



IMPROVING TRANSITIONS OF CARE FROM THE INTENSIVE CARE AND HIGH DEPENDENCY UNIT TO THE WARD SETTING



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THE ISSUE

Patients in the Intensive Care / High Dependency Unit (ICU/ HDU) are, by definition, some of the sickest patients in the hospital. There is a gap between the high-technology, high staff ratio of ICU/HDU and the ward environment. Transition of these patients to the ward is a high risk process which potentially exposes our vulnerable patients to preventable adverse events.

THE AIM

To improve transitions of care for our most at-risk ICU/HDU patients.

WHERE DID WE START?

Literature review – ascertain best evidence based practice

A safe transition involves co-ordination, optimal timing, participation and a MDT approach

Survey of ICU/HDU nursing staff to ascertain current discharge practices

Revealed variable discharge practices

Survey of other ICU/HDU's around New Zealand to compare discharge practices

All other units had a more structured process for discharging 'long-term' ICU/HDU patients

Survey of ward staff to gain insight into their experience of taking over patients from ICU/HDU

Handover issues, timing of transitions not ideal

Gained feedback on discharge experience from small group of patients and family members

“Leaving ICU/HDU was ‘frightening’”

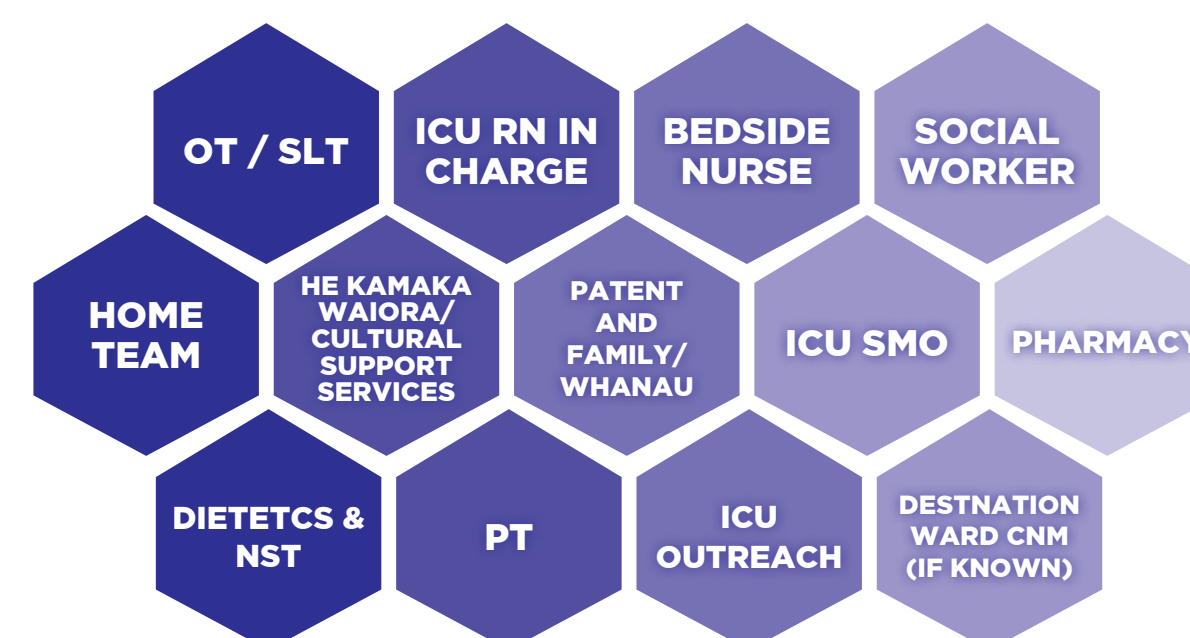
WHAT WE DID

DEFINING THE MOST VULNERABLE ICU/HDU PATIENT

WDHB ICU/HDU criteria for a long-term ICU/HDU patient:

72 hours ventilated or any patient with ICU/HDU length of stay (or expected LOS) of 7 days or more.

WEEKLY MULTI DISCIPLINARY TEAM MEETINGS



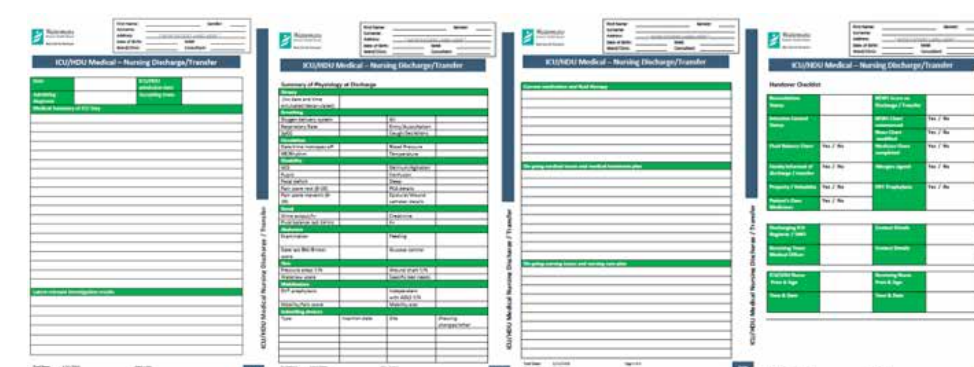
Implemented 1st September 2014

PRE-DISCHARGE VISITS BY CRITICAL CARE OUTREACH TEAM

- All patients meeting 'at-risk' criteria visited prior to discharge
- Introduce CCOT follow-up service
- Provide information and reassurance about ward transfer
- Answer questions about ward environment
- Emphasise progress made
- Discuss ongoing care requirements with bedside nurse



COMBINED NURSING & MEDICAL DISCHARGE DOCUMENT



OUTCOMES

PATIENT OUTCOMES

- Yet to be assessed
- No patient adverse events reported since practice change

STAFF OUTCOMES

- Greater awareness and ownership of discharge process
- Improved communication and collaboration
- Greater ability to provide holistic care during transition period

“MDT communication and planning has greatly improved”
– Physiotherapist

“The ICU SMO team feel a greater sense of ownership over the discharge process since implementation of the MDT meetings”
– ICU SMO

“I really welcome the opportunity to be involved in planning transitions of care for patients coming to my area”
– Ward CNM

PROCESS OUTCOMES

- Consistent identification of long-term / vulnerable patients
- All those identified receive MDT meetings and CCOT Pre-discharge visits
- Increased MDT referrals and collaboration
- Increased utilization of 'going to the ward' patient/family information leaflet
- Improved handover process

“Handovers from ICU/HDU are very thorough”
– ward staff nurse

KEY PERFORMANCE INDICATORS

- Readmission Rate
- Delayed Discharge
- Out-of-hours Discharges
- Measured monthly - no adverse effects noted since practice change, however it is too soon to draw a conclusion on improvements

SUMMARY

Feedback from staff on our new process for improving transitions of care from ICU/HDU to the ward setting has been overwhelmingly positive, with all stakeholders agreeing that this is making a positive difference to our most at-risk patients.

FUTURE WORK

- Obtain patient feedback of their experience of transition
- Monitor and evaluate KPI data
- Continue implemented changes