DEMAND MANAGEMENT AND ESCALATION PLAN

POLICY©

DOCUMENT SUMMARY/KEY POINTS

- The aim of this policy is to establish consistent measurement of demand for services and outline appropriate responses to changing service demands. Managing changing demand requires effective communication and cooperation among all hospital services.
- This policy is a guide, as individual triggers may put one department or the whole of hospital into escalation.
- The Bed Manager (BM), Nurse Manager Patient Flow (NMPF) and the After Hours Nurse Manager (AHNM) are responsible for coordinating patient transfers and bed management decisions to meet patient care demand.
- Patient demand is managed according to the four level plan described below that uses traffic light system of **Green**, **Amber**, **Red** and **Black**.

CHANGE SUMMARY

- This policy has been revised to reflect capacity throughout the Sydney Children's Hospital Network (SCHN)
- The document has been revised to remove any duplication in process and replaces the CHW "Demand Management and Escalation" policy and SCH "Overcrowding Escalation Plan".
- **26/6/20**: Minor review. Updated demand escalation matrixes for CHW and SCH. See section 12.1 - 12.4.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st November 2018	**Review Period**: 3 years
Team Leader:	Patient Flow Manager SCH	**Area/Dept**: Patient Flow

READ ACKNOWLEDGEMENT

- Patient Flow staff and all managers of clinical areas are to read and acknowledge they understand the contents of this document.
- Senior Medical staff are to read and acknowledge that they understand the contents of this document.
- Staff working in clinical areas should be aware of this document.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st November 2018	**Review Period**: 3 years
Team Leader:	Patient Flow Manager SCH	**Area/Dept**: Patient Flow

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1 Purpose

The purpose of the Demand Escalation Framework is to strengthen SCHN's (and the 2 hospitals within) capacity to predict, prepare and effectively manage flow, maintaining performance during variations in service demand.

The Demand Escalation Framework is to outline the core business, with clear processes for escalation, communication and accountability.

This document is to provide staff with clear understanding of their roles and responsibilities and accountability for patient flow.

The Demand Escalation Framework operationalises two core elements of the NSW Health Patient Flow Systems:

- Demand and Capacity Planning (CAP)
- Demand Escalation (Short Term Escalation Plans – STEPs)

2 Key Principles

1. Patient centred: patient safety for all patients (current and future) will be the primary consideration for the management of patient flow at SCHN.
2. Patient flow is everyone's responsibility: all staff have a part to play to ensure best possible patient care from admission to discharge.
3. Act early: preventing, predicting and initiating a proactive planned response to managing demand or capacity mismatches will assist in improving patient outcome and reducing avoidable delays in the patient journey.
4. Quality assured: the use of agreed and standardised process to reduce variation will allow for the process to be monitored, reviewed and changed as required.
5. Listening to the system: appropriate communication pathways that allow for timely sharing of this information across the system.
6. Engage and empower: all staff know their roles and are capable of fulfilling their responsibilities in escalation and return to business as usual.

3 Procedure

The patient flow units at SCH and CHW will coordinate the assessment and notification of patient flow capacity and monitor the response to escalation.

The escalation procedure involves three important components:

1. Monitor – Demand and capacity levels monitored in key areas of the hospital
2. Notify – When capacity has been reached in two or more of the key areas of the hospital, a Capacity alert is raised and key staff and roles are notified.
3. Activate – Responses are actioned according to the SCHN STEPs.

3.1 Monitoring of capacity levels

Capacity levels will be monitored at 0800, 1530, and 2230. This is to coordinate with Hospital Team Talk (HTT) and Network Team Talk (NTT) that occur at CHW and SCH at approximately the following times: HTT 09:00 – 10:00, 16:00, 23:00 (21:30hrs on weekends at SCH). NTT 17:00 M-F and 10:00 on weekends.

SCH and CHW have developed a demand management matrix. The matrix scores key triggers that then identify what level each facility is at. There is an in hours and after hours matrix for both hospitals. The matrix is a guide to the capacity level and operational judgement of the NMPF/AHNM will also need to be considered.

(See Appendix 12.1-12.4 for SCHN Matrixes, See Table 1 for SCHN Capacity Alert Criteria).

Key areas such as the Emergency Department (ED), Paediatric and Neonatal Intensive Care Units (PICU/NICU), Operating Suite and Mental Health (MH) should monitor their capacity. Local STEPs should be developed for these areas. Part of this escalation process is the notification of patient flow of the change in their capacity.

3.2 Notify

Reports of the key areas current capacity levels will occur at each team talk. When escalation is underway, additional briefings may be scheduled as required. This capacity level will be described as: *Green (business as usual), Amber (moderate compromise), Red (severe compromise), and Black (extreme compromise).*

The NMPF or AHNM is responsible for deciding the level of capacity of the organisation. This will be done prior to each team talk.

The NMPF is responsible for instigating notification to specific personnel in regards to the level of escalation required. An alert will be deployed by switchboard by pager and selected mobile phones. There will different levels of communication for amber/red/black alerts.

3.3 Activate the SCHN STEPs (Short Term Escalation Plans)

Each capacity level (see Table 1.1) has specific SCHN STEPs. All STEPs from the previous level must be addressed prior to escalating to the next level. STEPs advise alert notifications required, actions to be taken, and the responsible action owners.

Each action owner has a responsibility to notify BM/AHNM as bed capacity is released (e.g. as discharges are identified) via phone, text, page, or email. They are also responsible for escalation of issues through their direct line manager or the AHNM after hours.

