

# Placer County Hospital Surge Plan Template

This Hospital Surge Plan Template was developed by the Placer County Healthcare Surge Advisory Committee to assist the hospitals within Placer County. This document was intended to be a template only, and not the final Hospital Surge Plan. The numbers, percentages, floor plans, and other internal operation references depicted within this document are for reference only and should be customized by each facility within Placer County.

Revised: 2/15/08

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**A. Purpose:**

The purpose of this Surge Plan is to develop a systematic approach toward providing patient care services during surge events that may affect our community and hospital. As a leader in patient care services, we are in the best position to respond to a community wide medical crisis.

For this reason, we have developed a surge plan that outlines how we intend to respond to support such an event.

Our goal is to assess, plan, and implement operational strategies and processes outlined within this document that would enable us to support a Surge event.

This plan provides surge strategies intended to supplement existing HIGH CENSUS / CAPACITY DEMANDS policies.

**B. Assumptions:**

The development and implementation of this plan is based on the following assumptions:

1. Surge occurs when we have achieved maximum census (Licensed Bed Levels) for either Inpatient or Emergency Department Services.
2. A Surge event will require the Hospital to declare an Internal Disaster, therefore initiating elements of our Emergency Management Program.
3. The Placer County Health Officer will acknowledge the surge and declare a local Medical Disaster/Emergency for level III surge events.
4. Standards that outline Life Safety Codes and other Environment of Care will be deviated from in order to set-up Alternative Patient Care Sites.

**NOTE:** The intent of assumption 4 is not to degrade patient care services, but to provide exceptions that would allow life saving medical services to be provided during emergency crisis situations.

5. The Medical Center is not directly affected by an emergency event (fire, bomb, etc.), and is physically capable of providing basic utility services (Water, Sewage, and Electricity).
6. Adequate staffing is available as determined by Administration.
7. The hospital may exceed the surge plan levels reflected within this document only if capable before declaring a level III surge.

**C. Definitions:**

Alternative Patient Care Location (Internal)	Designated or non-designated locations used throughout the hospital property where a patient care bed will be set-up that is not designated as a licensed care location.
CAHAN	California Health Alert Network (CAHAN) The web-based CAHAN system is designed to broadcast warnings of impending or current disasters affecting the ability of health officials to provide disaster response services to the public.
Control Facility (CF)	The <i>Control Facility (CF)</i> must be operational 24 hours a day. The CF uses the County med-net radio system. Primary back up system is the Blast phone, cell or satellite phone. The CF is that entity responsible for the dispersal of patients during all Multi-Casualty Incidents (MCI). The CF will collect a Status Report (MCM #408) from all receiving facilities and notify them when patients have been dispersed to them.
Donor Facility	The healthcare facility that provides personnel, pharmaceuticals, supplies or equipment to a facility experiencing a medical disaster.
EOC	The Emergency Operations Center (EOC) - the location established by each city or county to centralize coordination of all aspects of a disaster response.
EMSystem	An Internet-based hospital system used by all area hospitals to report status (open/closed/diversion) and bed capacity in real-time. Data request and reporting via EMSystem can reach all hospitals simultaneously.
Healthcare Facility Indicators	A set of healthcare facility resource measures that are reported to <i>MHOAC</i> during a disaster drill or actual disaster. The indicators are designed to catalogue healthcare facility resources that could be available for other healthcare facilities during a disaster.
HCC	Hospital Command Center (HCC). An area established in a healthcare facility during an emergency that is the facility's primary source of administrative authority and decision-making.
HICS	Hospital Incident Command System (HICS). The incident command structure developed to meet the needs of the hospital response to a disaster.
Impacted Health Care Facility	The healthcare facility where the disaster occurred or disaster victims are being treated. Referred to as the recipient healthcare facility when pharmaceuticals, supplies, or equipment are requested or as the patient-transferring healthcare facility when the evacuation of patients is required.
JIC	Joint Information Center (JIC)- The location established for the purpose of coordinating the release of information to the press, media and general public. The hospital will participate in providing information to the JIC and help to convey a unified message developed for release to the public.
Level I Surge	“Level I Surge” means a surge in patients presenting to the Emergency Department or Inpatient Setting resulting in significant stress to hospital resources, not requiring waivers for normal patient care services.
Level II Surge	“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	“Level III Surge” means a surge in patients exceeding the local facilities capability of providing Alternative Patient Care, requiring the activation and

