GIG CYMRU NHS WALES

SAFER

RED TO GREEN

National minimum standards for the application of **SAFER**, **RED2GREEN** and **Discharge to Recover then Assess (D2RA)** in support of the 6 Goals for Urgent and Emergency Care, Wales.

Key principles of optimising patient flow using SAFER, RED2GREEN and D2RA

Managing hospital patient flow and discharge effectively to:

- Ensure that discharge plans reflect "what matters to me" conversations
- Ensure that patients get the **right care** in the **right place** at the **right time**
- Ensure a culture of not tolerating avoidable delays for patients – every day in hospital is a day away from home and should be a 'green day' for patients helping them return home
- Reinforce that Red2Green directly relates to the last 1000 days NHS initiative. Patient's time is the most important currency in healthcare. If you had 1,000 days to live, how many of these would you choose to spend in hospital?
- Mitigate against the fact that the longer time older, frail people spend in hospital the greater risk of clinical deconditioning:
  - 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 (Gill et al 2004)
  - 48 per cent of people over 85 die within one year of hospital admission (Clark et al 2014)
- Drive proactive acute hospital flow and discharge by embracing the SAFER, Red2Green and D2RA minimum standards as 'business as usual' throughout hospital processes
- Working smartly for the benefit of our patients by being clear on the different key roles and responsibilities of staff/professional groups relating to flow and discharge
- Drive good clinical practice improving clinical outcomes and therefore improving patient flow using the standards as a toolkit
- Achieve the following outcomes –
  - Better quality care to patients, right bed first time
  - Decongestion in Emergency Departments
  - Promptly offloading ambulances releasing them back into the community for those emergency patients who need them.
  - Reduction in mortality, falls and harm
- Reduce clinical deconditioning and deterioration to ensure the patient is able to regain their independence quicker
- Drive the D2RA approach to ensure more patients can be assessed in their own environments (we will add link to D2RA doc once we have the final weblink)

What is SAFER?

SAFER principles act as a guide to good practice that will improve patient flow and clinical outcomes when delivered as 'business as usual' on all wards. **SAFER** is a simple set of rules intended to optimise patient experience and safety by ensuring patients are fully involved in the decision-making process throughout their stay in hospital and enabling them to return home as quickly as possible.

Implementation of **SAFER** needs to be part of a well-managed improvement programme with clear plans and deadlines. A 'social movement' needs to be created to win hearts and minds, involving leaders who are passionate about patient care, and this way we can create compelling narratives that describe the link between implementing **SAFER** and improving patient care.

There may be a need for local teams to adapt **SAFER** slightly to fit with locally available services and logistics, and this is clearly sensible as long as the rules are broadly followed each day, every day. We can easily monitor the extent to which the principles of the SAFER guidance are being followed through measurement of the relevant indicators. Installing 'know how you're doing' boards to demonstrate success in delivering the five elements of the guidance in all wards is simple but effective.

SAFER should be considered within the context of co-production, with patients and their families playing an equal part alongside effective collective leadership across whole integrated health and social care systems. **SAFER** is not a prescriptive approach, but enables practitioners, clinicians, and system leaders to work together to deliver the five elements in a way that is tailored to local circumstances. It also needs to be used in conjunction with the principles of Red2Green and Discharge to Recover and then Assess (**D2RA**).

Putting patients at the centre of the decision-making process and making sure they are able to recover and return to their communities as quickly as possible is key. Together we can make a difference and achieve the best outcomes possible for the people of Wales.

"The key question was "how do we ensure our patients have value added time in our health settings?". The framework provides the scaffolding for staff to attach and exercise clinical judgement on, aiming to minimise waste as much as possible to ensure the right care is provided to the right patient at the right time."

ROB FOLEY, RN & PROGRAMME LEAD
FOR UNSCHEDULED CARE

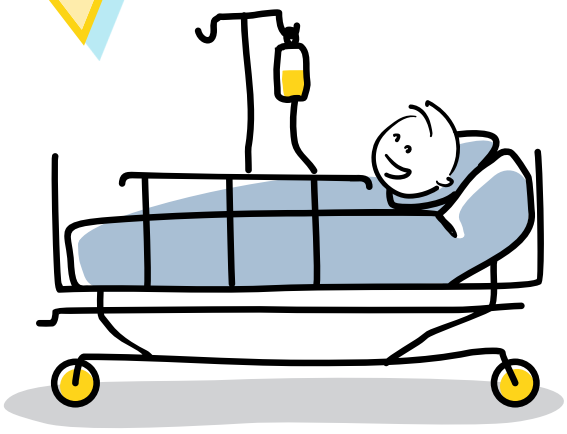
S SEEN

All patients (acute & community hospitals) will have a senior review before midday by a professional able to make patient treatment/care management and discharge decisions.

