


Standard Operating Procedure for:**'RAPID FLOW'**University Hospitals of Leicester 
NHS Trust

Trust ref: B25/2022

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1. Introduction

- 1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust Standard Operating Procedure (SOP) for the Management of Adult Rapid Flow Patients across UHL. The SOP describes the process of sharing risk across the organisation when the Emergency Department (ED) and Clinical Decisions Unit (CDU) has more patients than it can safely care for and to prevent holding patients on ambulances which has a direct impact in delays to responding to emergencies in the Community. Allocating one additional patient to suitable Wards on a risk assessment basis shares this risk across the Trust and reduces risk within the ED and the Community.
- 1.2 The Rapid flow of patients is when specialty patients are transferred from the admitting areas: Emergency Department (ED) and Emergency Floor (GP Assessment Unit, Acute Medical Unit, Emergency Decisions Unit, Emergency Frailty Unit, Acute Frailty Unit) and The Clinical Decisions Unit (GH) by specialty Base Wards to a bed space of a patient identified as being discharged that day from the specialty Ward/or a designated area of the Ward (e.g. day room). These patients will be transferred against that Ward's known discharge patterns.
- 1.3 The principle will be in the first phase of Rapid Flow of Patients; patients will be transferred from ED into the Assessment Units (maximum x2 patients on AMU). In the second phase the patients will be transferred from the Emergency Floor Areas to Wards in relation to CMG normal discharge patterns to facilitate patient safety.
- 1.4 Patients nominated for Rapid Flow should not be placed to another specialty base Ward e.g., Medicine to Surgery or Surgery to Medicine. Patients will be transferred to the correct receiving Ward when they are ready to proceed from the ED.
- 1.5 Rapid Flow of patients (the queuing of patients outside the ED/CDU) is a documented risk on the Trusts Clinical Management Group Risk registers. This can occur when a decision to admit a patient has been made but there are no beds to move patients into. This causes crowding in the ED/CDU leading to a reduction in efficiency and increased risk for the safety of our patients in the ED and the Community.
- 1.6 The purpose of this SOP is to support safe, decision making when Rapid Flow is instigated. It is recognised the decision making will be based on the specific risk assessment for each patient that is to be placed in the context of the risk on the accepting Ward. This SOP will outline the principles to be considered. The key principle is that the decision to place any patient will have patient safety concerns at the centre of the decision-making process, balancing the risk to patients across UHL and Community setting.
- 1.7 The aims of the Rapid Flow SOP (where patients are sent from an admitting area to a receiving Ward prior to the bed being available on the receiving Ward are to:
 - a) Stop the need for patients to be held on ambulances due to high occupancy within the ED
 - b) To facilitate specialty patients moving at the earliest opportunity to the right Ward
 - c) To promote each Ward discharging patients before 12:00hrs and maximize utilisation of the Discharge Lounge
 - d) To improve flow and operational performance into admitting areas

- 1.8 This SOP will guide and support all staff involved in the Rapid Flow of patients within their Clinical Management Groups (CMG) to ensure:
- a) Equitable access to appropriate beds for all patients admitted to UHL
 - b) Patients are treated with respect, dignity and in accordance with UHL values
 - c) Accommodation of patients in single sex areas (with the exception to Critical Care / High Dependency Unit (HDU))
 - d) The risk of patients being exposed to Hospital Acquired Infections is minimised
 - e) The risk of having un-assessed patients in ambulances and/or the Community
 - f) Patients waiting extended lengths of time in ED/CDU for beds are minimised
- 1.9 Rapid Flow definition is where patients are sent from an admitting area to a receiving Ward prior to the bed being available on the receiving Ward. This is not to be confused with **'bed chains'** which is the sequence of linked patient transfers that occur when transferring patients from admitting areas to Wards within the Trust.

