Transforming Acute Care using Single Clerking and Innovative Staffing Solutions

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The BSUH back story...
Patients get efficient, equal care whether they are undifferentiated ED or expected specialty across the acute floor

**Aim:** Full clerking and specialty senior review with decision to admit or discharge within 3.5 hours of arrival
Thank you for your support

Reforming the front door: single clerking
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How

1. Single clerking workforce efficiency

2. Clinical fellows clerking team

3. Innovative rota staff satisfaction
Single Clerking

Trust develops a single clerking system where a junior doctor fully clerks a patient and presents to a senior for review, reducing waiting time and improving patient experience.
Concept

- Remove traditional step of re-clerking by specialty junior before senior review
- Facilitate early senior decision making
- Single full clerking for majors, specialty referred/expected, longer stay patients

Thank you for your support
• Junior = <ST3+

• Senior = ST3 and above
  – NB some rare cases where no ST3+ residential 24/7 to receive referral / review referred patient
    • E.g. ENT

Thank you for your support
Full Clerking

- **Full clerking** = *all of*:
  1. Comprehensive completed proforma
  2. Full drug chart
  3. VTE assessment
  4. Going with specialty senior to review patient + do urgent jobs from review
    - (jobs taking >5 minutes = handover to specialty team junior)
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<td><strong>Surname:</strong></td>
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<td><strong>DOB:</strong></td>
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<td><strong>Team currently responsible (e.g. ED or specialty):</strong></td>
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Process 1

Undifferentiated A&E Patient

0 – Hours from Arrival

Patient

A&E or Specialty Junior Full Clerking +/- D/W A&E Senior

A&E Senior

PAT running 12-9 Mon-Fri

Refer to Speciality

CDU/SSW

Discharge

Senior Speciality Review

Specialty or A&E Junior

Full Clerking

Refer to Speciality

CDU/SSW

Discharge

Senior Speciality Review

Full Clerking by A&E SHO
Process 2

Specialty Expected Patient

- Specialty Junior Full Clerking
- A&E Junior Full Clerking
- Patient
- Senior Specialty Review
- Discharge
- DTA
- Refer to Another Specialty

0 – Hours from Arrival
• A single, high quality full clerking by acute floor juniors
  – A&E and specialty juniors as combined team

• A&E seniors and specialty seniors do not fully clerk patients.
  – They senior review and perform rapid assessment.
Specialty juniors fully clerk:

1. All GP referrals and specialty expected patients directly
2. Patients identified by ED senior as
   a) Likely for admission under that specialty
   b) Those educationally beneficial for that specialty junior
3. Patients formally referred by ED senior

ED juniors full clerk:

1. Undifferentiated patient next in queue / on acuity basis as usual
2. Support specialty teams with specialty patients if long waits/acuity
Process

• Deciding who needs full clerking
  1. By ED Senior Clinician at Streaming / Triage / PAT
  2. By location of arrival – Majors vs UCC

• Minors / UCC
  – Minor injury/illness, not referred, short stay
    • ED clerking on UCC Profoma / Symphony Clinical Data
  – Patients likely to be referred to specialty or stay > 4 hours
    • Full clerking
  – Specialty expected patients
    • Full clerking

• Majors patients
  – Full clerking
• Full clerking must be completed by ED or specialty team before patient moves from ED
  — (unless immediate, critical intervention only available outside of ED required)
  — Or true acute floor system in place and generic acute floor junior follows the patient across acute area once decision for assessment unit / ambulatory care made.
• **Referral**

• Full clerking ED / specialty junior discuss patient with ED ST3+ prior to referral
  – Ensure appropriate referrals
• **Senior review**
  
  – Can occur anywhere on Acute Floor
    
    - ED / Ambulatory / Assessment Unit
  
  – Verbal decision by senior decision maker to admit or transfer patient from ED can be followed as long as documented
  
  – Always discuss suitability to move from ED with specialty ST3+
  
  – Caveat
    
    - Unstable/risky patients may need physical ED review prior to move
• Senior Review Decisions
  1. Discharge
     • +/- Follow Up
  2. Ambulatory Care
     • Same Day / Future
  3. Decision to Admit (DTA)
     • A DTA should occur within 3.5 hours of a patient’s arrival in A&E
     • A DTA can be made after physical senior review of patient in ED, or following discussion and documentation of the decision
  4. Refer on to a different specialty
• Have referrals gone up?
  – No, stable and
• Has it slowed down ED?
  – No, maintain 1hour to see Dr, 2hr referral
  – Adequate staff essential
• Has it improved 4 hour target?
  – No, but we achieve full clerking, an senior review within this time.
  – If we had capacity...but our focus = quality
• Please watch this for a summary overview of single clerking:
  – https://www.youtube.com/watch?v=N54HvyRynig&feature=youtu.be&list=PLuVl_N14jxdjKSXiUTupGGk5s-C8aoZj8
Where are we now?

