

Improving Patient Flow in various areas

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Effective Patient Flow plays a fundamental role in providing a better patient experience and practitioner efficiency. In the current world condition, appointments cannot be used as the only means to seek the doctors' attention as well as get treatment. In the current medical centers, the emergency department or room (ER) team feels like most of the time they are "forcing" admissions to Intensive Care Units and the medical-surgery units (Belson & Hall, 2006). The team in these units is reluctant to admit any new patient.

These nurses in the intensive care unit and the medical-surgery nurses counter that they only allow admission when they can, except when staffing is tight and the census is high. These patient flow issues need a means of dealing with them. Therefore, it is important to improve patient flow. Focusing on good practice in various areas will result in an improved flow of patients in hospitals.

The Ambulatory Emergency Care (AEC)

There should be core principles in this area. Clinical stable patients need EAC as a recommended choice. This Ambulatory Emergency Care area must be open for more than fourteen hours every day for patient reception from the emergency department and primary care. The AEC rooms should be near the emergency room (Belson & Hall, 2006). The AEC facility is for any patient with surgical, medical, and gynecological problems. Immediate access and consultation with senior doctors responsible for agreeing to the required patient management plan is vital. A similar medical review and initial assessment timeframe must exist in AEC and the emergency department. Also, patients should access diagnostics at the same period as those in the emergency department (Belson & Hall, 2006).

Maximizing criteria is necessary when selecting patients for AEC. The AEC clinicians must undertake daily board rounds with the emergency department team to help pinpoint patients. There is a need to display common condition lists which aid in identifying the appropriate AEC patients (Arthur, 2016). At the same time, it is important to grant the ACEC staff access to an emergency department to identify patients and allow automatic patient referral from this emergency department.

Outcome

Patients involved in emergency admissions are quickly assessed and, where necessary, taken to AEC. In AEC, the patient's treatment and diagnosis are done immediately. This aids in eliminating overnight admission where necessary. Therefore, adopting the AEC departments converts almost one-third of acute medical admissions of adult patients into emergency medical care incidents (Arthur, 2016).

Acute Medical Unit (AMU)

The Acute Medical Unit needs principles that govern it. This unit needs a consultant and an acute physicians' team supported by other specialized physicians available 24 hours daily. This unit should receive patients who are stable directly from the GP but not through the emergency department (Belson & Hall, 2006). The AMU departments need a multidisciplinary team that is dedicated to nurses, discharge coordinators, and associated health professionals such as occupational therapists, physiotherapists, and pharmacists. At the same time, AMU needs to have in-teach services access to support early discharge as well as patient care, including social workers, inpatient specialists nurses, associated health professionals such as language and speech therapists or dietitians, and specialists doctors. The AMU team should make ward assessments and restrict short beds (Belson & Hall, 2006). The service design should also confirm a Royal College report. The department must have access to all hospital executive teams to encourage corroborative work, particularly during peak demand periods. The handover and communication rotas application is necessary for the promotion of care continuity. Frequent board rounds and acute assessment of cores are essential. Patient arrival in AMU should trigger the start of the patient discharging processes which involve estimating the expected discharge date and time. Specific pathways need to have a standardized process. For example, the acute kidney injury or sepsis pathways (Belson & Hall, 2006).

At the same time, close collaboration between managers and clinicians is vital. This close collaboration between the two teams will optimize the use of the AMU, for example, by preventing delays in patient transfers and discharges. For efficient patient admissions from the emergency department to the AMU, this AMU must run between 84% and 91% bed occupancy.

Outcome

A team of acute multi-professionals assess and treat any acute medical condition. The patients in this department are received from the primary care or the emergency department. Following the treatment and assessment, the patient is either transferred and admitted to respective wards or discharged within seventy-two hours after the arrival.

Specialty and Acute Surgery Assessment

A consultant leads the acute assessment service. This area's operation should ideally be 24 hours every day when the patient numbers are high (Hall, 2005). The specialized trainee or a doctor with the same abilities is responsible for treating and seeing acutely ill patients. This personnel should report to the consultant any patient concerns. The process of patient assessments begins at most 25 minutes after patient arrival. The patients referred to Acute Assessment Service are always stable patients. This team should include qualified pharmacists, nurses, and associated professionals such as occupational therapists, physiotherapists, and discharge coordinators (Hall, 2005). This department

must have direct access to the in-reach and diagnostic services. Also, an expected discharge date and time should accompany the patient's arrival at this ward.

