Operationalisation of Escalation Tool Actions & Responses

Demand Escalation Forum

4 February 2016

Jo Campbell

Whole of Health Program Lead

Port Macquarie Base Hospital

Home of Integrated Care

NSW GOVERNMENT Health
Mid North Coast Local Health District

IF IT WAS MY FAMILY MEMBER WOULD I BE HAPPY WITH THE ACCESS TO CARE?

I'm here, what do I do?

What next?

How do I communicate this ?

How do I know I've been heard?

How do I see the whole picture?

WHAT RESPONSE CAN I EXPECT?

Where do I get the information from?

Why didn't we see this coming?

Are the patients that are here, sick enough to be here?

How many discharges today?

DO I NEED TO OPEN MORE BEDS?

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Hastings Macleay Network

Port Macquarie Base Hospital

Escalation Plan

To be read in conjunction with the following documents:

- Port Macquarie Base Hospital HealthPlan – Counter Disaster Plan
- Port Macquarie Base Hospital Critical Care Surge Plan
- Port Macquarie Base Hospital Winter Bed Strategy Demand Management Plan
- Port Macquarie Base Hospital Sustainable Access Plan

Escalation Access to Patient Care

Tipping Points	A	B	C	D
Occupancy (ED accessible beds)	≤ 89%	90 – 96%	97 – 99% Usually involving outliers +/- surge beds	≥ 100% Surge beds at capacity
Predictive Tool	>0 beds available	-5 to 0 beds available	-10 to -5 beds required	>-10 beds required
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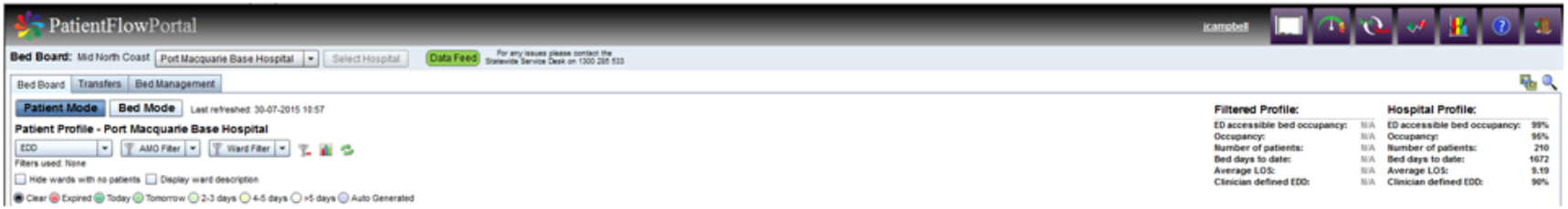

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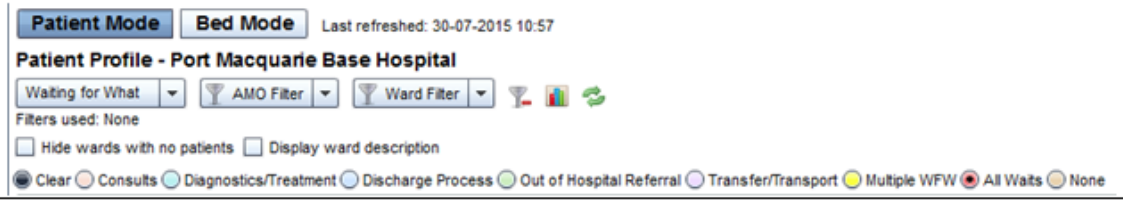
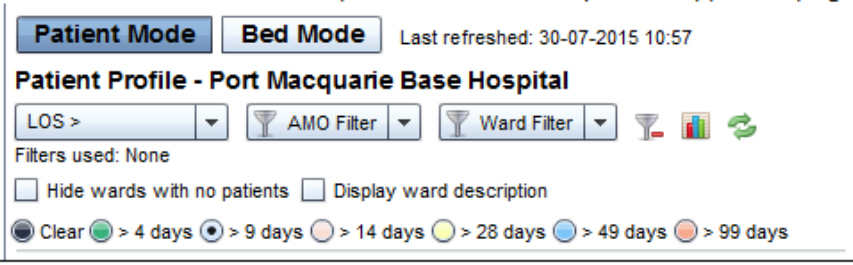
WFW	Select "Waiting for What" from the drop down box under patient profile, top left hand corner on Bed Board screen of Patient Flow Portal (currently EDD is selected). Select red dot "All Waits". The number appears under "Filtered Profile", top right hand corner on Bed Board screen of Patient Flow Portal 
Long stayers >9 days	As above but select "LOS>" and pale blue dot for >9 days. Total appears top right hand corner under "Filtered Profile" 
Discharges previous day	Report from "Discern Analytics" in Powerchart
Average LOS	Average LOS can be found under "Hospital Profile", top right hand corner on Bed Board screen of Patient Flow Portal "Average LOS"

