Policy Directive: compliance is mandatory

Ambulance Distribution for Demand Management Policy Directive

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Summary
The Ambulance Distribution for Demand Management Policy Directive outlines the principles and processes for proactive demand management of ambulance distribution to ensure, as far as possible, the balanced distribution of ambulances carrying unplanned patients requiring emergency treatment and care across metropolitan hospital Emergency Departments. Balanced ambulance distribution will minimise service demand surges and will ensure the safe delivery of services to all patients requiring emergency care.

Keywords
Ambulance, distribution, demand management, policy directive, threshold, decision making, escalation, Ambulance Distribution for Demand Management Policy Directive

Policy history
Is this a new policy? Y
Does this policy amend or update an existing policy? Y
Does this policy replace an existing policy? Y
If so, which policies? Metropolitan Flow through Load Levelling Policy Directive

Applies to
All SA Health Portfolio

Staff impacted
All Staff, Management, Admin, Students; Volunteers

EPAS compatible
NA

Registered with Divisional Policy

Contact Officer
Yes/No

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D0446

Version control and change history

<table>
<thead>
<tr>
<th>Version</th>
<th>Date from</th>
<th>Date to</th>
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Ambulance Distribution for Demand Management
Policy Directive
### Document control information

<table>
<thead>
<tr>
<th>Document owner</th>
<th>Executive Director, Operational Service Improvement and Demand Management</th>
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| Contributors   | Local Health Network Chief Operating Officers  
|                 | SA Ambulance Service Director, Service Performance and Improvement  
|                 | LHN Emergency Department medical leads                                   |
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### Document history

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<tr>
<td>18 May 2017</td>
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1. **Objective**

SA Ambulance Service (SAAS) and Local Health Networks (LHNs) operate within a complex network of health service providers and play a fundamental role in providing safe, effective and efficient care.

This Policy Directive outlines the principles and processes for proactive demand management of ambulance distribution to metropolitan hospital Emergency Departments to, as far as possible, balance ambulance distribution and demand and minimise the impact of acute increases in activity for both hospitals and SAAS.

Demand management frameworks support the distribution and flow of patients across and within health services, and are separate from clinical decision making (including tools that are developed to support clinical decision making).

2. **Scope**

This Policy Directive applies to LHNs and SAAS, and the Department for Health and Ageing (DHA) in relation to ambulance distribution to metropolitan hospital Emergency Departments.

Priority 1 and 2 patients being transported under ‘lights and sirens’ are considered to be outside the scope of the ambulance distribution framework and will be transported to, and accepted by, the nearest Emergency Department with the appropriate level of facilities required to meet the patient’s immediate life threatening needs.

Clinically unstable patients being transported from country hospitals by volunteer ambulance officers are considered to be outside the scope of the ambulance distribution framework and will be directed to the nearest metropolitan Emergency Department.

3. **Principles**

1. The establishment of an ambulance distribution framework will ensure, as far as possible, an appropriate balance of ambulance arrivals across metropolitan Emergency Departments to minimise the potential impact of surges in Emergency Department demand and to ensure the safe delivery of services to all patients requiring emergency care.

2. The SAAS Hospital Network Coordinator (HNC) in collaboration with the paramedics/ambulance officers will determine the most appropriate hospital destination for ambulances, in line with the established ambulance distribution framework and with reference to the SAAS Destination Triage Tool as a resource to support decision making about a clinically appropriate destination for patient transport.

3. Key elements guiding decision making will include ambulance thresholds, hospital clinical service profiles, hospital capacity, SAAS operational requirements and information about any current or ongoing care being provided to the patient by the public hospital system. Patient requests may be considered in line with the other ambulance distribution decision making elements.

4. Consideration will be given to the availability of the clinical specialities within a hospital such as mental health, paediatrics and obstetrics. The designation of hospitals as state specialists will be maintained for example, the Royal Adelaide Hospital (RAH) as the state provider of burns treatment.

5. Consideration will be given to the availability of condition-specific beds within metropolitan public hospitals. For example, the distribution of cardiac patients may be dependent upon the availability of cardiac beds within hospitals.

6. Patients considered by the treating clinician i.e. paramedic/ambulance officer, to be at significant ‘life’ threat, will be transported to, and accepted by, the nearest Emergency Department with the appropriate level of facilities required to meet the patient’s immediate life threatening needs, without exception.
7. At times where maximum ambulance thresholds have been reached, even distribution arrangements have been applied, and surges in activity remain, it may be necessary to escalate decision making via an ambulance demand escalation teleconference. In these circumstances:

- **In hours day shift** (7.00am-5.00pm) decision making will occur with participation of all LHN Chief Operating Officers (COOs), SAAS On-Call Director and the Executive Director, Operational Service Improvement and Demand Management (OSIDM), DHA.
- **In hours evening shift** (5.00pm-12 midnight) decision making will occur with participation of all LHN Executives On-Call, the SAAS On-Call Director and the ED OSIDM, DHA.
- **Weekends (7am – 12 midnight)** decision making will occur with participation of all LHN Executives On-Call, the SAAS On-Call Director and the Executive Director, OSIDM, DHA.

8. Where planned ambulance transport is approved for admission by the receiving hospital, the SA Health Direct Admission to a Hospital Inpatient Unit Guideline will be followed. Unless the patient is clinically unstable or their condition has deteriorated on route to the hospital the patient will be transferred to the agreed designated treatment area for admission and will avoid the Emergency Department.

9. Where Country Health SA Local Health Network (CHSALHN) patients have been assessed by a country clinician, and transfer of the patient to a metropolitan hospital for further assessment has been agreed to by the metropolitan receiving hospital, every effort will be made for the patient to be transported to that hospital. It is acknowledged that, under exceptional circumstances, there may be instances where the final destination is not the same as that initially intended.

10. The management of demand and capacity on a day-to-day basis for hospitals will occur in line with the provisions of the SA Health Hospital Escalation Policy Directive, and local Hospital Escalation and Business Continuity plans. The **SA Health Hospital Escalation Policy Directive** details the circumstances and processes for consideration of a statewide escalation response.

11. SAAS and Emergency Departments share the responsibility of escalation should any patient not be accepted into an Emergency Department for care within 15 minutes of ambulance arrival at a hospital. Escalation is to occur in line section 4.9.1 of this Policy Directive.

### 4. **Detail**

The overall aim of the ambulance distribution framework outlined within this Policy Directive is to ensure, as far as possible, the balanced distribution of ambulances carrying unplanned patients requiring emergency treatment and care across metropolitan hospital Emergency Departments. Balanced ambulance distribution will minimise service demand surges and will ensure the safe delivery of services to all patients requiring emergency care.

#### 4.1 Ambulance Distribution for Demand Management Decision Making

The SAAS HNC is responsible for the coordination of ambulance distribution. The SAAS HNC will monitor activity and available ambulance resources while providing direction to ambulance crews on the most appropriate hospital destination.

Decision making about the hospital destination will occur in line with ambulance thresholds and with consideration to:

- Advice provided by the attending paramedic/ambulance officer about the patient’s clinical condition and any current or ongoing care. In particular, where a patient has been discharged from a metropolitan public hospital in the previous 72 hours, every effort should be made to transport that patient to the same hospital;
- Metropolitan hospital clinical service profiles;
- Established clinical pathways;
- Availability of condition-specific beds, for example the distribution of cardiac patients may be dependent upon the availability of cardiac beds within a hospital;
- Data available on the SA Health Emergency Department and Inpatient Dashboards;
- Consultation with hospital representatives;
- Current and expected operational demand for SAAS services.
Information sharing processes between the HNC and Hospital staff is detailed in section 4.4.2 (Communication and Information Sharing) on page 6 of this policy.

The SAAS Destination Triage Tool will be utilised by the SAAS HNC and treating paramedics as a resource to support decision making about a clinically appropriate destination for patient transport.

The postcode/suburb where the patient is initially treated by the SAAS Paramedic is not the primary factor in determining the most appropriate hospital destination however, every effort will be made to ensure that where possible, the patient is able to remain in their local catchment.

