Southern Health-Santé Sud Capacity Management Protocol

Site Specific Plan – Altona Memorial Health Centre (AMHC)

Purpose:
Coordination of patient flow and identification of priority areas of concern related to overcapacity requires active management of overall beds, across all services within a facility. Prioritization (inflows/outflows) considerations, based on degree of risk occurring related to overcapacity, include:

- Patient need;
- Specialized services only available at specific sites;
- Capacity across all service deliver organizations; and/or
- Provider resources including physical space.

Provide a standardized process that supports appropriate response to surges in activity and overcrowding in Emergency Department (ED) and to mitigate barriers to patient flow. The Capacity Management Protocol outlines standard work under conditions moving from "No Safety Risk" (white) to "System Safety Risk Exceeded Available Capacity" (black), see Capacity Management Protocol CLI.4110.PL.030.

Transfers:

- Lower acuity patients flow from higher acuity EDs/facilities reporting higher occupancy levels to the site closest to the patient's home within their home health region that can meet the patients care needs.
- Transfers to a facility outside a patient's home health region are considered if the patient needs to be moved further away from home within their home region than to the site outside their home region.
- Sites with available beds may not delay or refuse acceptance of patients when safe patient care can be provided at the facility with available capacity.
- Where patients and families have concerns regarding repatriations, transfers or destination decisions, patient flow along with clinical teams and leadership work with the patients to support the transition of care. Provincial tools are available to support teams/staff.

ED Overcrowding Score:

- Regional Sites – as indicated by Emergency Department Information System (EDIS)
- Community Acute Sites – total patients registered in ED divided by total funded spaces

Legend: The following levels and minimum standards apply to Service Delivery Organization/Health Authorities and Health organizations, their staff, operational, clinical, and medical leadership supporting a provincial response standard to reduce risks and manage system, regional and facility capacity levels. The actions within each level are progressive, building off the other across each level.

Level		ED Overcrowding Score (NEDOCS/CEDOCS/ ED/UC OCCUPANCY	Site Occupancy
0	Level 0 (White) – No Safety Risk - Capacity Available	< 50	Occupancy < 70%;
1	Level 1 (Green) – Low Safety Risk Due to Overcapacity	51 - 100	Occupancy* 71 - 85%;
2	Level 2 (Orange) – Medium Safety Risk Due to Overcapacity	101 - 140	Occupancy 86 - 90%;
3	Level 3 (Red) – High Safety Risk Due to Overcapacity	141 - 180	Occupancy 91 - 100%;
4	Level 4 – (Black) System Safety Risk and Exceed Available Capacity	Greater than 181	Occupancy exceeds 100%

Site Capacity: Baseline Funded Beds - (insert name of site)

ED Beds (including Outpatient): 6	Medicine: 22

See Provincial Dashboard for more detailed information.

Standard Actions:

Facility Units			Date, Time, Initial
Inpatient Unit Staff	Level 0	• Daily site round to assess patient's readiness for discharge and identify barriers to discharge. • Monitor capacity and identify flow risks. • Actively working to maximize occupancy by pulling ED admissions to inpatient units within 30 minutes. • Regularly review Infection, Prevention & Control (IPC) processes and cohorting patients where possible. • Bed management – units/sites are actively reporting bed census in Electronic Patient Record (EPR) including beds in operation, bed closures, Alternate Level of Care (ALC) designations, occupancy and patient discharges. • Where patients or families have concerns re: transfer/repatriation, work with patient flow, Clinical Resource Nurse (CRN), site manager, director and physicians to problem solve. • Coordinate off site transport for follow up appointments, diagnostics, specialty services to	

