Emergency Care Improvement Programme

Safer, faster, better care for patients

The SAFER patient flow bundle

Red to Green days

Steve Christian

26th May 2016

@SteChristian21

Does Edward Bear sound familiar?

Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think about it.

A study by Richardson found a 43% increase in mortality at 10 days after admission through a crowded A&E

Richardson DB. *Increase in patient mortality at 10 days associated with emergency department overcrowding*. Med J Aust*2006;184:213-6*

For patients who are seen and discharged from an A&E, *the longer they have waited to be seen*, the higher the chance that they will die during the following 7 days

- Guttmann A, Schull MJ, Vermeulen MJ, Stukel TA. *Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada*. BMJ*2011;342:d2983*

10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80

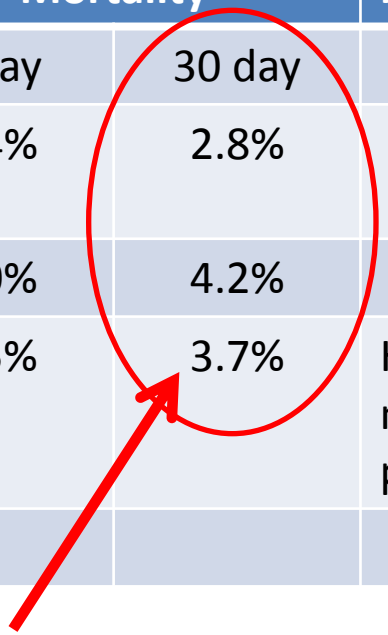
Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity. Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

Pines found that in crowded emergency departments, administration of 70% of prescribed IV antibiotics for patients with community acquired pneumonia were delayed over 4 hours

Pines JM et al. *The impact of emergency department crowding measures on time to antibiotics for patients with community acquired pneumonia*. Annals of Emergency Medicine, 2005, 50(5):510-516

Patients outlying on the wrong ward: 50% higher mortality; adds 2 days to length of stay

	Ave LoS	Readmissions		Mortality		Notes
		7 day	30 day	7 day	30 day	
Non-Boarded	2.3	4.6%	7.5%	1.4%	2.8%	
Boarded	6.5	7.5%	11.0%	2.0%	4.2%	
Wards boarding pts out	4.2	4.8%	10%	2.5%	3.7%	Highest no of patients



Mortality on wards that outlie patients is 30% higher than on those that don't

Lowering levels of bed occupancy is associated with decreased inhospital mortality and improved performance on the 4-hour target in a UK District General Hospital

D G Boden,[1] A Agarwal,[2] T Hussain,[2] S J Martin,[2] N Radford,[3] M S Riyat,[1] K So,[1] Y Su,[4] A Turvey,[5] C I Whale[2]

- Mean medical bed occupancy decreased significantly from 93.7% to 90.2% (p=0.02)
- Mean reduction in all markers of mortality (range 4.5–4.8%). SHMI (p=0.02) and crude mortality (p=0.018) showed significant trend changes after intervention
- Improved 95% performance

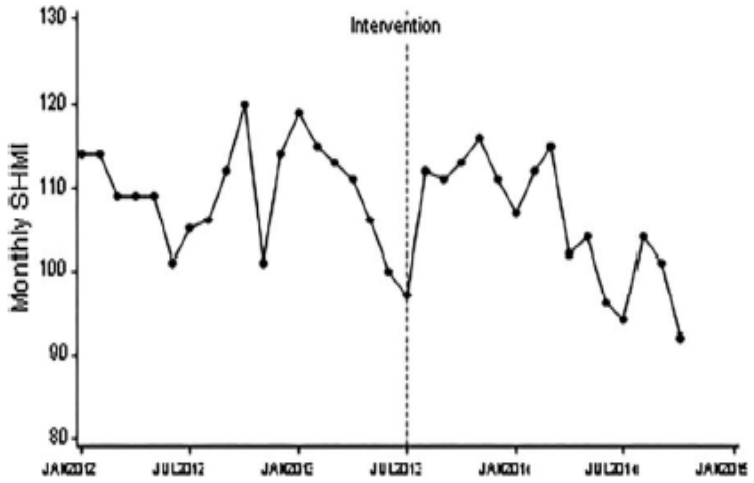


Figure 4 Monthly summary hospital-level mortality indicator (SHMI) (January 2012–October 2014).

