Surge Action Plan for Transfer of Admitted Patients from the Emergency Department

Introduction

The Surge Action Plan is a "pull system" into the appropriate program for treatment and care. The plan is one of many strategies to improve patient flow. PHC will continue to implement other solutions that are in progress to improve patient flow, including implementing real time demand capacity planning (RTDC) improving LOS, decreasing ALC rates, implementation of Bed Allocation Methodology, and exploring additional space for care areas (e.g. relocation of offices).

Objectives of Plan:

Key Deliverable: To ensure triaged emergent and urgent Emergency Department patients are moved rapidly into Emergency Department care areas.

Other Objectives:

- To reduce time delays to appropriate inpatient unit.
- To reduce time to emergency assessment and treatment.
- To reduce the number of acutely ill patients left in Emergency Department hallways.
- To reduce ambulance off-load delays.

How Does the Plan Work?

- There are 3 Surge Levels: 1, 2, and 3.
- The Access Leader or Clinical Coordinator lead the process.
- Inpatient units are required to accept over-census patients into their Over-Census beds, as per Table 4, before Surge can be triggered.
- The criteria for triggering Surge Level 1, and for subsequent escalation to Levels 2 and 3 are indicated as part of the Surge Action Plan below.
- Once the surge response has escalated to Level 2, or 3, the site will remain at the Surge Level until all conditions causing Surge have been resolved. Post Surge the priority is to return units to normal census.
- The expectation during Surge is that inpatient units will accept patients into their Over Census spaces, except under extenuating circumstances i.e. patient resuscitation in progress on the receiving unit. The aim is to begin the transfer of patients within 10 minutes when the Emergency Department is overcapacity.
- Staff skills will be aligned with patient needs as much as possible. An assessment of resources available, acuity and level of expertise will be led by the Access Leader/ Clinical Coordinator in collaboration with the CNL/ CN, OL, LOC.

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SURGE LEVEL 1 Table 1 — Mon to Fri 8AM to 5PM			
SPH		**MSJ**	
ED Census	< 40	**ED Census**	> 25
(and) ED Waiting Room Census	< 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	MED > 100%, MH > 100% (including Over Census spaces)	**(and) Inpatient Occupancy**	100% (incl. Over Census spaces)
(and) Surgery Slate:	Slate Placed	**(and) Surgery Slate**	Slate Placed
(and) ED Dashboard Status	YELLOW		

Responsible	Action	Time Frame
Access Director or delegate (Mon-Fri 8AM - 5PM)	**Notification:** Notify the following via email [SUBJECT: **Action Requested: Surge Level 1**] outlining the challenge and include the capacity planning tips:- PHC Department and Division Heads (Medicine, Surgery, Mental Health), VP Acute Clinical Programs, VP Elder Care Programs, VP Medical Affairs, IPAC, all PHC Site Leads, Inpatient OLs, Access CNLs, Program Directors, Physician Program Directors, Chief Medical Resident, Professional Practice Leaders, TST Site Lead, TST Manager, Priority Access Manager, Housekeeping Supervisor, Director Pharmacy, Site Leader Diagnostic Imaging, Vancouver Community Director (PHC Liaison), TST Director, PTN Director, Community MH&A Director, Community Housing Director, Public Health & Chief Medical Health Officer, Home Health Managers, Community Home Health Director, respective Administrative Assistants	At the start of Surge Level 1
Clinical Coordinator	**Patient Placement:** - To the designated off-service Over Census spaces, at the discretion of the Clinical Coordinator depending on patient care needs. If no patients are suitable for such placement and all Over Census spaces are full, proceed to Surge Level 2. - Escalate PTN to PTN Manager.	Within 15 minutes of Surge

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SURGE LEVEL 1 (cont.) Mon to Fri 8AM to 5PM			
SPH		**MSJ**	
ED Census	< 40	**ED Census**	> 25
(and) ED Waiting Room Census	< 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	MED > 100%, MH > 100% (including Over Census spaces)	**(and) Inpatient Occupancy**	100% (incl. Over Census spaces)
(and) Surgery Slate:	Slate Placed	**(and) Surgery Slate**	Slate Placed
(and) ED Dashboard Status	YELLOW		

