# Policy & Procedure

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| **Policy Title:** | Overcrowding and Site Overcapacity | |
| **Applies To:** | Team Members and System Partners | |
| **Approved:** | **Effective:** | **Next Review:** |
| November 30, 2023 | December 12, 2023 | November 30, 2027 |
| **Sponsor:** | Senior Director, Access and Flow Network<br>Senior Medical Director, Access and Flow Network | |
| **Approval Authority:** | Clinical Operations Council<br>Health Authority Medical Advisory Committee | |
| **Number:** AD-AO-020 | **Manual:** Administrative | |

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## PURPOSE

This policy guides site, zone, organizational, and System responses to Patient Overcrowding and Site Overcapacity.

## POLICY STATEMENTS

1. Nova Scotia Health uses the best data available to guide operational decision-making regarding Overcapacity:
    1.1. Health Care Providers use data to promote optimal care and discharge planning
    1.2. Management uses data to monitor and predict trends in Patient Access and Flow
    1.3. Leadership uses data to inform strategies addressing barriers to access to care and the flow of Patients through the health care System
2. Surge levels are automatically calculated from System data and visualized with computer software used by Nova Scotia Health Team Members and other System partners.
3. Overcrowding and Overcapacity situations (refer to Overview of Levels) are escalated from the Access and Flow Operations Council or the Care Coordination Centre (C3) to the Executive Leadership Team (ELT).
4. ELT:
    4.1. Stands up the corporate Nova Scotia Health Emergency Operation Centre (EOC)
    4.2. Requests a "virtual" standing up of the Provincial EOC, inviting IWK Health, Emergency Health Services, Emergency Medical Care, Seniors and Long Term Care, Department of Community Services, and Department of Health when:
        - One or more zones are at Level 6 for more than 48 hours, and:
            - Other zones and local System partners are not able to respond or assist, or
            - The response does not improve the surge level
    4.3. The EOC participants:
        - Have the authority to make decisions for their organization.
        - Are responsible for providing a status report for their respective zone or organization and prepared to present options to alleviate pressures in the system.
    4.4. Frequency of meetings is set at first EOC briefing
5. Ambulance Offloading must be prioritized and organized. Patients are Offloaded in order, based on acuity and time of arrival.
6. Facilities across Nova Scotia Health must be "Bed Ready" during Overcrowding situations:

6.1. Appropriate Patient spaces are identified in the event of Overcrowding (as per site-specific procedures).

6.2. Patients are accepted and transferred to assigned locations or units (as per site-specific bed placement procedures).

6.3. Units accept Patients on a no-refusal basis to alleviate localized departmental or unit pressures and create Flow within the broader System.

6.4. Patients may be moved to units at suboptimal times to allow the Emergency Department to care for additional Patients and allow ambulances to respond to additional EHS calls.

6.5. Alternate Care Locations can be used to expedite Patient Flow only when Patient safety and the ability for the Patient to receive the required care can be ensured.

7. Discharge planning, considering People-Centred Care and Home First principles, must begin at the time of the Patient's admission and align with the SAFER-f Patient Flow Medicine Bundle.

8. As per the NSHA AD-AO-050 Repatriation policy, each site must prioritize the transfer of Patients to their Closest to Home facility once the Patient is deemed suitable for transfer.

9. In Level 5 or above, if Continuing Care deviates from the Nova Scotia Department of Health and Wellness Facility Placement Policy, the reasoning must be documented.

10. When zones are in Level 5 or 6 they will leverage all community partnerships to liaise with Department of Community Services, Seniors and Long Term Care, and Emergency Health Services to explore zone specific mitigations or responses.

11. Zones must submit their supplemental site procedures to the Access and Flow Network and the Care Coordination Centre (C3) on an annual basis to monitor the effectiveness of this policy and to address any issues or concerns.

12. System partner's policies are shared with zone leadership and reviewed yearly.

## ROLES AND RESPONSIBILITES

The interdisciplinary care team must:

- Identify the Patient's needs and estimated date of discharge (EDD) within 24 hours of the Patient's arrival to the inpatient unit.
- Identify and document potential discharge barriers during the Patient's hospital stay.
- Develop care plans to address identified Patient needs.

