



11 March 2020

Dear [REDACTED]

**Re: OIA request – COVID-19 pandemic preparations**

Thank you for your Official Information Act request received on 17 February 2020 seeking information about COVID-19 pandemic preparations from Waitematā District Health Board (DHB).

After discussions with the Ministry of Health (MoH), it was agreed on 24 February that DHBs would respond directly to most of your questions but that the MoH would reply where appropriate. This response notes where questions have been transferred to the MoH.

The Northern Region DHBs are working together on a coordinated response to the COVID-19 challenge through the Northern Region Health Coordination Centre, drawing on resources and expertise from across the four DHB areas (Northland, Waitematā, Auckland and Counties Manukau).

Our focus is on ensuring our systems and processes are aligned in the management of COVID-19 so that we provide consistent, high-quality care to our communities. The situation is evolving and we have provided the best information available at the time without diverting specialist staff from their critical key priorities.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā DHB serves a population of more than 630,000 across the North Shore, Waitakere and Rodney areas, the largest and one of the most rapidly growing DHBs in the country. We are the largest employer in the district, employing around 7,500 people across more than 80 different locations.

In addition to providing services to our own population, we are also the metropolitan Auckland provider of forensic psychiatry, child disability services, child community dental services and community alcohol and drug services.

Our responses to your questions are provided below.

**1) Availability of Intensive Care Unit (ICU) beds and oxygen delivery machinery**

1. Has your agency done detailed expert modelling to model the amount of resources (healthcare workers, machines, ICU beds etc) necessary to respond to certain levels of

*COVID-19 case numbers with consideration to the specific nature of the COVID-19 disease? If yes, please supply the information.*

There is no specific modelling for COVID-19 at this time but our DHB is well-accustomed to managing care during times of peak demand, such as during the winter flu season. We continue to work together regionally to advance our COVID-19 planning as the situation develops.

*2. What is the total number of ICU beds, capable of caring for infectious patients without undue risk to healthcare workers and other patients, currently operational in your region?*

Waitematā DHB has 14 Intensive Care Unit and High Dependency Unit beds and we are able to cohort patients together as required in response to any situation.

*3. On average, at any given time, approximately and generally, how many of these ICU beds are available to receive new patients?*

There are four-to-five beds available, on average.

*4. How many machines capable of high-flow oxygen therapy does your region have?*

Waitematā DHB currently has 33 high-flow oxygen therapy machines and is securing another 20 this week (commencing 9 March). More machines are able to be ordered and received under urgency within a 24-hour period if required.

*5. How many machines capable of non-invasive ventilation does your region have?*

There are 24 machines available in total.

*6. How many machines capable of invasive ventilation does your region have?*

There are 14 machines available in total.

*7. How many machines capable of extracorporeal membrane oxygenation (ECMO) does your region have?*

Waitematā DHB does not offer this service; Auckland DHB is the national provider.

## **2) Emergency procurements**

*Considering the following list of materials, medicines and items:*

- 1. P2/N95 Masks.*
- 2. PPE Goggles.*
- 3. PPE Face Shields.*
- 4. PPE Gowns.*
- 5. PPE Hazmat/coverall suits.*
- 6. Machines and related supplies for High-flow oxygen therapy.*
- 7. Machines and related supplies for Non-invasive ventilation.*
- 8. Machines and related supplies for Invasive ventilation.*
- 9. Machines and related supplies for Extracorporeal membrane oxygenation (ECMO).*
- 10. Other materials, machines and medicines that medical experts have advised you will help to respond to a COVID-19 epidemic.*

*The National Reserve Supply does not appear to contain many of those items and primarily contains medication for the treatment of and vaccination against influenza, which are not effective with COVID-19.*

*Further, it states that DHBs are responsible to store PPE according to their needs. I request the following information:*

- 1. How many of each of those 10 items does your region currently have suitable for use in a COVID-19 outbreak with consideration to the specific nature of the COVID-19 disease?*

Waitematā DHB is part of a regional and national procurement process. Contracts are held by lead procurement agencies; not by the DHBs.

The Northern Region DHBs are working closely together to manage availability of supplies and numbers are changing on a daily basis.

- 2. Has your agency undertaken any consultation with medical experts since January 15, 2020, regarding what numbers and types of medical equipment will be necessary to respond specifically to a COVID-19 epidemic, reducing healthcare worker infections and lowering the Case Fatality Rate? And have these consultations taken into account the latest scientific papers being released regarding COVID-19?*

Waitematā DHB fully aligns with World Health Organization and Ministry of Health requirements for the management of COVID-19.

- 3. Are any emergency procurements related to the above list of 10 materials, medicines and items, already underway, or currently being planned since January 1, 2020?*
  - a. If yes, please provide documents related to these procurements or proposals since January 1, 2020.*
  - b. If average prices or vendor names cannot be released under section 9 of the Official Information Act, please remove vendor names or prices and provide only the number of units of each item being procured or proposed to be procured and the estimated delivery time.*
  - c. The existence of procurements, related activities and the number of units of each item being procured cannot reasonably be withheld under section 9.*

The Ministry of Health will respond separately to this question.

### **3) Documents related to the inability to provide hospital care**

*Page 130 of the NZIPAP states:*

*As demand in a moderate to severe pandemic is likely to exceed supply, public and private hospitals will need to prioritise admissions, rationalise non-acute services and review staff rosters. Capacity to admit people to hospital during the Manage It phase is likely to be limited during a mild to moderate pandemic and considerably constrained during a severe pandemic. District health boards will need to liaise with local councils, **CDEM groups and voluntary groups, who can then assist in providing community care.***

- 1. Please provide any documents relating to the meaning of "community care" and what medical care from qualified medical workers and medical equipment and medicines will be provided to COVID-19 patients in "community care"?*

This phase of the response has not yet been reached. The situation is evolving and, at present, the DHBs are working closely with primary healthcare and Auckland Regional Public Health

Service to advise self-isolation where appropriate in accordance with Ministry of Health guidance.

2. *Given that recent papers and official Singapore MOH statistics show that approximately ~20% of COVID-19 admissions require oxygen treatment/ventilation, has your agency done any modelling on the number of COVID-19 patients who will likely need hospital/ICU treatment but be unable to obtain it due to hospital overload, depending on various ranges of COVID-19 case numbers? If yes, please supply documents.*

See response above.

3. *If it is justified that the treatment of COVID-19 patients, who would normally be cared for in ICU/hospital, is instead done by volunteer groups without medical training or advanced equipment, has your agency considered undertaking:*
  - a. *Emergency procurements of relevant medical devices and equipment listed in question 2, to at least provide these volunteer groups with medical equipment such as oxygen ventilators and;*
  - b. *Emergency training of these unqualified volunteers in the basic care of COVID-19 patients and the use of these medical devices and equipment, in order to increase the survival rates of those unable to be cared for in medical facilities?*
  - c. *If yes, please provide documents relating to these emergency plans.*

No consideration has been given to involving voluntary groups without the appropriate medical training.

4. *What is the number of unqualified volunteers/workers available from CDEM and voluntary groups in your region available to care for patients when hospitals and other medical facilities cannot provide care? How recent is this information?*

See response above.

5. *What is the list of facilities (hotels, motels, schools etc) that you have identified as candidates for requisition under section 71(1) of the Health Act 1956 to house COVID-19 patients? How many beds can each of these facilities accommodate?*

The Ministry of Health will respond separately to this question.

#### **4) Documents related to emergency planning for mass infection of healthcare workers**

*In a recent paper regarding admissions in a hospital, 41% of 138 hospitalized COVID-19 patients were infected in hospital ("nosocomial" infections). 29% of the 138 patients were healthcare workers.<sup>11</sup> As of February 12, 2 of the 8 cases (25%) in the U.K are healthcare workers. China's National Health Commission <sup>12</sup> has stated 1700 healthcare workers have been infected in China.*

1. *Does your agency have emergency plans to replace healthcare workers as they become infected? If yes, please supply documents you have relating to such plans.*

The DHB has standard operating procedures for managing staff absences and safe staffing, which are considered business-as-usual procedures. As previously mentioned, we continue to work together with the Northern Region DHBs to monitor developments and support planning around significant events. For your reference, our standard operating procedures are outlined in the following documents:

**Attachment 1** - Assisting on Wards – Staff Deployment  
**Attachment 2** - Variance Response Management  
**Attachment 3** - Bed Capacity Management & Escalation Plan.

#### **5) Expansion of test capacity**

- 1. What is the number of SARS-CoV-2 tests that can be performed in your region in a 24-hour period?*

Laboratory testing of suspected COVID-19 cases for the Waitematā district is performed by the regional provider, LabPlus at Auckland DHB. Currently, LabPlus is able to perform 128 tests in a 24-hour period. This capacity is expected to increase in the near future.

- 2. On average, how quickly can a test be performed from sample to result?*

The daily specimens are batched. The cut-off time for inclusion in the batch is 10.30am. This allows specimens collected overnight at DHBs across the region to get to LabPlus in time for testing that day, providing a 24-hour turnaround time.

- 3. Do plans exist to expand this capacity and what is the projected capacity increase and date by which the increase will be achieved?*

See the response to question one above.

#### **6) Diagnostic and COVID-19 surveillance criteria**

- 1. What are the current guidelines for your medical professionals to request a SARS-CoV-2 diagnostic test?*
- 2. Do the surveillance guidelines require recent travel to China to trigger a SARS-CoV-2 diagnostic test?*
- 3. Outside of normal disease surveillance, what additional reporting requirements have been put in place?*

The Ministry of Health will respond separately to this question.

#### **7) Public information campaigns**

*Whilst COVID-19 can kill, and indeed appears to be a very dangerous disease, it has also been noted by experts that most cases appear to be mild, potentially little more than the common cold. This combination of potentially very dangerous but usually mild, does not appear to be well understood by the wider public.*

- 1. Please provide any documents you hold related to emergency public health information campaigns of TV, radio and social media that are currently being prepared or have been prepared since January 15, 2020.*

The Ministry of Health will respond separately to this question.

#### **8) Meetings in your region related to COVID-19 pandemic preparations**

1. *Since January 15, what leadership/committee meetings have occurred in your agency solely related to preparations for a potential COVID-19 pandemic?*
2. *Since February 1, what meetings have been held that included trained medical experts, to specifically discuss the latest clinical information regarding COVID-19 cases (E.G Lancet , NEJM , JAMA ), and the projected requirements for equipment, ICU, beds, medicines and healthcare workers to respond appropriately to a potential COVID-19 pandemic, with specific consideration for the COVID-19 disease.*
3. *Since January 15, what activities, such as additional training and simulations, have been undertaken related to preparations for a potential COVID-19 pandemic?*

Waitematā DHB is fully coordinated with the other Northern Region DHBs, as previously detailed, via the activation of the Northern Region Health Coordination Centre (NRHCC). This group meets daily and draws on expertise and resources within the four DHBs.

