Lakeridge Health	**Bed Management, Bed Allocation, Surge Management – Policy and Procedures**	
	Manual: Clinical	Document No.:
	Section: Admission/Discharge/Transfer	Original Date: 11SEPT 2013
	Document Sponsor/Owner Group: Patient Flow	Revision Date(s): 17SEPT2019
	Approved by: Senior Management Team	Review Date: DDMONYYYY
☑ Harmonized	Cross Reference to: Placement, bed spacing and specialized accommodation and signage Procedure: Emergency Departments(s) Surge Plans	
	Document Applies to: All LH Staff and Physicians	
A printed copy of this document may not reflect the current, electronic version on Lakeridge Health's Intranet, 'The Wave.' Any copies of this document appearing in paper form should ALWAYS be checked against the electronic version prior to use.		

Introduction

The goal at Lakeridge Health (LH) is to effectively manage the allocation of resources and the flow of patients across the system and throughout all 5 hospitals to support timely access to the appropriate type of bed and service. Lakeridge Health is committed to ensuring each patient gets to the right bed, in the most timely and safe manner. Beds across all five hospitals are a corporate resource and programs are required to ensure optimal utilization.

If access to life and limb saving resources, such as critical care, emergency services, and/or the operating room is seriously compromised, an emergent system-wide response is required to restore normal operations.

This policy addresses corporate bed resource planning, routine patient flow management, gridlock management and surge management, up to moderate surge scenarios and is to be used as a guide as each surge situation may vary and require additional action as necessary. Major surge scenarios are addressed in emergency preparedness policies (Code Orange).
While this policy addresses corporate bed resource and surge planning, if one hospital site and/or one emergency department is at yellow and predicting to shift to red, or is in red; Lakeridge Health as a corporation will respond as outlined in this policy in support of each of our hospitals and emergency departments.

This policy has been guided by Ontario's Critical Care Surge Capacity Management Program and the provincial Emergency Department (ED) Wait Time Strategy. Under the ED Wait Time Strategy, provincial wait time targets have been identified for specific clinical activities

Policy

Inpatient beds across all five hospitals are a key resource. It is the corporation's responsibility to ensure that the allocation of beds to specific departments optimizes access to care for the community. Beds will be managed in a manner that will facilitate the movement and placement of

patients to locations which will management of all admissions and/or transfers will be coordinated through the Patient Flow Office.

Bed assignment will be supported by using the standardized process defined in Appendix A (bed allocation placement assignment matrix). The patient's clinical condition and care needs will define the most appropriate services required and will guide bed placement discussions across LH.

Lakeridge Health will not cohort inpatients unless absolutely necessary. The exception to this is the Acute Cardiac Unit (ACU) at LHO given the highly specialized nature of care provided in this room. Patients being admitted to the ACU will be informed of the requirement for short term cohorting.

As inpatients will not be cohorted with opposite sex patients, should a situation arise where this is thought to be necessary, the Director responsible for Patient Flow will escalate this request to the Executive Vice President of Patient Services for approval. If cohorting is deemed necessary explicit patient consent by all patients impacted is required. Every attempt will be made to realign cohort accommodation as soon as possible.

While we will endeavour to consider patient preference and preferred accommodations, optimal utilization of beds is essential and may require innovative solutions such as utilizing safe temporary locations (i.e hallway) to care for patients.

Patients can be admitted to all sites within LH as bed capacity is identified. Communication with patients and families related to cross site bed assignment starts in the emergency department (ED) at all sites to set the expectations for patients and families. Patient information about all sites and the expectation that the patient may receive services at another site is available on the Wave and a patient admission brochure will be provided to all admitted patients. *https://www.lakeridgehealth.on.ca/en/patientsandvisitors/gettingtous.asp* Notification to physician as early as possible in the discussions related to cross site transfer is essential to ensure timely transfer of accountability (TOA). The sending unit will notify the sending physician of this.

If a patient has a personal support worker (PSW) or security guard, the PSW/security guard must move with the patient as they move from one area to another. Units may not refuse to take patients because they have a PSW/security guard. If a PSW/security guard are monitoring more than one patient a conversation between the Unit Coordinator and/or delegate on the sending and receiving unit will determine which program will secure additional resources.

Inpatient bed requirement is based on the number of patients admitted in the ED at all sites, number of patients ready to be discharged from the Critical Care Unit (CrCU), number of repatriation and number of patients from ambulatory areas that require admission across all LH sites. Surgical patients without assigned beds will be reviewed with the surgical unit leadership to determine if there are surgical patients at risk of OR cancellation due to inability to assign a bed with notification made to the Surgical Program Clinical Director or designate.
If so, these will be considered as part of larger corporate bed planning in an effort to avoid surgical cancellations if possible.

In all instances, assessment of clinically unstable patients is the priority. The priority for assessment of new admissions, planned discharge and ongoing care will shift based on organizational priority needs.