## PRINCIPLES AND VALUES

During times of Overcrowding, decision makers abide by the following principles, drawing on work completed by Ethics at Nova Scotia Health:

- **Constrained Resources, Ethics, and Risk**: The health care System becomes Overcrowded often because of constrained resources (for example: physical space, human resources, equipment, time). Decision makers face difficult choices, including how to allocate one single resource to one of many Patients (for example: which Patient will be admitted to an available bed? Which Patient's surgery must be cancelled?).
- Every decision produces risk for at least one of the parties involved. Constrained resources result in the need for enterprise risk management (see Enterprise Risk Management - Policy and Procedure - NSHA AD-EP-001). Nova Scotia Health strives to make the most ethical decision whenever possible.
- **Structured and Values Driven Decision Making:** Decisions are approached using standardized processes and are guided by relevant values and the best available evidence. Decisions recognize and encourage the interconnectedness of health care delivery.
- **Pragmatic:** Nova Scotia Health recognizes that constrained resources often force a choice between imperfect responses when distributing risk and benefit between the parties involved. Limiting services and prioritizing Access in ways that may cause harm is only justified when limiting services and prioritizing Access are necessary to create benefit elsewhere in the health care System.
- **Evidence and Data Informed:** The use of the best available evidence and data minimizes influence from bias, increases likelihood of efficacy, and promotes responsiveness in decision making.
- **Collaboration:** No site works in isolation. All sites work collaboratively through C3 when appropriate. Sites and zones will contribute to the management of Overcrowding, helping other sites and zones when possible, and can expect reciprocity when facing their own Overcrowding pressures. Timely and seamless transitions from the hospital System require strong relationships and cooperation with external System partners.

## PROCEDURE

The table and descriptors below provide an overview of the different levels of and responses to Overcrowding. Levels 1 and 2 are optimal occupancy states and no response is required.

| | Level 3 | Level 4<br>Site Response | Level 5<br>Zone Response | Level 6<br>System Response |
|---|---|---|---|---|
| **Description** | Busy but Manageable | Overcrowded Site: Site level response required | Overcrowded Site: Zone level response required | Overcrowded Zone: System response required |
| **NEDOCS / CEDOCS** | 1 – 115 | 115 – 160 | 160 – 210 | Greater than 210 |

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| **Bed Capacity, including Overcapacity spaces** | Less than 85% | 85% – 91% | 91-100 % | Greater than 100% |

**Overcrowding Levels**

Level 3: Busy but Manageable

1. Care is delivered according to the Integrated Health Services Planning Framework.

**Level 4: Site Overcrowded, Site Response** (Appendix C)

2. The site executes its site level Overcrowding plan.

**Level 5: Site Overcrowded, Zone Response** (Appendix C)

3. Zones leverage all community partnerships to liaise with Department of Community Services, Seniors and Long Term Care, and Emergency Health Services to explore zone specific mitigations or responses.
4. Other sites within the zone help to reduce Patient Flow pressures.
5. The zone begins to move Patients and mitigate further Overcrowding at the site(s) experiencing Access and Flow pressures.

**Level 6: Zone Overcrowded, System Response** (Appendix C)

6. The site(s) within the zone continue(s) to move Patients within the zone and moves Patients to other zones as space is available to improve Flow.
7. The Overcrowded zone fills every Accessible Bed available.
8. A System response includes local representatives from IWK Health, SLTC, DCS, working with C3 or the zone to exhaust every option to decant Patients from its sites safely.
9. Surgical capacity is reduced within the Overcrowded zone by cancelling surgeries.

**Escalation to a Provincial EOC**

10. The Access and Flow Operations Council *or* C3 asks ELT to stand up a Nova Scotia Health EOC and request a provincial EOC be stood up when:
    - One or more zones are at Level 6 for more than 48 hours, and
        - □ Other zones and local System partners are not able to respond or assist, or
        - □ The response does not improve the surge level.

**Standing Down**

11. Following the completion of the Level 6 Provincial Response that made the EOC necessary, a full investigation and debrief is required.

    11.1. The investigation and debrief are conducted based on each individual case of Overcrowding.

12. 'Lessons Learned' events (for example: workshops, root cause investigations) are held locally, and the actions and barriers identified are incorporated into future response plans.

13. Site and zone designates complete a Root Cause Analysis and document Lessons Learned.

## REFERENCES

Root Cause Analysis Explained: Definition, Examples, and Methods. (n.d.). Tableau. https://www.tableau.com/learn/articles/root-cause-analysis

LibGuides: SAFER-f Patient Flow Medicine Bundle: What is SAFER-f? (n.d.). https://library.nshealth.ca/c.php?g=730777

Province of New Brunswick. (2001, January). Planning Guide for the Emergency Operations Centre. Retrieved December 21, 2022, from https://www2.gnb.ca/content/dam/gnb/Departments/ps-sp/pdf/emo/opscentre-e.pdf

## RELATED DOCUMENTS

### Policies

Direct to Chairs – Policy and Procedure – NSHA CL-EC-055

Repatriation - Policy and Procedure - NSHA AD-AO-050

### Procedures

QEII Emergency Department to Inpatient Unit Transfers - Procedure - NSHA AD-C3-080

