Government of **Western Australia**
Department of **Health**

Assertive Patient Flow and Bed Demand Management for Adult Services

Policy and Practice Guidelines

Delivering a **Healthy WA**

Foreword

Access to appropriate inpatient care in a safe and timely way is one of the fundamentals emphasised in the National Standards for Mental Health Services.

This policy has been constructed with the goodwill of many people involved in the continuum of mental health care in Western Australia. It allows a better understanding of the processes involved in managing the patient journey through community, emergency department and inpatient services for the benefit of all of our patients and the wider system.

South East Sydney Mental Health Service has generously shared their overall framework for the policy. Services across Australia have similarly shared their experiences and we have been able to contextualise them to Western Australia.

Mr Michael Finn and Mr Kieran Byrne have been pivotal in championing the principles of Assertive Patient Flow. We now have much better systems which allow us to use data to inform our practice, and more clearly defined processes which improve patient care.

The policy has been scrutinised and endorsed by SHEF (the State Health Executive Forum). Details in this policy will be amended as the configuration of mental health services change with the ongoing development of the Western Australian Clinical Services Plan.

Dr Elizabeth Moore

Executive Director Mental Health
South Metropolitan Area Health Service

Dr Ann Hodge
Area Executive Director
North Metropolitan Area Health Service

Richard Menasse
Area Director
WACHS Mental Health

Contents

1. Executive summary

All persons requiring mental health services deserve timely and efficient access to the best possible care. Patient flow to acute and non-acute care facilities should be viewed within a continuum of care in which the complimentary inpatient and ambulatory care settings collaborate to assertively promote rehabilitation and recovery for people with a mental illness.

South East Sydney Mental Health Services (2007)
Acute Bed Management and Sustainable Access Policy Guidelines

This document provides policy direction for consistency in patient flow processes and sustainable bed management practices within and between mental health services in Western Australia.

(Acknowledgement is made to South East Sydney Mental Health Services and Access and Service Integration Manager Angela Karooz for kind permission to utilise elements of their service model and operational guidelines in this document.)

2. Introduction

Across Australia, the demand for mental health beds is high. Bed occupancy rates for mental health services consistently exceed 95%, and for every bed vacated there is a waitlist of patients requiring admission.

Mental health services are required to develop, implement and maintain a planned and predictive patient flow model that enhances capacity and accommodates peaks in bed demand.

While a number of strategies are being developed to assist in bed demand management, this policy will guide consistent patient flow processes and equitable bed management practices.

3. Purpose

This policy document has been developed to maximise the efficient use of acute mental health beds and to ensure improvement and consistency in the management of patient flow across the wider mental health system. Other aims include:

- Achieving self–sufficiency in managing acute mental health bed demand within each district / area mental health service
- Encouraging the engagement of senior clinicians in ongoing reviews of their bed management and related clinical practices, including bed usage, discharge planning, quality improvement and continual evaluation of programs and treatments
- Improving patient flow and coordination between hospital Emergency Departments (EDs) and community and inpatient mental health services
- Improving the flow of mental health inpatients from acute units to medium and long-term care facilities and other alternate care.

4. Scope of policy

This document applies to the referral / admission / transfer of any patient from any location or facility to the care of an adult acute mental health inpatient service in Western Australia.

5. Overarching policy principles

While the bed management system assists all services to monitor and manage bed capacity, focus should remain on providing an integrated approach to the continuum of mental health care. These principles include:

- Patient-focused care, ensuring access to a seamless continuum of care
- Contemporary service delivery, including use of least restrictive options for care
- Effective coordination between community-based elements of care and inpatient units
- The local service has primary responsibility to meet bed requirements for those patients within their catchment
- All patients requiring admission will be prioritised on risk and need
- It is recognised that EDs have specific needs within the broader system for timely decision making and discharge or transfer to a more appropriate setting
- Appropriate patient flow for all patients with mental health issues within the general hospital setting
- All public mental health services form a part of the wider public mental health system and are required to comply with this policy.

6. Service responsibilities

There are two clear overarching responsibilities:

(i) Units providing inpatient public mental health services are, via the designated bed management contact (see Appendix 1), responsible for locating an appropriate bed to accommodate a referral.

