AIM

Patient Flow is inextricably linked to patient safety in the acute care setting. A hospital Huddle and Patient Flow Group were set up to improve recognised blockages in flow across the Hospital with the overall aim of improving whole systems flow as evidenced by data.

METHOD

Guided by improvement methodology (Langley et al 2009) and adopting an aggregation of marginal gains approach both the Hospital Huddle and Patient Flow Group were set up in 2013. Two Hospital Huddles take place each day with a clear focus on safety, prediction and flow. The Patient Flow Group meets bi-monthly examining flow data in detail and taking required improvement actions. A multidisciplinary, collaborative approach ensures the right people are round the table required to correct small steps in all parts of system which when aggregated demonstrate significant improvements in outcome data.

RESULTS

- Patients spending excess time (>4 hrs) in ED reduced by 75 patients per month (96% to 98% monthly compliance)
- Theatre cancellations due to no ward or PICU bed, halved
- Number of patients delayed (>4 hrs) when transferred out of PICU halved (Median 50% to median 25%)
- Predicted discharge accuracy improved to 72% from 34%
- Cultural change with great sense of camaraderie between areas

CONCLUSION

Safety, prediction and flow have significantly improved. For staff it has allowed a collective ownership and shared urgency for finding and fixing patient flow issues. For patients unnecessary waits and cancellations have reduced resulting in an improved hospital experience. Spread across the directorate and beyond is in progress.

References