- Version 3 Sep 2018 (began Feb 2016)
- Interview work 200 staff – embedded in to v3
- National leads HEE working with us to develop national model
- HSJ Award winner + Patient Safety finalist
Key clinical outcomes

• Time to senior review as driving force
  – Shorter LOS
  – Lower Mortality
  – Higher Quality
  – Better Education
  – Better Patient Experience

• RSCH now achieve senior review within 3.6 hours from arrival for all specialties (median)
### Data on DTAs

<table>
<thead>
<tr>
<th>Specialty</th>
<th>% DTA 3h 30m Pre- single clerking</th>
<th>% DTA 3h 30m Post - single clerking</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>36%</td>
<td>70%</td>
</tr>
<tr>
<td>Medicine</td>
<td>27%</td>
<td>76%</td>
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</tbody>
</table>

Thank you for your support

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>Twice as fast to senior review

<table>
<thead>
<tr>
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<th>Post Single Clerking Overall</th>
<th>Pre Single Clerking</th>
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<tr>
<td></td>
<td>Arrival to Initial Clerking</td>
<td>Arrival to Specialty Referral</td>
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<td><strong>75th percentile</strong></td>
<td>1.9 hrs</td>
<td>2.7 hrs</td>
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<tr>
<td><strong>Median</strong></td>
<td>1 hrs</td>
<td>1.4 hrs</td>
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<tr>
<td><strong>25th percentile</strong></td>
<td>24 mins</td>
<td>32 mins</td>
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Endorsement

- HEE England
- 60 NHS organisations in touch, site visits
- SAM, RCEM, RCP, ECIST, NHSI
- Director of Medical Education
- Supports specialist and generalist requirements
  - Shape of Training
- Meets the clinical needs of our patients
- LFGs + Trainee Reps
- Clinical Directors
- Nursing + Midwifery Board
- HSJ
- Executive Committee
Other Benefits

• **Better patient experience**
  – Patient feedback and interviews
    • Less repetition
    • More confidence in acute care team

• **Staff support**
  – 80% of 200 staff 2017 support single clerking and preferring it to traditional system
    • 75% in 2016

Thank you for your support
Other Benefits

• **Facilitates senior oversight of department**
  – ST3 and above do not clerk. Review only. Prepare for consultant role.

• **Less duplication, more efficient**
  – ED and specialty juniors more free to see new patients quickly
    • Time not taken up reclerking
  – 90% of patients seen within 1 hour arrival
  – >90% those with sepsis Abx within 1 hour
  – If demand requires, specialty can focus on ambulatory care, procedures
• Improved acute floor teamwork and culture
  – ED and specialties as integrated team and service to match patient needs

RSCH Acute Floor Meetings

When? Mon–Fri 0845 AND Sat–Sun 0900
Where? Acute Floor Hub – Zone 4 A&E

Purpose and Agenda?
• Introduce Acute Floor team and sign in
• Follow ED Consultant Agenda on wall
• Identify and respond to any issues on Acute Floor
• Know the site, escalation and staffing position
• Share latest Acute Floor updates to whole team
• Split into Trauma and MET / Arrest Meetings

NB: Sat-Sun the MET/Arrest meeting is at 0800 at start of medical handover

Who must come?
• Doctors: A&E team (Cons, Regs, SHOs), on-call medics (Cons, Reg, SHOs, FIs), frailty cons if available, general surgeons (Reg, SHO), T&O (Reg, SHO), anaesthetics (Cons, Reg, SHO).
  ○ NB: At weekends registrar representation is acceptable
• Nurses: clinical site managers, AAU and EAC coordinators/nurses in charge, A&E shift leader/available area coordinators, outreach, MHLT
• Resus practitioners (Mon–Fri)
• Social and therapy teams: HRDT and In Reach
• Encourages review (+ awareness) of whole workforce

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<tr>
<th>Acute Floor</th>
<th>Draft Acute Floor Rota 2017</th>
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Other Benefits