2. Scope

- 2.1 This SOP applies to all staff working for UHL, those staff working in a contracted capacity and staff contracted with partner agencies or NHS Trusts working within UHL.
- 2.2 This SOP applies to patients admitted through ED/CDU and the Emergency Floor areas and will be the responsibility of the Clinical Site Flow and Bed Management Team, ED Coordinators, Matron and Ward Managers to implement.
- 2.3 This SOP relates specifically to the Rapid Flow of Adult patients admitted to adult beds within University Hospitals of Leicester (UHL) NHS Trust.
- 2.4 This SOP applies to 16 – 18 year-olds who must be placed into the speciality which they require, in order to maintain and safeguard their needs as a vulnerable patient group.

3. Rapid Flow Placement Triggers

- 3.1 The daily UHL Tactical Bed Meeting considers activation of the Rapid Flow SOP process when one or more of the following criteria have been met:
- a) OPEL Level 4 **and/or**
 - b) <5 spaces in ambulances assessment with limited outflow and >4 ambulances inbound
 - c) Unable to handover patients on ambulances or due to no capacity within ED or no capacity for inbound ambulances **and/or**
 - d) No Capacity in Resus with no out flow **and/or**
 - e) Majors full of DPS 2 category patients in the waiting room waiting to access majors cubicles

4. Roles

- 4.1 Chief Operating Officer, Chief Nurse and Medical Director are the Executive Leads for this SOP:
- a) All beds within the Trust remain under the executive responsibility and management of the Chief Operating Officer / Chief Nurse / Medical Director

- b) The day-to-day operational responsibility for Capacity and Flow through UHL is managed by the Trust Capacity and Flow Team
- c) Has overall responsibility for decisions made to place patients during normal operating hours during the week, in line with Tactical Bed Meetings and placement triggers
- d) Out of Hours responsibility (evenings, weekends and Bank Holidays) is via the On Call Director (Strategic Command), Senior Manager (Tactical Command) and the Capacity and Flow Team as appropriate
- e) Have responsibility for safe operationalisation of this policy, monitoring safety, patient, and staff experience incidents

4.2 Head of Operations / Deputy Head of Operations / Heads of Nursing / Deputy Heads of Nursing:

- a) Have a responsibility to ensure that Rapid Flow is carried out in line with this SOP and in line with CMG Operational Pressures Escalation Levels (OPEL)
- b) Ensure that processes are in place to monitor each patient, the length of time patients are waiting for an available bed and document any concerns via the Datix reporting system
- c) Ensure that processes are in place to provide a list of suitable discharge patients to place to the Bed, Capacity and Flow Teams
- d) Ensure electronic patient records are updated to reflect predicted discharge dates

4.3 UHL Senior operational manager (SOM) / Duty Manager:

- a) Support and facilitate plans made by CMG Heads of Operations (HoOps) and Head of Nursing (HoN) to enable the emergency and elective flow of patients throughout the Trust
- b) The UHL Tactical Bed Meetings held x 4 daily should determine the ability to provide sufficient admitting capacity and influence the decision making around Rapid Flow

4.4 Consultants:

- a) Responsible in conjunction with the multidisciplinary team for identification of patient's suitable for a morning discharge at 'Daily Board'/'Ward Rounds' and at 'Afternoon Huddles'. Documentation to be completed on both Nerve Centre and in the patients medical notes
- b) Patients who are Rapid flowed will become the responsibility of the named Ward Consultant

4.5 Matrons

- a) Provide clinical advice, and where necessary, practical support with the implementation of the Rapid Flow SOP with particular reference to ensuring patients are identified and those identified meet the criteria
- b) The Matrons are responsible for undertaking a professional nursing assessment in the Base Wards to understand the relative risk in the clinical areas at the time

Rapid flow is required. This assessment will include the acuity and dependency of the current patients and the skill mix of the Ward on the given day

- c) Support as required the respective team in providing clinical expertise and advice on clinical risk issues associated with the Rapid Flow of patients

