

Diversion Policy (Excerpt)

IMPLEMENTATION

The decision to divert patients is a serious one and needs to be made as collaboration between the emergency department physician on duty, the nursing supervisor, and administration. When available, the chief of staff, the vice president of medical affairs, the medical and surgical department heads, the emergency department director, and the emergency department nurse manager also should be consulted in this decision. Time is of the essence in making this decision; therefore, no unreasonable delays in contacting all personnel should be allowed to delay implementation.

Patient diversion (both EMS and direct admissions) should occur only after the hospital has exhausted all internal mechanisms to avert a diversion, including recruitment of additional staff, utilization of alternative units, delays in elective admissions, etc.

Diversion must be temporary. All hospital personnel need to be notified and make every effort to cooperate during a diversion crisis so that the system may return to normal operation as quickly as possible. It will be the responsibility of the vice president of medical affairs, the vice president of nursing affairs, the chief of staff, and the medical/surgical department heads (or designates of the above) to ensure diversion procedures are followed.

PROCEDURE

1. Identify situations in which a hospital's resources are not available. This identification ideally will occur well in advance of a possible need to divert to prepare alternative arrangements.
2. Diversion only is considered after exhausting all possibilities as outlined in our "bed/telemetry management" policy, e.g., open flex unit; expansion of beds to the post-anesthesia care unit or ambulatory surgery, delaying elective admissions or surgeries, etc.
3. The clinical nurse coordinator (CNC) or nurse director will assign an associate to pull the diversion call list and to immediately telephone all emergency medical service squads and administrative staff listed on the call list the need for diversion. Document date and time diversion initiated.
4. The CNC or bed manager will assign an associate to telephone surrounding hospitals our diversion status and acquire a list of their available beds if needed. A courtesy call also will be made to local nursing homes and to the Appalachian Behavioral Center.
5. Physician offices will be notified of diversion status through the medical staff office. Direct admissions to the hospital will not be accepted during diversion unless those patients either have arrangements made for their transfer by the admitting physician or a bed is available for that category of admission (i.e., telemetry not required, maternity, etc.)
6. The vice president of medical affairs and the surgery department head will evaluate the need to cancel or delay elective surgeries that may take a bed space away from another patient requiring an acute care admission.
7. There will be an ongoing evaluation of bed availability and staffing resources. Diversion will end as soon as possible. The decision again should be a collaborative effort.