AMBULANCE DIVERSION (# 5700)

AUTHORITY: California Administrative Code, Title 13, Section 1105 (c): "In the absence of decisive factors to the contrary, ambulance drivers shall transport emergency patients to the most accessible medical facility equipped, staffed, and prepared to receive emergency cases and administer emergency care appropriate to the needs of the patient.

1. **PROTOCOL PHILOSOPHY**

Receiving hospitals may divert patients from their Emergency Departments when certain pre-established conditions exist that negatively and profoundly impact the facility's ability to provide safe patient care. It is the intent of this policy that all hospitals participating in the EMS system abide by equally strict internal procedures for diversion that results in a fair and equitable system.

Ambulance diversion by Basic Emergency Departments shall only occur as the result of circumstances which result in a disruption of essential hospital services. The ultimate goal of this protocol is to ensure patient safety and maximize efficiency during times of over-load.

2. **DIVERSION CATEGORIES** - The Emergency Medical Service system will allow ambulances to be diverted when certain predetermined conditions exist. Diversion may occur partially, for specific types of patients, or completely, for all patients. See #3 for a description of the specific diversion categories. See table at the end of this policy for a summary of diversion categories and actions to be taken.

2.1 **PARTIAL DIVERSION** – Conditions that may necessitate partial diversion are:

CT Failure

Adult Trauma Center Overload

2.2 COMPLETE DIVERSION – Conditions that may necessitate complete diversion.

ED Saturation

Physical Plant Casualty

Facility Critical Patient Overload

2.3 EXCEPTIONS (EXCLUSIONS)- the following patients <u>may not</u> be diverted:

- Obstetric patients.
- Patients with any uncontrollable problem. (*e.g. - unmanageable airway, uncontrolled hemorrhage, unstable cardiopulmonary condition, full arrest etc*.)
- Unstable patients requiring specialized treatment (e.g. burn) only available at certain facilities must be transported to the closest facility with appropriate services, regardless of diversion status
- Unstable patients who in the judgment of the paramedic may experience greater risk by being transported past a hospital on diversion. The patient should be transported to the closest most appropriate facility regardless of the diversion status.

3. **RECEIVING HOSPITAL INTERNAL DIVERSION PLAN** - **Hospital responsibilities prior to requesting diversion** - The hospital's Internal Diversion Plan shall be implemented prior to requesting diversion status.

3.1 All hospitals will adapt the following system-wide diversion criteria definitions

3.1.1 **CT Failure** - When the CT scanner is inoperative, patients demonstrating neurological signs/symptoms of stroke, or acute head injury will be diverted.

3.1.2 **Adult Trauma Center Overload** - when it has been determined that the hospital is unable to meet the criteria for a Level II Trauma Center in Alameda County.

3.1.3 **ED saturation** - The hospital's Emergency Department resources are fully committed to critically and/or severely ill/injured patients and are not available for additional ALS patients.

3.1.4 **Physical Plant Casualty** - A hospital may go on diversion because of a physical plant breakdown (e.g., fire, bomb threat, power outage, etc.) that renders patient care unsafe. A Receiving Hospital or Trauma Center may divert any patient, including CTPs, as deemed necessary by the facility and with the approval of EMS.

3.1.5 **Facility Critical Patient Overload** - when it has been determined that all critical care monitoring capability (including ICU, ER, PAR etc...) has been depleted.

3.2 **Internal Measures to Resolve** - The facility must exhaust all measures to resolve the condition(s), according to its internal diversion plan. These include but are not limited to:

- Increase in department staff
- Increase in physician staff
- Review of attempts by department/ administrative supervisors
- Increase in ancillary staff
- Activation of backup patient care areas
- Cancellation of elective surgical procedures

3.3 Facility authorization - Prior to requesting ambulance diversion, the hospital must obtain authorization from the following:

- Emergency Department supervisor/designee
- Emergency Department physician director/designee
- Senior Administrative Officer on Duty

4. **REQUESTING DIVERSION STATUS – Receiving Hospitals**

4.1 The requesting hospital ED Manager/Designee shall contact ALCO-CMED at 667-7777 and advise the dispatcher that the hospital is requesting ambulance diversion. The hospital must indicate:

- The category (reason)
- The name of the senior administrative officer at the hospital approving the diversion
- The expected duration of the diversion

4.2 The diverting hospital must update ALCO-CMED every two hours regarding its diversion status.

4.3 ALCO-CMED will:

- Initiate a "roll-call" to all receiving hospitals, announcing the hospital's diversion status.
- Notify county emergency ambulance providers and private ambulance providers via telephone to inform them of the diversion.

