NHS Greater Glasgow and Clyde

Essential Action 3:
Daily Dynamic Discharge
Case Study – Queen Elizabeth University Hospital

NHS Greater Glasgow and Clyde: Getting it Right One Ward at a Time

6 ESSENTIAL ACTIONS Unscheduled Care

Healthier Scotland
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Getting It Right One Ward at a Time

In Summer 2015, NHS Greater Glasgow and Clyde (NHSGGC) health board merged three ED departments and the inpatient services from five former sites into a new flagship hospital for Glasgow. The Queen Elizabeth University Hospital is the largest acute hospital site in the UK, with 1500 beds, arranged across 40+ wards.

Bringing together staff from so many different hospitals, each with different cultures and different ways of working, proved to be a major challenge for NHS Greater Glasgow and Clyde. It has taken time for staff to adjust to new colleagues, a new environment and new ways of working.

The hospital adapted the Daily Dynamic Discharge model[1] from the Scottish Government's programme, 6 Essential Actions to Improve Unscheduled Care, rebranding it as Exemplar Ward. The aim was to improve patient flow and provide structure to the day-to-day ward routine. Rather than trying to introduce service improvements on all wards simultaneously, Queen Elizabeth University Hospital uses Exemplar Wards. Getting things right one ward at a time ensures the approach is cascaded to all of its wards in a measured and sustained way. This is their story…

1 http://www.gov.scot/Publications/2016/06/5432

The move to a brand new state-of-the-art hospital was an exciting opportunity for staff in NHS Greater Glasgow and Clyde and a positive development for patients. But it was also hugely challenging, as Service Improvement Manager, Peter McInnes explained:

“It was necessary to allocate staff to wards to ensure an even mix of skills coming together from the original hospitals. At first it was difficult for them to establish a team ethos and develop leadership roles in a completely new setting. They were still being measured against all of the usual performance measures so it was important to establish the authority of Senior Charge Nurses as quickly as possible and to empower them to take charge of their wards and create a well-functioning and efficient environment. Pre-noon discharge was a key aim.”

Ward 7B – Senior Charge Nurse Anne Green, Jackie Walker HCSW, Anman Mamhood Charge Nurse, Sehirish Rehman Pharmacist, Stephanie Greig Charge Nurse, Elise Inrig AHP, Anne Green Senior Charge Nurse, Evelyn Millar Consultant, Katherine Newton Deputy Charge Nurse, Mohammed Alahnie Junior House Officer, Anne Farrugia Senior House Officer and Josephine McLaughlin Ward Clerk.

Exemplar Ward

The hospital was keen to implement the Daily Dynamic Discharge model as a way of enabling Senior Charge Nurses to manage patient flow more effectively. However, there were not sufficient resources to implement the different components on all 40+ wards simultaneously. It had tried previously to implement an Exemplar Ward approach with limited success. Although the process began well, when winter pressures hit it was harder for the wards that had not been Exemplar Wards to develop their processes.

The hospital learned some important lessons from this and the second time around, the team leading the project was proactive in sharing improvement data from the Exemplar Wards and using staff from these wards as ambassadors for the process. It also made greater use of its Service Improvement Manager, Peter McInnes to support the follow-on wards and Unscheduled Care Clinical Lead, Dr Alisdair MacConnachie to provide clinical input. The approach is pioneered by each Exemplar Ward, which then role model it to other wards on their floor. There are four wards on each inpatient floor. This new way of implementing Exemplar Ward has proved to be far more successful than the first time around.

"It was important to establish the authority of Senior Charge Nurses as quickly as possible and to empower them to take charge of their wards."

Service Improvement Manager, Peter McInnes

Queen Elizabeth University Hospital utilised all of the component parts of the Daily Dynamic Discharge model which include: Golden Hour structured ward rounds, EDDs (Estimated Date of Discharge), criteria-led discharge and use of the discharge lounge. However, it has also introduced a degree of flexibility, giving individual wards the autonomy

to make minor adaptations to suit their particular circumstances, such as moving the time of the board rounds to fit around peak activity times. Alisdair MacConnachie is Consultant Physician and Unscheduled Care Clinical Lead at the hospital. He said:

"Providing the core elements of the approach are implemented, we are pragmatic about wards making adjustments as we believe it is important for them to feel ownership of the approach."

