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| |  |  |  | | --- | --- | --- | | **Huron Perth Healthcare Alliance** | | | | **1. Clinical Policies and Procedures** | Original Issue Date: | August 16, 2018 | | **Patient Flow** | Review/Effective Date: | August 16, 2018 | | **Approved By: VP People and Chief Quality Executive** | Next Review Date: | August 16, 2020 | |
| https://intranet.hpha.ca/myalliance/imgs/spacer.gif |
| This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the document (titled as above) on the file server prior to use. |
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The HPHA will strive to meet the Length of Stay (LOS) (defined as the time triaged to the time the patient leaves the ED) targets for the following:   * Non-Admitted Non-Complex LOS * Non-Admitted Complex LOS * Admitted LOS * Physician Initial Assessment (PIA) - triage date and time to MD Assess Time   The targets are adjusted periodically by HPHA Management Team, based on performance to ensure we are continually striving to improve flow and access.  **1.4** To improve throughput of inpatients and manage capacity by achieving an acute bed occupancy rate of 85% at all HPHA sites.  **1.5** To maintain timely access to level 3 critical care beds by targeting Critical Care Unit (CCU) occupancy under 90%.  **1.6** To optimize access, all planned discharges should occur by 1030, whenever treatment plan allows. Unplanned discharges may occur at any time during day or night; the departure should occur as soon as possible after discharge orders are written.  **1.7** To sustain the culture of person centred care and process optimization that is pivotal in discharge planning and patient flow.  **1.8** To reinforce that patient flow is a collaborative effort between the inpatient units, Emergency Department staff, regulated health care professionals, support services, SW LHIN Home and Community Care, Physicians, Bed Allocator, and outpatient and community resources and is fully supported by the management team.  **2.0 Definitions**   |  |  | | --- | --- | | Admit Same Day | Refers to patients that have a scheduled surgery, will present to hospital on the day of surgery and then be admitted to the inpatient unit post-surgical procedure and recovery room stay. | | Alternative Level of Care (ALC) | The ALC designation applies to any patient who no longer requires the intensity of resources of the bed they are occupying but cannot be discharged to their next destination for any reason. ALC can apply to patients in Medicine, Surgical, Pediatric, Telemetry, ICU, Obstetrical, Rehab, CCC or Mental Health beds. The hospital does not receive funding for ALC patients. ALC patients block access to beds for those who require the bed the ALC patient is occupying. The ALC order entered into Meditech is sent to the Ministry, who utilize the information to determine what type of resources our communities require to assist in facilitating discharge. | | Bed Allocator | The Bed Allocator role is staffed 24 hours a day 7 days a week. They are responsible for admitting, transferring and discharging patients in the Meditech system as well as decision support about bed moves to provide the right bed type for the patient and to create capacity for all types of admissions. | | Bed Board | Alliance wide Meditech bed capacity viewing tool. | | Bed Management Huddle | Occurs daily at 1030, 7 days per week. Mandatory huddle, attended by ED, OR and PACU, and In-patient unit managers, Team Leaders, Patient Flow Manager, Bed Allocator, Administrator on Call, a Housekeeping representative, SW LHIN Home and Community Care and Infection Control when available. Purpose of the meeting is to view bed availability across the HPHA, review confirmed and pending discharges and known admissions so all are aware of the capacity status of the HPHA and patient flow priorities for the day. Time to inpatient bed metrics is reviewed. This data is obtained from the Patient Flow Huddle Report. Staffing status is also addressed. | | Case Mix Group (CMG) | Refers to a diagnosis upon admission that is applied to the patient, as the most responsible diagnosis for admission to hospital. Each CMG has an accompanying estimated length of stay (ELOS). The ELOS does not take into consideration comorbidities or complications that arise in hospital that would factor into overall length of stay. | | Complex Discharge Reviews | Complex Discharge Reviews occur weekly. Managers, Directors, Team Leaders, Social Work and SWLHIN Home and Community Care meet to discuss patients who are complex discharges to assist in exchanging information and ideas to facilitate discharge planning. | | Conservable Bed Day | Acute Medical, Surgical, Pediatric, Telemetry, ICU and Obstetrical patients are funded based on Case Mix Group (i.e. diagnosis). Comorbidities and complications that arise during hospital stay are taken into account and are required to be documented. If a patient continues their length of stay in an acute bed, beyond their funded length of stay, without a documented acute reason for requiring the bed, and with no Alternative Level of Care (ALC) designation, each additional hospital bed days is referred to as a conservable day. Conservable days are unfavourable and want to be avoided at all costs as it means we have a patient in an acute bed who does not require the acute bed services, that we have not