County of San Luis Obispo
Public Health Department

Emergency Triage

Standard Operating Procedure

ORIGINAL PROCEDURE

July 2009

REVISED
March 2015
May 2018

AUTHENTICATION

Organization / Name	Date / Signature
County Health Officer Name: *Penny Borenstein, MD*	Date: 5/28/15 Signature: [signature]
Arroyo Grande Community Hospital Name:, *Kenneth Dalebout, CAO*	Date: 6/2/15 Signature: [signature]
French Hospital Medical Center Name: *Daniel Farnum*	Date: 6/4/15 Signature: [signature]
Sierra Vista Regional Medical Center Name: *Joseph DeSchryver., CEO*	Date: 6/1/15 Signature: [signature]
Twin Cities Community Hospital Name: *Mark Lisa, CEO*	Date: 6/4/15 Signature: [signature]
San Luis Ambulance Name: *Joe Piedalue, Operations Director*	Date: 5-28-2015 Signature: [signature]
County of San Luis Obispo Sheriff's Department Name: *Sheriff Ian Parkinson*	Date: 6-2-15 Signature: [signature]
Criminal Justice Administrators Association Name: *Sheriff Ian Parkinson, Chair*	Date: 6-2-15 Signature: [signature]
San Luis Obispo County Fire Chiefs Association Name: *Chief Garret Olson, San Luis Obispo City Fire*	Date: 6/8/2015 Signature: [signature]
CAL FIRE / San Luis Obispo County Fire Name: *Chief Rob Lewin*	Date: 6-2-15 Signature: [signature]
Community Health Centers of the Central Coast Name: *Ronald Castle, CEO*	Date: 6-4-15 Signature: [signature]
Med Stop Urgent Care Name: *Brian Roberts, MD*	Date: 6-2-15 Signature: [signature]
Long Term Care Ombudsman Name: *Karen Jones, Executive Director*	Date: 5/28/15 Signature: Karen Jones
Compass Health, Inc. Name: *Daren Smith, President/CEO*	Date: 5-29-15 Signature: [signature]
Bella Vista Transitional Care Center Name: *Eric Thacker, Operations Manager*	Date: 6/4/15 Signature: [signature]

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DISTRIBUTION

COPY	QUANTITY	LOCATION	DATE
Original	1	County Public Health Department Office File	
Working Copy	1	County Public Health Department Office File	
EOC	3	County OES Office	
Health Care Facilities			
	1	Arroyo Grande Community Hospital	
	1	French Hospital Medical Center	
	1	Sierra Vista Regional Medical Center	
	1	Twin Cities Community Hospital	
	1	Atascadero State Hospital	
	10	Community Health Centers of the Central Coast	
	1 each (9 total)	Urgent Care Facilities	
	1	Long Term Care Ombudsman Office	
	1 each (7 total)	Skilled Nursing Facilities	
Ambulance Services			
	1	Cambria Healthcare District	
	1	San Luis Ambulance Services	
Police Departments			
	1	San Luis Obispo PD	
	1	Arroyo Grande PD	
	1	Morro Bay PD	
	1	Grover Beach PD	
	1	Pismo Beach PD	
	1	Atascadero PD	
	1	Paso Robles PD	
	1	Cal Poly State University PD	
	1	Cuesta College PD	
CHP and Sheriff Department			
	1	California Highway Patrol—SLO Area Office	
	1	Sheriff's Office Headquarters	

COPY	QUANTITY	LOCATION	DATE
City and Community Fire Departments			
	1	Atascadero City FD	
	1	Cambria CSD FD	
	1	Cayucos Fire Protection District	
	1	Diablo Canyon Power Plant FD	
	1	Five Cities Fire Authority	
	1	Morro Bay FD	
	1	Paso Robles Department of Emergency Services	
	1	San Luis Obispo City FD	
	1	San Miguel CSD FD	
	1	Santa Margarita FD	
	1	Templeton CSD FD	
CAL FIRE / County of San Luis Obispo Fire			
	40	CAL FIRE / SLO County Fire Department	

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PART ONE – OVERVIEW

1. INTRODUCTION

1.1 Objective

1.1.1 Provide San Luis Obispo County emergency services personnel and health care providers guidance for management of increased patient volume This procedure does not supersede the use of Simple Triage and Rapid Treatment (START) System triage (or other routine triage system) by field response personnel.

1.1.2 Describe the interagency coordination between the Public Health Department, Law Enforcement Agencies (LEA), Hospitals, Fire Departments, Ambulance Providers, Long Term Care facilities and Outpatient Facilities during an emergency.

1.1.3 Define Public Health Emergency Triage and establish procedures that can be used throughout the healthcare continuum to manage an increased patient volume and scarce resources during an emergency.

1.1.4 Provide for the safety and welfare of affected individuals and health care providers during an emergency.

1.1.5 Provide procedure for triage to be utilized in the identification of persons who might have a communicable disease of public health importance, separate them from others to reduce the risk of disease transmission, and identify the type of care required (i.e., homecare, hospitalization, or government authorized alternate site care).

1.2 Background

1.2.1 During the peak of an emergency, hospital emergency departments and outpatient facilities may be overwhelmed with patients seeking care.

1.2.2 The County Health Officer has the authority and responsibility to take whatever steps deemed necessary to maintain the health of the community.

1.2.3 This procedure was prepared by the County of San Luis Obispo Public Health Department in coordination with the County Office of Emergency Services, representatives of hospitals, outpatient facilities, law enforcement agencies, ambulance providers, long term care facilities and fire agencies.

1.3 Authorities and References

1.3.1 California Health and Safety Code, Section 120175: *"Each Health Officer knowing or having reason to believe that any case of the diseases made reportable by regulation of the department, or any other contagious, infectious or communicable disease exists, or has recently existed, within the territory under his or her jurisdiction, shall take measures*

as may be necessary to prevent the spread of disease or occurrence of additional cases."

1.3.2 San Luis Obispo County EMSA Policy No. 210, Multi-Casualty Incident Response Plan

2. CONCEPT OF OPERATIONS

2.1 Scope

This procedure is designed to be a companion document to the County of San Luis Obispo Public Health Department Surge Capacity SOP and the County of San Luis Obispo Isolation and Quarantine SOP, and will provide guidance for Emergency Medical Services (EMS), hospital and other healthcare providers in determining the appropriate location and level of care for patients.

This procedure does not supersede the use of Simple Triage and Rapid Treatment (START) System triage (or other routine triage system) by field response personnel.

2.2 Definitions

2.2.1 Public Health Emergency

An occurrence or imminent threat of an illness or health condition, caused by bio terrorism, epidemic or communicable disease of public health importance disease, or (a) novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents or permanent or long-term disability.

2.2.2 Ambulatory Care

Medical care including diagnosis, observation, treatment and rehabilitation that is provided on an outpatient basis. Facilities providing ambulatory care include doctor's offices, community clinics, urgent care centers, and ambulatory surgery centers.

2.2.3 Disposition

Determination by health care professional, in pre-hospital, ambulatory care, or hospital setting, of patient's ability to stay home or return home for self-care, receive care from ambulatory care or alternate care facility, or be evaluated at a hospital.

2.2.4 Disposition Home

Patient is able to stay home or return home for self-care and/or has family or other support for care, including oral hydration, antipyretics, and oral antibiotics if needed and available. Patient and caregivers are instructed on personal protective equipment, isolation, and disinfection procedures. Patients will be contacted at regular intervals by county staff, to include Public Health Department and Department of Social Services staff.

2.2.5 Disposition Ambulatory Care or Alternate Care Facility

Patient requires intravenous or oral hydration, intravenous or oral antibiotics, oxygen therapy, specialized medical services, access to a health care practitioner and/or patient is unable to care for self at home or does not have family or others to provide basic care ("board and care"). Patients will be cared for in a group setting outside of a hospital campus. Location will be determined by the Public Health Department and based on incident type and available resources, e.g. motel, congregate care shelter.

2.2.6 Disposition Hospital

Patient requires hospital admission in order to provide intensive or high level medical supportive care. These patients may require ventilator support, critical care, ongoing radiological or laboratory monitoring in addition to basic medical care.

2.2.7 Disposition Designated Hospice Facility

Patient requires hospice/supportive care to include fluids, oxygen, pain relief, etc. Patients will be cared for either at home, in a special care facility or at another facility designated by the Public Health Department.

2.3 Responsibilities

2.3.1 *County Health Officer or designee shall:*

2.3.1.1 Direct all aspects of community health including but not limited to isolation, quarantine and prophylaxis.

2.3.1.2 Facilitate, through coordination with the local Emergency Medical Services Agency (EMSA) Medical Director and State Emergency Medical Services Authority, waivers to the Health and Safety Code Division 2.5 and or California Code of Regulations Title 22, Division 9: Prehospital Emergency Medical Services to allow for modifications to local EMSA policies and procedures, including disaster triage and alternate destination directions.

2.3.1.3 Work with Medical Health Operational Area Coordinator (MHOAC) to obtain resources for distribution and/or use during a surge event.

2.3.1.4 Communicate situation and necessary actions to all healthcare providers, community partners, Regional Disaster Medical Health Coordinator (RDMHC) Program, California Department of Public Health, State Emergency Medical Services Authority and the general public.

2.3.2 Local Area Hospitals Shall:

2.3.2.1 Provide optimal care to the greatest number of patients in the most expeditious manner possible.

2.3.2.2 Coordinate with the Public Health Department on disposition of patients outside of the hospital setting, i.e. home, Urgent Care, hospice, etc.

