Inpatient Flow Management Plan Procedure

Effective: 15 December 2016

Contents

1. Procedure

The pro-active management of hospital occupancy and the number of patients in the Emergency Department who are waiting for a ward bed is critical for successful hospital patient flow.

The Patient Flow Management Team (PFMT) membership includes:

- Coordinator of Nursing and Midwifery (CONM)
- Clinical Nurse Managers (CNM)
- Clinical Nurse Specialist (CNS)
- Nurse Manager.

This team is to meet Monday to Friday at 1000 hours and at additional times as required to discuss the current status of the hospital and to pre-empt the management of increased activity. If the hospital is at capacity (see section 7), then an additional 21.00 teleconference will be held between the evening and night duty Nurse Manager, CONM and any other personal determined by the CONM.

The Patient Flow Management Plan aims to predict periods of increased activity using data collected twice daily and develop a pro-active management plan to reduce the impact on hospital patient flow. This plan is designed to provide a coordinated response to the hospital wide bed capacity demands both elective and emergency.

The plan outlines the procedures and processes required to monitor the hospital bed capacity status 24 hours a day 7 days per week and ensure implementation of appropriate action when required.

The focus is on early action and the development of preventative strategies to avoid escalation to the next level. However in the event of unexpected increased activity, this plan details the processes linked to escalation and associated management strategies.

This will include:

- Emergency Department escalation status
- Bed capacity status for all clinical areas
- Hospital occupancy status
- Patients waiting more than 12 hours for emergency surgery
- Staffing levels (medical /nursing/clerical/allied health)

Linked to these processes is a traffic light system that will dictate the ongoing management. This is the Status Report and will trigger:

- Hospital Escalation Plan
- Nursing Staff Contingency Plan and Management of Over-census Patients.
- Daily breach reviews

1.1. Purpose

The purpose of the Inpatient Patient Flow Management Plan is to provide operational procedures for the Nurse Managers

1.2. Exclusions

This Inpatient Patient Flow Management Plan does not include the Adult Mental Health Inpatient Unit (beds=16), as this unit is managed by Great Southern Mental Health Services and the bed accountability is under the jurisdiction of the GS Mental Health Manager. The GS Mental Health service will collaborate with the Nurse Manager regarding bed status, and if the surge management plan is activated.

2. Definitions

For the purposes of this document the following definitions apply.

Bed Capability	Is defined as the number of normally staffed nursing multiday beds, this is determined by average bed occupancy.
Bed Capacity	Is the total number of multi-day beds (81), note this excludes mental health (16) and level 2 nursery beds (2).
Surge Beds	Is the difference between bed capacity and capability, with utilisation dependent of sourcing appropriately skilled nursing / unregulated staff to care for patients.
NHpPD	Nursing Hours per Patient per Day

3. Patient Flow

Patients are to be preferentially admitted into the ward that has the appropriately skilled nursing or midwifery staff to care for the patient according to the ward classification. That is:

- adult multi-day surgical patients will be admitted to the twenty two (22) bed surgical ward
- adult multi-day medical patients will be admitted to the twenty two (22) bed medical ward
- all paediatrics (defined < 16yrs) will be admitted to the paediatric ward (8), this includes short-stay paediatric patients and newborns (> 28 days old) whom require re-admission. Newborns (<28 days old) whom require re-admission are preferably admitted to Maternity as appropriately equipped and staffed with midwives skilled in this speciality area. Note Albany hospital does not have designated child and adolescent mental health unit.
- all pregnant women with a gestation > 20 weeks will be admitted to the maternal and newborn unit, with a primary maternity related presentation, with overflow onto the surgical ward.
- Acute rehabilitation patients whom have been assessed as having potential to benefit from a period of rehabilitation will be waitlisted for the Subacute Inpatient Unit /or will be admitted directly to the Subacute Inpatient Unit.
- Albany Health Campus contracts 1, 460 bed days per annum of inpatient palliative care beds from Albany Hospice Inc, determining suitability for transfer is coordinated via the Clinical Nurse Manager – Palliative Care.

Unit	Baseline Nurse Staffing	Patient Flow Principles
Medical	Staffed for average bed occupancy to meet NHpPD 5.5 nursing hours per patient per day Combined Medical / Paediatric nurse staffing of 7:7:4 roster profile. This includes the shift coordinator	Once adult medical bed capacity of 22 beds is reached, adult admissions need to be diverted as follows: 1. Surgical Ward 2. Subacute Ward 3. Maternity Ward 4. Commence filling paediatric beds, with adult medical patients. If full occupancy occurs, patient acuity needs to be considered with >2 patients requiring greater than 30 minute observations. It is appropriate to utilise Assistants in Nursing (AIN) for this added support.
Paediatric	Staff for average bed occupancy of 8 as part of the medical ward staffing profile.	Paediatric admission defined as >28 days old - 16 years. Newborns readmitted <28 days old and not having an infectious illness – need to consider if admission to maternity or paediatric ward location based on available skill mix and what is best for the newborn. Aim to keep one paediatric bed available for emergency presentations (however this should not be at the expense of an adult patient waiting in the emergency department for a bed). Need to consider day procedure admissions for the following day, prior to filling with adult medical patients
Surgical / Medical	Staffed for average bed occupancy to meet NHpPD 5.75 nursing hours per patient per day target. Two beds (rooms 9 &10, commonly referred to as maternity surge beds) which can be utilised for maternity patients.	If additional beds are utilised by maternity, support by surgical ward staff in the care of these patients would be provided. Staffing levels are assessed on a shift by shift basis, where staffing numbers may be increased or decreased depending on acuity and actual bed occupancy of the ward, including utilisation of AIN's
Subacute Inpatient Unit	Staffed for average bed occupancy to meet NHpPD target of 5.0 nursing hours per patient per day.	If additional beds are being utilised to a total of 15 patients, an additional 7 hours of nursing is required across the am/ pm shifts An AIN can be utilised on evening shift.

Continued…

Unit	Baseline Nurse Staffing	Patient Flow Principles
Maternity and newborn	Staffed to meet the NHpPD target of 9.95 nursing & midwifery hours per patient per day (inclusive of birthing and OT time) 1-2 labouring woman and 8 patients Roster profile is 3:3:3	Additional staff can be RN or EN, whom works under the delegation of the midwife.
High Dependency Unit	Staffed to meet the NHpPD target of 12 hours nursing time per patient per day, generally for 1:2-3 ratio, however if haemodynamically stable this ratio can be higher or if unstable or requires supported ventilation then 1:1 RN required	Third staff member can be experienced EN, or junior RN working under delegation of RN

3.1. Considering Paediatric Safety at Albany Health Campus

Paediatric safety is considered in all departments and wards that deliver services to children. The context of our facility is that we are unable to provide quarantined locations but steps are taken to minimise risk. PMH is available for consult at any time and Telehealth can be arranged. Close liaison with Dept. of Child Protection facilitates any special need requirement and involvement of the Social Worker.

Emergency Department		HDU		Medical / Children's Ward		Maternity	
Physical	**Clinical**	**Physical**	**Clinical**	**Physical**	**Clinical**	**Physical**	**Clinical**
Waiting room play area fenced – area not large enough to segregate from adults. Able to view room from triage	Rostered FACEM – management and discharge of children must be discussed with FACEM	Entry requires swipe access	Rostered Medical Specialist	Segregated wing	Rostered Paediatric trained nurses	Entry and exit requires swipe access	Medical Practitioner present at all births
		Small area, high staff ratio	Advanced skill nurses	Scrutinised allocation of beds to non-paediatric patients	Annual PLS	E-tag on newborns	All staff qualified Midwives
No dedicated bay – staff aware of admission and location of equipment	Paediatric experienced nurses		Telehealth ETS & PMH	All males > 16yrs admitted to adult section	Paediatric resus trolley	Restricted visiting hours	Annual neonatal resus
Decided on an individual basis visibility weighed against the child viewing ED activity	Annual PLS % with PALS		Annual PLS	Restricted visiting hours	Dedicated paediatric equipment		
	Designated paediatric resus equipment		Deploy Paediatric nurses from ward if special required	Parents welcome to stay			
Walled cubicles	Designated paediatric equipment			Doors on order to enhance segregation			
Entry and exit requires swipe access	Pre calculated paediatric drug doses available						
Paediatric appropriate distraction e.g. iPad, toys	Telehealth ETS & PMH						
	ORC PORC or NORC						
	NP with paediatric background						

- Across the facility all clinical staff are required to have a current Working with Children Check as a prerequisite to recruitment and ongoing employment. This process is managed by Human Resources.
- Any future redevelopment would take into account paediatric requirements.

