OLIVE VIEW-UCLA MEDICAL CENTER
POLICY & PROCEDURE

NUMBER: 11714
VERSION: 1

SUBJECT/TITLE: **OLIVE VIEW MEDICAL CENTER COMPREHENSIVE OVERCROWDING PLAN**

PURPOSE: To establish an interdepartmental approach to handle an increase in demand for patient care services that results in hospital crowding and boarding admitted patients in the Emergency Department (ED). To mitigate and manage issues affecting patient flow, staffing and productivity throughout the patient care areas.

DEPARTMENTS: **ALL**

DEFINITIONS:

ED Internal Waiting Rooms – Existing waiting rooms within the ED patient care area that are used for stable patients during their ED visit. Currently consists of Purple and Blue Waiting Rooms.

NEDOCS - National Emergency Department Overcrowding Scale.

Out of Plan (OOP) – Patients that **do not** fall within any of the following categories:

1. LA Care and Health Net patients that are assigned to a Department of Health Services (DHS) primary care provider
2. Patients with Medicare or Medi-Cal who do not have a health plan and an assigned primary care provider
3. My Health LA members
4. Los Angeles County residents with no health insurance

Rapid Medical Exam (RME) Provider – ED Attending or Nurse Practitioner who is responsible for Medical Screening Exams for patients in the ED Waiting Room.

RME Unit – Existing ED protocol that utilizes ED 4 for ESI Level 4 and 5 patients Monday through Sunday 8am to 8pm to be evaluated, managed and discharged primarily by RME Unit NPs

Vertical Patients – Stable ED patients who are moved from an ED bed to an ED Internal Waiting Room to wait for the completion of their ED visit.

POLICY:

Any robust Emergency Department (ED) or hospital overcrowding plan should include a graded response to varying levels of ED overcrowding or patient surges. This plan will utilize an objective measure of Emergency Department and Hospital Overcrowding that will automatically dictate an interdepartmental response. This utility is designed for rapid notification and plan implementation. Hospital overcrowding plan will be activated when the NEDOCS criteria are met as the hospital overcrowding plan addresses high hospital occupancy with reduced capacity. Internal communication between ED leadership (Medical and Nursing) and hospital administration will activate the hospital overcrowding plan.

NEDOCS: (National Emergency Department Overcrowding Scale) will be used as the objective measure of emergency department and hospital overcrowding. Studies have validated this instrument as an effective measure of overcrowding including large academic centers that are frequently overcrowded. Levels of overcrowding are determined by the "score "which is calculated using statistically significant variables.

The **NEDOCS calculator** is based on the following variables:

Institutional Constants	Situational Variables
Number of ED Beds*	Total Patients in the ED**
Number of Hospital Beds*	Number of Ventilators in use in the ED
	Longest Admit Time (in hours)
* Based on budgeted beds	Total Admits in the ED
	Wait Time for the Last Patient Called (from triage)
	**Does not include Waiting Room (WR) patients if not undergoing evaluation and treatment. Does include WR patients who have had their Medical Screening Exam (MSE) and have laboratory tests, imaging studies or medications ordered by the RME providers. Does include vertical patients in Red and Purple Waiting Rooms (RWR and PWR)

The NEDOCS calculator has a range of -20 to 200 with 6 distinct color-coded score-based levels of overcrowding ranging from Not Busy (<20) to Dangerously Overcrowded (>180). Although the colors of each level may vary slightly between organizations, the 6 distinct levels of overcrowding and the scores within each range should not vary.

NEDOCS (Overcrowding Scale)						
Score	< 20	21-60	61-100	101-140	141-180	> 180
Condition	**Not Busy**	**Busy**	**Extremely Busy**	**Overcrowded**	**Severely Overcrowded**	**Dangerously Overcrowded**

PROCEDURE:

As a standing procedure, ED overcrowding will be assessed by the ED SSN at regular intervals (every 2 hours) using the NEDOCS calculator. The corresponding condition will be updated on the OVMC intranet homepage. If the level changes from previous interval, the ED SSN will notify the ANOs office, that will then notify the appropriate hospital management staff. This includes personnel in Hospital Administration, Nursing and Medical Staff, and Ancillary Services that require notification and/or are an integral part of the response. In addition, the ED SSN will notify key ED staff at various levels of NEDOCS.

The hospital will respond with the appropriate intervention as described below.

Each NEDOCS level of overcrowding corresponds to and necessitates institutional response with respect to, among other things, systems and departmental operations; bed capacity, utilization, and conversion; staff responsibilities; and supplies. As the crowding increases, the degree of response escalates to prevent and mitigate further overcrowding and the consequences of such. Response guidelines will continue into the next level unless a change is specified.

The first level is **Green** (Not Busy). This level mandates standard operational procedures, elements of which are itemized to emphasize their importance in maximizing efficiency on a routine basis to improve ED and hospital throughput which will decrease the occurrence of ED and hospital overcrowding, and ultimately, improve patient care. The second and third levels are **Blue** and **Yellow** (Busy and Extremely Busy respectively). OVMC is a moderately-sized institution with a large emergency department that should be able to tolerate moderate patient surges. No significant changes to the institutional response will occur at these first three levels. The fourth level is **Orange** (Overcrowded); the fifth level is **Red** (Severely Overcrowded); and the sixth level is Black (Dangerously Overcrowded). This is the highest level of overcrowding.

