

What good looks like in the emergency pathway



[@ECISTNetwork](#)



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I'm going to cover

- The evidence
- Myths
- What we've found – over 150 engagements
- Why we need simple rules
- We recommend

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

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 Aust2006;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

- Guttman 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.* BMJ2011;342:d2983

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

- 48% of people over 85 die within one year of hospital admission

Imminence of death among hospital inpatients: Prevalent cohort study

David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 *Palliat Med*

**If you had 1000 days left to
live how many would you
chose to spend in hospital?**

- 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.

Patients outlying in 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 outly patients out 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 Whale²

- 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

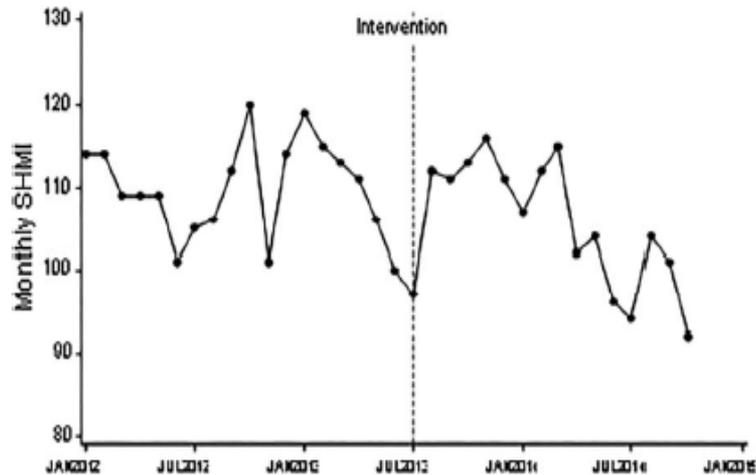


Figure 4 Monthly summary hospital-level mortality indicator (SHMI) (January 2012–October 2014).

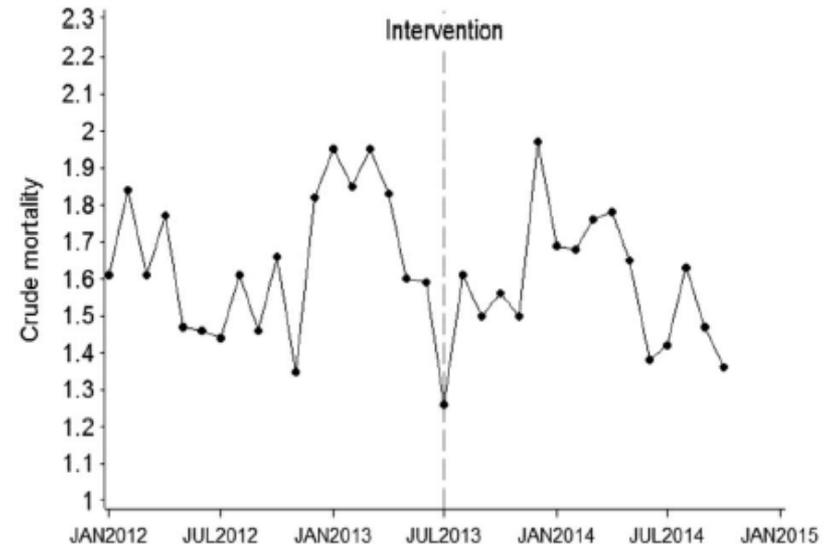
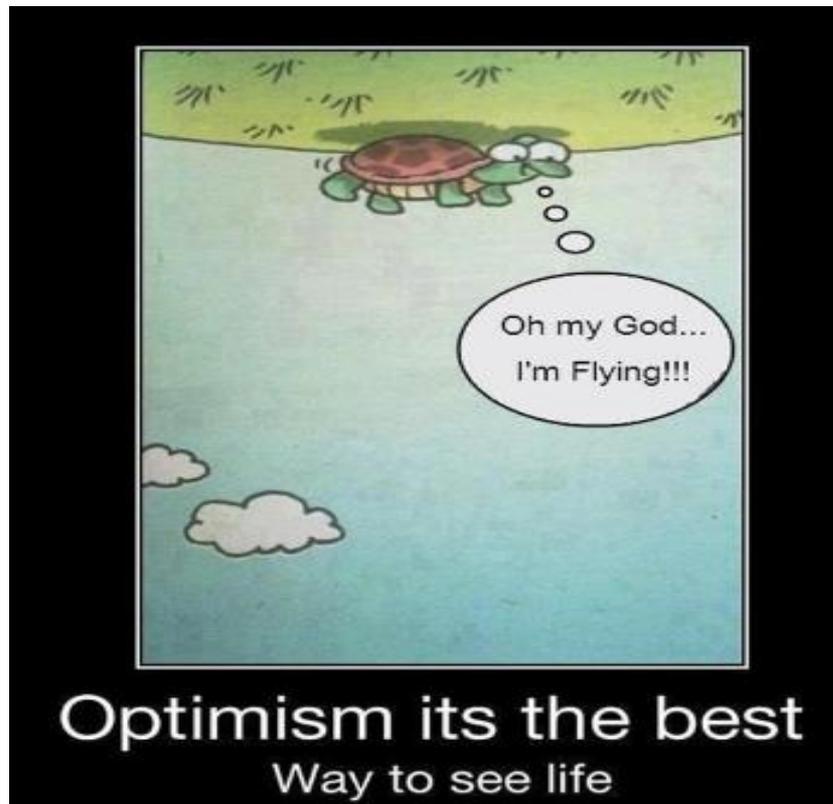