3.2. Patient Flow Communication - Hospital

The Nurse Manager is responsible for

- Completing the bed state am report and circulating via email daily before 07.30 hours to the designated distribution list.
- Attending the daily 8.00 hours meeting in Emergency Department to update medical staff on the bed status of the hospital, patients of concern, numbers of discharges required, numbers of elective theatre requiring overnight bed and number of patients being transferred into Albany Hospital
- Attending the daily multidisciplinary meeting on the Medical and Children's, Subacute and Surgical wards
- Attend and document the 10.00 bed management meeting held with CONM and each Clinical Nurse Manager on duty
- Completing the pm bed state report and circulate to the CONM and RDNMS by 16.00 hours
- Establish if further reporting is required on an as needed basis, and dependent on the hospital capability.
- Timely recruitment of casual AIN's, EN's and RN's.

The CONM is responsible for:

- Attending the Medical & Children's Ward, Surgical Ward and Subacute Ward daily discharge meeting every Friday
- Reporting to the GS Executive weekly each Friday by 15.00 hours:
  - length of stay > 7 days for inpatients in AHC and discharge management plan
  - patients whom are care awaiting placement, nominated residential care facilities
  - patients on dialysis waitlist as ready for care
  - emergency department breach report summary

The Clinical Nurse Manager – Palliative Care is responsible for:

- Facilitating the correct inpatient classification for palliative care
- Maintaining a waitlist and priority of transfer to Albany Hospice and communicating this to the Nurse Manager
- Providing a daily report (Monday – Friday) to the Nurse Manager, CONM, CNM Medical & Paediatric, CNM Surgical and Director Nursing & Midwifery on community, inpatient and hospice activity.

3.3. Safe Nurse Staffing Principles

The Clinical Nurse Managers (CNM) utilise safe nurse staffing principles by:

- Rostering to the units designated NHpPD and activity profile to manage nursing workload
- Actively managing planned leave to ensure service continuity, particularly known increased activity times or reduced availability of casual nurses.

- Timely recruitment following reduction in FTE to staffing establishment
- Forward planning for booking of agency nurses, so as not to deplete casual nurse utilisation for unplanned leave.

Prioritisation for unplanned leave replacement includes utilising:

- Internally re-deploying staff, from areas of lower activity, including third midwife if no women labouring; second nurse from HDU if only wardable patients in HDU. Nurses/midwives redeployed from maternity, HDU, ED, Surgical services may not be able to take a patient load, but be tasked with nursing care duties to enable return to their clinical area should the situation change.
- On-call staff if available (excluding theatre)
- Casual nursing staff
- Offer extra hours to part-time nursing staff
- Redeployment of nurses from essential skills or training to clinical area
- Offer overtime to full time nursing staff then to non-rostered CNM and Nurse Managers.
- Clinical Nurse Manager/specialist for area redeployed from non-clinical to shift-coordinator for morning staff (consideration will need to be made of the CNM's schedule and how often they have been redeployed). The Nurse Manager is then responsible for staffing of that ward area for the next 24 hours.
- Staff development nurses redeployed to clinical area (consideration will need to be made if the SDN is scheduled to be delivering training)
- Redeploy HITH staff on rostered management day
- Redeploy outpatient clinic staff to inpatient clinical area;
- Coordinator of Nursing & Midwifery deployed to be Nurse Manager, Nurse Manager to clinical area.

Prioritisation to manage surge activity:

- Review HITH activity and consider impact of redeploying HITH nurses to inpatient areas
- Specialist nurses – infection control, diabetes nurse, workforce nurse redeployed to nursing tasks in clinical area
- Coordinator of Nursing & Midwifery deployed to be nurse manager, nurse manager to clinical area
- Nurse Director is redeployed to nursing tasks in clinical areas
- Allocation of a transfer Nurse to ensure prompt movement between departments
- Rescheduling of elective theatre lists and redeployment of theatre staff to clinical areas
- Closure of outpatient clinics in order of priority:
  - Maternity booking in clinic, Pre-Admission Clinic
  - Cancer Nurse / Breast Care Nurse / Palliative Care
  - Wound clinic / urology clinic / medical specialist nurse

- Closure of either Bremer Bay or Jerramungup Nursing Post and deployment to Albany

· Regional request for nursing staff, including child health and school health nurses

· Consider changing shift profile to 2 x 12 hours, particularly in maternity, HDU and ED

3.4. Bed Capacity Strategies

The three BCS levels are outlined below and contain descriptors of scenarios which can trigger the hospital wide response. In each level a series of actions will be implemented to ensure that the risk to patients is minimised.

The colour coded BCS will be declared at 0830 and 1500 (will include 2100 in the future, should the hospital be functioning in the red zone).

Green	Ward notification of capacity to manage patient flow. Continue with normal daily operations
Amber	Nearing Capacity and requirement for opening of over capability beds, if available staffing allows Inpatient Teams will contact respective Consultants regarding transfer of patients to hospitals within GS and for early discharge decision making Over capacity beds includes · Two beds in subacute unit · One bed in high dependency unit · Four ED Observation beds Consideration of rescheduling elective theatre admissions – can only be determined by the CONM or delegate
Red	Working over capability bed capacity with the opening of additional beds on subacute (2); HDU (1) and ED Observations (4), additional day stay beds may need to be considered utilised for multi-night beds · Twelve DOSA beds · Three birthing suite beds Contact CONM to determine need to call Code Yellow

3.4.1. Maternal and Newborn Unit

Should there be more than eight women requiring multi-night admission, the Maternity Clinical Nurse Manager or delegate (shift coordinator) will be required to identify women whom may be:

- Delay booked inductions and LUSCS if safe to do so
- Antenatal admissions, for internal transfer to medical ward
- Safe for discharge
- discharged on early discharge program
- likely for discharge within the next 24 hours
- identify care that can be delivered by a nurse

There are a further two designated maternity surge capacity beds (rooms 9 and 10) that form part of the mother and baby tagging system. Should additional beds for maternity be required, these rooms will continue to flow on following room 10, into the surgical unit.

It is expected that the Maternity Clinical Nurse Manager or delegate, will be required to identify women whom can be cared for by nurses. It is expected that these women will be provided with at least a daily midwifery assessment, review and update of their written plan of care, including next expected review time. The nurses will be providing care under the delegation of the midwifery staff.

Should maternal beds be required to be utilised for non-maternal patients, then the following decision making is applied in order of priority

- gynaecological surgical women
- surgical adult females
- general surgical adolescent females (15-18), minor (appendectomy)
- medical adult females, without respiratory illness, highly infective process, dementia or confusion
- surgical adolescents males (15-18 year old)

3.4.2. Surgical Unit

The surgical unit is a 22 bed unit. The unit is staffed with 5.75 nursing hours/day per patient consisting of a rostering profile of 6:6:3.

3.4.3. Medical and Children's Ward

The Medical and Children's Unit is a 22 bed adult medical unit and an 8 bed Paediatric Unit. The combined unit is staffed with 5.5 nursing hours/day per patient consisting of a rostering profile of 7:7:4 Monday to Sunday.

Where possible the Medical and Children's Ward will admit to a total of 29 patients. This will ensure there is capability to admit an emergency paediatric theatre case, whether a multi-day or single day stay admission, but not at the expense of an appropriate patient remaining in ED for greater than 4 hours over night.

Paediatric admitted patients will be given preference for admission to this ward, therefore greater than eight paediatric patients, will be accommodated on the medical ward. Adult medical patients may need to be transferred to Surgical or Subacute, to accommodate paediatric patients.

Where possible, the Medical / Paediatric Ward will admit to a total of 29 patients. This will ensure there is capability to admit an emergency paediatric theatre case, whether a multi-day or single day stay admission.

The wing of the eight paediatric beds are utilised for, in order of priority

- paediatric patients
- female adult
- male patients requiring 1-2 person assist with mobilisation

Prisoners should not be located in this wing of the ward.

3.4.4. High Dependency Unit

The high dependency unit is staffed to enable care for patients on a 1:(2-3) ratio or 12 hours per/day/patient of nursing care. Patients with invasive or acute non-invasive ventilation assistance will require 1:1 nursing. Due to the high variability of admissions to this unit, the nurse manager may admit non-HDU criteria patients to utilise the existing nursing staff, particularly those patients that may require a nurse special until more definitive arrangements can be put in place. This should be undertaken in consultation with the HDU Clinical Lead and the medical governance for the patient should be clearly articulated to the nurses, that is the patient under the care of the HDU medical staff or admitting team.