2.3.2.2.1 Utilize standardized triage procedures contained within this SOP to determine patient disposition.

2.3.2.3 Utilize Isolation and Quarantine SOP and follow PPE recommendations provided by the County Health Officer.

2.3.3 Law Enforcement Agencies Shall:

2.3.3.1 Provide security and traffic control to all areas in which care is being provided.

2.3.3.2 Utilize Isolation and Quarantine SOP and follow PPE recommendations provided by the County Health Officer.

2.3.4 Emergency Medical Services (EMS) Providers Shall:

2.3.4.1 Provide field triage and transportation to appropriate facilities.

2.3.4.1.1 Facilities may include hospitals or other locations designated by the Public Health Department (these may include government authorized alternate care sites and designated hospice facilities if available).

2.3.4.1.2 Triage may include providing homecare instructions and not transportation.

2.3.4.2 Utilize Isolation and Quarantine SOP and follow PPE recommendations provided by the County Health Officer.

2.3.5 Ambulatory Care Providers Shall:

2.3.5.1 Consult with Public Health Department to determine appropriate disposition for patients.

2.3.5.2 Prepare for receipt and care of patients triaged to facility as appropriate.

2.3.5.3 Provide patient care as appropriate within capability of facility utilizing standardized triage procedures.

2.3.5.4 Utilize Isolation and Quarantine SOP and follow PPE recommendations provided by the County Health Officer.

2.3.6 Long Term Care Facilities Shall:

2.3.6.1 Provide care for residents within the facility unless patient is triaged utilizing Long Term Care Facility Triage Checklist (Attachment 8) for transfer by the County Health Officer to an alternate location.

2.3.6.2 Utilize Isolation and Quarantine SOP and follow PPE recommendations provided by the County Health Officer.

2.3.6.3 Communicate with the Public Health Department, via Long Term Care Ombudsmen, about current status as well as resource needs and availability.

2.3.6.4 Prepare for receipt and care of patients triaged to long term care facilities as appropriate.

2.3.7 Dispatch Centers (MedCom and CAL FIRE Emergency Command Center):

2.3.7.1 Notify Emergency Medical Services providers, local law enforcement agencies, and fire agencies of current situational status.

2.3.7.2 Provide Health Officer directives to Emergency Medical Services providers, LEA, and fire agencies.

3. EQUIPMENT

Equipment for triage of patients includes signage (Attachment 9), patient disposition record (Attachments 1-4), vital signs monitoring equipment (thermometer, blood pressure cuff, stethoscope), masks for patients, tissues, disposal bags, personal protective equipment for staff (gloves, masks and/or respirators, gowns) and hand hygiene supplies (hand sanitizer and/or soap and running water).

4. TRAINING

4.1 The Public Health Department will develop training materials on these procedures and provide initial training to Public Health Department staff, County OES, and Sheriff's Office Watch Commanders.

4.2 The Hospitals, Ambulatory Care Facilities, Long Term Care Facilities, Emergency Medical Services Providers, Law Enforcement Agencies, and Fire Agencies will provide training to their agency personnel, as appropriate. The Public Health Department will provide assistance in these trainings upon request.

5. PROCEDURE REVIEW AND REVISION

This plan will be reviewed and updated every three years or as needed by the Public Health Department. Revisions will be based on after action reports and quality improvement process reviews completed following significant trainings, drills, exercises and actual events. The County Health Officer, Public Health Emergency Preparedness Program Manager or the Emergency Medical Services Division Manager will determine whether a particular training, drill, exercise or actual event was significant, and, therefore requires an after action report and/or quality improvement process review.

PART TWO – CHECKLISTS

CHECKLIST 1 – **COUNTY OF SAN LUIS OBISPO PUBLIC HEALTH DEPARTMENT**

CHECKLIST 2 – **HOSPITALS**

CHECKLIST 3 – **AMBULATORY CARE FACILITIES**

CHECKLIST 4 – **LONG TERM CARE FACILITIES**

CHECKLIST 5 – **EMERGENCY MEDICAL SERVICES PROVIDERS**

CHECKLIST 6 - **LAW ENFORCEMENT AGENCIES**

CHECKLIST 7 – **SHERIFF'S OFFICE WATCH COMMANDER (WC)**

CHECKLIST 8 – **CAL FIRE EMERGENCY COMMAND CENTER (ECC)**

CHECKLIST 1: PUBLIC HEALTH DEPARTMENT

1. ACTIVATION

_____ 1.1 Activate Triage SOP and communicate activation to all agencies via Sheriff's Office Watch Commander.

_____ 1.2 If communicable disease outbreak, develop, refine and communicate "Case Definition".

_____ 1.3 Consider activation and staffing of County Health Agency Department Operations Center (CHADOC).

_____ 1.3.1 Request agency representative from Long Term Care Ombudsman's Office for coordination with long term care facilities.

_____ 1.4 Establish communications with hospitals via ReddiNet and provide ongoing situation reports.

_____ 1.5 Establish communication with Regional Disaster Medical Health Coordinator (RDMHC) Program, California Department of Public Health (CDPH) and State Emergency Medical Services Authority (EMS Authority) and complete a Situation Report (see CDPH Emergency Operations Manual [EOM]).

2. RESPONSE

_____ 2.1 Assess ability of non-impacted hospitals to receive transfer patients and work with ambulance providers to accomplish transfers.

_____ 2.2 If communicable disease outbreak, convey Case Definition to all healthcare providers.

_____ 2.3 Customize Triage Patient Disposition Record and Patient Disposition Instructions found in Attachments 1-3.

_____ 2.3.1 In Pandemic Influenza, customize Pandemic Influenza Triage Guidelines found in Attachment 4. Use Pan Flu Triage Guidelines in place of Attachments 1-3.

_____ 2.4 Direct hospitals, ambulatory care facilities, and long term care facilities to utilize Triage Patient Disposition Record and Patient Disposition Instructions found in Attachments 1-3 or Pandemic Influenza Triage Guidelines founds in Attachment 4.

_____ 2.4.1 Utilize Public Health Department fax server at 805-781-5543 and ReddiNet to communicate this direction.

_____ 2.5 County Health Officer (CHO) to proclaim a local health emergency.

_____ 2.6 CHO requests Board of Supervisors proclaim a Local emergency.

_____ 2.7 Designate Government Authorized Alternate Care Site (GAACS) location as available and appropriate.

_____ 2.8 CHO and Emergency Medical Services Agency (EMSA) Medical Director request Emergency Medical Services Authority or Governor to waive regulations in the Health and Safety Code Division 2.5 and or California Code of Regulations Tittle 22, Division 9: Prehospital Emergency Medical Services to allow for modifications to local EMSA policies and procedures, including disaster triage and alternate destination directions.

_____ 2.8.1 Review and determine, as necessary, disaster triage criteria in the Triage Patient Disposition Records (see Attachment 1 and 2).

_____ 2.8.2 Develop destination directions to identify where patients will be transported, including non-transport.

_____ 2.8.3 Communicate with MedCom to notify EMS providers of modifications to local EMSA policies and procedures, including disaster triage and alternate destination directions.

_____ 2.9 Communicate self-triage procedures and guidelines (including Pandemic Influenza home care guidance in Attachment 7 if applicable) to healthcare providers and the general public via:

_____ 2.9.1 Media Releases

_____ 2.9.2 Website updates and social media posts

_____ 2.9.3 Public Health Information Line (PHIL) messages

_____ 2.9.4 Provider Alerts

_____ 2.10 Coordinate and communicate with healthcare providers and RDMHC Program.

_____ 2.10.1 Receive and fill resource requests from healthcare providers.

_____ 2.10.2 Request situation status information from healthcare providers.

_____ 2.10.3 Disseminate situational status information to healthcare providers

_____ 2.10.4 Communicate with and provide situation reports to RDMHC Program as appropriate.

______ 2.11 Communicate with Long Term Care Facilities via Long Term Care Ombudsman Office.

______ 2.11.1 Provide Long Term Care Facility Triage Checklist to all facilities (see Attachment 8).

______ 2.11.2 Authorize transfer of patients to higher level of care if appropriate and space available.

______ 2.11.3 Authorize transfer of triaged skilled nursing, intermediate care and residential care facility patients to home or a facility providing different level of care if deemed appropriate.

______ 2.11.4 Request waiver for non-allowed medical treatments to be provided at residential care facilities.

______ 2.12 Review admission status of all long term care facilities.

______ 2.12.1 Restrict closures of skilled nursing facilities.

______ 2.13 Customize Telephone Triage Guidelines (see Attachment 5) for use by Public Health Department to triage clients and individuals requesting assistance.

______ 2.13.1 Telephone Triage Guidelines may also be used to screen individuals isolated or quarantined based on contact tracing.

______ 2.13.2 Perform health screenings at regular intervals of all patients triaged to home setting.

______ 2.13.3 Staff triage phone lines with County personnel or medical volunteers.

______ 2.14 Facilitate expanding scope of practice for licensed healthcare workers as outlined in Surge Capacity SOP.

______ 2.15 Receive notification via ReddiNet or fax from Hospitals, EMS providers, and ambulatory care facilities of all patients that have been triaged to home settings.

3. DEMOBILIZATION

______ 3.1 Develop Demobilization Plan

______ 3.2 Declare end of emergency.

_____ 3.3 Communicate resumption of normal operations to Public Health Department staff, hospitals, EMS providers, MedCom, community health care partners and RDMHC Program.

_____ 3.4 Suspend field triage and notify EMS providers of suspension.

_____ 3.5 Demobilize ACSs as appropriate.

_____ 3.6 Debrief staff.

_____ 3.7 Develop After Action Report and Corrective Action Plan.

CHECKLIST 2: HOSPITALS

1. ACTIVATION

_____ 1.1 Designate specific locations on the hospital campus for patient triage.

_____ 1.1.1 Institute appropriate protective measures such as respiratory and hand hygiene.

_____ 1.1.1.1 Post signs at entrances and waiting areas.

_____ 1.1.1.2 Provide masks, tissues, hand hygiene supplies, disposal receptacles.

_____ 1.1.2 If necessary, designate separate waiting triage evaluation areas for persons with symptoms.

_____ 1.1.3 Review Triage Patient Disposition Record and Instructions found in Attachments 1-3.

_____ 1.1.3.1 In pan flu incident, review Pan Flu Triage Guidelines worksheets found in Attachment 4.

_____ 1.2 Assign a "Triage Coordinator" to manage patient flow, including deferring or referring patients who do not require emergency care.

