Overcapacity Protocol - Mount Saint Joseph Hospital

Site Applicability: MSJ Hospital only

Skill Level:

Basic: within the scope of practice of every practitioner

Refer to Appendix A for definitions

Clinical Indication:

- to reduce patient risks associated with delayed assessments and extended stays in the emergency department
- to ensure that all patients are receiving the most appropriate care available in the most appropriate location available i.e. patients are not accommodated in a hallway or lounge when a bedhead exists in a unit that can meet their clinical needs
- to ensure that all hospital and community staff are aware when the site is experiencing a surge event
- to ensure that patient flow is maximized within both the hospital and the community
- to ensure that all staff understand their role during a surge event
- to ensure the equitable distribution of workload amongst care providers and teams
- to ensure the most efficient use of available resources such as baseline staff and funded bed heads

Need to Know:

A surge is a sudden, significant increase in what is usually a relatively consistent volume of activity. It is time limited and has an identifiable beginning and end. A surge requires management strategies that are distinct from those used to manage congestion resulting from normal daily activities.

The Site Overcapacity Protocol is a planned escalation framework for managing critical site wide congestion resulting from a surge in demand for inpatient capacity. The Overcapacity Protocol (OCP) will be activated when all of the following have occurred:

- the emergency department has reached site specific triggers
- all potential discharges within the site have been realized
- all funded bed heads have been assigned

Published by: Providence Health Care, Vancouver, BC

- all off-service options have been exhausted

If critical site wide congestion persists after the OCP has been completed (refer to Appendix C), the Executive on Call will be contacted for direction regarding the opening of PODs (refer to Appendix D).

Each program will be responsible for the development of a program/unit specific protocol that aligns with the clinical indications and principles of the site based protocol. This protocol will be used when there is program surge versus site wide surge.

PRACTICE GUIDELINE

Principles

- Each inpatient unit will identify two (2) unfunded locations to be used for this protocol (refer to Appendix B)
- OCP locations will be bedheads wherever possible
- Staffing resources for OCP locations will come from unit baseline staffing
- OCP will be called between 0800 and 2300, Monday to Friday. After hours, the Leader on Call will be contacted to direct responses to any surge activities
- The Access Coordinator/Clinical Coordinator will assess the need to move to OCP and will ensure that processes are consistently followed
- The Access Coordinator/Clinical Coordinator will support the placement of appropriate patients into OCP locations to ensure patient needs match services provided
- Beds cannot be held on speculation of potential need. They must be associated with designated incoming patients
- Once OCP is called and patient is identified for a unit, the patient move will occur within 15 minutes
- The post surge priority on the unit is to return to normal census
- The post surge priority for the site is to repatriate off-service patients to their appropriate service

Refer to Appendix C for Protocol

Expected Outcomes:

This protocol is intended to provide a consistent, system wide framework for managing surge activity. It is not intended to manage unit or program specific surge activity that is guided by unit or program specific protocols.

Published by: Providence Health Care, Vancouver, BC
Questions, concerns, comments about PHC guidelines can be emailed to: nursingstds@providencehealth.bc.ca

Persons/Groups Consulted:

Clinical Nurse Leader, Surgery
Coordinator, Distribution Services
Mental Health Bed Coordinator
Patient Care Manager, Access Services and Staff Scheduling office
Patient Care Manager, Cardiac
Patient Care Manager, Emergency, Access
Patient Care Manager, HIV/AIDS and Addictions
Patient Care Manager, Maternity
Patient Care Manager, Medicine
Patient Care Manager, Mental Health
Patient Care Manager, Palliative Care and Geriatric Ambulatory Services
Patient Care Manager, Renal
Patient Care Manager, Surgery
Patient Flow Committee (October, November 2017)
Professional Practice Leader, Occupational Therapy
Professional Practice Leader, Physical Therapy
Professional Practice Leader, Social Work
Program Director, Emergency, ICU, Cardiac
Project Leader, Mental Health
Senior Leadership Team (December 2017)

Developed By:

Corporate Director Acute

Approved By: Professional Practice Standards Committee

Date of Creation/Review/Revision:

February 2018

Appendix A: Definitions

Bed head: a bed location designed for patient care. In most clinical areas this will include gases, suction, nurse call systems, curtains or walls.

