Patient Transport/Escort Assistance with Discharges and Transfers

A Best Practice for Resource Capacity Management

Objective: Allow your resource capacity management tools (the **Bed Management** Suite™) to timely and accurately reflect your true resource capacity.

Definitions: As it relates to your in patient population, resource capacity is comprised of essentially three main components:

1. Available Beds
2. Available Staff
3. Imminent Changes (within 3 to 8 hrs.) to 1 or 2, as listed above.

Available Beds: Available beds are a function of two major activities; patient departure and bed turnover. Bed turnover entails multiple workflow steps for communications about dirty bed, their priority, the actual performance of cleaning, and then the final communication back to those that need to know. This key sub process, however, can not even begin if the patient departure step is not handled properly.

Available Staff: Available staff is directly impacted by a combination of current census and new resource demand (patients waiting for bed assignments). This too will be impacted by the critical first step of patient departure. If the patient's departure is not communicated immediately upon leaving the unit, then the unit will reflect a census or level of patient care activity that is not accurate. Personnel involved in determining the proper staffing levels can be lead to believe that there are more patients on a given unit than actually exist, thus potentially allocating more staff to that unit than is required. This has the proverbial snow ball affect of potentially impacting the number of patients that can be accepted on an incoming basis, resulting in turning away patients from non emergency sources (rendering a negative financial consequence which will be addressed later in this document).

Imminent Changes: Resource capacity is directly affected by those patients who are 'Pending' to move as well. Those that now require a different level of care (an internal transfer) and those that are expected to go home (as per Case

Management and/or the Physician directive) represent available beds within the next few hours. While this information alone is extremely useful for planning and managing resources, the benefit that is often overlooked is the implications this has for the level of clinical staffing required on a given patient unit. Consider the two extremes — if you have a patient unit filled with 20 patients who all were admitted today, the work load on the nursing personnel is at its absolute highest. The additional "intake" work of a new admission, as well as the acuity of a new patient both combine to represent a higher level of care for that individual patient. Multiply this by the number of new patients, and you begin to get the picture.

However, this concept applies to the other side of the equation as well. Consider a patient unit of 20 patients that are all ready to either go home or transfer off the unit. While the transferring patient may not require a lower level of care, it is safe to say that the discharging patients are indeed less demanding of clinical resources. The very fact that they are clinically cleared to be discharged is proof of the fact that they are stable enough to leave the hospital. Consequently we can engage in our "multiplying" exercise to see the cumulative affect of multiple discharges and transfers lowering the level of care and hence, the proportionate level of staffing for a given unit. The point of looking at these two extremes is to see Pending Discharges and Pending Transfers as more than a bit of "wouldn't it be nice to know" information – but to see these vital pieces of information as directly related to *both* bed availability and potential nurse staffing – two of the three key components of your total resource capacity.

The issue of obtaining timely notice of both Pending Discharges and Pending Transfers is not the focus of this position paper, but suffice it to say that this is a valuable subject to continue to explore as you seek to improve your ability to manage resource capacity.

Best Practice Policy: Any best practice starts with a best practice policy. Leadership must make it clear to all levels in the organization that any given best practice that is worth doing, is worth doing consistently, reliably, and with accountability. In the case of securing knowledge and action regarding the three major component of resource capacity, Tele-Tracking Technologies recommends that the hospital adopt a policy of requiring patient transport or escort assistance for 100% of all internal transfers and patient discharges. This would even include those patients who are being discharged and are ambulatory.

Best Practice Workflow: In order to implement this policy, we recommend that your current workflow tool, **Transport**TrackingVIP™ be used to request transport for all patients who must be transferred and those that are ready to be

discharged. Because this tool is made by the same company as the **Bed Management *Suite*™**, there will be automatic trigger events sent to the **electronic bedboard™** by the simple act of the patient escort performing their normal steps of logging their progress (via the phone) into the transport system. The burden of communication and managing the flow of information is therefore removed from the nursing department, and instead enabled through the transport department. This also supports a key principal in *any* efficient workflow design – allowing the staff closest to the information to be the one that conveys that information. Unless nursing actually moves the patient, they are getting that information second hand, and in less than real time. Thus, they are seldom in a position to convey it reliably or timely. By having the person who is moving the patient perform this function, we can expect a near 100% consistency and reliability for this critical event.

