Central Adelaide Local Health Network

Demand Escalation Framework for the Management of Patient Flow and Demand.

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Government of South Australia

Health

Central Adelaide Local Health Network

Introduction

Patient flow is the movement of patients through a healthcare facility or system, and involves multidisciplinary care, resources and system support. The aim of patient flow is to provide access to patients which is timely, quality driven and provides community confidence in those services. At Central Adelaide Local Health Network (CALHN), our clinical care is provided by Programs and Services (including State-wide Clinical Support Services) and our systems and processes are enabled by the Network Operations Centre.

Hospitals are required to manage patient flows and demand to optimise their capacity to care for both planned and unplanned presentations and admissions. An effective strategy to manage capacity and meet demand is to have effective visualisation of the current state and the future forecast.

CALHN patient flow practices ensure there is the correct capacity (resources) available to meet the various demands for our services (planned and unplanned). It is recognised that there are many drivers as to why at times the demand may exceed availability including

- Periods of demand surge, including seasonal fluctuations
- Clinical variation including length of stay elongation
- Reduced community access and social support options
- Various improvement strategies around care provision such as reducing elective overdues or reducing outpatient waitlists
- During disaster or pandemic response

Purpose

The purpose of the CALHN Demand and Escalation Framework is to outline the staged responses, roles and responsibilities and triggers to activate targeted and coordinated escalation and action. This document describes a systematic process that is required to better manage activity demand by providing staff with clear roles and responsibilities and accountability in relation to optimising patient flow.

Objective

The objectives of the framework are to:

- Provide a patient centred approach to patient flow resulting in safe and quality patient outcomes.
- Better predictions (using CAPLAN) and providing a focussed and timely response to capacity mismatches (SystemView).
- Formalise an integrated proportionate response from all Programs and Services.
- Support efficient, robust, and resilient internal operational procedures to ensure an appropriate response to optimise outcomes.
- Preserve and provide smooth and timely access to quaternary services for the South Australian community that is only available at the Royal Adelaide Hospital.
- Work in tandem with other Local Health Networks (LHN's) who are also using the same framework to ensure language and system response is targeted (Table 1).

Table 1: Department of Health and Wellbeing Definitions

Category	Escalation	Definition
STANDARD ESCALATION Managed locally by individual Local Health Networks (LHNs)	**Green** Business as usual Level 1	Definition: Business as usual Hospitals able to maintain good patient flow and meet anticipated demand within available resources Action: Continue with local business as usual protocols and practices
	Amber Moderate Compromise Level 1	Definition: Initial signs of increased demand are starting to show. Focused actions are required to mitigate further escalation Action: Enact Local Escalation and Business Continuity Plans and execute minimum standard actions/ strategies in accordance with this policy. Enact over-census policy.
	Red Severe Compromise Level 2	Definition: The hospital and/or SA Ambulance Service (SAAS) is experiencing major pressure. Actions undertaken have not been successful and demand continues to increase Action: Risk mitigation required to ensure patient safety is maintained. Increase level of collaboration with peers and seek assistance across system to share the load
	White Extreme Compromise Level 3	Definition: Sustained excessive demand may impact the hospitals and/or SAAS ability to deliver comprehensive critical care and ensure patient and/or staff safety Action: initiate state-wide teleconference to determine further intervention. State-wide teleconference may result in escalation to State alert (Black/ State-wide escalation) and automatically trigger mandatory action
STATEWIDE ESCALATION Managed by DHW	**Black** **State Alert/ State-wide Escalation**	Definition: Pressure across the health system continues to escalate, leaving sites unable to deliver comprehensive critical care and ensure patient and/or staff safety Action: All available local escalation actions taken, external extensive support and intervention required. Decisive action must be taken to recover capacity and ensure patient safety.

Roles and Responsibilities

The roles and responsibilities in the CALHN Demand and Escalation Framework are linked to a series of escalation levels. Once the escalation level has been decided and communicated the risk matrix process is to commence. The Program Delivery team engagement across the sites is essential to ensure a proactive approach to effective flow, capacity, and recovery – that is, this escalation plan required a multi-site and multi-program/service response to be successful.

Early escalation of any capacity issues is key to enabling awareness, identify key actions and ensure patient flow is efficient and can responds to the need of increased capacity requirements. The process will also ensure appropriate and timely de-escalation so that all relevant staff members are aware of when normal business-as-usual function has resumed.

The following two tables provide a summary of the escalation levels and responsibilities of key staff within the organisation.

Escalation Summary

<table>
<tr><th>Escalation</th><th>Escalation Measure</th><th>Responsibility</th><th>Action Required</th></tr>
<tr>
<td>Green

Business as usual</td>
<td><u>Adequate capacity to maintain business and performance</u>

• ED able to maintain flow and objectives
• Nil processing delays (Decision to admit or discharge and out of ED within 6hrs)
• Surgical Activity able to be maintained
• Direct admissions able to be allocated
• Good patient flow through ED and access points
• Nil ambulance delays
• ICU has capacity with no exit block</td>
<td>Managed by the duty Patient Flow Coordinator and Patient Flow Manager through the Network Operations centre (NOC).