Inpatient Unit Staff		optimize efficiency and reduce delay and minimize unnecessary travel. • Enter patient transport requests as soon as known. • Transport Delay: Contact MTCC for status update. • Ensure housekeeping is notified of discharges. • Ensuring vaccinations are offered at point of care contacts within acute care (i.e. ED visits, offering to long stay in patients).	
	Level 1	• Sites in Level 1 hold admissions in ED to accommodate incoming transfers from higher acuity sites reporting a higher overcapacity risk. • Begin utilization of 'over census' beds where applicable. • Proactively move patients where estimated remaining length of stay (LOS) is greater than 3 days into facilities that regularly have capacity within their own health region. • CONSIDER ALC or lower acuity patients transferred to facilities at Level 0 where estimated LOS is greater than 3 days, ALC and/or low acuity transport is available.	
	Level 2	• Sites in Level 2 or higher with incoming repatriations or lower acuity transfer from a site reporting higher capacity risk level accommodate by: ○ Hold admissions in ED; ○ Utilize all off census or temporary spaces available; ○ Redirecting requests to alternate sites within patients' home health region; OR ○ Redirecting request to alternate sites in another health region that is reporting lower overcapacity risk AND is closer to their home community/Personal Care Provider (PCP); ○ Off service patients to utilize all available spaces. • Expedite discharges on the unit.	
	Level 3	• Pending consults, diagnostics and investigations are triaged and expedited to account for facility risk. • Ensure rooms are cleaned promptly to facilitate bed availability. • ALC or lower acuity patients transferred to facilities at Level 0 where estimated LOS is greater than 3 days, ALC and/or low acuity transport is available.	
	Level 4	• All available spaces are being used and additional bed spaces are made available.	

		• Call in Heavy Workload Relief (HWR) nursing, Health Care Aide (HCA) or unit clerk as required, with manager approval. • Follow Code Orange if applicable.	
ED Staff	Level 0	• Bed management – EDs are actively reporting bed census in ERP/EDIS including ED closures, ventilated and transferrable patients in critical care. • Where patients or families have concerns re: transfer/repatriation, work with patient flow, CRN, site manager, director and physicians to problem solve. • Coordinate off site transport for follow up appointments, diagnostics, specialty services to optimize efficiency and reduce delay and minimize unnecessary travel. • Actively working to maximize occupancy by sending ED admissions to inpatient units within 30 minutes. • Flag ED patients pending reassessment and/or pending admission orders. • Continually re-evaluate patient need to occupy stretcher in collaboration with physicians (i.e. move to chair or waiting room). • Ensure faxed/phone report is completed when bed available on receiving ward. • ED patient is discharged from Admission/Discharge/Transfer (ADT)/EPR and or changed service level 24-7. • To include Regional Pharmacy Support to complete Med Requisitions.	
	Level 1	• Consider holding patients to relieve other units' who are experiencing higher safety risks, within region and provincially. • Begin utilization of 'off census' beds where applicable. • Proactively move patients where estimated remaining LOS is greater than 3 days into facilities that regularly have capacity (within their own health region). • Consider ALC or lower acuity patients transferred to facilities at Level 0 where estimated LOS is greater than 3 days, ALC and/or low acuity transport is available.	
	Level 2	Unit in Level 2 or higher with incoming repatriations or lower acuity transfer from a site reporting higher capacity risk level accommodate by: • Utilize all over census or temporary spaces available; • Redirecting requests to alternate sites within patient's home health region; OR	

		• Redirecting request to alternate sites in another health region that is reporting lower overcapacity risk AND is closer to their home community/PCP; • Expedite discharge of patients in ED; • Actively coordinate flow of patients through the ED (i.e. lab result review). • Ensure nursing handover to unit team completed within 5 hours of bed assignment. • Enter patient transport request as soon as known. • Transport delay, contact MTCC for status update. • Ensure housekeeping notified of discharge prior to 1430 daily.	
	Level 3	• Pending consults, diagnostics and investigations are triaged and expedited to account for facility risk. • Consider implementing Nurse Managed Care. • Ensure ED nursing handover to receiving unit team within 3 hours of bed assignment. • For sentinel events related to clinical acuity consider calling a Code Blue for additional supports.	
	Level 4	• All available spaces are being used and additional bed spaces are made available. • Consider implementing Nurse Managed Care Call in HWR nursing, HCA or unit clerk as required, as approved by manager. • Follow Code Orange if applicable.	
	Level 0	• Daily site rounding to proactively identify barriers to discharge and set/monitor expected date of discharge with manager and physician. • Monitor capacity and identify flow risks. • Monitor patients' length of stay and hold regular case planning/rounds to ensure monitoring and discharge planning occur. • ED and direct admissions of lower acuity are safely directed to community, primary care or lower acuity facility (including Transitional Care Unit (TCU)), active presence of home care case coordinators in ED to facilitate discharge to community. • Interdisciplinary teams actively collaborate with community partners on discharge planning and solutions for patients deemed to be ALC. • Bed management – units/sites are actively reporting bed census in EPR including beds in operation, bed closures, ALC designations, occupancy and patient discharges.	