This is the normal distribution process and ambulance crews and hospital staff alike are required to adhere to decisions made by the SAAS HNC about the ambulance destination. If an ambulance crew makes a decision to transport the patient to a hospital other than that advised by the SAAS HNC, the SAAS HNC is required to document details of this decision. Information collected about decision making not aligned to the ambulance distribution framework will be considered as part of the quarterly evaluation process as detailed in section 11 of this Policy Directive.

4.2 Ambulance Thresholds – Normal Distribution

Ambulance thresholds identify the usual expected number of ambulance arrivals per hour for each metropolitan hospital Emergency Department that can be effectively managed under normal circumstances, without additional demand management strategies. While the threshold is considered usual demand it is not intended that any Emergency Department will receive the threshold number for consecutive hours, wherever possible, as the overall aim is to balance distribution to minimise service demand surges. Additionally, the usual thresholds have been calculated for the busiest times of the day, and therefore the thresholds are expected to be lower between 1am and 6am. There are times when the usual threshold may be reached during this time period.

The thresholds have been determined based on hospital capacity and historical activity profiles and are outlined in Table 1 below. Ambulance thresholds may be amended in line with service configuration changes and will be continuously reviewed as part of the ambulance distribution framework quarterly evaluation process set out in section 11 of this Policy Directive.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of Ambulances per hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Adelaide Hospital</td>
<td>7</td>
</tr>
<tr>
<td>The Queen Elizabeth Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Flinders Medical Centre</td>
<td>6</td>
</tr>
<tr>
<td>Noarlunga Health Service</td>
<td>2</td>
</tr>
<tr>
<td>Lyell McEwin Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Modbury Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Women's and Children's Hospital</td>
<td>2</td>
</tr>
</tbody>
</table>

Ambulance thresholds do not include ambulances waiting to offload at an Emergency Department after the one hour period. Whilst these situations will be taken into account by the SAAS HNC when providing direction to ambulance crews, delays are to be managed in line escalation processes detailed in section 4.9.1 of this Policy Directive.

4.3 Clinical service profiles

The hospital clinical service profile will be considered by the SAAS HNC in decision making about ambulance distribution. Each LHN is responsible for providing SAAS with its clinical service profile, at a minimum, on an annual basis and for immediately providing updated service profiles upon the movement or decommissioning of any services provided at sites within the LHN.

In determining the destination hospital for ambulances, specific consideration will be given to the availability of the following key clinical services:

- Intensive Care Beds and Neonatal Intensive Care Beds.
- Cardiac services.
- Burns.
- Renal services.
- Stroke services.
4.4 Current Demand and Capacity

4.4.1 SA Health Dashboards

There are two SA Health Dashboards that the SAAS HNC will refer to for information on current demand to assist in decision making:
- Emergency Department Dashboard.
- Inpatient Service Dashboard.

4.4.2 Communication and Information Sharing

Communication and information sharing between the SAAS HNC and metropolitan Hospital Nominees is a key element in ensuring that the SAAS HNC is equipped with information about current hospital demand and capacity issues to inform decision making about ambulance distribution. Hospital Nominees may include the Bed Manager, Flow Coordinator (morning shift) and the After Hours Hospital Coordinator (afternoon shift).

The following principles and processes will guide communication and information sharing about ambulance distribution, demand and capacity issues between the SAAS HNC and Hospital Nominees:
- It is recommended that the SAAS HNC contact the Hospital Nominee via direct telephone call early in the commencement of the SAAS HNC shift to discuss any issues and/or priorities. It is anticipated that any time hospital internal operational issues (an example could be staff absence, bed availability etc) that would influence the decision making of ambulance distribution, then the LHN would proactively contact the HNC at any time during the day (7am – 12 midnight) and the State Duty Manager (midnight – 7am).
- Communication can be either initiated by the SAAS HNC or the Hospital Nominee.
- Where an LHN is experiencing pressures at one site, and wishes to manage the demand within the LHN, the Hospital Nominee should communicate this information to the SAAS HNC. Each LHN currently has in place internal escalation processes which support patient movement between hospitals (for example between Flinders Medical Centre and Noarlunga Health Service to manage the LHN demand).
- Where a metropolitan LHN is experiencing pressure, support may be sought from a peri-urban hospital for example, Northern Adelaide LHN may seek to temporarily flow some ambulances that would have otherwise been directed to the Lyell McEwin Hospital (LMH) or the Modbury Hospital (MOD) to the Gawler Hospital. A request to flow clinically appropriate ambulances to peri-urban hospitals may be initiated by a metropolitan LHN and agreed upon in negotiation with the relevant peri-urban hospital via internal communication processes (an ambulance demand escalation teleconference is not required for activation). The requesting metropolitan LHN is responsible for informing SAAS of any agreement to flow ambulances to peri-urban hospitals.
- Where a metropolitan LHN is experiencing pressure specific to peri-natal/paediatric demand, support may be sought from the Women’s and Children’s LHN for example, Southern Adelaide LHN may seek to temporarily flow some peri-natal/paediatric ambulances that would have otherwise been directed to Flinders Medical Centre (FMC) to the Women’s and Children’s Hospital. A request to flow clinically appropriate ambulances to the Women’s and Children’s Hospital may be initiated by a metropolitan LHN and agreed upon in negotiation with the Women’s and Children’s Hospital via internal communication processes (an ambulance demand escalation teleconference is not required for activation). The requesting metropolitan LHN is responsible for informing SAAS of any agreement to flow ambulances to the Women’s and Children’s Hospital.
- In discussions about site pressures, hospitals should be clear about any request for assistance from SAAS. This may include prioritising non-emergency transfers, facilitating discharges and expediting communication with the Patient Transport Services (PTS) team.
- Whilst the processes for ambulance distribution and escalation directly relate to metropolitan hospitals, there may be country patients who are being transported via ambulance for clinical assessment at a metropolitan Emergency Department. Therefore, specific CHSALHN roles will be included in communication and information sharing as required. CHSALHN will also receive ambulance escalation demand teleconference notifications.
- Contact details for the SAAS HNC, Hospital Nominees, LHN COOs, Executives On-Call, SAAS On-Call-Director and Executive Director, OSIDM are provided in Appendix 7. Each
LHN is responsible for providing the SAAS HNC and the Executive Director, OSIDM with a current contact list, at a minimum, on an annual basis and immediately upon the changeover of staff.

- Hospital staff should escalate hospital demand issues to COOs and Executive-On-Call to develop a management plan to resolve issues. In extenuating circumstances Emergency Department Shift Leads can contact the HNC directly to ensure they are aware of Hospital issues. The Emergency Department Lead is required to notify the Executive of the information they have provided to the HNC to ensure communication continues to flow and decision making is appropriate.

- In addition:
  - Each LHN will provide the SAAS HNC via email DL:Health SAAS HNC with an Executive On-Call roster including mobile phone numbers on a weekly basis to ensure SAAS is able to contact the LHN relevant decision maker at all times.
  - SAAS will provide the LHN COOs with the On-Call Director roster and contact details on a weekly basis to ensure LHNs are able to contact relevant SAAS decision maker at all times.

4.5 Demand Above the Ambulance Thresholds – Maximum Threshold followed by Even Distribution

During peaks in demand, each hospital has the ability to increase their usual hourly threshold to the maximum thresholds via the process outlined below and in Appendix 2. Where all hospitals within an LHN have reached their usual threshold and that LHN continues to be identified as the most appropriate hospital destination for forthcoming ambulances, the HNC will contact the COO or Executive On-Call via text message to notify them that the threshold has been reached and an increase to the maximum threshold will occur for the remainder of the hour.

As an example, on occasions where both the RAH and The Queen Elizabeth Hospital (TQEH) have received 7 and 4 ambulances respectively within an hour period, the SAAS HNC may contact the COO or Executive On-Call to advise that additional ambulances may be flowed, up to 10 at the RAH and up to 6 at TQEH.

