	• Consolidate holds into H1& H2	• Notify ED Medical director to evaluate the need for additional non-resident providers • Consolidate holds into H1, H2 & H3 **ED MEDICAL DIRECTOR** • Obtain additional providers non-resident providers. • Consider Medical Director coming in to ER. **ED LEADERSHIP & SENIOR LEADERSHIP** • Consider need for re-direct • Consider need for EMS diversion o Communicate diversion status, reason and projected duration to appropriate teams as applicable.	**ED MEDICAL DIRECTOR** • Obtain additional providers non-resident providers. • Consider Medical Director coming in to ER. **ED LEADERSHIP & SENIOR LEADERSHIP** • Consider need for re-direct • Consider need for EMS diversion o Communicate diversion status, reason and projected duration to appropriate teams as applicable. • ED Nursing Leader on call considers coming into the department to support the team.	
HOUSE SUPERVISOR / BED MANAGEMENT o Standard Operating Procedure o Sends daily status update message, indicating level of surge	**HOUSE SUPERVISOR / BED MANAGEMENT** • Text Case Management, unit charge RN's and FLR managers the ED is in Code yellow and discharges need to be expedited. • Compile information from each unit to assess facility. • Keep Senior Executive Leadership informed. • Allocate plan to cover the ED Holds with inpatient nurses, or communicate plan to get hold patients out of the ED.	**HOUSE SUPERVISOR / BED MANAGEMENT** • Notify all Charge Nurses/Managers/Director/AOC. **All Report to Liaisons office for Administrative Huddle.** • Send iMobile alert to indicating current level of surge • Allocate resources to ER to assist as needed. • Helping Hands as available to ER to help. (Ancillary staff "Code surge" approach using I-Mobile Broadcast) • Evaluate in-house staffing and resources. o EVS to priority beds first.	**HOUSE SUPERVISOR / BED MANAGEMENT** • Notify all Charge Nurses/Managers/Director/AOC. **All Report to Liaisons office for Administrative Huddle.** • Continual contact with ED Charge nurse, telemetry and ICU leaders with updates as applicable. • Round in ED with Charge RN at least every hour while on Level Red status. • The decision to go on ED Divert will be made by the ED Director, AOC, ED Charge RN & Liaison. • Allocate plan to cover the ED Holds, including pulling charge RN's from the floors. • Assess all licensed staff and determine who can assist with transport and throughput	

