

Background Patients admitting from the ED to inpatient units can be delayed for a variety of reasons including high ED volume, practice variation among key admissions personnel, or the lack of open, clean, and staffed beds.

Objectives To reduce the median length of stay for admitted patients from 310 minutes to 251 minutes through the elimination of waste and creation of standard work throughout the Door-to-Floor value stream.

Methods 1. Direct observation of patients, operators, and processes within the Door-to-Floor value stream 2. ‘Waste Walks’ with frontline staff to identify wastes that could be immediately eliminated or developed into larger projects 3. Rapid Process Improvement Workshops (RPIW) with frontline staff to identify and prioritize solutions associated with observations 4. Plan-Do-Study-Act (PDSA) cycles: (1) Discharge Effective Time (2) Right Patient, Right Floor (3) Microsoft OneNote to create a ‘pull’ system (4) Standardized ED Hand-off Report.

Results Overall median LOS for admitted patients reached 251 minutes in October 2018 and has remained below the lower control limit. Through creation of standard work, Discharge Effective time of <5 minutes increased from 50% to 90%. Charge RNs using OneNote and the standardization of patient type to appropriate unit, resulted in decreased bed-requested to bed-assigned times from 37 to 13 minutes. A standardized ED Handoff Report did not result in time savings, but did increase the quality and consistency of patient information transfer.

Conclusions By using Lean applications of observation, eliminating waste, data control charts, and standard work, the median LOS for admitted patients decreased by one hour.

26

IMPROVING TIMELINESS OF SPECIALIST REFERRAL AND DIAGNOSIS FOR PATIENTS WITH SUSPECTED LUNG CANCER THROUGH STANDARDIZATION

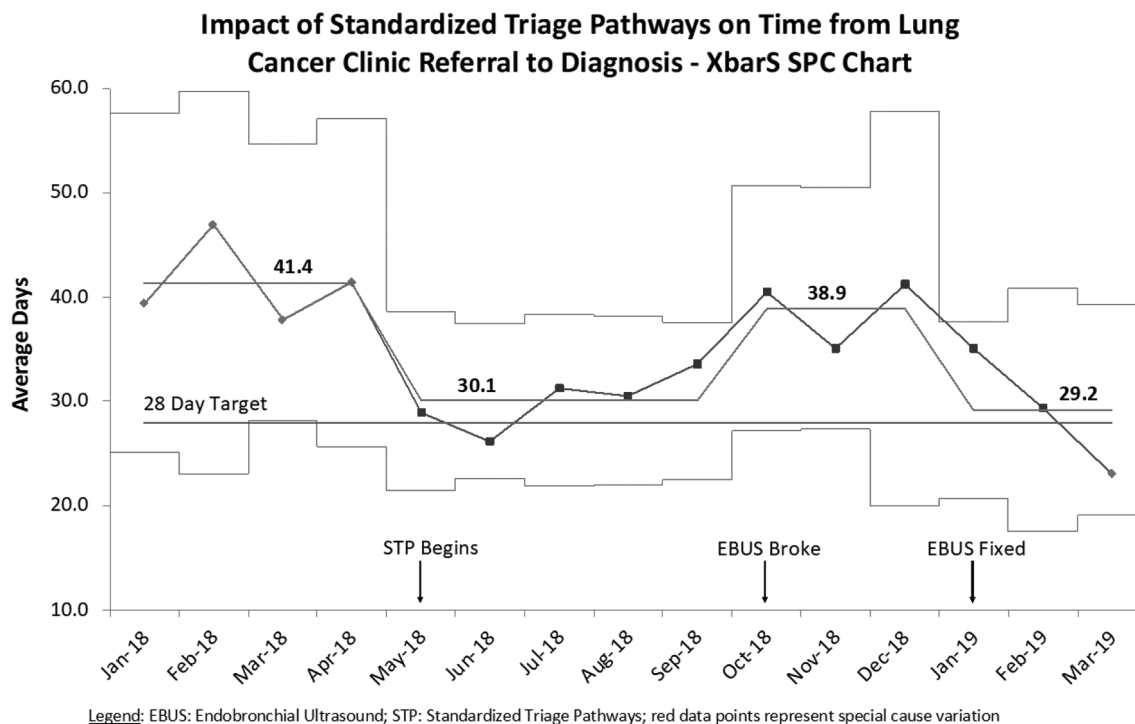
¹Breanne Golemic, ¹Monica LL Mullin, ¹Audrey Tran, ²Christine Noseworthy, ¹Christopher JL Stone, ³Thomas Howard, ³Gurmohan Rob Dhillon, ⁴Christopher M Parker, ⁵Geneviève C Digby. ¹Queen’s University Department of Medicine, Canada; ²Cancer Centre of Southeastern Ontario, Kingston Health Sciences Centre, Canada; ³Queen’s University Department of Radiology, Canada; ⁴Queen’s University Department of Medicine, Division of Respiriology, Canada; ⁵Queen’s University Department of Medicine, Division of Respiriology, Department of Oncology, Canada