Achieving Staff Buy-in

The Queen Elizabeth University Hospital recognised that getting clinicians on board at the outset was key to a successful outcome. Alisdair took on the task of liaising with clinicians on the Exemplar Wards, and the subsequent roll-out to other wards. He said:

"As in anyone who works in the NHS, consultants can be wary of change and may feel change-saturated, therefore it is important to work with them so they are part of the process. Sometimes in the past, improvement programmes have been framed around targets but there is a degree of cynicism about this from clinicians. However, we are all motivated by a desire to make things better for patients; that is why we are here after all. I spoke to each of the consultants on the Exemplar Ward individually and, during our conversations, we discussed the need to improve patient care, to work more efficiently and manage our time better. We spoke about how the Daily Dynamic Discharge process could support us by helping staff to prioritise and by adding more structure to what we were already doing. I pointed out that it was not about doing more work but about working more effectively. Everyone bought into the process in a slightly different way but the important thing was that they bought into it."

“We have been clear to stress that improving the number of discharges before noon is the function of a well-structured, well-functioning ward, it is not another target that wards are measured against.”

Dr Alisdair MacConnachie,
Consultant Physician and Unscheduled Care Clinical Lead

Alisdair also spoke to all of the junior members of staff on the ward. He pointed out:

“Although consultant buy-in is important, it is the junior medical staff and the nurses who make the ward function on a day-to-day basis and we needed them to understand what we were doing and why so they could enact the plan. We wanted them to be completely clear about the rationale for Exemplar Ward and to feel confident enough to make small adjustments to the process when the consultants are not on the ward.”

“I really appreciate having the morning board round. I can see exactly what I have to do that day, it brings the whole team together, it encourages better timekeeping and it helps with the smooth running of the ward.”

Dr Evelyn Millar, Consultant
Respiratory Physician

Twice Daily Board Rounds

Dr Evelyn Millar is a Consultant Respiratory Physician on ward 7B, which was the first Exemplar Ward. She said:

"From the beginning we were under pressure to work more efficiently and particularly to improve patient flow. It was challenging and we began working with Peter and Alisdair to identify how we could rapidly improve our efficiency. One of the first improvements was to re-empower the Senior Charge Nurses (SCNs) – and put the management of the wards firmly back in their hands."

One of the ways the hospital did this was to give SCNs responsibility for hosting the twice-daily multidisciplinary team board round. This is a short, sharp, focused meeting, usually around the nurses' station, to plan the running of the ward and, in particular, to discuss patient priorities and discharge plans for the next three or four days. The board rounds bring together the multidisciplinary team to identify, discuss and assign tasks for the day ahead and bring all staff up to speed on safety 'hotspots'. They take place seven days a week, morning and afternoon.

"We cascaded this approach down to other wards and they could see that not only had it improved the way the Exemplar Wards were run but, crucially, these improvements were being maintained even through challenging times."

Peter McInnes,
Service Improvement Manager

Morning Board Rounds

The morning huddle is hospital-wide and takes place at 8.30am each day. Its aim is to 'wake the hospital up'. It is attended by every SCN and they then return to their individual wards to host their own ward-based morning board round.

Afternoon Board Rounds

There is a second daily board round at around 3pm on each ward. The purpose is to bring staff together to begin to 'lockdown' the ward going into the evening and nightshift. The team discusses patients who are causing concern, as well as today's new admissions and tomorrow's discharges. They also look beyond the next day to plan in advance for staffing challenges, admissions and discharges.

