The role of a flow coordinator in an emergency assessment unit

THE BIRMINGHAM Heartlands and Solihull NHS Trust is one of 11 national pilot sites working with the Ideal Design of Emergency Access (IDEA) programme from the Department of Health’s Modernisation Agency. The programme’s core objectives are to:
- Improve the patients’ process time;
- Reduce variance;
- Improve the flow of patients.

The IDEA programme invited bids during 2002 for new innovations to improve the process time from the patient arriving to his or her final destination. Funding was secured for a one-year project in the GP Emergency Assessment Area (EAA) for a patient-flow coordinator who would support nursing, medical staff and ancillary staff by centralising communications and documentation at times of peak departmental activity.

Emergency assessment area

The EAA is situated next door to the A&E department and forms part of the emergency patient pathway for medical and surgical patients who require an emergency (same day) assessment. The primary function of the EAA is to offer a comprehensive assessment.

The EAA differs from an A&E department; for example it does not treat patients who have experienced an accident that results in a trauma or orthopaedic injury. Patients can be referred to the EAA via two routes:
- Directly from their GP (60 per cent);
- Redirected from the A&E department (40 per cent), once it has been determined whether their problem is medical or surgical in nature.

The ultimate goal of the EAA is to achieve a discharge rate of 40 per cent. Although this is regarded as ambitious by senior clinicians, a rise to a consistent 33 per cent discharge rate has been achieved since the unit opened in September 2001.

Three methods were used to provide evidence for the patient-flow coordinator role:
- Observations from practice;
- Process mapping;
- Filming departmental activities.

Observations from practice

By working with staff in the EAA during peak activity periods (weekday afternoons), the consultant nurse observed it was departmental administrative functions that frequently ‘grounded’ a senior member of the nursing team within the central nursing station for the entire shift.

This left only two other members of nursing staff able to assess and initiate complex clinical care for up to 25 patients (peak activity), divided among 10 cubicles, two clinic rooms and a large patient waiting area.

This meant that nurses were constrained in their role by a sudden influx of the following:
- Telephone enquiries;
- Pager requests;
- Waiting for return calls;
- Patient liaison;
- Documentation requests.

Moreover, doctors, with the best of intentions, often intervened by answering telephone calls, entering messages in patient notes or on pieces of paper, or, sometimes, confusing or not passing on messages. Furthermore, the quality of care varied considerably depending on the time of a patient’s arrival in EAA.

Box 1. Core objectives and key functions of the patient-flow coordinator

Core objectives
- Work as a flexible team member towards achieving the latest four-hour policy targets (Department of Health, 2002)
- Promote smooth ‘seamless’ flow of patients through the emergency assessment area (EAA) to admission or discharge, by progress-chasing, updating and liaising with all EAA staff
- Free nurses’ time by carrying out appropriate administrative tasks
- Improve the accuracy of audit data by the timely entry of key times and points of referral in EAA
- Promote patient involvement and choice by networking with the patient advice and liaison managers

Key functions
- Meet and greet patients as they arrive from the A&E department and the EAA
- Ensure patients are handed to clerical staff to book details into EAA
- Organise transfers from the EAA to X-ray and back to EAA
- Answer the telephones
- Notify doctors of patients’ arrival
- Book beds via bed managers
- Progress-chasing blood results and bed availability
- Inform relatives of changes and updates
- Update the nurse in charge of changes
- Centralise communication. Write in patients’ notes
- Maintain a calm environment by updating staff of changes in the situation
- Ensure patients are seen in the appropriate order
- Monitor waiting time and alert staff to four-hour wait
This situation was clearly untenable because it posed serious clinical risks to patients by:

■ The inappropriate use of nursing skills;
■ Fragmented communication channels, as described by Handy (1999);
■ A lack of cohesive coordination, as explained by Belbin (1993).

**Process mapping**

The departmental activities were also observed within the EAA patient waiting area. The process adopted by staff when a patient arrived in the EAA was mapped, with a particular focus on which team members assumed what roles (Fig 1).

Concerns were later shared via feedback to staff, but the situation could be summarised as a chaotic working environment (Handy, 1999). The most frequent causes of the apparent chaos were extrapolated and noted:

■ Patients were often not formally welcomed upon arrival to the EAA;
■ Nurses were unsure of where patients were situated within the department;
■ Doctors frequently could not find their patients or their medical notes;
■ Porters were often contacted several times by different nurses about the same thing;
■ Bed managers were repeatedly hassled by staff trying to locate beds;
■ Ward nurses were regularly contacted several times regarding the handover of the same patients.

The problems underpinning the chaos were multifaceted. They included poor leadership, which resulted in badly differentiated or duplicated team roles as demonstrated by Belbin (1993) and a lack of clear communication channels. These difficulties were compounded by the sheer volume of patients arriving at the same time. Nevertheless, some staff could not see what was wrong with the status quo, after all ‘everything seemed to get done, albeit two or even three times over’.

The existing communication channels appeared to be decentralised, creating a situation in which all professionals were unsure of where to report information. In some cases, although decentralised communication is known to give superior performance for complex tasks (Huczynski and Buchanan, 1999), most of the tasks that created the chaos during peak times were simple. With this in mind, a centralised communication was thought to be preferable (Fig 2, p34).

**Filming departmental activities**

The aim of filming the department was to show the level of interactions taking place among staff, patients and ambulance crews at key times of the day. By analysing the film it was hoped that key areas for improvement would be noted.