_____ 1.3 Identify area on hospital campus to care for non-urgent patients that cannot be referred for treatment elsewhere.

_____ 1.4 Identify logistical support and operations needs for facility.

2. RESPONSE

_____ 2.1 Institute standardized triage procedures utilizing Triage Patient Disposition Record and Instructions found in Attachments 1-3.

_____ 2.1.1 In a pan flu incident, utilize Pan Flu Triage Guidelines worksheets found in Attachment 4.

_____ 2.2 Activate designated triage evaluation and waiting area for persons with symptoms.

_____ 2.3 Post security at main entrance and designated areas as necessary.

_____ 2.3.1 Lock down all other entrances to the facility.

_____ 2.4 Post signs at all entrances directing patients and staff to appropriate areas.

_____ 2.4.1 Sign templates can be found in Attachment 9.

_____ 2.5 Institute (reinforce) appropriate protective measures such as respiratory and hand hygiene.

_____ 2.5.1 Post signs at entrances and waiting areas.

_____ 2.5.2 Provide masks, tissues, hand hygiene supplies, disposal receptacles.

_____ 2.6 Identify patients who need emergency care and those who can be referred to a medical provider, ambulatory care facility or home care.

_____ 2.6.1 Notify Public Health Department via ReddiNet or fax at 805-781-5543 of any persons who have been triaged to a home setting.

_____ 2.7 Refer patients who call in for medical advice to Public Health Information Line (PHIL): 805-788-2903.

3. DEMOBILIZATION

_____ 3.1 Notify all agencies that hospital is returning to normal operations.

_____ 3.2 Implement Recovery Plan

_____ 3.2.1 Recover all equipment and restore to pre-emergency location and condition.

_____ 3.2.2 Repair damaged equipment and ensure repairs are charged to the incident.

_____ 3.3 Collect all incident records and complete an After Action Report/Improvement Plan.

CHECKLIST 3: AMBULATORY CARE FACILITIES

1. ACTIVATION

_____ 1.1 Develop strategy for triage during an emergency.

_____ 1.1.1 Designate specific locations internal and external to the facility for patient triage.

_____ 1.1.2 Assure availability of Personal Protective Equipment (PPE) and institute appropriate protective measures such as respiratory and hand hygiene.

_____ 1.1.2.1 Post signs at entrances and waiting areas.

_____ 1.1.2.2 Provide masks, tissues, hand hygiene supplies, disposal receptacles.

_____ 1.1.3 If necessary, designate separate triage evaluation and waiting areas for persons with symptoms.

_____ 1.1.3.1 Triage Patient Disposition Record and Instructions found in Attachments 1-3.

_____ 1.1.3.2 In pan flu incident, review Pan Flu Triage Guidelines worksheets found in Attachment 4.

_____ 1.1.3.3 Review telephone Triage Guidelines found in Attachment 5.

_____ 1.2 Assign a “Triage Coordinator” to manage patient flow, including deferring or referring patients who do not require immediate care.

_____ 1.3 Identify logistical support and operations needs for facility

2. RESPONSE

_____ 2.1 Institute standardized triage procedures utilizing Triage Patient Disposition Record and Instructions found in Attachments 1-3.

_____ 2.1.1 Notify Public Health Department that facility is instituting triage procedures.

_____ 2.1.2 In pan flu incident, utilize Pan Flu Triage Guidelines worksheets found in Attachment 4.

_____ 2.2 Activate designated triage evaluation and waiting area for persons with symptoms.

_____ 2.3 Post security at main entrance and other areas as necessary.

_____ 2.3.1 Lock down all other entrances to the facility.

_____ 2.4 Post signs at all entrances directing patients and staff to appropriate entrance or area.

_____ 2.4.1 Sign templates can be found in Attachment 9.

_____ 2.5 Institute (reinforce) appropriate protective measures such as respiratory and hand hygiene.

_____ 2.5.1 Post signs at entrances and waiting areas.

_____ 2.5.2 Provide masks, tissues, hand hygiene supplies, disposal receptacles.

_____ 2.6 Identify patients who can be treated at your facility, those who must be referred to a hospital, those that can be referred to a different ambulatory care facility or those who can be triaged home.

_____ 2.6.1 Notify Public Health Department via fax at 805-781-5543 of any persons who have been triaged to a home setting.

_____ 2.7 Utilize phone triage (see attachment 5) to identify patients that can be treated at your facility and those who should be seen at a facility with a higher level of care (i.e., hospital triage center), those that can be referred to a different ambulatory care facility or those who can be triaged home.

_____ 2.8 Activate identified area within facility to care for non-urgent patients that cannot be referred for treatment elsewhere.

3. DEMOBILIZATION

_____ 3.1 Notify all agencies that facility is returning to normal operations.

_____ 3.2 Implement Recovery Plan

_____ 3.2.1 Recover all equipment and restore to pre-emergency location and condition.

_____ 3.2.2 Repair damaged equipment and ensure repairs are charged to the incident.

_____ 3.2.3 Replace missing batteries and charge to the incident

_____ 3.3 Collect all incident records and complete an After Action Report/Improvement Plan.

CHECKLIST 4: LONG TERM CARE FACILITIES

1. ACTIVATION

_____ 1.1 If communicable disease outbreak, develop and implement strategy for isolation/cohorting of possible residents with communicable disease of public health importance.

_____ 1.1.1 Train staff on procedures for care of residents during a communicable disease of public health importance.

_____ 1.1.2 Consider resident and visitor education.

_____ 1.1.3 Choose specific locations within the facility to isolate/cohort residents with symptoms consistent with the communicable disease of public health importance case definition.

_____ 1.1.4 Institute appropriate protective measures such as respiratory and hand hygiene.

_____ 1.1.4.1 Post signs at entrances and waiting areas.

_____ 1.1.4.2 Provide masks, tissues, hand hygiene supplies, disposal receptacles.

_____ 1.2 Review Triage Patient Disposition Record and Instructions found in Attachments 1-3.

_____ 1.2.1 In pan flu incident, review Pan Flu Triage Guidelines worksheets found in Attachment 4.

_____ 1.2.2 Review telephone Triage Guidelines found in Attachment 5.

_____ 1.3 Assess residents' care needs to determine:

_____ 1.3.1 Residents who could be discharged to care of family member.

_____ 1.3.1.1 Provide Pan Flu home care guidance found in Attachment 7 if applicable.

_____ 1.3.2 Notify Public Health Department via fax at 805-781-5543 of any persons who have been triaged to a home setting.

_____ 1.3.3 Residents who must continue to be cared for in skilled nursing, intermediate care or residential care facility.

_____ 1.4 Identify logistical support and operations needs for facility.

2. RESPONSE

_____ 2.1 Institute standardized procedures for identifying residents with symptoms meeting the communicable disease of public health importance case definition, if applicable.

_____ 2.2 Determine need to institute cohorting/isolation procedures.

_____ 2.3 Notify Public Health Department when resident(s) have been diagnosed with the communicable disease of public health importance.

_____ 2.4 Educate staff, residents, and visitors on procedures.

_____ 2.5 Post security at main entrance and other locations as necessary.

_____ 2.5.1 Lock down all other entrances to the facility.

_____ 2.6 Post signs at all entrances directing patients and staff to appropriate entrance.

_____ 2.6.1 Sign templates can be found in Attachment 9.

_____ 2.7 Institute (reinforce) appropriate protective measures such as respiratory and hand hygiene.

_____ 2.7.1 Post signs at entrances and waiting areas.

_____ 2.7.2 Provide masks, tissues, hand hygiene supplies, disposal receptacles.

_____ 2.8 Reassess residents' care needs to determine:

_____ 2.8.1 Residents who could be discharged to care of family.

_____ 2.8.1.1 Provide Pan Flu home care guidance found in Attachment 7 if applicable.

_____ 2.8.2 Notify Public Health Department via fax at 805-781-5543 of any persons who have been triaged to a home setting.

_____ 2.8.3 Residents who must continue to be cared for in skilled nursing facility, intermediate care or residential care facility.

3. DEMOBILIZATION

_____ 3.1 Notify all agencies that facility is returning to normal operations.

_____ 3.2 Implement Recovery Plan

_____ 3.2.1 Recover all equipment and restore to pre-emergency location and condition.

_____ 3.2.2 Repair damaged equipment and ensure repairs are charged to the incident.

_____ 3.3 Collect all incident records and complete an After Action Report/Improvement Plan.

CHECKLIST 5: EMERGENCY MEDICAL SERVICE PROVIDERS

1. ACTIVATION

_____ 1.1 Review Triage Patient Disposition Record and Instructions found in Attachments 1-3.

_____ 1.1.1 In pan flu incident, review Pan Flu Triage Guidelines worksheets found in Attachment 4.

_____ 1.2 Educate staff on triage record and potential of alternate destination or non-transport.

2. RESPONSE

_____ 2.1 Receive initial notification

_____ 2.1.1 Ambulance Transport Providers: from Sheriff's Watch Commander

_____ 2.1.2 Non-transport EMS: from CAL FIRE Emergency Command Center (ECC)

_____ 2.2 Utilize appropriate PPE in accordance with Public Health Department directive.

_____ 2.3 Assist hospitals with triage at their facility if requested by MHOAC.

_____ 2.4 Perform field triage and transport to appropriate facilities in accordance with Public Health Department directive.

_____ 2.4.1 Triage patient to home as appropriate and fax Triage Patient Disposition (Attachment 1, 2, or 4) to the Public Health Department at 805-781-5543.

