Update on Overcapacity Protocols

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“Hospitals with overcrowded Emergency Departments are overcrowded hospitals that have chosen to manifest the overcrowding in a single location”

Peadar Gilligan & Gareth Quin

What is an Overcapacity Protocol?

• Fundamentally a hospital protocol which under appropriate circumstances triggers some redistribution of admitted patient workload between ED and other locations
• Various definitions (wordy and otherwise) are used
• Sometimes standalone, commonly introduced as part of a package of flow reforms

• Synonyms
  – Overcapacity Protocol/Policy (OCP)
  – Overcensus Protocol/Policy (OCP)
  – Full Capacity Policy/Protocol (FCP)

• OCP is simply the right thing to do: Who has done it?
What is an Overcapacity Protocol?

• This audience mostly knows, but just in case…

• Imagine you work in a 350 bed hospital
• It is 0900 on a winter Monday morning
• Hospital Occupancy is 104% - 363 patients admitted
This is your hospital

- ED top left
- ICU next
Occupancy

- 345 patients in ward beds
- 5 empty ward beds
- 2 patients in ICU suitable for general ward, unable to “get out”
Future

- 20 of these patients already known to be going home today (90%+)
- Another 40 will go home after review
- That means wards are each 92-100% occupancy
- How can hospital be 104%?
Emergency Department

- 48 patients = 192%
- 18 admissions in ED designed for 2 = 900%
ED: 48 patients = 192%

- Arrest to mortuary = 1 Resus trolley
- Ventilated COPD overdose – needs ICU
- Dying 86yo awaiting bed for 8 hours
- Silent infarct (ATS 3) in waiting room
Overcapacity Protocol
Overcapacity Protocol

- When ED is dangerously overcrowded
- Each ward takes 1-2 ED/ICU overcensus patients to their hallway
Overcapacity Protocol

- Actually-
- Wards put patients for discharge in lounge or discharge area
- “Hallway” patients get beds
- Waiting patients in ED get moved inside and seen
- Wards 100-108%
- ICU has one bed (96%)
- ED 132%
  - 150% for admissions
- Better to do it on reaching threshold, not all at once
History

- Peter Viccellio
- Stonybrook “Full Capacity Protocol”
- “Address high hospital census in a distributive and safe fashion”
History

- Concept dates from 1990s
- Implemented Feb 2001

Emergency Department Overcrowding: An Action Plan

From the time I began working in emergency departments (EDs) in New York City as a full-time profession in 1980 until I left the city in 1988, I do not recall a single shift at any time of day or night, in any of five different EDs, on any day or in any week, month, or year, where there were not admissions stacked up knee-deep in the ED. The entire borough of Queens ran at over 100% occupancy every day for more than a year. When holding 30 admitted patients in a ten-bed ED, I once called a nearby ED to attempt transfer of some of our admitted patients. The receiving ED politely declined the transfers, as they were holding more than 50 admitted patients in their ED. We had been averaging 20 admissions held in the ED on each shift for an entire year. In 1987, I had the opportunity to treat a 45-year-old male (a malpractice lawyer, as is usual for such stories) with an acute anterior wall myocardial infarction. He represented the first time in my career I had ever provided the first moments of care to a patient on a blanket on the floor of our ED, having utilized all our stretchers, the hospital's stretchers, and additional stretchers brought in by an outside company.

Interestingly, it simply never occurred to me at that time to de-tendents in the ED, and to become narcotized by our daily Sisyphus drama.

New York and California were particularly active during this period, the mid-90s, at bringing this issue to the public. Articles in the New York Times and major magazines appeared. National news shows featured stories on the "crisis" of ED overcrowding. It made for great story. Similar stories recycled in the mid to late 90s. Overcrowding didn't reach Suffolk County, where I work now, until four or five years ago. When it did, it was "worthy" of a CNN special report.

