Sutter Health

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Assembly Bill 40 (AB40) mitigation protocol for Ambulance Patient Offload Time (APOT).

On behalf of its network of hospitals, Sutter Health is submitting the following to comply with Assembly Bill 40 (AB40) mitigation protocol for Ambulance Patient Offload Time (APOT).

This protocol meets the requirements stated below:

SEC. 2. Section 1797.120.6 is added to the Health and Safety Code, to read:

1797.120.6. (a) A licensed general acute care hospital with an emergency department shall, by September 1, 2024, develop, in consultation with its emergency department staff, and its exclusive employee representatives, if any, an ambulance patient offload time reduction protocol that addresses all of the following factors:

(1) Notification of hospital administrators, nursing staff, medical staff, and ancillary services that the local EMS agency standard for ambulance patient offload time has been exceeded for one month.

(2) Mechanisms to improve hospital operations to reduce ambulance patient offload time, which may include, but are not limited to, activating the hospital's surge plan, transferring patients to other hospitals, suspending elective admissions, discharging patients, using alternative care sites, increasing supplies, improving triage and transfer systems, and adding additional staffing.

(3) Systems to improve general hospital coordination with the emergency department, including consults for emergency department patients.

(4) Direct operational changes designed to facilitate a rapid reduction in ambulance patient offload time to meet the local EMS agency standard adopted pursuant to subdivision (b) of Section 1797.120.5.

Sutter Health Mitigation Plan Assembly Bill 40 2024

In the event of a high patient volume and/or acuity in the Sutter Emergency Department, the Emergency Department will use a standardized scale, the Sutter Health Hospital Overcapacity Scale (SHHOCS), to quickly mobilize maximal resources and adjust operations in a structured and automated fashion to safely meet patient's needs. The SHHOCS Tool will be used as an objective measure of emergency department and hospital overcrowding. The score generated by the SHHOCS Tool uses variables found to be statistically significant in hospital overcrowding, and the "score" corresponds to a given level of operational capacity.

Response Matrix

Each level corresponds to and necessitates an institutional response with respect to systems (i.e. functional and departmental operations), space (bed capacity, utilization, and conversion), staff (responsibilities and operations), and supplies. As overcrowding increases, the degree of response escalates to prevent or mitigate further overcrowding and the consequences of such. Response actions will continue into the next level unless a change is specified.

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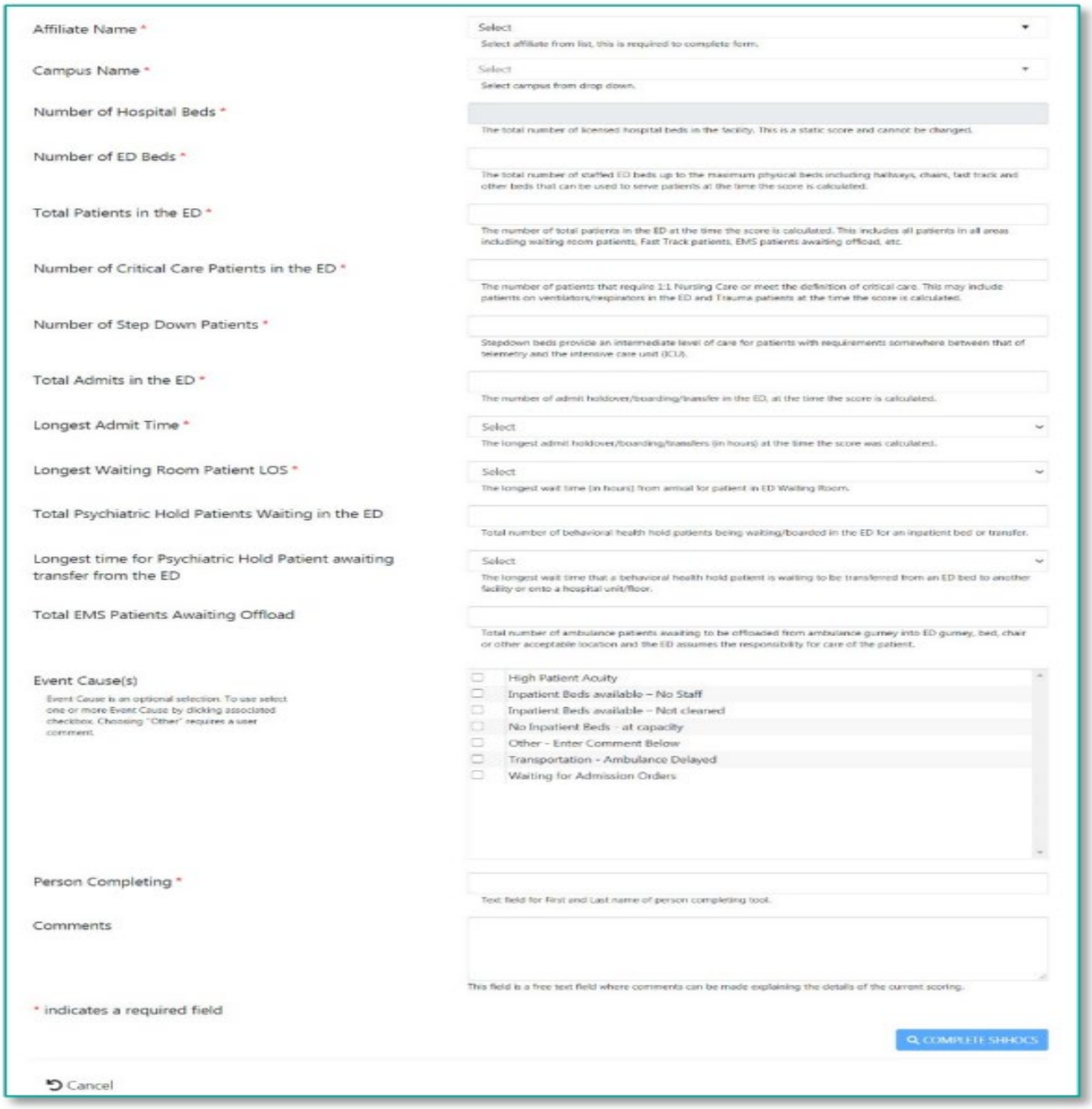
Complete a New SHHOCS

Click here to complete SHHOCS



Affiliate Name *
Select
Select affiliate from list, this is required to complete form.

Campus Name *
Select
Select campus from drop down.

Number of Hospital Beds *
The total number of licensed hospital beds in the facility. This is a static score and cannot be changed.

Number of ED Beds *
The total number of staffed ED beds up to the maximum physical beds including hallways, chairs, fast track and other beds that can be used to serve patients at the time the score is calculated.

Total Patients in the ED *
The number of total patients in the ED at the time the score is calculated. This includes all patients in all areas including waiting room patients, Fast Track patients, EMS patients awaiting offload, etc.

Number of Critical Care Patients in the ED *
The number of patients that require 1:1 Nursing Care or meet the definition of critical care. This may include patients on ventilators/respirators in the ED and Trauma patients at the time the score is calculated.

Number of Step Down Patients *
Stepdown beds provide an intermediate level of care for patients with requirements somewhere between that of telemetry and the intensive care unit (ICU).

