Centre universitaire de santé McGill | McGill University Health Centre

Overcapacity Plan

Glen Site, Montreal General Hospital, Lachine Hospital

1- Objectives of the Overcapacity Plan

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 is:

- Decongest the Emergency Department (ED)
    - Implement measures to reduce ED length of stay for patients
    - Eliminate or minimize 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 minimize cancellations due to bed shortages.

2- Definitions

- **Overcapacity bed**: bed on care unit use over the number of regular beds open without any additional staff. Those beds are only to be used in a context of helping fluidity (ED overcrowding or risk of OR cancellation).
- **Transit area**: Transit areas are designed spaces on care units to allow a rapid movement of soon to be discharged patient thus liberating a regular bed for transfers of a critical care area patient. Typical patients for this area are patients waiting for transport, a test result or completion of a last consultation to be discharged. Patients waiting for room cleaning may also wait there.
- **"Infirmière en suivi systématique"- ISS**: Nursing role on the care unit following the patient trajectory and coordinating preparation to discharge with the help of other healthcare professionals.
- **ED Medical Coordinator**: ED medical coordinator's role is to ensure there is a clear plan for stretcher patients and, as needed, has DPS authority to assign a service/unit for patients requiring admission. The role also includes optimising flow in the ED to ensure optimal use of resources and prioritise discharges or trajectories other than admission. In the absence of ED medical coordinator, the ED physician in charge of the zone where the patient is located acts as substitute.
- **"Répartitrice"**: Nursing role within the Glen and MGH ED to help identify vulnerable patients (starting the SSPPCC process before the admission on the care unit) and identify possible patient in the ED that could be reoriented toward ambulatory services.
- **Expected date of discharge - EDD**: Date associated to every admission estimating the duration of the stay of the patient. All discharge planning activities should be organized aiming at the estimate discharge date.
- **Most Responsible Physician - MRP**: can be either ED physician or consultant. In general, his/her name will be the one identified in medurge.

3- Regular Daytime Operations (Including Weekends and Holidays)

3.1 Patient flow coordinators: best practices to prevent issues with fluidity

3.1.1 Managing Patients in the ED waiting for a bed for more than 24 hrs or with total LOS 36 hrs or more

- **Reassessing Admission Needs**: A systematic review of "boarded patients awaiting admission" by the MRP and "Répartitrice" or the Nurse practitioner or the nurse in charge is realized daily. Elderly patients with good functional baseline and patients still in the ED after 36 hours, fast track them to available beds. Elderly patients with a good baseline autonomy should also be prioritised.
- **Expediting surgical patient waiting for the OR**: Surgical patient should not wait for OR in the ED. Instead, should be transferred in an available regular surgical bed, ERAS bed (MGH) or overcapacity bed on a surgical unit. These patients should have priority for admissions over surgical admissions not planned for OR.

3.1.2 Critical Care Areas flow management

- **Maintaining target ideal minimal capacity**: For critical care areas, (ICU/CCU/PACU/Intermediate care-Lachine) the transfer of stable patients should be a priority to ensure minimal remaining capacity. This needs to be balanced with maintaining ED and OR access to the same beds. The **ideal** minimal capacity should be on each site:
    - Two overnight patients maximum in the Post-Anesthesia Care Unit (PACU) (MGH & Glen)
    - One remaining bed in the Intensive Care Unit - ICU (MGH & Glen)
    - One remaining bed in the CCU (MGH & Glen)
    - One remaining bed in the Intermediate care unit (Lachine)
- **Minimizing delay to transfers**: All patients in critical care areas ready to be transferred should be flagged in real time to ensure all partners are aware. Overcapacity bed use is reserved to facilitate transfer of patients from critical care areas (note that this does not imply transfer from ICU to OC bed; OC bed eligibility criteria bed always apply). Transit areas are also used to liberate bed more rapidly and speed up transfers from critical care areas.
- **Respecting overcapacity bed use algorithms**: Overcapacity beds must be used primarily to support objectives of overcapacity. Good examples of this are: free up regular beds to facilitate flow, as preop beds, or as overflow to accommodate ED, ICU or PACU patients etc.
- **Utilizing Overflow Systems**: When overcapacity is not possible, the ICU staff should employ the Centre d'Optimisation de l'Occupation des Lits de Soins Intensifs (COOLSI) following the overflow plan of the ICU. The ED physician can make the calls if the ICU physicians has other unstable patients to manage at the time.