Definition(s)

The Ontario Ministry of Health and Long-Term Care's Critical Care Secretariat has defined **surge** as follows:

- ***Any situation where demand exceeds planned resources*.**

For clarity and consistency across the health care sector, three levels of critical care surge have been identified:

MINOR SURGE: an acute increase in demand for hospital services; up to 15% above budgeted capacity; localized to Lakeridge Health. A minor surge could result from unplanned admissions from the OR, deteriorating patients on the ward, or going into a minor surge state for the purpose of accepting life or limb threatened patients from a referring hospital

MODERATE SURGE: an increase greater than 15% in demand beyond our budgeted capacity but additional physical capacity is available. A moderate surge occurs when a hospital in minor surge is no longer able to maintain services and needs to rely on the resources of other hospitals to assist with managing surge. A moderate surge could also result from a single event (infectious or casualty) requiring the response of several hospitals in a region to respond to the increase in demand.

MAJOR SURGE: an increase greater than 20% in demand beyond our budgeted capacity and overwhelms LH for an extended period of time. May require notification to CELHIN to initiate a LHIN-wide response if surge is sustained.

As Lakeridge Health is composed of five hospital sites (4 sites that can admit patients from ED to inpatient beds), the table below provides the numbers of admissions which are used to indicate when the organization and specific hospitals are in green, yellow or red status.

Hospital Specific & Corporate Surge Levels					
	LHAP (Ajax- Pickering)	LHO (Oshawa)	LHPP (Port Perry)	LHB (Bowmanville)	LH (Corporate)
Green	<=7	<=18	<=2	<=3	<=30
Yellow	8-12	19-30	3	4-5	31-50
Red	>12	>30	>3	>5	50-80

Gridlock: when there are more admitted patients than inpatient beds available; the corporation is operating at overcapacity (minor, moderate or major surge) and will have to implement special, temporary measures to accommodate all admitted patients in a timely and safe manner.

Gridlock (waiting for IP beds, corporate)		Surge (occupancy above budget)	
Green	30	No surge	100%
Yellow	31-50	Minor	100-115%
Red	50-80	Moderate	115%-120% gridlock likely to be reduced with action plans
Scarlet (only if in high levels of surge)	>80	Major	As above however gridlock not likely to be resolved &/or greater than 120% occupancy

The following table illustrates the goals of stage versus surge level that the corporation is identified to be in:

Stage (Gridlock)	**Minor Surge (100-115% above capacity)**	**Moderate Surge (115-120% above capacity)**	**Major Surge (>120% above capacity)**
Green <30	The primary goal when in green and minor surge is to sustain green status and prevent increased length of stay (LOS) in waiting (for example, Critical Care Unit sign- outs)	N/A (not possible to be in green and moderate surge status)	N/A (not possible to be in green and major surge status)
Yellow 31-50	The primary goal when in yellow gridlock and minor surge status is to prevent going into a moderate surge and red gridlock status. It is also to preserve access to the Critical Care Units and decrease excess length of stay wait times.	The primary goal when in yellow gridlock and moderate surge status is to prevent going into a major surge and red gridlock status. It is also to preserve access to the Critical Care Units and access to A case beds (surgery)	N/A (not possible to be in yellow and major surge)
Red 50-80	The primary goal when in red gridlock and minor surge is to get back to yellow status as well as decrease excess length of stay in waiting. All interventions prior to relying on a moderate surge plan will be exhausted. The objective during red gridlock at any stage of surge is to increase the	The primary goal when in red gridlock and moderate surge is to prevent major surge, preserve critical care access and get back to yellow status. As well, to preserve A case beds and ED access. The objective during red gridlock at any stage of surge is to increase the intensity of oversight,	The primary goal when in red gridlock and major surge is to preserve critical care access, a case beds, ED access and to prevent further gridlock while working to get back to yellow status. The objective during red gridlock at any stage of surge is to increase the intensity of oversight, monitoring and response strategies in order to alleviate the overwhelmed

	intensity of oversight, monitoring and response strategies in order to alleviate the overwhelmed situation and bring service back to within budgeted bed base.	monitoring and response strategies in order to alleviate the overwhelmed situation and bring service back to within budgeted bed base.	situation and bring service back to within budgeted bed base.

