

## Hospital Surge Plan Template

### DEFINITIONS

**“Disaster”** means a situation or event, natural or manmade, that overwhelms a community’s or hospital’s ability to respond with existing resources. Disasters are responsible for producing human death, suffering, and change in the community environment.

**“Hospital Command Center (HCC)”** means the location where the Incident Commander is located when the Emergency Preparedness Plan is activated.

**“Hospital Incident Command System (HICS)”** means an emergency management system that employs a logical, unified management (command) structure, defined responsibilities, clear reporting channels, and a common nomenclature to help unify hospitals with other emergency responders.

**“Incident Command System (ICS)”** means a nationally used standardized on-scene emergency management concept specifically designed to allow its user(s) to adopt an integrated organizational structure equal to the complexity and demand of single or multiple incidents without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures and communications operation within a common organizational structure, with the responsibility of managing resources to effectively accomplish stated objectives pertinent to an incident.

**“Level I Surge”** means a surge in patients presenting to the Emergency Department resulting in significant stress to hospital resources.

**“Level II Surge”** means a surge in patients affecting all local medical providers, requiring regularly scheduled planning sessions or conference calls in order to strategize, coordinate, collaborate, and communicate among all community medical/health providers, EMS agency, Public Health, Fire, and OES representatives.

**“Level III Surge”** means a surge in patients countywide and in neighboring counties, resulting in a lack of capacity to provide impacted service or services. State of emergency has been declared or is being sought. Regional coordination is necessary in order to meet the medical and health needs of the public.

**“Level IV Surge”** means a surge in patients requiring EMS and hospital standards of care be recalibrated using pre-approved alternate care protocols, and less-acute hospital patients be triaged from hospitals to appropriate alternate care providers. Regional/statewide coordination is necessary.

**“Medical/Health Operational Area Coordinator (MHOAC)”** means the individual(s) responsible for coordinating the medical and health system and medical resource needs for

Placer County. The MHOAC may be activated 24-hour per day by contacting:  
\_\_\_\_\_.

**“Public Health Department Operations Center (PH DOC)”** means the center established by the Placer County Public Health Department for coordination of medical and health operations during a disaster or state of emergency.

## PURPOSE

As a healthcare provider and community leader, the hospital and staff shall assume a primary role and responsibility for providing emergent and acute care services (safely and within the scope of their service) to the community during times of medical crisis. The hospital shall work directly with the Placer County Public Health Departmental Operations Center (PH DOC) to plan and coordinate medical disaster response, operations, and recovery activities during times of medical crisis.

The hospital has adopted the Hospital Incident Command System (HICS) standard as a mitigation strategy. HICS serves as the hospital operations response structure during a disaster event and is designed to provide clearly defined job duties and responsibilities. In addition, this policy and related disaster response policies and procedures (Disaster Preparedness, Hazardous Materials, Decontamination, and Facility Lock-down), shall provide detailed facility specific guidance in managing all aspects of medical disaster response. A well-coordinated response to a disaster saves lives and minimizes pain and suffering.

The approach used in any disaster should follow the same format: mitigation, preparation, response, and recovery. This procedure is only intended to provide guidelines for actions should such a disaster occur, and applies to the hospital, sponsored clinics, and medical practices.

## POLICY

1. **LEVEL I SURGE (local):**
  - a. Triggers:
    - (1) >30 minute delay in Emergency Department triage; or
    - (2) >30 minute delay in Ambulance turn-around times at ED; or
    - (3) >4 patients awaiting admission, or >2 ICU patients awaiting admission; or
    - (4) Determination by the House Supervisor and on-call Administrator that Level I is necessary.
  - b. Activation:
    - (1) ED staff shall immediately notify the House Supervisor when any of the above triggers have been met.
    - (2) The House Supervisor shall assume the role of Incident Commander and notify the Nurse Administrator on-call of the Level I Surge.
  - c. Determine Size and Scope

