Southern Health-Santé Sud Capacity Management Protocol

Site Specific Plan – Regional Health Centre

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 Emergency Department (ED)/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)*

Unit	ED:	Medicine:	Rehab:	Surgical:	Obstetrical:	Special Care Unit:	Total Beds

See Provincial Dashboard for more detailed information.

Standard Actions:

Facility Units			Date, Time, Initial
Inpatient Unit Staff – Across All Units	Level 0	• Daily site rounds to assess patient's readiness for discharge, and identify barriers to discharge. • Monitor capacity and identify flow risks. • Actively working to maximize occupancy and 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 optimize efficiency and reduce delay and minimize unnecessary travel. • Enter patient transport requests as soon as known, per procedure.	

		• Transport Delay: Contact MTCC for status update. • Notify housekeeping of discharges promptly. • Weekly multidisciplinary disposition planning. • Ensure early consults/referrals (i.e. homecare/social work/allied health). • Daily huddle at 0845/1830. Determine number of probable admissions – community, ED, repatriations. • Expected date of discharge discussed with patient, support/family daily. Updated on Whiteboards each shift. • Discharge planning starts at admission, with assessment of potential barriers to discharge each shift. Aim for discharge by 1100. Communication with patient/family to ensure transportation arranged in advance.	
	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. • Consider proactively moving patients where estimated remaining length of stay (LOS) is greater than 3 days into facilities that regularly have capacity within Southern Health-Santé Sud. • 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: o Hold admissions in ED. o Utilize all off census or temporary spaces available. o Redirecting requests to alternate sites within patients' home health region; OR o Redirecting request to alternate sites in another health region that is reporting lower overcapacity risk AND is closer to their home community and or Primary Care Provider (PCP). o Off service patients to utilize all available spaces. • Expedite discharges on the unit. • Ensure nursing handover to unit team completed and patient pulled to unit within **30 mins** of bed assignment for ED patients. • Escalate capacity concerns for CRN/Charge Nurse.	
	Level 3	• Pending consults, diagnostics and investigations are triaged and expedited to account for facility risk. • Notify housekeeper directly of discharges; if unable to reach housekeeper contact housekeeping supervisor/manager.	
	Level 4	• All available spaces are being used and beds and additional bed spaces are made available.	

		• With approval from Regional Acute On-Call, Call in Heavy Work Relief (HWR): nursing, Health Care Aide (HCA) or Unit Clerk as required. • Follow Code Orange if applicable.	
Unit Specific (Inpatient Rehab, Obstetrics, Surgery)	Level 0	• Reference guidance across all units	
	Level 1		
	Level 2	• **Rehab:** Reassess applications for off service admission to Rehab Unit.	
	Level 3	• **Obstetrics:** consider obstetrical diversion.	
	Level 4	• **Obstetrics:** implement obstetrical diversion.	
ED Staff	Level 0	• Bed management – EDs are actively reporting bed census in Electronic Patient Record (EPR)/EDIS including ED closures, ventilated and transferrable patients in critical care. Communicate admission decisions to unit clerk at time of order. EDIS updated promptly to note patient disposition (i.e. discharge admission location, change in level of service). • 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. • 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. • Transfer to open bed within 30 minutes. • Escalate long stay/transfer or discharge barriers to CRN.	
	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 'off census' beds where applicable. • Consider proactively moving 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. • Consults to be completed within 2 hours.	

	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 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). • Notify CRN/Charge unit manager as needed. • Consider gaining approval for providing alternate methods of transport for patients awaiting transfer out of facility. • ED lab and imaging prioritized over outpatients unless discharge related.	
	Level 3	• Pending consults, diagnostics and investigations are triaged and expedited to account for facility risk. • For sentinel events related to clinical acuity, consider calling a code blue for additional supports. • Reassess Capacity Safety Risk status every 90 minutes. • Consider implementing Nurse Managed Care.	
	Level 4	• All available spaces are being used and additional bed spaces are made available. • Call in HWR nursing, HCA or Unit Clerk as required with manager approval. • Consider implementing Nurse Managed Care. • Follow Code Orange if applicable.	
CRN/Charge Nurse – Across all units	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. Review LOS greater than 14 days to ensure care plans up to date with stated EDDs. • 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. • 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. • Attend site and regional daily huddles as required. • Daily review of inter-regional repatriation requests/out of region and out of province/country. • Pull patients from ED **within 30 mins** and provide times beds will be ready. • Follow CLI.4110.PL.008 Interim Placement for Patients Waiting Personal Care Home Placement.	
	Level 1	• Escalate barriers to timely admission, discharge, transfer to unit manager promptly.	
	Level 2	• Off service patients to utilize all available spaces. • Review closed/blocked beds for capacity to reopen. Assess required resources to support. • Consult with IPC to consider reassignment of isolation patients to private rooms on another unit or cohorting/discontinuing isolation where appropriate. • With manager and hospitalist, review all patients to identify possible discharges that could be **safely** expedited. • Direct staff to discharge patients that do not require nursing intervention to await pick up in public spaces (i.e. main lobby, etc.). • Direct staff to move confirmed discharged patients that require nursing intervention to common areas on unit for care until discharged (i.e. hallway, lounge, etc.). • Determine availability at Acute Community sites, TCU, and Personal Care Home (PCH). • Contact Regional Emergency Response Services (ERS) for transfer delays. • Evaluate staffing resources required, communicate with manager/on call as needed.	
	Level 3	• Patients are admitted into available beds beyond existing admission criteria as long as their clinical needs can be met. • Arrange for additional beds/equipment to be sourced from other units within site/storage. • Assess staffing resources required. Assess available/qualified staff to meet unit needs within the facility. • Evening, Night, Weekends – Regional On-Call.	

