(HOSPITALS / EMS PROVIDERS)

SUBJECT: **REGIONAL EMS SURGE ASSISTANCE PLAN** REFERENCE NO. 1114

PURPOSE: To manage 9-1-1 ambulance resources during periods of prolonged ambulance patient offload delays at hospital emergency department (EDs) due to regional influx of patients, beyond day-to-day capacity, by coordinating resources through a regional EMS/Fire Department Response Framework.

AUTHORITY: Health & Safety Code, Division 5, Sections 1797.220, 1798
Title 22, California Code of Regulations, Section 100170 (a)(5)

DEFINITIONS:

Administrator on Duty (AOD): Designated administrator of the hospital or Emergency Medical Services (EMS) Agency.

Ambulance Receiving Spaces (ARS): These are temporary designated areas outside the hospital's emergency ambulance entrance, often created by the use of tents, canopies or other overhead structures.

Coordinating Dispatch Center: The Dispatch Center in which the EMS Provider Agency Representative (AREP) is assigned.

EMS Provider Agency Representative (AREP): The designated representative of an EMS Provider Agency who is responsible for coordinating staffing, resources, and patient flow into the ARS in partnership with the Hospital EMS Triage Officer

EMTALA: Emergency Medical Treatment and Active Labor Act.

Hospital EMS Triage Officer: A registered nurse, Advanced Practitioner or ~~MD~~ physician designated by the hospital to evaluate patients on arrival and to act as liaison between the ED staff and the EMS providers in the ARS.

Medical Alert Center (MAC): Department of Health Services**,** EMS Agency disaster coordination communication center.

Medical Officer on Duty (MOD): Designated medical officer of the EMS Agency.

PRINCIPLES:

1. Hospital EMS Surge Assistance Plan will be implemented as a coordinated system directed by the Los Angeles County Emergency Medical Services (EMS) Agency and the local EMS provider agency working with the impacted hospital.

2. The purpose of the ARS is to enable ALS and BLS emergency transport ambulances to return to service as soon as possible.

APPROVED: _____ _____
Director, EMS Agency Medical Director, EMS Agency

3. The ARS does not remove EMTALA responsibility; it is intended to minimize the effects of the patient surge on the EMS system.

4. While EMS personnel may assist with monitoring patients in the ARS, patient care in the ARS is the responsibility of the hospital.

5. The ED attending physician and charge nurse must initiate a plan for appropriate triage and care of all patients in the ARS.

6. The hospital AOD shall be notified by the ED attending or ED charge nurse when the Hospital EMS Surge Assistance Plan is implemented.

7. The AREP coordinates all EMS resources in the ARS and determines when EMS personnel are no longer needed for monitoring.

8. Each EMT and Paramedic may observe up to 4 patients in the ARS. EMTs and Paramedics will provide care, as per their scope of practice.

9. The ARS EMT or Paramedic observing patients in the ARS shall immediately notify the Hospital EMS Triage Officer if any patient shows signs of deterioration.

I. CRITERIA FOR IMPLEMENTATION OF HOSPITAL EMS SURGE ASSISTANCE PLAN:

A. All available patient treatment areas, including hallways, within the ED are fully occupied and ambulance patients are being managed outside of the ED, and;

B. Three (3) or more ambulances are waiting to offload patients for greater than one (1) hour ***or;***

C. Three (3) or more Immediate patients are being managed by EMS personnel in ambulances waiting to be triaged by emergency department (ED) personnel.

II. PROCEDURE FOR IMPLEMENTATION:

A. Hospital ED personnel or EMS Provider Agency personnel will contact the Los Angeles County EMS Agency's Medical Alert Center (MAC) when the Criteria for Implementation are met (Section I).

B. MAC will contact the EMS Agency AOD and MOD who will assess and determine the need for implementation as well as the need to divert ALS and/or BLS patients to other facilities. Upon approval from the AOD/MOD, the MAC shall notify the Coordinating Dispatch Center that the Hospital EMS Surge Assistance Plan should be implemented.

