The Shrewsbury and Telford Hospital NHS Trust

HOSPITAL FULL PROTOCOL (HFP)

Additionally refer to: **Escalation Policy**
Major Incident Policy

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Lead Director	Director of Nursing, Midwifery and Quality, Chief Operating Officer
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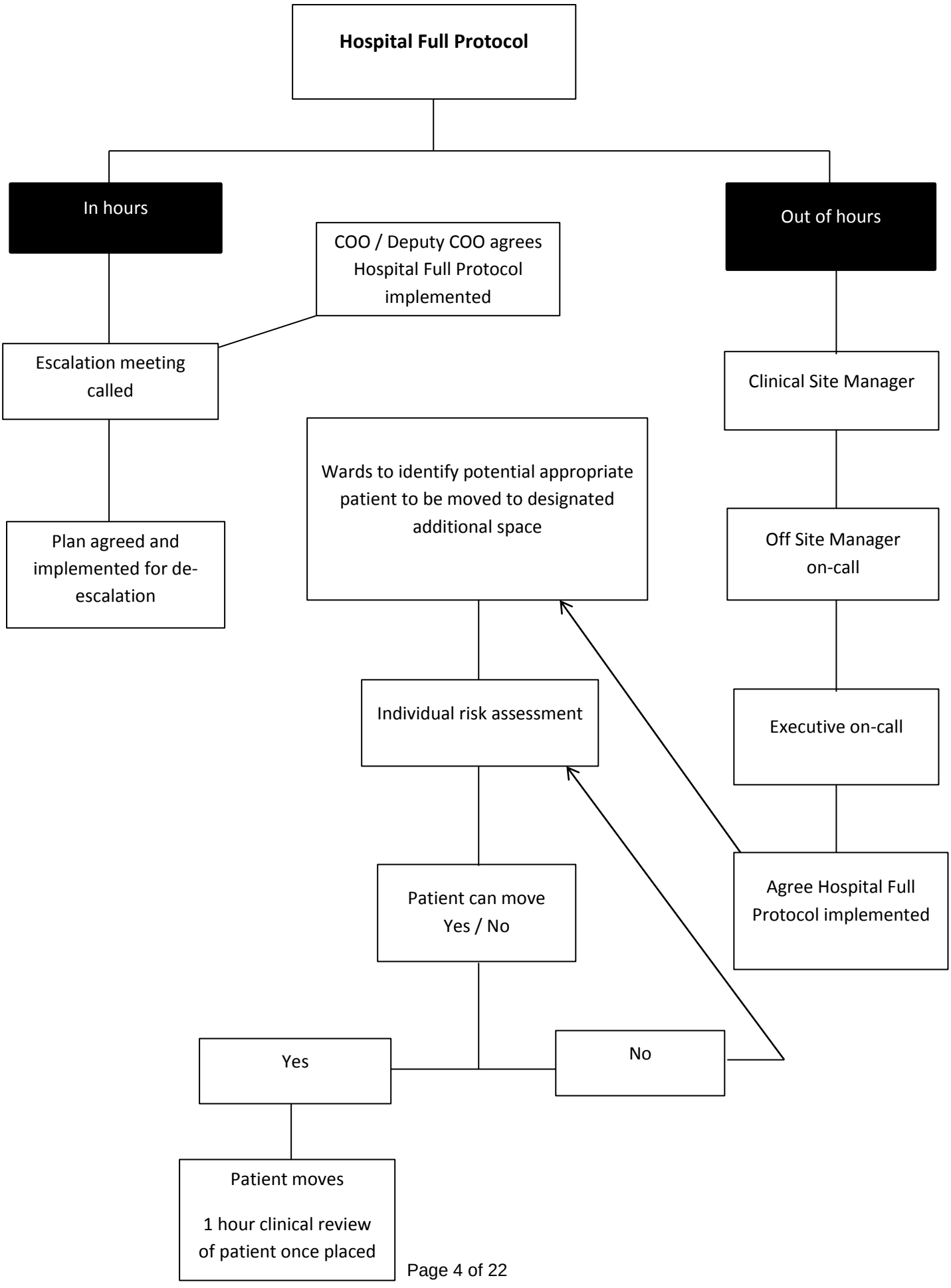

