**** This policy applies at ALL sites.**

Title:	**Bed Management Policy**		
Manual:	Corporate		
Section:	Patient Flow		
Approval Body:	SLT Final – COO, CNE, EVP		
Original Effective Date: *(mm/dd/yyy)*	November/2020	**Reviewed Date:** *(mm/dd/yyy)*	
Revised Date: *(month/yyyy)*		**Next Revision Date:** *(month/yyyy)*	November/2023
Cross References:	Infection Control Emergencies, all Code policies		
Key Words:	Beds, surge protocols, critical care surge, ALC, intersite transfers		
Developed by: *(Name & Title)*	**Manager, Patient Flow**	**Owner:** *(Name & Title)*	**Director, ED, ICU, Ambulatory Care**

POLICY:

The management of all admissions or transfers to inpatient beds will be coordinated through the Capacity Optimization and Resourcing (COR) office, including Bed Allocation, Patient Care Coordinators, Patient Flow Manager, and Shift Managers. Inpatient beds allocated specifically for Maternal Newborn care will be managed by Labour and Delivery in collaboration with the Mother Baby Unit. Inpatient beds allocated for mental health and post acute care will be managed collaboratively with the COR team and the respective program leads.

The hospital's Capacity Optimization and Resourcing office (COR) will facilitate and manage the information required to appropriately place patients based on two main factors:

a) patient clinical needs and conditions

b) availability of appropriate equipment, resources and services

Inpatient beds are corporate resources allocated to specific departments to enable the effective and efficient delivery of quality services by getting the patient to the right environment for care from providers who are best able to meet the patient's needs, and ensure patient safety as a priority . When volume and acuity demands overwhelm normal operations, patient and staff satisfaction decline, and fiscal pressures rise, and risks to staff

and patients increase. An urgent, coordinated, hospital-wide response will be required to restore normal operations. If access to life and limb saving resources, such as critical care, emergency services, and/or the operating room is seriously compromised, an emergent system-wide response is required.

This policy addresses corporate bed resource planning, routine patient flow management and surge management, up to moderate surge scenarios only and is to be used as a guide as each surge situation may vary and require additional action as necessary. Major surge scenarios are addressed in emergency preparedness policies (Code Orange, pandemic planning).

This policy has been guided by Ontario's Critical Care Surge Capacity Management Program and the provincial Emergency Department (ED) Wait Time Strategy. Under the ED Wait Time Strategy, provincial wait time targets have been identified for specific clinical activities. Admitted patients remaining in the emergency department longer than 8 hours from their time of arrival at triage are indicative of a flow issue somewhere along the continuum of services. Along with set wait time targets for surgical/interventional priority areas, an 8- hour target has been set for patients admitted through the emergency department.

DEFINITION(S):

The Ontario Ministry of Health and Long-Term Care's Critical Care Services has defined surge as follows:

Definition of Surge: Any situation where demand exceeds planned resources.

For clarity and consistency across the health care sector, three (3) levels of critical care surge have been identified:

- MINOR SURGE: An acute increase in demand for hospital services; up to 15% above normal capacity; localized to Mackenzie Health.
- MODERATE SURGE: An increase greater than 15% in demand beyond our budgeted capacity but additional physical capacity is available.
- MAJOR SURGE: Overwhelms Mackenzie Health for an extended period of time. May require notification to CLHIN to initiate a LHIN-wide response if surge is sustained

PROCEDURE:

1) Admission order is received by Bed Allocator
2) The Bed Allocator will assign the patient to an 'appropriate bed' based on the following criteria:
   a. Isolation status
   b. Patient safety considerations and clinical needs
   c. Physician type/service
3) Once there is a confirmed discharge, the Bed Allocator will assign the bed accordingly.
4) If an 'appropriate bed' is not available the Bed Allocator will work in collaboration with the Patient Flow Team, including Patient Flow Coordinator /Patient Flow

**** This policy applies at ALL sites.**

Manager/Shift Manager to identify and assign the patient in the next best available bed (Refer to Appendix B for moving patients between units)

5) If an 'appropriate bed' is not available, Patient Flow team will assign the patient to the next available bed using the following criteria:
   a. Isolation status
   b. Patient safety considerations and clinical needs
   c. Wait time
   d. Service /physician
   e. Gender

6) Bed Allocator will assign beds for elective, urgent, and emergent admissions, as well as patient transfers in collaboration with COR team

7) Bed assignments will be prioritized according to Emergency Department (ED) Length of Stay (LOS), diagnosis, acuity, isolation requirements, and preferred accommodation.

8) When a sitter is required for patient care upon admission from Emergency Department (ED) to inpatient unit:
   - If sitter already in place whenever possible send the sitter with the patient.
   - If sitter is with more than one patient then Patient Flow team will inform the receiving in patient unit of the need for a sitter.
   - Upon arrival to the inpatient unit the Receiving nurse will liaise with the team to determine the ongoing need for a sitter.
   - Unit to unit transfers outside of ED must communicate with the receiving unit on the need for a sitter.

Note: Communication regarding sitters will not impede the transfer of the patient unless patient is under the mental health act.

9) Beds will be assigned to a bed space where there is an identified written physician discharge order. Efforts should be made to minimize unnecessary patient movement between units, when possible. This may require collaboration with infection prevention and control (Refer to Appendix B).

10) All discharges are entered through order entry in Epic within 30 minutes of patient leaving (applicable to expired patients as well). Each service is responsible for pulling admitted patients from emergency into beds in a timely manner (within 90 minutes of the bed being vacated)

11) Inpatient transfers will take place within 30 minutes of bed availability. If the receiving or sending nurse is not available, the covering nurse or resource nurse on either unit should complete electronic transfer of accountability (eTOA) or face-to-face transfers depending on the units. The sending and receiving programs/units will both be responsible for facilitating a timely transfer from one area to the other ensuring transfer of accountability.

**** This policy applies at ALL sites.**

12) If additional patients are identified for discharge throughout the day, the unit Patient Care Coordinator or designate notifies the Bed Allocation and Patient Care Coordinator of Flow when a discharge has been identified. Effective and efficient discharge planning is critical to patient flow, and it is the responsibility of all members of the interdisciplinary team to actively participate in daily care planning, goal setting and tracking progress towards discharge.

13) Mental Health Program and Reactivation Care Centre will collaborate with the bed allocator to make the most appropriate bed assignment according to various unit criteria.

14) Operating Room (OR) cases on the trauma board will take priority, therefore, ED surgical patients with a booked OR time will receive bed priority over ED surgical patients without a booked OR time.

15) No patient considered 'Life or Limb or Organ" will be refused treatment by Central LHIN designated hospitals except in the circumstances whereby accepting the patient would potentially compromise the safety or pose a risk to the patient/staff. Mackenzie Health must be able to provide the required service to the patient in an effort not to delay treatment (Refer to Appendix E – Critical Care Surge Protocol, Refer to Appendix F - Life and Limb Protocol).

16) A representative from all inpatient areas are required to attend the daily Bed Management Meetings. Any changes to flow status throughout the day should be communicated to the patient Flow team as soon as possible.

17) At Mackenzie Health, we strive to provide patients with care in the right place by the right provider to ensure the safest level of care. Off-servicing of patients should only be considered as a temporary measure to provide ED capacity to avoid a major surge situation.

18) Infection Prevention and Control (IPAC) will work collaboratively with COR to ensure timely assessments of isolated patients by daily bed meeting. The goal would be to reach minimal blocked beds.

This policy uses a three-stage color-coded framework to describe surge capacity status for key clinical areas and for the hospital as a whole (Refer to Appendix A: C3 Capacity and Preparedness & Escalation Protocol)

**** This policy applies at ALL sites.**

Conventional (GREEN- Refer to Appendix A for C.3 Capacity Preparedness & Escalation Protocol)

i. As a general principle, and when acuity is not an issue, patients will be moved to the next available on- service bed in order of wait time by site, except when specialty designated programs are only available at one site (such as mental health, , inpatient stroke care, behavioural care). When the specialty program is available at one site only, patients will be moved to the next available bed in order of acuity, then in order of wait time, regardless of site.

ii. Exceptions to wait time order may be made by the manager/manager-on-call and/or bed allocation, based on clinical need or priority. Priority must be given to ensure patients transferred to another facility under the provincial life or limb policy and repatriated within 48 hours. Patients signed out of critical care will also be prioritized to create up to 1-2 beds of critical care capacity at each site.

iii. Cross-site bed meetings are run daily at 1000 hours by the Patient Flow Manager or Patient Care Coordinator. The purpose of bed meeting is to corporately review bed capacity against current and anticipated demand for the next 48 hours in order to allow for early intervention to ensure patient flow is maintained. Patient Care coordinators/MRN, Patient Care managers, staffing office, support services, diagnostic imaging, infection control and manager-on-call are expected to attend.

Contingency (YELLOW- Refer to Appendix A for C.3 Capacity Preparedness & Escalation Protocol)

i. When a unit/services moves from the GREEN stage to the YELLOW, the Patient Care Manager (or delegate) will implement a response that should include the following steps along with executing on their departmental escalation plans:
   a. alerting unit staff and the interprofessional team of patient flow demands
   b. assess the potential of all patients for discharge within the next 24 to 48 hours, particularly for those patients beyond their expected date of discharge
   c. liaise with Central LHIN Health Integration Network to expedite transition plans, where possible, for patients in acute beds who no longer have acute treatment issues if discharge home is not possible
   d. reassess ALC patients for potential discharge home or possibly to another more appropriate setting
   e. identify and review patients awaiting lab, procedures and/or diagnostic imaging investigations; expedite timing where possible
   f. twice daily rounding on all patients physician Chief lead should be notified to round and/or to assist with any discharge issues related to medical care needs
   g. consider accepting patients before discharged patient has left into hallway spaces or moving discharged patients into the hallway (Refer to Appendix C for Hallway Patient Criteria)

ii. When a unit/service is in the YELLOW stage, and is at risk of moving to the RED stage, the PCM(or delegate) informs the Program Director as early as possible to assist with the response and to begin to plan for a moderate surge response. Program Director will

liaise with the Chief of the program.

iii. All programs are to follow up and remove barriers to discharge daily while initiating departmental escalation plans as outline in the C3 Capacity Preparedness & Escalation Protocol (Appendix A).

iv. The Program Director (delegate) will collaborate with the PCM and bed allocation to review potential options to restore flow which may include the movement of patients cross-site and temporarily utilizing unfunded spaces

v. It is expected that many patients would prefer to stay admitted to the site where they first presented, if possible. In situations where staffed beds are available at the alternate site, consideration will be given to move the patients to the next available bed at the alternate site. This is ultimately a clinical decision that will be made by the Most Responsible Physician. While patient consent is not required, it is preferable to move patients who are agreeable to the transfer.

vi. Under the Ministry of Health and Long-Term Care Life or Limb policy – patients waiting for repatriation back to Mackenzie Health have priority access to an appropriate bed at either site. As per #4 above, while patient preference is to be considered, consent is not required to repatriate the patient to the first available appropriate bed.

Crisis (RED- Refer to Appendix A for C.3 Capacity Preparedness & Escalation Protocol)

i. The Vice-President (or delegate) will review the patient flow situation with the Program Director and/or Physician Chief/SWAT physician lead to ensure YELLOW stage response has been completed and other alternatives have been exhausted.

ii. The RED surge management response may also include the following:
    a. Movement of patients cross site to available beds
    b. Cohorting male and female patients (must be sensitive to individual patient's needs and wishes)
    c. Opening unbudgeted beds
    d. Off-servicing
        i. The EVP (or delegate) will contact the CEO (or delegate) to advise of the clinical situation and the proposed plan to open unbudgeted beds that will require additional staffing.

iii. Only the EVP (or delegate) can approve the opening of unbudgeted beds.

iv. The EVP (or delegate) is responsible to communicate the approved plan and any subsequent changes to the plan to bed allocation, manager, managers-on-call, administrator-on-call, director and Physician Chief/physician leads.

v. The Physician Chief will be responsible for keeping physicians updated. Most Responsible Physician (MRP) coverage is unchanged.

vi. The Program Director will be responsible for communicating the surge with appropriate community partners, to enlist their support to enable the transition of appropriate patients along the continuum of care.

vii. The EVP (delegate) will continue to monitor and update the CEO and Senior Management Team until normal operations are resumed.