3.4.5. Subacute Rehabilitation Inpatient Unit

The Subacute Inpatient unit is staffed for 13 beds on the current nursing roster profile, and 12 beds for rehabilitation. There is no additional FTE currently funded to provide allied health cover to inpatients when bed capacity exceeds 12 beds.

The current bed management principle is for 12 subacute patients and one medical patient. In consideration of allied health input for the additional medical patient and if the additional 2 beds are utilised during surge periods allied health intervention will be based on patient needs/priority. Ideally patient selection for transfer when beds increase from 12 to 13+ beds to include:

1. patients requiring minimal rehabilitation / allied health intervention
2. patients with discharge plans completed or near completion

3.4.6. Emergency Department

Albany Hospital generally admits an average of thirteen (13) patients through the emergency department per day.

Refer to ED surge management plan, for intra-departmental surge strategies.

3.5. Hospital Surge Management Strategies

The Clinical Nurse Managers or Nurse Manager after-hours is responsible for filling all staffed beds according to the previously described prioritisation, then following approval:

1. Review multiday patients on the theatre list and reschedule
2. Reschedule inter-regional transfers
3. Reschedule intra-regional transfers (both admitted and emergency)
4. Fill HDU to six beds, this may include 'wardable' patients
5. Open Ed Observation beds with one registered nurse, ensure that the inpatient medical teams are informed that the medical governance is with the nominated SMP teams
6. Cancel day procedure cases and utilise day procedure beds and staffing for patients.

	Predicted or Actual Hospital Bed Occupancy	Bed Capacity (n=81)	Nurse Manager Actions
Green	< 85% total bed occupancy Nurse staffing within NHpPD	<69 beds	Normal discharge planning strategies
Amber	85 – 98%, nurse staffing within NHpPD and less than 5% under NHpPD	73-78	**73 - 77 bed utilisation** Review all nursing specials for the need of a nurse or carer or if can be co-located i.e. 1:2 Seek approval from CONM, to staff beds in Subacute 1300 and 2100 hours bed report sent to CONM and ND Active discharge actions: · Early engagement with inpatient medical teams for active discharge follow-up with all medical teams for those patients close to discharge · Delay inter-hospital transfer for patients located outside of the Great Southern · Negotiate early transfer of GS patients back to hospital closer to home.

	Predicted or Actual Hospital Bed Occupancy	Bed Capacity (n=81)	Nurse Manager Actions
Amber *Cont'd…*			**>77 beds utilised** 1300 hours bed management meeting between CONM & Nurse Manager and relevant CNM's (e.g. Surgical Services) Theatre manager to review elective surgery list with surgeon for potential delay of surgery. CONM to approve all postponements of elective surgery patients. CONM, in consultation with the Director of Medical Services, to request Medical Directors Office to send out SMS message to all GP's: *"Albany Hospital very full. Please assist by discharging patients ASAP if safe to do so"* Request Medical Director to undertake review of nurse identified patients that can be discharged and facilitate discharge discussions with admitting team. **Direct admissions requests from GPs** Negotiate delayed admission; or GP to facilitate discharge of another patient to accept admission, or admission will need to be directed through the emergency department **Inter-hospital transfers within GS** Negotiate delayed transfer time or day; or patient will need to be transferred to another suitable hospital. **Adult Mental Health**, if APU does not have beds, then MHM to alert Mental Health State-wide bed management.

	Predicted or Actual Hospital Bed Occupancy	Bed Capacity (n=81)	Nurse Manager Actions
Amber *Cont'd…*			**Care Awaiting Placement**– Aged Care Duty Officer to be contacted to assist with any respite or potential transfers to RCF in Albany. Contact the MPS Operations Manager re decanting to MPS sites. Theatre manager to review elective surgery list with surgeon for potential delay of surgery. CONM approval is required for all postponements of elective surgery patients.
Red	>98% beds, nurse staffing <10% under NHpPD	>79	Implement nurse staffing strategies to care for patients that cannot be accommodated in inpatient units
Code Yellow alert declared by the Coordinator of Nursing & Midwifery or delegate once hospital at bed capacity of 81 beds AND 4 ED Observation beds open. **Code Yellow response is declared by the Coordinator of Nursing & Midwifery or delegate once hospital meets above criteria and:** · **3 labour suite beds required and/or** · **DOSA beds are opened for multi-day stay patients.**			

Addendum 1: Action Plan to Utilise DOSA for Ward Patient

Issue	Action	Responsibility Business Hours	Responsibility After hours
Decision made to use DOSA area	Open DOSA	CONM	Nurse Manager
Communicate decision	Notify Regional Medical Director, Regional Nurse Director, Administration Services, Hotel Services, Supply, Pharmacy A/hrs notify -switch/medical records/reception	CONM	Nurse Manager
Staffing (nursing) for DOSA (in hours)	Source senior RN who can work independently	Nurse Manager	
Staffing (nursing) for DOSA (after hours)	Two nurses (one a senior RN), may need to consider use of AIN's		Nurse Manager
PSA for meals / cleaning / assist nurse	Source PSA	Hotel Services Coordinator	Nurse Manager
Suitable patients	Preferably short term patients, independent transfer, no micro alerts, clinically stable. If a patient deteriorates, they are to be swapped with another ward patient.	Nurse Manager	Nurse Manager
Clerical support	Consider extra clerical support or use existing clerks	Administration Services Manager	Administration Services Manager or Nurse Manager

Issue	Action	Responsibility Business Hours	Responsibility After hours
Patient stretcher/trolley/beds	Stretchers / trolleys / beds required, existing day chairs to be relocated	Theatre CNM	Orderlies
Linen	Consider extra supply or extra restocking of linen	Support Services	Nurse Manager
Medication	Patients medication in marked container, located in medication room in recovery	RN	RN
Heart tables for patient meals	5 heart tables to be located	Support Services	Orderlies
Nutrition needs	Use recovery area 3 journey board	RN to update journeyboard N:\journey boards\Overflow	Nurse manager to advise Kitchen N:\journey boards\Overflow
IT access	2 computers available at nurses station, may need to consider laptops or COW	Theatre CNM assesses on a needs basis	
Tracking of patient	Use the current journey board system	RN	N:\journey boards\Overflow

Issue	Action	Responsibility Business Hours	Responsibility After hours
Phone access	Dedicated Wi-Fi phone to ensure consistent phone calls to area – reducing disruption to the DOSA staff	CNM theatre CNM to allocate a Wi-Fi phone number	Nurse Manager to allocate phone and advise switch
Patient information	Patient pamphlet explaining why they are located in recovery area 3, (including requesting limited property, limited phone access, no TV, restricted visitors, no flowers, mobile phones can be used)	CONM	

Addendum 2: Maternity and Newborn Escalation Plan	
Green	No action Required · The unit has a designated shift coordinator. · Nurse staffing levels are in accordance with NHpPD model **and** skill mix is optimal to cover key designated roles (ward, nursery, clinics and visiting maternity services). · The unit is **able** to accommodate elective admissions and commence inductions of labour. · There is capacity to enable unplanned admission of a patient requiring full maternity intervention.
Amber Actual activity at bed capacity and/or minimum staffing levels and is insufficient to safely manage any further activity	Shift Coordinator to escalate to CNM (in hours) or NM (after hours) with documented contingency. · Impact of red status elsewhere on campus is impacting staffing levels and bed status. · Nurse staffing levels are **not** in accordance with NHpPD model **and** skill mix is sub optimal, viable contingency. · The unit is **unable** to accommodate elective admissions **or** commence inductions of labour. · There is no capacity to enable unplanned admission of a patient requiring full maternity intervention. The CNM (in hours), or most senior midwife (after hours) following discussion with CONM/NM will: Inform the Consultant or on-call GPO to discuss the capacity and access issues and develop a plan to: · delay booked inductions and LUSCS if safe to do so · antenatal admissions, for internal transfer to medical ward · safe for discharge · discharged on early discharge program · likely for discharge within the next 24 hours · identify care that can be delivered by a nurse It is expected that the Maternity Clinical Nurse Manager or delegate, will identify women whom can be cared for by nurses. It is expected that these women will be provided with **at least a daily midwifery assessment, review and update of their written plan of care, including next expected review time.** The nurses will be providing care under the delegation of the midwifery staff. This list is to be provided to the Nurse Manager / CONM.
Red Maternity services have exhausted all potential solutions	Escalation to CNM (in hours) or NM (after hours) for hospital wide contingency · Nurse staffing levels are not in accordance with NHpPD model and skill mix is sub optimal, no viable contingency. · The unit is unable to accommodate elective admissions and commence inductions of labour. · There is no capacity to enable unplanned admission of a patient requiring full maternity intervention. · Labour suites, clinic rooms and residential units are occupied.