1 Introduction

The maintenance of patient safety and the provision of high quality care and a good patient experience is the aim for The Shrewsbury & Telford Hospitals NHS Trust. Organisational pressures and operational workload can limit the ability of key areas to provide this along with expected patterns of care. When this pressure stops normal daily functioning, it significantly increases the risk of a failure in care occurring.

This protocol is designed to support safety and quality across all areas, including wards, when the hospital is full and clarifies the escalation plan. It also describes the mandated actions necessary when the ED (as the main point of entry for emergency admissions) has more patients than it can potentially safely care for.

There will be times when the hospital needs to operate differently. Balancing and sharing risk is part of the organisations action in discharging its duty of care to patients. A balance of risk has to be achieved to ensure safety and quality is maintained; this protocol is to be used only in exception and not become the norm, when all other actions have been exhausted. This procedure is to be followed and each area is to be individually risk assessed so decisions, when made, ensure patient safety is maintained.

Unlike many other departments, the Emergency Department (ED) is unable to close its doors when all available patient care spaces are occupied. The risk of serious incidents occurring not only increases with every new patient that arrives but is also concentrated in one area. This means that the hospital is holding all of this risk in one area – at the front door. This has a knock on effect to a number of other services including the Ambulance Service cannot respond to emergencies if crews are being prevented from offloading; due to lack of space in ED - this has a knock on effect of putting patients who are at greatest risk being left unseen in the community.

2 Overview

This protocol describes the process of sharing risk across the organisation when the ED has more patients than it can safely care for. It has been documented that patients spending excessive time within the ED increases the mortality across the Trust.

The protocol is a default list of actions and is not exhaustive. It is to be used when the Trust is operating at full capacity. Other measures or situations could still affect the operational safety and are not specifically described here and so should not be excluded. It should also be appreciated that some measures should be adopted early at relatively lower levels of escalation in order to prevent the risks from occurring in the first place.

This protocol is to be activated in agreement by the Chief Operating Officer (COO) or Deputy COO and Medical Director and Director of Nursing, Midwifery, and Quality. Out of Hours, the Executive Director on-call will make the decision in consultation with the off-site Managers and Clinical Site Mangers (CSM).

Allocating one extra patient to suitable wards shares this risk across the Trust and reduces risk within the ED as recommended by the Emergency Care Intensive Support Team.

3 Purpose

- To maintain the safety of patients and staff in the ED;
- To facilitate the admission of patients held in the ED into acute beds or referred and discharged on as required;
- To enable the operational, safe functioning of the ED;
- Maintain patient safety on wards and department areas;
- Maintain staff safety in all areas.
- To provide clear guidance to all staff involved in managing a full hospital

The Hospital Full Protocol is an end state escalation when there is failure to deliver patient flow through daily business as usual. These include:

- Timely assessment In ED and early referral for all patients who require admission.
- Use of alternatives to admission including ambulatory care pathways
- Daily review of all patients in every bed by a consultant/senior decision maker
- Structured board and ward rounds.
- Whole system partnership working to remove barriers to discharge and minimise delayed transfers of care.

4 Activating the Protocol

The HFP describes the actions required when ED has more patients than it can safely provide care for and the actions are intended to instigate a prompt Trust-wide response to promote safety for both patients and staff in ED. The HFP designed in 2 phases.

Phase 1 can be enacted at any time by the Ops Team (Head of Capacity in hours, Off-site Manager out of hours) when:

- ANY patient is waiting for a bed when all ED cubicles are full and ambulances cannot off load within the 15 minute standard.

