Emergency Department Overload Plan
Christchurch Hospital
(EDOD Plan)
3rd April 2009

Step		Appendix	
1	Nursing team leaders and doctors in charge of the two ends of the department will maintain a 'capacity status' watch, by regularly completing the RESUS Capacity Plan and WU Capacity Plan and updating the 'capacity flip chart' accordingly.	**A**	RESUS Capacity Plan
		B	Work Up Capacity Plan
2	ACNM and SMO in charge will regularly (and as required), complete an EDOD score for the department, using the EDOD assessment tool and they will respond according to the EDOD Algorithm.	**C**	EDOD Assessment Tool
		D	EDOD Response Algorithm
3	The ED ACNM and SMO will respond to EDOD according to their guidelines.	**E**	ED ACNM / SMO Response to EDOD
4	When in EDOD the Patient Flow/Duty Manager and Clinical Team Coordinator (CTC) will be notified and will respond according to the guidelines.	**F**	Patient Flow / Duty Manager Response
		G	CTC Response
5	Specific responses to help alleviate EDOD may be instituted by the ED ACNM or SMO, with assistance from the Patient Flow/Duty Manager and other staff:	**H**	Emergency Department Overflow to OOPD Process
		I	Guidelines for Patients Waiting for a Specialist Registrar
		J	ED to Ward Fast Track Form
		K	Safest Place for Patient Process, Checklist and Protocol

ED Overload Plan – Appendix A

RESUS CAPACITY PLAN

GREEN → **≥ 5 available R bays**

YELLOW → **4 R bays available** *and* ***Unable to move patients into M Bays***

- Identify patients in R and M bays suitable for admission to ED Obs
- Identify unseen patients in R and M bays suitable for transfer to WU
- Identify patients in R and M bays awaiting beds
- Check all beds have been ordered for patients
- Ensure that patients with allocated beds are transferred within 15 minutes
- Team leader/clerical officer notify ACNM/SMO
- Clerical officer ensure Queue screen and Bed management screen up to date
- Ensure ACC forms completed and patients discharged off the attendance screen

ORANGE → **3 R Bays available** *and* ***Unable to move patients into M Bays***

Complete tasks as per Yellow and

- Team leader/clerical officer notify ACNM/SMO
- SMO contact specialty consultants as appropriate
- SMO redistribute medical staff, as appropriate
- Contact CTC for medical assistance as appropriate
- ACNM redistribute nursing staff, as appropriate.
- ACNM/SMO activate EDOD plan, if appropriate, and implement ED overload tasks accordingly. (These tasks include patients in the M bays)

RED → **≤ 2 R bays available** *and* ***Unable to move patients into M Bays***

Complete tasks as per Yellow and Orange and

- Implement EDOD plan tasks as directed.

ED Overload Plan – Appendix B

WORKUP CAPACITY PLAN

GREEN → **More than 5 beds available**

YELLOW → **3-5 empty beds**

- Identify patients suitable for admission to ED Obs.
- Identify patients awaiting beds.
- Check all beds have been ordered for patients.
- Ensure that patients with allocated beds are transferred within 15 minutes
- Team leader/clerical officer notify ACNM/SMO
- Clerical officer ensure Queue screen and Bed management screen up to date
- Ensure ACC forms completed and patients discharged off the attendance screen

ORANGE → **1-2 empty beds**

Complete tasks as per Yellow and

- Team leader /clerical officer notify ACNM/SMO
- SMO contact speciality consultants as appropriate
- SMO redistribute medical staff, as appropriate
- ACNM redistribute nursing staff, as appropriate.
- ACNM/SMO activate EDOD plan, if appropriate, and implement ED overload tasks accordingly.

RED → **Full**

Complete as per Yellow and Orange and

- WU patients should not be cared for by ambulatory staff but if there are sufficient WU staff then 1-2 ambulatory beds can be 'flexed up' into WU beds with WU staff caring for these patients.
- Implement EDOD Plan tasks as directed.