Figure 5 Monthly crude mortality (January 2012–October 2014).

Optimism bias – do you ever see this?

The tendency to overstate benefits and understate timescales, costs and risks of failure



Key learning from over 150 engagements with local health communities

Some comfortable myths:

- We lack acute capacity. Capacity is beds. We need more beds
- Spiralling demand from a sicker population is the problem
- Demand management of A&E attendances is the key
- Social care delays are the main cause of delayed transfers (DTOCs)
- 7-day working will solve most of the problems



What we have found

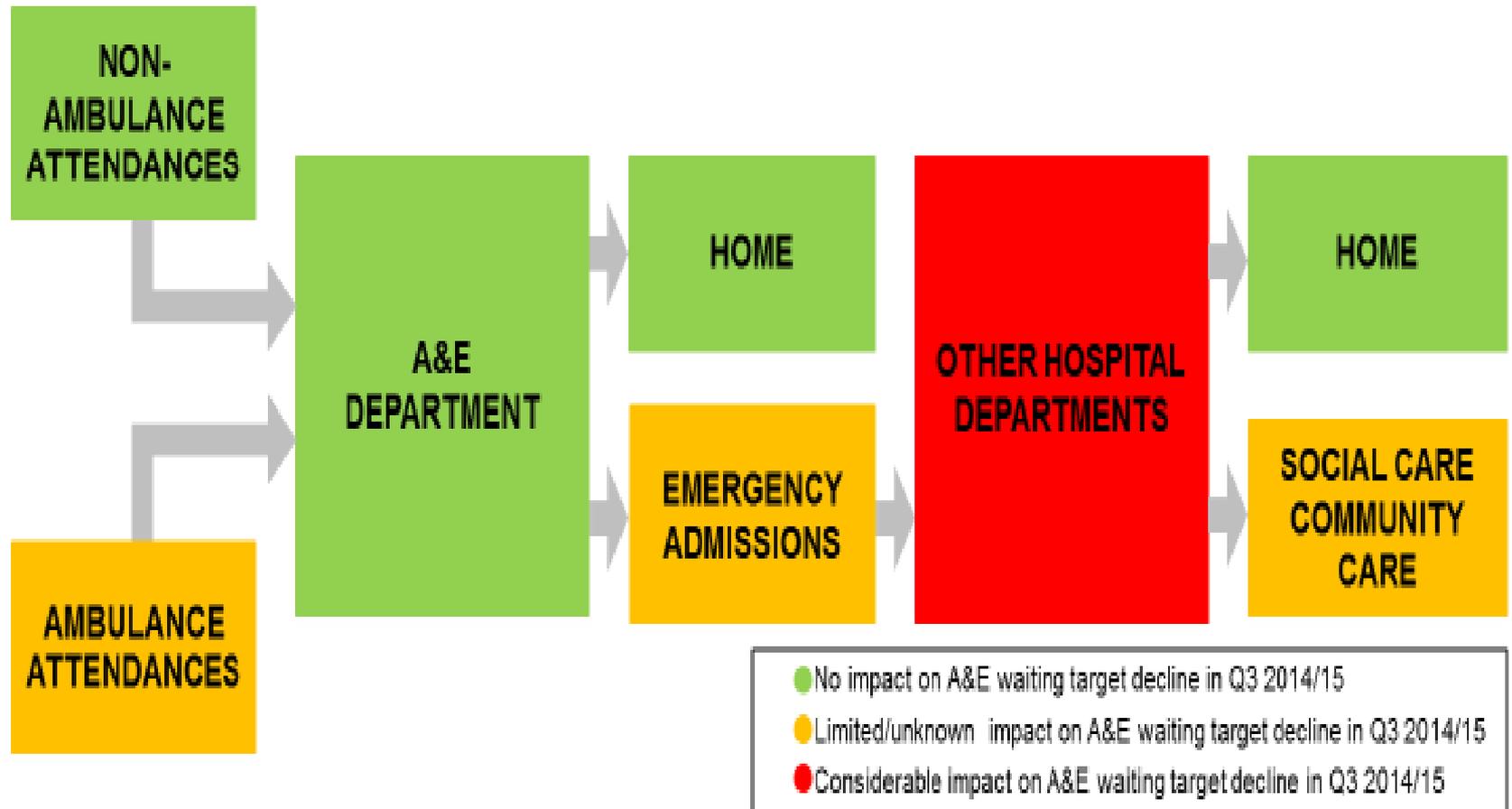
- Most hospitals have enough beds – different parts work at different paces
- Complexity rather than acuity is an issue as the population ages and becomes increasingly frail
- Current demand management schemes have weak impacts, often exaggerated
- NHS delays are twice those of social care delays
- Most delays are down to internal hospital processes
- Poor patient flow through acute inpatient beds is the key issue
- High bed occupancy is as much an in-day problem as an absolute one – left shifting the discharge profile can make a huge difference



