Allied health capacity & demand

There are a variety of ways to create visibility of capacity and demand for allied health. Determining the capacity required to meet service demand is fundamental to the attainment of clinical outcomes and staff wellbeing.

Capacity

Capacity refers to the staffing and physical resources required to deliver a service. The allied health team leader/coordinator/manager should have readily available access to what staffing hours are available daily.

This includes the following:

1. Daily - total hours available for each service setting (as appropriate) - inpatient, outpatient, community. This excludes planned and unplanned leave and vacancy.
2. Ability to access retrospective data on total time attributed to clinical and non-clinical activities for the team.

The team leader/coordinator/manager will also be cognisant of the staff and skill mix of their available resource. This is a critical factor in achieving clinical outcomes and staff wellbeing.

Demand

Demand refers to all patients who require an allied health intervention. A high level of visibility and system capability is required to efficiently assess and track progress against demand in real-time.

Demand data includes, but is not limited to, the following three components:

1. The number of patients requiring allied health interventions across all wards in the organisation.
2. What 'status' they are at - new referral or in-progress
3. The acuity of those patients. In the absence of validated acuity data for allied health, one method available is to assign a priority level to each patient. This is the method described in the current process.

Processes and tools to help assess and visualise demand

1. Prioritisation guideline

Clinical prioritisation is a triage process, through which referred patients are considered in an equitable and timely manner. A prioritisation guideline supports clinical staff to consistently determine clinical status and assign an appropriate response time. Prioritisation should therefore be undertaken by a suitably qualified / skilled clinician. Templates exists, see

Appendix 1 Allied health examples of prioritisation guidelines, to support allied health teams develop their own guideline.

The guideline assists clinical staff to:

- Consider the nature and urgency of the patient's needs
- Achieve time critical and high priority care
- Meet the therapeutic priorities to maintain the immediate patient and professional safety needs
- Maximise the optimal use of available staffing resource
- Promote clarity and consistency of practice across inpatient services
- Allow visibility of prioritisation criteria to service leaders, managers, referral co-ordinators and other members of the multidisciplinary team.

Once developed, guidelines should be routinely reviewed to ensure they continue to meet organisational priorities, clinical best-practice and patient pathways.

2. Electronic referral management systems

There are numerous risk and quality issues involved in having multiple referral methods for allied health across inpatient wards. Referral methods may include verbal (in person, over phone, MDT meeting), pager, fax, email and paper referrals - or a combination of all of these. Inconsistencies in referral process can lead to missed or delayed allied health assessment and interventions. This has many impacts, including impacted patient flow and discharge coordination.

An electronic referral management system addresses these issues, and enables data collation and analytics, i.e. referral numbers, referral reasons and priority level. Electronic whiteboards are one solution and have proven to be a key system enabler for providing immediate visibility. Benefits of electronic whiteboards are realised immediately on both an organisational and service level. See *Appendix 2 Benefits of electronic whiteboards* for more details.

3. Team huddle

A huddle is a short, stand-up meeting — 10 minutes or so— that is typically used once at the start of each workday. The huddle can be repeated later in the day to re-evaluate the situation, as needed.

A huddle enables the collective review and management of daily workload as a team. A huddle gives teams a way to generate visibility of demand if electronic referral management systems do not exist.

If a team is in a negative variance status (yellow, orange or red), a huddle better enables them to implement their standard operating procedure and prioritise patients with the highest clinical need.

Appendix 1 - Allied health examples of prioritisation guidelines

Occupational Therapy

Priority	Description	Response time
1 - High	Not safe to be discharged home from inpatient environment e.g. • Lives alone – concerns re safety with essential transfers, toileting, getting in and out of bed or chair • Is cognitively impaired and requires assessment to establish ability to perform essential tasks required to manage at home • Unsafe physical home environment that may require modification • Without assessment client is at risk of injuring themselves at home, require admission or unnecessary admission to long term care Planning for discharge may require a home visit Delay in assessment will result in deterioration of health status – Pressure/equipment maintenance	Same working day
2 - Medium	Noted change in cognitive functioning including problem solving, confusion, inability to process information, delayed response to requests; includes cognitive screening of CVA and TIA's. Risk of pressure areas – though not urgent. Risk of falls. General decline in management in Activities of Daily Living – e.g. showering, dressing.	Within 2 working days
3 - Low	Need to provide education in work simplification and/ or fatigue management Rehabilitation.	1-2 x per week, or as clinically indicated

