RCPE UK Consensus Conference on "Acute Medicine: Improving quality of care through effective patient flow – it's everyone's business!"

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Introduction

Growing demand from an ageing population, increased complexity and co-morbidities brings challenges and opportunities for acute medicine. Improving the flow of patients across the health and social care system is essential. Action must be taken to ensure that patients are treated safely and effectively, and with care and compassion in a system that they trust.

Key Points:

- Quality, safety, and dignity in patient care are paramount. It's everyone's business to ensure that we continually listen to patient experience, and act on it, to improve all aspects of care.
- Clear communication is vital. There must be a culture where all parts of the system communicate with each other, and with patients/carers, to facilitate flow and improve the patient experience.
- To create flow there needs to be seven-day and extended hours working in hospital and across the system; senior clinical decision-makers must be available 24/7.
- Patients must be treated in the right place, and in the shortest time possible. This requires the right numbers of staff and mix of skills across health and social care.
- All systems must have good patient flow to eliminate boarding.
- Information systems to produce real-time data must be used by clinical teams to improve patient care and flow; there must be a culture of continual improvement.

How can we improve the experience of being admitted to hospital for acute medical patients?

Patients in hospital want to be treated with compassion and respect, in a safe environment, and to know what is happening and why.

To improve patient experience we need:

- clear communication at all levels, including between patient and health professionals, family/carers and health professionals, and across health and social care;
- patients to feel safe: this requires a clear explanation of what is happening and why, and appropriate reassurance to be given as soon as possible; they must know who is in charge of their care;
- a competent clinical decision-maker to see the patient promptly to decide whether or not to admit;
- a plan, developed with active involvement of the patient, where possible, and with family/carers. Patients should be supported to make informed choices about their own care even where this involves risk.
- to ensure people are not admitted unless necessary and that they go directly to the right place;
- systems to be designed on the basis that a significant number of patients will have cognitive impairment and other complex care needs;
- to listen to, and hear patients. We must capture patient experience with validated local and national surveys conducted regularly, supplemented by patient stories. Results must be fed back promptly to clinical teams, and acted on.

How can the multi-disciplinary team work together to improve patient experience and clinical outcome?

Each acute medical unit must have a dedicated, effective multidisciplinary team (MDT) with consistent and appropriate membership, which should be centred on patients/carers. Individual patient care must be led and co-ordinated by the most appropriate member of the MDT. There must be strong cross-disciplinary leadership and clear agreed goals for patient care based on a shared understanding of risk.

The MDT will:

- undertake an appropriate assessment within 14 hours and aim to produce an individualised care plan in conjunction with the patient within 24 hours;
- ensure that patients are reviewed regularly, twice daily as a minimum; care plans and goals should be updated;

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- seek and act upon real-time patient feedback as standard practice;
- provide extended hours and seven-day working. Advanced practice roles and shared skills must be developed to maximise staff resource and availability;
- include the senior nurse who is responsible for the overall co-ordination of ward activity; this will be recognised as a supervisory role;
- plan the patient's discharge from the time of admission, including an estimated date of discharge; working with the primary/social care teams, and the patient/family is vital.

What should patient flow look like in a system where acute medical patients experience effective, efficient and timely care, with no adverse impact on other clinical areas?

Emergency activity is predictable. Capacity must be aligned to meet demand. This will require an extension of seven-day working by clinicians and support services both in hospital and community.

To make this happen we need:

- patients to be seen promptly by the right competent clinical decision-maker;
- safe, effective alternatives to admission, such as ambulatory care;
- patients to be seen as soon as possible by the admitting consultant physician in line with Society for Acute Medicine clinical quality indicators for acute medical units;
- the medical registrar role in the admissions process to be locally defined and appropriately supported for that registrar's level of competence;
- the admitting consultant physician to have no other clinical commitments in line with Royal College of Physicians of London guidance (Consultant physicians: working with patients revised 5th edition, 2013) and to adopt a flexible and dynamic role in managing flow;
- all relevant specialties to contribute to the care of the acute medical patient; this includes medical subspecialties and others such as radiology and mental health;
- plans to be clearly documented to allow action without further consultant review;
- patients to move to the right clinical area first time. Boarding is a symptom of a dysfunctional system; we should have an ambition to eliminate it by tackling the underlying causes;
- patients to be moved only for clinical reasons and with a structured handover;
- to ensure continuity of care through innovative working patterns and communication;
- to recognise the high variability of elective activity; it must be separated from emergency activity and spread more evenly;
- effective utilisation of integrated IT systems to facilitate flow, discharge and alternatives to admission;
- patients to be reviewed and discharged as early in the day as possible from all clinical areas, seven days a week.

How does hospital design influence patient flow through acute medical units?

Hospital buildings, processes and staffing must be designed to optimise the flow of patients through the system in a safe, timely, and efficient way. They must be flexible and have enough capacity to accommodate surges in demand now and in the future.

To make this happen we need:

- all acute medical units to have the capacity to provide ambulatory care;
- the unit to be near radiology, critical care, and the emergency department;
- a split, as far as possible, between acute and elective services and accommodation;
- hospital wards to be designed or adapted to provide enough space to be a safe, clean, quiet and dignified environment for patients;
- patients and other stakeholders to be involved in design and continuing development of hospitals;
- standardisation of room layout and equipment;
- environments designed to meet the needs of people with sensory, cognitive, physical and other impairments;
- to build in the infrastructure to support new technology.

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