Te Whatu Ora
Health New Zealand

18 July 2022

[redacted]

Tēnā koe [redacted]

Your Official Information Act request - Mixed gender hospital bed accommodation

Thank you for your Official Information Act request received 20 June seeking information from the former Waitematā District Health Board (DHB) about mixed gender hospital bed accommodation.

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

Waitematā is the largest and one of the most rapidly growing health districts in the country, serving a population of around 650,000 across the North Shore, Waitakere and Rodney areas. We are the largest employer in the district, employing more than 8,900 people across more than 80 locations.

In addition to providing care to our own resident population, we are the Northern Region provider of forensic mental health services and child rehabilitation services, plus the metro Auckland provider of child community dental services and community alcohol and drug services.

In response to your request, we are able to provide the following information:

I am assisting a colleague who is conducting background research on whether many hospitals in Aotearoa NZ are aware of issues relating to mixed gender bed accommodation (sometimes called "same sex" accommodation policy) and have their own position or policy on this. This is also known as mixed gender hospital or ward accommodation.

My email is to ask if Waitematā DHB has any policies, standard operating procedures, or hospital standards on this matter. I could not source any on your website.

Please note my request is not to seek confidential documents – it is not necessary to provide anything not readily available. It is helpful enough to hear if there is a policy or plans to introduce one.

Please find attached policies in relation to the use of hospital beds and gender-appropriate rooms.
Attachment 1 - Daily Assessment Treatment and Rehabilitation (AT&R) Admission Process
Attachment 2 - Bed Capacity Management and Escalation Plan
Attachment 3 - Patient Flow and Allocation of Beds and Resources NSH & WTH
Attachment 4 - Bed Shortages - Transfer to AT&R Wards
Attachment 5 - Admission – Acute Inpatient and Hospital to Hospital Transfers
Attachment 6 - Patient Placement – Inpatient Settings NSH & WTH
Attachment 7 - Waiting List Management – AT&R
Attachment 8 - Standards: Safe and Appropriate Environment

Our bed management protocols are patient-focused – i.e. right patient, right bed and gender-appropriate. Wherever possible, our four-bedded rooms are assigned to patients of one gender.

This is managed by the duty nurse managers and ward staff who take in to account the age and life experiences of a patient which may make being in a room with someone of another gender a problem.

This assists us providing the best environment to care for patients based on individual clinical need.

I trust that this information is helpful.

Waitematā 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

Executive Director Hospital Services
Te Whatu Ora Health New Zealand Waitematā

Waitematā District Health Board
Best Care for Everyone

Speciality Medicine & Health of Older People Division
Older Adults/ Assessment, Treatment & Rehabilitation

Daily Assessment, Treatment & Rehabilitation (AT&R) Admissions Process

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1. Overview

Objective

With the increasing demand for beds, it has become imperative that the daily Assessment, Treatment & Rehabilitation (AT&R) service admissions process becomes formalised to ensure that appropriate patients are admitted to the AT&R ward promptly during weekdays and weekends, preventing bed block.

Additional drivers for this process include:

- Appropriately managing patients outlying on the AT&R wards to ensure that they are admitted to a rehabilitation team promptly when appropriate.
- Appropriate patients in Emergency Department (ED)/Assessment Diagnostic Unit (ADU), who would benefit from early comprehensive geriatric assessment and rehabilitation, are transferred promptly.
- Ensuring that patients are prioritised appropriately according to: key performance indicators, multi-resistant organism (MRO) status, bed availability and revenue source.

Associated Documents

Type	Title
Contracts	NAR contract
Policies	[P] Admission – ED to AT&R [P] Bed Shortages – Transfer to AT&R Wards [P] Entry Criteria – AT&R

2. Meeting Process

Meeting attendees:

- Charge Nurse Managers (CNMs) from the AT&R wards
- Clinical Director of Geriatric Medicine
- Gerontology Nurse Specialist (GNS)
- On-call AT&R Registrar at North Shore Hospital (NSH)
- Clinical Nurse Directors (CNDs) for NSH and Waitakere Hospital (WTH).

The meeting takes place in the Clinical Director's office at NSH.

Daily Assessment, Treatment & Rehabilitation (AT&R) Admissions Process

Patients are accepted for admission on weekdays according to the following priorities, bed availability and (MRO) status (in order of priority):

1. Inpatient in another DHB hospital and needing repatriation to rehabilitation
2. Inpatient in a private surgical hospital requiring rehabilitation
3. ED/ADU patients who have been identified by the GNS or the ADU-based Geriatrician as requiring AT&R admission
4. Patients awaiting admission to either NSH or WTH rehabilitation wards on the AT&R waiting list
5. Interim Care Scheme patients in residential care facilities who have been cleared for weight-bearing
6. Community admissions for assessment and/or rehabilitation.

NOTE: Patients who are awaiting admission to Muriwai ward but currently in NSH may be transferred to wards 14/15 and admitted under the care of a Geriatrician. Transfer of these west-domiciled patients to Muriwai ward from wards 14/15 is discussed and agreed on a case-by-case basis between the respective CNMs and Clinical Director/Geriatrician.

NOTE: Patients should be cohorted in rooms according to gender, and there should be no mixed-gender rooms unless absolutely necessary.

Following the AT&R Admissions Meeting, a detailed plan of the day's admissions and wards transfers is emailed to the Duty Nurse, Bed and Operations Managers.

3. Beds Remaining Empty Following the AT&R Admissions Meeting

Any beds on the AT&R ward remaining empty following the AT&R Admissions Meeting should be filled as much as is practical. Suitable patients to be transferred to the AT&R wards are as follows (in order of priority and dependant on MRO status):

1. Any patient who is added to the AT&R waiting list following the AT&R Admissions Meeting. This includes patients who are awaiting a bed on Muriwai ward but are current inpatients in NSH. These patients are then admitted under the care of a Geriatrician the following day (7 days/week).
2. Patients in ED/ADU identified by the GNS or the ADU-based Geriatrician should be discussed on a case-by-case basis with the on-call registrar or CNM. Any patient reviewed by the ADU-based Geriatrician on a post-acute ward round does not need a formal admission by the AT&R team. Direct admissions from ED/ADU are considered as part of the daily AT&R team admissions and transferred to the ward as soon as practicable. The team house officer and/or registrar will review the patient and complete the admission documentation (if not reviewed by the ADU-based Geriatrician). Admissions over and above the usual daily team admission quota (two admissions per team) will be admitted by the on-call registrar during the day or in the evening depending on the time of transfer.
3. Appropriate medical patients who are not on the AT&R waiting list. This includes patients waiting to be transferred to a residential care facility or those that are expected to discharge within the next few days. This does NOT include patients referred to the Older Adults service who are still undergoing review as they may not be medically suitable for transfer. If there is any concern about the suitability of a medical outlier to transfer to the AT&R ward, this should be discussed with the on-call Geriatrician.

Daily Assessment, Treatment & Rehabilitation (AT&R) Admissions Process

NOTE: A review by a Geriatrician, Geriatrics Registrar or Gerontology Nurse Specialist (including completion of a Global Geriatric Assessment) does not constitute acceptance for transfer to the rehabilitation ward unless specifically stated.

NOTE: Patients should be cohorted in rooms according to gender and there should be no mixed-gender rooms unless absolutely necessary.

The NSH CNMs will send an email to the Duty Nurse, Bed and Operations Managers in the afternoon (weekdays) with a detailed plan of the patient transfers to the AT&R wards after hours.

4. Direct ED/ADU Admissions

Direct ED/ADU admissions after hours will continue using existing protocols. Suitable patients for direct ED/ADU admission are those that will benefit from comprehensive geriatric assessment and/or rehabilitation.

Suitable patients may include:

- Simple non-injurious fall and not cleared for discharge by multi-disciplinary Team (MDT)
- Recurrent non-injurious falls requiring further MDT assessment
- Fall with non-operative fracture and cleared for full weight-bearing as tolerated (WBAT)
- Acute delirium but able to participate in rehabilitation
- Off usual baseline and able to participate in rehabilitation
- Need for rehabilitation care on a case-by-case basis.

Other potential patients can be discussed with the on-call Geriatrician and accepted for transfer as appropriate.

Exclusion criteria include:

- Patients who are not domiciled in the Waitematā DHB area
- Patients requiring acute medical intervention or diagnostic tests including telemetry, non-invasive ventilation, vasopressor support or high-flow oxygen
- Patients who are not able to participate in a rehabilitation programme, either because they are too unwell or have major cognitive deficits or psychiatric illness
- Patients who will be considered for the Interim Care Scheme including those that are non-weight bearing.

5. Weekend Planning

On Friday afternoon, the AT&R CNMs will send an email to Duty Nurse, Bed and Operations Managers and on-call medical staff to detail the AT&R admissions for the weekend. Patients who are transferred to the AT&R ward (and on the AT&R Waiting List) are admitted by the on-call registrar over the weekend.

Daily Assessment, Treatment & Rehabilitation (AT&R) Admissions Process

6. Process

Step	Action
1	GNS or ADU-based Geriatrician identifies suitable ED/ADU admissions prior to 8:00 am according to the inclusion and exclusion criteria.
2	Daytime on-call AT&R Registrar liaises with GNS to review suitable ED/ADU patients.
3	AT&R Registrar attends the daily AT&R Admissions Meeting at 8:45 am with the CNMs and Clinical Director.
4	Patients are accepted for transfer to wards 14, 15 and Muriwai according to the priorities stated.
5	Administration clerk is informed of the daily admissions plan and transfers to the ward are completed as soon as is practicable. A detailed summary of the day's admissions are emailed to the distribution list.
6	Patients transferred to the ward are seen as part of the team's daily admissions (two admissions per team per day). Additional patients may be admitted by individual teams depending on their overall workload.
7	• Admissions identified by the GNS or ADU-based Geriatrician following the AT&R Admissions Meeting should be discussed with the on-call registrar and CNM and admitted on a case-by-case basis. Admission documentation may be completed by the daytime on-call registrar or individual teams depending on the number of allocated admissions to each team. Patients seen by the ADU-based Geriatrician do not need a formal admission. • Admissions identified after 4:00 pm on weekdays or on weekends are admitted by the on-call registrar as per existing protocols.
8	• Beds remaining empty following the above process can be filled according to the priorities outlined above. • CNMs will send a detailed email on weekday afternoons with the list of patient transfers to the ward after hours.

Waitematā District Health Board
Best Care for Everyone

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).

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.

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

- 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.

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

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

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

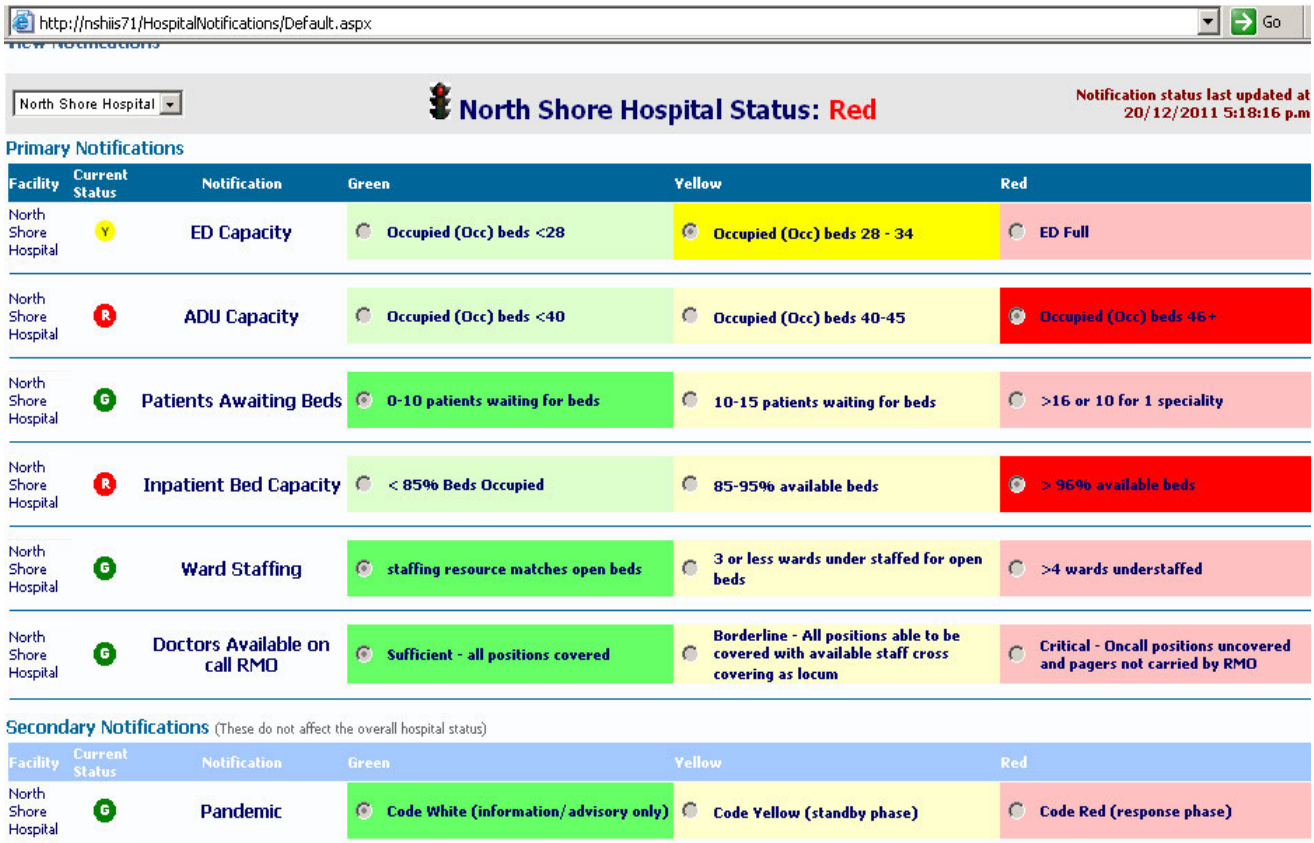
- Provides assistance and support as required by DNM
- Communicates with GM, DON, COO and Communications as required and request assistance/options
- Attends hospital after-hours if requested by DNM to assist
- Authorises any actions that are over DNM delegated authority
- Sets up EOC if required to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

