

**SHADY GROVE ADVENTIST HOSPITAL
PATIENT CARE POLICY MANUAL**

CAPACITY MANAGEMENT PLAN

Effective Date: January 1, 1999
Cross Referenced:
Reviewed:
Revised: 5/02; 2/04; 6/05

Policy No: 25129
Origin: ED
Authority:
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PURPOSE:

To structure a procedure to be used by all departments during times of high census or bed shortage, so that patients may be placed in an appropriate bed as soon as possible, ambulance diversion is minimized, and access to care is improved.

DEFINITION:

- High Census = greater than 200 patients with strategic units full.
- A bed shortage occurs when multiple patients are waiting for an inpatient bed and/or beds on an appropriate unit and the beds are unavailable due to a high census situation. Examples: two or more patients are waiting for a bed assignment in the Emergency Department (ED), Post Anesthesia Care Unit (PACU), Labor and Delivery (L&D), or direct admissions and no beds are anticipated for 2 or more hours.

POLICY:

1. When a bed shortage exists, the Clinical Bed Controller or Administrative Supervisor will initiate the high census plan.
2. As appropriate, the Clinical Bed Controller or Administrative Supervisor will notify the Medical Director of the specialty units to assist with prioritization of admission and transfer decisions. The Medical Staff Office will be alerted by Clinical Bed Controller or Administrative Supervisor when a high census alert exists. Medical Staff Office personnel (or the Administrative Supervisor, when the office is closed), will post the "High Census Alert" notice at the medical staff entrance, and will place notices in the medical staff lounge areas to alert physicians of the high census and of areas with the greatest need for beds. Other methods of communication with physicians may be implemented as needed.
3. Census meetings are generally conducted twice daily. Additional census meetings may be held when the High Census Alert has been issued, at the discretion of Clinical Bed Controller or Administrative Supervisor. During census meeting, the following items are reviewed:
 - A. Hospital census and patient boarding situations
 - B. Available beds
 - C. Anticipated admissions/discharges
 - D. Discharges awaiting transfer or transportation issues
 - E. Staffing

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4. Assignments will be appropriate to the needs of the patient population. The Nursing Administration Office personnel/Unit Director or designee(s) will explore all options to provide sufficient staffing through the following:
 - Reassign staff from one unit to another based on competency of the nurse and the unit's needs;
 - Utilize limited part-time (PRN), Float or Part-time staff;
 - Request existing staff to provide additional hours;
 - Clinical Nurse Specialists and Nurse Educators assume clinical care assignment;
 - Request on-call staff to report for duty;
 - Call supplemental/agency staffing;
 - Call in unscheduled off-duty staff;
 - Charge nurse/designee assumes clinical care assignment;
 - Manager assumes clinical care assignment.

5. Bed Control, in collaboration with the unit directors and Administrative Supervisor, will implement the following:
 - A. When possible, patients may be assigned to a bed on another unit.
 - 1) Pediatric patients age 16 and above may be assigned to a Med/Surg unit or to the Short Stay Unit.
 - 2) Postpartum patients may be assigned to Pediatrics or maintained in L&D, or other areas as appropriate.
 - 3) GYN patients may be assigned to Pediatrics, Med/Surg, or Short Stay Unit.
 - 4) Med/Surg patients may be assigned to IMCU, Pediatrics, Critical Care or Short Stay Unit.
 - 5) Critical care patients may be assigned to PACU.

 - B. Alternative patient care areas may be used for temporary patient placement:
 - 1) Pre-Op Holding area
 - 2) Cath Lab Holding area

 - C. The Patient Representative may be asked to visit patients and families who may be temporarily assigned in alternative areas.

5. Unit Charge Nurses will contact attending physicians for transfer/discharge orders and will ensure that all discharges are entered into the computer within five minutes of patient leaving the floor.

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6. STAT cleaning of patient rooms will be facilitated by Bed Control.
7. Case Management staff will facilitate patient transportation to post-acute care facilities as early in the day as possible.
8. Situations may arise when the hospital is operationally full, and consideration may be given to canceling elective procedures, initiating ambulance diversion, or delaying direct admissions. The Administrator On-Call will consult with the appropriate leadership staff, including but not limited to, the Medical Staff President, Medical Directors, and other clinical leaders. The Administrator On-Call must approve these actions before they may be implemented.

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HIGH CENSUS MANAGEMENT

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- A. Staff for extra shifts
 - B. Agency
 - C. Clinical Specialists
9. Bed Control in conjunction with the unit Directors/Administrative Supervisors will implement the following:
- A. When possible, patients may be assigned to a bed on another unit within the desired module or related module:
 - 1) Pediatric patients, ages 16 and above may be assigned to a Med/Surg unit.
 - 2) Postpartum patients may be assigned to Antepartum, Pediatrics or held in L&D.
 - 3) Gyn patients, may be assigned to Antepartum, Pediatrics, Med/Surg.
 - 4) IMCU patients may be assigned to Critical Care.
 - 5) Med/Surg patients may be assigned to IMCU, Pediatrics, Critical Care or Antepartum.
 - 6) Critical care patients may be held in PACU.
 - B. Alternative patient care areas may be used after normal operational hours. When utilizing alternative placement areas, the future use of that area and ability to staff must be considered.
 - 1) 2 South
 - 2) 3rd floor pre-operative holding (available weekends, holidays and evenings)
 - C. If patients are awaiting transfer to other facilities, alternative areas might be used to facilitate new admissions, including transfer to the admit/discharge unit.
 - D. The Patient Representative may be asked to visit patients/families who may be boarded in alternative areas.
6. Unit charge nurses will contact attending physicians for transfer/discharge orders and assist Bed Control by ensuring all discharges are entered into the computer within 5 minutes of discharge.
7. “STAT” cleaning of patient rooms will be facilitated by Bed Control. “STAT” cleans may be requested when a patient is awaiting admission (ED, OR/PACU, direct, transfer) or there is an emergent isolation need.
8. Social Service and/or Case Management will facilitate transportation as early in the day as reasonable.
9. Situations may arise when the hospital is operationally full and consideration may be given to canceling elective procedures, ambulance diversion, delaying direct admissions or managing patients in non-traditional areas. The Administrator On-Call will consult with the appropriate leadership staff, including but not limited to, the Medical Staff President, Medical Directors/Section Chairperson, and other directors.