

Surge Discharge

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Surge Discharge is an important contributor to the ability of a healthcare facility to accommodate mass casualty patients. It is the total number of current inpatients appropriate for early discharge from the hospital during a disaster in order to make room for incoming patients. This number has been shown to vary substantially between facilities based on their elective admission volumes and may range from less than 15% to 40% or more - contributing significantly to initial surge capacity. A key illustration of this was the night of the October 1 shootings in Las Vegas, Sunrise Hospital was able to discharge 170 patients (representing roughly 25% of their 692 operating beds) which was the largest single contributor to their ability to admit the disaster patients. An exercise involving 46 New York Hospitals in 2013 demonstrated that 32% of patients were appropriate for discharge in case of a specific overwhelming scenario using a Rapid Patient Discharge Tool (RPDT). Studies by Kelen and others suggest that these early discharges are safe for patients in addition to generating significant bed capacity.

Surge discharge is difficult to perform effectively when it is improvised or when rapid discharges are only performed during a disaster. Rapid ability to perform discharges, as in the case of Sunrise, relies on a streamlined daily process involving discharge management and the unit staff to identify and prepare patients for anticipated discharge. These processes contribute significantly to overall flow and effective bed utilization and can contribute to reduced emergency department boarding times. Optimally, this process occurs at all hours so that there is not an issue with night staff not being familiar with the processes. Surge discharges need to be tailored to the demands of the incident – the lowest risk, easiest to discharge patients should be discharged first as others are assessed and moved to a holding area awaiting additional information about the incident demands. This template provides a structure that hospitals can modify to help categorize patients for their process.

Every time a mass casualty incident is declared at the hospital, each inpatient unit should assess available beds and potential discharges according to a standard process established by the hospital. They should also prepare to accept ‘hall boarders’ according to facility plans. As soon as it is clear that the numbers of incoming victims will require surge discharge, this should be communicated to the inpatient units and the discharging of patients started in a structured fashion proceeding from easiest to most difficult discharges depending on the incident demands.

A discharge waiting area can support this process while immediately making the inpatient beds available and is encouraged on a routine basis as a way to open beds while final details are arranged or the patient awaits their transportation. In some cases, a facility may not use a discharge waiting area on a routine basis in which case a location, staffing, and resources should be defined as part of the disaster plan.

When planning for surge discharge, the emergency manager should build off existing bed management systems at the facility. Discharge management, patient placement, nursing supervisors, and others should be engaged to understand how usual processes work and can be augmented (or, in fact, how new daily processes that might improve patient flow could be implemented, benefiting both daily operations as well as disaster operations). This may involve designations of patients likely to be discharged in the next 24h in the electronic health record (EHR), manual tracking, tracking by unit, or other means. The discharge process should be streamlined and delays in the following areas should be anticipated and minimized:

- Prescriptions
- Transportation

- Home health services
- Social services
- Follow up – including additional studies, appointments, and includes chemical dependency and mental health follow up
- Placement in rehabilitation or long-term care facilities

When a disaster occurs, rapid verification of potential discharges should occur between nursing staff and care teams and an expedited process followed to assure that the patient is safely discharged.

Patients that could be discharged may be grouped into three categories:



Easy – patient is at their baseline and can be discharged immediately with paper prescriptions and instructions. They can arrange their own transportation, and/or have family members with them or that can come and pick them up.



More Difficult – the patient must await transportation, prescriptions, or final assistance (e.g. gait training) and should be moved to the discharge waiting area.



Most Difficult – **appropriate for discharge** but have cognitive or physical limitations that require specialized transport or destination (e.g. skilled nursing facility) – these patients will need to be kept on the unit pending further arrangements though may be appropriate to move to a bed in the hall so their room can be used for an incoming disaster-related admission.

Additional patients may be identified by the physician care teams in the ‘most difficult’ category that could be suitable for discharge if outpatient specialty testing can be arranged or other conditions met. The risk / benefit of this should be weighed against the capacity of not only the hospital, but other local hospitals as significant changes in the standard of care should be avoided if local capacity is available and transfers can be arranged. Hospitals may also elect to form a ‘rapid discharge team’ with physician, nursing, social work, bed management, pharmacy, and other personnel that can assess and facilitate additional potential discharges in the ‘most difficult’ category.

