

St. Joseph's Hospital & Medical Center: Comprehensive Diversion Reduction Plan

Problem to Be Resolved:

- Increase in-patient bed capacity

Hospital: St. Joseph's Hospital & Medical Center

Location: 350 West Thomas Road
Phoenix, AZ 85013

Categories:

- Output
- Communication/IT

Key Words:

- Hospital beds
- Discharges
- Diversion Reduction Plan
- Inpatient Intake
- Turnaround Time

Hospital Metrics:

(Taken from the FY2005 AHA Annual Survey)

- 2005 ED Volume: 62,315
- Hospital Beds: 539
- Ownership: Not-for-profit
- Trauma level: 1
- Teaching status: Yes

Tools Provided:

- Diversion Reduction Plan
This tool is a two-page document providing a succinct purpose, problem statement, and eight-step procedure for implementation of the diversion reduction plan.
- Diversion Reduction Policy & Procedure
This tool is a five-page document outlining the detailed purpose, definitions, and procedures pertaining to the diversion reduction plan.
- Diversion Reduction Protocol
This tool is a seven-page document describing the protocol for each hospital employee during a capacity code, and is used to ensure that the capacity code operates correctly.
- Code Diversion Critique
This tool is a four-slide presentation of survey results compiled from hospital staff regarding various aspects of the diversion reduction plan, and is used to assess the efficiency and perception of the program.

Strategy Description

The hospital developed a **comprehensive diversion reduction plan** to improve efficiency of hospital discharges and identified a team of individuals to oversee implementation of the plan. The plan sets guidelines for calling a "capacity code," which triggers the implementation of protocols to quickly discharge eligible patients. The Diversion Reduction Plan requires coordination and cooperation between multiple departments in the hospital. Staff in these departments were educated about the procedures in the new plan and their roles and responsibilities.

The Impetus for Change

When the ED at St. Joseph's Hospital and Medical Center (St. Joseph's) in Phoenix, Arizona, had to go on diversion due to overcrowding, responsibility for finding patient beds fell solely to the ED and House

Managers. While they struggled to find beds for the patients, the rest of the hospital was unaware of the urgency to find empty beds.

Buy-In and Implementation

St. Joseph's implemented a Comprehensive Diversion Reduction Plan to Improve Efficiency of Hospital Discharges by reducing the number of diversion hours in the ED. The Chief Nurse Executive (CNE) led the efforts by working with the ED Manager, the House Manager and additional hospital staff. After its creation, the Diversion Reduction Plan team held preliminary meetings with senior hospital staff to share their work and explain how it compared to what other hospitals were doing. (See [Diversion Reduction Plan](#)) To simplify implementation, the team avoided creating a large approval committee and secured approval one step at a time as they moved along in the process. Once the protocol had final approval by senior hospital staff, the team and the hospital nursing committee educated house staff on the plan and then put it into action. (See [Diversion Reduction Protocol](#))

The Diversion Reduction Plan team recognized that the way in which the hospital's various floors were handling patient discharges had a major impact on diversion. Consequently, crafting the Diversion Reduction Plan meant proactively involving a wide variety of staff in the discharge decision-making process – including patient care directors (Nursing, Case Management and Radiology), managers of patient care units (Floors, the Operating Room, ICUs and Rehabilitation), housekeeping, transportation, laboratory, radiology and ultrasound, the medical officer of the day, case managers and social workers.

The House Manager and the ED Manager then became responsible for initiating a hospital-wide “capacity” code. This code signaled that the hospital had reached maximum capacity (based on predetermined guidelines) and that the ED was poised to go on diversion. During a capacity code, each of the departments previously mentioned had specific responsibilities under the diversion plan protocol designed to focus all efforts on any patient ready or close to discharge. Once on capacity code, physicians and staff alike were to secure or provide whatever information was necessary to facilitate the patient's discharge.

Lessons Learned

As a result of the diversion protocols, the lab has improved their batching protocols. Radiology attends daily bed rounds to ensure that patients slated for discharge have had all of their tests read and reported. Case managers and social workers now conduct rounds twice a day to expedite discharges.