ED Overload Plan – Appendix C

Circle one box for each category, then record as subtotal. Add subtotals for final total **Date:** **Time:**

Points	Scheduled staffing	Points	ED capacity * at night respond to capacity of Resus area only	Points	ED Triage waiting times	Points	Case mix	Points	Speciality patients waiting outside triage times	Points	Seen by a Dr but waiting for specialty teams	Points	Availability of inpatient bed *(includes AMAU & SARA)*
0	Full staff	0	Green capacity in all areas	0	No ED patients beyond triage waiting time	0	No complicated patients in ED	0	< 2 Specialty patients beyond triage waiting time	0	< 3 patients waiting for specialty doctors	0	0-2 patients waiting for inpatient bed
10	1 nurse or doctor reduced and not able to be immediately replaced	10	Yellow capacity in one area	10	1-4 ED patients out of triage time	10	1 complicated patient in ED ***or*** expected within 30min	10	3-5 Specialty patients beyond out of triage time	10	4-6 patients waiting for specialty doctors	10	3-5 patients waiting for inpatient bed
20	2 nurses or doctors reduced and not able to be immediately replaced	20	Orange capacity in one area **or** Yellow in both areas	20	5-11 ED patients out of triage time	20	2 complicated patients in ED ***or*** expected within 30min	20	6-7 Specialty patients beyond triage time	20	6-9 patients waiting for specialty doctors	20	6-9 patients waiting for inpatient bed
30	**> 2 nurses or doctors reduced and not able to be immediately replaced**	**30**	**Orange in both areas or Red in any area**	**30**	**> 12 ED patients out of triage time**	**30**	**3 or more complicated patients in ED *or* expected within 30min**	**30**	**>8 Specialty patients out of triage time**	**30**	**> 10 patients waiting for specialty doctors**	**30**	**> 10 patients waiting for inpatient bed**
Subtotal		Subtotal		Subtotal		Subtotal		Subtotal		Subtotal		Subtotal	

Overload Status **< 30** = No overload; 30 - 49 = Early overload; **50 - 99** = Overload; **≥ 100 or Patients in corridor >30 minutes** = Extreme Overload **Total**

ED Overload Plan – Appendix D

EDOD Response Algorithm

EDOD Score < 30 = No overload

⇒ Continue with 4 hourly EDOD assessments: 0400, 0800, 1200, 1600, 2000, Midnight.

EDOD Score 30 – 50 = Early overload

⇒ Continue with EDOD assessment as above.
⇒ Expedite transfer of patients with allocated beds.
⇒ Review existing nursing and medical resources and redistribute as appropriate.

EDOD Score > 50 = Overload

⇒ Continue EDOD assessment 2 hourly
⇒ Contact Patient Flow/Duty Manager and CTC re: EDOD score inform that in ED overload
⇒ Reorganise nursing and medical resources as necessary.
⇒ Expedite transfer to wards or Reg review.
⇒ Discuss with Patient Flow manager/Duty Manager the 'next patient next bed' process if EDOD score includes 30 points in the 'availability of inpatient beds' section i.e. 10 patients waiting for inpatient beds. At night (2300-0700 hrs) activate 'next patient next bed' at 20 points for this section (6 – 9 patients waiting). ('Next patient next bed' process = ED patients waiting for beds will go to the next available bed, and will not wait for AMAU or other 'better' beds).
⇒ Consult EDOD Plan and respond with most appropriate actions

EDOD Score > 100 or Patient in corridor > 30 minutes = Extreme Overload

⇒ Complete as above and respond as per EDOD plan.
⇒ If at night and ED SMO not in ED, inform on-call SMO.
⇒ Patient Flow/Duty Manager informs Duty Service Manager.
⇒ If 'extreme overload' persists :
  ⇒ > 60 minutes inform the Clinical Director (or Nurse Manager)
  ⇒ > 90 minutes Clinical Director will inform General Manager Med/Surg.

ED Overload Plan – Appendix E
ED ACNM / SMO Response to EDOD

(1) The team leader nurse and SMO (or registrar) for Resus and for WU/A Bays should do a capacity assessment every 2 hours, and as required, and assign a colour code according to the capacity of their area.

The Capacity Flip Chart should be altered to reflect the current capacity state (green, yellow, orange or red) and appropriate actions should be taken (see Appendices 1, 2, 3 and 4).

(2) The ACNM (and Consultant in charge) should conduct regular "stock takes" of the total state of the ED (every 2 hours on the odd hour) and complete an EDOD form (Appendix 3).