4.6 Ward Sisters / Charge Nurses / Nurse in Charge

The Nurse in Charge (NIC) of ED is responsible for maintaining ED flow by ensuring the timely and appropriate transfer of patients to AMU, AFU, SAU and other receiving Wards

- a) The NIC of AMU and AFU are responsible for maintaining flow in AMU and AFU, collaborating to ensure 2 patients from AMU and 1 from AFU are transferred to Wards every hour between 08:00hrs and 20:00hrs. They will ensure that by 20:00hrs every night there are empty beds and on AFU

The NIC of each inpatient Ward is responsible for ensuring that all:

- a) Patients with a morning discharge plan have been discharged from the Ward before midday. They are also responsible for identifying the most suitable patients to transfer to one of the Trusts discharge lounges or a safe designated space on the ward for them to wait for the final stages of discharge to occur.
- b) They must ensure that the bed state accurately reflects expected discharges / transfers and work with the Matron to identify appropriate patient moves
- c) Provide support at Ward level for the implementation of the Rapid Flow patients SOP; with particular reference to ensuring patients identified meet the criteria
- d) Ensure discharge list is compiled and provided to the Bed, Capacity and Flow Teams in line with CMG OPEL levels
- e) Communicating with the patients' family / carers regarding placement of patients
- f) The NIC SDEC / Admissions Units will pull all appropriately triaged patients from ED during opening hours
- g) For Patient incidents relating to the rapid flow process complete a Datix form.

4.7 Bed Management Teams / Flow Coordinators / Bed Coordinators:

- a) Day to day responsibility in hours for the placement of elective and emergency admissions
- b) Maintains patient in flow and out flow of admission units and escalates capacity problems to the CMG Management Team
- c) Communicates timely and accurate bed states (Nerve Centre: E-beds), capacity issues and CMG actions if any to site Capacity and Flow Team
- d) Monitor and record patient movement and ensure early utilisation and maximise the utilisation of Discharge Lounge
- e) With the support of CMG Management Team, responsible for initiating, implementing, and communicating the CMG out of hour's bed management contingency plans and informing the site Capacity and Flow Team
- f) With the support of CMG Heads of Nursing and Management Team, responsible for initiating implementing and maintaining a register of each patient that is placed and the length of time they are waiting for an available bed and document any concerns on the log

4.8 Infection Prevention Team

- a) Provide Infection Prevention (IP) advice to Ward based nursing and medical staff, site Capacity and Flow Teams and CMG Bed Management Teams, with specific reference to identification of patients to be placed.

5. The Process of Rapid Flow

5.1 If there is a need to Rapid Flow patients, between 08:00hrs – 20:00hrs, this should be done in line with plans identified by CMG Management Teams and enacted by the Bed Management Teams at a specific threshold (section 3). This will take place at the 09:00hrs, 13:00hrs and 17:00hrs UHL Tactical Bed Meetings and the decision to enact discussed and agreed with the Chief Operating Officer / Chief Nurse or nominated Deputy.

