Essential Action 3: Patient Rather than Bed Management

The Daily Dynamic Discharge Approach

Improving the timeliness and quality of patient care by planning and synchronising the day's activities

GUIDANCE DOCUMENT

6 ESSENTIAL ACTIONS
Unscheduled Care

Healthier Scotland
Scottish Government

The Daily Dynamic Discharge Approach

Improving the timeliness and quality of patient care by planning and synchronising the day's activities

Contents

✴ Background

✴ The problem we need to solve

✴ The core of the approach

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An introduction to the 6 Essential Actions for Improving Unscheduled Care

The 6 Essential Actions to Improving Unscheduled Care[1] Improvement Programme was launched in May 2015. In consultation, 6 Essential Actions were identified as being fundamental to improving patient care, safety and experience for the unscheduled care pathways.

The Six Essential Actions

1. Clinically Focussed and Empowered Hospital Management

2. Capacity and Patient Flow Realignment

3. Patient Rather than Bed Management

4. Medical and Surgical Processes arranged for Optimal Care

5. Targeted 7 Day Services

6. Ensuring Patients are Cared for in their Own Home

The aim of the programme is 'safe, person centred, effective care delivered to every patient, every time without unnecessary waits, delays and duplication'.

Essential Action 3: patient rather than bed management, considers the management of the patient journey which requires a multi-disciplinary approach to care management and a dynamic discharge process that includes access to diagnostics, appropriate assessment, alignment of medical and therapeutic care; home when ready, discharge in the morning, transfer care back to the GP.

The Daily Dynamic Discharge approach is a key element of Essential Action 3. It is designed to ensure that local teams have everything they need to deliver tangible improvements in patient safety and flow.

| AIM | Improve | 6 Essential Action | Key Elements | Interventions | Metrics |

AIM — Safe and effective care delivered to every patient, every time without unnecessary waits, delays and duplication
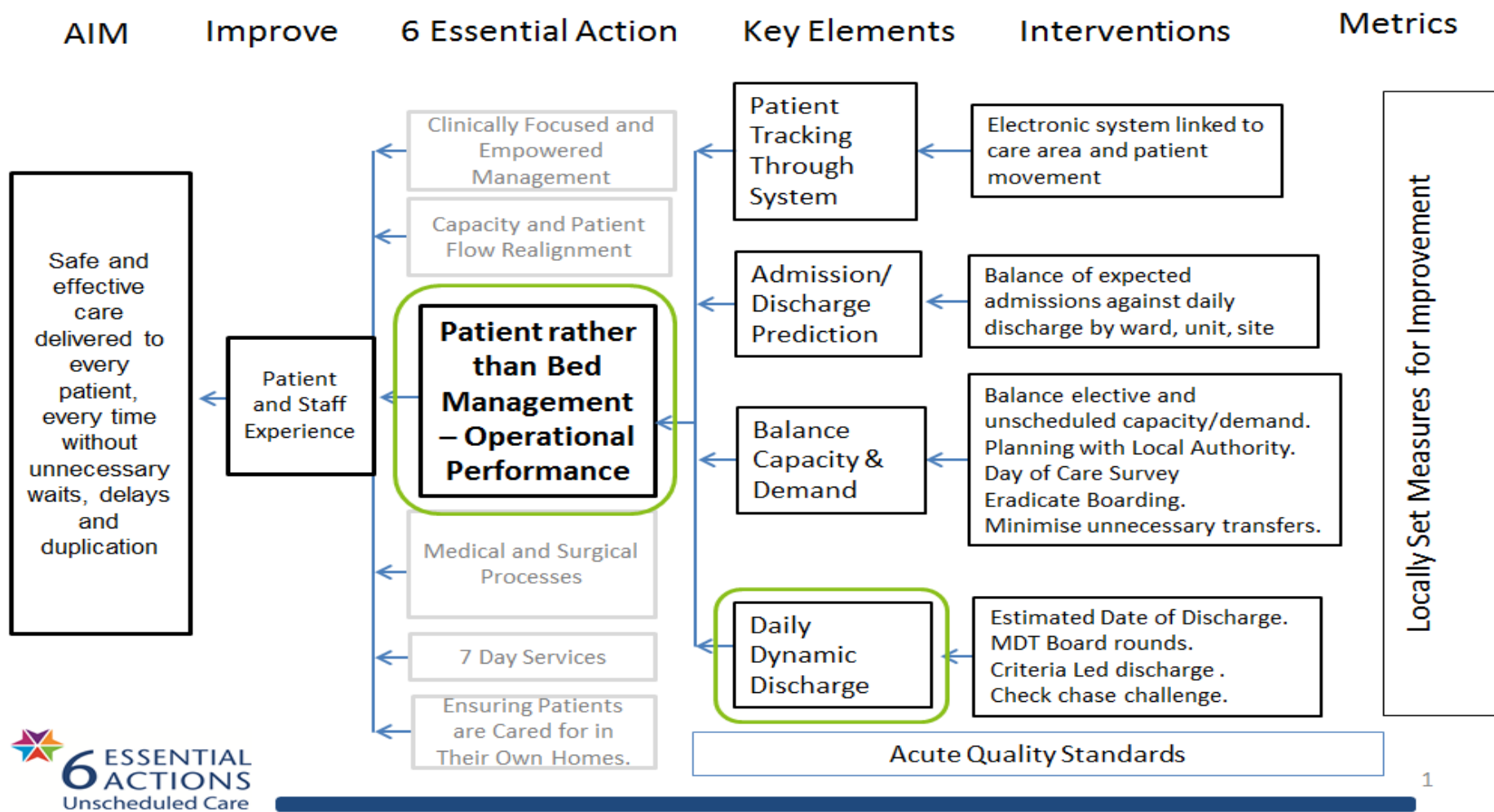
Improve — Patient and Staff Experience

