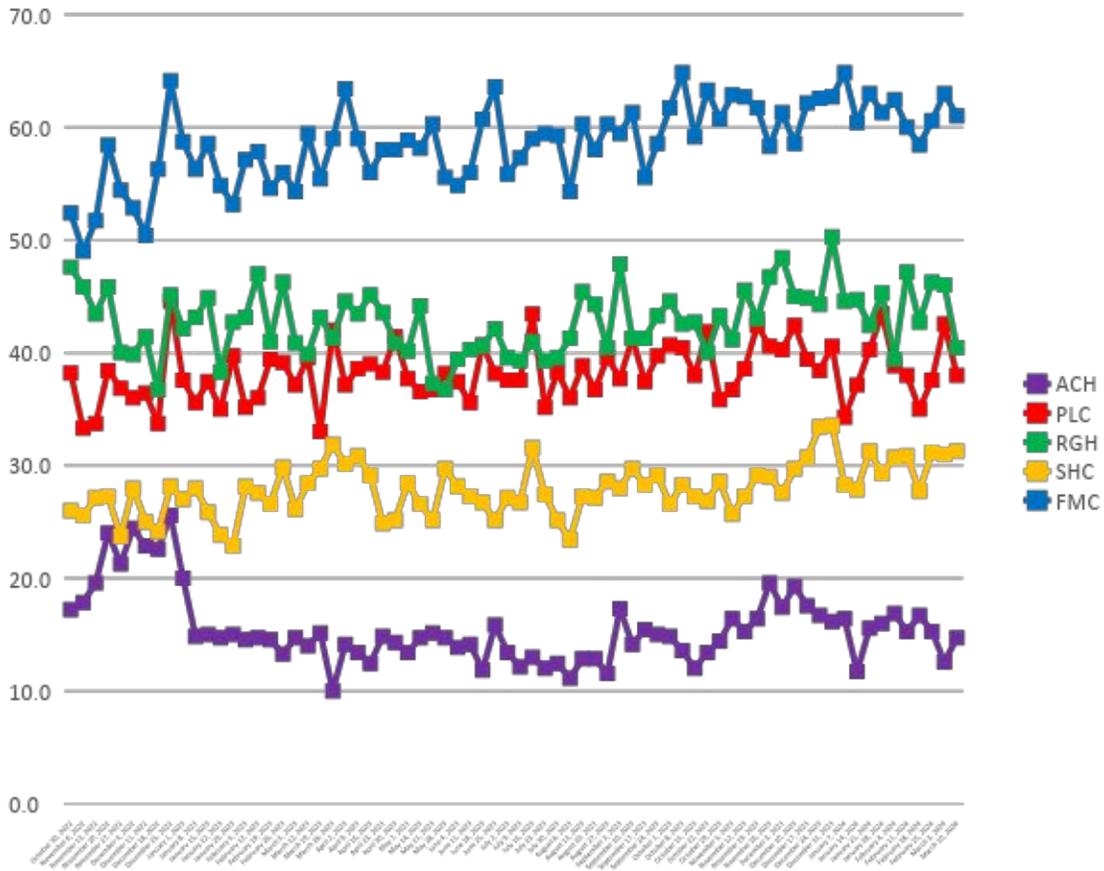


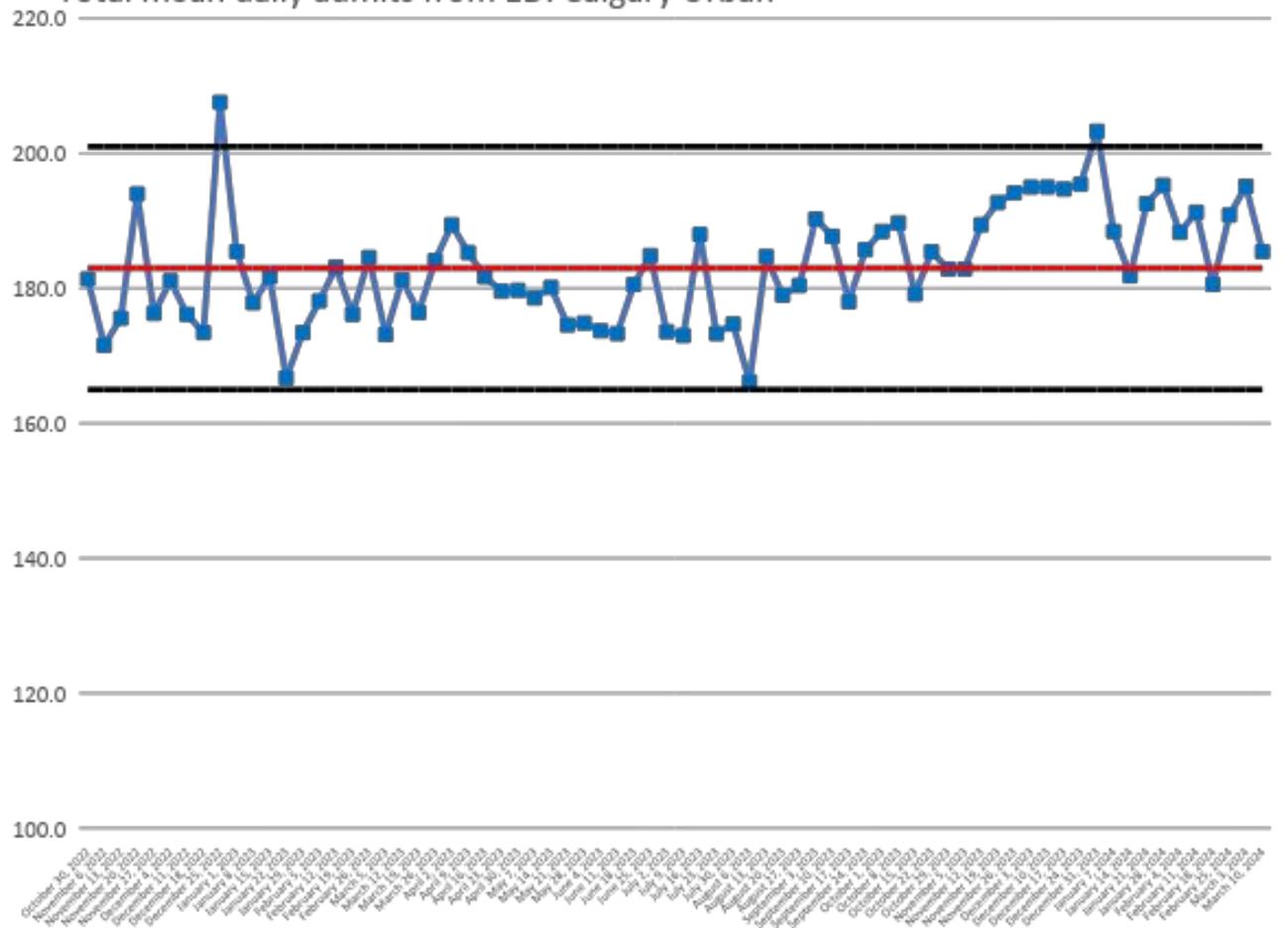
Calgary Zone Urban Bed Planning Streamlining and standardization

