Government of Western Australia
East Metropolitan Health Service

Government of Western Australia
North Metropolitan Health Service

Government of Western Australia
South Metropolitan Health Service

Government of Western Australia
WA Country Health Service

Mental Health

Bed Access, Capacity and Escalation

Statewide Policy

June 2019

Foreword

All persons requiring mental health services deserve timely and efficient access to the best possible inpatient care in a safe and timely way. This is one of the essential National Safety and Quality Healthcare Standards emphasised in the second edition (2017) and the unmapped National Standards for Mental Health Services.

Patient flow to acute and non-acute care facilities should be viewed within a continuum of care in which inpatient and ambulatory care providers collaborate to assertively promote recovery for people with a mental illness.

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.

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

Endorsement and sign off below

Liz Macleod

Chief Executive

East Metropolitan Health Service (EMHS)

Jeffrey Moffet

Chief Executive

WA Country Health Service (WACHS)

Dr Robyn Lawrence

Chief Executive

North Metropolitan Health Service (NMHS)

Paul Forden

Chief Executive

South Metropolitan Health Service (SMHS)

Dr Aresh Anwar

Chief Executive

Child and Adolescent Health Service (CAHS}

*applicable to 16-18 year old cohort only

Contents

Foreword 2
Structure of the Policy 5
SECTION ONE 6
1.1 Purpose 6
1.2 Scope 6
1.3 Introduction and Overview 6
1.4 Policy Principles 7
1.5 Indicator System 7
1.6 Policy Requirements 8
SECTION TWO: TIER 1 - HSP 9
2.1 HSP Responsibilities 9
2.2 Prioritisation for Admission 9
2.3 Bed Management Principles 10
2.4 Mandatory Business Rules for Bed Management 11
2.5 Referral to an Inpatient Mental Health Unit 14
2.6 WA Access and Emergency Target (WEAT) 15
2.7 Forensic Mental Health Patients 15
SECTION THREE – TIER 2 - STATEWIDE 17
3.1 Statewide response 17
3.2 Statewide Bed Status B.R.A.G Indicators 17
3.2 HSP and Statewide Operational Arrangements 19
3.3 Statewide Bed Status Amber and Above 20
3.3.1 Statewide Flex 20
SECTION FOUR – STATEWIDE RESPONSES 21
4.1 Statewide Escalation Plans 22
SECTION FIVE - ACTION CARDS 27
Action Card 1 28
HSP - Nurse Director Patient Flow Unit or delegate 28
Action Card 2 29
Statewide Nurse Director Mental Health Patient Flow 29
Action Card 2 31

Weekend (After-Hours) Rostered MHPFC 31
Action Card 3 33
Statewide Mental Health Medical Director (0800-midnight 7 days per week) 33
Abbreviations 34
Appendix 1: WACHS Alignments 35
Appendix 2: Clinical Prioritisation 36
Appendix 3: Bed Manager Contacts per Inpatient Mental Health Service 37
Statewide Mental Health EBM Business Rules 40

Structure of the Policy

This policy is divided into five sections.

Section 1

This contains the purpose, policy principles, responsibilities and mandatory business rules for mental health services and across the state.

Section 2

This section outlines the requirements for Health Service Providers (HSPs) as the Tier 1 Mental Health Patient Flow (MHPF) indicators, capacity making strategies and escalation plans.

Section 3

This section contains a summary of the Tier 2 Statewide Mental Health Bed Status indicators, corresponding criteria, escalation levels and Statewide response actions and how these responses interface with the HSP Mental Health Bed Status indicators, capacity making strategies and escalation plans.

Section 4

This section contains the Statewide Escalation Plans referred to as Statewide Responses. The actions in each section build on the preceding actions and escalation to the next level should not proceed until actions in the current stage are complete. If the issues cannot be resolved within 60 minutes the Statewide escalation status may be escalated to the next level.

Section 5

This section contains key staff action cards for scenarios where a Statewide response is required.

SECTION ONE

1.1 Purpose

In Western Australia, the demand for mental health beds is high with long waits for inpatient admission which is known to contribute to serious deterioration in the wellbeing of patients (ACEM, 2018). This policy mandates a two-tiered system with the first tier at the HSP level, which has clearly defined and distinct levels for capacity making, communication and escalation pathways where there is increased demand for inpatient mental health beds and the clinical acuity and clinical need is high. The second tier, that of the Statewide system, is one which has controls in place to limit delay and promote escalation, actions and coordination to promote access to mental health inpatient care where all tier one/HSP options have been exhausted.

The purpose of the policy is to provide direction to HSPs in relation to:

- Mandatory bed management practices and data entry systems
- HSP Mental Health Patient Flow mandatory systems (Black, Red, Amber, Green (BRAG) – all access points, communication, capacity making and escalation pathways, actions and expectations)
- HSP conditions and process for activating a statewide response
- Defining statewide responses and processes and
- Mandatory actions of HSPs and the outcomes expected of a statewide response.

1.2 Scope

This document applies to the coordination of the referral, admission, transfer and discharge of all public mental health patients, 16 years or older, from any location to inpatient care, including private providers of public (PPP) mental health inpatient services in Western Australia. This includes public private mental health service providers at Ramsay Health Care Joondalup and St John of God Midland Public Hospital (SJGMPH) where there is no contractual conflict between the provider and WA Health.

1.3 Introduction and Overview

The Mental Health Bed Access, Capacity and Escalation Statewide Policy (this policy) is designed to provide a coordinated response at a HSP level (and across mental health services within that HSP) to bed demand. The last step in the Mental Health Patient Flow processes are the statewide responses. These statewide responses are only initiated after HSP processes have been exhausted and patient flow issues remain unresolved or when certain conditions, set by the Chief Executives (CEs) for each of the HSPs referred to as Statewide, are reached (Sections Three and Four).

Mental Health Patient Flow resources are embedded resources within each HSP to provide a coordinated response for bed access, capacity making and escalation processes across the state. Statewide Mental Health Patient Flow resources are dedicated to work with HSPs and provide the coordinated statewide response. These

responses utilise both the HSP and statewide resources to address presenting mental health patient flow demand to inpatient beds.

This policy interfaces with each HSP Mental Health Access, Capacity Plan and Escalation Plan (or similar name) that details the coordinated HSP response to mental health inpatient demand. These policies are the first tier and the foundation for managing patient flow, ensuring there are consistent and equitable mental health patient flow processes and practices in place.

1.4 Policy Principles

Mental health patient flow

- **will include executive leadership** – there should be senior clinical and executive leads in HSPs who use near to live data (updating every 10 minutes) to track patient flow across the community, emergency departments (ED) and inpatient settings, to identify unnecessary variation and address bottlenecks
- **is about collaboration.** Mental health patients often have contact with different health and community organisations and multidisciplinary professionals across the patient care journey. All organisations and disciplines need to collaborate and act together to deliver effective and responsive patient care and to deliver care in partnership with the patient and their nominated representatives
- **will ensure that people are provided with the best possible treatment and care** with the least possible restriction of their freedom, the least possible interference with their rights and with respect and dignity in accordance with the *Mental Health Act, 2014* (MHA 2014).
- **is continuous.** Admissions occur relatively consistently through the week and so should reviews, transfers and discharges.
- **reflects patient and carer pathways and patient journeys**, to recognise the role of carers and families in the treatment, care and support of people and should encompass the consumer perspective to guide and improve processes and systems
- **is about each metropolitan HSPs being responsible** for a defined rural catchment for country people requiring inpatient care, which is beyond the capacity of country mental health services
- **demand management.** Understanding the clinical acuity and clinical needs of patients and how this varies across the day and the week to continuously review demand, supply and prioritisation
- **will have clear escalation principles and governance.** Services will come under significant stress at times of peak demand. Escalation occurs at the HSP level first, then at the statewide level if the HSP has not been able to create sufficient capacity. Escalation should be meaningful and act to relieve pressure where it occurs.

1.5 Indicator System

The Black Red Amber Green (B.R.A.G), “traffic light” system is an established system across hospital services that is used to indicate the status of presenting demand and

resource capacity. This system is to be applied to mental health services across HSPs and at a statewide level for patients requiring admission or transfer from hospital ED, mental health units (MHUs), also known as Acute Psychiatric Units (APUs), general health beds and community mental health services, as a combined criteria against each indicator colour.

Statewide, HSP and Hospital Status is monitored using a near to live dashboard Mental Health Patient Flow (MHPF) Dashboard (*'the dashboard'*) accessible through *Pulse* where the appropriate permissions have been granted. The dashboard does not take into consideration clinical acuity or clinical risk of each patient or staffing within each HSP and is an adjunct to clinical decision making. The dashboard therefore cannot be used solely used for the basis of escalation. The Dashboard provides reference to the HSP demand and capacity status and the corresponding Statewide demand and capacity status for Mental Health.

The demand status ranges from Green, through Amber, Red and then Black when a set criteria has been reached. At each escalation level, increasingly senior staff become involved, who have allocated roles and responsibilities, with the specific purpose of returning the HSP BRAG Status to Green and the Statewide Mental Health BRAG status to Green also.