Outcome

Immediately after a referral from primary care or the emergency department, the patient receives assessment as well as treatment services. The patient is then either discharged or admitted. Several model adoptions are available. However, they use the same principles (Hall, 2005).

Frailty

The core principles are essential to ensuring improved patient flow. Frailty must be measured and identified at the first entrance with an evidence-based assessment instrument like the Rockwood Frailty Scale (New Zealand, 2012). A competent multi-disciplinary team is required to deliver to old people with holistic management and assessment. This frailty process is embedded in AEC, emergency departments, specialized wards, CDUs, and AMUs. The frailty patients are involved in their health care when in a position of making their personal decisions. Hospitals, also, need to be aware of their patients, conditions even after leaving the hospital setting (George & Robert, 2010).

Outcome

The core principles aid in identifying the frailty of patients immediately after they arrive at the hospital. These patients are discharged immediately after acute care completion. These patients are also given the right support and care at their homes that aid their rehabilitation and recovery (George & Robert, 2010).

Specialties

In Specialties, simple core regulations are important. Specialties should ensure the use of simple regulations for standardizing ward processes as well as minimizing clinical teams and individual clinician variations. This process includes Red2Green days, checklists for ward rounds, and SAFER flow bundles. Every day, medical reviews from the senior medical doctor's generation must be done at least daily for a week. Delays in assessing or discharging a patient should have a reasonable explanation (George & Robert, 2010). Word rounds must include a senior nurse amongst other multidisciplinary members. At the same time, required procedures need completion at the right time such as writing a discharge statement as well as requesting a test for the patient.

Care continuity is necessary. A Royal College report explains that patient care must be continuously delivered and coordinated by one clinical team's consultant (George & Robert, 2010). A patient with

an acute illness needs restriction to a single ward and after the discharge of the patient, follow-up of the patient's condition is important. Each patient should have an approved consultant plan with clinical criteria, both functional and physiological, for discharge as well as the expected date and time for discharge. High-risk patients like a patient with a mortality prediction of more than 11% need more attention. As a result, the consultant should review his condition after every 4 hours. The morning discharge of patients will aid in minimizing [emergency department overcrowding](#) (Arthur, 2016). When patients are discharged, early more room is created for new patient admission. The specialized team must prioritize the activities involved in patient discharge. From admission time the patient needs to be aware of their treatment plan and discharge date and time (Arthur, 2016). A hospital must ensure correct ward admission for patients to prevent delayed treatment. Any request such as Specialty review and diagnostic tests should avoid delay to enable early patient treatment. Therefore, the multidisciplinary team should ensure they have a reason for delayed patient discharge.

Outcome

Inpatients in hospitals receive companionate, person-centered, and skilled care. This patient receives immediate admission to the correct ward and remains there for treatment that meets their need. The involved relatives or patient family members, as well as the patients, are included in making decisions about the achieved outcomes and the consultant-care relevant to their expectations without harm or delay exposures. The patients are discharged minus any delay after completing the required acute care, together with the right levels of care, which will enable them to continue with rehabilitation and recovery (George & Robert, 2010).

Admission, discharge, and transfer

These three processes, admission, discharge, and transfer involve core principles that contribute to improved patient flow in the hospital. The social and therapy work teams must work before acute care services or pathways. These team members must collect patient information on any home management and well-being before becoming unwell. On admission, the default expectation is to discharge the patient to their respectful staying places and take their long-term medication from there. A clinical treatment plan needs to be generated within 13 hours after being admitted together with the normal discharging time and date. The discharge time and date must be linked with physiological and functional discharge criteria. This process includes Red2Green days, checklists for ward rounds, and SAFER flow bundles (Arthur, 2016). Each day, board rounds ought to take place in the morning hours. Involved multidisciplinary teams must examine the patient's clinical plan, including the discharging date and time during these board rounds. The board's decision is then communicated to the patient (Jensen & Haraden, 2007).

Assessment duplications need to be minimized using a trusted assessor use. The assessment must build on the admission information records (Jensen & Haraden, 2007).