The maximum hourly ambulance thresholds that can be flowed to each hospital are detailed in table 2 below.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of ambulances already delivered in the hour</th>
<th>Additional ambulances that can be delivered in the existing hour with approval of the Hospital Nominee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Adelaide Hospital</td>
<td>7</td>
<td>+ 3 (10 maximum)</td>
</tr>
<tr>
<td>The Queen Elizabeth Hospital</td>
<td>4</td>
<td>+ 2 (6 maximum)</td>
</tr>
<tr>
<td>Flinders Medical Centre</td>
<td>6</td>
<td>+ 3 (9 maximum)</td>
</tr>
<tr>
<td>Noarlunga Health Service</td>
<td>2</td>
<td>+ 1 (3 maximum)</td>
</tr>
<tr>
<td>Lyell McEwin Hospital</td>
<td>5</td>
<td>+ 2 (7 maximum)</td>
</tr>
<tr>
<td>Modbury Hospital</td>
<td>3</td>
<td>+ 2 (5 maximum)</td>
</tr>
<tr>
<td>Women’s and Children’s Hospital</td>
<td>2</td>
<td>+ 3 (5 maximum)</td>
</tr>
</tbody>
</table>

It is expected that each hospital will accept ambulances up to their maximum threshold, where possible and practical. If there is any concern about the ability to facilitate this, the COO or Executive On-Call may contact the SAAS HNC upon receiving notification to discuss alternative options. The COO or Executive On-Call is to communicate the increase to the maximum threshold to relevant Emergency Department and Patient Flow staff in line with local communication processes.

4.5.1 Even Distribution above Maximum Thresholds

Where demand continues and the maximum hourly ambulance thresholds have been reached within an LHN for the hour period, the SAAS HNC will notify LHN COOs or Executives On-Call via text message that the maximum ambulance thresholds have been reached and even distribution arrangements will be implemented, where possible and practical, for the remainder of the hour. The COO or Executive On-Call is to communicate the even distribution above maximum thresholds to relevant Emergency Department and Patient Flow staff in line with local communication processes. The process for even distribution is set out in Appendix 3.
In these circumstances, the SAAS HNC will seek to evenly distribute ambulances between the three metropolitan regional LHNs, for example: one ambulance to each site within the Central Adelaide LHN; one ambulance to each site within the Southern Adelaide LHN; one ambulance to each site within the Northern Adelaide LHN, and so on until the hour is completed and normal distribution arrangements are reinstated.

During even distribution, decision making about the destination hospital will continue to occur with regard to the hospital clinical service profiles, SAAS operational requirements, any current or ongoing care being provided to the patient by the public hospital system, and the patient’s usual address and pick up location, with the aim to ensure that where possible the patient is able to remain in their local catchment. Opportunities for further paediatric distribution to the Women’s and Children’s Hospital will also be considered when distribution exceeds the maximum ambulance thresholds.

4.6 Ambulance Demand Escalation (7.00 am - 12.00 midnight)

When a LHN is unable to continue to manage its ambulance and Emergency Department/hospital demand, or where SAAS is experiencing excessive demand or delays in transfer of care that impact ambulance operational requirements, the LHN COOs/Executive On-Call or SAAS On-Call Director may request an ambulance demand escalation teleconference via the process outlined below and in Appendix 4.

It is important to note that an ambulance demand escalation teleconference is not required to activate temporary ambulance re-direction to peri-urban hospitals or the Women’s and Children’s Hospital. These circumstances can be negotiated at a local level as detailed in section 4.4.2 of this Policy Directive.

4.6.1 Teleconference Request Process

1. LHN COO/Executive On-Call or the SAAS On-Call Director contacts the SAAS HNC by telephoning 1300 117 362 to request an ambulance demand escalation teleconference.
2. Requesting COO/Executive On-Call or the SAAS On-Call Director advises the SAAS HNC of the primary issue and any specific clinical areas of concern for example, Mental Health.
3. The SAAS HNC sends a text message to all LHN COOs/Executives On-Call, the SAAS On-Call Director and the Executive Director, ODSIM requesting participation in teleconference. The text will contain teleconference phone number and pin.
4. The timeline for participation in the teleconference should be reasonable, for example 30 minutes from time of initial contact.

LHN COOs/Executive On-Call, SAAS On-Call Director and the Executive Director, OSIDM are requested to participate in the escalation teleconferences.

The officer requesting the teleconference should indicate whether the issue includes paediatrics, if it doesn’t then the text message should advise “no paediatric issues” so that representatives from the Women’s and Children’s Hospital are aware that they are not required to dial in.

LHN COOs/Executive On-Call, SAAS On-Call Director and the Executive Director, OSIDM may request additional participants to join the teleconference for example, Mental Health leads to join where mental health capacity is the primary concern.

4.6.2 Teleconference Delegations

The SAAS On-Call Director will chair the teleconference.

4.6.3 Preparing for a teleconference

Upon receiving the text message to participate in the teleconference, each participant will have a maximum of 30 minutes to obtain an update of current capacity/demand issues within their LHN/SAAS ensuring the LHN COO/Executive On-Call and the SAAS On-Call Director is equipped to negotiate and make decisions.

Information that should be prepared for the teleconference includes:
Metropolitan LHNs
- Current Emergency Department capacity and demand issues (obtain detail from Emergency Department lead);
- Back of house capacity and demand issues (obtain detail from Bed Manager/Patient Flow Coordinator), including availability of condition specific beds for example, cardiac beds;
- Current staffing issues and what strategies are being put in place to address deficits
- Current know confirmed discharges compared to the expected predicted number (obtain detail from Bed Manager/Patient Flow Coordinator/OBI Dashboards) for each metropolitan hospital. If the discharge numbers are not sufficient to achieve patient flow, what strategies are being established to increase appropriate discharges, or what assistance is need by the LHN/SAAS participants on Teleconference.
- Priority transfers for SAAS to be expedited;
- Metropolitan inpatients to be transferred to peri-urban hospitals including the total number of acute patients and total number of maintenance care patients suitable for transfer for each metropolitan hospital;
- Escalation strategies enacted at each hospital for example, additional staff resources rostered to assist in expediting patients appropriate for discharge.
- Issues of concern that are not yet resolved.

Country Health SA LHN
- CHSALHN to prepare information on the peri-urban inpatient and Emergency Department capacity to accept additional patients.

SAAS
- Ambulance demand or delay issues such as events waiting and priority, fleet capacity, ongoing incidents and opportunities to redirect (obtain details from the SAAS HNC).
- Total number of booked transfers booked for each metropolitan hospital.
- Total number of planned transfers booked, and actual transfers enacted, for the previous 24 hours for each metropolitan hospital.

4.6.4 Conducting the Teleconference
SAAS will Chair the teleconference via the process outlined below and in Appendix 5:

1. The Chair will ask the requesting officer (LHN or SAAS) to provide a summary of the major issue including any relevant details of the following: (5 mins max)
   - The events leading to the issue/situation;
   - Any other area of concern;
   - Ambulance details including arrivals, onsite, expected, delays;
   - Any Emergency Department concerns for example, limited emergency beds available;
   - Any back of house concerns for example, limited inpatient beds available;
   - Total number of expected discharges planned at each hospital within their LHN;
   - Total number of transfers to peri-urban hospitals planned including acute and maintenance patients at each metropolitan hospital;
   - Any other access blocks for example, transfer to country health but no ambulance available;
   - Internal demand escalation actions enacted for example, additional staff resources rostered, ceased elective surgery, opened beds.
   - For SAAS, the total number of transfers or discharges booked currently, and for the previous 24 hours, the number of transfers or discharges booked and actual transfers enacted.