recognized this fact (by designating Alternate Level of Care) and we have not discharged. Conservable bed days result in decreased access to beds for patients that truly require the bed. The HPHA does not receive funding for conservable bed days. | | CritiCall | 24-hour-day emergency referral service for physicians across the Province of Ontario, facilitating advice (consultation) and effecting decisions (patient referral) for life or limb and critically ill patients. Provides one access point for physicians seeking higher level of care (one call to CritiCall Ontario for any physician in the province of Ontario). | | Discharge Rounds | Daily unit based rounds Monday to Friday with Nursing, SWLHIN Home and Community Care, support staff, Allied Health Professionals and when possible Infection Control, Pharmacist, Respiratory Therapy and Physicians present to briefly discuss patient status and barriers to discharge. | | Discharge Time | For all planned discharges, discharge time is by 1030, whenever treatment plan allows. Unplanned discharges may occur at any time during day or night. | | ER admission target = 90 minutes | For all ER admissions, the HPHA has set a goal of a 90 minute maximum target from admit time (which is the time the ER physician completes the admission orders) to left ER (the ER nurses’ documented time that patient left ER). When the target cannot be met due to emergent needs in either the sending or receiving department; communication to Bed Allocator and the nursing department is required so everyone can understand reason for delay and determine next actions to plan for a safe admission. Conference call can be utilized in these situations. See [Admin on Call Conference Calling Standard Work](https://intranet.hpha.ca/myalliance/doc.aspx?id=7747). | | Estimated Date of Discharge (EDD) | Physicians, nurses and Team Leaders are responsible to identify Estimated Date of Discharge within 48 hours of admission (goal of 36 hours). Resources to assist in calculating length of stay include [Case Mix Group Length of Stay Tables 2016](https://intranet.hpha.ca/myalliance/doc.aspx?id=6688), physician & nurse discussion, physician notes and discharge rounds discussion. | | Gridlock Waves | To ensure access to care, patient flow status at HPHA will be communicated using Gridlock waves. Each status level is activated by trigger points and results in specific actions to move the organization back toward green status. [HPHA Bed Flow and Gridlock Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=7450) | | Hip Fracture Process | When the HPHA does not have an orthopedic surgeon on-call and will be unable to meet the 48 hour window from fracture to OR, alternative options should be sought using the [Fractured Hips Process](https://intranet.hpha.ca/myalliance/Default.aspx?cid=5688&lang=1). | | Home First Philosophy | Full support from the entire health care team to discharge the patient home. Hospital staff, the physician and the SW LHIN Home and Community Care as well as the patient and their family will work together towards discharge back to the patient’s home environment whenever it is safe to do so. Emphasis on early discharge planning and prevention of ALC designation. | | ICU Surge | Refers to a specific event, when ICU capacity is at its maximum and all patients within the ICU are “red” status, meaning that the patients require a level of care that can only be provided in the ICU. Surge protocols are clearly defined. | | Internal Transfer | Transfer of a patient within a specific program or across programs but within the same site of the HPHA. | | Internal transfer target = 60 minutes | For transfers between units, the target is a maximum of 60 minutes from assigning of bed by Bed Allocator to time patient left sending unit. When the target cannot be met due to emergent needs on either the sending or receiving unit, communication to Bed Allocator or the nursing department is required so everyone can understand the reason for delay and determine next actions to plan for a safe transfer. Conference call can be utilized in these situations. | | Manager- Patient Flow | The Manager of Patient Flow is responsible for patient flow and bed management across the four sites of the HPHA. This position is responsible for the operational work processes and evaluation of these processes to ensure HPHA bed resources are optimally utilized. This role works closely with the Bed Allocator, Emergency Departments, In-Patient units, Infection Control, Physicians, Managers and SW LHIN Home and Community Care to ensure patients are in the most appropriate available bed for the appropriate length of stay. | | Off-Service | Refers to those patients whose status is or becomes more appropriate for an alternative unit but are unable to transfer immediately due to bed availability. Also refers to patients admitted to the incorrect acute unit due to no bed availability on requested unit. | | ONE Number | Bed Allocator provides ONE Number service. ONE Number is a centralized access point for physicians to access urgent consults or direct admission within 24 to 48 hours, for any HPHA specialty. This is not for internal transfers within the same site of the HPHA. HPHA physicians ARE expected to use this service. | | Patient Flow Huddle Report | A Meditech generated report that prints daily to ED, Bed Allocator and the inpatient units at 0800. These reports are utilized by manager, Team Leader and nursing staff to determine met and unmet ED admissions in the past 24 hours. | | Pulse | HPHA Pulse is a business management tool available 24 hours/day to reflect various patient flow metrics. | | Repatriation | The process of transferring the patient to his or her referring acute care hospital or to an acute care hospital that is closer to his or her home address and can provide the required level of care.  