Overview and Introduction Of Patient Flow Business Rules

January 2012
Introduction
The development of Patient Flow Systems (PFS) provides a platform for the standardisation of practices and processes. The essential elements of standardised practices refer not only to clinical practices but to processes within an organisation.

Where standard practices are in place there is an increased level of confidence for staff and patients of the awareness of what is going to happen next. The development of standardised practices and processes for Patient Flow are vital and these are referred to as Business Rules.

Patient Flow Systems
Whilst each hospital and Local Health District will have its own local issues there are 7 core elements of improving patient flow:

1. Care Coordination: Navigating patients through the health system to prevent delays
2. Standardised Practice: Promote best practice to lock in expected outcomes
3. Variation management: Smoothing the peaks and troughs to distribute the load
4. Demand escalation: Act early to preserve capacity
5. Demand and Capacity Planning: Organising your service to build capacity
6. Quality: Structuring systems around an expected outcome
7. Governance: Transparent accountable leadership

Background
The development of Business Rules is part of an effective strategy in Patient Flow Systems which assists to clearly define local process for staff in delivering safe, effective and timely access to patient care.

The following group of Business Rules have been developed as generic guides with suggested format and content.

Business Rules serve to improve patient flow, provide consistent and standardise practices to improve the patient journey and experience.

It is important that Business Rules are simple, meaningful, clearly understood and represent the processes at the local facility where they apply. They must be approved as the standard process for the hospital and understood by all staff.

Policy links
Business Rules should provide clear processes with linkages to Patient Flow Systems and NSW Ministry of Health Policy where appropriate. This provides an effective framework of operation.
A number of policies that are helpful links include:

- *Inter-facility Transfer Process for Adults Requiring Specialist Care PD2011_031*
- *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals PD2011_015*
- *Emergency Department – Direct Admission to Inpatient Wards PD2009_055*
- *Medical Assessment Unit Guidelines*
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11. Discharge Case Conference with General Practitioner
12. Surge bed use
13. Transferring Patients to the Patient Transit Lounge
14. Ambulance Service NSW Bookings for Patient Transport
Generic Explanation of Format

INSERT BUSINESS RULE NAME HERE

OBJECTIVE:
States exactly what the business rule is describing or aims to achieve e.g.: transfer of an admitted patient from the Emergency Department to an inpatient ward.

APPLICATION:
- States the time period the business rule applies e.g. 24 hours 7 days per week.

PRINCIPLES:
- Description of the overarching standards which govern the process outlined for the business rule.
- Will shape the business rule in a specific direction providing consistency in process and improve patient care delivered, quality and safety and the patient journey.
- This information should be as brief as possible.
- Should reference any policies which support the patient flow business rule.
- Include ideas of how the patient flow business rule may operate more effectively e.g. one call phone number.

PROCESS:
Each business rule contains an example of a process you may choose to use or revise to suit hospital or Local Health District requirements.

1. Break down the whole process into steps. Describe the first action or behavior required. Try to be as specific as possible.
   Responsible Person: This would usually be one person. State the position not name

2. The second step of action or behavior required. Try to be as specific as possible.
   Responsible Person: State the position not name

3. The third step of action or behavior required. Try to be as specific as possible.
   Repeat these steps by describing each step in sequence using simple language.
   Responsible Person: State the position not name

ESCALATION:
Some examples of when a business rule may need to be escalated should be included. An indication of who is the most appropriate person to escalate the issues should be indicated. The escalation process should be aligned with the Standardised Escalation Plan (STEP) and/or the Capacity Action Plan (CAP).
Executive endorsement is important for governance of the business rule and shows final approval and support. A minimum sign off could be the Director of Nursing and the General Manager. Other considerations may be the Director of Operations if the business rule is for LHD use or other teams such as Mental Health if the business rule relates to that service.

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Director of Nursing and Midwifery  
(Hospital)

**Endorsed:** ________________________  
General Manager  
(Hospital)

**CONSULTATION PROCESS**
- The Patient Flow Manager should have a clear understanding of the issue to be addressed preferably with the use of clinical data and analysis.
- Key stakeholders and the Patient Flow Manager meet to discuss and establish the scope of the business rule to be described.
- A draft of a clinical service business rule should be developed and distributed to the clinical service team members and stakeholders.
- The review and edited draft business rule is brought together for further consultation. This process may need to be repeated before the business rule is finalised.
- Once the business rule is finalised it should be endorsed at an executive level.
- A communication strategy to stakeholders should be determined for implementation.
- A knowledge management plan may be required to understand the capability for change and any additional skills that may be required by staff.