- a) Nerve Centre must be regularly updated and always show current Ward position so that the bed state across the Trust can be accurately known. This will enable timely decision making and reduce the number of phone calls to confirm the bed state
- b) Early discharge (home or Discharge Lounge) before midday. The Discharge Lounge should be used for all patients waiting for TTO's or transport, in order to facilitate discharge before midday. Discharge Lounge should be used routinely for all discharges from elective and non-elective bed bases. Please refer to separate Discharge Lounge Guidance
- c) AMU South +1, AMU +2 (AFU+1) patients will transfer from the Emergency Department 24hrs a day 7 days a week
- d) Rapid Flow of patients occurs in line with normal CMG discharge patterns between 08:00hrs and 20:00hrs across all three sites (appendix 1).
- e) An Infection Prevention i5 Risk Assessment should be undertaken on all patients being considered for Rapid Flow. This should be clearly documented in the patient notes. Any potential risk of infection should be identified, in which case patients are not suitable for 'patient placement'
- f) In phase one of rapid flow of patients the incoming patient from the ED must be admitted to a bed space whilst the exiting patient is placed in the dedicated area
- g) In phase two of Rapid flow of patients the incoming patient from the CDU / Emergency Floor will either be admitted to the bed space on the Ward or into the dedicated area. This will depend on the clinical needs of the patients involved in the transfer and will require the professional judgement of the nurse receiving the patient transfer.
- h) Bed Management leads will liaise with CDU / Emergency Floor Ward Nurses in Charge to identify suitable patients to transfer to the relevant Wards. This will be dependent on the sex mix of the incoming patient admissions and Wards normal discharge pattern
- i) Prior to Rapid Flow taking place to inpatient Wards the patient must be accepted by the respective medical / surgical team as per current process. ED admissions rights still apply
- j) **Transferring Ward:** The registered nurses currently looking after the patient must update Nerve Centre detailing all clinical data relating to the patient's admission and care of the patient. Specific risk issues **must be** communicated verbally to the receiving Ward.

- k) **Receiving Ward:** The receiving Ward Sister / Charge Nurse coordinator takes overall responsibility for the Ward placement and on-going care and management of the patient who has been rapid flowed onto their Ward.
- l) The patient rapid flowed will become the clinical responsibility of the named Consultant for the Ward area.
- m) All Medical and Nursing documents, medication and property should transfer with the patient to the rapid flow ward.
- n) The receiving ward should inform the patient's family / carers of the transfer.
- o) Specific risk issues **must be** communicated verbally to the receiving Ward, staff on duty will need to re assess the patient when they arrive on the Ward.
- p) Bed Management leads will communicate regularly with the site Capacity and Flow Team to ensure that Rapid Flow patient information is up to date.
- q) Patients will continue to have timely, on-going treatment or continued discharge planning whilst Rapid Flow is occurring on inpatient Wards.
- r) Rapid Flow will not occur after 20:00hrs on the Base Wards.
- s) In the event at 20:00hrs there is an additional patient on the Ward after Rapid Flow has occurred and the scheduled discharge is no longer happening. The Ward based team must contact the site team to advise them and to ascertain if there is a more appropriate patient on the Ward to be allocated an alternative bed space within the organisation. **The patient should not be returned to the emergency floor.**
- t) The Deputy Chief Nurse and Head of Nursing will approve the cessation of Rapid Flow in Ward areas

5.2 Adult Patients suitable for Rapid Flow

- a) Patients nominated for rapid flow must have seen a Consultant or Registrar already during that admission to ensure medical clerking and a treatment plan /e-medications have been confirmed.
- b) Patients nominated for rapid flow will have been identified at the morning Board / Ward round/ 'Afternoon Huddle' by the Consultant or Registrar/ nominated deputy in conjunction with the Ward Sister / Charge Nurse / Ward coordinator / Nurse in Charge the previous day
- c) Patients must have a clear medical management plan and Estimated Date of Discharge that can be followed on the inpatient Ward
- d) Patients should only be moved under the Rapid Flow patient SOP if they meet criteria for transfer from ED / CDU / Emergency Floor/ Assessment areas, and the receiving Ward can accommodate the care needs of the individual patient. This will differ depending on the specialism of the Rapid Flow patient placed and the area being placed too (equipment needs etc.)
- e) The following groups of patients are excluded from patient placement:
 1. Clinically unstable with an early warning Score (EWS >4)
 2. Patients with an EWS of 3 in one parameter
 3. Patients requiring Humidified, High flow oxygen, NIV or oxygen therapy.
 4. Patients requiring High Dependency Unit level care.
 5. Patients requiring cardiac monitoring.
 6. Patients with severe cognitive impairment i.e. restless/agitated, delirium
 7. Patients with complex Learning Disabilities
 8. Patients in the last few days of Life
 9. Patients who require isolation because they are at risk of transmitting or acquiring an infection.