		• Call in HWR nursing, HCA or Unit clerk with manager/on call approval.	
	Level 4	• All available spaces are being used and additional bed spaces are made available. • Utilize contingency spaces (i.e. hallways/family room until unit beds can be arranged). • Follow Code Orange Protocol if applicable.	
ED CRN	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 EDIS board to prioritize activity at shift change and as needed. Review: Investigation required or actions, ordered needed, treatments pending, reassessment required, consults pending, discharges, reassess to be admitted, triage concerns/quick actions. • Report out ED Capacity Level and review ED admissions at shift huddle and facility huddle at 0845/1830. • 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. • Attend site and regional daily huddles as required. • Beds assigned prior to 1000h and 1500hrs daily (open and known discharges).	
	Level 1		
	Level 2	• Expedite discharge of patients in ED in collaboration with ED physicians. • Actively coordinate flow of patients through the ED (i.e. lab result review). • Escalate to manager or Regional Acute On-Call for problem solving/broader site awareness. • Assess staffing needs to support ED acuity/volume. • Review board with ED physician to consider decanting CTAS 4/5 to Primary Care Clinic. • Reassess Capacity Safety Risk status every 90 minutes. • Notify ED manager of increase in capacity level.	
	Level 3	• For sentinel events related to clinical acuity, consider calling a code blue for additional supports. • 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 heavy workload staffing (i.e. physicians, Nurse Practitioner (NP), nurses, HCA, clerks and consult with manager/on call for approval).	

		• Evening, Night, Weekends – notify Regional Acute On-Call Manager. • Consider implementing Nurse Managed Care.	
	Level 4	• Follow Code Orange Protocol if applicable • If community hospitals have empty beds, transfer low acuity patients directly from ED to be admitted in Acute Community Hospital - even if they are a local patient. • Consider implementing Nurse Managed Care.	
Manager, Health Services	Level 0	• Daily site rounding to set/monitor expected date of discharge with CRN and physician. • In collaboration with Health Information System (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 from 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/or regional 0930 bed call. Identify site risks, challenges. Input site bed numbers on Regional Bed Call Template via Teams Channel. • Ensure weekly admission and discharge rounds are set up for each unit. • Ensure actions outlined in capacity plan are being followed. • Support team to identify and remove discharge barriers. • Identify anticipated daily admissions/discharges, including expected and potential surgical post-operative admissions.	

		• 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 locate patients. Facilitate transfer to unit (i.e. delegate HCA to retrieve patient). • Collaborate with diagnostics charge technologist to prioritize diagnostics that will support expedited discharge (where not impeding ED needs). • With CRN and hospitalist review all patients to identify possible discharges that can be expedited. • Support teams to achieve timeline to pull patients from sending unit/department. • Assess staffing needs for the next 12 to 24 hours. • Source out additional staffing resources as required (i.e. nursing, physicians, support staff). • Reassign staff as appropriate. • Escalate to site director as needed.	
	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 Primary Care Provider review all patients to identify possible discharges that can be expedited. • Provide clear and concise direction to teams on pulling patients. • Anticipate need to attend an additional shift huddle. Which would include the Regional Utilization Coordinator, Chief of Staff, Medical/Surgical Leads, hospitalist, Emergency Department Provider and Director, Health Services. • Escalation to Director, Health Service. After hours to Regional Acute On-Call Leader – escalate to Senior Leadership Team (SLT). Notify (call/email) Regional Lead - Acute Care & Chief Nursing Officer on Weekdays 0730-1700h. If SLT assistance is needed after hours, Contact SLT On-Call as needed with implementation of Over Capacity Protocol (i.e. approval of additional staffing/medical resources, connecting with ERS for transport issues, connecting with site leadership/manager on call). • Potential considerations: o Suspension of Services (i.e. obstetrics).	