**DESIGN FACTORS TO CONSIDER:**
- Language is simple and minimal.
- Action is clear, concise and easily understood.
- Responsible person is designated by position.
- Engaging LHD hospitals may strengthen consistency of business rules in a specific LHD.

**ENDORSEMENT:**
- This should occur after final consultation and agreement by the key stakeholders.
REVIEW:
- The review process of the business rules should be determined during development and at regular intervals.

IMPLEMENTATION
- Implementation will be more effective where there has been engagement of the key stakeholders.
- Sponsorship of the business rule from hospital executive is the most important aspect for successful implementation

STORAGE:
- Business rules provide operational support and should be available and accessible to all key stakeholders 24 hours 7 days a week.
INTERHOSPITAL TRANSFER COMMUNICATION

OBJECTIVE:
To outline the communication process between hospitals regarding inter-hospital transfers (IHT) to facilitate timely and accurate information for transfer of patients.

APPLICATION:
24 hours 7 days per week

PRINCIPLES:
- Transfers should follow designated LHD established pathways.
- The contact and discussion about a patient for transfer should be made by the most senior medical officer to the consultant accepting care of the patient at the receiving hospital.
- IHTs should avoid the emergency department and go directly to a ward bed. If the patient is unstable on arrival to the receiving hospital, negotiation must occur on the most appropriate area for the patient to be stabilized.
- It is recommended a daily teleconference operated by the Patient Flow Unit is organized for IHTs to be discussed, prioritized and actioned.
- The Patient Flow Portal should be used to document all IHTs to allow for transparent transfer information and standardised communication.
- This business rule compliments PD 2011_031 Inter-facility Transfer process for Adults Requiring Specialist Care.

PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):
1. The sending hospital senior clinician contacts the receiving hospital senior clinician regarding advice, assessment, and urgency of transfer and accepting admission.
   **Responsible Person:** Senior clinician (sending hospital)

2. The sending hospitals Patient Flow Unit - Bed Manager or After Hours Nurse Manager is notified of the patient transfer.
   **Responsible Person:** Senior clinician (sending hospital)

3. All patient details are documented on the Patient Flow Portal. This will include detailed clinical information enabling bed placement. A phone call is made to the receiving hospital Patient Flow Unit.
   **Responsible Person:** Patient Flow Bed Manager / After Hours Nurse Manager (sending hospital)
4. A phone call may be made to the receiving hospital Patient Flow Unit or person responsible for patient flow.  
   **Responsible Person:** Patient Flow Bed Manager / After Hours Nurse Manager (sending hospital)

5. A phone call regarding the bed availability must be made to the sending hospital Patient Flow unit as soon as capacity is available for the patient. *Reference PD2011_031.*  
   **Responsible Person:** Patient Flow Bed Manager / After Hours Nurse Manager

6. The sending hospital Patient Flow Unit will notify the Nursing Unit Manager or team leader of the ward where the patient is located, that an available bed is ready at the receiving hospital and patient transport arrangements can be made.  
   **Responsible Person:** Patient Flow Bed Manager / After Hours Nurse Manager

7. The ward area of the sending hospital will make the appropriate patient transport arrangements to transfer the patient to the receiving hospital. The only exception to this rule is the deteriorating patient, where transfers will be considered urgent and should be transferred to the Emergency department for stabilization.  
   **Responsible Person:** Nursing Unit Manager / Team Leader

**ESCALATION:**

**Examples of issues to escalate regarding IHTs:**

- An extended delay in stabilizing a patient who needs transfer to another facility for Specialist services
- Multiple unsuccessful attempts to make contact with the senior medical officer at the receiving hospital to accept care of a patient
- A patient who needs specialist services not available at the sending hospital and the receiving hospital senior medical officer refuses to accept care of the patient
- A patient who is sent to a hospital with no senior medical officer accepting care and/or no bed available
- Significant delays in transport services to transfer a patient to another facility
- Patient or family aggression that escalates delaying the transfer of a patient

**Responsible person:** Patient Flow Manager or After Hours Nurse Manager

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Director of Nursing and Midwifery
(Hospital)
Endorsed: _______________________
General Manager
(Hospital)
CAPACITY & DEMAND COMMUNICATION

OBJECTIVE:
To communicate to key stakeholders within the hospital the relevant daily demand and capacity information for action.

