System Wide Escalation Framework and Procedures

21st December 2015

Background

This framework is designed to support Hospital Groups and Community Health Organisations in developing integrated escalation plans such that capacity and patient throughput is appropriately managed at a time of excess demand on emergency and acute services. It seeks to ensure that admission, discharge and escalation (surge capacity) procedures are organised in a controlled and planned way that supports and ensures the delivery of optimum patient care within national targets and in compliance with the recent Escalation Directive 27/11/2015. Of note it is essential that organisations understand their "normal variation and daily demand and are not constantly managing the normal as a "surge".

It consists of a tiered and incremental suite of actions intended to be adapted and implemented in Hospitals with an Emergency Department (ED) and the wider Local Health Economy as part of an inter -disciplinary, multi -provider system response to avoid Emergency Department overcrowding. It requires that local strategies and plans are in place to understand and respond to surges in demand in a responsive and planned way that meets national access and quality standards and underpins patient safety. It also requires that a suite of sub plans are considered and developed in discrete service and functional areas to support implementation e.g. Emergency Department internal escalation plan, ICU etc.

Organisational Arrangements

All Hospitals, Primary and Social Care services must work together to develop and implement comprehensive and integrated plans to meet the goals and standards specified in the mandatory Escalation Directive 27/11/2015. Clear, transparent and measurable organisational arrangements are required to be in place to implement and monitor adherence to the intent of the framework. This requires a focus not only on internal hospital processes but also on the nature and capacity of primary, social and continuing care services to be responsive and support admission avoidance and earlier discharges from hospital such that integrated care and communication is supported across the full care continuum.

Effective management of acute hospital beds and associated resources

The effective management of acute hospital beds and associated resources is vital if the growing demand is to be met.

Recognised impediments to patient 'flow 'in hospitals include:

- Delays in gaining timely access to inpatient beds i.e inadequate ward discharge levelling by time of day/day of week
- Ineffective use or absence of appropriate "patient streaming" e.g. AMUs, SAUs, Minor Injury Units, ambulatory and frailty pathways
- Ineffective daily management of throughput and addressing operational bottlenecks in acute centric timing ie completing today's work today.
- Retention of patients in hospital beds following medical and functional discharge
- Absence of physiological and functional goal setting to enable and effect purposeful predicted discharge planning
- Inefficient systems, practices and procedures such that demand and capacity are not aligned or managed optimally
- Lack of timely access to Senior Decision Makers and diagnostic services
- Lack of proactive planning and an escalation response based on the number of planned discharges v reactive to front door demands,

The active management of admissions, treatment and discharge should ensure that:

- There is appropriate and efficient bed utilisation (ambulatory care pathways, CSP pathways, day of procedure admission avoidance systems) underpinned by a proactive approach to managing patient flow such that beds are available when they are needed for those who most need them eg functioning navigation hub, meaningful use of PDD
- The quality and appropriateness of patient care is high.
- Patients are assessed and treated, admitted or discharged within 6 hours as outlined in the Emergency Department Clinical Programme . Specifically, the volume of patients should be line with agreed national targets for each Hospital (see attached). There is zero tolerance for breaches of 9 hours for admitted patients
- Care is integrated such that patients get the care and supports they require at each stage of their care pathway and upon discharge to home or other appropriate service.
- There are explicit plans and governance arrangements in place to ensure transparency and accountability for performance at all stages of the patient flow continuum
- Quality improvement methodologies are used within a structure to deliver continuous improvement in patient flow across the full care continuum
- Data is used proactively to understand and address patient flow bottlenecks.

The Framework

The framework for system wide escalation is intended to be universally applied across all hospitals with an Emergency Department and partner Community Healthcare Organisations. It is based on a process of moving through a series of timely incremental steps and defined actions by named personnel with appropriate status and authority to address overcrowding in compliance with national performance indicators and Escalation Directive.

