GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.:	PAGE:
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TITLE: PATIENT FLOW MANAGEMENT PLAN				
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OBJECTIVE:

Patient flow in Guam Memorial Hospital Authority (GMHA) is a multidisciplinary approach, that shall be prioritized when the overall hospital's resources (bed availability and available staff) has reached its full capacity. To meet the recommended The Joint Commission Standard on patient flow, GMHA will implement its patient flow plan to ensure boarding patients in the Emergency Department and other areas in the hospital, including the PACU and direct admissions from the community hospitals, has been transferred to its prescribed level of care within four (4) hours of receipt of an admission order or transfer order.

POLICY:

When a patient requires admission or a transfer to an inpatient unit and the respective nursing unit cannot accommodate the patient because of a lack of sufficient beds, the patient will be receive the same level of care as ordered by the attending physician until transferred to the designated nursing unit. Every effort must be made to ensure that bed availability is initiated, and patient is transferred to his/her assigned room within four (4) hours, while meeting our hospital's mission of providing quality care in a safe environment.

The assignment of available beds to boarding patients will be the responsibility of the House Nursing Supervisor on duty. In the event that arranged plans have changed due to a deterioration of condition of a patient on a regular nursing unit needing a higher acuity, the House supervisor on duty shall communicate changes to the charge nurses and the boarded patients it will affect.
In the event that it has been determined that there will be delays in patient flow during implementation of its plan, the Nursing Supervisor, in collaboration with the ED physician on duty and Hospital Administration shall determine the need to be in ED saturation diversion (refer to policy).

Per EMS Diversion policy, hospital diversion is temporary and is allotted 4 hours. At such time, a reevaluation of the need to continue the diversion shall be determined and communicated to EMS dispatch and the other hospital facilities.

The House Supervisor in collaboration with the admitting unit's nursing supervisor shall ensure that all admission assessments are completed on boarded patients within 24 hours.

DEFINITIONS:

Boarding Patients: Boarding is the practice of holding patients in the Emergency Department or another temporary location after the decision to admit or transfer has been made.

Overflow Area: An area designated for holding patients who are for admission or possible discharge. The overflow area is to be staffed by nursing personnel as appropriate. The designated overflow areas are the Medical Surgical Annex, Pediatrics Ward, PACU, or ED.

PROCEDURES:

The Nursing Supervisor shall be notified every shift by each unit supervisor/charge nurse of the current bed census to include possible discharges. This should be reflected in the nursing unit's 24 hour report. When the Nursing Supervisor determines that the hospital has reached a critical capacity, or full capacity (see Attachment I) in either the acute adult units or the Maternal Child Health (MCH) units, the Nursing Supervisor will then initiate the patient flow plan.

I. PATIENT FLOW PLAN FOR ACUTE ADULT UNITS

A. When PATIENT FLOW PLAN FOR ACUTE ADULT UNITS is activated, unit supervisors/charge nurses shall assess the status of each patient in the unit, and identify the patients for possible discharge or transfer.

B. The Unit supervisor/charge nurses will notify physicians and request that they assess their patients for possible discharge or transfer. If the attending physician is uncooperative with the Patient Flow Management Plan, the Nursing Supervisor shall be notified, who will communicate with the respective Medical Staff Department Chair(s) and/or Medical Director to assist with the prioritization of admission, transfer, or discharge decisions. Physicians are required to re-evaluate their admitted patients when the Patient Flow Plan is activated.

C. Quality Management staff shall be notified and assist with facilitating potential discharge using accepted criteria such as Interqual that can be provided to Attending Physicians.

D. The Laboratory Department shall ensure that morning labs for those patients who are for possible discharge or transfer, are available no later than 0900 to help facilitate the physician's decision to possibly discharge or transfer the patient to another unit, or to Skilled Nursing Unit. Those patients shall be identified in order entry via the comment block. Patients are to be prioritized base on their acuity level.

E. Radiology Department shall ensure that all in-patient radiological procedures are performed as soon as possible. Preliminary reports shall be completed in a reasonable time no more than 24 hours after completion of a procedure. Patients are to be prioritized base on their acuity level.