Total Admits in the ED *
The number of admit holdover/boarding/transfer in the ED, at the time the score is calculated.

Longest Admit Time *
Select
The longest admit holdover/boarding/transfers (in hours) at the time the score was calculated.

Longest Waiting Room Patient LOS *
Select
The longest wait time (in hours) from arrival for patient in ED Waiting Room.

Total Psychiatric Hold Patients Waiting in the ED
Total number of behavioral health hold patients being waiting/boarded in the ED for an inpatient bed or transfer.

Longest time for Psychiatric Hold Patient awaiting transfer from the ED
Select
The longest wait time that a behavioral health hold patient is waiting to be transferred from an ED bed to another facility or onto a hospital unit/floor.

Total EMS Patients Awaiting Offload
Total number of ambulance patients awaiting to be offloaded from ambulance gurney into ED gurney, bed, chair or other acceptable location and the ED assumes the responsibility for care of the patient.

Event Cause(s)
Event Cause is an optional selection. To use select one or more Event Cause by clicking associated checkbox. Choosing "Other" requires a user comment.

- High Patient Acuity
- Inpatient Beds available – No Staff
- Inpatient Beds available – Not cleaned
- No Inpatient Beds - at capacity
- Other - Enter Comment Below
- Transportation - Ambulance Delayed
- Waiting for Admission Orders

Person Completing *
Text field for first and last name of person completing tool.

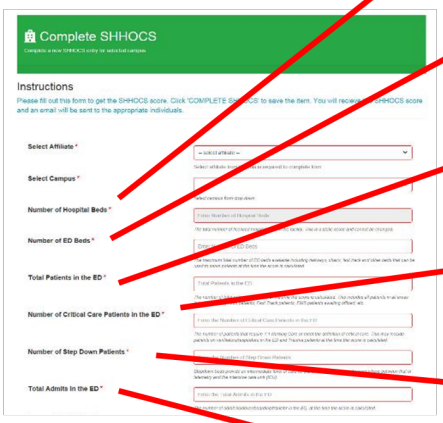
Comments
This field is a free text field where comments can be made explaining the details of the current scoring.

* indicates a required field

COMPLETE SHHOCS

Cancel

In Detail



Hospital Beds
The total number of licensed hospital beds in the facility. This is a static score and cannot be changed.

ED Beds
The maximum total number of ED beds available including hallways, chairs, fast track, and other beds that can be used to serve patients at the time the score is calculated.

Total Patients in ED
The number of total patients in the ED at the time the score is calculated. This includes all patients in all areas including waiting room patients, Fast Track patients, EMS patients awaiting offload, etc.

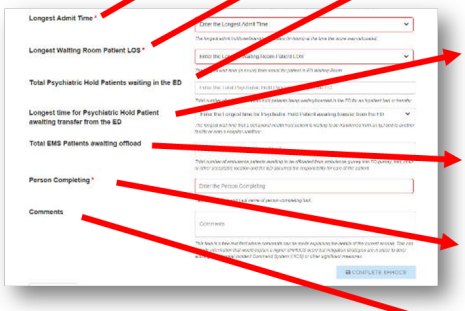
Critical Care Patients
The number of patients that require 1:1 Nursing Care or meet the definition of critical care. This may include patients on ventilators/respirators in the ED and Trauma patients at the time the score is calculated.

Step Down Patients
Stepdown beds provide an intermediate level of care for patients with requirements somewhere between that of telemetry and the intensive care unit (ICU). If this field does not apply to your affiliate, leave at zero (0).

Total Admits in ED (including transfers)
The longest admit holdover/boarding/transfers (in hours) at the time the score was calculated.

15

In Detail



Longest Admit
The longest admit holdover/ boarding/transfer (in hours) at the time the score was calculated.

Longest Waiting Room Patient LOS (in hours)
The longest wait time (in hours) from arrival for patient in ED Waiting Room.

Total Psychiatric Hold Patients waiting in the ED
Total number of behavioral health hold patients waiting/being boarded in the ED for an inpatient bed or transfer.

Longest time for Psychiatric Hold Patient awaiting transfer from the ED (in hours)
The longest wait time that a behavioral health hold patient is waiting to be transferred from an ED bed to another facility or onto a hospital unit/floor.

Total EMS Patients awaiting offload
Total number of ambulance patients awaiting to be offloaded from ambulance gurney into ED gurney, bed, chair or other acceptable location and the ED assumes the responsibility for care of the patient. This includes the longest offload time.

Person completing
Typed name of the person submitting the SHHOCS scoring/report. This is a required field and the form will not be submitted without.

Comments
This field is a free text field where comments can be made explaining the details of the current scoring. This can include information that would explain a higher SHHOCS score but mitigation strategies are in place to defer activing the Hospital Incident Command System (HICS) or other significant measures.

16

Sutter Health Hospital Over Capacity Scale (SHHOCS)

Phase I	Phase II	Phase III	Phase IV	Phase V	Phase VI
00-100	101-150	151-200	201-250	>251	Disaster.
Normal Operations	**Daily Operations.** not exceeding current capacity/ resources.	**Over crowded.** need for hospital/ emergency services is nearing the limitations of available resources.	**Over Capacity.** need for hospital/ emergency services exceeds available resources. **Code Triage Internal Alert, Hospital Incident Command System (HICS)** and **Ambulance Patient Diversion** may, but not always, be initiated (situational dependent)	**Critical Over Capacity.** **Code Triage Internal Activation, Hospital Incident Command System (HICS)** and **Ambulance Patient Diversion** is strongly recommended for activation (situational dependent)	**NO SCORE REQUIRED** Extreme Acute or Extended Disaster Response, Local and State and possible Federal Disaster involvement, Alternate Care Sites and Austere Care Activated. **HICS would be activated every time.**

Surge Response Actions

Phase I Score 00-100	
Department	**Response Actions May Include**
House/RN Supervisor	☐ Take pro-active measures to staff beds ahead, ensure open beds, and expeditiously receive admitted patients.
Emergency	**ED Charge Nurse** ☐ Standard operating procedures in effect. ☐ Run SHHOCS score. ☐ Attend bed huddles and report SHHOCS Scores ☐ ED Charge Nurse will update SHHOCS as needed. ☐ Fast Track of appropriate triage patients to appointment as indicated. ☐ Unit Attending MDs and Nurse Managers continually round to evaluate the workload and productivity of the areas and redistribute patients and staff as indicated. ☐ Continual and periodic physician assessment of triage patients with work-up and treatment initiated as necessary. ☐ ED Observation Area utilized for appropriate patients to make available acute treatment beds. ☐ When inpatient bed is ready, send ED bedside RN name and extension to inpatient Charge RN ☐ Ensure RN to RN report initiated within 15 minutes of receiving bed assignment for admitted patients. ☐ If report has not been requested or given within 15 minutes of bed becoming available, escalate to inpatient Charge RN for transport and bedside report. If delay continues, contact House/RN Supervisor for resolution. **Emergency Department– Physicians and PAs:** ☐ Maintain situational awareness of SHHOCS score. ☐ Review ED census with ED Charge RN regularly (before every bed meeting or more often) regarding patients' anticipated admission (Floor, Tele, ICU) or discharge disposition ☐ Maintain communication with ED Charge RN regarding trend of SHHOCS score for anticipated needs. ☐ Identify on EHR the following to facilitate timely disposition planning by RN and House/RN Supervisor and Case Management: ○ Hallway appropriate patients ○ Possible admissions ○ Conditions for conditional discharges

