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Urgent and Emergency Care Pathway Improvement

Tom Ladlow – Head Nurse Urgent and Emergency Care

one culture of care

Reality we often talk about:

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- High bed occupancy within CHFT impacting patient flow:
  - **November – 99%, December – 97.9%, January – 99%, Feb (to date) – 98.8%**
- Prolonged bed waits in ED (organisational priority appears to have has switched for admitted patients, we are now targeting 12hr DTA time and not the 4hour Emergency Care Standard):
  - **January data to date – ECS = 63.6%, admitted 9.4%, non-admitted 73.6%**
  - **Number of admitted patients waiting >12 hours – Nov – 951, Dec – 1,092, Jan – 1,002**
  - **Average LoS for admitted patients – Nov 10 hours, Dec 11 hours, Jan 10 hours**
- Increased ambulance queuing resulting in delayed patient handovers.
- ED overcrowding – resulting in delays to care - delays to IVABx, assessment, critical investigations ECG, cannulation.

Reality we don't often talk about:

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5 February 2024

HRI ED 21:00:

85 patient in department

28 patients waiting to see clinician @ 4 hours 23 minutes

18 patients waiting in-patients beds (10 cubicles in Majors all full, 8 further bed waits in 4 MIU cubicles + 2 in Surge Spaces + 2 in Lounge)

10 patients waiting in MIU – only 1 cubicle available to see patients.

10 patients currently in the assessment stream (6 assessment cubicles):

- 5 patients have been assessed and all waiting majors cubicles – 3h20m, 2h30m, 2h26m, 2h19m, 1h45m.
- 5 patients waiting assessment (longest wait 1h15m) – only 1 assessment cubicle available to do all assessment, bloods, ECGs, rapid treatments.

CRH ED:

81 patient in department

30 patients waiting to see clinician @ 3 hours

9 patients waiting in-patients beds (12 cubicles in Majors 3 cubicles to see waiting patients)

Reality we don't often talk about:

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Message sent from ED band 7 on duty to nursing leadership team:

I felt like I had to warn you as I know it would be coming your way tomorrow. A patient has died in the waiting room waiting for assessment, in front of everybody whilst waiting for triage, at the same time we have had 7 back to back seizing patients, with reduced GCS – all have airways insitu, 4RTCs arrived from an incident in Calderdale, we got them placed everywhere – on top of the 80 patients here already, and we now have to move the deceased patients out of the waiting room in full view of everyone,

There has also been a large machete fight in Calderdale – a lot of patients self presenting to the CRH site from the incident – one patients attended with full hand amputation – taking a lot of senior medical and nursing support away from the shop floor. I have checked in with CRH, but unfortunately I am unable to send them any staffing support due the department here, it has been absolutely horrendous.

“If you do not change direction, you may end up where you are heading.” – *Lao Tzu*

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Key Improvement Areas

Rational for change:

- Improve patient outcomes and experience by ensuring access to appropriate care.
- Our organisational priority must be to ensure the ED can provide timely emergent care to all who require it.
- Sustained high-pressure environments without adequate support lead to staff burnout, reduced morale, and increased turnover. Ensuring appropriate resourcing and system improvements will help protect our workforce and maintain a safe, effective service.
- The current demand and overcrowding is creating an unacceptable clinical risks within the ED, increasing the likelihood of avoidable harm, delayed interventions, and poor outcomes.

The Urgent and Emergency Care pathway improvement trial focus's on three key areas:

- Urgent and Emergency Care Same Day Emergency Care (SDEC) Unit
- Minor Injury Clinic
- Review of Medical SDEC Exclusion Criteria & Expansion of Patient Acceptance Hours

Key Objectives of the trial

- **Organisational commitment to ensure patients spend no more than 12 hours within the UEC system.**
- Ensure patients are seen by the correct speciality at the earliest opportunity.
- Ensure a home-first approach is taken for all non-emergent patients.
- Reduce pressure within the ED to ensure emergent treatments can be delivered at the earliest opportunity.
- Utilise PDSA (Plan-Do-Study-Act) cycles for optimisation and safety:
  - Daily operational PDSA Monday – Friday – with weekly meeting into divisional SMT

UEC SDEC

Rational for UEC SDEC

Due to the current situation, a significant group of urgent (but non-emergent) patients can be identified. This group often requires significant inputs as they have the potential for same day discharge after investigation and treatment.

