SE MINNESOTA

DISASTER HEALTH COALITION

Enhancing Regional Preparedness, Response and Recovery

Medical Surge: Rapid Discharge Guidelines

September 2014

TABLE OF CONTENTS

Introduction 3

Definitions & Abbreviations 4

Radid Discharge Actions & Tasks 6

Appendix A – Rapid Discharge Team 12

Appendix B – Emergency Census Tool Worksheets 15

Appendix C – Unit-Based Rapid Discharge Teams (UBRDT) 17

Appendix D – Patient Care Unit "Walk Through" Teams 19

Appendix E – Timely Rapid Discharge Assessment/Reporting Tool 21

INTRODUCTION

The SEMN Disaster Health Coalition consists of organizations with responsibilities to mitigate the likelihood of a hazard negatively impacting the ability of a healthcare system to provide services and to prepare for, respond to, recover from consequences of a disaster to the healthcare system, the purpose of the SEMN Disaster Health Coalition is to facilitate preparedness to assist communities with building a Health and Medical Services (Emergency Support Function 8/ESF8) Capability to respond to and recover from disasters.

The following groups are represented as part of the SEMN Disaster Health Coalition:

- Hospitals
- Local Public Health
- Emergency Management
- Emergency Medical Services Regulatory Board (EMSRB)
- South East Emergency Medical Services (SE EMS)
- Long Term Care Facilities
- Specialty Services such as(e.g. dialysis centers, hospice centers, American Red Cross)
- Volunteer Organizations Active in Disasters (VOAD)

In a mass casualty incident, there will most likely be an immediate demand for additional, available beds. This demand is known as surge, and a hospital's ability to accommodate such an increase in patient volume is often referred to as surge capacity. The two most effective methods for quickly increasing bed capacity are rapid patient discharge and capacity expansion. The former is the subject of this document.

Rapid discharge supports the goal to quickly provide higher-level care to more serious patients during a disaster with no new space, personnel, or equipment. As a region, which is supported by actions at the organization level, the goal is to provide no less than 20% bed availability of staffed operational beds within four hours of onset of a disaster.

The document can be used to assist hospital partners with achieving immediate bed availability/medical surge goals. Information should be integrated within organizational operational documents as applicable.

Special thanks to the New York City Bioterrorism Hospital Preparedness Program for developing the Rapid Patient Discharge Tool (April 2008), which this documented was adapted from to support regional hospitals.

Definitions

Action: An action is a set of planning or response activities that leads to a greater number of additional, available staffed beds.

Attending Physicians - Doctors with admitting privileges.

Bed Board – Tool used to keep track of patients, patient status and bed availability; also used to describe meetings to review patient admission, discharge and transfer activity.

Bed Tracking Manager (HICS Position) - Maintains information on the status, location, and availability of all patient beds, including disaster cots and stretchers.

Bed Tracking System - A software program used to track patients and initiate such activities as bed turnover and patient discharge.

Bed Yield Potential: an experience-based *estimate of how many additional, available beds will result from taking an action*. A simple "high-medium-low" scale is used to quickly convey each action's potential in yielding beds:

- HIGH: increase in bed surge capacity up to 35% of current bed inventory (i.e., total number of additional, available beds)
- MED: increase in bed surge capacity up to 20% of current bed inventory
- LOW: increase in bed surge capacity up to 10% of current bed inventory

Emergency Census Tool - A census-capture form used during emergencies to profile vacant beds, potential and definite discharges, and transfer activity on all patient care units.

Estimated Time Required: The approximate time for completing an Action's steps and activities.

Holds - Patients in the Emergency Department who are awaiting staffed beds.

Hospitalists - Physicians employed by hospitals.

House Staff - Physicians (residents and chief residents) who are in a residency program.

Length of Stay - Patient stay duration (usually calculated in number of days from time of admission to time of discharge).

Patient Tracking Manager (HICS) - Monitor and document the location of patients at all times within the hospital's patient care system, and track the destination of all patients departing the facility.

Outcome: The result(s) of a team's conducting an Action's steps and activities.

Rollover Capacity - Closed unit beds that can be made available for inpatient use within a short period of time (i.e., one shift).

Step: Activities outlined within an ***Action*** that are intended to achieve one or more outcome(s).

Bed Management Committee - A group of clinical and administrative bed management experts who are charged with organizing and directing activities related to inpatient admissions, discharges and transfers.