Conditions that will supersede the NEDOCS score include a Medical, Trauma, or Mass Casualty incident or an Internal/External Disaster. In this case, "**Code TRIAGE**" is declared. During "Code Triage", the hospital will implement level BLACK response actions until the time that the event has resolved and the hospital has returned to baseline operations.

Emergency Preparedness-Activation of Hospital Incident Command System (HICS)

Any situation with a significant impact to hospital operations generating a large number of patients or in preparation for a large number of patients, including events such as mass casualty incidents, public health emergencies, or emergency evacuations to the medical center.

The activation of this plan is outlined in Surge Plan located in the Emergency

Operation Plan.

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. The NEDOCS score > 100, Overcrowded, will be the trigger to initiate the actions of the Overcrowded Procedure.

When criteria for a level are met or justified by circumstances that compromise safe patient care, the ED Patient Flow Facilitator and 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 overcrowding. Managers should notify Hospital Administration of actual/anticipated staffing or capacity issues.

NOT BUSY **NOTE – standard daily operations**

MEDICAL CENTER RESPONSE

EMERGENCY DEPARTMENT:
- No notification beyond the Emergency Department is required
- Update NEDOCS on Intranet home page every two hours.
- ED Status – Open to all traffic
- ED Standard Operations

PATIENT FLOW/ADMINISTRATIVE NURSING OFFICE:
- Deploy Patient Flow discharge nurses to unit with highest admission request.
- Consult with Infection Control to identify patients who can be cohorted.
- Conduct multidisciplinary bed huddle every morning at 9:45 am. Participants include ANO, Bed Control, Attending Hospitalist, Med Surg Unit Charge Nurses/Nurse Managers, Infection Control (business hours) Utilization Management and Environmental Services.
- Communicate needs to Transportation Department and other ancillary departments as needed, to facilitate patient flow.

PATIENT ACCESS REGISTRATION (PAR):
- Financially screen all patients to verify financial resource and add the Out Of Plan (OOP) or DHS icon to the banner bar

INPATIENT SERVICES:
- Participate in daily Collaborative Care Rounds (CCR) and actively works to

facilitate discharges.

- Residents/Attendings work closely with Nurse Managers (NM)/Shift Manager/Charge Nurses (CN) to identify patients who are eligible for imminent, safe discharge/transfer; facilitate timely discharges/transfers.
- Residents/Attendings work closely with Pediatrics, OB/GYN, and TB units to identify patients who can be transferred/admitted to beds that are under-utilized.
- The Team Attending (and/or Hospitalist), Residents, and CN will review all patients and conduct discharge and downgrade rounds.

NURSING:

- Manager:
    - Round on their units to assess and act upon bed availability, barriers to discharge and staffing or resource issues.
    - Evaluate all patients in isolation, constant observation and close observation to determine ability to discontinue isolation/observation or to cohort patients.
    - Review staffing for next 24 hours by 10 am each morning during business hours.
    - Initiate efforts to smooth out staffing and fill in staffing deficiencies when core staffing is not met.
    - Periodically check OVMC ED Census Monitor for current NEDOCS.
- Charge Nurse:
    - Attend the regularly scheduled Bed Huddle meeting in the designated location to report and plan pending discharges, transfers, staffing, and resources.
    - Round with Team Attending (and/or Hospitalist) and Residents to identify patients for discharge or downgrades.
    - Check OVMC ED Census Monitor on Intranet page for current NEDOCS at 3:00 pm to prepare for 5:15 pm bed huddle, if needed.
- All discharged patients meeting the following pre-established criteria will go to the Discharge Waiting Lounge:
    - Have a written discharge order
    - Stable and capable of self-care
    - No history of hostile or aggressive behavior
    - Do not require isolation
    - Destination known
    - Pre-arranged transportation

ENVIRONMENTAL SERVICES:

- Attend Bed Huddle, and keep in close communication with Patient Flow/ANO to expedite cleaning of dirty rooms by deploying resources to area of need (as directed by Bed Control).

TRANSPORT/LIFT TEAM:

- Evaluates need for additional equipment and personnel to expedite patient movement for discharges and transfers.
- Communicate with units to prioritize transportation in order to expedite discharges.

UTILIZATION MANAGEMENT:

- Attend Bed Huddle meeting during business hours.
- Participate in daily Collaborative Care Rounds (CCR) and actively works to facilitate discharges.
- Communicate same day and next day anticipated discharges from the medicine service to appropriate provider, social work and nursing stakeholders.
- Confer with physician and medical department chairpersons as needed to resolve physician discharge barriers.
- Seek alternative placement for OOP patients for whom we are a contracted facility when there are DHS responsible patients that need repatriation to a DHS facility.
- Repatriate DHS responsible patients based on DHS Managed Care Services/Medical Alert Center transfer lists.

LABORATORY SERVICES:

- Lab Supervisor/Designee for each shift/section will assess staffing adequacy and prioritize testing of specimens.
- Appropriate staffing will be re-assessed as overcrowded status changes.

RADIOLOGY SERVICES:

- Radiology Supervisor/Designee for each shift/section will assess staffing adequacy and prioritize diagnostic studies and therapeutic services
- Appropriate staffing will be re-assessed as overcrowded status changes.