### Other

Integrated Health Services Planning Framework

Overcrowding and Overcapacity Action Flow Chart

### Appendices

Appendix A: Definitions

Appendix B: NEDOCS and CEDOCS

Appendix C: Interventions to Guide Zone Procedures

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## Appendix A: Definitions

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| **Access and Flow** | Access refers to entry points to acute care settings, such as the Emergency Department, that allow Patients to request health care services.<br>Flow is a coordinated, collaborative, and Patient-centered approach to improve transitions at all points of care, reduce backlogs at System entry points, and improve Patient movement within the site.<br>Together, a Patient's experience is qualified by accessibility of care and a Patient's ability to Flow seamlessly through the hospital System. |
| **Alternate Care Locations** | Areas within a facility that do not normally accommodate Patient admissions (for example: ambulatory care areas, day surgery units, lounges, etc.). |
| **Bed Ready** | A bed or space prepared and available for a Patient. Indicates a traditional or non-traditional space has been vacated, been appropriately housecleaned, and is ready for Patient occupancy. |
| **Capacity** | The ability of the System to manage and treat Patients effectively. |
| **Community Emergency Department Overcrowding Score (CEDOCS)** | CEDOCS is the Community ED Overcrowding Scale, which is a measure or proxy of how busy (Overcrowded) a rural/community Emergency Department is experiencing. |
| **Closest to Home** | Refers to the site receiving the Patient during a transfer. It is determined with considerations for geography and Patient support systems, provided the Patient can receive the ongoing care required at the receiving site. |
| **Emergency Operations Council** | A group formed to gather and share information and disaster analyses. The Council ensures decisions and policies governing the emergency response are planned and implemented properly. |
| **Flow Accessible Bed** | An acute care bed typically used for Patients that do not require specialized care during Overcrowding situations. |
| **Health Care Provider** | A Team Member who is either regulated or unlicensed who is responsible for the direct care of Patients. |
| **Interdisciplinary Team** | A group of individuals from various teams and with varying areas of expertise working toward common goals. |
| **National Emergency Department Overcrowding Score (NEDOCS)** | A linear regression model that associates multiple variables to the degree of Overcrowding. It is a statistically derived calculation with construct validity and discrimination for predicting ED Overcrowding (see Appendix B). |
| **Non-Flow Accessible Bed** | An acute care bed not typically used for Patients during Overcrowding. Reasons the bed is not typically being used include specialized care beds, designated as an Overcapacity space, or is otherwise a protected bed. |
| **Offload** | The transfer of a Patient's care from Emergency Health Services to Emergency Department Team Members. |

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| **Overcrowding** | Demand for services within the site, including exceeding Emergency Department Capacity, to provide quality care within acceptable time frames. The intensity of Overcrowding is reflected in both the NEDOCS/CEDOCS and the occupancy rates. |
| **Patient** | All individuals including clients, residents, and members of the public who receive or have requested health care or services from Nova Scotia Health and its Health Care Providers. |
| **Repatriation** | The process of transferring the Patient to their referring site or to the site that is Closest to Home once the Patient is deemed suitable for transfer. Team Members involved in the process also consider how the transfer of a single Patient will impact the Flow of all Patients across Nova Scotia Health. |
| **Root Cause Analysis** | The process of discovering the root causes of problems to identify appropriate solutions. The analysis assumes that it is much more effective to systematically prevent and solve underlying issues rather than treating symptoms ad hoc and responding to emergencies. |
| **Surge Capacity** | The ability of the health care System to convert quickly from their normal service operation to a significantly increased Capacity to serve an influx of Patients during an emergency. An effective Surge Capacity plan involves all the health care resources available within the System. |
| **System** | Refers to all partners that collaborate to provide health care services (for example: Nova Scotia Health, IWK, EHS, government departments). |
| **Team Members** | Unless specifically limited by a certain policy, refers to all employees, physicians, learners, volunteers, board members, contractors, contract workers, franchise employees, and those with affiliated appointments and other individuals performing activities within Nova Scotia Health. |
| **Time to In-patient Bed (Boarded Patients)** | The time between the decision to admit a Patient and when the Patient departs the Emergency Department to an inpatient unit. It is a key interval and reflects bed availability at the time of admission, as well as hospital administrative efficiencies in assigning beds and arranging transfer of care and transportation.<br>NOTE: Nova Scotia Health strives to meet a target of total length of stay (LOS) of an average of 8 hours as per the Canadian Association of Emergency Physicians (CAEP). |

## Appendix B: NEDOCS and CEDOCS

NEDOCS = - 20 + 85.8(LED/bED) + 600(Ladmit/bh) + 5.64WED + 0.93Wadmit + 13.4Lrp

**LED:** total number of Patients in the Emergency Department (includes hallway beds and waiting room)

**bED:** total number of available Emergency Department beds (including resuscitation beds)

**Ladmit:** total number of admitted Patients in the Emergency Department (i.e., Patients waiting to be transferred from the Emergency Department to an inpatient unit, but does not include Patients who have do not have orders)