Financial Analysis: Naturally, workflow changes often produce cost increases or decreases. However, *best practices* should *always* produce cost decreases unless their service improvements are dramatic enough to otherwise justify it. Fortunately, the best practice of using transport services for 100% of all discharges and transfers offers significant cost reductions, in addition to service (or quality of care) improvements. Let's briefly look at both:

Cost Reductions/Revenue Implications

1. **Hourly Rates:** The hourly rate for a patient escort is significantly lower than the hourly rate of a registered nurse (RN) or licensed practical nurse (LPN). In most cases, this would be true for a nurse aide, as well. Hence, using transport staff will always be less costly.

2. **Environmental Services Labor**: Environmental Services or housekeeping departments will project and schedule labor on the 2nd shift for bed cleaning. Their labor projections and deployment will be based on the number of discharge requests and completions they average on that shift. Unfortunately, these numbers are inflated when transport does not trigger the bed status to dirty, and thus do not trigger the employee to clean the bed. Consequently, even if only *one* bed is left on each patient unit, no doubt a conservative estimate in most hospitals, the result can be an 'artificial' demand for 2nd shift bed cleaning labor. Given that a given housekeeper can do about 12 to 20 beds per shift, this can easily be 1.4 to 3.0 additional full-time-equivalents (FTEs) for bed cleaning in even small to medium size hospitals.

3. **Patient Days**: As a bed sits idle, the hospital loses hours that could normally count towards a 24 hour stay. A patient, who could have come in today, may be delayed till tomorrow; simply put – patient days are lost.

4. **ER Diversion**: Inaccurate bed availability may be a contributing factor to directing emergency patients to other facilities if it appears that there are "no available beds", or if the ***patient flow*** is slowed as a result – even if only for a few hours at a time.

5. **Competition**: If a physician has admitting privileges to several hospitals, and the hospitals bed availability situation requires that he/she wait for a bed assignment, they may choose to send the patient elsewhere while the given hospital's resource capacity issues are being solved. Repeating patterns of this scenario can have repeating negative consequences as well.

6. **Unit Staffing**: Staffing is based not only on current census, but also the impending changes. If this information is inaccurate, it would not be unlikely to assign an additional nurse to a given unit that may not actually be required. Even if this only happens with a "net" of one additional nurse per shift, the cost implications would have a significant cumulative affect over multiple shifts and 365 days per year.

Customer Service / Quality of Care

1. **Nurse Ratios:** If a nurse assists in a patient transfer or discharge (critical care transfers notwithstanding), they are 'off the floor' and away from their current patients. Consequently, those patients have to wait for his/her return and other nurses have to cover. In either case, it is not a good situation for other nurses or the patients.

2. **Risk Management**: Getting 'lost' or injury, such as encountering a fall, are all possibilities for patients who leave unescorted. In either case, it behooves the hospital to insure a direct and safe departure of the patient. This is especially true in larger more geographically complex facilities.

3. **Final Steps**: When patients depart, there may be loose ends to attend to such as medications that need to be picked up from the pharmacy, or paper work that needs to be completed in admissions. If these loose ends are not tied up in short order, the patient will

ultimately be inconvenienced later. To get the medications in the patient's hand, and the paper work completed is also in the best interest of the hospital. Transport staff can help accomplish this step, whereas the demands on a nurse would make this impossible.

What would it cost to implement this best practice?

1. **Escort Labor:** The following equation should yield (within a 90% confidence level) the cost of providing this service:

   Entry level labor rate X Average trip time X Average # of Discharges and Transfers

   To this number, add 10% - 20% of "idle time" to allow for optimal response time.

2. **Equipment**:Add 2 to 4 additional wheel chairs to the transport department if they are currently a scarce commodity.

Summary: While a detailed spreadsheet analysis could further explore the cost implications of this best practice, what is delineated here should provide a good understanding of the fact that the financial and quality benefits well outweigh the cost of implementation. Beware of 'analysis paralysis' in studying an issue of this significance.

While you study, resource capacity management issues await.

For more information on any of Tele-Tracking Technologies **Capacity Management *Solutions***™, please contact:

Christopher Anderson
Director of Marketing
412-391-6369
canderson@teletracking.com