• Patient Flow Coordinators
• Patient Flow Demand Manager NOC
• Program Nurse Leads
• Nurse Managers ED, Theatres and ICU
• Medical and Surgical Programs and teams
• Allied Health Teams</td>
<td>Inpatient Daily overnight stay Discharge Targets (as of June 2022)

<table>
<tr><th>Discharge target</th><th>RAH</th><th>QE</th></tr>
<tr><td>Acute & Urgent Care</td><td>19</td><td>13</td></tr>
<tr><td>Surgery</td><td>42</td><td>20</td></tr>
<tr><td>Speciality Med 1</td><td>3</td><td></td></tr>
<tr><td>Cancer</td><td>8</td><td></td></tr>
<tr><td>Heart and lung</td><td>16</td><td>6</td></tr>
<tr><td>Neurosciences</td><td>9</td><td>1</td></tr>
<tr><td>Spec Med 2</td><td>2</td><td></td></tr>
<tr><td>Mental Health</td><td>5</td><td>3</td></tr>
</table>
</td>
</tr>
<tr>
<td>Amber

Moderate Compromise

Level 1</td>
<td><u>Signs of increasing demand are starting to show</u>

• Discharges below predicted by Midday
• Delays in admissions from ED to the ward
• Delays in decisions to admit
• Increased attendances to ED with longer LOS
• Anticipated and facilitating SAAS and TOC delays
• ICU capacity pressures</td>
<td>Managed and escalated by

• Patient Flow Coordinators
• ED NM/ NUM/ Medical Leads
• NL/PDM for information/ direction from the PFNM in addition to relevant stakeholder escalation
• Allied Health Teams</td>
<td>• ED to follow internal escalation plan
• PFC to escalated to PFNM
• NOC ensure optimum use of short stay beds ASU/AAU
• NOC/Program Leads non-urgent IHT patients postponed if/where appropriate (must be approved by EDO)
• Action as per escalation plan for ambulance TOC delays
• Ward NUM and Medical review of all inpatients on wards
• Ward identify causes of delays and resolve where possible
• Enact over-census across inpatient wards

AIM TO HAVE ACTION WITHIN 1 HOUR</td>
</tr>
<tr>
<td>Red

Severe Compromise

Level 2</td>
<td><u>Major pressure to the hospital/s is occurring. Actions undertaken have not been successful and continue to increase</u>

• Hospital and ED capacity is insufficient to meet the current demand
• SAAS delays greater than 45 minutes
• ICU over census</td>
<td>PFC to PFDM
• ED Nursing Directors/NUM/ Medical Lead
• Program Nursing Leads
• Allied Health (AH

For information purposes- Program Delivery Mangers, EDMS, EDON, EDO via NOC PFDM or Director NOC</td>
<td>• In addition to level 1- notification as indicated
• Consider utilisation of surge capacity
• Prioritisation of discharges to PDU and queries if appropriate
• Ensure networking options across CALHN have been considered.
• Liaison with SAAS services for site prioritisation
• Allie Health teams prioritise patients for discharge

AIM TO HAVE RESOLUTION IN PROGRESS WITHIN 2 HOURS</td>
</tr>
<tr>
<td>White

Extreme Compromise

Level 3</td>
<td><u>Sustained excessive demand may impact the hospitals and/or sass ability to deliver comprehensive critical care and ensure patient and/or staff safety</u>

• Extensive SAAS delays over 90 minutes with no offload plan
• External triaging occurring
• Major service gridlock with no capacity and no forecasted capacity across the site</td>
<td>• PFC, PFDM, NOC Nurse Lead, PDM, NL, AH
• <u>For information purposes and facilitation where able:</u>
• PDM, EDMS, EDON

VIA NOC Director or Nurse Lead NOC- LHN EDO, CE</td>
<td>As above addition to:
• Utilisation of surge beds (with EDO approval)
• Notification as indicated
• Cancellation of surgery (EDO approval via Surgery Program managers
• Executive tele-conference led by NOC Nurse Lead/Director NOC. Situation report to be provided by NOC Nurse Lead. Present EDO, Program leads, Nurse leads, ED NM, Patient flow co-ordinator/Manager
AIM TO HAVE CLEAR RECOVERY PLAN FOR NEXT 24 HOURS WITH CLEARLY OUTLINED ACTIONS, INDIVIDUAL RESPONSIBLE AND COMMUNICATION STRATEGY.</td>
</tr>
</table>

Notification and Escalation Process

Escalation will be initiated by the Patient Flow Demand Manager in the first instance. Subsequent escalation and initiation of levels and actions will be communicated by the Director of the NOC via text message or phone call.

