



DIVISION OF MEDICINE, CANBERRA HEALTH SERVICES

Mon 19 December 2022 to Friday 13 January 2023

CASE FOR CHANGE:
ACUTE MEDICAL UNIT
EXPANSION
AND
INPATIENT BED BASE
REALIGNMENT

ACKNOWLEDGEMENT OF COUNTRY

We begin today by acknowledging the Ngunnawal people, Traditional Custodians of the land on which we meet today, and pay my respects to their Elders past and emerging.

We extend that respect to Aboriginal and Torres Strait Islander peoples here with us today, and thank them for their on-going custodianship of these lands.

AGENDA

Background

Introduction

Context

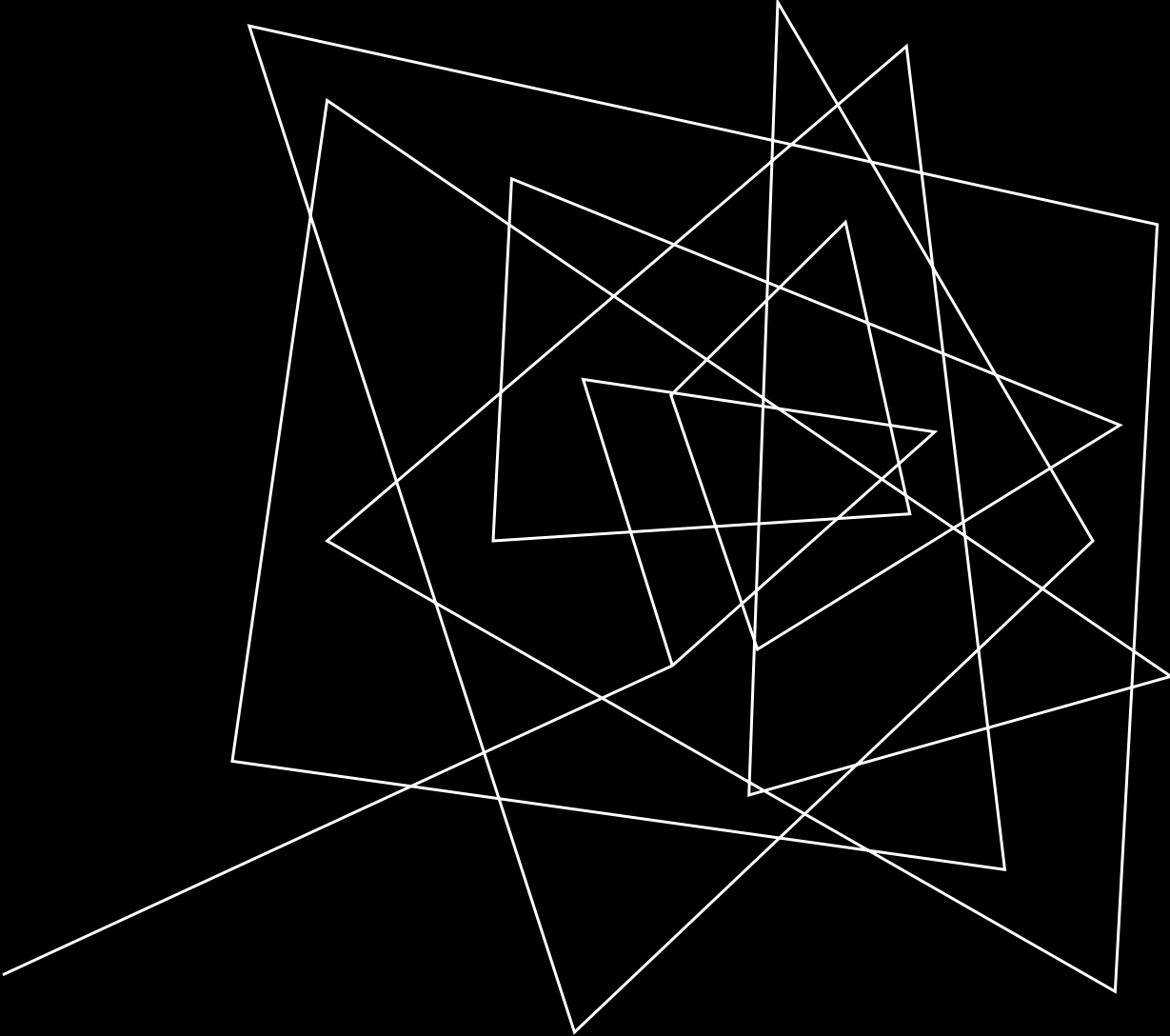
Benefit realisation

Current & Proposed Footprint

Timelines

Summary

Questions



UP FRONT:

- There are no proposed reductions to any permanent staff member or group as a result of this inpatient bed base realignment.
- There will be some new positions created to open the Acute Medical Unit to 24 beds

OUT-OF-SCOPE:

- Non inpatient areas including renal dialysis, sexual health, forensic medicine
- Outpatients
- Ambulatory care
- Emergency Department

BACKGROUND

- Each health service in each jurisdiction would normally undertake an annual (or 6 monthly) review of their bed base to ensure that the footprint matches the historical, future and planned case mix and volume to ensure it is fit for purpose for both emergency and planned/elective activities. This may also include any new activity or activity 'drives' to focus on growing waitlists.
- Canberra Health Service also needs to consider modern approaches to deliver patient activities including 'In the Home' services (HITH, GITH, RITH, CITH etc), virtual health services, non-admitted models of care as well as admission avoidance or outreach community models – preserving the bed base for those acute and tertiary patients with greatest needs; and creating the care level (right place, right time) required for the patient acuity.