This group could be managed on SDEC's, however, current SDEC's struggle to provide:

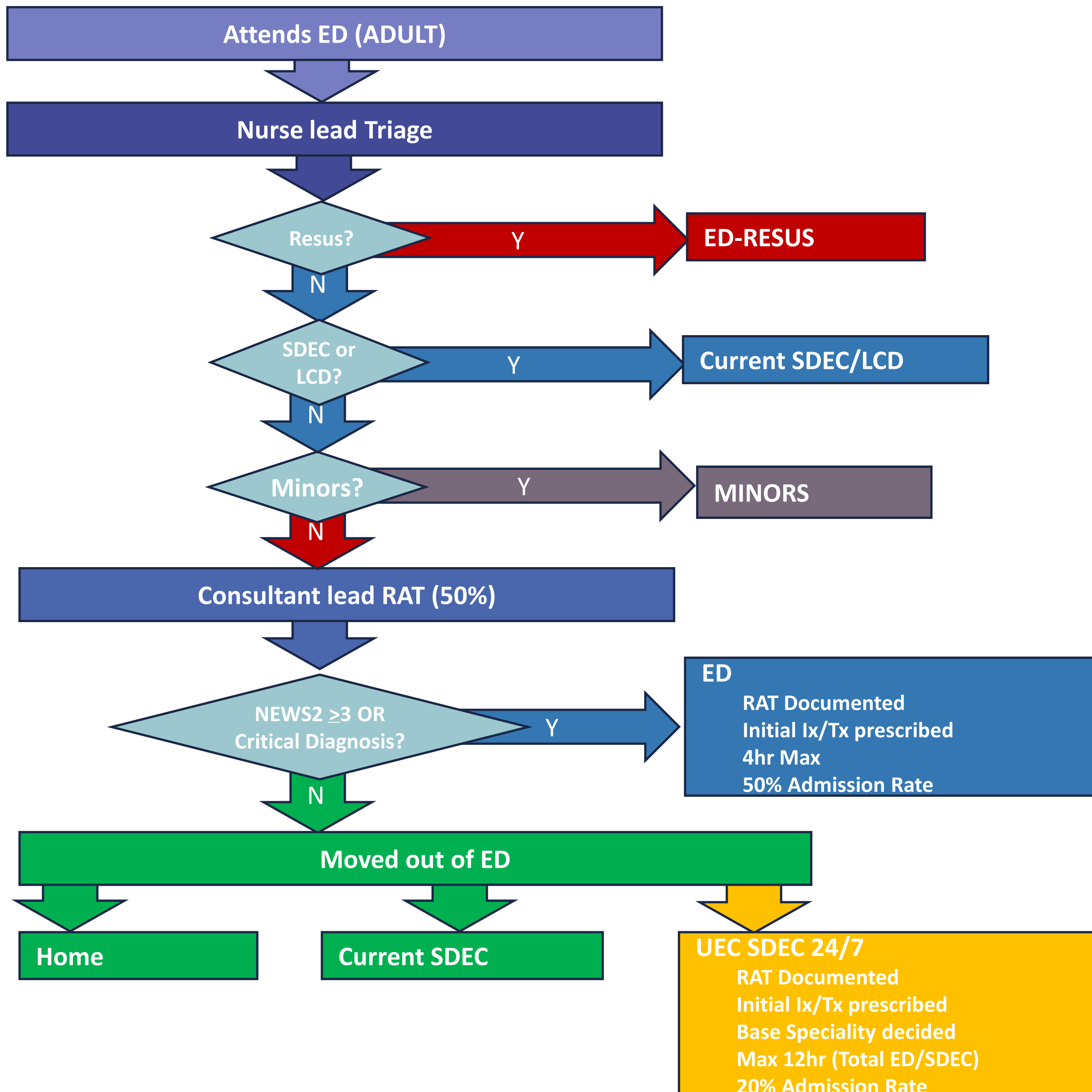
- 24/7 patient access
- Space for all UEC specialities
- Ability to manage patients who fall between specialities.

