Llywodraeth Cymru
Welsh Government

SAFER

Patient *flow* Guidance

Working together to enable people to return home well, safe and in a timely manner

This is one of a series of quick guides providing practical tips to support integrated health and care systems.

GIG CYMRU NHS WALES

RCEM Wales

Gwella Gofal Brys
Unscheduled Care Improvement

Foreword

Working together to enable people to return home well, safe and in a timely manner: "Everybody's business".

When people are sick or injured and need care we know it makes a difference to their outcome if they receive the right treatment, in the right place, at the right time.

We know admission to a community or acute hospital bed is the right thing for some people but not all, and that hospital inpatients are also increasing, especially among those who are older, often living with frailty or have co-morbidities. Unfortunately, many such patients leave hospital less mobile and independent than when they were admitted, with many losing confidence and the ability to care for themselves very quickly, when they are away from their familiar surroundings.

The recent NHS Wales Delivery Unit reports on discharge practices highlighted many areas of excellent care in Wales. They also identified significant opportunities to improve practices when it comes to enabling people to return home, or as close to home as possible, from a hospital bed. We need to work together to ensure that this practice becomes 'business as usual' on every ward and in every hospital.

> ***There are significant opportunities to improve practices when it comes to enabling people to return home from a hospital bed***

This guidance is intended to harness the prudent healthcare principles by putting the individual at the centre of the care they receive, and reducing inappropriate variation. It also fosters co-production by encouraging professionals and patients to work together as equal partners. This will help to make the best decision for the individual about when they should leave hospital and – equally as importantly – ensuring they receive the appropriate support when they go home or to step down care to enable them to regain their independence as quickly as possible.

The guidance is clear that these outcomes cannot be delivered by practitioners working in isolation and needs to be seen in the wider context of what health and social care can do together. The integrated nature of services in Wales means we have a real opportunity to deliver person-centred care and effective planning and facilitation of discharge. Patients' time is the greatest currency in health and social care, and we need to spend it wisely.

The focus should be on preventing the need for hospitalisation. When this does occur, treating the acute symptoms promptly and then enabling the individual to be supported back to their own home is vital. There are no 'heroes', it comes down to everyone working together to manage the peaks and troughs to make a difference to every individual patient. Planning a prompt discharge should begin on admission, wherever possible, and involve everyone – the individual, their family and health and social care professionals – working together to achieve a smooth and timely discharge.

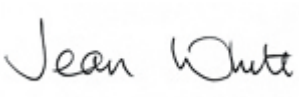
Health, social services, housing, the wider statutory, and third sector organisations, all play important parts in people's lives; but the best outcomes are delivered when these organisations work in partnership and offer an integrated approach. Community Resource Teams (CRTs), provide the foundation for re-ablement and support to people in their localities and are excellent examples of joint working. The Regional Partnership Boards, established under the Social Services and Wellbeing (Wales) Act, provide the mechanism by which the greater integrated approach can be driven forward, and traditional barriers between organisations begin to be removed.

Everyone's aim should be to optimise people's outcomes and enable as many people as possible to live their lives independently at home. Effective discharge practices are a key component in making that happen for people of all ages.

We hope you find this guidance useful. Alongside this guidance practitioners should be aware of the following:

- *The Social Services and Wellbeing (Wales) Act 2014* which seeks to ensure that practitioners work with people to identify what matters to them, and gives them greater voice and control over their lives; www.ccwales.org.uk/the-act/
- '*Passing the Baton – A Practical Guide to Effective Discharge Planning*' http://howis.wales.nhs.uk/sitesplus/407/page/36206
- Consider the NHS Wales Delivery Unit's national and local reports on discharge practices.
  - National discharge audit – acute sites (September 2016)
  - National discharge audit – community hospitals (December 2016)
  - National review of the decision making process for care home placement following admission to hospital in Wales (January 2017)
- Information on the aims of *Making Choices Together*, a 1000Lives project intended to focus on the dialogue between healthcare professionals and patients to determine and agree what is the right course of action/treatment for the individual: www.1000livesplus.wales.nhs.uk/making-choices-together
- Guidance on the effective use of Discharge To Assess: www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
- Reducing the pressure on hospitals: A report on the value of occupational therapy in Wales: http://cotimprovinglives.com/wp-content/uploads/2016/11/Reducing-the-pressure-on-hospitals-A-report-on-the-value-of-occupational-therapy-in-Wales-English-1.pdf
- *"Living, not Existing: Putting prevention at the heart of care of older people"* http://cotimprovinglives.com/