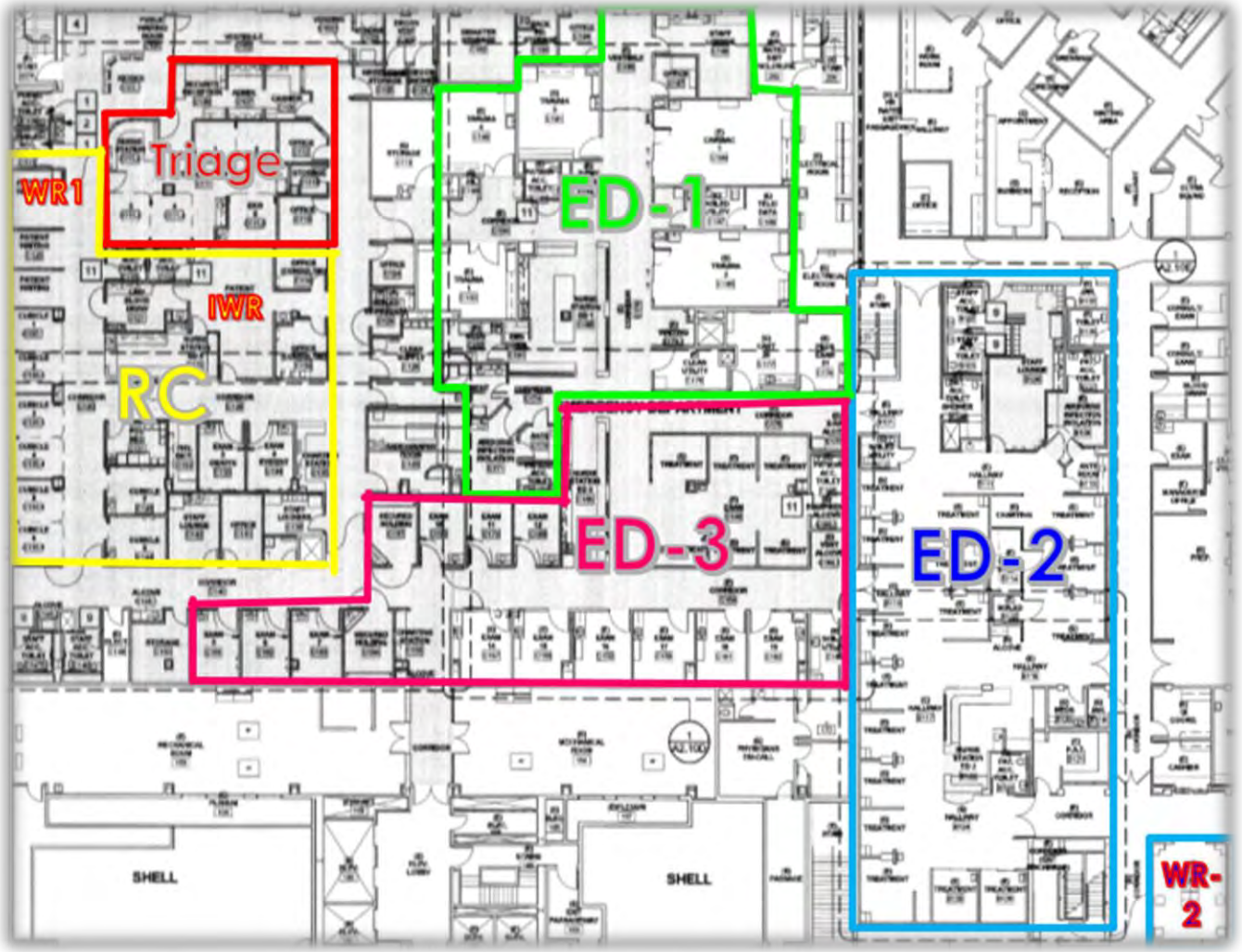
	• If 1/3 of ED scheduled staff is treating inpatient holds, then notify AOC and consider escalating surge level to Orange.	• Nursing leadership: to inform nurse liaison's office about how many beds are available, how many discharges are pending with times • Let nurse liaisons know if they have any staff that they can lend o Hospitalists to dc / transfer patients as needed. o Re-eval capacity options (open units, PACU, semi-private rooms etc.) • Allocate plan to cover the ED Holds, including pulling charge RN's from the floors. • The decision to go on ED Divert will be made by the ED Director, AOC, ED Charge RN & Liaison. • If 1/2 of ED scheduled staff is treating inpatient holds, then notify AOC and consider escalating surge level to Red. • Assess all licensed staff and determine who can assist with transport and throughput		
Radiology • Standard Operating Procedure	**Radiology** • Screen priority of exams with guidance of ED Charge/Supervisor. **X-Ray:** • Allocate x-ray tech to ED and prioritize portables in RC. • Non-portables staged in radiology if stable. **CT:** • Prioritize Critically ILL patients first.	**Radiology** • Director to be notified of Tier Orange to evaluate the need for additional resources. • Screen priority of exams with guidance of ED Charge/Supervisor. **X-Ray:** • Allocate x-ray tech to ED and prioritize portables in RC. • Non-portables staged in radiology if stable. **CT:**	**Radiology** • Director to be notified of Tier Red to evaluate the need for additional resources. • Screen priority of exams with guidance of ED Charge/Supervisor. **X-Ray:** • Allocate x-ray tech to ED and prioritize portables in RC. • Non-portables staged in radiology if stable. **CT:** • Prioritize Critically ILL patients first.	

