Appendix G

TIDEWATER REGIONAL AMBULANCE DIVERSION POLICY

Ambulance Diversion- Summary

At times the Emergency Department (ED) treatment area becomes overwhelmed with patients, exceeding the capacity for physicians and nurses to safely and adequately treat and monitor these patients. When this occurs, ambulances are requested to divert to other area hospitals. Ambulance diversions are considered "extreme actions," occurring only after the hospital has exhausted all internal mechanisms to relieve the overcrowding situation.

Ambulance Diversion Criteria

The following criteria are used when determining the need to place the ED in diversion:

- There are no monitored beds available in the ED to accept patients, and/or
- The ED is saturated with patients, and/or
- There are a number of in-patients being held in the ED, and/or
- There is/are "unusual circumstance(s)" occurring in the ED.

Hospital diversion decisions must not be based on factors such as:

- The protection of beds for elective cases
- The protection of significant numbers of beds for unforeseen needs (deterioration in condition of floor patients, walk-ins)
- The desire not to call in "overtime" or "on-call" staff, or
- The availability of ICU/CCU beds.

Ambulance Diversion Procedure

The following are steps the ED must follow to move into a diversion status:

1. When the ED Physician, in collaboration with the ED Charge Nurse, determines the need to place the ED on diversion they will:
    a. Call and determine ability of each of the facility's communicating facilities (see list page 3 below) to receive diverted patients. These calls represent one-to-one discussion between the ED physicians to determine the relative risk/benefit measure of patient diversion. Upon determination that one or more facilities can accept diverted patients the ED physician or designee will place the ED on diversion.
    b. Contact the local EMS agency(s) supervisor or dispatch center and indicate the need for a temporary diversion of patients to facilities that have indicated they are able to receive diverted patients. Local EMS/dispatch center contacts and telephone numbers will be provided by the EMS agency. Hospitals should also update their status in WebEOC to "Full" for as long as diversion is needed. WebEOC will not send pages or messages to EMS supervisors notifying them of a change in the hospital's diversion status. Supervisors can anticipate obtaining hospital diversion status information via their respective ECC/911 dispatch center or via direct communications with the hospital's emergency department.
    c. If communicating facilities are NOT able to accept diverted patients, the ED may not go on diversion.

2. Hospitals in diversion status will still receive critical patients as defined in the appendix of this policy (see Critical Patient definition, page 4 below).
3. After diversion is initiated, hospital status must be updated with the EMS agency(s) **at least every two hours**; otherwise, diversion will automatically expire. When diversion has ended, the hospital should update their status in WebEOC to "Open".
4. When diversion is called, designated trauma centers will continue to receive trauma patients that meet Regional Trauma Triage Criteria (refer to the current *Tidewater Regional Trauma Triage Plan*).
5. In all cases of single or multiple hospital diversion (MHD), EMS supervisors must take an active role to balance the distribution of ambulance patients.

EMS Angency/Dispatch Center Procedure

EMS agencies/dispatch centers must ensure that EMSunits and supervisors in the field are informed of the status of hospitals in their zones so that patients can be routed to the most appropriate facility. It is up to each EMS agency to determine what they will do with diversion requests, in consultation with their operational plans to their local emergency department(s), and further communicate their operational plans to their local emergency department(s).It is also the responsibility of each EMS agency to maintain up-to-date contact information with their primary hospitals to facilitate diversion notification.

Monitoring of WebEOC

WebEOC may be monitored from the Internet by the jurisdiction Emergency Communications Center (ECC)/911 dispatch center. The ECCs/911dispatch Centers will have view-only privileges.

WebEOC Status Definitions

Open

1. The hospital emergency department is open to all ambulance traffic

Full

1. The emergency department is functioning but needs to divert ambulance patients due to a temporary resource limitation.
2. One or more of the following shall be selected when placing the ED on "Full"
    a. ED is saturated/high volume
    b. Holding in-patient admissions (number required in comments field)
    c. No monitored beds available in the ED
    d. Unusual circumstances (detail required in comments field)
3. The last names of the Charge Nurse and Attending Physician approving this status are required in the "comments" field.
4. The hospital will still receive critical patients as defined in this policy. Trauma centers will still receive patients that meet trauma triage criteria as defined in the Regional Trauma Triage Plan.
5. Ambulances enroute to a hospital before diversion is posted will continue to that hospital.