	☐ ED Provider will place bed requests and non-ICU admission bridging orders after consultation with admitting Hospitalists; Hospitalist will place bridging orders for ICU admissions, per normal workflow.
Hospital Administration	☐ Standard operating procedures in effect. ☐ May be consulted by Administrative Supervisor on additional bed control meetings, rounding as necessary, to meet throughput demand depending on the incident.
Hospitalists	☐ Standard operating procedures in effect.
Inpatient Units: Medical Surgical, Surgical, Telemetry, Oncology, ICU, Pediatrics, Family Birth Center	☐ Units will expeditiously process discharges and prepare bed for new occupancy. ☐ Reports bed status and attends bed huddles and reports bed status as required. ☐ Units will assist ED transport teams when patients are delivered to their respective units.
Diagnostic Imaging	☐ Standard operating procedures in effect.
Laboratory	☐ Standard operating procedures in effect.
Respiratory Therapy	☐ Standard operating procedures in effect.
Pharmacy	☐ Standard operating procedures in effect.
EVS	☐ Standard operating procedures in effect.
Transportation	☐ Standard operating procedures in effect.
Security	☐ Standard operating procedures in effect.
Medical Staff	☐ Standard operating procedures in effect.

Phase II Score 101 to 150	
Department	**Response Actions May Include**
House/RN Supervisor	☐ Take pro-active measures to staff beds ahead, ensure open beds, and expeditiously receive admitted patients. ☐ Maintain SHHOCS awareness
Emergency	**ED Charge Nurse:** ☐ Standard operating procedures in effect. ☐ Run SHHOCS score. ☐ Attend bed huddles and report SHHOCS Scores ☐ ED Charge Nurse will update SHHOCS as needed. ☐ Fast Track of appropriate triage patients to appointment as indicated. ☐ Unit Attending MDs and Nurse Managers continually round to evaluate the workload and productivity of the areas and redistribute patients and staff as indicated. ☐ Continual and periodic physician assessment of triage patients with work-up and treatment initiated as necessary.

	☐ ED Observation Area utilized for appropriate patients to make available acute treatment beds. ☐ Ensure RN to RN report initiated within 15 minutes of receiving bed assignment for admitted patients. ☐ If report has not been requested or given within 15 minutes of bed becoming available, escalate to inpatient Charge RN for transport and bedside report. If delay continues, contact House/RN Supervisor for resolution. **Emergency Department– Physicians and PAs:** ☐ Maintain situational awareness of SHHOCS Score ☐ Review ED census with ED Charge RN regularly (before every bed meeting or more often) regarding patients' anticipated admission (Floor, Tele, ICU) or discharge disposition ☐ Maintain communication with ED Charge RN regarding trend of SHHOCS score for anticipated needs. ☐ Identify on EHR the following to facilitate timely disposition planning by RN and House/RN Supervisor and Case Management: o Hallway appropriate patients o Possible admissions o Conditions for conditional discharges ☐ ED Provider will place bed requests and non-ICU admission bridging orders after consultation with admitting Hospitalists; Hospitalist will place bridging orders for ICU admissions, per normal workflow
Hospital Administration	☐ Standard operating procedures in effect. ☐ May be consulted by House/RN Supervisor on additional bed control meetings, rounding as necessary, to meet throughput demand depending on the incident.
Hospitalists	☐ Standard operating procedures in effect.
Inpatient Units: Medical Surgical, Surgical, Telemetry, Oncology, ICU, Pediatrics, Family Birth Center	☐ Units will expeditiously process discharges and prepare bed for new occupancy. ☐ Reports bed status and attends bed huddles and reports bed status as required. ☐ Units will assist ED transport teams when patients are delivered to their respective units.
Diagnostic Imaging	☐ Expedite pending CTs/Imaging/MRI/Ultrasound and maintain awareness of SHHOCS score.
Laboratory	☐ Expedite pending labs and maintain awareness of SHHOCS score.
Respiratory Therapy	☐ Standard operating procedures in effect.
Pharmacy	☐ Standard operating procedures in effect.
EVS	☐ Standard operating procedures in effect.

Transportation	☐ Standard operating procedures in effect.
Security	☐ Standard operating procedures in effect.
Medical Staff	☐ Standard operating procedures in effect.

Phase III Score 151 to 200	
Department	**Response Actions May Include**
House/RN Supervisor	☐ Reports to the ED and coordinates with the ED Shift Coordinator for a situation report. ☐ Coordinate as needed with ED Director and ED Clinical Manager in regard to patient flow. ☐ May schedule additional bed control meetings, rounding as necessary, to meet throughput demand. ☐ Obtains updated unit readiness information from all patient care areas ☐ Consider SHHOCS notification via text/Everbridge/email message. Consideration based on ability to return to yellow less than 1 hour versus impending progression to Red. ☐ Consider reprioritization of the order in which patients are granted inpatient beds from our current standard of surgical, patients in downgrading level of care, then ED. Reprioritize based upon most urgent need. ☐ Refocus EVS to priority STAT cleans for urgent needs. ☐ Deploy Transport with a focus on ED Admissions ☐ Consider bedside report from ED to units for admitted patients. ☐ Communicate with inpatient unit leadership to accept ED admissions. ☐ Consider request for inpatient units to accept stable, alert and oriented admit or transfer patient to hallway when staffed bed is “In Progress” (EVS stationed in room actively cleaning. Maximum number of hallway beds allowed is one per wing. This requires notification and approval of Unit Director or Clinical Manager and will occur only when unit leadership present. ☐ Consider fast track transfer of most recently admitted, appropriate patients transferring non-neuro, non-trauma, stable, ICU patients to other Sutter Affiliates ☐ Consider a floating Admit/Discharge RN – reassign available RN or call staff in ☐ Evaluate impact of elective surgeries that require a post op, inpatient bed. ☐ Communicate with Case Manager to expedite pending discharges