What was lacking, however, was any useful solution to the problem. Ambulance diversion was tried with little success, given that entire regions were saturated with patients. Directive to cancel elective admissions were issued, but elective admissions were, by that time, a thing of the past. Hospitals in New York were cited for not providing adequate privacy, for not documenting repeatedly on the patient's chart that an inpatient bed was not available, for not calling in additional staff (which didn't exist) to provide needed care, and for not providing the appropriate nursing ratios to intensive care unit (ICU) patients boarding in the ED. The ED nurses began completing the ten.

Why do admitted patients remain in the ED? It is indeed a strange acquiescence on our part to embrace the notion that, when hospitals have no inpatient beds, the patient will naturally have to remain in the hallway of an ED. (Even stranger is how they remain in the ED when there are inpatient beds.) This logic, one should note, is differentially applied. Obstetrical patients don't remain in EDs; they are moved to the obstetrical suite, regardless of occupancy. It is illogical that this does not occur in other areas of the hospital, which has far greater square footage than the ED. The suggestion of hoarding patients in the operating room would be met with ridicule, for obvious reasons. Why is it not obvious that the critical ability
History

- The 2006 revision (current)

SUBJECT: Full Capacity Protocol

RESPONSIBLE DEPARTMENT, DIVISION OR COMMITTEE: Medical Director's Office

EFFECTIVE DATE ORIGINAL POLICY: 2/2/2001
EFFECTIVE DATE REVISED POLICY: 2/2/2001
SUPERSEDES POLICY NUMBER:

LAST REVIEW DATE: 6/15/06
DATED:

SUBJECT: SBUH staff facilitates the admission of patients held in the Emergency department awaiting Acute Unit Bed assignments through utilization of the Full Capacity Protocol.

SCOPE: Hospital wide

PURPOSE: To facilitate the admission of patients held in the Emergency Department awaiting Acute Unit Bed Assignment.

POLICY: When a patient requires admission to an Acute Care Unit from the Emergency Department and that area cannot accommodate the patient because of lack of sufficient beds, the patient will be admitted to the next most appropriate bed. In the event appropriate hospital bed utilization has been maximized, and the number of admitted patients holding in the Emergency Department has prohibited the evaluation and treatment of incoming patients to the Emergency Department in a timely fashion, the admitted Emergency Department patients already awaiting in house acute care bed assignments will be admitted to acute care unit hall beds.

The Bed Utilization Coordinator will facilitate this policy. When unavailable the house wide and will assume responsibility and assign hall beds in conjunction with the Bed Control Supervisor. On nights and weekends the ADN on duty serves this role.

The placement of patients to hall beds will be implemented by the Bed Utilization Coordinator only after the Emergency Department Attending Physician, the Charge Nurse and the Bed Utilization Coordinator have declared the need to implement Full Capacity Protocol. The decision of patient placement by the Bed Utilization Coordinator after discussion with the Emergency Department Attending physician (if indicated) shall be binding.
2006: Another big year

- St Paul’s Hospital Vancouver introduced their Overcapacity protocol
- Institute of Medicine report marked the widespread acceptance outside the EM community that there is a problem
  - Multiple recommendations
  - Improved efficiency and flow
  - Coordination and accountability
  - Increased resources
  - Pay attention to Children
  - Research agenda
2007 CJEM / AEM Abstract: IMPACT of an overcapacity care protocol on emergency department overcrowding
Innes GD, Grafstein E, Stenstrom R, Harris D, Hunte G, Schwartzman A. Department of Emergency Medicine, Providence Health Care and St. Paul's Hospital, Vancouver, BC

Introduction: In 2005, at this tertiary inner city hospital, because of prolonged boarding of admitted patients, 9249 triage level 2 and 3 (emergent and urgent) patients were blocked in ED waiting areas for 3 hours (estimated access gap= 27,750 hrs). Serious adverse events and waiting room deaths led to implementation of the overcapacity protocol (OCP) in February, 2006. The OCP dictates that arriving level 1-3 patients are placed in overcapacity ED care spaces rather than waiting areas. When the ED goes overcapacity by 2 patients, admitted patients boarded in the ED move to overcapacity care spaces on inpatient units. Our objective is to describe OCP impact on EDLOS and patient flow.