Calgary Zone changes to OC and Surge space utilization

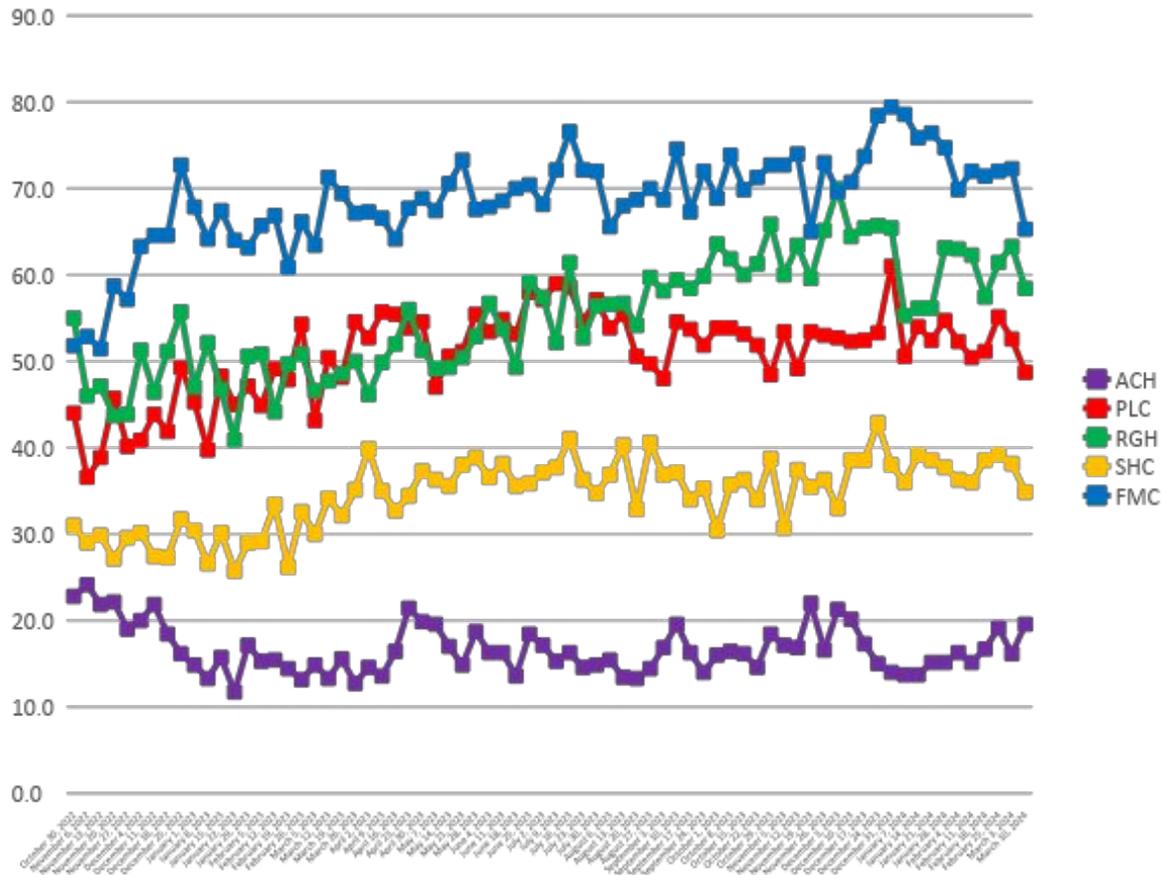
