LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HARBOR-UCLA MEDICAL CENTER

SUBJECT: SURGE CAPACITY PLAN **POLICY NO.** 337

CATEGORY: Provision of Care	**EFFECTIVE DATE:** 8/11
POLICY CONTACT: Joy LaGrone, RN	**UPDATE/REVISION DATE:** 4/22
REVIEWED BY COMMITTEE(S): Patient Flow Steering Committee	

PURPOSE:
To define the process to ensure continued ability to provide patient care at times of increased patient volume and overcrowding.

POLICY:
At specified utilization and resource levels, the hospital staff will implement proactive, systematic actions to mitigate overcrowding and pre-hospital ambulance/emergency medical services diversion. These actions consist of, but are not limited to:

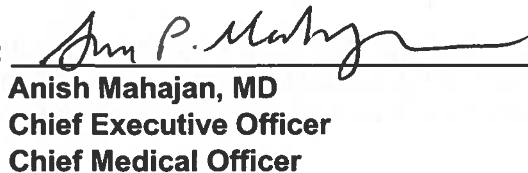
- Internal and external communication regarding the status of Emergency Department (ED) volume and boarding, inpatient occupancy, and anticipated demand for beds from surgeries, outpatient clinics, and direct admit transfers
- Authorization of transfers out of the ED
- Diversion to Adult Advanced Life Support (ALS) ambulances, Basic Life Support (BLS) ambulances, Trauma and STEMI (ST-elevation myocardial infarction) receiving center (SRC) transfers
- Cancellation of elective surgeries and clinic admissions
- Expedited inpatient discharges and inter-unit transfers

DEFINITIONS:
ED Boarder: An admitted patient who is located in the ED that has the "admit to inpatient" (hospital icon) order placed.

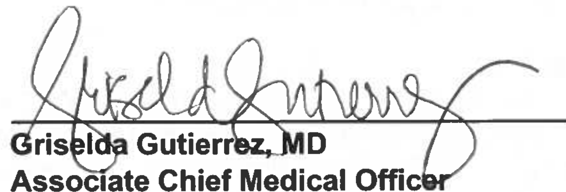
Emergency Department Acuity Index (ESI): The Emergency Severity Index (ESI) is a tool for use in the emergency department triage. The ESI yields rapid, reproducible, and clinically relevant stratification of patients into five groups, from Level 1 (most urgent) to level 5 (least urgent). The ESI provides a method for categorizing ED patients by both acuity and resource needs. This definition is taken directly form Agency for Healthcare Research and Quality (AHRQ) ESI version 4.

REVISED: 10/14, 2/17, 4/22
REVIEWED: 10/14, 2/17, 4/22

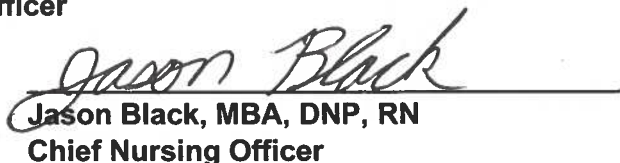
APPROVED BY:



Anish Mahajan, MD
Chief Executive Officer
Chief Medical Officer



Griselda Gutierrez, MD
Associate Chief Medical Officer



Jason Black, MBA, DNP, RN
Chief Nursing Officer

Surgical Acuity Tiers: Pursuant to Department of Health Services guidelines, surgical acuity tiers are as follows:

Tier 0 – Needs immediate care
Tier 1 – Care is needed within two weeks
Tier 2 – May need care within two to four weeks
Tier 3 – May need care within one to two months
Tier 4 – May need cared within two to three months
Tier 5 – Care can be postponed for greater than three months

Nurse Staff Capacity/Levels (red, yellow, green):