Continued…

Addendum 2: Maternity and Newborn Escalation Plan	
Red **Maternity services have exhausted all potential solutions** *Cont'd…*	Red light indicates that the maternity service is on bypass. A decision has been made to temporarily restrict admission until capacity can be restored. The decision to go in maternity bypass is made collaboratively by the most senior midwife, in collaboration with the CONM/Regional Director Nursing & Midwifery Services, Consultant and Medical Director. **A code yellow is declared.** Following authorisation by the CONM, the Nurse Manager: · Birthing suite beds maybe utilised to hold admitted women, until a bed becomes available. · Theatres may need to be utilised for birthing if no other bed capacity to manage. · Midwifery shifts transition to 12 hour shifts where possible. · Community and clinic staff with midwifery experience are called to assist (this may involve cancelling clinic appointments). Inform GS district hospitals that women presenting in labour will be required to be transferred to another birthing site, not transferred or directed to Albany Health Campus; All relevant staff on duty will be informed of the bypass situation. St John Ambulance control is to be informed of the bypass status.

Addendum 3: Surgical Unit Escalation Plan	
Green	No action Required Nurse staffing levels are in accordance with NHpPD model and skill mix is optimal to cover key designated roles (ward, clinic and admission liaison) Elective admissions can be accommodated There is capacity to enable unplanned admission of a patient requiring full surgical intervention
Amber	**Shift Coordinator to escalation to CNM (in hours) or NM (after hours) with documented contingency.** · Nurse staffing levels are not in accordance with NHpPD model and skill mix is optimal, viable contingency · The ward is **unable** to accommodate elective admissions · There is **no** capacity to enable unplanned admission of a patient requiring full surgical intervention. High risk patients on wards were visual surveillance of > 30 minutes is required (falls, cognitive impairment), requires escalation to CNM or NM. Bed management strategies will look to move non-surgical patients to accommodate adult surgical patients on this unit.
Red	**Escalation to CNM (in hours) or NM (after hours) for hospital wide contingency** · Nurse staffing levels are **not** in accordance with NHpPD model **and** skill mix is sub optimal, **no** viable contingency. · The ward is **unable** to accommodate elective admissions. · There is **no** capacity to enable unplanned admission of a patient requiring full surgical intervention. Bed management strategies will look to move non-surgical patients to accommodate adult surgical patients on this unit. If nurse staffing shortage and no immediately available assistance is available, the shift coordinator is to: · change the care delivery model from patient allocation to team model of nursing care · nominate a team leader (Registered Nurse) for a nominated group of patients · Team Leader is to designate nursing care tasks – medication administration, vital sign observation surveillance to staff in team · call 1-2 hourly team briefings · escalate to CONM/Regional Nurse Director if patient safety is at risk. Consideration of rescheduling elective theatre cases is undertaken in the context of hospital wide capacity and staffing.

Addendum 4: Medical and Children's Unit Escalation Plan	
Green	No action Required Nurse staffing levels are in accordance with NHpPD model **and** skill mix is optimal to cover key designated roles (ward, clinic and admission liaison) Elective admissions can be accommodated There is capacity to enable unplanned admission of a patient requiring full surgical intervention
Amber	**Shift Coordinator to escalation to CNM (in hours) or NM (after hours) with documented contingency.** · Nurse staffing levels are **not** in accordance with NHpPD model **and** skill mix is optimal, viable contingency · The ward is **unable** to accommodate elective admissions · There is **no** capacity to enable unplanned admission of a patient requiring full medical and/or paediatric High risk patients on wards were visual surveillance of > 30 minutes is required (Falls, Cognitive Impairment, Suicide Risk); requires escalation to CNM or NM. Bed management strategies will look to move adult patients to accommodate paediatric medical and surgical patients on this ward
Red	**Escalation to CNM (in hours) or NM (after hours) for hospital wide contingency** · Nurse staffing levels are **not** in accordance with NHpPD model **and** skill mix is sub optimal, **no** viable contingency · The ward is **unable** to accommodate elective admissions · There is **no** capacity to enable unplanned admission of a patient requiring full surgical intervention Bed management strategies will look to move adult patients to accommodate paediatric medical and surgical patients on this ward. If nurse staffing shortage, and no immediately available assistance is available the shift coordinator is to: · Change the care delivery model from patient allocation to team model of nursing care · Nominate a team leader (registered nurse) for a nominated group of patients · Team leader is to designate nursing care tasks – medication administration, vital sign observation surveillance to staff in team. · Call 1-2 hourly team briefings · Escalate to CONM/Regional Nurse Director if patient safety is at risk. Consideration of rescheduling elective theatre cases is undertaken in the context of hospital wide capacity and staffing

Addendum 5: High Dependency Unit Escalation Plan	
Green	No action Required Nurse staffing levels are in accordance with NHpPD model and skill mix is optimal to cover key designated roles (ward, clinic and admission liaison) There is capacity to enable unplanned admission of a patient requiring high dependency intervention
Amber	**Shift Coordinator to escalation to CNM (in hours) or NM (after hours) with documented contingency.** · Nurse staffing levels are **not** in accordance with NHpPD model **and** skill mix is optimal, viable contingency · The unit is **unable** to accommodate admissions · There is **no** capacity to enable admission of a patient requiring full high dependency care. · Impact of red status elsewhere on campus is impacting staffing levels and bed status Bed management strategies will look to move 'wardable' patients from high dependency unit Patients requiring high dependency support will need to be transferred to another appropriate hospital.
Red	**Escalation to CNM (in hours) or NM (after hours) for hospital wide contingency** · Nurse staffing levels are **not** in accordance with NHpPD model **and** skill mix is optimal, viable contingency · The unit is **unable** to accommodate admissions · There is **no** capacity to enable admission of a patient requiring full high dependency care. If nurse staffing shortage, or particularly skill shortage (ventilation) and no immediately available assistance is available the shift coordinator is to: · Change the care delivery model from patient allocation to team model of nursing care · Team leader is to designate nursing care tasks – medication administration, vital sign observation surveillance to staff in team, this may include unregulated workers or nurses not familiar with the environment · Call 1-2 hourly team briefings Patients requiring high dependency support will need to be transferred to another appropriate hospital.

Addendum 6: Subacute Inpatient Rehabilitation Unit Escalation Plan	
Green	No action Required Nurse staffing levels are in accordance with NHpPD model and skill mix is optimal to cover key designated roles (ward, clinic and admission liaison). Elective admissions can be accommodated. There is capacity to enable unplanned admission of a patient requiring full surgical intervention.
Amber	**Shift Coordinator to escalation to CNM (in hours) or NM (after hours) with documented contingency.** · Nurse staffing levels are **not** in accordance with NHpPD model **and** skill mix is optimal, viable contingency · The ward is **unable** to accommodate elective admissions · There is **no** capacity to enable unplanned admission of a patient requiring full surgical intervention High risk patients on wards were visual surveillance of > 30 minutes is required (Falls, Cognitive Impairment, Manual Handling); requires escalation to CNM or NM. Bed management strategies will look to move non subacute patients to take subacute patients. May also include filling to 15 beds.
Red	**Escalation to CNM (in hours) or NM (after hours) for hospital wide contingency** · Nurse staffing levels are **not** in accordance with NHpPD model **and** skill mix is sub optimal, **no** viable contingency · The ward is **unable** to accommodate elective admissions · There is **no** capacity to enable unplanned admission of a patient requiring full surgical intervention · Impact of red status elsewhere on campus is impacting staffing levels and bed status. Consideration of accepting out of inter-hospital patient transfer's is undertaken in the context of hospital wide capacity and staffing If nurse staffing shortage and no immediately available assistance is available the shift coordinator is to: · change the care delivery model from patient allocation to team model of nursing care · nominate a team leader (Registered Nurse) for a nominated group of patients · Team Leader is to designate nursing care tasks – medication administration, vital sign observation surveillance to staff in team · call 1-2 hourly team briefings · escalate to CONM/Regional Nurse Director is patient safety is at risk. Consideration of rescheduling elective theatre cases is undertaken in the context of hospital wide capacity and staffing

Addendum 7: Theatre Escalation Plan	
Green	No action Required Direct care nurse staffing levels are in accordance with ACORN and skill mix is optimal to cover key designated roles (theatre, recovery and day procedure). Elective admissions can be accommodated. There is capacity to enable unplanned admission of a patient requiring full surgical intervention. Instrumentation and surgical implants are available.
Amber	**Shift Coordinator to escalate to CNM (in hours) or NM (after hours) with documented contingency.** · Nurse staffing levels are **not** in accordance with ACORN **and** skill mix is optimal to cover key designated roles, viable contingency. · Elective admissions **cannot** be accommodated. · There is **no** capacity to enable unplanned admission of a patient requiring full surgical intervention. · Instrumentation and surgical implants are **not** available.
Red	**Escalation to CNM (in hours) or NM (after hours) for hospital wide contingency** · Nurse staffing levels are **not** in accordance with ACORN Standards **and** skill mix is sub optimal to cover key designated roles, **no** viable contingency. · Elective admissions **cannot** be accommodated. · There is **no** capacity to enable unplanned admission of a patient requiring full surgical intervention. · Instrumentation and surgical implants are **not** available.

