

Increasing the Rate of Discharges Before 11 AM at Osceola Regional Medical Center

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Background

Late hospital discharges (LHD) have become a major topic of discussion in the last decade, having implications on many different components of hospital workflow. Strong interest has been shown in increasing the rate of early discharges in many hospitals across the nation to optimize throughput and patient flow.

Delays in discharge can impact hospital flow by increasing ED boarding and unit transfer time, could delay treatment or other interventions such as elective procedures. LHD have been shown to increase hospital length of stay [LOS] which in turn can be associated with increased nosocomial infections, depression, and increased patient mortality. Increased LOS has also been associated with higher readmission risks and decreased patient satisfaction.

Objective

We aimed to increase the number of early discharges before 11 AM on resident teaching teams from 19% to 25% team by May 2022.

Methods

A process map of the discharge process showed that some of the delays in discharge occurred from late discussion with the attending, delayed labs or imaging and follow up from consultants. The most commonly mentioned delay by residents was “unable to staff before 11am” (Figure 1).

Our first intervention focused on encouraging residents to pre-round with their attending before 9am, as well as identify the possible discharges the day before and expedite obtaining relevant data and communicating with consultants. We discussed this expectation with faculty in the faculty meeting and with residents at morning report.

We displayed flyers in our work areas and asked the medical admitting resident remind the residents. We also sent out weekly text reminders to attendings. We tracked the discharges through information provided by the hospital and shared this information with inpatient teams. We also created a contest with incentives for the team with the most discharges before 11am.

References

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Results

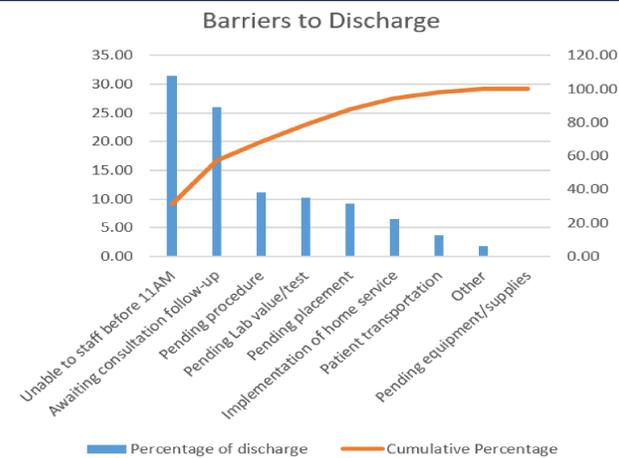


Figure 1. Pareto Chart from resident survey of Barriers to recent discharges.

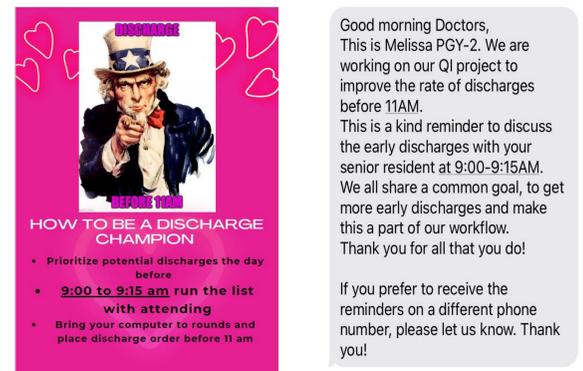


Figure 2. Sample flyer and text message reminders for early discharges

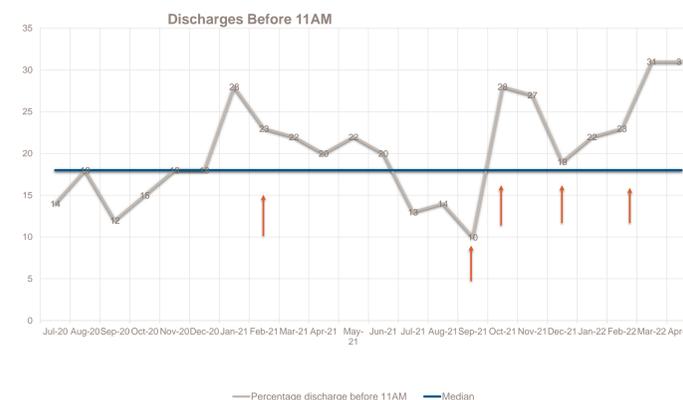


Figure 3. Run Chart of Tracking Early Discharge Rate

Discussion

The first step to implementation of our QI project was by identifying barriers to early discharges (Figure 1). This was achieved by distributing surveys to our residents. The most common barrier to early discharge rate (EDR) was “inability to staff with attending” with delay in consultant recommendations being a close second. We used this as a major area of concentration to which we could intervene. We implemented several interventions during this project with each point of intervention indicated with the red arrows in Figure 3. The first intervention was an introduction to our QI project where we gave a brief presentation to the project during our morning report (MR) session in February of 2021 (First red arrow in figure 3). There was not much improvement in the early discharge percentage (EDP) from March 2021 to September 2021. We then proceeded with our second intervention with the intention to reach a bigger audience where we focused on resident education and awareness through PowerPoint presentations both during morning report and academic half day (AHD) and this time we also started with reminders every Monday morning during our MR. There was a significant increase in the EDP from September 2021 to October 2021.

Though analysis of the results were promising, there was still room for improvement. Therefore, we implemented three more interventions. In October 2021, we incorporated number of early discharges into the role of our medical admitting resident (MAR) where they gather information from each resident team daily regarding early discharges. The EDP did remain at a steady number however, we noticed a drop in EDP in December 2021 during which we implemented our 4th intervention which was a weekly reminder text message to residents on the teaching team to discuss early discharges with their attending prior to morning rounds. We then started sending reminder text messages (Figure 2) to attendings with the same goal of discussing early discharges with their residents prior to morning rounds. We also placed flyers (Figure 2) on “how to be a discharge champion” in the resident workroom.

Seeing that we needed more buy-ins from our residents, we implemented weekly incentives in the form of free lunch to the resident team with the highest number of discharges before 11am. Figure 3 illustrates the percentages of early discharges during our interventions (red arrows) and the implementation of incentives to the residents showed the highest percentage of EDR in April and May 2022. From the data analyzed, we were able to sustain an early discharge rate (EDR) above our median line with an average rate over 25%, our goal. Implementation of incentives to the team with the most early discharges created the biggest jump in the EDR. Though there were periods which we had significant drop in our EDP, this can be attributed to COVID peak and well as new interns starting in July 2021.

Conclusion

Our interventions were able to increase the EDR. We will have to track this to make sure the change is sustainable over time and with new residents.