- (1) The House Supervisor shall work with the Nurse Administrator on-call to complete a high level assessment of the potential operational impact on the facility and determine the need to activate the HCC.
  - (2) House Supervisor or designee shall determine the risk and need for a facility-wide lockdown and work in collaboration with Plant Operations to ensure immediate actions to implement the lockdown.
  - (3) The House Supervisor shall conduct regularly schedule meetings with ED and Inpatient Managers to address patient throughput issues and assess needs.
- d. Internal Alert
- (1) The House Supervisor or designee shall contact the Switchboard Operator, providing any pertinent information about the announcement to be made.
  - (2) The Switchboard Operator will announce THREE TIMES over the public address system: (Note: If a Drill, please identify as a “Drill.”)  
“ATTENTION PLEASE. CODE TRIAGE: LEVEL I.”
- e. Staffing
- (1) The House Supervisor shall immediately assign available staff to support the Emergency Department
  - (2) Consider activation of staff call-back
  - (3) Consider implementation of staffing ratio flex
- f. Bed Capacity (Level I Diagram)
- (1) Available gurneys shall be brought to the Emergency Department by the Lift Tech or designee.
- g. Communicate ED/Hospital Status
- (1) ED staff shall update EMS system with current hospital/ED status, and keep updated as status /resources change (at least every hour).
  - (2) ED staff or the House Supervisor shall contact neighboring hospitals to assess levels of saturation and communicate the current hospital status.
  - (3) ED staff shall notify Ambulance Dispatch of the Level I Surge.
  - (4) Nurse Administrator shall notify the Administrator on-call of the Level I Activation.
- h. Accelerate Discharge
- The House Supervisor, in collaboration with managers of inpatient units, shall identify patients who can potentially be discharged and make the appropriate discharge arrangements with the attending physician and other applicable patient care service providers.

## 2. **LEVEL II SURGE (Op Area):**

- a. Triggers:
  - (1) Determination by the Administrator on-call that multi-agency or multi-county coordination is necessary to mitigate the impact on the facility, with possible need for activation of Alternate Care Site(s)
  
- b. Activation
  - (1) Only the Incident Commander or Nurse Administrator on-call are authorized to activate Level II Surge.
  - (2) The Incident Commander shall activate the HCC, and notify the MHOAC.
  - (3) The Incident Commander or Safety Officer shall determine the risk and need for a facility-wide lockdown and work in collaboration with security (or their designee) to ensure immediate actions to implement the lockdown.
  
- c. Determine Size and Scope
  - (1) The Incident Commander shall develop an Incident Action Plan, assign HICS positions and activate staff call-back as necessary.
  
- d. Internal Alert
  - (1) The Incident Commander or designee shall contact the Switchboard Operator, providing any pertinent information about the announcement to be made.
  - (2) Switchboard Operator will announce **THREE TIMES** over the public address system: (Note: If a Drill, please identify as a "Drill.")  
"ATTENTION PLEASE. CODE TRIAGE: LEVEL II."
  - (3) Switchboard Operator will contact other departments which do not have overhead paging available – see list located in area.
  
- e. Staffing
  - (1) Conduct staff call-back of available personnel as requested by the Incident Commander.
  - (2) Implement 6:1 or 7:1 staffing ratio flex plan to meet the needs of the patient population.
  
- f. Bed Capacity
  - (1) Cancel Elective, Routine, or Non-Essential Surgery
  - (2) The Operations Chief shall work in collaboration with Surgery and other assigned departments to assess the needs for cancellation of non-essential elective surgical or interventional services
  - (3) If services are to be delayed or canceled, the managers or designee for the applicable service area shall be responsible to notify the particular physicians those patients being impacted by the change.
  - (4) Expand Inpatient Bed Capacity
  - (5) Consider deployment of Surge Tent (alternate triage point, families, etc.)
  - (6) Consider referral of Minor patients to outpatient clinics.
  - (7) Consider utilization of SNFs and other LTC facilities
  - (8) Participate in Operational Area/PH DOC Planning Sessions
  
- g. Communicate ED/Hospital Status

- (1) ED staff shall update EMS system with current hospital/ED status, and keep updated as status /resources change (at least every hour).
  - (2) ED staff or the House Supervisor shall contact neighboring hospitals to assess levels of saturation and communicate the current hospital status.
  - (3) ED staff shall notify the Control Facility of current status.
  - (4) Nurse Administrator shall notify the Administrator on-call of the Level II Activation.
- h. Communicate Resource Needs
- (1) The Incident Commander (or designee) shall work in collaboration with the MHOAC (or PH DOC if activated) to ensure that adequate resource needs are being assessed on an ongoing basis and necessary resources acquired to address the needs.
3. **LEVEL III SURGE (regional):**
- a. Triggers
 

Determination by the HCC or Administrator on-call that the hospital is unable to meet the medical needs of the public without intervention or mitigation of regional or state resources.
  - b. Activation
    - (1) Only the Public Health Officer or designee is authorized to activate Level III Surge.
    - (2) The HCC shall be fully activated.
  - c. Determine Size and Scope
    - (1) The Incident Commander shall complete a high level assessment of the potential operational impact on the facility.
  - d. Internal Alert
    - (1) The Incident Commander or designee shall contact the Switchboard Operator, providing any pertinent information about the announcement to be made.
    - (2) Switchboard Operator will announce THREE TIMES over the public address system: (Note: If a Drill, please identify as a "Drill.")  
"ATTENTION PLEASE. CODE TRIAGE: LEVEL III."
    - (3) Switchboard Operator will contact other departments which do not have overhead paging available – see list located in area.
    - (4) Switchboard Operator will contact associated clinics, if open, informing them of the Level III Surge.
  - e. Staffing
    - (1) Implement staffing ratio increase up to 10:1 in order to meet the needs of the patient population.
  - f. Bed Capacity
    - (1) Deployment of Surge Tent (alternate triage point, families, etc.)
    - (2) Consider Establishing External Triage

