Emergency Care Improvement Programme

Safer, faster, better care for patients

Patients' time is the most important currency in health and social care

#Red2Green #Last1000days #endPJparalysis

Focus on the important not just the urgent – waiting isn't passive

Tim Gillatt

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@ECISTNetwork @timgillatt #last1000days #Red2Green

“Patients time is the greatest currency in health and social care” Prof Brian Dolan

Time is precious #Last1000days

Care

Communication

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

Compassion

Commitment

Courage

Competence

A compelling story

- #last1000days #Red2Green #endPJparalysis
- ***"Patient time is the greatest currency in health & social care"***

Prof Brian Dolan @BrianwDolan

•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*

•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.

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

@ECISTNetwork @timgillatt
#last1000days #Red2Green

Risks of Hospital based De-conditioning Habitual Inactivity

NHS Improvement

Impact of Bed Rest in Older People in first 24 hours

- ↓ Muscle power – 2-5%
- ↓ Circulating volume by up to 5%

In first 7 days

- ↓ Circulating volume by up to 20%
- ↓ VO_2 Max by 8-15%
- ↓ Muscle strength – 5-10%
- ↓ FRC – 15-30%
- ↓ Skin integrity

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Connect emotionally as well as logically

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#last1000days #Red2Green

Consent to admit?

Consent Form 1

Patient agreement to investigation or treatment

Patient details (or printed label)

Surname

First name

Date of birth

Male ☐ Female ☐

NHS Number

Responsible consultant

Job title

Special requirements *(eg. other language, communication method)*

Name of proposed procedure of course of treatment *Include brief explanation if medical term not clear*

Admission to hospital because it is 'safer' than going home

Statement of health professional

To be filled in by health professional with appropriate knowledge of proposed procedure as specified in consent policy

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits: Possibly early investigations; Not falling or collapsing with nobody there to help; having time to arrange better social circumstances / care

Serious or frequently occurring risks: Loss of confidence; loss of muscle power; loss of mobility; loss of sleep; increased confusion; increased risk of falling; risk of hospital acquired infection; not getting back to your own home ... ever.

Any extra procedures which may become necessary during the procedure

☐ Blood transfusion

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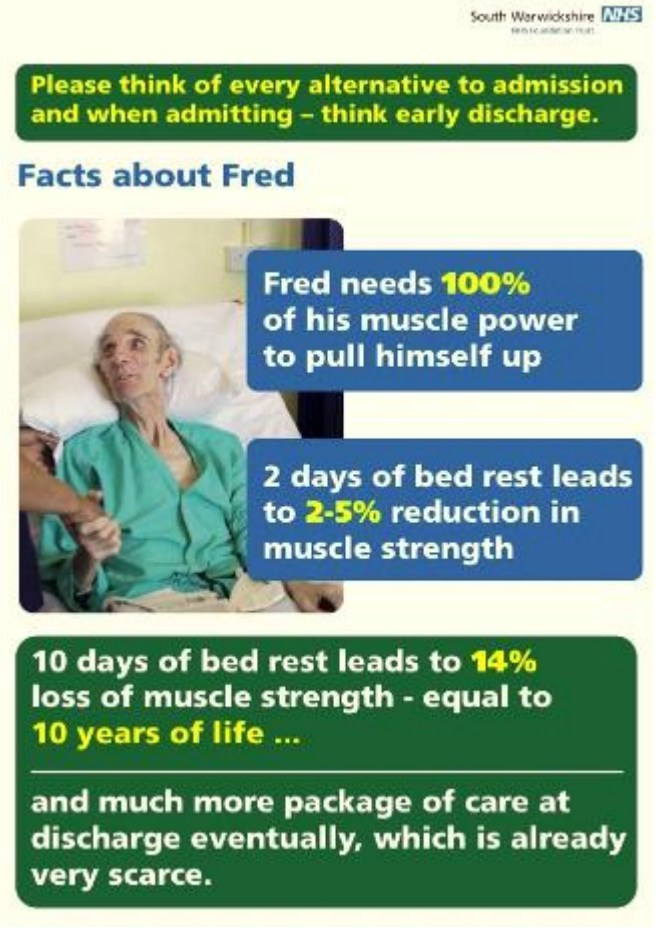
#last1000days #Red2Green

Red2Green days and the SAFER patient flow bundle are tools



Health warning – do not try and performance management the number of red days! Encourage areas to declare them.