Although staff were initially extremely apprehensive, it was acknowledged as a good way to examine behaviour in practice. A comparison film made after the introduction of the new role demonstrated an improvement.

**Patient-flow coordinator**

Creating a new patient-flow coordinator role could address some of the problems causing chaos in the EAA. Furthermore, a centralised communication model could be tested within the EAA by the patient-flow coordinator performing simple tasks to facilitate information flows all around the system (Fig 2).

Conversely, risks were anticipated. For example it was possible the work could have saturated one person or that staff may not have adjusted to the new way of working. However, it was hoped that these risks would not be insurmountable.

Finally, a whole-system approach incorporating changes from other policy directives, such as the Single Assessment Process from the National Service Framework for Older People (DoH, 2001), could be realised by allowing senior nurses the time to focus on instituting clinical changes rather than concentrating on administrative functions.

The core objectives and key functions of the patient-flow coordinator are shown in Box 1. Although the role was broadly defined by the core objectives within a job description, it was felt that the key functions should be allowed to evolve as the post holder deemed appropriate. Some constraints were evident. However, these were not imposed in a rigid job description but via organisational changes affecting the EAA and individual resistance to change, as exemplified by Handy (1999).

A patient-flow coordinator can make some senior nursing staff feel threatened and potentially undermine their authority (Adair, 1983). The idea that it was not necessary to have an F or G-grade nurse in the central nursing station performing the key functions identified (Box 1) as shown by Vroom and Yetton (1986) was not easy to sell. A model of change (Vroom and Yetton, 1986) to ‘tell, sell and consult’ staff together with leadership coaching methods (Manley, 2000) were used.

The patient-flow coordinator was also supported to help manage the tension and thereby change staff views within the organisational culture. Nine months into the role, after a relatively rocky ride, even the most sceptical

**References**


Staff appear to have been convinced of its merit.

The patient-flow coordinator role has been evaluated according to the following measures:
- Reduction in patient journey time;
- Reduction in process variability;
- Improvement in patient and carer experience.

Reduction in patient journey time
Routine sampling was already taking place to measure the overall patient journey time in the EAA. A sample of patients (a minimum of five per week) who came into direct contact with the flow coordinator were process-mapped and timed.

The trust has made a gradual improvement in its four-hour patient target times, starting from 72 per cent and rising to a peak of 96 per cent in March 2003. Inevitably, it remains difficult to separate the contribution of this role to the improvement in target times, because it is inextricably linked to the concerted effort of many staff and initiatives. Nevertheless, the patient-flow coordinator acts as lubricant, central to the healthy functioning and smooth running of the EAA.

Reduction in process variability
One of the key aims of this role is to reduce the variation inherent in the current patient pathway by adopting a standard approach. This has been tested by mapping the patient process before the post holder began his or her duties and at an interim point, as well as filming the EAA.

Filming demonstrated that fewer staff were congregated around the central nurses’ station and the patient-flow coordinator was performing the functions outlined. The post holder ensures that all patients are met and greeted, booked into the EAA and better informed of what to expect. Visiting staff and doctors based in the EAA continue to be a cohesive part of the hospital.

Improvement in patient and carer experience
Samples of patients have been intermittently followed up with patient satisfaction surveys. Information booklets were felt to be informative and an accurate reflection of what to expect. Suggestions have been implemented, such as providing more comfortable seating, privacy notices on curtains (to prevent relatives from peeping behind during examinations) and noticeboards in each patient cubicle to answer commonly asked questions.

Other improvements
Other demonstrable improvements include:
- The department is better organised and calmer;
- Nurses are able to concentrate on clinical duties and more nurse-led assessments;
- An ambulance-tracking system has been introduced that gives accurate details of when ambulances are expected. This acts as an early warning system to predict peak periods of activity;
- A series of future improvements are planned (Box 2).

Conclusion
The EAA continues to develop rapidly with new initiatives, which makes it incredibly difficult to separate and measure the contribution of this new role because they are all inextricably linked. A measure of success can perhaps be taken from the sheer number of coordinators in various guises being introduced within the hospital. Moreover, there has been overwhelming interest in replicating transferable aspects of the job description.

The underlying theme of the role appears to be to improve communication and coordination from wards, by allocating one person to be responsible for the timely admission and discharge process. The result is a proactive approach to a ‘network’ of other coordinators, pulling patients through the hospital.

This has a knock-on and positive effect for transferring patients out of the EAA. Therefore, good networking within such a role may prove imperative elsewhere for the early discharge of patients and to release beds, thus achieving the targets associated within the latest reforms (DoH, 2002).

The funding of the coordinator beyond the life of the project has just been agreed, ensuring this post will continue to be a cohesive part of the hospital.

### BOX 2. FUTURE IMPROVEMENTS

- Introduce a series of coloured lines to direct patients to key areas, such as X-ray.
- Lower the main reception desk to make it more patient-focused, especially for those in wheelchairs.
- Increase the number of hours for the patient-flow coordinator role, allowing for greater cover at peak times in the EAA.

### FIG 2. PROCESS MAPPING AFTER THE CREATION OF THE PATIENT-FLOW COORDINATOR ROLE

- Patient-flow coordinator
- Porter
- Manager
- Nurse
- Doctor
- Nurse
- Doctor

Ensuring information flows around the emergency assessment area (EAA)