WHEN BEDS DON'T MOVE

How Flow Physics™ Reveals the Hidden Breakdowns Costing Hospitals Millions

By Donald Sipp Jr., MBA, RESE, CHESP, CHTI-2, CMIP, PMP

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Foreword

It is a privilege to write this foreword for Donald Sipp's book, When Beds Don't Move.

I first met Donald after contacting Georgie Shockey, co-owner of Ruck-Shockey & Associates, in search of expertise to help address challenges within our organization's Environmental Services department. From our very first conversation, I was impressed by Donald's depth of knowledge, practical experience, and thoughtful approach to improving healthcare operations.

Donald didn't simply offer recommendations. He provided a comprehensive assessment that met and exceeded my expectations. His knowledge and expertise helped guide our organization in the right direction, leading to significant improvements in patient throughput and a greater understanding of the critical role Environmental Services plays in the overall success of a healthcare system. The strategies and insights he shared enabled our team to improve operational efficiency, reduce delays, and create a more effective patient flow process that benefited both our patients and our caregivers.

Too often, Environmental Services is viewed as a support function rather than a strategic partner in patient care. Donald understands that every delayed discharge, every

room waiting to be cleaned, and every bed sitting idle has a direct impact on patients, caregivers, and an organization's ability to deliver timely, high-quality care. His ability to connect operational efficiency with patient outcomes is what sets him apart.

This book provides a holistic approach to how support services can work together to improve patient flow and operational outcomes. Donald demonstrates that achieving efficient throughput is not the responsibility of a single department but a coordinated effort across Environmental Services, nursing, patient transport, bed management, and other essential support teams. By viewing these functions as interconnected parts of the patient care continuum, healthcare organizations can reduce delays, increase bed availability, enhance the patient experience, and improve overall organizational performance.

When Beds Don't Move captures the insight, experience, and leadership that Donald has demonstrated throughout his career. More than a discussion of Environmental Services, this book serves as a practical guide for healthcare leaders who are committed to improving patient flow, strengthening collaboration across departments, and achieving operational excellence. Whether you are an executive, clinician, or support services professional, you will find practical strategies that can be implemented to

create lasting improvements in patient care and organizational performance.

I am grateful to Georgie Shockey for introducing me to Donald and even more grateful for the opportunity to benefit from his expertise. His guidance helped our organization achieve measurable and lasting improvements in patient throughput, and I am confident this book will help other healthcare organizations realize similar results.

I recommend “When Beds Don’t Move” to you and encourage you to read it with an open mind. The insights contained in these pages have the potential to transform how you think about support services, patient flow, and the essential collaboration required to ensure that every patient receives timely, efficient, and compassionate care.

Antoinette “Toni” Watkins MS, RDN

System Director of Food, Nutrition & Environmental Services

Riverside Health System

PART ONE

The Framework

Understanding the invisible system that governs hospital movement.

Introduction: How Hospitals Lose the Day

Hospitals talk about capacity constantly. Dashboards measure it. Leadership meetings debate it. Strategic plans attempt to expand it.

Yet the crisis most hospitals face every day is not a shortage of beds.

It is a shortage of movement.

At 7:06 a.m. on a Tuesday, a 420-bed regional hospital had three beds physically available on a medical-surgical floor. The ED had two admitted patients waiting. Transport was staffed. Placement was at the desk.

By 8:30 a.m., the ED had five holds. The OR was flagging a PACU backup. Leadership was on a call asking why the morning had “gone sideways.”

Nothing unusual had happened. No callouts. No surge. No equipment failure.

What had happened: the linen cart for the high-turnover corridor had been stocked out of sequence the night before. One EVS tech lost eleven minutes retrieving supplies for the first room. Transport's first cycle shifted. Two admits stacked instead of spacing. Nursing absorbed them simultaneously during a medication pass. Placement lost its matching rhythm.

By the time leadership noticed the pressure, the cause was ninety minutes old and three departments upstream.

The Sequence That Repeats Every Morning

6:47 a.m.

A linen cart is delivered to the wrong unit. The surgical floor gets Telemetry's linen. The surgical closet is short on high-use items.

7:04 a.m.

An EVS technician enters the first assigned room. The cabinet is missing towels. She walks back to the closet. Three minutes there. One minute searching. One minute back. Five minutes lost. The first room is not released on time.