**** This policy applies at ALL sites.**

REFERENCES:

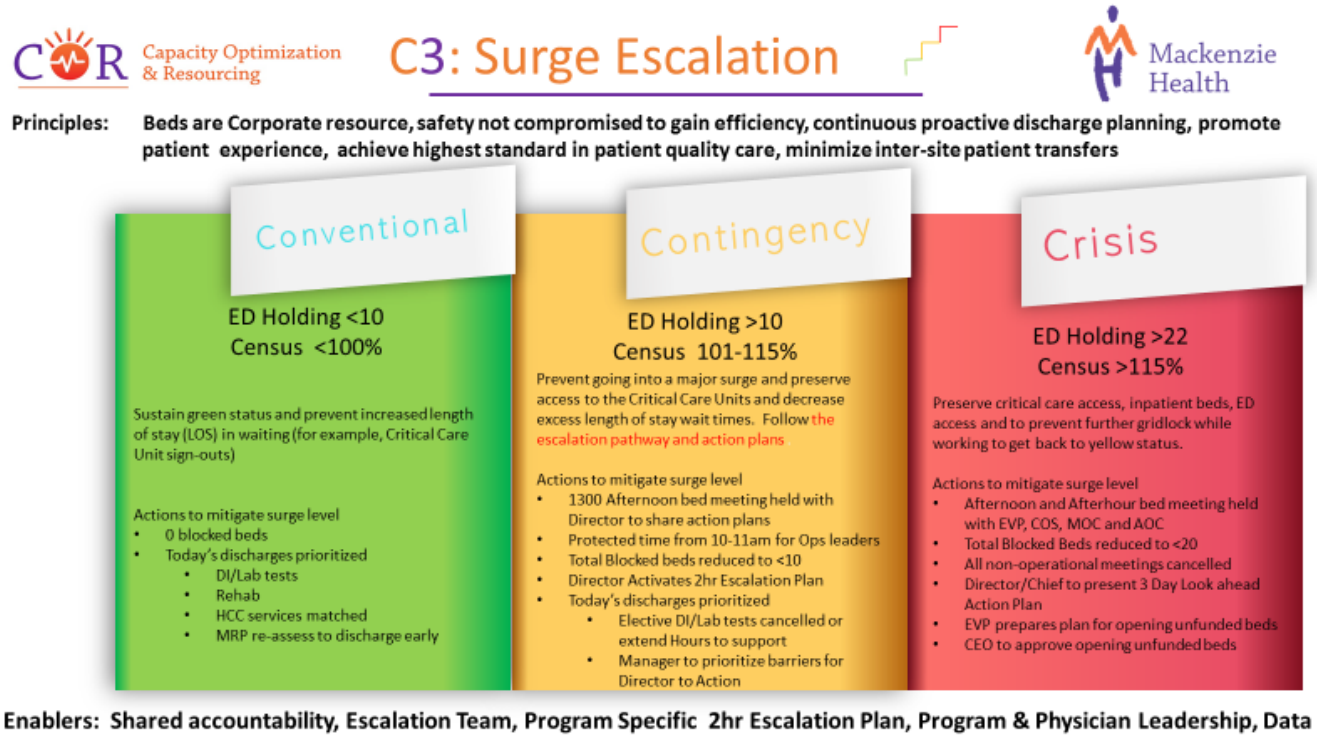
1. Ontario's Critical Care Surge Capacity Management Plan Version 2.0, September 2013
2. Ontario's Life or Limb Policy, December 2013
3. Ontario Emergency Department Wait Time Strategy, May 2008

APPENDICES:

Appendix A – C3 Capacity Preparedness & Escalation Protocol
Appendix B – Algorithm for Moving Patients Between Units
Appendix C – Hallway Patient Criteria
Appendix D – 5 Phase Plan to Open Unfunded Beds
Appendix E – Critical Care Surge Protocol
Appendix F – Algorithm for Life and Limb

**** This policy applies at ALL sites.**

Appendix A - C3 Capacity Preparedness & Escalation Protocol



**** This policy applies at ALL sites.**

C3 Capacity Preparedness & Escalation Protocol

C3 Capacity Preparedness & Escalation consists of 3 bed escalation levels: Convectional, Contingency and Crisis. There are processes, actions and expected outcomes outlines in each surge level to support the management of hospital capacity.

Guiding Principles:

- Mackenzie Health is committed to ensuring each patient gets to the right bed, in the most timely and safe manner. Beds across all 3 sites are a corporate resource and programs are required to ensure optimal utilization.
- Create daily bed capacity through active discharges, pro active planning, meeting program ELOS, staffing to census, and addressing care transition barriers within the interdisciplinary team.
- Build and support shared accountability with the care plan for our patients and maintain routine patient flow management.
- Delivering the outcomes as outlined in C.3 through active participation in bed meetings and abiding by appropriate protocols as descried in the bed management policy.
- Daily bed meetings will be held at 10 AM with mandatory attendance.

Daily Bed Meetings

1000 Weekday & 1030 Weekend Bed Meeting- (Managers, Directors, Support Services (AOC & MOC Attend)

I. IPAC to review all isolation requirements
II. Identify patients on QBP pathway
III. Identify next day discharges and barriers to discharge
IV. Problem solve patient-specific barriers to non-acute flow streams with Home and Community Care (HACC) and site partners

1330 Second Bed Meeting (At call of Manager Patient Flow)

I. Review corporate demand and ED Surge status
II. Review unassigned SDA's and consider off service placement of appropriate patients
III. Review next day discharges
IV. Managers to ensure all patients have an EDD identified in EPIC
V. Review future need to utilize corporate unfunded Surge beds (where appropriate) in consultation with EVP/Delegate
VI. Review stated discharges vs. actual discharges
VII. Review staffing
VIII. Review Critical Care demand and ED status
IX. Review that IP units remain over census
X. Review organizational demand vs capacity and create an end of day forecast

**** This policy applies at ALL sites.**

Hospital Specific & Corporate Surge Levels

	MRHH	CVH	Mackenzie Health Corporate Surge
GREEN - Conventional	10	10	20
YELLOW- Contingency	11-22	11-22	22-44
RED - Crisis	>22	>22	>44
CODE GRIDLOCK	>30	>30	>60

Gridlock: when there are more admitted patients than inpatient beds available; the corporation is operating at overcapacity (minor, moderate or major surge) and will have to implement special, temporary measures to accommodate all admitted patients in a timely and safe manner.

Corporate Surge Levels

	Waiting for IP Beds	SURGE	Occupancy Level
GREEN - Conventional	20	No Surge	100%
YELLOW - Contingency	22-44	Minor	100-115%
RED - Crisis	>44	Moderate-Major	115-120% gridlock to be reduced with action plans
CODE GRIDLOCK	>60	CODE GRIDLOCK initiated by EVP/AOC	>120%

****> 120% consider IMS activation through EVP/AOC*

**** This policy applies at ALL sites.**

Program	Beds by Site opening day		
	MRHH	MVH	RCC
Mental Health	0	32	
Critical Care	20	21	
Surgery	34	58	
Medical	97	81	54
Acute Stroke	0	18	
Rehab Stroke	0	18	
CCC	40	0	58
LBRP	0	15	
Ante/Post	0	11	
Peds	0	7	
NICU		*12	
Total	191	261	112
	564 Beds		

1) **Conventional: <20 no bed admissions in ED**

Continue daily operations and follow escalation pathway. The primary goal when in green and minor surge is to sustain green status and prevent increased length of stay (LOS) in waiting (for example, Critical Care Unit sign-outs)

Escalation pathway:

a) All department managers/PCCs will report on staffing, bed capacity, and throughput daily through attendance in bed meetings.

Barriers:

I. All managers will identify remain barriers that they will action themselves
II. All managers will identify barriers that requires escalation to Director (list options and recommendations)

b) All department managers will remove and action on barriers through attendance by 10 AM bed meetings.
c) All directors will escalate on unresolved barriers through attendance in bed meetings and focused huddles as needed with Program Chiefs and EVP by 1330.
d) All unresolved barriers for each program will be escalated to the Chief of Staff and EVP for *action planning* before end of day.

**** This policy applies at ALL sites.**

Action	Accountability	Expected Outcomes
< 20 admits unassigned in ED	ED, IP units, COR	All no bed admissions placed by end of day
ED consult time and total ED consults	ED, COR	Seamless ED flow meeting offload delays and PIA times
Intersite Transfers	ED, IP units, COR	Seamless transfer of patients between sites
100% SDA placement	OR, IP units, COR	All SDAS placed
< 2 Blocked Beds < 10 isolations	IPAC assesses isolations to reduce number of blocked beds by 10 AM where applicable	Isolations and blocked beds reduced and cleared where possible; Cohorting opportunities will be reviewed
Critical care has capacity to place patient	ED, critical care, COR	Sign outs are placed accordingly

2) Contingency: 22-44 no bed admissions in ED

The primary goal when in yellow gridlock and minor surge status is to prevent going into a moderate surge and red gridlock status. It is also to preserve access to the Critical Care Units and decrease excess length of stay wait times. Follow the escalation pathway and action plans will be documented through COR.

Escalation pathway:

a) All department managers/PCCs will report on staffing, bed capacity, and throughput daily through attendance in bed meetings.

Initiate **Departmental Escalation Plans**

Barriers:

I. All managers will identify remain barriers that they will action themselves
II. All managers will identify barriers that requires escalation to Director (list options and recommendations)

b) All department managers will remove and action on barriers through attendance by 10 AM bed meetings.

c) All directors will escalate on unresolved barriers through attendance in bed meetings and focused huddles as needed with Program Chiefs and EVP by 1330.

**Department Escalation algorithm will be initiated by the Director

**** This policy applies at ALL sites.**

d) All unresolved barriers for each program will be escalated to the Chief of Staff and EVP for action planning before end of day.

**** This policy applies at ALL sites.**

Action	Accountability	Expected Outcomes
22-44 admits unassigned in ED	ED, IP units, COR	All no bed admissions placed by end of day
ED consult time and total ED consults	ED, COR	Seamless ED flow meeting offload delays and PIA times
Intersite Transfers	ED, critical care, IP units, COR	Seamless transfer of patients between sites
75% SDA placement	OR, IP units, COR	All SDAS placed
> 10 Blocked Beds > 20 isolations	IPAC assess isolations to reduce number of blocked beds by 10AM where applicable	Isolations and blocked beds reduced and cleared where possible Cohorting opportunities will be reviewed
Critical care has planned capacity for transfers out	ED, critical care, COR	Sign outs are placed where possible
Direct admits to be triaged with potential delay	ED, critical care, IP units, COR	Potential delays in direct admits, repats will be prioritized and aligned with bed pressures accordingly. Throughput must exceed demand to clear the corporate surge.
Post acute flow out to be reviewed and prioritize transfer out to RCC	IP units, RCC, COR	RCC beds will prioritized accordingly to align with bed pressures. Post JDO meeting, the ALC demand will reduce to create acute inpatient bed capacity. Throughput must exceed demand to clear the corporate surge.

**** This policy applies at ALL sites.**

3) Crisis: > 44 no bed admissions in ED

The primary goal when in red gridlock and major surge is to preserve critical care access, inpatient beds, ED access and to prevent further gridlock while working to get back to yellow status.