**bh:** total number of hospital beds (i.e., occupied and vacant inpatient beds that are not closed)

**WED:** the time waiting between triage to Emergency Department bed placement

**Wadmit:** the longest boarding time of Patients waiting for admission. Measured in hours (may include decimals) and measures total LOS from time of registration (not from decision to admit)

**Lrp:** the number of Patients receiving 1:1 care.

**CEDOCS = –29.53 + (3.14 x critical care Patients in the ED) + (0.52 x waiting time of longest admitted Patient) + (1.14 x number of Patients in waiting room) + (20.55 x ratio of total ED Patients to number of ED beds) + (0.00124 x ED visits per year) + A + B + C + D (additional variables based on number of ED visits per year)**

| **Threshold** | Additional Variables |
|---|---|
| **If ED visits per year greater than or equal to 18,811** | A = – [(1.09 x 10-12) x (ED visits per year – 18,811)3] |
| **If ED visits per year ≥43,012** | B = [(8.18 x 10-12) x (ED visits per year – 43,012)3] |
| **If ED visits per year ≥49,466** | C = – [(8.18 x 10-12) x (ED visits per year – 49,466)3] |
| **If ED visits per year ≥67,273** | D = [(1.08 x 10-12) x (ED visits per year – 67,273)3] |

**Appendix C: Interventions to Guide Zone Procedures**

| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
|---|---|---|---|
| Acute Care Units | ○ Identify potential Patients for discharge and movement of Patients, as soon as possible, to mitigate further Overcrowding<br>○ Identify opportunities to place Patients in non-traditional spaces<br>○ Complete bullet rounds prior to clinics, surgeries, or regular unit rounds<br>○ Consider and investigate Patients with upcoming EDDs who may be safely discharged.<br>○ Review all Patients for potential delays, unclear discharge plans, or potential transfers to community spaces<br>○ Write Patient orders the day before, where possible, to facilitate evening or morning discharges<br>○ Evening team identifies next day discharges and prepares Patients for their discharge (e.g., ensuring transportation and support are ready) | ○ Look for any situations that, if addressed, may mitigate Overcrowding. Examples include:<br>○ Patients on passes and not physically in the facility<br>○ Out-of-zone Patients that can be treated or recover in their home hospital<br>○ Patients who still need hospital-level assessment and care, but could spend the night at home (or be moved to an Overcapacity space)<br>○ Patients whose blood work could be followed as an outpatient<br>○ Patients waiting for a diagnostic procedure that could be followed up as an outpatient<br>○ Maximizes use of clinical and functional criteria for discharge that supports a team approach<br>○ Conducts a second daily bed round to follow-up on morning action items and identify further | ○ Ongoing liaising with the ED to arrange for real time reports and "pull" Patients to the assigned inpatient unit<br>○ Consider reassigning Team Members from across the organization to support unit Flow<br>○ Liaise with Continuing Care to identify Patients that may be able to be temporarily placed in a respite bed. Patients placed in respite beds become top priority for transfer to more long-term placement |

| **Appendix C: Interventions to Guide Zone Procedures** | | | |
|---|---|---|---|
| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
| | | opportunities to improve Patient Flow throughout the evening<br>○ Reviews discharge thresholds to identify further opportunities for Patients to be discharged sooner than their EDD<br>○ Contacts all relevant on-call Team Members and initiates overtime and reassignments to mitigate unit staffing pressures when possible<br>○ Engages in reverse triage to move stable Patients to Overcapacity and/or intake beds, making room for more acute Patients, including infectious or suspected infectious Patients<br>○ Distributes the most stable admitted ED Patients one by one, on a no-refusal basis, on the most appropriate unit, except for any units in an outbreak situation, as determined by Infection Prevention and Control | |

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|---|---|---|---|
| | | ○ Receives reports from the ED and prepare to receive a Patient within 15 minutes of the report | |
| Allied Health | ○ Attends unit rounds/huddles, as possible, to identify priorities for the day, including discharges that are pending assessment<br>○ Prioritizes assessments and interventions for Patients who could be discharged that day pending further assessment or clinical action<br>○ Liaises with others to identify resources for Patients who could be discharged with increased community support<br>○ Front line Allied Health Team Members (e.g., Social Workers, Occupational Therapists, Dietitians, Physiotherapists, etc.) escalate any barriers to discharge, including equipment issues or delays in community resources, to the Rehab & Supportive Care Program | ○ Participates in identifying Patients that can be moved to non-traditional spaces to make room for newly admitted Patients to be placed in rooms (i.e., placing the most stable Patient in the Overcapacity bed)<br>○ Front line Team Members, with manager support, continues to explore all potential discharge options following Home First philosophies and utilizing all available community resources<br>○ Management escalates to unit and senior leadership when the absence of community supports/resources impacts timely discharge | ○ Proactively utilizes replacement / extra Team Members, when possible, to support provision of Patient care and facilitate the Flow and discharge of Patients<br>○ Manager considers the cancelation of outpatient procedures and reassigns Team Members to inpatient areas to support Flow |