7:09 a.m.

Transport's first cycle shifts. A patient in the ED who was ready to move is now waiting. The ED hold clock starts.

7:23 a.m.

Placement sequences two admits simultaneously because the first bed was expected to open by now. It hasn't. Both moves are stuck behind the same delayed room.

7:51 a.m.

Nursing on two floors absorbs back-to-back admissions during the morning medication pass. Both charge nurses are now managing three simultaneous tasks instead of one.

8:30 a.m.

The ED board shows four holds. The house supervisor called an escalation. The surgical schedule flags a potential PACU backup. Leadership asks: why is this morning so heavy?

8:47 a.m.

The linen cart is still on the wrong floor.

No one traces the 8:30 pressure back to 6:47. The escalation call discusses staffing. Communication. Volume. The actual cause, a misdelivered cart and a five-minute supply detour, never comes up. It will happen again tomorrow.

This sequence is not unusual. In most hospitals, some version of it happens every day.

What makes it a flow problem rather than a logistics problem is this: the people involved are not failing. The EVS tech did exactly what she was trained to do. The transporter responded the moment the room released. The nurses managed the admits professionally. The house supervisor called the escalation at the right time.

The system failed. Not the people. And because the system failure was invisible, untracked, and owned by no one, it will repeat with the same consequences tomorrow morning.

Here is the part that matters most: you have probably sat in that 8:30 escalation call. You have probably heard staffing cited. Volume cited. Communication cited. You may have left with action items about huddles, or escalation protocols, or staffing ratios. And the next morning, the pressure returned at the same time, for the same reasons, because nothing discussed in that call had anything to do with a linen cart delivered to the wrong unit at 6:47 a.m.

That is not a failure of leadership. It is a failure of visibility. The cause of your morning pressure is almost never where you are looking for it. It is upstream, it is small, it is structural, and it happened before most of your leaders arrived at work. The hospital is not reacting to the day. It is inheriting a sequence that was already broken.

Once you see that, you cannot unsee it. And once you name it, you can fix it.

That is what this book is about.

The same question gets asked every day in hospitals across the country: if beds are open, why can't patients move?

This is the Patient Flow Paradox. A hospital can have available beds and still function as if it is completely full. The reason is simple.

Capacity and movement are not the same thing.

A bed only matters when it activates at the moment a patient needs it. If activation is delayed by timing gaps, sequencing failures, or readiness problems, the hospital experiences gridlock even when beds exist on paper. Most hospitals try to solve this by focusing on people: adding staff, increasing communication, creating escalation meetings. These efforts rarely fix the underlying problem. Not because the people are incapable, but because the issue is structural.

The visible symptoms are chaos. The underlying cause is structure.

Patient flow follows patterns. Once those patterns are understood, delays become predictable and preventable. This book reveals the system behind hospital movement: the Flow Operating System™. Inside every hospital, invisible operational forces determine whether patients move smoothly or whether pressure builds. Throughout this book you will see how those forces interact, including:

- The Stagnation Gap™, where hospitals quietly lose the momentum needed to start the day
- The laws of Flow Physics™, which explain how timing, sequencing, velocity, and load shape hospital movement
- Activation Windows™, which determine whether departments enter the day aligned or already behind
- The Support Services Chain™, the operational engine that converts clinical decisions into real bed movement
- The governance discipline required to keep the system aligned

I have spent more than two decades inside hospitals studying these patterns. Not from the outside, not in theory, but in the corridors, the EVS closets, the transport bays, and the command centers where operational pressure actually lives. Academic medical centers, regional health systems, community hospitals. Different cities,

different leadership, different staffing. The same collapse, repeating.

Once that system becomes visible, flow stops feeling mysterious. Delays become measurable. Capacity, often assumed to be permanently constrained, can begin to unlock.

A note on sources and methodology: the operational patterns and case scenarios in this book reflect direct field observation across more than two decades of hospital assessments spanning academic medical centers, regional health systems, and community hospitals. Composite case scenarios are illustrative representations of recurring patterns and do not represent any single institution or individual. The financial consequences of the flow failures described throughout this book are supported by published research. Studies published in the Annals of Emergency Medicine and peer-reviewed healthcare operations literature document that ED boarding alone costs hospitals millions of dollars annually in extended care costs, lost throughput, and suppressed capacity. The Flow Physics™ framework presented here is not a theoretical model. It is a pattern that already exists in your hospital. This book makes it visible.