Phase 2 of the protocol can be enacted by Chief Operating Officer (COO) in response to any of the following:

4.1 RSH site

- A&E department has over 50 patients and **any** of the other 2 triggers:
    - bed occupancy >97%,
    - >5 ambulance handover delays over 60 minutes or
- 10 or more patients awaiting beds that are not immediately available
- Safety concerns raised by ED Consultant in Charge or Nurse in Charge due to overcrowding

4.2 PRH site

- A&E attendances > 60 and **any** of the other 2 triggers
    - bed occupancy >97%,
    - >5 ambulance handover delays over 60 minutes or
- 10 or more patients awaiting beds that are not immediately available
- Safety concerns raised by ED Consultant in Charge or Nurse in Charge due to overcrowding

4.3 Responsibility

Following initial assessment against the criteria noted above, the ED consultant in charge or senior nurse in charge of ED will inform the Head of Capacity (HoC) who must escalate the capacity/flow concerns to the COO and make clear the recommendation to activate the HFP. If the COO is not available, the discussion should take place with the Deputy Chief Operating Officer (DCOO) or deputy chief nurse-operations (DCN) in hours; or Executive on- call out-of-hours.

The protocol will be activated and hourly assessment undertaken of the impact on flow and/or 2 or more wards unable to absorb the additional patient within 4 hours. This assessment will be undertaken by the matrons for each ward area in discussion with the Head of Capacity/ Clinical Site Manager.

The decision to de-activate the protocol or step down certain elements of it will be made by the Chief Operating Officer/Deputy or the Executive on call.

The COO may call an additional Site capacity meeting, to be held in ED if possible and to be attended in hours by:

- Director of Nursing, Midwifery, and Quality
- Medical Director
- ED consultant and Nurse in Charge
- Care Group Medical Directors
- Asst COO for Unscheduled and Scheduled Care
- Centre Managers
- Matrons
- Care Group Director for Support Services
- Hospital Transport Lead Representative and HALO
- Portering, Catering and Support Services Leads
- Pharmacy Lead
- Radiology Lead

The purpose of this meeting is to allocate specific tasks to implement the protocol. This meeting should also reconvene at the point of de-escalation and provide a review of how the escalation was managed.

At the point of activation, there will be a requirement to send additional patients to ward areas to enable the ED function to continue. The order of escalation is detailed at appendix. 1.

4.4 Risk Assessment

A risk assessment prior to moving patients to escalation areas (Ward 8 & 27) is required. (See appendix 2 for specimen risk assessment). This assessment must be undertaken by the nurse in charge of the transferring ward, ensuring that the admission criterion for the ward is met. The receiving ward (ward 8 and ward 27) must check the risk assessment to ensure it meets the criteria of the escalation ward. If the receiving ward disputes the risk assessment then this needs to be escalated to the Head of Nursing or out of ours the Clinical Site Manager (CSM). Authorization to utilise these areas will come from Director of Nursing, Midwifery, and Quality or nominated Deputy in conjunction with the Chief Operating Officer, Deputy COO, ACOO's for USC and SC Groups or nominated deputy.

The decision to admit additional patients to ward areas will be sought by the COO or out-of-hours by the Executive on-call. This decision will be based on the site risk assessment and the ward risk assessment.

When transferring additional patients to wards the following must be adhered to:

- Screens must be available at the time of admission to the ward to maintain privacy and dignity;
- Patients must be clinically stable and not receiving active treatment or monitoring;
- Patients must be orientated and not suffering from Dementia, Delirium, or confused state;
- Patients must not be at risk of falls;

The nurse in charge will need to consider moving a patient out of a bed space into the additional bed space to accommodate the extra patient.

Where a patient is transferred to a ward without a risk assessment being completed and the nurse in charge feels this is a risk, then the receiving ward nurse will need to do a risk assessment and DATIX the event. This will be raised through the daily huddle and actioned by the matron.