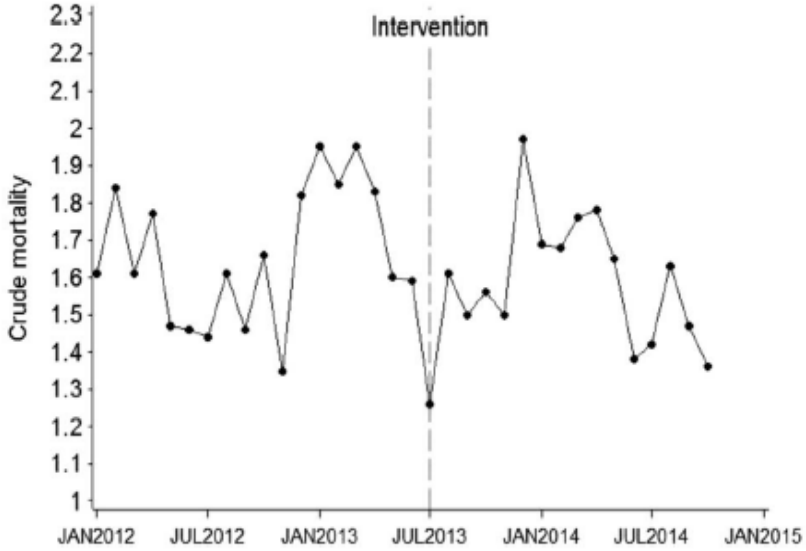


Figure 5 Monthly crude mortality (January 2012–October 2014).