6 Essential Action:
- Clinically Focused and Empowered Management
- Capacity and Patient Flow Realignment
- **Patient rather than Bed Management – Operational Performance**
- Medical and Surgical Processes
- 7 Day Services
- Ensuring Patients are Cared for in Their Own Homes.

Key Elements:
- Patient Tracking Through System
- Admission/ Discharge Prediction
- Balance Capacity & Demand
- Daily Dynamic Discharge

Interventions:
- Electronic system linked to care area and patient movement
- Balance of expected admissions against daily discharge by ward, unit, site
- Balance elective and unscheduled capacity/demand. Planning with Local Authority. Day of Care Survey Eradicate Boarding. Minimise unnecessary transfers.
- Estimated Date of Discharge. MDT Board rounds. Criteria Led discharge. Check chase challenge.

Acute Quality Standards

Metrics — Locally Set Measures for Improvement

6 ESSENTIAL ACTIONS Unscheduled Care

1

http://www.qihub.scot.nhs.uk/unscheduled-care.aspx

4

Delay in a Patient's Journey
Inevitable or Preventable?

There are many things which have the potential to cause delay and unnecessarily prolong a patient's stay in hospital, some of which can be categorised as 'external' (services or resources external to the ward or hospital which may not be available when the patient needs them). However, there are also internal causes of non-clinical delay, and these equally contribute to poor patient experience; for those patients in a bed, waiting for what they need **and** for those waiting to access the bed.

Evidence from the Day of Care Audits[2] carried out across NHSScotland indicates that at any one time, between 20% and 40% of patients in hospital beds no longer require acute care but their transfer to another area for continuing care, or discharge to General Practitioner has been delayed.

The complexity of the discharge planning process; the way the plan is communicated and the choices made in the way the plan is executed, can lead to what appears to be inevitable delays for patients during their stay. For most, the human response to the many conflicting demands on their time is to locally optimise and work in a way which may be best for them as individuals (or in a way that may seem most logical for someone who works across wards), but which may not support the optimal flow of patients. In fact this 'mis-synchronisation' of the Multi-Disciplinary Team (MDT) often causes delay, and this can add significantly to a patient's length of stay.

Extended length of stay and discharge patterns which are more in line with how wards and individuals tend to work than the patient's needs, wreak chaos every day in hospitals everywhere.

Balancing the day's clinical and care delivery needs, with the timely completion of tasks required to ensure timely discharge is an ever-present challenge for ward teams. Staff constantly juggle doing what's best to support patient flow and making the best use of often scarce resources.

This guidance seeks to define a framework and provide guiding principles to help better manage this balance, supporting the safe and timely transfer of patient care out of hospital, and thereby also improving the timeliness of access to treatment.

Daily Dynamic Discharge
Forming an evidence base

The Royal College of Physicians, in 'Right Patient, Right Place – Right Time'[3] dictates that 'transfer of care planning should commence at the point of entry to acute care and involve the appropriate components of the multi-professional team at the earliest opportunity'.

The NHS Institute for Improvement[4], concurs, and adds that 'planning for discharge with clear dates and times reduces a patient's length of stay, emergency readmissions and pressure on hospital beds, and that there are key elements when planning for discharge, regardless of whether a patient is receiving emergency or elective (inpatient or day case) care. These are:

- specifying a date and/or time of discharge as early as possible
- identifying what a patients discharge needs are and how they will be met
- deciding the identifiable clinical criteria that the patient must meet for discharge'

The institute bases its view on evidence of the commonly observed phenomena of periods of mismatched demand and capacity in hospitals. This occurs when the total number of new admissions necessitates patient discharge so that their beds become available.

The recently published Scottish Government Emergency Department Capacity Management[5] Guidance states that 'while the most visible and widely publicised example of pressure and patient care delays are cited as patients on trolleys in EDs, this is not just an ED problem; crowding in the ED affects various parts of the hospital in different but interrelated ways. We recognise the multi-disciplinary issues and we must do more to minimise the risk to patients on a whole-system, integrated basis.

At times of peak demand, hospitals are, to all intents and purposes, 'gridlocked' until patients are discharged [6] as there are often a few hours each day when admissions are likely to outpace discharges. The evidence states that moving even 30% of discharges ahead of admissions would reduce the maximum peak of bed requirement, and concludes that planning discharges before the peak in admissions is an effective way to smooth the total demand for beds.

