

Guidelines for the Allocation of Scarce Resources

The information contained in this document is not intended as legal advice, but is information only to assist the hospital in developing a policy based on the uniqueness of each facility. The names of functions such as “Security”, titles such as “RN”, departments such as “Nursing Department” in this document are meant only to be examples. The hospital should insert the positions, functions, departments that are appropriate for the hospital. In addition this policy is not meant to be prescriptive except for those sections referring to Wisconsin statutes.

Part A: Basic Principles: This document is intended to provide guidelines for healthcare providers to continue to provide treatment in an ethical manner to patients in a mass casualty incident, when there may be a significant imbalance between the needs of the patients and the resources available to the healthcare provider. Although the healthcare system is “stressed” on a day-to-day basis, for the most part, there is somewhat of a balance between healthcare “needs” and “resources.”

Document Purpose

This document is intended to assist hospitals to

- maximize positive patient outcomes when health care needs exceed available resources
- establish guidelines to assist health care providers to provide care in an ethical manner during circumstances which make delivery of healthcare services in the normal course difficult
- establish these guidelines prior to any disaster so that health care providers can come to consensus about these guidelines both personally and as a members of a healthcare facility

These guidelines assume the commitment of all healthcare workers and organizations to these overarching responsibilities:

- The responsibility of every professional to maintain a state of professional readiness for emergency response¹.
- The responsibility of every organization or institution² to plan for and exercise their emergency response.³

¹ “Ethical Responsibilities of Health Care Professionals”, Wisconsin State Expert Panel on the Ethics of Disaster Preparedness, available at www.pandemic.wisconsin.gov under “Health Care”.

² “Ethical Responsibilities of Health Care Leadership”, Wisconsin State Expert Panel on the Ethics of Disaster Preparedness, available at www.pandemic.wisconsin.gov under “Health Care”.

³ “Adapting Standards of Care Under Extreme Conditions: Guidance for Professionals during Disasters, Pandemics and Other Extreme Emergencies”, American Nurses Association, March 2008, page 5.

Implementation of These Guidelines

A disaster is defined as an incident that overwhelms the resources of any institution. Thus, it is possible that, in a given incident with limited resources, healthcare providers may need to implement these or portions of these guidelines as deemed necessary. However, it is anticipated that these guidelines will be implemented on a wider geographical scale when there is a declaration of a public health emergency locally, state-wide or nationally⁴.

It is also anticipated that, based on historical precedent, the federal government and, in particular, the Secretary of Health and Human Services will issue certain waivers to assist healthcare providers in the management of a surge of patients under federally reimbursed programs. The Wisconsin Legislature is also considering legislation that would allow the Secretary of Health Services to waive state rules and regulations to assist healthcare providers in the management of a surge of patients.

The assumptions for the implementation of the following guidelines are:

1. The hospital is operating under the Incident Command System.
2. The hospital has implemented its Inpatient and Outpatient Surge Capacity Plan, which not only describes how the hospital will increase the number of inpatient beds, but also describes how the hospital will establish a Triage Center and alternative treatment sites for GREEN (ambulatory) patients, to the extent possible.

Establishing the Triage and Treatment Process

1. The Hospital Incident Commander may order the lockdown of the facility, including the Emergency Department.
2. The Hospital Incident Commander may order the establishment of a Triage Center, which is geographically separate from the Emergency Department, if at all possible.
3. The Hospital Incident Commander may designate staff to serve as the Triage Team.
 - a. If at all possible, these persons should be selected prior to any disaster and have the training necessary to complete this function.
 - i. The hospital should decide prior to an incident which functions⁵ and/or persons will staff these positions. It may be beneficial to utilize staff

⁴ Further research needs to be done to define the “trigger that indicates that the hospital may need to consider the allocation of scarce resources. This is both a national and state task. The Institute of Medicine (IOM) has convened such a national task force to make recommendations about such “triggers”.

⁵ It is recommended that, to the extent possible, that functions be identified, since persons are apt to change and the plan may need to be up-dated with personnel changes.

NOT from the Emergency Department so that Emergency Department staff can continue to be utilized for the treatment of patients in the Emergency Department.

- ii. The hospital should consider Mid-Level Providers and Registered Nurses for this triage function, if sufficient physicians are not be available.
 - iii. The hospital should ensure that the Medical Staff By-Laws include provisions for medical screening by Mid-Level Providers and Registered Nurses, if the hospital selects to use this option.
- b. Each person in the Triage Center should have a Job Action Sheet that outlines their responsibilities.
 - c. These persons should be familiar with *Disaster Triage and Initial Treatment*⁶ to document patient care in the Triage Center.
 - d. These persons should be proficient in standard triage protocols.

NOTE: The hospital must be aware of the fact that these Triage Officers will be under stress, especially in smaller hospitals and communities, where staff may need to make decisions about patients that may be well-known to them.