	• Patients staged outside CT. CT will not wait for IV Access, if patients have labs back they will be staged outside CT and CT to place access. Communicate with ED on status updates, delays	• Prioritize Critically ILL patients first. • Patients staged outside CT. CT will not wait for IV Access, if patients have labs back they will be staged outside CT and CT to place access **Staffing:** • Request on call staff • Request registry staff Communicate with ED on status updates, delays	• Patients staged outside CT. CT will not wait for IV Access, if patients have labs back they will be staged outside CT and CT to place access **Staffing:** • Request on call staff • Request registry staff Communicate with ED on status updates, delays	
LABORATORY DEPARTMENT • Standard Operating Procedure	**LABORATORY DEPARTMENT** • Prioritize the processing of all ED labs. • Send 1 Phlebotomist to ED to clear back log. • Notify the ED on status updates	**LABORATORY DEPARTMENT** • Notify the lab director and managers of the need for additional resources. • Allocate a 2nd phlebotomist to the ED to clear the Back Log. • Call in extra CLS staff and phlebotomists to expedite STAT labs and Routine Draws. • Continue to notify ED on status (instruments, staffing, etc.)	**LABORATORY DEPARTMENT** • Notify the lab director and managers of the need for additional resources. • Send a 3rd phlebotomist to the ED to clear the back log if available. • Call in extra CLS staff and phlebotomists to expedite STAT labs and Routine Draws. • If chemistry analyzer is broken, encourage to use ISTAT (chem 8) • Continue to notify ED on status (instruments, staffing, etc.)	
EVS • Standard Operating Procedure	**EVS** • STAT cleans placed on all available rooms • Notify ED Charge RN or House Supervisor of any change in status as appropriate • House Liaison to assist with direction of stat cleans for floors. • Send additional staff for ED turnover times.	**EVS** • EVS supervisor to setup 4 additional spaces in S1 & 12 additional spaces in S2 area at discretion of ED Leadership. • Clean highest priority beds first. Coordinating with House Supervisor and Bed Management • Redirect additional EVS staff to restock and supply and turnover rooms • Call in staff earlier for shifts. • **Equipment** o Set up 8 treatment chairs in S1	**EVS** • EVS Supervisor to setup additional 12 recliners in S3 & 4 Additional Recliners in S4. • Clean highest priority beds first. Coordinating with House Supervisor and Bed Management • Redirect additional EVS staff to restock and supply and turnover rooms • Call in staff earlier for shifts. • **Equipment** o Set up 8 treatment chairs in S1 o Set up 12 treatment chairs in S2	

		o Set up 12 treatment chairs in S2		
ICU • Standard operating procedure	• Provide nursing supervisors a status update (open beds, potential discharges, 1:1 assignment updates, etc.) every 4 hours via iMobile	• Provide nursing supervisors a status update (open beds, potential discharges, 1:1 assignment updates, etc.) every 2 hours via iMobile • Nurse leaders/Charge nurse to communicate with case management and intensivists to expedite discharges and downgrades • Evaluate staffing and resources available on the unit	• Provide nursing supervisors a status update (open beds, potential discharges, 1:1 assignment updates, etc.) every 2 hours via iMobile • Nurse leaders/Charge nurse to communicate with case management and intensivists to expedite discharges and downgrades • Evaluate staffing and resources available on the unit	
Telemetry • Standard operating procedure	• Provide nursing supervisors a status update (open beds, potential discharges, downgrades, sitters, isolation patients, etc.) every 4 hours via iMobile	• Provide nursing supervisors a status update (open beds, potential discharges, downgrades, sitters, isolation patients, etc.) every 2 hours via iMobile • Nurse leaders/Charge nurse to communicate with case management and intensivists to expedite discharges and downgrades • Inform nursing supervisors on how many tele boxes are available for patient monitoring	• Provide nursing supervisors a status update (open beds, potential discharges, downgrades, sitters, isolation patients, etc.) every 2 hours via iMobile • Nurse leaders/Charge nurse to communicate with case management and intensivists to expedite discharges and downgrades • Inform nursing supervisors on how many tele boxes are available for patient monitoring	
If change from Level 1 complete ED SURGE Check List and initiate appropriate level of response	**If Level 2 ED SURGE criteria met, complete ED SURGE checklist and page ED SURGE Group with plan and appropriate time for re-eval. If Level 2 for greater than 60 minutes without anticipation of timely resolution, consider Level 3 ED SURGE after approval of AOC.**	**If Level Orange ED SURGE continues past initial re-eval time, or large change in status, re-page ED SURGE group with update and plan for conference call. Conference call complete when a Surge plan has been agreed upon. Continue to re-evaluate as needed. Re-page ED SURGE group when status returns to lower level.**	**Conference Call Completed AOC initiating possible Command Center only at discretion of AOC. Re-evaluate as needed. Re Page ED Surge group when status returns to lower level. Follow up as needed.**	**Command Center Approval from all action required**.