_____ 2.4.1.1 Provide Pan Flu home care guidance found in Attachment 7 if applicable.

_____ 2.5 Perform increased scope of practice in accordance with County Health Officer and EMSA Medical Director directive.

_____ 2.6 Communicate with and provide situation status information to Public Health Department/MHOAC.

3. DEMOBILIZATION

_____ 3.1 Notify all agencies that operations are returning to normal.

_____ 3.2 Implement Recovery Plan

_____ 3.2.1 Recover all equipment and restore to pre-emergency location and condition.

_____ 3.2.2 Repair damaged equipment and ensure repairs are charged to the incident.

_____ 3.3 Collect all incident records and complete an After Action Report/Improvement Plan.

CHECKLIST 6: LAW ENFORCEMENT AGENCIES

1. ACTIVATION AND RESPONSE

_____ 1.1 Receive notification from dispatch/MedCom.

_____ 1.2 Utilize appropriate PPE in accordance with Public Health Department directive.

_____ 1.3 Assist in securing healthcare facility perimeters as requested.

_____ 1.4 Assist in locking down healthcare facilities as requested.

_____ 1.5 Provide traffic control to healthcare facilities as requested.

2. DEMOBILIZATION

_____ 2.1 Notify all agencies that operations are returning to normal.

_____ 2.2 Implement Recovery Plan

_____ 2.2.1 Recover all equipment and restore to pre-emergency location and condition.

_____ 2.2.2 Repair damaged equipment and ensure repairs are charged to the incident.

_____ 2.3 Collect all incident records and complete an After Action Report/Improvement Plan.

CHECKLIST 7: SHERIFF'S OFFICE WATCH COMMANDER

1. ACTIVATION AND RESPONSE

_____ 1.1 Receive notification regarding Public Health Emergency from County Office of Emergency Services or County Health Officer.

_____ 1.2 Coordinate Operational Area law enforcement response

_____ 1.2.1 Provide situational status information to law enforcement agencies
_____ 1.2.2 Coordinate law enforcement resource allocation

_____ 1.3 Direct MedCom to notify Emergency Medical Service (EMS) Providers and Cal Fire Emergency Communication Center (ECC) of current situation.

_____ 1.4 Direct MedCom to coordinate with Public Health Department/MHOAC on providing situation updates and directives to EMS Providers.

2. DEMOBILIZATION

_____ 2.1 Notify all agencies that operations are returning to normal.

_____ 2.2 Collect all incident records and complete an After Action Report/Improvement Plan.

CHECKLIST 8: CAL FIRE EMERGENCY COMMAND CENTER

1. ACTIVATION AND RESPONSE

_____ 1.1 Receive notification regarding Public Health Emergency from Sheriff's Office Watch Commander.

_____ 1.2 Notify all Fire Departments of current situation.

_____ 1.3 Maintain communication with MedCom and/or Public Health Department/MHOAC to provide situation updates.

2. DEMOBILIZATION

_____ 2.1 Notify all agencies that operations are returning to normal.

_____ 2.2 Implement Recovery Plan

_____ 2.2.1 Recover all equipment and restore to pre-emergency location and condition.

_____ 2.2.2 Repair damaged equipment and ensure repairs are charged to the incident.

_____ 2.3 Collect all incident records and complete an After Action Report/Improvement Plan.

PART THREE – ATTACHMENTS

Attachment 1 TRIAGE PATIENT DISPOSITION RECORD: Adults and Teens

Attachment 2 TRIAGE PATIENT DISPOSITION RECORD: Children

Attachment 3 TRIAGE PATIENT DISPOSITION RECORD INSTRUCTIONS

Attachment 4 PANDEMIC FLU TRIAGE GUIDELINES

Attachment 5 TELEPHONE TRIAGE GUIDELINES

Attachment 6 COMMUNICABLE DISEASE HOME CARE INSTRUCTIONS TEMPLATE

Attachment 7 PANDEMIC INFLUENZA HOME CARE INSTRUCTIONS

Attachment 8 LONG TERM CARE FACILITY TRIAGE CHECKLIST

Attachment 9 TEMPLATES FOR SIGNAGE

ATTACHMENT 1: TRIAGE PATIENT DISPOSITION RECORD (ADULTS AND TEENS)

For Use with ADULTS AND TEENS > 14 years of age

This patient may have a communicable disease!

(Consider using gloves, eye protection, respirator/mask, and/or gown if close contact)

Patient Information (Section 1):				
Name:		Phone #		Alt Phone #
Address:		Contact Person: Relationship:		Contact #
DOB:	Age:	Date:	Time:	Person Filling Out Form:

Symptoms: Check all that apply:

❑ Fever >38.3ºC (101ºF) and ❑ sore throat ❑ cough ❑ shortness of breath ❑ weakness ❑ muscle pain ❑ abdominal symptoms ❑ conjunctivitis ❑ nasal congestion ❑ chills ❑ headache ❑ confusion ❑ drowsiness❑ other ____________

Does Patient meet Case Definition (defined by Public Health Department)? ❑ no ❑ yes

PPE:	Patient: Mask on presentation ❑	Staff: Respiratory and Universal / Standard Precautions❑

Patient History:

Patient under physician care?
❑ no ❑ yes, for what?_____________________________

Has patient had contact with person/s with same symptoms? ❑ no ❑ yes, when (mm/dd/yyyy)____________	Lives ❑ at home ❑ alone? ❑ Caregiver available? ❑ Facility ______________ ❑ other_______________
Comorbid conditions:	❑ Congestive heart failure ❑ diabetes ❑ hematologic/blood abnormality ❑ renal failure/dialysis ❑ pregnancy ❑ Asthma ❑ liver disease ❑ immunosuppression ❑ other ____________________

Calculation to determine disposition

Characteristic	Points assigned	Points
Comorbid condition	+20	
Physical exam:		
Altered mental status	+20	
Respirations <10 or >30	+20	
Systolic blood pressure <90	+20	
Pulse >125	+20	
Capillary refill >2 secs	+20	
	Total	

Total Score: ≥80 = evaluation at hospital, <80 but needs to be seen by medical professional = referral to ambulatory care facility or alternate care facility (if available), <80 able to care for self = home, ≥80 but poor prognosis = home or designated hospice facility (if available)

Disposition: ❑ Home ❑ Ambulatory Care Facility or Alternate Care Facility (if available) ❑ Hospital ❑ Designated Hospice Facility (if available)

Case Definition: ____

Definition to be provided at time of emergency by Public Health Department

Public Health Department Fax # 805-781-5543

ATTACHMENT 2: TRIAGE PATIENT DISPOSITION RECORD (CHILDREN)

For Use with CHILDREN < 14 years of age
This patient may have a communicable disease!
(Consider using gloves, eye protection, respirator, and/or gown if close contact)

Patient Information (Section 1):				
Name:		Phone #		Alt Phone #
Address:		Contact Person: Relationship:		Contact #
DOB:	Age:	Date:	Time:	Person Filling Out Form:

Symptoms: Check all that apply (Section 2):
❑ Fever >38.3ºC (101ºF) and ❑ sore throat ❑ cough ❑ shortness of breath ❑ weakness ❑ muscle pain ❑ abdominal symptoms ❑ conjunctivitis ❑ nasal congestion ❑ chills ❑ headache ❑ confusion ❑ drowsiness❑ other ____________
Does Patient meet Case Definition (defined by Public Health Department)? ❑ no ❑ yes

Patient History (Section 3):	
Patient under physician care? ❑ no ❑ yes, for what?____________________________	
Has patient had contact with person/s with same symptoms? ❑ no ❑ yes, when (mm/dd/yyyy)____________	Lives ❑ at home ❑ Caregiver available? ❑ Facility ______________ ❑ other________________
Comorbid conditions:	❑ Congestive heart failure ❑ diabetes ❑ hematologic/blood abnormality ❑ renal failure/dialysis ❑ Asthma ❑ liver disease ❑ immunosuppression ❑ other ____________________

Calculation to determine disposition (Section 4):

Characteristic	Points assigned	Points
Comorbid condition	+20	
Physical exam:		
Fever and age < 2months	+20	
Respirations: Infant >60 Toddler >40 School Age under 14 years >30	+20	
Hot and dry, duskiness, pallor with or without rash, listless, irritable, and/or inconsolable	+20	
Systolic Blood Pressure: < 8 years of age: <80 >8 years of age: <90	+20	
Chest retractions, nasal flaring, grunting	+20	
	Total	

Total Score: ≥80 = evaluation at hospital, <80 but needs to be seen by medical professional = referral to ambulatory care facility or alternate care facility (if available), <80 able to be cared for by guardian = home, ≥80 but poor prognosis = home or designated hospice facility (if available) ≥80

Disposition: ❑ Home ❑ Ambulatory Care Facility or Alternate Care Facility (if available) ❑ Hospital ❑ Designated Hospice Facility (if available)

Case Definition:____
Definition to be provided at time of emergency by Public Health Department
Public Health Department Fax # 805-781-5543

ATTACHMENT 3: TRIAGE PATIENT DISPOSITION RECORD INSTRUCTIONS

Section 1:

Complete with patient's personal information.

Section 2:

Check all of patient's symptoms and determine if patient meets case definition. Case definition will be defined and provided by Public Health Department at time of Public Health Emergency and activation of Triage Standard Operating Procedure.

Section 3:

Complete with patient's history including comorbid conditions. Comorbid conditions are important to determining disposition of patient. Include if patient has been in contact with person(s) with similar symptoms and if caregiver is available at home or facility.

