Overcapacity Plan (adult sites)
Executive Summary for Non-admitting 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.

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).*

Physicians on the unit: best practices to prevent fluidity issues

- Coordinate with clinical team by aligning care to the **expected date** of discharge.
- Physicians should complete all related documentation **the day before** discharge.

Phases of the Overcapacity Plan

Phase 1: Capacity optimization

Inpatient unit actions: aim to discharge by 10:00

- ANM (or nurse in charge or delegate) to contact consultants to prioritize the evaluation of **expected** discharged patients (if necessary). These must be evaluated by 10:00 (ideally the assessment should have been completed the day before as per EDD
- Same for potential discharges which must be seen so discharge can occur by 14:00 (these will be flagged by the treating team and are not the same as expected discharges)

Emergency Department actions:

- Unit coordinator and main responsible physician for each ED zone must identify stretcher patients awaiting **consult completion which would allow discharge** within **1 hr** (timeframe may be adjusted depending on volume of consults)
- Interventions for patients that will lead or likely lead to discharge after completion are prioritized (e.g. endoscopies).
- Main responsible physician ensures that non-admitting subspecialties are consulted directly for patients likely to be discharged.

Phase 2: Early overcapacity measures (intercom announcement)

- Phase 1 measures are continuing.
- ED: Relocate patients awaiting procedures to appropriate areas for direct discharge post-procedure (e.g. discharge from IR or Endoscopy).

Off Hours Protocol (prior or following an Overcapacity Code)

- ED: **Until 22:00** all patients for which a consult will likely **result in discharge** of stretcher patient that evening must have arrangements made for clinic visit/return the next day after discussion with ED physician or be completed.[1]

Read the full Overcapacity Plan.

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

[1]All usual or reasonable tests must have been completed before the consult is requested by 22:00. Requesting a consultant to come in to do an onsite consult at this time should be a rare occurrence.