CRN/Charge Nurse		• Sites with available beds may not delay or refuse acceptance of patients when safe patient care can be provided at a facility with capacity. • Where patients or families have concerns re: transfer/repatriation, work with patient flow, site manager, director and physicians to problem solve. • Daily review of inter-regional repatriation requests/out of region and out of province/country. • Pull patients from ED and provide times beds will be ready. • Attend daily site and regional huddles as when required. • Follow CLI.4110.PL.008 Interim Placement for Patients Waiting Personal Care Home Placement.	
	Level 1		
	Level 2	• Off service patients to utilize all available spaces, if applicable.	
	Level 3	• Patients are admitted into available beds beyond existing admission criteria as long as their clinical needs can be met.	
	Level 4	• All available spaces are being used and additional bed spaces are made available. • Follow Code Orange if applicable.	
CRN/Charge Nurse - ED Specific Tasks	Level 0	• Bed management – EDs are actively reporting bed census in ERP/EDIS including ED closures and ventilated and transferrable patients in critical care. • Review admitted patients in ED and flag patients who meet surge criteria. • Report out ED Capacity Level and review ED admissions at shift huddle. • Flag ED patients pending reassessment and/or pending admission orders. • Continually re-evaluate patient need to occupy stretcher in collaboration with physicians (i.e. move to chair or waiting room). • Ensure faxed/phone report is completed to receiving unit.	
	Level 1		
	Level 2	• Expedite discharge of patients in ED. • Actively coordinate flow of patients through the ED (i.e. lab result review).	
	Level 3	• Notify manager of increase in capacity level. • Consider transferring patients from ED directly to another site if appropriate (lower acuity patients could	

		be admitted to community hospitals instead of regional center). • Consider implementing Nurse Managed Care. • Consider implementing Suspension of Services, in collaboration with ED Physician, Director, Health Services and/or Manager, Health Services. • For sentinel events related to clinical acuity consider calling a Code Blue for additional supports.	
	Level 4	• Follow Code Orange Protocol if applicable. • Emergency huddle with MDs, Manager, CRN and Director/SLT. • Consider implementing Nurse Managed Care. • Consider implementing Suspension of Services, in collaboration with ED Physician, Director, Health Services and/or Manager, Health Services. • If community hospitals have empty beds, transfer low acuity patients directly from ED to be admitted in community hospital (even if local patient).	
Health Services Manager(s)	Level 0	• Daily site rounding to set/monitor expected date of discharge with CRN and physician. • In collaboration with HIS actively monitor/report beds in operation and closed beds. • Monitor capacity and identify flow risks. • Monitor patients' length of stay and hold regular case planning/rounds to ensure monitoring and discharge planning occur. • ED and direct admissions of lower acuity are safely directed to community, primary care or lower acuity facility (including TCU), active presence of home care coordinators in ED to facilitate discharge to community. • Interdisciplinary teams actively collaborate with community partners on discharge planning and solutions for patients deemed to be ALC. • Promote PCH paneling form home rather than hospital whenever possible and safe to do so. • Bed management – units/sites are actively reporting bed census in EPR including beds in operation, bed closures, ED closures and ventilated, transferrable patients in critical care, ALC designations, occupancy and patient discharges. • Sites with available beds may not delay or refuse acceptance of patients when safe patient care can be provided at a facility with capacity.	

