Waitematā
District Health Board
Best Care for Everyone

Hospital Services
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3 May 2021

[redacted]

Dear [redacted]

Re: OIA request – Instances where Code Black or Code Red alerts were issued

Thank you for your Official Information Act request received 25 March seeking information from Waitematā District Health Board (DHB) about any Code Black or Code Red instances at our hospitals.

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 DHBs in the country, serving a population of around 650,000 across the North Shore, Waitākere and Rodney areas. We are the largest employer in the district, employing around 8,600 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:

1. **I would like to request reports on all instances where the Waitematā DHB equivalent of a Code Black or Code Red alert was issued at North Shore and Waitākere hospitals for the period 1 January 2011 to 24 March 2021.**

Waitematā DHB did not have a Code Black alert system in place, so we can advise that this has not occurred during this timeframe.

We have a "Whole of Hospital Huddle" each weekday morning that identifies our status at the start of the day, which is attended by all services. If we are in Status Alert Red and look to be compromised by 11.00am, a contingency meeting with senior staff is set up for early afternoon to plan and mitigate any potential risks going into the evening.

These standard operating responses ensure that our hospitals remain safe for patients and all aspects of patient care and hospital operations are routinely monitored and responded to.

Waitematā DHB is currently in the process of setting up a Demand Response Framework for the organisation that ensures that each service is responsible for managing increases in capacity and a clear escalation pathway is followed to ensure an early response during periods of fluctuating demand.

It provides an objective assessment process with clear role accountabilities and communication.

The following table provides the number of days that North Shore (NSH) and Waitākere (WTH) hospitals were at Alert Status Red for the ***majority of a 24-hour period***, by calendar year from 1 January 2011 to 21 March 2021.

Of note, for some of these days, the hospitals would not have been in Alert Status Red for a full 24 hours. Each day, we continuously work on plans to manage capacity and, following implementation, the alert status is often downgraded to Amber or Green within that period.

It should be noted that our hospitals are undergoing a period of expansion in order to meet the growing needs of our population.

Located at the North Shore Hospital campus, construction of the new Tōtara Haumaru hospital building is under way and will increase capacity in the Waitematā DHB district and the region in general.

It will consist of:

- Eight surgical theatres, including associated pre and post-operative facilities and clinical support services
- An endoscopy suite comprising four procedure rooms, preparation and recovery space and sterilisation facilities
- Four 30-bed inpatient wards on two floors, with shelled space for a fifth ward providing 120-150 beds in total.

At Waitākere Hospital, a $40 million funding package to build a new 30-bed inpatient ward has recently been announced.

Construction on the new ward is planned to begin at the end of 2022 and is aligned with the Northern Region Long Term Investment Plan, which forecasts that 320 additional inpatient beds will be needed at Waitakere Hospital by 2037.

In the past six years at Waitakere Hospital, the DHB has installed two new CT scanners, upgraded the Emergency Department to include 52 treatment spaces, created a new endoscopy room for bowel screening, provided 11 additional children's health beds and 15 additional general medicine beds.

Table 1: Number of days Code Red alert status at Waitematā DHB hospitals

Calendar year and site	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2011												
NSH	7	14	7	0	0	0	1	8	4	6	0	3
WTH	0	2	0	0	1	2	5	2	4	1	1	3
2012												
NSH	11	5	1	10	5	7	13	13	8	2	3	1
WTH	2	2	2	3	11	4	13	6	4	9	0	0
2013												
NSH	1	0	5	1	4	10	9	5	7	9	1	8
WTH	5	2	0	0	3	1	5	2	1	1	1	1
2014												
NSH	4	2	4	7	7	11	14	9	10	4	4	3

WTH	0	3	0	2	0	1	3	5	0	4	0	2
2015												
NSH	2	9	17	7	12	11	13	22	23	15	11	5
WTH	0	0	0	0	2	1	7	12	10	3	2	1
2016												
NSH	0	1	14	11	1	14	19	12	8	11	14	0
WTH	3	2	3	4	4	5	10	2	7	5	2	0
2017												
NSH	5	11	5	2	9	15	19	2	5	11	2	4
WTH	4	2	3	7	19	10	25	16	3	9	4	3
2018												
NSH	19	20	5	15	12	18	14	26	15	8	18	5
WTH	8	5	7	8	16	9	15	26	21	15	20	5
2019												
NSH	6	1	7	8	7	13	20	14	7	3	14	2
WTH	5	10	7	8	23	24	25	16	6	6	3	6
2020*												
NSH	2	5	3	0	7	14	19	15	24	22	24	21
WTH	19	17	5	0	8	13	25	18	13	8	21	25
2021												
NSH	24	17	24									
WTH	24	16	21									

*These figures demonstrate the significant ongoing impacts of the COVID-19 pandemic. Numbers for the first half of 2020 demonstrate the low numbers of patients through our hospitals during Auckland's various lockdown levels, with some patients choosing to defer treatment. At Alert Level 1, Auckland's hospitals have been operating at capacity. To manage this demand at North Shore and Waitakere hospitals, we have been offering Saturday clinics and theatre lists to further increase timeliness of care.