People will derive the greatest benefit when they, their families and carers are involved from the outset in well planned, well communicated, well informed and timely discharge and we are seeking your support to make it everybody's business.



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Contents

The SAFER patient flow guidance 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 guidance we will improve patients' experience when they are admitted to our hospital.

With thanks to the Emergency Care Improvement Programme (NHS Improvement), creators of the SAFER Patient Flow Bundle and'Red2Green days' guidance.

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Introduction

Why implement SAFER?

This document is the first in a series of quick guides launched to support the National Programme for Unscheduled Care "Improving Patient Flow: A Whole System Approach" good practice guide.

It acts as a guide to good practice that will improve patient flow and clinical outcomes when delivered as 'business as usual' on all wards. SAFER is a simple set of rules intended to optimise patient experience and safety by ensuring patients are fully involved in the decision-making process throughout their stay in hospital, and enabling them to return home as quickly as possible.

The NHS Delivery Unit *Improving Experience and Flow* event on 9th November 2017 provided an opportunity to recognise the excellent initiatives that are already being implemented in some areas of Wales. What we need to do now is build on this to develop a shared sense of purpose, with everyone pulling together to make this common practice. We need to move from pockets of good practice to consistency across the piece.

The good practice guide is not new. Many of the core principles featured in *Passing the Baton: A Practical Guide to Discharge Planning* are present in SAFER and, much like that and all other guidance, successful implementation is contingent on strong clinical leadership.

> ***Make it easy to do the right thing because we are all responsible for all patients***

We know SAFER works. Where implemented effectively by well-led teams and communicated clearly to staff enabling them to fully understand all elements, hospitals have seen real benefits to patient outcomes and staff satisfaction. Hospital crowding reduces. Emergency departments decongest. Mortality falls. Harm is reduced. Staff feel less pressured.

We also know that hospitals are buildings that are full of ill people and admitting patients to the hospital system increases risk to each patient, and others too. In line with the principles of *Making Choices Together*, we need to improve the dialogue between healthcare professionals and patients to determine and agree what is the right course of action/ treatment for the individual. We can use these principles to ensure that only people who are too unstable to be treated at home, or are at high risk of serious harm, should be admitted to a hospital bed. Admission as routine should not be considered the safest option.

All other patients should be managed somewhere else for the benefit of their own experience and outcome. The efficacy of treating patients as close to home as possible is well-founded and makes a real difference to patients' recovery and longer term outcomes. The Social Services and Wellbeing (Wales) Act 2014 puts people at the centre of their care and is designed to ensure that people, and their families and carers, have a voice and

control over their lives. Hospitals should be offering the same person-centred approach, and this guide can be seen as the hospital plan to support the Act. The SAFER guide promotes a similar strengths-based approach, supporting more assessment of people in their own environments, and building trust between professionals and patients to work effectively for all.

We know that poor discharge practice can result in deconditioning, and causes higher mortality. Overcrowding means that patients can get treated in the wrong place (medical outliers) and staff can be distracted from the truly sick patients. It also necessitates more bed moves and means everyone works less efficiently. Proactive executive support for the implementation of SAFER, and active involvement of the executive team, is important in overcoming many of these challenges.

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, involving leaders who are passionate about patient care, and this way we can create compelling narratives that describe the link between implementing SAFER and improving patient care.

There may be a need for local teams to adapt SAFER slightly to fit with locally available services and logistics, and this is clearly sensible as long as the rules are broadly followed each day, every day. We can easily monitor the extent to which the principles of the SAFER guidance are being followed through measurement of the relevant indicators. Installing 'know how you're doing' boards to demonstrate success in delivering the five elements of the guidance in all wards is simple but effective.