Staff should make reference to the following Trust document for further guidance and direction "Risk assessment to support the decision to move a patient where it is not clinically indicated"

- The patient will be allocated to a designated nurse on the ward.

A&E staff should clearly explain to the patient and their next of kin, where they are being moved to and the reason for the move. The Nurse in Charge of the admitting ward should receive and greet the patient and keep the patient and next of kin informed of progress.

Any such incidents should be reported through the hospital Datix system.

5 Duties of Key Personnel

5.1 Chief Executive

The Chief Executive is the Trust's Accountable Officer and is ultimately responsible for the care and functioning of the organisation.

5.2 Chief Operating Officer (COO)

The COO or their deputies are the senior executive responsible for the operational functioning of the Trust in hours and the Executive on call out of hours. Within the constraints outlined within this document they are responsible for activating this protocol, ensuring there is sufficient support for ED (both clinical and non-clinical) and on the wards and that all patients have received a review by a senior clinical decision maker. They are responsible for ensuring systems are in place to liaise with external agencies for support and assistance. The COO will also ensure that all internal and external communications are managed.

5.3 Medical Director

The Medical Director, or their deputy, is responsible for ensuring the overall quality of medical care within the Trust. Within the constraints outlined within this document, they are responsible for providing guidance, advice on medical support to the COO and would seek assurance from the Care Group Medical Directors that medical risk assessments are carried out and contribute to the decision to implement the protocol.

5.4 Director of Nursing, Midwifery & Quality

The Director of Nursing, Midwifery & Quality or their nominated deputy is responsible for ensuring overall governance and quality of care within the organisation. Within these guidelines they must be involved in the decision to activate the Hospital Full Protocol and for overseeing the provision of the Additional Nursing Support and would seek assurance from the Heads of Nursing / Site Head Nurse

that appropriate acuity risk assessments are carried out and contribute to the decision to implement the protocol.

5.5 Head of Nursing

Nursing staff can be re-allocated from a number of locations. It is the responsibility of the Head of Nursing or Head of Capacity, supported by the Matrons to co-ordinate this or allocate a senior individual Matron to perform this role.

The contact senior personnel who will support the re-allocation of staff are as per table below:

Normal working hours (out of hours Clinical Site Manager would reallocate staff – using Safe Care):

Area	Roles	Telephone Number
Outpatients	Patient Access & Outpatient Nursing Support Matron	Ext: 3402
ICU and Endoscopy	ITU Matron / Surgery Matron	Ext: 3906
Blood Transfusion Nurse	Associate Transfusion Practitioner	Ext: 3543 (RSH) / 4369 (PRH)
Clinical Nurse Specialists	Heads of Nursing	Unscheduled Care Ext: 2680 (RSH) / 4420 (PRH) Scheduled Care Ext: 3269 (RSH) / 4420 (PRH)
Corporate Nursing	Deputy Director of Nursing & Midwifery	Ext: 1390

6.6 Head of Capacity

To cascade the status of the hospital, and to enact the Hospital Full Protocol following authorization.

5.7 Clinical Support Services

The Director of Clinical Support Services will ensure all appropriate staff are deployed to the emergency department, AMU and wards to expedite discharges with the clinical teams and avoid admissions. Any outstanding tests or treatments will be chased by the operational team and forwarded to the relevant department for action.

The contact senior personnel who will support the re-allocation of staff are:

Normal working hours (out of hours Clinical Site Manager would reallocate staff):

Area	Role	Telephone Number
Therapies	Centre Manager	Ext: 3945
Radiology	Centre Manager	Ext: 1125
Pharmacy	Head of Pharmacy	Ext: 3800
Pathology	Business Manager	Ext: 3069

5.8 Head of Portering, Security & Housekeeping

Upon activation of the Protocol, the Heads of Portering and Security and Housekeeping should to be contacted to provide additional support to A&E and agree the provision of any additional resources that may be required such as equipment, portering staff, housekeeping, catering requirements and

supplies etc. Representatives should be asked to attend the Site meetings at 08.45 and 15.45 or if an extraordinary meeting is deemed necessary.

