Overcapacity Plan (adult sites)
Executive Summary for Radiology

This plan aims to provide a clear and cohesive strategy for managing overcapacity situations, ensuring that critical services, the **ED, OR** and **ICU** can fulfil their mandates. The inclusion of detailed protocols aims to **streamline patient care** and **enhance interdepartmental collaboration** by presenting the communication mechanisms necessary for adequate mobilization. The key objectives of this plan are to:

- **Decongest the Emergency Department (ED)**
  - Implement measures to reduce ED length of stay for patients
  - Eliminate or minimise barriers to optimal patient trajectories by establishing timely orientation decisions.
  - Expedite discharge or transfer patients from the ED to inpatient units.
- **Preserve Operating Room (OR) Functionality**
  - Ensure surgical schedules and emergency cases proceed without delays and minimise cancellations due to bed shortages.

Triggers for general activation of the Overcapacity Plan (one trigger is needed to activate the plan)

1) During the first six months of go-live

ED occupancy thresholds	Extended ED stays	Surgical capacity	Medicine capacity
- Glen: **170 %** - MGH: **150 %** - Lachine: **120 %**	**Five** patients in the ED over **48 hrs** waiting for admissions per admit algorithm with no anticipated discharge in the next **6 hrs.**	**More than two** surgeries face cancellation due to lack of PACU or surgical bed availability. Emergency surgery: If OR is available but unable to proceed due to lack of PACU or surgical bed availability.	Medicine patients (includes all medical specialties) in ED awaiting admission exceeds: • **20** Glen • **12** MGH • **4** Lachine ***Excluding patients with imminent discharges***

2) After the first six months of go-live

ED occupancy thresholds	Extended ED stays	Surgical capacity	Medicine capacity
- Glen: **150 %** - MGH: **130 %** - Lachine: **110 %**	**No patients** in the ED over **48 hrs** waiting for admissions per admit algorithm with no anticipated discharge in the next **6 hrs.**	OR is available but cannot proceed due to lack of PACU or surgical bed availability. Emergency surgery: OR is available but unable to proceed due to lack of PACU or surgical bed availability.	Medicine patients (includes all medical specialties) in ED awaiting admission exceeds: • **16** Glen • **10** MGH • **4** Lachine ***Excluding patients with imminent discharges***

**The triggers listed in 2) will be reviewed 4 months post go live before replacing triggers listed in 1).*

Phases of the Overcapacity Plan

Phase 1: Capacity optimisation

- In-patients: ANM (or nurse in charge or delegate) to contact consultants, Multidisciplinary Services, **radiology** and labs to prioritize the evaluation of expected discharged patients (target: d/c by **10:00**).
- ED: NIC and MDs: complete urgent interventions (labs, **radiology**, meds etc. within **60 mins** for stretcher patients **if it impacts disposition** (likely discharge or admission to an available bed).

Phase 2: Early overcapacity measures (overhead announcement)

- In-patients: prioritize exams for dischargeable patients that day; report US, CT< MRIs ASAP to allow discharge (these patients/exams will be specifically identified).
- ED: same.
- IR: for patients that **can be discharged post procedure**, patients can be moved to the IR area and discharged without need to return to the ED (these to be specifically identified by the ED team).

Phases 3 and 4:

- Continue efforts from phase 1 and 2.

Off Hours Protocol (before or after an Overcapacity Code)

- Aim to report CT, MRI and US within **30 mins** of imaging being done for patient **likely to be discharged or to go for OR** (ED team to identify specifically).

Read the full Overcapacity Plan.

If you have any questions or comments, please send an email to: dps.admin@muhc.mcgill.ca