Implementing the good practice will have a positive, cumulative effect on improving patient flow. Only partially implementing SAFER will be much less effective.

SAFER should be considered within the context of co-production, with patients and their families playing an equal part alongside effective collective leadership across whole integrated health and social care systems. SAFER is not a prescriptive approach, but enables practitioners, clinicians and system leaders to work together to deliver the five elements in a way that is tailored to local circumstances. Integrated Medium Term Plans (IMTPs) must demonstrate how the SAFER guidance is being implemented in the health board, and how this is being taken forward.

Putting patients at the centre of the decision-making process, and making sure they are able to recover and return to their communities as quickly as possible is key. Together we can make a difference and achieve the best outcomes possible for the people of Wales.

SAFER Patient Flow Guidance

Good practice that should feature in the standard operating policy for local hospital wards.

Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions. This should be informed by a multi-professional assessment, where appropriate, and clear consideration of social and environmental factors to facilitate discharge.

All patients, and their families will be involved in the setting of an Expected Discharge Date based on the clinical and functional criteria for discharge. This is set assuming ideal recovery and no avoidable delays.

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

Early discharge: >33% of patients will be discharged from inpatient wards before midday on their day of discharge. Where possible, medication to take home (TTOs) for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge.

Review: a systematic multi-disciplinary team review, including patients and their families for those with extended lengths of stay (>6 days) with a clear 'home first' mindset.

Senior Review

- All patients should have a senior review before midday.
- Use simple rules to standardise ward and board round processes.
- Minimise variation between individual clinicians and clinical teams to ensure all patients receive an effective daily senior review.
- Daily review undertaken by a senior clinician able to make management and discharge decisions is essential seven days a week.

Effective ward and board rounds are crucial to decision making and care co-ordination:

Ward rounds:

- Should add value, leading to clear actions, written up in notes and acted upon. A detailed description of ward round best practice is contained in the RCP/RCN document **here**.
- Use checklists to reduce variation and prevent actions being omitted.
- Always include a qualified nurse, other members of the MDT – including therapists and community staff – and involve the patient and / or their family from the outset.
- Use a *'dedicated member of staff'*, to lead on the management of ward patients.
- Let specialty colleagues focus on elective and other activities.
- Most tasks (e.g. the writing up of take home medications (TTOs) or the ordering of a scan) to be completed before the round moves onto the next patient to avoid overloading junior staff, batching tasks and creating delays, with a mobile computer as an enabler.

Board Rounds:

- Should be undertaken daily, in the early morning, to enable teams rapidly to assess the progress of every patient in every bed, inform them and / or their family of progress and address any delays to treatment or discharge. A second afternoon board round is best practice to review progress.

Red and Green Days

- This is a useful approach to optimising flow. The team discuss for every patient whether the day ahead is 'red' (a day where there is little or no value adding care) or 'green' (a day of value for the patient's progress towards discharge). If 'red', action needs to be agreed by the team to create a 'green' day instead.
- The purpose of board rounds is to ensure as many days are 'green' for the patient as possible. If patients require an investigation to progress care, then investigations need to occur that day and need a clear plan of action following results.
- Where patients are receiving active interventions to meet clinical criteria for discharge the following day, the day is only 'green' if the discharge prescription medications are ready by the evening before.
- 'Red' days should be recorded so that common causes of delays can be identified and addressed.
- Measuring compliance is important. During early afternoon bed meetings, patients who have not had a senior review should be highlighted, discussed and mitigating action taken. Ongoing measurement of day to day compliance to be used to identify how many patients are receiving a senior review before midday every day, and any trends.