Procedure(s)

- Operations supervisors will review all aspects of patient flow and assess needs to develop the daily bed management plan prior to the morning bed management meeting
- The plan will be shared and confirmed with the key stakeholders present at the bed management meeting (unit coordinators or PCMs from each inpatient unit and ED is required to be at all bed management meetings or attend via teleconference if not at the Oshawa site)
- The managers (or delegate) of Infection Prevention and Control, Support Services and Staffing will be in attendance at bed management meetings to support any corporate priorities for the day.
- ***A corporate bed status report will be generated at 0800, 1400 and 2200 each day and communicated via email for bed status updates to the corporate leadership group.***
- Additional capacity protocols will be implemented at identified triggers to initiate actions that facilitate patient flow. The bed escalation process will be initiated by the Operations Supervisor.
- A bed management tool provides a consistent and transparent overview of patient demand for services and bed availability. The information captured in this tool assists the clinical management team to proactively approach bed management planning. **Clinical units remain accountable for updating the bed management tool throughout their shift.**
- In the event of intranet downtime, Operations Supervisors will be responsible for consolidating key information
- Preferred accommodation will be provided where possible. When unavailable, patients will be given an explanation and admitted into the next *appropriate* available bed. *This may need to include consideration of a bed at an alternate LH hospital site as would be the situation for all patients requiring an inpatient bed.*
- Infection control will notify operations supervisor/patient flow office by 1700 each day those patients that may have isolation discontinued within the next 24 hours if they meet criteria

Responsibilities and Accountabilities

(Refer to Appendix C, D and E for role details and expectations in each phase of surge)

GREEN – 30 or less patients requiring inpatient bed confirmed admissions (Refer to Appendix C for detailed roles and accountabilities)

- If there are confirmed discharges, the *Bed Control Specialist* will assign a patient to confirmed discharge bed. When the bed becomes available move patient to permanent bed location. This is to occur 7 days per week.
- As a general principle, and when acuity is not an issue, patients will be moved to the next

available on-service bed in order of wait time by site, except when specialty designated programs are only available at one site (such as mental health, cardiac priority services, inpatient stroke care, behavioural care). When the speciality program is available at one site only, patients will be moved to the next available bed in order of acuity, then in order of wait time, regardless of site.

- Exceptions to wait time order may be made by the operations supervisor/patient flow office, manager/manager on call, based on clinical need or priority. Priority must be given to ensure patients transferred to another facility under the provincial life or limb policy are repatriated within 48 hours. Patients signed out of critical care will also be prioritized to create up to 2 beds of critical care capacity at each site.
- Morning bed meeting will likely not be required when in Green status, however if the operations supervisor deems it is necessary this will be communicated to the leadership team.

YELLOW – 31-50 patients requiring inpatient bed: all above 'green' process expectations continue unless otherwise stated (Refer to Appendix D for detailed roles and accountabilities)

- When a unit/services moves from GREEN to YELLOW, the patient flow office will implement a response that should include the following steps:
- Alerting unit coordinators/PCM of patient flow demands who will relay these demands to their staff and interprofessional team and assess the potential of all patients for discharge within the next 24 to 48 hours, particularly for those patients beyond their expected date of discharge.
- if there are no confirmed discharges and there are 31 or more patients in ED waiting for an inpatient bed, patient flow office will assign one patient to a temporary location on each appropriate nursing unit
- Beds at all sites must be reviewed during yellow and red status. All beds, at all sites must be filled with the most appropriate patient prior to opening over capacity beds
- It is expected that many patients would prefer to stay admitted to the site where they first presented, if possible. In situations where staffed beds are available at the alternate site, consideration will be given to move the patients to the next available bed at the alternate site. This is ultimately a clinical decision that will be made by the Most Responsible Physician based on acuity and clinical need. *While patient consent is not required, it is preferable to move patients who are agreeable to the transfer*.
- continue the above process until number of patients requiring beds are less than 31

RED – 50-80 patients requiring inpatient beds: All 'green and yellow' process expectations continue unless otherwise stated. Continue in a state of 'red' until the patients requiring inpatient bed value reduces to 30 or less (Refer to Appendix E for detailed roles and accountabilities)

- whenever the number of admitted patients requiring a bed reaches 50, open overcapacity beds as appropriate to meet the clinical needs of patients
- when additional staffing is required, it is most efficient to open beds on units where there is physical capacity for an additional 4-5 beds
- when all available overcapacity beds have been filled and there are 50 or more patients waiting for an inpatient bed implement pandemic planning (Appendix E)

- off-servicing patients when appropriate to do so
- open overcapacity beds must be reviewed on a daily basis to ensure beds are closed at the first available opportunity
- bed meetings in Red status are to include at least a PCM from each unit along with laboratory services, DI, transition management as well as key clinical directors

Repatriations:

- Under the Ministry of Health and Long-Term Care Life or Limb policy, patients that have been deemed Life or Limb are required to be repatriated back to their home LHIN within 48 hours of being deemed medically stable.

Ajax Emergency Department Surge Plan

*Situational factors are not to be considered in isolation. Critical thinking and collaboration with unit level leadership and physicians must occur, including operations supervisor after hours.