(ii) Referring public mental health clinicians will remain responsible for ensuring the ongoing care of a patient until the unit formally receives the patient. This responsibility includes, either directly or via comprehensive handover of care, the ongoing assessment of risk and ongoing communication to catchment inpatient service of any escalation of risk to assist the process for re prioritisation of admission.

See Appendix 2: Referral Pathway for Admission to a Mental Health Bed.

7. Principles of assertive patient flow

- Patients are preferably treated in the community. As a patient becomes unwell, the opportunity for community treatment decreases progressively while the requirement for inpatient treatment increases progressively.
- When a patient is assessed to be appropriate for inpatient treatment, admission can be facilitated if a bed is available.
- If a bed is not immediately available, the risk assessment for community care should be evaluated against the anticipated delays in obtaining an inpatient bed.
- Increasingly higher risk requires increasingly more assertive admission facilitation / early discharge planning.
- Lower risk assessment justifies continuation of assertive community treatment until a bed can

be found or as an alternative to admission.

- At any point in time, inpatient teams and community teams have a shared responsibility to ensure that inpatient beds are utilised efficiently, so that the most appropriate patient group occupy available inpatient beds.
- Assertive admission and early discharge strategies should be utilised concurrently to ensure access to beds for acutely unwell community patients.
- When inpatient units experience high levels of acuity, referring community clinicians should explore alternative options and consider treating patients more assertively in the community and/or accept early discharge inpatients who can be managed assertively in the community.
- Each service will have a coordinated and planned admission and discharge process to optimise patient flow.
- Services will adopt criteria led discharge processes to promote best practice in patient flow.
- Discharge planning starts at the point of admission.
- A planned date of discharge for each inpatient will be entered onto the journey board / TOPAS / medical notes on admission and reviewed within 72 hours.
- The initial planning and subsequent review of discharge dates should occur routinely. Weekend discharges should be planned before Fridays to establish the potential number of bed vacancies before the weekend or public holidays to allow for appropriate deployment of community resources.
- Community teams will remain involved with patient care throughout the inpatient admission episode; initially to facilitate entry and then to facilitate transfer back to community care.

8. Mental health bed management system

The local Clinical Director/Head of Clinical Service of the receiving inpatient catchment unit is responsible for:

- Allocation of patients to secure/open units
- Prioritisation of patients on expected admission list
- Admissions and discharges
- Negotiation with referring services as required.

Bed utilisation is locally managed but centrally coordinated by the Nurse Director Mental Health Patient Flow, 8:30am–5:00pm, Monday–Friday. This post supports effective coordination and utilisation of adult acute mental health beds within mental health services in WA, together with Assertive Patient Flow Coordinators / local Bed Managers.

After hours bed utilisation is coordinated by the Mental Health Bed Management Medical Director on-call.

9. Mental health assertive patient flow coordinators

There are a number of dedicated Assertive Patient Flow Coordinator posts that operate across both the north and south metropolitan mental health services. These positions are located within and operate across district mental health services, and maintain a system-wide perspective and

report directly to the Area Mental Health Executive Directors.

Assertive Patient Flow Coordinators monitor bed capacity against bed demand, and coordinate prioritisation of bed resources across the metropolitan area and facilitate patient flow.

Each site with mental health beds will have a designated Bed Manager (or nominated responsible person; refer to Appendix 1). This clinician (usually a nurse, but this may vary between sites) is the designated contact for discussion and facilitation relating to bed availability. The Bed Manager will also manage the local expected admission list.

Assertive Patient Flow Coordinators work closely with local Bed Managers in the effective coordination and management of mental health beds and patient flow, utilising a statewide perspective, especially during peak demand periods.

Assertive Patient Flow Coordinators ensure the accuracy of data for the Nurse Director Mental Health Patient Flow, and proactively identify admission, internal flow and discharge from inpatient units to build capacity in the services. Assertive Patient Flow Coordinators operate seven days a week, 7:00am–5:00pm.

10. Mental health bed census

All beds that are designated as mental health beds are monitored via a central electronic bed management system that is coordinated by the Nurse Director Mental Health Patient Flow. Designated mental health clinicians and administrators have access to the information.

Strict business rules are in place to ensure the accuracy of the system and these rules govern the currency of the bed stock at the major mental health sites in the state.

The Nurse Director Mental Health Patient Flow is responsible for the currency of the State mental health bed stock and the accuracy of the bed management system.