Escalation Level	Escalation required	Escalation Message
Green – 0 **Business as Usual**	• Nil escalation required	• No escalation
Amber – 1 **Moderate Compromise**	• Patient Flow Coordinator (PFC) communicates to the NUMs of increased pressure all NUMs of NUMs of certain areas • Patient Flow Demand Manager (PFDM) to provide targeted response to the Nurse Lead (NL) for Clinical Programs who are not able to meet demand in timely manner also Allied Health Lead • PFDM to alert NOC NL and/or Director.	• PFC to NUM's • PFDM – Nurse Lead for areas of concern (Or operations manager if program has this role). • NL – to discuss with PFDM if ongoing issues • NL to feedback to PFDM in 2hrs
Red – 2 **Severe Compromise**	• PFDM to arrange a NOC escalation huddle with the Nurse Leads (+/- targeted PDM response) all areas or affected areas • If after two hours remain on level 2 – PFDM convenes escalation huddle with Executive/ PDM's/NL and all relevant members if remains on level 2 after 2hours – EDO will be notified via Director of NOC	• PFDM -to send invite for NOC huddle either in NOC or via teams. • NL/ PDM and PFDM to discuss actions required to facilitate recovery and de-escalation back to level 1 • PDM to discuss with respective Medical and Allied Health Leads to action and target response to facilitate recovery • Update required to NOC in 2hrs
White – 3 **Extreme Compromise**	• Urgent single meeting with Executive, PDM's, NL and Medical and Allied Health Leads for situation update and actions as per task card. • NOC take control of all beds and meetings to facilitate recovery • Formal notification to DRU for early awareness/ intelligence	• Urgent meeting set up by NOC. • Update required back to NOC and patient flow ongoing to facilitate recovery via phone

- Normal business measures with each of the programs are undertaken at levels 0 & 1
- Level 2- consideration to notify the EDO CALHN via the Director of NOC as per plan on page X
- Level 3- must be escalated to the EDO CALHN via the Director of NOC as per plan on page X
- Escalation level 2 & 3 will be advised by SMS and subsequent email correspondence by Patient Flow Demand Manager, Nurse Lead NOC or delegate, in relation to actions taken or planned actions.

CALHN Emergency Department and escalation process for notification of ramping

CALHN is committed to ensure the patients in the community are safe by ensuring there is a reduction in ramping and clear communication pathway when there is increased demand in the Emergency Departments

Key principles of Emergency Department patient flow include:

- A responsible person is focused on watching the ramp and facilitating timely offload and escalation of ramping issues early to the Patient Flow Demand Manager of the Network Operations Centre (NOC) At RAH a HALO is on site 7 days/ week and is available on 0428 657 337
- Escalation to the Patient Flow Demand Manager for the NOC via the ED Level 3 shift coordinator/ navigator role is required when the ED demand level raises from 1 to 2 or 2 to 3 or when there is 2 episodes of ramping at 45min and not able to be offloaded.
- The HALO is deployed to the ramp at RAH when there are issues providing assessment, to determine as to whether there are alternate pathways eg Calvary, Virtual Care Services, TQEH and provide clear ongoing communication to the PFDM and HNC with plan for offload.
- At TQEH the ED sends out an automated message once the department is at 35 patients regarding imminent ramping. PFDM follows up with TQEH
- Escalation to the Director of NOC should occur when there are ongoing ramping delays by the PFDM. The Director of NOC will notify the EDO and CEO of current state and actions underway. This should be escalated if offloading cannot be achieved in 1 hour and if there are multiple SAAS vehicles on the ramp.

Escalation point

- 0800 – 1600 – Patient Flow Demand Manager
- 1600 – 2300 – Patient Flow Coordinators
- 2300 – 0800 – After Hours Nurse Manager

Long Stay General Admitted Patients in the ED escalation

The NOC PFC will monitor general admitted patients LOS in the ED. Any patients with a LOS of greater >16hrs should be prioritised to move out of the ED as soon as possible. Should the patient not have a resolution in 2hrs then this should be escalated to the PFDM to work through a plan to ensure patients do not exceed greater then 24hrs in the ED unless in exceptional circumstances.

The NL NOC and Director of NOC should be notified at 20hrs (during business hours) if there are concerns this will not occur.

Patients who are reaching 24hrs prior to 1000hrs may be challenged to get there in time but every effort should be made to prioritise a bed for the patients.