BUSY

MEDICAL CENTER RESPONSE

- No interval changes – standard daily operations as in level GREEN
- No additional notifications required

EXTREMELY BUSY

MEDICAL CENTER RESPONSE

EMERGENCY DEPARTMENT:

- **Update the NEDOCS on Intranet home page**
- **ED Attending will evaluate all ED patients for placement in observation**

status, inclusive of patients with placement issues.

- **Divert low acuity patients to Urgent Care Clinic (UCC):**
    - ED throughput nurse will notify UCC charge nurse of initiation of diversion from ED to UCC and UCC Charge Nurse will notify the UCC Attending.

  Waiting Room DHS responsible patients (DHS icon on the tracking board) with an Emergency Severity Index (ESI) Level 4 and 5 will be sent over to UCC using the following protocol:
    - RME Provider will complete a Medical Screening Exam on the ESI 4 and 5 patients in the ED Waiting Room
    - Based on the UCC scope of care and intake policy, RME Provider will write "OK for UC" in the Nurse Comments column
    - ESI 4 and 5 patients sent over to UCC will remain on the ED Tracking Board until UCC staff changes the encounter and changes the bed on the Tracking Board
    - Once patient arrives at the UCC, Patient Access Registration staff (PAR) will conduct the usual financial screening.
    - UCC staff will huddle to assess the UCC's ability to continue receiving patients from the ED:
        - When the UCC has reached capacity based on staffing, space, patient acuity and number of walk-in's.
        - Toward the end of the operating hours of the UCC (approximately 1 hour before closing).
    - UCC staff retain the right to stop the flow of ESI Level 4 and 5 patients being sent from the ED.
    - If UCC is unable to accept patients from the ED, UCC charge nurse will contact the ED Throughput Nurse to notify to stop sending patients from the Emergency Department
    - If necessary, the UCC lead physician and the ED Attending will consult on the ability to move patients from the ED to the UCC.

PATIENT FLOW/ANO:

- Conduct multidisciplinary bed huddles at 9:45 am and 5:15 pm. Participants include ANO, Bed Control, Attending Hospitalist, All Charge Nurses/Nurse Managers, Infection Control, Utilization Management, Clinical Social Work and Environmental Services. Infection Control may provide recommendations to ANO for inclusion in the pm bed huddle.

UTILIZATION MANAGEMENT:

- Attend multidisciplinary bed huddles at 9:45 am and 5:15 pm
- Deny admission to OOP patients for whom OVMC is a contracted facility and require their insurance to find an alternate facility for admission.

INFECTION CONTROL
- Attend multidisciplinary bed huddles at 9:45 am and 5:15 pm

CLINICAL SOCIAL WORK
- Attend multidisciplinary bed huddles at 9:45 am and 5:15 pm
- Assess patients on Observation Status to facilitate discharge placement

ENVIRONMENTAL SERVICES
- Attend multidisciplinary bed huddles at 9:45 am and 5:15 pm

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OVERCROWDED

MEDICAL CENTER RESPONSE

Notification:

1. ED SSN will notify the ANO office of the "Overcrowded" NEDOCS score
2. If between the hours of 6:00 am and 10:00 pm, Patient Flow Manager/ANO Nurse Administrator notifies the following regarding Overcrowded status via Everbridge: Hospital Administration, Nursing Administration, Medical Administration, Attending Hospitalist/Medicine On-Call, Service Chiefs, Clinical Nursing Directors, Nurse Managers, Laboratory Services, Radiology Services, Respiratory Therapy, Environmental Services and LASD.
3. Patient Flow Manager/ANO Nurse Administrator notifies CEO, COO, CMO and CNO during business hours. If after business hours, notified AOD, MOD and NOD. AOD, MOD and NOD to determine if there is a need for onsite hospital presence of hospital administration and/or Everbridge notification between hours of 10:00 pm and 6:00 am.
4. ED SSN will additionally notify:
    a. ED Throughput Nurse
    b. ED RME NP and/or MD
    c. ED Gray Area Attending or another on-duty ED Attending
    d. UCC Nursing Supervisor or lead provider during UCC operational hours

EMERGENCY DEPARTMENT:
- ED Status
    a. No interval changes
- ED Operations
    a. RME Unit may be utilized for ESI Level 3 patients
        i. RME Unit NPs and/or RME NP in Triage 4 will be responsible for choosing which ED Waiting Room ESI Level 3 patients will be seen in the RME Unit

1. NPs will choose ESI Level 3 patients who are likely to have simpler workups

ii. ESI Level 3 patients who are seen in the RME Unit will follow the existing RME Unit protocol and can be placed back into the ED Waiting Room to await laboratory testing results, imaging studies, consultations or discharge

b. ED Attending will attend Bed Huddles at 9:45 am and 5:15 pm.