The HPHA is held accountable to the LHIN and CritiCall Ontario for a 48 hour accountability agreement from receipt of repatriation request to patient left sending facility, for all acute repatriations. All acute repatriations must be tracked using the Provincial Hospital Resource System (PHRS) repatriation tool.  Stroke repatriation has a 24 hour accountability timeline.  Code STEMI: STEMI’s (ST elevated MI’s) that are sent from ED directly to the catheter lab will be accepted back the following morning for repatriation, whenever requested. The ED Registration Clerk gives notification to Bed Allocator when sending a STEMI patient out and faxes the patient’s face sheets to the Telemetry or Medical unit that will be accepting the patient the next day. | | Stroke Protocol | Stratford General Hospital (SGH) is designated as a District Stroke Centre. SGH is prepared to accept stroke patients from across Huron and Perth counties at all times. The exception to this occurs when the CT scanner is not functioning either due to planned or unplanned reasons. At these times the SGH ER goes on stroke bypass. See [HPHA Stroke Program](http://forms.pkanyware.com/download/?drawer=Stroke) on the StartHub |   **3.0 Policy**  **3.1 Daily Patient Flow Process**  **0830 -1130 -** Inpatient Unit Discharge Rounds take place. Bed Board is updated during or immediately following Discharge Rounds.  **1030 -** Bed Management Huddle- facilitated by Bed Allocator and Manager Patient Flow. Managers and Team Leaders attend, as well as Housekeeping, Infection Control and Admin on Call when able. Agenda:  1) Review bed status across the Alliance  2) Review staffing Issues  3) Assess for Formed Patients in HPHA  **3.2 Inpatient Area Responsibilities**  3.2.1 Ensure effective patient discharge planning is initiated immediately upon admission, including messaging about “Home First” as well as providing and directly discussing the CEO discharge letter. (**Note**: The CEO Discharge Letter is not posted in the Maternal Child area). **See CEO Letter for Inpatient, Forms Online AD0027.**  3.2.2 Ensure Bed Board is up to date 24 hours a day; specifically that the EDD and isolation status are correct and confirmed discharges are updated immediately.  3.2.3 Utilize bedside white boards to communicate discharge related information with patient and family.  3.2.4 Estimated Date of Discharge (EDD): Nursing and Team Leader ensure Estimated Date of Discharge is determined for a patient within 48 hours of admission for acute patients. EDD’s are to be up to date in Bed Board, on Discharge White Boards and on Patient Bedside Whiteboards. Physicians provide input into the EDD.  Mental Health - admissions do not have Case Mix Group estimated length of stay. EDD can be determined via physician and team discharge planning rounds. For some discharge plans, the discharge date is not provided to the patient.  OB - many lengths of stay are shorter than 48 hours. Case Mix Group tables can be utilized to determine LOS, as well as physician input.  3.2.5 If the patient requires Rehabilitation or Complex Continuing Care, completion of the Acute Care to Rehab and CCC referral form is required and is sent, along with accompanying patient care notes and assessments to the SW LHIN Home and Community Care to determine eligibility and load the referral to the requested hospitals’ referral list. For those Team Leaders with Rehab and CCC beds, review the Health Partners Gateway (HPG) website daily to review new referrals and accept/decline referrals within 72 hours of posting. When more information is required for a referral, contact the sending hospital/site/unit to request more information when the application is from within the HPHA.  3.2.6 Ensure patients are discharged from unit as early in the day as possible. For planned discharges, aim for discharge by 10:30 a.m. for those that can have treatments finished and are able to do so. For all unplanned discharges, the departure should occur as soon as possible after discharge orders written.  3.2.7Ensure discharges are called to the Bed Allocator/Registration Clerk immediately to facilitate discharge from the Meditech system and bed turn around. A double identifier of full name and hospital account number is required for verification prior to discharge. The discharge destination must be specific i.e. home with home care, home without homecare, new admission to LTC, return to LTC. An accurate discharge time is required as well.  3.2.8 Ensure accurate and timely information precedes a patient transferring to another unit, hospital or health care institution.  3.2.9 Nurses attend discharge rounds with knowledge of patient’s care plan and barriers to discharge and are prepared to follow the discharge rounds script and meet the discharge rounds expectations. See [Discharge Rounds Questions](https://intranet.hpha.ca/myalliance/doc.aspx?id=6690)  3.2.10 It is a mutual responsibility between all regulated healthcare professionals and physicians to connect during physician rounds or discharge rounds to discuss information about patient’s progress and plan of care.  3.2.11 It is a nursing responsibility to collaborate with the Physician to determine if ALC should be applied to a patient or stopped based on medical stability.  