Table 1: SCHN Capacity Alert Criteria

Level Green: Business as usual.	Business as usual as identified by the Demand Escalation Matrix. There is adequate capacity to sustain core business; patient flow systems functioning and maintaining performance. **Outcome:** SCHN has optimised bed management and patient flow, proactively managing capacity and demand. Standard hospital operations maintained (e.g. elective surgery, state-wide responsibilities). ED is functioning and meeting all performance indicators. Patients entering ED are placed in a designated patient care space safely and appropriately in a timely manner. There is intensive care capacity for internal and external referrals. Staffing is adequate to meet demand.
Level Amber: Moderate compromise	Moderate compromise to core business activities as identified by Demand Escalation Matrix. There is inadequate capacity to sustain core business; thresholds breached impacting on performance and patient flow. **Outcome:** SCHN has optimised bed management and patient flow, proactively managing capacity and demand with strategies in place to resolve Amber status to Green by the next Hospital Team Talk. Standard hospital operations continue in most service lines. Hospital operations prioritised and rescheduled where required. Patients entering ED are placed in a designated patient care space safely and appropriately in a timely manner.
Level Red: Severe compromise	Severe compromise to core business activities as identified by Demand Escalation Matrix. Core business disruption intensified; all thresholds breached inhibiting performance and patient flow. **Outcome:** SCHN has optimised bed management and patient flow, proactively managing capacity and demand with strategies in place to resolve Red status to Amber by the next scheduled Network/Hospital team talk. Standard hospital operations resume in most service lines. Hospital operations prioritised and rescheduled where required. Patients entering ED are placed in a designated patient care space safely and appropriately in a timely manner.
Level Black: Extreme compromise	Extreme compromise to core business activities as identified by Demand Escalation Matrix. Unable to sustain core business activities; all thresholds breached despite all contingencies fully operational (Level Red status unresolved for more than 24hrs results in escalation to Level Black). **Outcome:** SCHN has optimised all STEPS. Executive on call reviews overall hospital status and declares resolution of capacity alert, or progression to Code Yellow. Strategies in place to resolve Code Yellow/Black status within two hours. Standard hospital operations resume in most service lines. Hospital operations prioritised and rescheduled where required. Patients entering ED are placed in a designated patient care space safely and appropriately in a timely manner. Admitted patients flagged as watchers if they require inter-ward transfer to a more appropriate specialty.

4 Escalation STEPs

4.1 Alert Notifications

ALERT NOTIFICATIONS	RESPONSIBLE PERSON
In hours: Level alert made at the commencement of HTT. Status updated if required prior to completion (those present should include CPDs, NUMS, medical representation, allied health, HITH, and domestic services).	NMPF
Out of Hours: Level alert made at 1600hrs bed meeting, 1700hrs NTT (1000hrs on weekends/public holidays) and 2200-2300hrs handover.	AHNM

4.2 Escalation Level Green: STEPs all Staff

Level Green: Business as usual	
ALERT NOTIFICATIONS/ACTIONS	RESPONSIBLE PERSON
The PFP is up to date with planned PICU/ICU inter-ward transfers (IWT).	NMs/NUMs/TLs
The PFP is up to date with EDDs, W4W, and G2G	NMs/NUMs/TLs
ED identifies patients who will require admission and/or have been in ED greater than four hours.	ED TL
PICU/ICU identifies patients for transfer/discharge each morning by 0630hrs. Allocation of beds discussed with AHNM by 0700hrs and theatres informed if surgical cases requiring PICU bed can be commenced.	AHNM PICU TL
Mon-Fri: Meeting held with BM, NMPF, PICU/ICU NM/TL, OT NUM, WLM, ED and relevant Surgical Ward NUMs to assess ability to proceed with planned elective surgical activity (This meeting varies on both sites).	BM/ NMPF/PICU/ICU NM/TL/ OT NUM/ WLM/ ED/ Surgical NUMs
Mon-Fri: HTT occurs with a representative from all clinical areas, medical, allied health and domestic services.	As mentioned

Mon-Fri: At HTT, the NMPF reports last 24hrs of hospital data including overall ETP, DNWs, and admissions to wards.	NMPF
Mon-Fri: All NUMs/TLs to provide information regarding current status; actual and predicted discharges, expected admissions, staffing shortfalls, and flag any watchers.	All NUMs/TLs
Predicted activity is presented at the SCHN weekly operational meeting to identify areas of mismatch in demand and capacity, so mitigating strategies can be implemented. Weekly data is also presented to identify areas for improvement	NMPF/PICU NM/WLM Attendees at meeting
In-hours: Patient flow team to be notified of 'watchers'	NMPF/BM/AHNM
Out of hours: AHNM to request update on changes to patients 'watcher' status	AHNM
IWTs and IHTs are allocated ward beds and direct ward transfers are arranged in an agreed timeframe.	BM in consultation with accepting medical and nursing teams
All teams update the Estimated Date of Discharge (EDD) on a daily basis or as changes arise.	All medical, allied health and nursing teams
Mon-Fri: At the completion of HTT, the SCHN AM Patient Flow report is sent to SCHN Network executives, CPDs and other key staff. An updated PM Patient Flow report is sent to the Executive on call by 1600hrs.	NMPF
Mon-Fri: CHW and SCH AHNM run NTT with a representative from ED, PICU, NICU, NETS and the Executive unit at 1700hrs. Weekends: NTT at 1000hrs.	As mentioned

4.3 Escalation Level STEPs by Divisional Services: Patient Flow

Level Amber: Moderate Compromise Patient Flow	
ACTIONS	RESPONSIBLE PERSON
To include all Green notifications/actions	
Review of IHTs, emergency theatre list, and elective admission lists with view to cancel or postpone medical and surgical admissions if required, or	BM/NMPF/AHNM

identify alternative models e.g. day care, HITH, CBP for all patients requiring overnight beds.	
Wards or department that are of concern are identified and NMs/CPDs are advised to review staffing levels for each area with view to re-allocating staff to key areas of capacity.	NMPF/BM/AHNM/NMS
Out of hours: Review nursing staff levels / skill mix for next 24 hours with TLs with view to matching staffing to projected activity	AHNM/TLs
In-hours: Request MDU/TUDS to accept patients waiting for treatment prior to discharge.	NMPF NUM Ambulatory Services NUMs/TLs
Review Waiting for Whats and escalate to relevant NUMs/CPDs to action	NMPF/BM/AHNM
Request review of all patients requiring isolation.	NMPF/AHNM
Identify opportunities for back transfer options, including suitable neonates returning to maternity, older adolescents to adult services or privately insured patients to private facilities.	BM/AHNM/NUM/TL/SMO