The NRHCC includes a clinical technical advisory group and is closely linked to key primary health organisations (PHOs). Waitematā DHB has its own Incident Management Team overseeing the local COVID-19 response and ensuring it is consistent with the regional and national approach.

Medical and nursing staff are being provided additional information on COVID-19 as it becomes available, including simulation sessions for frontline emergency department staff on how to appropriately manage suspected cases.

#### **9) Emergency actions to secure your supply chains, particularly relating to medical supplies**

*Scott Gottlieb, Former Commissioner of the U.S FDA, made a statement on February 12 to the Senate Committee on Homeland Security and Governmental Affairs on February 12, including the following:*

*About 40 percent of generic drugs sold in the U.S. have only a single manufacturer. A significant supply chain disruption could cause shortages for some or many of these products. Last year, manufacturing of intermediate or finished goods in China, as well as pharmaceutical source material, accounted for 95 percent of U.S. imports of ibuprofen, 91 percent of U.S. imports of hydrocortisone, 70 percent of U.S. imports of acetaminophen, 40 to 45 percent of U.S. imports of penicillin, and 40 percent of U.S. imports of heparin, according to the Commerce Department. In total, 80 percent of the U.S. supply of antibiotics are made in China.*

*Taiwan has banned export of face masks. India has banned export of PPE and n95 masks. The Secretary General of the Indian Drug Manufacturers Association, which represents over 900 drug producers, has said he expects drug supplies to be disrupted from April.*

*New Zealand's medical supply chains are likely to be just as, or more vulnerable as the United States. New Zealand's National Reserve Supply only stores a small range of items, most of which are only relevant to responding to an influenza pandemic (e.g antiviral drugs and vaccines that are not effective against SARS-CoV-2), and certainly not supplies related to maintaining the general needs of your region's healthcare during supply chain disruptions.*

1. *Please provide information relating to any emergency actions, not normally undertaken, underway since January 1 2020, to secure supplies of medical equipment and supplies for your day to day healthcare provisioning obligations.*

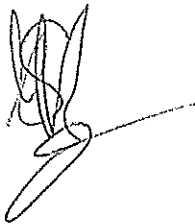
A national approach has been taken to liaise with suppliers of personal protective equipment to ensure stocks are ringfenced for clinical use by DHBs, as well as to ensure adequate supplies to primary care.

I trust that this information is helpful.

Waitemata DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Matt Rogers', with a long horizontal line extending to the right.

**Dr Matt Rogers**  
**Incident Controller – COVID-19**  
**Waitemata District Health Board**

# Assisting on Wards - Staff Deployment

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## 1. Overview

### Purpose

This document provides guidelines for staff deployment in the event that there is a need to move staff to ensure safe patient care and support teams under pressure.

- There is also consideration of quality and cost effective allocation of the permanent WDHB nursing workforce where there are additional staff available staff and constant observer roles are required.

### Scope

Northshore and Waitakere Hospitals

### Definitions

CNM	Charge Nurse Manager
DHB	District Health Board
DNM	Duty Nurse Manager
HCA	Health Care Assistant
HODN	Head of Division Nursing
NSH	North Shore Hospital
OM	Operations Manager who have nursing FTE responsibility only
OM WC	Operations Manager Waitemata Central
RN	Registered Nurse
WTH	Waitakere Hospital
Homeward	Ward RN is employed to work on

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## Assisting on Wards - Staff Deployment

### 2. Planning for appropriate staffing

#### 2.1 Rostering

It is expected that in all clinical areas the Charge Nurse/Midwife Manager ensures that there is full employment and that staff are rostered to cover all shifts – this is done in advance and documented on a roster.

Weekly and daily assessment of roster coverage is undertaken by the Charge Nurse/Midwife Manager to ensure gaps are filled *across the 24 hours*. Arrangements must be made to cover with the right skill mix, shift clinical coordination and team support so that staff are able to provide the patient care required in a safe manner.

Where gaps are identified all reasonable effort is made to fill this in discussion with the Clinical Nurse Director MHOPS / Heads of Division Nursing/ Midwifery and the Bureau.

Staff are employed to work at Waitemata DHB in the first instance and into teams in clinical areas where they are oriented to the systems and processes of the DHB and specialty. Staff are required to apply the essentials of practice for which they are prepared regardless of the setting they are deployed.

The DHB employment contract states that a nurse may be deployed to work in another area. The DHB has a responsibility to ensure that were this occurs the nurse is communicated with clearly, has the required nursing competence to work in the clinical setting to meet essential patient care needs and receives support in the deployment.

### 3. Approval for additional staff over the 'cover model'

Any request for additional RN above 'cover model' must be discussed and pre-approved by Head of Division (HOD) Nursing (or their delegated senior nurse) in-hours or Duty Nurse Manager (DNM) out of hours.

- Out of hours this needs to be clearly documented on the DNM Bed Management Template.

All external agency shifts RN/HCA must be pre-approved by the Divisional Operations Manager (OM) and HOD Nursing in-hours and the DNM out of hours and documented on the DNM Bed Management Template.

### 4. Constant Observers / patient attendants

Waitemata DHB nursing staff will cover constant observer / patient attendant requests in preference to an external agency nurse.

- If the need arises, a Waitemata DHB RN may be required to cover a constant observer shift where there are extra RNs available / rostered.

If there is greater than 2 constant observers per ward, the situation must be reviewed by the HOD Nursing / DNM out of hours and options to cohort patients in rooms/other wards will be explored.

- Any allocation of more than 2 constant observers per ward must be pre-approved by HOD Nursing/DNM out of hours.

### 5. Annual Leave / Leave Arrangements

Every inpatient ward is required to have an annual leave planner and ensure that the minimum leave is allocated every week (pro-rata of vacancies).

- Any additional annual leave must be approved by the HoD Nursing /Divisional Operations Manager on the leave form or in workforce central.

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## Assisting on Wards - Staff Deployment

No short notice annual leave days should be approved until all shifts across Northshore and Waitakere Hospitals are filled to ensure that no external agency are used where there are additional RNs or HCAs rostered. Numbers on annual leave should form part of the discussion with HOD Nursing or Divisional OM in-hours and DNM after hours.

Where an area has staff surplus to requirements the Operations Manager Waitemata Central (OM WC) in hours and DNM out of hours should be advised and they will make the final decision regarding retaining staff member, redeployment or short notice leave. Short notice leave will be offered within a reasonable timeframe as soon as operational requirements of hospital are covered and confirmed.

### 6. Overtime

All overtime to cover a vacancy must be approved by the Divisional OM and the HOD Nursing (or delegate) during office hours and the DNM after hours.

If bureau is required for a specialist area while additional RNs are available in other areas, then this must be pre-approved by the Divisional OM and HOD Nursing (or delegate) /DNM out of hours. Out of hours this must be documented on the Bed Management Template.

### 7. Closing beds

When bed capacity exceeds the demand for the beds, clusters of 5 beds will be closed on a shift by shift basis by ward. This plan must be clearly stated on the Bed Management Template.

- If there are beds currently empty but have patients allocated to move from ED or ADU, these patients must be moved within 1 hour.

### 8. Deployment Decision Making and Communication with staff

Where a situation arises that staff need to be asked to move from one area to another to ensure safe staffing or support of a ward team that is under unexpected pressure, the decision

- [a] is made after all reasonable options have been explored (own cover, shift extension, bed flex).
- [b] after a discussion between the Operations Manager Waitemata Central in hours/DNM out of hours & CNM/Clinical Charge Nurse/shift coordinator of redeploying and cluster wards.

Issues to be considered include area staffing (numbers and skill mix), workload (current number of patients and acuity), and expected admissions. If agreement cannot be reached then a final decision will be made by the HoD Nursing for the service during business hours or the DNM after-hours.

The ward/unit coordinator sending the staff member will communicate with the nursing team and follow the unit process for deciding on who can be deployed. Each ward is expected to have a process in place to ensure redeployment occurs in fair manner.

The Operations Manager Waitemata Central in hours and DNM out of hours must talk with the shift coordinators **from both redeploying and receiving areas**.

- The OM WC/DNM must discuss with redeploying area whether the assisting nurse skill level is adequate to assume a patient load
- The nurse being deployed should be briefed by the shift coordinator prior to going to the receiving ward/unit. Both redeploying and receiving areas must work together to avoid any delay in redeploying staff.

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## Assisting on Wards - Staff Deployment

**New Graduate Nurses should ideally not be deployed to another area for the first six months of their employment on the NETP programme.** The new graduate needs continuity in a familiar setting to consolidate and achieve competence.

Nurses should be deployed to areas where they have relevant expertise to be able to provide safe patient care as per cluster wards table.

### 8.1 Nurse being deployed

The decision is communicated clearly so that the receiving ward can allocate resource appropriately

- where the deployment is for the *full shift*, the assisting nurse assumes a patient load. Tasking or team nursing is preferred due to the nurse being unfamiliar with the area.
- where the deployment is for *part of the shift*, the assisting nurse does not assume a patient load *but works closely/teams with a ward nurse* and assists with key tasks or activities to ensure safe patient care. This rule also applies to staff working four hours shifts.

The Operations manager Waitemata Central/ Duty Manager will ensure the clinical area receiving assistance is aware of the expectations/responsibilities outlined below.

Redeployed Staff Responsibility	Receiving Area Responsibility
<ul style="list-style-type: none"> <li>• Redeployed staff will report to the shift coordinator of the receiving ward/unit to be allocated a patient load within a team or a nurse to work with as a team during their shift</li> <li>• Redeployed nurses will follow the standards of nursing practice e.g. medication administration, essentials of care and infection control practices</li> <li>• Redeployed staff will provide the highest standard of care possible for the patient/group of patients under their care.</li> </ul>	<ul style="list-style-type: none"> <li>• The receiving ward shift coordinator will know the length of time the redeployed staff member can stay and allocate the redeployed staff member to work with ward/unit RN i.e. preference is team nursing - caring for a group of patients. The deployed nurse can care for a designated group of patients and provide total care, but must be allocated a ward nurse to provide support.</li> <li>• Orientation will be provided to the area/cluster ward, following the WDHB Bureau Nurse Policy. Orientation guidelines are to be printed from CAAG.</li> <li>• Welcome and assist the redeployed staff member with local routines</li> <li>• Ensure the redeployed staff member has a meal break</li> </ul>

Clinical areas have guidelines for staff deployed to assist them, to assist safe orientation.