Impact

Since implementing the Diversion Reduction Plan and the associated protocol, St. Joseph's has reduced their time on diversion significantly. The percentage of patients that left without being seen (LWBS) in the ED fell from 21 percent to 7 percent. Improved efficiencies in hospital discharges increased hospital occupancy by 5 percent, and the average hospital discharge time has moved from 3:50 p.m. to 2:00 p.m. The average bed turnaround time has decreased from 85 minutes to 30 minutes, a 63 percent reduction. Average time from inpatient bed assignment to bed placement decreased from 100 minutes to 60 minutes, a 40 percent reduction.

The success of the data collection process has engaged senior executive staff and house staff. The hospital has had a 50 percent reduction in diversion hours, while the ED's diversion hours have decreased from 70 hours to 43 hours, a 39 percent reduction. ED patient admission turn around time (TAT) has moved from 6 to 5 hours, and from 6 hours, 40 minutes to 4 hours, 10 minutes for discharging home patients.

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Diversion Reduction Plan

Purpose:

To maximize efficiency, to increase patient care quality and patient satisfaction by decreasing the amount of time that St. Joseph's is on Capacity holding patients in the Emergency department or unable to accept transfers.

Problem statement:

Providing care to acutely ill patients continues to be a prime objective for St. Joseph's Hospital. Since nearly 30% of the patients admitted flow through the Emergency department (ED) holding patients in the ED and ED closure is frustrating for staff, patients and physicians. Though the hospital are aware of the need for beds, the work of finding a bed and bedding the patient is "owned" primarily by the ED and the House Manager. The rest of the hospital is often unaware of the crisis and on a day to day basis does not alter "business as usual" when the ED closes or if unable to meet the needs of the patients.

Procedure:

1. When the hospital has reached maximum capacity, (see attached definition of maximum capacity), the hospital House Manager and the Emergency Room Manager or Supervisor will determine the need for a Capacity Code. The House Manager will notify the Administrator on call prior to calling the code.
2. If a Capacity code is required, the House Manager will instruct the operator to announce the Capacity status (see operator Diversion protocol).
3. All patient care units, diagnostic units and support areas will follow their Diversion protocols (see attached).
4. An Emergency crisis patient staffing meeting will be held 45 minutes (or at a time designated by the house manager) after the code is called and will be repeated every 45 minutes until the Diversion situation is resolved. Attendance at each meeting is expected from:
 - Patient Care directors (Nursing, Case Management & Radiology)
 - Managers of patient care units (Floors, OR's ICU's & Rehab)
 - Manager of housekeeping
 - Manager of transportation
 - Manager of lab, radiology, ultrasound
 - Medical Officer of the Day
 - Manager Case Manager/Social Work
 - Neonatal ICU is the only excused unit

5. The manager of each patient care unit will be expected to identify 2 patients for discharge within one hour by the 1st meeting (see protocol).
6. All residents and all employed Nurse Practitioners will be notified by the House Manager or designee, to conduct emergency rounds to identify discharges.
7. When the Capacity status is resolved (i.e. beds identified, patients discharged, ED decompressed), the House Manager will instruct the operator to call all clear.
8. Security will be invited only as needed by the House Manager.



<small>SUBJECT</small>	<small>POLICY NO.</small>	<small>PAGE</small>
POLICY TITLE PRE-DIVERSION AND DIVERSION	DRAFT	1 OF 5
<small>SOURCE</small>	<small>POLICY OWNER</small>	<small>EFFECTIVE DATE</small>
CLINICAL	EMERGENCY DEPARTMENT MANAGER	DRAFT

“We believe in the dignity of all and the promotion of human wholeness.”

1 POLICY STATEMENT

 1.1

2 PURPOSE

 2.1 To establish internal criteria in order to avoid ambulance diversion and assist with the decision to divert ambulance traffic from the Emergency Department.

3 DEFINITIONS

 3.1 Diversion is the closure of the Emergency Department to all incoming transfers through the Emergency Department and the inability to accept incoming ambulance traffic.

 3.2 Code Diversion is an internal procedure that allows the mobilization of resources to alleviate an overcrowding issue in order to prevent the organization to go on diversion status.