- (3) Consider redirecting Minor patients to outpatient sites (e.g. clinics, surge tents, alternate care sites).
  - g. Communicate ED/Hospital Status
    - (1) ED staff shall update EMS System with current hospital/ED status, and keep updated as status /resources change (at least every hour).
  - h. Communicate Resource Needs
    - (1) The Incident Commander (or designee) shall work in collaboration with the PH DOC to ensure that adequate resource needs are being assessed on an ongoing basis and necessary resources acquired to address the needs.
  - i. Participate in Operational Area/Regional Planning Sessions.
    - (1) Coordinate any public information with the county EOC and PH DOC.
    - (2) Consider implementing disaster hotline for the public (e.g. triage, nurse call line).
4. **LEVEL IV SURGE (region/state):**
- a. Triggers
    - (1) Determination by the HCC and PHDOC that implementation of Austere Medical Protocols is needed in order to provide the most good to the most people in need of medical care resources.
  - b. Activation
    - (1) Only the Public Health Officer or designee is authorized to activate Level IV Surge.
    - (2) The HCC shall be fully activated.
  - c. Determine Size and Scope
    - (1) The Incident Commander shall complete a high level assessment of the potential operational impact on the facility.
  - d.
  - e. Internal Alert
    - (1) The Incident Commander or designee shall contact the Switchboard Operator, providing any pertinent information about the announcement to be made.
    - (2) Switchboard Operator will announce THREE TIMES over the public address system: (Note: If a Drill, please identify as a “Drill.”)  
“ATTENTION PLEASE. CODE TRIAGE: LEVEL IV.”
    - (3) Switchboard Operator will contact other departments which do not have overhead paging available – see list located in area.
    - (4) Switchboard Operator will contact associate clinics, if open, informing them of the Level IV Surge.
  - f. Staffing
    - (1) Implement staffing ratio increase in appropriate areas to meet the needs of the increased patient population.

- g. Bed Capacity
  - (1) Coordinate/prioritize inpatient care with all inpatient care sites
  - (2) Re-assign inpatient areas according to patient needs (e.g. expanded isolation unit, expanded ICU, surgical care unit, etc.)
  - (3) Implement re-assessment, transfer, or discharge of patients according to Austere Medical protocols approved by the HCC.
  
- h. Communicate ED/Hospital Status
  - (1) ED staff shall update EMSSystem with current hospital/ED status, and keep updated as status /resources change (at least every shift).
  
- i. Communicate Resource Needs
  - (1) The Incident Commander (or designee) shall work in collaboration with the PH DOC to ensure that adequate resource needs are being assessed on an ongoing basis and necessary resources acquired to address the needs.
  
- j. Participate in Operational Area/regional/statewide Planning Sessions

**DHS L&C Temporary Permission for Increased Patient Accommodations Request Worksheet**

District office: \_\_\_\_\_ Date: \_\_\_\_\_  
Facility Name: Mark Twain St. Joseph's Hospital  
Address: \_\_\_\_\_  
Phone \_\_\_\_\_ Facility Contact \_\_\_\_\_  
Brief description of Problem: \_\_\_\_\_

Increased Patient Accommodations requested: \_\_\_\_\_  
\_\_\_\_\_

Facts to Consider For Increased Patient Accommodation Request:

- Reschedule non-emergent surgeries and diagnostic procedures.
- Transfer patients to other beds or discharge as appropriate.
- Set up clinics for non-emergency cases. (If possible)
- Request ambulance diversion from LEMSA.
- LEMSA area of operation is impacted i.e. Multiple hospitals on diversion due to hospital overcrowding.
- Other

Permission Granted:  No  Yes From: \_\_\_\_\_ To: \_\_\_\_\_

L&C Staff Sign \_\_\_\_\_

Comments / Conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Instructions** – Permission to increase patient accommodations will be granted only in “justified emergencies” per CCR T 22 § 70809 (a). Permission will be time limited for a period of time to be determined for each request, depending of the facts presented. Initial approvals are given verbally, and then a signed written approval will be faxed to the facility and the L&C disaster preparedness coordinator (916) 440-7369. A copy of the approval should be filed in the facility folder. This worksheet is an optional form, but the L&C district office, when reviewing these requests, should consider the facts identified above, and all other information deemed relevant by the hospital or the Department under the specific circumstances.