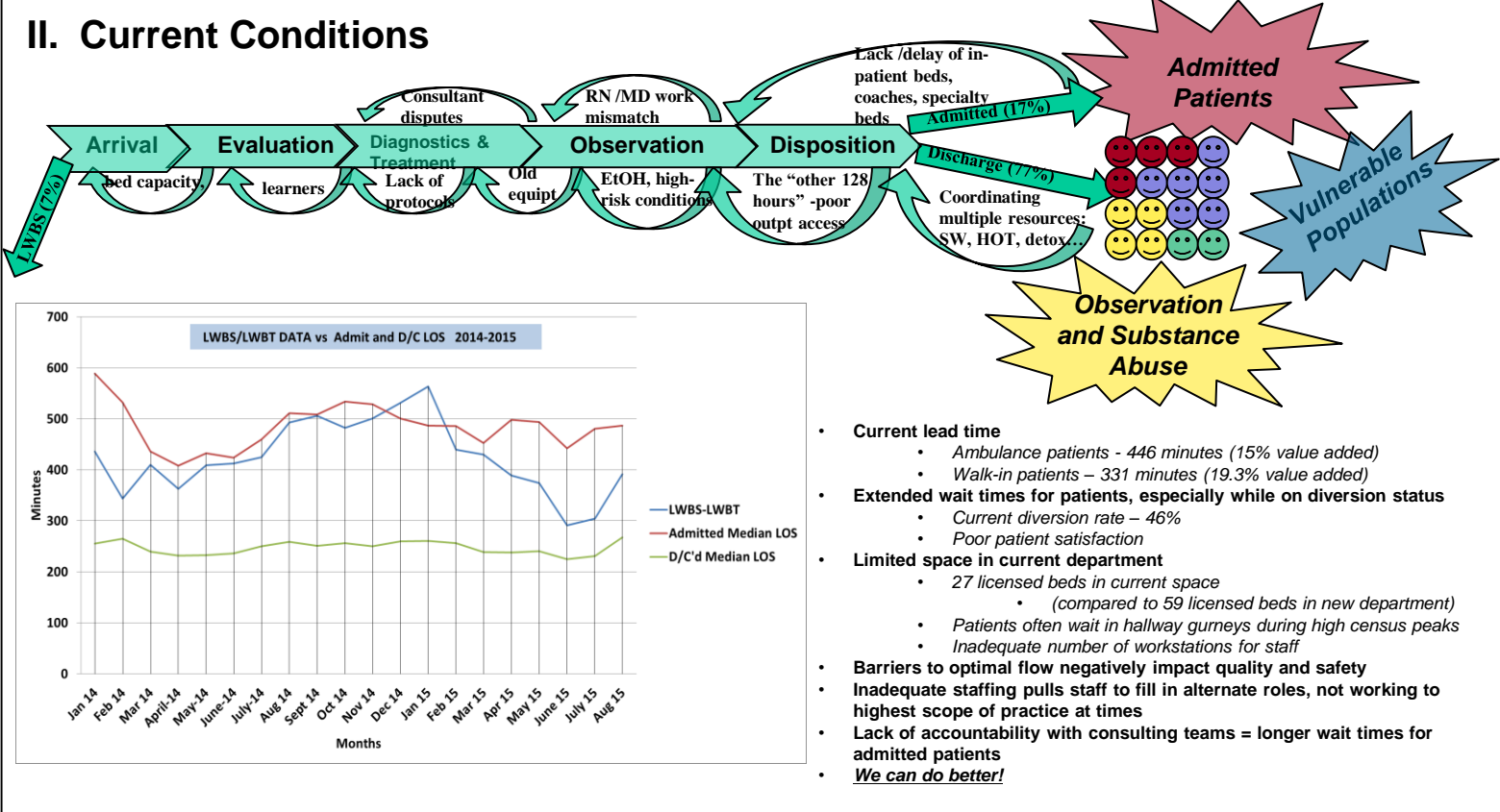**Title: ED FLOW**

Owner/Date: Staconis, 11/12/15

I. Background

SFGH Emergency Department, the only Level 1 Trauma Center in the city, is a busy, high acuity ED that serves as the entry point for the majority of SFGH in-patients. The ED sees many acute and complex patients- including cardiac arrest, trauma, stroke, STEMI, forensic and those with behavior health comorbidities. Our population faces challenges with accessing primary health care in the community. That, combined with DPH's siloed electronic medical record systems, results in lengthy ED work-ups. Additionally, timely coordination of care is a challenge with several services involved with patient care. Combined with limited physical space and long wait times it results in a poor patient and staff experience, and unacceptable wait times. With the upcoming move to Building 25, there are opportunities to improve throughput in the ED.