4 PROCEDURES

 4.1 Code Diversion

 4.1.1 The Emergency Department Clinical Supervisor will notify the House Manager when the Emergency Department is nearing saturation. Saturation can be established by referring to the guidelines listed below:

 4.1.1.1 Unable to bed a critical patient.

 4.1.1.2 Greater than fifteen (15) patients in the waiting room.

 4.1.1.3 Staffing ratios exceeded.

 4.1.1.4 Greater than four (4) hour wait times.

 4.1.1.5 Greater than three (3) patients enroute.

 4.1.1.6 Greater than three (3) ICU patients in Zone 1 that are unable to be relocated to Zone 2 for holding.

 4.1.1.7 Greater than twenty (20) minutes to see the Triage RN and all available resources are committed.

<small>REVISION NO.</small>	<small>DISTRIBUTION</small>	<small>ISSUE DATE</small>
ORIGINAL	GENERAL	DRAFT



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- 4.1.1.8 Two hospitals inn the Central sector are currently on diversion.
- 4.1.2 The House Manager will notify the Administrator on call that the Organization is nearing capacity
 - 4.1.2.1 A decision to call a Code Diversion will be made by the Administrator on call.
 - 4.1.2.2 The House Manager will notify the Emergency Department Clinical Supervisor of the decision.
- 4.1.3 When a Code Diversion is called, The House Manger will notify the Hospital Operator who will initiate a mass page announcing "The hospital is at 100 % capacity. Please follow your posted diversion protocols. The first bed capacity meeting will be at ____ time"
 - 4.1.3.1 The timeframe should be within 45 minutes of the code diversion announcement.
 - 4.1.3.2 The Emergency Department Clinical Supervisor and House Manager will co-chair the code diversion meeting.
 - 4.1.3.3 The Emergency Department Clinical Supervisor will ensure the following steps have been followed prior to initiating a code diversion based on Emergency Department Saturation:
 - 4.1.3.3.1 Discuss potential admits and timeframes with all Emergency Department physicians.
 - 4.1.3.3.2 Discuss potential discharges with all Emergency Department Physicians and expedite the process.
 - 4.1.3.3.3 Move patients to chairs that are awaiting simple disposition as able.
 - 4.1.3.3.4 Evaluate the possibility of providing care to the non urgent patient population in the sub waiting room.
 - 4.1.3.3.5 Assess the possibility of expediting patient movement during upcoming Physician shift change.
 - 4.1.3.4 The following areas will send a Supervisor or Manger to all code diversion meetings.
 - 4.1.3.4.1 All Clinical Units
 - 4.1.3.4.2 Environmental Services



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4.1.3.4.3 Laboratory

4.1.3.4.4 Radiology

4.1.3.4.5 Case Management

4.1.3.4.6 Transportation

4.1.3.5 Each Clinical Unit will report the next two available beds on their unit and an estimated time frame for disposition along with any barriers to the disposition.

4.1.3.6 The Emergency Department Clinical Supervisor will report the following information:

4.1.3.6.1 Quantity and type of known admissions in the Emergency Department.

4.1.3.6.2 Quantity and type of predicted admissions in the Emergency Department.

4.1.3.6.3 Quantity of potential admissions based on the waiting room census.

4.1.3.6.4 Consults from outside physicians that are impacting patient movement in the Emergency Department.

4.1.3.6.5 Current wait time in the Emergency Department and number of patients in the waiting room.

4.1.3.6.6 Ancillary Service needs that could impact patient movement.

4.1.3.6.7 Case Management needs that could facilitate patient movement.

4.1.3.6.8 Any miscellaneous issues that are impacting patient flow (ie: equipment, staffing, Information Services)

4.1.3.7 All ancillary departments will assist with facilitating the upcoming dispositions by prioritizing the needs of these patients.

4.1.3.8 The entire team will meet every 45 minutes to 1 hour until the saturation point is relieved.

4.1.3.9 The House Manager in consultation with the Emergency Department Clinical Supervisor will advise the Administrator on call when the code diversion can be terminated.



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4.1.3.10 The House Manager will notify the Hospital Operator that the Code Diversion is all clear.

4.1.3.11 The Hospital Operator will announce overhead that the code diversion is all clear as well as mass page the all clear.

4.2 Diversion Status Closed

4.2.1 The Emergency Department Clinical Supervisor will notify the House Manager when the Emergency Department has reached saturation and been placed on diversion.

4.2.1.1 Saturation will be determined by the ability to meet three of the criteria described in 4.1.1

4.2.1.2 The Emergency Department Clinical Supervisor will complete the on line EMS form to officially place the organization on diversion.