Responsible	Action	Time Frame
Inpatient OLs, PDs, PPDs (MED, MH, SURG, HC)	- Support patient placement in off-service spaces. - Utilize all available Over Census spaces on all inpatient units. - Connect with teams and Physicians to identify a plan to expedite flow. - Attend Bed Meeting at 1000 (SPH), 0945 (MSJ). Come prepared to articulate the plan. - Review ARTG patients for escalation and resolution with Community resources.	Before Bed Meeting
Housekeeping	- Prioritize and expedite bed turnover based on direction from Clinical Coordinator	At start of Surge
TST Site Lead	- Review and expedite all assessments in progress. - Attend Bed Meeting at 1000 (SPH), 0945 (MSJ). Come prepared to articulate the plan.	Before Bed Meeting
Priority Access Manager TCU Manager Community Home Health Director Community MH&A Director Community Housing Director Residential Director	- Review ARTG list for potential patients to expedite. - Review patients returning to residential for potential expedited discharge / transfer back. - Review all potential discharges for enhanced home based resources to expedite including emergency and adding resources above normal. - Send email to Program Directors and Access Leader outlining plans.	Before Bed Meeting

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SURGE LEVEL 1 Table 1A — Off-Hours and Weekends			
SPH		**MSJ**	
ED Census	< 40	**ED Census**	> 25
(and) ED Waiting Room Census	< 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	MED > 100%, MH > 100% (including Over Census spaces)	**(and) Inpatient Occupancy**	100% (incl. Over Census spaces)
(and) Surgery Slate:	Slate Placed	**(and) Surgery Slate**	Slate Placed
(and) ED Dashboard Status	YELLOW		

Responsible	Action	Time Frame
Leader on Call (Weekends, Mon - Fri 5PM - 8AM)	**Notification:** Notify the following via email [SUBJECT: **Action Requested: Surge Level 1**] outlining the challenge and include the prognosis until the regular Surge Plan can take effect (Mon-Fri 8AM-5PM):- PHC Site Leads, Inpatient OLs, Access Leader, Access CNLs, Program Directors, Physician Program Directors, Chief Medical Resident, Professional Practice Leaders, TST Site Lead, Housekeeping Supervisor, Director Pharmacy, Site Leader Diagnostic Imaging	At the start of Surge Level 1
Clinical Coordinator	**Patient Placement:** - To the designated off-service Over Census spaces, at the discretion of the Clinical Coordinator depending on patient care needs. If no patients are suitable for such placement and all Over Census spaces are full, proceed to Surge Level 2. - Send email updates via email to Leader on Call, Access Leader, Inpatient OLs, PHC Site Leads every shift until the regular Surge Plan can take effect (Mon to Fri 8AM to 5PM)	Within 15 minutes of Surge Every Shift

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SURGE LEVEL 2 Table 2. Mon to Fri 8AM to 5PM			
SPH		**MSJ**	
ED Census	≥ 40	**ED Census**	≥ 5
(and) ED Waiting Room Census	≥ 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	MED, MH, SURG > 100% (into Green spaces)	**(and) Inpatient Occupancy**	120% (Green Space all used)
and) Surgery Slate:	At Risk	**(and) Surgery Slate**	At Risk
(and) ED Dashboard Status	RED		

Responsible	Action	Time Frame
Access Director or delegate (Mon-Fri 8AM - 5PM)	**All Actions for Surge Level 1, and:** **Notification:** Notify the following via email [SUBJECT: Action Requested: Surge Level 2] outlining the escalating challenge and include the capacity planning tips:- PHC Department and Division Heads (Medicine, Surgery, Mental Health), VP Acute Clinical Programs, VP Elder Care Programs, VP Medical Affairs, IPAC, all PHC Site Leads, Inpatient OLs, Access CNLs, Program Directors, Physician Program Directors, Chief Medical Resident, Professional Practice Leaders, TST Site Lead, TST Manager, Priority Access Manager, Housekeeping Supervisor, Director Pharmacy, Site Leader Diagnostic Imaging, Vancouver Community Director (PHC Liaison), TST Director, PTN Director, Community MH&A Director, Community Housing Director, Public Health & Chief Medical Health Officer, Home Health Managers, Community Home Health Director, respective Administrative Assistants	At the start of Surge Level 1 At start of Surge Level 2
Access Leader	**Access and Flow Call**: Set up a conference call with Vancouver Community, including Priority Access Manager, TCU Manager, Community Housing, HH and MH&A Directors, Residential Director, PHC Site Lead, TST Site Lead, PHC Program Directors or designates as applicable, PHC System Navigator	Within 15 minutes of Surge Level 2

