



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

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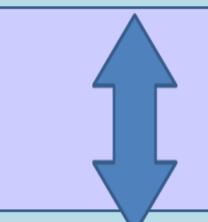
## A frustrated patient who knows what they want...

Interviewer: Have you had any updates at all?

Patient: No. I don't know when ... you can't get one, but I don't want to stop in here another night, that's why I'm [annoyed at myself] for coming in ... I'm getting right frustrated now.

Interviewer: I guess it's just not knowing um, what's going to happen in the next six hours.

Patient: Well, I think they should be able to contact somebody, you know, bleep them or something, and just say I need discharging, and come up and say that's fine and that's it. I think that's what they could do, I mean if they were short of a bed they would.



#### **Striving to meet targets**

Senior nurse [after answering phone call]: See what I mean? We're at 94.05.

Researcher: Right, and what's your...
Senior nurse: 95 per cent, we should really hit 95 per cent, because we've worked so hard in the last three months to improve. Erm, but we've just had a really bad – Researcher: It's just relentless.
Senior nurse: Yeah, yeah, it is.

#### Problems with staff retention and recruitment

... so as of [month] we'll move to a [number] rota which will give us an extra [doctor] overnight. However, those doctors are pulling out left right and centre, so it looks like we're going to have some difficulty manning that rota. (...) we're understaffed overnight, and we recognise that. In fact we're understaffed the whole time to a degree ... [Consultant]

#### A complex system under stress

These quotes illustrate findings from the ethnographic component of our mixed-methods study, a two-year research project on four acute hospital sites with contrasting models of care across South-West England. Early analysis shows how multiple players all contribute to trying to keep an overloaded system going.

#### **Research questions**

- 1. How do organisational factors and senior input influence decision-making about acute admission and discharge?
- 2. How is the acute admissions process experienced by patients, carers, managers and practitioners?

#### Methods

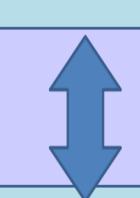
Ethnographic observation and semi-structured interviews; input from a Patient and Public Involvement group with experience of acute admissions.

#### **Ethnography participants**

41 senior clinicians and managers, ~ 300 other practitioners, 65 patients, 30 carers.

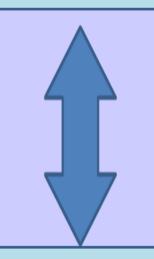
#### High demand, crowding, and the "takeall" way in which emergency departments function

... we're absolutely rammed with people down the corridor and ambulances queuing and we say to community service, "Can you take one additional person" and they say "No", that creates a huge amount of frustration ... we don't have the capacity, you know, in the emergency department to have all those people there which is why we end up queuing ... but we can't say no, so... [Manager]



#### Staff adapting to resource limitations

So if a ward is full, we've made our decisions on three people but they're waiting for a bed, three more ambulances come in and we kind of say, "Look we can't assess them, we can't do their obs, we can't do ECGs at present", you know, all that sort of stuff... (Consultant)

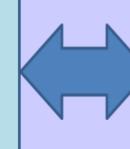


### Multiple initiatives for admission avoidance - here's one

I have developed a few things that help to facilitate early discharge. For instance you'll probably have heard people talking about a Triple Marker System and therefore early diagnosis or early exclusion I should say of a cardiac event or a major cardiac event (...) So that's aimed at avoiding round about two to three patients a day. [Consultant]

## When patients are dealt with as objects to move through the system

I think as nurses, um, if you forget that you're dealing with human beings and you start thinking you're dealing with boxes, which is sometimes how you get made to feel you should do, then you shouldn't be here ... it's so difficult when you're got six patients that you're trying to be an advocate for, because you can't do it, you're cut too thinly. [Senior nurse]



Patient's daughter: I think what's been good is that the doctors have actually listened to what we've said. Because obviously one concern is that Dad had a fall Thursday night and with his

Carers' contributions to decision-making

that Dad had a fall Thursday night and with his previous brain injuries they would have thought he would have needed those sorts of scans and all those sort of things, but we, from our previous experience as a family, think it's more related to some sort of infection.

Patient's wife: ... it was a positive thing that they were prepared to listen and take that on board because we were giving him [doctor] some history on [patient] that he wasn't aware of.

