Peter Mac
Medical Day Unit Project

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What is the MDU ?

- A 4 bed + 4 chair L-shaped ambulatory treatment area ~ 3500 patients pa. staffed by 3 nurses
- 65% planned work (BMBx and Blood Transfusion)
- 35% unplanned (unwell patients for review)
- % planned work is increasing putting pressure on ability to accommodate unplanned patients

What was the problem ?

- Senior medical staff believed that growing activity pressures on the unit were causing unsafe delays in treating unplanned time critical unwell patients

"…we need more staff and more space!"

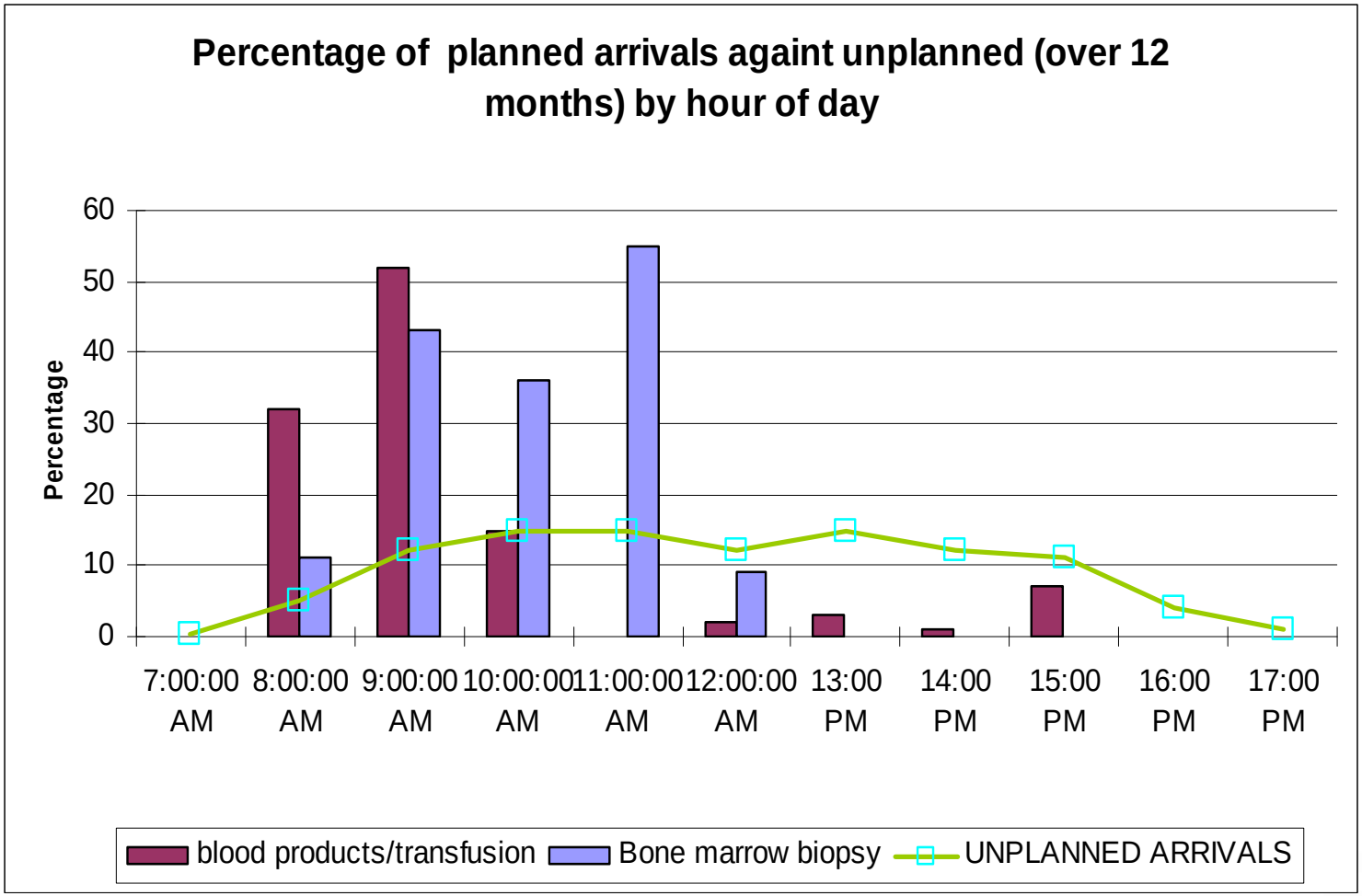
Was this the problem……?

- How would I know ?
- Better do some pre-diagnostic diagnostics!

What did we do next ?

- *Went down to the real world !!*

What did we discover ?



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Why is there a morning bottleneck?

Why, Why, Why……

- True clinical demand for planned work is much higher in the am than the pm

- Peaks in planned workload were exacerbated by sub-optimal workforce integration, role clarity & demand management of the BMBx workload

Baseline performance

- Oral/Nil sedation median LOS 180 mins
    - Range 60-430 minutes

  IV Sedation: Median LOS 240 mins
    - Range 120-435mins

- 2 patients/week forget to fast, some are delayed in DI
- 1-2 unplanned patients are knocked back every day
- Over half of all BMBx don’t start til after 11.30am

Intervention 1. Nursing workforce

- Put the Pathology/BMBx nurse on the MDU roster
- Developed role statements for the 3 nursing roles & rotated staff through roles 2 & 3
- Commenced pre: procedure phone calls to patients
- Put BMBx management front & centre in MDU role

Intervention 2.
Minimum data set & score card report

- 5S'd the activity and demand data set data set
- Developed basic score card reporting expectations
- Displayed the data on the "How are we doing" wall
- Celebrated the ↓ BMBx LOS & knockbacks

Intervention 3. Load levelling

- Increased predictability of LOS by ensuring we collected all the info needed to plan the care
- Developed agreed start times with the Registrar
- *Try* and put the simple predictable work first
- Have limits for the numbers booked each day Quarantined 1-2 beds for BMBx

Intervention 4.

- One point of contact for ambulatory bookings …..

  Didn’t get this off the ground

What did we achieve

- Overall 29% reduction in BMBx LOS releasing 2.8 hrs of extra chair time per day
    - (↓ variation by 3.5 hrs)
- 33% reduction in knockbacks in 8 week trial period- dropped even further… now tracking @ 1-2 /week
    - (~ 80+ extra patients can be accommodated/year)
- 55% of BMBx patients commencing 1.5 hrs earlier

What would we do differently…

- Do the Pre-diagnostics before asking for funding
- Clarify the roles of all on the project team /steering committee
- Don’t let Exec sponsor slip off to 8 weeks LSL mid project
- Don’t make the mistake of doing stuff for the process owners because you feel guilty that you have more time than them

What would we do differently

- Don’t cancel meetings -you’ll loose momentum
- Work harder to deliver the what’s in it for me for your key stakeholders e.g. BP machines and new patient chairs
- **& Finally**: wherever possible choose projects where staff already accept that they have a problem that needs fixing

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