• **Quicker to senior review plan and decision**
  – Improves potential flow
    • Those suitable for discharge / ambulatory have decision

• **Safe and sorted**
  – Fully clerked and senior reviewed patients safe and sorted despite long stays in ED

• **Each patient can receive equitable care**
  – National and local safety and quality features on single proforma and process to benefit all
  – Same process for patients cared for in ED and moved to AAU
Other Benefits

• **Single place to document**
  – One place to find the information

• **Larger audit tool**
  – Continuous improvement and evaluation
  – Embedded CQUIN, KPI, SUI

• **Fewer medication errors**
  – One place to prescribe
Other Benefits

• **Educational opportunities**
  – High GMC acute care satisfaction surveys
  – ED and specialty juniors develop specialist and generalist skills
  – All acute floor seniors can offer assessments
  – Specialty seniors develop senior review skills
  – Specialty involvement in resuscitation
  – ED involvement in specialty care
Other Benefits

• **Educational opportunities**
  – High GMC acute care satisfaction surveys
  – ED and specialty juniors develop specialist and generalist skills
  – All acute floor seniors can offer assessments
  – Specialty seniors develop senior review skills
  – Specialty involvement in resuscitation
  – ED involvement in specialty care

Thank you for your support
Risks (and solutions)

• Ineffective handover
  – All patients must be handed over
    • Mix ED /specialty – extra care with handover and which team currently responsible

• No full clerking
  • ED ST3+ referred patients need prompt specialty / ED junior full clerking
    – Ensure time / communication for rapidly referred patients to have full clerking prior to senior review
    – During referral/discussion agree time of senior review
• **Insufficient contact detail documentation**
  – ED do not carry bleeps, names are important.
  – Tannoy, shared IT / use names / learn shift times

• **Missed education opportunities**
  – Clerking junior should go with senior reviewer if they are still on shift – for all patients
  – Environment and attitude of feedback, education and assessments in real time welcomed
  – Opportunity to develop specialty skills in both ED and specialty juniors
• Incomplete / Inadequate Full Clerking
  – All sections of the proforma, drug chart and VTE assessment must be completed or robustly handed over by the clerking doctor before they go off shift
  – 20% full clerkings incomplete – strive to reduce this
  – Defeats point of single clerking if time spent reclerking
  – Things which may not seem relevant initially may become highly relevant later – e.g. social history, cognition, frailty, wishes for overall goal of care
  – Develop real-time / feedback mechanism
• **Unclear Who is Responsible for Patient**
  
  – Mix ED / specialty responsible
  
  – A referred patient may still be the responsibility of an ED doctor until specialty senior review.
  
  – **Any change in responsibility for the patient should be clearly documented in real time and communicated to the nurse coordinator.**
• **Unclear Progress of Patient**
  – Shared method ED/specialty for showing which tasks complete /not

• **Unequal engagement between ED and different specialty teams**
  – Need to ensure standard process adopted for all patients, e.g. medical and surgical for clarity, consistency and quality
Risks

- Inequality in waiting time between specialty expected / ED ST3+ referred patients and ED patients
  - Ensure ED/specialty senior review and awareness of both ED and specialty team workloads to allocate acute floor resource where required
  - Encourage collaboration

Thank you for your support
Staff to Support the System

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<th>Admin</th>
<th>Jonathan Payne</th>
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Thank you for your support.
Staff to Support the System

Staff to Support the System

Thank you for your support

https://www.rcem.ac.uk/docs/Wor
kforce/Engage%20and%20Retain%20Sept%202018.pdf
Staff to Support the System

Risky Business 2017 - Dr. Rob Galloway

https://vimeo.com/219295413
General Email to the 3 of us:
– acutefloorproject@bsuh.nhs.uk

– Rota software:
  • Health Rota
    – jimbarry@healthrota.co.uk

– Twitter:
  • @PhilipRankin
  • @DrRobGalloway
  • @mrtnduff
Breakout session 2

- **Bedside handover in a community hospital including the patient in the conversation** (Rolls Suite: First floor)
- **Transforming A&E using single clerking and innovative staffing solutions** (Royce Suite: First floor)
- **How to develop a home first model with new roles** (Lancaster Suite: First floor)
- **Developing a frailty model** (Stanley Suite: First floor)
- **Collaborative approach to SAFER and Red2Green in the North** (Victoria Suite: Lower ground floor)
- **Treating staff fairly and consistently when care doesn’t go to plan: NHS Improvement’s Just Culture guide** (Fairclough Suite: First floor)
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Context

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Single clerking workforce efficiency

Clinical fellows clerking team

Innovative rota staff satisfaction

1.