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| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
|---|---|---|---|
| | Manager and/or Unit Health Service Managers as appropriate | | |
| Continuing Care | ○ Increases support to Patients at home to prevent admission to hospital or long-term care<br>○ Attends unit rounds/huddles, when possible, to identify priorities for the day, including discharges that are pending assessment<br>○ Prioritizes assessments and interventions for Patients who could be discharged that day pending further assessment or clinical action<br>○ Liaises with other Allied Health Team Members to identify resources for Patients who could be discharged with increased community support<br>○ Escalates any barriers to discharge, including equipment issues or delays in community resources, through the Continuing Care Program Manager and/or Unit | ○ Identifies Patients that have placement dates within the next week and calls facilities requesting they admit these Patients sooner<br>○ Works with Occupational Therapy/Physiotherapy and liaises with SLTC contracted equipment providers to expedite the procurement of equipment that would result in quicker placement<br>○ A variance to the Facility Placement Policy is permitted, giving Nova Scotia Health acute care leadership the ability to identify high priority Patients for placement, even if they are not next on the list, if more optimal for Patient Flow and mitigation of Overcrowding.<br>○ The reasoning for deviating from the policy is documented | ○ Reviews each unit and identifies any previously missed opportunities or improvements in Patients' condition that could result in a placement<br>○ Reviews staffing complement and overtime requirements to expedite placements<br>○ |

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|---|---|---|---|
| | Health Service Managers as appropriate<br>○ Strives to meet SLTC response time standards for Nova Scotia Health Continuing Care placement to mitigate further Overcrowding | | |
| Diagnostic Imaging (DI) | ○ Prioritizes emergent ED procedures and any procedures that would expedite a discharge<br>○ An inpatient procedure only meets the threshold for emergent if the discharge of the Patient is contingent upon the receiving the results of the procedure<br>○ Not all procedures on inpatients are emergent and the emergent status cannot be used to artificially augment the priority of a procedure | ○ The site's Patient Flow Manager and DI Manager connect to enable the prioritization of emergent procedures, especially at sites lacking electronic lists to enable procedure prioritization<br>○ Ensures dedicated emergent slots are utilized for legitimately emergent procedures<br>○<br>○ | ○ Prioritizes all ED procedures and any inpatient procedures that would expedite a discharge<br>○ Considers calling in additional Team Members as necessary<br>○ |
| Emergency Department | ○ Enters all relevant information into the Emergency Department Information System (EDIS) and PatientTrak, especially during times of Overcrowding. This relays the state of the ED so that leadership, | ○ Moves up to two admitted Patients in the ED to the receiving unit, even before the assignment or availability of a clean bed. Patients flow on a no-refusal basis. The ED Charge Nurse liaises with the Site | ○ Physicians collaborate with other Team Members regarding disposition, prior to learner/resident involvement. Every effort is taken to arrive at disposition quickly |

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| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
|---|---|---|---|
| | C3, external partners, and internal units are aware of the situation<br>○ Utilizes reverse triage by moving Patients awaiting test results or disposition back to main waiting area or internal waiting areas to free up stretcher space for more acutely ill Patients<br>○ The Charge Nurse works with the site's Patient Flow Manager / Bed Manager to mitigate sources of Overcrowding and identify opportunities for admitted Patients to move to inpatient spaces faster<br>○ The Charge Nurse and Emergency Department Medical Lead or designate monitor the elements contributing to high NEDOCS/CEDOCS scores and make every effort to mitigate the highest triggers (e.g., address the Overcrowded waiting room)<br>○ Triage Nurses or delegates continue to reassess Patients experiencing | Flow Manager and receiving Health Services Manager to coordinate the movement of the Patient<br>○ ED Senior Clinical Decision Maker is present in ED department 24/7 when possible<br>○ The Charge Nurse and ED physicians escalate barriers to movement to C3 and/or local BED [governance] Team<br>○ The Charge Nurse and Transition Team liaise with EHS Paramedic Crews to manage ambulance Offload delays. The Charge Nurse proactively identifies opportunities to utilize the Direct to Chair policy and works to alleviate any barriers to Offloading Patients<br>○ Utilizes non-traditional spaces to Surge over usual Capacity, including hallways, family, and conference rooms | ○ The Charge Nurse liaises with the EHS Supervisor to prioritize ambulance Offloading and mitigate barriers |