1.6 Policy Requirements

HSPs must develop a local policy regarding the detailed procedures for articulating capacity and access to mental health inpatient services consistent with this policy and must include:

- A Mental Health Access, Capacity and Escalation Plan specific to the HSP using the traffic light system, indicating the procedures, actions and points of escalation for Black, Red, Amber and Green criteria for all access points to mental health inpatient care
- HSP specific escalation pathways for clinical decision making and dispute resolution
- HSP bed management processes and pathways outlining roles and responsibilities to ensure entry of mandatory information.

Contracted Health Entities have the option of partnering with the relevant HSP in wish they are placed to develop a HSP policy that outlines the capacity and access requirements to mental health services in conjunction with the contract manager. In terms of mental health service delivery at Ramsay Joondalup, section JDHSA3 specifies that mental health services will be guided by specific legislation, policies and standards with a number (not exclusive) listed in the contract.

SECTION TWO: TIER 1 - HSP

2.1 HSP Responsibilities

There are three clear overarching HSP responsibilities:

i. MHUs or APUs providing inpatient public mental health services, including private providers of public mental health inpatient services are **responsible** for locating an appropriate bed to accommodate a referral. That is, wherever possible, an inpatient bed that is within the patient's catchment area, or where there is an identified connection to community. No authorised inpatient service has the right to refuse a patient referred on Form 1A under the *MHA 2014*. The patient must be received by the authorised site that is referenced on the Form 1A.

ii. Designated 'catchment' inpatient units have primary responsibility to meet bed demand requirements for those patients within their catchment referred for an inpatient admission. This includes WACHS patients accessing a mental health bed through the agreed WACHSLink Alignments (Appendix 1).

iii. Referring mental health clinicians will remain responsible for ensuring the ongoing care of a patient until the destination 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 the catchment inpatient service of any escalation of risk to assist the process for re-prioritisation for admission.

2.2 Prioritisation for Admission

HSP services are to adhere to established bed access clinical priorities (Appendix 2). Prioritisation is the process of deciding the relative importance or urgency for admission of referrals entered onto Enterprise Bed Management (EBM) so that patients receive access to beds according to specified principles. Prioritisation for a mental health bed must also be undertaken in accordance with the *MHA 2014*. This policy does not over-ride the requirements of the *MHA 2014*.

Bed access prioritisation relates to patients requiring open or secure acute mental health beds. Mental Health Services aim to provide the best possible treatment and care in the least restrictive way. Generally speaking, a mental health patient under the *MHA 2014* will have a higher priority for an inpatient bed especially where transfer to a mental health bed has been delayed for greater than 24 hours or there is a requirement for a Detention Order (Form 3A). This does not mean voluntary patients are low priority, it means that bed prioritisation and allocation is to be determined by assessing the greatest clinical need at that point in time.

Bed prioritisation reflects the needs of the individual patient, noting that this may be impacted by statewide re-prioritisation of patients where a statewide response or escalation plan is activated (refer to Sections Three, Four and Five).

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 service Bed Manager or delegate to any change of status of a patient on the

Expected Admission List (EAL).

Prioritisation and re-prioritisation of referrals for admission is a clinical role and are to be based on the patient's clinical need and immediacy of risk which is assessed and reviewed at regular intervals against three (3) factors:

- The degree of containment, with the less contained designated highest priority. This refers to management of an acute patient during a period of psychiatric crisis where the ability of the clinical team to maintain safety whilst providing a safe and therapeutic environment. Both non-pharmaceutical (special observations, de-escalation etc.) and pharmaceutical methods are used
- The rural and remote: the level of care that can be provided at the site is taken into consideration and varies across the WACHS. Provision of care at another WACHS site is taken into consideration along with transport options and flows
- The degree of risk an environment poses to an individual with high risk environments provided with the highest priority for admission. High risk may refer to the particular environment and social circumstances that are the determinants of high risk.

Each of these factors provides a basis for comparative analysis of each referral independently and against all referrals for admission and finally against the requirements stated within the *MHA 2014* in respect to involuntary patients.

2.3 Bed Management Principles

The following responsibilities are to be in place within Mental Health Services within HSPs. Bed Managers in mental health services are either a designated position or a role within a position and should be in close communication with the Mental Health Patient Flow Coordinator (MHPFC) for the assigned HSP. The Bed Manager receives the referral paperwork and liaises with the admitting Consultant at a ward level. The Bed Manager advises on expected admissions and discharges and follows the following responsibilities:

- Bed access prioritisation by Bed Managers (Appendix 3) within MHUs or APUs start before 8am every day, including weekends and public holidays, and are reprioritised over a 24-hour period
- Bed Managers as a defined or assigned role are to continually liaise with the referrer and vice versa to collect information for those on the EAL for their inpatient service. Contact between the Bed Manager and the referrer is to occur at regular intervals and escalated if the need and risk increases for the patient requiring admission. Likewise referrals on the EAL should not be made when there is a degree of certainty that admission is required and there is a plan in place on the same day to confirm the requirement. Referrals without any update or plan to determine the requirement should be cancelled or follow a planned pathway to ensure that demand needs can be met
- Information collected by the referrer should be based on clinical need and

clinical risk and the requirement for an inpatient bed, in order to establish relative priority. A comprehensive mental health assessment is therefore required to outline the clinical need and clinical risk to the Bed Manager and the admitting Consultant. The standardised mental health risk assessment should be used for equity of access and reviewed regularly (see 2.5 for minimum requirements)

- The highest acuity patients across the system are to be assigned the highest priority access, with level 1 the highest priority for a mental health bed. Any patient whose risk is exceedingly high based on immediacy of risk, high level of aggression 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 in the first instance.

2.4 Mandatory Business Rules for Bed Management

All mental health services are required to have capacity status and capacity making management plans in place. These plans are a list of actions that are required as 'business as usual' operations to occur on a daily basis and escalation processes on an 'as needed basis' dependent on the Bed Indicator status at that time.

The Bed Indicator status will be reported using a BRAG rating scale.

All mental health services are to use EBM as the WA Health System for bed management.

The Mandatory Business Rules for Bed Management, outlined below, are to be adhered to:

Leave Bed including Absent Without Leave
A "leave bed" is an "available 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 HSP. HSPs are to follow their escalation processes should the decision to use a leave bed be disputed. Each HSP must have a contingency plan in the event that the patient returns from leave early. Likewise, an "Absent Without Leave Bed" (AWOL) should be viewed as an "available bed" where the patient has been declared AWOL for greater than 12 hours.
Over Count or Over-Census
Each HSP and mental health unit is to have an identified contingency plan, and accompanying policy for going over census at times of high demand for beds. The contingency plan for each unit should take into account factors such as a particular unit configuration, current patient acuity levels and sustainable available staffing profile, which may vary from time to time. The Statewide Mental Health Medical Director (Statewide MHMD) is informed by the Statewide Nurse Director Mental Health Patient Flow, of the current applicable "over-census" provision at each inpatient unit, and they 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.

When directing an admission to a PPP mental health service the contract manager needs to be involved to ensure there is no conflict or potential for abatement. PPPs are not to go over their licenced number of beds.

Patients of ‘No Fixed Address’ referred for admission

Patients with ‘No Fixed Address’(NFA) will be admitted to services where they are known based on the following priority order:

- If the patient has been admitted to a unit within the 90 days prior to the current admission, admit to that MHU
- If the patient has been an active patient of a community mental health service within the last six months, admit to the catchment MHU
- If there is a history of greater than two admissions over several years to an inpatient MHU, admit to that MHU
- If there are significant social supports or links/connection to community in the area, the patient is to be admitted to the MHU within that area

Patients of No Fixed Address without links/connection to community, from interstate, tourists or recently homeless:

- Return patient to MHU they were discharged from if 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 and the above criteria cannot be satisfied or there is no secure bed available, then:

- Royal Perth Hospital (RPH) NFA patients are to be admitted to Bentley MHU
- Armadale NFA patients are to be admitted to Armadale MHU
- Peel ED NFA patients are to be admitted to Rockingham Hospital
- Fiona Stanley Hospital NFA patients are to be admitted to Alma Street Centre
- Sir Charles Gairdner Hospital (SCGH) ED NFA patients are to be admitted to SCGH MHU or Graylands Hospital
- Joondalup Hospital (JH) ED NFA patients are to be admitted to JH MHU
- SJGMPH ED NFA patient are to be admitted to SJGMPH MHU
- Forensic Civil patients who are NFA and do not meet any of the listed criteria above, are to be admitted to the next available secure bed at any location.

Readmission

If a patient requires readmission within 90 days of discharge, the catchment inpatient MHU (excluding Frankland Centre) for the patient’s residential suburb is to be approached first. If a bed is not available then the MHU that most recently provided inpatient care will readmit to ensure optimal continuity of care and to reduce any incentive for services to avoid responsibility for patients who are difficult to place.

In circumstances where a patient is in the metropolitan area, but last received care in WACHS hospital, an admission to a metropolitan mental health inpatient facility will

take place first, prior to consideration for transfer to a regional service.

In circumstances where a patient requires readmission and was last discharged to **supported accommodation**, the patient is to be readmitted to the MHU where the transition to supported accommodation occurred.

The readmission period of 90 days of discharge occurs in all circumstances specified.

Repatriation Negotiation/Requesting Transfer to an alternative Mental Health Facility

Repatriation refers to transfer of an inpatient to the nominated catchment inpatient mental health unit, determined by the residential address and suburb entered into the Patient Administration System (PAS). Mental Health Services are responsible for ensuring that on each admission the demographic details recorded for a patient are correct and up-to-date.