All patients will have an expected discharge date and clinical criteria for discharge

- Patients and their families should be involved in the agreement of a consultant approved care plan containing an Expected Discharge Date (EDD) and Clinical Criteria for Discharge (CCD), set within 14 hours of admission. Remember 'a plan costs nothing'.
- The CCD should include physiological and functional criteria, but not focus on medically 'optimising' a patient or returning them to their pre-admission baseline. A period of post-hospital recovery and rehabilitation should be anticipated and allowed for.
- EDDs should be set by a consultant with the MDT, and represent a professional judgement of when a patient is anticipated to achieve their clinical and functional goals and can leave hospital to recover or rehabilitate in a non-acute setting (usually and optimally their normal place of residence).
- A challenging EDD 'goal' should be set to reduce avoidable delays and help teams focus on getting patients home promptly (rather than focusing on getting the EDD exactly 'right').
- Patient progress towards EDD should be assessed every day at a board or ward round led by a senior clinical decision maker (normally the consultant). Patients should be routinely involved and aware of the progress they are making. Patients (and/or their families) should be able to answer these questions:

    1. What is wrong with me or what are you trying to exclude?
    2. What have we agreed will be done and when to 'sort me out'?
    3. What do I need to achieve to get me home?
    4. Assuming my recovery is 'ideal' and there is no unnecessary waiting, when should I expect to go home?

- All members of ward / departmental teams should be able to discuss and explain the EDD.
- Some local systems have found simple patient information cards can help them and their families/carers by clearly stating what is going to happen today and tomorrow.
- If the EDD is exceeded for non-clinical reasons, it can be helpful to record this on 'at a glance boards' as the EDD plus the number of days (e.g. EDD+1, EDD+2 etc.).

Flow early from assessment units

- Every ward that routinely admits patients from assessment units should ensure the first patient arrives on their ward before 10am every day.
- Ward teams should be in regular communication with assessment units to agree the first patient. Assessment unit teams should review patient care at the ward/board round and ensure patients are informed beforehand that they will be transferred to the receiving ward at a specified time (e.g. before 10am).
- If discharges on the receiving wards are late, ward teams should consider sitting patients out, transferring patients to the discharge lounge or expediting discharge.
- It is essential for flow that patients are transferred from assessment units early in the morning, to ensure space for incoming patients and to reduce ED overcrowding and associated safety risks.

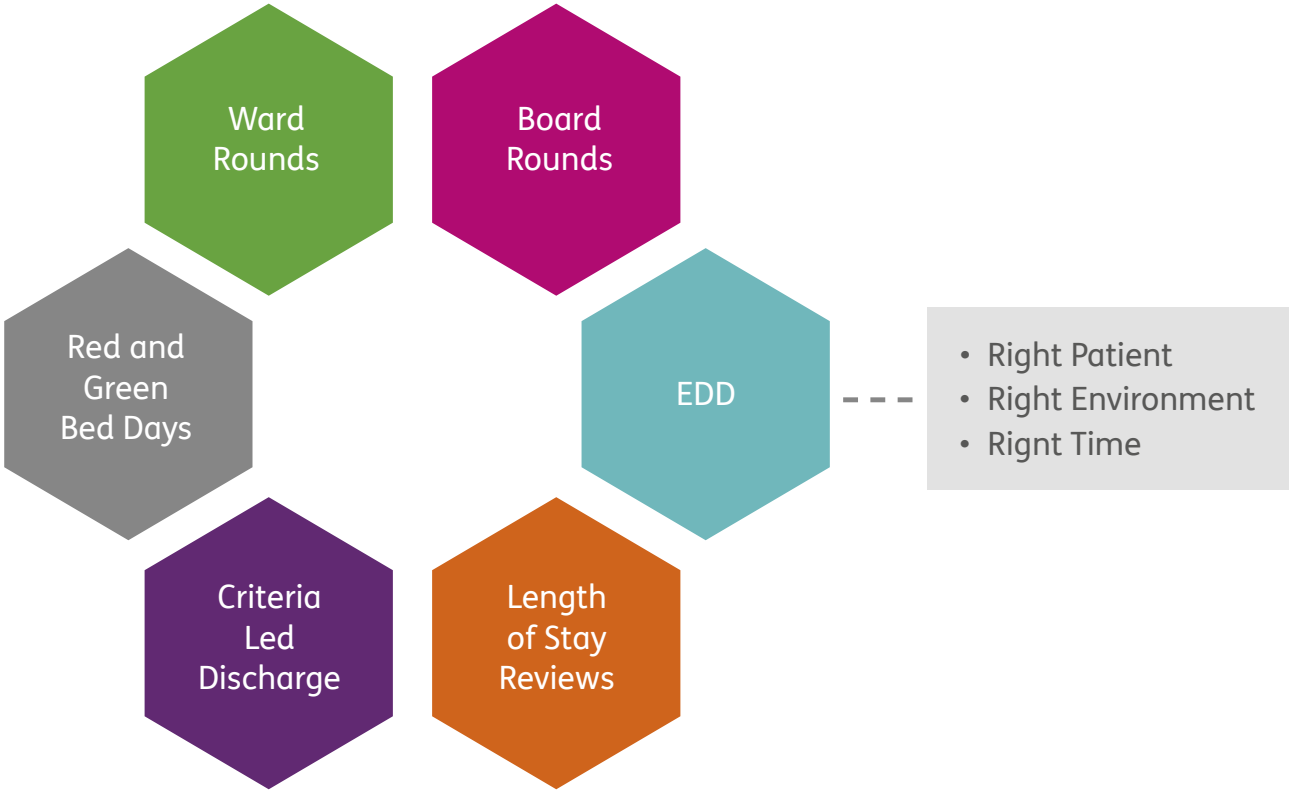
Early discharge – a third of patients should be discharged before midday from inpatient wards