3.2 Nursing leadership on the unit: best practices to prevent issues with fluidity

- **Keep a hospital wide perspective on patient fluidity**: Patient fluidity issues need the mobilization of all clinical sectors to be addressed and thus are the responsibility of all sectors.
- **Prioritize discharges and early admission in the day**: Planning of the work on the unit should aim at discharging patient in the morning (before 10:00) to allow admissions on the unit starting at 11:00 as much as possible. This implies several measures outlined in the discharge protocol, in particular; preparing the discharge the day prior, ensuring last tests are done early (am bloods) and all members of the team and the patient/family are informed.
- **Maintaining 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 and communicate confirmed discharges on the unit to the patient flow coordinator.
- **Proactive planning of activities following the expected date of discharge**: Plan activities guided by the expected date of discharge and update following patient needs.

3.3 Physicians on the unit: best practices to prevent issues with fluidity

- **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**: Physicians should complete 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 10:00 to facilitate discharge process on the unit. Nursing/UC should be informed in real-time of confirmed discharges.
- **Active and rapid participation to the Overcapacity code**: Overcapacity code communicated with the Intercom system should trigger immediately a mobilisation of admitting services toward the units to participates in Immediate Discharge Confirmation.
- **Aligning elective activities with expected discharges**: At a coordination level, a validation of SDAs or any other elective procedure should be done with the expected planned discharges to prevent preventable overcapacity situations.

4 Overcapacity plan

4.1 Triggers for Activation of the Overcapacity Plan (first 6 months of go-live)

Triggers for general activation of the Overcapacity Plan (one trigger is needed to activate the plan)			
ER Occupancy Thresholds: ▪ Glen ED occupancy over 170% ▪ Montreal General Hospital (MGH) over 150%. ▪ Lachine Hospital over 120%.	Extended ED Stays: Five patients in the ED over 48 hours waiting for admissions per admit algorithm with no anticipated discharge in the next 6 h	Surgical Capacity: Scheduled surgery: If 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. More than 12 admitted patients (Glen or MGH)	Medicine Capacity: Medicine patients in ED awaiting admission exceeds 20 (Glen), 12 (MGH), 4 (Lachine) Excluding patients with imminent discharges Medicine includes all specialties – (e.g. includes SSU, cardio etc.

Triggers for Activation of the Overcapacity Plan (after 6 months go-live)

Triggers for general activation of the Overcapacity Plan (one trigger is needed to activate the plan)			
ER Occupancy Thresholds: ▪ Glen ED occupancy over 150% ▪ Montreal General Hospital (MGH) over 130%. ▪ Lachine Hospital over 110%.	Extended ED Stays: No patients in the ED over 48 hours waiting for admissions per admit algorithm with no anticipated discharge in the next 6 h	Surgical Capacity: If 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 with emergency cases due to lack of PACU or surgical bed availability. More than 10 admitted patients (Glen or MGH)	Medicine Capacity: Medicine patients in ED awaiting admission exceeds 16 (Glen), 10 (MGH), 4 (Lachine) Excluding patients with imminent discharges Medicine includes all specialties – not just internal medicine

*The triggers listed in 3.4.2 will be reviewed 4 months post go live before replacing triggers listed in 3.4.1.

4.2 Phases of the Overcapacity Plan

Phases of the overcapacity protocol are activated in sequence. The resolution of the OC protocol is once the situation reaches 10% below activation level.

4.2.1 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. Patient flow coordinator can trigger this phase as early as the daily morning bed management meeting with all the units or any later time as appropriate. The following actions are designed to prioritize work and prevent worsening of the situation. If one of the triggers is still active after 90 mins or these actions are already in place, subsequent phases are to be activated.

Inpatient unit actions

- ANM (or nurse in charge or delegate) to contact consultants, allied health professionals, radiology and labs to prioritize the evaluation of expected discharged patients and report back. (target : d/c within 1 hr)[1]
- "Infirmières en suivi systématique" with ANM and MDs identifies potential discharges on units to free up beds. Potential discharges are reported to patient flow coordinator (target discharge 14:00 or 5 hours after activation)
- Discharges and potential discharges to be announced within 60 mins
- Actual discharges to be declared as they occur
- 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.

