Overcapacity Plan (adult sites)
Executive Summary for Managers

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).*

Phases of the Overcapacity Plan

Phase 1: Capacity optimization

- Triggered to avoid escalating measures
- Confirm discharges and identify potential discharges by 10:00 (or 60 mins after activation)
- Potential discharges should occur by 14:00
- Identify and facilitate resolution of any process that prevents a discharge (test, consult etc.)

Phase 2: Early overcapacity measures

Activated on the hospital Intercom system by the patient flow coordinator (bed manager or NRM):

- **90 min.** after activation of phase 1
- Earlier, if phase 1 processes have been implemented and one of the triggers is still active
- Use transit space (OC room, corridor etc.) as appropriate to move patient awaiting transport or new admitted patient (ED or PACU) waiting for room cleaning

Phase 3: Overcapacity

- Will often require a second bed management meeting – with selected people.
- Patient flow coordinator (or NRM) allocates beds following specific algorithms (see annex) and extra patients are distributed fairly by service as much as possible.
- If there is no specific algorithm in annex, the unit uses their own OC beds (medicine and surgery both sites; psychiatry MGH, Lachine).
- If the situation calls for broader admission criteria, either request an additional bed management meeting or escalate the situation to ADONs (administrative director on call), Chief of Surgery and/or Chief of Medicine (or delegate) to oversee and ensure efficient bed allocation.
- Additional patient assignments in phase 3 will be discussed with given services.
- The CTUs (Clinical Teaching units) are capped at 24 patients each.
- Reminder: Off-service use of surgical beds must conform to annex 1 (expected max use of 24 hrs, or 48 hrs Fridays and Saturdays).

Phase 4: Expansion of overcapacity

- **Triggered by the DMSP or Associate Director of Medical and Professional Services fluidity (ADMSP-fluidity)** when Phase 3 has not resolved the situation, with the recommendation of clinical directors.
- ADMSP-fluidity communicates it to ADONs, Chief of Surgery and/or Chief of Medicine (or delegates) or service directors as appropriate.
- Measures from Phases 1, 2 and 3 continue.
- A mandatory debriefing of phase 4 will be planned post activation.
- If still overcap at the end of the afternoon, (Glen) consider asking Respirology/Hemo/Oncology/PCU or SSU to:
    - Identify 1 admitted patient that can go up off hours
    - Write admit orders (if any).

Read the full Overcapacity Plan.

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