Methods: This before-after analysis uses administrative data to compare the post-OCP period (March through August, 2006) to the corresponding control period in 2005. Outcomes include mean ED LOS for admitted patients as well as EDLOS and hospital LOS for admitted medical, surgical and mental health (MH) patients.

Results: During the post-OCP period, ED volume rose from 30483 to 30846 (1.2%), CTAS 1-3 volume rose from 13078 to 13828 (5.7%), and daily ambulance arrivals rose from 46.1 to 46.6 per day (1%). Despite this, mean ED LOS for 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 MH patients respectively. Similarly, hospital LOS fell by 1.0, 0.8 and 0.8 days for medical, surgical and MH patients (p<0.001 for all). After OCP, arriving emergent-urgent patients were rarely left in ED waiting areas. During the postOCP period, no critical events were reported in ED waiting areas or inpatient OCP care spaces.

Conclusions: A 5.0 hour mean reduction in EDLOS for 8200 annual admissions provides access to an additional 41,000 hours of ED stretcher and nursing time, more than the access gap estimated prior to OCP implementation. The OCP reduces ED LOS for admitted patients, reduces ED access block and appears to reduce adverse outcomes for ED patients.

Key Words: Triage, Overcrowding, Overcapacity
2008: ACEP

- Statement without level 1 evidence

**High-Impact Solutions**

The following solutions would have significant impact on reducing boarding and improving the flow of patients through emergency departments:

- **Move emergency patients who have been admitted to the hospital out of the emergency department to inpatient areas, such as hallways, conference rooms, and solaria** (see Full Capacity Protocol at www.hospitalovercrowding.com). If each hospital unit would care for a small number of additional patients, the burden of boarding would be more evenly spread across the hospital, thus freeing the emergency department to function effectively without unduly stressing the inpatient units.

- **Coordinate the discharge of hospital patients before noon.** Research shows that timely discharge of patients can significantly improve the flow of patients through the emergency department by making more inpatient beds available to emergency patients. However, the discharge process has become more complex, and discharging patients by noon will require leadership and a change in culture and process that must involve physicians, nurses, and staff from ambulances, nursing homes, social work, care management, pharmacy, radiology, lab, and housekeeping.

- **Coordinate the scheduling of elective patients and surgical patients.** Studies show that the uneven influx of elective surgical patients (heaviest early in the week) is a prime contributor to hospitals exceeding their capacity.
2 years later, said to be widespread

- In a survey, 40% of 27 crowded EDs claimed to be using Inpatient Full Capacity Protocols
- 25% of “good balance” EDs
- All still without much evidence

2009: Stonybrook Reviewed

- 50% of “hallway” patients bedded within one hour
- Mortality rates in “Hallway” patients half that of regular ward patients

In about 25% of cases, an appropriate inpatient bed was found for patients assigned to a hallway bed immediately on arrival to the inpatient unit; another 25% were placed in a room within an hour. The remaining 50% boarded on the inpatient unit approximately 8 hours before room placement (from hospital continuous quality improvement data).

Inhospital mortality rates were higher among patients admitted to standard beds (2.6%; 95% CI 2.5% to 2.7%) than among patients admitted to hallway beds (1.1%; 95% CI 0.7% to 1.7%). ICU admissions were also higher in the standard bed admissions (6.7% [95% CI 6.5% to 6.9%] versus 2.5% [95% CI 1.9% to 3.3%]).