Part of the surge discharge process involves an assessment on critical care and stepdown units of patient acuity and potential for transfers to a lower level of care so that critically injured/ill patients can be accommodated. Many institutions have ‘bump lists’ of patients that can safely be moved out of an ICU or who could have their cardiac monitoring discontinued. Depending in the situation, physician and nursing leadership will need to work together to determine if modifications of care standards on units may be needed (e.g. moving stable intubated patients to intermediate care units or changing thresholds for neuro or glucose checks) in order to accommodate the demand.

The outline that follows should serve as a guide for hospitals looking to improve their surge discharge plan and should be tailored and adapted to the services and processes in place at the facility. It can also assist as a paper back-up in case EHR systems are down. In no case should the following be adopted without modification to the specifics of the facility. In all cases, integration with daily practices will assure not only better patient flow on a daily basis, but familiarity with processes and ability to execute the plan in a disaster.

Surge Discharge Actions

1. HICS Inpatient Unit Leader takes responsibility for assuring patient placement and surge discharge activities. This may involve appointing a Discharge Unit Leader depending on the situation / staffing.
2. Unit Charge RN will assess the potential discharges / transfers on their unit in conjunction with hospitalist and house staff and update the Hospital Command Center (HCC) (or Bed Control if the hospital has a centralized patient placement center) regarding their status.
3. When the scope of the incident requires Surge Discharge, this should be communicated to the units and the Discharge Waiting Area opened / alerted and:
4. Unit staff should discharge all ● easy patients and advise HCC / Bed Control
5. Unit staff should move all ■ more difficult patients to the discharge waiting area.
6. If ◆ most difficult patients need to be discharged the Discharge Unit Leader (or designee) should work with the Liaison Officer to determine available transportation, rehabilitation, and SNF resources.
7. Chief Medical Officer should work with the Inpatient Unit Leader to determine whether additional patient movement / discharges are needed and what changes in care / processes may be required to facilitate appropriate care (in conjunction with an assessment of regional hospital capacity to accept transfers)

Intensive Care / Stepdown Transfer Assessment*

Unit: XXX	Bed A	B	C	D	E	F	G	H	I	J	K
Age/Sex											
ICU											
Intubated?											
If yes, possible extubate?											
Potential for d/c in 24h?											
Stable for transfer to stepdown/intermediate?											
Stable for transfer to floor?											
Special needs on transfer?											
If yes, what?											
Stepdown											
Potential immediate d/c?											
Cardiac monitor required?											
Stable for transfer to floor?											

*Templates for each hospital unit should be created with bed numbers that can be rolled up to a hospital-wide snapshot

Medical / Surgical Floor Beds - Unit Assessment for Discharge

1. Charge RN complete this table as soon a disaster alert is announced
2. Contact Hospital Command Center at X-XXXX as soon as completed (or _____ if not opened yet)
3. Report total patient numbers by category (● easy, ■ more difficult, ◆ most difficult) to Hospital Command Center
4. If Surge Discharge is advised, proceed with physician staff to:
 - a. Rapidly discharge all ● (easy discharges) with electronic or paper prescriptions and discharge instructions.
 - b. Move ■ (more difficult discharges) to discharge holding area (located at _____)
 - c. Be prepared to move other patients to hall beds or assist Discharge Unit Leader as required

	Bed A	B	C	D	E	F	G	H	I	J	K
Age/Sex											
Check the appropriate box in the disposition row below											
Not appropriate for early d/c											
● Easy discharge											
■ More difficult discharge											
◆ Most difficult discharge											
Discharge Issues											
Pharmacy / DME issue?											
Transport issue? (insert car, WC, BLS)											
Home health needs? (Insert need – IV, HCA, etc.)											
Social work needs?											
Follow up needs? (including tests, referral, CD / mental health)											
Mobility / gait training? (type?)											
Specialized destination (SNF, rehab, etc.)											
Other issue / delay											

- Easy – patient is at their baseline and can be discharged immediately with paper prescriptions and instructions. They can arrange their own transportation, have family with them or that can come and pick them up.
- Intermediate – patient must await transportation, prescriptions, or final assistance (e.g. gait training for a fracture) and should be moved to the discharge waiting area
- ◆ Difficult – appropriate for discharge but has cognitive or physical limitations that require specialized transport or destination (e.g. skilled nursing facility) they will need to be kept on the unit pending further arrangements though may be appropriate to move to a bed in the hall so their room can be used