PACU: reassess overnight patients to confirm orientation and advise bed managers (target 09:30)

Emergency Department actions

- Admitting Services: Confirm emergency admission or discharge decisions within 1 hour [2].
- NIC and MDs: Complete urgent interventions (labs, radiology, meds etc. **within 60 min.** for stretcher patients if it impacts disposition (likely **discharge** or admission to an **available** bed)
- 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: 1.5 hour (may be adjusted depending on volume of new or unfinished consults)
- Fast-Track Discharges by the main responsible physician: Prioritize discharges of patients not requiring inpatient admission to free up ED space.
- Unit coordinator: ensure all external transports from previous shifts are still booked

[1] Note that normal discharge time is 10:00 (excluding patients with specialized transport needs) thus d/c within 1 hour of the bed management meeting (09:00) should be seen as "usual"
[2] It is understood that depending on the volume of cases, this may take longer

- Main responsible physician ensures that the usual consultation procedure is respected:
    - Limiting ED Consultations: ED physicians typically place only one admitting service consult per patient.
    - Consulting Non-Admitting Subspecialties: Non-admitting subspecialties are consulted directly for patients likely to be discharged.
    - Review pertinence of consults

4.2.2 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. Patient flow coordinator (or NRM) set off the Overcapacity Phase 2 code on the hospital Intercom system to relay the information to all sectors. The following actions should be put in place while continuing actions from Phase 1.

In patient unit actions

- Immediate Discharge Confirmation: The nurse manager with the ANM or the nurse in charge confirms all discharges as they occur to the patient flow coordinator.
- Admitting service doctors, prioritize, in the next hour following the Overcapacity code, assessment and confirmation (if so) of **potential** discharges on their units.
- 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 are used. (if hallway, use criteria for non-traditional space as guideline to decide appropriateness)
- Patients on oxygen can wait in hallways if saturation > 90 % on room air (ensure adequate supplemental oxygen)
- At Lachine Hospital, Manager of the IPS Clinic review the ED and inpatient lists to identify possible patients that could be reoriented toward ambulatory services.
- Prioritize Transport and Housekeeping: Transport and housekeeping dispatch services, briefed by patient flow coordinator (or NRM), to prioritize demands related to transfers from critical care areas or ED toward care units for the next 2h following the Overcapacity code and then patients requiring tests that will lead to discharge.
- Staffing planning: ANM (or nurse in charge) modulates assignments by acuity of care to optimise resources.
- Review of priority of admissions from home vs patient in the ED (Bed management/ admitting service)

PACU: identify patients that fit overcapacity criteria and those who could wait outside rooms while cleaning in process and advise bed management

Emergency Department actions

- Finalize Consultations Promptly: Complete consultations within one hour for patients likely to require surgery or Medicine beds.
- Redirect Non-Urgent Cases: Main responsible physician or ED NIC or Inf “repartitrice” arranges for non-urgent cases to be managed through outpatient clinics, day hospital or scheduled follow-up appointments, alleviating ED congestion.
- Relocate Patients Awaiting Procedures: Move patients to appropriate areas for direct discharge post-procedure.
- Adhere to Consultation Protocols of phase 1: Continue to follow established consultation protocols to streamline patient care and minimize delays.

4.2.3 Phase 3: Overcapacity

Phase 3 is an escalation from the previous phases. All over capacity bed to be filled (as appropriate). If situation requires widening admission criteria outside of the regular specialty-based algorithms, ADONs (or administrative director on call), Chief of Surgery and/or Chief of Medicine (as appropriate) become more involved in the overcapacity plan This phase should occur approximately 2.5-3 hrs after the Overcapacity code during the day (Off hour protocol to be used if after 17:00). The patient flow coordinator (or NRM) will not make additional calls through the Intercom system but will communicate directly with specific sectors. Measures from Phases 1 and 2 continue.