- e. These persons should know the procedures for use of the Patient Tracking wristbands.
- f. Disposition of Patients
 - i. RED, YELLOW and BLACK (expectant – GRAY⁷ patients under SALT) are to be admitted to the hospital or transferred to the appropriate facility.
 - ii. GREEN patients are to be directed to the alternative treatment sites for care and prescriptions, if needed.
 - iii. Each hospital should have a standardized Discharge Instruction Sheet⁸ for distribution to all GREEN patients.

⁶ The State Expert Panel on Documentation in a Disaster has provided recommendations to record interdisciplinary patient care, treatment and services by those involved in direct patient care during an incident where there is a surge of patients.

⁷ On the SALT Flowchart, these are patients that have a “No” answer to the question “likely to survive given current resources?”

⁸ This is one of the recommended documents from the State Expert Panel on Documentation in a Disaster.

Criteria for Triage Guidelines

Guidelines for the allocation (triage) of scarce resources should meet the following criteria:

1. they be applied consistently across the state
2. they be founded on evidence-based practices to the extent that these practices are available
3. they reflect the current best practices for the triage of critical care patients
4. they are tiered so that, as the number of patients increases and resources are further depleted, these criteria can become more stringent
5. they allocate resources to save as many lives as possible
6. they have the consensus of health care providers, especially those involved in the response to the disaster, through open review and discussion and an opportunity for comment
7. they have the consensus of the general public through open review and discussion and an opportunity for comment

Clinical Review Committee

The hospital should establish, prior to any incident, a multi-disciplinary committee⁹ to review guidelines for the allocation of resources so that the Committee can learn how to make such decisions without the stress and urgency that will occur in a disaster. This committee should meet regularly to discuss triage protocols so that it is prepared to implement these guidelines when necessary. This could be an existing committee that takes on this responsibility.

This will necessarily involve the education of physicians and health care professionals in the application of these protocols through educational programs and especially table-top exercises and other such simulations.

The Clinical Review Committee should also discuss the role of the Ethics Committee or the Ethics Consultation process during the time that these guidelines are in place. Although patients and family members have the right to question the decisions of their providers, there will be limited resources available to the hospital to respond to each request of a patient or family member when they are faced with the consequences of the decisions being made to allocate scarce resources. This committee should also be a resource for staff, who may have questions and concerns about the decisions being made.

⁹ “Guidelines for Triage of Patients”, Wisconsin State Expert Panel on the Ethics of Disaster Preparedness, available at www.pandemic.wisconsin.gov under “Health Care”.

Part B: Guidelines for the Triage of Patients

Triage Guidelines: These clinical triage guidelines are based on a tiered time-table, given that the volume of patients affected by a mass casualty incident, especially in a sustained incident such as pandemic. Thus, these clinical triage guidelines may become more stringent as the incident affects more and more patients.

- a. Hospitals: *Clinical Management Guidelines for Hospital Healthcare Providers When Routine Critical Care Resources Are Not Available*
- b. Nursing Homes and Assisted Living Facilities: It is a critical part of the planning process for hospitals to have discussions with nursing homes and assisted living facilities and their Medical Directors in the hospital service area about these Triage Guidelines and how hospitals are planning on managing a surge of patients.
 - i. The hospital should work with the Medical Director of the Nursing Home and Assisted Living Facility so that treatment plans can be developed so that the resident, to the extent possible, can be treated in the nursing home or assisted living facility versus being transferred to the hospital.
 1. This will also necessarily involve education of family members of residents of nursing homes and assisted living facilities about the protocols that may be implemented by hospitals and EMS.
 2. Because of their rights, residents also need to be informed of these protocols and how these protocols may affect the resident.
 - ii. Nursing Homes and Assisted Living Facilities are encouraged to have their residents execute Advance Directives so that the wishes of the patient can be honored.

Part C: Physicians and Inpatient Care

Physicians need to be informed of the guidelines for the allocation of scarce resources, be involved in the development and discussion of these guidelines and come to consensus that it may be necessary to implement such guidelines in a disaster.

Because it will be difficult to achieve consensus among all physicians and because physicians serve as advocates for their patients, it is recommended that there be an inpatient Triage Officer such as a Critical Care Specialist, who will make these triage decisions, supported by Medical Staff By-Laws, versus the attending physician. Another option may be to use the Hospitalist(s) as the inpatient Triage Officer. If the hospital has specialized units such as Oncology, it may be advisable that the Triage Officer to be a specialist in this service. Centralizing this decision-making will allow the inpatient Triage Officer to have a “big picture” perspective, make decisions based on preceding decisions and thus become more scientific and objective in the decisions made.

Based on the number of beds and various specialty services, the facility may choose to have a number of Triage Officers to handle the volume of decisions necessary on a daily basis. There should then be a process in place for these various Triage Officers to meet periodically to ensure that there is consistency in the decisions that are being made.

This process also holds true for the discharge of patients. The responsibility for discharge or transfer to other hospitals or other facilities should be that of the Inpatient Triage Officer or the Hospitalist, who is serving as the Triage Officer.