The objective during red gridlock at any stage of surge is to increase the intensity of oversight, monitoring and response strategies in order to alleviate the overwhelmed situation and bring service back to within budgeted bed base. The escalation pathway will be followed, action plans will be documented through COR, and EVP and CEO to determine timelines and approve opening of unfunded beds. The opening and closure of unfunded beds will be determined after a sustained surge in 24-48 hours continuously. If the crisis surge has not been resolved in 24-48 hours, consider initiating IMS through contacting Flow Director during business hours and MOC, AOC, EVP during after hours . Surge Yellow sustained for greater than 24 hrs; Action phases close in reverse order of opening. Use the Five Phase Plan to support the rapid access of opening unfunded beds with appropriate staffing and support.

Escalation pathway:

a) All department managers/PCCs will report on staffing, bed capacity, and throughput daily through attendance in bed meetings.

Initiate Departmental Escalation Plans.

Barriers:

I. All managers will identify remain barriers that they will action themselves
II. All managers will identify barriers that requires escalation to Director (list options and recommendations)

b) All department managers will remove and action on barriers through attendance by 10 AM bed meetings.

c) All directors will escalate on unresolved barriers through attendance in bed meetings and focused huddles as needed with Program Chiefs and EVP by 1330.**Department escalation algorithm will be initiated by the Director

d) All unresolved barriers for each program will be escalated to the Chief of Staff and EVP for action planning before end of day.

**** This policy applies at ALL sites.**

Action	Accountability	Expected Outcomes
> 44 admits unassigned in ED	ED, IP units, COR	Assign to IP hallways as needed, 2nd bed meeting to be scheduled at 1330
ED consult time and total ED consults EMS offload delay > 30 minutes, PIA > 2.5 hours, ED consults	ED, COR	Seamless ED flow meeting offload delays and PIA times
Intersite Transfers	ED, critical care,IP units, COR	COR team to review and prioritize, transfers will be delayed Expedite discharges to clinics (PUCC, MUCC, ILI) Direct admits will be delayed for transfer and reassessed in 48 hours
50% SDA placement	OR, IP units, COR	Cancel SDA as needed with Surgical Leadership team. Pre and Post surgical focused bed meeting as needed
> 20 Blocked beds > 50 isolations	IPAC assesses isolations to reduce number of blocked beds by 10AM where applicable	Isolations and blocked beds reduced and cleared where possible Maximize cohorting where possible
Critical care full, no capacity to accept external transfers (Activate Critical Care Surge Protocol if applicable)	ED, critical care, COR	Activate Critical Care Surge Protocol if applicable with Critical Care Leadership team. Pre and Post critical focused bed meeting as needed
Post acute flow out to be reviewed and prioritize transfer out to RCC	IP units, RCC, COR	- COR team will prioritize transfers to RCC as needed - Urgent ALC Review to be done (JDO meeting)

Reference**

**** This policy applies at ALL sites.**

**** This policy applies at ALL sites.**

Bed Spaces MRHH - MVH

	MRHH 2020	MRHH 2021	MVH 2021
RESUS	5	2	3
Acute	14	12	11
Sub-Acute	20	13	14
Mental Health	10	4	5
Ambulatory	10	10	11
Minor Treatment	8	6	6
Total	**67**	**47**	**50**

**** This policy applies at ALL sites.**

C3 Capacity Preparedness & Escalation Departmental Plan

**Includes MRHH, CVH, and RCC

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
ED	• 0-9 admissions with no bed • 2 or more resuscitation beds available	• >10 admissions with no bed • 1-2 resuscitation beds available • Ambulance offload delay • Admitted ED patients with LOS >12 hours • >12 consults in progress with high probability of admission • Plan for CUC/manager after hour support for 24 hours	• >24 admissions with no bed • No monitored or resuscitation beds available • Significant offload delays • Admitted ED patients with LOS <24-36 hours • >20 consults in progress with high probability of admission • Plan for CUC/manager after hour support for 72 hours
Critical Care CVH = 21 beds MRHH = 20 beds Total beds = 41 beds	• 2 or more critical care beds available (includes transfers out) • ICU leadership team continue to review and forecast sign outs for next day as needed	• 1 critical care bed available (includes transfer out) • Initiate repatriations back to home hospitals for those patients outside of catchment area • ICU leadership team continue to review and forecast sign outs for next day as needed • Activate Critical Care Surge Protocol with Central LHIN • 1330 Afternoon and Afterhours bed meeting held with managers, directors, EVP, COS, MOC and AOC • All non-operational meetings cancelled as needed • Weekend and after hour CUC/manager program support will be arranged until conventional	• No critical care beds available • Activate Critical Care Surge Protocol with Central LHIN • 1330 Afternoon and After hour bed meeting held with managers, directors, EVP, COS, MOC and AOC • All non-operational meetings cancelled • Director/Chief to present 3 Day Look ahead Action Plan • Weekend and after hour CUC/manager program support will be arranged until conventional surge is maintained for 48 hours at minimum. Focused program bed meeting will be done with COR after hours as needed with MOC and AOC.

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
		surge is maintained for 48 hours at minimum. Focused program bed meeting will be done with COR after hours as needed with MOC and AOC.	
Medicine (includes telemetry) MRHH= 40 CVH = 138 Total beds = 178	• Able to accommodate all requests for beds from the ED • Continue with daily operations • Managers/PCCs to ensure EDDS are completed and accurate prior to bed meeting daily • Initiating RMRs as needed for patients meeting ALC designation ○ Identifying EDD either in Daily Action Rounds or through Progress Notes ○ Ensure EDDs are entered and accurate, prior to 1000hrs ○ H&CC prior service information to be entered on all patient by 0900hrs ○ GIMs to begin rounding by 9am ○ Family discharge planning meeting with 48hrs of admission ○ 24hr in advance confirmation of discharge conversation with family ○ EDD update on Pt's white board and IPASS	○ Reviewing any outstanding consults and tests and prioritizing completion of them ○ Call all families, and notifiy them that pt will be moved to hallway for discharges ○ Identify all patients who can wait in the hallways and unconventional spaces by 10 AM and reassess hourly. ○ Review all inpatient admissions to ensure barriers are removed to meet ELOS. Patients with greater than 2 days LOS will have a definitive discharge date. Patients with EDD in 48-72 hours will be prioritized for earlier discharge. ○ Review all patient demographics and prepare for transfer to home hospital. COR will initiate the ticket in PHRS once identified by the teams. ○ Review all ALC admissions and follow escalation ALC policy. Patients with greater than 7 days of LOS will be reviewed for expedited transition to post acute destination or home. Initiate all RMRs to transition patients out of the hospital to their home and	• Initiate 2 hr escalation plan • 1330 Afternoon and After hour bed meeting held with managers, directors, EVP, COS, MOC and AOC • All private rooms prioritized for clinical needs (ie. Isolation) • Total Blocked Beds reduced to <20 • All non-operational meetings cancelled • Director/Chief to present 3 Day Look ahead Action Plan • Utilize overcapacity beds

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
	○ Today's discharges prioritized (DI/Lab tests / Rehab / HCC services matched / MRP re-assess to discharge early) "Establish discharge readiness and discharge safety: --Assess and create plan for post-hospital needs (involve family early) -- Provide discharge teaching (ID learners, use teach back and written material) -- Real-time pt/family handoff (ID caregivers) --Ensure follow up appts are scheduled (within 2-7 days)" HaCC to participate in Action rounds daily -prepared with community information-and documented in EPIC ○ MackenzieHelps to provide information/document in epic to what type of services patients are getting at home when they get readmitted by 0900hrs ○ Weekend Unit Action Rounds, identifying EDD (process to be put in place -weekend flow PCC) ○ Consider Tue - Tue coverage of GIM ○ Reinforce discharge time "before 11am" and that pt will be moved to hallway on day of	liase with HCC to expedite same day discharges. ALC patients will be moved to unconventional spaces as needed. ○ Weekend and after hour PCC program support for discharge planning will be arranged until conventional surge is maintained for 48 hours at minimum. Focused program bed meeting will be done with COR after hours as needed with MOC and AOC. ○ Call H&CC to expedite any home care arrangements	

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
	discharge after 11am (signage and in meetings, thus MD to prioritize assessing discharges at 0900 ○ Daily afternoon review of Care Pathways documentation and adherence ○ Have unit secretary round to ensure pts are discharged in EPIC within 15 min of being discharged ○ Reassess isolation status of patient to reduce blocked or empty beds ○ Initiating RMRs early (Inter-professional) as needed (ie: ALC designation pts) ○ 0 blocked beds (open/close different rooms to maintain unit capacity)		
Surgery & OR MRHH = 32 inpatient MRHH = 5 ORs CVH = 64 inpatient CHV = 7 ORs Total Beds = 96 Total ORs =11 ORs	• 100% of elective OR cases can be placed in beds • No surgical cancellations required • All surgical patients off serviced can bed placed in beds (critical care downgrades, tele downgrades, etc.) • Able to accommodate all requests for beds from the ED • Continue with daily operations • Managers/PCCs to ensure EDDS are completed and	• Initiate 2 hour escalation plan: Director will initiate interdepartmental huddle with Escalation team post bed meeting at 1030. Trigger is Contingency and Crisis Surge levels. Goal is to meet 100% occupancy or less within the program and to clear the program admissions in the ED and meet the demand cross sites within budgeted beds. Each unit will receive maximum of 2 over cense patients in the hallways	• Initiate 2 hr escalation plan • 1330 Afternoon and After hour bed meeting held with managers, directors, EVP, COS, MOC and AOC • All private rooms prioritized for clinical needs (ie. Isolation) • Total Blocked Beds reduced to <20 • All non-operational meetings cancelled • Director/Chief to present 3 Day Look ahead Action Plan • Review all surgeries and categorize cancer, urgent, those that can be

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
	accurate prior to bed meeting daily • Initiating RMRs as needed for patients meeting ALC designation • Periop: ensure all patients who are able to be discharged via Day Surgery are booked as such.	before 10 AM. • Identify all patients who can wait in the hallways and unconventional spaces by 10 AM and reassess hourly. • Review all inpatient admissions to ensure barriers are removed to meet ELOS. Patients with greater than 2 days LOS will have a definitive discharge date. Patients with EDD in 48-72 hours will be prioritized for earlier discharge. • Review all patient demographics and prepare for transfer to home hospital. COR will initiate the ticket in PHRS once identified by the teams. • Review all ALC admissions and follow escalation ALC policy. Patients with greater than 7 days of LOS will be reviewed for expedited transition to post acute destination or home. Initiate all RMRs to transition patients out of the hospital to their home and liase with HCC to expedite same day discharges. ALC patients will be moved to unconventional spaces as needed. • OR leadership team to review next day cases and identify those cases who can be discharged in day surgery, reassess if next day cases need to be cancelled	postponed to identify if cancellations are possible • Determine if any emergency cases can be postponed until out of Red category

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
		• Weekend and after hour PCC program support for discharge planning will be arranged until conventional surge is maintained for 48 hours at minimum. Focused program bed meeting will be done with COR after hours as needed with MOC and AOC. • 1330 Afternoon and Afterhours bed meeting held with EVP, COS, MOC and AOC • All non-operational meetings cancelled as needed • Team liaise with physician and the health care team to review all patients and identify patients who could be discharged earlier with Community resources and other services • Explore opening surge beds • Have a discussion with patients and families on admission to give an overview of discharge plan. This will allow for time to resolve any identified barriers • PCM and PCC review together all inpatients' discharge plans, for any next day discharge patient, identify discharge barrier, explore a possibility of going home on the surge day. • PCC work with patient/families to arrange early discharge time. if unfeasible, consider transferring	