11. Mental health bed management medical director

A Mental Health Bed Management Medical Director is available after hours for consultation on bed management issues across WA. A senior Consultant Psychiatrist is rostered to provide this function. It is expected that the Mental Health Bed Management Medical Director is contacted once all other provisions in this document have been explored.

The Mental Health Bed Management Medical Director will be kept informed of any high risk situations.

The Mental Health Bed Management Medical Director has the authority to direct patient admissions. This includes any adult acute mental health inpatient service in Western Australia.

During business hours, the relevant Clinical Director/Head of Clinical Service should be contacted where local Bed Managers are unable to resolve an issue. The Area Mental Health Executive Director can be contacted if there is a situation that cannot be resolved at the local level.

12. Referral pathway for admission to a mental health bed

The referral pathway should be consistent irrespective of the source of the referral.
See Appendix 2.

13. Admissions from WA Country Health Service

The referral pathway is applied consistently across the State. It is acknowledged that application of and adherence to the pathway can be complex in remote areas and both referring and admitting services will work collaboratively to ensure the best outcome for the patient.

Transfers and bed management practices should allow for consideration of both:

- what is closest geographically
- what facility is most suitable to provide the care required.
- Reference should be made to relevant policies

See Appendix 4.

14. Referral pathway from the Frankland centre and the courts

The referral pathway for Frankland Centre patients who are no longer under legal orders and no longer require the level of security provided by the Frankland Centre is as follows:

- Consider which service is most suitable to provide the care required.
- If there are any concerns, hold a case conference immediately.
- The patient should remain in the Frankland Centre until the referral pathway is agreed.
- If the patient has been an active patient of a mental health service prior to admission to the Frankland Centre refer to that service.

Patients referred from the courts who are not under legal orders and do not require the level of security provided by the Frankland Centre should be referred according to their catchment area.

Patients with no fixed address should be referred as per this policy.

If no links exist escalate immediately to Nurse Director Mental Health Patient Flow. If a decision cannot be reached the Nurse Director Mental Health Patient Flow will refer to the Area Mental Health Executive Directors for final decision.

15. Patients of no fixed address

Patients should be admitted to services where they are known based on the following priority order:

1. If the patient has been admitted to a unit within the 90 days prior to the current admission, admit to that unit
2. If the patient has been an active patient of a community mental health service within the last six months, admit to that unit
3. If there is a history of numerous admissions over several years to an inpatient unit, admit to that unit
4. If significant social supports or links in the area, admit to that unit.

For patients of no fixed address (NFA) without links, from interstate, tourists or recently homeless:

- Return patient to unit if discharged within the last 90 days
- Assessing service must make robust enquiries to try to identify patient community links
- If no links exist, patient is to be admitted wherever they present.

The following applies to NFA patients presenting at hospitals requiring a secure bed when there is no secure bed available:

- Royal Perth Hospital NFA patients are to be admitted to Bentley Hospital
- Sir Charles Gairdner Hospital NFA patients are to be admitted to Graylands Hospital
- Peel ED NFA patients are to be admitted to Rockingham Hospital.

Patients referred from WACHS to metropolitan area:

- If patient has moved to the country area within the last 90 days and has previous substantial links with a particular metropolitan area, admit to an inpatient unit in that metropolitan area
- All other country patients are to be admitted to Graylands Hospital.

16. Managing mental health patients admitted to an emergency department

This object of this protocol is to transfer mental health patients to an appropriate clinical environment within 24 hours of admission to an ED. The following procedure applies both to patients who have been referred under the Mental Health Act to an authorised hospital as well as voluntary patients:

(i) The referrer from ED (ED mental health liaison, Consultant Psychiatrist, GP or delegate) contacts the Bed Manager of the designated catchment area hospital. If a bed is available, the patient is transferred as soon as possible. If a bed is not available, authorised / non authorised units as appropriate are contacted, starting with those in closest proximity to ED by the Bed Manager or delegate. The ED mental health liaison staff, local Bed Managers and Assertive Patient Flow Coordinators all have responsibility to work together to locate a bed in the shortest possible time. If a bed is not available at any unit, the patient is placed upon the wait list of the designated catchment area hospital.

(ii) (ii) If no bed is available, the patient is to be assessed by a Consultant Psychiatrist within ED within a reasonable period. Where this cannot be provided within a reasonable period (e.g. remote areas) consultation by phone or videoconference will occur.

