

## Ambulance Handover Performance



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## Contents



- Background
- Outcomes
- Ambulance arrival survey – patients attendances
- Ambulance survey – process
- Improvement plan

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## Background



GWAS reported on a weekly basis the ambulance handover times, this is reported for all Trusts. Reporting in relation to NBT indicated significant delays at Frenchay ED.

To ensure accuracy of information a qualitative survey and data validation exercise was undertaken. This showed considerable variance in activity to that which had been previously reported.

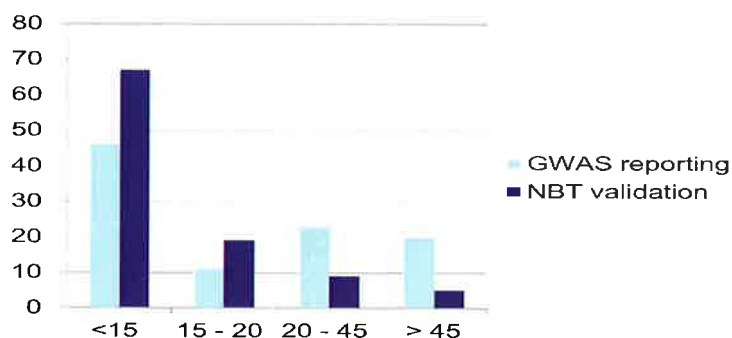
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## Outcomes



Our data validation and qualitative survey demonstrated the following :-



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## Ambulance Arrival Survey



### What we found about patient attendances...

- 17% (n=35) patients were sent by ambulance to Ed by a GP. Only 5 of these patients had a GP letter. None had been discussed with ED.
- 34% (n=64) patients had been seen by a healthcare professional in the previous 72 hours.
- Of these 73% (n= 47) had been seen by a GP.
- 51% (n=97) were admitted to an in patient bed with 49% being able to be discharged.

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## Ambulance Arrival Survey



### What we found about our process ....

- GWAS crews not pressing the handover button in a timely way, making it look like there are delays occurring when in fact this is not the case
- Some patients that could have bypassed ED and been directly admitted to AAU did not follow this pathway.
- ED staff needed to “police” the GWAS handover screen.

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## Improvement Plan

- Enter and view visit and recommendations.
- ECIST patient flow recommendations – Flow out of ED has a direct link to ambulance off load delays.
- Implementation of the “IAN” nurses.
- Agreed joint handover process.
- Joint escalation plan for NBT and UHB.
- New hospital capacity improvements.
- Direct admission pathway reviews.

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