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| | delays in the waiting room, monitoring Patients for any increases in acuity and re-triage the Patient's score as needed | | |
| Environmental Services | ○ Supervisor attends bed rounds to learn about what the housekeeping priorities are for the day to enable Flow | ○ Supervisor attends bed rounds to learn what the housekeeping priorities are for the day, and to learn about any non-traditional care spaces that may have become available<br>○ Supervisor dispatches Team Members to high priority areas (e.g., to a unit with several discharges that day) | ○ Redeploys housekeeping Team Members from nonclinical areas to speed up bed cleaning as they become available after discharge<br>○ Reviews staffing compliment and overtime requirements<br>○ |
| Pathology and Laboratory Medicine | ○ Works with each site to better schedule lab orders, collections, and reporting for inpatients to facilitate more efficient Patient discharge<br>○ Prioritizes inpatient and emergent lab work within standard response turnaround times | ○ Considers the delay of outpatient lab work to prioritize inpatient and emergent lab work to facilitate Patient Flow and discharge<br>○ Lab representatives liaise with inpatient Health Service Managers to expedite procedures for inpatients | ○ Inpatient, ED, and emergent lab procedures are prioritized over non-urgent outpatient work<br>○ Reviews staffing compliment and overtime requirements<br>○ |

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| | ○ Evaluates routine turnaround time needs and adjusts laboratory processes accordingly<br>○ If laboratory results are delayed, impacting inpatient discharge or ED Patient Flow, the Laboratory Manager / Laboratory Medical Director on-call (when available) coordinates immediate actions to correct the issue(s) | | |
| Mental Health and Addictions (MHA) | ○ Conducts routine morning rounds with the MHA team to facilitate discharges early in the day<br>○ A Patient who is homeless may be discharged to an appropriate shelter with adequate MHA community follow up<br>○ Increases support to Patients at home to prevent admission<br>○ Reviews ED reports about consult delays and barriers to Flow<br>○ The MHA Provincial Bed Manager coordinates the placement of MHA Patients to inpatient beds, | ○ Community clinics and outpatient services ensures that Overcapacity spaces are available to see Patients in the community who have been identified as having urgent needs. The goal is to prevent or divert ED visits<br>○ Continues to expedite discharges, increase Capacity, and lower Access thresholds to prevent admissions where possible<br>○ Dedicates Team Members from existing community services to participate in discharge planning in | ○ MHA beds can be used by any clinically appropriate Patients requiring a bed until a bed on a non-MHA unit becomes available. Patients placed in MHA beds become top priority for transfers to a different unit |

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| | transferring Patients to less crowded sites where possible, and ensures optimal bed utilization<br>○ Psychiatrists are expected to respond to ED Patients within two (2) hours of the consult request<br>○ An urgent MH ambulatory clinic Team Member attends bed huddles | step down / ambulatory units to provide enhanced follow-up and case management and provide a coordinated approach to link inpatient services with community support<br>○ Provincial MHA Bed Manager attends site huddles and C3 meetings at the affected site<br>○ Facilitates potential discharges by writing orders with any requirements and prescriptions the day prior to discharge when possible<br>○ Repatriates Patients to the community and other zones by maximizing the use of virtual healthcare<br>○ Determines whether community alternatives to hospitalization could be utilized<br>○ Community Mental Health and Addictions services prioritizes | |

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|---|---|---|---|
| | | Patients who were just discharged from the inpatient hospital System | |
| Perioperative Services | ○ Generally, inpatient surgeries should not be canceled when a site is in Level 4 Overcrowding due to bed availability, but a surgery may be canceled for other reasons (e.g., lack of Team Members)<br>○ Surgeries may be reorganized to improve bed availability | ○ Zone Director of Perioperative Services liaises with the Site Lead to evaluate the reduction of surgical services.<br>○ Canceling surgeries should only ever occur as a last resort, after every measure to avoid it has been taken. Careful consideration must be used to avoid canceling surgeries for Patients with cancer diagnoses, Patients who have had a surgery canceled in the past, Patients who have traveled a great distance, or Patients who have already been prepped for surgery<br>○ At applicable sites, Overcrowding may warrant the extended use of PACUs to care for inpatients (e.g., holding post surgical Patients longer in PACUs or the use of a PACU as a non-traditional Overcrowding area) | ○ Further consideration is given to the reduction of surgical services |

