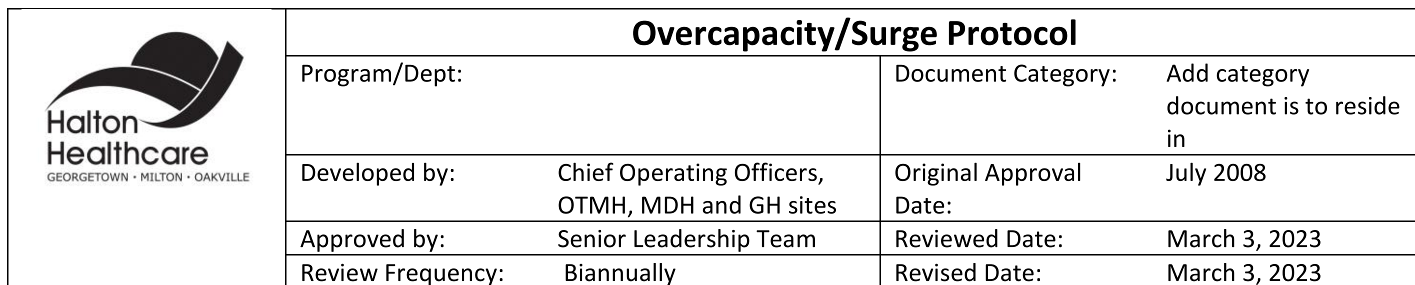


Halton Healthcare GEORGETOWN • MILTON • OAKVILLE	Overcapacity/Surge Protocol			
	Program/Dept:		Document Category:	Add category document is to reside in
	Developed by:	Chief Operating Officers, OTMH, MDH and GH sites	Original Approval Date:	July 2008
	Approved by:	Senior Leadership Team	Reviewed Date:	March 3, 2023
	Review Frequency:	Biannually	Revised Date:	March 3, 2023

Purpose
The Overcapacity Protocol (OCP) is an organization wide response to deal with an overwhelming volume of admitted patients in the Emergency Department (ED) and insufficient inpatient bed capacity at any one (1) and/or all three (3) sites. This may include limited access to critical care beds. The overall OCP strives to maintain patient safety and ensure timely access to emergency services and appropriate inpatient beds while continuously ensuring quality care.

Scope
All Halton Healthcare staff.

Policy
Patient flow management processes will incorporate normal daily proactive bed allocation and discharge planning in order to optimize efficiencies of inpatient bed utilization. These practices aim to mitigate the patient safety risks associated with access delays for all patients and to contribute to overall patient satisfaction.

Objectives

- To achieve timely access to the most appropriate inpatient bed.
- To improve the patient and family experience
- To ensure attainment of Ministry of Health and Long Term Care (MOHLTC) target for ED length of stay for admitted patients.
- To achieve the wait time metrics for non-admitted patients and high acuity CTAS 1-3 patients.
- To achieve Physician Initial Assessment (PIA) target time and improve time to treatment.
- To achieve ambulance offload time targets as set by the MOHLTC
- To avoid cancellation of scheduled procedures due to lack of available beds

Principles

- Beds are a corporate resource; not owned by programs, services, individual physicians or sites.
- Beds are made available to care for patient requiring an inpatient admission, achieve provincial workload targets and corporate strategic objectives.

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions

- All bed requests and requests for transfers within a site *must* be made through the Patient Flow Navigators / delegate (Admitting) at Oakville Trafalgar Memorial Hospital (OTMH) or Admitting at Milton District Hospital (MDH) and Georgetown Hospital (GH).
- Patients will be placed in the most appropriate available bed. During periods of overcapacity, patients may be placed in an appropriate off- service bed where their specific clinical needs can be met e.g. medical patient in a surgical bed, surgical patient on obstetrics. Consideration will be given to all-opportunities, such as cohorting, in order to minimize the number of empty beds and unnecessary room transfers, and maximize patients' healthcare time.
- Patients requiring direct admission including repatriations will be admitted directly to the most appropriate available inpatient bed.
- Patients with life or limb threatening conditions will be prioritized appropriately in accordance with the Provincial Life or Limb policy even during periods of overcapacity.
- Surge beds are used for "No Bed Admits" during periods of overcapacity.
- All staff and physicians share a collective responsibility to ensure that patients are admitted to the best available bed.
- Programs and services are expected to operate within their approved bed plan and case volumes.

