

Continuous Flow at RCHT Phased Improvement Plan

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*Outstanding
Care for One+All*

Where we are 02/02/2024



- 3pm bed meeting- golden patient for each ward identified and AMU pull patient to specialty ward identified
- Every hour from 7 am 2 patients will leave ED and go to AMU. Day 2 patients should be prioritised for transfers to AMU as they have been waiting the longest for a bed and should have a more complete management plan (we note that infections, gender and acuity are also considered).
- At 7am 2 patients will leave AMU to 2 wards (Wellington, Roskear, Phoenix, Tintagel, Kerensa, Grenville, GLU) If there is no space available and no one is imminently leaving for home or the discharge lounge the leading team for that day will contact a member of the UEE, SSS and Spec Med triumverate to complete a risk assessment
- This risk assessment will include: a review of the PDD's, what actions those patients are awaiting and a review of the safest patient to await this ongoing care at home, in a chair on the ward, or in one of the available discharge lounge options. The tri will discuss this with the continuous flow team leading that day and the clinical team caring for that patient for full support and risk review.
- huddles on AMU to take place at 8.30, 9.30 and 10.30 with: AMU NIC, UEE MoD, SPEC Med MoD, AMU Matron. Once the 8.15 bed meeting has finished Site will join the 8.30
- The process will lead to AMU pushing (if not pulled) patients to base wards based on Golden patients and PDDs.
- If there are no specialty patients identified, or the specialty team hasn't pulled the specialty patient then the longest waiting general medical patient will be transferred
- If a 'pull' by the ward area is not achieved, AMU will send the most appropriate patient from their assessment which includes use of Nerve Centre specialty destination and assessment of gen med patients
- If unable to complete for any reason escalate to Care Group leadership team for support by 8.45 (during this first phase of this PDSA)
- To note, AMU discharge are additional to this model, despite the number of discharges 2 transfers from AMU are the target hourly.
- The Nurse in Charge is responsible for enacting this plan supported by the MoDs and Matrons from UEE and Spec Med and CPOC from ED.
- At 11.30 on AMU each day there will be a de-brief led by Ness, Natalie or PoC of what's worked well, what hasn't and what do we need to do next time to build on the test of change.

Issues with where we are



- There are not enough planned golden discharges in the teams document to prepare for the following day

ACTION: Ness will take a snip of the continuous flow patient list and golden patient list each day post 4.30 night planning session and send to the CD's for their information and action

- At 7 am and then every hour until 11am 2 patients will leave ED and go to AMU. Despite there being PDDs on each ward there is often feedback that it is not safe to sit out/move to discharge lounge until review and all actions completed

ACTION: all medical bed holding MoDs need to meet at 8.30, 9.30, 10.30, 11.30 on AMU to review and assess who could sit out/go to the lounge based on PDDs. If there is no resolve, then the MoD's need to escalate to their HoN to support. This currently is not happening as BAU and needs to happen to move forward. The risk assessment is as below

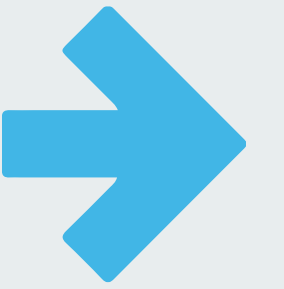
- This risk assessment will include: a review of the PDD's, what actions those patients are awaiting and a review of the safest patient to await this ongoing care at home, in a chair on the ward, or in one of the available discharge lounge options. The tri will discuss this with the continuous flow team leading that day and the clinical team caring for that patient for full support and risk review.
- The process will lead to AMU pushing (if not pulled) patients to base wards based on Golden patients and PDDs- this is challenging as MoDs aren't always at the huddles.

ACTION: MoDs to be at AMU huddles

- If there are no specialty patients identified, or the specialty team hasn't pulled the specialty patient then the longest waiting general medical patient will be transferred

ACTION: the pull patient is to be added to the night plan and specialty destination to be completed by specialty on Nervecentre

AMU Nurse in Charge Actions



7am NIC pulls the continuous flow list from the night plans and the PDD's for all medical wards

AMU NIC communicates with the base ward (aim is that base-wards start actively pulling) to confirm that the specialty destination patient for their ward is being pulled/received

If the AMU NIC and the base-wards are unable to agree a pull patient then this is escalated to the relevant MoDs for the areas

The MoDs risk assess with clinical teams the PDDs and risk assess for discharge lounge/TES/boarding

If by quarter to the hour no patients identified a member of each Care Group TRI to be contacted to be resolved

AMU will hold one patient in the corridor if continuous flow is unsuccessful until 12pm

Roadmap for the continuous flow test of change



Phase 1

MILESTONE 11/01/2024-

For 4 medical wards to start the continuous flow test of change. Roskear, Wellington, Phoenix and Tintagel 9-11.