PROCEDURE:
As hospital capacity reaches or exceeds maximum utilization, clinical and administrative leaders are to follow a process of escalating communication/notification and initiate actions to alleviate high census and overcrowding. Actions taken are appropriate to the situation and may be modified based on specific challenges. In the tables below, there are four levels of resource utilization (Pre-Surge, Level 1, Level 2, and Level 3) with associated communication requirements and action steps to be taken. It is important to note: **To initiate the actions for any level of the Surge Capacity Plan, <u>any three (3)</u> of the *Resource Utilization Criteria* must be met.**

When criteria for a level are met or are justified by circumstances that compromise safe patient care, the Patient Flow Facilitator (PFF), Overall Charge Nurse (OCN), and/or ED attending will consult to initiate the communication plan. All clinical department heads are expected to review staffing and workload and make adjustments to ensure continuity of service until routine operations are resumed. Flexibility is required of managers and staff in support of efforts to relieve dangerous overcrowding. Managers should notify Hospital Administration of actual/anticipated staffing or capacity issues.

The surge status may or may not precipitate ED ALS diversion. Diversion is determined by the hospital Chief Executive Officer (CEO) or administrative designee in consultation with the on-duty ED attending and OCN after a huddle with designated responsibility to the house supervisor.

REOPENING AFTER DIVERSION
For diversions to STEMI or Trauma, the PFF will notify Cath Lab staff, Cardiology Attending, and the Trauma Attending of decisions per the Chief Medical Officer (CMO), or Administrative Officer of the Day (AOD). Unless renewed by hospital and medical leadership, diversion status will end as soon as possible. The Mobile Intensive Care Nurse (MICN) and PFF on duty will reopen in the ReddiNet and notify Transfer Center/Medical Alert Center (TC/MAC) supervisors of open status.

REPORTING
Each time the Surge Plan is enacted, the PFF will submit a report within 24 hours to the Chair of the Patient Flow Steering Committee and the Chief Executive Officer (CEO), Chief Nursing Officer (CNO) and Chief Medical Officer (CMO). The PFF will submit a new report for each 24 hours the hospital remains in surge status. The report will contain the following information:

For Surge Level 1:
- Time Surge Level 1 was activated.

- The time the emergency department was placed on ambulance diversion, if diversion was needed.
- The name of the MAC supervisor notified of our surge status, and the time of notification.
- Time of termination of Surge I status.
- Additional comments/suggestions about the surge plan.

For Surge Level 2, all of the above and:

- Time Surge Level 2 was activated.
- Name of the MAC supervisor notified of our Level II Surge Status, and time of notification.
- Time of termination of Surge II status.
- Additional comments/suggestions about the surge plan.

For Surge Level 3, all the above and:

- Time Surge Level 3 status activated.
- Time command center opened (at the discretion of hospital leadership) and name(s) and position(s) of individuals staffing the center.
- Time the Chief of Trauma or ED leadership or CMO/designee contacted to consider diversion to trauma or BLS diversion, and the final decision.
- Time of each communication between the PFF and command center about bed status, and brief summary of that communication.
- Name of the MAC supervisor notified of Surge Level III Status, and time of notification.
- Time of termination of Surge III status.
- Additional comments/suggestions about the surge plan.

PRE-SURGE CONSIDERATION
The below list is not all encompassing but counter measures to consider as the hospital begins approaching Surge Level I criteria.

- Utilize chair outside room for discharges to aid in quicker Environmental Services (EVS) turnaround times (TAT).
- Discharge patients from waiting room (can use curtain in alcove) or triage (if space is available).
- Consider second clerk or router RN if staffing allows.
- Identify possible nursing assistant (NA) to take vitals before router.
- Identify possible staff who can assist in triage.
- Urgent Care Clinic (UCC) expands scope to include out-of-plan (OOP) patients.
- Consider additional ED physician staffing for mid-shift to meet demand.