### Where the situation changes

The donating ward /unit shift coordinator must notify the Operations Manager WC/ DNM with as much notice as possible if the staff member is required to return to the base ward for a clinical situation.

The Operations Manager WC /DNM will liaise with the receiving ward, after considering whether alternative assistance is possible and when the staff member can be released.

- The nurse will receive notice of 30 minutes if the situation changes and they are called back to the base ward/unit, they so that they can complete what they are doing and handover to the ward staff member.
- The nurse must provide a clinical handover prior to leaving the ward. It is expected that the nurse can return within 30 minutes of such notice being given.

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## Assisting on Wards - Staff Deployment

### 9. Cluster wards for redeployment.

#### 9.1 Surgical and Ambulatory Services (SAS) -North Shore Hospital

Home Ward	Cluster Wards	Wards staff can be redeployed to if no gap on cluster wards
Ward 4	Hine Ora, SSW, Wd 8, HDU	Wd 7 & Wd 9, Transit if ACLS trained
Ward 7	SSW, Wd 9, Wd 4	Wd 8 & Hine Ora
Ward 8	Wd 4, SSW, Hine Ora, HDU	Wd 7 & Wd 9, Transit if ACLS trained
Ward 9	SSW, Wd 7, Wd 4	Wd 8 & Hine Ora
Hine Ora	SSW, Wd 4, Wd 8, Maternity N	Wd 7 & Wd 9
Short Stay	Hine Ora, Wd 7, Wd 9	Wd 4 & Wd 8
HDU	Transit, Wd 8, Wd 4	
ESC	Wd 4, Wd 8, Wd 7, Wd 9	Hine Ora, SSW

- If no staff required on cluster wards then staff can be redeployed from any Surgical ward to another Surgical ward. If no gaps on cluster wards or other surgical wards, surgical nurses can be redeployed to ADU to look after surgical patients.

#### 9.2 Child Women and Family Services- North Shore Hospital & Waitakere Hospital

Home Ward	Cluster Ward	Comments Ward staff can be redeployed to if no gap on cluster wards
Rangatira	SCBU, ED WTH (child health), Maternity West	ED WTH can assist Rangatira/SCBU. There are approximately 6 nurses in child health (Rangatira, SCBU north and west), where their scope of practice allows them to only work in child health.
SCBU WTH	Rangatira, SCBU North, Maternity West	ED WTH can assist Rangatira/SCBU
SCBU NSH	Maternity, SCBU WTH, ICU, Rangatira, Hine Ora, ED	Staff need to have the flexibility to return to SCBU as part of emergency response as SMOs are off site. SCBU NSH does not have registrar cover There are bureau staff that have worked on SCBU
Maternity North (Registered Nurses)	Hine Ora SCBU North	May task on Surgical or medical wards
Maternity West (Registered Nurses)	SCBU west Rangatira	May task on medical wards
Maternity West (Enrolled Nurses)	SCBU West Rangatira	
Maternity North	Maternity West, SCBU,	Midwifery scope of practice enables midwives to work with pregnant women, postnatal mothers to 6 weeks and newborns less than 6 weeks. All other patients are outside their scope of practice
Maternity West	Maternity North, SCBU, Theatres West	

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## Assisting on Wards - Staff Deployment

### 9.3 Medicine and Health of Older People Services (MHOPs)

#### North Shore Hospital

Home Ward	Cluster Wards	Comments
Ward 2	Ward 10 and 11	An RN can be moved from any medical ward to another medical ward or to ADU or to AT&R at NSH or WTH
Ward 3	Ward 5 and 6	
Ward 5	Ward 3 and 6	
Ward 6	Ward 3 and 5	
Ward 10	Ward 2 and 11	
Ward 11	Ward 2,14 and 15	
Ward 14	Ward 15 & 11	Staff should not be redeployed to ED or ADU. Staff can be redeployed to any medical or AT&R ward at NSH or WTH
Ward 15	Ward 14, Ward 11	Staff should not be redeployed to ED or ADU. Staff can be redeployed to any medical or AT&R ward at NSH or WTH
ADU NSH	ED NSH	Staff can be redeployed to any medical, surgical cardiology wards and ED on site
LCC Cardiology	ADU NSH, Huia ward WTK	If no staff available in cluster staff can be redeployed from any medical ward.
ED NSH	ADU NSH	Staff can be redeployed to any medical, surgical cardiology wards on site

**Note: Support can be given to Short Stay Ward from any of the medical wards if it is to care primarily for medical patients or very simple surgical patients**

- If no staff required on cluster wards then staff can be redeployed from any Medical/ AT&R ward to another Medical ward or to SSW to enable a SSW RN to be redeployed to a Surgical ward.
- If there is extra nursing resource in Cardiology (LCC) a nurse can be redeployed to task on any medical ward, ED/ADU/HDU.

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## Assisting on Wards - Staff Deployment

### Waitakere Hospital

Home Ward	Cluster Wards	Comments
Titirangi	Anawhata	Staff can be redeployed from any medical ward at NSH or WTH or WTH ADU/ ED.
Anawhata	Titirangi	Staff can be redeployed from any medical ward at NSH or WTH or WTH ADU/ ED.
Wainamu	Huia	Staff can be redeployed from any medical ward at NSH or WTH or WTH ADU/ ED.
Huia	Wainamu / LCC	Staff can be redeployed from LCC or any medical ward at NSH or WTH or WTH ADU/ ED.
Muriwai	Wainamu, Huia, Anawhata and Titirangi ward	Staff can be redeployed from any medical ward or AT&R ward on either site.
ADU WTH	ED WTH	Staff can be redeployed to any medical wards/ ED on site
ED WTH	ADU WTH	Staff can be redeployed to any medical wards / ADU at WTH and paediatric staff to Rangitira

**Note: Staff can be redeployed to Short Stay Ward in day stay unit from any of the WTH medical wards WTH ED or WTH ADU**

### 10.Related documents

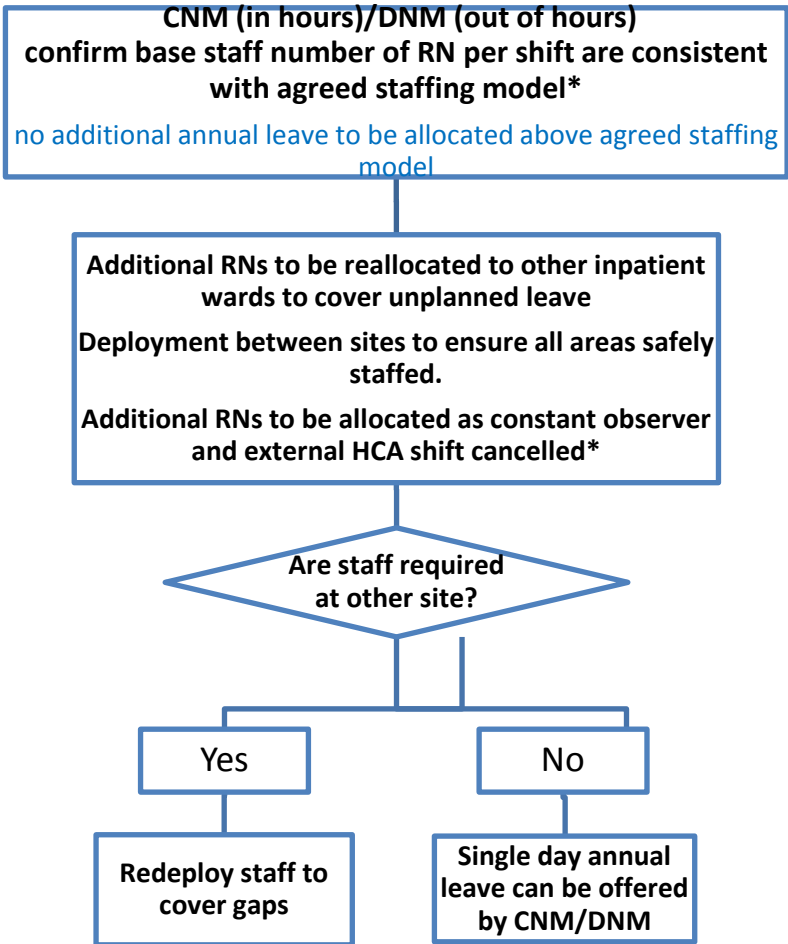
Roster Planning – Scheduling Safe Staffing – Nursing & Midwifery Oct 2016  
Temporary Closure of Ward / Reduction in Ward Beds [Flex]

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# Assisting on Wards - Staff Deployment

## Appendix: Staff Management Plan



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# Variance Response Management

Standard Operating Procedure  
(Adult and Child Inpatient Wards)







# Excess Capacity

## Shift Co-ordinator/Charge Nurse Manager

- Complete TrendCare data input/workload allocation
- Complete/update Variance Indicator Board for current shift
- Review and update expected admissions and estimated discharges
- Review staffing forecast for shift in TrendCare
- Admit patients from same division wards/units who need assistance with capacity and retain any existing outliers
- Redeploy staff as per policy when requested by Waitematā Central or Divisional Clinical Nurse Director
- Consider staff short term leave following discussions with Waitematā Central and Divisional Clinical Nurse Director
- Consider quality improvement activities

## Divisional Clinical Nurse Director/ Head of Division

- Review Divisions section of Capacity-at-a-Glance with Waitematā Central
- Review expected admissions and discharges
- Assist with transfer/retrieval of high need outliers
- Reallocate staff within Division
- Inform Waitematā Central of excess capacity
- Offer short notice study leave
- Offer short notice annual leave following discussion with Waitematā Central

**EXCESS CAPACITY**





# Excess Capacity

## Waitematā Central Team

- Review whole hospital Capacity-at-a-Glance to assess areas of need
- Flex beds as appropriate
- Commence redeployment plan as per policy
- Cancel external bureau in first instance
- Cancel Waitematā Central Staffing Team casual staff if appropriate
- Inform manager of Waitematā Central Staffing Team of any Resource Team surplus
- If appropriate offer Resource Team short notice annual leave

## Executive Team

### Executive On Call – normal working hours

- Oversight as required

### Executive On Call – after hours

- Full on-call responsibilities from 17:00 – 07:00
- Check in with Waitematā Central at 21:00 (by phone)
- Receive routine Waitematā Central notifications (by text)
- Phone in to gauge/review incidents severity as appropriate

## EXCESS CAPACITY





# Standard Operating

## Shift Co-ordinator/Charge Nurse Managers

- Complete TrendCare data input/workload allocation
- Complete/update Variance Indicator Board for current shift
- Review and update expected admissions and estimated discharges
- Review staffing forecast for shift in TrendCare
- Direct Clinical Nurse Educator and Clinical Coach to staff/ training needs
- Routine liaison with Medical Teams
- Ensure work breaks are allocated

