An Coimisiún um Chaidreamh san Áit Oibre
Workplace Relations Commission

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WRC Revised Proposals (11th January 2016)

Hospital Emergency Departments

Introduction:

The Commission notes the non-acceptance of Proposals of 14th December 2015 by the INMO, and in particular the concerns expressed by the INMO regarding their lack of confidence in the implementation of those proposals by management. The Commission decided in the light of the announcement of industrial action on January 14th and 26th in certain Hospital Emergency Departments to invite both the HSE and INMO to further talks over the weekend of January 9th/10th.

After an intensive level of engagement and negotiation with and between the parties the WRC has decided to issue additional Revised Proposals with a view towards avoiding disruptive action in Hospital and Emergency Departments.

Commissions 'Revised Proposals:

The Commission believe the attached Revised Proposals, building on the December 14th document, constitute a reasonable and effective basis in assisting both the HSE and the INMO in agreeing the necessary 'confidence measures' which are now required under the original proposals of 14th December 2015.

These Revised Proposals of 11th January 2016 of the WRC are recommended in good faith to both parties for acceptance by the Commission. These Revised Proposals should be given serious consideration by the parties as a matter of urgency.

If accepted, the Commission will reconvene the parties after one month in order to review and evaluate the effectiveness of this Agreement and any implementation issues which may arise.

Signed

Kieran Mulvey
Director General
WRC

John Kelly
Senior Industrial Relations Officer
WRC

January 11th 2016.

WRC Revised Proposals January 11th 2016.

Section 1- Confidence Building – Monitoring / Ensuring Implementation:

The parties acknowledge that there is a very significant lack of communication, trust and confidence, among ED nursing staff, with regard to the full implementation of these proposals.

It is accepted that trust and confidence can only be restored by active, visible and constant monitoring and implementation of any agreement involving senior management staff.

In that context, and as an integral part of this agreement, the following structures will be established immediately:

Group Wide Executive Forum

A Group wide Executive Forum will be established to monitor the implementation of the agreement and specifically the National Escalation Framework (ref: December 2015)

This Forum, which will be established immediately, will have the following membership:

- Group CEO(Forum Chair)/Group Director of Nursing/Group Clinical Director/COO, plus senior level hospital level management and any other grades/professionals as deemed required by the Forum;
- INMO ED representatives, from each of the emergency departments within the Group, and relevant INMO full time Industrial Relations Officers;
- The Group CEOs/or the staff side may require the attendance of other senior managers or clinicians from individual hospitals in the group to address specific issues relating to the implementation of the escalation plan;
- This standing, mandatory, Forum will meet, for the first time, this week and will convene, on a weekly basis, until at least the 31st March; and
- After this date, if agreed by the parties within the Forum, the frequency can move to every two weeks.

The primary purpose, of this Forum, will be the following:

- Specifically review, monitor and ensure that 24/7 application of the system wide escalation framework and procedures to ensure full adherence to all aspects of those procedures;
- Monitor the implementation of all aspects of the agreement which are subject to local application/action;
- To issue, on a weekly basis, a report (copied to the Joint Chairs of the ED Taskforce Implementation Group {Tony O'Brien, HSE/Liam Doran, INMO}) to the National Director Acute Hospitals, detailing the ongoing implementation of the agreement;

- The Chair of the Forum and/or the lead staff side representative may refer, any matter , to the joint chairs, for immediate clarification in the event of any difficulty arising with regard to interpretation of the overall agreement and, particularly the escalation policy; and

- Consider any other matters/actions viewed as essential to improve the environment within the Emergency Department e.g. staffing/proactive rostering of teams across the hospital and other relevant performance indicators.

Hospital level Forum

It is also agreed that, beginning this week, there will be weekly hospital level engagement, between senior hospital management, including the clinical director, and INMO representatives, to oversee the operational implementation of the escalation process locally and clarify all necessary measures required to implement the full escalation policy. This process will ensure:

- The identification of senior decision makers, in ED and core specialisms, at all times within the hospital;

- Ensure that all clinical concerns, held by ED nursing staff, are acknowledged and responded to in a timely manner;

- Review the role of site managers, at weekends, and out of hours managers to ensure that they can immediately identify, and address, all necessary measures in relation to patient flow; and

- To ensure that within the ED there is a senior nurse manager present, on a 7/7 basis, with the necessary autonomy to immediately address all issues to ensure patient flow.