10.1136/bmj-2019-ihl.26

Background Delays in lung cancer (LC) diagnosis are associated with worse clinical outcomes. Our rapid assessment LC clinic identified referral delays following thoracic imaging suspicious for LC and delays associated with unstructured triage.

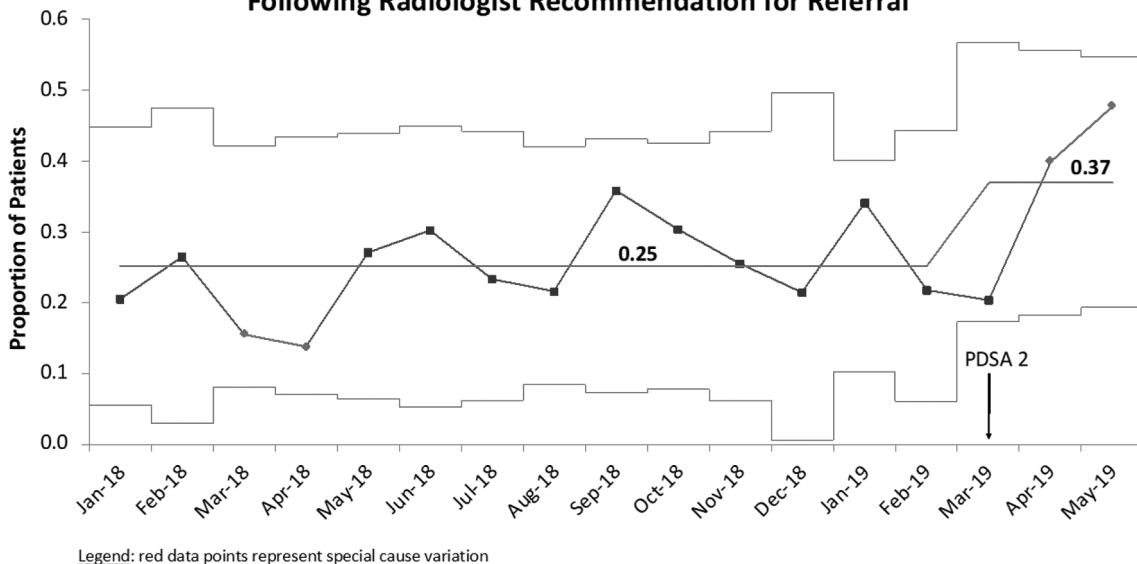
Objectives Decrease time from suspicious CT chest to LC clinic referral and decrease time from referral to diagnosis and staging.

Methods Retrospective baseline chart review (Jan–Apr 2018) and prospective monitoring (May 2018–May 2019). PDSA cycles: 1) Standardized Triage Pathways (nurse-physician triage to diagnostic pathways, pre-ordered staging tests, small nodule clinic); 2) local standardization and regional implementation of CT reporting recommending LC clinic referral (March 2019). Data include dates of: imaging suspicious for LC, CT chest, specialist referral and assessment, staging tests, radiologist recommendations and diagnosis. Data are reported as mean days; statistical process control XbarS charts and unpaired t-tests were used to assess for significance.