- Admissions
  a. DEM Attending and Resource Nurse will prioritize the admissions and communicate this priority list to Bed Control and ANO office.
  b. DEM attending will identify boarder patients who can be assigned to an unclean, empty bed on an inpatient unit and wait on gurney in the hall until room is clean. Patients who are in restraints, on isolation precautions or have altered mental status are not eligible for placement in the hallway. The ED attending will consult with charge nurse of the receiving unit prior to the transfer.
  c. This priority list will be updated every 2 hours at a minimum.
- Transfers (Inter-facility)
  a. No interval changes

PATIENT FLOW/ANO:

- Conduct multidisciplinary bed huddles at 9:45 am and 5:15 pm. Participants include ANO, Bed Control, Attending Hospitalist, ED Attending, All Charge Nurses/Nurse Managers, Infection Control, Utilization Management, Clinical Social Work, Respiratory Therapy and Environmental Services. Lab Supervisor will attend if Lab identifies staffing issues that impact on patient flow. Infection Control may provide recommendations to ANO for inclusion in the pm bed huddle. Metrics to be presented are unit census, potential discharges/transfers, blocked rooms and projected staffing.
- Notify Attending Hospitalist on call - best accessed via the "Medicine On Call" pager on Amion.
- Consult with CMO or MOD and Attending Hospitalist to assess on the condition and bed availability, pending discharges/transfers and staffing level to determine ability to increase inpatient bed capacity.
- Assign additional nursing staff to units to expedite care and discharges. Evaluate the status of beds closed due to administrative holds and re-open these beds.
- Notify Infection Control to identify patients who can be cohorted. NOTE: In Overcrowded Status, VRE, ESBL, MRSA and Influenza patients can be cohorted without IC approval. C difficile infection (CDI) cases will be approved by IC or designee.
- Call back any staff that are available.

INPATIENT SERVICES:

- Attending Hospitalist to notify house staff regarding overcrowding status to facilitate movement though continuum of care and to open beds for admissions. This includes down grade to lower level of care, discharge and discontinuation of isolation or neutropenic status as well as close/constant observation, when appropriate. Enter orders into ORCHID to discontinue isolation and observation status, if necessary.
- Psychiatry Attending to evaluate all patients in medical surgical beds to assess need for continued close/constant observation and discontinue when appropriate.
- Attending Hospitalist to work closely with Pediatrics, OB/GYN, and TB services to identify patients who can be transferred/admitted to beds that are under-utilized.
- Attending Hospitalist to consult with Pediatric Attending to consider admitting patients who are less than 21 years old to any available pediatric bed.
- Service chiefs to increase staffing in high risk situations by calling in additional staff.

NURSING:

- Nurse Manager:
    - Check ORCHID Orders for transfer, discharge, discontinuation orders for isolation/companions and facilitate patient movement. NOTE: In Overcrowding Status, VRE, ESBL, MRSA and Influenza patients can be cohorted without IC approval. C difficile infection (CDI) cases will be approved by IC or designee
    - Work with staffing office to utilize overtime and registry to increase resources in patient care areas. All available nursing resources, inclusive of supervising/administrative nurses, educators and quality improvement staff, will be deployed to clinical areas.
- Charge Nurse: Will attend the regularly scheduled and adhoc Bed Huddle meeting in the designated location to report and plan pending discharges, transfers, staffing, and resources.
- Admitted patients who are boarding in the ED may be assigned to an uncleaned, empty bed on unit and will wait on gurney in hall until room is cleaned. Identified patients will be reviewed by the charge nurse of the receiving unit and the ED attending prior to acceptance. No patients in restraints, on isolation precautions, and/or altered mental status will be placed in hallway. EVS will be notified to expedite cleaning of room and contents.

ENVIRONMENTAL SERVICES:

- Attend Bed Huddle, close communication with Patient Flow/ANO to expedite cleaning of dirty rooms by deploying resources to area of need (as directed by patient flow).

- Redirect housekeeping staff from non-patient care areas to patient care areas.

TRANSPORT/LIFT TEAM:
- Communicate with units to prioritize transportation to expedite discharges.

UTILIZATION MANAGEMENT:
- Attend multidisciplinary bed huddles at 9:45 am and 5:15 pm.
- Deny admission to OOP patients for whom OVMC is a contracted facility and require their insurance to find an alternate facility for admission.
- UM Medical Director to consult with Attending Hospitalist and Emergency Department to prioritize ancillary services (Lab, Radiology, Cardiology, etc) to facilitate hospital discharges and balance throughput in the ED.

LABORATORY SERVICES:
- Lab Supervisor will attend bed huddle at 9:45 am and 5:15 pm if Lab staffing is impacting efficient patient flow.
- ED lab staff will regularly observe the "OVMC ED Census Monitor". Lab Manager or ED Lab Supervisor/Designee will be notified by ANO through Everbridge system to initiate overcrowding plan.
- The Lab supervisor/Designee/CPTII (CPTI- in their absence) will communicate with the Lead ED Charge nurse or Lead ED physician to receive directions for which group of patients need blood drawing.
- At this time, the CPTII/ CPTI will use the prepared chart to document the workload/staff data.
- To achieve additional staff to help in the patient overcrowded situation:
    1. Lab Supervisor/CPTII (CPTI- in their absence) will assess to see if one of the Main Lab Phlebotomist may help the ED for couple of hours, until there is additional staff.
    2. Lab Supervisor/ CPTII will assess staffing and ask working staff (Phlebotomist, LA or CLS) to stay 3-4 hours after work or come 3-4 hours early to work depending on shift needs.
    3. If phlebotomist, LA and/or CLS does not agree to work on overtime, CPTII/ CLS will call staff to work overtime (Lab supervisor will later assess and approve the overtime).
- One ED Phlebotomist will be dedicated to draw waiting room patients in the ED waiting rooms.
- The phlebotomists will continue to work together until the numbers of ordered draws return to normal levels of draws (below one hundred). ED CLS may have to send specimens to the main Lab for back up (especially if the ED Lab instrument is down).
- Lab supervisor/CPTII will notify the LA & CLS of the overcrowding plan activation and will continue to cope with the workload.
- PM/Night shift CPTI will send specimens through Pneumatic tube system to

the main lab after 10:45 pm. Phlebotomist will notify General Lab staff by saying "The Emergency Room is in the OVERCROWDED STAGE and the OVERCROWDING PLAN has been activated. The ED STAT specimens are being tubed down now to be tested quickly". The General Lab will prioritize the STAT specimens and post lab results in the CERNER system quickly.