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
		patients in the hallway to wait or hospital to arrange early transportation. • Consider cohorting patients to increase capacity • PCM/PCC review the list of ALC or near ALC patients, collaborate with RCC or external rehab team to determine potential transfers • PCM/PCC identify any on call to OR patient could be discharged the same day post OR. liaise with OR team and OT/PT to ensure patients get early OR time and discharge directly from PACU	
WCP (including Paeds) CVH LBRP = 15 suites CVH Ante/Post = 11 beds CVH Paediatrics = 7 beds CVH NICU = 12 beds	• Able to accommodate all bed requests through ED • Continue with daily operations • Managers/PCCs to ensure EDDS are completed and accurate prior to bed meeting daily	• Initiate and follow WCP Surge Plan	• Initiate and follow WCP Surge Plan
Mental Health CVH = 32 beds	• Able to accommodate all bed requests from ED and inpatient admissions • Continue with daily operations • Managers/PCCs to ensure EDDS are completed and accurate prior to bed meeting daily	**4-5 patients admitted in ED with no bed in EPU or Inpt unit** • Initiate 2hr escalation plan: • Director will initiate interdepartmental huddle with Escalation team post bed meeting at 1030. Trigger is Contingency and Crisis Surge levels. • Goal is to meet 100% occupancy or less within the program and to	**> 5 patients admitted in ED with no bed** • Communicate with the LIHN's bed registry to determine if another facility can take a transfer. May be appropriate for director to director request for assistance • Psychiatry will re-assess all admissions waiting in the ED. • Review all inpatient admissions to ensure those who can be

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
		clear the program admissions in the ED and meet the demand within budgeted beds. • Communicate with the LIHN's bed registry to determine if another facility can take a transfer • Psychiatry will re-assess all admissions waiting in the ED. • Review all inpatient admissions to ensure those who can be discharged-- barriers are removed. • Review all ALC patients to determine if they are appropriate to be transferred to RCC. • Review all patient demographics and prepare for transfer to home hospital when appropriate. PCC to contact home hospital to request transfer. • 1330 Afternoon and Afterhours bed meeting held with EVP, COS, MOC and AOC	discharged-- barriers are removed. • Review all ALC patients to determine if they are appropriate to be transferred to RCC. • Review all patient demographics and prepare for transfer to home hospital when appropriate. PCC to contact home hospital to request transfer. • Discharges waiting to leave the unit can be placed in a 9999 bed so an admission can be brought up • A second bed can be placed in the Bariatric Room • •1330 Afternoon and After hour bed meeting held with managers, directors, EVP, COS, MOC and AOC • All non-operational meetings cancelled • Director/Chief to present 3 Day Look ahead Action Plan
Stroke, Rehab, CCC, Palliative RCC CVH acute stroke = 18 beds CVH stroke rehab = 18 beds MRHH = 40 CCC beds RCC = 112 beds (58 CCC + 54 medical) Community Support Team	• Able to accommodate all bed requests from ED and inpatient admissions • Continue with daily operations • Managers/PCCs to ensure EDDS are completed and accurate prior to bed meeting daily • Community Support Team: to encourage the homes to call when planning to transfer to hospital to assess if there can be a virtual	• 1-2 patients admitted in ED with no bed • Initiate 2hr escalation plan: Director will initiate interdepartmental huddle with Escalation team post bed meeting at 1030. Trigger is Contingency and Crisis Surge levels. Goal is to meet 100% occupancy or less within the program and to clear the program admissions in the ED (i.e. palliative and/or stroke	•> 3 patients admitted in ED with no bed •1330 Afternoon and After hour bed meeting held with managers, directors, EVP, COS, MOC and AOC •All private rooms prioritized for clinical needs (ie. Isolation) •Total Blocked Beds reduced to <20 •All non-operational meetings cancelled •Director/Chief to present 3 Day Look ahead Action Plan • Goal is to prioritize corporate flow pressures, working within COVID

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
	assessment/consult and prevent avoidable transfers • To support the hospital team to facilitate timely discharge back to congregate settings	patients) and meet the demand cross sites within budgeted beds. Accept early admissions for corresponding "same day" discharges on post acute units in the hallways before 10 AM up to a maximum of 2 patients (excluding RCC and palliative patients) • Identify all patients who can wait in the hallways and unconventional spaces by 10 AM and reassess hourly. • Review all inpatient admissions to ensure barriers are removed to meet ELOS. All patients with greater than 2 days LOS will have a definitive discharge date. Patients with EDD in 48-72 hours will be prioritized for earlier discharge. • Review all patient demographics and prepare for transfer to home hospital. COR will initiate the ticket in PHRS once identified by the teams. • Weekend and after hour PCC/PCM program support for discharge planning and community support will be arranged on a rotating "on call" basis until conventional surge is maintained for 48 hours at minimum. Focused program bed meeting will be done with COR after hours as needed with MOC and AOC. • 1330 Afternoon and Afterhours	IPAC isolation guidelines and Humber Hospital landlord restrictions at RCC. •Community Support Team: to encourage the homes to call when planning to transfer to hospital to assess if there can be a virtual assessment/consult and prevent avoidable transfers; extended hours of community support to 24/7 as funding permits •To support the hospital team to facilitate timely discharge back to congregate settings

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
		bed meeting held with EVP, COS, MOC and AOC • All non-operational meetings cancelled as needed • Goal is to prioritize corporate flow pressures, working within COVID IPAC isolation guidelines and Humber Hospital landlord restrictions at RCC. • Community Support Team: to encourage the homes to call when planning to transfer to hospital to assess if there can be a virtual assessment/consult and prevent avoidable transfers; extended hours of community support to 24/7 as funding permits • To support the hospital team to facilitate timely discharge back to congregate settings	
Ambulatory Clinics	• No direct admission requests from clinics • Continue with daily operations	• Expedite all clinic appointments to support inpatient discharges • 1330 Afternoon and Afterhours bed meeting held with EVP, COS, MOC and AOC • All non-operational meetings cancelled as needed • Evaluate for virtual or cancellations	• 1330 Afternoon and After hour bed meeting held with managers, directors, EVP, COS, MOC and AOC •All private rooms prioritized for clinical needs (ie. Isolation) •All non-operational meetings cancelled •Director/Chief to present 3 Day Look ahead Action Plan
Chronic Kidney Disease Program (CKD)	• No direct admissions requests • Continue with daily operations	• Expedite all clinic appointments to support inpatient discharges • 1330 Afternoon and Afterhours bed meeting held with EVP, COS, MOC and AOC • All non-operational meetings	• 1330 Afternoon and After hour bed meeting held with managers, directors, EVP, COS, MOC and AOC • All private rooms prioritized for clinical needs (ie. Isolation) • All non-operational meetings

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
		cancelled as needed	cancelled • Director/Chief to present 3 Day Look ahead Action Plan
Rehab	• Continue with daily operations • Review 48-72 hours inpatient discharges and start RMR applications as needed • Prioritize patients as per the priority matrix based on programs • Weekend rehab support for discharge planning across the inpatient acute care areas	• Review all inpatient admissions to ensure barriers are removed to meet ELOS. • Patients with EDD in 48-72 hours will be reassessed for discharge - recommendations and updates will be provided to care team. • Prioritize priority matrix 1 and 2 patients based on programs • Reassign floats and on-call staff to high flow units (example: ED, Ortho, D3MA, C3MO) • With director-level approval rehab staff would provide additional staff coverage for surge areas, as available • Department manager to attend 1330 afternoon bed meeting held with EVP, COS, MOC and AOC • All non-operational meetings will be cancelled as needed SLP: 1. Dedicated staff to work on COVID units to minimize risk of exposure. 2. Dedicated staff to work ax flu and ?query flu pts 3. Extra shift added to week-end pending SLP referral levels. Need for extra staffing will be determined 24 hours prior to said shift	• Prioritize priority matrix 1 patients based on programs • Daily caseload review by rehab leadership team and reassign existing staff to high pressure areas to facilitate flow and optimize early discharges • Redeploy therapy staff from the following areas and in the following order: 1) Outpatient 2) ALC 3) CCC 4) Rehab to acute care inpatient areas • Reach out to employees on LOA and casual pool to identify availability • With director-level approval, rehab staff would provide additional staff coverage for weekday/weekends and after hours as available. • Department manager to attend 1330 Afternoon and Afterhours bed meeting held with EVP, COS, MOC and AOC • All non-operational meetings will be cancelled SLP: 1. Dedicated staff to work on COVID units to minimize risk of exposure. 2. Dedicated staff to work ax flu and ?query flu pts 3. Extra shift added to week-end pending SLP referral levels. Need for extra staffing will be determined 24

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
		4. Extra shifts will be added to week-ends/weekdays pending referral levels. 5. Staff to stay past shift end time if pending discharge requires SLP involvement	hours prior to said shift 4. Extra shifts will be added to week-ends/weekdays pending referral levels. 5. Staff to stay past shift end time if pending discharge requires SLP involvement
Medical Imaging	• Continue with daily operations • PCC to prioritize all inpatients requiring D/C within 24 -72 hours where possible.	• PCC to prioritize all inpatients requiring D/C within 24 -72 hours where possible. • Consider cancelling OP appointments (20%) to accommodate inpatient discharge • Consider increasing staffing in X-Ray by 1 Tech on evenings, Echocardiography by 1 tech on either evenings or weekends	• Prioritize all inpatients requiring D/C within 24 – 72 hours • Consider cancelling OP appointments (30%– 50%) to accommodate inpatient discharge based on acuity • Consider increasing staffing on evenings and weekends to prioritize D/C. Increase X-Ray by 1 – 2 techs on days and evenings. Echocardiography by 2 techs on weekends and evenings. MRI increase by 1 tech on weekends • Procure additional equipment (portable X-Ray x 1, US x1, Echo x1 if needed)
Lab	○ Lab Staffing: Status Quo and Monitor. ○ Lab Equipment: Status Quo and Monitor. ○ Lab Reagents/Supplies: Status Quo and Monitor.	○ Lab Staffing: Lab Capacity can absorb. Monitor Phlebotomy draws (30 draws per staff is the threshold), Monitor Lab Test TAT and workflow to identify potential backlogs. Deploy resources as needed. ○ Lab Equipment: Assign addition Glucose Meter as needed.	○ Lab Staffing: Deploy Resources as needed. Utilize CVH staff at MRH before doors open, then Part Time staff to be assigned more shifts. ○ Lab Equipment: Deploy Glucose meters as needed from excess capacity bank. Utilize excess Capacity Phlebotomy Carts and

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
		○ Lab Reagents/Supplies: Increase stock Reagent/Supply volumes by 25%.	Rovers/Mobile Zebra Label printers already purchased as Surge Contingency planning Spring 2020. ○ Lab Reagents/Supplies: Maintain Elevated stock Reagent/Supply volumes. Supply of Downtime Req's have been printed.
Pharmacy	• Continue with daily operations	**Staffing:** Clinical • Review staffing for clinical coverage to determine if additional Pharmacist resources are needed. • Determine if additional BPMH resources needed. Distribution • Review impact on distribution and determine if additional technician resources are needed to assist with packaging, stocking, cartfills etc. for surge patients • Determine need for additional ADU, cartfill requirements, medication storage for new areas. • Determine need for additional ADU	**Staffing:** Clinical • Pharmacist clinical coverage as per pharmacy surge phase 1-5 plan. • Additional BPMH resources as per pharmacy surge phase 1-5 plan. Distribution • Additional technician resources are needed to assist with packaging, stocking, cartfills etc. for surge patients as per pharmacy surge phase 1-5 plan. • Additional ADU, cartfill requirements, medication storage for new areas as pharmacy surge phase 1-5 plan. • Build beds in connect Rx as per pharmacy surge phase 1-5 plan.
Sodexo (Transport, EVS, food services)	• Continue with daily operations • Supplies distribution, trays delivery	• Notified of opening unfunded beds • Staffing: unchanged	• Increase staffing levels to support surge. Bring in additional resources as needed.