Physiotherapy

Priority	Description	Response time
1 - High	Ventilated patients ICCU patients Patients at risk of respiratory complications Orthopaedic patients needing first time and progressive mobilisation Risk of delayed discharge Day one post abdominal surgery	Same working day

2 - Medium	Neurological conditions Respiratory conditions Musculoskeletal conditions General mobility difficulties and client management Post general surgery (smokers) Post mastectomy Progression of exercises or mobility	Within 2 working days
3 - Low	Post-natal management Rehabilitation (is awaiting rehabilitation) Has own exercise programme and is continuing well	1-2 x per week, or as clinically indicated

Social Work

Priority	**Description**	**Response time**
1 - High	Significant Trauma/Illness e.g. car accident, death, loss of limb/s, brain injury, distressing diagnosis Child, young person, partner and vulnerable adult where there is suspected or disclosed abuse/neglect High level of stress and/or anxiety impacting on coping abilities resulting from a physical health or disability issue Major Incident Pregnancy Options Counselling	Same working day
2 - Medium	Vulnerability e.g. elderly/fragile living alone, caregiver stress Moderate level of stress and/or anxiety resulting from a physical health or disability issue. This can include long term conditions Limited access or ability to access community resources Family, whanau or relationship issues impacting on the client's wellbeing Paediatric Support Package	Within 2 working days
3 - Low	Legal issues with pending urgency or moderate impact on daily living. This can include issues of capacity and consent. Significant financial hardship impacting on wellbeing and coping. Domestic environmental factors resulting in dangerous living conditions. Homelessness or risk of homelessness General advice and provision of information	1-2 x per week, or as clinically indicated

Speech & language Therapy

Priority	Description	Response time
1 - High	Nil By Mouth (NBM) Suspected aspiration Acutely unable to communicate Delayed referral Functional and social Impact • No established feeding (NGT or PEG) • About to go out of 2 day standard • Cannot express basic needs to staff/family Imminent patient transfer	Same working day
2 - Medium	Established diet needs review Low risk difficulty Communication impairment Functional and social Impact • Occasional coughing • Difficulties with tablets	Within 2 working days
3 - Low	Complex communication /dysphagia needs Sudden deterioration Functional and social Impact • Lack of input places patient on high risk medically, socially or psychologically • Has active rehab goals in place • Requires urgent review	1-2 x per week, or as clinically indicated

Dietetics

Priority	Description	Response time
1 - High	Enteral Feeding Parenteral Nutrition Newly Diagnosed Type 1 Diabetes Anaphylactic food reaction on the ward Refeeding syndrome Inborn Errors of Metabolism Gestational Diabetes Admitted Eating Disorders	Same working day

2 - Medium	MST (Malnutrition Screening Tool) 4 or greater Decompensated Liver disease Oesophageal cancer/stents Eating only a few teaspoons at a mealtime Burns Hyperemesis Pre-operative nutrition maximization Failing to thrive child Crohns Disease or Ulcerative colitis in the active state Bowel obstruction	Within 2 working days
3 - Low	MST (Malnutrition Screening Tool) 2 or 3 Chronic Wounds Poorly controlled diabetes on insulin Electrolyte imbalance requiring nutrition education e.g. low K diet Ileostomy/Colostomy formation Kidney disease Type 1 Diabetes children (not new) Liver disease +/- ETOH excess	1-2 x per week, or as clinically indicated

Appendix 2 - Benefits of electronic whiteboards

	Benefit
Organisational integration	**Coordination of care** • Key communication enabler for the multidisciplinary team. • Medical and nursing staff can see the patient's allied health status at a glance, improving patient flow and timely discharges.
	Standardised referral processes • All staff can view the electronic whiteboard of any ward and can enter referrals from wherever they are physically based. • It enables a real time view for each patient regarding referral status and progression from assessment, to being cleared for discharge from an allied health perspective.
	Shared information systems • Promotes whole of system transparency for demand management.
Service level	**Team management** • Staff can enter priority level against patients on triage. • Standardised referral reasons can be populated, promoting appropriate referrals. • Team coordinator/manager roles can see at a glance the status of all referrals for their service. • Supports equitable and appropriate distribution of work to staff. • Supports VRM so the patients with the highest needs are prioritised.

There are numerous possible reporting options available, including the ability to filter by:

- All active patients by discipline
- The priority level of all patients
- All patients cleared for discharge by allied health
- Response times from referral to first contact
- All patients declined for input
- Patients under active input from a community clinician
- All patients discharged from hospital while still having an ‘active’ status open to allied health.