Bed Capacity Management & Escalation Plan



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View Notifications

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	Y	ED Capacity	○ Occupied (Occ) beds <28	◉ Occupied (Occ) beds 28 - 34	○ ED Full
North Shore Hospital	R	ADU Capacity	○ Occupied (Occ) beds <40	○ Occupied (Occ) beds 40-45	◉ Occupied (Occ) beds 46+
North Shore Hospital	G	Patients Awaiting Beds	◉ 0-10 patients waiting for beds	○ 10-15 patients waiting for beds	○ >16 or 10 for 1 speciality
North Shore Hospital	R	Inpatient Bed Capacity	○ < 85% Beds Occupied	○ 85-95% available beds	◉ > 96% available beds
North Shore Hospital	G	Ward Staffing	◉ staffing resource matches open beds	○ 3 or less wards under staffed for open beds	○ >4 wards understaffed
North Shore Hospital	G	Doctors Available on call RMO	◉ Sufficient - all positions covered	○ Borderline - All positions able to be covered with available staff cross covering as locum	○ 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	G	Pandemic	◉ Code White (information/advisory only)	○ Code Yellow (standby phase)	○ Code Red (response phase)

Bed Capacity Management & Escalation Plan

7. Emergency Department and ADU Escalation Plan

Bed Status	ACCN	CNM	Medical Teams	Operations Manager
Green (Business As Usual)	• 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	• Attend daily Capacity Management Meeting. • Ensures rostering practices provide for unit cover.	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	• Monitor system for stress and proactively manage any pending blocks Monitor service demands. • Manage RMO staffing to reflect service needs in conjunction with CD.

Bed Capacity Management & Escalation Plan

Bed Status	Trigger	ACCN	CNM	Medical Teams	Operations Manager
Yellow	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 *(system required)* Instigates internal escalation plan • Re-assign staff to area of need • CCN in conjunction with Clerks Team Leader to assign a member of staff to assist with admitting patients in ambulance bay. • Ensure patients are aware of the waiting time and provide information as to other options for care (pamphlets) • Facilitates potential discharges within ED • Identification of staffing requirements • Text vacancies to off duty staff • Contact bureau / duty manager to confirm requirements for staff • Discuss capacity situation with DNM and FACEM so that collaborative planning can occur. • Communicate situation with CNM during business hrs.	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

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	• All doctors on non-clinical time to work on the floor seeing EM patients as necessary • Maintain flow with EM patients • Review patients with >LOS greater than 4 hrs to assess if pts can be discharged • 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.	Attend Escalation Meetings Communicate with staff on situation and actions being taken on the whole system
Bed Status Red (over capacity) requiring divisional decision making and contingency planning	**Trigger** No available medical/ surgical beds and ED/ADU at capacity	**ACCN** • Ensure breaching of 6 hr target is minimised • Assess staffing over the next 24hr and advise bureau of cover needed including HCA's. • Increased resource request for support nursing staff and for orderlies to DM. • Enact Prioritised care plan if necessary • Issue vouchers for low acuity patients to attend A&M • Request extra phlebotomy staff to attend ED	**CNM** See CNM actions above • Call in extra clerical staff to ensure data is maintained correctly • If in the morning cancel study leave, if in the PM offer nurses on study leave extra hours • Call in Senior ED/ADU Nursing Staff • Utilise CNE and CNM to support clinical areas	**Medical Teams** • CD oversight for backup and support of ED and ADU • Maintain flow with EM patients • Specialty escalation plan applies ED FACEM or CD to work with ED CCN to manage planning and decision making in Dept	**Operations Manager** 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
	ED/ADU overload and ward beds at capacity	See ACCN actions above	Allocate additional resources to assist in areas e.g. educator, nurses non clinical time. Review workload of ACCN and provide additional coordination support	Call in medical team back-up.	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

Bed Capacity Management & Escalation Plan

8. Patient Flow Plan - Reviewing ED Whiteboard to monitors SSED

3 Hours and under ED	
Review pts plan with ED Dr	Nurse
Chase up Radiology / Investigations	Nurse
Is the patient a potential ED Obs patient	Nurse
Refer onto Speciality Teams	ED Dr
If patient has been seen by Team chase plan	Nurse
Escalate delays for ED to ED Senior Doctor	ACCN
4 Hours under ED	
Chase up plan	Nurse / ACCCN
Escalate to ED Flow Consultant	ACCN
Refer pt to speciality Team	ED Dr
Move to ED OBs if appropriate	Nurse / ACCN
Chase investigations i.e. Radiology	Nurse / ED Dr
4 Hours Seen by team	
Chase up plan for patient	Nurse / ACCN
Escalation by ED doctor or notify DNM	ED Dr / DNM
Move to ADU if appropriate	ACCN
Pt allocated to ward bed	DNM
5 Hours	
If not seen elevate to Senior ED Doctor	ACCN
If seen chase disposition plan	Nurse
Move to ADU if appropriate	ACCN
Escalate to DNM if pt requires a bed	ACCN / DNM
Move ED pt to Obs if appropriate	Nurse / ACCN

4 Hours Referred but not yet seen	
Follow up with Team	ACCN
Escalate delays to ED Senior Doctor	ACCN
Senior ED Dr to escalate to speciality team consultant or DNM	ACCN/ DNM

* If at any point patient flow is compromised please alert the Duty Nurse Manager and during hours also contact the Charge Nurse Manager of ED for guidance and assistance

- Process and System issues should also be escalated to SSED Project Lead

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	Monitor system for stress and proactively manage any pending blocks Monitor service demands. Manage RMO staffing to reflect service needs in conjunction with CD. *What happens afterhours?*	• Assess acute patients in a timely fashion. • Complete discharges in a timely manner. • Teams to discharge 1 patient at start of ward round (1 well home). • All patients have documented EDD. • Identification of patients who can have an early discharge back to GP care or utilisation of Primary Options GP respite care. • Ensure weekend plans are in place for all patients. • Hand over with on call teams regarding any potential deceased patients to ensure medical certification can be completed within 24 hrs. • A and B call teams present in ED/ADU for timely pt assessment and treatment. •	• Monitors all pts care journey's to ensure clear plans and decisions including documented EDD. • Review EDD every 24 hrs. • Proactively manage patient discharges - consider Primary Options/Discharge with community assistance. • Progress transfer of longstanding patients to rehabilitative care or rest-home respite care. • Proactively manage staff vacancies – refer to safe staffing document. • Alert Duty Managers to any staffing or patient problems – discuss planned actions Regularly update patient numbers and expected discharges to DNM. • Provide information for Capacity Management Meeting and identify any blocks and barriers for escalation and action. • Contact medical staff for any patients not seen in the last 24 hours. • Request acceleration of tests for patients to discharge. • Collaborate with medical staff to ensure all care plans and timelines are clear. • Ensure weekend plans are in place for all patients. •	Assist CNM to resolve longstanding patient management issues and known staffing gaps. Support CNM with staffing plans. Assist with identified blocks to discharge. Attend weekly bed management meeting.	Attend weekly bed management meeting.

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.

Bed Capacity Management & Escalation Plan

Bed Status	Triggers	Operations Manager	Medical Teams	CNM	Head of Division	GM
Red (over capacity) requiring divisional decision making and contingency planning	• Acute and elective surgical bed demand over capacity and no overflow possible • > 15 medical patients in ADU/ED waiting for beds. • > 15 medical patients to be seen • Patients in ED unable to be processed within the 5 hr target	• Alert all SMO's to bed crisis and request urgent assistance in discharging patients. • Meet with CD and GM to agree actions over the next 2 hrs. • Receive reports back from Medical teams to confirm discharging of 2 pts per team has been completed. Meet with Operations Manager ED/ADU to discuss plan. Provides report back to Escalation meeting.	**In hours** ADU SMO or A Call SMO to take GP referral phone to free Registrar and to defer presentations as appropriate. • 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. • Review all team patients in conjunction with CNM to ensure focus is on EDD. • C Call team to attend ED/ADU to assist with patient assessment. • ADU SMO to be present in department to assist RMO. • Defer discharge summaries till following day if appropriate.	• 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 • Regularly update patient numbers and expected discharges to DNM. • Identify patients who could have early discharge with Primary Options and contact medical team. • Liaise with medical staff re discharge plans **After Hours** • May be requested to attend the hospital to assist with staffing deficits that are adversely affecting patient care.	Alert service CD's of RED status. **Attend Escalation Meeting:** • Develop a plan with CNM's and DNM to manage and allocate staffing resources for immediate period and next 24 hours. • Undertake a ward walk-around to assess ward status and assist with identifying and managing bed blocks. • Ask for all available non direct clinical staff to support clinical areas. • Authorise the implementation of the Safe Staffing Plan including a plan to utilise un-resourced beds.	Meet with Clinical Directors and HOD's to review situation Authorise cancellation of non-essential work • non clinical nursing positions to assist on wards • Non urgent clinics deferred • Study days cancelled. **Outpatient procedures** cancelled to facilitate inpatient procedures • Develop a service response with Clinical Director in accordance with service escalation plan.

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

After Hours

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

- 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

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
Green (Business As Usual)	Acute and elective surgical bed demand can be accommodated.	Monitor system for stress and proactively manage any pending blocks Monitor service demands Manage RMO staffing to reflect service needs in conjunction with CD. Review daily production planning for electives against acute admission numbers. Monitor cancellations. Monitor acute surgical wait list minutes.	• Assess acute patients in a timely fashion • EDD is documented in each clinical record • Work with CNMs on discharge plans • Consider POAC or patient to return to acute clinic. • Prompt discharge of patients – see at least 1 patient for discharge first in ward round • Identification of patients who can have an early discharge back to GP care or utilisation of Primary Options GP respite care • Ensure weekend plans are in place for all patients.	• Monitors all pts care journey's to ensure clear plans and decisions including documented EDD. • Proactively manage patient discharges consider Primary Options/Discharge with community assistance. • Progress transfer of longstanding patients to rehabilitative care or rest-home respite care • Proactively manage staff vacancies – refer to safe staffing document. • Alert Duty Managers to any staffing or patient problems – discuss planned actions. • Provide information for Capacity Management Meeting and identify any blocks and barriers for escalation and action. • Contact medical staff for any patients not seen in the last 24 hours.	• Monitor ward occupancy levels • Assist CNM with staffing issues and models of care to ensure beds maximised in all areas • Assisting CNM to resolve longstanding patient management issues and known staffing gaps • Support CNM with staffing plans • Assist with identified blocks to discharge	Attends weekly bed management meeting

Bed Capacity Management & Escalation Plan

Bed Status	Trigger	Operations Managers	Surgical Teams	CNM	Head of Division Nursing	General Manager
			• Communicate with on call teams regarding any potential deceased patients to ensure medical certification can be completed within 24 hrs.	• Request acceleration of tests for patients to discharge. • Ensure weekend plan are in place for all • Utilise discharge lounge for patients waiting for papers and relatives • Facilitate MDT and discharge planning • Regularly update patient numbers and expected discharges to DNM.	Attends weekly bed management meeting	
Yellow	Acute and elective surgical bed demand at capacity *Need trigger for planned acute surgical OT minutes e.g. >360 minutes*	• Liaise with surgical teams to expedite discharges. • Consider opening an acute theatre to clear acute board • Attend daily Capacity management Meetings. • Alert GM of status and actions taken.	• Have clear date of discharge • Consider early discharge to GP care • Utilise transitional care beds • Urgent discharge of patients - complete 1 patient discharge per team ASAP • Actions from service specific plan	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. • Challenge all unclear management plans and timelines for delivery of care. **Receive alert from DNM** **Immediate Actions:** • Identify 2 patients for discharge and move to dayroom or transit lounge • 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 extra patients to ward • Continue staffing plans, call casual staff, extend shifts • Refer to Safe Staffing Plan	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	Briefed. Attend Escalation meetings Awareness of systems stress Actions taken report from Operations Manager Implement Service specific escalation plan as required.