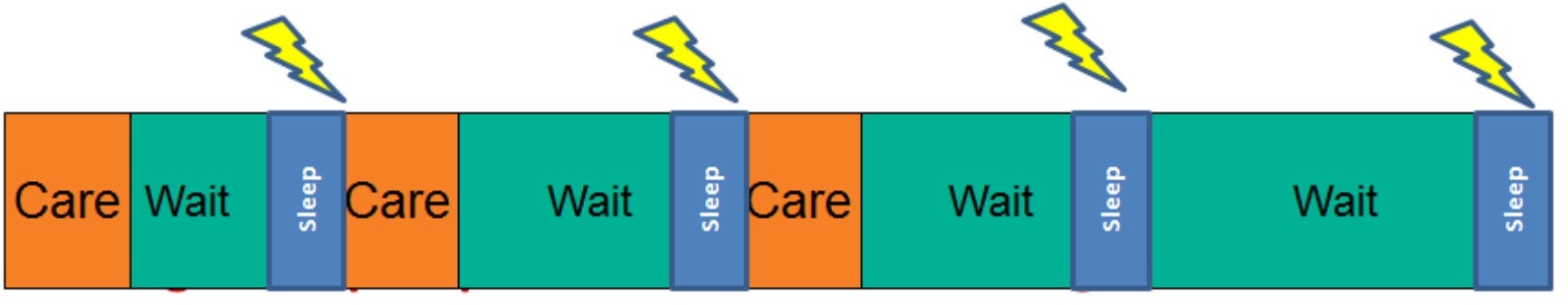
Patients' time as the greatest currency

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

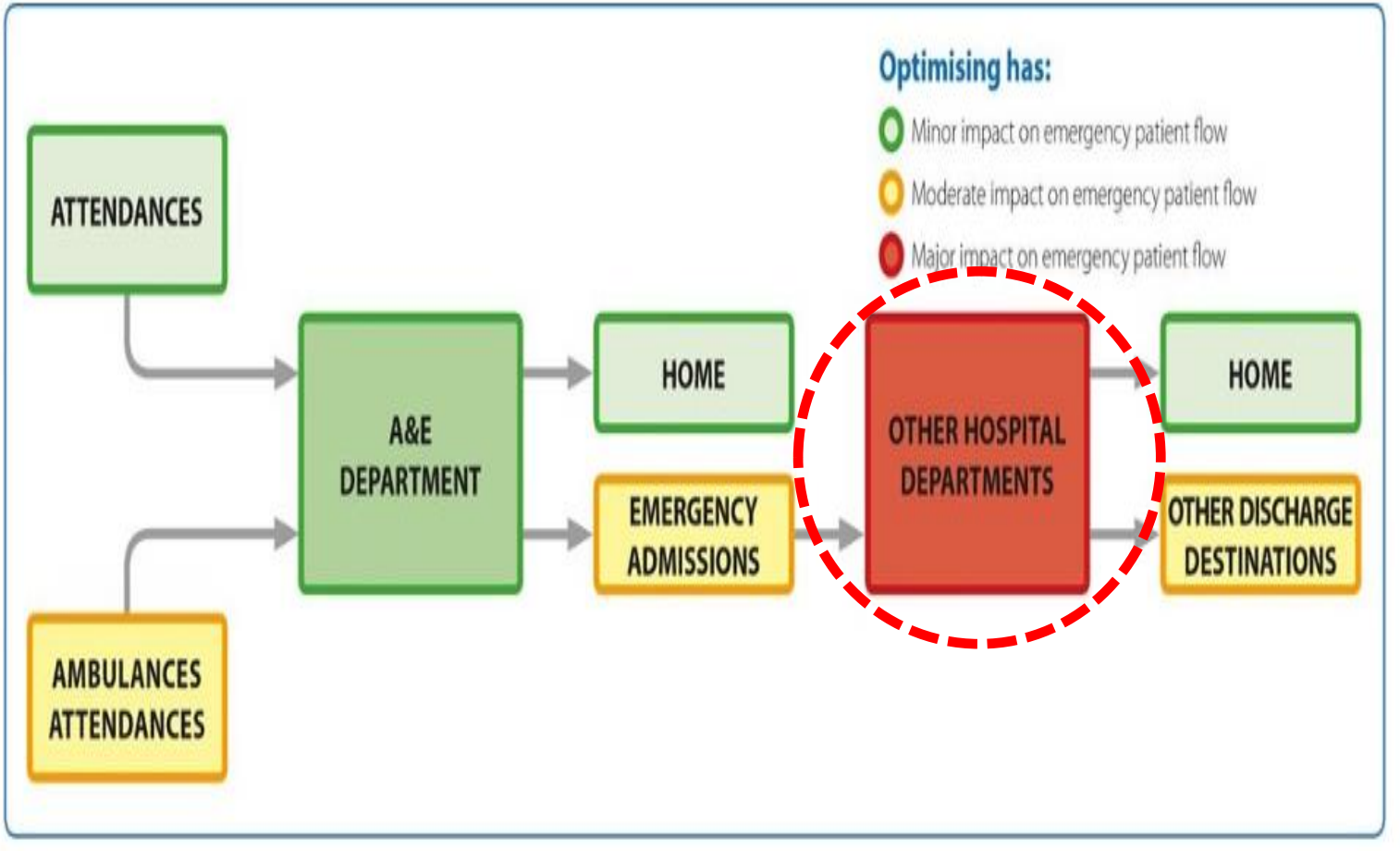
Mind set should be:

You only get care from a bed if that is the only way we can deliver your care

#last1000days



Where is the greatest unnecessary patient waiting?



The SAFER patient flow bundle

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.

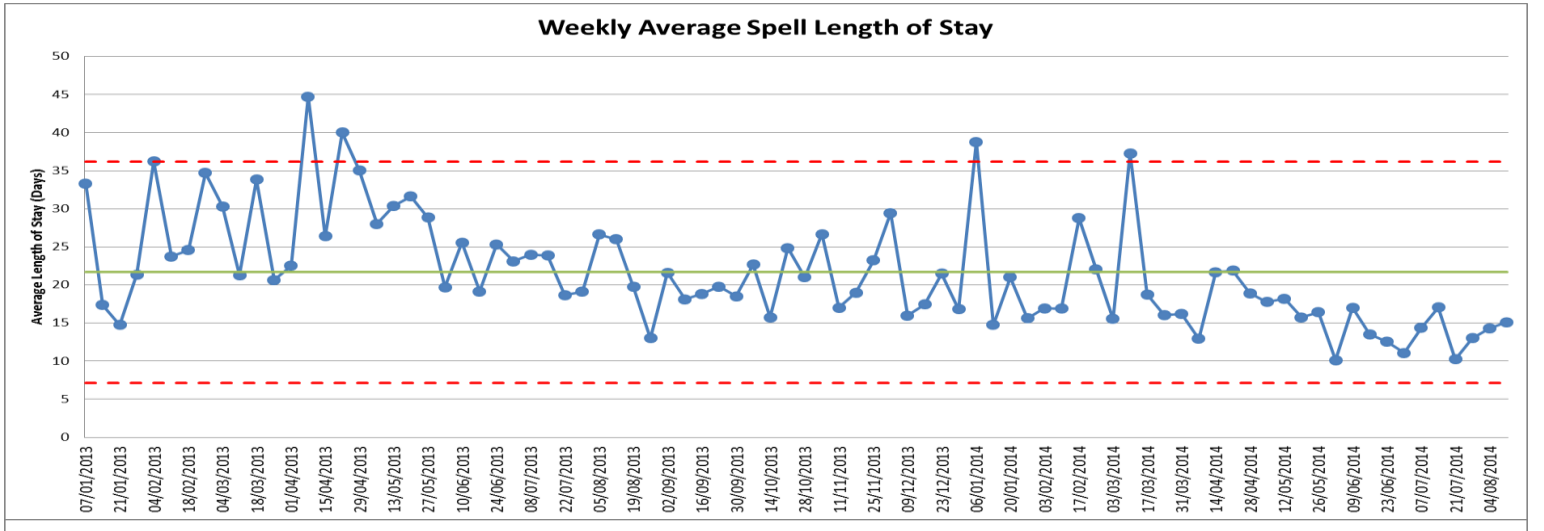
F - **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