4.4 If a second hospital in one area (north county or south county with San Leandro Hospital being the cutoff for North county) requests diversion, ALCO will contact the EMS representative on-call. Continuation of the diversion status will be determined by the EMS representative on-call based on dialogue with the affected facilities.

5. **REQUESTING DIVERSION STATUS – Adult Trauma Centers**

5.1 Adult Trauma Centers will adapt the system-wide criteria for diversion – Adult Trauma Centers may divert trauma patients when all resources have been depleted.

5.2 Each Adult Trauma Center shall develop an Internal Trauma Diversion Plan which will be approved by EMS and remain on file at the EMS Agency. This plan is to include but not be limited to policies and procedures for:

- Criteria for Trauma Center diversion
- Initiating Trauma Center diversion
- Canceling of Trauma Center diversion
- Documentation of Trauma diversion

5.3 Procedure for initiating diversion: When the Adult Trauma Center resources have been depleted the Sending Trauma Surgeon will call the Receiving Trauma Surgeon at the opposite Adult Trauma Center with the following information:

- Status of the Trauma Center
- Reason/Reasons for diversion request
- Approximate time needed for trauma diversion

5.4 If the Receiving Trauma Surgeon agrees to accept the patient(s) from trauma diversion the Sending Trauma Surgeon/designee will call ALCO-CMED at 667-7777

5.5 If the Receiving Trauma Surgeon is unable to agree to the trauma diversion the Sending Trauma Surgeon/designee will notify ALCO-CMED. ALCO-CMED will contact the EMS on-call representative with this information.

5.6 When the diverting Trauma Center is able to come off trauma diversion, they will notify the receiving Trauma Center and ALCO-CMED..

5.7 The receiving Trauma Center will forward the medical record number of each patient received during the diversion to the EMS office within 72 hours.

6. **TIME LIMITS OF DIVERSION**:

6.1 In general, a hospital may be on diversion for no more than 6 hours in any 24 hour period. Exceptions will need the approval of the on-call EMS representative.

6.2 **CT Failure, Physical Plant Casualty and Trauma Center Overload:** the hospital should come off diversion as soon as possible once the situation has resolved.

7. **TERMINATING DIVERSION STATUS:**

7.1 The diverting hospital shall notify ALCO-CMED as soon as it is able to remove its diversion status.

7.2 ALCO-CMED will inform all affected hospitals and ambulance providers when the diversion status is terminated.

7.3 EMS Agency staff are available by phone 24 hours per day to assist with solving system related problems. The EMS person on-call can be reached by calling ALCO-CMED at 667-7777.

8. **MONITORING AND REVIEW**

8.1 The diverting facility shall perform an internal review of the diversion and submit a written critique to the EMS Office *within 72 hours* that includes:

- Facility name
- Date of diversion
- Reason for diversion
- Times on and off diversion
- Name of hospital administrator authorizing diversion
- Summary of attempts to mitigate conditions requiring diversion

8.2 Any problems associated with patient care for diverted patients will be submitted to EMS on an Unusual Occurrence report form within 2 weeks.

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Type of Diversion	Maximum time allowed	Condition	Types of patients diverted	Appropriate facilities for diverted patients
● **Partial**				
Computerized Tomography (CT)	Until resolved	CT inoperative	1.Acute head injury 2. CVA (aphasic, dysarthria, one-sided weakness)	1. Nearest Trauma Center 2. Closest ED
Adult Trauma Center Overload	Until resolved	Trauma resources depleted	Critical Trauma Patients	Designated Trauma Center
● **Complete**				
Emergency Department (ED) Saturation	6 hours	Overwhelming volume of patients in ED	All except noted exclusions	Closest appropriate facility
Plant Casualty	Until resolved	Physical plant breakdown	All	Closest appropriate facility
Facility Critical Patient Overload	6 hours	Facility's Critical Care capacity exhausted	All except noted exclusions	Closest appropriate facility

Exclusions	Transport to appropriate facility regardless of diversion status.
OB	Closest most appropriate facility
Unmanageable airway	Closest most appropriate facility
Unstable burns	Closest, most appropriate Burn center,
Direct admits	Designated receiving hospital
Unstable Patients	Closest most appropriate facility