Background A guardianship is a legal process that takes place when a patient cannot make informed healthcare decisions and there is no Health Care Proxy. A court appoints a person to serve as guardian. The burden was on a patients family to navigate the court system when a guardianship was necessary. This was difficult because Massachusetts has no public guardian program. BMC began this project to: improve the overall length of stay for patients who need a guardian; to avoid delays in care while awaiting appointment of a guardian; and to reduce costs related to discharge delays.

Objectives To significantly reduce the number of days a patient who lacks capacity remains inpatient because of judicial guardianship issues.

Methods We formed a multi-disciplinary group consisting of hospital stakeholders. This group identified, planned and executed interventions to streamline the guardianship processes. The group followed IHIs Model for Improvement using PDSA cycles.

Results We implemented three simultaneous interventions: engaging outside counsel to handle guardianship cases; establishing a weekly guardianship committee to review the status of inpatients who might need a guardian; pursuing the completion of Health Care Proxy forms. These interventions immediately created a more efficient guardianship process.

Conclusions Using outside counsel and establishing a guardianship oversight group to regularly review the status of patients admitted longer than the hospitals average length of stay will: reduce unnecessary hospital stays caused by delays in the process; reduce the costs related to prolonged stays; and increase the availability of hospital beds for patients in need of acute health care services.

IHI ID 24

IMPROVING DOOR-TO-GROIN PUNCTURE TIME FOR ACUTE STROKE PATIENTS IN THE ER WITH LARGE VESSEL OCCLUSION

¹Robin Dharia, ²Megan Carney, ²Mackenzie O'Connor, ¹Robin D'Ambrosio. ¹Thomas Jefferson University, USA; ²Sidney Kimmel Medical College at Thomas Jefferson University, USA

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Background Given the rapid increase in endovascular-eligible acute ischemic stroke patients, it became imperative to improve and streamline our stroke alert algorithm for ER patients particularly given the two city blocks between the ER and endovascular lab. Delays in door-to-groin puncture time (DTG) for stroke patients with large vessel occlusions are associated with worse clinical outcomes.

Objectives To improve DTG time, an interdisciplinary quality committee was formed. This committee identified barriers by retrospective data review, developed novel QI approaches, and implemented a redesigned stroke algorithm incorporating evidence-based practices and a team approach (figures 1 and 2).

Methods A new stroke alert protocol was implemented and data was prospectively collected for six months for two groups of patients:

1. Transfers from ER for possible LVO who underwent thrombectomy,
2. Transfers for possible LVO but deemed not a candidate for thrombectomy.

The co-primary outcomes were DTG time and door-to-door (ER->endovascular lab) time. Retrospective comparison data was obtained from 2015 to 2017.

Abstract IHI ID 24 Figure 1 Stroke alert algorithm pre-QI implementation

Abstract IHI ID 24 Figure 2 Stroke alert algorithm post-qi implementation

Abstract IHI ID 24 Figure 3 2018-post QI implementation; door-to-groin puncture time (red), door-to-door time (ER to endovascular lab) (blue), national goal for DTG time (green)

Results Average DTD times for 2015, 2016, 2017 were 114, 162, 120 min and the average DTG times were 263, 136, and 165 min, respectively. After enactment of the new algorithm, our DTD time decreased to 96 min and most importantly, the DTG time decreased to 104 min (figure 3).

Conclusions We report that an emphasis on quality improvement and resulting efficient stroke alert algorithm decreased our DTG time for acute stroke patients with large vessel occlusion undergoing mechanical thrombectomy. By decreasing time to reperfusion, we decrease core infarct size and ultimately improve patients functional outcomes.