5.9 Transport

Upon activation of the Protocol, the need for additional transport support should be determined and if necessary arranged. The patient transport representative will be asked to attend the Site meetings by the HOC/CSM.

5.10 Integrated Discharge Team

To contact the relevant Directors of Services to expedite any outstanding delays.

5.11 Head of Capacity

Contact Local Authority to expedite DTOC delays request spot purchasing of additional beds.

Treat and Transfer cross site

Beds may be available cross site to enable general medical and surgical transfer. Head of Capacity will outline the capacity available and the care groups will agree a treat and transfer plan. This requires specialty registrar to registrar agreement and will be facilitated by the site team. The Deputy Chief Operating Officer will arrange an ambulance divert or Out of Hours Executive on-call.

Cancellation of all Non-Urgent Meetings, Sub Committees and Committees

At the discretion of each Meeting/Subcommittee/Committee Chair during activation of the Hospital Full Protocol, it is expected that some staff may be required to leave all but urgent meetings, even at short notice, to ensure the maximum amount of clinical and management time can be devoted to the Hospital Full Protocol.

Cancellation of Educational Activities

At the discretion of the Medical Director, Director of Nursing & Quality or nominated deputy.

6 Escalation Fracture plan

There may be occasions when the number of patients in ED with limb fractures prevents the normal functioning of the department or they cannot be treated quickly enough to prevent complications. On these occasions, additional staff will be requested and an additional area will be set up to accommodate these patients. The **nurse in charge of ED** will assess the number of patients in the department, their presenting condition and will trigger the request to open the additional area. This request will be made to the ED operations manager or on call manager, both of whom will escalate to the COO/Deputy COO or the Executive on call. Additional requirements to be considered by the operations manager would include:

- additional staff; to manage the additional area;
- one Anaesthetist — to provide sedation;
- one Orthopaedic Registrar or above — to manipulate;
- one senior A&E nurse to plaster and co-ordinate;
- in- hours the assistant COO for scheduled care will co-ordinate the opening of the area and will assist to source the additional requirements.

7 De-Escalation

As part of any process of escalation, de-escalation after any decision to implement the Hospital full protocol is also vitally important. This should not be an onerous task but should be done immediately after a reduction in pressure within ED, and allow the site to be reset back to a normal mode of working. De-escalation will be instructed by the COO or Executive on call when the normal functioning of ED is re-instated.

Wards should be returned to recognised bed capacity levels as safely and as quickly as possible. This will ensure that site normality returns without any compromising of patient care.

- Wards with escalation beds should either discharge patients as planned or agree to move patients to an appropriate bed on another ward. This requirement will be highlighted to the Clinical Site Manager who will arrange the move.
- Staffing should be stood down across wards, department and site move back to normal patient levels.
- Any area used as additional flex should be closed as soon as practically possible, allowing the site to maintain flow and not necessitate a re-escalation. This will be planned with the Head of Capacity/CSM and specialty operations managers/matrons and discussed at the Site Capacity meetings.
- Each area to be reassessed as required by the Director of Nursing, Midwifery, Midwifery, Midwifery & Quality / Deputy in support of the site and Head Nurse to ensure quality and safety are maintained.
- All patients and relatives affected by this protocol are to be communicated to and any reassurance provided by nurse in charge of the wards and departments.

8 Monitoring of compliance

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
A&E Actions		senior nurse and duty consultant in A&E	On activation of protocol	
Frequency of activation		Assistant Chief Operating Officer/Heads of Capacity	On activation of protocol	
Speed of transfer and the provision of the additional nursing support		site team;	On activation of protocol	Quality and Safety Committee
Care of the additional patients on the ward		Head of Nursing and Matrons	On activation of protocol	Quality and Safety Committee

9 Training

There is training associated with this guidance. All senior management on-call staff, and staff in the capacity team must attend a training session with the Emergency Planning and Resilience Officer.

