STEP Implementation

Short Term Escalation Plan

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Shoalhaven Hospital 200? beds

Part of ISLHD, Illawarra Shoalhaven Local Health District

Population of 385,250

9 hospitals, 45 community based services, 7300 staff

Large geographic region 250km of coast line

105 ED presentation a day, 20% admission rate

Admission ratio (ED/all other) 30% / 70%

Development

Extensive consultation including substantial MO input, allied health, NM/NUM/MUM's, executives both site and district. Each department represented

Our aim was to document & support the processes that already existed but varied greatly and introduce/trial new processes

Our goals were to be;

Process driven NOT PERSON DEPENDANT

INCLUSIVE NOT EXCLUSIVE

SPECIFIC AND DETAILED

REALISTIC

A Good day when it works

07:30: ED (10 acute beds, 2 resus beds, 1 iso room) 16 acute patients, 10 for admission = **4 more acute pts than beds.**

Bed base - All over census beds & ICU full (23hr ward, 6 beds + 8 chairs + 2 toilets + 1 bathroom: 10 acute pts, 36 day only pts = **patients in recovery**) 4 overnight beds required for theatre pts.

- **RED** (severe compromise) STEP announced at 0830hrs bed meeting (NUM/NM/MUM/Exec), district informed 09:00 area teleconference
- NUMs returned to wards communicated to JMOs and Registrars.
- VMOs and Staff Specialists notified by TXT, Pager sent to JMO's
- Increased attendance at epjbs

20 discharges by 1300hrs, ICU decanted, STEP **GREEN** (Business as usual) de-escalation notification to site & district.

What has supported or been built around the STEP

Epjb mdt meetings

District teleconferences and bed utilisation

Patient flow meetings

LOS >9days & WFW meetings

Post intake ward rounds

Ongoing Challenges

- STEP **after hours** escalation
- 23hr ward utilisation
- new endoscopy unit opening December 16, Remodel ED, Introduction of an ESSA, remodel geriatric ward all totally new to us!!!
- **Increasing activity** particularly Aug & Sep 16 30% increase in admissions and ambulances pres. on last year!!!
- Review of ED in charge process.
- ICU outward bed block
- **competing interests** of ED, theatres, transfers in, direct admits, unplanned admissions

Shoalhaven District MemorIDMH Short Term Escalation Plan (STEP)

Escalation level	Department	Triggers	Resources	Actions	Position Responsible	Time Frame	*Notification Pathway/ Communication plan
1. Business as usual	Emergency Department	>15 Patients LOS > 9 days Discharges previous day same as admissions	PFP citrix	• Mandatory attendance at 8am medical handover and update medical teams of predicted discharges by specialty.	PFM/AHNM	Immediatey	Escalation page "Moderate compromise" to be sent to all Registra and JMO pagers.
3. Severe compromise	Emergency Department	≤ 20 Patients LOS > 9 days 5 discharges < previous day admisions	PFP Citrix	1. Notify hospital 2. Open overcencus beds	PFM/AHNM PFM/AHNM	Immediately Immediately	Notify Exec team (DON, DDON & DCS) SMS, notify Site (NUM/NM or I/C departments) via direct call. Escalation page
4.Extreme compromise	Patient flow	≤ 25 Patients LOS > 9 days 10 discharges < previous day admisions > 35% Bed base Waiting for whats ≥ 8 NWB patients ≥ 8 Pts in ED waiting bed allocation	PFP FirstNet	1. Escalate transfer delays to divisional co directors 2. liaise with ambulance service, exec on call to district exec on call 3. a representative from exec team or second patient flow attend urgent district patient flow meeting	Exec	Immediately	Divisional co directors department related to delay
		Staffing matched to acuity at unsafe levels		Discuss with executive calling in additional PFM/AHNM and Exec decision making	PFM/AHNM	Immediately	Exec on call
		≥ 8 unplaced IHT waiting to come in/out > 110% ED accesible bed occupancy ≥ -10 bed base on predictive tool ≥ 8 Pts discha EDD's	PFP	• Open all over census/surg beds • Elective surgery cases postponed • Devert to recovery staff and use OT staff	Exec	Immediately	Complete Feedback Template within 24 hours

Shoalhaven District Memorial Hospital Short Term Escalation Plan (STEP) Matrix

	Trigger/s	Source	0. Business as usual	2. Moderate compromise	3. Severe compromise	4. Extreme compromise
Patient flow	No. of admissions in ED @	FirstNet	0	≥ 2	≥ 5	≥ 8
	Waiting Mental health	EMR	≤ 2	≥ 4	≥ 6	≥ 8
	Transport/transfer delays	NEPT/A	≤ 4	≥6	≥8	≥10
	Patients LOS > 9 days	PFP	< 15	> 15	> 20	> 25
	Discharges previous day	Citrix	> or same as admissions	5 < admissions	10 < admissions	15 < admissions
	Unplaced IHT IN & OUT	PFP	<4	> 5	> 8	> 10
	% ED accesible bed	PFP	< 93%	> 100%	> 105%	> 110%
	Predictive Tool	PFP	≥ +1	0	-5	-10
	Waiting for whats	PFP	< 20% bed base	<25%	> 30%	> 35%
ED	Acute beds available in ED	FirstNet	≥ 1 Acute beds available or available in ED within the next 30	No acute beds becoming available in <	All acute beds full + acute pts. In	All acute beds full, FT in bed
	Ambulance delays (TOC)	FirstNet	0	≤1 at 30 min		@ 60
	ESSA appropriate Patients in department ≥ 22 hours	Senior ED staff	0	≥ 1		
	Admit/transfer patients in	FirstNet	0	≥5		
	Resus bed availability	FirstNet	> 1 resus bed available	2 resus beds		and r
	Patients waiting to be seen	FirstNet	< 6	≥ 6		
	Waiting Mental health	FirstNet	≤ 2	≥ 3		
	High complexity/resourse intensive Patients	Senior ED staff	≤ 1	≥2 (0700-23 ≥ 1 (2300-07		
ICU	Patients needing cardiac	PFP	≤ 12	≥ 13		
	Admitting capacity in ICU	Senior ICU staff	staffing > acuity and beds available	staffing = ac available +		
STAFFING	Nursing vacancies	P Drive	Acuity meets NPPH or agreed staffing establishment	Acuity above staffing esta		
	Medical vacancies (any 1 of the combinations listed)	Direct notific-ation	0	A vacancy S ED		

SDMH STEP Matrix

3. Severe Compromise

- Intake Medical Registrar remains in ED
- All patients with EDD's today to have discharge confirmed and delays escalated to NUM/AHNM
- Communicate all definite discharges immediately
- Doctors facilitating transfers or dischargeso utside SDMH (MUH, SHH, DBH).
- All patients must have a documented plan of discharge
- Mandatory attendance at epjb meetings by registrars.
- All patients that have not been reviewed for ≥24 hrs VMO's will be contacted by NUMs and asked to review and document plan immediatley?
- Discuss with (HOD) reallocation of junior medical staffing per team

SDMH STEP Matrix

4. Extreme Compromise

- Intake Medical Consultant and Registrar remain in ED
- DCS consider rounding with assistance of Senior Registrar and discharge suitable patinets.
- All patinets with unclear plans or EDD's within 24hrs to be escalated to HOD's/Exec on call

DCS and HODS to review workload and potentially reallocate medical resources.

Facility Level

0 Business as usual | 2 Moderate compromise | 3 Severe Compromise | 4 Extreme compromise

MUST BE ESCALATED TO EXECUTIVE AND AREA Patient Flow Manage