POLICY:	**Capacity Management Protocol**
Program Area:	**Across All Care Areas**
Section:	**General**
Reference Number:	**CLI.4110.PL.030**
Approved by:	**Regional Lead – Acute Care & Chief Nursing Officer**
Date:	Issued 2024/Nov/01 Revised

PURPOSE:

- The overarching goal of the Provincial Capacity Management Standard Protocol is to facilitate cooperation between all stakeholders within Southern Health-Santé Sud (SH-SS) to support a system approach to capacity management that is driven by real-time objective data and risk quantification.
- A consistent standard for regional capacity management creates a transparent and staged approach to inform decision making with the intent of mitigating and distributing risk associated with overcapacity situations based on objective and consistent measures.
- The scope of the capacity management protocol extends across acute care, long-term care (LTC), primary care and the community thereby allowing an all-system response to support appropriate utilization and access to timely healthcare across SH-SS and Manitoba.
- By ensuring timely access to appropriate care the healthcare system can:
  - Reduce Emergency Department (ED) and Urgent Care overcrowding, minimize/avoid disruption to service delivery (any program), support early identification of system pressures,
  - Maintain operational access to care 24/7,
  - Facilitate a timely response to demand/capacity imbalances within sites, regions and provincially.

BOARD POLICY REFERENCE:

Executive Limitations (EL-3) Treatment of Staff
Executive Limitations (EL-7) Corporate Risk

POLICY:

- A provincial Shared Health Capacity Management Standard has been established and is used as a basis for SH-SS actions outlined below. The Standard includes guiding principles, clarifies the roles and responsibilities for relevant stakeholders, and outlines methods for assessing as well as standards for responding to risk as measured by changes in system capacity and ED overcrowding.
- The following safety risk levels (see table below) and minimum standards apply to Service Delivery Organization (SDO)/Health Authorities and Health organizations, which includes all facilities and units within SH-SS, their staff, operational, clinical, and medical leadership, which supports a standardized provincial response to reduce risks and manage system.
- Operational processes outlined within this policy support other actions as needed to address capacity within SH-SS facilities and services. Each facility has an operational plan that is congruent across each safety risk level (see table below) and outlines standard actions for within each safety risk category. Site plans are reviewed as needed and at minimum annually. Sites use CLI.4110.PL.030.FORM.01 Community

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Acute Capacity Management Protocol Site Plan or CLI.4110.PL.030.FORM.02 Regional Health Centre Capacity Management Protocol Site Plan.

	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%

DEFINITIONS:

Manitoba's Provincial Capacity Management Standard - a comprehensive framework that integrates service delivery organizations (SDOs) and each of their respective facilities across the province work into a cohesive system that optimizes all available capacity within the province. The framework includes processes and protocols for our acute care system to objectively assess overcapacity risk and defines triggers for escalation within the protocol.

Licensed Bed - funded and available as part of normal operational capacity.

Overcapacity - the state at which demand exceeds the available capacity of resources. This is defined as Licensed beds and Flex beds at 100% occupancy; or total staffed and open beds as per Canadian Institute for Health Information (CIHI).

Occupancy Rate - total licensed beds as a percentage (total number of beds occupied/total number of licensed beds).

Capacity Rate - total available beds occupied as a percentage (total number of beds occupied/total number available/open beds).

Temporary Bed Closures - a short term (up to 48 hours) and unexpected bed closure related to extreme staffing shortages, increased patient acuity, infection prevention and control standards, or physical plant disruptions.

Non-Census Space - spaces that are not included in the total number of the inpatient beds for a facility, but if an inpatient is in the space, the patient is counted in the Inpatient Census (i.e. virtual spaces used for administrative purposes only).

Overflow Bed - not funded, and additional staff above baseline are required to operate.

Flex Bed - not funded, and no additional staff are required to operate.

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Contingency Bed - not funded, and additional staff above baseline are required to operate. Not physically available and need additional resources to open (i.e. Disaster, Surge, etc.).

Off Service - number of beds occupied by off-service patients as entered in Admission/Discharge/Transfer (ADT)/Electronic Personal Record (EPR) as per CIHI definitions.

Daily Huddle/Operational Meeting - at facility, SDO, provincial level, daily meeting to discuss each unit's demand for beds and existing bed capacity as captured in the Provincial Capacity Management Dashboard in order to plan to match demand (from ED, direct admits from outside the facility, the Operating Room (OR) and repatriations with actual/planned unit capacity).

Repatriation - transfer of a patient who has completed their episode of care at the current tertiary, regional, community health care facility, but requires further care and is determined to be ready for transfer to a health care facility near their home community. It applies to patients who required specialized care that they could not receive locally. In addition, repatriations include Manitoba residents currently out of country or out of province. Patients and families cannot refuse repatriation at the risk of impacting care for another patient; however, patient flow teams and SDO leadership works with patients to ensure they receive the right care that is culturally appropriate, and trauma informed as required.

Provincial Capacity Management Dashboard - a digital platform which provides real-time data to guide operational decision-making to promote optimal care and service delivery.