Steady State:

A Steady State exists when demand and capacity for acute in-patient care, both current and predicted unscheduled and scheduled care is being managed such that there is timely access to emergency (unscheduled) care and treatment within national agreed key performance indicators (95% less than 6 hour wait and no waits greater than 9 hours).

The events of admission and discharge are pivotal in delivering an integrated approach to patient care and patient flow. This requires an inter-disciplinary and whole systems approach across the full care continuum necessitating the development of clinical protocols, pathways and standards, which can be audited and evaluated to demonstrate clinical and operational effectiveness. These are implemented and governed in line with the principles, standards and recommended practices contained within national policy and guidance documents and the National Clinical Programmes.

Escalation:

The state of escalation involves using a systematic controlled and incremental process to facilitate the movement of patients from Emergency Departments (EDs) & Acute Medicine Assessment Units (AMAU) where a decision to admit has been made but for whom there are insufficient available beds available on inpatient units.

It consists of a series of clearly defined incremental steps which are triggered by the active or threatened failure to meet agreed care standards i.e. any patient threatening to breach 9 hour admission wait, potential of red trolleygar return at any point during the day. All breaches of 9 hours for admission waits must be communicated to the Special Delivery Unit (SDU) in line with mandatory Escalation Directive dated 27/11/2015. Hospital Group executive management team and relevant CHO's must also be notified.

It is important that escalation measures are undertaken across the full health system including primary, community and continuing care services to ensure that all available capacity and options are utilised and brought to bear on the situation

Key trigger points, any one or a combination of which will activate escalation include:

- Delays in any of the timed internal steps in the Emergency Department / AMAU from presentation to disposition
- Length of time waiting (total waiting time) in Emergency Department i.e. numbers of patients waiting over 6hours from time of registration.
- Level of overcrowding i.e. % of ED/AMAU bays or trolleys occupied, level of acuity and volume of patients presenting
- Numbers waiting for assessment by dept/unit teams and in-house teams in the Emergency Department/AMAU
- No of appropriate patients being seen in AMAU (capacity to review triage categories 2 & 3 etc)
- Rate of patients being discharged from ED and AMAU or CDU.
- Number of In-Patient boarders in the Emergency Department/AMAU
- Ambulance activity – number of presentations and/or ramping due to delays in accessing hospital care and services
- Delay of greater than 30 minutes from triage to transfer to AMAU
- Diagnostic access mismatch of capacity and demand
- Staffing levels not aligned with demand profile
- Notification of expected increase in attendance e.g major public event/incident
- Frontline staff competency in assessment and decision making skills
- Threshold at which the complexity of presentations/ those awaiting assessment (triage 1&2's) impact on the ability to provide safe, timely effective service.
- Level of bed occupancy or anticipated occupancy based on demand/capacity forecasting
- Numbers or percentage of acute beds occupied by patients who are clinically discharged-awaiting LTC, Home Care, rehab, transport etc (approaching or above agreed threshold levels)
- Level of infectious diseases and isolation requirement and/or containment of infection – associated bed closures
- Tertiary referral demands for speciality services or delays in repatriating patients

Final Stage Full Capacity Protocol and Special Measures

In the event that all possible escalation steps have been exhausted and overcrowding persists, then, as a last resort ,a range of extraordinary special measures will be activated. It should be noted that the INMO have not agreed to the use of the Full Capacity Protocol However the Ministerial Directive issued 27th November 2015 provides for its use as a last resort as part

of a whole system, whole health response to create additional surge capacity. The FCP may include the admission of patients to "extra" beds on inpatient units and their environs. It can also include the option of time limited ambulance diversion to provide protection to the hospital from new demand. These measures can improve the flow of admitted patients through unscheduled care pathways by both dampening demand and temporarily increasing capacity across the health system. The ED and AMAU may temporarily accommodate a locally agreed number of extra patients subject to maintaining an appropriate level of patient flow which it will be critical to maintain, to address the overcrowding.