APPLICATION:
7 days per week

PRINCIPLES:
- Communicating demand and capacity issues and tipping points is a way of informing key stakeholders of demand on services and available capacity.
- This communication should align with the Short Term Escalation Plan (STEP) developed for the hospital.
- This information should be delivered to enable 7 days per week communication for key executive, operational staff and the Ambulance Liaison Officer (ALO) to action as required.
- Determination of information for circulation is based upon the hospital’s activity.
- After hours, weekends and public hospitals information should be sent to the executive team on call in all instances.
- Additional information may include Patient Transit Lounge capacity, length of stay and escalation processes currently in place

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| 2100     | Capacity Text       | Executive on call, Ambulance Liaison Officer

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allocated), >4 hours >8 hours, discharges, Interhospital transfers from ED, ICU patients, HDU patients, Ambulance waits >30 minutes Hospital empty beds, discharges at time of text

Abbreviated version:
SL_:ED_empty, admits (not allocated) _4/24, _8/24, IHT _IN_OUT, ICU, HDU, AMB waits >30 min. HOSPITAL_empty_D/C

### Escalation
- Status level: ED_empty, admits (not allocated), Amb _>30 min

### De-escalation
- Ambulance offload resolved

### Suggested groups
1. Executive team
2. Executive on call
3. Nursing/Allied Health
4. Medical Registrars
5. Ambulance Liaison Officer
6. Critical Caesarean Section
7. Surgical Registrars

### PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):

1. The Nurse Manager of Patient Flow is informed of the current status of the hospital and emergency department.  
   **Responsible Person:** Patient Flow Bed Manager

2. The appropriate decision is determined for escalation or de escalation in accordance with the hospital STEP.  
   **Responsible Person:** Patient Flow Manager

3. The appropriate decision is determined for the type of information to be communicated and to what specific groups.  
   **Responsible Person:** Patient Flow Manager

4. The centralized communication is initiated (or given to the switchboard operator to complete) including text type, group and timeframe of urgency.  
   **Responsible Person:** Patient Flow Manager

5. Executive team and other operational managers action as required according to information provided and changes needed to impact capacity and demand  
   **Responsible Person:** all as required

6. An electronic record is recommended for future analysis.  
   **Responsible Person:** Patient Flow Manager
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DIRECT WARD ADMISSIONS

OBJECTIVE:
Provide admission of patients directly to a unit/ward avoiding the emergency department.

APPLICATION:
24 hours 7 days per week

PRINCIPLES:
- This business rule supports the hospital admission policy and refers to unscheduled admissions who require overnight, urgent or semi-urgent care within the next 24-48 hours and will avoid the emergency department.
- These patients may come from a variety of locations and include the Ambulatory Care Unit, clinics, specialist rooms, private consulting rooms, General Practitioners (previously known admission), community, outpatients and Day Only Units.
- Patients are placed in specific appropriate units based upon their clinical condition and medical requirements.
- The Patient Flow Portal (PFP) – Direct Ward Admission (DWA) screen supports data entry for these patients.
- A centralized bed management process should be considered that provides a one call number system for medical staff admitting patients during hours and after hours as a DWA.

PROCESS: (this is an example of a process you may choose to use or revise to suit local requirements):
1. A patient requires an admission and the Patient Flow Unit or After Hours Nurse Manager is contacted. A clinical picture is given regarding the patient, acuity and time frame for admission.
   **Responsible Person:** Medical officer referring the patient for admission

2. All appropriate patient information is completed on the PFP Direct Ward Admission screen.
   **Responsible Person:** Patient Flow Bed Manager or After Hours Nurse Manager

3. A Recommendation for Admission is completed and sent to the Bookings and Admissions department.
   **Responsible Person:** Medical Officer referring the patient for admission

4. The patient is allocated to the appropriate ward area or Hospital in the Home service. Direct communication to the Nursing Unit Manager (NUM) or team leader about the patient is completed. This includes location, acuity and time frames.
   **Responsible Person:** Patient Flow Bed Manager or After Hours Nurse Manager
5. Information about bed availability, ward allocation, delays including cleaning and timeframe for admission is communicated to the medical officer referring the patient for admission.

**Responsible Person:** Patient Flow Bed Manager or After Hours Nurse Manager

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BED ALLOCATION OF EMERGENCY DEPARTMENT PATIENTS

OBJECTIVE:
The allocation of emergency department (ED) patients to an inpatient ward bed.