## Divisional Clinical Nurse Director/ Head of Division

- Review division's Capacity-at-a-Glance with Charge Nurse Managers
- Monitor ward Variance Indicator Boards
- Review expected admissions and discharges
- Assist with transfer/retrieval of high need outliers
- Reallocate staff within Division as required
- Routine liaison with Charge Nurse Managers

**STANDARD OPERATING**



# Standard Operating

## Waitematā Central Team

- Review whole hospital Capacity-at-a-Glance to assess areas of need
- Flex beds as appropriate
- Review shift-by-shift external Bureau and internal Waitematā Central Staffing Team usage
- Review staffing plan for next 24 hours
- Routine liaison with Waitematā Central Staffing Team
- Routine liaison with divisional Clinical Nurse Directors/Head of Division re staff deployment
- Routine liaison with Charge Nurses/ward/unit coordinators
- Routine overview Elective flow
- Routine liaison with ED/ADU
- After-hours provide clinical support to wards/units as required

## Executive Team

### Executive On Call – normal working hours

- Oversight as required

### Executive On Call – after hours

- Full on-call responsibilities from 17:00 – 07:00
- Check in with Waitematā Central at 21:00 (by phone)
- Receive routine Waitematā Central notifications (by text)
- Phone in to gauge/review incident severity as appropriate

**STANDARD OPERATING**





# Stretch Plan

## Shift Co-ordinator/Charge Nurse Manager

- Hold group huddle
- Check/update Trendcare to reflect capacity and demand
- Complete/update Variance Indicator Board for current shift
- Accelerate patient discharges as able
- Assess outliers for transfers as required
- Identify patients who can be moved to discharge lounge
- Review/redistribute workloads (Child Health wards CNM to take patient load or floor tasking) and re-prioritise patient care
- Stagger admissions if possible in discussion with Waitematā Central
- Make divisional Clinical Nurse Director/Head of Division aware
- Assess need for additional part/full shifts
- Ask divisional Clinical Nurse Director/Head of Division or Waitematā Central about resource availability
- Prepare for re-deployed staff arrival e.g. Short Term Assistance sheets

## Division Clinical Nurse Director/ Head of Division

- Review Division's Capacity-at-a-Glance with Charge Nurse Managers
- Discuss with Charge Nurse Managers if able to supply short term tasking help
- Co-ordinate short term taskers
- Approve part/full extra shifts

**STRETCH**



# Stretch Plan

---

## Waitematā Central Team

- Review whole hospital Capacity-at-a-Glance to assess areas of need
- Liaise with Waitematā Central Staffing Team about available staff
- Assist Charge Nurse Manager/Ward Co-ordinator with any available resource
- Discuss situation with Divisional Clinical Nurse Director/Head of Division and Waitematā Central Clinical Nurse Director in-hours
- After-hours, Duty Nurse Manager liaises with Executive On Call as required
- After-hours provide clinical support to wards/units as required

## Executive Team

### Executive On Call – normal working hours

- Monitor Division's ability to manage by attending 08:15 access and 16:00 ED/ADU meeting

### Executive On Call – after hours

- Liaise with Duty Nurse Manager as appropriate to monitor situation
- Respond to Duty Nurse Manager request for further advice/guidance
- Update Director Hospital Services as required

**STRETCH**



# High Risk

## Shift Co-ordinator/Charge Nurse Manager

- All actions from Stretch plan completed
- Check/update Trendcare to reflect capacity and demand
- Following group huddle review and update ward/unit Variance Indicator Board for shift
- Re-allocate non-assigned nurses to clinical tasks
- Consider minimum care package and, if implementing, discuss in-hours with divisional Clinical Nurse Director and after-hours with Duty Nurse Manager
- Request Waitematā Central for staggered or delayed admissions
- Charge Nurse Manager to remain on the ward/unit tasking or coordinating; take patient load if required
- Escalate to divisional Clinical Nurse Director/Head of Division or Waitematā Central Operations manager in-hours, Duty Nurse Manager after-hours
- Assess need to complete Riskpro regarding situation

## Divisional Clinical Nurse Director/ Head of Division

- All actions from stretch plan completed
- Review division's Capacity-at-a-Glance with Charge Nurse Managers
- Review divisions acute/elective admissions and discharges
- Review all incoming transfers for ability to accommodate
- Liaise with Charge Nurse Manager and Waitematā Central to assess events and actions needed
- Arrange for accelerated discharges
- Discuss with other Clinical Nurse Directors the clinical use of Clinical Nurse Specialist, Clinical Nurse Educator and Clinical Coaches
- Approve requests from Charge Nurse Managers for part/full and overtime shifts
- Cancel non-essential meetings
- Walk round your affected areas
- Inform divisional Assistant Director of Nursing/General Manager of actions taken

**HIGH RISK**





# High Risk

## Waitematā Central Team

- All actions from stretch plan completed
- Review hospital Capacity-at-a-Glance
- Advise ICU Outreach Team of situation
- Advise Waitematā Central Clinical Nurse Director in-hours and after-hours Executive On Call
- After-hours, brief the ED/ADU Medical and Nursing team during huddles (21:30, 24:00 and 05:00)

## Executive Team

### Executive On Call normal working hours

- Monitor division's ability to manage by attending 08:15 access and 16:00 ED/ADU meeting

### Executive On Call after-hours

- Proactively contact Waitematā Central Duty Nurse Manager for updates at mutually agreed times
  - Review actions taken and resource available
  - If requested, attend site in person
  - Update Director Hospital Services and review situation on a regular basis
  - Monitor effectiveness of management plan
- » Executive team responsibility includes sign-off on patient diversions, temporary closure of a service to admissions, deferment of elective lists and non-essential booked admissions

**HIGH RISK**





# Critical

## Shift Co-ordinator/Charge Nurse Manager

- All actions from High Risk Plan completed
- Maintain clinical leadership on the ward/unit

## Divisional Clinical Nurse Director/ Head of Division

- All actions from High Risk Plan completed
- Escalate to (Assistant) Director of Nursing
- Maintain visibility to ward/unit staff
- Consider cancelling RN training/study days

## Waitematā Central Team

- All actions from High Risk Plan completed
- After-hours, also complete Clinical Nurse Director tasks
- Escalate to Waitematā Central Clinical Nurse Director/ Executive on Call
- Participate in Incident Management Team response

## Executive Team

## Executive on Call – all hours

- Inform and discuss with Director Hospital Services
- Inform and discuss with Waitematā DHB Incident controller on call
- Respond to site and review situation with Waitematā Central
- Initiates Incident management Team (set-up if required)

**CRITICAL**





# Minimum Care Package

- Complete **clinical observations (ABCD)** on all patients. Monitor sickest patients.
- Provide **complex care needs** – NZEWS/Obs, FBC, O2, IVF, falls prevention, pressure, monitor delirium.
- Administer **medications and pain relief**.
- **Communicate** with patients and relatives. Advise who to call, when you will be back, what to do if you're delayed.
- Assign **appropriate person** (e.g. RN, HCA, Ward Clerk, or family member) to **complete rounding, answer call bells, assist with essential cares** (e.g. hygiene, continence and nutrition), **provide watches**.
- Monitor **patient status hourly**.

## MINIMUM CARE PACKAGE DEFINITION



# Bed Capacity Management & Escalation Plan

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## 1. Introduction

This document outlines the capacity management processes for acute *Medicine & Health of Older People and Surgery & Ambulatory Divisions* at Northshore Hospital, supported by the Waitemata Central Daily Operations Unit.

Explains how capacity management occurs and how escalation is managed when the situation reaches certain indicators.

This document

- is an ‘all of hospital’ approach for the North Shore and Waitakere Hospital general services and relates to admission, transfers and/or discharge patients
- guides staff who are responsible for or involved in ensuring appropriate bed allocation, bed management and resourcing of in-patient areas.

**Exclusions**

Direct admissions to Mental Health, particular procedures in Women’s Health, SCBU, Rangitira, Intensive Care Unit (ICU).

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# Bed Capacity Management & Escalation Plan

## 2. Expectations

Acute medical-surgical hospital capacity management is managed as an integrated system across 24/7 under the leadership of the Waitemata Central Daily Operations Unit. The aim is to have systems and processes in place that provide a co-ordinated, clinically appropriate response every day across the 24 hours. Planning and response takes account of acute admission demand, elective admissions and transfers from ICU/HDU and CCU.

The General Managers and Operations Managers of all Divisions [Acute and Emergency Medicine , Specialty Medicine and Health of Older People, Surgery & Ambulatory, Child Women and family and Specialist Mental Health] work with the Waitemata Health Daily Operations Unit to ensure that patient throughput is managed safely and allows for free flow of patients from ED and ADU to available beds efficiently.

- Good capacity management requires regular forecasting, careful planning each week/day and cooperative communication of changes in the balance between elective and acute demand.

Escalation occurs when identified trigger points are reached. Management of an over-capacity situation requires a whole system approach or the implementation of a service specific plan.

## 3. Business as Usual

### 3.1 Waitemata Central [WC]

Waitemata Central has been established to manage the two main hospitals 24 hours a day. The service has the following roles:

- Clinical Nurse Director Patient Care and Access
- Operations Managers – Northshore Hospital and Waitakere Hospital
- Duty Nurse Managers
- Clinical Nurse Managers – with nursing team
- Bed Assignment Coordinator
- Bureau staff support

### 3.2 24/7 WC Operations Manager and Duty Nurse Manager role

The WC Operations Manager and Duty Nurse Managers maintain 24/7 close, accurate, minute-by-minute knowledge of hospital capacity. This includes ED/ADU demand, elective surgical admissions, transfers and available human resources

Allocation of beds is managed through an effective centralised 24 hour bed allocation and management process by the Duty Nurse Manager.

