Welcome to the Medical department, Höglandssjukhuset in Eksjö
Brief overview of the Medical department

- 118,000 patients in the county of Highland in Sweden, increasing elderly population
- 80 beds
- About 280 employees
- Patient focused organization
- Inpatient care based on “Patient Focused Care” (TCAB=transforming care at the bedside)
- ESTHER – A network between community services, hospital and primary care supporting process oriented health care
- Team based integrated inpatient care and outpatient care in wards (cardiology, endocrinology, gastroenterology, nephrology, neurology, hematology, respiratory)
- IT based patient administration system including patient documentation
- All employees have been educated in various quality improving methods which is implemented in the daily work
Focus patient process – a work to reduce readmissions

Camilla Strid, Medical department, Höglandssjukhuset
Focus process – for whom?

A patient mostly +65 years old who has at least one of the following criterias:

- Readmission within 30 days and/or
- Caregiver assessed that there is a risk of readmission
- Multimorbidity
- Diagnosis as diabetes, atrial fibrillation, heart failure, COPD or stroke
Focus process

- Early identification of patients at risk for readmission
- Healthcare Prevention - identifying risks and initiate actions
- Pharmaceuticals - checklist
- Focus referral to primary care within one day of discharge
- Primary care coordinator nurse; follow-up phone call within 24-72 hours.
- Consultation is assessed and planned by the primary care physician and nurse together with the patient and often with municipality.
The goal

- The goal is to reduce readmissions that are not necessary
- Reduce readmissions compared with the month previous year by 10%
- Primary care should clearly be the basis for the patient's health care – close to the patients home
Andel akut återinskrivna fokuspatienter på M-kliniken
Oplanerade återinskrivningar bland patienter som fått fokusremiss, Medicinkliniken Jkp, Ryhov

År och månad: Grupp (29 av 31)
Resultatenhet: Medicinkliniken Jkp
Åldersgrupp: >=65 år
Vetlanda kommun
åldersgrupp 65+

- Antal utskrivna med fokusremiss
- Andel oplanerade återinskrivningar med fokusremiss, %

Antal
Andel, %

This we have done.....
Person-centered care in the Focus Process on Höglandet

- Partnership
- Storytelling
- Documentation

A network between municipality, hospital and primary care supporting process oriented health care

"Is this the best for Esther?"
The risk assessment Focus in the record

Day note – assessment Focus

Camilla Strid, Medical department, Höglandssjukhuset
Medicinkliniken

Jourshema och sökarnummer 2014-10-01

Bekl: 134 45 Reijer, Martin
Pirmek: 332 07, Wrede, Johan
Nett: mva 332:06 Sjövik, Per
Sekunderkpr dag 332 29, Eke, Charlotte
Sekundkpr kväll 332 91, Wiklund, Johan

Inf. Jour-biväx 35400
Pals 112
Sverig Svensk 081-175 49

FOKUS-patienter

Rensvens Telefon- Teknologiskt Datum
Med A 15 g 3 g 2014-06-05
Med B 17 g 2 g 2014-06-06
Med C 4 g 3 g 2014-06-05
Med D 7 g 3 g 2014-06-02
Med E 6 g 3 g 2014-06-02

Inskrivningsoversikt

Varande enhet: Med E och Eks
Medicinkliniken ansvarig enhet: Medicinkliniken Eks

Inskrivos patienter

| Plats | Frånvaro | Personnummer | Namn | Inskrivningsdatum | Information till inskrivning | Adress
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Camilla Strid, Medical department, Högländssjukhuset
2016-02-03

Daily control
Planning discharge from hospital

- Security receipt to the patient
- Focus information – self care – teach back
- Social and medical care planning
- Information transfer
- Esther cooperation network – contact security
- Common routines in the county council of Jönköping
Primary care should clearly be the basis for the patient's health care

From 150101: Care coordinator on each primary care unit in the county council of Jönköping (total 48 nurses)
Follow-up in primary care and municipality

- **Primary care** – Consultation is assessed and planned by the primary care physician and nurse

- **Municipality** - Patients in nursing homes; follow ups are planned in cooperation with the nurses in primary care and the assistance administrators.
Conclusion

• Hospital care will make complete / correct discharges

• Primary care should have a coordinator role to the focus patient, and is responsible to have a dialogue with the municipality's home healthcare to increase cooperation and security for both patients and the different professional categories.

• Home care that is closest to many of these patients will have a natural entrance to the patient's primary care and medically responsible physician and nurse.

For our common patients, this means a big improvement in quality and improved patient safety!
Safe and effective admission and discharge process in hospital

1. **Message Esther in Meddix** → **Discharge**
2. **Planning documentation**
3. **Message** → **Care planning - team**
   - Car plan
   - Education
   - Time
   - Risk assessment → **Discharge**
4. **Message/call – right personnel** → **Care planning in patient record and Meddix** → **Discharge**

Camilla Strid, Medical department, Höelandssjukhuset

2016-02-03
Who is in need for care planning?

- Patients who has changed needs (activity level)
- Patients in need for palliative care
- Always be considered in Focus patients
Care planning team

- Nurse and/or occupational therapists from the hospital meets Esther with relatives and municipality nurse, social worker and rehabilitation personals on the ward (in patient care)

OR

- ”Come home” intervention - where municipality nurse, social worker and rehabilitation personals meets Esther at home.