- During overcrowding, all ED patient results will be faxed to ED1 nursing station at fax @ x74298, by Core lab.
- For any delayed Lab result, Nursing staff or Physicians are encouraged to call x 73476 or x74038 to keep the patient's care continuous without any patient backups.

Lab Supervisor/Designee/CPTII for each shift/section will assess staffing adequacy and prioritize testing of specimens.
Appropriate staffing will be re-assessed as overcrowded status changes.

RADIOLOGY SERVICES:

- Radiologists to work with clinicians to identify pending studies on ED patients that are not truly emergent and can be deferred to later outpatient study.
- No additional incremental changes.

INFECTION CONTROL:

- Review all patients in isolation at 7:30 am to see whether isolation can be discontinued.
    - Infection Control MD (or designee) to write orders to discontinue isolation in ORCHID.
    - When isolation is discontinued by Infection Prevention Nurse, send ORCHID communication order to primary care team to discontinue isolation.
- Contact Patient Flow/ANO no later than 8:00 am to identify patients that can be cohorted – NOTE: VRE, ESBL, MRSA and Influenza patients can be cohorted without IC approval. C difficile infection (CDI) cases will be approved by IC or designee.

CLINCIAL SOCIAL WORK

- Attend multidisciplinary bed huddles at 9:45 am and 5:15 pm.
- Assess patients on Observation Status to facilitate discharge placement

RESPIRATORY THERAPY

- Attend multidisciplinary bed huddles at 9:45 am and 5:15 pm.

SEVERELY OVERCROWDED

MEDICAL CENTER RESPONSE

Notification:

1. ED SSN will notify the ANO of the "Seriously Overcrowded" NEDOCS score
2. Patient Flow Manager/ANO Nurse Administrator notifies the following regarding Severely Overcrowded status via Everbridge: Hospital Administration, Nursing Administration, Medical Administration, Attending Hospitalist/Medicine On-Call, Service Chiefs, Clinical Nursing Directors, Nurse Managers, Laboratory Services, Radiology Services, Respiratory Therapy, Environmental Services, Infection Control and LASD.
3. Patient Flow Manager/ANO Nurse Administrator notifies CEO, COO, CMO and CNO during business hours. If after business hours, notify AOD, MOD and NOD. AOD, MOD and NOD to determine if there is a need for hospital presence on site.
4. ED SSN will additionally notify:
    a. ED Throughput Nurse
    b. ED 1A Attending(s) and ED Gray Area Attending
    c. ED Senior Resident

EMERGENCY DEPARTMENT:

1. ED Status
    a. Close to ED Saturation (Diversion)
        i. Exceptions are transferred from the LA County DHS Comprehensive Health Centers – Mid-Valley, San Fernando and Glendale Health Centers
        ii. ED Throughput Nurse will notify the ANO of Diversion status and ANO will update the ReddiNet, as needed.
    b. Close to ED to ED Transfers
        i. ED SSN will notify the ANO of Closure to ED to ED Transfers and the ANO will contact the Medical Alert Center (MAC)
2. ED Operations
    a. Use of ED Internal Waiting Rooms – Purple (PWR) and Blue Waiting Rooms (BWR).
        i. Purple Waiting Room will be used for stable patients who have been evaluated by the ED provider and are waiting for the results of laboratory testing, imaging studies, consultations or discharge.
        ii. ED Provider and ED RN taking care of the patient will determine if patient is a candidate to wait in an internal waiting room
        iii. Purple Waiting Room (PWR) will be used for vertical

patients in ED 3 and 5
    1. Maximum of five (5) patients may be in the PRW at any given time
    2. PWR will also be shared with RME Unit from 8am-8pm for patients requiring plain films

iv. ED Provider will use the "Vertical Patient" icon to communicate to ED bedside RN and ED Throughput Nurse which patients are appropriate to move to an internal waiting room
v. ED SSN will determine which patients with the Vertical Patient icon will be moved to an internal waiting room and will communicate this to the bedside RNs.
    1. ED SSN will make every effort to ensure that the increased patient load per nurse is balanced throughout the department.
vi. Family members may need to be asked to wait in the external ED Waiting Room, Cafeteria or other lobbies in the hospital as space is limited in the internal waiting rooms and in our ED Waiting Room
    1. Family members may leave a contact number so we can reach them
vii. Patients who are now waiting in the internal waiting rooms will be known as Vertical Patients.
viii. ED Provider's and Attending's initials will remain on the Tracking Board associated with that vertical patient's name
ix. ED RN's initials will remain on the Tracking Board associated with that vertical patient's name
x. ED RN or NA will escort or direct the patient to the designated internal waiting room and move the patient's name on the Tracking Board
xi. Blue Waiting Room (BWR) may be used for provider-patient discussions and for discharge instructions to be reviewed by nursing staff.
    1. Patient's name does not need to move to the BWR for this discussion or discharge
    2. Family members may be called into BWR as needed for a provider discussion or the discharge instructions
    3. If patient requires further care, patient may be moved back to the designated internal waiting room or back to an ED bed

