
Plumas
DISTRICT HOSPITAL

## 1. 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.

## 2. 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 Operations/Preparedness Program.

3. The Plumas 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 may 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 lifesaving medical services to be provided during emergency crisis situations.*

5. PDH 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.

8. Restrictions that may factor into Plumas District Hospital's Surge Capabilities:

- Weather/Other - Weather related inability to transfer patients from the facility to a tertiary care facility.

A. Aircraft use is not possible with heavy cloud cover.
B. Ground Transport is restricted due to impassible roads, snow; wildfire; etc.

**3. Definitions:**

1. 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.

2. 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.

3. Control Facility (CF) - The CF referenced in this document refers to Enloe Medical Center and must be operational 24 hours a day. The CF is that entity responsible for the dispersal of patients during all Multi-Casualty Incidents (MCI). The CF will collect a Status Report from all receiving facilities and notify them when patients have been dispersed to them.

4. Donor Facility - The healthcare facility that provides personnel, pharmaceuticals, supplies or equipment to a facility experiencing a medical disaster.

5. EOC The Emergency Operations Center (EOC) - the location established by each jurisdiction to centralize coordination of all aspects of a disaster response.

6. EM Resources - An Internet-based hospital system used by all area hospitals to report open/closed/divert status in real-time. Data request and reporting via EM Resources can reach all hospitals simultaneously.

7. Healthcare Facility Indicators - A set of healthcare facility resource measures that are reported to MHOAC 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.

8. 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.

9. Hospital Incident Command System (HICS) - The incident command structure developed to meet the needs of the hospital response to a disaster.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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 utilization of medical resources from the regional agencies.

15. Level IV Surge - “Level IV Surge” means a surge in patients requiring the assistance from State and Federal Agencies.

16. 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.

17. 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 *local and regional Control Facilities, the local MHOAC* and may involve loan of medical and support personnel, pharmaceuticals, supplies and equipment from another facility, or the emergent evacuation of patients.

18. Medical Health Operational Area Coordinator (MHOAC) - 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).

19. Partner - The designated facility (or healthcare system) that a healthcare facility communicates with as a facility's "first call for help" during a medical disaster.

20. 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.

21. Patient Transferring Facility - An impacted facility -- The healthcare facility that evacuates patients to a patient-receiving facility in response to a medical disaster.

22. Participating Hospitals - Healthcare facilities that have fully committed to the MOU. This list of Participating Hospitals shall be maintained and disseminated by the Hospital Care Coalition.

23. Plumas County Public Health Agency Emergency Operations Center (PCPHA EOC) - The center established by the Plumas County Health for coordination of medical and health operations during a disaster or state of emergency.

24. Recipient Facility - The impacted facility. The healthcare facility where disaster patients are being treated and have requested personnel or materials from another facility.

25. Regional Disaster Medical Health Coordinator (RDMHC) - 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 six mutual aid regions during times of disaster or other major event requiring medical or health mutual aid.

26. Regional Disaster Medical Health Specialist (RDMHS) - 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.

27. Operational Area - 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.

## 4. Surge Capacity

| Available Inpatient Beds | Additional Licensed Inpatient Beds Available Within 24 Hours | Additional Inpatient Beds Available During Patient Surge | Total Inpatient Beds Available During Patient Surge | % of Increase Over Available Inpatient Beds | Total Inpatient Surge Capacity |
|---|---|---|---|---|---|
| 16 | 9 | 3 | 28 | 75% | 28 |

## 5. Surge Level Activation:

A. LEVEL I SURGE (local)

1. Triggers:

a. >30 minute delay in Emergency Department triage; or

b. >30 minute delay in Ambulance turn-around times at ED; or

c. Determination by the Charge Nurse and on-call Administrator that Level I is necessary.

2. Activation:

a. ED staff shall immediately notify the Charge Nurse when any of the above triggers have been met.

b. The Charge Nurse shall assume the role of Incident Commander and notify the Nurse Administrator on call of the Level I Surge. If the Nursing Administrator is in house, that individual will assume the role of Incident Commander.