(iii) The Consultant Psychiatrist may determine that admission is no longer necessary, in which case other management options will be pursued. If the patient continues to require inpatient care, the Consultant Psychiatrist or delegate re-checks bed availability with the assistance of the Bed Manager.

(iv) If no bed is available in any hospital and admission continues to be required, the patient will remain admitted within the ED. While the patient remains in the ED, care of the patient should be regularly reviewed by the Consultant Psychiatrist or delegate.

17. Bed demand management

All mental health services are required to have bed demand management plans in place to ensure early notification of “at or near capacity status” and to facilitate a rapid operational response.

The following options should be considered, where safe and clinically appropriate:

- Identify “out of area” patients who may be considered for repatriation to catchment service.
- Identify patients who may be considered for transfer and admission to a private mental health facility.
- Identify and review status of any patients on leave. A “leave bed” is an “available leave bed” where an admitted patient is on prolonged leave (overnight or longer). Where a mental health service has available leave beds, new patients should always be admitted to those beds in preference to seeking transfer to an inpatient unit in another district or Area Health Service.
- Identify clinically appropriate patients, above and beyond those who have been identified for planned discharge, who would be appropriate for discharge to assertive, community based mental health care. The final authority regarding discharge rests with the respective Clinical Director / Head of Clinical Service.
- Transfers between units for bed availability reasons should occur within local district and area services before exploring options to access beds in other area health services.
- Each unit has an identified contingency plan for going “over the count” or “over-census” at times of high demand for beds. The contingency plan for each unit takes into account factors such as particular unit configuration, current patient acuity levels and sustainable available staffing profile, which may vary from time to time. Members of the Mental Health Bed Management Medical Director roster will be apprised regularly of the currently applicable “over-census” provision at each inpatient unit, and have the authority to direct the allocation of patients to such beds. These “over-census” places are not to be confused with “leave beds” which have been used to accommodate newly admitted patients. A unit is not deemed to have become full or to be “at census”, until every available bed, including any “leave bed”, is occupied.
- Over Census Policies

    1. **Alma Street Centre**
       http://cmsdata.smahs.health.wa.gov.au/default.aspx?stream=inline&ID=36102&FileName=census.pdf
    2. **Armadale**
       http://akhs.health.wa.gov.au/Policies/Mental_Health_Policies/Emergency%20Transfer%20to%20Karri%20Ward%202010%20.pdf
    3. **Bentley**
       http://cmsdata.smahs.health.wa.gov.au/default.aspx?stream=inline&ID=37872&FileName=overcensus.pdf
    4. **Royal Perth Hospital 2K**
       http://servio.rph.health.wa.gov.au/pls/portal30/docs/FOLDER/RPH_PSYCHIATRY/PROCEDURES/POLICY+OVERCENSUS+REVISED+10-10+DEP+PSYCH.PDF

5. **Graylands**
   http://graylands.health.wa.gov.au/policies/Overcensus30052011.doc
6. **Swan Valley Centre**

   http://intranet.health.wa.gov.au/nmahsmh/policies/index.cfm?cid=3
7. **Sir Charles Gairdner Hospital D20**

   http://intranet.health.wa.gov.au/nmahsmh/policies/docs/Over_Census_Policy_A.doc

- A referrer may wish to request the interim management of a referred patient in an ED because no beds are available in authorised hospitals. In these circumstances, the Clinical Director / Head of Clinical Service during business hours or the Mental Health Bed Management Medical Director after hours must contact the ED physician in charge to negotiate temporary placement.

18. Bed access prioritisation

Bed access prioritisation refers to management of the expected admission list (EAL) for mental health inpatient beds so that patients receive access to beds according to specified principles. Bed prioritisation reflects the needs of the individual patient, noting that this may be impacted by systemic needs of all patients on all EAL.

Bed access prioritisation relates specifically to patients requiring open or secure secondary acute mental health beds. Patients with tertiary requirements (including forensic, slow stream rehabilitation, chronic medical co-morbidity) should be registered through the appropriate tertiary service referral process.