INTRODUCTION

At Canberra Health Services, we are aware that our Relative Stay Index (RSI) for most medical specialties is above the National average. This is expressed operationally as long length of stay (LLOS) where we see higher volumes of patients >7, >14 and >21days. From the evidence, we know patients who have an elongated length of stay are more likely to have a hospital acquired variation to their care - for example falls, thromboembolism, deconditioning, errors or incidents.

High RSI or LLOS leads to patients being on other wards (not of the home treating team), safari ward rounds, and importantly reduces the speed by which patients in the Emergency Department can get to a ward bed. This in turn keeps the ED highly occupied and reduces access to those patient who awaiting emergency assessment from the community.

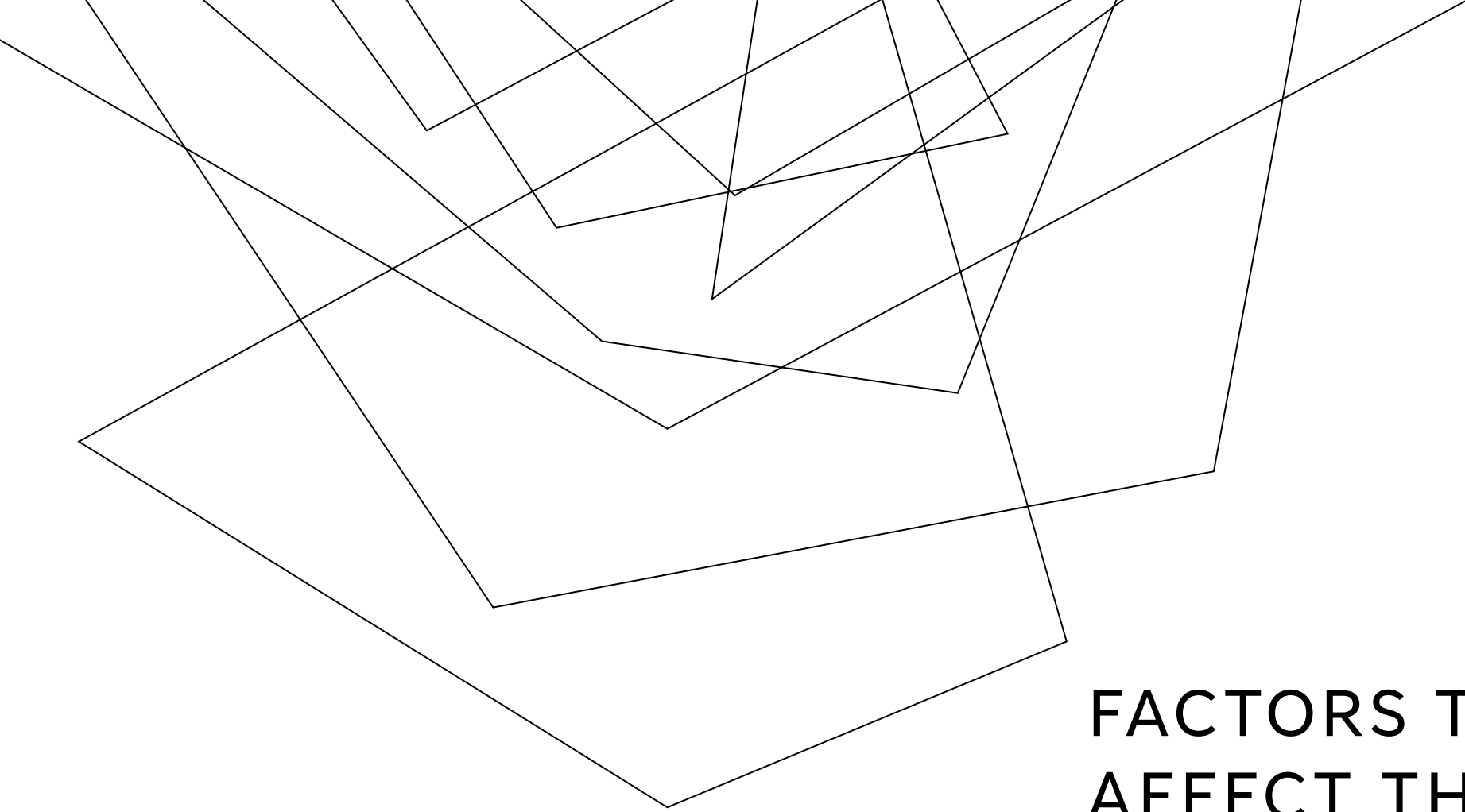
A review was undertaken by Ernst and Young (with Dr Frank Daly) to confirm the data, and to make recommendations. Those recommendations included the implementation of an Acute Medical Unit to front-load care in the first 48hours of admission to lower length of stay and assist in moving patients from the Emergency Department.