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|---|---|---|---|
| | | ○ Surgical Booking Representatives are responsible to participate in Access and Flow and C3 discussions regarding the prioritization of procedures | |
| Porter Services | ○ Supervisor attends bed rounds to learn about the priority areas for the day | ○ Deploys extra Team Members to the ED if needed or assist Patient Attendants if required<br>○ Liaises with the Diagnostic Imaging Manager to understand Porter needs (e.g., whether a dedicated Porter is needed to enable inpatient imaging that would result in discharge) | ○ Reviews staffing complement and overtime requirements<br>○ Calls in extra Team Members as needed, especially if the need for extra Porters is demonstrated to directly improve Flow (e.g., the anticipation of movement of several Patients within a short amount of time) |
| Primary Care | ○ Primary Care Providers participate in the provision of ongoing care, enhancing access to same day and next day appointments in the community to prevent ED visits | ○ Providers are engaged in identifying and supporting alternative pathways to admission and support their Patients being discharged to home with same day or next day appointments as possible<br>○ Where possible, increase Primary Care Provider Capacity in the community | ○ Zone Primary Care Leaders work with site Flow leadership to communicate Level 6 – Zone or Provincial Overcrowded and System Response to all Primary Care Providers in the province<br>○ Primary Virtual Care schedule allows for urgent appointments to support individuals being |

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| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
|---|---|---|---|
| | | ○ Primary care teams liaise with their zone hospital system to manage their patients who have been discharged to support a plan for increased support at home and same day / next day appointments as possible. | discharged home who have no primary care provider |
| Project Services and Performance Improvement | ○ No actions required | ○ Reaches out to Zone leaders to determine if assistance is needed | ○ Zone Project Manager and Industrial Engineering resources provides logistic support to site leadership on a temporary basis, until Overcrowding has resolved. Example of duties could include temporary planning support (e.g., supporting the opening of an Overcrowding space) or the utilization of corporate planning software (e.g., Smartsheet) to sequence and prioritize tasks |
| Site Flow Structure | ○ Enacts the site level Surge Plan and ensures it is utilized to its full scope, with ongoing monitoring by the Zone Leadership Team | ○ Alerts the whole System to take appropriate and timely action to reduce the pressure as quickly<br>○ As possible, includes working with primary care to inform providers in | ○ Communicates Level 6 – Zone or Provincial Overcrowding and System response to appropriate Primary Care Providers and SLTC to support broad communication |

**Appendix C: Interventions to Guide Zone Procedures**

| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
|---|---|---|---|
| | ○ Liaises with EHS/C3 to prioritize incoming and outgoing transfers to the Overcrowded site<br>○ Escalates unresolved issues to the program Director or Site Director, as per zone escalation procedures<br>○ Identifies site-wide issues (staffing, closed beds for cleaning, maintenance, etc.)<br>○ Utilizes the capacity information available from C3 in real time or Tableau to identify opportunities for improved Flow<br>○ Coordinates the redirection of Patients towards Alternative Care Locations as appropriate<br>○ Authorizes the use of off-service beds<br>○ Patient Flow Coordinators review all unusual unit-based situations and work to solve problems and reduce barriers to Flow wherever possible | the zone and Continuing Care to alert Nursing Homes and Home Care agencies<br>○ Ensure accountability zones are being followed<br>○ Liaises with EHS/C3 to reprioritize incoming and outgoing transfers to the Overcrowded site, along with all transfers in the zone to identify high priority transfers that would improve System Flow<br>○ Leads a second daily site level bed huddle to identify any further opportunities for discharge, considering a lowered threshold for discharge<br>○ Contributes to care team planning for discharge, works to reduce barriers to Flow and discharge<br>○ Escalates barriers to discharge to site leadership and C3 as appropriate<br>○ Identifies opportunities to decant Patients from the Overcrowded site | with facilities and home care agencies in the zone and province<br>○ Escalates requirement for Provincial EOC to Zone Executive Leadership, as per policy<br>○ Completes a Root Cause Analysis<br>○ Ensures that “Lessons Learned” events are held locally and updates plans to reflect the actions identified<br>○ Ensures a full investigation and debrief takes place following a System-wide escalation to Level 6, and ensures plans are developed and implemented to prevent reoccurrence<br>○ |

| **Appendix C: Interventions to Guide Zone Procedures** | | | |
|---|---|---|---|
| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
| | | to another regional or community site in the zone<br>○ Liaises with C3 and the Operations Council for escalation of issues and alleviating barriers to Flow<br>○ Communicates with all community providers in the zone experiencing Level 5 Overcrowding<br>○ Liaises with bordering zones on any issues which may impact their own pressures, and advise leadership if there are any actions that cannot be taken locally<br>○ Reviews direct admissions and determines the urgency or if the admission can be delayed. Notifies the Site Medical Director if assistance is required<br>○ Ensures equitable distribution of "unattached" Patients across sites<br>○ Liaises with services to identify opportunities to Flow Patients into non-traditional areas, including MHA, Mat-Child, and Palliative | |