- Patients should be **SEEN before midday** in both acute and community hospital wards, to establish **early clinical/rehab decision making, flow and proactive discharge plans.**
- **'10 golden rules for board rounds'** ***(Appendix 1)*** should be systematically adopted on a daily basis.
- SORT process for effective boards rounds should be utilised ***(Appendix 2).***
- Ward rounds must **add value** for both patients and the ward-based clinical team, leading to **clear actions, written up** in notes and **acted upon.**
- Most tasks (e.g. the writing up of take home medications or the ordering of a scan/test) to be completed before the round moves onto the next patient, to **avoid batching tasks and creating unnecessary delays,** with ideally a **mobile digital infrastructure** as an enabler.
- Plan the resources and services required to support a **safe and timely discharge** of the patient if they no longer need the support and services of an acute hospital.
- **Outlying patients in an acute hospital should be avoided** – this means they are not in the right specialty bed to ideally manage their specialist care needs **(right patient, right place, right care, right time).**
- Senior operational managers should **support** senior ward based clinicians to avoid the incidence of outlying by ensuring the **specialty base meets the demand** and take any remedial actions to **redress any imbalance.**

'Patient flow is vital to any acute hospitals operations, therefore the implementation and embedding of schemes such as SAFER is of a paramount importance in ensuring our patients receive the treatment they require, but then recover in the most appropriate place which will often be away from an acute setting'

KATE HANNAM, MORRISTON SERVICE GROUP DIRECTOR, SBUHB



AIM

All patients (acute & community hospitals) must have a clear and appropriate discharge plan and expected date of discharge, that is agreed with them and reviewed on a daily basis to reflect patient's recovery progress.

- Patients and their families should be **involved** in the agreement of a **co-produced** care plan containing an **Expected Discharge Date (EDD)**, **Clinical Criteria for Discharge (CCD)** and **D2RA pathway**
- Patients should be routinely involved and aware of the progress they are making:
  1. What do you think is wrong with me? (Diagnosis)
  2. What is going to happen to me today? (Tests, interventions etc)
  3. What is needed to get me home? (Clinical Criteria for Discharge & Recovery Plan)
  4. When am I going home? (EDD)
- EDD and CCD must be clearly defined and used consistently. They should be set by a consultant **in conjunction with the MDT,** and represent a professional judgement of when a patient is anticipated to achieve their clinical and functional goals and are in a position to leave hospital to recover or rehabilitate in a non-acute setting (usually their normal place of residence – **'home first'**) in accordance with D2RA.
- The CCD is the minimum physiological, therapeutic and functional status the patient needs to achieve before discharge. They should be agreed with the patient and carers where necessary.
- The EDD should be set at the first consultant review and no later than the first consultant post-take ward round the next morning. If a patient is to be transferred to a ward-based specialty team, then the EDD and CCD should be set by the team who will be responsible for their discharge.
- Patient progress towards CDD/EDD should be **assessed every day** at a board round or huddle **led by a senior decision maker.** Ensure the following questions form a basis for reviewing Clinically Optimised:
  - Does the person require the level of care that they are receiving, or can it be provided in another setting?
  - A D2RA pathway should be identified, recorded and reviewed as part of the board round discussions
  - What value are we adding for the person staying in an acute hospital balanced against the risks of them being discharged home or to a non-acute setting?
  - What do they need next and what action is required?
  - 'Why not home, why not today?
- All members of ward / departmental teams should be able to **discuss and explain the CCD/EDD** – it is a date that must be **meaningful to patients/families/carers** and provide recovery focus and also enable any plans to be made
- All effort must be made to discharge the patient once **Clinically Optimised to avoid them being a Pathways of Care Delay**

FLOW

All patients (acute & community hospitals) need to easily flow through all parts of their journey and not be subjected to any avoidable delays. Acute hospital beds must be available for those patients who are acutely unwell and require acute care as an inpatient. To maintain effective flow, 'every hour counts, every bed counts'.