Abbreviations

ADT – Admission, Discharge, and Transfer

BMC – Bed Management Committee

CARD – Cardiology

CCU – Critical Care Unit

HICS – Hospital Incident Command System

ICU – Intensive Care Unit

ISO – Isolation

MED – Medicine

MICU – Medical Intensive Care Unit

PACU – Post Anesthesia Care Unit

PCU – Patient Care Unit

PEDS - Pediatrics

PICU – Pediatric Intensive Care Unit

SURG – Surgery/Surgical

UBRPDT - Unit Based Rapid Patient

RADID DISCHARGE ACTIONS & TASKS

Every day, SEMN hospitals routinely discharge from 20 to 70% of hospital patients. As such, the goal of providing for 20% staffed operational beds is readily achieved on a typical day with little non-routine actions and tasks. With additional actions, even more patients may be available for discharge. Clinically stable patients with few parenteral medications may be appropriate for early discharge. Strategies to expedite discharge:

- Discharge holding lounge
- Convert private rooms to double rooms
- Reopen closed areas
- Utilize hallways
- Convert patient areas to critical care areas
- Temporary external structures for patient holding
- “Flat space” (e.g. lobbies, waiting rooms, hallways) can open 10% operating bed capacity

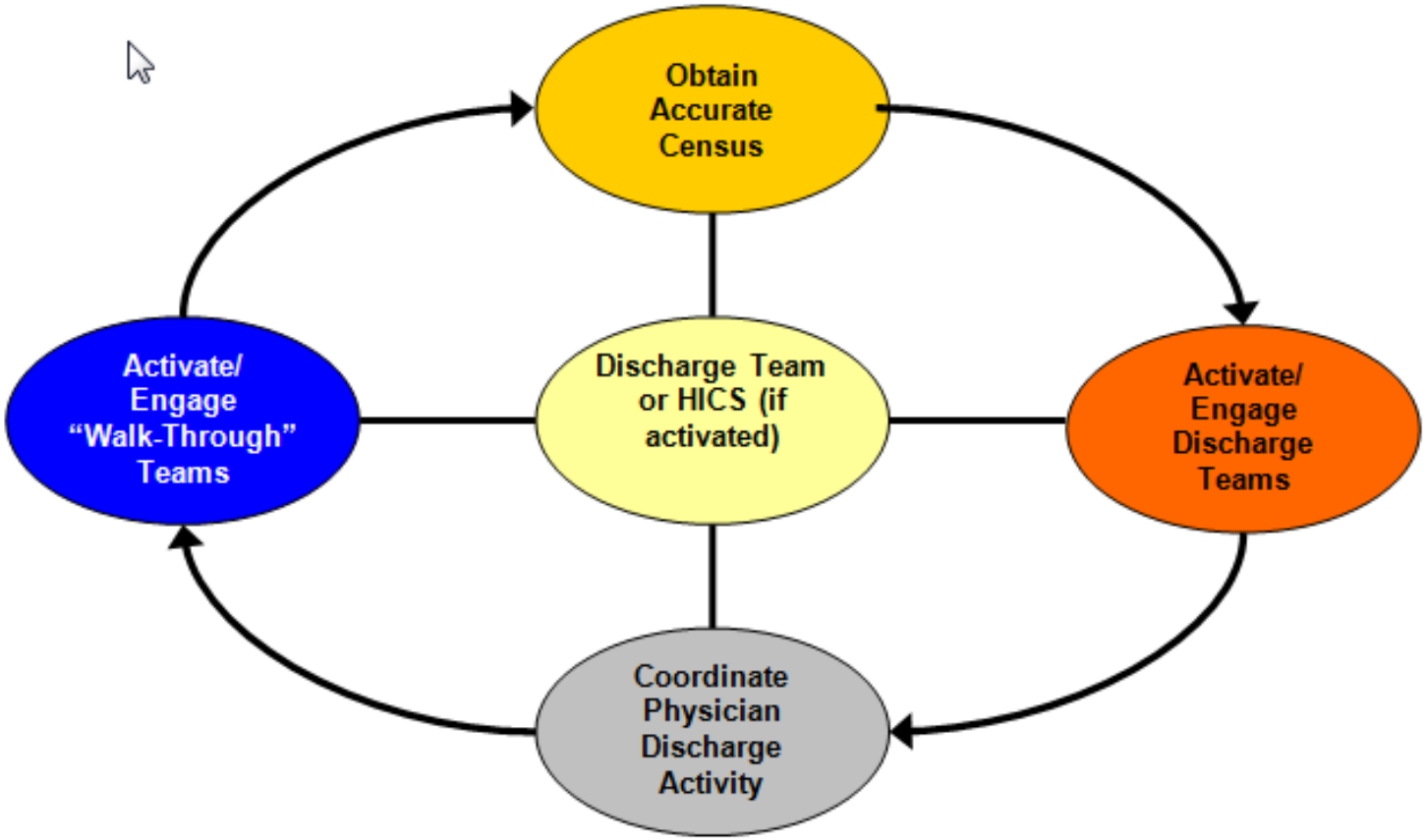
Staffing is likely to be the key restriction on the number of patients that facilities can accommodate. Hospitals might consider the following to support staffing needs to achieve staff operational bed goals:

- Protocols for revision of staff work hours
- Callback of off-duty personnel
- Use of non-clinical staff
- Local Medical Reserve Corps
- Untraditional patient care providers (e.g. family members, nonprofessional personnel such as city employees)
- Surge plans for home care agencies and clinics
- Fewer, larger staffed off-site facilities will benefit from economies of scale

Appendices A through E are designed to assist hospitals in preparing for and responding to unexpected increases in patient volume during the immediate phase of a disaster by providing them with clearly defined activities organized around a Rapid Discharge Team or HICS. These activities include:

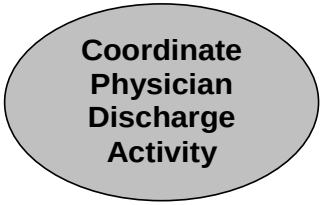
- Forming a Rapid Discharge Team or HICS Patient Flow Branch (or equivalent)

- Using an Emergency Census Monitoring Tool
- Organizing Unit-Based Rapid Patient Discharge Teams (or equivalent)
- Increasing Physician Support and Involvement in Rapid Patient Discharging
- Assembling Patient Care Unit Walk-Through Teams (or equivalent)
- Considering Barriers to Patient Discharge



Action	Step(s)	Outcome(s)	Estimated Time Required	Bed Yield Potential
☐ **Assemble Rapid Discharge Team/HICS Patient Flow Branch.** A core group of clinical and administrative bed management experts. The team is charged with organizing and directing activities related to inpatient admissions, discharges and transfers in accordance with hospital policies and procedures. **Rapid Discharge Team/HICS Patient Flow Branch**	☐ Notify Rapid Discharge Team members (may occur through HICS activation process) immediately and then again at beginning of each shift or as directed by HICS. ☐ Include appropriate representatives ***See Appendix A.***	✧ Rapid Discharge Team/HICS will initiate and monitor all rapid patient discharge activity.	1-2 Hours x3 times/day	**N/A**
☐ **Obtain accurate census of all Patient Care Units and identify patients for discharge.** The Emergency Census Tool will profile vacant beds and discharge potential on all patient care units; it may also include Additional Beds in Non-Traditional Clinical Space, Isolation Capacity,	☐ Capture data at Rapid Discharge Team/HICS Patient Flow Branch meetings using *Emergency Census Tools.* Ongoing, maintain and update tool with changes affecting bed capacity. ***See Appendix B.***	✧ Provides snapshot of current census. ✧ Details impending admission, discharge and transfer (ADT) activity. ✧ Allows management to quickly convey information/ instructions to PCU representatives.	1-2 Hours x3 times/ day	**HIGH**

Action	Step(s)	Outcome(s)	Estimated Time Required	Bed Yield Potential
and Rollover Capacity. **Obtain Accurate Census**	☐ Continually update electronic or manual *Bed Tracking System*.	✧ Provides data for MNTrac/HAvBED submission. ✧ Up-to-date tool will assure that data can be compiled quickly and accurately. ✧ Updates data reported to Rapid Discharge Team/HICS. ✧ Captures information not reported at Rapid Discharge Team/HICS meetings. ✧ Expedites bed turnover by alerting Environmental Services to discharge beds.	1-2 Hours x3 times/ day	**MED to HIGH**
☐ **Activate Unit-Based Rapid Patient Discharge Teams.** A unit-based team of clinical professionals whose primary goal is to assure that discharge policies and procedures are applied to all patients timely, preferably using a discharge planning tool such as an *Intend to Discharge Form*.	☐ Unit-based teams assess patients and make appropriate, safe discharge referrals, preferably using a standardized discharge planning tool, such as an *Intend to Discharge* form. ☐ Teams identify and resolve barriers to discharging. **See Appendix C.** ☐ Teams communicate with	✧ Form will communicate progress in discharge process to all team members (i.e., a checklist that leads to discharge when complete). ✧ Once barriers are identified, team will take actions to remove them. ✧ Timely physician	(up to) 1 Hour ½ Hour + 1 Hour +	**HIGH** **MED** **HIGH**