APPLICATION:
24 hours 7 days per week

PRINCIPLES
- Clear standardised processes should be in place for the allocation of ED patients to inpatient ward beds.
- Communication regarding bed allocation should be limited to as few calls as possible with direct communication with staff in regular positions such as nurse in charge in the ED.
- A one call number system 24 hours 7 days a week should be in place for the Patient Flow Unit/bed allocation team/After Hours Nurse Manager. Allocation of patients should be completed electronically to allow for future analysis of process. Use of the Patient Flow Portal should be an integral part of the bed allocation process.
- Transfer of the patient to an inpatient bed should occur once the bed is immediately available and there are no further delays such as bed cleaning.
- Allocation of ED patients to ward beds should be in line with local policy such as Emergency Department Direct Admission to Inpatient Wards PD2009_055 and the Emergency Surgery guidelines (e.g. dedicated beds for Emergency Surgery patients).

PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):
1. Following the decision to admit a patient, all admission information should be entered electronically including HDU requirement, infectious status and cardiac monitoring. This completes the bed request.
   Responsible Person: ED staff, administration staff

2. Electronic systems will be checked at regular intervals to obtain all admissions from the ED (suggestion hourly).
   Responsible Person: Patient Flow Bed Manager / After Hours Nurse Manager

3. The Nursing Unit Manager or team leader in ED will be notified by phone immediately a bed is available for an admitted patient to hospital. The bed allocation process will be completed electronically.
   Responsible Person: Patient Flow Bed Manager/ After Hours Nurse Manager
4. Transport and escorting of the patient to the allocated inpatient unit will be organized according to local inter-ward transfer process.

   **Responsible Person:** As per local procedure

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MENTAL HEALTH REFERRALS

OBJECTIVE:
To ensure patients receive timely mental health consultation and placement to mental health (MH) services.

APPLICATION:
24 hours 7 days per week

PRINCIPLES
- The Patient Flow Unit works with the MH service in a consultative and cooperative manner as a single point of communication.
- The consultation and transfer of a patient to MH services should be a simple, streamlined process which avoids delays.
- The Patient Flow Portal should be utilised in order to understand the demand on services and act as a centralised point of information on patients awaiting transfer to MH beds
- A single once call number should be available for MH services or MH patient flow where possible.

PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):
1. A patient is identified needing a MH consultation; the MH senior medical officer is consulted for review of the patient. This is recorded in the patient notes.
   **Responsible Person:** senior medical officer

2. Clear documentation is made that a patient is fit for interview.
   **Responsible Person:** senior medical officer

3. Once a MH review of the patient occurs, a decision is made regarding the level of MH involvement and requirement for transfer to MH beds.
   **Responsible Person:** MH senior medical officer

4. The Patient Flow Unit is called if the patient is deemed to require admission under the care of the MH team.
   **Responsible Person:** MH senior medical officer or Nursing Unit Manager

5. The patient details are entered on the Patient Flow Portal
   **Responsible Person:** PFU Bed Manager or After Hours Nurse Manager

6. Immediately a bed is available in a MH service, the PFU Bed Manager or Nurse Manager After Hours is contacted regarding the bed availability.
   **Responsible Person:** MH Patient Flow Unit
7. The bed availability is communicated to the ward or unit where the patient is located immediately the information is available. Allocation should include documentation in the Patient Flow Portal closing the bed allocation process. 
**Responsible Person:** PFU Bed Manager or After Hours Nurse Manager

8. The patient is transferred to the ward as per the hospital transfer process. 
**Responsible Person:** Nurse

**ESCALATION:**
Escalation should occur in the first instance to the General Manager or Executive on call. Examples where escalation may be required may include:

- Significant delays in the consultation process or patient journey when other solutions have been exhausted to minimize delays.
  
  **Responsible person:** Patient Flow Manager or After Hours Nurse Manager

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TRANSFER OF PATIENTS FROM EMERGENCY TO MEDICAL ASSESSMENT UNIT (MAU) & OUT TO AN INPATIENT WARD AT 48 HOURS

OBJECTIVE:
To ensure a seamless patient transfer process occurs for patients in and out of MAU.

APPLICATION:
24 hours 7 days per week

PRINCIPLES:
- Local processes should be in place which allows for early and streamlined direct referral to MAU from ED. This may include patient selection criteria which can be activated from triage following direct consultation with the MAU.
- When a patient has reached 48 hours in the MAU the decision of continued treatment and the appropriate admitting specialty service required will be made.
- Patients who require a more protracted stay will be transferred to an appropriate inpatient ward.
- Where a dispute occurs regarding the appropriateness of continued admission at 48 hours, the MAU medical team should discuss this with the appropriate specialty team.