Procedure: Initiating the Overcapacity Protocol

- The Emergency Department PCM/CRN/ delegate, in consultation with Patient Flow Navigator / Admitting, will utilize their knowledge and expertise to move patients out of the ED as soon as possible. They will monitor and reassess the number of 'No Bed' Admissions and communicate directly with the Director/delegate and or COO/delegate as deemed necessary.
- The Emergency Department PCM /CRN may enact the **'Consideration to Redirect Protocol' in Appendix A** to allow a one (1) hour period to create a plan to manage ongoing volume & challenges.
- **Site specific Surge Placemats/Protocols:**
    - **Appendix B – Oakville;**
    - **Appendix C – Milton;**
    - **Appendix D – Georgetown.**
- The Patient Flow Navigator and/or Admitting, has full authority to place patients in available beds or spaces.
- The goal is for units to return to normal census as soon as possible. The PCM/ CRNs Nurses must identify patients are most ready for discharge on a frequent and regular basis working collaboratively with the Most Responsible Physician to remove barriers to discharge.

Patient Placement Guidelines

Placement of patients into surge or unconventional locations is a collaborative decision between the Patient Flow Navigator PCM/CRN/delegate and the Most Responsible Physician based on clinical status of the patient.

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions

OTMH Unconventional Locations

Inclusion/considerations

Patients approaching discharge requiring IV antibiotics, additional diagnostic testing, and/or additional bloodwork

Exclusion Criteria

- Patients requiring greater than 4 liters of oxygen via nasal cannula
- Imminent death of a patient
- Patients requiring ICU, including ventilator dependent patients or tracheostomies, and those on CPAP/ BiPAP
- Patients that require telemetry
- Patients that require suctioning
- Patients receiving or recently received cytotoxic drugs (refer to Hazardous Drugs policy)
- Patients who are currently formed (e.g. Form 1)
- Patients cognitively impaired, requiring constant care/observation related to responsive behaviors and/or are exit seeking
- Patients requiring Infection control precautions or from a facility on outbreak
- Patients with active seizures or withdrawal symptoms (DTs)
- Patients with active vomiting and/or diarrhea (includes those taking procedure preparation).
- Patients who are incontinent of stool
- Patients requiring greater than 1 person assist
- Patient at high risk for falls (as per MORSE)

OTMH 4 North Unit 3 Internal Field Hospital – Short Stay Medical/ Surgical Unit:

Inclusion considerations:

- Stable patients approaching discharge (2-5 days) requiring IV antibiotics, additional diagnostic testing, and/or additional bloodwork before discharge i.e. CBI, require blood transfusions, stable CHF patients, PD patients being trained to manage at home (case by case and if support available by the dialysis team), patients without withdrawal symptoms (DTs) (Patients >72hrs post CIWA)
- Adult surgical patients with predicted length of stay less than 72 hours, including pre-op patients waiting to go to OR i.e. cholecystectomies, appendectomies, hernia repairs, simple mastectomies, gynecology cases (including D&C, hysterectomy), small bone fractures, TURP/TURBT, upper extremity joint replacement, general orthopedic trauma patients (includes external fixation, but excludes hip fractures)
- Patients with single shot spinal analgesia without Morphine for procedures on the inclusion list

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions

- Select Acute Pain Service (APS) patients: Those requiring single shot spinal with intrathecal morphine OR single shot peripheral nerve block(s) for the following surgeries if the patient is stable post-op: hysterectomy, TURP/TURBT, small bone fractures, upper extremity joint replacement
    - All other APS patients not listed in inclusion considerations must be verified by the OR anesthesiologist that their patient is a suitable candidate for post op recovery on 4N U3
- Ambulation status: up to a maximum of 1 person assistance; will consider bed ridden patients with short LOS (case by case)
- ALC/MSRD Patients (case by case): Home, Retirement Home, LTC - appropriate ALC patients will be identified by the DCP manager in collaboration with the FH Manager