		○ Consider contingency bed spaces (where available). ○ No repatriations. ○ Evaluate staffing resources needs for the next 12 to 24 hours. Source additional staffing. Reassign/redeploy as required. • ED Specific - Consider implementing Nurse Managed Care.	
	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. • Notify site director/SLT for consultation and further guidance. • Once notified, support teams to accept admissions out of ED as assigned. • Schedule additional urgent bed huddle to reassess site capacity and make plans to get through evening/night. Communicate plans to all applicable units at afternoon huddle. • ED Specific - Consider implementing Nurse Managed Care.	
OR Manager	Level 0	• Surgical slates at baseline are scheduled so bed and slate capacity is maintained to address anticipated emergency case volume. • Scheduled surgeries are slated according to priority and time to which surgical care needs to be provided (cases over target date will be scheduled first). • Scheduled surgical slating are reflective of the capacity for surgical in-patient bed base. • Scheduled surgical slates take into consideration the health human resource capacity of the site. • Report any cancellations or interruptions in surgical service to Regional Patient Flow Coordinator. • All elective slate cases are prepped in Same Day Surgery. • Attend site and or regional huddles where applicable.	
	Level 1		
	Level 2		
	Level 3	• In collaboration with Surgical Attending and/or Chief of Surgery, 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. • Consult site director. Consultation with SLT as needed.	
	Level 4	• Scheduled surgical slates which are priority 3, 4, 5 and non-cancer are cancelled to accommodate emergency cases or other system demands and notify Regional Patient Flow Coordinator.	

		• Notify staff that they may be reassigned to other departments. • Reassign staff to other departments as feasible/required. • Inform SLT.	
Bed Utilization			
Site Bed Coordinator	Level 0	• Monitor capacity and identify flow risks. • Monitor patients' LOS 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. • Participate in facility huddle. • Ensure ALC clients have discharge plan and are coded correctly/reported in daily bed and Provincial Capacity Dashboard. • Attend weekly Admission and Discharge rounds on all inpatient units call. • Communicate discharge barriers to appropriate team members • Accept repatriations appropriate for site. • HMO Physician daily huddle.	
	Level 1		
	Level 2	• Prioritize patients ready for discharge to facilitate their discharge from site. • Consider delaying repatriations. • Confirm that hospital capacity has been communicated to physician groups for support to prioritize discharging patients. • Consider afternoon daily huddle.	
	Level 3	• Patients are admitted into available beds beyond existing admission criteria as long as their clinical needs can be met. • Delay repatriations. • Afternoon daily huddle.	
	Level 4	• Follow Code Orange protocol.	

		• All available spaces are being used and additional bed spaces are made available. • No repatriations, may require transfer out of patients to other sites.	
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 LOS. • Monitor patients' LOS 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. • Review repatriation requests and refer to appropriate site contact between regional centers and community hospitals to support patient movement that allows access/flow. 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 Service Delivery Organization (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. • Escalate to appropriate community program leadership to seek approval regarding options for patients waiting in	

		acute care who are designated as ALC for access to options which include: o Providing enhanced home care support for patients that can be discharged early. o Temporary ALC placement. o Temporary living situation. o Emergency housing/rent aid. o Authorization to purchase, reimburse or provide compensation to third party or family as temporary option (i.e. Allied Health Services). • Consider deferring repatriations and send to alternative site.	
	Level 4	• In partnership with PCH operators and continuing care facility operators consider opening additional spaces in TCU or PCH facilities. • Defer repatriation and refer to appropriate alternative site.	
Medical Team			
Physician	Level 0	• Daily site rounds to set/monitor expected date of discharge with CRN and manager. • Monitor capacity and identify flow risks. • Monitor patients' LOS 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. • With team, establish goals of care and EDDs. • Daily review of patient's progress towards discharge including list of Awaiting 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, including required prescriptions, medication reconciliation, consults/referrals and letters. • Support discharges occurring prior to 1100. • Support acceptance of repatriation/admissions promptly to support goal of admission from ED/neighboring community.	
	Level 1	• Escalate barriers to acceptance of admissions/repatriations to unit manager/site director.	
	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).	