**** This policy applies at ALL sites.**

Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
	• Staffing: unchanged	• Support opening of surge spaces as needed • Bring in additional resources for support • Make adjustments to job routines and/or create new temporary job routines and checklist to support operations • Huddle with staff in all shifts (days, evening, nights and weekends) • May increase par levels on certain items if required • 1800 and 2200 calls to shift manager for updates and delays	• Make adjustments to job routines and/or create new temporary job routines and checklist to support operations • Huddle with staff in all shifts (days, evening, nights and weekends) • May increase par levels on certain items if required
IPAC	• Normal Operation ≤ 10 blocked beds • Review isolation – including labs, physician and nursing notes, flowsheets etc. • Attend bed meeting	• Greater than 10 blocked beds • Review isolations (including labs, physician and nursing notes, flowsheets etc.) x2 per business day • Prioritize pressure areas • Identify patients for cohorting as needed • After hours: review labs and assess specific patients with results that have come back	• Greater than 20 blocked beds - Review isolations (including labs, physician and nursing notes, flowsheets etc.) x3 per business day - Maximize cohorting where possible - After hours ○ review labs and assess specific patients with results that have come back ○ review ED patients ○ Weekend on-site trigger - 20 blocked bed **and** greater than 100 isolation
Patient Experience	• Continue with daily operations	• Attend bed meeting as needed • Follow Patient Relations escalation process, redirect as needed	• Attend all bed meetings • Follow Patient Relations escalation process, redirect as needed
Central LHIN/Region	• Continue with daily operations	• Expedite RMRS referrals for discharges • Send Idol beds lists to Flow Director and Manager	• Expedite RMRs referrals for discharges • Send Idol bed lists to Flow Director and Manager

**** This policy applies at ALL sites.**

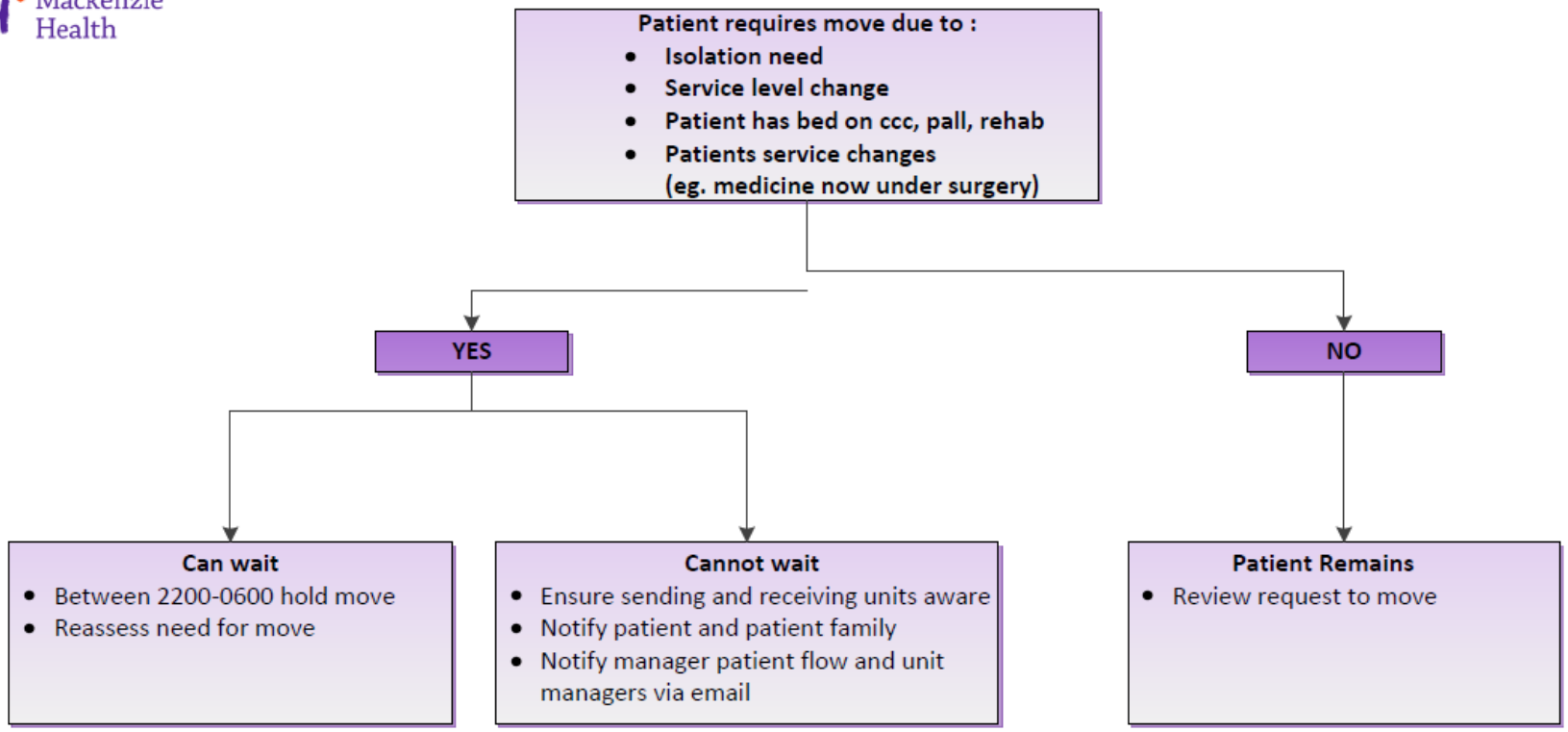
Department	Conventional (Green)	Contingency (Yellow)	Crisis (Red)
ICAT	• Continue with daily operations	• Support opening of surge spaces as needed	• Support opening of surge spaces as needed
Clinical Informatics	• Continue with daily operations	• Support opening of surge spaces as needed	• Support opening of surge spaces as needed

**** This policy applies at ALL sites.**

Appendix B – Algorithm for Moving Patients Between Units

Mackenzie Health

Guidelines for Moving Patients Between Units



1. When making patient move ensure review completed on rationale for move
   - Service level change
   - Clinical reason
   - Safety reason
2. Ensure family aware of patient move (if unable to contact ensure receiving unit aware to contact family)
3. Ensure sending and receiving unit aware of move

April 2017

**** This policy applies at ALL sites.**

Appendix C – Hallway Patient Criteria

Patient care coordinators, shift managers and Inpatient nurse leaders will collaboratively assess patients for appropriateness for hallway placement based on the following criteria:

Our goal would be to place the least acute patients in hallways such as those closest to discharge.

Patients should not remain in a hallway longer than 24 hours. All floors are available to take over census/hallways patients when the ED or critical care areas are in Red status.

Exclusion Criteria:

1. Patients requiring ICU/CCU.
2. No isolated patients would be appropriate for hallways
3. Patients requiring oxygen greater than 4LPM via nasal cannula or suctioning.
4. Violent patients or Form 1 patients.
5. Patients that have diarrhea or are incontinent of stool.
6. Patients admitted for recurrent seizures.

Telemetry Hallway Patients

The following criteria need to be considered to decide if the patient can be placed in the Hallway on telemetry in Cardiology:

- No new ischemic ECG changes or rise in cardiac enzymes after 24 hours
- No significant arrhythmias Chest pain free x 24 hours and/or 48 hours for ACS patients
- Appropriate Pacemaker/ICD functioning (pacing and firing) x 24 hours
- Toxic (drug) levels within acceptable parameters
- Cardiac specific lab values improving or within normal limits
- Electrolyte imbalances corrected

The following are absolute contraindications for Telemetry Hallways:

- New arrhythmias or changes in rhythm, or heart rate associated with symptoms or hemodynamic instability.
- Ventricular tachycardia with or without symptoms.
- New onset multifocal PVC/ couplets/ or triplets associated with symptoms.
- A change in heart rate greater than 150 beats per minute or less than 40 beats per minute with or without symptoms.
- Heart Block (second degree AV Block type 2 or complete heart block) with or without symptoms.

**** This policy applies at ALL sites.**

- Pauses greater than 3 seconds with or without symptoms (identifying patient's activity at time of pause i.e. sleeping).
- Patients who may be actively receiving ACUTE treatment for an UNSTABLE atrial arrhythmia.
- New onset hemodynamic instability (e.g. symptomatic hypotension, prolonged chest pain unresponsive to nitroglycerine; loss of consciousness; respiratory distress) without rhythm disturbances. Inappropriate implanted device (e.g. ICD or PPM) function.

Privacy screens, bells, and bedside tables should be available for patients in hallways where possible. Patients placed in the hallways will be considered for the next available bed on the inpatient unit occupied.

**** This policy applies at ALL sites.**

Appendix D – 5 Phase Plan to Open Unfunded Beds

Pre-Planning prior to opening unfunded beds

1. Contingency Surge (Yellow): All units over census by 2 patients and remain until return to Conventional; escalation plans to be executed.
2. Sustained Contingency Surge (>48 hours) and Crisis Surge (Red): In addition to all units over census by 2 patients; an additional 2 patients assigned to inpatient hallways
    a. Patients in the inpatient hallways will be reassigned into available rooms, within 8-12 hours

Criteria for opening unfunded beds

- Crisis Surge (Red)- without potential for Surge decrease within next 8 hrs.
- Five phase plan which supports rapid access to available beds and appropriate staffing
- Opening of unfunded beds requires EVP/Delegate approval – Activate Incident Management System
- Criteria for Surge Area Closure from Phase 5 to Phase 1 reflects a sustain Conventional Surge (Green) for greater than 24 hours

MRHH Closed Beds (closed in grey second column and available for surge) ***Total = 60 closed beds***

MRHH																												
Level	**A Wing**						**C Wing**																	**D Wing**					
5							Mother/Baby	14	10	NICU	8	4												ICU	22	0			
4							Medicine	30	4	Medicine/COVID	32	2	Surgery	28	5									Surgery	28	0	Peds/PUCC	6	0
3							Mental Health	25	3	ICU Level 2	12	0	Medicine	24	0	Medicine	24	10						CCU	4	0	Medicine	30	0
2	Stroke	22	0	CCC	16	0																		BHC			Emergency Department		
1	CCC	10	22							MDRD			Pharmacy/Labs															

Level	RCC					
4	4E ALC	30	0	4W CCC/Rehab	26	0
5	3E CCC	32	0	3W ALC	24	0

**** This policy applies at ALL sites.**

Resources	Phase 1 (Trigger = Contingency)	Phase 2 (Trigger = Contingency >8 hours)	Phase 3 (Trigger = Contingency > 24-48 hours)	Phase 4 (Trigger = Crisis)	Phase 5 Trigger = Crisis > 8 hours (eg Pandemic) Incident Management System
Location	10 beds C3MedO **Total = 10 beds** ***During Surgical Slow Down Periods:*** 8-10 beds Closed Surgical Unit.	5 beds C4SurgeryA 4 beds C4 MedP 2 beds C4 MedO **Total = 11 beds**	10-18 beds A1CCC West 13 stretchers in ED Surge Overflow (old fracture/plastics space) **Total = 18 beds + 13 stretcher bays** **See "Patient Criteria for Surge Spaces"(page 42)**	4 beds A1CCC East 10 beds Surge A175 10 stretcher spaces in Covid Clinic **Total = 24 beds + 13 stretcher bays** *****Phase 1-4 = Opens 53 closed beds*** *****Consider opening additional closed beds where possible (70 closed beds in total)*** ***Mother/Baby = 10*** ***Mental Health = 3*** ***NICU = 4***	***Phase 1-4 in place*** ***Considerations:*** ***Cancel all elective Cases** ***Cancel out patient activity where possible (ie. Medical imaging)** ***Spaces below to be used and prioritized as discharge spaces initially to free up acute beds on the inpatient units.** 1) Private to Semi = 54 beds 2)Day Surgery : **9** stretchers 3)PACU: **10** stretcher bays or 5 vents 4) C5 Procedures: **13** stretcher bays 5) Berwick auditorium: maximum is **20** patients in stretchers 6) Clinics: *Chemo: **10** stretchers, **12** chairs with suction and oxygen *MUCC : **11** stretchers, but no bathroom, no oxygen or suction *Fracture/Plastics/NAC Space :**13** stretchers with suction and oxygen *Breast (adjacent to fracture): **1** stretcher with suction and oxygen **Total = 141 beds, 12 chairs**

