University Hospitals Birmingham NHS
NHS Foundation Trust

CONTROLLED DOCUMENT

FULL CAPACITY PROTOCOL - QUEEN ELIZABETH HOSPITAL

Category:	Procedure
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• **Information for:**	All staff

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1. Introduction

1.1 Patient safety and the provision of high quality care and a good patient experience are the Trust's strategic priorities at all times. Sometimes demand and operational pressures result in ED reaching full capacity

1.2 The Emergency Department (ED) does not have the option to stop demand when all available patient cubicles are occupied. The risk of serious incidents happening increases with every additional patient that arrives over and above capacity. Currently, this risk is concentrated into one geographical area – the Emergency Department.

1.3 This paper sets out a protocol that allows some of this risk to be shared across the organisation, in the safest way possible. It describes the actions necessary when the ED (as the main point of entry for emergency admissions) or Intensive Care Unit (ITU) reaches full capacity. It is not necessarily exhaustive and does not replace the Trusts current escalation policy. The Trust Escalation Policy includes measures that should be adopted early at relatively lower levels of escalation in order to prevent the risks from occurring in the first place. Please refer to the Standard Operating Procedure for Trust Capacity Escalation (ref: 925).

2. Principles of the Full Capacity Protocol

2.1 The Full Capacity Protocol will be partially or fully activated depending upon the number of patients in ED, the number of patients waiting for beds, the number of planned discharges and transfers out of ITU.

2.2 Instigation of the protocol may also be considered if there are overall high levels of acuity of illness in the ED, which are considered to be high risk, regardless of absolute numbers of patients in the department.

2.3 In these extreme circumstances to mitigate the patient safety risk of those patients awaiting access to assessment in ED it will be necessary to transfer patients with a clear decision-to-admit to a ward without a bed being immediately available. The agreed risk assessed areas to safely take an additional patient are detailed in Appendix 1. These designated spaces are not of the same specification to a normal bed space (Section 5) and a risk assessment must be considered before a patient is nursed there.

2.4 The Full Capacity Protocol will be partially or fully activated depending upon the number of patients in ED, the number of patients waiting for beds, number of planned discharges and the specialty match. One-Up or Plus-One beds are designated clinical escalation space.

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2.5 Table 1 below demonstrates the difference between "One Up" and "Plus One"

One-Up bed	Plus-One Bed
A ward has a patient whose discharge has been agreed where the vacated bed will be used to transfer an appropriate patient from SAU, CDU or ED OR the ward needs to admit a patient to avoid cancellation e.g. pre procedure.	Additional in-patient is nursed on the ward. Activation of the Plus-One Bed should be determined by the Divisional Capacity Plan handed over to the Site Team in the Site Meetings, and should be following approval from the Divisional head of Nursing and/or the Divisional Director, or appropriate Deputies. Out of Hours Activation can be made by the Clinical Site manager following discussion with the On Call Manager.
Nurse in charge to identify the most appropriate and suitable patient to be moved to the One-Up bed.	Nurse in charge to identify the most appropriate and suitable patient to be moved to the Plus-One bed.
Nurse in charge to communicate with patient/ family explaining situation and rationale. Communication to be documented in the patients' medical records.	Nurse in charge to communicate with patient/ family explaining situation and rationale. Communication to be documented in the patients' medical records.
Expedite discharge of patient.	Continue to review need for patient to be nursed in Plus-One bed and move to a standard bed space as soon as one is available. If the patient remains in the Plus-One bed for an extended period of time the following escalation should take place: 12 hours – Nurse in charge to communicate with the Clinical Site Manager 16 hours – Clinical Site Manager to communicate with the On Call Manager (out of hours) or Head of Operations (in hours) and a Datix will be completed documenting the actions taken to mitigate the problems.

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	At 24 hours the On Call manager (out of hours) or Head of Operations (in hours) will communicate with the Senior Manager On Call

3. Responsibility

3.1 Between 08.00hrs and 17.00hrs, the decision to instigate the protocol will be made by the Head of Operations following presentation of the Divisional Capacity Plan at one of the Site Meetings. It is the responsibility of Divisional Management Teams to review capacity and demand during the day so that capacity shortfalls can be forecasted and proactively managed.

3.2 Patients being treated in “One Up” beds and “Plus One” beds should be tracked by the Clinical Site Manager with a list being held in the Operations Centre. Deactivation will be discussed at Site Meetings and should occur at the soonest possible opportunity.