- Morning discharges should be the norm, with at least a third of patients to be transferred home to have left their wards by midday. This reduces Emergency Department (ED) overcrowding and allows new patients to be admitted early enough to be properly assessed and a treatment plan to be established and commenced.
- Early morning ward and board rounds should set the pace for early discharge. Teams should prioritise activities associated with discharge, particularly medication to take home (TTOs) and patient discharge letters, which should be prepared beforehand or during one-stop ward rounds. If staff have to continually chase up TTOs, it is highly likely this is an opportunity to improve current processes and facilitate earlier discharge.
- Pharmacy teams should be actively engaged to help reduce delays with TTO processes. Examples include the introduction of generalist prescribing pharmacists and satellite pharmacies nearer ward areas as described **here**.
- Knowledge and confidence about the environment, and the skills the individual needs to function safely are key components of a safe and effective discharge. Therapists should be actively engaged with patients from the start of their admission and seen as part of the team to ensure that any necessary community care and support is available, and any assistive equipment for use at home is provided in a timely manner.
- Effective communication between ward and community teams or services is essential to facilitate early discharge. Early conservations with the community resource team (GP, District Nurse and Social Worker) should be considered to enable earlier discharge and subsequent review at home later in the day.
- Thinking about what community support is available in someone's locality should be one of the things staff think about during discharge planning, especially for those with few friends or family living close by.

Review all patients in hospital six days or more

- Patients should be transferred to their usual place of residence as soon as they cease to benefit from acute care (i.e. have achieved CCD). The risk of deconditioning and decompensation for older patients increases with each day in hospital. At every board and ward round, the following should be considered:
  - Today is a red day until we prove otherwise and take actions to make it a green day.
  - If the patient was seen for the first time as an outpatient or in the ED today, would admission to hospital be the only option to meet their needs?
  - Considering the balance of risks, would the patient be better off in an acute hospital or in an alternative setting?
  - Is the patient's clinical progress as expected?
  - What needs to be done to help the patient recover as quickly as possible?
  - What are the patient's views on their care and progress?
- Most patients benefit from assessment in their normal place of residence where they can surprise professionals with their ability to cope in familiar surroundings.
- Prescribing long term 'solutions' for patients (e.g. nursing home placements) may set inappropriate expectations for professional teams, patients and their families and lead to self-fulfilling prophecies.
- There should be an effective process that enables a daily MDT (health and social care) review of **all patients who have spent six days or more in hospital**, with the default assumption that patients will be **transferred** to their normal place of residence. To enable this, organisations need to agree a process that should include:
  - Agreement between health and social care services that packages of care can be restarted, without reassessment, where a patient's care needs remain largely unchanged. This can be facilitated by implementing a 'trusted assessor' model.
  - Has a community assessment by the community resource team with a trusted assessor relationship been considered? The MDT should have same day access to the community resource team and the name social worker for that team. Facilitating their input through technology should be actively considered.
  - Agreement between health and adult social care to share the risk of 'funding without prejudice' while responsibility for the long term funding of a patient's care is being established. This will allow assessment to take place outside hospital, ideally at home with support.
  - Agreement by health and social care communities that all referral processes are as simple as possible (i.e. through the use of the Welsh Community Care Information System).
- This should be measured **using the long length of stay metric (>6 days)** with information so trends and real improvements can be seen.