2011: Formal Review with mortality

- 3 yr of admissions in academic ED
- Stratified by boarding interval
- Adjusted for measures of severity and comorbidity
- Hospital with an overcapacity protocol: low-risk boarders could be moved to ward hallways
- 41256 patients

2011: Formal Review with mortality

- Highly significant dose-response relationship between boarding duration and ICU admission, mortality and inpatient LOS
- Overcapacity protocol is a theoretical weakness but the data is compelling
Late 2000s: More Evidence


Patients prefer this approach


The role of full capacity protocols on mitigating overcrowding in EDs

Cristina Villa-Roel MD, Xiaoyan Guo*, Brian R. Holroyd MD, Grant Innes MD, Lyndsey Wong MD, Maria Osipina, Michael Schull MD, Benjamin Vandermeer, Michael J. Buillard MD, Brian H. Rowe MD

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Abstract

Objective: Overcrowding is an important issue facing many emergency departments (EDs). Access block (admitted patients occupying ED stretchers) is a leading contributor, and expedited placement of admitted patients is an area of research interest. This review examined the effectiveness of full capacity protocols (FCPs) on mitigating ED overcrowding.

Methods: A comprehensive literature search was undertaken to identify potentially relevant studies between 1996 and 2009. Intervention studies in which an FCP was used to influence ED hospital length of stay and ED hospital access block were included as a single program or part of a systems-wide intervention. Two reviewers independently assessed citation relevance, inclusion, study quality, and extracted data, because of limited data, pooling was not undertaken.

Results: From 14 446 potentially relevant studies, 2 abstracts from the same comparative study were included. From 29 studies on systems-wide intervention, 4 contained an FCP component. The included study was a single-center ED study using a before-after design; its methodological quality was rated as weak. One of the abstracts reported that an FCP was associated with less ED length of stay (5-hour reduction) when compared with the comparison period; the other reported that an FCP decreased ED overcrowding.

One strategy designed to address this issue is called the full capacity protocol (FCP). Full capacity protocols have been implemented in an effort to increase the ED functional capacity by transporting admitted patients from the ED to temporary care spaces (e.g., inpatient care spaces designed for admitted ED patients). The goal of the FCP is to safely share the burden of inpatients without assigned beds throughout the hospital, with the intent of improving clinical operations and mitigating the negative effects of ED overcrowding. Moreover, FCP interventions have been embedded within several systemwide interventions (SWIs) that have been implemented in an effort to improve the efficiency of admitted patients’ flow, liberate ED care spaces, and share the patient volume among inpatient services. Despite the promise of this intervention, the consequences and effectiveness of the intervention are largely anecdotal.
2012: Review Article

- Looked at 5 studies
- Concluded “Not enough Evidence”, “More Research Needed”

<table>
<thead>
<tr>
<th>Reference</th>
<th>Study assessing FCP</th>
<th>Location</th>
<th>Sample size</th>
<th>Intervention period</th>
<th>Study design</th>
<th>Intervention</th>
<th>Comparison</th>
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<tbody>
<tr>
<td>Innis et al., 2008 [10]</td>
<td>Innis et al., 2007 [11]</td>
<td>Canada</td>
<td>61 329</td>
<td>6 mo</td>
<td>Before-after</td>
<td>FCP: whenever ED overcapacity by 2 patients, boarded patients were moved to inpatient care spaces. 2-h rule: maximum for ED assessment, 2 h maximum from the decision to admit, 2 h maximum to transfer patients to inpatient spaces.</td>
<td>Pre-FCP</td>
</tr>
<tr>
<td>Schauer et al., 2007 [18]</td>
<td>United States</td>
<td>7132</td>
<td>3 mo</td>
<td>Before-after</td>
<td>SWI with an FCP component: Patients were transferred to the floor at 90 min post-bed assignment, regardless of unit acceptance.</td>
<td>Preintervention</td>
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<tr>
<td>Rowe et al., 2009 [19]</td>
<td>Canada</td>
<td>NR</td>
<td>18 mo</td>
<td>CCT</td>
<td>SWI with an FCP component: No more than 2 patients were placed on wards when “triggers” (based on ED size) were reached.</td>
<td>Preintervention</td>
<td></td>
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<tr>
<td>Mason et al., 2008 [20]</td>
<td>United Kingdom</td>
<td>56 000</td>
<td>6 y</td>
<td>ITS</td>
<td>SWI with an FCP component: to meet the 4-h target between arrival and discharge or admission; various protocols.</td>
<td>Preintervention</td>
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<tr>
<td>Cardin et al., 2003 [21]</td>
<td>Canada</td>
<td>3621</td>
<td>12 mo</td>
<td>Before-after</td>
<td>SWI with an FCP component: transfer to ward within 1 h of bed assignment.</td>
<td>Preintervention</td>
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NR indicates not reported; ITS, interrupted time series.