Level Red Severe Compromise Patient Flow	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Amber notifications/STEPs have been implemented	NMPF/AHNM
In hours: Level RED alert made at the commencement of HTT. Status updated if required prior to completion (those present should include CPDs, NUMS, medical representation, allied health, HITH, and domestic services).	NMPF
Out of Hours: Level Amber alert made at 1600hrs bed meeting, 1700hrs NTT (1000hrs on weekends/public holidays) and 2200-2300hrs handover.	AHNM
In hours: NM ED/TL to alert ED SMO or their delegate of Level Red alert. ED SMO/delegate to	NM ED ED SMO/or delegate

notify Consultants on call if there are patients in ED requiring specialty consultation	
Out of hours: ED SMO/delegate to notify Consultant-on-call if there are patients in ED requiring specialty consultation	ED SMO
NMPF/AHNM notifies CPDs/DCO (in hours) and Executive on call (out of hours) if Level Red Capacity Status will not be resolved by *next scheduled team talk*.	NMPF AHNM
Inpatient areas and JMOs notified by page/ward mobile of Red status (08:00, 15:00, 23:00).	NMPF/AHNM
NMPF/AHNM to notify other SCHN facility of changes in status.	NMPF/AHNM
Urgent review of IHTs, emergency theatre list, and elective admission lists. Non urgent medical and surgical admissions are deferred, or placed in alternative models e.g. day care, HITH or CBP for all patients requiring overnight beds.	BM/NMPF/AHNM/CPDs
Request opening of surge beds, to DCO or Executive on call	NMPF/AHNM
Request staff to open surge beds.	NMPF/NUM/NMS
Wards or department that are of concern are identified and NMS/NMs/CPDs to re-allocate staff to key areas of capacity.	NMPF/AHNM/NMS/CPD
Out of hours: Review nursing staff levels / skill mix for next 24 hours with TLs with view to covering all vacancies to ensure all beds remain open.	AHNM/TLs
Check status of other metropolitan facilities for capacity for IHTs	NMPF/BM/AHNM
Delays in transport (PTS/ASNSW) are escalated to relevant services	NMPF/AHNM
Delays in inter hospital transfers are escalated to relevant LHD PFNM	NMPF
Review unresolved W4Ws and escalate to relevant NUMs/CPDs to action.	NMPF/BM/AHNM

Request review of all patients requiring isolation by infection control.	CNC Infection control
Over census beds to be used on appropriate wards where possible to minimise congestion in ED	NMPF/BM/AHNM
NMPF/AHNM to discuss referral of all urgent admissions to other SCHN site if there is capacity to do so.	NMPF/AHNM

Level Black: Extreme Compromise Patient Flow	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red notifications/STEPs have been implemented	NMPF/AHNM
NMPF/AHNM contacts switchboard to enact a Level Black STEP via page/ text (capacity page).	NMPF
In hours: Level Black alert made at the commencement of HTT. Status updated if required prior to completion (those present should include CPDs, NUMS, medical representation, allied health, HITH, and domestic services).	NMPF
Out of Hours: Level Black alert made at 1600hrs bed meeting, 1700hrs NTT (1000hrs on weekends/public holidays) and 2200-2300hrs handover. AHNM to contact the Executive on call.	AHNM
NMPF/AHNM notifies CPDs/DCO (in hours) and Executive on call (out of hours) of Level Black status. If status will not be resolved by the *next HTT,* Disaster response page to be sent – code yellow for internal emergency.	NMPF/AHNM
Only clinically urgent referrals are accepted. Urgent review of emergency theatre list to prioritise current inpatients. Non urgent medical and surgical admissions are deferred.	BM/NMPF/AHNM/CPDs
Pts with W4W for IHTs are escalated to DCO/Exec on call	NMPF/AHNM
Delays with ASNSW transport are escalated to DCO/exec on call.	NMPF/AHNM

PTS is contacted re hospital status and delays in transport.	BM/AHNM
In-hours: Each ward to identify a patient that can be transferred to MDU/TUDS prior to discharge.	NMPF NUM Ambulatory Services NUM/TL
Pts for discharge to be placed in play room and pt care area cleaned for next admission.	BM/AHNM NUM/TL
Over census beds to be used on appropriate wards were possible to reduce congestion in ED	NMPF/BM/AHNM
All closed beds are used.	NMPF/AHNM
NMPF/AHNM fulfills role as Demand Controller. Areas of concern escalated by BM/CPDS/NUM/TLs escalated to HoDS	NMPF/AHNM
Patients in the ED placed in the most appropriate available inpatient bed and flagged for inter-ward transfer if specialty care is required.	NMPF/BM/AHNM NUM/TL
NMPF/AHNM to discuss capacity for admissions at other SCHN site.	NMPF/AHNM
Request senior medical ward round (CPD, MMPF) of all areas, to identify pts that could be discharged or transferred to other facilities.	NMPF/DCO/MMPF/CPD

4.4 Escalation Level STEPs by Divisional Services: Clinical Program Directors (Medical, Surgical, Critical Care, Priority Populations, CARPA and Diagnostics)

Level Amber: Moderate Compromise Clinical Program Directors	
ACTIONS	RESPONSIBLE PERSON
Liaise with SMOs and NUMs/TLs/CNCs to consider alternative models of care for current or potential inpatients- e.g. HITH; use of MDU (SCH only); outpatient care; ARC; Care by Parent; IHT.	CPDs
Contact inpatient wards to address any areas of delay, capacity concerns.	CPDs

Talk to consultants re plan of care for any patient that has been escalated by NUM/TL	CPDs
Action WFWs that have been escalated by NUMs/TL.	CPDs
Review specialties with increased number of patients with a LOS>9 days. (discuss with HOD)	CPDs
Review planned activity for the next day to see what can be deferred if amber is not going to be resolved.	CPDs

Level Red: Severe Compromise Clinical Program Directors	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Amber STEPs have been implemented	CPDs
Review PFP for patients requiring admission in ED (per specialty). HoDs for these specialties are notified of capacity alert and advised to take action.	CPDs
Consultant-on-call of any medical, surgical or subspecialty service with an admitted patient in ED is contacted.	CPDs
All HoD are notified of hospital status	CPDs
Contact inpatient wards to address any areas of delay, capacity concerns.	CPDs
Talk to consultants re plan of care for any patient that has been escalated by NUM/TL	CPDs
Action WFWs that have been escalated by NUMs/TL.	CPDs
Discuss with NUMs/NMs staffing coverage to assist with nursing workload to maintain capacity.	CPDs
Discuss Junior Medical staffing with CRMO to assist with medical workload.	CPDs
Areas of concern are identified and NMS/NMs/CPDs to re-allocate staff to key areas of capacity.	CPDs
Urgent review of IHTs, emergency theatre list, and elective admission lists with view to cancel or postpone medical and surgical admissions, or identify	CPDs/BM/AHNM

alternative models eg day care or HITH for all patients requiring overnight beds.	
Report back to NMPF any outcome of issues that have been escalated to you (CPD) to resolve.	CPDs