**** This policy applies at ALL sites.**

					Phase 1-5 bed count= 183 (plus 12 chairs)
Communication Cascade	- **Business Hours:** COR notifies Flow Director, Flow Director notifies EVP. Consider opening IMS Command Center and refer to the IMS document. - **After hours/ Weekends:** shift manager notifies MOC, MOC notifies AOC. Consider opening IMS Command Center and refer to the IMS document.	- **Business Hours:** COR notifies Flow Director, Flow Director notifies EVP. Consider opening IMS Command Center and refer to the IMS document. - **After hours/ Weekends:** shift manager notifies MOC, MOC notifies AOC. Consider opening IMS Command Center and refer to the IMS document.	- **Business Hours:** COR notifies Flow Director, Flow Director notifies EVP. Consider opening IMS Command Center and refer to the IMS document. - **After hours/ Weekends**: shift manager notifies MOC, MOC notifies AOC. Consider opening IMS Command Center and refer to the IMS document.	- **Business Hours:** COR notifies Flow Director, Flow Director notifies EVP. Consider opening IMS Command Center and refer to the IMS document. - **After hours/ Weekends:** shift manager notifies MOC, MOC notifies AOC. Consider opening IMS Command Center and refer to the IMS document.	- **Business Hours:** COR notifies Flow Director, Flow Director notifies EVP. Consider opening IMS Command Center and refer to the IMS document. - **After hours/ Weekends:** shift manager notifies MOC, MOC notifies AOC. Consider opening IMS Command Center and refer to the IMS document.
Facilities Management (B. Player)	Facility Team to check area Staffing: unchanged	Facility Team to check area Staffing: unchanged	Facility Team to check area Staffing: unchanged	Facility Team to check area Staffing: unchanged	Facility Team to check area Staffing: unchanged
Staffing NRT (M. Logan-Johnbaptiste) Home unit PCM	1 RN C4 Surgery; No additional required for C4 Med Purple or C4 Med Orange	2 RN/ 1 RPN MED Staffing needs to take into consideration acuity & service	1 RN & 1 RPN & 1 PCA (10 Beds) **Each nurse can have maximum 6 patients	1 RN & 1 RPN & 1 PSW (10 Beds) Shared Unit Secretary with A1	- HR Plan **Review Nurse to Patient Ratios (**refer to staffing plan considerations below) **extend chemo RN, secretarial and pharmacy staff to 10-12 hour shifts with half of the chemo clinic closed
Occupational Health E. Simach	Extend roaming flu cart service to offer flu shots to staff in the area.	Extend roaming flu cart service to offer flu shots to staff in the area.	Extend roaming flu cart service to offer flu shots to staff in the area.	**Plan:** Assess the area prior to opening the space to identify potential hazards and provide possible solutions to keep the working environment safe. **Outstanding:** eye wash station – order bottles	**Plan:** Assess the area prior to opening the space to identify potential hazards and provide possible solutions to keep the working environment safe. **Outstanding:** depends on the inspection of the area prior to occupancy. **Recommendation:** Clear communication on the situation and

**** This policy applies at ALL sites.**

				from Facilities as a temp solution **Recommendation:** Clear communication on the situation and next steps including expectations and delivery timelines.	next steps including expectations and delivery timelines.
Physician Coverage Dr. Plenk	GIM	GIM	GIM	GIM	GIM *Nurse Practitioners
IPAC M. Sinno	Refer to Infection Control Emergencies Policy Staffing: unchanged	Refer to Infection Control Emergencies Policy Staffing: unchanged	Refer to Infection Control Emergencies Policy Staffing: unchanged	Refer to Infection Control Emergencies Policy Staffing: unchanged	Refer to Infection Control Emergencies Policy Staffing: unchanged
Support Services Staffing: Rehab services (PT, OT) CSSO: Dietitian & Social Worker PPL	Support from C 4 Surgery Aqua Staffing for Rehab: No changes to current FTE allocation	Access additional services via St. Eliz if required Staffing: Coverage via Roster process-PPLs to coordinate Staffing for Rehab: Add 0.5 OT and 1.0 TA	Access additional services via St. Eliz if required Staffing: Coverage via Roster process-PPLs to coordinate Staffing for Rehab: O.5 PT, 0.5 OT, 1 TA	Access additional services via St. Eliz if required Staffing: Coverage via Roster process-PPLs to coordinate Staffing for Rehab: 0.5 PT, 0.5 OT, 0.5 TA	Access additional services via St. Eliz if required Staffing: Coverage via Roster process-PPLs to coordinate Staffing for Rehab: Depending on the needs of the patients: 1.0 PT, 1.0 OT, 1.5 TA
RRT – Vents ****Consider Critical Care Surge Protcol**	-borrow from Ventilator Pool -They have PB840 vents which we currently use at MH. We have a total of 30 Critical care ventilators 3 transport ventilators and 4 Bipaps. Staffing: Refer to RT surge protocol specific to Respiratory patients	borrow from Ventilator Pool -They have PB840 vents which we currently use at MH. We have a total of 30 Critical care ventilators 3 transport ventilators and 4 Bipaps.- Staffing: Refer to RT surge protocol specific to Respiratory patients	borrow from Ventilator Pool -They have PB840 vents which we currently use at MH. We have a total of 30 Critical care ventilators 3 transport ventilators and 4 Bipaps. Staffing: Refer to RT surge protocol specific to Respiratory patients	borrow from Ventilator Pool -They have PB840 vents which we currently use at MH. We have a total of 30 Critical care ventilators 3 transport ventilators and 4 Bipaps. Staffing: Refer to RT surge protocol specific to Respiratory patients	borrow from Ventilator Pool -They have PB840 vents which we currently use at MH. We have a total of 30 Critical care ventilators 3 transport ventilators and 4 Bipaps. Staffing: Refer to RT surge protocol specific to Respiratory patients
ICAT/EPIC	Utilize equipment	Utilize	EPIC Build	Using 2 med WOWs	-**Epic: requires 95 hours of build for**

**** This policy applies at ALL sites.**

F Zhang S MacSween	already on unit	Wows on existing unit	requirements for acute patient class 2 WOW needed	and 1 desk top PCs -2 workstations from Fracture Clinic -Need Multifunction printer from ICAT	**Phase 5** -all other spaces have existing work stations -pull 5 Workstations from C5 Procedures for Berwick - access printer from CKD program
Central Equipment: B Footwinkler M Dixon	share equipment with units Staffing:	Share equipment with units Staffing:	Share equipment with A1 CCC Staffing:	Retrieve equipment from central stores and reallocate equipment resources across clinical areas -20 rental stretchers ordered Oct 2019. -12 new IV poles ordered Oct 2019. -Assume only 80% patients require infusion: **499 x 0.8 = 399 pumps would be required With 411 infusion pumps total available at MRHH there will be only 12 spares assuming there are none down for repair. There can be 5-10 down at any given time in biomed for repair. Staffing: add 7.5hrs daily support	**Recommendation for IV pumps/poles:** - Pull infusion pumps from offsite locations (is there a courier running overnight/weekends?) - Pull infusion pumps from outpatient clinics - Clinical assessment of stable patients whether infusion pump required - Options for renting infusion pumps limited and not practical - Gravity infusion option: understand this is not ideal (clinical decision) Staffing: add 7.5 hrs daily support
Support Services EVS/Portering/ Call Center Communication	Support services notified of opening unfunded beds	Support services notified of opening unfunded beds	Support services notified of opening unfunded beds	A175 remains locked until a decision by EVP to open	**Plan:** housekeepers to newly added patient care areas; Transport notified of additional areas for potential pick up and drop off – review staffing

**** This policy applies at ALL sites.**

(B Footwinkler and K MacMillan)	Staffing: All Unchanged	Staffing: All Unchanged	Staffing: EVS – add 4HRS daily support Transport – add 4HRS daily support Call Centre – no change	**Plan:** Housekeeper assigned to this space; Transport notified of new location for pick up and drop off; Call Centre notified of potential for codes coming through x 5555. Staffing – EVS – add 7.5HRS daily support Transport – add 4HRS daily support Call Centre – no change	levels and increase; Notify Call Centre for possibility of increased codes from clinic areas especially after hours. Staffing: EVS – add 15HRS daily support and reassign OR staff to newly opened bed spaces. Transport – add 11.5HRS daily support and reassign OR transporter for additional assistance. Call Centre – no change **Outstanding:** Will EVS and Transport requests come through EPIC? Staffing:
Support Services Logistics (B Footwinkler and K MacMillan)	Support services notified of opening unfunded beds Staffing: no change	Support services notified of opening unfunded beds Staffing: no change	Support services notified of opening unfunded beds Staffing: notify existing staff of additional stocking location	Support services notified of opening unfunded beds **Plan:** Order and stock all necessary JIT items (as per last years request) minimum 2 days notice required. Assign JIT staff to this location for re-orders **Outstanding:** Review and update JIT par level list to ensure accuracy Staffing: No change	Support services notified of opening unfunded beds **Plan** Order and stock all necessary JIT items. Assign JIT staff to these locations for re-orders. **Outstanding:** Clinical team to review existing JIT par level lists for these clinic areas and add any necessary items for occupancy. **Recommendation:** The above list(s) be completed in advance so that items can be ordered if in a rush. Staffing: Add 7.5 additional hours to assist with new locations and increased part levels
Pharmacy/Lab/MI (A Soheili)	notified of opening unfunded beds • MI to cancel	notified of opening unfunded beds • MI to cancel 10% of	notified of opening unfunded beds • MI to cancel 20% of	Pharmacy – ADU Lab – Glucometer to be deployed	• MI to cancel **all** outpatient

**** This policy applies at ALL sites.**

	5% of outpatient appointments to accommodate inpatient volumes Staffing: **MI** to increase staffing by 1 Tech in X-ray, CT, Echo	outpatient appointments to accommodate inpatient volumes Staffing: **MI** to implement surge plan staffing increasing by 1 Tech in X-Ray, CT during weekdays and Echo on weekends and evenings	outpatients to accommodate inpatient volumes Staffing: **MI** to increase by 1 Tech in X-Ray, CT during weekdays and Echo on weekends and evenings	• MI to cancel 50% of outpatient appointments to accommodate inpatient volumes Staffing: **MI** to increase staffing in all modalities based on demands and availability of staff	appointments to accommodate inpatient volumes Staffing: **MI** to increase staffing in all modalities based on demands and availability of staff
Pharmacy	No impact to distribution services. Clinical pharmacy coverage absorbed by unit pharmacists. **Staffing:** Bring in second ED pharmacist + 1 FTE pharmacist if more than 29 admitted patients in ED	No impact to distribution services. C3 Med Orange pharmacist covers full unit and one third of current clinical load needs to be reassigned to a different pharmacy. **Staffing:** increase by 0.3 FTE pharmacist	**Distribution** -2 medication wows are currently in place and will be used to deliver patient-specific cartfill. -Will need a medication fridge for any patient-specific refrigerated deliveries. Will not need an ADU lock. (note: lorazepam not stocked in this unit, crash cart used from A2 and refrigerated benzos come from A2 or A1E) **Staffing:** Clinical coverage – no additional – second ED pharmacist will cover. Bring in additional +1FTE BPMH pharmacy technician	**Pharmacy:** - remove ADU tower from A1W and place in A175 -Patient specific medications will be delivered to ADU tower. Fridge available in tower. **Outstanding:** Rx disposal bin needs to be secured for narcotics; tower will need to be moved **Recommendation:** mobilize above plan if A175 needs to be opened, otherwise, leave tower as status quo. Recommend securing the disposal bin.	**Pharmacy:** -Build beds in Connect Rx and test -Determine which area will loan a medication WOW and swap with WOW from Fracture clinic -Any required medications will be sent from pharmacy -Determine which ADU nurse will remove any required narcs/benzo based on location -RX disposal bin needs to be secured to each location if not currently available - cartfill requirements and storage locations for medications would need to be determined based on patient disposition and length of stay in these areas. **Outstanding:** -EPIC naming convention on build of unit/room and bed **Staffing:**