This case for change is about implementing that model of care at scale to the 24beds that was proposed (from the current 12 bed pilot model as the set-up bed platform based on the space that was available).

'Patient time is the most valuable currency in healthcare.'

Let's make every minute count'

(Prof Brian Dolan, OBE)



**FACTORS THAT
AFFECT THE BED
FOOTPRINT**

CONTEXT (1): THE CURRENT DoM BED BASE IS INEFFICIENT

THIS IS WHAT THE ACUTE MEDICAL UNIT MODEL OF CARE IS AIMING TO RESOLVE

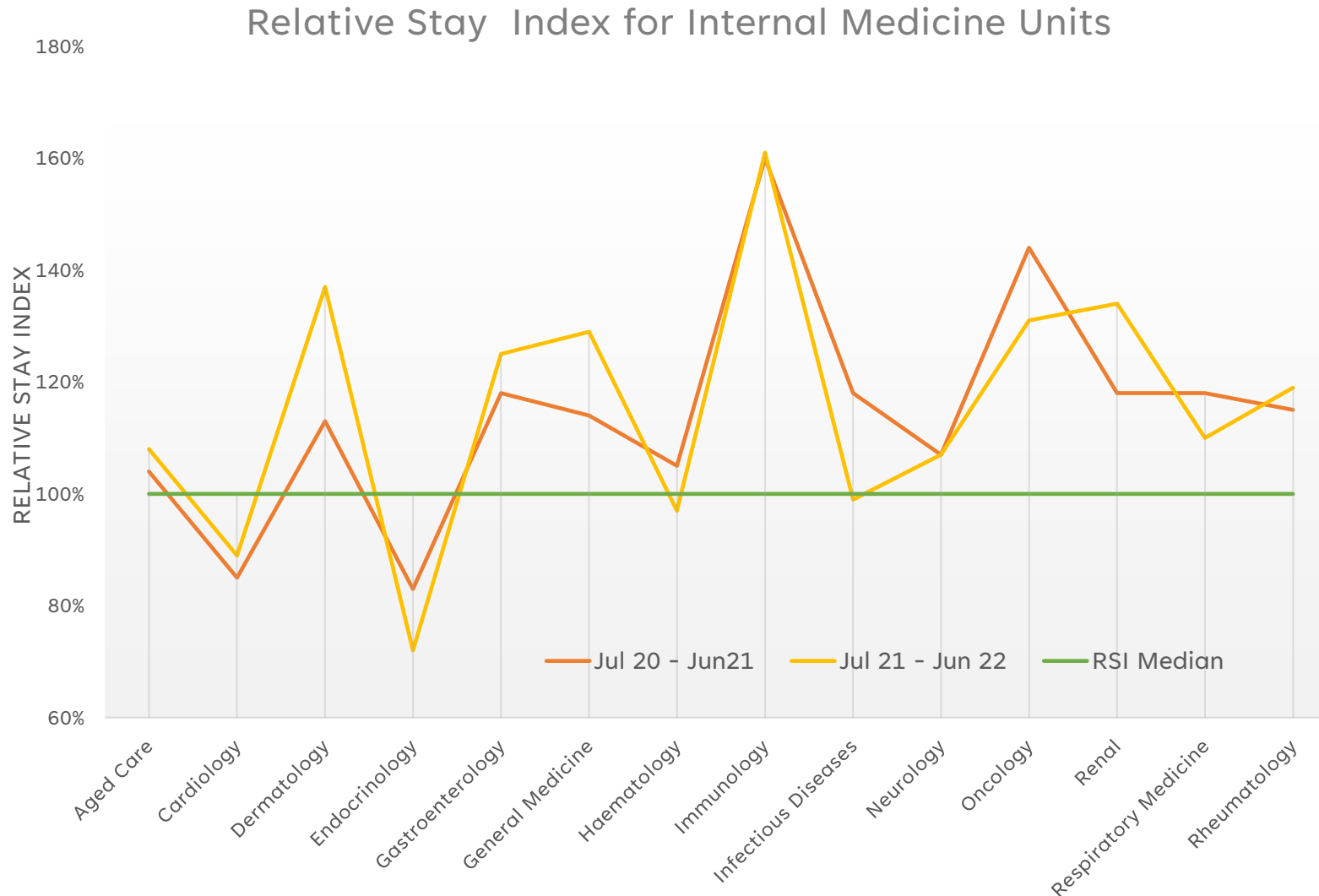
Bed No	CCU (19)	4B (20)	6A (32)	7A (32)	7B (32)	9A (24)	T (16)		
1									
2	CCU 15	RENAL	Resp	STROKE	GEN MED	GASTRO	AMU		
3	CPEU 4	12	Card	4	26	24	12		
4			Rheum				(SURGE BEDS)		
5			Endo						
6									
7									
8									
9									
10									
11				Neuro					
12				ID					
13				Derm					
14				28					
15									
16		ACDL							
17		8							
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29					SURGE				
30					(OPEN 24/7)				
31									
32									
	19	12	32	32	32	24	12	TOTAL	163
									plus 8 D/C

