Six to Help Fix:

Acute Medicine guidance for improving in-hospital flow

July 2023

GIRFT is part of an aligned set of programmes within NHS England

Introduction

In conjunction with the Society for Acute Medicine (SAM), Getting It Right First Time (GIRFT) has produced this guidance, setting out six steps acute hospitals should take to improve flow in acute medicine. This forms the basis for ongoing work focussed on medium and long-term strategies to provide consistent high-quality care, improve flow through the hospital and achieve better outcomes.

This document has been developed using specialist knowledge, intelligence from provider and system visits, and a specialist stakeholder sub-group representing SAM, GIRFT and the Emergency Care Intensive Support Team (ECIST). Consequently, it represents the views of acute physicians currently working in a range of clinical settings across the country, with an awareness that ‘one size won’t fit all’.

The six recommendations made in this document aim to help hospitals manage their acute medical take during the winter months. Implementation of these steps will improve patient care, safety and staff well-being. It is acknowledged that these recommendations will not solve all of the issues that winter demand brings, but, if adopted and followed in a comprehensive manner, it is hoped they will help to reduce some of the burden.

Summary of the Six Steps:

1. **Protect Same Day Emergency Care (SDEC) capacity and function:**
    - SDEC units should never be bedded;
    - Avoid moving the SDEC staff to separate areas due to extra demand elsewhere within the hospital.
2. **Ward rounds and handover:**
    - Acute Medical Unit (AMU) – twice daily review on AMU, 7-days per week which should consist of:
        - an initial structured face-to-face ward round (F2F WR)
        - followed by an afternoon board round (BR) and targeted face-to-face review or a structured second ward round (WR).
        - All ward rounds should have a registered nurse present who is cognisant about the patients to be reviewed. This recommendation also includes short stay ward(s) associated with the AMU.
    - Base Medical/Specialty Wards – a daily structured BR followed by a structured WR (e.g. SHOP model, see appendix 1) on weekdays for all patients unless it has been determined that the review would not affect the patient's care pathway.
    - Acute and general medicine patients should be identified on Friday for weekend review (unstable, medication or result review, potential discharges etc.).
3. **Pharmacy:**
    - Extended 7-day services provided to facilitate discharges throughout the hospital.
    - Specific extended 7-day pharmacy cover to the AMU to facilitate discharges and for medicine reconciliation.
4. **Investigations:**
    - Availability of diagnostics should be based on clinical need; but areas such as AMU, SDEC and Emergency Department (ED) must have the same level of access in terms of priority and reporting times.
5. **Workforce optimisation:**
    - Acute medicine teams should consider options to optimise the workforce which can help deliver safe, high-quality care to patients and service users based on the overall hospital and individual unit demand. This should include increasing the breadth of capability acquisition across all members of the multi-professional team.
    - Review rotas to meet peaks in demand and provide continuity of care where possible, with consideration for how long a complete review takes.
    - Use evidence-based decision support tools (e.g., Shelford tool) for setting the nursing establishment. If not possible in the short term, the minimum registered nurse to patient ratio recommended by SAM is 1:6 for the AMU.
6. **Allied Health Professionals and Acute Frailty Service:**
    - ED, AMU and SDEC should have 7-day extended access to supportive discharge services (such as Intermediate Care) and Acute Frailty Service.
    - Occupational Therapy and Physiotherapy should provide extended 7-day provision for patient assessment, management and to help complete comprehensive geriatric assessments (CGA).

These interventions are best supported by the development of a local comprehensive strategy for achieving flow in acute medicine.

The Six Steps:

1. Protect SDEC capacity & function

SDEC units should never be bedded. This is different from providing chairs and trolleys depending on patient need, and beds should be seen as the very last resort option. While providing extra capacity overnight, this action is significantly outweighed by the knock-on effect of a non-functioning SDEC unit at least the following morning and potentially for longer. This will impede patient flow well into the next day and importantly, prevents the early gains that are possible from transferring patients from the ED first thing in the morning.

a. The capacity of the SDEC includes the multi-disciplinary team, as well as the physical areas. Staffing for SDEC must be protected so that staff are not relocated or reduced in number as this will prevent the SDEC from working optimally.
b. SDEC must be supported by other specialties in a timely manner, especially where access to advice or specialist follow-up is required. Mechanisms to arrange specialist outpatient follow-up should be discussed and organised with specialty medical teams to facilitate necessary patient follow-up.
c. Teams should review and update Site Management Plans and the Operational Pressures Escalation Level (OPEL) framework to ensure that the SDEC is not used as an escalation area.
d. **In extremis** if SDEC is bedded, the trust should enact standard operating procedures (SOPs) to de-escalate and prioritise patients within the ED and Acute Medicine based on clinical needs rather than physical location. Aiming to get the SDEC functioning as soon as possible should be a priority, even if this is only partial functioning. Clinical and administrative teams working within the SDEC area should implement a reporting function so that any instances of the SDEC being used as an escalation area can be audited.

2. Ward rounds and handover

Every weekday morning on the wards, and weekends on the AMU, a board round (BR) should occur in association with the ward round (WR). BRs are a summary discussion of the patient journey. They facilitate allocation of the daily tasks required for the journey to progress and identify and resolve any delays in the patient's hospital stay.

