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| Example CLD Measurement guide |
| Appendix 11 – Criteria Led Discharge toolkit |
| OFFICIAL |

The following document provides some guidance as to how to build a case for change. This document should act as a supplementary resource when completing your organisation's business case template.

Criteria Led Discharge (CLD) has the potential to improve patient and staff experience, as well as improve health service delivery. This document explains why baseline data is important, suggested family of measures and there definitions and tips on collecting data to ascertain whether any changes introduced result in an improvement.

## Why do we need baseline measures?

The purpose of the baseline information is to assess the effect of the changes you are testing and to compare what happens before and after CLD has been introduced. Without baseline data, it's difficult to understand any changes or demonstrate progress. Baseline data collection is essential for us to learn the impact of the key processes and outcomes following the introduction of CLD. It allows us to observe any trends over time and to quantify the degree of intended benefits. The collection of baseline measures will also help test the suitability of the proposed measurement strategy and allow for adjustment of the measurement approach (and framework) if required.

## How do we baseline?

* Baseline measures capture retrospective data of the chosen cohort over a selected period of time.

There are two options to collect your baseline measures, and the one most appropriate for you will depend on the availability of decision support/business intelligence resources and what data is available in pre-existing data collection methods.

### Option 1 Utilise existing data collection (recommend exploring this option first):

Suggested steps

* Speak to your business intelligence team or equivalent to see whether the baseline measures are available retrospectively
* Request a report to be generated for all available measures that presents each measure weekly or monthly for the last 3-6 months prior to the commencement of testing changes to discharge processes through the introduction of CLD.

### Option 2 Manual retrospective review

**If your business intelligence team does not collect the measures needed, you will need to go back and review medical records. This can be a sample size e.g. 10 patient’s notes for each month.**

Suggested steps:

* Decide on your sample size from your selected cohort
* Number of patients to be reviewed
* How will you decide who to review? e.g. 2 discharges per week, first and last 5 discharges for the month
* Review records for each patient
* Calculate your monthly totals and note that this is a sample size

Please ensure it is clearly noted if a sample is used and use the sample number as your total number of patients (denominator).

## Other sources of data

The Victorian Agency for Health Information (VAHI) in partnership with the Planned Care Recovery and Reform program and Safer Care Victoria has developed the Surgery Quality and Safety dashboard. This dashboard includes important quality and safety measures including unintended readmissions and ED presentations to any Victorian hospital. This will help in the collection of readmission and ED representations. To gain access to the dashboard email [portal.support@vahi.vic.gov.au](mailto:portal.support@vahi.vic.gov.au).

## Other data collection considerations

Alongside the family of measures, it is also important to collect demographic data such as sex and cultural background e.g. Aboriginal or Torres strait islander or CLAD (culturally and linguistically diverse), to ensure health interventions are equitable. It allows health providers and policymakers to identify and address disparities that certain groups may face, ensuring that healthcare services are accessible and tailored to diverse needs.

## Presenting and sharing data

### Plot data over time

Improvement requires change, and change happens over time. To understand a system and how to make it better, we can gather data over time—like length of stay, volume, and patient satisfaction—and look for trends and patterns. Monitoring a few important measures over time is the most effective way for a team to track progress and make informed decisions. Using charts such as a run chart is a simple way to track changes over time.

### Seek usefulness, Not Perfection

Remember, measurement is not the goal; improvement is the goal. In order to move forward to the next step, a team needs just enough data to know whether changes are leading to improvement.  Also, try to leverage existing measures the team is already collecting data for and reporting on so it’s also easier and not additional work.

### Integrate Measurement into the daily routine

Valuable data can often be gathered without depending on complex information systems. Instead of waiting two months for the information systems department to provide data on patients' average hospital stay length, create a straightforward data collection form and assign someone to collect this data regularly as part of their responsibilities. Often, a few basic measures will give you all the information necessary.

### Share data to build momentum and celebrate success

Find a shared space to display data on the ward. Review data regularly as part of team meetings to inform next steps and celebrate improvements.