Please complete the CHECKLIST below to ensure the patient is appropriate- <u>ALL</u> boxes must be checked:

☐ Does NOT require oxygen greater than 2L/Min
☐ Does NOT have an insulin infusion
☐ Does NOT have delirium
☐ Does NOT have acute vertigo
☐ Does NOT require continuous IV Lasix
☐ Does NOT require critical care (hi-flow, ventilator, tracheostomies, and new CPAPs, BiPAP)
☐ Does NOT require telemetry
☐ Does NOT require continuous oxygen saturation monitoring
☐ Does NOT require frequent suctioning
☐ Does NOT receive or have recently received **<u>IV</u>** cytotoxic drugs as per to Hazardous Drugs policy (refer to Hazardous Drug List)
☐ Does NOT have a lower extremity joint replacement on this admission (hips and knees)
☐ Does NOT receive immunosuppressant drugs (i.e. chemo)
☐ Does NOT wander/exit seek and/or require constant care/observation due to responsive behaviors
☐ Does NOT require infection control precautions or from a facility on outbreak
☐ Does NOT have active seizures (seizure within last 72 hours)
☐ Does NOT have frequent vomiting and/or diarrhea, including GI procedure preparation
☐ Does NOT have a high risk for falls on a recent MORSE assessment (within 72 hours) and/or the high risk for falls is not related to acute vertigo, bed and chair climbing behavior, +ve CAM

- If patient was initially admitted with a high risk MORSE score and has improved, repeat MORSE assessment. MORSE assessment should be completed with any significant change in patient condition (improving or deteriorating)

☐ Does NOT have a PCA, Epidural, continuous nerve block catheter
☐ Are NOT currently formed under Mental Health Act

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions

Daily Bed Management Planning

- Patient access and flow optimization within each hospital site will require a proactive Daily Bed Management plan with effective coordination between the units and services including Home & Community Care.
- Communication is crucial to the successful flow of patients.
- Each unit will be accountable for: providing accurate and timely data for the daily bed management plan using the Visibility System. This information will be used to determine the Hospital Capacity Status.
- Daily feedback regarding the impact of overcapacity will be discussed as part of the bed meeting(s) held at each site with a focus on ongoing improvements.
- COO's/delegates will communicate pressures beyond the ability of their site to manage with the other two (2) sites and a tri-site bed meeting will occur at a mutually agreed upon time to review and create a plan.
- Tri-site bed management meetings will be held daily to support patient flow and staffing requirements The priority for unit(s) over census is to return to normal census as quickly as possible. PCM's, CRN's and Medical Leadership will develop plans and processes to return the unit census to normal as soon as possible.

Bed Placement Strategy

1: Patients move to appropriate unit's beds in appropriate service
2: Patients move to fill next most appropriate beds (off service)
3: The most appropriate patients move into identified surge spaces

Units are expected to prepare for utilization of their surge space in accordance with site specific algorithms.

Oakville Appendix B, Milton Appendix C, Georgetown Appendix D.

Patient Flow

- Stable patients will be transferred from ED once the bed is assigned.
- During OCP discharge from hospital should occur as soon as possible and ideally by 11:00 am. When this time is exceeded, units will ensure discharged patients are provided with a safe place to wait (i.e. discharge lounge and or/ unit lounge), meals, and access to a washroom until they have left the hospital

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions

- Each unit determines how to "flex up" and help each other and will identify their own flex/surge spaces.

Roles and Responsibilities:

Directors/Managers/Clinical Resource Nurses

- Keep Visibility System current and up to date.
- Attend the daily bed meetings promptly at the site specific time.
- Attend Physician Directed Rounds where applicable.
- Attendance additional bed meetings (i.e. Tri-site Meetings) as required in person or via teleconference.
- Ongoing identification of appropriate patients for Surge Locations and for the Internal Field Hospital
- Escalate unresolved issues and barriers to discharge to the appropriate resource for resolution.
- Initiate flex / surge beds as required.