(3) If EDOD score is over 50 points then liaise with Duty Manager as per EDOD plan (Appendix 6) and use components of EDOD plan to move patients.

(4) **Perform a <u>Primary Survey</u>** (ABCs – see below) for all areas in the following order:

1. Resus
2. WU
3. Waiting room
4. A Bays
5. ED Obs

Respond according to these priorities:

A. **Patient safety**:

- Are patients stable?
- Are Waiting Room patients safe?
- Is there a working knowledge of all patients?

B. **Patient comfort**:

- Are there patients who should have received analgesia (especially in Waiting Room)?
- Are there patients who should/could be moved into cubicles / ED Obs / inpatient areas?

C. **Appropriate patient disposition**:

- Are there patients who would benefit from being admitted to inpatient area or ED Obs, referred or discharged?
- Are there patients going home/waiting for PES review-who can wait in WR/family rooms?

(5) **Perform a <u>Secondary Survey</u>** – 'clipboard' review of patients to assist with decision making and disposition.

(6) In Extreme EDOD engage non clinical ED doctors and nurses to assist, as appropriate.

(7) Contact inpatient teams to assist with fast tracking speciality patients

(8) **Facilitate communication with outside agencies as required**

- St John Ambulance – 89010
- After Hours (24 Hr Surgery) 365 7777 if AHS has capacity use vouchers as an option for suitable patients (ask ACNM for these) DDI: 353 9958 (24 Hr Surgery Manager)

(9) Plan / distribute tasks with Duty Manager (Appendix 6) and other medical and nursing staff.

Note: The Shift Management Standards and the guidelines for the use of ED Obs beds stress that patients should not overflow into less 'acute' areas ('flex up' but don't 'flex down')

ED Obs beds should only be used for patients with a 90% chance of discharge within 12 hours.

However, in extraordinary circumstances the risk associated with putting WU-type patients in ED Obs beds or Ambulatory beds may be considered to be less than leaving these beds empty. Decisions of this type should only be made by the SMO, CNM/ACNM, and documented in the shift report.

ED Overload Plan – Appendix F
Patient Flow / Duty Manager Response to EDOD

(Tick or cross beside each of the following items, as relevant or as completed)

(1) When contacted about EDOD the following is expected:
- 2.1 Early Overload (points 30-49) - for information
- 2.2 Overload (points ≥ 50) - action required (as below).
- 2.3 Extreme Overload (points ≥ 100) - extreme action required including 'next patient to next bed' and 'best place for patient' processes.

(2) Liaise with the SMO and CNM / ACNM to review the ED Overload Assessment Tool, and the most appropriate actions under the circumstances.

(3) The actions may include any of these;

3.1 **Activate notification cascade via text pagers**
- Pagers will encourage all services to consider activating their 'back-up plans', if their own workload suggests it may be helpful, and to check ED Queue Screen to see if there are patients they could take from ED.

3.2 **Mobilise staff according to specific requirements**.
- Contact additional staff to assist ED according to need eg nursing, clerical, medical, Ward Assistants, cleaning staff etc

3.3 **Arrange for movement of admitted patients to:**
- Inpatient wards if beds are available
- Areas outside of ED eg MDU if there is a delay in finding a bed.

3.4 In 'Extreme Overload': if there are more than 10 patients waiting for a bed, then discuss with DM **'next patient to next bed'**.

3.5 **Notify key management staff re ED situation** according to requirements for assistance.
- Service Managers
- Directors of Nursing
- Operations Managers
- General Manager

(**Note**: If 'Extreme Overload' persists for:
> 60 minutes, ED will notify the ED Clinical Director and
>90 minutes, the Clinical Director will notify the GM of Med/Surg.)