The temporary placement of patients to extra beds is implemented as a final institutional response to continued overcrowding after all other possible measures have been implemented to facilitate the delivery of safer patient care across the health system.

The SDU must be notified on escalation through all levels of escalation via the trolleygar SBAR system. The decision to escalate to FCP is a specific function for the CEO/Hospital Group CEO, as appropriate. Where exercised it must be notified to the Joint Chairs of the ED Forum via the SDU. The Joint Chairs may assign the SDU to audit the process leading to the use of FCP to establish whether Steps 1 and 2 of this protocol were executed in line with Escalation Directive and have been used appropriately. Escalation to FCP is also to be regarded as a notifiable Serious Reportable Event (SRE) and national policy in this regard should be followed (Jan 2015).

De-Escalation and Review Opportunities for Learning and Improvement

It is important that de-escalation happens in a planned, controlled, timely and explicit manner. When the escalation process has been stood down or discontinued, it is important that a full review of the impact is conducted to understand causative factors and explore learning opportunities for the purpose of continuous learning and improvement.

It is recognised that using extraordinary special measures (eg FCP) to manage ordinary variation is inappropriate and if this is the case then a fundamental review of demand and capacity combined with systemic clinical and operational process changes is required.

If there have been persistent breaches of > 9 hour for admission target, excessive Patient Experience Times or red trolleygar returns at any of the time points during the day, the SDU has the authority to conduct a full independent review in line with recent escalation directive. This is to ensure that appropriate and timely escalation and de-escalation measures have been invoked to mitigate the situation.

If it cannot be demonstrated that all such measures have been taken, a budget deduction of €10,000 will be applied for each breach event.

Steady State	**TRIGGER**	**ACTION**
Steady State Pre Activation of Escalation Procedures	bed occupancy sufficient to meet known demand Emergency / Elective medical activity accommodated Waiting times in ED within targets and processes such as Standard Hourly quick assessment of ED by ED Nurse team leader and ED lead clinician occurring	Controlled patient flow system in operation across the full health system Effective Triage and Streaming of patients in place in line with Clinical Programmes. Discharge, emergency flow processes integrated and working effectively and efficiently. Demand and capacity understood system wide and aligned across the full patient flow continuum All patient flow processes happening in a timely manner. Primary and Community services supporting timely and appropriate admission avoidance and discharges (simple and complex) Diagnostic access aligned to demand

Step	Trigger	Action	Responsibilities In Hours	Out of Hours
Step 1	30% of ED bay`s occupied by patients awaiting admission. Admissions and discharges mismatch and delays in accessing in-patient beds Sustained threat of 9 hour trolley breach Anticipated pressure in	Inform Clinical Director of initiation of escalation plan. Notify relevant staff and stakeholders (including staff representatives) that the Escalation plan is about to be activated. Notify SDU Liaison Officer of status-document on trolleygar SBAR	• Lead Physician AMAU/MAU • Case Manager/Patient Flow Manager / Bed Manager [lead person] *to liaise with* • Director of Nursing Service Nurse Manager	Site manager/On call team
		Communicate to the named Consultant caring for the patient that their patient has exceeded the six hour target time. Communicate, as appropriate, numbers in ED to all consultants to promote pro-active discharging (each team to conduct additional discharging rounds ensuring all patients have plan of care and parameters for discharge set. To target an additional agreed number of patients). Further patient reviews to be arranged where likely discharges are contingent upon diagnostics a. Patients in the ED/AMAU to be prioritised for diagnostics b. Inpatients discharge decisions – diagnostics for these to be prioritised	• Clinical Director/AMAU Lead Physician • ED Nurse Team Leader (ADON)to make the requests to patient flow/bed management. ED Nurse team leader (ADON) and ED lead Physician continue to monitor the ED situation hourly.	Manager-On-Call