Section 4:

Adults and teens >14 years of age: calculation to determine disposition

Characteristics	Points Assigned
Comorbid condition	+ 20
Physical exam	+ 20
Altered mental status	+ 20
Respirations <10 or >30	+ 20
Systolic BP <90	+ 20
Pulse >125	+ 20
Capillary refill > 2 secs	+ 20

Children 14 years of age and younger: calculation to determine disposition

Characteristics	Points Assigned
Comorbid condition	+ 20
Fever and < 2months	+ 20
Respirations:	
Infant >60	+ 20
Toddler >40	+ 20
School Age under 14 years >30	+ 20
Hot & dry, duskiness, pallor with or without rash, listless, irritable, and/or inconsolable	+ 20
Systolic Blood Pressure:	
≤ 8 years of age: <80	+ 20
>8 years of age: <90	+ 20
Chest retractions, nasal flaring, grunting	+ 20

(TRIAGE PATIENT DISPOSITION RECORD INSTRUCTIONS CONTINUED)

(1) Evaluation at hospital: Score ≥80 or
  a. Toxic appearance or rapid decompensation (especially important in adolescents and in pregnant women)
  b. Significant hypoxia
  c. Patients whose level of disability or medical complexity (e.g., on dialysis, severe quadriplegia, dementia, etc.) would overwhelm the ability of home or facility caregiver.

(2) Triage to Ambulatory Care Facility or Alternate Care Facility (if available): Score of <80 and
  a. Needs closer monitoring and care (for example, IV fluids, IV antibiotics, etc.), or
  b. Unable to care for self or return if symptoms worsen, or
  c. No hospital beds available

(3) Discharge to home:
  a. Score ≥80 with poor prognosis and unlikely to benefit from hospitalization, or
  b. Score <80 and able to care for self or has caregiver, and able to return if symptoms worsen.
  c. Patient shall be given home care instructions and record shall be faxed to Public Health Dept.
  d. Public Health Department or other County Agency will contact patient on a daily basis to check on status.

ATTACHMENT 4: PANDEMIC FLU TRIAGE GUIDELINES

Source: https://health.utah.gov/preparedness/downloads/medical_care_triage_app9.pdf

USE IN PLACE OF ATTCHMENTS 1-3 IN PAN FLU INCIDENT

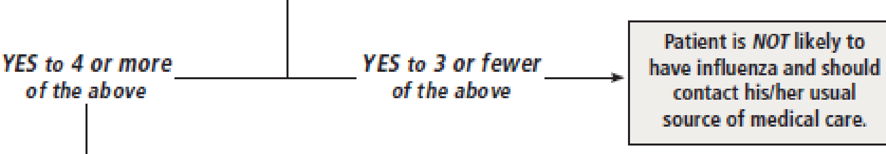
Can be used as phone triage guidelines during pan flu

INITIAL TRIAGE for Pandemic Influenza

Purpose: Initial triage is intended to help patients who are concerned about influenza determine whether or not they should seek medical help.

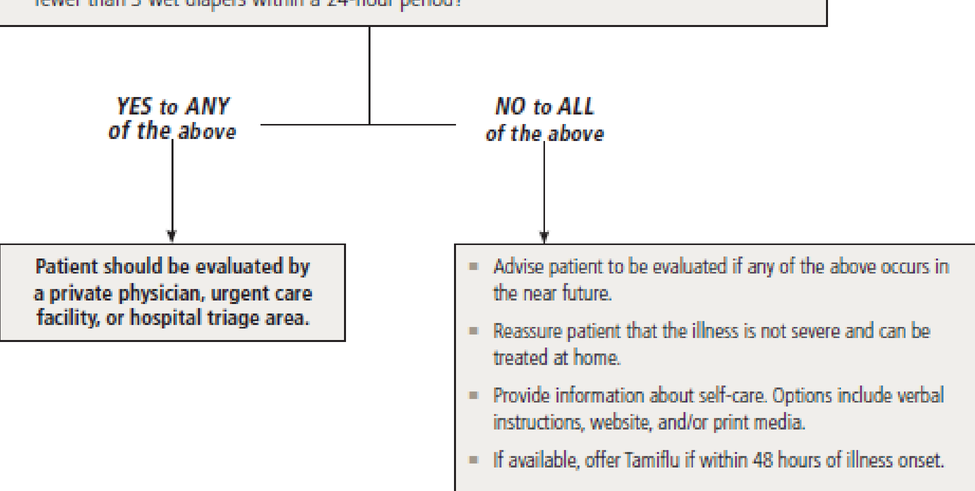
ASK these initial questions

1. **Within the past 10 days**, has the patient been **exposed to someone with influenza**?
2. Did the patient **get sick fairly quickly**, over 1-2 days?
3. Does the patient have a **fever over 101° F or 38° C**?
4. Does the patient have a **sore throat**?
5. Does the patient have a **cough**?
6. Does the patient have **severe muscle aches**?



Patient *IS* likely to have influenza.
CONTINUE with the following questions

1. Is the patient **struggling to breathe** or **breathing very rapidly?**
2. Is the **breathing very shallow, slow, or weak? (respiratory suppression)**
3. Are the **lips, tongue, or face blue? (cyanosis)**
4. Has it been **more than 12 hours since the patient last urinated? (dehydration)**
5. Is the patient **too weak to walk to the bathroom** or **not moving around in bed** AND/OR is the **skin pale and cool to the touch? (shock)**
6. Is the patient an **infant younger than 2 months** with a fever, feeding poorly, or with fewer than 3 wet diapers within a 24-hour period?



ADULT PATIENT WORKSHEET for Pandemic Influenza Triage

STEP 1: If any of the following are present, DO NOT ADMIT. Transfer to palliative care.

The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

☐ (1) **Known "Do Not Resuscitate" (DNR) status.**

☐ (2) **Severe and irreversible chronic neurologic condition** with persistent coma or vegetative state

☐ (3) **Acute severe neurologic event with minimal chance of functional neurologic recovery (physician judgment).** Includes traumatic brain injury, severe hemorrhagic stroke, and intracranial hemorrhage.

☐ (4) **Severe acute trauma** with a **REVISED TRAUMA SCORE <2** (see **(d)** and **(e)**)

GCS: ____ SBP:_____ RR:_____

Revised trauma score: _____

☐ (5) **Severe burns** with **<50% anticipated survival** (patients identified as **"Low" or worse on the TRIAGE DECISION TABLE FOR BURN VICTIMS (f)).** Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Medical Center Burn Center under normal circumstances). Score: __ __

☐ (6) **Cardiac arrest not responsive to ACLS interventions within 20-30 minutes.**

☐ (7) **Known severe dementia** medically treated and requiring assistance with activities of daily living.

☐ (8) **Advanced untreatable neuromuscular disease** (such as ALS or end-stage MS) requiring assistance with activities of daily living or requiring chronic ventilatory support.

☐ (9) **Incurable metastatic malignant disease.**

☐ (10) **End-stage organ failure** meeting the following criteria:

- ☐ **Heart: NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM Class III or IV (g).** Class: ____
- ☐ **Lung** (any of the following):
  - ☐ Chronic Obstructive Pulmonary Disease (COPD) with Forced Expiratory Volume in one second (FEV_1) < 25% predicted baseline, PaO_2 <55 mm Hg, or severe secondary pulmonary hypertension.
  - ☐ Cystic fibrosis with post-bronchodilator FEV_1 <30% or baseline PaO_2 <55 mm Hg.
  - ☐ Pulmonary fibrosis with VC or TLC < 60% predicted, baseline PaO_2 <55 mm Hg, or severe secondary pulmonary hypertension.
  - ☐ Primary pulmonary hypertension with NYHA class III or IV heart failure **(g)**, right atrial pressure >10 mm Hg, or mean pulmonary arterial pressure >50 mm Hg.
- ☐ **Liver: PUGH SCORE >7 (h)**, when available. Includes bili, albumin, INR, ascites, encephalopathy.
  Total score: ____

☐ (11) **Age:**

- ☐ Triage Level 1: >95 years
- ☐ Triage Level 2: >90 years
- ☐ Triage Level 3: >85 years

STEP 2: Modified Sequential Organ Failure Assessment (MSOFA)

The MSOFA requires only one lab value, which can be obtain using bedside point-of-care testing (creatinine obtained through ISTAT).

MSOFA scoring guidelines

Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Score for each row
SpO_2/FIO_2 ratio* or nasal cannula or mask O_2 required to keep SpO_2 >90%	SpO_2/FIO_2 >400 or room air SpO2 >90%	SpO_2/FIO_2 316-400 or SpO_2 >90% at 1-3 L/min	SpO_2/FIO_2 231-315 or SpO_2 >90% at 4-6 L/min	SpO_2/FIO_2 151-230 or SpO_2 >90% at 7-10 L/min	SpO_2/FIO_2 ≤150 or SpO_2 >90% at >10 L/min	____
Jaundice	no scleral icterus			clinical jaundice/ scleral icterus		____
Hypotension†	None	MABP <70	dop <5	dop 5-15 or epi ≤0.1 or norepi ≤0.1	dop >15 or epi >0.1 or norepi >0.1	____
Glasgow Coma Score	15	13-14	10-12	6-9	<6	____
Creatinine level, mg/dL (use ISTAT)	<1.2	1.2-1.9	2.0-3.4	3.5-4.9 or urine output <500 mL in 24 hours	>5 or urine output <200 mL in 24 hours	____
					MSOFA score = total scores from all rows:	____

* SpO_2/FIO_2 ratio:
SpO_2 = Percent saturation of hemoglobin with oxygen as measured by a pulse oximeter and expressed as % (e.g., 95%); FIO_2 = Fraction of inspired oxygen; e.g., ambient air is 0.21
Example: If SpO_2=95% and FIO_2=0.21, the SpO_2/FIO_2 ratio is calculated as 95/0.21=452

† Hypotension:
MABP = mean arterial blood pressure in mm Hg (diastolic + 1/3(systolic - diastolic))
dop= dopamine in micrograms/kg/min
epi = epinephrine in micrograms/kg/min
norepi = norepinephrine in micrograms/kg/min

STEP 3: Determine admission priority based on MSOFA

Score >11: Unlikely to survive. Discharge to palliative care.
Score 8-11: Intermediate priority for hospital admission.
Score 1-8: Highest priority for hospital admission.
Score 0: Lowest priority for hosptial admission. Likely to survive without treatment. Discharge to home

STEP 4: Record disposition

Disposition: ______________________________

Signature: ______________________________

Date and time: ______________________________

PEDIATRIC PATIENT WORKSHEET For Pandemic Influenza Triage

STEP 1: If any of the following are present, DO NOT ADMIT. Transfer to palliative care.

