JOHNS HOPKINS WHITING SCHOOL of ENGINEERING | Center for Leadership Education

Meeting	Hospital project: Meeting with stakeholders- Inpatient Department
Venue	8:00 AM- 11:00 AM at Johns Hopkins Bayview Medical Campus

Attendees

Johns Hopkins Hospital	**Patient Safety Collaborative**
Dr. Renee Blanding	Sharvi Dadhich
Dr. V Gundareddy	Chuyang Yu
Dr. Che Harris	Siddhay Kapat
Dr. Shahida Khan	
Leilani Turman	
Nurse Lee & Paul	

Minutes of meeting:

General Observations:

1. There is a tunnel between the Emergency Department (ED) and Burton Pavilion (inpatient ward).
2. There are 10 observation beds on the top floor of the ED.

With Dr. Che Harris (Medicine Faculty):

1. Patient Admission: A patient was admitted at 6:35 PM on Sep 12th, and Dr. Harris received this patient at 7:00 AM on Sep 13th. Stable patients stay in the ward or get discharged; unstable patients are admitted to the ED.
2. Process Delays: Dr. Harris needs to check test results and notes/orders from other teams or departments on EPIC, which can take hours due to full beds and unclear medication response times.
3. Daily Routine: Dr. Harris visits the exam room in the ED daily to check patient conditions, while his office is on the 4th floor of Burton Pavilion.

With Leilani Turman (Registered Nurse):

1. JBASH Meeting: At 9:00 AM in the education center, involving various departments. Topics include bed availability, patient admission and discharge, safety issues, longest patient wait times, and hallway patients. A daily multidepartment meeting at 1:00 PM discusses patient needs and discharge plans.
2. Bed Availability: Open beds are currently available in inpatient wards. A red light at the nurse's station indicates all beds are occupied, requiring discharge doctors and nurses to assess current patients for early discharge.
3. Patient Discharge Challenges: Patients may be unable or unwilling to leave the hospital due to homelessness, lack of in-home care, insurance issues, or unapproved medications.
4. Discharge Process:
    - Conduct pre-discharge examinations (X-ray, etc.)
    - Generate a report for the doctor's review
    - Doctors and nurses discuss follow-up plans with patients
    - Provide discharge papers if everything is in order
    - Nurses ensure all tasks are complete, and patients see a Social Worker for a 5-minute pick-up service
    - Nurses then empty the bed
5. Nurse Shortage: The nurse station is often empty due to a shortage of nurses.
6. Daily Plan Board: A hard copy is used to track every nurse in case they are needed and cannot be found.

With Nurses- Lee and Paul:

1. Nurse Workload: The patient care floor has 35 beds and 7 nurses, each responsible for 5 beds. Currently, there are 3 available beds.
2. Work Hours: Working hours are from 7:00 AM to 7:00 PM with a 12-hour shift. Morning tasks typically end at 11:00 AM, and afternoon tasks start at 12:00 PM. Emergencies may necessitate clustering the midday break.
3. Communication: Nurses and doctors communicate using EPIC via computer and hospital phone. EPIC includes individual daily work lists, orders from doctors, overall timetables, and medical reminders for each patient. Nurses must log into the system to check they have completed all scheduled items before finishing work.
4. Daily Tasks: Include checking vital signs, changing bed linens, assisting with body cleaning, reminding patients of upcoming care plans, administering medication, and addressing patient needs.
5. Patient Rounds: Time varies per patient. Stable patients take 10-15 minutes, while complex cases can take over half an hour. Special circumstances, such as doctor-patient communication during rounds, may extend this time.
6. Morning vs. Afternoon: Mornings are busier as patients want to know their condition, leading to concentrated afternoon discharges. Morning discharges may occur if there's no ambulance available or a change in the medical condition.
7. Medication Pickup: Nurses use the MedStation, a machine at the nurse's station, for medication. They enter fingerprints, select medication, and a corresponding locker pops up. Patient's change of clothes and bed linen are picked up in the nearby supply room.

Case Observations:

1. Case 25A: Patient's discharge to a Rehab facility was delayed because the patient refused to go.
2. Case 328B: Patient's discharge was delayed by a day due to a sudden increase in heart rate (140 BPM), leading to ambulance refusal.
3. Case 325A: Patient, post-hip surgery, insisted on going home instead of Rehab, causing a delay as the doctor couldn't sign the discharge note without stable vitals.

General Causes of Delay:

1. Patient-End Delays:
    - Refusal to leave
    - No one to take care of them at home
    - Insurance or medication approval issues
2. Hospital-End Delays:
    - Doctors taking long to see patients and write discharge notes
    - Delay in ambulance arrival
    - Loss of patient items during admission from ED
    - Limited equipment for patients needing customized medication
    - Delayed diagnostics
    - Involvement of social workers in cases of insufficient funds

Conclusion: The meeting highlighted several potential causes of delays in the patient discharge process. Both patient and hospital-end factors contribute to these delays. Further analysis and targeted interventions are required to optimize the discharge process and improve patient flow.

1. **Actionable for Next week**:
    1. Observe on the inpatient floor, meet with meet with **CMIO Dr. Amy Knight**, who is a hospitalist.
    2. Analyze the gathered data to identify patterns and common issues.
    3. Attend a JBOSH and Multi-D meeting next to understand the throughput better.