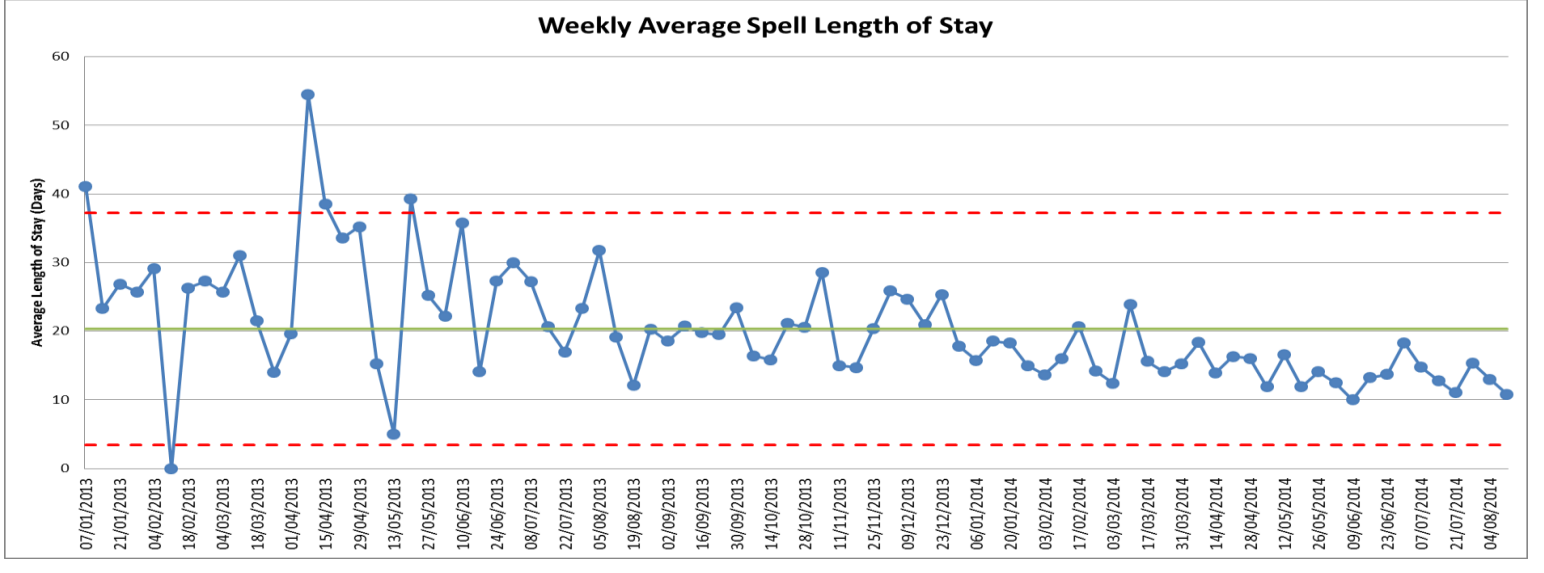
E – **Early discharge. 33%** of patients will be discharged from base inpatient wards before midday.

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

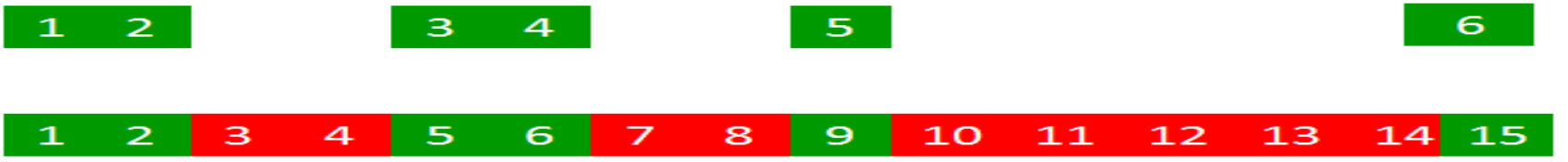
SAFER patient flow bundle - examples from 2 medical wards

NHS Improvement





Red and Green bed days



A **Red** day is when the patient no longer requires an 'acute level of care'

- 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:

- A planned diagnostics is not undertaken as requested
- A planned therapy intervention does not occur
- Medical management plans are not reflective of interventions and required outcomes to progress the patient's pathway of care
- The patient no longer requires an acute level of care

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

@EQISTNetwork @timgillatt #last1000days #Red2Green

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 requires an acute level of care

A GREEN day is a day of value for a patient

Rapid Improvement Guide – Test it & localise it

Emergency Care Improvement Programme
Safer, faster, better care for patients

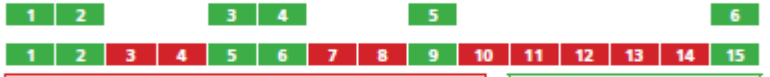
NHS

Rapid Improvement Guide to:

Red and Green Bed Days

Introduction

'Red Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey. It is most applicable to in-patient wards in acute and community settings. It is not appropriate for high turnover areas such as Emergency Departments, Assessment Units, Clinical Decision Units/Observation Units, and Short Stay Units where using Red Green on an hours/minutes basis may be more appropriate.



