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

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/bmj-2019-ih.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

Percent of Patients Receiving Family Centered Rounds

Abstract 28 Figure 2 Percent of patients receiving family centered rounds (FCR). Patients receiving FCR increased from 93 (59%) to 136 (93.6%), achieving the project's aim. Thirty percent more patients received FCR following PDSA Cycle 4 compared to baseline (95% CI 19, 40). *Data was not collected for PDSA Cycle 3

Occurrence of Trio Rounds

Abstract 28 Figure 3 Percent of patients receiving trio rounds. The second outcome measure involved improving physician-nursing communication utilizing trio (physician, nurse, caregiver) rounds. There was a 22% increase in trio rounds since implementing geographic-based teams and increasing daily FCR, thus far. *Data was not collected for PDSA Cycle 3. Data for PDSA Cycle 4 is currently being collected and results will be available at time of post presentation

Percent of Rounds Exceeding Allotted Time

Abstract 28 Figure 4 Percent of rounds exceeding allotted time. This balancing measure looked at the time it took to conduct rounds. The percentage of rounds exceeding the allotted time remained relatively stable from a baseline of 36% (N=5) to 31% (N=5) as of PDSA Cycle 4. *Data was not collected for PDSA Cycle 3. Unit-based teams potentially allowed for more efficient rounding as more patients received FCR without increasing the duration of rounds

Objectives This project's aim was to increase the percentage of patients receiving FCR from 59% to 90% in 6 months.

Methods The Model for Improvement and sequential PDSA cycles were utilized. The process of assigning patients to physician teams was delineated, teams were restructured, and FCR was standardized. The percentage of patients on their geographic team-based unit (process measure) was collected daily. Convenience sampling was used to obtain the frequency of FCR, care team communication measured via 'trio rounding' between physician, nurse, and caregiver (outcome measures), and duration of rounds (balancing measure).

Results The percentage of patients geographically assigned improved from a median of 40% (25th, 75th percentiles 38, 41) to 96% (25th, 75th percentiles 95, 100), figure 1. Patients receiving FCR increased from 93 (59%) to 136 (93.6%), figure 2, achieving the project's aim. Trio rounding frequency is improving (33, 35% to 38, 45%), figure 3, with data for the current PDSA cycle being collected. Rounds exceeding the allotted time remained stable (5, 36% to 5, 31%), figure 4.

Conclusions By increasing the percentage of patients on unit-based teams, 30% more patients received FCR (95% CI 19, 40) without prolonging rounding time. Results may be generalizable to similarly sized hospitals and residency programs. Future interventions will focus on improving FCR effectiveness.

29

ACHIEVING MEANINGFUL HEART FAILURE READMISSION REDUCTIONS IN A SAFETY NET HOSPITAL

Deborah Whalen, Eric Awtry, Ann Carey, Lisa Caruso, Diane Gauthier, Deepa Gopal, Nicole Lincoln, Ludwine Paul, Donald Johnstone, Jennifer Plummer, Christine Saraf, Alexandra Yurkovic. *Boston Medical Center, USA*

10.1136/bmjopen-2019-ih1.29

Background Heart Failure (HF) the most frequent MS-DRG resulting in 30 day readmission is a major focus of readmission reduction initiatives. Achieving meaningful and sustained reductions in HF readmissions in a Safety Net Hospital is particularly challenging. Boston Medical Center achieved this goal through designing a robust slate of multidisciplinary interventions tapping existing institutional resources in new ways.

Objectives Design a slate of multidisciplinary interventions that lower BMC's average 30 day Medicare HF readmission to less than 19% by May 2019.

Methods Using PDSA methodology a multidisciplinary team implemented interventions addressing care processes, co-morbidities and social determinants of health. Effectiveness was monitored through automated performance dashboards. Interventions included (1) Inpatient HF Consult Criteria patients not on Cardiology teams; (2) Standardized RN Teach Back and EPIC smart phrases discharge documentation; (3) VNA support HF home discharges, preferential respite admission when homelessness; (4) HF Clinic Nurse Practitioner follow up appointments within 7-14 days discharge ;(5) Scripted call day prior Cardiology appointment to mitigate barriers to arrival;(6) Concurrent Renal consultation CKD IV or V patients not on hemodialysis.