Mean daily admits from ED



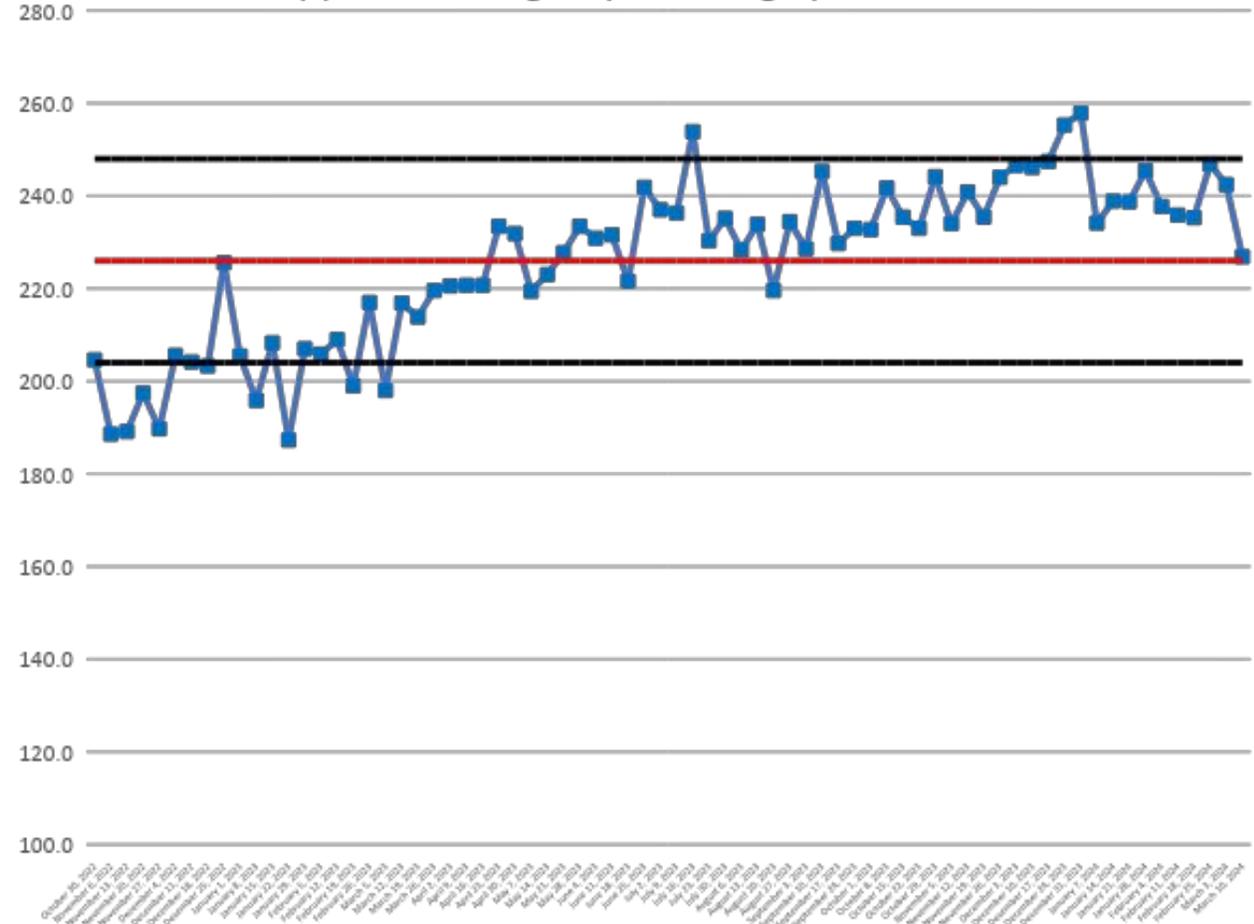
Total mean daily admits from ED: Calgary Urban