ECIP's focus

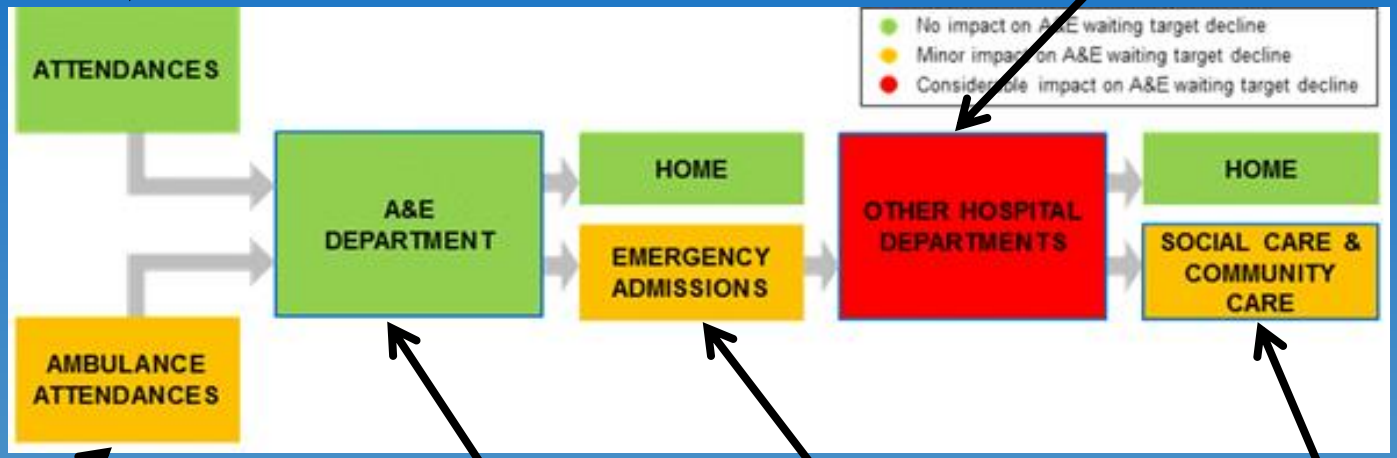
Whole system

***Governance**
***Leadership**

Primary care, mental health, community health services and NHS 111

Frailty pathways

*In-hospital flow
*Ward processes
*Discharge



*Ambulance handover
*Queuing
*Alternative pathways

*Crowding
*Escalation
*Streaming
*Assessment
*Control

*Front-end
*Assessment units
*Short stay
*Ambulatory emergency care

*Health and social care interface
*Voluntary sector

EMA Emergency Medicine Australasia

Emergency Medicine Australasia (2016) 28, 164–170 doi: 10.1111/1742-6723.12543

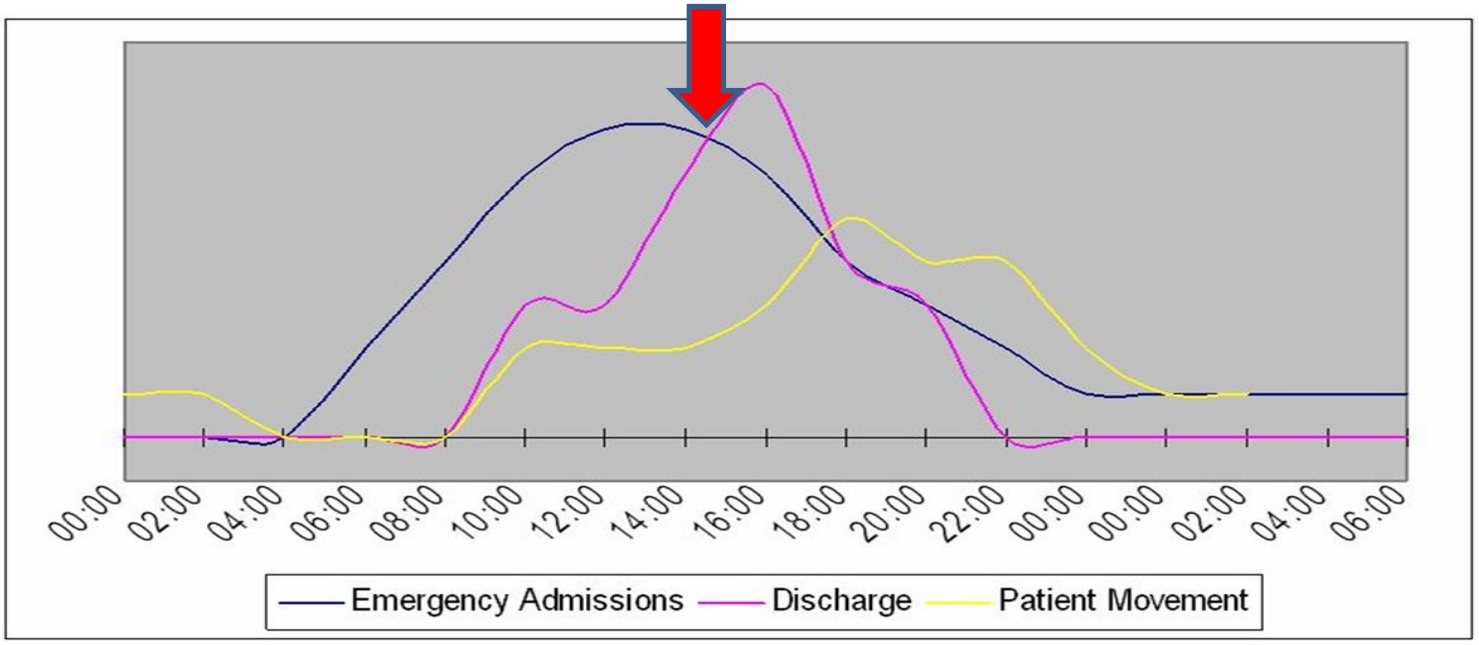
ORIGINAL RESEARCH

Discharge timeliness and its impact on hospital crowding and emergency department flow performance

Sankalp KHANNA,[1] David SIER,[2] Justin BOYLE[1] and Kathryn ZEITZ[3]

[1]CSIRO Australian e-Health Research Centre, Brisbane, Queensland, Australia, [2]CSIRO Digital Productivity Flagship, Melbourne, Victoria, Australia, and [3]Mental Health Directorate, Central Adelaide Local Health Network, Adelaide, South Australia, Australia

- "Changing the timing of when patients are discharged from hospital can improve patient flow – not just inpatient flow but also ED performance"



TTOs – do nursing staff chase them daily?

