COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

SUBJECT: DIVERSION REQUEST REQUIREMENTS FOR EMERGENCY DEPARTMENT SATURATION

PURPOSE: To outline the minimum requirements for hospitals to be placed on diversion of advanced life support (ALS) patients due to emergency department (ED) saturation.

DEFINITIONS:

Ambulance patient offload time (APOT): Time interval between the arrival of an ambulance at the location outside the hospital ED where the patient will be unloaded from the ambulance and the time the patient is transferred to the ED gurney, bed, chair or other acceptable location and the emergency department assumes responsibility for care of the patient.

Diversion: Hospital Diversion is a request by a hospital or an EMS provider agency to have advanced life support (ALS) patients bypass a facility for a limited period of time and should be requested only when necessary. This is not an absolute closure (see Principle 7). Basic life support (BLS) patients may not be diverted with the exception of diversion due to internal disaster.

Diversion hour: Hospitals and EMS provider agencies may request diversion to ED Saturation for any amount of time up to 60 minutes. If the hospital is not re-opened by the end of the 60 minute period, it will be automatically re-opened by the ReddiNet system.

EMS provider agency diversion threshold: Three ambulance crews (ALS and/or BLS) who transported their patient via the 9-1-1 system and each crew have been waiting for over 30 minutes to transfer their patient to hospital equipment (gurney, wheelchair, chair, etc.).

Hospital diversion threshold categories: All ED treatment bays are full and 30% or greater of the ED has patients who fall into one or both categories below, including ED beds occupied by admitted patients but excluding fast track beds and waiting room patients.

1. Resuscitative (unstable condition): the patient is hemodynamically unstable, requires an immediate airway or emergency medications. Other criteria: already intubated, apneic, pulseless, severe respiratory distress, acute mental status changes or unresponsive

2. Immediate/Emergent (requires timely treatment): the patient has symptoms indicative of a potential threat to life and their condition is likely to change to “resuscitative” without aggressive intervention. Examples include but are not limited to the following: stable but active chest pain; stroke symptoms; abdominal pain in pregnancy or suspected pregnancy; suicidal or homicidal ideation; new onset confusion; lethargy or disorientation; severe pain

Special considerations: Unusual circumstances that overwhelm ED resources and are documented by hospital administration.
PRINCIPLES:

1. High quality emergency medical services (EMS) is the result of prehospital care providers, emergency departments and hospitals working together as a team to care for ill and injured patients.

2. Prolonged diversion and APOT are not an emergency department problem alone; it is a hospital and EMS systemwide issue, both have negative impacts to the EMS providers’ ability to respond to subsequent 9-1-1 medical calls which results in prolonged response times and may affect public safety and patient outcomes.

3. Each hospital shall have a diversion policy and a multidisciplinary team approach to ensure the ability of the facility to remain open and to flex to Surge Capacity, thereby preventing or minimizing time of hospital diversion and APOT.

4. As per EMTALA, the responsibility for patient care lies with the receiving facility once the patient being transported via ambulance arrives at the hospital property. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible.

5. Hospitals that have a consistently prolonged APOT should assign appropriate personnel to remain with patients while awaiting for an ER treatment bay in order to release EMS personnel back to the community.

6. Hospital personnel shall acknowledge and provide a visual assessment of patients arriving via ambulance within 10 minutes of arrival in the ED to determine whether the patient needs an ED treatment bay or can be sent to other areas of the emergency department.

7. In accordance with Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients, final authority for patient destination rests with the base hospital handling the call. Whether the diversion request will be honored depends on available system resources.

8. The State of California Emergency Medical Services Authority has adopted Standardized Methods for Data Collection and Reporting of APOT. The APOT Standard for Los Angeles County is 90% of all ambulance transports have an APOT of 30 minutes or less.

9. The accurate documentation by EMS providers of the time metrics for APOT is imperative to appropriately evaluate and monitor APOT.

POLICY:

I. Responsibilities Prior to reaching Hospital Diversion Threshold

   A. ED Charge Nurse

      1. Identifies that all ED treatment bays are occupied and patients are waiting for an open treatment bay.

      2. Consults with all ED team members to determine if patient discharges or admissions can be expedited.
3. Ensures that all ED treatment bays are appropriately utilized.
4. Notifies the Laboratory and Radiology departments to expedite orders.
5. Notifies the Nursing Supervisor that the ED is near threshold.

B. Hospital Administration (CEO or administrative designee)

1. Consults with the ED physician and ED charge nurse.
2. Performs a walk-through of the ED and reviews options that can be utilized to prevent hospital diversion (CEO or administrative designee).
3. Assesses the ED for special considerations.
4. Activates the hospital’s internal multidisciplinary surge plan.
5. Assesses the Medical/Surgical, Intensive Care and Telemetry units for available beds and possible discharges.
6. Expedites environmental services, ancillary services and patient admissions as necessary.
7. Approves diversion due to ED saturation via the ReddiNet when ED capacity reaches the defined diversion threshold.
8. Reassesses ED capacity during diversion with the goal of remaining open.
9. Monitors hospital diversion hours.
10. Includes diversion in the ED performance improvement process.

C. Hospitals may request ED diversion via the ReddiNet for up to one hour at a time. At the end of one hour of diversion, ReddiNet will automatically re-open the hospital to all 9-1-1 traffic. The hospital may request additional ED diversion time in one-hour increments.

II. Request for diversion of a hospital by an EMS Provider Agency

An EMS provider agency may request to put a hospital on diversion due to ED saturation when the EMS provider agency diversion threshold is met. Each EMS provider agency shall have a diversion request policy that is consistent with the following guidelines:

A. EMS provider agency personnel who are waiting to offload and transfer care to hospital staff shall contact the EMS provider agency’s on-duty supervisor and provide the following information:

1. Units waiting to offload
2. Time of arrival at hospital of the unit waiting the longest to offload
3. Time of arrival at hospital of the unit waiting the shortest to offload
4. Estimated time to offload, obtain from ED Charge Nurse

B. The EMS provider agency’s on-duty supervisor shall

1. Physically visit the emergency department and verify the report provided by the transport crew(s).

2. Collaborate with the charge nurse, on-duty physician, or house supervisor to identify alternatives to facilitate the transfer of the patients from EMS personnel to emergency department staff.

3. If the EMS provider agency diversion threshold is met, contact the Medical Alert Center and request the facility to be placed on Diversion due to ED Saturation.

C. The Medical Alert Center shall:

1. Obtain all the necessary information to verify diversion threshold is met.

2. Contact the hospital emergency department to verify information provided by the EMS provider agency’s on duty supervisor.

3. Place the hospital on diversion due to ED Saturation.

4. Notify hospital administration or designee that the hospital has been placed on diversion.

D. Hospital Administration (CEO or administrative designee)

1. Reassess ED capacity during diversion with the goal of lifting the diversion status.

2. Monitors diversion hours

3. Includes diversion in the ED performance improvement process.

E. Diversion requests will be up to one hour at a time. Additional diversion time may be requested in one hour increments if the EMS provider agency diversion threshold is met. Diversion request shall be made through the Medical Alert Center.

III. Diversion Audits

The EMS Agency reserves the right to conduct unannounced diversion audits as indicated.

CROSS REFERENCE:

Prehospital Care Manual:
Reference No. 502, Patient Destination
Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients
California EMSA: Ambulance Patient Offload Time (APOT) Standardized Methods for Data Collection and Reporting