A **Red** day is when a patient is waiting for an action to progress theircare 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 'psychological 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** bed 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 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, 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

At the centre of the system is the person receiving the acute care whose experience should be one of total involvement and personal control, with an expectation of what will be happening. It can be useful to consider whether that person is able to answer these simple questions as soon as possible after their arrival at hospital:

1. *Do I know what is wrong with me or what is being excluded?* This requires a competent senior assessment and discussion.
2. *What is going to happen now, later today and tomorrow to get me sorted out?* The 'inputs' needed (diagnostic tests, therapeutic interventions etc.) with specified timelines.
3. *What do I need to achieve to get home?* The 'clinical criteria for discharge' (CCD), a combination of physiological and functional parameters. 'Back to baseline' is rarely a useful phrase.
4. *If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?* This is the 'expected date of discharge' (EDD) which should be set along with the CCD at the point of admission.

Lack of clarity to the answers to any one of these four questions will result in delays, with frustration and confusion for the patient. Items 3 and 4 together can be used together to flush out unnecessary waiting along the pathway.

A Red day is defined as a day when the patient is not in receipt of 'care that is required to be delivered as an in-patient, above the provision of intravenous antibiotics and usual medication and observations unless the patient is triggering on the 'Track and Trigger' observations'. The key question is *what is this patient waiting for to progress to the next phase of their care?* It is only a Green day if any action undertaken could only be done as an inpatient for that particular patient's circumstances on that day. If an investigation is being undertaken that day, the day remains a Red day until the result of the investigation is acted upon. Likewise, if a patient is due for discharge that day and the discharge prescription medications are not ready, then it is a Red day. For many patients, weekends and Bank Holidays are frequently Red days. Another way of looking at this is to ask the question *if this patient was seen in out-patients as they are physically presenting today, would they immediately be admitted to hospital?*

If the approach to judging days as Red or Green is less than rigorous, few Red days will be identified and opportunities for reducing patient length of stay will be lost. Those wards that are rigorous at the process will identify many Red days and will be proactively trying to resolve the unnecessary waiting. Those wards that are not actively identifying many Red days or only around 'discharge processes' are either already extremely efficient (relatively rare) or are missing an opportunity to improve care delivery and flow.

The Process

1. Start the Board Round with all patients marked as 'Red'.
2. The day remains as 'Red' if there is inadequate senior presence at the Board Round
3. The day remains as 'Red' if there is no clinically owned EDD (set assuming ideal recovery and no unnecessary waiting) with CCD and a clear case management plan.
4. The Board round should ensure that a patient's case management plan is progressed necessarily as an in-patient and converts the day to Green. 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 action with regard to the result. If the patient has not met their CCD and is receiving active interventions to get them to that state by tomorrow, the day is only 'Green' if the discharge prescription medications are ready by the evening before the expected date of discharge.
5. The team must be clear on what actions constitute a day being 'Green'. For example, these do not include observations being undertaken, oral medications, IV antibiotics etc. as these can be delivered out of hospital unless the patient is physiologically unstable.
6. The Red Green process is linked to the **SAFER patient flow bundle**
7. The key is to link flow, safety and reliability with visual demonstration using a 'Ward Improvement Board' as described in the Productive Ward Programme. Ward level metrics for SAFER and Red Green days are:
   a. Impact – statistical process control run chart (SPC) of weekly average length of stay of discharges from the ward. These should reduce significantly as Red days are proactively reduced.
   b. Process – e.g. % discharge drugs ordered and prepared the day before discharge, % of patient records with an EDD and CCD recorded in the medical notes etc.
   c. Balancing – number of unplanned re-admissions
   d. Quality – pressure sores, HCAI, catheter days, cannula days, falls.
8. The constraints identified by wards to convert a Red day to a Green day need to be proactively managed at the Board round. Those that cannot be immediately resolved need an in-day escalation process.
9. The escalation process needs to pro-actively manage the constraint. Failure to resolve constraints proactively and just 'report them' is a non-value added process.
10. Link the generation of the Red Green days to the day to day operational management strategy by standardising the 'Operational Meetings' using a bundle such as '**RESPONSE**'. The escalation process can be intricately linked to the daily 'operational meetings'.
11. At the end of each week, the top five constraints that cannot be resolved by ward teams and the escalation process ought to be the focus of the system improvement programme moving forward.

