Three Pillars of change – A qualitative governance model to safer inpatient antenatal and postnatal care in a tertiary Sydney hospital

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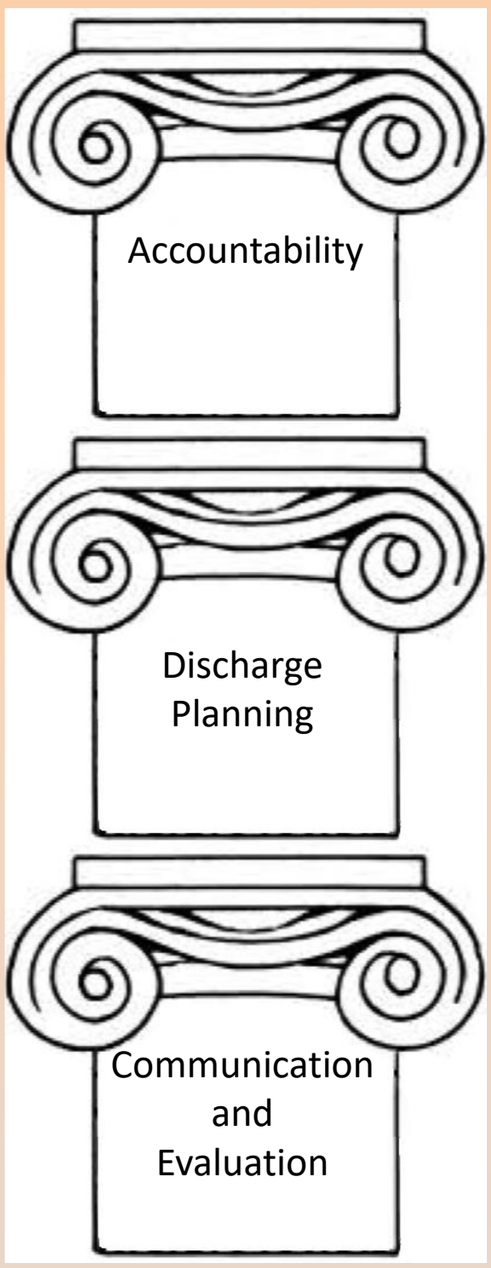
Many models of inpatient care exist and these are influenced by workflow, patient load and team structure. Inpatient care was largely a team-based framework involving four O&G teams .Motivation for change arose from difficulty in maintaining accountability and follow up for inpatients throughout the day alongside busy outpatient clinics and other clinical duties. Consistency in patient care and difficulty in effective communications between clinical care stakeholders influenced a need to reassess our model of care. We implemented a change to inpatient team care model at our hospital for 4 weeks and sought stakeholder feedback.



Pillar 1 – Accountability:

- A ward based team for a full week without other duties to ensure all patients have comprehensive care.
- Due to clinical pressures, previous inpatient teams were not efficient at organising and following up investigations and plans throughout the day due to pressures from other clinical areas.
- A continuity of care team of a registrar and resident was proposed to manage all inpatient issues while also covering emergency department consults

Pillar 2 – Discharge Planning:

- Early discharge for postnatal patients to improve patient flow of the journey from home or antenatal ward, to birth unit, to postnatal ward and subsequent discharge.
- Identifying at risk patients clearly
- A checklist was developed to communicate easily regarding which patients were cleared for discharge.

Pillar 3 – Communication and Evaluation

- Prompting questionnaires – Why am I in Hospital? What is happening today? What needs to happen for discharge?
- Daily discussion of Plan, Do, Study, Act to make assess appropriateness of the new model and make changes daily.
- Staff feedback sought for ongoing work model.

Outcomes and Discussion:

1. Daily review of new processes resulted in altering the role of the ward based team to focus on antenatal and gynaecology patients only in addition to the ED consult responsibility. Postnatal reviews were conducted by the rest of the O&G team as these generally required less ongoing management.
2. Reallocation of duties consolidated acute obstetric care for maternity assessments to be reviewed by birth unit staff with an added unaccredited registrar.
3. General feedback was that trainees were able to attend clinical duties in a timely manner.
4. As a result of the new model there was anecdotal feedback of earlier postnatal discharge. The checklist was difficult to implement as it coincided with other patient safety initiatives being implemented amongst the postnatal patients.
5. The PDSA model was effective at identifying ineffective and inefficient processes.
6. Overall there was majority of obstetric and gynaecology staff in continuing the new ward based model.