- Ward teams should be in regular communication with assessment units to agree the first patient. Assessment unit teams should review patient care at the first 'post-take' ward round and ensure patients are informed beforehand that they will be transferred to the receiving ward at a specified time (e.g. before 10am)
- If discharges on the receiving wards are late, transfer patients to the discharge lounge (if available), if able enact sitting pre-discharge patients out (pre-emptive transfer), or simply safely expediting discharge within the next 1-2 hours as a priority activity
- Patients should be transferred to their usual place of residence as soon as they cease to benefit from acute care (i.e. they are clinically optimised) on the correct D2RA pathway.

  At every Board Round/Huddle, the following should be considered:
  - What are the patient's views on their care and progress?
  - Is the patient's clinical progress as expected?
  - What needs to be done to help the patient recover as quickly as possible?
  - Today is a red day until we prove otherwise and take actions to make it a green day.
  - If the patient was seen for the first time as an outpatient or in the ED today, would admission to hospital be the only option to meet their needs?
  - Considering the balance of risks, would the patient be better off in an acute hospital or in an alternative setting?
- Board Round daily attendees should include:
  - Nurse in charge of area
  - Medical Staff this can vary ward to ward but the Consultant need to ensure it is a decision-making Doctor
  - Therapies – OT & Physio
  - Discharge Liaison Nurse
  - Flow coordinator
  - Social Workers
  - Pharmacist
  - Community Representation
- Ensure patients are on the correct D2RA pathway and referrals have been actioned. Avoid the patient becoming a Pathways of Care Delay.
- Patients for next day discharge must be identified early and transferred at the earliest opportunity

E EARLY DISCHARGE

Early discharge: Morning discharges should be the norm, with at least a third of patients to be transferred home to have left their wards by midday ('home for lunch'). Patients should not have avoidable discharge delays and be enabled to leave hospital at the earliest opportunity.

- This **reduces Emergency Department overcrowding** and allows new patients be properly assessed and a treatment plan to be established and commenced.
- **Home for lunch** also allows for patients on **D2RA Pathway 1** to be **assessed same day** and for safe and adequate care provision to be mobilised. 33% of patients should be **discharged from inpatient wards before midday** on their day of discharge.
- Early morning Board rounds/Huddles should set the **'battle rhythm' of the ward for the morning** as well as the pace and focus for early discharge. Teams should **prioritise activities associated with discharge,** particularly medication to take home and patient discharge letters, which should be prepared beforehand or during **one-stop ward rounds.**
- The majority of acute hospital discharges should be **planned**. Focus on **"doing tomorrow's work today"** – this equally applies to the **booking of transport the day before discharge** for those that require it.
- Ensure there are weekly planned Integrated reviews (Health & Social care) of Patients who have been **21 days or more in hospital**, with the default assumption that patients will be transferred to their normal place of residence. Acute Hospitals with **tertiary services** may also find it beneficial to formally review patients with a **LOS >21 days.**
- Ensure Pathways of Care Delays are reviewed weekly with Action plans and assurance.
- **Effective communication** between ward and community teams or services is essential to facilitate early discharge. **Early conversations** with the community resource team or equivalent (GP, District Nurse and Social Worker) should be considered to enable earlier discharge and subsequent **review at home later in the day,** in accordance with the D2RA model.

"SAFER provides information and standards to guide and inform staff on actions to optimise patient experience and discharge, minimising delays and ensuring that the patient is discharged to the right place. "

SUE PEARCE, DIVISIONAL NURSE USC ABUHB

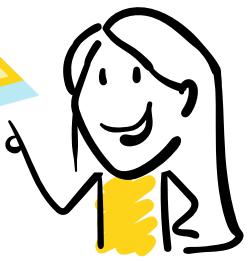
R RECOVERY

Recovery: Patients must be supported and enabled to recover from an acute period of illness as soon as possible, independence promoted and maximised, and a D2RA model adopted where a supported discharge is required.

- **Early conversations** need to be held with the patient to set their own goals and expectations.
- All patients should have a **co-produced recovery plan** that is regularly updated & reviewed.
- **D2RA** must be the default supported discharge model.
- Patient to have a good balance between providing sufficient opportunities for **good nutrition and rest/sleep** (to promote healing, wellbeing and recovery), alongside the need for **reasonable activity and mobilisation.**
- Care should be given in a way that it **promotes and maximises independence** and enables patients to recover optimally. This approach to care also aligns with a **D2RA model** and **'home first'.**
- **Focus and efforts should be on patient rehabilitation** and trying to return the patient as soon as possible to their usual place of residence.
- Daily Board rounds/Huddles should focus on **whether the patient needs to be in hospital bed.**
- Some patients choose to live in **'risky' situations and/or environments** that we may feel uncomfortable with, but if they have **capacity to make these decisions** then we **respect their wishes.**
- Where **frail, older patients** are clinically optimised but **delayed in hospital**, we must make **every collective effort to expedite discharge** to reduce the extent of clinical deconditioning.