3.6 **Facilitate communication with outside agencies as required;**
- Nursing Homes via the **Transfer of Care Co-ordinator** (Jane Evans)

3.7 **Alert special areas if patients require immediate treatment elsewhere**
- Operating rooms
- Radiology
- Cardiac Catheter Lab
- Radiology
- Angiography suite
- CT

3.8 **Facilitate the use of the EDOD specific responses**, as appropriate:
- Overflow to OOPD process (Appendix 8)
- Guidelines for Patients Waiting for Specialist Registrar (Appendix 9)
- Fast Tracking (Appendix 10)
- Safest Place for the Patient Process (Appendix 11)

3.9 **Mobilise the Service Manager to facilitate the following:**
- The Operations Manager or After Hours on Call Service Manager may be requested to assist in mobilising inpatient teams.
- In consultation with ED SMO and ACNM, consider which services should activate their 'Back-up Plans" and assist these services in doing so.

ED Overload Plan – Appendix G
Clinical Team Coordinator Response to EDOD

1) When contacted about EDOD the following is expected;
   1.1 Early Overload (points 30-49) - for information
   1.2 Overload (points ≥ 50) - action required (as below).
   1.3 Extreme Overload (points ≥ 100) - extreme action required including mobilising all available medical personnel to assist – may include calling extra medical staff and consultants of inpatient teams requiring assistance to clear backlog

(2) Liaise with the SMO and CNM/ACNM to review the ED Overload Assessment Tool, and the most appropriate actions under the circumstances.

(3) The actions may include any of these:
   3.1 **Activate all house officers via text pagers and request assistance**
   3.2 **Mobilise additional medical staff in the hospital according to specific requirements**
   - Contact additional staff to assist ED according to need e.g. house officer to assist with triage 4 and 5 patients
   - House officers to assist in patient teams with admissions or fast tract admissions

   3.3 **Assist with the movement of admitted patients to:**
   - inpatient wards if beds are available
   - areas outside of ED e.g. MDU if there is a delay in finding a bed
   - CTC to liaise with ACMN to identify patients who may be able to be fast tracked. Routine tasks such as suturing may be considered appropriate for house officers to attend to.

   3.4 **In 'Extreme Overload' assist with 'next patient to next bed' plans**
   3.5 **Liaise with DNM re Notification of medical staff re ED situation** according to requirements for assistance
   3.6 **Liaise with DNM re plans to alert or involve special areas if patients require immediate treatment elsewhere**
   - Operating rooms
   - Radiology
   - Cardiac Catheter Lab
   - Radiology
   - Angiography suite
   - CT

   3.7 **Facilitate the use of the EDOD specific responses and medical staff to act according to EDOD processes**
   - Overflow to OOPD process (Appendix 8)
   - Guidelines for Patients Waiting for Specialist Registrar (Appendix 9)
   - ED to Ward Fast Tracking (Appendix 10)
   - Safest Place for the Patient Process (Appendix 11)

   3.8 **Assist in the service manager in the mobilisation of inpatient teams.**
   - In consultation with ED SMO and ACNM, assist the medical personnel of the services required to activate their 'Back-up Plans"

ED Overload Plan – Appendix H
Emergency Department Overflow to OOPD Process

Introduction

During periods of extreme Emergency Department activity with overcrowding some patients may overflow to Orthopaedic Outpatients' Plaster Room to be observed there

Criteria for activation of overflow to the Orthopaedic Outpatients Department

This process can only be activated when the ED Overload Plan is activated. The ED Overload Plan is activated when a threshold number of points are gained. The points are gained from a number of scored parameters of Emergency Department overcrowding.

Activation of ED Overflow

When the ED is in overload then patients may be considered for transfer to the Orthopaedic Outpatients' Plaster Room if the following criteria are met:

(1) Orthopaedic Outpatient Department nursing staff have space and capacity to take these patients. If the OOPD staff consider that they do not have space and capacity then the patient will not be transferred

(2) The patients are waiting for review by the Orthopaedic Registrar e.g. hip, pelvic, leg or back pain with or without fracture, possible bone or joint sepsis, or post-operative orthopaedic patients awaiting review. (**Note:** Consider direct admission to ward instead – discuss with Orthopaedic Registrar)

(3) Patients awaiting the Plastic Surgery or Hands Registrar for assessment of wounds or other injuries with a view to either admission or surgery in the operating theatre

(4) The patients are stable (ie physiological recordings are normal for that patient and are not expected to change within the next 1-2 hours)

(5) Instructions for the nursing staff (regarding observation and plan) are clearly documented in the patient notes

(6) The ED doctor-in-charge or ACNM agree that the patient meets the criteria.