Bed Capacity Management & Escalation Plan

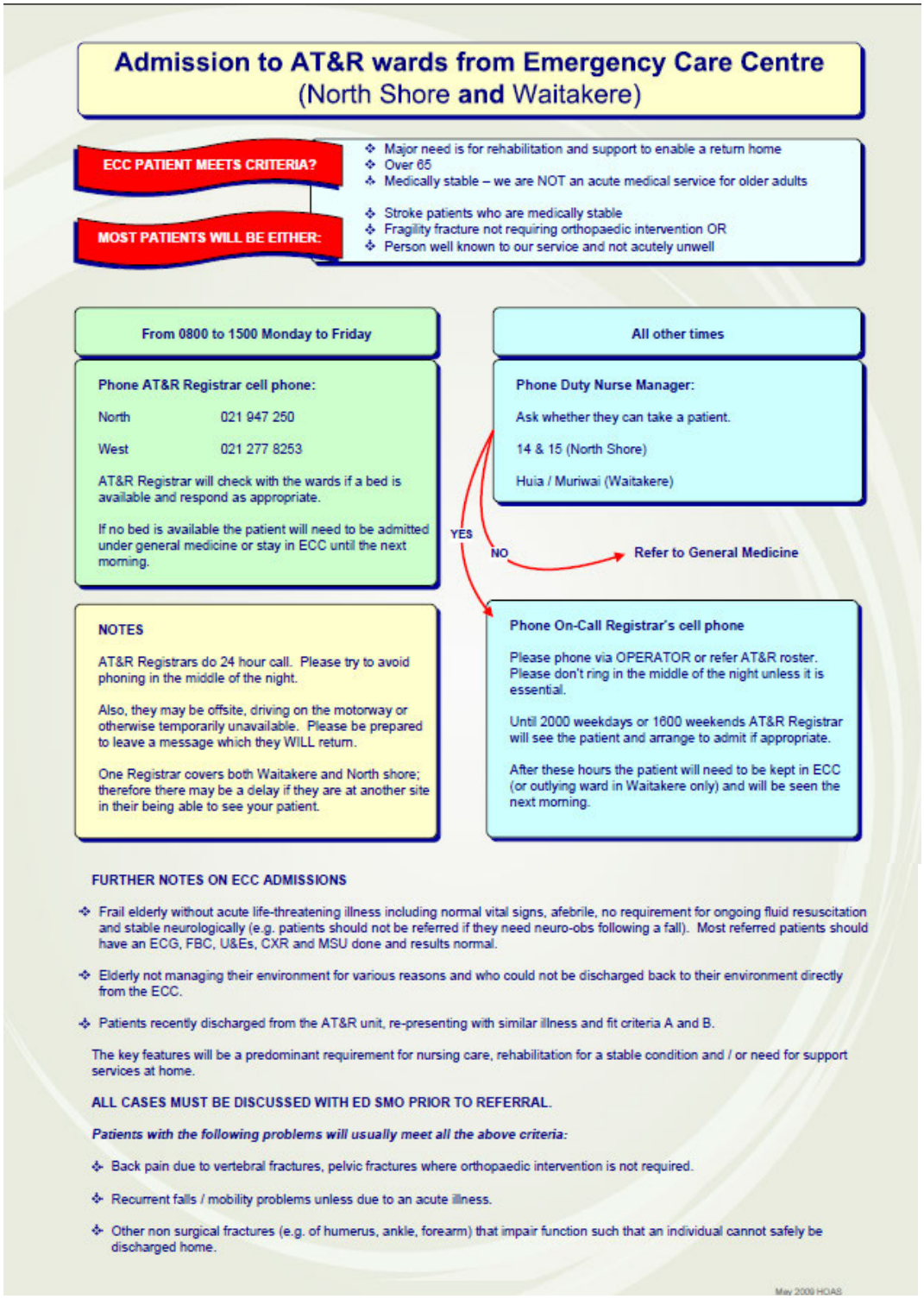
	ED / ADU overload but ward beds available	• Ascertain which specialties affected. Alert Clinical Director and on-call teams to attend ED / ADU to ensure treatment plans current and on track, reassess need for admission. • Utilise POAC where possible	• Relevant specialty teams on call to go to ED/ADU 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

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.	the Safe Staffing Plan • Discuss overflow options with other HODs. • Develop and authorise a plan for the utilisation of un-resourced beds Provide written service plan to DNM for afterhours management **After Hours** May be requested to attend the hospital to assist with staffing deficits that are adversely affecting patient care.	• Reprioritise own 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

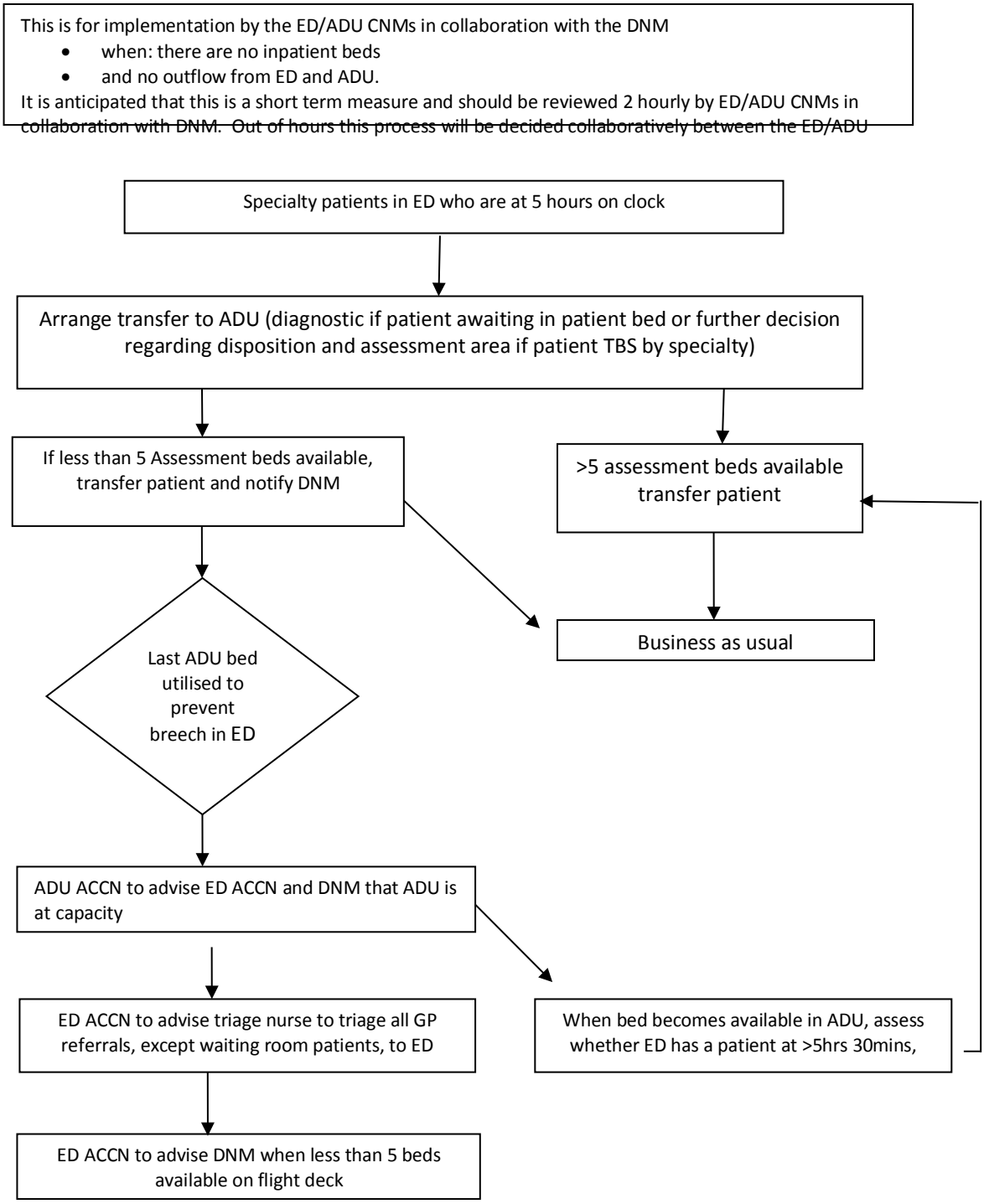
Bed Capacity Management & Escalation Plan

Appendix: Admission to AT&R from ED and ADU



Bed Capacity Management & Escalation Plan

Appendix: Escalation Patient Flow Process ED / ADU



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 ≥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.

Patient Flow and Allocation of Beds and Resources NSH & WTH

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1. Overview

Purpose

This document is to provide clear guidelines for patient flow facilitation and allocation of beds and resources in accordance to the principles in this procedure.

Waitematā District Health Board provides centralised 24-hour patient flow facilitation and allocation of beds and resources in accordance with the principles in this procedure. This supports an environment appropriate to the patients clinical needs, the planned, timely, efficient and effective transfer of patients requiring secondary and tertiary intervention, and the principle that all bed allocations will be made with the knowledge of the Duty Nurse Manager or delegate.

Scope

Staff who request, admit, transfer and or discharge patients to and from North Shore and Waitakere Hospitals.

Staff who are responsible for or involved in ensuring appropriate bed allocation, patient flow facilitation and resourcing of in-patient areas.

Patient Flow and Allocation of Beds and Resources NSH & WTH

2. Definitions

Resourced Beds	Beds identified in a ward/unit/department to accommodate expected patient throughput and budgeted staffing levels. Area staff establishment is to be sufficient to resource these beds on a daily basis.
Physical Beds Capacity	(total of resourced and unresourced): Beds physically available in a ward/unit/department. Subject to staff resource availability, these beds can be opened when deemed necessary.
Capacity Levels	(excludes SCBU, Maternity, Paediatrics, ICU, CCU and Mental Health): **To establish Level 2 or 3, two or more points need to be met**
Level 1 Business as Usual *	Capacity to meet expected demand (< 90% occupancy) for a ward bed, and/or ED capacity is exceeded. Emergency Department (ED) has 8 or more patients waiting longer than 6 hours
Level 2 Triggers for Action *	Limited capacity to meet expected demand (> 95% occupancy)
Level 3 Overload *	No capacity to meet expected demand. Lack of staff resources. All available resourced beds utilised. * Patient Flow Escalation Plans Appendix 2
Outlier patient	A patient located in a ward/unit/department outside the specialty under which the patient is admitted.
External ED overload	Transfer of patients to inpatient beds is compromised by hospital access block. ED cubicles full with patients for admission to inpatient areas and unable to take into ED presenting patients.
Internal ED overload	Volume of patients waiting for ED care exceeds ED space and staffing capacity.

3. Bed Allocation Prioritisation Criteria

Whenever possible, acute patients should be admitted to their *home or specialty wards*. This may not always be possible and stable patients may be admitted acutely to outlying wards.