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	utilization of medical resources from the regional agencies.
Level IV Surge	“Level IV Surge” means a surge in patients requiring the assistance from State and Federal Agencies.
Master Mutual Aid Agreement	The California Disaster and Civil Defense Master Mutual Aid Agreement made and entered into by and among the State of California, its various departments and agencies of the State, in 1950. The agreement provides for support of one jurisdiction by another.
Medical Disaster	An incident that exceeds a facility's effective response capability or that facility cannot appropriately resolve solely by using its own resources. Such disasters will very likely involve <i>local and regional Control Facilities, the local MHOAC</i> and may involve loan of medical and support personnel, pharmaceuticals, supplies and equipment from another facility, or the emergent evacuation of patients.
MHOAC	<u>Medical Health Operational Area Coordinator (MHOAC)</u> An individual appointed by the County Health Officer and LEMSA Administrator who is responsible in the event of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of resources within the Operational Area (county) as defined in Region IV Manual 3 – Medical Health Mutual Aid. The MHOAC 24-hour contact number is: (530) 886-5375-Placer Co PSAP, Fax (530) 886-5343-Placer OES
OES Region IV Multi-Casualty (MCI) Plan	The current OES Region IV Multi-Casualty (MCI) Plan is comprised of 3 interdependent manuals: Manual I – MCI Field Operations; Manual II – MCI Patient Dispersion (Control Facility Operations); and Manual III – Medical Health Mutual Aid.
Partner ("Buddy")	The designated facility (or healthcare system) that a healthcare facility communicates with as a facility's "first call for help" during a medical disaster (developed through an optional partnering arrangement).
Patient-Receiving Facility	The healthcare facility that receives transferred patients from an impacted facility responding to a disaster. When patients are evacuated, the receiving facility is referred to as the patient-receiving healthcare facility.
Patient Transferring Facility	An impacted facility -- The healthcare facility that evacuates patients to a patient-receiving facility in response to a medical disaster.
Participating Hospitals	Healthcare facilities that have fully committed to the MOU. This list of Participating Hospitals shall be maintained and disseminated by the MHOAC.
Public Health Department Operations Center (PH DOC)	The center established by the Placer County Health and Human Services Department for coordination of medical and health operations during a disaster or state of emergency.
Recipient Facility	The impacted facility. The healthcare facility where disaster patients are being treated and have requested personnel or materials from another facility.

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<p>Regional Control Facility</p>	<p>The Regional Control Facility (RCF) will operate under the same guidelines as a county CF. The State of California is divided into six regions for purpose of mutual aid during emergency situations. Region IV consists of eleven counties:</p> <ul style="list-style-type: none"> <li>• Alpine - Amador - Calaveras - El Dorado - Nevada -Placer</li> <li>• Sacramento - San Joaquin - Stanislaus - Tuolumne - Yolo</li> </ul> <p>The Regional <i>Control Facility (RCF)</i> must be operational 24 hours a day. The RCF uses MedNet for radio communications. Primary back up systems are other redundant communication systems.</p>
<p>Regional Disaster Medical Health Coordinator (RDMHC)</p>	<p>A volunteer local health officer, EMS agency Coordinator of Emergency Services or EMS agency administrator jointly appointed by the Directors of the California Department of Health Services (DHS) and the Emergency Medical Services Authority (EMSA) based upon the recommendation of the local health officer for a mutual aid region. The role of the RDMHC is to plan for and coordinate medical and health resources within one of California’s sic mutual aid regions during times of disaster or other major event requiring medical or health mutual aid.</p>
<p>Regional Disaster Medical Health Specialist (RDMHS)</p>	<p>An individual selected by a local EMS agency, under contract with EMSA and California Department of Public Health, as a staff function to coordinate preparedness activities, and assist the RDMHC in coordinating services in the event of a disaster or in the event that medical mutual aid of some type is requested.</p>
<p>Operational Area</p>	<p>The operational area is the intermediate level of the state emergency services organization consisting of a county and all political subdivisions within the county geographic area.</p>