2.

3.

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**Single Clerking Process**

The single clerking process improves patient safety, avoids duplication of work, ensures our patients have earlier reviews by a senior doctor, enables effective team working and enhances the teaching of our doctors in training.

---

**Trust develops a single clerking system where a junior doctor fully clerks a patient and presents to a senior for review, reducing waiting time and improving patient experience**

**Winners!**

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS TRUST</th>
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</thead>
<tbody>
<tr>
<td>CATEGORY</td>
<td>HSJ VALUE AWARDS 2018/ ACUTE SERVICE REDESIGN</td>
</tr>
<tr>
<td>AWARD</td>
<td>WINNER</td>
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**Challenge**

**Action**

**Result**
• Remove traditional step of re-clerking by specialty junior before senior review

• Facilitate early senior decision making

• Single full clerking for majors, specialty referred/expected, longer stay patients
• Junior = <ST3+

• Senior = ST3 and above
  – NB some rare cases where no ST3+ residential 24/7 to receive referral / review referred patient
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## Full Clerking

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Thank you for your support

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### FULL CLERKING

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<thead>
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<th>Name:</th>
<th>Date:</th>
<th>Consultant currently responsible for the patient:</th>
<th>Consultant currently responsible (e.g. ED or specialty):</th>
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<td>Your Specialty:</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age:</th>
<th>Relevant Prehospital Care:</th>
</tr>
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</table>

<table>
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<tr>
<th>PC:</th>
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<table>
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<tr>
<th>HPC:</th>
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</table>
Process 2

Specialty Expected Patient

1. Specialty Junior Full Clerking
2. Senior Specialty Review
3. DTA
4. Refer to Another Specialty
5. Discharge

Patient

A&E Junior Full Clerking

0 – Hours from Arrival

Thank you for your support

Acute Floor
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST

Reforming the front door: single clerking
acutefloorproject@bsuh.nhs.uk
• A single, high quality full clerking by acute floor juniors
  – A&E and specialty juniors as combined team

• A&E seniors and specialty seniors do not fully clerk patients.
  – They senior review and perform rapid assessment.
Who sees Who

• **Specialty juniors fully clerk:**
  1. All GP referrals and specialty expected patients directly
  2. Patients identified by ED senior as
     a) Likely for admission under that specialty
     b) Those educationally beneficial for that specialty junior
  3. Patients formally referred by ED senior

• **ED juniors full clerk:**
  1. Undifferentiated patient next in queue / on acuity basis as usual
  2. Support specialty teams with specialty patients if long waits/acuity
Deciding who needs full clerking
1. By ED Senior Clinician at Streaming / Triage / PAT
2. By location of arrival – Majors vs UCC

Minors / UCC
- Minor injury/illness, not referred, short stay
  - ED clerking on UCC Profoma / Symphony Clinical Data
- Patients likely to be referred to specialty or stay > 4 hours
  - Full clerking
- Specialty expected patients
  - Full clerking

Majors patients
- Full clerking
Process

- Full clerking must be completed by ED or specialty team before patient moves from ED
  - (unless immediate, critical intervention only available outside of ED required)
  - Or true acute floor system in place and generic acute floor junior follows the patient across acute area once decision for assessment unit / ambulatory care made.

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Process

• Referral

• Full clerking ED / specialty junior discuss patient with ED ST3+ prior to referral
  – Ensure appropriate referrals
• **Senior review**
  – Can occur anywhere on Acute Floor
    • ED / Ambulatory / Assessment Unit
  – Verbal decision by senior decision maker to admit or transfer patient from ED can be followed as long as documented
  – Always discuss suitability to move from ED with specialty ST3+
  – Caveat
    • Unstable/risky patients may need physical ED review prior to move
• **Senior Review Decisions**

1. Discharge
   - +/- Follow Up
2. Ambulatory Care
   - Same Day / Future
3. Decision to Admit (DTA)
   - A DTA should occur within 3.5 hours of a patient’s arrival in A&E
   - A DTA can be made after physical senior review of patient in ED, or following discussion and documentation of the decision with
4. Refer on to a different specialty
FAQ