3. Determine Size and Scope:

a. The Charge Nurse or designee 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).

b. The Nurse Administrator or designee shall determine the risk and need for a facility-wide lock down and work in collaboration with

Safety Officer and Maintenance to ensure immediate actions to implement the lock down per the lockdown plan.

c. The Charge Nurse or designee shall determine the risk and need to close all outpatient services in the Hospital Building (Laboratory, Imaging, Cardio Pulmonary, Surgical Outpatient Procedures, etc.). Any services in progress at the time of the Surge will be completed and the patient disposed appropriately, no new procedures that have not been started will be completed.

d. The Charge Nurse or designee shall conduct regularly schedule meetings with ED, Inpatient and Skilled Nursing Managers (Charge Nurses) to address patient throughput issues and assess needs.

4. Internal Alert:

a. The Charge Nurse or designee shall using the overhead PA System in the hospital announce "Code Triage" and provide any other pertinent information during the announcement.

b. Note: If a drill is being conducted, please ensure to state "Code Triage Drill" during the announcement.

c. Admissions will contact other departments which do not have overhead paging available – see list located in area. Notify departments of pertinent information such as Code Triage and lockdown if applicable.

5. Staffing

a. The Nurse Administrator/Designee shall immediately assign available staff to support the Emergency Department.

b. Consider activation of staff call-back, full or partial – Disaster Call Roster

c. Consider implementation of staffing ratio flex

6. Bed Capacity

a. Available gurneys shall be brought to the Emergency Department by the Maintenance Staff upon request.

7. Communicate ED/Hospital Status

a. ED staff or designee shall update EMResource with current

hospital/ED status, and keep updated status/resources. Update at least once per hour.

b. ED staff or the Charge Nurse/designee shall contact Local Hospital Care Coalition Hospitals to assess levels of saturation and communicate the current hospital status.

c. ED staff shall notify Susanville Interagency Ambulance Dispatch, and Plumas County Sheriff's Office Dispatch of the Level I Surge.

d. Nurse Administrator/designee shall notify the Administrator on-call of the Level I activation.

8. Accelerate Discharge

a. The Charge Nurse, 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.

B. LEVEL II SURGE (Local):

1. Triggers:

a. 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).

b. Facility has exceeded its licensed bed capacity

2. Activation:

a. Only the Incident Commander or Nurse Administrator on-call are authorized to activate Level II Surge.

b. The Incident Commander shall activate the HCC and notify the MHOAC.

c. 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 ensure the lockdown.

d. Notify Plumas County Medical Health Operational Area Coordinator (MHOAC). (i) Provide a Situation Report to the MHOAC: Plumas County MHOAC: (530) 283-6330, or cell at (530) 249-3679

e. DHS L&C Temporary Permission for Increased Patient Accommodations Request Worksheet. (See Appendix 1 for form and contact information).

3. Determine Size and Scope:

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

4. Internal Alert

a. The Incident Commander or designee will announce TWO TIMES over the public address system (Note: If a Drill, please identify as a "Drill.") "ATTENTION PLEASE. CODE TRIAGE: LEVEL II."

b. Admissions will contact other departments which do not have overhead paging available – see list located in area. Notify departments of pertinent information such as Code Triage (Level) and lockdown if applicable.

5. Staffing

a. Conduct staff call-back of available personnel as requested by the Incident Commander.

b. Implement staffing ratio flex plan to meet the needs of the patient population.

c. Open the personnel pool in the accounting area at the clinic building, and have all non-assigned staff available and ready for assignments as request are made.

6. Bed Capacity

a. Cancel Elective, Routine, or Non-Essential Surgery/Surgical Outpatient Procedures.

b. Close all ancillary services to Outpatient activity.

c. The Nurse Administrator shall work in collaboration with Surgery and other assigned departments to assess the needs for cancellation of non-essential elective surgical or outpatient procedure services.

d. 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.

e.Expand Inpatient Bed Capacity
**Consider set up and utilization of the North Fork Clinic Waiting Room as an alternate care site for (24 Hour) care and treatment of patients.*

f. Alternate Triage points will be set up: 1. Ambulance Entrance 2. North Fork Clinic Use a Bi-Directional Triage approach with the ED triaging minor patients to the North Fork Clinic and the North Fork Clinic triaging to the ED as needed.

g. Consider the need to set up the Family Information Center in the Education Building, and provide temporary child care for staff. Call in Auxiliary Volunteers to staff as needed.

h. Participate in Operational Area/PCH EOC Planning Sessions.

i. Paper documentation may be utilized in lieu of electronic documentation.