This excludes mental health patients who will be managed by the program

Hospital Triggers

Triage Groups	Level 0 – Business as Usual	Level 1- Moderate Compromise	Level 2 – Severe Compromise	Level 3- Extreme Compromise
Emergency Department	• No ramping • Adequate capacity in acute spaces • ED occupancy <80% (RAH and TQEH)	• 2 ambulances ramped >30min • Limited acute care capacity • Resus x 2 capacity • 6-8 unallocated admissions • ED occupancy 80-95% (RAH and TQEH)	• 4 ambulances ramped >30min and/or 2 ambulance >60min • ED at capacity with 9 - 12 unallocated admissions • ED Occupancy 95-125% (RAH and TQEH)	• Multiple ambulances ramping • ED at capacity with no resus capacity • >12 unallocated admissions • ED occupancy >125% (RAH and TQEH)
Inpatient Units- All programs	• Capacity available • Discharge targets being met across the programs	• Limited immediate available capacity • Identified definite discharges are below target in minimum two programs	• Significant shortfall in identified discharges across all IPU's • Limited identified transfers for discharge unit • Unable to place theatre list • Unable to move cleared critical care patients • Unable to place admitted ED patients	• No existing capacity available • All surge beds in use • Unable to place > 20 patients admitted patients in the ED • Radiology and non- traditional surge spaces opening
Critical Care	• Capacity Available • Able to place theatre patients	• Capacity limited in ICU but able to accommodate bookings • Cleared patients for ward	• Unplaced Critical care patients in the ED • Booked demand unable to be accommodated • Risk of theatre patients being cancelled	• No critical care capacity • No cleared patients • Cannot accommodate theatre cases • Risk to interfacility transfers ie; trauma
Theatres	• Capacity available • Able to place theatre patients	• Risk to theatre and difficulty/delay in placement of cases	• Delays in theatres commencing due to capacity issues in both IPU and critical care	• Unable to place planned surgery as a result, patients cancelled
Standby bed utilisation	• No surge beds open	• Sub specialty demand higher then bed base available, beds opened	• Half of surge beds opened	• All surge beds and over census beds in use All available inpatient capacity options exhausted
External demand/interfacility incoming demand and other third door areas wanting to admit (eg outpatients)	• Able to accommodate interfacility transfers • IHT's able to be placed • Bed request/ unplanned from clinic able to be placed	• Consider delay in repatriating transfers • Review IHT's and postpone as appropriate	• Unable to repatriate patients • Review IHT's and postpone all unless urgent/ emergency	• Unable to repatriate patients or admit IHT's • Delays in unplanned admissions from clinics and outpatient areas resulting in ED presentations

Clinical Program Actions/ Task Cards in response to escalation levels

Acute and Urgent Care

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • Identify and refer patient suitable for admission avoidance programs • Referral and transfer to private facilities/ rehab etc • Actual and potential discharges identified at the daily meeting • Ward rounds undertaken with NUM & delays from ward round are actioned and documented • Outlier patients identified by NUM and patient flow coordinator and repatriated back to home wards where possible • Routine rounds take place by medical specialty teams with early clearance of patients for discharge by 1000 • NUMS to review inpatient LOS profile • Identify and plan for the next day activity	NUMS/ ward staff Medical Teams PFC's Allied Health Teams	Nil
Level 1 • Phase 0 strategies actioned • Identify all subspecialties with high volumes of inpatients • Request medical review +/- discharge with services or through community-based programs • Escalate for review and management options to clinical nurse consultant • 24- hour capacity planning initiated with review of planned discharges for the following day	Inpatient NUMS Medical Teams Allied Health Teams	PFDM/ PFC PDM NL's Medical Leads
Level 2 • Phase 1 strategies actioned • Round attended by Nurse Lead of all inpatient ward's areas • Escalation and action meeting held with Nurse Leads and Operations Manager to identify areas of deficits and priorities for action	Inpatient NUMS Medical Teams NL PDM's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads
Level 3 • Review all current business practices and where possible suspend noncritical activities for 2 hours redeploying those resources of area of need including ED, and wards for review and discharge management	Inpatient NUMS Medical Teams Nurse Leads PDM's Allied Health Teams	NOC Team EDO PDM NLs Medical Leads Medical teams Allied Health Leads

Surgery

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • Actual and potential discharges identified at the daily meeting • Ward rounds undertaken with NUM & delays from ward round are actioned and documented • Update PDD's to reflect accurate discharge date • Outlier patients identified by NUM and patient flow coordinator and repatriated back to home wards • Routine rounds take place by medical specialty teams with early clearance of patients for discharge by 1000 • Elective Surgery able to proceed and all patients allocated post operatively • Identify and plan for the next day activity	NUMS/ ward staff Medical Teams PFC's Allied Health Teams	Nil
Level 1 • Phase 0 strategies actioned • Identify all subspecialties with high volumes of inpatients • Request medical review +/- discharge with services or through community-based programs • Escalate for review and management options to clinical nurse consultant • 24- hour capacity planning initiated with review of planned discharges for the following day	Inpatient NUMS Medical Teams Allied Health Teams	PFDM/ PFC's PDM NL's Medical Leads Allied Health Leads
Level 2 • Phase 1 strategies actioned • Round attended by Nurse Lead of all inpatient ward's areas • Escalation and action meeting held with Nurse Leads and Operations Manager to identify areas of deficits and priorities for action • Review and potential cancellation of surgery at direction of Executive	Inpatient NUMS Medical Teams NL's PDM's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical Teams Allied Health Leads
Level 3 • Review all current business practices and where possible suspend noncritical activities for 2 hours redeploying those resources of area of need including ED, and wards for review and discharge management • Cancellation of some Elective Surgery (Category 2 and 3). Category 1 require medical decision for delay	Inpatient NUMS Medical Teams NL's PDM's Allied Health Teams	NOC Team PDM's NLs Medical Leads Medical Teams Allied Health Leads