Addendum 8: Day of Surgery Escalation Plan	
Green	No action Required Nurse staffing levels are in accordance with NHpPD model / roster profile **and** skill mix is optimal to cover key designated roles (theatre, recovery and day procedure) Elective admissions can be accommodated
Amber	**Shift Coordinator to escalation to CNM (in hours) or NM (after hours) with documented contingency.** Nurse staffing levels are in accordance with NHpPD model / roster profile **and** skill mix is **not** optimal to cover key designated roles (theatre, recovery and day procedure) Elective admissions **cannot** be accommodated.
Red	**Escalation to CNM (in hours) or NM (after hours) for hospital wide contingency** Nurse staffing levels are not in accordance with roster profile and skill mix is sub optimal to cover key designated roles, no viable contingency. Elective admissions cannot be accommodated. Impact of red status elsewhere on campus is impacting staffing levels and bed status.

Addendum 9: Hospital in the Home / Dialysis / Chemotherapy Escalation Plan	
Green	No Action required · Direct nurse staffing levels are in accordance with roster profile and NHpPD model and skill mix is optimal to cover key designated roles (HITH, Dialysis and Chemotherapy) · New patients can be accommodated in all specialties.
Amber	**HITH** · Nurse staffing levels are less than roster profile with viable contingency i.e. HITH nurse cannot work full shift. New admissions cannot be accommodated. HITH patients rescheduled if possible. Patients to attend HITH clinic to eliminate travel time. Patient list assessed and patients referred to external providers if possible. Escalated to CNM or CN. In the event of AHC Code Yellow due to bed block: · HITH patients assessed and referred to external provider if possible. · HITH patients to attend HITH clinic to eliminate travel time and increase capacity to admit. · Assess rostered workforce and their ability to work overtime to increase capacity to admit. · Plan to conduct extra short HITH clinic, in addition to on road schedule, to increase capacity to admit. **DIALYSIS** · Nurse staffing levels are not in accordance with roster profile and skill mix is suboptimal with viable contingency i.e. only one trained dialysis nurse available. Dialysis patients rescheduled when optimal staffing available which could include Sunday. Escalated to CNM or NM. The unit could manage 2 days of suboptimal staffing levels. · Waitlisted Dialysis patient list exceeds service capacity. · Escalate to CNM. BN with request to increase FTE and expand service to accommodate waitlisted patient/s submitted to CONM and ND for consideration and decision. · Unable to provide dialysis services due to RO failure. Engage maintenance and equipment service provider to assess and give estimated time when dialysis services can resume. If within 2 days, patients to be rescheduled. Service resumption time to be evaluated every 8 hours and escalation plan revised. Escalated to CNM, NM, CONM and ND. **CHEMOTHERAPY** · Nurse staffing levels are not in accordance with roster profile and skill mix is sub optimal with viable contingency (chemo trained CN plus general RN) Chemotherapy may need to be rescheduled. Task orientated nursing model adopted to allocate non cytotoxic duties to general RN. Escalated to CNM or NM. Overtime may be necessary.

Red	**HITH** · HITH service cannot be provided due to lack of qualified staff. New admissions cannot be accommodated. HITH patients rescheduled if possible. Patients referred to external provider if appropriate. HITH patients to attend ED for treatment or be transferred to inpatient ward. Escalate to CNM or NM and CONM. **DIALYSIS** · Nurse staffing levels are not in accordance with roster profile and skill mix is suboptimal with no viable contingency i.e. suboptimal staffing for more than 2 days and unable to continue service Dialysis patients triaged and those in need of urgent dialysis transferred to Metro for immediate dialysis. Escalate to CNM or NM and CONM. · Unable to provide dialysis services due to RO failure for more than 2 days Dialysis patients referred to Metro for dialysis until Albany Dialysis services resume. Escalate to CNM, CONM and ND. **CHEMOTHERAPY** · Nurse staffing levels are not in accordance with roster profile and skill mix is suboptimal with not viable contingency i.e. no qualified staff available or only one qualified staff available for more than one week. Medical Registrar engaged to triage current booked chemo patients and refer all urgent cases to Metro chemotherapy services. Escalate to CNM or NM and CONM.

Addendum 10: Emergency Department Escalation Plan

Background

It is not possible, by virtue of the nature of the workloads in the Emergency Department, to adequately resource the department to manage all eventualities.

To assist both the ED and Albany Hospital manage times of peak demand and / or high acuity, a tool using commonly understood language and triggers has been developed. The ED Escalation Tool:

- considers the multiple factors that increase clinical risk
- outlines the steps to be taken to prevent or minimise the clinical risk during peak demand and / or acuity

Purpose

The purpose of this policy is to ensure a safe standard of patient care and a safe working environment for staff. The document provides decision making frame work consisting of;

- A standardised tool for determining departmental status impacting on patient flows, known as the “Escalation Matrix”
- Internal action and communication task list

Accompanying this is a statement of **ED Patient Flow Safety Standards** that underpin the aims of the ED in relation to safe and timely patient throughput.

Definitions

Escalation procedure: in the context of the Emergency Department, refers to the steps to be taken when the level of clinical risk does not meet defined patient flow safety standards. The escalation procedure is put into effect when a designated threshold, as per the matrix, is reached.

Escalation matrix: in the context of the Emergency Department, refers to the tool that staff will use to measure the departmental status in terms of

- Staffing
- Acuity
- Occupancy
- Disposition Expected patients
- Time of day
- Day of week

Green (score 7-10) – Business as usual. Meeting routine access targets, i.e. ATS targets, NEAT targets. Care is being delivered in an environment safe for both patient and staff.

Amber (score 11-13) – Department busy. Safety standards being compromised - clinical risk moderate. Routine access targets beginning to breach for reasons other than clinical appropriateness.

Red (score14-17) – Unsustainable workloads. Safety standards being breached - clinical risk high. Access targets being breached.

Flashing Red (score 18-24) – Unsustainable workloads. Safety standards being breached - clinical risk extreme. Continued breach of access targets.

Monitoring and Evaluation

1. Data collection

- An Escalation Matrix will be completed by the ED Shift Coordinator. If necessary, in collaboration with the FACEM or in their absence the Senior Medical Officer on duty.
- An Escalation Matrix will be completed **daily** at the following times:
  O955 hours / 1300 hours / 1600hours / 2100 hours and as required.
- This information will be communicated to the Nurse Manager Operations.

2. Evaluation

- The above data will be collected as above and saved for collation on a fortnightly basis.
- In collaboration with senior nursing staff the data will be analysed by the CNM ED and the Clinical Lead FACEM on a monthly basis.
- Recommendations from data analysis will be forwarded to:
  - Medical Director
  - Regional Nurse Director
  - Coordinator of Nursing

EMERGENCY DEPARTMENT PATIENT FLOW SAFETY STANDARDS

The Patient Flow Safety Standards are to ensure:

a) a safe standard of care is provided to all patients
b) unnecessary delays are minimised
c) the work environment for staff is optimal

Standard 1

All ATS 1 (immediately) and 2s (10 minutes) to be seen within allocated time frames.

Standard 2

All ATS 3/4/5s to be seen in order of clinical necessity.

Standard 3

Patients in the waiting room will be observed at least hourly.
This is to documented on the patients MR1.

Standard 4

All patients to have clinical decision, including inpatient team referral/admission (if applicable) within 90 minutes.