Emergency	**ED Charge Nurse:** ☐ Review the Emergency Department census with the Attending Emergency MD and House/RN Supervisor to look for disposition opportunities: ○ Tests/Procedures /Medications/Treatments ○ Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...) ○ Transfer of Appropriate Patients ☐ Discuss announcing SHHOCS Orange with House/RN Supervisor and ED MD ☐ Discuss opportunities and barriers with ED team leads, radiology, laboratory, security, registration, pharmacy, inpatient Charge RNs, and other stakeholders. ☐ Assign additional staff to: ○ Optimize space and location of boarding patients in the ED. ○ Designate specific treatment areas as needed (i.e., boarding area, ED Treatment area, Discharge area, triage area) ○ Allocate resources to each designated area as appropriate. ☐ Update SHHOCS Score at least every 4 hours or more frequently, as needed. ☐ Assure rapid transport of admissions to floor (either by transport, ED, or floor staff) ☐ Ensure RN to RN report initiated within 15 minutes of receiving bed assignment for admitted patients ☐ If report has not been requested or given within 15 minutes of bed becoming available, escalate to inpatient Charge RN for transport and bedside report. If delay continues, contact House/RN Supervisor for resolution. **Emergency Department– Physicians and PAs:** ☐ Run board with House/RN Supervisor and ED Charge RN ☐ Discuss if SHHOCS Orange level notification should be executed. ☐ ED MD may request a current SHHOCS score if concerned for over capacity. ☐ ED Physicians should initiate bridging orders in collaboration with hospitalists if delay greater than one (1) hour for patient evaluation and admission and the hospitalist will see the patient on the floor after admission. ☐ If no beds, or very limited beds, available in the facility, the Lead ED Physician or the ED Medical Director may work with admitting physicians and the Nursing/Administrative

	Supervisor to arrange and coordinate transfer of ED patients awaiting admission to other Sutter Health facilities if applicable. ☐ Review the Emergency Department Census with the ED Charge Nurse and House/RN Supervisor to look for disposition opportunities. ○ Tests/Procedures /Medications/Treatments ○ Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...) ○ Transfer of Appropriate Patients ☐ Contact flex or backup provider, if available and indicated ☐ Consider additional care sites may be opened. ☐ Consider mass notification (Everbridge) if elevation of SHHOCS score anticipated. ☐ Consider Rapid Medical Evaluation with Provider and RN Teams to initiate Medical Screening Exams on waiting patients. ☐ ED Provider will place bed requests and non-ICU admission bridging orders after consultation with admitting Hospitalists; Hospitalist will place bridging orders for ICU admissions, per normal workflow.
Hospital Administration	☐ Continue daily operations. ☐ May be consulted by Nursing/Administrative Supervisor on additional bed control meetings, rounding as necessary, to meet throughput demand depending on the incident.
Hospitalists	☐ Prioritize discharges before and after rounds. ☐ Evaluate admitted patients boarded in the ED related to possible downgrades/ discharges/ transfers. ☐ If in transfer mode, facilitate transfers. ☐ Communicate during rounds to RN Staff and SM/MSW potential same day and next day discharges. ☐ Write Conditional Discharge Orders as appropriate (pending labs, imaging, cardiologic test, etc.,) ☐ Huddle with Case Management / Social Work early afternoon about discharges and barriers to discharges. ☐ Extra Hospitalist can be called in based on the hospitalist group census and the SHHOCS score (extra day shift rounding hospitalist for next day).
Inpatient Units: Medical Surgical, Surgical, Telemetry, Oncology, ICU, Pediatrics, Family Birth Center	**Inpatient Department Clinical Managers/Directors:** ☐ Implement leadership rounding on departments/units with a focus on service recovery, patient throughput and identify potential discharges. ☐ Report available beds to Nursing/Administrative Supervisor. ☐ Facilitate timely discharge of patients in collaboration with Case Management/Discharge Planning and physicians.

	Inpatient Shift Coordinators/RNs: □ Ensure inpatient beds are maximally occupied. □ Ensure rooms are operational, clean, and ready to accept patients. □ Ensure the STAT discharges are a priority. □ Ensure staff can accept report within 15 minutes of notification of room readiness on the EHR system. □ Encourage discharges; hold staff accountable for STAT discharge once the discharge order has been written. Inform department Clinical Manager or Director of delays and causative factors. □ If staff awaiting patient transfer from the ED and transfer is delayed, staff may go to the ED to receive and transport their patient if staff available to do so. □ Facilitate prompt discharge by calling families arranging for transport home, negotiating early Skilled Nursing Facility (SNF) placement if available; contact Case Management/Discharge Planning to assist with this process as needed.
Diagnostic Imaging	**Director of Imaging, Point Person or Assigned ED DI Tech on duty**: □ Reports to the ED and coordinates with the ED Shift Coordinator for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of all imaging studies. □ Attend bed huddles. □ Call in addition staff. □ Consider need for transport resources
Laboratory	**ED Phlebotomist on duty:** □ Reports to the ED and coordinates with the ED Shift Coordinator for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of blood draws. □ Reports to their Supervisor/Manager on duty as needed regarding the surge capacity situation and requests assistance if needed and applicable.
Respiratory Therapy	**Respiratory Therapy Practitioner Lead on duty:** □ Reports to the ED and coordinates with the ED Shift Coordinator for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of all Respiratory Therapy.
Pharmacy	Follow standard patient procedures for all in patient holds in ED; meds should follow patient to placement.

EVS	**ED EVS Technician:** ☐ Checks in with the ED Shift Coordinator for a situation report and expedites bed cleaning to assist with the surge situation as needed. ☐ Quickly updates Sutter EHR by changing dirty rooms to clean once turnover is completed. ☐ Reports to their Director or Supervisor on Duty as needed regarding the surge capacity situation. **Director or Supervisor on Duty:** ☐ Attends bed huddles. ☐ May coordinate with Administrative House/RN Supervisor to Prioritize In-Patient Bed Cleaning responsibilities if applicable. ☐ May assign more EVS staff to the ED, if needed ☐ Dispatch assigned ED EVS Personnel to next room that needs cleaning in house to expedite turnaround times (TAT) for admission to the floor.
Transportation	**Transportation Dispatcher on Duty:** ☐ Contacts and coordinates with the ED Shift Coordinator for a situation report and if they can assist with the surge situation. ☐ Reports to their Director or Supervisor on Duty as needed regarding the surge capacity situation and requests assistance if needed and applicable. **Director or Supervisor on Duty:** ☐ May coordinate with Administrative Supervisor to Prioritize patient transport responsibilities if applicable. ☐ May provide additional personnel to as needed and available to expedite turnaround times (TAT) for patient transportation.
Security	**Site Lead on duty:** ☐ Reports to the ED and coordinates with the ED Shift Coordinator for a situation report and if Security can assist with the surge situation.
Medical Staff	**Physicians/Hospitalists/Intensivists/Surgeons:** ☐ Work in collaboration with the ED Physicians and Utilize Bridging Orders as applicable. ☐ Assist with the focus on prioritizing discharges and transfers.