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## Bed Capacity Management & Escalation Plan

### 3.3 Principles of bed allocation

Allocation of beds ensures the best environment to care for the patient based on patient clinical need – all requests made through the Duty Nurse Manager

1. Bed management will be patient focused – Right patient, right bed, gender appropriate
2. ED is an inappropriate place for those requiring an inpatient bed
3. All patients will be managed in accordance with the 6 hr targets
4. Patients shall only have a bed request when they are ready to move to a bed (or are in theatre and need a bed post operatively)
5. Patients should be moved to an inpatient bed from ED/ADU as soon as possible after the bed request has been received by the DNM. This should be completed within the hour.
6. Wait times for beds will be monitored and the information used to reduce wait times and improve patient focused bed management
7. Where possible and without causing extended wait times for patients, medical pts should be placed in medical beds, surgical pts in surgical beds, and orthopaedic pts in orthopaedic beds. If no bed is available in the correct speciality or is unlikely to be within one hour – the next best place should be allocated (these patients are named ‘outliers’).
8. 4 bedded rooms should be assigned to patients of one gender. The gender/ethnic/age/other mix of a multi-bedded room shall be managed by the ward staff in conjunction with the DNM. (Refer to patient placement policy)
9. Ward beds can only be deemed ‘closed’ by the General Manager and or Clinical Director. The Duty Nurse Manager, may deem a bed to be ‘flexed’, that is not used unless necessary, due to resourcing or other issues.
10. All available beds will be used as they become vacant to minimise wait times for patients. Patients on ward leave should be noted on ward board for next available bed on return (No beds are to be saved for patients on leave)
11. Wards are to advise the Duty Nurse Manager of available beds/beds that will be available in a timely and accurate manner.
12. Ward day rooms are to accommodate patients waiting for completion of the discharge process in order to minimise bed wait times for patients.
13. The bulk of discharges should occur before 11am to facilitate the movement of patients waiting for beds in ED/ADU. In peak activity times, clinical teams and wards will be required to identify suitable patients for earlier discharge or transfer to another services, or who could be discharged with an outpatient appointment for appropriate non-urgent diagnostic tests
  - A bed request (decision to admit) will be made when the patient is ready to move within 30 minutes of the request being made.
  - Resourced beds are used before unresourced beds
14. Unresourced beds are used as a last resort when all other appropriate alternatives have been explored

### 3.4 Daily ‘Balancing’ Capacity Management meetings

There is a week day, daily balancing capacity management meeting held on both North Shore and Waitakere sites.

Chaired by the Daily Operations Manager and attended by all Charge Nurse Managers and senior Nurse Leaders, to review

- Accurate current bed state and projected bed state
- Any expected admissions (including elective admissions)
- Actual and predicted discharges/transfers

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## Bed Capacity Management & Escalation Plan

- Next 24 hours staffing levels including potential redeployment opportunities and/or predicted staff requests to meet expected activity, and considering impact of potential acute admissions

Decisions are made on resource sharing and planned disposition. The spreadsheet is emailed to # **Bed Management Group**

### 3.5 After-hours Review of Hospital Status

The Waitemata Central team review with ED and ADU the status of the hospital and forecast next 12 hours. After-hours the Waitemata Central team discuss bed capacity management issues with the on-call executive.

### 3.6 Transfers

Internal transfers of patients are secondary to patients waiting for beds in ED/ADU, unless there is imminent demand or pressure on a specialist bed.

External transfers of patients to NSH or WTH are to be accommodated as able, and are also secondary to patients waiting for beds in ED/ADU.

Relative to resource, ICU/CCU transfer may be delayed if it will negatively impact on care the patient will receive in the ward and ICU/CCU bed not needed immediately.

### 3.7 General Managers, Clinical Leaders and Operations Manager review of utilisation and performance

There is a weekly bed management meeting to:

- Plan inpatient bed availability based on capacity forecast
- Review performance to plan
- Prepare information for ward managers to utilise for rostering and budget purposes
- Plan initiatives to improve performance against agreed targets

### 3.8 Infection control considerations

Patients with transmissible infectious diseases will be isolated as per the Waitemata DHB policy, *Transmission based isolation precautions*.

In the event of an infectious disease outbreak, the outbreak committee has the authority to determine bed use and/or closure (see Waitemata DHB policy, *Outbreak management of infectious disease*)

## 4. Capacity - Escalation where demand increases

### 4.1 Monitoring

PIMs is the 'single source of truth' for tracking admissions and discharges.

The Clerical team are required to enter data on PIMs immediately there is a change.

- After-hours discharges/transfers should be forwarded to the Admissions Clerks in ED/ADU to maintain the updated system
- Information from PIMS is updated on CapPlan every 5 minutes and on ED/ADU Whiteboard.

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## Bed Capacity Management & Escalation Plan

- IT knows the importance of ensuring these systems remain functioning.

### 4.2 Escalation Meeting

An Escalation Meeting is initiated by the Waitemata Central team with the General Managers where there are key escalation needs [bed demand, emergency scenario] by sending a notification to **# Bed Management Group** that the hospital is in RED alert.

**Key members are phoned. Members meet in half an hour of receiving Alert.**

Attendees will review presented information [note range of spreadsheets and other screens of real-time information]. A plan is formulated. The Director of Hospital Services notifies the Chief Executive when impact of bed crisis affects other DHBs or adverse media coverage is likely.

The purpose is to brief the key managers of the scenario, escalation actions required and agree an agreed plan for the next 12-24 hrs

- Agreed actions will be communicated to the wider Divisions and actions implemented. Refer to service plans below. Plans will not be re-litigated at the Escalation meeting.
- Repeat meetings e.g. 2 hours post initial meeting, will be held to report back individual service progress

The frequency of the meeting in a 24 hour period depends on resolution.

### 4.3 Response to escalation

Response to escalation varies depending on:

1. ED/ADU overload due to unavailability of inpatient beds
2. ED/ADU overload where there are available beds
3. Limited staffing and other resources
4. External pressure on hospital resources

### 4.4 Levels of escalation

Levels of escalation range from

- Green - business as usual
- Yellow - system pressured
- Red - over capacity
- Both yellow and Red require Divisional decision making and contingency planning.

This plan merges seamlessly with the Emergency Planning documents for mass casualty, pandemic and other emergencies

## 5. Hospital Alert System

Two triggers at the highest level indicate response required

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## Bed Capacity Management & Escalation Plan

ED	ADU	Inpatient	Patients	Ward Staffing	Doctors
Capacity	Capacity	Bed Capacity	Awaiting Beds		Available on call RMO
Occupied beds < 28	Occupied beds < 40	< 85% Beds Occupied	0-10 pts waiting	Staffing resource matches open beds	Sufficient – all call positions covered
Occupied beds 28-34	Occupied beds 40-45	>85% Beds Occupied	10-15 patients waiting for beds	30% of 3 or less wards under staffed for open beds	Borderline – All positions able to be covered with available staff cross covering as locum
ED Full	Occupied beds 46 +	> 96% Beds Occupied	>16 Patients Waiting OR > 10 patients waiting for 1 specialty	> 4 wards under staffed	Critical – Oncall positions uncovered and pagers not carried by RMO.

### 6. Waitemata Operations Manager and Duty Nurse Manager

#### Green – Business as Usual

- Oversight of the hospital
- Plan and monitor resources – respond to changes in demand – utilise staffing resource appropriately
- Timely bed allocation
- Bed Management – flex beds to demand and resources

#### Yellow – System Pressured

1. Update alert with DM report and as required
2. Send alert to # bed management Group during working hours
3. Send alert to all CNM's

#### Immediate Actions:

- Power page wards to expect 1 extra admission per ward within the next hour – repeat as necessary
- Request orderlies deliver 1 extra bed to each ward area to allow day rooms to be set up
- Meet ED/ADU CCN to identify suitable patients and instigate 1 pt admit per ward plan
- Request Bureau as required
- Consider extra transit, cleaning and orderlies depending on need
- Flex up beds as required and as staffing allows.
- Implement plans to balance patients across sites – discuss potential with Waitakere Duty Manager

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# Bed Capacity Management & Escalation Plan

## Red – Over Capacity

1. **Send alert to # Bed Management Group during working hours**
  2. **During business hours, prepare for escalation meeting.**
  3. **Notify On Call GM A/H**
- Plan to open overflow areas or taking over an area's function in-order to create capacity space
  - Plan which patients could go to which overflow areas, cohort to specialty.
  - Request assistance from 'On call' manager as required
  - Increase dedicated transit to ED/ADU
  - Request more cleaners/ cleaning support from Non-Clinical Services if required
  - Alert appropriate service of the need for escalation. If after hours follow service specific plan

## 6.1 Roles and Responsibilities

### Role of 'on call' Manager/General Managers

- Provides assistance and support as required by DNM
- Communicates with GM, DON, COO and Communications as required and request assistance/options
- Attends hospital after-hours if requested by DNM to assist
- Authorises any actions that are over DNM delegated authority
- Sets up EOC if required to manage situation.

### Role of Chief Medical Officer/Chief Executive

- Briefed by on call Manager
- Provides a challenge to decision making
- Authorises formal internal and external communication of escalation status
- Undertakes a walk through with General Managers to look at response if requested

CapPLAN uses Escalation Criteria and is used by the Daily Operations Unit

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# Bed Capacity Management & Escalation Plan

http://nshis71/HospitalNotifications/Default.aspx Go

North Shore Hospital

**North Shore Hospital Status: Red**

Notification status last updated at  
20/12/2011 5:18:16 p.m

**Primary Notifications**

Facility	Current Status	Notification	Green	Yellow	Red
North Shore Hospital	<span style="color: yellow;">Y</span>	ED Capacity	<input type="radio"/> Occupied (Occ) beds <28	<input type="radio"/> Occupied (Occ) beds 28 - 34	<input type="radio"/> ED Full
North Shore Hospital	<span style="color: red;">R</span>	ADU Capacity	<input type="radio"/> Occupied (Occ) beds <40	<input type="radio"/> Occupied (Occ) beds 40-45	<input type="radio"/> Occupied (Occ) beds 46+
North Shore Hospital	<span style="color: green;">G</span>	Patients Awaiting Beds	<input type="radio"/> 0-10 patients waiting for beds	<input type="radio"/> 10-15 patients waiting for beds	<input type="radio"/> >16 or 10 for 1 speciality
North Shore Hospital	<span style="color: red;">R</span>	Inpatient Bed Capacity	<input type="radio"/> < 85% Beds Occupied	<input type="radio"/> 85-95% available beds	<input type="radio"/> > 96% available beds
North Shore Hospital	<span style="color: green;">G</span>	Ward Staffing	<input type="radio"/> staffing resource matches open beds	<input type="radio"/> 3 or less wards under staffed for open beds	<input type="radio"/> >4 wards understaffed
North Shore Hospital	<span style="color: green;">G</span>	Doctors Available on call RMO	<input type="radio"/> Sufficient - all positions covered	<input type="radio"/> Borderline - All positions able to be covered with available staff cross covering as locum	<input type="radio"/> Critical - Oncall positions uncovered and pagers not carried by RMO

**Secondary Notifications** (These do not affect the overall hospital status)

Facility	Current Status	Notification	Green	Yellow	Red
North Shore Hospital	<span style="color: green;">G</span>	Pandemic	<input type="radio"/> Code White (information/ advisory only)	<input type="radio"/> Code Yellow (standby phase)	<input type="radio"/> Code Red (response phase)

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## Bed Capacity Management & Escalation Plan

### 7. Emergency Department and ADU Escalation Plan

#### Bed Status

**Green**  
(Business As Usual)

#### ACCN

- Manages capacity within the department. Maintains patient flow.
- Facilitates the movement of speciality patients to ADU
- Oversees the Triage area for presentation numbers so surges are quickly identified and managed.
- Co-ordinates with Discharge planner to manage potential admissions in community.
- Active Management of patients suitable for direct admission to AT&R.
- Proactively manages staff vacancies.
- Liaises with Bureau and casual staff to fill shortfalls
- Alerts Duty Manager to unresolved staffing issues
- Liaises closely with ADU/ED CCN to ensure bed management and patient flow is maintained
- Liaises with ADU/ED CCN to redeploy staff between depts according to patient needs.
- Redistribute patient loads within department
- Alerts CNM / ED/ADU Ops Manager to any staffing or patient problems – discuss plan to manage department

#### CNM

- Attend daily Capacity Management Meeting.
- Ensures rostering practices provide for unit cover.