Patients requiring repatriation to their country of birth or country of residence are not covered by this policy but remain the responsibility of inpatient services and HSPs.

Repatriation Conditions

- Repatriation is beneficial to a patient where it occurs within the first 7 days of admission and to prevent any negative consequences to a patients overall length of stay. This does not apply for rural and remote admissions to a metropolitan MHU or APU or admissions to the State Forensic Mental Health Service (SFMHS) Frankland Centre.
- At times of high demand, repatriation of a patient may be delayed. The request for repatriation via an inter-hospital transfer request in EBM has an upper limit of 7 days; therefore, repatriations are to not occur post a length of stay of 7 days and the patient is to complete treatment at the inpatient unit they are admitted to unless the patient and/or family are seeking repatriation. Future admissions should always be based on an individual catchment hospital and connection to community wherever possible.

Establishing Catchment Area

Establishing the catchment area is determined by confirmed residential address. However, this can be unclear for a variety of reasons including but not limited to:

- The patient has just been released from prison
- The patient has been admitted directly from the airport
- The patient is homeless – see NFA business rules
- The patient has an Apprehension Violence Restraining Order (AVO) preventing them returning to their accommodation.

When the address is unclear other factors are be taken into consideration to determine which catchment area the patient is best serviced by the following:

- The patient has had previous mental health treatment in the last three months. – see NFA business rules

- The patient has relatives or identified support networks? If so where?
- The patient has an identified area they wish to live and the *MHA 2014* requires that the patient's best wishes have been taken into account
- The patient has an identified care coordinator or a case manager and the coordinator has been consulted
- The patient has a complex medical condition requiring local specialist care.

Repatriation Negotiation

- Repatriation negotiation occurs between each Mental Health Service and the designated Patient Flow/Bed Management structures in the first instance
- This can be escalated to Site Registrars, Consultant Psychiatrists and/or Co-Directors if there is uncertainty about suitability of a patient for repatriation
- If the issue remains unresolved and is impacting on patient flow, escalation to the Statewide MHMD may be required following HSP escalation processes.

Referral pathways for civil patients within the Frankland Centre (forensic inpatient unit) who require ongoing treatment

Civil patients within the Frankland Centre must be transferred to a civil inpatient bed once there is a change in their legal status that precludes them from treatment in forensic inpatient services. This includes patients who have received bail, community release order and conditional release orders.

The referral pathway is:

- The catchment area where the patient lives/lived. Note: prison address should not be considered the residential address of the patient
- If the patient has been an active patient of a mental health service prior to admission to the Frankland Centre the patient will be referred to that service
- Patients with no fixed address should be referred as per this policy based on the principle of clinical need and next available bed and can be escalated to the Statewide Nurse Director Mental Patient Flow and the Statewide MHMD. The patient should remain in the Frankland Centre until the referral pathway is agreed.

Detention Centres

- Referral to a mental health unit from a Detention Centre (as the place of residence) follows the inpatient mental health catchment flows
- Christmas Island flows to Fiona Stanley Hospital.

2.5 Referral to an Inpatient Mental Health Unit

The minimum information required to consider a referral for inpatient admission is as follows:

1. History of presenting complaint
2. Past psychiatric and medical history
3. Current list of medications
4. Mental state examination including formulation and plan

5. Any physical problems that need follow up and monitoring within the first 24 hours of admission to a ward
6. Any risks identified at the time (self, others, dependents or property etc.)
7. A copy of the *MHA 2014* forms that are in place.

Items 1-7 are to be completed in a Statewide Standardised Clinical Documentation (SSCD) form, either the Triage or Assessment form as long as the minimum information is provided. Completion of both forms is not mandatory. Completion of the BRA or RAMP is mandatory.

Evidence of medical oversight of the referral can be documented in the chosen SSCD form by detailing the doctor with whom the referral plan was discussed and agreed, including the doctor's name and their contact details.

The content, depth and breadth of the information listed in the abovementioned headings must be at an acceptable quality to the service receiving the information. The receiving service has a one-hour window in which to check the information provided and then discuss with the referring service should there be inadequate or poor quality referral information. Lower quality referrals that delay decision making will be escalated to the Clinical Director of the referring service. The referring HSP is therefore responsible for ensuring there are mechanisms to address poor quality referrals.

This applies to metropolitan, rural and remote and Mental Health Consultation Liaison (CL) referrals.

It is acknowledged that there are several issues with the documentation process and that this recommended change will not address all. This is a first step with a review of the pathway and associated issues and variations across HSPs is planned for further review.

2.6 WA Access and Emergency Target (WEAT)

The WEAT is a WA Health target that requires 90 per cent of all patients, including mental health, presenting to a public hospital emergency department (ED) will be seen and admitted, transferred or discharged within four hours. HSPs are to continue to aim to address this target, however where is not met and where HSP escalation process have been exhausted, a Statewide response will take place as outlined in Sections Three, Four and Five.

2.7 Forensic Mental Health Patients

Acute clinical mental health care for prisoners is provided initially through inreach mental health services to prisons. Where an acute admission is required the request is made to the Frankland Centre. Demand numbers for prisoners is monitored and all HSPs have access to the total count of prisoners awaiting admission to Frankland Centre. Creating capacity within Frankland is challenging and is dependent on transfers out of the facility (to prison or an acute mental health unit). Where a patient is made civil

during the Frankland admission and there are prisoners awaiting transfer to Frankland, the civil patient transfer is of highest priority to an acute mental health unit (Clinical Prioritisation Appendix 2).

For under 18 year olds, referred from a detention centre (Banksia Hill) to a youth bed, the standard mental health patient flow processes are applicable and patients are to be accommodated within acute mental health wards with appropriate arrangements for custodial staff on the ward.

SECTION THREE – TIER 2 - STATEWIDE

3.1 Statewide response

Mental Health Patient Flow resources are embedded resources within each HSP to provide a coordinated response for bed access, capacity making and escalation processes across the state. Statewide Mental Health Patient Flow resources are dedicated to work with HSPs and provide the coordinated statewide response. These responses utilise both the HSP and statewide resources to address presenting mental health patient flow demand to inpatient beds.

The Mental Health Bed Access, Capacity and Escalation is designed to provide a coordinated response at a HSP level and across mental health services within that HSP to bed demand. The last step in the Mental Health Patient Flow process, is the Statewide Escalation plans referred to as statewide responses. These statewide responses are only initiated after HSP processes have been exhausted and patient flow issues remain unresolved or when certain conditions, set by the CE's of each of the CE referred to as statewide, are reached (Sections Three and Four).

A Statewide response occurs when one or more of the following conditions are met:

- Mental Health Patient Transport delays greater than 4 hours
- HSP to HSP resolution for a bed request
- Patient waiting 10 hours from bed request or greater for admission to a MHU or APU
- Statewide BRAG Indicator Amber, Red or Black.

3.2 Statewide Bed Status B.R.A.G Indicators

The Statewide Bed Status B.R.A.G Indicators are outlined below and contain descriptors of scenarios, which can trigger the statewide response. From Amber onwards, mental health services statewide are required to complete a series of actions to ensure that risk to patients is minimised. These actions are outlined in Sections Three, Four and Five.

Statewide Green	**No Action**
Statewide Amber	**Prepare and Assess**
Statewide Red	**Statewide Response and Coordination**
Statewide Black	**Statewide Response and Coordination**

GREEN
The MHPF dashboard showing the Statewide demand for a Mental Health bed as Green when: • Less than or equal to 19 patients requiring an admission to a mental health bed

as a cumulative total across all HSPs
- No delay notification in transport for Inter-hospital transfers (IHT) or internally to HSPs
- Working within active (resourced) bed capacity
- Staffing profiles (community and inpatient) not affecting active beds and community response/caseload management capacity[1].

AMBER

MHPF dashboard showing the Statewide demand for a Mental Health bed as Amber when

- 20-30 patients requiring an admission to a mental health bed as a cumulative total across all HSPs

Status Amber may indicate the following:

- Fewer secure beds than expected
- Fewer than expected predicted discharges
- Higher number of attendances to EDs, and community mental health Assessment and Treatment Teams (ATTs) for planned admissions
- Working within active (resourced) bed capacity
- Some MHUs within HSPs working below staffing profile but continuing to admit to vacant beds[1]
- Community teams working below routine staff numbers affecting response times[1].

RED

MHPF dashboard showing the Statewide demand for a Mental Health bed as Red when:

- 31-45 patients requiring an admission to a mental health bed as a cumulative total across all HSPs and where 12 or more patients within the total await an admission to a secure bed.
- The upper end of Indicator Red reverts to a Statewide Flex where all HSPs work together to address demand with the Statewide roles.

Status Red may indicate the following:

- Notification of delays in transport for Inter-hospital transfers (IHT) or internally to HSPs
- Unable to place the majority of admissions against their catchment MHU
- Working above active (resourced) bed capacity across HSPs[1]
- A number of wards are working below staffing profile.
- Community teams working below routine staff numbers with an affect on referral response times[1].

BLACK

MHPF dashboard showing the Statewide demand for a Mental Health bed as Black, when:

- Greater than 45 patients requiring an admission to a mental health bed as a cumulative total across all HSPs and where 15 or more patients within the total await an admission to a secure bed.

Status Black may indicate the following:

[1] Staffing information is reported at a site base and to the rostered Mental Health Patient Flow Coordinator – this information is not displayed on the MHPF dashboard.