		• Where patients or families have concerns re: transfer/repatriation, work with patient flow, CRN, director and physicians to problem solve. • Participate in daily site and regional 0930 bed call. Identify site risks, challenges. Input site bed numbers on regional bed call template via Teams Channel. • Ensures weekly A&D rounds are set up for each unit. • Ensure actions outlined in capacity plan are being followed. • Follow CLI.4110.PL.008 Interim Placement for Patients Waiting Personal Care Home Placement.	
	Level 1		
	Level 2	• Off service patients to utilize all available spaces. • Communicate to inpatient unit teams that site is Alert Level 2. • Ensure teams are aware of timelines to pull patients. • Support teams in determining where to transfer patients.	
	Level 3	• Patients are admitted into available beds beyond existing admission criteria as long as their clinical needs can be met. • Communicate to inpatient unit teams that site is Alert Level 3. • With PCC (physician) review all patients to identify possible discharges that could be expedited. • Provide clear and concise direction to teams on pulling patients. • Attend afternoon shift huddle. • ED Specific – consider implementing Nurse Managed Care. • ED Specific - Consider implementing Suspension of Services, in collaboration with ED Physician, Director, Health Services and/or Manager, Health Services.	
	Level 4	• All available spaces are being used and additional bed spaces are made available. • Follow Code Orange if applicable. • Communicate to inpatient unit teams that site is Alert Level 4. • Once notified, support teams to accept admissions out of ED as assigned. • Schedule additional 1230 bed huddle to reassess site capacity and make plans to get through evening/night. Communicate plans to units at afternoon huddle.	

		• ED Specific – consider implementing Nurse Managed Care. • ED Specific - Consider implementing Suspension of Services, in collaboration with ED Physician, Director, Health Services and/or Manager, Health Services.	
OR/SDS Specific	Level 0		
	Level 1		
	Level 2		
	Level 3		
	Level 4		
Bed Utilization			
Regional Patient Flow Coordinator	Level 0	• Monitor capacity and identify flow risks. • Lead daily regional flow call that includes on an 'ad hoc' basis primary and community stakeholders which reviews site-based reporting, escalation of flow risks, patient safety risks, potential or imminent service disruption, opportunities to facilitate regional cooperation that mitigate flow risks and reduce length of stay. • Monitor patients' length of stay and hold regular case planning/rounds to ensure monitoring and discharge planning occur. • ED and direct admissions of lower acuity are safely directed to community, primary care or lower acuity facility (including TCU), active presence of home care coordinators in ED to facilitate discharge to community. • Bed management – units/sites are actively reporting bed census in EPR including beds in operation, bed closures, ED closures and ventilated, transferrable patients in critical care, ALC designations, occupancy and patient discharges • Sites with available beds may not delay or refuse acceptance of patients when safe patient care can be provided at a facility with capacity. • Where patients or families have concerns re: transfer/repatriation, work with CRN, site manager, director and physicians to problem solve • Monitor risks across the SDO related to capacity and disruptions. • Work in partnership with provincial Patient Flow Teams to coordinate incoming transfers to sites that provide specialized services in a manner that aims to distribute and mitigate risk.	
	Level 1		

	Level 2	• Senior Clinical Leads work to remove barriers to flow (i.e. authorization of reasonable expenses such as equipment, local private transport)	
	Level 3	• Patients are admitted into available beds beyond existing admission criteria as long as their clinical needs can be met. Escalation to 'Department' to seek approval regarding options for patients waiting in AC who are designated as ALC for access to options which include: • Providing enhanced home care support for patients that can be discharged early; • Temporary ALC placement; • Temporary living situation; • Emergency housing/rent aid; • Authorization to purchase, reimburse or provide compensation to third party or family as temporary option (i.e. Allied Health Services).	
	Level 4	• In partnership with PCH operators and continuing care facility operators consider opening additional spaces in TCU or PCU facilities.	
Medical Team			
Physician – Inpatient Specific	Level 0	• Daily site rounds to set/monitor expected date of discharge with CRN and manager. • Monitor capacity and identify flow risks. • Monitor patients' length of stay and hold regular case planning/rounds to ensure monitoring and discharge planning occur. • Where patients or families have concerns re: transfer/repatriation, work with patient flow, CRN, site manager, and director to problem solve. • Ensuring continuation of the offering of vaccinations at inpatient and all primary care visits. • With team, establish goals of care and EDDs. • Daily review of patients progress towards discharge including list of Waiting Placement patients that is discussed at weekly rounds. • Identify complex discharges and work with the interdisciplinary team to address barriers to discharge. • Ensure patient under correct service (transfer care to different service as needed). • Write anticipatory discharge orders. • Support discharges occurring prior to 1100.	
	Level 1		