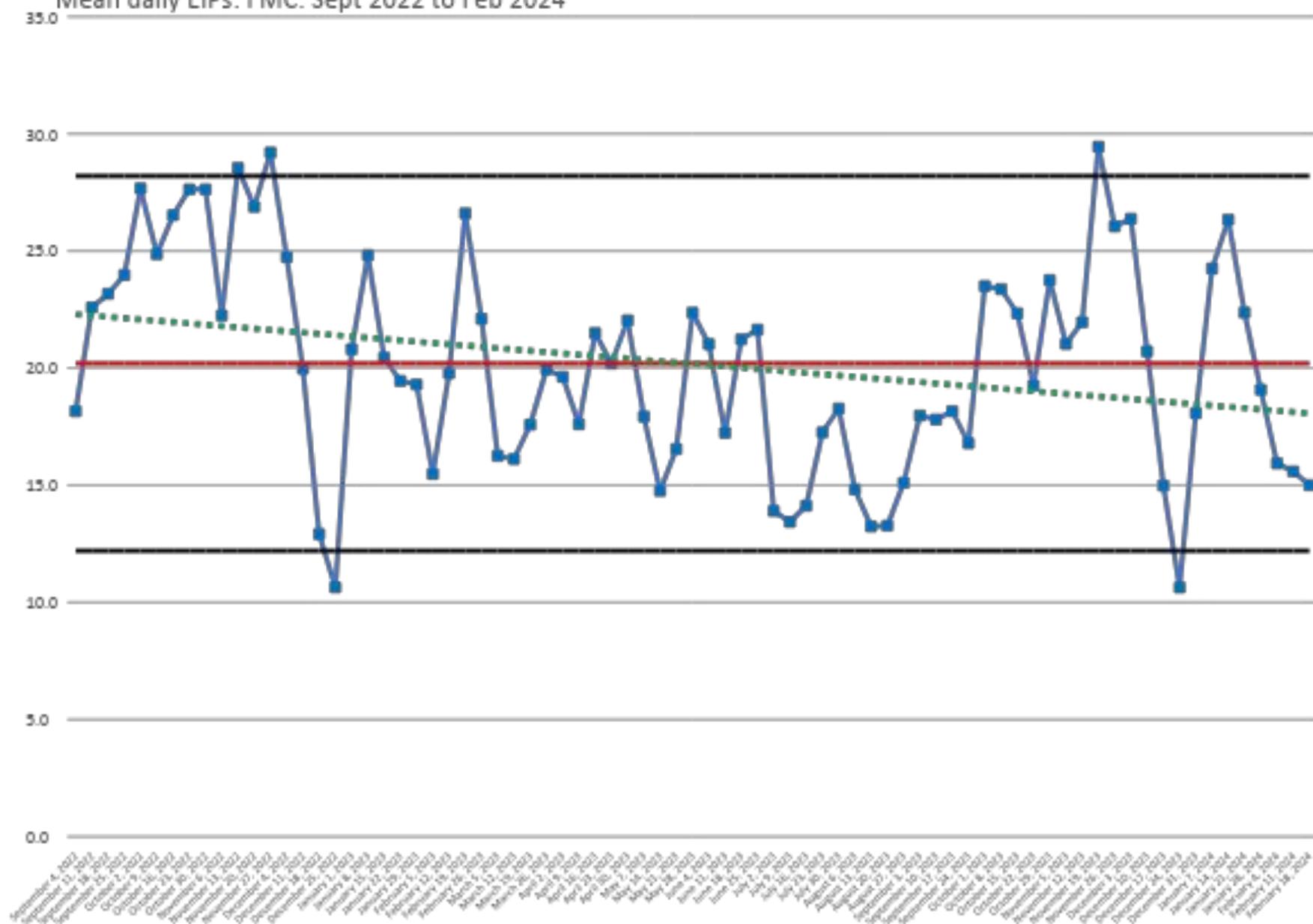
Mean daily patients brought by EMS



Total mean daily patients brought by EMS: Calgary Urban



Mean daily EIPs: FMC: Sept 2022 to Feb 2024



FMC implications and engagement

Mainly for bed planners

- Connect care capacity dashboards ✓
- Rural participation in bed huddle processes ✓
- Load levelling activation and communication processes ✓
- System wide capacity reporting twice daily ✓