C. The MAC will coordinate communication between EMS Agency AOD/MOD and the EMS Provider AREP to discuss deployment to the hospital.

D. The AREP will respond to the hospital.

E. The AREP will communicate with the ED Attending physician on duty, the ED charge nurse and/or the hospital AOD.

F. If prolonged ambulance patient offload time (e.g., > 2 hours) is anticipated, the EMS Provider AREP will notify their Dispatch Center for EMS Patient Surge assistance.

G. The AREP will coordinate with EMS ambulance crews on scene to allow for monitoring of multiple patients based on available resources; the following strategies may be employed:

1. One EMS crew on scene will be designated to remain in the ARS to observe patients and communicate with the Hospital EMS Triage Officer. Departing EMS crews will provide information on patient status to remaining EMS providers in the ARS and the Hospital EMS Triage Officer.

2. If additional EMS resources are needed, the AREP will notify their respective Dispatch Centers and request for additional resources (e.g., Battalion Chief, engine, truck, and ambulances)

3. The EMS Provider AREP will coordinate with the MAC and the EMS Agency MOD to assist in ambulance triage, and to screen ambulance traffic for possible diversion to less impacted hospitals.

H. The hospital shall designate and deploy a Hospital EMS Triage Officer who will coordinate with the AREP for the offload and monitoring of patients by EMS personnel.

1. The role of the Hospital EMS Triage Officer is to ensure that patients are entered into the hospital's electronic medical record (eMR), assist EMS personnel in directing units, and communicating directly with the ED charge nurse for patients that require an immediate life or limb saving intervention.

2. Unless otherwise designated, the Hospital EMS Triage Officer shall not be assigned direct patient care responsibilities within the ED and there shall be no ratio of patients for this position.

I. Hospital shall identify an ambulance receiving space (ARS).

1. These spaces need to be supplied with chairs, stretchers or cots, blankets, oxygen tanks, and medical supplies/equipment as available.

2. Ideally the ARS should be a tent with climate control and separate spaces for suspected infectious patients, and those that have other complaints. If a tent is not available, EZ-Ups may be used. If no shelter is available, then tarps may be deployed.

3. These items should be procured from local vendors or from the hospital disaster caches. If unable to procure, submit a resource request to the EMS Agency as some items may be obtained from the Disaster Resource Center cache, or the EMS Agency Disaster cache.

4. The hospital will provide a means to communicate with the Hospital EMS Triage Officer and the AREP and EMS crew in the ARS (e.g., walkie/talkie or cell phone).

J. Patients arriving via ambulance shall be categorized as:

a. Expectant – Patients arriving at the hospital shall be immediately assessed for prognosis and futility of effort. If futility is determined, resuscitation shall be terminated. Expectant patients shall be received by the hospital and captured in the hospital eMR. The decedent shall not be transferred to an ED treatment station but rather transported to the hospital morgue in order to release the ambulance crew back into service.