	Level 2	• Senior Clinical Leads and Chief Medical Officer work to remove barriers to flow (i.e. authorization of reasonable expenses such as equipment, local private transport). • "Run the board" of inpatients to see if discharge could be considered for each patient. • Work with interdisciplinary team to consider discharges and non-hospital environment of care. • Consider awaiting placements, and transfer to transitional care. • Weekend alert to Home Care re: possible weekend discharges. • Provide Doc-to-Doc for transferred patients. Make transfer issue list for on-call physicians who may transfer patient.	
	Level 3	• Patients are admitted into available beds beyond existing admission criteria as long as their clinical needs can be met. • Consider calling in additional Prescribers to assist with overflow. • Discuss with team about curtailing services. • If weekday, Chief of Staff to communicate with medical staff re: capacity level at site and strategize on options to discharge patients or send to other sites. • Charge Nurse gives physician a list of facilities that could accept patients for weekend transfers. Identify priority patients to be transferred. (Charge Nurse to get family discussion underway), if needed notify family and do transfers to accepting physicians. • Be informed regarding transfer level of agreement (Willing vs mandatory transfers – awaiting placement vs. only acute medicine transfers).	
	Level 4	• Site physician and Chief Medical Officer - After all other options have been exhausted, sites in Level 4 with incoming repatriation/low acuity transfer from sites also in Level 4, redirect all requests for clinical service that can be provided at alternative sites in any health regions with available capacity within 200kms from home community. • Communication with patient and family and assessment of social supports is considered. • Follow Code Orange Protocol if appropriate. • Emergency huddle with physician, manager, CRN and Director/Senior Leadership Team.	

Physician – ED Specific	Level 0	• Monitor capacity and identify flow risks within ED.	
	Level 1	•	
	Level 2	• "Run the board" of ED and Inpatients to see if discharge could be considered for each patient. • Identify patient for early discharge with ED reassessment.	
	Level 3	• Patients are admitted into available beds beyond existing admission criteria as long as their clinical needs can be met. • Consider calling in additional Prescribers to assist with overflow. • Discuss with team about curtailing services. • Consider implementing Nurse Managed Care. • Consider implementing Suspension of Services, in collaboration with ED Physician, Director, Health Services and/or Manager, Health Services.	
	Level 4	• Follow Code Orange Protocol if appropriate • Emergency huddle with physician, manager, CRN and Director/SLT • Consider implementing Nurse Managed Care. • Consider implementing Suspension of Services, in collaboration with ED Physician, Director, Health Services and/or Manager, Health Services.	
Acute Care Leadership			
Director, Health Services - Community Acute Hospitals	Level 0	• Identify and escalate imminent system impacts to Regional Patient Flow Coordinator. • Where patients or families have concerns re: transfer/repatriations, work with patient flow, site manager, CRN and physicians to problem solve. • Attend/lead daily site briefing/huddle to help expedite flow coordination and remove barriers to flow.	
	Level 1		
	Level 2	• Senior Clinical Leads work to remove barriers to flow (i.e. authorization of reasonable expenses such as equipment, local private transport). • Work with other community sites to identify potential available beds/staff.	
	Level 3	• If applicable, review of scheduled surgical cases by priority and target date, consider rescheduling cases that are within target, non-cancerous and priority 3, 4, 5 which require an in-patient bed to accommodate emergency cases or other system demand. • Redirect any available staff to high need areas for support (note within Collective Agreement).	