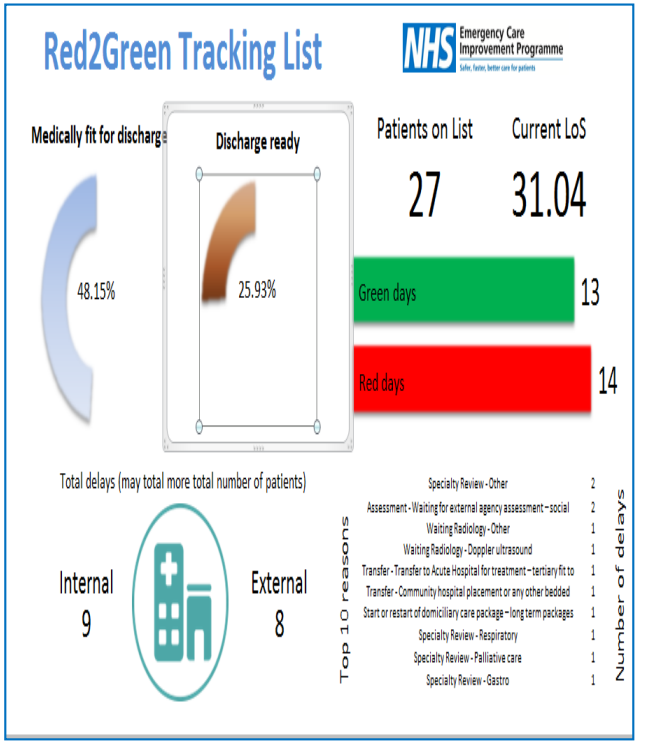
@ECISTNetwork @timgillatt #last1000days
#Red2Green

Red2Green Days – Localise the approach

- Start each day with all patients marked red
- Stay red if senior decision makers not present
- Stay red if there is not an EDD and CCD (clinical criteria for discharge)
- For discharge tomorrow – TTOs completed?
- Decide what will turn today green for each patient
- Ensure there are internal professional standards in place
- Allocate responsibility for actions
- Identify constraints and resolve within the team if possible
- Escalate constraints that cannot be resolved. Use SBAR (situation, background, assessment and recommendation). Not escalitis
- Review actions and constraints at afternoon huddle 2-3pm
- Localise it e.g. can the patient be dressed. If they can and they are not, is it a red day? #endPJparalysis

Tracking the delays

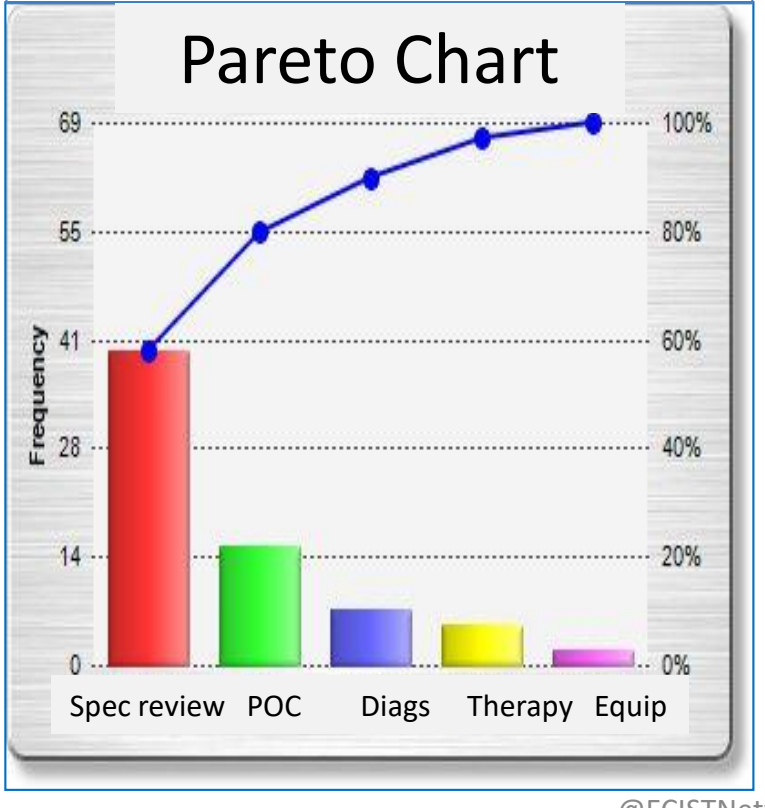
- You need a method – start on paper
- Track the delays / next steps at board rounds
- A mid afternoon huddle / board round to check actions have been completed is required
- Action focussed – todays work today