DRAFT Escalation Actions and Responses

Escalation communication Escalation Page initiation by Patient Flow Manager, AHNM, or WoH Program Lead	**A:** Cheat sheets included in all staff orientation packages. **R:** All staff informed and able to engage in organisational escalation.	**A:** Cheat sheets included in all staff orientation packages. **R:** All staff informed and able to engage in organisational escalation.	**A:** Cheat sheets included in all staff orientation packages **R:** All staff informed and able to engage in organisational escalation **A:** Escalation page **"At capacity" to Registrars and JMO's** **R:** JMO from each "VMO team – eg Surg A or Med B" confirms with NUM of each ward that each patient has been reviewed and has a plan. Discharges are accurate. -All patients have a clinician defined EDD ***by the Bed Meeting at 10am.*** **A:** Patients not reviewed by VMO in last 24 hours, with no current plan, escalated to Executive. **R:** Executive discussion with VMO's of patients who do not have a plan. - All patients have been reviewed by a VMO. -Plans for all in-patients communicated.	**A:** Cheat sheets included in all staff orientation packages **R:** All staff informed and able to engage in organisational escalation **A:** Escalation page **"Extreme Escalation" to VMO's, Registrars & JMO's** **R:** VMO, in consultation with their team, communicates ***actual*** and ***potential*** (stating discharge condition eg INR result for potentials) discharges to NUM's ***prior to Bed Meeting at 10am.*** -All patients have a clinician defined EDD. - **A:** Patients not reviewed by VMO in last 24 hours, with no current plan, escalated to Executive. **R:** Executive discussion with VMO's of patients who do not have a plan. -All patients have been reviewed by a VMO. -Plans for all in-patients communicated.

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Action: Escalation Page **"At Capacity"** [redacted]	**Action:** Escalation Page **"Extreme Escalation"**
Response: Registrar/JMO from each "VMO team – eg Surg A or Med B" confirms with NUM of each ward that each patient has been reviewed and has a plan. Discharges are accurate. -All patients have a clinician defined EDD ***by the Bed Meeting at 10am.*** **A:** Patients not reviewed by VMO in last 24 hours, with no current plan, escalated to DMS. **R:** DMS discussion with VMO's of patients who do not have a plan. - All patients have been reviewed by a VMO. -Plans for all in-patients communicated.	**Response: VMO /Advanced Trainee** communicates ***actual*** and ***potential*** discharges (stating discharge condition eg INR result for potentials) to NUM's ***prior to Bed Meeting at 10am.*** -All patients have a clinician defined EDD. **A:** Patients not reviewed by VMO in last 24 hours, with no current plan, escalated to DMS. **R:** DMS discussion with VMO's of patients who do not have a plan. -All patients have been reviewed by a VMO. -Plans for all in-patients communicated.

[redacted]

Your business and knowledge is medicine.
The organisational commitment is to ensure patient access to care.
We would like to make the "business" part straight forward to allow you to concentrate on your craft.
In the event of escalation please join our "team patient focus" with your response overleaf.