Action	Step(s)	Outcome(s)	Estimated Time Required	Bed Yield Potential
	service and/or private attendings to expedite discharges. ☐ Teams report results to the Rapid Discharge Team/HICS.	cooperation will greatly assist discharging. ✧ Information will be used to assign beds to incoming patients.	½ Hour	N/A
☐ **Engage physicians in the rapid patient discharge process.** 	☐ Increase physician support of and involvement in rapid patient discharging ☐ Access house staff through Medicine/ Surgery Leadership. ☐ Access hospitalists through Department of Medicine. ☐ Access/utilize attending physicians through Medicine/Surgery Leadership.	✧ Physician involvement will help to eliminate barriers to patient discharge, and result in a more timely delivery of available, staffed beds.	1-2 Hours ½ Hour ½ Hour 1 Hour +	MED to HIGH MED to HIGH MED HIGH
☐ **Activate small "walk-through" teams to capture unreported discharges and vacant beds on all patient care units.** Patient status changes occurring in-between team/HICS meetings may go unreported. Small	☐ Rapid Discharge Team/HICS assigns small teams comprised of admitting managers/ staff to walk through PCUs in-between Rapid Discharge Team/HICS sessions and conduct patient-by-patient bed status reviews. **See Appendix D.**	▪ Capture unreported discharges. ▪ Reconciliation of unit bed census against *Emergency Census Tool*. **See Appendix B.**	(up to) 1 Hour	LOW to MED

Action	Step(s)	Outcome(s)	Estimated Time Required	Bed Yield Potential
teams of Admitting representatives walk through patient care units noting empty beds and confirming patient discharge status. 	☐ Repeat walk-throughs at least once during each shift, preferably in-between Rapid Discharge Team/HICS meetings. ☐ Teams report results to the Rapid Discharge Team/HICS.	✧ Capture unreported discharges. ✧ Increased monitoring yields better overall discharging results.	(up to) 1 Hour ½ Hour	**LOW to MED** **N/A**

APPENDIX A – RAPID DISCHARGE TEAM

LEADERSHIP
Leadership of the Rapid Discharge Team should be assigned to one of the core team members, preferably the most senior Admitting or Nursing representative – or both.

TEAM COMPOSITION
Because much of the planning and response activity relating to rapid patient discharge and capacity expansion will need to be directed by individuals who are expert in these areas, it is suggested that the Rapid Discharge Team be comprised of a core group of senior level individuals from the following departments:

- Administration
- Admitting
- Bed Tracking Manager (HICS)
- Emergency Medicine
- Environmental Services
- Medicine
- Nursing
- Patient Tracking Manager (HICS)
- Social Work
- Surgery

Other departments can be called upon as necessary; these may include, but are not limited to:

- Dietary / Food Services
- Facilities / Engineering
- Infection Control
- Information Services
- Laboratory
- Materials Management
- Mental Health
- Patient Accounts/Finance
- Patient Transport
- Pediatrics
- Pharmacy
- Radiology
- Respiratory Care
- Safety
- Telecommunications
- Union

Alternatively, a HICS Patient Flow Branch (within an Operations or Medical Operations Section) should consist of the following functions:

- Admitting

- Branch Director
- Bed Management
- Discharge Services/Case Management/Social Services
- Emergency Department
- Patient Family Assistance Services
- Patient Transportation

PURPOSE
The Rapid Discharge Team, or if activated HICS, will have primary responsibility for planning and implementing those activities that will yield the greatest number of additional, available inpatient beds.

REPORTING
In a mass casualty incident that requires rapid discharge of patients as a method for creating surge capacity, Hospital Incident Command System (HICS) activation is assumed. Therefore, reporting of patient census and beds data will be routed to the Hospital Emergency Operations Center/Coordination Center. This information might also be requested by the SEMN Healthcare Multi-Agency Coordination Center.