5. Conclusion

In summary, the evidence upon which administrators, clinicians, and others base decisions about the implementation of FCPs to address ED overcrowding is limited. Although ancillary evidence can be derived from SWI with an FCP component, the operational definitions of all FCP plans varied remarkably. This important field could benefit from a concerted effort by administrators and health service researchers to collaborate not only to improve the quality of the evaluation of FCP interventions, but also to promote a more comprehensive outcome reporting and a wider dissemination of ED overcrowding research.
This is likely to change

- Consensus view of experts is that there will be enough evidence once the Canadian experience is published
- 2012 series of abstracts from Alberta
- Canadian Emergency Medicine meeting, International conference on Emergency Medicine, Society for Academic Emergency Medicine (prize winning)
- Cannot really call it equivalent to peer-reviewed study until it is published, but this is the most exciting work
- Unfortunately, 3 years later, still in abstract form
Impact of an Overcapacity Protocol on ED access and flow in a Health Region

Grant Innes, Andrew McRae, Dongmei Wang, Eddy Lang

Department of Emergency Medicine, University of Calgary
Access Block in Alberta

- Many flow projects and capacity expansions: 2005 - 2008
- A multi-million dollar system-wide acute access program (GRIDLOCC – 2007 / 2008) failed to improve hospital access or reduce ED boarding times
- For > a decade, ED and hospital access block increasing
- Overcapacity plan written in 2009, politically blocked
- Dec 2010: Implementation of the Alberta Overcapacity Plan
- 14 Teaching Hospitals across Alberta simultaneously
- >650,000 patients /year
**OCP simplified**

**ED Inflow:**
1) Arriving CTAS 2/3 patients will move within 15/30 min into an ED acute care space.
2) If no ED space available, patients will move to an ED overcapacity or intake space so care can be initiated.

**Hospital Inflow:** If . . .
- a) ED is overcapacity by 10%, and
- b) 35% of ED stretchers are blocked, and
- c) arriving patient needs stretcher-based care

The most stable admitted patients go to OCP spaces on the most appropriate inpatient units.
Results

Primary outcomes:
- Mean ED LOS (ADM pts) fell by 33% (17.2 to 11.6 hr.)
- Mean # of admitted pts at 10am fell by 46% (11.3 to 6.1)

Secondary outcomes:
- Wait time to MD fell from 113.2 min to 99.3 min
- LWBS rate fell from 4.0% to 3.8%
- OCP effects sustained over time; but varied by site

*All differences significant at p<0.001 (sample size)*
5 Philosophical tenets of a successful OCP

• The same care standards apply throughout the hospital, from patient arrival to discharge

• Overcrowding (access block) is addressed by the entire system

• Best outcomes and efficiencies occur when patients are matched to the right unit and team ASAP

• All units have important care missions and require reasonable access to their resources in order to provide acceptable care and meet performance targets

• Hallways are undesirable locations for patient care

This was SWI

- 25 different components to the intervention
  - Not originally including overcensus policies
- Marked improvement in NEAT
  - Admission NEAT from 10% to 30%
- Inverse relationship between NEAT and Mortality
A MODIFIED OVERCAPACITY PROTOCOL AFTER 15 MONTHS: EFFECTIVENESS FALLS WITHOUT ONGOING ADMINISTRATIVE SUPPORT
Richardson DB, Hall M

Background: A modified Overcapacity Protocol (OCP) introduced in The Canberra Hospital (TCH) in June 2013 demonstrated a strong association with decreased ED admission occupancy (AOCC, patients waiting for beds) and an even greater reduction in periods of dangerous (AOCC >10) and critical (AOCC>13) overcrowding. Subsequently administrative changes were made to the OCP activation and procedure.

