SHA Saskatoon System Overcapacity Protocol

Department Name: **Acute Care Saskatoon System Flow**

Lead: **Sandra Jensen, Director, System Flow, Integrated Saskatoon Health**

Triggers Levels will be noted in the 0600, 1400, and 2100 reports by SFCC.

Level 1 (Green) – Low Safety Risk Due to Overcapacity	Level 2 (Yellow) – Medium Safety Risk Due to Overcapacity	Level 3 (Red) – High Safety Risk Due to Overcapacity
Trigger Criteria	***Trigger Criteria***	***Trigger Criteria***
RUH (36 Beds) → up to 18 ANB SCH (20 Beds) → up to 9 Direct Admits to other sites SPH (32 Beds) → up to 16 ANB ***AND*** Site Adult Medicine/Surgery* Occupancy less than or equal to 95% *Includes: Medicine, Surgery, Cardio, Neuro	RUH (36 Beds) → 18-40 ANB SCH (20 beds) → 10-15 Direct Admits to other sites SPH (32 Beds) → 17-29ANB ***AND*** Site Adult Medicine/Surgery* Occupancy between 96-105% *Includes: Medicine, Surgery, Cardio, Neuro	RUH (36 Beds) → greater than 40 ANB (and all ED surge spaces in use) SCH (20 Beds) → Consideration of Direct Admits to other sites SPH (32 beds) → greater than 30 ANB (and all ED surge spaces in use) ***AND*** Site Adult Medicine/Surgery* Occupancy greater than 105% *Includes: Medicine, Surgery, Cardio, Neuro

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Actions for all	***Actions for site in overcapacity*** ***(All action from level 1 plus the following)***	***Actions for site in over capacity*** ***(All actions from level 1 and 2 plus the following)***
Acute Care: ☐ Frontline leaders (Charge Nurses, Managers, Clinical Recourses Nurses, Team Leads, Clinical Coordinators, Supervisors etc.) in acute, non-acute, and community programs are responsible for supporting the timely Coordination of Care of their patients and for understanding and initiating the appropriate processes to pull patients as soon as required and in accordance with bed management and system flow standard work and policies. ☐ Programs are responsible for supporting their program areas through regular communication and monitoring of capacity and performance.	***Acute Care:*** ☐ SFCC will utilize up to 2 overcapacity beds (OCP) beds per unit at a time as identified in Table 1 – see below (SFCC has the authority to access OCP and bed borrowing per the triggers while still maintaining ORs and booked procedures. a. SFCC Charge Nurse to work in collaboration with units to identify options to transfer an appropriate inpatient to the OCP bed prior to assigning an ED patient to the OCP bed based on the OCP bed WS. b. In the event transferring an existing inpatient to an OCP bed will result in the ED patient being placed in a borrowed bed (off-service), SFCC Charge Nurse will have authority to grant approval until next business day. c. The Director of System Flow (or delegate) can authorize the use of OCP beds when triggers have not been met to address a specific need. ☐ SFCC to utilize beds as per the following work standards at all levels: a. Lending off-service bed process to facilitate flow at Bed Meeting by units as facilitated by the Saskatoon System Flow Coordinator b. Bed borrowing process to facilitate flow outside of Bed Meeting by SFCC Charge Nurse ☐ Units to prepare staffing their own surge areas/beds for own flow within 24 hours of	***Acute Care:*** ☐ CSSU will hold the cardiology transfers (up to 4) and 6000 will take D-1 patients from another service line to allow ANB patients to transfer up to their appropriate service units. ☐ PACU (at RUH) will hold up to 4 surgical cases/transfers allowing for surgery to accommodate D-1 pts be accommodated on the units and ANB patients to transfer up to their appropriate service units. ☐ The holding of patients in both PACU and CSSU will be reassessed q 12 hours/24 hours to facilitate the collapse of these areas. ☐ SPH Amb Care to open to accept ED pts utilizing existing WS. *If above has not eliminated triggers proceed to below. ☐ The Director of System Flow in consultation with the Executive Directors of System Flow, Acute Care, and Tertiary Care Services will explore the active reduction of volumes by not rescheduling vacant appointments, including DI/IR/Outpatient procedures that required post-interventional inpatient beds up to next 5 business days, including not rescheduling other DAS/elective surgeries. ☐ The ED of Acute Care and Tertiary Care Services will communicate to the physician department heads/ACOS of the need for expedited discharge rounds, and will encourage

