perioperative Clinical Nurse Consultant (CNC) of the Perioperative Medicine Service (PoMS) to progress. Much of the solution planning now involves clinical review of optimisation pathways, including anaesthetic flags, that are appropriate for decision making by this group. They will be supported by the Service Improvement team.

Solution stream two has been handed over to the Nurse Unit Managers of the SSSU. The brief outlining the relocation is still awaiting signoff by the General Manager.

Solution stream three has been embedded into usual processes and is the ongoing responsibility of the Anaesthetics Fellow. The KPIs for this solution will be fed back into the PoMs Steering Committee for RNSH. This committee will also be responsible for monitoring KPIs from solution stream four, with the committee's membership including DoSA Executive, Anaesthetics and the CPC and PoMs CNC.

Conclusion

Implementation of Personify will benefit the eRFA and Single Digital Patient Record system in the long term. Personify may also be scaled up for other facilities within NSLHD, if established as effective at RNSH. Realigning perioperative services with DoSA governance supports the commitment to proactive management of surgical patients and could be reviewed at other hospitals.

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Contact

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