Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS Improvement

Rapid Improvement Guide to:

Red and Green Bed Days

Introduction

'Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey. Applicable to in-patient wards in both acute and community settings, this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle. 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 and Green on an hours/minutes basis may be more appropriate.



A **Red** day is when a patient receives little or no value adding acute care. The following questions should be considered:

- Could the care or interventions the patient is receiving today be delivered in a non-acute setting?
- If I saw this patient in out-patients, would their current 'physiological status' require 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:

- A planned investigation, clinical assessment, procedure or therapy intervention does not occur.
- The patient is in receipt of care that does not require an acute hospital bed.
- The medical care plan lacks a consultant approved expected date of discharge.
- There are no consultant approved physiological and functional clinical criteria for discharge in the medical care plan.

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

A **Green** day is when a patient receives value adding acute care that progresses their progress towards discharge.

A **Green** day is a day when everything planned or requested gets done.

A **Green** day is a day when the patient receives care that can only be in an acute 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 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. Questions 3 and 4 together can be used together to flush out unnecessary waiting along the pathway.

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On a Red day, patients typically receive care that could be provided in a non-acute setting (such as personal care, routine observations, IV antibiotics, usual medication). 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 rigorously apply 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 daily, morning multi-disciplinary Board Round with all patients marked as 'Red'.
2. The day remains as 'Red' if there is inadequate senior presence at the Board Round to allow firm decisions to be made
3. The day remains as 'Red' 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.
4. The Board round should ensure that a patient's case management plan is progressed 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 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 and Green days process is linked to the **SAFER patient flow bundle**
7. It is helpful to link flow, safety and reliability with visual demonstration using a 'Ward Improvement Board' as described in the Productive Ward Programme. Examples of ward level metrics that might be used include:
    a. Impact Metrics – 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 Metrics – 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 Metrics – number of unplanned re-admissions
    d. Quality Metrics – pressure sores, HCAI, catheter days, cannula days, falls.
8. The constraints identified by wards to converting 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 adding process.
10. At the end of each week, the top five constraints that could not be resolved by ward teams or following escalation should be considered by senior operational managers and where appropriate, added to local improvement plans.

A YouTube video on Red and Green Bed Days, presented by the ECIP Team and Ipswich Hospital NHS Trust, can be found here: https://youtu.be/Dc-b6GclTq4