Note:

If the patient is still waiting for registrar review at 2230 hours, when OOPD is due to close, then transfer back to the ED will occur.

If patients cannot be transferred despite meeting the criteria because of lack of space or capacity in OOPD (see 1 above), or if OOPD staff encounter difficulties managing transferred patients, then an incident form should be completed.

The purpose of recording the event is to collate information about the process so that appropriate resources can be obtained or the protocol can be modified.

ED Overload Plan – Appendix I
Guidelines for Patients Waiting for a Specialist Registrar

This guideline is for the patient's primary nurse, the triage nurse, the resus triage nurse or the junior medical staff when referring patients to specialty registrars.

1. Referrals to the Service from the General Practitioner

On arrival of the patient in the ED the Registrar of the service (the Registrar) will be notified and told the Triage Code of the patient.

Triage Code	Triage Standards -Time for pt to be seen within
1	Patient should be seen Immediately. Unless the inpatient registrar is already present, the ED staff will see the patient and call the registrar indicating how soon they would like him or her to attend.
2	Patient should be seen within 10 minutes. Unless the registrar can come promptly, the ED staff will see the patient and call the registrar indicating how soon they would like him or her to attend. The ED assessment may be a 'rapid assessment' simply to ensure the patient is safe to wait for the registrar.
3	Patient should be seen within 30 minutes*
4	Patient should be seen within 60 minutes*
5	Patient should be seen within 120 minutes*

The registrar will be asked when they expect to be able to see the patient (NB. The Registrar or House Surgeon may see the patient, but a Trainee Intern assessment of the patient is not considered an assessment by a doctor). If that time either exceeds the standards (*for triage category 3, 4 or 5) **or** they do not attend within this time then the Actions listed below should be undertaken.

2. Referrals to the Service from Emergency Department Doctors.

a) The patient is seen by an ED Doctor.
b) ED Doctor refers the patient to the registrar.
c) The registrar is asked if they expect to be able to see this patient within one hour. (NB. The Registrar or House Surgeon may see the patient, but a Trainee Intern assessment of the patient is not considered an assessment by a doctor).
d) If yes - no further action is required.
e) If no, or if they do not come within the hour, then the actions listed below should be undertaken.

Actions

1) Call the registrar and
   a) Remind them they have a patient/patients waiting.
   b) Unless they can come promptly inform them that their Service Back Up Plan should be activated.
2) If they cannot come promptly and they do not indicate that they will activate their Service Back Up Plan, then the ACNM or SMO complete an incident form and notify the ED Consultant.
3) The ED consultant has the following options;
   - Call the registrar her or himself.
   - Call the specialty consultant.
   - Call another registrar, if a different specialty team might be as or more appropriate.
   - Expedite ED review of the patient, with a view to then admitting the patient to the specialist ward (NB the Fast Tracking Patients form should be completed – refer Appendix 10 of this document) or discharging them.

Notes

- The purpose of this guideline is to improve the patient's experience and to free up ED space for other patients.
- The purpose of completing incident forms for long waits is to document the number of times these occur, and the contributing factors, it is not for punitive reasons.

ED Overload Plan – Appendix J

Canterbury District Health Board
Te Poari Hauora ō Waitaha

ED to Ward Fast Track Form

This protocol is to be used when the ED is in EDOD, as determined by the EDOD protocol, and only for patients determined to be suitable by the ED senior doctor.
Suitable patients are those for whom there is a reasonable certainty they need admission under a defined team, and there is a delay before they can be seen in the ED by that team, and who are stable (see definition of the stable patient, in the 'Balancing the Risk Protocol' for guidance).

Note: This form should go in the patient's notes. Please write appropriate plan of care in the clinical notes. Ensure all drugs and fluids are appropriately charted on the QMR0004 and QMR400B charts.

Inpatient label:	**Date**: **Time**:

Brief Diagnosis/Problem List:

Notification of admitting team:
Which team: …… Doctor notified (name): …… Time: ……

Who did the fast tracking: Authorised by: (indicate one)

☐ ED consultant – Name: …….

☐ **Or** Admitting team registrar ☐ **Or** Admitting team consultant

ED doctor who did the fast track assessment – Name: ……..…….