Level Black: Extreme Compromise Clinical Program Directors	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	CPDs
Review PFP for patients requiring admission in ED (per specialty). HoDs for these specialties are notified of capacity alert and advised to ensure patients are reviewed as a priority.	CPDs
Contact relevant teams/HODs to undertake consultant-led “rapid rounds” beginning with access blocked patients in Emergency and inpatient wards for discharge. Consultant or Fellow to lead. Consider treatment in ED, referral to alternate models of care, HITH or private hospital care if appropriate.	CPDs
Talk to consultants re plan of care for any patient that has been escalated by NUM/TL as not having a clear care plan.	CPDs
Report back to NMPF any outcome of issues escalated.	CPDs
Discuss increase in Junior Medical staffing with CRMO to assist with medical workload for the next 24 hours.	CPDs
Areas of concern are identified and NMS/NMs/CPDs to re-allocate staff to key areas of capacity for the next 24 hours.	CPDs
Only clinically urgent referrals are accepted. Urgent review of emergency theatre list to prioritise current inpatients. Non urgent medical and surgical admissions are deferred.	CPDs
All non-urgent multidisciplinary meetings cancelled and off-line clinical staff redeployed to assist patient flow/ patient care.	CPDs

4.5 Escalation Level STEPs by Divisional Services: Waitlist Manager

Level Amber: Moderate Compromise Waitlist Manager	
ACTIONS	RESPONSIBLE PERSON
Elective surgical admission lists to be reviewed with view to prioritisation of admissions, or look at alternative models of care.	WLM

Level Red: Moderate Compromise Waitlist Manager	
ACTIONS	RESPONSIBLE PERSON
Elective surgical admission lists to be reviewed with view to cancellation or postponement of admissions, or look at alternative models of care.	WLM

Level Black: Moderate Compromise Waitlist Manager	
ACTIONS	RESPONSIBLE PERSON
Elective surgical admission lists to be reviewed with view to cancellation or postponement of admissions, or look at alternative models of care for the next 24 hours.	WLM

4.6 Escalation Level STEPs by Divisional Services: Heads of Departments

Level Amber: Moderate Compromise Heads of Departments	
ACTIONS	RESPONSIBLE PERSON
Review plan of care for inpatients with a LOS>9 days.	HoDs
Notify teams of admitted patients in ED requiring early review.	HoDs
Liaise with SMOs and CNCs to consider alternative models of care for current or potential inpatients- e.g. HITH; use of MDU (SCH only); outpatient care; ARC; Care by Parent; IHT.	HoDs

Level Red Severe Compromise Heads of Departments	
ACTIONS	RESPONSIBLE PERSON
Consultants on call notified of Level Red status.	HoDs
Ensure all Level Amber STEPs have been implemented	HoDs
Ensure that consultants and on call teams are aware of hospital status	HoDs
Ensure Consultant-on-call of any medical, surgical or subspecialty service with an admitted patient in ED is contacted to provide consultant-led “rapid rounds” beginning in ED	HoDs
Review allocation of junior staff within service to assist with reviewing and discharging inpatients.	HoDs

Level Black: Extreme Compromise Heads of Departments	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	HoDs
Ensure that consultants and on call teams are aware of hospital status and potential disaster response.	HoDs
Ensure Consultant-on-call of any medical, surgical or subspecialty service with an admitted patient in Emergency is contacted to provide immediate consultant-led “rapid rounds” beginning in ED	HoDs

4.7 Escalation Level STEPs by Divisional Services: Senior Medical Staff

Level Amber: Moderate Compromise Senior Medical Staff	
ACTIONS	RESPONSIBLE PERSON
Junior medical staff are to be notified of Amber status.	SMO
Ensure all patients have an EDD and plan of care documented in progress notes	SMO

Ensure ward rounds occur as early as possible and potential discharges are prioritised.	SMO
Ensure Criteria Lead Discharge (CLD) in place where appropriate	SMO
Consider alternative models of care for current or potential inpatients- e.g. HITH; use of MDU (SCH only); outpatient care; ARC; Care by Parent.	SMO
Identify patients that no longer require tertiary care and can complete care at a local facility. Action requests for review of potential IHT from NUMs/TLs.	SMO
Notify the patient flow team of patients that can be transferred to another facility as soon as possible.	SMO
Ensure consultations are performed in a timely fashion	SMO
Notify HOD or CPD of any problems in actioning discharges.	SMO
Early review of admitted patients in ED	SMO
Liaise with BM/AHNM prior to accepting any IHT	SMO
Discharges identified for the next day and investigations completed.	SMO

Level Red: Severe Compromise Senior Medical Staff	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Amber STEPs have been implemented	SMO
Junior medical staff are to be notified of Red status.	SMO
Ward rounds to occur early and potential discharges prioritised.	SMO
Pending consultations are prioritised.	SMO
Review expected planned admissions for the proceeding days with WM/BM.	SMO

Attend "rapid rounds" with Consultant-on-call beginning in ED	SMO
Review allocation of junior staff within service to assist with reviewing and discharging inpatients.	SMO

Level Black: Extreme Compromise Senior Medical Staff	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	SMO
Ensure that Junior medical staff are aware of hospital status and potential disaster response.	SMO
Ward rounds to occur immediately and potential discharges are prioritised	SMO
Current and planned admissions for the proceeding days are reviewed and postponed with WM/BM.	SMO
Consider discharge for inpatients with an EDD within the next 24 hours with HITH/ARC/MDU follow up.	SMO