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The Patient Journey…

The health system delivers the required care, is it in a time frame that suits the patient, carer or staff ?

Waiting + Sleep Deprivation = Deconditioning

Physical
Cognitive
Psychological
Social

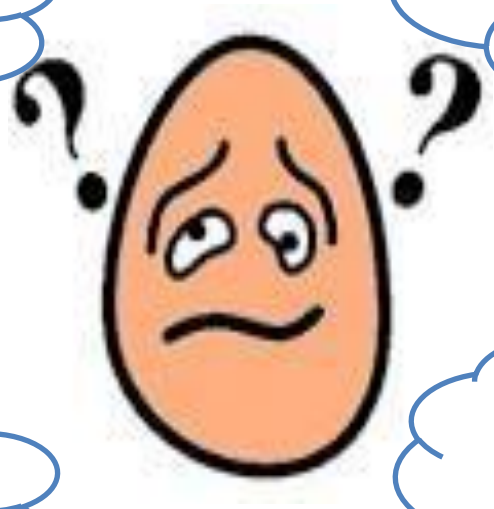
By reducing the waiting time overall LOS is reduced without changing the clinical care received by the patient

Back to Basics…The Patient

From the time of admission, all patients (and their carers) need to know four things

When can I expect to go home?

How well do I need to be before I can go home? You do not know my baseline in hospitall?



What is going to happen to me today?

What is going to happen to me tomorrow?

It is important that patients are actively engaged in the discharge process as this promotes realistic expectations and can improve outcomes, self-care ability and patient experience.

Is putting a man on the moon the same (in principle) – as raising a child?

Complicated

Complex

Simple Rules and doing what is known to work each day every day

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NHS

SAFER

Patient Flow Bundle

The patient flow bundle is similar to a clinical care bundle. It is a combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients.

If we routinely undertake all the elements of the SAFER patient flow bundle we will improve the journey our patient's experience by reducing unnecessary waiting

Safer Faster Better - http://www.ecip.nhs.uk/Resource/Safer-Faster-Better

The SAFER Patient Flow Bundle

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S - **Senior** Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – **All** patients will have an **Expected Discharge Date and Clinical Criteria for Discharge**. This is set assuming ideal recovery and assuming no unnecessary waiting.

F - **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – **Early discharge. 33%** of patients will be discharged from base inpatient wards before midday.

R – **Review**. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

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Senior Review

The Board Round introduces structure to the day to day running of the ward and helps the ward team to manage the patients safely and effectively

Board Rounds

Initial early Review

- Consider sick and unstable patients first – is the patient deteriorating? What actions are required?
- Have new patients been given an Expected Date of Discharge (EDD) and Clinical Criteria for Discharge (CCD) that the MDT agree on?
- Are there any patients to be discharged today/tomorrow? What needs to be done to ensure they go before midday?
- Are there any delays that need to be expedited?

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Senior Review

The ward round should promote a consistent organised and disciplined approach to ensure an efficient use of time and resources , ensuring care is coordinated appropriately

MDT one-stop Ward Rounds

- The ward round should follow the board round in the morning each day
- Use a ward round checklist
- Patients should be seen in a specific order:
  - Sick unstable patients
  - Potential discharges
  - The remaining patients
- A record of the round, with clear management plans, should be written in the patient's notes
- TTOs /TTAs (medication) should be prescribed and diagnostics ordered in real time or beforehand
- Identify patients for early discharge tomorrow

Reduce variation in ward rounds

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Western Sussex Hospitals Wards Round Considerative Checklist

Make one member of the team the "Safety Checker" who uses this checklist before leaving each patient.