Specialty Medicine 1

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • Actual and potential discharges identified at the daily meeting • Ward rounds undertaken with NUM & delays from ward round are actioned and documented • Outlier patients identified by NUM and patient flow coordinator and repatriated back to home wards • Routine rounds take place by medical specialty teams with early clearance of patients for discharge by 1000 • Movement of discharging patients to dialysis early and readmit under 126 (day procedure) • NUMS to review inpatient LOS profile • Identify and refer patient suitable for hospital avoidance programs • Referral and transfer to private facilities/ rehab etc • Identify and plan for the next day activity • Patients temporarily moved to waiting area prior to discharge	NUMS/ ward staff Medical Teams PFC's Allied Health Teams	Nil
Level 1 • Phase 0 strategies actioned • Identify all subspecialties with high volumes of inpatients • Request medical review +/- discharge with services or through community-based programs • Escalate for review patient discharges and discuss management options with nurse unit manager • Review of planned discharges for the following day to initiate 24 hour capacity planning • Deploy complex care nurse consultant to ED to review admitted ED patients under 026 • Deploy nurse practitioner for PD and HD to identify strategies for supported discharge • Use of overflow room on 7FD to facilitate timely movement of patients from ED	Inpatient NUMS Medical Teams Allied Health Teams	PFNM/ PFC's PDM NL'S Medical Leads Allied Health Leads
Level 2 • Phase 1 strategies actioned • Round attended by Nurse Lead of all inpatient ward's areas • Liaises with NUM re identified possible discharges • Escalation and action meeting • Consider use of renal day centre for discharging patients	Inpatient NUMS Medical Teams NL's PDM's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads
Level 3 • Review all current business practices and where possible suspend noncritical/clinical activities for 2 hours redeploying those resources of area of need including ED, and wards for review and discharge management	Inpatient NUM Medical Teams NL's PDM's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical Teams Allied Health Leads

Specialty Medicine 2

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • Actual and potential discharges identified at the daily bed meeting [NUM/ TL] • Routine rounds take place by medical specialty teams with early clearance of patients for discharge by 1000 or as soon as clinically ready thereafter • Ward rounds undertaken with NUM & delays from ward round are actioned and documented with active follow up across the day • Outlier patients identified by NUM and patient flow coordinator and repatriated back to home wards when possible [engagement of specialty nursing by unit to ensure patient progress on track/ PDD] • NUMs to review/ monitor inpatient LOS profile • Identify and refer patient suitable for admission avoidance programs including HITH / MyHH [Team] • Referral and transfer to private facilities/ rehab / CAP [NUM] • Identify and plan for the next day activity [Team]	NUMs/ ward staff Medical Teams PFC's Allied Health Teams	Nil
Level 1 • Phase 0 strategies actioned • Ensure Specialty Consults are responded to within 24-hours by program teams to other inpatient services • Identify all program inpatients waiting for subspecialty input by Consult order and escalate to consultant for response/ action • Request medical review +/- discharge with services or through community-based programs and support from Specialty Nurses • 24-hour capacity planning initiated with review of planned discharges for the following day	Inpatient NUMs Medical Teams Allied Health Teams	PFNM/ PFC's PDM NL'S Medical Leads
Level 2 • Phase 1 strategies actioned • Round attended by Nurse Lead of all inpatient ward's areas • Escalation and action meeting held with Nurse Lead and NUM to identify areas of deficits and priorities for action	Inpatient NUMs Medical Teams PDM's NL's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads
Level 3 • Review all current business practices and where possible suspend non-critical activities for 2 hours redeploying those resources of area of need including ED, and wards for review and discharge management	Inpatient NUMs Medical Team PDM's NL's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads

Neuroscience and Rehab

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • Actual and potential discharges identified at the daily meeting • Ward rounds undertaken with NUM/NC/TL & delays from ward round are actioned and documented • Outlier patients identified by NUM/NC and patient flow coordinator and repatriated back to home wards • Routine rounds take place by medical specialty teams with early clearance of patients for discharge by 1000 • NUMS to review inpatient LOS profile • Identify and refer patient suitable for admission avoidance programs including RITH/HITH • Referral and transfer to private facilities/ rehab etc. Decant for surgery in private where possible. • Identify and plan for the next day activity	NUMS Medical Teams PFC's Allied Health Teams	Nil
Level 1 • Phase 0 strategies actioned • Identify all subspecialties with high volumes of inpatients • Request medical review +/- discharge with services or through community-based programs such as RITH/HITH with support from speciality Nurse Consultants. • 24- hour capacity planning initiated with review of planned discharges for the following day	Inpatient NUMS Medical Teams Allied Health Teams	PFNM/ PFC's PDM NL'S Medical Leads
Level 2 • Phase 1 strategies actioned • Round attended by medical team and/or Nurse Lead/CPD/Patient flow at HRC of all inpatient ward's areas • Escalation and action meeting held with Nurse Leads and Operations Manager to identify areas of deficits and priorities for action	Inpatient NUMS Medical Teams PDM's NL's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads
Level 3 • Review all current business practices and where possible suspend noncritical activities for 2 hours redeploying those resources of area of need including ED, and wards for review and discharge management	Inpatient NUMS Medical Teams PDM's NL's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads

Cancer

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • Actual and potential discharges identified at the daily meeting • Ward rounds undertaken with NUM & delays from ward round are actioned and documented • Outlier patients identified by NUM and patient flow coordinator and repatriated back to home wards • Routine rounds take place by medical specialty teams with early clearance of patients for discharge by 1000 • NUMS to review inpatient LOS profile • Identify and refer patient suitable for admission avoidance programs • Referral and transfer to private facilities/ rehab etc • Identify and plan for the next day activity	NUMS/ ward staff Medical Teams Patient Flow Coordinators Allied Health Teams	Nil
Level 1 • Phase 0 strategies actioned • Identify all subspecialties with high volumes of inpatients • Request medical review +/- discharge with services or through community-based programs • Escalate for review and management options to clinical nurse consultant • 24- hour capacity planning initiated with review of planned discharges for the following day	Inpatient NUMS Medical Teams Allied Health Teams	PFNM/ PFC's PDM NL'S Medical Leads
Level 2 • Phase 1 strategies actioned • Round attended by Nurse Lead of all inpatient ward's areas • Escalation and action meeting held with Nurse Leads and Operations Manager to identify areas of deficits and priorities for action	Inpatient NUMS Medical Teams PDM's NL's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads
Level 3 • Review all current business practices and where possible suspend noncritical activities for 2 hours redeploying those resources of area of need including ED, and wards for review and discharge management	Inpatient NUMS Medical Teams Allied Health Teams PDM's NL's	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads

Heart and Lung

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • Actual and potential discharges identified at the daily meeting • Ward rounds undertaken with NUM & delays from ward round are actioned and documented • Daily multidisciplinary Huddles to identify PDD and discharge plans • Outlier patients identified by NUM & patient flow coordinator and repatriated back to home wards • Routine rounds by medical specialty teams with early clearance of patients for discharge by 1000 • NUMS to review inpatient LOS profile • Identify and refer patient suitable for admission avoidance programs, Refer & transfer to private facilities/ rehab etc • Identify and plan for the next day activity • Documentation of PDD and discharge plan in EMR	NUMS/ ward staff Medical Teams PFC's Allied Health Teams	Nil
Level 1 • Phase 0 strategies actioned • Identify all subspecialties with high volumes of inpatients • Request medical review +/- discharge with services or through community-based programs • Escalate for review and management options to clinical nurse consultant • 24- hour capacity planning initiated with review of planned discharges for the following day • Escalate discharge delays via program leads • Review of procedural activity that requires admission	Inpatient NUMS Medical Teams PDM's NL's Allied Health Teams	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads
Level 2 • Phase 1 strategies actioned • Huddle attended by NUM of all inpatient ward's areas • Early ward rounds with multi team representation • Review of PDD and escalation of discharge delays for same day and next day discharges • Review of direct ward admissions and diversion to HITH/MHH/ MRU as able • Review of country transfer and delay if able • Escalation and action meeting held with Nurse Leads and Operations Manager to identify areas of deficits and priorities for action	Inpatient NUMS Medical Teams Allied health teams PDM's NL's	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads
Level 3 • Review all current business practices and where possible suspend noncritical activities for 2 hours redeploying those resources of area of need including ED, and wards for review and discharge management	Inpatient NUMS Medical Teams PDM's NL's	NOC Team PDM's NL's