	Situation	Response
	Admits: 0-5 Emerg Volumes: 0 – 30 total Waiting to be seen: <15 PIA: < 2.5 hours	No response required
	Admits: 5-10 Emerg Volumes: 30-40 Waiting to be seen: 15-20 PIA: < 2.9 hours	Evaluate acuity and resource allocations for bed flow in the ED depending on needs. Consider additional RN for fast track and patient flow through the department
	Admits: >10 Emerg volumes: > 40 total Waiting to be seen: >20 PIA: >2.9 Hours	Consider additional RN to care for admitted patients. Triggers **Second on call Policy** for physician supports Consider additional RN for fast track and patient flow through the department, support second on call physician activities Consider overflow spacing – hallway stretchers, Fracture Clinic (after 1600 hrs. Weekdays; 24/7 weekends/holidays

Second On Call Policy: link

Bowmanville Emergency Department Surge Plan

*Situational factors are not to be considered in isolation. Critical thinking and collaboration with unit level leadership and physicians must occur, including operations supervisor after hours**.**

	Situation	Response
	Admits: 0 – 2 Emerg Volumes: 0 – 20 total Waiting to be seen: 0-10 PIA: < 2.5 hours	No response required
	Admits: 2-4 Emerg Volumes: 20 – 30 total Waiting to be seen: 10-15 PIA: < 2.5 hours	Evaluate acuity and resource allocations for bed flow in the ED depending on needs. Consider additional RN for fast track and patient flow through the department
	Admits: 5- 10 Emerg volumes: > 30 total Waiting to be seen: >15 PIA: >2.5 Hours	Consider additional Nurse to ensure treatment zone is open 24 hours. Triggers **Second on call Policy** for physician supports Consider additional RN for fast track and patient flow through the department, support second on call physician activities Consider overflow spacing – Physio room and hallway space. (if additional space is opened, additional RN support required)

Second On Call Policy: link

Oshawa Emergency Department Surge Plan

*Situational factors are not to be considered in isolation. Critical thinking and collaboration with unit level leadership and physicians must occur, including operations supervisor after hours.

	Situation	Response
	Admits: 0 – 15 Emerg Volumes: 0 – 50 total Waiting to be seen: 0-15 PIA: < 2.5 hours	No response required
	Admits: 15-20 Emerg Volumes: 50-75 total Waiting to be seen: 15-20 PIA: < 2.5 hours	Evaluate acuity and resource allocations for bed flow in the ED depending on needs. Consider additional RN or RPN for fast track and patient flow through the department
	Admits: >25 Emerg volumes: >75 Waiting to be seen: >25 PIA: >2.5 Hours	Consider additional RN or RPN to care for admitted patients. Triggers Second on call Policy for physician supports Consider additional RN for fast track and patient flow through the department, support second on call physician activities Consider overflow spacing – hallway stretchers in all areas, surge to fracture clinic for fast track

Second On Call Policy: link

Port Perry Emergency Department Surge Plan

*Situational factors are not to be considered in isolation. Critical thinking and collaboration with unit level leadership and physicians must occur, including operations supervisor after hours.

	Situation	Response
	Admits: 0 – 2 Emerg Volumes: 0 –10 total Waiting to be seen: 0-5 PIA: < 2.5 hours	No response required
	Admits: 2-3 Emerg Volumes: 10-20 total Waiting to be seen: 5-10 PIA: <2.5 hours	Evaluate acuity of the patients and resource allocations for bed flow in the ED Consider additional RN for fast track and patient flow through the department
	Admits: 4- 6 Emerg volumes: > 20 total Waiting to be seen: >10 PIA: >2.5 hours	Consider additional RN/RPN to look after admitted patients in ER Triggers Second on call policy Identify appropriate pts. to send to NL from ER or Med Surg. Fill 26th bed on unit (consider an extra RPN staff on Med Surg on nights and/or on days depending on the current staffing, acuity and heaviness of the unit) Consider filling 27th bed in the lounge on Med Surg (requires extra RPN staff on Med Surg during the night and consider an extra RPN staff on Med Surg on days depending on the current staffing, acuity and heaviness of the unit) **If we use the 27th bed there is no room for Emergency OR cases – these patients would need to stay in PACU (unless a simple and clean OR case and NL has a bed to admit to). If NL cannot take the patient the PACU nurse would need to do 1 to 1 with patient. If PACU is monitoring one to one this will cancel stat C-Sections and will cancel the next day's OR patients. Ask Surgery to assess the need for OR cancellations. Consider overflow spacing – DI seating/waiting area and/or physio area for fast track. (requires additional nursing support). If Physio area needed (require meds & cart, supplies, equipment including stretchers)

Second On Call Policy: link

Reference(s)

https://www.criticalcareontario.ca/EN/Surge%20Capacity%20Management/Ontario_Critical_Care_Minor_Surge_Toolkit_January2017.pdf

https://www.criticalcareontario.ca/EN/Toolbox/Implementing%20Life%20or%20Limb%20Policy/The%20Life%20or%20Limb%20Policy%20Implementation%20Guide.pdf

Appendices

A: Bed Allocation Placement and Assignment Matrix
B: Green – Detailed Roles and Accountabilities
C: Yellow – Detailed Roles and Accountabilities
D: Red – Detailed Roles and Accountabilities
E: Guidelines for Caring for Patients in Temporary Locations

