

Solving problems and making decisions

[Health & Medicine](#), [Hospital](#)



The Health Board was established in 2009 following the integration of the two former NHS Trusts and two Local Authorities'. The Vision was to 'Create Altogether Healthier Communities' by aiming to prevent ill health, protect good health and promote better health' through working with partners to provide services as locally as possible and reducing the need for hospital inpatient care wherever feasible. The acute service at one of the District General Hospital provides assessment of functional need and implements interventions to enable patients to safely leave hospital.

A small team of qualified and unqualified staff covers the 430 beds the District General Hospital. As a senior qualified team member, I am responsible for four busy surgical, neurological and cardiac wards. I am also responsible to the clinical development of junior and unqualified staff members. I review the length of time a referral is waiting to be seen, picking up referrals due to breach waiting targets as agreed by management. I generally hold a larger caseload than other team members and support my team with complex referrals and a high referral turn over. Description of the problem

Referrals to the service are made primarily via ward nursing staff and other members of the multi-disciplinary team. Patient information is entered into a referral book and then non-qualified staff members collect the referral information twice daily. This generates a referral card with basic information relating to the patient's reason for admission and general current health, which is submitted to a referral folder within the department. The qualified staff members use these referral cards to prioritise referrals. Inappropriate referrals to the acute Service are unfortunately a common occurrence.

Patients' are referred for assessment, which becomes a requirement prior to discharge. Any referral requires staff time, which has financial implications. A non-complex referral can take an average of 2 -4 hours to fully assess, complete the required paperwork and implement required recommendations. A complex referral can take a couple of days. An inappropriate referral can cause an unnecessary delayed discharge not only for the patient referred inappropriately, but also for other patients appropriately referred as often they must wait for the qualified to work with the inappropriate referral before they can be seen.

This may result in a hospital bed being blocked; occupied by someone that could have been discharged rather than made to wait for an assessment. The rough average costing of a night's stay in a NHS hospital bed is ? 500. Analysis of the problem Consistent feedback from all therapists within the acute medical team indicated a flaw in the current referral system. Team members highlighted large numbers of referrals that did not meet the criteria for acute medical assessment and similarly large numbers of referrals made at inappropriate times. Following lengthy discussion at a team meeting, it was agreed that the current system was failing.

The demand for assessment and interventions to plan for safe discharge from hospital is high. The indication of knowledge and understanding of the purpose of the assessment and intervention within the context of discharge planning is not so high. This was the consensus after reviewing the numbers of, reasons for and timing of referrals. Generally a referral is made by a qualified nurse sticking a patient information label onto a referral card and

selecting a tick box option to indicate reason for referral. An estimation of the time this would take is 10 minutes.

Based on an annual salary of a newly qualified staff nurse, this would equate to ? 1. 80. An Assistant visits each ward twice daily, collecting the referral cards and completing information from the patient's medical notes including reason for admission, social history and past medical history. This fully completed referral is then placed into the referral folder which is located within the department. This part of the process will take up to 30 minutes per referral dependent on the complexity of the admission and medical history, if the medical notes can be located and if ward staff are to hand to discuss.

Based on an annual salary of an experienced Assistant, this would equate to ? 4. 40. For a referral to be made and information collected will cost approximately ? 6. 20 (in wages.) If a hospital bed costs approximately ? 500 per night, and a patient is not discharged home to await an assessment, an inappropriate referral has then cost ? 506. 20, which is a very large sum if the assessment was not required. An average initial assessment will take an hour, with another hour of paperwork.

If a home visit or functional assessment is indicated, this may take up to three hours. If equipment is required, or referrals to other agencies indicated, this may take another couple of hours. Based on an annual salary of a mid-range senior qualified, the 7 hours would equate to ? 105. To complete a full assessment and implement required interventions, a patient may require a further two nights in hospital i. e. ? 1000. So, in total, ? 6. 20

to complete an appropriate referral, ? 105 to fully assess, ? 1000 to implement interventions equals ? 1111. 20.

Once the problem of the impact inappropriate referrals have on delivering an effective and efficient acute service delivery, a focus group was set up to explore potential solutions. The aim was agreed – prevent unnecessary referrals to improve the effectiveness of the service, reduce delayed discharges and prevent bed blockages. Resolution of the problem Possible solutions were discussed as a team, which included management. Each potential solution was reviewed and realistic outcome potential considered. It was decided to target the referral process, to include the appropriateness and the timing of referrals made.