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SURGE LEVEL 2 (continued) Mon to Fri 8AM to 5PM			
SPH		**MSJ**	
ED Census	≥ 40	**ED Census**	≥ 5
(and) ED Waiting Room Census	≥ 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	MED, MH, SURG > 100% (into Green spaces)	**(and) Inpatient Occupancy**	120% (Green Space all used)
and) Surgery Slate:	At Risk	**(and) Surgery Slate**	At Risk
(and) ED Dashboard Status	RED		

Responsible	Action	Time Frame
Clinical Coordinator	**Patient Placement:** - Utilize all available Over Census and Green spaces for patient placement, taking into account patient condition and appropriateness of placement in hallway/lounge spaces. If no patients are suitable for lounge / hallway placement and all Over Census and Green spaces are full, proceed to Surge Level 3. - Schedule an Extraordinary site Bed Meeting with a call-in number. Notify via email all on the list above to come to the Bed Meeting with their plan to expedite flow.	

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SURGE LEVEL 2 (continued) Mon to Fri 8AM to 5PM			
SPH		**MSJ**	
ED Census	≥ 40	**ED Census**	≥ 5
(and) ED Waiting Room Census	≥ 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	MED, MH, SURG > 100% (into Green spaces)	**(and) Inpatient Occupancy**	120% (Green Space all used)
and) Surgery Slate:	At Risk	**(and) Surgery Slate**	At Risk
(and) ED Dashboard Status	RED		
Responsible	**Action**		**Time Frame**

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ALL Clinical OLs, PDs, PPDs	**All Actions for Surge Level 1, and:** - Utilize all available Green spaces (unfunded beds, designated lounge & hallway spaces) on all inpatient units. - Pull at least 1 (ONE) patient from the ED immediately. If no patient identified to pull, Clinical Coordinator will place a patient from ED in any available spaces (clean or yet-to-be-cleaned). - Attend the Extraordinary site Bed Meeting. Come prepared to articulate the plan. - Program Directors to contact Physician Program Directors to do a sweep of all patients for possible discharges. - Physician Program Directors to help expedite discharges; send out pre-scripted communication to their physicians. - Refer to Regional Mental Health Surge Plan for MH-specific actions. - Program Directors and Site Leaders to identify all Green Spaces available at all sites and plan for patient transfers if needed. Articulate the plan at Bed Meeting. - Review Surgical Day Care and Slate for the next day in case there is a need for cancellations. - Implement PTN screening process. Ask: Can non-LLTO transfers be delayed. Send PTN list to the PDs for those services and they will have the first screen and then alert the surgeon/MRP if there is a question about their need to come. - Director, Access and Flow to escalate PTN repatriations to PTN Director level	Within 15 minutes of Surge Level 2. At Bed Meeting

SURGE LEVEL 2 (continued)
Mon to Fri 8AM to 5PM

SPH		MSJ	
ED Census	**≥** 40	**ED Census**	≥ 5
(and) ED Waiting Room Census	**≥** 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	MED, MH, SURG > 100% (into Green spaces)	**(and) Inpatient Occupancy**	120% (Green Space all used)
and) Surgery Slate:	At Risk	**(and) Surgery Slate**	At Risk
(and) ED Dashboard Status	RED		

Responsible	Action	Time Frame
IPAC	- Assess all cohorted patients and identify spaces that can be utilized to admit patients from ED. - Identify all closed beds and articulate what is needed to open the beds for admissions. Communicate the plan to Site Leader.	At start of Surge as needed
Housekeeping	**All Actions for Surge Level 1, and:** - Mobilize extra resources in communication with IPAC and Site Leader to expedite bed turnover.	At start of Surge
TST Site Lead, Manager TST Director	**All Actions for Surge Level 1, and:** - Attend the Extraordinary site Bed Meeting. Come prepared to articulate the plan. - Implement added care above and beyond the usual to safely move people back to residential care.	Before Bed Meeting
Priority Access Manager, Director TCU Manager, Director Community Directors Residential Director Home Health Managers	**All Actions for Surge Level 1, and:** - Implement added care above and beyond the usual to safely move people back to residential care. - Negotiate with Public Health & Chief Medical Health Officer around transferring Clients back to facilities that are in outbreak situations.	Before Bed Meeting

SURGE LEVEL 2

Table 2A **Off Hours and Weekends**

SPH		MSJ	
ED Census	≥ 40	**ED Census**	≥ 5
(and) ED Waiting Room Census	≥ 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	MED, MH, SURG > 100% (into Green spaces)	**(and) Inpatient Occupancy**	120% (Green Space all used)
and) Surgery Slate:	At Risk	**(and) Surgery Slate**	At Risk
(and) ED Dashboard Status	RED		