- Unable to place any internal transfers, elective and emergency admissions
- Working above active (resourced) bed capacity
- Wards across HSPs are working below staffing profile or working above active (resourced) bed capacity across HSPs[1].

3.2 HSP and Statewide Operational Arrangements

Hospitals (SCGH, Fiona Stanley Hospital (FSH), RPH, Armadale Hospital (AH), Rockingham General Hospital (RGH), Joondalup Hospital (JH) and St John of God Midland Public Hospital (SJGMPH)) across the metropolitan area have responsibility for operational management of the site bed capacity status using Emergency Department Status Viewer (EDSV) and the established Bed Capacity Plan and Action Cards. Within these plans, mental health should be established as a bed flow specialty division with a set of mental health specific B.R.A.G indicators, capacity making strategies and escalation plans to operate across the given HSP or governance group (FSFHG and RPG). The hospital based EDSV rating may correspond to a different rating; however, actions to resolve the capacity steps required to address demand, where possible, cannot and should not be delayed.

The hospital-based bed capacity and escalation processes are coordinated and facilitated by the Patient Flow Unit within a hospital within each HSP. After hours, this is coordinated through the General Hospital Bed Manager or delegate. The HSP Mental Health bed capacity and escalation process is coordinated through the following mechanisms:

- For NMHS, the SCGH Patient Flow Unit within the hospital via the MHPFC. After hours this is coordinated through the SCGH Patient Flow Unit Bed Manager from 1700 to 0730. The Statewide Nurse Direct Mental Health Patient Flow position resides under the governance of NMHS Mental Health, Public Health and Ambulatory Care, reporting to the Executive Director.
- For EMHS, the RPH Patient Flow Unit within the hospital via the MHPFC. After hours this is coordinated through the site based mental health bed manager 1700 to 0730 (Appendix 3).
- For SMHS, by two groups:
    1. Fiona Stanley Fremantle Hospitals Group (FSFHG) Capacity and Access Service within FSH via the MHPFC. After hours this is coordinated through the FSFHG Bed Manager from 1536[3] to 0730.
    2. Rockingham Peel Group Patient Flow Unit within the hospital via the MHPFC. After hours this is coordinated through the Rockingham Peel Group Patient Flow Unit Bed Manager from 1600 to 0730.
- For WACHS, the HSP Mental Health bed capacity and escalation process is coordinated and facilitated by the WACHS Command Centre Monday to Sunday 0830-1630. After hours referrals are facilitated via the established WACHS Link Alignments (Appendix 2) and corresponding site Patient Flow Services.
- For Child and Adolescent Health Service (CAHS) the Mental Health HSP bed capacity and escalation process is coordinated and facilitated by the Perth Children's Hospital (PCH) Patient Flow Unit.
- The Statewide MHMD is a rostered position within the Ambulance Distribution

[3] The finish time of 1536 is due to each MHPFC working 7.6 hrs per day

Coordination (ADC) roster. The ADC for Mental Health is the Statewide MHMD. There is equal representation on this roster per HSP. The Statewide MHMD is the senior clinical decision maker whose responsibilities are to arbitrate between HSPs and/or direct an admission to, or across a HSP when efforts at a HSP level have been exhausted; and HSPs (Mental Health Services) cannot agree on a joint resolution independent of the MHMD; and there remains a clinical indication to admit.

Each hospital Patient Flow Unit will conduct twice-daily Bed Status meetings, at which Mental Health will be routinely reported. Where the HSP status for Mental Health is Amber or higher, there will be specific reporting and escalation strategies for the HSP.

3.3 Statewide Bed Status Amber and Above

Where the Statewide Bed Status is Amber, the Statewide Nurse Director Mental Health Patient Flow or delegate will immediately contact with the HSP Patient Flow Units to commence the Statewide Mental Health Response and Actions.

The Statewide responses can be activated between 0900 and 1600hrs 7 days per week. The Statewide Nurse Director Mental Health Patient Flow activates the statewide response between 0900-1600hrs Monday to Friday. On weekends, there is a rotating MHPFC, a senior mental health clinician, who is rostered across HSPs as the single point of contact. The roster is available on the MHPF dashboard and the Statewide Nurse Director Mental Health, Patient Flow will circulate this roster and that of the Statewide MHMD to ensure each HSP Patient Flow Unit is advised.

3.3.1 Statewide Flex

Statewide B.R.A.G status indicator Red indicates high demand for mental health inpatient beds across the health system. In order address this demand in a systematic way, mental health services are required to work together to meet demand. This is largely due to the uneven bed type and bed number distribution across HSPs. In these circumstances a ‘Statewide Flex’ is called by the Statewide MHMD and Statewide Nurse Director Mental Health Patient Flow when all HSP options have been confirmed as exhausted. Statewide Escalation Plans (Section Four) outline the steps that are to occur by designated role or position in order to carry out the statewide response. Statewide Flex is one of these escalation plans; refer to Statewide Escalation Plan D in Section Four.

SECTION FOUR – STATEWIDE RESPONSES

Statewide Escalation Plans

A. Mental Health Patient Transport Delays

B. HSP to HSP Conflict/Dispute Resolution

C. Patient waiting time[2] for a MHU 10hrs or greater

D. Statewide BRAG Indicator Amber, Red, Black

[2] Waiting time defined as the time from bed request for a mental health bed entered into EBM

4.1 Statewide Escalation Plans

The Statewide Escalation Plans have been developed to take into consideration the multiple factors and scenarios that contribute to increased demand and greater waiting times for admission and transfer to a MHU. These Escalation Plans (A to D) and corresponding actions by position (read vertically) outline the steps that are to be taken to prevent/minimise the impact on patient care. Each set of actions per designated role or position are required to be completed within 60 minutes and are required to be completed in order, prior to moving to the next action step.

There is a need to consider patient acuity independent of total patient numbers, as high numbers of patients may not reflect high or low acuity but will impact on the available options and resources to manage this.

		A	**B**	**C**	**D**
		MH Patient Transport delays	**HSP to HSP Dispute/Conflict**	**Patient waiting time[2] for a MHU 10hrs or greater**	**Statewide BRAG Indicator Amber, Red, Black** *Upper end of Indicator Red is Statewide Flex – where HSPs work together to address demand prior to gridlock being reached*
TIER 1: HSP	**Nurse Director Patient Flow Unit, HSP specific/ MHPFC** (SCGH, FSH, RPH, AH, RGH)	• Action plan reported (by site-based bed managers or by the MHPFC) to Nurse Director at hospital Bed Status Meeting, reporting the HSP or governance group status and an action plan is determined • Greater than or expected greater than 4 hour wait from referral for Mental Health transport, the	• Action plan reported (by site-based bed managers or by the MHPFC) to Nurse Director at hospital Bed Status Meeting, reporting the HSP or governance group status and an action plan is determined • Follow escalation and reporting pathway within Hospital/HSP plan • Either HSP/Mental	• Action plan reported (by site-based bed managers or by the MHPFC) to Nurse Director at hospital Bed Status Meeting, reporting the HSP or governance group status and an action plan is determined • Follow escalation and reporting pathway within Hospital/HSP plan • Informs Statewide	• Action plan reported (by site-based bed managers or by the MHPFC) to Nurse Director at hospital Bed Status Meeting, reporting the HSP or governance group status and an action plan is determined • Nurse Director or delegate informs the Statewide Nurse Director Mental Health Patient Flow of HSP situation in the morning and afternoon,

[2] Waiting time defined as the time from bed request for a mental health bed entered into EBM

4.1 Statewide Escalation Plans

		A	B	C	D
		MH Patient Transport delays	**HSP to HSP Dispute/Conflict**	**Patient waiting time[2] for a MHU 10hrs or greater**	**Statewide BRAG Indicator Amber, Red, Black** *Upper end of Indicator Red is Statewide Flex – where HSPs work together to address demand prior to gridlock being reached*
		Statewide Nurse Director Patient Flow is to be informed of the patient circumstances and priority for transfer. • Follow escalation and reporting pathway within Hospital/HSP plan	Health service can escalate to the Statewide Nurse Director Mental Health Patient Flow and/or the Statewide MHMD for opinion or arbitration • The MHPFC advises the Patient Flow Unit Nurse Director or relevant HSP escalation role where a decision between HSPs has not been resolved within **3 hours of a bed request to outcome, where the request has been made between 0700 -0000 hrs. The bed request to outcome falls within the 10-hour time frame**	Nurse Director Mental Health Patient Flow of actions taken, actions pending and reasons for delay. • The MHPFC advises the Patient Flow Unit Nurse Director or relevant HSP escalation role where a decision between HSPs has not been resolved within **3 hours of a bed request to outcome, where the request has been made between 0700 -0000hrs. The bed request to outcome falls within the 10-hour time frame**	including plans for moves both within and across HSPs and current barriers or challenges faced

[2] Waiting time defined as the time from bed request for a mental health bed entered into EBM