2. The SAAS Chair will ask each metropolitan LHN to provide a summary and current state for each site including: (2 mins each LHN, total 6 minutes max)
   - Current Emergency Department demand and capacity i.e. availability of emergency beds;
   - Current and expected back of house demand and capacity (including number of planned discharges for each hospital);
   - Current ambulances delayed in transfer of care;
   - Internal strategies and escalation actions that have been activated.
3. The SAAS Chair will provide a summary of current ambulance issues and expected arrivals at each site for the next hour. (5 mins max)

4. The SAAS Chair will ask CHSALHN to provide a summary of each peri-urban site and where metro transfer or ambulance redirection to peri-urban Emergency Department could occur. (2 mins max)

5. The SAAS Chair will ask the Executive Director, OSIDM to provide any additional information that may be relevant to the current situation. (2 mins max)

6. Where the solution is clear, the SAAS Chair will suggest the action and seek agreement from all participants for example, Southern Adelaide LHN has requested the teleconference and Central Adelaide LHN has indicated capacity to receive additional ambulances within their LHN for a limited time.

7. Where the solution is complex and requires additional coordination, the SAAS Chair will aim to negotiate a fair and equitable solution that ensures one LHN is not more burdened than another. For example, transfer of patients to peri-urban hospitals.

SAAS may need to confirm its ability to transfer ambulances to peri-urban hospitals and will require time to coordinate this. In this event, it is likely that the SAAS Chair will request that participants check options and the teleconference will be reconvened in 90 minutes.

8. In situations where participants cannot agree on a resolution or require statewide strategies to be enacted, for example cancellation of elective surgery, the SAAS Chair will escalate to the LHN/SAAS Chief Executive Officers (CEOs) and the Deputy Chief Executive, Transforming Health Division, DHA to seek further advice/approval.

4.6.4 Teleconference Outcomes
Upon conclusion of the teleconference, the SAAS Chair will ensure that the agreed actions and outcomes are documented and circulated to teleconference participants via email. LHN/SAAS CEOs will be included in the email for information.

The teleconference outcomes will include the timeframes for which the agreed actions will occur for example, one hour from teleconference completion.

The agreed outcomes will be enacted as soon as possible or as agreed.

The outcomes may include an agreement to reconvene the teleconference at a later time to discuss the impact of the agreed actions and any further action that may be required for example, teleconference will be reconvened in 3 hours.

Teleconference participants are responsible for communicating the outcomes to relevant staff members for example, where Central Adelaide LHN has agreed to accept ambulances that would have otherwise been directed to Southern Adelaide LHN, the Central Adelaide LHN COO will ensure the RAH and TQEH Emergency Department leads and other relevant staff are aware of this agreement.

The Executive Director, ODSIM will ensure the Minister’s Office and other DHA staff including the Communication and Media teams are made aware of agreed outcomes as necessary.

4.7 After Hours Demand Escalation (12.01 am – 6.59 am)
It is expected that a coordinated approach to distribution through the ambulance distribution framework, and as required, demand escalation during in-hours (day shift and evening shift) will support effective patient flow overnight. However, there may be occasions after hours (between 12.01 am - 6.59 am) when hospitals need to action a proactive approach to ambulance demand management, due to various factors.

The LHN Executive On-Call will negotiate after hours ambulance distribution on a case-by-case basis with the LHN Executive On-Call of the proposed alternative receiving hospital. If after hours
ambulance demand management is agreed, the requesting LHN Executive On-Call will advise SAAS of this decision.

After hours ambulance demand management will initially apply for a period of two hours. The Executive On-Call is to notify as soon as possible if the LHN no longer requires case by case ambulance distribution management.

Case by case management does not apply to:
- Patients classified by SAAS as clinically unstable.
- Patients who are under ‘Care and Control’ as provided for under the Mental Health Act 2009 who must be transported to their nominated hospital.

CHSALHN staff are to refer to CHSALHN policies and procedures for after-hours ambulance demand management.

4.8 Patient Requests
To ensure the safe delivery of services to all patients requiring emergency care, patient requests should not be prioritised over the clinical needs of the patient, and should be considered in line with all relevant elements of the established ambulance distribution framework.

There may be instances where the destination hospital is outside of the local area in which the patient normally resides, or from where the patient is picked up. The following points are provided to guide discussions between paramedics/ambulance officers, patients and their families:
- Based on information provided by the SAAS HNC, the SAAS paramedic/ambulance officer needs to be clear on the designated Emergency Department to attend prior to discussing this with the patient and their family.
- If the patient or their family request that the patient is transported to a hospital other than the planned destination hospital, then the SAAS paramedic/ambulance officer should explain that the patient will be taken to the most appropriate hospital, based on the patients clinical needs and the current levels of demand across hospitals. This will assist in ensuring that the patient will be treated as quickly as possible at the hospital that has capacity to treat them, and that other patients requiring emergency care will be able to access the most appropriate service for them in a timely manner.
- If the patient insists on attending a different hospital, the SAAS paramedic/ambulance officer is to contact the Extended Care Paramedic, located at SAAS Emergency Operations Centre to obtain clinical advice regarding where to transport the patient. If a patient is transported to a hospital other than that which the SAAS HNC has advised, the decision should be documented by the SAAS HNC as described in section 4.1 of this Policy Directive.

4.9 Transfer of Care from SAAS to Hospital
Patient care is a shared responsibility between the two service providers (SAAS and the hospital). The timely reception and transfer of ambulance patients into Emergency Departments, or agreed designated treatment areas, is essential to delivering responsive and safe patient care. Collaboration and coordination between the Emergency Department/hospital agreed designated treatment areas and SAAS paramedics/ambulance officers is critical to facilitating a coordinated approach to patient reception and handover processes, and achieving case completion to allow ambulance crews to attend other emergency call outs.

Transfer of clinical care occurs when handover from the SAAS paramedic/ambulance officer to hospital clinical staff is complete, and the paramedic/ambulance officer and their equipment is no longer required.

The transfer of information at the time of patient clinical handover should be timely, accurate and completed only once. The hospital clinician is to record the time that handover or transfer of care occurred in the Hospital Medical Patient Record. Paramedics/ambulance officers will record the same handover time on their Patient Report Form and notify the SAAS Emergency Operations Centre that transfer of clinical care is complete.

SAAS paramedics/ambulance officers should be available for further tasking as soon as practicable without compromising the operational readiness of the ambulance.
Under normal circumstances, it is expected that the ambulance crew and hospital staff will complete the transfer of clinical care of an ambulance patient in less than or equal to 15 minutes from ambulance arrival at the hospital, and that the ambulance is available for further tasking as soon as practicable, without compromising the operational readiness of the ambulance. The following figure (figure 1) presents a diagrammatic view of expected completion time of transfer of care of ambulance patients to the Emergency Department, or the direct admission to the agreed hospital designated treatment area, and case completion.

**Figure 1. Ambulance Turnaround Time including Transfer of Care**

<table>
<thead>
<tr>
<th>Arrival at Hospital ED or Ward</th>
<th>Patient transfer of care complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient transfer of care time</td>
<td>≤ 15 minutes</td>
</tr>
<tr>
<td>≤ 30 minutes</td>
<td>Case completion</td>
</tr>
<tr>
<td>Patient transfer time</td>
<td>Stretcher time</td>
</tr>
<tr>
<td>(includes triage or ward admission registration, patient transfer and handover)</td>
<td>Paramedic completion of patient record, restock and make ready vehicle</td>
</tr>
</tbody>
</table>

**NB: 'ward' relates to areas as agreed in the Direct Admission to a Hospital Inpatient Unit Guideline, 2011**

### 4.9.1 Delays in Transfer of Care

If the SAAS paramedic/ambulance officer is not able to transfer care within 15 minutes of the recorded arrival time at the hospital due to access block, then the SAAS paramedic/ambulance officer is to escalate to the SAAS HNC when on shift and State Duty Manager at other times. If transfer of care has not been achieved within 30 minutes, then the SAAS State Duty Manager must alert the hospital COO /Executive On-Call to manage the delay in accordance with their strategies. A flowchart is included at Appendix 6.

Delays in transfer of care greater than 30 minutes, where there is a direct clinical incident or adverse event, will be recorded in the Safety Learning System (SLS) Incident Management. Hospitals should be informed of any delay as soon as possible, including the cause of the delay and actions taken to resolve any delay to the patient’s transfer into the Emergency Department or direct admission to the agreed designated treatment area.