Dr Millar commented:

"We have been doing something like this informally for years but this is the first time it has been formally organised and structured. The meetings take place at the nurses' station and because all of the patients now have private rooms, we can talk in complete confidence. I really appreciate having the morning board round. I can see exactly what I have to do that day, it brings the whole team together, it encourages better timekeeping and it helps with the smooth running of the ward."

"When I arrived at the Queen Elizabeth University Hospital, I didn't particularly want to change the way I'd always worked, but now I wouldn't change back."

Senior Charge Nurse, Ann Green

Alisdair added:

"Wards are busy places so the board round needs to be time-efficient and effective. To achieve this, they are carefully structured as follows:

1. Discuss patients who are giving clinical concerns
2. Discuss patients for discharge that day, focusing on what needs to be done to facilitate discharge
3. Discuss planned discharges for the next 48 hours and what needs to be done to facilitate this
4. Discuss today's planned admissions
5. Discuss any ward safety concerns e.g. staffing levels."

"There are no more evening admissions or discharges, which are very disruptive. Everything is far more streamlined. Staff are finishing their shifts on time. Senior Charge Nurses feel empowered again. The process has handed control of the ward back to them."

Dr Alisdair MacConnachie,
Consultant Physician and
Unscheduled Care Clinical Lead

Building the Confidence of Senior Charge Nurses (SCNs)

Peter added: "At the beginning of this process, we needed to build the confidence of our SCNs to chair the board rounds. It can be hard for them, at first, to tell consultants, junior doctors and the wider multidisciplinary team that they must report to them, so I co-chair the first few meetings with them until everyone becomes familiar with this new way of working."

Claire Russell is a Senior Charge Nurse on ward 8C, which specialises in Gastroenterology. She said:

"I thought we had a good structure on the ward before we started with Exemplar Ward but this has just made everything a lot sharper. At our 9am board round we agree our priorities for the day, discussing sick patients, discharge tasks and ward safety issues, looking ahead and looking back. We look at the most unwell patients who require medical review before moving on to patients who are due for discharge that day and, finally, patients who will be discharged over the next few days."

SCN, Ann Green said:

"The twice-daily board rounds are attended by consultants, nurses, Occupational Therapists, physios, pharmacists… They help to ensure that everyone knows what is going on and who is being discharged today and over the next few days. The meetings are now so well-embedded that they happen when I'm not here."

"Nurses are typically on the ward by 7am. If they don't have to wait for the consultant to be able to discharge patients it can really speed up the process. Providing the discharge criteria are specific, there is no reason why discharge cannot be delegated to nurses."

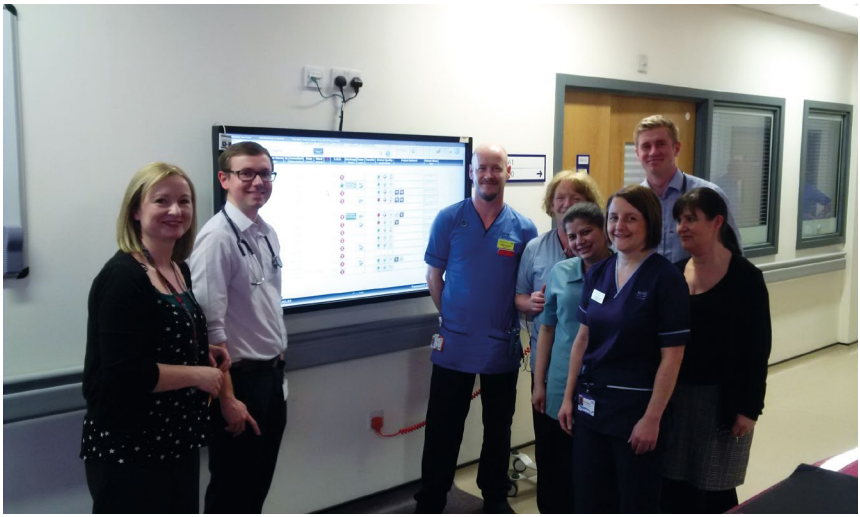
Dr Evelyn Millar,
Consultant Respiratory Physician

Electronic Whiteboards

Electronic whiteboards are used to log all of the information concerning individual patients and the status of their care plan or treatment plan. Any team member who is authorised to log in can access up-to-date information, which includes Estimated Discharge Dates (EDDs), risks, social work or Allied Health Professional referral, and the stage of that referral.