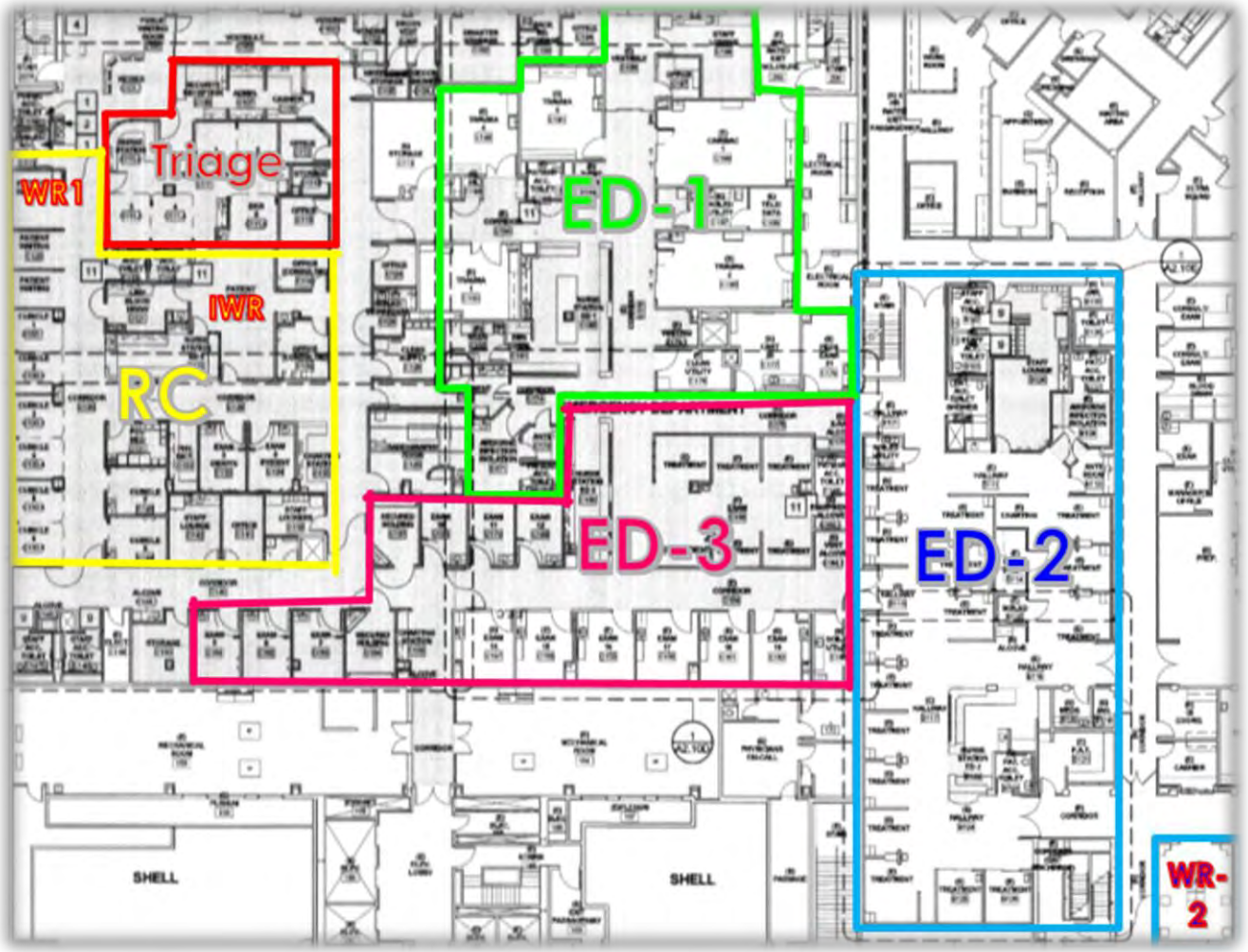
ED POD GOALS:

- A patient centered initiative in which brings the entire care team to the patients.
- Promotes a strong cohesive team approach, in which clear communication amongst the multidisciplinary team is the foundation. Improved communication has been proven time and again to reduce errors and improve outcomes.
- MD's, Residents, PA's, RN's, Techs and secretaries in each pod will be able to focus on a finite group of patients assigned to them.
- The Pod concept will create purposeful patient movement, thus improving overall throughput and overcrowding in certain areas of the ED.
- POD's will improve physician efficiency, by reducing excessive walking and time spent looking for patients and places to examine them.
- Rolling out the pod system will improve throughput, decrease waiting time and improve communication between the team members.



FLOW OF THE ROOM:

- Patients will be brought to the doctors in their respective pods, which will alleviate wasted time for providers.
- Either a Triage Nurse, Tech 1 or Tech 2 will move the patient to their team.
- All patients will still be MSE'd/RME'd in triage and the ambulance bay.
- We will now have 2 pods with dedicated waiting rooms, RME & ED 2. Both RME & ED will have private MD Evaluation Rooms.



POD CAPACITY

- Monitored Rooms – 48
- Vertical Treatment Spaces – 20
- Hallway – 8
- WR – 68
- Total care spaces for patients in treatment – 76
- Total Capacity Without Expansion – 144 Patients