		• Patients are admitted into available beds beyond existing admission criteria as long as their clinical needs can be met. • Escalate the situation to Regional Lead - Acute Care & Chief Nursing Officer. • ED Specific – consider implementing Suspension of Services, in collaboration with ED Physician, Director, Health Services and/or Manager, Health Services.	
	Level 4	• In partnership with PCH operators and continuing care facility operators consider opening additional spaces in TCU or PCH facilities. • After all other options have been exhausted, sites in Level 4 with incoming repatriation/low acuity transfer from sites also in Level 4, redirect all requests for clinical service that can be provided at alternative sites in any health regions with available capacity within 200kms from home community. • Communication with patient and family and assessment of social supports is considered • ED Specific – consider implementing Suspension of Services, in collaboration with ED Physician, Director, Health Services and/or Manage, Health Services. • Follow Code Orange if applicable.	
Senior Leadership Team	Level 0	• Standard practice.	
	Level 1		
	Level 2	• Senior Clinical Leads work to remove barriers to flow (i.e. authorization of reasonable expenses such as equipment, local private transport).	
	Level 3	• Redirect any available regional staff to high need areas for support (note within Collective Agreement). Chief Medical Officer: • Escalation to 'Department' to seek approval regarding options for patients waiting in Acute Care who are designated as ALC for access to options which include: ○ Providing enhanced home care support for patients that can be discharged early; ○ Temporary ALC placement; ○ Temporary living situation; ○ Emergency housing/rent aid; ○ Authorization to purchase, reimburse or provide compensation to third party or family as temporary option (i.e. Allied Health Services).	

	Level 4	• In partnership with PCH Directors consider opening additional spaces in TCU or PCH facilities. • After all other options have been exhausted, sites in Level 4 with incoming repatriation/low acuity transfer from sites also in Level 4, redirect all requests for clinical service that can be provided at alternative sites in any health regions with available capacity within 200kms from home community. • Communication with patient and family and assessment of social supports is considered.	
Support Services & Allied Health Onsite			
Support Services (EVS)	Level 0	Standard practice	
	Level 1		
	Level 2	• Meet with team and instruct to prioritize patients where discharge is pending. • Prioritize cleaning of patient rooms on units so patients can be transferred.	
	Level 3	• Explore calling in HWR or moving resources from other areas to come and support site to promote discharges. • Support team in removing barriers to discharge. • Approve overtime as required.	
	Level 4	• Call in HWR, per manager approval. • Follow Code Orange protocol if appropriate.	
Rehab Services Manager and Director	Level 0	• Weekly monitor of Rehabilitation Services workloads at community and regional acute sites.	
	Level 1	• Reallocation of OT, PT and Rehab Assist staff from same area lower acuity caseloads in Community, Long Term Care and Outpatient services to acute care in both regional and community sites.	
	Level 2	• Consider shifting staffing resources from one regional site area to site areas of higher caseload needs.	
	Level 3	• Consider opportunities to support increased discharges through improved weekend coverage staffing ratios and approval of overtime/additional shifts.	
	Level 4	• Site Specific Huddles to review clients awaiting services and assignment of resources. • Consider utilizing staff from Children and Youth services to augment adult services staffing (where competency allows for this reallocation of caseload).	
	Level 0	• Standard practice.	
	Level 1		