PROCESS:
1. The senior medical officer of the specialty team will be contacted regarding the patient’s condition and requirement for admission or continued admission beyond 48 hours.
   **Responsible Person:** MAU senior medical officer

2. The Patient Flow Unit will be contacted regarding the MAU admission or requirement to move the patient to a suitable ward/unit. MAU or ward bed is allocated.
   **Responsible Person:** MAU Nursing Unit Manager or Team Leader

3. The patient will be notified of the impending transfer.
   **Responsible Person:** MAU Nursing Unit Manager or Team Leader

4. MAU receives care of the patient from ED
   **Responsible Person:** MAU Nursing Unit Manager or Team Leader

5. For patients moving out of MAU at 48 hours, once a ward bed is available, the MAU will be notified of the transfer and the MAU NUM or team leader will be notified of the new ward for the patient.
   **Responsible Person:** PFU Bed Manager or After Hours Nurse Manager
6. The patient is transferred to the ward as per the hospital escort guideline.
   **Responsible Person:** MAU Nurse

**ESCALATION:**
Escalation should occur in the first instance to the General Manager or Executive on call.
Examples where escalation may be required may include:
- significant delays in the consultation process
- significant delays finding a team to take over care of a patient
- significant delays in locating an inpatient bed due to other competing demands
   **Responsible person:** Patient Flow Manager or After Hours Nurse Manager

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ALLOCATION OF PLANNED ADMISSION PATIENTS TO HOSPITAL BEDS

OBJECTIVE:
To ensure clear process in the allocation of patients for planned admission to beds reflecting hospital wide or global demands on capacity.

APPLICATION:
24 hours 7 days per week

PRINCIPLES:
- The Patient Flow Unit (PFU) or After Hours Nurse Manager should receive information on all global demand and capacity issues throughout the hospital.
- A variety of electronic tools provide assistance for the PFU to assess demand and capacity including: Patient Administration System, ED system such as EDIS or Firstnet, Ambulance Status Board, Patient Flow Portal Bedboard and Pharmacy discharge dispensing such as Pharmtrack. These tools assist with predictive planning
- The PFU seeks to balance the logistics of moving patients, taking into account current demand, predicted demand, booked demand, unexpected demand and other considerations including gender, multiple resistant organisms, specialty, acuity and preferences
- The PFU seeks to ensure the right patient is in the right bed, at the right time and if possible, the first time the bed is allocated.

PROCESS: (this is an example of a process you may choose to use or revise to suit local requirements):
1. An assessment of all demand is made to ascertain the admissions requiring allocation from ED, inter-hospital transfers (IHT), inter-ward transfers (IWT), direct ward admissions and Day of Surgery admissions.
   **Responsible Person:** Patient Flow Unit Bed Manager

2. Allocation of patients for planned admissions to inpatient beds occurs based on time, acuity and demand.
   **Responsible Person:** Patient Flow Unit Bed Manager

3. Appropriate wards or units are contacted to allocate patients as per available beds including priority demands from ED, Day of Surgery Admission, IHT, IWT and Direct Ward Admission. The Nursing Unit Manager or team leader is contacted regarding the patient.
   **Responsible Person:** Patient Flow Unit Bed Manager
4. Regular information regarding discharge and transfer of patients out of a ward is delivered timely to the PFU.
   **Responsible Person:** Nursing Unit Manager or Team Leader

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DISCHARGE CASE CONFERENCE WITH GP

OBJECTIVE:
To provide General Practitioners (GP) with information to assist with coordinating care of patients for discharge who have chronic &/or complex illnesses.

APPLICATION:
9-5pm 7 days per week (pending GP availability)

PRINCIPLES:
- Care Coordination requires referral and liaison regarding patient transfer of care to GPs.
- It is imperative that complex patients who are returning to the community have accurate information about their hospital episode and ongoing care needs communicated to their GP.
- This process involves engaging early with the GP which can assist in the transition of patients back to the community, provide the GP with options for care and contacts where required. This coordinated approach also aims to avoid unnecessary re-presentation to the acute care hospital.
- Designation of a lead for the case conference should be decided on the basis of who has the most comprehensive knowledge of the patient’s issues.
- The NSW Health Policy -Care Coordination: Planning from admission to transfer of care in public hospitals PD2011_015 supports this business rule

PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):
1. A decision is made for a case conference with the GP.
   **Responsible Person:** Nursing Unit Manager / Continuing Care Coordinator / Senior Medical Officer

2. The GP is notified of the discharge case conference date and time.
   **Responsible Person:** NUM or CCC

3. Once the date and time for the case conference is organized, liaison about this occurs with the family, medical/nursing and allied health staff at the hospital and GP. The room is booked for the teleconference and the teleconference facilities are made available.
   **Responsible Person:** NUM or CCC

4. Documentation is made in the patient’s medical record once the teleconference time is decided with all agreed persons.
   **Responsible Person:** NUM or CCC

5. The GP is contacted with 24-48 hours notice regarding the date and time of the case conference. The room for the teleconference and resources required is booked.
   **Responsible Person:** NUM or CCC
6. Documentation is made in the patient’s medical records of the case conferencing issues and outcomes made with the GP.

