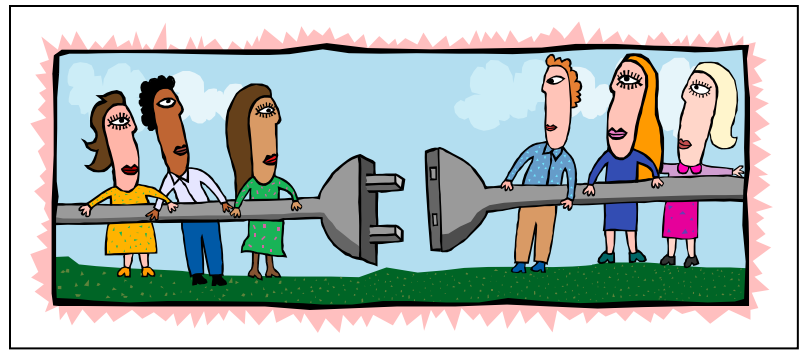


South West LHIN Patient Access & Flow Project -

Project Bulletin #2
October 21, 2009



Purpose of this Bulletin

The purpose of this Project Bulletin is to keep you informed about the South West LHIN Patient Access & Flow Project. The Bulletin will be published following each Project Steering Committee meeting and more often if warranted.

In addition to being circulated by e-mail this Bulletin can be accessed by going to the ISAN (Integrated Strategic Alliances & Networks) [website](#)

Project Update

The Project Steering Committee has proposed a slight modification to the project title. The intent is to be more descriptive. We hope you like it.

Hospital Patient Access & Flow Project - South West LHIN ***Improving access to care through collaboration***

General Outline of the Project

In the first newsletter we provided a general outline of the work that will be undertaken. Here is a summary of the status of each of these pieces of work.

1. Confirmation of the project's purpose and tasks to be completed – **Completed**
2. Recruitment of Project Steering Committee and Project Team members - **Completed**
3. Consultation with key stakeholders and groups to gain a clear understanding of the current inter-hospital referral and transfer issues and their support for a standardized LHIN-wide protocol – **In process**
4. Collection and analysis of data showing dominant patterns of patient flow across the region – **In process**
5. Development of a draft region-wide protocol based on the Champlain LHIN protocol and input from the consultations – **In process: Draft #1 was presented to the Project Steering Committee on October 15th. A second draft is being prepared and it will undergo additional review and editing. This will be an iterative process with several versions being developed, reviewed and modified based on feedback received**
6. Development of an evaluation framework and a process to ensure on-going monitoring and correction of the protocol – **In process: Ideas about indicators of success discussed by the Project Steering Committee on October 15th. Follow-up work to be undertaken.**
7. Review of the final draft protocol by the Project Steering Committee, South West LHIN hospital CEOs, Chiefs of Staff, MACs and others – **to be done**
8. Presentation of a final draft protocol to hospitals for endorsement– **to be done**
9. Endorsement of the protocol by all hospitals – **to be done**
10. Implementation of the protocol by all hospitals across the SW LHIN – **to be done**
11. Evaluation of the protocol some months after it is implemented to assess its usefulness and effectiveness – **to be done**

Draft Protocol – process steps only

Please note that this information is draft and will be changed based on additional input. Nevertheless, it should give readers a general understanding of the direction the work is taking and should therefore be informative.

As noted above, an initial working draft of the protocol was tabled with the Project Steering Committee on October 15th. The initial draft focussed only on the protocol from a process perspective and not on the tools or staff resources that would be responsible for each step. As a result of the input received the protocol will be revised and strengthened. This revised version will be reviewed by the project's physician leadership group before it goes back to the Steering Committee for further review.

The current draft identifies eight steps in the process.

1. Initiation
2. Patient Triage
3. Handshake 1
4. Patient Transfer
5. Meet & Greet
6. Clinical Care
7. Handshake 2
8. Patient transfer & repatriation

Step One - INITIATION (First contact)

- Initial contact would be physician directed but would not require their direct involvement
- The role of CritiCall in the process has yet to be finalized, but it is suggested that CritiCall be called directly if immediate action is required.
- Nature of the request could range from immediate patient transfer to assessment of the patient's condition to a request for consultation
- Patient's condition could range from being immediately life threatening, to requiring treatment within 24 hours (emergent), to requiring treatment within 48 hours (urgent)
- Suggested enabler – that each hospital have one number to call to support patient transfers or repatriation that can be accessed 24X7

Step Two – PATIENT TRIAGE (Conversations prior to patient transfer)

- Develop and use a standard language to describe the patient's condition that is known and understood by everyone (the SBAR process developed by Kaiser Permanente has been suggested)
- Use a standardized patient transfer document to capture essential patient information that will be sent prior to patient arrival
- Staff from referring and receiving hospitals will have an initial conversation focussed on forwarding patient information, identifying the nature of the issue and identifying the specialist or consulting physician to be contacted. The medical, nursing and allied health needs of the patient will need to be identified to ensure the receiving hospital has the appropriate resources available to treat the patient
- If a bed is known to be required, current bed availability information is collected

Step Three - HANDSHAKE 1 (Physician to physician consultation)

- When the two physicians talk the focus is on the nature of the patient's condition and determining next steps (the referring physician will already know if an appropriate bed is available or not)
- If physician accepts the patient then Admitting is notified of decision to accept. Depending on whether the patient will be coming to the ED for assessment or will go directly to the floor, ED and/or floor at the receiving hospital are notified.
- This stage may also include nurse to nurse conversation to exchange information about the patient's condition (may occur at specialized hospital if nurse accompanies patient)