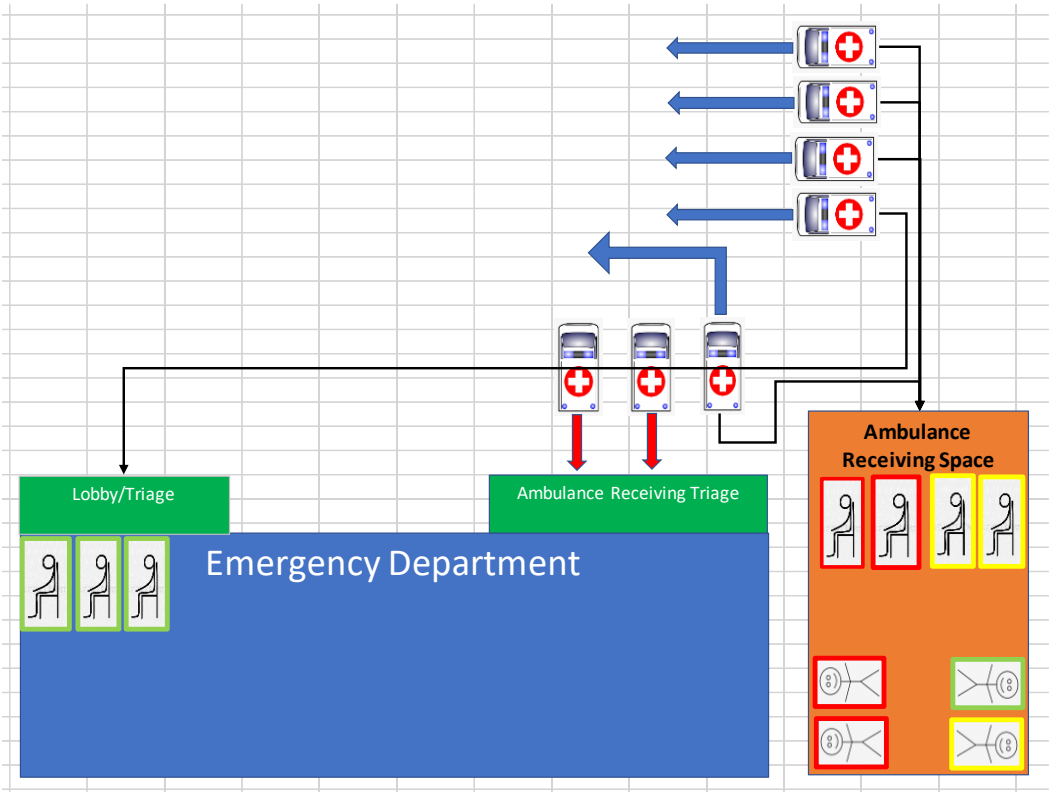
b. **Immediate (red)** – These are patients who exhibit severe respiratory, circulatory or neurological symptoms that would likely result in significant morbidity or mortality if not addressed within 1 hour. These patients require rapid assessment and medical intervention. The hospital EMS Triage Officer shall notify the Charge Nurse upon the arrival of an immediate patient. Patients in this category shall be given priority to offload to an ED treatment station when available. In the absence of an available ED treatment station, these patients shall be offloaded in the ARS or assigned an ambulance parking space closest to the hospital EMS Triage Officer. In this situation, the ambulance back doors should remain open so patients may be directly observed. Immediate patients shall further be categorized to ensure that the most gravely ill is assigned a place closest to the ED ambulance entrance for transport into the ED as soon as directed by the hospital EMS Triage Officer or the AREP may notify the MAC and the EMS Agency MOD for possible rerouting.

c. **Delayed (yellow)** – These are patients who have a potentially serious medical or surgical condition but who are stable to wait until resources are not encumbered. These patients will typically require a gurney upon arrival at the hospital. Delayed patients shall be offloaded to stretcher or cots in the ARS. The Hospital EMS Triage Office shall ensure that delayed patients are captured

in the hospital's eMR. Hospital personnel or EMS Providers shall be assigned to monitor these patients. EMTs and/or paramedics may be assigned to observe up to 4 patients.

d. **Minor (green)** – These are patients who are alert and oriented, able to sit in a chair, and medically stable. These patients shall be taken to the ED waiting room as per Ref. No. 505, Ambulance Patient Offload Time, Policy II. C. The Hospital EMS Triage Officer shall ensure these patients are captured in the hospital's eMR.

III. TEMPLATE FOR AMBULANCE ORIENTATION AND PATIENT PLACEMENT WITHIN THE ARS:



CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Ref. No. 503.1, **Diversion Request Requirements for Emergency Department Saturation**
Ref. No. 505, **Ambulance Patient Offload Time (APOT)**