WRs are the key decision-making process to undertake clinical assessments and care planning with patients. Co-ordination of assessments, plans and communication is essential for effective and efficient care and the WR is central to delivering this.

a. To achieve adequate flow of patients through the hospital, ward rounds of all patients on the AMU should start in the morning, **ideally 08:00h or before**, with priority given to the unstable patients first, followed by those where discharge is anticipated and then the remainder (an example of this is the SHOP model (appendix 1) in place at St George's University Hospitals NHS Foundation Trust).

b. A registered nurse who has been appropriately updated regarding the status of the patients, or the nurse responsible for the care of the patient should be present on the ward round, board rounds and handover.
c. Further ongoing consultant assessment can be performed by late afternoon BR followed by either a rolling review on the AMU or a second, structured WR.
d. Opportunities to maximise training, including workplace-based assessments (WpBAs) or supervised learning events (SLEs) where relevant, should be taken during ward rounds and patient reviews. Starting the morning WR at 08:00h on the AMU can facilitate the educational opportunity for trainee doctors working overnight on-take, and this is invaluable to their professional development. Shift times should be modified if necessary to maximise training opportunities.
e. A formal, structured handover **must** occur for each change of shift. Time must be allocated to perform this appropriately. The handover process should be audited and reviewed regularly to ensure it functions well.

For supporting information, follow these links:
Modern ward round collaborative
RCP Acute Care Toolkit: Handover
RCP Acute Care Toolkit: Teaching on the AMU
RCP Modern ward rounds

3. Pharmacy

Pharmacy teams and the service they provide are integral to achieving and maintaining hospital flow with a particular reference to the acute medical flow for the full week, levelling out the activity, with a focus on medicine reconciliation.

- Extended 7-day pharmacy services (a minimum of 8am – 6pm)
- Directed support for the AMU and medicine reconciliation
- Pharmacy services should be available on, and to, the AMU during extended-day working hours, 7-days per week to:
    - provide specialist advice;
    - manage medicines reconciliation;
    - prepare and dispense discharge medication(s) in a timely manner;
    - write discharge letters and TTOs;
    - improve the accuracy of information provided on the WR;
    - provide medication counselling.

For supporting information, follow this link:
Transformation of 7-day clinical pharmacy services

4. Investigations

- Diagnostics should be provided based on clinical need. But areas such as AMU, SDEC, and the ED must have the same level of access in terms of availability, priority and reporting times.
- Access may be affected by the location of the AMU or SDEC being geographically distant to the diagnostic facility in which case efforts should be made to reduce this impediment. Improvements may include:
    - Increased or dedicated portering;
    - air tube/pod systems;
    - point-of-care ultrasound.
- Blood tests from the acute medical service (AMU, SDEC and ED) should be prioritised with the aim of providing results within one hour of the sample arriving to the lab for the common tests performed.
- Point of care (PoC) testing with the appropriate quality assurance should be considered if it can facilitate urgent turnaround of results leading to earlier same day discharge especially where the pathology lab is on another geographical site.
- Pathology services should monitor the turnaround time for investigations to these acute areas and provide a monthly report to both the Emergency Medicine and the Acute Medicine (AM) services using SPC run charts.

For supporting information, follow these links:
Diagnostics: Recovery and Renewal
SAME DAY Strategy

5. Workforce Optimisation

Acute medicine teams should consider options to optimise the workforce which can help deliver safe, high-quality care to patients and service users. Options include:

- Consider the capabilities of all multi-disciplinary team members to increase workforce effectiveness including the use of criteria led discharge and use of non-medical prescribers.
- Utilise additional roles to release clinical time, for example:
    - Ward clerks;
    - Porters;
    - Patient flow co-ordinators;
    - Medical scribes;
    - Volunteers.
- Maximise use of technology to improve effectiveness of clinical time through adequate access to computers and use of electronic patient tracking systems.
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For supporting information, follow these links:

A better future for the NHS workforce

Clinical workforce optimisation

SAME DAY Strategy

5a. Medical staffing

Acute medical illness is a 7-day problem, with patients just as likely to develop an acute illness requiring an emergency admission on a Saturday or Sunday as on a weekday. Evidence that patients admitted at weekends have poorer outcomes than those admitted on weekdays, and that patient mortality is higher at weekends, led to the Royal College of Physicians (RCP) and the Society for Acute Medicine (SAM) recommending that a consultant physician – dedicated to the care of acutely ill patients – should be available on site to review patients for at least 12 hours a day, every day. Acute medicine teams should consider options to optimise the medical workforce:

- There should be adequate direct clinical care programmed activities within consultant job plans to provide senior cover for AM services including; acute take, SDEC and short stay.
- Review rotas and amend to meet peaks in demand and provide continuity of care where possible.

For supporting information, follow these links:

RCP Acute Care Toolkit 4: Delivering 12 hour 7-day consultant presence AMU

Staffing tools and demand/capacity informatic tools

5b. Nurse staffing

Patients on the AMU are often unstable and/or have a higher acuity of illness/disease than many other ward areas, requiring a higher concentration of dedicated and skilled nursing care. Staffing levels should be protected to ensure safe, timely care and patient flow.

