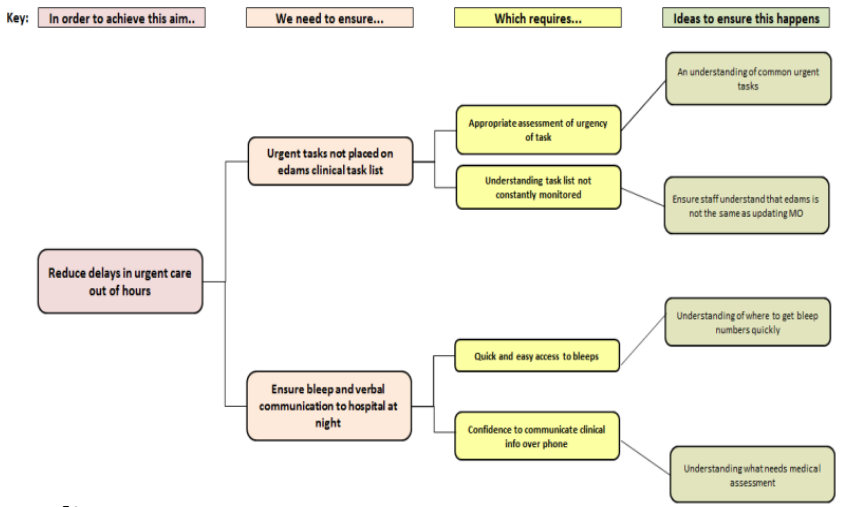
Reducing delays in urgent care using electronic communication systems; South Eastern Health and Social Care Trust, NHS, Northern Ireland, UK

Authors: Jordan Bamford, Kamran Hennessy
Supervisor: Dr David Wilson
Data collection team: Emma Donaldson, Amy Ross, Sarah McGuckin, Elly Warnock

South Eastern Health and Social Care Trust

Context:

- Based at the Ulster Hospital, a regional hospital for the South Eastern Health and Social Care Trust in Northern Ireland
- The Ulster Hospital utilizes an electronic clinical task system calls EDAMS
- It allows health care professionals to log tasks which are required to be completed by medical staff. This is the first of its kind in Northern Ireland
- Inadvertently urgent clinical tasks may be placed on this list and this can create time delay in urgent care
- The team involved in this project was a group of F1 junior doctors, senior consultant input, Clinical coordinators from hospital at night and support from QI leads.
- Our focus was reducing time delays in urgent care for patients



Aims:

Cycle 1: **50% of urgent tasks out of hours are completed within 2 hours over 2/12/20- 18/12/20**

Cycle 2: **Increase in bleeps and aiming for greater than 50% of out of hours tasks completed within 2 hours 18.1.21 till 14.2.21**

Measures:

Outcome measure: **mean time to complete urgent tasks OOH**

Process measure: **number of urgent tasks on edams with corresponding bleep to hospital at night**

Balancing Measures: **1) total number of bleeps to hospital at night 2) total number of tasks appearing on edams**

Intervention:

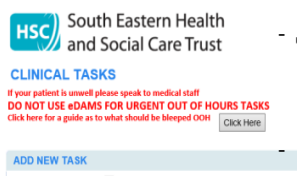
- Cycle 1: ward based poster and education
- Cycle 2: Electronic warning and access to guide across hospital site

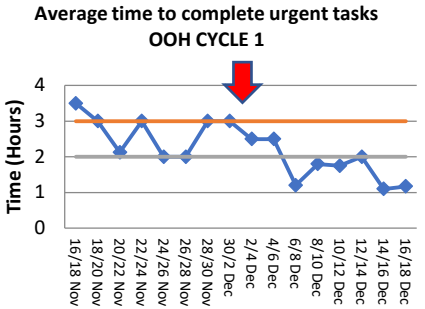
Cycle 1 Poster:

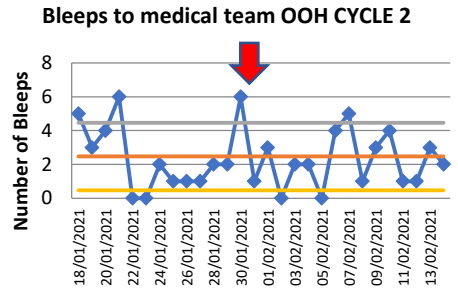
- act a visual indication for nursing staff to be able to triage clinical tasks, and have information on when and how to contact the out of hours medical team
- This poster was placed initially on one ward at nursing stations, and an electronic version was emailed to all staff working out of hours

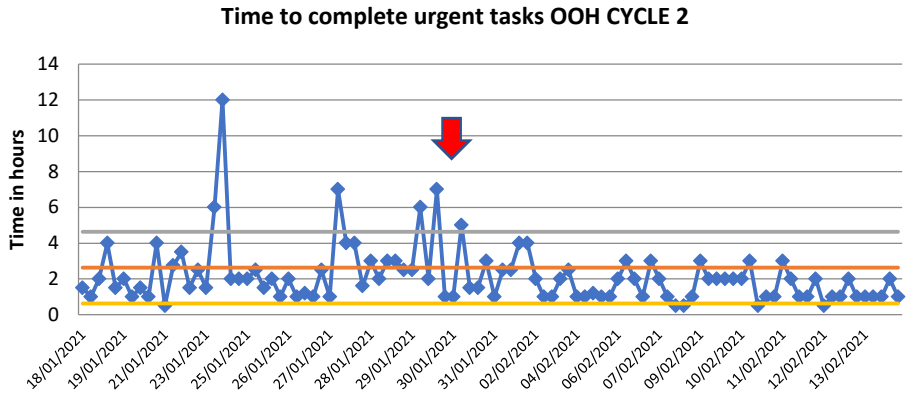
Cycle 2 Built in warning

- Success of cycle 1 guided cycle 2
- we engaged with changing the electronic system
- developed an online accessible version of the guide which was placed on resources for those learning about EDAMS
- We then also created a warning when staff added a clinical task – this warning would encourage staff to verbally communicate with their medical colleagues if a patient was urgently unwell
- This warning provided a link to the guide









Findings

- Results from the first cycle showed that on average we achieved our aim; we found a downward shift in delays to urgent care
- The second cycle showed further reduced delays in urgent care with a corresponding improvement in verbal communication
- Overall we created a sustainable shift in reducing delays to urgent care and improving verbal communication that was evident over months
- This reduction in time delays are beneficial as they reduce morbidity and mortality for inpatients, and ensure improved patient satisfaction

Lessons Learned

- We were concerned that we found some evidence that electronic communication systems may erode verbal communication. This presents as a challenge for implementing these systems elsewhere
- We were able to successfully show that visual aids and in built warnings can avoid introducing delays and improve patient safety