Phase IV Score 201 to 250	
Department	**Response Actions May Include**
House/RN Supervisor	☐ Consult with ED Charge RN, ED Clinical Manager, ED Director, and ED Medical Director for possible declaration of a Code Triage: Internal Alert if the Surge Capacity Score remains between 201-250 for at least two (2) consecutive hours or deemed activation needed due to a full census inability to accommodate surgeries and ED admissions. ☐ Work with the AOC/AOD to complete a high-level assessment of the potential operational impact on the facility and determine the need to activate a Code Triage: Internal Alert and the Hospital Command Center (HCC) or other designated location for briefing if applicable. ☐ Reprioritize the order in which patients are granted inpatient beds from our current standard of surgical, patients in downgrading level of care, then Emergency Dept. Reprioritize based upon most urgent need. ☐ Collaborate with Clinical Managers and Case Management and Discharge Planning, to identify patients who can potentially be discharged and make the appropriate discharge arrangements with the attending physician and other applicable patient care service providers. ☐ Review surgical schedule with the Administrator on Call and the Surgical Services Director and Clinical Manager to and consider delaying, altering, or cancelling elective and add-on surgeries if OR availability is an issue. ☐ Provide additional staff (e.g.,nursing assistants, RN floats, etc.) to ED upon request to assist with patient care and monitoring the ED Lobby. ☐ Consult with ED Charge RN, ED Clinical Manager, ED Director, ED Medical Director and Administrative on Call (AOC) to determine need for Surge Capacity resources (e.g., tents, cots, etc.) and potential staffing needs. ☐ Refocus EVS to priority STAT cleans for urgent needs. ☐ Deploy Transport with a focus on ED Admissions ☐ Alert specific units to accept bedside report. Floor RNs should come to ED for report and transfer patients to floors. ☐ Communicate with inpatient unit leadership to accept ED admissions and in house transfers during change of shift report. ☐ Notify inpatient units to accept stable, alert, and oriented admit or transfer patient to hallway when staffed bed is “In Progress” EVS stationed in room actively cleaning. Maximum number of hallway beds allowed is one per wing. This requires notification

	and approval of Unit Director or Clinical Manager and will occur only when unit leadership present. ☐ Consider fast track transfer of most recently admitted, appropriate patients transferring non-neuro, non-trauma, stable, ICU patients to other Sutter Affiliates ☐ Call in extra staff with a focus on supporting ED with admitted, holding patients. ☐ Consider postponing elective surgeries that require a post op, inpatient bed – Consult with AOC/AOD and Surgical providers ☐ Consider reassigning any available Nurse Manager to function as a 2nd House/RN Supervisor (one to manage beds, 2nd to manage house) ☐ Recommend Case Manager facilitate early discharges and transfers of admitted patients to other facilities. ☐ Consider opening PACU for transfers from ICU of stable patients to decompress ICU and open beds for admissions.
Emergency	**ED Charge Nurse:** ☐ Discuss announcing SHHOCS RED with House/RN Supervisor and ED MD ☐ Review the Emergency Department Census with the Attending Emergency MD and House/RN Supervisor to look for disposition opportunities: o Tests/Procedures /Medications/Treatments o Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...) o Transfer of Appropriate Patients ☐ Update SHHOCS Score at least every 2 hours or more frequently, as needed. ☐ Discuss opportunities and barriers with ED team leads, radiology, laboratory, security, registration, pharmacy, inpatient Charge RNs, and other stakeholders. ☐ Assign additional staff to: o Optimize space and location of boarding patients in the ED. o Designate specific treatment areas as needed (i.e., boarding area, ED Treatment area, Discharge area, triage area) o Allocate resources to each designated area as appropriate. ☐ Attend bed huddles and provide ED updates. ☐ Consider expanding the Triage Staffing to include additional provider, RN and ED Technician and requesting EVS and Transport staff. ☐ Determine and request additional supplies a needed.

	☐ Assure rapid transport of admissions to floor (ether by transport, ED, or floor staff) ☐ When inpatient bed is staffed and ready and notified by text, send ED bedside RN name and extension to inpatient Charge RN ☐ Ensure RN to RN report initiated within 5 minutes of receiving bed assignment for admitted patients. ☐ If report has not been requested or given within 5 minutes of bed becoming available, escalate to inpatient Charge RN for transport and bedside report. If delay continues, contact House/RN Supervisor for resolution. If after two (2) hours of no change, consecutive Surge Capacity scores between 201 – 251, or based on patient census in department, worsening of the surge or deemed increased response needed due to the hospital at full census, or inability to discharge patients, accommodate surgeries and ED admissions: ☐ Consider request to Administrative Supervisor for additional staff to ED assist with patients and monitoring the ED Lobby, such as Nurse's Aides, Float/Hold Nurses. ☐ May request EVS and Transportation assigned to the ED to bring additional, available supplies, such as inpatient beds for ED holds, gurneys, IV Poles, portable monitors and more etc., the needed item types and locations of items to be delivered. ☐ Ensure no delay in report and transfer of inpatients and inpatient holds to rooms when they are available on the EHR Screen. Report will be called by the ED RN to the assigned unit, when the EHR **Emergency Department– Physicians and PAs:** ☐ Run board with House/RN Supervisor and ED Charge RN ☐ Discuss if SHHOCS Red level notification should be executed. ☐ If no beds, or very limited beds, available in the facility, the Lead ED Physician or the ED Medical Director may work with admitting physicians and the Administrative Supervisor to arrange and coordinate transfer of ED patients awaiting admission to other Sutter Health facilities if applicable. ☐ Review the Emergency Department Census with the ED Charge Nurse and House/RN Supervisor to look for disposition opportunities ○ Tests/Procedures /Medications/Treatments ○ Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...) ☐ Contact flex or backup provider, if available and indicated

	☐ Consider additional care sites may be opened. ☐ Consider mass notification (Everbridge) notification if elevation of SHHOCS score anticipated. ☐ Consider Rapid Medical Evaluation with Provider and RN Teams to initiate Medical Screening Exams on waiting patients. ☐ ED Provider will place bed requests and non-ICU admission bridging orders after consultation with admitting Hospitalists; Hospitalist will place bridging orders for ICU admissions, per normal workflow. ☐ Coordinate and work together with ED Charge Nurse, ED Clinical Manager and ED Director in assisting with patient flow and throughput. ☐ Lead ED Physician or the ED Medical Director may contact additional ED Physicians and PAs not on duty to respond to the department to assist.
Hospital Administration	☐ Round with House/RN Supervisor to complete a high-level assessment of the potential operational impact on the facility. ☐ Determine the need to activate a Code Triage: Internal Alert and the Hospital Command Center (HCC) or other designated location for briefing if applicable. ☐ Chief Nursing Executive or AOC/AOD will serve as the Incident Commander (IC), if Hospital Incident Command System (HICS) is activated, and conduct meetings to provide information and bed status, rounding as necessary, to meet increased throughput demand. Conduct HICS briefings as needed or requested. ☐ The AOC/AOD/IC will work with the House/RN Supervisor and to send out a Situational Update in regard to the status at a minimum after every Emergency Bed Control Briefing. This message will go out to Clinical Managers/Directors, Hospitalists and Chief of Staff. Message will be in SBAR Format and include: ○ **Situation:** Include SURGE CAPACITY SCORES, ED Patient Load of ED and Waiting rooms, Time Alert Called. ○ **Background:** Key information, including needs, holds etc. and needs from departments, managers and more. ○ **Assessment:** Key information on the situation and how handling, from triage to transfers and more. ○ **Recommendation/Response:** Ongoing plans and reminders. ☐ Evaluate acceptance of all incoming transfers.