Phase 2

MILESTONE 22/01/2024-05/02/2024

The addition of GLU, Grenville and Kerensa and extended times from 7-11

Confirmed the H+S and Fire advice as per slide 7

Created new night plan forms

Agreed funding to trail transfer team 24/7 for 4 weeks

Phase 3

MILESTONE 05/02/2024-26/02/2024

The addition of Lowen and Zennor to the test of change. This is all medical wards excluding wheal prosper in the model.

Addition of alerting the CD's to a reduced list of patients impacting flow.

Addition: HoN to be contacted of all medical holding wards when its not achieved

Embed: MoDs attending the 8.30, 9.30, 10.30, 11.30 huddle

Review of effectiveness of transfer team

Phase 4

MILESTONE 26/02/2024-11/03/2024

Extended times from 7am to 5pm, noting that no patients can be corridor holding after 12pm and this must be moves based on discharge lounge use, TES and PDD's

Aim is for 80% of PDDs to have been discharged by 5pm

To have a phase 5 plan for hours of 5-7

Areas where temporary corridor holding can take place, whilst awaiting a bed space – in extremis



- AMU
- Roskear/Welly (being mindful of the needs and behaviours of the holding patient and those possible waiting pleural procedures)
- Phoenix
- Tintagel (or additional bed in centre to wait)

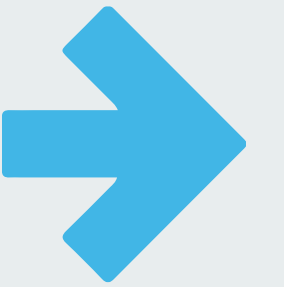
We need to ensure certain measures in place from a Fire Safety perspective. Fire review and approvals: Gary Martin

- The patient must be always supervised and cannot be left unattended (this will be from the ward the patient is waiting to enter).
- The beds are only allowed between 07:00-12:00 each day this must not be exceeded without a discussion with all members involved.
- The corridor must remain clear with no cages with bedding or any combustibles.
- The Evacuation plan for each area will need to be updated and all staff made familiar with the SOP for their area.
- No more than one bed should be in place in any corridor.
- There will be no more than 30 beds within in the compartment under the HTM05-02 3.25

We need to ensure certain measures are in place from a Health and Safety perspective: Health and Safety Actions and approvals: Gavin Griffiths

- A full risk assessment to be completed by Sarah (or other SLT clinician)
- Patient to be toileted prior to the move
- Patient to have water (or other fluid) with them for the move
- Patient to be subject to direct supervision when in the corridor and never left alone at any point
- Patient supervisor to be at least an experienced and competent HCA
- Supervisor to have comms device to enable contact with NiC without leaving the patient
- Plugs to be available in the area where the bed is located in the corridor for bed adjustment (or the bed fully charged and capable of being adjusted for the duration of the hold)
- The patient must be clinically stable enough for the hold
- There must be no clutter in the corridor
- IPAC must be consulted regarding the suitability of the corridor for the hold
- IPAC must be consulted regarding any issues with cleaning the vacated bedspace, with a patient holding in the corridor for immediate occupation
- A daily review of the previous days performance to ensure the management criteria have been adhered to (an in-depth report of actual movement times, not a simple 'we didn't exceed the limits' statement)- this will take place at the 11.30 huddle

Moving to continuous flow at RCHT (REMINDER OF THE DRAFT PROPOSAL)



- We must achieve 2 patient transfers to AMU every hour from 7am to 7pm
- If there is no space available on AMU there will be a queue into AMU
- This holding pattern will lead to AMU pushing (if not pulled) patients to base wards based on Golden patients and PDDs and the same holding pattern outside of base wards will take place.
- If there are no specialty patients identified, or the specialty team hasn't pulled the specialty patient then the longest waiting general medical patient will be transferred
- If a 'pull' by the ward area is not achieved, AMU will send the most appropriate patient from their assessment which includes use of Nerve Centre specialty destination and assessment of gen med patients
- If unable to complete for any reason escalate to Care Group leadership team for support by 8.15 (during this first phase of this PDSA)
- The Nurse in Charge is responsible for enacting this plan supported by the Matron and CPOC from ED.

Focusing on the clear identification of golden patients, flowing to the discharge lounge and using the SHOP ward round model coupled with specialty destination is intended to prevent patients being in corridors in ED and on boarding spaces onwards. This action is part of our response to risk 9048 which is ED being over crowded. Note that ED is designed for 46 patients and frequently twice and sometimes three times that capacity