	facilitating ambulance handovers Delayed discharges approaching threshold levels	Labs and Radiology to provide rapid turn around time for critical tests	Clinical Director / Hospital Manager	Manager-On-Call
		Patient Flow lead and Discharge Co-ordinator/s to identify Identify all available capacity in other Group Hospitals /local private acute capacity c)Definite number of discharges d)Probable discharges (date and times) e)Optimise bi-directional flow (repatriation) discharges and make the necessary arrangements to discharge and sit out patients for discharge where appropriate (convert potential to actuals)	Bed Manager	All Staff
		Notify CHO of escalation activation and request escalation in responses from primary, community and continuing care services in terms of: • Maximise and prioritise access to long stay and intermediate care beds-provide agreed number of additional egress options to support discharges • Provide additional number of slots for Rapid Access and CIT services etc • Fast track assessment and decision processes for home care, intermediate and long term care services (offer agreed number and range of services) • Make staff available for liaison and patient streaming e.g. social cases / mental health/addiction services Increase availability of OPAT.	• **CEO/Hospital Manager Community Health Organisation manager**	**Manager-On-Call**

Step 2	>50% of ED bay`s occupied by patients awaiting admission Threatened 9 hour trolley breaches Predicted discharges continue to be below	Convene Medical Rapid Response meeting	• Case Manager/Patient Flow Manager / Bed Manager [lead person] *to liaise with* • Director of Nursing • Clinical Director	• Site Nurse Manager • Manager-On-Call
		Communicate escalation to Step 2 to all appropriate staff and partner service providers incl Ambulance and record on trolleygar. Communicate to named Consultant the fact that their patient has exceeded the six hour target for admitted patients Allocate senior decision makers from in-patient clinical teams to support Emergency Department or AMU for effective patient flow and treatment Rapid Assessment and Treatment has commenced. Confirm that all inhouse patients have been reviewed by Consultant /SpR Review requirement for opening of additional surge capacity incl beds/diagnostics with the focus to be on in house diagnostics	• Clinical Director/CEO/Hospital Manager	• ED Staff • Site Nurse Manager • Manager-On-Call
		Identify and utilise all potential for additional capacity including community and transport services to provide additional emergency responses to facilitate discharges.	• ED Nurse Team Leader to make the request to Patient Services Dept.	• Site Nurse Manager • Manager-On-Call

	predicted admissions	Expedite transfer of patients from ED to allocated beds. Inform Group and CHO Leadership of severity of situation	• All Staff	• All Staff
	Unable to offload ambulances	Review elective v emergency demand identifying non urgent elective patients for cancellation in consultation with relevant consultants and notify Admissions Office (who will, in turn, advise patients of decision). Redeploy staff from scaled back services appropriately	• CEO, DON & Clinical Director (Lead decision makers.)	• Manager-On-Call
Step 2 Cont		**<u>Nurse in Charge of Ward must;</u>** • Identify patients who could be discharged pending an urgent investigation slot. • Assess patients who could be safely "sat out" pending discharge. • Identify patients whose treatment can continue in a community setting with support of community services. • Identify patients on overnight / weekend leave (these patients should be discharged and readmitted) • Inform GP, Social Workers and Pharmacy of patients who need urgent attention / services to facilitate discharge. • Inform Bed Manager / Patient flow Manager promptly regarding the outcome of the above actions. **<u>Senior Decision Making Medical Staff must</u>**; • Review patients admitted but waiting in the ED with a view to providing alternatives to immediate admission including rapid access to OPD clinics. • Review patients awaiting second decision pending discharge and patients with next day PDD. • Confirm patients who could be discharged pending urgent investigation slot and ensure same is done. • Confirm patients whose treatment can continue in a community setting with support of community nurses. • Authorise the safe transfer of patients to other facilities, through discussion with their named consultants	• Case Manager/Patient Flow Manager / Bed Manager *to liaise with* • Director of Nursing • Service Nurse Managers • Medical and Surgical Consultants re applicable elective cancellations • Medical and Surgical Ward Teams • Clerical/Admin staff • Diagnostic services • OPD services	• Site Nurse Manager • Manager-On-Call • Medical and Surgical Consultants re applicable elective cancellations
		Ensure all primary, community and continuing care capacity is prioritised and optimised to support patient discharges in terms of access to CIT services, OPAT, home care packages, intermediate and long term care beds. Extra discharging rounding in community facilities to be expedited. In reach activity to ED to be maximised Alert GPs to escalation and request alternatives to ED referral where feasible	• CEO/Hospital Manager/CHO Lead	
		Inform HSE Corporate Leads and SDU of severity of overcrowding and seek additional emergency whole health economy supports (community discharge packages/beds, transport etc) Inform the public that it is essential that all patients ready for discharge are collected by their family/carer.	• Internal Communications Manager	