Special Diversion

1. That either a piece of critical equipment is broken or failed; ie., CT scanner out of service awaiting repairs; or
2. The hospital or emergency department has suffered structural damage, fire, loss of power, has an active security threat, or other condition that precludes the care and admission of new patients. The reason for special diversion should be noted in the Diversion Comments section on the WebEOC page.
3. Provider Response to Special Hospital Diversion - If a hospital lists the reason as failed or broken equipment, the EMS provider should contact Medical Control at that facility to determine if their patient can be accepted at that facility. If the reason for special diversion is for some sort of structural compromise or ongoing incident within the hospital, the EMS provider does not need to contact Medical Control at that facility. The EMS Provider must bypass that facility and proceed to the closest, appropriate hospital.

EMS Medical Operations Committee / Nurse Managers, OMD Committee, Septemebr 2009

Quality Assurance Procedure

Issues and problems associated with system processes shall be referred to the EMS Performance Improvement Committee utilizing the form found at the Tidewater EMS Web site (www.tidewaterems.org) or by contacting the Tidewater EMS Field Coordinator.

Communicating Facilities

These are the ED's that each hospital is required to call before they place their ED on diversion.

Bon Secours DePaul Hospital
-Sentara Norfolk General Hospital -Sentara Leigh Hospital

Bon Secours Health Center at Harbour View
-Sentara BelleHarbour -Bon Secours Maryview Medical Center -Sentara Obici Hospital

Bon Secours Maryview Medical Center
-Sentara Obici Hospital -Sentara Norfolk General Hospital -Chesapeake General Hospital

Chesapeake General Hospital
-Bon Secours Maryview Medical Center -Sentara Leigh Hospital

Sentara Bayside Hospital
-Sentara Virginia Beach Hospital -Sentara Leigh Hospital -Sentara Princes Anne Health Campus

Sentara BelleHarbour
-Bon Secours Health Center at Harbour View -Bon Secours Maryview Medical Center -Sentara Obici Hospital

Sentara Leigh Hospital
-Sentara Norfolk General Hospital -Chesapeake General Hospital -Sentara Bayside Hospital

Sentara Norfolk General Hospital
-Bon Secours DePaul Medical Center -Sentara Leigh Hospital

Sentara Obici Hospital
-Bon Secours Maryview Medical Center -Chesapeake General Hospital

Sentara Virginia Beach Hospital
-Sentara Leigh Hospital -Sentara Bayside Hospital -Sentara Princes Anne Health Campus

Sentara Princess Anne Health Campus
-Sentara Virginia Beach General Hospital -Sentara Bayside Hospital -Sentara Leigh Hospital

Children's Hospital of the King's Daughters, Naval Medical Center Portsmouth, Shore Memorial Hospital and Southampton Memorial Hospital are exempt from the list of Communicating Facilities.

Definition of a “Critical Patient”

These are guidelines and are not meant to be comprehensive and apply to this Ambulance Diversion Policy:

A “critical patient” is any patient:

- Currently undergoing cardiopulmonary resuscitation (CPR) or has undergone successful CPR.
- Who required prehospital endotracheal intubation and continues to deteriorate.
- Who required prehospital ventricular pacing.
- Whose vital signs are acutely deteriorating.
- Who, despite prehospital treatment:
  a. is in severe respiratory distress, resulting in severe hypoxemia as manifested by cyanosis or SpO2 < 90%
  b. is severely hypotensive (for example, an adult with systolic BP < 80 mmHg), accompanied by or resulting in acutely altered level of consciousness
  c. is in persistent malignant cardiac dysrhythmia, such as ventricular tachycardia or symptomatic bradycardia
- Who, in the judgment of prehospital personnel, in consultation with on-line medical control, is in such a condition that cardiopulmonary failure is impending or bypassing the nearest hospital jeopardizes their condition.

A "critical pediatric patient" is any patient under the age of 14:

- Currently undergoing cardiopulmonary resuscitation (CPR) or has undergone successful CPR.
- Who required prehospital endotracheal intubation.
- Whose vital signs are acutely deteriorating. ☐Who, despite prehospital treatment:
  a. is in severe respiratory distress, resulting in severe hypoxemia as manifested by cyanosis or SpO2 <85%
  b. is severely hypotensive accompanied by or resulting in acutely altered level of consciousness
  - Who, in the judgment of prehospital personnel, in consultation with on-line medical control, is in such a condition that cardiopulmonary failure is impending or bypassing the nearest hospital jeopardizes their condition.