- Additional bed management meeting may be convened to facilitate this
- Use of 100% of the hospital capacity: Guided by ADONs (or administrative director on call), Chief of Surgery and/or Chief of Medicine (or delegate), the patient flow coordinator (or NRM) assigns a patient to every bed remaining (note that the CTUs are capped at 24 patients each). Additional patient assignments in phase 3 will be discussed with given services.
- Specialty-Based Overcapacity Management (RVH site): Allocation by patient flow coordinator (or NRM) follows 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). The nurse manager (or the nurse in charge) escalates the situation to ADONs (or the administrative director on call) and, as needed, the Chief of Surgery and/or Chief of Medicine to oversee and to ensure efficient bed allocation.

- Reminder that off-service use of surgical beds must conform to annex 1 (expected max use of 24 hrs/48 hrs Fri/Sat)
- Enhanced Transport Support: Transport manager to
    - Plan additional support (manpower) to reduce delays in discharging patients and internal movements
    - Ask Urgence Santé for support to get people out of the MUHC for patients awaiting transports / review necessity of ambulance transports if any alternative possible
    - Ask ANM/NC to reassess the right kind of transport has been selected for the patient
- Pre-Op Patient Movement: Transfer **stable** same-day OR patients (from the ED) to the Same Day Admission (SDA) area promptly to maintain the surgical schedule.
- Activation of mandatory re-orientation directive for emergency patients (DMSP/DG)

4.2.4 Phase 4: Expansion of overcapacity

Phase 4 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.

The DMSP or Associated director of Medical and Professional Services fluidity (ADMSP-fluidity) may trigger this phase when phase 3 has not resolved the situation and with the recommendation of the clinical directors.

The 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.

- Overcapacity Response Team: The ADSP fluidity convenes an Overcapacity Response Team including senior administrative leaders, clinical directors, Patient flow coordinator, and NRMs to:
    - Assess the situation, implement extraordinary measures or do other specific actionable items.
    - Ensure clear and timely communication to all departments and staff about the situation and measures being taken.
    - Continuously monitor the situation and reassess the measures in place, adjusting as necessary. Update every 90 mins.
    - Additional command center Meetings: ADPS Fluidity convene, as needed, additional command center meetings to address surgical flow and ED congestion, preventing cancellations and delays.
- Implement Extraordinary Measures: The Overcapacity Response Team will consider and implement extraordinary measures, which could include:
    - Open additional overcapacity beds.
    - Review elective interventional procedure: the ADON, DSI and Medical chief review Program for elective interventional activities (EP Lab, Cath lab). The Medical Day hospital hours to be expanded.
    - Review surgical planning: the ADON, DSI, DPI and Chief of Surgery/ Perioperative medical director / site directors review the program and adjust the level of activity of the OR according to the situation.
    - Mobilizing additional staff or resources.
- Interventions by the ADMSP-fluidity and the DMSP with partner hospitals, Santé Quebec, CIUSSS and others to move patients out of the MUHC.
- Additional coordination with technical service and the technical service director might be required to ensure availabilities of additional medical equipment depending on the expansion of care units.
- A mandatory debriefing of phase 4 will be planned post activation.

4.2.5 Debriefing

If the protocol phase 4 is activated, a debrief is mandatory

- Immediate Notification: ADPS Fluidity must promptly notify senior management, including the PDGA, Director of Nursing (DSI), Director of Professional Services (DPS), Director of multidisciplinary services (DSM) and Director of Perioperative and Imaging (DPI) about the critical overcapacity situation.
- Post-Escalation Review: ADMSP Fluidity will conduct a debriefing to identify lessons learned and update the overcapacity plan accordingly after resolving the situation and presented in a command center meeting

5- Off Hours Protocol (prior or following an Overcapacity Code)

No overhead call – coordinate with NRM

At the end of the day, patient flow coordinator (or NRM) briefs the evening NRM through the bed management report of the actions of the day and the follow-ups:

- Monitor and assess staffing needs in real-time to support overcapacity measures.
- Communicate with nursing teams about overcapacity status and protocols.
- (Glen) Respirology/Hemo/Oncology/PCU and SSU to identify 1 patient that can go up off hours/off service and write admit orders (there may be none)

5.1 Threshold of activation

Wait three hours to avoid activation for temporary peak. Activation can be made earlier depending on circumstances

- RVH: ED at 180 % for 3 hrs
- MGH: ED at 160 % for 3 hrs
- Lachine: ED at 130 % for 3 hrs