Wherever possible, patients should be admitted to *gender appropriate beds*. When this cannot occur special account needs to be taken of patient's age, nature of condition etc. Such patients should be transferred to a gender appropriate bed in the same ward as soon as a suitable bed becomes available.

As a priority, all complex specialty patients should be admitted / transferred to their *specialty wards* to optimise patient care and minimise clinical risk. On occasions this will require the transfer of a suitable patient to another ward.

Whenever possible, *elective admissions* should be admitted to the appropriate speciality beds. However, when there is limited bed availability, any available appropriate surgical beds will be considered to prevent cancellation of elective admissions.

All admissions will be compliant with Infection Control guidelines in place at the time of admission.

Suitable patients can be an outlier in available AT&R beds (as per Appendix 3)

Patient Flow and Allocation of Beds and Resources NSH & WTH

3.1 Over-capacity

In exceptional situations, where no free inpatient beds are available and hospital is over-capacity, bed placement must be appropriate e.g. double in a larger side room, placement in Day Room. All patients must have call bells, curtains around beds, a locker; be allocated to a nurse; moved into a standard room at the earliest opportunity.

4. Patient Flow Principles

4.1 Duty Nurse Manager

- Is informed of all patients requiring admission or transfer
- Applies prioritisation criteria for bed allocation.
- Works collaboratively with wards/units/departments when placing elective and acute admissions into available beds.
- Is responsible for actively facilitating 95 percent of patients being admitted, discharged, or transferred from ED within six hours.
- Maintains an accurate record of all available beds by ward and gender and facilitates placement of patients into appropriate beds.

Where possible, medical patients shall be placed in Medical beds, Surgical patients in Surgical beds and Orthopaedic patients in Orthopaedic beds etc. The next best ward should be allocated as service outliers.

- There are no cancellations of elective surgery due to bed unavailability unless authorised by the General Manager Surgery and Ambulatory Care or delegate.
- The gender/ethnic/age mix of a multi-bedded room must be managed but must not lead to an extended wait for beds.

Beds can only be deemed closed by the General Manager of the relevant service and after consideration of total hospital bed requirements. The Duty Nurse Manager, in consultation with the Head of Division Nursing as appropriate may deem a bed “temporarily on hold”, due to resourcing or other issues.

4.2 ED Associate Clinical Charge Nurse

- Patient shall only go on the waiting list for a bed when the patient is ready for admission.
- Responsible for actively facilitating that 95 percent of patients will be admitted, discharged, or transferred from ED within six hours of presentation.

4.3 Charge Nurse Manager or delegate

- Responsible for and ensures that at least 2 patients are discharged from each ward before 11 am each day
- Ensures that there are robust and actively managed discharge plans in place for all patients and that the current estimated date of discharge is documented on ward whiteboard following discussion with Multi-Disciplinary Team.
- Is aware of all patients with length of stay greater than 10 days and ensures they are actively managed to promote early and appropriate discharge.
- Ensures that patients are discharge on PiMS within 15 minutes of discharge during ward-clerk hours.
- After-hours patients shall be discharged from PiMS within 15 minutes by those trained, or nursing staff must advise ED clerk (by fax) who will complete this task.
- Wards must advise the Duty Nurse Manager of available bed(s) in an expedient manner via power page or phone 24/7.

Patient Flow and Allocation of Beds and Resources NSH & WTH

Ward Day rooms are not to be used to accommodate any patients except in an emergency situation and then only clinically stable and appropriate mobile patients waiting for completion of the discharge process in order to minimise bed waiting times for other patients. These patients need ongoing care/supervision prior to hospital discharge.

4.4 Medical Staff

- Responsible for considering all treatment options for a patient in primary and community care and/or prevent unnecessary admission and/or promote early discharge.
- Responsible for requesting inpatient beds for those patients who require a stay of greater than 18 hrs and observation beds for those who require less than an 18 hrs stay.
- Ensure all disposition decisions are made within a maximum of 5 hrs of presentation to ED.
- Responsible for ensuring that medically the patient is ready to move to a bed within 30 minutes of a bed request being made by nursing staff.
- Responsible for ensuring all team patients have a current on track discharge date documented in clinical record.
- Responsible for completing the medical discharge requirements of at least 2 patients before 11 am each day.

5. Resourced beds and physical beds

Resourced beds are to be used before unresourced beds
Unresourced beds are used when all other appropriate alternatives have been explored and subject to temporary staffing or staffing reallocation.

6. Admission to outlier wards

Acute unstable or complex patients must be placed/maintained in the appropriate speciality ward/unit/department, with more stable patients transferred to other areas as outliers as required.

CNMs/Clinical Nurse Managers must review all patients in their area at least once per shift and escalate any concerns in patient condition or treatment.

Children must not be placed into unsuitable areas.

7. Unresourced beds

The decision to use unresourced beds needs to take account of staffing and patient safety

Inter-hospital admissions The Duty Nurse Manager must be notified of all inter hospital admissions/ transfers and is responsible for bed allocation for all patients.

8. Bed Balancing Meetings

8.1 Routine Bed Balancing meeting (Levels 1 and 2)

The Duty Nurse Manager coordinates the meeting held Monday – Friday at 0945 hours. The purpose of the meeting is to establish the overall hospital status to enable patient flow, allocation of staff and associated issues for the next 24 hours and weekends. Develop contingency plans where necessary.

Patient Flow and Allocation of Beds and Resources NSH & WTH

Ward/unit/department attendees (CNM or delegate) are to provide:

- Accurate bed state and projected bed state.
- Expected admissions.
- Predicted discharges/transfers.
- Next 24-hour or weekend staffing levels.
- Staff reallocations

8.2 Level 3 Bed Meeting

Convened for consideration and resolution of patient flow problems arising from the issues limiting capacity.

- This meeting is convened half an hour after notification has been made.
- Attendees are General Managers, HoD Nursing and Medicine and Surgical, Ward/unit/department representatives

9. Appendices

9.1 Bed Balancing Meetings – Level 1 Business as Usual

Purpose

- To provide an overall picture of hospital status to facilitate a timely patient flow process, allocation of staff, and any associated issues for next 24 hours.
- The ultimate goal is to facilitate communication between wards/departments/units in order to achieve the best results for the patients and organisation, in managing predicted activity within available resources, for next 24 hours
- To identify and agree on contingency plans for the next 24 hours when necessary
- To provide an accurate bed state, staffing, expected admissions and discharges.

Objectives

- Identify predicted bed state of the hospital
- Identify outlier activity, intra and inter hospital transfers
- Assist with allocation of staff based on availability and need in order to maximise resource utilisation
- Facilitate smooth and timely flow of patients through the organisation
- Identify and manage potential risks associated with patient flow, staff allocation, high nursing agency component
- Advise key stakeholders of any issues and expected blockages
- Formulate a contingency plan when necessary to address the blocks

Meeting rules

Be on time

- CNM to advice DNM with information if unable to attend
- Phones and pagers turned off or on 'silent'
- Listen
- Challenge ideas
- Be open minded and open to finding solutions

Accountability

Clinical Nurse Director - Patient Care and Access

Patient Flow and Allocation of Beds and Resources NSH & WTH

Membership

CNMs or delegate of all in-patient areas
Representatives from, ED, ICU, CCU, CVU theatre
Apology required if not able to attend

Chairperson

Operations Manager or Duty Nurse Manager

Meetings

The group meets Monday to Friday from 1015 hours

Minutes

Data emailed to mailing recipients

9.2 Level 3 Overload

Purpose

- To provide a short intense level of activity in response to a Patient Flow Crisis
- To gather together the key players accountable for managing the patient flow crisis and to co-ordinate an immediate clinically appropriate response

Objectives

- Identify the bed state and blocks to patient flow within the hospital
- Identify patient numbers awaiting admission from ED.
- To inform Clinical Directors, HoDs Nursing and CNMs or delegate of the need to look critically at admissions and discharges
- Identify and manage risks associated with bed crisis.
- Advise key stakeholders

Accountability

GM on call

Membership

As for Patient Flow Meeting with CNMs or delegate, General Managers, Operations Managers, HoDs

Chairperson

On Call General Manager

Meetings

As required

Agenda

DNM to come to meeting with the following information: confirm bed state, confirm demand, confirm capacity level and confirm actions to date

Minutes

No minutes.

Appendix 2 Patient Flow Escalation Plans

The Patient Flow Escalation Plan enables Waitematā District Health Board to identify and respond to hospital(s) changing status at any given time. The levels identify capacity to admit patients and actions to implement.

Patient Flow and Allocation of Beds and Resources NSH & WTH

9.3 Capacity Level 1 Business as Usual

DUTY NURSE MANAGER ACTIONS	WARD ACTIONS	SERVICE ACTIONS	ED ACTIONS
• 0700 Duty Nurse Manager handover - identify potential problems/ solutions including detailed bed status: • Acute admissions overnight • ED, ICU, CCU, CVU status • Staffing • Theatre status– problems solved by 0830 hours, Theatre to start on time for first cases • 0830 Duty Nurse Manager visits areas • Priority ED/ICU/CCU/Theatres/ surgical units • 0945 Bed Balancing Meeting • 1015 • Elective and acute admissions allocated beds in appropriate area • Beds coming available e.g. transfer/discharge identified • Staffing for next 24 hours ascertained • Allocation of casual resource with Nursing Bureau • 1400-2200 Duty Nurse Manager coordinates patient flow • Allocate beds for acute/elective admissions • Meet with Theatre team to manage next day • 2200-0700 Manage acute admissions. • Clinical coordination	0700 Night staff handover to day staff. Active planning to create capacity for elective/acute admissions CNM or delegate identify patients potentially fit for next day discharge and discuss with Doctor Patients identified fit for discharge previous day, reviewed early, able to leave ward pre 11am Outlier patient review, fit for discharge. Check if clinical need to transfer to home ward – Notify Duty Nurse Manager Patients awaiting inter-hospital transfer ready and discussed with DNM Patients awaiting return/ transfer to rest homes ready to leave before 11 am (transport arranged day/evening before to ensure pre 10am discharge) 0945 hours Bed Balancing Meeting	Business as usual General monitoring of situation Operations Manager	Book patients for beds as soon as decision to admit made Inform Duty Nurse Manager of patients for admission, potential overload – internal or external developing

Patient Flow and Allocation of Beds and Resources NSH & WTH

9.4 Capacity Level 2 Triggers for Action

DUTY MANAGER	WARD ACTIONS	SERVICE ACTIONS	ED ACTIONS
ACTIVATE LEVEL 2 RESPONSE • Identify at least 2 criteria (see 3.3 Capacity Levels) that escalate hospital capacity to Level 2 • Duty Nurse Manager initiates group alert "Level 2 Alert" • Those notified respond to their clinical areas • Duty Nurse Manager liaises with area Coordinators and review forecasted discharges for following day able to discharge today go on leave etc	• Contain own area activity, ensure appropriate admission–is there any acceptable alternative to inpatient admission. • **CNMs or delegate consider:** • Patients suitable for transfer to alternative facility/hospital/ward • Accelerated discharges, patients who could go on leave, etc • Contact relevant Doctors • Enlist back up from consultant(s), Operations Managers, HoDs • Explore area/service redeployment options • Review staffing and options • Identify part time staff (& others) who may be called in • Escalate irresolvable issues to relevant leadership as appropriate • **Clinicians notified of Level 2:** • Respond to area and expedite safe discharges • Review all potential options to relieve area occupancy	• **Operations Managers:** • Ensure areas are implementing and fully exploring contingency planning • Consider use of unresourced beds • Identify all patients waiting for transfer back to other hospitals/DHBs. • Accept acute transfers in on condition that a current in-patient will be accepted back. • Redeploy clinical staff from non-clinical/admin posts to clinical areas • Senior nurses to in-patient areas for leadership • **Theatre/surgical areas:** • Review theatre lists - confirm cases that are urgent or able to be day cases	• Patients/families informed of factors resulting in delays in assessment, care or admission • ED CNM/delegate and SMO discuss capacity - determine if impending overload is external or internal and work together to manage • **ED Duty SMO** • Consider accepting only urgent GP referrals • Convene urgent handover meeting • Fast track suitable patients to wards • Operate Rapid Assessment Procedure • Ask admitting consultants/ registrars to expedite patient assessment and admission/ discharge

Patient Flow and Allocation of Beds and Resources NSH & WTH

9.5 Capacity Level 3 3 Overload (not to last any longer than 24 hrs)

DUTY NURSE MANAGER	WARD ACTIONS	SERVICE ACTIONS	ED ACTIONS
ACTIVATE LEVEL 3 RESPONSE • Identify at least 2 criteria (see 3.3 Capacity Levels) that escalate hospital capacity level to Level 3 • Duty Nurse Manager initiates group alert "Level 3 Alert" • Those notified respond to their clinical areas • Convene Bed Crisis Meeting within 30 minutes of reaching capacity Level 3 alert • Admit patients to unresourced beds and ward treatment rooms (max 2 per area) • Advise Waitakere hospital or vice versa • Notify St John of situation inform that there may be delays with patient handover • Advise GPs to send only urgent patients	All staff work as a team to manage patient flow actively: regular meetings, problem solving, ideas and options generation etc. • **Teams** • Do rounds/ additional rounds and expedite safe discharges • **CNM or delegate** • Discuss with Consultants early discharge plan for suitable patients • Admit patients to unresourced beds and day rooms (maximum 2 per ward) if patient safety manageable • Redeploy any clinical staff from non-clinical duties to ward areas to assist staff	• Stop all non-essential activity • Participate in Bed Crisis Meeting and undertake actions agreed • **Consultants** • Additional consultant rounds to review further discharge or transfers out • Early discharge plan for suitable patients	• As per Level 2 actions and: • **ED CNM** • Liaise closely and regularly with Duty Nurse Manager • Participate in Bed Crisis Meeting • **ED SMO** • Call inpatient teams to ED to assess patients • As appropriate return non-urgent patients to community care • Lead coordination of ED flows with CNC rather than provide direct patient care

10. Appendix 3: Guidelines to assist the selection of suitable Medical Patients as Outliers in AT&R

The following allows for 3 types of patients to be moved to AT&R as outliers to ensure AT&R beds are used effectively.