Mainly for inpatients and bed planners

- Pre huddle sheet ✓
- Bed huddle ✓
- Bed request to bed assigned ✓
- Bed ready to admission ✓
- OC and surge criteria and utilization **(starting Mon 25th)** ✓
- Connect care capacity management tools **(coming March/April)**

Classification of overcapacity and surge/hallway spaces

Unfunded bed spaces used to support inpatient demand which exceeds funded capacity include what have been referred to as overcapacity spaces (OC) and also surge or hallway spaces. Calgary Zone will align with a revised provincial approach to the naming of these unfunded spaces by combining these types of spaces into a single term: OC spaces. Beds which have been virtually built in Connect Care as “H beds” will also be referred to as OC spaces (though will retain the “H” nomenclature in EPIC).

Utilization of OC spaces will follow the Calgary Zone “best available bed” Bed Planning Principle and Provincial Team Targets, and therefore be expected to be routinely used based upon inpatient demand.

Based upon the infrastructure available to a bed space, an OC bed will be of one of two types:

- **Headwall OC space** – an inpatient treatment space that has continuous access to oxygen and suction.
- **Non-headwall OC space** – an inpatient treatment space that requires portable oxygen and suction.

Headwall OC spaces will have no additional exclusion criteria and treated therefore in the same way as funded bed spaces.

Non-headwall OC space exclusion Criteria

There are three exclusion criteria for use of a non-headwall OC space.

1. Airway impairment or requiring > 3L O2 via nasal prongs
2. Continuous suction
3. Airborne or Airborne and Contact Isolation

Units will continue to be expected to follow the “best available bed” principle in choosing which patients receive their care in non headwall OC spaces. This should include reference to the patient’s medical stability, behavioral profile, mobility and functional needs and also follow the guidance outlined by IPC (see links below).

However, an inpatient unit will be expected to admit patients into these beds following a request from the Bed Planning team if these spaces are the only available capacity and if a patient meets none of the exclusion criteria. As usual if a patient is not best suited for this bed on arrival, internal shuffles will occur to ensure each patient is in the best available bed to meet their care needs.

[IPC Risk Assessment Checklist for Use of Overcapacity Patient Spaces \(albertahealthservices.ca\)](#)

[Infection Prevention and Control Risk Assessment Checklist for Use of Overcapacity Patient Spaces \(albertahealthservices.ca\)](#)

ED to IP Surge Guideline Changes

This

Within-Unit Inpatient Surge

4. No further clinically appropriate and subspecialty matched EIPs can be identified for a surge bed (i.e. no other ED to inpatient surge opportunities exist).
5. Consider creating expanded capacity when a surge trigger is met to support broader system support (e.g. allowing transfer out of ICU or PACU, or providing a bed space for a future ED admission should surge triggers continue to be met).

Changes to this

Within-Unit Inpatient Patient Movement (formerly referred to as “Within-Unit Surge”)

4. Units are expected to follow the “best available bed” principle in choosing patients to proactively move into their overcapacity spaces thus maintaining expanded capacity to provide broader system support (e.g. allowing transfer out of ICU or PACU, or providing a bed space for a future ED admission should surge triggers continue to be met).



Beginning March 25th

• What changes (at all sites)

- OC and Surge beds now all referred to as OC beds
- Exclusion criteria for all OC beds (without headwalls) streamlined to
 1. Airway impairment or requiring > 3L O2 via nasal prongs
 2. Continuous suction
 3. Airborne or Airborne and Contact Isolation
- OC utilization is not linked to the 3 empty bed rule in the previous guideline
- Within unit moves now not linked to surge beds
- Weekly reporting of OC utilization at unit/portfolio/site level

• What doesn't change

- Leveraging unit team's skill, expertise, and experience in placing patients in the best available bed
- Surging patients when in triggers to regular and OC beds if meeting surge and OC criteria
- The need to utilize all OC spaces to manage demand on a routine basis
- Monitoring of bed pre-assigned and bed ready time intervals at unit/portfolio/site level

Some additional perspectives/assumptions

- Perfection is not expected overnight
- A lot of hard work from everyone has got us to the place we are now
– we are very grateful for it
- Streamlining the OC approach and criteria will reduce extra processing, delay (waits), and friction (rub)
- We will try and balance greater autonomy for the units with monitoring of utilization