

IMPLEMENTATION OF OVER CAPACITY PROTOCOL



Editor's Summary: In *Implementation of an Overcapacity Protocol*, Providence Health Care in British Columbia rethought the limitations of physical space in order to care for the most urgent cases during periods of overcapacity. They identified “zones” in non-traditional areas of the hospital which were identified as “overcapacity spaces”. Each ward within the hospital designated such a space so that nursing and medical attention could be safely provided to urgent cases provided that the patient did not have any of the conditions or requirements that were identified on a checklist. The deliberate use of space in this manner coupled with safety and staffing considerations, allowed for a reduction in Emergency Length of Stay (LOS) between 5-7 hours depending on the group of patients. During the evaluation period, there were no adverse events indicating that the policy is a safe way to improve access during period of overcapacity.

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Purpose:	During the year of 2005 St. Paul's Hospital showed a situation of overcrowding in the Emergency Department because of prolonged boarding of admitted patients; serious adverse events and patient deteriorations in the ED waiting room led to implementation of an Over Capacity Protocol.
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Context:	<p>The Over Capacity protocol is a fundamental change in the way patients flow into the ED and into inpatient services. Overcapacity protocol is a “pull system” that enhances access to ED treatment and inpatient care. The OCP incorporate 5 philosophical tenets:</p> <ol style="list-style-type: none"> 1.The same standard of (or expectation for) patient centered care, applied throughout the hospital: dignity, respect, safety, and quality begin at the time of patient arrival and extends until patient discharge. 2.Hospital overcrowding needs to be addressed with the support of the entire health care system 3.The best health outcomes and efficiencies are achieved when patients are matched at the earliest time to the right program and the appropriate skill of care provier 4.All hospital programs have important care missions and require reasonable access to their care resources: space, staff, equipment and budget. 5.Hallways are undesirable locations for patient care
Resources:	<p>Operating \$: 600,000 . The funding came trough the “Region”. Any other hospital might have not need any additional funding if the system and the people is in place by the time of implementation FTEs: Unit Coordinator, Clinical Coordinators, CNL, WardAid.</p>
Source of resource:	<p><input type="checkbox"/> <i>In kind</i> contributions from the organization <input type="checkbox"/> Dedicated internal funding <input checked="" type="checkbox"/> External funding (example grant, Ministry etc.)</p>
Population group:	<p>Admitted patients through the ED</p>
Patient flow entry and end points:	<p>Admitted patients is defined as when there has been a decision to admit the patient to an in-hospital bed and there has been a written admission order, until the patient is transfer to the unit/ward.</p>

Description/ approach:	<p>OCP dictates that, rather than being left in waiting areas, all arriving level 1-3 patients are quickly placed in overcapacity ED spaces where they will receive necessary nursing and medical care.</p> <p>-When no staffed ED stretchers are available and the ED is caring for 2 overcapacity patients, and there is 1 CTAS Level 2-3 in the waiting room unable to be placed - admitted patients waiting in the ED for a hospital bed move rapidly to overcapacity care spaces on inpatient units.</p> <p>-OCP spaces may be existing beds, solariums, lounges, conference rooms, or unit hallways. Each unit determined the location.</p> <p>-Admitted patients move to the most appropriate ward hallway, one at a time with following criteria:</p> <ul style="list-style-type: none"> • No rule-out Acute Coronary Syndrome • No one requiring > 4L oxygen • Medical exception to transfer • Identify units where there are OCP spaces • No unit gets more than 2 hallway patients • Sensitivity around “busy” periods on the wards <p>Under the direction of the Access Leader and/or Clinical Coordinator, inpatient units would be required to accept up to two admitted patients who meet the defined criteria. The units will work under a “no refusal” policy and aim to begin the transfer of patients within 10 minutes when the ED is overcapacity. Only admitted patients will be transferred to the most appropriate inpatient unit and staff skills will be aligned with patient needs as much as possible.</p>
Tools and tactics:	<p>This initiative resulted in the Overcapacity Protocol Guidelines for Transfer of Admitted patients from ED.</p>
Measurement approach:	<p>Outcomes include mean ED LOS for admitted patients, as well as EDLOS and hospital LOS stratified by inpatient service. (Innes G., Stenstrom R., Harris D., Hunte G., & Schwartzman A. Impact of an overcapacity care protocol (OCP) on ED flow and overcrowding. Feb 2007.)</p>
Impact/ evaluation:	<p>The mean ED LOS (all admitted patients) fell from 18.9 to 13.9 hrs ($p < 0.001$). EDLOS fell by 9.0 hours, 1.6 hours and 9.2 hours for admitted medical, surgical and mental health patients respectively. Hospital LOS fell by 1.0, 0.8 and 0.8 days for medical, surgical and mental health patients respectively ($p < 0.001$ for all). After OCP, arriving emergent-urgent patients were rarely left in ED waiting areas. During the post-OCP period, no critical events were reported in ED waiting areas or inpatient OCP care spaces. Evaluation period 2005 (pre-implementation) and March-Aug 2006 (post implementation).</p>
Observation/ Discussion:	<p>The evaluation has shown that the OCP protocol has provided care for a greater number of patients throughout the hospital and timeliness of care for all patients has improved. It has also indicated that there are areas for improvement and further work is required. The goal is to provide quality care to the patients we serve.</p>

Critical success factors/ lessons:	Having a champion dedicated for this initiative and strong support from Senior Leadership Team. Constant evaluation and reporting results back to the staff. Recognize that this is not an ED issue, but a system issue for flow and access. Listen to staff concerns and follow up in a timely manner.
Limiting factors:	<p>In order to make further improvements the ED team needs to continue to address system issues as infection control throughout the hospital. Also to continue to support staff and services and improve communication regarding changes in processes and roles. Increase equipment and supplies for OCP patients on each clinical area and continue to work with the inpatients units to improve discharge planning.</p> <p>The Overcapacity Protocol is based on the principles that all patients should receive the same standard of care throughout the hospital and that congestion needs to be addressed with the support of the entire hospital.</p>