What we have found (more)

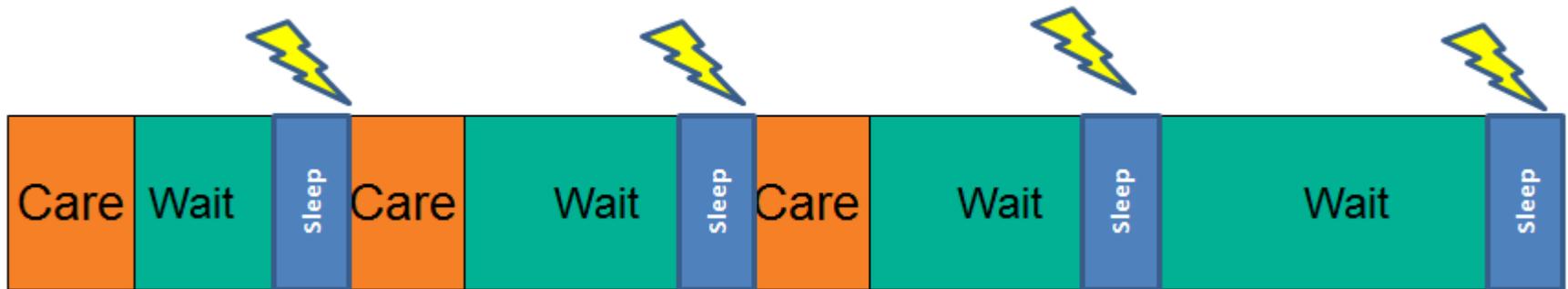
- Poor flow out of emergency departments is due to ‘outflow obstruction’
- Poor flow causes a spiral of hospital and ED crowding, outliers, stretched resources, harm and excess mortality – all of which push up length of stay
- Flow can be generated through effective ward and medical processes
- Closing beds for financial reasons without improving flow reduces resilience
- Out-of-hospital bed closures (community or care home beds) can destabilise the system if not matched by increased domiciliary capacity
- Lack of community or social care capacity (caused by staffing or funding issues), eventually destabilises even strong systems