Patient Flow Navigator (OTMH) and Admitting (MDH; GH)

- The Patient Flow Navigator / Admitting, has full authority to place patients in available beds or spaces.
- Patient Flow / Admitting will collaborate with the inpatient Managers / Clinical Resource Nurses to facilitate patient flow activities at the site wide level.

Medical Directors/Physicians

- Manager(s), Director(s) and on-call management will notify the appropriate physician leader(s) for each service experiencing overcapacity. As required, they will participate in the strategy and planning for safe management for admitted patients in the ED and across the organization.
- Medical staff in each service will re-evaluate patients for discharge regularly in collaboration with the interdisciplinary team.

Definitions

- **Surge** is an organizational response to a high volume of admitted patients in the ED. Surge response is triggered by a site specific threshold. **Surge space** is any identified space in an inpatient care area above funded physical bed capacity to be used for admitted patients during periods of overcapacity
- **Capacity** is defined as the hospital's ability to maintain patient access and flow (i.e. right patient in the right bed at the right time)

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions

- **Overcapacity** is the inability of the ED to function and meet the demand of the community due to the impact of admitted patients in the ED without assigned beds and or acuity.
- **No Bed Admits (NBA)** are patients who have been admitted to hospital but remain in the ED without an assigned bed
- **Closed Bed** is an unstaffed and unfunded bed

Related Documents

- Critical Care Surge Policy (Compliant with Critical Care Secretariat Guidelines)
- Code Orange
- Infection Control Emergencies (ICE) Plan
- Christmas Contingency Plans created annually.

Key Words

- Gridlock
- Capacity
- Contingency
- Beds

Reviewed by/Consultation with

COO, OTMH
COO, MDH
COO, GH
Senior VP Clinical Programs & CNE
Program Directors,
Manager Patient Flow, Social Work & Discharge Planning
Patient Flow Navigators
Halton Region EMS

References

College of Nurses of Ontario (August 2009). *Nursing in temporary locations: Listening to Ontario's nurses.*

Providence Health Care (2009). *Overcapacity protocol guidelines for transfer of admitted patients from the emergency department.*

St Joseph's Health Centre, Toronto (2009). *Escalation Policy.*

St. Michael's Hospital (2008). *Hospital Patient Access and Flow Optimization Policy.*

Trillium Health Centre (2010). *Appropriate placement of patients by health system #6410*