	Allied Health Teams	Medical Leads Medical teams Allied Health Leads

Mental Health

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • Actual and potential discharges identified at MH flow meeting • Ward rounds undertaken with NUM & delays from ward round actioned & documented • Update PDD's to reflect accurate discharge date on Journey Boards and BAS. • D/C reviews by consultant the day prior with early clearance of patients for d/c by 1000. • Patients in ED allocated beds • Identify and plan for the next 48 hour activity • Identify and refer patient suitable for hospital avoidance programs including HITH and Urgent MH Care Centres, Consider TAC referrals	NUMS/Allied Health Seniors MDT/ Ward Staff Medical Teams Patient Flow Coordinator	Nil
Level 1 • Phase 0 strategies actioned • Request medical review +/- d/c with community support or through in-reach from community mental health services • 24 hour capacity planning initiated with review of planned d/c for the following day identified in MH flow calls • Transitional Care Co-ordinator engaged to assist with discharge support packages • Escalate for review and management options to Head of Unit/NUM and Allied Health Seniors	Inpatient/HITH/ICC NUMS Allied Health Seniors Medical Seniors Team Managers Community Mental Health	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads
Level 2 • Phase 1 strategies actioned • Huddle attended by MDT seniors of all bedded services • Early ward rounds with MDT representation • Review of PDD and escalation of discharge delays for same day and next day discharges • Review of country expects and delay/divert if able • Consider other LHN bed options • Ensure ED MH Nurse Practitioners are exploring all discharge options • Round attended by Service Managers of all inpatient ward's areas • Liaises with NUM and HOU re identified possible discharges	Inpatient NUMS Allied Health Lead Medical Heads of Unit /Site leads Team Managers Community Mental Health Service Manager	NOC Team PDM's NL's Medical Leads Medical teams Allied Health Leads

• MH Escalation and action meeting • Escalation and action meeting held with Service Managers /Heads of Units and MH senior leadership team		

L**evel 3** • Review all current business practices and where possible suspend noncritical/clinical activities for 2 hours redeploying those resources of area of need including ED, and wards for review and discharge management • Escalate to Nursing Lead for consideration of deployment of additional nursing staff • Escalate to Allied Health Lead for consideration of deployment of additional Allied Health staff • Escalate to Medical lead for consideration of deployment of additional medical staff • Escalate and activate Bed Management Directive	Inpatient /ICC/HITH NUMS Allied Health Leads Medical Heads of Unit /Site leads Community Team Managers Service Managers	Director NOC Nurse Lead NOC Executive Director MH Program Manager Nurse Lead Allied Health Lead Medical Lead Director of Mental Health Strategy

ICU (Intensive Care Unit)

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • ICU bed base below 38 • Identified ICU discharges allocated a bed • No Bed blocks • State-wide capacity	Duty NUM ICU Co-ordinator PFC Allied Health Teams	Nil
Level 1 • ICU bed base 38 at RAH and 8 at TQEH • Unallocated ICU discharges • Bed block • ICU admissions/discharges will take bed base above 38 • State-wide capacity	Duty NUM ICU Co-ordinators PFC Allied Health Teams	ICU NUM's Duty Intensivist PFDM NOC
Level 2 • ICU bed base above 38 with admissions and discharges • FTE mismatch with ICU bed base • Unexpected admissions creating bed pressure • State-wide ICU position of concern • Escalation of Bed Block to the NOC • Medstar divert • Review elective admissions for the next day	Duty NUM Duty Intensivist NUM's PFC Allied Health Teams	Nursing Director Ops/NL Duty Intensivist PDM Allied Health Leads NOC
Level 3 • ICU predicted to be above 40 with admissions and discharges • Escalate BB to NOC • Medstar divert • Source additional staff • Hold theatre for elective cases • Review elective cases for the following day	ICU TL Duty Intensivist Duty Anaesthetist NUM's PFC Allied Health Teams	ND Ops NL Duty Intensivist Medical Lead PDM Allied Health Leads NOC

Perioperative Services

Escalation status and strategy	Responsibility	Escalate and liaise
Level 0 - Green • Emergency list session time greater than demands • All DOSA/DSON patients placed • ARRC patients placed	TS Co-ordinator Perioperative Bay Co-ordinator ARRC TL	Nil
Level 1 • Emergency List session equals demand • Unallocated DOSA/DSON less than 4 • ARRC all placed	TS Co-ordinator Perioperative Bay Co-ordinator ARRC TL	Technical suite NUM's NUM's perioperative bays
Level 2 • DOSA/DSON unplaced • Surgical patients in ED unplaced • Cases in breach prioritised and allocated • Prioritise patients in beds that can go home to be operated on first & second on the list. • Use of Elective time to operate • ARRC unplaced • Surgery to review following days theatre lists	TS NUM's Duty Anaesthetist Perioperative bay NUM's ARRC NUM	ND Ops/NL Duty Anaesthetist PDM Medical Lead
Level 3 • Surgery to Cancel Cat 2 & 3 elective surgery day prior • Surgical unplaced in ED more than bed capacity • Surgery to review all Cat 1's • Hold all second cases requiring a bed • Emergency List more than session time with breach • Look at possibility of running an extra TS for Emergency • Prioritise inpatients that can go home on the Emergency list • Utilise spare elective session time for Emergency cases	TS NUM's Perioperative bay NUM's Duty Anaesthetist ARRC NUM	ND Ops/NL Duty Anaesthetist PDM Medical Lead