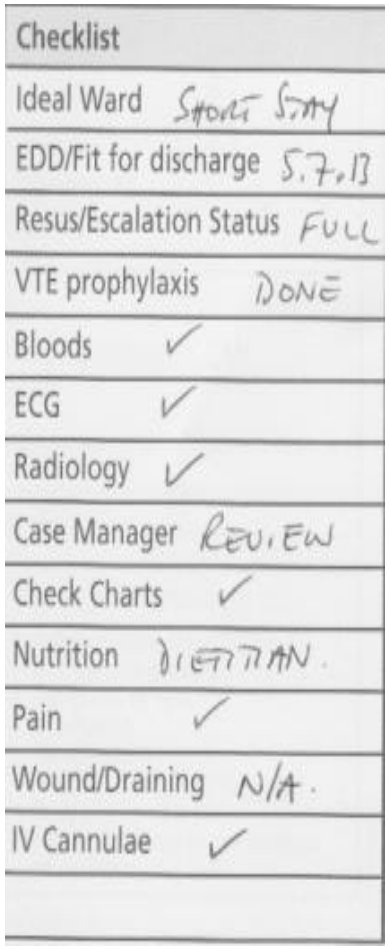
The checker must highlight anything omitted, speak up and get it done!

Key = ☐ **these sections must be checked in all patients**

Date	Checker's Name	Checker's Status	Signed	Clinical Team	Type of Round
…/…./2010					Routine/Post take
Start time	Finish time	Number of patients	Number of doctors on team		

Aspect of Care	Item done	√	Not yet done	O	Not applicable	-------	
Patient Initials							
Bed number							
Preparatory Discussions	**Preparation Before Going to the Bedside**						
Filed Notes in Main Notes							
Checked New Results							
Clinical Thinking * Nurse present during discussion							
Consultation	**Patient Consultation**						
Ask and Listen							
Focussed exam							
Pain or discomfort?							
Eating and Drinking							
Diarrhoea / Constipation							
Urine / catheter							
Cannula and iv lines							
Skin mouth + eye care							
DVT prophylaxis							
Wounds and Drains							
Nurse present at bedside?							
Charts	**Check All Relevant Bedside Charts**						
Vital Signs (TPR etc)							
Drugs Chart							
Fluid Prescription/Balance							
Weight							
Diabetes / Glucose							
Discharge Planning	**Start Discharge Planning**						
EDD in notes?							
Discharge Team?							
Write TTOs now?							
Ceiling of Care							
And CPR Status							
Planning	**Agree Blood Tests, Radiology, Consider Need for Senior Advice or Referral**						
Agree Future Tests							
Referral or Senior Help?							
Documentation	**Write in the notes, consider need for night or weekend handover**						
Today's Note written?							
Weekend or Night Plan Needed?							
Sum up to: Patient							
Report back to Nurse							
Spoke with relatives?							

* Mark tick for nurse present during preparatory discussions



Dr Gordon Caldwell

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A

ALL Patient have an expected date of discharge and clinical criteria for discharge

Expected Date of Discharge (EDD) and the Clinical Criteria for Discharge (CCD) are the 'clinical goal' for each and every patient.

Expected Date of Discharge (EDD) & Clinical Criteria for Discharge (CCD)

- Has the patient's EDD been set within 24 hours of admission?
- Is the EDD realistic and does it reflect the actual date and time the patient is expected to go home?
- Has the EDD been reviewed? If the EDD has elapsed for non clinical reasons, display as EDD plus 1, 2,3 days etc
- Is Clinical Criteria for Discharge (CDD) documented?
- Is the patient aware of the **date and time** they are expected to go home? Have they been given a welcome card or letter? Do patients and / or their loved ones know what's going to happen today, tomorrow and what they need to do to leave hospital?