- Bed access prioritisation by Bed Managers should start before 9am every day, including weekends and public holidays, and be updated as required during each 24 hour period.
- Bed Managers (or at some services triage staff) continually liaise with the referrer and collect information for those on the EAL for their inpatient service. Information collected is based on clinical need and risk in order to establish relative priority. A standardised risk assessment should be used for equity of access on EAL, and reviewed regularly.
- The highest acuity patients across the system get the highest priority access to a mental health bed. Any patient whose risk is exceedingly high based on immediacy of risk, high level of dangerousness and low level of containment / containability or other considerations will be escalated to higher priority by agreement between the referrer and the inpatient service Clinical Director / Head of Clinical Service.
- The Nurse Director Mental Health Patient Flow is responsible for collating / comparing the various EAL across metropolitan mental health inpatient units.
- Creation of a secure bed for a patient requiring that level of acute care will generally take priority over access to an open bed. No authorised inpatient service has the right to refuse receival of a patient referred on Form 1 under the *WA Mental Health Act*.
- A high acuity patient in an Emergency Department should be considered an urgent priority for bed access.
- If a patient has been on a EAL for an increasingly unacceptable time, this would escalate their priority.

- The inpatient Clinical Director / Head of Clinical Service is responsible for ratifying daily bed access prioritisation at each inpatient service.
- The referrer should discuss with the inpatient service any specific, significant concerns about level of risk for their patient on the wait list. The referrer should alert the inpatient service to any change of status of patients on the EAL.
- Once an inpatient service has advised the referrer to arrange transport and send the patient, this process can only be reversed in rare and extreme circumstances, with the agreement of both the referrer and the inpatient service Clinical Director / Head of Clinical Service.
- The inpatient Clinical Director / Head of Clinical Service has recourse to speak with the Area Executive Director if a referral matter cannot be resolved locally. The Area Executive Directors will be the final arbiters of bed access prioritisation in business hours. After hours, the Mental Health Bed Management Medical Director will be the final arbiter of bed access prioritisation.

19. Police transportation of mental health patients

A protocol exists between the WA Police and the Mental Health Division in respect to hospital to hospital transportation of mental health patients (http://www.chiefpsychiatrist.health.wa.gov.au/publications).

Appendix 1: Bed management contact list

WA Mental Health Services Bed Management Contact List

All initial requests for beds must be made in accordance with this endorsed list of contacts

UNIT	BUSINESS HOURS	AFTER HOURS	CLINICAL LEADER
Leschen Unit Armadale	Shift Coordinator Adult Inpatient Open Ward 9391 2300	Shift Coordinator Adult Inpatient Open Ward 9391 2300	Clinical Director 9319 7202 (business hours) mobile via switchboard (a/h)
Mills Street Centre Bentley	Triage 9334 3666 Page: 501	Duty CNS 9334 3666 Page: 504	Clinical Director 9334 3907 (business hours) mobile via switchboard (a/h)
Alma Street Centre Fremantle	Bed Manager 9431 3333 Page: 3481	Bed Manager 9431 3333 Page: 3481	Clinical Director 9431 3333 (business hours) mobile via switchboard (a/h)
Swan Valley Centre	Duty CNS 9347 5797 Mobile 0414 339 538	Duty CNS 9347 5797 Mobile 0414 339 538	Head of Clinical Service 9347 5700 (business hours) 9347 5797 (a/h)
Graylands Hospital	Triage 9347 6407 9347 6600 (switchboard)	Triage 9347 6407 9347 6600 (switchboard)	Head of Clinical Service 9347 6600 (switchboard)
Royal Perth Hospital Ward 2K	Psychiatric Liaison Nurse 0404894094 page 3000	Psychiatric Liaison Nurse 0404894094 page 3000	Head of Clinical Service 9224 1750 Page: 7777
Sir Charles Gairdner Hospital Ward D20	CNS/Bedmanager 0426 232 263	Duty Medical Officer 9346 3333 Page: 4299	Head of Clinical Service 9346 2100 (business hours) mobile via switchboard (ah)
Bunbury Mental Health Unit	Psychiatric Liaison Nurse 0428 154 896	Duty Medical Officer 9722 1000	Duty OnCall Psychiatrist 9722 1000
Rockingham Mental Health Unit Mimidi Park	Bed Manager 95994990	Bed Manager 95994990	Clinical Director 9528 0600 (business hours) mobile via switchboard (ah)
Joondalup Mental Health Unit	Duty CNS 9400 9784	Nurse Coordinator 9400 9784	Head of Department 9400 9784

