Norrbotten, Sweden: The patient journey through emergency medical care

Part 1: General Information

Publication on EIP on AHA Portal	Yes
Copyright	Yes
Verification of the Good Practice	Yes
Evaluation of the Good Practice	No
Type of the Good Practice	Promising practice

Part 2: Description of the Good Practice

Name of the Good Practice	The patient journey through emergency medical care
Short name (Acronym)	IVAK
URL of the Good Practice	www.nll.se
Geographical scope	Local level
Country	Sweden
Region(s) involved	Norrbotten
Status of the Good Practice	On-going
Stakeholders involved	• Hospitals • Primary care centres • Home care centres • Nursing
Size of population covered	1,000-9,999
Targeted audience	65-79; 80+

Summary of the Good Practice

Our goal has been to reduce the transportations and provide better accessibility for patients to local hospitals. Everyone who seeks the hospital gets a call and a prioritizing where we determine the level of care according to an interview guide. Then, we take care of the sick patients directly, while others who are not acutely ill refer to other instances. This saves energy and time for the elderly. They may also meet familiar health professionals, without long waiting times. The references are made both at the hospital and from the ambulances in Piteå. Many times, the paramedics to meet the person's needs are done already in their homes by treating and safeguarding patients directly, without bringing them to the hospital. We work together with the patient through the use of person-centred care. We listen to the patient's story, forming a partnership with the elderly and documenting what we come up with together. Person-centred care means to respect and acknowledge the person's experiences and interpretation of health and illness and to promote health for this particular individual. We often interact with the elderly, health centres, home care, district nurses and with the patient in order to find the most convenient solution. The patient receives a folder where we write down what we agreed on and how all the vital parameters. Here, the elderly get information about where to call. The patient also receives the name

of the health care professionals as they talked to. We see the patient as a capable person with resources and abilities. Introducing this method had reduced the need for emergency and intensive care and increased the patient safety.
Key words: Process working, collaboration
Good practice being part of the larger programme No.
Challenges / problems addressed by the good practice Our goal has been to reduce the transportations and provide better accessibility for patients to local hospitals
Importance of the challenges / problems before starting to implement good practice To improve the care and continuum of care for the elderly people, it is important to short down the time for waiting and reduce the number of unnecessary care contacts. Also patients, who already are, at the hospital must be followed up and if worsening occurs in the vital parameters, monitoring must be conducted, as soon as possible.
Environment before the good practice was implemented Before the development work began, the emergency care in Pitea worked by conventional methods with little interaction between internal and external stakeholders.
Key innovative elements of the good practice and how the good practice improved situation compared to previous practice We work for right care to right patient at the right time, provided by right professional. In order to meet future needs, we have adapted to the urgent care for today's conditions. Our aim is that the patients are provided a well- coordinated care chain where the transitions between the different institutions are covered. Keywords are process thinking and collaboration. Our improvement efforts have improved and make it easier for patients to get a well- coordinated way in the care chain. Today, many patients who call the ambulance are secured already in the home and get an assessment according to a standardized approach. Then they can be cared for directly, be referred another health-care provider, get support for self-care or brought to the Emergency Department, depending on the results from the assessment. Previous, the ambulance brings all the patients to the hospital, when they had been alerted to it. This led to long waiting lists and unnecessary journeys back and forth home and hospital. In Piteå, priorities have led to an improved flow for the patients. The sickest is quickly disposed of while non-acutely ill patients are referred to other health care providers or self-care, depending on the situation. Non-value adding time for our patients is decreasing and those who are acutely ill receive emergency medical care right away. From the intensive care, we can support the hospital's other divisions; since we have introduced a standardized evaluation method. All estimates according to an

assessment and we know exactly when to alert on. It doesn't matter who conducted the assessment. The titles they find patients who are deteriorating and they get emergency care faster than before. In the past it sometimes took a long time to find these patients and handling was different depending on experience, time of day, and profession. In every stage of this improvement, we have used person-centred care. We listen to the patient's story, forming a partnership and documenting what we come up with together. To work based on person-centred care gives patients more satisfaction and everyone gets a larger picture of the patients' whole situation. In addition patients who are involved in decisions concerning their health care can "speed up" the rehabilitation process and professionals and patient can work towards common goals.