4.8 Escalation Level STEPs by Divisional Services: CRMO and Junior Medical Staff

Level Amber: Moderate Compromise CRMO and Junior Medical Staff	
ACTIONS	RESPONSIBLE PERSON
Prioritise discharge planning including identification of actual discharges, completion of paperwork, follow up appointments, and prescriptions.	JMO
Ensure all patients have an EDD and plan of care documented in progress notes – discuss with SMO if unable to be completed.	JMO
Address inpatients with expired EDD	JMO
Ensure communication of discharges and timing at ward Team Talk and to NUM/TL	JMO
Notify SMO of problems in actioning discharges	JMO

Discuss patients that have been identified as being for transfer to a peripheral hospital with consultant.	JMO
Discuss patients for IHT with patient flow team as early as possible (to assist with getting a bed and being able to get transport).	JMO
Ensure consultations occur in a timely fashion	JMO

Level Red: Severe Compromise CRMO and Junior Medical Staff	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Amber STEPs have been implemented	JMO
Action discharges, completion of paperwork, follow up appointments, and prescriptions.	JMO
CRMO/Team to consider reallocation of Junior Medical staff to cover medical workload.	CRMO
Identify patients for IHT/HITH/MDU/TCBP	JMO
Prepare discharge planning for inpatients with an EDD within the next 24 hours.	JMO

Level Black: Extreme Compromise CRMO and Junior Medical Staff	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	JMO
Attend to patients as directed by the SMO (rapid rounds, ward rounds, discharge planning).	JMO
CRMO/Team to reallocate Junior Medical staff to cover medical workload.	CRMO
Identify patients for IHT/HITH	JMO
After discussion with SMO, deferred bookings are communicated to admissions, and discussed with patients and families.	JMO

4.9 Escalation Level STEPs by Divisional Services: Nurse Unit Managers/Team Leaders

Level Amber: Moderate Compromise Nurse Unit Managers/Team Leaders	
ACTIONS	RESPONSIBLE PERSON
In-hours: Watchers are flagged at Hospital Team Talk. NMPF/BM to be notified of changes to patients 'watcher' status	NUM/TL
Out of hours: Watchers require regular review by the TLs. AHNM to be notified of changes to patients 'watcher' status/chase status changes	TL
Consider moving to a team nursing model to assist with skill mix allocation as an alternative to bed closures.	NUM/TL
Escalate to CPDs any patient that does not have a clear plan of care or EDD.	NUM/TL
Escalate to CPD any patient that has a WFW that has not been resolved.	NUM/TL
Review nursing staff levels / skill mix for next 24 hours with NMS with view to matching staffing to projected activity	NUM/ TL
Identify patients suitable for inter ward transfer on the PFP (to make capacity on their ward).	NUM/TL
Identify patients that could complete treatment in MDU/TUDS/TCBP	NUM/TL
Identify delays to discharge and flag patients who are in the hospital beyond EDD with JMO	NUM/TL
Review all pts currently in isolation rooms with a view to de- isolate – liaise with infection control if required	NUM/TL
Identify patients that are out of area and no longer require tertiary care, to be escalated to the patients treating team as possible transfers out.	NUM/TL
Contact Patient Flow to facilitate transfer of patients identified as suitable for IHT.	NUM/TL

Ensure all families are aware of EDD and escalate any barriers to discharge (e.g. social work support).	NUM/TL

Level Red: Severe Compromise Nurse Unit Managers/Team Leaders	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Amber STEPs have been implemented	NUM/TL
Review nursing staff levels / skill mix for next 24 hours with NMS with view to open surge beds (pending physical capacity).	NUM/TL
Identify delays to discharge and flag patients who are in the hospital beyond EDD with SMO immediately.	NUM/TL
Wards to accommodate over census admission (pending physical capacity).	NUM/TL
Confirmed discharges to be relocated to a non-inpatient area to allow bed space to be utilised.	NUM/TL

Level Black: Extreme Compromise Nurse Unit Managers/Team Leaders	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	NUM/TL
Review nursing staff levels / skill mix for next 24 hours with NMS to keep surge beds open (pending physical capacity).	NUM/TL
Confirmed discharges to be relocated to a non-inpatient area to allow bed space to be utilised.	NUM/TL
Each ward to identify a patient that can be transferred to MDU/TUDS prior to discharge.	NUM/TL
Over census beds to be used on appropriate wards to reduce ED congestion.	NUM/TL
All closed beds are used.	NUM/TL

4.10 Escalation Level STEPs by Divisional Services: Ambulatory Care Services

Level Amber: Moderate Compromise Ambulatory Care	
ACTIONS	RESPONSIBLE PERSON
Review admitted ED patients or those awaiting admission and alert the appropriate team if suitable for ambulatory services	Ambulatory Care staff
Review MDU/Turner capacity to accommodate patients waiting for treatment prior to discharge.	Ambulatory Care staff
Discuss with NUMS current inpatients suitable for TUDS/MDU/HITH/CBP/ARC.	Ambulatory Care staff

Level Red: Severe Compromise Ambulatory Care	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Amber STEPs have been implemented	Ambulatory Care staff

Level Black: Extreme Compromise Ambulatory Care	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	Ambulatory Care staff
MDU/Turner to accommodate 1 patient from each ward waiting for treatment prior to discharge.	Ambulatory Care staff

4.11 Escalation Level STEPs by Divisional Services: Infection Control

Level Amber: Moderate Compromise Infection Control	
ACTIONS	RESPONSIBLE PERSON
Identify inpatients that can commence clearance processes.	CNC Infection Control
Identify inpatients that can be cohorted.	CNC Infection Control

Identify inpatients nearing 24 hours of intravenous antibiotics that can be de-isolated.	CNC Infection Control

Level Red: Severe Compromise Infection Control	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Amber STEPs have been implemented.	CNC Infection Control
Review all patients in single rooms.	CNC Infection Control
Identify inpatients that can be cohorted according to policy.	CNC Infection Control
Cohort patients with same MRO strains	CNC Infection Control in consultation with ID/Microbiology

Level Black: Extreme Compromise Infection Control	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	CNC Infection Control

4.12 Escalation Level STEPs by Divisional Services: Mental Health

Level Amber: Moderate Compromise Mental Health	
ACTIONS	RESPONSIBLE PERSON
Review mental health specials daily	Mental Health staff
Consider IHT for any inpatients or patients requiring admission through ED.	Mental Health staff