Outcome

A patient is discharged immediately they do not gain from the acute hospital treatment or care. Mostly, patient discharges involve patients going to their homes, and inter-hospital transfers are involved (Hall, 2005).

Primary Care Streaming

Primary Care Streaming principles aid in improved patient flow outcomes. The hospital must establish a clear criterion that supports patient streaming and the main care service. Patient redirection to various places requires safeguards. These safeguards make sure that the patient is safe and at the exact place as well as patient acceptance to the off-site services. Clinical streaming is done by trained emergency room clinicians (Rouse, 2014). This streaming process must receive immediate attention, especially 16 minutes after the patient's arrival. Achievement of this streaming is ensured on a daily and hourly basis, not on an average demand basis. Capacity and demand analysis is essential in determining the model, staffing profile, and primary care opening hours. Communication between the emergency department and the primary care services needs to be effective and regular. Joint governance plays a primary role in this unit. Governance meetings held monthly should aid in analyzing the streaming process and primary care effectiveness (Hall, 2005). Risk incidents and reports will also be generated during this meeting. Four-hour A and E standards apply to any patient streamed to the co-located Primary Care Service (Rouse, 2014).

Outcome

Any patient attending emergency room care with any condition that is suitable for treatment and assessment in any primary care unit is streamed into a co-location Primary Care Unit (Rouse, 2014).

Emergency Departments

The emergency department's principal activities can aid in improving the patient flow in the hospital. Trained emergency department clinicians must stream any patient attending an emergency room to the relevant clinician and area before starting admission. Streaming entails brief history-taking as well as basic observation performance (Jensen & Haraden, 2007). The information aids in supporting triage prioritization that has streams if needed. Streaming needs to involve any prior warning score calculation (Hall, 2005). Emergency room clinicians should prioritize treatment and the assessment of the most unwell patients. These sick patients include those having life-threatening conditions as well as time-critical illnesses, old patients as well as vulnerable patients like physically challenged individuals, people with self-harm risk, and children (New Zealand, 2012).

The emergency room clinicians further stream any patient to majors, resuscitation, low acuity, or minor injuries, among other hospital services such as AEC, rapid assessment, and assessment services for outpatients and inpatients (New Zealand, 2012).

Outcome

Any patient receives timely assessment as well as clinically appropriate, emergency department best care (Jensen & Haraden, 2007).

Mental Health

The basic principle is that improvement in mental health can result in better patient outflow. Patients having mental health problems require assessment in environments that are safe, quiet as well as supportive. When waiting for treatment as well as assessment, reducing this patient's distress is vital (Wilson, & George 2004). These people with mental problems need special care, and trained staff should handle them. The priority is physical need identification such as overdose use, self-injury, and self-harm resulting from people having alcohol-related conditions, diabetes, liver diseases, pulmonary diseases, and dementia. The multidisciplinary health team responsible for treating these patients must always be available. This team needs to identify a patient as a risk of committing suicide first and handle them first. As well as, identifying the intoxicated people and providing the necessary support, keeping them safe, and needing transient suicidal assessment. Waiting rooms play an essential room in managing these patients as they wait for admission (Wilson, & George 2004).

Outcome

Patients receiving services in the emergency room or those in inpatient wards with mental problems and related physical injuries get compassionate care. Skilled healthcare providers are available all day in the hospital. Therefore, all patients receive international treatment and admission if necessary.

In conclusion, smoothing patient flow into hospitals as well as out of healthcare or hospital settings will aid in reducing delays, poor service delivery, and overcrowding in a hospital setting. The hospital needs to develop strategies to help solve this problem, which may increase with more people having healthcare insurance (Wilson & George 2004). As a result, the implementation of good practice in Ambulatory Emergency Care (AEC), Primary Care Streaming, Mental Health, Frailty, Admission, discharge and transfer, Emergency Departments, and Specialty and Acute Surgery Assessment among other hospital departments can improve patient flow. Improvement in patient flow gives great outcomes (New Zealand, 2012). Patient waiting time is reduced, and discharges are made early to ensure that new patients are admitted. At the same time, patients can make decisions early on the treatment offered and resolve to better medication without wasting much time. Also, the relevant multidisciplinary team is involved, and the patient gets the appropriate treatment easily, and home

medical follow-up is provided.

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