SAFER components



Benefits

- **Patients** will benefit from improved care co-ordination and standardisation of approach (the same as with a clinical care bundle) wherever possible;
- **Patients** will benefit from a well planned, informed and timely discharge;
- **Patients** will suffer less deconditioning and deterioration, and be more likely to regain their independence more quickly;
- More **patients** will be able to be assessed in their own environments so that their ongoing support is more reflective of their actual needs;
- **Patients**, and their family and carers, should feel a sense of partnership with clinical staff, and know what is happening and when; and what part they can play;
- **Patients** will be less likely to be outliers (i.e. cared for on the wrong ward);
- **Patients** will be less likely to be cared for in crowded wards and departments;
- Staff will have more control in the management of their own wards (as a result of fewer outliers and a 'pull mentality';
- Less clinical time will be lost in reviewing outlying patients / through additional ward rounds;
- There will less exposure to risk (errors and omissions can happen to outlying patients).

Consideration should be given locally to how these benefits can be measures and act as system drivers to improve outcomes and experience for patients.

Key points

- The SAFER guidance is a set of simple rules intended to optimise patient experience and safety by ensuring they can go home (or closer to home) as quickly as possible, whenever possible. If these simple rules are followed it will reduce variation and improve patients' health outcomes. There may be a need for local teams to adapt it slightly. This is clearly sensible, as long as the rules are followed each day, every day – the key is to make them routine.

Many hospitals find that where **SAFER** becomes 'business as usual' on all wards, the average length of stay falls and clinical outcomes improve. We have examples here in Wales.

Essential components of successful implementation of **SAFER** are:

- **Clinical leadership** – implementation and sustaining momentum requires great clinical leadership to support operational teams.
- **Strong teamworking** – essential to ensure all staff are able to do what they do best and work to the top of their professional licence. This ensures the best quality of intervention, most effective outcomes and staff and patient satisfaction.
- **Communication** – staff need to be fully briefed and understand all elements of SAFER and why it will help patient flow and benefit patient safety.
- **Executive support** – senior teams need to proactively support the implementation of SAFER. The active involvement of all members of the executive team is important to success.
- **Measurement** – all elements need to be measured using SPC run charts (statistical process control). All wards should have 'know how you're doing' boards to demonstrate success in delivering the five elements of the guidance.
- **Social Movement** – Implementation 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, involving leaders who are passionate about patient care, creating compelling narratives that describe the link between implementing SAFER and improving patient care.
- **Implementing** all elements of the guidance consistently will deliver the greatest benefits for patients and staff.

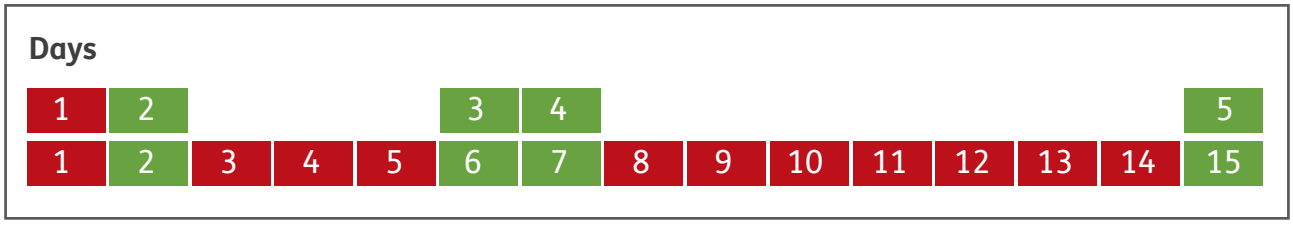
Well communicated and robust multi-professional planning from the moment a decision is made to admit a patient to a hospital bed is central to enabling them to go home, go home with intermediate care/social care, or palliative support to die with dignity and comfort.