SURGE CRITERIA

LEVEL 1 - Hospital resources are nearing maximum utilization on both ED and inpatient sides with demand expected to increase. Must meet 3 criteria. PFF sends out PFF report email to hospital leadership every 4 hours.			
Surge 1 Criteria (activate if any 3 criteria are met)	**Counter Measures**	**Who can initiate:**	**Owners:**
50 or more in waiting room (Triage rooms+AWR+R1 through R5+Ambulance Triage)	• Maximize use of all staffed ED rooms. • If all rooms being used, consider using X-Chairs in RME Hallway. • Assign additional Fast Track patients to Adult teams if they have capacity. • Strongly consider closing to ALS to decompress rooms, especially if anticipating trauma or critical medical patients. • Discharge stable patients to the waiting room while awaiting a ride. • Urgent Care Center to help offload ED by seeing all ESI 4 and 5 patients using current criteria. • Consider using FastTrack rooms for ESI 3 patients.	Router, RME Charge, OCN, ED attending RME Director, UCC Director	OCN UCC Director
5 or more ESI 2 in WR and ambulance triage	Consider closing to ALS to decompress rooms, especially if anticipating traumas or critical medicals	MICN, Acute Charge, OCN, ED attending	MICN
PACU at capacity based on staffing/ratio acuity	• Hold patients in OR and procedural areas as needed • Triage OR throughput to outpatient first, as needed • Charge Nurse OR/PACU notifies PFF	Charge Nurse OR/PACU	Charge Nurse OR/PACU
≥ 16 or more ED boarders	• ED Hospitalist rounds with ED Charge Nurse and contact inpatient attendings for downgrades and discharges • ICU teams identify stable ICU patients for transfer to Rancho Los Amigos or LAC+USC • Obtain approval to transfer appropriate female inpatients to 7W if capacity/staffing permits.	Hospitalist ICU teams Inpatient Associate Medical Director	Hospitalist Inpatient Associate Medical Director

LEVEL 1 - Hospital resources are nearing maximum utilization on both ED and inpatient sides with demand expected to increase. Must meet 3 criteria. PFF sends out PFF report email to hospital leadership every 4 hours.			
Surge 1 Criteria (activate if any 3 criteria are met)	**Counter Measures**	**Who can initiate:**	**Owners:**
	• Inpatient Charge Nurse to identify potential discharge and downgrades within 2 hours of surge 1 being declared.	Inpatient Charge RNs, PFF, Utilization Review (UR)	Inpatient Associate Medical Director PFF
3 or more inpatient units staffing in yellow (only include units based on identified patient admission needs).	• Contact additional nurses and nursing registry companies for availability to work.	Nurse Manager (NM)/House Supervisor	NSO
ED nursing staffing in yellow (no breakers)	• ED Manager and Nursing Office contact additional nurses and nursing registry companies for availability to work. • Adjust ED staffing assignments as needed.	OCN	NM

LEVEL 2 - Hospital resources are at maximum utilization with 100% ED and inpatient bed capacity reached. Additional resources are needed to meet demand. Must meet 3 criteria. PFF sends out PFF report email to hospital leadership every 4 hours.			
Surge 2 Criteria (activate if any 3 criteria are met)	**Action Plan**	**Who can initiate:**	**Owners:**
60 or more in waiting room (Triage rooms+AWR+R1 through R5+Ambulance Triage)	• All actions from Surge Level 1. • Utilization Management (UM) requests transfers to capitated hospitals, and transfer for decompression and/or lower level of care	Router, RME Charge, OCN Utilization Management	OCN Utilization Management

	• UCC offload ED by seeing all ESI 4 and 5 patients without exclusions	RME Director, UCC Director, RME Charge	RME/UCC Directors
8 or more ESI 2 in waiting room and ambulatory triage	• Close to ALS for 1-2 hours to decompress rooms, then reopen. • Evaluate patients for ability to move to chairs or hallway beds to free up monitored ED rooms.	MICN, Acute Charge, OCN, ED attending huddle OCN	MICN OCN
2 or more inpatient units staffing in red (only include units based on identified patient admission needs).	• Contact additional nurses and nursing registry companies for availability to work.	NM/House Supervisors	NSO
ED nursing staffing in red	• Follow Surge Level 1 actions	ED Charge RNs	OCN
PACU at capacity based on staffing or bed availability	• Reschedule end-of-day Tier 2 and above inpatients	Charge Nurse OR/PACU Anesthesia on Call (AOC)	Charge Nurse OR/PACU AOC