Appendix A – Bed Allocation Placement Assignment Matrix

Lakeridge Health: Patient Flow Office Bed Placement and Assignment Matrix

Purpose of the document:

This matrix was created by an inter-departmental team of healthcare leaders to give permission and authority to the Patient Flow Office where best to place and assign patients which present the following primary needs in order to achieve timeliness of transfer of patient between departments and/or site at Lakeridge Health

LEGEND: most appropriate unit for patient | next appropriate unit for patient

[redacted]	Surgical Inpatient Units				Critical Care Units			Mental Health Units			Women & Children's Units									Medicine Units														PASS UNITS										
	G7	G6	F6	4E LHAP	LHO CRCU	LHB CRCU	LHAP CRCU	PICU	C4 MHGEN	A4 MHSSU	G3 F3 OBS	NICU	NLS LHPP	L&D LHAP	MNS LHAP	NUR LHAP	PAEDS	PAEDS M/S	PAEDS/ CAIP	LHB M/S	LHPP M/S	LHB MED	G9-ISO MED	G8	C7 Tele	C7 ACU	C6 ONC	G5 CARDIO	G1	2E LHAP	2W LHAP	3W LHAP	4W LHAP	C5 ISU-A	C5 ISU-R	IRU	GARU	RCU	F4 PALLIATIVE CCC	CCC LHW 4W (lock unit)	CCC LHB PALL	CCC LHW 4E	2N	3E
1:1-1:2 Nsg Care																																												
Acute DKA management-insulin infusion																																												
Acute Ventilation																																												
Admit by Psych > 5 days																																												
Admit by Psych 3-5 days																																												
Amp rehab																																												
Bariatric >600lbs																																												
Birthing related >20 wks																																												
Bowel Surgery																																												
Cardiac Monitoring																																												
Caridac system + 1 cardiac infusion																																												
CODE STEMI repatriations																																												
CRRT																																												
End of life (LOS < 3months)																																												
Epidural																																												
Gen Medicine <72 hr stay																																												
General Surg-Urology																																												
Hemodialysis																																												
Peritoneal dialysis																																												
High flo oxygen																																												
Inotropes																																												
Mental Health requiring 3:1 (LOCK)																																												
Minor gyne surgery																																												
MSK rehab																																												
Negative pressure																																												
Neurological injury with NO neuro monitoring																																												
Oncology services																																												
Ortho services																																												
Ortho surgery																																												
Paeds Sx+med																																												
Paeds with Mental Health																																												
Palliative with short term respite																																												
Rehab for 1-30 days																																												
Restorative 1-40 days																																												
Stroke for TPA first 24hrs																																												
Stroke post TPA 24hrs																																												
Stroke-NO TPA																																												
Thoracic Surg																																												
Thyroid treatment																																												
Tracheostomy																																												

Trigger for Bed Management Decision Making - Detailed Responsibility & Accountability

Appendix B - GREEN - 30 or less Patients Requiring Inpatient Bed Roles and Accountabilities

GREEN - 30 or less Patients Requiring Inpatient Bed confirmed admissions Detailed Responsibilities and Accountabilities		
Who	**Action required**	**When**
ED Unit Coordinator	• Validation of appropriate bed type (Isolation, SSU, Telemetry) etc. Accuracy of information, specifically that it matches Meditech admission order information • Ensure that patients are continually prepped to be admitted to a bed at any point • Fax TOA • Continue to monitor status of ED and communicate with patient flow office • Identify possible discharges from ED and communicate to MRP, PCM/Unit Coordinator and Operations Supervisor • Identify patient that could be provided a bed at alternate sites if beds are available	• Within 15 minutes of admission • Ongoing • Ongoing • Ongoing • By 0830 and ongoing • Ongoing
ED Unit Clerk	• Be aware of bed assigned in ED tracker/bed management tool and communicate to Charge Nurse or delegate	• Ongoing

GREEN - 30 or less Patients Requiring Inpatient Bed confirmed admissions Detailed Responsibilities and Accountabilities		
Who	**Action required**	**When**
Unit Coordinator	• Review issues/barriers with team. Resolve and provide learning for immediate resolvable concerns. Discharge issues should be emailed to the Transition Management team for further support	• Ongoing
	• Validate that the bed management tool is updated with most current information on confirmed and probable discharges at all times	• Ongoing
	• Validate that transfer requests related to bed locations are updated in the bed management tool when a patient is to be transferred	• After patient transferred from temp bed
	• Identification of all potential and real barriers to discharge and profession of care. Attempt to resolve barriers if possible	• Daily
	• Escalate barriers to discharge to the manager of Transition Management/Director of the Clinical Program impacted if they are not resolvable by the interprofessional team and unit leadership	• Ongoing
	• Discharge information is communicated to the health care team to facilitate timely discharge	• Ongoing
	• Review FRI/unit surveillance tool printed each morning on inpatient unit	• Ongoing
	• Follow up with front line nurse and MRP to ensure all consults are taking place in a timely manner	• Ongoing
Inpatient Unit Clerk	• Update bed management tool when patient status has changed (i.e. from probable to confirmed discharge)	• Ongoing
	• update bed management tool with a request for transfer when a patient is transferring from an overcapacity or temporary bed to their regular inpatient bed if applicable	• Ongoing • Prior to transferring patient
Environmental Services Porters	• Utilize the SA Tool to communicate when rooms are in progress of being cleaned and clean	• Ongoing
	• Ensure that discharged rooms are being cleaned in timely manner	• Ongoing
	• Ensure that 90-minute turnaround of when bed assigned to patient being transferred is met	• Ongoing