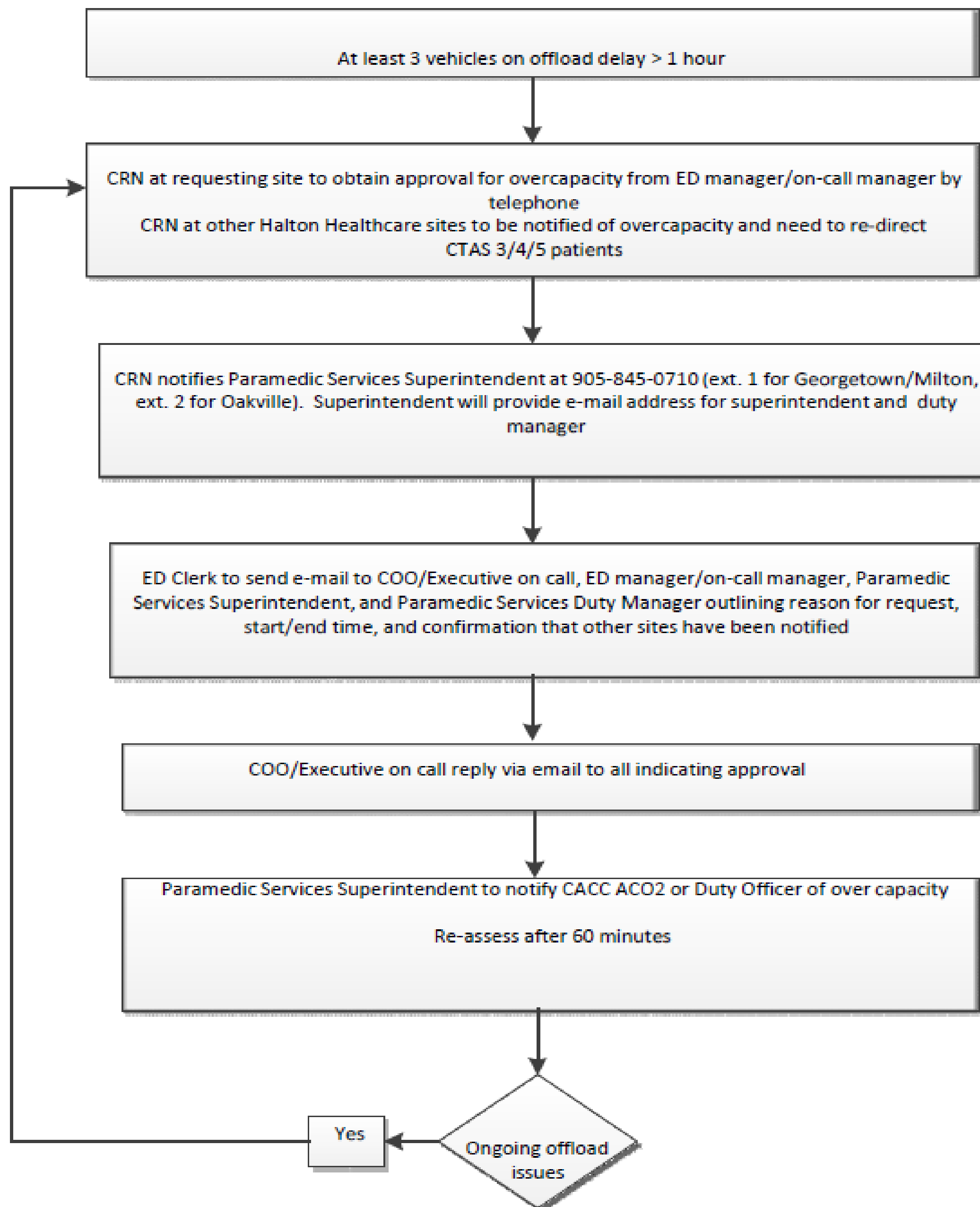
University Health Network (2008). *Escalation Policy for Admitted Patients in the Emergency Department*

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions

Signed by ______________________________

Title ______________________________

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions



*If required to go on overcapacity more than 3 times the manager on call will call the Executive on call to discuss options

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions

Appendix B- Oakville Surge & Overcapacity Plan

OTMH SURGE & OVERCAPACITY PLAN

Key Principles

1)Surge at one site is a corporate issue. Potential solutions need to include a tri-site approach

2) Potential discharge and pending discharges, repatriations, ICU transferrable patients (in and/or out) must be considered and part of decision making

3) All efforts should be made to transfer patients between sites before 4pm

4) Patient flow can make decisions on when to utilize identified unconventional locations, open 75 & Zone E based on established criteria - 0530 decision to open beds, using identified criteria, is made by ED in collaboration with Central Staffing.

5) The decision to open additional surge bed/units is a decision that will be made at bed rounds (a.m. or p.m.) **and is dependent on staffing for the next 24 hours (all units/sites)**

6) Patients from both inpatient rooms and the ED can be identified as unconventional space appropriate

Note - Do not move patients into unconventional space location from inpatient rooms between 1930-07:00 unless the below 3 alternatives have been exhausted

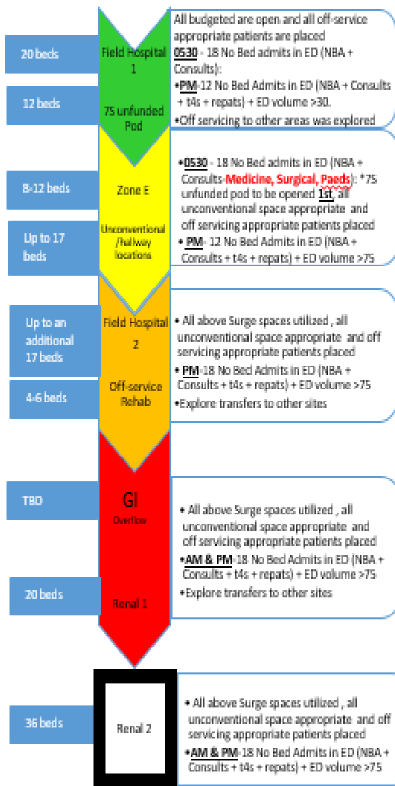
a) SS will ensure they have ONE available bed each night for medically unstable inpatient patients from Rehab, MH, CTC, or an inpatient patient that needs telemetry

b) Another ONE medically unstable inpatient patient can be temporarily placed on surgery if they have >2 empty beds during the night