**Responsible Person:** GP Liaison Nurse and CCC

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SURGE BED USE

OBJECTIVE:
To provide a clear process for opening of surge beds and once patients reach 48 hours occupancy in a surge bed.

APPLICATION:
24 hours 7 days per week

PRINCIPLES:
- Surge beds are additional hospital capacity beds that are not staffed or operational, which can be deployed if necessary.
- For these reasons, the turnover of patients within these beds is at 48 hours at which time patients will either be discharged or transitioned to a long stay bed.
- The decision to open surge beds is usually recommended by the Patient Flow Manager and approval sought from hospital executive.
- Determination of the trigger to utilize surge capacity is detailed in the Short Term Escalation Plan (STEP).
- The utilization of these beds can be best facilitated by:
  - Sending patients who will be discharged the next day to these bed areas (considering gender and MRO)
  - Patients from the emergency department with expected length of stay 24-48 hours
  - Patients required to stay longer than 48 should be transitioned to long stay beds.
  - Reflection of surge bed usage in the Patient Flow Portal
- The identification of a person/role responsible for data collection and monitoring of surge bed occupancy should be part of the review process.

PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):
1. Determination of utilization of surge capacity is made.
   **Responsible person:** Patient Flow Manager or After Hours Nurse Manager

2. All relevant information is gathered and communicated to the General Manager or executive on call of the need to utilize the surge capacity, the number of beds and expected time of utilisation.
   **Responsible person:** Patient Flow Manager or After Hours Nurse Manager

3. Continued communication each shift is made with the General Manager or executive on call regarding use of surge capacity.
   **Responsible person:** Patient Flow Manager or After Hours Nurse Manager
4. Visualisation of the LOS of patients occupying surge beds will be identified using the Patient Flow Portal Bedboard. Discussion with the admitting medical officer/NUM will occur regarding the plan of care for the patient. 
   **Responsible person:** Nursing Unit Manager or Team Leader

5. The Patient Flow Unit or After Hours Nurse Manager will be contacted by the ward NUM regarding those patients plan that have occupied a surge bed for 48 hours including the identification of those patients require transfer to an inpatient bed. 
   **Responsible person:** Nursing Unit Manager or Team Leader

6. The prioritization of patients occupying surge beds against global facility demands will be determined. Allocation of the patients to appropriate inpatient beds will be completed and communicated to the Nursing Unit Manager or Team Leader. 
   **Responsible person:** Patient Flow Manager or After Hours Nurse Manager

7. The Patient Administration System will be updated once the patient has an available bed and be reflected in the Patient Flow Portal. 
   **Responsible person:** Administration Assistant or Nurse

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**Endorsed:** ________________________
Director of Nursing and Midwifery the Hospital

**Endorsed:** ________________________
General Manager the Hospital
TRANSFERRING PATIENTS TO THE PATIENT TRANSIT LOUNGE

OBJECTIVE:
To provide a clear process for patients transferring to the Patient Transit Lounge (PTL).

APPLICATION:
Monday – Friday 5 days per week or when operational.

PRINCIPLES:
- The Patient Transit Lounge (PTL) is a designated area for appropriate patients who will be discharged or may be transported to another health care facility.
- Clear communication and flexible entry of patients to the PTL is essential and this may include streamlined processes for ward, the Emergency Department, clinics staff to transfer to the PTL.
- PTL staff should assist in patient wards by undertaking rounds for the early identification and transfer of suitable patients for the PTL.
- When a patient is transferred to the PTL, all medications, belongings and documentation including medical records should be transferred with the patient completing their discharge from the ward.
- Patients for discharge from clinics or the emergency department can be transferred to the PTL for finalization of discharge.
- Any stable patient awaiting transfer to another facility can be transferred to the PTL whilst waiting for transportation.
- Patients deemed not suitable for the PTL include:
  - A patient with a multi resistant organism requiring isolation
  - Patients requiring nursing staff resources beyond the capabilities of those available in PTL

PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):
1. The patient is identified for discharge and documentation in the medical record is completed.
   Responsible Person: Senior Medical Officer