4.2.2 The House Manager will notify the Emergency Department Clinical Supervisor when the organization is at 100% capacity and there is a need to go on diversion.

4.2.3 The House Manager is responsible for notifying the Administrator on call and Neurosurgery resident that the Emergency Department has been placed on diversion.

4.3 Diversion Status Open

4.3.1 The Emergency Department Clinical Supervisor will notify the House Manager when the Emergency Department re-opens.

4.3.2 The House Manager will notify the Emergency Department when the internal capacity issues are resolved to allow the Emergency Department to re-open.

4.3.3 The House Manager is responsible for notifying the Administrator on call and the Neurosurgery resident that the Emergency Department has been re-opened.

4.3.4 The Emergency Department Clinical Supervisor is responsible for ensuring the completion of all required documentation regarding closure and re-opening. See Attachment A

5 ATTACHMENTS

5.1 Emergency Department Closure form.



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REVISIONS/APPROVALS

Original Policy: Emergency Department Committee - 00/00/00
 Clinical Policy Committee - 00/00/00
 Quality Council - 00/00/00
 Medical Executive Committee - 00/00/00
 SJHMC Community Board of Directors - 00/00/00

Diversion Protocol

Patient Care Areas

When the overhead Capacity Code is called the Manager will return immediately to his/her unit and:

1. Review all patients status for discharge.
2. Identify at least 2 patients who could be discharged with in one hour as well as all pending transfers. In addition, managers will identify pending diagnostics or reasons for delayed discharge.
3. For those with discharge orders, determine any delays and approximate time of departure.
4. If no patients have discharge orders, delegate calls to MD's to obtain orders.

Report to the emergency patient staffing meeting (Bed Board – in CCO conference room) at specified time. Bring:

- Names of 2 patients who can be discharged within the hour
- List of other potential discharges and what is “pending” on their discharge.
- List of what resources the floor needs to take more patients and any ideas regarding obtaining those resources.
- Steps 1-5 will be repeated every 45 minutes (or as instructed by House Manager) until the Capacity code is cancelled.
- Supervisors and or charge nurses can substitute for the manager if the manager is off campus

Diversion Protocol:

Social Work/Case Management

When the Capacity Code is called overhead:

1. All CM/SW staff will report pending discharges and delays to either their Manager or the Unit Manager.
2. The CM/SW staff will attend the emergency bed board meeting to help facilitate discharges, remove barriers and suggest alternatives for patient placement.

3. The CM/SW Manager will attend all subsequent meetings until the Capacity Code is completed.
4. The CM/SW Manager will serve as a resource for the ED and Patient Care areas.

Diversion Protocol:

Patient Care Diagnostics: (Lab, Radiology, Nuclear Med., Resp. Therapy etc.)

When the overhead Capacity Code is called the Managers of each department will return immediately to their unit and:

1. Determine if there are any pending results that are delaying patient disposition (discharge from acute or admission to ED).
2. Expedite any pending test or reports (i.e. reading results).
3. Report to the emergency patient staffing meeting (Bed Board, CCO Conference room, central census office in the operations center).
4. After nurse managers identify needs, return to work area to assist staff to produce results need for patient disposition.
5. Steps 1-4 will be repeated every 45 minutes (or as instructed by house manager) until the Capacity Call is cancelled.
6. Supervisors can substitute for the manager if the manager is off campus.

Diversion Protocol:

Housekeeping - Transportation

When to overhead Capacity Code is called Manager will:

1. Contact staff to determine or review bed tracker (when installed) to determine bed and patient flow.
2. Identify any need for stat cleaning and or transport move resources to meet the needs.

3. Report to the Emergency patient staff meeting (Bed board in CCO in the central census office located in the operations center).
4. Repeat 1-3 every 45 minutes (or as instructed by House Manager) until the Capacity Code is cancelled.
5. Supervisors can substitute for the manager if the manager is off campus.