3.2.12 It is the mutual responsibility of the inpatient nurse and ED nurse to ensure that the admitted patient arrives in their inpatient bed as soon as possible after admission orders are written. The Inpatient Unit census can fluctuate beyond capacity temporarily to facilitate pulling admissions from ED or transfers from other units when there are confirmed discharges that have not left their bed yet.  **3.3 ED Responsibilities**  3.3.1 When admission orders are written, ED Registration Clerk or Nurse enters bed request into Bed Board. Ensure accurate request based on – type of bed required, coverage (ward, semi, private) and isolation status. (Stratford Site only)  3.3.2 ED Registration Clerk or Nurse inputs accurate decision to admit time into Meditech bed request to ensure accuracy of Patient Flow Huddle Report. (Stratford Site Only)  3.3.3 ED nurse is responsible for completing the Complex Discharge Screening Tool on all admissions to Telemetry, Surgery and Medicine. Ensure a positive screen is communicated during transfer of accountability with the inpatient nurse and referrals to SWLHIN Home and Community Care and HPHA Social Work are entered into Meditech via Order Entry.  3.3.4 Work with Bed Allocator to facilitate admissions to appropriate bed.  3.3.5 Promote Home First philosophy.  3.3.6 Utilize SW LHIN Home and Community Care to assist in discharge from ED, when appropriate for the patient.  3.3.7 When bed assignment given for the admission, expedite transfer of patient and transfer of accountability to inpatient unit.  3.3.8 ED nurse and inpatient nurse collaborate to arrange transport of the patient to the inpatient unit.  3.3.9 Nurse inputs “left ED time” into Meditech chart, to ensure data quality of Patient Flow Huddle Report.  3.3.10 When code STEMI sent to an outlying hospital from ED, notification is given to Bed Allocator and patient’s ER record is faxed to Telemetry or the Medical unit that will be accepting the patient the following day.  3.3.11 When ED patient is going to the OR, send notification to Bed Allocator. This ensures awareness in case a bed is required post-operatively, for recovery, short stay or admission.  3.3.12 ED nurse notifies Bed Allocator when admitted patient is leaving ED. This allows Bed Allocator to create the inpatient account in time for arrival of the patient.  **3.4 Nursing Manager Responsibilities**  3.4.1 Managers will have a focus on promoting patient flow, 0800-1100, through data review, supporting discharge planning and attending bed management huddle (Managers and Team Leader). Daily Rounding and meeting-free mornings will support this.  3.4.2 Managers will support their staff and actively participate when experiencing difficult discharges by participating in discharge planning meetings as needed and assisting with difficult conversations with patients, families, physicians, and other care providers.  3.4.3 Managers and Team Leaders will be responsible for monitoring alternative level of care and conservable bed days for the unit and working with staff and physicians to manage both.  3.4.4 Team Leaders and Managers are responsible for ensuring the Alternative Level of Care – Long Term Care (ALC-LTC) sign-off process is followed prior to a patient being designated Alternative Level of Care awaiting discharge to a long term care home. They are also responsible for notification to the patient/individual with Power of Attorney and the business office when co-payment will be initiated.  3.4.5 Promote Home First Philosophy  3.4.6 Responsible to ensure bedside white boards, discharge rounds boards and Bed Board are up to date and utilized to full potential.  3.4.7 Attend Complex Discharge Reviews weekly.  **3.5 Allied Health Professionals Responsibilities**  3.5.1Staff from the Departments of Occupational Therapy, Physiotherapy, Social Work, Clinical Nutrition and Speech-Language Pathology will update their coloured magnet indicators on Discharge White Boards, where discharge boards are available, on the inpatient units prior to discharge rounds and throughout their shift as updates are required.  3.5.2 Attend discharge rounds on assigned units daily Monday to Friday, providing input to discharge planning and seeking appropriate patients for consult. Follow-up to receive physician orders to proceed with treatment when appropriate.  3.5.3 Promote Home First philosophy  3.5.4 Attend discharge planning meetings as required to support discharge planning  3.5.5 Communicate with respective Managers to ensure staffing resources are deployed to areas where impact can be made on discharge planning.  3.5.6 Social Workers to attend Complex Discharge Reviews weekly.  **3.6 Respiratory Therapy, Pharmacy Responsibilities**  3.6.1 Attend discharge rounds as required.  3.6.2 Support ED and inpatient units as required.  **3.7 SW LHIN Home and Community Care Responsibilities**  3.7.1 Attend discharge rounds on assigned units.  3.7.2 Assist with discharge planning.  