Bed Manager / AHNM
0434735340

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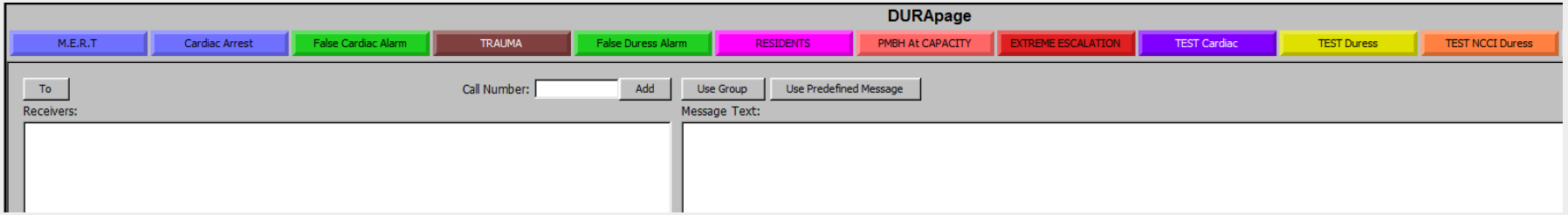

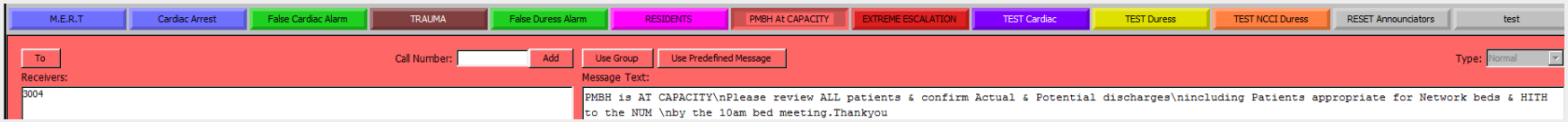

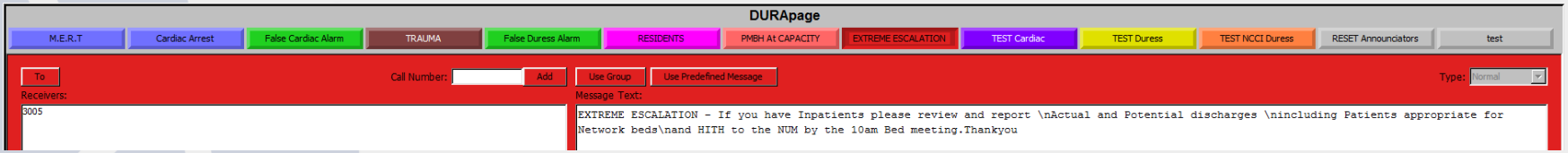

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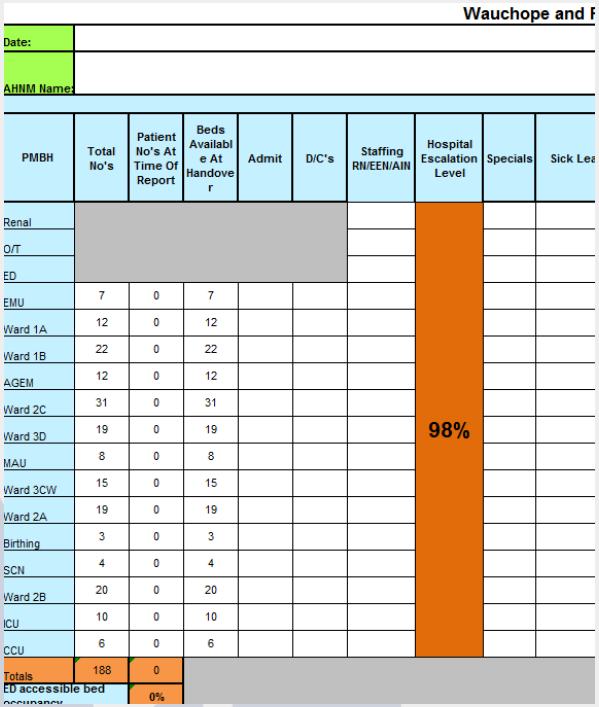