Responsible	Action	Time Frame

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Leader on Call (Weekends, Mon - Fri 5PM to 8AM)	**All Actions for Surge Level 1 (Off-Hours and Weekends), and:** **Notification:** Notify the following via email [SUBJECT: Action Requested: Surge Level 2] outlining the escalating challenge and include the prognosis until the regular Surge Plan can take effect (Mon-Fri 8AM-5PM):- PHC Site Leads, Inpatient OLs, Access CNLs, Program Directors, Physician Program Directors, VP Acute Clinical Programs, VP Elder Care Programs, VP Medical Affairs, IPAC, Chief Medical Resident, TST Site Lead, Housekeeping Supervisor, Director Pharmacy, Site Leader Diagnostic Imaging, Vancouver Community Director (PHC Liaison), Admin. Assist. Notify the Access Leader and Director, Access and Flow via text/phone re: escalating situation.	At the start of Surge Level 1 At start of Surge Level 2
Clinical Coordinator	**Patient Placement:** - Utilize all available Over Census and Green spaces for patient placement, taking into account patient condition and appropriateness of placement in hallway/lounge spaces. If no patients are suitable for lounge / hallway placement and all Over Census and Green spaces are full, proceed to Surge Level 3. - Check-in with other sites to explore opportunities to transfer patients safely and appropriately.	Within 15 minutes of Surge Level 2
Senior Leader on Call	- Contact Leader on Call to discuss available options re: escalating situation. - Contact Site Leads as needed to discuss available patient placement options to de-escalate the situation until the regular Surge Plan can take effect (Mon-Fri 8AM-5PM).	

Table 3

SURGE LEVEL 3

Mon to Fri 8AM to 5PM

SPH		MSJ	
ED Census	≥ 55	**Patients in ED Overnight**	≥ 5
(and) ED Waiting Room Census	≥ 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	ALL > 100% (Green space all used)	**(or) Inpatient Occupancy**	120% (Green Space all used)
(and) Surgery Slate	UNABLE to Place	**(and) Surgery Slate**	UNABLE to Place
(and) ED Dashboard Status	RED		

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Responsible	Action	Time Frame
Access Director or delegate (Mon-Fri 8AM - 5PM)	**All Actions for Surge Level 1, 2, and:** **Notification:** Notify the following via email [SUBJECT: **Action Requested: Surge Level 3**] outlining the escalating challenge and include the steps taken already:- PHC SLT, PHC CLT, PHC Communications Director, COO Vancouver Community, PHC Department and Division Heads (Medicine, Surgery, Mental Health), VP Acute Clinical Programs, VP Elder Care Programs, VP Medical Affairs, IPAC, all PHC Site Leads, Inpatient OLs, Access CNLs, Program Directors, Physician Program Directors, Chief Medical Resident, Professional Practice Leaders, TST Site Lead, TST Manager, Priority Access Manager, Housekeeping Supervisor, Director Pharmacy, Site Leader Diagnostic Imaging, Vancouver Community Director (PHC Liaison), TST Director, PTN Director, Community MH Director, Community Housing Director, Public Health & Chief Medical Health Officer, Home Health Managers, Community Home Health Director, respective Administrative Assistants	At start of Surge Level 3
Leader, Access and Flow	**Patient Placement:** - Schedule a Surge site Bed Meeting with a call-in number. Notify via email all on the list above to come to the Bed Meeting with their plan to expedite flow. - Frequency of Surge site Bed Meetings depends on the resolution of surge.	Within 15 minutes of Surge Level 3

SURGE LEVEL 3 **Mon to Fri 8AM to 5PM**			
SPH		**MSJ**	
ED Census	≥ 55	**Patients in ED Overnight**	≥ 5
(and) ED Waiting Room Census	≥ 15		
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)
(and) Inpatient Occupancy	ALL > 100% (Green space all used)	**(or) Inpatient Occupancy**	120% (Green Space all used)
(and) Surgery Slate	UNABLE to Place	**(and) Surgery Slate**	UNABLE to Place