7. Communicate Status

a. ED staff shall update EMResource with current hospital/ED status, and keep updated as status/resources change (at least every hour).

b. ED staff or the Charge Nurse/designee shall contact Local Hospital Care Coalition Hospitals to assess levels of saturation and communicate the current hospital status.

c. ED staff shall notify the Control Facility of current status.

d. Charge Nurse shall notify the Administrator on-call of the Level II Activation.

e. Provide Situational Report - Plumas County (MHOAC). Plumas County MHOAC: (530) 283-6330, or cell at (530) 249-3679

8. Communicate Resource Needs

a. The Incident Commander (or designee) shall work in collaboration

with the MHOAC (or PCH EOC if activated) to ensure that adequate resource needs are being assessed on an ongoing basis and necessary resources acquired to address the needs. Send Resource requests to PCH EOC.

C. LEVEL III SURGE (regional):

1. Triggers:

a. 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.

b. Facility has exceeded both its licensed bed capacity and its surge bed capacity.

2. Activation:

a. Only the Public Health Officer or designee is authorized to activate Level III Surge.

b. The HCC shall be fully activated.

c. Hospital may be required to send/participate with an Incident Management Team to assist the County to plan for the activation of external Alternative Care Sites within Plumas County.

d. Incident Management Team Requirements:

(i) Incident Commander (Chief Executive Officer)
(ii) Medical Branch Leader (Chief Nursing Officer)
(iii) Infrastructure Branch Leader (Chief Operating Officer)
(iv) Logistics Branch Leader (Materials Management Manager or designee)
(v) Security Branch Leader (Safety Officer)

3. Determine Size and Scope

a. The Incident Commander shall complete a high level assessment of the potential operational impact on the facility.

4. Internal Alert

a. The Incident Commander or designee will announce TWO TIMES over the public address system (Note: If a Drill, please identify as a "Drill.") "ATTENTION PLEASE. CODE TRIAGE: LEVEL III."

b. Admissions will contact other departments which do not have overhead paging available – see list located in area. Notify departments of pertinent information such as Code Triage and lockdown if applicable.

5. Staffing

a. Implement staffing ratio increase up to 10:1 in order to meet the needs of the patient population.

b. Activate personnel pool.

c. Activate Auxiliary Volunteer Call In as needed to staff the Family Information Center and to provide temporary child care for staff, and victim children if needed.

6. Bed Capacity

a. Cancel Elective, Routine, or Non-Essential Surgery/Surgical Outpatient Procedures.

b. Close all ancillary services to Outpatient activity.

c. The Nurse Administrator shall work in collaboration with Surgery and other assigned departments to assess the needs for cancellation of non-essential elective surgical or outpatient procedure services.

d. 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.

e.Utilize all Outpatient Clinic areas as needed and cancel all patient appointments – Utilize and staff one of the provider clinics to accommodate Walk In Patients that may not be directly related to the original medical disaster.

f. Expand Inpatient Bed Capacity

g. Alternate Triage points will be set up: 1. Ambulance Entrance

h. Set up the Family Information Center in the hospital lobby, and provide temporary child care for staff. Call in Volunteers to staff as needed.

i. Participate in Operational Area/PCH EOC Planning Sessions

7. Communicate ED/Hospital Status

a. ED staff shall update EMResource with current hospital/ED status, and keep updated as status/resources change (at least every hour or as directed by the Control Facility).

8. Communicate Resource Needs

a. The Incident Commander (or designee) shall work in collaboration with the PCH MHOAC to ensure that adequate resource needs are being assessed on an ongoing basis and necessary resources acquired to address the needs.

9. Participate in Operational Area/Regional Planning Sessions.

a. Coordinate any public information with the county EOC (JIC) and PCH MHOAC.

b. Consider implementing disaster hotline for the public (e.g. triage, nurse call line).