5.2 Emergency Department actions

- ED to focus on discharges and then on stretcher patients waiting to be seen (treating MDs; H2/MC2 MD)
- All tests and treatments to be prioritized to finalize discharges (ED NIC)
- Any patient who will see consultant in AM to be assessed for possible return in am (treating MD)
- Radiology reports on CT / MRI and US already done should which can result **in discharge or decision to operate** of stretcher patients should be complete in 30 min. (NIC / MRP to flag as needed)
  (radiologist / radiology resident)
- Until 22:00 : All patient for which a consult will likely result in patient discharge must be done or arrangements for clinic visit / return the next day be discussed with ED physician **[3]
- Until midnight: all consults which will likely result in admission in an available bed must be done if a bed is available for the patient (or arrangements be made to allow transfer to the floor) **[4]

[3] **If on-site consultation is deemed necessary, consultant must be advised by 22:00 and usual workup completed before the call**; for phone discussion, calls to occur until 24:00. These hours can be extended by DPS on call on a case-by-case basis

[4] ED orders are valid for 24 hrs

5.3 Patient flow actions

- Prioritize Overcapacity Bed Utilization: NRM to allocate overcapacity beds to surgical and Medicine patients to maintain OR availability and decongest the ED.
- 24/7 PACU Patient Transfers: NRM to continuously moves PACU patients to appropriate beds to prevent bottlenecks
- Patients waiting for transport can be moved to corridor[5]; similarly, admitted patient can wait in the corridor while room is being cleaned.
- Units to report discharges to the NRM as they occur.
- Preparation for Morning Discharges: Nurses in charge on care units to follow up on transport planning and finalize discharge plans for patients scheduled for morning discharge and create early morning bed capacity.
- Radiology Prioritization: Imaging on-call manager expedite tests and readings for patients awaiting discharge or requiring immediate results with the teams covering the evening shift.
- Transport and Housekeeping capacity: NRM to follow up with managers of Transport and Housekeeping on adjusting work force according to the needs to prioritize Overcapacity actions.
- "overnight keep in ED because of d/c the next day" must be admitted if bed is available

[5] Judgment to be used depending on type of transport etc.

Annex 1: Patient criteria for Overcapacity room

Type of room	Oxygen	Suction	Mobility	Isolation	Behavior
Non – traditional space: conference or antechamber to neg pressure room	Max 2 L or 28% mask to maintain target sat. *: for resp patients, pls see annex 2 6.6	OK only for NGT (no Chest tubes)	Mobile / or able to do transfers autonomously If bed-ridden at baseline, use clinical judgment	Contact iso OK – provide commode for the patient (as done in ED) NO airbone risks	Reliable unless not mobile (bed ridden)
Single rooms that are doubled up or any traditional room where an additional patient is placed	Usual ward requirement Home CPAP only exceptionally if reason for admission is not cardio or pulmonary	No specific requirements	If patient remains on a stretcher should be able to get off with assistance	Isolation OK if cohorted with same needs	Cannot be aggressive/ severe agitation

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Overcapacity beds must be used primarily to support objectives of overcapacity: free up regular beds to facilitate flow, as preop beds, or as overflow to accommodate ED<ICU or PACU patients etc.

General selection (in addition to above) - Glen site

If a bed in surgery is used for a “medical” patient (as detailed below), the patient must be either expected to be discharged the next day or moved to the usual ward the next day (i.e. a discharge is anticipated). Depending on need, a patient for discharge the next day can be moved to OC space to optimize resources.

In general, PCU, SSU, Hemo/Onc and Resp can have a maximum of 2 extra patients without needing formal approval (beyond that, services must agree or DMSP involved). The workload should be as evenly distributed as possible while respecting criteria.

Annex 2: Specialty specific algorithms for use of overcapacity beds GLEN SITE

The patients should be distributed between services as much as possible, so no service ends up over quota all the time. Except for cardiology on C7, in general, services have agreed to have up to 2 patients over. Any more than that needs to be approved by the service or discussed with the DPS on-call.