Functioning of UEC SDEC

UEC SDEC will be managed by the Emergency Directorate as it can uniquely provide generalist oversight of all patients, however, for best functioning and outcomes, specialty input is essential and clinical responsibility with follow the agreed pathway.

Referral

Patients will flow from the ED to UEC SDEC on the trusted assessor model provided they meet the criteria. If potentially suitable patients who fall outside the criteria are identified a Senior-Senior conversation must happen (this also includes patients identified in ED and referred to speciality care who may be discharged after further work-up)



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UEC SDEC Flow:

Flow within the UEC is vital.

- Patients must not spend >12hrs within the UEC (Combined ED/UEC SDEC)
- Patients will preferentially be sent to available speciality SDECs if possible.
- Patients should not take backward steps.

Minor Injuries Clinic

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1. **Triage & Eligibility Assessment** (22:00 onwards)
2. **Appointment Allocation** (next day 09:00–13:00 slots)
3. **Follow-up assessment by Emergency Nurse Practitioners**

Exclusions for Minor Injuries Clinic:

- Deformities / neurovascular compromise
- Wounds requiring closure or exploration
- Non-weight-bearing injuries
- Children <16 years
- Facial injuries, burns > palm size

Safeguarding concerns / intoxicated patients

Review of Medical SDEC Exclusion Criteria & Expansion of Patient Acceptance Hours

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1. Expansion of SDEC Acceptance hours

Monday – Friday 0800-2000 (increase of 2 hours per day)

Saturday – Sunday – To be reviewed through PDSA

2. Exclusion Criteria: Patients meeting the following criteria are not suitable for Medical SDEC:

- Age under 16 years.
- Conditions managed by Trauma, Surgery, Haematology/Oncology, Renal, Obstetrics/Gynaecology, or Mental Health services.
- New oxygen requirements unless discussed with the SDEC clinician.
- NEWS2 scores greater than 5 or individual scores of 3 on any parameter.
- Time-critical diagnoses, including:
    - High-risk chest pain (e.g., STEMI, new acute ECG changes, HEAR score >4).
    - Suspected or confirmed stroke, including TIA.
    - High-risk sepsis (NEWS2 score ≥7).
    - Seizures.
- Patients requiring isolation when all doored isolation cubicles are occupied.
- Patients suitable for ED Urgent Care Hub or Local Care Direct.

Flexibility for Consultant-Led Decisions:

- Patients outside of the exclusion criteria can be considered for SDEC if reviewed and deemed appropriate by an Acute Medical Consultant, following discussion with the SDEC coordinator.

Consultant workflow:

- 0900 – Acute Medical Consultant to attend UEC SDEC and ED to review and pull patients into MSDEC
- 1300 - Acute Medical Consultant to attend UEC SDEC and ED to review and pull patients into MSDEC

Trial Staffing Requirements:

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UEC SDEC Clinical Space:

- Integrated Flow Hub Main Area (Old ED Majors)

Clinical Staff UEC SDEC (Daily):

- 1 ED Consultant (08:00–00:00)
- 1 Tier 4+ ED clinician (24 hours)
- 2 Tier 2+ clinicians (24 hours)

Nursing Staff (UEC SDEC):

- Early Shift: 3 RNs + 2 HCAs (1 RN Band 7/6 in charge)
- Late Shift: 4 RNs (incl. 1 twilight shift: 11:00–00:00) + 2 HCAs
- Night Shift: 3 RNs + 2 HCAs (1 RN Band 7/6 in charge)

Additional Support Staff (UEC SDEC):

- 1 Porter (20:00–08:00)
- 1 Housekeeper (24/7)

Minor Injuries Clinic:

- 2 Emergency Nurse Practitioners 0900-1300 7 days per week.