3. Admissions
    a. No interval changes
4. Transfers (Inter-facility)
    a. ED Utilization Review Nurse to coordinate with MAC for patient transfers out per County Code 2.76 (Emergency Transfer Authorization Guidelines)
5. Space, Staff, Supplies
    a. Space
        i. ED Internal waiting rooms (Purple Waiting Room) will be used for stable ED patients who are moved from an ED bed to an ED Internal Waiting Room to wait for the completion of their ED visit.
    b. Staff
        i. Nursing staff may be moved from Urgent Care when possible to help staff in the ED during NEDOCS "Seriously Overcrowded"

PATIENT FLOW/ANO:

- Update the Reddi-Net to reflect Diversion status.
- Communicate overcrowding plan status and diversion decisions to MAC supervisor
- Verify all efforts in Overcrowded status, have been operationalized.
- Call an <u>immediate</u> Bed Huddle with ANO, Bed Control,
- Attending Hospitalist, ED Attending, Nurse Managers/Charge Nurses, EVS, UM, Clinical Social Work (if available) and RT to communicate demand for inpatient beds. Discuss type of beds needed for patients boarding in DEM, identify patients who are eligible for imminent, safe discharge/transfer; facilitate timely discharges/transfers.
- Work with Attending Hospitalist to assess for ability to admit low acuity medical surgical patients into 2F, admit non-OB/GYN female patient into 3D and patients between the ages of 18-21year of age into 4C.
    - 2F Criteria
        - First plan of action is to identify patients on 2F that can be transferred to medical surgery units along with nursing staff with competency in the care of the adult medical surgical patient. After hours, ID attending on call will facilitate transfers and confirm primary team assignment with assistance of the Attending Hospitalist.
        - In the event of a situation when all other possibilities have been exhausted, the CMO or MOD may authorize placement of non-TB/MOTT (mycobacteria other than TB) patients requiring airborne isolation on 2F (e.g., varicella, rubeola (measles) suspect or confirmed case, etc). These

patients will follow hospital policy of remaining in room except for urgent/emergent procedures and follow the restrictive visitor policy of the unit. In this eventuality, 2F will default to their ACRD (Acute Communicable Respiratory Disease) isolation policy to minimize risk of any TB exposure and provide CD (communicable disease) isolation unit education to new admissions. These patients will be grouped, whenever possible, in rooms designated by IC in the ACRD policy. The patients will be assigned to internal medicine teams and will be repatriated to units other than 2F as expediently as possible.

- 3D Criteria – No confirmed, active infection with MDRO; No airborne/respiratory/droplet isolation (TB, influenza, varicella, etc); No need for specialized nursing care (chemo, dialysis, etc); or no significant behavioral problem/psychiatric hold.
- 4C Criteria – Pediatric attending will be consulted for appropriateness of admitting patients between the ages of 18-21 years of age to 4C. With the approval of the CMO or MOD, patients over the age of 21 years of age may be placed on 4C under the care of licensed nurses with competency in the care of the adult medical surgical patient.

- Re-assess movement and staffing plan every 2 hours until NEDOC score returns to NEDOCS <101, "Not Busy".

INPATIENT SERVICES:

- Attending Hospitalist to participate in Bed Huddles at 9:45 am and 5:15 pm.
- Attending Hospitalist to round on patients boarding in DEM.
- Work with ANO Supervisor/Bed Control to assess for ability to admit low acuity medical surgical patients into 2F, admit non-OB/GYN female patient into 3D and patients between the ages of 18-21year of age into 4C.
  - 2F Criteria
    - First plan of action is to identify patients on 2F that can be transferred to medical surgery units along with nursing staff with competency in the care of the adult medical surgical patient. After hours, ID attending on call will facilitate transfers and confirm primary team assignment with assistance of the Attending Hospitalist.
    - In the event of a situation when all other possibilities have been exhausted, the CMO or MOD may authorize placement of non-TB/MOTT (mycobacteria other than TB) patients requiring airborne isolation on 2F (e.g., varicella, rubeola (measles) suspect or confirmed case). These patients will follow hospital policy of remaining in room except for urgent/emergent

procedures and follow the restrictive visitor policy of the unit. In this eventuality, 2F will default to their ACRD (Acute Communicable Respiratory Disease) isolation policy to minimize risk of any TB exposure and provide CD (communicable disease) isolation unit education to new admissions. These patients will be grouped, whenever possible, in rooms designated by IC in the ACRD policy. The patients will be assigned to internal medicine teams and will be repatriated to units other than 2F as expediently as possible.

  - 3D Criteria – No confirmed, active infection with MDRO; No airborne/respiratory/droplet isolation (TB, influenza, varicella, etc); No need for specialized nursing care (chemo, dialysis, etc); or no significant behavioral problem/psychiatric hold.
  - 4C Criteria – Pediatric attending will be consulted for appropriateness of admitting patients between the ages of 18-21 years of age to 4C. With the approval of the CMO or MOD, patients over the age of 21 years of age may be placed on 4C under the care of licensed nurses with competency in the care of the adult medical surgical patient.