Effective Discharge Planning

By knowing in advance which patients will require discharge letters, Junior Doctors can get them underway far sooner than they would have done previously, resulting in fewer hold-ups on the day of discharge. During the Friday board round, teams look ahead to the weekend to identify what needs to be done to facilitate weekend discharges.



Ward 8c – Senior Charge Nurse Claire Russell, Person TBC, Nathan Smith Junior House Officer, Garry McDowell Deputy Charge Nurse, Sangeeta Chand Ward Clerk, Karyn Morrow HCSW, Claire Russell Senior Charge Nurse, Rory Gibson Junior House Officer and Person TBC.

"By knowing in advance which patients will require discharge letters, Foundation Year 1's can get them underway far sooner than they would have done previously, resulting in fewer hold-ups on the day of discharge."

The Queen Elizabeth University Hospital has also introduced criteria-led discharges, whereby consultants specify in advance that, providing the patient meets certain pre-determined criteria, they can be discharged by the nurse or junior doctor without having to wait to see the consultant again.

Other improvements introduced at the Queen Elizabeth University Hospital include patient discharge lounges, which are well-equipped and available for patients to use for 12 hours every weekday. They play a part in ensuring that beds are freed up earlier in the day.

Sustaining the Change

So far, Queen Elizabeth University Hospital has created four Exemplar Wards which have cascaded best practice down to a further 30 wards. Alisdair said:

"By 5pm the wards are full and staff know what is happening. There are no more evening admissions or discharges, which are very disruptive. Everything is far more streamlined. Staff are finishing their shifts on time. Senior Charge Nurses feel empowered again. The process has handed control of the ward back to them."

"Once the Senior Charge Nurses could see the difference that this approach made, it became easier to get them to buy into it. We cascaded this approach down to other wards and they could see that not only had it improved the way the Exemplar Wards were run but, crucially, these improvements were being maintained even through challenging times. This was a major incentive for them to get involved."

Peter added:

"We encourage the wards to get as far as they can with introducing the changes and, wherever necessary we step in to provide additional support and leadership."

"Before the introduction of Exemplar Ward, we were achieving an average of 20% of patient discharges before lunchtime. On some of the Exemplar Wards, we are now up to 50%."

Peter McInnes,
Service Improvement Manager

Impact

The Exemplar Ward model is having a positive impact on patient flow at Queen Elizabeth University Hospital, as Peter explained:

"If we can discharge patients by lunchtime it frees up beds for the morning intake of patient admissions. Before the introduction of Exemplar Ward, we were achieving an average of 20% of patient discharges before lunchtime. On some of the Exemplar Wards, we are now up to 50%."

"By discharging earlier in the day, wards are able to refill beds by mid- to late-afternoon, with no more new admissions after this time. We call this 'locking down' the ward and staff love it as it means quieter ward activity in the evening and a less stressful nightshift when staff numbers are lower. It also means that staff are free to talk to patients and their visitors in the evening and to catch up with core duties, rather than having to deal with new admissions. This impacts bed availability across the hospital. By discharging early, downstream wards are able to refill beds early. This means that we have a steady stream of free beds for incoming GP and Emergency Department admissions."

Alisdair added:

"Six months after launch, our Exemplar Wards are continuing to maintain the improvements in patient flow and discharge with, typically, a twenty to thirty per cent uplift in pre-noon discharges. We have been clear to stress that improving the number of discharges before noon is the function of a well-structured, well-functioning ward, it is not another target that wards are measured against. The key thing here is improving patient care. Wards need to be encouraged and complimented on their achievements, not pushed to achieve more targets. This breeds resentment and does not encourage sustainability."