The first option is:

- Those patients on the active waitlist for NSH AT&R beds.
- Suitable pts in ED under Emergency Medicine who have been accepted by AT&R.
- Suitable geriatric orthopaedic patients in ED who are clearly pre-op and are relatively stable.

The second option is:

- To select from those patients that have been referred to AT&R but not yet assessed.

Patient Flow and Allocation of Beds and Resources NSH & WTH

The third option is:

- Select stable NSH inpatients who are currently on the Waitakere Hospital waitlist
- Identify appropriate, stable medical patients who can be safely cared for in the AT&R area and would benefit from this area's nursing expertise. Ideally this should be discussed first with the patient's medical team.

To help ensure appropriate patients are selected from all the above options, the following guidelines are the guidelines of the AT&R Service.

- Discuss AT&R bed and staffing status with AT&R ward CNM/Coordinator.
- Consider isolation requirements.
- Patients need to have been medically stable over past 8 hrs. NEWS score normal.
- Consider requirements for oxygen as not all bed spaces in AT&R wards have piped Oxygen.
- Consider and communicate if the patient may need a higher level of constant observation.
- Medical Team contact details are clearly documented.

Patients being selected from Option 3 should be from the Medical Service (not surgery or orthopaedics), medically stable, frail elderly who may have had previous contact with the AT&R service.

Waitematā District Health Board
Best Care for Everyone

Clinical Practices

Bed Shortages – Transfer to AT&R Wards

1. Overview

Purpose

Outlines the expected practices to be followed by Duty Managers/Waitematā Central Operations Managers when urgent patient transfers need to be made to the Assessment Treatment & Rehabilitation Service (AT&R) inpatient beds due to bed shortages in either North Shore or Waitakere hospitals. The hospital will be in 'yellow' or 'red' bed status as per the *Bed Capacity Management & Escalation Plan*.

Scope

- Duty Managers and Waitematā Central Operations Managers at North Shore and Waitakere hospitals.
- Applies to the AT&R Wards in both hospitals.
- Policy will apply most often after hours (evenings, weekends or public holidays) or post-weekend when usual admitting processes to AT&R are unavailable.

Associated documents

Type	Title/ Description
Policy	[G] Entry Criteria – AT&R
	[G] Admission from ED to AT&R
	[P] Bed Capacity Management & Escalation Plan
	[G] Infection Prevention and Control of MRO – Patients Admitted to AT&R Wards

2. Process to identify most appropriate Patients to Transfer to AT&R Wards

Purpose

This process outlines how to identify the most appropriate patients to transfer to AT&R when medical or surgical beds are at capacity, both Short Stay and the Assessment and Diagnostic Units are fully occupied with the need to create flow and the hospital bed status is identified as yellow or red (system pressured).

2.1 Guiding principles

The following principles should guide decision making:

- Transferring patients off the active (accepted referrals) AT&R wait list or those already referred and likely to be accepted to AT&R. The Duty Nurse Manager /Operations Manager may contact the on-call Geriatrician for advice regarding the suitability of the patients for transfer to AT&R – a senior medical officer (SMO) is available 24 hours.

- Due to limited wall oxygen, no piped suction and no telemetry in the North AT&R wards, only suitable, medically stable patients can be considered as medical/surgical outliers.

- Transferred patients remain under the care of the original team unless admitted by AT&R RMO staff.

- AT&R accepts suitable patients direct from ED. See *Admission - ED to AT&R* policy.

Bed Shortages – Transfer to AT&R Wards

- Multi-bedded rooms should be assigned to patients of one gender (exceptions should only be made for suitable patients and as a last resort).

- Wherever possible west or north domiciled AT&R patients will remain in the catchment local to their home. This can help with discharge planning (e.g. occupational therapy home visits). However, if this is not possible then patients on the AT&R waiting list should be prioritised over the correct domicile.

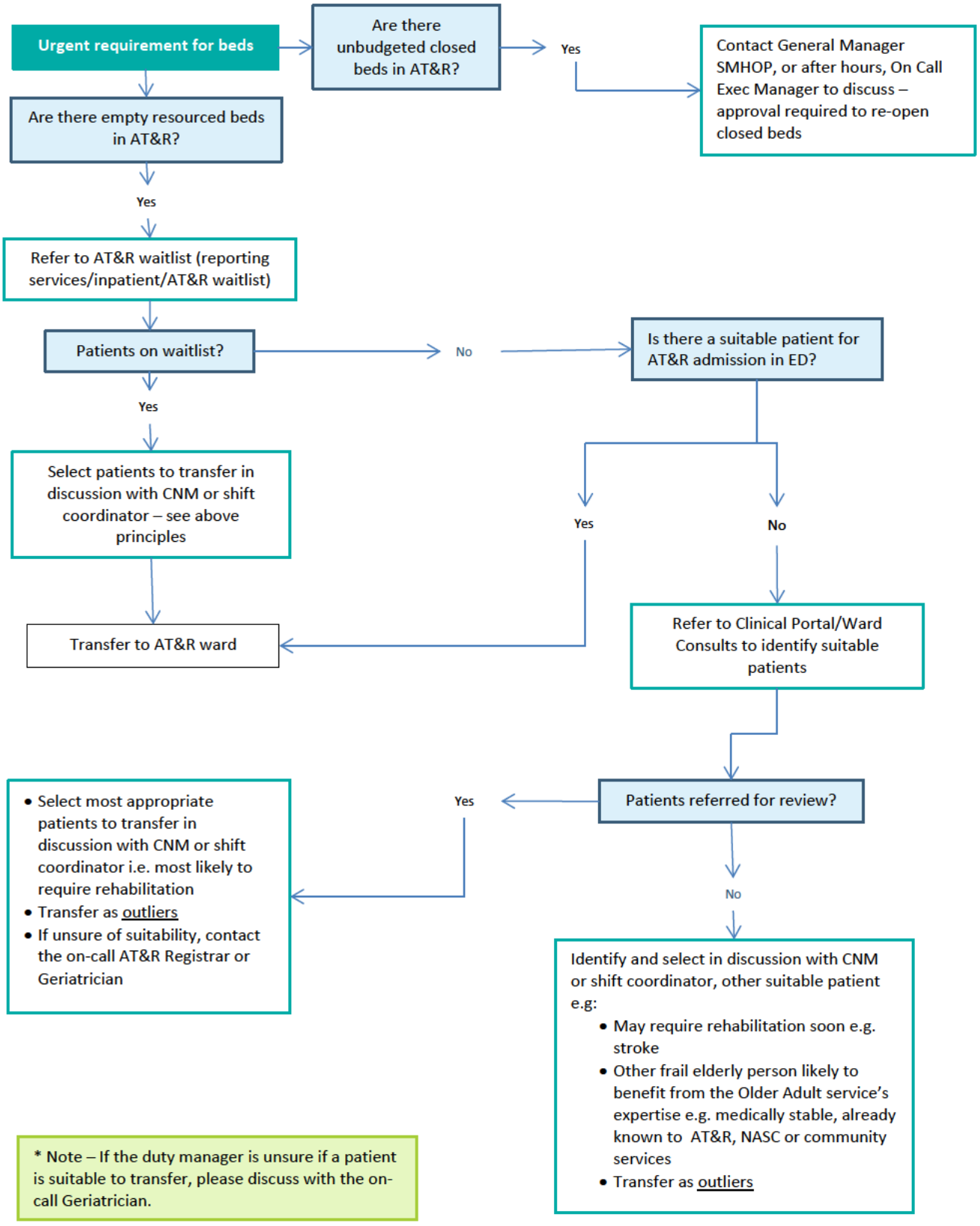
- Patients not on the AT&R waiting list selected for transfer should be > 65 years (55+ for Māori and Pacific people) or close in age or interest.

- The Duty Manager/Operations Manager needs to discuss the AT&R ward's staffing levels and acuity with the ward coordinator prior to transferring patients.

- Waitematā Central can review the AT&R waitlist to assist with bed flow over the weekend and out of hours: Intranet/ A-Z/ Reporting Services/ Inpatients/ AT&R Waitlist

Bed Shortages – Transfer to AT&R Wards

Process to identify most suitable patients - flowchart



* Note – If the duty manager is unsure if a patient is suitable to transfer, please discuss with the on-call Geriatrician.

Admission – Acute Inpatient & Hospital to Hospital Transfers

Contents

1. Overview 1
2. Pre-Warding Process – Acute Admission 1
3. Warding & Implementing the Care Plan 2
4. Hospital to Hospital Transfer for admission 3
5. Care Planning 4

1. Overview

Purpose

The clinical admission process must be managed carefully to ensure the staff know what care needs are, put in place appropriate care plans and ensure that the patient and their family is comfortable with the place in which they have been placed.

The objective is to perform the admission procedure in a timely, professional and sensitive manner – promoting physical and psychological comfort of the patient and relevant others.

Scope

Relevant to North Shore and Waitakere Hospital systems

2. Pre-Warding Process - Acute Admission

The table below describes the process to be completed prior to the generic patient/client arriving in the ward/unit.