CHALLENGES

- Discharge area often used for inpatient care so does not assist with patient flow best practice
- Whilst we only have 6 'surge' beds open at the moment, this has been higher, and we do not open/close in line with their short-term capacity creation function. This in turn does not help patient flow best practice.
- High Relative Stay Index (or long length of stay) results in high volumes of patients for some teams, but also leads to safari ward rounds and patients not being on home wards where we know care is optimised by the home MDT
- The AMU is open to 50% of the beds it requires which is not at a scale to fully benefit from the model; and the funding source is the current patient activity (these are not new or more patients) so has to be absorbed into the existing funded bed footprint where possible
- The current bed allocation footprint does not match the current case mix, and does not take into account benchmark length of stay for those patients
- The total of 163 is above the funded footprint for DoM (145) – and also **does not** include our outliers who are in other divisional beds.

CONTEXT (2): RELATIVE STAY INDEX DATA (LONG LENGTH OF STAY)

THIS IS WHAT THE ACUTE MEDICAL UNIT MODEL OF CARE IS AIMING TO RESOLVE



- 69% of medical patients have higher length of stay when compared to other jurisdictions
- This is then expressed as high outliers in other medical and surgical wards and surge beds open / being used constantly (safari ward rounds)
- This requires additional bed and staffing resources which come at a cost to the organisation
- The launch of the AMU is not specifically funded at this time and needs to be absorbed into the funded footprint
- DoM budget (as at December 2022) is \$3.2m in deficit

CONTEXT (3): OTHER INITIATIVES ARE BEING PUT INTO PLACE

TO SUPPORT IMPROVED PATIENT FLOW AND TO LOWER THE LONG LENGTH OF STAY/RSI

Goal	Actions
<p>1. Improve daily flow by increasing pre-10am and pre-12md discharge and overall discharge numbers to match demand.</p>	<ul style="list-style-type: none"> • Set ward discharge targets and times by day of week (eg 1 before 10am, 2 before 12md) • Patient flow is everyone's responsibility and 24hrs a day • Consider patient groups suitable for criteria led discharge as the main discharge tool • Confirm day of discharge on admission or within 48hrs • Confirm all discharge plans are in place the day before discharge • Ensure clinical MDTs are not taken off the floor in the mornings (eg for meetings, teaching etc) to allow them to focus on patient rounding, discharges and care coordination • Improve HITH transfers/utilisation and earlier in the patients journey if possible • Access to urgent virtual care options for follow up • A centralised model of complex care coordination and discharge/transfer (and CHS Coordination Hub) to be introduced and supported by DoM
<p>2. Improve bed turnover and reduce clinical variation by reducing Relative Stay Index and long length of stay.</p>	<ul style="list-style-type: none"> • Benchmark DRG groups with peers and consider quality improvements such as care pathways or guidelines • 7 day ward rounding which is early in the day (pre-10am) and which has MDT attendance • Establish the peer LOS for the DRG group and use that as the expected day of discharge to assist in synchronising care • Ensure a 'waiting for what' task list is developed to reduce any delays and escalate where delays need more assistance to enact positive outcomes • Review >7, >14 and >21days LLOS stranded patients for problem-solving • Establish modernised ways of working in preparation for transition into the new Critical Services Building (CSB)
<p>3. Improve demand management systems and processes</p>	<ul style="list-style-type: none"> • Establish daily (7 days) ward admission averages and discharge targets • Ensure ED/AMU/ICU to inpatient bed allocation and transfer is <30mins • Predict and report 3 days ahead what the demand and capacity will be so that early notification and problem-solving of mismatches are better managed • Implement an approval process for the opening and closing of surge beds • Each ward and DOM to consider the 7 patient flow systems and how it relates to their area/role – and how it may improve the patient experience • Improve visibility of data, actions and projects for improvement at DOM Governance Committee • Undertake a patient flow systems assessment to inform future improvement opportunities using the NSW Health tool. • Adopt the best practice principles of UTAS/NSWH training resource Deliverable 1-Final 20121022 (nsw.gov.au)