In addition, models used to determine bed capacity management and short-stay emergency care indicate that, if a patient's discharge is facilitated by 1 pm, the hospital has sufficient capacity to carry out elective work and accommodate patients admitted as an emergency without waits and delay or breaching the four-hour emergency access standard. To realise and sustain this discharge performance indicator at ward level, nurses are encouraged to take individual responsibility and ownership of the discharge processes.[7]

The Royal College of Physicians' 'ward rounds best practice' guide[8] states that the wider multi-disciplinary team – doctors, nurses, pharmacists, therapists and allied health professionals – must be given dedicated time to participate, with clarity about individual roles and responsibilities during and after ward rounds. This includes:

- structuring ward rounds: preparation, scheduling and post-round review with allocation of tasks
- ensuring nursing involvement, sharing information about the patient and being informed of all key decisions about their care
- discharge planning: setting a date for discharge and giving patients a detailed plan on how to manage their care outside hospital.

Why Patients Get Delayed

Many things can delay patients throughout their episode of care, but lots of it is preventable, and results from poor planning, communication and the mis-synchronisation of tasks, due to:

Unclear treatment planning
  what, how, for how long
Unclear dependency
  when should therapy start/finish
Unclear treatment end point
  inability to plan other tasks in parallel
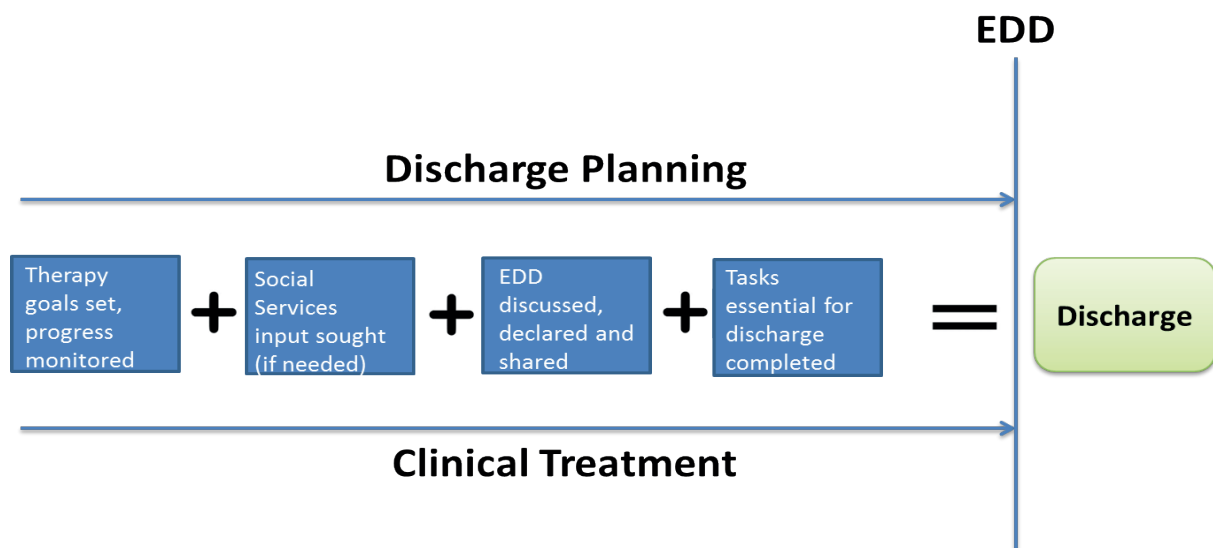Last minute planning of non-clinical tasks
  care needs, housing, long term placement
Poor communication of changes
  change in recovery/discharge date to be brought forward or extended
Mis-synchronisation
  dis-jointed multi-disciplinary team, subjectivity

EDD

Discharge Planning

| Therapy goals set, progress monitored | **+** | Social Services input sought (if needed) | **+** | EDD discussed, declared and shared | **+** | Tasks essential for discharge completed | **=** | **Discharge** |

Clinical Treatment

In theory, these things should run in parallel but often they do not. The plans can be incoherent and unclear and the execution of the plans mis-synchronised.

What Do We Mean by 'Mis-synchronisation'?

In the absence of one clear priority order, each member of the MDT will choose the order in which to work which often means patients wait.

The more individuals involved in the plan, the less likely the Estimated Date of Discharge (EDD) will be met.[9]
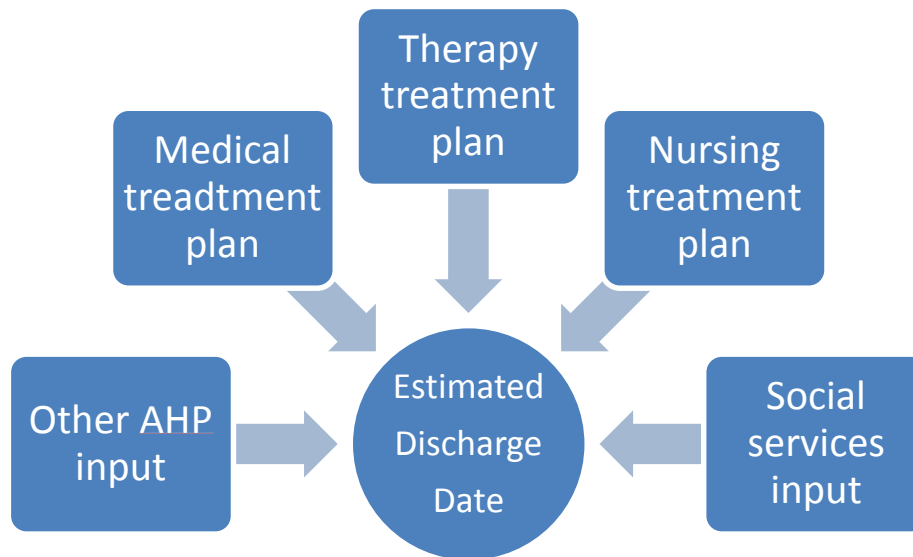
No of resources involved in discharge plan	Reliability of on time completion of tasks	Probability of on time discharge
3	90%	72.9%
3	70%	34.3%
5	90%	59%
5	70%	16.8%
7	90%	8.2%
7	70%	0.8%