The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

- ☐ **(1) Known "Do Not Resuscitate" (DNR) status.**
- ☐ **(2) Persistent coma or vegetative state.**
- ☐ **(3) Severe acute trauma with a REVISED TRAUMA SCORE <2 (see (d) and (e) on following pages).**
  GCS: ____ SBP:____ RR:_____
  Revised trauma score: _____
- ☐ **(4) Severe burns with <50% anticipated survival** (patients identified as "Low" or worse on the TRIAGE DECISION TABLE FOR BURN VICTIMS (f)). Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Medical Center Burn Center under normal circumstances).
- ☐ **(5) Cardiac arrest not responsive to PALS interventions within 20-30 minutes.**
- ☐ **(6) Short anticipated duration of benefit,** e.g., underlying condition with >80% mortality rate at 18-24 months:
  - ☐ a) Known chromosomal abnormalities such as Trisomy 13 or 18
  - ☐ b) Known metabolic diseases such as Zellweger syndrome
  - ☐ c) Spinal muscular atrophy (SMA) type 1
  - ☐ d) Progressive neuromuscular disorder, e.g., muscular dystrophy and myopathy, with inability to sit unaided or ambulate when such abilities would be developmentally appropriate based on age
  - ☐ e) Cystic fibrosis with post-bronchodilator FEV_1 <30% or baseline PaO_2 <55 mm Hg
  - ☐ f) Severe end-stage pulmonary hypertension

OTHER CONSIDERATIONS:

- Resuscitation of extremely premature infants with anticipated mortality rates greater than 80% should not be offered. See http://www.nichd.nih.gov/about/org/cdbpm/pp/prog_epbo/
- The use of ECMO will be decided on an individual basis by the Chief Medical Officer (with input from attending physician, nursing supervisor, and ECMO representative) based on prognosis, suspected duration of ECMO run, and availability of personnel and other resources. Patients should have an estimated survival of >70% with an estimated ECMO run of <7-10 days.

STEP 2: Determine if patient meets ICU/Ventilator INCLUSION CRITERIA.

Patients must have NO EXCLUSION CRITERIA (1) and at least one of the following INCLUSION CRITERIA:

- ☐ **(1) Requirement for invasive ventilatory support**
  - ☐ Refractory hypoxemia ($SpO2$ < 90% on non-rebreather mask or FIO_2 > 0.85)
  - ☐ Respiratory acidosis (pH < 7.2)
  - ☐ Clinical evidence of impending respiratory failure
  - ☐ Inability to protect or maintain airway
- ☐ **(2) Hypotension* with clinical evidence of shock** refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting**

  * **Hypotension** = Systolic BP < 90 mm Hg for patients age > 10 years old, < 70 + (2 x age in years) for patients ages 1 to 10, < 60 for infants < 1 year old, or relative hypotension

  ** **Clinical evidence of shock** = altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure

STEP 3: Determine admission priority.

- ☐ Unlikely to survive. Discharge to palliative care.
- ☐ Hospital treatment is likely to be life-saving.
  - ☐ Admit to Floor
  - ☐ Admit to ICU if room available
- ☐ Lowest priority for hospital admission. Likely to survive without treatment. Discharge to home.

STEP 4: Record disposition

Disposition: ______________________________

Signature: ______________________________

Date and time: ______________________________

ATTACHMENT 5: TELEPHONE TRIAGE GUIDELINES

Source: http://www.nursingceu.com/courses/465/index_nceu.html#assessment

Telephone triage requires specialty skills, including a strong emphasis on communication, assessment, and critical thinking.

Four-Tier Triage: The limits of telephone triage allow for four typical triage disposition categories. These include the following:

- Emergent
- Urgent
- Acute
- Non acute

Each category refers to a flexible timeframe within which the triage nurse determines what is safe, prudent, and reasonable. Thus, the nurse has the professional responsibility to use his or her best professional judgment.

1. **Emergent-level calls**. Generally speaking, these calls require paramedic transport. They involve severe, life-threatening symptoms. Patients must be kept NPO (nothing by mouth). Whenever possible, the triage nurse should remain on the line with the patient or implement a three-way conference call as appropriate with services such as suicide prevention, 911, poison control, or rape crisis. When a caller is advised to go to the ED or to labor and delivery, the nurse should call and notify the department of the impending patient arrival.
2. **Urgent-level calls**. Urgent-level callers should be seen within 1–8 hours. However, some urgent symptoms may need to be seen as soon as possible at the most appropriate site. These patients must be kept NPO and will require paramedic transport if there is no readily available car or if the driver (caregiver/parent) is alone and/or too anxious to drive.
3. **Acute-level calls**. In this model, acute-level calls are seen within 8–24 hours or given a next-day appointment.
4. **Non acute-level calls**. Generally speaking, non acute-level callers are directed to their primary care physician as appropriate. Non acute symptoms usually can be managed with telephone advice for self-care and/or an appointment.

When in Doubt

"When in doubt, always err on the side of caution" is a cardinal rule in telephone triage. Triage nurses must rely on their best professional judgment and use every means at their disposal to ensure that patients are treated in a timely manner. Time frames designated on the template are intended as a general guide. If a nurse has doubts about the severity of symptoms and condition, safety dictates the patient come in sooner rather than later.

Triage nurses may upgrade dispositions as appropriate (from urgent to emergent, non acute to acute). However, nurses must never downgrade (urgent to non acute) without a physician consultation. If the patient is noncompliant, the nurse should seek advice from the physician advisor.

(TELEPHONE TRAIGE GUIDELINES CONTINUED)

Closure

The triage nurse should end each call with the final question “Is anything else worrying you?” or “Do you have any additional questions?” This step may reveal that a patient has an entirely different motivation and may even open the door to a new triage process.

Documenting a closing statement helps ensure that the patient has given informed consent. In other words, they comprehend the provisional diagnosis and proposed treatment, with the following understanding:

- This is an impression, not a medical diagnosis.
- The advice or home treatment is based on the impression.
- If a patient disagrees with the impression, they may make an appointment.
- If symptoms worsen or fail to respond to the home treatment, the patient agrees to seek care.
- The patient agrees to the plan.

A key element to documentation is to elicit and document what the patient plans to do at the end of the call. This will demonstrate that there was agreement to a certain plan of action. Further, it ensures that the patient understands what to do and under what conditions he or she may need to ask for further help. The chain of command may also be used; nurses should not be afraid to go to the next higher level.

(TELEPHONE TRAIGE GUIDELINES CONTINUED)

MASTER TEMPLATE (ALL AGES)
GENERIC PROTOCOL

(For Pediatric Patients, Always Use with TOXICITY ASSESSMENT and DEHYDRATION ASSESSMENT)

ASSOC SX/SPECIFIC/CONSIDERATIONS	DISPOSITION/ADVICE
EMERGENT SYMPTOMS	**ED IN 0 MIN–1 HOUR**
• **TRAUMA (MAJOR):** BLUNT, MVA, FALL > 15 FT? • LOSS OF CONSCIOUSNESS? • SHOCK or Impending Shock? • OB CRISIS or Impending Birth? • SEVERE RESPIRATORY DISTRESS? • PATIENT PRESENTS DANGER to Self or Others? • CARETAKER PRESENTS DANGER to Patient? • DISORIENTATION/Sudden Confusion or Marked Behavior Change? • DECOMPENSATION or Threat of Decompensation of Vital Functions of Sensorium, Respiratory, Circulation, Excretion, Mobility, or Sensory Organs? • CHILD: SEVERE TOXICITY? (See TOXICITY ASSESSMENT) • CHILD: SEVERE DEHYDRATION? (See DEHYDRATION ASSESSMENT) • Does RN feel symptoms are severe, extreme or emergent?	
URGENT SYMPTOMS	**ED/MD/APPT IN 1–8 HOURS**
• TRAUMA (ALL) + SUSPICIOUS HISTORY? (Abuse)(See ABUSE) →	• **COME TO E.D. NOW.**
• CHILD: TOXIC—VERY ILL? (See TOXICITY ASSESSMENT) →	• **COME TO E.D. NOW.**
• CHILD: SEVERE-MODERATE DEHYDRATION? (See DEHYDRATION ASSESSMENT) →	• **COME TO E.D. NOW.**
• SEVERE PAIN? • SEVERE, SUSPICIOUS or SUDDEN ONSET of SYMPTOMS: Pain, Bleeding or Unusual Symptoms, New, Unexpected, Changing Rapidly, Awakened Patient from Sleep? (Worsening or Marked Change) • ACUTE INFECTION SYMPTOMS: Fever/Chills, Joint Pain, Fatigue, "Flu" Symptoms, Lack of Appetite? (Possible Infection) • ANY INFECTIOUS PROCESS Requiring Antibiotics? (> Risk of Infection) • FAILURE TO IMPROVE on Antibiotics × 24–48 Hr? (> Risk of Infection)	
• CHILD: **Age < 3 Mo + FEVER > 38°C or 100.4°F®?** →	• **BRING CHILD TO E.D. NOW.**
• ALL AGES: FEVER > 40°C or 104°F? • MODERATE SYMPTOMS + HISTORY OF RECENT SURGERY? (Poss. Post-Op Complications) • Does RN feel symptoms are urgent or require appt. today?	
ACUTE SYMPTOMS	**ED/MD/APPT IN 8–24 HOURS**
• Moderate Symptoms + Risk Factors (Age, Veracity, Emotional Distress, Debilitation/ Distance) = POSS. UPGRADE? (> Risk) • CHILD: Sick Infant/Child? (See TOXICITY ASSESSMENT) • CHILD: Mild Dehydration? (See DEHYDRATION ASSESSMENT) • Symptoms that are persistent, worsening or fail to improve on home treatment x 24–48 Hr = POSS. UPGRADE? (> Risk) • Does RN feel symptoms are acute?	
NON-ACUTE SYMPTOMS	**HOME TREATMENT W OR W/O APPT IN 24 + HOURS**
• Minor Self-Limiting (Isolated/Unchanging) Symptoms Existing over 1 Wk, Not Becoming Markedly Worse? • HOME TREATMENT ITEMS/PHONE NOT AVAIL. = POSSIBLE UPGRADE? • Does RN feel symptoms are non-acute?	

