Overcapacity Plan (adult sites)

Executive Summary for Emergency Departments, Internal Medicine (ED), and Psychiatry (ED) - RVH and MGH

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: 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).*

Regular Daytime Operations (including weekends and holidays)

- Main Physician and "Répartitrice", or the Nurse practitioner, or the nurse in charge, carries out a daily systematic review of "boarded patients awaiting admission."
- Elderly patients with good functional baseline and patients still in the ED after **36 hrs** must be fast-tracked to available beds.
- Surgical patients should not wait in the ED for OR. (These patients should have priority for admissions over surgical admissions not planned for OR). Instead, they should be transferred to:
  - an available regular surgical bed
  - ERAS bed (MGH)
  - overcapacity bed on a surgical unit

Phases of the Overcapacity Plan

Phase 1: Capacity optimisation

- **Admitting Services**: confirm admission or discharge decisions **within 1 hour[1].**
- **Nurse in charge and physician must:**
  - identify and expedite radiology and laboratory testing, as well as medication administration or other interventions that will lead to rapid discharge
  - Complete urgent diagnostics **within 60 mins.** for patients awaiting, if it impacts disposition (likely discharge or admission to an available bed).

[1]*It is understood that depending on the volume of cases, this may take longer (generally this would be done by 10:00).*

- **Consultations should take place within 1 hr**. The unit coordinator and main responsible physician for each ED zone must identify patients awaiting consult completion **that would allow discharge or admission to an available bed;** these are given high priority (1 hr timeframe may be adjusted depending on volume of consults).
- **Main responsible physician** must fast-track discharges. Patients not requiring inpatient admission must be a discharge priority in order to free up ED beds.

- **Main responsible physician** must identify procedures (eg. interventional radiology, endoscopy) that will or likely will lead to discharge and coordination with the service.
- **Main responsible physician** ensures that the usual consultation procedure is respected:
    - limit ED consults: ED physicians typically place only one admitting service consult per patient
    - consult non-admitting subspecialties: non-admitting subspecialties are consulted directly for patients likely to be discharged
    - Review consults outstanding to ensure still pertinent

Phase 2: Early overcapacity measures (overhead announcement)

- Measures from Phase 2 are put in place while simultaneously continuing measures from Phase 1.
- Finalize Consultations Promptly: Complete consultations within one hour for patients likely to require surgery or available beds.
- Main responsible physician or ED nurse in charge, or “repartitrice” arranges for non-urgent cases to be managed through outpatient clinics, day hospital, or scheduled follow-up appointments.
- Relocate patients awaiting procedures to appropriate areas for direct discharge post-procedure.

Phase 3: Overcapacity (second bed management meeting called)

- Phase 1 and Phase 2 measures are continuing.
- Pre-Op Patient Movement: Transfer **stable** same-day OR patients (from the ED) to the Same Day Admission (SDA) area
- Activation of mandatory re-orientation directive for emergency patients (DMSP).

Phase 4: Expansion of overcapacity

The DMSP or Associated director of Medical and Professional Services fluidity (ADMSP-fluidity) may trigger this phase when phase 3 has not resolved the situation and with the recommendation of the clinical directors.

Off Hours Protocol (before or after an Overcapacity Code)

No overhead call – coordinate with NRM

- Suggestion: wait **3 hrs** to avoid activation for temporary peak. Activation can be made earlier, depending on the circumstances.
    - RVH: ED at **180 %** for 3 hrs
    - MGH: ED at **160 %** for 3 hrs
- **Physicians**: prioritize discharges and then on-stretcher patients waiting to be seen.
- **Nurse in charge**: prioritize all tests and treatments to finalize discharges.
- **Treating physician**: any patient who will see consultant in the morning is to be assessed for possible return in the morning.
- **Radiologist/radiology resident**: Radiology reports on already done CT/MRI and US must be complete in 30 min. If it allows discharge – ED staff to identify these tests)
    - **Until 22:00**: All patients for which a consult will likely result in discharge that evening must be done or have a clinic visit/return the next day arranged, for discussion with ED physician.
- NOTE: **If on-site consultation is deemed necessary, consultant must be advised by 22:00 and usual workup completed before the call**;

- *Note: The vast majority of these patients are expected to return to the ED or clinic the following morning.*
- **Until midnight:** all consults which will **result in admission to an available bed** (check with NIC before calling) must be done if a bed is available for the patient (or arrangements must be made to allow transfer to the floor).
- *Note: emergency prescriptions are valid for 24 hours in the care units.*
- "Overnight keep in ED because of d/c the next day" must be admitted if bed is available.

Read the full Overcapacity Plan.
If you have any questions or comments, please sent an email to: dps.admin@muhc.mcgill.ca