Delay Caused by 'Human Behaviours'

This doesn't mean we consciously choose to behave in a way which causes delay, it is an inevitable side effect of working in such a complex environment dominated by high levels of variation and uncertainty, with many conflicting demands on our time. We tend to create 'coping mechanisms', these include:

- Acceptance of delay

- Batching/Bad multi-tasking/Silo-working

- Parkinson's Law and Student Syndrome

    - Think setting an EDD around known delays and 'realistic' completion time rather than the patients recovery rate - enter 'Parkinson's Law' (work expands to fill the time allotted)

    - Student Syndrome: Leaving things until the last minute – enter 'Murphy', or picking off easy tasks at the cost of complex ones. Think simple discharges vs complex discharges.

The Solution – Daily Dynamic Discharge

The key features

THE DAILY DYNAMIC DISCHARGE APPROACH

Creating the plan
- Dynamic MDT Planning
- Early EDD Setting
- Effective Ward Round

Execution of the plan
- Daily Whiteboard Meetings
- Golden Hour Ward Rounds
- Non-slip Task Management
- Check, Chase, Challenge
- Ward Access Targets
- Pre-noon discharge

1. Dynamic MDT Planning

The Multi-Disciplinary Team get together within 12 hours of a patient's admission and develop an understanding of the component parts of a patient's discharge plan – what treatment is required, with what – and for how long. They also consider what other things need to be done in parallel with the clinical treatment, in order for each patient to be discharged safely onto the next appropriate area of care.

Identifying what are the dependant tasks and agreeing when they each need to start (and finish) to ensure the patient can be discharged without delay is essential.

The term 'dynamic' relates to the movable nature of the estimated discharge date, and the dependant tasks relative to the patient's recovery rate.
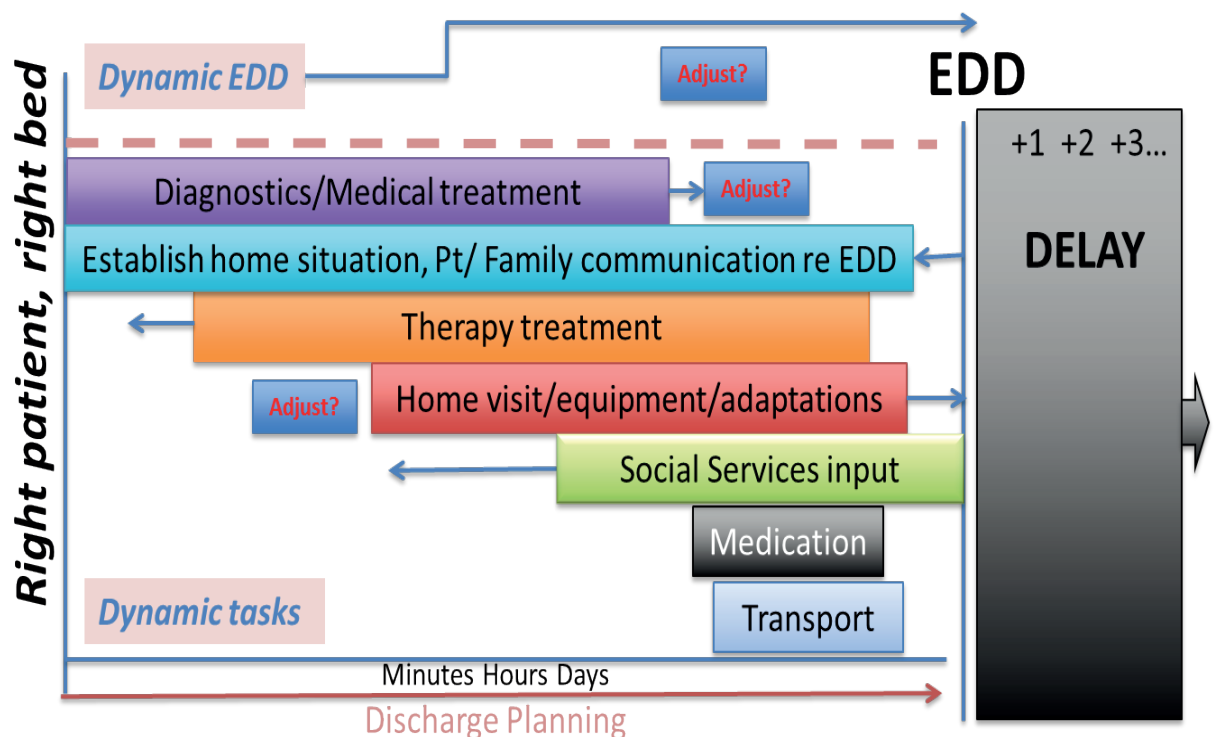
2. Setting and Reviewing an Estimated Date of Discharge (EDD)

The estimated date of discharge (EDD) is the date when the MDT believes the patient can be safely discharged from the acute hospital setting. This may be to home or another place of care.