### 4.9.2 Ambulance Presentation

The steps in the process for unplanned ambulance presentation include:

1. Ambulance arrival to a metropolitan public hospital Emergency Department;
2. Triage assessment of the patient by the Emergency Department clinician;
3. Handover between the paramedic/ambulance officer and Emergency Department clinician;
4. Transfer of ongoing patient care to the Emergency Department clinical team;
5. Ambulance readiness to respond to the next emergency call.

The measurement of ambulance turnaround time commences with the ambulance arrival to the hospital ambulance arrival bay.
The SAAS paramedic/ambulance officer records their arrival time when their vehicle arrives at the hospital ambulance bay. The ambulance arrival time at the hospital is recorded electronically in the SAAS SA Computer Aided Dispatch (SACAD) system and manually on the Patient Report Form.

The hospital triage nurse is to inform SAAS paramedics/ambulance officers and the Hospital Nominee of any delay impacting transfer of care as soon as possible, including the cause of the delay and actions taken to resolve any delay. If further detailed information is required on delays related to the Emergency Department, the hospital triage nurse may refer the matter to the Emergency Department Nursing Shift Coordinator. If information is required about broader hospital delays impacting transfer of care, information is to be provided by the Flow Coordinator or Hospital Coordinator.

SAAS paramedics/ambulance officers are to provide patient details and clinical information to the hospital triage nurse to enable effective clinical triage assessment to be performed. The triage category and time of assessment is to be recorded and entered in the hospital’s electronic Emergency Department system (for most sites this is HAS–ED or EPAS).

Once the patient has been triaged the patient should be moved to a cubicle, waiting room or holding bay until the allocated hospital clinician is available to care for the patient.

To assist in timely patient clinical handover and ambulance turnaround, clinically appropriate patients may be transferred from the ambulance stretcher to a chair in the Emergency Department waiting room to await further assessment and treatment. This may be considered where:

- The patient is clinically stable;
- The paramedic/ambulance officer and triage nurse agree it is appropriate;
- There is patient agreement;
- The patient’s family/carer is in attendance.

4.9.3 Direct Admission
The SA Health Direct Admission to a Hospital Inpatient Unit Guideline will be followed for planned (pre-arranged) direct admissions.

4.10 Data Collection

Daily Emergency Department and Ambulance Activity Summary Report:
The daily Emergency Department and Ambulance report for each metropolitan hospital is distributed via email each morning to Emergency Department medical and nursing leads, Bed Managers/Patient Flow Coordinators, SAAS Operations and LHN/SAAS Executives and provides the following information:

- Total number of Emergency Department presentations each hour (this includes walk ins and ambulance arrivals);
- Number of ambulance arrivals to the Emergency Department for assessment (how many ambulances arrive each hour for Emergency Department treatment, does not include no ambulances transporting patients for direct hospital admission);
- Emergency Department occupancy each hour.

The report provides users with the ability to identify points where Emergency Department patient flow and ambulance arrivals may have impacted on capacity/flow and further investigation can be initiated if required.

Daily Ambulance Turnaround Time and Transfer of Care Time Reports
Daily ambulance turnaround time and transfer of care time reports will be generated by SAAS and circulated to each metropolitan LHN COO each day.

Both SAAS paramedics/ambulance officers and hospital staff have responsibilities to record the commencement or completion of particular activities that contribute to the recording of patient clinical handover and ambulance turnaround time. These responsibilities are in table 3 below.
Table 3: Responsibilities for recording data

<table>
<thead>
<tr>
<th>Ambulance Presentation (Emergency)</th>
<th>Where recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action (time of)</td>
<td></td>
</tr>
<tr>
<td>Ambulance arrival at ED</td>
<td>SAAS system</td>
</tr>
<tr>
<td>Triage/Clinical Assessment/ED Admission</td>
<td>Hospital EDIS/EPAS</td>
</tr>
<tr>
<td>Handover by paramedic/ambulance officer</td>
<td>SAAS system</td>
</tr>
<tr>
<td>Hospital clinician takes over patient care</td>
<td>Patient Medical Record/EPAS</td>
</tr>
<tr>
<td>Ambulance vehicle and paramedic/ambulance officer clear for tasking</td>
<td>SAAS system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Direct Admission (to agreed designated treatment areas)</th>
<th>Where recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action (time of)</td>
<td></td>
</tr>
<tr>
<td>Ambulance arrival at Transfer Bay</td>
<td>SAAS system</td>
</tr>
<tr>
<td>Admission at hospital agreed designated treatment area</td>
<td>Hospital Patient Administration System (homer)/EPAS</td>
</tr>
<tr>
<td>Handover by paramedic/ambulance officer</td>
<td>SAAS system</td>
</tr>
<tr>
<td>Hospital clinician takes over patient care</td>
<td>Patient Medical Record/EPAS</td>
</tr>
<tr>
<td>Ambulance vehicle and paramedic/ambulance officer clear for tasking</td>
<td>SAAS system</td>
</tr>
</tbody>
</table>

4.11 Hospital Escalation and Statewide Escalation
The SA Health Hospital Escalation Policy Directive sets out standard system-wide escalation strategies and actions to ensure a consistent approach to the day-to-day management of demand and capacity of hospitals, these are summarised in Appendix 1. LHNs are required to develop and maintain local Hospital Escalation Plans and Business Continuity Plans for each site in alignment with standard escalation strategies and actions. The SA Health Hospital Escalation Policy Directive details the circumstances and processes for consideration of a statewide escalation response.

5. Roles and Responsibilities

Chief Executive Officers, LHNs and SAAS are responsible for:
- Considering demand issues and actioning management strategies for situations that have not been resolved through ambulance demand escalation outlined in section 4.6 of this Policy Directive.

Chief Operating Officers/Executives On-Call, LHNs are responsible for:
- Initiating local capacity meetings at times when a hospital has reached red escalation status (see Appendix 1).
- Requesting ambulance demand escalation via a teleconference, as outlined in section 4.6 of this Policy Directive.
- Participating in ambulance demand escalation teleconferences, as outlined in section 4.6 of this Policy Directive.
- Negotiating after hours case by case ambulance distribution, as outlined in section 4.7 of this Policy Directive.
- Communicating and sharing information about changes to usual ambulance demand management for example, any temporary change to usual ambulance thresholds or activation of even distribution arrangements, to relevant staff as necessary.
- Working in partnership to make demand escalation decisions about ambulance distribution with an aim to assist in balancing demand, as far as possible, across the system.

On-Call Director SAAS is responsible for:
- Requesting ambulance demand escalation via a teleconference, as outlined in section 4.6 of this Policy Directive.
- Facilitating after hours case by case ambulance distribution, as outlined in section 4.7 of this Policy Directive.
- Chairing the ambulance demand escalation teleconference.
- Working in partnership to make demand escalation decisions about ambulance distribution with the aim to assist in balancing demand, as far as possible, across the system.

Executive Director, OSIDM is responsible for:
- Participating in ambulance demand escalation teleconferences, as outlined in section 4.6 of this Policy Directive.
- Ensuring the Minister’s Office and other DHA staff are made aware of agreed ambulance demand teleconference outcomes as necessary.
Hospital Network Coordinators (SAAS) are responsible for:

- Monitoring activity and available ambulance resources while providing direction to ambulance crews about the most appropriate hospital destination for ambulances in line with the ambulance distribution framework established in this Policy Directive.
- Communicating and sharing information with metropolitan Hospital Nominees about day to day capacity and demand management.
- Notifying LHN COOs/Executives On-Call and Hospital Nominees when usual ambulance thresholds have been reached and advising that an increase to the maximum ambulance threshold will occur for the remainder of the hour, as outlined in section 4.5 of this Policy Directive.
- Notifying LHN COOs/Executives On-Call and Hospital Nominees when ambulance thresholds have been reached and even distribution has been enacted as outlined in section 4.5 of this Policy Directive.
- Facilitating the ambulance demand escalation teleconference communication processes as outlined in section 4.6 of this Policy Directive.
- Documenting occasions where ambulance crews have transported the patient to a hospital Emergency Department other than that advised by the SAAS HNC.