Figure 2: Drivers of the decline in A&E performance against the four-hour target in Q3 2014/15



Key message - Beds aren't capacity

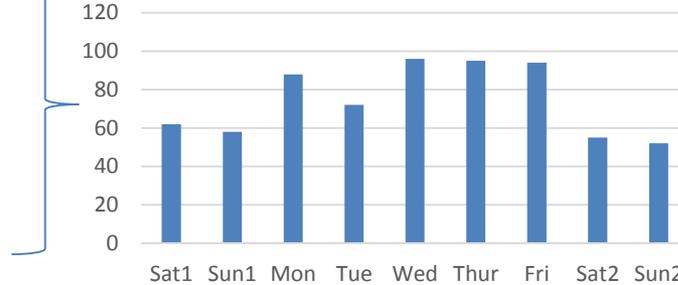
"Beds are where patients wait for the next thing to happen"



The weekend discharge rate from specialist medical wards?

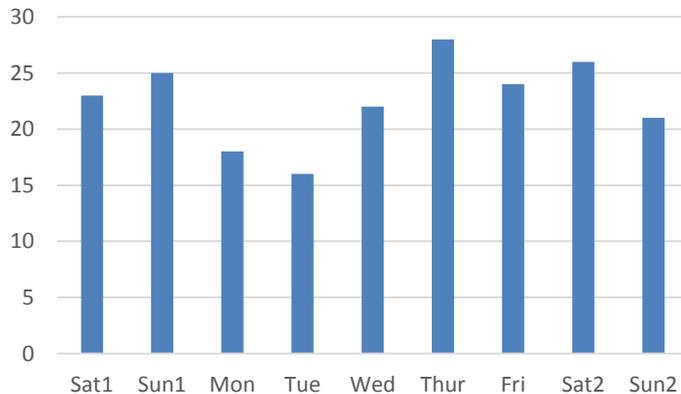
One hospital?

Total medical discharges by day
($p < 0.05$)

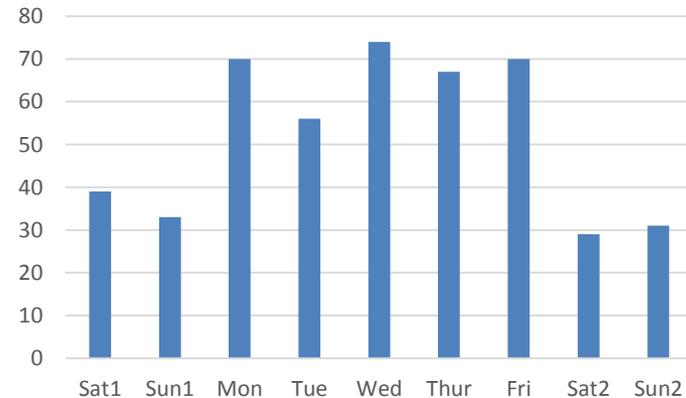


Two processes

General/acute medicine discharges
by day



Specialist medical discharges by
day ($p < 0.01$)