BENEFIT REALISATION

PATIENTS

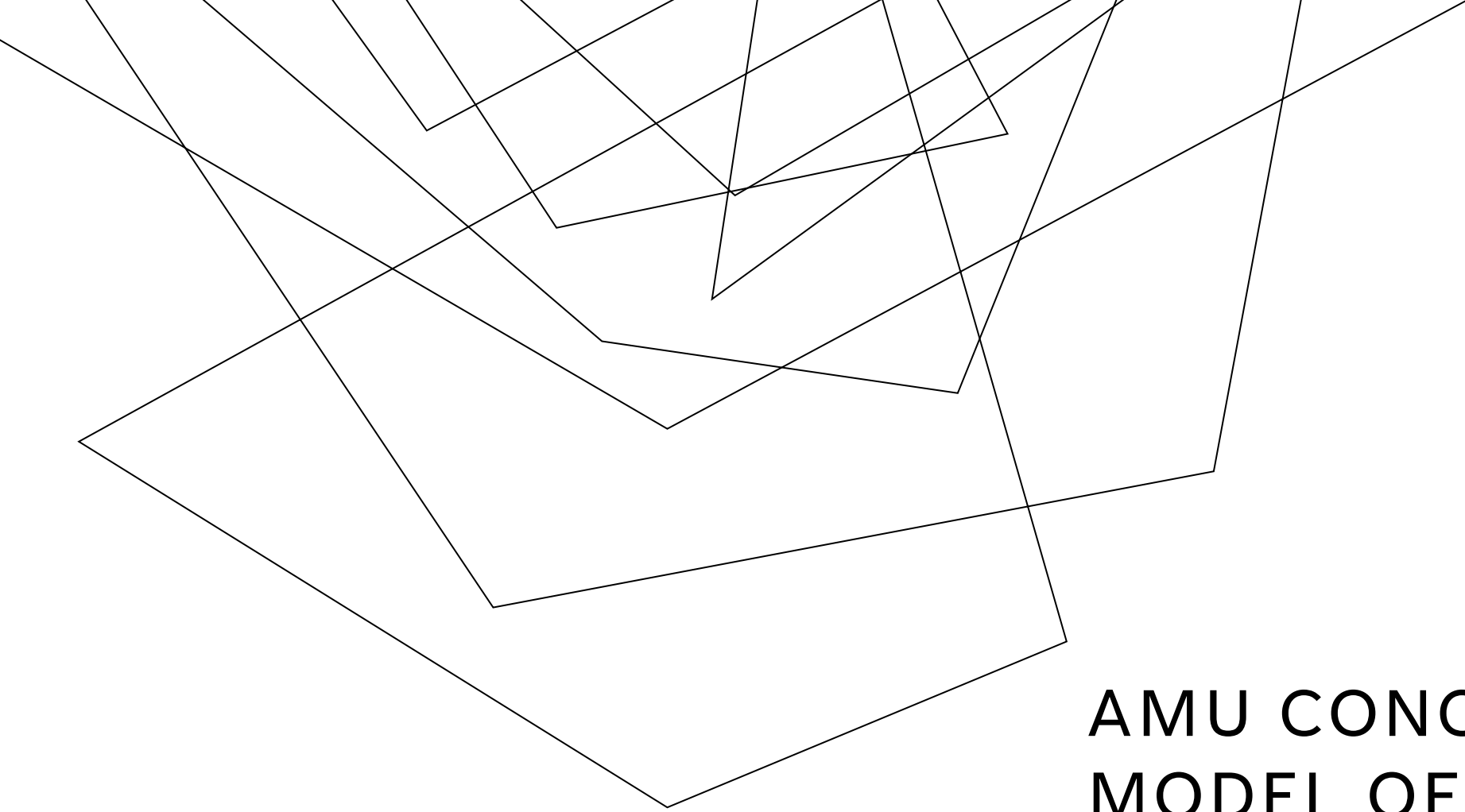
- Improved access to services
- Quicker journey through the Emergency Department
- Right ward, first time and most of the time
- Lower length of stay and less deconditioning / untoward variations
- Improved satisfaction

WORKFORCE

- Improved care pathways and care excellence with a modernised approach
- Improved patient flow and discharge planning
- Reduced outliers so reduced safari ward rounds, freeing up time to care
- Evidence-based approach to bed footprint which can be replicated in 6 or 12 months time to match case mix
- No loss of FTE, although some staff will be offered a choice in location of work
- Improved satisfaction