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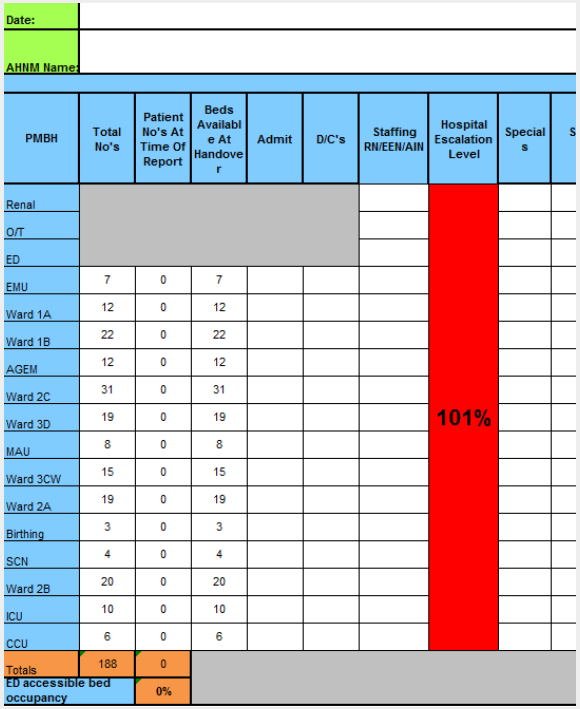
Date:

AHNM Name:

PMBH	Total No's	Patient No's At Time Of Report	Beds Available At Handover	Admit	D/C's	Staffing RN/EEN/AIN	Hospital Escalation Level	Specials	Sick Lea
Renal							98%		
O/T									
ED									
EMU	7	0	7						
Ward 1A	12	0	12						
Ward 1B	22	0	22						
AGEM	12	0	12						
Ward 2C	31	0	31						
Ward 3D	19	0	19						
MAU	8	0	8						
Ward 3CW	15	0	15						
Ward 2A	19	0	19						
Birthing	3	0	3						
SCN	4	0	4						
Ward 2B	20	0	20						
ICU	10	0	10						
CCU	6	0	6						
Totals	188	0							
ED accessible bed occupancy		0%							



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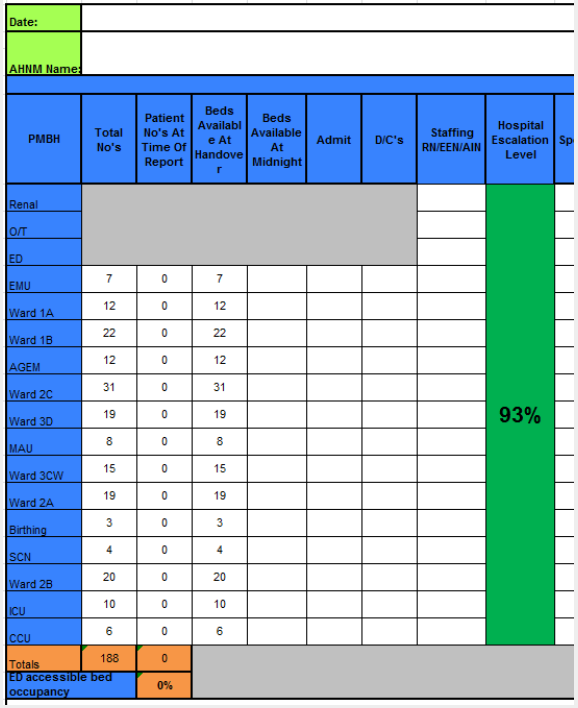

Date:

AHNM Name:

PMBH	Total No's	Patient No's At Time Of Report	Beds Available At Handover	Beds Available At Midnight	Admit	D/C's	Staffing RN/EEN/AIN	Hospital Escalation Level	Sp
Renal								93%	
O/T									
ED									
EMU	7	0	7						
Ward 1A	12	0	12						
Ward 1B	22	0	22						
AGEM	12	0	12						
Ward 2C	31	0	31						
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Consultation
Design Phase

- 24 July – Car trip to Kempsey
- 3 July – DON&M
- 4 Aug - GM
- 10 Aug – GM, DMS, DoN&M
- 10 Aug - WoH Governance Team
- 28 August - DMS
- Nov - 2 weeks of trialing tipping points

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Consultation
Implementation Phase

- 9 Sept - AHNM meeting
- 16 Sept - NUM's
- 12 Oct - Medical Staff Council
- 14 Nov – Medical consensus on text to personal phones
- Dec - Included in Bed Manager /AHNM shift report
- For trial for 3 months from December
- Reminder - Medical Staff Council agenda for duration of trial
- Introduction at annual medical orientation for the year

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PMBH Escalation Actions and Responses

One week in July, 2015…Comparison with same week last year…

	2014	2015
ED Presentations	521	641
Admissions	173	245
Overall NEAT	71.02%	70.83%
Admitted NEAT	38.73%	41.22%
Non-Admitted NEAT	87.07%	89.14%

So…

- More ED patients!
- More Admissions!
- Admitted more within 4hours!
- Sent more home within 4 hours!

With this increase in community demand for access to care we are reviewing our daily escalation and patient flow processes. We used to be able to absorb occasional peaks and clusters in activity however these are becoming a daily expectation.

Attached is a proposal of how this communication, action and response plan could look.

AIM:

- Identify PMBH's daily level of escalation using tipping points specific to PMBH.
- Utilise accurately communicated capacity and demand to ensure patient access to care.
- Optimal Patient Flow results from a collaboration of respectful communication of key stakeholders in patient care.
- Each patient has the best possible access to care from admission, as an in-patient and discharging through our organisation.

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The proposed Escalation Actions and Responses tool is attached in 4 parts.

The 1st 2 attachments- will be laminated as one back-to-back sheet and will identify PMBH's level of escalation for that day. The reverse side is a guide to gathering the information required.

The 3rd attachment- offers colour coded "Actions and Responses" for the identified level of escalation. It should be noted that with the improved weekend discharge activity of the last 6 months and decreased surgical demand for beds over the weekend period (compared to Monday – Friday) the periods of "Extreme Escalation" have occurred early to mid-week, during morning to late afternoon hours.

The 4th attachment- is an ID size communication cheat sheet (laminated to attach to staff ID) to be given to all medical staff during orientation. It acknowledges their business as Medicine, and asks them to join our team patient focus in the event of increased community demand to services. There will be 2 "escalation pages" to represent 100% capacity and >100% with maximum surge capacity utilised. It clearly outlines information that needs to be communicated to ensure access to care is maintained.

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Positives

- Engagement with tool
- Linking with patient flow reports
- Agreement that escalation is everyone's business
- Familiarity with Tool prior to winter

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Challenges

- Medical consensus on how to communicate
- Time lag between educating everyone and commencing trial
- Keeping it on peoples' radar's

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To Do List

- Due to people's leave over December/ January there still needs to be 2 Executive lead discussions
  - HITH – outside their criteria to maintain capacity
  - Network Beds – 1 phone call for transfer
- Assess response to pages next period of escalation

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Questions?