Trial KPI's - UEC SDEC

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UEC SDEC KPIs:

1. Flow & Efficiency:
   - Number and percentage of ED attendances redirected to UEC SDEC.
   - Average time from ED arrival to UEC SDEC arrival.
   - Average time to clinician.
   - Average length of Stay (LoS) in UEC SDEC.
   - Discharge rate from UEC SDEC *(Target: 70-80% home-first approach)*
2. Patient Safety & Experience:
   - Number and content of patient safety incidents in UEC SDEC.
   - Unplanned ED re-attendance rate within 72 hours.
   - Patient experience feedback (Friends & Family Test, qualitative feedback).
   - Patient complaints or concerns related to Medical SDEC
   - Use of EDEN tool to evidence care quality.
3. Workforce & Resource Use:
   - UEC SDEC staffing fill rate.
   - ED staffing levels vs. UEC SDEC staffing.
   - Staff experience – qualitative feedback

Trial KPI’s - Minor Injuries Clinic

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Minor Injuries Clinic KPIs:

1. Operational Efficiency:
    - Clinic slot utilisation & fill rate.
    - DNAs
    - Average LoS for minor injuries patients (2200-0800).
2. Impact on ED:
    - Bounce-back rate from Minor Injuries Clinic into ED Majors.
    - Number of minor injury patients spending >4 hours in ED.
3. Workforce & Resource Use:
    - MIU Clinic staffing fill rate.
    - Staff experience – qualitative feedback
4. Safety & Patient Experience:
    - Number and content of patient safety incidents in UEC SDEC.
    - 72-hour reattendance rate (unplanned).
    - Patient feedback on service experience.

Trial KPI's - Medical SDEC

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Medical SDEC KPIs:

1. Flow & Efficiency:
    - Percentage of ED attendances referred to Medical SDEC
    - Average time from ED arrival to Medical SDEC referral
    - Average time to clinician.
    - Average length of stay in Medical SDEC
    - Percentage of patients admitted from Medical SDEC
2. Safety & Quality:
    - Number and content of patient safety incidents in UEC SDEC.
    - Unplanned re-attendance to ED or Medical SDEC within 72 hours
3. Patient & Staff Experience:
    - Patient experience feedback (Friends & Family Test, qualitative feedback).
    - Patient complaints or concerns related to Medical SDEC
    - Staff feedback on the effectiveness of the Medical SDEC model

Trial KPI’s - ED

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ED KPIs to monitor impact of the trial:

1. Impact on ED:
   - Average ED LoS (split by discharged & admitted patients).
   - 4-hour performance in ED:
     - Total
     - Admitted
     - Non-admitted
   - Treated within 60 minutes
   - Number of 4-12 hour DTAs
   - Number of 12 hour DTAs
   - Number of >12 hour waits.
   - Ambulance handover delays:
     - >15-30 minutes
     - 30-60 minutes
     - >60 minutes
   - Patient experience feedback (Friends & Family Test, qualitative feedback).
   - Staff experience – qualitative feedback

PDSA cycles: Continuous Improvement in action

Why PDSA?

Enables real-time problem-solving and rapid iteration.

Ensures data-driven decision-making for sustained improvements.

Promotes collaborative learning across teams and specialities.

How Will This Work?

Daily PDSA cycles will be conducted throughout the trial period to rapidly test and refine improvements.

Weekly PDSA review meetings with the Divisional Senior Management Team (SMT) to assess progress and adapt strategies.

Cross-speciality collaboration: Representatives from other specialities will be invited as needed to ensure cross speciality improvements and suggestions are noted.

Full team approach: PDSA review will be open to all members of the team to ensure a wide range of opinions/improvements are obtained.

Microsoft Teams Form: Feedback will also be obtained via a Microsoft Form to ensure those who are unable to attend the PDSA meeting can contribute.

Daily PDSA cycles:

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Daily PDSA Meeting Structure

Frequency: Monday – Friday
Duration: 30 minutes
Attendees:

- Operational Team

Agenda:

1. **Review of the day:**
   - What worked well?
   - What challenges were encountered?
   - Safety Incidents
   - What, if anything should we change tomorrow?
   - Any specific staff and patient feedback?
   - Any barriers requiring additional support?
2. **Escalations**
   - Anything to escalate to divisional SMT?
   - Who is on for escalation tomorrow?
   - Actions to be allocated and changes communicated to team.

Weekly SMT PDSA updates:

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Weekly Divisional SMT PDSA update:

A concise summary of the week will be prepared for SMT, including:

- What worked well?
- What challenges were encountered?
- Safety Incidents
- Change made through PDSA cycles?
- Any specific staff and patient feedback?
- Any barriers requiring additional support?
- KPI update
- Summary of feedback from staff and patients
- Any urgent risks or escalation points

Discussion / Questions