Age 66y
LoS 6.6d

Age 59y
LoS 3.4d

ORIGINAL RESEARCH

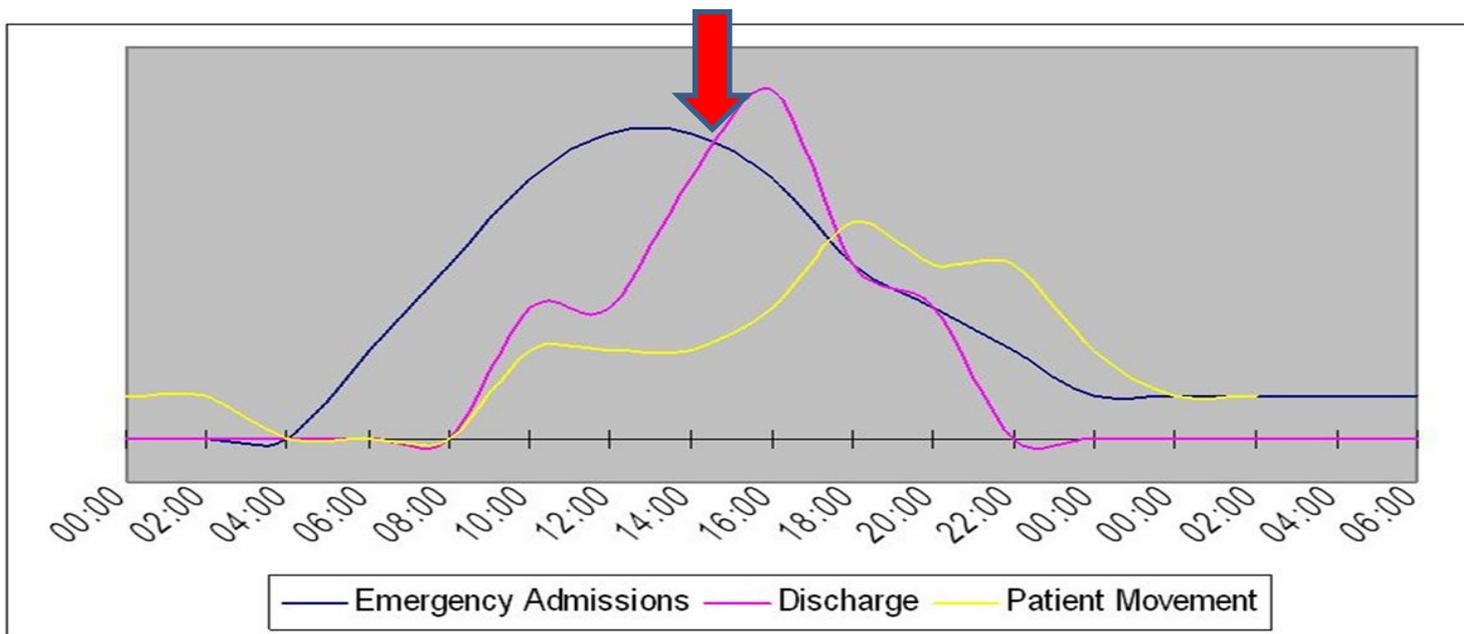
Discharge timeliness and its impact on hospital crowding and emergency department flow performance

Sankalp KHANNA,¹ David SIER,² Justin BOYLE¹ and Kathryn ZEITZ³

¹CSIRO Australian e-Health Research Centre, Brisbane, Queensland, Australia, ²CSIRO Digital Productivity Flagship, Melbourne, Victoria, Australia, and

³Mental 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?

Reduce variation in ward rounds

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 <i>N</i>	Not yet done <i>O</i>	Not applicable <i>-----</i>		
Patient Initials					
Bed number					
Preparatory Discussions					
Preparation Before Going to the Bedside					
Filed Notes in Main Notes					
Checked New Results					
<i>Clinical Thinking</i>					
* 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 G Caldwell January 2010

Checklist	
Ideal Ward	SHORT STAY
EDD/Fit for discharge	5.7.13
Resus/Escalation Status	FULL
VTE prophylaxis	DONE
Bloods	✓
ECG	✓
Radiology	✓
Case Manager	REVIEW
Check Charts	✓
Nutrition	DIETITIAN.
Pain	✓
Wound/Draining	N/A.
IV Cannulae	✓