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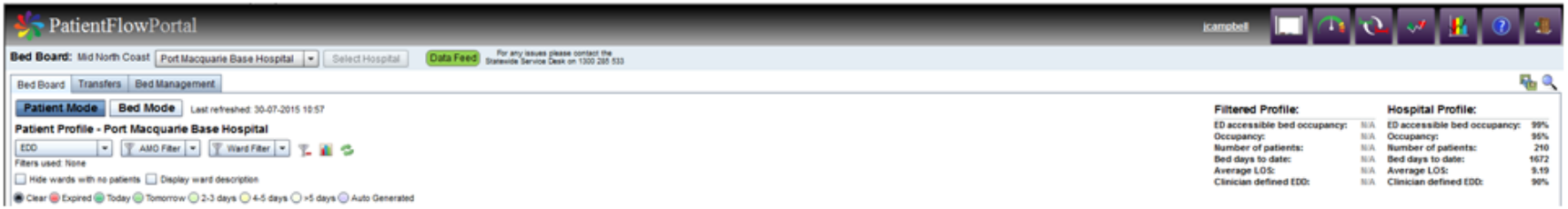

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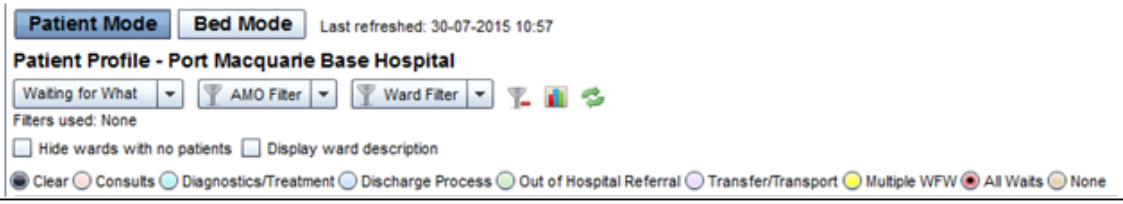
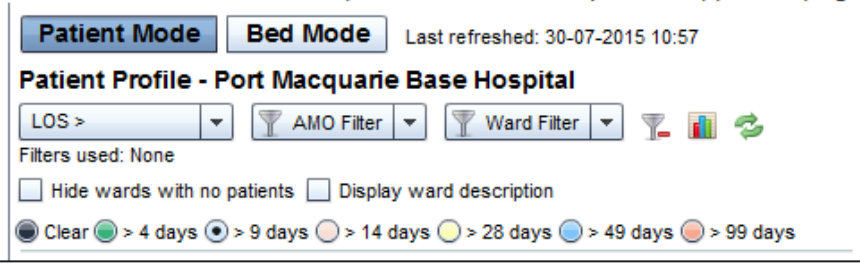
WFW	Select "Waiting for What" from the drop down box under patient profile, top left hand corner on Bed Board screen of Patient Flow Portal (currently EDD is selected). Select red dot "All Waits". The number appears under "Filtered Profile", top right hand corner on Bed Board screen of Patient Flow Portal 
Long stayers >9 days	As above but select "LOS>" and pale blue dot for >9 days. Total appears top right hand corner under "Filtered Profile" 
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DRAFT Escalation Actions and Responses