The key to setting an accurate EDD is:

1. a clinical process to estimate and document a date of predicted medical fitness (i.e. when the patient no longer needs medical treatment in hospital)

2. followed by a communication process to document an estimated date of discharge based on the holistic/MDT view

3. changed to reflect the most recent view of the patient's recovery rate (is this still the date we expect this patient to be well enough to leave our care?)

Figure 1 below shows an example from a hospital site of the process established to ensure consistency in setting an EDD across all wards to ensure full compliance with the Daily Dynamic Discharge approach.

Figure 1: an example from an NHSScotland Hospital site

Guidance	
Electives	➢ For elective admissions, the EDD is set by the admitting nurse when clerking in the patient ➢ Some common conditions have typical EDDs, e.g. Troponin 1 day, UTI/Delirium 5-7 days, angioplasty 1 day, graph 5-7 days, amputation 3-4 weeks (sometimes the same procedure is performed differently by surgeons (EDD can be between 1-5 days)
Emergencies	➢ For patients admitted from the receiving unit, an initial EDD of 2-3 days is usually set
Admission	➢ The admission nurse on the specialty ward completes the admission paperwork and, depending on their level of experience and the level of information available about the patient's presenting condition, will set the EDD
Setting the EDD	➢ On occasions, it may be the Nurse in Charge or the Ward Clerkess who sets the EDD. If the admitting nurse does not have the level of clinical experience to estimate a discharge date, the Nurse in Charge will set the EDD. ➢ On occasion, the Ward Clerks may set the EDD to complete the information needed for the whiteboard
Reviewing the EDD	➢ The next morning, before the 8am ward huddle, the EDDs are reviewed and the nurse leading each team will be asked about their patients' EDDs and whether they require to be changed ➢ The whiteboards would be updated by nursing staff as a result
On the ward round	➢ The Consultant involved in the patient's care would review the EDD at the first ward round ➢ Nursing staff would then update the whiteboard ➢ The EDD would then be reviewed daily and/or at subsequent ward rounds
Communication with the patient	➢ Generally the patient and family are told the proposed EDD following the first Consultant review. If the patient/family are given the EDD this is done verbally and recorded in the notes

3. Effective Ward Rounds

A fundamental part of the approach is clarity around the plan for the patient's clinical treatment to ensure that all other tasks are able to commence timeously and be aligned with the date the patient is medically fit for discharge.

To ensure that the EDD is truly dynamic and reflective of the patient's treatment and recovery, the treatment plan must be clearly communicated to the multi-disciplinary team involved.

Ensuring that ward rounds are effective and that the Senior Decision Maker's treatment plan has been clearly articulated is essential to ensuring that all elements are in place for that patients care.

It is useful to test this effectiveness and identify any areas for improvement. A proforma template is recommended to be completed during discussions for each patient; ensuring the following questions around the discharge plan are answered.

- What is it we are treating (diagnosis)?
- What treatment are we providing?
- For what period of time?
- What is the remaining duration of that today?
- What other things need to be in place for discharge?
- Does the EDD need to be changed?
- Does this patient need to be seen again by a consultant before discharge (suitable for criteria led discharge)?

This process of using a proforma ensures each patient's treatment plan is consistently considered and reviewed as appropriate.

4. Daily Dynamic Discharge Whiteboard Meetings

What are they?

Every day, getting together for 10 minutes to discuss, agree and prioritise the day's tasks first thing in the morning, answering the question for the whole team, 'of all the things I could do today, which should I do, and in what order'?

What do they achieve?

They ensure that time is not lost and avoid delays caused through poor communication of the plan, or incomplete tasks which have been 'forgotten' or 'lost in translation'. They ensure that the team do not make subjective choice of what to do today, and in what order, but that care is delivered consistently in a patient-centred way and prevents delay. They ensure that patients are able to leave the ward without delay on the MORNING of their discharge, as everything they needed was planned and executed in advance of their EDD. They ensure that any potentially delay-causing issues are escalated first thing.

This is a brief introduction to the prescribed process, full details, scripts and supporting documents can be found in the appendices section of this document.

✵ The DDD Whiteboard Meeting Process

–   Display your whiteboard by EDD order and sort the patients closest to EDD first
–   Review the EDD – is this still correct?
–   What do we need to do TODAY to make sure this patient is discharged on their EDD?
–   Complete the task sheet in order of 'first to complete'
–   Agree a 'catch up and capture' follow up time to check on task completion and to escalate anything which could delay the discharge
–   Agree the order of patients to be seen first
–   Follow the whiteboard meeting with a golden hour ward round

✵ Conditions for starting:

–   Everyone is at the whiteboard (Therapists, Nurse in Charge, Doctors)
–   There is a facilitator leading
–   There is a scribe for tasks
–   There is a task sheet

5. 'Golden Hour' Ward Rounds

Ward rounds are either daily short sharp 'golden hours', or infrequent, full consultant led ward rounds held several times a week. This will be locally agreed however several principles exist to ensure prompt discharge and minimal waits and delays in the transfer of care.