The work/actions/decisions of this hospital level Forum will be advised to the Group Wide Executive Forum on a weekly basis.

Section 2 - Escalation Policy and Health and Safety:

Promoting a Just Culture

It is the policy of the HSE as set out in the National Disclosure Policy that we operate in a just culture and that this would be promoted across the health service.

In line with this policy, staff are encouraged to report incidents, adverse events, near miss events, including their own in the knowledge that there is fair minded and positive treatment of this information and that there are structures in place within each hospital to promote learning from these events and risks.

The Open Disclosure policy is clear that staff will not be held personally accountable for system risks over which they have no control; the HSE will prioritise training and education of this policy for hospitals and nurse managers

Incident and Risk Reporting

The HSE is committed to the continued rollout of the national incident management system with a focus on simplifying reporting and ensuring that information on incidents reported is made available at each level within the hospital, including the emergency department.

Each hospital group through its relevant quality safety and risk function will be responsible for ensuring risks identified within emergency departments are reviewed and reflected in the hospitals risk register. Mitigating actions for these risks will be identified and the quality safety and risk function will be responsible for ensuring staff in emergency departments are kept appraised of these actions on a daily basis and an audit plan set up under a QPS framework to monitor and provide the feedback loop.

Health and Safety

The HSE acknowledges that at each level of escalation there is potential for the emergency department to be operating in a heightened risk state.

When the escalation policy is invoked, it is recognized that the ED is evolving into an unsafe work environment which must then be addressed through the effective implementation of the escalation policy.

The factors contributing to this environment will be the subject of an immediate health & safety risk assessment by hospital management.

In a period of escalation while every effort will be made to ensure there is no diminution in standards of clinical care, the responsibility for maintaining adequate staffing levels appropriate to the level of activity at that time lies with the directorate and/or hospital management who must prioritise staffing of the ED.

During periods of escalation, the provision of good clinical care will continue to be a key priority. In circumstances where staff have not been enabled to deliver this care in a timely manner in line with established clinical protocols, examples of which are set out below, Management reiterate that staff will not be held personally accountable for system risks over which they have no control. We have a shared concern that care is provided in a timely manner including the items listed below:

- Manchester triage system;
- Mews protocol for sepsis;
- Head Injury;
- Administration of medication;
- Non-delivery of fundamentals of care;
- Follow up Investigation results;
- Paediatric protocols to include Children first guidelines, PEWS, discharge planning, parental education.

To the extent that there is delay in this area it will be a call for immediate decision by management and collective implementation in order to reduce the risk. To the extent that these issues persist further escalated action will be required by management. It is anticipated that concerns in this area would be raised by nursing staff in writing or verbally with management.

Due cognisance will be taken by management of the conditions under which staff are working which will include the level of staffing for the level of activity.

Each ED will have its own Health & Safety Statement which will reference the operation of the escalation framework. The establishment of Health & Safety representation will include an INMO representative in each ED department. These functions will be supported as provided for under Part 4 of the safety health and welfare at work act 2005.

Specific measures will be taken to support staff experiencing work related stress. These will be developed within each group and hospital and will include timely access to appropriate occupational health support.

Section 3 - Attracting and Retaining Staff:

Pending the completion of this ED Task Force, on determining staffing levels for ED, it is agreed that it is imperative that immediate measures are taken to address staffing deficits.

The HSE will therefore work with the INMO to identify innovative and progressive mechanisms/initiatives to secure and retain staff to ensure that EDs are adequately staffed at all times.

This is necessary:

- to ensure the implementation of all existing staffing agreements for Emergency Departments;
- to ensure staff have manageable workloads and to minimise concerns regarding safe practice;
- to support improved functioning and management of the ED; and
- that whole hospital patient flow is supported and enabled.

