Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS Improvement

Rapid Improvement Guide to:

The SAFER Patient Flow Bundle

Introduction

SAFER is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity).

The SAFER bundle blends five elements of best practice. It's important to implement all five elements together to achieve cumulative benefits. It works particularly well when it is used in conjunction with the '**Red** and **Green** Days' approach. When followed consistently, length of stay reduces and patient flow and safety improves.

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 (EDD) and Clinical Criteria for Discharge (CCD), set by assuming ideal recovery and assuming no unnecessary waiting.

F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving 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 multi-disciplinary team (MDT) review of patients with extended lengths of stay (>7 days – also known as 'stranded patients') with a clear 'home first' mind set.

S - 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 check lists to reduce variation and prevent actions being omitted.
- Always include a qualified nurse, other members of the MDT and involve the patient.
- Use a 'consultant of many days', 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 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 – if undertaken daily, in the early morning, enable teams rapidly to assess the progress of every patient in every bed and address any delays to treatment or discharge. A second, afternoon board round is best practice to review progress.

'**Red and Green Days**' are 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 tomorrow, 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 using statistical process control (SPC) run charts should be used to identify how many patients are receiving a senior review before midday every day, and any trends.

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

All patients should have a consultant approved care plan containing an EDD and CCD, set within 14 hours of admission.

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 his/her clinical and functional goals and can leave hospital to recover or rehabilitate in a non-acute setting (usually their normal place of residence).

A challenging EDD 'goal' should be set to reduce procrastination 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 next of kin) 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. Simple patient information cards can help by clearly stating what is going to happen to patients 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.).

F - Flow early from assessment units

Every ward that routinely admits patients from assessment units should ensure they 'pull' the first patient to their ward before 10am every day.

Ward teams should be in regular communication with assessment units to agree the first patient, with assessment unit teams reviewing patient care at the ward/board round and ensuring patients are informed beforehand that they will be transferred to the receiving ward at a specified time (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 early morning from assessment units, to ensure space for incoming patients and to reduce ED crowding and associated safety risks.

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

Morning discharges should be the norm, with at least one in every three of the day's discharges to have left their wards by midday. This reduces emergency department (ED) crowding 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 TTOs (medication to take home) and 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.

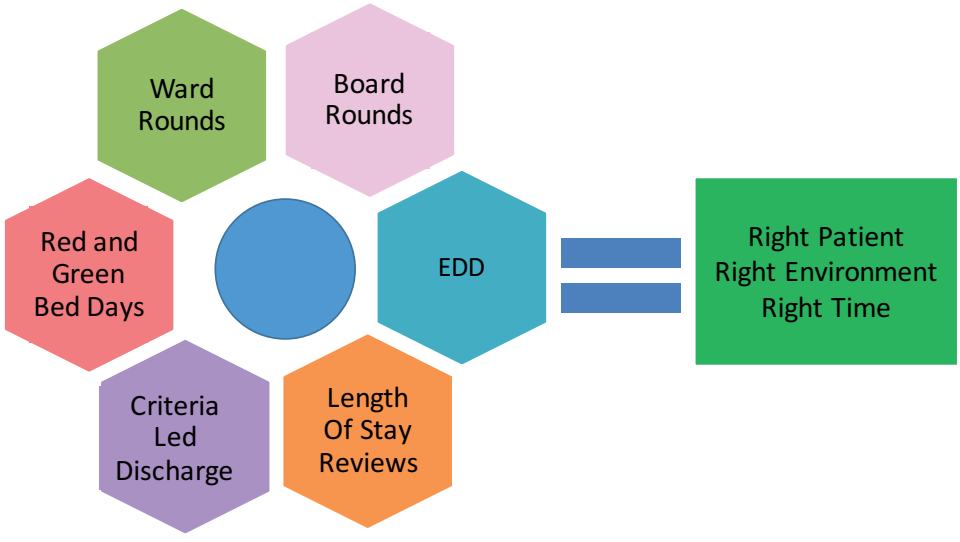
Pharmacy teams should be actively engaged to help reduce delays with TTO processes. Examples include the introduction of generalist prescribing pharmacists and satellite pharmacies nearer ward areas as described here.

R – Review all 'stranded' patients (all patients in hospital seven 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 alternate 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?

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. Most patients benefit from assessment in their normal place of residence where they can surprise professionals with their ability to cope in familiar surroundings.



There should be an effective process that enables a daily MDT (health and social care) review of all stranded patients with the default assumption that patients will be discharged to their normal place of residence. To enable this, system partners 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.
- For the majority of patients, definitive assessment of social care needs should occur outside of hospital (discharge to assess).
- The MDT should have same-day access to social care advice, ideally at the morning board round, or by phone.
- 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. using simple, brief electronic documentation that is quick and easy to complete).

This should be measured using the 'stranded patient metric', with information presented in SPC run charts so trends and real improvements can be seen.

Conclusion

Many hospitals find that where SAFER becomes 'business as usual' on all wards, length of stay falls and clinical outcomes improve. Essential components of successful implementation of SAFER are:

- **Clinical leadership** – implementation and sustaining momentum requires great clinical leadership to support operational teams
- **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 proactively to 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 bundle
- **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.