	☐ Consider staffing up to accommodate plans for satellite units and/or patients holding in the ED. ☐ Consider reassigning any available Nurse Manager to function as a 2nd House/RN Supervisor (one will manage beds; 2nd will support house) ☐ Cancel non-essential meetings to allow focus on surge capacity situation. ☐ Review the surgical schedule with the Administrative Supervisor and the Surgical Services Director and Clinical Manager, and consider delaying, altering, or cancelling elective and add-on surgeries if OR availability is an issue. ☐ If alternate patient care areas are considered for holds, complete and submit refer to the Program Flex and 1135 Waiver policy to ensure appropriate permissions are granted from regulatory agencies. ☐ Recommend Case Management facilitate early discharges and transfers of admitted patients to other facilities. ☐ Consider strategies to recover services. **Chief Nursing Executive, AOC/AOD and/or Chief of Staff or designee:** ☐ May notify physicians and direct or recommend transfer of ED patients requiring admission to other Sutter Health hospitals as needed. o Contact primary MDs as needed and assess use of hospitalists and intensivists to round on all inpatients, writing discharge orders if appropriate. Medical staff chain of command will be followed, as needed.
Hospitalists	☐ For ICU admits, ED attending will sign out to intensivist and will enter holding/bridging orders for ICU patients to be transferred to ICU as soon as possible. Hospitalist will provide admit order and rest of admission orders as soon as possible. ☐ If in transfer mode, facilitate transfers. ☐ Communicate during rounds to RN Staff and SM/MSW potential same day and next day discharges. ☐ Write Conditional Discharge Orders as appropriate (pending labs, imaging, cardiologic test, etc.,) ☐ Huddle with CM/MSW early afternoon about discharges and barriers to discharge ☐ Continue calling in Extra Hospitalist until census and score no longer reflects overcrowding/overcapacity.
Inpatient Units: Medical Surgical, Surgical, Telemetry, Oncology, ICU,	**Inpatient Clinical Managers/Directors:** ☐ If a Code Triage Internal Alert is called in this phase, the Department Director, Clinical Manager (if on-site) or Shift

Pediatrics, Family Birth Center	Coordinator would complete the Departmental Disaster Status Report. ☐ Assist with staffing needs and patient care on units, if needed and applicable. ☐ Implement leadership rounding on departments and units with a focus on service recovery and identify unresolved problems. ☐ May provide/assign departmental staff to the ED as requested and if applicable. ☐ Report to emergency bed control meetings/HICS Briefings as requested. ☐ Consider calling in additional staff to facilitate admits and discharges. ☐ Encourage discharge or transfer ASAP; assist with discharge and hold staff accountable for prompt discharge once the discharge order has been written (ASAP). Eliminate bed occupancy due to waiting discharge transportation. **Inpatient Shift Coordinators/RNs:** ☐ If a Code Triage Internal Alert is called in this phase, the Department Director, Clinical Manager (if on-site) or Shift Coordinator would complete the Departmental Disaster Status Report when requested. ☐ Ensure no delay in report and transfer of inpatients and inpatient holds to rooms when available. Report to be called from ED when room is listed as ready on EHR for patient. If receiving nurse unable to take initial report from ED and has not called ED back for report within 15 minutes, the patient to be transported to room and receiving RN may call the ED with any questions.
Diagnostic Imaging	**Radiologist:** ☐ Receives updates regarding surge status. ☐ Expedites interpretation of emergency exams or inpatient exams that are pending discharge. ☐ Place preliminary results on all ER exam reads. ☐ Consider calling ER physician with read results. **Director of Imaging or Imaging Admin on Call:** ☐ Huddle with ED Charge Nurse to determine how Imaging could assist in this phase of surge management when Code Triage Internal Alert is announced. ☐ As requested, focus on other key locations in the department and vary their daily assignments. ED patients with acute needs take precedence over holding patients in department. Expedite any pending imaging exams for pending discharge patients.

	☐ Consider the need to call in additional Imaging personnel if requested to do so by ED Shift Coordinator, House/RN Supervisor and/or Incident Commander to ensure adequate staffing to support ED and/or in-house increased patient capacity. ☐ Consult with House/RN Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.
Laboratory	**Laboratory Director or on-duty Supervisor:** ☐ Attend bed huddles and HICS meetings to assist with surge management when Code Triage Internal Alert is announced. ☐ Expedite lab draws for pending discharge patients. ☐ Consider the need to call in additional laboratory personnel if requested to do so by ED Shift Coordinator, House/RN Supervisor and/or Incident Commander to ensure adequate staffing to support ED and/or in-house increased patient capacity. ☐ Depending upon the incident, utilize Down Time forms. ☐ Consult with House/RN Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing. ☐ Report to emergency bed control meetings/HICS Briefings as applicable. **ED Phlebotomist on duty:** ☐ Focus on other key locations in the department, as requested by ED leadership.
Respiratory Therapy	**Respiratory Therapy Practitioner Lead on duty:** ☐ Contact the ED Shift Coordinator to determine how RT could assist in this phase of surge management when Code Triage Internal Alert paged overhead. ☐ Focus on other key locations in the department and vary daily assignments to address urgent needs first, as requested by ED leadership. ED patients with acute needs take precedence over holding patients in department. ☐ Consider the need to call in additional RT personnel if requested to do so by ED Charge Nurse, House/RN Supervisor and/or Incident Commander to ensure adequate staffing to support ED and/or in-house increased patient capacity. ☐ Consult with House/RN Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.
Pharmacy	**Pharmacy Director or Supervisor on Duty:**

	☐ Contact the ED Shift Coordinator for a situation report and to see how the pharmacy can assist with the surge situation management when Code Triage Internal Alert paged overhead. ☐ Evaluates Pyxis and stock for additional med supplies as needed. ☐ Expedites meds for pending discharge patients. ☐ Follow standard patient procedures for all in patient holds in ED; meds should follow patient to placement. ☐ Calls in additional staff as requested to do so by ED Charge Nurse, House/RN Supervisor and/or Incident Commander to ensure adequate staffing to support ED and/or in-house increased patient capacity. ☐ Consult with Administrative Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.
EVS	**ED EVS Technician:** ☐ Checks in with the ED Shift Coordinator for a situation report and expedites bed cleaning to assist with the surge situation as needed. ☐ Quickly updates Sutter EHR by changing dirty rooms to clean once turnover is completed. ☐ Reports to their Director or Supervisor on Duty as needed regarding the surge capacity situation. **Director or Supervisor on Duty:** ☐ Attends bed huddles and Hospital Incident Command System (HICS) meetings as required. ☐ Coordinates with House/RN Supervisor to prioritize in-patient bed cleaning responsibilities if applicable. ☐ Assigns additional EVS staff to the ED, to assist with room cleaning or other issues in ED such as the transportation of additional needed equipment like gurneys, IV poles, monitors and other items requested at the time to the ED, ED Lobby or other locations utilized for emergency triage and treatment, such as the MCI Triage Surge Tent or other identified surge capacity locations. ☐ Dispatches assigned ED EVS Personnel to next room that needs cleaning in house to expedite turnaround times (TAT) for admission to the floor. ☐ Consults with Administrative Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.