House Manager and ED Manager

1. When the ED is nearing Capacity status, the ED supervisor will contact the House Manager and the ED Manager (ED Supervisor, off shift and weekends)
2. Together, the ED and House Manager will determine the need for a Capacity Code. Note: A Capacity Code can be called for ED crowding, lack of inpatient beds for post-op bedding or transfers, long waits in waiting room or any other situation impacting ability to bed patients.
3. If a code is required, the House Manager will notify the hospital operator who will announce overhead:

“The Hospital has reached 100% Capacity status please follow Diversion protocol”
The first meeting will be _____ (operator will announce time) based on House Manager instruction).
4. The House Manager will page the Administrator on call to notify of the code.
5. The House Manager and ED Manager will chair an emergency bed board meeting 45 minutes after calling the code or at another time determined by the House Manager.
6. Every patient care unit must respond to the Capacity code and attend the meeting prepared with at least 2 potential discharges.
7. All support and diagnostic areas must also attend the emergency meeting to assist with discharge delays.
8. The goal of the meeting will be to decompress the ED, provide beds for surgery patients, and enable the hospital to accept transfers.
9. The House Manager and ED Manager will co-chair an emergency patient staffing meeting (bed board) every 45 minutes (or at an interval determined by the House Manager) until the Capacity code is cancelled.

Hospital Operators

When the hospital has reached Capacity status the hospital operator will:

1. Receive a call from the House Manager to call a Capacity Code.
2. The operator will announce:

“The Hospital has reached 100% Capacity please follow diversion protocol”. This will be done without bells and will be repeated 3 times.

In addition to an overhead announced the operator will send a text page to all who carry a code 5000 pager.
3. When the Capacity situation is resolved the operator will receive a call from House Manager and will announce:

“Capacity Status all Clear”

This message will be without bells and repeated 3 times.

Patient Care Directors

When a Capacity Code is called, the patient care directors will:

1. Respond to the emergency patient staffing meeting at the time determined by the House Manager.
2. After the first meeting, round on any unit with delayed discharges.
3. Attend all subsequent at the time specified by the House Manager meetings every 45 minutes until the Capacity is resolved.
4. Off-hours, the process will be handled by the House Manager.
5. As administrator on call, the nursing director will called off-hours and will determine the need to return to the hospital.
6. As administrator on call, the nursing director will work closely with the House Manager and ED Manager to resolve the Capacity Status.

Emergency Department

When patient care becomes compromised due to over crowding, the ED supervisor will:

1. Contact the House Manager and ED Manager (Monday – Friday days).
2. Provide information about bed needs, number of patients in waiting room, wait times and other pertinent information.
3. Supply the House Manager and ED Manager with a list of patients waiting for admission or diagnostic test, patient acuity and/or type of beds needed.

After a Capacity Code is called the ED Supervisor will:

1. Round all patients, determine status.
2. Report any reason for delay to House Manager, ED Manager.
3. Attend the patient staffing meeting as called by the House Manager when the ED Manager is unavailable (Bed Board – central staff office in operation center).

Operating Rooms

When a Capacity code is called the OR Manager will:

1. Assess all cases that have not yet started and have that information for the House Manager.
2. Assess all patients on the schedule for post-op bedding needs (ICU, ICA, floors if inpatient return to bed or not).
3. Round in the PACU to determine situation, number of patients with assigned beds and number of patients PACU could continue to hold.
4. Attend the emergency patient staffing meeting, at the time determined by House Manager and subsequent meetings until dismissed by House Manager.

Medical Officer of the Day

When the overhead Capacity Code is called the Medical officer of the day will:

1. Respond to the emergency patient staffing meeting (bed board, central census office, operations center) at time determined by the House Manager.
2. Assist any patient care units who have patients identified for discharge but for whom physicians' orders are not forthcoming.
3. Round on all patient care units that cannot identify patients for discharge.
4. Notify all residents (peds, trauma, neuro, internal medicine and family practice) and all employed Nurse Practitioners to conduct emergency rounds.
5. Contact: Attending MD's, Program Directors and Residents to expedite discharges, focusing on units with multiple possible discharges and/or units with no discharges.
6. Check in frequently with the House Manager.

Attendings, Residents, Employed Nurse Practitioners

When the overhead Capacity Code is called all available Attendings, Residents and Employed Nurse Practitioners will:

1. Round on all inpatients.
2. Determine which patients can be discharged within the hour and those who could be discharged later in the day.
3. Report all discharges and planned discharges to the unit manager/supervisor within 45 minutes, along with all pending test results or activities that must be completed prior to discharge.
4. Write discharge orders.
5. Respond to pages as needed to assist in resolution of the Capacity code.