Standard 5

All patients awaiting cubicle allocation are accommodated within 10 minutes of a suitable cubicle becoming vacant.

Standard 6

All patients not requiring a trolley will be decanted in times of need (i.e. into a chair/back into waiting room)

Standard 7

In the circumstances listed below, the Escalation Matrix is to be reviewed by the Coordinator to determine if escalation is required:

a) Requirement for patient specials, e.g. mental health or intubated
b) Workloads preventing staff accessing suitable meal breaks as per the award

These business rules are to be adjusted following a twice yearly review of the Albany ED Escalation Tool.

ALBANY EMERGENCY DEPARTMENT ESCALATION MATRIX								
Total Score		**Green 7-10**	**Amber 11-13**	**Red 14-17**	**Red Flashing 18-24**			
Staffing (whole ED)	**Acuity (main ED)**	**Occupancy**		**Disposition / Transfer**	**Expected Patients**	**Time of Day**	**Weekend or PH**	**Total Score**
No nursing staff available outside of resuscitation area, excluding the Coordinator and Triage Nurse >1 patient 1:1 nursing care **4**	Actively treating ATS 1 patient or x 2 ATS 2s within 30 minutes **4**	All cubicles occupied with no alternative areas **3**	Waiting room occupancy 6-8 + fast track ≥6 patients ED Main patients in Fast track no nurse allocated **3**	> 3 patients awaiting transfer to ward **3**	>2 patients **3**	ND **3**	Yes **1**	
1 less than rostered staff, i.e. 1:1 nursing or medical patient special or out of department Support Services not meeting departmental needs **2**	Unable to see ATS 2s within 10 minutes Unable to see ATS 3s within 30 minutes Unable to observe waiting room pts at least hourly **2**	3 cubicles vacant No ability to decant to alternative areas **2**	Waiting room and fast track occupancy 4-5 patients Fast track operating without nurse allocated	≥ 2 patients waiting ward transfer or Obs ward open **2**	1 patient **2**	PM **2**		
All staff appropriately skilled, staffing numbers OK **1**	All patients seen within ATS targets **1**	Less than 4-5 patients and resuscitation room available **1**	Waiting room occupancy 2-3 patients **1**	< 1 patient waiting ward/transfer **1**	No one **1**	AM **1**		

ED Escalation Status: GREEN ED Capacity Escalation Score between 7 - 10	
Responsibility	**Action**
ED Coordinator	· Coordinate and monitor patient flow ensuring ATS and NEAT targets are met. · Prompts medical staff at 60 minutes re patient plan of care. · Facilitates staff meal break. · Completes ED status reports at 0955 / 1300 / 1600 / 2100. · Communicates ED status to Nurse Manager.
Clinical Manager ED	· Attends to managerial duties
ED Medical Staff	**FACEM / Senior Doctor on duty** · Ensure ATS and NEAT targets are met. · Ensure patient have a decision regarding disposition within 90 min · Receives all GP and inter-hospital referrals. · Approves holding of any patients awaiting team review / results of investigations, based on clinical need. **ED Medical staff** · Ensure ATS and NEAT targets are met. · Ensure patient have a decision regarding disposition within 90 mins. · Ensure nurse assigned to patient is aware of overall clinical plan.

<table>
<tr><th colspan="2">ED Escalation Status: AMBER
ED Capacity Escalation Score between 11 – 13
If you are commencing the escalation in AMBER status
ensure all GREEN actions have been implemented</th></tr>
<tr><th>Responsibility</th><th>Action</th></tr>
<tr><td>ED Coordinator</td><td>· ED Status Report → Discuss with FACEM or senior doctor on duty.
· Decant Clinically appropriate patients to waiting room.
· Decant clinically appropriate admissions to ward.
· Consider extra resource to monitor waiting room.
· Notify ED CNM (and after hours Nurse Manager) of Amber Status.
· In hours, expediate MI and pathology. After hours, Nurse manager to expediate.
· Reprioritize patients.</td></tr>
<tr><td colspan="2">There will be situations where it is more appropriate to call in ED nursing staff and not ward/HDU staff.
Call extra ED staff when
· Excepting 2 or more critically ill/trauma patients
· Overwhelming numbers of high acuity patients
Ward/HDU nursing assistance for
· Overcrowding of Department
· Additional staff for above situations but not instead of these staff
· Bed block, so ward nurse can commence ward admission and care for pt.
· Critically ill patient awaiting RFDS transfer (HDU Nurse or similar)</td></tr>
<tr><td>Clinical Manager ED</td><td>· Notifies Nurse Manager of Amber Status
· In hours, considers options of extra clinical and non clinical staff availability.</td></tr>
<tr><td>ED Medical Staff</td><td>FACEM or Senior Doctor on duty
· Ensure awareness of status of all patients in ED.
· In consultation with shift Coordinator:
- where clinically appropriate, expediate ward transfer of patients
- re-prioritise patients.
· Expediate consultations.
ED Medical Staff
· Actions as per Green status.
· Report to FACEM / Senior Doctor the status of their patients.
· Expediate referral of patients.</td></tr>
</table>

<table>
<tr><th colspan="2">ED Escalation Status: RED
ED Capacity Escalation Score between 14 – 17
If you are commencing the escalation in RED status
ensure all AMBER actions have been implemented</th></tr>
<tr><th>Responsibility</th><th>Action</th></tr>
<tr><td>ED Coordinator</td><td>· ED Status Report
· Review allocation of resources
· Activate staffing resources see below
· Notify FACEM and discuss situation
· Inform patients in waiting room of ED workloads and expected delays using proforma message

Re-consider extra resource to monitor waiting room</td></tr>
<tr><td colspan="2">There will be situations where it is more appropriate to call in ED nursing staff and not ward/HDU staff.

Call extra ED staff when
· Excepting 2 or more critically ill/trauma patients
· Overwhelming numbers of high acuity patients

Ward/HDU nursing assistance for
· Overcrowding of Department
· Additional staff for above situations but not instead of these staff
· Bed block, so ward nurse can commence ward admission and care for pt.
· Critically ill patient awaiting RFDS transfer (HDU Nurse or similar)
· X Ray nurse companion</td></tr>
<tr><td>Clinical Manager ED</td><td>· Becomes a clinical resource</td></tr>
<tr><td>ED Medical Staff</td><td>FACEM or Senior Doctor on duty
· Facilitate expedient review of patients.
· Consider invoking medical escalation if patients numbers / acuity preventing medical review in a clinically appropriate timeframe.
ED Medical Staff
· Actions as per Amber status.
· Report to FACEM / Senior Doctor the status of their patients.
· Expediate patient referrals and request review in ED as soon as possible.
· Expediate discharge of patients where clinically appropriate.</td></tr>
</table>

<table>
<tr><th colspan="2">ED Escalation Status: RED FLASHING
ED Capacity Escalation Score between 18 – 24
If you are commencing the escalation in RED FLASHING status
ensure all RED actions have been implemented</th></tr>
<tr><th>Responsibility</th><th>Action</th></tr>
<tr><td>ED Coordinator</td><td>· ED Status Report
Inform patients in waiting room of ED workloads and expected delays using proforma message</td></tr>
<tr><td colspan="2">There will be situations where it is more appropriate to call in ED nursing staff and not ward/HDU staff.
Call extra ED staff when:
· accepting 2 or more critically ill/trauma patients
· overwhelming numbers of high acuity patients.
Ward/HDU nursing assistance for:
· overcrowding of department
· additional staff for above situations but not instead of these staff.
· bed block, so ward nurse can commence ward admission and care for patient.
· critically ill patient awaiting RFDS transfer (HDU Nurse or similar).</td></tr>
<tr><td>Clinical Manager ED</td><td>· Is a clinical resource.</td></tr>
<tr><td>ED Medical Staff</td><td>FACEM or Senior Doctor on duty
· If after hours FACEM to come to ED Need to discuss other options.
· Consider further clinical escalation if clinically required.
· Consider notification of Medical Director.
ED Medical Staff
· Fast tracking admissions to ward areas for continuing medical workup.</td></tr>
</table>

Addendum 11: Authorised Psychiatric Unit Escalation Plan

Bed access prioritisation refers to the management of the expected admission list (EAL) for mental health inpatient beds so that patients receive access to beds according to specified principles in accordance with the *Mental Health Act 2014*.

Bed prioritisation reflects the needs of the individual patient, noting that this may be impacted by systemic needs of all patients on EAL and critical bed occupancy across Albany Hospital not just the APU. Consideration is to be given to the number of APU inpatients, the number of outlying mental health inpatients and medical ward bed capacity, and presentations to the emergency department either awaiting assessment and potential admission, or assessed and awaiting admission.