The order in which patients are reviewed in the ward rounds has an impact on how promptly appropriate tasks are carried out, which supports the optimal operational flow of patients and therefore quality of care; by discharging patients as soon as they are ready to go, thus ensuring timely admission to appropriate specialties.

The order of the 'golden hour' round is always:

- – sick patients from overnight or anyone who the team are worried about
- – new patients who are unwell and have not been seen yet
- – patients who require a discharge review
- – patients who require discharge tasks to be completed
- – all other patients.

This has proved to be effective in terms of reducing 'on the day' delay and improving the level of morning discharges.

Although it may feel inconvenient to weave across a ward, the benefits are a reduction in boarding with appropriate patients being pulled to specialty beds, reduction in delays to discharge and transfers of care, and fewer interruptions to the ward round ensuring those patients who are unwell can be prioritised.

6. 'Non-slip' Task Management

The outcome of the morning whiteboard meeting should be a completed 'task sheet' with tasks identified as being a priority for completion within a certain timescale and named 'task managers'. The aim is to make sure that these tasks are completed without delay.

The facilitator of the morning meeting will agree a location for the task sheet and a time to 'catch up and capture' the progress with the MDT. This would usually be after the ward round and would follow the guiding principles below.

- Did what we agree needed to happen today, happen?
- Are there any outstanding tasks which need to be escalated or which anyone needs help with?
- Did the patients we agreed would be discharged this morning, go?
- If not, why not, and what do we need to prioritise over the rest of the day?
- Are there any extra tasks which were identified in the ward round for patients who could go home later today which need to be allocated and prioritised for the afternoon?
- Are there any changes to EDDs?
- Are there any tasks which need to happen this afternoon for patients who may now be discharged tomorrow?

This ensures that the morning meetings are not 'updates' and remain short, sharp and focused on agreeing and prioritising the days tasks.

7. Check, Chase and Challenge

Check, Chase and Challenge (CCC) is used during implementation, in order to maximise the early impact of implementation, rapidly eradicate the acceptance of delay and to ensure sustainability. Lead Nurses, Service Managers and General Managers should provide additional support to the Wards by promoting enhanced discussion and exploration of alternatives.

This process should be utilised every day until established by the nurse in charge and then may form part of an escalation process.

This supporting role uses the 'check, chase and challenge' script.

- **Check:**

  - ✓ Is the meeting ready to start; attendees convened?
  - ✓ Are we making timely/reasonable decisions?
  - ✓ Are all tasks agreed and responsible person identified?
  - ✓ Have we completed previously agreed tasks?

- **Chase:**

  - ✓ Anything outstanding that can be escalated

- **Challenge:**

  - ✓ Is there an alternative to an inpatient stay to consider?
  - ✓ Does 'x' need to happen as an inpatient?
  - ✓ Can the EDD be earlier if I can help you get 'x' ?
  - ✓ If this patient can be a 'criteria led' discharge[10]
  - ✓ The acceptance of delay

On implementation the CCC script has been found to be useful in helping to identify frequent delaying tasks and 'myths' which keep patients in hospital unnecessarily, beyond the implementation phase they continue to use it as part of escalation in times of pressure to identify potential additional discharges.

8. Ward Access Targets

� Understanding the 'ought to be' numbers

Every day in hospitals, there is a relentless balancing act between demand and capacity, get the balance wrong and the consequences for everyone are severe; for patients – long waits, poor care, increased risk, poorer outcomes, boarding, increased length of stay. For staff this can be challenging to ensure patient safety and experience are not compromised by waits, delays and bottlenecks encountered.

The front door is the barometer for the rest of the hospital, and the only way to ensure that patients who require admission, get into the right bed, and in a timely way, is to ensure that the downstream wards understand the 'ought to be numbers' on any given day and at the times they are most often required and work to create that capacity.

The Basic Building Blocks[10] analysis toolkit allows Boards to calculate this data for each ward, and allows the Check, Chase and Challenge discussions a focus.

9. Pre-noon Discharge

Managing Capacity and demand at hospital level and ensuring admissions and discharges align is a key operational and performance goal.

Afternoon peaks in attendances with a rise in required admissions is the norm for many hospitals. The same afternoon peak in discharges also occurs causing crowding to occur in ED and assessment units as patient flow slows down or stops.

The solution is early in day discharge or transfer.

A key improvement measure of the 6 Essential Actions to Improving Unscheduled Care programme aims for is 40% of ward discharge to occur before 12.00 midday. Achieving this goal will require the MDT to work together across the Daily Dynamic Discharge model and ensure all elements are in place.

This includes communication of the discharge plan, and timely completion of the tasks necessary for discharge.