4.1 Statewide Escalation Plans

		A	B	C	D
		MH Patient Transport delays	**HSP to HSP Dispute/Conflict**	**Patient waiting time[2] for a MHU 10hrs or greater**	**Statewide BRAG Indicator Amber, Red, Black** *Upper end of Indicator Red is Statewide Flex – where HSPs work together to address demand prior to gridlock being reached*
	HSP Executive	• Briefed as per HSP escalation plan • Discusses clinical need and clinical risks and options to manage contracted provider for transport against contracted services (Feedback to WA Health on service delays broadly at regular intervals)	• Briefed through HSP escalation pathway • Works to resolve or determine a way forward with the HSP Co-Directors	• Briefed through HSP escalation pathway • Works to resolve or determine a way forward with the HSP Co-Directors	• Briefed through HSP escalation pathway • Works to resolve or determine a way forward with the HSP Co-Directors. • Informed as required to support Statewide action plan to resolve bed demands indicator Statewide
TIER 2: STATEWIDE	**Statewide Nurse Director Mental Health Patient Flow**	• Determines Statewide prioritisation for Mental Health Patient Transport and advises providers. This is based on clinical need and clinical risk • Informs respective HSPs of the prioritisation for each metro transport	• Appraises circumstances for conflict, parties involved (site and statutory) and receives case information • Direct HSPs to conduct case conferences and reach agreement otherwise escalation to Statewide MHMD	• Appraises circumstances for patient delay, any sources of conflict and an outline of all parties involved (site and statutory) and receives case information • Advocates for use of leave and over-census beds • Seeks the use of beds in another HSP where	• Receives HSP demand, prioritisation, capacity making strategies and action plan for all HSPs • Informs Statewide MHMD of the circumstances, action plans statewide including prioritisation for admissions and any issues requiring resolution

[2] Waiting time defined as the time from bed request for a mental health bed entered into EBM

4.1 Statewide Escalation Plans

		A	B	C	D
		MH Patient Transport delays	**HSP to HSP Dispute/Conflict**	**Patient waiting time[2] for a MHU 10hrs or greater**	**Statewide BRAG Indicator Amber, Red, Black** *Upper end of Indicator Red is Statewide Flex – where HSPs work together to address demand prior to gridlock being reached*
		• Contacts the Statewide MHMD if there is dispute concerning prioritisation of MH patient transport between HSPs Role function: Informs Department of Health as of delays experienced, reasons provided, booking reference etc. for contract performance management	for final decision and directed actions (this role has the authority to Direct the processes to fulfil the outcome) • Informs Statewide MHMD need for arbitration and circumstances of the case	there is capacity • Escalates to the Statewide MHMD where there is any disagreement	
	Statewide Mental Health Medical Director	• Provides clinical opinion and final decision on prioritisation of cases when contacted by Statewide Nurse Director Mental Health Patient Flow should arbitration between HSP re:	• Activated by Statewide Mental Health Nurse Director Patient Flow • Arbitration by MHMD between parties and evaluation of risks, benefits and outcome likelihood • Directs parties to	• Activated by Statewide Nurse Director Mental Health Patient Flow • Arbitration by MHMD between parties and evaluation of risks, benefits and outcome likelihood • Directs parties to take actions required	• Reviews case information, reasons for delays, Statewide prioritisation and directs sites in discussion /consultation with Heads of Clinical Service (Mental Health) to fulfil Statewide action plan to resolve bed demand Indicator Statewide.

[2] Waiting time defined as the time from bed request for a mental health bed entered into EBM

4.1 Statewide Escalation Plans

		A	B	C	D
		MH Patient Transport delays	**HSP to HSP Dispute/Conflict**	**Patient waiting time[2] for a MHU 10hrs or greater**	**Statewide BRAG Indicator Amber, Red, Black** *Upper end of Indicator Red is Statewide Flex – where HSPs work together to address demand prior to gridlock being reached*
		transport prioritisation be required.	take actions required • Informs HSP Executives of assessment, outcome and actions taken (this will also occur through the HSP escalation plan).	• Informs HSP Executives of assessment, outcome and actions taken (this will also occur through the HSP escalation plan).	

[2] Waiting time defined as the time from bed request for a mental health bed entered into EBM

SECTION FIVE - ACTION CARDS

- TIER 1: HSP - Nurse Director Patient Flow Unit OR Mental Health Patient Flow Coordinator - (SCGH, FSH, RPH, AH, RGH)
- TIER 2: STATEWIDE - Statewide Nurse Director, Mental Health Patient Flow
- TIER 2: STATEWIDE: Statewide Mental Health Medical Director

Action Card 1

HSP - Nurse Director Patient Flow Unit or delegate- (SCGH, FSH, RPH, RGH)/Mental Health Patient Flow Coordinator

This Action Card summarises the responsibilities of the HSP Nurse Director, Patient Flow Unit in relation to the Statewide Escalation Plans. It highlights actions to be undertaken in addition to normal duties. Please refer to the full Plan for a more complete explanation of levels and actions. **All actions must be completed before escalating to the next level**.

GREEN

Nil at a Statewide Level

Ensures MHPF Coordinator participation on the weekend roster as delegate Statewide Coordinator for Mental Health Patient Flow

AMBER

- Coordinates the Hospital Bed Status Meeting that will report the HSP or governance group bed demand and capacity status for mental health. Where there are delays or issues experienced these are discussed and an action plan is determined
- Twice daily correspondence to the Statewide Nurse Director Mental Health Patient Flow to provide information in respect to the HSP or governance group bed demand and capacity. This is required even if the HSP BRAG is green and the Statewide BRAG is Amber or Higher.

RED

- Coordinates the Hospital Bed Status Meeting that will report the HSP or governance group bed demand and capacity status for mental health. Where there are delays or issues experienced these are discussed and an action plan is determined
- Twice daily correspondence to the Statewide Nurse Director Mental Health Patient Flow to provide information in respect to the HSP or governance group bed demand and capacity. This is required even if the HSP BRAG is green and the Statewide BRAG is Red or Higher
- Notified by the Statewide Nurse Director Mental Health Patient Flow when the Statewide response is activated
- Required to take direction from the Statewide Nurse Director Mental Health Patient Flow and the Statewide MHMD RE: accepting admission of mental health patients outside of the designated catchment area in response to a Statewide Escalation Plan or Statewide response

BLACK

- Leads Hospital Bed Status Meeting that will report the HSP or governance group bed demand and capacity status for mental health. Where there are delays or issues experienced these are discussed and an action plan is determined
- Twice daily correspondence with the Statewide Nurse Director Mental Health Patient Flow to provide information in respect to the HSP or governance group bed demand and capacity. This is required even if the HSP BRAG is green and the Statewide BRAG is Black
- Notified by the Statewide Nurse Director Mental Health Patient Flow when the Statewide response is activated
- Required to take direction from the Statewide Nurse Director Mental Health Patient Flow and the Statewide MHMD this may mean accepting admission of mental health patients outside of the designated catchment area in response to a Statewide Escalation Plan or Statewide response

Action Card 2

Statewide Nurse Director Mental Health Patient Flow

This Action Card summarises the responsibilities of the Statewide Nurse Director, Mental Health Patient Flow in relation to the Statewide Escalation Plans. It highlights actions to be undertaken in addition to normal duties. **All actions must be completed before escalating to the next level.**

GREEN
Nil at a Statewide Level
AMBER
• Receives information from each HSP twice daily from the Nurse Director Patient Flow Unit or MHPFC regarding the bed demand and capacity at that given time. The MHPF Dashboard is used but these meetings are to validate the information recorded and obtain additional information not reported to determine clinical need and prioritisation statewide • Contacts the Statewide MHMD as per Statewide Escalation Plans and or Transport providers to ensure prioritisation statewide • Requests additional information based on clinical situation
RED
• Receives information from each HSP or governance group Hospital Bed Status Meeting twice daily from the Nurse Director Patient Flow Unit or delegate regarding the bed demand and capacity at that given time. The MHPF Dashboard is used but these meetings are to validate the information recorded and obtain additional information not reported to determine clinical need and prioritisation statewide • Contacts the Statewide MHMD as per Statewide Escalation Plans and or Transport providers to ensure prioritisation statewide. • Activates Statewide response via email distribution list, and or phone contact with MHPFC. • Convenes Teleconference with the Mental Health Medical Director and MHPFCs • Presents information obtained above to determine action plan for discussion at the Statewide response meeting • Action plan and outcome email sent to mental health services via email at a minimum of every three hours (whilst on shift). Mental health services can to contact Statewide roles to receive additional information. • Statewide MHMD and Statewide Nurse Director Mental Health Patient Flow stand down the Statewide response
BLACK
• Receives information from each HSP or governance group Hospital Bed Status Meeting twice daily from the Nurse Director Patient Flow Unit or MHPFC regarding the bed demand and capacity at that given time. The MHPF Dashboard is used but these meetings are to validate the information recorded and obtain additional information not reported to determine clinical need and prioritisation statewide • Activates Statewide response [assumed process is SMS notification and MHPF

dashboard] and convenes Teleconference and Mental Health Medical Director. Presents information obtained above to determine action plan for discussion at the Statewide response meeting

- Actions of the Statewide response Action plan are carried out, notification to HSP Patient Flow Units and CE's re: plan and progress
- Action plan and outcome email sent to mental health services via email at a minimum of every three hours (whilst on shift). Mental health services can to contact Statewide roles to receive additional information.
- Statewide MHMD and Statewide Nurse Director Mental Health Patient Flow stand down the Statewide response

Action Card 2

Weekend (After-Hours) Rostered MHPFC
(as delegate Statewide point of contact on weekends)

