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 Handoff 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.
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.

Abstract 26 Figure 2

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.

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

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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.