Improving Patient Safety During off Campus LOA “Leave Of Absence” Diagnostic Testing

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Background
Mass General Brigham’s Faulkner Hospital (BWFH) is a 375-bed community hospital closely affiliated with Brigham and Women’s hospital (BWH), which is located 2.5 miles away. Patient care at BWFH is supported by robust access to diagnostics and advanced testing from subspecialists located at BWH. To access some advanced diagnostic testing and procedures, patients are physically transported to the BWH campus, and then return to BWFH via a process called a Leave of Absence “LOA”. On average LOA is used for 1-2 patients daily. While LOA has provided access to timely tertiary care for BWFH based patients, multiple stakeholders have identified patient safety issues related to this process.

Purpose
• Evaluate the current process for LOA from BWFH to BWH.
• Identify best practices and opportunities for quality and safety improvement for LOA
• Implement an improved process for LOA, without reducing patient access to timely advanced diagnostic or therapeutic procedures at BWH.

Description
• Reviewed reports of patient safety events from a variety of sources including: formal patient safety reports, adverse event reports, patient and family relations, and individual interviews with medical providers
• Data collected on the volume of LOA by BWH destination department and specific test or procedure
• Qualitative interviews were conducted with all departments at both hospitals involved in the LOA process including: Interventional radiology, diagnostic imaging, interventional-cardiology, gastroenterology, cardiology, and areas of risk included: communication and coordination of care challenges, lack of access to nursing support, no designated on campus assigned clinician, inability to disperse necessary medications including insulin or pain medications, delayed patient transport back to the BWFH campus

Examples / Results

Distribution of BWH destinations for LOA over a 12-month period

<table>
<thead>
<tr>
<th>Destination of LOA</th>
<th>BWH</th>
<th>BWHF</th>
<th>Mass General Brigham</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>315</td>
<td>196</td>
<td>12</td>
<td>18</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Case A, Ms. Heart</th>
<th>LOA to BWFH requested for Cardiac MRI</th>
<th>BWH team confirmed time of test and arranged transportation</th>
<th>BWFH unaware Ms. Heart was on high risk telemetry monitoring and could not provide needed RN support or on campus monitoring during testing</th>
<th>BWFH primary team unaware of telemetry consent, no opportunity to readiness the need for monitoring in priority of testing</th>
<th>BWH team unable to place new telemetry for Ms. Heart while on a LOA from his BWFH admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case B, Mr. Sweet</td>
<td>MRI ordered during the day but not scheduled until early evening</td>
<td>Post MRI, return transportation with BWFH was delayed by several hours due to ambulance staffing</td>
<td>While at BWFH, no clinical team assigned, no access to glucose monitoring, insulin or meals</td>
<td>The LOA check list created to anticipate and prepare for safe patient care during LOA</td>
<td></td>
</tr>
</tbody>
</table>

Example cases that highlight safety events that could occur during LOA

Case B Mr. Sweet
Pt with diabetes, admitted with back pain due to prior pacemaker placement

Case A, Ms. Heart
Admitted with atypical chest pain and ordered high risk telemetry. Additional cardiac imaging recommended at BWH

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<th>Description, cont.</th>
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• Best practices models were derived from high functioning departments with enhancements built to address specific patient safety concerns.
• Multidisciplinary teams were invited from both BWFH and BWH campus to review these results and create engagement from stakeholders at both campuses.
• Pre-LOA safety check list was designed (see graph) to embed best practice workflows consistently across LOA.
• Expectation and work flow created for situations when on campus MD, APP and RN provider support needed, and EMR updates to support new clinical order entry when necessary

Implementation
• Engagement with leadership across campus required multiple stakeholder meetings
• Some details of nursing responsibilities for non-sterile procedures at BWFH remain in discussion

Conclusions
• Access to advanced diagnostics and therapies via an LOA can be a valuable element of effective care in a community hospital setting
• LOA can also present important patient safety challenges including anticipating patient risks while off campus, and coordinating the safe transition of care
• Use of a pre-screening checklist can identify high risk patients and allow pre-planning for appropriate nursing support
• Easy access to department specific transfer algorithms and contact information for LOA within the hospital EMR can provide effective guidance and improve communication and coordination of care

Next Steps
• Continue to monitor patient safety events during LOA
• Address ongoing gaps in care coordination across campuses
• Support staff and provider education around best practices for LOA

Distribution of BWFH destinations for LOA over a 12-month period

7% of LOAs over 12 months had safety reports. Most safety reports (89%) fall into the Coordination of Care Category

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<th>LOA Related Safety Reports by Category November 2021 - October 2022</th>
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<td>EMS/Transport Issues</td>
</tr>
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<td>----------------------</td>
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<tr>
<td>Count of Safety Reports</td>
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