**Appendix C: Interventions to Guide Zone Procedures**

| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
|---|---|---|---|
| | | ○ Transfers Patients to optimal unit(s) where possible; one Overcapacity bed in each unit is opened at a time.<br>○ Inpatient units actively reverse triage and decide on the most appropriate Patient to place in the Overcapacity space | |
| Site Administrative and Site Medical Leadership | ○ Remains on standby to receive and respond to escalated issues and prevent further Overcrowding<br>○ Notifies Department Heads/Medical Directors of any outstanding physician issues or delays<br>○ Site Leadership is accountable to ensure that the site executes its local Surge Plan effectively to prevent further escalation<br>○ Operational Site Leadership manages on site resources to enable Flow (e.g., reassigning Team Members to Overcrowded areas) | ○ Approves charges for medical equipment required to facilitate a discharge to home<br>○ Medical Site Leads directs physicians to round on Patients with potential for discharge first in the day<br>○ Resolves conflicts regarding placement of Patients and Most Responsible Health Care Provider<br>○ Considers all options to open additional Capacity on site or flex other areas (e.g., Day Surgery, PACU, etc.) | ○ Last resort measures are taken to increase staffing levels, including the possibility of vacation recall or short shift change notice. These last resort measures are outlined in collective agreements |

**Appendix C: Interventions to Guide Zone Procedures**

| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
|---|---|---|---|
| | | ○ Supports Team Members and to ensure emergency Patients are assessed rapidly<br>○ Attends C3/Zone Flow meetings in person and participates in reducing barriers and alleviating Overcrowding, especially where decision making or conflict resolution is required<br>○ Provides advice and guidance to site Flow structure for escalating situations<br>○ Troubleshoots when a disposition decision has not been reached for an ED Patient who has not been seen by a consultant within the time outlined in the policy<br>○ Assigns Attending Physicians as appropriate when there are delays in having an ED Patient be admitted to a service<br>○ Encourages early discharges utilizing Home First principles | |

**Appendix C: Interventions to Guide Zone Procedures**

| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
|---|---|---|---|
| | | ○ Considers the proactive postponement of surgery and ambulatory care procedures that are at higher risk for admission if it is identified that these actions will be of overall benefit to Patient Flow<br>○ Site Leader notifies Executive Directors of significant delays in admitting to specific programs or services that cannot be resolved<br>○ Site Leadership, in collaboration with local DCS and SLTC, prioritizes quick solutions to improve Flow<br>○ Site Leadership may consider increasing staffing levels to respond to Overcrowded areas. Actions could include exhausting casual relief, part time Team Members, offering overtime, or utilizing contracted services<br>○ The escalation of accessing extra resources takes place in the order outlined in the collective agreements | |

**Appendix C: Interventions to Guide Zone Procedures**

| | Level 4 Interventions | Level 5 Interventions<br>(Level 4 and above) | Level 6 Interventions<br>(Levels 4, 5, 6) |
|---|---|---|---|
| Executive Leadership Team: Zone ED's/VP's ZMEDS and Provincial ELT | ○ No actions required | ○ Participates in the zone response by attending meetings and solving problems when they arise<br>○ Executive Leadership of neighbouring zones help the affected zone by offering Capacity where possible<br>○ | ○ Facilitates the site and System responses by participating in Zone Flow Oversight meetings<br>○ Mitigates barriers to Flow when issues are escalated<br>○ Liaises with government and partner organizations to mitigate identified barriers to Patient Flow and discharge<br>○ Escalates Nova Scotia Health issues to government departments when needed<br>○ Escalates extended Zone Level 6 to a provincial system EOC response as per the policy |
| We are continuing to work with Seniors and Long-Term Care, Department of Community Services, and EHS to link their respective actions related to Surge Levels. This Policy will be updated with links to their related policies and procedures as they are developed. | | | |

# VERSION HISTORY

| Version: | Effective: | Approved by: | What's changed: |
|---|---|---|---|
| Original | 2019-06-03 | Executive Leadership Team | N/A |
| Minor Revision | 2019-06-03 | | Removed Procedure 2.1.3 |
| Major Revision | 2023-04-28 | Executive Leadership Team<br>Clinical Operations Council | Reviewed / updated policy and procedure, including more information about responses. |
| Minor Revision | 2023-06-13 | Senior Director, Integrated Access & Flow | Changed statement in Appendix B to correct error. |
| Minor Revision | 2023-10-20 | Manager, Integrated Access & Flow | Flow diagram removed from appendices and linked as related document. |
| Major revision | 2023-12-12 | HAMAC<br>Clinical Operations Council | • Clarified role of EOC<br>• Clarified role of system and community partners |