Hospital Emergency Department Staff are responsible for:

- Working with SAAS paramedics/ambulance officers to facilitate patient reception, handover processes, and case completion in a timely manner.
- Escalating access blocks as outlined in section 4.9 of this Policy Directive.
- Documenting key time points including handover and triage as outlined in section 4.9 of this Policy Directive.

Hospital Nominees are responsible for:

- Communicating and sharing information with the SAAS HNC about day to day capacity and demand management.
- Communicating with the SAAS HNC when an LHN wishes to manage the demand within the LHN.
- Escalating any concerns about Emergency Department capacity and demand management to the relevant LHN COO as necessary.

SAAS Paramedics/Ambulance Officers are responsible for:

- Providing patient details and clinical information for the SAAS HNC consideration which may assist in determining an appropriate hospital destination.
- Discussing the proposed destination with the patient and their family/carer.
- Working with hospital Emergency Department staff to facilitate patient reception, handover processes, and case completion in a timely manner.
- Escalating access blocks as outlined in section 4.9 of this Policy Directive.
- Documenting key time points including arrival, handover and transfer of care as outlined in section 4.9 of this Policy Directive.

SAAS State Duty Manager is responsible for:

- Alerting the LHN COO/Executive On Call about delays in transfer of care as outlined in section 4.9 of this Policy Directive.

6. Reporting

6.1 Key Performance Indicators

The following Key Performance Indicators are established in LHN and SAAS Service Level Agreements:

*Ambulance Transfer of Care*
% of P1-5 carries which take less than/or equal to 15 minutes from ambulance arrival to handover of care to hospital staff for urban centre public hospitals

| SAAS Target and LHN Target | 50% |
Hospital Clearance

% of hospital clearance time: <30 minutes (Priority 1-5)
% of hospital clearance time: <40 minutes (Priority 1-5)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAAS Target</td>
<td>&lt;30 minutes (Priority 1-5) = 65%</td>
</tr>
<tr>
<td></td>
<td>&lt;40 minutes (Priority 1-5) = 85%</td>
</tr>
</tbody>
</table>

6.2 Quarterly Evaluation

SAAS will produce a quarterly report, utilising data extracted from SAAS data systems, to provide LHN COOs and the Executive Director, OSIDM with information about ambulance distribution.

The report will include data on the following process measures:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total transport count</td>
<td>Total number of emergency and urgent cases (SAAS priority 1 to 5) transported to major metropolitan public hospitals</td>
</tr>
<tr>
<td>Transport count for each individual hospital</td>
<td>Proportion of each individual hospital transport to the total transports</td>
</tr>
<tr>
<td>Number of transports by hour of the day</td>
<td>Total number of emergency and urgent cases (SAAS priority 1 to 5) transported to major metropolitan public hospitals by hour of the day</td>
</tr>
<tr>
<td>Weekly Transports by LHN</td>
<td>Weekly number of transports by LHN and trends</td>
</tr>
<tr>
<td>Average Ambulances per hour/hospital</td>
<td>Average number of Ambulances per hour at each hospital</td>
</tr>
<tr>
<td>Average number of emergency and urgent presentation by hour of the day and day of the week</td>
<td>Average number of emergency and urgent (SAAS priority 1 to 5) presentation by hour of the day and day of the week</td>
</tr>
<tr>
<td>Ambulance up-transfer counts</td>
<td>Number of emergency and urgent cases (SAAS priority 1 to 5) transported to a metropolitan hospital Emergency Department where the patient subsequently required a second ambulance up-transfer to a major tertiary hospital. For example, initial transport to NHS and up-transfer to FMC</td>
</tr>
<tr>
<td>Ambulance Threshold transports</td>
<td>Proportion of transports to metropolitan hospital Emergency Departments that were undertaken in line with the Ambulance Thresholds, where the thresholds were not exceeded</td>
</tr>
<tr>
<td>Median and range of hourly transports</td>
<td>Median and range of SAAS (priority 1 to 5) transported to major metropolitan public hospital Emergency Departments, by hospital and hour of day</td>
</tr>
<tr>
<td>Destination compliance</td>
<td>Number of incidents where SAAS paramedic/ambulance officer determined transport to a hospital different to the planned destination hospital &amp; reasons why</td>
</tr>
<tr>
<td>Average transfer of care time/hospital</td>
<td>Average time taken to transfer care from SAAS to hospital</td>
</tr>
<tr>
<td>Median transfer of care</td>
<td>Median time taken to transfer care from SAAS to hospital</td>
</tr>
<tr>
<td>Delays over 30 minutes in transfer of care from paramedic/Ambulance officer to hospital clinician</td>
<td>Number of incidents where transfer of care from SAAS to clinician &gt; 30 minutes and reason why</td>
</tr>
<tr>
<td>Comparison of transfer of care time</td>
<td>Transfer of care time compared to the previous quarter</td>
</tr>
<tr>
<td>Major metropolitan hospitals weekly transfer of care greater than 30 minutes</td>
<td>Transfer of care &gt;30 minutes by week per hospital</td>
</tr>
<tr>
<td>Transfer of care breakdown</td>
<td>% of total count of transfer of care breakdown and sum of transport count for each destination</td>
</tr>
<tr>
<td>Average clearance time/hospital</td>
<td>Average ambulance clearance time at each hospital</td>
</tr>
<tr>
<td>Measure</td>
<td>Definition</td>
</tr>
<tr>
<td>Median clearance time</td>
<td>Median time taken for SAAS to clear hospital</td>
</tr>
<tr>
<td>% successful redirection of crews</td>
<td>Success rate for redirection of crews following HNC instruction</td>
</tr>
<tr>
<td>External triaging</td>
<td>Number of incidents where external triaging occurred per hospital per time of the day/day of the week</td>
</tr>
<tr>
<td>Communication effectiveness</td>
<td>Total number of teleconferences held, hosted by SAAS regarding ED demand and capacity</td>
</tr>
</tbody>
</table>
Any issues encountered in relation to ambulance distribution that impact on patient quality of care are to be recorded through the SLS.

7. EPAS

Not applicable.

8. Exemption

Not applicable.

9. National Safety and Quality Health Service Standards

10. Risk Management

LHNs and SAAS are responsible for establishing local guidelines and procedures to support this Policy Directive which will ensure a valid risk management approach to the coordination of ambulance distribution and acceptance of ambulance arrivals by hospitals.

11. Evaluation

The ambulance distribution framework and established ambulance thresholds will be evaluated on a quarterly basis by SAAS, LHNs and the DHA in partnership. The report to be developed to inform the quarterly evaluations are set out in section 6 of this Policy Directive.

This Policy Directive will be evaluated and reviewed five years from date of approval, in line with DHA requirements. Review and amendment may occur more frequently if new information becomes available.

12. Definitions

**Ambulance demand escalation (teleconference)** means the processes that may be activated, in line with the provisions of this Policy Directive, by an LHN COO or SAAS On-Call Director, when an LHN or SAAS determines it is unable to continue to manage current ED/ambulance demand.

**Ambulance distribution framework** means the supporting framework ensuring, as far possible, the appropriate balance of Ambulance arrivals across metropolitan Emergency Department to minimise the potential impact of surges in Emergency Department demand.

**Ambulance threshold** means the number of ambulance arrivals per hour for each metropolitan hospital Emergency Department that can be effectively managed under normal circumstances.

**Ambulance turnaround time** means the total time from ambulance arrival at the hospital ambulance arrival bay to the time available for another emergency dispatch (clear for next dispatch).

**Case-by-case distribution** means distribution organised between two COOs/Executives On-Call for specific types of patients, occurring after hours (between 12.01am and 6.59 am).
Even distribution means where ambulance thresholds have been reached within the hour period and SAAS distributes ambulances evenly between the three metropolitan regional LHNs.