- Inpatient team Attending (and/or Hospitalist), Residents, Discharge Coordinator and CN will review all patients and identify those patients who can be discharged quickly or downgrade to lower level of care.
- Inpatient team Attending to work with Discharge Coordinator to coordinate and assist in obtaining necessary ancillary/diagnostic studies, consults, procedures, etc. with assistance from the on-call Radiology Supervising Staff or Radiologist, if needed. Inpatients who are pending studies, consults or procedures that can be done as an outpatient will scheduled as outpatient and the patient will be discharged with appointments and follow up instructions.
- Inpatient team Attending to work with Case Manager to coordinate and assist in patient discharge and discharge planning (i.e. social work, placement, transportation, continuity follow-up, patient education, prescriptions, etc.)

NURSING:

- NMs/Charge Nurses, Care Managers and the primary medical teams huddle to identify potential discharges/transfers and obtain discharge/transfer order to increase available beds for admission from the ED.
- Charge Nurse will communicate anticipated discharges to Patient Flow/ANO.
- Charge Nurses identifies all potential discharges and works with Case Management to contact attending physicians to obtain discharge orders for appropriate patients.
- Charge Nurses assess staffing with Nurse Manager and Staffing Office to call in additional staff
- Nursing staff working in non-patient care assignments (e.g. education, quality, risk) will be reassigned to direct patient care areas, where appropriate.

ENVIRONMENTAL SERVICES:

- Participate in ad hoc multidisciplinary bed huddles as well as set huddles at 09:45 am and 5:15 pm.
- Housekeeping supervisor contact bed flow for clarification of beds to be cleaned; mobilize all available housekeeping resources to get all dirty beds cleaned.
- EVS Management will review staffing levels and adjust as necessary in order to meet the increased demands.
- Mobilize all available housekeeping resources to clean dirty beds in both the ED and inpatient services.

TRANSPORT/LIFT TEAM:

- Continue efforts of Overcrowding Status

UTILIZATION MANAGEMENT:

- Participation in ad hoc multidisciplinary bed huddles as well as set huddles at 09:45 am and 5:15 pm.
- Refuse admission to OOP patients for whom OVMC is the contracted facility and require their insurance to find an alternate facility for admission.
- UM Medical Director to consult with Attending Hospitalist and Emergency Department Attending to prioritize ancillary services (Lab, Radiology, Cardiology, etc) to facilitate hospital discharges and balance throughput in the ED.
- UR Nurse contacts ED Attending or Admitting Resident to identify patients for potential 2.76 transfer
- Add one additional discharge coordinator in the ED
- Deploy UM resources to units to assist with physician discharge barriers. Discharge Coordinators to huddle with respective primary medical teams to identify potential discharges/transfers, and facilitate discharges/transfers to increase available beds for admissions from the ED.

LABORATORY SERVICES:

- Continue efforts of Overcrowding Status

RADIOLOGY SERVICES:

- Continue efforts of Overcrowding Status

INFECTION CONTROL:

- Participate in ad hoc multidisciplinary bed huddles as well as set huddles at 09:45 am and 5:15 pm.
- Continue efforts of Overcrowding Status

RESPIRATORY THERAPY

- Participate in ad hoc multidisciplinary bed huddles as well as set huddles at 09:45 am and 5:15 pm.

CLINICAL SOCIAL WORK

- Attend multidisciplinary bed huddles at 9:45 am and 5:15 pm
- Assess patients on Observation Status to facilitate discharge placement

DANGEROUSLY OVERCROWDED

MEDICAL CENTER RESPONSE

Notification

1. ED SSN will notify the ANO of the "Dangerously Overcrowded" NEDOCS score
2. Patient Flow Manager/ANO Nurse Administrator notifies the following regarding Dangerously Overcrowded status via Everbridge: Hospital Administration, Nursing Administration, Medical Administration, Attending Hospitalist/Medicine On-Call, Service Chiefs, Clinical Nursing Directors, Infection Control, Nurse Managers, Laboratory Services, Radiology Services, Respiratory Therapy, Environmental Services and LASD.
3. Patient Flow Manager/ANO Nurse Administrator notifies CEO, COO, CMO and CNO during business hours. If after hours, notify AOD, MOD and NOD. AOD, MOD and NOD or designee to report to hospital.
4. AOD will consult with Hospital leaders regarding the need to open the hospital incident command center to assess the situation and implement actions to mitigate the crisis
5. ED SSN will additionally notify:
    a. ED Throughput Nurse
    b. ED 1A Attending(s) and ED Gray Area Attending
    c. ED Senior Resident

EMERGENCY MEDICINE:

1. ED Status
    a. Remain closed to ED Saturation and closed to ED to ED Transfers
2. ED Operations
    a. Use of ED Hallways for Stable Med/Surg ED Boarders
        i. The main hallway (straight west from ambulance entrance) shall be used for five (5) stable boarding patients awaiting med/surg beds
        ii. Throughput RN in consultation with the bedside ED RNs will decide which patients are appropriate to move to the hallway

iii. The following conditions are considered not appropriate to move to the hallway:
   1. Step-down or ICU admissions
   2. Mechanically ventilated or Bi-Pap patients
   3. Patients requiring more than 4L of O2
   4. Patients requiring suctioning
   5. Patients requiring Droplet or Airborne isolation (e.g., TB, Measles, Meningococcal Disease, Varicella, etc)
   6. 4-point restraints
   7. 5150 or 5585 patients or behaviorally challenged patients
   8. DNR/DNI patients who are expected to die while in the ED
   9. Patients on 1:1 observation may be considered on a case by case basis e.g. elderly patient who is on 1:1 for potential fall

iv. Respiratory Therapy will be notified when any patient on O2 is placed in a hallway bed.

