# Overcapacity plan (adult sites)
## Executive Summary for Multidisciplinary Services

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.

### Best practices to prevent issues with fluidity: in-patient units

- **Access and review the expected date of discharge as a coordination mechanism:** Coordinate with the clinical team by aligning the care to the expected date of discharge
- **Completing proactively the documentation to the discharge**: completion the day before the discharge all related documentation.
- **Early discharge signature**: Patient planned for discharge should be rounded on first rather than on their usual sequence. All discharge to be signed before 10 am to facilitate discharge process on the unit. Nursing/UC should be informed in real-time of confirmed discharges.

### **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***

| ER occupancy thresholds | Extended ED stays | Surgical capacity | Medicine capacity |
|---|---|---|---|
| - Glen: **170 %**<br><br>- MGH: **150 %**<br><br>- 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.<br><br>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:<br>• **20** Glen<br>• **12** MGH<br>• **4** Lachine<br><br>***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 %.**<br><br>- MGH: **130 %**.<br><br>- 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.<br><br>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:<br>• **16** Glen<br>• **10** MGH<br>• **4** Lachine<br><br>***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 Overcapacity Plan

**Phase 1: Capacity optimisation**

This phase is an optimisation phase to avoid escalating measures. At this stage, the patient flow coordinator and assistant nurse managers (NRM & nurses in charge during weekends and holidays) lead most actions related to inpatient flow.

***Inpatient unit actions***

- ANM (or nurse in charge or delegate): contacts Multidisciplinary Services professionals to prioritize the evaluation of expected discharged patients and report back. **Target: d/c by 10:00.**
- "Infirmières en suivi systématique" with ANM: identifies potential discharges on units to free up beds. Potential discharges are reported to patient flow coordinator. **Target discharge time: 14:00.**

***Emergency Department actions: Timely Consultations***

- Unit coordinator and Main responsible physician for each ED zone or MRP: identify patients awaiting consult completion that would allow **discharge or admission to an available bed** so these are given high priority. **Target: 1 hour** (may be adjusted depending on volume of new or unfinished consults).

**Phase 2: Early overcapacity measures (overhead announcement)**

- Phase 2 is an escalation from phase 1 and should be activated after **90 mins** or earlier if phase 1 processes have been implemented and one of the triggers is still active.
- This phase includes moving discharged patients and newly admitted patients to transit spaces in the unit until room is available.
- Multidisciplinary Services: continue measures in phase 1 - complete assessment of potential discharges as priority

**Phase 3: Overcapacity**

- Includes use of off service beds, overcapacity beds in rooms or in non-traditional spaces.
- Multidisciplinary Services: continue measures in phase 1.

**Phase 4: Expansion of overcapacity**

- Represents the highest level of the overcapacity plan involving continuing of efforts on previous phase as well as medium term measures requiring the mobilisation of directors.
- It is called by the DMPS/ADMSP and involves directors to explore other measures.

Read the full Overcapacity Plan.

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