**D. Surge Capacity and Rationale:**

Each facility will plan for the following capacity during a surge event:

Facility	Current Inpatient Beds	Percent of Increase*	Total Inpatient Surge Capacity
Sutter Auburn Faith	106	23%	<b>155</b>
Sutter Roseville	180	40%	<b>300</b>
Kaiser Roseville	166	37%	<b>296</b>

Rationale used for planning our Surge Capacity, was based on a Pandemic event, with a 35% Gross Attack Rate, using the maximum scenario admission rates. Reference: CDC, Flu Surge Version 2.0 planning document. <http://www.cdc.gov/flu/tools/flusurge/>

We also factored in the 2006 Placer County Population Estimates from the California Department of Finance:

Age Group (years)	Population
0-19	74,496
20-64	199,000
+ 65	43,784

\*Percentage of Surge increase was based upon the 2006/07 percentage of inpatient beds within Placer County. This methodology was approved by the Placer County Health & Human Services on May 14, 2007 during a Planning meeting with the County. Inpatient bed numbers and population figures to be updated every 5 years, beginning in 2011.

Placer County Cumulative Data Adult Beds:

Hospital	Type of Bed	Date reported	Total licensed Beds	Average Daily Occupancy	Pandemic Surge Increase (% beds within the county X peak surge) + (average Census)
Sutter Auburn Faith		2/21/06			
	Critical care/monitored beds		20	13	
	General medical – surgical beds (Unmonitored)		86	52	23% x 393 + 65=155 Surge Capacity
			106	65 or 68%	Plan for 155 Capacity
Sutter Roseville		2/24/06			
	Critical care/monitored beds		32	20	
	General medical – surgical beds (Unmonitored)		148	122	40% x 393 + 142=300 Surge Capacity
			180	142 or 79%	Plan for 300 Capacity
Kaiser		2/23/06			
	Critical care/monitored beds		70	60	
	General medical – surgical beds (Unmonitored)		96	88	37% x 393 + 148 =296 Surge Capacity
			166	148 or 89%	Plan for 296 Capacity.
	TOTAL		452	355	

NOTE: Based on a 35% Attack Rate using the CDC guidelines, with a peak admission of 393.

**E. Surge Level Activation:**

**1. LEVEL I SURGE (local):**

**a. Triggers**

- i. >30 minute delay in Emergency Department triage; or
- ii. >30 minute delay in Ambulance turn-around times at ED; or
- iii. Determination by the House Supervisor and on-call Administrator that Level I is necessary.

**b. Activation**

- i. ED staff shall immediately notify the House Supervisor when any of the above triggers have been met.
- ii. 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**

- i. 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 Hospital Command Center (HCC).
- ii. 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.
- iii. The House Supervisor shall conduct regularly schedule meetings with ED and Inpatient Managers to address patient throughput issues and assess needs.

**d. Internal Alert**

- i. The House Supervisor or designee shall contact the Switchboard Operator, providing any pertinent information about the announcement to be made.
- ii. 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**

- i. The House Supervisor shall immediately assign available staff to support the Emergency Department
- ii. Consider activation of staff call-back
- iii. Consider implementation of staffing ratio flex

**f. Bed Capacity**

- i. (Level I Diagram) Available gurneys shall be brought to the Emergency Department by the Lift Tech or designee.