ED nurse who completed fast track arrangements – Name: ……..

Care Plan Recorded in Clinical Notes:
(Please complete all of these in the notes, indicate on this form when done, or N/A if not applicable).

☐ Yes ☐ NA – Analgesia charted

☐ Yes ☐ NA – Antibiotics charted

☐ Yes ☐ NA – Medications charted

☐ Yes ☐ NA – IV fluids charted

☐ Yes ☐ NA – Nil-by-mouth status recorded

☐ Yes ☐ NA – Nursing observations ordered (type and frequency)

☐ Yes ☐ NA – Completed investigations documented

Time of Transfer: ……..

Photocopy this form and keep copy with ED shift report, to record for audit purposes, the fact the patient was 'fast tracked'. Leave original in notes and write in clinical notes that this form has been used.

ED TO WARD FAST TRACK FORM

C000000

ED Overload Plan – Appendix K
Safest Place for Patient Process

Introduction

This process is designed as collaboration between the Emergency Department and inpatient staff so that patients can be accommodated in an environment which is safest for them and for other acute patients, during periods of ED overcrowding.

The protocol involves sending patients to a ward even though the ward does not have a resourced bed available at that time. The reason for this is that they (and other ED patients in corridors) will be more comfortable and better observed in the ward than in the ED.

Criteria for Activation of Safest Place for Patient Process

- This process can only be activated if the ED Overload Plan is activated.
- The ED Overload Plan is activated when a threshold number of points are gained.
- The points are gained from a number of scored parameters of ED overcrowding.

The Safest Place for Patient Process

Patients will be eligible for transfer to a ward even though a resourced bed is not available if:

(1) They have been seen by the inpatient team doctor, have had the admission clerking completed, an appropriate management plan documented and appropriate fluids and drugs charted, or they have been seen by an ED doctor and had the ED to ward fast track form, Appendix 9, completed.

(2) They are stable (i.e. physiological recordings are normal for that patient and are not expected to change within the next 1-2 hours)

(3) The ward chosen for the patient to go to is deemed to be (according to the Duty Manager) an appropriate place for the patient to go.

(4) There are no other 'Safest Place for Patient' patients (i.e. patients waiting for a bed) on that ward at that time

(5) The ED doctor-in-charge or ACNM agree that the patient meets the criteria

(6) The Duty Manager consults with the Ward(s) and provides the necessary information to facilitate the transfer of the patient

NURSING CHECKLIST FOR SAFEST PLACE FOR THE PATIENT PROTOCOL

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Patient Label

Discussed with ACNM or CNM ☐ Yes

Circle the appropriate answers

Does this patient need telemetry?	☐ Yes	☐ No
Does this patient have a GCS of less than 15	☐ Yes	☐ No
Does this patient have a static guard or hospital aide watch?	☐ Yes	☐ No
Does this patient need isolation?	☐ Yes	☐ No
Does this patient need bed in a high dependency area?	☐ Yes	☐ No

If Yes is circled for any of these question the patient CANNOT transfer to the ward under the safest place for the patient protocol

If No is circled for all questions then complete Early Warning Score

Early Warning Score: (circle appropriate recordings, then total score)

Score	*3*	*2*	*1*	*0*	*1*	*2*	*3*
Airway				Patent			*Under threat
Breathing RR/min		<9		9-14	15-20	21-29	>30
Heart Rate/min		<40	41-50	51-100	101-110	111-120	>120
Systolic BP	<80	81-90	91-100	101-170	171-199	>200	
Conscious level/state		New confusion/ agitation		Alert	Responding to voice		No response/ Responds to pain
Urine output*	<10	11-20	21-30	>30			
Temp °C		<35		35-38	38.1-39	>39	
Totals							

*Urine ouput to be averaged over 4 hours. If no IDC – score zero initially and consider bladder scan / IDC if concerned

Score ≤ 5 Patient is able to transfer under this protocol
Score > 5 OR one score of 3 Patient cannot transfer under this protocol

NURSING CHECKLIST FOR SAFEST PLACE FOR THE PATIENT

C240023

FLOWCHART FOR SAFEST PLACE FOR THE PATIENT PROTOCOL