## Family of measures definitions

### Essential measures

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| **Measure** | **Definition** | **Tips on collection and analysing data** |
| **Length of stay (LOS)**  **(Outcome)** | Median\* LOS in days of the target cohort | How to calculate median: Arrange the data points from smallest to largest. If the number of data points is odd, the median is the middle data point in the list. If the number of data points is even, the median is the average of the two middle data points in the list.  **Tip:** This can also be done using Excel or similar programs |
| **Consumer experience (**[**see example questions**](bookmark://_Example_consumer_experience)**)**  **(Outcome)** | Ask patients a set of questions to measure their experience as a patient receiving CLD. | These questions are examples and can be adjusted to meet the needs of individual health services.  In addition to a set of questions consider collecting stories about patients’ experiences and sharing them with staff so they gain an understanding of the impact the discharge process can have on the patient experience both positive and negative. |
| **Staff experience (**[**see example questions**](bookmark://_Quality_improvement_tools)**)**  **(Outcome)** | Ask staff a set of questions to measure their experience using CLD. | These questions are examples and can be adjusted to meet the needs of individual health services.  **It is suggested at a minimum conduct a staff survey at the beginning and end of the change process.**  In addition to set questions consider collecting stories about the staff experience using CLD. |
| **% of patients discharge using CLD**  **(Process)** | A patient who is discharged using the clinical criteria for discharge that was established by the MDT on admission. This excludes patients who are escalated and removed for the CLD pathway. | When the process working effectively not all patients will be discharged using CLD. Effective CLD involves recognising when a patient is not suitable for discharge and escalating appropriately. |
| **Readmissions within 48hrs**  **(Balancing)** | Percentage of readmissions with 48hrs of discharge from target cohort\* | i) Number of readmissions – enter the number of readmissions within 48hrs (numerator)  ii) Total number of discharges from target ward/cohort (denominator) |
| Readmissions within 28 days  (Balancing/check) | Percentage of readmissions within 28days of discharge from target cohort\*\* | i) Number of readmissions – enter the number of readmissions within 28 days (numerator)  ii) Total number of discharges from target ward/cohort (denominator) |
| Presentations to ED within 48hrs and 28 days  (Balancing/check measure) | Percentage of representations to ED within 48hrs and 28 days from target cohort\*\* | i) Number of patients who represent to ED within 48hrs and 28 days of discharge (numerator)  ii) Total number of discharges from target cohort\*\* (denominator) |
| **Optional measures: choose measures that are relevant to your local aim and objectives** | | |
| **Measure** | **Definition** | **Tips on collection and analysing data** |
| **Time of discharge**  **(Outcome)** | Median\* time of discharge/transfer from ward for targeted cohort\*\* | How to calculate median: Arrange the data points from smallest to largest. If the number of data points is odd, the median is the middle data point in the list. If the number of data points is even, the median is the average of the two middle data points in the list.  **Tip:** This can also be done using Excel or similar programs |
| **Number or percentage of weekend discharges/transfers**  **(Outcome)** | The percentage of the chosen cohort\* that is discharged/transferred on a Saturday or Sunday |  |
| **Documented estimated discharge date (EDD)**  **(Process)** | Percentage of documented estimated discharge date (EDD) | i) Total number of patients in target cohort\* with documented EDD (numerator)  ii) Total number of patients discharged from target ward/cohort (denominator)  It is understood that EDD is often changed throughout the admission for this measure you want to capture the EDD set on admission to then compare this to the actual discharge date and see if the EDD was accurate or not. If a high % of patients EDD does not match the actual date of discharge this might indicate a need to review how the EDD is calculated. |
| **Discharge summaries completed within 48 hrs**  **(Balancing/check)** | Percentage of discharge summaries completed within 48 hrs of discharge | i) Number of discharge summaries completed within 48 hrs of discharge for target cohort\*\* (numerator)  ii) Total number of discharges for target ward/cohort (denominator) |

\*Using a median LOS instead of an average LOS makes the measure less affected by outliers or extreme values

\*\*Chosen cohort that CLD is being introduced e.g. surgical speciality or ward change is being tested in

References and resources

Institute for Healthcare Improvement (IHI) (2024) *Model for improvement: Establishing Measures*. Available at: <https://www.ihi.org/resources/how-to-improve/model-for-improvement-establishing-measures> (Accessed June 21st 2024)

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