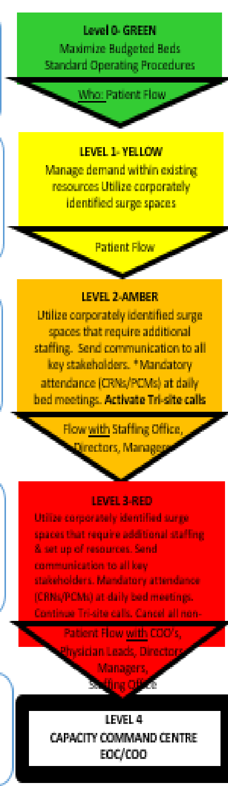
c) Consider patient swap between units where appropriate (i.e. Rehab sends acute patient to Medicine in exchange for a medically stable patient from Medicine)

- Flow to ensure hospitalists are aware of any patients off-serviced in other areas

Surge Guidelines-OTMH



Surge Levels/ Action Plans



Occupancy Rates (Med/Surg Beds)

100% or less
236 Open beds

100-112%
265 Open beds

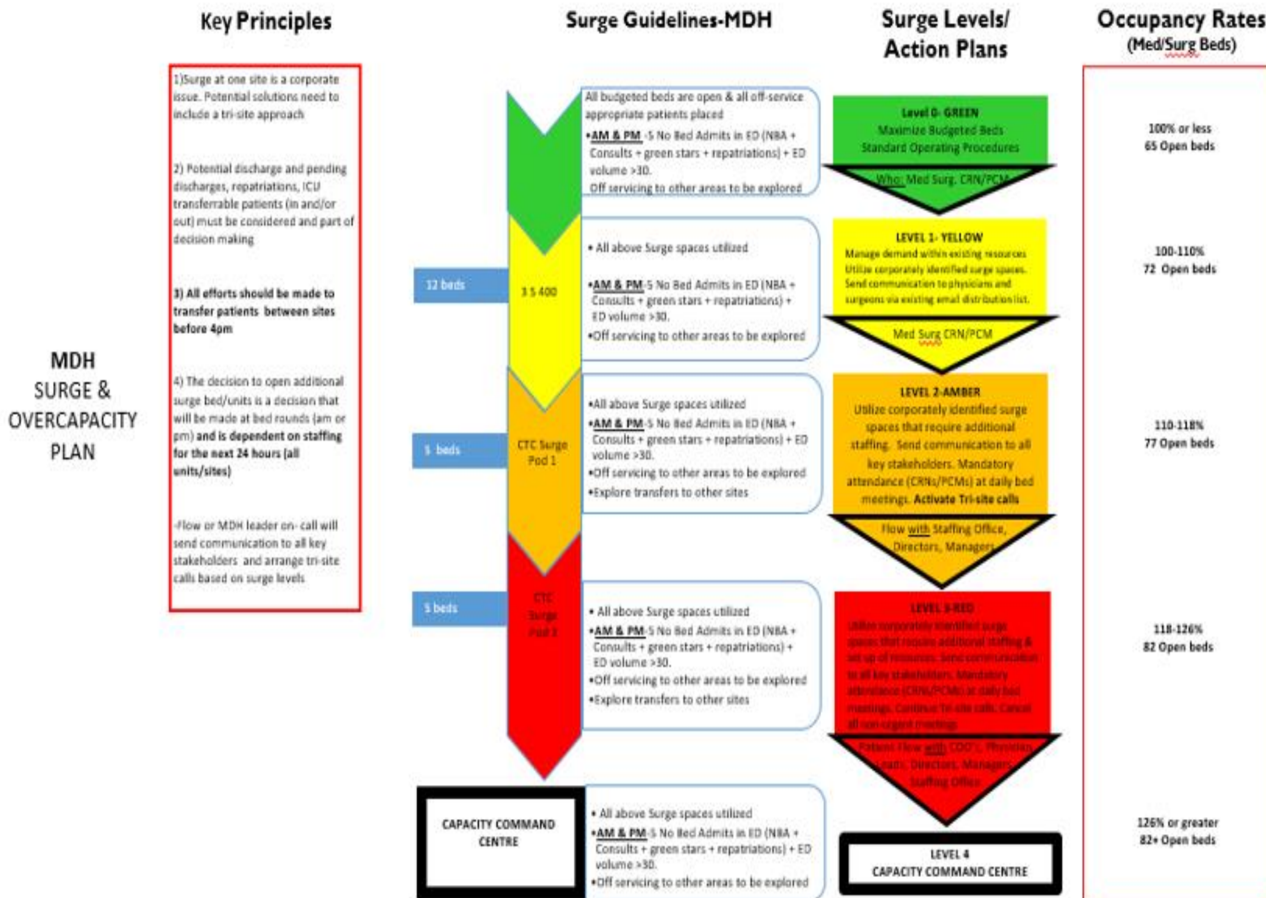
112-122%
288 Open beds

122-131%
308 Open beds