Level red Severe Compromise Mental Health	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Amber STEPs have been implemented	Mental Health staff

Deploy available staff with appropriate skill mix to other inpatient wards/Emergency if needed for mental health patient.	Mental Health staff
Discuss with team use of overnight leave beds and potential for extension of gate leave if patient not suitable for discharge.	Mental Health staff

Level Black: Extreme Compromise Mental Health	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	Mental Health staff

4.13 Escalation Level STEPs by Divisional Services: Allied Health

Level Amber: Moderate Compromise Allied Health	
ACTIONS	RESPONSIBLE PERSON
Allied health staff to be notified of Amber status by hospital team talk representative.	Allied Health staff
Allied health to collaborate with nursing and medical teams to look at alternative plans for families that can remain in the local area and could continue treatment in MDU/CBP and/or be accommodated in the local area.	Allied Health staff
Pharmacy prioritises discharge scripts from inpatient wards.	Pharmacy staff
Expedite consults for inpatients flagged for discharge.	Allied Health staff
Ensure all inpatients requiring allied health review have active EMR referral	Allied Health staff
Relevant HOD attends weekly chronic patient ward round and escalate any patient to CPD where there are issues impacting discharge.	Allied Health staff

Level Red Severe Compromise Allied Helath	
ACTIONS	RESPONSIBLE PERSON

Ensure all Level Amber STEPs have been implemented	Allied Health staff
Allied health staff to be notified of Red status by hospital team talk representative.	Allied Health staff
After hours staffing reviewed to ensure appropriately skilled clinicians available to facilitate patient discharges.	Allied Health staff
Ensure all unplanned vacant hours/FTEs for inpatients and HITH are filled from casual pool OR existing departmental resource (i.e. part time staff flexing up)	Allied Health staff
Allied health managers informed of patients pending allied health input to facilitate discharge.	Allied Health staff
Allied health clinical time reallocated to inpatients where applicable (e.g. outpatient appointments rescheduled)	Allied Health staff

Level Black: Extreme Compromise Allied Health	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	Allied Health staff
Allied health staff to be notified of Red status by hospital team talk representative.	Allied Health staff
Workload prioritised with medical teams to assess suitability of discharge for inpatients with an EDD within the next 24 hours with HITH/ARC/MDU follow up.	Allied Health staff

4.14 Escalation Level STEPs by Divisional Services: Diagnostics

Level Amber: Moderate Compromise Diagnostics	
ACTIONS	RESPONSIBLE PERSON
Expedite investigations for inpatients flagged for discharge by the NUM/TL.	Diagnostic Staff

Level Red: Severe Compromise Diagnostics

ACTIONS	RESPONSIBLE PERSON
Ensure all Level Amber STEPs have been implemented	Diagnostic Staff

Level Black: Extreme Compromise Diagnostics	
ACTIONS	RESPONSIBLE PERSON
Ensure all Level Red STEPs have been implemented	Diagnostic Staff

5 Surge Beds Guidelines

Surge Beds are additional hospital capacity beds that are not staffed or operational. Surge beds are a way of responding to peaks in demand and can be activated at short notice, with additional staff. The Director of Clinical Operations (DCO) or Executive on call approval is required to open these beds.

5.1 Activation of surge beds

Surge beds maybe activated to assist with demand management for short periods or for longer periods when the demand for inpatient beds is expected to continue i.e. during winter.

Short term activation can occur when the hospital is at AMBER in the escalation plan. As soon as the hospital returns to Green the surge beds should be deactivated. The decision to open surge beds is usually recommended by the Patient Flow Manager or delegate. Approval for the short term opening of the surge beds is by the DCO/Executive on call.

Longer term activation can occur during periods of known or predicted increase in activity. This allows longer term planning for staffing of the beds. Approval for the opening of surge beds for a longer term is required from the DCO.

Opening of surge beds will be done in consultation with the ward NUM or TL. Staffing for these beds will be through the usual strategies.

Opening of surge beds will be documented in the usual process and be reported to Ministry of Health as opened beds and will also be tabled at the Operational Patient Flow meeting.

6 Over Census Beds Guidelines

A over census bed is a bed that is used that is over the opened number of beds on that ward. An over census bed is only available if there is a physical bed space available for use. An over census bed does not require additional staff.

6.1 Activation of Over Census Beds

Over census beds are activated when the hospital is at RED in the escalation plan. The use of the over census beds are to relieve overcrowding in the Emergency Department, create ICU capacity, or place an unexpected urgent admission that would otherwise go to the ED.

Use of an over census bed will be with the following conditions:

- The ward should be staffed for that and the next shift (if possible).
- The acuity on the ward allows for an additional patient to be accepted.
- Skill mix should be appropriate.
- The patient being transferred to the ward should be an appropriate patient.

The decision to activate the over census beds will be made by the NMPF during normal operating hours, with the NUM/team leader and CPDs.

After hours the decision will lie with the AHNM in consultation with the ward TL, after liaison with the Executive on call.

The use of over census bed will be documented in the usual process and be reported to Ministry of Health as opened beds and will also be tabled at the Operational Patient Flow meeting.

7 Process for transferring referrals from one SCHN hospital to the other

The need for the transfer between CHW and SCH should be established before acceptance of the transfer. Patients should only be transferred if they require ongoing tertiary level care. This should always involve discussion with the relevant specialist teams. It is possible that there may be an appropriate alternative hospital to which the patient may be transferred. Please also refer to Ministry of Health's Children and Adolescent – Inter- Facility transfer Policy http://www0.health.nsw.gov.au/policies/pd/2010/PD2010_031.html

- The Bed Manager must be notified by the SCHN accepting doctor of any impending admission in order to establish the availability or non-availability of a bed.
- All patients requiring transfer are to be placed on the Patient Flow Portal by the sending hospital.
- If required, a Pop Up Team Talk should occur (see **Appendix 12.5**)

Should there be capacity issues at the accepting site the admission may not go ahead. Considerations for doing so should take into account patient location, whether the patient is known to either site, the service and care required, and capacity for the admission. The Bed Manager will be responsible for communicating the outcome to the referring hospital and relevant teams.