(and) ED Dashboard Status	RED		
Responsible	**Action**		**Time Frame**
VP Acute Clinical Programs VP Elder Care Program Inpatient OLs, PDs, PPDs Director, Professional Practice	**All Actions for Surge Level 1, 2, and:** - Establish SWAT Team (OL, PPD, Clinical Coordinator) to review discharge planning for off service patients. - Develop a Communication Plan for site. - Escalate PTN repatriations to site COO level. - Open Green Space at other sites to transfer appropriate patients. - Refer to Regional Mental Health Surge Plan for MH-specific actions. - PDs/OLs to not accept PTN and direct admits unless higher level of care, LLTO, SPH specific. - PPDs to notify physicians to route all non-LLTO requests through PPD and Clinical Coordinator.		Within 60 minutes of Surge Level 3
IPAC	**All Actions for Surge Level 1, 2, and:** - Communicate with Public Health & Chief Medical Health Officer to repatriate clients waiting to go back to closed facilities due to outbreaks.		At start of Surge
COO Vancouver Community TST Manager, Director Priority Access Director TCU Manager, Director Community Directors Residential Director	**All Actions for Surge Level 1, 2, and:** - Open Flex Capacity in Residential sites if there are appropriate clients on the ARTG list. - Prioritize clients who are waiting to return to a closed facility (due to outbreak).		Emergency Site Bed Meeting

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Table 3A	SURGE LEVEL 3 Off-Hours and Weekends			
SPH		**MSJ**		
ED Census	≥ 55	**Patients in ED Overnight**	≥ 5	
(and) ED Waiting Room Census	≥ 15			
(and) # of Admits in ED	≥ 10 (for whom there is no anticipated bed)	**(and) # of Admits in ED**	≥ 1 (for whom there is no anticipated bed)	
(and) Inpatient Occupancy	ALL > 100% (Green space all used)	**(or) Inpatient Occupancy**	120% (Green Space all used)	
(and) Surgery Slate	UNABLE to Place	**(and) Surgery Slate**	UNABLE to Place	
(and) ED Dashboard Status	RED			
Responsible	**Action**			**Time Frame**

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Leader on Call (Weekends, Mon - Fri 5PM - 8AM)	**All Actions for Surge Level 1, 2 (Off-Hours and Weekends), and:** **Notification:** Notify the following via email [SUBJECT: **Action Requested: Surge Level 3**] outlining the escalating challenge and include the steps taken already:- PHC SLT, PHC CLT, PHC Site Leads, Inpatient OLs, Access CNLs, Program Directors, Physician Program Directors, PHC Department and Division Heads (Medicine, Surgery, Mental Health), IPAC, Chief Medical Resident, TST Site Lead, TST Manager, Priority Access Manager, Housekeeping Supervisor, Director Pharmacy, Site Leader Diagnostic Imaging, Vancouver Community Director (PHC Liaison), TST Director, Community MH Director, Community Home Health Director, respective Administrative Assistants Notify the Access Leader and Director, Access and Flow via text/phone re: escalating situation.	At start of Surge Level 3
Clinical Coordinator Senior Leader on Call	**Patient Placement: All Actions for Surge Level 1, 2 (Off-Hours and Weekends), and:** - Schedule a Surge Bed Meeting with all charge nurses. - With direction from Leader on call, notify key participants to come to the Bed Meeting with their plan to de-escalate the situation until the regular Surge Plan can take effect (Mon-Fri 8AM-5PM). - Contact Leader on Call to discuss available options re: escalating situation and whom to call to participate in Surge Bed Meeting. - Facilitate the Surge Bed Meeting.	Within 15 minutes of Surge Level 3

Table 4: Over Census spaces by Unit

Max Spaces: *Total number of designated patient care spaces available in the area, including unfunded space*
Over Census or Flex Space: *Unfunded space used for patient placement with no additional staffing*
Additional Space: *Unfunded space used for patient placement, with additional staffing, after Over Census spaces are full*

SPH Unit	Max Spaces	Location of Over Census space	Location of Additional Space	SPH Unit	Max Spaces	Location of Over Census space	Location of Additional Space
ICU	19	0	4 unfunded	10A Surgery	26	2 Over Census spaces – Flex beds	1 unfunded - lounge
CCU	11	n/a		10B Surgery	26	2 Over Census spaces – Flex beds	1 unfunded - lounge