- The staffing levels should be considered not just in relation to the physical footprint (beds/trolleys), but in relation to the care demands (including acuity, and numbers of admissions, discharges and transfers) which assessment units by design, need to meet. Local data could inform this.
- The registered nurse to patient ratio should be preserved at a level reflective of the acuity and dependency of patients on the unit, and to maintain safety and the efficient turnover of patients within the AMU. Biannual safe staffing audits should be used to inform establishments and record *Care hours per Patient Day* (typically using the Shelford safer nursing care tool). If it is not possible in the short term, then a ratio of 1:6 should be viewed as the minimum required for safe and effective care.

- Given the high volume, acuity and rapid turnover of patients, co-ordination of the team should be led by a dedicated, supernumerary, registered senior nurse on shift.
- The need for a registered nurse to accompany a patient transfer should be determined on a case-by-case basis and can be delegated to a competent member of staff.
- For patients requiring enhanced care, staffing should be increased appropriately to the level of acuity, and 1:2 for those units that provide Level 2 or HDU care in accordance with national enhanced care guidance.

For supporting information, follow these links:

Shelford safer nursing care tool

Enhanced care guidance

6. Allied Health Professionals and Acute Frailty Service

- Extended 7-day supportive discharge - Intermediate care and Acute Frailty Service to provide support to the emergency/acute floor (ED, AMU and SDEC) with extended 7-day working e.g., 10 hours per day.
- Extended OT and PT for persons living with frailty - Occupational therapy and physiotherapy should provide extended 7-day working e.g., 10 hours per day for patient assessment, management and to start the comprehensive geriatric assessment (GCA) if needed.
- There should be a dedicated allied health professional (AHP) team on the AMU, with appropriate support workers, who are trained to recognise and understand the complexities of acute medicine, particularly in the frail person. This team should be an integral part of the acute medical service.
- The AHP service should mirror the patient demand over an extended hours 7-day period. This is particularly important for occupational therapy (OT) and physiotherapy (PT). The AHP team should provide part of the complex geriatric assessment (CGA) for the frail older person.
    - Some AHPs such as speech and language therapists, need only to be available in a timely manner when contacted but this will require weekend working.
    - Other key individuals such as discharge co-ordinators or social care professionals should also provide support to the acute medical service.
- Key guidance aiming to support hospital teams in their work to improve care of older people living with frailty is available, in a collaboration between GIRFT and the British Geriatrics Society (BGS): https://gettingitrightfirsttime.co.uk/six-steps-to-better-care-for-older-people-in-hospital-are-outlined-in-new-guidance/

For supporting information, follow these links:

AHPs into action

Six Steps to Better Care for Older People in Acute Hospitals

Comprehensive Geriatric Assessment

The comprehensive geriatric assessment (CGA) is defined as a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial and functional limitations of a frail older person in order to develop a co-ordinated plan to maximise overall health with aging. CGA is an organised approach to assessment designed to determine an older person's medical conditions, mental health, functional capacity and social circumstances. Its purpose it to develop and implement a co-ordinated and integrated plan for treatment, rehabilitation, support and long-term follow-up. CGA is based on the premise that a full evaluation of a frail older person by a team of healthcare professional may identify a variety of treatable health problems, resulting in a co-ordinated plan and delivery of care leading to better health outcomes.

Appendix 1

Sick Patients

Senior decision-maker to see patient NOW if deteriorating or overnight/un-reviewed admission

- Is there a clear diagnosis?
- Are any tests outstanding?
- Is there clarity on who is doing what next?
- Is there an adequate management plan?
- Is the predicted date of discharge (PDD) still appropriate?

Home patients

Today's and tomorrow's discharges

- Are all necessary arrangements in place - TTOs, care package, transport?
- Can any outstanding investigations be booked as OP appointments?
- What needs to happen to enable pre-noon discharges?
- Can your patient go to Discharge Lounge early?

Other patients

Review plans and revise (as necessary)

- Is your patient medically stable?
- Is there a PDD and active discharge plan?
- Are any tests or interventions outstanding (are they still appropriate)?
- Has your patient waited more than 24 hours for an internal service (has this been escalated?)
- Can TTOs be done?

Plan

1. Incoming patients and outliers

- How many beds to you have?
- Expected admissions?
- Outliers in other specialties

2. Weekend plans

- Does every patient have a plan of care and management?
- Is the patient suitable for nurse-facilitated discharge?

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About GIRFT and the GIRFT Academy
Getting It Right First Time ('**GIRFT**') is an NHS programme designed to improve the quality of care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The GIRFT Academy has been established to provide easily accessible materials to support best practice delivery across specialties and adoption of innovations in care.

Importantly, GIRFT Academy is led by frontline clinicians who are expert in the areas they are working on. This means advice is developed by teams with a deep understanding of their discipline.

GIRFT Academy has also published other pathways and case studies which are available via FutureNHS. These are available at: Getting It Right First Time - FutureNHS Collaboration Platform

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