Practical tips aligned to **SAFER** and timely discharge practices

Red and **Green** Days

There are no magical solutions to improve urgent and emergency patient flow. It is a complex system and, therefore, does not work particularly well when complicated rules are used.

One approach that is linked to the principles of the **SAFER** patient flow bundle and has proved to be popular with a number of health and care systems in Wales and the rest of the UK is known as '**Red** and **Green** Days'.



What are "**Red** and **Green** Days"?

The Red and Green Days approach is a great example of using simple rules to help reduce delays for patients by making 'non-value' adding days (from a patient 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 patients often experience significant periods of time waiting for things to happen, as illustrated by the NHS Wales Delivery Unit discharge audit reports.

NHS Wales Delivery Unit discharge audit reports and the 'Passing the Baton' (2008) guidance were clear that unnecessary waiting in an acute or community hospital carries significant risks, particularly for older patients. For patients who are ready for discharge or transfer to a non-acute setting, hospitals are not the best place.

How to start the Red and Green Days approach

There is no definitive way to implement red and green days, but a popular approach is to initially test it out on a couple of wards using an approach that could include:

- All multi disciplinary team (MDT) members asking on every board or ward round if today is going to be a red or a green day;
- If it is going to be a red day, the MDT makes every effort to resolve the problem in real time;
- If the MDT cannot resolve the problem i.e. prevent the patient from having a red day, there should be clear and simple escalation processes in place that involve all levels of health, social care and other staff groups (including the third sector) again responding to delays in real time;
- Recording red and green days in a visual manner i.e. so it's clear for all to see the number of red and green days on patient status at a glance boards (ward boards) and IT systems; and
- After testing it out on a couple of wards, devise a plan to implement it across a hospital site (with system wide health and social care support) so it starts to be part of 'the way we do things around here'.

A more comprehensive guide is described overleaf.

Quick Guide: Red and Green Days

Step 1:

Start the board round with all patients marked as '**Red**'.

Step 2:

The day remains as a '**Red Bed Day**' if there is inadequate senior presence at the board round.

Step 3:

The day remains as a '**Red Bed Day**' if there is no clinically owned expected date of discharge (set assuming ideal recovery and no unnecessary waiting) with clinical criteria for discharge and a clear case management plan.

Step 4:

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, IV antibiotics of themselves do not make a day a **Green Bed Day** as these can be delivered out of hospital unless the patient is physiologically unstable.

Step 5:

The key is to link flow, safety and reliability with visual demonstration. Ward level metrics for **SAFER** and **Red:Green Bed Days** are:

- **Impact** – run chart (SPC) of weekly average length of stay of discharges from the ward. The aim is for this to significantly reduce as Red Bed Days are proactively reduced.
- **Process** – e.g. % discharge drugs ordered and prepared the day before discharge, % of patient records with an EDD recorded in the medical notes etc.
- **Balancing** – number of unplanned re-admissions.
- **Quality** – pressure sores, health care acquired infections, catheter days, cannula days, falls.

Quick Guide: Red and Green Days

Step 6:

The constraints identified by wards to convert a **Red Bed Day** to **Green** need to be pro-actively managed by the ward at the board round, those that they cannot resolve need an in-day escalation process to be managed.

Step 7:

The escalation process then needs to pro-actively manage the constraint. This is crucial, failure to resolve constraints proactively and just 'reporting them' is a 'non value added' reporting process.

Step 8:

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.

This guidance will be reviewed in summer 2018 through the National Programme for Unscheduled Care.