What is occurring at one hospital may force decisions at another hospital. Hospitals that serve as referrals centers must take into consideration that referring hospitals may need to transfer patients that they cannot appropriately care for at their facility. This may cause the referral hospital to further triage its existing patients to determine if lesser acuity patients can be discharged to admit higher acuity patients.

Examples of other recommendations for physicians, involved in inpatient care include:

1. Discharge Orders should be written at the first opportunity and should be based on established criteria.
2. Orders should be standardized
3. RNs should be permitted to initiate patient transfers to a lower level of care, following pre-identified criteria.

Part D: Conservation and Rationing of Scarce Resources

Conservation means the planned limiting of human and material resources so as to extend the supply of these resources without jeopardizing patient and staff safety.

Rationing means the planned limiting of human and material resources when the supply is becoming depleted so as to provide treatment to those who will achieve the greatest benefit, based on their clinical presentation.

The following are examples of conservation tactics:

1. Single use items may be reused for the same patient with appropriate cleaning
2. IVs can be administered through gravity
3. IV tubing does not need to be changed for the same patient

It is a basic principle of disaster preparedness that **Conservation begins immediately at the beginning of an incident**. As soon as the hospital recognizes that it may be faced with a sustained disaster that may deplete both human and material resources, the hospital should implement its conservation strategies.

Each department and service within the hospital should establish guidelines for the conservation of resources that should be implemented at the beginning of the incident. Each department and service within the hospital also needs to have a program for educating its staff along with testing these guidelines through periodic exercises.

An example of departmental guidelines for conservation of resources is the document, *Oxygen Conservation Strategies*.

There are three basic principles that govern the conservation and rationing of resources:

1. Triage decisions should be centralized using the Hospitalist or the Inpatient Triage Officer

The rationale for this has been explained in Part C. The hospital may also want to consider using the Clinical Review Committee or its equivalent to assist the Hospitalist or the Inpatient Triage Officer with these decisions. The Hospitalist and Triage Officer must have access not only to the information that can be brought to the table by the different disciplines but also benefit from the clinical expertise and experience of the committee members during the incident.

2. Inpatient Triage should occur on a daily basis and more often, if necessary, so as to allocate available resources

It is likely that guidelines for the allocation of scarce resources will, over time, be developed with more specificity. However, most decisions will be patient-specific, taking into consideration the number of patients that are being treated at the hospital, the acuity of these patients and the human and material resources that are available at this moment to treat these patients. For this reason, the hospital should establish a process to allow for decision-making to take place daily and more often, if necessary.

The hospital may choose to allow the Hospitalist or the Inpatient Triage Officer to make these decisions personally and/or to review these decisions through a Committee format. As stated previously, the hospital may need to have multiple Triage Officers if the hospital is large and/or has multiple specialty services.

3. Supplies should be managed centrally to ensure appropriate availability.

This is recommended because the only way for the hospital and its staff to get an accurate count of and control over what supplies and equipment are available is to have critical¹⁰ supplies and equipment returned to a centralized location. This then allows the Hospitalist or Triage Officer to make better decisions regarding the allocation of these scarce resources. The Materials Management Department then can better manage and try to acquire needed supplies and equipment. The hospital should review its security policy

¹⁰ It is very likely that what supplies and equipment are critical will be defined by the incident, e.g. N95 respirators in the spring 2009 outbreak of H1N1 influenza.

to make sure there is sufficient security for supplies and equipment that are held centrally.

Part E: Consequences of Allocation of Scarce Resources

1. **Patients:** It may be necessary to segregate patients who did not meet the triage criteria to receive certain treatments. These patients should be instructed that they may not be able to receive curative treatments. These patients may need palliative care. (See *Template Policy on Guidelines for Palliative Care in a Disaster*).
2. **Staff:** It is recommended that direct care staff be relieved of the responsibility of telling patients that they do not meet the triage criteria for receiving certain curative treatments. Since this may be a frequent occurrence during an incident, the hospital may want to consider using trained staff for this purpose so that staff caring for the patient are not the one explaining these decisions to the patients¹¹. If at all possible, a team approach should be used and these discussions with patients should be scripted, if at all possible.
3. Administration¹² and supervisors are advised to implement the recommendation in the *“Caring for a Seriously Ill Person at Home: Guidelines for the Caregiver”* so as to monitor the physical and especially the emotional well-being of staff who are serving as Triage Officers along with those involved in allocation of scarce resource decisions and all staff involved in managing the incident.
 - a. There should be special attention to the fact that Triage Officers and other staff may be involved in making decision for patients who are well-known to them, which increases the emotional burden for these staff persons.

¹¹ The Expert Panel recognizes that hospitals have not had sufficient experience with decision-making for the allocation of scarce resources.

¹² The reader is referred to “Ethical Responsibilities of Health Care Leadership”¹² for other issues that administration should consider to support staff during a disaster.