10 Equality Impact Assessment

This document has been subject to an Equality Impact Assessment and is anticipated to have a positive impact by ensuring that risk assessments are carried out for all patients prior to placement

11 Review Arrangements

This document will be reviewed in 1 year of its approval date, or sooner if required. The document will be reviewed in light of feedback and learning from any adverse events. In order that this document remains current, any of the appendices to the protocol can be amended and approved during the lifetime of the protocol without the document having to return to the ratifying committee.

12 Associated Documentation

This policy should be read in conjunction with the Trust Escalation Policy and the Trust Major Incident

Policy.

Appendix 1

Escalation Prioritisation as 28th August 2018

PRH	Order of Priority	Number of Beds
Phase 1		
Ward 7 Bay A	1	6
Ward 8 *	2	10
Phase 2		
AEC	3	2
NIV room (if ITU capacity available)	4	1
Phase 3		
Day surgery unit (in extremis)	5	12
Total		**31**

RSH	Order of Priority	Number of Beds
Phase 1		
Ward 32 (Annex)	1	2
Ward 26 (ICA Bay)	2	1
Ward 27 *	3	15
Phase 2		
SAU clinic	4	2
AEC clinic	4	2
NIV room (if ITU capacity available)	5	1
Phase 3		
Day Surgery unit (in extremis)	6	12
Total		**35**

* Note:

Additional capacity on ward 27 and ward 8 is to be employed from 2000-1000 in order to avoid use of additional escalation areas and boarding

Appendix 2 Comparative Risk Assessment

Patients waiting for beds kept in ED department vs Patients transferred to wards when no immediate capacity available (boarding)

Nature of Risk	Patients waiting for beds kept in ED department				Patients transferred to wards when no immediate capacity available (boarding)			
	Likeli-hood	Impact	Risk Score	Potential Mitigations	Likeli-hood	Impact	Risk Score	Potential Mitigations
Patient Safety & Clinical Effectiveness								
Unable to access in emergency situation	5	5	25	Unable to mitigate risk in ED therefore boarding will mitigate risk	1	3	3	Ward level risk assessment (include equipment requirement, staffing, environment)
Equipment not available in emergency situation	2	5	10	Ensure process to risk assess equipment requirements during shift however limited facilities available if multiple patients waiting therefore boarding will mitigate risk	1	3	3	Ward level risk assessment as above
Staffing levels not sufficient to assess patient risks and prevent harm (e.g. falls/ deterioration/ pressure ulcers)	4	5	20	ED escalation process, oversight by SLT to ensure safe staffing in ED and escalation in use (RED, AMBER, GREEN) Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	2	3	6	Ward level risk assessment staffing (risk assessment) Matron/ on-call manager/site team oversight Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact

Nature of Risk	Patients waiting for beds kept in ED department				Patients transferred to wards when no immediate capacity available (boarding)			
	Likeli-hood	Impact	Risk Score	Potential Mitigations	Likeli-hood	Impact	Risk Score	Potential Mitigations
Risk of falls due to inability to safely monitor	4	5	20	Cohort where possible where appropriate use Care Rounding tool Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	2	3	6	Falls RA to determine suitability to board Ward level risk assessment Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Risk of pressure ulcers due to inappropriate surface	4	5	20	Rounding tool space for beds TVN visit dept and audit practice Noted that in ED multiple patients may be waiting (20 plus at times) which significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	2	3	6	PU RA to determine suitability to board/ trolley/bed/chair needs Ward level risk assessment Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Missed/delayed Medications	3	3	9	ED escalation process to support staffing Prescription charts Medication audits Matron in dept. to oversee audit practice Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which significantly impacts ability to mitigate risk further therefore boarding will mitigate	2	3	6	Boarding SOP (with staff allocation) Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Highest Risk	**5**	**5**	**25**		**2**	**3**	**6**	