6.1 Surgical (incl. Gyne) patients

- Goals: Maximize surgical bed capacity to minimize OR cancellations due to lack of beds
- Identified dynamics:
    - Frequent cancellation of SDA due to lack of beds
    - Limited use of OC on surgical units (esp at the Glen site)
    - Overnight use of the PACU
    - Overcapacity beds criteria have been revised to offer better access to beds.
    - Surgical overcapacity beds are always used for surgical patients before they get offered to other
    - When surgical OC beds are used for other clientele, the targeted transit is 24 hrs (Sunday to Thursday; 48 hrs Friday and Saturday)
- When no surgical beds are available:
    - Pre-op patients go to OC beds
    - Postop patients who underwent procedure with short LOS (e.g. appendectomy etc.) can be placed in OC beds
    - At the Glen, any patients that meets MGH ERAS eligibility can go to OC beds
    - Patients at the end of stay are to be moved to OC beds as appropriate, the targeted transit for non-surgical patients is 24-48 hrs

6.2 Cardiac surgery / pre post interventional cardiology / cardiology patients

- Goals: Maximize flexibility for surgical services, while providing some extra capacity for cardiology on D7
- Identified dynamics:
    - There is a large volume of surgery admissions
    - There are some under-used beds on D7 that are owned and controlled by surgery but may be used for short-stay cardiology patients
    - Urgent circumstances linked to cardiac surgery type of patients might require repatriating immediately transferred patients in the CCU
- Criteria for patients:
    - Post-cath (no intervention) or uncomplicated PCI for NSTEMI/unstable angina or stable coronary artery disease
    - Pre-procedure TAVI, clips, ASD closure, LAA closure
    - Post-structural heart procedure namely ASD closure, LAA closure
    - Post-pacemaker/ICD implant
    - Post-SVT, flutter ablation
    - Pre-op prior to planned surgery or patient accepted by cardiac surgery and transferred to inpatient cardiology (although ongoing discussion regarding possibility of some of these patients being transferred for MRP under cardiac surgery census)
- When no beds are available:
    - Patients with an anticipated stay will be 24 hours or less (may be 48 hours on Friday or Saturday)
    - Patients admitted to these D7 beds may be pre- or post-interventional procedure where patient may be transferred ahead of procedure from ED, or recover in D7 pod.
    - Additionally, patients with recent ED visits or in-hospital transfer may return for expedited outpatient procedure to help offload ED census and avoid return ED visits.
    - The priority is to facilitate admissions from the ED or to reduce inpatient volumes for patients ready to leave hospital pending a procedure.
    - All on-call issues go to the primary team. On-call cardiology teams (including house staff and physicians) will not provide care
    - Cases which may become complicated, or unstable should be admitted to CCU
- Responsibility for coverage: Patients must be discharged in a timely manner, EP service, interventional cardiology service, and/or inpatient cardiology service are responsible for covering these patients overnight also discharging the following morning pending other necessary testing –this to be performed as soon as possible in the morning to make room for new patients.
    - D7 Pod patients with recent ED visit diverted for expedited for outpatient EP procedures: admitted under and fully managed by the EP team
    - D7 Pod patients with recent ED visit diverted for expedited for outpatient CATH procedures: admitted under and fully managed by the CATH team
    - D7 Pod patients from ED or in-hospital: As they currently are, admitted under and managed by Inpatient Cardiology Red/Blue teams. The CICU MD not teaching on any given morning will see these patients at 08:30 after sign-over and discharge them so long as ready, with a comprehensive discharge care plan carried forward from the ED/inpatient unit

6.3 Hemo/Onc patients

- Goals: Allow Hemo/Onc patients better access to beds by minimizing waiting in the ED and prioritize access to patients requiring chemotherapy and treatments that cannot be given on other in-patient units
- Identified dynamics:
    - Hemo/Onc care unit is usually full
    - Chemotherapy and bone marrow transplant cannot be done on other units
    - Several patients present to the emergency with complications of treatment (mainly febrile neutropenia, GVHD, reaction to biological agents…) which require active involvement of Hemo/Onc
- The admission algorithm already addresses other issues which affect the trajectory of Hemo/Onc patients
- Wait times for these patients to access treatment need to be respected in the context of possible progression of disease.
- The MUHC is referral center for rare cancers (e.g sarcomas, CNS etc.) as well as some treatment which are not offered elsewhere in our RIUS or have limited availability in the province
- When no Hemo/Onc beds are available
    - Priority is given to patients requiring specialized treatments
    - Patients coming in before their treatments start can be in overcapacity rooms until the treatment
    - Patients who are near discharge (last 24/48 hrs) and no longer requiring negative pressure rooms can be moved to overcap room
    - Febrile neutropenic patients who are expected to recover rapidly can be admitted to overcap room
    - Other patients requiring admission in the ED can be admitted to off-service beds overcapacity beds on other units (surgical beds) depending on availability and eligibility criterea (i.e. anticipated length of admission 24-48 hrs)
    - Note that the in-patient capacity for the team is 24; arrangements for extra patients will need to be discussed if needed.

