Time for care?

Patients’ and emergency practitioners’ voices

Jonathan Pinkney [1], Susanna Rance [1], Heather Brant [2], Debra Westlake [1], Dawn Swancutt [1], Ingrid Holme [3], Siobhan Sharkey [4], Richard Byng [1]

[1] Plymouth University Peninsula Schools of Medicine and Dentistry
[4] Independent Consultant
Avoidable Acute Admissions

NIHR-funded study on 4 acute hospital sites in South-West England, 2013-15:

“How can frontline expertise and new models of care best contribute to safely reducing avoidable acute admissions?”

• How do patients and practitioners experience the admissions process?
• What influences decision-making?
• How are patients, relatives and carers involved?
Project components

• Ethnography
  • Participant observation and interviews
    ➢ 25 patient case studies

• Value Stream Mapping
• Patient and Public Involvement
• Learning Sets
• Clinical Panel
• Stakeholder workshops
Emergency Department (ED) pressures

- International focus on ED crowding; UK focus on throughput.
  Higginson 2012

- Intelligent use of targets: “Do my actions benefit the patient?”
  Cooke 2014

- Teams under pressure: 4-hour target, workload, staff shortages.
  Flowerdew 2012

- Positive organisations can have unstable platforms.
  Weick 2003
All in a day’s work

In the war zone

Packaging and moving

It’s a horrendous thing to do, to work in a department that’s overcrowded and unsafe. The intensity, the stress levels ...
(Consultant)

When we’re over capacity, 110% full, things fall apart, and we crisis manage ...
(Consultant)

I understand that that’s their job, to do the boxes: move that box from there within four hours ...
(Nurse)

When things line up

... when staffing’s at full capacity, everything works when the hospital’s green.
(Nurse practitioner)

Tipping point
“It’s been swift hasn’t it, the service that we’ve been given? (...) what’s been good is that the doctors have actually listened to what we’ve said.” (Relative)

“I look at every patient with a view to trying to discharge them, and I didn’t used to do that, (...) that’s become our raison d’être ...” (Nurse)

“... we’re waiting for beds to come up. So those patients, some of them have been on trolleys for a lot longer than four hours.” (Manager)

... it can just be the swing of a patient. (...) something tips it and it goes from a department which is constantly thinking five or six steps ahead of itself (...) all of a sudden (...) it all just sort of goes... (Nurse)
Patient Case Study 1

Wife of patient (65) raises alert about his slurred speech. GP refers him to ED - ? mini-stroke. Friday p.m.

Consultant contacts stroke nurse who arranges outpatient appointment that afternoon.

**Outcome:** Admission avoided; positive patient experience.

**Influential factors:** Reliable information from patient; comprehensive GP letter; team collaboration; hot clinic.

“I thought Monday morning follow-up might be too long.” (Consultant)
Patient Case Study 2

Woman, 60: right side weakness, disorientation. GP fast-tracks patient via ambulance for neurology appointment - ? mini-stroke. Monday a.m.

Junior doctor consults neurology registrar: long wait for CT (brain) scans; patient advised to go home and return next day. Patient considered not unwell so ineligible for transport home; unhappy about night travel to rural area by public transport.

**Outcome:** Admission avoided; negative patient experience.

**Influential factors:** Confusing referral via ED; scan delays; rigid transport policy; patient reluctant to burden system.

“It’s been one of those days that I have not kept track of things; we’ve had to juggle.” (Nurse)
Patient Case Study 3

Woman, 41: acute episode of chronic neck pain; 3 previous ED attendances for this problem; outpatient appointment too far ahead. Patient calls GP; 111 arranges ambulance.

Patient admitted to observation ward, then acute medical ward for pain relief. Consultant says he will book her with pain team and neurologist.

**Outcome:** Discharged home at 2 a.m.; negative patient experience.

**Influential factors:** Long wait for clinic appointments. Nurse questions patient’s need to attend ED, given sudden improvement after treatment.

“I was on my own, and they sent me home in a taxi, and like, high as a kite on drugs. I was crawling up my stairs to get to bed.” (Patient)
Conclusions

• Patients mainly report positive experiences, and tend to self-ration use of emergency resources. They are most often dissatisfied with the lack of information, and delays in discharge and outpatient appointments.

• The departments and staff providing emergency medical care often work under immense pressure.

• Emergency departments are insufficiently resourced to cater for complex medical and social care needs.

• The culture of efficiency and target compliance can detract from other dimensions of quality including time for individualised care.

• Late-night transfers, bed moves and discharges are sometimes done in ways that are expedient for the system but have negative effects on patients.
Questions

Through what measures can...

• Emergency Department work be made more sustainable for organisations?

• Emergency Department work be made less pressurised for staff?

• Foreseeable complex medical and social care needs of people with long term conditions be better met?

• Admission avoidance be guided more consistently by patient-centred values rather than organisational considerations?
Acknowledgements

Funding Acknowledgement:
This project was funded by the National Institute for Health Research [HS&DR] (project number 10/1010/06).

This research was supported by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care South West Peninsula at the Royal Devon and Exeter NHS Foundation Trust.

Disclaimer:
The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, the HS&DR programme or the Department of Health.

Contact for further information:
jonathan.pinkney@plymouth.ac.uk