Aim: To describe the effects of the OCP after 62 weeks.

Methods: Prospective descriptive study of all ward admissions in a mixed tertiary ED comparing (1) the four 3-month periods after OCP with the preceding year, and (2) the 10 week period after introduction with the same periods in the preceding two years and the following year. AOCC was calculated minutely from ED information system data, and the mean AOCC and the proportion of time corresponding to dangerous and critical overcrowding for each period.

Results: Improvement was confined to the first quarter after the change, when the mean number AOCC was 6.06, compared to 6.78 in the control quarter (P<0.0001), the means were identical in the second quarter (6.54) and higher in the third and fourth quarters after the OCP (6.02 vs 4.49, 6.27 vs 5.98, both P<0.0001). Dangerous overcrowding was lower in the first two quarters (8.4% vs 14.6% then 11.5% vs 14.2%, P<0.0001), but higher in the third (11.9% vs 6.4%) and fourth (13.0 vs 11.4%) and critical overcrowding was similar. The ten week analysis showed presentations rising steadily (16.7% over 3 years, ward admissions rising steadily (21%) and mean AOCC rising unevenly by 13% with a fall of 15% after OCP and a rise of 30% the following year. Dangerous overcrowding fell 49% after OCP then rose 153%, and critical overcrowding fell 87% then rose 750%.

Conclusion: This study provides clear evidence that the OCP significantly mitigated overcrowding, but without ongoing administrative support its effect was lost after 6 months. Overcrowding is a whole of hospital problem requiring whole of hospital solutions. This experience suggests that mandatory and automatic activation criteria form an important part of any OCP.
Higher Quality Studies would be good

- Really hard hospital wide
- Can be done: this is a cluster randomised trial in ED
  - Setting of financial incentives
  - Intervention was an additional nurse and doctor working in Triage area
- Intervention effective for non-consulted discharged patients
  - Wait decreased 25min
  - High Acuity LOS decreased 24min
  - Low Acuity LOS by 56min if seen
- LWBS 1.5% vs 2.2% (p=0.06)
- Hospitals not waiting for studies

Proposed in NSW

- 2003 SWSAHS
- 2003 ECT DOH
- 2004 SESIAHS
- 2008 Sally McCarthy for NSW Emergency Care Taskforce

**Proposal**

It is proposed that a similar “Full Capacity Protocol” be instituted in NSW hospitals

**Emergency Department Criteria** for implementation:

1. Triage category 2 or 3 patient on chair > 10 minutes OR ambulance off-load delayed > 45 minutes
2. Department has no vacant resuscitation bed AND
3. Admitted patients suitable for immediate transfer are occupying beds in ED

**Procedure:**

4. Hospital patient flow manager, duty emergency physician (or delegate) and senior emergency nurse agree on requirement for Full Capacity Protocol and notify Administrator on call (usual avenues to free ED space have already been exhausted eg. Patients are transferred to next available bed in the hospital, wards and inpatient teams have expedited discharges etc)
5. ED boarded inpatient moves to ward bed space or corridor, becoming an overcensus ward patient, rather than an overcensus ED patient. The decision of patient placement by the Patient Flow Manager after discussion with the Emergency physician (if indicated) shall be binding.
6. Chair, waiting room or ambulance patients off-loaded to now vacated bed space/s in ED
7. Emergency Department maintains operational status whilst boarder inpatients are now accommodated in hallways within the hospital, OR inpatient units place pre-discharge patients in chairs/hallway beds to accommodate new patients in ward bed
8. A maximum of 2 hallway patients will be accommodated in any single ward
Implemented in Liverpool – Sep 2012