This Action Card summarises the responsibilities of the Weekend (Afterhours) rostered Statewide MHPFC in relation to the Statewide Escalation Plans and carrying out the statewide responses. It highlights actions to be undertaken in addition to normal duties. **All actions must be completed before escalating to the next level.**

GREEN
Nil at a Statewide Level
AMBER
• Receives information from each HSP regarding the bed demand and capacity at that given time. The MHPF Dashboard is used but these meetings are to validate the information recorded and obtain additional information not reported to determine clinical need and prioritisation statewide • Contacts the Statewide MHMD as per Statewide Escalation Plans and or Transport providers to ensure prioritisation statewide and to keep them up to date with relevant information • Fulfills requests from the Statewide MHMD • Addresses queries from HSP Escalation role or redirect to the Statewide MHMD as required
RED
• Receives information from each HSP regarding the bed demand and capacity at that given time. The MHPF Dashboard is used but these meetings are to validate the information recorded and obtain additional information not reported to determine clinical need and prioritisation statewide • Contacts the Statewide MHMD as per Statewide Escalation Plans and or Transport providers to ensure prioritisation statewide • Activates SMS for Statewide response and contacts the Statewide MHMD with the information for each HSP • Action plan devised by the Statewide MHMD relayed to MHPFCs for action • Fulfills requests from the Statewide MHMD • Addresses queries from HSP Escalation role or redirect to the Statewide MHMD as required
BLACK
• Receives information from each HSP regarding the bed demand and capacity at that given time. The MHPF Dashboard is used but these meetings are to validate the information recorded and obtain additional information not reported to determine clinical need and prioritisation statewide.

- Contacts the Statewide MHMD as per Statewide Escalation Plans and or Transport providers to ensure prioritisation statewide.
- Activates SMS for Statewide response and contacts the Statewide MHMD with the information for each HSP.
- Action plan devised by the Statewide MHMD relayed to MHPFCs for action
- Fulfills requests from the Statewide MHMD
- Addresses queries from HSP Escalation role or redirect to the Statewide MHMD as required

Action Card 3

Statewide Mental Health Medical Director (0800-midnight 7 days per week)

This Action Card summarises actions that the rostered Statewide MHMD in relation to the Statewide Escalation Plans and carrying out the statewide responses. It highlights actions to be undertaken in addition to normal duties. **All actions must be completed before escalating to the next level.**

GREEN
Nil at a Statewide Level
AMBER
• Informed by Statewide Nurse Director Mental Health Patient Flow or MHPFC who is rostered for the weekend, of the bed demand and capacity statewide • Requests additional information to be provided based on clinical situation • Acts as per Statewide Escalation Plans • Assesses circumstances of escalation and/or Statewide Amber – arbitrates and/or directs admission as required
RED
• Informed by Statewide Nurse Director Mental Health Patient Flow or MHPFC who is rostered for the weekend, of the bed demand and capacity statewide • Requests additional information to be provided based on clinical situation • Acts as per Statewide Escalation Plans • Leads and participates in the statewide response tele or videoconference. Leads development of the Statewide Action Plan • Statewide MHMD and Statewide Nurse Director Mental Health Patient Flow stand down the Statewide response
BLACK
• Informed by Statewide Nurse Director Mental Health Patient Flow or MHPFC who is rostered for the weekend, of the bed demand and capacity statewide • Requests additional information to be provided based on clinical situation • Acts as per Statewide Escalation Plans • Leads and participates in the Statewide response tele or videoconference. Leads development of the Statewide Action Plan and directs actions as per the plan until the Statewide response is stood down • Statewide MHMD and Statewide Nurse Director Mental Health Patient Flow stand down the Statewide response

Abbreviations

ADC	Ambulance Distribution Co-ordinator
AH	Armadale Kelmscott Hospital
APU	Adult Psychiatric Unit
ATT	Assessment and Treatment Team
BRAG	Black, Red, Amber, Green
CAHS	Child and Adolescent Health Service
CE	Chief Executive
CL	Consultation Liaison
EAL	Expected Admission List
EBM	Enterprise Bed Management
ED	Emergency Department
EDSV	Emergency Department Status Viewer
EMHS	East Metropolitan Health Service
FSH	Fiona Stanley Hospital
HSP	Health Service Provider
JH	Joondalup Hospital
MHA 2014	Mental Health Act, 2014
MHMD	Mental Health Medical Director
MHU	Mental Health Unit
NFA	No Fixed Address
NMHS	North Metropolitan Health Service
PCH	Perth Children's Hospital
RGH	Rockingham General Hospital
RPH	Royal Perth Hospital
SSCD	Statewide Standardised Clinical Documentation
SCGH	Sir Charles Gairdner Hospital
SJoGMPH	St John of God Midland Public Hospital
SMHS	South Metropolitan Health Service
WACHS	Western Australian Country Health Service

Appendix 1: WACHS Alignments

Appendix 2: Clinical Prioritisation

- **Priority 1: Emergency Department (ED) referrals**

- Community referrals may be re-prioritised (to Priority 1) given the less contained nature of the referral and the potential for this to be a higher risk environment.
- Alternative options such as moving the patient in ED to an inpatient bed and then to move the community patient to ED may be considered. Holding the patient in ED and accepting the community patient as a priority may also occur in consultation with the ED.
- Inpatient/Consultation Liaison referrals may be prioritised (to Priority 1) where the referral arises from a time-critical ward (ICU) or where unexpected risks are posed as a result of an admission to a particular ward or environment.
- Civil patients that require repatriation to the local catchment MHU will be reprioritised as Priority 1 where:
    - a Hospital Order has been written by a Court for a person in court who requires transfer to the Frankland Centre for assessment.
    - a prisoner under the *MHA 2014* who requires transfer to the Frankland Centre for involuntary treatment

- **Priority 2: Community and Rural and Remote tertiary care referrals** (the latter including MH patients “outlied” on rural general medical wards)

- **Priority 3: Forensic civil patients and Consultation Liaison on medical wards**

- **Priority 4: Catchment repatriation of a patient**

Appendix 3: Bed Manager Contacts per Inpatient Mental Health Service

Mental Health Patient Flow - North	**Mental Health Patient Flow - South**
0406 402 829 0404 863 114 0415 257 281	Fiona Stanley Fremantle Hospital Group: 0406 580 783 Rockingham Peel Group: 0404 821 386
Mental Health Patient Flow - East	**Mental Health Patient Flow - WACHS**
0404 871 033	TBA
Statewide Mental Health Nurse Director	
0414 680 097	

Child and Adolescent Health Service	
CAHS 0466419342 camhsipubedrequests@health.wa.gov.au	
North Metropolitan Health Service	
Sir Charles Gairdner Hospital Main Switch: 6457 3333 MHU Switch: 6383 1000 ED PLN 6457 6727 Fax: 6457 2620 SCGH MHOA – via Main Switch 6457 3333 ARDT/Bed Mgr Page via switch 6383 1000 eMail referrals: SCGH MHU *SCGHMHUTriage@health.wa.gov.au*	Joondalup Health Campus Switch 9400 9400 JHC Bed Mgr 9400 9038 Fax: 9400 9069 JHC CNS 9400 9784 JHC MHOA contact via switch 9400 9400
Graylands Hospital 0410 645 918 Triage 9347 6407/6499 Fax: 9347 6838 eMail referrals: GH, Triage *Triage.GH@health.wa.gov.au*	Osborne Park Older Adult Mental Health Unit 9346 8000 Fax: 9346 8311 During Business Hours, please request to be put through to Triage (Duty Officer) After Hours, please follow prompts to be put through to the Shift Coordinator
Selby Older Adult Mental Health Unit 9382 0800 Fax: 9382 0820 During Business Hours , please request to be put through to Triage (Duty Officer) After Hours, please follow prompts to be put through to the Shift Coordinator	
Child and Adolescent Health Service	
PCH Bed Flow: 0466 419 342 Fax: 6456 2303 eMail referrals: PCH IPU Bed Requests *camhsipubedrequests@health.wa.gov.au*	
East Metropolitan Health Service	
Leschen Unit Armadale Switch: 9391 2000 Office hours bed mgr (M-F 0730 – 1300) 9391 2000 ask for MH bed manager eMail referrals: AHS, MH Inpatient Referrals ahs.mhinpatientref@health.wa.gov.au Leschen Open 9391 2304/2248 Fax: 9391 2253/2329 Leschen Secure 9391 2104	RPH Ward 2K Switch: 9224 2244 2K shift coordinator: 0404 894 233 2K CNS: 0404 039 964 eMail referrals: RPH, Ward 2K Referrals *RPH.Ward2KReferrals@health.wa.gov.au* 2K ward: 9224 2247/2514 Fax: 9224 1168 9224 2213 Fax: 9224 3636/2212

<table>
<tr><td>ED PLN 9391 2182 pg# 913</td><td>CL: 0404 894 097</td></tr>
<tr><td>Mills Street Centre Bentley
Switch: 9416 3666 Fax: 9416 3875
Contact bed manager via switch
eMail referrals: BL MH Bed flow manager
BLMHBedFlowManager@health.wa.gov.au
W6: 9416 3878 W7: 9416 3883
W8: 9416 3886</td><td rowspan="2">SJG Midland MH
Switch: 9462 4000
Bed req 7am – 10pm (ad/dc coord)
9462 4996 Fax to Wd 4b
Bed req 10pm – 7am (gen bed manager)
9462 5140 Fax to Ward 4b
eMail referrals: mimhuadmissions@sjog.org.au
ED PLN 9462 4182 ED Fax: 9462 4185
4A Open 9462 5170
4B Secure 9462 5133/5134/5135
Fax: 9462 5179