Funded bed head: has allocated budget. Staffing budgets are based on the number of these.

Unfunded bed head: does not have allocated budget. May require additional staff to operate.

OCP bed: locations identified to be used only as part of the OCP. The may be unfunded bed heads or non-equipped locations i.e. hallways, lounges

Designated incoming patient: includes but may not be limited to patients on the scheduled and emergency surgical slates, patients for admissions to tertiary level programs with scheduled procedures, patients accepted through PTN for LLTO or higher level of care, direct admits scheduled for cancer treatment.

POD: a group of co-located beds that can be opened to serve a specific patient population and, unlike OCP beds, will require additional staffing resources to operate. Opening of these groups of beds will require the approval of a member of the Senior Leadership Team.

Published by: Providence Health Care, Vancouver, BC
Questions, concerns, comments about PHC guidelines can be emailed to: nursingstds@providencehealth.bc.ca

Appendix B: OCP Bed Locations

PROGRAM	UNIT	BEDS (2)
Medicine	3A	2
	3B	2
	4W	2
Psychogeriatrics	1S	2
HAU		2
Geriatrics	4E	2
TOTAL		12

Published by: Providence Health Care, Vancouver, BC

Appendix C: Protocol

Overcapacity		
All Triggers Appear to be Met		
• the emergency department has reached site specific triggers: less than 2 acute stretchers available, CTAS 1-3 targets for triage to Doctor time are not being met. • all potential discharges within the site have been realized • all funded bed heads have been assigned • all off-service options have been exhausted		
Responsible	**Action**	**Time Frame**
Access Manager/Clinical Coordinator	• Verify occupancy and discharge status with each unit to confirm triggers have been met. ○ If verified, notify Access Manager or Leader on Call that triggers have been met ○ Call an extraordinary bed meeting within 30 minutes. The regularly scheduled bed meeting may be used if it is occurring during this time frame. • Notify the following via email [SUBJECT: **Action Requested: Surge Level 1**] outlining the challenge, request for support to identify additional discharges, request for support for staff to manage additional workload. **TO:** 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 PCMs, 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	At the start of Surge Level 1 Within 15 minutes of Surge

Published by: Providence Health Care, Vancouver, BC

	• Announce OCP on overhead paging system	
Responsible	**Action**	**Time Frame**
Inpatient CNLs, PCMs, PDs, PPDs	• - Connect with teams and Physicians to identify a plan to expedite discharges and transfers. • Ensure Overcapacity locations are prepared to receive patients • Review any barriers to discharge and escalate to Community resources/partners. • Communicate plans to Access Manager/Clinical Coordinator • Liaise with patients and families as necessary	Within 30 minutes of notification
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. • - Report updates to unit CNL/charge	Within 30 minutes of notification
Access Manager, Clinical Coordinator or Leader on call after hours	**Patient Placement:** • To the designated off-service Over Census spaces, at the discretion of the Clinical Coordinator depending on patient care needs. • Send email updates via email original distribution list as necessary	Within 45 minutes of Surge
Inpatient CNLs, PCMs, PDs, PPDs	• Ensure that patients are pulled quickly to Overcapacity beds and admitted to unit	Within 15 minutes of bed assignment

Published by: Providence Health Care, Vancouver, BC

Appendix D: POD Beds Activated by Senior Leadership Team

Unfunded bed heads on 3A/B in increments of 4

These beds will require additional staffing resources in order to open. The Clinical Coordinator will identify the service best suited to occupy the beds (e.g. medicine, geriatrics) and coordinate the request for staff and support services that have the skill sets to best manage the clinical needs of that patient population. The most responsible program will provide leadership support around decanting these beds to the appropriate service as soon as possible. Staff will be costed to the unit where the activity is occurring.

Published by: Providence Health Care, Vancouver, BC
Questions, concerns, comments about PHC guidelines can be emailed to: nursingstds@providencehealth.bc.ca