Overcapacity Plan (adult sites)
Executive Summary for Bed 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: If 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 optimisation

- Patient flow coordinator can trigger this phase to avoid escalating measures during the daily morning bed management meeting with all units or later as appropriate.

- It involves:

  A) For the inpatient units:
  - Complete/confirm known discharges (target: **1 hr**).
  - Identify potential discharges with goal to d/c **5 hrs** later.
  - Units to contact bed managers/NRMs for discharges and potential discharges within **60 mins** and actual discharges **as they occur**.

  B) In the ED:
  - Confirm admissions for services where beds are open and potential discharges (target: **1 hr)**.
  - Complete consults that will result in d/c (target **1.5 hrs**) (this may vary based on consult volumes)
  - Identify and prioritise tests that will result in d/c for stretcher pts (target: **1 hr**).

Example: if phase 1 activated at the end of bed management (9:00), then units report discharges and potential discharges by 10:00; discharged patient rooms are free by 10:30 at the latest, potential discharges are confirmed (or not) and room is free by 14:00).

Phase 2: Early overcapacity measures (overhead announcement)

- **Patient flow coordinator (bed manager or NRM) triggers this phase via intercom,**
  - **90 minutes** after Phase 1 is triggered if actions in phase 1 will not resolve the issue
  - **Earlier** if Phase 1 processes have been implemented and one of the triggers are still active.
  - These measures are in place while simultaneously continuing measures from Phase 1.
- It involves:

  A) For the inpatient units:
  - Confirm “tentative discharges” (**1 h**) (i.e. decide if discharge is possible that day or not).
  - Use of transit spaces (corridors for patients waiting transport or for ED/PACU patients waiting for room cleaning (if hallways, refer to non-traditional space criteria and adapt to specific patient needs).
  - Re-arrange units for optimal use of resources.

  B) In the ED:
  - Complete all tasks in phase 1 and continue measures of prioritisation
  - Prioritise assessment of new stretcher patients
  - Re-directs patients to other resources as much as possible
  - Arrange for discharge home post-procedure without return to ED as appropriate

Phase 3: Overcapacity

- Phase 1 and Phase 2 measures are continuing.
- Triggered approx. **2.5-3 hours** after the Overcapacity code during the day (off-hour protocol to be used after 17:00).
- The patient flow coordinator (or NRM) will not make additional calls through intercom but will communicate directly with specific sectors.
- All over capacity beds to be filled (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). The CTUs (Clinical Teaching units) are capped at 24 patients each.
- Off-service use of surgical beds must conform to annex 1 (expected max use of **24 hrs**, or **48 hrs** Fridays and Saturdays).
- 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.
- Re-evaluation of transport demands and coordination with US if possible.
- Stable ED patients being operated that day to go to SDA area.
- Possible activation of mandatory re-orientation (DMSP/DG).

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.
- Continue measures from previous phases.
- Exceptional measures to be discussed.

Read the full Overcapacity Plan.

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