Bed access prioritisation for APU relates specifically to patients requiring open or secure secondary acute mental health beds and those requiring outlying beds. Patients with tertiary requirements, including forensic or chronic medical co-morbidity, should be registered through the appropriate tertiary referral service.

The highest acuity patients across the system get the highest priority access to a mental health bed in the APU and Albany Hospital. Any patient whose risk is exceedingly high based on immediacy of risk to self and others and low level of containment/containability who is unable to secure a bed in Albany Hospital should be escalated to the state-wide mental health bed management system.

	Predicted or Actual APU bed occupancy	**Bed capacity (n=16)**	**Nurse Manager Actions in consultation with Director of Psychiatry and/or Consultant Psychiatrist and/or Senior Medical Practitioner**
Green	81-87% occupancy	13 - 14 beds	Normal discharge planning strategies
Amber	93% occupancy	15 beds	Consider active discharge actions, prioritisation and resourcing. · Delay intra-regional hospital transfers if risk can be managed in MPS · Review capacity to accept state-wide bed management admissions · Actively review voluntary patients who may be suitable for discharge, discharge with community follow up, or transfer to another regional hospital to flag possible discharge to avoid 100% occupancy · Actively consider bed capacity on outlying wards and/or need for extra nursing staff to provide support to outlying wards if beds are available, or within APU due to increased acuity following transfer of lower risk patients to outlying wards

	Predicted or Actual APU bed occupancy	Bed capacity (n=16)	Nurse Manager Actions in consultation with Director of Psychiatry and/or Consultant Psychiatrist and/or Senior Medical Practitioner
Red	100% occupancy	16 beds	Consider active discharge actions, risk management and resourcing. Advise Manager GSMHS of bed status. · No intra-regional hospital transfers accepted. Specialist advice provided to admitting GPs to contain risk with MHLN assistance between hours of 0800 to 2000 and Rural Link after hours to negotiate metropolitan mental health beds · Community Mental Health (0830 to 1630) and Mental Health Liaison Nursing (0800 to 2200) support to prevent hospital admissions for voluntary patients · No capacity to accept state-wide bed management mental health admissions for patients outside of GS region. State-wide bed management to be advised of this situation. · Actively review voluntary patients who may be suitable for discharge, discharge with community follow up, or transfer to another regional hospital with in reach community mental health support · Refer high acuity patients to state-wide mental health bed management (9347 6641) for RFDS (1800 625 800) or road transfer to metropolitan or Bunbury APU while evaluating available mental health resources to ED to manage risk in the interim

Addendum 12: Pharmacy Escalation Plan	
Green	No action required. Business as usual.
Amber	No action required. Business as usual. Pharmacist prioritise discharge planning and coordination of medications of discharge.
Red	Pharmacists facilitate discharge medication coordination including supply of medication if required. Supply of basic medication to ED obs. Arrange regular top-up of imprest medication for ED and HDU. Prepare a list of on-call staff for the disaster coordinator to provide after hours service of medication supply or discharge coordination to the facility if required.

Addendum 13: Supply Escalation Plan	
Green	No action required · Business as normal · Supply operates Monday to Friday from 07:30 to 15:30 (excluding public holidays). · Inpatient Imprest areas checked and restocked as per set schedule - 3 times per week (ED, HDU, Medical and Surgical) - 2 times a week (Maternity and Subacute)
Amber	No major actions required · Business as normal · Inpatient Imprest areas – set schedule maintained. · Capacity to provide extra checks and top-ups to any areas experiencing increased bed occupancy. · ED Observation Beds (non Imprest area) – if staffed and open, stock checked and restocked on a regular basis as necessary.
Red	**Hospital in Red BCS and/or Code Yellow declared** · Supply team briefed on hospital situation. · Workload reviewed and prioritised. · Coverage planned for the possibility of service provision required outside of normal working hours. · Provide list of on-call staff to the disaster coordinator if after-hours/weekend Supply services are required. **Initial Action** · Supply increases the scheduled frequency of all inpatient Imprest areas to **daily** (excluding weekends and public holidays) checks and restocking. **Additional Actions** · Secondary daily checks and top ups of inpatient Imprest areas provided as necessary on a priority basis. · Hotel Services Imprests that service the inpatient areas are assessed and if required; increased checks and top ups are also implemented. · ED Observation Beds (non Imprest area): if staffed and open, stock checked and restocked on a regular basis as necessary. · DOSA beds (non Imprest area): if opened for multi-day stay patients; liaise with Shift Coordinator to determine what products required, location and frequency. Regular checks and top ups are provided as necessary. · Supply services required outside of normal working hours and on weekends/public holidays are to be determined in consultation prior with and/or as required by the disaster coordinator.

Addendum 14: Hotel Services Escalation Plan	
Green	No action required Business as usual
Amber	No action required for increasing resources. Business as usual. Prioritise PSA coverage to areas involved in Surge Management away from non-clinical areas. PSA prioritise tasks associated with discharge planning. Increase number of meals supplied to HDU/ED (affected area) trolley. Fully stock all ward linen trolleys at regular intervals. If extended, ensure P Card access for staff feeding contingencies.
Red	PSAs prioritise duties associated with discharge planning. Supply additional “floating” PSA support to ED Observation Ward and ward support. Prioritise PSA coverage to areas involved in surge management away from non-clinical areas. Prepare a list of staff contacts for the disaster coordinator to call staff as required. Fully stock all ward linen trolleys at regular intervals. Laundry shift extended to ensure linen flow. Increase spare meals supplied to all wards. Ensure P Card access for staff feeding contingencies.

Escalation for increased demand on services - Hotel Services					
	Situation	**Strategy**	**How**	**Who**	**Comments**
Hotel Services	**Open beds:**				
	Subacute	Absorbed			
	Short stay	Escalate	Extend PSA on shift. 2. call in on OT	Nse Mgr or Orderly on NM instruction	Notify kitchen to store food
	Obs beds	Escalate	Extend PSA on shift. 2. call in on OT	Nse Mgr or Orderly on NM instruction	Notify kitchen to store food
	Increased discharges/bed moves:				
	0630-2030	No escalation	Covered by shift and/or CMH and/or Sub acute. Notify kitchen to store food		Notify kitchen to store food
	2000-2330	No escalation if < 5	Covered by 'floater' and ED		
	2000-2330	Escalate if > 5	Extend Floater PSA and/or Theatre cleaners on OT, call avail casual or OT	Nse Mgr or Orderly on NM instruction	Notify kitchen to store food
	2100-0600	Escalate if greater than > 4	Extend Floater PSA and/or Theatre cleaners on OT or call in available casual or OT	Nse Mgr or Orderly on NM instruction	Notify kitchen to store food
	Activity increase ED				
	0630 - 1900	Absorbed	In house		
	2000 - 2330	Escalate	Extend Floater PSA and/or Theatre cleaners on OT or call in avail casual or OT (night cleaner of Orderly off)	Nse Mgr or Orderly on NM instruction	
	2300 – 0630	Escalate	Extend Floater PSA and/or Theatre cleaners on OT or call in avail casual or OT. Second night cleaner for Orderly support and catch up after.	Nse Mgr or Orderly on NM instruction	

Addendum 15: Administration Services Escalation Plan	
Green	No action required Business as usual
Amber	No action required Business as usual Administration Staff prioritise administration duties associated with discharge planning, phone calls, file preparation.
Red	Administration Staff prioritise administration duties associated with discharge planning, Phone calls, file preparation. Supply additional administration support to ED Observation Ward. Additional A/H ward support. Arrange regular top-up of paperwork supplies in and around key areas. Prepare a list of available staff for the disaster coordinator to provide after hours service of administration needs, including discharging, reception, switch.

Escalation for increased demand on services - Administration					
	Situation	**Strategy**	**How**	**Who**	**Comments**
Admin Services	**Open beds:**				
	Subacute	Absorbed	In House	nil	
	Short stay	Absorbed in work hours	In House	nil	
	Obs beds	Absorbed	In House	nil	
	Increased Discharges/bed moves:				
	0630-2030	No escalation	In house	nil	
	2000-2330	No escalation	In house	nil	
	2000-2330	No escalation unless ED over activity capacity	Prioritise immediate work at hand. Call in 0630 for catch up		
	2100-0600	Escalate by shift extension to switch or pm shift	Prioritise immediate work at hand. Call in 0630 for catch up	Nurse Manager (NM) or Med recs staff on NM instruction	
	Activity increase in ED				
	0630 - 1900	Absorbed	In house		
	2000 - 2330	Escalate	Extend pm shift. Prioritise immediate work at hand and catch up later.	NM or Med recs staff on NM instruction	
	2300 - 0630	Escalate	As above. Prioritise immediate work at hand. Call in 0630 for catch up	NM or Med recs staff on NM instruction	
Note: Every situation is different and it can be a 'fluid' environment. On advice from Nurse Manager/CONM instruction would follow during office hours from Manager, Administration Services. After hours Nurse Manager strategy prevails.					