		• Work with interdisciplinary team to consider discharges and non-hospital environment of care. • Consider Awaiting Placements, and Transfer to TCU. • Weekend alert to Home Care regarding possible weekend discharges. • "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. • 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. • If weekday, Chief of Staff to communicate with Medical Staff regarding capacity level at site and strategize on options to discharge patients or send to other sites. • Consider calling in additional Prescribers to assist with overflow. • Collaborate with CRN to review Provincial Capacity Management Dashboard to identify facilities with capacity to accept transfers. Identify priority patients to be transferred (nurse to get family discussion underway), if needed notify family and do transfers to accepting physicians. • Discuss with team about curtailing services (ED for overcapacity bed reasons). • ED - Consider implementing Nurse Managed Care.	
	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 must be considered • Follow Code Orange Protocol if appropriate. • ED - Consider implementing Nurse Managed Care	
Acute Care Leadership			
	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. • Ensure daily access and flow activities are occurring as per standard work.	

Director, Health Service	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, staffing). • Work with other Acute Community Hospitals to identify potential available beds/staff. • Review repatriation requests and support referral to appropriate site. • Liaise between Regional Centers and Acute Community Hospitals to support patient flow. • **Contact SLT IF assistance required.** • Contact Regional Lead - Acute Care & Chief Nursing Officer on Weekdays 0730-1700. If after hours, contact SLT On-Call for assistance.	
	Level 3	• 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 regional 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. Notify (call/email) Regional Lead - Acute Care & Chief Nursing Officer on Weekdays 0730-1700h. If SLT assistance is needed after hours, contact SLT On-Call as needed with implementation of Over Capacity Protocol (i.e. approval of additional staffing/medical resources, connecting with ERS for transport issues, connecting with site leadership/manager On-Call). • Attend regional bed call and initiate additional site huddles as required.	
	Level 4	• All available spaces are being used and beds are being stood up where possible. • Scheduled surgical slates which are priority 3, 4, 5 and non-cancer are cancelled to accommodate emergency cases or other system demands and notify Regional Patient Flow Coordinator. • 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 are considered. • Follow Code Orange if applicable. • Facilitate additional urgent site huddle bed call to reassess site capacity and make plans to get through evening/night shift.	
Senior Leadership Team	Level 0	• SLT actively work with site leadership/Regional Patient Flow Coordinator to assist in the movement of patients to decrease risk as needed.	
	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 Community Program leadership to seek approval regarding options for patients waiting in acute care who are designated as ALC for access to options which include: o Providing enhanced home care support for patients that can be discharged early. o Temporary ALC placement. o Temporary living situation. o Emergency housing/rent aid. o Authorization to purchase, reimburse or provide compensation to third party or family as temporary option (i.e. Allied Health Services).	
	Level 4	• Follow Code Orange Protocol. • 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 are considered	
Support Services & Allied Health Services Onsite			
	Level 0	• Standard practice.	
	Level 1		
	Level 2	• Housekeeping: Prioritize cleaning of patient rooms on units so patients can be transferred.	

Support Services Manager (EVS)	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. • 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).	
Lab & Diagnostics	Level 0	• Standard practice.	
	Level 1		
	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 in Shared Health Diagnostic Administrator on Call.	
	Level 4	• Follow Code Orange Protocol if applicable.	
Community Programs			
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: o Acute Care Awaiting Discharge o Palliative Care o 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.	
Hospital Based Home Care Case Coordinator/ Case Coordinators where no HBCC present	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. • 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 SLT direction.	
Long Term Care (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	• 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 2	• Prioritize urgent admission of ALC patients to available TCU 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 1 actions continue plus: • Work with Regional Bed 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/TCU 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 1 and 2 actions continue plus: • Review with Regional Bed 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.	
TCU/PCH Sites	Level 0	• Work in collaboration with LTC Access Coordinator to admit into available TCU/PCH per usual practice. • Those PCHs who offer respite services can continue as per usual schedule. • Ensuring continuing offers of vaccinations at PCHs/TCUs are made available to all residents.	
	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 over capacity 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 are 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/TCs directed to admit into all available beds immediately from ALC patients waiting placement in acute care. Expedited admission process is 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 Service 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.	
PCH 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. • Support the LTC Access Coordinator with site discussions as needed.	
	Level 1	• Support the LTC Access Coordinator with site discussions as needed. • Ensuring continuation of the offering of vaccinations at PCHs/TCUs.	
	Level 2	• 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 over capacity status decreases.	
	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. • 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 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 and 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 set up of services.	
Eden Mental Healthcare Centre	Level 0	• Standard actions.	
	Level 1	•	
	Level 2	•	
	Level 3	• LTCAC/SH-SS Site Lead to contact EMHC Medical Director to consider suitable patient transfers to available EMHC beds.	
	Level 4	• (Level 3 standard actions apply)	