#### Medical Teams

Senior EM Dr to coordinate ED

Timely processing of EM patients

Intervene with speciality patients who are not progressing through the dept within 6 hrs

Discuss consultant back up as required with speciality consultants

#### Operations Manager

- Monitor system for stress and proactively manage any pending blocks Monitor service demands.
- Manage RMO staffing to reflect service needs in conjunction with CD.

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## Bed Capacity Management & Escalation Plan

### Bed Status Yellow

Trigger	ACCN	CNM	Medical Teams	Operations Manager
Less than 5 available medical/surgical ward beds but ADU not at capacity	See ACCN actions above Liaise with DNM re: needs Consider placement in ADU Receives alert from triage when internal presentation triggers are reached ( <i>system required</i> ) Instigates internal escalation plan <ul style="list-style-type: none"> <li>• Re-assign staff to area of need</li> <li>• CCN in conjunction with Clerks Team Leader to assign a member of staff to assist with admitting patients in ambulance bay.</li> <li>• Ensure patients are aware of the waiting time and provide information as to other options for care (pamphlets)</li> <li>• Facilitates potential discharges within ED</li> <li>• Identification of staffing requirements</li> <li>• Text vacancies to off duty staff</li> <li>• Contact bureau / duty manager to confirm requirements for staff</li> <li>• Discuss capacity situation with DNM and FACEM so that collaborative planning can occur.</li> <li>• Communicate situation with CNM during business hrs.</li> </ul>	See CNM actions above	Discuss with EM specialist alerting GP's as to ED status (system would be required)  Review of all EM patients in department consider primary options	Liaise with DNM and other Ops Managers Attend Escalation Meetings Communicate with staff on situation and actions being taken on the whole system

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## Bed Capacity Management & Escalation Plan

	ED less than 5 beds in each area but ward beds available	See ACCN actions above Alert DNM of situation. Assess numbers by specialty and call on-call teams to review and plan treatment. Identify patients to move to ADU for their continued assessment	See CNM actions above	<ul style="list-style-type: none"> <li>All doctors on non-clinical time to work on the floor seeing EM patients as necessary</li> <li>Maintain flow with EM patients</li> <li>Review patients with &gt;LOS greater than 4 hrs to assess if pts can be discharged</li> <li>In conjunction with Ops Mgr, consider using vouchers for lower acuity patients to attend Shore Care to off load department – this must be balanced with CNS workload.</li> </ul>	Attend Escalation Meetings Communicate with staff on situation and actions being taken on the whole system
<b>Bed Status Red</b> (over capacity) requiring divisional decision making and contingency planning	<b>Trigger</b> No available medical/surgical beds and ED/ADU at capacity  ED/ADU overload and ward beds at capacity	<b>ACCN</b> <ul style="list-style-type: none"> <li>Ensure breaching of 6 hr target is minimised</li> <li>Assess staffing over the next 24hr and advise bureau of cover needed including HCA's.</li> <li>Increased resource request for support nursing staff and for orderlies to DM.</li> <li>Enact Prioritised care plan if necessary</li> <li>Issue vouchers for low acuity patients to attend A&amp;M</li> <li>Request extra phlebotomy staff to attend ED</li> </ul> See ACCN actions above	<b>CNM</b> See CNM actions above <ul style="list-style-type: none"> <li>Call in extra clerical staff to ensure data is maintained correctly</li> <li>If in the morning cancel study leave, if in the PM offer nurses on study leave extra hours</li> <li>Call in Senior ED/ADU Nursing Staff</li> <li>Utilise CNE and CNM to support clinical areas</li> </ul> Allocate additional resources to assist in areas e.g. educator, nurses non clinical time. Review workload of ACCN and provide additional coordination support	<b>Medical Teams</b> <ul style="list-style-type: none"> <li>CD oversight for backup and support of ED and ADU</li> <li>Maintain flow with EM patients</li> <li>Specialty escalation plan applies</li> </ul> ED FACEM or CD to work with ED CCN to manage planning and decision making in Dept Call in medical team back-up.	<b>Operations Manager</b> Attend Escalation Meetings  Communicate with staff on situation and actions being taken on the whole system  Provide written service plan to DNM for afterhours management  Attend Escalation Meetings Communicate with staff on situation /actions being taken on the whole system. Provide written service plan to DNM for after hrs Mgt

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## Bed Capacity Management & Escalation Plan

### 9. Medicine Service Escalation Plan

Bed Status	Triggers	Operations Manager	Medical Teams	CNM	Head of Division	GM
Green (Business As Usual)	Acute and elective medical bed demand can be accommodated in medical bed capacity	<p>Monitor system for stress and proactively manage any pending blocks Monitor service demands.</p> <p>Manage RMO staffing to reflect service needs in conjunction with CD.</p> <p><i>What happens afterhours?</i></p>	<ul style="list-style-type: none"> <li>Assess acute patients in a timely fashion.</li> <li>Complete discharges in a timely manner.</li> <li>Teams to discharge 1 patient at start of ward round (1 well home).</li> <li>All patients have documented EDD.</li> <li>Identification of patients who can have an early discharge back to GP care or utilisation of Primary Options GP respite care.</li> <li>Ensure weekend plans are in place for all patients.</li> <li>Hand over with on call teams regarding any potential deceased patients to ensure medical certification can be completed within 24 hrs.</li> <li>A and B call teams present in ED/ADU for timely pt assessment and treatment.</li> </ul>	<ul style="list-style-type: none"> <li>Monitors all pts care journey's to ensure clear plans and decisions including documented EDD.</li> <li>Review EDD every 24 hrs.</li> <li>Proactively manage patient discharges - consider Primary Options/Discharge with community assistance.</li> <li>Progress transfer of longstanding patients to rehabilitative care or rest-home respite care.</li> <li>Proactively manage staff vacancies – refer to safe staffing document.</li> <li>Alert Duty Managers to any staffing or patient problems – discuss planned actions</li> <li>Regularly update patient numbers and expected discharges to DNM.</li> <li>Provide information for Capacity Management Meeting and identify any blocks and barriers for escalation and action.</li> <li>Contact medical staff for any patients not seen in the last 24 hours.</li> <li>Request acceleration of tests for patients to discharge.</li> <li>Collaborate with medical staff to ensure all care plans and timelines are clear.</li> <li>Ensure weekend plans are in place for all patients.</li> </ul>	<p>Assist CNM to resolve longstanding patient management issues and known staffing gaps.</p> <p>Support CNM with staffing plans.</p> <p>Assist with identified blocks to discharge.</p> <p>Attend weekly bed management meeting.</p>	<p>Attend weekly bed management meeting.</p>

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## Bed Capacity Management & Escalation Plan

### Bed Status Yellow

#### Triggers

- Acute and elective medical bed demand at capacity.
  - 10 medical Patients in ED/ADU waiting for beds.
  - ED/ADU overload but ward beds available
  - > 12 medical patients TBS in ED/ADU
- Patients in ED unable to be processed within the 5 hr target

#### Operations Manager

- Alert all non-acute medical team consultants of Yellow status
- Alert A and B Call Consultants of yellow status ensure that teams are presenting ED and ADU.
- Discuss with CD re Call C call team to assist A and B call in ED/ADU with patient assessment.
- Assess medical staffing for the next 48 hours.
- Request assistance from HOD.
- Alert GM of status and actions.
- Power page C on call acute team to attend ED/ADU to assist Registrars
- Create internal contingency plans to deal with backlogs

#### Medical Teams

- All non-post-acute teams focus on urgent discharge of patients - complete 1 patient discharge per team at start of ward round.
- All post-acute teams to immediately review their pts in ED and ADU to ensure treatment plans current and on track including EDD.
- Evening round by C call consultant in ADU/ED.
- A and B Call SMOs advised of Yellow status and to review teams workloads in ED/ADU. Request extra assistance if necessary from CD.
- Evening round of On Call consultants in ED/ADU.

#### CNM

##### Receive alert from DNM Immediate Actions:

- Identify 2 patients for discharge and move to dayroom.
- Identify potential to double side-rooms.
- Consider all options to create space- group isolation patients into a 4 bed room or group watch patients into a 4 bed room.
- Prepare to receive an extra patient into the ward.
- Continue staffing plans, call casual staff, extend shifts.
- Refer to Safe Staffing Plan.
- Advise Allied Health staff of priority patients to facilitate discharge.
- Alert diagnostic areas of priority for patients for discharge to have tests – follow up or escalate.
- Review model of care to ensure all beds utilised.
- Lead discharge process – cancel non-essential meetings to be present on ward.
- Challenge all unclear management plans and timelines for delivery of care.

##### Update Info for Capacity Management Meeting

*Staffing shortage, group discussion about flexing staff across service to gain better cover*

#### Head of Division

Receives staffing report from Duty Manager.

Oversee plans in areas with critical staff shortages.

Support nurses in decision making as required.

Alert Allied Health teams of capacity issue and request assistance with facilitating discharges.

#### GM

Briefed by Ops Manager.

Meet with Clinical Directors to review situation.

Actions taken report from Operations Manager.