Step Four – PATIENT TRANSFER

- This step involves the logistics and process of patient transfer including CACC¹ notification, patient preparation, staff or physician accompaniment if required, and collection of necessary documentation not already forwarded

Step Five – MEET & GREET (connection with and assessment of the patient)

- At the receiving hospital, as noted above, EMS will take the patient to the ED or floor for assessment and treatment as directed by the accepting physician
- If a patient is assessed and it is determined that they do not need the services of the specialty hospital, they will be returned to the referring facility accompanied by treatment advice or plan as soon as possible, preferably by return ambulance

Step Six – CLINICAL CARE

- Provided by the receiving hospital
- As early as possible expected discharge or transfer day is established and repatriation arrangements are initiated
- Discharge/transfer decision made
- Admitting department notified to arrange patient transfer and accepting physician identified at the hospital to which the patient will be repatriated (if not already known)
- EMS or private patient transfer service notified as soon as possible
- Accompaniment needs if any, determined and arranged
- Documentation of medical, nursing and allied health care needs completed to provide continuity of care assembled and summarized in a patient transfer form (same one as in Step Two) – sent to repatriating hospital

Step Seven – HANDSHAKE 2 (Physician to physician consultation re: repatriation)

- Physician at the specialized hospital talks to the physician at the originating hospital about the patient's on-going medical needs, advice and recommendations given
- This step may also include nursing and allied health care needs of the patient being discussed between the nursing staff at the sending and receiving hospitals

Step Eight – PATIENT TRANSFER & REPATRIATION

- This step involves the logistics and process of patient transfer and hand-off to the repatriating hospital including CACC notification (as required), patient preparation, staff or physician accompaniment if required and collection of necessary documentation not already forwarded

If you have any comments about this preliminary work that you would like to pass on, please send your comments to steve.elson@lhsc.on.ca

If there is information you would like to see included in a Project Bulletin or if you have a question or comment that you would like published, please contact Steve Elson at steve.elson@lhsc.on.ca

¹ Central Ambulance Communication Centre

New members are noted in bold.

Name	Project Steering Committee Members (updated list) October 16-09	Organization
Margret Comack*	CEO and Project Steering Committee Chair	Listowel Wingham Hospitals Alliance
Sue McCutcheon	Vice President Clinical Services	Grey Bruce Health Services
Mary Jane Dandeno	Corporate Manager, Utilization Management	Grey Bruce Health Services
Reta Sproule	Vice President Patient Care	Hanover and District Hospital
Cheryl Taylor	Chief Nursing Executive	Alexandra Marine & General Hospital (Goderich)
Mary Cardinal	VP Patient Care (interim)	Huron Perth Healthcare Alliance
Karen Bartlett	Vice President Patient Care/ Chief Nursing Officer	Woodstock General Hospital
Laurie McGill	Occupational Therapist	Middlesex Hospital Alliance
Lisa Gardner	Chief Nursing Officer/ Director of Patient Services	Alexandra Hospital (Ingersoll)
Brenda Lambert	VP Patient Services	St. Thomas Elgin General Hospital
Dr. Paul Cooper +	Integrated Senior Medical Director, Medicine Services	London Health Sciences Centre and St. Joseph's
Dr. Murray Girotti +	Medical Director, Trauma Care	London Health Sciences Centre
Dr. David Sanders +	Orthopedic Surgeon, Surgical Services	London Health Sciences Centre
Dr. Rob Annis +	Chief of Staff	Listowel Memorial Hospital
Dr. Don Eby +	Chief of Staff	Grey Bruce Health Services
Dr. Marie Gear +	Past Chief of Staff	Wingham & District Hospital
Dr. Laurel Moore +	Chief of Staff	Huron Perth Healthcare Alliance
Dr. Malcolm Macleod +	Chief of Staff	Woodstock General Hospital
Dr. Lisa Shepherd +	Emergency Physician & South West LHIN ED Lead	London Health Sciences Centre
Catherine Glover	Director, Corporate Clinical Operations	London Health Sciences Centre
Kelly Verhoeve	Executive Leader Patient Services	Tillsonburg District Memorial Hospital
Dianne Waram	Vice President, Clinical Services	South Bruce Grey Health Centre
Cheryl Pfaff	Corporate Manager	South Huron Hospital (Exeter)
Kim White	Planning and Integration Lead	South West LHIN
Donna Ladouceur	Senior Director, Client Services	South West CCAC
Sherry Fletcher	Regional Manager, Client Services	South West CCAC
* South West LHIN/Hospital and SW CCAC Leadership Forum members +members of the Regional Physician Leaders Group		
	Project Team Members	
Maurice Williams	Team Leader, Continuous Improvement Team	London Health Sciences Centre
Sue Nugent	Coach/Facilitator, Continuous Improvement Team	London Health Sciences Centre
Steve Elson	Director, Integrated Strategic Alliances & Networks, Co-Lead, Project Team	LHSC & St. Joseph's
David Heaton	Project Leader, Integrated Strategic Alliances & Networks	LHSC & St. Joseph's
Catherine Glover	Director, Corporate Clinical Operations, Co-lead Project Team	London Health Sciences Centre
Cindy Mooney	Manager, Learning & Organization Effectiveness	London Health Sciences Centre