3.7.3 Promote Home First philosophy  3.7.4 Sustain [SWLHIN Home and Community Care Standard Work](https://intranet.hpha.ca/myalliance/doc.aspx?id=6691)  3.7.5 Send a representative to Bed Management daily  **3.8 Housekeeping Responsibilities**  3.8.1Provide housekeeping support to clean discharged beds as first priority.  3.8.2 Use Bed Board as per Standard Work. Housekeeping standard process requires the inpatient units to notify Bed Allocator immediately upon discharge of each patient.  3.8.3 Communicate with inpatient units to learn possible discharges and types of isolations.  3.8.4 Audit Housekeeping processes on an ongoing basis to address any barriers to patient flow.  **3.9 Physician, Residents and Midwife Responsibilities**  3.9.1Admission and discharge of patients is the responsibility of the most responsible physician (MRP)/designate or Midwife and is based on medical needs and available resources.  3.9.2 Persons may only be admitted to the hospital on the order of a Physician/designate or Midwife who is a member of the Professional Staff with admitting privileges.  3.9.3 The admission order must be documented in the patient’s health record and signed by the Admitting Physician/designate or Midwife.  3.9.4 All physicians will promote the Home First Philosophy.  3.9.5 Physicians are to support the HPHA in achieving 85% occupancy across the four sites by assisting with identification of the medical needs of the patient and the site(s) that best fit the needs of the patient.  3.9.6 All admissions throughout the HPHA are communicated to the Bed Allocator who facilitates coordination with the inpatient units and assigns a bed for the patient.  3.9.7 When a patient in the community requires direct admission, the admitting physician/designate or Midwife must contact Bed Allocator and provide details related to patient’s admission, including surname, given name, date of birth, diagnosis, contact information, Health Card Number and required service type. This includes patients who will go to the Operating Room prior to the inpatient unit. When the required bed/service type is not available, the Bed Allocator will assist in arranging a plan for admission, including admission via the local ED if necessary to assess the patient prior to admission. If the patient requires admission at a future date (i.e. to prep for surgery) the Bed Allocator also requires the best contact number for the patient so they can contact them on the day of admission to provide bed number and time to arrive.  3.9.8 Upon admission to hospital a provisional/admitting diagnosis is provided.  3.9.9 If there is a change in the provisional diagnosis, the physician will document in the physician orders “Change diagnosis to \_\_\_\_\_.” The member of the healthcare team processing the order will update the diagnosis on the Meditech Process Intervention screen and the primary and secondary diagnosis in the Admin Data screen, and will contact Bed Allocator to edit the diagnosis in the “reason for visit” field in the admissions module.  3.9.10 The Team Leader and nursing staff will use the provisional or any altered diagnosis to attach a length of stay and estimated date of discharge to the patient. This will be documented by the nurse within the Messages/Discharge Planning Intervention (which updates in Bed Board). Physician input towards the estimated date of medical stability can be used by nursing to assist in calculating and setting an estimated date of discharge. Please note that ELOS is not cumulative (i.e. if patient is admitted with a diagnosis of COPD (with ELOS of 7) and develops Pneumonia (with ELOS of 6), ELOS will NOT be 13).  3.9.11 On the patient’s EDD, the physician must provide one of three things: 1) discharge order, 2) documentation stating acute reason for continued length of stay and a new estimated date of discharge or 3) ALC designation. Please note that Nursing staff may also designate ALC.  3.9.12 For all planned discharges, discharge time is by 1030, whenever treatment plan allows. Unplanned discharges may occur at any time during day or night.  3.9.13 For acute patients, update notes will be entered into Meditech on a daily basis via Patient Keeper, Patient Notes, written notes or by dictation.  3.9.14 It is a mutual responsibility between all regulated healthcare professionals and physicians to connect during physician rounds or discharge rounds to discuss information about patient’s progress and plan of care and plan for discharge.  3.9.15 When MRP will change to a new physician, the current physician speaks to the receiving physician. The current physician writes a change to Most Responsible Physician order on the patient’s chart i.e. “Change MRP to Dr. \_\_\_\_\_.” The newly identified physician becomes MRP immediately. The new physician’s first order on the patient’s chart is that they accept MRP status on this patient i.e. “I accept MRP status for this patient”.  **3.10 Senior Leadership Team and Chief of Staff Responsibilities**  3.10.1 Senior Leadership Team and Chief of Staff are to support and advocate for patient flow initiatives and practices as described in the policy.  3.10.2 Senior Leadership Team and Chief of Staff are responsible for supporting the resolution of conflict-disagreements around patient needs and movement between HPHA sites that arise from physicians, patients and family members.  