Appendix 2: Referral pathway for admission to a mental health bed

Note: The metropolitan to Bunbury referral pathway has a preferential alignment with Peel /Rockingham (see Appendix 3 however during Gridlock other metropolitan hospitals can access Bunbury beds[2]

Referral to mental health inpatient bed once all other less restrictive alternatives have been explored

Referrer contacts local inpatient service Bed Manager or delegate

Bed available - transfer arranged

No immediate bed at local inpatient service:
- It is the responsibility of the receiving service to find a bed
- Local Bed Manager advises referrer of time frame until bed available

Time frame acceptable to referrer; wait list process commences

Time frame unacceptable

Local Solution
Patient acuity requires faster transfer - local bed demand strategies commence. Options might include:
- Identify and review status of any patients for leave or transfer to open bed
- Identify "out of area" patients who may be considered for repatriation to catchment service
- Identify patients who may be considered for transfer and admission to a private mental health facility / veteran
- Identify patients for close observation / specialing / transfer patient to non-acute area
- At night, it is accepted that there is less capacity for these strategies given that it is unreasonable to move patients who are already asleep in bed

Local bed demand strategy allows transfer of patient to local inpatient service

Local bed demand strategy unsuccessful

Area Solution (North or South)
- In business hours, Nurse Director Mental Health Patient Flow clarifies other Area beds, in discussion with Assertive Patient Flow Coordinators, Bed Managers and if required Clinical Director / Head of Clinical Service
- After hours, local Bed Manager or delegate liaises with the other Bed Managers, in discussion with their Duty Consultant Psychiatrist if required

Other area inpatient service accepts transfer of patient

No other metropolitan beds available

"Over-Census" Strategies
- Apply local protocols
- In business hours, approved by local Clinical Director / Head of Clinical Service or delegate
- After hours, contact Mental Health Bed Management Medical Director

Mental Health unable to create bed

Admit to Emergency Department
- In business hours, inpatient Clinical Director / Head of Clinical Service or delegate contacts ED physician in charge to negotiate temporary placement
- After hours, the on– call consultant or delegate contacts ED physician in charge to negotiate temporary placement
- The inpatient Clinical Director / Head of Clinical Service has recourse to speak with the Area Executive Director (in hours) if a referral matter cannot be resolved or after hours with Mental Health Bed Management Medical Director