The aim was to ensure only people in need are referred and done so at an appropriate time. The chosen solutions were to educate referrers, facilitate morning handover a meeting with ward staff and therapists to discuss patients, create and cascade out referral flow-charts and to establish a clear criterion of those to refer and those who do not require assessment or interventions. The team evaluated each solution individually, reviewing the barriers and gains for each option and noted what would be required to implement each solution.

Focus groups were recognised at the most cost-effective tool to progress solutions and a referral flow chart and appropriate/inappropriate referral criteria established. This was approved by the head and approved to role out onto the wards. There was of course resource implications, including clinical time spent away from assessments educating referrers. This reduced the scope for patients to be assessed by therapists. Similarly, Assistants spent

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the time they would usually collect referral information printing and laminating referral pathways/criteria and delivery them the wards.

The most costly resource expenditure was a senior qualified attending a daily bed managers meeting, where delayed discharges could be highlighted and bed pressures discussed. Attendance to such meetings enabled our purpose and profile to be raised and the cost implications of frequent inappropriate referrals could be flagged. Other potential solutions were considered but not implemented primarily due to cost implications. For example, a triage system where a qualified would take all the referrals, attend relevant wards and review each referral on a 1: 1 basis to establish it's priority and appropriateness.

This was deemed cost ineffective. Another potential solution was to create a referral duty desk and all referrals would need to be telephoned through during a set three hour time period. Though this would ensure all required information would be gathered, and priority/appropriateness could be established with the referrer straight away, it was not implemented. The department was unable to offer more than one therapist to operate the telephone for the entire hospital. Ward staff feedback was they were unable to commit to having time to make and discuss referrals within the duty desk operating hours.

Similarly, it was agreed within the team that 3 hours a day out of clinical practice would be too cost effective and detrimental to managing the busy waiting list. The aim was agreed – prevent unnecessary referrals to improve the effectiveness of the service, reduce delayed discharges and prevent bed blockages. The solution was also agreed – a multi faceted approach to <https://assignbuster.com/solving-problems-and-making-decisions/>

include establishing a referral pathway, referral criteria, establishing a morning ward handover, education for referrals and therapy attendance at bed managers meeting.

Implementation and communication of the solution Action plan: Solutions identified and agreed. Action plan of how to, when to and who to lead on implementing each aspect of the solutions created. Referral pathway – myself to lead, completion within 2 week time frame for approval by service head. Once approved copies to be printed and laminated. Laminated pathways to be displayed on each ward, in nurse station area, in referral folders and in ward managers' office. Referral criteria – focus group, completion within 2 week time frame for approval by service head.

Criteria to be printed, laminated and to be displayed on each ward, in nurse station area, in referral folders and in ward managers' office. Establishing a morning ward handover – ward allocated to lead, completion within two week time frame Education for referrers – myself to lead. PowerPoint presentation to be created within two week time frame for approval by service head. Education sessions to be arranged within two weeks following head approval. Attendance at bed managers meeting – senior to attend for immediate effect. Communication –

Email sent to all ward managers and bed managers to inform them of referral Pilot. Information session offered for drop-in attendance for staff to openly discuss concerns and desired aim of planned changes. Meeting with Ward managers to explain full scope of Service, importance and impact of inappropriate referrals Feedback emails encouraged regarding referrers experiences of how the service altered if at all following the changes.

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Positive improvement monitoring – No official audit was completed during or immediately following the pilot. Conclusion

The problem highlighted was the impact of inappropriate referrals and inappropriately timed referrals on Service delivery in acute patient care. Solutions were identified and implemented over time. Although no formal audit was identified or carried out during this period to formalise outcomes and findings, staff feedback from all disciplines summarised positive change. The number of delayed discharges reduced, the amount of time spent with appropriate referrals increased and general team morale improved. Overall, the action plan to resolve the problem was successful.

Ward staff approached therapy staff to discuss referrals, rather than simply making a referral without thought for appropriateness. The implementation of morning handover with nursing and therapy staff created time on a daily basis for such discussion, including addressing if a patient was ready to engage in assessment. No adjustment was made to the referral flowchart following its implementation. However, natural adjustments occurred with multi-disciplinary discussions on a daily basis. On reflection, methods evidence collection such as audit should have been carried out in order to formalise the effect of the change implemented.