- f) Any concerns in relation to placement of patients, at any time should be escalated to the Matron on shift that day, through to the CMG Head of Nursing as required.
- g) Ward areas should only have one placed patient at any one time. (all areas are a maximum of +1)

6. On-going Management of Rapid Flow patients

- 6.1 The receiving Ward takes overall responsibility for the Rapid Flow patient and on-going care and management of the patient who has been placed onto their Ward
- 6.2 The rapid flow patient will become the clinical responsibility of the named Consultant for the Ward area
- 6.3 The Rapid Flow patient should be placed into an identified bed space with the query / confirmed discharge or another appropriate patient placed into the dedicated flow space
- 6.4 The Ward Leader or Nurse in Charge needs to ensure that the Rapid flow patient has appropriate treatment, observations and medication regimes prescribed including TTOs and a designated Registered Nurse accountable for their care
- 6.5 The CMG Bed Management Team will be responsible for populating and updating a CMG / centralised placed patient list to oversee the coordination of Patients Rapid flowed
- 6.6 In the event at 20:00hrs there is an additional patient on the Ward after Rapid Flow has occurred and the scheduled discharge is no longer happening. The Ward based team must contact the site team for the most appropriate patient on the Ward to be allocated an alternative bed space within the organisation

7. UHL Tactical Bed Meeting

- 7.1 Identification and need for patients to be placed is to be determined at the Trust Tactical Bed Meetings. These meetings are held at specific points in the day, but times can be adjusted according to the organisational response levels required.
- 7.2 These meetings will focus on the provision and availability of daily admitting capacity for Emergency and Elective activity.
- 7.3 Numbers of patients placed will be reviewed during these meetings.
- 7.4 Escalate any delays in Rapid Flow patient placement to the respective CMG
- 7.5 At 20:00hrs if there is an additional patient on the Ward after Rapid Flow has occurred and the scheduled discharge is no longer occurring, support the Ward based to identify an alternative bed space within the organisation for the most appropriate patient on the Ward. **The patients should not be returned to the emergency floor.**

8. Education and Training

- 8.1 Training should be given to the necessary individuals responsible for bed management within the CMG and Ward staff operationalising the placement of patients' process. This should be mandatory as part of the local induction for staff commencing employment within UHL

9. Supporting References

- Capacity and Flow Escalation Policy B52/2017
- UHL Discharge Policy for Adult Patients leaving Hospital B2/2003
- The SAFER Patient Flow Bundle, NHS Improvement 2017
- The Royal College of Emergency Medicine – tackling Department Crowding, December 2015.

10. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring lead	Frequency	Reporting arrangements
a) Number of Times rapid flow of patients SOP enacted b) No. of Datix incidents received in relation to Rapid Flow c) Patient Experience indicators / Complaints	Recording sheets / Nerve Centre reports once tracking available Datix incidents Complaints	CMG leadership team	Quarterly	CMG Quality and Safety Groups / CMG reports to Nursing Midwifery Board Quality Excellence Board
d) Patient impact: 1) Timely administration of treatment 2) Delays in the completion of assessments due to additional patients on Wards 3) Reduced visibility of patients due to increased RN / HCA ratio 4) Delays in meeting patients personal hygiene requirements due to increased RN / HCA ratio 5) Altered patient experience due to being allocated a non-clinical bed space	Datix incidents Complaints	CMG leadership team	Quarterly	CMG Quality and Safety Groups / CMG reports to Nursing Midwifery Board Quality Excellence Board
e) Colleague experience	Datix incidents	CMG leadership team	Quarterly	CMG Quality and Safety Groups / CMG reports to Nursing Midwifery Board Quality Excellence Board