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	system OCP triggers being met when it has been identified that planned demand over the next 24-78 hours exceeds known capacity (i.e. OR slate, ED demand or urgent direct admit demand combined is greater than D-1, D-2, D-3, respectively) *If above has not eliminated triggers and all OCP beds have been exhausted, proceed to below. ☐ All surge area units (Flex 3100 and 2M) are to be opened and staffed within 48 hours of system triggers being met at their respective sites. ☐ If service line surge beds are not required for their own flow, they will be opened and staffed to be utilized for overall system flow by SFCC- exclusion for PACU and CSSU see Level 3. This will be achieved through collaboration with the surge bed units and SFCC Charge Nurse and those beds will become overcapacity beds per OCP process at Step 1 by transferring appropriate D-1 and 2 service line patients from unit beds to service line surge beds, freeing up regular ward beds for flow. ☐ All surge beds at RUH are to be filled by the respective service lines by 1400 if it has been noted at the bed meeting that they are required for service line internal flow. If they are not used by 1400, they will be utilized for system flow per OCP process at Step 1, including appropriate off-servicing through the bed-borrowing process.	physicians to factor the overcapacity situation into admission decisions and care in place vs sending into ER. ☐ CPAS Acute will pause complex discharges and LTC assessments for 3 days to focus on urgent discharges home with services to be evaluated after 3 days. ☐ Bypass considerations. **Next steps require approval of VP/PE of Saskatoon Integrated Health** ☐ The Director of System Flow will consider the proactive postponement of surgical and non-surgical procedures if it is identified these actions will be overall beneficial to system flow and the removal of triggers. a. The Executive Directors of Tertiary Care, Acute Care and System Flow will be consulted by the Director of System Flow or delegate, to identify potential options and timelines for reduction of SDS volumes/interventional cardiology/DI procedures. ☐ Based on the joint recommendation between the Director of System Flow, ED's of System Flow, Acute Care and Tertiary Care, and VP/PE the proposed actions for implementation will be identified. ☐ The Directors of Surgical Services and Cardio-Sciences will execute the operational components of approved actions.

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Actions for all	***Actions for site in overcapacity*** ***(All action from level 1 plus the following)***	***Actions for site in over capacity*** ***(All actions from level 1 and 2 plus the following)***
	☐ At 1400, if triggers remain at SPH, OCP2 beds are to be filled with appropriate D-1 or DIS patients using the OCP Bed Work Standard. ☐ CPAS Acute will pause complex discharge planning and prioritize urgent discharges home with services If actions in Level 2 do not result in removal of triggers, proceed to Level 3.	☐ The Executive Directors of System, Flow, Acute Care and/or Tertiary Care and Director of System Flow will engage Corporate Communications to implement a communication strategy. ☐ The Director of System Flow will monitor and communicate outcome of the identified actions to SLT and determine if additional action is required.

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	Over Capacity & Surge Beds				
Unit	**OC1**	**OC2**	**SG1**	**SG2**	**Comments**
SPH					
2M			24		***Only admitted medicine pts from units from SPH (see 2M WS for criteria) DO NOT USE as part of OCP and 4 closed***
4B		1			OCP2 hallway bed
5A		1			hallway bed
5B		2			hallway bed
5M		1			hallway bed
6M	2	2			OCP2 – hallway beds
7M	1	2			OC2 – hallway beds
ICU			2		***ICU criteria only and for pre-bypass consideration***
SSU			2		SSU criteria only for placement when unit open
Total	**3**	**9**	**32**	**0**	44
RUH	**OC1**	**OC2**	**SG1**	**SG2**	
5000	1	4			
5100/5200	10	2			OCP2-hallways beds
5300	2	2			OCP2 – hallway beds
6000	2				
6200		2			OCP2 – 1 hallway beds
6300	1				
CCU			2		CCU criteria only
MIU		2			
ICU			15		***ICU criteria only and for pre-bypass consideration***
Total	**16**	**12**	**2**	**0**	30

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Surge Areas					
Unit	**SG1**	**SG2**	**Comments**		
RUH CSSU	12		4 beds for OCP at Level 3 only-will keep own pts instead of transfer-do not place from APF		
RUH PACU	8		4 beds for OCP at Level 3 only -will keep own pts instead of transfer-do not place from APF		
RUH 3100	8		Place per bed attributes		
Total	**28**				28

Legend Criteria:

Level 1 OCP bed: regular acute care bed – appropriate for any medical/surgical acute admission

Level 2 OCP bed: room with limited resources (no bathroom, no O2, no suction, etc.) therefore patients not appropriate * include:

- Patients with diarrhea or other gastrointestinal symptoms
- Patients that require O2
- Patients with tracheostomy
- Unstable patient
- Patients requiring isolation precautions
- Patients requiring immediate post op care
- Patients with equipment requiring suction (i.e. NG tube)
- Patients with mobility concerns

* OC Beds on IMH, and Peds designated for service specific patients

ALL Surge Beds: Use of beds under the discretion of Service Line at Step 1.

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At Step 2, if not utilized by service lines med/surgical/cardio/neuro Surge beds all become system OCP beds Level 2.
At Step 3 all surge areas are to be opened and operational.

Surge 1 bed: regular acute care bed – appropriate respective service line acute admission, includes surge areas such as PACU, CCSU or Flex 3100 that may require additional staffing and equipment to be operational.

Surge 2 bed: room with limited resources (no bathroom, no O2, no suction, etc.) therefore patients not appropriate * include:

- Patients with diarrhea or other gastrointestinal symptoms
- Patients that require O2
- Patients with tracheostomy
- Unstable patient
- Patients requiring isolation precautions
- Patients requiring immediate post op care
- Patients with equipment requiring suction (i.e. NG tube)
- Patients with mobility concerns

* Surge Beds on IMH, and Peds designated for service specific patients