Addendum 16: Allied Health Escalation Plan	
Green	· No action required. · Staffing levels are sufficient and skill mix is appropriate to support normal inpatient, ED, and outpatient services.
Amber	· Allied Health Manager to will consider redistribution of lower priority outpatient Allied Health resources to AHC inpatient wards, ED and high acuity outpatient services, consistent with WACHS Allied Health discipline specific Prioritisation Matrices. · Allied Health Manager to facilitate review with AHC Allied Health department and Supply regards the need to increase stocks of patient consumables and assistive equipment that maybe required for discharge or ED treatment. · No extra staffing or out of hours services required beyond existing rostering arrangements.
Red	· When AHC is required to increase inpatients beds if Code Yellow is declared, Allied Health Manager will consider redistribution of all outpatient Allied Health resources to inpatient and ED to facilitate safe and timely discharge, or provide emergency based treatment to assist in preventing admission, consistent with WACHS Allied Health discipline specific Prioritisation Matrices. · Allied Health Manager to facilitate review with AHC Allied Health department and Supply regards the need to increase stocks of patient consumables and assistive equipment that maybe required for discharge or ED treatment. · Consideration of high acuity Outpatient services will depend on GS Medical Services escalation plan re provision of OP services. · For periods of sustained Code Yellow activity that extend into weekends – Allied Health Manager to consider extra staffing requirements to maintain high acuity Inpatient and ED services for activity that would continue to facilitate safe and timely discharge or emergency based treatment that would assist in preventing admission.

Prioritisation Matrices

WACHS Intranet: WACHS Allied Health Clinical Prioritisation Framework

Addendum 17 Aged and Subacute Care (Whitehouse) Escalation Plan	
Green	· No action required. · Staffing levels are sufficient and skill mix is appropriate to support normal ACAT, OPI, HACC, gerontology and outpatient Subacute rehabilitation programs, including outreach to MPS sites.
Amber	· If inpatient Subacute ward is required to increase to 15 beds, Subacute Coordinator will consider redistribution of outpatient Allied Health resources to inpatient unit, consistent with continuing function of Subacute outpatient programs and regional outreach. Staffing and skill mix of outreach services may vary from normal staffing. · Daily ACAT/OPI team meeting will confirm appropriate prioritisation of hospital ACAT referrals for home, transitional and residential care packages. ACAT will action referrals accordingly. · Aged and Subacute Care team will monitor CAP Journey Board to ensure all known information is updated.
Red	· If inpatient Subacute ward is required to increase to 15 beds, Subacute Coordinator will consider redistribution of outpatient Allied Health resources to inpatient unit. If Code Yellow is declared, this may include reducing Subacute outpatient programs but maintaining 1:1 appointments and home visits for vulnerable outpatients. · Daily ACAT/OPI team meeting will confirm appropriate prioritisation of hospital ACAT referrals for home, transitional and residential care packages. ACAT will action referrals accordingly. If Code Yellow is declared, this may include rebalancing some ACAT activity from regional areas to Albany, depending on status and prioritisation of AHC referrals. · If Code Yellow is declared, Whitehouse Duty Officer will liaise with Albany aged care providers to confirm home care, transitional and residential care package vacancies and communicate this information to PFMT daily.

Addendum 18: Medical Services Escalation Plan	
Green	No action required.
Amber	**Working hours**: SMS authorised by Medical Director to all HODs and SMPs and GPs in Hospital "Bed occupancy nearing capacity, please review admissions towards discharging patients if safe to do so." Alerted medical staff to prioritise discharging of patients where safe to do so. Additionally with Inpatient Medical Unit: Nurse manager to alert medical staff at morning and afternoon handover. SMPS and interns to identify potential discharges. **After hours** (5PM to 8AM): AHNM to call ED SMP, Ward SMP on call and Surgical intern on call and advise them of situation. SMPs to consider and prioritise discharges for the following day..
Red	**Working hours**: SMS authorised by Medical Director to all HODs and SMPs and GPs in Hospital "Bed occupancy over capacity; please review admissions towards discharging patients if safe to do so." Alerted medical staff to prioritise discharging of patients where safe to do so. Medical Director to be alerted re direct admissions from Outpatients and GPs if Nursing requires assistance. Additionally with Inpatient Medical Unit: Nurse manager to alert medical staff at morning and afternoon handover. SMPS and interns to identify potential discharges. **After hours** (5PM to 8AM): Text as above to be sent to all HODs and SMPs. AHNM to call ED SMP, Ward SMP on call and Surgical intern on call and advise them of situation. SMPs are expected to come in and discharge patients where appropriate. If Code Yellow called, Medical Director to be alerted on the phone by CON.

Addendum 19: Palliative Care Team	
Green	· No Action required · Continued collaboration with community nursing providers/RACF to ensure palliative care patients are cared for effectively and in a timely manner in their own homes. · Regular updates regarding unstable, terminal ill patients from Silver chain and Clarence Community Care to plan suitable admissions to hospice if required. · Assist in discharge/transfer planning. · Monitor for any increase in support required for RACF. · Support of families/carers to prevent carer strain/burnout. · Promote Advance Care Planning and AHD.
Amber	· Morning handover for palliative care to prioritise unstable/terminally ill patients. · Update community services re reduced bed availability, increase home/RACF services as required. · Assist in discharge/transfer planning. · Attend ED as required to assist patients presenting, that are able to be discharged back to their home with increased support. · Promote GP home visits and or specialist palliative care reviews. · Seek respite beds for suitable patients. · Provide SW support for patients and families re RACF/ACAT options. · Support of families/carers to prevent carer strain/burnout. · Promote Advance Care Planning and AHD.
Red	· Liaise with primary care providers re maximising home care support. · Assist in discharge/transfer planning. · Attend ED as required to assist patients presenting, that are able to be discharged back to their home with increased support. · Liaise with RACF to ensure palliative care patients are managed in their own home, attend as necessary for symptom review etc. · Promote GP home visits and or specialist palliative care reviews. · Delay any potential palliative care patients visiting the Great Southern (unless terminal). · Support of families/carers to prevent carer strain/burnout. · Promote Advance Care Planning and AHD.

4. Compliance

It is a requirement of the WA Health Code of Conduct that employees "comply with all applicable WA Health policy frameworks."

A breach of the Code may result in Improvement Action or Disciplinary Action in accordance with the WA Health Discipline Policy or Breach of Discipline under Part 5 of the *Public Sector Management Act*.

WACHS staff are reminded that compliance with all policies is mandatory.

5. Evaluation

Monitoring of compliance with this document is to be carried out by Coordinator Nursing & Midwifery, Albany Health Campus every two (2) years, and/or following debrief of declared Code Yellow.

6. Standards

National Safety and Quality Health Care Standards (1-10), 1.1.2 and 1.2.1

EQuIPNational Standards (11-15), 11.3.1 and 13.2.1

7. References

Australian Nursing Federation - Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses – Industrial Agreement 2016

Draft, WACHS-SW Inpatient Patient Flow Procedure

Princess Margaret Hospital Patient Flow Management Plan Winter (2013)

Royal Perth Hospital, Communication and Escalation plan for Emergency Department Operations Manager and Bed Manger, After Hours Patient Flow Coordinator and Night Nurse Manager (2014).

Rural Palliative Care Model of Care

8. Related Policy Documents

WACHS Emergency (Disaster) Management Arrangements Policy

WACHS Nursing Roster Procedure (2015).

9. Related WA Health Policies

Admission, Readmission, Discharge and Transfer Policy for WA Health Services (2014)

Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is identified as at Risk of abuse and/or Neglect

Elective Surgery Access and Waitlisting List Management Policy (2015)

Emergency Codes in Hospitals and Health Care Facilities

Guidelines for Protecting Children 2015

10. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

This document can be made available in alternative formats on request for a person with a disability

Contact:	Regional Director of Nursing and Midwifery (C.Stainton)		
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