External

- Communication with family or home support as early as possible to understand estimated date of discharge
- Early identification of transport needs – own transport where possible and only ambulance if physical/medical need
- Early identification of support needs – principles of discharge to assess should be followed
- Expectation that discharge from the ward will be before noon as the norm (and via the Discharge Lounge if appropriate or necessary)
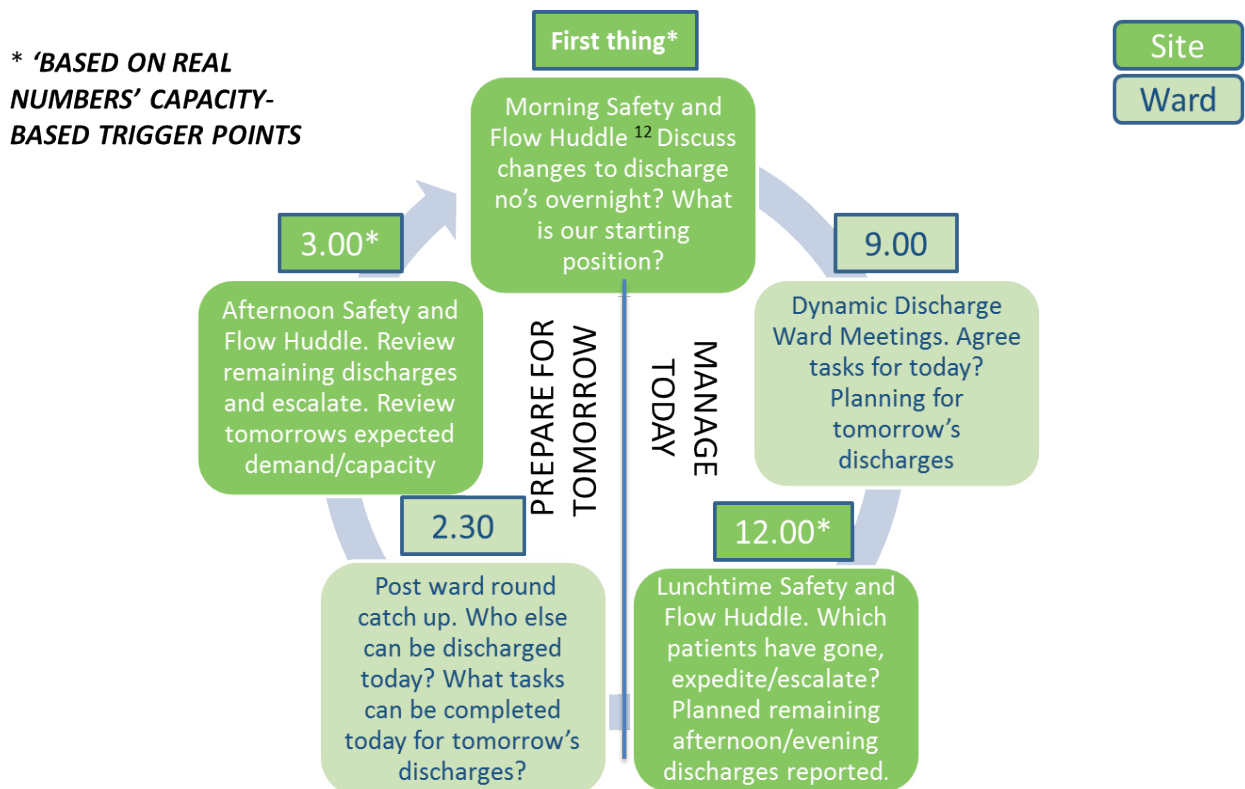
Internal

- Follow the elements of the Daily Dynamic Discharge approach
- Ensure any decision making diagnostics are completed early in day
- Ensure all pharmacy requests are timely
- Ensure Immediate Discharge Letters are completed in advance of discharge (the day before if possible, if not – must be available before noon)
- If not discharged directly from ward – transfer to Discharge Lounge

The Underpinning Operational Structure

In order for a site to maximise the DDD approach, a robust operational structure is necessary. This ensures sites can fully capitalise on the increased accuracy of the discharge position, and increased awareness of the need to create capacity at key points across each day.

* 'BASED ON REAL NUMBERS' CAPACITY-BASED TRIGGER POINTS

Site

Ward

First thing*

Morning Safety and Flow Huddle [12] Discuss changes to discharge no's overnight? What is our starting position?

3.00*

Afternoon Safety and Flow Huddle. Review remaining discharges and escalate. Review tomorrows expected demand/capacity

9.00

Dynamic Discharge Ward Meetings. Agree tasks for today? Planning for tomorrow's discharges

PREPARE FOR TOMORROW

MANAGE TODAY

2.30

Post ward round catch up. Who else can be discharged today? What tasks can be completed today for tomorrow's discharges?

12.00*

Lunchtime Safety and Flow Huddle. Which patients have gone, expedite/escalate? Planned remaining afternoon/evening discharges reported.

Implementation

✤ Getting it right from the start – the implementation framework

In order to ensure that the DDD process becomes business as usual, it is necessary to consider all of the things that cause people to revert to 'safe' historical practices. The following table (page 23) is a high level example of what needs to be considered during implementation.