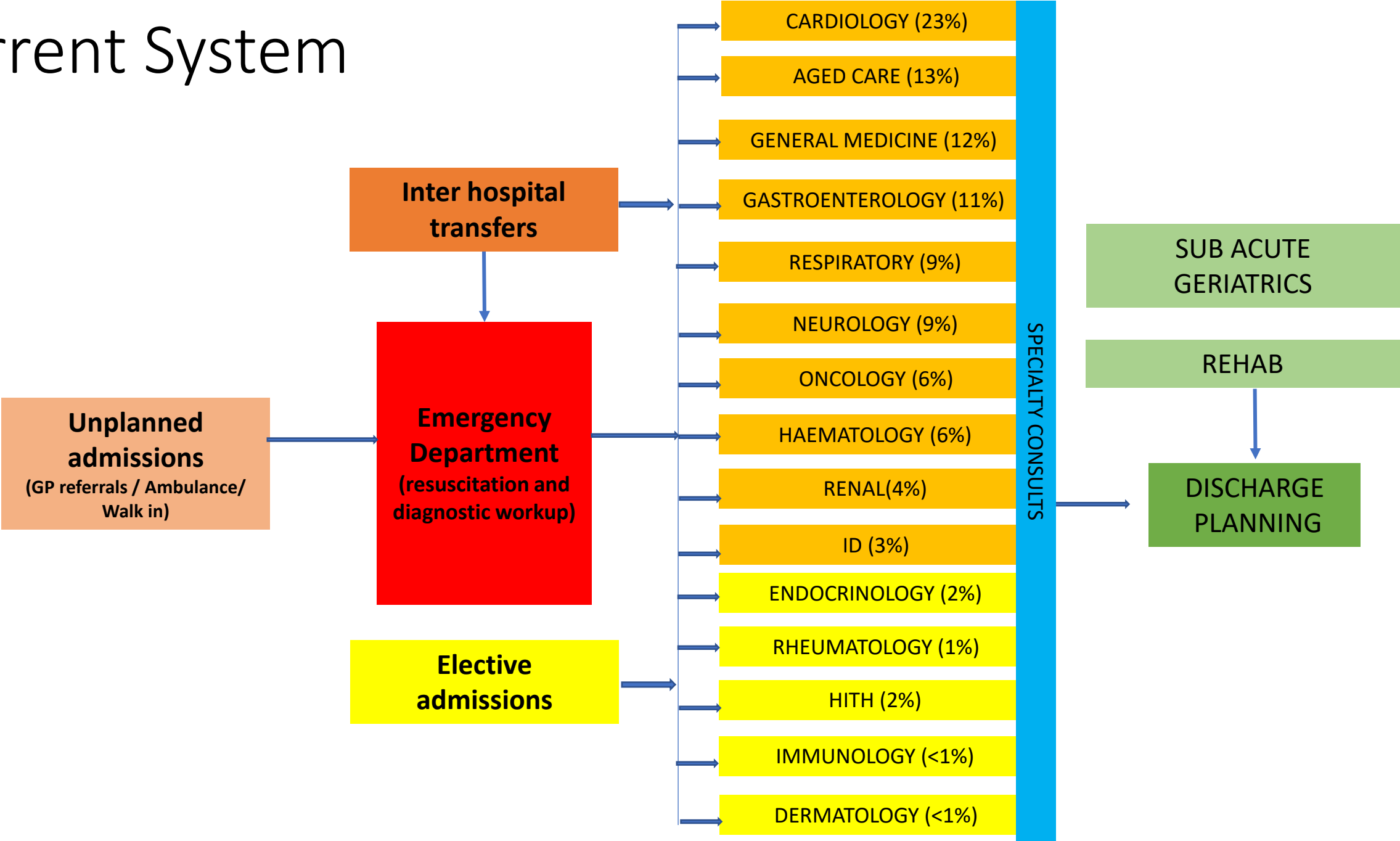
CLINICAL SERVICES

- Reduced surge beds and therefore reduced additional bed and workforce costs making us more efficient
- Improved resource effectiveness and acute bed utilisation demonstrating confidence back to the public for wisely spending the tax dollar
- Allows improved and positive benchmarking with other jurisdictions thereby making Canberra Health Services a great place to work
- Reduced Hospital Acquired Complications (HACs)

An abstract graphic consisting of several thin, black, overlapping lines that form various geometric shapes and polygons, primarily located in the upper left and center of the page.