11. Key words

- Patient Placement
- Rapid Flow

CONTACT AND REVIEW DETAILS	
Standard Operating Procedure Lead (Name and Title)	Executive Lead
Robin Binks Deputy Chief Nurse Operations	Julie Hogg Chief Nurse
Details of Changes made during October 2023 review:	
<p>Addition/removal of:</p> <p>1.3 removed at a rate of 1 per hour</p> <p>3.1 (b) added <5 spaces in ambulances assessment with limited outflow and >4 ambulances inbound</p> <p>4.3 confirmation of job title Senior operational manager SOM</p> <p>5.1 (c) change from AFU1 to AFU+1</p> <p>5.1 (d) removal of 1 per hour</p> <p>5.2 (a) added or registrar</p> <p>5.3 (g) removal of (+1 AMU and +1 AMU south AFU which is zero)</p> <p>6.4 amended job title from Ward Sister/Charge Nurse to Ward Leader</p> <p>7.5 the last sentence now in bold for ease of reference</p>	

Appendix 1

Clinical Management Group	Admitting Hospital Code	Ward Code	Average No of Discharges Weekdays	Average No of Discharges Weekends	Average No of Discharges
Emergency and Specialist Medicine	LGH	G1	9.47	1.91	7.30
Emergency and Specialist Medicine	LGH	G15	2.20	0.91	1.83
Emergency and Specialist Medicine	LRI	R07	2.87	4.48	3.33
Emergency and Specialist Medicine	LRI	R24	1.85	0.78	1.54
Emergency and Specialist Medicine	LRI	R25H	0.63	0.96	0.73
Emergency and Specialist Medicine	LRI	R26	1.71	1.20	1.56
Emergency and Specialist Medicine	LRI	R29	2.01	0.91	1.69
Emergency and Specialist Medicine	LRI	R30	1.96	1.07	1.70
Emergency and Specialist Medicine	LRI	R31	2.20	1.22	1.92
Emergency and Specialist Medicine	LRI	R33	1.39	0.80	1.22
Emergency and Specialist Medicine	LRI	R34	1.94	1.15	1.71
Emergency and Specialist Medicine	LRI	R36	1.51	0.63	1.26
Emergency and Specialist Medicine	LRI	R38	2.20	0.85	1.81
Emergency and Specialist Medicine	LRI	RAMU	5.87	5.43	5.74
Emergency and Specialist Medicine	LRI	REDU	12.41	10.91	11.98
Emergency and Specialist Medicine	LRI	REFU	1.75	1.70	1.73
Clinical Management Group	Admitting Hospital Code	Ward Code	Average No of Discharges Weekdays	Average No of Discharges Weekends	Average No of Discharges
CHUGGS	GH	F35*	1.84	1.37	1.71
CHUGGS	GH	F36	2.96	2.65	2.87
CHUGGS	LGH	G28	4.53	3.72	4.29
CHUGGS	LGH	G28A*	8.79	3.43	7.25
CHUGGS	LRI	R15	1.96	1.46	1.81
CHUGGS	LRI	R21	4.33	3.15	3.99
CHUGGS	LRI	R22	2.53	2.07	2.39
CHUGGS	LRI	R39*	2.68	2.22	2.54
CHUGGS	LRI	R40*	2.46	1.91	2.31
CHUGGS	LRI	R41*	1.89	1.76	1.85
CHUGGS	LRI	R42	2.33	0.96	1.94
CHUGGS	LRI	R43	2.90	1.00	2.36
CHUGGS	LRI	RSAU	6.10	5.48	5.92
CHUGGS	LGH	G29			
CHUGGS	LGH	G20	2.78	2.43	2.68
Non-Rapid Flow area	LRI	Onc	Patients will be sat out to enable patients to be brought up to the ward		
Clinical Management Group	Admitting Hospital Code	Ward Code	Average No of Discharges Weekdays	Average No of Discharges Weekends	Average No of Discharges
MSS Nonrapid flow area	LRI	R09	9.57	6.20	8.60
MSS	LRI	R17	2.18	1.28	1.93
MSS	LRI	R18	1.53	1.28	1.46
MSS	LRI	R32	1.29	1.09	1.23
MSS	LRI	RKIN	Nonrapid flow area		