Hospital Nominee means the Bed Manager, Patient Flow Coordinator, or Hospital Coordinator during business hours; the After Hours Coordinator for after hours.

Patient transfer of care time means the total time for the patient to be transferred from the paramedic/ambulance officer’s care to that of the hospital staff taking responsibility for ongoing clinical care. The time includes triage, the physical transfer of the patient and clinical handover to hospital clinical staff.

Triage means the formal process used to immediately assess all patients arriving in an Emergency Department to determine the urgency of their care requirements.

13. Associated Policy Directives / Policy Guidelines

- SA Health Hospital Escalation Policy Directive (draft)
- SA Health Direct Admission to a Hospital Inpatient Unit Guideline, 2011
- LHN Hospital Escalation Policies and Business Continuity Plans

14. References, Resources and Related Documents

Not applicable.
## Appendix 1 SA Health Standard Escalation Strategies and Actions

<table>
<thead>
<tr>
<th>Alert</th>
<th>Trigger</th>
<th>Strategies &amp; Actions</th>
</tr>
</thead>
</table>
| **Green Alert**     | <90% Occupancy           | - Usual capacity management processes to occur, in line with Bed Capacity Management Framework Policy Directive 2016  
- Clinical Service Coordinators capacity meeting to be convened as necessary, to discuss identify demand pressures  
- Identify and monitor potential barriers to flow using tools such as OBI Emergency Department and Inpatient Dashboards  
- Active ward rounds and clinical review to prioritise appropriate discharges  
- Enact hospital avoidance strategies through the use of hospital substitution and community home support programs  
- Prioritise assessment of emergency patients requiring ambulatory trauma surgery to determine if clinically suitability for discharge home prior to surgery within 24-72 hours  
- Pharmacy, radiology and Allied Health to be prioritised to support timely patient discharge  
- Patient transport to be arranged as early as possible to support timely patient discharge  
- Use of discharge/transit lounges maximised to ensure beds are available for new admissions  
- Repatriate clinically appropriate patients to originating Local Health Network, including Country Health SA Local Health Network  
- Active identification of discharge delays and escalation to Nursing Director  
- Identify long stay patients medically fit for discharge/transfer and escalate to Divisional Director |
| **Amber Alert**     | 90 – 95% Occupancy       | - Chief Operating Officer/Executive On-Call to be notified of Amber Alert status  
- Heads of Unit/Divisional Directors to be notified of Amber Alert status  
- Divisional Directors capacity meeting to discuss increased demand and identify additional actions to relieve pressure  
- Orderly transfers and cleans to be prioritised to fast track bed availability for new admissions  
- Additional ward rounds by medical and nursing staff to be conducted to fast track clinically appropriate discharges and Criteria Led Discharge  
- Review planned admissions to identify patients that may be postponed and rebooked at a later date  
- Review overnight elective surgery list to identify patients who may be postponed and rebooked at a later date  
- Consideration of internal processes that support patient movement between hospitals to balance demand. |
| **Red Alert**       | 95 - 100% Occupancy      | - Chief Operating Officer/Executive On-Call (or delegate) capacity meeting to discuss increased demand and identify additional actions to relieve pressure  
- Assess the need for additional staff resources to ensure patient care/treatment is performed in a safe and timely manner  
- Review private patients and identify opportunities for transfer to a private hospital  
- Review non-aligned metropolitan patients to identify opportunities for transfer to peri-urban country hospitals  
- Consideration of Ambulance demand escalation teleconference |
| **Grey/White Alert**| >100% Occupancy          | - Consider adjustments to bed base capacity in line with Bed Capacity Management Framework Policy Directive 2016  
- Statewide teleconference with Local Health Networks, SA Ambulance Service and Department for Health and Ageing to discuss demand pressures and activation of additional state-wide strategies |
Appendix 2 Process for Demand above Usual Ambulance Thresholds – Maximum Thresholds

During peaks in demand, each hospital has the ability to increase their usual hourly threshold to the maximum threshold via the process outlined below.

1. Where all hospitals within a Local Health Network (LHN) have reached their usual threshold and that LHN continues to be identified as the most appropriate hospital destination for forthcoming ambulances, the SA Ambulance Service (SAAS) Hospital Network Coordinator (HNC) will contact the Chief Operating Officer (COO) of Executive On-Call via text message.

2. The text message will notify the COO or Executive On-Call that all thresholds within the LHN have been reached and an increase to the maximum threshold will occur.

As an example, where both the Royal Adelaide Hospital (RAH) and The Queen Elizabeth Hospital (TQEH) have received 7 and 4 ambulances respectively within the hour period, the SAAS HNC may contact the COO or Executive On-Call to advise that additional ambulances may be flowed, up to 10 at the RAH and up to 6 at TQEH.

3. An increase to the maximum threshold will occur for the remainder of the hour.

4. If COO or Executive On-Call has any concerns about the ability to facilitate ambulance arrivals up to the maximum thresholds, the COO of Executive On-Call may contact the SAAS HNC upon receiving notification to discuss alternative options.

5. The COO or Executive On-Call is to communicate the increase to the maximum threshold to relevant Emergency Department and Patient Flow staff in line with local communication processes.
### Appendix 3 Process for Demand above Usual Ambulance Thresholds – Even Distribution

Where ambulance thresholds have been reached within the hour period, SA Ambulance Service (SAAS) will distribute ambulances evenly between the three metropolitan Local Health Networks (LHNs) via the process outlined below.

1. Where demand continues and the maximum hourly ambulance thresholds have been reached within an LHN for the hour period, the SAAS Hospital Network Coordinator (HNC) will notify the LHN Chief Operating Officers (COOs) or Executives On-Call via text message.

2. The text message will notify the COOs or Executives On-Call that maximum ambulance thresholds have been reached and even distribution arrangements will be implemented, where possible and practical, for the remainder of the hour.

3. The SAAS HNC will seek to evenly distribute ambulances between the three metropolitan LHNs.

4. Activation of even distribution will mean one ambulance to each site within the Central Adelaide LHN; one ambulance to each site within the Southern Adelaide LHN; one ambulance to each site within the Northern Adelaide LHN, and so on until the hour is completed and normal distribution arrangements are reinstated.

5. The COO or Executive On-Call is to communicate the increase to communicate the even distribution above maximum thresholds to relevant Emergency Department and Patient Flow staff in line with local communication processes.
Appendix 4 Ambulance Demand Escalation Teleconference Request Process

When a Local Health Network (LHN) is unable to continue to manage its ambulance and Emergency Department/hospital demand or; where SA Ambulance Service (SAAS) is experiencing excessive demand or delays in transfer of care that impact ambulance operational requirements, a LHN or SAAS Chief Operating Officer (COO)/Executive On-Call may request an ambulance demand escalation teleconference via the process outlined below.

1. LHN COO/Executive On-Call or the SAAS On-Call Director contacts the SAAS Hospital Network Coordinator (HNC) by telephoning 1300 117 362 to request an Ambulance demand escalation teleconference.

2. Requesting LHN COO/Executive On-Call or the SAAS On-Call Director advises the SAAS HNC of the primary issue and any specific clinical areas of concern e.g. Mental Health.

3. The SAAS HNC sends a text message to all LHN COOs/Executive On-Call, the SAAS On-Call Director and the Executive Director, Operational Service Improvement and Demand Management (OSIDM), requesting participation in teleconference. The text will contain teleconference phone number and pin.

4. The timeline for participation in the teleconference should be reasonable, for example 30 minutes from time of initial contact

5. LHN COOs/Executive On-Call, the SAAS On-Call Director and the Executive Director, OSIDM are requested to participate in the escalation teleconferences.

6. In receiving the text message, each participant will have maximum 30 minutes to obtain an update of capacity/demand issues within their LHN/SAAS ensuring the COO/Executive On-Call/On-Call Director is equipped to negotiate and make decisions.