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F

Flow early from assessment units

Wards that routinely have patients transferred to them from assessment units on a daily basis will 'pull' the first (and appropriate patient before 10am every day to create the required capacity for incoming patients

Flow early from assessment units to IP wards

- Inpatient wards that routinely have patients transferred to them from assessment units need to 'pull 'the first patient to their wards before 10am everyday
- Ward and assessment unit teams will communicate effectively to ensure wards know the details of the next patient they need to 'pull' from the assessment unit ensuring there are no delays for patients
- By creating assessment unit capacity earlier in the day, unnecessary waiting for patients awaiting admission will be significantly reduced

Earlier discharge

Earlier discharge

- A third of discharges from inpatient wards should be before midday
- Patients are pre-prepared on admission for early discharge and use of the discharge lounge (if there is a discharge lounge)
- Non use of discharge lounge by exception (if there is a discharge lounge)
- TTOs/TTAs written up in advance or real time
- Patients transport arrangements confirmed
- Nurse led / facilitated discharge for patients with clear Clinical Criteria for Discharge (CCD)

R

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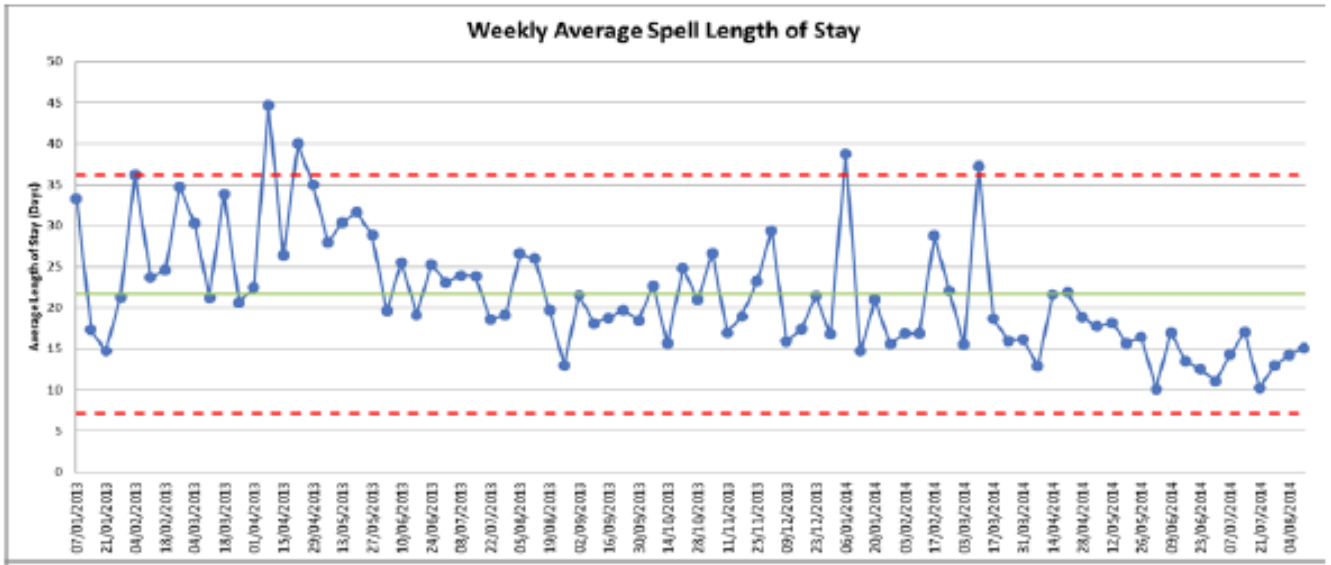
Review stranded patients (length of stay > 7 days)