GREEN - 30 or less Patients Requiring Inpatient Bed confirmed admissions Detailed Responsibilities and Accountabilities		
Who	**Action required**	**When**
Bed Allocation Clerk	• Identify appropriate bed in collaboration with Operations Supervisor • Update bed management tool with bed assignment for all admitted patients • If there is an empty temporary bed and the patient is appropriate to be admitted, assign patient into temporary location on the BMT • Calculate patients requiring inpatient beds, record and communicate to the organization (Operations Supervisor during off hours) • Provide end of shift change report indicating direction for the next shift with operations supervisor	• Ongoing • Hourly • When a confirmed discharge is indicated • 0800, 1400 • End of shift
Operations Supervisor	• Facilitate the daily movement of patients • Liaise with bed allocation clerk to address any issues or barriers related to bed allocation • Develop a day time bed management plan at the start and end of shift and communicate to the organization and to the night Operations Supervisor	• Ongoing • Ongoing • End of shift
Operations Supervisor (evening, nights, weekends)	• Ensure the day time bed management plan is implemented with minimal changes (unless absolutely necessary) • Distribute shift report to on call team. • Round to units and identify current and anticipated status to support bed allocation planning. This includes contact with all sites	• Ongoing • 0600 • By 2300
Off Hours Inpatient Charge Nurse	• Dialogue with Operations Supervisor for access or bed allocation issue to support timely resolution	• Ongoing

GREEN - 30 or less Patients Requiring Inpatient Bed confirmed admissions Detailed Responsibilities and Accountabilities		
Who	**Action required**	**When**
Physicians: MRP, Consultants	• MRP – document plan for patient discharge and goals of care/barriers to progression • MRP – review their admitted patients and identify those who are ready and potential for discharge on the unit white board and/or bed management tool • MRP – attend daily discharge rounds (where applicable) • MRP – identify expected date of discharge which will be documented in most appropriate location (i.e. bed management tool/whiteboard) • MRP – communicate early with patient/families in collaboration with the interprofessional team when a discharge is expected to be less than 48 hours and /or ensure flagged as yellow to facilitate team planning • Consultants – attend to request for consult consistent with priority of referral request and/or provide direction for discharge/follow up • When possible and without delaying discharge, ensure all required paperwork is prepared (order written, prescriptions, etc) and ready for next day discharge to ensure early AM discharge once all issues have been addressed	• Ongoing
Infection Prevention and Control Professional	• Attend daily bed meeting and bring updated information on possible discontinuations of isolation precautions	• Daily

Appendix C – YELLOW – 31-50 Patients Requiring Inpatient Bed Roles and Accountabilities

All "Green" process expectations continue unless otherwise stated

- If there are no confirmed discharges and there are 31 or more patients waiting for an inpatient bed, move one patient to a temporary location on the appropriate nursing unit. One patient per unit can be assigned **without** an identified discharge on all medical floors

- Continue the above process until number of patients requiring beds is less than 30

YELLOW – 31-50 Patients Requiring Inpatient Bed Detailed Responsibilities and Accountabilities *All "Green" process expectations continue unless other stated*		
Who	**Action required**	**When**
ED Unit Coordinator	• Identify possible discharges from ED and communicate to MRP, PCM and Operations Supervisor • Identify patients that could be provided a bed at alternate sites if beds available	• Ongoing • Ongoing
ED Supervisor/PCM	• Communicate with MRP/Consultants any potential admissions that could be avoided when possible • Where appropriate this should be assessed by the ED physician and patient discharged with appropriate follow up	• Ongoing

