REDUCING DELAYS TO DISCHARGING PATIENTS FROM THE ACUTE MEDICAL UNIT

**THE PROBLEM:**

On the acute medical unit (AMU) there is often a significant delay between a patient being identified for discharge on the ward round to actual discharge from the unit. Discharge delays cause an upstream tidal wave of patient flow constraints which negatively impacts patient satisfaction, safety, hospital capacity and financial performance¹.

**THE OBJECTIVE:**

Identify the cause of delays to discharging patients from the acute medical unit and develop interventions to minimise such delays.

**THE BACKGROUND:**

- **CURRENT DISCHARGE PROCESS**
  - Number of doctors
  - Number of patients
  - Severity of doctors
- **POTENTIAL CAUSES OF DELAY**
  - Competing clinical priorities
  - Adequate information for GP letter
  - Number of medications
  - Prior medicines reconciliation
  - Complexity discharge letter
- **ALTERNATIVE PATHWAY TO DISCHARGED**
  - Staff availability to transport TTO
  - Medications immediately available on ward as soon as doctor prescribes TTO, therefore reducing subsequent delays.
  - Medications dispensed in advance by pharmacy.
  - Doctor reviews drug chart and ticks medication to be continued
  - Nurse availability to discharge

**THE RESULTS:**

- **GRAPH A:**
  - Average time of discharge from AMU is late in the day (mean discharge 18:03) (A)
  - Peak time of discharge from AMU (18:00-20:00) (A) is later than peak time of referrals from A&E (16:00-18:00)
  - Significant time between ward round and actual discharge (mean 06:45). Earlier ward round linked to earlier discharge (B)
  - Time between patient fit for discharge and actual discharge is major source of delay (mean 4:10) (C)
  - Patients seen earlier and fit for discharge earlier in the day wait longer for TTO prescription and discharge when compared to patients seen later in the day (B/C/D).
  - The major delay from fit for discharge to TTO completed by pharmacy is the prescription of TTO by doctor (mean 02:05) (D)
  - Higher numbers of junior doctors are associated with earlier ward round, earlier TTO and combination with GP letter making the process too time-consuming for completion on the ward round.

**THE PROPOSED BENEFIT**

- Doctor time previously spent doing TTOs available for other clinical duties.
- Avoid duplication of work by doctor/pharmacist, Short form could be completed on ward round allowing TTO to be processed much earlier in the day, hence reducing delays.
- Promote good practice and incentive to doctors to keep drug charts up to date to enable pharmacist to prescribe TTO. More likely prescribing doctor will still be on duty for pharmacist to discuss discrepancies, if TTO processed earlier in the day.

**THE PROGRESS & PROBLEMS**

- Met with relevant stakeholders to present findings
- Problems encountered with intervention design:
  1) Trust committed to not separating TTO and GP letter to ensure timely GP letter
  2) Requires prescribing pharmacist – only one in trust
- Currently working with AMU pharmacist to implement modified intervention on AMU called ‘one-stop’
- Doctor reviews drug chart and ticks medications to be continued on discharge.
- Medications dispensed in advance by pharmacy.
- Medications immediately available on ward as soon as doctor prescribes TTO, therefore reducing subsequent delays.

**THE INTERVENTION DESIGN:**

- **GRAPH C:**
  - Delay in doctors prescribing TTO, particularly earlier in day is major delay to discharge.
  - This is commonly due to doctors giving priority to completion ward round/other clinical duties and length of TTO and combination with GP letter making the process too time-consuming for completion on the ward round.
  - We wanted to design an intervention to theoretically separate the TTO and GP letter and reduce time taken to do a TTO prescription to facilitate TTO prescription earlier in the day e.g. on the ward round.
  - This would mean medications already prepared once patient fit for discharge and GP letter completed allowing a timely discharge rather than further long wait for medications.

**THE FUTURE:**

- Re-audit once ‘one-stop’ intervention fully implemented
- Pursue other potential quality improvement interventions we identified e.g. electronic medicines reconciliation, morning MDT board round, specialty in-reach, physicans assistants.

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¹ Sawyer, Ben (2010). Effective Discharge Begins at Admission. [online]. Last accessed on 11 April 2013 at www.patientplacement.com