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CSICU	11	0	2 unfunded	10C HIV	25	1 Over Census space – Flex bed	
PAR/SHAU		Flex beds		10D Palliative	17	Flex beds x 3	2 unfunded
Maternity/NICU	22	Flex beds		PASU MH	13	NA	
5A Cardiac	26	1 Flex bed, 1 lounge		2N MH	20	2 flex beds	
5B Cardiac (surgical)	26	1 Flex bed, 1 lounge	1 unfunded lounge	4NW Eating Disorders	8	1 Over Census space – Flex bed	
6B Renal/Neph/Urol	26	1 Flex bed	10 short stay beds	9A MH	17	2 flex beds	
7A Medicine	25	1 Flex bed		**MSJ Units**			
7B Medicine	27	2 Flex bed, & 1 lounge		1S Geri Psyc		Flex beds x 2	
7C Medicine	26	Flex bed & lounge		3B/C Medicine		Flex beds x 4	6 unfunded
7D Medicine	26	Flex bed & lounge					
8A Medicine	25	Flex bed x 2	4 OPAT spaces	4W Medicine/Surgery		Flex beds x 2	
8C Mental Health	16	Flex beds x 2		4E Geri Medicine		450 & 452	
9CD Ortho/SRU	40	2 Over Census spaces – Flex beds	2 unfunded	ICU		Flex beds x 2	

Table 5: All other available patient care spaces at SPH and MSJ

SPH Area	Spaces	Type of space	MSJ Area	Spaces	Type of space
GI Clinic	12	Stretchers	4 West	4	Closed inpatient spaces
Cardiac Short Stay	18	Stretchers	Surgical Day Care	22	Stretchers (ambulatory spaces)
Surgical Day Care	13	Stretchers (ambulatory spaces)	ED	10	Stretchers
Medical Short Stay	15	Outpatient spaces			

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ED	35	Stretchers

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Exclusions to Surge Action Plan:

The following patients will be kept in the Emergency Department until the assigned bed is available. *All efforts will be made to ensure that the admitted patient will be transferred as soon as possible*.

- Patients requiring greater than 4 litres of oxygen via nasal cannula in hallway or lounge.
- At the discretion of the Emergency Department charge nurse, the patient may be kept in the Emergency Department longer than 30 minutes. (For example, the imminent death of the patient, etc.)
- Patients requiring ICU.
- Rule-out MI or high risk for cardiac event.
- Ventilator dependent patients.
- Mechanical BPAP, CPAP patients.
- Ward (non-mental health) patients requiring constant care attendants or certification until appropriate resources are in place.
- Patients at high risk of invasive infections. See IPAC policy/guidelines to determine priority room allocation for patients requiring Infection Control Precautions during Surge.
- Patients with a Medical Exception to transfer.

References:

Regional Psychiatric Surge Plan

Approved by: Clinical Leadership Team 04 May 2015

Developed By:

Program Director Acute Services

Date of Creation/Review/Revision:

May 2015

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Appendix A - Funding for Staff Redeployment and Off-Service Patients

In instances where a unit's staff and/or beds are available for potential use by another Clinical Program (the off-service program), the following guidelines will be used for deploying and costing the staffing resources.*

Underlying Principles:

1. **Budgeted beds** are an organizational resource. Units will not unilaterally close beds or send staff home without consulting the Clinical Coordinator/Access OL to see if those resources are required organizationally.

2. **Unbudgeted beds (Green Space)** are not an organizational resource. There is no obligation for a program to open closed, unbudgeted beds to accommodate off-service patients unless the off-service program assumes responsibility for staffing and funding the beds.

Scenario Costing Guidelines:

1. If a unit has empty *budgeted* beds:

(a) With staff available

i) The home unit pays for the staff when the beds are utilized for off-service patients.
ii) If staff are redeployed off the unit, the receiving unit incurs the cost of the staff.

(b) With no staff available Prior to closing any beds, the unit checks with the Clinical Coordinator to see if staff should be replaced so that the empty beds can be used for off-service patients. If the beds are used for off-service patients, the home unit pays for the replacement staff. The decision to replace staff will be made in conjunction with capacity planning at the daily bed meeting.

2. If a unit has closed, *unbudgeted* beds (e.g., unfunded beds or planned seasonal closures):

(a) With staff available Prior to sending the extra staff home, the unit checks with the Clinical Coordinator to see if the staff are needed on another unit, in which case the off-service program pays for the staff that are redeployed.

(b) With no staff available The closed beds will not be opened without a discussion with the unit's OL; if a decision is made to open the closed beds to accommodate off-service patients, the off-service program will pay for the staff.

** In all instances, the best interests of the patient will be considered when determining whether staff are redeployed vs. patients moved off-service.*

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