v. ED Hallway boarding patients will be listed under OF1, OF2, OF3, OF4, OF5 on the Tracking Board

vi. ED Hallway boarding patients will be placed under the designated number in the hallway with the patient facing the ambulance entrance

vii. A "WOW" and mobile supply/linen cart will be moved into the hallway for use by the RN assigned to the boarding patients in the hallway

viii. An isolation cart will be placed near patients on contact precautions (CP). Whenever possible, CP patients will be grouped together.

ix. The SSN will determine which RN will be pulled and re-assigned to this area
   1. Suggestions include calling someone in from home, pulling RN from the pod that usually has 3 staff, assigning the educator RN, or lastly assigning the SSN on-duty

x. ED Hallway boarding patients will remain in the hallway until they have been assigned an inpatient bed or until the time NEDOCS score has lowered and the ED is easily able to move the patient back to a regular ED bed to await admission

xi. If patient becomes unstable while in the hallway (e.g. develops hypotension), the patient will be immediately moved to a monitored bed in the ED

3. Admissions
   a. No interval changes
4. Transfers (Inter-facility)
   a. No interval changes
5. Space, Staff, Supplies
   a. Space

i. Main ED hallway running west from ambulance entrance will be used for stable boarding med/surg patients

b. Staff
   i. Additional RN may be called in and assigned to hallway boarding med/surg patients or reassigned elsewhere

c. Supplies
   i. "WOW" will be moved to the ED main hallway to be used by RN assigned to the hallway boarding med/surg patients
   ii. Mobile supply cart with linens and patient supplies will be moved to the hallway
   iii. ED Gurneys will be stored in the TB Unit

PATIENT FLOW/ANO:

- Verify all efforts in Overcrowding and Severely Overcrowding have been managed
- Patient Flow/ANO communicates bed status and demand to Administrative leaders every two hours
- Patient Flow/ANO communicates overcrowded status and diversion decision to MAC supervisor.
- In consultation with onsite hospital leadership, may conduct more frequent multidisciplinary bed huddles.

INPATIENT SERVICES:

- CMO or designee determines need to reschedule all non-emergent surgeries/special procedures and admission from clinic

NURSING:

- Verify all efforts in Overcrowding and Severely Overcrowding have been managed
- Non-ICU admitted patients will be assigned any open clean bed according to level of care (patients may be assigned off-service beds)
- Chief Nursing Officer or designee to identify inpatient areas that can accept admitted patients, inclusive of converting unused, licensed rooms into patient care rooms and placing admitted patients into hallway beds.
- Nursing staff working in non-patient care assignments (e.g. education, quality, risk) will be reassigned to direct patient care areas, where appropriate.

ENVIRONMENTAL SERVICES:

- .EVS Director will review staffing levels and adjust as necessary to meet increased demands.
- EVS Director will communicate with Hospital Administration Liaison to obtain approval for additional staffing to meet hospital's priorities
- EVS Director mobilizes all available housekeeping resources to meet

hospital's priorities.
- EVS Director assures all vacant beds remain ready to admit a patient at any time.

UTILIZATION MANAGEMENT:
- Deny admission to OOP patients for whom OVMC is contracted facility and require their insurance to find an alternate facility for admission.
- UM Medical Director to consult with Attending Hospitalist and Emergency Department Attending to prioritize ancillary services (Lab, Radiology, Cardiology, etc) to facilitate hospital discharges and balance throughput in the ED.
- UR Nurse contacts ED Attending or Admitting Resident/Attending to identify patients for potential 2.76 transfer
- Add two additional Discharge Coordinators in the ED
- Deploy UM resources to units to assist with physician discharge barriers.

LABORATORY SERVICES:
No interval changes

RADIOLOGY SERVICES:
No interval changes

INFECTION CONTROL:
- Continue efforts of Overcrowding Status
- Discontinue empiric isolation for Nursing Home/SNF patients, with the exception of the ICU.
- Discontinue preemptive *C. difficile* isolation of suspected patients until results return, unless there is gross environmental contamination from stool.

CLINICAL SOCIAL WORK
- Attend multidisciplinary bed huddles at 9:45 am and 5:15 pm
- Assess patients on Observation Status to facilitate discharge placement

HOSPITAL ADMINISTRATION:
- AHAs work with service directors to support maximum patient movement
- Extend hours of ancillary services

ACRONYMS:
A. ANO: Administrative Nursing Office
B. AHA: Assistant Hospital Administrator
C. AOD: Administrator of Day
D. CCR: Collaborative Care Rounds

E. CEO: Chief Executive Officer
F. CMO: Chief Medical Officer
G. CN: Charge Nurse
H. CNO: Chief Nursing Officer
I. COO: Chief Operational Officer
J. EVS: Environmental Services
K. ICU: Intensive Care Unit
L. NM: Nurse Manager
M. MOD: Medical Officer of the Day
N. NOD: Nursing Officer of the Day
O. UM: Utilization Management
P. PAR: Patient Access Registration staff

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