3.3 Medical outliers should not go into a plus one bed on a none Div C Ward

3.4 A ward registered nurse must be clearly identified to nurse the patient. All patients’ privacy and dignity will be maintained at all times.

4. Actions

4.1 The actions required when the ED or ITU is operating at full capacity are illustrated in Appendix 2.

4.2 Activation of the protocol will be discussed at the Site meeting when it is understood, which specialty beds are needed, where appropriate discharges have been identified and where there are appropriate patients to move to create flow. The Head of Operations will immediately inform the relevant Divisional Head of Nursing or nominated deputy.

4.3 <u>Speciality In-reach to the Emergency Floor</u>

4.3.1 Each Divisional Head of Nursing will ensure a nominated individual attends the Operations centre to represent the Division, a minimum of 3 times daily to liaise with the Clinical Site Manager. The first attendance must be within 30 minutes of the call to activate the protocol. The Clinical Site Manager must be informed of the name of the nominated individual.

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The priority will be for the Divisional Heads of Nursing (or nominated deputy) to identify patients to move directly to the discharge lounge. If there is a requirement for specialty in-reach into ED this should be considered prior to enacting the policy.

4.3.2 Useful activities include the review of specialty-type patients (regardless of a decision to admit), triage, admission avoidance actions including the provision of early/ immediate outpatient/ ambulatory care clinic appointments, expediting procedures and investigations.

4.3.3 Specialty teams visiting the ED should expect assistance from the junior medical teams in the delivery of their management plans. Clinical Nurse Specialists will be expected to assist with this in-reach work in association with their medical colleagues.

4.3.4 Patients moved to identified beds will be medically clerked within the ward setting. The Divisional Capacity team must track patient clerking, and escalate within the speciality where there is a delay to expedite clerking of patient.

5. Patients Suitable for the One-Up or Plus-One beds

5.1 Patients:

- must be stable (SEWS<3)
- must not be acutely confused
- must not be receiving oxygen
- must not be receiving continuous cardiac monitoring

6. Environmental Requirements for One-Up or Plus-One beds

6.1 Clear of all storage. No consumables or equipment can be stored in the room.
6.2 Have suction, oxygen and nurse call bell in place.
6.3 Window on the door
6.4 Dimmable lighting

7. Triggers for "Plus One"

7.1 Avoiding 12 hour breaches
7.2 Mitigating risk in ED by reducing volume of patients waiting for admission.
7.3 Clinically urgent/time sensitive elective patient.
7.4 Mitigating risk in ITU caused by a backlog of patients waiting to step down.

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Appendix 1: Escalation Bed Locations

Ward	Plus-one	One-Up	Comments
728			No A1 room available. Used as clinic room.
727	Plus-one available	One-Up available	
726	Plus-one available	One-Up available	
620			No A1 room available. Used as clinic room.
306	Plus-one available	One-Up available	
305		One-Up available	Used for admission avoidance (dressings etc)
304	Plus-one available	One-Up available	
303			No A1 room available. Used as on-call dialysis room overnight.
302			No A1 room available. Overspill for Renal Assessment day and night.
513	Plus-one available	One-Up available	
514			No A1 room available. Room used for direct TIA admissions from ED.
515	Plus-one available	One-Up available	
516	Plus-one available	One-Up available	
517	Plus-one available	One-Up available	
518	Plus-one available	One-Up available	
Bournville			No A1 room available
Harborne			No A1 room available
Edgbaston			No A1 room available
West 1			No A1 room available
West 2	Plus-one available	One-Up available	

Appendix 2: Full Capacity Protocol Actions

Risk demand in Emergency Department due to:

- Number of patients in the department
- Number of patients requiring inpatient beds
- No immediate cubicles available

And Site Team have a clear awareness of all expected beds coming up later following a review of Ward Viewer.

Head of Operations to identify that the Full Capacity Protocol is to be activated and contact appropriate Associate Director of Nursing (depending upon Specialty beds required).

Associate Director of Nursing to:

- Facilitate review of identified beds for planned later TCI's
- Facilitate identification of definite discharges with bed availability times
- Facilitate identification of which of the patients could:
    - Move to the discharge lounge
    - Be transferred into a "One Up" room or a "Plus One" room"
    - Sit in the ward environment while waiting for discharge arrangements to be completed.

Associate Director of Nursing to feed back to Head of Operations/ Clinical Site Manager.

Specialty patients to be transferred to the identified specialty bed from SAU or CDU

In times of increased demand in the Emergency Department, the Full Capacity Protocol will be discussed at the 09.00, 12.00 and 16.30hrs bed meetings.

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