2. The staff in the PTL are to be contacted to take basic information about the patient. The patient is prepared for transfer and transport to PTL is organized.
   Responsible Person: Nurse

3. The patient is transported to the PTL with belongings, valuables and own medications.
   Responsible person: Transport assistant
4. Discharge scripts are to be completed.  
   **Responsible Person:** Medical Officer

5. Discharge scripts are to be forwarded to Pharmacy. Ambulance transport must be booked and confirmed.  
   **Responsible Person:** Administration Assistant

6. Any unforeseen delay in discharge scripts will be communicated to the PTL.  
   **Responsible Person:** Pharmacy Services

7. All transport will be finalized in the PTL including area transport, community transport and Ambulance. Taxi vouchers will be authorized from the PTL where required. Escalation to the Patient Flow Manager or After Hours Nurse Manager will occur if there are unresolved delays.  
   **Responsible Person:** Patient Transit Lounge staff

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General Manager the Hospital
AMBULANCE SERVICE NSW BOOKINGS FOR PATIENT TRANSPORT

OBJECTIVE:
To provide a process for booking ambulances, which occur unexpectedly, after 1200pm during weekdays.

APPLICATION:
24 hours 7 days per week

PRINCIPLES:
• Discussions about a patient’s transport home should occur as early as possible in the patient’s admission to the facility and should be in line with local transport services and guidelines.
• Patients requiring transport with the Ambulance Service of NSW (ASNSW) should have notification to ASNSW as early as possible.
• Where a decision to discharge a patient has occurred in the afternoon and transport with ASNSW is required, determination of the appropriate type of transport is required.
• Patients will be transferred to the Patient Transit Lounge (PTL) where one is available to await transport.
• AS NSW Ambulance Liaison Officers are a valuable resource to communicate with regarding transport issues arising and assisting with resolving delays.

PROCESS: (this is an example of a process you may choose to use or revise to suit local requirements):
1. The decision for a patient to be discharged is made and written in the patient’s medical record.
   Responsible person: senior medical officer

2. If the patient is deemed to require transport via AS NSW as per local transport guidelines the Patient Flow Manager or After Hours Nurse Manager should be contacted in the first instance regarding the pending discharge of a patient and the need for ASNSW transport.
   Responsible person: Nursing Unit Manager or Team Leader

3. Where appropriate the local Ambulance Liaison Officer should be contacted to discuss the transport request and details, particularly for long distance travel that may require significant ASNSW coordination of services.
   Responsible person: Patient Flow Manager or After Hours Nurse Manager

4. Where advised by ASNSW, the booking should be completed through the Electronic Booking System (EBS).
   Responsible person: Administration Assistant or Nurse
5. The ASNSW booking should be confirmed before discharge arrangements are finalized
   **Responsible person:** Ambulance Liaison Officer or Area Transport service

6. Once the ASNSW booking is confirmed the patient should be moved to the PTL where this is available.
   **Responsible person:** Nursing Unit Manager or Team Leader

7. All arrangements regarding transport will occur in the PTL including liaison with area transport or ASNSW. Where an exceptional delay beyond operating times occurs or transport is deferred the Patient Flow Manager or After Hours Nurse manager will be contacted to resolve.
   **Responsible person:** PTL staff

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**Endorsed:** ________________________
General Manager the Hospital
DISCHARGE MEDICATIONS

OBJECTIVE:
To provide a process for Pharmacy dispensing of discharge medications.

APPLICATION:
__ hours Monday to Friday
__ hours Saturday & Sunday

PRINCIPLES:
- Early identification of patients for discharge should include early processing of discharge medications from pharmacy.
- The processing of discharge medications should be organized in the facility so as not to delay patient discharge.
- Discharge medications will be sent to the Patient Transit Lounge (PTL) where this is available.
- A tracking system such as Pharmtrack should be available to allow visibility of discharge medication progress and decrease disruptions to pharmacy staff.

PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):
1. The patient is identified for discharge and documentation is made in the medical record.
   **Responsible Person:** senior medical officer

2. The patient is transferred to the PTL.
   **Responsible Person:** Nurse Unit Manager or team leader

3. The discharge medication script is completed and is organized to send to Pharmacy for processing preferentially the day before discharge.
   **Responsible person:** senior medical officer

4. Correction of scripts, counselling of the patient’s medications and any other specific medication follow up to patient and/or carer will be completed in the PTL.
   **Responsible person:** Pharmacist

5. Tracking of a patient’s medication can be done utilizing Pharmtrack
   **Responsible person:** PTL Nurse or Pharmacist

6. The discharge medications will be given to the patient in the PTL. Any additional medication education or clarification will be organized for the patient before discharge.
   **Responsible person:** PTL Nurses
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General Manager the Hospital
ICU/HDU EXIT TO WARDS

OBJECTIVE:
To outline the streamlined process for flow of patients out of ICU/HDU

APPLICATION:
24 hours 7 days per week

PRINCIPLES
- Intensive care beds are a statewide resource i.e. the beds are managed to meet local demand and to accommodate referred critically ill patients for definitive care according to the NSW Critical Care Tertiary Referral and ICU Default Policy Directive PD2010_021.
- It is imperative that the ICU/HDU management and patient flow units communicate openly and frequently to ensure all are aware of both local and referred demand for ICU/HDU beds.
- For these reasons ICU/HDU exit block to general wards should be minimized with proactive bed management strategies. Examples of this include:
  - A pre-determined (based on ICU/HDU size and historical data) quota of general ward beds is made available to ICU/HDU each morning at 0800 based on predicted requirements for discharges and in consultation with the hospital bed manager. This quota of beds remains available for ICU for 4 hours before being returned to the general hospital bed stock.
  - A second quota of ward beds is made available to the ICU/HDU at 1400 based on predictive requirements and they remain available to the ICU for 4 hours till 1800hrs.
  - If not used these beds are returned to the general hospital bed-stock at 1200 hrs or 1800hrs.
- After-hours discharge from ICU (after 1800hrs and before 0600hrs) to general wards is associated with higher mortality, clinical deterioration and ICU readmission and should be avoided where possible.

OTHER CONSIDERATIONS:
- Consideration of Inter-facility Transfer process for Adults Requiring Specialist Care PD2011_031.

PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):
1. The decision regarding a patient requiring transfer from ICU/HDU to a general ward bed is made. 
   Responsible Person: ICU Intensivist
2. The patient details are entered on the Patient Flow Portal Inter-ward transfer screen allowing visualization of all competing demands from ICU and HDU. Determination of bed type and other details are decided.
   Responsible person: PFU Bed Manager
3. When the patient is ready for transfer out of ICU, this is communicated to the Patient Flow Unit Bed Manager.
   **Responsible person:** Nursing Unit Manager or team leader

4. A bed is located, details discussed with the receiving ward and the information fed back to the Nursing Unit Manager or team leader of ICU. The Patient Flow Portal Inter-ward transfer screen is updated.
   **Responsible person:** Patient Flow Unit Bed Manager or After Hours Nurse Manager

**ESCALATION:**
**Responsible person:** Patient Flow Manager or After Hours Nurse Manager

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Director of Nursing and Midwifery
(Hospital)

**Endorsed:**
General Manager
(Hospital)
MEDICAL TERM CHANGEOVER

OBJECTIVE:
To outline the process for minimizing the impact of medical term changeover on patient flow.

APPLICATION:
Each medical term changeover

PRINCIPLES:
- Medical term changeover should have a minimal impact upon patient flow.
- Processes should be in place to ensure the transition of medical staff at the beginning of the term does not result in delays to discharge of patients.
- Outgoing medical staff should ensure that each patient has a clearly documented management plan or discharge instructions to ensure seamless transfer of care to the incoming medical team.

PROCESS (this is an example of a process you may choose to use or revise to suit local requirements):
1. All patients identified for discharge on the changeover day will have discharge preparations completed on the Friday prior to changeover by the outgoing medical team. This will include discharge summaries, discharge scripts, letters to GPs, appointments and any other arrangements and consultations.

2. A clear documented medical management plan will be recorded in the patient medical record, which will include the instructions for discharge on the changeover day.

3. Any patient not being discharged on the changeover day will require a medical management plan to be documented in the medical record on the Friday preceding the changeover day.

4. No junior medical staff (Interns, RMOs and Registrars) are to be allowed to take a rostered day off on the last Friday of each clinical term except with the permission of the respective department manager and only for exceptional circumstances.

5. Examination of the booked surgical load for the changeover day is to be undertaken on the Friday preceding changeover by the Patient Flow Units, in conjunction with the surgical teams. The capacity/demand analysis tools will be utilised by the Patient Flow Units to evaluate the facility loads and to determine and initiate appropriate actions.

6. On changeover day early activation of discharges is to be undertaken and patients will be escorted to the Patient Transit Lounge.
Endorsed: ______________________
Director of Nursing and Midwifery
(Hospital)

Endorsed: ______________________
General Manager
(Hospital)