Rapid Improvement Guide to:

Reviewing 'stranded' patients in hospital - what are patients waiting for?

Stranded patients can be identified as those with a length of stay (LOS) of seven days or more. The aim of any review of these patients is to understand *what is the plan* and *what is the next thing* that these patients are waiting for on the day of review.

The review should capture both qualitative and quantitative information on the reasons for the wait, with a report compiled from all the material gathered, and should aim to:

- Understand why patients are in hospital for seven days or more
- Identify themes, where possible
- Identify patient characteristics so patient groups can be identified early
- Identify areas of good practice
- Identify areas requiring focus where there is the opportunity for improvement.

The outcomes from the report should be used to ensure that lessons learnt or questions still to be answered can be built into the local system action plans.

The process

The review should be completed by a multi-agency team of six to ten members (no greater than 12); ten people should be able to complete the review in around three hours in a medium size DGH. Recommended members include representatives from social care, community/integrated care, therapy services, discharge teams, mental health, the acute trust and commissioners.

It is important all participants follow the same review guidelines to minimise variation in recording and reporting, and to increase the value and validity of the outcomes. The event should start with a briefing session led by a facilitator and attended by all members of the team.

The information team should run a report that captures all hospital inpatients with a length of stay of seven or more days including patient name, ward, date admitted and length of stay in days. Exclusion criteria for the review includes paediatrics, maternity and critical care. The report should be produced the day before the review and sent to the facilitator. Wards should be distributed randomly between the review teams by the facilitator.

The introductory session by the facilitator includes coding discussions and a review of standards. Local codes can be added and agreed on the day of the review if required. A data capture form will need to be created with space for the collection of codes and of qualitative notes.

All review members need to be aware of infection control procedures when entering ward environments. When entering a ward area a member of the review team needs to identify and make contact with the ward manager or nurse in charge to make them aware that the Trust is conducting a review of all patients with a length of stay of seven or more days.

Wherever possible, the review information should be obtained from the ward manager or nurse in charge. Staff should be reassured that all information will remain anonymous. Staff should be encouraged to share what works well and what could be improved with regard to patient pathways in the Trust. This should be noted on the data capture form.

Review team members must not share concerns, judgments or opinions regarding any information shared during the ward review process. Review team members must not take on actions for patients during the review. Any actions can be followed up individually at the completion of the review.

Review team members should record any ward observations and conversations with staff to add qualitative information to the review, noting the review commitment of anonymous information. All patient identifiable information will be destroyed following the review. No patient identifiable information will be shared in the reporting or feedback processes.

Every review member is responsible for familiarising themselves with the review coding before completing a ward review. As wards are reviewed the discussion and outcomes for each individual patient should be captured and coded by the review team. Coding outcomes that capture 'what patients are waiting for' will be agreed and reported at the end of the review. An example of coding outcomes is attached under Appendix A.

Post Review

The report compiled from all the material gathered is shared with review leads for both discussion of the issues highlighted and a check on factual accuracy. A final version of the report should be made available to all participating partners.

The final report should be shared widely both with the local system leads, who supported the review, and with senior managerial and clinical leads to ensure that the lessons learnt or questions still to be answered can be built into the local system action plans. Agreed actions should include testing the opportunities identified for improvement using a small scale 'plan, do, study, act' approach rather than planning three to six month pilots with long lead in times. This approach can be used to help identify the focus of subsequent multi-agency discharge events and exemplar ward programs.

If you need further information or would like to discuss any aspect of this paper, please contact the Emergency Care Improvement Programme by emailing: ecip.pmo@nhs.net.

Appendix A

Ask the person in charge of the ward for each patient – What is the plan for the patient and is there an expected date of discharge/planned date of discharge?	
F1	Waiting return to other acute hospital – fit to travel
F2	Waiting for transfer to acute hospital for treatment – tertiary fit to travel
F3	Waiting for community hospital placement or any other bedded intermediate care
F4	Waiting for continuing health care panel decision
F5	Waiting for continuing health care package
F6	Waiting for equipment / adaptations
F7	Housing needs / homeless
F8	Waiting for patient/family choice or input to decision making
F9	Waiting for internal CHC processes e.g. checklist completion, assessments
F10	Waiting for occupational therapy/physiotherapy approval for discharge
F11	Ready for home today – ask whether they are confident nothing will stop discharge?
F12	Waiting for hospice place
F13	Waiting for internal transfer – ward to ward
F14	Discharge planned for tomorrow – what is stopping the patient going today?
F15	Waiting for time limited social care reablement or home based intermediate care
F16	Waiting for internal assessments/results before discharge agreed
F17	Waiting for external agency assessment – social care/mental health/nursing home or residential home assessment
F18	Waiting for start or restart of domiciliary care package – long term packages
F19	Out of county/borough assessments
F20	Waiting for residential or nursing home, social care or self-funder
F21	Fit and no clear plan of what is needed for discharge
NF1	LCP/ end of life care and wants to die in hospital
NF2	Active ongoing clinical treatment non-specific and not as sick as categories below
NF3	Waiting for internal test, specialist opinion or similar – provide details
NF4	Unpredictable and erratic condition that may require immediate intervention
NF5	Intravenous therapy that cannot be given in the community – ask why not?
NF6	MEWs score of 5 or above
NF7	Requiring clinical intervention that can only be achieved in this hospital
NF8	No clear plan
NF9	Infectious, risk to others therefore cannot be discharged
NF10	Other – please free text
NF11	Other – waiting return to another acute trust not fit to travel
NF12	Other – waiting transfer to an acute trust for treatment not fit to travel