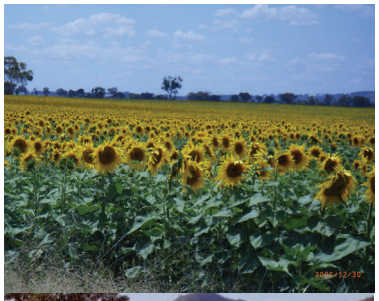





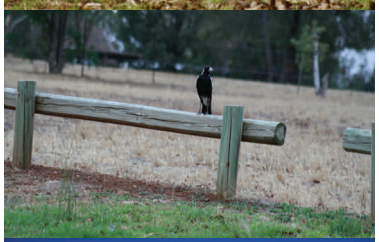


BARIATRIC PATIENT JOURNEY

HETI
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Background

Patients presenting to hospital frequently need assistance to move between departments, to and from equipment, change posture for tests or procedures and everyday care or hygiene activities. With obese and bariatric patients this poses specific challenges. At present staff members experience with bariatric patients are identified within their own departments and work roles. The commonality of issues and needs related to patient handling and transfers are not readily identified across the hospital.

Study design and methods

The study compares rural Australian experience in a single facility with the five generic risk categories in bariatric patient pathways identified in the British study by Hignett et al (2007)[1]. This qualitative study used an action research methodology with staff interviews, patient journey modelling and interviewer-administered patient feedback questionnaires. Essomenic Patient Journey Modelling software for health care settings by Curry (2007)[2] was used to analyse processes, with focus group input for proposed changes and an improved model of service delivery.

Results

Content analysis of six key staff interview transcripts and the patient journey modelling of four inpatient pathways identified obstacles across the five generic risk categories of equipment, patient factors, building and design, communication and organisational factors. Ishikawa diagrams present two issues identified through second level analysis of staff interviews and demonstrate the interactions of risk categories and consequences. Pattern matching was used to compare the five generic risk categories with the obstacles identified for both staff interviews and patient journey modelling. A diagrammatic synthesis of all obstacles is presented. A report of 12 key recommendations in action plan format and a proposed bariatric patient model was provided to the health facility.

Discussion

There were confounding effects identified where obstacles were present across multiple risk categories. The diagrammatic Essomenic Patient Journey Modelling provides a tool for clear presentation and communication of obstacles to safety as they occurred in patient pathways and to present an improved model of care. The research demonstrates obstacles to safety with bariatric patients who are normally independently mobile.

Conclusion

The five generic risk categories in bariatric patient pathways identified in the British study by Hignett et al (2007)[1], concerning equipment, patient factors, building and design, communication and organisational factors were clearly present in a large rural Australian hospital. It is beneficial for health facilities to identify their own specific obstacles to manual handling safety with bariatric patients to see what currently happens and facilitate appropriate targeted intervention strategies.

Recommendations include improving communication through advance notice and patient alerts and the provision of patient mobility assessment information. A culture of safety should be fostered by reporting bariatric patient issues and incidents; review resources needed to support implementing the facility's procedure for management of bariatric patients and training in consistent safe patient handling techniques, with wardsperson and nursing staff sharing tasks. A range of improvements in equipment were identified including the need for visible SWL, additional bariatric equipment, equipment trials and prioritisation for funding, better access to equipment and need for preventative maintenance.

For the full report on this project visit our website, follow the link to the Rural Research Capacity Building Program and click on 'view completed projects'

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