Clinical Management Group	Admitting Hospital Code	Ward Code	Average No of Discharges Weekdays	Average No of Discharges Weekends	Average No of Discharges
Renal, Respiratory and Cardiovascular	GH	F15	3.67	1.20	2.96
Renal, Respiratory and Cardiovascular	GH	F16	4.18	1.11	3.30
Renal, Respiratory and Cardiovascular	GH	F17	4.26	1.74	3.54
Renal, Respiratory and Cardiovascular	GH	F20	3.02	1.09	2.46
Renal, Respiratory and Cardiovascular	GH	F23	3.92	2.46	3.50
Renal, Respiratory and Cardiovascular	GH	F24	2.25	0.87	1.85
Renal, Respiratory and Cardiovascular	GH	F26	3.13	3.35	3.19
Renal, Respiratory and Cardiovascular	GH	F27	1.36	0.72	1.18
Renal, Respiratory and Cardiovascular	GH	F28	4.39	1.91	3.68
Renal, Respiratory and Cardiovascular	GH	F29	4.25	1.35	3.42
Renal, Respiratory and Cardiovascular	GH	F30	1.65	0.98	1.46
Renal, Respiratory and Cardiovascular	GH	F31	2.37	1.35	2.08
Renal, Respiratory and Cardiovascular	GH	F31H	0.25	0.13	0.21
Renal, Respiratory and Cardiovascular	GH	F32	10.89	2.87	8.58
Renal, Respiratory and Cardiovascular	GH	F33	4.20	2.24	3.64
Renal, Respiratory and Cardiovascular	GH	F33A	2.47	1.04	2.06
Renal, Respiratory and Cardiovascular	GH	FCCU	3.39	2.33	3.08
Renal, Respiratory and Cardiovascular	GH	FCDU	21.13	20.11	20.84
Clinical Management Group	Admitting Hospital Code	Ward Code	Average No of Discharges Weekdays	Average No of Discharges Weekends	Average No of Discharges
Women's and Children's	LGH	G31	4.06	5.76	4.55
Women's and Children's	LRI	RGAU	20.79	12.26	18.34

RAPID FLOW on a page

Rapid Flow of Patients Process activated only when:

- OPEL Level 4 **and/or**
- Unable to handover patients on ambulances or due to no capacity within ED or no capacity for inbound ambulances **and/or**
- 50% occupancy of the PEP area (Patient on ambulance Escalation Area POD).
- No Capacity in Resus with no out flow **and/or**
- Majors full of DPS 2 category patients in the waiting room waiting to access majors cubicles



- CMG Bed Management Team / CMG Matron utilise daily discharge list to identify patients to be transferred to the Discharge Lounge. Identify potential discharges and prepare areas to accept Rapid Flow patients from 08:00hrs

- We would Rapid Flow transfer from ED to Assessment areas 24/7 as required
- We will Rapid Flow from the Emergency Floor to Base Wards 08:00hrs- 20:00hrs
- All areas will accept a maximum of +1 except AMU (+1) AMU south 1 and AFU (0)

The following groups of patients are excluded from Rapid Flow:

- Clinically unstable with an early warning Score (EWS >4)
- Patients with an EWS of 3 in one parameter
 - Patients requiring Humidified, High flow oxygen, NIV or oxygen therapy.
- Patients requiring High Dependency Unit level care.
- Patients requiring cardiac monitoring.
- Patients with severe cognitive impairment i.e. restless/agitated, delirium
- Patients with complex Learning Disabilities
- Patients in the last few days of Life
- Patients who require isolation because they are at risk of transmitting or acquiring an infection.

At 20:00hrs if there is an additional patient on the Ward after Rapid Flow has occurred and the scheduled discharge is no longer happening. The Ward based team must contact the site team for the most appropriate patient on the Ward to be allocated an alternative bed space within the organisation.
The patient should not be returned to the emergency floor