Step 3	Steps 1-2 unsuccessful Contingency measures utilised and demand continues to exceed capacity Any patient awaiting admission in excess of 9 hrs	Activation of Special Measures/Full Capacity Protocol for overcrowding in the Emergency Department should only happen as a last resort when all other measures have been taken and overcrowding persists. Must be authorised by CEO/Group CEO. Notify Joint Chairs of the ED Forum.via SDU and appropriate internal/external stakeholders Inform the public via a press release that capacity issues have necessitated the activation of the Full Capacity Protocol. Activate ambulance divert protocol as appropriate **Begin placement of <u>additional trolleys / beds</u> on each inpatient ward in pre-determined area according to agreed rotation**. All elective procedures to be reviewed and cancelled where appropriate in consultation with relevant consultant. Available elective medical and nursing staff redeployed to acute service to facilitate patient flow discharge where possible. All admissions to cease, except through ED. Any other urgent admissions must be agreed with the Clinical Director The medical rapid response team must meet at 8am and 2pm to review progress to de- escalation. The Clinical Director and Director of Nursing complete a full review of all patients in the hospital with a view to optimising bed capacity and bed utilisation. Responsible persons must repeat certification of this Step at 24 hour intervals and notify the SDU of continuance (trolleygar) Primary, Community and Continuing Care plans escalated to maximum alert to support prioritised and additional discharge packages of care e.g., home care packages, rehabilitation, CIT services, access to long stay beds.	CEO/Hospital Manager/Clinical Director/Director of Nursing/ Consultant in Emergency Medicine	Must be triggered In Hours
De-Escalate		De escalate to steady state –stand down escalation procedures Notify Group/CHO and SDU Liaison Leads and notify Joint Chairs EDTF Review process and learning. Update plans if required. Report as Serious Reportable Event if FCP invoked and review in accordance with national policy	• Joint Chairs EDTF • CEO/Hospital Manager • Director of Nursing • Clinical Director • Consultants in Emergency Medicine	

Trolley Volumes (TrolleyGar)			
	Daily Trolley Threshold	**Daily Trolley Target**	**Daily Target that each hospital would have to achieve to report a green status on the National target of 70**
Beaumont	12	7	6
Galway	12	7	6
OLOL	12	7	6
Cork UH	12	7	4
SVUH	12	7	3
Naas	4	2	3
Limerick	12	7	3
Tallaght	12	7	3
Connolly	8	5	2
Mater	12	7	2
St. Lukes	8	5	2
Sligo	8	5	2
Tullamore	4	2	3
Waterfor	8	5	2
South Tip	4	2	2
Portlaoise	8	5	2
Mayo	8	5	2
Mercy	4	2	2
Portiuncula	4	2	2
Mullingar	8	5	2
Letterkenny	8	5	1
SJH	12	7	1
Kerry	8	5	1
Temple St	8	5	1
Navan	4	2	1
Wexford	8	5	0
Crumlin	4	2	0
Tallaght Paeds	4	2	0
Cavan	8	5	0
Total	**236**	**139**	**64**