3.10.3 Senior Leadership Team is responsible in supporting front-line staff, managers and directors in patient flow and discharge planning and for enforcing through Management Team and Administrator on Call, the support of front-line staff and physicians in endeavours to utilize capacity at all sites to promote access for patients.  **3.11 Infection Control Responsibilities**  3.11.1 Attend discharge rounds on assigned units.  3.11.2 Support ED, inpatient units and Bed Allocator as required. See [Infection Control Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=6692)  **3.12 OR Responsibilities**  3.12.1 OR staff inform Bed Allocator as soon as possible about OR add-ons that may require an inpatient Surgical bed.  3.12.2 OR staff inform Bed Allocator as soon as possible when a bed will be required for a short stay patient.  3.12.3 OR staff inform Bed Allocator when a patient who was to be admitted post-operatively is now discharged home.  **3.13 Bed Allocator Responsibilities**  3.13.1 Responsible for admitting, transferring and discharging patients in the Meditech system.  3.13.2 Collaborates with nurses, physicians and infection control to place patients in the right bed, while endeavouring to create capacity for all types of admissions across the HPHA.  3.13.3 Enters all required information for repatriations into the Provincial Hospital Resource System (PHRS), per CritiCall Ontario.  3.13.4 Updates PHRS 4 times daily at required intervals.  3.13.5 Ensures Alternative Level of Care data quality and submission and message failure management for ALC.  3.13.6 Supports time to inpatient bed metrics through resolving and recording barriers.  3.13.7 Supplies information for daily Bed Management huddle.  3.13.8 One Number phone operator. When One Number call results in patient coming to ED for consultation or for admission to inpatient unit, the Bed Allocator will notify the accepting area of the patient’s pending arrival.  3.13.9 CritiCall phone operator.  3.13.10 Records accurate Bed Logs of all admissions.  3.13.11 Registration of direct admissions and contacting patients on the day of direct admission to communicate bed number and time of arrival.  **3.14 Manager Patient Flow Responsibilities**  3.14.1 Supports Bed Allocators.  3.14.2 Monitors patient flow metrics (ALC and conservable bed days, time to inpatient bed etc.) and works to develop strategies to improve patient flow.  3.14.3 Supports internal and external patient flow initiatives, undertakes initiatives to improve patient flow and develops policy and procedures to support HPHA patient flow.  3.14.4 Supports inpatient units with difficult discharges.  3.14.5 Supports patient flow with stakeholders from outside the HPHA.  3.14.6 Ensures Alternative Level of Care data quality and submission.  3.14.7 Attends Complex Discharge Reviews Weekly  **3.15 Administrator on Call Responsibilities**  3.15.1 Attend Bed Management Huddle daily while on call.  3.15.2 Assist with patient flow decisions when assistance required.  3.15.3 Assist with difficult conversations with patients and/or Substitute Decision Makers/Family when required.  **4.0 Procedure**  **4.1 Critical Care Capacity**  4.1.1 ICU bed availability must be maintained for patient safety reasons. The ICU is the only location to optimally provide level 3 Intensive Care at the HPHA, the demand for which is unpredictable and emergent in nature. ICU beds are part of a provincial strategy related to Life or Limb & CritiCall, the SWLHIN surge capacity management and the District Stroke Program.  4.1.2 When a patient meets criteria for transfer out of ICU, the transfer should be done as soon as possible to get ICU to a minimum capacity level of being able to accept 2 level 3 ICU patients. Another inpatient unit may need to go over-capacity by one patient to facilitate this transfer. Further transfers out of ICU are done in priority sequence.  4.1.3 ICU has defined surge protocols. (protocols being revised; please contact ICU)  4.1.4 The unit will strive to meet the required discharges or transfers out every 24 hours to meet the needs of incoming admissions.  [ICU Gridlock Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=7459)  [Minor Surge Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=7460)  [Moderate Surge combined document](https://intranet.hpha.ca/myalliance/doc.aspx?id=7477)  **4.2 Telemetry**  4.2.1 The SGH Telemetry over-capacity location is in the Stroke unit if bed is available as per stroke unit off-service guidelines or in the ED at SGH.  4.2.2 When a STEMI patient is out (i.e. off-site), the 7th Telemetry bed will remain open for return transfer.  **4.3 Assignment of beds to patients in ED**  4.3.1 Once ICU has at minimum, two beds available for level 3 patients, Emergency Department admissions take priority in the organization in order to maintain access to care and to ensure the safety and quality of care for patients.  4.3.2 All staff work towards a target of 90 minute “decision to admit” to “left ED” target for admissions.  4.3.3 Patients can be admitted from the ED to inpatient units at any site within the HPHA. Admissions across sites are to be avoided in the evening and night hours when possible. ED physicians determine the most appropriate service and site(s) for admission based on the medical needs of the patient. Bed Allocator is utilized to determine bed availability 24 hours a day. Over-capacity beds and locations are used as per the [HPHA Bed Flow and Gridlock Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=7450). The appropriate bed service is always looked at being utilized prior to off-service locations.  