Note: ***Refer to specific procedures for speciality relevant issues e.g. CCU, ICU, patients with mental health needs, paediatrics [see specific processes]***

Step	Action	Who
1	All patients presenting for care are registered into the Patient Information System [PIMS] **Acute admission notification is received.** • Once the patient is assessed and confirmed for admission, the ED/ADU Administrator completes the request on the database which messages the Bed Manager • The Waitemata Central Bed Manager is paged to find a bed where the patient can be nursed according to the documented care plan • The Bed Manager pages ward/unit • The Bed Manager confirms bed to ED/ADU	ED/ADU Administration Bed Manager
2	**Ward/Unit Admission environment is prepared** Bed Manager pages new patient to ward/unit shift coordinator Before the patient/client arrives the shift coordinator and HCA ensures: a. A room is allocated by the ward/unit shift co-ordinator. Appropriate room is allocated i.e. gender appropriate, appropriate for illness severity, isolation needs b. The health care assistant/nurse is delegated to prepare the room c. The bed allocation is identified on the e-white board d. An appropriate nurse is assigned to look after patient/client on arrival and advised to expect the patient e. Appropriate documentation is prepared for admission (e.g. named chart folder is made ready for patient) by Ward Clerk	Shift Co-ordinator HCA/EN/RN Shift Co-ordinator Ward Clerk

Admission – Acute Inpatient & Hospital to Hospital Transfers

Step	Action	Who
3	**Room/bed space is prepared** Before the patient/client arrives, the allocated room/bed space is prepared as followed: a. bed is prepared b. the call bell, wall suction and oxygen is checked as functioning safely c. hand-written labels are prepared x 3 for the room (for the bed head, locker, door, and chart) with the patient's name d. towels and washcloth are placed in the room on the back of locker/ in the bedside locker drawer. e. a filled water jug and a glass is placed on top of locker (check if patient will be nil by mouth orally)	HCA/RN/EN

3. Warding & Implementing the Care Plan

Step	Action	Who
1	The ward/unit RN receives verbal handover information by phone from the unit preparing to transfer the patient. • Complete the appropriate ***phone and e-handover form***	RN to RN handover
2	Staff at the ward/unit reception desk must • receive patient/client and visitors onto the unit **in a welcoming manner**. • show them to their bed/ bedspace • assist them to settle them into the prepared room and bed.	HCA/RN/EN
3	The allocated RN must be called to • welcome the patient and family, introducing self and role • receive a verbal hand over from the transferring nurse • review the clinical record/notes and handover sheet • check patients ID	
4	The nurse allocated to the patient should: a. Explain the processes for care and ward routine to the patient/client b. Show the patient how to use the call bell and to call for assistance when they get up for the first time. c. Introduce the patient to the other room occupants d. Show the patient around the ward (if appropriate) noting location of the toilets, showers, kitchen, family room/ day room/dining room, water cooler, flower room and patient phone. e. Advise of ward routine, doctor's rounds, visiting hours. Point out the pamphlets about Patient Rights, complaints/ customer Service f. Ensure admission package is given to the patient with clear explanation of contents.	Allocated RN
5	**Examination & treatment initiation (hospitals)** Nurse must undertake vital signs assessment and risk assessment on all patients within **60 minutes of admission to the ward/unit**. This includes: • Temperature, pulse, blood pressure, respiratory rate, weight • Falls risk assessment • Waterlow – skin integrity assessment • complete Trendcare acuity assessment, including meal orderin	Assigned RN

Admission – Acute Inpatient & Hospital to Hospital Transfers

Step	Action	Who
	A full nursing assessment and history of the patient/client should be completed by an **RN within 24 hours of admission.** This includes: • Making referrals to other therapists or social worker as identified in assessment. • Commence discharge planning Take note of: • Relevant past medical/surgical history • Potential risks • Current medications • Allergies/alerts	
6	Nurse should to contact the on call house surgeon ASAP if the patient needs any care prescribed. Inform them of any concerns – use ISBAR	Assigned nurse
7	**Initiate the treatment care plan as prescribed:** a. Commence **documentation of a care plan** b. Order appropriate pressure relieving devices as required e.g. mattress c. Complete any requested procedures (including taking laboratory specimens etc.) d. Continue with any charted treatments (e.g. medications/IV therapy) e. Commence documentation as required diabetic record, vital sign record	Assigned nurse
8	**Check any specific dietary requirements:** • Order a meal/contact the diet department if necessary.	Assigned nurse
9	**Complete required registration/documentation processes:** a. Identify if the patient is MRSA positive, Rh-ve or Hepatitis B positive on-line – feeds into the SNAP form b. Place patient's ID label in the Admission book for ward clerk double check. c. Update computer d. Complete paper copy record and on-line electronic record. Place paper folder in ward book shelf	
10	**Discharge planning is commenced from day of admission:** • Education needs identified • Refer to physiotherapy / occupational therapy/social worker for assessment as appropriate	

4. Hospital to Hospital Transfer for admission

Medical to medical referral

1. The registrar from the referring Medical team must discuss patient for transfer with the receiving medical team registrar to confirm acceptance, describe care needs and information requiring continuity of care. This handover must be documented in the transfer documents, including the name of the doctor spoken with.
2. The accepting medical registrar must communicate acceptance of the patient to Admitting clerk and Waitemata Central team [Operations Manager and Duty Nurse Manager]

Bed Allocation

1. The Duty Nurse Manager of the referring hospital will call the receiving Waitemata Central Operations manager/Duty Nurse Manager to discuss the availability of a bed, and the need for a Transit nurse.
2. The WC DNM talks with the relevant Charge Nurse Manager [CNM] to identify the appropriate bed/placement.
   - *If patient requires transfer to HDU/ICU this is negotiated using local ICU/HDU procedures*
3. Once bed is confirmed, the DNM confirms details with the referring DNM so that an Ambulance can be booked.
4. The Transit Nurse is briefed and plans travel to retrieve the patient. They receive a formal handover in order to prepare for handover and briefing of the receiving ward team.
   - If no Transit required, the DNM is informed of planned ETA [estimated time of arrival] and confirms this with the CNM.

Admission – Acute Inpatient & Hospital to Hospital Transfers

Nurse to Nurse handover

The referring CNM must contact the receiving CNM to provide a handover. If there is no phone call, the receiving CNM must contact the referring CNM to request a handover.

Transfer to the ward/unit

On arrival the Transit nurse brings the patient through the ED triage area for brief overview and tracking into the hospital.

- Where possible the patient is taken directly to the ward/unit expecting the patient.
- The Transit nurse provides a full handover to the receiving RN and documents the handover in the clinical record.

The medical team undertake an initial admission assessment within 60 minutes of arrival and provide appropriate care plan instructions.

- The senior medical consultant reviews the patient within 12 hours of admission and at regular ward rounds thereafter.

5. Care Planning

All patients have a plan of care documented following initial assessment and regular review of progress against the care plan.

Patients with complex needs must have a detailed multidisciplinary team care plan developed which records referral to appropriate team and specialist teams. There is a formal case review at weekly/regular intervals to review progress against the agreed plan of care.

Concerns regarding patient response to treatment must be escalated to the SMO and Head of Division Nursing. This may include refusal of treatment.

Patient Placement – Inpatient Settings NSH & WTH

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4. Patient Bathrooms 2
5. Maintaining Privacy at all Times 2
5.1 Privacy During Clinical Consultations 2
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1. Overview

Purpose

This document outlines expectations about how to manage patient placement managed in acute in-patient settings in compliance with the Code of Consumer Rights. The aim is to take all reasonable attempts in the circumstance to respect patient dignity and privacy, and as well place the patient for ease of monitoring depending on their needs.

2. Consumer Rights

Decisions should be made based on compliance with the Code of Consumer Rights

- Respect
- Privacy
- Dignity
- Care at an appropriate standard
- Care appropriate to the needs of the person
- Safety through monitoring

3. Patient Placement and Management

The Bed Assignment Coordinator [NSH] and Duty Nurse Manager [NSH and WTH] assign patients to wards where appropriate beds are available.

Staff on the ward ideally will place a patient into a bed space that separates male and female patients, so that privacy and dignity is maintained. Sharing of males and females must be an exception only.

Staff need to be sensitive to age-appropriate and life experiences which make being in a room with someone of the other gender is a problem

In specialist assessment (ED & ADU) and treatment areas (ICU), segregation may not be possible. All attempts must be made to minimise exposure and maintain dignity and privacy.
Any confused patients must be monitored by the available staff, especially if they wander and all attempts made to not allow them to be intrusive to others.

Complaints about placement must be addressed immediately.

3.1 If Preferred Bed Placement is Not Possible

On the occasion that segregation is not possible, because of bed crisis situations or for clinical management reasons, then:

- The situation must be discussed with the patient and their potential roommate (s)
- Their agreement must be sought prior to placement

Patient Placement – Inpatient Settings NSH & WTH

If they strongly object, then an alternative should be reasonably attempted.

- If no alternative is possible, then this should be explained to them and the matter corrected at the nearest available opportunity

They should be given an undertaking that as soon as a bed in a male or female room is available then they will be given the opportunity to be transferred.

4. Patient Bathrooms

There are a set number of toilets and bathrooms available on each ward and are used by all of the patients in the unit. This means that privacy is not easy to maintain.

- Patients should be advised that the bathrooms are not gender specific
- Signage must be present which advises patients of the multi- use area
- Signage must remind patients to knock before entering
- Where toilets are designated for males and females, there should be appropriate signage

5. Maintaining Privacy at all Times

- Patient privacy must be at the fore-front of staff thinking at all times to maintain privacy, whether there is male-female sharing or not.
- All attempts are made to keep the curtains closed during treatments and where personal care is being given.
- Patients must have access to a dressing gown when out of bed where they do not have this for themselves
- Patients must be covered for dignity when transported.
- Generic patient areas i.e. bathrooms and toilets must be managed to maintain privacy and dignity
  - The showers and toilets must be labelled for male and female use and the doors closed when patients are using the shower/toilet
  - Patients are reminded to knock to respect the privacy of other users of the bathroom areas
  - Patients washing at the basin must use the washrooms in each area and *not* the generic hand basins in the main bathrooms.
- The patient placed in the corridor for closer monitoring must be observed by the nurses to ensure that their privacy is maintained
- The nurses/midwives move continuously through the wards and check the patients every 60 minutes. If they notice anything untoward they take immediate action.

5.1 Privacy During Clinical Consultations

Where at all possible, patients should have privacy during clinical consultations by using treatment/consultation rooms.
Where this is not possible, staff must be aware of others in the room and speak discretely, keeping curtains closed.

5.2 Privacy During Visitors

Visiting should limit the number of people crowded in the 4-bedded rooms or wandering around the ward, especially those people staying overnight.

Where someone (individual) remains with a patient between visiting hours

- This must have formal permission by the nurse/midwife in charge and the acceptance of the other people in the room i.e. the nurse in charge must ask the other patients first
- The patient and remaining person should preferably be in a side room to minimise impact
- The person remaining should preferably be of the same gender of the people in the room

Patient Placement – Inpatient Settings NSH & WTH

The person remaining must remain with their relative and *not* wander around the room or the ward.

6. Allocation of Side Rooms

Side room allocation is on the basis of clinical need

- This includes the need for isolation, deteriorating/acutely unwell patients, care of the dying patient and their family, patients requiring some form of restraint or any other clinical situation which may arise in which the use of side room would be considered by clinical staff to be in the best interests of the patient and or the ward.

From time to time patients in a side room may be required to move from that room if their clinical condition no longer requires the use of the room and to accommodate a patient whose clinical condition does necessitate the use of the room.

Waitematā District Health Board
Best Care for Everyone

Specialty Medicine & Health of Older People Division
Assessment Treatment & Rehabilitation (AT&R) Service

Waiting List Management – AT&R

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1. Overview

Purpose

- The AT&R Waiting List is the management tool that documents the current status of all patients accepted for inpatient Assessment, Treatment and Rehabilitation (AT&R) within Older Adults Service at Waitematā DHB.
- The AT&R Waiting List is a "live" document. It is important for planning daily admissions activity, and is also an important source of outcome data for the service. It must be kept up to date and accurate.
- The purpose of this document is to outline the process for managing the AT&R Waiting List both clerically and clinically, ensuring equity of access for all patients.

Scope

All clinical and non-clinical AT&R staff.

Associated documents

Type	Description
WDHB policies	Interim Care Scheme – Waitematā District [Aug18] Interim Care Service – Service Guidelines (In Dev) Multi-Drug Resistant Organism (MDRO) Management [Apr22]
AT&R policies	Entry Criteria – Assessment Treatment & Rehabilitation (AT&R) [Nov20] Admission - ED to AT&R [Sep20] Infection Prevention and Control of Multidrug Resistant Organism (MRO) – Patients Admitted to AT&R Wards [Aug20]
OA&HH/ AT&R forms	Older Adults Outpatient Clinic Visit – Outcome form [May20] OA&HH Referral [Mar21]

Waiting List Management – AT&R

2. Placing Patients on the Waiting List

2.1 Identifying patients for the AT&R Waiting List

- Patients for transfer to AT&R will be identified from various sources:
    - Older Adults daily eReferrals triage
    - Community Geriatrician/GNS/GNP assessment
    - Review of patients in the Emergency Department or Admissions Diagnostic Unit (ED/ADU)
    - Outpatient clinic appointments
    - Inpatient ward consults
    - Referral from other hospitals (other DHB or private hospitals).
- A member of the service's senior staff i.e. Senior Medical Officer (SMO), Registrar or Gerontology Nurse Specialist (GNS), approves entry onto the waiting list. In all cases a written document (referral letter, outcome of a ward consult, documentation of telephone conversation, email etc.) must be provided to the Community Administration Support (CAS) staff before a person is added to the waiting list.
- Waiting list patients are categorised as "active", meaning they are ready to be admitted under the AT&R service as soon as a bed becomes available, or "suspended" meaning these patients are not currently appropriate to transfer to the rehabilitation ward but remain under review by the service and may enter the "active" list when their medical condition changes.
- If there is disagreement about whether a patient should be entered on to the waiting list the Clinical Director will decide. Patients under 65 years (or 55 years Māori and Pasifika) or non-residents may not be added to the waiting list without the approval of the Clinical Director.