The First Failure of the Day

Hospitals don't begin the day in readiness. They begin the day in Drift™.

You feel this the moment you walk onto any unit. The hospital is already behind, and the first move of the day hasn't even happened yet. Discharges aren't ready. Orders are pending. Rooms aren't cleared. EVS doesn't have a clean first target. Transport has nowhere to send the first patient. Before the sun rises, the first sequence of the day is already broken.

The collapse doesn't happen at noon, or during the surge, or when the ED starts boarding. It happens the moment the hospital enters the day without alignment. Nights are built to stabilize, not to move. Day shift isn't creating Drift. They're inheriting it.

The chain is mechanical:

- If the first discharge is late, EVS starts late.
- If EVS starts late, Transport starts late.
- If Transport starts late, Placement starts late.
- If Placement starts late, the ED boards earlier.
- If the ED boards earlier, the hospital loses capacity by mid-morning.

Every department believes it is responding to the problem. In reality, it is responding to the effect of an earlier Drift. By mid-morning, leaders ask the same questions they ask every day: Why is the ED backing up? Why aren't beds moving? Who's not communicating?

These questions assume the collapse is caused by people. The collapse is caused by timing.

Hospitals measure everything except the one thing that decides the whole day:

First Movement Time™ (FMT™).

FMT™ is the timestamp of the first confirmed patient move of the day. It drives flow, pressure, Drift, and capacity recovery. Yet almost no hospital measures it, monitors it, or manages it.

What FMT Measurement Reveals: A Composite Case

> *In a 350-bed regional medical center, leaders consistently reported that the ED "got busy early." Morning escalation calls started at 9:00 a.m. Staffing and communication were the recurring explanations.*
>
> *When the hospital began tracking First Movement Time™, a different picture emerged. The average FMT was 7:34 a.m., but on high-pressure days it*

slipped to 8:11 a.m. Every day FMT exceeded 7:45 a.m., ED holds by mid-morning increased by an average of 40 percent. There had been no staffing change. No communication failure. The only variable was when the first movement happened.

Once the hospital set a protected FMT target of 7:20 a.m. and assigned ownership to a single operational coordinator, the pattern broke. Over ninety days, mid-morning ED holds declined measurably and morning escalation calls dropped by more than half.

Composite scenario representing patterns observed across multiple hospital assessments.

The Stagnation Gap™

Even when timing slips are not catastrophic, hospitals lose the day in another way: the Stagnation Gap™.

This is the invisible period between “the day has started” and “the hospital is actually moving.” Every hospital has one. Staff are working. Tasks are completing. Documentation is updating. But beds aren’t moving.

Everyone looks busy. The hospital is stuck.

The Gap looks like momentum. It is the system stalling while people inside it work harder than ever. The morning isn't a preparation window. It is the only time the hospital can get ahead. If that window stagnates, the rest of the day collapses with predictable force.

In a slackless system, the distinctions that matter are not about effort:

- Work is not movement.
- Movement is not readiness.
- Readiness is not timing.
- Timing is not sequencing.
- Sequencing is not flow.

Most organizations never see these distinctions. They see effort and miss alignment. They see activity and miss architecture, because timing is invisible, not measured, and owned by no one; the Stagnation Gap becomes permanent.

Over time, it shapes culture. It convinces the organization that early stagnation is normal, that late discharges are expected, that the ED should live in pressure. Once a hospital normalizes the Gap, it stops seeing delay as delay. It sees delay as routine. This is how Drift becomes identity.