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## Bed Capacity Management & Escalation Plan

Bed Status	Triggers	Operations Manager	Medical Teams	CNM	Head of Division	GM
<b>Red</b> (over capacity) requiring divisional decision making and contingency planning	<ul style="list-style-type: none"> <li>Acute and elective surgical bed demand over capacity and no overflow possible</li> <li>&gt; 15 medical patients in ADU/ED waiting for beds.</li> <li>&gt; 15 medical patients to be seen</li> <li>Patients in ED unable to be processed within the 5 hr target</li> </ul>	<ul style="list-style-type: none"> <li>Alert all SMO's to bed crisis and request urgent assistance in discharging patients.</li> <li>Meet with CD and GM to agree actions over the next 2 hrs.</li> <li>Receive reports back from Medical teams to confirm discharging of 2 pts per team has been completed.</li> </ul> <p>Meet with Operations Manager ED/ADU to discuss plan.</p> <p>Provides report back to Escalation meeting.</p>	<p><b>In hours</b></p> <p>ADU SMO or A Call SMO to take GP referral phone to free Registrar and to defer presentations as appropriate.</p> <ul style="list-style-type: none"> <li>All non-acute medical teams advised of Code Red and work to discharge at least 2 patients per team) within next 2 hrs. Report back to Ops Manager when completed.</li> <li>Review all team patients in conjunction with CNM to ensure focus is on EDD.</li> <li>C Call team to attend ED/ADU to assist with patient assessment.</li> <li>ADU SMO to be present in department to assist RMO.</li> <li>Defer discharge summaries till following day if appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>CNM takes over ward co-ordination as a priority task.</li> <li>Utilise non direct clinical nursing staff to assist in providing direct patient care.</li> <li>If staffing resources an issue refer to safe staffing policy.</li> <li>Enact prioritised care plan as necessary.</li> <li>Report to HOD Nursing ward situation</li> <li>Regularly update patient numbers and expected discharges to DNM.</li> <li>Identify patients who could have early discharge with Primary Options and contact medical team.</li> <li>Liaise with medical staff re discharge plans</li> </ul> <p><b>After Hours</b></p> <ul style="list-style-type: none"> <li>May be requested to attend the hospital to assist with staffing deficits that are adversely affecting patient care.</li> </ul>	<p>Alert service CD's of RED status.</p> <p><b>Attend Escalation Meeting:</b></p> <ul style="list-style-type: none"> <li>Develop a plan with CNM's and DNM to manage and allocate staffing resources for immediate period and next 24 hours.</li> <li>Undertake a ward walk-around to assess ward status and assist with identifying and managing bed blocks.</li> <li>Ask for all available non direct clinical staff to support clinical areas.</li> <li>Authorise the implementation of the Safe Staffing Plan including a plan to utilise un-resourced beds.</li> </ul>	<p>Meet with Clinical Directors and HOD's to review situation</p> <p>Authorise cancellation of non-essential work</p> <ul style="list-style-type: none"> <li>non clinical nursing positions to assist on wards</li> <li>Non urgent clinics deferred</li> <li>Study days cancelled.</li> </ul> <p><b>Outpatient procedures</b> cancelled to facilitate inpatient procedures</p> <ul style="list-style-type: none"> <li>Develop a service response with Clinical Director in accordance with service escalation plan.</li> </ul>

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## Bed Capacity Management & Escalation Plan

*SMOs for Acutes advised (stand by) Clinical Director has authority to request assistance from RMOs and SMOs in admissions and discharges*

CD to consider cancelling non-inpatient activities including clinics and procedures.

Review with Operations Manager re: stop all activities and be present in hospital

**After Hours** – DNM to contact C call consultant to attend hospital. Other SMO may also be requested to attend

- Discuss overflow options with other HODs.
- Provide written service plan to DNM for afterhours management
- Requests back up of HOD as required
- Advises other Service GM's and DHB as and when appropriate
- Informs COO
- Reprioritise workload
- Deploy clinically qualified staff employed in non-clinical area throughout hospital to clinical inpatient areas
- Cancel all non-acute admissions as appropriate to specialty

### **After Hours**

May be requested to attend the hospital to assist with staffing deficits that are adversely affecting patient care.

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## Bed Capacity Management & Escalation Plan

### 10. Surgical and Ambulatory Services Escalation Plan

#### Principles

- Red status situation should be highly unusual with normal fluctuation in demand managed via ongoing capacity planning processes.
- In reconciling surgical bed demand and surgical bed capacity priority is to be given to acute surgical patients in the Emergency Care Centre.
- Cancellation of some elective admissions may be unavoidable on occasions but should be considered an exceptional measure and a last resort following the exhaustion of all reasonable measures to expedite discharges and create surge capacity.

Bed Status	Trigger	Operations Managers	Surgical Teams	CNM	Head of Division Nursing	General Manager
<b>Green (Business As Usual)</b>	Acute and elective surgical bed demand can be accommodated.	<p>Monitor system for stress and proactively manage any pending blocks Monitor service demands</p> <p>Manage RMO staffing to reflect service needs in conjunction with CD.</p> <p>Review daily production planning for electives against acute admission numbers.</p> <p>Monitor cancellations.</p> <p>Monitor acute surgical wait list minutes.</p>	<ul style="list-style-type: none"> <li>• Assess acute patients in a timely fashion</li> <li>• EDD is documented in each clinical record</li> <li>• Work with CNMs on discharge plans</li> <li>• Consider POAC or patient to return to acute clinic.</li> <li>• Prompt discharge of patients – see at least 1 patient for discharge first in ward round</li> <li>• Identification of patients who can have an early discharge back to GP care or utilisation of Primary Options GP respite care</li> <li>• Ensure weekend plans are in place for all patients.</li> </ul>	<ul style="list-style-type: none"> <li>• Monitors all pts care journey's to ensure clear plans and decisions including documented EDD.</li> <li>• Proactively manage patient discharges consider Primary Options/Discharge with community assistance.</li> <li>• Progress transfer of longstanding patients to rehabilitative care or rest-home respite care</li> <li>• Proactively manage staff vacancies – refer to safe staffing document.</li> <li>• Alert Duty Managers to any staffing or patient problems – discuss planned actions.</li> <li>• Provide information for Capacity Management Meeting and identify any blocks and barriers for escalation and action.</li> <li>• Contact medical staff for any patients not seen in the last 24 hours.</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor ward occupancy levels</li> <li>• Assist CNM with staffing issues and models of care to ensure beds maximised in all areas</li> <li>• Assisting CNM to resolve longstanding patient management issues and known staffing gaps</li> <li>• Support CNM with staffing plans</li> <li>• Assist with identified blocks to discharge</li> </ul>	Attends weekly bed management meeting

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## Bed Capacity Management & Escalation Plan

Bed Status	Trigger	Operations Managers	Surgical Teams	CNM	Head of Division Nursing	General Manager
			<ul style="list-style-type: none"> <li>Communicate with on call teams regarding any potential deceased patients to ensure medical certification can be completed within 24 hrs.</li> </ul>	<ul style="list-style-type: none"> <li>Request acceleration of tests for patients to discharge.</li> <li>Ensure weekend plan are in place for all</li> <li>Utilise discharge lounge for patients waiting for papers and relatives</li> <li>Facilitate MDT and discharge planning</li> <li>Regularly update patient numbers and expected discharges to DNM.</li> </ul>	Attends weekly bed management meeting	
<b>Yellow</b>	Acute and elective surgical bed demand at capacity <i>Need trigger for planned acute surgical OT minutes e.g. &gt;360 minutes</i>	<ul style="list-style-type: none"> <li>Liaise with surgical teams to expedite discharges.</li> <li>Consider opening an acute theatre to clear acute board</li> <li>Attend daily Capacity management Meetings.</li> <li>Alert GM of status and actions taken.</li> </ul>	<ul style="list-style-type: none"> <li>Have clear date of discharge</li> <li>Consider early discharge to GP care</li> <li>Utilise transitional care beds</li> <li>Urgent discharge of patients - complete 1 patient discharge per team ASAP</li> <li>Actions from service specific plan</li> </ul>	Review bed allocation to ensure beds used "just in time". Discuss with DNM ability to take acute patients into beds that electives require later in day Assist ward coordinator with planning & bed management. Reconfigure models of care per Safe Staffing guideline. <ul style="list-style-type: none"> <li>Challenge all unclear management plans and timelines for delivery of care.</li> </ul> <p><b>Receive alert from DNM</b></p> <p><b>Immediate Actions:</b></p> <ul style="list-style-type: none"> <li>Identify 2 patients for discharge and move to dayroom or transit lounge</li> <li>Identify potential to double side-rooms</li> <li>Consider all options to create space-group isolation patients into a 4 bed room or group watch patients into a 4 bed room.</li> <li>Prepare to receive extra patients to ward</li> <li>Continue staffing plans, call casual staff, extend shifts</li> <li>Refer to Safe Staffing Plan</li> </ul>	Receives staffing report from Duty Manager  Oversees plans in areas with critical staff shortages  Support nurses in decision making as required  Alert Allied Health teams of capacity issue and request assistance with facilitating discharges	Briefed. Attend Escalation meetings  Awareness of systems stress  Actions taken report from Operations Manager  Implement Service specific escalation plan as required.

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# Bed Capacity Management & Escalation Plan

Yellow

ED / ADU overload but ward beds available

- Ascertain which specialties affected. Alert Clinical Director and on-call teams to attend ED / ADU to ensure treatment plans current and on track, reassess need for admission.
- Utilise POAC where possible
- Relevant specialty teams on call to go to ED/ADU promptly to admit pts
- SMO round in ED / ADU late afternoon

- Advise Allied Health staff or priority patients to facilitate discharge
- Alert diagnostic areas of priority for dischargeable pts to have tests – follow up or escalate
- Review model of care to ensure all beds available
- Lead discharge process – cancel non-essential meetings to be present on ward

**Update Info for Capacity Management Meeting**  
Staffing shortage, group discussion about flexing staff across service to gain better covers.

Red (over capacity) requiring divisional decision making and contingency planning

Acute and elective surgical bed demand over capacity and no overflow possible 5 acute surgical patients waiting for beds in ED

*Need trigger for planned acute OT*

- Alert all SMOs to bed crisis and request assistance in discharging patients.
- Assess whether reduction in elective admissions necessary
- Implements Service escalation Plan
- Meets with CD of service to agree actions over the next 2hrs
- Contacts SMO and RMO with actions
- Provides report back to Escalation meeting
- Request on call team to attend ED/ADU and review all acute surgical
- Review pts booked for admission prior to surgery and consider deferring to DOSA or consider cancellation with General Manager.
- All specialties do extra round to review potential discharges
- Consider early discharge to GP /POAC care
- Assist with admissions and discharges
- Each team to aim to discharge at least 3 patients in next 2 hours
- Defer completion of discharge summaries
- Review with Operations Manager re: stop all activities and be present in hospital

- Provide clinical input into potential cancellations of OR based on nursing availability and ward occupancy.
- CNM takes over ward co-ordination as a priority task
- Utilise non direct clinical nursing staff to assist in providing direct patient care
- If staffing resources an issue refer to safe staffing policy
- Enact prioritised care plan as necessary.
- Report to HOD Nursing ward situation
- Identify patients who could have early discharge with Primary Options and contact medical team.