• Have referrals gone up?
  – No, stable and
• Has it slowed down ED?
  – No, maintain 1 hour to see Dr, 2 hr referral
  – Adequate staff essential
• Has it improved 4 hour target?
  – No, but we achieve full clerking, an senior review within this time.
  – If we had capacity...but our focus = quality

Thank you for your support
Please watch this for a summary overview of single clerking:

– [https://www.youtube.com/watch?v=N54HvyRynig&feature=youtu.be&list=PLuVl_N14jxdjKSXiUTupGGk5s-C8aoZj8](https://www.youtube.com/watch?v=N54HvyRynig&feature=youtu.be&list=PLuVl_N14jxdjKSXiUTupGGk5s-C8aoZj8)
Where are we now?

• Version 3 Sep 2018 (began Feb 2016)

• Interview work 200 staff – embedded in to v3

• National leads HEE working with us to develop national model

• HSJ Award winner + Patient Safety finalist
Key clinical outcomes

• Time to senior review as driving force
  – Shorter LOS
  – Lower Mortality
  – Higher Quality
  – Better Education
  – Better Patient Experience

• RSCH now achieve senior review within **3.6 hours** from arrival for all specialties (median)
### Data on DTAs

<table>
<thead>
<tr>
<th>Specialty</th>
<th>% DTA 3h 30m Pre- single clerking</th>
<th>% DTA 3h 30m Post - single clerking</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>36%</td>
<td>70%</td>
</tr>
<tr>
<td>Medicine</td>
<td>27%</td>
<td>76%</td>
</tr>
</tbody>
</table>

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>Twice as fast to senior review

<table>
<thead>
<tr>
<th></th>
<th>Post Single Clerking Overall</th>
<th>Pre Single Clerking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Arrival to Initial Clerking</td>
<td>Arrival to Specialty Referral</td>
</tr>
<tr>
<td>75th percentile</td>
<td>1.9 hrs</td>
<td>2.7 hrs</td>
</tr>
<tr>
<td>Median</td>
<td>1 hrs</td>
<td>1.4 hrs</td>
</tr>
<tr>
<td>25th percentile</td>
<td>24 mins</td>
<td>32 mins</td>
</tr>
</tbody>
</table>
Endorsement

- HEE England
- 60 NHS organisations in touch, site visits
- SAM, RCEM, RCP, ECIST, NHSI
- Director of Medical Education
- Supports specialist and generalist requirements
  - Shape of Training
- Meets the clinical needs of our patients
- LFGs + Trainee Reps
- Clinical Directors
- Nursing + Midwifery Board
- HSJ
- Executive Committee
Other Benefits

• **Better patient experience**
  – Patient feedback and interviews
    • Less repetition
    • More confidence in acute care team

• **Staff support**
  – 80% of 200 staff 2017 support single clerking and preferring it to traditional system
    • 75% in 2016
Facilitates senior oversight of department
  - ST3 and above do not clerk. Review only. Prepare for consultant role.

Less duplication, more efficient
  - ED and specialty juniors more free to see new patients quickly
    - Time not taken up reclerking
  - 90% of patients seen within 1 hour arrival
  - >90% those with sepsis Abx within 1 hour
  - If demand requires, specialty can focus on ambulatory care, procedures
Improved acute floor teamwork and culture

- ED and specialties as integrated team and service to match patient needs

RSCH Acute Floor Meetings

When? Mon – Fri 0845 AND Sat – Sun 0900
Where? Acute Floor Hub – Zone 4 A&E

Purpose and Agenda?

- Introduce Acute Floor team and sign in
- Follow ED Consultant Agenda on wall
- Identify and respond to any issues on Acute Floor
- Know the site, escalation and staffing position
- Share latest Acute Floor updates to whole team
- Split into Trauma and MET / Arrest Meetings

NB Sat-Sun the MET/Arrest meeting is at 0800 at start of medical handover

Who must come?