Nature of Risk	Patients waiting for beds kept in ED department				Patients transferred to wards when no immediate capacity available (boarding)			
	Likeli-hood	Impact	Risk Score	Potential Mitigations	Likeli-hood	Impact	Risk Score	Potential Mitigations
Patient & Relatives Experience								
Increased anxiety due to nature of environment/ high levels of activity	4	2	8	ED escalation process to support staffing Oversight by SLT Rounding tool Communications externally Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	3	2	6	Boarding SOP (with staff allocation) Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Unable to provide personalised care	3	2	6	ED escalation process to support staffing Rounding tool Noted that in ED multiple patients may be waiting (20 plus at times) which significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	2	2	4	Boarding SOP (with staff allocation) Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Difficulty accommodating relatives/ carers	4	2	8	Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	3	2	6	Boarding SOP (with staff allocation) Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact

Nature of Risk	Patients waiting for beds kept in ED department				Patients transferred to wards when no immediate capacity available (boarding)			
	Likeli-hood	**Impact**	**Risk Score**	**Potential Mitigations**	**Likeli-hood**	**Impact**	**Risk Score**	**Potential Mitigations**
Lack of staff to communicate with patients/ relatives	4	2	8	ED escalation process to support staffing Oversight by SLT Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	3	2	6	Impact Boarding SOP (with staff allocation) Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Highest Risk	**4**	**2**	**8**		**3**	**2**	**6**	
Staff Safety								
Risk of staff safety incidents due to staffing levels/ workload pressures	3	3	9	ED escalation process to support staffing Oversight by SLT Datix reporting Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which along with additional unpredictable emergency activity significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	2	3	6	Boarding SOP (with staff allocation) Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact

Nature of Risk	Patients waiting for beds kept in ED department				Patients transferred to wards when no immediate capacity available (boarding)			
	Likeli-hood	**Impact**	**Risk Score**	**Potential Mitigations**	**Likeli-hood**	**Impact**	**Risk Score**	**Potential Mitigations**
Difficulty with recruitment and retention due to workload pressures	4	2	8	ED escalation process to support staffing Oversight by SLT/exec team Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which along with additional unpredictable emergency activity significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	3	2	6	Boarding SOP (with staff allocation) Staffing app SLT oversight Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Highest Risk	**3**	**3**	**9**		**3**	**2**	**6**	
Staff Experience								
Poor staff morale due to workload pressure	4	3	12	ED escalation process to support staffing Oversight by SLT/exec team Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which along with additional unpredictable emergency activity significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	3	2	6	Boarding SOP (with staff allocation) Staffing app SLT oversight Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact

Nature of Risk	Patients waiting for beds kept in ED department				Patients transferred to wards when no immediate capacity available (boarding)			
	Likeli-hood	**Impact**	**Risk Score**	**Potential Mitigations**	**Likeli-hood**	**Impact**	**Risk Score**	**Potential Mitigations**
Potential for high rates of sickness due to poor staff morale	3	3	9	ED escalation process to support staffing Oversight by SLT/exec team Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which along with additional unpredictable emergency activity significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	2	2	4	Boarding SOP (with staff allocation) Staffing app SLT oversight Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Potential for staff attrition due to poor staff morale	4	3	12	ED escalation process to support staffing Oversight by SLT/exec team Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which along with additional unpredictable emergency activity significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	3	2	6	Boarding SOP (with staff allocation) Staffing app SLT oversight Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Highest Risk	**4**	**3**	**12**		**3**	**2**	**6**	