IT PREP	SET-UP	GO LIVE	SUSTAINABILITY
Ensure wardview, or the mechanism to view EDD is viewable/accessible	Identify area to hold the morning meeting	Identify a facilitator for the first few days, and a 'scribe' each day, coach and teach as necessary	Ensure 'golden hour' ward rounds become the appropriate next step – sick patients, then discharges, then all other patients
Ensure everyone knows how to log on and sort in 'EDD order'	Ensure the MDT know where and when the meeting will be	Write a rota for the first two weeks to support via the 'CCC' role to enforce escalation	Create escalation process with examples of delay and names/numbers to call (eradicate acceptance of delay)
Test the log in and 'change view' process	Publicise where/when/why/how often you hold these meetings	Benchmark ward data pre-start, number of discharges, pre-noon discharges, LOS, discharge lounge utilisation, delayed days, delayed patients etc	Revisit the numbers – devise an improving trajectory of discharge numbers and pre-noon discharges – use as part of PDP/development sessions
Ensure ward-view (or other system) is up to date with EDDs for all patients	Meet with management team (GM, CSM, Lead Nurse), Consultants, Senior Charge Nurses, Ward Managers) to explain the process and agree the supporting structure	Link the improved understanding of discharge numbers into the huddle/bed managers/discharge lounge	Ensure the meetings happen at weekend, even if it's just the nurses who agree and prioritise discharge tasks, induct all new staff to this process on day 1

Implementation

✳ The measurement framework

In all tests of change, measuring improvements is not just important but necessary. This may be done as part of a 'test of change' or PDSA cycle in the first instance. Defining an improvement trajectory based on this data is key to sustaining the initial improvements and further improving. Delivering incremental improvement across several wards should equal improved flow across the site.

MEASURE AT WARD LEVEL	MEASURE AT SITE LEVEL
Reduction in average length of stay	Reduction in length of stay overall
Increase in number of discharges	Improvement in performance against emergency access target
Reduction in delay (number of patients and number of days)	Reduction in occupied bed days (reduction in % occupancy), improved access – both emergency and elective
Increase in number of discharges pre-noon and less discharges late in the evening	Improved flow – peak of demand better aligned with peak of capacity, less ED crowding at peak times
Improvement in patient experience (less delays in access AND in discharge)	Improved staff morale (less tension about beds, fewer 'in extremis' days)
Reduction in Datix incident/risk reporting – better planning, fewer clinical incidents and better relationships with facilities/pharmacy/transport as last minute requests decrease	Easier identification of ACTUAL gaps in rotas (less trying to build a rota around bad practice related to late in the day discharge)

Implementation - Resource Requirements

What you will need

- An implementer (service improvement manager, programme manager, other identified lead)

- Engagement of the full ward team including consultants and junior doctors (the ward manager will become the leader and sustain post implementation)

- Engagement of the management team in order to support implementation and sustainability (lead nurse, general manager, service manager)

- Engagement of the wider flow team (bed managers, discharge team, senior managers)

Implementation packs

A resource pack has been created to assist with the implementation of the Daily Dynamic Discharge approach. This will be available on the 6EA Unscheduled Care website and includes the following appendices.

APPENDIX NUMBER	ITEM
1	Quick Guide to Whiteboard Meetings
2	Whiteboard Meeting Task Sheet
3	Facilitators Script
4	Supporters Script (CCC)
5	CCC Update Proforma
6	Frequently Asked Questions

Please use the 'contact us' section on the 6 Essential Actions website to get in touch with the team to discuss implementation further, or email the team at unscheduledcareteam@gov.scot if you would like an implementation pack.

References

Below are the links to documents, guidance and papers which have been mentioned. Where links are unavailable, guidance may not yet be published. Get in touch with the team for more information.

1. 6 Essential Actions to Improving Unscheduled Care
http://www.qihub.scot.nhs.uk/quality-and-efficiency/unscheduled-care.aspx

2. Day of Care Audit
 http://www.qihub.scot.nhs.uk/media/950950/dayofcare_ed.pdf

3. Royal College of Physicians - Acute medical care: the right person, in the right setting - first time paper
http://shop.rcplondon.ac.uk/products/acute-medical-care-the-right-person-in-the-right-setting-first-time?variant=6297968773

4. NHS Institute Discharge Planning Toolkit
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/discharge_planning.html#sthash.iG5k9A6C.dpuf

5. ED Capacity Management Guidance – Eliminating Crowding
http://www.qihub.scot.nhs.uk/quality-and-efficiency/unscheduled-care.aspx

6 and 7. Nursing Times Article
http://www.nursingtimes.net/nursing-practice/clinical-zones/management/facilitating-an-effective-discharge-from-hospital/200070.article

8. Ward Rounds Best Practice Principles
https://www.rcplondon.ac.uk/projects/outputs/ward-rounds-medicine-principles-best-practice

9. Why patients get delayed algorithm
http://www.qficonsulting.com/_literature_100617/Why_patients_get_delayed

10. Criteria Led Discharge guidance
http://www.qihub.scot.nhs.uk/quality-and-efficiency/whole-system-patient-flow/criteria-led-discharge.aspx

11. Basic Building Blocks Guidance
http://www.qihub.scot.nhs.uk/quality-and-efficiency/unscheduled-care/6-essential-actions/capacity-and-patient-flow-realignment.aspx

12. Huddle National Guidance
http://www.qihub.scot.nhs.uk/media/864807/huddles%20guidance%20document_ed.pdf

www.gov.scot