F. Social Services personnel shall provide support to the nursing personnel by ensuring that patients have the necessary supplies/equipment and homecare follow up upon discharge. Social Services shall advocate for required services and navigate complex social system and assist in locating potential resources.

G. Housekeeping Department shall prioritize cleaning discharged patient room to help facilitate the transfer of waiting patients. The available room must be ready within 60 minutes to receive patients for admission.

H. When an admitted patient is assigned a room by Nursing Supervisor, the unit who is receiving the patient shall have 60 minutes to receive hand off on the patient. Any licensed nurse shall receive hand off on the patient for admission.

I. When it is determined that it will be more than four hours for boarded patients to be transferred to their assigned unit, the Nursing Supervisor in collaboration with the Unit Supervisor shall find adequate staffing to open the overflow area when there are four (4) or more admissions for the Medical or Surgical Unit, when there are four (4) or more admissions for Telemetry, or when there are two (2) or more admissions for Intensive Care Unit (ICU) or Progressive Care Unit (PCU). These alternate areas shall be opened upon determination of adequate staffing based on patient level of care by using the following:

1. Room assignments shall be made appropriately to meet the needs of the patient population. The Nursing Supervisor/Charge Nurse shall explore all options to provide sufficient staffing through the following:
    a. Reassign staff from one unit to another base on competency of the nurse or the unit's needs.

    b. Activate on-call staff to report for duty (refer to Policy No. 6301-I-D-9, Nursing Services Staffing Plan on the Nursing Services Manual).

    c. Request for staff to work additional hours.

    d. When all efforts have been exhausted to safely staff the nursing units, any licensed nursing personnel that are not assigned to a clinical area will be notified and assigned to work in the nursing units base on their competency and experience.

2. When a desired unit has reached its maximum capacity and other units have available beds, patients for admission may be assigned to the following overflow areas:

    a. Regular and surgical patients age 17 and above may be assigned to either the Medical-Surgical or Surgical unit. When both units have reached its full capacity, consider opening the Medical-

Surgical Annex, the Pediatrics Unit, or other areas as appropriate.

b. Critical care patients may be assigned to PCU, or other areas as appropriate. Operative patients who remain at a critical condition, may be held at recovery room.

J. Nursing Unit Supervisors/Charge Nurses shall immediately notify Nursing Supervisor of all discharged patients, and shall ensure that all discharges are expedited, and the room is ready for the next admission.

K. In the event that adult patients are assigned a room at SNU, hand off and transfer of patient shall be expedited.

II. PATIENT FLOW PLAN FOR MATERNAL CHILD HEALTH (MCH) UNITS.

A. When PATIENT FLOW PLAN FOR MATERNAL CHILD HEALTH UNITS is activated, unit supervisors/charge nurses shall assess the status of each patient in the unit, and identify the patients for possible discharge or transfer.

B. The Unit supervisor/charge nurses will notify physicians and request that they assess their patients for possible discharge or transfer. If the attending physician is uncooperative with the Patient Flow Management Plan, the Nursing Supervisor shall be notified, and communicate with the respective Medical Staff Department Chair(s) and/or Medical Director to assist with the prioritization of admission, transfer, or discharge decisions. Physicians are required to re-evaluate their admitted patients when the Patient Flow Plan is activated.

C. Quality Management staff shall be notified and assist with facilitating potential discharge using accepted criteria such as Interqual that can be provided to Attending Physicians.

D. The Laboratory Department shall ensure that morning labs for those patients who are for possible discharge or transfer, are available no later than 0900 to help facilitate the physician's decision to possibly discharge or transfer the patient to another unit, or to the Skilled Nursing Unit. Those patients shall be identified in iMED via the comment block. Patients are to be prioritized base on their acuity level.

E. Radiology Department shall ensure that all in-patient radiological procedures are performed as soon as possible. Preliminary reports shall be completed in a reasonable time no more than 24 hours after completion of a procedure. Patients are to be prioritized base on their acuity level.

F. Social Services personnel shall provide support to the nursing personnel by ensuring that patients have the necessary supplies/equipment and homecare follow up upon discharge.