Capacity Protocol:

Implementation Plan

Hospital Staff:

- Review with teams
- Present at manager director meeting

Physicians

- Letter from VP Medical affairs
- Blast FAX
- Newsletter
- Poster
- Resident training sessions



St. Joseph's Hospital and Medical Center

CODE DIVERSION CRITIQUE

Date: _____ Time Called: _____ 1st Meeting: _____

Subsequent Meeting Times: _____

Midnight Census: _____ 0600 Census: _____

Is the ED currently on diversion? Y N Closure Time: _____

Is Trauma currently on diversion? Y N Closure Time: _____

ED Status		OR Status		House Status
Pre	Post	Pre	Post	Pre
# of patients in the waiting room: _____	# of patients in the waiting room: _____	# of cases scheduled: CV _____	# of cases scheduled: CV _____	# on Waiting list Floor _____
Longest wait time: _____	Longest wait time: _____	BNI _____	BNI _____	Tele _____
# of holds: _____	# of holds: _____	General _____	General _____	ICU _____
Floor _____	Floor _____	Specials _____	Specials _____	ICA _____
Tele _____	Tele _____	Cath Lab _____	Cath Lab _____	Peds _____
ICU _____	ICU _____	PACU Holds _____	PACU Holds _____	ICU bed availability (pre) _____
ICA _____	ICA _____			ICU bed availability (post) _____
Peds _____	Peds _____			
Key findings:			Staffing Issues:	



St. Joseph's Hospital and Medical Center

EVALUATION CODE DIVERSION

	Not at All	Somewhat	Most of the Time	Nearly Always	# of Surveys
Question 1-When a Code Diversion (C-D) is called, everyone knows what to do.		2	5	6	13
Question 2-Is clear about what needs to be done to reduce crowding that causes the (C-D) to be called.			9	4	13
Question 3-Everyone works hard to reduce length of time a C-D is in place.		4	4	5	13
Question 4-Physicians with whom we work understand their responsibilities during a C-D.	2	5	5		12*
Question 5-Circumstances that create need for a C-D are understood by everyone who works in the unit/dept.		4	8	1	13
Question 6-Even when a C-D is not in place, those in unit/dept. provide needed care in a timely & efficient way.			9	4	13
Question 7-Physicians we work with make every effort to discharge patients who are ready to go when a C-D is called.	2	9	1		12*
Question 8-People in unit/dept. are aware of circumstances in ED that may lead to calling a C-D	4	2	5	2	13
Question 9-The C-D process increases our ability to obtain timely results from diagnostic tests.		4	3	5	12*
Question 10- People in unit/dept. know what they can do to reduce amt. Of time patients wait for inpatient bed assignment.		3	7	2	12*
Question 11-At C-D mtgs. most unit reps what is needed to discharge patients in a more timely manner.			9	4	13
Question 12-Time & effort spent in responding to a C-D is in proportion to the value of being able to care for more patients.	1	9	2	1	13
Question 13-At C-D mtgs. everyone who needs to be present is there.		2	9	2	13
Question 14-On days when C-D is called, we are able to move pts. through system (discharge & admission) more quickly	1	10	1		12*
Question 15-Because C-Ds are called so frequently, we've become used to them & don't make much effort to do things differently during those times.	3	7	3		13
TOTAL	13	61	80	36	190

* 1 Survey answered N/A

Comments regarding statement "One thing I'd like to see done differently regarding Code Diversion is":

1. House manager knows who is holding in the ED- frequent meeting (q1h or q2h) should be reserved for those units that are specific to "holding patients."
2. To have the code diversion more specific to the areas being impacted
3. I'd like all ED-patients called to the floor even if there's no beds. We have no way of knowing how many are waiting. I don't like batch calls in the morning- with 6-8 patients holding. We don't even know when we start the am shift.
4. Calling those who are the main "players."
5. Make unit/specialty specific (Peds, ICU, Med/Surg)
6. If at all the first meeting Couplet Care isn't needed, they should be dismissed for the following meetings. It is not a good use of their time if they're not needed.

Comments regarding statement "The thing that I think we do well regarding Code Diversion is":

1. Identify appropriate transfers.
2. Reduce status on our patients, report off patient who have potential.
3. Communicating needs.
4. Work together as a team.
5. Getting results for lab, radiology in a timely manner.
6. The ancillary services and OR's are involved from their end of things.