IMPORTANT POINTS TO CONSIDER:

- The intended outcome of this standard is a coordinated system level strategy that efficiently mitigates and distributes risks while maintaining timely access to care.
- When access to care is delayed due to overcapacity situations, patient safety, quality and outcomes are compromised resulting in longer hospital lengths of stay and increased risk of patient harm.
- The Provincial Capacity Management Dashboard provides real-time monitoring with the potential to evaluate trends in bed utilization, bed closures, ED closures, Alternate Level of Care (ALC) volumes and overcapacity risk. Access to accurate and standardized bed utilization data enables teams to identify areas for improvement and respond to pressures facing providers and patient care risks in real-time.
- The Provincial Capacity Management Standard builds the framework that outlines the 'rules of the road', reducing negotiation around patient movement with timely decision making, eliminating unnecessary delays and removing barriers to ensure all Manitobans have equitable access to high quality care.
- An ED accepts a patient back to their ED, following transferred out for a consult/test/procedure (ED – ED), unless exceptional circumstances are present.

GUIDING PRINCIPLES:

The following principles set out the common framework for all health providers, health care facilities, health organizations and regional health authorities to guide decision-making:

- Patients are moved to ensure right care, right place and right time whenever possible.
- Accountability for flow does not just reside within acute care but is a whole system approach including primary, community and long-term care.
- To ensure access to care for all Manitobans regardless of where they live, all capacity within the province is optimized. To ensure efficient and safe utilization of provincial capacity all healthcare resources and facilities are treated as an integrated system resource.

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- Facilities across Manitoba including continuing care (i.e. Personal Care Homes (PCH)) are 'bed ready', meaning they are actively prioritizing, triaging and pulling patients to beds where available.
- All capacity within healthcare facilities are identified and all attempts are made to avoid bed closures.
- When capacity is available; facilities and providers accept patients, whose care can be managed appropriately and safely, on a no refusal basis.
- Patients are matched to appropriate facilities, across regions, and moved in a fashion that minimizes delay and supports improved flow throughout the system.
- Proactive (i.e. Patient Handbook upon admission) communication with the patient and family occurs to prepare them for a move.
- Patients are accepted and transferred based on appropriateness of patient, capacity, safety risk and location of home community to assigned locations or units. Where there are competing demands, clinical judgment considers all factors in the decision.
- Health-care teams are supported by patient flow and care coordination resources regionally and provincially and have access to near real-time data on where beds are available across the system, to work as a system.
- Facilities have identified appropriate spaces to support surge situations. These are reported in the provincial bed map and include off census and temporary spaces that can be opened with required staff, beds, equipment with operational processes to activate.
- No facility works in isolation. Effective capacity management and active response to demand is everyone's responsibility 24 hours a day, 7 days a week (24/7). Patient flow management spans across regional boundaries and all levels of care including moving patients to units at suboptimal times to help improve flow and wait times in areas that are over capacity and cannot meet demand.
- Care is provided as close to home as possible, recognizing that the most appropriate site to provide care, at times, may be outside of the patient's home health region.
- Care within a home health region is not always the closes care to a patient's home, in accordance with capacity management standard protocol, facilities accept patients on a no-refusal basis to alleviate region, facility, unit or other regional pressures and create flow within the broader Manitoba system.
- 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.
- The use of best available evidence/data minimizes influence from bias, increases likelihood of efficacy, and promote responsiveness in decision-making.

ROLES AND RESPONSIBILITIES:

- Facilities - responsible to ensure:
    - All admissions, waiting to admit, transfers and waiting ALC are entered into EPR 24/7 in near real time so up to date information is displayed in the Provincial Capacity Management Dashboard;
    - All bed and ED closures are entered into EPR 24/7 in near real time so service disruptions are displayed accurately in the Provincial Capacity Management Dashboard;
    - After-hours and weekend coverage (i.e. Facility Patient Care Managers/Nursing Supervisors, Patient Flow Leads, CRN) act on patient flow protocols and applicable discharge plans; Associate Chief Medical Officer coverage is in place.
    - Where capacity exists and an admitting physician is not immediately available; the Associate Chief Medical Officer/Chief Medical Officer temporarily assumes responsibility until handover of care is provided to facilitate flow.
- SDO - SH-SS:
    - Actively participate in provincial clinical planning and use provincial data to support

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healthcare providers in meeting established outcomes and to identify gaps in care for particular geographies or populations.
  - Actively participate in provincial clinical planning to support standardized practice, pathways and protocols.
  - Actively managing access and transition to ensure appropriateness of care across acute and long-term care.
  - Actively participate in provincial patient flow and capacity management calls, meetings and activities through regional care coordination or patient flow in alignment with the capacity management standard.
  - Develop and implement detailed local action site specific CLI.4110.PL.030.FORM.01 Community Acute Site Capacity Management Protocol Site Plan or CLI.4110.PL.030.FORM.02 Regional Health Centre Capacity Management Protocol Site Plan.
  - Actively working with community partners to support flow and capacity management.
- Refer to Manitoba Capacity Management Standard for Shared Health and Manitoba Health roles and responsibilities.