II. Current Conditions

- **Current lead time**
  - Ambulance patients - 446 minutes (15% value added)
  - Walk-in patients – 331 minutes (19.3% value added)
- **Extended wait times for patients, especially while on diversion status**
  - Current diversion rate – 46%
  - Poor patient satisfaction
- **Limited space in current department**
  - 27 licensed beds in current space
    - (compared to 59 licensed beds in new department)
  - Patients often wait in hallway gurneys during high census peaks
  - Inadequate number of workstations for staff
- **Barriers to optimal flow negatively impact quality and safety**
- **Inadequate staffing pulls staff to fill in alternate roles, not working to highest scope of practice at times**
- **Lack of accountability with consulting teams = longer wait times for admitted patients**
- ***We can do better!***

Problem Statement (Gap)

- Poor coordination of teams, team members, and inefficient flow of information and staff results in an ED LOS 25% longer than the national average, patients experiencing long wait times, and poor patient and staff satisfaction.

III. Goals & Targets

- Reduce median/LOS for patients from door to disposition 250 minutes to 135 minutes by October 2016
- Reduce median LOS for admitted patients from decision to admit to discharge from 220 minutes to 90 minutes by October 2016
- Decrease LWBS percentage rate from 7% to 0% by October 2016
- Improve score on the patient survey question *"How often were the different providers and nurses consistent with each other in providing you information and care?"* from 58.5% to 80%

IV. Analysis

V. Proposed Counter Measures

a. ED Flow/Processes
  i. Develop Provider/Fast-Track process with defined team and standard work. Utilize staff to fullest scope and further clarify roles and responsibilities
  ii. Implement Visitor/Patient workflow at the Greeter Desk
  iii. Begin discharge planning earlier in visit
  iv. Re-evaluate Pharmacy's medication profiling to remove delays in administration
  v. Develop/Implement clinical pathways/standardized procedures for low acuity patients to facilitate faster discharges
  vi. Implement immediate bedding/Pull-till-Full process

b. Hospital Wide
  i. Review admission process MOU to ensure accountability of services
  ii. Tap-In System for all consult services

c. Communication
  i. Improve Staff morale opportunities through staff recognition, staff appreciation, and team building activities
  ii. Redesign workflow used to keep patient location accurate on PulseCheck tracking board---engage ancillary services in use of PulseCheck notification and location abilities
  iii. Improve coordination of care and communication methods amongst ED staff—Team Huddles, Patient Arrival Team Huddle, VOiP phone workflow
  iv. Add care boards to patient rooms, develop content and educate staff on use
  v. Develop and Launch an ED website
  vi. Add phone tree to ED phone system

d. Equipment/Supplies
  i. Verify equipment red-tag and repair process to ensure timely turn-around and that backfill equipment is available
  ii. Add scanners to all zones for MEA use

VI. PLAN

ED Flow/Processes	Activity Type	Timeline
Fast-Track/Low Acuity/Front end Redesign	KW	Nov/Dec
Flow Coordinator Role	KW	Jan
Pharmacy Medication Profiling	PDSA vs KW	Jan
Initial Assessment/Behavioral Health Team Huddle Model	KW	Feb
Discharge Process	KW	March
Hospital Wide		
Engagement with In-Patient Flow Team	JDI	Nov/Dec
Communication		
Monthly Employee Recognition Program	PDSA	Dec
Patient Visual Care Boards	PDSA	Jan
Communication Plan for ED	KW vs PDSA	April
Daily Management System	PDSA	Jan
Equipment/Supplies		
Add scanners to all areas	JDI	Nov
ED Phone Tree System	JDI	Dec
Model Trauma Room Roll-Out	JDI	Jan
5 Minute 5S	?	Feb

VII. Follow-Up

•Write script for phone tree, test, educate, announce to services	•Finalize dates and content for KW
•Test scanners	•Pharmacy Liaison
•Redesign Trauma room cart resupply process based on # available	•In-Patient Flow Steering Committee
•Boards for DMS, establish content, process	•Develop Visual Board Content, Education
•Create monthly staff recognition calendar	•Identify IT Resource for website, identify content