- Doctors: A&E team (Cons, Regs, SHOs), on-call medics (Cons, Reg, SHOs, F1s), frailty cons if available, general surgeons (Reg, SHO), T&O (Reg,SHO), anaesthetics (Cons, Reg, SHO).
  - NB: At weekends registrar representation is acceptable
- Nurses: clinical site managers, AAU and EAC coordinators/nurses in charge, A&E shift leader/available area coordinators, outreach, MHLT
- Resus practitioners (Mon-Fri)
- Social and therapy teams: HRDT and In Reach
Encourages review (+ awareness) of whole workforce
Other Benefits

• **Quicker to senior review plan and decision**
  – Improves potential flow
    • Those suitable for discharge / ambulatory have decision

• **Safe and sorted**
  – Fully clerked and senior reviewed patients safe and sorted despite long stays in ED

• **Each patient can receive equitable care**
  – National and local safety and quality features on single proforma and process to benefit all
  – Same process for patients cared for in ED and moved to AAU
Other Benefits

• **Single place to document**
  – One place to find the information

• **Larger audit tool**
  – Continuous improvement and evaluation
  – Embedded CQUIN, KPI, SUI

• **Fewer medication errors**
  – One place to prescribe
Other Benefits

- **Educational opportunities**
  - High GMC acute care satisfaction surveys
  - ED and specialty juniors develop specialist and generalist skills
  - All acute floor seniors can offer assessments
  - Specialty seniors develop senior review skills
  - Specialty involvement in resuscitation
  - ED involvement in specialty care

Thank you for your support
Other Benefits

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Risks (and solutions)

- **Ineffective handover**
  - All patients must be handed over
    - Mix ED /specialty – extra care with handover and which team currently responsible

- **No full clerking**
  - ED ST3+ referred patients need prompt specialty / ED junior full clerking
    - Ensure time / communication for rapidly referred patients to have full clerking prior to senior review
    - During referral/discussion agree time of senior review
• **Insufficient contact detail documentation**
  – ED do not carry bleeps, names are important.
  – Tannoy, shared IT / use names / learn shift times

• **Missed education opportunities**
  – Clerking junior should go with senior reviewer if they are still on shift – for all patients
  – Environment and attitude of feedback, education and assessments in real time welcomed
  – Opportunity to develop specialty skills in both ED and specialty juniors
• Incomplete / Inadequate Full Clerking
  – All sections of the proforma, drug chart and VTE assessment must be completed or robustly handed over by the clerking doctor before they go off shift
  – 20% full clerkings incomplete – strive to reduce this
  – Defeats point of single clerking if time spent reclerking
  – Things which may not seem relevant initially may become highly relevant later – e.g. social history, cognition, frailty, wishes for overall goal of care
  – Develop real-time / feedback mechanism
• Unclear Who is Responsible for Patient
  – Mix ED / specialty responsible
  – A referred patient may still be the responsibility of an ED doctor until specialty senior review.
  – Any change in responsibility for the patient should be clearly documented in real time and communicated to the nurse coordinator.
• **Unclear Progress of Patient**
  – Shared method ED/specialty for showing which tasks complete /not

• **Unequal engagement between ED and different specialty teams**
  – Need to ensure standard process adopted for all patients, e.g. medical and surgical for clarity, consistency and quality
Inequality in waiting time between specialty expected / ED ST3+ referred patients and ED patients

- Ensure ED/specialty senior review and awareness of both ED and specialty team workloads to allocate acute floor resource where required
- Encourage collaboration

Thank you for your support
### Staff to Support the System

[Image of HealthRota interface]

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Staff to Support the System

Staff to Support the System

https://www.rcem.ac.uk/docs/Workforce/Engage%20and%20Retain%20Sept%202018.pdf
Thank you for your support

Acute Floor

Brighton and Sussex University Hospitals NHS Trust

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Staff to Support the System

https://vimeo.com/219295413

Risky Business 2017 - Dr. Rob Galloway
General Email to the 3 of us:
– acutefloorproject@bsuh.nhs.uk

– Rota software:
  • Health Rota
    – jimbarry@healthrota.co.uk

– Twitter:
  • @PhilipRankin
  • @DrRobGalloway
  • @mrtnduff
Refreshment break

**Wifi:** ECISTconferences  |  **Password:** FLOWNHS710

**Glisser:** glsr.it/ECIST2018

**Twitter:** #TBC
Breakout session 3

- Bedside handover in a community hospital including the patient in the conversation (Rolls Suite: First floor)
- Transforming A&E using single clerking and innovative staffing solutions (Royce Suite: First floor)
- How to develop a home first model with new roles (Lancaster Suite: First floor)
- Developing a frailty model (Stanley Suite: First floor)
- Collaborative approach to SAFER and Red2Green in the North (Victoria Suite: Lower ground floor)
- Treating staff fairly and consistently when care doesn’t go to plan: NHS Improvement’s Just Culture guide (Fairclough Suite: First floor)