**g. Communicate ED/Hospital Status**

- i. ED staff shall update EMSsystem with current hospital/ED status (e.g. Advisory: Level I Surge...), and keep updated as status /resources change (at least every hour).
- ii. Nurse Administrator shall notify the Administrator on-call of the Level I Activation.

**h. Accelerate Discharge**

- i. 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 (Local):**

**a. Triggers**

- i. Administrator on-call determines 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)
- ii. Facility has exceeded its licensed bed capacity.

**b. Activation**

- i. Only the Incident Commander or Nurse Administrator on-call are authorized to activate Level II Surge.
- ii. The Incident Commander shall activate the HCC, and notify the MHOAC.
- iii. 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.
- iv. Notify Placer County Medical Health Operational Area Coordinator (MHOAC).

Share information with MHOAC:

Placer County MHOAC: (530) 886-5375-Placer Co PSAP, Fax (530) 886-5343-Placer OES DHS L&C Temporary Permission for Increased Patient Accommodations Request Worksheet. (See page 14 for form and contact information).

**c. Determine Size and Scope**

- i. The Incident Commander shall develop an Incident Action Plan, and assign HICS positions and activate staff call-back as necessary.

**d. Internal Alert**

- i. The Incident Commander or designee shall contact the Switchboard Operator, providing any pertinent information about the announcement to be made.

- ii. 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.”
- iii. Switchboard Operator will contact other departments which do not have overhead paging available – see list located in area.

**e. Staffing**

- i. Conduct staff call-back of available personnel as requested by the Incident Commander.
- ii. Implement staffing ratio flex plan to meet the needs of the patient population.

**f. Bed Capacity**

- i. Cancel Elective, Routine, or Non-Essential Surgery
- ii. 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
- iii. 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.
- iv. Expand Inpatient Bed Capacity
- v. Consider deployment of Surge Tent (alternate triage point, families, etc.)
- vi. Consider referral of Minor patients to outpatient clinics.
- vii. Consider utilization of SNFs and other LTC facilities
- viii. Participate in Operational Area/PH DOC Planning Sessions

**g. Communicate Status**

- i. ED staff shall update EMS system with current hospital/ED status, and keep updated as status /resources change (at least every hour).
- ii. ED staff or the House Supervisor shall contact neighboring hospitals to assess levels of saturation and communicate the current hospital status.
- iii. ED staff shall notify the Control Facility of current status.
- iv. Nurse Administrator shall notify the Administrator on-call of the Level II Activation.

**h. Communicate Resource Needs**

- i. 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**

- i. Determination by the Incident Commander that the hospital has reached maximum surge levels and is unable to meet the medical needs of the public without intervention or mitigation of regional or state resources.
  - ii. Facility has exceeded both its licensed bed capacity and its surge bed capacity.
- b. Activation**
- i. Only the Public Health Officer or designee is authorized to activate Level III Surge.
  - ii. The HCC shall be fully activated.
  - iii. Hospital may be required to send an Incident Management Team to the County to plan for the activation of external Alternative Care Sites within Sacramento County.
- c. Incident Management Team Requirements**
- i. Incident Commander (Administrator)
  - ii. Medical Branch Leader (Patient Care Services Director or designee)
  - iii. Infrastructure Branch Leader (Facility Director or designee)
  - iv. Logistics Branch Leader (Materials Management Manager or designee)
  - v. Security Branch Leader (Security)
- d. Determine Size and Scope**
- i. The Incident Commander shall complete a high level assessment of the potential operational impact on the facility.
- e. Internal Alert**
- i. The Incident Commander or designee shall contact the Switchboard Operator, providing any pertinent information about the announcement to be made.
  - ii. 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.”
  - iii. Switchboard Operator will contact other departments which do not have overhead paging available – see list located in area.
  - iv. Switchboard Operator will contact associated clinics, if open, informing them of the Level III Surge.
- f. Staffing**
- i. Implement staffing ratio increase up to 10:1 in order to meet the needs of the patient population.
- g. Bed Capacity**
- i. Deployment of Surge Tent (alternate triage point, families, etc.)
  - ii. Consider Establishing External Triage