2. Definitions for Waitematā DHB's levels of escalation and a brief explanation of the plan to manage each.

For each service, we have worked through the triggers that identify which escalation point they are at and have a specific capacity and demand response to each level. This ensures early identification and clear understanding of our current status as this changes throughout the day.

Our current Bed Capacity Management & Escalation Plan is attached – see **Attachment 1**.

Please note that contact details for our Assessment, Treatment and Rehabilitation (AT&R) registrars have been redacted from page 21 of this attachment under section 9(2)(a) of the Official Information Act 1982 to protect the privacy of natural persons.

You have the right to seek an investigation and review of this decision by the Ombudsman. Information about how to seek a review is available at www.ombudsman.parliament.nz or Freephone 0800 802 602.

We are in the process of setting up a new Demand Response Framework and can advise it will cover:

- Green – Business-As-Usual: adequate capacity in all areas.
- Amber – Moderate Compromise: busy but flowing.

- Red – Severe Compromise: occupied beds full; limited or slow movement to ward beds.
- Black* – Extreme Compromise: no flow, 100 + % occupancy.

*Please note that this new status will be added under the new Demand Response Framework.

I trust that the information we have been able to provide is helpful.

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

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

Yours sincerely

Executive Director Hospital Services
Waitematā District Health Board

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

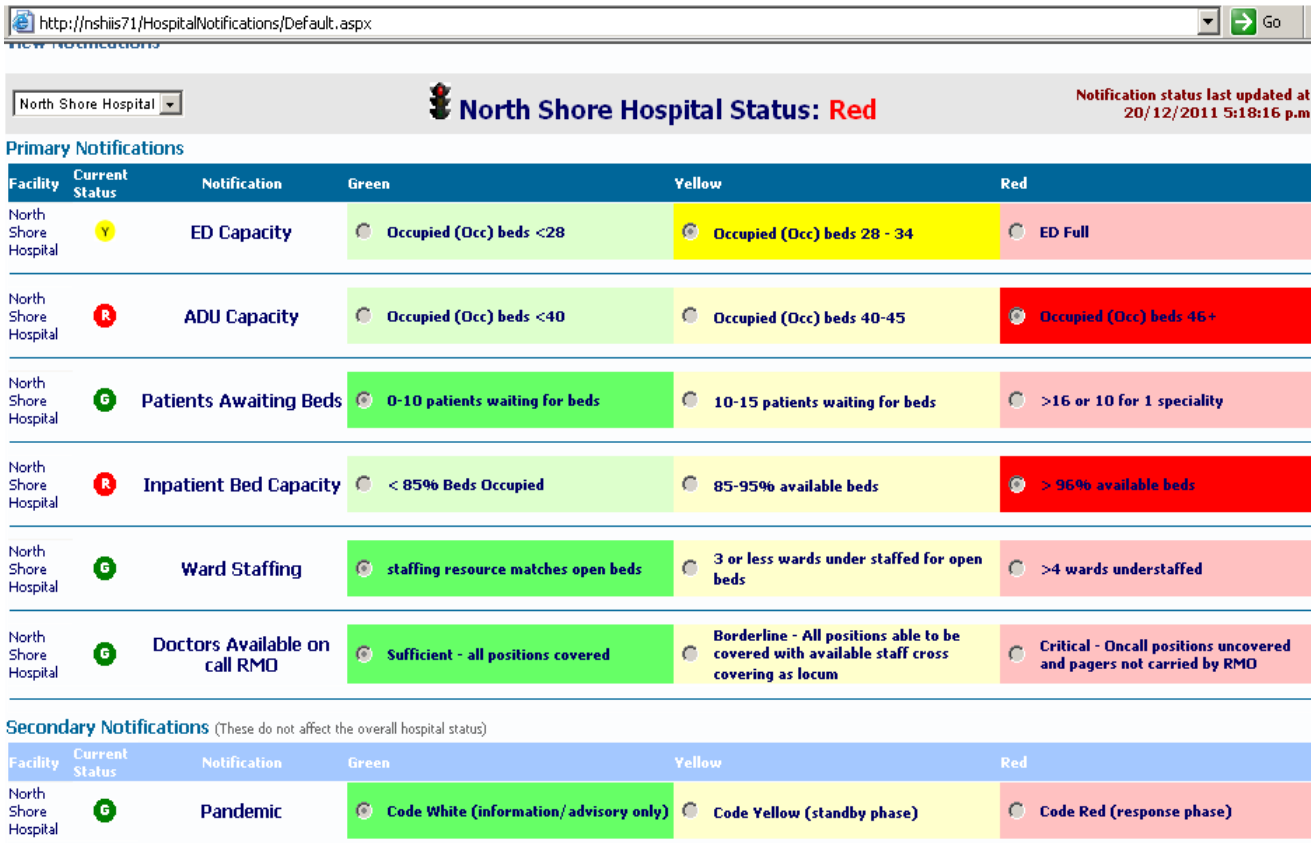
- Provides assistance and support as required by DNM
- Communicates with GM, DON, COO and Communications as required and request assistance/options
- Attends hospital after-hours if requested by DNM to assist
- Authorises any actions that are over DNM delegated authority
- Sets up EOC if required to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