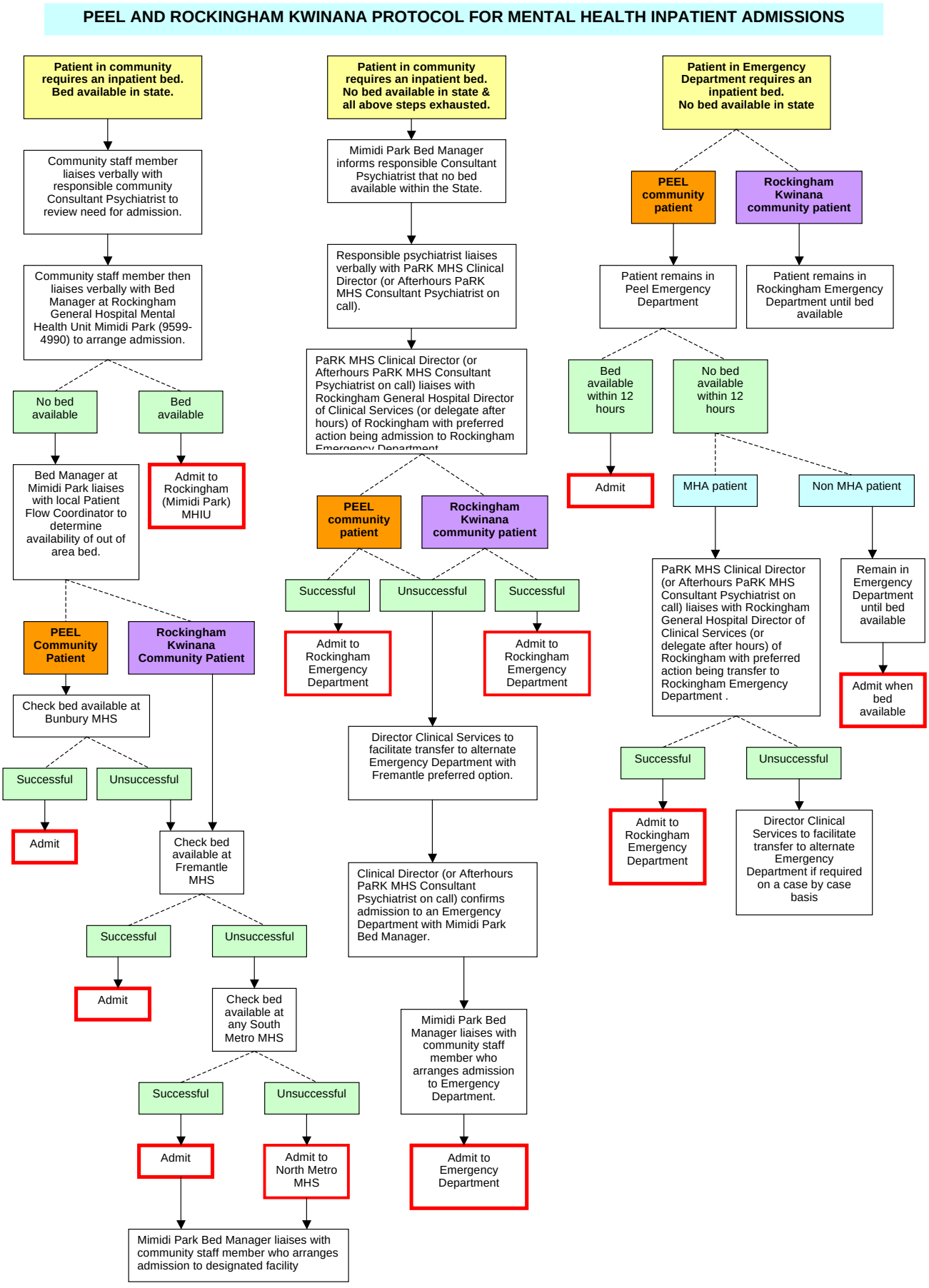
NB: THIS IS ONLY FOR USE IN EXTREME EMERGENCY WITH AN UNDERTAKING THAT THE MENTAL HEALTH SERVICE REGULARLY REVIEW THE PATIENT (*please note that the specifics around this liaison with the different metropolitan Emergency Departments is currently being negotiated by the Area Executive Directors, it has not been finalised)

Emergency Department unable to accept patient
- Refer to Area Executive Directors during business hours or Mental Health Bed Management Medical Director after hours

Explanatory notes:

- Some of the early patient flow processes may occur in parallel rather than as a linear process for efficiency
- There are several key assumptions
  - There must be a standardised risk assessment process and understanding
  - The referrer must update the risk profile with the receiving unit as appropriate
  - The local Clinical Director/Head of Clinical Service must be involved prior to the matter being referred to the Area Executive Director or the Mental Health Bed Management Medical Director
  - If the referrer is concerned about the delay in receipt process they should have access to discuss with the local Clinical Director/Head of Clinical Service to ensure the local Clinical Director/Head of Clinical Service is aware of the risk and complexity issues
  - Whilst the local receiving service carries primary responsibility for the finding of a bed, it is acknowledged that both the referrer and the local receiving service have some joint responsibility in the bed finding process

Appendix 3: Referral pathway for Peel/Rockingham



Appendix 4: Referral pathway from WA Country Health Service

Referral to mental health inpatient bed

Once assessment completed including contact with local Community Mental Health Service (business hrs) or after hrs Rural–link (1800552002) for all information relating to the transfer

Referrer contacts local designated catchment inpatient service Bed Manager or delegate

→ Bed available transfer arranged in accordance with WACHS IHPT

↓

No immediate bed at local service

- It is the responsibility of the receiving service to find a bed
- Local bed manager or delegate advises referrer of time frame until bed available and requests hand over information.

→ Time frame manageable within patient needs and resource availability acceptable to referrer, pt placed on expected admission list and process commences

↓

Time frame unacceptable/Escalation

Patient acuity requires faster transfer local service unable to manage. Doctor to Doctor conversation to review and develop an interim care plan.

Delivering a **Healthy WA**

Contact us

Moore House, Brockway Road,

MT CLAREMONT WA 6010

Tel: 9347 6843

This document can be made available in alternative formats on request for a person with a disability.

Produced by the Patient Flow Implementation Group

© Department of Health 2011

HP11334 NOV'11