



How Best Practices Transform Patient Discharge

A LITTLE ART & A LOT OF SCIENCE





*ONE OF THE BIGGEST CHALLENGES FACING
BUSY HOSPITALS TODAY IS FINDING
EFFECTIVE WAYS TO MANAGE CAPACITY
AND IMPROVE THROUGHPUT IN ORDER
TO CARE FOR MORE PATIENTS. HAVING
EFFICIENT PATIENT DISCHARGE PROCESSES
IS ONE WAY TO ACHIEVE SUCCESS.*

So often however, hospitals interpret discharge as getting the greatest number of patients out, as early as possible. Patient flow projects focused on “out by 11am” and “home by noon” continue to be very popular. However, the science of queuing theory and the utilization curve provides a new perspective on this concept.

Think about when you’re at Starbucks—the longer the line, the longer it takes to get your Americano. That’s the utilization curve. So, if hospital census is high, it’s going to take longer to assign beds to patients who are waiting. When a hospital is at 95% or greater capacity, extended wait times in the ED and in the PACU are a certainty. The typical response to freeing up capacity is to discharge as many patients as possible, as early as possible. If all of the efforts are focused on early discharges, clinical staff are torn between assessing and caring for new patients admitted overnight, providing ongoing morning care, dispensing medication, and dealing with the added stress of a high number of discharges. Patient Transport and Environmental Services are also impacted because they are stretched with the high number of patients that need to be transported and the number of rooms that need to be cleaned. Despite this effort, most hospitals are still not successful in discharging more than 10% of their patients by 11am. Additionally, there is evidence that suggests that with all this activity at high occupancy, corners may be cut and mistakes can be made. This is where the utilization curve also holds the key to solving this problem and providing staff with a more achievable and safer goal.

We know that wait times grow exponentially once capacity moves beyond 85%, while at the same time, small increases

in capacity (via discharges) can result in large reductions in waits and delays. This means that during the times when utilization is near capacity in a hospital, planning for the timely transitioning of a few appropriate patients can increase available capacity and have a substantial effect on delays. Rather than discharging as many patients as possible early, focus on a few appropriate patients—a goal of 25% is the standard. On a typical 30-bed med-surg unit, with an average of eight discharges per day, that would only be two discharges by 11am. For some hospitals, even two discharges by 11am may be nearly impossible. That’s where TeleTracking’s best practices serve as an excellent guide—and when successfully implemented, can make this goal achievable. Once capacity is created by way of early discharges, additional best practices should be in place to expedite room cleanings. Accuracy and success in achieving at least two discharges by 11am each day is dependent upon the use of a TeleTracking best practice known as the 24-Hour Discharge Cycle. With this best practice, there are four steps to ensuring greater accuracy in predictions.

01.

Conduct a daily discharge huddle with multidisciplinary rounds and an interdisciplinary team to identify likely discharges for the following day. This session should be held mid-morning, making it possible to finalize that day’s discharges and identify the next day’s with their contingent needs. At that time, the team should choose at least two patients that they feel have the likelihood of being ready for discharge by 11am. Pending discharges and their contingent needs should be entered in to TeleTracking during, or shortly after this meeting.

02.

During the mid-afternoon, the case manager and charge nurse should review the day’s remaining discharges and the pending list for the next day. (Using the list in the pending and confirmed tab in PatientTracking Portal is very helpful for this.) The pending discharges for the next day can be updated (add new patients or delete those no longer likely to be discharged). Specifically, the early discharges should be clearly identified.

03.

The handover from the daylight charge nurse to the night charge nurse at 7pm should include a second review of the pending discharge list. Identify those tasks the evening and night shift can complete to assist with discharge the next day. Emphasis is placed on the tasks needed for the patients identified as early discharges.

04.

The final review occurs at 7am, when the night charge nurse hands things off to the daylight charge nurse. This review should include any remaining tasks for the day's discharges, especially those anticipated to be ready to leave by 11am.

There are two methods that can ensure real-time notification of a vacated bed. The first is to have a transporter take the patient to a discharge location. When the transporter updates the job to "in progress," EVS is automatically notified of the dirty bed. The second is using Real-Time-Locating System (RTLS) technology to badge patients upon admission/remove the badge at discharge

thus triggering those same actions. When neither of these methods is used, staff rely on nursing or a unit secretary to indicate that the bed is dirty by removing the patient from the ADT system. This can contribute to something we call "batching"—when a bolus of work enters the system in a relatively short period of time. This batching makes a timely response to dirty beds very difficult for EVS staff. For this reason, it is very important that EVS leadership analyze the pattern of dirty beds by hour of day, with their staffing model by hour of day. The traditional staffing model with the greatest number of staff on a traditional 7am-3pm shift will not support the increasing number of dirty beds beginning at 11am and continuing throughout the afternoon. By staffing to demand, modifications in shifts that allow for staggered starts means a "discharge SWAT team" can be accomplished.

The use of the best practice tools described above can assist hospitals in ensuring the timely and safe discharge of patients, and give EVS staff the greatest chance to respond to these dirty beds in a timely manner. Both steps go a long way in helping TeleTracking achieve its mission—"to ensure that no one will ever have to wait for the care they need."



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Deb Kaczynski serves as a Managing Consultant with TeleTracking's Advisory Services team. In her role, she supports organizations by influencing how they adopt technology through change management and process redesign. Ms. Kaczynski joined TeleTracking after more than 20 years with the University of Pittsburgh Medical Center (UPMC), where her work focused on hospital operations and administration. Her passion and energy for improving patient flow in the acute care setting began over fifteen years ago within the UPMC system. Experience with Toyota Production System methods, certification as a Six Sigma Black Belt, and engagement with the Institute for Healthcare Improvement have all supported her previous process improvement work with the UPMC system.



KEEP

IN MIND

- 01.** Creating capacity by discharging patients is the first step in improving throughput.
- 02.** Getting the bed cleaned and ready for the next admission is equally important.
- 03.** Real time notification of dirty beds is essential so that EVS staff can respond quickly.

- 04.** Even with the use of RTLS, transport and staggered start times, there will be times when the workload exceeds the ability of staff to respond to the dirty beds.
- 05.** It is very important that all EVS supervisors have escalations turned on for their pagers/phones that will alert them when dirty beds are not being responded to in a timely fashion.
- 06.** They are then able to provide additional support to ensure that beds are made available to patients awaiting an inpatient bed.