Transportation	**Transportation Dispatcher on duty:** ☐ Contacts the ED and coordinate with the ED Charge RN for a situation report and assist with the surge situation. ☐ Reports to their Director or Supervisor on Duty as needed in regard to the surge capacity situation and requests assistance if needed and applicable. **Director or Supervisor on Duty:** ☐ Report to emergency bed control meetings/HICS Briefings as needed. ☐ Assure adequate staffing to support ED and in-house patient needs. ☐ Call-in additional Transportation personnel, if requested, to assist with transportation issues such as the transportation of additional needed equipment like gurneys, IV poles, monitors and other items requested at the time to the ED, ED Lobby or other locations utilized for emergency triage and treatment, such as the MCI Triage Surge Tent or other identified surge capacity locations. ☐ Coordinate with House/RN Supervisor to prioritize patient transport responsibilities, if applicable. ☐ Provide additional personnel as needed and available to expedite turnaround times (TAT) for patient transportation. ☐ Consult with House/RN Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.
Security	**Site Lead on duty:** ☐ When Code Triage Internal Alert is paged overhead, reports to the ED and coordinates with the ED Shift Coordinator for a situation report and if Security can assist with the surge situation. ☐ May consider recall and potential posting of additional Security Personnel on-site in key locations such as the ED Waiting Area and potential posting in ED Surge Triage sites if applicable. ☐ Consult with Administrative Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing. ☐ Reports to emergency bed control meetings/HICS Briefings as requested.
Medical Staff	**Physicians/Hospitalists/Intensivists/Surgeons:** ☐ When Code Triage Internal Alert is activated, Physicians/Hospitalists/ Intensivists/Surgeons may be called in early for rounding as applicable.

	☐ Work in collaboration with the ED Physicians and utilize bridging orders as applicable. ☐ May be requested to delay or cancel elective surgical cases until situation stabilizes. ☐ Assist with potential admission to other Sutter affiliates. ☐ Assist with the focus on prioritizing discharges and transfers

PHASE V SCORE >251	
Department	**Response Actions May Include**
House/RN Supervisor	☐ Communicate with ED Charge Nurse and ED MD and Unit Charge Nurses- for situational awareness. ☐ Communicate with AOC/AOD regarding SHHOCS score - Activate: ○ Code Triage ○ HICS ○ Hospital Command Center (HCC) ○ Emergency Bed Huddle ☐ Discuss State notification requirements. ☐ Assume role of Incident Commander until relieved by AOC. Provide SBAR to AOC/AOD upon arrival. ☐ Evaluate acceptance of all incoming higher level of care transfers, to include neuro patients (Trauma consideration at the direction of the Incident Commander and Trauma Program Director). ☐ Reprioritize the order in which patients are granted inpatient beds based upon most urgent need. ☐ Refocus EVS to priority STAT cleans for urgent needs. ☐ Deploy Transport with a focus on ED Admissions ☐ Alert specific units to accept bedside report. ☐ Alert units regarding placing of stable, alert and oriented admit or transfer patient to hallway of Med Surg unit when staffed bed is “In Progress” (EVS stationed in room actively cleaning. Maximum number of hallway beds allowed is one per wing. This requires notification and approval of Unit Director or Clinical Manager and will occur only when unit leadership present. ☐ Initiate labor pool at the direction of the Incident Commander ☐ Transfer non-neuro, non-trauma, stable, ICU patients to other facilities at the direction of the Incident Commander. Consider initiating disaster transfer response. ☐ Postpone elective surgeries that require a post op, inpatient bed if instructed by the Incident Commander ☐ Reassign any available Nurse Manager to function as a 2nd House/RN Supervisor (one to manage beds, 2nd to manage house) ☐ Case Manager to facilitate early discharges and transfers of admitted patients to other facilities. ☐ Open PACU for transfers from ICU of stable patients to decompress ICU and open beds for admissions at the direction of the Incident Commander.
Emergency	**ED Charge Nurse:** ☐ Discuss announcing SHHOCS BLACK with House/RN Supervisor and ED MD Confirm House/RN Supervisor (or designee) will discuss with AOC/AOD a possible need to activate Code Triage alert.

	☐ Update SHHOCS Score at least every 2 hours or more frequently, as needed and provide additional updates to ED MD, House/RN Supervisor (or designee) as per SHHOCS protocol ☐ Contact EMS ☐ Review the Emergency Department Census with the Attending Emergency MD and House/RN Supervisor to look for disposition opportunities. o Tests/Procedures /Medications/Treatments o Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...) o Transfer of Appropriate Patients ☐ Discuss opportunities and barriers with ED team leads, radiology, laboratory, security, registration, pharmacy, inpatient Charge RNs, and other stakeholders. ☐ Assign additional staff to: o Optimize space and location of boarding patients in the ED. o Designate specific treatment areas as needed (i.e., boarding area, Ed Treatment area, Discharge area, triage area) o Allocate resources to each designated area as appropriate. ☐ Attend emergency briefings and bed control meetings to provide ED situation reports. ☐ Consider expanding the Triage Staffing to include additional provider, RN and ED Technician and requesting EVS and Transport staff. ☐ Determine and request additional supplies a needed. ☐ Assure rapid transport of admissions to floor (ether by transport, ED, or floor staff) ☐ Confirm with House/RN Supervisor (or designee) opening of Surge Areas, as directed by Incident Commander ☐ Facilitate patient movements appropriately. ☐ Discuss with ED Director to open alternative care sites (MCI tent, MOB, Urgent Care) as directed by Incident Commander ☐ Perform service recovery as needed. Physicians/Hospitalists/Intensivists/Surgeons: ☐ Run bed board with House/RN Supervisor and ED Charge RN Confirm: o Incident Commander is aware. o SHHOCS Black and/or Code Triage Internal will be alerted. ☐ If no beds, or very limited beds, available in the facility, the Lead ED Physician or the ED Medical Director may work with admitting physicians and the Administrative Supervisor to arrange and coordinate transfer of ED patients awaiting admission to other Sutter Health facilities if applicable. ☐ Confirm with Hospitalist, Intensivist, and Trauma Surgeon that extra staff have been call in if indicated.

	☐ Review the Emergency Department Census with the ED Charge Nurse and House/RN Supervisor to look for disposition opportunities. ○ Tests/Procedures /Medications/Treatments ○ Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...) ☐ Conduct Rapid Medical Evaluation with Provider and RN Teams to initiate Medical Screening Exams on waiting patients as able. ☐ Staff additional ED Surge Areas, if open, according to emergency response plan if code triage and HICS activated ☐ ED Provider will place bed requests and non-ICU admission bridging orders after consultation with admitting Hospitalists; Hospitalist will place bridging orders for ICU admissions, per normal workflow. ☐ Coordinate and work together with ED Charge Nurse, ED Clinical Manager and ED Director in assisting with patient flow and throughput. ☐ Lead ED Physician or the ED Medical Director may contact additional ED Physicians and PAs not on duty to respond to the department to assist.
Hospital Administration	☐ Round with House/RN Supervisor to complete a high-level assessment of the potential operational impact on the facility. ☐ Communicate with House/RN Supervisor regarding SHHOCS activation via Everbridge, and consider activation of: ○ Code Triage ○ Emergency Bed Huddle ☐ Discuss State Notification requirement. ☐ If Code Triage initiated Chief Nursing Executive, AOC/AOD will assume role of Incident Commander. Receive SBAR report from House/RN Supervisor and conduct meetings to provide information and bed status, rounding as necessary, to meet increased throughput demand. Conduct HICS briefings as needed or requested. ☐ Initiate labor pool as needed. ☐ Reassign any available Nurse Manager to function as a 2nd House/RN Supervisor (one will manage beds; 2nd will support house) ☐ Consider opening satellite inpatient unit on Peri-op or L&D. ☐ Consider postpone elective surgeries that require a post op, inpatient bed. ☐ Case Management to facilitate early discharges and transfers of admitted patients to other facilities. ☐ Consider opening PACU for transfers from ICU of stable patients to decompress ICU and open beds for admissions.
Inpatient Units: Medical Surgical, Surgical, Telemetry, Oncology, ICU, Pediatrics, Family Birth Center	Inpatient Clinical Managers/Directors: ☐ Upon activation of Code Triage Internal Alert, the Department Director, Clinical Manager (if on-site) or Shift Coordinator will complete the Departmental Disaster Status Report. ☐ Assist with staffing needs and patient care on units, as needed. ☐ Implement leadership rounding on departments and units with a focus on service recovery and identify unresolved problems.