Older Adult
SJOG Mt Lawley Ursula Frayne
9370 9785 Fax: 9370 9896
SJOG Midland 4c
9462 5167 Fax: 9462 5179</td></tr>
<tr><td>Bentley EMyU: 9416 3666 ask for EMyU
email referrals: BL MH Bed flow manager
BLMHBedFlowManager@health.wa.gov.au</td></tr>
<tr><td colspan="2">South Metropolitan Health Service</td></tr>
<tr><td>Fiona Stanley Hospital
Switch: 6152 2222 (All enquiries)

Afterhours 1430-2230 Monday to Friday, 0700-2230 weekends and public holidays
MH HOOT CNS: 6152 7658
Capacity and Access Service Co-ordinator: 6152 4021 pg#/ph: 6152 8899
MH NUM 6152 8700 pg#/ph: 6152 7852</td><td>Emergency Department
Duty Consultant:
6152 7642
Desk – 6152 5327
Duty Med Co-ord 6152 7642
ED PLN: 6152 1584
Fax: 6152 7804
Psych Registrar: 6152 7660
CL: CNS/Triage Adult MHLS:
6152 1586/1587/1581
CNS/Triage Older Adult MHLS:
6152 1580

ED email address:
FSH.MHEDLiaison@health.wa.gov.au</td></tr>
<tr><td>Mental Health Assessment Unit: MHU A
Nurse Unit Manager (0800-1630): 6152 7852
Mobile pager 6152 8700
Shift Co-ord: 6152 7795/7885/7884
Fax: 6152 7806
Registrar: 6152 7660 (on call)</td><td>Mother and Baby Unit MBU:
Shift Co-ord: 6152 7866/7794
Fax: 6152 4867
CNS: 6152 1583</td></tr>
<tr><td colspan="2">Youth B:
Shift Co-ord: 6152 7796
Fax: 6152 4868
CNS: 6152 1585 6152 8604
eMail referrals: FSH, Mental Health Youth Unit FSH.MHYouthUnit@health.wa.gov.au</td></tr>
<tr><td colspan="2">Fremantle Hospital
Switch: 9431 3333
eMail referrals: FH, ASC ATT FHMHS_ATT@health.wa.gov.au
Referrals Office hours Mon – Fri - call catchment ward CNM:
W41 9431 3484 CNM 0478 331 107
Fax 9431 2288
W42 (Fre/C’brn)</td></tr>
</table>

9431 3502 CNM 0404 890 178
Fax 9431 3496
W43 (Older Adult)
9431 3524 CNM 0404 890 416
Fax 9431 3766
W51 (Melville)
9431 3448 CNM 0481 038 983
Fax 9431 3447
A/hrs Bed Mgr
(1500 – 0730) 0404 890 174 pg# 3481
Saturday, Sunday and Public Holidays 24hrs - 0404 890 174 pg# 3481
ATT Office 9431 3480 Fax: 9431 3479
Teleconference
No: 9431 3570 Monday – Friday 0900
Weekends and public holiday 08.45am
CL: 0404 890 437 pg# 3455
Hampton Road Service:
9433 2509 Fax: 9433 2740

Rockingham Hospital
Switch: 9599 4000
Ward Coordinator:
9599 4990 (Dect Ph)
Ward Ph: 9599 4951
eMail referrals: PARK MHS Inpatient Unit Triage
PARKMHSInpatientUnitTriage@health.wa.gov.au
NUM pg# 700
Front Office Fax = 9599 4949 Ward Fax = 9599 4966
ED PLN 9599 4729/4738 pg# 210
0408 910 216 Fax: 9599 4684
ED Psych Reg: 9599 4994
Rockingham Comm 9528 0600

Peel
Peel Comm 9531 8080
Peel Hospital Switch: 9531 8000
ED PLN 9583 6235 pg# 131

WA COUNTRY HEALTH SERVICE

Bunbury Hospital
Switch: 9722 1000
eMail referrals: WACHS-SW MH Inpatient Referral
WACHSSW.mhInpatinetReferral@health.wa.gov.au)
CNS: 0427 480 738 Fax: 9722 1580

A/Hrs referrals via ED PLN
MH Unit Mgr: 0429 097 756
APU: 9722 1584/1590 PICU: 9722 1562
ED PLN: 0428 154 896 Fax: 9722 1017

Statewide Mental Health EBM Business Rules

FOR DECISION Ref #

BRIEFING NOTE

ISSUE

Agreed Statewide practices for streamlined and standardised bed allocation and management of patient transfers.

BACKGROUND

- The Mental Health Patient Flow (MHPF) Project commenced in July 2018 to investigate mental health patient flow practices to determine areas of efficiency, standardisation and potential management strategies for addressing bed access block, code yellows and extended waiting times in emergency departments (EDs) and community mental health services.

CURRENT SITUATION

- Standardisation in bed allocation and management practices across general and mental health services will allow for live tracking and recording of patient flow both within and across services.
- Standardised entry will allow processes of bed management to be monitored to ensure efficiency and easy identification of bed access block or process errors at a high level.
- The use of EBM against the attached business rules will enable the development of a MHPF dashboard to monitor the mental health queue for an admission from multiple access points (community, prison, private hospital, ED etc.).

RECOMMENDATION/ACTION

That the MHPF Steering Committee notes the contents of the EBM Business Rules attached and endorses the implementation of these rules within HSP mental health services.

Prepared by: Kirsty Snelgrove
Project Manager
Mental Health Patient Flow Project
9224 1983

Date: 21 December 2018

Approved ☑ Noting RL to follow up re inclusion KEMH EM 4.1.19

Recommended ☐

Not Approved ☐

Noted ☐

Comments:

Sign off: E MacLeod Date 4.1.19

Liz MacLeod
CHIEF EXECUTIVE
EAST METROPOLITAN HEALTH SERVICE

Approved ☑
Recommended ☐
Not Approved ☐
Noted ☐

Comments:

Sign off: Date 4.1.19

Dr Robyn Lawrence
CHIEF EXECUTIVE
North METROPOLITAN HEALTH SERVICE

Approved ☑
Recommended ☐
Not Approved ☐
Noted ☐

Comments:

Sign off: Date 4/1/19

pp Paul Forden
CHIEF EXECUTIVE
SOUTH METROPOLITAN HEALTH SERVICE

Approved ☑
Recommended ☐
Not Approved ☐
Noted ☐

Comments:

Sign off: Date 4/1/19.

Jeffrey Moffett
CHIEF EXECUTIVE
WA COUNTRY HEALTH SERVICE

Aresha Anwar 4/1/2019.

Approved x CS CAHS

Scope:

- All metropolitan public mental health services
- All WA Country Health Service public mental health services

Exclusion

Nil

1.0 Introduction

Standardisation in data entry and process across specialty areas is essential for accurate data reporting. This business rule has been drafted specifically for the specialty area Mental Health to clearly outline and standardise processes and entry practices. Consultation across the metropolitan and country areas has occurred in order to set out the process and pathways documented.

This document should be read in conjunction with the EBM User Guide: https://hss-healthpoint.hdwa.health.wa.gov.au/business-at-health/ICT-servicedelivery-and-operations/ebm/Pages/default.aspx

2.0 Terminology

Bed Management	The allocation and provision of beds in a mental health inpatient unit performed by a dedicated team that are part of a larger patient flow management process.
Direct Admission	Direct admissions can be performed for a patient awaiting admission in the community (including correctional facilities), or a referral from a public private provider hospital (PPP) directly to the mental health ward, bypassing an Emergency Department. The direct admission ability is limited to the Bed Manager permission roles in EBM.
Destination Hospital	The hospital identified that the patient will be transferred to.
Expected Admissions List (EAL)	Operationally: A list of patients who are accepted for admission to a mental health inpatient unit. For EBM: A combination of the 'Request List' and IN section of the 'IN/OUT List' in EBM.
Inter-hospital Transfer (IHT)	Refers to patient transfers between hospitals with EBM. An IHT process[i] should be followed to ensure that both the referring and receiving[ii] service can view the request and information on EBM. For non-EBM hospitals the transfer is listed as a Direct request to a non-EBM or a Direct request from a non-EBM hospital. Although these transfers are an IHT, EBM requires them to be entered as a Direct request.

Intra-hospital Transfers - EBM Ward Transfer	Refers to transfers between wards within a hospital. Used for transfers between wards within a hospital.
ED Request	An ED request is raised for a patient who is in an ED of which the disposition is likely to be admission. The request is usually entered by a medical staff member. A ward transfer or IHT will need to be raised to fulfil the admission to a bed.
In/Out List	A list in EBM that lists all IHT requests and Direct Admissions for patients awaiting transfer both into and out of the hospital that is being viewed.[iii] A Direct Admission can be added to the Inbound List without an expected admit date but good practice is to ensure that an expected admission date is added.
Originating Hospital	The hospital where the patient is currently admitted.
Patient Flow Notes (PFU)	The PFU notes field is intended for use by staff at the destination location. PFU notes can be entered by either the originating or destination site.

