Over Capacity Protocols within Vancouver Coastal Health Region

1. Introduction

An Over Capacity Protocol (OCP) is one of many tools to help decongest the Emergency Departments within Vancouver Coastal Health (VCH) and Providence Health Care (PHC) when there is severe limitation to access of either a provider, nurse, and/or a care space in the ED.

This policy addresses the expectation that all acute care sites within the Vancouver Coastal Health Region have an OCP in place.

1.1. Scope

VCH and PHC Overcapacity Protocols will be utilized at the following hospitals: St. Paul's Hospital, Vancouver General Hospital, Lion's Gate Hospital, Richmond Hospital, Mount Saint Joseph Hospital and Sechelt Hospital.

2. Policy

All VCH and PHC Acute Care facilities will develop a site specific OCP to address the situation where no Emergency Department (ED) care spaces are available for patient care due to admitted patients being held in the ED. These protocols will have defined triggers and outline specific actions to achieve rapid distribution of admitted patients from the emergency department to pre-defined overcapacity care spaces on inpatient units. The OCP and existing site patient flow algorithms will ensure the safest possible and most consistent approach for the care of admitted patient throughout each site, including over census and OCP patients.

Each acute care site within VCH and PHC will develop specific Overcapacity Protocols (OCP) that describe the following:

1. ED specific: ED implements internal surge process when no or few admitted patients.
2. Site/Program specific over capacity response for admitted patients: Specifies the maximum number of admitted patients in the emergency department, beyond which the OCP would be triggered.

    a. Aligns the targeted length of stay of the admitted patients in the emergency department with the Ministry of Health target of less than 10 hours to be transferred to an inpatient bed.
    b. Pre- determined locations for the OCP spaces on the inpatient units defined within the Admission Discharge Transfer (ADT) system.
    c. Defined maximum Length of Stay (LOS) for the patients who are transferred to the pre-determined OCP spaces to be monitored by the inpatient unit Manager and Director. Inclusion and exclusion criteria for those admitted patients who are appropriate to send to OCP spaces

d. Clearly defined roles and responsibilities for Directors, Managers, Patient Care Coordinators (Charge RN's), and Patient Flow Leaders with the OCP

The essence of these protocols is to ensure the rapid transfer of these admitted patients to inpatient overcapacity spaces until none of the above conditions are met.

The key components of the Overcapacity Protocols are:

1. Only admitted patients will be transferred to an inpatient unit.
2. The identification of patients that are appropriate for placement into pre-identified OCP spaces will be collaboration between ED/Acute inpatient units and Patient Flow/Access as appropriate.
3. The placement of patients to units will be guided by determining the safest available location and matching care delivery to patient needs as much as possible.
4. Inpatient units are expected to monitor the status of the emergency department, begin planning for the admitted patients under their program prior to the implementation of the OCP, and 'pull' patients into the pre-identified surge spaces on their units.
5. Once the OCP triggers have been met, patients will be transferred immediately to the inpatient units. The OCP will be activated by the Patient Flow Leader / designate once the OCP triggers have been met.
6. Sites will create a plan that promotes continuous placement of patients that have been transferred to OCP spaces in order to achieve the best possible patient care quality for those patients who are in an OCP space and to ensure that should the protocol require enacting again there are spaces available to do so.
7. It is the responsibility of the individual inpatient units to ensure that there is enough space for the next patient who requires admission.

3. Compliance

Flow outcome indicators will be monitored and include the number of admitted patients in the Emergency Department, the Total Patient volume in the ED, and the EDP admitted patient target (number of patients with time to leave ED of ≤ 10 hours), the number of patients in OCP spaces, number of CTAS 2 patients in waiting room (where able).

4. Supporting Documents

4.1. Related Policies

- Higher Level of Care (HLOC) Transfers (VCH and PHC)
- Life, Limb and Threatened Organ Transfer (VCH and PHC)

4.2. Guidelines/Procedures/Forms

- Overcapacity Protocol: Admitted Patients from the ED (PHC)
- Overcapacity Protocol MSJ (PHC)
- Overcapacity Protocol SPH (PHC)
- Surge Plan MSJ Geriatric Psychiatry (PHC)

- Transport from MSJ: Urgent Life, Limb or Threatened Organ (LLTO) and Higher Level of Care (HLOC) (PHC)

5. References

1) Viccellio P, Zito JA, Sayage V, Chohan J, Garra G, Santora C, Singer AJ. Patients overwhelmingly prefer inpatient boarding to emergency department boarding. J Emerg Med. 2013 Dec; 45(6):942-6.

2) http://www.albertahealthservices.ca/3376.asp Alberta Health Services Launches Overcapacity Protocols. accessed December 18, 2013

3) Singer AJ, Thode HC Jr, Viccellio P, Pines JM. The association between length of emergency department boarding and mortality. Acad Emerg Med. 2011 Dec; 18(12):1324-9.

4) Bernstein SL, Aronsky D, Duseja R, Epstein S, Handel D, Hwang U, McCarthy M, John McConnell K, Pines JM, Rathlev N, Schafermeyer R, Zwemer F, Schull M, Asplin BR; Society for Academic Emergency Medicine, Emergency Department Crowding Task Force. The effect of emergency department crowding on clinically oriented outcomes. Acad Emerg Med. 2009 Jan; 16(1):1-10

Questions

Contact: Regional Emergency Services Program