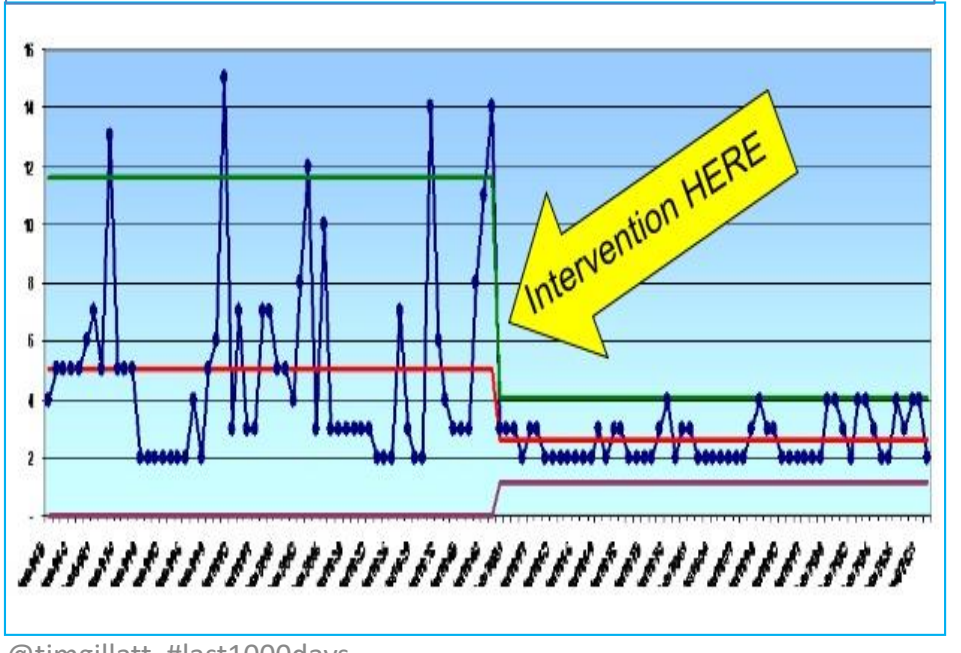
Measurement for improvement

The opportunities for improvement? Not performance management

What are the top 3-5 constraints?



Have the interventions made a difference e.g. number of stranded patients (LOS greater than 6 days)



Questions patients and their loved ones should know the answer to – is it a Red day if they can't answer the questions?

1. ***Do I know what is wrong with me or what is being excluded?*** This requires a competent senior assessment and discussion.

2**.** ***What is going to happen now, later today and tomorrow to get me sorted out?*** The 'inputs' needed (diagnostic tests, therapeutic interventions etc.) with specified timelines.

3. ***What do I need to achieve to get home?*** The 'clinical criteria for discharge' (CCD), a combination of physiological and functional parameters. 'Back to baseline' is rarely a useful phrase.

4. ***If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?*** This is the 'expected date of discharge' (EDD) which should be set along with the CCD at the point of admission.

#endPJparalysis

Brian Dolan
@BrianwDolan

They done that thing again!
The latest #endPJparalysis briliant #Lego poster by the super talented and witty @Courtney_Comms at @CUH_NHS

06/03/2017 08:17 from Christchurch City, New Zealand

6CsLive!
@6CsLive

#EndPJparalysis - brilliant example of how nurses across the country are and can lead change.
#Lead2Add #cnosummit #Last1000days

14/03/2017 10:30

53 RETWEETS 61 LIKES

We will help you to;

Salford Royal NHS
NHS Foundation Trust
University Teaching Hospital
safe • clean • personal

🛏 Get **UP**
👗 Get **DRESSED**
🏃 Get **MOVING**

So you can;