(TELEPHONE TRAIGE GUIDELINES CONTINUED)

Gather toxicity and dehydration information for all pediatric patients. Marked changes in any of these indicators can be a sign of severe illness.

USING CRASS TO ASSESS TOXICITY/DEHYDRATION		
C	Color	Lips/skin/nailbeds
R	Respirations	Rapid/slow/labored
A	Activity	Work/play/daily routine
S	Skin turgor	Dry lips/tongue/tenting/sunken or bulging fontanel
S	Sleep pattern	Too much or too little

ATTACHMENT 6: COMMUNICABLE DISEASE HOME CARE INSTRUCTIONS TEMPLATE

Prevention Steps for People Confirmed to Have, or Being Evaluated for Communicable Disease

If you are confirmed to have, or being evaluated for Communicable Disease you should follow the prevention steps below until a healthcare provider or local or state health department says you can return to your normal activities.

- **Stay home**
  You should restrict activities outside your home, except for getting medical care. Do not go to work, school, or public areas, and do not use public transportation or taxis.

- **Separate yourself from other people in your home**
  As much as possible, you should stay in a different room from other people in your home. Also, you should use a separate bathroom, if available.

- **Call ahead before visiting your doctor**
  Before your medical appointment, call the healthcare provider and tell him or her that you have, or are being evaluated for Communicable Disease. This will help the healthcare provider's office take steps to keep other people from getting infected.

- **Wear a facemask**
  You should wear a facemask when you are in the same room with other people and when you visit a healthcare provider. If you cannot wear a facemask, the people who live with you should wear one while they are in the same room with you.

- **Cover your coughs and sneezes**
  Cover your mouth and nose with a tissue when you cough or sneeze, or you can cough or sneeze into your sleeve. Throw used tissues in a lined trash can, and immediately wash your hands with soap and water.

- **Wash your hands**
  Wash your hands often and thoroughly with soap and water. You can use an alcohol-based hand sanitizer if soap and water are not available and if your hands are not visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.

- **Avoid sharing household items**
  You should not share dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items with other people in your home. After using these items, you should wash them thoroughly with soap and water.

- **Monitor your symptoms**
  Seek prompt medical attention if your illness is worsening (e.g., difficulty breathing). **Before** going to your medical appointment, call the healthcare provider and tell him or her that you have, or are being evaluated for Communicable Disease. This will help the healthcare provider's office take steps to keep other people from getting infected. Ask your healthcare provider to call the local or state health department.

Prevention Steps for Caregivers and Household Members

If you live with, or provide care at home for, a person confirmed to have, or being evaluated for Communicable Disease, you should:

- Make sure that you understand and can help the person follow the healthcare provider's instructions for medication and care. You should help the person with basic needs in the home and provide support for getting groceries, prescriptions, and other personal needs.

- Have only people in the home who are essential for providing care for the person.
  - Other household members should stay in another home or place of residence. If this is not possible, they should stay in another room, or be separated from the person as much as possible. Use a separate bathroom, if available.
  - Restrict visitors who do not have an essential need to be in the home.
  - Keep elderly people and those who have compromised immune systems or certain health conditions away from the person. This includes people with chronic heart, lung or kidney conditions, and diabetes.
- Make sure that shared spaces in the home have good air flow, such as by an air conditioner or an opened window, weather permitting.

- Wash your hands often and thoroughly with soap and water. You can use an alcohol-based hand sanitizer if soap and water are not available and if your hands are not visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.

- Wear a disposable facemask, gown, and gloves when you touch or have contact with the person's blood, body fluids and/or secretions, such as sweat, saliva, sputum, nasal mucus, vomit, urine, or diarrhea.
  - Throw out disposable facemasks, gowns, and gloves after using them. Do not reuse.
  - Wash your hands immediately after removing your facemask, gown, and gloves.
- Avoid sharing household items. You should not share dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items with a person who is confirmed to have, or being evaluated for Communicable Disease. After the person uses these items, you should wash them thoroughly (see below "Wash laundry thoroughly").
- Clean all "high-touch" surfaces, such as counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables, every day. Also, clean any surfaces that may have blood, body fluids and/or secretions or excretions on them.

   - Read label of cleaning products and follow recommendations provided on product labels. Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves or aprons and making sure you have good ventilation during use of the product.

   - Use a diluted bleach solution or a household disinfectant with a label that says "EPA-approved." To make a bleach solution at home, add 1 tablespoon of bleach to 1 quart (4 cups) of water. For a larger supply, add ¼ cup of bleach to 1 gallon (16 cups) of water.

- Wash laundry thoroughly.
   - Immediately remove and wash clothes or bedding that have blood, body fluids and/or secretions or excretions on them.

   - Wear disposable gloves while handling soiled items. Wash your hands immediately after removing your gloves.

   - Read and follow directions on labels of laundry or clothing items and detergent. In general, wash and dry with the warmest temperatures recommended on the clothing label.

- Place all used gloves, gowns, facemasks, and other contaminated items in a lined container before disposing them with other household waste. Wash your hands immediately after handling these items.

- Monitor the person's symptoms. If they are getting sicker, call his or her medical provider and tell him or her that the person has, or is being evaluated for Communicable Disease. This will help the healthcare provider's office take steps to keep other people from getting infected. Ask the healthcare provider to call the local or state health department.

- Caregivers and household members who do not follow precautions when in close contact[2] with a person who is confirmed to have, or being evaluated for Communicable Disease, are considered "close contacts" and should monitor their health. Follow the prevention steps for close contacts below.

Prevention Steps for Close Contacts

If you have had close contact[2]with someone who is confirmed to have, or being evaluated for Communicable Disease, you should:

- Monitor your health starting from the day you were first exposed to the person and continue for 14 days after you were last exposed to the person. Watch for these signs and symptoms:

   - Fever - Take your temperature twice a day.

   - Coughing

   - Shortness of breath

   - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea/vomiting, and runny nose.

- If you develop symptoms, follow the prevention steps described above, and call your healthcare provider as soon as possible. **Before** going to your medical appointment, call the healthcare provider and tell him or her about your possible exposure to Communicable Disease. This will help the healthcare provider's office take steps to keep other people from getting infected. Ask your healthcare provider to call the local or state health department.

- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.

You are not considered to be at risk for Communicable Disease if you have not had close contact with someone who is confirmed to have, or being evaluated for Communicable Disease. CDC advises that people follow prevention steps to help reduce their risk of getting infected with Communicable Disease.

Based on MERS guidance: http://www.cdc.gov/coronavirus/mers/hcp/home-care-patient.html#people

Footnotes

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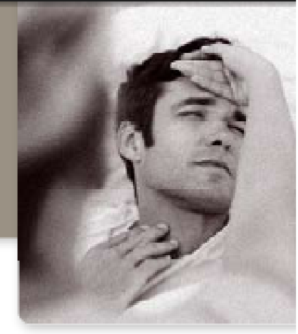
1. Close contact is defined as: a) being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection– see Infection Prevention and Control Recommendations); or b) having direct contact with infectious secretions of a confirmed or probable case (e.g., being coughed on) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection – see Infection Prevention and Control Recommendations). Data to inform the definition of close contact are limited. At this time, brief interactions, such as walking by a person, are considered low risk and do not constitute close contact.

ATTACHMENT 7: PANDEMIC INFLUENZA HOME CARE INSTRUCTIONS

Caring for Someone with Influenza at Home



During this influenza ("flu") outbreak, some people will need care at a hospital. **But many influenza patients must be cared for at home.** *This handout will help you care for an influenza patient — a friend or family member — at home. Follow these instructions carefully, as well as any others the doctor gives you.*

Protect yourself and prevent the spread of flu.

- Wash your hands often — especially after touching things that have been used or touched by the patient.
- Wear a mask when you're with the patient.
- Cover your coughs and sneezes with your elbow.
- **Keep a trashcan near the patient's bed, and line it with a plastic bag.** Toss every used tissue, straw, etc. Seal the plastic bag before emptying it into the garbage.
- Take care of yourself. Get plenty of rest and exercise, and make healthy food choices.

Keep the patient comfortable.

- Let the patient sleep or rest as much as they like. This will help the patient recover.
- Treat aches and fever with medication (see below). Sponging the patient's body with lukewarm (wrist-temperature) water may lower the patient's temperature, but only for a brief time. Do not sponge with alcohol.

Give medication as directed.

- For pain and fever, give ibuprofen (Advil or Motrin) or acetaminophen (Tylenol) regularly, as instructed on the bottle or box. Do not give aspirin to children or teenagers because it can cause Reye's syndrome, a life-threatening illness.
- For flu or any other medical condition the patient has, follow the doctor's advice carefully. If you have any questions about medication, contact the patient's doctor.

Prevent dehydration.