A Change in Culture

"This is about changing perception and changing culture," concluded Peter. "It is about getting wards to really understand the impact that it has on patient experience – both for those being discharged and those waiting to be admitted – when patients are discharged late in the day when community services are less available. We have witnessed some major shifts in the confidence of individual ward staff as a result of these changes, as well as major benefits in terms of patient flow. One Senior Charge Nurse told me that she used to call in every day, even on her days off, to check how things are going. She had the ward on her mind seven days a week. Now she feels confident enough not to call on her days off because she knows that her team will manage the daily meetings and things will continue to run smoothly even without her there."

Exemplar Ward Flow Indicators

Table1, Jan-Jun 6 month average.

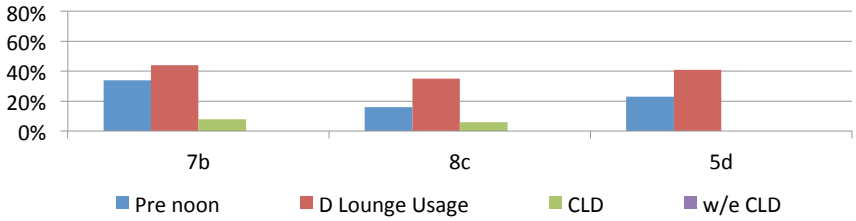
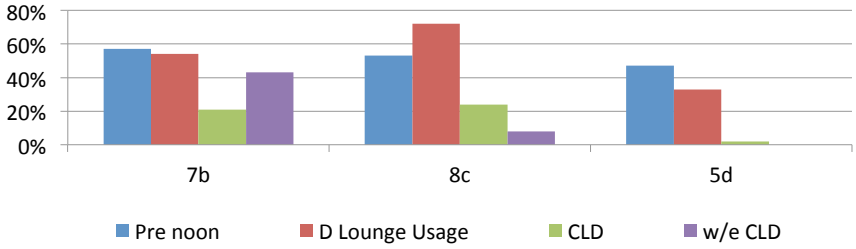


Table2, July finishing position, Exemplar ward period.



Dr Millar added:

"Personally I love the ward board rounds. They have improved bed turnover, improved teamwork and helped to clarify exactly what needs to be done and by when. With the layout of the new wards, with every patient in separate rooms, nurses can sometimes feel a bit isolated. This brings them together and helps to establish a good sense of teamwork as well as embedding best practice."

"Being involved in a twice-daily board round is the key to building this confidence. Everyone in the team knows exactly what is going on with each patient. This empowers them to be able to discharge patients even when the consultant is not there."

Dr Alisdair MacConnachie,
Consultant Physician and
Unscheduled Care Clinical Lead

Overcoming Challenges

One of the biggest challenges has been instilling the confidence in staff to implement criteria-led discharge. Alisdair said:

"It is one thing to write down the criteria under which a patient can be discharged, but it is quite another to give junior medical staff and nurses the confidence to discharge patients. Being involved in a twice-daily board round is the key to building this confidence. Everyone in the team knows exactly what is going on with each patient. This empowers them to be able to discharge patients even when the consultant is not there. We are talking about two 15-minute board rounds each day. It is not a lot of time to ask people to commit to, but the impact on inpatient efficiency is huge. We are not completely there yet with criteria-led discharge but we are making positive steps forward and this will be a major contributor to improving patient flow once staff feel completely confident with this approach."

"Daily Dynamic Discharge helps to improve patient care on the wards. One of the spin-offs of this is that we are able to discharge patients earlier in the day. This enables us to align the front door with the back door more effectively. Everyone benefits – patients, staff, the hospital as a whole."