Shared Health: Lab and Diagnostics	Level 2	• Collaborate on interdisciplinary team to identify needs and strategies. • Prioritize processing ED patients' laboratory and diagnostic imaging needs without placing other patients at risk. • Consider the need to increase staffing to respond to the overcapacity need and call in extras based on need. • Assess need for extra supplies/resources. Respond according to need's assessment.	
	Level 3	• Call in extra staff to process more diagnostic investigations if indicated. • Call Shared Health Diagnostic Administrator On Call.	
	Level 4	• Follow Code Orange Protocol if applicable.	
Community Programs			
LTC Access Coordinator	Level 0	• Continue usual practice of filling transitional care beds according to prioritized need: 1. Community urgent or palliative requests. 2. Repatriation requests that are appropriate for sub-acute care. 3. ALC patients who are waiting placement in acute care.	
	Level 1		
	Level 2	• Prioritize urgent admission of ALC patients to available transitional care (TC) beds to free up acute care bed capacity. • Work with PCHs to review prioritization of admission of patients from acute care, balancing community urgent/palliative needs as well to reduce the number of individuals that may present to ED.	
	Level 3	• Level 0 & 2 actions continue plus: ○ Work with Regional Patient Flow Coordinator to identify patients that are appropriate for expedited PCH/TCU admission including interim placement. ○ Disseminate potential patient information to available sites for review. • Once PCH/TC site has been identified for admission work with sites to help facilitate communication of required information. • Communicate with Director, Health Services/PCH Managers over capacity status. • Compile list of closed PCH/TC Beds/Units from the sites and share with Director, Health Services.	
	Level 4	• Level 0, 2 & 3 actions continue plus:	

		○ Review with Regional Patient Flow Coordinator individuals that are appropriate to be placed in identified TC treatment rooms. Ideally, patients can ambulate independently (with or without aide) in order to facilitate toileting.
Home Care Program	Level 0	• Interdisciplinary teams actively collaborate with community partners on discharge planning and solutions for patients deemed to be ALC. • Promote PCH paneling from home rather than hospital whenever possible and safe to do so. • ED and direct admissions of lower acuity are safely directed to community, primary care or lower acuity facility (including TCU), active presence of home care case coordinators in ED (where available) to facilitate discharge to community. • Priorities for service provision: 1. Acute Care Waiting Discharge; 2. Palliative Care; 3. Community Urgent. • Weekly Home Care Huddles held to review clients awaiting services and assignment of resources.
	Level 1	
	Level 2	
	Level 3	• Discussions and planning to balance needs of community urgent and palliative clients with the needs of the clients' requiring discharge, to mitigate presentation to acute care.
	Level 4	• Site Specific Huddles to review clients awaiting services and assignment of resources. • Discussion and planning to balance needs of community urgent and palliative clients with the needs of clients' requiring discharge, to mitigate presentation to acute care.
	Level 0	• Receives new referrals (CLI.5410.PL.003.FORM.01 and CLI.5410.PL.003.FORM.02). • Receives communication re: existing clients who have been admitted to hospital (Facility/Home Care Coordinator Communication Tool). • Attends rounds on each inpatient unit. • Plans for client discharge, including client assessment; discussion with caregiver; planning with health care team for necessary supplies and equipment. Reviews options for home care services, including Self and Family Managed Care.

Hospital Based Home Care Case Coordinator/ Case Coordinators where no HBCC present		• Collaborate with acute care teams to identify barriers to discharge and explore solutions. • Prioritizes work based on patients that could be discharged same day/next day.	
	Level 1	•	
	Level 2	• Prioritizes work based on hospital discharges 24 hours out.	
	Level 3	• Prioritizes work based on hospital discharges 48 hours out to determine if they can be expedited. • Reviews existing home care clients to see if possible to discharge patient home with community/family supports while they await home care supports. • Reviews barriers to discharge to determine if there is an interim solution (i.e. supplies, equipment, agency) • Anticipate escalation from Acute Care team partners to seek approval regarding options for patients waiting in acute care or transitional care beds who are designated as ALC for access to options could include: ○ Providing enhanced home care support for patients that can be safely be discharged early.	
	Level 4	• Prioritizes work based on hospital discharges 72 hours out to determine if they can be expedited. • Reviews existing home care clients to see if possible to discharge patient home with community/family supports while they await home care supports. • Reviews barriers to discharge to determine if there is an interim solution (i.e. supplies, equipment, agency). • Reviews clients who are ALC waiting placement to bring forward for discussion if any of them can be discharged and wait at home with an increase in supports.	
Home Care Leadership	Level 0	• Support the Case Coordinators and Resource Coordinators with discharge planning as required.	
	Level 1		
	Level 2		
	Level 3	• Explore options to expedite discharges, inclusive of staffing resources and reprioritization of clients/work	
	Level 4	• Explore options to expedite discharges, inclusive of staffing resources, reprioritization of clients/work, and Senior Leadership direction.	
	Level 0	• Work in collaboration with Long Term Care (LTC) Access Coordinator to admit into available TCU/PCH per usual practice.	