**** This policy applies at ALL sites.**

			Distribution – need additional 0.5FTE pharmacy technician to assist with additional packaging, stocking, cartfills, etc for surge patients.	**Staffing** Will combine clinical coverage to cover these beds. Staffing same as stage 3 with extra ED pharmacist and BPMH tech as well as 0.5FTE pharmacy technician.	+1 FTE pharmacist to float and provide coverage and discharge counselling/resolve issues in these areas. Additional +0.5 FTE pharmacy technician to support additional packaging, cartfill and delivery workload (at this point, would have additional 1 FTE pharmacy tech in total)
Food Services	notified of opening unfunded beds Staffing: unchanged	notified of opening unfunded beds Staffing: unchanged	notified of opening unfunded beds Staffing: unchanged	notified of opening unfunded beds Staffing: unchanged	**Dependent on Epic Build** Staffing: Increase one of our shifts for an extra 1.5hrs per day
Bed Allocation (L Lankin)	MED/SURG patient in consult with IPAC Staffing: No Change	MED/SURG patient in consult with IPAC Staffing: No Change	MED patient in consult with IPAC Staffing: No Change	MED patient in consult with IPAC Staffing: No Change	MED patient in consult with IPAC Staffing: Add BA Mid-Shift from 10am to 6pm, Add X2 Pt. Schedulers to Support Outpatient Pt. Re-Scheduling/ Re-assign duties internally.
Finance	All costs will be associated to unit/program. Variance reporting to be monitored and shared with SLT during financial review	All costs will be associated to unit/program. Variance reporting to be monitored and shared with SLT during financial review	All costs will be associated to unit/program. Variance reporting to be monitored and shared with SLT during financial review	All costs will be associated to unit/program. Variance reporting to be monitored and shared with SLT during financial review	All costs will be associated to unit/program. Variance reporting to be monitored and shared with SLT during financial review
Patient Experience & Volunteers	Rounding	Rounding	Rounding	Rounding	Rounding
Security	Rounding	Rounding	Rounding	Rounding	Rounding
Communication	As per Flow Director/SLT	As per Flow Director/SLT	As per Flow Director/SLT	As per Flow Director/SLT	As per Flow Director/SLT

****Staffing Plan Considerations:**

**** This policy applies at ALL sites.**

1. Agency Usage
2. Nursing Resource Team
3. Maximize Nurse to Patient Ratios (1-2 nurses from each med-surge unit will be reassigned to the surge spaces as needed = 10 nurses max)
4. Team Nursing Model on all units

**** This policy applies at ALL sites.**

Patient Criteria for ED Surge Overflow Space (old Fracture/Plastics Clinic):

Exclusion criteria:

- Airborne Isolation admissions
- High acuity patients requiring telemetry monitoring and critical care (High flow oxygen needs)
- WCP, Pediatrics and mental health admissions

Inclusion criteria:

- ALC patients
- Patients waiting to go back to congregate setting due to facility outbreak
- Medicine and surgery admissions (includes isolations for covid positive and covid PUI)

Patient Criteria for A1 175 space:

Exclusion criteria:

- No isolated patients
- High acuity patients requiring telemetry monitoring and critical care
- WCP, Pediatrics and mental health admissions

Inclusion criteria:

- ALC patients
- *Preferably patients who are bed bound – only 1 bathroom in that space*
- Patients waiting to go back to congregate setting
- Medicine and surgery admissions

Patient Criteria for A1 CCC West beds

Exclusion criteria:

- Covid positive
- High acuity patients requiring telemetry monitoring and critical care
- WCP, Pediatrics and mental health admissions

Inclusion criteria:

- ALC patients
- Patients waiting to go back to congregate setting due to facility outbreak
- Medicine and surgery admissions (isolated patients will be reviewed by IPAC before moving where possible)

**** This policy applies at ALL sites.**

Appendix E – Critical Care Surge Protocol

Mackenzie Health

Critical Care Surge Definitions

Health

Minor Surge

An acute increase in demand for critical care services, up to 15% beyond the normal occupancy (>100% and <115%). See table 1 (Minor Surge row) for the number of patients in the hospital located in the Critical Care Unit (CCU) including level 3, level 2, and level 2 coronary care, Emergency Department (ED), and Post-Anesthetic Care Unit (PACU), that would qualify as a Minor Surge. A Minor Surge could result from unplanned admissions from the OR, deteriorating patients on the ward, or going into a minor surge as a result of accepting life or limb patients from a referring hospital. (2015, April, Critical Care Services Ontario).

Moderate Surge

A larger increase (≥115% occupancy) in demand for critical services. See table 1 (Moderate Surge row) for the number of Critical care patients in hospital with locations spreading between CCU, ED, and PACU that would require an organized response at the Local Health Integration Network (LHIN)/ regional network level. Occurs when a hospital in Minor Surge is no longer able to maintain services and needs to rely on the resources of other hospitals to assist with managing the surge. A Moderate Surge could also result from a single event (infectious or casualty) requiring the response of several hospitals in a region to respond to the increase in demand. (2015, April, Critical Care Services Ontario).

Major Surge

An unusually high increase in demand that overwhelms the health care resources of individual hospitals and regions for an extended period of time, where an organized response at the provincial or national level is required. See table 1 (Major Surge row) for the number of patients in the hospital spread between the CCU, ED, and PACU that would qualify as a Major Surge.

Table 1. Capacity constraints and surge demand for MRHH and CVH during each phase of burn-in and opening

	Current – June 6th, 2021
MRHH Critical Care Bed Capacity	20
CVH Critical Care Bed Capacity	**30**
Total Critical Care Bed Capacity	**50 Beds**

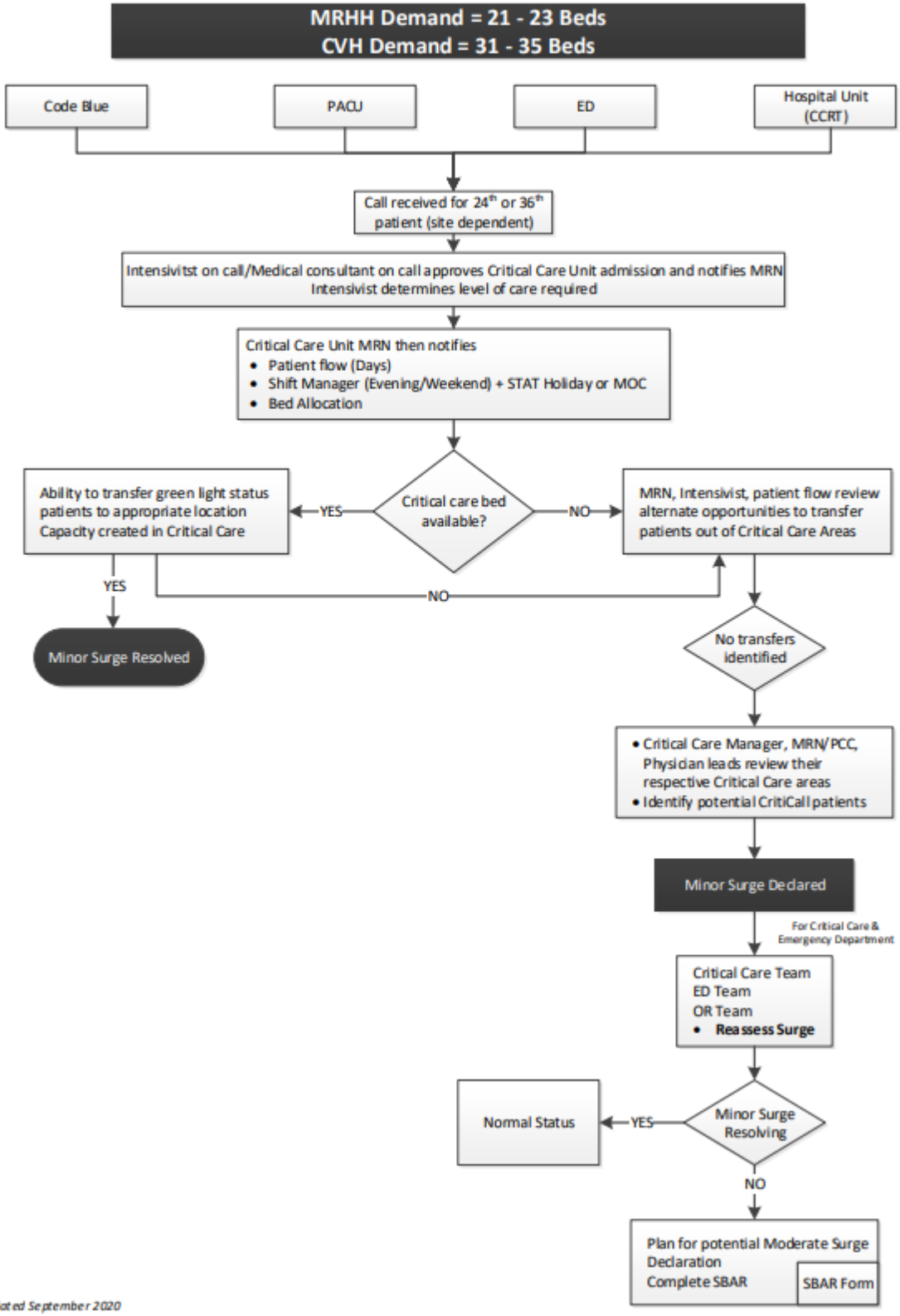
	MRHH	**CVH**
Minor Surge Demand	21-23 Beds	31 – 35 Beds
Moderate Surge Demand	24 - 28 Beds	36 – 40 Beds
Major Surge Demand Continues	Greater than 28	Greater than 40

**** This policy applies at ALL sites.**

Mackenzie Health

Process for Minor Surge Declaration
(Current – Jun 6, 2021)

An acute increase in demand for critical care services, ***up to 15% beyond the normal occupancy (>100% and <115%)***