**AMU CONCEPT,
MODEL OF CARE
AND EXPANSION**

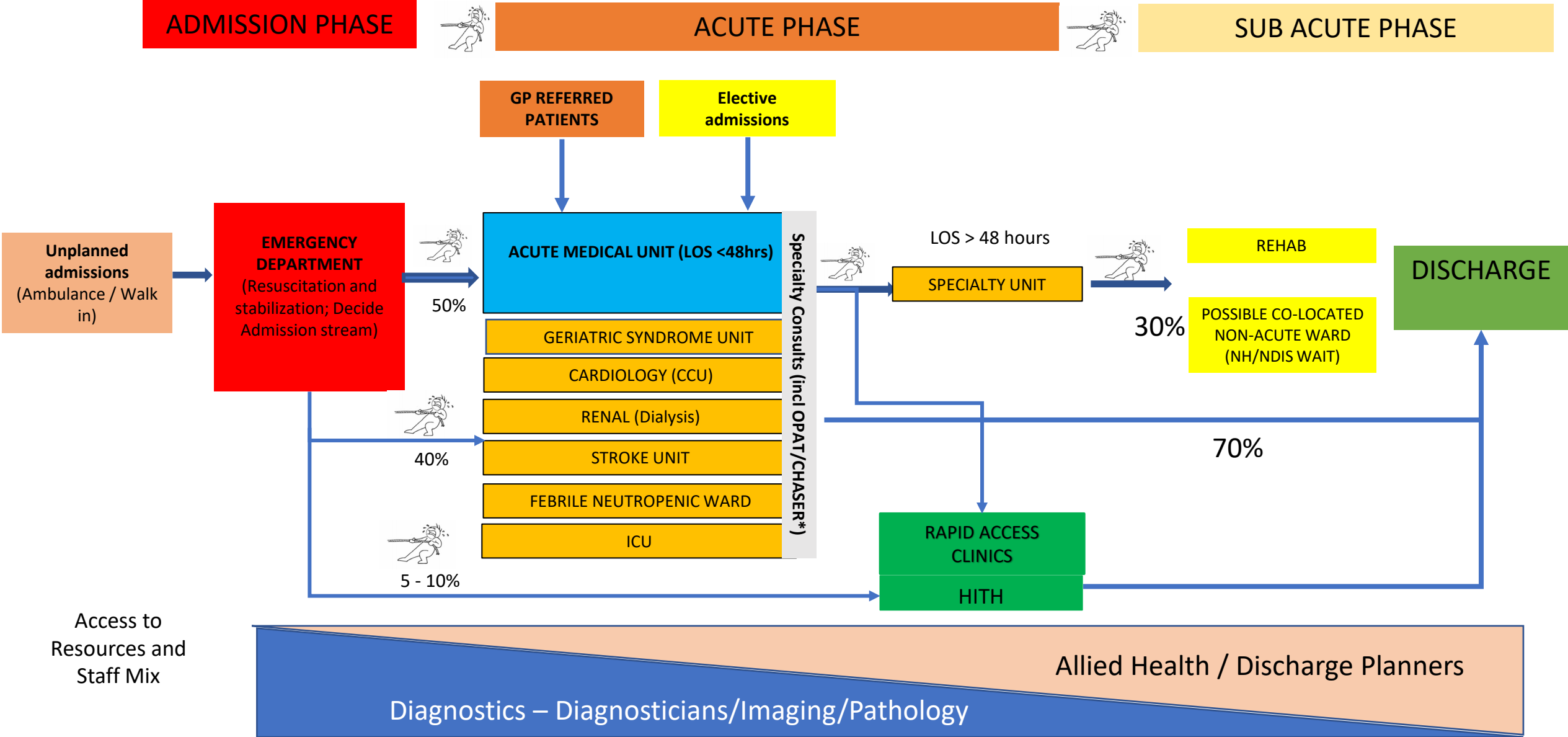
Current System



Attributes of an Effective, Efficient IP System

ATTRIBUTE	CURRENT STATE
Care pathways for common conditions	Few
Phases of care that are well defined (form and function)	No
Appropriate staff mix for phase of care	Variable
Differential access to investigations / interventions by phase of care	No
Bed-base alignment with inpatient activity	No
Flexibility and redundancy in the system to cope with variable activity	No
Staff working to their scope of practice	Limited
Trust in the Assessments of others in the Journey	Variable
Patient-centred & coordinated pathway (patient's time is valued)	Variable
Staff working under reasonable conditions / hours (i.e. minimize unrostered overtime, well supervised)	Variable

Expanding and refining the model



Acute Medical Unit

48 hours maximum stay (or 2 nights)

Admission criteria

- Pts with conditions amenable to pathways where hospital LOS can be maintained <48 hours
- Undifferentiated or multi-morbid conditions needing intensive workup from a multidisciplinary team

Senior medical staff oversight 7 days per week, onsite including the evening

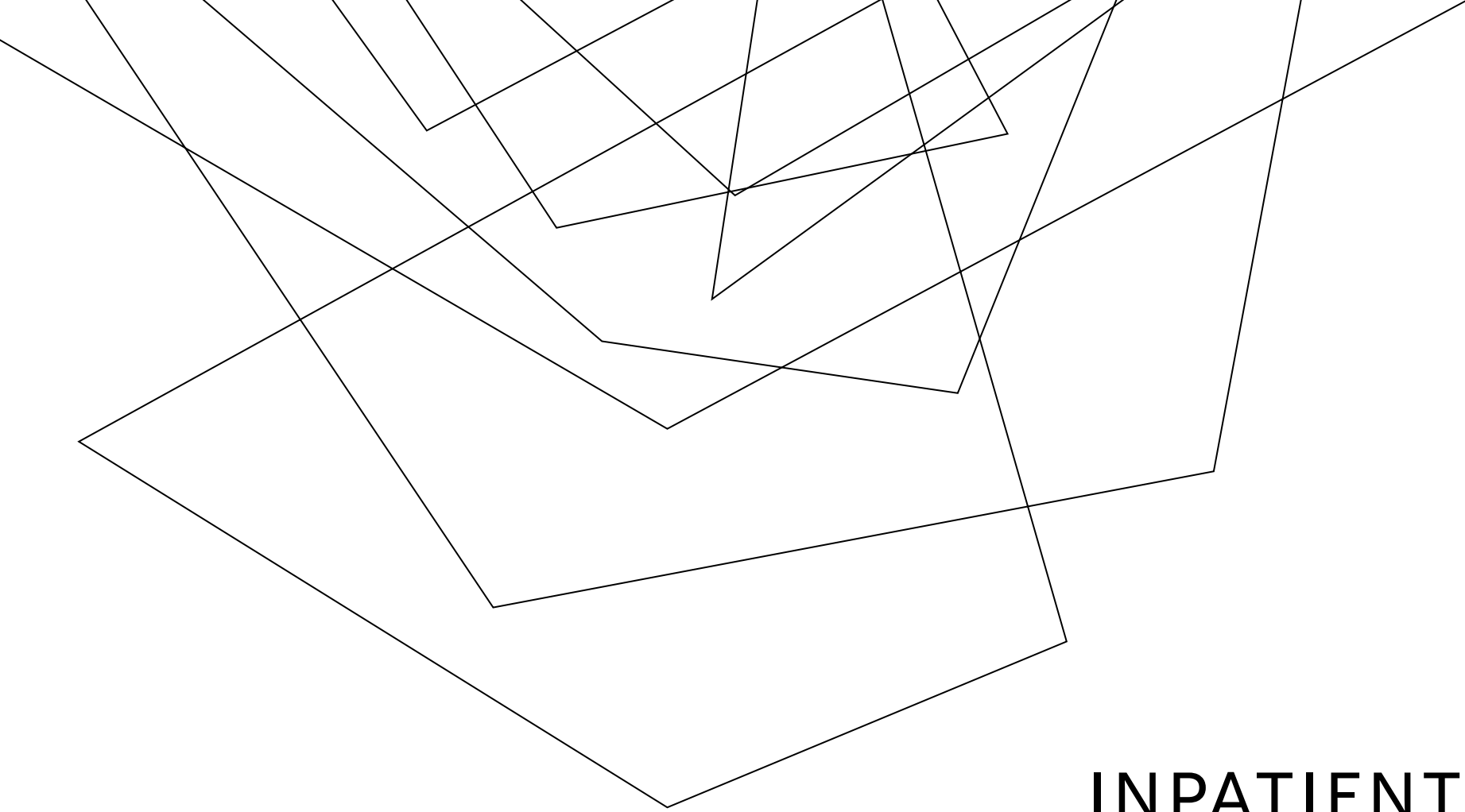
Appropriate Nurse to patient ratios given acuity and TOT