4.3.4 For patients presenting in ED who do not require acute care, but have social or safety reasons that impact ability to return home, SW LHIN Home and Community Care should be contacted by the assigned nurse. All opportunities for discharge home with community supports should be investigated prior to admission.  **4.4 Medical Bed Assignment Process**  4.4.1 Medicine patients in ICU are provided a Medical bed as first priority if necessary to get ICU to, at minimum, two beds available for level 3 patients. If ICU is in green status, ED takes priority.  4.4.2 Medicine patients in the Emergency Room, repatriations and direct admissions are provided a bed.  4.4.3 All general Medical admissions are assessed and assigned to the most appropriate medical bed across the HPHA taking into consideration the patient’s medical needs and the resources at each site. Admissions across sites are to be avoided in the evening and night hours when possible.  4.4.4 All appropriate Medical beds Alliance-wide are utilized prior to a patient being assigned to over-capacity, or off-service locations.  4.4.5 Inpatients are assessed daily to determine the appropriateness of transfer to an alternative site to continue care in order to support achieving 85% occupancy across the four sites of the HPHA.  4.4.6 Off-service patients are provided a bed.  4.4.7 Off-service patients are chosen to move to correct service, according to priority in the organization at that time (including remaining ICU patients).  4.4.8 All Medicine beds are filled to capacity. When all Medicine beds are full, or the next admission requires resources at one particular site, that site reviews their inpatients for a potential discharge or transfer. If a bed will not be available, overcapacity beds are then utilized. See [HPHA Bed Flow and Gridlock Algorithm](https://intranet.hpha.ca/myalliance/doc.aspx?id=7450)  4.4.9 The inpatient units will strive to meet the required discharges every 24 hours to meet the needs of incoming admissions (please refer to HPHA Pulse).  **4.5 Surgical Bed Assignment Process**  4.5.1 Surgical patients in ICU are provided a surgical bed as first priority if necessary to get ICU to, at minimum, two beds available for level 3 patients. If ICU in green status, ED takes priority.  4.5.2 Surgical patients in the Emergency Department are provided a bed.  4.5.3 Patients that are “Admit Same Days” (ASD) are assigned beds.  4.5.4. Surgical Repatriations will receive a bed.  4.5.5 Surgical add-ons receive beds.  4.5.6 Remainder of “off-service” surgical patients are provided a bed, according to priority in the organization at that time (including remaining ICU patients).  4.5.7 OR schedules will be level-loaded on a daily and weekly basis to optimize patient flow.  4.5.8 In the event that there are not enough beds to assign for admit same day patients, Team Leader & Surgical Unit Manager are to assess all patients for discharge/transfer. All options are identified for meeting needs. If Maternal Child has available beds and nursing resources, consideration of placing gynecological patients on the Maternal/Child Unit. Chief of Surgery is contacted by OR/Surgical Unit Manager to review patients for discharge and Surgical cases for cancellation. Cancellation of surgery should be a last resort.  4.5.9 All Surgical beds are filled to capacity. When all beds are full, each patient is reviewed for potential discharge or transfer.  4.5.10 When all inpatient Surgical beds are utilized, the most stable Surgical patients should be transferred or admitted to the off-service location, making room for the fresh post-op or sickest Surgical patients on the Surgical unit.  **4.6 Mental Health Bed Assignment Process**  4.6.1 Mental Health patients in ICU are provided a bed on Mental Health if necessary to get ICU to, at minimum, two beds available for level 3 admissions. If ICU is in green status, ER patient takes priority.  4.6.2 Mental Health patients in the Emergency Department are provided a bed.  4.6.3 Direct admissions are provided a bed.  4.6.3 Off-service Mental Health patients are assigned a bed.  4.6.4 Over-capacity is within the Mental Health Unit utilizing the 3 additional beds. (Mental Health over-Capacity documents being revised; please contact Mental Health Unit).  **4.7 OB Bed Assignment Process**  4.7.1 The OB unit will occasionally exceed the 11 bed census. The decision to do so is made by the Team Leader/Nurse in charge and the Obstetrical physician on-call. The Manager or Administrator on Call can also be included in decision making when necessary.  4.7.2 When the OB unit is overcapacity, “restricted status” will be entered in the Maternal Resource Board in CritiCall Ontario’s Provincial Hospital Resource System.  **4.8 Paediatric Bed Assignment Process**  4.8.1 Patients age 17 years old and younger will be assigned to Paediatrics, unless diagnosis warrants admission to an alternative unit (I.e. IV drug users). Consult Paediatrician on-call to determine if admission to Paediatric unit is appropriate.  4.8.2 Over-capacity is within the Paediatric Unit.  **4.9 Special Care Nursery**  4.9.1 The Special Care Nursery (SCN) will occasionally exceed the 6 bed census. The decision to do so is made by the Team Leader/Nurse in charge and the Paediatrician on-call. The Manager or Administrator on Call can be included in decision making when necessary.  