YELLOW – 31-50 Patients Requiring Inpatient Bed Detailed Responsibilities and Accountabilities *All "Green" process expectations continue unless other stated*		
Who	**Action required**	**When**
Unit Coordinators	• Secure and prepare nursing staff and prepare temporary locations as patients will be admitted regardless of a confirmed discharge • Prepare to review discharge plans with clinical team • Liaise with LHIN to expedite transition plans, where possible, for patients in acute beds who no longer have acute treatment issues if discharge home is not possible • Reassess ALC patients for potential discharge home or possibly to another more appropriate unit • Identify and review patients awaiting lab, procedures and/or diagnostic imaging investigations; expedite timing where possible • Communicate/remind the unit that the patient flow status is in a status of "yellow" and that patients will continue to be admitted to temporary beds without a confirmed discharge as appropriate	• After "Yellow" triggered and start of shift • Ongoing • After "Yellow" triggered and start of shift
Patient Care Manager /Unit Coordinator	• Review discharge plans with Unit Coordinator • Assess the status of the inpatient unit to determine any potential discharges • Resolve immediate issues and barriers to discharging patients • Escalate issues that cannot be resolved by contacting Transition Management/Program Director and/or physician lead (if physician barriers) and outline specific issues/concerns to the group • Notify Division Head of any physicians who have not attended/checked in on the unit by 10am (on all applicable units)	• Ongoing • Ongoing • Ongoing • Ongoing • Daily as required
Bed Allocation Clerk	• Prepare to open overcapacity • Assign beds and temporary location • Use information from IPAC to cohort patients according to precautions	• Ongoing • Ongoing • Daily after the communication from IPAC

YELLOW – 31-50 Patients Requiring Inpatient Bed Detailed Responsibilities and Accountabilities *All "Green" process expectations continue unless other stated*		
Who	**Action required**	**When**
Operations Supervisor	• Communicate clinical information to bed allocation clerk to ensure appropriate patients are selected for temporary locations • Identify and remove barriers to ensure smooth flow of patients to temporary locations • Communicate with unit coordinators and/or PCM if needed re: Yellow status • Escalate issues that can't be resolved to clinical director of program being impacted immediately • Will call for afternoon bed meeting as needed and communicate with leadership team	• Ongoing • Ongoing • Ongoing • Ongoing
Manager on Call	• Receive and discuss bed state with Operations Supervisor including overnight plan, if necessary	
IPAC	• Review and reassess on possible discontinuations of isolation status • Attend bed meeting and provide updated information regarding isolation status of admitted patients to patient flow	
Physicians: MRP, Consultants	• Consultants - prioritize responding to referrals for consults • MRP – review all acute patients and discuss with the nurse/unit coordinator/allied health team a plan for discharge and resolution of barriers to discharge • Round on acute patients daily and/or call into nursing units if out of hospital • As care planning progresses connect back with unit coordinator regarding action plans; status of admitted patients/discharges. Any unresolved disputes escalate to Division Head and/or section leads	
Department Chiefs and/or section leads/Medical Directors	• Support team with any unresolved issues related to discharge planning • The program director (delegate) will collaborate with unit manager(s) and operations supervisor to review potential options to restore flow which may include the movement of patients cross-site and temporarily opening one or two beds above budget in units with available capacity	

Appendix D – RED –50-80 or more Patients Requiring Inpatient Bed Roles and Accountabilities

All "Green and Yellow" process expectations continue unless otherwise stated. Continue in a state of "red" until the patients requiring inpatient bed value reduces to 30 or less.

- When all appropriate units, at all sites, have accepted one additional patient as defined in yellow, and there continues to be 50 or greater unassigned patients, move to open most appropriate overcapacity beds.

RED – 50-80 or more Patients Requiring Inpatient Bed Detailed Responsibilities and Accountabilities *All "Green and Yellow" process expectations continue unless other stated*		
Who	**Action required**	**When**
ED Unit Coordinator	• Identify possible discharges from ED and communicate to MRP, Supervisor and Operation Supervisor	• Ongoing
ED Supervisor/PCM	• Communicate with MRP/Consultant of potential admissions that could be avoided when possible and update bed management tool when they have been identified	• Ongoing
Unit Coordinators/Charge nurse	• Prepare for overcapacity beds and confirm with patient flow office the specific beds that will be considered overcapacity • Continue to review discharge plans with supervisor/PCM • Ensure appropriate staffing is in place to care for patients in overcapacity spaces	• Immediately • Ongoing • Immediately when red triggered
Unit Coordinators (in collaboration with PCM)	• Review discharge plans with clinical team • Assess the status and performance of the inpatient unit to determine any potential discharges • Resolve issues and barriers to discharging patients • Escalate issues that cannot be resolved by communicating to clinical director immediately • Attend bed meeting to discuss and resolve issues	• Ongoing • Ongoing • Ongoing