123% or greater
291+ Open beds

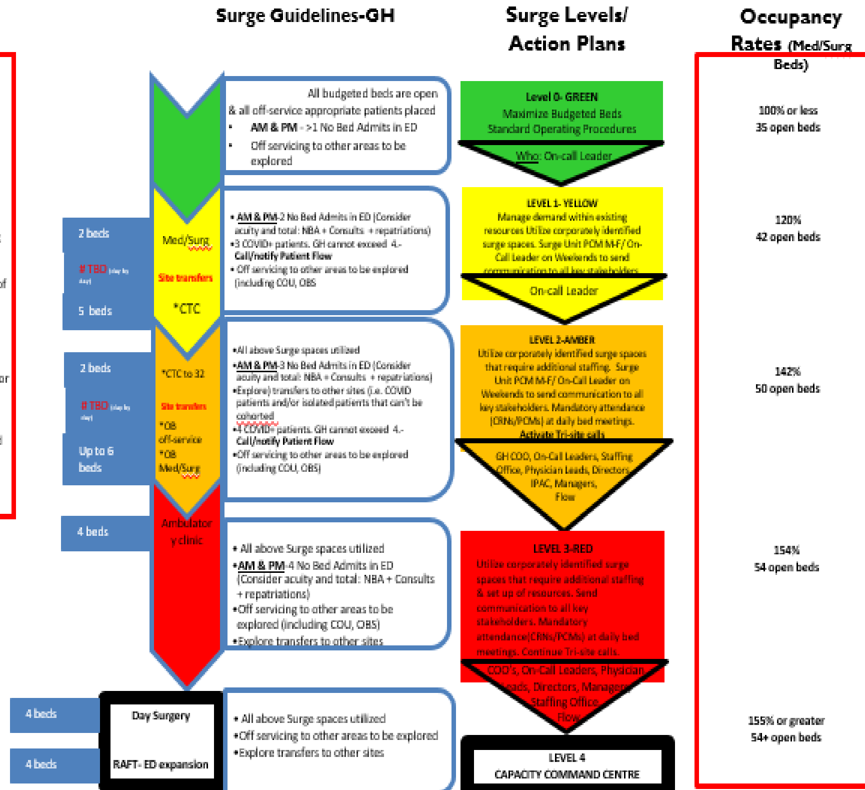
A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions

Appendix C- MDH Surge & Overcapacity Plan



Appendix D- GH Surge & Overcapacity Plan

GH SURGE & OVERCAPACITY PLAN



* Indicates that these beds are only available if the locations are not already at full capacity

A printed copy of this document may not reflect the current, electronic version. Prior to use, paper versions must be cross - checked with the electronic versions