In the event of a bed not being available the potential for the patient to remain at the referring hospital in the short term should be considered if clinically appropriate. If this is not clinically appropriate the Bed Manager at each site will discuss with involved teams and agree as to where the patient should be placed. If agreement cannot be reached the executive on call is to be notified

It is the responsibility of the accepting team at the SCHN hospital to arrange the bed for the Inter Hospital Transfer (IHT). This is done by contacting the Bed Manager at the SCHN hospital.

The following information is required: name, age, diagnosis, reason for admission, urgency of transfer, infectious status, accepting doctor and estimated date of discharge. A RFA is to be completed. The Bed Manager will contact the sending hospital when a bed is available.

If the accepting team determines that the patient is unable to be transferred directly to an inpatient ward bed within hours, the team is to discuss the transfer with the ED Admitting Officer unless the patient has been accepted by Intensive Care or Mental health services.

The stability of the child's condition and the mode of transport should be discussed with the referring hospital to establish appropriate mode of transfer and escort requirements. The referring hospital will need to arrange ambulance transfer, or NETS retrieval (if a medical team is required) as needed. To discuss with NETS the referring hospital should be asked to call 1300 36 2500 and the SCHN accepting doctor should join the conference call.

8 Definition of Terms

Beds numbers for determining occupancy: The number of inpatient overnight beds that are available for patient use, excludes day areas and ward areas as listed: C2North, C1South West day area, Medical Day Unit, Renal Treatment Centre, Oncology Treatment Centre, imaging suites, Care By Parent, Community Acute Post Acute Care, Telemetry, Intensive Care Units, Grace Centre Newborn Care, Emergency Medical Unit and Emergency Department beds.

9 Abbreviations

ABBREVIATION	DEFINITION
AHNM	Afterhours Nurse Manager
ARC	Acute Review Clinic
ASNSW	Ambulance Service New South Wales
BM	Bed Manager
CBP/TCBP	Care By Parent/Turner Care By Parent
CHW	Children's Hospital Westmead
CLD	Criteria Led Discharge
CNC	Clinical Nurse Consultant
CPD	Clinical Program Director
CRMO	Chief Resident Medical Officer
DCO	Director of Clinical Operations
DNW	Did Not Wait
DON	Director of Nursing
ED	Emergency Department
EDD	Estimated Date of Discharge
ETP	Emergency Treatment Performance
G2G	Good to Go
HITH	Hospital In The Home
HOD	Head of Department
HTT	Hospital Team Talk
ID	Infectious Disease
IHT	Inter Hospital Transfer

IWT	Inter Ward Transfer
JMO	Junior Medical Officer
LHD	Local Health District
LOS	Length of Stay
MDU	Medical Day Unit
MH	Mental Health
MMPF	Medical Manager Patient Flow
NETS	Newborn and paediatric Emergency Transport Service
NICU	Neonatal Intensive Care Unit
NMPF	Nurse Manager Patient Flow
NM	Nurse Manager
NMS	Nurse Manager Staffing
NP	Nurse Practioner
NTT	Network Team Talk
NUM	Nurse Unit Manager
OT	Operating Theatre
PICU	Paediatric Intensive Care Unit
PFP	Patient Flow Portal
PTS	Patient Transport Service
SCH	Sydney Children's Hospital (Randwick)
SMO	Senior Medical Officer
STEP	Short Term Escalation Plan
TUDS	Turner Day Stay
TL	Team Leader
WLM	Waitlist Manager
W4W	Waiting for What

10 Supporting Documents and References

1. Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals PD2011_015 http://webapps.schn.health.nsw.gov.au/epolicy/policy/2644 http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_015.pdf
2. Age for Admission/Treatment – Principles Regarding Inpatient, Outpatient and Outreach Clinic Care and Clinical Research http://webapps.schn.health.nsw.gov.au/epolicy/policy/3249
3. Admissions Policy http://webapps.schn.health.nsw.gov.au/epolicy/policy/3898
4. NSW Ministry of Health Demand Escalation Framework 2015
5. Children's Health Queensland Hospital and Health Service, Patient Flow Escalation Response
6. Respiratory Viral Infection Policy CHW (surge plan) http://webapps.schn.health.nsw.gov.au/epolicy/policy/681
7. Disaster (Randwick Campus Emergency Plan) – SCH http://webapps.schn.health.nsw.gov.au/epolicy/policy/3634/download http://seslhnweb/POWH/documents/Randwick_Campus_Emergency_Plan_Final_2015.pdf
8. Disaster Response Plan CHW Health Plan http://webapps.schn.health.nsw.gov.au/epolicy/policy/4116
9. Children and Adolescent – Inter- Facility transfer Policy http://www0.health.nsw.gov.au/policies/pd/2010/PD2010_031.html

11 Audit/Evaluation Strategy

- Review of hospital status at weekly operational meeting review with actions.

12 Appendices

12.1 SCH Matrix

Facility Demand Escalation Matrix - Sydney Children's Hospital Randwick AM					
Tipping Points	1 Point or each Criteria	2 Point or each Criteria	3 Point or each Criteria	4 Point or each Criteria	total
Available ED accessible beds/Occupancy	9 or more beds (<90%)	4 to 8 beds (90-95%)	1 to 3 beds (96-100%)	0 (100% or greater)	
Overcensus beds in use	N/A	N/A	1	2 or more	
Patients waiting for a bed in ED	0 - 1	2	3	4 or more	
Number of DOSA	6 or less	7-8	9-10	11 or more	
Numbers of booked admissions (for ED accessible	3	4	5	6 or more	
Predicted discharges	20 or more	15-19	14-10	9 or less	
Number of beds closed (any reason)	0	1	2	3 or more	
number of pts LOS> 9 days	< 15	16 - 20	21 to 25	26 or more	
Number of single rooms available.	3	2	1	0	
ICU capacity available beds	3 or more	2	1	0	
Surge Beds in use	N/A	N/A	N/A	Yes	
Patient specials	0	1	2	3	

Level 0 Green	Business as usual	23 or less
Level 1 Amber	Moderate compromise	24-29
Level 2 Red	Severe compromise	30-34
Level 3 Black	Extreme compromise	35 or greater

Date and time _____
Status from score _____
What does the status feel like _____
completed by: _____