Abstract 26 Figure 1

Proportion of Lung Cancer Clinic Patients Referred Following Radiologist Recommendation for Referral



Legend: red data points represent special cause variation

Abstract 26 Figure 2

Results Following PDSA 1, there were reductions in mean time from referral to PET (40.5 to 27.3 days), to CT/MRI Brain (35.8 to 18.8 days), and to diagnosis (41.4 to 30.1 days), all significant by special cause variation. Following PDSA 2, the percentage of LC clinic patients with a CT chest recommending clinic referral increased (25.2% to 37.0%, $p=0.041$), with increased recommendations from regional hospitals (4.2% to 16.5%, $p=0.022$). When a radiologist recommended LC clinic referral, time to referral and assessment were faster (7.3 vs. 15.5 days, $p=0.0001$; 20.3 vs. 26.2 days, $p=0.001$, respectively).

Conclusions Standardization of radiologist reporting and LC clinic triage led to significant improvement in timeliness of specialist access, diagnosis and staging investigations.

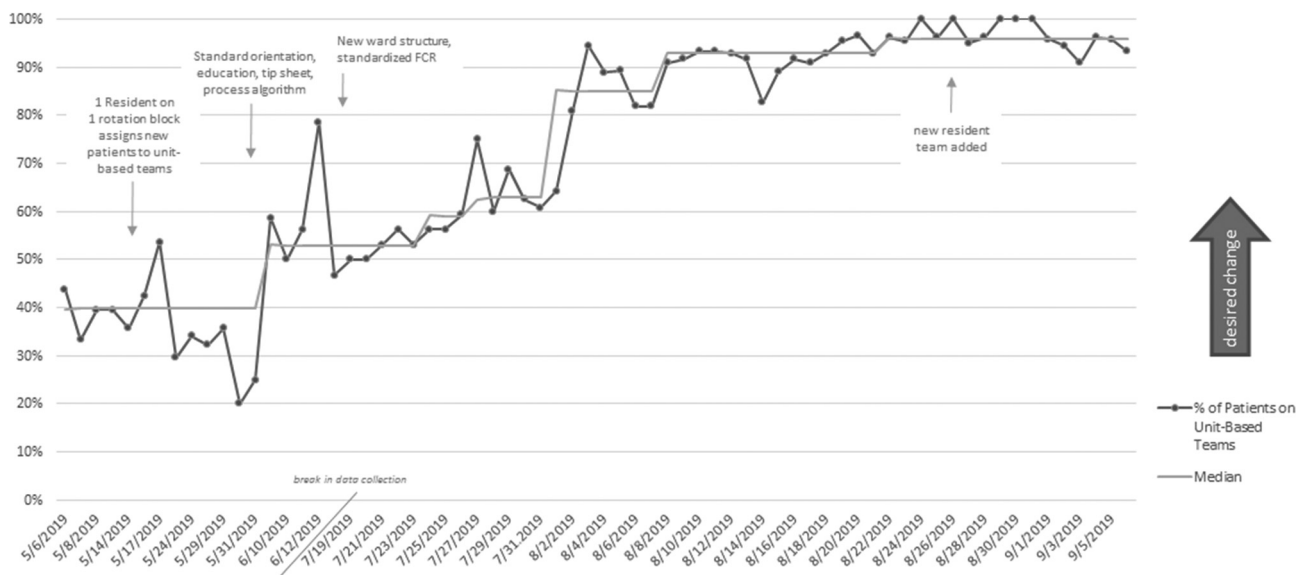
28 THE ROADMAP TO SUCCESS: CREATING UNIT-BASED TEAMS TO INCREASE FAMILY CENTERED ROUNDING AND IMPROVE CARE TEAM COMMUNI

Courtney Port, Sarah Calardo, Nadia Chaudhry-Waterman, Lesya Tomlinson. *Inova Children's Hospital, USA*

10.1136/bmjoc-2019-ihl.28

Background Family Centered Rounding (FCR) allows the medical team to partner with patients and families in medical decisions, improving patient satisfaction, advocacy, communication, and safety. However, daily implementation is uncommon due physical and time constraints and a lack of training and standardization.

Percent of Patients on Assigned Unit of Geographic-Based Teams



Abstract 28 Figure 1 Percent of patients on assigned unit of geographic-based teams. The percentage of patients on assigned unit of geographic-based teams increased from a baseline median of 40% (25th, 75th percentiles 38, 41) to 96% (25th, 75th percentiles 95, 100). The median line was adjusted when trends and shifts were met according to run chart rules