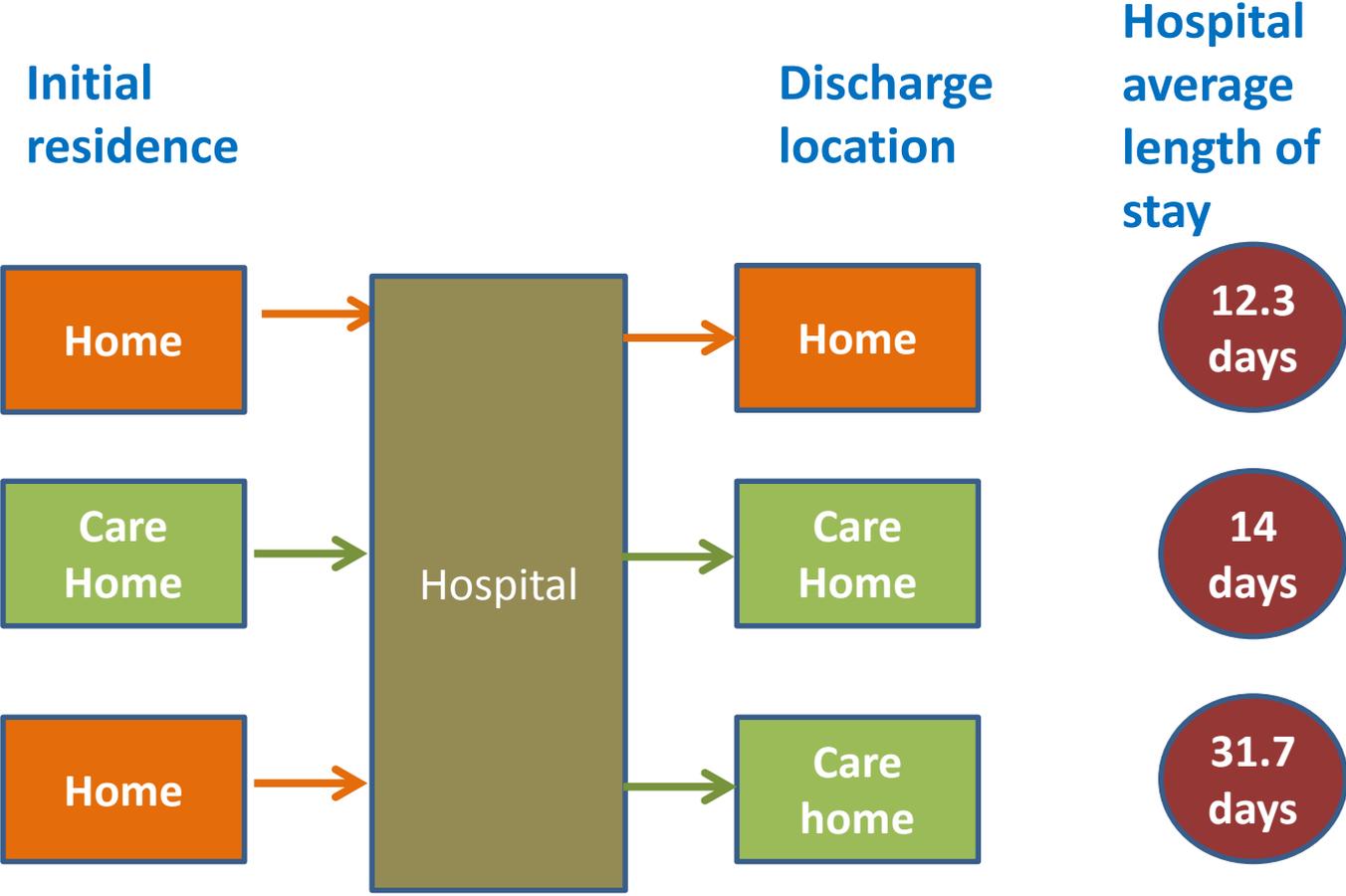
Demand management – target frail elders

Most studies suggest that admissions can be avoided in 20-30% of >75 year old frail persons

- Needs high quality decision making at time of admission (GPs or hospital Dr)
- Needs sufficient capacity in non acute settings – most notably intermediate care



Avoid 'bedded' discharge destinations where possible – we should 'discharge to assess'.



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



Complicated



Complex

The rules that govern complex systems are not the same as the rules that govern complicated systems



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



Red and Green Days

1 2

3 4

5

6

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

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.

- Could the current interventions be feasibly (not constrained by current service provision) delivered at home?
- If I saw this patient in out-patients, would their current 'physiological status' require immediate emergency admission?

If the answers are 1. Yes and 2. No, then this is a 'Red bed day'.

Examples of what constitutes a **Red** Day:

- Medical management plans do not include the expected date of discharge, the clinical criteria for discharge and the 'inputs' necessary to progress recovery
- A planned diagnostic/referral is not undertaken the day it is requested
- A planned therapy intervention does not occur
- The patient is in receipt of care that does not require a hospital bed.