Effective patient flow is important for all, but especially for frail older patients who so often come to harm through long waits, multiple ward moves and deconditioning. This framework focusses on what matters to older patients right from the moment of arrival into urgent care: promoting independence, empowering patient voices and reducing time spent away from home.

DR SIOBHAN LEWIS, CONSULTANT GERIATRICIAN, CAVUHB



S A F E R

Is the **Right Patient,** in the **Right Place,** having the **Right Care**, **first time?**

SEEN

SEEN BEFORE MIDDAY

Key Staff Questions:

- Clear actions and accountability with a timeframe?
- Patient waiting for a diagnostic/ treatment? Can this happen today, if not, why not?
- Is the patient clinically optimised for discharge or transfer?
- A senior support structure in place for escalation.

AIM

WHAT MATTERS TO ME?

Key Patient Questions:

1. What do you think is wrong with me? (Diagnosis)
2. What is going to happen to me today? (Tests, interventions etc.)
3. What is needed to get me home, and is there anything I can do to help? (Clinical criteria for discharge and Recovery Plan)
4. When can I go home? (EDD) Patient, family/ carers involved in care planning.

FLOW

RIGHT BED FIRST TIME

Prepare for early morning transfer to wards

- Front door, can admission be avoided?
- All patients on correct D2RA pathway?
- Identification of patients requiring supported discharges.
- Review discharges daily
- Are tomorrow's discharges planned?
- Patients discharged at earliest opportunity – Each day a **GREEN** day.

EARLY DISCHARGE

HOME FOR LUNCH/ASAP

Ward battle rhythm set?

- Prioritise patients being discharged today.
- Pharmacy to be on board round to review medications?
- Link with Family, Friends, Carers to arrange transport.
- Key/ keycode available?
- Book patient transport service if no alternative.
- Identify, clear actions and accountability with a timeframe to avoid delays

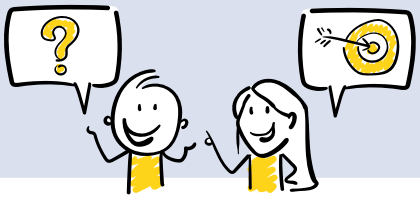
RECOVERY

WHAT MATTERS TO ME?

- Discussion with patient on recovery goals and expectations and plan updated regularly?

Can they go home?

- Stakeholder communication: Think GPs, DNs,3rd sector, Community Services, Social Workers.
- Right support for recovery? Think : AHP, social worker, carer, volunteer support.



GIG CYMRU NHS WALES

Click on the link to **Goal 5** where you will find the main documents

SAFER ENABLERS • Get up, Get Dressed, Keep Moving • Board Rounds • Huddles • Red2Green • Discharge Lounge • Community Liaison • Integrated Hubs (Single Point of Access)

Appendix 1:
10 Golden Rules for Board Rounds/Huddles

1. Board rounds/Huddles should be **completed by 10.30am at the latest** to ensure patients and ward flow and discharge planning tasks have been prioritised. The only exception to this is acute medical assessment/admission areas where an early morning post-take ward round should take place beforehand, with the first board round then starting by 10.30am. There must also be an **afternoon board round/ huddle** usually between 2-3.30pm in order to review the position and patient progress from the morning, with a particular focus on **planning for discharges tomorrow** (e.g. suitability for discharge lounge, booking of transport etc) and **reviewing any unconverted red delays** to agree immediate next steps. Actions must be documented and allocated to an individual and outcomes feedback with any constraints escalated and documented
2. There must be an agreed **consistent approach** to conducting an effective board round/huddle and they must be action driven
3. **Board round scripts for key roles** will ensure clarity of focus, optimum efficiency and consistency of approach
4. There are **generic core principles** for conducting an effective board round, with only **4 areas of differential specific focus:**
   a. Adult acute assessment/short stay units – there will be more of a medical/acute focus given the acuity of the patients
   b. Adult inpatient wards (unscheduled care) – require a focus on safely expediting acute treatment and care, along with proactive and appropriate discharge planning
   c. Adult inpatient wards (scheduled care) – may be nurse/therapy led where surgical colleagues may be in operating theatres – requires a degree of delegated decision making which may be enhanced by formal integrated care pathways
   d. Community hospital wards – may be therapy led, to recognise the emphasis on rehab/reablement for most patients (in accordance with D2RA Pathways)
5. It must be clear **who does what** on the board round, making best use of roles, skillsets and experience for the benefit of the patients.
6. It must be determined each day whether a patient is likely to require a **simple discharge** (D2RA Pathway 0) or a **supported discharge** (D2RA Pathway 1,2 or 3) – this will inform the type and level of discharge assessment and planning required