INSTRUCTIONS
Use the form on the next page to list the team members. Be certain to list HICS roles (where applicable), and to consider (and document) how the actions outlined in the Rapid Patient Discharge Tool will be coordinated/engaged off-hours (evening, night, weekend). It is recommended that a separate form be used for each of these shifts. The form will need to be kept up-to-date, with copies routinely placed in the Hospital Emergency Operations Center/Coordination Center and other key locations.

Rapid Discharge Team Roster				
Name	**Title/Department**	**HICS Title (if applicable)**	**Shift**	**Contact Information**

APPENDIX B – EMERGENCY CENSUS TOOL WORKSHEETS

In a mass casualty incident, the Emergency Census Tool will be the most up-to-date and accurate measurement of patient census compiled by the Rapid Discharge Team/HICS Patient Flow Branch. The following forms are provided as samples that can be adapted to meet organizational needs.

Date:_____ **Time:**_____ **Manager/Representative:**_____

UNIT (Medicine)	Cap	Vac	P/D	D/C	Trans	
					In	Out
Total						

UNIT (Surgery)	Cap	Vac	P/D	D/C	Trans	
					In	Out
Total						

UNIT (ICU)	Cap	Vac	P/D	D/C	Trans	
					In	Out
CCU						
SICU						
MICU						
PACU						
PICU						
Total						

Notes

Rollover Capacity	
Source/Area	**# Beds**
Total	

Additional Beds	
Source	**# Beds**
Short Stay	
Blood Bank	

ED Holds	
Acute	**#**
Med	
Surg	
ICU	
Card	
Iso	
Peds	

Key: **Cap** – Capacity; **Vac** – Vacant; **P/D** – Potential Discharge; **D/C** – Discharge; **Trans** – Transfer

Date:_____ **Time:**_____ **Manager/Representative:**_____

UNIT (Medicine)	Cap	Vac	1	2	3	4
Total						

UNIT (Surgery)	Cap	Vac	1	2	3	4
Total						

UNIT (ICU)	Cap	Vac	1	2	3	4
CCU						
SICU						
MICU						
PACU						
PICU						
Total						

Notes

Rollover Capacity	
Source/Area	**# Beds**
Total	

Additional Beds	
Source	**# Beds**
Short Stay	
Blood Bank	

ED Holds	
Acute	**#**
Med	
Surg	
ICU	
Card	
Iso	
Peds	

Key: **Cap** - Capacity; **Vac** - Vacant; **1** - Patients ready for discharge; **2** - Patients who do not require oxygen or cardiac monitoring; **3** - Patients who require oxygen and/or cardiac monitoring; **4** - Patients who require isolation. (Note: **1** and **2** rankings are those patients who have been evaluated as being closest to discharge)

APPENDIX C – UNIT-BASED RAPID DISCHARGE TEAMS (UBRDT)

LEADERSHIP

Leadership of the UBRPDT should be assigned to one of the core team members, preferably the Nurse Manager.

TEAM COMPOSITION

Because staffing and position descriptions may vary widely from one hospital to another, so too does the membership profile of the UBRPDTs. In virtually all hospitals, however, the following individuals will comprise these teams' core group: Attending Physician, Nurse Manager, Case Manager, and Social Worker. Adding to this group (i.e., a pharmacy representative) is at the discretion of each hospital and, more particularly, dependent upon the specific needs and resources of each unit.

PURPOSE

Teams of clinicians are formed on every medicine and surgery unit to specifically assess patients and coordinate discharge readiness decisions, preferably using a standardized discharge planning tool such as an *Intend to Discharge* form. These teams actively identify and resolve barriers to discharging and communicate with service and/or private attending physicians to expedite discharges.

REPORTING

Unit-Based Rapid Patient Discharge Teams consistently and timely report their results to the Rapid Discharge Team/HICS.

INSTRUCTIONS

For every patient care unit, use a UBRPDT Membership Roster, on the following page, to list the core team members. Be certain to consider (and document) how each team will be coordinated/engaged off-hours (evening, night, weekend). It is recommended that a separate form be used for each of these shifts. The UBRPDT Membership Roster(s) will need to be kept up-to-date, with copies routinely given to the BMC. Unit staff should also have ready access to this information.