Network Beds	**A:** Review PFP for impending transfers. **R:** Optimises state-wide patient access to care.	**A:** Liaise at Patient Flow Manager Level after PMBH Bed Meeting. **R:** Patients identified as potential transfers pending medical acceptance.	**A:** Liaise at Patient Flow Manager level Discuss appropriate patients for available beds **R:** Appropriate patients accepted for available beds. Transport is co-ordinated as a priority. 1 phone call after bed meeting.	**Immediate transfer when Network beds available** **A:** Liaise at Exec level (GM/DMS) between sites for immediate transfer **R:** **Apropriate** patients accepted into available beds Transport is co-ordinated as a priority.
Operating Theatre List	Patient Flow Manager meets with surgical bookings the previous day to discuss next day demand. Patient Flow Manager preliminarily allocates beds at 07:00. Beds confirmed at 10am bed meeting. NUM's have access to daily theatre list to anticipate admissions.	Patient Flow Manager meets with surgical bookings the previous day to discuss next day demand. Patient Flow Manager preliminarily allocates beds at 07:00. Beds confirmed at 10am bed meeting. NUM's have access to daily theatre list to anticipate admissions.	**A:** Patient Flow Manager / AHNM discuss required beds with Executive at 07:00 **R:** Commence with in-patients. Phone and place patients on standby Reassess after bed meeting.	**A:** Executive review possible cancellations **R:** Cancellation plan. Executive to cancel Cat A. AHNM / Surg bookings to cancel Cat B – C.
Staffing	**A:** Reduce staffing within NHPPD allocation. Sick leave not replaced if skill mix allows. **R:** FTE remains within budget	**A:** Ensure staffing within NHPPD allocation Sick leave replaced with like for like, permanent pool or 7 hour casual **R:** Skill mix maintained within FTE for optimal patient care. FTE remains within budget.	**A:** Discharge Planner rostered to Saturday. **R:** Optimal Saturday discharges achieved, plans updated for Sunday. **A:** TU sickleave replaced as a priority. **R:** TU remains operational to assist in immediate access to acute beds. **A:** Transport RN sick leave, if unable to be replaced from outside currently rostered staffing, is replaced from	**A:** Discharge Planners rostered to weekends. **R:** Optimal weekend discharges achieved. **A:** TU sickleave replaced as a priority. **R:** TU remains operational to assist in immediate access to acute beds. **A:** Permanent pool staff allocated to surged areas. **R:** Core staff, familiar with PMBH patient flow, optimise care and discharges.

DRAFT Escalation Actions and Responses

			ward of patient requiring transfer. **R:** Spreads burden of replacement across wards. -Allows TU staff to maintain discharge role. -Minimises handover time as staff familiar with patient.	**A:** Casual pool staff allocated to support areas with core staff. **R:** Casual staff provide clinical support to core staff who have the knowledge to optimise patient flow. **A:** Transport RN sick leave, if unable to be replaced from outside currently rostered staffing, is replaced from ward of patient requiring transfer. **R:** Spreads burden of replacement across wards. -Allows TU staff to maintain discharge role. -Minimises handover time as staff familiar with patient.
Clinician Defined EDD's	**A:** NUM's review EDD's and update clinician defined. **R:** PFP shows Clinician Defined EDD's >95%.	**A:** NUM's review EDD's and update clinician defined. **R:** PFP shows Clinician Defined EDD's >95%.	**A:** NUM's review EDD's and update clinician defined. **R:** PFP shows Clinician Defined EDD's >95%.	**A:** NUM's review EDD's and update clinician defined. **R:** PFP shows Clinician Defined EDD's >95%.
Long Stayers >9 days	**A:** Reviewed at weekly Long Stay Meeting. **R:** All patients with LOS >9days are reviewed weekly to update their plan. WFW's are entered to capture delays in discharge. Issues are escalated to Executive.	**A:** Reviewed at weekly Long Stay Meeting. **R:** All patients with LOS >9days are reviewed weekly to update their plan. WFW's are entered to capture delays in discharge. Issues are escalated to Executive	**A:** Print list for review every day. - WFW and delays are escalated to Executive. **R:** All long stayers are reviewed, network delays are escalated by Executive.	**A:** Print list for review every day. - WFW and delays are escalated to Executive. **R:** All long stayers are reviewed, network delays are escalated by Executive.