http://nshiis71/HospitalNotifications/Default.aspx

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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

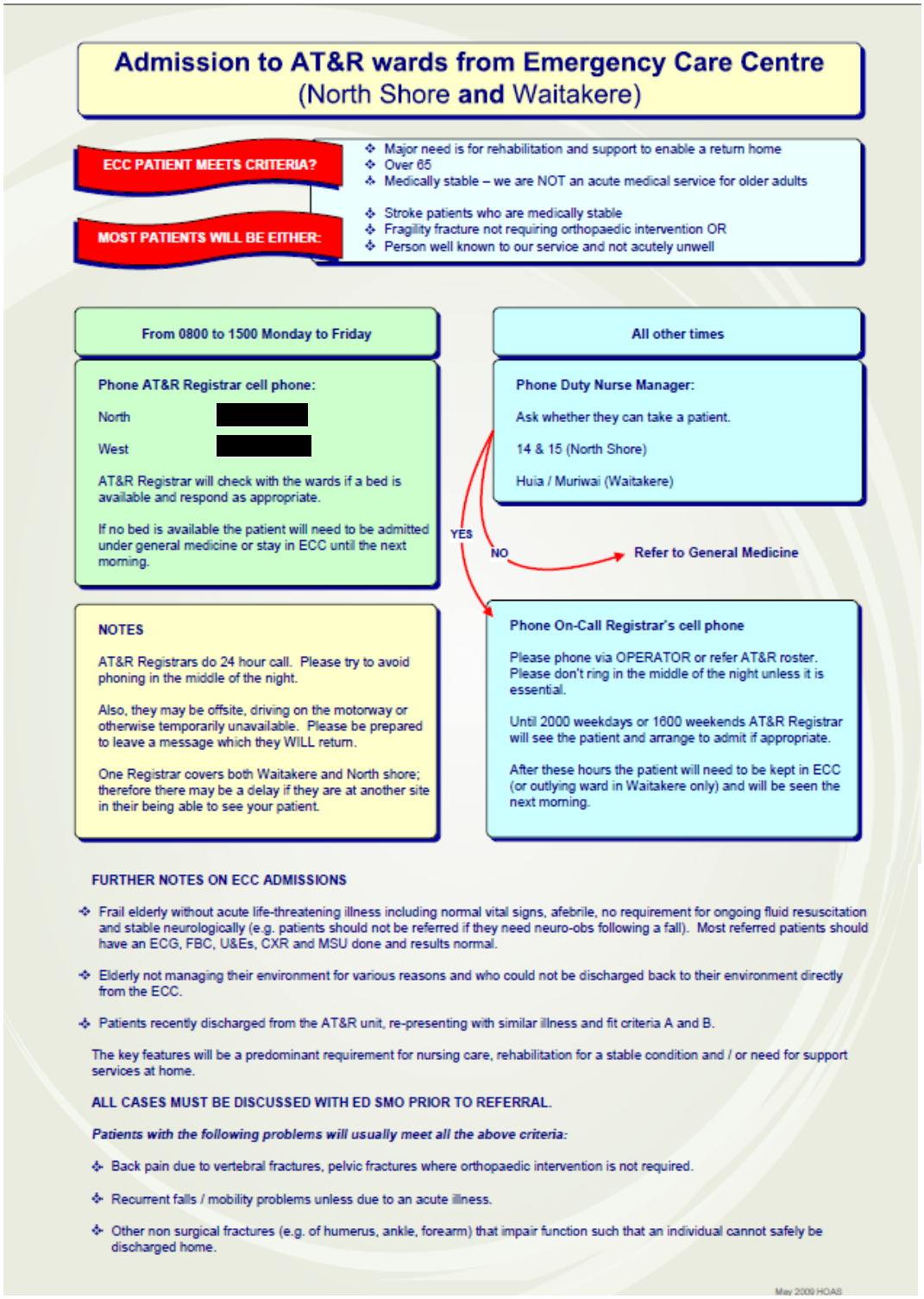
	ED / ADU overload but ward beds available	• Ascertain which specialties affected. Alert Clinical Director and on-call teams to attend ED / ADU to ensure treatment plans current and on track, reassess need for admission. • Utilise POAC where possible	• Relevant specialty teams on call to go to ED/ADU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