Nature of Risk	Patients waiting for beds kept in ED department				Patients transferred to wards when no immediate capacity available (boarding)			
	Likeli-hood	Impact	Risk Score	Potential Mitigations	Likeli-hood	Impact	Risk Score	Potential Mitigations
Organisational Risks								
Risk of adverse media attention	3	3	9	Complaints process PE metrics Documentation Rounding tool Oversight of SLT/exec team Communications Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which along with additional unpredictable emergency activity significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	2	2	4	Complaints process PE metrics Documentation Oversight of SLT Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Risk of high levels of patient dissatisfaction	3	3	9	Complaints process Documentation Rounding tool Oversight |SLT/exec team Communications Noted that in ED multiple patients may be waiting (50 at PRH and 40 at RSH plus at times) which along with additional unpredictable emergency activity significantly impacts ability to mitigate risk therefore boarding will mitigate risk further	2	3	6	Complaints process Noted that each ward likely to have only 1 additional patient which does make it easier to mitigate risk than in ED reducing likelihood of adverse impact
Highest Risk	**3**	**3**	**9**		**2**	**3**	**6**	

Nature of Risk	Patients waiting for beds kept in ED department				Patients transferred to wards when no immediate capacity available (boarding)			
	Likeli-hood	Impact	Risk Score	Potential Mitigations	Likeli-hood	Impact	Risk Score	Potential Mitigations
Regulatory/Contractual								
Enhanced surveillance by regulators due to continued failure to meet constitutional targets	5	4	20	Briefings and communication with CCG Emergency planning	3	4	12	Briefings/communication with CCG Emergency planning Boarding should improve internal patient flow and make achievement of constitutional targets more likely
Contractual sanctions by commissioners due to continued failure to meet constitutional targets	5	4	20	Briefings/communication with CCG Emergency planning	3	4	12	Briefings/communication with CCG Emergency planning Boarding should improve internal patient flow and make achievement of constitutional targets more likely
Highest Risk	**5**	**4**	**20**		**3**	**4**	**12**	

Risk assessment to support the decision to move a patient to supported discharge unit
To be completed by the ward staff considering the move with support from Matron/CSM

This risk assessment is to be used when deciding to move a patient to the discharge unit when there is no clinical requirement to move them but discharge date is within 48 hours. Therefore this risk assessment does not apply to those patients required to be moved to a clinical area or specialty based on their particular clinical need and safety.

Any recorded **NO** response in the essential criteria below indicates that the patient should **not** be moved from wards (excludes SAU/AMU/SSS). If hospital capacity is such that patients are being put at clinical risk in other areas (e.g. Emergency Department trolley waiting) there may be pressure to move patients who meet essential but not all desirable criteria. The decision to move will need to include the following:

- Clinical risk assessment/judgement that is documented in the patient record
- Discussion with the Nurse in Charge of Ward/Department
- Clinical Site Manager
- TTO
- Discharge Summary

And/or

- Discussion with the Off Site Manager on-call
- Datix any breach to criteria

PATIENT NAME……**DOB**……..

ID……**DATE/TIME OF ASSESSMENT**……..

TRANSFERRING FROM……**TO** Discharge Unit

NAMES OF TEAM CONTRIBUTING TO THE DECISION (please print)

1. ……
2. ……
3. ……
4. ……

Prioritisation	Criteria	Yes	No
Essential: These criteria MUST be met for ALL patients. Any **NO** response = The patient **should not** be moved**.**	The patient has a confirmed diagnosis and/or a treatment and discharge plan is in place.		
	The patient has been identified by the ward team as being medically fit for discharge.		
	The patient is free from symptoms of diarrhoea or vomiting within the last 72 hours.		
	The patient is clinically stable, has not experienced deterioration in their condition in the last 24 hours. EWS score is <2 or is within expected limits for patient.		
	Resuscitation status is known/clearly documented.		
	The patient does not pose a risk to other patients, staff or themselves.		
	The patient is safe to be cared for by nursing staff who do not have speciality knowledge or experience.		
	The patient is not at end of life stage.		
	The patient does not have mental health condition or learning disability.		
Speciality	The patient has been stabilised post operatively within their own specialty.		
	Agreed speciality plans/criteria must be followed.		
	Special equipment is available or can be transferred with the patient.		