G. Housekeeping Department shall prioritize cleaning discharged patient room to help facilitate the transfer of waiting patients. The available room must be ready within 60 minutes to receive patients for admission.

H. When an admitted patient is assigned a room by Nursing Supervisor, the unit who is receiving the patient shall have 60 minutes to receive hand off on the patient. Any licensed nurse shall receive hand off on the patient for admission.

I. The Nursing Supervisor in collaboration with the Unit Supervisor shall find adequate staffing to open the backfill area when there are five (5) or more admissions for regular Pediatrics or when there are two (2) or more admissions for the Pediatric Intensive Care Unit (PICU). These alternate areas shall be opened upon determination of adequate staffing based on patient level of care by using the following:

1. Room assignments shall be made appropriately to meet the needs of the patient population. The Nursing Supervisor/Charge Nurse shall explore all options to provide sufficient staffing through the following:

   a. Reassign staff from one unit to another base on competency of the nurse or the unit's needs. For example:

      i. Pediatric staff can be reassigned to OB Ward, Nursery, or ED (to care for the Pediatric holding patients)
      ii. OB Ward can be reassigned to Labor and Delivery, Regular Nursery, Surgical Unit or Pediatrics, if they meet the competency requirement for each respective area
      iii. OB Ward can receive additional staff from the Labor and Delivery Unit, or Medical Surgical Unit, Pediatrics, or Nursery Unit
      iv. Nursery staff can be reassigned to the Pediatrics Unit

   b. Activate on-call staff to report for duty (refer to Policy No. 6301-I-D-9, Nursing Services Staffing Plan on the Nursing Services Manual). For Labor and Delivery unit, activate on-call base on its unit specific policy (refer to Policy No. 6310-I-E-15, Labor and Delivery On-call)

   c. Request for staff to work additional hours.

   d. When all efforts have been exhausted to safely staff the nursing units, any licensed Nursing Personnel that are not assigned to a clinical area will be notified and assigned to work in the nursing units base on their competency and experience.

2. When a desired unit has reached its maximum capacity and other units have available beds, patients for admission or discharge may be assigned to the following overflow areas:

   a. Patients age 17 and above may be assigned to Medical-Surgical or Surgical units.

   b. Patients age 17 and above may be assigned to the Pediatrics unit by the discretion of the Nursing Supervisor in such cases as those admitted with the diagnosis of Cerebral palsy, developmental delay, severe mental retardation, and/or physical abnormalities/deformities, due to patients not mentally developing past a certain age.

   c. Postpartum patients may be assigned to the surgical or Medical-Surgical units or other areas as appropriate (with Staffing of the same level of care).

   d. Labor patients refer to Policy No. 6310-I-C-5, Labor and Delivery Contingency Plan of the Labor & Delivery Policy Manual.

   e. Intermediate Nursery/Nursery Intensive Care Unit (NICU) patients are to remain in the nursery unit. Additional staff are to be provided from the Pediatrics, Labor and Delivery room or OB Ward. If additional isolettes/bassinettes/warmers are needed, the Nursing Supervisor shall inform Nursing Administrator, and the Medical Director for further alternatives.

J. Nursing Unit Supervisors/Charge Nurses shall immediately notify Nursing Supervisor of all discharged patients, and shall ensure that all discharges are expedited, and the room is ready for the next admission.

III. OPERATING ROOM

A. When a PATIENT FLOW MANAGEMENT PLAN FOR ACUTE ADULT UNITS is activated, the Nursing Supervisor will inform the Operating Room Unit Supervisor/Charge Nurse and the OR Director.

B. The OR Director shall then collaborate and confer with the Surgical Department Chairperson and Surgeons with the prioritization of elective surgeries. Non-essential elective surgery for patients who need to be admitted shall be cancelled and rescheduled for a later date as permitted. For scheduled Cesarean Section procedure, the OR Director shall collaborate with the OB Department Chairperson.

C. Elective surgery for outpatients who need no admission and admitted patients with room assignment shall continue as schedule.