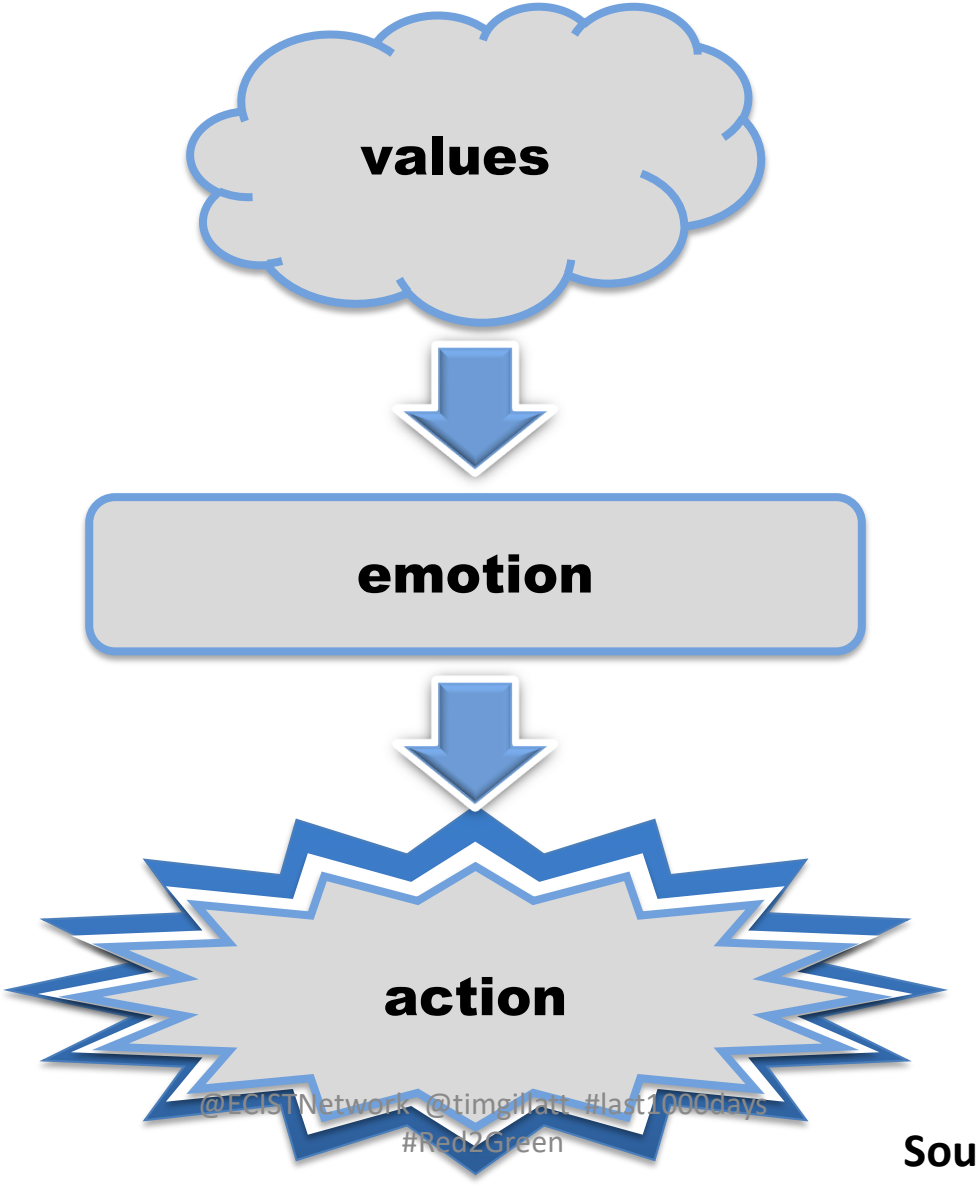
😁 Get **WELL**
🏡 Get **HOME**

#endPJparalysis #standupforindependence

My 91 YO Father, WW2 navigator getting close to end of life. He supports #endPJparalysis and #last1000days. Dressed for dignity!!

@ECISTNetwork @timgillatt #last1000days
#Red2Green

If we want people to take action, we have to connect with their emotions through values



@ECISNetwork @timgillatt #last1000days
#Red2Green

Source: Marshall Ganz

There's a big difference between a rebel and a troublemaker

Troublemaker	Rebel
complain	create
me-focused	mission-focused
anger	passion
pessimist	optimist
energy-sapping	energy-generating
alienate	attract
problems	possibilities
alone	together

Source : Lois Kelly www.rebelsatwork.com

NHS England

NHS Improvement

"Patients time is the greatest currency in health and social care"

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

#Red2Green #last1000days #endPJparalysis

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