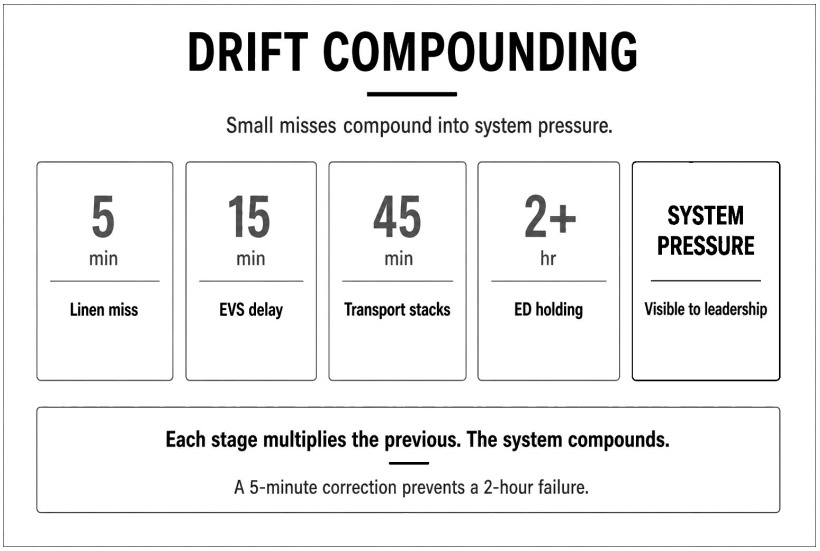

Figure 1: Drift Compounding

Measuring the Gap: A Composite Case

At a 500-bed academic medical center, nursing directors reported that mornings felt "busy but unproductive." Staff were active by 6:30 a.m. Yet the first confirmed bed move rarely occurred before 8:45 a.m.

When operations leaders began auditing activity versus movement, the Stagnation Gap became visible. On average, 2 hours and 15 minutes elapsed between shift start and first movement. During that window, more than 40 tasks were completed across units, none of which directly enabled a patient move.

Once leaders named the Gap and restructured morning sequencing around movement triggers

rather than activity milestones, the Gap compressed to under 45 minutes within sixty days. Downstream ED boarding pressure dropped consistently in the weeks that followed.

Composite scenario representing patterns observed across multiple hospital assessments.

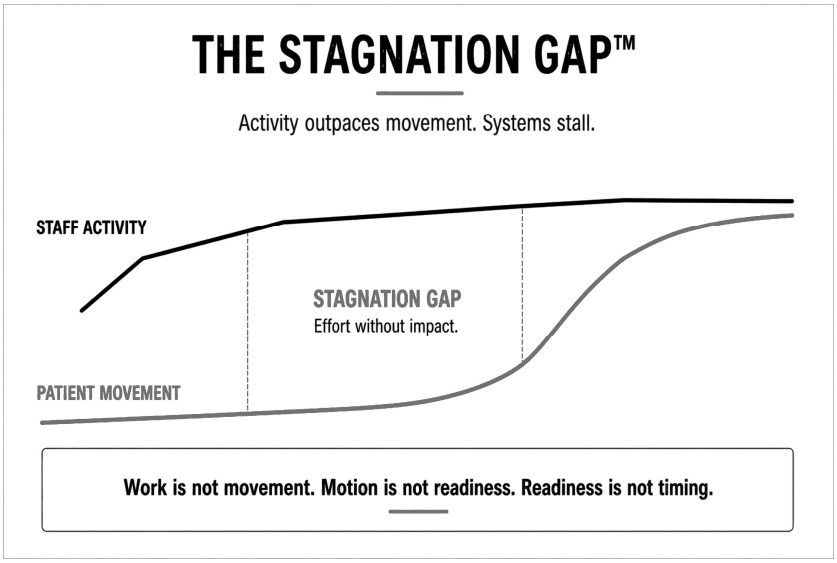

Figure 2: The Stagnation Gap

What This Book Does

The Stagnation Gap is not a slow morning. It is structural delay wearing the uniform of normal operations. Hospitals lose the day not in the surge but in the quiet stretch before

it, when activity is high, movement is absent, and no alarm has fired.

Naming it is the first act of leadership. You cannot close a gap you have not seen.

The Flow Operating System™ is not a new program. It is a description of forces already operating in your hospital every day. The question is whether those forces are aligned, or quietly compounding against you. Flow Physics™ explains why. The seven engines in Part Two show where those laws are honored or broken. The governance chapters that follow show what it takes to hold them.

Hospitals do not struggle because beds are full. They struggle because the system that unlocks those beds is invisible.

This book makes that system visible.

Movement inside a hospital is not luck. It is architecture. And architecture can be fixed.

Keep reading.

You've just read the foreword and introduction of When Beds Don't Move: How Flow Physics(TM) Reveals the Hidden Breakdowns Costing Hospitals Millions.

The full book covers the seven engines, the Five Laws of Flow Physics(TM), the Stagnation Gap(TM), and the leadership discipline that protects flow once you can see it.

Get the book:

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