Key Learning Points

- After a previous attempt to implement Exemplar Ward the hospital learned the importance of supporting follow-on wards to embed the process. They now use Exemplar Ward staff as ambassadors, share improvement data and provide senior-level clinical support and one-to-one support from the Service Improvement Manager.
- It was important to get consultants and junior medical staff on board. The Unscheduled Care Clinical Lead had one-to-one conversations with consultants and junior staff to discuss their concerns and explain the reasons for introducing Daily Dynamic Discharge. These conversations were framed around improving patient care rather than meeting targets.
- The hospital is committed to the Daily Dynamic Discharge approach but wants to give individual wards some autonomy to make minor adaptations. For example, wards might choose to change the time of the morning board round to suit their individual processes. This has encouraged greater buy-in and sustainability.
- Criteria-led discharge has proved to be the biggest challenge. It is one thing to list the criteria that mean a patient is suitable for discharge and it is another to give junior medical staff the confidence to discharge patients when the consultant is not there. Involving the whole team in twice-daily board rounds helps to foster this confidence.
- The hospital believes in encouraging and complimenting wards rather than pushing them to achieve targets or creating competition between them. It believes the right culture is important for sustaining the change.
- Queen Elizabeth University Hospital regards pre-noon discharges as a function of a well-structured, well-functioning ward rather than seeing them as a target to aim for.
- It is easier to get buy-in for the Daily Dynamic Discharge approach once there is clear evidence of the difference it makes. It is important to share the data and to invite staff to be ambassadors for the new way of doing things.

Deliver: safe, person-centred, effective care to every patient, every time, without waits, delays and duplication

In order to: improve the experience of patients and staff

The 6 Essential Actions:

Clinically Focused and Empowered Management

The operation of basic hospital and facilities management, visible leadership and ownership through managerial, nursing and medical triumvirate team, creation of clear escalation policies and improved communication supported by safety and flow huddles.

Capacity and Patient Flow Realignment

Establishing and then utilising appropriate performance management and trend data to ensure that the correct resources are applied at the right time, right place and in the right format. This will include Basic Building Blocks, Bed Management Toolkit, Workforce Capacity Toolkit and alignment with Guided Patient Flow Analysis.

Patient Rather Than Bed Management

Managing the patient journey requires a coordinated multi-disciplinary approach to care management, dynamic discharge processes: access to diagnostics, appropriate assessment, alignment of medical and therapeutic care; home when ready with appropriate medication and transport arrangements, discharge in the morning, criteria led discharge, transfers of care to GP.

Medical and Surgical Processes Arranged for Optimal Care

Designed to pull patients from ED through assessment/receiving units , provide access to assessment and clinical intervention, prompt transfer to specialist care in appropriate place designed to give care without delay, move to downstream specialty wards without delay and discharge when ready, utilising criteria-led discharge where appropriate.

7 Day Services

The priority is to reduce evening, weekday and weekend variation in access to assessment, diagnostics and support services focussed on where and when this is required to: avoid admission where possible, optimise in-patient care pathway, reduce length of stay and improve weekend and early in the day discharges safely.

Ensuring Patients are Cared for in Their Own Homes

Considers pathways to support avoiding attendance, and how someone who has an unscheduled care episode can be optimally assessed without need for full admission, if required they will be cared for and discharged to their own home as soon as ready. Anticipatory Care Plans, redirection to appropriate health care practitioner and shift from emergency to urgent care is the focus for sustainability.

6 ESSENTIAL ACTIONS
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Acknowledgments

We would like to thank everyone who has contributed to this case study. By openly sharing your experiences, your challenges and your learning, you are helping to spread best practice and drive system-wide improvement.

These stories serve to inspire others and celebrate the hard work of individuals who are committed to making things better for patients. In particular, we would like to acknowledge:

- Service Improvement Manager, Peter McInnes;
- Unscheduled Care Clinical Lead, Dr Alisdair MacConnachie;
- Consultant Respiratory Physician, Dr Evelyn Millar;
- Senior Charge Nurse, Ann Green, and all staff at the Queen Elizabeth University Hospital;
- Case study writer, Kate Philbin and the National Unscheduled Care Team.

If you are inspired to share your improvement story, we would love to hear from you. Please get in touch at UnscheduledCareTeam@gov.scot

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