2.2 Patients referred from the community

- Patients referred from the community requiring inpatient admission will be identified by clinicians at the Older Adults daily morning eReferrals triage meeting or discussed with the on-call Geriatrician/registrar.
- Clerical staff enter patient details into the IPM waiting list on the date the decision is made.
    - 'Letter date' is the date identified on the referral letter
    - 'Referral received date' is the date referral received into the service
    - 'Waiting list date' is the date of the decision to place the patient on the waiting list.

2.3 Internal referrals from North Shore and Waitakere hospitals

- Patients requiring AT&R admission are assessed for suitability via a ward consult. Ward consults are carried out by GNSs, Registrars, and Geriatricians in ED/ADU and the inpatient wards.
- Clerical staff "create" a referral in IPM on the day the referral is received. The outcome ('accept', 'decline', or 'review') is recorded in IPM "as at" the date the decision is made.
- Following a ward consult, the reviewing clinician will outcome the Ward Consult Referral identifying whether or not admission to the AT&R Service is considered appropriate for the patient. If admission to AT&R is required the patient is placed on the appropriate North or West waiting list. This decision is also noted in the clinical file by the reviewing clinician.
- The referring ward must ensure that any required swabs, as identified by the Infection Prevention and Control team, are undertaken to ensure that admission is not delayed. Should the required swabs not be completed, the patient will not be transferred and may be 'suspended' from the active wait list.
- The Ward Consult Referral list is available on Clinical Portal.

- Patients that are referred may also be declined, in which case a reason for decline will be documented on the Ward Consult Referral and clinical notes and entered into IPM by CAS staff who will then close the referral.
- If a patient becomes unwell whilst on the "active" waiting list, they may be removed from the waiting list or moved to the "suspended" waiting list until they are ready for rehabilitation. For patients accepted after a review period, the 'waiting list date' is the date that it is decided to put the patient back on the active waiting list.
- INTERIM CARE SERVICE: A separate policy exists that outlines the full process for patients discharged to temporary residential care under the interim care service. For the purposes of this policy, all such patients are considered as patients referred from the community.
-

2.4 Referrals from non-Waitematā DHB hospitals

- Referrals may be placed directly on the waiting list (without going through triage) from other DHB hospitals only if a patient has been assessed by a Geriatrician or Geriatrics Registrar at the parallel Older Adults Service of the referring DHB. In these cases, 'referral date' and 'waiting list date' is the date the referral is received into the service.
- Referrals from private surgical hospitals will be reviewed at the daily eReferrals triage. Usually these patients will be placed on the "suspended" waiting list pending suitability for transfer. If a patient is ready for immediate transfer from a private surgical hospital, they should be placed on the "active" waiting list.
- If a patient is not ready for admission to AT&R they will be placed on the "suspended" list for further review at a specified date.
- If the patient is not suitable for admission to AT&R, the triaging Geriatrician outcomes the eReferral with the reason for decline.
- Patients identified as appropriate for AT&R are placed on the IPM waiting list by CAS clerical staff. The 'waitlist date' is the date the decision was made to place the patient on the waitlist.

3. Ongoing Waiting List Management

3.1 Ongoing management

- Patients accepted onto the waiting list remain the clinical responsibility of the referring team until the patient is medically admitted under the AT&R service.
- The waitlist is available to all Charge Nurse Mangers (CNMs) in reporting services. All referring CNMs are asked to review the list and notify the clerical staff of any changes which could affect bed allocation for their patients. This would include a change in infection control status, deterioration in the patient's condition or if the patient has been discharged.
- For inpatients from Counties Manukau DHB, Auckland DHB and private hospitals the admission status checking process will be done through the appropriate admitting office or referring ward.
- For patients referred from the community, CAS staff will contact the referrer or the patient to advise of waiting list status.
- If patients are discharged from hospital before a bed is available in AT&R, they are removed from the waiting list (see process below) – backdated to the date of discharge.
- If there are concerns about the patient's appropriateness or readiness for admission to AT&R, the AT&R CNM will investigate the referral further. Based on the clinical information received, the CNM

may make a decision as to whether or not the patient is placed on the "suspended" waiting list, or may discuss further with senior staff.

3.2 Management of "suspended" patients

The above process also applies for "suspended" patients.

- When updated information is received about a "suspended" patient, this information is entered in the comment field on the IPM waiting list.
- When a patient's status is changed from "suspended" to "waiting" the clerical staff will enter the 'waitlist date' as the date notification is received that the person may go on the active list. The original referral date is not altered.

4. Removing Patients from Waiting List

4.1 Removing patients from the waiting list

- Patients are removed from the waiting list for a number of reasons including:
  - Admission to an AT&R bed
  - Clinician request
  - AT&R inpatient stay is no longer required/patient discharged home or to EDARS
  - Patient is deceased.
- The 'date of removal' is the date the decision is made to remove, or the date of death.
- When a patient is removed from the waiting list for any reason other than admission to an AT&R bed, the clerical staff enter the "remove" reason on the waiting list entry.

4.2 Prioritisation of patients when admitting to AT&R beds

- Each weekday morning the AT&R Charge Nurse Managers review the waiting list and make a plan for the day's admissions. This plan is emailed to the Older Adults Operations Manager, Clinical Director Older Adults and Clinical Nurse Directors. A number of factors are considered to ensure appropriate bed allocation including:
  - Infection control compliance
  - Gender segregation
  - Clinical sub-speciality i.e. Stroke or Orthopaedics
  - Waiting time
  - Need for specialised staff or equipment.
- As much as is practical, patients will be admitted to AT&R beds close to their place of domicile. Occasionally patients may be admitted to their non-domicile catchment unit if bed pressures are unbalanced across the two hospitals or there is a clinical reason to remain in North Shore Hospital i.e. requiring inpatient dialysis or ongoing surgical review.

4.3 Admission to an AT&R bed

- The Admission clerk creates a "pre-admission pack" that sits in the Ward Events until the patient physically presents to the ward.
- For patients coming from another DHB or private hospital, ambulance transport is arranged by the referring hospital.

- If the patient is coming from overseas, air ambulance is arranged in conjunction with the insurance company (where applicable) and the referring hospital.
- When the patient arrives on the ward and admission details are entered and the wait list entry in IPM is automatically removed.
- Ward clerk confirms that patient has been admitted by checking IPM.

4.4 Patients transferred from AT&R to an Acute Ward

On occasion a patient may require transfer to an acute ward. In this instance, if the patient requires a further inpatient stay in AT&R a new waiting list entry is required, as the original waiting list entry will no longer be active.

- The acute team should first discuss the need for readmission to AT&R with the Geriatrician or registrar originally involved in the patient's care. The AT&R team will then decide whether a further review is required.
- If agreed that the patient should return to AT&R, a new waiting list entry is created and attached to the original referral (or to a new referral if one is received).
- The patient is placed on the active waiting list in IPM with the 'waitlist date' being the date the patient is placed on the active waitlist.
- Patients transferred for a brief and defined intervention (e.g. West patents taken to North Shore for a surgical review) will be transferred back as soon as possible so that rehabilitation can continue with as little interruption as possible.

Waitematā District Health Board
Best Care for Everyone

Standards: Safe & Appropriate Environment

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1. Introduction

Purpose

The purpose of this document is to explain how WDHB has addressed the criteria identified by the Health & Disability Sector Standards in relation to Safe & Appropriate Environment.

Scope

Across WDHB, although each service will have local documentation where appropriate to address specific processes in the service or client group

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2. Physical Privacy

2.1 Sharing a Room

Staff are aware of the accepted procedures for ensuring privacy where consumers share a room.

- Alternative space for sensitive discussion or examination is available in many clinical settings
- Curtains are maintained appropriately to ensure adequate visual privacy
- Gender appropriate allocation is managed by the Charge Nurse Manager or shift coordinator where at all possible. Where this cannot be managed, the patient and family receive an explanation and all reasonable efforts are made to achieve same gender rooming.

(See policy: Patient Placement in Inpatient Settings)

Where possible, side/single rooms are allocated for patient use according to acuity, changing condition, patient type or visitor group.

2.2 Respect for Privacy & Personal Space

Staff are aware of the expected practice for privacy and personal space

- Staff knock on doors prior to entering where appropriate
- Staff do not remove things from consumers lockers without discussion with them
- Staff do not use consumer items e.g. mobile phones

Consumer personal belongings are not shared between consumers; they remain the property of the person.

(See policy: Patient Property & Valuables; Privacy]

2.3 Personal Hygiene

- In most settings, the general washroom areas are not gender specific i.e. they are a shared/communal area. This means that staff are required to take specific action to protect the privacy of the consumer.
- Each ward/unit manager is responsible to ensure that the toilet and shower doors are labelled appropriately to either identify the room as male or female or that the facilities may be used by both genders and that knocking before entry is essential. Patients are oriented to this on arrival to the ward and ongoing
- Safe, disability appropriate locking systems are used on bathroom doors. The system allows staff to access the room in an emergency.
- Except for routine general activities, i.e. hand hygiene, consumer **may not** be washed in the communal hand basin area. Separate washroom areas are accessible in most settings for personal washing.

(See policy: Patient Care Essentials)

2.4 Visitors

- Where possible the consumer is able to have a private interaction with their visitors. This may be difficult in a 4-6 bedded room
- A communal lounge area is available in each ward/unit
- A whanau room is available on each hospital site

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(*See policy: Visitors including After Hours at NSH & WTH*)

2.5 Telephone Calls

- Consumers have access to ward remote phones if they receive a call for personal use.
- Most patients have personal mobile phones. Patients are asked to mute their personal mobile phones so as not to disturb the other patients in the room
- Use of ward/unit main phones is generally discouraged for consumer or staff private use because the phone may be needed for emergency use or other business purposes. The phones are also in the staff office areas where patient information can be inadvertently seen or overheard.
  If agreed with the ward staff, a patient may access a ward phone to contact family.

2.6 Noise Levels

Staff are aware of the need to keep the noise levels in the ward setting to a minimum to:

- Ensure a calm therapeutic environment
- Facilitate rest and recovery
- Maintain privacy.

Staff are supported to manage visitor or other consumer noise to minimise impact on other consumers. This includes limiting large groups in 4 bedded rooms and reinforcing visiting hour

Staff are discouraged from using radios in clinical settings, especially if the sound is discernible to the patient rooms

Staff are discouraged from holding personal mobile phones in the work setting for personal use as that interrupts clinical care delivery. They may access their phone during breaks.

If the patient or family use a television or have music playing this must be kept to an acceptable volume or preferably use headphones. Staff may not have radios or music playing that is intrusive or prevents staff hearing patient needs.

3. Facility Specifications

3.1 Building 'Warrant of Fitness'

Key buildings e.g. inpatient clinical / specific buildings have the warrant of fitness which is renewed annually

- The warrant is applied for by WDHB Facilities Maintenance teams where buildings. The warrant of fitness is visible in the main reception area for reference
- If the building is leased, the landlord is responsible for ensuring that an annual warrant of fitness is renewed annually as appropriate.

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3.2 Maintenance of Buildings & Plant

General Maintenance

Facilities Maintenance Team has an annual plan for maintenance of all buildings managed by WDHB.

- There are documented processes for staff to follow for identifying items to be repaired. This includes a reliable after-hours essential service process.
- Facilities Maintenance respond to BIEMS reports to identify items that need repair. This includes replacement of lights, replacement of ceiling tiles
- Staff log repair requests using the BIEMS system
- If the maintenance issue is urgent, the Duty Nurse Manager can call in on-call Facilities and Maintenance staff/shift engineer.

Essential Equipment Maintenance/Replacement

Clinical Engineering manages the essential equipment maintenance register for annual checking. The team and assists with planning for a replacement programme. CAPEX funding is applied for annually.

- There is a replacement programme for general patient beds, infusion pumps and other pool items. This is monitored by a named person
- There is a contract with an ISO-accredited provider of Medical Electronic equipment commissioning, maintenance and audit.

Managers of key departments monitor equipment, specialty maintenance schedules and replacement programmes – see below.