Unit-Based Rapid Discharge Team Roster			
Name	**Title/Department**	**Shift**	**Contact Information**

APPENDIX D – PATIENT CARE UNIT "WALK THROUGH" TEAMS

LEADERSHIP
Leadership of the "Walk-Through" Teams should be assigned to members from admitting/patient access.

TEAM COMPOSITION
Staffing permitted, admitting/patient access managers and representatives are best suited for this activity. Representatives from nursing who are knowledgeable about bed management could equally be considered for team inclusion.

PURPOSE
Many patient status changes occurring in-between Rapid Discharge Team/HICS meetings may go unreported. There are numerous reasons why this occurs - from simple oversight to change-in-shift staff dynamics. Small teams comprised of admitting/patient access managers and/or representatives can walk through patient care units noting empty beds and confirming patient discharge status. The optimal time to "walk the floors" is in-between Rapid Discharge Team/HICS meetings, though this activity can take place at any time. In a tight bedding situation, the importance of capturing even one additional, available bed cannot be overestimated.

INSTRUCTIONS
Use a separate Patient Care Unit "Walk Through" Teams Membership Roster, on the following page, to list the members of the team. Be certain to consider (and document) how each team will be coordinated/engaged off-hours (evening, night, weekend). It is recommended that a separate form be used for each of these shifts. The Patient Care Unit "Walk Through" Teams Membership Roster will need to be kept up-to-date, with copies routinely given to the Rapid Discharge Team/HICS. Admitting/Patient Access management and staff should also have ready access to this information.

Patient Care Unit “Walk Through” Team Roster				
Name	**Title/Department**	**HICS Title (if applicable)**	**Shift**	**Contact Information**

APPENDIX E – TIMELY RAPID DISCHARGE ASSESSMENT/REPORTING TOOL

PURPOSE

Use this tool to identify and report primary and secondary causes for discharge delays. In a mass casualty incident, a full understanding of the problems associated with timely discharging will help the Rapid Discharge Team/HICS accomplish the following:

- Unit-Based Rapid Discharge Teams will anticipate discharge barriers and issue appropriate instructions/orders to avoid them. These teams will also effectively problem resolve barriers they encounter with pre-designed solutions.
- Physician Involvement will be more productive, as doctors gain a greater understanding of their role in both creating and eliminating barriers to timely discharging.
- Patient Care Unit "Walk Through" Teams will quickly identify how and where barriers are causing discharge delays and communicate this information back to the Rapid Discharge Team/HICS.

INSTRUCTIONS

Rank each Clinical and Non-Clinical Barrier by placing a check mark (✓) in the appropriate column, then complete questions 3 & 4. Create and use extra lines/spaces as needed.

Department/Work Area Name:	**Not a Problem**	**Minor Problem**	**Major Problem**	**Not Sure**
1. Clinical Barriers				
■ Waiting for lab results				
■ Waiting for prescriptions				
■ Weekdays: MD not available to write Discharge Order				
■ Weekends/Holidays/Off-Hours: MD not available to write Discharge Order				
■ Unit activity delays discharge (i.e., codes)				
■ Discharge practices vary widely from unit to unit				
■ Waiting for consulting physicians				
■ Inconsistent discharge team composition				
■ Lack of discharge planning tool in patient charts (i.e., *Intend to Discharge Form*)				

■ Hospital policy requires attending physician to “sign-off” on discharges				
■ Doctors do not usually estimate (and document) date of discharge				
■ Private physicians round late due to their office hour’s conflict with discharge rounds/activity.				
■ Residency education activities (i.e., conflicting with morning discharge activity)				
2. Non-Clinical Barriers				
■ Late notification (to patient) of discharge decision				
■ Patient awaiting transportation or escort home				
■ Patient/family refusing to leave early (or at all)				
■ No assigned waiting area for discharged patients				
■ Inclement weather prevents patient pick-up				
■ Staffing shortage				
■ Patient referral notifications taking a long time				
■ Change of shift issues				
■ Patient awaiting bed assignment at sub-acute care facility				

3. Please list any additional clinical and non-clinical barriers that represent a major problem for timely discharging in your hospital:_____

_____

_____

_____

4. Please rank your top 5 clinical <u>and</u> non-clinical barriers to timely discharging. In the “Solution” column, briefly describe how you plan to address each of the barriers:

BARRIER	SOLUTION
Clinical	
1.	
2.	
3.	
4.	
5.	
Non-Clinical	
1.	
2.	
3.	
4.	
5.	