A RED day is a day of no value for a patient

A **Green** day is when a patient receives an intervention that supports their pathway of care through to discharge

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

A **Green** day is a day when the patient receives care that can only be delivered in a hospital bed

A GREEN day is a day of value for a patient

The SAFER Patient Flow Bundle

S - Senior Review. All patients will have a senior review before midday.

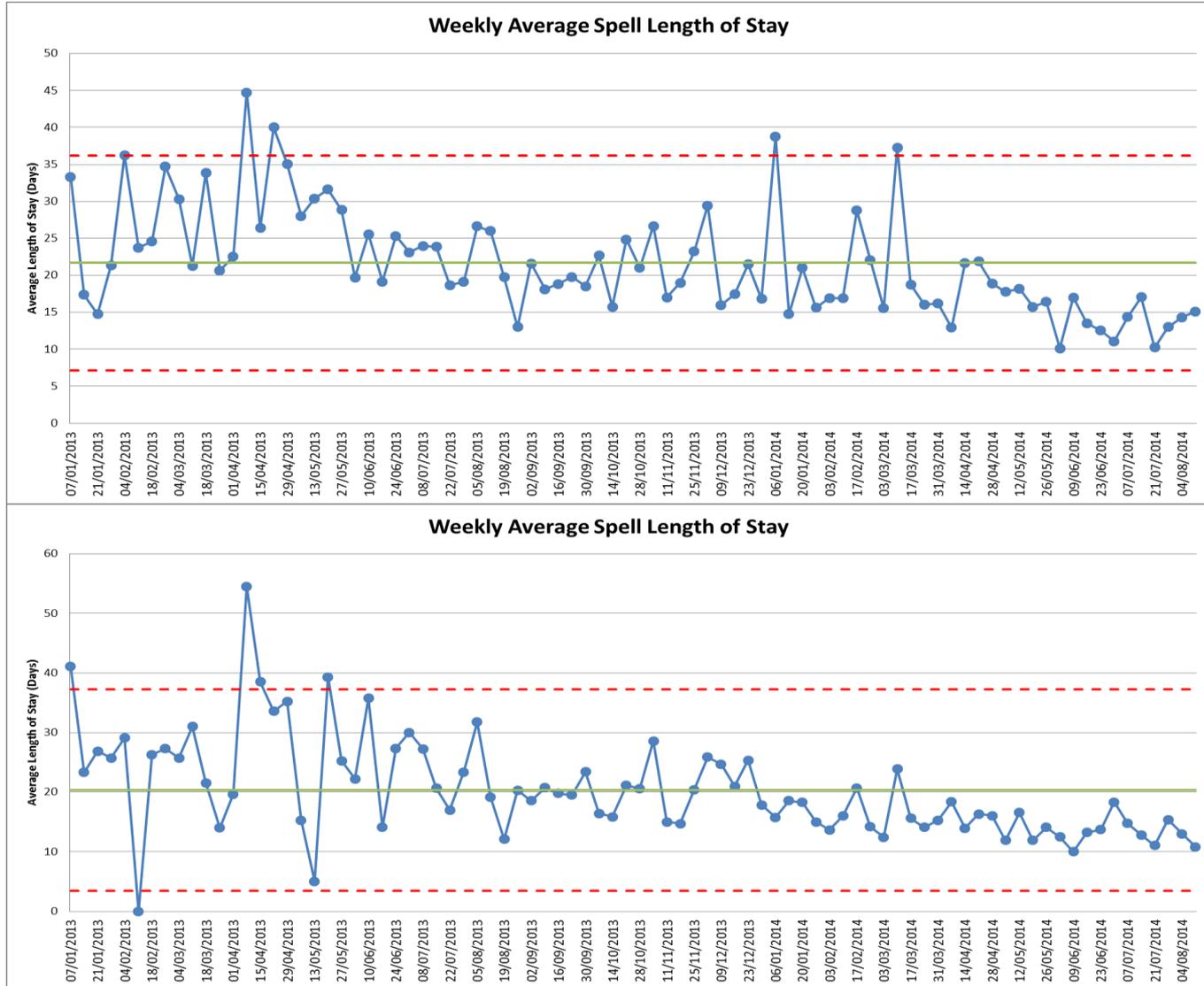
A - All patients will have an **Expected Discharge Date**. This is set assuming ideal recovery and assuming no unnecessary waiting. Do patients and / or their loved ones know what's going to happen today, tomorrow and what they need to do to leave hospital?