4.9.2 When the SCN has 4 or less admitted patients, open access is indicated in CritiCall Ontario’s Provincial Hospital Resource System. When 5 admitted patients, “restricted access” is entered and when 6 or more admitted patients, “closed access” status will be entered in the Neonatal Level 2 Resource Board in CritiCall Ontario’s Provincial Hospital Resource System.  **4.10 Complex Continuing Care (CCC) Bed Assignment Process**  4.10.1 SW LHIN Home and Community Care determines eligibility for admission to CCC. All patients from across the region have equal access to CCC beds once deemed eligible.  4.10.2 If the patient applies to a CCC bed within the HPHA, the HPHA determines which site is most appropriate for the eligible CCC patient.  4.10.3 Every attempt will be made to work with patients and the SW LHIN Home and Community Care to ensure that no CCC bed will remain empty if there is a patient with a discharge designation of CCC within the Alliance and the patient’s care needs can be appropriately met in the available CCC bed.  4.10.4 Palliative patients will be admitted to a CCC bed at any site following determination of eligibility.  4.10.5 All patients from across the region have equal access to the Complex Continuing Care beds. Patients are assigned based on a first come, first serve basis and using SW LHIIN Home and Community Care priority codes.  4.10.6 Patients who are ALC-LTC do not meet eligibility criteria for CCC. Patients remaining in hospital waiting LTC can be moved into empty CCC beds. See [Flow Algorithm for Admission of ALC LTC Patients to CCC](https://intranet.hpha.ca/myalliance/doc.aspx?id=6693) and [SWLHIN Eligibility Guidelines Rehab and CCC](https://intranet.hpha.ca/myalliance/doc.aspx?id=6694)  **4.11 Rehabilitation Bed Assignment Process**  4.11.1 SW LHIN Home and Community Care determines eligibility for admission to Rehab. All patients from across the region have equal access to a Rehabilitation bed once deemed eligible. Patients are assigned beds based on a first come, first serve basis and by using SW LHIN Home and Community Care priority codes. The Rehab Unit at the Stratford site is specifically for stroke patients. The Rehab beds at the Seaforth site are for patients with general Rehab needs. See [SWLHIN Eligibility Guidelines Rehab and CCC](https://intranet.hpha.ca/myalliance/doc.aspx?id=6694)  **4.12 Stroke Unit Assignment Process**  4.12.1 All patients across Huron Perth requiring admission to hospital for stroke careare admitted to the Integrated Stroke Unit (ISU) at the Stratford General Hospital District Stroke Centre.  4.12.2 75% of the ISU patient complement must be Stroke or Transient Ischemic Attack (TIA) patients.  4.12.3 Internal Medicine physicians determine the appropriate level of care at time of admission of the acute stroke patient.  4.12.4 ALC Stroke Rehab patients occupying an acute stroke bed will be assessed for movement to an alternative location to facilitate Rehab. See [SWLHIN Eligibility Guidelines Rehab and CCC](https://intranet.hpha.ca/myalliance/doc.aspx?id=6694)  4.12.5 Stroke patients who are identified to require Inpatient Rehabilitation receive this care in the Stroke Rehab beds on the ISU. Stroke patients are required to be deemed eligible for Rehab through the SW LHIN Home and Community Care eligibility criteria. They are assigned an “Urgent” priority code by the SW LHIN. These patients are assigned Stroke Rehab beds on a chronological (i.e. first come first serve) basis. See [HPHA Stroke Program](http://forms.pkanyware.com/download/?drawer=Stroke) on the StartHub.  **4.13 General Guidelines**  4.13.1 Cohorting by gender is preferred, but not mandatory. The patient or Substitute Decision Maker will be advised of the cohorting arrangement.  4.13.2 If patient is occupying an incorrect bed service, but is to be discharged within 24 hours, they will only be moved to appropriate service if bed is required for appropriate service patient.  4.13.3 Bed Allocator makes every attempt to make moves of inpatients prior to 1900 hours, when greater numbers of resources are available.  4.13.4 Do not wake an inpatient and move them to make space for ED admission between the hours of 2300 and 0500 UNLESS ED is declared unsafe and move cannot be avoided. This does not apply to ICU beds.  4.13.5 Patient with longest length of stay in ED will be pulled to inpatient bed first whenever possible.  4.13.6 HPHA policy is that patients will be admitted to the most appropriate bed type which may be located at any one of the Alliance sites. This policy will be communicated through various means to all patients at their initial point of entrance to an HPHA site. Planning for and discussion regarding such moves should occur throughout the daily discharge rounds so patients and families are involved in the planning. Standard checklists will be used to determine appropriate bed type and location, based on the patient’s specific care needs. In the event that a patient, family or member of the healthcare team have concerns about transfer across sites, the discussions begin at the level of the front-line nurses, and physicians and would escalate to manager, then director, then VP. After hours the Administrator on-Call would be contacted. Transport is to be arranged. Concerns can be brought forth to the CEO. |