- iii. Consider redirecting Minor patients to outpatient sites (e.g. clinics, surge tents, alternate care sites).
  - h. Communicate ED/Hospital Status**
    - i. ED staff shall update EMS system with current hospital/ED status, and keep updated as status /resources change (at least every hour or as directed by the Control Facility).
  - i. Communicate Resource Needs**
    - i. The Incident Commander (or designee) shall work in collaboration with the PH DOCMHOAC 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 Planning Sessions.**
    - i. Coordinate any public information with the county EOC and PH DOCMHOAC.
    - ii. Consider implementing disaster hotline for the public (e.g. triage, nurse call line).
- 4. LEVEL IV SURGE (REGION/STATE):**
- a. Triggers**
    - i. Determination by the HCC and PHDOC that implementation of Austere Alternate Medical Protocols is needed in order to provide the most good to the most people in need of medical care resources.
  - b. Activation**
    - i. Only the Public Health Officer or designee is authorized to activate Level IV Surge.
    - ii. The HCC shall be fully activated.
  - c. Determine Size and Scope**
    - i. The Incident Commander shall complete a high level assessment of the potential operational impact on the facility.
  - d. Internal Alert**
    - i. The Incident Commander or designee shall contact the Switchboard Operator, providing any pertinent information about the announcement to be made.
    - ii. 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.”**
    - iii. Switchboard Operator will contact other departments which do not have overhead paging available – see list located in area.
    - iv. Switchboard Operator will contact associate clinics, if open, informing them of the Level IV Surge.
  - e. Staffing**

- i. Implement staffing ratio increase in appropriate areas to meet the needs of the increased patient population.

**f. Bed Capacity**

- i. Coordinate/prioritize inpatient care with all inpatient care sites
- ii. Re-assign inpatient areas according to patient needs (e.g. expanded isolation unit, expanded ICU, surgical care unit, etc.)
- iii. Implement re-assessment, transfer, or discharge of patients according to Austere Alternate Medical protocols approved by the HCC.

**g. Communicate ED/Hospital Status**

- i. ED staff shall update EMS system with current hospital/ED status, and keep updated as status /resources change (at least every shift).

**h. Communicate Resource Needs**

- i. 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/statewide Planning Sessions**

**A. Planning Factors for determining Alternative Patient Care Sites:**

1. Alternative Patient Care Site is a designated location within the hospital for providing inpatient and triage medical care services that would not normally be used for such services. Examples would be visitor waiting areas, hallways, conference room, or an outpatient medical office building.
2. Review the Infection Control Manual for Patient Care risk reduction and exposure control considerations and protocols.
  - a. Do we have or can we provide:
    - i.  Temperature and ventilation exhaust control to the space?
    - ii.  Access Control/Security?
    - iii.  Electrical power?
    - iv.  Emergency back-up Power?
    - v.  Patient care process flow that allows accessible supervision and services?
    - vi.  Waste disposal?
    - vii.  Sprinkled building (Fire Suppression System)?
    - viii.  Same level Emergency Egress with access widths not less than 45 inches?
    - ix.  Personal Hygiene Capabilities (hand washing, changing, and bathroom resources)?
    - x.  Communications-telephonic and or overhead capabilities.
  - b. Evacuation: Since a 24 hour stay would be expected for inpatient, we need to ensure the evacuation of patients could occur during a fire related event, therefore should consider evacuation impacts when setting up Alternative Care Sites on multi level floors.
  - c. Storage of Flammable liquids and ignitions sources would need to be assessed and controlled to reduce fire potential in non Hospital Building Occupancy Classifications.
  - d. Space Configuration:

Purpose	Item description	Quantity	Type of item
1. 3 Feet of distance aisle way between Patients to reduce spread of infectious diseases.	36 inches between beds.	NA	Privacy Curtain
2. Access Space for equipment or staff.	24 inches	NA	Run plugs away from walking paths if possible.
3. Minimum support items.	1. Privacy curtains 2. Waste container 3. Medical Waste container 4. Bed pan/urinals 5. Y Connectors for Oxygen and Suction	Sharps rated.	Portable
4. O2 services.	Yes	TBD	
5. Power needs.	Electrical Surge Strip with a	1 ea	Extension cord to connect

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	five plug outlet.		surge strip outlet.
6. Nurse Call system.	Manual system (bell)	1 ea	
7. Hand Sanitation.	Disinfection for staff. For infectious patients.	1 each mounted to bed.	Manual dispensing.
8. Respiratory Protection for staff.	Designate storage.	As needed.	N95 or PAPR for infectious patients.

B. Surge Configuration for Inpatient and Triage Care: (SAMPLE: Kaiser Roseville)

**Surge Configuration Table for Inpatient Care:**

Surge Set-Up Time	Location	> Capacity for Surge	Type of Services
24 hours	ROS HOSP ICU Three beds will be added in hallways of suite, or by doubling up rooms.	23	Inpatient
*24 hours	ROS HOSP 1 <sup>st</sup> Floor MED Surge 1. 17 beds can be added to larger rooms. 2. 20 beds can be added to main hallway on both wings (south and north). Beds would be on side utilizing electrical outlets.	87	Inpatient
*24 hours	ROS HOSP 2 <sup>nd</sup> Floor MED Surge 1. 17 beds can be added to larger rooms. 2. 20 beds can be added to main hallway on both wings (south and north). Beds would be on side utilizing electrical outlets.	87	Inpatient
*24 hours	ROS HOSP 3rd Floor MED Surge (Double up rooms and use hall way space).	80	Inpatient
7 Days	ROS HOSP OR (4 rooms @ 4 per room) 2 reserved for Surgeries, and 2 for recovery.	16	Inpatient
7 Days	ROS HOSP PACU	28	Inpatient
7 days	ROS EUR MOB 2 <sup>nd</sup> floor GI	7	Inpatient
	Total	328	Inpatient

NOTE:

1. **Surge Availability Timeline:** Emergency Triage and Inpatient Surge Planning with an asterisk in the table above requires the facility to maintain within its operational control (Roseville Service Area) the necessary equipment and resources to execute our surge plan without relying on outside support.
2. **387 Beds/Gurneys** would be needed to support 100% surge for Emergency Triage and Inpatient. We currently have an estimated 299 bed/gurneys at the Medical Center (3/13/07).
3. **34 Military style** cots are available in the Emergency Supply Storage Container in ED Parking lot.

**Surge Configuration Table for Triage Care: (SAMPLE: Kaiser Roseville)**

<b>Surge Set-Up Time</b>	<b>Location Emergency Department</b>	<b>&gt; Capacity for Surge</b>	<b>Type of Services</b>
0-8 hours	Rooms 1 and 2	6	Triage
0-8 hours	Rooms 3,4, and 5	4	Triage
0-8 hours	Rooms 6,7, and 8	5	Triage
0-8 hours	Rooms 9, 10, and 11	5	Triage
0-8 hours	Room 12	2	Triage
0-8 hours	Room 13 Negative Pressure	2	Triage
0-8 hours	Rooms 14 & 15	4	Triage
0-8 hours	Room 16 (Eye room)	1	Triage
0-8 hours	Room 17	1	Triage
0-8 hours	Rooms 18, 19 and 20	6	Triage
0-8 hours	Rooms A, B, C, D	4	Triage
0-8 hours	Hallway in suite	8	Triage
24-72 hours	Waiting Room	10	Triage
24-72 hours	Hallway next to X-Ray	4	Triage
	<b>Total</b>	<b>62</b>	<b>Triage</b>

**NOTE:**

1. Surge Availability Timeline: Emergency Triage and Inpatient Surge Planning with an asterisk in the table above requires the facility to maintain within its operational control (Roseville Service Area) the necessary equipment and resources to execute our surge plan without relying on outside support.
2. A receiving and waiting area would need to be relocated outside of ED. Consider setting up the portable tent to support this task.