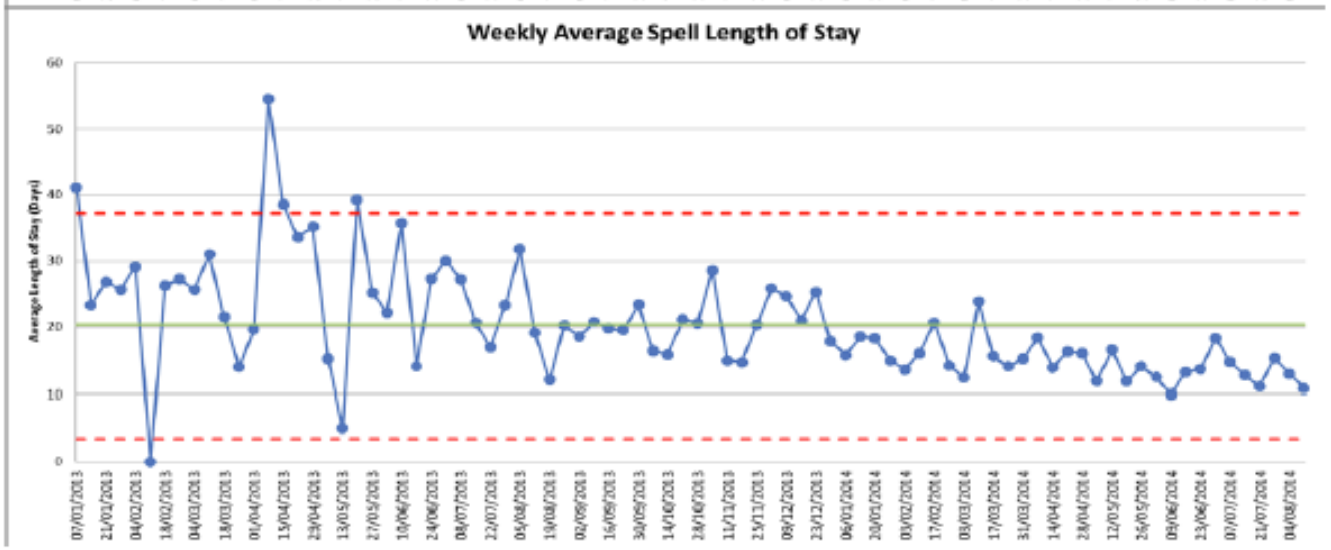
We need to proactively respond and reduce unnecessary waiting for stranded patients

Review of stranded patients

- Do all patients have clear management plans with Clinical Criteria for Discharge (CCD)
- Is the patient waiting for any procedures or tests? Do these need chasing?
- For the majority of patients, definitive assessment of social care needs should occur outside of hospital (discharge to assess).
- What is being done to expedite appropriate discharge and what could have been done earlier in the patients journey to prevent an extended length of stay
- Use red and green days to highlight non value adding days - http://wp.me/p5H5EW-1tQ
- Measure and track the stranded patient metric - http://wp.me/p5H5EW-1fC

SAFER in action





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The Challenge, *should you choose to accept…*

Red to **Green** Bed Days – Simple Rules

Red to Green Introduction

One approach that has proved to be popular with a number of NHS health and care systems is **red and green days**. It's a great example of using simple rules to help reduce delays for patients by making non value adding days (from a patients perspective) visible and a daily topic of conversation for clinical and managerial staff. It works particularly well when it is used across inpatient wards where patient 's often experience significant periods of time waiting for things to happen.

Green Bed Days

- A green day is a day when then patient has received an intervention that supports their journey through to discharge.
- Examples of what could constitute a ‘Green Day’
  - Formal review by the medical team, with clinical management plan being devised
  - Therapy assessment or intervention
  - A diagnostic intervention that supports the progress of the patient through their episode of care
- A Green day is a day when all that is planned or requested happened on the day it is requested, equalling a positive experience for the patient

Red Bed Days

- A Red day is when the patients not receive an intervention to support their pathways of care through to discharge.

- Examples of what constitutes a ‘Red Day’

  - A planned diagnostics is not undertaken as requested.
  - If planned therapy intervention does not occur
  - There is no senior clinical review ~ Monday to Friday
  - Medical management plans are not reflective of interventions and required outcomes to progress the patient’s pathway of care.