Our bodies need fluids to function well. But sickness can lead to dehydration (lack of fluid in the body). To prevent this, do the following:

- Unless the patient is vomiting (throwing up), offer small amounts of liquids frequently throughout the day. Do this even if the patient doesn't feel thirsty and especially if the patient has a fever. (A person with a fever needs more fluids than usual.) Here are some targets for patients of different ages:
  - For young children, give 1½ ounces of liquid per pound of body weight every day (multiply 1.5 times the weight of the child). For example, a toddler weighing 30 pounds needs 45 ounces of liquid a day (30 x 1.5 = 45).
  - For older children and adults, give at least 1½ to 2½ quarts of liquid per day — 3 to 5 eight-ounce cups or 2 to 3 twelve-ounce cans or bottles.
- If the patient isn't eating solid foods, offer liquids that contain sugars and salts. For example, offer broth or soups, sports drinks like Gatorade® mixed with water (aim for half water, half sports drink), Pedialyte® or Lytren® drinks, and any soda that is NOT diet and does NOT have a lot of caffeine.
- Pay attention to how much the patient urinates (pees). (Dehydration causes people to urinate less often and the urine to have a dark yellow color.) An infant should have at least 3 wet diapers in 24 hours. An adult should urinate at least every 8 to 12 hours. If the patient is not meeting these targets, offer frequent sips and spoonfuls of liquids for a 4-hour period, and watch for signs of dehydration (see "Call the doctor" at the end of this handout).

Limit food and drink to a patient who is vomiting (throwing up). Follow this procedure:

- For 1 hour after a patient vomits, don't give any liquid or food. Let the stomach rest.
- Next, offer a very small amount of clear liquid such as water, weak tea, ginger ale, or broth. Start with 1 to 3 teaspoons of clear liquid every 10 minutes (or give the patient an ice cube to suck on). If the person vomits, let the stomach rest for an hour, then try again with small, frequent amounts of clear liquid.
- When there is no vomiting, gradually increase the amount of liquid offered, and add liquids that contain sugars and salts. After 6 to 8 hours of a liquid diet without vomiting, add foods that are easy to digest, such as saltine crackers, dry toast, mashed potatoes or rice. Gradually, return to a regular diet.

Note: Continue to breastfeed a baby who is vomiting. Let the baby nurse more often — for 4 to 5 minutes every 30 to 45 minutes or so. You can also give the baby small amounts (½ ounce or less) of Pedialyte or Lytren every 10 minutes in a bottle.

Keep a daily record of symptoms

If the patient should need further medical attention, detailed information will be helpful to the doctor. Write down the following information every day:

- **Temperature.** Using an oral or ear thermometer, take the patient's temperature at least once a day (more often if symptoms change). Write down the reading along with the date and time.
- **Skin condition.** Once a day — more often if symptoms change — note the patient's skin color (pink, pale or bluish) or whether there is a rash.
- **How much liquid the patient drinks.** Write down the approximate number of ounces taken in during the day and through the night.
- **Urination.** Record how many times the patient goes to the bathroom each day and the color of the urine (clear to light yellow, dark yellow, orange, brown, or red).
- **Medications given.** For every medication you give the patient, write down what you gave, how much you gave, and the time you gave it.
- **Symptoms.** Write down any changes in these common flu symptoms:
  - Fever (often high — should go away as the patient gets better)
  - Headache
  - Tiredness (can be extreme)
  - Cough
  - Sore throat
  - Runny or stuffy nose
  - Body aches
  - Nausea and vomiting
  - Diarrhea (more common in children than adults)

Call the doctor if you notice any of the following:

- **Signs of dehydration that continue** even after 4 hours of increased liquids as described in the "Prevent dehydration" section. Signs of dehydration include:
  - Weakness or unresponsiveness
  - Dry mouth and tongue, decreased saliva (spit)
  - Dry eyes (and no tears if crying)
  - Sunken eyes
  - Urinating less than 3 times in 24 hours
- **Worsening symptoms** (especially if the patient seems worse after appearing to improve)
- **An infant younger than 2 months old** has a fever, is **feeding poorly,** or has **fewer than 3 wet diapers in a 24 hour period.**

Call 911 or take the patient to the hospital emergency room if you notice any of these complications:

- **Difficulty breathing, fast breathing, or bluish color to the skin or lips**
- **Coughing up blood**
- **Difficulty responding or communicating, confusion**
- **Convulsions (seizures)**

ATTACHMENT 8: LONG TERM CARE FACILITY TRIAGE CHECKLIST

Source:
https://www.harvardpilgrim.org/pls/portal/docs/PAGE/PROVIDERS/MEDMGMT/MEDICAL_REVIEW_CRITERIA/SNF%20SUBACUTE%20LOC%20CRITERIA-EFF062712-RVW052213.PDF

Service Specific LOC Criteria Service	Skilled Intervention	Location of Care (LOC)	Comments
Catheters	Nursing management of indwelling bladder catheter, nephrostomy tube, or suprapubic tube during the early post-insertion period, or in the presence of catheter complications. Insertion, sterile irrigation, and/or replacement of suprapubic catheters.	SNF	Routine maintenance of an indwelling bladder catheter or suprapubic catheter does not constitute SNF LOC.
Central Lines	Administration of TPN, PPN, medications, or fluids via a central line (e.g., Hickman Catheter, Porta-Cath).	Sub-Acute	Central lines that are in place, but not in active use, do not constitute either SNF or Sub-Acute LOC.
Diabetic Care	Daily monitoring of unstable blood sugars, and administration of sliding scale insulin.	SNF	Subcutaneous (SC) insulin injections (stable dose) in a stable diabetic do not constitute SNF LOC, regardless of whether the member is able to self-inject. A physician's order for sliding scale insulin that is not being administered daily does not constitute SNF LOC.
Enteral Tube Feedings	Skilled management of enteral feeding regimen for a member with a newly inserted NG-tube, J-tube, or G-tube, who is functionally incapable of sufficient oral intake to sustain life.	SNF	Maintenance of a stable enteral feeding regimen, or stable NG-tube, J-tube, or G-tube alone does not constitute SNF LOC.
Medication Administration and Monitoring	Skilled monitoring of medication effects including a complicated p.o. medical regime.	SNF	SC injections alone do not constitute SNF LOC.
Ostomy Care	Management and/or teaching re: management of a new colostomy or ileostomy during the early post-operative period.	SNF	Routine ostomy care does not constitute SNF LOC.
Pain Management	Monitoring and adjustment of a complex pain management treatment plan including frequent dose adjustment, changes in the route of	Sub-Acute	

	medication administration, or skilled intervention for uncontrolled pain and/or an unstable medical condition.		
Parenteral Fluids and/or Medications	Administration of at least one IV or IM injection per day.	SNF	SC injections alone do not constitute SNF LOC. SC insulin injections (stable dose) in a stable diabetic do not constitute SNF LOC, regardless of whether or not the member is able to self-inject.
Parenteral Fluids and/or Medications	Administration of 2 or more different IM or IV medications on a daily basis (may include dosage adjustments and/or monitoring of lab results.)	Sub-Acute	
Rehabilitative Care	At least 1-2 hours of direct therapy (PT, OT, S/LT) per day, at least 5 days/week.	SNF	Direct therapy time does not include time for documentation, family or team meetings, etc. Dysphagia treatment by a Speech/Language Pathologist may qualify as skilled care, but Speech/Language therapy for language therapy alone does not constitute SNF LOC.
Rehabilitative Care	At least 2 hours of direct therapy per day, at least 6 days/week (i.e. at least 12 hours of direct therapy per week). Member must be physically and cognitively willing and able to participate in, and benefit from, the rehabilitation program.	Sub-Acute	Direct therapy time does not include time for documentation, family or team meetings, etc.
Respiratory Care	1. Skilled administration of a system of care including skilled nursing observation and assessment to evaluate the member's need for modifications of treatment: a. Chest PT and/or aerosol delivery of medication (to mobilize secretions) at least 3x/day; or b. New respiratory treatments including initial phases of a regimen involving administration of medical gases (e.g., oxygen, bronchodilator therapy); or	SNF	A physician's order for any of these systems of care does not constitute SNF LOC if PRN services are routinely utilized on a less than daily basis.

	c. Naso-pharyngeal or tracheostomy suctioning provided on a frequent basis, with a documented need for member observation for respiratory distress; or d. Respiratory treatments provided (at least daily) on a PRN basis in response to changes in the member's clinical condition. 2. Routine respiratory care of the stable, chronic vent-dependent member including chest PT, suctioning, tracheostomy care, and occasional need for changes in vent settings.		
Respiratory Care	1. Administration of chest PT and/or aerosol delivery of medication >3x/day including: a. >30% oxygen therapy; or b. Monitoring of oxygen saturation levels (and subsequent changes in O2 orders); or c. New nebulizer treatments; or d. Skilled respiratory assessment, suctioning, and/or unstable tracheostomy care. 2. Respiratory care of the newly admitted vent-dependent member who requires chest PT, suctioning, and tracheostomy care with close clinical monitoring, to assure stability in the transition period.	Sub-Acute	Slow weaning from oxygen, or routine tracheostomy care does constitute Sub-acute LOC.
Wound Care	Skilled care of decubitus ulcers, wounds, and/or widespread skin disorders involving: 1. Aseptic technique; 2. Prescription medication; and 3. Skilled nursing observation/ evaluation of the wound or ulcer. Complex treatment of decubitus ulcers that, as a practical matter, can only be provided in a skilled nursing facility.	SNF	
Wound Care	Complex wound care requiring aseptic technique, packing, debridement, irrigation, and/or frequent assessment for complications such as infection or vascular compromise.	Sub-Acute	May include surgical wounds, burns, or Stage 3-4 decubiti.

ATTACHMENT 9: TEMPLATES FOR SIGNAGE

All employees and medical staff: Use the Main Hospital Entrance for entry and exit for all shifts and work locations