Part 3: Transferability of the Good Practice

Cost-effectiveness of the good practice (including all kind of costs and outcomes such as better health, quality of life or other resources)	Lower costs, improved outcomes
Resources required for the deployment of the good practice (personnel, equipment, facilities, ICT and other resources required. To deploy the example is (only) education of health care providers required, concerning the changing approach.	
Total budget of the Good Practice	Not available
Source of funding	Local funding
The main actions that have to be done to deploy the Good Practice The above described improvement work does not require resources in terms of equipment or personnel. What is needed is preparatory meetings where managers and health care providers from relevant organisations collaborate and take decisions on how to act and how to work. All staff has received training and introduction in the new way of working, so that they can feel secure with the new way of working.	
Issues during the implementation of the Good Practice Improvement works take time and it is important to include all staff professionals at the same. In all our improvements, we have been working with interdisciplinary groups so that all personnel come to speak. In today's health care is in short supply. We want to do a lot, but we have to prioritize the time so that it is enough for a lot. Emergency medical care is difficult to plan because we rarely have a steady business without "peaks and dales". Sometimes it is hard to get the managers with you, since they may not be familiar with the topic/activity. They may not see the long-term achievements by working with improvement work. Our ambition has been to influence the whole patient journey through the health care, this requires the involvement of many actors. The difficulty can be to get everyone to make quick profits. Often leads one to the other and the achievements gains first in the long run.	

Additional resources required to scale up Good Practice No.
Basis to support sustainability of the Good Practice We have included the County Council plan and the plan of the Division in the improvement process. In the work we see all as the winner. All working towards the same goal and everyone sees the benefits of change. Today, no one wants to change it back to the previous way of working. We have especially gained time by creating a unified vision and common documents that will guide us in our daily work. The improvement work has made that everyone feels like there are important persons in the process. Our range is unique and it will lead to many improvements for patients, staff and the economy. On all our meetings, we go through what achievements we make by highlighting statistics, benefits, hours and follow-ups. We also try to disseminate good examples to others by presenting our improvement work.
Evidence to observe the Good Practice A practice report.

Part 4: Viability assessment of the Good Practice

Time needed to deploy the Good Practice Less than a year. Right now, we continue our improvement by interacting with other actors such as: other clinics at the hospital, primary care, and management. It is important to have meetings and partnership meetings to inform and involve everyone in the way of working in the future health care. Together, we can continue to improve the patient journey through the healthcare system so that it is efficient and effective. Process leader convenes and chairs the meetings. First on the agenda is our monitoring locations which we want to observe, care for, monitor and treat our patients. Many times, patients can stay for observation, while waiting for a non-emergency transport or while waiting for test results or given treatment and then go home without having to be admitted to a ward. We see this as a new part of our improvement, team work similarly.
Investment per citizens / patient / client in terms of financial resources No available calculation.
Evidence behind the Good Practice Apparent evidence. Evidence is based on qualitative success stories. By continuing to follow up the statistics both from the ambulance transportations' and the work inside the ambulance and the statistics from the acute health care in our patient

documentation system (VAS), the benefits can be shown continuously.
Maturity of the Good Practice Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept. We have implemented the improvement work in ordinary work tasks and, also, have plans to continue to work with other challengers.
Estimated time of impact of the Good Practice Low impact – e.g. impact has been seen only while a pilot project was running
Impact observed Shorter stay in hospital (economic). Emergency medical care resources are now used more efficiently. The ambulances are tangible for the new missions with higher priority. The ambulances remain on each city to a greater extent. The Emergency Department at Piteå hospital are getting into fewer people, this leads to more time to the people who need emergency care. The patients avoid unnecessary transports. Better accessibility for patients to local hospitals. Increased patient safety by getting all staff to do the same in a standardized way of working. Better patient security through assessment and follow-up meetings. Fewer hospital visits. Fewer care contacts. Economic savings to find the patients deteriorates rapidly leads to economic gains, decreased cardiac arrest and shortened treatment times. Similarly, we see a win for patients where the paramedics can facilitate/support staff at homes for the elderly. Patients can remain in their normal environment. Person-centred care, this means that the person will be seen as a resource and as an expert himself.
Transferability of the Good Practice Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way.

Part 5: Your organisation

Name of the organisation	The County Council of Norrbotten, IVAK Pitea hospital
Address of the organisation	Norrbottens läns landsting Piteå sjukhus, Akutsjukvården Lasarettsvägen 94150 Piteå
Type of organisation	Hospitals
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