Specifically the HSE and INMO will examine the following:

- all measures necessary to target new graduates and other nursing staff (working with non-permanent contracts) by offering permanent contracts, attractive career structures (including early access to specialist post-graduate programmes) and opportunities for other learning, education and skills development;
- how to ensure the new CNM1 grade will have a leadership role in supporting and mentoring new graduates, and other new nursing staff to ED, in terms of orientation, skills development and training;
- support, as far as possible, flexible working arrangements to enable retention of staff;
- use of targeted and accelerated local recruitment processes to enable early and effective replacement of staff; and
- develop the use of nursing banks to support the filling of rosters pending recruitment of agreed permanent staffing numbers.

The following job descriptions/specifications elaborate upon those described in Paragraph 3 of the Proposals of December 14th 2015.

Job Specifications – ED Discussions

The provisions outlined below are in addition to, and not replacement of, the contents of the nationally agreed job descriptions in relation to the posts of CNM1, CNM2, and ADON, and the

provisions of the generic sections will apply in addition to the specific points raised below. In addition the parties agree in relation to the ADON post that it is desirable for the post holder to have relevant senior ED experience.

CNM1

This post is based in the Emergency Department, and is remunerated at CNM1 grade. The responsibilities include accountability for delivery of direct patient care inclusive of taking an allocation of patients.

The post holder will have specific responsibility for the education, professional development and mentoring of staff to ensure staff meet the required competency to deliver on the agreed standards for patients accessing care via the Emergency Department pathway.

The CNM1 will be liable to work over a 24/7 period.

The CNM1 post is in addition to CNM2 shift leaders and Clinical Facilitators, and will not be used as a replacement. The CNM 1 reports to the CNM 2 shift leader

CNM2 for Admitted patients (Emergency Department)

This post is based in the Emergency Department, and is remunerated at CNM 2 Grade. The responsibilities include the co-ordination and supervision of the Nursing Care of the admitted patients within the Emergency Department, optimally in a designated area for the care of such patients.

This role is distinctly separate from the role of CNM2 (Shift Leader) within the department.

The post holder will have responsibility for the development of policies, procedures and practices, in conjunction with Hospital Management, to ensure the best possible care environment for admitted patients within the ED

The CNM2 (for Admitted Patients) will report to the CNM 3 (ED) and will advise and implement the agreed Nursing Workforce plan for this area, in consultation with both the CNM 3 and the ADON

The CNM 2 (for Admitted Patients) is in addition to the CNM 2 (Shift Leader ED).

ADON Emergency Department

The post is specific to the ED and associated assessment units.

The ADON must have a key role in the management of patient flow from the ED to other departments within the hospital and externally. In order to facilitate this, the ADON is empowered to engage directly with clinical decision makers, nursing managers and via the local management structure with general/ operation managers, (up to and including group CEO).

The reporting relationship for the post holder will be in line with each Directorate/ Hospitals Nursing Management structure.

The ADON will engage and influence the performance of the Hospital patient flow system.

In order to enhance the effectiveness of patient flow across the Hospital, the ADON will engage and influence the prioritisation of patient access to diagnostic facilities.

The ADON has responsibility for developing and enhancing relationships across the Primary and Community Care structures in order to reduce unnecessary attendances and support early discharge to the most appropriate setting.

The ADON will collaborate with established clinical programmes to facilitate timely patient flow, will also collaborate on the introduction of new pathways, and will report on the performance of the patient pathways.

The ADON will identify opportunities to develop IT practices to enhance patient care and flow, and to increase efficiency while decreasing workload e.g. the development of systems to facilitate rapid ordering, tracing, and review of diagnostic testing.

The ADON will be involved in ongoing workforce planning to ensure the availability of appropriate numbers, and levels, of staff to meet patient need including identifying opportunities for the development and roll out of advanced nursing practice roles which could increase the quality of patient care and clinical effectiveness, assist with departmental efficiency, and improve patient flow. The ADON is also empowered to procure additional staff as needed up to and including Agency staff, in accordance with local arrangements, to ensure that the appropriate staffing complement in available.