RED – 50-80 or more Patients Requiring Inpatient Bed Detailed Responsibilities and Accountabilities *All "Green and Yellow" process expectations continue unless other stated*		
Who	**Action required**	**When**
Program Directors	• Communicate to the department chiefs/medical director of red status and indicate any barriers/conflicts and expectations to manage discharges. If department chief is not available program director will communicate to covering physician • Help PCM/unit coordinators remove barriers to discharging patients as required	• Immediately • During days only
Bed Allocation Clerk	• Assign, in collaboration with Operations Supervisor, patients to overcapacity beds until patients requiring inpatient bed value reaches 30 or less. Once this happens, ensure new patients are not admitted to overcapacity locations • Assign beds to temporary location • Use information from IPAC to cohort patients if feasible	• Immediately • Ongoing • Daily after communication from IPAC
Operations Supervisor	• Communicate with PCM/unit coordinator that the hospital is in 'Red' Status. On weekends, review with the Manager on Call to determine strategies for escalation to other organizational leaders as determined • Provide clinical expertise to bed allocation clerk to ensure appropriate patients are selected for overcapacity locations • Identify and remove barriers to ensure smooth flow of patients to overcapacity locations • Escalate issues that can't be resolved to PCM and/or program director • Notify staffing office of potential staffing needs. If staffing cannot be available overnight, organize with staffing office to ensure staff is available as early as possible • Round on units to help facilitate discharges on evenings and nights, if feasible • Notify staffing office when overcapacity beds are not required	• Immediately • Ongoing • Ongoing • Immediately • Ongoing • Ongoing • Days
Manager on Call	• Receive and discuss bed state with Operations Supervisor including overnight plan	• 1700 via phone • 2300 via email

RED – 50-80 or more Patients Requiring Inpatient Bed Detailed Responsibilities and Accountabilities *All "Green and Yellow" process expectations continue unless other stated*		
Who	**Action required**	**When**
IPAC	• Review isolation status of all admitted patients and inform patient flow office of any discontinuations or potential cohort arrangements that can be made if feasible • Attend bed meeting and provide unit coordinators as well as patient flow office with updates regarding isolation status	• Ongoing
Physicians: ED, MRP, Consultants	• MRP/Consultant Physicians – assess all admitted patients to identify if any can be discharged with additional resources • Consultants – prioritize attending to consults for inpatients • MRP (on units applicable) – must attend discharge rounds to expedite discharge planning and escalation of barriers. Review patients waiting for consults or medical imaging and assess if these can be done as outpatient or expedited to facilitate more timely discharge	
Dept Chiefs/Medical Directors	• Connect with Division Heads to ensure they have communicated with all related physicians the need to expedite discharges and are working with the unit leadership to facilitate discharge planning. Where dispute exist will facilitate resolution with team • Correspond with Program Director and suggest any other course of action required	• As early as possible in the day • After rounding complete

Appendix E – Guidelines for Caring for Patients in Temporary Locations

High demand for inpatient beds may result in the need to care for patients in temporary locations.

A temporary location is a location that is not designed specifically as a patient room. Temporary locations may be in the emergency department or on the units and may include rooms used for other purposes, lounges or hallways.

Temporary locations are to be used as a short term solution to manage high patient volume and flow throughout the organization. Patients in temporary locations on the inpatient units will be given first consideration to move to a patient room when a room becomes available on that unit.

The following guidelines are intended to assist in decision making regarding the most appropriate space on a unit/in a department to use as a temporary location including what resources should be considered as well as considerations for the type of patient most suitable and processes that should be in place.

Guidelines

ENVIRONMENT

Consider the following items/equipment that should be available in/near the temporary location:

- Bed*
- Call bell-wall pull station or push bell (must be audible to nursing station)
- Commode (if no access to washroom facilities; washroom could be shared with another patient room)
- Curtains for privacy (hanging or standalone)
- Bedside chair (optional)
- Overbed table/bedside table (optional)

*Note: a stretcher may be used for very short term situations if space is not conducive to a bed, however need to have a pressure relief stretcher mattress

CLINICAL

- Portable vital sign machine
- Portable oxygen tank/tubing
- Portable suction
- PPE station

PATIENT

The following should be considered when choosing a patient for a temporary location:

- Patient should not be isolated
- Patient should not have long term oxygen therapy requirements (unless space has piped oxygen)
- Patient should not have significant behavioural, psychological or psychiatric issues that would threaten safety of self or others, or result in a decompensation of the patient's mental status
- Patient should not require palliation
- Patient should not require telemetry monitoring

COMMUNICATION

Sending Unit/Department

The patient shall be informed prior to moving that they will be going to a temporary location.

Receiving Unit/Department Routine

- The PCM/unit coordinator shall follow up with patients/families regarding the use of temporary location
- The patient will be registered to the unit using a temporary location code which will ensure the patient is on the unit census
- A chart and all the usual tools will be created for the patient and kept in the usual locations (i.e. chart rack)
- A nurse will be assigned to the patient
- Ensure MRP has been identified for the patient
- The patient name will be added to the whiteboard/BMT for rapid rounds
- The patient will be discussed during rapid rounds

Other

1. Operations Supervisors will be aware of the units where patients are in temporary locations and support the staff and/or patients/families with any questions or concerns
2. Based on unit assessment, a patient may be moved from a room to a temporary location to accommodate a new patient into a room if more appropriate.

References:

CNO Report *Nursing in Temporary Locations: Listening to Ontario's Nurses* August 2004