Allied health staff 7 days per week

- Physiotherapist
- Social Worker
- Pharmacist

Ancillary staff

- Dedicated wardperson
- Administrative staff



INPATIENT BED FOOTPRINT OPTIONS

PROPOSED INPATIENT FOOTPRINT

FOR
CONSULTATION

Bed No	CCU (19)	4B (20)	6A (32)	7A (32)	7B (32)	9A (24)	T (16)						
1	CARDIAC 19	RENAL 10	AMU 24	STROKE 4	GEN MED 32	GASTRO 19	CHS WINTER WARD (SURGE)						
2													
3													
4													
5													
6													
7													
8													
9													
10													
11		ENDO 2		NEURO 10									
12													
13		ACDL 8											
14													
15													
16													
17													
18													
19													
20													
21				GEN MED & RESP LLOS 12	ID 5								
22													
23													
24													
25			RESP 8										
26													
27													
28					SURGE 6								
29													
30													
31													
32													
	19	12	32	26	32	24		TOTAL	145				
									plus 8 D/C				

Modelled IP Beds

		Model 3		
Unit	Description	Average FBDs	Median FBDs	75th Percentile
GER	Geriatric Medicine	48	48	53
Gen Med	General Medicine	49	49	53
AMU	Acute Medical Unit	23	23	25
GAS	Gastroenterology	19	19	22
RES	Respiratory	10	9	12
CAR	Cardiology	18	17	20
NEU	Neurology	14	14	17
INF	Infectious Diseases	6	5	8
RHE	Rheumatology	2	2	3
END	Endocrinology	2	1	2
IMM	Immunology	1	1	2
DER	Dermatology	1	1	1

REN RENAL 10

****RHEU & DER MOVING INTO CAS BED BASE SOON**

TIMELINES (1)

November 2022

Bed down the Acute Medical Unit model of care in the temporary 12 bedded T ward next to ED.

Implement and consolidate learnings from DHR go-live.

December 2022

Analyse data for length of stay and option appraisal for inpatient realignment for efficient patient journeys

Begin consultation (workforce, patients, industrial partners) on principles and the bed footprint options

Mid-January 2023

Take in feedback and adjust the preferred option if required and on-going

Continue working with staff on preferred areas of specialty work if affected by the proposal

February 2023

Identify date for move – in line with JMO/Registrar rotation and other operational factors.

Align logistics and support to enable the relocation of patients to their new area

Update and adjust DHR

Continue to monitor the AMU effectiveness, and the length of stay and the RSI data for effect

TIMELINES (2): HOW WE WILL GET THERE

PATIENTS

The case for change for the new Acute Medical Unit has already been approved and supported.

Patient flow pathways from the Emergency Department to the AMU and other wards are already in place and will continue with the new inpatient locations.

Patient care plans for the AMU admission and either discharge or transfer after 48hrs are already in place.

WORKFORCE

Over January and early February we will be working with nursing staff on their preferred ward as their base

We will work with the Division of Acute Allied Health with any relevant ward staff allocation and case mix changes so that staff can be matches to specialties as before.

We will work with our Medical and Administration staff on their new ward locations and assess any requirements to their work environment

LOGISTICS

We will work with our clinical support services (ISS etc) to arrange ward moves, and synchronise those in a way which makes sense to minimise patient and workforce disruption.

We will plan to move any specialties over a weekend with additional staff on duty to ensure patient safety is optimised.

The Emergency Department will be briefed and aware of dates and changes as they occur.

DHR locations and information will be updates as they occur.



SUMMARY

This bed base realignment in the Division of Medicine has many patient-centred and workforce focused benefits.

- Decreased waits in the Emergency Department and improved community response
- Getting patients to the right bed, at the right time, in the right place
- Reduces clinical variation in care and improves evidence-based care pathways for home teams

It is recommended that our workforce, patient advocates and our industrial partners consider the case for change and support implementation in February 2023.



THANK YOU

Any questions?