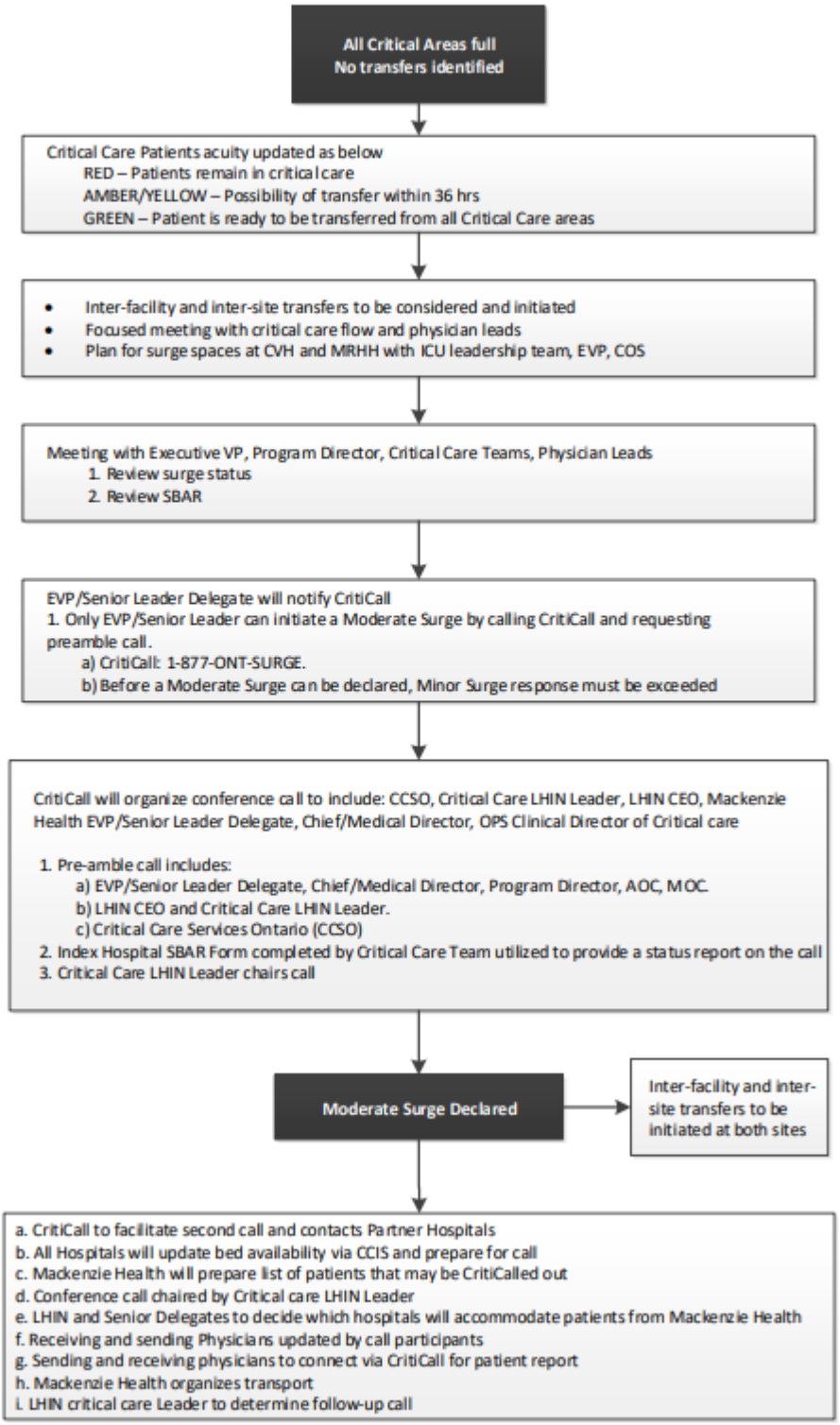
Updated September 2020

**** This policy applies at ALL sites.**

Mackenzie Health

Process for Moderate Surge Declaration

A larger increase (≥115%) occupancy in demand for critical services



Updated September 2020

**** This policy applies at ALL sites.**

Mackenzie Health

Internal Response to LHIN Needs (Moderate Surge Declared at Partner Hospital)

Trigger: Partner hospital has identified internal resources have been exhausted

Locating receives a call from CritiCall (1-800-668-4357)
Identifying a Moderate Surge response in effect for the LHIN

↓

Locating puts the page/call through to EVP/AOC
- Notification provided that LHIN wide Surge response in effect
- EVP/AOC provided teleconference call details

↓

EVP/AOC asks locating to notify following individuals regarding moderate surge. Conference call is requested and details given to:
- EVP
- Critical Care Team
- Program Director Critical Care
- Program Director Surgery
- Intensivist on-call
- Manager, Critical Care Unit (both sites)
- Manager, Patient Flow Manager
- OR/PACU Team (both sites)

↓

Above individuals meet in set location to determine next steps.
Partner hospital reporting form to be completed prior to call

Partner Hospital Reporting Form.pdf

↓

Critical Care Manager/MRN/CUC updates CCIS with current MH status

↓

EVP and critical care leadership to participate in LHIN teleconference

Updated September 2020

**** This policy applies at ALL sites.**

Index Hospital SBAR Form

SBAR Report	Date:
Time preamble call will start:	Call in Number at CritiCall: Participant code:
Index Hospital & LHIN:	
Name of Index Hospital CEO/delegate: Title (of delegate): Phone #:	
Situation: Please Provide Summary of the Situation in the section below	
What is your current status? Please insert # : _____ critical care capacity at Moderate Surge level (≥ 115%) _____ critical care bed capacity (insert bed occupancy rate from CCIS)	
Confirm that your CCIS bed availability is updated daily? ☐ Yes ☐ No	
Confirm that the hospital's senior management team has been informed? ☐ Yes ☐ No	
Background: What Factors Led to the Moderate Surge Event?	
Assessment: What are the threats to patients/operations (e.g. lack of vents/beds/staff)	
What is your current patient compliment? (Please insert the # of patients in each category) ___ # patients are red (i.e. will remain in ICU) ___ # patients are yellow (i.e. possibility of transfer within 1-2 days) ___ # patients are green (i.e. ready to leave ICU immediately)	
What responses have been executed? (e.g. flexed up, activated fan-out/call-in, called other sites)	

**** This policy applies at ALL sites.**

List of patients requiring possible transfer? Fill out section below:

NOTE: For patient privacy this portion of the form will be for internal use only

SBAR Reporting Form: Patients Needing Transfer

Pt #	Patient Identifier	Age	M/F	Diagnosis	Vented Y/N	Location	MRP Service	Necessity of Isolation? Y/N
1								
2								
3								
4								
5								

Recommendation

What are the recommended actions from the preamble call, proposed to sustain and provide safe patient care?

End of Form

**** This policy applies at ALL sites.**

Partner Hospital Reporting Form

Partner Hospital Reporting Template *Please complete prior to joining the Moderate Surge teleconference (organized by CritiCall)*	
Call-in Number at CritiCall: **Time to call-in:**	
Partner Hospital:	
Corporation:	
Name of participant on call: **Title:** **Phone:**	
Situation	
Date: **Time:**	
Identify your current critical care capacity:	☐ **Moderate Surge**, critical care capacity is ≥ 115% ☐ **Minor Surge**, critical care capacity >100-115% ☐ Critical Care Capacity is ≤ 100%
What is your current patient compliment? (Please insert the number of patients in each category)	___ # patients are red (i.e. will remain in ICU) ___ # patients are yellow (i.e. possibility of transfer within 1-2 days) ___ # patients are green (i.e. ready to leave ICU immediately)
Current Capacity: *The number of beds available to provide care for a critically ill patient*	
Current Capability: *The resources available to you at the time of the event*	

End of Form

**** This policy applies at ALL sites.**

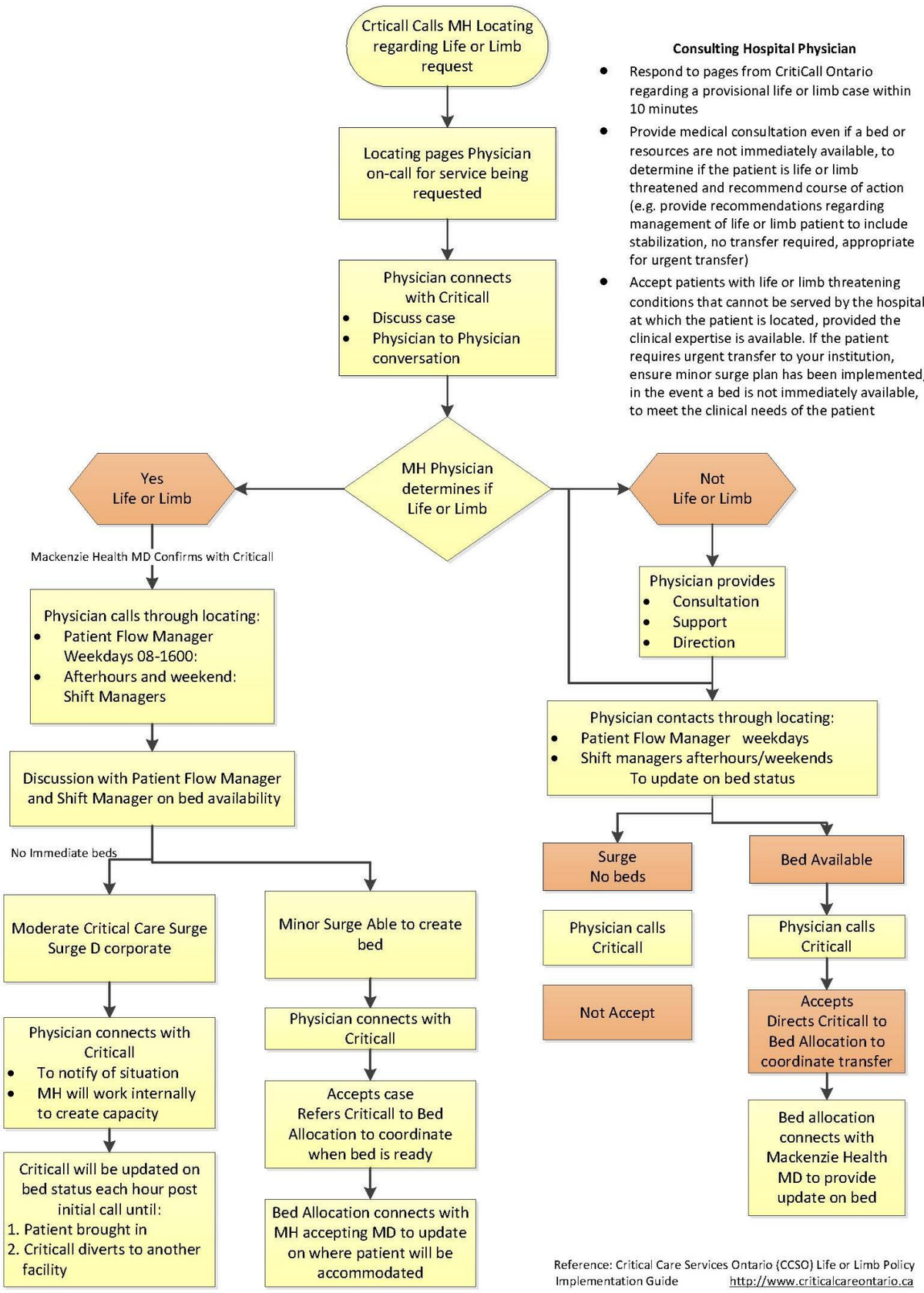
Appendix F - Algorithm for Life and Limb

**** This policy applies at ALL sites.**

Life or Limb Incoming Patients

Guiding Principles

- Life or Limb Policy is in effect when a patient is life or limb threatened and therapeutic options exist, which are needed within 4 hours
- A patient's life or limb threatening condition is a priority and the identification of beds is a secondary consideration
- No patient with a life or limb threatening condition will be refused care
- LHIN geographic boundaries will not limit a patient's access to appropriate care in another LHIN
- Repatriation within a best effort window of 48 hours once a patient is deemed medically stable and suitable for transfer is key to ensuring ongoing access for patients with life or limb threatening conditions (applies to both transfers within Ontario, and out-of-country (OOC) transfers)



Consulting Hospital Physician

- Respond to pages from CritiCall Ontario regarding a provisional life or limb case within 10 minutes
- Provide medical consultation even if a bed or resources are not immediately available, to determine if the patient is life or limb threatened and recommend course of action (e.g. provide recommendations regarding management of life or limb patient to include stabilization, no transfer required, appropriate for urgent transfer)
- Accept patients with life or limb threatening conditions that cannot be served by the hospital at which the patient is located, provided the clinical expertise is available. If the patient requires urgent transfer to your institution, ensure minor surge plan has been implemented, in the event a bed is not immediately available, to meet the clinical needs of the patient

Reference: Critical Care Services Ontario (CCSO) Life or Limb Policy Implementation Guide http://www.criticalcareontario.ca