	☐ May provide/assign departmental staff to the ED or labor pool as requested. ☐ Attend emergency bed control meetings/HICS Briefings as requested. ☐ Consider calling in additional staff to facilitate admits and discharges. ☐ Assist with discharge and transfers, hold staff accountable for prompt discharge once the discharge order has been written (ASAP). ☐ Implement strategies to recover services.
Diagnostic Imaging	**Radiologist:** ☐ Receives updates regarding surge status. ☐ Expedites interpretation of emergency exams or inpatient exams that are pending discharge. ☐ Place preliminary results on all ER exam reads. ☐ Consider calling ER physician with read results. **Director of Imaging or Imaging Admin on Call:** ☐ Attend bed huddles and HICS meetings. ☐ As requested, focus on other key locations in the department and vary their daily assignments. ED patients with acute needs take precedence over holding patients in department. ☐ Expedite any pending imaging exams for pending discharge patients. ☐ Call in additional Imaging personnel if needed to ensure adequate staffing to support ED and/or in-house increased patient capacity. ☐ Consult with House/RN Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.
Laboratory	**Laboratory Director or on-duty Supervisor:** ☐ Attend bed huddles and Hospital Incident Command System (HICS) meetings to assist with surge management when Code Triage Internal Alert paged overhead. ☐ Expedite lab draws for pending discharge patients. ☐ Consider the need to call in additional laboratory personnel if requested to do so by ED Shift Coordinator, House/RN Supervisor and/or Incident Commander to ensure adequate staffing to support ED and/or in-house increased patient capacity. ☐ Depending upon the incident, utilize Down Time forms. ☐ Consult with House/RN Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing. ☐ Report to emergency bed control meetings/HICS Briefings as applicable. **ED Phlebotomist on duty:** ☐ Focus on other key locations in the department, as requested by ED leadership. Note that, ED patients with acute needs take precedence over holding patients in department.
Respiratory Therapy	**Respiratory Therapy Practitioner Lead on duty:**

	☐ Contact the ED Shift Coordinator to determine how RT could assist in this phase of surge management when Code Triage Internal Alert paged overhead. ☐ Focus on other key locations in the department and vary daily assignments to address urgent needs first, as requested by ED leadership. ED patients with acute needs take precedence over holding patients in department. ☐ Consider the need to call in additional RT personnel if requested to do so by ED Charge Nurse, House/RN Supervisor and/or Incident Commander to ensure adequate staffing to support ED and/or in-house increased patient capacity. ☐ Consult with House/RN Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.
Pharmacy	**Pharmacy Director or Supervisor on Duty:** ☐ Attends bed huddles and HICS meetings to assist with the surge situation management when Code Triage Internal Alert is announced. ☐ Evaluates Pyxis and stock for additional med supplies as needed. ☐ Expedites meds for pending discharge patients. ☐ Follow standard patient procedures for all in patient holds in ED; meds should follow patient to placement. ☐ Calls in additional staff as requested to do so by ED Charge Nurse, House/RN Supervisor and/or Incident Commander to ensure adequate staffing to support ED and/or in-house increased patient capacity. ☐ Consult with Administrative Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.
EVS	**ED EVS Technician:** ☐ Checks in with the ED Shift Coordinator for a situation report and expedites bed cleaning to assist with the surge situation as needed. ☐ Quickly updates Sutter EHR by changing dirty rooms to clean once turnover is completed. ☐ Reports to their Director or Supervisor on Duty as needed regarding the surge capacity situation. **Director or Supervisor on Duty:** ☐ Attends bed huddles and Hospital Incident Command System (HICS) meetings. ☐ Coordinates with House/RN Supervisor to prioritize in-patient bed cleaning responsibilities. ☐ Assigns additional EVS staff to the ED, to assist with room cleaning or other issues in ED such as the transportation of additional needed equipment like gurneys, IV poles, monitors and other items requested at the time to the ED, ED Lobby or other locations utilized for emergency

	triage and treatment, such as the MCI Triage Surge Tent or other identified surge capacity locations. ☐ Dispatches assigned ED EVS Personnel to next room that needs cleaning in house to expedite turnaround times (TAT) for admission to the floor. ☐ Consults with Administrative Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.
Transportation	**Transportation Dispatcher on Duty:** ☐ Contacts the ED and coordinate with the ED Charge RN for a situation report and assist with the surge situation. ☐ Reports to their Director or Supervisor on Duty as needed regarding the surge capacity situation and requests assistance if needed and applicable. **Director or Supervisor on Duty:** ☐ Report to emergency bed control meetings/HICS Briefings as needed. ☐ Assure adequate staffing to support ED and in-house patient needs. ☐ Call-in additional Transportation personnel, if requested, assist with transportation issues such as the transportation of additional needed equipment like gurneys, IV poles, monitors and other items requested at the time to the ED, ED Lobby or other locations utilized for emergency triage and treatment, such as the MCI Triage Surge Tent or other identified surge capacity locations. ☐ Coordinate with House/RN Supervisor to prioritize patient transport responsibilities, if applicable. ☐ Provide additional personnel to as needed and available to expedite turnaround times (TAT) for patient transportation. ☐ Consult with House/RN Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing.
Security	**Site Lead on duty:** ☐ When Code Triage Internal Alert is paged overhead, reports to the ED and coordinates with the ED Shift Coordinator for a situation report and if Security can assist with the surge situation. ☐ May consider recall and potential posting of additional Security Personnel on-site in key locations such as the ED Waiting Area and potential posting in ED Surge Triage sites if applicable. ☐ Consult with Administrative Supervisor, ED Clinical Manager/Director and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing. ☐ Reports to emergency bed control meetings/HICS Briefings as requested.
Medical Staff	**Physicians/Hospitalists/Intensivists/Surgeons:**

	☐ When Code Triage Internal Alert is activated, Physicians/Hospitalists/ Intensivists/Surgeons may be called in early for rounding as applicable. ☐ Work in collaboration with the ED Physicians and utilize bridging orders as applicable. ☐ May be requested to delay or cancel elective surgical cases until situation stabilizes. ☐ Assist with potential admission to other Sutter affiliates. Assist with the focus on prioritizing discharges and transfers