D. If elective surgeries cannot be cancelled and the patient needs to be admitted and is assigned a room by Nursing Supervisor, the unit who is receiving the patient shall have 60 minutes to receive hand off on the patient. Any licensed nurse shall receive hand off on the patient for admission.

E. In the event that Recovery/PACU is holding three (3) or more admissions, and there are identified boarding patients in other areas of the hospital, the Nursing Supervisor in collaboration with the OR Unit Supervisor shall find adequate staffing to safely care for the patients. The patient shall remain in PACU until an overflow areas is opened and adequately staffed, or the patient is transferred to his/her assigned room, whichever comes first. During after hours, the first PACU RN on-call shall inform the Nursing Supervisor to activate the second PACU RN on-call

F. When all efforts have been exhausted to safely staff nursing units any licensed nursing personnel not assigned to a clinical area shall be reassigned to work in the nursing unit based on their competency and experience.

G. Activate PACU on-call staff to report for duty (refer to Policy No. 6301-I-D-9, Nursing Services Staffing Plan on the Nursing Services Manual).

H. Request for staff to work additional hours.

IV. QUALITY IMPROVEMENT

Will monitor monthly total number of hours an admitted patient is boarding in the ED to include the ED annex until patient is transferred to an appropriate unit.

Each department that has a role in patient flow management shall have a performance measure for patient flow included in their performance improvement report, which is reviewed by the GMHA leadership, in accordance with the Quality Assurance & Performance Improvement Plan policy.

RELATED POLICIES:

Policy No. 6301-I-D-9, Nursing Services Staffing Plan, of the Nursing Services Manual.

Policy No. 6310-I-C-5, Labor and Delivery Contingency Plan, of the Labor and Delivery Policy Manual.

Policy No. 6310-I-E-15, Labor and Delivery On Call, of the Labor and Delivery Policy Manual

RECISSION(S):

Policy No. A-PC200, Patient Flow Management Plan, of the GMHA Administrative Manual made effective October 23, 2012.

ATTACHMENT

I. Patient Flow Alert Process

ATTACHMENT I

PATIENT FLOW ALERT PROCESS

Guidelines:

Determine the hospital's current patient flow status, conduct an assessment on the current hospital's census (as it relates to bed capacity and its staffing ability). A separate census assessment should occur for the adult units (ICU, Tele/PCU, Med Surg, Surgical, SNU) and the Maternal Child Health Units (Peds/PICU, OBW, and NICU).

Base on the current hospital census and the foreseen factors that contribute to patient flow (such as discharges and transfers of patients) and the current status of the Emergency Department, determine the Patient Flow Level.

When the hospital reaches Level 2 or above, communicate the status of such to the hospital's leaders, to include the Medical Director(s) (ie Hospital Medical Director, ICU Medical Director, Operating Room Director, etc). Also consider placing the hospital in an Emergency Department Saturation Diversion with Guam EMS.

PATIENT FLOW ALERTS

PATIENT FLOW LEVEL	COLOR Alert System	Occupancy Rate	Admit/ Transfer Times	ED Available Resource	Comments
Level 0: Flow Effectiveness	Green	< 80%	< 90 mins	No boarded patient	
Level 1: Approaching Critical Capacity	Yellow	80-90%	> 90 mins	Approx 3 boarded pt. Bed availability between 30-50%	
Level 2: Critical Capacity	RED	> 90-100%	> 2 hours	More than 5 boarded patients Bed availability < 30% Possible activation of on-call staff to care for current patient load	Lack of available cardiac monitors, or ventilators; may activate ED Saturation Diversion Consider canceling Elective Surgeries needing inpatient admission/observation
Level 3: Internal Patient Flow Disaster	BLACK	>100%	> 6 hours	More than 5 boarded patients Bed availability < 15% All available licensed staff at or over the expected patient ratio (on-call staff activated).	Lack of available cardiac monitors or ventilators; activate ED Saturation Diversion Cancel Elective Surgeries needing inpatient admission/observation

NOTE: Individual units may be over their occupancy rates compared to the overall hospital occupancy. These units should implement a unit base plan for patient flow, such as contacting the attending MD to downgrade or discharge a patient.