

### Temporary Permission for Program Flexibility and for Emergencies

When the MHCC is activated, Providers and DO's will submit requests to [CHCQDutyOfficer@cdph.ca.gov](mailto:CHCQDutyOfficer@cdph.ca.gov).

This form is to be used **ONLY** for program flexibility requests when providers temporarily need to comply with licensing requirements by using alternative concepts, methods, procedures, techniques, equipment, or personnel.

Providers are required to submit a program flexibility request to the California Department of Public Health (CDPH), Center for Health Care Quality (CHCQ) for approval. This form is a mechanism to expedite the request directly to the Medical Health Coordination Center (MHCC) for approval in emergency situations.

<https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx>

Facility Name Placentia-Linda Hospital			Date of Request 07/06/2020	
License Number 050589			Facility Phone 714-993-2000	Facility Fax Number 714-961-8427
Facility Address 1301 N. Rose Drive			E-mail Address [REDACTED]	
City Placentia	State CA	Zip Code 92870	Contact Person Name [REDACTED]	

#### Approval Request

Complete one form total per facility

#### Duration of Request

- Staffing
- Tent use (High patient volume)
- Space conversion (other than tent use)
- Other
- Bed use
- Over bedding

Start Date: 07/07/2020  
End Date: 09/30/2020

#### Program Flex Request

What regulation are you requesting program flexibility for? Title 22 Section 70217

#### Justification for the Request

- A disease outbreak (verifiable through sources such as the local emergency medical service agency (LEMSA), local Public Health Officer, CDPH Division of Communicable Disease Control, the Centers for Disease Control and Prevention) is present in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: Increased cases of seasonal influenza, onset of a severe acute respiratory syndrome-type or other highly contagious virus requiring acute care, an epidemic/pandemic, a bioterrorism agent, or a declared public health emergency.
- An emergency resulting in the need for increased patient accommodations has occurred in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: A natural or human-caused disaster, a crime incident or transportation accident resulting in numerous mass casualties, an emergency causing the evacuation of patients or diversions from another hospital (LEMSA diversion has been implemented).

Facility Name	License Number	Request Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Justification for the Request**

Other:

Staffing ratio flex related to an influx of COVID-19 patients.

**Exhausting Available Alternatives**

The provider must exhaust available alternatives before requesting increased patient accommodations.

Check all that apply:

- Rescheduling non-emergent surgeries and diagnostic procedures.
- Transferring patients to other beds or discharge as appropriate.
- Setting clinics for non-emergency cases (if possible).
- Requesting ambulance diversion from LEMSA, if appropriate.
- Other:

**Adequate Staff, Equipment and Space**

The provider must make arrangements for adequate staffing, equipment and space for increased patient accommodations. Check all that apply:

- A plan is in place for staff if the request is for use of alternate space.
- A plan is in place for equipment if the request is for use of alternate space.
- The proposed space for care of patients provides sufficient square footage to ensure access for safe care.
- Other:

**Additional Information**

Provide a brief description of your conditions and explain the need for program flexibility. Provide a brief description of the alternative concepts, methods, procedures, techniques, equipment or personnel to be used, and the conditions under which this program flexibility will be used. Attach additional supporting documentation as needed.

The facility is requesting a waiver of minimum nurse-to-patient ratios related to an influx of COVID-19 patients and other impacts of COVID-19. We are requesting the flex for all adult inpatient units. This includes ICU, Telemetry, and Medical/Surgical units. The patients that are out of ratio will be based on acuity with the lowest acuity patients being placed out of ratio.

All efforts will be made to maintain nurse:patient ratio. This includes mass communication to all nurses listing needed shifts and units, use of floating and PRN staff, and the use of short term registry staff. In addition, we are attempting to gain travelers to alleviate the shortage. All available resources will be exhausted and documented prior to going out of nurse:patient ratio.

ICU ratio will go up to 1:4 after all efforts are exhausted to find adequate staffing. The patients placed out of ratio will be the lowest acuity patients.  
 DOU ratio will go to 1:6 after all efforts are exhausted to find adequate staffing. The patients placed out of ratio will be the lowest acuity patients.  
 Medical/Surgical ratio will go to 1:7 after all efforts are exhausted to find adequate staffing. The patients placed out of ratio will be the lowest acuity patients.

Additional Supporting Information:

- Over the past 14 days we gone from 6 patients that are pending COVID results or are positive to 18 as of 7/6/2020 with a steady daily increase during this 2 week period.
- 13 self-quarantined employees
- 18 employees on Leave of Absence (LOA), 10 of those are RN's
- Averaging 3-5 nursing sick calls per shift

Below is our current schedule for on-boarding additional nursing staff:  
 April: 4 (MS, ICU, PACU, ED)  
 May: 1 DOU  
 June: 1 ED  
 July: 6 DOU, 1 MS

\_\_\_\_\_  
 Signature of person requesting program flexibility  
 \_\_\_\_\_  
 Printed name

Director of Quality and Patient Safety  
 \_\_\_\_\_  
 Title

**Note:** Approval for tent use, space conversion, bed use and over-bedding will be time limited and dependent on the facts presented that substantiate the emergency. Initial approval may be given verbally by the local DO; however, a signed written approval must be distributed (faxed) to the facility and filed in the facility's folder.

For CDPH Use Only:

**Center for Health Care Quality Approval:**

Permission Granted from: 7/1/20 to 9/30/20

Permission Denied: Briefly describe why request was denied in comments / conditions below:

                     / conditions:                     

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CHCQ Printed Name: \_\_\_\_\_

CHCQ Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
 L&C District Office Staff Signature

District Manager  
 \_\_\_\_\_  
 Title

7/22/20  
 \_\_\_\_\_  
 Date