While recognising that the escalation policy contains automatic trigger, the ADON will be responsible for both ensuring that the policy is promptly implemented and recorded as implemented, as appropriate in accordance with the provisions of the escalation policy, and in action to ensuring that the implementation of the Escalation policy overall, is subject to regular and rigorous review.

The ADON will ensure as part of the management team that prompt action is taken to identify general and specific health and safety risks. To facilitate this, the post-holder will be provided with adequate training and/or in-house support. In addition, the post-holder will introduce appropriate risk elimination measures, or where this is not possible will introduce risk management measures. The process of monitoring and responding to Health and Safety concerns will be ongoing. This will include regular consultation with appointed H&S representatives in the ED.

The ADON will monitor patterns of attendance at the department and use that date to establish patters of inappropriate attendance. Specific steps will be taken by the ADON to address patterns which are identified.

The ADON will lead on Quality improvement methodologies to ensure the delivery of safer better healthcare across the Emergency Department patient pathway.

The ADON will lead on the Quality Assurance and Verification agenda to ensure the delivery of safer better healthcare across the Emergency Department Patient Pathway.

Section 4 - Commission Proposals of 14th December 2015:

The above Revised Proposals are in addition to the measures recommended in the Commission proposals of 14th December 2015.

Appendix

11 January 2015

System Wide Escalation Framework and Procedures

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 adopted in consultation with INMO local ED Representatives 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. It is agreed that the activation of Step 1 in the Escalation Plan simultaneously recognises that the workplace is evolving into an unsafe environment with a heightened level of risk.

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" AMUs, e.g. SAUs, Minor Injury Units, ambulatory and frailty pathways;
- Ineffective daily management of throughput and addressing operational bottlenecks in acute centric timing i.e. 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 e.g. 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 Emergency Department is fully staffed based upon its current agreed staffing levels (ref Note 2 of Step 1) (Steady State Step 1).

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. An agreed recording system at both hospital manager and senior ED nursing level will be agreed and retained at each site.

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 and on inpatient environs. The activation of ambulance divert protocol to provide protection to the hospital from new demand is equally a legitimate response as part of the last resort measures. 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. A decision to activate the ambulance divert protocol is a specific function of the hospital management team in the first instance and after that the Group CEO in conjunction with the National Ambulance Service (NAS). Within Dublin diversion can operate across group boundaries where appropriate and required. Where either last resort measures are 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 (e.g. 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. The SDU in conducting a review will engage with the INMO Representative and the Safety Representative of the Emergency Department.

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, staffed in accordance with agreed staffing levels (see note 2) 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
		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. Identification and recording of ED as evolving into an unsafe working environment arising from escalation may require increase in staffing. This will also impact the relative safety of the workplace under the SHW Act 2005.	• Lead Physician AMAU/MAU • Case Manager/Patient Flow Manager/Bed Manager (lead person) *to liaise with* Director of Nursing Service Nurse Manager • • Manager/designate and most senior nurse manager in the ED.	Site Manager/ On call team

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	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). Ensure senior clinical medical decision maker presence in ED for the duration of the escalation. 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 turnaround 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. Implement triage escalation policy immediately.	• **CEO/Hospital Manager** **Community Health Organisation manager**	**Manager-On-Call**

*** Note 1:** Interim arrangement until recommendations for ED staffing emerge from the Review of Staffing Levels in EDs, point 5 of WRC Agreement.

*** Note 2:** The HSE remains bound by existing agreements and through the WRC and locally pending completion of the review process relating to staffing numbers.

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

	[redacted]	Expedite transfer of patients from ED to allocated beds. Inform Group and CHO Leadership of severity of situation	•All Staff	•All Staff
	[redacted]	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		**Nurse in Charge of Ward must;** • Identify patients who could be discharged pending an urgent investigation slot. • Assess patients who could be safely • 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. **Senior Decision Making Medical Staff must;** • 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	