7. The SAAS On-Call Director will chair the teleconference via the following process outlined in Appendix 3.
Appendix 5 Conducting the Ambulance Demand Escalation Teleconference

1. SAAS Chair asks requestor to provide a summary of the major issue including any relevant details of the following:
   - The events leading to the issue/situation;
   - Any other area of concern;
   - Ambulance details including arrivals, onsite, expected, delays;
   - Any Emergency Department concerns for example, limited Emergency Department beds available;
   - Any back of house concerns for example, limited inpatient beds available;
   - Total number of expected discharges planned at each hospital within their LHN;
   - Total number of transfers to peri-urban hospitals planned including acute and maintenance patients at each metropolitan hospital;
   - Any other access blocks e.g. transfer to county health but no Ambulance available;
   - Internal demand escalation actions enacted for example, additional staff resources rostered, ceased Elective Surgery, opened beds.
   - For SAAS, the total number of transfers or discharges booked currently, and for the previous 24 hours, the number of transfers or discharges booked and actual transfers enacted.
   -(Total duration 5 minutes maximum)

2. SAAS Chair asks each metropolitan Local Health Network (LHN) to provide a summary and current state for each site including:
   - Current Emergency Department demand and capacity i.e. availability of Emergency Department beds;
   - Current and expected back of house demand and capacity (including number of planned discharges for each hospital);
   - Current Ambulances delayed in transfer of care;
   - Internal strategies and escalation actions that have been activated.
   - (2 minutes each LHN, total duration 6 minutes maximum)

3. SAAS Chair provides a summary of current ambulance issues and expected arrivals at each site for the next hour.
   -(Total duration 5 minutes maximum)

4. SAAS Chair asks Country Health SA to provide a summary of each peri-urban site and where metro transfer or ambulance redirection to peri-urban Emergency Department could occur.
   -(Total duration 2 minutes maximum)

5. SAAS Chair asks the Executive Director, OSIDM to provide any additional information that may be relevant to the current situation.
   -(Total duration 2 minutes maximum)

6. Where the solution is clear, the SAAS Chair will suggest the action and seek agreement from all participants.

7. Where the solution is complex and requires additional coordination, the SAAS Chair will aim to negotiate a fair and equitable solution that ensures one LHN is not more burdened than another.

8. In situations where participants cannot agree on a resolution or require statewide strategies to be enacted the SAAS Chair will escalate to the LHN and SAAS Chief Executive Officers and the Deputy Chief Executive, Transforming Health Division, Department for Health and Ageing to seek advice/approval.
Appendix 6 Ambulance Patient Arrival & Transfer of Care in the Emergency Department

1. Ambulance arrival at hospital
2. Hospital to facilitate patient to triage
3. Emergency Department Triage
4. Transfer of patient to Emergency Department cubicle or other areas such as holding bay

- **Timely SAAS handover/transfer of care to Emergency Department Clinician**: < 15 min from Emergency Department arrival
- **Delayed SAAS handover/transfer of care to Emergency Department Clinician**: > 15 min from Emergency Department arrival

- **Time of SAAS transfer of care to Emergency Department Clinician** to be recorded in patient Hospital Medical Record and SAAS system

- **30 Min**
  - SAAS paramedic to notify delay to HNC and SAAS SDM. SDM or HNC must call Hospital Chief Operating Officer (COO).
  - COO arrange SAAS handover/transfer of care to ED Clinician

- **15 min**
  - SAAS paramedic to notify delay to Hospital Network Coordinator (HNC) and SAAS State Duty Manager (SDM)

- Delays in patient transfer from Ambulance to Emergency Department (ED) to be recorded in the Safety Learning System (SLS) Incident Management

- Notify ‘clear for tasking’ to SAAS Emergency Operation Centre

- Complete documentation
- Restock ambulance

- ‘Ambulance turnaround time commences’
### Appendix 7 Contact Details

#### Hospital Nominees

<table>
<thead>
<tr>
<th>Role</th>
<th>Phone</th>
<th>Pager</th>
<th>Mobile</th>
<th>Role</th>
<th>Phone</th>
<th>Pager</th>
<th>Mobile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lyell McEwin Hospital</td>
<td>8182 9180</td>
<td>6007</td>
<td>0409 478 943</td>
<td>Divisional Nurse Coordinator</td>
<td>8182 9180</td>
<td>6007</td>
<td>0409 478 943</td>
</tr>
<tr>
<td>Modbury Hospital</td>
<td>8161 2000</td>
<td>0001</td>
<td>0435 966 974</td>
<td>Bed Manager</td>
<td>8161 2000</td>
<td>4001</td>
<td>0435 966 974</td>
</tr>
<tr>
<td>Royal Adelaide Hospital</td>
<td>8222 0707</td>
<td>SD1818</td>
<td>0401 123 770</td>
<td>Hospital Flow Coordinator</td>
<td>8222 0707</td>
<td>SD1818</td>
<td>0401 123 770</td>
</tr>
<tr>
<td>The Queen Elizabeth Hospital</td>
<td>8222 7679</td>
<td>3897</td>
<td>0466 151 646</td>
<td>Capacity Manager</td>
<td>8222 6000</td>
<td>6112</td>
<td>0466 151 646</td>
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<tr>
<td>Flinders Medical Centre</td>
<td>8204 5409</td>
<td>38043</td>
<td>0477 367 730</td>
<td>Central Flow Coordinator</td>
<td>8204 4923</td>
<td>3726</td>
<td>0477 367 730</td>
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<tr>
<td>Noarlunga Hospital</td>
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<td>-</td>
<td>0434 079 508</td>
<td>Bed Flow Coordinator</td>
<td>8384 9448</td>
<td>-</td>
<td>0401 124 772</td>
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<tr>
<td>Women’s and Children’s Hospital</td>
<td>8161 6650</td>
<td>3843</td>
<td>0402 855 965</td>
<td>Nursing Service Director ED</td>
<td>8161 6558</td>
<td>3715</td>
<td>0434 079 541</td>
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<tr>
<td>SA Ambulance Service</td>
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<td></td>
<td></td>
<td>SAAS Hospital Network Coordinator</td>
<td>1300 117 362</td>
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*Note: Mobile phone contact is the preferred option in the first instance*

#### Ambulance Demand Escalation Contact Details (Executive)

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<tr>
<th>Role</th>
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<th>Pager</th>
<th>Mobile</th>
<th>Role</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Lyell McEwin Hospital</td>
<td>8182 9230</td>
<td>-</td>
<td>0478 301 837</td>
<td>Executive on-call</td>
<td>Switchboard on 8182 9000</td>
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<tr>
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<td></td>
<td>Executive on-call</td>
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<tr>
<td>Royal Adelaide Hospital</td>
<td>8222 0808</td>
<td>-</td>
<td>0475 941 922</td>
<td>Executive on-call</td>
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<tr>
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<td></td>
<td>Executive on-call</td>
<td>Switchboard on 8222 6000</td>
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<tr>
<td>Flinders Medical Centre</td>
<td>8204 5513</td>
<td>-</td>
<td>0419 365 596</td>
<td>Executive on-call</td>
<td>Switchboard on 8204 5511</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>Executive on-call</td>
<td>Switchboard on 8384 9222</td>
</tr>
<tr>
<td>Women’s and Children’s Hospital</td>
<td>8161 8259</td>
<td>-</td>
<td>0410 459 895</td>
<td>Executive on-call</td>
<td>Switchboard on 8161 7000</td>
</tr>
<tr>
<td>Country Health SA</td>
<td></td>
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<td></td>
<td>Chief Operating Officer</td>
<td>0417 842 394</td>
</tr>
<tr>
<td>Department for Health &amp; Ageing</td>
<td>8226 6197</td>
<td>-</td>
<td>0419 435 773</td>
<td>Executive Director, OSIDM</td>
<td>0419 435 773</td>
</tr>
<tr>
<td>SA Ambulance Service</td>
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<td></td>
<td></td>
<td>On-Call Director</td>
<td>as per SAAS roster</td>
</tr>
</tbody>
</table>

*It is recommended that LHNs regularly review their contact details and provide any updated information to [DLHealthSAASHNC@sa.gov.au](mailto:DLHealthSAASHNC@sa.gov.au)*