3.1 Decision to Admit

a) The Admission process follows a clinical decision that a patient requires same day or overnight care or treatment.

b) The decision to admit a patient rests with the Consultant Psychiatrist under whom the patient is admitted, or their nominated delegate.

c) The decision to admit must be clearly documented as part of the assessment processes and this assessment is held within the patient's medical record.

d) A bed will be sourced according to patient flow policy and principles.

e) Clinicians at the originating site only (depending on the request type) or originating and destination sites will discuss the admission over the phone prior to raising the request via EBM.

f) The site based mental health bed manager or role responsible for coordinating the admission process (e.g. NUM, CNS etc. – this differs across sites) is responsible for ensuring that each referral for admission is entered into EBM. Where EBM is in place in the community, the originating site/referrer is responsible for ensuring entry into EBM and liaising with the Bed Manager at the destination site to ensure that information remains current.

g) Acknowledging an IHT referral in EBM means that the request has been **received only**, it is not accepting the request. The acknowledgement of the request is to occur within three hours of the request date/time stamp.

Process

4.1 Direct Admission

a) A direct admission request in EBM should be performed in the following circumstances:

   i. Referral for a patient in the community requesting inpatient admission. The request from the community mental health service to the site based mental health bed manager.

   ii. Referral for a patient from a public private provider hospital (PPP).

   iii. Referral from a private mental health service (inpatient or community) who will contact the site based mental health bed manager who will enter the request for the bed.

   iv. Referral from a custodial facility or criminal court for a patient that is requiring admission to the Statewide Forensic Mental Health Inpatient Service (Frankland Centre). The bed manager at Frankland will complete the direct admission request on EBM.

b) In NMHS (including SFMHS) and CAHS: The destination site mental health bed manager is responsible for coordinating the admission process and is responsible for ensuring that each referral for admission is entered into EBM as a Direct Admission.

c) In SMHS and EMHS: Direct admissions may be entered into EBM by community mental health services. Community mental health clinicians are responsible for discussing the referral with the destination site prior to entry into EBM. If accepted by the destination hospital the request is entered and the community clinician entering the request is responsible for coordinating the admission with the destination site bed manager. A request for an inpatient bed should be entered where there is a degree of certainty that admission may be required and where a planned visit on the same day has been arranged to confirm the need for admission. Community bed requests

are not to be entered into EBM for an indefinite period. Planned or booked admissions can be entered with an admission date for this purpose.

d) Direct admissions entered on EBM must be accepted by the destination site prior to entry into EBM.

e) If the admission is from community, this is to be indicated in the 'referral source' section, with the relevant community clinic listed in the adjacent free text section. The location field should be listed as CO1.

f) If the admission is for a secure bed, this is to be documented on the request.

g) In order to appear on the EBM IN/OUT list the direct admission will need to have a 'Proposed Transfer Date' entered if they require a bed in the future (not today or the next 24 hours) and then *transferred* to the Inbound List. It will not automatically appear on the IN/OUT List [see Mental Health Clinician's guide].

h) The request is completed once the patient is admitted to an inpatient bed. If the steps are not fulfilled in EBM and the admission occurs irrespective of EBM steps, the request will need to be cancelled. WebPAS records will reflect the admission.

5.0 Inter-hospital Transfer (IHT)

a) An IHT request should occur in EBM when a patient is being transferred between different public hospital sites. The originating service may include public mental health inpatient services, EDs or general hospitals.

b) Circumstances where this will occur include:

   i. Referral from an ED to a public mental health inpatient unit across hospital sites.

   ii. Referral from short-stay units such as Mental Health Observation Areas (MHOA) or Mental Health Assessment Units (MHA) being transferred to another site. If occurring across the same site follow the **intra-hospital transfer process** (Ward Transfer).

   iii. Repatriation of patient to their local catchment inpatient service, inclusive of patients at Frankland Centre who are now a civil patient.

c) Assessment of the patient indicates inpatient admission is required or clinical decision to transition care of patient to another service is made. This primarily

should be the patient's catchment inpatient service.

d) Originating site rings bed manager at destination site to discuss referral.

e) Clinical information to support the referral is sent from originating site to the destination site via email or fax.

f) An IHT request is entered into EBM by the originating site.

g) An IHT request is **acknowledged** by the destination site once clinical information is received.

h) **Acknowledging a referral** means that the request has been received only.

i) The destination site is required to review the content of the referral documentation within one hour of the receipt of information and inform the originating (referral) site if additional information is required.

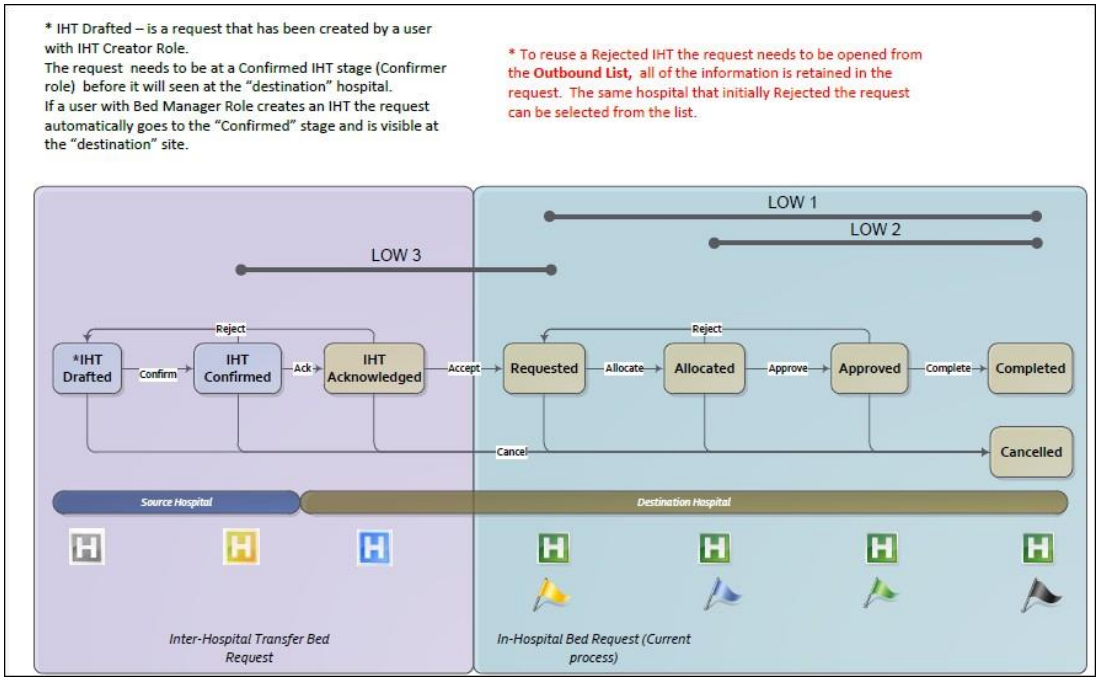
j) The destination site is required to make a decision on the referral outcome within three hours of the bed request time and date stamp.

k) Destination site contacts the originating site to inform of outcome.

j) If referral is accepted, destination site accepts referral in EBM, and allocates the patient to a bed/ adds the patient to the waitlist. This will complete the request.

k) If referral is declined, destination site rejects referral in EBM and a reason for the rejection is to be included in the free text box. This will complete the request.

EBM process steps:



6.1 Intra-hospital Transfer (Ward or ED Bed Request)

a) An Intra-hospital transfers are transfers between wards within a hospital or across a single site (e.g. SCGH and SCGH MHU is an intra hospital transfer).

b) If a patient requires an intra-hospital transfer, the referring Consultant (or their nominated delegate) is to contact the Consultant (or their nominated delegate) from the appropriate specialty to:

   i. Discuss the patient's condition.

   ii. Provide a medical handover.

   iii. Confirm acceptance of care.

c) Once accepted, the referring ward/originating ward then completes a ward transfer request in EBM specifying the destination ward.

d) The destination ward allocates the patient to an available bed in EBM, indicating a bed ready time.

e) When the patient arrives at the destination ward, the ward clerk enters the allocated bed into webPAS. This will complete the request.

7.0 Expected Admission List (EAL)

f) The EAL is the 'Request List' and 'IN' section of the 'IN/OUT List' in EBM. The EAL provides all of the patients referred for admission (direct, intra hospital and inter hospital). Note: direct admission and intra hospital requests will only appear on the inbound list *if they have been transferred to the inbound list.*

g) The list will outline the originating site and the stage in the process the referral is at.

Sites with EBM

Metro sites		WACHS sites
Fiona Stanley Hospital		Albany
Fremantle Health Service		Bunbury
Rockingham Hospital		Kalgoorlie
Armadale Hospital		Broome

Metro sites		WACHS sites
Bentley Health Service		please note the larger WACHS sites who do not have MH wards also have EBM i.e. Geraldton, Pilbara – Hedland, Karratha
Royal Perth Hospital		
Kalamunda Hospital		,
Sir Charles Gairdner Hospital		
Graylands Hospital		
Selby Lodge (Lower West Older Adult Mental Health Service)		
Osborne Park Hospital		
State Forensic Mental Health Service		
King Edward Memorial Hospital		
Perth Children's Hospital		

[i] Referred to as Originating Hospital in/on EBM documentation

[ii] Referred to as Destination Hospital in/on EBM documentation

[iii] Direct Admissions with a Proposed Transfer date identified on the request will be added to the In/Out List