7. For a supported discharge the ward MDT must use available information (and reflect discussions with the patient) to determine the **current proposed** discharge pathway. Nearly all patients requiring supported discharge would be suitable for a D2RA pathway (see below for exceptions).
8. To identify the right D2RA pathway to meet each patient's care needs (and help everyone to think 'home first'), the following **3 D2RA board round questions** should be asked:
   a. Does the patient **actually need any new care support at home** (i.e. what do they want? – *What matters to me*) - If they can manage their care needs independently or require no change to their existing arrangements **(Pathway 0)**, then the ward can manage the discharge independently.
   b. Why not D2RA? - D2RA should be the **default supported discharge position**
   c. Is the patient **physically/cognitively safe between visits/overnight – Depending on the answer D2RA Pathway 1, 2 or 3**
9. Red2Green – identification of **green or red status** for each patient. If a patient is denoted as having a red day, **agreeing the red delay reason(s) and codes**, and agreeing actions required to convert to green (see Red2Green section below). Actions should be written and allocated to an individual with a timescale for feedback. Actions that cannot progress to an outcome needs clear escalation process.
10. **Use of a whiteboard** – given each patient should be reviewed within approx. 2 minutes, it is essential that wards make use of a whiteboard (ideally electronic with interactive large screens) that provides 'patient status at a glance' and enables **review of a key minimum set of board round indicators** to inform decision making and onward care:

- Date of admission
- Length of stay
- Clinically optimised status
- D2RA Pathway
- Expected date of discharge
- Suitability for discharge lounge
- Suitability for criteria led discharge

Your Board Round

What actions need to be **taken today** to progress their careand get them **home sooner?**

BEFORE YOU START:

- Ensure the board is updated (new patients/ bed moves)
- Mark all patients as RED on the board
- Check Clinical Criteria for discharge (CCD) [if condition allows], Estimated Date for Discharge (EDD) and D2RA pathway are set and updated on the board
- Assign a person who will update the board round actions on the board

Remember to S O R T your patients

S SICK PATIENTS

- What is the current diagnosis?
- Any tests/ interventions needed?
- Who is chasing the tests/ interventions?
- Today's management plan- including who will see/ review the patient and measures to prevent deconditioning
- Review and confirm Expected COFD/ EDD?
- Respect form & confirm Resus Status

O OUT TODAY

- What needs to be done to get the patient home for lunch? Action who will be responsible for any outstanding arrangements to facilitate discharge today
- Arrangements for relevant D2RA Pathway, transport, equipment are in place
- TTA's written and sent to pharmacy
- Outstanding investigations/ interventions arranged for an out-patient/ day case/ community setting
- Hospital at home or rapid response to support discharge informed and ready to start
- Transfer to the discharge lounge as early as possible (within 1 hour of COFD decision for pathway 0 patients)

R REST OF PATIENTS

- Action who will be responsible for any arrangements to progress their care
- Clinical criteria for discharge- set/ review and agree actions to enable CCD if condition allows
- Estimated date of discharge- set/ review and agree actions to enable EDD
- Are they clinically optimised for discharge?
- Agree/ confirm D2RA pathway and discharge plan and actions needed to progress discharge
- Identify recovery/ rehabilitation needs and agree plan to address these
- Agree today's management plan- including who needs to see/ review the patient, any test and interventions, and active measures to prevent deconditioning
- Review outstanding tests or interventions. Are they still appropriate/ needed?
- Respect form & Resus Status confirmed
- Can the patient go home tomorrow? Can they go home today?
  - Can their family provide their care or bridge a care gap?
  - TTAs written, transport and care arrangements in place
  - Aim to get patient home for lunch tomorrow

T TO COME IN

At the end of the board round - confirm:

- How many beds do you have?
- Expected admissions – ITU handover etc.
- Outliers in other specialties?
- Have admission unit/ED requests been actioned?
- Review weekend plans- Does every patient have a plan for care, treatment and management?
- Any internal delays of more than 24 hours? Escalate

AFTERNOON HUDDLE

- Update completed actions on the board
- If all actions are completed for a patient - change from Red to Green on the board
- Identify any outstanding actions and delays
- Action plan to address outstanding actions and agree local escalation plans as appropriate
- Identify potential discharges for tomorrow and actions needed to facilitate the discharge

Appendix 2:
SORT Principles of a board round (acute hospital)

RED2GREEN

Red2Green helps patients to become more independent and is also directly linked to the national NHS "End PJ Paralysis" initiative. It should support patients to speed up their own discharge process.

Simple steps like dressing in normal clothes, moving around the ward or even just thinking about what food needs to be bought on the way home can make a person feel less like a patient and can help put them in the frame of mind that they are ready to leave.

All multi-disciplinary team (MDT) members asking on every board or ward round if today is going to be a red or a green day - every inpatient will start the day assuming they are red (even if they were green the day before) in accordance with national guidance.

If it is going to be a red day, the MDT makes every effort to resolve the problem in real time - the day remains as a 'Red Bed Day' if there is no clinically owned expected date of discharge (set assuming ideal recovery and no unnecessary waiting) with an appropriate proposed pathway for discharge and a clear case management plan

If the MDT cannot resolve the problem i.e. prevent the patient from having a red day, there should be clear and simple escalation processes in place that involve all levels of health, social care and other staff groups (including the third sector), again responding to delays in real time - the escalation process then needs to pro-actively manage the constraint. This is crucial; failure to resolve constraints proactively and just 'reporting them' is a 'non-value added' reporting process

Record red and green days in a visual manner i.e. so it's clear for all to see the number of red and green days on patient status at a glance boards (ward whiteboards) and IT systems - there should be a hospital wide set of internal professional standards that clearly define when something is a delay to enable appropriate escalation.

The team assure themselves that they are clear what actions must be delivered to ensure the day is a 'Green Bed Day'. Having observations undertaken, oral medications and IV antibiotics, by themselves do not make a day a Green Bed Day as these can be delivered out of hospital unless the patient is physiologically unstable.

As well as providing delay reasons about individual patients, and then unblocking the delay, one of the main functions of R2G is also to identify delay themes and trends for actions to be taken to improve, such as:

- Response times of services (especially where supported by a contract) – e.g. diagnostics, support services, Patient Transport Service (PTS) (WAST)
- Particular themes on a particular ward or site
- Available discharge/out of hospital capacity for specific D2RA pathways or Services
- Efficiency within certain community D2RA pathways or Services.

Where there are actual/emerging trends around internal red delays, operational managers should support ward managers to review data with diagnostics/support services/PTS to agree and implement improvement actions.

RED TO GREEN

GIG CYMRU NHS WALES

Click on the link to **Goal 5** where you will find the main documents

A DAY OF NO VALUE

KEY QUESTIONS

1. Can the patient care or interventions received today be delivered at HOME or in a non-acute setting?
   YES – It's a RED DAY
2. If I saw the patient in an outpatient setting, would their current 'physiological status' require an emergency admission? **NO – It's a RED DAY**

- Inadequate MDT presence at the Board Round to allow firm decisions to be made.
- The care or interventions the patient is receiving today could be delivered in a non-acute setting.
- Tests and investigations have occurred but the results have not been reviewed by the Medical team and acted upon.
- A planned investigation, clinical assessment, discharge assessment or therapy intervention for today does not occur.
- Acute - The medical care plan lacks a Senior Medic approved expected date of discharge.
- Acute - The patient is a new admission and has not yet had a medical review/there is no initial diagnosis/treatment plan.
- If a patient is due for discharge today and the discharge prescription medications are not ready (Pathways of Care Delay).
- Transport delaying discharge or causing plans to fail today.

A DAY OF VALUE

- Patient progresses towards discharge
- Everything planned and requested is done
- Patient needs this bed for Acute care

- Everything that was planned for today gets done
- The patient requires acute hospital care
- The patient requires community hospital care
- The results from tests and investigation have been reviewed by the Medical team and acted upon
- The patient is receiving active interventions to get them to be discharged by tomorrow, and the discharge prescription medications are ready by the evening before the expected date of discharge.