Overwhelmed Hospital

Medical Leader	•
Medical Expert	•
Communicator	•
Advocate	•
Scholar	
Professional	
Collaborator	•
Manager	

2014 (November) - DAY 1 – Q3

You are the Director of Medical Services for a tertiary-level metropolitan hospital and are responsible for hospital clinical operations. It has been a particularly busy week at the beginning of winter. It looks like the winter months are going to provide a real challenge in service provision.

You come to work on the Friday morning to find that the National Emergency Access Target (NEAT) (for Australian candidates, the 'four-hour rule', for New Zealand Candidates, the 'six-hour rule') performance overnight has been 52%. There are 15 patients awaiting an in-patient bed, including 5 medical and 5 cardiac patients. The average length of stay for the patients currently in your Emergency Department is 9 hours 40 minutes with the longest wait to see a doctor being 3 hours 40 minutes.

This morning there are also 19 patients in the hospital who are awaiting emergency surgery (including several in your ED). The advice from your Director of Surgery is that it will require an estimated 35 hours of operating time required to clear this emergency list. There are also 24 day-of-surgery admissions booked with 13 'day-only' cases. The only beds currently available are three beds in the postnatal ward. All wards are 'stretched to the limit' and those that normally would be expected to provide surge capacity are already 'surged' to their maximum.

Yesterday, there were ambulance offload issues for most of the day, with an average of 3 ambulances waiting to offload at any one time.

Over the last two years, your ED has experienced an average 9% annual growth rate in patient presentations. The in-patient admission rate for these patients has been steady at about 40%.

Questions

1. What initial steps would you take to manage the current situation?
2. How are you going to meet the challenges of the rest of the winter peak and into the future?

Guidance for Censors:

ISSUES

1. **Management of clinical demand, access and patient flow during periods of peak demand**

Initial Response

- Review of long stayers, greater than 10 days, greater than 20 days
- Analysing patients for "waiting for what"
- Reviewing patients waiting to be transferred
- Immediate management of the patients scheduled for elective surgery
- Contingency plans for weekend discharges?
- Cooperative approach with other hospitals? (Also longer term strategy)
- Criteria led discharges
- Are there sufficient beds for rehabilitation, slower stream care?
- Sufficient supervision of junior staff, sufficient senior input, sufficient consultant led triage in ED
- Management of mental health and intoxication patients (drug and alcohol)
- Clinical team response to patients waiting in ED for review
- Management of elderly patients in nursing homes and the community, to prevent them coming in (also longer term strategy)
- Management of staff workload and morale through period of peak demand

Medium to Longer Term Strategies

- Surgical throughput – it is only one day's figures but the ratio of 24 DOSA to 13 same day surgeries seems high: this is an opportunity to discuss elective surgery targets (such as NEST).
- High number of emergency surgeries: again, audit and analyse with reference to appropriateness. Could there be a relationship with problems meeting the demands for elective surgery?
- Understanding emergency access targets such as NEAT or the NZ time-based access targets.
- Does the organisation have any thresholds for escalation responses in place?
- Be able to articulate some whole of hospital initiatives to improve patient flow (e.g. consider Patient Flow Executive for multi-disciplinary whole-of-hospital approach to the surge in demand.
- Changes to ED flow? (Push or pull models for admission to inpatient beds)
- Annual growth in ED presentations – review appropriateness, acuity, any GP-type patients? Look at building capacity in primary health sector.
- Hospital avoidance strategies.

- The 40% admission rate is also high – audit and analysis of this rate: what factors may explain this and are there any categories of admission that could be reduced or avoided?
- ED diversion schemes, nurse practitioners, FastTrack, GP clinics, shortstay units
- Management of elderly patients in nursing homes and the community, to prevent them coming in – also promotion of Advance Care Directives or Living Wills to ensure that elderly patients have some say in the level of acute care access
- Ambulatory care services
- Long term service planning: ED diversion programs and primary health capacity building; reconfiguration for surgical access (such as maximising day-only surgery, or using theatres for elective work after-hours)