1) Introduce (or adapt) the Morning Board Round Ideally no longer than 20 minutes

- Start the Board Round (no later than 9am) with all patients marked as 'Red'.
- Use the Red and Green Bed Day Audit Form to record agreed actions and track progress, ***for every patient***.
- The purpose of the Board round is to ensure that the patient's case management plan is being progressed necessarily as an in-patient thus converting the day to Green. So, if a patient requires an investigation that day to progress their care, then the day will only become Green if the investigation occurs that day and there is a clear plan of what the action with regard to the result will be.
- The team assure themselves that they are clear what actions must be delivered to ensure the day is a 'Green Bed Day'. Having observations undertaken, oral medications, maintenance IV fluids do not make a day a Green Bed Day.
- Identify issues or delays for escalation…. And escalate

2) Afternoon Check and Challenge Process Ideally no longer than 10 minutes

- Review the Red and Green Bed Day Audit Form to check whether the required actions are completed for each patient.
- If not complete, explore further possibilities for resolution that day or as a priority action for the following morning.
- Identify issues or delays for escalation.
- Identify your ‘golden patient’ morning discharge for the following day before 10am. Contact site management following Check and Challenege to confirm name and time for a patient to be pulled to ward.
- Update the audit form; ensuring delays and issues are recorded.
- Record what worked well that day and any opportunities for improvement.

Benefits

- Supports good nursing leadership and day to day management of ward.
- Reduces time of Board Rounds with greater emphasis on action and adding value to patient's on-going care and recovery
- Improved numbers of early discharges.
- Identify opportunities for improvement at ward level – empowering staff to suggest and make changes.
- A visual tool to demonstrate improvement on a daily basis.
- Generates a real buzz.
- Reduces unnecessary waiting for our patients therefore improving the overall patient experience

"Slicker and Swifter"

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Conclusion

The SAFER patient flow bundle is similar to a clinical care bundle. Many hospitals have found that where the SAFER bundle becomes 'business as usual' on all hospital wards, length of stay falls and clinical outcomes improve. To ensure successful implementation of SAFER there are a number of essential components:

- **Clinical leadership** – implementation and sustaining momentum requires great clinical leadership supported by supportive operational teams.
- **Communication** – all staff need to be fully briefed and know all the elements of SAFER and why it will help patient flow and benefit patient safety.
- **Executive support** – senior teams need proactively to support the implementation of SAFER. The active involvement of all members of the executive team is important to success.
- **Measurement** – all elements of SAFER need to be measured using SPC run charts (statistical process control). All wards should have ***'knowing how you're doing boards'*** to demonstrate their success in delivering the five elements of the bundle
- **Social movement** – implementation of SAFER needs to be part of a well-managed improvement programme with clear plans and deadlines. A 'social movement' needs to be created to win hearts and minds. This involves leaders who are passionate about patient care creating compelling narratives that describe the link between implementing SAFER and improving patient care.

My Team


S
A
F
E
R
S
Senior Review before MIDDAY
A
All Patients have an Expected Discharge Date
F
FLOW of patients to commence early. IDENTIFY & PULL patients before 10am from AMU
E
Early discharge 33% discharged before MIDDAY
R
Review – MDT review of patients with >7 days LOS "Stranded Patients"
A Red day is when a patient is waiting for an action to progress their care and/or this action could take place out of the current setting.
A RED day is a day of NO VALUE for a patient
DATE 20/5/16
TODAY WE HAVE
8
RED BED DAYS
DATE 20/5/16
TODAY WE HAVE
17
GREEN BED DAYS
A GREEN day is a day of value for a patient
A Green day is when a patient receives an intervention that supports their pathway of care through to discharge
A Greenday is a day when all that is planned or requested happened on the day it is requested, equalling a positive experience for the patient
A Greenday is a day when the patient receives care that can only be delivered in a hospital bed

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Thank You

Create a Buzz, make it fun and promote SAFER in your ward, for your patient's !

@SteChristian21

Safer Faster Better

NHS England

Transforming urgent and emergency care services in England

Safer, faster, better: good practice in delivering urgent and emergency care

A guide for local health and social care communities