PCH/TCU Sites		• Those PCHs who offer respite services can continue as per usual schedule. • Ensuring continuation of the offering of vaccinations at PCHs/TCUs.	
	Level 1		
	Level 2	• Work with LTC Access Coordinator to review prioritization of admission of patients from acute care, balancing community urgent/palliative needs as well to reduce the number of individuals that may present to ED.	
	Level 3	• Notify admitting providers of overcapacity protocol and the need to expedite admissions. • Pause any maintenance projects that affect bed flow until over capacity protocol ended. • Review with Support Service Leads the potential to bring in additional staffing to expedite terminal cleans, etc. to turn beds around quickly. • Review potential to bring in additional Nursing/HCA staff to support the expedited admission process. • PCHs who offer respite postpone scheduled respite to admit temporary ALC patient on respite until acute care capacity stabilizes, at which time the ALC patient is returned to acute care if a PCH bed not available. • Provide LTC Access Coordinator with number of any PCH/TC beds/units that are currently closed due to staffing.	
	Level 4	• PCHs/TCUs directed to admit into all available beds immediately from ALC patients waiting placement in acute care. Expedited admission process to be followed. • Review with Director, Health Services any current respite admissions and determine if admission can be ended early. • Determine staffing needs for any closed PCH beds/units and review with Director, Health Services to determine if additional beds can be opened with increased staffing. • Work with Human Resources to review redeployment as needed to open closed beds/consideration to liaise with agency staff as well to support staffing for opening units. • Review/Consider admitting into TC treatment rooms if available safety resources in place in the rooms (i.e.	

		call bell), and patient is identified as short stay admission. • Review any medical TCU patients that are awaiting service initiation. Work with Home Care/Palliative Care to see if initiation of services can be expedited and discharge can occur.	
Personal Care Home Director/Manager	Level 0	• PCH and TCU facilities must be 'bed ready', meaning they are actively prioritizing, triaging and pulling patients to beds where available. • Ensuring continuation of the offering of vaccinations at PCHs/TCUs. • Support the LTC Access Coordinator with site discussions as needed.	
	Level 1		
	Level 2	• Work with LTC Access Coordinator to review prioritization of admission of patients from acute care, balancing community urgent/palliative needs as well to reduce the number of individuals that may present to ED.	
	Level 3	• Anticipate the need to partner with PCH and TCU teams for possible opening of additional spaces. • Support the LTC Access Coordinator with site discussions as needed. • Review list of closed TCU/PCH beds/units received from LTC Access Coordinator with site leadership closely to determine if any can be opened to assist. • Communication to Home Care and LTC sites that respite admissions are halted until directed otherwise. • Communicate to Home Care that Community urgent admissions are paused until overcapacity status decreases.	
	Level 4	• In partnership with PCH operators and continuing care facility operators consider opening additional spaces in TCU or PCH facilities. • Support the LTC Access Coordinator with site discussions as needed. • Meeting with LTC Access Coordinator, Directors East/West+ LTC admin to strategize bed flow options. • Support sites managers in discussions with family's and residents re: ending respite admissions early. • Support TC sites in communicating with Home Care/Palliative Care to expedite discharge of	

		medical/palliative patients to the community that are awaiting the setup of services.	
Eden Mental Healthcare Centre	Level 0	• Standard actions.	
	Level 1	•	
	Level 2	•	
	Level 3	• LTCAC/SH-SS Site Lead or Manager on Call/SLT to contact EMHC Medical Director to consider suitable patient transfers to available EMHC beds.	
	Level 4	• (Level 3 standard actions apply)	