DRAFT Escalation Actions and Responses

WFW	**A:** NUM's review WFW's to ensure accuracy and action. **R:** All WFW are reviewed, actioned and closed as appropriate.	**A:** NUM's review WFW's to ensure accuracy and action. **R:** All WFW are reviewed, actioned and closed as appropriate.	**A:** Patient Flow Manager review's WFW. **R:** Network WFW prioritised -IHT escalated with receiving hospitals.	**A:** Executive escalation of Network WFW. **R:** Network WFW prioritised.
Transit Unit (TU)	**A:** RN identifies daily discharges from PFP clinician defined EDD's. -NUM's to identify patients for Transit Unit by Bed Meeting. **R:** RN proactively rounds wards "pulling" patients. -EN maintains patient care of Transit Unit.	**A:** RN identifies daily discharges from PFP clinician defined EDD's. -NUM's to identify patients for Transit Unit by Bed Meeting. **R:** RN proactively rounds wards "pulling" patients. -EN maintains patient care of Transit Unit.	**A:** NUM's to identify 2 patients per ward by Bed Meeting for TU. -TU RN to attend Bed Meeting. **R:** TU RN immediately aware of imminent transfers from wards.	**A:** NUM's to send 2 patients per ward to TU by 9:30. **R:** RN & EN remain in TU to receive patients. -TU receives 2 patients per ward by 9:30. -Hospitalist / JMO prioitise to discharge in TU. -Pharmacy to prioitise to discharge in TU. **A:** TU sickleave is to be replaced as a priority. **R:** TU maintains prioritised discharge service. -Staff are not deployed to replace other sickleave or complete transfers.
HITH	**A:** Attend Bed Meeting. **R:** Potential patients identified for HITH for assessment.	**A:** Attend Bed Meeting. **R:** Potential patients identified for HITH for assessment.	**A:** Attend Bed Meeting. -Proactively identify patients for "waiting list" for HITH to replace HITH discharges over next 48hours. **R:** HITH occupancy at capacity.	**A:** Liase with Discharge Planners for most appropriate patients outside normal criteria prior to Bed Meeting. **R:** HITH occupancy at capacity.

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PMBH Bed Meeting	**A:** NUM's attend Bed meeting communicating demand and capacity. **R:** Admissions and discharges communicated within the organisation.	**A:** NUM's attend Bed meeting communicating demand and capacity. **R:** Admissions and discharges communicated within the organisation.	**A:** Executive to attend bed meeting. -Patients not reviewed by VMO in last 24 hours escalated to Executive. **R:** Executive discussion with VMO's of patients who don't have a plan. - All patients have been reviewed by a VMO. -Plans for all in-patients communicated. **A:** NUM's communicate updated demand and capacity to AHNM at 14:30. **R:** AHNM has accurate demand and capacity to commence shift.	**A:** Executive to attend bed meeting. -Patients not reviewed by VMO in last 24 hours escalated to Executive. **R:** Executive discussion with VMO's of patients who don't have a plan. -All patients have been reviewed by a VMO. -Plans for all in-patients communicated. **A:** NUM's communicate updated demand and capacity to AHNM at 14:30. **R:** AHNM has accurate demand and capacity to commence shift. **A:** Executive attends DEN for 14:30 to discuss plan for next 16hours with AHNM. **R:** AHNM has executive support and current plan communicated for next 16hours.

Action: Escalation Page "At Capacity" [redacted]	**Action:** Escalation Page "Extreme Escalation"
Response: Registrar/JMO from each "VMO team – eg Surg A or Med B" confirms with NUM of each ward that each patient has been reviewed and has a plan. Discharges are accurate. -All patients have a clinician defined EDD ***by the Bed Meeting at 10am.*** **A:** Patients not reviewed by VMO in last 24 hours, with no current plan, escalated to DMS. **R:** DMS discussion with VMO's of patients who do not have a plan. - All patients have been reviewed by a VMO. -Plans for all in-patients communicated.	**Response: VMO /Advanced Trainee** communicates ***actual*** and ***potential*** discharges (stating discharge condition eg INR result for potentials) to NUM's ***prior to Bed Meeting at 10am.*** -All patients have a clinician defined EDD. **A:** Patients not reviewed by VMO in last 24 hours, with no current plan, escalated to DMS. **R:** DMS discussion with VMO's of patients who do not have a plan. -All patients have been reviewed by a VMO. -Plans for all in-patients communicated.

[redacted]

Your business and knowledge is medicine.
The organisational commitment is to ensure patient access to care.
We would like to make the "business" part straight forward to allow you to concentrate on your craft.
In the event of escalation please join our "team patient focus" with your response overleaf.

Bed Manager / AHNM
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NSW GOVERNMENT Health
Mid North Coast Local Health District