6.4 Palliative patients

- Goals: Allow Palliative care patients better access to beds and minimize the number of palliative care patients dying in the ED
- Identified dynamics:
    - Palliative care unit is often full
    - Palliative patients dying in the ED for lack of beds is a regular occurrence
    - Many patients are admitted for symptom control rather than terminal phase of disease
    - There are some non-cancer patients dying in the ED who could benefit from PCU services
- The MSSS issued a directive that dying patient have a private room
- When no PCU beds are available
    - Non-terminal patients can be admitted to overcapacityroom on PCU
    - Patients with life expectancy less than 48 hrs can be admitted to any off-service regular bed. Generally, this will be on C8
    - If no regular room, patient and/or family can be given the option of overcap room or staying in ED
    - Non-terminal patients can be admitted off service if another bed is expected to be free on PCU in the following 24 hrs
    - When no bed is available at the Glen, transfer to Lachine should de prioritized ahead of off-service beds (patient at risk of dying during transport should not be transported)
    - Patients expected to go home in the next 24 hrs can be moved to overcap rooms when appropriate

6.5 SSU patients

- Goals: Allow SSU patients better access to beds and minimize the number of SSU patients in the ED
- Identified dynamics:
    - SSU generally has a high turnover rate
    - SSU candidates are frequent, and the capacity is fully used
    - SSU often accepts to take off-service patients by admitting the patient with the collaboration of another service
    - Off-service patients can be on any unit and spread across several floors making work more difficult
- Proposal- when no SSU beds are available:
    - SSU patients can be admitted off-service to C8 regular, overcap room or doubled up rooms
    - Patients admitted to surgical bed must have an anticipated length of stay of 24 hours (48 hours on Friday or Saturday).
    - If the patient is admitted to a regular room on C8 and the room is required for a surgical patient, the SSU patient will be repatriated to SSU in the next available bed ahead of a patient waiting in the ED
    - Off service SSU will not be admitted to other units unless there are exceptional circumstances

6.6 Respirology patients

- Goals: Allow respirology patients better access to beds and minimize the number of resp patients in the ED
- Identified dynamics:
    - Respirology beds (incl beds on medical units) are usually full
    - Respirology patient often need airborne isolation (thus not candidates for non-traditional spaces)
    - Some respirology patient require a reliable oxygen supply 24 hrs a day
    - There are peaks of bed demand during the fall/winter/spring season
- The admission algorithm already addresses other issues which affect the trajectory of respirology patients
- The chest hospital offers comprehensive support for the care of patients in the day hospital
- The MUHC is referral center for conditions that are not treated elsewhere on a routine basis (cystic fibrosis, interstitial lung disease etc.)
- when no resp beds are available:
    - New admissions should be prioritized to resp beds
    - Patients should be admitted in order of wait time unless under exceptional circumstances
    - Order of preference for overcap beds: C8, doubling of beds in resp, overcap rooms
    - Patient in non-traditional rooms must for the current algorithm (which does not include patients with chest tubes)
    - The use of C8 beds must be limited to patients who are expected to stay there for 24 hrs or less, may include patients who have nearly completed their stay or patients that will be moved to resp the next day. (48 hrs on weekends)
    - Patients on C8 that will be discharged must be assessed first on morning round

** If a respirology patient requiring oxygen goes to a non-conventional room (e.g. conference room), he needs to be at baseline (i.e. on home O2 at 1-2 L and not requiring more O2 or not expected to have increasing O2 needs – this to be determined by respirology consult service)

Last revision: May 14, 2025

This document will be reviewed 6 months after go-live