Go With The Flow- From Charge Nurse to Patient Flow Coordinator

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About PCMC

• Not for profit hospital, part of Intermountain Health Care
• Only children’s hospital in Utah
• Designated Level I trauma center
• 233 licensed beds
About PCMC ED

- Staffed with board certified pediatric emergency physicians, fellows, NPs, pediatric residents, nurses and ED techs
- 23 beds, including 2 bed trauma bay and 2 bed resuscitation area
- Fast track – opened in September 2003
- RTU – 18 bed short stay area adjacent to ED
- 39,764 visits in 2004
Why We Needed to Change

- Increased volumes and complexity
- Increased LWOTS
- Decreased patient satisfaction
- Decreased staff satisfaction
- Ineffective communication between caregivers
Waiting Area

1. Chart Started
2. Ready for Registration
3. RN Chart Rack: Patients To Be Taken to Exam Room
4. Resident, Fellow, NP, Attending To See Patient
5. Orders Taken Off By Unit Clerk
6. RN Orders To Be Completed
7. Lab Collection slips
8. Waiting For Results Or Treatment In Progress
9. Attending Dictation
10. Chart Assembled and Copied After D/C

= Medical Chart Flow. Does Not Include Providers Carrying Chart to Exam Rooms or Other Locations
The Beginning of Change: 2000

- ED doctors present a report to administration
- Recommended in-room registration
- Identified need to change nursing practice
- Identified problems OUTSIDE the ED
- Did not identify true bottleneck
- **Did** identify important role of the ED charge nurse
April, 2002

• ED was assigned reengineering consultant

• Hospital goals:
  – Decrease wait times
  – Decrease LWOTs
  – Improve resource utilization
  – Improve patient and family satisfaction
Data Analysis

- Triage not the problem
- Triage to registration only a small part
- Door to doctor time a big cause for delay
- No plan for handling large volumes
- No real set process
Recommendations 2002

- Adapt the charge nurse role to that of a patient flow coordinator (PFC)
- Standardize triage and discharge process
- Better use of patient tracking system
- Improve coordination of ancillary services
From Charge Nurse to PFC

- Posting the position
- Interviewing
- Hiring staff
- Implementing the role
Patient Flow Coordinator

Responsibilities

- Patient room assignment
- RN patient assignment
- Point person for RN, Tech, MD communication
- Directs and Assists care providers with prioritization
- Provides indirect clinical consultation
- Keeps Logicare current
- Receives printed lab results, places on chart, notifies providers
- Checks on delays in Lab, Imaging, Rx, Consults
- Admission Arrangements
- Referral calls
- EMS calls
- Staffing
- Narcotics and Keys
- Assigns students
- Checks/changes EMS tapes
- Orders floor stock meds
- Reassigns trauma RN patients
- Arranges transfers
- Attends bed control
- Finds help during crises
- Management representative
How Is The PFC Role Different?

- Charge nurse was the clinical expert and resource
- Charge nurse was not responsible for flow in the department
- Charge nurse did not assign rooms or nurses
The New PFC Role

• PFC expected to take more responsibility in directing care of doctors, nurses and techs
• PFC would be held accountable for LOS
Why Didn’t This Work?

- Too many variables in flow
- Not enough by-off by the MDs initially
- PFCs found it hard to stay at the desk and to assign patients
- We needed another clinical expert
- We had made no other improvements
Some Good Came of Our First Attempts

• PFC role became more standardized – stronger than old charge nurse role.
• Confirmed benefit of PFC.
• We developed self-scheduling so the PFC was scheduled 24/7.
• PFC received a pay increase.
Medical Chart Flow. Does Not Include Providers Carrying Chart to Exam Rooms or Other Locations
Second Attempts: The Little Red Headed Guy (Spring 2003)
A New Perspective…..

• What is the true bottleneck?
• Is our process designed to maximize the use of the bottleneck?
• Do our previous ideas really save time?
• Does the organization of the ED promote the use of the bottleneck?
• Do we just need more staff?
....And Some New Ideas

- Use of Rapid Cycle Testing to try new things
- Thinking like a systems analyst
- Involving the physicians in the process
- Solving simple flow problems
- Creating change
Some Changes in the PFC Role

- New responsibilities in ED flow
- Mentor relationship
- Leadership responsibilities
- Hospital wide responsibilities
Creating ED Teams

• Layout issues
• Staffing issues
• Experiments
• Waiting room issues: Is it better to put patients in rooms or leave them in the waiting room?
Two Team Experiments

- East Team - Education Team
- West Team – Crank Team
Other Changes

• Use only one chart rack
• ED clerk puts patients in rooms
• Chart tags and room numbers
• Okay for doctor to see patient before nurse
• Zones
Chart Tags to Identify Room
East Team
West Team
Challenges With the Teams

- Staffing to keep teams even
- Assigning patients to the teams
- Helping staff to act like a team
- Creating a team leader
Measuring Success: LWOT Rates 2003-2004

LWOT RATE

Oct 2002- Sep 2003
Oct 2003- Sep 2004

OCT NOV DEC JAN FEB MAR APR MAY JUN JUL AUG SEP
Measuring Success – 2003-2004

Visit Volumes

Oct 2002- Sep 2003
Oct 2003- Sep 2004
Comparison of LOS

Average ED Length of Stay (Minutes)

Oct 2002- Sep 2003
Oct 2003- Sep 2004

Oct  NOV  DEC  JAN  FEB  MAR  APR  MAY  JUN  JUL  AUG  SEP

Average ED Length of Stay (Minutes)

Oct  NOV  DEC  JAN  FEB  MAR  APR  MAY  JUN  JUL  AUG  SEP

Oct 2002- Sep 2003
Oct 2003- Sep 2004
Volumes Vs Wait Times

Scatterplot: Volume vs. Wait Time
Before and After Changes

Daily Visit Volume
Daily Avg Door to Doc Wait Time (Minutes)

Oct 2002 thru Sep 2003
Oct 2003 thru Sep 2004

OCT 2002 THRU SEP 2003
OCT 2003 THRU SEP 2004
Other Improvements

- Fax report pilot
- Tube orders to pharmacy
- Improved patient satisfaction
- PRN nurses from adult hospital
- Increased staff satisfaction, including float nurses
Things We Still Need to Do

• Improve triage process – use of NP
• Revisit in-room registration
• Improve discharge and admission process
• Change the culture
• Involve overall hospital in ED overcrowding
What We Learned

• Variations in volumes need to be planned for
• Need to look at the types of patient and the workload, not just numbers
• Need to constantly reinforce and reward the change and hold people accountable
What is Necessary for Improvement?

• Administrative support
• A “little red headed guy”
• Clean up your own house first
• Experiments rather than making a big change
• Staff involvement
• Realize you are never done