Overcapacity Plan (adult sites)
Executive Summary for Care Units and 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 ER 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 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: If OR is available but unable to proceed due to lack of PACU or surgical bed availability.	Medicine patients (includes all 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)

Nursing leadership on the unit:

- To liberate beds before **10:00** and allow admissions starting at **11:00**:
  - prepare discharge the day prior
  - ensure that last tests are done early (am bloods)
  - ensure all members of the team and the patient/family are informed.
- Maintain a continuous flow of communication:
  - update continuously the tableau des lits /white board on the unit with most up to date information regarding bed utilization
  - communicate confirmed discharges on the unit to the patient flow coordinator
- Proactive planning of activities
  - plan activities guided by the expected date of discharge
  - update following patient needs

Physicians on the unit:

- Coordinate with clinical team by aligning care to the **expected date** of discharge.
- Physicians should complete all related documentation **the day before** discharge.
- All discharges must be signed **before 10:00**. Nursing or unit coordinator should be informed in real-time of confirmed discharge. Patient planned for discharge should be rounded on first, rather than on their usual sequence.
- Overcapacity code communicated with the Intercom system should trigger **immediately** a mobilization of admitting services toward the units to participate in Immediate Discharge Confirmation.

Phases of the Overcapacity Plan

Phase 1: Capacity optimisation

Inpatient unit actions: aim to discharge by 10:00

- ANM (or nurse in charge or delegate): contacts consultants, Multidisciplinary services professionals, radiology and labs 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
- Potential discharges are reported to patient flow coordinator. **Target discharge time: 14:00.**
- Patient Cohorting: The ANM (or the nurse in charge) with the help of the infection control service group patients with similar isolation requirements to optimize bed utilization without increasing the total number of beds on the units. Immunocompromised patient populations are excluded.

Emergency Department actions

- Admitting Services: confirm admission or discharge decisions **before 10:30**.

Phase 2: Early overcapacity measures (intercom announcement)

Inpatient unit actions

- Patient flow coordinator (or NRM) with the help of the ANM (or nurse in charge) use transit spaces for discharged patients or for newly admitted patients waiting for room cleaning.
- Nurse manager, with ANM (or nurse in charge), confirms all discharges to the patient flow coordinator as they occur.
- **In the hour** following the Overcapacity code, admitting service doctors prioritize assessment and confirmation of **<u>potential</u>** discharges on their units. Target discharge time: **14:00**.
- To optimise resources, ANM (or nurse in charge) modulates assignments by acuity of care.
- Review of priority of admissions from home vs patients in the ED (Bed management / Admitting service)

Emergency Department actions

- Finalize consultations **within 1 hr** for patients likely to require urgent surgery or available beds.

Phase 3: Overcapacity

- 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.
- Reminder: Off-service use of surgical beds must conform to annex 1 (expected max use of 24 hrs, or 48 hrs Fridays and Saturdays).
- The CTUs (Clinical Teaching units) are capped at 24 patients each.

Phase 4: Expansion of overcapacity (triggered by DMSP or directors)

- Continue measures from previous phases.
- Deploy medium term measures requiring the mobilisation of directors.

Respirology/Hemo/Oncology/PCU or SSU (Glen)

- On weekends or at the end of the afternoon, if the MUHC is still in overcapacity mode, (as appropriate) please:
  - identify 1 admitted patient that can go up off hours on off-service bed
  - write admit orders (if any)

Off Hours Protocol (before or after an Overcapacity Code)

- Prioritize Overcapacity Bed Utilization: **NRM** allocates overcapacity beds (following algorithm) to surgical and medicine patients to maintain OR availability and decongest ED.
- Patients waiting for transport can be moved to corridor; similarly, admitted patients can wait in corridor while room is being cleaned.
- Units to report discharges to the NRM as they occur.
- NRM continuously moves PACU patients to appropriate beds to prevent bottlenecks.
- To prepare for morning discharges, nurses in charge on care units must:
  - follow up on transport planning
  - finalize discharge plans for patients scheduled
- **Imaging on-call manager** expedites tests and readings for patients awaiting discharge or requiring immediate results with the teams covering the evening shift.
- NRM to follow up with managers of Transport and Housekeeping on adjusting workforce to prioritize Overcapacity actions.
- **Until midnight:** all consults which will **result in admission to an available bed** must be done if a bed is available for the patient (or arrangements must be made to allow transfer to the floor - ED MD can print orders from Medurge with a note to call admitting service PRN as appropriate).
- "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 send an email to: dps.admin@muhc.mcgill.ca