**After Hours**  
May be requested to attend the hospital to assist with staffing deficits that are

**Attend Escalation Meeting:**

- Develop a plan with CNM's and DNM to manage and allocate staffing resources for immediate period and next 24 hours
- Perform a ward walk around to assess ward status and assist with identifying and managing bed blocks.
- Ask for all NE and available non direct clinical staff to support clinical areas
- Authorises the implementation of
- Review reduction in elective admissions
- Authorise any cancellation of elective theatre cases.
- Develop a service response with Clinical Director in accordance with service escalation plan.
- Request back up of HOD as required
- Advise other Service GM's and DHB as and when appropriate
- Inform COO

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## Bed Capacity Management & Escalation Plan

minutes  
e.g. >400  
ED/ADU  
overload  
but ward  
beds  
available

patients to confirm  
admission required.

- ADU SMO to be present in department to assist RMO
- ED FACEM or CD to work with ED CCN to manage planning and decision making in Dept.
- Calls from General Practitioners covered by a senior registrar or senior medical officer

adversely affecting patient care.

- Discuss overflow options with other HODs.
- Develop and authorise a plan for the utilisation of un-resourced beds

- Reprioritise own workload
- Deploy clinically qualified staff employed in non-clinical area throughout hospital to clinical inpatient areas

Provide written service plan to DNM for afterhours management

Cancel all non-acute admissions as appropriate to specialty

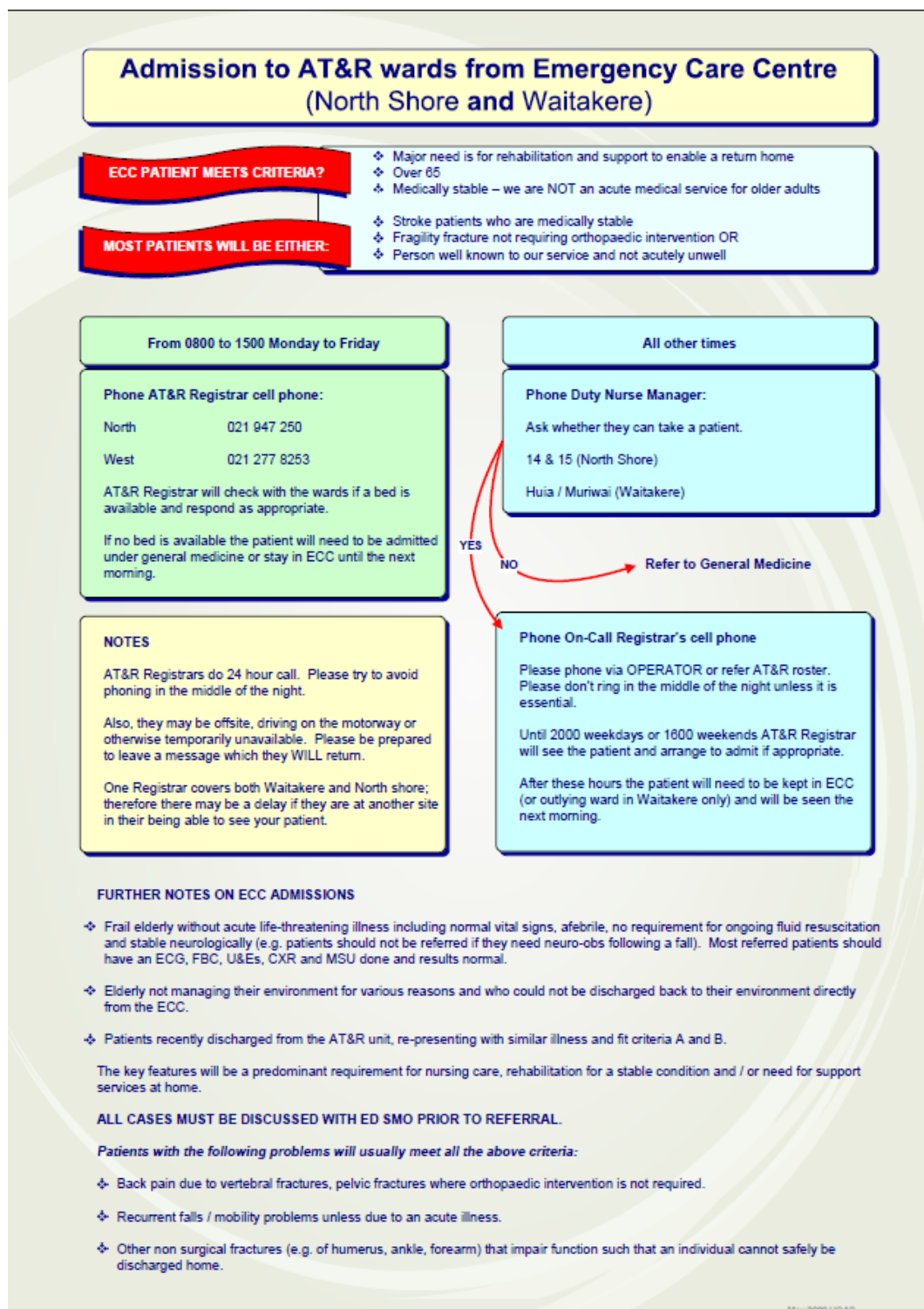
### After Hours

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## Appendix: Admission to AT&R from ED and ADU



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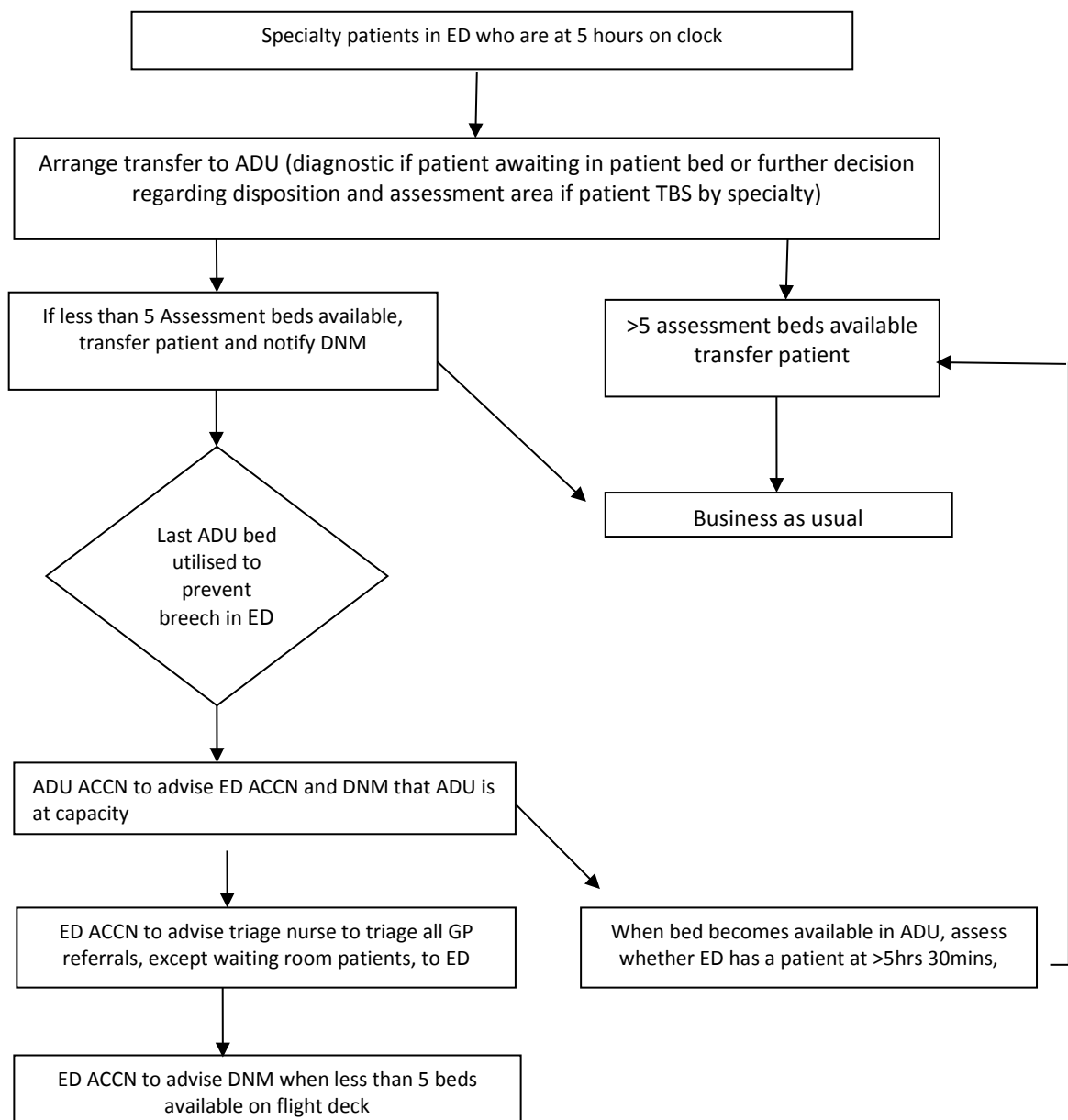
## Bed Capacity Management & Escalation Plan

### Appendix: Escalation Patient Flow Process ED / ADU

This is for implementation by the ED/ADU CNMs in collaboration with the DNM

- when: there are no inpatient beds
- and no outflow from ED and ADU.

It is anticipated that this is a short term measure and should be reviewed 2 hourly by ED/ADU CNMs in



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## Bed Capacity Management & Escalation Plan

### Appendix: Cardiology Process when Inpatient Angio List is greater than 8 patients

Please note, the following refers to operation of a single catheter lab only:

Inpatients waiting for angio/pacemaker/PCI are reviewed at the beginning of each weekday and entered into a spreadsheet template.

When the # is >8 the cell will change to orange and the CNM will know to review the situation with the Lead Interventionalist.

If it is unlikely that the # will reduce to in the same day the CNM will advise the Angio Nurse Specialist to identify some elective patients who could be cancelled.

Elective patients will be cancelled for the rest of the week if the total # of patients waiting by Tuesday pm is  $\geq 12$ . (exceptions to elective cancellations are patients who have previously had their procedure cancelled more than once).

If by Thursday of the week the # waiting continues to increase, despite elective cancellations, the Cardiology Operations Manager will liaise with the CNM CVU and the Lead Interventionalist to plan an extended weekday session or a weekend inpatient session.

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