Facilities and Maintenance manage

- Essential plant testing and replacement of equipment is managed e.g. generators.

Compliance with Manufacturers Specifications

Facilities and Maintenance Services have the documentation of all manufacturer specifications of infrastructure and ensure that core essential items are managed to comply with these specifications.

Where an item is held in a department and managed by that department e.g. Anaesthetic machine, CT Scan, Steriliser device, the manager of the department is responsible to

- hold the equipment manuals in a safe place / hold in Medical Electronics
- ensure that staff have been appropriately trained to use the equipment safely and area aware of essential information e.g. diathermy
- to ensure that maintenance is maintained according to the agreed contract
- maintain records of all maintenance
- plan a replacement programme according to recommended replacement dates.

(*See policy: Clinical Product & Device Selection; Clinical Product/Device Problem Management; Product or Equipment or Device Problems (Reporting)*)

3.3 Safe Environment

Public and clinical area corridors are:

- Planned to be large enough for bed and public access
- Monitored to be uncluttered. Equipment not in use is stored appropriately
- Have safety rails in place so that people can use these if required

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- Safe by minimising changes in floor surface and levels. Spills are monitored for. Floor cleaning works to stop over polished surfaces which can contribute to falls.

Safe Choice of Items

Appropriate staff, consumers and specialists are consulted when selecting amenities, fixtures, equipment and furniture is selected, located and installed to ensure that what is acquired is appropriate, acceptable and safe.

- Items that are not suitable should be replaced after appropriate consultation.
- Items selected must meet appropriate standards and specifications for safety e.g. lifting devices, chairs, non-slip flooring
- Items selected should foster independence where possible.

(*See policy: Design, Commission and Construction; Clinical Product & Device Selection*)

Floor Surfaces

- Floor surface maintenance is managed in good order
- All attempts are made to minimise the gradient between surfaces or coverings
- Ramps must meet the requirements of NZMP 4122:1989 Design for Access by Disabled Persons
- Problems with surfaces are immediately reported for repair. Appropriate identification [tape, signs] are put in place to alert of potential danger.

(*See policy: Disability Compliance Guidelines*)

3.4 Long-Term Living Spaces

Where consumers remain in the same space for some time e.g. mental health, forensic, child disability, rehabilitation, the patient/service users is encouraged to bring familiar and personal items to create personalised space.

The areas are monitored by the unit and service manager and maintenance organised to ensure appropriate environmental standards.

3.5 Equipment Availability

Essential equipment is identified in each setting

- Staff are orientated to the place where equipment is kept and how to use it safely
- Staff are allocated responsibility for regular checking of its presence and functioning
- Broken equipment is immediately identified and repair organised.

Equipment is updated/replaced according to recommendations, as above.

4. Toilet, Shower & Bathing Facilities

4.1 Availability of toilet, shower and bathing facilities

Adequate Quantity of Facilities

There are adequate numbers of facilities in all buildings to meet the requirements of the Building Regulations 1992.

- Toilets have appropriate access for consumers based on need and ability.
- Disability appropriate facilities must be available in identified locations.

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- Communal spaces must have a system for indicating engaged or vacant and for safe locking.
- Appropriately secured handrails in toilet/shower and bathing areas

Hand Basin & Hand Drying Facilities

- Facilities for hand washing are within close proximity to the toilet and are an appropriate height
- Appropriate cleaning and infection control practice is monitored.

Identification of Spaces

Appropriate signage for toilets/shower/bathing facilities is present as described above and in line with recognised standards.

4.2 Construction Quality

Specialist advice is sought when selecting fixtures, fittings; floor and wall surfaces are constructed to ensure good hygiene and cleaning. This is according to the Building regulations 1992 and regulations.
(*See policy: Design, Commission and Construction; Design, Construction and Renovation Policy & Procedures; Contractor Management*).

4.3 Hot Water Control

Hot water is monitored to ensure that appropriate temperature delivery meets the recommendations in the Building Regulations 1992.

- Where this cannot be achieved, signage is present warning that water may be hot.
- Planning for new or upgraded areas is required to comply with the regulations where at all possible.

5. Personal Space & Bed Areas

Space for movement around the bed

The manager of the area ensures that there is:

- adequate space in each bed space
- appropriate equipment for storage and comfort
- regular removal of clutter each shift

Specialist and direct care staff advice is sought with new designs, including consumer input.

(*See policy: Patient Lifting and Transfer; Disability Compliance Guidelines; Restraint Safe Practice; Staff Accidents/Incidents at Work; Safety; Violent/Potentially Violent Situations – Management of*).

Egress Accessibility

Public corridor access is designed to accommodate limited bed and trolley access, including clinical equipment. The Orderly Service ensures that where possible equipment is stored aware from the corridor areas. This is monitored by the Fire Training Specialist.

6. Lounge, Day room, Play room, Dining Area

Dedicated Space

Space as a lounge/day room is retained in each clinical area for communal use.

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- Furniture, fixtures and fittings in these areas is adequate, safe and maintained e.g. day room. Dining space is limited
- Where space is shared, staff are required to manage the situation where some people inhibit access for the other patients/families. Alternate space is limited.

Access to these Areas

- Arrangement of furniture allows for mobilisation safely and with dignity
- Emergency access must not be obstructed

Appropriate Furniture

Appropriate advice is essential when selecting furniture and this must comply with the Procurement generic catalogue:

- Height of the furniture
- Stability
- Combustibility of materials
- Cleaning properties of materials
- Risk of causing injury
- Disability needs, including vision-impaired consumers.

7. Essential & Emergency Systems

Emergency response systems (clinical and non-clinical) are established in each setting to ensure that consumers are safe and their needs met.

This includes information, training and equipment.

- Policies and procedures are documented.
- Leadership roles are identified and key people trained.
- Incident controllers are prepared for managing these situations in liaison with external agencies.

(*See policy: ESP1 Major Incident Plan for Waitemata District; Emergency Response Processes; Clinical Emergency Team Response; Security; Fire Protection, Management and Evacuation – NSH*).

7.1 Staff Training

- Staff received training to ensure their ability to respond. This occurs in induction and ongoing.
- Mandatory training occurs annually.

(*See policy: Learning & Development*)

7.2 Immediate Attention in an emergency situation

There are staff on duty in all facilities who know how to respond to provide immediate attention and access specialist assistance as required

- Non-clinical staff know how to access clinical expert staff as needed [777]
- All staff are supported to use their common sense if faced with an unexpected situation
- The Duty Nurse Manager is the Incident Control on the main hospital sites and they know to contact the on-call Executive and the Emergency Systems Planner for support as needed

(*See policy: Emergency Response Processes; Clinical Emergency Team Response; Code Orange Team – North Shore & Waitakere sites; Security; Fire Protection and Management*).

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7.3 Fire Safety & Evacuation Schemes

The Fire Training Specialist works with the Emergency Systems Planner to finalise the fire safety plans and evacuation schemes that are approved by the Fire Service and form the basis of the staff training and preparation.

- As new areas are built or refurbished the plans are revised and adapted.
- Staff training is revised and considerable effort being made to cover all staff emergency response needs.
- Warden and deputy warden training occurs twice a year.

(*See policy: Fire Protection and Management*).

7.4 Emergency Management Systems

The DHB has appropriate systems and procedures in place to ensure compliance with the Civil Defence and Emergency Management Act 2002. This legislation designates District Health Boards (DHB) as "emergency services", active members of their regional Civil Defence and Emergency Management Group.

- DHB's are responsible for planning and provision of health care services necessary to restore the health status of those of its population affected by a declared emergency.
- Each DHB is required to document a major incident plan, not just internally but also for responsibilities to remote communities and rest homes and private hospitals.

The focus of work is:

- External agency relationships
- Primary health/community preparedness
- Internal service/facility preparedness
- Providers in Waitemata District (rest homes and private hospitals)
- Training and preparation.

A range of documents have been prepared to assist staff training and for reference. Each work setting has a red 'Emergency Management' box with key information and resources for staff use. Each unit must be able to be self-sufficient in the first instance as the Incident Controller assesses the situation and deploys available resources.

(*See policy: Emergency Incident Response Processes; HEP Health Emergency Plan WDHB)*

7.5 Backup / Essential Power / Utility

The main facilities have backup and essential power and utility services. These are being upgraded as required and are tested weekly.

Work is underway with the Lifelines Group (Regional Emergency Response) to consider what our needs would be in relation to:

- Electricity
- Water
- Vacuum
- Gases
- Essential temperature requirements
- Waste
- Communication/telephone

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7.6 Call Systems

- All clinical settings have call systems in place for patient use and duress systems for staff use as needed
- The manager of the area/unit has responsibility for testing these regularly and arranging repair / replacement where problems are identified
- There are paging systems and mobile phones systems used across WDHB.

Personal Alarm System

- Duress buttons are available in certain areas to ensure very rapid response in certain circumstances.
- In the mental health settings, there are procedures for calling for assistance where there is a calming and restraint situations.
- Similarly at North Shore Hospital, there is a Code Orange team that is called using 777 to assist wards/units cope with situations.

7.7 Supervision

Staff are present in all inpatient settings 24/7 where there are patients / service users in order to provide appropriate support and supervision for safety

- There is monitoring of appropriate staff numbers, experience and skills required
- Where the patient / service user is confused or at risk, staff are required to provide additional supervision and monitoring. This may include: 15 minute checks [15/60], a 'constant observer' or 1:1 observation. There are clear guidelines for staff use.

Where possible an appropriate environment is found to ensure safety and equipment used

- Staff are aware of the requirements of restraint minimisation and how to manage supervision appropriately

(*See policy: Delirium Management; Fall Prevention – Avoiding Harm; Restraint Safe Practice; Safety; Violence Management & Code Orange Teams; Observation of Behaviours of Concern*)

8. Security Systems

8.1 Security

There is a security team employed on the North Shore and Waitakere Hospital sites

The buildings at North Shore, Waitakere, Mason Clinic and Detox have been fitted with external lock-down mechanisms and controlled entry devices to manage security in approved areas

- Swipe card access limits who may go where and allows for tracking
- There are monitors on certain areas at North Shore and Waitakere Hospitals and Mason Clinic and these are viewed by available security staff
- Wards at North Shore and Waitakere Hospitals have lock devices which allows for control of who enters and exit
- Security have systems in place to manage unwanted or restricted visitors.

8.2 Staff Identification

- Staff are required to wear photo ID at all times when on site.
- All contractors must similarly sign on and wear appropriate ID.
- Students are required to have appropriate identification and sign on each time they come on site.

(*See policy: Security; Induction; Identification*)

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8.3 Visitor Identification

Official visitors are required to sign in the register in certain restricted areas across WDHB and are issued with approved ID badges.

Visitors of patients / service users do not have ID but must be known to Security if remaining overnight and are issued with a sticker for identification

- There are particular rules of conduct where people remain in the inpatient setting overnight and if breached can result in people being requested to leave.
- At North Shore Hospital, visitors staying in the Whanau Room accommodation have specific rules to abide by.

(*See policy: Security; Contractor Management; Bureau Business Rules; Student Clinical Experience; Visitors Including After-Hours at NSH and WTH*)

9. External Areas

The environment allows for appropriate external areas for consumer and visitor access.

- All new buildings have outside areas for patient and staff use. Garden areas are being upgraded.
- Areas are appropriately lighted and protected, including safety.
- Access is safe – paths are checked as safe and repaired as needed
- There are mechanisms in place to call for assistance if required.

(*See policy: Disability Compliance Guidelines*)

10. Natural Light, Ventilation and Heating

Patient Areas

There is appropriate ventilation, light and heating in public and consumer areas

- Lighting in main corridors is an appropriate lux level
- Night lighting is adequate to assist consumers
- The air conditioning where it is present has manual and automatic monitoring
- Bathroom areas have adequate ventilation to minimise damp and odour
- Where consumers comment about the environment, all reasonable effort is made to correct the situation e.g. too cold
- Ventilation systems are regularly formally monitored and the results reviewed to identify issues

External Windows for Patient Rooms

- Consumer accommodation has an external window in each room
- Some rooms may not have much natural light

10.1 Smokefree Areas

WDHB has a policy of being 'smokefree'.

- At present no one may smoke in any DHB building or on any site managed by the DHB
- All reasonable attempts are made to minimise the chance of being exposed to tobacco smoke and smoking in the main entrances is discouraged.

(*See policy: Smoke free Environment*)