F - Flow of patients will commence at the earlier 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’ mindset.

SAFER patient flow bundle - examples from 2 medical wards



ASCH experiment – conforming to the group



What we recommend

- Target *demand management* on frail, older people:
 - General practice response
 - Intermediate care (including rapid response)
 - Care homes
- Get patients into the right ‘flow stream’ from the outset and avoid outliers
- Focus on flow beyond the ED
 - Early senior review
 - Daily senior reviews / board rounds
 - Focus on discharge:
 - SAFER bundle – simple rules day in day out
 - Red and green days
 - Ward round checklists



What we recommend (more)

- Implement ambulatory emergency care (include surgery)
- Implement a whole system frailty model with early CGA, rapid turnaround, discharge to assess
- Extend services into the evening, not just the weekend
- Try a 'perfect week' to put it all together and then try some more..
- Reduce distractions (where possible) that sap management resources



Summary

- Resources are often unevenly distributed, leading to bottlenecks.
- So we need to consider:
 - Redistributing resources to match capacity to emergency demand:
 - Invest in generalists, not more 'ologists'
 - 1:20 on calls are not acceptable
 - Think ward based consultants of many days
- Create the 24/hour hospital – 7/7 working is only part of the story
- Increase standardisation – simple rules for a complex adaptive system (e.g. SAFER or red and green days or both)

@ECISTNetwork on FabStuff

Recognize and Rescue

By Terri | March 14th, 2016

This Future Hospital Programme case study comes from Dr Mark Simmonds at Nottingham University Hospitals (NUH) NHS Trust. He describes how the 'Recognise and Rescue' programme is improving the care of the deteriorating patient.

Key recommendations

• [...]

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The way we do things here.....making internal professional standards work for you

By Pete Gordon | March 10th, 2016

The working relationships between people in an organisation are more powerful, positively or negatively, than a bookcase full of policies, procedures and escalation flow charts. The way professional staff work together can make or break [...]

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David Oliver: Who is to blame for older people's readmission?

By Pete Gordon | March 9th, 2016

Nurse practitioner for care homes supporting discharges in Acute hospital



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The Academy of Fab NHS Stuff and the ECIST Network

The emergency care intensive support team (ECIST) is a clinically led national NHS team that has been designed by clinicians to help health and care systems deliver high quality emergency care.

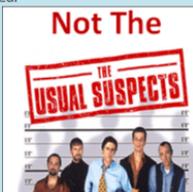
We have visited many health and care systems aiming to help them improve urgent and emergency care by encouraging the implementation of known good practice. One thing we consistently observe is amazing staff and the great ideas they have to improve urgent and emergency care. However, we often notice that staff feel a level of frustration that they can't share their ideas or link up with colleagues in other parts of the country who are doing similar jobs or who have similar ideas. Often these people aren't the 'usual suspects' e.g. people in senior management roles, but staff who each day every day see and know how improvements to urgent and emergency care can be made. It's these people in particular that we'd like to help connect with each other using the Academy of Fab NHS Stuff as the place where great improvement stories and ideas are shared.



ECIST's Medical Director Dr Vincent Connolly is really keen for clinicians to share the great stuff they are doing.

"We believe that meeting the challenge to improve urgent and emergency care requires clinical staff to engage in a conversation that will tease out the key service improvement steps needed for better patient outcomes."

ECIST love the Academy of Fab NHS Stuff and are delighted that they have kindly agreed to host



Submit Fab NHS Stuff for ECIST

Simply complete the fields below to tell us about your fab NHS stuff for ECIST in 500 words or less! You can add up to three optional images. Once submitted it will be reviewed by a member of our team and you will be emailed when it is published.

Title

Content (max approx. 500 words or 4000 characters)

Start with Safer Faster Better



Pete.gordon@nhs.net



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