D. LEVEL IV SURGE (REGION/STATE):

1. Triggers

a. Determination by the HCC and PCH EOC 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.

2. Activation

a. Only the Public Health Officer or designee is authorized to activate Level IV Surge.

b. The HCC shall be fully activated.

3. Determine Size and Scope

a. The Incident Commander shall complete a high level assessment of the potential operational impact on the facility.

4. Internal Alert

a. The Incident Commander or designee will announce TWO TIMES over the public address system (Note: If a Drill, please identify as a "Drill.") "ATTENTION PLEASE. CODE TRIAGE: LEVEL IV."

b. Admissions will contact other departments which do not have overhead paging available – see list located in area. Notify departments of pertinent information such as Code Triage and lockdown if applicable.

5. Staffing

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

6. Bed Capacity

a. Coordinate/prioritize inpatient care with all inpatient care sites

b. Re-assign inpatient areas according to patient needs.

c. Implement re-assessment, transfer, or discharge of patients according to Austere Alternate Medical protocols approved by the HCC/Incident Management Team.

7. Communicate ED/Hospital Status

a. ED staff shall update EMResource with current hospital/ED status, and keep updated as status/resources change (at least every shift).

8. Communicate Resource Needs

a. The Incident Commander (or designee) shall work in collaboration with the PCH EOC to ensure that adequate resource needs are being assessed on an ongoing basis and necessary resources acquired to address the needs.

9. Participate in Operational Area/regional/statewide Planning Sessions

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

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: ambulance bay, PACU, or outpatient North Fork Clinic building.

Review the Infection Control Manual/CDC Guidelines as appropriate for Patient Care risk reduction and exposure control considerations and protocols.

a. Do we have or can we provide:

1. Temperature and ventilation exhaust control to the space?
2. Access Control/Security?
3. Electrical power?
4. Emergency back-up Power?
5. Patient care process flow that allows accessible supervision and services?
6. Waste disposal?
7. Sprinkled building (Fire Suppression System)?
8. Same level Emergency Egress with access widths not less than 45 inches?
9. Personal Hygiene Capabilities (hand washing, changing, and bathroom resources)?
10. 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.

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:

1. 3 Feet of distance aisle way between Patients to reduce spread of infectious diseases. 36 inches between beds.

2. Access Space for equipment or staff. 24 inches minimum - Run electrical cords, oxygen tubing etc. plugs away from walking paths at the heads of the beds if possible.

3. Minimum support items.

- Privacy curtains
- Waste container
- Medical Waste container
- Bed pan/urinals/Commodes
- Suction – Portable

- Sharps and Pharmaceutical Waste Containers
- Oxygen – Portable H Cylinders in stands with regulators. (Oxygen Yoke for multiple)
- Power needs. Electrical Surge Strip with a five plug outlet. (Extension Cords?)
- Oxygen Y Connectors/Flow Meters
- Nurse Call system. Manual system (Hand bell) 1 per patient
- Hand Sanitation. Disinfection for staff. (Alcohol Based Hand Rub, and Handwashing Sink.
- For infectious patients – Mount Alcohol Based Hand Rub at Bedside.
- Respiratory Protection for staff. Designate storage. As needed. N95 or PAPR.
- Other PPE as needed or required.

**7. Surge Configuration for Inpatient and Triage Care:**

| **Set up Time** | **Location** | **# of Surge Beds** | **Service** |
|---|---|---|---|
| 0-1 hour | Ambulance Bay | 10 | Triage |
| 0-1 hour | PACU | 3 | Inpatient |
| 0-3 hours | North Fork Clinic | 10 | Triage |
| 0-24 hours | Med Surg | 9 | Inpatient |
| Total | | 32 | |

1. **Surge Availability Timeline:** Emergency Triage and Inpatient Surge Planning in the table above requires the facility to maintain within its operational control (on PDH Premises) the necessary equipment and resources to execute our surge plan without relying on outside support.

Addendum: For COVID19 related surge Plumas District Hospital will refer to California SARS-CoV-2 Pandemic Crisis Care Guidelines.
https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/California%20SARS-CoV-2%20Crisis%20Care%20Guidelines%20-June%208%202020.pdf