LEVEL 3 - Hospital resources are insufficient to provide safe services to existing and continued demand. ED and inpatient capacity exceed 100% with no immediate solution. Modified disaster plan activated. Must meet 3 criteria. Electronic notification every 4 hours.			
Surge 3 Criteria (activate if any criteria are met)	**Counter Measures**	**Who can initiate:**	**Owners:**
75 or more patients in triage/waiting room (AWR+R1-R5+AmbTri)	• Evaluate closing to BLS to decompress rooms (needs MAC approval) • Evaluate closing to Trauma Close to STEMI • All actions from surge 1 and 2	• MICN, Acute Charge, OCN, ED attending • Trauma Division Chief and CEO/designee • Interventional cardiology attending on duty • ED Department Chair	CEO

10 or more ESI 2 in WR and Amb Tri	• Assign ED staffing that allows for optimal monitoring of all patients. • Follow all Surge Level 1 and 2 actions.	RME Charge	OCN
PACU at capacity based on staffing/ratio acuity	• Follow all Surge Level 1 and 2 actions. • Evaluate need to cancel elective surgeries and procedures	Charge Nurse OR/PACU Anesthesia on Call (AOC) Peri-Operative Leadership Team (PLT)	Charge Nurse OR/PACU AOC PLT
30 or more ED boarders	• Evaluate need to implement alternative staffing model/plan. • Evaluate need to open Hospital Command Center • Evaluate the need cancel elective surgeries following tier criteria • Attendings to see patients and decide dispositions	CNO CNO, CMO, and CEO CEO/CMO CEO/CMO CEO/CMO/CNO/COO	CNO CNO, CMO, and CEO CEO/CMO Inpt Assoc Med Dir/UR Med Dir CEO/Designated Institutional Officer
$\geq$ 3 inpatient units in red staffing level	• Contact additional nurses and nursing registry companies for availability to work. • CNO to consider alternative staffing model/plan.	CNO	CNDs
ED in red staffing level	•ED Manager and Nursing Office contact additional nurses and nursing registry companies for availability to work. •Adjust ED staffing assignments as needed.	CNO	CNDs

Reviewed and Approved by:
Medical Executive Committee on 04/2022

Beverley A. Petrie

Beverley A. Petrie, M.D.
President, Professional Staff Association

Abbreviations Used in Surge Level Table

AED - Adult Emergency Department
AOD - Administrative Officer of the Day
CEO - Chief Executive Officer
CMO - Chief Medical Officer
CORE - Cardiovascular Open-Access Rapid Evaluation
CNO - Chief Nursing Officer
DEM - Department of Emergency Medicine
ED - Emergency Department
ICU - Intensive Care Unit
MICN – Mobile Intensive Care Nurse
NM - Nurse Manager
OB-GYN - Obstetrics/Gynecology
OBS/CORE - ED Observation/Cardiovascular Open-Access Rapid Evaluation
PAR - Post Anesthesia Recovery
PCU - Progressive Care Unit
PFF - Patient Flow Facilitator
RME - Rapid Medical Evaluation
STEMI - ST-Elevation Myocardial Infarction
UR - Utilization Review

Appendix A
Procedure for Canceling Scheduled Admissions

Only admissions that are anticipated to use a hospital bed, and more particularly, the type of hospital beds that are in short supply, should be canceled.

The physician assigned to the procedure/admission should be notified ASAP after cancellation.

PROCEDURE

1. The Patient Flow Facilitator (PFF) should obtain permission to proceed with scheduled admissions and procedure cancellations from the CMO/Designee.