12.2 SCH Matrix – after hours

Facility Demand Escalation Matrix - Sydney Children's Hospital Randwick After Hours					
Tipping Points	1 Point or each Criteria	2 Point or each Criteria	3 Point or each Criteria	4 Point or each Criteria	Total
Available ED accessible beds/Occupancy	9 or more beds (<90%)	4 to 8 beds (90-95%)	1 to 3 beds (96-100%)	0 (100% or greater)	
Over Census beds in use	N/A	N/A	1	2 or more	
Patients waiting for a bed in ED	0 - 1	2	3	4 or more	
Predicted discharges	25 or more	20 - 24	15- 19	14 or less	
Number of beds closed (any reason)	0	1	2	3 or more	
number of pts LOS> 9 days (ED accessible beds)	< 15	16 - 20	21 to 25	26 or more	
Number of single rooms available.	3	2	1	0	
ICU capacity available beds	3 or more	2	1	0	
Surge Beds in use	N/A	N/A	N/A	Yes	
pt specials	0	1	2	3	

Level 0 Green	Business as usual	19 or less
Level 1 Amber	Moderate compromise	20 - 25
Level 2 Red	Severe compromise	26 -29
Level 3 Black	Extreme compromise	30 or greater

Date and time _____
Status from score _____
What does the status feel like _____
completed by: _____
Comments

12.3 CHW Matrix

CHW Demand Escalation Matrix - AM					
Tipping Points	1 Point or each Criteria	2 Point or each Criteria	3 Point or each Criteria	4 Point or each Criteria	total
Available ED accessible beds/Occupancy	25 or more beds (<90%)	13-24 beds (90-95%)	12- 1 beds (96-100%)	0 (100% or greater)	
Overcensus/ surge beds in use	N/A	N/A	1	2 or more	
Patients waiting for a bed in ED	0 - 1	2- 3	4-5	6 or over	
Number of DOSA	10 or less	11-15	16-20	21 & over	
Numbers of booked admissions (for ED accessible	4 or less	5 -8	9-11	12 or more	
Predicted discharges	30 or more	25-29	15-24	14 or less	
Number of beds closed (any reason)	0	1-2	3-4	5 or more	
number of pts LOS> 9 days	< 40	41 -49	50 - 59	60 or above	
Number of single rooms available.	3	2	1	0	
ICU & COU capacity (available beds)	5 or more	4	3	2 or less	
PICU/ COU pt's waiting >24 hrs for ward transfer	0	1	2	3 or more	
Patient specials	0	1	2	3	

Level 0 Green	Business as usual	24 or below
Level 1 Amber	Moderate compromise	25 - 31
Level 2 Red	Severe compromise	32 - 39
Level 3 Black	Extreme compromise	40 & above

Date and time _____
Status from score _____
What does the status feel like _____
completed by: _____

24/06/2020

12.4 CHW Matrix – after hours

CHW Demand Escalation Matrix - After Hours					
Tipping Points	1 Point or each Criteria	2 Point or each Criteria	3 Point or each Criteria	4 Point or each Criteria	total
Available ED accessible beds/Occupancy	25 or more beds (<90%)	13-24 beds (90-95%)	12- 1 beds (96-100%)	0 (100% or greater)	
Overcensus beds in use	N/A	N/A	1	2 or more	
Patients waiting for a bed in ED	0 - 1	2- 3	4-5	6 or over	
Predicted discharges	30 or more	25-29	15-24	14 or less	
Number of beds closed (any reason)	0	1-2	3-4	5 or more	
number of pts LOS> 9 days	< 40	41 -49	50 - 59	60 or above	
Number of single rooms available.	3	2	1	0	
ICU & COU capacity (available beds)	5 or more	4	3	2 or less	
PICU/ COU pt's waiting >24 hrs for ward transfer	0	1	2	3 or more	
Surge Beds in use	N/A	N/A	N/A	Yes	
Patient specials	0	1	2	3	

Level 0 Green	Business as usual	19 or under
Level 1 Amber	Moderate compromise	20- 25
Level 2 Red	Severe compromise	26- 31
Level 3 Black	Extreme compromise	32 or over

Date and time _____
Status from score _____
What does the status feel like _____
completed by: _____

12.5 Pop Up Team Talk script

SCH/CHW Pop Up Team Talk on _____ commencing at _____
Issue raised for discussion is _____
When it comes to talking about our patient's safety, we all play an essential role therefore all staff present have an equal voice.

ROLLCALL (REFERRING NMPF/AHNM TO FACILITATE)		
	SCH	CHW
NMPF/AHNM		
Referring Consultant		
Accepting Consultant		
ED NUM/TL/SS/Reg		
ICU NUM/TL/SS Reg		
CPD/DCO/Exec on call		
NETS		
Other		

PATIENT HANDOVER (REFERRING CONSULTANT TO FACILITATE)

- Name, age, diagnosis and history
- Current status and plan of care
- Social alerts/Isolation requirements
- Transport plans
- Bed required (Ward/ICU/Mental Health)

DISCUSSION/OUTCOME (REFERRING NMPF/AHNM TO FACILITATE)

ACCEPTANCE OF TRANSFER (ACCEPTING NMPF/AHNM TO FACILITATE)	
Care assumed by Accepting Consultant	Yes ☐ No ☐ Clinicians name: _____ Review on admission to be performed by: _____
Bed availability	Yes ☐ Time: _____:_____hrs No ☐
Expected time of arrival	____:____hrs
Direct Ward/ICU/Mental Health transfer	Yes ☐ Where: _____ No ☐ Requires review in Emergency☐
Requirements for transfer	Equipment: Yes ☐ No ☐ Medication: Yes ☐ No ☐ Medical Imaging: Yes ☐ No ☐ Discharge Summary: Yes ☐ No ☐ Medical/Nursing Handover: Yes ☐ No ☐
Parent/Carer aware of plan	Yes ☐ No ☐ Parent/Carer to be notified by: _____

UNRESOLVED ISSUES/RISKS REQUIRING ESCALATION TO CPD/DCO or EXEC (ACCEPTING NMPF/AHNM TO FACILITATE)
(Actions to be taken to mitigate issues/risks- Who is responsible for actions?)

TELECONFERENCE: 1800 062 923 **HOST PIN:** 776 527 695 512 **GUEST PIN:** 776 527 690 597