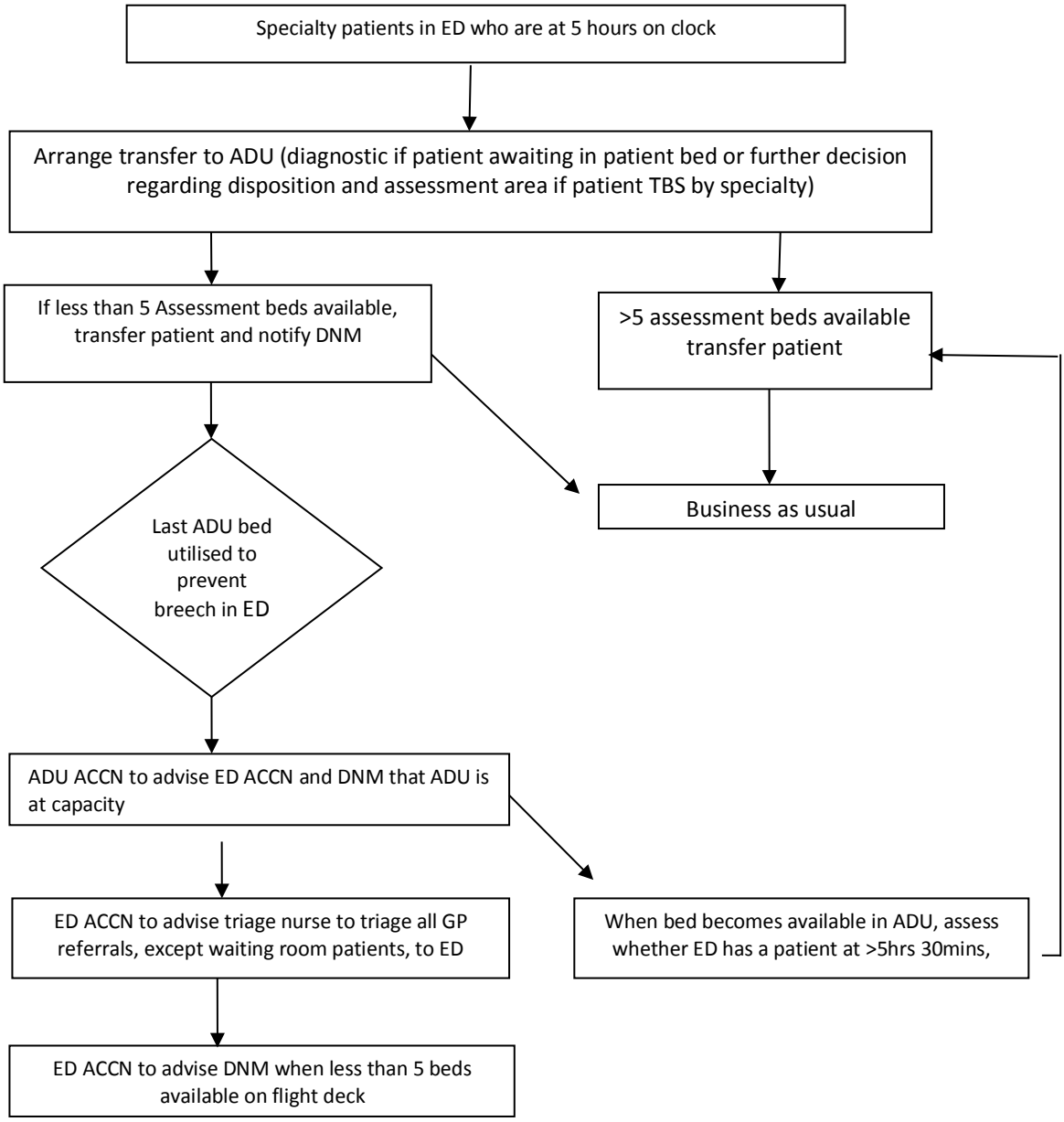
Bed Capacity Management & Escalation Plan

Appendix: Escalation Patient Flow Process ED / ADU

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

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

It is anticipated that this is a short term measure and should be reviewed 2 hourly by ED/ADU CNMs in collaboration with DNM. Out of hours this process will be decided collaboratively between the 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.