2. The CMO/Designee, with assistance from clinical chairs, reviews the scheduled admissions and scheduled procedures for potential cancellation. S/he then directs the scheduling office (during business hours) or the clinical chairs (after business hours) to contact the patients to initiate cancellation. Cancellations should not occur later than 10 PM. The CMO/Designee should refer to the list of types of elective admissions that clinical service agree can be cancelled without their input ("Approved for Cancellation").

Canceling "Allowed with Approval" Scheduled Medical and Surgical Admissions

1. Contact the designated contact person for the appropriate service for the type of scheduled admission or procedure and obtain approval or reason for denial. Reason for denial should be forwarded to be Patient Flow Steering Committee as part of the Surge reporting.
2. Peri-operative Leadership Team activates cancellation of Tiers 2 through 4 surgeries and procedures, as appropriate.

APPENDIX B
To Be Used for Reporting

Time surge activated: __________ Surge Level: _____________
Surge Levels upgrades or downgrades:
Surge Level: _____________ Time surge activated: __________
Surge Level: _____________ Time surge activated: __________
Surge Level: _____________ Time surge activated: __________
Was ambulance diversion activated: Yes or No. If Yes, time the emergency department was placed on ambulance diversion: __________.
Name of MAC supervisor notified of our surge status: ________, and the time of notification: _________.
Was Chief of Trauma notified: Yes or No. If notified time of contact: __________.
Was command center opened: Yes or No. If Yes, Time the command center was opened: ___________.
Date surge level was deactivated: ________. Time surge level ended: _________.

Additional Notes:

Surge Level 1 Counter Measures
Maximize use of all staffed ED rooms. If all rooms being used, consider using X-Chairs in RME Hallway. Assign additional Fast Track patients to Adult teams if they have capacity. Strongly consider closing to ALS to decompress rooms, especially if anticipating trauma or critical medical patients. Discharge stable patients to the waiting room while awaiting a ride. Urgent Care Center to help offload ED by seeing all ESI 4 and 5 patients using current criteria. Consider using FastTrack rooms for ESI 3 patients. Consider closing to ALS to decompress rooms, especially if anticipating traumas or critical medicals. Hold patients in OR and procedural areas as needed. Triage OR throughput to outpatient first, as needed. Charge Nurse OR/PACU notifies PFF. ED Hospitalist rounds with ED Charge Nurse and contact inpatient attendings for downgrades and discharges. ICU teams identify stable ICU patients for transfer to Rancho Los Amigos or LAC+USC. Obtain approval to transfer appropriate female inpatients to 7W if capacity/staffing permits. Inpatient Charge Nurse to identify potential discharge and downgrades within 2 hours of surge 1 being declared. Contact additional nurses and nursing registry companies for availability to work.

ED Manager and Nursing Office contact additional nurses and nursing registry companies for availability to work. Adjust ED staffing assignments as needed.
Surge Level 2 - Additional Counter Measures
Utilization Management (UM) requests transfers to capitated hospitals, and transfer for decompression and/or lower level of care. UCC offload ED by seeing all ESI 4 and 5 patients without exclusions. Close to ALS for 1-2 hours to decompress rooms, then reopen. Evaluate patients for ability to move to chairs or hallway beds to free up monitored ED rooms. Reschedule end-of-day Tier 2 and above inpatients.
Surge Level 3 - Additional Counter Measures
Evaluate closing to BLS to decompress rooms (needs MAC approval). Evaluate closing to Trauma Close to STEMI. Assign ED staffing that allows for optimal monitoring of all patients. Follow all Surge Level 1 and 2 actions. Follow all Surge Level 1 and 2 actions. Evaluate need to cancel elective surgeries and procedures. Evaluate need to implement alternative staffing model/plan. Evaluate need to open Hospital Command Center. Evaluate the need cancel elective surgeries following tier criteria. Attendings to see patients and decide dispositions. Contact additional nurses and nursing registry companies for availability to work. CNO to consider alternative staffing model/plan. ED Manager and Nursing Office contact additional nurses and nursing registry companies for availability to work. Adjust ED staffing assignments as needed.