PROCEDURE:

1. Coordination and Site Plans
   - 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.
   - Site plans include all safety risk levels and standard actions required within each level. Site plans are available for leadership (CRNs, managers, directors) to access at the unit/site level. The actions within each level are progressive, each building off the other across each level.
2. Escalation and Communication Process
   - When capacity and flow challenges are not able to be resolved within the SDO and are resulting in barriers to timely repatriation or negative impacts on patient flow, issues are escalated to the Associate Chief Medical Officer for Shared Health and the Shared Health Director of Provincial Patient Flow. This may include, but is not limited to, where temporary bed closures, ED closure, or service disruptions result in system risk.
   - Escalation pathways are identified in CLI.4110.PL.030.FORM.01 Community Acute Site Capacity Management Protocol Site Plan or CLI.4110.PL.030.FORM.02 Regional Health Centre Capacity Management Protocol Site Plan.
   - Refer to CLI.4110.PL.030.SD.02 Escalation Process Pathway Algorithm.
   - Actions when escalation occurs - Regional Patient Flow connects with Site Manager/Director to help problem solve the barrier.
     - **<u>Site Manager/Unit Manager – has 1 hour to facilitate</u>**
       - Regional Patient Flow Coordinator follows up with Director/Site Manger/Designate to understand the situation.
       - Director/Site Manager/Designate troubleshoots through admission barriers.

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- Director/Site Manager/Designate advises Regional Patient Flow Coordinator via email if able/unable to accept transfers.
- If unable to resolve decision within 1-hour, Regional Patient Flow Coordinator attempts to secure alternate location.
- Regional Patient Flow Coordinator documents on Provincial Patient Flow Tracker.

➢ Associate Chief Medical Officer connects with site Physician to help problem solve and remove barriers
  - **Associate Medical Officer/Designate – As soon as possible**
    - Calls site Physician who declined to accept patient bed match to:
      - Understand the situation and reason for decline.
      - Consider/discuss safety risk(s) of sending/receiving sites.
      - Engage to help find solution options to enable patient transfer.
    - Associate Chief of Staff makes decision to accept/not accept bed match and communicates with Regional Patient Flow regarding next steps.

3. 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 do not delay or refuse acceptance of patients when safe patient care can be provided at the facility with available capacity.
➢ Sites follow the CLI.4110.PL.030.SD.03 Interfacility Transfer Communication Pathway Algorithm.
➢ Sites complete the Provincial Repatriation Request Summary and submit to Regional Patient Flow Coordinator via email patientflow@southernhealth.ca.
➢ 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.
  - Communication to patient's and families is paramount to ensure awareness of possible transfer occurs at the earliest time possible. The following CLI.4110.PL.030.SD.04 and CLI.4110.PL.030.SD.04.F Interfacility Transfer Poster are posted in EDs to make patients and families aware of possible transfer.
  - Upon admission, sites provide CLI.4510.PL.008 Patient Handbooks in Acute Care to all new admissions which provides information on possible transfer occurring while care is required.

4. No Refusal

➢ Sites are required to accept patients that:
  - Require access to higher or lower level services/acuity based on patients needs.
  - No longer require higher level of care, need further hospital care, and are residents of the receiving health authority.
  - Are inpatients being repatriated for compassionate reasons.
  - Require transfer to a maternity facility that providers obstetrical care. Reunification of separated mother/neonates should take place within 24 hours of birth.

5. Respiratory Virus Season – refer to CLI.4110.PL.030.SD.01 Capacity Management Protocol Actions Specific to Respiratory Virus Season.

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SUPPORTING DOCUMENTS:

CLI.4110.PL.030.FORM.01 Capacity Management Protocol Site Plan – Acute Community Site
CLI.4110.PL.030.FORM.02 Capacity Management Protocol Site Plan – Regional Health Centre
CLI.4110.PL.030.SD.01 Capacity Management Protocol Actions Specific to Respiratory Virus Season
CLI.4110.PL.030.SD.02 Escalation Process Pathway Algorithm
CLI.4110.PL.030.SD.03 Interfacility Transfer Communication Pathway Algorithm
CLI.4110.PL.030.SD.04 Interfacility Transfer Poster
CLI.4110.PL.030.SD.04.F Interfacility Transfer Poster
Shared Health Provincial Repatriation Request Summary

REFERENCES:

Manitoba Capacity Management Standard Version 2 (June 28, 2024)

ORG.1010.PL.001 Suspension of Services

CLI.4510.PL.007 Observation Services Designation

CLI.4110.PL.008 Interim Placement for Patients Waiting Personal Care Home Placement

CLI.4510.PL.008 Patient Handbooks in Acute Care

Benson, Scarlet, Pirotte, Benjamin. Refusal of Care; National Library of Medicine Refusal of Care - StatPearls - NCBI Bookshelf (nih.gov)

CRNM. Code of Ethics

Provincial Capacity Management Dashboard (2024) Capacity Management Dashboard - Shared Health Intranet (sharedhealthmb.ca)

Guidelines for Repatriation of Patients between Provincial Service Delivery Organizations of Manitoba

Repatriation SOP-v10 Aug 2023.docx

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