Appendix 1 – Over census options

Program	Ward	Over census options
Spec Med 1	7FD	• Pull dialysis dependant patients from ED to the acute dialysis room first thing in the am (advantage is that treatment is initiated early, and patients are effectively flowed from ED) • Use of the procedure room on 7FD as overflow for discharging patients • Use of renal day centre when in phase 2 of escalation
Spec Med 2	TQEH NGB	• Incoming patient to wait in Discharge Lounge where needs can be met • Outgoing patient to wait in ward lounge or discharge lounge where needs can be met (fit to sit) • Over-census bed / treatment room is physically present between NGA/ NGB which can be activated as an over-census space for NGB as a very last resort
Spec Med 2	RAH 6GG	• Options are limited because often patients are in 6GG for respiratory precautions and therefore are unable to wait at the ward entrance or the lounge, for pick up / medication dispensing • Where the patient can sit/ doesn't require active respiratory precautions – this can be activated provided they are 'fit to sit'. • 6GG does not have or share any lounge facilities to enable a patient to have a meal for example, a diabetic patient to ensure they are stable post meal to go home.
Cancer	RAH 6E & 7E	• There is no appropriate over census space in the inpatient areas, any over census patients would be in the corridor so is a very last resort that may be considered if known that allocated bed is imminent, and the patient will not be in the corridor for an extended period. • Patients to go over census need to be ambulatory/mobile and will need to be assessed by NUM/TL on a case-by-case basis. • Where possible a patient for D/C will be moved to transit lounge, over census or another unit within the Cancer program if available to facilitate early movement of patients from ED • ED avoidance strategies will continue such as utilisation of RAC room
Surgery	RAH	• Only options are corridors, there are no lounges/treatment areas to house patients, new or discharging. • Teams are working on sitting out patients that are discharging and now utilise D/C lounge.
Surgery	TQEH	• over census patients usually go into an unused bed space location – this works well when we aren't flexed open to 36 beds • D/c lounge and same actions as RAH
Neuroscience and Rehab	Neuro Surg	• Corridor is the only option for an over census patient • Strategy is to identify suitable patients for discharge to sit in the corridor waiting areas to make bed available early or D/C lounge when it is available

Neuroscience and Rehab	Stroke	• Over census from ED – corridor is the only option. • Most discharges are either transfer back to local LHNs post clot retrievals and they require SAAS transfers. Or these patients go rehab facilities post stroke, again not suitable to go out to corridors. • To support early transfer outs, we did start pm bed state from subacute to go out so that staff can book early transfer outs for next day to facilitate early discharges.
Heart and Lung		• Pull patient directly to interventional units (Cardiac and thoracic) directly from ED. • Prioritise ECHO service for to facilitate discharges • Use ECHO room on 4E1 to facilitate urgent over census STEMI admission overnight (used during the day for ECHO's) • Use the Gym space in 8E1 as overflow for discharging respiratory patients. • Review of CTS patient and elective procedural intervention that require admission • Delay or divert elective admission were possible • Commence IVAB's for chronic lung disease patient via HITH to delay or avoid admission (CF model) • Divert country patients to alternate CALHN site
Mental Health 2G		• Acute and SSU can pull a patient from the ED if a discharge is confirmed. If patient is identified as needing limited support they can go to the discharge lounge. • PICU is out of scope
Mental Health Glenside		• Eastern Acute (18 beds) can pull one early transfer from the RAH if discharge is confirmed • Rural and Remote (not under the CALHN governance) (23 beds) can pull from the RAH early if discharge is confirmed
Mental Health SE QEH		• SE Older Persons Mental Health acute beds. (20 beds) can pull from RAH ED if discharged confirmed. –
Acute and Urgent Care	RAH	• AUC wards have the capacity to over census one patient per ward if the patient meets over census clinical criteria. • AUC patients when confirmed for discharge, are to be sat out when safe to do so. • AUC will utilise discharge lounge if patient meets clinical criteria • AUC will transfer patients from the AAU in the corridor of AUC level 8 and 9 on the back of confirmed discharges to maximise flow to early from the Emergency department to the AAU –
Acute and Urgent Care	TQEH	• AUC wards have the capacity to over census one patient per ward if the patient meets over census clinical criteria. • AUC patients when confirmed for discharge, are to be sat out when safe to do so. • South ground 1 can take over census from the GEMU wait list in consultation with Consultant and GEM liaison service • North 1 B and South 1 can over census a second patient each if the patient meets over census clinical criteria and is suitable to be grouped with current inpatients on ward.

For more information

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