**Appendix Section**

<b>Topic</b>	<b>Tab Section</b>
Patient DECON Capacity (HAZMAT) Planning	TBD
DHS L&C Temporary Permission for Increased Patient Accommodations Request Form	TBD
Medical Health Operational Area Coordinator (MHOAC) Request Order Form	TBD
Placer Healthcare MOU	TBD
Hospital Emergency Supply Inventory	TBD
Hospital Emergency Room Surge Floor Plans	TBD
Hospital Inpatient Care Surge Floor Plans	TBD

**C. Patient DECON Capacity:** (SAMPLE: Kaiser Roseville)

The facility has the following patient DECON capabilities to support the community.

**1. Mass Casualty Incidents (Six or more patients).**

- a. **Quick-E 2 Line Hospital DECON System.** The 2 line Decontamination Shelter is for effective decontamination of mass casualties. The system provides shelter for two lines of four stations.
  - i. Station one allow privacy for patients to de-cloth.
  - ii. The next two stations provide rinse decontamination capabilities
  - iii. The last station continues to provide privacy for patients who are provided with temporary clothing.
- b. **Storage Location:** All Patient DECON Equipment is stored in the ED Parking lot housed in the Portable Storage Trailer.
  - i. Engineering, Security, and EHS has key access to the equipment.
- c. **Support requirements:**
  - i. Water-is the primary resource requirement to provide DECON capability.
  - ii. Portable heater, HAZMAT protective equipment, portable generator, secondary sumps and pumps, and other miscellaneous items are also housed in the Portable Storage Trailer, and the Emergency Supply Conex Container adjacent to Portable Trailer.
- d. **Set-Up expectations:**
  - i. Engineering and HAZMAT Team members are responsible for setting up this equipment to support ED’s patient care services.
  - ii. HAZMAT Team members will also provide patient DECON support, thus requiring them to suit-up in protective gear which includes the Breathe Easy FR 57 Hood system.
  - iii. **Time:** It could take approximately 30-40 minutes to properly assemble the Mass Casualty 2 line Hospital DECON system when staff PPE to include respiratory protection is required.
- e. **Rate of DECON:**
  - i. With both lines operational, and adequate staff to support operations, this system could process the following Ambulatory Patients based on two lines operational:

<b>Time factors to consider</b>	<b>One minute minimum rinse/patient Total process per hour</b>	<b>15 minute shower rinse/patient Total process per hour</b>
Station one-removing clothing (2 minute step). Station four-clothing patient (2 minute step). Total 4 minutes	60 minutes / (4 min + 1 min) = 12 12 patients x 2 lines = 24 patients	60 minutes / (4 min + 15 min) = 3.2 patients x 2 lines= 6.4 patients

**2. Small Casualty system (<six patients):**

- a. **Single Stall DECON Shower:** This system consist of a simple PVC assembled shower over a collection sump that provides continues rinse for single person use
- b. **Storage Location:** Stored in the ED Parking lot housed in the Portable Storage Trailer.
- c. **Support requirements:** Water-is the primary resource requirement and electricity to operate sump pump to remove contaminated water.
- d. **Set-Up expectations: Engineering and HAZMAT Team** members are responsible for setting up this equipment to support ED's patient care services.
- e. **Time:** It could take approximately 10-15 minutes to set-up system.

**DHS L&C Temporary Permission for Increased Patient Accommodations Request Worksheet** (revised 9/27/07)

District office: \_\_\_\_\_ Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_

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.