- **NEAT:** August 32%  October 60%
- **Antibiotics for Sepsis:** August 54m  October 39m
- **Flow:** Subjectively Better
- **Complaints:** Reduced

- **Source:** Unpublished Data
- **Staff:** Difficult to implement but improved care
Liverpool: Current Protocol

- Balanced and Timely Transfer of patients to home wards from ED, ICU and MAPU (including use of transit beds)
- Does not use the language of “overcapacity”
- Clearly is an overcensus approach
Princess Alexandra Hospital

Management of Hospital Capacity Escalation Plan

Does not use the language of “overcapacity”

Explicitly is an overcensus approach
- One patient per ward
Townsville General Hospital

Escalation Procedure - Management of Patient flow during Levels of Escalation

Quietly uses the language of “overcapacity”

Modified overcapacity approach of using real hospital beds
Royal Darwin Hospital

Over Crowding Escalation RDH ED Plan

This plan is to be used in an ongoing trial operating 0800-2000 Monday

Target Audience
Areas applicable: RDH Emergency Department staff

Purpose
To identify changes in occupancy/capacity/patient flow within the emergency department and implement strategies to:
- Maximize safety for all patients in the Emergency Department;
- Maintain safe capacity and access to care in all patient streams (Major Paediatrics, Resuscitation);
- Minimize ambulance offload delay; and
- Ensure that inpatients housed within the emergency department flow to wards in a timely manner.

Author / Contributors
Name               Position                Service/Program
Didier Palmer       Director of Emergency Medicine         Royal Darwin Hospital

Alternative Search Words
Patient flow, Over Census code.

Level 3 – Extreme Pressure

Care plans are continuing to increase.

Contact with the Hospital Response Group or delegate if overflow extends beyond 4 hours or exceeds predicted or actual bed availability.

ED Nurses are accessing care.

Actions Required

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<th></th>
<th>ED Nurse Team Leader</th>
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<tr>
<td>Monitoring Checklist</td>
<td>Hospital Response Group</td>
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<th>Title: Over Crowding Escalation RDH ED Plan</th>
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<td>Version: 4.0</td>
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Printed: 9/06/2015 3:36:00 PM - Printed copies are for reference only. For the latest version, refer to the Policy Guideline Centre on the Department's intranet. Department of Health is a Smoke Free Workplace.
Royal Darwin Hospital

- Overcrowding Escalation RDH ED Plan
- Does actually use the language of “Over Census”
- Not automatic, requires Senior committee input
Others

- Royal Hobart Hospital draft “Capacity Escalation System”
- Canberra Hospital “High Demand Policy” – with minister
- Other examples from around Australia and New Zealand
- Clearly “overcensus” and “overcapacity” are not popular words for document titles
- Little consistency in exactly how they work – local effects
- Nevertheless, beyond the “early adopter” phase (3 years)
  - Overcapacity protocols are spreading
- Expect to see more research and evaluation
SUMMARY

• Overcapacity protocols are now regarded as international best practice, in use for nearly 15 years
• Morally the right way to deal with overcrowded hospitals
• Proven safe, proven to be the patients’ preference
• Evidence base for degree of effectiveness could be improved
  – Opportunity for a multicentre trial
  – There is evidence for improved ED flow, decreased waiting times, decreased access block, and decreased inpatient LOS
• Already taken up by “early adopter” hospitals in Australia
• Spreading although some unwilling to call them by name
• Overcapacity protocols should be regarded as an essential part of modern hospital management
“Hospitals with overcrowded Emergency Departments are overcrowded hospitals that have chosen to manifest the over-crowding in a single location”

Peader Gilligan & Gareth Quin