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Mercy General Hospital

## **Mercy General Hospital**

APOT (AB 40) Protocol

September 1, 2024

### Plans for Compliance:

1. The Emergency Department Staff have been working on an APOT plan since 6/10/2023. This plan was created with consultation and feedback from frontline staff including Registered Nurses, ER Technicians, Safety Attendants, and Emergency Room Providers. The Unit Practice Council meets monthly to discuss throughput challenges and operational efficiency. Additionally, once AB 40 was announced, Emergency Department leadership has shared the requirements and plan with hospital leadership and administration for their feedback, support and input. In order to take a proactive and strategic approach to this complicated problem, the Discharge Lounge was created June 2023. APOT continues to be discussed monthly at the hospital throughput meeting
2. An APOT workgroup has been created to notify hospital administration, nursing staff, medical staff and ancillary services when APOT has been exceeded for a given month. The data is pulled directly from the county and shared via e-mail and TigerConnect. An action plan may be developed when the average APOT time is excessive
3. In response to staffing challenges, Emergency Department Charge Nurses have approval to call in staff when needed and flex down when appropriate. For hospital and inpatient staffing, a TigerConnect group has been created with Department Managers and ANS. Staffing and census is shared at least daily to safely staff each department and offload Emergency Department patients. The ED Fast-Track Charge Nurse will call a "Code Discharge" when there are more than 4+ patients awaiting Discharge teaching and instruction. ED patients can also be discharged to the Discharge Lounge when there are anticipated delays
4. The systems put into place to improve general hospital coordination with the Emergency Department are detailed in Protocol IV. Consults are performed when appropriate by ER Physicians/Providers. For any cases where consultants are not available, the transfer center will be contacted

5. The direct operational changes designed to facilitate a rapid reduction in APOT to meet the LEMSA's standard are outlined in Protocol IV.

## **I. SETTING**

Mercy General Hospital

## **II. PURPOSE**

The purpose of this protocol is to meet Ambulance Patient Offload Time (APOT) standards outlined in Assembly Bill 40 (AB 40) and California Health and Safety Code Section 1797.120.6.

### SCOPE

This protocol applies to all Mercy General Employees, including: Hospital Administration, Emergency Department Staff, Physicians, Advanced Providers, Nurses, Ancillary Employees, and EMS personnel delivering patients to Mercy General Hospital

## **III. DEFINITIONS**

- a. APOT Standard: AB 40 Statute 1797.120.6 require an APOT standard of less than 30 minutes, 90% of the time for general, acute care hospitals with EDs
- b. Ambulance Arrival Time: The time an ambulance wheels stop in the EMS bay outside the ED where the patient will be unloaded from the ambulance
- c. Ambulance End Time: The time a patient is transferred to an ED gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient
- d. Ambulance Patient offload time (APOT): The interval between the arrival of an ambulance patient at an ED and the time the patient is transferred to an ED gurney, bed, chair, or other acceptable location and the ED assumes responsibility for care of the patient
- e. Ambulance Patient Offload Delay (APOD): The occurrence of a patient remaining on an ambulance gurney and/or the receiving facility staff has not assumed patient care beyond the EMS agency-approved APOT standard of 30 minutes

## **IV. PROTOCOL**

1. Activate Appropriate Hospital Surge Plans and/or ED Level 6 Saturation Protocol to support timely ED decompression to mitigate APOT offload delays.

Capacity Plans include services/department/actions steps below but are not limited to:

- a. Bed meetings held twice a day (0830 and 2030) led by ANS and Inpatient Leader (Charge Nurse/Nurse Shift Manager) to discuss ED census, discharge planning, and any barriers to discharge. All ED Admissions are reviewed to facilitate movement
- b. 0900 daily huddle in the Emergency Department that includes leadership from patient transport, imaging, ANS, hospitalist and the discharge lounge. Staffing challenges, barriers to admission and discharge are discussed to prioritize needs
- c. Multidisciplinary Rounding in the Emergency Department every day at 1100. This includes Case Management, Social Work, Primary Nurse, Charge Nurse and the Emergency Department Provider. Case Management holds and Psychiatric Patients are reviewed by the team to develop and reassess discharge planning. Complex patients are escalated immediately to Case Management leadership
- d. Nursing leaders to utilize "on-call/standby" process for bedside nursing staff rather than LC/HC (low census/hospital convenience - canceling for an entire shift). This allows for more flexibility when census increases
- e. TigerConnect Leadership group created to communicate high census and throughput issues to be resolved real-time
- f. Level6 Saturation announced overhead and meetings held in the Emergency Department with representation from ANS and department leaders. Leaders will take patients with ready beds upstairs with them after the meeting and handoff
- g. Discharge Lounge utilization by inpatient units and Emergency Department. Discharge Lounge RN can complete discharge teaching, coordinate medication pick up, call for rides and provide nursing tasks (remove IV, reinforce learnings)
- h. Monthly throughput meeting with leaders to review data and monitor progress
- i. APOT escalation process when APOT time exceeds 30

minutes. Charge Nurse → NSM → ANS/ED Manager → ED Director → Administrator/AOC

- j. Any lobby-appropriate patient should be sent to the waiting room via EMS gurney. This also includes the Internal Waiting Room (IWR) if they need closer monitoring. Those patients appropriate for the IWR or lobby should not be held on the wall. Patients with IVs that are saline-locked may wait in the waiting room
  - k. For excessive wall-times, the Charge Nurse will develop a plan with the NSM/Manager to offload the Medic. When physical space is not an issue, this may include pulling a Break Nurse, Resource Nurse, or Fast-Track Nurse to offload the Medic
  - l. Any time there is a delay in triaging Ambulance Patients, the Charge Nurse should be notifying the NSM or designee to assist with triaging to expedite the offloading process
2. ED & Hospital Staff receive education/training on APOT mitigation strategies and AB 40 compliance. Charge Nurses will have more in depth training to ensure the above plan is followed
3. APOT Monitoring and Reporting
- a. APOT metrics will be monitored and reported monthly to ensure compliance. An action plan and/or gap analysis may be required
  - b. The Quality Department will help analyze APOT data and implement quality improvement initiatives as needed
4. Collaboration with Sacramento County
- An MGH representative will attend regular meetings with county and all stakeholders to learn best practices, receive feedback and review APOT performance
5. Review and Revision

This plan will be reviewed annually and revised as needed to ensure ongoing compliance with AB 40 and the continuous improvement of APOT protocols.